

20232510er

1
2 An act relating to health; amending s. 296.37, F.S.;
3 increasing the income threshold for certain
4 contributions required by residents of veterans'
5 nursing homes; amending s. 409.814, F.S.; revising
6 eligibility conditions for participation in the
7 Florida Kidcare program; amending s. 409.908, F.S.;
8 revising the payment methodology for a certain
9 component of the state Title XIX Long-Term Care
10 Reimbursement Plan for nursing home care; amending s.
11 409.909, F.S.; revising the hospitals and qualifying
12 institutions that are eligible for participation in
13 the Graduate Medical Education Startup Bonus Program;
14 establishing the Slots for Doctors Program for a
15 specified purpose; requiring the Agency for Health
16 Care Administration to allocate a specified amount to
17 hospitals and qualifying institutions for certain
18 newly created resident positions for specified
19 physician specialties or subspecialties; providing
20 construction; prohibiting the use of allocated funds
21 under the program for resident positions that have
22 previously received certain other funding; amending s.
23 409.967, F.S.; revising the criteria for determining
24 achieved savings rebates for purposes of Medicaid
25 prepaid plans; creating s. 409.9855, F.S.; requiring
26 the Agency for Health Care Administration to implement
27 a pilot program for individuals with developmental
28 disabilities in specified Statewide Medicaid Managed
29 Care regions to provide coverage of comprehensive

20232510er

30 services; authorizing the agency to seek federal
31 approval as needed to implement the program; requiring
32 the agency to submit a request for federal approval by
33 a specified date; requiring the agency to administer
34 the pilot program in consultation with the Agency for
35 Persons with Disabilities; requiring the Agency for
36 Health Care Administration to make specified payments
37 to certain organizations for comprehensive services
38 for individuals with developmental disabilities;
39 providing applicability; requiring the agency to
40 evaluate the feasibility of implementing a statewide
41 capitated managed care model used by the pilot program
42 for certain individuals; providing that participation
43 in the pilot program is voluntary and subject to
44 specific appropriation; requiring the Agency for
45 Persons with Disabilities to approve a needs
46 assessment methodology to determine certain needs for
47 prospective enrollees; providing program enrollment
48 eligibility requirements; requiring that enrollees be
49 afforded an opportunity to enroll in any appropriate
50 existing Medicaid waiver program under certain
51 circumstances; requiring participating plans to cover
52 specified benefits; providing requirements for
53 providers of services; providing eligibility
54 requirements for plans; providing a selection process;
55 requiring the Agency for Health Care Administration to
56 give preference to certain plans; requiring that plan
57 payments be based on rates specifically developed for
58 a certain population; requiring the agency to ensure

20232510er

59 that the rate be actuarially sound; requiring that the
60 revenues and expenditures of the selected plan be
61 included in specified reporting and regulatory
62 requirements; requiring the agency to select
63 participating plans and begin enrollment by a
64 specified date; requiring the agency, in consultation
65 with the Agency for Persons with Disabilities, to
66 conduct certain audits of the selected plans'
67 implementation of person-centered planning and to
68 submit specified progress reports to the Governor and
69 the Legislature by specified dates throughout the
70 program approval and implementation process; providing
71 requirements for the respective reports; requiring the
72 Agency for Health Care Administration, in consultation
73 with the Agency for Persons with Disabilities, to
74 conduct an evaluation of the pilot program;
75 authorizing the Agency for Health Care Administration
76 to contract with an independent evaluator to conduct
77 such evaluation; providing requirements for the
78 evaluation; requiring the Agency for Health Care
79 Administration, in consultation with the Agency for
80 Persons with Disabilities, to conduct quality
81 assurance monitoring of the pilot program; requiring
82 the Agency for Health Care Administration to submit
83 the results of the evaluation to the Governor and the
84 Legislature by a specified date; requiring
85 participating plans to consult with the Agency for
86 Persons with Disabilities regarding capacity limits;
87 requiring the Agency for Health Care Administration to

20232510er

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

93

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

95

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

98 296.37 Residents; contribution to support.—

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

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

110 409.814 Eligibility.—A child who has not reached 19 years
111 of age whose family income is equal to or below 200 percent of
112 the federal poverty level is eligible for the Florida Kidcare
113 program as provided in this section. If an enrolled individual
114 is determined to be ineligible for coverage, he or she must be
115 immediately disenrolled from the respective Florida Kidcare
116 program component.

20232510er

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

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

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

129 Section 3. Paragraph (b) of subsection (2) of section
130 409.908, Florida Statutes, is amended to read:

131 409.908 Reimbursement of Medicaid providers.—Subject to
132 specific appropriations, the agency shall reimburse Medicaid
133 providers, in accordance with state and federal law, according
134 to methodologies set forth in the rules of the agency and in
135 policy manuals and handbooks incorporated by reference therein.
136 These methodologies may include fee schedules, reimbursement
137 methods based on cost reporting, negotiated fees, competitive
138 bidding pursuant to s. 287.057, and other mechanisms the agency
139 considers efficient and effective for purchasing services or
140 goods on behalf of recipients. If a provider is reimbursed based
141 on cost reporting and submits a cost report late and that cost
142 report would have been used to set a lower reimbursement rate
143 for a rate semester, then the provider's rate for that semester
144 shall be retroactively calculated using the new cost report, and
145 full payment at the recalculated rate shall be effected

20232510er

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

159 (2)

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

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

20232510er

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

186 a. Peer Groups, including:

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

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

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

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

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

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

196 c. Floors:

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

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

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

200 d. Pass-through Payments.....Real Estate and

201Personal Property

202Taxes and Property Insurance.

203 e. Quality Incentive Program Payment

20232510er

204 Pool.....10 ~~6~~ percent of September
2052016 non-property related
206payments of included facilities.

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

209 g. Fair Rental Value System Payment Parameters:

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

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

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

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

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

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

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

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

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

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

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

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

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

20232510er

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

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

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

248 6. A direct care supplemental payment may be made to
249 providers whose direct care hours per patient day are above the
250 80th percentile and who provide Medicaid services to a larger
251 percentage of Medicaid patients than the state average.

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

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

20232510er

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

268
269 It is the intent of the Legislature that the reimbursement plan
270 achieve the goal of providing access to health care for nursing
271 home residents who require large amounts of care while
272 encouraging diversion services as an alternative to nursing home
273 care for residents who can be served within the community. The
274 agency shall base the establishment of any maximum rate of
275 payment, whether overall or component, on the available moneys
276 as provided for in the General Appropriations Act. The agency
277 may base the maximum rate of payment on the results of
278 scientifically valid analysis and conclusions derived from
279 objective statistical data pertinent to the particular maximum
280 rate of payment. The agency shall base the rates of payments in
281 accordance with the minimum wage requirements as provided in the
282 General Appropriations Act.

283 Section 4. Present subsections (6) and (7) of section
284 409.909, Florida Statutes, are redesignated as subsections (7)
285 and (8), respectively, a new subsection (6) is added to that
286 section, and subsection (5) of that section is amended, to read:

287 409.909 Statewide Medicaid Residency Program.—

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

20232510er

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

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

20232510er

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

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

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

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

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

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

20232510er

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

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

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

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

367 Section 5. Paragraph (f) of subsection (3) of section
368 409.967, Florida Statutes, is amended to read:

369 409.967 Managed care plan accountability.—

370 (3) ACHIEVED SAVINGS REBATE.—

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

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

20232510er

378 percent of revenue shall be retained by the plan.

379 2. Fifty percent of income above 5 percent and up to 10
380 percent shall be retained by the plan, and the other 50 percent
381 shall be refunded to the state and adjusted for the Federal
382 Medical Assistance Percentages. The state share shall be
383 transferred to the General Revenue Fund, unallocated, and the
384 federal share shall be transferred to the Medical Care Trust
385 Fund, unallocated.

386 3. One hundred percent of income above 10 percent of
387 revenue shall be refunded to the state and adjusted for the
388 Federal Medical Assistance Percentages. The state share shall be
389 transferred to the General Revenue Fund, unallocated, and the
390 federal share shall be transferred to the Medical Care Trust
391 Fund, unallocated.

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

394 409.9855 Pilot program for individuals with developmental
395 disabilities.-

396 (1) PILOT PROGRAM IMPLEMENTATION.-

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

401 (b) The agency may seek federal approval through a state
402 plan amendment or Medicaid waiver as necessary to implement the
403 pilot program. The agency shall submit a request for any federal
404 approval needed to implement the pilot program by September 1,
405 2023.

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

20232510er

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

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

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

420 (2) ELIGIBILITY; VOLUNTARY ENROLLMENT; DISENROLLMENT.—

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

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

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

20232510er

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

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

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

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

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

451 3. The pilot program ceases to operate.

452
453 Such enrollees must receive an individualized transition plan to
454 assist him or her in accessing sufficient services and supports
455 for the enrollee's safety, well-being, and continuity of care.

456 (3) PILOT PROGRAM BENEFITS.-

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

459 1. All benefits included in s. 409.973.

460 2. All benefits included in s. 409.98.

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

463 a. Adult day training.

464 b. Behavior analysis services.

20232510er

- 465 c. Behavior assistant services.
466 d. Companion services.
467 e. Consumable medical supplies.
468 f. Dietitian services.
469 g. Durable medical equipment and supplies.
470 h. Environmental accessibility adaptations.
471 i. Occupational therapy.
472 j. Personal emergency response systems.
473 k. Personal supports.
474 l. Physical therapy.
475 m. Prevocational services.
476 n. Private duty nursing.
477 o. Residential habilitation, including the following
478 levels:
479 (I) Standard level.
480 (II) Behavior-focused level.
481 (III) Intensive-behavior level.
482 (IV) Enhanced intensive-behavior level.
483 p. Residential nursing services.
484 q. Respiratory therapy.
485 r. Respite care.
486 s. Skilled nursing.
487 t. Specialized medical home care.
488 u. Specialized mental health counseling.
489 v. Speech therapy.
490 w. Support coordination.
491 x. Supported employment.
492 y. Supported living coaching.
493 z. Transportation.

20232510er

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

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

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

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

508 (4) ELIGIBLE PLANS; PLAN SELECTION.—

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

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

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

20232510er

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

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

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

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

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

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

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

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

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

20232510er

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

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

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

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

569 (5) PAYMENT.-

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

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

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

579 (6) PROGRAM IMPLEMENTATION AND EVALUATION.-

580 (a) The agency shall select participating plans and begin

20232510er

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

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

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

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

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

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

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

603 b. Any complaints received.

604 c. Access to approved services.

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

20232510er

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

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

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

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

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

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

643 Section 8. Except as otherwise expressly provided in this
644 act and except for this section, which shall take effect upon
645 this act becoming a law, this act shall take effect July 1,
646 2023.