311896

LEGISLATIVE ACTION

Senate	.	House
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05/05/2023 09:35 AM	.	05/05/2023 10:44 AM
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The Conference Committee on SB 2510 recommended the following:

1 **Senate Conference Committee Amendment (with title**
2 **amendment)**
3
4 Delete everything after the enacting clause
5 and insert:
6 Section 1. Subsection (1) of section 296.37, Florida
7 Statutes, is amended to read:
8 296.37 Residents; contribution to support.—
9 (1) Every resident of the home who receives a pension,
10 compensation, or gratuity from the United States Government, or
11 income from any other source of more than $160 ~~$130~~ per month,

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12 shall contribute to his or her maintenance and support while a
13 resident of the home in accordance with a schedule of payment
14 determined by the administrator and approved by the director.
15 The total amount of such contributions shall be to the fullest
16 extent possible but may not exceed the actual cost of operating
17 and maintaining the home.
18 Section 2. Subsection (7) of section 409.814, Florida
19 Statutes, is amended to read:
20 409.814 Eligibility.—A child who has not reached 19 years
21 of age whose family income is equal to or below 200 percent of
22 the federal poverty level is eligible for the Florida Kidcare
23 program as provided in this section. If an enrolled individual
24 is determined to be ineligible for coverage, he or she must be
25 immediately disenrolled from the respective Florida Kidcare
26 program component.
27 (7) A child whose family income is above 200 percent of the
28 federal poverty level or a child who is excluded under ~~the~~
29 ~~provisions of~~ subsection (5) may participate in the Florida
30 Kidcare program as provided in s. 409.8132 or, if the child is
31 ineligible for Medikids by reason of age, in the Florida Healthy
32 Kids program, subject to the following:
33 (a) The family is not eligible for premium assistance
34 payments and must pay the full cost of the combined-risk
35 premium, including any administrative costs.
36 (b) The board of directors of the Florida Healthy Kids
37 Corporation may offer a reduced benefit package to these
38 children in order to limit program costs for such families.
39 Section 3. Paragraph (b) of subsection (2) of section
40 409.908, Florida Statutes, is amended to read:

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41 409.908 Reimbursement of Medicaid providers.—Subject to
42 specific appropriations, the agency shall reimburse Medicaid
43 providers, in accordance with state and federal law, according
44 to methodologies set forth in the rules of the agency and in
45 policy manuals and handbooks incorporated by reference therein.
46 These methodologies may include fee schedules, reimbursement
47 methods based on cost reporting, negotiated fees, competitive
48 bidding pursuant to s. 287.057, and other mechanisms the agency
49 considers efficient and effective for purchasing services or
50 goods on behalf of recipients. If a provider is reimbursed based
51 on cost reporting and submits a cost report late and that cost
52 report would have been used to set a lower reimbursement rate
53 for a rate semester, then the provider's rate for that semester
54 shall be retroactively calculated using the new cost report, and
55 full payment at the recalculated rate shall be effected
56 retroactively. Medicare-granted extensions for filing cost
57 reports, if applicable, shall also apply to Medicaid cost
58 reports. Payment for Medicaid compensable services made on
59 behalf of Medicaid-eligible persons is subject to the
60 availability of moneys and any limitations or directions
61 provided for in the General Appropriations Act or chapter 216.
62 Further, nothing in this section shall be construed to prevent
63 or limit the agency from adjusting fees, reimbursement rates,
64 lengths of stay, number of visits, or number of services, or
65 making any other adjustments necessary to comply with the
66 availability of moneys and any limitations or directions
67 provided for in the General Appropriations Act, provided the
68 adjustment is consistent with legislative intent.
69 (2)

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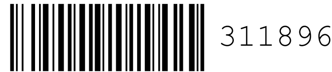
70 (b) Subject to any limitations or directions in the General
71 Appropriations Act, the agency shall establish and implement a
72 state Title XIX Long-Term Care Reimbursement Plan for nursing
73 home care in order to provide care and services in conformance
74 with the applicable state and federal laws, rules, regulations,
75 and quality and safety standards and to ensure that individuals
76 eligible for medical assistance have reasonable geographic
77 access to such care.
78 1. The agency shall amend the long-term care reimbursement
79 plan and cost reporting system to create direct care and
80 indirect care subcomponents of the patient care component of the
81 per diem rate. These two subcomponents together shall equal the
82 patient care component of the per diem rate. Separate prices
83 shall be calculated for each patient care subcomponent,
84 initially based on the September 2016 rate setting cost reports
85 and subsequently based on the most recently audited cost report
86 used during a rebasing year. The direct care subcomponent of the
87 per diem rate for any providers still being reimbursed on a cost
88 basis shall be limited by the cost-based class ceiling, and the
89 indirect care subcomponent may be limited by the lower of the
90 cost-based class ceiling, the target rate class ceiling, or the
91 individual provider target. The ceilings and targets apply only
92 to providers being reimbursed on a cost-based system. Effective
93 October 1, 2018, a prospective payment methodology shall be
94 implemented for rate setting purposes with the following
95 parameters:
96 a. Peer Groups, including:
97 (I) North-SMMC Regions 1-9, less Palm Beach and Okeechobee
98 Counties; and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99 (II) South-SMMC Regions 10-11, plus Palm Beach and
100 Okeechobee Counties.
101 b. Percentage of Median Costs based on the cost reports
102 used for September 2016 rate setting:
103 (I) Direct Care Costs............................100 percent.
104 (II) Indirect Care Costs..........................92 percent.
105 (III) Operating Costs.............................86 percent.
106 c. Floors:
107 (I) Direct Care Component.........................95 percent.
108 (II) Indirect Care Component....................92.5 percent.
109 (III) Operating Component...............................None.
110 d. Pass-through Payments.....................Real Estate and
111 ....Personal Property
112 ....Taxes and Property Insurance.
113 e. Quality Incentive Program Payment
114 Pool..................................10 ~~6~~ percent of September
115 ....2016 non-property related
116 ....payments of included facilities.
117 f. Quality Score Threshold to Quality for Quality Incentive
118 Payment...................20th percentile of included facilities.
119 g. Fair Rental Value System Payment Parameters:
120 (I) Building Value per Square Foot based on 2018 RS Means.
121 (II) Land Valuation......10 percent of Gross Building value.
122 (III) Facility Square Footage.........Actual Square Footage.
123 (IV) Moveable Equipment Allowance............$8,000 per bed.
124 (V) Obsolescence Factor.........................1.5 percent.
125 (VI) Fair Rental Rate of Return...................8 percent.
126 (VII) Minimum Occupancy..........................90 percent.
127 (VIII) Maximum Facility Age........................40 years.

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128 (IX) Minimum Square Footage per Bed....................350.
129 (X) Maximum Square Footage for Bed.....................500.
130 (XI) Minimum Cost of a renovation/replacements.$500 per bed.
131 h. Ventilator Supplemental payment of $200 per Medicaid day
132 of 40,000 ventilator Medicaid days per fiscal year.
133 2. The direct care subcomponent shall include salaries and
134 benefits of direct care staff providing nursing services
135 including registered nurses, licensed practical nurses, and
136 certified nursing assistants who deliver care directly to
137 residents in the nursing home facility, allowable therapy costs,
138 and dietary costs. This excludes nursing administration, staff
139 development, the staffing coordinator, and the administrative
140 portion of the minimum data set and care plan coordinators. The
141 direct care subcomponent also includes medically necessary
142 dental care, vision care, hearing care, and podiatric care.
143 3. All other patient care costs shall be included in the
144 indirect care cost subcomponent of the patient care per diem
145 rate, including complex medical equipment, medical supplies, and
146 other allowable ancillary costs. Costs may not be allocated
147 directly or indirectly to the direct care subcomponent from a
148 home office or management company.
149 4. On July 1 of each year, the agency shall report to the
150 Legislature direct and indirect care costs, including average
151 direct and indirect care costs per resident per facility and
152 direct care and indirect care salaries and benefits per category
153 of staff member per facility.
154 5. Every fourth year, the agency shall rebase nursing home
155 prospective payment rates to reflect changes in cost based on
156 the most recently audited cost report for each participating

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157 provider.
158 6. A direct care supplemental payment may be made to
159 providers whose direct care hours per patient day are above the
160 80th percentile and who provide Medicaid services to a larger
161 percentage of Medicaid patients than the state average.
162 7. For the period beginning on October 1, 2018, and ending
163 on September 30, 2021, the agency shall reimburse providers the
164 greater of their September 2016 cost-based rate or their
165 prospective payment rate. Effective October 1, 2021, the agency
166 shall reimburse providers the greater of 95 percent of their
167 cost-based rate or their rebased prospective payment rate, using
168 the most recently audited cost report for each facility. This
169 subparagraph shall expire September 30, 2023.
170 8. Pediatric, Florida Department of Veterans Affairs, and
171 government-owned facilities are exempt from the pricing model
172 established in this subsection and shall remain on a cost-based
173 prospective payment system. Effective October 1, 2018, the
174 agency shall set rates for all facilities remaining on a cost-
175 based prospective payment system using each facility's most
176 recently audited cost report, eliminating retroactive
177 settlements.
178
179 It is the intent of the Legislature that the reimbursement plan
180 achieve the goal of providing access to health care for nursing
181 home residents who require large amounts of care while
182 encouraging diversion services as an alternative to nursing home
183 care for residents who can be served within the community. The
184 agency shall base the establishment of any maximum rate of
185 payment, whether overall or component, on the available moneys

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186 as provided for in the General Appropriations Act. The agency
187 may base the maximum rate of payment on the results of
188 scientifically valid analysis and conclusions derived from
189 objective statistical data pertinent to the particular maximum
190 rate of payment. The agency shall base the rates of payments in
191 accordance with the minimum wage requirements as provided in the
192 General Appropriations Act.
193 Section 4. Present subsections (6) and (7) of section
194 409.909, Florida Statutes, are redesignated as subsections (7)
195 and (8), respectively, a new subsection (6) is added to that
196 section, and subsection (5) of that section is amended, to read:
197 409.909 Statewide Medicaid Residency Program.—
198 (5) The Graduate Medical Education Startup Bonus Program is
199 established to provide resources for the education and training
200 of physicians in specialties which are in a statewide supply-
201 and-demand deficit. Hospitals and qualifying institutions as
202 defined in paragraph (2)(c) eligible for participation in
203 subsection (1) or subsection (6) are eligible to participate in
204 the Graduate Medical Education Startup Bonus Program established
205 under this subsection. Notwithstanding subsection (4) or an
206 FTE's residency period, and in any state fiscal year in which
207 funds are appropriated for the startup bonus program, the agency
208 shall allocate a $100,000 startup bonus for each newly created
209 resident position that is authorized by the Accreditation
210 Council for Graduate Medical Education or Osteopathic
211 Postdoctoral Training Institution in an initial or established
212 accredited training program that is in a physician specialty in
213 statewide supply-and-demand deficit. In any year in which
214 funding is not sufficient to provide $100,000 for each newly

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215 created resident position, funding shall be reduced pro rata
216 across all newly created resident positions in physician
217 specialties in statewide supply-and-demand deficit.
218 (a) Hospitals and qualifying institutions as defined in
219 paragraph (2)(c) applying for a startup bonus must submit to the
220 agency by March 1 their Accreditation Council for Graduate
221 Medical Education or Osteopathic Postdoctoral Training
222 Institution approval validating the new resident positions
223 approved on or after March 2 of the prior fiscal year through
224 March 1 of the current fiscal year for the physician specialties
225 identified in a statewide supply-and-demand deficit as provided
226 in the current fiscal year's General Appropriations Act. An
227 applicant hospital or qualifying institution as defined in
228 paragraph (2)(c) may validate a change in the number of
229 residents by comparing the number in the prior period
230 Accreditation Council for Graduate Medical Education or
231 Osteopathic Postdoctoral Training Institution approval to the
232 number in the current year.
233 (b) Any unobligated startup bonus funds on April 15 of each
234 fiscal year shall be proportionally allocated to hospitals and
235 to qualifying institutions as defined in paragraph (2)(c)
236 participating under subsection (3) for existing FTE residents in
237 the physician specialties in statewide supply-and-demand
238 deficit. This nonrecurring allocation shall be in addition to
239 the funds allocated in subsection (4). Notwithstanding
240 subsection (4), the allocation under this subsection may not
241 exceed $100,000 per FTE resident.
242 (c) For purposes of this subsection, physician specialties
243 and subspecialties, both adult and pediatric, in statewide

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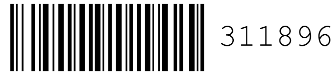
244 supply-and-demand deficit are those identified in the General
245 Appropriations Act.
246 (d) The agency shall distribute all funds authorized under
247 the Graduate Medical Education Startup Bonus Program on or
248 before the final business day of the fourth quarter of a state
249 fiscal year.
250 (6) The Slots for Doctors Program is established to address
251 the physician workforce shortage by increasing the supply of
252 highly trained physicians through the creation of new resident
253 positions, which will increase access to care and improve health
254 outcomes for Medicaid recipients.
255 (a) Notwithstanding subsection (4), the agency shall
256 annually allocate $100,000 to hospitals and qualifying
257 institutions for each newly created resident position that is
258 first filled on or after June 1, 2023, and filled thereafter,
259 and that is accredited by the Accreditation Council for Graduate
260 Medical Education or the Osteopathic Postdoctoral Training
261 Institution in an initial or established accredited training
262 program which is in a physician specialty or subspecialty in a
263 statewide supply-and-demand deficit.
264 (b) This program is designed to generate matching funds
265 under Medicaid and distribute such funds to participating
266 hospitals and qualifying institutions on a quarterly basis in
267 each fiscal year for which an appropriation is made. Resident
268 positions created under this subsection are not eligible for
269 concurrent funding pursuant to subsection (1).
270 (c) For purposes of this subsection, physician specialties
271 and subspecialties, both adult and pediatric, in statewide
272 supply-and-demand deficit are those identified as such in the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273 General Appropriations Act.
274 (d) Funds allocated pursuant to this subsection may not be
275 used for resident positions that have previously received
276 funding pursuant to subsection (1).
277 Section 5. Paragraph (f) of subsection (3) of section
278 409.967, Florida Statutes, is amended to read:
279 409.967 Managed care plan accountability.—
280 (3) ACHIEVED SAVINGS REBATE.—
281 (f) Achieved savings rebates validated by the certified
282 public accountant are due within 30 days after the report is
283 submitted. Except as provided in paragraph (h), the achieved
284 savings rebate is established by determining pretax income as a
285 percentage of revenues and applying the following income sharing
286 ratios:
287 1. One hundred percent of income up to and including 5
288 percent of revenue shall be retained by the plan.
289 2. Fifty percent of income above 5 percent and up to 10
290 percent shall be retained by the plan, and the other 50 percent
291 shall be refunded to the state and adjusted for the Federal
292 Medical Assistance Percentages. The state share shall be
293 transferred to the General Revenue Fund, unallocated, and the
294 federal share shall be transferred to the Medical Care Trust
295 Fund, unallocated.
296 3. One hundred percent of income above 10 percent of
297 revenue shall be refunded to the state and adjusted for the
298 Federal Medical Assistance Percentages. The state share shall be
299 transferred to the General Revenue Fund, unallocated, and the
300 federal share shall be transferred to the Medical Care Trust
301 Fund, unallocated.

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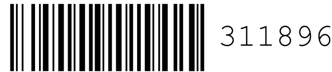
302 Section 6. Effective upon becoming a law, section 409.9855,
303 Florida Statutes, is created to read:
304 409.9855 Pilot program for individuals with developmental
305 disabilities.—
306 (1) PILOT PROGRAM IMPLEMENTATION.—
307 (a) Using a managed care model, the agency shall implement
308 a pilot program for individuals with developmental disabilities
309 in Statewide Medicaid Managed Care Regions D and I to provide
310 coverage of comprehensive services.
311 (b) The agency may seek federal approval through a state
312 plan amendment or Medicaid waiver as necessary to implement the
313 pilot program. The agency shall submit a request for any federal
314 approval needed to implement the pilot program by September 1,
315 2023.
316 (c) Pursuant to s. 409.963, the agency shall administer the
317 pilot program in consultation with the Agency for Persons with
318 Disabilities.
319 (d) The agency shall make capitated payments to managed
320 care organizations for comprehensive coverage, including
321 community-based services described in s. 393.066(3) and approved
322 through the state’s home and community-based services Medicaid
323 waiver program for individuals with developmental disabilities.
324 Unless otherwise specified, ss. 409.961-409.969 apply to the
325 pilot program.
326 (e) The agency shall evaluate the feasibility of statewide
327 implementation of the capitated managed care model used by the
328 pilot program to serve individuals with developmental
329 disabilities.
330 (2) ELIGIBILITY; VOLUNTARY ENROLLMENT; DISENROLLMENT.—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331 (a) Participation in the pilot program is voluntary and
332 limited to the maximum number of enrollees specified in the
333 General Appropriations Act.
334 (b) The Agency for Persons with Disabilities shall approve
335 a needs assessment methodology to determine functional,
336 behavioral, and physical needs of prospective enrollees. The
337 assessment methodology may be administered by persons who have
338 completed such training as may be offered by the agency.
339 Eligibility to participate in the pilot program is determined
340 based on all of the following criteria:
341 1. Whether the individual is eligible for Medicaid.
342 2. Whether the individual is 18 years of age or older and
343 is on the waiting list for individual budget waiver services
344 under chapter 393 and assigned to one of categories 1 through 6
345 as specified in s. 393.065(5).
346 3. Whether the individual resides in a pilot program
347 region.
348 (c) The agency shall enroll individuals in the pilot
349 program based on verification that the individual has met the
350 criteria in paragraph (b).
351 (d) Notwithstanding any provisions of s. 393.065 to the
352 contrary, an enrollee must be afforded an opportunity to enroll
353 in any appropriate existing Medicaid waiver program if any of
354 the following conditions occur:
355 1. At any point during the operation of the pilot program,
356 an enrollee declares an intent to voluntarily disenroll,
357 provided that he or she has been covered for the entire previous
358 plan year by the pilot program.
359 2. The agency determines the enrollee has a good cause

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360 reason to disenroll.
361 3. The pilot program ceases to operate.
362
363 Such enrollees must receive an individualized transition plan to
364 assist him or her in accessing sufficient services and supports
365 for the enrollee’s safety, well-being, and continuity of care.
366 (3) PILOT PROGRAM BENEFITS.—
367 (a) Plans participating in the pilot program must, at a
368 minimum, cover the following:
369 1. All benefits included in s. 409.973.
370 2. All benefits included in s. 409.98.
371 3. All benefits included in s. 393.066(3), and all of the
372 following:
373 a. Adult day training.
374 b. Behavior analysis services.
375 c. Behavior assistant services.
376 d. Companion services.
377 e. Consumable medical supplies.
378 f. Dietitian services.
379 g. Durable medical equipment and supplies.
380 h. Environmental accessibility adaptations.
381 i. Occupational therapy.
382 j. Personal emergency response systems.
383 k. Personal supports.
384 l. Physical therapy.
385 m. Prevocational services.
386 n. Private duty nursing.
387 o. Residential habilitation, including the following
388 levels:

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389 (I) Standard level.
390 (II) Behavior-focused level.
391 (III) Intensive-behavior level.
392 (IV) Enhanced intensive-behavior level.
393 p. Residential nursing services.
394 q. Respiratory therapy.
395 r. Respite care.
396 s. Skilled nursing.
397 t. Specialized medical home care.
398 u. Specialized mental health counseling.
399 v. Speech therapy.
400 w. Support coordination.
401 x. Supported employment.
402 y. Supported living coaching.
403 z. Transportation.
404 (b) All providers of the services listed under paragraph
405 (a) must meet the provider qualifications outlined in the
406 Florida Medicaid Developmental Disabilities Individual Budgeting
407 Waiver Services Coverage and Limitations Handbook as adopted by
408 reference in rule 59G-13.070, Florida Administrative Code.
409 (c) Support coordination services must maximize the use of
410 natural supports and community partnerships.
411 (d) The plans participating in the pilot program must
412 provide all categories of benefits through a single, integrated
413 model of care.
414 (e) Services must be provided to enrollees in accordance
415 with an individualized care plan which is evaluated and updated
416 at least quarterly and as warranted by changes in an enrollee’s
417 circumstances.

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418 (4) ELIGIBLE PLANS; PLAN SELECTION.—
419 (a) To be eligible to participate in the pilot program, a
420 plan must have been awarded a contract to provide long-term care
421 services pursuant to s. 409.981 as a result of an invitation to
422 negotiate.
423 (b) The agency shall select, as provided in s. 287.057(1),
424 one plan to participate in the pilot program for each of the two
425 regions. The director of the Agency for Persons with
426 Disabilities or his or her designee must be a member of the
427 negotiating team.
428 1. The invitation to negotiate must specify the criteria
429 and the relative weight assigned to each criterion that will be
430 used for determining the acceptability of submitted responses
431 and guiding the selection of the plans with which the agency and
432 the Agency for Persons with Disabilities negotiate. In addition
433 to any other criteria established by the agency, in consultation
434 with the Agency for Persons with Disabilities, the agency shall
435 consider the following factors in the selection of eligible
436 plans:
437 a. Experience serving similar populations, including the
438 plan's record in achieving specific quality standards with
439 similar populations.
440 b. Establishment of community partnerships with providers
441 which create opportunities for reinvestment in community-based
442 services.
443 c. Provision of additional benefits, particularly
444 behavioral health services, the coordination of dental care, and
445 other initiatives that improve overall well-being.
446 d. Provision of and capacity to provide mental health

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447 therapies and analysis designed to meet the needs of individuals
448 with developmental disabilities.
449 e. Evidence that an eligible plan has written agreements or
450 signed contracts or has made substantial progress in
451 establishing relationships with providers before submitting its
452 response.
453 f. Experience in the provision of person-centered planning
454 as described in 42 C.F.R. s. 441.301(c)(1).
455 g. Experience in robust provider development programs that
456 result in increased availability of Medicaid providers to serve
457 the developmental disabilities community.
458 2. After negotiations are conducted, the agency shall
459 select the eligible plans that are determined to be responsive
460 and provide the best value to the state. Preference must be
461 given to plans that:
462 a. Have signed contracts in sufficient numbers to meet the
463 specific standards established under s. 409.967(2)(c), including
464 contracts for personal supports, skilled nursing, residential
465 habilitation, adult day training, mental health services,
466 respite care, companion services, and supported employment, as
467 those services are defined in the Florida Medicaid Developmental
468 Disabilities Individual Budgeting Waiver Services Coverage and
469 Limitations Handbook as adopted by reference in rule 59G-13.070,
470 Florida Administrative Code.
471 b. Have well-defined programs for recognizing patient-
472 centered medical homes and providing increased compensation to
473 recognized medical homes, as defined by the plan.
474 c. Have well-defined programs related to person-centered
475 planning as described in 42 C.F.R. s. 441.301(c)(1).

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476 d. Have robust and innovative programs for provider
477 development and collaboration with the Agency for Persons with
478 Disabilities.
479 (5) PAYMENT.—
480 (a) The selected plans must receive a per-member, per-month
481 payment based on a rate developed specifically for the unique
482 needs of the developmentally disabled population.
483 (b) The agency must ensure that the rate for the integrated
484 system is actuarially sound.
485 (c) The revenues and expenditures of the selected plan
486 which are associated with the implementation of the pilot
487 program must be included in the reporting and regulatory
488 requirements established in s. 409.967(3).
489 (6) PROGRAM IMPLEMENTATION AND EVALUATION.—
490 (a) The agency shall select participating plans and begin
491 enrollment no later than January 31, 2024, with coverage for
492 enrollees becoming effective upon authorization and availability
493 of sufficient state and federal resources.
494 (b) Upon implementation of the program, the agency, in
495 consultation with the Agency for Persons with Disabilities,
496 shall conduct audits of the selected plans' implementation of
497 person-centered planning.
498 (c) The agency, in consultation with the Agency for Persons
499 with Disabilities, shall submit progress reports to the
500 Governor, the President of the Senate, and the Speaker of the
501 House of Representatives upon the federal approval,
502 implementation, and operation of the pilot program, as follows:
503 1. By December 31, 2023, a status report on progress made
504 toward federal approval of the waiver or waiver amendment needed

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505 to implement the pilot program.
506 2. By December 31, 2024, a status report on implementation
507 of the pilot program.
508 3. By December 31, 2025, and annually thereafter, a status
509 report on the operation of the pilot program, including, but not
510 limited to, all of the following:
511 a. Program enrollment, including the number and
512 demographics of enrollees.
513 b. Any complaints received.
514 c. Access to approved services.
515 (d) The agency, in consultation with the Agency for Persons
516 with Disabilities, shall establish specific measures of access,
517 quality, and costs of the pilot program. The agency may contract
518 with an independent evaluator to conduct such evaluation. The
519 evaluation must include assessments of cost savings; consumer
520 education, choice, and access to services; plans for future
521 capacity and the enrollment of new Medicaid providers;
522 coordination of care; person-centered planning and person-
523 centered well-being outcomes; health and quality-of-life
524 outcomes; and quality of care by each eligibility category and
525 managed care plan in each pilot program site. The evaluation
526 must describe any administrative or legal barriers to the
527 implementation and operation of the pilot program in each
528 region.
529 1. The agency, in consultation with the Agency for Persons
530 with Disabilities, shall conduct quality assurance monitoring of
531 the pilot program to include client satisfaction with services,
532 client health and safety outcomes, client well-being outcomes,
533 and service delivery in accordance with the client’s care plan.

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534 2. The agency shall submit the results of the evaluation to
535 the Governor, the President of the Senate, and the Speaker of
536 the House of Representatives by October 1, 2029.
537 (7) MANAGED CARE PLAN ACCOUNTABILITY.—Plans participating
538 in the pilot program must consult with the Agency for Persons
539 with Disabilities for the express purpose of ensuring adequate
540 provider capacity before placing an enrollee of the pilot
541 program in a group home licensed by the Agency for Persons with
542 Disabilities.
543 Section 7. The Agency for Health Care Administration shall
544 distinguish private duty nursing services and attendant nursing
545 care services from skilled home health services in its Medicaid
546 provider enrollment process. As of October 1, 2021, the agency
547 may not require a home health agency that does not provide
548 Medicaid-skilled home health services and provides only
549 attendant nursing care services or private duty nursing
550 services, or both, to meet the requirements of Medicare
551 certification or its accreditation equivalents for participation
552 in the Medicaid program.
553 Section 8. Except as otherwise expressly provided in this
554 act and except for this section, which shall take effect upon
555 this act becoming a law, this act shall take effect July 1,
556 2023.
557
558 ================= T I T L E A M E N D M E N T ================
559 And the title is amended as follows:
560 Delete everything before the enacting clause
561 and insert:
562 A bill to be entitled

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563 An act relating to health; amending s. 296.37, F.S.;
564 increasing the income threshold for certain
565 contributions required by residents of veterans'
566 nursing homes; amending s. 409.814, F.S.; revising
567 eligibility conditions for participation in the
568 Florida Kidcare program; amending s. 409.908, F.S.;
569 revising the payment methodology for a certain
570 component of the state Title XIX Long-Term Care
571 Reimbursement Plan for nursing home care; amending s.
572 409.909, F.S.; revising the hospitals and qualifying
573 institutions that are eligible for participation in
574 the Graduate Medical Education Startup Bonus Program;
575 establishing the Slots for Doctors Program for a
576 specified purpose; requiring the Agency for Health
577 Care Administration to allocate a specified amount to
578 hospitals and qualifying institutions for certain
579 newly created resident positions for specified
580 physician specialties or subspecialties; providing
581 construction; prohibiting the use of allocated funds
582 under the program for resident positions that have
583 previously received certain other funding; amending s.
584 409.967, F.S.; revising the criteria for determining
585 achieved savings rebates for purposes of Medicaid
586 prepaid plans; creating s. 409.9855, F.S.; requiring
587 the Agency for Health Care Administration to implement
588 a pilot program for individuals with developmental
589 disabilities in specified Statewide Medicaid Managed
590 Care regions to provide coverage of comprehensive
591 services; authorizing the agency to seek federal

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592 approval as needed to implement the program; requiring
593 the agency to submit a request for federal approval by
594 a specified date; requiring the agency to administer
595 the pilot program in consultation with the Agency for
596 Persons with Disabilities; requiring the Agency for
597 Health Care Administration to make specified payments
598 to certain organizations for comprehensive services
599 for individuals with developmental disabilities;
600 providing applicability; requiring the agency to
601 evaluate the feasibility of implementing a statewide
602 capitated managed care model used by the pilot program
603 for certain individuals; providing that participation
604 in the pilot program is voluntary and subject to
605 specific appropriation; requiring the Agency for
606 Persons with Disabilities to approve a needs
607 assessment methodology to determine certain needs for
608 prospective enrollees; providing program enrollment
609 eligibility requirements; requiring that enrollees be
610 afforded an opportunity to enroll in any appropriate
611 existing Medicaid waiver program under certain
612 circumstances; requiring participating plans to cover
613 specified benefits; providing requirements for
614 providers of services; providing eligibility
615 requirements for plans; providing a selection process;
616 requiring the Agency for Health Care Administration to
617 give preference to certain plans; requiring that plan
618 payments be based on rates specifically developed for
619 a certain population; requiring the agency to ensure
620 that the rate be actuarially sound; requiring that the

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621 revenues and expenditures of the selected plan be
622 included in specified reporting and regulatory
623 requirements; requiring the agency to select
624 participating plans and begin enrollment by a
625 specified date; requiring the agency, in consultation
626 with the Agency for Persons with Disabilities, to
627 conduct certain audits of the selected plans’
628 implementation of person-centered planning and to
629 submit specified progress reports to the Governor and
630 the Legislature by specified dates throughout the
631 program approval and implementation process; providing
632 requirements for the respective reports; requiring the
633 Agency for Health Care Administration, in consultation
634 with the Agency for Persons with Disabilities, to
635 conduct an evaluation of the pilot program;
636 authorizing the Agency for Health Care Administration
637 to contract with an independent evaluator to conduct
638 such evaluation; providing requirements for the
639 evaluation; requiring the Agency for Health Care
640 Administration, in consultation with the Agency for
641 Persons with Disabilities, to conduct quality
642 assurance monitoring of the pilot program; requiring
643 the Agency for Health Care Administration to submit
644 the results of the evaluation to the Governor and the
645 Legislature by a specified date; requiring
646 participating plans to consult with the Agency for
647 Persons with Disabilities regarding capacity limits;
648 requiring the Agency for Health Care Administration to
649 distinguish certain services in its Medicaid provider

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650 enrollment process; prohibiting the agency from
651 requiring certain home health agencies to meet certain
652 requirements for participation in the Medicaid
653 program; providing effective dates.