By Senator Harrell

31-01043A-24 2024794__

1 A bill to be entitled
2 An act relating to Medicaid managed care plan
3 performance metrics; creating s. 409.9673, F.S.;
4 requiring Medicaid managed care plans to submit
5 certain performance metrics monthly to the Agency for
6 Health Care Administration; providing requirements for
7 such performance metrics; requiring the agency to
8 contract to develop and display on its public website
9 a dashboard containing certain information; requiring
10 the agency to update the information monthly;
11 requiring the agency to create a quarterly report,
12 beginning on a specified date, make it available to
13 the public, and submit it to certain entities;
14 providing an effective date.
15
16 Be It Enacted by the Legislature of the State of Florida:
17
18 Section 1. Section 409.9673, Florida Statutes, is created
19 to read:
20 409.9673 Managed care plan performance metrics.—
21 (1) Each managed care plan shall submit monthly to the
22 agency the managed care plan performance metrics specified in
23 this subsection by region and by county in a format prescribed
24 by the agency. Each managed care plan shall provide metrics that
25 include, at a minimum, all of the following:
26 (a) Credentialing:
27 1. The percentage and total number of providers for which a
28 submitted provider application has been fully uploaded and
29 processed within 60 days for provider billing.

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30 2. The percentage and total number of providers for which a
31 submitted provider application has not been fully uploaded and
32 processed for provider billing in excess of:
33 a. Sixty days.
34 b. Ninety days.
35 c. One hundred twenty days.
36 (b) Prior authorization:
37 1.a. The percentage and total number of standard prior
38 authorization requests approved.
39 b. The percentage and total number of standard prior
40 authorization requests denied.
41 c. The percentage and total number of standard prior
42 authorization requests approved after appeal and the length of
43 time it took to complete the appeal process, from the beginning
44 of the appeal until the approval.
45 2. The percentage and total number of expedited prior
46 authorization requests approved and the length of time it took
47 to receive approval.
48 3. The average and median time between submissions of
49 requests and decisions for:
50 a. Standard prior authorizations.
51 b. Expedited prior authorizations.
52 (c) Prompt payment:
53 1. The percentage and total number of claims that are:
54 a. Rejected before review.
55 b.(I) Paid.
56 (II) Partially paid.
57 (III) Denied.
58 (IV) Suspended.

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59 2. The average length of time it took to pay clean claims,
60 or claims that did not have any errors, deficiencies, or other
61 issues.
62 3. The percentage of clean claims paid within:
63 a. Seven days.
64 b. Ten days.
65 c. Twenty days.
66 d. In excess of 120 days.
67 4. The top 10 reasons for claims denial, with the
68 percentage and total number of claims for each reason cited.
69 (2) The agency shall contract to develop and display on its
70 public website a dashboard containing the data provided under
71 subsection (1) by each managed care plan to show managed care
72 plan performance and utilization management. In addition to the
73 data provided under subsection (1), the agency shall publish on
74 the public dashboard all of the following information regarding
75 managed care plan complaints:
76 (a) The number of Medicaid recipients enrolled in the
77 statewide managed medical assistance program.
78 (b) The number of complaints per 1,000 Medicaid recipients.
79 (c) By each managed care plan:
80 1. By provider category, the number of complaints received
81 by physicians, hospitals, outpatient services, skilled nursing
82 facilities, assisted living facilities, therapy services,
83 transportation services, laboratories, and home and community-
84 based services.
85 2. The number of Medicaid recipient complaints received for
86 each region.
87 3. The number of Medicaid recipient complaints resolved for

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88 each region.
89 4. By provider category:
90 a. The number of provider complaints resolved for each
91 region.
92 b. The number of complaints pending resolution for each
93 region.
94 c. The average length of time it took to resolve provider
95 complaints for each region.
96 d. The average length of time it took to resolve Medicaid
97 recipient complaints for each region.
98 5. The number of complaints pending resolution for each
99 region.
100 6. The average length of time it took to resolve provider
101 complaints for each region.
102 7. The average length of time it took to resolve Medicaid
103 recipient complaints for each region.
104 (3) The agency shall update monthly on the dashboard the
105 information described in subsections (1) and (2).
106 (4) The agency shall create a quarterly report, beginning
107 July 31, 2025, containing the information described in
108 subsections (1) and (2) and shall make the report publicly
109 available on its website no later than 30 days after the close
110 of each quarter. The agency shall also submit the report to the
111 agency's Medical Care Advisory Committee, the Governor, the
112 President of the Senate, and the Speaker of the House of
113 Representatives.
114 Section 2. This act shall take effect July 1, 2024.

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