CHAPTER 2026-236

House Bill No. 5301-E

An act relating to health care; amending s. 381.4015, F.S.; providing that a specified loan program administered by the Department of Health is subject to appropriation; amending s. 383.14, F.S.; providing that, beginning on a specified date, the department must require newborns to be screened for infantile Krabbe disease and metachromatic leukodystrophy; creating s. 383.1401, F.S.; authorizing the department to create an educational pamphlet on the nutritional needs of preterm infants; requiring the department to provide the pamphlet electronically by a specified date; providing requirements for such pamphlet; amending s. 393.066, F.S.; requiring the Agency for Persons with Disabilities to reimburse certain providers using monthly and hourly rates for certain recipients; amending s. 395.4025, F.S.; providing requirements for specified designation of certain specialty licensed children's hospitals; amending s. 395.902, F.S.; removing a specified allocation for specified positions at behavioral health teaching hospitals; amending s. 395.903, F.S.; revising uses for certain grant funding for behavioral health teaching hospitals; amending s. 409.145, F.S.; revising the monthly room and board rates the department is required to pay to certain foster parents and caregivers; amending s. 409.1455, F.S.; renaming the Step into Success Workforce Education and Internship Pilot Program as the Step into Success Workforce Education and Internship Program; removing a provision limiting the duration of the program; requiring the Office of Continuing Care within the Department of Children and Families to develop certain cohorts within specified regions, to collaborate with certain organizations to recruit mentors and organizations, and to provide eligible former foster youth with internship placement opportunities; removing a provision requiring that the program be administered in a certain manner; requiring the office to develop trauma-informed training for mentors of certain former foster youth; providing requirements for the training; authorizing the office to provide certain additional trainings on mentorship of special populations; revising the amount of monthly financial assistance that the office provides to participating former foster youth; requiring the office to assign experienced staff to serve as program liaisons for a specified purpose; revising qualifications to serve as a mentor; authorizing the department to offer certain training to mentors; authorizing an employee who serves as a mentor to participate in certain additional trainings; removing a provision authorizing the offset of a reduction in or loss of certain benefits due to receipt of a Step into Success stipend by an additional stipend payment; creating s. 409.1475, F.S.; providing legislative findings and intent; creating the Foster and Family Support Grant Program within the department; requiring the department to award grants to not-for-profit, faith-based organizations for specified purposes; requiring that the program emphasize certain support; specifying authorized uses for awarded grant funds; requiring grant recipients

to submit reports to the department in a format and at intervals prescribed by the department; authorizing the department to adopt rules; amending s. 409.908, F.S.; revising specified rate setting parameters for a specified reimbursement payment methodology; amending s. 409.909, F.S.; revising and providing allocation requirements for the Slots for Doctors Program; defining the term "Medicaid payments"; amending s. 409.91195, F.S.; revising the purpose of the Medicaid Pharmaceutical and Therapeutics Committee to include creation of a Medicaid preferred product list; requiring the Agency for Health Care Administration to adopt such list upon recommendation of the committee; specifying the frequency with which the committee must review such list for certain recommendations; specifying parameters for such recommendations; providing that reimbursement for products not included on such list is subject to prior authorization; requiring the agency to publish and disseminate such list to all Medicaid providers in the state by posting on the agency's website or in other media; providing requirements for public testimony relating to proposed inclusions on or exclusions from such list; amending s. 409.912, F.S.; revising Medicaid preferred drug coverage guidelines; requiring the agency to implement a Medicaid therapeutic supplies spending-control program; authorizing the agency to negotiate with manufacturers for rebates and participate in multistate organizations negotiating for such rebates; requiring the agency to establish a preferred product list; providing requirements for such list; exempting the agency from the rulemaking procedures of ch. 120, F.S., when publishing such lists and updates; creating s. 409.9207, F.S.; providing legislative intent; providing definitions; creating the Eligibility Assistance Program within the department; providing program requirements; requiring the department to be operated by an independent contractor that shall be selected based on specified criteria; amending s. 409.967, F.S.; revising the maximum term for Medicaid managed care contracts; requiring the agency to establish by contract a quality withhold incentive for certain purposes; providing requirements for such incentive; amending s. 409.968, F.S.; providing adjustment requirements for specified payments made to managed care plans; amending s. 409.982, F.S.; authorizing the agency to establish a provider reimbursement fee schedule for certain purposes; amending s. 409.9855, F.S.; providing waiver transfer funding requirements for specified individuals; amending s. 409.986, F.S.; defining the term "qualified provider"; amending s. 409.990, F.S.; revising the amount of documented unexpended state funds a lead agency may carry forward; amending s. 409.996, F.S.; authorizing the department to establish a standard statewide provider contract for certain purposes; providing contract requirements; requiring the department to publish such contract on its website; authorizing lead agencies to establish additional contract terms under certain circumstances; amending s. 414.56, F.S.; conforming a provision to changes made by the act; reenacting ss. 409.978(2) and 409.9855(1)(b), F.S., relating to the long-term care managed care program and the pilot program for individuals with developmental disabilities, respectively; amending ss. 409.91196 and 393.065, F.S.; conforming cross-references; providing effective dates.

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

Section 1. Subsection (7) of section 381.4015, Florida Statutes, is amended to read:

381.4015 Florida health care innovation.—

(7) REVOLVING LOAN PROGRAM.—The department shall, subject to appropriation, administer a revolving loan program for applicants seeking to implement innovative solutions in this state.

(a) Administration.—The council may make recommendations to the department for the administration of the loans. The department shall adopt rules:

1. Establishing an application process to submit and review funding proposals for loans. Such rules must also include the process for the council to review applications to ensure compliance with applicable laws, including those related to discrimination and conflicts of interest. If a council member participated in the vote of the council recommending an award for a proposal with which the council member has a conflict of interest, the division may not award the loan to that entity.

2. Establishing eligibility criteria to be applied by the council in recommending applications for the award of loans which:

a. Incorporate the recommendations of the council. The council shall recommend to the department criteria based upon input received and the focus areas developed. The council may recommend updated criteria as necessary, based upon the most recent input, best practice recommendations, or focus areas list.

b. Determine which proposals are likely to provide the greatest return to the state if funded, taking into consideration, at a minimum, the degree to which the proposal would increase efficiency in the health care system in this state, reduce strain on the state's health care workforce, improve patient outcomes, increase public access to health care in this state, or provide cost savings to patients or the state without reducing the quality of patient care.

3. It deems necessary to administer the program, including, but not limited to, rules for application requirements, the ability of the applicant to properly administer funds, the professional excellence of the applicant, the fiscal stability of the applicant, the state or regional impact of the proposal, matching requirements for the proposal, and other requirements to further the purposes of the program.

(b) Eligibility.—

1. The following entities may apply for a revolving loan:

a. Entities licensed, registered, or certified by the Agency for Health Care Administration as provided under s. 408.802, except for those specified in s. 408.802(1), (3), (13), (23), or (25).

b. An education or clinical training provider in partnership with an entity under sub-subparagraph a.

2.a. Council members may not receive loans under the program.

b. An entity that has a conflict-of-interest relationship with a council member as described in sub-subparagraph (3)(c)1.b. or sub-subparagraph (3)(c)1.c. may not receive a loan under the program unless that council member recused himself or herself from consideration of the entity's application.

3. Priority must be given to applicants located in a rural or medically underserved area as designated by the department which are:

a. Rural hospitals as defined in s. 395.602(2).

b. Nonprofit entities that accept Medicaid patients.

4. The department may award a loan for up to 50 percent of the total projected implementation costs, or up to 80 percent of total projected implementation costs for an applicant under subparagraph 3. The applicant must demonstrate the source of funding it will use to cover the remainder of the total projected implementation costs, which funding must be from nonstate sources.

(c) Applications.—

1. The department shall set application periods to apply for loans. The department may set multiple application periods in a fiscal year, with up to four periods per year. The department shall coordinate with the council when establishing application periods to establish separate priority, in addition to eligibility, within the loan applications for defined categories based on the current focus area list. The department shall publicize the availability of loans under the program to stakeholders, education or training providers, and others.

2. Upon receipt of an application, the department shall determine whether the application is complete and the applicant has demonstrated the ability to repay the loan. Within 30 days after the close of the application period, the department shall forward all completed applications to the council for consideration.

3. The council shall review applications for loans under the criteria and pursuant to the processes and format adopted by the department. The council shall submit to the department for approval lists of applicants that it recommends for funding, arranged in order of priority and as required for the application period.

4. A loan applicant must demonstrate plans to use the funds to implement one or more innovative technologies, workforce pathways, service delivery models, or other solutions in order to fill a demonstrated need; obtain or upgrade necessary equipment, hardware, and materials; adopt new technologies or systems; or a combination thereof which will improve the quality and delivery of health care in measurable and sustainable ways and which will lower costs and allow savings to be passed on to health care consumers.

(d) Awards.—

1. The amount of each loan must be based upon demonstrated need and availability of funds. The department may not award more than 10 percent of the total allocated funds for the fiscal year to a single loan applicant.

2. The interest rate for each loan may not exceed 1 percent.

3. The term of each loan is up to 10 years.

4. In order to equitably distribute limited state funding, applicants may apply for and be awarded only one loan per fiscal year. If a loan recipient has one or more outstanding loans at any time, the recipient may apply for funding for a new loan if the current loans are in good standing.

(e) Written agreement.—

1. Each loan recipient must enter into a written agreement with the department to receive the loan. At a minimum, the agreement with the applicant must specify all of the following:

a. The total amount of the award.

b. The performance conditions that must be met, based upon the submitted proposal and the defined category or focus area, as applicable.

c. The information to be reported on actual implementation costs, including the share from nonstate resources.

d. The schedule for payment.

e. The data and progress reporting requirements and schedule.

f. Any sanctions that would apply for failure to meet performance conditions.

2. The department shall develop uniform data reporting requirements for loan recipients to evaluate the performance of the implemented proposals. Such data must be shared with the council.

3. If requested, the department shall provide technical assistance to loan recipients under the program.

(f) Loan repayment.—Loans become due and payable in accordance with the terms of the written agreement. All repayments of principal received by the department in a fiscal year shall be returned to the revolving loan fund and made available for loans to other applicants.

(g) Revolving loan fund.—The department shall create and maintain a separate account in the Grants and Donations Trust Fund within the department as a fund for the program. All repayments of principal must be returned to the revolving loan fund and made available as provided in this section. Notwithstanding s. 216.301, funds appropriated for the revolving loan program are not subject to reversion. The department may contract with a third-party administrator to administer the program, including loan servicing, and manage the revolving loan fund. A contract for a third-party administrator which includes management of the revolving loan fund must, at a minimum, require maintenance of the revolving loan fund to ensure that the program may operate in a revolving manner.

Section 2. Paragraph (a) of subsection (2) of section 383.14, Florida Statutes, is amended to read:

383.14 Screening for metabolic disorders, other hereditary and congenital disorders, and environmental risk factors.—

(2) RULES.—

(a) After consultation with the Genetics and Newborn Screening Advisory Council, the department shall adopt and enforce rules requiring that every newborn in this state shall:

1. Before becoming 1 week of age, have a blood specimen collected for newborn screenings;

2. Be tested for any condition included on the federal Recommended Uniform Screening Panel which the council advises the department should be included under the state's screening program. After the council recommends that a condition be included, the department shall submit a legislative budget request to seek an appropriation to add testing of the condition to the newborn screening program. The department shall expand statewide screening of newborns to include screening for such conditions within 18 months after the council renders such advice, if a test approved by the United States Food and Drug Administration or a test offered by an alternative vendor is available. If such a test is not available within 18 months after the council makes its recommendation, the department shall implement such screening as soon as a test offered by the United States Food and Drug Administration or by an alternative vendor is available;

3. At the appropriate age, be tested for such other metabolic diseases and hereditary or congenital disorders as the department may deem necessary; and

4. ~~Subject to legislative appropriation,~~ Beginning January 1, 2027, be screened for all of the following:

a. Duchenne muscular dystrophy.

b. Infantile Krabbe disease.

c. Metachromatic leukodystrophy.

Section 3. Section 383.1401, Florida Statutes, is created to read:

383.1401 Neonatal Nutrition.—The Department of Health shall create an evidence-based, educational pamphlet on the nutritional needs of preterm infants. By January 1, 2027, the department shall make the pamphlet available electronically to hospitals licensed under chapter 395 to provide neonatal intensive care services. Such hospitals may provide the pamphlet to parents and guardians of infants receiving care in a neonatal intensive care unit. The pamphlet must include, but need not be limited to, information on preterm infants relating to all of the following:

(1) The specific nutritional needs of preterm infants;

(2) The health risks associated with nutritional deficits and the potential need for nutritional supplementation;

(3) Different nutritional sources for infants, including maternal breast milk, pasteurized human donor milk, infant formula, human-milk-derived fortifiers, and bovine-milk-derived fortifiers, and the recommended uses for each type of nutritional source;

(4) The importance of maternal breast milk for meeting the nutritional and developmental needs of infants, and the alternative of pasteurized human donor milk if maternal breast milk is not available;

(5) The importance of having a physician discuss with family members the risks and benefits of all nutritional sources available, based on the preterm infant's individual situation; and

(6) Necrotizing enterocolitis, the risk factors for necrotizing enterocolitis, and the potential for a human-milk-based diet, including maternal and pasteurized donor breast milk, to reduce the risk of necrotizing enterocolitis.

Section 4. Subsection (9) of section 393.066, Florida Statutes, is renumbered as subsection (10), and a new subsection (9) is added to that section to read:

393.066 Community services and treatment.—

(9) The agency shall utilize a monthly reimbursement rate, developed by the Agency for Health Care Administration in consultation with the agency, for Life Skills Development Level 3 and Level 4 services. The monthly reimbursement rate shall apply to services for clients who receive at least 80

hours of such services during a calendar month. For clients who receive less than 80 hours of services during a calendar month, providers shall be reimbursed using an hourly reimbursement rate.

Section 5. Paragraph (g) of subsection (16) of section 395.4025, Florida Statutes, is redesignated as paragraph (h), and a new paragraph (g) is added to that subsection to read:

395.4025 Trauma centers; selection; quality assurance; records.—

(16)

(g) Notwithstanding the statutory capacity limits established in s. 395.402(1), the provisions of subsection (8), or any other provision of this part, specialty licensed children's hospitals licensed by the agency shall be designated by the department as a Level I or Level II pediatric trauma center based on documentation of a valid certification of trauma center verification by the American College of Surgeons.

Section 6. Subsection (6) of section 395.902, Florida Statutes, is amended to read:

395.902 Behavioral health teaching hospitals.—

(6) Upon designating a behavioral health teaching hospital under this section, the agency shall award the hospital funds as follows:

(a) For up to 10 resident positions through the Slots for Doctors Program established in s. 409.909. ~~Notwithstanding that section, the agency shall allocate $150,000 for each such position.~~

(b) Through the Training, Education, and Clinicals in Health Funding Program established in s. 409.91256 to offset a portion of the costs of maintaining integrated workforce development programs.

Section 7. Section 395.903, Florida Statutes, is amended to read:

395.903 Behavioral Health Teaching Hospital grant program.—

(1) There is established within the agency a grant program for the purpose of funding designated behavioral health teaching hospitals, subject to legislative appropriation. Grant funding may be used for operational expenses for the delivery of comprehensive wrap-around rehabilitative services for behavioral health patients ~~operations and expenses~~ and ~~for~~ fixed capital outlay expenses that are directly related to the provision of behavioral health services by the behavioral health teaching hospital or its subcontracted behavioral health care provider, including, but not limited to:~~,~~

(a) Facility renovation and upgrades, as necessary, to:

1. Establish new beds for patients requiring behavioral health services; or

2. Enhance a facility's treatment environment specific to the provision of behavioral health services.

(b) Establishing new or increasing the capacity of existing behavioral health services provided by the behavioral health teaching hospital or its subcontracted behavioral health care provider; and

(c) Creating and maintaining an integrated workforce development program pursuant to s. 395.902(2)(d).

(2)(a)~~1.~~ For the 2024-2025 fiscal year, the agency shall hold a 30-day, open application period beginning November 1, 2024, to accept applications from the behavioral health teaching hospitals designated under s. 395.902(4), in a manner determined by the agency. Applicants must include a detailed spending plan with the application.

(b)~~2.~~ For the 2025-2026 and 2026-2027 fiscal years, the agency shall hold a 30-day, open application period beginning October 1 of each year to accept applications from behavioral health teaching hospitals designated under s. 395.902, in a manner determined by the agency. Applicants must include a detailed spending plan with the application. On or before January 1, 2025, and January 1, 2026, hospitals desiring to apply for designation in the next fiscal year shall submit letters of intent to the agency.

(3)~~(b)~~ The agency, in consultation with the department, shall evaluate and rank grant applications based on compliance with s. 395.902(2) and the quality of the plan submitted under s. 395.902(2)(e) or plan implementation, as applicable, related to achieving the purposes of the behavioral health teaching hospital program. The agency, in consultation with the department, shall make recommendations for grant awards and distribution of available funding for such awards. The agency shall submit the evaluation and grant award recommendations to the President of the Senate and the Speaker of the House of Representatives within 90 days after the open application period closes.

(4)~~(c)~~ Notwithstanding ss. 216.181 and 216.292, the agency may submit budget amendments, subject to the notice, review, and objection procedures under s. 216.177, requesting the release of the funds to make awards. The agency is authorized to submit budget amendments relating to expenses under this subsection under the grant program only within the 90 days after the open application period closes.

(5)~~(2)~~ Notwithstanding s. 216.301 and pursuant to s. 216.351, the balance of any appropriation from the General Revenue Fund for the program which is not disbursed but which is obligated pursuant to contract or committed to be expended by June 30 of the fiscal year for which the funds

are appropriated may be carried forward for up to 8 years after the effective date of the original appropriation.

(6)~~(3)~~ The agency may adopt rules necessary to implement this section.

Section 8. Subsection (3) of section 409.145, Florida Statutes, is amended to read:

409.145 Care of children; "reasonable and prudent parent" standard.—The child welfare system of the department shall operate as a coordinated community-based system of care which empowers all caregivers for children in foster care to provide quality parenting, including approving or disapproving a child's participation in activities based on the caregiver's assessment using the "reasonable and prudent parent" standard.

(3) ROOM AND BOARD RATES.—

(a) Effective July 1, 2026 ~~2022~~, room and board rates shall be paid to foster parents, including relative and nonrelative caregivers who are licensed as a level I child-specific foster placement, and to relative and nonrelative caregivers who are participating in the Relative Caregiver Program and receiving payments pursuant to s. 39.5085(2)(d)1. or 2., as follows:

Monthly Room and Board Rate		
0-5 Years Age	6-12 Years Age	13-21 Years Age
$663.03 ~~$517.94~~	$680.01 ~~$531.21~~	$795.94 ~~$621.77~~

(b) Each January, foster parents, including relative and nonrelative caregivers who are licensed as a level I child-specific foster placement and relative and nonrelative caregivers who are participating in the Relative Caregiver Program and receiving payments pursuant to s. 39.5085(2)(d)1. or 2., shall receive an annual cost of living increase. The department shall calculate the new room and board rate increase equal to the percentage change in the Consumer Price Index for All Urban Consumers, U.S. City Average, All Items, not seasonally adjusted, or successor reports, for the preceding December compared to the prior December as initially reported by the United States Department of Labor, Bureau of Labor Statistics. The department shall make available the adjusted room and board rates annually.

(c) The amount of the monthly room and board rate may be increased upon agreement among the department, the community-based care lead agency, and the foster parent.

(d) Effective July 1, 2022, community-based care lead agencies providing care under contract with the department shall pay a supplemental room and board payment to foster parents, including relative and nonrelative

caregivers who are licensed as a level I child-specific foster placement and relative and nonrelative caregivers who are participating in the Relative Caregiver Program and receiving payments pursuant to s. 39.5085(2)(d)1. or 2., on a per-child basis, for providing independent life skills and normalcy supports to children who are 13 through 17 years of age placed in their care. The supplemental payment must be paid monthly in addition to the current monthly room and board rate payment. The supplemental monthly payment shall be based on 10 percent of the monthly room and board rate for children 13 through 21 years of age as provided under this section and adjusted annually.

Section 9. Section 409.1455, Florida Statutes, is amended to read:

409.1455 Step into Success Workforce Education and Internship ~~Pilot~~ Program for foster youth and former foster youth.—

(1) SHORT TITLE.—This section may be cited as the "Step into Success Act."

(2) CREATION.—The department shall establish the ~~3-year~~ Step into Success Workforce Education and Internship ~~Pilot~~ Program to give eligible foster youth and former foster youth an opportunity to learn and develop essential workforce and professional skills, to transition from the custody of the department to independent living, and to become better prepared for an independent and successful future. The ~~pilot~~ program must consist of an independent living professionalism and workforce education component and, for youth who complete that component, an onsite workforce training internship component. In consultation with subject-matter experts and the community-based care lead agencies, the office shall develop and administer the ~~pilot~~ program for interested foster youth and former foster youth; however, the department may contract with entities that have demonstrable subject-matter expertise in the transition to adulthood for foster youth, workforce training and preparedness, professional skills, and related subjects to collaborate with the office in the development and administration of the ~~pilot~~ program. The independent living professionalism and workforce education component of the program must culminate in a certificate that allows a former foster youth to participate in the onsite workforce training internship.

(3) DEFINITIONS.—For purposes of this section, the term:

(a) "Community-based care lead agency" has the same meaning as in s. 409.986(3).

(b) "Former foster youth" means an individual 18 years of age or older but younger than 26 years of age who is currently or was previously placed in licensed care, excluding Level I licensed placements pursuant to s. 409.175(5)(a)1., for at least 60 days within this state.

(c) "Foster youth" means an individual older than 16 years of age but younger than 18 years of age who is currently in licensed care, excluding Level I licensed placements pursuant to s. 409.175(5)(a)1.

(d) "Office" means the department's Office of Continuing Care.

(e) "Participating organization" means a state agency, a corporation under chapter 607 or chapter 617, or another relevant entity that has agreed to collaborate with the office in the development and implementation of a trauma-informed onsite workforce training internship program pursuant to subsections (6) and (7).

(4) REQUIREMENTS OF THE DEPARTMENT AND OFFICE.—The department shall establish and the office shall develop and administer the ~~pilot~~ program for eligible foster youth and former foster youth. The office shall do all of the following:

(a) Develop eligible foster youth and former foster youth cohorts within the department's regions.

(b) Collaborate with local chambers of commerce and recruit mentors and organizations within the department's regions, emphasizing recruitment of mentors and organizations in the following counties:

1. Duval.

2. Escambia.

3. Hillsborough.

4. Palm Beach.

5. Polk.

(c) Provide eligible former foster youth with a variety of internship placement opportunities, including by connecting existing third-party mentorship organizations that focus on former foster youth with eligible former foster youth who have an interest in such organizations' programs ~~The pilot program must be administered as part of an eligible foster youth's regular transition planning under s. 39.6035 or as a post-transition service for eligible former foster youth. The office must begin the professionalism and workforce education component of the program on or before January 1, 2024, and the onsite workforce training internship component of the program on or before July 1, 2024~~.

(5) INDEPENDENT LIVING PROFESSIONALISM AND WORKFORCE EDUCATION COMPONENT REQUIREMENTS.—The office shall do all of the following in connection with the independent living professionalism and workforce education component for eligible foster youth and former foster youth:

(a) Designate and ensure that the number of qualified staff is sufficient to implement and administer the component, which may be part of a larger independent living or life skills training program if the larger program meets the requirements of this subsection.

(b) Develop all workshops, presentations, and curricula for the component, including, but not limited to, all written educational and training materials for foster youth and former foster youth. Resources may include, but are not limited to, workshops and materials to assist with preparing résumés, mock interviews, experiential training, and assistance with securing an internship or employment. The office must review and update these materials as necessary. The training materials must address, but are not limited to, the following:

1. Interview skills;

2. Professionalism;

3. Teamwork;

4. Leadership;

5. Problem solving; and

6. Conflict resolution in the workplace.

(c) Require that the training provided be in addition to any other life skills or employment training required by law. The training may be developed or administered by the department, community-based care lead agencies, or the lead agencies' subcontracted providers, or in collaboration with colleges or universities or other nonprofit organizations in the community with workforce education and training resources.

(d) Provide relevant written materials from the component and any relevant tools developed to ensure participants' successful transition to internships to all participating organizations that offer workforce training internship opportunities.

(e) Provide materials to inform eligible foster youth and former foster youth of the program, the requirements for participation, and contact information for enrollment. The community-based care lead agencies shall ensure that any subcontracted providers that directly serve youth receive this information.

(f) Advertise and promote the availability of the education and internship program to engage as many eligible foster youth and former foster youth as possible.

(g) Assess the career interests of each eligible foster youth and former foster youth who expresses interest in participating in the program and

determine the most appropriate internship and post-internship opportunities for that youth based on his or her expressed interests.

(6) ONSITE WORKFORCE TRAINING INTERNSHIP COMPONENT REQUIREMENTS.—The office shall do all of the following in connection with the onsite workforce training internship program for eligible former foster youth:

(a) Develop processes and procedures to implement a trauma-informed onsite workforce training internship component. The processes and procedures of the internship component must be designed so that they can be replicated and scaled to meet various organizational structures and sizes. The component must include:

1. Recruitment of agencies, corporations, and other entities to host interns as participating organizations;

2. Assisting participating organizations with mentor recruitment, training, and matching;

3. Mentor-led performance reviews, including a review of the intern's work product, professionalism, time management, communication style, and stress-management strategies;

4. Daily mentorship and coaching on topics such as:

a. Professionalism;

b. Teamwork;

c. Leadership;

d. Problem solving; and

e. Conflict resolution in the workplace;

5. Development of opportunities for interns to become employees of the participating organization; and

6. Reporting requirements specified in subsection (11).

(b) Develop a ~~minimum of 1 hour of~~ required trauma-informed training for mentors to satisfy the requirements of sub-subparagraph (7)(b)1.e. Such training must include interactive or experiential components, such as role-playing, scenario discussion, or case studies. The office may provide at least four additional 1-hour trainings on mentorship of special populations as optional training opportunities, which must be asynchronous and accessible to mentors online at their convenience, and must inform participating organizations of these optional training opportunities ~~teach the skills necessary to engage with participating eligible former foster youth~~.

(c) Provide assistance to eligible foster youth and former foster youth interested in participating in the internship component, including, but not limited to, identifying and monitoring internship opportunities, being knowledgeable of the training and skills needed to match eligible foster youth and former foster youth with appropriate internships, and assisting eligible foster youth and former foster youth with applying for post-internship employment opportunities.

(d) Publicize specific internship positions in an easily accessible manner and inform eligible foster youth and former foster youth of where to locate such information.

(e) Provide a participating former foster youth with financial assistance in the amount of $1,717 ~~$1,517~~ monthly and develop a process and schedule for the distribution of payments to former foster youth participating in the component, subject to the availability of funds.

(f) Distribute funds appropriated for the compensation of mentors who are participating in the component as provided in paragraph (7)(b).

(g) By May 1, 2024, provide to the Board of Governors and the State Board of Education all relevant internship information necessary to support the award of postsecondary credit or career education clock hours for internship positions held by former foster youth participating in the onsite workforce training internship component.

(h) Develop and conduct follow-up surveys with:

1. Former foster youth within 3 months after their internship start date to ensure successful transition into the work environment and to gather feedback on how to improve the experience for future participants.

2. Mentors assigned to participating former foster youth. Such data must be collected by October 1, 2024, and by October 1 annually thereafter, for inclusion in the independent living services annual report.

3. Any other persons the office deems relevant for purposes of continued improvement of the internship component.

(i) Assign experienced staff to serve as program liaisons who are available for mentors to contact whenever the mentors need to debrief or have questions concerning a former foster youth.

(7) REQUIREMENTS FOR PARTICIPATING ORGANIZATIONS.—Each organization participating in the onsite workforce training internship component shall:

(a) Collaborate with the office to implement a trauma-informed approach to mentoring and training former foster youth.

(b) Recruit employees to serve as mentors for former foster youth interning with such organizations.

1. To serve as a mentor, an employee must:

a. Have worked in his or her career field or area ~~for the participating organization~~ for at least 1 year;

b. Have experience relevant to the job and task responsibilities of the intern;

c. Sign a monthly hour statement for the intern;

d. Allocate at least 1 hour per month to conduct mentor-led performance reviews, to include a review of the intern's work product, professionalism, time management, communication style, and stress-management strategies; and

e. Complete ~~a minimum of 1 hour of~~ trauma-informed training to gain and maintain skills critical for successfully engaging former foster youth. Before being matched with a former foster youth, the employee must complete a 1-hour training that covers core topics, including, but not limited to:

(I) Understanding trauma and its impacts.

(II) Recognizing and responding to trauma-related behaviors.

(III) De-escalation strategies and crisis response.

(IV) Boundaries and mentor self-care.

(V) Communication skills.

The department may offer a 1-hour training to review topics covered by the training required under this sub-subparagraph every subsequent year that the employee chooses to serve as a mentor.

2. Subject to available funding, an employee who serves as a mentor and receives the required trauma-informed training is eligible for a maximum payment of $1,200 per intern per fiscal year, to be issued as a $100 monthly payment for every month of service as a mentor.

3. An employee may serve as a mentor for a maximum of three interns at one time and may not receive more than $3,600 in compensation per fiscal year for serving as a mentor. Any time spent serving as a mentor to an intern under this section counts toward the minimum service required for eligibility for payments pursuant to subparagraph 2. and this subparagraph.

4. An employee who serves as a mentor may participate in additional trainings on the mentorship of special populations as made available by the office.

(c) When necessary, have a discussion with an intern's assigned mentor, the participating organization's internship program liaison, and the office about the creation of a corrective action plan to address issues related to the intern's professionalism, work product, or performance and, if applicable, after giving the intern a reasonable opportunity to comply with the corrective action plan, document the intern's failure to do so before discharging him or her.

(d) Provide relevant feedback to the office at least annually for the office to comply with paragraph (6)(h).

(e) Collaborate with the department to provide any requested information necessary to prepare the annual report required under subsection (11).

(8) TIME LIMITATIONS FOR PARTICIPATION.—A former foster youth who obtains an internship with a participating organization may participate in the internship component for no more than 1 year, calculated as 12 monthly stipend periods. The year begins on his or her start date with a participating organization. A former foster youth may intern under the internship program with more than one participating organization, but may not intern with more than one participating organization at the same time. A participating organization may hire the intern as an employee, but the hiring of a former foster youth may not be for an internship under this section.

(9) AWARD OF POSTSECONDARY CREDIT.—The Board of Governors and the State Board of Education shall adopt regulations and rules, respectively, to award postsecondary credit or career education clock hours for eligible former foster youth participating in the internship component pursuant to subsection (4). The regulations and rules must include procedures for the award of postsecondary credit or career education clock hours, including, but not limited to, equivalency and alignment of the internship component with appropriate postsecondary courses and course descriptions.

(10) CONDITIONS OF PARTICIPATION IN THE INTERNSHIP COMPONENT.—

(a) To become a participant in the internship component of the program, the applicant must be a foster youth or a former foster youth as those terms are defined in subsection (3) at the time such youth applies for an internship position with a participating organization. A foster youth or former foster youth who has completed the training component with the department may apply for a position with a participating organization but may not begin an internship until attaining the age of 18 years.

(b) If offered an internship, a former foster youth must be classified as an intern and must work 80 hours per month to be eligible for the stipend payment.

(c) A former foster youth must spend any stipend funds specified for clothing on clothing that is in compliance with the dress code requirements of the participating organization with which the former foster youth is interning. Notwithstanding any limitation on funds provided to purchase clothing, the former foster youth must comply with any dress code requirements of the participating organization with which he or she is interning.

(d) Stipend money earned pursuant to the internship component may not be considered earned income for purposes of computing eligibility for federal or state benefits, including, but not limited to, the Supplemental Nutrition Assistance Program, a housing choice assistance voucher program, the Temporary Cash Assistance Program, the Medicaid program, or the school readiness program. ~~Notwithstanding this paragraph, any reduction in the amount of benefits or loss of benefits due to receipt of the Step into Success stipend may be offset by an additional stipend payment equal to the value of the maximum benefit amount for a single person allowed under the Supplemental Nutrition Assistance Program.~~

(e) A former foster youth may, at the discretion of a postsecondary educational institution within this state in which such youth is enrolled, earn postsecondary credit or career education clock hours for work performed as an intern under the internship component. Postsecondary credit and career education clock hours earned for work performed under the internship component may be in addition to any compensation earned for the same work performed under the internship component and may be awarded for completion of all or any part of the internship component. Participating organizations shall cooperate with postsecondary educational institutions to provide any information about internship positions which is necessary to enable the institutions to determine whether to grant the participating former foster youth postsecondary credit or career education clock hours toward his or her degree.

(f) A former foster youth who accepts an internship with a participating organization pursuant to this section may only be discharged from the internship component after the participating organization engages the intern's assigned mentor and the participating organization's internship program staff to assist the intern in performing the duties of the internship. Before discharging the former foster youth, the participating organization must also document the intern's failure to comply with a corrective action plan after being given a reasonable opportunity to do so.

(11) REPORT.—The department shall include a section on the Step into Success Workforce Education and Internship ~~Pilot~~ Program in the independent living annual report prepared pursuant to s. 409.1451(6) which includes, but is not limited to, all of the following:

(a) Whether the ~~pilot~~ program is in compliance with this section, and if not, barriers to compliance.

(b) A list of participating organizations and the number of interns.

(c) A summary of recruitment efforts to increase the number of participating organizations.

(d) A summary of the feedback and surveys received pursuant to paragraph (6)(h) from participating former foster youth, mentors, and others who have participated in the ~~pilot~~ program.

(e) Recommendations, if any, for actions necessary to improve the quality, effectiveness, and outcomes of the ~~pilot~~ program.

(f) Employment outcomes of former foster youth who participated in the ~~pilot~~ program, including employment status after completion of the program, whether he or she is employed by the participating organization in which he or she interned or by another entity, and job description and salary information, if available.

(12) RULEMAKING.—The department shall adopt rules to implement this section.

Section 10. Section 409.1475, Florida Statutes, is created to read:

409.1475 Foster and Family Support Grant Program.—

(1) The Legislature recognizes that children and families thrive when caregivers are engaged, supported, and equipped to meet their responsibilities. It is the intent of the Legislature to strengthen community-based support that promotes stable caregiving relationships, responsible parenting, and improved outcomes for vulnerable children. Therefore, the Foster and Family Support Grant Program is created within the department.

(2) The department shall award grants to not-for-profit, faith-based organizations to support their efforts in the recruitment of foster and adoptive families through faith-based organizations and strengthening local capacity to support foster, adoptive, and kinship families and families caring for vulnerable children in underserved and rural communities. The program shall emphasize sustained, community-based support beyond initial licensure or training in order to improve caregiver retention and outcomes for children.

(3) Awarded grant funds must be used to provide education, resources, training, and technical assistance to eligible faith-based organizations involved in foster care, adoption, and family preservation activities and to support the development of trauma-informed, community-based support systems for families throughout the caregiving continuum. Allowable uses of funds include, but are not limited to:

(a) Outreach and recruitment activities to increase the number of licensed foster and adoptive families;

(b) Training and support for organizations and volunteers assisting foster, adoptive, and kinship families and families;

(c) Trauma-informed training, coaching, and counseling services for caregivers, families, and individuals involved in supporting children in out-of-home care or at risk of entry into care;

(d) Program support and other activities to strengthen local capacities to support foster, adoptive, and kinship families and families;

(e) Expansion of foster parent training initiatives designed to improve caregiver engagement, retention, and placement stability;

(f) Development of volunteer-based wrap-around support services for foster and adoptive families, including kinship caregivers;

(g) Assistance with essential family needs for families actively fostering, adopting, or pursuing licensure, consistent with federal and state law; and

(h) Ongoing family mentoring and peer support to promote placement stability, permanency, and family well-being.

(4) Grant recipients must submit reports to the department in a format and at intervals, at least annually, as prescribed by the department.

(5) The department may adopt rules to implement this section.

Section 11. Upon the expiration and reversion of the amendments made to s. 409.908, Florida Statutes, pursuant to section 26 of chapter 2025-199, Laws of Florida, paragraph (b) of subsection (2) of section 409.908, Florida Statutes, is amended to read:

409.908 Reimbursement of Medicaid providers.—Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. If a provider is reimbursed based on cost reporting and submits a cost report late and that cost report would have been used to set a lower reimbursement rate for a rate semester, then the provider's rate for that semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be effected retroactively. Medicare-granted extensions for filing cost reports, if applicable, shall also apply to Medicaid cost reports. Payment for Medicaid compensable services made on behalf of Medicaid-eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates,

lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(2)

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

1. The agency shall amend the long-term care reimbursement plan and cost reporting system to create direct care and indirect care subcomponents of the patient care component of the per diem rate. These two subcomponents together shall equal the patient care component of the per diem rate. Separate prices shall be calculated for each patient care subcomponent, initially based on the September 2016 rate setting cost reports and subsequently based on the most recently audited cost report used during a rebasing year. The direct care subcomponent of the per diem rate for any providers still being reimbursed on a cost basis shall be limited by the cost-based class ceiling, and the indirect care subcomponent may be limited by the lower of the cost-based class ceiling, the target rate class ceiling, or the individual provider target. The ceilings and targets apply only to providers being reimbursed on a cost-based system. Effective October 1, 2018, a prospective payment methodology shall be implemented for rate setting purposes with the following parameters:

a. Peer Groups, including:

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

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

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

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

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

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

c. Floors:

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

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

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

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

e. Quality Incentive Program Payment Pool.....18.1373 ~~10~~ percent of September 2016 non-property related payments of included facilities.

f. Quality Score Threshold to Qualify for Quality Incentive Payment.....33 percent of all available points in the Medicaid Quality Incentive Program ~~20th percentile of included facilities~~.

g. Fair Rental Value System Payment Parameters:

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

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

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

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

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

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

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

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

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

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

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

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

2. The agency shall revise its methodology for calculating Quality Incentive Program payments to:

a. Include the results of consumer satisfaction surveys conducted pursuant to s. 400.0225 as a measure of nursing home quality. The agency shall so revise the methodology after the surveys have been in effect for an amount of time the agency deems sufficient for statistical and scientific validity as a meaningful quality measure that may be incorporated into the methodology.

b. During the next rebasing for the Quality Incentive Program, consider implementing the recommendations proposed in sections 3.1.1-3.1.5 of the

Study of Nursing Home Quality Incentive Programs Final Report pursuant to section 20 of chapter 2025-204, Laws of Florida, and presented to the agency on December 22, 2025.

c. Delay the effective date of any change made to its methodology or scoring due to rebasing for 1 year after any recalculations have been completed and the scores have been made available to the public.

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

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

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

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

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

8. Pediatric, Florida Department of Veterans Affairs, and government-owned facilities are exempt from the pricing model established in this subsection and shall remain on a cost-based prospective payment system. Effective October 1, 2018, the agency shall set rates for all facilities remaining on a cost-based prospective payment system using each facility's most recently audited cost report, eliminating retroactive settlements.

9. By October 1, 2025, and each year thereafter, the agency shall submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives a report on each Quality Incentive Program payment made pursuant to sub-subparagraph 1.e. The report must, at a minimum, include all of the following information:

a. The name of each facility that received a Quality Incentive Program payment and the dollar amount of such payment each facility received.

b. The total number of quality incentive metric points awarded by the agency to each facility and the number of points awarded by the agency for each individual quality metric measured.

c. An examination of any trends in the improvement of the quality of care provided to nursing home residents which may be attributable to incentive payments received under the Quality Incentive Program. The agency shall include examination of trends both for the program as a whole as well as for each individual quality metric used by the agency to award program payments.

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

Section 12. Effective July 1, 2027, paragraph (b) of subsection (2) of section 409.908, Florida Statutes, as amended by this act, is amended to read:

409.908 Reimbursement of Medicaid providers.—Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. If a provider is reimbursed based on cost reporting and submits a cost report late and that cost report would have been used to set a lower reimbursement rate for a rate semester, then the provider's rate for that semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be effected retroactively. Medicare-granted extensions for filing cost reports, if applicable, shall also apply to Medicaid cost reports. Payment for Medicaid compensable services made on behalf of Medicaid-eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates,

lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(2)

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

1. The agency shall amend the long-term care reimbursement plan and cost reporting system to create direct care and indirect care subcomponents of the patient care component of the per diem rate. These two subcomponents together shall equal the patient care component of the per diem rate. Separate prices shall be calculated for each patient care subcomponent, initially based on the September 2016 rate setting cost reports and subsequently based on the most recently audited cost report used during a rebasing year. The direct care subcomponent of the per diem rate for any providers still being reimbursed on a cost basis shall be limited by the cost-based class ceiling, and the indirect care subcomponent may be limited by the lower of the cost-based class ceiling, the target rate class ceiling, or the individual provider target. The ceilings and targets apply only to providers being reimbursed on a cost-based system. Effective October 1, 2018, a prospective payment methodology shall be implemented for rate setting purposes with the following parameters:

a. Peer Groups, including:

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

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

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

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

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

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

c. Floors:

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

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

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

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

e. Quality Incentive Program Payment Pool..... 16.5482 ~~18.1373~~ percent of September 2016 non-property related payments of included facilities.

f. Quality Score Threshold to Qualify for Quality Incentive Payment.....33 percent of all available points in the Medicaid Quality Incentive Program.

g. Fair Rental Value System Payment Parameters:

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

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

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

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

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

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

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

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

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

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

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

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

2. The agency shall revise its methodology for calculating Quality Incentive Program payments to:

a. Include the results of consumer satisfaction surveys conducted pursuant to s. 400.0225 as a measure of nursing home quality. The agency shall so revise the methodology after the surveys have been in effect for an amount of time the agency deems sufficient for statistical and scientific validity as a meaningful quality measure that may be incorporated into the methodology.

b. During the next rebasing for the Quality Incentive Program, consider implementing the recommendations proposed in sections 3.1.1-3.1.5 of the

Study of Nursing Home Quality Incentive Programs Final Report pursuant to section 20 of chapter 2025-204, Laws of Florida, and presented to the agency on December 22, 2025.

c. Delay the effective date of any change made to its methodology or scoring due to rebasing for 1 year after any recalculations have been completed and the scores have been made available to the public.

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

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

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

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

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

8. Pediatric, Florida Department of Veterans Affairs, and government-owned facilities are exempt from the pricing model established in this subsection and shall remain on a cost-based prospective payment system. Effective October 1, 2018, the agency shall set rates for all facilities remaining on a cost-based prospective payment system using each facility's most recently audited cost report, eliminating retroactive settlements.

9. By October 1, 2025, and each year thereafter, the agency shall submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives a report on each Quality Incentive Program payment made pursuant to sub-subparagraph 1.e. The report must, at a minimum, include all of the following information:

a. The name of each facility that received a Quality Incentive Program payment and the dollar amount of such payment each facility received.

b. The total number of quality incentive metric points awarded by the agency to each facility and the number of points awarded by the agency for each individual quality metric measured.

c. An examination of any trends in the improvement of the quality of care provided to nursing home residents which may be attributable to incentive payments received under the Quality Incentive Program. The agency shall include examination of trends both for the program as a whole as well as for each individual quality metric used by the agency to award program payments.

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

Section 13. Subsection (6) of section 409.909, Florida Statutes, is amended to read:

409.909 Statewide Medicaid Residency Program.—

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

(a)1. Notwithstanding subsection (4), the agency shall annually allocate funding ~~$100,000~~ to hospitals, qualifying institutions, and behavioral health teaching hospitals designated under s. 395.902 for each newly created resident position that is first filled on or after June 1, 2023, and filled thereafter, and that is accredited by the Accreditation Council for Graduate Medical Education or the Osteopathic Postdoctoral Training Institution in an initial or established accredited training program which is in a physician specialty or subspecialty in a statewide supply-and-demand deficit.

a. Beginning in the 2024-2025 fiscal year, for purposes of distributing funds appropriated in the General Appropriations Act, the agency shall use exclusively the following formula to calculate every participating hospital's and qualifying institution's allocation factor for the funding allocated for the

enumerated statewide specialties and subspecialties as provided in paragraph (c) and separately calculate every participating behavioral health teaching hospital's allocation fraction for the funding allocated for those hospitals designated under s. 395.902:

HAF = [0.9 x (HP/TP)] + [0.1 x (HMP/TMP)]

Where:

HAF = A hospital's and qualifying institution's or behavioral health teaching hospital's allocation fraction.

HP = A hospital's and qualifying institution's or behavioral health teaching hospital's total number of positions.

TP = The total positions for all participating hospitals and qualifying institutions or behavioral health teaching hospitals.

HMP = A hospital's and qualifying institution's or behavioral health teaching hospital's Medicaid payments.

TMP = The total Medicaid payments for all participating hospitals and qualifying institutions or behavioral health teaching hospitals.

As used in this sub-subparagraph, "Medicaid payments" means the estimated total payments for reimbursing a hospital and qualifying institutions or behavioral health teaching hospitals for direct inpatient and outpatient services for the fiscal year in which the allocation fraction is calculated based on the hospital inpatient appropriation and outpatient appropriation and the parameters for the inpatient diagnosis-related group base rate and the parameters for the outpatient enhanced ambulatory payment group rate, including applicable intergovernmental transfers, specified in the General Appropriations Act, as determined by the agency.

b. A hospital's and qualifying institution's or behavioral health teaching hospital's annual allocation shall be calculated by multiplying the funds appropriated for the Slots for Doctors Program in the General Appropriations Act by that hospital's and qualifying institution's or behavioral health teaching hospital's allocation fraction. If the calculation results in an annual allocation that exceeds two times the average per-position amount for all hospitals and qualifying institutions or behavioral health teaching hospitals, the hospital's and qualifying institution's or behavioral health teaching hospital's annual allocation shall be reduced to a sum equaling no more than two times the average per position. The funds calculated for that hospital and qualifying institution or behavioral health teaching hospital in excess of two times the average per position amount for all hospitals and qualifying institutions or behavioral health teaching hospitals shall be redistributed to participating hospitals and qualifying institutions; or

2. Notwithstanding the requirement that a new resident position be created to receive funding under this subsection, the agency may allocate funding ~~$100,000~~ to hospitals and qualifying institutions, pursuant to subparagraph 1., for up to 100 resident positions that existed before July 1, 2023, if such resident position:

a. Is in a physician specialty or subspecialty experiencing a statewide supply-and-demand deficit;

b. Has been unfilled for a period of 3 or more years;

c. Is subsequently filled on or after June 1, 2024, and remains filled thereafter; and

d. Is accredited by the Accreditation Council for Graduate Medical Education or the Osteopathic Postdoctoral Training Institution in an initial or established accredited training program.

3. If applications for resident positions under this paragraph exceed the number of authorized resident positions or the available funding allocated, the agency shall prioritize applications for resident positions that are in a primary care specialty as specified in paragraph (2)(a).

(b) This program is designed to generate matching funds under Medicaid and distribute such funds to participating hospitals, qualifying institutions, and behavioral health teaching hospitals designated under s. 395.902, on a quarterly basis in each fiscal year for which an appropriation is made. Resident positions created under this subsection are not eligible for concurrent funding pursuant to subsection (1).

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

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

Section 14. Section 409.91195, Florida Statutes, is amended to read:

409.91195 Medicaid Pharmaceutical and Therapeutics Committee.—There is created a Medicaid Pharmaceutical and Therapeutics Committee within the agency for the purpose of developing a Medicaid preferred drug list and a preferred product list.

(1) The committee shall be composed of 11 members appointed by the Governor. Four members shall be physicians, licensed under chapter 458; one member licensed under chapter 459; five members shall be pharmacists licensed under chapter 465; and one member shall be a consumer representative. The members shall be appointed to serve for terms of 2 years from the date of their appointment. Members may be appointed to

more than one term. The agency shall serve as staff for the committee and assist them with all ministerial duties. The Governor shall ensure that at least some of the members of the committee represent Medicaid participating physicians and pharmacies serving all segments and diversity of the Medicaid population, and have experience in either developing or practicing under a preferred drug list. At least one of the members shall represent the interests of pharmaceutical manufacturers.

(2) Committee members shall select a chairperson and a vice chairperson each year from the committee membership.

(3) The committee shall meet at least quarterly and may meet at other times at the discretion of the chairperson and members. The committee shall comply with rules adopted by the agency, including notice of any meeting of the committee pursuant to the requirements of the Administrative Procedure Act.

(4) Upon recommendation of the committee, the agency shall adopt a preferred drug list as described in s. 409.912(5) and a preferred product list as described in s. 409.912(14). To the extent feasible, the committee shall review all drug and product classes included on the preferred drug list or preferred product list every 12 months, and may recommend additions to and deletions from the lists ~~preferred drug list~~, such that the preferred drug list provides for medically appropriate drug therapies and products for Medicaid patients which achieve cost savings contained in the General Appropriations Act.

(5) Except for antiretroviral drugs, reimbursement of drugs or products not included on the preferred drug list or preferred product list are ~~is~~ subject to prior authorization.

(6) The agency shall publish and disseminate the preferred drug list and the preferred product list to all Medicaid providers in the state by Internet posting on the agency's website or in other media.

(7) The committee shall ensure that interested parties, including pharmaceutical manufacturers agreeing to provide a supplemental rebate as outlined in this chapter, have an opportunity to present public testimony to the committee with information or evidence supporting inclusion of a product on the preferred drug list or preferred product list. Such public testimony shall occur before ~~prior to~~ any recommendations made by the committee for inclusion or exclusion from the preferred drug list. Upon timely notice, the agency shall ensure that any drug that has been approved or had any of its particular uses approved by the United States Food and Drug Administration under a priority review classification will be reviewed by the committee at the next regularly scheduled meeting following 3 months of distribution of the drug to the general public.

(8) The committee shall develop its preferred drug list and preferred product list recommendations by considering the clinical efficacy, safety, and cost-effectiveness of a product.

(9) The Medicaid Pharmaceutical and Therapeutics Committee may also make recommendations to the agency regarding the prior authorization of any prescribed drug covered by Medicaid.

(10) Medicaid recipients may appeal agency preferred drug formulary decisions using the Medicaid fair hearing process administered by the Agency for Health Care Administration.

Section 15. Paragraph (a) of subsection (5) of section 409.912, Florida Statutes, is amended, and subsection (14) is added to that section, to read:

409.912 Cost-effective purchasing of health care.—The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. To ensure that medical services are effectively utilized, the agency may, in any case, require a confirmation or second physician's opinion of the correct diagnosis for purposes of authorizing future services under the Medicaid program. This section does not restrict access to emergency services or poststabilization care services as defined in 42 C.F.R. s. 438.114. Such confirmation or second opinion shall be rendered in a manner approved by the agency. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services. The agency shall contract with a vendor to monitor and evaluate the clinical practice patterns of providers in order to identify trends that are outside the normal practice patterns of a provider's professional peers or the national guidelines of a provider's professional association. The vendor must be able to provide information and counseling to a provider whose practice patterns are outside the norms, in consultation with the agency, to improve patient care and reduce inappropriate utilization. The agency may mandate prior authorization, drug therapy management, or disease management participation for certain populations of Medicaid beneficiaries, certain drug classes, or particular drugs to prevent fraud, abuse, overuse, and possible dangerous drug interactions. The Pharmaceutical and Therapeutics Committee shall make recommendations to the agency on drugs for which prior authorization is required. The agency shall inform the Pharmaceutical and Therapeutics Committee of its decisions regarding drugs subject to prior authorization. The agency is authorized to limit the entities it contracts with or enrolls as Medicaid providers by developing a provider network through provider credentialing. The agency may competitively bid single-source-provider contracts if procurement of goods or services results in demonstrated cost

savings to the state without limiting access to care. The agency may limit its network based on the assessment of beneficiary access to care, provider availability, provider quality standards, time and distance standards for access to care, the cultural competence of the provider network, demographic characteristics of Medicaid beneficiaries, practice and provider-to-beneficiary standards, appointment wait times, beneficiary use of services, provider turnover, provider profiling, provider licensure history, previous program integrity investigations and findings, peer review, provider Medicaid policy and billing compliance records, clinical and medical record audits, and other factors. Providers are not entitled to enrollment in the Medicaid provider network. The agency shall determine instances in which allowing Medicaid beneficiaries to purchase durable medical equipment and other goods is less expensive to the Medicaid program than long-term rental of the equipment or goods. The agency may establish rules to facilitate purchases in lieu of long-term rentals in order to protect against fraud and abuse in the Medicaid program as defined in s. 409.913. The agency may seek federal waivers necessary to administer these policies.

(5)(a) The agency shall implement a Medicaid prescribed-drug spending-control program that includes the following components:

1. A Medicaid preferred drug list, which shall be a listing of cost-effective therapeutic options recommended by the Medicaid Pharmacy and Therapeutics Committee established pursuant to s. 409.91195 and adopted by the agency for each therapeutic class on the preferred drug list. At the discretion of the committee, and when feasible, the preferred drug list should include at least two products in a therapeutic class. The agency may post the preferred drug list and updates to the list on an Internet website without following the rulemaking procedures of chapter 120. Antiretroviral agents are excluded from the preferred drug list. The agency shall also limit the amount of a prescribed drug dispensed to no more than a 34-day supply unless the drug products' smallest marketed package is greater than a 34-day supply, or the drug is determined by the agency to be a maintenance drug in which case a 100-day maximum supply may be authorized. The agency may seek any federal waivers necessary to implement these cost-control programs and to continue participation in the federal Medicaid rebate program, or alternatively to negotiate state-only manufacturer rebates. The agency may adopt rules to administer this subparagraph. The agency shall continue to provide unlimited contraceptive drugs and items. The agency must establish procedures to ensure that:

a. There is a response to a request for prior authorization by telephone or other telecommunication device within 24 hours after receipt of a request for prior authorization; and

b. A 72-hour supply of the drug prescribed is provided in an emergency or when the agency does not provide a response within 24 hours as required by sub-subparagraph a.

2. A provider of prescribed drugs is reimbursed in an amount not to exceed the lesser of the actual acquisition cost based on the Centers for Medicare and Medicaid Services National Average Drug Acquisition Cost pricing files plus a professional dispensing fee, the wholesale acquisition cost plus a professional dispensing fee, the state maximum allowable cost plus a professional dispensing fee, or the usual and customary charge billed by the provider.

3. The agency shall develop and implement a process for managing the drug therapies of Medicaid recipients who are using significant numbers of prescribed drugs each month. The management process may include, but is not limited to, comprehensive, physician-directed medical-record reviews, claims analyses, and case evaluations to determine the medical necessity and appropriateness of a patient's treatment plan and drug therapies. The agency may contract with a private organization to provide drug-program-management services. The Medicaid drug benefit management program shall include initiatives to manage drug therapies for HIV/AIDS patients, patients using 20 or more unique prescriptions in a 180-day period, and the top 1,000 patients in annual spending. The agency shall enroll any Medicaid recipient in the drug benefit management program if he or she meets the specifications of this provision and is not enrolled in a Medicaid health maintenance organization.

4. The agency may limit the size of its pharmacy network based on need, competitive bidding, price negotiations, credentialing, or similar criteria. The agency shall give special consideration to rural areas in determining the size and location of pharmacies included in the Medicaid pharmacy network. A pharmacy credentialing process may include criteria such as a pharmacy's full-service status, location, size, patient educational programs, patient consultation, disease management services, and other characteristics. The agency may impose a moratorium on Medicaid pharmacy enrollment if it is determined that it has a sufficient number of Medicaid-participating providers. The agency must allow dispensing practitioners to participate as a part of the Medicaid pharmacy network regardless of the practitioner's proximity to any other entity that is dispensing prescription drugs under the Medicaid program. A dispensing practitioner must meet all credentialing requirements applicable to his or her practice, as determined by the agency.

5. A hospital facility administering long-acting injectables for severe mental illness shall be reimbursed separately from the diagnosis-related group. Long-acting injectables administered for severe mental illness in a hospital facility setting shall be reimbursed at no less than the actual acquisition cost of the drug.

6.~~5.~~ The agency shall develop and implement a program that requires Medicaid practitioners who issue written prescriptions for medicinal drugs to use a counterfeit-proof prescription pad for Medicaid prescriptions. The agency shall require the use of standardized counterfeit-proof prescription pads by prescribers who issue written prescriptions for Medicaid recipients.

The agency may implement the program in targeted geographic areas or statewide.

7.~~6.~~ The agency may enter into arrangements that require manufacturers of generic drugs prescribed to Medicaid recipients to provide rebates of at least 15.1 percent of the average manufacturer price for the manufacturer's generic products. These arrangements shall require that if a generic-drug manufacturer pays federal rebates for Medicaid-reimbursed drugs at a level below 15.1 percent, the manufacturer must provide a supplemental rebate to the state in an amount necessary to achieve a 15.1-percent rebate level.

8.~~7.~~ The agency may establish a preferred drug list as described in this subsection, and, pursuant to the establishment of such preferred drug list, negotiate supplemental rebates from manufacturers that are in addition to those required by Title XIX of the Social Security Act and at no less than 14 percent of the average manufacturer price as defined in 42 U.S.C. s. 1936 on the last day of a quarter unless the federal or supplemental rebate, or both, equals or exceeds 29 percent. There is no upper limit on the supplemental rebates the agency may negotiate. The agency may determine that specific products, brand-name or generic, are competitive at lower rebate percentages. Agreement to pay the minimum supplemental rebate percentage guarantees a manufacturer that the Medicaid Pharmaceutical and Therapeutics Committee will consider a product for inclusion on the preferred drug list. However, a pharmaceutical manufacturer is not guaranteed placement on the preferred drug list by simply paying the minimum supplemental rebate. Agency decisions will be made on the clinical efficacy of a drug and recommendations of the Medicaid Pharmaceutical and Therapeutics Committee, as well as the price of competing products minus federal and state rebates. The agency may contract with an outside agency or contractor to conduct negotiations for supplemental rebates. For the purposes of this section, the term "supplemental rebates" means cash rebates. Value-added programs as a substitution for supplemental rebates are prohibited. The agency may seek any federal waivers to implement this initiative.

9.a.~~8.a.~~ The agency may implement a Medicaid behavioral drug management system. The agency may contract with a vendor that has experience in operating behavioral drug management systems to implement this program. The agency may seek federal waivers to implement this program.

b. The agency, in conjunction with the Department of Children and Families, may implement the Medicaid behavioral drug management system that is designed to improve the quality of care and behavioral health prescribing practices based on best practice guidelines, improve patient adherence to medication plans, reduce clinical risk, and lower prescribed drug costs and the rate of inappropriate spending on Medicaid behavioral drugs. The program may include the following elements:

(I) Provide for the development and adoption of best practice guidelines for behavioral health-related drugs such as antipsychotics, antidepressants, and medications for treating bipolar disorders and other behavioral conditions; translate them into practice; review behavioral health prescribers and compare their prescribing patterns to a number of indicators that are based on national standards; and determine deviations from best practice guidelines.

(II) Implement processes for providing feedback to and educating prescribers using best practice educational materials and peer-to-peer consultation.

(III) Assess Medicaid beneficiaries who are outliers in their use of behavioral health drugs with regard to the numbers and types of drugs taken, drug dosages, combination drug therapies, and other indicators of improper use of behavioral health drugs.

(IV) Alert prescribers to patients who fail to refill prescriptions in a timely fashion, are prescribed multiple same-class behavioral health drugs, and may have other potential medication problems.

(V) Track spending trends for behavioral health drugs and deviation from best practice guidelines.

(VI) Use educational and technological approaches to promote best practices, educate consumers, and train prescribers in the use of practice guidelines.

(VII) Disseminate electronic and published materials.

(VIII) Hold statewide and regional conferences.

(IX) Implement a disease management program with a model quality-based medication component for severely mentally ill individuals and emotionally disturbed children who are high users of care.

10.~~9.~~ The agency shall implement a Medicaid prescription drug management system.

a. The agency may contract with a vendor that has experience in operating prescription drug management systems in order to implement this system. Any management system that is implemented in accordance with this subparagraph must rely on cooperation between physicians and pharmacists to determine appropriate practice patterns and clinical guidelines to improve the prescribing, dispensing, and use of drugs in the Medicaid program. The agency may seek federal waivers to implement this program.

b. The drug management system must be designed to improve the quality of care and prescribing practices based on best practice guidelines, improve patient adherence to medication plans, reduce clinical risk, and

lower prescribed drug costs and the rate of inappropriate spending on Medicaid prescription drugs. The program must:

(I) Provide for the adoption of best practice guidelines for the prescribing and use of drugs in the Medicaid program, including translating best practice guidelines into practice; reviewing prescriber patterns and comparing them to indicators that are based on national standards and practice patterns of clinical peers in their community, statewide, and nationally; and determine deviations from best practice guidelines.

(II) Implement processes for providing feedback to and educating prescribers using best practice educational materials and peer-to-peer consultation.

(III) Assess Medicaid recipients who are outliers in their use of a single or multiple prescription drugs with regard to the numbers and types of drugs taken, drug dosages, combination drug therapies, and other indicators of improper use of prescription drugs.

(IV) Alert prescribers to recipients who fail to refill prescriptions in a timely fashion, are prescribed multiple drugs that may be redundant or contraindicated, or may have other potential medication problems.

11.~~10.~~ The agency may contract for drug rebate administration, including, but not limited to, calculating rebate amounts, invoicing manufacturers, negotiating disputes with manufacturers, and maintaining a database of rebate collections.

12.~~11.~~ The agency may specify the preferred daily dosing form or strength for the purpose of promoting best practices with regard to the prescribing of certain drugs as specified in the General Appropriations Act and ensuring cost-effective prescribing practices.

13.~~12.~~ The agency may require prior authorization for Medicaid-covered prescribed drugs. The agency may prior-authorize the use of a product:

a. For an indication not approved in labeling;

b. To comply with certain clinical guidelines; or

c. If the product has the potential for overuse, misuse, or abuse.

The agency may require the prescribing professional to provide information about the rationale and supporting medical evidence for the use of a drug. The agency shall post prior authorization, step-edit criteria and protocol, and updates to the list of drugs that are subject to prior authorization on the agency's Internet website within 21 days after the prior authorization and step-edit criteria and protocol and updates are approved by the agency. For purposes of this subparagraph, the term "step-edit" means an automatic electronic review of certain medications subject to prior authorization.

14.~~13.~~ The agency, in conjunction with the Pharmaceutical and Therapeutics Committee, may require age-related prior authorizations for certain prescribed drugs. The agency may preauthorize the use of a drug for a recipient who may not meet the age requirement or may exceed the length of therapy for use of this product as recommended by the manufacturer and approved by the Food and Drug Administration. Prior authorization may require the prescribing professional to provide information about the rationale and supporting medical evidence for the use of a drug.

15.~~14.~~ The agency shall implement a step-therapy prior authorization approval process for medications excluded from the preferred drug list. Medications listed on the preferred drug list must be used within the previous 12 months before the alternative medications that are not listed. The step-therapy prior authorization may require the prescriber to use the medications of a similar drug class or for a similar medical indication unless contraindicated in the Food and Drug Administration labeling. The trial period between the specified steps may vary according to the medical indication. The step-therapy approval process shall be developed in accordance with the committee as stated in s. 409.91195(7) and (8). A drug product may be approved without meeting the step-therapy prior authorization criteria if the prescribing physician provides the agency with additional written medical or clinical documentation that the product is medically necessary because:

a. There is not a drug on the preferred drug list to treat the disease or medical condition which is an acceptable clinical alternative;

b. The alternatives have been ineffective in the treatment of the beneficiary's disease;

c. The drug product or medication of a similar drug class is prescribed for the treatment of schizophrenia or schizotypal or delusional disorders; prior authorization has been granted previously for the prescribed drug; and the medication was dispensed to the patient during the previous 12 months; or

d. Based on historical evidence and known characteristics of the patient and the drug, the drug is likely to be ineffective, or the number of doses have been ineffective.

The agency shall work with the physician to determine the best alternative for the patient. The agency may adopt rules waiving the requirements for written clinical documentation for specific drugs in limited clinical situations.

16.~~15.~~ The agency shall implement a return and reuse program for drugs dispensed by pharmacies to institutional recipients, which includes payment of a $5 restocking fee for the implementation and operation of the program. The return and reuse program shall be implemented electronically and in a manner that promotes efficiency. The program must permit a pharmacy to

exclude drugs from the program if it is not practical or cost-effective for the drug to be included and must provide for the return to inventory of drugs that cannot be credited or returned in a cost-effective manner. The agency shall determine if the program has reduced the amount of Medicaid prescription drugs which are destroyed on an annual basis and if there are additional ways to ensure more prescription drugs are not destroyed which could safely be reused.

(14) The agency shall implement a Medicaid therapeutic supplies spending control program. The agency may negotiate and enter into arrangements with supplies manufacturers which require manufacturers to provide rebates and may participate in multistate organizations negotiating for such rebates. The spending control program shall include a preferred product list, which shall be a listing of cost-effective therapeutic supplies recommended by the Medicaid Pharmaceutical and Therapeutics Committee established pursuant to s. 409.91195 and adopted by the agency for each product class listed on the preferred product list. The agency may publish the preferred product list and updates to the list on the agency website without following the rulemaking procedures of chapter 120.

Section 16. Section 409.9207, Florida Statutes, is created to read:

409.9207 Medicaid eligibility assistance for persons with disabilities.—

(1) LEGISLATIVE INTENT.—It is the intent of the Legislature to create a program that supports and enables persons with disabilities to become Medicaid eligible. The Department of Children and Families shall be responsible for this program; however, all agencies with any duties related to Medicaid are responsible for collaborating with the department and the independent contractor selected to implement the program.

(2) DEFINITIONS.—As used in this section, unless otherwise specified, the term:

(a) "Agency" means any state or local governmental entity.

(b) "Independent contractor" means a nonprofit organization with experience operating an information and referral program that includes person-centered services to successfully navigate eligibility procedures for state and federal assistance.

(c) "Person with disabilities" means any person who has one or more permanent physical or mental limitations which restrict his or her ability to perform the normal activities of daily living and impede his or her capacity to live independently with relatives or friends without the provision of community-based services.

(3) ELIGIBILITY ASSISTANCE PROGRAM.—

(a) The Eligibility Assistance Program is created within the Department of Children and Families to offer information, referral, and navigation

services to persons with disabilities to initiate and successfully complete the actions required to secure eligibility for Medicaid and other community-based services enabling such persons to remain in their homes and communities.

(b) The program shall be operated by an independent contractor selected based on the following criteria:

1. A tax-exempt organization incorporated in this state and in good standing with the Division of Corporations of the Department of State.

2. At least 20 years' experience operating local or regional programs that provide services for persons with disabilities.

3. Capability to operate call center and online access points.

Section 17. Subsection (1) and paragraph (f) of subsection (2) of section 409.967, Florida Statutes, are amended to read:

409.967 Managed care plan accountability.—

(1) ~~Beginning with the contract procurement process initiated during the 2023 calendar year,~~ The agency shall establish a 10-year ~~6-year~~ contract with each managed care plan selected through the procurement process described in s. 409.966. A plan contract may not be renewed; however, the agency may extend the term of a plan contract to cover any delays during the transition to a new plan. The agency shall extend until January 31, 2035 ~~December 31, 2024~~, the term of existing plan contracts awarded pursuant to the invitations ~~invitation~~ to negotiate published in 2023 ~~July 2017~~.

(2) The agency shall establish such contract requirements as are necessary for the operation of the statewide managed care program. In addition to any other provisions the agency may deem necessary, the contract must require:

(f) Continuous improvement.—The agency shall establish specific performance standards and expected milestones or timelines for improving performance over the term of the contract.

1. Each managed care plan shall establish an internal health care quality improvement system, including enrollee satisfaction and disenrollment surveys. The quality improvement system must include incentives and disincentives for network providers.

2. Each managed care plan must collect and report the Healthcare Effectiveness Data and Information Set (HEDIS) measures, the federal Core Set of Children's Health Care Quality measures, and the federal Core Set of Adult Health Care Quality Measures, as specified by the agency. Each plan must collect and report the Adult Core Set behavioral health measures beginning with data reports for the 2025 calendar year. Each plan must stratify reported measures by age, sex, race, ethnicity, primary language,

and whether the enrollee received a Social Security Administration determination of disability for purposes of Supplemental Security Income beginning with data reports for the 2026 calendar year. A plan's performance on these measures must be published on the plan's website in a manner that allows recipients to reliably compare the performance of plans. The agency shall use the measures as a tool to monitor plan performance.

3. Each managed care plan must be accredited by the National Committee for Quality Assurance, the Joint Commission, or another nationally recognized accrediting body, or have initiated the accreditation process, within 1 year after the contract is executed. For any plan not accredited within 18 months after executing the contract, the agency shall suspend automatic assignment under ss. 409.977 and 409.984.

4. The agency shall develop a coordinated statewide initiative of value-based strategies to drive cost-effective service delivery and improved health outcomes by directing managed care plans to implement a coordinated program of rewarding providers who deliver patient-centered, high-quality services. The initiative shall be predicated on a strategic plan, submitted to the President of the Senate and the Speaker of the House of Representatives by December 15, 2026, and implemented over a multiyear period that begins when the plan is approved by the Legislature.

a. The strategic plan must set measurable goals, establish action plans and timelines, and define evaluation methods. The strategic plan must include procedures for making implementation adjustments necessary due to changing conditions. The agency shall review value-based payment models in other states with well-developed programs and incorporate best practices and elements which contribute to the success of those programs.

b. The initiative will consist of the following focus area phases:

(I) Year 1 will focus on perinatal health.

(II) Year 2 will add a focus on behavioral health to the Year 1 initiatives.

(III) Year 3 will add a focus on management of chronic conditions to the Year 1 and Year 2 initiatives.

c. The agency shall augment staff expertise for planning and implementation of this initiative with consultants who specialize in value-based payment. The agency must ensure active engagement of both providers and plans in developing the strategic plan and in implementation of the initiative, in a manner which fosters collaborative effort and mutual commitment to achieving goals in each focus area.

d. Upon legislative approval of the strategic plan, the agency shall replace all other contractual requirements for value-based payment set by the agency with those developed through this initiative.

Section 18. Subsection (1) of section 409.968, Florida Statutes, is amended to read:

409.968 Managed care plan payments.—

(1)(a) Prepaid plans shall receive per-member, per-month payments negotiated pursuant to the procurements described in s. 409.966. Payments shall be risk-adjusted rates based on historical utilization and spending data, projected forward, and adjusted to reflect the eligibility category, geographic area, and clinical risk profile of the recipients.

(b) In negotiating rates with the plans, the agency shall consider any adjustments necessary to encourage plans to use the most cost-effective modalities for treatment of chronic disease such as peritoneal dialysis.

(c) Per-member, per-month payments made to any managed care plan contracted under this part or part III that are subsequently refunded to or recovered by the agency, or initially withheld by the agency prior to payment and not later paid to a managed care plan pursuant to the terms of its contract, shall be adjusted for the Federal Medical Assistance Percentages. The state share shall be transferred to the General Revenue Fund, unallocated, and the federal share shall be transferred to the Medical Care Trust Fund, unallocated.

Section 19. Subsection (5) of section 409.982, Florida Statutes, is amended to read:

409.982 Long-term care managed care plan accountability.—In addition to the requirements of s. 409.967, plans and providers participating in the long-term care managed care program must comply with the requirements of this section.

(5) PROVIDER PAYMENT.—Managed care plans and providers shall negotiate mutually acceptable rates, methods, and terms of payment.

(a) Plans shall pay nursing homes an amount equal to the nursing facility-specific payment rates set by the agency; however, mutually acceptable higher rates may be negotiated for medically complex care.

(b) Plans shall pay hospice providers through a prospective system for each enrollee an amount equal to the per diem rate set by the agency. For recipients residing in a nursing facility and receiving hospice services, the plan shall pay the hospice provider the per diem rate set by the agency minus the nursing facility component and shall pay the nursing facility the applicable state rate.

(c) Plans must ensure that electronic nursing home and hospice claims that contain sufficient information for processing are paid within 10 business days after receipt.

(d) The agency may establish a fee schedule to reimburse providers for adult day care services.

Section 20. Subsection (8) is added to section 409.9855, Florida Statutes, to read:

409.9855 Pilot program for individuals with developmental disabilities.

(8) WAIVER TRANSFER FUNDING.—

(a) For individuals enrolled in the Medicaid home and community-based services waiver program under chapter 393 who choose to enroll in the pilot program, funding associated with the individual shall be transferred from the Agency for Persons with Disabilities to the Agency for Health Care Administration. The funding shall be equivalent to the total state share cost of the individual for the remaining months in the fiscal year based on the pilot program's managed care plan monthly rate.

(b) For individuals enrolled in the pilot program who choose to enroll in the Medicaid home and community-based services waiver program under chapter 393, funding associated with the individual shall be transferred from the Agency for Health Care Administration to the Agency for Persons with Disabilities. The funding shall be equivalent to the total state share cost of the individual for the remaining months in the fiscal year based on the pilot program's managed care plan monthly rate.

(c) The Agency for Persons with Disabilities and the Agency for Health Care Administration shall reconcile the amounts on a quarterly basis. The Agency for Health Care Administration may submit a budget amendment pursuant to chapter 216 to transfer the funds between the agencies.

Section 21. Paragraph (e) of subsection (3) of section 409.986, Florida Statutes, is redesignated as paragraph (f), and a new paragraph (e) is added to that subsection to read:

409.986 Legislative findings and intent; child protection and child welfare outcomes; definitions.—

(3) DEFINITIONS.—As used in this part, except as otherwise provided, the term:

(e) "Qualified provider" means an entity that meets the required regulatory or licensing standards for the service being procured, that has not had a contract for that service terminated due to a failure to meet contractual requirements, and that does not have any active formal corrective action plan or performance improvement plan associated with a license or contract for the service being procured.

Section 22. Subsection (5) of section 409.990, Florida Statutes, is amended to read:

409.990 Funding for lead agencies.—A contract established between the department and a lead agency must be funded by a grant of general revenue, other applicable state funds, or applicable federal funding sources.

(5) A lead agency may carry forward documented unexpended state funds from one fiscal year to the next; however, the cumulative amount carried forward may not exceed 8 percent of the annual amount of the ~~total~~ contract. Any unexpended state funds in excess of that percentage must be returned to the department.

(a) The funds carried forward may not be used in any way that would create increased recurring future obligations, and such funds may not be used for any type of program or service that is not currently authorized by the existing contract with the department.

(b) Expenditures of funds carried forward must be separately reported to the department.

(c) Any unexpended funds that remain at the end of the contract period shall be returned to the department.

(d) Funds carried forward may be retained through any contract renewals and any new procurements as long as the same lead agency is retained by the department.

Section 23. Subsection (2) of section 409.996, Florida Statutes, is amended to read:

409.996 Duties of the Department of Children and Families.—The department shall contract for the delivery, administration, or management of care for children in the child protection and child welfare system. In doing so, the department retains responsibility for the quality of contracted services and programs and shall ensure that, at a minimum, services are delivered in accordance with applicable federal and state statutes and regulations and the performance standards and metrics specified in the strategic plan created under s. 20.19(1).

(2)(a) The department must adopt written policies and procedures for monitoring the contract for delivery of services by lead agencies which must be published on the department's website. These policies and procedures must, at a minimum, address the evaluation of fiscal accountability and program operations, including provider achievement of performance standards, provider monitoring of subcontractors, and timely followup of corrective actions for significant monitoring findings related to providers and subcontractors. These policies and procedures must also include provisions for reducing the duplication of the department's program monitoring activities both internally and with other agencies, to the extent possible. The department's written procedures must ensure that the written findings, conclusions, and recommendations from monitoring the contract

for services of lead agencies are communicated to the director of the provider agency and the community alliance as expeditiously as possible.

(b) The department shall establish a standard statewide provider contract to reduce administrative burden and expense by establishing uniform reporting, accounting, billing, and budgeting requirements. The contract shall establish terms for the provision of core child welfare services, including case management, foster home licensing, independent living, and residential group care, with standardized attachments by provider type. The standard statewide provider contract shall include provisions for provider probation, termination for cause, and emergency termination for actions or inactions of a provider that pose an immediate and serious danger to the health, safety, or welfare of children, and shall include provider appeal procedures for these actions. During the pendency of an appeal of an emergency termination, the provider may not continue to provide services. In developing the statewide provider contract, the department shall work directly with both lead agencies and providers of each service type. The department shall publish the standard statewide provider contract on its website and require lead agencies to use the contract, at a minimum, for provider contracting. Lead agencies may establish additional contract terms to respond to particular regional needs and circumstances.

Section 24. Subsection (5) of section 414.56, Florida Statutes, is amended to read:

414.56 Office of Continuing Care.—The department shall establish an Office of Continuing Care to ensure young adults who age out of the foster care system between 18 and 21 years of age, or 22 years of age with a documented disability, have a point of contact until the young adult reaches the age of 26 in order to receive ongoing support and care coordination needed to achieve self-sufficiency. Duties of the office include, but are not limited to:

(5) Developing and administering the Step into Success Workforce Education and Internship ~~Pilot~~ Program for foster youth and former foster youth as required under s. 409.1455.

Section 25. For the purpose of incorporating the amendment made by this act to section 409.968, Florida Statutes, in a reference thereto, subsection (2) of section 409.978, Florida Statutes, is reenacted to read:

409.978 Long-term care managed care program.—

(2) The agency shall make payments for long-term care, including home and community-based services, using a managed care model. Unless otherwise specified, ss. 409.961-409.969 apply to the long-term care managed care program.

Section 26. For the purpose of incorporating the amendment made by this act to section 409.968, Florida Statutes, in a reference thereto,

paragraph (b) of subsection (1) of section 409.9855, Florida Statutes, is reenacted to read:

409.9855 Pilot program for individuals with developmental disabilities.

(1) PILOT PROGRAM IMPLEMENTATION.—

(b) The agency shall administer the pilot program pursuant to s. 409.963 and as a component of the Statewide Medicaid Managed Care model established by this part. Unless otherwise specified, ss. 409.961-409.969 apply to the pilot program. For purposes of the pilot program, compliance with s. 409.966 is deemed satisfied by the competitive procurement procedures conducted for contracts effective on February 1, 2025.

Section 27. Subsection (1) of section 409.91196, Florida Statutes, is amended to read:

409.91196 Supplemental rebate agreements; public records and public meetings exemption.—

(1) The rebate amount, percent of rebate, manufacturer's pricing, and supplemental rebate, and other trade secrets as defined in s. 688.002 that the agency has identified for use in negotiations, held by the Agency for Health Care Administration under s. 409.912(5)(a)8. ~~s. 409.912(5)(a)7.~~ are confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

Section 28. Paragraph (b) of subsection (5) of section 393.065, Florida Statutes, is amended to read:

393.065 Application and eligibility determination.—

(5) Except as provided in subsections (6) and (7), if a client seeking enrollment in the developmental disabilities home and community-based services Medicaid waiver program meets the level of care requirement for an intermediate care facility for individuals with intellectual disabilities pursuant to 42 C.F.R. ss. 435.217(b)(1) and 440.150, the agency must assign the client to an appropriate preenrollment category pursuant to this subsection and must provide priority to clients waiting for waiver services in the following order:

(b) Category 2, which includes clients in the preenrollment categories who are:

1. From the child welfare system with an open case in the Department of Children and Families' statewide automated child welfare information system and who are either:

a. Transitioning out of the child welfare system into permanency; or

b. At least 18 years but not yet 22 years of age and who need both waiver services and extended foster care services; or

2. At least 18 years but not yet 22 years of age and who withdrew consent pursuant to s. 39.6251(5)(c) to remain in the extended foster care system.

For individuals who are at least 18 years but not yet 22 years of age and who are eligible under sub-subparagraph 1.b., the agency must provide waiver services, including residential habilitation, and must actively participate in transition planning activities, including, but not limited to, individualized service coordination, case management support, and ensuring continuity of care pursuant to s. 39.6035. The community-based care lead agency must fund room and board at the rate established in s. 409.145(3) and provide case management and related services as defined in s. 409.986(3)(f) ~~s. 409.986(3)(e)~~. Individuals may receive both waiver services and services under s. 39.6251. Services may not duplicate services available through the Medicaid state plan.

Within preenrollment categories 3, 4, 5, 6, and 7, the agency shall prioritize clients in the order of the date that the client is determined eligible for waiver services.

Section 29. Except as otherwise provided in this act, this act shall take effect July 1, 2026.

Approved by the Governor June 29, 2026.

Filed in Office Secretary of State June 29, 2026.