HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1435 Disclosure of Health Care Financial Information
SPONSOR(S): Zapata and others
TIED BILLS: **IDEN./SIM. BILLS:** 1488

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Healthcare Council		Quinn-Gato/ Massengale	Gormley
2)			
3)			
4)			
5)			

SUMMARY ANALYSIS

House Bill 1435, which shall be cited as the "Health Care Financial Information Act," requires 501(c)(3) hospitals in Florida to meet community benefits requirements created in s. 212.08(7)(p), F.S. in order to retain their sales and lease tax exemption certificate. The bill defines terms related to the new requirement, requires nonprofit hospitals to develop an organization mission statement and community benefits plan, and requires such hospitals to provide community benefits on an annual basis. The bill creates standards for, and reporting requirements related to, the provision of community benefits. The bill requires the Agency for Health Care Administration ("AHCA") to publish and submit to the Attorney General and Chief Financial Officer an annual report, due by January 1, listing each exempt hospital that AHCA determines did not meet the community benefits requirements during the previous fiscal year, as well as a report pertaining to all exempt hospitals containing specified information. The bill also includes public notification requirements, and authorizes the Chief Financial Officer to revoke the tax exempt status of a hospital that fails to comply with community benefits requirements. The bill allows for a hospital facing revocation of its tax exemption certificate to apply for a grace period under certain situations, and limits the number of applications for grace period to one every five years. The bill provides for specified exemptions of nonprofit hospitals designated as disproportionate share hospitals under the Medicaid Program.

The bill also seeks to create more transparency for patients by requiring practitioner and facilities to itemize estimates of charges and bills and publish pricing information, including lowest, average, and highest charges be provided to patients. Additionally, the bill modifies the current reporting and data collection requirements pertaining to AHCA and health care facilities by requiring AHCA to consider publishing a price list of procedures, supplies, and services, range of charges from highest to lowest, and requiring facilities to report to AHCA price lists for not fewer than the 100 most commonly performed procedures, based upon the statewide average of procedures, and the 500 most commonly used supplies.

Finally, the bill modifies the definition of charity care in s. 409.911, F.S., to provide that the amount of charity care and uncompensated care shall only be valued and reported at Medicaid rates.

The bill will have a negative fiscal impact on state general revenue funds of $490,517 in Fiscal Year 2008-09 and $188,675 in Fiscal Year 2009-10.

The effective date of the bill is July 1, 2008.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Limited government – The bill creates additional reporting requirements for hospitals providing charity care in Florida.

Empower families – By modifying current reporting, publication, and billing requirements pertaining to health care providers and facilities, the bill creates more transparency and allows families to make more informed decisions about their health care needs.

B. EFFECT OF PROPOSED CHANGES:

Current Situation

Hospital Reporting Requirements

Florida Hospital Uniform Reporting System

Currently, all hospitals in Florida are required to report both financial data and utilization statistics using a uniform chart of accounts known as the Florida Hospital Uniform Reporting System ("FHURS").[1] In general, FHURS requires hospitals to report revenues, expenses, assets, liabilities and net assets in accordance with generally accepted accounting principles.[2]

Within 120 days subsequent to the end of the fiscal year, hospitals are required to file their actual financial experience, which is a prior year report, and such report must be prepared from hospital financial data audited by a Florida licensed Certified Public Accountant using generally accepted auditing standards and accounting principles.[3] The auditor's report must contain an opinion, and without an opinion, such as an audit report with a disclaimer of opinion, disqualifies the report from the acceptance.[4] Furthermore, any differences between the FHURS report and the audited financial statements must be reconciled and/or explained.

The Agency has 90 days to conduct an initial review of the prior year report.[5] The report is reviewed to determine whether it is complete, conforming, and verified.[6] The report is deemed complete if all forms, documentation, and the auditor's report, with an opinion, have been received. The report is deemed conforming if it has been prepared in accordance with the FHURS requirements and GAAP. [7] The report is deemed verified when the financial data are mathematically accurate, reasonable and supported. AHCA's FHURS Manual providing for reporting principles and instructions to hospitals is available on its website.[8]

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[1] 59E-5.102, F.A.C.

[2] An example of a significant departure from GAAP is found in the reporting of bad debts. Under GAAP, bad debts are classified as an operating expense; however, pursuant to FHURS, bad debts are reported as a deduction from revenue.

[3] *See* s. 408.061(4), F.S; and 59E-5.101(3), (10)-(12) and 59E-5.201, F.A.C.

[4] s. 408.07(7), F.S.; 59E-5.101(6), F.A.C.

[5] 59E-5.204, F.A.C.

[6] 59E-5.205, F.A.C.

[7] s. 408.07(1), F.S.

[8] *See* Agency for Health Care Administration website; located on April 15, 2008 at http://ahca.myflorida.com/MCHQ/CON_FA/fa_data/documents/FHURS_MANUAL_7-2005.pdf.

Pursuant to the FHURS Manual, hospitals are required to report reductions from gross revenue arising from bad debts, contractual adjustments, uncompensated care, administrative, courtesy, and policy discounts, and other revenue deductions. In many instances, the hospital receives less than its full established charges for the services it renders. Thus, reported data must reflect both the gross revenue and related revenue "adjustments" resulting from the inability to collect established charges for services provided.

Charity care is one such category of revenue adjustment that hospitals report as deductions from revenue. The FHURS manual defines "charity care" or "uncompensated charity care" as:

> that portion of hospital charges reported to AHCA for which there is no compensation, other than restricted or unrestricted revenues provided to a hospital by local governments or tax districts regardless of the method of payment, for care provided to a patient whose family income for the 12 months preceding the determination is less than or equal to 200 percent of the federal poverty level, unless the amount of hospital charges due from the patient exceeds 25 percent of the annual family income. However, in no case shall the hospital charges for a patient whose family income exceeds four (4) times the federal poverty level for a family of four be considered charity.[9]

Pursuant to the FHURS Manual, each hospital determines which patients are charity care patients by a verifiable process, which includes obtaining any the following types of documentation:

- W-2 withholding forms
- Paycheck stubs
- Income tax returns
- Forms approving or denying unemployment compensation or worker's compensation.
- Written verification of wages from employer
- Written verification from public welfare agencies or any governmental agency which can attest to the patient's income status for the past twelve (12) months
- A witnessed statement signed by the patient or responsible party, as provided for in the Hill-Burton Act, except that such statement need not be obtained within the 48 hours of the patients' admission to the hospital as required by the Hill-Burton Act. The statement shall include an acknowledgement that, in accordance with Section 817.50 F.S., providing false information to defraud a hospital for the purpose of obtaining goods or services is a misdemeanor in the second degree.
- A Medicaid remittance voucher which reflects that the patient's Medicaid benefits for that Medicaid fiscal year have been exhausted.

One of the ways in which AHCA uses a hospital's reported charity care is to determine the allocation available to a hospital pursuant to the Low Income Pool and Disproportionate Share Hospital Programs. Sections 409.911 and 409.9113, F.S., provide the methodologies for calculating the state share available to hospitals qualifying for funding under the Disproportionate Share Hospital Program ("DSH"). The methodology for distributing Low Income Pool funds is accordance with the Special Terms and Conditions (STCs) for waiver number 11-W-00206/4, Medicaid reform Section 1115 Demonstration, that AHCA submitted to the Centers for Medicare and Medicaid Services.[10] Methodologies for calculating both DSH and LIP funding use the amount of charity care reported by hospitals pursuant to the FHURS requirements as a factor.

Medicaid Cost Reporting

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[9] *See* FHURS Manual at 3.9. This definition is identical to the definition of "charity care" or "uncompensated charity care" provided in s. 409.911, F.S.
[10] *See* http://ahca.myflorida.com/medicaid/medicaid_reform/lip/pdf/final_reimbursement_and_funding_methodology_052907.pdf.

Hospitals that are Medicaid providers are also required to submit a Medicaid Cost Report[11] to AHCA no later than five calendar months after the close of their cost-reporting year.[12] In their reports, hospitals are required to detail their costs for the entire reporting year, and reports must be prepared in accordance with general accepted accounting principles. Furthermore, the hospital's administrator or chief financial officer must execute the report and certify that the services identified in the cost report were provided in compliance with applicable laws and regulations. For hospitals not covered by the common audit agreement with Medicare intermediaries, AHCA performs desk and field audits. Desk audits are conducted on all cost reports within six months after received by AHCA

Medicaid Cost Reports are used by AHCA in order to determine the Medicaid per diem rate applicable to each hospital. Medicaid participating hospitals are reimbursed at a daily rate (per-diem) that is calculated using a cost-based reimbursement methodology. To calculate the daily rate, the methodology uses each hospital's prior year costs inflated forward with a health care indexing inflation factor. However, there are factors within the methodology (called ceilings) that limit the growth in the calculated daily rate each year. Due to the ceilings, the final daily rate may not equal a hospital's actual cost of providing services.

To account for this difference, the Legislature has allowed certain hospitals to qualify for "exemptions" from the ceiling limitations. To qualify, a hospital's sum of charity care and Medicaid days as a percentage of adjusted patient days must equal or exceed 11 percent (7.3 percent if designated or are a provisional trauma center), or must be a Specialized Statutory Teaching and Community Hospital Education Program (CHEP) hospital. The exempt amount is equal to the difference between a hospital's actual daily cost and the final calculated daily rate that is limited by the ceilings in the methodology. To pay for the exemptions, the state certifies local funds, or Intergovernmental Transfers (IGT's), as the state contribution in order to draw down federal matching funds. [13]

Sales Tax Exemptions for 501(c)(3) Corporations

Section 212.08(7)(p) provides for an exemption from sales and lease taxes for entities determined by the Internal Revenue Service to be currently exempt from federal income tax pursuant to s. 501(c)(3) of the IRS Code of 1986, as amended, when such leases or purchases are used in carrying on their customary nonprofit activities. Entities meeting this requirement must, pursuant to s. 212.08(7), F.S., must obtain a sales tax exemption certificate from the Department of Revenue ("DOR"), or obtain or provide the DOR with information otherwise required by DOR. Strict compliance with this subsection is required in order for an entity to retain its tax exemption certificate, and tax certificates are valid for five years.

There is currently no system in Florida to monitor whether the sales tax exemption enjoyed by non-profit hospitals is financially greater, less than, or equivalent to the partially reimbursed community services, or un-reimbursed community services provided by the hospital that provide benefit to the local community. Several other state; however, including Texas, Indiana and California, have developed community benefits programs. In Texas, non-profit hospitals must provide community benefits, which include charity care and government-sponsored indigent health care, at specified levels in order to qualify as a charitable organization under the Texas Tax Code.[14]

The Florida Patient's Bill of Rights and Responsibilities

[11] Medicaid Cost Reports are submitted along with a hospital's FHURS Report. Cost reports include cost reports for outpatient hospital reimbursement and inpatient hospital reimbursement.

[12] If a hospital's certified Medicaid cost report is being audited by independent auditors of the hospital, then the hospital may notify AHCA of such in writing and receive a 30-day extension for filing its cost report.

[13] Senate Bill Analysis and Fiscal Impact Statement for SB 1508 (2008).

[14] ss. 311.042 and 311.043, Tex.Stat. Ann.

Florida law provides for a patient's bill of rights for patients of licensed facilities and health care providers in this state.[15] The rights generally include the right of the patient to:

- *individual dignity*, including the right to privacy, to have prompt answers to questions or concerns, and to retain and use personal clothing or possessions as space permits.
- *information*, including information about the providers tending to the patient, what patient support services are available at the facility, information concerning diagnoses and the planned course of treatment, alternatives, risks, and prognoses, what facility rules and regulations apply to patient conduct, what express grievances or file complaints with regulators, interpreters if the patient does not speak English.
- *financial information and disclosure*, including information about known resources for the patient's health care, information about whether the provider accepts assignment under Medicare reimbursement, a reasonable estimate of charges performance outcome and financial data, receive a copy of an itemized bill. (See below).
- *access to health care*, including impartial access to medical treatment or accommodations regardless of race, national origin, sex, handicap, or source of payment; treatment for emergency medical care; any mode of treatment that is best for the patient based upon the patient's and practitioner's judgment.
- *experimental research*, the patient has a right to know if medical treatment is for purposes of experimental research and consent prior to participation in such.
- *knowledge of rights and responsibilities*, patient has a right to know these in receiving health care.[16]

The financial information and disclosure provisions pertaining to the Patient's Bill of Rights provide that:

- 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 and explanation of charges upon request.

Further, the patient must receive a "Summary of the Florida Patient's Bill of Rights," including specified information within, from health care facilities and providers upon request.[17] The Agency for Health Care Administration is required to make printed materials and make a summary of the Patient's Bill of Rights and Responsibilities available to health care facilities and practitioners. Upon request, health care providers and facilities are required to provide patients of the address and telephone number of each state agency responsible for patient complaints related to a facility's or practitioner's noncompliance with licensing requirements, and are required to have policies and procedures to ensure that patients receive information about their rights and how to file complaints with the facility and

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[15] s. 381.026, F.S.
[16] *Id.*
[17] *Id.*

appropriate state agencies.[18] Administrative action may be taken against a facility for failure to comply with these statutory requirements.[19]

Health Care Facility Disclosures Related to Patient Bills

Hospitals, ambulatory surgical centers, and mobile surgical facilities are health care facilities licensed under and regulated by chapter 395, F.S.[20] Pursuant to s. 395.301(7), F.S., a health care facility 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(1), 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.

Facility Charges

Hospitals generally have a variety of charges for a procedure depending upon whether the procedure will be paid for by public funds, such as Medicaid or Medicare; private insurance, in which case the charge could vary depending upon contractual or negotiated rates; or private funds. Some hospitals also offer discounted rates for patients who are uninsured or underinsured and meet the particular hospital's eligibility criteria. Ambulatory surgical facilities do not typically bill for detailed items associated with medical supplies and pharmaceuticals. Many hospitals no longer bill for supplies.

Agency Published Comparative Data

Both the Florida Patient's Bill of Rights and Responsibilities and the health care facilities' regulatory provisions in s. 395.301, F.S., require each licensed facility to make available on its website a link to performance outcome and financial data that is published by the Agency, and to post a notice in the reception area that this information is available along with the website address.

Pursuant to chapter 408, the Florida Center for Health Information and Policy Analysis (Florida Center) within AHCA, is responsible for collecting, compiling, analyzing, and disseminating health-related data and statistics. The information is published on the Florida Health Finder website at http://www.floridahealthfinder.gov. Health care providers and health care facilities are subject to administrative sanctions for failure to comply with data and record submission requirements.

One component of the Florida Center's responsibilities involves making available health care quality measures and financial data to allow consumers to compare health care services. Specific patient charge data that the Florida Center is required to disclose include the average charge, average net revenue per adjusted patient day, average cost per adjusted patient day, and average cost per admission.

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[18] s. 381.0261, F.S.

[19] *Id.*

[20] s. 395.002(16), F.S.

The Agency currently displays charges (undiscounted prices) on the Florida Health Finder website for 71 selected high-volume inpatient and outpatient procedures, as recommended by the Consumer Health Information Policy Advisory Committee. The procedures are determined by analysis of the procedure codes in the patient discharge data submitted by licensed facilities.

Effect of Proposed Changes

House Bill 1435 shall be cited as the "Health Care Financial Information Act." The Health Care Financial Information Act creates a community benefits program tied to a 501(c)(3) hospital's sales and lease tax exemptions, and amends current law with regard to the information that must be provided to patients by health care providers and facilities, the information that must be submitted to and collected by AHCA for the Florida Center for Health Information and Policy Analysis, and modifies how charity care is calculated by AHCA for the disproportionate share program. Specifically, the bill does the following:

Community Benefits Program

The bill amends in s. 212.08(7)(p), F.S., relating to exemptions from sales or lease taxes for 501(c)(3) corporations by creating community benefits requirements that all 501(c)(3) hospitals in Florida must meet in order to retain their sales and lease tax exemptions. In doing so, the bill defines the following terms:

- "Agency"—which means AHCA.
- "Charity Care"—which means that portion of hospital charges reported to AHCA for which there is no compensation, other than restricted or unrestricted revenues provided to a hospital by local governments or tax districts regardless of the method of payment, for care provided to a patient whose family income for the 12 preceding months is equal to or below 200 percent of the federal poverty level, unless the amount of charges due from the patient exceeds 25 percent of the patient's annual family income. However, in no case shall the hospital charges for a patient whose family income is exceeds four times the federal poverty level for a family of four be considered for charity care.
- "Community"—which means the primary geographic area and patient categories for which a hospital provides health care services.
- "Community benefits"—which means the unreimbursed cost to a hospital of providing charity care, uncompensated government-sponsored indigent health care, donations, education, uncompensated government-sponsored program services, research, and subsidized health services provided by the hospital. Community benefits do not include the cost to the hospital of paying any taxes or other governmental assessments.
- "Hospital"—which means a health care institution licensed by AHCA under chapter 395.
- "Uncompensated government-sponsored indigent health care"—which means the unreimbursed cost to a hospital of providing health care services to recipients of Medicaid and other federal, state, or local indigent health care programs which base eligibility on financial need.
- "Uncompensated government-sponsored program services"—which means the unreimbursed cost to the hospital of providing health care services to the beneficiaries of Medicare, the Civilian Health and Medical Program of the Uniformed Services, and other federal, state, or local government health care programs. The Civilian Health and Medical Program of the Uniformed Services has been replaced by TRICARE.

The bill requires each exempt hospital to:

- Develop an organization mission statement that identifies the hospital's commitment to serving the health care needs of the community

- Develop a community benefits plan, which sets out the goals and objectives for providing community benefits, including charity care and government-sponsored indigent health care, and identify the populations and communities served by the hospital. The plan shall include:
  - A mechanism to evaluate the effectiveness of the plan, including a method to solicit the views of individuals in the communities served by the hospital and identification of community groups and other local government officials consulted during the plan's development
  - Measurable objectives to be achieved within a specified timeframe
  - A proposed budget
- Provide community benefits on an annual basis pursuant to its plan.

The bill allows hospitals to use their independent, prudent business judgment in determining the appropriate level of government sponsored indigent care and charity care based upon the needs of the community, the hospital's available resources, the tax-exempt benefits received by the hospital, and other factors that may be unique to the hospital, such as the number of Medicaid are Medicaid patients it serves. Community benefits may be provided, at the election of the parent corporation, in order to satisfy the requirements for each of the hospitals within the organization on a consolidated basis. The bill creates the following standards for providing charity care and government sponsored health care to meet the community benefits requirement:

- Such care must be provided at a level which is reasonable in relation to the community's needs, as determined through a community needs assessment, the available resources of the hospital, and the tax-exempt benefits received by the hospital;
- Such care must be provided in an amount equal to at least 100 percent of the hospital's tax-exempt benefits, excluding federal income tax; or
- Such care must be provided in an amount equal to at least 5 percent of the hospital's net patient revenue, provided that such care are provided in an amount equal to at least 4 percent of the hospital's net patient revenue.

Additionally, the bill creates the following reporting requirements for each exempt hospital:

- Community benefits plans for the next fiscal year – due by April 30
- Report to AHCA regarding compliance with the community benefits plan – due no later than 120 days after the conclusion of the hospital's fiscal year. The plan must include the hospital's:
  - Mission statement
  - Disclosure of its consideration of the health care needs of the community when drafting its plan
  - Disclosure of the amount and type of community benefits provided, with a separate reporting for charity care
  - Statement of total operating expenses computed in accordance with generally accepted accounting principles for hospitals, including a completed worksheet that computes the ratio of cost-to-charge for the fiscal year, from the most recent completed and audited prior fiscal year
  - Disclosure of the amount of tax-exempt benefits for that fiscal year if the hospitals provides community benefits according to the standards provided in sub-subparagraph 3.a. or sub-subparagraph 3.b.

The bill requires AHCA to publish and submit an annual report (by January 1) to the Attorney General and Chief Financial Officer listing each exempt hospital that did not meet these requirements during the prior fiscal year, which shall identify the manner of noncompliance. For all hospitals, AHCA is also required to submit an annual report to the Attorney General and Chief Financial Officer that includes the amount of charity care, government-sponsored indigent health care, and community benefits provided, as well as the following:

- The amount of net patient revenue and the amount constituting four percent of such revenue

- The dollar amount of the hospital's charity care and community benefits
- The amount of tax-exempt benefits if the hospital provides community benefits according to sub-subparagraphs 3.a. or 3.b.
- The amount of charity care expenses reported to the hospital's financial statement

The bill creates notice requirements, which require hospitals to notify the public of the availability of community benefits plan annual report, including that the report is filed with AHCA and available to the public upon request. This notice shall be posted in prominent places throughout the hospital, including the emergency room waiting area and the admissions office waiting area, and the hospital must include such statement in the printed patient guide or other material that provides patients with information about the admissions criteria of the hospital. Further, the bill requires hospitals to provide notice to all persons seeking health care, in appropriate languages, about the availability of charity care, including charity care and eligibility policies of the program, and how to apply for charity care. "Appropriate language" is not defined. The notice must also be posted conspicuously in the general waiting area, in the emergency room waiting area, in the business office, and in such other areas that the hospital deems likely to give notice of the charity care program and policies. Each hospital must annually publish notice of the hospital's charity care program and policies in a local newspaper of general circulation in the county. Each notice must be written in language readily understandable by the average reader.

The bill requires the Chief Financial Officer to revoke the tax-exempt status of a hospital that fails to comply with any of the requirements. Any hospital that is facing revocation may apply for a grace period of one fiscal year within which to become compliant. During this time, the hospital must also provide an additional amount of charity care and government-sponsored indigent health care that is equal to the shortfall from the previous year. Hospitals are entitled to one grace period for each five-year period.

The bill creates an exemption from these requirements for hospitals that have been designated as disproportionate share hospital under the state Medicaid program in the current fiscal year or in either of the previous two fiscal years.

Florida Patient's Bill of Rights

The bill amends the current rights of patients provided under s. 381.026, F.S., by requiring all health care providers and facilities to disclose to each patient eligible for Medicare, in advance of treatment, whether the health care provider or facility accept the assignment under Medicare reimbursement as payment in full for medical services and treatments rendered, to notify each patient of his or her right to receive an itemized bill, and to submit such itemized bill to the patient within 7 days following the patients' discharge. Current law limits a provider's or facility's obligation to provide this information to a patient only upon the request of the patient.

Further, the bill requires that the estimate of charges provided to patients be in an itemized format, and that licensed facilities publish, electronically or on their website, pricing information, including the lowest charge, the average charge, and the highest charge. The bill removes a provision that allows the facility to include a statement on its electronic publication or website that provides that pricing is based upon a compilation of charges.

Additionally, the bill require each facility to provide, upon written request of a prospective patient, a written, itemized good faith estimate of reasonably anticipated charges prior to providing nonemergency medical services to patients. The bill removes a provision allowing such estimate to be the average charges for that diagnosis related group or the average charge for that procedure, requires that the facility notify the patient if the estimate is revised, and allows the facility or provider to exceed the good faith estimate based upon changes in the patient's medical condition or treatment needs if such are itemized on the patient's billing statement.

Florida Center for Health Information and Policy Analysis and Data Provided by Health Care Facilities

The bill amends s. 408.05, F.S. by requiring AHCA, when determining which health care quality measures to disclose related to patient charge data, to consider such measures as a price list of procedures, supplies, and services and range of charges from lowest to highest charge. These measures are in addition to average charge, average net revenue per adjusted patient day, average cost per adjusted patient day, and average cost per admission provided for in current law. Moreover, the bill amends s. 408.061, F.S., by including a price list for not fewer than the 100 most commonly performed procedures, based upon the statewide average of procedures, and the 500 most commonly used supplies, among the other items that facilities that must be submitted to AHCA by health care facilities.

Disproportionate Share Program

The bill amends the definition of "charity care" provided in s. 409.911, F.S., relating to the disproportionate share program by providing that the amount of uncompensated or charity care shall only be valued and reported at Medicaid rates.

The bill provides for an effective date of July 1, 2008.

C. SECTION DIRECTORY:

Section 1. Provides that this act shall be cited as the "Health Care Financial Information Act."

Section 2. Amends s. 212.08, F.S.; relating to sales, rental, use, consumption, distribution, and storage tax; specified exemptions.

Section 3. Amends s. 381.026, F.S.; relating to Florida Patient's Bill of Rights and Responsibilities.

Section 4. Amends s. 395.301, F.S.; relating to Itemized patient bill; form and content prescribed by the agency.

Section 5. Amends s. 408.05, F.S.; relating to Florida Center for Health Information and Policy Analysis.

Section 6. Amends s. 408.061, F.S.; relating to data collection; uniform systems of financial reporting; information relating to physician charges; confidential information; immunity.

Section 7. Amends s. 409.911, F.S.; relating to disproportionate share program.

Section 8. Providing an effective date of July 1, 2008.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill requires all hospitals to report and the Agency to publish a price list for not fewer than the 100 most commonly performed procedures, based on a statewide average of procedures, and the 500 most commonly used supplies. To calculate the fiscal impact of this provision, the agency

assumed that a consistent coding system exists for gathering data on procedures across hospitals. As such, gathering the information requested in this section relative to procedures would not have a significant fiscal impact since that information is currently available in the existing data collected. There would be minimal fiscal impact for the procedures portion of the Act.

The agency indicates that the opposite is true for the requirement to collect data on commonly used supplies. There is no consistent coding system across hospitals to collect data on supplies. A methodology would need to be developed in order to collect the data on supplies and the computer programs at the agency would need to be created to capture, process, and report on the information collected.

A non-recurring OPS position (pay grade 24) would be needed for the first year to develop a methodology for identifying the top 500 supplies, developing rules for reporting, establishing reporting procedures, and assigning passwords and log on information to facilities submitting data to the Agency. Two additional recurring FTEs would be required to manage the reporting system, performing facility liaison work including quality control, and to maintain updates to the top 500 supplies.

Building the application needed to collect the data would require a team of three people for three months to develop the application. This results in 1,440 hours of development time. The program could be developed in house, but it would necessitate reordering agency priorities and would result in other scheduled projects being postponed. The agency recommends that this application be developed using a staff augmentation contract. These contracts typically result in an hourly charge rate of $125.00 per hour; a rounded estimate of cost would be $180,000 for development of the programs.

The website contractor would be required to expand the data displayed on the Florida Health Finder website as well as link the additional procedures to the symptom navigator and medical encyclopedia. There will be a cost of $28,000 for the initial set up and $60,000 in recurring funds to update this information on a quarterly basis.

	2008-09	**2009-10**
OPS Expenditures	$87,842	$
Contracted Services	$268,000	$ 60,000
AHCA (2.0 FTE)	$134,675*	$128,675
Total Expenditures	$490,517	$188,675
General Revenue Fund	$490,517	$188,675

*Fiscal Year 2008-09 includes $6,000 in non-recurring funding for equipment for the new staff positions.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill creates more administrative and reporting requirements for facilities and practitioners. Moreover, if implemented, hospitals that fail to comply with the community benefits requirements could lose their sales and lease tax exemptions.

D. FISCAL COMMENTS:

The Department of Revenue (DOR) analysis indicates that the bill specifies that the Chief Financial Officer is to revoke the tax-exempt status of any hospital that does not meet the community benefits requirement. However, the bill provides no procedures or notification requirements that would let the DOR know that the Chief Financial Officer has revoked a hospital's tax-exempt status.

In addition, because the bill does not provide any tie between this new requirement and the hospital's consumer's certificate of exemption, there may be problems with accurately determining when a hospital lost its tax-exempt status. This may result in purchases being made tax-exempt after the hospital has been found by the Chief Financial Officer to not be meeting its community benefits requirement.

The Agency for Health Care Administration states that Section 7 of the bill provides changes to the criteria for exemptions and reporting requirements used to determine exemptions from reimbursement ceilings to be paid to hospitals. The additions and modifications provided in this bill will not have a direct impact on Medicaid. Changes in the data available for Disproportionate Share Hospital (DSH) and Low Income Pool (LIP) calculations may require modifications to the methodology for distributions and or have an impact on the distributions to individual hospitals that are impacted because of the changes in reporting and pricing of charity care. However, the agency anticipates that the aggregate funding level and support would continue; and, therefore no fiscal impact is anticipated for Medicaid related to the bill.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill creates a number of new requirement pertaining to the AHCA with regard to the community benefits program, including providing AHCA with the authority to determine whether an entity has failed to comply with the community benefits requirement; however, AHCA is not provided with rulemaking authority to implement this Section 2 of the bill. Moreover, the Chief Financial Officer is required to revoke a 501(c)(3) hospital's sales and lease tax exemption certificate based upon AHCA's determination that the hospital failed to comply with the community benefits requirement; however, the CFO is not provided with rulemaking authority to implement Section 2 of the bill. Moreover, the bill does not provide the hospital with notice or hearing rights typically afforded to citizens or entities affected by agency action.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The bill at lines 116-117 requires hospitals to consider the health care needs of the community as determined by the “communitywide needs assessment.” “Communitywide needs assessment” is not defined in the bill.

The bill at lines 124-125 requires hospitals to include in their community benefits plan “measurable objectives” to be achieved. The bill does not specify those “measurable objectives,” and, therefore, does not provide AHCA with guidance for determining whether those measurable objectives were sufficient and/or achieved by the hospital.

The bill at lines 129-136 leaves it to the “prudent business judgment” of the hospital to determine the appropriate level of charity care and government-sponsored indigent health care; however, because AHCA is required to determine compliance with community benefits requirements under this paragraph, the bill will result in requiring AHCA to substitute its judgment for the “prudent business judgment” of the hospital without any guidance or standards for doing so.

At line 179, the bill requires hospitals to include a “completed worksheet that computes the ratio of cost-to-charge for the fiscal year.” The bill does not specify whether the completed worksheet will be developed by AHCA or whether each hospital will create its own individualized worksheet.

The bill at lines 186-191 requires AHCA to report non-compliant hospitals to the Attorney General and Chief Financial Officer; however, the bill does not provide for dissemination of that information to the Department of Revenue, which issues the certificates of tax exemption.

The bill at lines 231-233 requires the Chief Financial Officer to revoke the tax-exempt status of a hospital that fails to comply with any provision of s. 212.08(7)(p), F.S; however, the bill does include procedures or notification requirements for the Chief Financial Officer to communicate his or her revocation decision to the DOR, who issues and revokes Florida Consumers Certificates of Exemption. According to the DOR, because the bill does not provide any tie between this new requirement and the hospital’s consumer’s certificate of exemption, there may be problems with accurately determining when a hospital lost its tax-exempt status. This may result in purchases being made tax-exempt after the hospital has been found by the Chief Financial Officer to not be meeting its community benefits requirement. DOR also stated that these issues cannot be resolved through rulemaking[21]

D. STATEMENT OF THE SPONSOR

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES

[21] Department of Revenue 2008 Bill Analysis.