The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	CS/SB 1550
INTRODUCER:	Health Policy Committee and Senator Artiles
SUBJECT:	Health Information Transparency
DATE:	April 5, 2017
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Stovall	HP	**Fav/CS**
2.			AP	
3.			RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1550 requires the Agency for Health Care Administration (AHCA) to contract with a vendor to evaluate health information technology in the state and report to the Legislature by December 31, 2017, on the development of systems that will use existing public and private health care data sources to provide health care providers with real-time access to information about their patients' health records, ensure that health care services are clinically appropriate, and ensure cost avoidance by eliminating duplicative and overused services.

The bill also amends sections of the Florida Statutes related to Medicaid third party liability to clarify who is a third party, extend the time frame for the AHCA to file a claim of lien, require an entity to respond to a claim by the AHCA within 90 days, require an entity to either pay or deny a claim within 140 days, and to repeal language that requires the AHCA to enter into cooperative agreements with the Office of Insurance Regulation (OIR) and the Department of Revenue (DOR) for information sharing related to third party liability.

The bill takes effect July 1, 2017.

II. Present Situation:

Florida Center for Health Information and Transparency

The Florida Center, housed within the AHCA, collects, compiles, coordinates, analyzes, indexes, and disseminates health-related data and statistics.[1] 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
- Specific quality-of-care initiatives involving various health care providers available to the public.[2]

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.[3] 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.[4] 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.[5]

The Florida Electronic Health Records Exchange Act

Section 408.051, F.S., establishes the Florida Health Records Exchange Act. The act requires a healthcare provider that receives an authorization form containing a request for the release of an

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[1] Section 408.05(1), F.S.
[2] Section 408.05(2), F.S.
[3] Section 408.051(2)(a), F.S.
[4] HHS.gov, "The Security Rule," available https://www.hhs.gov/hipaa/for-professionals/security/index.html(last visited March 29, 2017). Covered entities include health care practitioners, health plans, and health care clearinghouses, as well of the business associates of these entities.
[5] 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 29, 2017).

identifiable health record to accept the form as a valid authorization to release the record.[6] Any release of health information after the receipt of an authorization form completed and submitted as prescribed by the Agency for Health Care Administration (AHCA) creates a rebuttable presumption that the release was appropriate.[7] Additionally, the act shields a health care provider that acts in good faith to release or access an identifiable health record without the patient's consent for the use in treatment of an emergency medical condition when the health care provider is unable to obtain the patient's or the patient's representative's consent when the patient requires immediate medical attention.[8]

In addition to the provisions contained within the Florida Electronic Health Records Exchange Act, s. 408.062(5), F.S., requires the AHCA to develop and implement a strategy for the adoption and use of electronic health records, including the development of an electronic health information network for the sharing of electronic health records among health care facilities, health care providers, and health insurers.

Federal Requirements for the Meaningful Use of EHR

In order to qualify for EHR Incentive Programs[9] offered by the Federal Centers for Medicare and Medicaid Services (CMS) hospitals and eligible professionals[10] (EP) must attest to demonstrating the meaningful use of EHR. Meaningful use is defined as using EHR to:

- Improve quality, safety, efficiency, and reduce health disparities;
- Engage patients and family;
- Improve care coordination, and population and public health; and
- Maintain privacy and security of patient health information.

Meaningful use sets specific objectives that EPs and hospitals must achieve to qualify for incentives and these objectives have evolved in three stages over five years:

- Stage 1, from 2011-2012, included data capture and sharing;
- Stage 2, in 2014-2015, included advanced clinical processes; and
- Stage 3, in 2016, included improved outcomes.[11]

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

[6] Section 408.051(4)(c), F.S.
[7] Section 408.051(4)(e), F.S.; however, pursuant to s. 408.051(4)(d), F.S., the use of the form adopted by the AHCA is not required to authorize release of protected health information.
[8] Section 408.051(3), F.S.
[9] For a description of the EHR Incentive Programs, see https://www.healthit.gov/providers-professionals/ehr-incentive-programs, (last visited on March 30, 2017).
[10] Eligible professionals are doctors of medicine, osteopathy, dental surgery, dental medicine, podiatry, and optometry and chiropractors. See https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/eligibility.html, (last visited on March 30, 2017)
[11] See https://www.healthit.gov/providers-professionals/meaningful-use-definition-objectives, (last visited on March 30, 2017). For more details on the specific on the objectives see https://www.healthit.gov/providers-professionals/how-attain-meaningful-use, (last visited on March 30, 2017).

validation.[12] However, the availability of such databases varies depending on geographic location, and the participating health insurers vary. The NORC at the University of Chicago[13] is an independent research organization that 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.[14] 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.

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 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.[15] 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.[16] 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.[17] 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.[18] In contrast, the pay-and-chase method is used when a state

[12] 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 29, 2017).

[13] 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 29, 2017).

[14] 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).

[15] Chapter 2011-134, Laws of Fla. Full implementation occurred in 2014.

[16] 42 U.S.C. s. 1396a(a)(25). States are not required to seek reimbursement if is not cost-effective to do so.

[17] The state may contract with a vendor to fulfill this responsibility.

[18] 42 CFR s. 433.139(b).

pays health care service providers for submitted claims and then attempts to recover payments from liable third parties.[19] This usually occurs when TPL is later identified.

In 2005, Congress passed the Deficit Reduction Act (DRA)[20] 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;
  - 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,[21] 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.[22]

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.[23] A Medicaid lien is automatically applied when a beneficiary receives services paid by Medicaid for which a third

[19] 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.
[20] Pub. Law No. 109-171.
[21] Section 409.910, F.S.
[22] 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 April 5, 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 April 5, 2017).
[23] Section 409.910(6), F.S.

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.[24]

III. Effect of Proposed Changes:

CS/SB 1550 amends s. 408.05, F.S., to require that the AHCA contract with a vendor to evaluate health information technology in the state and report to the Legislature on best practices in for the development of systems that will leverage existing public and private health care data sources in order to:

- Provide health care providers with real-time access to information about their patients' health records.
- Methods to increase interoperability across delivery systems and geographic locations, including a review of public and private insurance eligibility, to ensure that health care services, including Medicaid services, are clinically appropriate;
- Ensure cost avoidance through elimination of duplicative services and overutilization of services.

The bill requires that the AHCA submit the report to the Legislature by December 31, 2017.

The bill also amends ss. 409.901 and 409.910, F.S., relating to the Medicaid Third Party Liability Program, to bring the statutes into conformity with the federal DRA and improve efficiencies. The bill:

- Includes within the definition of "third party" a 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.
- Extends the amount of time the AHCA has to file a TPL lien from one year to three years after last payment for medical care, date of the AHCA's discovery of third party liability, or date of the discovery of a cause of action.
- Requires an entity to respond to a claim within 90 days with payment, a written request for more information, or a written denial of the claim stating a reason for denial.
- Establishes an uncontestable obligation to pay the claim if the entity fails to pay or respond to a claim within 140 days.
- Repeals provisions requiring the AHCA to enter into cooperative agreements with OIR and DOR to adopt rules for information sharing related to third party liability.
- 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 only if amount of the recovery is limited by federal law.[25]

[24] Section 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.

[25] Federal law prohibits a Medicaid agency from recovering more than the amount of a recovery that is attributable to past and future medical needs. 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

The bill's provisions take effect on July 1, 2017.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

CS/SB 1550 may have an impact on the private sector if the AHCA recovers funds from the person or entity through TPL action beyond the current timeframe or if funds that would have been contestable but have become uncontestable through inaction of the person or entity are recovered through the TPL program.

C. Government Sector Impact:

CS/SB 1550 may have an indeterminate negative fiscal impact to the AHCA for contracting with a vendor to develop the report required in the bill.

CS/SB 1550 may have an indeterminate positive fiscal impact on the AHCA if the AHCA is able to recover more funds through TPL.

VI. Technical Deficiencies:

The title for CS/SB 1550 is "An act relating to the health information transparency." Sections two and three of the bill amend provisions related to TPL and do not appear to amend provisions related to health information transparency. As such, the current title of the bill may not be broad enough to incorporate all of the substantive provisions of the bill. The title should be amended so that it incorporates all substantive provisions. A title such as "An act relating to health care costs" may be sufficient.

AHCA's calculation of the amount that should have been allocated as past and future medical expenses is incorrect. 42 U.S.C. s. 1396a(a)(25).

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 408.05, 409.901, and 409.910.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Health Policy on March 3, 2017:
The CS:

- Amends current bill language to:
  - Require the report be delivered by December 31, 2017;
  - Remove the automatic repeal date.
- Adds new language that:
  - Amends the definition of "third party" in part III of ch. 409, F.S., (related to Medicaid) to specifically include health insurers; self-insured plans, group health plan;, service benefit plans; managed care organizations; liability insurance; workers' comp laws or plans; or other parties that are legally responsible for payment of a claim for a health care item or service by statute, contract, or agreement.
  - Extends the time for AHCA to file a claim of lien from one year to three years after last payment for medical care, date of AHCA's discovery of third party liability; or date of the discovery of a cause of action.
  - Requires an entity to respond to a claim within 90 days with payment, a written request for more information, or a written denial of the claim stating a reason for denial. Failure to pay or respond to a claim within 140 days creates an uncontestable obligation to pay the claim.
  - Repeals provisions requiring the AHCA to enter into cooperative agreements with OIR and DOR to adopt rules for information sharing related to third party liability.
  - Clarifies that a beneficiary may contest the amount of reimbursement from a recovered medical expense by filing a petition with the DOAH only if amount of the recovery is limited by federal law.

B. Amendments:

None.