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 Appropriations

BILL:	CS/SB 1060
INTRODUCER:	Appropriations Committee on Health and Human Services and Senator Brodeur and others
SUBJECT:	Medicaid Oversight
DATE:	April 21, 2025
REVISED:	4/23/25

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Morgan	Brown	HP	**Favorable**
2.	Barr	McKnight	AHS	**Fav/CS**
3.	Barr	Sadberry	AP	**Favorable**

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1060 establishes the Joint Legislative Committee on Medicaid Oversight to ensure the state Medicaid program is operating in accordance with the Legislature's intent and to promote transparency and efficiency in government spending.

The bill creates a statutory definition for the term "Legislative Committee on Medicaid Oversight" to specify a committee designated by joint rule of the Legislature, by the presiding officer of either house of the Legislature, or by agreement between the presiding officers.

The bill authorizes the committee chair to create subcommittees and requires the committee to convene at least twice a year, and as often as necessary to conduct its business. Meetings may be held through teleconference or other electronic means.

The bill requires the committee to identify and recommend policies and authorizes the committee to submit periodic reports, including recommendations, to the Legislature on issues related to the state Medicaid program and any affiliated programs.

The bill requires the Auditor General and the Agency for Health Care Administration (AHCA) to enter into and maintain a data-sharing agreement by July 1, 2025. The bill requires the Auditor General to assist the committee in its work. The bill also requires the committee to be given access to any relevant record, paper, or document in possession of a state agency, any political

subdivision of the state, or any entity engaged in business or under contract with a state agency during the course of its official duties. The committee may compel the attendance and testimony of any state official or employee before the committee or secure any evidence.

The bill requires the AHCA to notify the committee of any change to the Medicaid managed care capitation rates and to appear before the committee to provide a report detailing the managed care capitation rates and administrative costs built into the capitation rates before implementation of any change to the capitation rates.

If the AHCA or any division within the AHCA is required by law to report to the Legislature or to any legislative committee or subcommittee on matters relating to the state Medicaid program, the bill requires the AHCA to submit a copy of the report to the committee.

The bill will have an indeterminate impact on state expenditures. See Section V., Fiscal Impact Statement.

The bill takes effect upon becoming a law.

II. Present Situation:

Joint Legislative Committees

A joint legislative committee is composed of members of the Senate and the House of Representatives appointed by their respective presiding officers to oversee a specified legislative function.[1] Joint legislative committees and other joint units of the Legislature are governed by joint rules of the Senate and the House of Representatives.[2]

The 2024-2026 Joint Rules of the Florida Legislature

The Joint Rules of the Florida Legislature, previously adopted in November 2024, address the following subjects:[3]

- JOINT RULE ONE – Lobbyist Registration and Compensation Reporting
- JOINT RULE TWO – General Appropriations Review Period and Budget Conference Committee Rules
- JOINT RULE THREE – Joint Offices and Policies
- JOINT RULE FOUR – Joint Committees
- JOINT RULE FIVE – Auditor General
- JOINT RULE SIX – Joint Legislative Budget Commission
- JOINT RULE SEVEN – Qualifications of Members
- JOINT RULE EIGHT – Adjourning and Reconvening of Each House of the Legislature and Providing for Adjournment Sine Die

[1] The Florida Senate, *Glossary*, *available at* https://www.flsenate.gov/reference/glossary (last visited Mar. 16, 2025).
[2] Section 11.147(2), F.S.
[3] SCR 2 ORG (2024), enrolled.

JOINT RULE FOUR – Joint Committees

Joint Rule Four establishes the following standing joint committees:[4]

- The Joint Administrative Procedures Committee (JAPC);[5]
- The Joint Committee on Public Counsel Oversight;[6] and
- The Joint Legislative Auditing Committee (JLAC).[7]

The rule requires that no other joint committee may exist except as agreed to by the presiding officers or by concurrent resolution approved by the Senate and the House of Representatives. The rule also requires that each standing joint committee appoint no fewer than five and no more than seven members from each house.[8]

The rule establishes procedures for the appointment of the chair and vice chair of the standing joint committees and procedures for joint committees other than conference committees. The rule also establishes the powers and administration of joint committees.[9]

JOINT RULE FIVE – Auditor General

Joint Rule Five provides rulemaking authority to the Auditor General and requires the Auditor General to prepare and submit a proposed budget for the ensuing fiscal year annually to the President of the Senate and the Speaker of the House of Representatives for joint approval. The rule has provisions related to the salaries and expenses of the Auditor General. The rule also requires the Auditor General to distribute copies of each audit report to certain state officers, including the Governor; the Chief Financial Officer; the officer or person in charge of the state agency or political subdivision audited; the board of county commissioners of the county in which the audit was made, if applicable; each member of the JLAC; appropriate substantive and fiscal committees of the Senate and House of Representatives; and any other person who, in the opinion of the Auditor General, is directly interested in the audit or who has a connected duty to perform.[10]

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[4] SCR 2 ORG (2024), enrolled.

[5] The primary function of the JAPC is to generally review agency action pursuant to the operation of the Florida Administrative Procedure Act, particularly as these actions relate to the rulemaking process.
Florida Administrative Law Central Online Network, *About the Joint Administrative Procedures Committee, available at* https://www.japc.state.fl.us/Pages/About.aspx (last visited Mar. 15, 2025).

[6] The Joint Committee on Public Counsel Oversight appoints a Public Counsel, pursuant to s. 350.061, F.S. The committee may file a complaint with the Commission on Ethics alleging a violation of ch. 350, F.S., by a current or former public service commissioner, an employee of the Public Service Commission, or a member of the Public Service Commission Nominating Council. [SCR 2 ORG (2024), enrolled.]

[7] In general, the responsibilities of the JLAC are broad and affect all areas of government in the state. For instance, the JLAC may direct the Auditor General or the Office of Program Policy Analysis and Government Accountability (OPPAGA) to conduct an audit, review, or examination of any entity or record as specified in s. 11.45(3), F.S. The JLAC is responsible for appointing the Auditor General, pursuant to s. 11.42(2), F.S., when there is a vacancy in the position.
The Florida Legislature, Online Sunshine, *Joint Legislative Auditing Committee, available at* http://www.leg.state.fl.us/cgi-bin/View_Page.pl?File=about.cfm&Directory=committees/joint/Jcla/&Tab=committees (last visited Mar. 15, 2025).

[8] SCR 2 ORG (2024), enrolled.

[9] *Id*.

[10] *Id*.

The Auditor General

Florida's Auditor General is a constitutional and legislative officer, a certified public accountant, and the state's independent auditor providing unbiased, timely, and relevant information that the Legislature, citizens of the state of Florida, public entity management, and other stakeholders can use to promote government accountability and stewardship, as well as improve government operations.[11]

The Constitution of the State of Florida requires the Legislature to appoint an auditor to audit public records and perform related duties as prescribed by law or concurrent resolution. Section 11.42, F.S., designates the constitutional auditor as the Auditor General, and ss. 11.42, 11.45, and 11.47, F.S., establish the general authority and duties. Independently, and in accordance with applicable professional standards, the Auditor General:

- Conducts financial audits of the accounts and records of state government, state universities, state colleges, and school districts.
- Conducts operational and performance audits of public programs, activities, and functions, as well as information technology systems.
- Adopts rules, in consultation with the Florida Board of Accountancy, for audits performed by independent certified public accountants of local governmental entities, charter schools and technical career centers, school districts, and certain nonprofit and for-profit organizations.
- Conducts reviews of audit reports of local governmental entities, charter schools and technical career centers, school districts, and certain nonprofit and for-profit organizations.
- Conducts examinations of school district records to evaluate compliance with state requirements governing the Florida Education Finance Program student enrollment and student transportation funding allocations.
- Conducts quality assessment reviews of the internal audits performed by state agency offices of inspector general. [12]

The Florida Medicaid Program

The Medicaid program is a voluntary, federal-state program that finances health coverage for individuals, including eligible low-income adults, children, pregnant women, elderly adults, and persons with disabilities.[13] The federal Centers for Medicare & Medicaid Services (CMS) within the U.S. Department of Health and Human Services is responsible for administering the Medicaid program at the federal level. Florida Medicaid is the health care safety net for low-income Floridians. Florida's program is administered by the Agency for Health Care (AHCA) and financed through state and federal funds.[14]

Statewide Medicaid Managed Care

Approximately 80 percent of Florida Medicaid recipients receive services through a plan contracted with the AHCA under the Statewide Medicaid Managed Care (SMMC) program. The

[11] Florida Auditor General, *About the Florida Auditor General, available at* https://flauditor.gov/pages/aboutus.html#tab (last visited Mar. 16, 2025).
[12] *Id.*
[13] Medicaid.gov, *Medicaid, available at* https://www.medicaid.gov/medicaid/index.html (last visited Mar. 16, 2025).
[14] Section 20.42, F.S.

SMMC program has three components: Managed Medical Assistance (MMA), Long-Term Care (LTC), and Dental. Florida's SMMC program benefits are authorized through federal waivers and are specifically required by the Florida Legislature in ss. 409.973 and 409.98, F.S.[15]

The AHCA awarded contracts to the current SMMC managed care plans through a competitive procurement process called an Invitation to Negotiate. The AHCA awarded and executed new contracts for SMMC 3.0 in October 2024, and officially rolled out the new SMMC 3.0 program on February 1, 2025. The rate year for the SMMC contracts is October 1 through September 30 of each contract year.[16]

Managed care plans providing MMA program services are required to cover acute, preventive, and other health care services, such as:

- Hospital services;
- Physician services;
- Pharmacy services;
- Behavioral health services;
- Transportation to medical services;
- Nursing facility services; and
- Other service benefits, including, but not limited to, medical equipment and supplies, therapies, and home health services.[17]

The AHCA contracts with LTC plans in each region to provide LTC services, including all home and community-based waiver services, through their provider networks. Currently, all of the LTC plans contracted with the AHCA are also contracted to provide MMA services, streamlining care with a more comprehensive enrollment approach where a Medicaid recipient can enroll with one plan for all services.[18]

Managed care plans are considered "at-risk" because they are required to pay for the medically necessary services their members require, regardless of whether the capitation rates are sufficient to cover those costs. For instance, since the AHCA pays a fixed price per-member per-month PMPM capitation rate that covers all (or nearly all) the services a plan provides, if the plan spends more than it is paid, the plan loses money; however, if the plan needs to spend less than it is paid and still fulfills its contract with the AHCA and provides the services it's supposed to provide, then the plan makes money.[19]

Achieved Savings Rebate

Pursuant to s. 409.967(3), F.S., the AHCA implemented the Achieved Savings Rebate (ASR) Program as an incentive for proper use of state funds. The program monitors the premium revenues, medical and administrative costs, and income or losses for each plan. The ASR allows plans to retain a profit margin specified in statute; however, if the profit margin exceeds the

[15] Agency for Health Care Administration, *Senate Bill 1060 Bill Analysis* (Feb. 28, 2025) (on file with Senate Committee on Health Policy).
[16] *Id.*
[17] *Id.*
[18] *Id.*
[19] *Id.*

limits specified in statute, plans must share a portion of the profits with the state or return the entire dollar amount beyond a certain threshold to the state.

The detailed financial reports for each plan are audited by an independent public accountant. The AHCA has program rules to ensure the independence of the public accountant and to establish criteria for the independent auditor.[20] The plans are responsible for paying the audit expenses incurred by the AHCA and, as part of the audit process, must provide all books, accounts, documents, files, and information pertaining to Medicaid transactions to the AHCA and the contracted certified public accounting firm.[21]

The ASR is established by determining pre-tax income as a percentage of revenues and applying the following income sharing ratios:[22]

- 100 percent of income up to and including five percent of revenue shall be retained by the plan.
- 50 percent of income above five percent and up to 10 percent shall be retained by the plan, and the other 50 percent shall be refunded to the state and adjusted for the Federal Medical Assistance Percentages. The state share shall be transferred to the General Revenue Fund, unallocated, and the federal share shall be transferred to the Medical Care Trust Fund, unallocated.
- 100 percent of income above 10 percent of revenue shall be refunded to the state and adjusted for the Federal Medical Assistance Percentages. The state share shall be transferred to the General Revenue Fund, unallocated, and the federal share shall be transferred to the Medical Care Trust Fund, unallocated.

The program is tied to plan performance; if a plan exceeds the AHCA-defined quality measures in the reporting period, it may retain an additional one percent of revenue.[23]

The following may not be included as allowable expenses in calculating income for determining the achieved savings rebate:[24]

- Payment of achieved savings rebates.
- Any financial incentive payments made to the plan outside of the capitation rate.
- Any financial disincentive payments levied by the state or federal government.
- Expenses associated with any lobbying or political activities.
- The cash value or equivalent cash value of bonuses of any type paid or awarded to the plan's executive staff, other than base salary.
- Reserves and reserve accounts.
- Administrative costs, including, but not limited to, reinsurance expenses, interest payments, depreciation expenses, bad debt expenses, and outstanding claims expenses in excess of actuarially sound maximum amounts set by the AHCA.

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[20] Office of Program Policy Analysis & Government Accountability, *Report No. 16-03, AHCA Reorganized to Enhance Managed Care Program Oversight and Continues to Recoup Fee-for-Service Overpayments* (Feb. 2016), *available at* https://oppaga.fl.gov/Documents/Reports/16-03.pdf (last visited Mar. 16, 2025).
[21] Agency for Health Care Administration, *Senate Bill 1060 Bill Analysis* (Feb. 28, 2025) (on file with Senate Committee on Health Policy).
[22] Section 409.967(3), F.S.
[23] *Id*.
[24] *Id*.

Plans that incur a loss in the first contract year may apply the full amount of the loss as an offset to income in the second contract year.[25]

If, after an audit, the AHCA determines that a plan owes an additional rebate, the plan has 30 days after notification to make the payment. Upon failure to timely pay the rebate, the AHCA will withhold future payments to the plan until the entire amount is recouped. If the AHCA determines that a plan has made an overpayment, the AHCA will return the overpayment within 30 days.[26]

Fee-for-Service and Managed Care Capitation Payments

In the state of Forida, Medicaid services can be delivered through a fee-for-service (FFS) or managed care delivery model. In FFS, providers contract directly with the AHCA to provide services, followed by billing and receiving direct reimbursement from the AHCA. In a managed care delivery model, managed care plans contract with the AHCA and are paid a per-member, per-month (PMPM) capitation rate for each plan enrollee to provide medical, dental, or home and community-based care, depending on the type of managed care plan. Providers contract with the managed care plans and bill the plans for services rendered to enrollees.[27]

The AHCA maintains provider fee schedules, which include the rates the AHCA pays FFS providers for services. However, in managed care, the managed care plans negotiate mutually agreed-upon rates with contracted providers for most services. The capitation rates reflect historical utilization and spending for covered services projected forward, and the PMPM capitation rate is paid to each plan each month regardless of the actual expenditure or level of claims of an individual enrollee. Currently, managed care plan capitation rates are both calculated and certified as actuarially sound by the AHCA's actuarial services vendor;[28] however, in the past, the AHCA conducted rate setting in-house and the certification was performed independently.[29]

Florida's Medicaid capitation rate-setting process is guided by standards and regulations set by the federal CMS. Actuaries must adhere to multiple standards and codes of conduct, including:[30]

- All federal requirements related to Medicaid;
- The federal CMS Medicaid Managed Care Rate Development Guide;[31]

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[25] Section 409.967(3), F.S.
[26] *Id.*
[27] Florida Agency for Health Care Administration, *Senate Bill 1060 Bill Analysis* (Feb. 28, 2025) (on file with Senate Committee on Health Policy).
[28] *Id.*
[29] The Florida Senate, *Issue Brief 211-226, Medicaid Managed Care Rate-Setting* (November 2010), *available at* https://www.flsenate.gov/UserContent/Session/2011/Publications/InterimReports/pdf/2011-226hr.pdf (last visited Mar. 16, 2025).
[30] *Supra* note 27.
[31] The Federal CMS Medicaid Managed Care Rate Development Guide outlines the necessary documentation required for the federal CMS review and approval of capitation rates.
U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, *2024-25 Medicaid Managed Care Rate Development Guide, available at* https://www.medicaid.gov/medicaid/managed-care/downloads/2024-2025-medicaid-rate-guide-01222024.pdf (last visited Mar. 16, 2025).

- The American Academy of Actuaries (AAA) Actuarial Standards of Practice (ASOPs);[32] and
- The AAA[33] and Society of Actuaries Code of Conduct.[34]

To ensure full compliance with these standards and regulations, a comprehensive appendix is included in all final rate setting reports to address each relevant item of the federal CMS Medicaid Managed Care Rate Development Guide. Each rate submission is accompanied by an actuarial certification that verifies the accuracy and regulatory adherence of the rates. Additionally, all capitation rates undergo a thorough review by the federal CMS, involving multiple rounds of question and answers to validate the methodology utilized to develop rates for the approval.[35]

The AHCA's actuarial services vendor is Milliman Inc. (Milliman), and using encounter data in conjunction with financial data reported by the plans, Milliman develops capitation rates through the following steps:[36]

- Establishes the base data set using historical utilization and cost data;
- Adjusts the base data for any program changes, fee schedule increases, or legislative directives;
- Applies utilization, trend, seasonality, and acuity adjustments to reflect the new or current rating period; and
- Builds in managed care plan administrative costs and profit margins.

Capitation rates are risk-adjusted monthly for LTC and quarterly for MMA, but once the rates are set on October 1, they generally remain constant throughout the rate year unless a generational event or a material mistake requires a technical correction.[37]

Legislative increases to facility rates or provider fee schedules are built into the capitation rates for the health plans to pass-through to the providers during the following state fiscal year. Administrative expenses and increases to administrative expenses as a result of programmatic changes are built into the capitation rates as well, along with a two-percent profit margin for the plans, which may be more or less depending on the health of a plan's membership.[38]

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[32] Standard 49 of the ASOPs, Medicaid Managed Care Capitation Rate Development and Certification, provides detailed guidance for setting Medicaid managed care capitation rates.
American Academy of Actuaries, Actuarial Standards Board, *All Standards, available at* https://www.actuarialstandardsboard.org/standards-of-practice/ (last visited Mar. 16, 2025).
[33] American Academy of Actuaries, *Code of Professional Conduct, available at* https://www.actuary.org/content/code-professional-conduct (last visited Mar. 16, 2025).
[34] Society of Actuaries, *Code of Professional Conduct, available at* https://www.soa.org/about/governance/about-code-of-professional-conduct/ (last visited Mar. 16, 2025).
[35] Agency for Health Care Administration, *Senate Bill 1060 Bill Analysis* (Feb. 28, 2025) (on file with Senate Committee on Health Policy).
[36] *Id*.
[37] *Id*.
[38] *Id*.

The total capitated amount the health plans are paid is used to forecast the Medicaid budget for the following state fiscal year. At the Social Services Estimating Conference (SSEC),[39,40] managed care expenditures are combined with FFS expenditures and other appropriations to arrive at a total program cost, which is then trended forward to estimate the budgetary need for the coming state fiscal year.[41]

As part of the rate-setting process, Milliman and the AHCA meet with the managed care plans to share base data and assumptions on costs of upcoming Medicaid program changes and potential changes and trends to the cost of the health care delivery system in general. Draft rates are developed during and shortly after each legislative session and most legislative changes are incorporated into the draft rates. After the legislative session, Milliman and the AHCA meet with the plans again to share and discuss the draft rates, and the plans are given an opportunity to provide feedback before the rates are finalized. Managed care plan feedback, post-legislative session changes to the General Appropriations Act, and additional months of experiential data can result in minor changes to the final rates when compared to the draft rates.[42]

Managed Care Plan Accreditation

Accreditation is a "seal of approval" given to a plan by an independent organization that evaluates the practices and performances of the plan. Accreditation indicates the plan meets specific quality standards. Accreditation status is one of the quality selection criteria the AHCA considers in the selection of eligible plans. Section 409.967(f)(3), F.S., requires each plan to be

[39] The SSEC is a conference body consisting of members of the Legislature, representatives from the Governor's Office, and designees from various state agencies, which meets to develop Medicaid caseload or workload data and revenue/expenditure projections as it relates to TANF/WAGES, Medicaid, and KidCare to assist in the budgeting and appropriations process. Florida Office of Economic & Demographic Research, *Consensus Estimating Conference Process, available at* https://edr.state.fl.us/Content/conferences/confprocess.pdf (last visited Mar. 16, 2025).
[40] The Florida Senate, *Glossary, available at* https://www.flsenate.gov/reference/glossary (last visited Mar. 16, 2025).
[41] Agency for Health Care Administration, *Senate Bill 1060 Bill Analysis* (Feb. 28, 2025) (on file with Senate Committee on Health Policy).
[42] *Id.*

accredited by the National Committee for Quality Assurance (NCQA),[43] the Joint Commission,[44] or another nationally recognized accrediting body, or have initiated the accreditation process, within one year after the contract is executed. Each accrediting organization assesses plan performance against applicable standards and elements and establishes quality and performance standards, including, but not limited to, provider credentialing, prior authorization of services, and prompt payment of provider claims.[45]

SMMC Plan Provider Networks

The SMMC plans must adhere to all requirements as specified in their contract with the AHCA, including requirements to enter into provider agreements with a sufficient number of providers to deliver all covered services to enrollees and ensure that each medically necessary covered service is accessible and provided with reasonable promptness. If the managed care plan declines to include individual or group providers in its provider network, the plan is required to give written notice to the affected provider(s) of the reason for its decision.[46] Managed care plans conduct credentialing and recredentialing for network providers and offer onboarding activities for new providers joining their networks.[47]

The new SMMC 3.0 contracts include strict requirements for improving quality and incorporating value-based purchasing (VBP) in provider agreements. VBP is a reimbursement strategy that links provider payments to high-quality performance. This agreement holds the providers accountable for both the quality and cost of care rendered. VBP supports a holistic approach to care that addresses both mental and physical health needs. VBP promotes the use of innovative health care models, such as telehealth and patient-centered medical homes, enhancing accessibility and coordination of care.[48]

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[43] The NCQA Health Plan Accreditation provides a current, rigorous, and comprehensive framework for essential quality improvement and measurement. Organizations use the NCQA to perform a gap analysis and align improvement activities with areas that are most important to states and employers, such as network adequacy and consumer protection. Standards evaluate plans on quality management and improvement, population health management, network management, utilization management, credentialing and recredentialing, members' rights and responsibilities, member connections, and Medicaid benefits and services. The use of Healthcare Effectiveness Data and Information Set (HEDIS) data focuses attention on activities that keep members healthy.
National Committee for Quality Assurance, *Health Plan Accreditation, available at* https://www.ncqa.org/programs/health-plans/health-plan-accreditation-hpa/ (last visited Mar. 16, 2025).

[44] Accreditation by the Joint Commission is the objective evaluation process helping health care organizations measure, assess, and improve performance to provide safe, high-quality care to patients. Accreditation is awarded upon successful completion of an on-site survey. The on-site survey is conducted by a specially trained Joint Commission surveyor, or team of surveyors, who assess the organization's compliance with the Joint Commission standards. During the survey, surveyors select patients randomly and use medical records as a roadmap to evaluate standards compliance. As surveyors trace a patient's experience in a health care organization, they speak to doctors, nurses, and other staff who interacted with the patient. Surveyors also observe doctors and nurses providing care and often speak to the patients themselves. All regular Joint Commission accreditation surveys are unannounced. Accreditation for most types of organizations is a three-year award. The exception is laboratory accreditation, which is a two-year award.
The Joint Commission, *What is Accreditation, available at* https://www.jointcommission.org/what-we-offer/accreditation/become-accredited/what-is-accreditation/ (last visited Mar. 16, 2025).

[45] Agency for Health Care Administration, *Senate Bill 1060 Bill Analysis* (Feb. 28, 2025) (on file with Senate Committee on Health Policy).

[46] 42 C.F.R. § 438.12(a)(1)

[47] *Supra* note 45.

[48] *Id*.

Provider Credentialing Timeframes

Credentialing is the systematic process of verifying the qualifications of health care workers providing medical services. This important safety check ensures health care workers have the proper education, training, and licenses to care for patients, and reduces improper payments in Medicaid by minimizing the risk of unscrupulous providers billing the Medicaid program.[49]

To become a plan provider, the health care provider must obtain a Medicaid identification number from the AHCA and complete the plan's credentialing process. The average time required for a provider to obtain a Medicaid provider identification number from the AHCA is 61 days. The AHCA's contracts require the SMMC plans to fully enroll or on-board providers it chooses to contract with within 60 days of the provider submitting a complete application to the plan. Plans that fail to meet provider credentialing requirements could pay up to $5,000 per occurrence to the AHCA in liquidated damages.[50]

Both federal regulations[51] and state law[52] require each plan to have a system for verification and examination of the credentials of each of its providers. The same is true for plan accrediting bodies; however, no timeliness standard exists for the credentialing of plan providers.[53]

As part of the AHCA's federally required redesign of the Florida Medicaid Management Information System (FLMMIS), the AHCA contracted with an NCQA-certified vendor for its Provider Services Module to handle all aspects of the provider credentialing process, including those currently performed by the plans. The Provider Services Module will combine the Medicaid provider enrollment and plan credentialing processes into a single source to minimize errors and confusion in the provider community. Transitioning providers from the current FLMMIS to the new Provider Services Module is scheduled to begin in fall of 2025.[54]

Prior Authorization Timeframes

Prior authorization is part of the overall utilization management program for a plan, which serves to identify patterns of over-utilization and under-utilization of services, identifying fraud, waste, and abuse. Prior authorization is a decision-making process conducted by a plan to determine whether a health care service or good is medically necessary before it is rendered. Not all Medicaid services require prior authorization. Federal regulations[55] require Medicaid managed care plans to conduct a prior authorization program that complies with the requirements of s. 1927(d)(5) of the Social Security Act. State Medicaid programs and contracted plans have the discretion to determine which services require prior authorization. Prior authorization processes are most often required for costly services and for services subject to a high-risk of fraud, waste, or abuse; however, plans are prohibited from requiring authorization for emergency services.[56]

[49] Agency for Health Care Administration, *Senate Bill 1060 Bill Analysis* (Feb. 28, 2025) (on file with Senate Committee on Health Policy).
[50] *Id*.
[51] 42 C.F.R. § 438.214
[52] See Part IV of ch. 409, F.S., and s. 641.495(6), F.S.
[53] *Supra* note 49.
[54] *Id.*
[55] 42 C.F.R. § 438.3(s)(6)
[56] *Supra* note 49.

Federal regulations[57] require Medicaid managed care plans to provide standard authorization decisions within 14 calendar days following receipt of the request for service. An additional 14 calendar day extension is available upon request of the enrollee or provider, or if the plan justifies a need for additional information and how the extension is in the enrollee's interest. The AHCA reduced this timeframe by negotiating a standard authorization timeframe of seven days with an extension period of four additional days, if necessary, reducing the authorization period from a maximum of 28 days to 11 days.

Federal regulations[58] also require Medicaid managed care plans to provide expedited authorization decisions within 72 hours following receipt of the request for service; an additional 14 calendar day extension remains available, if applicable. The AHCA further reduced this timeframe by negotiating an expedited authorization timeframe of two days with an extension period of one additional day, reducing the authorization period from a maximum of 17 days to three days.[59]

The AHCA currently requires plans to report monthly on all service authorization requests completed during the previous reporting month. Service authorizations are identified in one of four categories: standard authorization, extended standard authorization, expedited authorization, or extended expedited authorization. Plans that fail to meet provider credentialing requirements could pay up to $2,500 per occurrence to the AHCA in liquidated damages.[60]

Prompt Payment Timeframes

Federal Medicaid law[61] sets requirements for timely claims payment to providers and defines a "claim" to mean a bill for services, a line item of service, or all services for one beneficiary within a bill. It also defines a "clean claim" to mean one that can be processed without obtaining additional information from the provider of the service or from a third-party. A clean claim does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.[62]

To receive timely payment, a provider must submit a clean claim that includes multiple, mandatory pieces of information about the patient and medical service. A claim that contains invalid or missing data elements required for acceptance of the claim into the claim processing system can be rejected. If all minimum edits pass and the claim is accepted, it will be entered into the system for processing. A denial is a claim that has passed minimum edits and is entered into the system but has been billed with invalid or inappropriate information causing the claim to be denied. There are hundreds of legitimate reasons a plan could and should deny payment for a health care service, all of which are standardized across the industry in the X12 Claim

[57] 42 C.F.R. § 438.210(d)
[58] *Id*.
[59] Agency for Health Care Administration, *Senate Bill 1060 Bill Analysis* (Feb. 28, 2025) (on file with Senate Committee on Health Policy).
[60] *Id*.
[61] 42 C.F.R. § 447.45
[62] *Supra* note 59.

Adjustment Reason Code set,[63] referenced in the Health Care Claim Payment/Advice (835) Consolidated Guide, available from the Washington Publishing Company.[64]

Federal regulations[65] require state Medicaid programs to pay 90 percent of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within 30 days of the date of receipt. States must pay 99 percent of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within 90 days of the date of receipt. States must pay all other claims within 12 months of the date of receipt, except in certain circumstances that allow the states to have additional time.[66]

Section 409.966(3)(c)6., F.S., requires SMMC plans to have a claims payment process that ensures claims that are not contested or denied will be promptly paid pursuant to s. 641.3155, F.S. Section 641.3155(3), F.S., specifies electronic claims payment standards and requires the plan to pay the claim or notify a provider if the claim is denied or contested within 20 days after receipt of the claim. If required, a provider must submit additional information and documentation as requested by the plan within 35 days after receipt of the plan notification. The claim must be paid or denied within 90 days of receipt of the claim. If the plan neither pays nor denies the electronic claim within 120 days, the plan is then obligated to pay the claim.[67]

For non-electronically submitted claims, a plan must pay the claim or notify a provider if the claim is denied or contested within 40 days after receipt of the claim. If required, a provider must submit additional information and documentation as requested by the plan within 35 days after receipt of the plan notification. The claim must be paid or denied within 90 days of receipt of the claim. If the plan has not paid or denied the nonelectronic claim within 120 days, the plan is then obligated to pay the claim within 140 days.[68]

As with the provider credentialing and prior authorization standards, the AHCA further reduced the claims payment timeframes by negotiating more stringent claims payment standards for the 2025-2030 SMMC contracts. Pursuant to the contracts, a plan must pay or notify the provider that the claim is denied or contested within 10 business days of receipt of nursing facility and hospice clean claims and within 15 days after receipt of all other claims. If the claim is denied or contested, the claim must be paid or denied within 90 days after receipt of the claim. If the plan neither pays nor denies the electronic claim within 120 days, the plan is then obligated to pay the claim. For non-electronically submitted claims, the plan must pay the paper claim or notify the provider that the claim is denied or contested within 20 days after receipt of the claim. If the plan neither pays nor denies the non-electronic claim within 140 days, the plan is then obligated to pay the claim.[69]

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[63] X12, *External Code Lists, Claim Adjustment Reason Codes, available at* https://x12.org/codes/claim-adjustment-reason-codes (last visited Mar. 16, 2025).
[64] Agency for Health Care Administration, *Senate Bill 1060 Bill Analysis* (Feb. 28, 2025) (on file with Senate Committee on Health Policy).
[65] 42 C.F.R. § 447.45
[66] *Supra* note 64.
[67] *Id.*
[68] *Id.*
[69] *Id.*

Additionally, the AHCA applies the following timely claims processing standards, which if not met, could result in a plan compliance action from the AHCA:[70]

- The managed care plan must pay 85 percent of all clean claims submitted within seven days.
- The managed care plan must pay 95 percent of all clean claims submitted within 10 days.
- The managed care plan must pay 98 percent of all clean claims submitted within 20 days.

Plans that fail to comply with claims processing requirements could pay up to $10,000 per month to the AHCA in liquidated damages for each month the AHCA determines the managed care plan is not in compliance.[71]

Managed Care Plan Complaints

The AHCA has a centralized complaint operations center to resolve Medicaid complaints timely and to determine if plans are complying with contract terms. All complaints are captured, whether substantiated or not, and the AHCA collects, aggregates, and trends the data for quality improvement initiatives.[72]

Federal laws and rules governing the Medicaid managed care plans do not define enrollee complaints. Instead, the AHCA has distinguished between "complaint" and "grievance" in the SMMC plan contracts, which are reviewed and approved by the federal CMS. Federal regulation[73] defines "grievance" as an expression of dissatisfaction about any matter other than an adverse benefit determination.[74]

For purposes of the SMMC program, the AHCA's contracts with the plans define a "complaint" as any oral or written expression of dissatisfaction by an enrollee submitted to the managed care plan or to a state agency and resolved by close of business the following business day. A complaint is a subcomponent of the grievance and appeal system. A complaint that is not resolved timely by close of business the following day becomes a grievance, for which the plan must provide the enrollee with a written notice of resolution within 90 days from receipt of the grievance. This process of escalation can continue from grievance to plan appeal, from plan appeal to Medicaid fair hearing, from Medicaid fair hearing to District Court of Appeals (DCA), and from DCA to the Florida Supreme Court. Each of these processes includes maximum timeframes mandated by the Code of Federal Regulations.[75]

Consistent with federal law, s. 409.967(2)(h), F.S., requires that each plan establish an internal process for reviewing and responding to grievances from enrollees. Each plan submits quarterly reports to the AHCA on the number, description, and outcome of grievances filed by enrollees. Plans that do not comply with grievance and appeal requirements could pay between $250 and $10,000 per occurrence to the AHCA in liquidated damages depending on the contract requirement the plan was out of compliance with.[76]

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[70] Agency for Health Care Administration, *Senate Bill 1060 Bill Analysis* (Feb. 28, 2025) (on file with Senate Committee on Health Policy).
[71] *Id*.
[72] *Id*.
[73] 42 C.F.R. § 438.400(b)
[74] *Supra* note 70.
[75] *Id*.
[76] *Id*.

External Quality Review Organization

Federal regulations[77] require states to contract with a qualified external quality review organization (EQRO) to perform an annual, independent assessment of each managed care organization with which the state contracts. To conduct this assessment, the EQRO conducts activities consistent with the associated external quality review protocols developed by the federal CMS. The purpose of these activities, in general, is to improve the state's ability to oversee and manage plans they contract with for services and help plans improve their performance with respect to quality, timeliness, and access to care. Activities conducted by the EQRO each year are as follows:[78]

- Review of compliance, determining the extent to which plans comply with federal managed care regulations and state standards.
- Validation of performance measures, monitoring the performance of individual plans to track performance over time and to compare performance among the plans.
- Validation of performance improvement projects (PIPs), assessing the validity and reliability of PIPs.
- Validation of network adequacy, ensuring health plans maintain sufficient provider networks to provide adequate access to covered services for all enrollees.

Each April, the AHCA must submit the Annual Technical Report (ATR)[79] produced by the EQRO to the federal CMS and publish the report on the AHCA's external website. The ATR is a comprehensive report that describes the collection and analysis of data from all external quality review activities, as well as provides conclusions drawn related to the quality, timeliness, and access to care provided by the plans. Another element in the ATR is an assessment of the degree to which each plan has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's external quality review activities. The federal CMS reviews the EQRO's recommendations, including the ATR's overall compliance with federally required elements, and provides the state with its findings.[80]

Healthcare Effectiveness Data and Information Set Measures

By July 1 of each year, Medicaid health plans are required to report to the AHCA a number of Healthcare Effectiveness Data and Information Set (HEDIS) measures, and Medicaid and CHIP Core Sets of Health Care Quality measures (the Child and Adult Core Set measures). HEDIS measures are developed and validated by the NCQA and used by over 90 percent of managed care plans in the nation to track their performance. The federal CMS requires states to report the Child Core Set and Adult Behavioral Health Core Set measures to the federal CMS on an annual basis. Many of the core set measures are HEDIS measures but there are also non-HEDIS measures in the core sets.[81]

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[77] 42 C.F.R. § 438.358
[78] Agency for Health Care Administration, *Senate Bill 1060 Bill Analysis* (Feb. 28, 2025) (on file with Senate Committee on Health Policy).
[79] Florida Agency for Health Care Administration, *SFY 2022-23 External Quality Review Technical Report* (April 2024), *available at* https://ahca.myflorida.com/content/download/24499/file/FL_2022-2023_EQR-TR_Report_F1.pdf (last visited Mar. 16, 2025).
[80] *Supra* note 78.
[81] *Id*.

Plans report HEDIS data based on the services enrollees received in the previous calendar year (e.g., performance measure data reported on July 1, 2025, represents calendar year 2024 services). The AHCA requires the plans to use NCQA-certified software vendors for running and calculating performance measures and requires the plans to have performance measures reviewed and certified by NCQA-certified HEDIS auditors prior to submitting performance measure results to the AHCA. Examples of required performance measures are well-child visits, immunizations, mammograms and other cancer screenings, pregnancy-related care, mental and behavioral health care, and diabetes care. The performance measure data provided by the plans are reviewed by the AHCA's staff and validated by the AHCA's EQRO. The AHCA compares performance measure data to national benchmarks to calculate performance measure liquidated damages and create the Florida Medicaid Health Plan Report Card.[82,83]

The AHCA compares plan performance on performance measures to benchmarks that are set in the plan contracts and plans may be assessed liquidated damages for measures where performance is worse than the benchmarks. When assessed liquidated damages, plans are required to pay the AHCA within 30 days after receipt of the notice of damages, regardless of any dispute in the amount or interpretation which led to the notice. Plans may dispute the imposition of liquidated damages by requesting that the AHCA's Deputy Secretary for Medicaid or designee hear and decide the dispute.[84]

Under the 2025-2030 SMMC contracts, the AHCA established a new quality continuum of incentives and accountability based on performance measure results. There is a quality withhold that plans may earn back based on their performance on specified performance measures, as well as a Quality Bonus Pool, built with the funds from plans that have not earned their full withhold back. Plans that earn their whole withhold may also earn funds from the Quality Bonus Pool, and the top plans may earn a quality preferred assignment incentive. The highest performing plans may qualify for the Achieved Savings Rebate one percent quality incentive. The plans that do not meet specific benchmarks set in the contract may be assessed for liquidated damages or sanctions.[85]

Performance Improvement Projects

In accordance with federal law[86] and as part of a comprehensive quality assessment and performance improvement program, states must require managed care plans to implement performance improvement projects (PIPs). The purpose of these projects is to achieve significant

[82] The Florida Medicaid Health Plan Report Card is a tool that enrollees can use when comparing and choosing plans based on quality of care. Plans are compared using a five-star rating scale in five categories: Pregnancy-related Care, Keeping Kids Healthy, Keeping Adults Healthy, Living with Illness, and Behavioral Health Care.
Agency for Health Care Administration, Health Care Transparency, *Quality of Care Indicators – Ratings, Medicaid Health Plan Report Cards, available at* https://quality.healthfinder.fl.gov/Facility-Provider/Medicaid-ReportCard?&type=-13 (last visited Mar. 16, 2025).
[83] Agency for Health Care Administration, *Senate Bill 1060 Bill Analysis* (Feb. 28, 2025) (on file with Senate Committee on Health Policy).
[84] *Id.*
[85] *Id.*
[86] 42 C.F.R. § 438.330

improvement in measurement of quality performance with objective indicators, as well as to generally sustain this improvement over time.[87]

States must[88] require plans to conduct clinical and nonclinical PIPs to examine access to and quality of care. PIPs must include four key elements:[89]

- Performance measurement;
- Implementation of interventions;
- Evaluation of the interventions' impact using the performance measures; and
- Activities to increase or sustain improvement.

Under the 2025-2030 SMMC contracts, the MMA plans are required to conduct PIPs focused on the following topics: promoting healthy birth outcomes for mothers and infants, improving child and adolescent mental health, Hope Florida, and closing gaps in health care outcomes between plan sub-populations. Plans providing specialty product lines are required to conduct an additional PIP focused on a clinical area in need of improvement for each specialty area. Plans providing LTC services are also required to conduct a PIP focused on improving mental health in adults and a PIP focused on maximizing home and community-based placement, as well as services to improve independence, well-being, and safety.[90]

Historically, the plans have submitted PIP documentation annually for the AHCA's review and validation by the EQRO. Under the 2025-2030 SMMC contracts, the AHCA is requiring the plans to submit quarterly progress reports on PIPs to allow for more frequent monitoring of the plans' progress toward reaching the goals identified in the PIPs.[91]

Plan Performance Dashboard

The AHCA maintains an extensive internal plan performance dashboard, which allows the AHCA to comprehensively track the performance of each plan on executing the terms of their contract. The AHCA first launched this dashboard in January 2020. The dashboard visualizes how the SMMC plans are performing and compares the performance of each plan across key performance areas, such as Potentially Preventable Events, Performance Measures, Provider Network Adequacy, Quality Indicators, Birth Outcomes, LTC Performance, Administrative and Financial, and Delivery System Performance. The AHCA posts a new dashboard every quarter for plans to review performance compared to their peers.[92]

Compliance Actions

The AHCA is responsible for imposing compliance actions as a result of plan failure to meet any aspect of the responsibilities of a contract and its exhibits. The three types of compliance actions that may be imposed include liquidated damages, sanctions, and/or corrective action plans. Liquidated damages are the lowest level of compliance actions and are considered non-punitive,

[87] Agency for Health Care Administration, *Senate Bill 1060 Bill Analysis* (Feb. 28, 2025) (on file with Senate Committee on Health Policy).
[88] 42 C.F.R. § 438.330
[89] *Supra* note 87.
[90] *Id*.
[91] *Id*.
[92] *Id*.

as they reflect the projected financial loss or damage to the AHCA. Sanctions may be monetary or non-monetary (e.g., freeze in enrollment) and are issued for more egregious non-compliance issues. Corrective action plans are utilized when non-compliance rises to the level of immediate remediation and steps are put into place to ensure the non-compliance does not reoccur.[93]

Ongoing plan monitoring is a responsibility across all the AHCA's functional units. Functional units contain subject matter experts (SMEs) needed to monitor and improve plan or program performance. Monitoring is conducted through a variety of channels including review of reports, ad hoc requests, standard contract monitoring, and monitoring of complaints received by the AHCA.[94]

For the state fiscal year 2023-2024, the AHCA executed 354 compliance actions, which resulted in a total of approximately $33.8 million in liquidated damages paid by the plans.[95]

Medical Care Advisory Committee (MCAC)

Federal regulations[96] require each state Medicaid program to establish a committee to serve in an advisory capacity on health and medical care issues. The committee must include the following:[97]

- Board-certified physicians and other representatives of the health professions familiar with the medical needs of low-income people and the resources available for their care;
- Members of consumer groups, including Medicaid recipients; and
- Agency heads from the Department of Children and Families and the Florida Department of Health.

The committee may be asked to provide the AHCA with advice on improving Medicaid recipients' access to specialists and enhancing communication with Medicaid recipients. Members may also be asked to review and provide input on a variety of Medicaid materials and to make recommendations to the AHCA about Medicaid policies, rules, and procedures.[98]

Medicaid Oversight Committees in Other States

Medicaid oversight committees similar to the committee created by the bill exist in the following states:

- Connecticut;[99]

[93] Agency for Health Care Administration, *Senate Bill 1060 Bill Analysis* (Feb. 28, 2025) (on file with Senate Committee on Health Policy).
[94] *Id.*
[95] *Id.*
[96] 42 C.F.R. § 431.12
[97] Florida Agency for Health Care Administration, *Medical Care Advisory Committee, available at* https://ahca.myflorida.com/medicaid/medical-care-advisory-committee (last visited Mar. 16, 2025).
[98] Florida Agency for Health Care Administration, *Medical Care Advisory Committee, available at* https://ahca.myflorida.com/medicaid/medical-care-advisory-committee (last visited Mar. 16, 2025).
[99] The Connecticut Council on Medical Assistance Program Oversight, referred to as the Medical Assistance Program Oversight Council (MAPOC), biannually reports to the General Assembly as required under state law. The Medical Assistance Program Oversight Council (previously called the Medicaid Managed Care Council) is a collaborative body established by the General Assembly in 1994 to initially advise the Connecticut Department of Social Services (DSS) on the development and implementation of Connecticut's Medicaid Managed Care Program (HUSKY A). Legislation in 2011

- Illinois;[100]
- Indiana;[101]
- Iowa;[102]
- Louisiana;[103]
- North Carolina;[104] and

revised state law to include council oversight of the Medicaid HUSKY Health Program that encompasses all Medicaid enrollees' health care. State statute charges the council with monitoring and advising DSS on matters including, but not limited to, program planning and implementation of the new delivery system under Administrative Service Organizations (ASOs), transitional issues from managed care, eligibility standards, benefits, health care access, and quality measures. Connecticut General Assembly, *Council on Medical Assistance Program Oversight, available at* https://www.cga.ct.gov/ph/med/ (last visited Mar. 16, 2025).

[100] The Illinois Medicaid Managed Care Oversight Commission was created within the Illinois Department of Healthcare and Family Services (HFS) to evaluate the effectiveness of the Illinois managed care program. The HFS details the membership composition and the commission requirements.
Illinois Department of Healthcare and Family Services, *Medicaid Managed Care Oversight Commission, available at* https://hfs.illinois.gov/about/boardsandcommisions/medicaidmanagedcareoversightcommission.html (last visited Mar. 16, 2025).

[101] The Indiana Medicaid Oversight Committee was created to review, consider, and make recommendations concerning all requests for new services and changes in existing services for the state Medicaid program.
Indiana General Assembly, *Medicaid Oversight Committee, available at* https://iga.in.gov/2023/committees/interim/medicaid-oversight-committee (last visited Mar. 16, 2025).

[102] The Iowa Joint Health Policy Oversight Committee was established in 2015 to provide continuing oversight for Medicaid managed care, ensure effective and efficient administration of the program, address stakeholder concerns, monitor program costs and expenditures, and make recommendations to the General Assembly.
Levin Center for Oversight and Democracy, Levin Center Home, *New Series Oversight Overview: Medicaid Oversight Committees, available at* https://www.levin-center.org/introducing-oversight-overview-medicaid-oversight-committees/ (last visited Mar. 16, 2025).
The Iowa Legislature, *Health Policy Oversight Committee (J), available at* https://www.legis.iowa.gov/committees/committee?groupID=24165&ga=91 (last visited Mar. 16, 2025).

[103] The Louisiana Joint Medicaid Oversight Committee was established in 2020 to improve oversight and teach appointed legislators the complexities of the program, which consists of nearly half of the state's budget. Duties of the committee are as follows: to monitor, review, and make recommendations; to review the compliance of the Louisiana Department of Health; and to plan, advertise, organize, and conduct forums, conferences, and other meetings in which representatives of state agencies, and other individuals with expertise in the state Medicaid program, may participate to increase knowledge and understanding of the state Medicaid program, as well as propose improvements. The committee can hold hearings, require the production of books and records, and may call upon staff of any department, agency, or official of the state for data and assistance.
Levin Center for Oversight and Democracy, Levin Center Home, *New Series Oversight Overview: Medicaid Oversight Committees, available at* https://www.levin-center.org/introducing-oversight-overview-medicaid-oversight-committees/ (last visited Mar. 16, 2025).

[104] North Carolina's Joint Legislative Oversight Committee on Medicaid and NC Health Care is responsible for examining the budget, finance, administration, and operational issues related to the programs. The committee can gain access to any paper or document and may compel the attendance of any state official or employee before the committee or secure any evidence and issue subpoenas. The committee receives reports from the North Carolina Department of Health and Human Services (DHHS) throughout the session, and the DHHS is required to send a copy of any report to the General Assembly or committee to the co-chairs of the Medicaid Oversight Committee.
Levin Center for Oversight and Democracy, Levin Center Home, *New Series Oversight Overview: Medicaid Oversight Committees, available at* https://www.levin-center.org/introducing-oversight-overview-medicaid-oversight-committees/ (last visited Mar. 16, 2025).

- Ohio.[105]

III. Effect of Proposed Changes:

Section 1 modifies s. 1.01, F.S., to create a statutory definition for the term "Legislative Committee on Medicaid Oversight" to specify a committee designated by joint rule of the Legislature, by the President of the Senate or the Speaker of the House of Representatives, or by agreement between the President of the Senate and the Speaker of the House of Representatives.

Section 2 creates s. 11.405, F.S., to establish the Joint Legislative Committee on Medicaid Oversight to ensure the state Medicaid program is operating in accordance with the Legislature's intent and to promote transparency and efficiency in government spending.

The bill requires that the committee be composed of five members of the Senate appointed by the President of the Senate and five members of the House of Representatives appointed by the Speaker of the House of Representatives, with each member serving a two-year term. The chair and vice chair must be appointed for one-year terms, with the appointments alternating between the President of the Senate and the Speaker of the House of Representatives. The chair and vice chair may not be members of the same house of the Legislature, and if both the chair and the vice chair are absent at any meeting, the members present must elect a temporary chair by a majority vote.

The bill requires that members serve without compensation, but authorizes reimbursement for per diem and travel expenses pursuant to s. 112.061, F.S. The bill authorizes the chair to establish subcommittees as needed to fulfill committee duties. The bill also requires the committee to convene at least twice a year, and as often as necessary to conduct its business. Meetings may be held through teleconference or other electronic means.

The bill requires the committee to evaluate all aspects of the state Medicaid program related to program financing, quality of care and health outcomes, administrative functions, and operational functions to ensure the program is providing transparency in the provision of health care plans and providers, ensuring access to quality health care services to Medicaid recipients, and providing stability to the state's budget through a health care delivery system designed to contain costs.

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[105] The Ohio General Assembly established the Joint Medicaid Oversight Committee in 2014 to continuously oversee the state's Medicaid program. The committee's responsibilities include ensuring Medicaid compliance aligns with legislative objectives, assessing the long-term effects of legislation on Medicaid, and aiding in controlling spending growth while enhancing the quality of care and health outcomes for Medicaid beneficiaries in the state. Apart from possessing subpoena power, the committee and its staff are authorized to conduct unannounced inspections of Medicaid offices within state and local governments. The committee requires regular reports from the Ohio Department of Medicaid on issues, including access barriers, program participation, and the needs of low-income pregnant women and children. The State Auditor provides reports to the committee upon request.
Levin Center for Oversight and Democracy, Levin Center Home, *New Series Oversight Overview: Medicaid Oversight Committees, available at* https://www.levin-center.org/introducing-oversight-overview-medicaid-oversight-committees/ (last visited Mar. 16, 2025).

The bill requires the committee to identify and recommend policies that limit Medicaid spending growth while improving health care outcomes for Medicaid recipients. In developing its recommendations, the committee must do the following:

- Evaluate legislation for its long-term impact on the state Medicaid program.
- Review data submitted to the Agency for Health Care Administration (AHCA) by Medicaid managed care plans pursuant to statutory and contract requirements, including, but not limited to, timeliness of provider credentialing, timely payment of claims, rate of claim denials, prior authorization for services, and consumer complaints.
- Review the Medicaid managed care plans' encounter data, financials, and audits and the data used to calculate the plans' achieved savings rebates and medical loss ratios.
- Review data related to health outcomes of Medicaid recipients, including, but not limited to, Healthcare Effectiveness Data and Information Set measures for each Medicaid managed care plan, each Medicaid managed care plan's performance improvement projects, and outcome data related to all quality goals included in the Medicaid managed care organization contracts to improve quality for recipients.
- Identify any areas for improvement in statute and rule relating to the state Medicaid program.
- Develop a plan of action for the future of the state Medicaid program.

The bill authorizes the committee to submit periodic reports, including recommendations, to the Legislature on issues related to the state Medicaid program and any affiliated programs.

The bill requires the Auditor General and the AHCA to enter into and maintain a data sharing agreement by July 1, 2025, to ensure the committee has full access to all data needed to fulfill its responsibilities. The Auditor General must assist the committee in its work by providing credentialed professional staff or consulting services, including, but not limited to, an actuary not associated with the state Medicaid program or any Medicaid managed care organization who currently has a contract with the state.

The bill requires the committee to be given access to any relevant record, paper, or document in possession of a state agency, any political subdivision of the state, or any entity engaged in business or under contract with a state agency during the course of its official duties. The committee may compel the attendance and testimony of any state official or employee before the committee or secure any evidence as provided in s. 11.143, F.S. The bill provides that the committee shall also have any other powers conferred on it by joint rules of the Senate and the House of Representatives, and any joint rules of the Senate and the House of Representatives applicable to joint legislative committees apply to the proceedings of the committee.

The bill requires the AHCA to notify the committee of any change to the Medicaid managed care capitation rates and to appear before the committee to provide a report detailing the managed care capitation rates and administrative costs built into the capitation rates before implementation of any change to the capitation rates. The report must include the AHCA's historical and projected Medicaid program expenditure and utilization trend rates by Medicaid program and service category for the rate year, an explanation of how the trend rates were calculated, and the policy decisions that were included in setting the capitation rates.

If the AHCA or any division within the AHCA is required by law to report to the Legislature or to any legislative committee or subcommittee on matters relating to the state Medicaid program, the bill requires the AHCA to submit a copy of the report to the committee.

Section 2 provides that the bill takes effect upon becoming a law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The bill could result in an indeterminate fiscal impact on state expenditures. While member reimbursement for per diem and travel expenses, pursuant to s. 112.061, F.S., is nominal, the Office of the Auditor General, the Agency for Health Care Administration (AHCA), and the Statewide Medicaid Managed Care (SMMC) plans may experience an increased workload, impacting all entities administratively and/or operationally, potentially creating a need for additional staff and resources.

According to the AHCA, the function of the committee would result in the duplication of efforts already conducted by the AHCA, its contracted vendors, the Office of the Auditor General, the SMMC plans, and the federal Centers for Medicare & Medicaid Services.[106]

VI. Technical Deficiencies:

None.

VII. Related Issues:

The Agency for Health Care Administration (AHCA) expressed the bill may cause delays in Statewide Medicaid Managed Care rate setting that could impact the AHCA's ability to comply with federal Medicaid managed care laws.[107]

VIII. Statutes Affected:

This bill substantially amends section 1.01 of the Florida Statutes.

This bill creates section 11.405 of the Florida Statutes.

IX. Additional Information:

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

CS by Appropriations Committee on Health and Human Services on April 15, 2025: The committee substitute modifies s. 1.01, F.S., to provide a definition for the term "Legislative Committee on Medicaid Oversight" to specify a committee designated by joint rule of the Legislature, by the presiding officer of either house of the Legislature, or by agreement between the presiding officers. The committee substitute also removes the language that would establish the new joint committee within the Office of the Auditor General.

B. Amendments:

None.

[106] Agency for Health Care Administration, *Senate Bill 1060 Bill Analysis* (Feb. 28, 2025) (on file with Senate Committee on Health Policy).
[107] Agency for Health Care Administration, *Senate Bill 1060 Bill Analysis* (Feb. 28, 2025) (on file with Senate Committee on Health Policy).