59A-5.032

ASC Price Transparency and Patient Billing

59A-5.032 Price Transparency and Patient Billing.

(1) Website. Each center shall make available to patients and prospective patients price transparency and patient billing information on its website regarding the availability of estimates of costs that may be incurred by the patient, financial assistance, billing practices, and a hyperlink to the Agency's service bundle pricing website. The content on the center's website shall be reviewed at least every 90 days and updated as needed to maintain timely and accurate information. For the purpose of this rule, service bundles means the reasonably expected center services and care provided to a patient for a specific treatment, procedure, or diagnosis as posted on the Agency's website. In accordance with Section 395.301, F.S., the center's website must include:

(a) A hyperlink to the Agency's pricing website upon implementation of the same that provides information on payments made to the facilities for defined service bundles and procedures. The Agency's pricing website is located at: http://pricing.floridahealthfinder.gov;

(b) A statement informing patients and prospective patients that 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;

(c) A statement informing patients and prospective patients of their right to request a personalized estimate from the center;

(d) A statement informing patients of the center's financial assistance policy, charity care policy, and collection procedure;

(e) A list of names and contact information of health care practitioners and medical practice groups contracted to provide services within the center, grouped by specialty or service; and,

(f) A statement informing patients to contact the health care practitioners anticipated to provide services to the patient while in the center regarding a personalized estimate, billing practices and participation with the patient's insurance provider or health maintenance organization (HMO) as the practitioners may not participate with the same health insurers or HMO as the center.

(2) Estimate. The center shall provide an estimate upon request of the patient, prospective patient, or legal guardian for nonemergency medical services.

(a) An estimate or an update to a previous estimate shall be provided within 7 business days from receipt of the request. Unless the patient requests a more personalized estimate, the estimate may be based upon the average payment received for the anticipated 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 to financial assistance policies, charity care policy, and collection procedure,

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 center'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.

(b) If the center provides a non-personalized estimate, the estimate shall include a statement that a personalized estimate is available upon request.

(c) A personalized estimate must include the charges specific to the patient's anticipated services.

(3) Itemized statement or bill. The center shall provide an itemized statement or bill upon request of the patient or the patient's survivor or legal guardian. The itemized statement or bill shall be provided within 7 business days after the patient's discharge or release, or 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), F.S.;

(b) Contact information for health care practitioners or medical practice groups that are expected to bill separately based on services provided; and,

(c) The center's contact information for billing questions and disputes.

Rulemaking Authority 395.301 FS. Law Implemented 395.301 FS. History–New 2-19-18.

59A-3.256

Hospital Price Transparency and Patient Billing

59A-3.256 Price Transparency and Patient Billing.

(1) Website. Each hospital shall make available to patients and prospective patients price transparency and patient billing information on its website regarding the availability of estimates of costs that may be incurred by the patient, financial assistance, billing practices, and a hyperlink to the Agency's service bundle pricing website. The content on the hospital's website shall be reviewed at least every 90 days and updated as needed to maintain timely and accurate information. For the purpose of this rule, service bundles means the reasonably expected hospital services and care provided to a patient for a specific treatment, procedure, or diagnosis as posted on the Agency's website. In accordance with Section 395.301, F.S., the hospital's website must include:

(a) A hyperlink to the Agency's pricing website upon implementation of the same that provides information on payments made to the facilities for defined service bundles and procedures. The Agency's pricing website is located at: http://pricing.floridahealthfinder.gov;

(b) A statement informing patients and prospective patients that 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;

(c) A statement informing patients and prospective patients of their right to request a personalized estimate from the hospital;

(d) A statement informing patients of the hospital's financial assistance policy, charity care policy, and collection procedure;

(e) A list of names and web addresses of health insurers and health maintenance organizations (HMO) contracted with the hospital as a network provider or participating provider;

(f) A list of names and contact information of health care practitioners and medical practice groups contracted to provide services within the hospital, grouped by specialty or service; and,

(g) A statement informing patients to contact the health care practitioners anticipated to provide services to the patient while in the hospital regarding a personalized estimate, billing practices, and participation with the patient's insurance provider or HMO as the practitioners may not participate with the same health insurers or HMO as the hospital.

(2) Estimate. The hospital shall provide an estimate upon request of the patient, prospective patient, or legal guardian for nonemergency medical services.

(a) An estimate or an update to a previous estimate shall be provided within 7 business days from receipt of the request. Unless the patient requests a more personalized estimate, the estimate may be based upon the average payment received for the anticipated 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.

(b) If the hospital provides a non-personalized estimate, the estimate shall include a statement that a personalized estimate is available upon request.

(c) A personalized estimate must include the charges specific to the patient's anticipated services.

(3) Itemized statement or bill. The hospital shall provide an itemized statement or bill upon request of the patient or the patient's survivor or legal guardian. The itemized statement or bill shall be provided within 7 business days after the patient's discharge or release, or 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), F.S.;

(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.

Rulemaking Authority 395.301 FS. Law Implemented 395.301 FS. History–New 2-19-18.

59E-9.010

Claims Data Collection

59E-9.010 Claims Data Collection.

(1) Definitions.

(a) “Affiliate” means an entity that exercises control over or is directly or indirectly controlled by the insurer through equity ownership of voting securities; common managerial control; or collusive participation by the management of the insurer and affiliate in the management of the insurer or the affiliate as defined in Section 624.10(1), F.S.

(b) “Agency” means the Florida Agency for Health Care Administration (AHCA) as defined in Section 408.032(1), F.S.

(c) “Claims Data” means complete and accurate eligibility data, medical claims data, and pharmacy claims data of Covered Lives held by Payers as specified in the Submission Guide.

(d) “Covered Lives” means individuals for whom Florida Claims Data is held by the Payer inclusive of insureds, individual policyholders, group certificate-holders, subscribers, members and dependents.

(e) “Facility” means Florida licensed facility pursuant to Chapter 395, F.S.

(f) “HIPAA” means the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 and its implementing regulations (45 C.F.R. Parts 160-164), and any requirements of the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009 and its implementing regulations.

(g) “Payer” means health insurers as defined in Chapter 624, F.S., or Health Maintenance Organizations as defined in Chapter 641, F.S., including their Affiliates, that participate in the Florida state group health insurance plan created under Section 110.123, F.S., or Medicaid managed care pursuant to Part IV of Chapter 409, F.S.

(h) “Service or Care Bundle” means a typical treatment plan for a medical condition that consists of one or more procedures, tests and services. Bundles are broken down into treatment steps and those steps may include one or more procedures, tests or services.

(i) “Submission Guide” means the document entitled “Florida Claims Data Submission Guide,” November 2017, that sets forth the required schedules, data file format, record specifications, data elements, definitions, code tables and edit specifications for Payers’ submission of Claims Data to the Agency through its Vendor, hereby incorporated by reference and available at https://www.flrules.org/Gateway/reference.asp?No=Ref-09235.

(j) “Vendor” means the organization that is under contract with the Agency pursuant to Section 408.05(3)(c), F.S.

(2) Claims Data Collected.

(a) The Vendor shall collect Claims Data from all Payers as specified in Rule 59E-9.010, F.A.C.

(b) Payers shall be exempt from providing Claims Data from health plans covered by the Employee Retirement Income Security Act (ERISA) of 1974 when such employer(s) affirmatively elects not to share these Claims Data.

(c) The Vendor shall not collect Claims Data that reflects the types of coverage referenced in Sections 627.6385(3)(a) through (3)(l) and 641.54 (7)(a) through (7)(l), F.S.

(d) Before delivering Claims Data to the Vendor, each Payer shall remove all information subject to restrictions on use or restrictions of disclosure set forth in 42 C.F.R. Part 2, if applicable.

(3) Claims Data Submission.

(a) Payers shall submit Claims Data for all Covered Lives held by the Payer and its Affiliates to the Agency, through its Vendor, as defined in the Submission Guide.

(b) All Payers submitting their Claims Data shall submit according to the schedule defined in the Submission Guide.

(c) The submission of Claims Data by Payers will be pursuant to a Data Contribution Agreement hereby incorporated by reference as Exhibit B, AHCA Form 4200-0008, November 2017, in the Submission Guide and specified by the Agency and subject to federal and state law and regulation. Payers cannot condition submission on any additional terms, conditions, or restrictions.

(4) Claims Data Audit, Resubmission, and Certification Procedures.

(a) The Submission Guide specifies Claims Data audits, and resubmission policies and procedures.

(b) All Payers submitting data in compliance with this rule shall certify that the data submitted is accurate, complete and verifiable using the Certification of Claims Form hereby incorporated by reference in Exhibit A, AHCA Form 4200-0007, November 2017, in the Submission Guide.

(5) Requirements for Claims Data Publication.

(a) The Agency, as specified in Section 408.05(3)(c), F.S. through its Vendor, shall publish and make available to the public estimated pricing data (de-identified in accordance with HIPAA) based on the Claims Data, on a consumer-friendly website. The website shall allow users to search for the price of health care services by condition or Service Bundles as defined by the Vendor and

the Agency.

(b) The Vendor shall calculate an estimated average payment and range of payments for a condition or service bundle to be displayed on the website.

(c) Florida specific state, county and facility-level price estimates will be calculated from the claims dataset based on the location of the provider in the Claims Data.

(d) Price estimates will be reported on the website at the facility or geographic level as directed by the Agency. Price estimates will be derived from historic Claims Data trended forward, and reported using a data suppression methodology such that calculated prices for Service or Care Bundles at a facility or geographic level are based on a designated minimum number of Payers per facility and/or geographic level and a minimum number of claims per Payer needed to disconnect specific prices from any particular Payer.

Rulemaking Authority 408.05(3)(e) FS. Law Implemented 408.05(3) FS. History–New 4-2-18.