HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 637 Electronic Health Records
SPONSOR(S): Healthcare Council; Grimsley and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 1998

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Healthcare Council	17 Y, 0 N, As CS	Owen/Massengale	Gormley
2) Policy & Budget Council			
3)			
4)			
5)			

SUMMARY ANALYSIS

The bill creates the "Florida eHealth Initiative Act" to "promote and coordinate the establishment of a secure, privacy-protected, and interconnected statewide health information exchange." The bill amends the agency's authority to provide grants to RHIOs by requiring dollar for dollar match of state funds with local or private funds and issuance of grants in three categories: development, operation, and collaboration. The bill also creates an Electronic Medical Records System Adoption Loan Program. The agency is required to provide one-time, no-interest loans to physicians or business entities whose shareholders are physicians for the initial costs of implementing an electronic medical records system.

The bill creates the Florida Health Information Exchange Advisory Council, composed of 12 members, to promote participation in health information exchanges, conduct outreach to stakeholders, and provide guidance regarding the effective use of health information exchanges and standards for privacy and security.

The bill clarifies that a patient's records held by a hospital may be disclosed without the consent of the patient, or his or her legal representative, to health care practitioners and providers involved in the care or treatment of the patient. The bill also clarifies that clinical lab results may be provided by a lab to other health care practitioners and providers involved in the care or treatment of the patient for use in connection with the treatment of the patient.

The bill requires the agency to maintain on its internet website information regarding federal and private sector health information exchange funding programs and a clearinghouse of state and national legislative, regulatory, and public awareness activities related to health information exchanges.

The bill requires the agency to develop and implement a plan to promote participation in health information exchanges and the adoption of electronic medical record systems by physicians in consultation with the council and professional associations.

Finally, the bill requires the OPPAGA to complete an independent evaluation of the grants program administered by the agency. The report must be provided to the Governor and the Legislature by July 1, 2009.

The bill has an indeterminate fiscal impact on the agency (see fiscal analysis).

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide limited government – the bill creates a loan program to encourage and to provide incentives for the use of electronic medical records by physicians.

B. EFFECT OF PROPOSED CHANGES:

Present Situation

Widespread adoption of electronic medical records holds the promise of improving patient safety and reducing the cost of health care by preventing unnecessary procedures. However, in a recent report, the National Center for Health Statistics (NCHS) within the United States Centers for Disease Control and Prevention noted that adoption of information technology within the health care sector is trailing behind other sectors in the economy of the United States.[1] The adoption of electronic medical records (EMRs) by hospitals and physicians has been particularly slow. As part of its annual National Health Care Survey, NCHS found that, from 2001 through 2003:

- The most frequent IT application used in physician offices was an electronic billing system. Nearly three-fourths (73 percent) of physicians submitted claims electronically. Electronic submission of claims was more likely among physicians in the Midwest and South, in nonmetropolitan areas, among physicians under 50 years of age, and for physicians with 10 or more managed care contracts. Physicians in medical specialties such as psychiatry, dermatology, or sports medicine (among others) were least likely to submit claims electronically.
- EMRs were used more frequently in hospital settings (31 percent in emergency departments) than in physician offices (17 percent). Among physician office practices, there were no statistically significant differences in EMR use by region, metropolitan status, specialty, physician age, type of practice, or number of managed care contracts.

Federal

On April 27, 2004, President George W. Bush issued an Executive Order[2] in order to encourage the development of a nationwide interoperable health information technology infrastructure. The Executive Order directed the Secretary of Health and Human Services to establish within the Office of the Secretary the position of National Health Information Technology Coordinator. The Office of the National Coordinator (ONC) is tasked with developing, maintaining, and implementing a strategic plan to guide the nationwide implementation of interoperable health information technology in both the public and private health care sectors in order to reduce medical errors, improve quality, and produce greater value for health care expenditures.

In 2004, President Bush also set the goal for most Americans to have access to an interoperable electronic medical record by the year 2014. In order to accomplish this goal, the United States Department of Health and Human Services (HHS) created a "Strategic Framework",[3] which outlines the vision and goals of HHS' health information technology initiative. The plan of action consists of four sequential main goals; each goal is supported by three major strategies. The four goals are diagramed in Figure 1.[4]

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[1] C.W. Burt and E. Hing, *Use of Computerized Clinical Support Systems in Medical Settings: United States, 2001–03*, Advance Data from Vital and Health Statistics no. 353, March 15, 2005.

[2] *Executive Order: Incentives for the Use of Health Information Technology and Establishing the Position of the National Health Information Technology Coordinator* (visited December 4, 2007) http://www.whitehouse.gov/news/releases/2004/04/20040427-4.html

[3] U.S. Department of Health and Human Services, "Summary of Strategic Framework," (visited December 13, 2007) www.hhs.gov/healthit/framework.html.

[4] *Id.*

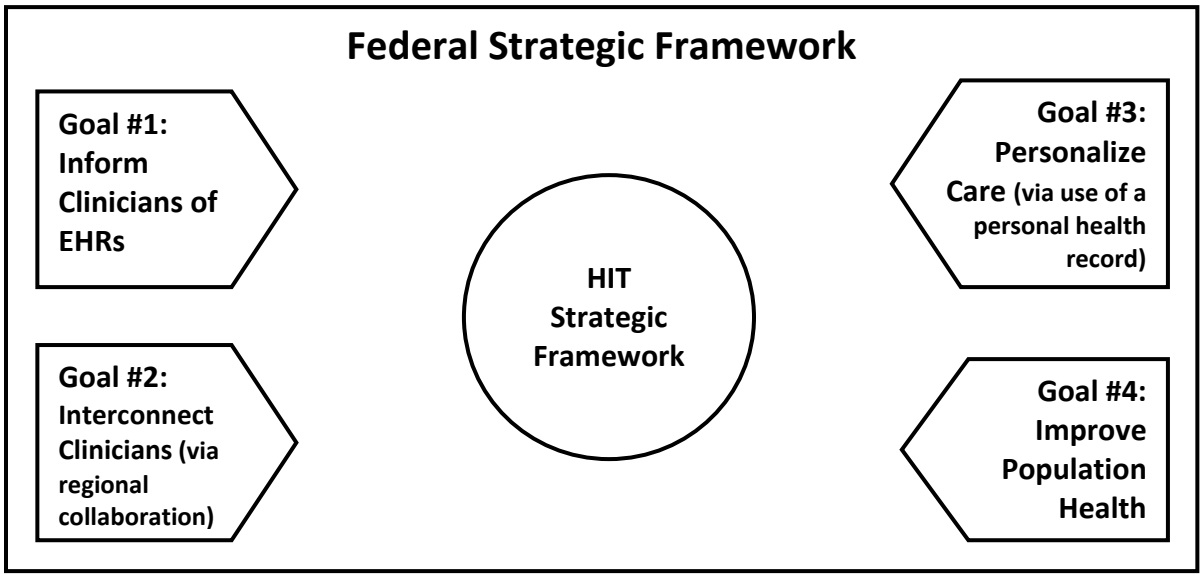

Figure 1

The federal government has taken an active role in ensuring the necessary steps are taken to achieve the outlined goals. The ONC awarded multiple contracts in 2005 to entities conducting work in the field of health information technology (HIT). Project goals included:

- Identifying interoperability standards (such as to facilitate the exchange of patient health data), through a contract with the Healthcare Information Technology Standards Panel (HITSP).
- Defining a certification process for health IT products, through a contract with the Certification Commission for Healthcare Information Technology (CCHIT).
- Designing and evaluating standards-based prototype architectures for the Nationwide Health Information Network (NHIN).

State and federal governments are both actively working to set technical interoperability standards, though for different purposes. Technical interoperability standards are important to state governments to enable the multiple participating entities to connect to each other, whether through a statewide HIE or other means. The federal government is pursuing technical interoperability standards to enable states to communicate with each other through the NHIN. Both state and federal government technical standards are equally important to overall HIE and should complement each other.

The federal government has also created a program aimed at increasing the adoption of electronic health records (EHR) among physician practices. The five-year project, which will begin in the spring of 2008, will provide annual bonuses to physician groups using nationally certified EHR systems to meet clinically qualified measures. During the five year project, it is estimated that 3.6 million consumers will be directly affected as their primary care physicians adopt certified EHRs in their practices.[5]

Other States

States across the nation have recognized the potential benefit of HIT and many are moving forward with HIT efforts. However, states differ in their vision of incorporating HIT into their healthcare system and the roadmap to achieve their vision. Smaller states are better positioned to create a statewide health information exchange (HIE), due to the fact that they have smaller, centrally-located populations and fewer healthcare stakeholders to coordinate, while larger states tend to have a greater number of stakeholders and a larger, more diverse population.[6] Regional health information organizations

[5] U.S. Department of Health and Human Services, "HHS Announces Project to Help 3.6 Million Consumers Reap Benefits of Electronic Health Records," October 30, 2007.

[6] Avalere Health, "Evolution of State Health Information Exchange, A Study of Vision, Strategy, and Progress, as prepared for the Agency for Healthcare Research and Quality," AHRQ Publication No. 06-0057, January 2006, 5.

(RHIOs) across states are many and varied, with minimal inter-RHIO connection. Many states have multiple RHIOs, but their participants, organization, structure, and activities are as varied as the communities they represent.[7]

The state plays a variety of roles in statewide HIE projects across the nation, including:

- The main cross-stakeholder facilitator.
- A primary driver of the project.
- A funding resource.
- A data resource.[8]

Some states have partnered in creating a legal entity, such as a 501(c)(3), to implement a roadmap to statewide HIE, while others have formed a steering committee, advisory council, or task force to continue to research the process by which statewide interoperability should be achieved. One commonality across states is the presence of a statewide advisory body to oversee the process by which a state reaches interoperability. Figure 2 illustrates the varied level of HIE adoption across the nation.[9]

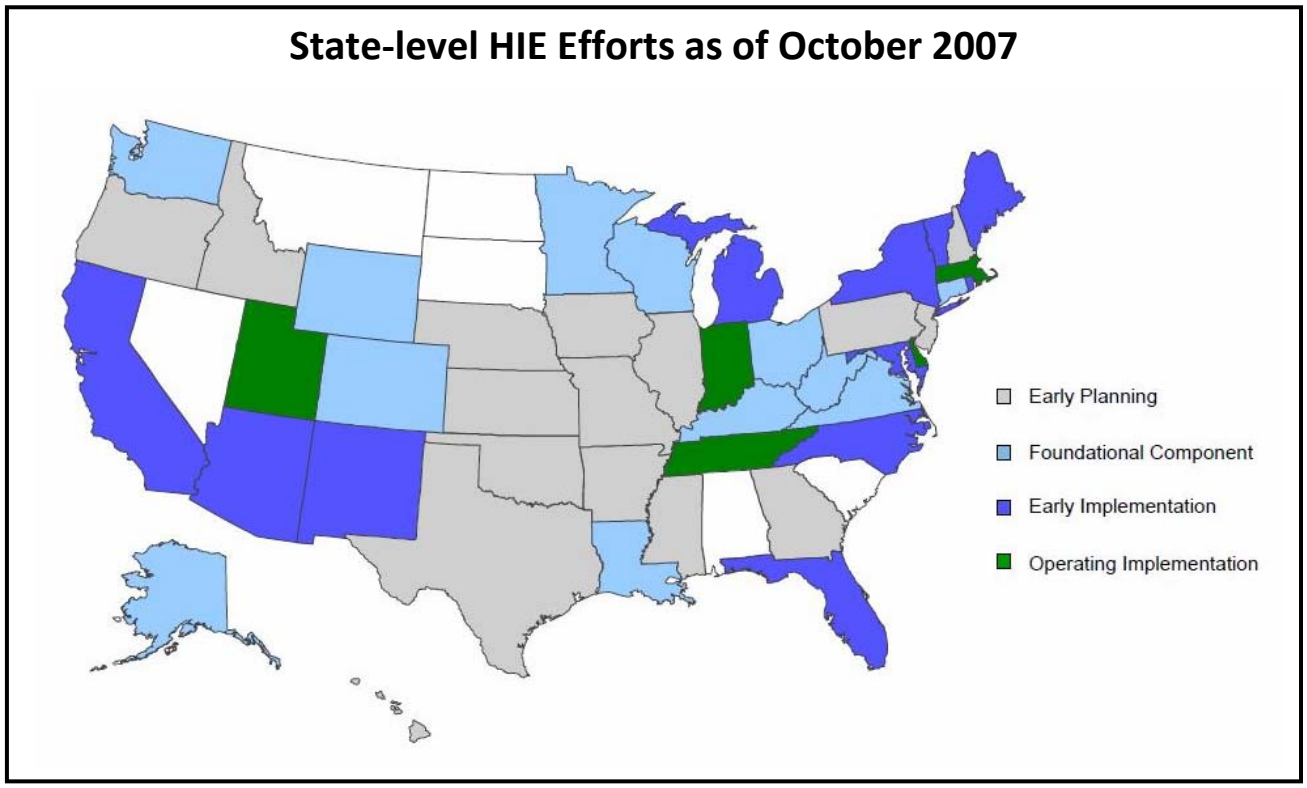

Figure 2

For example, the state of Georgia has formed an advisory board to advise the state Department of Community Health in establishing a statewide strategy that will enable health information to be available across the full continuum of care.[10] Georgia also administers a grants program to foster health information exchange, which awarded $853,088 in grants in 2007.[11] The state of Minnesota has formed

[7] *Id.*
[8] *Id.* at 7.
[9] American Health Information Management Association's Foundation of Research and Education, "Building Sustainable Health Information Exchange: Roles for State Level Public-Private Partnerships," State-Level HIE Consensus Project, Consensus Conference, November 5-6, 2007, 15.
[10] Executive Order of Georgia Governor Sonny Perdue, October 17, 2006.
[11] Press release, Georgia Department of Community Health, "Four Georgia Health Partnerships Receive $853,088 in Grants," November 5, 2007.

a public-private collaborative to enhance the statewide HIE infrastructure, which is scheduled to go live in early 2008.[12] Minnesota also operates an EHR adoption grant program aimed at supporting the adoption and use of EHRs by healthcare providers in rural and underserved areas of the state.[13]

The state of Kentucky's roadmap to statewide HIE is very similar to the previously proposed Florida Health Information Network. The state approved the creation of the Kentucky e-Health Corporation which is an independent public-private entity responsible for managing the development and operations of the statewide Kentucky e-Health Network currently under development.

According to the e-Health Initiative, the top sources of upfront funding in the United States for health information exchange initiatives in 2007 were hospitals (53%), federal government grants and contracts (44%), state government grants and contracts (43%), private payers (32%), and philanthropic sources (31%).[14]

Florida

In Florida, the development of a statewide HIE began on May 4, 2004, when Governor Jeb Bush created the Governor's Health Information Infrastructure Advisory Board (board) by executive order.[15] The executive order required the board to "advise and support the Agency for Health Care Administration as it develops and implements a strategy for the adoption and use of electronic health records and creates a plan to promote the development and implementation of a Florida health information infrastructure." Complementing the Governor's Executive Order was the passage of the 2004 Affordable Health Care for Floridians Act, which directed the agency to "develop and implement a strategy for the adoption and use of electronic health records."[16]

The board issued an interim report to Governor Bush in 2005 that called for, among other recommendations, the immediate development of the Florida Health Information Network (FHIN) in order to encourage the adoption of electronic health records.[17] The vision for the FHIN is outlined in the board's white paper, "Florida Health Information Network, Architectural Considerations for State Infrastructure".[18] The model outlined by the board relies heavily on the RHIO as the vehicle for statewide HIE. The FHIN will act as the conductor of health information among healthcare providers and has two main components: regional HIE (through RHIOs) and a statewide infrastructure that will connect the RHIOs to enable statewide HIE.[19] The report also recognized two main obstacles facing the development of the FHIN: the low number of healthcare providers who have adopted electronic health record systems, and the lack of an infrastructure to share health information effectively.

Over the course of three years, the board and the agency worked together to implement recommendations related to advancing the adoption and utilization of EHRs and establishing RHIOs and regional HIE.[20] The board published its final report to Governor Charlie Crist on July 6, 2007.[21]

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[12] Press release, Minnesota Office of the Governor, "Minnesota Health Information Exchange to be among largest 'e-initiatives' in the nation," September 10, 2007.
[13] Minnesota Department of Health, "Minnesota e-Health Initiative Funding Opportunities," http://www.health.state.mn.us/e-health/funding.html (visited January 5, 2008).
[14] e-Health Initiative, "Fourth Annual Survey of Health Information Exchange at the State, Regional, and Community Levels," December 19, 2007, http://www.ehealthinitiative.org/2007HIESurvey/Financing.asp (visited January 5, 2008).
[15] Executive Order Number 04-93 (2004), available at http://www.fdhc.state.fl.us/dhit/Board/executive_order.pdf. (visited December 17, 2007).
[16] Chapter 2004-297, L.O.F., s. 408.062(5), F.S.
[17] Governor's Health Information Infrastructure Advisory Board, "First Interim Report to Governor Jeb Bush," http://ahca.myflorida.com/dhit/Board/interim_rept_gov.pdf (visited December 17, 2007).
[18] Governor's Health Information Infrastructure Advisory Board, "Florida Health Information Network, Architectural Considerations for State Infrastructure," Version 6.2, April 19, 2007.
[19] Florida Health Policy Center, "Florida's Health Information Network: What will it cost to develop?," February 2007, http://www.floridahealthpolicycenter.org/research/pdfs/FHIN%20brief.pdf (visited December 19, 2007).
[20] Florida Center for Health Information and Policy Analysis, "Privacy and Security Solutions for Interoperable Health Information Exchange, Florida Implementation and Impact Report," December 3, 2007, 4.

The report said that the foundation for a statewide network is in place and recommended the following actions to Governor Crist to implement the FHIN:

- Promote and support the continuing development of the state's local health information exchanges.
- Establish a new advisory board as soon as possible to guide the direction and development of the FHIN.
- Require action on specific steps to assist in developing the network from Florida Medicaid, the Department of Health, and the Department of Management Services, and possibly other state agencies.
- Insist on a "bias in favor of action" on this initiative by members of the administration, placing an emphasis on data exchange operations over the occasional government tendency to conduct further studies before taking substantive action.

The board was not extended by Executive Order and ceased to operate on June 30, 2007. In January 2008, agency Secretary Andrew Agwunobi appointed a 14-member Health Information Exchange Coordinating Committee. The committee is organized "to advise and support the agency in developing and implementing a strategy to establish a privacy-protected, secure and integrated statewide network for the exchange of electronic health records among authorized physicians."[22]

FHIN Grants Program

In 2006, the Legislature authorized the agency to administer a grants program to advance the development of a health information network.[23] According to the agency, grants are currently awarded in three categories:[24]

- Assessment and planning grants, which support engaging appropriate healthcare stakeholders to develop a strategic plan for health information exchange in their communities.
- Operations and evaluation grants, which support projects that demonstrate health information exchange among two or more competing provider organizations.
- Training and technical assistance grants, which support practitioner training and technical assistance activities designed to increase physician and dentist use of electronic health record systems.

From Fiscal Year 2005-2006 through Fiscal Year 2007-2008, a total of $5.5 million has been appropriated by the legislature to fund the grants program.

Approximately half of the RHIOs that have received state grants are operational in exchanging data within their region, but on a very limited basis. The scope of the exchange and number of users participating in the exchange is still relatively small. The remaining RHIOs that have received state grants are pre-operational and continuing to develop and test various elements of their HIE. The RHIOs and their aggregate funding levels include:

- Big Bend RHIO – $810,422
- Central Florida RHIO – $200,000
- Community Health Informatics Organization – $222,384
- Healthy Ocala – no funding sought
- Northeast Florida Health Information Consortium – $406,944
- Northwest Florida RHIO – $776,589
- Palm Beach County Community Health Alliance – $692,812
- South Florida Health Information Initiative – $742,151
- Tampa Bay RHIO – $1,043,957

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[21] Governor's Health Information Infrastructure Advisory Board, "Final Report of the Governor's Health Information Infrastructure Advisory Board," July 6, 2007, http://ahca.myflorida.com/dhit/Board/Brdmtg63007.pdf (visited December 19, 2007).
[22] Agency for Health Care Administration, http://ahca.myflorida.com/dhit/Governance/HIECCIndex.shtml (visited January 21, 2008).
[23] Section 408.05(4)(b), F.S.
[24] Agency for Health Care Administration, "FY 2007-2008 Grants Program Requirements," http://ahca.myflorida.com/dhit/FHINgrantsProgram/FGPSched0708.pdf (visited January 21, 2008).

- Veterans' Health Information Exchange Network – $70,614

Health Information and Security Privacy Collaboration Project
The Health Insurance Portability and Accountability Act (HIPAA) established baseline health care privacy requirements for protected health information and established security requirements for electronic protected health information.[25] However, many states vary on their application of HIPAA -- some have not adopted policies stronger than HIPAA, while some have adopted policies that are stronger than HIPAA. The inconsistency in the way in which HIPAA is interpreted and applied and the differences between state privacy laws and HIPAA have caused great concern amongst those interested in a nationwide HIE.

RTI, Inc. (RTI), a private, nonprofit corporation, was awarded a contract from HHS in 2005 totaling $11.5 million. The purpose of the project was to asses variations in organization-level business practices, policies, and state laws that affect HIE and to identify and propose practical ways to reduce the variation to those "good" practices that will permit interoperability while preserving the necessary privacy and security requirements set by the local community.[26] RTI sub-contracted with 34 states and territories to complete the project. The state of Florida was among the sub-contract recipients.

The state teams were required to convene steering committees comprised of both public and private leaders and work groups with specific charges through which all research and recommendations would be made.

The project enabled states to engage stakeholders on a local level to identify the barriers to electronic health information exchange specific to their location. The final report issued by RTI in June of 2007, "Assessment of Variation and Analysis of Solutions", outlines issues that state project teams all identified as possibly affecting a private and secure nationwide HIE along with possible solutions to the identified challenges, both at the state and national levels.

Among the challenges identified were: differing interpretations and applications of HIPAA privacy rule requirements, misunderstandings and differing applications of the HIPAA security rule, trust in the security of health information exchange, fragmented and conflicting state laws relating to privacy and security of health information exchange, and disclosure of personal health information. Among the solutions to the challenges identified by the participating states were: creation of uniform state policy as it relates to the interpretation and application of the HIPAA rules, consolidation of state statutes related to health information exchange, creation of national standards for a master patient index or record locater to accurately match records to the appropriate patient, and education of consumers and healthcare professionals about federal and state privacy law.[27]

With regard to Florida law, the agency's Privacy and Security Project Legal Work Group identified several barriers to health information exchange in statutory law, including:
- Inconsistent language regarding the disclosure of patient records without consent in the hospital and physician patient records sections.[28]
- Lack of authority for treating physicians to access lab results directly from the clinical lab under chapter 483, F.S.[29]

Effect of Proposed Changes

[25] The MITRE Corporation, "ONC- NIH Analysis Report to the National Institutes of Health, National Center for Research Resources," March 2006, 11.
[26] Dimitropoulos, Linda L., "Privacy and Security Solutions for Interoperable Health Information Exchange, Assessment of Variation and Analysis of Solutions," June 30, 2007, 2-1.
[27] *Id.* at ES-5 through ES-8.
[28] Sections 395.3025 and 456.057, F.S., respectively.
[29] Section 483.181, F.S.

The bill clarifies that a patient's records held by a hospital may be disclosed without the consent of the patient, or his or her legal representative, to health care practitioners and providers currently involved in the care or treatment of the patient. The bill also clarifies that lab results may be provided by a clinical laboratory to other health care practitioners and providers involved in the care or treatment of the patient for use in connection with the treatment of the patient.

The bill creates the "Florida eHealth Initiative Act" to "promote and coordinate the establishment of a secure, privacy-protected, and interconnected statewide health information exchange." The bill amends the agency's authority to provide grants to RHIOs by requiring:

- Dollar for dollar match of state funds with local or private funds.
- Issuance of grants in three categories: development, operation, and collaboration.
- Establishment of specific eligibility criteria to qualify for a grant in each area, including demonstration of local or private matching dollars and policies and procedures to protect the privacy and security of electronic medical records.

The bill requires grants to be awarded in consultation with the Florida Health Information Exchange Advisory Council. The agency is prohibited from awarding a grant to a recipient for more than 6 aggregate years. The grants program is subject to a specific appropriation.

The bill creates an Electronic Medical Records System Adoption Loan Program, subject to a specific appropriation. The agency is required to provide one-time, no-interest loans to physicians or business entities whose shareholders are physicians for the initial costs of implementing an electronic medical records system. The agency is prohibited from providing a loan to an applicant who has:

- Been found guilty of violating s. 456.072(1) or been disciplined under the applicable licensing chapter in the previous 5 years.
- Been found guilty of or entered a plea of guilty or nolo contendere to a violation of ss. 409.920 or 409.9201, F.S. (Medicaid fraud).
- Been sanctioned pursuant to s. 409.913 for fraud or abuse (Medicaid fraud).

The agency is authorized to distribute the loan in a lump-sum amount, and the loan proceeds may be used to purchase hardware and software, as well as subscription services, professional consultations, and staff training. The agency is required to provide loan recipients a list of electronic medical record systems recognized or certified by national standards-setting entities. The agency is further required to distribute a minimum of 25 percent of loan funds to physicians or business entities operating within a rural county. The loan must be repaid within 6 years and payments must commence within 3 months of the funding of the loan.

The physician or business entity must further provide the following security for the loan:

- An irrevocable letter of credit in an amount equal to the amount of the loan;
- An escrow account in an amount equal to the amount of the loan; or
- A pledge of the accounts receivable of the physician or business entity.

If a physician or business entity defaults, and the default continues for 30 days, the entire balance of the loan becomes due and payable, subject to an interest rate of 18 percent annually.

The bill creates the Florida Health Information Exchange Advisory Council adjunct to the agency. The stated purpose of the council is to promote participation in health information exchanges, conduct outreach to inform stakeholders of the benefits of using a health information exchange, and provide guidance to stakeholders regarding the effective use of health information exchanges and standards for protecting the privacy and security of electronic medical records.

The council is composed of 12 members:

- The Secretary of the agency, or his or her designee.
- The State Surgeon General, or his or her designee.

- Two members appointed by and serving at the pleasure of the Governor:
    - A person from the health insurance industry.
    - A consumer who is a resident of the state.
- Four members appointed by and serving at the pleasure of the President o the Senate:
    - A person from a hospital utilizing an electronic medical records system.
    - A physician utilizing an electronic medical records system in his or her practice.
    - A representative of an operating health information organization in the state.
    - A person from a federally-qualified health center or other rural health organization utilizing an electronic medical records system.
- Four members appointed by and serving at the pleasure of the Speaker of the House of Representatives:
    - A person from a hospital utilizing an electronic medical records system.
    - A physician utilizing an electronic medical records system in his or her practice.
    - A representative of an operating health information organization in the state.
    - A person from a federally-qualified health center or other rural health organization utilizing an electronic medical records system.

Members serve for a term of 4 years. The council must meet at least quarterly and may be held via teleconference or other electronic means.

The duties of the council include developing recommendations to:

- Establish standards for all state-funded health information exchange efforts.
- Remove barriers that limit participation by health care providers and facilities and health insurers in health information exchanges.
- Remove barriers that prevent consumers from accessing their electronic medical records.
- Provide incentives to promote participation by health care providers and facilities and health insurers in health information exchanges.
- Identify health care data held by state agencies and remove barriers to making that data available to authorized recipients through health information exchanges.
- Increase state agency participation in health information exchanges.
- Partner with other state, regional, and federal entities to promote and coordinate health information exchange efforts.
- Create a long-term plan for an interoperable statewide network of health information organizations.

The council is required, beginning July 1, 2009, to annual provide a report to the Governor and the Legislature recommendations regarding the council's duties described above. In addition, the council must, by July 1, 2010, recommend a long-term plan to create an interoperable statewide network of health information organizations to the Governor and the Legislature.

The council is repealed effective July 1, 2012.

The bill requires the agency to maintain on its internet website information regarding:

- Federal and private sector health information exchange funding programs.
- A clearinghouse of state and national legislative, regulatory, and public awareness activities related to health information exchanges.

In addition, the agency is required to develop and implement a plan to promote participation in health information exchanges and the adoption of electronic medical record systems by physicians in consultation with the council and professional associations.

Finally, the bill requires the Office of Program Policy Analysis and Government Accountability (OPPAGA) to complete and independent evaluation of the grants program administered by the agency, including assessments of the distribution process, the spending of grant dollars, the level of

participation by entities within each grantee's project; the extent of clinical data exchange among entities within each grantee's project; the sources of funding for each grantee; and the feasibility of each grantee achieving long-term sustainability without state funding. The report must be provided to the Governor and the Legislature by July 1, 2009.

C. SECTION DIRECTORY:

Section 1. Amends s. 395.3025, F.S, relating to patient and personnel records.

Section 2. Amends s. 408.05, F.S., relating to the Florida Center for Health Information and Policy Analysis.

Section 3. Creates s. 408.051, F.S., relating to the Florida eHealth Initiative Act.

Section 4. Amends s. 408.062, relating to research, analyses, studies, and reports.

Section 5. Amends s. 483.181, relating to acceptance, collection, identification, and examination of specimens.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None

2. Expenditures:

   The agency has requested four positions to review and process loan applications, monitor loan repayments, and conduct outreach activities. According to the agency, the bill will have a $380,981 fiscal impact on the agency in Fiscal Year 2008-09 and $282,861 in Fiscal Year 2009-10, apart from funding for the loan program.

   Healthcare Council staff believes that the fiscal impact of the bill is indeterminate, as the loan program and the grant program are subject to a specific appropriation. In addition, it is not clear that four positions are justified in light of the unknown, but likely small, number of applications and loan recipients.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None

2. Expenditures:

   None

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill will provide one-time, no-interest loans to physicians or business entities whose shareholders are physicians for the initial costs of implementing an electronic medical records system.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to spend funds or take action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenues.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The agency is provided rulemaking authority to implement the provisions of this bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

D. STATEMENT OF THE SPONSOR

While all other sectors of our economy have reaped the enormous benefits of information technology, the healthcare sector is lagging behind. Healthcare needs an injection of transformative information technology solutions like electronic medical records to revolutionize the delivery and quality of patient care.

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES

On March 25, 2008, the Healthcare Council adopted one amendment. The strike-all amendment:

- Removes the deletion of the agency's current authority to oversee the integration of health care data from state agencies;
- Revises the restriction on the length of time an organization may receive state grant funding from two years in each category to not more than six aggregate years;
- Specifies that the loan program is subject to a specific appropriation; and
- Revises the due date of the council's long-term statewide plan from July 1, 2012 to July 1, 2010.

The bill was reported favorably as a Council Substitute. The analysis reflects the Council Substitute.