# Appropriations Conference Chairs

# BUMP ISSUES

## Senate Health and Human Services Appropriations

## House Health Care Appropriations

### Senate Offer # 1

**Conforming Bill**

**Thursday, May 4, 2017**
**2:00 p.m.**
**412 Knott Building**

**HOUSE HEALTH CARE APPROPRIATIONS / SENATE HEALTH AND HUMAN SERVICES APPROPRIATIONS**
**CONFORMING BILLS – FISCAL YEAR 2017-18**

| | HB 5201 | Bump Issues | SB 2514 | Senate Offer #1 |
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| 1 | | **Bump** | **Section 3.** (s. 394.9082, F.S.) –<br>• Amends language specific to the DCF acute care services utilization database to revert to the language as created in 2015, and requires the DCF to post the data on its website.<br>• Amends language relating to behavioral health managing entities, to create a Substance Abuse and Mental Health (SAMH) Safety Net Network. | **Modified Senate position**<br>**Section 3.** (s. 394.9082, F.S.) – Amends language specific to the DCF acute care services utilization database to revert to the language as created in 2015, and requires the DCF to post the data on its website. |
| 2 | | **Bump** | **Section 4.** – Directs AHCA, in conjunction with DCF, to seek federal authority for administrative claiming for Community Action Teams and Family Intensive Treatment Teams, for Community Based Care case management activities, and central receiving facilities. | **House position—No language** |
| 3 | | **Bump** | **Section 5.** – Directs DCF, in collaboration with AHCA, to document the extent to which local funding is used for behavioral health services, and directs AHCA to seek federal matching funds for this local contribution as certified public expenditures. | **House position—No language** |
| 4 | | **Bump** | **Section 7.** (s. 400.179, F.S.) – Amends language to provide that money deposited in to the Grants and Donations Trust Fund as a leasebond alternative, may be used by AHCA to pay enhanced payments to nursing facilities as specified in the General Appropriations Act. | **Senate position**<br>**Section 5.** (s. 400.179, F.S.) – Effective July 1, 2018, amends language to provide that money deposited in to the Grants and Donations Trust Fund as a leasebond alternative, may be used by AHCA to pay enhanced payments to nursing facilities as specified in the General Appropriations Act. |
| 5 | **Section 4.** (s. 409.908, F.S.) –<br>• Deletes language related to ambulatory surgical centers that will allow for prospective payment effective July 1, 2017.<br>• Removes the rate freeze for Hospital Outpatient and Prepaid Health Plan rates.<br>• Adds new language to provide a deadline for Intergovernmental Transfer (IGTs) letters of | **Bump** | **Section 9.** (s. 409.908, F.S.) –<br>• Amends language to direct that, beginning October 1, 2017, and ending September 30, 2020, the Agency reimburse nursing home providers the greater of their September 2016 cost-based reimbursement rate or their prospective payment rate. Effective October 1, 2020, the Agency shall reimburse providers the | **Modifies Senate position**<br>. (s. 409.908)<br>• **Section 8.** Effective July 1, 2018, **a**mends language to direct that, beginning October 1, 2018, and ending September 30, 2021, the Agency reimburse nursing home providers the greater of their September 2017 cost-based reimbursement rate or their prospective payment |

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| | agreement to be provided to AHCA by October 1st and requires the funds to be submitted to AHCA no later than October 31st, unless an alternative plan is approved by AHCA. | **Bump** | greater of 95 percent of their cost-based rate or their rebased prospective rate, using the most recently audited cost report for each facility.<br>• Specifies that Medicaid reimbursement will be provided for mobile x-ray services rendered to a person who is Medicare and Medicaid dually eligible when such services are delivered in an assisted living facility or a home, just as such reimbursement is presently provided for a nursing home resident. | rate. Effective October 1, 2021, the Agency shall reimburse providers the greater of 95 percent of their cost-based rate or their rebased prospective rate, using the most recently audited cost report for each facility.<br>• **Section 9**. Effective July, 2017:<br>o Deletes language related to ambulatory surgical centers that will allow for prospective payment effective July 1, 2017.<br>o Removes the rate freeze for Hospital Outpatient and Prepaid Health Plan rates.<br>o Adds new language to provide a deadline for Intergovernmental Transfer (IGTs) letters of agreement to be provided to AHCA by October 1st and requires the funds to be submitted to AHCA no later than October 31st, unless an alternative plan is approved by AHCA.<br>o Specifies that Medicaid reimbursement will be provided for mobile x-ray services rendered to a person who is Medicare and Medicaid dually eligible when such services are delivered in an assisted living facility or a home, just as such reimbursement is presently provided for a nursing home resident. |
| 6 | | **Bump** | **Section 10.** (s. 409.9082(4), F.S.) – Amends language relating to the uses of revenue generated by the quality assessment on nursing home facilities, to authorize as a use the partial funding of the quality incentive program for nursing facilities that exceed quality benchmarks. | **Modified Senate position**<br>**Section 10.** (s. 409.9082(4), F.S.) – Effective July 1, 2017, amends language relating to the uses of revenue generated by the quality assessment on nursing home facilities, to authorize as a use the partial funding of the quality incentive program for nursing facilities that exceed quality benchmarks. |

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| 7 | **Section 5.** (s. 409.909(2)(b), F.S.) – Amends language to include Hospital Outpatient Medicaid payments to the parameters required for calculating distributions for the Graduate Medical Education program. | **Bump** | | **House position** |
| 8 | | **Bump** | **Section 15.** (s. 409.975, F.S.) –<br>• Makes optional, rather than mandatory, that Medicaid managed care plans offer a network contract to each home medical equipment and supplies vendor in the plan's region, provided the vendor meets established standards.<br>• Amends language relating to managed care plan accountability, to direct AHCA to contract with the Safety Net to plan, coordinate, and contract for the delivery of certain community SAMH services. The contract must require the managing entities to provide specified services to Medicaid-eligible individuals. Prior to contracting, AHCA, with participation by the DCF, shall conduct a readiness review based on specified criteria. The AHCA is directed to work with the DCF and the managing entities in developing rates for contracted services. | **Modified Senate position**<br>**Section 15.** (s. 409.975, F.S.) – Makes optional, rather than mandatory, that Medicaid managed care plans offer a network contract to each home medical equipment and supplies vendor in the plan's region, provided the vendor meets established standards. |
| 9 | | **Bump** | **Section 17.** (s. 409.983, F.S.) – Amends statute to eliminate language requiring nursing home reimbursement be based on facility costs adjusted for inflation and other factors. | **Modifies Senate position**<br>**Section 17.** (s. 409.983, F.S.) – Effective July 1, 2018, amends statute to eliminate language requiring nursing home reimbursement be based on facility costs adjusted for inflation and other factors. |
| 10 | | **Bump** | **Section 18.** - Directs AHCA, subject to federal approval to become a Program for All Inclusive Care for the Elderly (PACE) site, to contract with an additional not-for-profit organization located in Miami-Dade County to approve up to 250 initial enrollees who reside in Miami-Dade County. | **House position—No language** |

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| | | | | **New**<br>**Section 18.** (s. 409.901(27), F.S.) – Amends the definition of "third party" as applicable under the Florida Medicaid program. (Relates to section 21 of the bill.)<br>See attached language. |
| | | | | **New**<br>**Section 19**. (s. 409.910, F.S.) – Amends statutory provisions specific to Medicaid third-party liability.to bring the requirements into compliance with federal regulations, and to delete outdated statutory provisions.<br>See attached language. |
| 11 | | **Bump** | **Section 21.** - Effective June 30, 2017, amends section 9 of chapter 2016-65, Laws of Florida, which amended s. 409.905, F.S., relating to Medicaid mandatory services, to delay from July 1, 2017 to July 1, 2018, the implementation of a prospective payment system for Medicaid outpatient hospital services, referred to as enhanced ambulatory payment group (or EAPGs). | **House position—No language** |
| 12 | | **Bump** | **Section 23.** - Directs AHCA, subject to federal approval to become a PACE site, to contract with one not-for-profit organization that satisfies specific criteria to provide PACE services to frail and elderly persons who reside in Alachua County to approve up to 150 initial enrollees in this PACE program. | **House position—No language** |
| 13 | | **Bump** | **Section 24.** - Directs AHCA, subject to federal approval to become a PACE site, to contract with an organization located in Miami-Dade County that owns and operates primary care medical centers in South Florida to approve up to 300 initial enrollees in this PACE program. The AHCA is authorized to seek any necessary waiver or state plan amendments to implement this section. | **House position—No language** |
| 14 | **Section 8.** (s. 391.055, F.S.) – Conforming cross-references. | **Bump** | | **House position** |

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| 15 | **Section 9.** (s. 393.0661, F.S.) – Conforming cross-references. | **Bump** | | **House position** |
| 16 | **Section 10.** (s. 409.968, F.S.) – Conforming cross-references. | **Bump** | | **House position** |
| 17 | **Section 11.** (s. 427.0135, F.S.) – Conforming cross-references. | **Bump** | | **House position** |
| 18 | **Section 12.** (s. 1011.70, F.S.) – Conforming cross-references. | **Bump** | | **House position** |
| 19 | **Section 13.** Provides an effective date of July 1, 2017. | **Bump** | **Section 25.** - Provides that, except as otherwise expressly provided in the act, and this section, which shall take effect upon becoming law, the bill has an effective date of July 1, 2017. | **Senate position** |
| 20 | Proposed New Language related to Low Income Pool<br><br>Section XX. For the 2017-2018 fiscal year, $578,918,460 in nonrecurring funds from the Grants and Donations Trust Fund and $924,467,313 in nonrecurring funds from the Medical Care Trust Fund is appropriated to the Agency for Health Care Administration for the purpose of implementing a Low Income Pool Program. These funds shall be held in reserve. Subject to the federal approval of the final terms and conditions of the Low Income Pool, the Agency for Health Care Administration shall submit a budget amendment requesting release of the funds held in reserve pursuant to the provisions of chapter 216, Florida Statues. If the chair or vice chair of the Legislative Budget Commission or the President of the Senate or the Speaker of the House of Representatives objects in writing to a proposed amendment within 14 days following notification, the Governor shall disapprove the proposed amendment. The amendment shall include the Reimbursement and Funding Methodology Document, as specified in the terms | **Bump** | Proposed New Language related to Low Income Pool<br><br>Section XX. For the 2017-2018 fiscal year, $578,918,460 in nonrecurring funds from the Grants and Donations Trust Fund and $924,467,313 in nonrecurring funds from the Medical Care Trust Fund is appropriated to the Agency for Health Care Administration for the purpose of implementing a Low Income Pool Program. These funds shall be held in reserve. Subject to the federal approval of the final terms and conditions of the Low Income Pool, the Agency for Health Care Administration shall submit a budget amendment requesting release of the funds held in reserve pursuant to the provisions of chapter 216, Florida Statutes. If the chair and vice chair of the Legislative Budget Commission or the President of the Senate and the Speaker of the House of Representatives objects in writing to a proposed amendment within 14 days following notification, the Governor shall disapprove the proposed amendment. The amendment shall include the | **Modified Senate position**<br><br>**Section 29.** For the 2017-2018 fiscal year, $578,918,460 in nonrecurring funds from the Grants and Donations Trust Fund and $924,467,313 in nonrecurring funds from the Medical Care Trust Fund are appropriated to the Agency for Health Care Administration for the purpose of implementing a Low Income Pool Program. These funds shall be held in reserve. Subject to the federal approval of the final terms and conditions of the Low Income Pool, the Agency for Health Care Administration shall submit a budget amendment requesting release of the funds held in reserve pursuant to the provisions of chapter 216, Florida Statutes. If the chair and vice chair of the Legislative Budget Commission or the President of the Senate and the Speaker of the House of Representatives object in writing to a proposed amendment within 14 days following notification, the Governor shall void the action. In addition to the proposed amendment, the agency must submit: |

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| | and conditions, that documents permissible Low Income Pool expenditures, a proposed distribution model by entity, and a proposed listing of entities contributing Intergovernmental Transfers to support the state match required. Low Income Pool payments to providers under this section are contingent upon the nonfederal share being provided through intergovernmental transfers in the Grants and Donations Trust Fund. In the event the funds are not available in the Grants and Donations Trust Fund, the State of Florida is not obligated to make payments under this section of law. This section expires July 1, 2018. | | Reimbursement and Funding Methodology Document, as specified in the terms and conditions, that documents permissible Low Income Pool expenditures, a proposed distribution model by entity, and a proposed listing of entities contributing Intergovernmental Transfers to support the state match required. Low Income Pool payments to providers under this section are contingent upon the nonfederal share being provided through intergovernmental transfers in the Grants and Donations Trust Fund. In the event the funds are not available in the Grants and Donations Trust Fund, the State of Florida is not obligated to make payments under this section of law. This section expires July 1, 2018. | the Reimbursement and Funding Methodology Document, as specified in the terms and conditions, that documents permissible Low Income Pool expenditures; a proposed distribution model by entity; and a proposed listing of entities contributing Intergovernmental Transfers to support the state match required. Low Income Pool payments to providers under this section are contingent upon the nonfederal share being provided through intergovernmental transfers in the Grants and Donations Trust Fund. In the event the funds are not available in the Grants and Donations Trust Fund, the State of Florida is not obligated to make payments under this section of law. This section expires July 1, 2018 |
| 21 | Proposed New Language related to Physician Supplemental Payments<br><br>Section XX. For the 2017-2018 fiscal year, $94,414,800 in nonrecurring funds from the Grants and Donations Trust Fund and $151,585,200 in nonrecurring funds from the Medical Care Trust Funds is appropriated to the Agency for Health Care Administration to continue medical school faculty physician supplemental payments. These funds shall be held in reserve. These funds shall be used to continue supplemental payments for services provided by doctors of medicine and osteopathy as well as other licensed health care practitioners acting under the supervision of those doctors who are employed by or under contract with a medical school in Florida. These funds may also be used for pass-through, sub-capitation, differential fee, or directed lump sum payments for doctors of medicine and osteopathy as well as other licensed health care practitioners acting under the supervision of those doctors who are employed by or under contract with a medical school in Florida. Subject to federal approval to continue the supplemental and/or pass-through, sub-capitation, | **Bump** | Proposed New Language related to Physician Supplemental Payments<br><br>Section XX. For the 2017-2018 fiscal year, $94,414,800 in nonrecurring funds from the Grants and Donations Trust Fund and $151,585,200 in nonrecurring funds from the Medical Care Trust Funds is appropriated to the Agency for Health Care Administration to continue medical school faculty physician supplemental payments. These funds shall be held in reserve. These funds shall be used to continue supplemental payments for services provided by doctors of medicine and osteopathy as well as other licensed health care practitioners acting under the supervision of those doctors who are employed by or under contract with a medical school in Florida. These funds may also be used for pass-through, sub-capitation, differential fee, or directed lump sum payments for doctors of medicine and osteopathy as well as other licensed health care practitioners acting under the supervision of those doctors who are employed by or under contract with a medical school in Florida. Subject to federal approval to continue the supplemental and/or | **Modified Senate position**<br><br>**Section 30.** For the 2017-2018 fiscal year, $94,414,800 in nonrecurring funds from the Grants and Donations Trust Fund and $151,585,200 in nonrecurring funds from the Medical Care Trust Funds are appropriated to the Agency for Health Care Administration to continue medical school faculty physician supplemental payments. These funds shall be held in reserve. These funds shall be used to continue supplemental payments for services provided by doctors of medicine and osteopathy as well as other licensed health care practitioners acting under the supervision of those doctors who are employed by or under contract with a medical school in Florida. These funds may also be used for pass-through, sub-capitation, differential fee, or directed lump sum payments for doctors of medicine and osteopathy as well as other licensed health care practitioners acting under the supervision of those doctors who are employed by or under contract with a medical school in Florida. Subject to federal approval to continue the supplemental and/or pass-through, sub- |

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| | differential fee, or directed lump sum payments, the Agency for Health Care Administration shall submit a budget amendment requesting release of the funds held in reserve pursuant to the provisions of chapter 216, Florida Statues. If the chair or vice chair of the Legislative Budget Commission or the President of the Senate or the Speaker of the House of Representatives objects in writing to a proposed amendment within 14 days following notification, the Governor shall disapprove the proposed amendment. The amendment shall include the federal approvals, a proposed distribution model by entity and a proposed listing of entities contributing Intergovernmental Transfers to support the state match required. Payments to providers under this section are contingent upon the nonfederal share being provided through intergovernmental transfers in the Grants and Donations Trust Fund. In the event the funds are not available in the Grants and Donations Trust Fund, the State of Florida is not obligated to make payments under this section of law. This section expires July 1, 2018. | | pass-through, sub-capitation, differential fee, or directed lump sum payments, the Agency for Health Care Administration shall submit a budget amendment requesting release of the funds held in reserve pursuant to the provisions of chapter 216, Florida Statutes. If the chair and vice chair of the Legislative Budget Commission or the President of the Senate and the Speaker of the House of Representatives objects in writing to a proposed amendment within 14 days following notification, the Governor shall disapprove the proposed amendment. The amendment shall include the federal approvals, a proposed distribution model by entity and a proposed listing of entities contributing Intergovernmental Transfers to support the state match required. Payments to providers under this section are contingent upon the nonfederal share being provided through intergovernmental transfers in the Grants and Donations Trust Fund. In the event the funds are not available in the Grants and Donations Trust Fund, the State of Florida is not obligated to make payments under this section of law. This section expires July 1, 2018. | capitation, differential fee, or directed lump sum payments, the Agency for Health Care Administration may submit a budget amendment requesting release of the funds held in reserve pursuant to the provisions of chapter 216, Florida Statutes. If the chair and vice chair of the Legislative Budget Commission or the President of the Senate and the Speaker of the House of Representatives object in writing to a proposed amendment within 14 days following notification, the Governor shall void the action. The amendment shall include the federal approvals, a proposed distribution model by entity, and a proposed listing of entities contributing Intergovernmental Transfers to support the state match required. Payments to providers under this section are contingent upon the nonfederal share being provided through intergovernmental transfers in the Grants and Donations Trust Fund. In the event the funds are not available in the Grants and Donations Trust Fund, the State of Florida is not obligated to make payments under this section of law. This section expires July 1, 2018. |

reimburse actual payments to nursing facilities resulting from changes in nursing home per diem rates, but may not be reconciled to actual days experienced by the long-term care managed care plans.

Section 18. Subsection (27) of section 409.901, Florida Statutes, is amended to read:

409.901 Definitions; ss. 409.901-409.920.—As used in ss. 409.901-409.920, except as otherwise specifically provided, the term:

(27) "Third party" means an individual, entity, or program, excluding Medicaid, that is, may be, could be, should be, or has been liable for all or part of the cost of medical services related to any medical assistance covered by Medicaid. A third party includes a third-party administrator; ~~or~~ a pharmacy benefits manager; a health insurer; a self-insured plan; a group health plan, as defined in s. 607(1) of the Employee Retirement Income Security Act of 1974; a service benefit plan; a managed care organization; liability insurance, including self-insurance; no-fault insurance; workers' compensation laws or plans; or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.

Section 19. Subsection (4), paragraph (c) of subsection (6), paragraph (h) of subsection (11), subsection (16), paragraph (b) of subsection (17), and subsection (20) of section 409.910, Florida Statutes, are amended to read:

409.910 Responsibility for payments on behalf of Medicaid-eligible persons when other parties are liable.—

(4) After the agency has provided medical assistance under

the Medicaid program, it shall seek ~~recovery of~~ reimbursement from third-party benefits to the limit of legal liability and for the full amount of third-party benefits, but not in excess of the amount of medical assistance paid by Medicaid, as to:

(a) Claims for which the agency has a waiver pursuant to federal law; or

(b) Situations in which the agency learns of the existence of a liable third party or in which third-party benefits are discovered or become available after medical assistance has been provided by Medicaid.

(6) When the agency provides, pays for, or becomes liable for medical care under the Medicaid program, it has the following rights, as to which the agency may assert independent principles of law, which shall nevertheless be construed together to provide the greatest recovery from third-party benefits:

(c) The agency is entitled to, and has, an automatic lien for the full amount of medical assistance provided by Medicaid to or on behalf of the recipient for medical care furnished as a result of any covered injury or illness for which a third party is or may be liable, upon the collateral, as defined in s. 409.901.

1. The lien attaches automatically when a recipient first receives treatment for which the agency may be obligated to provide medical assistance under the Medicaid program. The lien is perfected automatically at the time of attachment.

2. The agency is authorized to file a verified claim of lien. The claim of lien shall be signed by an authorized employee of the agency, and shall be verified as to the

employee's knowledge and belief. The claim of lien may be filed and recorded with the clerk of the circuit court in the recipient's last known county of residence or in any county deemed appropriate by the agency. The claim of lien, to the extent known by the agency, shall contain:

a. The name and last known address of the person to whom medical care was furnished.

b. The date of injury.

c. The period for which medical assistance was provided.

d. The amount of medical assistance provided or paid, or for which Medicaid is otherwise liable.

e. The names and addresses of all persons claimed by the recipient to be liable for the covered injuries or illness.

3. The filing of the claim of lien pursuant to this section shall be notice thereof to all persons.

4. If the claim of lien is filed within 3 years ~~1 year~~ after the later of the date when the last item of medical care relative to a specific covered injury or illness was paid, or the date of discovery by the agency of the liability of any third party, or the date of discovery of a cause of action against a third party brought by a recipient or his or her legal representative, record notice shall relate back to the time of attachment of the lien.

5. If the claim of lien is filed after 3 years ~~1 year~~ after the later of the events specified in subparagraph 4., notice shall be effective as of the date of filing.

6. Only one claim of lien need be filed to provide notice as set forth in this paragraph and shall provide sufficient notice as to any additional or after-paid amount of medical

assistance provided by Medicaid for any specific covered injury or illness. The agency may, in its discretion, file additional, amended, or substitute claims of lien at any time after the initial filing, until the agency has been repaid the full amount of medical assistance provided by Medicaid or otherwise has released the liable parties and recipient.

7. No release or satisfaction of any cause of action, suit, claim, counterclaim, demand, judgment, settlement, or settlement agreement shall be valid or effectual as against a lien created under this paragraph, unless the agency joins in the release or satisfaction or executes a release of the lien. An acceptance of a release or satisfaction of any cause of action, suit, claim, counterclaim, demand, or judgment and any settlement of any of the foregoing in the absence of a release or satisfaction of a lien created under this paragraph shall prima facie constitute an impairment of the lien, and the agency is entitled to recover damages on account of such impairment. In an action on account of impairment of a lien, the agency may recover from the person accepting the release or satisfaction or making the settlement the full amount of medical assistance provided by Medicaid. Nothing in this section shall be construed as creating a lien or other obligation on the part of an insurer which in good faith has paid a claim pursuant to its contract without knowledge or actual notice that the agency has provided medical assistance for the recipient related to a particular covered injury or illness. However, notice or knowledge that an insured is, or has been a Medicaid recipient within 1 year from the date of service for which a claim is being paid creates a duty to inquire on the part of the insurer as to any injury or illness for which the

insurer intends or is otherwise required to pay benefits.

8. The lack of a properly filed claim of lien shall not affect the agency's assignment or subrogation rights provided in this subsection, nor shall it affect the existence of the lien, but only the effective date of notice as provided in subparagraph 5.

9. The lien created by this paragraph is a first lien and superior to the liens and charges of any provider, and shall exist for a period of 7 years, if recorded, after the date of recording; and shall exist for a period of 7 years after the date of attachment, if not recorded. If recorded, the lien may be extended for one additional period of 7 years by rerecording the claim of lien within the 90-day period preceding the expiration of the lien.

10. The clerk of the circuit court for each county in the state shall endorse on a claim of lien filed under this paragraph the date and hour of filing and shall record the claim of lien in the official records of the county as for other records received for filing. The clerk shall receive as his or her fee for filing and recording any claim of lien or release of lien under this paragraph the total sum of $2. Any fee required to be paid by the agency shall not be required to be paid in advance of filing and recording, but may be billed to the agency after filing and recording of the claim of lien or release of lien.

11. After satisfaction of any lien recorded under this paragraph, the agency shall, within 60 days after satisfaction, either file with the appropriate clerk of the circuit court or mail to any appropriate party, or counsel representing such

party, if represented, a satisfaction of lien in a form acceptable for filing in Florida.

(11) The agency may, as a matter of right, in order to enforce its rights under this section, institute, intervene in, or join any legal or administrative proceeding in its own name in one or more of the following capacities: individually, as subrogee of the recipient, as assignee of the recipient, or as lienholder of the collateral.

(h) Except as otherwise provided in this section, actions to enforce the rights of the agency under this section shall be commenced within 6 ~~5~~ years after the date a cause of action accrues, with the period running from the later of the date of discovery by the agency of a case filed by a recipient or his or her legal representative, or of discovery of any judgment, award, or settlement contemplated in this section, or of discovery of facts giving rise to a cause of action under this section. Nothing in this paragraph affects or prevents a proceeding to enforce a lien during the existence of the lien as set forth in subparagraph (6)(c)9.

(16) Any transfer or encumbrance of any right, title, or interest to which the agency has a right pursuant to this section, with the intent, likelihood, or practical effect of defeating, hindering, or reducing reimbursement to ~~recovery by~~ the agency for ~~reimbursement of~~ medical assistance provided by Medicaid, shall be deemed to be a fraudulent conveyance, and such transfer or encumbrance shall be void and of no effect against the claim of the agency, unless the transfer was for adequate consideration and the proceeds of the transfer are reimbursed in full to the agency, but not in excess of the

amount of medical assistance provided by Medicaid.

(17)

(b) If federal law limits the agency to reimbursement from the recovered medical expense damages, a recipient, or his or her legal representative, may contest the amount designated as recovered medical expense damages payable to the agency pursuant to the formula specified in paragraph (11)(f) by filing a petition under chapter 120 within 21 days after the date of payment of funds to the agency or after the date of placing the full amount of the third-party benefits in the trust account for the benefit of the agency pursuant to paragraph (a). The petition shall be filed with the Division of Administrative Hearings. For purposes of chapter 120, the payment of funds to the agency or the placement of the full amount of the third-party benefits in the trust account for the benefit of the agency constitutes final agency action and notice thereof. Final order authority for the proceedings specified in this subsection rests with the Division of Administrative Hearings. This procedure is the exclusive method for challenging the amount of third-party benefits payable to the agency. In order to successfully challenge the amount designated as recovered medical expenses ~~payable to the agency~~, the recipient must prove, by clear and convincing evidence, that the ~~a lesser~~ portion of the total recovery which should be allocated as ~~reimbursement for~~ past and future medical expenses is less than the amount calculated by the agency pursuant to the formula set forth in paragraph (11)(f). Alternatively, the recipient must prove by clear and convincing evidence ~~or~~ that Medicaid provided a lesser amount of medical assistance than that asserted by the

agency.

(20)(a) Entities providing health insurance as defined in s. 624.603, health maintenance organizations and prepaid health clinics as defined in chapter 641, and, on behalf of their clients, third-party administrators, ~~and~~ pharmacy benefits managers, and any other third parties, as defined in s. 409.901(27), which are legally responsible for payment of a claim for a health care item or service as a condition of doing business in the state or providing coverage to residents of this state, shall provide such records and information as are necessary to accomplish the purpose of this section, unless such requirement results in an unreasonable burden.

(b) An entity must respond to a request for payment with payment on the claim, a written request for additional information with which to process the claim, or a written reason for denial of the claim within 90 working days after receipt of written proof of loss or claim for payment for a health care item or service provided to a Medicaid recipient who is covered by the entity. Failure to pay or deny a claim within 140 days after receipt of the claim creates an uncontestable obligation to pay the claim.

~~(a) The director of the agency and the Director of the Office of Insurance Regulation of the Financial Services Commission shall enter into a cooperative agreement for requesting and obtaining information necessary to effect the purpose and objective of this section.~~

~~1. The agency shall request only that information necessary to determine whether health insurance as defined pursuant to s. 624.603, or those health services provided pursuant to chapter~~

~~641, could be, should be, or have been claimed and paid with respect to items of medical care and services furnished to any person eligible for services under this section.~~

~~2. All information obtained pursuant to subparagraph 1. is confidential and exempt from s. 119.07(1). The agency shall provide the information obtained pursuant to subparagraph 1. to the Department of Revenue for purposes of administering the state Title IV-D program. The agency and the Department of Revenue shall enter into a cooperative agreement for purposes of implementing this requirement.~~

~~3. The cooperative agreement or rules adopted under this subsection may include financial arrangements to reimburse the reporting entities for reasonable costs or a portion thereof incurred in furnishing the requested information. Neither the cooperative agreement nor the rules shall require the automation of manual processes to provide the requested information.~~

~~(b) The agency and the Financial Services Commission jointly shall adopt rules for the development and administration of the cooperative agreement. The rules shall include the following:~~

~~1. A method for identifying those entities subject to furnishing information under the cooperative agreement.~~

~~2. A method for furnishing requested information.~~

~~3. Procedures for requesting exemption from the cooperative agreement based on an unreasonable burden to the reporting entity.~~

Section 20. Notwithstanding section 27 of chapter 2016-65, Laws of Florida, and subject to federal approval of the application to be a site for the Program of All-inclusive Care