HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 7115 PCB FTC 15-02 Capital Recovery
SPONSOR(S): Appropriations Committee, Finance & Tax Committee, Fant
TIED BILLS: HB 7117 **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Finance & Tax Committee	10 Y, 5 N	Wolfgang	Langston
1) Appropriations Committee	17 Y, 10 N, As CS	Hawkins	Leznoff

SUMMARY ANALYSIS

This committee substitute (CS) requires hospital districts to collect and submit to an approved provider under contract with the Department of Financial Services (department) information on claims, and denial of claims, for payment for medical services issued to insurers and governmental entities. Using this information, the approved provider under contract with the department will calculate a "denial rate", which will affect whether the hospital district can levy additional ad valorem taxes.

Beginning in the 2017-2018 fiscal year, a hospital district may only levy increased ad valorem taxes in the year following the timely submission of its report to the approved provider under contract with the department if one of the following criteria are met:

- The denial rate for the hospital district was less than or equal to 10 percent for the reports submitted based on fiscal years 2015-2016, 2017-2018, and 2017-2018 (these reports will impact hospital district for fiscal years 2017-2018, 2018-2019, and 2019-2020, respectively), or
- The denial rate for the hospital district was less than or equal to 7 percent for reports based on fiscal year 2018-2019 and each year thereafter (these reports will impact hospital district funding for fiscal year 2020-2021 and each year thereafter); or
- The hospital district has reduced its denial rate by 33 percent within the previous three fiscal years and by 66 percent within the five previous fiscal years.

The approved provider under contract with the department will provide the denial rates to the relevant hospital district and provide a complete list of the denial rates of all the hospital districts to the Legislature.

On March 27, 2015, the Revenue Estimating Conference (REC) estimated the revenue impacts of similar language. The REC estimates the impact on local government tax revenues is indeterminate, contingent on whether or not the affected entities meet the denial rate requirements of the CS. The CS appropriates $400 thousand in recurring General Revenue in fiscal year 2015-2016 to the department to contract with an approved provider to calculate denial rates and authorizes $60 thousand in nonrecurring revenue for start-up costs of the program.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Special Districts
A "special district" is "a local unit of special purpose…government within a limited boundary, created by general law, special act, local ordinance, or by rule of the Governor and Cabinet."[1] Special districts are created to provide a variety of services, such as mosquito control, beach facilities, children's services,[2] fire control and rescue,[3] drainage control,[4] or hospital services.

A "dependent special district" is a special district meeting at least one of the following criteria:

- The members of the district governing body are identical to those on the governing body of a county or municipality;
- The members of the governing body are appointed by the governing body of a single county or municipality;
- The members of the district's governing body may be removed at will by the governing body of a single county or municipality; or
- The district budget is subject to approval or veto by the governing body of a single county or municipality.[5]

An "independent special district" is a special district meeting none of the above four criteria.[6]

Hospital Districts
Hospital districts are a type of special district. Florida has 31 active hospital and healthcare taxing districts, of which 5 are dependent districts and 26 are independent. Nineteen of those districts have the authority to levy ad valorem taxes, including 1 dependent district and 18 independent districts. Hospital districts may consist of one hospital or several hospitals and medical facilities. Additionally, counties have the authority to have their own public hospitals and levy ad valorem taxes to support building and operating those hospitals.

The ad valorem millage rate adopted by hospital districts for Fiscal Year 2014-2015 varies from 0 mills (Citrus County, Gadsden County, Madison County, and Lower Florida Keys) to 3.2908 mills (Hendry County). The taxes associated with the above tax rates vary from $0 (same list as 0 mill levy) to $155.7 million (North Broward). The total levy for all districts combined was $443.5 million for fiscal years ending in 2014.

A substantial portion of the revenues generated by a hospital or medical facility are from charges for patient care that are reimbursed by Medicare, Medicaid, or an insurance company. The claims that hospitals submit to these third party providers are either reimbursed at some contracted rate or denied. Denial can be caused by a wide variety of factors, many of which can be due to errors on the part of the hospital submitting the claim. Hospitals that enact policies and procedures to minimize denials can recover substantial revenues that otherwise might be lost.

The South Broward Hospital District, as one example, has a managed care collections capital recovery approach that has helped its hospitals increase profitability and decrease reliance on ad valorem tax

[1] Section 189.403(1), F.S.
[2] Section 125.901, F.S.
[3] Section 191.002, F.S.
[4] Section 298.01, F.S.
[5] Section 189.403(2), F.S.
[6] Section 189.403(3), F.S.

revenues. The district hired a third party to assist in revising their processes in order to reduce the number of denials.[7]

Effect of Proposed Changes

The CS requires that each hospital district submit a capital recovery report to the approved provider under contract with the Department of Financial Services (department) within 90 calendar days of the end of the fiscal year, which is defined as the period between October 1 and September 30. The report must contain data on all claims submitted electronically by all medical facilities in a hospital district to a government entity or insurance company for payment during the fiscal year, along with data on the response/payment status of all such claims. A certified public accountant must attest that the report is accurate and complete.

Each hospital district may prepare the report itself, or it may hire an approved provider to prepare the report on its behalf. The report is used by the department's approved provider to calculate a denial rate. The denial rate is defined as the dollar value of all unpaid electronically submitted claims (based on the contracted or published rate for such claims) as a percentage of the total claims submitted electronically during the same time period. Any claims made to an insurer that has declared bankruptcy are removed from the calculation of the denial rate.

An approved provider is a business that obtains at least 85% of its revenues from denied claims management practices, has been in existence for at least 5 years, and employs at least 30 certified claims specialists. A certified claims specialist is an individual who is certified by an entity that uses nationally recognized claims management principles to establish baseline competence for claims specialists. The department must maintain a list of approved certification providers.

Within 60 calendar days of receiving the capital recovery report, the approved provider under contract with the department must evaluate the data contained in each report to determine the denial rate of each hospital district. If a report is deemed incomplete because it does not contain enough data to calculate a denial rate, the department must notify the district, which then has 15 business days to provide further data. The department must report the hospital district denial rates to the Legislature by March 1 of each year.

The denial rate means the claims denials (denial amounts are calculated for all zero paid line items within 60 days of issuance of the claim and the magnitude is based on the contracted rate) divided by the total gross value of claims electronically billed during the fiscal year reflected on the hospital district'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.

The CS ties increases in certain funding to an entity's denial rate. Beginning in the 2017-2018 fiscal year, a hospital district may only levy increased ad valorem taxes in the year following submission of a capital recovery report if one of the following criteria are met:

- The denial rate for the hospital district was less than or equal to 10 percent for the reports submitted based fiscal years 2015-2016, 2017-2018, 2017-2018 (these reports will impact hospital district funding for fiscal years 2017-2018, 2018-2019, and 2019-2020, respectively), or
- The denial rate for the hospital district was less than or equal to 7 percent for reports based on fiscal year 2018-2019 and each year thereafter (these reports will impact hospital district funding for fiscal year 2020-2021 and each year thereafter); or
- The hospital district has reduced its denial rate by 33 percent within the previous 3 fiscal years and by 66 percent within the 5 previous fiscal years.

This restriction on levying or receiving increased ad valorem revenues also applies to hospital districts that fail to submit a timely completed report.

[7] Presentation to the House Finance & Tax Committee, 1/22/2015

The department may adopt emergency rules to implement this section and clarify what data must be submitted as part of the capital recovery report.

B. SECTION DIRECTORY:

Section 1: Creates s. 189.056, F.S., to set forth the capital recovery practices necessary for hospital districts to have in place to levy additional revenues.

Section 2: Provides an appropriation.

Section 3: Provides an effective date of July 1, 2015.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

The CS appropriates $400 thousand in recurring General Revenue to the Department of Financial Services to contract with an approved provider to calculate denial rates and appropriates $60 thousand in nonrecurring General Revenue to initiate the program.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

For hospital districts that fail to meet the denial rates set out in this CS, the hospital district would be prohibited from collecting additional ad valorem revenues for its hospitals and medical facilities.

2. Expenditures:

Hospital districts will be required to develop and submit to the Department of Financial Services capital recovery reports. The cost of these reports is unknown.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The CS may encourage hospital districts to hire approved providers to assist them in calculating and reducing their denial rates. Reduction in the denial rates and the potential reduction in tax revenues could shift costs away from the taxpayers and to insurers.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

None.

B. RULE-MAKING AUTHORITY:

The CS gives the Department of Financial Services emergency and regular rulemaking authority to specify the type and form of the data it needs for the calculation of the denial rates.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On April 7th the Appropriations Committee adopted a strike-all amendment which removed county hospitals from being subject to the provisions of the bill.