

1 A bill to be entitled
2 An act relating to health care; amending s. 381.4015,
3 F.S.; providing that a specified loan program
4 administered by the Department of Health is subject to
5 appropriation; amending s. 383.14, F.S.; providing
6 that, beginning on a specified date, the department
7 must require newborns to be screened for infantile
8 Krabbe disease and metachromatic leukodystrophy;
9 creating s. 383.1401, F.S.; authorizing the department
10 to create an educational pamphlet on the nutritional
11 needs of preterm infants; requiring the department to
12 provide the pamphlet electronically by a specified
13 date; providing requirements for such pamphlet;
14 amending s. 393.066, F.S.; requiring the Agency for
15 Persons with Disabilities to reimburse certain
16 providers using monthly and hourly rates for certain
17 recipients; amending s. 395.4025, F.S.; providing
18 requirements for specified designation of certain
19 specialty licensed children's hospitals; amending s.
20 395.902, F.S.; removing a specified allocation for
21 specified positions at behavioral health teaching
22 hospitals; amending s. 395.903, F.S.; revising uses
23 for certain grant funding for behavioral health
24 teaching hospitals; amending s. 409.145, F.S.;
25 revising the monthly room and board rates the

26 | department is required to pay to certain foster
27 | parents and caregivers; amending s. 409.1455, F.S.;
28 | renaming the Step into Success Workforce Education and
29 | Internship Pilot Program as the Step into Success
30 | Workforce Education and Internship Program; removing a
31 | provision limiting the duration of the program;
32 | requiring the Office of Continuing Care within the
33 | Department of Children and Families to develop certain
34 | cohorts within specified regions, to collaborate with
35 | certain organizations to recruit mentors and
36 | organizations, and to provide eligible former foster
37 | youth with internship placement opportunities;
38 | removing a provision requiring that the program be
39 | administered in a certain manner; requiring the office
40 | to develop trauma-informed training for mentors of
41 | certain former foster youth; providing requirements
42 | for the training; authorizing the office to provide
43 | certain additional trainings on mentorship of special
44 | populations; revising the amount of monthly financial
45 | assistance that the office provides to participating
46 | former foster youth; requiring the office to assign
47 | experienced staff to serve as program liaisons for a
48 | specified purpose; revising qualifications to serve as
49 | a mentor; authorizing the department to offer certain
50 | training to mentors; authorizing an employee who

51 serves as a mentor to participate in certain
52 additional trainings; removing a provision authorizing
53 the offset of a reduction in or loss of certain
54 benefits due to receipt of a Step into Success stipend
55 by an additional stipend payment; creating s.
56 409.1475, F.S.; providing legislative findings and
57 intent; creating the Foster and Family Support Grant
58 Program within the department; requiring the
59 department to award grants to not-for-profit, faith-
60 based organizations for specified purposes; requiring
61 that the program emphasize certain support; specifying
62 authorized uses for awarded grant funds; requiring
63 grant recipients to submit reports to the department
64 in a format and at intervals prescribed by the
65 department; authorizing the department to adopt rules;
66 amending s. 409.908, F.S.; revising specified rate
67 setting parameters for a specified reimbursement
68 payment methodology; amending s. 409.909, F.S.;
69 revising and providing allocation requirements for the
70 Slots for Doctors Program; defining the term "Medicaid
71 payments"; amending s. 409.91195, F.S.; revising the
72 purpose of the Medicaid Pharmaceutical and
73 Therapeutics Committee to include creation of a
74 Medicaid preferred product list; requiring the Agency
75 for Health Care Administration to adopt such list upon

76 recommendation of the committee; specifying the
77 frequency with which the committee must review such
78 list for certain recommendations; specifying
79 parameters for such recommendations; providing that
80 reimbursement for products not included on such list
81 is subject to prior authorization; requiring the
82 agency to publish and disseminate such list to all
83 Medicaid providers in the state by posting on the
84 agency's website or in other media; providing
85 requirements for public testimony relating to proposed
86 inclusions on or exclusions from such list; amending
87 s. 409.912, F.S.; revising Medicaid preferred drug
88 coverage guidelines; requiring the agency to implement
89 a Medicaid therapeutic supplies spending-control
90 program; authorizing the agency to negotiate with
91 manufacturers for rebates and participate in
92 multistate organizations negotiating for such rebates;
93 requiring the agency to establish a preferred product
94 list; providing requirements for such list; exempting
95 the agency from the rulemaking procedures of ch. 120,
96 F.S., when publishing such lists and updates; creating
97 s. 409.9207, F.S.; providing legislative intent;
98 providing definitions; creating the Eligibility
99 Assistance Program within the department; providing
100 program requirements; requiring the department to be

101 operated by an independent contractor that shall be
102 selected based on specified criteria; amending s.
103 409.967, F.S.; revising the maximum term for Medicaid
104 managed care contracts; requiring the agency to
105 establish by contract a quality withhold incentive for
106 certain purposes; providing requirements for such
107 incentive; amending s. 409.968, F.S.; providing
108 adjustment requirements for specified payments made to
109 managed care plans; amending s. 409.982, F.S.;
110 authorizing the agency to establish a provider
111 reimbursement fee schedule for certain purposes;
112 amending s. 409.9855, F.S.; providing waiver transfer
113 funding requirements for specified individuals;
114 amending s. 409.986, F.S.; defining the term
115 "qualified provider"; amending s. 409.990, F.S.;
116 revising the amount of documented unexpended state
117 funds a lead agency may carry forward; amending s.
118 409.996, F.S.; authorizing the department to establish
119 a standard statewide provider contract for certain
120 purposes; providing contract requirements; requiring
121 the department to publish such contract on its
122 website; authorizing lead agencies to establish
123 additional contract terms under certain circumstances;
124 amending s. 414.56, F.S.; conforming a provision to
125 changes made by the act; reenacting ss. 409.978(2) and

126 409.9855(1)(b), F.S., relating to the long-term care
 127 managed care program and the pilot program for
 128 individuals with developmental disabilities,
 129 respectively; amending ss. 409.91196 and 393.065,
 130 F.S.; conforming cross-references; providing effective
 131 dates.

132

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

134

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

137 381.4015 Florida health care innovation.—

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

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

145 1. Establishing an application process to submit and
 146 review funding proposals for loans. Such rules must also include
 147 the process for the council to review applications to ensure
 148 compliance with applicable laws, including those related to
 149 discrimination and conflicts of interest. If a council member
 150 participated in the vote of the council recommending an award

151 for a proposal with which the council member has a conflict of
152 interest, the division may not award the loan to that entity.

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

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

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

170 3. It deems necessary to administer the program,
171 including, but not limited to, rules for application
172 requirements, the ability of the applicant to properly
173 administer funds, the professional excellence of the applicant,
174 the fiscal stability of the applicant, the state or regional
175 impact of the proposal, matching requirements for the proposal,

176 and other requirements to further the purposes of the program.

177 (b) Eligibility.—

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

179 a. Entities licensed, registered, or certified by the
180 Agency for Health Care Administration as provided under s.
181 408.802, except for those specified in s. 408.802(1), (3), (13),
182 (23), or (25).

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

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

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

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

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

196 b. Nonprofit entities that accept Medicaid patients.

197 4. The department may award a loan for up to 50 percent of
198 the total projected implementation costs, or up to 80 percent of
199 total projected implementation costs for an applicant under
200 subparagraph 3. The applicant must demonstrate the source of

201 funding it will use to cover the remainder of the total
202 projected implementation costs, which funding must be from
203 nonstate sources.

204 (c) Applications.—

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

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

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

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

235 (d) Awards.—

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

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

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

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

248 (e) Written agreement.—

249 1. Each loan recipient must enter into a written agreement
250 with the department to receive the loan. At a minimum, the

251 agreement with the applicant must specify all of the following:

252 a. The total amount of the award.

253 b. The performance conditions that must be met, based upon

254 the submitted proposal and the defined category or focus area,

255 as applicable.

256 c. The information to be reported on actual implementation

257 costs, including the share from nonstate resources.

258 d. The schedule for payment.

259 e. The data and progress reporting requirements and

260 schedule.

261 f. Any sanctions that would apply for failure to meet

262 performance conditions.

263 2. The department shall develop uniform data reporting

264 requirements for loan recipients to evaluate the performance of

265 the implemented proposals. Such data must be shared with the

266 council.

267 3. If requested, the department shall provide technical

268 assistance to loan recipients under the program.

269 (f) Loan repayment.—Loans become due and payable in

270 accordance with the terms of the written agreement. All

271 repayments of principal received by the department in a fiscal

272 year shall be returned to the revolving loan fund and made

273 available for loans to other applicants.

274 (g) Revolving loan fund.—The department shall create and

275 maintain a separate account in the Grants and Donations Trust

276 Fund within the department as a fund for the program. All
 277 repayments of principal must be returned to the revolving loan
 278 fund and made available as provided in this section.
 279 Notwithstanding s. 216.301, funds appropriated for the revolving
 280 loan program are not subject to reversion. The department may
 281 contract with a third-party administrator to administer the
 282 program, including loan servicing, and manage the revolving loan
 283 fund. A contract for a third-party administrator which includes
 284 management of the revolving loan fund must, at a minimum,
 285 require maintenance of the revolving loan fund to ensure that
 286 the program may operate in a revolving manner.

287 Section 2. Paragraph (a) of subsection (2) of section
 288 383.14, Florida Statutes, is amended to read:

289 383.14 Screening for metabolic disorders, other hereditary
 290 and congenital disorders, and environmental risk factors.—

291 (2) RULES.—

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

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

297 2. Be tested for any condition included on the federal
 298 Recommended Uniform Screening Panel which the council advises
 299 the department should be included under the state's screening
 300 program. After the council recommends that a condition be

301 included, the department shall submit a legislative budget
302 request to seek an appropriation to add testing of the condition
303 to the newborn screening program. The department shall expand
304 statewide screening of newborns to include screening for such
305 conditions within 18 months after the council renders such
306 advice, if a test approved by the United States Food and Drug
307 Administration or a test offered by an alternative vendor is
308 available. If such a test is not available within 18 months
309 after the council makes its recommendation, the department shall
310 implement such screening as soon as a test offered by the United
311 States Food and Drug Administration or by an alternative vendor
312 is available;

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

316 4. ~~Subject to legislative appropriation,~~ Beginning January
317 1, 2027, be screened for all of the following:

318 a. Duchenne muscular dystrophy.

319 b. Infantile Krabbe disease.

320 c. Metachromatic leukodystrophy.

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

323 383.1401 Neonatal Nutrition.—The Department of Health
324 shall create an evidence-based, educational pamphlet on the
325 nutritional needs of preterm infants. By January 1, 2027, the

326 department shall make the pamphlet available electronically to
327 hospitals licensed under chapter 395 to provide neonatal
328 intensive care services. Such hospitals may provide the pamphlet
329 to parents and guardians of infants receiving care in a neonatal
330 intensive care unit. The pamphlet must include, but need not be
331 limited to, information on preterm infants relating to all of
332 the following:

333 (1) The specific nutritional needs of preterm infants;

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

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

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

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

349 (6) Necrotizing enterocolitis, the risk factors for
350 necrotizing enterocolitis, and the potential for a human-milk-

351 based diet, including maternal and pasteurized donor breast
352 milk, to reduce the risk of necrotizing enterocolitis.

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

356 393.066 Community services and treatment.—

357 (9) The agency shall utilize a monthly reimbursement rate,
358 developed by the Agency for Health Care Administration in
359 consultation with the agency, for Life Skills Development Level
360 3 and Level 4 services. The monthly reimbursement rate shall
361 apply to services for clients who receive at least 80 hours of
362 such services during a calendar month. For clients who receive
363 less than 80 hours of services during a calendar month,
364 providers shall be reimbursed using an hourly reimbursement
365 rate.

366 Section 5. Paragraph (g) of subsection (16) of section
367 395.4025, Florida Statutes, is redesignated as paragraph (h),
368 and a new paragraph (g) is added to that subsection to read:

369 395.4025 Trauma centers; selection; quality assurance;
370 records.—

371 (16)

372 (g) Notwithstanding the statutory capacity limits
373 established in s. 395.402(1), the provisions of subsection (8),
374 or any other provision of this part, specialty licensed
375 children's hospitals licensed by the agency shall be designated

376 by the department as a Level I or Level II pediatric trauma
377 center based on documentation of a valid certification of trauma
378 center verification by the American College of Surgeons.

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

381 395.902 Behavioral health teaching hospitals.—

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

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

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

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

395 395.903 Behavioral Health Teaching Hospital grant
396 program.—

397 (1) There is established within the agency a grant program
398 for the purpose of funding designated behavioral health teaching
399 hospitals, subject to legislative appropriation. Grant funding
400 may be used for operational expenses for the delivery of

401 comprehensive wrap-around rehabilitative services for behavioral
402 health patients operations and expenses and for fixed capital
403 outlay expenses that are directly related to the provision of
404 behavioral health services by the behavioral health teaching
405 hospital or its subcontracted behavioral health care provider,
406 including, but not limited to:r

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

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

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

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

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

418 (2)(a)1. For the 2024-2025 fiscal year, the agency shall
419 hold a 30-day, open application period beginning November 1,
420 2024, to accept applications from the behavioral health teaching
421 hospitals designated under s. 395.902(4), in a manner determined
422 by the agency. Applicants must include a detailed spending plan
423 with the application.

424 (b)2. For the 2025-2026 and 2026-2027 fiscal years, the
425 agency shall hold a 30-day, open application period beginning

426 | October 1 of each year to accept applications from behavioral
427 | health teaching hospitals designated under s. 395.902, in a
428 | manner determined by the agency. Applicants must include a
429 | detailed spending plan with the application. On or before
430 | January 1, 2025, and January 1, 2026, hospitals desiring to
431 | apply for designation in the next fiscal year shall submit
432 | letters of intent to the agency.

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

445 | (4)~~(e)~~ Notwithstanding ss. 216.181 and 216.292, the agency
446 | may submit budget amendments, subject to the notice, review, and
447 | objection procedures under s. 216.177, requesting the release of
448 | the funds to make awards. The agency is authorized to submit
449 | budget amendments relating to expenses under this subsection
450 | under the grant program only within the 90 days after the open

451 application period closes.

452 (5)~~(2)~~ Notwithstanding s. 216.301 and pursuant to s.
453 216.351, the balance of any appropriation from the General
454 Revenue Fund for the program which is not disbursed but which is
455 obligated pursuant to contract or committed to be expended by
456 June 30 of the fiscal year for which the funds are appropriated
457 may be carried forward for up to 8 years after the effective
458 date of the original appropriation.

459 (6)~~(3)~~ The agency may adopt rules necessary to implement
460 this section.

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

463 409.145 Care of children; "reasonable and prudent parent"
464 standard.—The child welfare system of the department shall
465 operate as a coordinated community-based system of care which
466 empowers all caregivers for children in foster care to provide
467 quality parenting, including approving or disapproving a child's
468 participation in activities based on the caregiver's assessment
469 using the "reasonable and prudent parent" standard.

470 (3) ROOM AND BOARD RATES.—

471 (a) Effective July 1, 2026 ~~2022~~, room and board rates
472 shall be paid to foster parents, including relative and
473 nonrelative caregivers who are licensed as a level I child-
474 specific foster placement, and to relative and nonrelative
475 caregivers who are participating in the Relative Caregiver

476 Program and receiving payments pursuant to s. 39.5085(2)(d)1. or
 477 2., as follows:

478 Monthly Room and Board Rate

479

0-5 Years	6-12 Years	13-21 Years
Age	Age	Age
<u>\$663.03</u> \$517.94	<u>\$680.01</u> \$531.21	<u>\$795.94</u> \$621.77

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

496 (c) The amount of the monthly room and board rate may be

497 increased upon agreement among the department, the community-
498 based care lead agency, and the foster parent.

499 (d) Effective July 1, 2022, community-based care lead
500 agencies providing care under contract with the department shall
501 pay a supplemental room and board payment to foster parents,
502 including relative and nonrelative caregivers who are licensed
503 as a level I child-specific foster placement and relative and
504 nonrelative caregivers who are participating in the Relative
505 Caregiver Program and receiving payments pursuant to s.
506 39.5085(2)(d)1. or 2., on a per-child basis, for providing
507 independent life skills and normalcy supports to children who
508 are 13 through 17 years of age placed in their care. The
509 supplemental payment must be paid monthly in addition to the
510 current monthly room and board rate payment. The supplemental
511 monthly payment shall be based on 10 percent of the monthly room
512 and board rate for children 13 through 21 years of age as
513 provided under this section and adjusted annually.

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

516 409.1455 Step into Success Workforce Education and
517 Internship ~~Pilot~~ Program for foster youth and former foster
518 youth.—

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

521 (2) CREATION.—The department shall establish the ~~3-year~~

522 Step into Success Workforce Education and Internship ~~Pilot~~
523 Program to give eligible foster youth and former foster youth an
524 opportunity to learn and develop essential workforce and
525 professional skills, to transition from the custody of the
526 department to independent living, and to become better prepared
527 for an independent and successful future. The ~~pilot~~ program must
528 consist of an independent living professionalism and workforce
529 education component and, for youth who complete that component,
530 an onsite workforce training internship component. In
531 consultation with subject-matter experts and the community-based
532 care lead agencies, the office shall develop and administer the
533 ~~pilot~~ program for interested foster youth and former foster
534 youth; however, the department may contract with entities that
535 have demonstrable subject-matter expertise in the transition to
536 adulthood for foster youth, workforce training and preparedness,
537 professional skills, and related subjects to collaborate with
538 the office in the development and administration of the ~~pilot~~
539 program. The independent living professionalism and workforce
540 education component of the program must culminate in a
541 certificate that allows a former foster youth to participate in
542 the onsite workforce training internship.

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

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

546 (b) "Former foster youth" means an individual 18 years of

547 age or older but younger than 26 years of age who is currently
548 or was previously placed in licensed care, excluding Level I
549 licensed placements pursuant to s. 409.175(5)(a)1., for at least
550 60 days within this state.

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

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

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

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

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

569 (b) Collaborate with local chambers of commerce and
570 recruit mentors and organizations within the department's
571 regions, emphasizing recruitment of mentors and organizations in

572 the following counties:

573 1. Duval.

574 2. Escambia.

575 3. Hillsborough.

576 4. Palm Beach.

577 5. Polk.

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

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

595 (a) Designate and ensure that the number of qualified
596 staff is sufficient to implement and administer the component,

597 | which may be part of a larger independent living or life skills
598 | training program if the larger program meets the requirements of
599 | this subsection.

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

- 609 | 1. Interview skills;
- 610 | 2. Professionalism;
- 611 | 3. Teamwork;
- 612 | 4. Leadership;
- 613 | 5. Problem solving; and
- 614 | 6. Conflict resolution in the workplace.

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

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

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

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

636 (g) Assess the career interests of each eligible foster
637 youth and former foster youth who expresses interest in
638 participating in the program and determine the most appropriate
639 internship and post-internship opportunities for that youth
640 based on his or her expressed interests.

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

645 (a) Develop processes and procedures to implement a
646 trauma-informed onsite workforce training internship component.

647 The processes and procedures of the internship component must be
648 designed so that they can be replicated and scaled to meet
649 various organizational structures and sizes. The component must
650 include:

- 651 1. Recruitment of agencies, corporations, and other
652 entities to host interns as participating organizations;
- 653 2. Assisting participating organizations with mentor
654 recruitment, training, and matching;
- 655 3. Mentor-led performance reviews, including a review of
656 the intern's work product, professionalism, time management,
657 communication style, and stress-management strategies;
- 658 4. Daily mentorship and coaching on topics such as:
 - 659 a. Professionalism;
 - 660 b. Teamwork;
 - 661 c. Leadership;
 - 662 d. Problem solving; and
 - 663 e. Conflict resolution in the workplace;
- 664 5. Development of opportunities for interns to become
665 employees of the participating organization; and
- 666 6. Reporting requirements specified in subsection (11).
 - 667 (b) Develop a ~~minimum of 1 hour of~~ required trauma-
668 informed training for mentors to satisfy the requirements of
669 sub-subparagraph (7) (b) 1.e. Such training must include
670 interactive or experiential components, such as role-playing,
671 scenario discussion, or case studies. The office may provide at

672 least four additional 1-hour trainings on mentorship of special
673 populations as optional training opportunities, which must be
674 asynchronous and accessible to mentors online at their
675 convenience, and must inform participating organizations of
676 these optional training opportunities ~~teach the skills necessary~~
677 ~~to engage with participating eligible former foster youth.~~

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

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

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

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

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

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

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

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

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

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

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

721 (a) Collaborate with the office to implement a trauma-

722 informed approach to mentoring and training former foster youth.

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

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

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

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

730 c. Sign a monthly hour statement for the intern;

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

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

740 (I) Understanding trauma and its impacts.

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

743 (III) De-escalation strategies and crisis response.

744 (IV) Boundaries and mentor self-care.

745 (V) Communication skills.

746

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

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

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

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

765 (c) When necessary, have a discussion with an intern's
766 assigned mentor, the participating organization's internship
767 program liaison, and the office about the creation of a
768 corrective action plan to address issues related to the intern's
769 professionalism, work product, or performance and, if
770 applicable, after giving the intern a reasonable opportunity to
771 comply with the corrective action plan, document the intern's

772 failure to do so before discharging him or her.

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

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

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

790 (9) AWARD OF POSTSECONDARY CREDIT.—The Board of Governors
791 and the State Board of Education shall adopt regulations and
792 rules, respectively, to award postsecondary credit or career
793 education clock hours for eligible former foster youth
794 participating in the internship component pursuant to subsection
795 (4). The regulations and rules must include procedures for the
796 award of postsecondary credit or career education clock hours,

797 including, but not limited to, equivalency and alignment of the
798 internship component with appropriate postsecondary courses and
799 course descriptions.

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

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

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

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

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

834 (e) A former foster youth may, at the discretion of a
835 postsecondary educational institution within this state in which
836 such youth is enrolled, earn postsecondary credit or career
837 education clock hours for work performed as an intern under the
838 internship component. Postsecondary credit and career education
839 clock hours earned for work performed under the internship
840 component may be in addition to any compensation earned for the
841 same work performed under the internship component and may be
842 awarded for completion of all or any part of the internship
843 component. Participating organizations shall cooperate with
844 postsecondary educational institutions to provide any
845 information about internship positions which is necessary to
846 enable the institutions to determine whether to grant the

847 participating former foster youth postsecondary credit or career
848 education clock hours toward his or her degree.

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

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

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

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

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

870 (d) A summary of the feedback and surveys received
871 pursuant to paragraph (6) (h) from participating former foster

872 youth, mentors, and others who have participated in the ~~pilot~~
873 program.

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

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

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

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

887 409.1475 Foster and Family Support Grant Program.—

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

895 (2) The department shall award grants to not-for-profit,
896 faith-based organizations to support their efforts in the

897 recruitment of foster and adoptive families through faith-based
898 organizations and strengthening local capacity to support
899 foster, adoptive, and kinship families and families caring for
900 vulnerable children in underserved and rural communities. The
901 program shall emphasize sustained, community-based support
902 beyond initial licensure or training in order to improve
903 caregiver retention and outcomes for children.

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

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

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

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

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

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

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

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

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

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

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

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

943 409.908 Reimbursement of Medicaid providers.—Subject to
944 specific appropriations, the agency shall reimburse Medicaid
945 providers, in accordance with state and federal law, according
946 to methodologies set forth in the rules of the agency and in

947 policy manuals and handbooks incorporated by reference therein.
948 These methodologies may include fee schedules, reimbursement
949 methods based on cost reporting, negotiated fees, competitive
950 bidding pursuant to s. 287.057, and other mechanisms the agency
951 considers efficient and effective for purchasing services or
952 goods on behalf of recipients. If a provider is reimbursed based
953 on cost reporting and submits a cost report late and that cost
954 report would have been used to set a lower reimbursement rate
955 for a rate semester, then the provider's rate for that semester
956 shall be retroactively calculated using the new cost report, and
957 full payment at the recalculated rate shall be effected
958 retroactively. Medicare-granted extensions for filing cost
959 reports, if applicable, shall also apply to Medicaid cost
960 reports. Payment for Medicaid compensable services made on
961 behalf of Medicaid-eligible persons is subject to the
962 availability of moneys and any limitations or directions
963 provided for in the General Appropriations Act or chapter 216.
964 Further, nothing in this section shall be construed to prevent
965 or limit the agency from adjusting fees, reimbursement rates,
966 lengths of stay, number of visits, or number of services, or
967 making any other adjustments necessary to comply with the
968 availability of moneys and any limitations or directions
969 provided for in the General Appropriations Act, provided the
970 adjustment is consistent with legislative intent.

971 (2)

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

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

997 parameters:

998 a. Peer Groups, including:

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

1000 Counties; and

1001 (II) South-SMMC Regions 10-11, plus Palm Beach and

1002 Okeechobee Counties.

1003 b. Percentage of Median Costs based on the cost reports

1004 used for September 2016 rate setting:

1005 (I) Direct Care Costs.....100 percent.

1006 (II) Indirect Care Costs.....92 percent.

1007 (III) Operating Costs.....86 percent.

1008 c. Floors:

1009 (I) Direct Care Component.....95 percent.

1010 (II) Indirect Care Component.....92.5 percent.

1011 (III) Operating Component.....None.

1012 d. Pass-through Payments.....Real Estate and

1013 Personal Property

1014 Taxes and Property Insurance.

1015 e. Quality Incentive Program Payment

1016 Pool 18.1373 ~~40~~ percent of September

1017 2016 non-property related

1018 payments of included facilities.

1019 f. Quality Score Threshold to Qualify for Quality

1020 Incentive Payment.....33

1021 percent of all available points in

1022 | the Medicaid Quality Incentive Program 20th
 1023 | ~~percentile of included facilities.~~
 1024 | g. Fair Rental Value System Payment Parameters:
 1025 | (I) Building Value per Square Foot based on 2018 RS Means.
 1026 | (II) Land Valuation.....10 percent of Gross Building value.
 1027 | (III) Facility Square Footage.....Actual Square Footage.
 1028 | (IV) Movable Equipment Allowance.....\$8,000 per bed.
 1029 | (V) Obsolescence Factor.....1.5 percent.
 1030 | (VI) Fair Rental Rate of Return.....8 percent.
 1031 | (VII) Minimum Occupancy.....90 percent.
 1032 | (VIII) Maximum Facility Age.....40 years.
 1033 | (IX) Minimum Square Footage per Bed.....350.
 1034 | (X) Maximum Square Footage for Bed.....500.
 1035 | (XI) Minimum Cost of a renovation/replacements.....\$500 per
 1036 | bed.
 1037 | h. Ventilator Supplemental payment of \$200 per Medicaid
 1038 | day of 40,000 ventilator Medicaid days per fiscal year.
 1039 | 2. The agency shall revise its methodology for calculating
 1040 | Quality Incentive Program payments to:
 1041 | a. Include the results of consumer satisfaction surveys
 1042 | conducted pursuant to s. 400.0225 as a measure of nursing home
 1043 | quality. The agency shall so revise the methodology after the
 1044 | surveys have been in effect for an amount of time the agency
 1045 | deems sufficient for statistical and scientific validity as a
 1046 | meaningful quality measure that may be incorporated into the

1047 methodology.

1048 b. During the next rebasing for the Quality Incentive
1049 Program, consider implementing the recommendations proposed in
1050 sections 3.1.1-3.1.5 of the Study of Nursing Home Quality
1051 Incentive Programs Final Report pursuant to section 20 of
1052 chapter 2025-204, Laws of Florida, and presented to the agency
1053 on December 22, 2025.

1054 c. Delay the effective date of any change made to its
1055 methodology or scoring due to rebasing for 1 year after any
1056 recalculations have been completed and the scores have been made
1057 available to the public.

1058 3. The direct care subcomponent shall include salaries and
1059 benefits of direct care staff providing nursing services
1060 including registered nurses, licensed practical nurses, and
1061 certified nursing assistants who deliver care directly to
1062 residents in the nursing home facility, allowable therapy costs,
1063 and dietary costs. This excludes nursing administration, staff
1064 development, the staffing coordinator, and the administrative
1065 portion of the minimum data set and care plan coordinators. The
1066 direct care subcomponent also includes medically necessary
1067 dental care, vision care, hearing care, and podiatric care.

1068 4. All other patient care costs shall be included in the
1069 indirect care cost subcomponent of the patient care per diem
1070 rate, including complex medical equipment, medical supplies, and
1071 other allowable ancillary costs. Costs may not be allocated

1072 directly or indirectly to the direct care subcomponent from a
1073 home office or management company.

1074 5. On July 1 of each year, the agency shall report to the
1075 Legislature direct and indirect care costs, including average
1076 direct and indirect care costs per resident per facility and
1077 direct care and indirect care salaries and benefits per category
1078 of staff member per facility.

1079 6. Every fourth year, the agency shall rebase nursing home
1080 prospective payment rates to reflect changes in cost based on
1081 the most recently audited cost report for each participating
1082 provider.

1083 7. A direct care supplemental payment may be made to
1084 providers whose direct care hours per patient day are above the
1085 80th percentile and who provide Medicaid services to a larger
1086 percentage of Medicaid patients than the state average.

1087 8. Pediatric, Florida Department of Veterans Affairs, and
1088 government-owned facilities are exempt from the pricing model
1089 established in this subsection and shall remain on a cost-based
1090 prospective payment system. Effective October 1, 2018, the
1091 agency shall set rates for all facilities remaining on a cost-
1092 based prospective payment system using each facility's most
1093 recently audited cost report, eliminating retroactive
1094 settlements.

1095 9. By October 1, 2025, and each year thereafter, the
1096 agency shall submit to the Governor, the President of the

1097 Senate, and the Speaker of the House of Representatives a report
1098 on each Quality Incentive Program payment made pursuant to sub-
1099 subparagraph 1.e. The report must, at a minimum, include all of
1100 the following information:

1101 a. The name of each facility that received a Quality
1102 Incentive Program payment and the dollar amount of such payment
1103 each facility received.

1104 b. The total number of quality incentive metric points
1105 awarded by the agency to each facility and the number of points
1106 awarded by the agency for each individual quality metric
1107 measured.

1108 c. An examination of any trends in the improvement of the
1109 quality of care provided to nursing home residents which may be
1110 attributable to incentive payments received under the Quality
1111 Incentive Program. The agency shall include examination of
1112 trends both for the program as a whole as well as for each
1113 individual quality metric used by the agency to award program
1114 payments.

1115
1116 It is the intent of the Legislature that the reimbursement plan
1117 achieve the goal of providing access to health care for nursing
1118 home residents who require large amounts of care while
1119 encouraging diversion services as an alternative to nursing home
1120 care for residents who can be served within the community. The
1121 agency shall base the establishment of any maximum rate of

1122 payment, whether overall or component, on the available moneys
1123 as provided for in the General Appropriations Act. The agency
1124 may base the maximum rate of payment on the results of
1125 scientifically valid analysis and conclusions derived from
1126 objective statistical data pertinent to the particular maximum
1127 rate of payment. The agency shall base the rates of payments in
1128 accordance with the minimum wage requirements as provided in the
1129 General Appropriations Act.

1130 Section 12. Effective July 1, 2027, paragraph (b) of
1131 subsection (2) of section 409.908, Florida Statutes, as amended
1132 by this act, is amended to read:

1133 409.908 Reimbursement of Medicaid providers.—Subject to
1134 specific appropriations, the agency shall reimburse Medicaid
1135 providers, in accordance with state and federal law, according
1136 to methodologies set forth in the rules of the agency and in
1137 policy manuals and handbooks incorporated by reference therein.
1138 These methodologies may include fee schedules, reimbursement
1139 methods based on cost reporting, negotiated fees, competitive
1140 bidding pursuant to s. 287.057, and other mechanisms the agency
1141 considers efficient and effective for purchasing services or
1142 goods on behalf of recipients. If a provider is reimbursed based
1143 on cost reporting and submits a cost report late and that cost
1144 report would have been used to set a lower reimbursement rate
1145 for a rate semester, then the provider's rate for that semester
1146 shall be retroactively calculated using the new cost report, and

1147 full payment at the recalculated rate shall be effected
1148 retroactively. Medicare-granted extensions for filing cost
1149 reports, if applicable, shall also apply to Medicaid cost
1150 reports. Payment for Medicaid compensable services made on
1151 behalf of Medicaid-eligible persons is subject to the
1152 availability of moneys and any limitations or directions
1153 provided for in the General Appropriations Act or chapter 216.
1154 Further, nothing in this section shall be construed to prevent
1155 or limit the agency from adjusting fees, reimbursement rates,
1156 lengths of stay, number of visits, or number of services, or
1157 making any other adjustments necessary to comply with the
1158 availability of moneys and any limitations or directions
1159 provided for in the General Appropriations Act, provided the
1160 adjustment is consistent with legislative intent.

1161 (2)

1162 (b) Subject to any limitations or directions in the
1163 General Appropriations Act, the agency shall establish and
1164 implement a state Title XIX Long-Term Care Reimbursement Plan
1165 for nursing home care in order to provide care and services in
1166 conformance with the applicable state and federal laws, rules,
1167 regulations, and quality and safety standards and to ensure that
1168 individuals eligible for medical assistance have reasonable
1169 geographic access to such care.

1170 1. The agency shall amend the long-term care reimbursement
1171 plan and cost reporting system to create direct care and

1172 indirect care subcomponents of the patient care component of the
 1173 per diem rate. These two subcomponents together shall equal the
 1174 patient care component of the per diem rate. Separate prices
 1175 shall be calculated for each patient care subcomponent,
 1176 initially based on the September 2016 rate setting cost reports
 1177 and subsequently based on the most recently audited cost report
 1178 used during a rebasing year. The direct care subcomponent of the
 1179 per diem rate for any providers still being reimbursed on a cost
 1180 basis shall be limited by the cost-based class ceiling, and the
 1181 indirect care subcomponent may be limited by the lower of the
 1182 cost-based class ceiling, the target rate class ceiling, or the
 1183 individual provider target. The ceilings and targets apply only
 1184 to providers being reimbursed on a cost-based system. Effective
 1185 October 1, 2018, a prospective payment methodology shall be
 1186 implemented for rate setting purposes with the following
 1187 parameters:

- 1188 a. Peer Groups, including:
 - 1189 (I) North-SMMC Regions 1-9, less Palm Beach and Okeechobee
 1190 Counties; and
 - 1191 (II) South-SMMC Regions 10-11, plus Palm Beach and
 1192 Okeechobee Counties.
- 1193 b. Percentage of Median Costs based on the cost reports
 1194 used for September 2016 rate setting:
 - 1195 (I) Direct Care Costs.....100 percent.
 - 1196 (II) Indirect Care Costs.....92 percent.

1197 (III) Operating Costs.....86 percent.
 1198 c. Floors:
 1199 (I) Direct Care Component.....95 percent.
 1200 (II) Indirect Care Component.....92.5 percent.
 1201 (III) Operating Component.....None.
 1202 d. Pass-through Payments.....Real Estate and
 1203 Personal Property
 1204 Taxes and Property Insurance.
 1205 e. Quality Incentive Program Payment
 1206 Pool 16.5482 ~~18.1373~~ percent of September
 1207 2016 non-property related
 1208 payments of included facilities.
 1209 f. Quality Score Threshold to Qualify for Quality
 1210 Incentive Payment.....33
 1211 percent of all available points in
 1212 the Medicaid Quality Incentive Program.
 1213 g. Fair Rental Value System Payment Parameters:
 1214 (I) Building Value per Square Foot based on 2018 RS Means.
 1215 (II) Land Valuation.....10 percent of Gross Building value.
 1216 (III) Facility Square Footage.....Actual Square Footage.
 1217 (IV) Movable Equipment Allowance.....\$8,000 per bed.
 1218 (V) Obsolescence Factor.....1.5 percent.
 1219 (VI) Fair Rental Rate of Return.....8 percent.
 1220 (VII) Minimum Occupancy.....90 percent.
 1221 (VIII) Maximum Facility Age.....40 years.

- 1222 (IX) Minimum Square Footage per Bed.....350.
- 1223 (X) Maximum Square Footage for Bed.....500.
- 1224 (XI) Minimum Cost of a renovation/replacements.....\$500 per
- 1225 bed.
- 1226 h. Ventilator Supplemental payment of \$200 per Medicaid
- 1227 day of 40,000 ventilator Medicaid days per fiscal year.
- 1228 2. The agency shall revise its methodology for calculating
- 1229 Quality Incentive Program payments to:
 - 1230 a. Include the results of consumer satisfaction surveys
 - 1231 conducted pursuant to s. 400.0225 as a measure of nursing home
 - 1232 quality. The agency shall so revise the methodology after the
 - 1233 surveys have been in effect for an amount of time the agency
 - 1234 deems sufficient for statistical and scientific validity as a
 - 1235 meaningful quality measure that may be incorporated into the
 - 1236 methodology.
 - 1237 b. During the next rebasing for the Quality Incentive
 - 1238 Program, consider implementing the recommendations proposed in
 - 1239 sections 3.1.1-3.1.5 of the Study of Nursing Home Quality
 - 1240 Incentive Programs Final Report pursuant to section 20 of
 - 1241 chapter 2025-204, Laws of Florida, and presented to the agency
 - 1242 on December 22, 2025.
 - 1243 c. Delay the effective date of any change made to its
 - 1244 methodology or scoring due to rebasing for 1 year after any
 - 1245 recalculations have been completed and the scores have been made
 - 1246 available to the public.

1247 3. The direct care subcomponent shall include salaries and
1248 benefits of direct care staff providing nursing services
1249 including registered nurses, licensed practical nurses, and
1250 certified nursing assistants who deliver care directly to
1251 residents in the nursing home facility, allowable therapy costs,
1252 and dietary costs. This excludes nursing administration, staff
1253 development, the staffing coordinator, and the administrative
1254 portion of the minimum data set and care plan coordinators. The
1255 direct care subcomponent also includes medically necessary
1256 dental care, vision care, hearing care, and podiatric care.

1257 4. All other patient care costs shall be included in the
1258 indirect care cost subcomponent of the patient care per diem
1259 rate, including complex medical equipment, medical supplies, and
1260 other allowable ancillary costs. Costs may not be allocated
1261 directly or indirectly to the direct care subcomponent from a
1262 home office or management company.

1263 5. On July 1 of each year, the agency shall report to the
1264 Legislature direct and indirect care costs, including average
1265 direct and indirect care costs per resident per facility and
1266 direct care and indirect care salaries and benefits per category
1267 of staff member per facility.

1268 6. Every fourth year, the agency shall rebase nursing home
1269 prospective payment rates to reflect changes in cost based on
1270 the most recently audited cost report for each participating
1271 provider.

1272 7. A direct care supplemental payment may be made to
1273 providers whose direct care hours per patient day are above the
1274 80th percentile and who provide Medicaid services to a larger
1275 percentage of Medicaid patients than the state average.

1276 8. Pediatric, Florida Department of Veterans Affairs, and
1277 government-owned facilities are exempt from the pricing model
1278 established in this subsection and shall remain on a cost-based
1279 prospective payment system. Effective October 1, 2018, the
1280 agency shall set rates for all facilities remaining on a cost-
1281 based prospective payment system using each facility's most
1282 recently audited cost report, eliminating retroactive
1283 settlements.

1284 9. By October 1, 2025, and each year thereafter, the
1285 agency shall submit to the Governor, the President of the
1286 Senate, and the Speaker of the House of Representatives a report
1287 on each Quality Incentive Program payment made pursuant to sub-
1288 subparagraph 1.e. The report must, at a minimum, include all of
1289 the following information:

1290 a. The name of each facility that received a Quality
1291 Incentive Program payment and the dollar amount of such payment
1292 each facility received.

1293 b. The total number of quality incentive metric points
1294 awarded by the agency to each facility and the number of points
1295 awarded by the agency for each individual quality metric
1296 measured.

1297 c. An examination of any trends in the improvement of the
1298 quality of care provided to nursing home residents which may be
1299 attributable to incentive payments received under the Quality
1300 Incentive Program. The agency shall include examination of
1301 trends both for the program as a whole as well as for each
1302 individual quality metric used by the agency to award program
1303 payments.

1304

1305 It is the intent of the Legislature that the reimbursement plan
1306 achieve the goal of providing access to health care for nursing
1307 home residents who require large amounts of care while
1308 encouraging diversion services as an alternative to nursing home
1309 care for residents who can be served within the community. The
1310 agency shall base the establishment of any maximum rate of
1311 payment, whether overall or component, on the available moneys
1312 as provided for in the General Appropriations Act. The agency
1313 may base the maximum rate of payment on the results of
1314 scientifically valid analysis and conclusions derived from
1315 objective statistical data pertinent to the particular maximum
1316 rate of payment. The agency shall base the rates of payments in
1317 accordance with the minimum wage requirements as provided in the
1318 General Appropriations Act.

1319 Section 13. Subsection (6) of section 409.909, Florida
1320 Statutes, is amended to read:

1321 409.909 Statewide Medicaid Residency Program.—

1322 (6) The Slots for Doctors Program is established to
 1323 address the physician workforce shortage by increasing the
 1324 supply of highly trained physicians through the creation of new
 1325 resident positions, which will increase access to care and
 1326 improve health outcomes for Medicaid recipients.

1327 (a)1. Notwithstanding subsection (4), the agency shall
 1328 annually allocate funding ~~\$100,000~~ to hospitals, qualifying
 1329 institutions, and behavioral health teaching hospitals
 1330 designated under s. 395.902 for each newly created resident
 1331 position that is first filled on or after June 1, 2023, and
 1332 filled thereafter, and that is accredited by the Accreditation
 1333 Council for Graduate Medical Education or the Osteopathic
 1334 Postdoctoral Training Institution in an initial or established
 1335 accredited training program which is in a physician specialty or
 1336 subspecialty in a statewide supply-and-demand deficit.

1337 a. Beginning in the 2024-2025 fiscal year, for purposes of
 1338 distributing funds appropriated in the General Appropriations
 1339 Act, the agency shall use exclusively the following formula to
 1340 calculate every participating hospital's and qualifying
 1341 institution's allocation factor for the funding allocated for
 1342 the enumerated statewide specialties and subspecialties as
 1343 provided in paragraph (c) and separately calculate every
 1344 participating behavioral health teaching hospital's allocation
 1345 fraction for the funding allocated for those hospitals
 1346 designated under s. 395.902:

1347 HAF = [0.9 x (HP/TP)] + [0.1 x (HMP/TMP)]

1348 Where:

1349 HAF = A hospital's and qualifying institution's or
 1350 behavioral health teaching hospital's allocation fraction.

1351 HP = A hospital's and qualifying institution's or
 1352 behavioral health teaching hospital's total number of positions.

1353 TP = The total positions for all participating hospitals
 1354 and qualifying institutions or behavioral health teaching
 1355 hospitals.

1356 HMP = A hospital's and qualifying institution's or
 1357 behavioral health teaching hospital's Medicaid payments.

1358 TMP = The total Medicaid payments for all participating
 1359 hospitals and qualifying institutions or behavioral health
 1360 teaching hospitals.

1361

1362 As used in this sub-subparagraph, "Medicaid payments" means the
 1363 estimated total payments for reimbursing a hospital and
 1364 qualifying institutions or behavioral health teaching hospitals
 1365 for direct inpatient and outpatient services for the fiscal year
 1366 in which the allocation fraction is calculated based on the
 1367 hospital inpatient appropriation and outpatient appropriation
 1368 and the parameters for the inpatient diagnosis-related group
 1369 base rate and the parameters for the outpatient enhanced
 1370 ambulatory payment group rate, including applicable
 1371 intergovernmental transfers, specified in the General

1372 Appropriations Act, as determined by the agency.

1373 b. A hospital's and qualifying institution's or behavioral

1374 health teaching hospital's annual allocation shall be calculated

1375 by multiplying the funds appropriated for the Slots for Doctors

1376 Program in the General Appropriations Act by that hospital's and

1377 qualifying institution's or behavioral health teaching

1378 hospital's allocation fraction. If the calculation results in an

1379 annual allocation that exceeds two times the average per-

1380 position amount for all hospitals and qualifying institutions or

1381 behavioral health teaching hospitals, the hospital's and

1382 qualifying institution's or behavioral health teaching

1383 hospital's annual allocation shall be reduced to a sum equaling

1384 no more than two times the average per position. The funds

1385 calculated for that hospital and qualifying institution or

1386 behavioral health teaching hospital in excess of two times the

1387 average per position amount for all hospitals and qualifying

1388 institutions or behavioral health teaching hospitals shall be

1389 redistributed to participating hospitals and qualifying

1390 institutions; or

1391 2. Notwithstanding the requirement that a new resident

1392 position be created to receive funding under this subsection,

1393 the agency may allocate funding \$100,000 to hospitals and

1394 qualifying institutions, pursuant to subparagraph 1., for up to

1395 100 resident positions that existed before July 1, 2023, if such

1396 resident position:

1397 a. Is in a physician specialty or subspecialty
 1398 experiencing a statewide supply-and-demand deficit;
 1399 b. Has been unfilled for a period of 3 or more years;
 1400 c. Is subsequently filled on or after June 1, 2024, and
 1401 remains filled thereafter; and
 1402 d. Is accredited by the Accreditation Council for Graduate
 1403 Medical Education or the Osteopathic Postdoctoral Training
 1404 Institution in an initial or established accredited training
 1405 program.

1406 3. If applications for resident positions under this
 1407 paragraph exceed the number of authorized resident positions or
 1408 the available funding allocated, the agency shall prioritize
 1409 applications for resident positions that are in a primary care
 1410 specialty as specified in paragraph (2) (a).

1411 (b) This program is designed to generate matching funds
 1412 under Medicaid and distribute such funds to participating
 1413 hospitals, qualifying institutions, and behavioral health
 1414 teaching hospitals designated under s. 395.902, on a quarterly
 1415 basis in each fiscal year for which an appropriation is made.
 1416 Resident positions created under this subsection are not
 1417 eligible for concurrent funding pursuant to subsection (1).

1418 (c) For purposes of this subsection, physician specialties
 1419 and subspecialties, both adult and pediatric, in statewide
 1420 supply-and-demand deficit are those identified as such in the
 1421 General Appropriations Act.

1422 (d) Funds allocated pursuant to this subsection may not be
1423 used for resident positions that have previously received
1424 funding pursuant to subsection (1).

1425 Section 14. Section 409.91195, Florida Statutes, is
1426 amended to read:

1427 409.91195 Medicaid Pharmaceutical and Therapeutics
1428 Committee.—There is created a Medicaid Pharmaceutical and
1429 Therapeutics Committee within the agency for the purpose of
1430 developing a Medicaid preferred drug list and a preferred
1431 product list.

1432 (1) The committee shall be composed of 11 members
1433 appointed by the Governor. Four members shall be physicians,
1434 licensed under chapter 458; one member licensed under chapter
1435 459; five members shall be pharmacists licensed under chapter
1436 465; and one member shall be a consumer representative. The
1437 members shall be appointed to serve for terms of 2 years from
1438 the date of their appointment. Members may be appointed to more
1439 than one term. The agency shall serve as staff for the committee
1440 and assist them with all ministerial duties. The Governor shall
1441 ensure that at least some of the members of the committee
1442 represent Medicaid participating physicians and pharmacies
1443 serving all segments and diversity of the Medicaid population,
1444 and have experience in either developing or practicing under a
1445 preferred drug list. At least one of the members shall represent
1446 the interests of pharmaceutical manufacturers.

1447 (2) Committee members shall select a chairperson and a
1448 vice chairperson each year from the committee membership.

1449 (3) The committee shall meet at least quarterly and may
1450 meet at other times at the discretion of the chairperson and
1451 members. The committee shall comply with rules adopted by the
1452 agency, including notice of any meeting of the committee
1453 pursuant to the requirements of the Administrative Procedure
1454 Act.

1455 (4) Upon recommendation of the committee, the agency shall
1456 adopt a preferred drug list as described in s. 409.912(5) and a
1457 preferred product list as described in s. 409.912(14). To the
1458 extent feasible, the committee shall review all drug and product
1459 classes included on the preferred drug list or preferred product
1460 list every 12 months, and may recommend additions to and
1461 deletions from the lists ~~preferred drug list~~, such that the
1462 preferred drug list provides for medically appropriate drug
1463 therapies and products for Medicaid patients which achieve cost
1464 savings contained in the General Appropriations Act.

1465 (5) Except for antiretroviral drugs, reimbursement of
1466 drugs or products not included on the preferred drug list or
1467 preferred product list are ~~is~~ subject to prior authorization.

1468 (6) The agency shall publish and disseminate the preferred
1469 drug list and the preferred product list to all Medicaid
1470 providers in the state by Internet posting on the agency's
1471 website or in other media.

1472 (7) The committee shall ensure that interested parties,
1473 including pharmaceutical manufacturers agreeing to provide a
1474 supplemental rebate as outlined in this chapter, have an
1475 opportunity to present public testimony to the committee with
1476 information or evidence supporting inclusion of a product on the
1477 preferred drug list or preferred product list. Such public
1478 testimony shall occur before ~~prior to~~ any recommendations made
1479 by the committee for inclusion or exclusion from the preferred
1480 drug list. Upon timely notice, the agency shall ensure that any
1481 drug that has been approved or had any of its particular uses
1482 approved by the United States Food and Drug Administration under
1483 a priority review classification will be reviewed by the
1484 committee at the next regularly scheduled meeting following 3
1485 months of distribution of the drug to the general public.

1486 (8) The committee shall develop its preferred drug list
1487 and preferred product list recommendations by considering the
1488 clinical efficacy, safety, and cost-effectiveness of a product.

1489 (9) The Medicaid Pharmaceutical and Therapeutics Committee
1490 may also make recommendations to the agency regarding the prior
1491 authorization of any prescribed drug covered by Medicaid.

1492 (10) Medicaid recipients may appeal agency preferred drug
1493 formulary decisions using the Medicaid fair hearing process
1494 administered by the Agency for Health Care Administration.

1495 Section 15. Paragraph (a) of subsection (5) of section
1496 409.912, Florida Statutes, is amended, and subsection (14) is

1497 added to that section, to read:

1498 409.912 Cost-effective purchasing of health care.—The
 1499 agency shall purchase goods and services for Medicaid recipients
 1500 in the most cost-effective manner consistent with the delivery
 1501 of quality medical care. To ensure that medical services are
 1502 effectively utilized, the agency may, in any case, require a
 1503 confirmation or second physician's opinion of the correct
 1504 diagnosis for purposes of authorizing future services under the
 1505 Medicaid program. This section does not restrict access to
 1506 emergency services or poststabilization care services as defined
 1507 in 42 C.F.R. s. 438.114. Such confirmation or second opinion
 1508 shall be rendered in a manner approved by the agency. The agency
 1509 shall maximize the use of prepaid per capita and prepaid
 1510 aggregate fixed-sum basis services when appropriate and other
 1511 alternative service delivery and reimbursement methodologies,
 1512 including competitive bidding pursuant to s. 287.057, designed
 1513 to facilitate the cost-effective purchase of a case-managed
 1514 continuum of care. The agency shall also require providers to
 1515 minimize the exposure of recipients to the need for acute
 1516 inpatient, custodial, and other institutional care and the
 1517 inappropriate or unnecessary use of high-cost services. The
 1518 agency shall contract with a vendor to monitor and evaluate the
 1519 clinical practice patterns of providers in order to identify
 1520 trends that are outside the normal practice patterns of a
 1521 provider's professional peers or the national guidelines of a

1522 provider's professional association. The vendor must be able to
1523 provide information and counseling to a provider whose practice
1524 patterns are outside the norms, in consultation with the agency,
1525 to improve patient care and reduce inappropriate utilization.
1526 The agency may mandate prior authorization, drug therapy
1527 management, or disease management participation for certain
1528 populations of Medicaid beneficiaries, certain drug classes, or
1529 particular drugs to prevent fraud, abuse, overuse, and possible
1530 dangerous drug interactions. The Pharmaceutical and Therapeutics
1531 Committee shall make recommendations to the agency on drugs for
1532 which prior authorization is required. The agency shall inform
1533 the Pharmaceutical and Therapeutics Committee of its decisions
1534 regarding drugs subject to prior authorization. The agency is
1535 authorized to limit the entities it contracts with or enrolls as
1536 Medicaid providers by developing a provider network through
1537 provider credentialing. The agency may competitively bid single-
1538 source-provider contracts if procurement of goods or services
1539 results in demonstrated cost savings to the state without
1540 limiting access to care. The agency may limit its network based
1541 on the assessment of beneficiary access to care, provider
1542 availability, provider quality standards, time and distance
1543 standards for access to care, the cultural competence of the
1544 provider network, demographic characteristics of Medicaid
1545 beneficiaries, practice and provider-to-beneficiary standards,
1546 appointment wait times, beneficiary use of services, provider

1547 turnover, provider profiling, provider licensure history,
1548 previous program integrity investigations and findings, peer
1549 review, provider Medicaid policy and billing compliance records,
1550 clinical and medical record audits, and other factors. Providers
1551 are not entitled to enrollment in the Medicaid provider network.
1552 The agency shall determine instances in which allowing Medicaid
1553 beneficiaries to purchase durable medical equipment and other
1554 goods is less expensive to the Medicaid program than long-term
1555 rental of the equipment or goods. The agency may establish rules
1556 to facilitate purchases in lieu of long-term rentals in order to
1557 protect against fraud and abuse in the Medicaid program as
1558 defined in s. 409.913. The agency may seek federal waivers
1559 necessary to administer these policies.

1560 (5) (a) The agency shall implement a Medicaid prescribed-
1561 drug spending-control program that includes the following
1562 components:

1563 1. A Medicaid preferred drug list, which shall be a
1564 listing of cost-effective therapeutic options recommended by the
1565 Medicaid Pharmacy and Therapeutics Committee established
1566 pursuant to s. 409.91195 and adopted by the agency for each
1567 therapeutic class on the preferred drug list. At the discretion
1568 of the committee, and when feasible, the preferred drug list
1569 should include at least two products in a therapeutic class. The
1570 agency may post the preferred drug list and updates to the list
1571 on an Internet website without following the rulemaking

1572 procedures of chapter 120. Antiretroviral agents are excluded
1573 from the preferred drug list. The agency shall also limit the
1574 amount of a prescribed drug dispensed to no more than a 34-day
1575 supply unless the drug products' smallest marketed package is
1576 greater than a 34-day supply, or the drug is determined by the
1577 agency to be a maintenance drug in which case a 100-day maximum
1578 supply may be authorized. The agency may seek any federal
1579 waivers necessary to implement these cost-control programs and
1580 to continue participation in the federal Medicaid rebate
1581 program, or alternatively to negotiate state-only manufacturer
1582 rebates. The agency may adopt rules to administer this
1583 subparagraph. The agency shall continue to provide unlimited
1584 contraceptive drugs and items. The agency must establish
1585 procedures to ensure that:

1586 a. There is a response to a request for prior
1587 authorization by telephone or other telecommunication device
1588 within 24 hours after receipt of a request for prior
1589 authorization; and

1590 b. A 72-hour supply of the drug prescribed is provided in
1591 an emergency or when the agency does not provide a response
1592 within 24 hours as required by sub-subparagraph a.

1593 2. A provider of prescribed drugs is reimbursed in an
1594 amount not to exceed the lesser of the actual acquisition cost
1595 based on the Centers for Medicare and Medicaid Services National
1596 Average Drug Acquisition Cost pricing files plus a professional

1597 dispensing fee, the wholesale acquisition cost plus a
1598 professional dispensing fee, the state maximum allowable cost
1599 plus a professional dispensing fee, or the usual and customary
1600 charge billed by the provider.

1601 3. The agency shall develop and implement a process for
1602 managing the drug therapies of Medicaid recipients who are using
1603 significant numbers of prescribed drugs each month. The
1604 management process may include, but is not limited to,
1605 comprehensive, physician-directed medical-record reviews, claims
1606 analyses, and case evaluations to determine the medical
1607 necessity and appropriateness of a patient's treatment plan and
1608 drug therapies. The agency may contract with a private
1609 organization to provide drug-program-management services. The
1610 Medicaid drug benefit management program shall include
1611 initiatives to manage drug therapies for HIV/AIDS patients,
1612 patients using 20 or more unique prescriptions in a 180-day
1613 period, and the top 1,000 patients in annual spending. The
1614 agency shall enroll any Medicaid recipient in the drug benefit
1615 management program if he or she meets the specifications of this
1616 provision and is not enrolled in a Medicaid health maintenance
1617 organization.

1618 4. The agency may limit the size of its pharmacy network
1619 based on need, competitive bidding, price negotiations,
1620 credentialing, or similar criteria. The agency shall give
1621 special consideration to rural areas in determining the size and

1622 location of pharmacies included in the Medicaid pharmacy
1623 network. A pharmacy credentialing process may include criteria
1624 such as a pharmacy's full-service status, location, size,
1625 patient educational programs, patient consultation, disease
1626 management services, and other characteristics. The agency may
1627 impose a moratorium on Medicaid pharmacy enrollment if it is
1628 determined that it has a sufficient number of Medicaid-
1629 participating providers. The agency must allow dispensing
1630 practitioners to participate as a part of the Medicaid pharmacy
1631 network regardless of the practitioner's proximity to any other
1632 entity that is dispensing prescription drugs under the Medicaid
1633 program. A dispensing practitioner must meet all credentialing
1634 requirements applicable to his or her practice, as determined by
1635 the agency.

1636 5. A hospital facility administering long-acting
1637 injectables for severe mental illness shall be reimbursed
1638 separately from the diagnosis-related group. Long-acting
1639 injectables administered for severe mental illness in a hospital
1640 facility setting shall be reimbursed at no less than the actual
1641 acquisition cost of the drug.

1642 ~~6.5.~~ The agency shall develop and implement a program that
1643 requires Medicaid practitioners who issue written prescriptions
1644 for medicinal drugs to use a counterfeit-proof prescription pad
1645 for Medicaid prescriptions. The agency shall require the use of
1646 standardized counterfeit-proof prescription pads by prescribers

1647 who issue written prescriptions for Medicaid recipients. The
1648 agency may implement the program in targeted geographic areas or
1649 statewide.

1650 ~~7.6.~~ The agency may enter into arrangements that require
1651 manufacturers of generic drugs prescribed to Medicaid recipients
1652 to provide rebates of at least 15.1 percent of the average
1653 manufacturer price for the manufacturer's generic products.
1654 These arrangements shall require that if a generic-drug
1655 manufacturer pays federal rebates for Medicaid-reimbursed drugs
1656 at a level below 15.1 percent, the manufacturer must provide a
1657 supplemental rebate to the state in an amount necessary to
1658 achieve a 15.1-percent rebate level.

1659 ~~8.7.~~ The agency may establish a preferred drug list as
1660 described in this subsection, and, pursuant to the establishment
1661 of such preferred drug list, negotiate supplemental rebates from
1662 manufacturers that are in addition to those required by Title
1663 XIX of the Social Security Act and at no less than 14 percent of
1664 the average manufacturer price as defined in 42 U.S.C. s. 1936
1665 on the last day of a quarter unless the federal or supplemental
1666 rebate, or both, equals or exceeds 29 percent. There is no upper
1667 limit on the supplemental rebates the agency may negotiate. The
1668 agency may determine that specific products, brand-name or
1669 generic, are competitive at lower rebate percentages. Agreement
1670 to pay the minimum supplemental rebate percentage guarantees a
1671 manufacturer that the Medicaid Pharmaceutical and Therapeutics

1672 Committee will consider a product for inclusion on the preferred
1673 drug list. However, a pharmaceutical manufacturer is not
1674 guaranteed placement on the preferred drug list by simply paying
1675 the minimum supplemental rebate. Agency decisions will be made
1676 on the clinical efficacy of a drug and recommendations of the
1677 Medicaid Pharmaceutical and Therapeutics Committee, as well as
1678 the price of competing products minus federal and state rebates.
1679 The agency may contract with an outside agency or contractor to
1680 conduct negotiations for supplemental rebates. For the purposes
1681 of this section, the term "supplemental rebates" means cash
1682 rebates. Value-added programs as a substitution for supplemental
1683 rebates are prohibited. The agency may seek any federal waivers
1684 to implement this initiative.

1685 ~~9.a.8.a.~~ The agency may implement a Medicaid behavioral
1686 drug management system. The agency may contract with a vendor
1687 that has experience in operating behavioral drug management
1688 systems to implement this program. The agency may seek federal
1689 waivers to implement this program.

1690 b. The agency, in conjunction with the Department of
1691 Children and Families, may implement the Medicaid behavioral
1692 drug management system that is designed to improve the quality
1693 of care and behavioral health prescribing practices based on
1694 best practice guidelines, improve patient adherence to
1695 medication plans, reduce clinical risk, and lower prescribed
1696 drug costs and the rate of inappropriate spending on Medicaid

1697 behavioral drugs. The program may include the following
 1698 elements:

1699 (I) Provide for the development and adoption of best
 1700 practice guidelines for behavioral health-related drugs such as
 1701 antipsychotics, antidepressants, and medications for treating
 1702 bipolar disorders and other behavioral conditions; translate
 1703 them into practice; review behavioral health prescribers and
 1704 compare their prescribing patterns to a number of indicators
 1705 that are based on national standards; and determine deviations
 1706 from best practice guidelines.

1707 (II) Implement processes for providing feedback to and
 1708 educating prescribers using best practice educational materials
 1709 and peer-to-peer consultation.

1710 (III) Assess Medicaid beneficiaries who are outliers in
 1711 their use of behavioral health drugs with regard to the numbers
 1712 and types of drugs taken, drug dosages, combination drug
 1713 therapies, and other indicators of improper use of behavioral
 1714 health drugs.

1715 (IV) Alert prescribers to patients who fail to refill
 1716 prescriptions in a timely fashion, are prescribed multiple same-
 1717 class behavioral health drugs, and may have other potential
 1718 medication problems.

1719 (V) Track spending trends for behavioral health drugs and
 1720 deviation from best practice guidelines.

1721 (VI) Use educational and technological approaches to

1722 promote best practices, educate consumers, and train prescribers
1723 in the use of practice guidelines.

1724 (VII) Disseminate electronic and published materials.

1725 (VIII) Hold statewide and regional conferences.

1726 (IX) Implement a disease management program with a model
1727 quality-based medication component for severely mentally ill
1728 individuals and emotionally disturbed children who are high
1729 users of care.

1730 ~~10.9.~~ The agency shall implement a Medicaid prescription
1731 drug management system.

1732 a. The agency may contract with a vendor that has
1733 experience in operating prescription drug management systems in
1734 order to implement this system. Any management system that is
1735 implemented in accordance with this subparagraph must rely on
1736 cooperation between physicians and pharmacists to determine
1737 appropriate practice patterns and clinical guidelines to improve
1738 the prescribing, dispensing, and use of drugs in the Medicaid
1739 program. The agency may seek federal waivers to implement this
1740 program.

1741 b. The drug management system must be designed to improve
1742 the quality of care and prescribing practices based on best
1743 practice guidelines, improve patient adherence to medication
1744 plans, reduce clinical risk, and lower prescribed drug costs and
1745 the rate of inappropriate spending on Medicaid prescription
1746 drugs. The program must:

1747 (I) Provide for the adoption of best practice guidelines
1748 for the prescribing and use of drugs in the Medicaid program,
1749 including translating best practice guidelines into practice;
1750 reviewing prescriber patterns and comparing them to indicators
1751 that are based on national standards and practice patterns of
1752 clinical peers in their community, statewide, and nationally;
1753 and determine deviations from best practice guidelines.

1754 (II) Implement processes for providing feedback to and
1755 educating prescribers using best practice educational materials
1756 and peer-to-peer consultation.

1757 (III) Assess Medicaid recipients who are outliers in their
1758 use of a single or multiple prescription drugs with regard to
1759 the numbers and types of drugs taken, drug dosages, combination
1760 drug therapies, and other indicators of improper use of
1761 prescription drugs.

1762 (IV) Alert prescribers to recipients who fail to refill
1763 prescriptions in a timely fashion, are prescribed multiple drugs
1764 that may be redundant or contraindicated, or may have other
1765 potential medication problems.

1766 ~~11.10.~~ The agency may contract for drug rebate
1767 administration, including, but not limited to, calculating
1768 rebate amounts, invoicing manufacturers, negotiating disputes
1769 with manufacturers, and maintaining a database of rebate
1770 collections.

1771 ~~12.11.~~ The agency may specify the preferred daily dosing

1772 form or strength for the purpose of promoting best practices
1773 with regard to the prescribing of certain drugs as specified in
1774 the General Appropriations Act and ensuring cost-effective
1775 prescribing practices.

1776 ~~13.12.~~ The agency may require prior authorization for
1777 Medicaid-covered prescribed drugs. The agency may prior-
1778 authorize the use of a product:

- 1779 a. For an indication not approved in labeling;
1780 b. To comply with certain clinical guidelines; or
1781 c. If the product has the potential for overuse, misuse,
1782 or abuse.

1783
1784 The agency may require the prescribing professional to provide
1785 information about the rationale and supporting medical evidence
1786 for the use of a drug. The agency shall post prior
1787 authorization, step-edit criteria and protocol, and updates to
1788 the list of drugs that are subject to prior authorization on the
1789 agency's Internet website within 21 days after the prior
1790 authorization and step-edit criteria and protocol and updates
1791 are approved by the agency. For purposes of this subparagraph,
1792 the term "step-edit" means an automatic electronic review of
1793 certain medications subject to prior authorization.

1794 ~~14.13.~~ The agency, in conjunction with the Pharmaceutical
1795 and Therapeutics Committee, may require age-related prior
1796 authorizations for certain prescribed drugs. The agency may

1797 preauthorize the use of a drug for a recipient who may not meet
1798 the age requirement or may exceed the length of therapy for use
1799 of this product as recommended by the manufacturer and approved
1800 by the Food and Drug Administration. Prior authorization may
1801 require the prescribing professional to provide information
1802 about the rationale and supporting medical evidence for the use
1803 of a drug.

1804 ~~15.14.~~ The agency shall implement a step-therapy prior
1805 authorization approval process for medications excluded from the
1806 preferred drug list. Medications listed on the preferred drug
1807 list must be used within the previous 12 months before the
1808 alternative medications that are not listed. The step-therapy
1809 prior authorization may require the prescriber to use the
1810 medications of a similar drug class or for a similar medical
1811 indication unless contraindicated in the Food and Drug
1812 Administration labeling. The trial period between the specified
1813 steps may vary according to the medical indication. The step-
1814 therapy approval process shall be developed in accordance with
1815 the committee as stated in s. 409.91195(7) and (8). A drug
1816 product may be approved without meeting the step-therapy prior
1817 authorization criteria if the prescribing physician provides the
1818 agency with additional written medical or clinical documentation
1819 that the product is medically necessary because:

1820 a. There is not a drug on the preferred drug list to treat
1821 the disease or medical condition which is an acceptable clinical

1822 alternative;

1823 b. The alternatives have been ineffective in the treatment
1824 of the beneficiary's disease;

1825 c. The drug product or medication of a similar drug class
1826 is prescribed for the treatment of schizophrenia or schizotypal
1827 or delusional disorders; prior authorization has been granted
1828 previously for the prescribed drug; and the medication was
1829 dispensed to the patient during the previous 12 months; or

1830 d. Based on historical evidence and known characteristics
1831 of the patient and the drug, the drug is likely to be
1832 ineffective, or the number of doses have been ineffective.

1833

1834 The agency shall work with the physician to determine the best
1835 alternative for the patient. The agency may adopt rules waiving
1836 the requirements for written clinical documentation for specific
1837 drugs in limited clinical situations.

1838 ~~16.15.~~ The agency shall implement a return and reuse
1839 program for drugs dispensed by pharmacies to institutional
1840 recipients, which includes payment of a \$5 restocking fee for
1841 the implementation and operation of the program. The return and
1842 reuse program shall be implemented electronically and in a
1843 manner that promotes efficiency. The program must permit a
1844 pharmacy to exclude drugs from the program if it is not
1845 practical or cost-effective for the drug to be included and must
1846 provide for the return to inventory of drugs that cannot be

1847 credited or returned in a cost-effective manner. The agency
1848 shall determine if the program has reduced the amount of
1849 Medicaid prescription drugs which are destroyed on an annual
1850 basis and if there are additional ways to ensure more
1851 prescription drugs are not destroyed which could safely be
1852 reused.

1853 (14) The agency shall implement a Medicaid therapeutic
1854 supplies spending control program. The agency may negotiate and
1855 enter into arrangements with supplies manufacturers which
1856 require manufacturers to provide rebates and may participate in
1857 multistate organizations negotiating for such rebates. The
1858 spending control program shall include a preferred product list,
1859 which shall be a listing of cost-effective therapeutic supplies
1860 recommended by the Medicaid Pharmaceutical and Therapeutics
1861 Committee established pursuant to s. 409.91195 and adopted by
1862 the agency for each product class listed on the preferred
1863 product list. The agency may publish the preferred product list
1864 and updates to the list on the agency website without following
1865 the rulemaking procedures of chapter 120.

1866 Section 16. Section 409.9207, Florida Statutes, is created
1867 to read:

1868 409.9207 Medicaid eligibility assistance for persons with
1869 disabilities.-

1870 (1) LEGISLATIVE INTENT.-It is the intent of the
1871 Legislature to create a program that supports and enables

1872 persons with disabilities to become Medicaid eligible. The
1873 Department of Children and Families shall be responsible for
1874 this program; however, all agencies with any duties related to
1875 Medicaid are responsible for collaborating with the department
1876 and the independent contractor selected to implement the
1877 program.

1878 (2) DEFINITIONS.—As used in this section, unless otherwise
1879 specified, the term:

1880 (a) "Agency" means any state or local governmental entity.

1881 (b) "Independent contractor" means a nonprofit
1882 organization with experience operating an information and
1883 referral program that includes person-centered services to
1884 successfully navigate eligibility procedures for state and
1885 federal assistance.

1886 (c) "Person with disabilities" means any person who has
1887 one or more permanent physical or mental limitations which
1888 restrict his or her ability to perform the normal activities of
1889 daily living and impede his or her capacity to live
1890 independently with relatives or friends without the provision of
1891 community-based services.

1892 (3) ELIGIBILITY ASSISTANCE PROGRAM.—

1893 (a) The Eligibility Assistance Program is created within
1894 the Department of Children and Families to offer information,
1895 referral, and navigation services to persons with disabilities
1896 to initiate and successfully complete the actions required to

1897 secure eligibility for Medicaid and other community-based
 1898 services enabling such persons to remain in their homes and
 1899 communities.

1900 (b) The program shall be operated by an independent
 1901 contractor selected based on the following criteria:

1902 1. A tax-exempt organization incorporated in this state
 1903 and in good standing with the Division of Corporations of the
 1904 Department of State.

1905 2. At least 20 years' experience operating local or
 1906 regional programs that provide services for persons with
 1907 disabilities.

1908 3. Capability to operate call center and online access
 1909 points.

1910 Section 17. Subsection (1) and paragraph (f) of subsection
 1911 (2) of section 409.967, Florida Statutes, are amended to read:

1912 409.967 Managed care plan accountability.—

1913 ~~(1) Beginning with the contract procurement process~~
 1914 ~~initiated during the 2023 calendar year,~~ The agency shall
 1915 establish a 10-year ~~6-year~~ contract with each managed care plan
 1916 selected through the procurement process described in s.
 1917 409.966. A plan contract may not be renewed; however, the agency
 1918 may extend the term of a plan contract to cover any delays
 1919 during the transition to a new plan. The agency shall extend
 1920 until January 31, 2035 ~~December 31, 2024,~~ the term of existing
 1921 plan contracts awarded pursuant to the invitations ~~invitation~~ to

1922 negotiate published in 2023 ~~July 2017~~.

1923 (2) The agency shall establish such contract requirements
 1924 as are necessary for the operation of the statewide managed care
 1925 program. In addition to any other provisions the agency may deem
 1926 necessary, the contract must require:

1927 (f) Continuous improvement.—The agency shall establish
 1928 specific performance standards and expected milestones or
 1929 timelines for improving performance over the term of the
 1930 contract.

1931 1. Each managed care plan shall establish an internal
 1932 health care quality improvement system, including enrollee
 1933 satisfaction and disenrollment surveys. The quality improvement
 1934 system must include incentives and disincentives for network
 1935 providers.

1936 2. Each managed care plan must collect and report the
 1937 Healthcare Effectiveness Data and Information Set (HEDIS)
 1938 measures, the federal Core Set of Children's Health Care Quality
 1939 measures, and the federal Core Set of Adult Health Care Quality
 1940 Measures, as specified by the agency. Each plan must collect and
 1941 report the Adult Core Set behavioral health measures beginning
 1942 with data reports for the 2025 calendar year. Each plan must
 1943 stratify reported measures by age, sex, race, ethnicity, primary
 1944 language, and whether the enrollee received a Social Security
 1945 Administration determination of disability for purposes of
 1946 Supplemental Security Income beginning with data reports for the

1947 2026 calendar year. A plan's performance on these measures must
1948 be published on the plan's website in a manner that allows
1949 recipients to reliably compare the performance of plans. The
1950 agency shall use the measures as a tool to monitor plan
1951 performance.

1952 3. Each managed care plan must be accredited by the
1953 National Committee for Quality Assurance, the Joint Commission,
1954 or another nationally recognized accrediting body, or have
1955 initiated the accreditation process, within 1 year after the
1956 contract is executed. For any plan not accredited within 18
1957 months after executing the contract, the agency shall suspend
1958 automatic assignment under ss. 409.977 and 409.984.

1959 4. The agency shall develop a coordinated statewide
1960 initiative of value-based strategies to drive cost-effective
1961 service delivery and improved health outcomes by directing
1962 managed care plans to implement a coordinated program of
1963 rewarding providers who deliver patient-centered, high-quality
1964 services. The initiative shall be predicated on a strategic
1965 plan, submitted to the President of the Senate and the Speaker
1966 of the House of Representatives by December 15, 2026, and
1967 implemented over a multiyear period that begins when the plan is
1968 approved by the Legislature.

1969 a. The strategic plan must set measurable goals, establish
1970 action plans and timelines, and define evaluation methods. The
1971 strategic plan must include procedures for making implementation

1972 adjustments necessary due to changing conditions. The agency
 1973 shall review value-based payment models in other states with
 1974 well-developed programs and incorporate best practices and
 1975 elements which contribute to the success of those programs.

1976 b. The initiative will consist of the following focus area
 1977 phases:

1978 (I) Year 1 will focus on perinatal health.

1979 (II) Year 2 will add a focus on behavioral health to the
 1980 Year 1 initiatives.

1981 (III) Year 3 will add a focus on management of chronic
 1982 conditions to the Year 1 and Year 2 initiatives.

1983 c. The agency shall augment staff expertise for planning
 1984 and implementation of this initiative with consultants who
 1985 specialize in value-based payment. The agency must ensure active
 1986 engagement of both providers and plans in developing the
 1987 strategic plan and in implementation of the initiative, in a
 1988 manner which fosters collaborative effort and mutual commitment
 1989 to achieving goals in each focus area.

1990 d. Upon legislative approval of the strategic plan, the
 1991 agency shall replace all other contractual requirements for
 1992 value-based payment set by the agency with those developed
 1993 through this initiative.

1994 Section 18. Subsection (1) of section 409.968, Florida
 1995 Statutes, is amended to read:

1996 409.968 Managed care plan payments.—

1997 (1) (a) Prepaid plans shall receive per-member, per-month
1998 payments negotiated pursuant to the procurements described in s.
1999 409.966. Payments shall be risk-adjusted rates based on
2000 historical utilization and spending data, projected forward, and
2001 adjusted to reflect the eligibility category, geographic area,
2002 and clinical risk profile of the recipients.

2003 (b) In negotiating rates with the plans, the agency shall
2004 consider any adjustments necessary to encourage plans to use the
2005 most cost-effective modalities for treatment of chronic disease
2006 such as peritoneal dialysis.

2007 (c) Per-member, per-month payments made to any managed
2008 care plan contracted under this part or part III that are
2009 subsequently refunded to or recovered by the agency, or
2010 initially withheld by the agency prior to payment and not later
2011 paid to a managed care plan pursuant to the terms of its
2012 contract, shall be adjusted for the Federal Medical Assistance
2013 Percentages. The state share shall be transferred to the General
2014 Revenue Fund, unallocated, and the federal share shall be
2015 transferred to the Medical Care Trust Fund, unallocated.

2016 Section 19. Subsection (5) of section 409.982, Florida
2017 Statutes, is amended to read:

2018 409.982 Long-term care managed care plan accountability.—
2019 In addition to the requirements of s. 409.967, plans and
2020 providers participating in the long-term care managed care
2021 program must comply with the requirements of this section.

2022 (5) PROVIDER PAYMENT.—Managed care plans and providers
 2023 shall negotiate mutually acceptable rates, methods, and terms of
 2024 payment.

2025 (a) Plans shall pay nursing homes an amount equal to the
 2026 nursing facility-specific payment rates set by the agency;
 2027 however, mutually acceptable higher rates may be negotiated for
 2028 medically complex care.

2029 (b) Plans shall pay hospice providers through a
 2030 prospective system for each enrollee an amount equal to the per
 2031 diem rate set by the agency. For recipients residing in a
 2032 nursing facility and receiving hospice services, the plan shall
 2033 pay the hospice provider the per diem rate set by the agency
 2034 minus the nursing facility component and shall pay the nursing
 2035 facility the applicable state rate.

2036 (c) Plans must ensure that electronic nursing home and
 2037 hospice claims that contain sufficient information for
 2038 processing are paid within 10 business days after receipt.

2039 (d) The agency may establish a fee schedule to reimburse
 2040 providers for adult day care services.

2041 Section 20. Subsection (8) is added to section 409.9855,
 2042 Florida Statutes, to read:

2043 409.9855 Pilot program for individuals with developmental
 2044 disabilities.—

2045 (8) WAIVER TRANSFER FUNDING.—

2046 (a) For individuals enrolled in the Medicaid home and

2047 community-based services waiver program under chapter 393 who
2048 choose to enroll in the pilot program, funding associated with
2049 the individual shall be transferred from the Agency for Persons
2050 with Disabilities to the Agency for Health Care Administration.
2051 The funding shall be equivalent to the total state share cost of
2052 the individual for the remaining months in the fiscal year based
2053 on the pilot program's managed care plan monthly rate.

2054 (b) For individuals enrolled in the pilot program who
2055 choose to enroll in the Medicaid home and community-based
2056 services waiver program under chapter 393, funding associated
2057 with the individual shall be transferred from the Agency for
2058 Health Care Administration to the Agency for Persons with
2059 Disabilities. The funding shall be equivalent to the total state
2060 share cost of the individual for the remaining months in the
2061 fiscal year based on the pilot program's managed care plan
2062 monthly rate.

2063 (c) The Agency for Persons with Disabilities and the
2064 Agency for Health Care Administration shall reconcile the
2065 amounts on a quarterly basis. The Agency for Health Care
2066 Administration may submit a budget amendment pursuant to chapter
2067 216 to transfer the funds between the agencies.

2068 Section 21. Paragraph (e) of subsection (3) of section
2069 409.986, Florida Statutes, is redesignated as paragraph (f), and
2070 a new paragraph (e) is added to that subsection to read:

2071 409.986 Legislative findings and intent; child protection

2072 and child welfare outcomes; definitions.—

2073 (3) DEFINITIONS.—As used in this part, except as otherwise
2074 provided, the term:

2075 (e) "Qualified provider" means an entity that meets the
2076 required regulatory or licensing standards for the service being
2077 procured, that has not had a contract for that service
2078 terminated due to a failure to meet contractual requirements,
2079 and that does not have any active formal corrective action plan
2080 or performance improvement plan associated with a license or
2081 contract for the service being procured.

2082 Section 22. Subsection (5) of section 409.990, Florida
2083 Statutes, is amended to read:

2084 409.990 Funding for lead agencies.—A contract established
2085 between the department and a lead agency must be funded by a
2086 grant of general revenue, other applicable state funds, or
2087 applicable federal funding sources.

2088 (5) A lead agency may carry forward documented unexpended
2089 state funds from one fiscal year to the next; however, the
2090 cumulative amount carried forward may not exceed 8 percent of
2091 the annual amount of the ~~total~~ contract. Any unexpended state
2092 funds in excess of that percentage must be returned to the
2093 department.

2094 (a) The funds carried forward may not be used in any way
2095 that would create increased recurring future obligations, and
2096 such funds may not be used for any type of program or service

2097 | that is not currently authorized by the existing contract with
 2098 | the department.

2099 | (b) Expenditures of funds carried forward must be
 2100 | separately reported to the department.

2101 | (c) Any unexpended funds that remain at the end of the
 2102 | contract period shall be returned to the department.

2103 | (d) Funds carried forward may be retained through any
 2104 | contract renewals and any new procurements as long as the same
 2105 | lead agency is retained by the department.

2106 | Section 23. Subsection (2) of section 409.996, Florida
 2107 | Statutes, is amended to read:

2108 | 409.996 Duties of the Department of Children and
 2109 | Families.—The department shall contract for the delivery,
 2110 | administration, or management of care for children in the child
 2111 | protection and child welfare system. In doing so, the department
 2112 | retains responsibility for the quality of contracted services
 2113 | and programs and shall ensure that, at a minimum, services are
 2114 | delivered in accordance with applicable federal and state
 2115 | statutes and regulations and the performance standards and
 2116 | metrics specified in the strategic plan created under s.
 2117 | 20.19(1).

2118 | (2) (a) The department must adopt written policies and
 2119 | procedures for monitoring the contract for delivery of services
 2120 | by lead agencies which must be published on the department's
 2121 | website. These policies and procedures must, at a minimum,

2122 address the evaluation of fiscal accountability and program
2123 operations, including provider achievement of performance
2124 standards, provider monitoring of subcontractors, and timely
2125 followup of corrective actions for significant monitoring
2126 findings related to providers and subcontractors. These policies
2127 and procedures must also include provisions for reducing the
2128 duplication of the department's program monitoring activities
2129 both internally and with other agencies, to the extent possible.
2130 The department's written procedures must ensure that the written
2131 findings, conclusions, and recommendations from monitoring the
2132 contract for services of lead agencies are communicated to the
2133 director of the provider agency and the community alliance as
2134 expeditiously as possible.

2135 (b) The department shall establish a standard statewide
2136 provider contract to reduce administrative burden and expense by
2137 establishing uniform reporting, accounting, billing, and
2138 budgeting requirements. The contract shall establish terms for
2139 the provision of core child welfare services, including case
2140 management, foster home licensing, independent living, and
2141 residential group care, with standardized attachments by
2142 provider type. The standard statewide provider contract shall
2143 include provisions for provider probation, termination for
2144 cause, and emergency termination for actions or inactions of a
2145 provider that pose an immediate and serious danger to the
2146 health, safety, or welfare of children, and shall include

2147 provider appeal procedures for these actions. During the
2148 pendency of an appeal of an emergency termination, the provider
2149 may not continue to provide services. In developing the
2150 statewide provider contract, the department shall work directly
2151 with both lead agencies and providers of each service type. The
2152 department shall publish the standard statewide provider
2153 contract on its website and require lead agencies to use the
2154 contract, at a minimum, for provider contracting. Lead agencies
2155 may establish additional contract terms to respond to particular
2156 regional needs and circumstances.

2157 Section 24. Subsection (5) of section 414.56, Florida
2158 Statutes, is amended to read:

2159 414.56 Office of Continuing Care.—The department shall
2160 establish an Office of Continuing Care to ensure young adults
2161 who age out of the foster care system between 18 and 21 years of
2162 age, or 22 years of age with a documented disability, have a
2163 point of contact until the young adult reaches the age of 26 in
2164 order to receive ongoing support and care coordination needed to
2165 achieve self-sufficiency. Duties of the office include, but are
2166 not limited to:

2167 (5) Developing and administering the Step into Success
2168 Workforce Education and Internship ~~Pilot~~ Program for foster
2169 youth and former foster youth as required under s. 409.1455.

2170 Section 25. For the purpose of incorporating the amendment
2171 made by this act to section 409.968, Florida Statutes, in a

2172 reference thereto, subsection (2) of section 409.978, Florida
 2173 Statutes, is reenacted to read:

2174 409.978 Long-term care managed care program.—

2175 (2) The agency shall make payments for long-term care,
 2176 including home and community-based services, using a managed
 2177 care model. Unless otherwise specified, ss. 409.961-409.969
 2178 apply to the long-term care managed care program.

2179 Section 26. For the purpose of incorporating the amendment
 2180 made by this act to section 409.968, Florida Statutes, in a
 2181 reference thereto, paragraph (b) of subsection (1) of section
 2182 409.9855, Florida Statutes, is reenacted to read:

2183 409.9855 Pilot program for individuals with developmental
 2184 disabilities.—

2185 (1) PILOT PROGRAM IMPLEMENTATION.—

2186 (b) The agency shall administer the pilot program pursuant
 2187 to s. 409.963 and as a component of the Statewide Medicaid
 2188 Managed Care model established by this part. Unless otherwise
 2189 specified, ss. 409.961-409.969 apply to the pilot program. For
 2190 purposes of the pilot program, compliance with s. 409.966 is
 2191 deemed satisfied by the competitive procurement procedures
 2192 conducted for contracts effective on February 1, 2025.

2193 Section 27. Subsection (1) of section 409.91196, Florida
 2194 Statutes, is amended to read:

2195 409.91196 Supplemental rebate agreements; public records
 2196 and public meetings exemption.—

2197 (1) The rebate amount, percent of rebate, manufacturer's
 2198 pricing, and supplemental rebate, and other trade secrets as
 2199 defined in s. 688.002 that the agency has identified for use in
 2200 negotiations, held by the Agency for Health Care Administration
 2201 under s. 409.912(5)(a)8. ~~s. 409.912(5)(a)7.~~ are confidential and
 2202 exempt from s. 119.07(1) and s. 24(a), Art. I of the State
 2203 Constitution.

2204 Section 28. Paragraph (b) of subsection (5) of section
 2205 393.065, Florida Statutes, is amended to read:

2206 393.065 Application and eligibility determination.—

2207 (5) Except as provided in subsections (6) and (7), if a
 2208 client seeking enrollment in the developmental disabilities home
 2209 and community-based services Medicaid waiver program meets the
 2210 level of care requirement for an intermediate care facility for
 2211 individuals with intellectual disabilities pursuant to 42 C.F.R.
 2212 ss. 435.217(b)(1) and 440.150, the agency must assign the client
 2213 to an appropriate preenrollment category pursuant to this
 2214 subsection and must provide priority to clients waiting for
 2215 waiver services in the following order:

2216 (b) Category 2, which includes clients in the
 2217 preenrollment categories who are:

2218 1. From the child welfare system with an open case in the
 2219 Department of Children and Families' statewide automated child
 2220 welfare information system and who are either:

2221 a. Transitioning out of the child welfare system into

2222 permanency; or
 2223 b. At least 18 years but not yet 22 years of age and who
 2224 need both waiver services and extended foster care services; or
 2225 2. At least 18 years but not yet 22 years of age and who
 2226 withdrew consent pursuant to s. 39.6251(5)(c) to remain in the
 2227 extended foster care system.
 2228
 2229 For individuals who are at least 18 years but not yet 22 years
 2230 of age and who are eligible under sub-subparagraph 1.b., the
 2231 agency must provide waiver services, including residential
 2232 habilitation, and must actively participate in transition
 2233 planning activities, including, but not limited to,
 2234 individualized service coordination, case management support,
 2235 and ensuring continuity of care pursuant to s. 39.6035. The
 2236 community-based care lead agency must fund room and board at the
 2237 rate established in s. 409.145(3) and provide case management
 2238 and related services as defined in s. 409.986(3)(f) ~~s.~~
 2239 ~~409.986(3)(e)~~. Individuals may receive both waiver services and
 2240 services under s. 39.6251. Services may not duplicate services
 2241 available through the Medicaid state plan.
 2242
 2243 Within preenrollment categories 3, 4, 5, 6, and 7, the agency
 2244 shall prioritize clients in the order of the date that the
 2245 client is determined eligible for waiver services.
 2246 Section 29. Except as otherwise provided in this act, this

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2247 | act shall take effect July 1, 2026. |