

1 A bill to be entitled
2 An act relating to health care; repealing s. 381.4015,
3 F.S., relating to Florida health care innovation;
4 amending s. 409.908, F.S.; revising the payment
5 methodology for reimbursement of Medicaid providers;
6 amending s. 409.912, F.S.; revising Medicaid preferred
7 drug coverage guidelines; creating s. 409.9207, F.S.;
8 providing legislative intent; providing definitions;
9 creating the Eligibility Assistance Program within the
10 Department of Children and Families; providing program
11 requirements; requiring the department to be operated
12 by an independent contractor that shall be selected
13 based on specified criteria; amending s. 409.967,
14 F.S.; revising the maximum term for Medicaid managed
15 care contracts; requiring the agency to establish by
16 contract a quality withhold incentive for certain
17 purposes; providing requirements for such incentive;
18 removing obsolete provisions; amending s. 409.9855,
19 F.S.; providing Medicaid waiver funding requirements
20 for certain individuals; requiring the Agency for
21 Persons with Disabilities and the Agency for Health
22 Care Administration to reconcile funding amounts in a
23 specified manner; amending s. 409.91196, F.S.;
24 conforming a provision to changes made by the act;
25 providing an effective date.

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

Section 1. Section 381.4015, Florida Statutes, is repealed.

Section 2. Paragraph (b) of subsection (2) of section 409.908, Florida Statutes, as amended by section 25 of chapter 2025-199, Laws of Florida, is amended to read:

409.908 Reimbursement of Medicaid providers.—Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. If a provider is reimbursed based on cost reporting and submits a cost report late and that cost report would have been used to set a lower reimbursement rate for a rate semester, then the provider's rate for that semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be effected retroactively. Medicare-granted extensions for filing cost reports, if applicable, shall also apply to Medicaid cost

51 reports. Payment for Medicaid compensable services made on
52 behalf of Medicaid-eligible persons is subject to the
53 availability of moneys and any limitations or directions
54 provided for in the General Appropriations Act or chapter 216.
55 Further, nothing in this section shall be construed to prevent
56 or limit the agency from adjusting fees, reimbursement rates,
57 lengths of stay, number of visits, or number of services, or
58 making any other adjustments necessary to comply with the
59 availability of moneys and any limitations or directions
60 provided for in the General Appropriations Act, provided the
61 adjustment is consistent with legislative intent.

62 (2)

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

71 1. The agency shall amend the long-term care reimbursement
72 plan and cost reporting system to create direct care and
73 indirect care subcomponents of the patient care component of the
74 per diem rate. These two subcomponents together shall equal the
75 patient care component of the per diem rate. Separate prices

76 shall be calculated for each patient care subcomponent,
77 initially based on the September 2016 rate setting cost reports
78 and subsequently based on the most recently audited cost report
79 used during a rebasing year. The direct care subcomponent of the
80 per diem rate for any providers still being reimbursed on a cost
81 basis shall be limited by the cost-based class ceiling, and the
82 indirect care subcomponent may be limited by the lower of the
83 cost-based class ceiling, the target rate class ceiling, or the
84 individual provider target. The ceilings and targets apply only
85 to providers being reimbursed on a cost-based system. Effective
86 October 1, 2018, a prospective payment methodology shall be
87 implemented for rate setting purposes with the following
88 parameters:

89 a. Peer Groups, including:

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

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

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

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

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

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

99 c. Floors:

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

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101 (II) Indirect Care Component.....92.5 percent.
 102 (III) Operating Component.....None.
 103 d. Pass-through Payments.....Real Estate and
 104 Personal Property
 105 Taxes and Property Insurance.
 106 e. Quality Incentive Program Payment
 107 Pool.....15.2344 ~~10~~ percent of September
 108 2016 non-property related
 109 payments of included facilities.
 110 f. Quality Score Threshold to Qualify for Quality
 111 Incentive Payment.....33
 112 percent of all available points in
 113 the Medicaid Quality Incentive Program ~~20th~~ percentile
 114 ~~of included facilities.~~
 115 g. Fair Rental Value System Payment Parameters:
 116 (I) Building Value per Square Foot based on 2018 RS Means.
 117 (II) Land Valuation.....10 percent of Gross Building
 118 value.
 119 (III) Facility Square Footage.....Actual Square
 120 Footage.
 121 (IV) Movable Equipment Allowance.....\$8,000 per bed.
 122 (V) Obsolescence Factor.....1.5 percent.
 123 (VI) Fair Rental Rate of Return.....8 percent.
 124 (VII) Minimum Occupancy.....90 percent.
 125 (VIII) Maximum Facility Age.....40 years.

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

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

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

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

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

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

4. All other patient care costs shall be included in the

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

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

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

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

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

176 settlements.

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

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

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

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

197
198 It is the intent of the Legislature that the reimbursement plan
199 achieve the goal of providing access to health care for nursing
200 home residents who require large amounts of care while

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

Section 3. Paragraph (a) of subsection (5) of section 409.912, Florida Statutes, is amended 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

226 aggregate fixed-sum basis services when appropriate and other
227 alternative service delivery and reimbursement methodologies,
228 including competitive bidding pursuant to s. 287.057, designed
229 to facilitate the cost-effective purchase of a case-managed
230 continuum of care. The agency shall also require providers to
231 minimize the exposure of recipients to the need for acute
232 inpatient, custodial, and other institutional care and the
233 inappropriate or unnecessary use of high-cost services. The
234 agency shall contract with a vendor to monitor and evaluate the
235 clinical practice patterns of providers in order to identify
236 trends that are outside the normal practice patterns of a
237 provider's professional peers or the national guidelines of a
238 provider's professional association. The vendor must be able to
239 provide information and counseling to a provider whose practice
240 patterns are outside the norms, in consultation with the agency,
241 to improve patient care and reduce inappropriate utilization.
242 The agency may mandate prior authorization, drug therapy
243 management, or disease management participation for certain
244 populations of Medicaid beneficiaries, certain drug classes, or
245 particular drugs to prevent fraud, abuse, overuse, and possible
246 dangerous drug interactions. The Pharmaceutical and Therapeutics
247 Committee shall make recommendations to the agency on drugs for
248 which prior authorization is required. The agency shall inform
249 the Pharmaceutical and Therapeutics Committee of its decisions
250 regarding drugs subject to prior authorization. The agency is

251 authorized to limit the entities it contracts with or enrolls as
252 Medicaid providers by developing a provider network through
253 provider credentialing. The agency may competitively bid single-
254 source-provider contracts if procurement of goods or services
255 results in demonstrated cost savings to the state without
256 limiting access to care. The agency may limit its network based
257 on the assessment of beneficiary access to care, provider
258 availability, provider quality standards, time and distance
259 standards for access to care, the cultural competence of the
260 provider network, demographic characteristics of Medicaid
261 beneficiaries, practice and provider-to-beneficiary standards,
262 appointment wait times, beneficiary use of services, provider
263 turnover, provider profiling, provider licensure history,
264 previous program integrity investigations and findings, peer
265 review, provider Medicaid policy and billing compliance records,
266 clinical and medical record audits, and other factors. Providers
267 are not entitled to enrollment in the Medicaid provider network.
268 The agency shall determine instances in which allowing Medicaid
269 beneficiaries to purchase durable medical equipment and other
270 goods is less expensive to the Medicaid program than long-term
271 rental of the equipment or goods. The agency may establish rules
272 to facilitate purchases in lieu of long-term rentals in order to
273 protect against fraud and abuse in the Medicaid program as
274 defined in s. 409.913. The agency may seek federal waivers
275 necessary to administer these policies.

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

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

procedures to ensure that:

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

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

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

3. The agency shall develop and implement a process for managing the drug therapies of Medicaid recipients who are using significant numbers of prescribed drugs each month. The management process may include, but is not limited to, comprehensive, physician-directed medical-record reviews, claims analyses, and case evaluations to determine the medical necessity and appropriateness of a patient's treatment plan and drug therapies. The agency may contract with a private organization to provide drug-program-management services. The

326 Medicaid drug benefit management program shall include
327 initiatives to manage drug therapies for HIV/AIDS patients,
328 patients using 20 or more unique prescriptions in a 180-day
329 period, and the top 1,000 patients in annual spending. The
330 agency shall enroll any Medicaid recipient in the drug benefit
331 management program if he or she meets the specifications of this
332 provision and is not enrolled in a Medicaid health maintenance
333 organization.

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

the agency.

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

~~6.5.~~ The agency shall develop and implement a program that requires Medicaid practitioners who issue written prescriptions for medicinal drugs to use a counterfeit-proof prescription pad for Medicaid prescriptions. The agency shall require the use of standardized counterfeit-proof prescription pads by prescribers who issue written prescriptions for Medicaid recipients. The agency may implement the program in targeted geographic areas or statewide.

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

~~8.7.~~ The agency may establish a preferred drug list as

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

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

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

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

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

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

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

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

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

(VII) Disseminate electronic and published materials.

(VIII) Hold statewide and regional conferences.

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

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

a. The agency may contract with a vendor that has experience in operating prescription drug management systems in order to implement this system. Any management system that is

451 implemented in accordance with this subparagraph must rely on
452 cooperation between physicians and pharmacists to determine
453 appropriate practice patterns and clinical guidelines to improve
454 the prescribing, dispensing, and use of drugs in the Medicaid
455 program. The agency may seek federal waivers to implement this
456 program.

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

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

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

473 (III) Assess Medicaid recipients who are outliers in their
474 use of a single or multiple prescription drugs with regard to
475 the numbers and types of drugs taken, drug dosages, combination

476 drug therapies, and other indicators of improper use of
477 prescription drugs.

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

482 ~~11.10.~~ The agency may contract for drug rebate
483 administration, including, but not limited to, calculating
484 rebate amounts, invoicing manufacturers, negotiating disputes
485 with manufacturers, and maintaining a database of rebate
486 collections.

487 ~~12.11.~~ The agency may specify the preferred daily dosing
488 form or strength for the purpose of promoting best practices
489 with regard to the prescribing of certain drugs as specified in
490 the General Appropriations Act and ensuring cost-effective
491 prescribing practices.

492 ~~13.12.~~ The agency may require prior authorization for
493 Medicaid-covered prescribed drugs. The agency may prior-
494 authorize the use of a product:

- 495 a. For an indication not approved in labeling;
496 b. To comply with certain clinical guidelines; or
497 c. If the product has the potential for overuse, misuse,
498 or abuse.

499
500 The agency may require the prescribing professional to provide

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

~~14.13.~~ The agency, in conjunction with the Pharmaceutical and Therapeutics Committee, may require age-related prior authorizations for certain prescribed drugs. The agency may preauthorize the use of a drug for a recipient who may not meet the age requirement or may exceed the length of therapy for use of this product as recommended by the manufacturer and approved by the Food and Drug Administration. Prior authorization may require the prescribing professional to provide information about the rationale and supporting medical evidence for the use of a drug.

~~15.14.~~ The agency shall implement a step-therapy prior authorization approval process for medications excluded from the preferred drug list. Medications listed on the preferred drug list must be used within the previous 12 months before the alternative medications that are not listed. The step-therapy prior authorization may require the prescriber to use the

medications of a similar drug class or for a similar medical indication unless contraindicated in the Food and Drug Administration labeling. The trial period between the specified steps may vary according to the medical indication. The step-therapy approval process shall be developed in accordance with the committee as stated in s. 409.91195(7) and (8). A drug product may be approved without meeting the step-therapy prior authorization criteria if the prescribing physician provides the agency with additional written medical or clinical documentation that the product is medically necessary because:

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

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

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

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

The agency shall work with the physician to determine the best

alternative for the patient. The agency may adopt rules waiving the requirements for written clinical documentation for specific drugs in limited clinical situations.

~~16.15.~~ The agency shall implement a return and reuse program for drugs dispensed by pharmacies to institutional recipients, which includes payment of a \$5 restocking fee for the implementation and operation of the program. The return and reuse program shall be implemented electronically and in a manner that promotes efficiency. The program must permit a pharmacy to exclude drugs from the program if it is not practical or cost-effective for the drug to be included and must provide for the return to inventory of drugs that cannot be credited or returned in a cost-effective manner. The agency shall determine if the program has reduced the amount of Medicaid prescription drugs which are destroyed on an annual basis and if there are additional ways to ensure more prescription drugs are not destroyed which could safely be reused.

Section 4. Section 409.9207, Florida Statutes, is created to read:

409.9207 Medicaid eligibility assistance for persons with disabilities.—

(1) LEGISLATIVE INTENT.—It is the intent of the Legislature to create a program that supports and enables persons with disabilities to become Medicaid eligible. The

Department of Children and Families shall be responsible for this program; however, all agencies with any duties related to Medicaid are responsible for collaborating with the department and the independent contractor selected to implement the program.

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

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

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

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

(3) (a) ELIGIBILITY ASSISTANCE PROGRAM.—The Eligibility Assistance Program is created within the Department of Children and Families to offer information, referral, and navigation services to persons with disabilities to initiate and successfully complete the actions required to secure eligibility for Medicaid and other community-based services enabling such

persons to remain in their homes and communities.

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

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

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

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

Section 5. Subsection (1) and paragraph (f) of subsection (2) of section 409.967, Florida Statutes, are amended to read:

409.967 Managed care plan accountability.—

(1) Beginning with the contract procurement process initiated during the 2023 calendar year, the agency shall establish a 8-year ~~6-year~~ contract with each managed care plan selected through the procurement process described in s. 409.966. A plan contract may not be renewed; however, the agency may extend the term of a plan contract to cover any delays during the transition to a new plan. ~~The agency shall extend until December 31, 2024, the term of existing plan contracts awarded pursuant to the invitation to negotiate published in July 2017.~~

(2) The agency shall establish such contract requirements

as are necessary for the operation of the statewide managed care program. In addition to any other provisions the agency may deem necessary, the contract must require:

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

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

2. Each managed care plan must collect and report the Healthcare Effectiveness Data and Information Set (HEDIS) measures, the federal Core Set of Children's Health Care Quality measures, and the federal Core Set of Adult Health Care Quality Measures, as specified by the agency. Each plan must collect and report the Adult Core Set behavioral health measures beginning with data reports for the 2025 calendar year. Each plan must stratify reported measures by age, sex, race, ethnicity, primary language, and whether the enrollee received a Social Security Administration determination of disability for purposes of Supplemental Security Income beginning with data reports for the 2026 calendar year. A plan's performance on these measures must be published on the plan's website in a manner that allows

651 recipients to reliably compare the performance of plans. The
652 agency shall use the measures as a tool to monitor plan
653 performance.

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

661 4. The agency shall establish by contract a quality
662 withhold incentive to generate plan competition and improvement
663 in a single quality measure over the course of the contract
664 term. For the contract term ending in 2033, the sole metric for
665 a quality withhold incentive is infant mortality. Each year, the
666 agency shall withhold 2 percent of the plan's capitation rate. A
667 plan may earn back the withheld amount based on the compared
668 performance of the prior 2 years or from the beginning of the
669 contract term, as follows:

670 a. The plan that reduces its rate of infant mortality by
671 the greatest amount compared to other plans shall earn the full
672 2 percent withhold.

673 b. The plan that reduces its rate of infant mortality by
674 the greatest number of lives compared to other plans shall earn
675 back the full 2 percent withhold.

676 c. Every other plan that reduces the rates of infant
677 mortality shall earn back 1 percent of the withhold.

678 d. For a plan that increases its rate of infant mortality,
679 the agency shall suspend automatic assignment under ss. 409.977
680 and 409.984 for a period of 4 months.

681
682 The agency's methodology for measuring performance for the
683 quality withhold incentive must account for varying plan
684 population sizes to achieve accurate comparisons of performance.

685 **Section 6. Subsection (8) is added to section 409.9855,**
686 **Florida Statutes, to read:**

687 409.9855 Pilot program for individuals with developmental
688 disabilities.—

689 (8) WAIVER TRANSFER FUNDING.—

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

698 (b) For individuals enrolled in the pilot program who
699 choose to enroll in the Medicaid home and community-based
700 services waiver program under chapter 393, funding associated

with the individual shall be transferred from the Agency for Health Care Administration to the Agency for Persons with Disabilities. The funding shall be equivalent to the total state share cost of the individual for the remaining months in the fiscal year based on the pilot program's managed care plan monthly rate.

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

Section 7. Subsection (1) of section 409.91196, Florida Statutes, is amended to read:

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

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

Section 8. This act shall take effect July 1, 2026.