COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	__	(Y/N)
ADOPTED AS AMENDED	__	(Y/N)
ADOPTED W/O OBJECTION	__	(Y/N)
FAILED TO ADOPT	__	(Y/N)
WITHDRAWN	__	(Y/N)
OTHER	____	

1 Committee/Subcommittee hearing bill: Select Committee on Health
2 Innovation
3 Representative Berfield offered the following:
4
5 **Amendment (with title amendment)**
6 Remove everything after the enacting clause and insert:
7 Section 1. Section 409.9673, Florida Statutes, is created
8 to read:
9 409.9673 Managed care plan performance metrics. —
10 The agency shall produce managed care plan performance data
11 related to the administration of provider contracts. Agency
12 reports shall include data reported by the plans to the agency
13 pursuant to statutory and contract requirements related to
14 provider credentialing, service prior authorization, claims
15 payment and consumer complaints. The agency shall contract with
16 a third party to analyze data and develop a dashboard on the

17 agency website to display the data, and shall publish the data
18 by plan and by region on the dashboard quarterly beginning
19 October 1, 2024. An annual report of the data analyses beginning
20 January 1, 2026 shall be submitted to the Medical Care Advisory
21 Committee, the Governor, the President of the Senate, and the
22 Speaker of the House of Representatives and published on the
23 website. The analyses shall include the following:
24 (1) Credentialing.
25 (a) The percentage and total number of providers for which
26 a submitted provider application has been fully loaded and
27 processed for provider billing within 60 days.
28 (b) The percentage and total number of providers for which
29 a submitted provider application has not been fully loaded and
30 processed for provider billing in excess of:
31 1. Sixty days.
32 2. Ninety days.
33 3. One hundred twenty days.
34 (2) Prior authorization.
35 (a) The percentage and total number of standard prior
36 authorizations requests approved by service type.
37 1. The percentage and total number of standard prior
38 authorizations requests denied.
39 2. The percentage and total number of standard prior
40 authorization requests approved after appeal and the length of

41 time of the appeal process, from the beginning of the appeal
42 until the approval.
43 (b) The percentage and total number of expedited prior
44 authorization requests approved and the length of time to
45 receive approval by service type.
46 (c) The average and median time between submissions of
47 requests and decisions for:
48 1. Standard prior authorizations.
49 2. Expedited prior authorizations.
50 (3) Prompt payment.
51 (a) The percentage and total number of claims that are:
52 1. Rejected before review.
53 2. Paid, partially paid, denied or suspended.
54 (b) The average length of time to pay clean claims.
55 (c) The percentage of clean claims paid within:
56 1. Seven days.
57 2. Ten days.
58 3. Twenty days.
59 4. In excess of 120 days.
60 (d) The top 10 reasons for claims denial, with the
61 percentage and total number of claims for each reason cited.
62 (4) Managed care plan complaints.
63 (a) The number of Medicaid recipients enrolled in the
64 statewide managed medical assistance program.

65 (b) The number of complaints per 1,000 Medicaid
66 recipients.
67 (c) By each managed care plan, per 1,000 Medicaid
68 recipients:
69 1. By provider category, the number of complaints received
70 by physicians, hospitals, outpatient services, skilled nursing
71 facilities, assisted living facilities, therapy services,
72 transportation services, laboratories, home care services, and
73 community-based services.
74 2. The number of Medicaid recipient complaints for each
75 region.
76 3. The number of Medicaid recipient complaints resolved
77 for each region.
78 4. By provider category:
79 a. The number of provider complaints resolved for each
80 region.
81 b. The number of complaints pending for resolution for
82 each region.
83 d. The average length of time to resolve provider
84 complaints for each region.
85 e. The average length of time to resolve Medicaid
86 recipient complaints for each region.
87
88 ---
89 **T I T L E A M E N D M E N T**

90 Remove everything before the enacting clause and insert:
91 An act relating to Medicaid managed care plan performance
92 metrics; creating s. 409.9673, F.S.; requiring the Agency for
93 Health Care Administration to analyze certain Medicaid managed
94 care performance data; requiring the agency to contract with a
95 third party vendor to publish data on a dashboard quarterly;
96 requiring an annual report and requiring the agency to submit it
97 to certain entities; providing an effective date.