A bill to be entitled

An act relating to health information transparency; amending s. 408.05, F.S.; requiring the Agency for Health Care Administration to contract with a vendor to evaluate health information technology activities to identify best practices and methods to increase interoperability; requiring a report to the Legislature by a specified date; amending s. 409.901, F.S.; revising the definition of the term "third party" for purposes of liability for payment of certain medical services covered by Medicaid; amending s. 409.910, F.S.; revising provisions relating to responsibility for Medicaid payments in settlement proceedings; extending period of time for filing a claim of lien filed for purposes of third-party liability; extending the period of time within which the agency is authorized to pursue certain causes of action; revising procedures for a recipient to contest the amount payable to the agency when federal law limits reimbursement under certain circumstances; requiring certain entities responsible for payment of claims to provide certain records and information and respond to requests for payment of claims within a specified timeframe as a condition of doing business in the state; providing circumstances under which such

parties are obligated to pay claims; deleting provisions relating to cooperative agreements between the agency, the Office of Insurance Regulation, and the Department of Revenue; providing an appropriation; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Paragraphs (d) through (j) of subsection (3) of section 408.05, Florida Statutes, are redesignated as paragraphs (e) through (k), respectively, and a new paragraph (d) is added to that subsection to read:

408.05 Florida Center for Health Information and Transparency.—

(3) HEALTH INFORMATION TRANSPARENCY.—In order to disseminate and facilitate the availability of comparable and uniform health information, the agency shall perform the following functions:

(d) Contract with a vendor to evaluate health information technology activities within the state. The vendor shall identify best practices for developing data systems which will leverage existing public and private health care data sources to provide health care providers with real-time access to their patients' health records. The evaluation shall identify methods to increase interoperability across delivery systems regardless

of geographic location and include a review of eligibility for public programs or private insurance to ensure that health care services, including Medicaid services, are clinically appropriate. The evaluation shall address cost avoidance through the elimination of duplicative services or overutilization of services. The agency shall submit a report of the vendor's findings and recommendations to the President of the Senate and the Speaker of the House of Representatives by December 31, 2017.

Section 2. 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; health insurer; self-insured plan; group health plan, as defined in s. 607(1) of the Employee Retirement Income Security Act of 1974; service benefit plan; 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 3. 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 that 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 4. For the 2017-2018 fiscal year, the sum of $500,000 in nonrecurring funds from the Health Care Trust Fund is appropriated to the Agency for Health Care Administration for the purpose of implementing this act.

Section 5. This act shall take effect July 1, 2017.