By the Committee on Health Policy; and Senators Gaetz and Brodeur

588-02430-26 20261758c1

A bill to be entitled

An act relating to public assistance; amending s. 409.904, F.S.; authorizing the Agency for Health Care Administration to conduct retrospective reviews and audits of certain claims under the state Medicaid program for a specified purpose; creating s. 409.9041, F.S.; providing legislative findings; requiring the agency to seek federal approval to implement mandatory work and community engagement requirements for able-bodied adults as a condition of obtaining and maintaining Medicaid coverage; prohibiting the agency from implementing such requirements until certain conditions are met; requiring the agency, in consultation with the Department of Children and Families, to develop a business plan to implement specified provisions; specifying requirements for the plan; requiring the agency to submit the plan to the Governor and the Legislature by a specified date; specifying populations that are subject to such work and community engagement requirements; providing exceptions; defining the term "family caregiver"; specifying the types of activities which may satisfy the work and community engagement requirements; providing that a certain population is required to engage in work or community engagement activities only during standard school hours; requiring persons eligible for Medicaid to demonstrate compliance with the work and community engagement requirements at specified times as a condition of maintaining Medicaid

coverage; requiring the agency to develop a process for ensuring compliance with the work and community engagement requirements; requiring that such process align, to the extent possible, with certain existing processes; requiring the department to verify compliance with the work and community engagement requirements at specified intervals; requiring the agency, in coordination with the department, to conduct outreach regarding implementation of the work and community engagement requirements; specifying requirements for such outreach; specifying procedures in the event of noncompliance; requiring the agency, in coordination with the department, to notify a Medicaid recipient of a finding of noncompliance and the impact to eligibility for continued receipt of services; specifying requirements for such notice; amending s. 409.905, F.S.; deleting a requirement that the agency discontinue its hospital retrospective review program under certain circumstances; revising construction; requiring the agency to maintain cost-effective purchasing practices in its coverage of hospital inpatient services rendered to Medicaid recipients; amending s. 409.906, F.S.; requiring the agency to seek federal approval to implement a program for expanded coverage of home- and community-based behavioral health services for a specified population; specifying the goal of the program; requiring the agency to work in coordination with the department to develop the program; requiring the agency and the

department to develop certain estimates and submit them to the Legislature in a specified manner before the program may be implemented; amending s. 409.91195, F.S.; revising the purpose of the Medicaid Pharmaceutical and Therapeutics Committee to include creation of a Medicaid preferred physician-administered drug list, a Medicaid preferred product list, and a high-cost drug list; requiring the agency to adopt such lists upon recommendation of the committee; specifying the frequency with which the committee must review such lists for any recommended additions or deletions; specifying parameters for such recommended additions and deletions; providing that reimbursement for drugs not included on such lists is subject to prior authorization, with an exception; requiring the agency to publish and disseminate such lists to all Medicaid providers in the state by posting on the agency's website or in other media; providing requirements for public testimony related to proposed inclusions on or exclusions from certain lists; requiring the committee to consider certain factors when developing such recommended additions and deletions; amending s. 409.912, F.S.; revising the components of the Medicaid prescribed-drug spending-control program to include the preferred physician-administered drug list, the preferred product list, and the high-cost drug list; providing requirements for such lists; providing that the agency does not need to follow rulemaking procedures of ch. 120, F.S.,

when posting updates to such lists; requiring the agency to establish certain procedures relating to prior authorization requests for drugs on the high-cost drug list; establishing an alternative reimbursement methodology for long-acting injectables administered in a hospital facility setting for severe mental illness; requiring the agency to contract with a vendor to perform a fiscal impact study of the federal 340B Drug Pricing Program; providing requirements for the study; requiring specified entities to submit certain data to the agency for purposes of the study; providing that noncompliance with such requirement may result in sanctions from the agency or the Board of Pharmacy, as applicable; requiring the agency to submit the results of the study to the Governor and the Legislature by a specified date; providing construction; amending s. 409.913, F.S.; revising the definition of the term "overpayment"; providing that determinations of an overpayment under the Medicaid program may be based upon retrospective reviews, investigations, analyses, or audits conducted by the agency to determine possible fraud, abuse, overpayment, or recipient neglect; providing that certain notices may be provided using other common carriers, as well as through the United States Postal Service; creating s. 414.321, F.S.; requiring the department to limit eligibility for food assistance to individuals meeting specified criteria; requiring that food assistance

recipients provide certain documentation for purposes of eligibility redeterminations; prohibiting the department from relying solely on an individual's self-attestations to determine certain expenses; authorizing the department to adopt policies and procedures to accommodate certain applicants and recipients; creating s. 414.332, F.S.; requiring the department to develop and implement a food assistance payment accuracy improvement plan for a specified purpose; requiring the department to reduce the payment error rate to below a specified percentage; providing requirements for the plan; requiring the department to submit the plan to the Governor and the Legislature by a specified date; requiring the department, by a specified date, to submit quarterly progress reports of specified information to the Governor and the Legislature; providing for future repeal; amending s. 414.39, F.S.; requiring the department to require photographic identification on the front of electronic benefits transfer (EBT) cards, to the extent allowable under federal law; amending s. 414.455, F.S.; revising criteria for individuals required to participate in an employment and training program to receive food assistance from the Supplemental Nutrition Assistance Program; requiring the department to apply and comply with certain work requirements in accordance with federal law for food assistance; amending s. 409.91196, F.S.; conforming a cross-reference; providing an effective date.

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

Section 1. Subsection (4) of section 409.904, Florida Statutes, is amended to read:

409.904 Optional payments for eligible persons.—The agency may make payments for medical assistance and related services on behalf of the following persons who are determined to be eligible subject to the income, assets, and categorical eligibility tests set forth in federal and state law. Payment on behalf of these Medicaid eligible persons is subject to the availability of moneys and any limitations established by the General Appropriations Act or chapter 216.

(4) A low-income person who meets all other requirements for Medicaid eligibility except citizenship and who is in need of emergency medical services. The eligibility of such a recipient is limited to the period of the emergency, in accordance with federal regulations. The agency may conduct retrospective reviews or audits of services rendered to the individual and claims submitted by the provider to validate the existence and duration of the emergency medical condition and whether the services rendered were necessary to treat the emergency medical condition, regardless of whether the provider obtained prior authorization for the services.

Section 2. Section 409.9041, Florida Statutes, is created to read:

409.9041 Medicaid work and community engagement requirements.—

(1) The Legislature finds that assisting able-bodied adult

Medicaid recipients in achieving self-sufficiency through meaningful work and community engagement is essential to ensuring that the state Medicaid program remains a sustainable resource for residents who are most in need of such assistance.

(2)(a) The agency shall seek federal approval to implement mandatory work and community engagement requirements for able-bodied adults, as specified in this section, as a condition of obtaining and maintaining coverage under the state Medicaid program. The agency may not implement the mandatory work and community engagement requirements until it receives federal approval through a Medicaid waiver and the agency's business plan submitted under paragraph (b) is specifically approved by the Legislature.

(b) The agency shall, in consultation with the Department of Children and Families and the Department of Commerce, develop a business plan to implement this section. The plan must include methods for determining Medicaid eligibility and the applicability of exemptions under subsections (3) and (4) on an ongoing basis and an analysis representing the potential effects that implementing this section will have on Medicaid enrollment and expenditures. The agency shall submit the plan to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than December 1, 2026.

(3)(a) Medicaid recipients between the ages of 19 and 64 years, inclusive, must meet the work or community engagement requirements of this section, unless they are one of the following:

1. Indian as defined under 42 C.F.R. s. 438.14(a).

2. A parent, guardian, caretaker relative, or family

caregiver of a dependent child younger than 14 years of age or of a disabled individual. For purposes of this paragraph, the term "family caregiver" means an adult family member or other individual who has a significant relationship with, and who provides a broad range of assistance to, an individual with a chronic or other health condition, disability, or functional limitation.

3. Former foster youth younger than 26 years of age.

4. 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.

5. 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.

6. An individual living in a household that receives Supplemental Nutrition Assistance Program benefits and who is already in compliance with work requirements pursuant to s. 445.024.

7. An individual participating in a residential substance use treatment program.

8. An inmate of a public institution.

9. A woman eligible for Medicaid coverage in a pregnancy-related or postpartum care category.

(b) A person may satisfy the work or community engagement requirements of this section by participating in one or more of the following activities for at least 80 hours per month:

1. Paid employment.

2. On-the-job-training.

3. Vocational educational training.

4. Job skills training directly related to employment.

5. Education directly related to employment.

6. Satisfactory attendance at a secondary school or in a course of study leading to a high school equivalency diploma.

7. Enrollment at least half-time as defined in 34 C.F.R. s. 668.2(b) in a postsecondary education program to obtain a credential on the Master Credentials List as maintained pursuant to s. 445.004(6)(e).

8. Any other work activity designated as such by the Department of Commerce and provided by a local workforce development board pursuant to s. 445.024.

(c) Parents with children ages 14 through 18 are required to engage in work or community engagement activities only during standard school hours.

(4)(a) Notwithstanding any other statutory provision, in order to maintain Medicaid coverage, an eligible Medicaid recipient must, before enrollment and upon any redetermination for coverage, demonstrate compliance with the work or community engagement requirements of this section.

(b) The agency shall develop a process for ensuring compliance with this section which aligns, to the extent possible, with the processes currently in place relating to work and community engagement requirements authorized under the state's Supplemental Nutrition Assistance Program, including, but not limited to, participant registration with a local CareerSource center, employment and training programs, and collaboration with the state's local workforce boards.

(c) The department shall verify, in accordance with its procedures, that an individual subject to the work and community engagement requirements of this section demonstrates compliance during the individual's regularly scheduled redetermination of eligibility and at least every 6 months thereafter.

(5) The agency, in coordination with the department, shall conduct outreach regarding the implementation of the work and community engagement requirements of this section. The outreach must include, at a minimum, notification to impacted individuals, including timelines for implementation, requirements for compliance, penalties for noncompliance, and information on how to request an exemption.

(6) If a recipient subject to the work and community engagement requirements of this section is determined to be in noncompliance with such requirements, the agency, in coordination with the department, must notify the recipient of the finding of noncompliance and the impact to his or her eligibility for continued receipt of Medicaid services. The notice must include, at a minimum, notification of all of the following:

(a) That the recipient is eligible for a grace period of 30 days to either come into compliance with the requirements or request an exemption from the requirements and that Medicaid coverage of services will continue during the grace period.

(b) That if, following the 30-day period, the individual has not come into compliance with or requested an exemption from the work and community engagement requirements, his or her application for assistance will be denied and services terminated at the end of the month following the month in which

such 30-calendar-day period ends.

(c) The right of the individual to request a fair hearing if he or she is determined to be noncompliant with program requirements and disenrolled from the state Medicaid program.

(d) The manner in which he or she can reapply for medical assistance under the state Medicaid program.

Section 3. Paragraph (a) of subsection (5) of section 409.905, Florida Statutes, is amended, and paragraph (f) is added to that subsection, to read:

409.905 Mandatory Medicaid services.—The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law. Mandatory services rendered by providers in mobile units to Medicaid recipients may be restricted by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, number of services, or any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216.

(5) HOSPITAL INPATIENT SERVICES.—The agency shall pay for all covered services provided for the medical care and treatment of a recipient who is admitted as an inpatient by a licensed physician or dentist to a hospital licensed under part I of chapter 395. However, the agency shall limit the payment for

inpatient hospital services for a Medicaid recipient 21 years of age or older to 45 days or the number of days necessary to comply with the General Appropriations Act.

(a)1. The agency may implement reimbursement and utilization management reforms in order to comply with any limitations or directions in the General Appropriations Act, which may include, but are not limited to: prior authorization for inpatient psychiatric days; prior authorization for nonemergency hospital inpatient admissions for individuals 21 years of age and older; authorization of emergency and urgent-care admissions within 24 hours after admission; enhanced utilization and concurrent review programs for highly utilized services; reduction or elimination of covered days of service; adjusting reimbursement ceilings for variable costs; adjusting reimbursement ceilings for fixed and property costs; and implementing target rates of increase.

2. The agency may limit prior authorization for hospital inpatient services to selected diagnosis-related groups, based on an analysis of the cost and potential for unnecessary hospitalizations represented by certain diagnoses. Admissions for normal delivery and newborns are exempt from requirements for prior authorization.

3. In implementing the provisions of this section related to prior authorization, the agency shall ensure that the process for authorization is accessible 24 hours per day, 7 days per week and authorization is automatically granted when not denied within 4 hours after the request. Authorization procedures must include steps for review of denials.

4. ~~Upon implementing the prior authorization program for~~

~~hospital inpatient services, the agency shall discontinue its hospital retrospective review program. However,~~ This paragraph ~~subparagraph~~ may not be construed to prevent the agency from conducting retrospective reviews under s. 409.913, including, but not limited to, reviews of prior-authorized claims and 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.

(f) In its coverage of services under this subsection, the agency shall maintain cost-effective purchasing practices as required by s. 409.912.

Section 4. Present subsections (14) through (29) of section 409.906, Florida Statutes, are redesignated as subsections (15) through (30), respectively, and a new subsection (14) is added to that section, to read:

409.906 Optional Medicaid services.—Subject to specific appropriations, the agency may make payments for services which are optional to the state under Title XIX of the Social Security Act and are furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any optional service that is provided shall be provided only when medically necessary and in accordance with state and federal law. Optional services rendered by providers in mobile units to Medicaid recipients may be restricted or prohibited by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or

directions provided for in the General Appropriations Act or chapter 216. If necessary to safeguard the state's systems of providing services to elderly and disabled persons and subject to the notice and review provisions of s. 216.177, the Governor may direct the Agency for Health Care Administration to amend the Medicaid state plan to delete the optional Medicaid service known as "Intermediate Care Facilities for the Developmentally Disabled." Optional services may include:

(14) HOME- AND COMMUNITY-BASED BEHAVIORAL HEALTH SERVICES.—The agency shall seek federal approval to implement a program that covers an expanded array of home- and community-based services for adults 18 years of age and older diagnosed with a serious mental illness who are high utilizers of behavioral health services in an institutional setting. The program must be designed to reduce the need for institutional levels of care for adults with a serious mental illness. The agency shall work in coordination with the Department of Children and Families to develop the program. The agency and the department shall produce estimates of the program's potential costs to the Medicaid program and cost-savings for the department. Such estimates must be submitted to the Legislature as legislative budget requests and appropriated in the General Appropriations Act before the program may be implemented.

Section 5. Section 409.91195, Florida Statutes, is amended to read:

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

physician-administered drug list, a Medicaid preferred product list, and a high-cost drug list.

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

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

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

(4) Upon recommendation of the committee, the agency shall adopt a preferred drug list, a preferred physician-administered drug list, a preferred product list, and a high-cost drug list as described in s. 409.912(5). To the extent feasible, the

committee shall review all drug or product classes included on the preferred drug list, the preferred physician-administered drug list, the preferred product list, and the high-cost drug list every 6 ~~12~~ months~~,~~ and may recommend additions to and deletions from the lists ~~preferred drug list~~, such that the lists provide ~~preferred drug list provides~~ for medically appropriate drug and product therapies for Medicaid patients which achieve cost savings contained in the General Appropriations Act.

(5) Except for antiretroviral drugs, reimbursement of drugs not included on the preferred drug list, preferred physician-administered drug list, preferred product list, or high-cost drug list is subject to prior authorization.

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

(7) The committee shall ensure that interested parties, including pharmaceutical manufacturers agreeing to provide a supplemental rebate as outlined in this chapter, have an opportunity to present public testimony to the committee with information or evidence supporting inclusion of a drug or product on the preferred drug list, preferred physician-administered drug list, preferred product list, or high-cost drug list. Such public testimony must ~~shall~~ occur before ~~prior to~~ any recommendations made by the committee for inclusion or exclusion from the preferred drug list, preferred physician-administered drug list, preferred product list, or high-cost

drug list. Upon timely notice, the agency shall ensure that any drug that has been approved or had any of its particular uses approved by the United States Food and Drug Administration under a priority review classification will be reviewed by the committee at the next regularly scheduled meeting following 3 months of distribution of the drug to the general public.

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

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

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

Section 6. Paragraph (a) of subsection (5) of section 409.912, Florida Statutes, is amended, and subsection (14) is added to that section, to read:

409.912 Cost-effective purchasing of health care.—The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. To ensure that medical services are effectively utilized, the agency may, in any case, require a confirmation or second physician’s opinion of the correct diagnosis for purposes of authorizing future services under the Medicaid program. This section does not restrict access to emergency services or poststabilization care services as defined in 42 C.F.R. s. 438.114. Such confirmation or second opinion

shall be rendered in a manner approved by the agency. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services. The agency shall contract with a vendor to monitor and evaluate the clinical practice patterns of providers in order to identify trends that are outside the normal practice patterns of a provider’s professional peers or the national guidelines of a provider’s professional association. The vendor must be able to provide information and counseling to a provider whose practice patterns are outside the norms, in consultation with the agency, to improve patient care and reduce inappropriate utilization. The agency may mandate prior authorization, drug therapy management, or disease management participation for certain populations of Medicaid beneficiaries, certain drug classes, or particular drugs to prevent fraud, abuse, overuse, and possible dangerous drug interactions. The Pharmaceutical and Therapeutics Committee shall make recommendations to the agency on drugs for which prior authorization is required. The agency shall inform the Pharmaceutical and Therapeutics Committee of its decisions regarding drugs subject to prior authorization. The agency is authorized to limit the entities it contracts with or enrolls as Medicaid providers by developing a provider network through

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

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

1. A Medicaid preferred drug list and a Medicaid physician-administered drug list. The preferred drug list~~, which~~ shall be a listing of cost-effective therapeutic options recommended by

the Medicaid Pharmacy and Therapeutics Committee established pursuant to s. 409.91195 and adopted by the agency for each therapeutic class on the preferred drug list. At the discretion of the committee, and when feasible, the preferred drug list should include at least two products in a therapeutic class. The physician-administered drug list shall be a listing of physician-administered drugs covered by the state Medicaid program, based on the United States Food and Drug Administration's approved indications and compendia in 42 U.S.C. s. 1396r-8(g)(1)(B). Within the preferred physician-administered drug list, there must be a section containing a list of preferred physician-administered drugs that are cost-effective therapeutic options recommended by the Medicaid Pharmaceutical and Therapeutics Committee established pursuant to s. 409.91195. The physician-administered drug list must be updated at least twice a year. The agency may post and update the preferred drug list and the preferred physician-administered drug ~~updates to the~~ list on the agency's ~~an Internet~~ website without following the rulemaking procedures of chapter 120. Antiretroviral agents are excluded from the preferred drug list. The agency shall also limit the amount of a prescribed drug dispensed to no more than a 34-day supply unless the drug products' smallest marketed package is greater than a 34-day supply, or the drug is determined by the agency to be a maintenance drug in which case a 100-day maximum supply may be authorized. The agency may seek any federal waivers necessary to implement these cost-control programs and to continue participation in the federal Medicaid rebate program, or alternatively to negotiate state-only manufacturer rebates. The agency may adopt rules to administer

this subparagraph. The agency shall continue to provide unlimited contraceptive drugs and items. The agency must establish procedures to ensure that:

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

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

2. A Medicaid preferred product list, which shall be a listing of cost-effective therapeutic supplies recommended by the Medicaid Pharmaceutical and Therapeutics Committee established pursuant to s. 409.91195 and adopted by the agency for each product class listed on the preferred product list and reimbursed by the state Medicaid program through the pharmacy point-of-sale. The agency may post the preferred product list and updates to the list on the agency's website without following the rulemaking procedures of chapter 120.

3. A list of high-cost drugs recommended by the Medicaid Pharmaceutical and Therapeutics Committee established pursuant to s. 409.91195 and adopted by the agency, for the purpose of coverage, reimbursement, or billing guidance. The agency may post the high-cost drug list and updates to the list on the agency's website without following the rulemaking procedures of chapter 120. The agency must establish procedures to ensure that:

a. There is a response to a request for prior authorization for a high-cost drug by telephone or other telecommunication device within 24 hours after receipt of the request for prior

authorization; and

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

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

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

6. The agency shall contract with a vendor to perform a detailed fiscal impact study to evaluate the 340B Drug Pricing Program administered by the Health Resources and Services Administration. The study must evaluate 340B compliance, 340B drug purchases, and reimbursement methodologies within the fee-for-service program and Statewide Medicaid Managed Care program. Statewide Medicaid Managed Care plans, pharmacy benefit managers, and Medicaid providers shall submit to the agency all data necessary for the completion of the study, including, but not limited to, information related to drug purchasing,

reimbursement, billing and coding, and dispensing. Noncompliance with the 340B data submission requirements of this subparagraph may result in sanctions from the agency or the Board of Pharmacy, as applicable. The agency shall submit the results of the study to the Governor, the President of the Senate, and the Speaker of the House of Representatives by June 30, 2027.

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

8.~~4.~~ The agency may limit the size of its pharmacy network based on need, competitive bidding, price negotiations, credentialing, or similar criteria. The agency shall give special consideration to rural areas in determining the size and location of pharmacies included in the Medicaid pharmacy network. A pharmacy credentialing process may include criteria

such as a pharmacy's full-service status, location, size, patient educational programs, patient consultation, disease management services, and other characteristics. The agency may impose a moratorium on Medicaid pharmacy enrollment if it is determined that it has a sufficient number of Medicaid-participating providers. The agency must allow dispensing practitioners to participate as a part of the Medicaid pharmacy network regardless of the practitioner's proximity to any other entity that is dispensing prescription drugs under the Medicaid program. A dispensing practitioner must meet all credentialing requirements applicable to his or her practice, as determined by the agency.

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

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

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

12.a.~~8.a.~~ The agency may implement a Medicaid behavioral drug management system. The agency may contract with a vendor that has experience in operating behavioral drug management

systems to implement this program. The agency may seek federal waivers to implement this program.

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

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

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

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

(IV) Alert prescribers to patients who fail to refill prescriptions in a timely fashion, are prescribed multiple same-

class behavioral health drugs, and may have other potential medication problems.

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

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

(VII) Disseminate electronic and published materials.

(VIII) Hold statewide and regional conferences.

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

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

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

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

drugs. The program must:

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

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

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

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

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

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

prescribing practices.

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

a. For an indication not approved in labeling;

b. To comply with certain clinical guidelines; or

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

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

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

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

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

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

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

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

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

19.~~15.~~ The agency shall implement a return and reuse program for drugs dispensed by pharmacies to institutional recipients, which includes payment of a $5 restocking fee for the implementation and operation of the program. The return and reuse program shall be implemented electronically and in a manner that promotes efficiency. The program must permit a pharmacy to exclude drugs from the program if it is not practical or cost-effective for the drug to be included and must provide for the return to inventory of drugs that cannot be credited or returned in a cost-effective manner. The agency shall determine if the program has reduced the amount of Medicaid prescription drugs which are destroyed on an annual basis and if there are additional ways to ensure more prescription drugs are not destroyed which could safely be reused.

(14) Neither this section nor this chapter prevents the agency from conducting retrospective reviews, investigations, analyses, audits, or any combination thereof to determine possible fraud, abuse, overpayment, or recipient neglect in the state Medicaid program pursuant to s. 409.913, including, but not limited to, reviews in which the services were the subject of a utilization review or prior authorization process.

Section 7. Paragraph (e) of subsection (1) and subsections (2) and (6) of section 409.913, Florida Statutes, are amended to

read:

409.913 Oversight of the integrity of the Medicaid program.—The agency shall operate a program to oversee the activities of Florida Medicaid recipients, and providers and their representatives, to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible, and to recover overpayments and impose sanctions as appropriate. Each January 15, the agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs shall submit a report to the Legislature documenting the effectiveness of the state's efforts to control Medicaid fraud and abuse and to recover Medicaid overpayments during the previous fiscal year. The report must describe the number of cases opened and investigated each year; the sources of the cases opened; the disposition of the cases closed each year; the amount of overpayments alleged in preliminary and final audit letters; the number and amount of fines or penalties imposed; any reductions in overpayment amounts negotiated in settlement agreements or by other means; the amount of final agency determinations of overpayments; the amount deducted from federal claiming as a result of overpayments; the amount of overpayments recovered each year; the amount of cost of investigation recovered each year; the average length of time to collect from the time the case was opened until the overpayment is paid in full; the amount determined as uncollectible and the portion of the uncollectible amount subsequently reclaimed from the Federal Government; the number of providers, by type, that are terminated from participation in the Medicaid program as a result of fraud and abuse; and all costs associated with

discovering and prosecuting cases of Medicaid overpayments and making recoveries in such cases. The report must also document actions taken to prevent overpayments and the number of providers prevented from enrolling in or reenrolling in the Medicaid program as a result of documented Medicaid fraud and abuse and must include policy recommendations necessary to prevent or recover overpayments and changes necessary to prevent and detect Medicaid fraud. All policy recommendations in the report must include a detailed fiscal analysis, including, but not limited to, implementation costs, estimated savings to the Medicaid program, and the return on investment. The agency must submit the policy recommendations and fiscal analyses in the report to the appropriate estimating conference, pursuant to s. 216.137, by February 15 of each year. The agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs each must include detailed unit-specific performance standards, benchmarks, and metrics in the report, including projected cost savings to the state Medicaid program during the following fiscal year.

(1) For the purposes of this section, the term:

(e) "Overpayment" includes any amount that is not authorized to be paid by the Medicaid program or that should not have been paid, including payments made ~~whether paid~~ as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake, and may include amounts paid for goods or services that were the subject of a utilization review or prior authorization process.

(2) The agency shall conduct, or cause to be conducted by contract or otherwise, reviews, investigations, analyses,

audits, or any combination thereof, to determine possible fraud, abuse, overpayment, or recipient neglect in the Medicaid program and shall report the findings of any overpayments in audit reports as appropriate. An overpayment determination may be based upon retrospective reviews, investigations, analyses, audits, or any combination thereof to determine possible fraud, abuse, overpayment, or recipient neglect in the Medicaid program, regardless of whether a prior authorization was issued. At least 5 percent of all audits shall be conducted on a random basis. As part of its ongoing fraud detection activities, the agency shall identify and monitor, by contract or otherwise, patterns of overutilization of Medicaid services based on state averages. The agency shall track Medicaid provider prescription and billing patterns and evaluate them against Medicaid medical necessity criteria and coverage and limitation guidelines adopted by rule. Medical necessity determination requires that service be consistent with symptoms or confirmed diagnosis of illness or injury under treatment and not in excess of the patient's needs. The agency shall conduct reviews of provider exceptions to peer group norms and shall, using statistical methodologies, provider profiling, and analysis of billing patterns, detect and investigate abnormal or unusual increases in billing or payment of claims for Medicaid services and medically unnecessary provision of services.

(6) Any notice required to be given to a provider under this section is presumed to be sufficient notice if sent to the mailing address last shown on the provider enrollment file. It is the responsibility of the provider to furnish and keep the agency informed of the provider's current mailing and service

addresses ~~address~~. United States Postal Service or other common carrier's proof of mailing or certified or registered mailing of such notice to the provider at the address shown on the provider enrollment file constitutes sufficient proof of notice. Any notice required to be given to the agency by this section must be sent to the agency at an address designated by rule.

Section 8. Section 414.321, Florida Statutes, is created to read:

414.321 Food assistance eligibility.—For purposes of eligibility determinations, the department shall:

(1) Limit eligibility to individuals who are residents of the United States and:

(a) Citizens or nationals of the United States;

(b) Aliens lawfully admitted for permanent residence as defined in the Immigration and Nationality Act, as amended;

(c) Aliens who have been granted the status of Cuban and Haitian entrant, as defined in the Refugee Education Assistance Act of 1980, as amended; or

(d) Individuals who lawfully reside in the United States in accordance with the Compacts of Free Association referred to in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

(2) Require each applicant, or recipient for redetermination purposes, to provide documentation evidencing his or her shelter or utility expenses.

(a) The department is prohibited from relying solely on an individual's self-attestation in determining shelter or utility expenses.

(b) The department may adopt policies and procedures to

accommodate an applicant or a recipient who, due to recent residency changes, is temporarily unable to furnish adequate documentation of shelter or utility expenses.

Section 9. Section 414.332, Florida Statutes, is created to read:

414.332 Food assistance payment accuracy plan.—

(1) The department shall develop and implement a comprehensive food assistance payment accuracy improvement plan to reduce the state's payment error rate. The department must reduce the payment error rate to below 6 percent. The plan must address the root causes of payment errors identified through an in-depth, data-driven analysis. The plan must include, but need not be limited to, all of the following:

(a) Enhanced employee training and quality assurance.

1. The department shall administer standardized training for all economic self-sufficiency program staff at least annually. Training must, at a minimum, review the most common reasons for payment errors and methods for preventing such errors, and include pre- and post-training testing to measure staff proficiency.

2. The department shall establish a robust quality assurance review process that frequently reviews a statistically significant sample of cases before final benefit determination. This process must incorporate real-time, corrective feedback and on-the-job training for program staff and may not delay benefit determinations.

(b) Improvement in data sourcing. In contracting with entities providing data for verification of applicant and recipient information, the department shall maximize use of high

quality automated data sources, including, but not limited to, comparing income and asset data with state, federal, and private sector data sources.

(2) By July 15, 2026, the department shall submit the food assistance payment accuracy improvement plan to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

(3)(a) Beginning October 1, 2026, the department shall submit quarterly progress reports to the Governor, the President of the Senate, and the Speaker of the House of Representatives detailing:

1. The state's most recent official and preliminary food assistance payment error rate.

2. A detailed breakdown of the most frequent and highest dollar value errors, including categorization by agency or client error and whether the error resulted in over- or under-payment.

3. Specific actions taken by the department under the food assistance payment accuracy improvement plan during the preceding quarter and data demonstrating the results of those actions.

4. A detailed plan to correct the most recently identified deficiencies.

(b) This subsection is repealed on October 1, 2028.

Section 10. Present subsections (6) through (11) of section 414.39, Florida Statutes, are redesignated as subsections (7) through (12), respectively, and a new subsection (6) is added to that section, to read:

414.39 Fraud.—

(6) The department shall require the use of photographic identification on the front of each newly issued and reissued electronic benefits transfer (EBT) card for each cardholder to the maximum extent allowed by federal laws and regulations.

Section 11. Subsection (2) of section 414.455, Florida Statutes, is amended to read:

414.455 Supplemental Nutrition Assistance Program; legislative authorization; mandatory participation in employment and training programs.—

(2) Unless prohibited by the Federal Government, the department must require a person who is receiving food assistance; who is 18 to 64 ~~59~~ years of age, inclusive; who does not have children under the age of 14 ~~18~~ in his or her home; who does not qualify for an exemption; and who is determined by the department to be eligible, to participate in an employment and training program. The department shall apply and comply with exemptions from work requirements in accordance with applicable federal law.

Section 12. Subsection (1) of section 409.91196, Florida Statutes, is amended to read:

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

(1) The rebate amount, percent of rebate, manufacturer's pricing, and supplemental rebate, and other trade secrets as defined in s. 688.002 that the agency has identified for use in negotiations, held by the Agency for Health Care Administration under s. 409.912(5)(a)11. ~~s. 409.912(5)(a)7.~~ are confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

Section 13. This act shall take effect July 1, 2026.