A bill to be entitled

An act relating to capital recovery; creating s. 155.50, F.S.; providing definitions; requiring the Department of Financial Services to maintain a list of claims specialist certification providers on its website; specifying the information to be included in a capital recovery report; providing the method used to calculate a denial rate; requiring hospital districts and county hospitals to comply with capital recovery reporting requirements; requiring the department to contract with an approved provider to calculate denial rates for certain hospital districts and county hospitals; prohibiting hospital districts and county hospitals from receiving increased tax revenues if they fail to timely submit a complete report; requiring the department to maintain a list of approved providers; requiring hospital districts and county hospitals to meet specified requirements before levying or receiving increased tax revenues; providing construction; providing the department with rulemaking authority to specify the type and form of data necessary to calculate a denial rate; requiring an annual report listing the denial rates for each hospital district and county hospital; providing a finding of important state interest; providing an appropriation; providing an effective date.

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

Section 1. Section 155.50, Florida Statutes, is created to read:

155.50 Capital recovery requirements for tax-supported hospitals.—

(1) As used in this section, the term:

(a) "Approved provider" means a business that generates at least 85 percent of its revenues from denied claims management, that has been in existence for at least 5 years, and that employs at least 30 certified claims specialists.

(b) "Capital recovery report" means a report of claims to an insurer or governmental entity and all related claim denials for all of the claims of hospitals and other medical facility operations of a hospital district or a county hospital, which must:

1. Include all claims data electronically submitted by all hospitals and other medical facilities and operations of the hospital district or county hospitals to a governmental entity or insurer and remittance advice or responses electronically transmitted by insurers or governmental entities in an electronic format that the approved provider hired by the department can use to calculate denial rates.

2. Include an attestation by a certified public accountant that the billing information reflected in the report is

accurate, complete, and consistent with generally accepted accounting principles.

3. Comply with federal and state confidentiality standards.

(c) "Certified claims specialist" means an individual who is certified by an entity that uses nationally recognized claims management principles to establish a baseline competency for claims specialists. The department shall maintain a list of recognized certification providers on its website.

(d) "Claim" means an itemized statement of health care services and costs submitted by a health care provider or facility to a governmental entity or a third party for payment.

(e) "County funding" means the funds appropriated by a county government to support a hospital or the proceeds of an ad valorem tax levied by a county to support a hospital.

(f) "County hospital" means a hospital receiving county funding.

(g) "Denial rate" means the denial value divided by the total gross value of claims electronically billed during the fiscal year reflected on the hospital district's or county hospital's claims submissions. The fiscal year for the denial value and the fiscal year for the gross value of claims must be the same. If an insurer declares bankruptcy, all claims issued to and claim denials by that insurer shall be removed from the numerator and denominator of this calculation.

(h) "Denial value" means the gross amount of all zero paid

line items on billed claims submitted in a given fiscal year for which specific payment is expected but for which no payment has been received within 60 days, as indicated in remittance advice electronically transmitted by insurers or governmental entities.

(i) "Department" means the Department of Financial Services.

(j) "Fiscal year" means the annual period beginning October 1 and ending September 30 of the following year.

(k) "Hospital district" means a dependent or independent special district that levies ad valorem taxes to support the operations of one or more hospitals or other medical facilities.

(l) "Increased tax revenues" means an increase in ad valorem tax revenues levied by a hospital district or an increase in county funding for a county hospital for a fiscal year compared to the levying or funding entity's immediately prior fiscal year.

(m) "Specific payment" means the reimbursement amount expected based on the Centers for Medicare and Medicaid Services' fee schedule or the contracted rates specific to each insurer.

(2)(a) The department shall contract with an approved provider to receive the capital recovery reports and calculate the denial rate for each hospital district or county hospital based on the data submitted in the capital recovery reports.

(b) An approved provider contracted by the department may not also work in any capacity for any hospital district or

county hospital that is required to submit a capital recovery report pursuant to this section.

(3) Each hospital district or county hospital must complete and submit to the approved provider under contract with the department a capital recovery report within 90 calendar days after the end of the fiscal year. The hospital district or county hospital may develop its own capital recovery report that meets the requirements of this section or may hire an approved provider to develop the capital recovery report. The first capital recovery report is due after the 2015-2016 fiscal year.

(4) Within 60 calendar days after receiving the complete capital recovery report, the approved provider under contract with the department shall calculate the denial rate for the hospital district or county hospital based on the data submitted in the capital recovery report and notify the board of the hospital district or county hospital of the denial rate. The capital recovery report is deemed incomplete until the approved provider has sufficient data in the proper format to allow it to accurately calculate a denial rate for the hospital district or county hospital. If the approved provider receives an incomplete report, the approved provider shall notify the governing board of the hospital district or county hospital. The hospital district or county hospital has 15 business days from the date that the approved provider issues the notification to provide the complete report to the approved provider. If the hospital district or county hospital fails to provide the complete report

within 15 business days, the hospital district or county hospital may not levy or receive increased tax revenues for the fiscal year following the year in which the capital recovery report was due.

(5) The department shall provide a list of at least five approved providers that meet the requirements of this section.

(6) A hospital district or county hospital may levy or receive increased tax revenues for fiscal years 2017-2018, 2018-2019, and 2019-2020 only if the denial rate calculated from the capital recovery report submitted to the approved provider under contract with the department in the immediately preceding fiscal year is 10 percent or less. A hospital district or county hospital may levy or receive increased tax revenues for each fiscal year after 2019-2020 only if the denial rate calculated from the capital recovery report submitted to the approved provider in the immediately preceding fiscal year is 7 percent or less. If the hospital district or county hospital fails to meet the denial rates described in this subsection, it may increase tax revenues if it can demonstrate that it has reduced its claim denial rate by 33 percent within the preceding 3 years and reduced its claim denial rate by 66 percent in the preceding 5 years.

(7) This section does not authorize a hospital district to increase its millage beyond the millage specified in its authorizing act or beyond 10 mills if tax revenues are received from the county. The provisions of this section are in addition

to any other statute or special act. To the extent that this section conflicts with any special act, resolution, or ordinance, this section supersedes the special act, resolution, or ordinance.

(8) The department may adopt rules to specify the type and form of records to be submitted as part of the capital recovery report used to calculate a denial rate for each hospital district or county hospital. The department is authorized, and all conditions are deemed met, to adopt emergency rules under ss. 120.536(1) and 120.54(4) for the purpose of implementing this section.

(9) By March 1 of each year, the department or an approved provider contracted by the department shall submit the denial rates for each county hospital and hospital district to the President of the Senate, the Speaker of the House of Representatives, and the standing committees of the Senate and the House of Representatives having jurisdiction over taxation.

Section 2. The Legislature finds that this act fulfills an important state interest.

Section 3. For the 2015-2016 fiscal year, the sums of $400,000 in recurring funds and $60,000 in nonrecurring funds from the General Revenue Fund are appropriated to the Department of Financial Services to contract with an approved provider to receive capital recovery reports from hospital districts and county hospitals and to calculate the denial rate for each such district or hospital to implement the provisions of this act.

Section 4. This act shall take effect July 1, 2015.