The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Appropriations

BILL:	CS/CS/SB 1758
INTRODUCER:	Appropriations Committee; Health Policy Committee; and Senator Gaetz and others
SUBJECT:	Public Assistance
DATE:	March 4, 2026 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Rainer	Brown	HP	**Fav/CS**
2.	Barr/Sneed	Sadberry	AP	**Fav/CS**

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/CS/SB 1758 makes changes to Florida's administration of the Medicaid Program and the Supplemental Nutrition Assistance Program (SNAP).

For Medicaid, the bill:

- Enacts work or community engagement requirements for program recipients to be eligible for the Florida Medicaid program.
- Directs the Agency for Health Care Administration (AHCA) to seek federal approval for a home and community-based behavioral health services program designed to cover an expanded array of services to adults with serious mental illness who are high utilizers of services in institutional settings.
- Expands the responsibilities of the Medicaid Pharmaceutical and Therapeutics Committee to include the development of a preferred physician-administered drug list, preferred product list, and high-cost drug list to promote cost-effective purchasing of prescribed drugs and therapeutic supplies.
- Authorizes the reimbursement of hospitals for long-acting injectables to patients with severe mental illness, outside of the diagnosis-related group reimbursement system that applies to inpatient care under the Florida Medicaid program.
- Authorizes the AHCA to engage a vendor and perform a study of the utilization of the federal 340B Discount Drug Purchase program in Florida.
- Clarifies that the AHCA may perform retrospective audits of provider claims irrespective of prior utilization reviews or prior authorizations.

- Authorizes the AHCA to send overpayment notice to providers by other common carriers in addition to the U.S. Postal Service.

For SNAP, the bill:

- Codifies in state statute federal SNAP eligibility requirements related to citizenship and immigration status and requires all SNAP participants to provide documentation verifying shelter and utility expenses at the time of application and redetermination.
- Requires the Department of Children and Families (DCF) to develop and implement a statewide SNAP payment accuracy plan designed to reduce the state's payment error rate to below six percent, submit an improvement plan to by July 15, 2026, and submit quarterly reports to the Governor and Legislature beginning October 1, 2026.
- Requires the DCF to issue SNAP electronic benefit transfer (EBT) cards that include photographic identification, to the extent allowed under federal law.
- Expands SNAP employment and training participation requirements to individuals aged 18 through 64 who do not have a child under the age of 14, replacing the current statutory upper age limit of 59 and the exemption for individuals with a child under age 18.

The bill will have a significant, negative fiscal impact on expenditures within the Florida Medicaid Program, the AHCA, and the DCF, and an indeterminate positive fiscal impact on the Florida Medicaid and SNAP programs in future years. **See Section V, Fiscal Impact Statement.**

The bill takes effect July 1, 2026.

II. Present Situation:

Medicaid Program

The Medicaid Program was established in 1965 under federal law. The Medicaid Act is codified as Title XIX of the Social Security Act and ch. 409, parts III and IV, of the Florida Statutes.[1] The purpose of the program is to provide medical assistance to the "categorically needy." It is a voluntary program for the states' participation. Florida has opted to participate in the Medicaid program.

Medicaid is a cooperative health care program jointly funded by the states and federal government. While it is a voluntary program, once a state elects to participate, the state must comply with all federal and statutory requirements. As a cooperative program, it is jointly funded by the state and federal government.[2] The federal government at this time is providing a sixty percent match with the remaining forty percent coming from the state.[3] The federal match is known as the Federal Medical Assistance Percentages (FMAP).[4]

[1] 42 U.S.C. § 1396 et seq.
[2] 42 U.S.C. §§ 1396b
[3] Federal Register, 54696/Vol. 90, No.227/Friday, November 28, 2025/Notices, available at https://www.govinfo.gov/content/pkg/FR-2025-11-28/pdf/2025-21332.pdf; The federal share for Florida Medicaid during the Federal Fiscal Year starting October 1, 2026, will be 55.43 percent.
[4] *Id.* FMAP is used for the Medicaid, TANF, child support collection, Child Care Mandatory and Matching Funds of the Child Care and Development Fund, Title IV-E Foster Care Maintenance payments, and Kinship Guardianship Assistance

On the federal side of the program, Medicaid is administered by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS). In the State of Florida, the Agency for Health Care Administration (AHCA) is designated as the "single state agency" for purposes of interacting with the federal CMS as to supervision and administration of the state Medicaid plan under federal law.[5] The Department Children and Families (DCF) is responsible for determining an individual's eligibility for Medicaid assistance.[6] The AHCA is responsible for all other aspects of the Medicaid program.[7]

To qualify a state for federal funding, the federal CMS must approve the state's Medicaid plan, or "state plan," which sets out numerous parameters for running the program.[8] It is also possible for the state to obtain a 1115, 1915(a), or 1915(b) waiver. A section 1115 waiver gives the federal CMS the "authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs."[9] The 1915(a) and 1915(b) waivers are utilized for implementing and changing a state's managed care delivery system.

As of December 31, 2025, a total of 3,928,797 persons were enrolled in Florida Medicaid.[10] Overall, the Medicaid Program in Florida is projected to expend approximately $35.1 billion for Fiscal Year 2025-2026.[11]

The One Big Beautiful Bill Act

On July 4, 2025, the federal law known as the One Big, Beautiful Bill Act (H.R.1, 2025, or OBBBA) was signed into law. The OBBBA deals with various tax and spending items. The law implements work requirements, with exceptions, for Medicaid adults under the age of 65 who are Medicaid-eligible in states that expanded their Medicaid eligibility under the Affordable Care Act.[12]

The OBBBA also requires verification of a person's eligibility upon application and at least every six months if the person is required to participate in work activities.[13] The work program is mandatory for states that have implemented Medicaid expansion.[14] Forty-one states (including

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programs. There is also an Enhanced Federal Matching Assistance Percentage (eFMAP) which applies to the Children's Health Insurance Program (CHIP).

[5] Section 409.902(15), F.S.; see also 42 C.F.R. § 431.10

[6] Sections 409.902(15) and (19), F.S.

[7] State of Florida, State Plan, available at: https://ahca.myflorida.com/content/download/5971/file/2021wu_Section_1-Single_State_Agency.pdf (last visited Jan. 30, 2026)

[8] 42 U.S.C. §§ 1396a

[9] Medicaid.gov, *Managed Care Authorities,* available at: https://www.medicaid.gov/medicaid/managed-care/managed-care-authorities (last visited Jan. 30, 2026).

[10] Number of Medicaid Eligibles by Age By Assistance Category as of Dec. 31, 2025.

[11] Office of Program Policy Analysis and Government Accountability, *Agency for Health Care Administration,* available at: https://oppaga.fl.gov/ProgramSummary/ProgramDetail?programNumber=5048 (last visited Jan. 30, 2026).

[12] Hinton, Diana,and Rudowitz, *A Closer Look at the Work Requirement Provisions in the Federal Budget Reconciliation Law,* KFF, July 30, 2025; https://www.kff.org/medicaid/a-closer-look-at-the-work-requirement-provisions-in-the-2025-federal-budget-reconciliation-law/ (last visited Jan. 30, 2026)

[13] Section 7119 of HR 1, (42 U.S.C. §1396a)

[14] *Id*.

Washington, D.C.) are expansion states.[15] Those states must implement the work requirements by December 31, 2026.[16] The ten states[17], including Florida, which are not expansion states are not mandated but may seek to implement work requirements under a section 1115 waiver or state plan amendment.[18]

Medicaid Eligibility

The DCF Office of Economic Self Sufficiency (ESS) handles eligibility determinations for Medicaid, as well as for the temporary cash assistance, temporary assistance to needy families (TANF), and food assistance (SNAP) programs.[19] The resources it uses to process and conduct such eligibility determinations are:

- Case workers.[20]
- Various webpages and resources.[21]
- A comprehensive ESS Florida Program Policy Manual.[22]
- Forty-one Family Resources Centers throughout the state.[23]
- A call center.[24]
- The ACCESS Florida system, to collect, verify client information, and determine benefit eligibility.[25]
- The MyACCESS Customer Portal, to enable individuals to apply for benefits, view program notices regarding their benefits, and self-report changes in household circumstances affecting eligibility, renew benefits, and upload documents.

[15] Status of State Medicaid Expansion Decisions, KFF https://www.kff.org/medicaid/status-of-state-medicaid-expansion-decisions/#:~:text=The%20Affordable%20Care%20Act's%20(ACA)%20Medicaid%20expansion,matching%20rate%20(FMAP)%20for%20their%20expansion%20populations (Jan 14, 2026). (last visited Jan. 30, 2026).
[16] Section 7119 of HR 1, (42 U.S.C. §1396a) and 42 U.S.C. §1315.
[17] Status of State Medicaid Expansion Decisions, KFF.
[18] Section 7119 of HR 1, (42 U.S.C. §1396a).
[19] Chianne D. v. Harris, No. 3:23-CV-985-MMH-LLL, 2026 WL 32126, at p. 4 (M.D. Fla. Jan. 6, 2026).
[20] They are expected to handle four hundred to six hundred case a month. *Chianne D. v. Harris*, No. 3:23-CV-985-MMH-LLL, 2026 WL 32126, at p. 30 (M.D. Fla. Jan. 6, 2026) The monthly volumes have ranged from 145,000 to 268,000. Public Assistance Caseload Report, available at: https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.myflfamilies.com%2Fsites%2Fdefault%2Ffiles%2F2026-01%2Fcaseload.xlsx&wdOrigin=BROWSELINK (last visited Feb. 4, 2026).
[21] Department of Children and Families, *Additional Resources and Services*, available at: https://www.myflfamilies.com/services/public-assistance/additional-resources-and-services (last visited Jan. 30, 2026).
[22] Department of Children and Families, *ESS Program Policy Manual,* available at: https://www.myflfamilies.com/services/public-assistance/additional-resources-and-services/ess-program-manual (last visited Jan. 30, 2026).
[23] Approximately 105,000 people visit a month. People. *Chianne D. v. Harris*, No. 3:23-CV-985-MMH-LLL, 2026 WL 32126, at p. 42 (M.D. Fla. Jan. 6, 2026).
[24] It operates from 7:00 a.m. to 6:00 p.m. Monday through Friday. Has budget authorization for about 960 positions of which 700 are frontline agents. It receives about 1.6 to 2.5 million calls per month. *Chianne D. v. Harris*, No. 3:23-CV-985-MMH-LLL, 2026 WL 32126, at p. 33 (M.D. Fla. Jan. 6, 2026).
[25] The system is a legacy mainframe system more than thirty years old. *Chianne D. v. Harris*, No. 3:23-CV-985-MMH-LLL, 2026 WL 32126, at p. 13 (M.D. Fla. Jan. 6, 2026) DCF is in the middle of a modernization project to incrementally replace the ACCESS system. The project has been funded since 2022. It is anticipated to be completed in 2028 and cost an estimated $183 Million. *Id* at p. 16.

The ESS budget within the DCF for Fiscal Year 2025-26 is $655,976,117 and includes 4,573 authorized full-time equivalent (FTE) positions.[26]

Supplemental Nutrition Assistance Program (SNAP)

SNAP is a federal program authorized by the Food and Nutrition Act of 2008 that provides food benefits to low-income families to supplement their grocery budget so they can afford the nutritious food essential to health and wellbeing. Anyone who meets income and other eligibility requirements is entitled by law to receive SNAP benefits. SNAP benefits are 100 percent federally funded, although states are responsible for general program administration and ensuring program integrity. States determine the eligibility of individuals and households to receive SNAP benefits and issue monthly allotments of benefits.[27] In Florida, the DCF is the designated state agency responsible for administering the SNAP program,[28] and the DCF's process for administering SNAP is memorialized in ch. 65A-1, Florida Administrative Code.

SNAP Alien Eligibility

Under federal law, an individual is eligible to participate in SNAP if the individual resides in the U.S. and is either:

- A citizen or national of the United States;
- A lawfully admitted permanent resident, as defined in 8 U.S.C. §§ 1101(a)(15) and 1101(a)(20), excluding individuals such as visitors, tourists, diplomats, and students who are admitted temporarily and do not intend to abandon a foreign residence;
- An individual granted Cuban or Haitian entrant status as defined in section 501(e) of the Refugee Education Assistance Act of 1980 (Public Law 96-422); or
- An individual lawfully residing in the United States pursuant to a Compact of Free Association described in 8 U.S.C. § 1612(b)(2)(G).[29]

To ensure compliance with federal SNAP eligibility requirements for citizens and noncitizens, the DCF verifies a SNAP participant's Social Security Number[30] or immigration status through the U.S. Citizenship and Immigration Service, supplemented by documents (e.g., U.S. birth certificate, U.S. passport, Certificate of Naturalization or Citizenship) when appropriate.[31]

According to information provided by the DCF, as of September 17, 2025, there were:

- 162,813 SNAP participants who were lawfully admitted for permanent residence.
- 111,174 SNAP participants who were Cuban or Haitian entrants.

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[26] Transparency Florida, *DCF Economic Self Sufficiency Services,* available at: http://transparencyflorida.gov/OperatingBudget/AgencyDetailLevel.aspx?FY=26&BE=60910708 (last visited Jan. 30, 2026).
[27] 7 U.S.C. §§ 2011-2036b; *SNAP*, Food and Nutrition Service, US Dept. of Agriculture (last visited Jan. 30, 2026), https://www.fns.usda.gov/snap/supplemental-nutrition-assistance-program; *State/Local Agency, SNAP*, Food and Nutrition Service, US Dept. of Agriculture (last visited on January 14, 2026), https://www.fns.usda.gov/snap/state.
[28] Supplemental Nutrition Assistance Program (SNAP) |Florida DCF (last visited Jan. 30, 2026), https://myflfamilies.com/services/public-assistance/supplemental-nutrition-assistance-program-snap (last visited Jan 30, 2026).
[29] 7 U.S.C. § 2015(f).
[30] 65A-1.302, F.A.C.
[31] 65A-1.301, F.A.C.

- 104 SNAP participants who were Compact of Free Association citizens of the Marshall Islands, Micronesia, and Palau.

SNAP Shelter Expense Verification

Federal regulations allow state agencies to set verification standards on certain information[32] and to mandate verification using documentary evidence.[33] To calculate shelter and utility expenses for SNAP participants currently, the DCF relies on a verification form[34] that is signed by the landlord of the SNAP participant.[35] For utilities that are not included as part of the SNAP participant's rent payments, the DCF uses statewide standard allowances of $419 for those who incur heating and cooling expenses separate from rent or mortgage, or a basic utility allowance of $339 for those who do not incur heating and cooling but do incur electricity, fuel, water, sewage, or garbage separate from rent or mortgage.[36] State regulation expressly disallows the use of "actual utility expenses" in lieu of those allowances.[37]

SNAP Quality Control Incentive

The OBBBA established a SNAP quality control incentive that consists of state-matching-funds requirements for the cost of SNAP benefit allotments. The matching requirements are determined based on a state's SNAP payment error rate and range from a state share of 0 to 15 percent of program allotments. These requirements generally begin in fiscal year 2028.[38]

See section III of this analysis, "Effect of Proposed Changes," for further discussion.

SNAP Photo Identification Requirement

State agencies issue electronic benefits transfer (EBT) cards to SNAP participants under federal SNAP rules.[39] States that are performing sufficiently well in administering SNAP may choose to implement a photo EBT card policy.[40] Before implementation, a state agency must demonstrate to the Food and Nutrition Service that it has successfully administered SNAP in accordance with established program performance standards. At a minimum, a determination of successful administration must consider metrics related to program access; the state's payment error rate; the state's case and procedural error rate; application processing timeliness, including compliance with both the seven-day expedited service standard and the 30-day processing standard; the timeliness of recertification actions; and any other performance measures relevant to the state agency's implementation of photo EBT cards.[41]

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[32] 7 C.F.R. § 273.2(f)(3).
[33] 7 C.F.R. § 273.2(f)(4).
[34] CF-ES 2622, available at https://flrules.org/Gateway/reference.asp?No=Ref-11648. (last visited Feb. 4, 2026).
[35] 65A-1.205(9)(c), F.A.C.
[36] 65A-1.603, F.A.C.
[37] *Id.*
[38] 7 U.S.C. § 2013(a)(2); and *Supplemental Nutrition Assistance Program Provisions of the One Big Beautiful Bill Act of 2025 – Information Memorandum*, Sept. 4, 2025, at pg. 4, https://fns-prod.azureedge.us/sites/default/files/resource-files/OBBB-SNAP-Provisions-Implementation-Memo.pdf.
[39] 7 U.S.C. § 2016; and 7 C.F.R. §274.2(a).
[40] 7 C.F.R. § 274.8(f).
[41] 7 C.F.R. § 274.8(f)(1).

SNAP Work Requirements

All people over the age of 15 and under the age of 60 applying for SNAP are subject to general work requirements.[42] This requires the individual to register for work, accept a suitable job offer, not voluntarily quit or reduce hours below 30, and participate in education and training (E&T) programs. A person who is eligible for SNAP may receive benefits for up to three (consecutive or nonconsecutive) months in a three-year period; however, the person will no longer be eligible after the cumulative three-month period unless they work 20 or more hours per week (averaged monthly), participate in a work program for 20 or more hours per week, are in a qualifying workfare program, or qualify for an exemption.[43] These post three-month-limit work requirements are applicable to all individuals unless they:

- Are under the age of 18 or over the age of 65;[44]
- Have been certified as physically or mentally unfit for employment;[45]
- Have a dependent under the age of 14;[46]
- Are pregnant;[47]
- Are an Indian or Urban Indian;[48]
- Are already meeting work registration requirements through Title IV of the Social Security Act or the Federal-State unemployment compensation system;[49]
- Are responsible for the care of a dependent child under six years of age or an incapacitated person;[50]
- Are students enrolled at least half-time in school, training program, or college;[51]
- Are regularly participating in a drug or alcohol treatment and rehab program;[52] or
- Are working at least 30 hours per week or earning the equivalent of the federal minimum wage multiplied by 30 ($217.50/week).[53] [54]

While SNAP work requirements are federally mandated, states have the flexibility to request waivers under certain conditions and to impose stricter rules if they choose. States can request waivers from the post three-month-limit work requirement for geographic areas where the

[42] 7 U.S.C. § 2015(d)(1).
[43] 7 U.S.C. § 2015(o).
[44] 7 U.S.C. § 2015(o)(3)(A). Federal guidance documents frequently reflect eligibility from ages 18–64; it is as an administrative shorthand that is employed because 64 is the last full year of applicability, with 65 being a partial-year transition.
[45] 7 U.S.C. § 2015(o)(3)(B).
[46] 7 U.S.C. § 2015(o)(3)(C).
[47] 7 U.S.C. § 2015(o)(3)(E).
[48] 7 U.S.C. § 2015(o)(3)(F).
[49] 7 U.S.C. §§ 2015(o)(3)(D) and 2015(d)(2)(A).
[50] 7 U.S.C. §§ 2015(o)(3)(D) and 2015(d)(2)(B).
[51] 7 U.S.C. §§ 2015(o)(3)(D) and 2015(d)(2)(C).
[52] 7 U.S.C. §§ 2015(o)(3)(D) and 2015(d)(2)(D).
[53] 7 U.S.C. §§ 2015(o)(3)(D) and 2015(d)(2)(E).
[54] Congress made changes to SNAP work requirements in 2025, raising the applicable age ceiling to 65 and removing exceptions for homeless individuals, veterans, and those 24 and younger who aged out of foster care. *Supplemental Nutrition Assistance Program Provisions of the One Big Beautiful Bill Act of 2025 – Information Memorandum*, Sept. 4, 2025, at pg. 2, https://fns-prod.azureedge.us/sites/default/files/resource-files/OBBB-SNAP-Provisions-Implementation-Memo.pdf.

unemployment rate is above 10 percent.[55, 56] Additionally, states receive a limited number of discretionary exemptions they can apply to certain covered individuals, such as: an able-bodied adult without dependents who is not working or participating in a qualifying work/training program; SNAP participant denied solely for not meeting the work rule; or a former participant whose prior work exemption expired.[57] States can also implement education and training programs that require more participation than federal minimums.[58]

Medicaid Behavioral Health

Behavioral health is not required to be covered under federal Medicaid law or regulations.[59] However, Florida has chosen to include certain aspects of mental services as Optional coverage in Florida, e.g. targeted case management and community mental health services, and state psychiatric inpatient hospital care to a recipient over 65 years old.[60] For the Florida KidCare program, both Medicaid and MediKids are required to provide behavioral health services.[61] The AHCA is also authorized to implement a Medicaid behavioral drug management program.[62]

Various programs and services for behavioral and mental health services are available for coverage and reimbursement under Florida Medicaid. The AHCA has promulgated 14 coverage policies as to behavioral and mental health services.[63] The AHCA has a separate Behavioral Health and Facilities Unit which develops policy and administers such services in behavioral health, hospital, long-term care, and assistive care facilities.[64]

As part of Florida's Statewide Medicaid Managed Care (SMMC) program, managed care plans are required to maintain a network of behavioral health providers, provide behavioral health service as part of early and periodic screening, diagnosis, and treatment (EPSDT), provide care coordination between primary care services and behavioral health service, work with the DCF's

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[55] 7 U.S.C. § 2015(o)(4). *See* also *ABAWD Waivers*, Food and Nutrition Service, US Dept. of Agriculture, https://www.fns.usda.gov/snap/abawd/waivers. (last visited on Jan. 30, 2026)

[56] In 2025, Congress removed the criterion that provides for waiver requests when an area "does not have a sufficient number of jobs to provide employment for the individuals" that reside there. This condition is replaced by an option for areas in Alaska and Hawaii to qualify for a waiver if their unemployment rate reaches or exceeds 150 percent of the national average. All other states may now only request waivers when the unemployment rate meets or exceeds 10 percent in an area. *Supplemental Nutrition Assistance Program Provisions of the One Big Beautiful Bill Act of 2025 – Information Memorandum*, Sept. 4, 2025, at pg. 2, https://fns-prod.azureedge.us/sites/default/files/resource-files/OBBB-SNAP-Provisions-Implementation-Memo.pdf.

[57] 7 U.S.C. § 2015(o)(6).

[58] 7 U.S.C. §§ 2015(d)(1)(A)(ii) and 2015(d)(4).

[59] Section 409.905, F.S.

[60] Section 409.906(5), (8), and (22), F.S.

[61] Section 409.815(2)(g), F.S.

[62] Section 409.912(5)8.a., F.S.

[63] Behavioral Analysis Services, Behavioral Health Assessment Services, Behavioral Health Community Support Services, Behavioral Health Intervention Services, Behavioral Health Medication Management Services, Behavioral Health Overlay Services, Behavioral Health Therapy Services, Florida Assertive Community Treatment Services, Inpatient Hospital Services, Mental Health Targeted Case Management, Specialized Therapeutic Services, State Mental Health, Statewide Inpatient Psychiatric Program, Therapeutic Group Care Services, available at: https://ahca.myflorida.com/medicaid/rules/adopted-rules-service-specific-policies (last visited Jan. 30, 2026).

[64] Agency for Health Care Administration, *Behavioral Health and Health Facilities,* available at; https://ahca.myflorida.com/medicaid/medicaid-policy-quality-and-operations/medicaid-policy-and-quality/medicaid-policy/medical-and-behavioral-health-coverage-policy/behavioral-health-and-health-facilities (last visited Jan. 30, 2026).

applicable managing entity in the service area as to such coordination, and provide, as a minimum benefit, mental health services. The AHCA's contract with managed care plans incorporates the various coverage handbooks for the health plans to follow for providing behavioral and mental health benefits.[65] The AHCA has allowed some substitution or different facilities in the provision of behavioral and mental health benefits under the federal "in lieu of service" (ILOS) program.[66] For the recent SMMC procurement, all of the plans were able to provide a Serious Mental Illness (SMI) product along with their regular Medicaid benefits. All of the plans are awarded (except Florida Community Care) the SMI product. SMI status for an individual is determined by a case finding algorithm of inpatient, outpatient and professional claims, with diagnosis codes for those mental health conditions of long duration and significant impact on daily functioning.[67]

Historically, the federal government has been reluctant to expand Medicaid benefits to include coverage for behavioral and mental health. From its inception in 1965, there was an exclusion to providing reimbursement to facilities classified as an "institution for mental disease" (IMD).[68] An IMD is currently defined as "a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services."[69] Over the years, however, the federal government has increased the ability, in limited cases, to use Medicaid funds for care in IMDs but has not removed the prohibition.[70] The federal government has also recognized the link between primary care and behavioral health.

Federal CMS announced in 2025 that it has three priorities over the next few years in the expansion of the Medicaid program as to mental and behavioral health benefits:

- Effective benefit design for mental health services for children, youth, and their families.
- Effective benefit design for substance use disorder services.
- Mental Health Parity and Addiction Equity Act (MHPAEA) application to Medicaid programs.[71, 72]

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[65] Managed Medical Assistance Program, Attachment II, Section V.A.1.a, p. 9-10; available at: https://ahca.myflorida.com/content/download/27249/file/Exhibit%20II-A%20Managed%20Medical%20Assistance%20%28MMA%29%20Program%20Oct%202025.pdf (last visited Jan. 30, 2026).

[66] Agency for Health Care Administration, *Statewide Medicaid Managed Care In Lieu of Services,* available at: https://ahca.myflorida.com/content/download/9115/file/ILOS_Program_Highlight_Document_Final_101618.pdf?version=1 (last visited Jan. 30, 2026).

[67] Florida Behavioral Health Association, *New SMMC Contract – Summary of Changes,* p. 2-4; available at: https://floridabha.org/wp-content/uploads/2025/03/Summary-SMMC-Contract-FINAL-Feb-2025-1.pdf (last visited Jan. 30, 2026).

[68] Congressional Research Service, *Medicaid's Institution for Mental Diseases (IMD) Exclusion,* (February 25, 2025); available at: https://www.congress.gov/crs_external_products/IF/PDF/IF10222/IF10222.15.pdf.

[69] *Id.*

[70] *Id.*

[71] Behavioral Health Services, available at: https://www.medicaid.gov/medicaid/benefits/behavioral-health-services (last visited Jan. 30, 2026).

[72] Mental Health Parity and Addiction Equity Act (MHPAEA), 42 U.S.C.A. § 300gg-26 Requires mental health and substance use disorder services are covered similar to medical benefits. Medicaid plans cannot impose limits on behavioral and mental health services more stringent than those for medical services.

Pharmacy, Drug Purchasing

Prescribed drugs are a standard benefit of the Florida Medicaid program and part of the reimbursement to providers.[73] Florida Medicaid program reimbursements for medications can be stand-alone payments, bundled into a prospective payment rate, e.g. diagnosis-related group (DRG), or part of the Medicaid capitation payment to health plans in SMMC.[74]

The reimbursement of drugs is subject to various statutory requirements. Section 409.908(14), F.S., limits the reimbursement to the lesser of:

- The actual acquisition cost as contained in the federal CMS National Average Drug Acquisition Cost pricing files,
- The wholesale acquisition cost,
- The state maximum allowable cost, or
- The usual and customary charge billed,
- Plus a dispensing fee.

Generic drugs must be used, unless the prescriber has received an exemption.[75]

Drugs are currently acquired pursuant to a Preferred Drug List (PDL). The PDL is developed, maintained and reviewed by the AHCA's Medicaid Pharmaceutical and Therapeutics Committee.[76] The committee is composed of 11 members appointed by the Governor – four members are allopathic physicians licensed under ch. 458, F.S., one member is an osteopathic physician licensed under ch. 459, F.S., five members are pharmacists, and one member is a consumer. The duties of the committee are to recommend the contents of the PDL to the AHCA and review the contents at least every twelve months.[77] The committee's standards and considerations for determining whether to include or delete a drug are:

- Is the drug medically appropriate drug therapy for Medicaid patients?[78]
- Does the drug achieve the cost savings contained in the General Appropriations Act?[79]
- Did the manufacturer agree to supplemental rebates as provided by law?[80]
- Does the drug have the requisite United States Food and Drug Administration (FDA) approval for the particular use?[81]
- Clinical efficacy.[82]
- Safety.[83]

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[73] Section 409.815(n), F.S. (KidCare); s. 409.905(3), F.S. (Mandatory Coverage, Family Planning Services); s. 409.906(20), F.S. (Optional Coverage, Prescribed Drug Services); and s. 409.906(29), F.S. (Optional Coverage, Bio Marker Testing Services).
[74] In plan year 2024 for MMA plans, $3,229,392,040 was spent by the health plans. Retrieved from AHCA Dashboard, Compare Medicaid Financial Data; available at: https://ahca.myflorida.com/medicaid/agency-dashboards (last visited Jan. 30, 2026).
[75] Section 409.908(14)(a), F.S.
[76] Section 409.91195, F.S.
[77] Section 409.91195(4), F.S.
[78] *Id*.
[79] *Id*.
[80] Section 409.91195(7), F.S.
[81] *Id*.
[82] Section 409.91195(8), F.S.
[83] *Id*.

- Cost effectiveness.[84]

The committee may make recommendations as to prior authorization requirements for any recommended drug.[85] The committee is required to allow public testimony before making recommendations to add or delete a drug.[86]

The AHCA must adopt the PDL; however, it does not have to follow the requirements of rulemaking pursuant to ch. 120, F.S. Instead, the AHCA may post the PDL and updates on an internet website.[87] In addition, the list must also comply with the requirement of the Medicaid prescribed-drug spending control program under s. 409.912(5)(a), F.S. The current list is effective as of January 1, 2026, and has been posted.[88]

Federal law gives states the option to provide coverage for prescribed drugs.[89] Florida has elected to do so,[90]as has every other state.[91] To be eligible for the FMAP, the drug must be deemed a covered outpatient drug (COD) by federal CMS. As an additional requirement, the manufacturer of the drug and federal CMS must have entered into a National Drug Rebate Agreement (NDRA).[92] The state FMAP is paid based on this rebate amount and any supplemental rebates achieved by the state.[93, 94]

States may also place limitations of the coverage of drugs, such as preferred drug lists. Federal law provides that a state may exclude or otherwise restrict coverage as to a COD, if it is on a formulary or part of a prior authorization plan.[95]

Long-Acting Injectables (LAI)

The AHCA, in coordination with the DCF, is authorized to implement a Medicaid behavioral drug management system as part of effective cost management.[96] The AHCA is authorized to implement prescribing practices and patient adherence to medication plans. The authority extends to all behavioral health drugs such as antipsychotics, antidepressants, and medications for treating bipolar disorders and other behavioral conditions. Further, the AHCA is authorized to monitor and implement programs to ensure patients engage in medication compliance.

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[84] Section 409.91195(8), F.S.
[85] Section 409.91195(9), F.S.
[86] Section 409.91195(7), F.S.
[87] Section 409.912(5)(a)1., F.S.
[88] Agency for Health Care Administration, *Florida Medicaid Preferred Drug List, Effective January 1, 2026,* available at: https://ahca.myflorida.com/content/download/22289/file/September%202025%20P%26T%20PDL%201.1.2026.pdf (last visited Jan. 30, 2026).
[89] 42 U.S.C. § 1396r-8.
[90] Section 409.906(20), F.S.
[91] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Report to Congress, Medicaid Services Investment and Accountability Act of 2019 Preventing the Misclassification of Drugs Under the Medicaid Drug Rebate Program, FFY 2024* (August 2025), p. 2; Available at: https://www.medicaid.gov/prescription-drugs/downloads/mdrp-misclassification-rtc.pdf (last visited Jan. 30, 2026).
[92] 42 U.S.C. § 1396r-8(a)(1).
[93] 42 U.S.C. § 1396r-8(b)(1)(B).
[94] Section 409.912(5)(a)1.6. & 7., F.S.
[95] 42 U.S.C. § 1396r-8(d).
[96] Section 409.912(5)8.a., F.S.

In 2012, the Florida Legislature required the AHCA to implement a Diagnosis-Related Groups (DRGs) system for paying hospital inpatient claims.[97] DRGs are based on the principal diagnosis, secondary diagnoses, surgical procedures, age, sex, and discharge status of the patients treated.[98] DRGs are classified and implemented using the latest version of the International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-CM/PCS) code set.[99] The DRG includes not only the inpatient stay and cost of any therapies, but also any drugs administered.

The AHCA reports that the DRG system is experiencing an unintended consequence for high-risk patients with schizophrenia or bipolar disorder.[100] In 2024, there were approximately 5,700 Medicaid recipients with such diagnoses and approximately 9,100 hospital inpatient admissions for such recipients. Of those hospital admissions, 3,400 were readmissions. The AHCA has determined that medication noncompliance is related to 50 percent of such readmissions.

The average DRG reimbursement of an inpatient admission for schizophrenia or bipolar disorder is $4,200. Such patients may be administered high-priced Long-Acting Injectables (LAI) to treat these disorders. The administration of such LAI should decrease noncompliance rates, reduce readmissions, and improve patient outcomes. Given the bundled DRG rate, some providers are reluctant to administer such drugs, given the fact that the DRG payment is consumed by the costs of the inpatient stay and other therapies administered. By allowing for separate reimbursement (outside of the DRG) for LAI, it is expected that readmissions will decline and the drugs will become rebate eligible.[101]

340B Program

Another drug reimbursement program adopted by federal law is pursuant to 340B of the Public Health Service Act.[102] It is a drug pricing program that requires drug manufacturers to provide to certain "covered entities" outpatient drugs at deeply discounted prices. A manufacturer who wants to participate in the NDRA and state Medicaid drug sales must agree to participate in the program.[103]

Covered entities are:
- Federally qualified health centers;
- Ryan White HIV/AIDS Program Grantees;
- Hospitals; and
- Specialized clinics.

[97] Section 409.905(5)(f), F.S., currently s. 409.905(5)(c), F.S. (2025).
[98] Centers for Medicare & Medicaid Services, Design and development of the Diagnosis Related Group, p. 14; https://www.cms.gov/icd10m/version37-fullcode-cms/fullcode_cms/Design_and_development_of_the_Diagnosis_Related_Group_(DRGs).pdf (last visited Jan. 30, 2026)
[99] *Id*.
[100] Agency for Health Care Administration, *Senate Bill 1758 Fiscal Analysis* (Jan.2026) (on file with staff of the Senate Committee on Health Policy).
[101] *Id*.
[102] 42 U.S.C. § 256b.
[103] 42 U.S.C. § 256b(a)(1).

Covered entities must recertify eligibility every year.[104]

Covered entities are permitted to buy drugs at a ceiling price.[105] The ceiling price is the average manufacturer price minus the Medicaid unit rebate amount.[106] The price can be further reduced by discounts negotiated by the covered entity or prime vendor, directly with the manufacturer (340B price).[107] The covered entity is able to buy all of its drugs at such 340B price, including those for patients who have private or commercial insurance, and are in Medicare or Medicaid managed care plans, or charity care.[108] The covered entity can then collect the difference in negotiated price with the insurer or managed care organization.[109] Federal law also prohibits states from billing rebates on drugs that have already been discounted through the 340B program ("duplicate discounts").[110]

The 340B program has experienced significant growth. In 2021, it is estimated that 50,000 covered entities participate in the program.[111] Significant issues have developed within the program as to covered entities' expansive use, through contract pharmacies, and appropriate reporting. Concerns have been raised by Medicaid programs as to duplicate discounts. A significant amount of litigation has occurred on all these topics.[112]

Medicaid Retrospective Reviews

An important component of Medicaid program integrity is its ability to conduct audits and reviews of paid claims. The bulk of the AHCA's authority and statutory standards for conducting such audits or reviews are contained in s. 409.913, F.S. Federal Medicaid law also contains numerous instances by which the AHCA or managed care plans must or have the authority to require prior authorization for a particular service.

In a pair of First District Court of Appeal cases, the interplay between prior authorization and retroactive audits was at issue as to certain hospital inpatient services. In the cases of *Lee Mem'l Health Sys. Gulf Coast Med. Ctr. v. Agency for Health Care Admin*., 272 So. 3d 431 (Fla. 1st DCA. 2019) and *N. Broward Hosp. Dist. v. Agency For Health Care Admin*., 398 So. 3d 1038 (Fla. 1st DCA, 2024), *reh'g denied* (Jan. 3, 2025), the factual situation of both cases dealt with a retrospective audit of emergency room claims paid on behalf of noncitizens for services considered beyond what was necessary for immediate stabilization.

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[104] 42 U.S.C. § 256b(a)(1).
[105] 42 C.F.R. §10.10
[106] *Id.*
[107] Congressional Budget Office, Growth in the 340B Drug Pricing Program (September 2025), p. 25; available at: https://www.cbo.gov/system/files/2025-09/60661-340B-program.pdf (last visited Jan. 30, 2026).
[108] *Id* at p.5.
[109] *Id.*
[110] *Id.* at p.7 fn. 2.
[111] *Id* at p. 1. *See* also fn 1.
[112] Congressional Research Service, The 340B Drug Discount Program: Litigation Topics and Trends (September 10, 2025); available at: https://www.congress.gov/crs-product/R48696?q=%7B%22search%22%3A%22r48696%22%7D&s=2&r=1 (last visited Jan. 30, 2026).

Both cases dealt with the language in s. 409.905(5)(a)4., F.S., which states:

> Upon implementing the prior authorization program for hospital inpatient services, the agency shall discontinue its hospital retrospective review program.

This language, which became law in 2002, was a central focus of both courts' decisions.

The Court in the *North Broward* decision did recognize that in 2020, the legislature adopted ch. 2020-156, §§ 38–39, Laws of Fla., so that s. 409.905(5)(a)4., F.S., reads as follows:

> Upon implementing the prior authorization program for hospital inpatient services, the agency shall discontinue its hospital retrospective review program. *However, this subparagraph may not be construed to prevent the agency from conducting retrospective reviews under s. 409.913, including, but not limited to, reviews in which an overpayment is suspected due to a mistake or submission of an improper claim or for other reasons that do not rise to the level of fraud or abuse.* (italics added by Court).

The *North Broward* Court as its legal logic, states: (1) the 2020 amendment declares that it "confirms and clarifies" existing law,[113] and (2) the legislature did not amend s. 409.913(1)(e), F.S., – the definition of "overpayment" to expand AHCA's review of prior authorized claims, nor (3) to include prior authorized claims in s. 409.913(2), F.S., which provides general authorization to "determine possible fraud, abuse, overpayment, or recipient neglect in the Medicaid program ....". Therefore, the ruling in *Gulf Coast* remains the same.

III. Effect of Proposed Changes:

Section 1 amends s. 490.904(4), F.S., to clarify that the Agency for Health Care Administration (AHCA) may conduct retrospective reviews or audit of claims for emergency medical services for noncitizens to validate necessity or the existence or duration of the emergency medical condition. Prior authorization of services would not prevent a review.

Section 2 creates s. 409.9041, F.S., to establish work or community engagement requirements for able-bodied adults who are receiving or applying for Medicaid benefits.

The AHCA, in consultation with the Department of Children and Families (DCF) and the Department of Commerce, must first develop and submit a business plan to the Governor and the Legislature as to its implementation of the work requirements. The plan must include the following:

- The methodology that will be used to determine the application of exemptions included in the bill.
- An estimate of the impact on enrollment and Medicaid program expenditures.
- A procedure for redetermining eligibility every six months for affected recipients.

[113] As opposed to stating it repeals *Gulf Coast*. *North Broward* at 1044. The words "confirms and clarifies" are specifically used in Section 39 of ch., 2020-156, §§ 38–39, Laws of Fla., as the Legislative intent.

- An outreach effort to notify recipients of the work requirements must be another component.
- A methodology for providing temporary Medicaid coverage to those who become ineligible based on income earned while complying with the work requirements. The methodology should be modeled on the existing program that allows families that lose temporary cash assistance due to earnings to remain eligible for Medicaid if private medical insurance from the employer is unavailable or unaffordable.[114]

The plan must be submitted by December 1, 2026, and must be approved by the Legislature before being implemented. The bill also directs the AHCA to seek federal waiver approval to implement the bill's mandatory work and community engagement requirements.

Under the bill, all Medicaid able-bodied, adult recipients between the ages of 19 and 64 are to meet the bill's work or community engagement requirements. However, the following individuals are exempt from such work or community engagement requirements:

- Indians as defined by federal law.
- A parent, guardian, caretaker relative or family caregiver of:
  - A child younger than 14 years of age,
  - A disabled individual,
  - To qualify as a caretaker a person must have a significant relationship with the above and must provide a broad range of services.
- Former foster youth under 26 years of age.
- A veteran with a total disability, as specified under 38 C.F.R. s. 3.340 or as specified by a Veteran Affairs Disability Ratings Letter issued by the United States Department of Veterans Affairs.
- An individual:
  - Classified as medically frail under the Medicaid Institutionalized Care Program;
  - Categorized as aged, blind, or disabled under the state Medicaid program; or
  - Who has a developmental disability as defined in s. 393.063
- An individual who already meets the work requirements under SNAP.
- An individual in a residential substance use treatment program.
- An inmate in a public institution.
- A woman eligible for Medicaid pregnancy-related or postpartum care.
- A person who is receiving hospice services and has a medical prognosis with a life expectancy of six months or less.

Affected individuals may satisfy the work or community engagement requirement by participating for 80 hours a month in one or more of the following activities:

- Paid employment,
- On-the-job training,
- Vocational education training,
- Job skills training directly related to employment,
- Education directly related to employment,

[114] Chapter 445.029, F.S. The transitional medical benefits program allows families to retain Medicaid coverage up to twelve months if the family includes a dependent child and does not achieve an average gross monthly income of more than 185 percent of the federal poverty level during the second six months of the twelve-month period.

- Satisfactory attendance at a secondary school or course of study leading to a high school equivalency diploma,
- Enrollment at least half time in a post-secondary education program to obtain a credential on the Masters Credential list,
- Any other work activity designated by the Department of Commerce, provided by a local workforce development board.

Under the bill, parents of children between 14 to 18 years old only have to engage in work or community engagement during school hours.

Individuals found in noncompliance will receive notice. The notice provides the individual a 30-day grace period to obtain compliance, after which their benefit will be terminated or they can pursue a fair hearing. The notice describes the procedure to reapply for Medicaid.

Section 3 amends s. 409.905(5)(a)4., F.S., by deleting the first sentence in that subparagraph, which is a basis for the *Gulf Coast* and *North Broward* cases. The bill amends the language to permit reviews of prior-authorized claims. The bill reiterates that the cost-effective purchasing principles of s. 409.912, F.S., apply.

Section 4 amends s.409.906, F.S., to add an optional Medicaid service for home and community-based services for behavioral health. The program is to be structured as a federal waiver and is to incorporate the following features:

- Applicable to adults eighteen and older, who:
  - Have a diagnosis of serious mental illness, and
  - Are high utilizers of behavioral health services in an institutional setting.
- Designed to reduce the need for institutional levels of care.

The bill directs the AHCA to work with the DCF on program design and cost estimates. The Legislature must approve the program and appropriate funds before it can be implemented.

Section 5 amends s. 409.91195, F.S., to authorize the Medicaid Pharmaceutical and Therapeutics Committee to develop the following additional lists, in addition to the current Preferred Drug List:

- Medicaid preferred physician-administered drug list.
- Medicaid preferred product list.
- High-cost drug list.

Under the bill, the committee, in addition to drugs purchased by Medicaid through the existing PDL and the bill's new drug lists, must also review and provide recommendations for therapeutic products and devices at least every six months. The approved drug lists must be published on the AHCA's website. Before an item is placed on or removed from the new lists, the committee must provide the opportunity for public testimony and the presentation of evidence. The committee must use the same standards of clinical efficacy, safety, and cost effectiveness as it currently uses to develop the PDL.

Section 6 amends s. 409.912, F.S., to:

- Conform the drug-control spending program to the new lists created under Section 5 of the bill.
- Direct the AHCA to compensate health care providers for long-acting injectables to severely mentally ill persons separately from hospital inpatient Diagnosis-Related Group (DRG) payments.
- Direct the AHCA to contract with a vendor to examine issues with the federal 340B program. Issues to be examined are drug purchasing reimbursement, billing, coding, dispensing and reimbursement and rebate interplay with the Medicaid program. The AHCA is directed to send out data requests to various stakeholders and is given enforcement powers to obtain data. The report is to be submitted to the Governor and the presiding officers of the Legislature by June 30, 2027.
- Reaffirm that the AHCA may conduct retrospective reviews and audits of claims regardless of prior utilization review or prior authorizations.

Section 7 amends s.409.913, F.S., to clarify that the definition of overpayment includes amounts that should not have been paid, even when a prior authorization has been granted The bill also specifies that retrospective reviews and audits of claims are authorized even if there is a prior authorization and to make an overpayment determination.

The bill also clarifies that the AHCA may send official provider notices to the mailing address on file with the agency and that such notices may be sent through common carriers other than the U.S. Postal Service.

Section 8 creates s. 414.321, F.S., relating to Supplemental Nutrition Assistance Program (SNAP) eligibility. The bill limits SNAP eligibility to U.S. citizens and nationals, lawful permanent residents, Cuban and Haitian entrants, and individuals covered under the Compact of Free Association (i.e., individuals from the Federated States of Micronesia, the Republic of the Marshall Islands, and Palau). These changes codify federal SNAP alien eligibility requirements into state law, aligning the state requirements with recent changes contained in the OBBBA.[115]

This section also requires SNAP participants to provide documentation evidencing shelter or utility payments during application and redetermination. The DCF is prohibited from relying solely on self-attestation under the bill regarding such payments.

Section 9 creates s. 414.332, F.S., relating to a SNAP payment accuracy plan. The bill requires the DCF to develop a comprehensive statewide plan to lower Florida's SNAP payment error rate below six percent. The plan must include the following:

- Enhanced employee training and quality assurance, through annual standardized training and frequent reviews of statistically significant samples of cases that incorporate real-time corrective feedback for staff.
- Improvement of data sourcing by maximizing the use of quality automated sources that compare income and asset data with government and private sector data sources.

[115] *Supplemental Nutrition Assistance Program Implementation of the One Big Beautiful Bill Act of 2025 – Alien SNAP Eligibility Information Memorandum*, October 31, 2025, https://fns-prod.azureedge.us/sites/default/files/resource-files/OBBB-Implementation-Memo-Alien-SNAP-Eligibility-Oct31.pdf#page=5. (last visited Jan. 30, 2026).

The plan is to be submitted to the Governor and the Legislature by July 15, 2026.

Starting on October 1, 2026, and continuing through October 1, 2028, quarterly reports are to be submitted to the Governor and Legislature detailing the SNAP error rate, a breakdown of payment errors, and a corrective action plan.

Florida's SNAP payment error rate was 15.13 percent for Federal Fiscal Year (FFY) 2024.[116] Pursuant to the OBBBA, if the DCF were to maintain this error rate, the state would be required to pay 15 percent of the cost of all SNAP benefits issued in the state during the fiscal year to which the error rate applies. This is a major fiscal shift, because SNAP benefits have historically been funded 100 percent by the federal government. Payment of state cost share begins in FFY 2028 unless the state qualifies for delayed implementation, which depends on whether the payment error rate multiplied by 1.5 is equal to or above 20 percent. Based on the delayed implementation criteria, if the DCF can reduce its error rate for FFY 2025 below 13.34 percent, FFY 2028 is the earliest the state would start to pay the state cost share. If the DCF maintains an error rate of 13.34 percent or higher into FFY 2026, then FFY 2030 is the latest the state would start to pay the state cost share.

Section 10 amends s. 414.39, F.S., to require the DCF to issue electronic benefits transfer (EBT) cards with photographic identification on the front, to the extent authorized under federal law. To implement this section, the DCF must demonstrate to the federal Food and Nutrition Service that it has successfully administered SNAP in accordance with established program performance standards.

Section 11 amends s. 414.455, F.S., to require SNAP participants aged 18 through 64, who do not have a child under the age of 14, to participate in employment and training (E&T) programs. Currently in statute, the upper age limit for required participation in E&T programs is set at 59 years of age, and it exempts individuals who have a child under the age of 18 in the home. These proposed changes align state law with the federal changes in the OBBBA.[117]

This section also directs the DCF to comply with all exemptions from work requirements in accordance with applicable federal law.

Section 12 makes a conforming change to a statutory reference to align with other provisions in the bill.

The bill takes effect July 1, 2026.

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[116] Fiscal Year 2024 SNAP Quality Control Payment Error Rates, at https://fns-prod.azureedge.us/sites/default/files/resource-files/snap-fy24QC-PER.pdf.

[117] U.S. Department of Agriculture, *Supplemental Nutrition Assistance Program Provisions of the One Big Beautiful Bill Act of 2025 – Information Memorandum*, Sept. 4, 2025, at pg. 2, https://fns-prod.azureedge.us/sites/default/files/resource-files/OBBB-SNAP-Provisions-Implementation-Memo.pdf.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None identified.

B. Public Records/Open Meetings Issues:

None identified.

C. Trust Funds Restrictions:

None identified.

D. State Tax or Fee Increases:

None identified.

E. Other Constitutional Issues:

None identified.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None identified.

B. Private Sector Impact:

Hospitals are likely to experience a significant positive fiscal impact from the bill's provisions relating to reimbursement for long-acting injectables administered on an inpatient basis.

C. Government Sector Impact:

The bill will have a significant recurring negative fiscal impact on state expenditures in the first fiscal year and an indeterminate positive fiscal impact on the Florida Medicaid Program and the Supplemental Nutrition Assistance Program (SNAP) in future years.

Retrospective Reviews or Audits

The bill will have a significant recurring positive fiscal impact on the Florida Medicaid program by addressing the Agency for Health Care Administration's (AHCA) current inability to audit prior-authorized claims under prevailing case law. The AHCA estimates the clarification of law will allow it avoid an estimated $12 million in annual losses.[118]

[118] Agency for Health Care Administration, *SB 1758 Fiscal Analysis* (Jan.2026) (on file with Senate Committee on Health Policy).

Home and Community-based Behavioral Health Services

The bill will have a significant recurring negative fiscal impact on Florida Medicaid expenditures ($25.6 million) and an indeterminate positive fiscal impact on expenditures within the Department of Children and Families (DCF) related to implementation of the waiver for home and community-based behavioral health services. The fiscal impact associated with this portion of the bill will be delayed, as the waiver cannot be implemented until both federal approval of the program and legislative approval of the associated costs have been granted.[119]

Medicaid Work and Community Engagement Requirements

The bill will have a significant positive fiscal impact on Florida Medicaid expenditures and an indeterminate negative fiscal impact on expenditures within the DCF related to Medicaid work and community engagement requirements. An estimated 111,789 Medicaid recipients would not be exempt from the bill's work and community engagement requirements. Assuming that 25 percent of these individuals are removed from the Florida Medicaid program due to noncompliance, approximately $80.2 million in savings could be realized within the program.[120]

The costs of implementing, monitoring, and enforcing the requirements are indeterminate and will not be known until the AHCA completes the business plan required to be submitted in December 2026.

Long-Acting Injectables (LAI)

The bill will have a significant recurring negative fiscal impact on Medicaid program expenditures ($14.8 million) due to the change in reimbursement methodology and the anticipated increase in utilization of long-acting injectables (LAIs). However, the bill is expected to have a significant recurring positive fiscal impact on state revenues (estimated at $7.4 million beginning in the second year) due to the AHCA's ability to collect pharmacy rebates on LAIs reimbursed under the new methodology. In addition, there will be an indeterminate positive fiscal impact associated with the avoidance of costly services typically required when the targeted population is not adequately medicated for severe mental illness.

New Medicaid Drug and Product Lists

The AHCA estimates recurring costs of $1.7 million to create and maintain the preferred physician-administered drug list, preferred product list, and high-cost drug list. The agency also estimates an additional $10 million in pharmacy rebate revenues resulting from implementation of the new drug and product lists.

[119] Agency for Health Care Administration, *SB 1758 Fiscal Analysis* (Jan.2026) (on file with Senate Committee on Health Policy).
[120] *Id.*

Fiscal Impact Study to Evaluate the 340B Drug Pricing Program

The AHCA anticipates a nonrecurring cost of $750,000 to contract with a vendor for this study.

SNAP Photo-EBT Cards

The DCF estimates that transitioning to photo electronic benefits transfer (EBT) cards will require its current EBT vendor to upgrade card production systems and add secure image storage and new data exchange capabilities. An estimate from the vendor indicates a one-time system change fee of $331,500 and approximately $8.95 million to implement the enhancement over a two-year period ($372,750 per month for 24 months). Following the two-year rollout, costs are projected to be recurring at $170,000 per month, or $2,040,000 annually. In addition, the DCF anticipates significant, but indeterminate, costs for potential technology upgrades to the ACCESS Florida System.[121]

VI. Technical Deficiencies:

None identified.

VII. Related Issues:

None identified.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 409.904, 409.905, 409.906, 409.91195, 409.912, 409.913, 414.39, 414.455, and 409.91196.

This bill creates the following sections of the Florida Statutes: 409.9041, 414.321, and 414.332.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS/CS by Appropriations on March 2, 2026:

The committee substitute:

- Requires the Agency for Health Care Administration to provide for transitional Medicaid coverage in its work requirement implementation plan for individuals losing eligibility due to earned income, using similar parameters to those that enable families who lose temporary cash assistance to retain Medicaid coverage under s. 445.029, F.S.
- Exempts individuals receiving hospice services with a life expectancy of less than six months from Medicaid work and community engagement requirements.

[121] Department of Children and Families, *SB 1758 Fiscal Analysis* (Feb. 2026) (on file with Senate Appropriations Committee on Health and Human Services).

CS by Health Policy on February 2, 2026:
The CS makes three changes to the underlying bill regarding the Medicaid Preferred Drug List and the other similar lists created by the bill. The CS:

- Requires the Agency for Health Care Administration's (AHCA) Pharmaceutical and Therapeutics Committee to review the contents of the Preferred Drug List and the bill's newly-created lists every six months;
- Requires the Pharmaceutical and Therapeutics Committee to take public testimony before making recommendations to the AHCA about changing the contents of the bill's new High-cost Drug List; and
- Adds requirements for the High-cost Drug List to match requirements for prior authorization that are already in place for the existing Preferred Drug List, in terms of requiring an expeditious response to a request for prior authorization for one of the drugs on the list. Under the CS, a response is required within 24 hours, and a three-day supply of the drug is required to be issued in emergency situations or when the 24-hour deadline for a prior-authorization response is not met.

B. Amendments:

None.