1 A bill to be entitled
2 An act relating to health care; amending s. 409.814, F.S.;
3 providing Florida Kidcare eligibility determination
4 requirements; amending s. 409.815, F.S.; revising
5 mandatory benefit requirements for behavioral health and
6 dental services; providing reimbursement requirements for
7 federally qualified health centers and rural health
8 clinics; amending s. 409.818, F.S.; requiring the Agency
9 for Health Care Administration to monitor the compliance
10 and quality of health insurance plans in the Florida
11 Kidcare program as required by federal law; amending s.
12 409.904, F.S.; revising the expiration date of provisions
13 authorizing the federal waiver for certain persons age 65
14 and over or who have a disability; revising the expiration
15 date of provisions authorizing a specified medically needy
16 program; amending s. 409.905, F.S., relating to mandatory
17 Medicaid services; requiring prior authorization for
18 certain home health services; requiring home health
19 agencies to submit certain supporting documentation when
20 requesting prior authorization; establishing reimbursement
21 requirements for home health services; providing an
22 exemption for certain home health agencies; revising
23 conditions for adjustment of a hospital's inpatient per
24 diem rate; amending s. 409.906, F.S., relating to optional
25 Medicaid services; providing limitations on the provision
26 of adult vision services; amending s. 409.9082, F.S.;
27 authorizing the agency to exempt certain nursing home
28 facility providers from quality assessments or apply a

29 lower assessment rate to the facility; modifying
30 circumstances requiring discontinuance of the quality
31 assessment on nursing home facility providers; creating s.
32 409.9083, F.S.; providing definitions; providing for a
33 quality assessment to be imposed upon privately operated
34 intermediate care facility providers for the
35 developmentally disabled; requiring the agency to
36 calculate the quality assessment rate annually; providing
37 requirements for reporting and collecting the assessment;
38 specifying the purposes of the assessment and an order of
39 priority; requiring that the agency seek federal
40 authorization to implement the act; specifying
41 circumstances requiring discontinuance of the quality
42 assessment; authorizing the agency to impose certain
43 penalties against providers that fail to pay the
44 assessment; requiring the agency to adopt rules; providing
45 for future repeal; amending s. 409.911, F.S.; revising the
46 share data used to calculate disproportionate share
47 payments to hospitals; amending s. 409.9112, F.S.;
48 revising the time period during which the agency is
49 prohibited from distributing disproportionate share
50 payments to regional perinatal intensive care centers;
51 amending s. 409.9113, F.S.; requiring the agency to
52 distribute moneys provided in the General Appropriations
53 Act to statutorily defined teaching hospitals and family
54 practice teaching hospitals under the teaching hospital
55 disproportionate share program for the 2009-2010 fiscal
56 year; amending s. 409.9117, F.S.; prohibiting the agency

57 from distributing moneys under the primary care
58 disproportionate share program for the 2009-2010 fiscal
59 year; amending s. 409.912, F.S.; providing that the
60 continuance of the integrated fixed-payment delivery pilot
61 program for certain elderly or dually eligible recipients
62 is contingent upon an appropriation; creating a pilot
63 project in Miami-Dade County to monitor the delivery of
64 home health services and provide for electronic claims for
65 home health services; authorizing the agency to seek
66 amendments to the state plan and waivers of federal law to
67 implement the project; requiring the agency to award
68 contracts based on a competitive solicitation process;
69 requiring a report to the Governor and Legislature;
70 creating a comprehensive care management pilot project in
71 Miami-Dade County for home health services; authorizing
72 the agency to seek amendments to the state plan and
73 waivers of federal law to implement the project; amending
74 s. 409.91211, F.S.; revising the date when provider
75 service networks convert from fee-for-service to
76 capitation rates; amending s. 430.04, F.S.; requiring the
77 Department of Elderly Affairs to administer all Medicaid
78 waivers and programs relating to elders and their
79 appropriations; amending s. 430.707, F.S.; requiring the
80 agency, in consultation with the Department of Elderly
81 Affairs, to accept and forward to the Centers for Medicare
82 and Medicaid Services an application for expansion of a
83 pilot project from an entity that provides certain

84 benefits under a federal program; providing an effective
85 date.
86
87 Be It Enacted by the Legislature of the State of Florida:
88
89 Section 1. Paragraph (c) is added to subsection (8) of
90 section 409.814, Florida Statutes, to read:
91 409.814 Eligibility.--A child who has not reached 19 years
92 of age whose family income is equal to or below 200 percent of
93 the federal poverty level is eligible for the Florida Kidcare
94 program as provided in this section. For enrollment in the
95 Children's Medical Services Network, a complete application
96 includes the medical or behavioral health screening. If,
97 subsequently, an individual is determined to be ineligible for
98 coverage, he or she must immediately be disenrolled from the
99 respective Florida Kidcare program component.
100 (8) In determining the eligibility of a child, an assets
101 test is not required. Each applicant shall provide written
102 documentation during the application process and the
103 redetermination process, including, but not limited to, the
104 following:
105 (a) Proof of family income, which must include a copy of
106 the applicant's most recent federal income tax return. In the
107 absence of a federal income tax return, an applicant may submit
108 wages and earnings statements (pay stubs), W-2 forms, or other
109 appropriate documents.
110 (b) A statement from all family members that:
111 1. Their employer does not sponsor a health benefit plan

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112 for employees; or
113 2. The potential enrollee is not covered by the employer-
114 sponsored health benefit plan because the potential enrollee is
115 not eligible for coverage, or, if the potential enrollee is
116 eligible but not covered, a statement of the cost to enroll the
117 potential enrollee in the employer-sponsored health benefit
118 plan.
119 (c) Effective no later than January 1, 2010, verification
120 of the potential enrollee's or enrollee's citizenship status to
121 the extent required under Title XXI of the Social Security Act.
122 Section 2. Paragraphs (g) and (q) of subsection (2) of
123 section 409.815, Florida Statutes, are amended, and paragraph
124 (w) is added to that subsection, to read:
125 409.815 Health benefits coverage; limitations.--
126 (2) BENCHMARK BENEFITS.--In order for health benefits
127 coverage to qualify for premium assistance payments for an
128 eligible child under ss. 409.810-409.820, the health benefits
129 coverage, except for coverage under Medicaid and Medikids, must
130 include the following minimum benefits, as medically necessary.
131 (g) Behavioral health services.--
132 1. Mental health benefits include:
133 a. Inpatient services, limited to not more than 30
134 inpatient days per contract year for psychiatric admissions, or
135 residential services in facilities licensed under s. 394.875(6)
136 or s. 395.003 in lieu of inpatient psychiatric admissions;
137 however, a minimum of 10 of the 30 days shall be available only
138 for inpatient psychiatric services when authorized by a
139 physician; and

140 b. Outpatient services, including outpatient visits for
141 psychological or psychiatric evaluation, diagnosis, and
142 treatment by a licensed mental health professional, limited to a
143 maximum of 40 outpatient visits each contract year.
144 2. Substance abuse services include:
145 a. Inpatient services, limited to not more than 7
146 inpatient days per contract year for medical detoxification only
147 and 30 days of residential services; and
148 b. Outpatient services, including evaluation, diagnosis,
149 and treatment by a licensed practitioner, limited to a maximum
150 of 40 outpatient visits per contract year.
151 3. Effective October 1, 2009, covered services include
152 inpatient and outpatient services for mental and nervous
153 disorders as defined in the most recent edition of the
154 Diagnostic and Statistical Manual of Mental Disorders published
155 by the American Psychiatric Association. Such benefits include
156 psychological or psychiatric evaluation, diagnosis, and
157 treatment by a licensed mental health professional and
158 inpatient, outpatient, and residential treatment services for
159 the diagnosis and treatment of substance abuse disorders. Any
160 benefit limitations, including duration of services, number of
161 visits, or number of days for hospitalization or residential
162 services may not be any less favorable than those for physical
163 illnesses generally for the care and treatment of schizophrenia
164 and psychotic disorders, mood disorders, anxiety disorders,
165 substance abuse disorders, eating disorders, and childhood
166 attention deficit disorders. The program may also implement
167 appropriate financial incentives, peer review, utilization

168 requirements, and other methods used for the management of
169 benefits provided for other medical conditions in order to
170 reduce service costs and utilization without compromising
171 quality of care.
172 (q) Dental services.--Effective October 1, 2009, dental
173 services shall be covered as required under federal law and may
174 also include those dental benefits provided to children by the
175 Florida Medicaid program under s. 409.906(6). Changes to the
176 dental benefit in order to comply with federal law are effective
177 October 1, 2009.
178 (w) Reimbursement of federally qualified health centers
179 and rural health clinics.--Effective October 1, 2009, payments
180 for services provided to enrollees by federally qualified health
181 centers and rural health clinics under this section shall be
182 reimbursed using the Medicaid Prospective Payment System as
183 provided for under s. 2107(e)(1)(D) of the Social Security Act,
184 42 U.S.C. s. 1397gg(e)(1)(D), as added by Pub. L. No 105-33,
185 Title IV, s. 4901(a). If such services are paid for by health
186 insurers or health care providers under contract with the
187 Florida Healthy Kids Corporation, such entities are responsible
188 for this payment. The agency may seek any available federal
189 grants to assist with this transition.
190 Section 3. Paragraph (c) of subsection (3) of section
191 409.818, Florida Statutes, is amended to read:
192 409.818 Administration.--In order to implement ss.
193 409.810-409.820, the following agencies shall have the following
194 duties:
195 (3) The Agency for Health Care Administration, under the

196 authority granted in s. 409.914(1), shall:
197 (c) Monitor compliance with quality assurance and access
198 standards developed under s. 409.820 and in accordance with s.
199 2103(f) of the Social Security Act, 42 U.S.C. s. 1397cc(f).
200
201 The agency is designated the lead state agency for Title XXI of
202 the Social Security Act for purposes of receipt of federal
203 funds, for reporting purposes, and for ensuring compliance with
204 federal and state regulations and rules.
205 Section 4. Subsections (1) and (2) of section 409.904,
206 Florida Statutes, are amended to read:
207 409.904 Optional payments for eligible persons.--The
208 agency may make payments for medical assistance and related
209 services on behalf of the following persons who are determined
210 to be eligible subject to the income, assets, and categorical
211 eligibility tests set forth in federal and state law. Payment on
212 behalf of these Medicaid eligible persons is subject to the
213 availability of moneys and any limitations established by the
214 General Appropriations Act or chapter 216.
215 (1) Effective January 1, 2006, and subject to federal
216 waiver approval, a person who is age 65 or older or is
217 determined to be disabled, whose income is at or below 88
218 percent of the federal poverty level, whose assets do not exceed
219 established limitations, and who is not eligible for Medicare
220 or, if eligible for Medicare, is also eligible for and receiving
221 Medicaid-covered institutional care services, hospice services,
222 or home and community-based services. The agency shall seek
223 federal authorization through a waiver to provide this coverage.

224 This subsection expires June 30, 2010 ~~2009~~.
225 (2)(a) A family, a pregnant woman, a child under age 21, a
226 person age 65 or over, or a blind or disabled person, who would
227 be eligible under any group listed in s. 409.903(1), (2), or
228 (3), except that the income or assets of such family or person
229 exceed established limitations. For a family or person in one of
230 these coverage groups, medical expenses are deductible from
231 income in accordance with federal requirements in order to make
232 a determination of eligibility. A family or person eligible
233 under the coverage known as the "medically needy," is eligible
234 to receive the same services as other Medicaid recipients, with
235 the exception of services in skilled nursing facilities and
236 intermediate care facilities for the developmentally disabled.
237 This paragraph ~~subsection~~ expires June 30, 2010 ~~2009~~.
238 (b) Effective July 1, 2010 ~~2009~~, a pregnant woman or a
239 child younger than 21 years of age who would be eligible under
240 any group listed in s. 409.903, except that the income or assets
241 of such group exceed established limitations. For a person in
242 one of these coverage groups, medical expenses are deductible
243 from income in accordance with federal requirements in order to
244 make a determination of eligibility. A person eligible under the
245 coverage known as the "medically needy" is eligible to receive
246 the same services as other Medicaid recipients, with the
247 exception of services in skilled nursing facilities and
248 intermediate care facilities for the developmentally disabled.
249 Section 5. Subsection (4) and paragraph (c) of subsection
250 (5) of section 409.905, Florida Statutes, are amended to read:
251 409.905 Mandatory Medicaid services.--The agency may make

252 payments for the following services, which are required of the
253 state by Title XIX of the Social Security Act, furnished by
254 Medicaid providers to recipients who are determined to be
255 eligible on the dates on which the services were provided. Any
256 service under this section shall be provided only when medically
257 necessary and in accordance with state and federal law.
258 Mandatory services rendered by providers in mobile units to
259 Medicaid recipients may be restricted by the agency. Nothing in
260 this section shall be construed to prevent or limit the agency
261 from adjusting fees, reimbursement rates, lengths of stay,
262 number of visits, number of services, or any other adjustments
263 necessary to comply with the availability of moneys and any
264 limitations or directions provided for in the General
265 Appropriations Act or chapter 216.
266 (4) HOME HEALTH CARE SERVICES.--The agency shall pay for
267 nursing and home health aide services, supplies, appliances, and
268 durable medical equipment, necessary to assist a recipient
269 living at home. An entity that provides services pursuant to
270 this subsection shall be licensed under part III of chapter 400.
271 These services, equipment, and supplies, or reimbursement
272 therefor, may be limited as provided in the General
273 Appropriations Act and do not include services, equipment, or
274 supplies provided to a person residing in a hospital or nursing
275 facility.
276 (a) In providing home health care services, the agency may
277 require prior authorization of care based on diagnosis or
278 utilization rates. Prior authorization is required for home
279 health services visits not associated with a skilled nursing

280 visit if the home health agency's utilization rates exceed the
281 state average by 50 percent or more. The home health agency must
282 submit documentation that supports the recipient's diagnosis and
283 the recipient's plan of care to the agency when requesting prior
284 authorization.
285 (b) The agency shall implement a comprehensive utilization
286 management program that requires prior authorization of all
287 private duty nursing services, an individualized treatment plan
288 that includes information about medication and treatment orders,
289 treatment goals, methods of care to be used, and plans for care
290 coordination by nurses and other health professionals. The
291 utilization management program shall also include a process for
292 periodically reviewing the ongoing use of private duty nursing
293 services. For a child, the assessment of need shall be based on
294 a child's condition, family support and care supplements, a
295 family's ability to provide care, and a family's and child's
296 schedule regarding work, school, sleep, and care for other
297 family dependents. When implemented, the private duty nursing
298 utilization management program shall replace the current
299 authorization program used by the Agency for Health Care
300 Administration and the Children's Medical Services program of
301 the Department of Health. The agency may competitively bid on a
302 contract to select a qualified organization to provide
303 utilization management of private duty nursing services. The
304 agency is authorized to seek federal waivers to implement this
305 initiative.
306 (c) The agency may provide reimbursement only for those
307 home health services that are medically necessary and if:

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308 1. The services are ordered by a physician.
309 2. The written prescription for services is signed and
310 dated by the recipient's physician before the development of a
311 plan of care and before any required request for prior
312 authorization.
313 3. The physician ordering the services is not employed,
314 under contract with, or otherwise affiliated with the home
315 health agency rendering the services. However, this provision
316 does not apply to a home health agency affiliated with a
317 retirement community, of which the parent corporation or a
318 related legal entity owns a rural health clinic certified under
319 42 C.F.R., part 491, subpart A, ss. 1-11, a nursing home
320 licensed under part II of chapter 400, and apartments and
321 single-family homes for independent living.
322 4. The physician ordering the services has examined the
323 recipient within 30 days before the initial request for services
324 and biannually thereafter.
325 5. The written prescription for the services includes the
326 recipient's acute or chronic medical condition or diagnosis; the
327 home health service required, including the minimum skill level
328 required to perform the service; and the frequency and duration
329 of the services.
330 6. The national provider identifier, Medicaid
331 identification number, or professional license number of the
332 physician ordering the services is listed on the written
333 prescription for the services, the claim for home health
334 reimbursement, and the prior authorization request.
335 (5) HOSPITAL INPATIENT SERVICES.--The agency shall pay for

336 all covered services provided for the medical care and treatment
337 of a recipient who is admitted as an inpatient by a licensed
338 physician or dentist to a hospital licensed under part I of
339 chapter 395. However, the agency shall limit the payment for
340 inpatient hospital services for a Medicaid recipient 21 years of
341 age or older to 45 days or the number of days necessary to
342 comply with the General Appropriations Act.
343 (c) The Agency for Health Care Administration shall adjust
344 a hospital's current inpatient per diem rate to reflect the cost
345 of serving the Medicaid population at that institution if:
346 1. The hospital experiences an increase in Medicaid
347 caseload by more than 25 percent in any year, primarily
348 resulting from the closure of a hospital in the same service
349 area occurring after July 1, 1995;
350 2. The hospital's Medicaid per diem rate is at least 25
351 percent below the Medicaid per patient cost for that year; or
352 3. The hospital is located in a county that has six ~~five~~
353 or fewer acute care bed hospitals, began offering obstetrical
354 services on or after September 1999, and has submitted a request
355 in writing to the agency for a rate adjustment after July 1,
356 2000, but before September 30, 2000, in which case such
357 hospital's Medicaid inpatient per diem rate shall be adjusted to
358 cost, effective July 1, 2002.
359
360 No later than October 1 of each year, the agency must provide
361 estimated costs for any adjustment in a hospital inpatient per
362 diem pursuant to this paragraph to the Executive Office of the
363 Governor, the House of Representatives General Appropriations

364 Committee, and the Senate Appropriations Committee. Before the
365 agency implements a change in a hospital's inpatient per diem
366 rate pursuant to this paragraph, the Legislature must have
367 specifically appropriated sufficient funds in the General
368 Appropriations Act to support the increase in cost as estimated
369 by the agency.
370 Section 6. Subsection (23) of section 409.906, Florida
371 Statutes, is amended to read:
372 409.906 Optional Medicaid services.--Subject to specific
373 appropriations, the agency may make payments for services which
374 are optional to the state under Title XIX of the Social Security
375 Act and are furnished by Medicaid providers to recipients who
376 are determined to be eligible on the dates on which the services
377 were provided. Any optional service that is provided shall be
378 provided only when medically necessary and in accordance with
379 state and federal law. Optional services rendered by providers
380 in mobile units to Medicaid recipients may be restricted or
381 prohibited by the agency. Nothing in this section shall be
382 construed to prevent or limit the agency from adjusting fees,
383 reimbursement rates, lengths of stay, number of visits, or
384 number of services, or making any other adjustments necessary to
385 comply with the availability of moneys and any limitations or
386 directions provided for in the General Appropriations Act or
387 chapter 216. If necessary to safeguard the state's systems of
388 providing services to elderly and disabled persons and subject
389 to the notice and review provisions of s. 216.177, the Governor
390 may direct the Agency for Health Care Administration to amend
391 the Medicaid state plan to delete the optional Medicaid service

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392 known as "Intermediate Care Facilities for the Developmentally
393 Disabled." Optional services may include:
394 (23) VISUAL SERVICES.--The agency may pay for visual
395 examinations, eyeglasses, and eyeglass repairs for a recipient
396 if they are prescribed by a licensed physician specializing in
397 diseases of the eye or by a licensed optometrist. Eyeglass
398 frames ~~Eyeglasses~~ for adult recipients shall be limited to one
399 pair ~~two pairs per year~~ per recipient every 2 years, except a
400 second ~~third~~ pair may be provided during that period after prior
401 authorization. Eyeglass lenses for adult recipients shall be
402 limited to one pair per year and may only be provided after
403 prior authorization.
404 Section 7. Subsection (6) of section 409.9082, Florida
405 Statutes, as created by chapter 2009-4, Laws of Florida, is
406 amended, and paragraph (d) is added to subsection (3) of that
407 section, to read:
408 409.9082 Quality assessment on nursing home facility
409 providers; exemptions; purpose; federal approval required;
410 remedies.--
411 (3)
412 (d) The agency may exempt a qualified public nursing
413 facility that is not owned or operated by the state from the
414 quality assessment or apply a lower quality assessment rate to
415 that facility if the facility's total annual census days for
416 indigent care exceed 25 percent of the facility's total annual
417 census days.
418 (6) The quality assessment shall terminate and the agency
419 shall discontinue the imposition, assessment, and collection of

420 the nursing facility quality assessment if ~~any of the following~~
421 ~~occur:~~
422 ~~(a)~~ the agency does not obtain necessary federal approval
423 for the nursing home facility quality assessment or the payment
424 rates required by subsection (4)~~; or~~
425 ~~(b) The weighted average Medicaid rate paid to nursing~~
426 ~~home facilities is reduced below the weighted average Medicaid~~
427 ~~rate to nursing home facilities in effect on December 31, 2008,~~
428 ~~plus any future annual amount of the quality assessment and the~~
429 ~~applicable matching federal funds~~.
430
431 Upon termination of the quality assessment, all collected
432 assessment revenues, less any amounts expended by the agency,
433 shall be returned on a pro rata basis to the nursing facilities
434 that paid them.
435 Section 8. Section 409.9083, Florida Statutes, is created
436 to read:
437 409.9083 Quality assessment on privately operated
438 intermediate care facilities for the developmentally disabled;
439 exemptions; purpose; federal approval required; remedies.--
440 (1) As used in this section, the term:
441 (a) "Intermediate care facility for the developmentally
442 disabled" or "ICF/DD" means a privately operated intermediate
443 care facility for the developmentally disabled licensed under
444 part VIII of chapter 400.
445 (b) "Net patient service revenue" means gross revenues
446 from services provided to ICF/DD facility residents, less
447 reductions from gross revenue resulting from an inability to

448 collect payment of charges. Net patient service revenue excludes
449 nonresident care revenues such as gain or loss on asset
450 disposal, prior year revenue, donations, and physician billings,
451 and all outpatient revenues. Reductions from gross revenue
452 include bad debts; contractual adjustments; uncompensated care;
453 administrative, courtesy, and policy discounts and adjustments;
454 and other such revenue deductions.
455 (c) "Resident day" means a calendar day of care provided
456 to an ICF/DD facility resident, including the day of admission
457 and excluding the day of discharge, except that, when admission
458 and discharge occur on the same day, 1 day of care exists.
459 (2) Effective October 1, 2009, there is imposed upon each
460 intermediate care facility for the developmentally disabled a
461 quality assessment. The aggregated amount of assessments for all
462 ICF/DDs in a given year shall be an amount not exceeding the
463 maximum percentage allowed under federal law of the total
464 aggregate net patient service revenue of assessed facilities.
465 The agency shall calculate the quality assessment rate annually
466 on a per-resident-day basis as reported by the facilities. The
467 per-resident-day assessment rate shall be uniform. Each facility
468 shall report monthly to the agency its total number of resident
469 days and shall remit an amount equal to the assessment rate
470 times the reported number of days. The agency shall collect, and
471 each facility shall pay, the quality assessment each month. The
472 agency shall collect the assessment from facility providers no
473 later than the 15th of the next succeeding calendar month. The
474 agency shall notify providers of the quality assessment rate and
475 provide a standardized form to complete and submit with

476 payments. The collection of the quality assessment shall
477 commence no sooner than 15 days after the agency's initial
478 payment to the facilities that implement the increased Medicaid
479 rates containing the elements prescribed in subsection (3) and
480 monthly thereafter. Intermediate care facilities for the
481 developmentally disabled may increase their rates to incorporate
482 the assessment but may not create a separate line-item charge
483 for the purpose of passing through the assessment to residents.
484 (3) The purpose of the facility quality assessment is to
485 ensure continued quality of care. Collected assessment funds
486 shall be used to obtain federal financial participation through
487 the Medicaid program to make Medicaid payments for ICF/DD
488 services up to the amount of the Medicaid rates for such
489 facilities as calculated in accordance with the approved state
490 Medicaid plan in effect on April 1, 2008. The quality assessment
491 and federal matching funds shall be used exclusively for the
492 following purposes and in the following order of priority:
493 (a) To reimburse the Medicaid share of the quality
494 assessment as a pass-through, Medicaid-allowable cost.
495 (b) To increase each privately operated ICF/DD Medicaid
496 rate, as needed, by an amount that restores the rate reductions
497 implemented on October 1, 2008.
498 (c) To increase each ICF/DD Medicaid rate, as needed, by
499 an amount that restores any rate reductions for the 2008-2009
500 fiscal year.
501 (d) To increase payments to such facilities to fund
502 covered services to Medicaid beneficiaries.
503 (4) The agency shall seek necessary federal approval in

504 the form of state plan amendments in order to implement the
505 provisions of this section.
506 (5)(a) The quality assessment shall terminate and the
507 agency shall discontinue the imposition, assessment, and
508 collection of the quality assessment if the agency does not
509 obtain necessary federal approval for the facility quality
510 assessment or the payment rates required by subsection (3).
511 (b) Upon termination of the quality assessment, all
512 collected assessment revenues, less any amounts expended by the
513 agency, shall be returned on a pro rata basis to the facilities
514 that paid such assessments.
515 (6) The agency may seek any of the following remedies for
516 failure of any ICF/DD provider to timely pay its assessment:
517 (a) Withholding any medical assistance reimbursement
518 payments until the assessment amount is recovered.
519 (b) Suspending or revoking the facility's license.
520 (c) Imposing a fine of up to $1,000 per day for each
521 delinquent payment, not to exceed the amount of the assessment.
522 (7) The agency shall adopt rules necessary to administer
523 this section.
524 (8) This section is repealed October 1, 2011.
525 Section 9. Paragraph (a) of subsection (2) of section
526 409.911, Florida Statutes, is amended to read:
527 409.911 Disproportionate share program.--Subject to
528 specific allocations established within the General
529 Appropriations Act and any limitations established pursuant to
530 chapter 216, the agency shall distribute, pursuant to this
531 section, moneys to hospitals providing a disproportionate share

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532 of Medicaid or charity care services by making quarterly
533 Medicaid payments as required. Notwithstanding the provisions of
534 s. 409.915, counties are exempt from contributing toward the
535 cost of this special reimbursement for hospitals serving a
536 disproportionate share of low-income patients.
537 (2) The Agency for Health Care Administration shall use
538 the following actual audited data to determine the Medicaid days
539 and charity care to be used in calculating the disproportionate
540 share payment:
541 (a) The average of the 2003, 2004, and 2005 ~~2002, 2003,~~
542 ~~and 2004~~ audited disproportionate share data to determine each
543 hospital's Medicaid days and charity care for the 2009-2010
544 ~~2008-2009~~ state fiscal year.
545 Section 10. Section 409.9112, Florida Statutes, is amended
546 to read:
547 409.9112 Disproportionate share program for regional
548 perinatal intensive care centers.--
549 (1) In addition to the payments made under s. 409.911, the
550 Agency for Health Care Administration shall design and implement
551 a system of making disproportionate share payments to those
552 hospitals that participate in the regional perinatal intensive
553 care center program established pursuant to chapter 383. This
554 system of payments shall conform with federal requirements and
555 shall distribute funds in each fiscal year for which an
556 appropriation is made by making quarterly Medicaid payments.
557 Notwithstanding the provisions of s. 409.915, counties are
558 exempt from contributing toward the cost of this special
559 reimbursement for hospitals serving a disproportionate share of

560 low-income patients. For the state fiscal year 2009-2010 ~~2008-~~
561 ~~2009~~, the agency shall not distribute moneys under the regional
562 perinatal intensive care centers disproportionate share program.
563 (2) ~~(1)~~ The following formula shall be used by the agency
564 to calculate the total amount earned for hospitals that
565 participate in the regional perinatal intensive care center
566 program:
567
568 TAE = HDSP/THDSP
569
570 Where:
571 TAE = total amount earned by a regional perinatal intensive
572 care center.
573 HDSP = the prior state fiscal year regional perinatal
574 intensive care center disproportionate share payment to the
575 individual hospital.
576 THDSP = the prior state fiscal year total regional
577 perinatal intensive care center disproportionate share payments
578 to all hospitals.
579 (3) ~~(2)~~ The total additional payment for hospitals that
580 participate in the regional perinatal intensive care center
581 program shall be calculated by the agency as follows:
582
583 TAP = TAE x TA
584
585 Where:
586 TAP = total additional payment for a regional perinatal
587 intensive care center.

588 TAE = total amount earned by a regional perinatal intensive
589 care center.
590 TA = total appropriation for the regional perinatal
591 intensive care center disproportionate share program.
592 (4) ~~(3)~~ In order to receive payments under this section, a
593 hospital must be participating in the regional perinatal
594 intensive care center program pursuant to chapter 383 and must
595 meet the following additional requirements:
596 (a) Agree to conform to all departmental and agency
597 requirements to ensure high quality in the provision of
598 services, including criteria adopted by departmental and agency
599 rule concerning staffing ratios, medical records, standards of
600 care, equipment, space, and such other standards and criteria as
601 the department and agency deem appropriate as specified by rule.
602 (b) Agree to provide information to the department and
603 agency, in a form and manner to be prescribed by rule of the
604 department and agency, concerning the care provided to all
605 patients in neonatal intensive care centers and high-risk
606 maternity care.
607 (c) Agree to accept all patients for neonatal intensive
608 care and high-risk maternity care, regardless of ability to pay,
609 on a functional space-available basis.
610 (d) Agree to develop arrangements with other maternity and
611 neonatal care providers in the hospital's region for the
612 appropriate receipt and transfer of patients in need of
613 specialized maternity and neonatal intensive care services.
614 (e) Agree to establish and provide a developmental
615 evaluation and services program for certain high-risk neonates,

616 as prescribed and defined by rule of the department.
617 (f) Agree to sponsor a program of continuing education in
618 perinatal care for health care professionals within the region
619 of the hospital, as specified by rule.
620 (g) Agree to provide backup and referral services to the
621 department's county health departments and other low-income
622 perinatal providers within the hospital's region, including the
623 development of written agreements between these organizations
624 and the hospital.
625 (h) Agree to arrange for transportation for high-risk
626 obstetrical patients and neonates in need of transfer from the
627 community to the hospital or from the hospital to another more
628 appropriate facility.
629 (5) ~~(4)~~ Hospitals which fail to comply with any of the
630 conditions in subsection (4) ~~(3)~~ or the applicable rules of the
631 department and agency shall not receive any payments under this
632 section until full compliance is achieved. A hospital which is
633 not in compliance in two or more consecutive quarters shall not
634 receive its share of the funds. Any forfeited funds shall be
635 distributed by the remaining participating regional perinatal
636 intensive care center program hospitals.
637 Section 11. Section 409.9113, Florida Statutes, is amended
638 to read:
639 409.9113 Disproportionate share program for teaching
640 hospitals.--
641 (1) In addition to the payments made under ss. 409.911 and
642 409.9112, the Agency for Health Care Administration shall make
643 disproportionate share payments to statutorily defined teaching

644 hospitals for their increased costs associated with medical
645 education programs and for tertiary health care services
646 provided to the indigent. This system of payments shall conform
647 with federal requirements and shall distribute funds in each
648 fiscal year for which an appropriation is made by making
649 quarterly Medicaid payments. Notwithstanding s. 409.915,
650 counties are exempt from contributing toward the cost of this
651 special reimbursement for hospitals serving a disproportionate
652 share of low-income patients. For the state fiscal year 2009-
653 2010 ~~2008-2009~~, the agency shall distribute the moneys provided
654 in the General Appropriations Act to statutorily defined
655 teaching hospitals and family practice teaching hospitals under
656 the teaching hospital disproportionate share program. The funds
657 provided for statutorily defined teaching hospitals shall be
658 distributed in the same proportion as the state fiscal year
659 2003-2004 teaching hospital disproportionate share funds were
660 distributed or as otherwise provided in the General
661 Appropriations Act. The funds provided for family practice
662 teaching hospitals shall be distributed equally among family
663 practice teaching hospitals.
664 (2) ~~(1)~~ On or before September 15 of each year, the Agency
665 for Health Care Administration shall calculate an allocation
666 fraction to be used for distributing funds to state statutory
667 teaching hospitals. Subsequent to the end of each quarter of the
668 state fiscal year, the agency shall distribute to each statutory
669 teaching hospital, as defined in s. 408.07, an amount determined
670 by multiplying one-fourth of the funds appropriated for this
671 purpose by the Legislature times such hospital's allocation

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672 fraction. The allocation fraction for each such hospital shall
673 be determined by the sum of three primary factors, divided by
674 three. The primary factors are:
675 (a) The number of nationally accredited graduate medical
676 education programs offered by the hospital, including programs
677 accredited by the Accreditation Council for Graduate Medical
678 Education and the combined Internal Medicine and Pediatrics
679 programs acceptable to both the American Board of Internal
680 Medicine and the American Board of Pediatrics at the beginning
681 of the state fiscal year preceding the date on which the
682 allocation fraction is calculated. The numerical value of this
683 factor is the fraction that the hospital represents of the total
684 number of programs, where the total is computed for all state
685 statutory teaching hospitals.
686 (b) The number of full-time equivalent trainees in the
687 hospital, which comprises two components:
688 1. The number of trainees enrolled in nationally
689 accredited graduate medical education programs, as defined in
690 paragraph (a). Full-time equivalents are computed using the
691 fraction of the year during which each trainee is primarily
692 assigned to the given institution, over the state fiscal year
693 preceding the date on which the allocation fraction is
694 calculated. The numerical value of this factor is the fraction
695 that the hospital represents of the total number of full-time
696 equivalent trainees enrolled in accredited graduate programs,
697 where the total is computed for all state statutory teaching
698 hospitals.
699 2. The number of medical students enrolled in accredited

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700 colleges of medicine and engaged in clinical activities,
701 including required clinical clerkships and clinical electives.
702 Full-time equivalents are computed using the fraction of the
703 year during which each trainee is primarily assigned to the
704 given institution, over the course of the state fiscal year
705 preceding the date on which the allocation fraction is
706 calculated. The numerical value of this factor is the fraction
707 that the given hospital represents of the total number of full-
708 time equivalent students enrolled in accredited colleges of
709 medicine, where the total is computed for all state statutory
710 teaching hospitals.
711
712 The primary factor for full-time equivalent trainees is computed
713 as the sum of these two components, divided by two.
714 (c) A service index that comprises three components:
715 1. The Agency for Health Care Administration Service
716 Index, computed by applying the standard Service Inventory
717 Scores established by the Agency for Health Care Administration
718 to services offered by the given hospital, as reported on
719 Worksheet A-2 for the last fiscal year reported to the agency
720 before the date on which the allocation fraction is calculated.
721 The numerical value of this factor is the fraction that the
722 given hospital represents of the total Agency for Health Care
723 Administration Service Index values, where the total is computed
724 for all state statutory teaching hospitals.
725 2. A volume-weighted service index, computed by applying
726 the standard Service Inventory Scores established by the Agency
727 for Health Care Administration to the volume of each service,

728 expressed in terms of the standard units of measure reported on
729 Worksheet A-2 for the last fiscal year reported to the agency
730 before the date on which the allocation factor is calculated.
731 The numerical value of this factor is the fraction that the
732 given hospital represents of the total volume-weighted service
733 index values, where the total is computed for all state
734 statutory teaching hospitals.
735 3. Total Medicaid payments to each hospital for direct
736 inpatient and outpatient services during the fiscal year
737 preceding the date on which the allocation factor is calculated.
738 This includes payments made to each hospital for such services
739 by Medicaid prepaid health plans, whether the plan was
740 administered by the hospital or not. The numerical value of this
741 factor is the fraction that each hospital represents of the
742 total of such Medicaid payments, where the total is computed for
743 all state statutory teaching hospitals.
744
745 The primary factor for the service index is computed as the sum
746 of these three components, divided by three.
747 (3) ~~(2)~~ By October 1 of each year, the agency shall use the
748 following formula to calculate the maximum additional
749 disproportionate share payment for statutorily defined teaching
750 hospitals:
751
752 TAP = THAF x A
753
754 Where:
755 TAP = total additional payment.

756 THAF = teaching hospital allocation factor.
757 A = amount appropriated for a teaching hospital
758 disproportionate share program.
759 Section 12. Section 409.9117, Florida Statutes, is amended
760 to read:
761 409.9117 Primary care disproportionate share program.--
762 (1) For the state fiscal year 2009-2010 ~~2008-2009~~, the
763 agency shall not distribute moneys under the primary care
764 disproportionate share program.
765 (2) ~~(1)~~ If federal funds are available for disproportionate
766 share programs in addition to those otherwise provided by law,
767 there shall be created a primary care disproportionate share
768 program.
769 (3) ~~(2)~~ The following formula shall be used by the agency
770 to calculate the total amount earned for hospitals that
771 participate in the primary care disproportionate share program:
772
773 TAE = HDSP/THDSP
774
775 Where:
776 TAE = total amount earned by a hospital participating in
777 the primary care disproportionate share program.
778 HDSP = the prior state fiscal year primary care
779 disproportionate share payment to the individual hospital.
780 THDSP = the prior state fiscal year total primary care
781 disproportionate share payments to all hospitals.
782 (4) ~~(3)~~ The total additional payment for hospitals that
783 participate in the primary care disproportionate share program

784 shall be calculated by the agency as follows:

785

786 TAP = TAE x TA

787

788 Where:

789 TAP = total additional payment for a primary care hospital.

790 TAE = total amount earned by a primary care hospital.

791 TA = total appropriation for the primary care

792 disproportionate share program.

793 (5) ~~(4)~~ In the establishment and funding of this program,

794 the agency shall use the following criteria in addition to those

795 specified in s. 409.911, payments may not be made to a hospital

796 unless the hospital agrees to:

797 (a) Cooperate with a Medicaid prepaid health plan, if one

798 exists in the community.

799 (b) Ensure the availability of primary and specialty care

800 physicians to Medicaid recipients who are not enrolled in a

801 prepaid capitated arrangement and who are in need of access to

802 such physicians.

803 (c) Coordinate and provide primary care services free of

804 charge, except copayments, to all persons with incomes up to 100

805 percent of the federal poverty level who are not otherwise

806 covered by Medicaid or another program administered by a

807 governmental entity, and to provide such services based on a

808 sliding fee scale to all persons with incomes up to 200 percent

809 of the federal poverty level who are not otherwise covered by

810 Medicaid or another program administered by a governmental

811 entity, except that eligibility may be limited to persons who

812 reside within a more limited area, as agreed to by the agency
813 and the hospital.
814 (d) Contract with any federally qualified health center,
815 if one exists within the agreed geopolitical boundaries,
816 concerning the provision of primary care services, in order to
817 guarantee delivery of services in a nonduplicative fashion, and
818 to provide for referral arrangements, privileges, and
819 admissions, as appropriate. The hospital shall agree to provide
820 at an onsite or offsite facility primary care services within 24
821 hours to which all Medicaid recipients and persons eligible
822 under this paragraph who do not require emergency room services
823 are referred during normal daylight hours.
824 (e) Cooperate with the agency, the county, and other
825 entities to ensure the provision of certain public health
826 services, case management, referral and acceptance of patients,
827 and sharing of epidemiological data, as the agency and the
828 hospital find mutually necessary and desirable to promote and
829 protect the public health within the agreed geopolitical
830 boundaries.
831 (f) In cooperation with the county in which the hospital
832 resides, develop a low-cost, outpatient, prepaid health care
833 program to persons who are not eligible for the Medicaid
834 program, and who reside within the area.
835 (g) Provide inpatient services to residents within the
836 area who are not eligible for Medicaid or Medicare, and who do
837 not have private health insurance, regardless of ability to pay,
838 on the basis of available space, except that nothing shall
839 prevent the hospital from establishing bill collection programs

840 based on ability to pay.
841 (h) Work with the Florida Healthy Kids Corporation, the
842 Florida Health Care Purchasing Cooperative, and business health
843 coalitions, as appropriate, to develop a feasibility study and
844 plan to provide a low-cost comprehensive health insurance plan
845 to persons who reside within the area and who do not have access
846 to such a plan.
847 (i) Work with public health officials and other experts to
848 provide community health education and prevention activities
849 designed to promote healthy lifestyles and appropriate use of
850 health services.
851 (j) Work with the local health council to develop a plan
852 for promoting access to affordable health care services for all
853 persons who reside within the area, including, but not limited
854 to, public health services, primary care services, inpatient
855 services, and affordable health insurance generally.
856
857 Any hospital that fails to comply with any of the provisions of
858 this subsection, or any other contractual condition, may not
859 receive payments under this section until full compliance is
860 achieved.
861 Section 13. Paragraph (g) is added to subsection (5) of
862 section 409.912, Florida Statutes, and subsections (54) and (55)
863 are added to that section, to read:
864 409.912 Cost-effective purchasing of health care.--The
865 agency shall purchase goods and services for Medicaid recipients
866 in the most cost-effective manner consistent with the delivery
867 of quality medical care. To ensure that medical services are

868 effectively utilized, the agency may, in any case, require a
869 confirmation or second physician's opinion of the correct
870 diagnosis for purposes of authorizing future services under the
871 Medicaid program. This section does not restrict access to
872 emergency services or poststabilization care services as defined
873 in 42 C.F.R. part 438.114. Such confirmation or second opinion
874 shall be rendered in a manner approved by the agency. The agency
875 shall maximize the use of prepaid per capita and prepaid
876 aggregate fixed-sum basis services when appropriate and other
877 alternative service delivery and reimbursement methodologies,
878 including competitive bidding pursuant to s. 287.057, designed
879 to facilitate the cost-effective purchase of a case-managed
880 continuum of care. The agency shall also require providers to
881 minimize the exposure of recipients to the need for acute
882 inpatient, custodial, and other institutional care and the
883 inappropriate or unnecessary use of high-cost services. The
884 agency shall contract with a vendor to monitor and evaluate the
885 clinical practice patterns of providers in order to identify
886 trends that are outside the normal practice patterns of a
887 provider's professional peers or the national guidelines of a
888 provider's professional association. The vendor must be able to
889 provide information and counseling to a provider whose practice
890 patterns are outside the norms, in consultation with the agency,
891 to improve patient care and reduce inappropriate utilization.
892 The agency may mandate prior authorization, drug therapy
893 management, or disease management participation for certain
894 populations of Medicaid beneficiaries, certain drug classes, or
895 particular drugs to prevent fraud, abuse, overuse, and possible

896 dangerous drug interactions. The Pharmaceutical and Therapeutics
897 Committee shall make recommendations to the agency on drugs for
898 which prior authorization is required. The agency shall inform
899 the Pharmaceutical and Therapeutics Committee of its decisions
900 regarding drugs subject to prior authorization. The agency is
901 authorized to limit the entities it contracts with or enrolls as
902 Medicaid providers by developing a provider network through
903 provider credentialing. The agency may competitively bid single-
904 source-provider contracts if procurement of goods or services
905 results in demonstrated cost savings to the state without
906 limiting access to care. The agency may limit its network based
907 on the assessment of beneficiary access to care, provider
908 availability, provider quality standards, time and distance
909 standards for access to care, the cultural competence of the
910 provider network, demographic characteristics of Medicaid
911 beneficiaries, practice and provider-to-beneficiary standards,
912 appointment wait times, beneficiary use of services, provider
913 turnover, provider profiling, provider licensure history,
914 previous program integrity investigations and findings, peer
915 review, provider Medicaid policy and billing compliance records,
916 clinical and medical record audits, and other factors. Providers
917 shall not be entitled to enrollment in the Medicaid provider
918 network. The agency shall determine instances in which allowing
919 Medicaid beneficiaries to purchase durable medical equipment and
920 other goods is less expensive to the Medicaid program than long-
921 term rental of the equipment or goods. The agency may establish
922 rules to facilitate purchases in lieu of long-term rentals in
923 order to protect against fraud and abuse in the Medicaid program

924 as defined in s. 409.913. The agency may seek federal waivers
925 necessary to administer these policies.
926 (5) The Agency for Health Care Administration, in
927 partnership with the Department of Elderly Affairs, shall create
928 an integrated, fixed-payment delivery program for Medicaid
929 recipients who are 60 years of age or older or dually eligible
930 for Medicare and Medicaid. The Agency for Health Care
931 Administration shall implement the integrated program initially
932 on a pilot basis in two areas of the state. The pilot areas
933 shall be Area 7 and Area 11 of the Agency for Health Care
934 Administration. Enrollment in the pilot areas shall be on a
935 voluntary basis and in accordance with approved federal waivers
936 and this section. The agency and its program contractors and
937 providers shall not enroll any individual in the integrated
938 program because the individual or the person legally responsible
939 for the individual fails to choose to enroll in the integrated
940 program. Enrollment in the integrated program shall be
941 exclusively by affirmative choice of the eligible individual or
942 by the person legally responsible for the individual. The
943 integrated program must transfer all Medicaid services for
944 eligible elderly individuals who choose to participate into an
945 integrated-care management model designed to serve Medicaid
946 recipients in the community. The integrated program must combine
947 all funding for Medicaid services provided to individuals who
948 are 60 years of age or older or dually eligible for Medicare and
949 Medicaid into the integrated program, including funds for
950 Medicaid home and community-based waiver services; all Medicaid
951 services authorized in ss. 409.905 and 409.906, excluding funds

952 for Medicaid nursing home services unless the agency is able to
953 demonstrate how the integration of the funds will improve
954 coordinated care for these services in a less costly manner; and
955 Medicare coinsurance and deductibles for persons dually eligible
956 for Medicaid and Medicare as prescribed in s. 409.908(13).
957 (g) The implementation of the integrated, fixed-payment
958 delivery program created under this subsection is subject to an
959 appropriation in the General Appropriations Act.
960 (54) The agency shall develop and implement a home health
961 agency monitoring pilot project in Miami-Dade County by January
962 1, 2010. The agency shall contract with a vendor to verify the
963 utilization and the delivery of home health services and provide
964 an electronic billing interface for home health services. The
965 contract must require the creation of a program to submit claims
966 for the home health services electronically. The program must
967 verify visits for the delivery of home health services
968 telephonically using voice biometrics. The agency may seek
969 amendments to the Medicaid state plan and waivers of federal
970 laws, as necessary, to implement the pilot project.
971 Notwithstanding s. 287.057(5)(f), the agency must award the
972 contract through the competitive solicitation process. The
973 agency shall submit a report to the Governor, the President of
974 the Senate, and the Speaker of the House of Representatives
975 evaluating the pilot project by February 1, 2011.
976 (55) The agency shall implement a comprehensive care
977 management pilot project in Miami-Dade County for home health
978 services by January 1, 2010, which includes face-to-face
979 assessments by a state-licensed nurse, consultation with

980 physicians ordering services to substantiate the medical
981 necessity for services, and onsite or desk reviews of
982 recipients' medical records. The agency may enter into a
983 contract with a qualified organization to implement the pilot
984 project. The agency may seek amendments to the Medicaid state
985 plan and waivers of federal laws, as necessary, to implement the
986 pilot project.
987 Section 14. Paragraph (e) of subsection (3) and subsection
988 (12) of section 409.91211, Florida Statutes, are amended to
989 read:
990 409.91211 Medicaid managed care pilot program.--
991 (3) The agency shall have the following powers, duties,
992 and responsibilities with respect to the pilot program:
993 (e) To implement policies and guidelines for phasing in
994 financial risk for approved provider service networks over a 5-
995 year ~~3-year~~ period. These policies and guidelines must include
996 an option for a provider service network to be paid fee-for-
997 service rates. For any provider service network established in a
998 managed care pilot area, the option to be paid fee-for-service
999 rates shall include a savings-settlement mechanism that is
1000 consistent with s. 409.912(44). This model shall be converted to
1001 a risk-adjusted capitated rate no later than the beginning of
1002 the sixth ~~fourth~~ year of operation, and may be converted earlier
1003 at the option of the provider service network. Federally
1004 qualified health centers may be offered an opportunity to accept
1005 or decline a contract to participate in any provider network for
1006 prepaid primary care services.
1007 (12) For purposes of this section, the term "capitated

1008 managed care plan" includes health insurers authorized under
1009 chapter 624, exclusive provider organizations authorized under
1010 chapter 627, health maintenance organizations authorized under
1011 chapter 641, the Children's Medical Services Network under
1012 chapter 391, and provider service networks that elect to be paid
1013 fee-for-service for up to 5 ~~3~~ years as authorized under this
1014 section.
1015 Section 15. Subsection (18) is added to section 430.04,
1016 Florida Statutes, to read:
1017 430.04 Duties and responsibilities of the Department of
1018 Elderly Affairs.--The Department of Elderly Affairs shall:
1019 (18) Administer all Medicaid waivers and programs relating
1020 to elders and their appropriations. The waivers include, but are
1021 not limited to, the following:
1022 (a) Alzheimer's Dementia-Specific Medicaid Waiver as
1023 defined in s. 430.502(7),(8), and (9).
1024 (b) Assisted Living for the Elderly Medicaid Waiver.
1025 (c) Aged and Disabled Adult Medicaid Waiver.
1026 (d) Adult Day Health Care Waiver.
1027 (e) Consumer-directed care program as defined in s.
1028 409.221.
1029 (f) Program of All-inclusive Care for the Elderly.
1030 (g) Long-term care community-based diversion pilot
1031 projects as defined in s. 430.705.
1032 (h) Channeling Services Waiver for Frail Elders.
1033 Section 16. Section 430.707, Florida Statutes, is amended
1034 to read:
1035 430.707 Contracts.--

(1) The department, in consultation with the agency, shall select and contract with managed care organizations and, on a prepaid basis, with other qualified providers as defined in s. 430.703(7) to provide long-term care within community diversion pilot project areas. All providers shall report quarterly to the department regarding the entity's compliance with all the financial and quality assurance requirements of the contract.

(2) The department, in consultation with the agency, may contract with entities that ~~which~~ have submitted an application as a community nursing home diversion project as of July 1, 1998, to provide benefits pursuant to the "Program of All-inclusive Care for the Elderly" as established in Pub. L. No. 105-33. For the purposes of this community nursing home diversion project, such entities are ~~shall be~~ exempt from the requirements of chapter 641~~,~~ if the entity is a private, nonprofit, superior-rated nursing home and if ~~with~~ at least 50 percent of its residents are eligible for Medicaid. The agency, in consultation with the department, shall accept and forward to the Centers for Medicare and Medicaid Services an application for expansion of the pilot project from an entity that provides benefits pursuant to the Program of All-inclusive Care for the Elderly and that is in good standing with the agency, the department, and the Centers for Medicare and Medicaid Services.

Section 17. This act shall take effect July 1, 2009.