HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1209 Health Information Transparency
SPONSOR(S): Health Innovation Subcommittee, Brodeur
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee	12 Y, 0 N, As CS	Siples	Poche
2) Appropriations Committee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Under state and federal law, Medicaid is the payor of last resort for medically necessary services provided to Medicaid beneficiaries. The Agency for Health Care Administration (AHCA) must pursue reimbursement from any third party that may be legally liable to pay for a beneficiary's medical services paid by Medicaid. HB 1209 specifies the types of entities that meet the definition of "third party." This provision will align Florida law with the federal definition of "third party."

The bill extends the time for AHCA to file a claim of lien against any recovery a beneficiary receives for an illness or injury for which a third party may be legally liable from one year to three years. AHCA will have additional time to enforce its rights and pursue recovery from liable third parties.

Under the bill, any entity that is legally responsible for the payment of health care services must respond within 90 days of receipt of a written proof of loss or claim for payment of health care services provided to a beneficiary covered by Florida Medicaid with payment of the claim, a written request for more information with which to process the claim, or a written denial stating the reason. Failure to pay or deny a claim within 140 days of receipt creates an uncontestable obligation to pay such claim.

The bill clarifies that a beneficiary may contest the amount of reimbursement from a recovered medical expense by filing a petition with the Division of Administrative Hearings (DOAH) only if the amount of the recovery for medical expense damages is limited by federal law. Medicaid may only recover those amounts that are attributable to past and future medical expenses.

The bill also repeals provisions requiring AHCA to enter into cooperative agreements with the Office of Insurance Regulation and Department of Revenue and promulgate rules pursuant to the agreements for obtaining and sharing information regarding potential third party coverage of Medicaid beneficiaries.

Health care providers and their staff may spend a significant amount of time dealing with patient eligibility inquiries, prior authorizations, and a number of other administrative tasks that may be better spent on providing patient care. Access to a patient's electronic medical records, in real time, may ease these administrative burdens. Also, real-time access to these records allow for efficient administration of health care, improving a patient's overall health.

HB 1209 requires AHCA to contract with a vendor to evaluate the health information technology in this state and identify best practices for developing data systems that will provide health care practitioners real-time access to patient information. The evaluation must identify methods to increase interoperability across delivery systems and geographic locations and allow health care practitioners to review eligibility for public health or private insurance, ensure that health care services are clinically appropriate, and avoid duplicative services or overutilization of services. AHCA must submit a report evaluating the contract outcomes to the President of the Senate and the Speaker of the House of Representatives by December 31, 2017.

The bill has an indeterminate positive and negative fiscal impact of up to $500,000 on AHCA. See Section II, Fiscal Analysis and Economic Impact Statement for more information.

The bill provides an effective date of July 1, 2017.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Medicaid Third Party Liability

Medicaid

Medicaid is a medical assistance program that provides access to health care for low-income families and individuals. Medicaid also assists aged and disabled people with costs of nursing facility care and other medical expenses. The Agency for Health Care Administration (AHCA) is the single state agency responsible for administering the Florida Medicaid Program, which is funded by state and federal funds. The statutory authority for the Medicaid program is contained in ch. 409, F.S.

In 2011, the Legislature enacted Part IV of ch. 409, F.S., which requires all Medicaid beneficiaries to enroll in a managed care plan unless they are specifically exempt.[1] The statewide Medicaid managed care program includes the long-term care managed care program and the managed care medical assistance program.

Responsibility for Third Party Recovery

Federal law requires that a state, in the administration of its Medicaid program, take reasonable measures to determine the legal liability of third parties to pay for any medical assistance provided, and seek recovery from a third party for any claims that have been paid for which a third party is liable.[2] When a state identifies probable third party liability (TPL), it uses one of two methods to ensure that Medicaid is the payer of last resort: cost avoidance and pay-and-chase.[3] Cost avoidance is the method used to avoid payment when other insurance resources are available to the beneficiary. Federal regulations generally require states to use cost avoidance when probable TPL is established.[4] In contrast, the pay-and-chase method is used when a state pays health care service providers for submitted claims and then attempts to recover payments from liable third parties.[5] This usually occurs when TPL is later identified.

In 2005, Congress passed the Deficit Reduction Act (DRA)[6] that, among other things, clarified a state's duties to pursue reimbursement from third parties for medical assistance provided by Medicaid. Specifically, the DRA:

- Clarified the specific entities considered "third parties" and "health insurers" that may be liable for payment;
- Prohibited third parties and health insurers from discriminating against individuals on the basis of Medicaid eligibility; and
- Required that states pass laws requiring health insurers to:
  - Provide the state with eligibility and coverage information needed to identify potentially liable third parties;
  - Accept the assignment to the state of the Medicaid beneficiary's right to payment by such insurers for health care items or services for which Medicaid has paid;

[1] Ch. 2011-134, Laws of Fla. Full implementation occurred in 2014.
[2] 42 U.S.C. s. 1396a(a)(25). States are not required to seek reimbursement if is not cost-effective to do so.
[3] The state may contract with a vendor to fulfill this responsibility.
[4] 42 CFR s. 433.139(b).
[5] Under 42 U.S.C. s. 1396a(a)(25), a state must also pay and chase for prenatal care, preventive pediatric care, or if the coverage is through a parent whose obligation to pay support is enforced by the state's child support enforcement agency.
[6] Pub. Law No. 109-171.

- Respond to any inquiry regarding a claim for payment of any health care item or service that is submitted within three years after the date of service; and
- Agree not to deny such assignment or refuse to pay claims by Medicaid based on procedural reasons, if the claim is submitted within three years of the date of service and any action to enforce the state's right with respect to such claim is commenced within six years of the state's submission of the claim.

Florida Medicaid Third Party Liability Act

Under the Medicaid Third Party Liability Act,[7] Medicaid is the payor of last resort for medically necessary goods and services furnished to Medicaid beneficiaries. All other sources of payment are primary to Medicaid. If third party benefits are discovered or become available after medical assistance is provided by Medicaid, state law requires Medicaid to be paid in full and prior to any other person, program, or entity. [8]

An individual who is eligible for Medicaid assigns his or her right to third party benefits or payments to AHCA by applying for or accepting Medicaid benefits.[9] A Medicaid lien is automatically applied when a beneficiary receives services paid by Medicaid for which a third party may be liable. A verified claim of lien may be filed with the clerk of the circuit court in the beneficiary's last known county of residence.[10]

Health Care Transparency

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

Florida Center for Health Information and Transparency

The Florida Center for Health Information and Transparency (Florida Center), housed within the AHCA, collects, compiles, coordinates, analyzes, indexes, and disseminates health-related data and statistics.[11] The information and data it collects include:

- Health resources, including licensed health care practitioners, by specialty and type of practice;
- Health service inventories, acute care, long-term care, and other institutional care facilities and specific services provided by hospitals, nursing homes, home health agencies, and other licensed health care;
- Service utilization for licensed health care facilities;
- Health care costs and financing, including trends in health care prices and costs, the sources of payment for health care services, and federal, state, and local expenditures for health care;
- The extent of public and private health insurance coverage in this state; and

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[7] S. 409.910, F.S.
[8] Id. Florida Medicaid contracts with Health Management Systems, which subcontracts to Conduent Payment Integrity Solutions to pursue these reimbursements. *See* http://flmedicaidtplrecovery.com/tortcasualty/ (last visited March 10, 2017). For recipients enrolled in the statewide Medicaid managed care program, the managed care organization is responsible for TPL collections. *See* AHCA, *SMMC Model Contract, Core Contract Provisions,* available at http://www.fdhc.state.fl.us/medicaid/statewide_mc/pdf/Contracts/2017-02-01/02-01-17_Attachment_II.pdf (last visited March 10, 2017).
[9] S. 409.910(6), F.S.
[10] S. 409.910(6)(c)2., F.S. A lack of a properly filed claim of lien will not affect AHCA's assignment rights or the existence of the lien, but only the effective date of notice.
[11] S. 408.05(1), F.S.

- Specific quality-of-care initiatives involving various health care providers available to the public.[12]

The Florida Center makes all information available to the public through www.FloridaHealthFinder.gov.

Electronic Health Records

An electronic health record (EHR) is a record of a person's medical treatment which is created by a licensed health care practitioner and stored in an interoperable accessible digital format.[13] The Health Insurance Portability and Accountability (HIPPA) Security Rule establishes national standards for the security and privacy of personal health information (PHI) that a covered entity creates, receives, maintains, or transmits in electric form.[14] A covered entity must:

- Ensure the confidentiality, integrity, and availability of all electronic PHI it creates, receives, maintains, or transmits;
- Identify and protect against reasonably anticipated threats to security or integrity of the information;
- Protect against reasonably anticipated, impermissible uses or disclosures; and
- Ensure compliance of its workforce.[15]

In 2009, Florida enacted the Florida Electronic Health Records Exchange Act[16] that provides civil liability protection for a health care practitioner that accesses or releases an EHR, in good faith, for the treatment of an emergency condition and who is unable to obtain the patient's consent.[17] A health care practitioner is also protected from civil liability for releasing information in reliance on information provided on a properly completed record release authorization form.

Florida Health Information Exchange

In 2010, Florida was awarded a $20.7 million grant from the Office of the National Coordinator of Health Information Technology (ONC) to implement the Florida Health Information Exchange (HIE).[18] The HIE is subscription service that provides a secure, electronic method of sharing information and is comprised of three services: patient look-up (PLU), event notification, and direct messaging.[19]

The PLU service allows participating health organizations and their authorized users to query the medical records of other authorized users for individual patient data. A patient must consent to his or her records being available for query through the Florida HIE. The queries can be based on a patient's name, date of birth, social security number, or other demographics.[20] The patient information available on the PLU is stored locally by the health care provider; the HIE does not own or maintain any data. This is not a centralized database. To participate in the PLU, a health care entity must be a legal entity, have an operational HIE of clinical data between affiliated health care providers, and demonstrate technical readiness and organizational capacity.[21] The annual fee for a participating health organization

[12] S. 408.05(2), F.S.
[13] S. 408.051(2)(a), F.S.
[14] HHS.gov, "The Security Rule," available at https://www.hhs.gov/hipaa/for-professionals/security/index.html (last visited March 11, 2017). Covered entities include health care practitioners, health plans, and health care clearinghouses, as well of the business associates of these entities.
[15] HHS.gov, "Summary of the HIPAA Security Rule," available at https://www.hhs.gov/hipaa/for-professionals/security/laws-regulations/index.html (last visited March 11, 2017).
[16] S. 408.51, F.S.
[17] Ch. 2009-172, Laws of Fla.
[18] Florida HIE, "What is the Florida Health Information Exchange (HIE)?," available at https://www.florida-hie.net/patients/general.html (last visited March 14, 2017).
[19] Id.
[20] AHCA, "Patient Look-Up Service," available at http://www.fhin.net/kms/plu.shtml (last visited March 14, 2017).
[21] Florida HIE, "What is the Patient Look-Up Services?," available at https://www.florida-hie.net/Files/PLU/ServiceDescription.pdf (last visited March 14, 2017).

includes a $49,000 base fee plus $14 per licensed bed (excluding skilled nursing beds), and an annual software maintenance fee of $25,000.[22] There are currently at least 420 separate providers or organizations that are connected to the PLU service.[23]

The event notification service provides participating health plans with timely alerts about their members' hospital encounters when discharged from a hospital or emergency department.[24] The alerts are sent to an authorized recipient with an existing relationship with the patient, such as a health insurer. An authorized recipient receives information about the facility, the type of admission, name, demographic and contact information, and information about the specific event, including the reason for admission or chief complaint.[25] Depending on the number of members, the annual fee for a participating health plan ranges from a minimum of $7,500 to $75,000 per 50,000 members.[26] Hospitals that only act as a data source are not charged a fee. The system currently averages 215,000 alerts per month and transmits from more than 210 hospitals.[27]

The direct messaging service provides health care organizations and providers with a secure internet-based message service for simple, HIPAA-compliant encrypted transmissions of protected health information.[28] The service allows for the transmission of orders, records, results, and any other documents that can be transmitted easily. The cost for the direct messaging service includes an initial fee of $186 and a renewal fee of $132. An organization may pay for additional access.

Health Information Databases

A number of commercial products provide a health care practitioner with real time patient eligibility information, centralized claim filings, preauthorization services, and medical necessity validation.[29] However, the availability of such databases varies depending on geographic location, and the participating health insurers vary. The NORC at the University of Chicago[30] is an independent research organization performs ongoing work in health care delivery and financing, including access to insurance, payment, and delivery system reform, and offers expertise in acquiring and analyzing health care claims data and national health-related datasets.[31] However, there is not a publicly accessible database that provides information on patient eligibility, claims data, and information regarding the clinical indications for the provision of specific medical services to a specific patient.

[22] Florida HIE, "Price List," (November 2016), available at https://www.florida-hie.net/Files/Resources/Price%20List%20for%20HIE%20Services%20November%202016.pdf (last visited March 14, 2017).
[23] AHCA, *Agency Legislative Bill Analysis for House Bill 1209*, (March 6, 2017), on file with the Health Innovation Subcommittee.
[24] Florida HIE, "Event Notification Service," available at https://www.florida-hie.net/Files/ENS/About%20ENS.pdf (last visited March 14, 2017). Additional fees may be assessed for technical assistance.
[25] Id.
[26] Supra, FN 22.
[27] Supra, FN 23.
[28] Florida HIE, "Direct Messaging Service," available at https://www.florida-hie.net/dm/index.html (last visited March 14, 2017).
[29] For example, *see* Ability Network, (https://abilitynetwork.com/about/); Transunion, Inc. (https://www.transunion.com/product/insurance-eligibility-verification?utmsource=Google&utmmedium=ppc&utmkeyword=%252Bhealthcare%2520%252Beligibility&utm_source=Google&utm_medium=cpc&utm_content=%252Bhealthcare%2520%252Beligibility&utm_campaign=628735576&gclid=CMHM4ryhz9ICFY4vgQodrzYBgQ); and SSI Group, Inc. (http://thessigroup.com/access-management/) (last visited March 11, 2017).
[30] NORC at University of Chicago was originally founded as the National Opinion Research Center. Since the original name no longer reflected its mission and the global nature of its work, the business name was established as NORC (not an acronym) in 2010. *See* NORC at the University of Chicago, "About Our Name," available at http://www.norc.org/Pages/about-our-name.aspx (last visited March 10, 2017).
[31] NORC at the University of Chicago, "Health Care," available at http://www.norc.org/Research/Departments/Pages/health-care.aspx (last visited March 10, 2017).

Effect of Proposed Bill

Medicaid Third Party Liability

HB 1209 adds types of entities that meet the definition of "third party" for purposes of TPL recovery to include a health insurer, self-insured plan, group health plan, service benefit plan, managed care organization, liability insurance, workers' compensation law or plan, or any other party that is, by state, contract, or agreement, legally responsible for payment of a claim for a health care item or service. This provision will align Florida law with the federal definition of "third party."

The bill extends the time for AHCA to file a claim of lien from one year to three years after the later of the:

- Last payment for medical care related the specific covered injury or illness;
- Date of AHCA's discovery of the liability of a third party; or
- Date of discovery of a cause of action against a third party by a Medicaid beneficiary.

The date of notice is the date of the attachment of the lien. If the claim of lien is filed after such time, the notice is effective on the date of filing. AHCA will have additional time to enforce its rights and pursue recovery from liable third parties.

Under the bill, an entity[32] must respond within 90 days of receipt of a written proof of loss or claim for payment of health care services provided to a beneficiary covered by Florida Medicaid with payment of the claim, a written request for more information with which to process the claim, or a written denial stating the reason. Failure to pay or deny a claim within 140 days of receipt creates an uncontestable obligation to pay such claim.

The bill also repeals provisions requiring AHCA to enter into cooperative agreements with the Office of Insurance and the Department of Revenue and promulgate rules pursuant to such agreements for obtaining and sharing information regarding TPL. Repeal of this section may conflict with federal law, which requires states to enter into cooperative agreements for the enforcement and collection of rights for payment for medical care by or through a parent.[33]

The bill clarifies that a beneficiary may contest the amount of reimbursement from a recovered medical expense by filing a petition with the Division of Administrative Hearings (DOAH) only if amount of the recovery is limited by federal law. Federal law prohibits a Medicaid agency from recovering more than the amount of a recovery that is attributable to past and future medical needs.[34] If a recovery does not provide an allocation, AHCA may recover 50 percent of the remaining recovery after payment of attorney fees and costs, up to the total amount of medical assistance provided. Therefore, the beneficiary may argue that the medical assistance provided is less than the remaining 50 percent of the recovery or that AHCA's calculation of the amount that should have been allocated as past and future medical expenses is incorrect.

[32] An entity may include certain health insurers, health maintenance organizations, prepaid health clinics, third party administrators, pharmacy benefit managers, and other third parties as defined in law, which are legally responsible for payment for a health car item or service as a condition of doing business in this state or providing coverage to residents of this state.
[33] 42 U.S.C. s. 1396k
[34] 42 U.S.C. s. 1396a(a)(25).

Health Information Transparency

The bill requires AHCA to contract with a vendor to evaluate health information technology in this state and identify best practices for developing data systems that will provide health care practitioners real-time access to patient information and EHRs. The vendor must also identify ways to improve interoperability of data systems across delivery methods and geographic locations to:

- Allow for the review of eligibility for public and private insurance;
- Ensure that health care services, including Medicaid services, are clinically appropriate; and
- Eliminate duplicative services and overutilization of services.

AHCA must submit a report evaluating the contract outcomes to the President of the Senate and the Speaker of the House of Representatives by December 31, 2017.

The bill provides an effective date of July 1, 2017.

B. SECTION DIRECTORY:

Section 1: Amends s. 408.05, F.S., relating to Florida Center for Health Information and Transparency.
Section 2: Amends s. 409.901, F.S., relating to definitions; ss.409.901 - 409.920.
Section 3: Amends s. 409.910, F.S., relating to responsibility for payments on behalf of Medicaid-eligible persons when other parties are liable.
Section 4: Provides an effective date of July 1, 2017

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   The bill may have an indeterminate positive fiscal impact on AHCA, as it may recover more reimbursements from third parties that are liable to pay for medical services under the extended time to file a lien, the extended time frame within which a cause of action for reimbursement may be brought, and the expanded definition of "third party."

2. Expenditures:

   The bill has an indeterminate negative fiscal impact on AHCA due to its obligation to contract with an entity to develop the system required under the bill. The bill may have an insignificant, indeterminate negative impact on AHCA to repeal rules associated with the repeal of the requirement to enter into cooperative agreements with OIR and the DOR.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Private entities responsible for the payment of medical services for a Medicaid beneficiary may be responsible for the payment of additional claims not currently subject to payment with the bill's authorization of additional time for AHCA to file a lien.

D. FISCAL COMMENTS:

Based on a review of its recently procured contract with comparable scopes of work, AHCA identified a need for budget authority of up to $500,000 to secure and execute the required vendor contract.[35] The state may be able to leverage existing efforts to obtain federal matching funds at a rate of up to 90 percent of the vendor contract. If approved for the federal matching funds, the state's 10 percent contribution could be derived from the Health Care Trust Fund. No additional staff positions or rate will be required to implement the project.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 14, 2017, the Health Innovation Subcommittee adopted an amendment that required AHCA to contract with a vendor to evaluate existing health information technology, identify best practices for developing a system that will permit a physician to have real-time access to patient electronic health records across a variety of platforms, and made other technical, but non-substantive changes.

The bill was reported favorably as a committee substitute. The analysis is drafted to the committee substitute.

[35] Supra FN 23.