A bill to be entitled

An act relating to Medicaid managed care plan performance metrics; creating s. 409.9673, F.S.; requiring the Agency for Health Care Administration to produce certain Medicaid managed care performance data; requiring the agency's reports to include certain data submitted by Medicaid managed care plans; requiring the agency to contract with a third party vendor to publish such data on a dashboard quarterly; requiring the agency to submit an annual report to certain entities; providing requirements for such report; 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.—The agency shall produce managed care plan performance data related to the administration of provider contracts. The agency's reports must include data submitted by the managed care plans to the agency pursuant to statutory and contract requirements related to provider credentialing, service prior authorization, claims payment, and consumer complaints. The agency shall contract with a third party to analyze the data and develop a dashboard on the

agency's website to display the data, and shall publish the data by managed care plan and by region on the dashboard quarterly, beginning October 1, 2024. An annual report of the data analyses, beginning January 1, 2026, shall be submitted to the Medical Care Advisory Committee, the Governor, the President of the Senate, and the Speaker of the House of Representatives and published on the website. The analyses must include the following:

(1) Credentialing.

(a) 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.

(b) 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:

1. Sixty days.

2. Ninety days.

3. One hundred twenty days.

(2) Prior authorization.

(a)1. The percentage and total number of standard prior authorizations requests approved by service type.

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

3. 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.

4. The percentage and total number of expedited prior authorization requests approved and the length of time to receive approval by service type.

(b) The average and median time between submissions of requests and decisions for:

1. Standard prior authorizations.

2. Expedited prior authorizations.

(3) Prompt payment.

(a) The percentage and total number of claims that are:

1. Rejected before review.

2. Paid, partially paid, denied, or suspended.

(b) The average length of time to pay clean claims.

(c) The percentage of clean claims paid within:

1. Seven days.

2. Ten days.

3. Twenty days.

4. In excess of 120 days.

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

(4) 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, per 1,000 Medicaid recipients:

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.

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

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

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