A bill to be entitled

An act relating to Medicaid managed care plan performance metrics; creating s. 409.9673, F.S.; requiring Medicaid managed care plans to submit each month certain performance metrics to the Agency for Health Care Administration; providing requirements for such performance metrics; requiring the agency to contract with a third party to develop and display a public dashboard with certain information; requiring the agency to update the information each month; requiring the agency to create a quarterly report, make it available to the public, and submit it to certain entities; providing an effective date.

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

Section 1. Section 409.9673, Florida Statutes, is created to read:

409.9673 Managed care plan performance metrics.—

(1) Each managed care plan shall submit to the agency each month the managed care plan performance metrics by region and by county in a format prescribed by the agency. Each manage care plan shall provide, at a minimum, the following:

(a) Credentialing:

1. The percentage and total number of providers for which

a submitted provider application has been fully loaded and processed for provider billing within 60 days.

2. The percentage and total number of providers for which a submitted provider application has not been fully loaded and processed for provider billing in excess of:

a. Sixty days.

b. Ninety days.

c. One hundred twenty days.

(b) Prior authorization:

1.a. The percentage and total number of standard prior authorizations requests approved.

b. The percentage and total number of standard prior authorizations requests denied.

c. The percentage and total number of standard prior authorization requests approved after appeal and the length of time of the appeal process, from the beginning of the appeal until the approval.

2. The percentage and total number of expedited prior authorization requests approved and the length of time to receive approval.

3. The average and median time between submissions of requests and decisions for:

a. Standard prior authorizations.

b. Expedited prior authorizations.

(c) Prompt payment:

1. The percentage and total number of claims that are:

a. Rejected before review.

b.(I) Paid.

(II) Partially paid.

(III) Denied.

(IV) Suspended.

2. The average length of time to pay clean claims.

3. The percentage of clean claims paid within:

a. Seven days.

b. Ten days.

c. Twenty days.

d. In excess of 120 days.

4. The top 10 reasons for claims denial, with the percentage and total number of claims for each reason cited.

(2) The agency shall contract with a third party to develop and display on the agency's public website a dashboard with the data provided by each managed care plan under subsection (1) to show managed care plan performance and utilization management. In addition to the data provided under subsection (1), the agency shall publish on the dashboard the following information, accessible to the public, regarding managed care plan complaints:

(a) The number of Medicaid recipients enrolled in the statewide managed medical assistance program.

(b) The number of complaints per 1,000 Medicaid

recipients.

(c) By each managed care plan:

1. By provider category, the number of complaints received by physicians, hospitals, outpatient services, skilled nursing facilities, assisted living facilities, therapy services, transportation services, laboratories, home care services, and community-based services.

2. The number of Medicaid recipient complaints for each region.

3. The number of Medicaid recipient complaints resolved for each region.

4. By provider category:

a. The number of provider complaints resolved for each region.

b. The number of complaints pending for resolution for each region.

d. The average length of time to resolve provider complaints for each region.

e. The average length of time to resolve Medicaid recipient complaints for each region.

(3) The agency shall update each month on the dashboard the information described in subsections (1) and (2).

(4) Beginning July 31, 2025, the agency shall create a quarterly report containing the information described in subsections (1) and (2) and shall make the report publicly

available no later than 30 days after the close of each quarter. The agency shall also submit the report to the Medical Care Advisory Committee, the Governor, the President of the Senate, and the Speaker of the House of Representatives.

Section 2. This act shall take effect July 1, 2024.