A bill to be entitled

An act relating to health; amending s. 296.37, F.S.; increasing the income threshold for certain contributions required by residents of veterans' nursing homes; amending s. 409.814, F.S.; revising eligibility conditions for participation in the Florida Kidcare program; amending s. 409.908, F.S.; revising the payment methodology for a certain component of the state Title XIX Long-Term Care Reimbursement Plan for nursing home care; amending s. 409.909, F.S.; revising the hospitals and qualifying institutions that are eligible for participation in the Graduate Medical Education Startup Bonus Program; establishing the Slots for Doctors Program for a specified purpose; requiring the Agency for Health Care Administration to allocate a specified amount to hospitals and qualifying institutions for certain newly created resident positions for specified physician specialties or subspecialties; providing construction; prohibiting the use of allocated funds under the program for resident positions that have previously received certain other funding; amending s. 409.967, F.S.; revising the criteria for determining achieved savings rebates for purposes of Medicaid prepaid plans; creating s. 409.9855, F.S.; requiring the Agency for Health Care Administration to implement a pilot program for individuals with developmental disabilities in specified Statewide Medicaid Managed Care regions to provide coverage of comprehensive

services; authorizing the agency to seek federal approval as needed to implement the program; requiring the agency to submit a request for federal approval by a specified date; requiring the agency to administer the pilot program in consultation with the Agency for Persons with Disabilities; requiring the Agency for Health Care Administration to make specified payments to certain organizations for comprehensive services for individuals with developmental disabilities; providing applicability; requiring the agency to evaluate the feasibility of implementing a statewide capitated managed care model used by the pilot program for certain individuals; providing that participation in the pilot program is voluntary and subject to specific appropriation; requiring the Agency for Persons with Disabilities to approve a needs assessment methodology to determine certain needs for prospective enrollees; providing program enrollment eligibility requirements; requiring that enrollees be afforded an opportunity to enroll in any appropriate existing Medicaid waiver program under certain circumstances; requiring participating plans to cover specified benefits; providing requirements for providers of services; providing eligibility requirements for plans; providing a selection process; requiring the Agency for Health Care Administration to give preference to certain plans; requiring that plan payments be based on rates specifically developed for a certain population; requiring the agency to ensure

that the rate be actuarially sound; requiring that the revenues and expenditures of the selected plan be included in specified reporting and regulatory requirements; requiring the agency to select participating plans and begin enrollment by a specified date; requiring the agency, in consultation with the Agency for Persons with Disabilities, to conduct certain audits of the selected plans' implementation of person-centered planning and to submit specified progress reports to the Governor and the Legislature by specified dates throughout the program approval and implementation process; providing requirements for the respective reports; requiring the Agency for Health Care Administration, in consultation with the Agency for Persons with Disabilities, to conduct an evaluation of the pilot program; authorizing the Agency for Health Care Administration to contract with an independent evaluator to conduct such evaluation; providing requirements for the evaluation; requiring the Agency for Health Care Administration, in consultation with the Agency for Persons with Disabilities, to conduct quality assurance monitoring of the pilot program; requiring the Agency for Health Care Administration to submit the results of the evaluation to the Governor and the Legislature by a specified date; requiring participating plans to consult with the Agency for Persons with Disabilities regarding capacity limits; requiring the Agency for Health Care Administration to

distinguish certain services in its Medicaid provider enrollment process; prohibiting the agency from requiring certain home health agencies to meet certain requirements for participation in the Medicaid program; providing effective dates.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (1) of section 296.37, Florida Statutes, is amended to read:

296.37 Residents; contribution to support.—

(1) Every resident of the home who receives a pension, compensation, or gratuity from the United States Government, or income from any other source of more than $160 ~~$130~~ per month, shall contribute to his or her maintenance and support while a resident of the home in accordance with a schedule of payment determined by the administrator and approved by the director. The total amount of such contributions shall be to the fullest extent possible but may not exceed the actual cost of operating and maintaining the home.

Section 2. Subsection (7) of section 409.814, Florida Statutes, is amended to read:

409.814 Eligibility.—A child who has not reached 19 years of age whose family income is equal to or below 200 percent of the federal poverty level is eligible for the Florida Kidcare program as provided in this section. If an enrolled individual is determined to be ineligible for coverage, he or she must be immediately disenrolled from the respective Florida Kidcare program component.

(7) A child whose family income is above 200 percent of the federal poverty level or a child who is excluded under ~~the provisions of~~ subsection (5) may participate in the Florida Kidcare program as provided in s. 409.8132 or, if the child is ineligible for Medikids by reason of age, in the Florida Healthy Kids program, subject to the following:

(a) The family is not eligible for premium assistance payments and must pay the full cost of the combined-risk premium, including any administrative costs.

(b) The board of directors of the Florida Healthy Kids Corporation may offer a reduced benefit package to these children in order to limit program costs for such families.

Section 3. Paragraph (b) of subsection (2) of section 409.908, Florida Statutes, is amended to read:

409.908 Reimbursement of Medicaid providers.—Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. If a provider is reimbursed based on cost reporting and submits a cost report late and that cost report would have been used to set a lower reimbursement rate for a rate semester, then the provider’s rate for that semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be effected

retroactively. Medicare-granted extensions for filing cost reports, if applicable, shall also apply to Medicaid cost reports. Payment for Medicaid compensable services made on behalf of Medicaid-eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(2)

(b) Subject to any limitations or directions in the General Appropriations Act, the agency shall establish and implement a state Title XIX Long-Term Care Reimbursement Plan for nursing home care in order to provide care and services in conformance with the applicable state and federal laws, rules, regulations, and quality and safety standards and to ensure that individuals eligible for medical assistance have reasonable geographic access to such care.

1. The agency shall amend the long-term care reimbursement plan and cost reporting system to create direct care and indirect care subcomponents of the patient care component of the per diem rate. These two subcomponents together shall equal the patient care component of the per diem rate. Separate prices shall be calculated for each patient care subcomponent, initially based on the September 2016 rate setting cost reports

and subsequently based on the most recently audited cost report used during a rebasing year. The direct care subcomponent of the per diem rate for any providers still being reimbursed on a cost basis shall be limited by the cost-based class ceiling, and the indirect care subcomponent may be limited by the lower of the cost-based class ceiling, the target rate class ceiling, or the individual provider target. The ceilings and targets apply only to providers being reimbursed on a cost-based system. Effective October 1, 2018, a prospective payment methodology shall be implemented for rate setting purposes with the following parameters:

a. Peer Groups, including:

(I) North-SMMC Regions 1-9, less Palm Beach and Okeechobee Counties; and

(II) South-SMMC Regions 10-11, plus Palm Beach and Okeechobee Counties.

b. Percentage of Median Costs based on the cost reports used for September 2016 rate setting:

(I) Direct Care Costs.....100 percent.

(II) Indirect Care Costs.....92 percent.

(III) Operating Costs.....86 percent.

c. Floors:

(I) Direct Care Component.....95 percent.

(II) Indirect Care Component.....92.5 percent.

(III) Operating Component.....None.

d. Pass-through Payments.....Real Estate and .....Personal Property .....Taxes and Property Insurance.

e. Quality Incentive Program Payment

Pool.....10 ~~6~~ percent of September .....2016 non-property related .....payments of included facilities.

f. Quality Score Threshold to Quality for Quality Incentive Payment.....20th percentile of included facilities.

g. Fair Rental Value System Payment Parameters:

(I) Building Value per Square Foot based on 2018 RS Means.

(II) Land Valuation.....10 percent of Gross Building value.

(III) Facility Square Footage.....Actual Square Footage.

(IV) Moveable Equipment Allowance.....$8,000 per bed.

(V) Obsolescence Factor.....1.5 percent.

(VI) Fair Rental Rate of Return.....8 percent.

(VII) Minimum Occupancy.....90 percent.

(VIII) Maximum Facility Age.....40 years.

(IX) Minimum Square Footage per Bed.....350.

(X) Maximum Square Footage for Bed.....500.

(XI) Minimum Cost of a renovation/replacements.$500 per bed.

h. Ventilator Supplemental payment of $200 per Medicaid day of 40,000 ventilator Medicaid days per fiscal year.

2. The direct care subcomponent shall include salaries and benefits of direct care staff providing nursing services including registered nurses, licensed practical nurses, and certified nursing assistants who deliver care directly to residents in the nursing home facility, allowable therapy costs, and dietary costs. This excludes nursing administration, staff development, the staffing coordinator, and the administrative portion of the minimum data set and care plan coordinators. The direct care subcomponent also includes medically necessary dental care, vision care, hearing care, and podiatric care.

3. All other patient care costs shall be included in the indirect care cost subcomponent of the patient care per diem rate, including complex medical equipment, medical supplies, and other allowable ancillary costs. Costs may not be allocated directly or indirectly to the direct care subcomponent from a home office or management company.

4. On July 1 of each year, the agency shall report to the Legislature direct and indirect care costs, including average direct and indirect care costs per resident per facility and direct care and indirect care salaries and benefits per category of staff member per facility.

5. Every fourth year, the agency shall rebase nursing home prospective payment rates to reflect changes in cost based on the most recently audited cost report for each participating provider.

6. A direct care supplemental payment may be made to providers whose direct care hours per patient day are above the 80th percentile and who provide Medicaid services to a larger percentage of Medicaid patients than the state average.

7. For the period beginning on October 1, 2018, and ending on September 30, 2021, the agency shall reimburse providers the greater of their September 2016 cost-based rate or their prospective payment rate. Effective October 1, 2021, the agency shall reimburse providers the greater of 95 percent of their cost-based rate or their rebased prospective payment rate, using the most recently audited cost report for each facility. This subparagraph shall expire September 30, 2023.

8. Pediatric, Florida Department of Veterans Affairs, and government-owned facilities are exempt from the pricing model

established in this subsection and shall remain on a cost-based prospective payment system. Effective October 1, 2018, the agency shall set rates for all facilities remaining on a cost-based prospective payment system using each facility's most recently audited cost report, eliminating retroactive settlements.

It is the intent of the Legislature that the reimbursement plan achieve the goal of providing access to health care for nursing home residents who require large amounts of care while encouraging diversion services as an alternative to nursing home care for residents who can be served within the community. The agency shall base the establishment of any maximum rate of payment, whether overall or component, on the available moneys as provided for in the General Appropriations Act. The agency may base the maximum rate of payment on the results of scientifically valid analysis and conclusions derived from objective statistical data pertinent to the particular maximum rate of payment. The agency shall base the rates of payments in accordance with the minimum wage requirements as provided in the General Appropriations Act.

Section 4. Present subsections (6) and (7) of section 409.909, Florida Statutes, are redesignated as subsections (7) and (8), respectively, a new subsection (6) is added to that section, and subsection (5) of that section is amended, to read:

409.909 Statewide Medicaid Residency Program.—

(5) The Graduate Medical Education Startup Bonus Program is established to provide resources for the education and training of physicians in specialties which are in a statewide supply-

and-demand deficit. Hospitals and qualifying institutions as defined in paragraph (2)(c) eligible for participation in subsection (1) or subsection (6) are eligible to participate in the Graduate Medical Education Startup Bonus Program established under this subsection. Notwithstanding subsection (4) or an FTE's residency period, and in any state fiscal year in which funds are appropriated for the startup bonus program, the agency shall allocate a $100,000 startup bonus for each newly created resident position that is authorized by the Accreditation Council for Graduate Medical Education or Osteopathic Postdoctoral Training Institution in an initial or established accredited training program that is in a physician specialty in statewide supply-and-demand deficit. In any year in which funding is not sufficient to provide $100,000 for each newly created resident position, funding shall be reduced pro rata across all newly created resident positions in physician specialties in statewide supply-and-demand deficit.

(a) Hospitals and qualifying institutions as defined in paragraph (2)(c) applying for a startup bonus must submit to the agency by March 1 their Accreditation Council for Graduate Medical Education or Osteopathic Postdoctoral Training Institution approval validating the new resident positions approved on or after March 2 of the prior fiscal year through March 1 of the current fiscal year for the physician specialties identified in a statewide supply-and-demand deficit as provided in the current fiscal year's General Appropriations Act. An applicant hospital or qualifying institution as defined in paragraph (2)(c) may validate a change in the number of residents by comparing the number in the prior period

Accreditation Council for Graduate Medical Education or Osteopathic Postdoctoral Training Institution approval to the number in the current year.

(b) Any unobligated startup bonus funds on April 15 of each fiscal year shall be proportionally allocated to hospitals and to qualifying institutions as defined in paragraph (2)(c) participating under subsection (3) for existing FTE residents in the physician specialties in statewide supply-and-demand deficit. This nonrecurring allocation shall be in addition to the funds allocated in subsection (4). Notwithstanding subsection (4), the allocation under this subsection may not exceed $100,000 per FTE resident.

(c) For purposes of this subsection, physician specialties and subspecialties, both adult and pediatric, in statewide supply-and-demand deficit are those identified in the General Appropriations Act.

(d) The agency shall distribute all funds authorized under the Graduate Medical Education Startup Bonus Program on or before the final business day of the fourth quarter of a state fiscal year.

(6) The Slots for Doctors Program is established to address the physician workforce shortage by increasing the supply of highly trained physicians through the creation of new resident positions, which will increase access to care and improve health outcomes for Medicaid recipients.

(a) Notwithstanding subsection (4), the agency shall annually allocate $100,000 to hospitals and qualifying institutions for each newly created resident position that is first filled on or after June 1, 2023, and filled thereafter,

and that is accredited by the Accreditation Council for Graduate Medical Education or the Osteopathic Postdoctoral Training Institution in an initial or established accredited training program which is in a physician specialty or subspecialty in a statewide supply-and-demand deficit.

(b) This program is designed to generate matching funds under Medicaid and distribute such funds to participating hospitals and qualifying institutions on a quarterly basis in each fiscal year for which an appropriation is made. Resident positions created under this subsection are not eligible for concurrent funding pursuant to subsection (1).

(c) For purposes of this subsection, physician specialties and subspecialties, both adult and pediatric, in statewide supply-and-demand deficit are those identified as such in the General Appropriations Act.

(d) Funds allocated pursuant to this subsection may not be used for resident positions that have previously received funding pursuant to subsection (1).

Section 5. Paragraph (f) of subsection (3) of section 409.967, Florida Statutes, is amended to read:

409.967 Managed care plan accountability.—

(3) ACHIEVED SAVINGS REBATE.—

(f) Achieved savings rebates validated by the certified public accountant are due within 30 days after the report is submitted. Except as provided in paragraph (h), the achieved savings rebate is established by determining pretax income as a percentage of revenues and applying the following income sharing ratios:

1. One hundred percent of income up to and including 5

percent of revenue shall be retained by the plan.

2. Fifty percent of income above 5 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.

3. One hundred 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.

Section 6. Effective upon becoming a law, section 409.9855, Florida Statutes, is created to read:

409.9855 Pilot program for individuals with developmental disabilities.—

(1) PILOT PROGRAM IMPLEMENTATION.—

(a) Using a managed care model, the agency shall implement a pilot program for individuals with developmental disabilities in Statewide Medicaid Managed Care Regions D and I to provide coverage of comprehensive services.

(b) The agency may seek federal approval through a state plan amendment or Medicaid waiver as necessary to implement the pilot program. The agency shall submit a request for any federal approval needed to implement the pilot program by September 1, 2023.

(c) Pursuant to s. 409.963, the agency shall administer the

pilot program in consultation with the Agency for Persons with Disabilities.

(d) The agency shall make capitated payments to managed care organizations for comprehensive coverage, including community-based services described in s. 393.066(3) and approved through the state's home and community-based services Medicaid waiver program for individuals with developmental disabilities. Unless otherwise specified, ss. 409.961-409.969 apply to the pilot program.

(e) The agency shall evaluate the feasibility of statewide implementation of the capitated managed care model used by the pilot program to serve individuals with developmental disabilities.

(2) ELIGIBILITY; VOLUNTARY ENROLLMENT; DISENROLLMENT.—

(a) Participation in the pilot program is voluntary and limited to the maximum number of enrollees specified in the General Appropriations Act.

(b) The Agency for Persons with Disabilities shall approve a needs assessment methodology to determine functional, behavioral, and physical needs of prospective enrollees. The assessment methodology may be administered by persons who have completed such training as may be offered by the agency. Eligibility to participate in the pilot program is determined based on all of the following criteria:

1. Whether the individual is eligible for Medicaid.

2. Whether the individual is 18 years of age or older and is on the waiting list for individual budget waiver services under chapter 393 and assigned to one of categories 1 through 6 as specified in s. 393.065(5).

3. Whether the individual resides in a pilot program region.

(c) The agency shall enroll individuals in the pilot program based on verification that the individual has met the criteria in paragraph (b).

(d) Notwithstanding any provisions of s. 393.065 to the contrary, an enrollee must be afforded an opportunity to enroll in any appropriate existing Medicaid waiver program if any of the following conditions occur:

1. At any point during the operation of the pilot program, an enrollee declares an intent to voluntarily disenroll, provided that he or she has been covered for the entire previous plan year by the pilot program.

2. The agency determines the enrollee has a good cause reason to disenroll.

3. The pilot program ceases to operate.

Such enrollees must receive an individualized transition plan to assist him or her in accessing sufficient services and supports for the enrollee's safety, well-being, and continuity of care.

(3) PILOT PROGRAM BENEFITS.—

(a) Plans participating in the pilot program must, at a minimum, cover the following:

1. All benefits included in s. 409.973.

2. All benefits included in s. 409.98.

3. All benefits included in s. 393.066(3), and all of the following:

a. Adult day training.

b. Behavior analysis services.

c. Behavior assistant services.

d. Companion services.

e. Consumable medical supplies.

f. Dietitian services.

g. Durable medical equipment and supplies.

h. Environmental accessibility adaptations.

i. Occupational therapy.

j. Personal emergency response systems.

k. Personal supports.

l. Physical therapy.

m. Prevocational services.

n. Private duty nursing.

o. Residential habilitation, including the following levels:

(I) Standard level.

(II) Behavior-focused level.

(III) Intensive-behavior level.

(IV) Enhanced intensive-behavior level.

p. Residential nursing services.

q. Respiratory therapy.

r. Respite care.

s. Skilled nursing.

t. Specialized medical home care.

u. Specialized mental health counseling.

v. Speech therapy.

w. Support coordination.

x. Supported employment.

y. Supported living coaching.

z. Transportation.

(b) All providers of the services listed under paragraph (a) must meet the provider qualifications outlined in the Florida Medicaid Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook as adopted by reference in rule 59G-13.070, Florida Administrative Code.

(c) Support coordination services must maximize the use of natural supports and community partnerships.

(d) The plans participating in the pilot program must provide all categories of benefits through a single, integrated model of care.

(e) Services must be provided to enrollees in accordance with an individualized care plan which is evaluated and updated at least quarterly and as warranted by changes in an enrollee's circumstances.

(4) ELIGIBLE PLANS; PLAN SELECTION.—

(a) To be eligible to participate in the pilot program, a plan must have been awarded a contract to provide long-term care services pursuant to s. 409.981 as a result of an invitation to negotiate.

(b) The agency shall select, as provided in s. 287.057(1), one plan to participate in the pilot program for each of the two regions. The director of the Agency for Persons with Disabilities or his or her designee must be a member of the negotiating team.

1. The invitation to negotiate must specify the criteria and the relative weight assigned to each criterion that will be used for determining the acceptability of submitted responses and guiding the selection of the plans with which the agency and the Agency for Persons with Disabilities negotiate. In addition

to any other criteria established by the agency, in consultation with the Agency for Persons with Disabilities, the agency shall consider the following factors in the selection of eligible plans:

a. Experience serving similar populations, including the plan's record in achieving specific quality standards with similar populations.

b. Establishment of community partnerships with providers which create opportunities for reinvestment in community-based services.

c. Provision of additional benefits, particularly behavioral health services, the coordination of dental care, and other initiatives that improve overall well-being.

d. Provision of and capacity to provide mental health therapies and analysis designed to meet the needs of individuals with developmental disabilities.

e. Evidence that an eligible plan has written agreements or signed contracts or has made substantial progress in establishing relationships with providers before submitting its response.

f. Experience in the provision of person-centered planning as described in 42 C.F.R. s. 441.301(c)(1).

g. Experience in robust provider development programs that result in increased availability of Medicaid providers to serve the developmental disabilities community.

2. After negotiations are conducted, the agency shall select the eligible plans that are determined to be responsive and provide the best value to the state. Preference must be given to plans that:

a. Have signed contracts in sufficient numbers to meet the specific standards established under s. 409.967(2)(c), including contracts for personal supports, skilled nursing, residential habilitation, adult day training, mental health services, respite care, companion services, and supported employment, as those services are defined in the Florida Medicaid Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook as adopted by reference in rule 59G-13.070, Florida Administrative Code.

b. Have well-defined programs for recognizing patient-centered medical homes and providing increased compensation to recognized medical homes, as defined by the plan.

c. Have well-defined programs related to person-centered planning as described in 42 C.F.R. s. 441.301(c)(1).

d. Have robust and innovative programs for provider development and collaboration with the Agency for Persons with Disabilities.

(5) PAYMENT.—

(a) The selected plans must receive a per-member, per-month payment based on a rate developed specifically for the unique needs of the developmentally disabled population.

(b) The agency must ensure that the rate for the integrated system is actuarially sound.

(c) The revenues and expenditures of the selected plan which are associated with the implementation of the pilot program must be included in the reporting and regulatory requirements established in s. 409.967(3).

(6) PROGRAM IMPLEMENTATION AND EVALUATION.—

(a) The agency shall select participating plans and begin

enrollment no later than January 31, 2024, with coverage for enrollees becoming effective upon authorization and availability of sufficient state and federal resources.

(b) Upon implementation of the program, the agency, in consultation with the Agency for Persons with Disabilities, shall conduct audits of the selected plans' implementation of person-centered planning.

(c) The agency, in consultation with the Agency for Persons with Disabilities, shall submit progress reports to the Governor, the President of the Senate, and the Speaker of the House of Representatives upon the federal approval, implementation, and operation of the pilot program, as follows:

1. By December 31, 2023, a status report on progress made toward federal approval of the waiver or waiver amendment needed to implement the pilot program.

2. By December 31, 2024, a status report on implementation of the pilot program.

3. By December 31, 2025, and annually thereafter, a status report on the operation of the pilot program, including, but not limited to, all of the following:

a. Program enrollment, including the number and demographics of enrollees.

b. Any complaints received.

c. Access to approved services.

(d) The agency, in consultation with the Agency for Persons with Disabilities, shall establish specific measures of access, quality, and costs of the pilot program. The agency may contract with an independent evaluator to conduct such evaluation. The evaluation must include assessments of cost savings; consumer

education, choice, and access to services; plans for future capacity and the enrollment of new Medicaid providers; coordination of care; person-centered planning and person-centered well-being outcomes; health and quality-of-life outcomes; and quality of care by each eligibility category and managed care plan in each pilot program site. The evaluation must describe any administrative or legal barriers to the implementation and operation of the pilot program in each region.

1. The agency, in consultation with the Agency for Persons with Disabilities, shall conduct quality assurance monitoring of the pilot program to include client satisfaction with services, client health and safety outcomes, client well-being outcomes, and service delivery in accordance with the client's care plan.

2. The agency shall submit the results of the evaluation to the Governor, the President of the Senate, and the Speaker of the House of Representatives by October 1, 2029.

(7) MANAGED CARE PLAN ACCOUNTABILITY.—Plans participating in the pilot program must consult with the Agency for Persons with Disabilities for the express purpose of ensuring adequate provider capacity before placing an enrollee of the pilot program in a group home licensed by the Agency for Persons with Disabilities.

Section 7. The Agency for Health Care Administration shall distinguish private duty nursing services and attendant nursing care services from skilled home health services in its Medicaid provider enrollment process. As of October 1, 2021, the agency may not require a home health agency that does not provide Medicaid-skilled home health services and provides only

attendant nursing care services or private duty nursing services, or both, to meet the requirements of Medicare certification or its accreditation equivalents for participation in the Medicaid program.

Section 8. Except as otherwise expressly provided in this act and except for this section, which shall take effect upon this act becoming a law, this act shall take effect July 1, 2023.