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FHA Guidance on Implementation on
Florida's Hospital Transparency Requirements
April 2019

Overview

For nearly 30 years, Florida hospitals have provided price, cost and quality data to the state and federal governments. Given the rise of consumerism in health care, there has been increased focus on hospital price transparency and how hospitals ensure that patients are informed about the cost of their care.

In 2015, the FHA Board of Trustees directed Association staff to create www.MissionToCare.org, a consumer-friendly website that compiles publicly available data on hospital costs and quality in an easier-to-use format. The site, which launched in January 2016, helped shape policy discussions during the 2016 Legislative Session and its updated annually.

The 2016 Legislature passed legislation, House Bill (HB) 1175 and HB 221 which expanded hospital responsibilities for pricing, billing and consumer notifications. Specifically, HB 1175 expanded and added requirements for hospital websites along with requiring the Agency for Health Care Administration (AHCA) to contract with a vendor to create a database using claims payment data submitted from health plans to show prices for bundles of care.

HB 221 addressed "surprise bills," which may occur when patients go to a hospital in their health plan's network and are treated by an 'out-of-network' provider. In this type of scenario, patients are subject to out-of-pocket fees. HB 221 requires hospitals, providers and health plans to post information about health plan network participation on their website.

This guidance details the requirements for both bills, HB 1175 and HB 221, and includes the final rules published by AHCA that outlines the requirements that hospitals must meet. The laws apply to all facilities licensed under Chapter 395, which includes hospitals, ambulatory surgery centers, urgent care centers and diagnostic imaging centers.

Since the state requirements were finalized, requirements tied to the Internal Revenue Code and the Centers for Medicare & Medicaid Services have been issued. This April 2019 update includes these additional requirements.

Guidance should not be interpreted as exhaustive or substitute legal counsel. Updates will be made as additional clarification is provided.

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FLORIDA LAW

Website Requirements (395.301(12), F.S.)

All licensed facilities must make available on its website the following information:

1. **Financial Information for Patients (NEW)**
   Effective Date: February 19, 2018

   Hospitals are required to provide a link to the AHCA price transparency site, FloridaHealthPricing website (https://pricing.floridahealthfinder.gov), which shows average payments for over 200 service bundles. The service bundles include all components of care, including physician, ancillary and hospital payments. The average payment data is based on claims data submitted on non-Medicare and non-Medicaid member health care encounters by health plans. This does not preclude hospitals from providing their own pricing information on the website.

   Hospitals must include a notice on the website that:

   a. The service bundle information is a non-personalized estimate of costs that may be incurred by the patient for anticipated services and that actual costs will be based on services actually provided to the patient;
   b. Patients have a right to request a personalized estimate from the hospital;
   c. Patients should contact the health care providers anticipated to provide services to the patient while in the hospital to obtain a personalized estimate of their costs, their billing practices and whether they participate in the patient's health plan.

2. **Quality of Service Data**
   Effective Date: July 1, 2004

   The new legislation maintains a current requirement that hospitals must include a link to Florida Health Finder on their website (www.FloridaHealthFinder.gov). AHCA's Florida Health Finder website, created by legislation in 2004, provides hospital quality metrics, including readmissions data, mortality rates, complication rates, infection rates, patient experience and other patient safety indicators. In addition to providing the required link to FHF, hospitals may also provide additional quality measures on their website or link to www.MissionToCare.org.

3. **Hospital Financial Assistance Policies**
   Effective Date: July 1, 2016

   Hospitals are required to post financial assistance policies, the application form, payment plans available, charity care policies, discount policies and collection procedures on their websites.

4. **Health Plans in which the Hospital Participates**
   Effective Date: July 1, 2016

   Hospitals are required to provide a list of health plans in which they are contracted on their website with hyperlinks to each health plan's websites. This only applies to those plans in which hospitals have a direct contract. For example, if a hospital contracts with an organization such as Multiplan, which allows other health plans to access their network, the hospital must only list Multiplan. FHA's Mission to Care website, http://www.missiontocare.org/cost-and-billing-resources/out-of-pocket-cost-calculators/, has hyperlinks for all major health plans licensed in Florida. Hospitals may choose to include clarifying language on their website to explain that hospitals might not be included in all health plan product offerings.

5. **Provider Groups Under Contract with the Hospital**
   Effective Date: July 1, 2016

   Hospitals are required to post on their websites a list of health care practitioners or medical groups in which the hospital has a contract to provide certain services within the hospital, such as anesthesiologist, emergency physicians, hospitalists, pathologist and radiologists. Information on these providers must include names, addresses and contact information so consumers can contact them directly to determine if they are a participating provider in the individual's health plan.

   **Note: this is not a new requirement for those hospitals that must comply with the Internal Revenue Service (IRS) 501(r) rules.*

6. **Notice About Providers Involved in Patient Care**
   Effective Date: July 1, 2016

   Hospitals must include a statement or warning on their website, along with pricing information, that patients might/will receive a separate bill from other providers and those providers may or may not participate in the same health plans as the hospital. The statement should encourage consumers to contact their provider to determine health plans participation.

FLORIDA LAW

Requirements to Provide Estimates for Non-Emergency Care
Effective Date: July 1, 2016

Hospitals are required to provide a cost estimate upon request of the patient, prospective patient or legal guardian for nonemergency medical services. This estimate must be provided within seven (7) days from the receipt of the request. Unless the patient requires a more personalized estimate, the estimate may be based on the average payment received for the service bundle. Every estimate shall include:

1. A statement informing the requestor to contact their health insurer or HMO for anticipated cost sharing responsibilities;
2. A statement advising the requestor that the actual cost may exceed the estimate;
3. The web address of the hospital's financial assistance policies, charity care policy, and collection procedures;
4. A description and purpose of any facility fees, if applicable;
5. A statement that services may be provided by other health care providers who may bill separately;
6. A statement, including a web address if different from above, that contact information for health care practitioners and medical practice groups that are expected to bill separately is available on the hospital's website; and
7. A statement advising the requestor that the patient may pay less for the procedure or service at another facility or in another health care setting.

The pricing estimates can be provided by electronic means in addition in writing. The hospital does not have to adjust the estimate based on any potential insurance coverage.

The estimate maybe be based on the service bundles, as opposed to DRGs, unless the patient request a more personalized estimate for their specific condition and characteristics.

The penalty for noncompliance is $1,000 per day until the estimate is provided to the patient, not exceeding $10,000.

Requirements to Provide Itemized Bills (395.301, F.S.)
Effective Date: July 1, 2017

The hospital must provide an itemized statement or bill upon request of the patient or the patient's survivor or legal guardian within seven (7) business days after the patient's discharge or release, or seven (7) business days after the request, whichever is later. The itemized statement or bill must include:

a) A description of the individual charges from each department or service area by date, as prescribed in subsection 395.301(1)(d);

b) Contact information for health care practitioners or medical practice groups that are expected to bill separately based on services provided; and
c) The hospital's contact information for billing questions and disputes.

Requires that the initial statement or bill list specific services received and expenses incurred by date and provider for items of service as prescribed by the AHCA including the unit price data on rates charged by the facility.

1. Requires the statement or bill to clearly identify any facility fee and explain the purpose of the fee.
2. The itemized bill or statement must identify each item as "paid", "pending payment by a third party", or "pending payment by the patient", and must include the amount due, if applicable, along with the due date, along with the directions to contact the patient's health plan regarding cost-sharing responsibilities. Any subsequent statement or bill provided to a patient relating to the episode of care must include all of the information outlined above.
3. The bill or statement must include a notice that hospital-based physicians and other health care providers may bill separately for their services.
4. The bill or statement requires that physical, occupational or speech therapy treatment must be listed by date, type and length of treatment, in addition to the brand or generic name of drugs.
5. Requires facilities to make patient records necessary to verify the accuracy of the bill within 10 business days after the request.
6. Requires that the records must also be made available electronically through a HIPAA compliant format, in addition to making them available at the facilities offices.
7. Requires the records to be available before and after payment of the bill.
8. If the patient is not satisfied with the response, the facility must provide the contact information for AHCA for which the issue will be sent for review.

Public Notice Requirements on Policies and Charges
Effective Date: July 1, 2016

Notifications
Hospitals are required to notify patients that information on their financial assistance, charity and discount policies is available on their website and that quality data is available on AHCA's Florida Health Finder website. This is part of the signage requirement for registration and admitting areas of the hospital. Hospitals are required to educate the public that pricing estimates are available upon request.

Posting of Charges
Urgent care centers, and hospital-owned diagnostic centers not located on a hospital campus, are required to publish and post a schedule of charges for the 50 most frequently provided services medical services in a conspicuous place in the reception area.

1. The schedule may group the services by three prices levels, listing services in each price level and must describe the medical services in language comprehensible to a layperson and include the prices charged to an uninsured person pay for such services by cash, check, credit card or debit card.
2. The posting of charges may be a sign, which must be at least 15 square feet in size, or through an electronic messaging board.
3. If the urgent care center is affiliated with a facility licensed under Chapter 395, F.S., then the sign must include text that notifies the patients whether the charges for will be the same as, or more than, charges for medical services received at the affiliated hospital.
4. The text notifying the patient of the schedule of charges shall be in a font size equal to or greater than the font size used for prices and must be in a contrasting color.
5. The text that notifies the insured patients whether the charges for medical services received at the center will be the same as, or more than, charges for medical services received at the affiliated hospital shall be included in all media and Internet advertisements for the center and in language comprehensible to a layperson.
6. The posted text describing the medical services must fill at least 12 square feet of the posting.
7. A facility may use an electronic device or messaging board to post the schedule of charges. Such a device must be at least 3 square feet, and patients must be able to access the schedule during all hours of operation of the facility.

Failure to publish and post the schedule of charges is subject to a fine of $1,000 per day until the schedule is published and posted.

Florida law defines “urgent care center” as a facility or clinic that provides immediate but not emergent ambulatory medical care to patients. The term includes an offsite emergency department of a hospital that is presented to the general public in any manner as a department where immediate and not only emergent medical care is provided. The term also includes:

a) An offsite facility of a facility licensed under this chapter, or a joint venture between a facility licensed under this chapter and a provider licensed under chapter 458 or chapter 459, that does not require a patient to make an appointment and is presented to the general public in any manner as a facility where immediate but not emergent medical care is provided.

b) A clinic organization that is licensed under Part X of Chapter 400, maintains three or more locations using the same or a similar name, does not require a patient to make an appointment, and holds itself out to the general public in any manner as a facility or clinic where immediate but not emergent medical care is provided.

Florida Transparency Laws Implementation Check List

Requirement	Area Impacted	Statutory Reference	Effective Date	Check When Done
Data on payments for defined service bundles of care https://pricing.floridahealthfinder.gov	Hospital Website	395.301(1) HB1175	February 19, 2018	
Data on quality – a link to AHCA's FloridaHealthfinder.gov website	Hospital Website	395.301(1)(c)	Existing requirement	
Posting hospital financial assistance policies	Hospital Website	395.301(1)(a)	July 1, 2016 (existing requirement for 501(r) hospitals)	
List of contracted health plans	Hospital Website	395.301(13)(a)	July 1, 2016	
List of contracted physician groups	Hospital Website	395.301(13)(c)	July 1, 2016 (existing requirement for 501(r) hospitals)	
Notice about providers involved in patient care might not participate with their plan	Hospital Website	395.301(13)(b)	July 1, 2016	
Requirements to provide estimates for non-emergency care	Patient Financial Services	395.301(1)(b)	July 1, 2016 for additional or modified requirements	
Requirements to provide itemized bills or statements	Patient Financial Services	395.301(1)(d)	July 1, 2016 for additional or modified requirements	
Requirements to educate the public on prices for urgent care and diagnostic imaging centers	Corporate Compliance	395.107	July 1, 2016 for additional or modified requirements	

The check list above should not be interpreted as exhaustive or substitute legal counsel. Updates will be made as additional clarification is provided.

INTERNAL REVENUE SERVICE

Hospital 501(r) Status Requirements

The Internal Revenue Service (IRS) continues to review hospital compliance with the requirements for maintenance of tax exempt status. One of the key methods to monitor compliance is to visit a hospital's website to check if the required information – community health needs assessment and financial assistance policy – is clearly posted.

Hospitals should be able to respond positively to the following questions to measure their degree of compliance:

- Does the hospital conduct a community health needs assessment (CHNA) at least once every three years? Note: the CHNA must define the community served, identify and prioritize significant health needs within the community, solicit and take into account input from persons representing the broad interest of the community, and be adopted by the Board or other governing body.
- Does the hospital make the CHNA publicly available on its website?
- Has the hospital adopted an implementation strategy to meet the needs identified in the CHNA?
- Has the hospital adopted a financial assistance policy (FAP) applicable to all emergency and other medically necessary care?
- Does the FAP describe the method used to determine amounts generally billed (AGB) and how the AGB percentage was determined?
- Does the FAP describe any collection actions that could be taken for non-payment?
- Does the hospital publicize the FAP on its website, as well as the FAP application and a plain language summary of the policy?
- Does the FAP list providers other than the hospital facility that deliver emergency or other medically necessary care in the facility, as well as which providers are, and are not, covered by the FAP?
- Is the FAP, application, and plain language summary available both in English and in any other language in which limited English proficient populations comprise the lesser of 1,000 individuals or five percent of the community served, or the population likely to be affected by the facility?

CENTERS FOR MEDICARE & MEDICAID SERVICES

Guidance on Final CMS Transparency Rule

In the FY2019 inpatient rule, the Centers for Medicare & Medicaid Services (CMS) finalized a requirement that hospitals make their standard charges available online in a machine-readable format as of January 1, 2019. The rule requires hospitals to publish standard charges for all items and services provided by the hospital and to update this information at least annually. FHA staff developed the following points for hospitals to consider when posting the required information:

- All hospitals operating within the United States are subject to this requirement, including acute care hospitals, critical access hospitals, inpatient rehab facilities and inpatient psychiatric facilities.

- While CMS does not require hospitals post the entire chargemaster, an identifying description for all items and services provided, along with their charge, is required. Revenue codes and charge codes are not required. In addition, chargemaster items developed for internal productivity purposes are not required as these are not items billed to patients.

- While CMS encourages hospitals to post quality information and charges at the diagnosis related group/ambulatory payment classification (DRG/APC) level that would be in addition to this new requirement to publish standard charges for all items and services, summary information cannot be substituted for detailed pricing.

- The CMS FAQs addresses the requirements for machine-readable format and notes that they do not consider a PDF to meet this requirement.

- Hospitals should be cautious about posting current procedural terminology/healthcare common procedure coding system (CPT/HCPCS) codes as these are copyrighted by the American Medical Association (AMA). More information could be released by the AMA at a future date.

- CMS has now issued an updated FAQ that requires all subsection (d) hospitals to also establish and update and make public a list of their standard charges for each diagnosis-related group (DRG) established under section 1886(d)(4) of the Social Security Act. Subsection (d) hospitals are those paid under the Medicare inpatient prospective payment system (IPPS).

While there is not yet information on how CMS will enforce these requirements, they have solicited feedback through several Requests for Information (RFIs). We expect enforcement mechanisms to be developed through future rulemaking. The FHA will continue to work with CMS and the American Hospital Association on this issue and will encourage CMS to focus on improving access to beneficiary deductible, copay and coinsurance estimates and to develop a tool that better meets patients' needs.