Select Committee on Affordable Healthcare Access

Wednesday, January 20, 2016
2:30 PM – 4:30 PM
Sumner Hall (404 HOB)

Steve Crisafulli
Speaker

Jose Oliva
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Select Committee on Affordable Healthcare Access

Start Date and Time:	Wednesday, January 20, 2016 02:30 pm
End Date and Time:	Wednesday, January 20, 2016 04:30 pm
Location:	Sumner Hall (404 HOB)
Duration:	2.00 hrs

Consideration of the following bill(s):

HB 1175 Transparency in Health Care by Sprowls

Consideration of the following proposed committee bill(s):

PCB SCAHA 16-01 -- Telehealth

Pursuant to rule 7.12, the deadline for amendments to bills on the agenda by non-appointed members is 6:00 p.m., Tuesday, January 19, 2016.

By request of the chair, all committee members are asked to have amendments to bills on the agenda submitted to staff by 6:00 p.m., Tuesday, January 19, 2016.

NOTICE FINALIZED on 01/15/2016 3:49PM by Iseminger.Bobbye

HB 1175

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1175 Transparency in Health Care
SPONSOR(S): Sprowls
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Select Committee on Affordable Healthcare Access		Poche	Calamas
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

The United States is experiencing significant changes in health care payment and delivery. Record numbers of newly-insured persons are enrolled in both public and private health insurance. Americans bear a greater share of health care costs, and more participate in high deductible health plans. Clear, accurate information about the cost and quality of health care is necessary for consumers to select value-based health care. HB 1175 ensures greater consumer access to health care price and quality information by requiring certain heath care providers, insurers and health maintenance organizations (HMOs) to give that information to patients.

The bill requires the Agency for Health Care Administration (AHCA) to contract with a vendor to for an all-payer claims database (APCD), which provides an online, searchable method for patients to compare provider price and quality, and a Florida-specific data set for price and quality research purposes. The bill requires insurers and HMOs to submit data to the APCD, under certain conditions.

The bill creates pre-treatment transparency obligations on hospitals, ambulatory surgery centers, health care practitioners providing non-emergency services in these facilities, and insurers and HMOs.

Specifically, the bill imposes certain pre-treatment transparency requirements. Facilities must post online the average payments and payment ranges received for bundles of health care services defined by the Agency for Health Care Administration (AHCA). This information must be searchable by consumers. Facilities must provide, within 3 days of a request, a good faith, personalized estimate of charges, including facility fees, using bundles of health care services defined by AHCA or patient-specific information. Failure to provide the estimate results in a daily licensure fine of $1,000. Facilities must inform patients of health care practitioners providing their nonemergency care in in hospitals must provide the same type of estimate, subject to a daily fine of $500, up to $5,000. Facilities and facility practitioners must publish information on their financial assistance policies and procedures. Insurers and HMOs must create online methods for patients to estimate their out-of-pocket costs, both using the service bundles established by AHCA and based on patient-specific estimates using the personalized estimate the patient obtains from facilities and practitioners.

Similarly, the bill imposes certain post-treatment transparency requirements. Facilities must provide an itemized bill within 7 days of discharge, meeting certain requirements for comprehension by a layperson, and identifying any providers who may bill separately for the care received in the facility.

The bill requires AHCA to develop standardized culture surveys for hospitals and ambulatory surgery centers, which must conduct the surveys annually and report the results to AHCA for publication.

Finally, the bill makes several changes to the Florida Center for Health Information and Policy Analysis, which is the health care data collection unit of AHCA. The bill changes the Center's name, and streamlines the Center's functions by eliminating obsolete language, redundant duties, and unnecessary functions.

The bill has an indeterminate, but likely significant, negative fiscal impact on AHCA to contract with the APCD vendor. The bill has a significant, negative fiscal impact on AHCA to design and process the facility patient safety culture surveys.

The bill provides an effective date of July 1, 2016.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

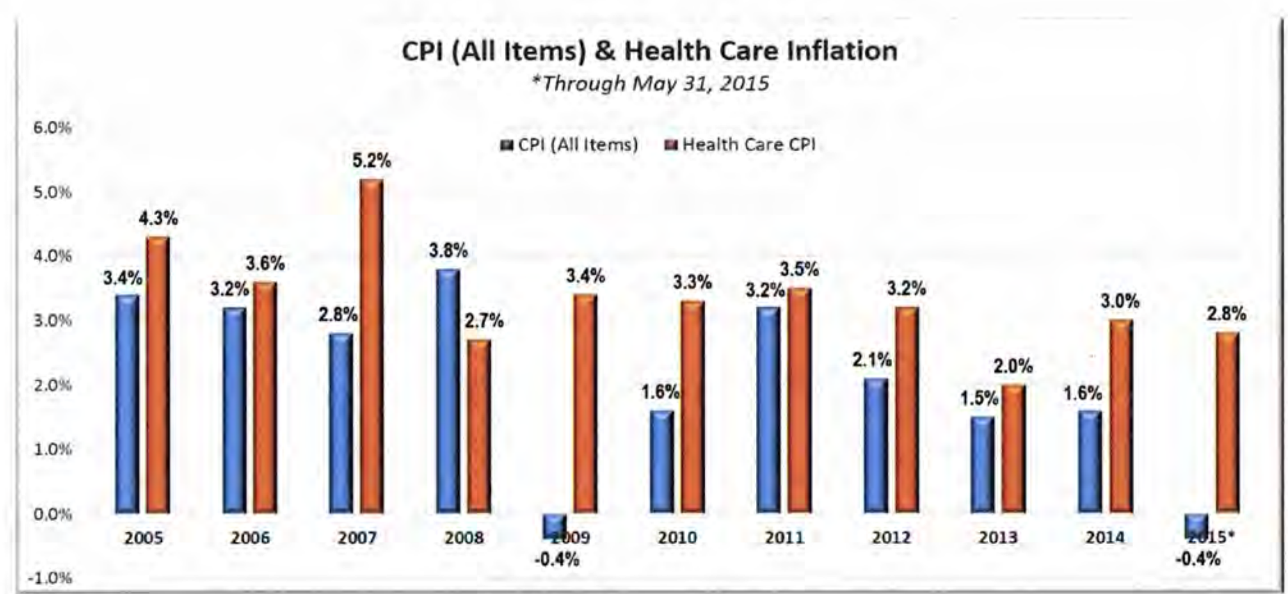
Health Care Price Transparency

The United States is experiencing significant changes in health care payment and delivery. Record numbers of newly-insured persons are enrolled in both public and private health insurance. Americans bear a greater share of health care costs, and more participate in high deductible health plans. Clear, factual information about the cost and quality of health care is necessary for consumers to select value-driven health care options and for consumers and providers to be involved in and accountable for decisions about health and health care services. To promote consumer involvement, health care pricing and other data should be free, timely, reliable, and reflect individual health care needs and insurance coverage.

Price transparency in health care can have different definitions. The term can refer to the availability of provider-specific information on the price for a specific health care service or set of services to consumers and other interested parties.[1] Price can be defined as an estimate of a consumer's complete cost on a health care service or services that reflects any negotiated discounts; is inclusive of all costs to the consumer associated with a service or services, including hospital, physician, and lab fees; and identifies a consumer's out-of-pocket cost.[2] Further, price transparency can be considered "readily available information on the price of health care services that, together with other information, helps define the value of those services and enables patients and other care purchasers to identify, compare, and choose providers that offer the desired level of value."[3] Indeed, the definition or the price or cost of health care has different meanings depending on who is incurring the cost.[4]

The annual increase in health care costs has outpaced inflation in every year for the past seven years, except 2008. The following chart shows the increase in costs each year from 2007 through 2014, adjusted and compared against the consumer price index, which is the measure of inflation of the cost of goods and services.[5]

[1] Government Accounting Office, *Meaningful Price Information is Difficult for Consumers to Obtain Prior to Receiving Care*, September 2011, page 2, available at http://www.gao.gov/products/GAO-11-791.
[2] Id.
[3] Healthcare Financial Management Association, *Price Transparency in Health Care: Report from the HFMA Price Transparency Task Force*, page 2, 2014, available at http://www.hfma.org/WorkArea/DownloadAsset.aspx?id=22279.
[4] Id.
[5] Patton, M., *U.S. Health Care Costs Rise Faster Than Inflation*, June 29, 2015, available at http://www.forbes.com/sites/mikepatton/2015/06/29/u-s-health-case-costs-rise-faster-than-inflation/ (last viewed January 18, 2016).



Further, PriceWaterhouse Cooper's Health Research Institute projects health care costs to rise 6.5 percent in 2016.[6]

As health care costs continue to rise, most health insurance buyers are asking their consumers to take on a greater share of their costs, increasing both premiums and out-of-pocket expenses. According to the Kaiser Family Foundation, more than one in five Americans with private insurance is enrolled in a high deductible health plan (HDHP). Most covered workers face additional out-of-pocket costs when they use health care services, such as co-payments or coinsurance for physician visits and hospitalizations. Eighty-one percent of covered workers have a general annual deductible for single coverage that must be met before most services are paid for by the plan.[7]

Among covered workers with a general annual deductible, the average deductible amount for single coverage is $1,318.[8] The average annual deductible is similar to last year ($1,217), but has increased from $917 in 2010.[9] Deductibles differ by firm size; for workers in plans with a deductible, the average deductible for single coverage is $1,836 in small firms, compared to $1,105 for workers in large firms.[10] Sixty-three percent of covered workers in small firms are in a plan with a deductible of at least $1,000 for single coverage compared to 39% in large firms; a similar pattern exists for those in plans with a deductible of at least $2,000 (36% for small firms vs. 12% for large firms)

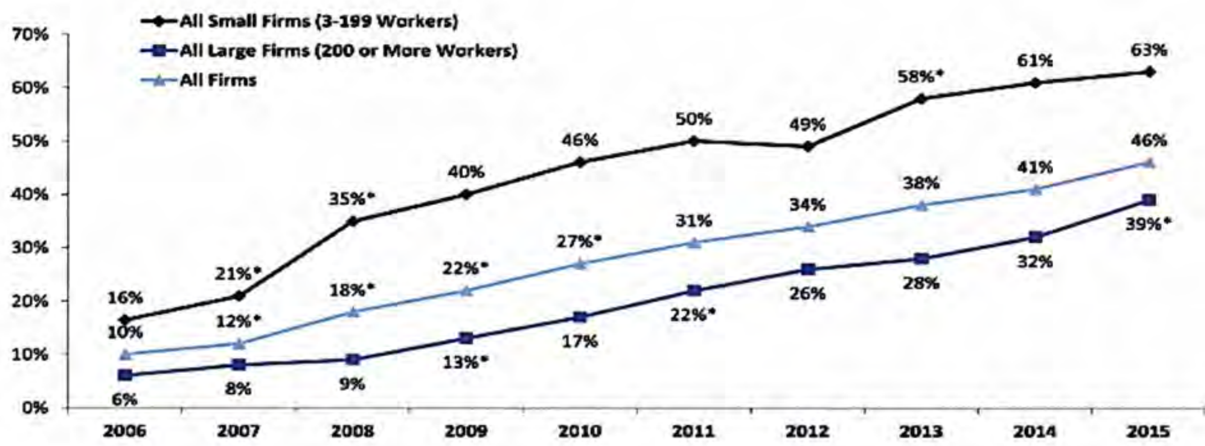
Looking at the increase in deductible amounts over time does not capture the full impact for workers because the share of covered workers in plans with a general annual deductible also has increased significantly, from 55% in 2006 to 70% in 2010 to 81% in 2015. If we look at the change in deductible amounts for all covered workers (assigning a zero value to workers in plans with no deductible), we can look at the impact of both trends together. Using this approach, the average deductible for all covered workers in 2015 is $1,077, up 67% from $646 in 2010 and 255% from $303 in 2006.

From 2010 to 2015, the average premium increase for covered workers with family coverage increased 27%, while wages have only increased 10%.[11] Furthermore, 63 percent of covered workers employed by a firm of 3 to 199 employees are in a plan with a deductible of $1,000 or more, while 39 percent of

[6] PwC, Health Research Institute, *Behind the Numbers, 2016*, available at http://www.pwc.com/us/en/health-industries/behind-the-numbers.html (last viewed January 18, 2016).
[7] The Henry J. Kaiser Family Foundation, *2015 Employer Health Benefits Survey*, September 22, 2015, page 4, available at http://files.kff.org/attachment/report-2015-employer-health-benefits-survey.
[8] Id.
[9] Id.
[10] Id.
[11] Id.

covered workers employed by a firm with 200 or more employee are in such a plan, more than three times the average in 2006.[12] In fact, the average annual deductible in 2015 is $1,217, up from $917 in 2010.[13] The chart below shows the percent of workers enrolled in employer-sponsored insurance with an annual deductible of $1,000 or more for single coverage by employer size for 2006 through 2015.[14]

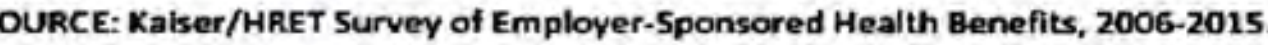
Percentage of Covered Workers Enrolled in a Plan with a General Annual Deductible of $1,000 or More for Single Coverage, By Firm Size, 2006-2015



* Estimate is statistically different from estimate for the previous year shown (p<.05).

NOTE: These estimates include workers enrolled in HDHP/SO and other plan types. Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services.

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2015.



According to the 2014 Mercer National Survey of Employer-Sponsored Health Plans, 48 percent of employers with 500 or more employees currently offer consumer-driven health plans (CDHPs), up from 39 percent in 2013, while 72 percent of jumbo employers, those with 20,000 or more employees, offer CDHPs, up from 63 percent the previous year.[15] Further, more employers plan on offering CHDPs in 2017. The chart below tracks the increase in CDHP offerings over the last five years.[16]

FIGURE 4
Sharp increase in offerings of consumer-directed health plans
Percent of employers offering/likely to offer CDHP, by employer size

Number of employees	2010	2011	2012	2013	2014	Very likely to offer in 2017
All employers (10+ employees)	17%	20%	22%	23%	27%	36%
All large employers (500+ employees)	23%	32%	36%	39%	48%	66%
Jumbo employers (20,000 + employees)	51%	48%	59%	63%	72%	88%

[12] Id.
[13] Id.
[14] Supra, FN 7, Exhibit G.
[15] Mercer, Newsroom, *Modest Health Benefit Cost Growth Continues as Consumerism Kicks Into High Gear*, November 19, 2014, available at http://www.mercer.com/newsroom/modest-health-benefit-cost-growth-continues-as-consumerism-kicks-into-high-gear.html (last viewed January 18, 2016).
[16] Id. Mercer National Survey of Employer Sponsored Health Plans.

These trends, coupled with overall increases in health care expenditures, mean consumers now spend $329.8 billion out-of-pocket annually.[17] Out-of-pocket medical spending by adults with employer-sponsored health insurance rose from $793 per capita in 2013 to $810 per capita in 2014.[18] Such spending accounted for 16.3 percent of total per capita health care expenditures in 2014.[19]

National Price Transparency Studies

There are 28 states with active health price transparency or price disclosure legislation.[20] Legislation ranges from requiring facilities and other providers to report prices to state agencies to requiring providers to notify patients and prospective patients of prices of the most common procedures.

To explore how expanding price transparency efforts could produce significant cost savings for the healthcare system, the Gary and Mary West Health Policy Center funded an analysis, "Healthcare Price Transparency: Policy Approaches and Estimated Impacts on Spending." This report, conducted in collaboration with researchers from the Center for Studying Health System Change and RAND, found that implementation of three policy changes could save $100 billion over ten years.

- Provide personalized out-of-pocket expense information to patients and families before receiving care.
- Provide prices to physicians through electronic health record systems when ordering treatments and tests.
- Expand state-based all-payer health claims databases (APCDs), which could save up to $55 billion by collecting and providing data and analytics tools that supply quality, efficiency and cost information to policy makers, employers, providers, and patients.[21]

The report specifically found that requiring all private health insurance plans to provide personalized out-of-pocket price data to enrollees would reduce total health spending by an estimated $18 billion over the next 10 years.[22]

As Americans shoulder more health care costs, research suggests that they are looking for more and better price information.[23]

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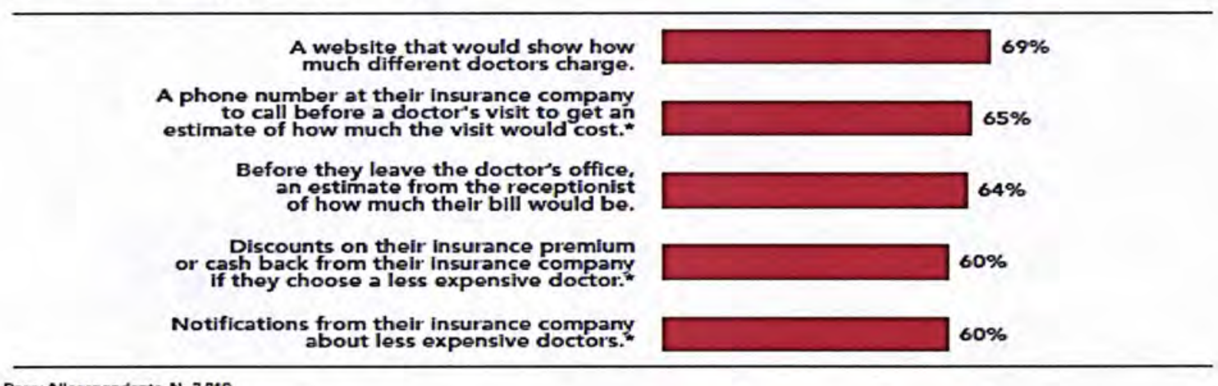
[17] U.S. Dept. of Health and Human Services, Centers for Medicaid and Medicare Services, *National Health Expenditure Data Fact Sheet-Historical National Health Expenditures, 2014*, available at https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.htm (last viewed January 18, 2016).
[18] Health Care Cost Institute, *2014 Health Care Cost and Utilization Report*, October 2015, page 5, available at http://www.healthcostinstitute.org/2014-health-care-cost-and-utilization-report (last viewed January 18, 2016).
[19] Id.
[20] Pallardy, C., *10 Things to Know About Price Transparency*, Becker's ASCReview, August 25, 2015, available at http://www.beckersasc.com/asc-coding-billing-and-collections/10-things-to-know-about-price-transparency.html (last viewed January 18, 2016).
[21] White, C., Ginsburg, P., et al., Gary and Mary West Health Policy Center, *Healthcare Price Transparency: Policy Approaches and Estimated Impacts on Spending*, May 2014, available at: http://www.westhealth.org/wp-content/uploads/2015/05/Price-Transparency-Policy-Analysis-FINAL-5-2-14.pdf.
[22] Id. at page 1.
[23] Public Agenda and Robert Wood Johnson Foundation, *How Much Will It Cost? How Americans Use Prices in Health Care*, March 2015, page 34, available at http://www.publicagenda.org/files/HowMuchWillItCost_PublicAgenda_2015.pdf.

Many Americans want help managing their health care spending.

Figure 16: Percent who say the following resources would help them a lot or some with their health care spending:



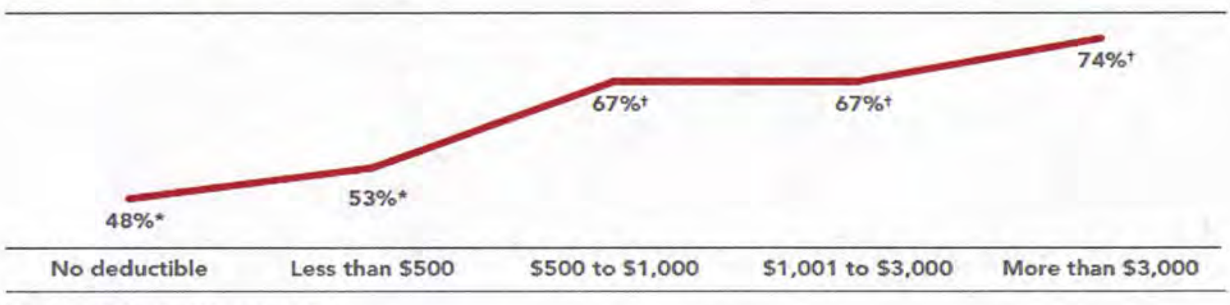
Base: All respondents, N=2,010.

* Base: Currently have health insurance, n=1,736.

One study in 2014, which conducted a nationally representative survey of more than 2,000 adults, found that 56 percent of Americans actively searched for price information before obtaining health care, including 21 percent who compared the price of health care services across multiple providers.[24] The chart below illustrates the finding that, as a consumer's health plan deductible increases, the consumer is more likely to seek out price information.[25]

People with deductibles over $500 are more likely to seek price information.

Figure 2: Percent who say they have tried to find price information before getting care, by deductible amount:



Base: Currently have health insurance, n=1,736.

Estimates for groups indicated by * are not statistically different from each other, and groups indicated by † are not statistically different from each other; groups indicated by * are statistically different from groups indicated by † at the p<.05 level.

The individuals who compared prices stated that such research impacted their health care choices and saved them money.[26] In addition, the study found that most Americans do not equate price with quality of care. Seventy one percent do not believe higher price impart a higher level care quality and 63 percent do not believe that lower price is indicative of lower level care quality.[27] Because of the high level of cost-sharing associated with CDHPs, these consumers are more price-sensitive than consumers with plans that have much lower cost-sharing obligations. In fact, these consumers find an estimate of their individual out-of-pocket costs more useful than any other kind of health care price

[24] Id. at page 3.
[25] Id. at page 13.
[26] Id. at page 4.
[27] Supra, FN 23.

transparency tool.[28] Another study found that when they have access to well-designed reports on price and quality, 80 percent of health care consumers will select the highest value health care provider.[29]

Additional research has found the use of price transparency tools to be associated with lower total claims payments for common medical services and procedures.[30] A recent study sought the measure the impact of consumer access to health care price data on the cost of three of the most common health services- laboratory tests, advanced imaging services, and clinician office visits.[31] Medical claims from 2010 to 2013 of more than 500,000 patients insured in the U.S. by 18 employers who provided a health care price transparency platform were reviewed to determine the total claims payment for the three services.[32]

Researchers accessed the price transparency platform to determine which claims were associated with a prior search of the platform. In the study sample, 6 percent of lab test claims, 7 percent of advanced imaging claims, and nearly 27 percent of clinician office visit claims were associated with a search.[33] Prior to accessing the price transparency platform, searchers had higher claim payments than non-searchers for each of the services. After using the price transparency platform, searchers paid nearly 14 percent less for lab test services, 13 percent less for advanced imaging services, and 1 percent less for doctor office visits than non-searchers.[34] The study concluded that patient access to pricing information before obtaining clinical services may result in lower overall payments made for clinical care.[35]

Florida Efforts in Health Care Price Transparency

Florida Patient's Bill of Rights and Responsibilities

In 1991, s. 381.026, F.S., enacted the Florida Patient's Bill of Rights and Responsibilities (Patient's Bill of Rights).[36] The statute established the right of patients to expect medical providers to observe standards of care in providing medical treatment and communicating with their patients.[37] The standards of care include, but are not limited to, the following aspects of medical treatment and patient communication:

- Individual dignity;
- Provision of information;
- Financial information and the disclosure of financial information;
- Access to health care;
- Experimental research; and
- Patient's knowledge of rights and responsibilities.

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[28] American Institute for Research, *Consumer Beliefs and Use of Information About Health Care Cost, Resource Use, and Value*, Robert Wood Johnson Foundation, October 2012, page 4, available at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf402126.

[29] Hibbard, JH, et al., *An Experiment Shows That a Well-Designed Report on Costs and Quality Can Help Consumers Choose High-Value Health Care*, Health Affairs 2012; 31(3): 560-568.

[30] Whaley, C., Schneider Chafen, J., et al., *Association Between Availability of Health Service Prices and Payments for These Services*, Journal of the American Medical Association. 2014;312(16): 1670-1676.

[31] Id.

[32] Id.

[33] Id.

[34] Id.

[35] Id.

[36] S. 1, Ch. 91-127, Laws of Fla. (1991); s. 381.026, F.S.; The Florida Patient's Bill of Rights and Responsibilities is intended to promote better communication and eliminate misunderstandings between the patient and health care provider or health care facility. The rights of patients include standards related to individual dignity; information about the provider, facility, diagnosis, treatments, risks, etc.; financial information and disclosure; access to health care; experimental research; and patient's knowledge of rights and responsibilities. Patient responsibilities include giving the provider accurate and complete information regarding the patient's health, comprehending the course of treatment and following the treatment plan, keeping appointments, fulfilling financial obligations, and following the facility's rules and regulations affecting patient care and conduct.

[37] S. 381.026(3), F.S.

Under s. 381.026(4)(c), F.S., a patient has the right to request certain financial information from health care providers and facilities.[38] Specifically, upon request, a health care provider or health care facility must provide a person with a reasonable estimate of the cost of medical treatment prior to the provision of treatment.[39] Estimates must be written in language "comprehensible to an ordinary layperson."[40] The reasonable estimate does not preclude the health care provider or health care facility from exceeding the estimate or making additional charges as the patient's needs or medical condition warrant.[41] A patient has the right to receive a copy of an itemized bill upon request and to receive an explanation of charges upon request.[42]

Currently, under the Patient's Bill of Rights financial information and disclosure provisions:

- A request is necessary before a health care provider or health care facility must disclose to a Medicare-eligible patient whether the provider or facility accepts Medicare payment as full payment for medical services and treatment rendered in the provider's office or health care facility.
- A request is necessary before a health care provider or health care facility is required to furnish a person an estimate of charges for medical services before providing the services. The Florida Patient's Bill of Rights and Responsibilities does not require that the components making up the estimate be itemized or that the estimate be presented in a manner that is easily understood by an ordinary layperson.
- A licensed facility must place a notice in its reception area that financial information related to that facility is available on the Agency's website.
- The facility may indicate that the pricing information is based on a compilation of charges for the average patient and that an individual patient's charges may vary.
- A patient has the right to receive an itemized bill upon request.

Health care providers and health care facilities are required to make available to patients a summary of their rights. The applicable regulatory board or Agency may impose an administrative fine when a provider or facility fails to make available to patients a summary of their rights.[43]

In 2011, the Legislature passed HB 935,[44] which amended the Patient's Bill of Rights to authorize, but not require, primary care providers[45] to publish a schedule of charges for the medical services offered to patients.[46] The schedule must include certain price information for at least the 50 services most frequently provided by the primary care provider.[47] The law also requires the posting of the schedule in a conspicuous place in the reception area of the provider's office and at least 15 square feet in size.[48] A primary care provider who publishes and maintains a schedule of charges is exempt from licensure fees for a single renewal of a professional license and from the continuing education requirements for a single 2-year period.[49]

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[38] S. 381.026(4)(c), F.S.
[39] S. 381.026(4)(c)3., F.S.
[40] Id.
[41] Id.
[42] S. 381.026(4)(c)5., F.S.
[43] S. 381.0261, F.S.
[44] Ch. 2011-122, Laws of Fla.
[45] S. 381.026(2)(d), F.S., defines primary care providers to include allopathic physicians, osteopathic physicians, and nurses who provide medical services that are commonly provided without referral from another health care provider, including family and general practice, general pediatrics, and general internal medicine.
[46] S. 381.026(4)(c)3., F.S.
[47] Id.
[48] Id.
[49] S. 381.026(4)(c)4., F.S.

The law also requires urgent care centers to publish a schedule of charges for the medical services offered to patients.[50] The schedule requirements are the same as those established for primary care providers.[51] An urgent care center that fails to publish and post the schedule of charges is subject to a fine of not more than $1,000 per day (until the schedule is published and posted).[52]

In 2012, the Legislature passed HB 787,[53] which built upon the transparency requirements established by HB 935. The law amended the definition of "urgent care center" to include any entity that holds itself out to the general public, in any manner, as a facility or clinic where immediate, but not emergent, care is provided, expressly including offsite facilities of hospitals or hospital-physician joint ventures; and licensed health care clinics that operate in three or more locations in the definitions.

The law requires a schedule of charges for medical services posted by an urgent care center to describe each medical service in language comprehensible to a layperson. This provision prevents a center from using medical or billing codes, Latin phrases, or technical medical jargon as the only description of each medical service. The law also requires the text of the schedule of medical charges to fill at least 12 square feet of the total 15 square feet area of the posted schedule, and allows use of an electronic device for the posting. The device must measure at least three square feet in size and be accessible to all consumers during business hours.

Health Care Facilities

Under s. 395.301, F.S., a health care facility[54] is required to provide, within 7 days of a written request, a good faith estimate of reasonably anticipated charges for the facility to treat the patient's condition. Upon request, the facility must also provide revisions to the estimate. The estimate may represent the average charges for that diagnosis related group or the average charges for that procedure. The facility is required to place a notice in the reception area that this information is available. A facility that fails to provide the estimate as required may be fined $500 for each instance of the facility's failure to provide the requested information.

Also pursuant to s. 395.301, F.S., a licensed facility is required to notify each patient during admission and at discharge of his or her right to receive an itemized bill upon request. If requested, within 7 days of discharge or release, the licensed facility must provide an itemized statement, in language comprehensible to an ordinary layperson, detailing the specific nature of charges or expenses incurred by the patient. This initial bill must contain a statement of specific services received and expenses incurred for the 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. The patient or patient's representative may elect to receive this level of detail in subsequent billings for services.

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[50] S. 395.107(1), F.S.
[51] S. 395.107(2), F.S.
[52] In 2012, the Legislature considered, but did not pass, HB 1329. The bill required ambulatory surgical centers and diagnostic-imaging centers to comply with the provisions of s. 395.107, F.S., established by HB 935 in 2011, and required physicians to publish, in writing, a schedule of medical charges. The bill would have imposed a fine of $1,000, per day, on an urgent care center, ambulatory surgical center, or diagnostic-imaging center that fails to post the schedule of medical charges. The failure of a practitioner to publish and distribute a schedule of medical charges subjected the practitioner to discipline under the applicable practice act and s. 456.072, F.S. Lastly, the bill addressed balance billing by requiring health insurers, hospitals, and medical providers to disclose contractual relationships among the parties and to disclose, in advance of the provision of medical care or services, whether or not the patient will be balance billed as a result of the contractual relationship, or lack thereof, among the insurer, hospital, and medical provider. Failure to provide disclosure to the insured as required by this provision of the bill resulted in a $500 fine, per occurrence, to be imposed by the AHCA.
[53] SS. 1-3, Ch. 2012-160, Laws of Fla.
[54] The term "health care facilities" refers to hospital, ambulatory surgical centers, and mobile surgical centers, all of which are licensed under part I of Chapter 395, F.S.

Health Care Quality Transparency

Most Americans believe that the health care they receive is the best available, but the evidence shows otherwise.[55] Although the U.S. spends more than $3 trillion a year on health care,[56] 17.4 percent of the gross national product,[57] research shows that the quality of health care in America is, at best, imperfect, and, at worst, deeply flawed.[58] Issues with health care quality fall into three categories:

- Underuse. Many patients do not receive medically necessary care.
- Misuse. Each year, more than 100,000 Americans get the wrong care and are injured as a result. More than 1.5 million medication errors are made each year.
- Overuse. Many patients receive care that is not needed or for which there is an equally effective alternative that costs less money or causes fewer side effects.

Research indicates that quality of care in the U.S. is uneven. For example, Americans receive appropriate, evidence-based care when they need it only 55 percent of the time.[59] Similarly, more than 400,000 people die each year as a result of preventable hospital errors in the U.S.[60], and more than 75,000 people died in 2011 from an infection obtained while in the hospital.[61]

There are hundreds of health care quality measures developed, maintained, and evaluated for relevancy and accuracy by many different organizations, including the federal Agency for Healthcare Research and Quality, the National Quality Forum, and the National Committee for Quality Assurance. In general, health quality measures can be sorted into four categories:[62]

- **Structure measures**- assess the aspects of the health care setting, including facility, personnel, and policies related to the delivery of care.
  - Example- What is the nurse-to-patient ratio in a neonatal intensive care unit?
- **Process measures**- determine if the services provided to patients are consistent with routine clinical care.
  - Example- Does a doctor recommend prostate-specific antigen testing for his male patients at average risk for prostate cancer beginning at age 50?
- **Outcome measures**- evaluate patient health as a result of care received.
  - Example- What is the infection rate of patients undergoing cardiac surgery at a hospital?
- **Patient experience measures**- provide feedback on patients' experiences with the care received.
  - Example- Do patients recommend their doctor to others following a procedure?

Data on health care quality measures come from a number of sources. Some of the most common source include:

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[55] National Committee for Quality Assurance, *The Essential Guide to Health Quality*, page 6, available at http://www.ncqa.org/Portals/0/Publications/Resource/%20Library/NCQA_Primer_web.pdf (last viewed January 18, 2016).
[56] The Henry J. Kaiser Foundation, Peterson-Kaiser Health System Tracker, *Health Spending Explorer-U.S. Health Expenditures 1960-2014*, available at http://www.healthsystemtracker.org/interactive/health-spending-explorer/?display=U.S.%2520%2524%2520Billions&service=Hospitals%252CPhysicians%2520%2526%2520Clinics%252CPrescriptions%2520Drug (last viewed January 18, 2016).
[57] The World Bank, *Data-United States*, available at http://data.worldbank.org/country/united-states (last viewed January 18, 2016).
[58] Supra, FN 55.
[59] McGlynn, E.A., Asch, S.M., et al., *The quality of health care delivered to adults in the United States*, New England Journal of Medicine, 348(26): 2635-45, June 2, 2003.
[60] James, J., *A New, Evidence-based Estimate of Patient Harms Associated with Hospital Care*, Journal of Patient Safety, 9(3): 122-128 (September 2013).
[61] Centers for Disease Control, *Healthcare-associated infections (HAI), Data and Statistics-HAI Prevalence Survey*, available at http://www.cdc.gov/HAI/surveillance/index.html (last viewed January 18, 2016).
[62] U.S. Government Accountability Office, *Health Care Transparency-Actions Needed to Improve Cost and Quality Information for Consumers*, October 2014, pgs. 6-7 (citing quality measure categories established by the U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality's National Quality Measures Clearinghouse, available at http://qualitymeasures.ahrq.gov/tutorial/varieties.aspx).

- Health insurance claims and other administrative documents;
- Disease registries, such as those maintained by the Agency for Toxic Substances and Disease Registry[63] in the Centers for Disease Control and national disease-specific registries, like the National Amyotrophic Lateral Sclerosis (ALS) Registry[64] and the Kaiser Permanente Autoimmune Disorder Registry[65];
- Medical records; and
- Qualitative data, including information from patient surveys, interviews, and focus groups.[66]

Standardized healthcare performance measures are used by a range of healthcare stakeholders for a variety of purposes. Measures help clinicians, hospitals, and other providers understand whether the care they provide their patients is optimal and appropriate, and if not, where to focus their efforts to improve. Public and private payers also use measures for feedback and benchmarking purposes, public reporting, and incentive-based payment. Lastly, measures are an essential part of making the cost and quality of healthcare more transparent to all, particularly for those who receive care or help make care decisions for loved ones. The Institute of Medicine's six domains of quality—safe, effective, patient-centered, timely, efficient, and equitable—are one way to organize the information.[67] Studies have found patients find effectiveness, safety, and patient-centeredness to be most meaningful in their consideration of health care options.[68]

As more and more health care consumers shop for their health care, value becomes more important than price alone. Determining value means comparing the cost of care with information on the quality or benefit of the service. Presenting health care price information without accompanying quality information leads consumers to assume that high-priced care is high quality care.[69] In fact, there is no evidence of a correlation between cost and quality in health care.[70]

Showing cost and quality information together helps consumers clearly see variation among providers.[71] Further, it helps consumers understand that high costs do not necessarily mean high quality—high-quality care is available without paying the highest price.[72] One way to accomplish this would be to present comparative quality and cost information on one, consumer-friendly website, using several specific measures or scores so multiple metrics can be compared at the same time.[73]

<u>All-Payer Claims Database (APCD)</u>

An APCD is a computer database, usually created by state mandate, which includes data derived from medical, pharmacy, and dental claims, with eligibility and provider files from private and public payers such as commercial insurance carriers, Medicaid, and Medicare.[74] There are both mandatory and voluntary APCDs, however the majority of APCDs established in the last 10 years are mandatory

[63] For more information, visit www.atsdr.cdc.gov/.
[64] For more information, visit https://wwwn.cdc.gov/ALS/Default.aspx.
[65] For more information, visit https://www.dor.kaiser.org/external/DORExternal/aidr/index.aspx.
[66] Supra, FN 62 at page 11.
[67] Institute of Medicine, *Report: Crossing the Quality Chasm: A New Health System for the 21st Century*, March 1, 2001, available at http://ion.nationalacademies.org/~/media/Files/Report%20Files/2001/Crossing-the-Quality-Chasm/Quality%20Chasm%202001%20%20report%20brief.pdf (last viewed January 18, 2016).
[68] Hibbard, JH, Greene, J, Daniel D., *What is Quality Anyway? Performance Reports That Clearly Communicate to Consumers the Meaning of Quality Care*, Med. Care Res. Rev., 67(3): 275-293 (2010).
[69] Supra, FN 23 at page 5.
[70] Carman, KL, Maurer M., et al., *Evidence That Consumers Are Skeptical About Evidence-Based Health Care*, Health Affairs, 29(7): 1400-1406 (2010).
[71] American Institute of Research, The Robert Wood Johnson Foundation, *How to Report Cost Data to Promote High-Quality, Affordable Choices: Findings from Consumer Testing*, February 2014, available at http://www.rwjf.org/content/dam/farm/reports/issue_brief/2014/rwjf410706 (last viewed January 18, 2016).
[72] Id.
[73] Id.
[74] APCD Council, *All Payer Claims Databases: An Overview*, presentation before the Select Committee on Affordable Healthcare Access, January 11, 2016, slide 3 (on file with Select Committee staff).

reporting initiatives.[75] Information contained in claims data reported to an APCD includes:

- Encrypted social security numbers;
- Patient demographics, such as date of birth, gender, residence, and relationship to subscriber or insured;
- Type of product, such as HMO, POS, or indemnity;
- Diagnosis codes;
- Procedure codes;
- NDC codes;
- Revenue codes;
- Service dates;
- Service provider, including name, tax identification number, payer identification number, specialty code, city, state, and zip code;
- Prescribing physician;
- Plan charges & payments;
- Member cost-sharing responsibilities, such as co-payments, coinsurance, and deductible; and
- Facility type.[76]

Information that is normally not included in claims data reported to an APCD includes:

- Services provided to uninsured
- Denied claims;
- Workers' compensation claims;
- Test results from lab work, imaging, etc.;
- Premium information;
- Capitation fees; and
- Administrative fees.[77]

Twenty states have implemented an APCD, designed to do various things. Most states developed and operate the APCD.[78] Other states were involved in the initial planning stages of the APCD, but delegated day-to-day operations of the database to private not-for-profit entity.[79] Two states, California and Washington, have private, voluntary reporting initiatives. Some of the purposes for which APCDs are being used include:[80]

- Understanding overall and categorical costs for care;[81]
- Creating tools for consumers to determine health care costs and quality;[82]
- Determining the variation in health care costs across states;[83]
- Establishing benchmarks for health care purchasers;[84] and
- Evaluating the medical home model.[85]

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[75] Robert Wood Johnson Foundation, APCD Council, *The Basics of All-Payer Claims Databases, A Primer for States*, January 2014, page 2, available at https://www.apcdcouncil.org/file/31/download?token=b7qtlhRQ (last viewed January 18, 2016).
[76] Jo Porter, APCD Council, *State Innovations in the Use of APCD Data*, presentation at the National Association of State Health Plans Conference, October 19-21, 2015, slide 5 (on file with Select Committee staff).
[77] Id. at slide 6.
[78] Id. at slide 10; Kansas, Maine, Massachusetts, Maryland, Minnesota, New Hampshire, Oregon, Tennessee, Utah, Vermont, W. Virginia, Rhode Island, Connecticut, New York, and Washington.
[79] Id.; Colorado, Virginia, Arkansas, and Washington (still in implementation).
[80] Id. at slide 16.
[81] Colorado, New Hampshire, Maine, Vermont, Utah, Massachusetts, and Maryland.
[82] Massachusetts, New Hampshire, and Maine.
[83] Colorado, Maine, New Hampshire, and Vermont.
[84] New Hampshire.
[85] Vermont and New Hampshire.

The cost of developing, operating and maintaining an APCD varies greatly across states. For example, Colorado has spent $6.7 million since 2010 on its APCD, and estimates $2.7 million in annual operations costs. Kansas projects an operations cost of $1.2 million to $1.4 million over a 5-year period. Other states have incurred lower costs for operating an APCD. Tennessee has annual APCD operating costs of $500,000. Utah uses $615,000 in General Revenue funds and $185,000 in federal matching funds each year to fund its APCD. West Virginia has operated its APCD, since 2010, on a total of $200,000. Reported state APCD funding, for a state with 1.3 million to 1.5 million covered lives, ranges from $350,000 to establish a basic data system to $1 million to $2 million for a more robust data system.[86] Start-up costs may range from $600,000 to $2 million, depending on the complexity of the APCD platform.[87]

States have also seen wide variation in the amount of time it takes to establish an operating APCD. Some states, like California, Colorado, New Hampshire, and Oregon, took less than one year to two years to have a functional database. Other states, like Kansas and Rhode Island, required four years to have an operational APCD. Still other states, like Connecticut and New York, passed authorizing legislation in 2011 and 2012, respectively, but are still in the implementation process.

States fund APCDs in a variety of ways.[88] Public APCDs are funded, at least in part, through general appropriations or fee assessments. States have also received grant funding to support the initial phases of APCD development. Some states have been able to use the federal grants to develop their APCD. More recently, states have been successful in securing federal rate review grants, and use part of that funding for APCD development, operation, and maintenance.[89] New Hampshire's APCD is used by its Medicaid program and leverages funding from Medicaid to support it.[90] Many states expect to use data product sales to fund, at least in part, the operation of APCDs into the future. Due to the APCD costs experienced by states, it appears that data sales revenue will not be sufficient to wholly fund operation and maintenance of APCDs over the long term, and other core revenue streams will be necessary to fully fund these databases.[91]

Health Insurer Regulation

The Florida Office of Insurance Regulation (OIR) regulates the business of insurance in the state, in accordance with the Florida Insurance Code (Code). The Life and Health Unit (Unit) of OIR provides financial oversight of health insurers, health maintenance organizations, and other regulated entities providing health care coverage pursuant to various chapters of the Code:

Chapter 624, F.S. – Insurance Code: Administration and General Provisions
Chapter 626, F.S. – Insurance Field Representatives and Operations
Chapter 627, F.S. – Insurance Rates and Contracts
Chapter 631, F.S. – Insurer Insolvency; Guaranty of Payment
Chapter 632, F.S. – Fraternal Benefit Societies
Chapter 636, F.S. – Prepaid Limited Health Service Organizations and Discount Medical Plan Organizations
Chapter 641, F.S. – Health Care Service Programs
Chapter 651, F.S. – Continuing Care Contracts

OIR insurance regulatory activities include licensing, rate and form approval, market conduct review, issuing certificates of authority, ensuring solvency, and administrative supervision. The following chart shows the type and number of each entity in the state:[92]

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[86] Multiple telephone conferences between APCD Council staff and Select Committee staff, Fall 2015.
[87] Id.
[88] Supra, FN 75 at pg. 5.
[89] Id.
[90] Id.
[91] Id.
[92] Email correspondence from OIR staff dated November 12, 2015 (on file with Select Committee staff).

Authority Category	Authorities
Health Insurers	442
Third Party Administrators	299
Continuing Care Retirement Communities	63
Discount Medical Plan Organizations	42
Health Maintenance Organizations	35
Fraternal Benefit Societies	36
Prepaid Limited Health Service Organizations/Prepaid Health Clinics	27

Florida Center for Health Information and Policy Analysis

Organization and Function

The Florida Center for Health Information and Policy Analysis (the Florida Center) provides a comprehensive health information system (information system) that includes the collection, compilation, coordination, analysis, indexing, dissemination, and utilization of health-related data.[93] The Florida Center is housed within AHCA[94] and is funded through appropriations in the General Appropriations Act, through grants, gifts, and other payments, and through fees charged for services.[95] Offices within the Florida Center, which serve different functions,[96] are:

- Data Collection and Quality Assurance, which collects patient discharge data from all licensed acute care hospitals (including psychiatric and comprehensive rehabilitation units), comprehensive rehabilitation hospitals, ambulatory surgical centers and emergency departments.[97]
- Risk Management and Patient Safety, which conducts in-depth analyses of reported incidents to determine what happened and how the facility responded to the incident.[98]
- Data Dissemination and Communication, which maintains AHCA's health information website,[99] provides technical assistance to data users, and creates consumer brochures and other publications.[100]
- Health Information Exchange and Policy Analysis, which monitors innovations in health information technology, informatics, and the exchange of health information and provides a clearinghouse of technical resources on health information exchange, electronic prescribing, privacy and security, and other relevant issues.[101]

The Florida Center identifies existing health-related data and collects data for use in the information system. The information collected by the Florida Center must include:

[93] S. 408.05(1), F.S.
[94] S. 408.05(1), F.S.
[95] S. 408.05(7), F.S.
[96] Agency for Health Care Administration, *Florida Center for Health Information and Policy Analysis*, available at: http://ahca.myflorida.com/SCHS/index.shtml (last viewed January 18, 2016).
[97] Agency for Health Care Administration, *Office of Data Collection & Quality Assurance*, available at: http://ahca.myflorida.com/schs/DataCollection/DataCollection.shtml (last viewed January 18, 2016).
[98] Agency for Health Care Administration, *Office of Risk Management and Patient Safety*, available at: http://ahca.myflorida.com/schs/RiskMgtPubSafety/RiskManagement.shtml (last viewed January 18, 2016).
[99] www.FloridaHealthFinder.gov
[100] Agency for Health Care Administration, *Office of Data Dissemination and Communication*, available at: http://ahca.myflorida.com/schs/DataD/DataD.shtml (last viewed January 18, 2016).
[101] Agency for Health Care Administration, *Office of Health Information Exchange and Policy Analysis*, available at: http://ahca.myflorida.com/schs/HIE/HIE.shtml (last viewed January 18, 2016).

- The extent and nature of illness and disability of the state population, including life expectancy, the incidence of various acute and chronic illnesses, and infant and maternal morbidity and mortality;
- The impact of illness and disability of the state population on the state economy and on other aspects of the well-being of the people in this state;
- Environmental, social, and other health hazards;
- Health knowledge and practices of the people in this state and determinants of health and nutritional practices and status;
- Health resources, including physicians, dentists, nurses, and other health professionals, by specialty and type of practice and acute, long-term care and other institutional care facility supplies and specific services provided by hospitals, nursing homes, home health agencies, and other health care facilities;
- Utilization of health care by type of provider;
- Health care costs and financing, including trends in health care prices and costs, the sources of payment for health care services, and federal, state, and local expenditures for health care;
- Family formation, growth, and dissolution;
- The extent of public and private health insurance coverage in this state; and
- The quality of care provided by various health care providers.[102]

The Florida Center electronically collects patient data from every Florida licensed inpatient hospital, ambulatory surgery center (ASC), emergency department, and comprehensive rehabilitation hospital on a quarterly basis. The data is validated for accuracy and maintained in three major databases: the hospital inpatient database, the ambulatory surgery database, and the emergency department database.[103]

- **The hospital inpatient database** contains records for each patient stay at Florida acute care facilities, including long-term care hospitals and psychiatric hospitals. These records contain extensive patient information including discharge records, patient demographics, admission information, medical information, and charge data.[104] This database also includes comprehensive inpatient rehabilitation data on patient-level discharge information from Florida's licensed freestanding comprehensive inpatient rehabilitation hospitals and acute care hospital distinct part rehabilitation units.[105]
- **The ambulatory surgery database** contains "same-day surgery" data on reportable patient visits to Florida health care facilities, including freestanding ambulatory surgery centers, short-term acute care hospitals, lithotripsy centers, and cardiac catheterization laboratories.[106] Ambulatory surgery data records include, but are not limited to, patient demographics, medical information, and charge data.[107]
- **The emergency department database** collects reports of all patients who visited an emergency department, but were not admitted for inpatient care. Reports are electronically submitted to the AHCA and include the hour of arrival, the patient's chief complaint, principal diagnosis, race, ethnicity, and external causes of injury.[108]

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[102] S. 408.05(2), F.S.
[103] Agency for Health Care Administration, Florida Center for Health Information and Policy Analysis, *2014 Annual Report*, p. 2, available at: https://floridahealthfinderstore.blob.core.windows.net/documents/researchers/documents/FC%20Annual%20Report%202014%20Final%20w%20cover%20-%202_16_15.pdf.
[104] Id., pg. 3.
[105] Id., pg. 4.
[106] Id., pgs. 3-4.
[107] Id., pg. 4.
[108] Id., pgs. 4-5.

In addition to these databases, the Office of Risk Management and Patient Safety collects adverse incident reports from health care providers including, hospitals, ambulatory surgical centers, nursing homes, and assisted living facilities.[109]

Reporting

The Florida Center is required to publish and make available the following reports:

- Member satisfaction surveys;
- Publications providing health statistics on topical health policy issues;
- Publications that provide health status profiles of people in Florida;
- Various topical health statistics publications;
- Results of special health surveys, health care research, and health care evaluations required under s. 408.05, F.S.; and
- An annual report on the Florida Center's activities.[110]

The Florida Center must also provide indexing, abstracting, translation, publication and other services leading to a more effective and timely dissemination of health care statistics. The Florida Center is responsible for conducting a variety of special studies and surveys to expand the health care information and statistics available for policy analyses.[111]

Public Access to Data

The Office of Data Dissemination and Communication, within the Florida Center, makes data collected available to the public in three ways: by updating and maintaining the AHCA's health information website at www.FloridaHealthFinder.gov, by issuing standard and ad hoc reports, and by responding to requests for de-identified data.[112]

The Florida Center maintains www.FloridaHealthFinder.gov, which was established to assist consumers in making informed health care decisions and lead to improvements in quality of care in Florida. The website provides a wide array of search and comparative tools to the public which allow easy access to information on hospitals, ambulatory surgery centers, emergency departments, hospice providers, physician volume, health plans, nursing homes, and prices for prescription drugs in Florida. The website also provides tools to researchers and professionals which allow specialized data queries, but requires users to have some knowledge of medical coding and terminology.[113] Some of the features and data available on the website include a multimedia encyclopedia and symptoms navigator, hospital and ambulatory surgery centers performance data, data on mortality, complication, and infection rates for hospitals, and a facility/provider locator.[114]

The Center disseminates three standard reports which detail hospital fiscal data including a prior year report, an audited financial statement, and a hospital financial data report. Also, ad hoc reports may be requested for customers looking for very specific information not included on a standard report or for customers who do not wish to purchase an entire data set to obtain information. One example of an ad hoc report would be a request for the average length of stay of patients admitted to a hospital with diabetes as a principle or secondary diagnosis.[115] The Center charges a set fee for standard reports[116] and a variable fee based on the extensiveness of an ad hoc report.[117]

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[109] Id.
[110] S. 408.05(5), F.S.
[111] Id.
[112] Supra, FN 106, pgs. 6-9.
[113] Id., pg. 9.
[114] Id., pgs. 9-13.
[115] Id., pgs.8-9.
[116] The price list for purchasing data from the Center is available at http://floridahealthfinderstore.blob.core.windows.net/documents/researchers/OrderData/documents/PRICE%20LIST%20Dec2014.pdf (last viewed January 18, 2016).
[117] Supra, FN 107, pg. 7.

The Center also sells hospital inpatient, ambulatory surgery, and emergency department data to the general public in a non-confidential format. However, the requester must sign a limited set data use agreement which binds the requester to only using the data in a way specified in the agreement. Information not available in these limited data sets include: patient ID number, medical record number, social security number, dates of admission and discharge, visit beginning and end dates, age in days, payer, date of birth, and procedure dates.[118]

The Florida Center is required to provide technical assistance to persons or organizations engaged in health planning activities in the effective use of statistics collected and complied by the Florida Center.[119]

Florida Center Administration

AHCA is required to complete a number of responsibilities related to the information system, in order to produce comparable and uniform health information and statistics for the development of policy recommendations.[120] These responsibilities are listed in statute and include the following:

- Undertake research, development, and evaluation regarding the information system for the purpose of creating comparable health information.
- Coordinate the activities of state agencies involved in the design and implementation of the information system and review the statistical activities of state agencies to ensure that they are consistent with the information system.
- Develop written agreements with local, state, and federal agencies to share health-care-related data.
- Establish by rule the types of data collected, compiled, processed, used, or shared.
- Establish minimum health-care-related data sets which are necessary on a continuing basis to fulfill the collection requirements of the center and which shall be used by state agencies in collecting and compiling health-care-related data.
- Establish advisory standards to ensure the quality of health statistical and epidemiological data collection, processing, and analysis by local, state, and private organizations.
- Prescribe standards for the publication of health-care-related data, which ensure the reporting of accurate, valid, reliable, complete, and comparable data.
- Prescribe standards for the maintenance and preservation of the Florida Center's data.
- Ensure that strict quality control measures are maintained for the dissemination of data through publications, studies, or user requests.
- Develop and implement a long-range plan for making available health care quality measures and financial data that will allow consumers to compare health care services.
- Administer, manage, and monitor grants to not-for-profit organizations, regional health information organizations, public health departments, or state agencies that submit proposals for planning, implementation, or training projects to advance the development of a health information network.
- Initiate, oversee, manage, and evaluate the integration of healthcare data from each state agency that collects, stores, and reports on health care issues and make the data available to any health care practitioner through a state health information network.[121]

<u>Patient Safety Culture Surveys</u>

In 2004, the federal Agency for Healthcare Research and Quality (AHRQ) released the Hospital Survey on Patient Safety Culture, a staff survey designed to help hospitals assess the culture of safety in their

[118] Id., pgs. 7-8.
[119] S. 408.05(4), F.S.
[120] S. 408.05(3), F.S.
[121] S. 408.05(3), F.S., s. 408.05(4), F.S.

institutions.[122] The survey has since been implemented in hundreds of hospitals across the United States, and in other countries. In 2006, AHRQ developed a comparative database on the survey, comprised of data from U.S. hospitals that administered the survey and voluntarily submitted the data.[123] The database allows hospitals wishing to compare their patient safety culture survey results to those of other hospitals in support of patient safety culture improvement.[124] In 2014, 653 hospitals submitted survey results to the database.[125]

The survey[126] asks respondents to indicate to what degree they agree or disagree with a statement, how often something occurs, or provide a specific number or grade. Excerpts of the survey follow.

- Teamwork Within Units
    - People support one another in this unit.
    - When a lot of work needs to be done quickly, we work together as a team to get the work done.
    - In this unit, people treat each other with respect.
    - When one area in this unit gets really busy, others help out.
- Supervisor/Manager Expectations & Actions Promoting Patient Safety
    - My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures.
    - My supervisor/manager seriously considers staff suggestions for improving patient safety.
    - Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts.
    - My supervisor/manager overlooks patient safety problems that happen over and over.
- Management Support for Patient Safety
    - Hospital management provides a work climate that promotes patient safety.
    - The actions of hospital management show that patient safety is a top priority.
    - Hospital management seems interested in patient safety only after an adverse event happens.
- Communication Openness
    - Staff will freely speak up if they see something that may negatively affect patient care.
    - Staff feel free to question the decisions or actions of those with more authority.
    - Staff are afraid to ask questions when something does not seem right.
- Handoffs & Transitions
    - Things "fall between the cracks" when transferring patients from one unit to another.
    - Important patient care information is often lost during shift changes.
    - Problems often occur in the exchange of information across hospital units.
    - Shift changes are problematic for patients in this hospital.
- Patient Safety Grade- Excellent, Very Good, Acceptable, Poor, Failing
    - Please give your work area/unit in this hospital an overall grade on patient safety.

AHRQ also developed the Ambulatory Surgery Center Survey on Patient Safety Culture in response to interest from ambulatory surgery centers (ASCs) in assessing patient safety culture in their facilities.

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[122] U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, *Hospital Survey on Patient Safety Culture*, available at http://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/hospital/index.html (last viewed January 18, 2016).
[123] Id.
[124] Id.
[125] U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, *2014 User Comparative Database Report-Hospital Survey on Patient Safety Culture*, available at http://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/hospital/2014/index.html (last viewed January 18, 2016).
[126] The survey is available at http://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/hospital/resources/hospscanform.pdf.

This survey is designed specifically for ASC staff and asks for their opinions about the culture of patient safety in their facility.[127]

Effect of Proposed Changes

HB 1175 establishes a Florida-specific APCD, using an existing national database, including an online price calculator for Florida consumers. It also requires hospitals, ASCs, insurers and HMOs to make prices transparent to patients, and make quality data available to them. .

All-Payer Claims Database

AHCA is directed to contract with a vendor to provide a user-friendly, Internet-based platform which allows a consumer to research and compare the cost of health care services and procedures. The vendor must also establish and maintain a Florida-specific dataset of health care claims information available to the public and any interested party. Access to state-specific data is designed to encourage research and innovation in the delivery and payment of health care in Florida. The bill delineates criteria that the vendor must meet in order to contract with AHCA for the purposes outlined in the bill. The vendor must:

- Be a non-profit research institute qualified to receive Medicare claims data;
- Receive claims data from multiple private insurers nationwide;
- Have a national database consisting of at least 15 billion claim lines of data from multiple payers, including employers with ERISA plans;
- Have a well-developed methodology for analyzing claims data within health care service bundles; and
- Have a bundling methodology available to the public to allow for consistency and comparison of state and national benchmarks with local regions and specific providers.

The patient must be able to search the price information based on specific services or procedures, and using service bundles that compose a whole episode of hospital care. The service bundles must be understandable to an ordinary layperson. Patients must be able to search the information without a password or registration requirement.

To ensure the collection of health claims data, the bill requires each insurer and HMO participating in the State Group Insurance plan or Statewide Medicaid Managed Care to contribute all Florida claims data to the vendor selected by AHCA. Further, the bill requires Medicaid managed care plans to comply with information disclosure and cost calculation requirements in s. 627.6385, F.S., or s. 641.54, F.S., as applicable. Finally, the bill requires the Department of Management Services to make arrangements to contribute State Group Insurance plan claims data to the vendor selected by AHCA and requires each contracted vendor for the State Group plan to do the same.

Hospital and ASC Transparency Requirements

Pre-Treatment Transparency

The bill requires hospitals, ASCs, health care practitioners providing non-emergency hospital services, insurers and HMOs to provide patients with information on price and quality prior to treatment.

[127] The survey is available at http://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/asc/resources/ascsurvey.pdf.

Hospitals and ASCs

The bill requires every licensed hospital and ASC (facilities) to provide timely and accurate financial information and quality of service measures to prospective and actual patients, or to patients' survivors or legal guardians. State mental health facilities and mobile surgical facilities are exempt from these requirements.

First, each facility must make information on the payments it receives for services available on its websites. The information must be searchable, and use the same format as that used by the APCD, including the descriptive bundles of services and procedures created by the vendor. The information must, at a minimum, provide the estimated average payment received and the estimated range of payment from all non-governmental payers for the bundles available at the facility. The facility must disclose to the consumer that these averages and ranges of payments are estimates, and that actual charges will be based on the services actually provided. The facility must also publish on its website information on the facility's financial assistance policy, including any application process, payment plans, discounts, and the facility's collections procedures.

Second, each facility must identify on its website all insurers and HMOs for which the facility is in-network, or is a preferred provider, and post a link to each of them. The facility must notify patients, on its website, that services in the hospital may be provided by health care providers who may separately bill the patient.

Third, each facility must provide to patients and prospective patients, on request, a personalized, written estimate of the reasonably anticipated charges by the facility. The estimate must be provided within 3 days of request. The estimate may be based on the service bundles created by the APCD vendor, or, if the patient requests, must be based on the specific condition and characteristics of the patient. The estimate must clearly identify any facility fees, explain their purpose, and notify the patient that another facility or setting may have lower cost. If the patient requests it, the facility must notify the patient of any revisions to the estimate. Actual charges can vary from the estimate.

In issuing the estimate, the facility is not required to take the patient's insurance coverage into account, but must inform the patient that the patient may contact his or her insurer to get information about cost-sharing obligations. The estimate must also include notice of the facility's financial assistance policy. The facility must inform patients that they may request this personalized estimate, both from the facility and from the health care providers who provide care in the facility but bill the patient separately.

For a facility that fails to provide the estimate timely, the bill requires AHCA to fine the facility $1,000 per day until the estimate is provided.

Finally, the bill requires facilities to post on their websites a weblink to the quality data available on the AHCA website FloridaHealthFinder.gov, and to notify the public that the data is available.

Health Care Practitioners

The bill requires health care practitioners to provide a written, good faith estimate of reasonably anticipated charges for nonemergency treatment of the patient's condition provided in a hospital or ASC within 3 days of a patient's request for the estimate. In issuing the estimate, the practitioner is not required to take the patient's insurance coverage into account, but must advise the patient that he or she may contact his or her insurer or HMO for more information on cost-sharing obligations related to the treatment. Actual charges can vary from the estimate.

These health care practitioners must also to provide to uninsured patients, and insured patients for whom the practitioner is out-of-network, information on the practitioner's financial assistance policy, including the application process, payment plans discounts and collection procedures. Failure to

provide the estimate within 3 business days shall result in disciplinary action against the HCP under his or her practice act and a daily fine of $500, capped at $5,000.

Insurers and HMOs

The bill requires each health insurer and HMO to make available on its website a method that consumers can use to estimate copayments, deductibles, and other cost-sharing requirements for health care services and procedures. The method to determine the consumer's cost-sharing obligations must be based on the service bundles established by the APCD vendor. The insured must be able to create an estimate using the service bundles, a specific provider, or a comparison of providers, or any combination thereof. Estimates must be calculated using the insured's policy and known plan usage during coverage period, and based on in-network or out-of-network providers.

Insurers and HMOs must also establish, on their websites, a method for patients to obtain a personalized estimate of their cost-sharing obligations, using the personalized estimates received from a facility or in-facility health care practitioner.

Insurers and HMOs must include, in every policy issued and in prospective enrollee materials, a notice that these estimates are available.

The bill requires insurers and HMOs to post on their websites a weblink to the quality data available on the AHCA website FloridaHealthFinder.gov.

Post-Treatment Transparency

Hospitals and ASCs

The bill amends current billing requirements in s. 395.301, F.S., to require hospitals and ASCs to meet additional standards for clear and comprehensible billing.

Following the patient's discharge, the bill requires the facility to provide an itemized bill or statement to the patient, upon request, within 7 days. The bill or statement must be in plain language. Services received and expenses incurred must be listed by date and by provider, enumerating items at a level of detail proscribed by AHCA. The bill or statement must clearly identify any facility fee and explain its purpose. . The itemized bill or statement must identify each item as "paid", "pending third-party payment", or "pending payment by the patient," and include the amount due. If an amount is due from the patient, the itemized bill or statement has to also the due date. Finally, the bill or statement must inform the patient or the patient's survivor or legal guardian to contact his or her insurer or HMO regarding the patient's cost-sharing obligation for the medical services and procedures. Any subsequent bills or statements must meet these requirements, and clearly identify any revisions.

Each bill or statement issued by a facility must notify the patient of any health care practitioners who will bill the patient separately.

The bill requires facilities to make available electronically, upon request of the patient, all records necessary for verifying the accuracy of the itemized bill or statement within 10 business days of the request. A facility must respond to patient questions about the itemized bill within 7 business days of receiving the question. Lastly, the facility must provide AHCA's contact information if the patient is not satisfied with the answers to his or her questions about the bill or statement.

Florida Center for Health Information and Transparency

The bill renames the Florida Center for Health Information and Policy Analysis as the Florida Center for Health Information and Transparency. The bill streamlines the Florida Center's functions, eliminating unnecessary language, obsolete provisions and duties that are redundant to the activities of other

agencies. The bill specifically prohibits AHCA from establishing an all payers claim database without express authority to do so from the Legislature.

Under the bill, the Florida Center must identify available datasets, compile new data when specifically authorized, and promote the use of extant health-related data and statistics. The Florida Center must maintain the datasets existing before July 1, 2016, unless those datasets duplicate information that is readily available from other credible sources. The Florida Center may collect or compile data on:

- Licensed health professionals, including physician surveys conducted under ss. 458.3191 and 459.0081, F.S.;
- Health service inventories;
- Service utilization data for licensed heath care facilities; and
- Specific health care quality initiatives when other extant data is not adequate to achieve the objectives of the initiative.

The bill revises data submission requirements that apply to facilities and health care practitioners. Specifically, the bill directs AHCA to require the submission of data to facilitate transparency in health care pricing data and quality measures. Also, data to be submitted by insurers may include payments to health care facilities and HCPs, as specified by rule. The bill further directs AHCA to consult with vendors, the State Consumer Health Information and Policy Advisory Council, and public and private users to determine the data to be collected and the use of the data. AHCA must monitor data collection procedures and test data quality to ensure the data is accurate, valid, reliable, and complete.

Patient Safety Culture Surveys

The bill requires AHCA to develop hospital and ASC patient safety culture surveys to measure aspects of patient safety culture, including frequency of adverse events, quality of handoffs and transitions, comfort in reporting a potential problem or error, the level of teamwork within hospital units and the facility as a whole, staff compliance with patient safety regulations and guidelines, staff's perception of facility support for patient safety, and staff's opinions on whether or not they would undergo a health care service or procedure at the facility. In designing the survey or surveys, AHCA must review and analyze nationally recognized patient safety culture survey products, including but not limited to the patient safety surveys developed by the federal Agency for Healthcare Research and Quality to develop the patient safety culture survey.

The bill requires facilities to annually conduct and submit the results of the AHCA-designed culture survey to the Florida Center, and authorizes AHCA to adopt rules to govern the survey and submission process. AHCA must include the survey results in the health care quality measures available to the public.

Finally, the bill also makes various conforming changes to reflect the provisions of the bill.

The bill provides an effective date of July 1, 2016.

B. SECTION DIRECTORY:

Section 1: Amends s. 395.301, F.S., relating to itemized patient bill; form and content prescribed by the agency; patient admission status notification.
Section 2: Amends s. 408.05, F.S., relating to Florida Center for Health Information and Policy Analysis.
Section 3: Amends s. 408.061, F.S., relating to data collection; uniform systems of financial reporting; information relating to physician charges; confidential information; immunity.
Section 4: Amends s. 408.810, F.S., relating to minimum licensure requirements.
Section 5: Amends s. 456.0575, F.S., relating to duty to notify patients.

Section 5: Amends s. 456.072, F.S., relating to grounds for discipline; penalties; enforcement.
Section 6: Creates s. 627.6385, F.S., relating to disclosures to policyholders; calculations of cost sharing.
Section 7: Amends s. 641.54, F.S., relating to information disclosure.
Section 8: Amends s. 409.967, F.S., relating to managed care plan accountability.
Section 9: Amends s. 110.123, F.S., relating to state group insurance program.
Section 10: Amends s. 20.42, F.S., relating to Agency for Health Care Administration.
Section 11: Amends s. 381.026, F.S., relating to Florida Patient's Bill of Rights and Responsibilities.
Section 12: Amends s. 395.602, F.S., relating to rural hospitals.
Section 13: Amends s. 395.6025, F.S., relating to rural hospital replacement facilities.
Section 14: Amends s. 400.991, F.S., license requirements; background screenings; prohibitions.
Section 15: Amends s. 408.07, F.S., relating to definitions.
Section 16: Amends s. 408.18, F.S., relating to Health Care Community Antitrust Guidance Act.
Section 17: Amends s. 408.8065, F.S., relating to additional licensure requirements for home health agencies, home medical equipment providers, and health care clinics.
Section 18: Amends s. 408.820, F.S., relating to exemptions.
Section 19: Amends s. 465.0244, F.S., relating to information disclosure.
Section 20: Amends s. 627.6499, F.S., relating to reporting by insurers and third-party administrators.
Section 21: Provides an effective date of July 1, 2016.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   AHCA may realize an increase in revenue by imposing fines on facilities for failing to timely provide an estimate to a patient or prospective patient. Similarly, the Department of Health may realize an increase in revenue by imposing fines on health care practitioners providing non-emergency services in a facility who do not timely provide the estimate to patients or prospective patients. The amount of fines that may be collected under the bill is indeterminate, and will offset costs of investigations and administrative actions.

2. Expenditures:

   States that have developed, implemented, and operated their own health care claims database have incurred several million dollars in start-up and annual operations costs. The bill directs AHCA to contract with a vendor that has already developed the database infrastructure and currently operates a database with the functionality required by the bill. It is likely that the estimated costs to contract with such a vendor will be significantly less than the costs incurred by other states to establish and operate the database on their own. Nevertheless, it is likely to be a significant, negative fiscal impact to AHCA to complete a contract with a vendor as directed in the bill.

   AHCA estimates the cost to implement the patient safety culture survey, including the cost of a contracted research organization to collect, analyze, and report survey findings and the cost of one additional staff to manage the contract and survey process, to be $500,000, based on an historical rate of $28 per completed survey charged by a contracted research organization for other surveys, multiplied by an estimated sample size of 17,857 surveys completed by staff from all licensed facilities.[128] AHCA intends to encourage online survey completion, which would reduce this

[128] Agency for Health Care Administration, *2106 Agency Bill Analysis-HB 1175*, January 11, 2016, page 7 (on file with Select Committee staff).

estimate.[129] AHCA is in the process of determining the cost of developing, distributing, and processing the surveys without a contractor.[130]

AHCA anticipates additional costs, including increasing the capacity of the Complaint Administration Unit by one full-time staff to accommodate an anticipated increase in volume of complaints received from consumers as a result of the new regulations and a senior attorney to address an increased volume of actions and fines for facilities in noncompliance with the new standards.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Hospitals and ASCs may incur costs associated with posting the required information on their websites, providing pre-treatment written, good faith estimates to patients and including more detailed information on itemized bills or statements provided to patients within 7 days of discharge from the facility.

Insurers and health maintenance organizations may incur costs associated with compiling and sending data to the vendor selected by AHCA to maintain the Florida-specific dataset accessible by the public and any interested party.

Consumers will have estimates of charges for health care, prior to receiving such care, and can plan financially for those costs. Also, the estimates will be clear and transparent, allowing a consumer to question charges and empowering him or her to negotiate prices.

Consumers will have access to a database that provides the average cost of health care service bundles for procedures or treatments. Such a tool will also empower a consumer to plan for health care and negotiate prices for medical services and treatment.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. The bill does not appear to affect county or municipal governments.

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[129] Email correspondence between AHCA staff and Select Committee staff on January 18, 2016 (on file with Select Committee staff).

[130] Telephone conference between AHCA staff and Select Committee staff on January 18, 2016.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill provides sufficient rule-making authority to AHCA to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The bill exempts mobile surgical facilities from the provisions of the bill related to facility price transparency and itemized patient statement or bill, patient safety culture surveys, and facility requirements to post a link to the data disseminated by AHCA. According to AHCA, there are no mobile surgical facilities licensed in the state.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to transparency in health care;
3 amending s. 395.301, F.S.; requiring a facility
4 licensed under chapter 395, F.S., to provide timely
5 and accurate financial information and quality of
6 service measures to certain individuals; requiring a
7 licensed facility to post certain payment information
8 regarding defined bundles of services and procedures
9 and other specified consumer information and
10 notifications on its website; requiring a facility to
11 provide a written, good faith estimate of charges to a
12 patient or prospective patient within a certain
13 timeframe; requiring a facility to provide information
14 regarding its financial assistance policy to a patient
15 or a prospective patient; providing a penalty for
16 failing to provide such estimate of charges to a
17 patient; deleting a requirement that a licensed
18 facility not operated by the state provide notice to a
19 patient of his or her right to an itemized bill within
20 a certain timeframe; revising the information that
21 must be included on a patient's statement or bill;
22 amending s. 408.05, F.S.; renaming the Florida Center
23 for Health Information and Policy Analysis; revising
24 requirements for the collection and use of health-
25 related data by the Agency for Health Care
26 Administration; requiring the agency to contract with

27 a vendor to provide an Internet-based platform with
28 certain attributes and a state-specific data set
29 available to the public; providing vendor
30 qualifications; requiring the agency to design a
31 patient safety culture survey for hospitals and
32 ambulatory surgical centers licensed under chapter
33 395, F.S.; requiring the survey to measure certain
34 aspects of a facility's patient safety practices;
35 exempting certain licensed facilities from survey
36 requirements; prohibiting the agency from establishing
37 a certain database without express legislative
38 authority; revising the duties of the members of the
39 State Consumer Health Information and Policy Advisory
40 Council; deleting an obsolete provision; amending s.
41 408.061, F.S.; revising requirements for the
42 submission of health care data to the agency; amending
43 s. 408.810, F.S.; requiring certain licensed hospitals
44 and ambulatory surgical centers to submit a facility
45 patient safety culture survey to the agency; amending
46 s. 456.0575, F.S.; requiring a health care
47 practitioner to provide a good faith estimate of
48 anticipated charges to a patient upon request within a
49 certain timeframe; providing for disciplinary action
50 and a fine for failure to comply; creating s.
51 627.6385, F.S.; requiring a health insurer to make
52 available on its website certain information and a

53 method for policyholders to estimate certain health
54 care services costs and charges; providing that an
55 estimate does not preclude an actual cost from
56 exceeding the estimate; requiring a health insurer to
57 provide notice in insurance policies that certain
58 information is available on its website; requiring a
59 health insurer that participates in the state group
60 health insurance plan or Medicaid managed care to
61 contribute all Florida claims data to the contracted
62 vendor selected by the agency; amending s. 641.54,
63 F.S.; requiring a health maintenance organization to
64 make certain information available to its subscribers
65 on its website; requiring a health insurer to provide
66 a hyperlink to certain health information on its
67 website; requiring a health maintenance organization
68 that participates in the state group health insurance
69 plan or Medicaid managed care to contribute all
70 Florida claims data to the contracted vendor selected
71 by the agency; amending s. 409.967, F.S.; requiring
72 managed care plans to contribute all Florida claims
73 data to the contracted vendor selected by the agency;
74 amending s. 110.123, F.S.; requiring the Department of
75 Management Services to contribute certain data to the
76 vendor for the price transparency database established
77 by the agency; requiring a contracted vendor for the
78 state group health insurance plan to contribute

79 Florida claims data to the contracted vendor selected
80 by the agency; amending ss. 20.42, 381.026, 395.602,
81 395.6025, 400.991, 408.07, 408.18, 408.8065, 408.820,
82 465.0244, and 627.6499, F.S.; conforming cross-
83 references and provisions to changes made by the act;
84 providing an effective date.
85
86 Be It Enacted by the Legislature of the State of Florida:
87
88 Section 1. Section 395.301, Florida Statutes, is amended
89 to read:
90 395.301 Price transparency; itemized patient statement or
91 bill; ~~form and content prescribed by the agency;~~ patient
92 admission status notification.—
93 (1) A facility licensed under this chapter shall provide
94 timely and accurate financial information and quality of service
95 measures to prospective and actual patients of the facility, or
96 to patients' survivors or legal guardians, as appropriate. Such
97 information shall be provided in accordance with this section
98 and rules adopted by the agency pursuant to this chapter and s.
99 408.05. Licensed facilities operating exclusively as state
100 mental health treatment facilities or as mobile surgical
101 facilities are exempt from this subsection.
102 (a) Each licensed facility shall make available to the
103 public on its website information on payments made to that
104 facility for defined bundles of services and procedures. The

105 payment data must be presented and searchable in accordance with
106 the system established by the agency and its vendor using the
107 descriptive service bundles developed under s. 408.05(3)(c). At
108 a minimum, the facility shall provide the estimated average
109 payment received from all payors, excluding Medicaid and
110 Medicare, for the descriptive service bundles available at that
111 facility and the estimated payment range for such bundles. Using
112 plain language comprehensible to an ordinary layperson, the
113 facility must disclose that the information on average payments
114 and the payment ranges is an estimate of costs that may be
115 incurred by the patient or prospective patient and that actual
116 costs will be based on the services actually provided to the
117 patient. The facility shall also assist the consumer in
118 accessing his or her health insurer's or health maintenance
119 organization's website for information on estimated copayments,
120 deductibles, and other cost-sharing responsibilities. The
121 facility's website must:
122 1. Identify and post the names and hyperlinks for direct
123 access to the websites of all health insurers and health
124 maintenance organizations for which the facility is a network
125 provider or preferred provider.
126 2. Provide information to uninsured patients and insured
127 patients whose health insurer or health maintenance organization
128 does not include the facility as a network provider or preferred
129 provider on the facility's financial assistance policy,
130 including the application process, payment plans, and discounts

131 and the facility's charity care policy and collection
132 procedures.
133 3. Notify patients and prospective patients that services
134 may be provided in the health care facility by the facility as
135 well as by other health care practitioners who may separately
136 bill the patient.
137 4. Inform patients and prospective patients that they may
138 request from the facility and other health care practitioners a
139 more personalized estimate of charges and other information.
140 (b)1. Upon request, and before providing any nonemergency
141 medical services, each licensed facility shall provide a
142 written, good faith estimate of reasonably anticipated charges
143 by the facility for the treatment of the patient's or
144 prospective patient's specific condition. The facility must
145 provide the estimate in writing to the patient or prospective
146 patient within 3 business days after receipt of the request and
147 is not required to adjust the estimate for any potential
148 insurance coverage. The estimate may be based on the descriptive
149 service bundles developed by the agency under s. 408.05(3)(c)
150 unless the patient or prospective patient requests a more
151 personalized and specific estimate that accounts for the
152 specific condition and characteristics of the patient or
153 prospective patient. The facility shall inform the patient or
154 prospective patient that he or she may contact his or her health
155 insurer or health maintenance organization for additional
156 information concerning cost-sharing responsibilities.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

157 2. In the estimate, the facility shall provide to the
158 patient or prospective patient information on the facility's
159 financial assistance policy, including the application process,
160 payment plans, and discounts and the facility's charity care
161 policy and collection procedures.
162 3. The estimate shall clearly identify any facility fees
163 and, if applicable, include a statement notifying the patient or
164 prospective patient that a facility fee is included in the
165 estimate, the purpose of the fee, and that the patient may pay
166 less for the procedure or service at another facility or in
167 another health care setting.
168 4. Upon request, the facility shall notify the patient or
169 prospective patient of any revision to the estimate.
170 5. In the estimate, the facility must notify the patient
171 or prospective patient that services may be provided in the
172 health care facility by the facility as well as by other health
173 care practitioners who may separately bill the patient.
174 6. The facility shall take action to educate the public
175 that such estimates are available upon request.
176 7. Failure to timely provide the estimate pursuant to this
177 paragraph shall result in a daily fine of $1,000 until the
178 estimate is provided to the patient or prospective patient.
179
180 The provision of an estimate does not preclude the actual
181 charges from exceeding the estimate.
182 (c) Each facility shall make available on its website a

183 hyperlink to the health-related data, including quality measures
184 and statistics, that are disseminated by the agency pursuant to
185 s. 408.05. The facility shall also take action to notify the
186 public that such information is electronically available and
187 provide a hyperlink to the agency's website.
188 (d)1. Upon request, and after the patient's discharge or
189 release from a facility, the facility must provide ~~A licensed~~
190 ~~facility not operated by the state shall notify each patient~~
191 ~~during admission and at discharge of his or her right to receive~~
192 ~~an itemized bill upon request. Within 7 days following the~~
193 ~~patient's discharge or release from a licensed facility not~~
194 ~~operated by the state, the licensed facility providing the~~
195 ~~service shall, upon request, submit~~ to the patient~~,~~ or to the
196 patient's survivor or legal guardian, as ~~may be~~ appropriate, an
197 itemized statement or bill detailing in plain language
198 comprehensible to an ordinary layperson the specific nature of
199 charges or expenses incurred by the patient.~~, which in~~ The
200 initial statement or bill ~~billing~~ shall be provided within 7
201 days after the patient's discharge or release. The initial
202 statement or bill must contain a statement of specific services
203 received and expenses incurred by date and provider for such
204 items of service, enumerating in detail as prescribed by the
205 agency the constituent components of the services received
206 within each department of the licensed facility and including
207 unit price data on rates charged by the licensed facility~~, as~~
208 ~~prescribed by the agency~~. The statement or bill must also

209 clearly identify any facility fee and explain the purpose of the
210 fee. The statement or bill must identify each item as paid,
211 pending payment by a third party, or pending payment by the
212 patient and must include the amount due, if applicable. If an
213 amount is due from the patient, a due date must be included. The
214 initial statement or bill must direct the patient or the
215 patient's survivor or legal guardian, as appropriate, to contact
216 the patient's insurer or health maintenance organization
217 regarding the patient's cost-sharing responsibilities.
218 2. Any subsequent statement or bill provided to a patient
219 or to the patient's survivor or legal guardian, as appropriate,
220 relating to the episode of care must include all of the
221 information required by subparagraph 1., with any revisions
222 clearly delineated.
223 (e)(2)(a) Each such statement or bill provided submitted
224 pursuant to this subsection section:
225 1. Must May not include notice charges of hospital-based
226 physicians and other health care practitioners who bill if
227 billed separately.
228 2. May not include any generalized category of expenses
229 such as "other" or "miscellaneous" or similar categories.
230 3. Must Shall list drugs by brand or generic name and not
231 refer to drug code numbers when referring to drugs of any sort.
232 4. Must Shall specifically identify physical,
233 occupational, or speech therapy treatment by as to the date,
234 type, and length of treatment when such therapy treatment is a

235 part of the statement or bill.
236 ~~(b) Any person receiving a statement pursuant to this~~
237 ~~section shall be fully and accurately informed as to each charge~~
238 ~~and service provided by the institution preparing the statement.~~
239 (2)~~(3)~~ On each itemized statement or bill submitted
240 pursuant to subsection (1), there shall appear the words "A FOR-
241 PROFIT (or NOT-FOR-PROFIT or PUBLIC) HOSPITAL (or AMBULATORY
242 SURGICAL CENTER) LICENSED BY THE STATE OF FLORIDA" or
243 substantially similar words sufficient to identify clearly and
244 plainly the ownership status of the licensed facility. Each
245 itemized statement or bill must prominently display the
246 telephone ~~phone~~ number of the medical facility's patient liaison
247 who is responsible for expediting the resolution of any billing
248 dispute between the patient, or the patient's survivor or legal
249 guardian ~~his or her representative~~, and the billing department.
250 ~~(4) An itemized bill shall be provided once to the~~
251 ~~patient's physician at the physician's request, at no charge.~~
252 ~~(5) In any billing for services subsequent to the initial~~
253 ~~billing for such services, the patient, or the patient's~~
254 ~~survivor or legal guardian, may elect, at his or her option, to~~
255 ~~receive a copy of the detailed statement of specific services~~
256 ~~received and expenses incurred for each such item of service as~~
257 ~~provided in subsection (1).~~
258 ~~(6) No physician, dentist, podiatric physician, or~~
259 ~~licensed facility may add to the price charged by any third~~
260 ~~party except for a service or handling charge representing a~~

261 ~~cost actually incurred as an item of expense; however, the~~
262 ~~physician, dentist, podiatric physician, or licensed facility is~~
263 ~~entitled to fair compensation for all professional services~~
264 ~~rendered. The amount of the service or handling charge, if any,~~
265 ~~shall be set forth clearly in the bill to the patient.~~
266 ~~(7) Each licensed facility not operated by the state shall~~
267 ~~provide, prior to provision of any nonemergency medical~~
268 ~~services, a written good faith estimate of reasonably~~
269 ~~anticipated charges for the facility to treat the patient's~~
270 ~~condition upon written request of a prospective patient. The~~
271 ~~estimate shall be provided to the prospective patient within 7~~
272 ~~business days after the receipt of the request. The estimate may~~
273 ~~be the average charges for that diagnosis related group or the~~
274 ~~average charges for that procedure. Upon request, the facility~~
275 ~~shall notify the patient of any revision to the good faith~~
276 ~~estimate. Such estimate shall not preclude the actual charges~~
277 ~~from exceeding the estimate. The facility shall place a notice~~
278 ~~in the reception area that such information is available.~~
279 ~~Failure to provide the estimate within the provisions~~
280 ~~established pursuant to this section shall result in a fine of~~
281 ~~$500 for each instance of the facility's failure to provide the~~
282 ~~requested information.~~
283 ~~(8) Each licensed facility that is not operated by the~~
284 ~~state shall provide any uninsured person seeking planned~~
285 ~~nonemergency elective admission a written good faith estimate of~~
286 ~~reasonably anticipated charges for the facility to treat such~~

287 ~~person. The estimate must be provided to the uninsured person~~
288 ~~within 7 business days after the person notifies the facility~~
289 ~~and the facility confirms that the person is uninsured. The~~
290 ~~estimate may be the average charges for that diagnosis-related~~
291 ~~group or the average charges for that procedure. Upon request,~~
292 ~~the facility shall notify the person of any revision to the good~~
293 ~~faith estimate. Such estimate does not preclude the actual~~
294 ~~charges from exceeding the estimate. The facility shall also~~
295 ~~provide to the uninsured person a copy of any facility discount~~
296 ~~and charity care discount policies for which the uninsured~~
297 ~~person may be eligible. The facility shall place a notice in the~~
298 ~~reception area where such information is available. Failure to~~
299 ~~provide the estimate as required by this subsection shall result~~
300 ~~in a fine of $500 for each instance of the facility's failure to~~
301 ~~provide the requested information.~~
302 (3) ~~(9)~~ If a licensed facility places a patient on
303 observation status rather than inpatient status, observation
304 services shall be documented in the patient's discharge papers.
305 The patient or the patient's survivor or legal guardian ~~proxy~~
306 shall be notified of observation services through discharge
307 papers, which may also include brochures, signage, or other
308 forms of communication for this purpose.
309 (4) ~~(10)~~ A licensed facility shall make available to a
310 patient all records necessary for verification of the accuracy
311 of the patient's statement or bill within 10 ~~30~~ business days
312 after the request for such records. The records ~~verification~~

313 ~~information~~ must be made available in the facility's offices and
314 through electronic means that comply with the Health Insurance
315 Portability and Accountability Act of 1996 (HIPAA). Such records
316 must ~~shall~~ be available to the patient before ~~prior to~~ and after
317 payment of the statement or bill ~~or claim~~. The facility may not
318 charge the patient for making such ~~verification~~ records
319 available; however, the facility may charge its usual fee for
320 providing copies of records as specified in s. 395.3025.
321 (5)~~(11)~~ Each facility shall establish a method for
322 reviewing and responding to questions from patients concerning
323 the patient's itemized statement or bill. Such response shall be
324 provided within 7 business ~~30~~ days after the date a question is
325 received. If the patient is not satisfied with the response, the
326 facility must provide the patient with the contact information
327 for ~~address of~~ the agency to which the issue may be sent for
328 review.
329 ~~(12) Each licensed facility shall make available on its~~
330 ~~Internet website a link to the performance outcome and financial~~
331 ~~data that is published by the Agency for Health Care~~
332 ~~Administration pursuant to s. 408.05(3)(k). The facility shall~~
333 ~~place a notice in the reception area that the information is~~
334 ~~available electronically and the facility's Internet website~~
335 ~~address.~~
336 Section 2. Section 408.05, Florida Statutes, is amended to
337 read:
338 408.05 Florida Center for Health Information and

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

339 Transparency ~~Policy Analysis~~.—
340 (1) ESTABLISHMENT.—The agency shall establish and maintain
341 a Florida Center for Health Information and Transparency to
342 collect, compile, coordinate, analyze, index, and disseminate
343 ~~Policy Analysis. The center shall establish a comprehensive~~
344 ~~health information system to provide for the collection,~~
345 ~~compilation, coordination, analysis, indexing, dissemination,~~
346 ~~and utilization of both purposefully collected and extant~~
347 health-related data and statistics. The center shall be staffed
348 as ~~with public health experts, biostatisticians, information~~
349 ~~system analysts, health policy experts, economists, and other~~
350 ~~staff~~ necessary to carry out its functions.
351 (2) HEALTH-RELATED DATA.—The ~~comprehensive health~~
352 ~~information system operated by the~~ Florida Center for Health
353 Information and Transparency ~~Policy Analysis~~ shall identify ~~the~~
354 ~~best~~ available data sets, compile new data when specifically
355 authorized, ~~sources~~ and promote the use ~~coordinate the~~
356 ~~compilation~~ of extant health-related data and statistics. The
357 center must maintain any data sets in existence before July 1,
358 2016, unless such data sets duplicate information that is
359 readily available from other credible sources, and may ~~and~~
360 ~~purposefully~~ collect or compile data on:
361 ~~(a) The extent and nature of illness and disability of the~~
362 ~~state population, including life expectancy, the incidence of~~
363 ~~various acute and chronic illnesses, and infant and maternal~~
364 ~~morbidity and mortality.~~

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365 ~~(b) The impact of illness and disability of the state~~
366 ~~population on the state economy and on other aspects of the~~
367 ~~well-being of the people in this state.~~
368 ~~(c) Environmental, social, and other health hazards.~~
369 ~~(d) Health knowledge and practices of the people in this~~
370 ~~state and determinants of health and nutritional practices and~~
371 ~~status.~~
372 (a)~~(e)~~ Health resources, including licensed ~~physicians,~~
373 ~~dentists, nurses, and other~~ health care practitioners
374 ~~professionals~~, by specialty and type of practice. Such data
375 shall include information collected by the Department of Health
376 pursuant to ss. 458.3191 and 459.0081.
377 (b) Health service inventories, including ~~and~~ acute care,
378 long-term care, and other institutional care facilities ~~facility~~
379 ~~supplies~~ and specific services provided by hospitals, nursing
380 homes, home health agencies, and other licensed health care
381 facilities.
382 (c)~~(f)~~ Service utilization for licensed ~~of~~ health care
383 facilities ~~by type of provider~~.
384 (d)~~(g)~~ Health care costs and financing, including trends
385 in health care prices and costs, the sources of payment for
386 health care services, and federal, state, and local expenditures
387 for health care.
388 ~~(h) Family formation, growth, and dissolution.~~
389 (e)~~(i)~~ The extent of public and private health insurance
390 coverage in this state.

391 (f) ~~(j)~~ Specific quality-of-care initiatives involving ~~The~~
392 ~~quality of care provided by~~ various health care providers when
393 extant data is not adequate to achieve the objectives of the
394 initiative.
395 (3) ~~COMPREHENSIVE~~ HEALTH INFORMATION TRANSPARENCY ~~SYSTEM~~.—
396 In order to disseminate and facilitate the availability of
397 ~~produce~~ comparable and uniform health information ~~and statistics~~
398 ~~for the development of policy recommendations~~, the agency shall
399 ~~perform the following functions~~:
400 (a) Collect and compile information on and coordinate the
401 activities of state agencies involved in providing ~~the design~~
402 ~~and implementation of the comprehensive~~ health information to
403 consumers ~~system~~.
404 (b) Promote data sharing through dissemination of state-
405 collected health data by making such data available,
406 transferable, and readily usable ~~Undertake research,~~
407 ~~development, and evaluation respecting the comprehensive health~~
408 ~~information system~~.
409 (c) Contract with a vendor to provide a consumer-friendly,
410 Internet-based platform that allows a consumer to research the
411 cost of health care services and procedures and allows for price
412 comparison. The Internet-based platform must allow a consumer to
413 search by condition or service bundles that are comprehensible
414 to an ordinary layperson and may not require registration, a
415 security password, or user identification. The vendor shall also
416 establish and maintain a Florida-specific data set of health

417 care claims information available to the public and any
418 interested party. The vendor must be a nonprofit research
419 institute that is qualified under s. 1874 of the Social Security
420 Act to receive Medicare claims data and that receives claims
421 data from multiple private insurers nationwide. The vendor must
422 have:
423 1. A national database consisting of at least 15 billion
424 claim lines of administrative claims data from multiple payors
425 capable of being expanded by adding third-party payors,
426 including employers with health plans covered by the Employee
427 Retirement Income Security Act of 1974 (ERISA).
428 2. A well-developed methodology for analyzing claims data
429 within defined service bundles.
430 3. A bundling methodology that is available in the public
431 domain to allow for consistency and comparison of state and
432 national benchmarks with local regions and specific providers.
433 (d) Design a patient safety culture survey or surveys to
434 be completed annually by each hospital and ambulatory surgical
435 center licensed under chapter 395. The survey or surveys shall
436 be anonymous to encourage staff employed by or working in the
437 facility to complete the survey. The survey or surveys shall be
438 designed to measure aspects of patient safety culture, including
439 frequency of adverse events, quality of handoffs and
440 transitions, comfort in reporting a potential problem or error,
441 the level of teamwork within hospital units and the facility as
442 a whole, staff compliance with patient safety regulations and

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443 guidelines, staff perception of facility support for patient
444 safety, and staff opinions on whether they would undergo a
445 health care service or procedure at the facility. The agency
446 shall review and analyze nationally recognized patient safety
447 culture survey products, including, but not limited to, the
448 patient safety surveys developed by the federal Agency for
449 Healthcare Research and Quality, to develop the patient safety
450 culture survey. This paragraph does not apply to licensed
451 facilities operating exclusively as state mental health
452 treatment facilities or as mobile surgical facilities.
453 ~~(c) Review the statistical activities of state agencies to~~
454 ~~ensure that they are consistent with the comprehensive health~~
455 ~~information system.~~
456 (e)~~(d)~~ Develop written agreements with local, state, and
457 federal agencies to facilitate ~~for~~ the sharing of data related
458 to health care ~~health-care-related data or using the facilities~~
459 ~~and services of such agencies. State agencies, local health~~
460 ~~councils, and other agencies under state contract shall assist~~
461 ~~the center in obtaining, compiling, and transferring health-~~
462 ~~care-related data maintained by state and local agencies.~~
463 ~~Written agreements must specify the types, methods, and~~
464 ~~periodicity of data exchanges and specify the types of data that~~
465 ~~will be transferred to the center~~.
466 (f)~~(e)~~ Establish by rule the types of data collected,
467 compiled, processed, used, or shared. ~~Decisions regarding center~~
468 ~~data sets should be made based on consultation with the State~~

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469 ~~Consumer Health Information and Policy Advisory Council and~~
470 ~~other public and private users regarding the types of data which~~
471 ~~should be collected and their uses. The center shall establish~~
472 ~~standardized means for collecting health information and~~
473 ~~statistics under laws and rules administered by the agency.~~
474 <u>(g) Consult with contracted vendors, the State Consumer</u>
475 <u>Health Information and Policy Advisory Council, and other public</u>
476 <u>and private users regarding the types of data that should be</u>
477 <u>collected and the use of such data.</u>
478 <u>(h) Monitor data collection procedures and test data</u>
479 <u>quality to facilitate the dissemination of data that is</u>
480 <u>accurate, valid, reliable, and complete.</u>
481 ~~(f) Establish minimum health-care-related data sets which~~
482 ~~are necessary on a continuing basis to fulfill the collection~~
483 ~~requirements of the center and which shall be used by state~~
484 ~~agencies in collecting and compiling health-care-related data.~~
485 ~~The agency shall periodically review ongoing health care data~~
486 ~~collections of the Department of Health and other state agencies~~
487 ~~to determine if the collections are being conducted in~~
488 ~~accordance with the established minimum sets of data.~~
489 ~~(g) Establish advisory standards to ensure the quality of~~
490 ~~health statistical and epidemiological data collection,~~
491 ~~processing, and analysis by local, state, and private~~
492 ~~organizations.~~
493 ~~(h) Prescribe standards for the publication of health-~~
494 ~~care-related data reported pursuant to this section which ensure~~

495 ~~the reporting of accurate, valid, reliable, complete, and~~
496 ~~comparable data. Such standards should include advisory warnings~~
497 ~~to users of the data regarding the status and quality of any~~
498 ~~data reported by or available from the center.~~
499 (i) Develop ~~Prescribe standards for the maintenance and~~
500 ~~preservation of the center's data. This should include~~ methods
501 for archiving data, retrieval of archived data, and data editing
502 and verification.
503 ~~(j) Ensure that strict quality control measures are~~
504 ~~maintained for the dissemination of data through publications,~~
505 ~~studies, or user requests.~~
506 (j)~~(k)~~ Make ~~Develop, in conjunction with the State~~
507 ~~Consumer Health Information and Policy Advisory Council, and~~
508 ~~implement a long-range plan for making~~ available health care
509 quality measures ~~and financial data~~ that will allow consumers to
510 compare outcomes and other performance measures for health care
511 services. ~~The health care quality measures and financial data~~
512 ~~the agency must make available include, but are not limited to,~~
513 ~~pharmaceuticals, physicians, health care facilities, and health~~
514 ~~plans and managed care entities. The agency shall update the~~
515 ~~plan and report on the status of its implementation annually.~~
516 ~~The agency shall also make the plan and status report available~~
517 ~~to the public on its Internet website. As part of the plan, the~~
518 ~~agency shall identify the process and timeframes for~~
519 ~~implementation, barriers to implementation, and recommendations~~
520 ~~of changes in the law that may be enacted by the Legislature to~~

521 ~~eliminate the barriers. As preliminary elements of the plan, the~~
522 ~~agency shall:~~
523 ~~1. Make available patient-safety indicators, inpatient~~
524 ~~quality indicators, and performance outcome and patient charge~~
525 ~~data collected from health care facilities pursuant to s.~~
526 ~~408.061(1)(a) and (2). The terms "patient-safety indicators" and~~
527 ~~"inpatient quality indicators" have the same meaning as that~~
528 ~~ascribed by the Centers for Medicare and Medicaid Services, an~~
529 ~~accrediting organization whose standards incorporate comparable~~
530 ~~regulations required by this state, or a national entity that~~
531 ~~establishes standards to measure the performance of health care~~
532 ~~providers, or by other states. The agency shall determine which~~
533 ~~conditions, procedures, health care quality measures, and~~
534 ~~patient charge data to disclose based upon input from the~~
535 ~~council. When determining which conditions and procedures are to~~
536 ~~be disclosed, the council and the agency shall consider~~
537 ~~variation in costs, variation in outcomes, and magnitude of~~
538 ~~variations and other relevant information. When determining~~
539 ~~which health care quality measures to disclose, the agency:~~
540 ~~a. Shall consider such factors as volume of cases; average~~
541 ~~patient charges; average length of stay; complication rates;~~
542 ~~mortality rates; and infection rates, among others, which shall~~
543 ~~be adjusted for case mix and severity, if applicable.~~
544 ~~b. May consider such additional measures that are adopted~~
545 ~~by the Centers for Medicare and Medicaid Studies, an accrediting~~
546 ~~organization whose standards incorporate comparable regulations~~

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547 ~~required by this state, the National Quality Forum, the Joint~~
548 ~~Commission on Accreditation of Healthcare Organizations, the~~
549 ~~Agency for Healthcare Research and Quality, the Centers for~~
550 ~~Disease Control and Prevention, or a similar national entity~~
551 ~~that establishes standards to measure the performance of health~~
552 ~~care providers, or by other states.~~
553
554 ~~When determining which patient charge data to disclose, the~~
555 ~~agency shall include such measures as the average of~~
556 ~~undiscounted charges on frequently performed procedures and~~
557 ~~preventive diagnostic procedures, the range of procedure charges~~
558 ~~from highest to lowest, average net revenue per adjusted patient~~
559 ~~day, average cost per adjusted patient day, and average cost per~~
560 ~~admission, among others.~~
561 ~~2. Make available performance measures, benefit design,~~
562 ~~and premium cost data from health plans licensed pursuant to~~
563 ~~chapter 627 or chapter 641. The agency shall determine which~~
564 ~~health care quality measures and member and subscriber cost data~~
565 ~~to disclose, based upon input from the council. When determining~~
566 ~~which data to disclose, the agency shall consider information~~
567 ~~that may be required by either individual or group purchasers to~~
568 ~~assess the value of the product, which may include membership~~
569 ~~satisfaction, quality of care, current enrollment or membership,~~
570 ~~coverage areas, accreditation status, premium costs, plan costs,~~
571 ~~premium increases, range of benefits, copayments and~~
572 ~~deductibles, accuracy and speed of claims payment, credentials~~

573 ~~of physicians, number of providers, names of network providers,~~
574 ~~and hospitals in the network. Health plans shall make available~~
575 ~~to the agency such data or information that is not currently~~
576 ~~reported to the agency or the office.~~
577 ~~3. Determine the method and format for public disclosure~~
578 ~~of data reported pursuant to this paragraph. The agency shall~~
579 ~~make its determination based upon input from the State Consumer~~
580 ~~Health Information and Policy Advisory Council. At a minimum,~~
581 ~~the data shall be made available on the agency's Internet~~
582 ~~website in a manner that allows consumers to conduct an~~
583 ~~interactive search that allows them to view and compare the~~
584 ~~information for specific providers. The website must include~~
585 ~~such additional information as is determined necessary to ensure~~
586 ~~that the website enhances informed decisionmaking among~~
587 ~~consumers and health care purchasers, which shall include, at a~~
588 ~~minimum, appropriate guidance on how to use the data and an~~
589 ~~explanation of why the data may vary from provider to provider.~~
590 ~~4. Publish on its website undiscounted charges for no~~
591 ~~fewer than 150 of the most commonly performed adult and~~
592 ~~pediatric procedures, including outpatient, inpatient,~~
593 ~~diagnostic, and preventative procedures.~~
594 ~~(4) TECHNICAL ASSISTANCE.—~~
595 ~~(a) The center shall provide technical assistance to~~
596 ~~persons or organizations engaged in health planning activities~~
597 ~~in the effective use of statistics collected and compiled by the~~
598 ~~center. The center shall also provide the following additional~~

599 ~~technical assistance services:~~
600 ~~1. Establish procedures identifying the circumstances~~
601 ~~under which, the places at which, the persons from whom, and the~~
602 ~~methods by which a person may secure data from the center,~~
603 ~~including procedures governing requests, the ordering of~~
604 ~~requests, timeframes for handling requests, and other procedures~~
605 ~~necessary to facilitate the use of the center's data. To the~~
606 ~~extent possible, the center should provide current data timely~~
607 ~~in response to requests from public or private agencies.~~
608 ~~2. Provide assistance to data sources and users in the~~
609 ~~areas of database design, survey design, sampling procedures,~~
610 ~~statistical interpretation, and data access to promote improved~~
611 ~~health-care-related data sets.~~
612 ~~3. Identify health care data gaps and provide technical~~
613 ~~assistance to other public or private organizations for meeting~~
614 ~~documented health care data needs.~~
615 ~~4. Assist other organizations in developing statistical~~
616 ~~abstracts of their data sets that could be used by the center.~~
617 ~~5. Provide statistical support to state agencies with~~
618 ~~regard to the use of databases maintained by the center.~~
619 ~~6. To the extent possible, respond to multiple requests~~
620 ~~for information not currently collected by the center or~~
621 ~~available from other sources by initiating data collection.~~
622 ~~7. Maintain detailed information on data maintained by~~
623 ~~other local, state, federal, and private agencies in order to~~
624 ~~advise those who use the center of potential sources of data~~

625 ~~which are requested but which are not available from the center.~~
626 ~~8. Respond to requests for data which are not available in~~
627 ~~published form by initiating special computer runs on data sets~~
628 ~~available to the center.~~
629 ~~9. Monitor innovations in health information technology,~~
630 ~~informatics, and the exchange of health information and maintain~~
631 ~~a repository of technical resources to support the development~~
632 ~~of a health information network.~~
633 ~~(b) The agency shall administer, manage, and monitor~~
634 ~~grants to not-for-profit organizations, regional health~~
635 ~~information organizations, public health departments, or state~~
636 ~~agencies that submit proposals for planning, implementation, or~~
637 ~~training projects to advance the development of a health~~
638 ~~information network. Any grant contract shall be evaluated to~~
639 ~~ensure the effective outcome of the health information project.~~
640 ~~(c) The agency shall initiate, oversee, manage, and~~
641 ~~evaluate the integration of health care data from each state~~
642 ~~agency that collects, stores, and reports on health care issues~~
643 ~~and make that data available to any health care practitioner~~
644 ~~through a state health information network.~~
645 ~~(5) PUBLICATIONS; REPORTS; SPECIAL STUDIES.—The center~~
646 ~~shall provide for the widespread dissemination of data which it~~
647 ~~collects and analyzes. The center shall have the following~~
648 ~~publication, reporting, and special study functions:~~
649 ~~(a) The center shall publish and make available~~
650 ~~periodically to agencies and individuals health statistics~~

651 ~~publications of general interest, including health plan consumer~~
652 ~~reports and health maintenance organization member satisfaction~~
653 ~~surveys; publications providing health statistics on topical~~
654 ~~health policy issues; publications that provide health status~~
655 ~~profiles of the people in this state; and other topical health~~
656 ~~statistics publications.~~
657 <u>(k)</u>~~(b) The center shall publish,~~ Make available~~, and~~
658 ~~disseminate, promptly and as widely as practicable,~~ the results
659 of special health surveys, <u>including facility patient safety</u>
660 <u>culture surveys,</u> health care research, and health care
661 evaluations conducted or supported under this section. ~~Any~~
662 ~~publication by the center must include a statement of the~~
663 ~~limitations on the quality, accuracy, and completeness of the~~
664 ~~data.~~
665 ~~(c) The center shall provide indexing, abstracting,~~
666 ~~translation, publication, and other services leading to a more~~
667 ~~effective and timely dissemination of health care statistics.~~
668 ~~(d) The center shall be responsible for publishing and~~
669 ~~disseminating an annual report on the center's activities.~~
670 ~~(e) The center shall be responsible, to the extent~~
671 ~~resources are available, for conducting a variety of special~~
672 ~~studies and surveys to expand the health care information and~~
673 ~~statistics available for health policy analyses, particularly~~
674 ~~for the review of public policy issues. The center shall develop~~
675 ~~a process by which users of the center's data are periodically~~
676 ~~surveyed regarding critical data needs and the results of the~~

677 ~~survey considered in determining which special surveys or~~
678 ~~studies will be conducted. The center shall select problems in~~
679 ~~health care for research, policy analyses, or special data~~
680 ~~collections on the basis of their local, regional, or state~~
681 ~~importance; the unique potential for definitive research on the~~
682 ~~problem; and opportunities for application of the study~~
683 ~~findings.~~
684 (4)~~(6)~~ PROVIDER DATA REPORTING.—This section does not
685 confer on the agency the power to demand or require that a
686 health care provider or professional furnish information,
687 records of interviews, written reports, statements, notes,
688 memoranda, or data other than as expressly required by law. The
689 agency may not establish an all-payor claims database or a
690 comparable database without express legislative authority.
691 (5)~~(7)~~ BUDGET; FEES.—
692 (a) The Legislature intends that funding for the Florida
693 Center for Health Information and Transparency ~~Policy Analysis~~
694 be appropriated from the General Revenue Fund.
695 (b) The Florida Center for Health Information and
696 Transparency ~~Policy Analysis~~ may apply for and receive and
697 accept grants, gifts, and other payments, including property and
698 services, from any governmental or other public or private
699 entity or person and make arrangements as to the use of same,
700 including the undertaking of special studies and other projects
701 relating to health-care-related topics. Funds obtained pursuant
702 to this paragraph may not be used to offset annual

703 appropriations from the General Revenue Fund.
704 (c) The center may charge such reasonable fees for
705 services as the agency prescribes by rule. The established fees
706 may not exceed the reasonable cost for such services. Fees
707 collected may not be used to offset annual appropriations from
708 the General Revenue Fund.
709 (6)~~(8)~~ STATE CONSUMER HEALTH INFORMATION AND POLICY
710 ADVISORY COUNCIL.—
711 (a) There is established in the agency the State Consumer
712 Health Information and Policy Advisory Council to assist the
713 center ~~in reviewing the comprehensive health information system,~~
714 ~~including the identification, collection, standardization,~~
715 ~~sharing, and coordination of health-related data, fraud and~~
716 ~~abuse data, and professional and facility licensing data among~~
717 ~~federal, state, local, and private entities and to recommend~~
718 ~~improvements for purposes of public health, policy analysis, and~~
719 ~~transparency of consumer health care information~~. The council
720 shall consist of the following members:
721 1. An employee of the Executive Office of the Governor, to
722 be appointed by the Governor.
723 2. An employee of the Office of Insurance Regulation, to
724 be appointed by the director of the office.
725 3. An employee of the Department of Education, to be
726 appointed by the Commissioner of Education.
727 4. Ten persons, to be appointed by the Secretary of Health
728 Care Administration, representing other state and local

729 agencies, state universities, business and health coalitions,
730 local health councils, professional health-care-related
731 associations, consumers, and purchasers.
732 (b) Each member of the council shall be appointed to serve
733 for a term of 2 years following the date of appointment~~, except~~
734 ~~the term of appointment shall end 3 years following the date of~~
735 ~~appointment for members appointed in 2003, 2004, and 2005~~. A
736 vacancy shall be filled by appointment for the remainder of the
737 term, and each appointing authority retains the right to
738 reappoint members whose terms of appointment have expired.
739 (c) The council may meet at the call of its chair, at the
740 request of the agency, or at the request of a majority of its
741 membership, but the council must meet at least quarterly.
742 (d) Members shall elect a chair and vice chair annually.
743 (e) A majority of the members constitutes a quorum, and
744 the affirmative vote of a majority of a quorum is necessary to
745 take action.
746 (f) The council shall maintain minutes of each meeting and
747 shall make such minutes available to any person.
748 (g) Members of the council shall serve without
749 compensation but shall be entitled to receive reimbursement for
750 per diem and travel expenses as provided in s. 112.061.
751 (h) The council's duties and responsibilities include, but
752 are not limited to, the following:
753 1. To develop a mission statement, goals, and a plan of
754 action for the identification, collection, standardization,

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755 sharing, and coordination of health-related data across federal,
756 state, and local government and private sector entities.
757 2. To develop a review process to ensure cooperative
758 planning among agencies that collect or maintain health-related
759 data.
760 3. To create ad hoc issue-oriented technical workgroups on
761 an as-needed basis to make recommendations to the council.
762 (7)~~(9)~~ APPLICATION TO OTHER AGENCIES.—~~Nothing in~~ This
763 section does not ~~shall~~ limit, restrict, affect, or control the
764 collection, analysis, release, or publication of data by any
765 state agency pursuant to its statutory authority, duties, or
766 responsibilities.
767 Section 3. Subsection (1) of section 408.061, Florida
768 Statutes, is amended to read:
769 408.061 Data collection; uniform systems of financial
770 reporting; information relating to physician charges;
771 confidential information; immunity.—
772 (1) The agency shall require the submission by health care
773 facilities, health care providers, and health insurers of data
774 necessary to carry out the agency's duties and to facilitate
775 transparency in health care pricing data and quality measures.
776 Specifications for data to be collected under this section shall
777 be developed by the agency and applicable contract vendors, with
778 the assistance of technical advisory panels including
779 representatives of affected entities, consumers, purchasers, and
780 such other interested parties as may be determined by the

781 agency.
782 (a) Data submitted by health care facilities, including
783 the facilities as defined in chapter 395, shall include, but are
784 not limited to: case-mix data, patient admission and discharge
785 data, hospital emergency department data which shall include the
786 number of patients treated in the emergency department of a
787 licensed hospital reported by patient acuity level, data on
788 hospital-acquired infections as specified by rule, data on
789 complications as specified by rule, data on readmissions as
790 specified by rule, with patient and provider-specific
791 identifiers included, actual charge data by diagnostic groups or
792 other bundled groupings as specified by rule, facility patient
793 safety culture surveys, financial data, accounting data,
794 operating expenses, expenses incurred for rendering services to
795 patients who cannot or do not pay, interest charges,
796 depreciation expenses based on the expected useful life of the
797 property and equipment involved, and demographic data. The
798 agency shall adopt nationally recognized risk adjustment
799 methodologies or software consistent with the standards of the
800 Agency for Healthcare Research and Quality and as selected by
801 the agency for all data submitted as required by this section.
802 Data may be obtained from documents such as, but not limited to:
803 leases, contracts, debt instruments, itemized patient statements
804 or bills, medical record abstracts, and related diagnostic
805 information. Reported data elements shall be reported
806 electronically in accordance with rule 59E-7.012, Florida

807 Administrative Code. Data submitted shall be certified by the
808 chief executive officer or an appropriate and duly authorized
809 representative or employee of the licensed facility that the
810 information submitted is true and accurate.
811 (b) Data to be submitted by health care providers may
812 include, but are not limited to: professional organization and
813 specialty board affiliations, Medicare and Medicaid
814 participation, types of services offered to patients, actual
815 charges to patients as specified by rule, amount of revenue and
816 expenses of the health care provider, and such other data which
817 are reasonably necessary to study utilization patterns. Data
818 submitted shall be certified by the appropriate duly authorized
819 representative or employee of the health care provider that the
820 information submitted is true and accurate.
821 (c) Data to be submitted by health insurers may include,
822 but are not limited to: claims, payments to health care
823 facilities and health care providers as specified by rule,
824 premium, administration, and financial information. Data
825 submitted shall be certified by the chief financial officer, an
826 appropriate and duly authorized representative, or an employee
827 of the insurer that the information submitted is true and
828 accurate.
829 (d) Data required to be submitted by health care
830 facilities, health care providers, or health insurers may ~~shall~~
831 not include specific provider contract reimbursement
832 information. However, such specific provider reimbursement data

833 shall be reasonably available for onsite inspection by the
834 agency as is necessary to carry out the agency's regulatory
835 duties. Any such data obtained by the agency as a result of
836 onsite inspections may not be used by the state for purposes of
837 direct provider contracting and are confidential and exempt from
838 ~~the provisions of~~ s. 119.07(1) and s. 24(a), Art. I of the State
839 Constitution.

840 (e) A requirement to submit data shall be adopted by rule
841 if the submission of data is being required of all members of
842 any type of health care facility, health care provider, or
843 health insurer. Rules are not required, however, for the
844 submission of data for a special study mandated by the
845 Legislature or when information is being requested for a single
846 health care facility, health care provider, or health insurer.

847 Section 4. Subsections (8), (9), and (10) of section
848 408.810, Florida Statutes, are renumbered as subsections (9),
849 (10), and (11), respectively, and a new subsection (8) is added
850 to that section to read:

851 408.810 Minimum licensure requirements.—In addition to the
852 licensure requirements specified in this part, authorizing
853 statutes, and applicable rules, each applicant and licensee must
854 comply with ~~the requirements of~~ this section in order to obtain
855 and maintain a license.

856 <u>(8) Each licensee subject to s. 408.05(3)(d) shall submit</u>
857 <u>the patient safety culture survey or surveys to the agency in</u>
858 <u>accordance with applicable rules.</u>

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859 Section 5. Section 456.0575, Florida Statutes, is amended
860 to read:
861 456.0575 Duty to notify patients.—
862 (1) Every licensed health care practitioner shall inform
863 each patient, or an individual identified pursuant to s.
864 765.401(1), in person about adverse incidents that result in
865 serious harm to the patient. Notification of outcomes of care
866 that result in harm to the patient under this section does ~~shall~~
867 not constitute an acknowledgment of admission of liability, nor
868 can such notifications be introduced as evidence.
869 (2) Every licensed health care practitioner shall provide
870 upon request by a patient, before providing any nonemergency
871 medical services in a facility licensed under chapter 395, a
872 written, good faith estimate of reasonably anticipated charges
873 to treat the patient's condition at the facility. The health
874 care practitioner must provide the estimate to the patient
875 within 3 business days after receiving the request and is not
876 required to adjust the estimate for any potential insurance
877 coverage. The health care practitioner must inform the patient
878 that he or she may contact his or her health insurer or health
879 maintenance organization for additional information concerning
880 cost-sharing responsibilities. The health care practitioner must
881 provide information to uninsured patients and insured patients
882 for whom the practitioner is not a network provider or preferred
883 provider which discloses the practitioner's financial assistance
884 policy, including the application process, payment plans,

885 discounts, or other available assistance, and the practitioner's
886 charity care policy and collection procedures. Such estimate
887 does not preclude the actual charges from exceeding the
888 estimate. Failure to provide the estimate in accordance with
889 this subsection shall result in disciplinary action against the
890 health care practitioner and a daily fine of $500 until the
891 estimate is provided to the patient. The total fine may not
892 exceed $5,000.
893 Section 6. Section 627.6385, Florida Statutes, is created
894 to read:
895 627.6385 Disclosures to policyholders; calculations of
896 cost sharing.—
897 (1) Each health insurer shall make available on its
898 website:
899 (a) A method for policyholders to estimate their
900 copayments, deductibles, and other cost-sharing responsibilities
901 for health care services and procedures. Such method of making
902 an estimate shall be based on service bundles established
903 pursuant to s. 408.05(3)(c). Estimates do not preclude the
904 actual copayment, coinsurance percentage, or deductible,
905 whichever is applicable, from exceeding the estimate.
906 1. Estimates shall be calculated according to the policy
907 and known plan usage during the coverage period.
908 2. Estimates shall be made available based on providers
909 that are in-network and out-of-network.
910 3. A policyholder must be able to create estimates by any

911 combination of the service bundles established pursuant to s.
912 408.05(3)(c), a specified provider, or a comparison of
913 providers.
914 (b) A method for policyholders to estimate their
915 copayments, deductibles, and other cost-sharing responsibilities
916 based on a personalized estimate of charges received from a
917 facility pursuant to s. 395.301 or a practitioner pursuant to s.
918 456.0575.
919 (c) A hyperlink to the health information, including, but
920 not limited to, service bundles and quality of care information,
921 which is disseminated by the Agency for Health Care
922 Administration pursuant to s. 408.05(3).
923 (2) Each health insurer shall include in every policy
924 delivered or issued for delivery to any person in the state or
925 in materials provided as required by s. 627.64725 notice that
926 the information required by this section is available
927 electronically and the address of its website.
928 (3) Each health insurer that participates in the state
929 group health insurance plan created under s. 110.123 or Medicaid
930 managed care pursuant to part IV of chapter 409 shall contribute
931 all claims data from Florida policyholders to the contracted
932 vendor selected by the Agency for Health Care Administration
933 under s. 408.05(3)(c).
934 Section 7. Subsection (6) of section 641.54, Florida
935 Statutes, is amended, present subsection (7) is renumbered as
936 subsection (8) and amended, and a new subsection (7) is added to

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937 that section, to read:
938 641.54 Information disclosure.—
939 (6) Each health maintenance organization shall make
940 available to its subscribers on its website or by request the
941 estimated copayment ~~copay~~, coinsurance percentage, or
942 deductible, whichever is applicable, for any covered services as
943 described by the searchable bundles established on a consumer-
944 friendly, Internet-based platform pursuant to s. 408.05(3)(c) or
945 as described by a personalized estimate received from a facility
946 pursuant to s. 395.301 or a practitioner pursuant to s.
947 456.0575, the status of the subscriber's maximum annual out-of-
948 pocket payments for a covered individual or family, and the
949 status of the subscriber's maximum lifetime benefit. Such
950 estimate does ~~shall~~ not preclude the actual copayment ~~copay~~,
951 coinsurance percentage, or deductible, whichever is applicable,
952 from exceeding the estimate.
953 (7) Each health maintenance organization that participates
954 in the state group health insurance plan created under s.
955 110.123 or Medicaid managed care pursuant to part IV of chapter
956 409 shall contribute all claims data from Florida subscribers to
957 the contracted vendor selected by the Agency for Health Care
958 Administration under s. 408.05(3)(c).
959 (8)~~(7)~~ Each health maintenance organization shall make
960 available on its ~~Internet~~ website a hyperlink ~~link~~ to the health
961 information ~~performance outcome and financial data~~ that is
962 disseminated ~~published~~ by the Agency for Health Care

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963 Administration pursuant to s. 408.05(3) ~~408.05(3)(k)~~ and shall
964 include in every policy delivered or issued for delivery to any
965 person in the state or in ~~any~~ materials provided as required by
966 s. 627.64725 notice that such information is available
967 electronically and the address of its ~~Internet~~ website.
968 Section 8. Paragraph (n) is added to subsection (2) of
969 section 409.967, Florida Statutes, to read:
970 409.967 Managed care plan accountability.—
971 (2) The agency shall establish such contract requirements
972 as are necessary for the operation of the statewide managed care
973 program. In addition to any other provisions the agency may deem
974 necessary, the contract must require:
975 (n) Transparency.—Managed care plans shall comply with ss.
976 627.6385(3) and 641.54(7).
977 Section 9. Paragraph (d) of subsection (3) of section
978 110.123, Florida Statutes, is amended to read:
979 110.123 State group insurance program.—
980 (3) STATE GROUP INSURANCE PROGRAM.—
981 (d)1. Notwithstanding ~~the provisions of~~ chapter 287 and
982 the authority of the department, for the purpose of protecting
983 the health of, and providing medical services to, state
984 employees participating in the state group insurance program,
985 the department may contract to retain the services of
986 professional administrators for the state group insurance
987 program. The agency shall follow good purchasing practices of
988 state procurement to the extent practicable under the

989 circumstances.
990 2. Each vendor in a major procurement, and any other
991 vendor if the department deems it necessary to protect the
992 state's financial interests, shall, at the time of executing any
993 contract with the department, post an appropriate bond with the
994 department in an amount determined by the department to be
995 adequate to protect the state's interests but not higher than
996 the full amount estimated to be paid annually to the vendor
997 under the contract.
998 3. Each major contract entered into by the department
999 pursuant to this section shall contain a provision for payment
1000 of liquidated damages to the department for material
1001 noncompliance by a vendor with a contract provision. The
1002 department may require a liquidated damages provision in any
1003 contract if the department deems it necessary to protect the
1004 state's financial interests.
1005 4. Section ~~The provisions of s.~~ 120.57(3) applies ~~apply~~ to
1006 the department's contracting process, except:
1007 a. A formal written protest of any decision, intended
1008 decision, or other action subject to protest shall be filed
1009 within 72 hours after receipt of notice of the decision,
1010 intended decision, or other action.
1011 b. As an alternative to any provision of s. 120.57(3), the
1012 department may proceed with the bid selection or contract award
1013 process if the director of the department sets forth, in
1014 writing, particular facts and circumstances that ~~which~~

1015 demonstrate the necessity of continuing the procurement process
1016 or the contract award process in order to avoid a substantial
1017 disruption to the provision of any scheduled insurance services.
1018 5. The department shall make arrangements as necessary to
1019 contribute claims data of the state group health insurance plan
1020 to the contracted vendor selected by the Agency for Health Care
1021 Administration pursuant to s. 408.05(3)(c).
1022 6. Each contracted vendor for the state group health
1023 insurance plan shall contribute Florida claims data to the
1024 contracted vendor selected by the Agency for Health Care
1025 Administration pursuant to s. 408.05(3)(c).
1026 Section 10. Subsection (3) of section 20.42, Florida
1027 Statutes, is amended to read:
1028 20.42 Agency for Health Care Administration.—
1029 (3) The department shall be the chief health policy and
1030 planning entity for the state. The department is responsible for
1031 health facility licensure, inspection, and regulatory
1032 enforcement; investigation of consumer complaints related to
1033 health care facilities and managed care plans; the
1034 implementation of the certificate of need program; the operation
1035 of the Florida Center for Health Information and Transparency
1036 ~~Policy Analysis~~; the administration of the Medicaid program; the
1037 administration of the contracts with the Florida Healthy Kids
1038 Corporation; the certification of health maintenance
1039 organizations and prepaid health clinics as set forth in part
1040 III of chapter 641; and any other duties prescribed by statute

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1041 or agreement.
1042 Section 11. Paragraph (c) of subsection (4) of section
1043 381.026, Florida Statutes, is amended to read:
1044 381.026 Florida Patient's Bill of Rights and
1045 Responsibilities.—
1046 (4) RIGHTS OF PATIENTS.—Each health care facility or
1047 provider shall observe the following standards:
1048 (c) Financial information and disclosure.—
1049 1. A patient has the right to be given, upon request, by
1050 the responsible provider, his or her designee, or a
1051 representative of the health care facility full information and
1052 necessary counseling on the availability of known financial
1053 resources for the patient's health care.
1054 2. A health care provider or a health care facility shall,
1055 upon request, disclose to each patient who is eligible for
1056 Medicare, before treatment, whether the health care provider or
1057 the health care facility in which the patient is receiving
1058 medical services accepts assignment under Medicare reimbursement
1059 as payment in full for medical services and treatment rendered
1060 in the health care provider's office or health care facility.
1061 3. A primary care provider may publish a schedule of
1062 charges for the medical services that the provider offers to
1063 patients. The schedule must include the prices charged to an
1064 uninsured person paying for such services by cash, check, credit
1065 card, or debit card. The schedule must be posted in a
1066 conspicuous place in the reception area of the provider's office

1067 and must include, but is not limited to, the 50 services most
1068 frequently provided by the primary care provider. The schedule
1069 may group services by three price levels, listing services in
1070 each price level. The posting must be at least 15 square feet in
1071 size. A primary care provider who publishes and maintains a
1072 schedule of charges for medical services is exempt from the
1073 license fee requirements for a single period of renewal of a
1074 professional license under chapter 456 for that licensure term
1075 and is exempt from the continuing education requirements of
1076 chapter 456 and the rules implementing those requirements for a
1077 single 2-year period.
1078 4. If a primary care provider publishes a schedule of
1079 charges pursuant to subparagraph 3., he or she must continually
1080 post it at all times for the duration of active licensure in
1081 this state when primary care services are provided to patients.
1082 If a primary care provider fails to post the schedule of charges
1083 in accordance with this subparagraph, the provider shall be
1084 required to pay any license fee and comply with any continuing
1085 education requirements for which an exemption was received.
1086 5. A health care provider or a health care facility shall,
1087 upon request, furnish a person, before the provision of medical
1088 services, a reasonable estimate of charges for such services.
1089 The health care provider or the health care facility shall
1090 provide an uninsured person, before the provision of a planned
1091 nonemergency medical service, a reasonable estimate of charges
1092 for such service and information regarding the provider's or

1093 facility's discount or charity policies for which the uninsured
1094 person may be eligible. Such estimates by a primary care
1095 provider must be consistent with the schedule posted under
1096 subparagraph 3. Estimates shall, to the extent possible, be
1097 written in language comprehensible to an ordinary layperson.
1098 Such reasonable estimate does not preclude the health care
1099 provider or health care facility from exceeding the estimate or
1100 making additional charges based on changes in the patient's
1101 condition or treatment needs.
1102 6. Each licensed facility, except a facility operating
1103 exclusively as a state mental health treatment facility or as a
1104 mobile surgical facility, ~~not operated by the state~~ shall make
1105 available to the public on its ~~Internet~~ website or by other
1106 electronic means a description of and a hyperlink ~~link~~ to the
1107 health information ~~performance outcome and financial data~~ that
1108 is disseminated ~~published~~ by the agency pursuant to s. 408.05(3)
1109 ~~408.05(3)(k)~~. The facility shall place a notice in the reception
1110 area that such information is available electronically and the
1111 website address. The licensed facility may indicate that the
1112 pricing information is based on a compilation of charges for the
1113 average patient and that each patient's statement or bill may
1114 vary from the average depending upon the severity of illness and
1115 individual resources consumed. The licensed facility may also
1116 indicate that the price of service is negotiable for eligible
1117 patients based upon the patient's ability to pay.
1118 7. A patient has the right to receive a copy of an

1119 itemized statement or bill upon request. A patient has a right
1120 to be given an explanation of charges upon request.
1121 Section 12. Paragraph (e) of subsection (2) of section
1122 395.602, Florida Statutes, is amended to read:
1123 395.602 Rural hospitals.—
1124 (2) DEFINITIONS.—As used in this part, the term:
1125 (e) "Rural hospital" means an acute care hospital licensed
1126 under this chapter, having 100 or fewer licensed beds and an
1127 emergency room, which is:
1128 1. The sole provider within a county with a population
1129 density of up to 100 persons per square mile;
1130 2. An acute care hospital, in a county with a population
1131 density of up to 100 persons per square mile, which is at least
1132 30 minutes of travel time, on normally traveled roads under
1133 normal traffic conditions, from any other acute care hospital
1134 within the same county;
1135 3. A hospital supported by a tax district or subdistrict
1136 whose boundaries encompass a population of up to 100 persons per
1137 square mile;
1138 4. A hospital with a service area that has a population of
1139 up to 100 persons per square mile. As used in this subparagraph,
1140 the term "service area" means the fewest number of zip codes
1141 that account for 75 percent of the hospital's discharges for the
1142 most recent 5-year period, based on information available from
1143 the hospital inpatient discharge database in the Florida Center
1144 for Health Information and Transparency ~~Policy Analysis~~ at the

1145 agency; or
1146 5. A hospital designated as a critical access hospital, as
1147 defined in s. 408.07.
1148
1149 Population densities used in this paragraph must be based upon
1150 the most recently completed United States census. A hospital
1151 that received funds under s. 409.9116 for a quarter beginning no
1152 later than July 1, 2002, is deemed to have been and shall
1153 continue to be a rural hospital from that date through June 30,
1154 2021, if the hospital continues to have up to 100 licensed beds
1155 and an emergency room. An acute care hospital that has not
1156 previously been designated as a rural hospital and that meets
1157 the criteria of this paragraph shall be granted such designation
1158 upon application, including supporting documentation, to the
1159 agency. A hospital that was licensed as a rural hospital during
1160 the 2010-2011 or 2011-2012 fiscal year shall continue to be a
1161 rural hospital from the date of designation through June 30,
1162 2021, if the hospital continues to have up to 100 licensed beds
1163 and an emergency room.
1164 Section 13. Section 395.6025, Florida Statutes, is amended
1165 to read:
1166 395.6025 Rural hospital replacement facilities.—
1167 Notwithstanding ~~the provisions of~~ s. 408.036, a hospital defined
1168 as a statutory rural hospital in accordance with s. 395.602, or
1169 a not-for-profit operator of rural hospitals, is not required to
1170 obtain a certificate of need for the construction of a new

1171 hospital located in a county with a population of at least
1172 15,000 but no more than 18,000 and a density of <u>fewer</u> ~~less~~ than
1173 30 persons per square mile, or a replacement facility, provided
1174 that the replacement, or new, facility is located within 10
1175 miles of the site of the currently licensed rural hospital and
1176 within the current primary service area. As used in this
1177 section, the term "service area" means the fewest number of zip
1178 codes that account for 75 percent of the hospital's discharges
1179 for the most recent 5-year period, based on information
1180 available from the hospital inpatient discharge database in the
1181 Florida Center for Health Information and <u>Transparency</u> ~~Policy~~
1182 ~~Analysis~~ at the Agency for Health Care Administration.
1183 Section 14. Paragraph (c) of subsection (4) of section
1184 400.991, Florida Statutes, is amended to read:
1185 400.991 License requirements; background screenings;
1186 prohibitions.—
1187 (4) In addition to the requirements of part II of chapter
1188 408, the applicant must file with the application satisfactory
1189 proof that the clinic is in compliance with this part and
1190 applicable rules, including:
1191 (c) Proof of financial ability to operate as required
1192 under s. <u>408.810(9)</u> ~~408.810(8)~~. As an alternative to submitting
1193 proof of financial ability to operate as required under s.
1194 408.810(8), the applicant may file a surety bond of at least
1195 $500,000 which guarantees that the clinic will act in full
1196 conformity with all legal requirements for operating a clinic,

1197 payable to the agency. The agency may adopt rules to specify
1198 related requirements for such surety bond.
1199 Section 15. Paragraph (d) of subsection (43) of section
1200 408.07, Florida Statutes, is amended to read:
1201 408.07 Definitions.—As used in this chapter, with the
1202 exception of ss. 408.031-408.045, the term:
1203 (43) "Rural hospital" means an acute care hospital
1204 licensed under chapter 395, having 100 or fewer licensed beds
1205 and an emergency room, and which is:
1206 (d) A hospital with a service area that has a population
1207 of 100 persons or fewer per square mile. As used in this
1208 paragraph, the term "service area" means the fewest number of
1209 zip codes that account for 75 percent of the hospital's
1210 discharges for the most recent 5-year period, based on
1211 information available from the hospital inpatient discharge
1212 database in the Florida Center for Health Information and
1213 Transparency ~~Policy Analysis~~ at the Agency for Health Care
1214 Administration; or
1215
1216 Population densities used in this subsection must be based upon
1217 the most recently completed United States census. A hospital
1218 that received funds under s. 409.9116 for a quarter beginning no
1219 later than July 1, 2002, is deemed to have been and shall
1220 continue to be a rural hospital from that date through June 30,
1221 2015, if the hospital continues to have 100 or fewer licensed
1222 beds and an emergency room. An acute care hospital that has not

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1223 previously been designated as a rural hospital and that meets
1224 the criteria of this subsection shall be granted such
1225 designation upon application, including supporting
1226 documentation, to the Agency for Health Care Administration.
1227 Section 16. Paragraph (a) of subsection (4) of section
1228 408.18, Florida Statutes, is amended to read:
1229 408.18 Health Care Community Antitrust Guidance Act;
1230 antitrust no-action letter; market-information collection and
1231 education.—
1232 (4)(a) Members of the health care community who seek
1233 antitrust guidance may request a review of their proposed
1234 business activity by the Attorney General's office. In
1235 conducting its review, the Attorney General's office may seek
1236 whatever documentation, data, or other material it deems
1237 necessary from the Agency for Health Care Administration, the
1238 Florida Center for Health Information and <u>Transparency</u> ~~Policy~~
1239 ~~Analysis~~, and the Office of Insurance Regulation of the
1240 Financial Services Commission.
1241 Section 17. Paragraph (a) of subsection (1) of section
1242 408.8065, Florida Statutes, is amended to read:
1243 408.8065 Additional licensure requirements for home health
1244 agencies, home medical equipment providers, and health care
1245 clinics.—
1246 (1) An applicant for initial licensure, or initial
1247 licensure due to a change of ownership, as a home health agency,
1248 home medical equipment provider, or health care clinic shall:

1249 (a) Demonstrate financial ability to operate, as required
1250 under s. 408.810(9) ~~408.810(8)~~ and this section. If the
1251 applicant's assets, credit, and projected revenues meet or
1252 exceed projected liabilities and expenses, and the applicant
1253 provides independent evidence that the funds necessary for
1254 startup costs, working capital, and contingency financing exist
1255 and will be available as needed, the applicant has demonstrated
1256 the financial ability to operate.
1257
1258 All documents required under this subsection must be prepared in
1259 accordance with generally accepted accounting principles and may
1260 be in a compilation form. The financial statements must be
1261 signed by a certified public accountant.
1262 Section 18. Section 408.820, Florida Statutes, is amended
1263 to read:
1264 408.820 Exemptions.—Except as prescribed in authorizing
1265 statutes, the following exemptions shall apply to specified
1266 requirements of this part:
1267 (1) Laboratories authorized to perform testing under the
1268 Drug-Free Workplace Act, as provided under ss. 112.0455 and
1269 440.102, are exempt from s. 408.810(5)-(11) ~~408.810(5)-(10)~~.
1270 (2) Birth centers, as provided under chapter 383, are
1271 exempt from s. 408.810(7)-(11) ~~408.810(7)-(10)~~.
1272 (3) Abortion clinics, as provided under chapter 390, are
1273 exempt from s. 408.810(7)-(11) ~~408.810(7)-(10)~~.
1274 (4) Crisis stabilization units, as provided under parts I

1275 and IV of chapter 394, are exempt from s. 408.810(9)-(11)
1276 ~~408.810(8)-(10)~~.
1277 (5) Short-term residential treatment facilities, as
1278 provided under parts I and IV of chapter 394, are exempt from s.
1279 408.810(9)-(11) ~~408.810(8)-(10)~~.
1280 (6) Residential treatment facilities, as provided under
1281 part IV of chapter 394, are exempt from s. 408.810(9)-(11)
1282 ~~408.810(8)-(10)~~.
1283 (7) Residential treatment centers for children and
1284 adolescents, as provided under part IV of chapter 394, are
1285 exempt from s. 408.810(9)-(11) ~~408.810(8)-(10)~~.
1286 (8) Hospitals, as provided under part I of chapter 395,
1287 are exempt from s. 408.810(7), (9), and (10) ~~408.810(7)-(9)~~.
1288 (9) Ambulatory surgical centers, as provided under part I
1289 of chapter 395, are exempt from s. 408.810(7), (9), (10), and
1290 (11) ~~408.810(7)-(10)~~.
1291 (10) Mobile surgical facilities, as provided under part I
1292 of chapter 395, are exempt from s. 408.810(7)-(11) ~~408.810(7)-~~
1293 ~~(10)~~.
1294 (11) Health care risk managers, as provided under part I
1295 of chapter 395, are exempt from ss. 408.806(7), 408.810(4)-(11)
1296 ~~408.810(4)-(10)~~, and 408.811.
1297 (12) Nursing homes, as provided under part II of chapter
1298 400, are exempt from ss. 408.810(7) and 408.813(2).
1299 (13) Assisted living facilities, as provided under part I
1300 of chapter 429, are exempt from s. 408.810(11) ~~408.810(10)~~.

1301 (14) Home health agencies, as provided under part III of
1302 chapter 400, are exempt from s. 408.810(11) ~~408.810(10)~~.
1303 (15) Nurse registries, as provided under part III of
1304 chapter 400, are exempt from s. 408.810(6) and (11) ~~(10)~~.
1305 (16) Companion services or homemaker services providers,
1306 as provided under part III of chapter 400, are exempt from s.
1307 408.810(6)-(11) ~~408.810(6)-(10)~~.
1308 (17) Adult day care centers, as provided under part III of
1309 chapter 429, are exempt from s. 408.810(11) ~~408.810(10)~~.
1310 (18) Adult family-care homes, as provided under part II of
1311 chapter 429, are exempt from s. 408.810(7)-(11) ~~408.810(7)-(10)~~.
1312 (19) Homes for special services, as provided under part V
1313 of chapter 400, are exempt from s. 408.810(7)-(11) ~~408.810(7)-~~
1314 ~~(10)~~.
1315 (20) Transitional living facilities, as provided under
1316 part XI of chapter 400, are exempt from s. 408.810(11)
1317 ~~408.810(10)~~.
1318 (21) Prescribed pediatric extended care centers, as
1319 provided under part VI of chapter 400, are exempt from s.
1320 408.810(11) ~~408.810(10)~~.
1321 (22) Home medical equipment providers, as provided under
1322 part VII of chapter 400, are exempt from s. 408.810(11)
1323 ~~408.810(10)~~.
1324 (23) Intermediate care facilities for persons with
1325 developmental disabilities, as provided under part VIII of
1326 chapter 400, are exempt from s. 408.810(7).

1327 (24) Health care services pools, as provided under part IX
1328 of chapter 400, are exempt from s. 408.810(6)-(11) ~~408.810(6)-~~
1329 ~~(10)~~.
1330 (25) Health care clinics, as provided under part X of
1331 chapter 400, are exempt from s. 408.810(6), (7), and (11) ~~(10)~~.
1332 (26) Clinical laboratories, as provided under part I of
1333 chapter 483, are exempt from s. 408.810(5)-(11) ~~408.810(5)-(10)~~.
1334 (27) Multiphasic health testing centers, as provided under
1335 part II of chapter 483, are exempt from s. 408.810(5)-(11)
1336 ~~408.810(5)-(10)~~.
1337 (28) Organ, tissue, and eye procurement organizations, as
1338 provided under part V of chapter 765, are exempt from s.
1339 408.810(5)-(11) ~~408.810(5)-(10)~~.
1340 Section 19. Section 465.0244, Florida Statutes, is amended
1341 to read:
1342 465.0244 Information disclosure.—Every pharmacy shall make
1343 available on its ~~Internet~~ website a hyperlink ~~link~~ to the health
1344 information ~~performance outcome and financial data~~ that is
1345 disseminated ~~published~~ by the Agency for Health Care
1346 Administration pursuant to s. 408.05(3) ~~408.05(3)(k)~~ and shall
1347 place in the area where customers receive filled prescriptions
1348 notice that such information is available electronically and the
1349 address of its ~~Internet~~ website.
1350 Section 20. Subsection (2) of section 627.6499, Florida
1351 Statutes, is amended to read:
1352 627.6499 Reporting by insurers and third-party

1353 administrators.—
1354 (2) Each health insurance issuer shall make available on
1355 its Internet website a <u>hyperlink</u> ~~link~~ to the <u>health information</u>
1356 ~~performance outcome and financial data~~ that is <u>disseminated</u>
1357 ~~published~~ by the Agency for Health Care Administration pursuant
1358 to s. <u>408.05(3)</u> ~~408.05(3)(k)~~ and shall include in every policy
1359 delivered or issued for delivery to any person in the state or
1360 <u>in</u> ~~any~~ materials provided as required by s. 627.64725 notice
1361 that such information is available electronically and the
1362 address of its ~~Internet~~ website.
1363 Section 21. This act shall take effect July 1, 2016.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCB SCAHA 16-01 Telehealth
SPONSOR(S): Select Committee on Affordable Healthcare Access
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Select Committee on Affordable Healthcare Access		McElroy LM	Calamas EC

SUMMARY ANALYSIS

PCB SCAHA 16-01 creates s. 456.47, F.S., relating to the use of telehealth to provide health care services.

The bill authorizes Florida licensed health care professionals to use telehealth to deliver health care services within their respective scopes of practice. The bill also authorizes out-of-state health care professionals to use telehealth to deliver health care services to Florida patients if they register with the Department of Health (DOH) or the applicable board, meet certain eligibility requirements, and pay a fee. A registered telehealth provider may use telehealth, within the relevant scope of practice established by Florida law and rule, to provide health care services to Florida patients, but is prohibited from opening an office in Florida and from providing in-person health care services to patients located in Florida.

The bill requires a telehealth provider to use the same standard of care applicable to health care services provided in-person. Additionally, the telehealth provider must conduct an in-person physical examination of the patient prior to providing services through telehealth, unless the telehealth provider is capable of conducting a patient evaluation in a manner consistent with the applicable standard of care sufficient to diagnose and treat the patient when using telehealth.

The bill places no service location limitations on health care professionals or patients. Specifically, both the telehealth provider and the patient may be in any location at the time the services are rendered.

The bill allows health care providers who are authorized to prescribe a controlled substance to use telehealth to do so. Telehealth may not be used to prescribe a controlled substance to treat chronic nonmalignant pain, except in certain limited circumstances.

The bill requires a telehealth provider to document the services rendered in the patient's medical records according to the same standard as that required for in-person services. The bill requires those records to be confidential in accordance with the current confidentiality requirements placed upon health care facilities and health care professionals providing in-person services.

The bill requires the Agency for Health Care Administration (AHCA), with assistance from DOH and the Office of Insurance Regulation (OIR), to survey health care providers, facilities and insurers on telehealth utilization and coverage. The bill requires AHCA to report on the surveys to the Governor, Senate President and Speaker of the House of Representatives.

The bill has a negative, indeterminate impact on AHCA, DOH and OIR for conducting the survey, which can be absorbed within existing resources and does not appear to have a fiscal impact on local government.

The bill provides an effective date of July 1, 2015.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Health Care Professional Shortage

There is currently a physician shortage in the U.S.[1] This shortage is predicted to continue into the foreseeable future and will likely worsen with the aging and growth of the U.S. population[2] and the passage of the Patient Protection and Affordable Care Act.[3] Aging populations create a disproportionately higher health care demand.[4] Additionally, as more individuals qualify for health care benefits, there will necessarily be a greater demand for more health care professionals to provide these services. There are several other factors which will likely increase the demand for a larger health care workforce. These include: [5]

- Shortage of health care professionals being educated, trained and licensed;
- Lack of specialists and health facilities in rural areas;
- Adverse events, injuries and illness at hospitals and physician's offices; and
- Need to improve community and population health.

Florida is not immune to the national problem and is experiencing a health care provider shortage itself. This is evidenced by the fact that for just primary care, dental care and mental health there are 615 federally designated Health Professional Shortage Areas (HPSA) within the state.[6] It would take 916 primary care[7], 860 dental care[8] and 83 mental health[9] practitioners to eliminate these shortage areas.

Numerous solutions have been proposed to combat the health care professional shortage. These proposals seek to address both the current and future shortages. Long-term proposals include the creation of new scholarships and residency programs for emerging health care providers.[10] These proposals address the shortage in the future by creating new health care professionals. Short-term

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[1] For example, as of June 19, 2014, the U.S. Department of Health and Human Services has designated 6,100 Primary Care Health Professional Shortage Area (HPSA) (requiring 8,200 additional primary care physicians to eliminate the shortage), 4,900 Dental HPSAs (requiring 7,300 additional dentists to eliminate the shortage), and 4,000 Mental Health HPSAs (requiring 2,800 additional psychiatrists to eliminate the shortage). This information is available at the U.S. Department of Health and Human Services' Health Resources and Services Administration's website, http://www.hrsa.gov/shortage/ (last visited on January 5, 2016).

[2] There will be a significant increase in the U.S. population, estimated to grow 20 percent (to 363 million) between 2008-2030.

[3] *Department of Health and Human Services Strategic Plan: Goal 5: Strengthen the Nation's Health and Human Service Infrastructure and Workforce*, U.S. Department of Health and Human Services, http://www.hhs.gov/secretary/about/goal5.html (last visited on January 5, 2016).

[4] One analysis measured current primary care utilization (office visits) and projected the impact of population increases, aging, and insured status changes. The study found that the total number of office visits to primary care physicians will increase from 462 million in 2008 to 565 million in 2025, and (because of aging) the average number of visits will increase from 1.60 to 1.66. The study concluded that the U.S. will require 51,880 additional primary care physicians by 2025. Petterson, Stephen M., et al., "Projecting U.S. Primary Care Physician Workforce Needs: 2010-2025", Annals of Family Medicine, vol. 10, No. 6, Nov./Dec. 2012, available at: http://www.annfammed.org/content/10/6/503.full.pdf+html (last visited on January 5, 2016).

[5] *Telemedicine: An Important Force in the Transformation of Healthcare*, Matthew A. Hein, June 25, 2009.

[6] *Providers & Service Use Indicators* , Kaiser Family Foundation. http://kff.org/state-category/providers-service-use/access-to-care/ (last visited on January 5, 2016).

[7] *Primary Care Health Professional Shortage Areas (HPSAs)*, Kaiser Family Foundation. http://kff.org/other/state-indicator/primary-care-health-professional-shortage-areas-hpsas/ (last visited on January 5, 2016).

[8] *Dental Care Health Professional Shortage Areas (HPSAs)*, Kaiser Family Foundation. http://kff.org/other/state-indicator/dental-care-health-professional-shortage-areas-hpsas/ (last visited on January 5, 2016).

[9] *Mental Health Professional Shortage Areas (HPSAs)*, Kaiser Family Foundation. http://kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/ (last visited on January 5, 2016).

[10] U.S. Department of Health and Human Services, *supra* note 3.

proposals include broadening the scope of practice for certain health care professionals[11] and more efficient utilization of our existing workforce through the expanded use of telehealth.[12]

Telehealth

There is no universally accepted definition of telehealth. In broad terms, telehealth is:

> The delivery of health care services, where distance is a critical factor, by all health care professionals using information and communication technologies for the exchange of valid information for diagnosis, treatment[13] and prevention of disease and injuries[14], research and evaluation, and for the continuing education of health care providers, all in the interests of advancing the health of individuals and their communities.[15]

More specific definitions vary greatly from country to country, as well as between the numerous states, authorizing the use of telehealth to deliver health care services. In fact, definitions of telehealth occasionally differ between the various professions within a specific state.[16] There are, however, common elements among the varied definitions of telehealth.

Telehealth generally consists of synchronous and/or asynchronous transmittal of information.[17] Synchronous refers to the live[18] transmission of information between patient and provider during the same time period.[19] Asynchronous telehealth is the transfer of data over a period of time, and typically in separate time frames.[20] This is commonly referred to as "store and forward". Definitions of telehealth also commonly contain restrictions related to the location where telehealth may be used. For example, the use of the "hub and spoke" model is a common location restriction. A hub site is the location from which specialty or consultative services originate, i.e., the provider. A spoke site is a remote site where the patient is presented during the telehealth encounter. Under this model, health services may be provided through telehealth only if the patient is located at a designated spoke site and the provider is located at a designated hub site.

Telehealth is a broad term which includes telemedicine and telemonitoring. Telemedicine is focused on the delivery of traditional clinical services, like diagnosis and treatment. Telemonitoring is the process of using audio, video, and other telecommunications and electronic information processing technologies to monitor the health status of a patient from a distance.[21] Telehealth more broadly

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[11] Id.

[12] *Department of Health and Human Services Strategic Plan: Goal 1: Strengthen the Nation's Health and Human Service Infrastructure and Workforce*, U.S. Department of Health and Human Services, http://www.hhs.gov/secretary/about/goal5.html (last visited on January 5, 2016).

[13] The University of Florida's Diabetes Center of Excellence utilizes telehealth to deliver treatment to children with diabetes and other endocrine problems who live in Volusia County. This allows the children to receive specialized treatment without the necessity of traveling from Volusia County to Gainesville. The Florida Department of Health's Children's Medical Services underwrites the program. https://ufhealth.org/diabetes-center-excellence/telemedicine (last visited on January 5, 2016).

[14] The University of South Florida has partnered with American Well to provide health care services to the residents of the Villages via telehealth. The goal is to reduce hospital admissions, readmission rates, and pharmacy costs, while maintaining Medicare beneficiaries in their homes rather than long-term care settings. http://hscweb3.hsc.usf.edu/blog/2012/06/22/usf-health-and-american-well-to-bring-telehealth-to-seniors-living-at-the-villages/ (last visited on January 5, 2016).

[15] *Telemedicine: Opportunities and Developments in Member States, Global Observatory for Ehealth Series- Volume 2*, Section 1.2, page 9.

[16] *State Telehealth Laws and Reimbursement Policies*, Center for Connected Health Policy, The National Telehealth Policy Resource Center, February 2015.

[17] The majority of telehealth definitions allow for both synchronous and asynchronous transmittal of information. Some definitions however omit asynchronous from the definition of telehealth.

[18] This is also referred to as "real time" or "interactive" telehealth.

[19] *Telemedicine Nomenclature*, American Telemedicine Association, located at http://www.americantelemed.org/resources/nomenclature#.VOuc1KNOncs (last visited on January 5, 2016). The use of live video to evaluate and diagnosis a patient would be considered synchronous telehealth.

[20] Id. A common example of synchronous telehealth is the transfer of x-rays or MRI images from one health care provider to another health care provider for review in the future.

[21] *Glossary and Acronyms*, U.S. Department of Health and Human Services http://www.hrsa.gov/ruralhealth/about/telehealth/glossary.html (last visited January 5, 2016).

includes non-clinical services, such as patient and professional health-related education, public health and health administration.[22]

Telehealth is not a type of health care service but rather is a mechanism for delivery of health care services. Health care professionals use telehealth as a platform to provide traditional health care services in a non-traditional manner. These services include, among others, primary and specialty care services and health management.[23]

Telehealth, in its modern form,[24] started in the 1960s in large part driven by the military and space technology sectors.[25] Specifically, telehealth was used to remotely monitor physiological measurements of certain military and space program personnel. As this technology became more readily available to the civilian market, telehealth began to be used for linking physicians with patients in remote, rural areas. As advancements were made in telecommunication technology, the use of telehealth became more widespread to include not only rural areas but also urban communities. Due to recent technology advancements and general accessibility, the use of telehealth has spread rapidly and is now becoming integrated into the ongoing operations of hospitals, specialty departments, home health agencies, private physician offices as well as consumer's homes and workplaces.[26] In fact, there are currently an estimated 200 telehealth networks, with 3,500 service sites in the U.S.[27]

Telehealth is used to address several problems in the current health care system. Inadequate access to care is one of the primary obstacles to obtaining quality health care.[28] This occurs in both rural areas and urban communities.[29] Telehealth reduces the impact of this issue by providing a mechanism to deliver quality health care, irrespective of the location of a patient or a health care professional. Cost is another barrier to obtaining quality health care.[30] This includes the cost of travel to and from the health care facility, as well as related loss of wages from work absences. Costs are reduced through telehealth by decreasing the time and distance required to travel to the health care professional. Two more issues addressed through telehealth are the reutilization of health care services and hospital readmission. These often occur due to a lack of proper follow-up care by the patient[31] or a chronic condition.[32] These issues however can potentially be avoided through the use of telehealth and telemonitoring.

Telehealth and Federal Law

Several federal laws and regulations apply to the delivery of health care services through telehealth.

Prescribing Via the Internet

Federal law specifically prohibits prescribing controlled substances via the Internet without an in-person evaluation. The federal regulation under 21 CFR §829 specifically states:

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[22] Id.

[23] *What is Telehealth?* U.S. Department of Health and Human Services. http://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/Telehealth/whatistelehealth.html (last visited January 5, 2016).

[24] Historically, telehealth can be traced back to the mid to late 19th century with one of the first published accounts occurring in the early 20th century when electrocardiograph data were transmitted over telephone wires. *Telemedicine: Opportunities and Developments in Member States, Global Observatory for Ehealth Series- Volume 2,* Section 1.2, page 9.

[25] *Telemedicine: Opportunities and Developments in Member States, supra* note14.

[26] *What is Telemedicine*, American Telemedicine Association, http://www.americantelemed.org/learn/what-is-telemedicine#.Uu6eGqNOncs (last visited on January 5, 2016).

[27] *Telemedicine Frequently Asked Questions*, American Telemedicine Association, http://www.americantelemed.org/learn/what-is-telemedicine/faqs#.Uu5vyaNOnct (last visited on January 5, 2016).

[28] U.S. Department of Health and Human Services, *supra* note 10.

[29] Id.

[30] Id.

[31] Post-surgical examination subsequent to a patient's release from a hospital is a prime example. Specifically, infection can occur without proper follow-up and ultimately leads to a readmission to the hospital.

[32] For example, diabetes is a chronic condition which can benefit by treatment through telehealth.

No controlled substance that is a prescription drug as determined under the Federal Food, Drug, and Cosmetic Act may be delivered, distributed or dispensed by means of the Internet without a valid prescription.

A valid prescription is further defined under the same regulation as one issued by a practitioner who has conducted an in-person evaluation. The in-person evaluation requires that the patient be in the physical presence of the provider without regard to the presence or conduct of other professionals.[33] However, the Ryan Haight Online Pharmacy Consumer Protection Act,[34] signed into law in October 2008, created an exception for the in-person medical evaluation for telehealth practitioners. The practitioner is still subject to the requirement that all controlled substance prescriptions be issued for a legitimate purpose by a practitioner acting in the usual course of professional practice.

Medicare Coverage

Specific telehealth[35] services delivered at designated sites are covered under Medicare. The Federal Centers for Medicare and Medicaid Services' regulations require both a distant site and a separate originating site (hub and spoke model) under their definition of telehealth. Asynchronous (store and forward) activities are only reimbursed under Medicare in federal demonstration projects.[36] To qualify for Medicare reimbursement, the originating site must be:

- Located in a federally defined rural county;
- Designated rural;[37] or
- Identified as a participant in a federal telemedicine demonstration project as of December 21, 2000.[38]

In addition, an originating site must be one of the following location types as further defined in federal law and regulation:

- The office of a physician or practitioner;
- A critical access hospital;
- A rural health clinic;
- A federally qualified health center;
- A hospital;
- A hospital-based or critical access hospital-based renal dialysis center (including satellites);
- A skilled nursing facility; or
- A community mental health center.[39]

Protection of Personal Health Information

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects personal health information. Privacy rules were initially issued in 2000 by the U.S. Department of Health and Human Services and later modified in 2002.[40] These rules address the use and disclosure of an individual's personal health information as well as create standards for information security.

[33] 21 CFR §829(e)(2).
[34] Ryan Haight Online Consumer Protection Act of 2008, Public Law 110-425 (H.R. 6353).
[35] Medicare covers a broader set of services using the term telehealth. Medicare defines telehealth as the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance.
[36] Only two states have a federal demonstration project that meets these qualifications, Hawaii and Alaska.
[37] The rural definition was expanded through a final federal regulation released on December 10, 2013 to include health professional shortage areas located in rural census tracts of urban areas as determined by the Office of Rural Health Policy. See 78 FR 74229, 74400-74402, 74812 (December 10, 2013).
[38] See 42 U.S.C. sec. 1395(m)(m)(4)(C)(i).
[39] See 42 U.S.C. sec. 1395(m)(m)(4)(C)(ii).
[40] *The Privacy Rule*, U.S. Department of Health and Human Services. http://www.hhs.gov/ocr/privacy/hipaa/administrative/privacyrule/ (last visited January 5, 2016).

Only certain entities are subject to HIPAA's provisions. These "covered entities" include[41]:

- Health plans;
- Health care providers;
- Health care clearinghouses; and
- Business associates of any of the above.

Covered entities are obligated to meet HIPAA's requirements to ensure privacy and confidentiality personal health information, regardless of the method in which the medical service is delivered.

In 2009, the Health Information Technology for Economic Clinical Health (HITECH) Act was enacted as part of American Recovery and Reinvestment Act (ARRA).[42] The HITECH Act promoted electronic exchange and use of health information by investing $20 billion in health information technology infrastructure and incentives to encourage doctors and hospitals to use health information technology.[43] HITECH was intended to strengthen existing HIPAA security and privacy rules.[44] It expanded HIPAA to entities not previously covered; specifically, "business associates" now includes Regional Health Information Organizations, and Health Information Exchanges.[45] Similarly, it made changes to the privacy rule to better protect personal health information held, transferred, or used by covered entities.[46]

Under the provisions of HIPAA and the HITECH Act, a health care provider or other covered entity participating in the electronic exchange of personal health information are subject to HIPAA and HITECH. These federal laws apply to covered entities in Florida, regardless of whether there is an express reference to them in Florida law.

<u>Telehealth Barriers</u>

There are several barriers which impede the use of telehealth. These barriers include:[47]

- Lack of a standard definition for telehealth;
- Lack of standard regulations for the practice of telehealth;
- Licensure requirements which prohibit cross-state practice; and
- Restrictions on the location where telehealth services may be provided.

Standardized Definition

Lack of a standard definition[48] presents a barrier to the use of telehealth. As previously noted, there is no universally accepted definition. A health care professional is left to speculate as to whether the service he or she is providing constitutes telehealth. This can have far-reaching consequences which range from a denial of reimbursement for the services provided to an inquiry as to whether the services provided equate to the unlicensed practice of medicine. Florida law does not define telehealth.

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[41] *For Covered Entities and Business Associates*, U.S. Department of Health and Human Services. http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/ (last visited January 5, 2016).
[42] "Complying with the Health Information Technology for Economic and Clinical Health (HITECH) Act, HIPAA, Security and Privacy, and Electronic Health Records", Deloitte, December 2009, available at https://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/us_lshc_LeadingPracticesandSolutionsforPrivacyandSecurityGuidelines_031710.pdf, (last visited January 5, 2016).
[43] Id.
[44] Id.
[45] Id.
[46] Id.
[47] *State Telehealth Laws and Reimbursement Policies*, Center for Connected Health Policy, The National Telehealth Policy Resource Center, July 2015.
[48] No two states define telehealth exactly alike, although some similarities exist between certain states. *State Telehealth Laws and Reimbursement Policies*, Center for Connected Health Policy, The National Telehealth Policy Resource Center, February 2015.

Standardized Regulations

The absence of a uniform regulatory structure governing the use of telehealth presents another barrier to its use. Currently, 7 states[49] do not have a statutory structure for the delivery of health care services through telehealth.[50] This absence places the burden upon individual professionals to determine what is appropriate, and invites health professional licensing boards to fill the regulatory gap. This can lead to an inconsistent regulation of telehealth amongst the varying health care professions and impede the use of telehealth.

For example, a common telehealth regulation is the requirement that a health care professional conduct an in-person examination of the patient prior to providing services via telehealth.[51] Many times an exception is expressly contained within the regulation which allows the in-person requirement to be met through telehealth.[52] This exception however can vary between the differing health care professions in the absence of a uniform regulation. For example, an audiologist may be authorized to conduct the initial evaluation through telehealth while a physical therapist is required to perform an in-person physical examination prior to providing services through telehealth. There may not be any reasonable justification for this disparate treatment.

Licensure

Licensure requirements present one of the greatest barriers to the use of telehealth. States, not the federal government, license and regulate health care professionals.

Currently, 37 states prohibit health care professionals from providing health care services unless he or she is licensed in the state where the patient is located.[53] Most states have exceptions to this requirement, applicable only in certain limited circumstances, which include: [54]

- Physician-to-physician consultations (not between practitioner and patient);
- Educational purposes;
- Residency training;
- U.S. Military;
- Public health services; and
- Medical emergencies (Good Samaritan) or natural disasters.

Additionally, a special telehealth license or certificate, which allows an out-of-state licensed health care professional to provide health care services through telehealth to patients located within that particular state, is currently offered in 7 states.[55] Two of these states (Tennessee and Texas), however, only offer the telehealth license to board eligible or board certified specialists.

In the absence of an exception or a state regulation authorizing otherwise, it appears that a health care professional will have to be licensed in the state where the patient is located to provide health care services through telehealth. Requiring health care professionals to obtain multiple state licenses to

[49] This includes Florida.
[50] *State Telehealth Laws and Reimbursement Policies*, Center for Connected Health Policy, The National Telehealth Policy Resource Center, July 2015. Even amongst states with telehealth statutory regulations, no two states regulate telehealth in exactly the same manner.
[51] *State Telehealth Laws and Reimbursement Policies*, Center for Connected Health Policy, The National Telehealth Policy Resource Center, July 2015.
[52] Id.
[53] Id. This includes Florida.
[54] *Licensure and Scope of Practice FAQs*, Telehealth Resource Centers, http://www.telehealthresourcecenter.org/toolbox-module/licensure-and-scope-practice#what-are-the-exceptions-to-state-licensure-require (last visited on January 5, 2016).
[55] *State Telehealth Laws and Reimbursement Policies*, Center for Connected Health Policy, The National Telehealth Policy Resource Center, July 2015. These states are AL, LA, MN, NM, OH, TN and TX. Additionally, six states (HI, MD, MS, OR, PA and WA) provide exceptions to their state licensure requirements under limited circumstances, i.e. only for radiology or only for border states, or were not telehealth specific exceptions.

provide health care services through telehealth may be burdensome and may inhibit the use of telehealth across state borders.

Location Restrictions

Generally, there are essentially two types of location restrictions. The first restricts the use of telehealth to certain designated areas within a state. For example, only individuals in areas designated as a rural area or a medically underserved area may be authorized to receive health care services through telehealth.

The second restriction relates to limitations on the specific location where telehealth services may be provided. The most common example of this type of limitation is the hub and spoke model.[56] Under this model, "hub" refers to the location to where the health care professional must be located while "spoke" refers to the location where the patient must be located.

The two types of restrictions are not mutually exclusive and are commonly used in conjunction. This presents a significant obstacle to access to care by placing arbitrary restrictions on the use of telehealth which inhibits the effectiveness, as well as the use of telehealth to deliver health care services.

Telehealth in Florida

Florida does not have a statutory structure for the delivery of health care services through telehealth. The only two references to telehealth in the Florida Statutes are contained within s. 364.0135, F.S. and s. 381.885, F.S. Section 364.0135, F.S., relates to the promotion of broadband internet services by telecommunication companies and does not define or regulate telehealth in any manner. Section 381.885, F.S., is related to epinephrine auto-injectors and expressly states that consultation for the use of the auto-injector through electronic means does not constitute the practice of telemedicine. Further, the only references to telehealth in the Florida Administrative Code relate to the Board of Medicine, Board of Osteopathic Medicine, and the Child Protection Team Program. The Florida Medicaid program also outlines certain requirements relating to telehealth coverage in its rules.[57]

Florida Board of Medicine

In 2003, the Florida Board of Medicine (Board) adopted Rule 64B8-9.014, F.A.C., "Standards for Telemedicine Prescribing Practice" (Rule).[58] The Rule sets forth requirements and restrictions for physicians and physician assistants prescribing medications.[59] The Rule also states that telemedicine "shall include, but is not limited to, prescribing legend drugs to patients through the following modes of communication: (a) Internet; (b) Telephone; and (c) Facsimile."[60] The Rule however fails to fully define telemedicine or regulate its use in any other way. The Board only regulates allopathic physicians, so this rule does not apply to any other profession.[61]

In 2014 the Board adopted a new rule[62] setting forth standards for telemedicine.[63] The new rule defines telemedicine as the practice of medicine by a licensed Florida physician or physician assistant where

[56] Florida's Department of Health's Children's Medical Services Program (CMS) currently uses the hub and spoke model to provide services via telehealth to children enrolled in the program.
[57] *See* Agency for Health Care Administration, Florida Medicaid, "Practitioner Services Coverage and Limitations Handbook," December 2012, pg. 2-119, available at: http://portal.flmmis.com/FLPublic/HiddenStaticSearchPage/tabid/55/Default.aspx?publicTextSearch=practioners%20services%20handbook (last visited on January 5, 2016).
[58] The current telemedicine rules and regulations for the Board of Medicine and the Board of Osteopathic Medicine are virtually identical. Rules 64B8-9.014 and 64B15-14.008, F.A.C.
[59] Rule 64B8-9.014, F.A.C.
[60] Id.
[61] The Board of Osteopathic Medicine rule only applies to osteopathic physicians.
[62] The Board of Medicine and the Board of Osteopathic Medicine rules for telemedicine are identical.
[63] Rule 64B8-9.0141, F.A.C.

patient care, treatment, or services are provided through the use of medical information exchanged from one site to another via electronic communications.[64] The definition could be interpreted to limit the use of telemedicine to physicians and physician assistants; however, the Board does not have the authority to regulate other professions.[65] The new rule provides that: [66]

- The standard of care is the same as that required for services provided in person;
- A physician-patient relationship may be established through telemedicine;
- A physician or physician assistant is responsible for the quality and safety of the equipment and used to provide services through telemedicine; and
- The same patient confidentiality and record-keeping requirements applicable to in-person services are applicable to services provided through telemedicine.

The new rule prohibits physicians and physician's assistants from providing treatment recommendations, including issuing a prescription, through telemedicine unless the following has occurred:[67]

- A documented patient evaluation, including history and physical examination to establish the diagnosis for which any legend drug is prescribed;
- A discussion between the physician or the physician assistant and the patient regarding treatment options and the risks and benefits of treatment; and
- Contemporaneous medical records are maintained.

The new rule however prohibits prescribing controlled substances through telemedicine but does not preclude physicians from ordering controlled substances through the use of telemedicine for patients hospitalized in a facility licensed pursuant to 395, F.S.[68]

Child Protection Teams

The Child Protection Team (CPT) is a medically directed multi-disciplinary program that works with local Sheriff's offices and the Department of Children and Families in cases of child abuse and neglect to supplement investigative activities.[69] The CPT program within the Children's Medical Services (CMS) program utilizes a telehealth network to perform child assessments. The use of telemedicine[70] under this program requires the presence of a CMS approved physician or advanced registered nurse practitioner at the hub site and a registered nurse at the remote site to facilitate the evaluation.[71] In 2014, CPT telehealth services were available at 9 sites and 667 children were provided medical or other assessments via telehealth technology.[72]

Florida Emergency Trauma Telemedicine Network

Various designated trauma centers participate in the Florida Emergency Trauma Telemedicine Network (FETTN). Coordinated by the Department of Health (DOH), the FETTN facilitates the treatment of trauma patients between trauma centers and community or rural hospitals.[73] The FETTN allows for

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[64] Rule 64B8-9.0141, F.A.C.

[65] The Board of Osteopathic Medicine definition only applies to osteopathic physicians.

[66] See footnote 68 *supra*.

[67] Id.

[68] Id.

[69] Florida Department of Health, *Child Protection Teams*, http://www.floridahealth.gov/AlternateSites/CMS-Kids/families/child_protection_safety/child_protection_teams.html (last visited January 5, 2016

[70] Rule 64C-8.001(5), F.A.C., defines telemedicine as "the use of telecommunication and information technology to provide clinical care to individuals at a distance and to transmit the information needed to provide that care."

[71] Rule 64C-8.003(3), F.A.C.

[72] Florida Department of Health, *Maternal and Child Health Block Grant Narrative for 2014, http://www.floridahealth.gov/healthy-people-and-families/womens-health/pregnancy/mch-fl-2013-1narrative.pdf* p.21, (last visited: January 5, 2016).

[73] Florida Department of Health, 2014 Agency Legislative Bill Analysis of HB 167, on file with the Florida House of Representative's Select Committee on Health Care Workforce Innovation (October 21, 2013).

multiple interface options and currently 7 out of 25 trauma centers are part of the network.[74] In 2011-12, the seven Level 1 or Level 2 trauma centers that participated as a hub site, known as the location where the consulting physician is delivering the services, were Holmes Regional Medical Center, Tallahassee Memorial Hospital, Sacred Heart Hospital, University of Miami, Shands-Gainesville, Shands-Jacksonville, and Orlando Health.[75]

Other Department of Health Initiatives

The DOH utilizes tele-radiology through the Tuberculosis Physician's Network.[76] The ability to read electronic chest X-Rays remotely can lead to a faster diagnosis, treatment and a reduction in the spread of the disease, according to DOH. This service is not currently reimbursed by Medicaid.

Florida Medicaid Program

Under the Medicaid Medical Assistance (MMA) Program implemented in 2014, the vast majority of Medicaid recipients are covered through managed care. Medicaid MMA contracts contain broader allowance for telehealth.[77] Not only may plans use telehealth for behavioral health, dental, and physician services as before but, upon approval by AHCA, may also use telehealth to provide other covered services.[78] The new contract additionally eliminates numerous prior restrictions related to types of services and the type of providers who may utilize telehealth but retains the hub and spoke model.[79]

Effect of Proposed Changes

The bill creates s. 456.47, F.S., relating to the use of telehealth to provide health care services.

"Telehealth" is defined in the bill to mean the use of synchronous or asynchronous telecommunications technology by a telehealth provider to provide health care services including, but not limited to, patient assessment, diagnosis, consultation and treatment, monitoring transfer of medical data, patient and professional health-related education, public health services and health administration. The definition of telehealth does not include audio-only telephone calls, e-mail messages or facsimile transmissions. Thus, health care professionals can use telehealth to provide services to patients through both "live" and "store and forward" methods. It also authorizes the use of telemonitoring. The definition does not place any additional limitations on the type of technology that can be used in telehealth. However, both HIPAA and HITECH continue to apply to covered entities.

Telehealth Providers

The bill defines "telehealth provider" as any person who provides health care related services using telehealth and who is licensed in Florida or is an out-of-state health care registered and is in compliance with the requirements of this bill. Florida licensed telehealth provides must be one of the following professionals:[80]

[74] Id.
[75] Florida Department of Health, *Long Range Program Plan* (September 28, 2012).
[76] Florida Department of Health, *supra* note 75.
[77] In Florida's Medicaid program the state reimburses physicians on a fee-for-service basis for health care services provided through telemedicine. The use of telemedicine to provide these services is limited to the hospital outpatient setting, inpatient setting, and physician office.
[78] Model Agreement, Attachment II, Exhibit II A, Medicaid Managed Medical Assistance Program, Agency for Health Care Administration, November 2015, available at http://ahca.myflorida.com/Medicaid/statewide_mc/plans.shtml (last viewed January 5, 2016).
[79] Id.
[80] These are professionals licensed under s. 393.17; part III, ch. 401; ch. 457; ch. 458; ch. 459; ch. 460; ch. 461; ch. 463; ch. 464; ch. 465; ch. 466; ch. 467; part I, part III, part IV, part V, part X, part XIII, and part XIV, ch. 468; ch. 478; ch. 480; part III, part IV, ch. 483; ch. 484; ch. 486; ch. 490; or ch. 491.

- Behavior analyst;
- Acupuncturist;
- Allopathic physician;
- Osteopathic physician;
- Chiropractor;
- Podiatrist;
- Optometrist;
- Nurse;
- Pharmacist;
- Dentist;
- Dental Hygienist;
- Midwife;
- Speech therapist;
- Occupational therapist;
- Radiology technician;
- Electrologist;
- Orthotist;
- Pedorthist;
- Prosthetist;
- Medical physicist;
- Emergency Medical Technician;
- Paramedic;
- Massage therapist;
- Optician;
- Hearing aid specialist;
- Clinical laboratory personnel;
- Respiratory therapist;
- Physical therapist;
- Psychologist;
- Psychotherapist;
- Dietician/Nutritionist;
- Athletic trainer;
- Clinical social worker;
- Marriage and family therapist; or
- Mental health counselor.

Out-of-state telehealth providers must register annually with DOH or the applicable board to provide telehealth services, within the relevant scope of practice established by Florida law and rule, to patients in this state. To register as an out-of-state telehealth provider, the health care professional must:

- Submit an application to DOH;
- Pay a $150 registration fee;
- Hold an active unencumbered license, consistent with the definition of "telehealth provider" listed above, in a U.S. state or jurisdiction and against whom no disciplinary action has been taken during the five years before submission of the application; and
- Never had his or her license revoked in any U.S. state or jurisdiction.

The bill prohibits an out-of-state telehealth provider from opening an office in Florida and from providing in-person health care services to patients located in Florida.

The bill requires out-of-state telehealth providers to notify the applicable board or DOH of restrictions placed on the health care professional's license to practice or disciplinary actions taken against the health care practitioner.

The bill authorizes DOH to revoke an out-of-state telehealth provider's registration if the registrant:

- Fails to immediately notify the department of any adverse actions taken against his or her license;
- Has restrictions placed on or disciplinary action taken against his or her license in any state or jurisdiction; or
- Violates any of the requirements for the registration of out-of-state telehealth providers.

The bill requires DOH to publish on its website the name of each registered out-of-state telehealth provider. It must also include the following background information for each registrant:

- Health care occupation;
- Completed health care training and education, including completion dates and any certificates or degrees obtained;
- Out-of-state health care license with license number;
- Florida telehealth provider registration number;
- Specialty;
- Board certification;
- 5 year disciplinary history, including sanctions and board actions; and
- Medical malpractice insurance provider and policy limits, including whether the policy covers claims which arise in this state.

Telehealth Provider Standards

The bill establishes that the standard of care for telehealth providers is the same as the standard of care for health care practitioners or health care providers providing in-person health care services to patients in this state. This ensures that a patient receives the same standard of care irrespective of the modality used by the health care professional to deliver the services.

Under the bill a telehealth provider is not required to research a patient's medical history or conduct a physical examination of the patient before providing telehealth services to the patient if the telehealth provider is capable of conducting a patient evaluation in a manner consistent with the applicable standard of care sufficient to diagnose and treat the patient when using telehealth. The bill also allows the evaluation to be performed using telehealth.

The bill provides that a patient receiving telehealth services may be in any location at the time that the telehealth services are rendered and that a telehealth provider may be in any location when providing telehealth services to a patient.

The bill allows health care providers who are authorized to prescribe a controlled substance to use telehealth to prescribe controlled substances. Telehealth may not be used to prescribe a controlled substance to treat chronic nonmalignant pain, unless ordered by a physician for an inpatient admitted to a facility licensed under ch. 395, F.S., prescribed for a patient receiving hospice services as defined under s. 400.601, F.S., or prescribed for a resident of a nursing home facility as defined under s. 400.021(12), F.S.

The bill requires that a telehealth provider document the telehealth services rendered in the patient's medical records according to the same standard as that required for in-person services. The bill requires that such medical records be kept confidential consistent with ss. 395.3025(4) and 456.057, F.S. Section 456.057, F.S., relates to all licensed health care professionals while s. 395.3025(4), F.S., relates to all health care facilities licensed under ch. 395 (hospitals, ambulatory surgical centers, and mobile surgical centers). Thus, the same confidentiality requirements placed upon health care facilities

and health care practitioners for medical records generated as part of in-person treatment apply to any medical records generated as part of treatment rendered through telehealth.

The bill provides that a non-physician telehealth provider using telehealth and acting within the applicable scope of practice, as established under Florida law, may not be interpreted as practicing medicine without a license.

The bill establishes, for jurisdictional purposes, that any act that constitutes the delivery of health care services shall be deemed to occur at the place where the patient is located at the time the act is performed. This will assist a patient in establishing jurisdiction and venue in Florida in the event he or she pursues a legal action against the telehealth provider.

The bill provides exceptions to the registration requirement for emergencies or physician to physician consultations.

The bill requires out-of-state pharmacists who are registered telehealth providers to use a permitted Florida pharmacy or a registered nonresident pharmacy to dispense medicinal drugs to Florida patients.

The bill authorizes DOH or an applicable board to adopt rules to administer the requirements set forth in the bill.

Telehealth Survey

The bill requires AHCA, DOH and OIR to survey health care facilities, health maintenance organizations, health care practitioners, and health insurers to determine:

- National and state utilization of telehealth;
- Types of health care services provided via telehealth;
- Costs and cost savings associated with using telehealth to provide health care services; and
- Insurance coverage for providing health care services via telehealth.

The bill authorizes AHCA, DOH and OIR to assess fines to enforce participation and completion of the surveys.

The bill requires DOH and OIR to submit their findings and research to AHCA. AHCA is required to submit a report to the Governor, the President of the Senate and the Speaker of the House of Representatives on telehealth utilization and insurance coverage by June 30, 2018.

The bill provides an effective date of July 1, 2016.

B. SECTION DIRECTORY:

Section 1: Creates s. 456.47, F.S., relating to the use of telehealth to provide services.
Section 2: Requires AHCA to report on telehealth utilization and insurance coverage.
Section 3: Provides an effective date of July 1, 2016.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

The bill requires all out-of-state telehealth providers to pay a $150 registration. The fiscal impact is indeterminable as the number of out-of-state health care professionals who will register as a telehealth provider is unknown.

2. Expenditures:

The bill requires AHCA, DOH and OIR to conduct a survey on various telehealth and insurance issues, and requires AHCA to compile the report and prepare a report. The costs to the agencies to perform this survey and report are unknown.

The bill requires all out-of-state health care professionals to register with DOH prior to providing any health care services through telehealth to individuals located in Florida. The cost to DOH to administer this registration is unknown; however, these costs may be offset by the bill's $150 registration fee.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. This bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill authorizes DOH or an applicable board to adopt rules to administer the requirements set forth in the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to telehealth; creating s. 456.47,
3 F.S.; defining terms; providing for certain practice
4 standards for telehealth providers; providing for the
5 maintenance and confidentiality of medical records;
6 requiring health care professionals not licensed in
7 this state to register to use telehealth to deliver
8 health care services; providing registration
9 requirements; prohibiting registrants from opening an
10 office or providing in-person health care services in
11 this state; requiring a registrant to notify the
12 appropriate board or the Department of Health of
13 certain actions against the registrant's professional
14 license; prohibiting a health care professional with a
15 revoked license from being registered as a telehealth
16 provider; providing exemptions to the registration
17 requirement; providing rulemaking authority; requiring
18 the Agency for Health Care Administration, Department
19 of Health, and Office of Insurance Regulation to
20 collect certain information; requiring the Agency for
21 Health Care Administration to report such information
22 to the Governor and Legislature by a specified date;
23 providing certain enforcement authority to each
24 agency; providing for the repeal of a section of law
25 on a specified date; providing an effective date.
26

27 Be It Enacted by the Legislature of the State of Florida:
28
29 Section 1. Section 456.47, Florida Statutes, is created to
30 read:
31 456.47 Use of telehealth to provide services.—
32 (1) DEFINITIONS.—As used in this section, the term:
33 (a) "Telehealth" means the use of synchronous or
34 asynchronous telecommunications technology by a telehealth
35 provider to provide health care services, including, but not
36 limited to, patient assessment, diagnosis, consultation,
37 treatment, and monitoring; transfer of medical data; patient and
38 professional health-related education; public health services;
39 and health administration. The term does not include audio-only
40 telephone calls, e-mail messages, or facsimile transmissions.
41 (b) "Telehealth provider" means any individual who
42 provides health care and related services using telehealth and
43 who is licensed under s. 393.17; part III of chapter 401;
44 chapter 457; chapter 458; chapter 459; chapter 460; chapter 461;
45 chapter 463; chapter 464; chapter 465; chapter 466; chapter 467;
46 part I, part III, part IV, part V, part X, part XIII, or part
47 XIV of chapter 468; chapter 478; chapter 480; part III of
48 chapter 483; chapter 484; chapter 486; chapter 490; or chapter
49 491; or who is registered under and in compliance with
50 subsection (4).
51 (2) PRACTICE STANDARD.—

52 (a) The standard of care for telehealth providers
53 providing health care services is the same as the standard of
54 care for health care professionals providing in-person health
55 care services to patients in this state. A telehealth provider
56 is not required to research a patient's medical history or
57 conduct a physical examination of the patient before using
58 telehealth to provide services to the patient if the telehealth
59 provider conducts a patient evaluation sufficient to diagnose
60 and treat the patient. The evaluation may be performed using
61 telehealth.
62 (b) A telehealth provider may not use telehealth to
63 prescribe a controlled substance to treat chronic nonmalignant
64 pain, as defined under s. 456.44, unless the controlled
65 substance is ordered for inpatient treatment at a hospital
66 licensed under chapter 395, is prescribed for a patient
67 receiving hospice services as defined under s. 400.601, or is
68 prescribed for a resident of a nursing home facility as defined
69 under s. 400.021(12).
70 (c) A telehealth provider and a patient may each be in any
71 location when telehealth is used to provide health care services
72 to a patient.
73 (d) A nonphysician telehealth provider using telehealth
74 and acting within the relevant scope of practice, as established
75 by Florida law and rule, is not a violation of s. 458.327(1)(a)
76 or s. 459.013(1)(a).

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77 (3) RECORDS.—A telehealth provider shall document in the
78 patient's medical record the health care services rendered using
79 telehealth according to the same standard as used for in-person
80 services. Medical records, including video, audio, electronic,
81 or other records generated as a result of providing such
82 services, are confidential pursuant to ss. 395.3025(4) and
83 456.057.
84 (4) REGISTRATION OF OUT-OF-STATE TELEHEALTH PROVIDERS.—
85 (a) A health care professional not licensed in this state
86 may provide health care services to a patient located in this
87 state using telehealth if the telehealth provider annually
88 registers with the applicable board, or the department if there
89 is no board, and provides health care services within the
90 relevant scope of practice established by Florida law or rule.
91 (b) The board, or the department if there is no board,
92 shall register a health care professional as a telehealth
93 provider if the health care professional:
94 1. Completes an application form developed by the
95 department;
96 2. Pays a $150 registration fee; and
97 3. Holds an active, unencumbered license for a profession
98 included in paragraph (1)(b) issued by another state, the
99 District of Columbia, or a possession or territory of the United
100 States and against whom no disciplinary action has been taken
101 during the 5 years before submission of the application. The

102 department shall use the National Practitioner Data Bank to
103 verify information submitted by an applicant.
104 (c) A health care professional may not register under this
105 section if his or her license to provide health care services is
106 subject to a pending disciplinary investigation or action, or
107 has been revoked in any state or jurisdiction. A health care
108 professional registered under this section must immediately
109 notify the appropriate board, or the department if there is no
110 board, of restrictions placed on the health care professional's
111 license to practice, or disciplinary action taken or pending
112 against the health care professional, in any state or
113 jurisdiction.
114 (d) A health care professional registered under this
115 section may not open an office in this state and may not provide
116 in-person health care services to patients located in this
117 state.
118 (e) A pharmacist registered under this section may only
119 use a pharmacy permitted under chapter 465, or a nonresident
120 pharmacy registered under s. 465.0156, to dispense medicinal
121 drugs to patients located in this state.
122 (f) The department shall publish on its website a list of
123 all registrants and include, to the extent applicable, each
124 registrant's:
125 1. Name.
126 2. Health care occupation.
127 3. Completed health care training and education, including

128 completion dates and any certificates or degrees obtained.
129 4. Out-of-state health care license with license number.
130 5. Florida telehealth provider registration number.
131 6. Specialty.
132 7. Board certification.
133 8. 5 year disciplinary history, including sanctions and
134 board actions.
135 9. Medical malpractice insurance provider and policy
136 limits, including whether the policy covers claims which arise
137 in this state.
138 (g) The department may revoke a telehealth provider's
139 registration if the registrant:
140 1. Fails to immediately notify the department of any
141 adverse actions taken against his or her license as required
142 under paragraph (c).
143 2. Has restrictions placed on or disciplinary action taken
144 against his or her license in any state or jurisdiction.
145 3. Violates any of the requirements of this section.
146 (5) VENUE.-For the purposes of this section, any act that
147 constitutes the delivery of health care services shall be deemed
148 to occur at the place where the patient is located at the time
149 the act is performed.
150 (6) EXEMPTIONS.—A health care professional who is not
151 licensed to provide health care services in this state but who
152 holds an active license to provide health care services in
153 another state or jurisdiction, and who provides health care

154 services using telehealth to a patient located in this state, is
155 not subject to the registration requirement under this section
156 if the services are provided:
157 (a) In response to an emergency medical condition as
158 defined in s. 395.002; or
159 (b) In consultation with a health care professional
160 licensed in this state and that health care professional retains
161 ultimate authority over the diagnosis and care of the patient.
162 (7) RULEMAKING.—The applicable board, or the department if
163 there is no board, may adopt rules to administer the
164 requirements of this section.
165 Section 2. Telehealth utilization and insurance coverage
166 report.—
167 (1) The Agency for Health Care Administration, the
168 Department of Health, and the Office of Insurance Regulation
169 shall, within existing resources, survey health care facilities,
170 health maintenance organizations, health care practitioners, and
171 health insurers, respectively, and perform any other research
172 necessary to collect the following information:
173 (a) The types of health care services provided via
174 telehealth.
175 (b) The extent telehealth is used by health care
176 practitioners and health care facilities nationally and in the
177 state.
178 (c) The estimated costs and cost savings to health care
179 entities, health care practitioners, and the state associated

180 with using telehealth to provide health care services.
181 (d) Which health care insurers, health maintenance
182 organizations, and managed care organizations cover health care
183 services provided to patients in Florida via telehealth, whether
184 the coverage is restricted or limited, and how such coverage
185 compares to that insurer's coverage for services provided in-
186 person. The comparison shall at a minimum include:
187 1. Covered medical or other health care services.
188 2. A description of whether payment rates for such
189 services provided via telehealth are below, equal to, or above
190 payment rates for such services provided in-person.
191 3. Any annual or lifetime dollar maximums on coverage for
192 services provided via telehealth and in-person.
193 4. Any copayments, coinsurance, or deductible amounts, or
194 policy year, calendar year, lifetime, or other durational
195 benefit limitation or maximum for benefits or services provided
196 via telehealth and in-person.
197 5. Any conditions imposed for coverage for services
198 provided via telehealth that are not imposed for coverage for
199 the same services provided in-person.
200 (e) The barriers to using, implementing the use of, or
201 accessing services via telehealth.
202 (2) The Agency for Health Care Administration shall
203 compile the surveys and research findings required by this
204 section and submit a report to the Governor, the President of
205 the Senate, and the Speaker of the House of Representatives by

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206 June 30, 2018.
207 (3) The Department of Health and Office of Insurance
208 Regulation shall report their survey and research findings to
209 the Agency for Health Care Administration and shall assist the
210 Agency for Health Care Administration in compiling and producing
211 the information into a report.
212 (4) The Agency for Health Care Administration, the
213 Department of Health, and Office of Insurance Regulation may
214 assess fines under s. 408.813(2)(d), s. 456.072(2)(d), and s.
215 624.310(5), respectively, to enforce the participation of health
216 care facilities, health maintenance organizations, health care
217 practitioners, and health insurers to complete surveys required
218 under this section.
219 (5) This section is repealed July 1, 2018.
220 Section 3. This act shall take effect July 1, 2016.