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:	HB 5301
INTRODUCER:	Health Care Budget Subcommittee and Representative Andrade
SUBJECT:	Health Care
DATE:	February 27, 2026
REVISED:	3/3/26

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Barr	Sadberry	AP	**Fav/1 amendment**

Please see Section IX. for Additional Information:

AMENDMENTS - Significant amendments were recommended

I. Summary:

HB 5301 conforms statutes to the House proposed General Appropriations Act (GAA) for Fiscal Year 2026-2027, making several changes related to Health Care. Specifically, the bill:

- Eliminates the Health Care Innovation Council and the Revolving Loan Program within the Department of Health.
- Increases the nursing home prospective payment reimbursement methodology for the Quality Incentive Program Payment Pool from ten percent of non-property funds to 15.2344 percent of non-property funds.
- Creates the Medicaid Eligibility Assistance Program for Persons with Disabilities within the Department of Children and Families.
- Requires funding to follow an individual who voluntarily transfers between the Home and Community-Based Services Waiver program and the Intellectual Developmental Disabilities Pilot Program.
- Requires the Agency for Health Care Administration (AHCA) to reimburse for long-acting injectable medications administered to Medicaid recipients with severe mental illness in an inpatient hospital setting at an amount no less than the actual acquisition cost.
- Requires the AHCA to re-procure contracts with Medicaid managed care plans every eight years instead of every six years.
- Requires the AHCA to establish a quality withhold incentive in each Statewide Medicaid Managed Care plan contract, with the sole metric being infant mortality.

The bill has a significant fiscal impact on state revenues and expenditures. See Section V., Fiscal Impact Statement.

The bill takes effect July 1, 2026.

II. Present Situation:

Health Care Innovation Council

In 2024, ch. 2024-16, F.S., created the Health Care Innovation Council (council), a 15-member council within the Department of Health (DOH). The Lieutenant Governor serves as the chair of the council and as an ex officio, nonvoting member. The Secretary of the Agency for Health Care Administration (ACHA), the Secretary of the Department of Children and Families (DCF), the director of the Agency for Persons with Disabilities (APD), the State Surgeon General, and the Secretary of the Department of Elder Affairs all serve as ex officio, nonvoting members. The chair of the Council of Florida Medical School Deans serves as a voting member.

The President of the Senate and the Speaker of the House of Representatives each make one appointment to the council. Legislative appointments must be a person from the health care sector who has senior level experience in reducing inefficiencies in health care delivery systems; from the private sector who has senior level experience in cybersecurity or software engineering in the health care sector; a person who has expertise in emerging technology that can be used in the delivery of health care; or who has experience in finance or investment or in management and operation of early stage companies.

The remainder of the council consists of the following appointments by the Governor:
- A licensed physician.
- An employee of a licensed hospital.
- A licensed nurse.
- A Florida resident to represent the interest of health care patients.
- An employee of a health insurer or health maintenance organization; and
- A representative of the long-term care facility industry.[1]

The council is required to meet at least quarterly at the call of the chair, and in order to provide an opportunity for the broadest public input, must hold a majority of its meetings during the year in geographically dispersed areas across the state. Meetings are encouraged to provide opportunities for demonstrations or presentations of innovative solutions in person.[2]

Council Duties

The council must facilitate public meetings at which innovators, developers, and implementers of technologies, workforce pathways, service delivery models, and other solutions may present information and lead discussions. The council's work:
- Must cover concepts that address challenges to the health care system as they develop in real time and concepts that advance the delivery of health care in this state through technology and innovation.
- Must consider how the concepts:
  - Increase efficiency in the health care system in this state;

[1] Section 381.4015(3)(a), F.S.
[2] Section 381.4015(3)(b), F.S.

  - Reduce strain on the state's health care workforce;
  - Improve patient outcomes;
  - Expand public access to health care services in this state; or
  - Reduce costs for patients and the state without reducing the quality of patient care.
- May consider broad community or statewide issues or needs to be addressed.
- May include how concepts can be supported, cross-functional, or scaled to meet the needs of health care consumers, including employers, payers, patients, and the state.
- May include coordination with the Small Business Development Center Network, the Florida Opportunity Fund, the Institute for Commercialization of Florida Technology, and other business incubators, development organizations, or institutions of higher education to include emerging and early-stage concepts in the discussions.
- May bring information technology technical experts to lead discussions on recommended structures and integrations of information technology products, services, and solutions.[3]

Council Goals

The Council has the following goals:
- Improve Patient Outcomes and Expand Access to Care: Leverage innovative technologies and new care delivery models to improve patient outcomes; promote health and wellness through proactive interventions, seamless care coordination, and enhanced patient engagement; and expand access to care, particularly in underserved communities.
- Reduce Health Care Costs: Work to reduce health care costs while maintaining or improving the quality of care delivered to patients.
- Enhance Efficiency in Health Care Delivery: Reduce administrative burdens and streamline processes to improve the overall efficiency of health care services through enhanced interoperability and seamless care coordination.
- Foster Health Care Innovation: Encourage collaboration among entrepreneurs, health care professionals, and policymakers to drive health care innovation that is scalable across the state to maximize impact.
- Strengthen Florida's Health Care Workforce: Address workforce shortages and improve workplace efficiency through innovative workforce pathways.
- Promote Cybersecurity and Interoperability: Foster a secure and interoperable health care environment that facilitates the seamless exchange of information across systems.[4]

The council must submit an annual report each December 1 on the council's activities, including:
- An update on the status of the delivery of health care in Florida.[5]
- Information on implementation of best practices by Florida health care industry stakeholders.
- Highlights of exploration, development, or implementation of innovative technologies, workforce pathways, service delivery models, or other solutions by Florida health care industry stakeholders.

[3] Section 381.4015(4), F.S.
[4] Section 381.4015(4)(b), F.S.
[5] Section 381.4015(4)(g), F.S.

To date, the council has met three times: on October 25, 2024, on November 19, 2024, and on June 26, 2025.[6]

Some key accomplishments of the council, as outlined in the December 1, 2025, Annual Report, are:[7]

- Adopted the Health Care Innovation Strategic Framework establishing a patient-centered mission and six strategic goals aligned with statutory requirements.
- Developed a comprehensive loan evaluation scoring framework using a 100-point scale to assess applications for the $50 million annual revolving loan program.
- Adopted emergency rules (Rules 64WER25-3 and 64WER25-4, Florida Administrative Code), pursuant to statutory authorization, to implement the revolving loan program.
- Launched the Innovation Hub website (Innovation.FloridaHealth.gov) to serve as a central resource for stakeholders statewide.
- Deployed the loan application portal to support low-interest financing for innovative health care solutions.
- Opened the first application period (October 3 through November 17, 2025) to accept proposals from eligible Florida health care facilities.
- Created a catalog of alternative funding sources to assist Florida health care entities in identifying additional resources.
- Established operational infrastructure including a tiered review process and evaluation criteria for scaling innovation across the state.[8]

Revolving Loan Program

A revolving loan program[9] is created within the DOH to provide funding for applicants seeking to implement innovative solutions. Certain entities licensed, registered, or certified by the Agency for Health Care Administration and educational or clinical training providers in partnership with one of the entities, may apply for a loan.[10] The program made operational progress in 2025, establishing the infrastructure necessary for launch.

The DOH is to establish eligibility criteria that:

- Incorporates recommendations of the council based on input received, focus areas developed, and best practices recommended.
- Determines which proposals are likely to provide the greatest return to the state, taking into consideration the degree to which the proposal would increase efficiency in the health care system in this state, reduce strain on the state's health care workforce, improve patient outcomes, increase public access to health care in this state, or provide cost savings to patients or the state without reducing the quality of patient care.

[6] Department of Health, *Florida Health Care Innovation Council Annual Report December 1, 2025*, (on file with the Senate Appropriations Committee).
[7] *Id.*
[8] Department of Health, *Florida Health Care Innovation Council Annual Report December 1, 2025* (on file with the Senate Appropriations Committee).
[9] Section 381.4015(7), F.S.
[10] The entities licensed, registered, or certified pursuant to s. 408.802, F.S., except for those under subsections (1), (3), (13), (23), and (25) of that section, are eligible to apply.

Application Process

The DOH is required to set application periods to apply for loans and may set up to four application periods in a fiscal year.[11] The DOH must work with the council if application periods include separate priority for current focus areas adopted by the council. The availability of loans will be publicized to stakeholders, education or training providers, and others. The DOH will receive the applications and determine whether the applications are complete and whether the applicant has demonstrated ability to repay the loan. Within 30 days of the close of the application period, the DOH will forward the complete applications to the council.

The DOH is required to establish an application process to receive revolving loan applications for review by the council, loan eligibility criteria to guide the council's review and recommendation of applications, and rules meant to vet applicants, project impact, and further the purposes of the revolving loan program.

Eligibility[12]

Different types of health care entities licensed, registered, or certified by the AHCA are authorized to apply for a revolving loan. In addition, educational and clinical training providers who partner with one of the eligible entities are eligible to apply for a revolving loan. The DOH and the council are to prioritize applicants located in DOH-designated rural or medically underserved areas that are rural hospital applicants or nonprofit applicants that accept Medicaid patients.

The council must review submitted applications using the criteria and processes and format adopted by the DOH by rule. Priority must be given to applicants that are located in a rural or medically underserved area and are either rural hospitals or nonprofit entities that accept Medicaid patients. A loan applicant must demonstrate plans to use the funds to implement one or more innovative technologies, workforce pathways, service delivery models, or other solutions in order to:

- Fill a demonstrated need;
- Obtain or upgrade necessary equipment, hardware, and materials;
- Adopt new technologies or systems; or
- A combination of the above, which will improve the quality and delivery of health care in measurable and sustainable ways and which will lower costs and allow savings to be passed on to health care consumers.

Awards

The amount of each loan must be based upon demonstrated need and availability of funds.[13] The DOH may not award more than ten percent of the total allocated funds for the fiscal year to a single loan applicant.

The revolving loan program launched its first application period from October 3 through November 17, 2025. This 45-day application window represents the loan program's transition

[11] Section 381.4015(7)(c), F.S.
[12] Section 381.4015(7)(b), F.S.
[13] Section 381.4015(7)(d), F.S.

from planning to active operations. The application period was widely publicized to eligible stakeholders including:

- Health care facilities licensed by the AHCA;
- Educational and clinical training providers in partnership with eligible facilities;
- Rural hospitals and nonprofit entities serving Medicaid patients; and
- Professional associations and industry groups.

Applications submitted during this period are currently under review by the council using the approved 100-point scoring framework and tiered review process. The council anticipates announcing the first loan awards in early 2026, with projects beginning implementation shortly thereafter.[14]

Loan Repayment

Loans become due and payable in accordance with the terms of the written agreement.[15] All repayments of principal received by the department in a fiscal year must be returned to the revolving loan fund and made available for loans to other applicants.

Revolving Loan Fund

Current law requires the department to create and maintain a separate account in the Grants and Donations Trust Fund within the department as a fund for the program.[16] All repayments of principal must be returned to the revolving loan fund and made available for loans to other applicants. Notwithstanding s. 216.301, F.S., funds appropriated for the revolving loan program are not subject to reversion. The department may contract with a third-party administrator to administer the program, including loan servicing, and manage the revolving loan fund. A contract for a third-party administrator which includes management of the revolving loan fund must, at a minimum, require maintenance of the revolving loan fund to ensure that the program may operate in a revolving manner.

Nursing Prospective Payment System

On October 1, 2018, Florida Medicaid nursing homes transitioned from facility-specific cost-based rates to the prospective rate reimbursement methodology, which determines rates in advance of payment. Section 409.908, F.S., provides the methodology[17] and parameters for rate setting, including reimbursement rates for direct care, indirect care, and operating costs.

[14] Department of Health, *Florida Health Care Innovation Council Annual Report December 1, 2025,* on file with the Senate Appropriations Committee.
[15] Section 381.4015(7)(f), F.S.
[16] Section 381.4015(7)(g), F.S.
[17] Nursing Home Prospective Payment System Calculation: (Operating Price + Direct Care Price - Floor Reduction + Indirect Care Price - Floor Reduction + FRVS Rate + Pass Through Payments) * Budget Neutrality Factor + Quality Incentive Payment + Medicaid Share of NFQA + Ventilator Supplemental Payment + High Medicaid Utilization and High Direct Patient Care Add-On)) + Unit Cost Rate Increase

The methodology includes a parameter for a Quality Incentive Payment, in which a provider is awarded points for process, outcome, structural, and credentialing measures using the most recently reported data on May 31 of the rate period year.[18]

The Quality Incentive Payment calculation[19] is as follows:

$$\frac{\text{Facility Annualized Medicaid Days}}{\text{Average Annualized Medicaid Days}} \times \frac{\text{Quality Points with Lower Limit}}{\text{Sum of Total Points Awarded to All Facilities}} \times \frac{\text{Total Quality Budget}}{\text{Facility Annualized Medicaid Days}}$$

Payment amounts are limited to a percentage of the September 2016 non-property related payments of included facilities.[20]

Effective July 1, 2025, Senate Bill 2502, the Fiscal Year 2025-2026 Implementing Bill for the General Appropriations Act, amended s. 409.908, F.S., increasing the Quality Incentive Payment percentage from ten percent to 17.862 percent.[21] The change is only valid for the fiscal year, and will revert back to ten percent on July 1, 2026.

Medicaid Eligibility Assistance for Persons with Disabilities

The Agency for Persons with Disabilities (APD) was created to serve the needs of Floridians with developmental disabilities. The APD works in partnership with local communities and private providers to assist people who have developmental disabilities and their families. The APD serves more than 60,000 individuals with autism, cerebral palsy, spina bifida, intellectual disabilities, Down Syndrome, Prader-Willi syndrome, and Phelan-McDermid syndrome.

While the APD provides services and support to individuals with developmental disabilities, Medicaid eligibility determinations and application processes are administered by the Department of Children and Families (DCF) and require coordination across multiple agencies.

Current law does not provide for a standalone statutory program specifically focused on assisting persons with disabilities in navigating Medicaid eligibility requirements through a centralized information, referral, and navigation model.

Long-Acting Injectables

Long-acting injectables (LAIs) are injectable medications used by individuals with mental illness. LAIs are typically the same medication as can be taken orally in pill form, often on a daily basis. However, the injected liquid formulation permits medication to be released into the

[18] Rule 59G-6.010(2)(y), F.A.C.
[19] *Id.*
[20] Section 409.908(2)(e), F.S.
[21] Chapter 25-199, Laws of Fla.

bloodstream over a longer period of time. This allows injections to be given only every two weeks to six months, depending on the medication and formulation.[22]

Advantages may include increased adherence and lower side effects. This can have the outcome of reduced readmissions for inpatient care. However, use of LAIs remains relatively low. Some barriers to increased LAI use include:

- Cost of LAIs, particularly newer second-generation medications.
- Fear of needles.
- Negative patient attitudes about LAIs or medication generally.[23]
- Clinician discomfort with administering injections.[24]
- Clinician perception that LAIs are more appropriate for nonadherent patients.

Patients typically begin receiving medication orally to identify which medicine is most effective for them before receiving the medication through an LAI. Some patients may receive an LAI while in inpatient care but discontinue use after discharge.[25]

LAIs are more widely available for treating schizophrenia, with some also available for bipolar disorder or opioid use disorder.[26] However, a 2019 study indicated that only about ten percent of patients with schizophrenia were taking LAIs.[27]

Florida Medicaid Program

Medicaid is the health care safety net for low-income Floridians. The Florida Medicaid program is a partnership of the federal and state governments established to provide coverage for health services for eligible persons. The program is administered by the Agency for Health Care Administration (AHCA) and financed by federal and state funds. The AHCA delegates certain functions to other state agencies, including the DCF, which makes eligibility determinations.

The structure of each state's Medicaid program varies, but what states must pay for is largely determined by the federal government, as a condition of receiving federal funds.[28] Federal law sets the amount, scope, and duration of services offered in the program, among other requirements. These federal requirements create an entitlement that comes with constitutional due process protections. The entitlement means that two parts of the Medicaid cost equation – people and utilization – are largely predetermined for the states. The federal government sets the

[22] National Alliance on Mental Illness, Long-Acting Injectables (LAIs), https://www.nami.org/about-mental-illness/treatments/mental-health-medications/long-acting-injectables-lais/ (last visited Feb. 10, 2026).
[23] S. Schwartz, et al., *Attitudes and perceptions about the use of long-acting injectable antipsychotics among behavioral health practitioners*, Mental Health Clinician, Aug. 23, 2022, https://mhc.kglmeridian.com/view/journals/mhcl/12/4/article-p232.xml (last visited Feb. 10, 2026).
[24] Lovett, L., *Behavioral Health Business*, Behavioral Providers Turn to Long-acting Injectables to Boost Adherence, Decrease Burden, July 3, 2024, https://bhbusiness.com/2024/07/03/behavioral-providers-turn-to-long-acting-injectables-to-boost-adherence-decrease-burden/ (last visited Feb. 10, 2026).
[25] *Id.*
[26] *Id.*
[27] S. Schwartz, et al., *Attitudes and perceptions about the use of long-acting injectable antipsychotics among behavioral health practitioners*, Mental Health Clinician, Aug. 23, 2022, https://mhc.kglmeridian.com/view/journals/mhcl/12/4/article-p232.xml (last visited Feb. 10, 2026).
[28] Title 42 U.S.C. §§ 1396-1396w-5; Title 42 C.F.R. Part 430-456 (§§ 430.0-456.725) (2016).

minimum mandatory populations to be included in every state Medicaid program. The federal government also sets the minimum mandatory benefits to be covered in every state Medicaid program. These benefits include physician services, hospital services, home health services, and family planning.[29] States can add benefits, with federal approval. Florida has added many optional benefits, including prescription drugs, ambulatory surgical center services, and dialysis.[30]

Florida Medicaid does not cover all low-income Floridians. Eligibility is determined by household income and by certain categorical eligibility standards, like disability.

Medicaid Managed Care

States have some flexibility in the provision of Medicaid services. Section 1915(b) of the Social Security Act provides authority for the Secretary of the U.S. Department of Health and Human Services to waive requirements to the extent that he or she "finds it to be cost-effective and efficient and not inconsistent with the purposes of this title." Also, Section 1115 of the Social Security Act allows states to use innovative service delivery systems that improve care, increase efficiency, and reduce costs.

States may also ask the federal government to waive federal requirements to expand populations or services, or to try new ways of service delivery. Many states have elected to provide Medicaid benefits through a managed care model. Traditionally, Medicaid services are paid for under a fee-for-service (FFS) reimbursement model. Under the FFS model, the state pays providers directly for each covered service received by a Medicaid beneficiary. Under managed care, the state pays a fee to a managed care plan for each person enrolled in the plan. In turn, the plan pays providers for all of the Medicaid services a beneficiary may require that are included in the plan's contract with the state.[31]

For example, Florida has a Section 1115 waiver to use a comprehensive managed care delivery model for primary and acute care services, the Statewide Medicaid Managed Care (SMMC) Managed Medical Assistance (MMA) program.[32] The MMA program was enacted in 2011 and fully implemented in 2014.

Managed Medical Assistance (MMA) Program

The MMA program provides acute health care services through managed care plans contracted with the AHCA in nine regions across the state.[33] Specialty plans are also available to serve distinct populations, such as the Children's Medical Services Network for children with special health care needs, or those in the child welfare system. Medicaid recipients with HIV/AIDS, serious mental illness, dual enrollment with Medicare, chronic obstructive pulmonary disease,

[29] Section 409.905, F.S.
[30] Section 409.906, F.S.
[31] Medicaid and CHIP Payment and Access Commission (MACPAC), *Provider payment and delivery systems*, https://www.macpac.gov/medicaid-101/provider-payment-and-delivery-systems/ (last visited Feb. 10, 2026).
[32] Section 409.964, F.S.
[33] Agency for Health Care Administration, *SMMC Region Map*, https://ahca.myflorida.com/var/site/storage/images/5/8/9/2/182985-1-eng-US/a49c585cebfc-regions_Current2025.png (last visited Feb. 10, 2026).

congestive heart failure, or cardiovascular disease may also select from specialized plans. Roughly 80 percent of Florida's Medicaid population is served through the MMA program, while the remainder of participants are served by traditional FFS Medicaid.[34]

Intellectual and Developmental Disabilities (IDD) Pilot Program

In 2023, the Legislature created the Intellectual and Developmental Disabilities (IDD) Pilot Program in SMMC Region D (Hardee, Highlands, Hillsborough, Manatee, and Polk counties) and Region I (Miami-Dade and Monroe counties).[35] This established a managed care model for integrating medical care and HCBS for persons with intellectual and developmental disabilities, as an alternative to the iBudget model. To obtain federal Medicaid funding for the IDD Pilot Program, Florida obtained a Medicaid waiver in April 2024.[36]

Eligibility

The IDD Pilot Program is available to individuals who:
- Are Medicaid-eligible and 18 years of age or older;
- Have been assigned to categories one through six on the iBudget pre-enrollment list; and
- Reside in a pilot program region.

The IDD Pilot is only available to people on the iBudget pre-enrollment list, not iBudget enrollees; and is available statewide. Beginning in July 2026, the IDD Pilot Program expands to allow enrollment to all individuals with Developmental Disabilities enrolled in either the individual budget waiver services program (iBudget Waiver) or in the long-term care managed care program.

Enrollees are allowed the opportunity to disenroll from the IDD Pilot Program and enroll in any appropriate existing Medicaid waiver program if any of the following conditions occur:
- At any point during the operation of the IDD Pilot Program, an enrollee declares an intent to voluntarily disenroll, provided that he or she has been covered for the entire previous plan year by the IDD Pilot Program.
- The AHCA determines the enrollee has good cause to disenroll.
- The IDD Pilot Program ceases to operate.

Benefits

Current law requires the following benefits for the pilot program, delivered through a single, integrated model of care:
- All the medical care benefits covered in the SMMC program, as described in s. 409.973, F.S., including access to prepaid dental plans;

[34] Agency for Health Care Administration, presentation by Beth Kidder, Deputy Secretary for Medicaid, to the House Health and Human Services Committee (February 17, 2021) available at: https://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=3085&Session=2021&DocumentType=Meeting%20Packets&FileName=hhs%202-17-21.pdf (last visited Jan. 6, 2022).
[35] The Agency for Health Care Administration competitively procures plans in the SMMC program by region; there are nine SMMC regions.
[36] Florida Comprehensive Intellectual Developmental Disabilities Managed Care Pilot Program (2346.R00.00), April 1, 2024, authorized under s. 1915b of the Social Security Act.

- All the long-term care benefits covered in the SMMC program, as described in s. 409.98, F.S.; and
- All the home- and community-based services (HCBS) covered in the iBudget program, as described in s. 393.066, F.S.

Additionally, each enrollee must have a Care Coordinator. AHCA's contract with the plan requires a ratio of one IDD Care Coordinator per 18 enrollees; this 1:18 staffing ratio varies significantly from the 1:60 staffing ratio required for long-term care.

As with other SMMC programs, the AHCA negotiates for expanded benefits from the plans. These are benefits plans offer without cost to the state: the costs are not built into the managed care capitated rate. Rather, plans offer these benefits to attract enrollees and increase quality; some expanded benefits can prevent medical decline and the need for catastrophic medical care.

Administration

The AHCA is required to administer the pilot program using a managed care model. The AHCA must contract with a Medicaid managed care plan currently under contract with the AHCA to provide long-term care services. Experience providing HCBS to a population requiring significant care coordination is thereby a predicate for obtaining the contract. Similarly, current law requires the plan to have experience serving similar populations and have contracts in place with providers who serve persons with developmental disabilities, among other requirements.

Under the IDD Pilot Program, the AHCA is responsible for:
- Negotiating with and selecting qualified plans to participate in the pilot program;
- Making capitated payments to managed care organizations for comprehensive coverage under the pilot program; and
- Evaluating the feasibility of statewide implementation of the capitated managed care model used by the pilot program to serve individuals with developmental disabilities.

Under the IDD Pilot Program, the APD is responsible for:
- Approving a needs assessment methodology to determine functional, behavioral, and physical needs of prospective enrollees; and
- Providing a consultative resource for the AHCA in the development of policy for the pilot program.

III. Effect of Proposed Changes:

Section 1 repeals s. 381.4015, F.S., to eliminate the Health Care Innovation Council, a 15-member council within the Department of Health (DOH) and the revolving loan program, which provides funding for applicants seeking to implement innovative solutions in the state's health care system.

Section 2 amends s. 409.908, F.S., to modify the parameters governing the nursing home prospective payment methodology for Medicaid provider reimbursement to increase the quality incentive payment pool from ten percent to 15.2344 percent of the September 2016 non-property related payments of included facilities.

Section 3 amends s. 409.912, F.S., to require the AHCA to amend the Medicaid reimbursement protocol to require that a hospital facility administering long-acting injectables (LAIs) for severe mental illness (SMI) shall be reimbursed separately from the diagnosis-related group. The bill specifies that LAIs administered for severe mental illness in an inpatient hospital setting be reimbursed for an amount no less than the Actual Acquisition Cost (AAC).

Section 4 creates s. 409.9207, F.S., to establish the Medicaid Eligibility Assistance Program for Persons with Disabilities within the Department of Children and Families (DCF) to provide information, referral, and navigation services to assist persons with disabilities in initiating and completing actions necessary to secure Medicaid eligibility and access other community-based support programs that enable individuals to remain in their homes and communities.

Section 5 amends s. 409.967, F.S., to require the AHCA to re-procure contracts with managed care plans in the Statewide Medicaid Managed Care (SMMC) program every 8 years instead of every 6 years, beginning with the contract procurement process initiated during the 2023 calendar year.

The bill also requires the AHCA establish a quality withhold incentive within the current SMMC contracts, with the sole metric of the incentive being infant mortality. The agency is required to withhold two percent of each plans capitated rate each year. The plans will be able to earn a portion or all of the withhold back in the following ways:

- The plan that reduces its rate of infant mortality by the greatest amount compared to other plans shall earn the full two percent withhold.
- The plan that reduces its rate of infant mortality by the greatest number of lives compared to other plans shall earn back the full two percent withhold.
- Each other plan that reduces the rates of infant mortality shall earn back one percent of the withhold.
- For a plan that increases its rate of infant mortality, the agency shall suspend automatic assignment under ss. 409.977 and 409.98, F.S. for a period of four months.

Each plan's performance is based on changes compared to the prior two years in the contract term. The AHCA is required to account for varying plan population sizes in the methodology for measuring performance for the quality withhold incentive, to achieve accurate comparisons of performance.

Section 6 amends s. 409.9885, F.S., to require funding to follow an individual who voluntarily transfers between the home and community-based services waiver program and the Intellectual Developmental Disabilities Pilot Program, at an amount equivalent to the total state share cost of the individual for the remaining months in the fiscal year based on the pilot program's managed care plan monthly rate. The bill directs the Agency for Persons with Disabilities and the AHCA

to reconcile the transfer amount quarterly and authorizes the agencies to submit a budget amendment to transfer the funds.

Section 7 amends s. 409.91196, F.S., to conform a cross-reference.

The bill takes effect July 1, 2026.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

HB 5001, the House of Representative's General Appropriations Act (GAA) for Fiscal Year 2026-2027, includes $82.4 million for the AHCA, of which $36.4 million is from the General Revenue Fund, to increase the quality component of nursing home Medicaid rates from ten percent of non-property funds to 15.2344 percent of non-property funds, effective July 1, 2026.

HB 5001contains provisions which will positively impact the General Revenue Fund due to removing the authority for the following appropriations:

- $1 million for administration of the Health Care Innovation Council.
- $50 million per year over ten years for the revolving loan fund.

The provision of the bill relating to Medicaid reimbursement for long-acting injectables (LAIs) administered to patients with severe mental illness would have an indeterminate fiscal impact to the state. To the extent that increased state-share Medicaid costs associated with reimbursing LAIs are offset by reductions in other mental health or behavioral health expenditures, the net fiscal impact may be mitigated.

Additionally, the provision of the bill establishing the Medicaid Eligibility Assistance for Persons with Disabilities Program would have an indeterminate fiscal impact on the Department of Children and Families. The extent to which additional state staffing resources may be required is currently unknown, and it is unclear whether any such workload increase can be absorbed within existing resources.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 409.908, 409.912, 409.967, 409.9855, and 409.91196.

This bill creates section 409.9207 of the Florida Statutes.

This bill repeals section 381.4015 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

Barcode 356566 by Appropriations on March 2, 2026:
This amendment deletes everything and does not insert additional language.
(WITH TITLE AMENDMENT)