

Amendment No.

CHAMBER ACTION

Senate

House

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The Conference Committee on HB 5301E offered the following:

**Conference Committee Amendment (with title amendment)**

Remove everything after the enacting clause and insert:

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

381.4015 Florida health care innovation.—

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

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12 (a) Administration.—The council may make recommendations  
13 to the department for the administration of the loans. The  
14 department shall adopt rules:

15 1. Establishing an application process to submit and  
16 review funding proposals for loans. Such rules must also include  
17 the process for the council to review applications to ensure  
18 compliance with applicable laws, including those related to  
19 discrimination and conflicts of interest. If a council member  
20 participated in the vote of the council recommending an award  
21 for a proposal with which the council member has a conflict of  
22 interest, the division may not award the loan to that entity.

23 2. Establishing eligibility criteria to be applied by the  
24 council in recommending applications for the award of loans  
25 which:

26 a. Incorporate the recommendations of the council. The  
27 council shall recommend to the department criteria based upon  
28 input received and the focus areas developed. The council may  
29 recommend updated criteria as necessary, based upon the most  
30 recent input, best practice recommendations, or focus areas  
31 list.

32 b. Determine which proposals are likely to provide the  
33 greatest return to the state if funded, taking into  
34 consideration, at a minimum, the degree to which the proposal  
35 would increase efficiency in the health care system in this  
36 state, reduce strain on the state's health care workforce,

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37 improve patient outcomes, increase public access to health care  
38 in this state, or provide cost savings to patients or the state  
39 without reducing the quality of patient care.

40 3. It deems necessary to administer the program,  
41 including, but not limited to, rules for application  
42 requirements, the ability of the applicant to properly  
43 administer funds, the professional excellence of the applicant,  
44 the fiscal stability of the applicant, the state or regional  
45 impact of the proposal, matching requirements for the proposal,  
46 and other requirements to further the purposes of the program.

47 (b) Eligibility.—

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

49 a. Entities licensed, registered, or certified by the  
50 Agency for Health Care Administration as provided under s.  
51 408.802, except for those specified in s. 408.802(1), (3), (13),  
52 (23), or (25).

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

55 2.a. Council members may not receive loans under the  
56 program.

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

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

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

66 b. Nonprofit entities that accept Medicaid patients.

67 4. The department may award a loan for up to 50 percent of  
68 the total projected implementation costs, or up to 80 percent of  
69 total projected implementation costs for an applicant under  
70 subparagraph 3. The applicant must demonstrate the source of  
71 funding it will use to cover the remainder of the total  
72 projected implementation costs, which funding must be from  
73 nonstate sources.

74 (c) Applications.—

75 1. The department shall set application periods to apply  
76 for loans. The department may set multiple application periods  
77 in a fiscal year, with up to four periods per year. The  
78 department shall coordinate with the council when establishing  
79 application periods to establish separate priority, in addition  
80 to eligibility, within the loan applications for defined  
81 categories based on the current focus area list. The department  
82 shall publicize the availability of loans under the program to  
83 stakeholders, education or training providers, and others.

84 2. Upon receipt of an application, the department shall  
85 determine whether the application is complete and the applicant  
86 has demonstrated the ability to repay the loan. Within 30 days

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87 after the close of the application period, the department shall  
88 forward all completed applications to the council for  
89 consideration.

90 3. The council shall review applications for loans under  
91 the criteria and pursuant to the processes and format adopted by  
92 the department. The council shall submit to the department for  
93 approval lists of applicants that it recommends for funding,  
94 arranged in order of priority and as required for the  
95 application period.

96 4. A loan applicant must demonstrate plans to use the  
97 funds to implement one or more innovative technologies,  
98 workforce pathways, service delivery models, or other solutions  
99 in order to fill a demonstrated need; obtain or upgrade  
100 necessary equipment, hardware, and materials; adopt new  
101 technologies or systems; or a combination thereof which will  
102 improve the quality and delivery of health care in measurable  
103 and sustainable ways and which will lower costs and allow  
104 savings to be passed on to health care consumers.

105 (d) Awards.—

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

110 2. The interest rate for each loan may not exceed 1  
111 percent.

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

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

118 (e) Written agreement.—

119 1. Each loan recipient must enter into a written agreement  
120 with the department to receive the loan. At a minimum, the  
121 agreement with the applicant must specify all of the following:

122 a. The total amount of the award.

123 b. The performance conditions that must be met, based upon  
124 the submitted proposal and the defined category or focus area,  
125 as applicable.

126 c. The information to be reported on actual implementation  
127 costs, including the share from nonstate resources.

128 d. The schedule for payment.

129 e. The data and progress reporting requirements and  
130 schedule.

131 f. Any sanctions that would apply for failure to meet  
132 performance conditions.

133 2. The department shall develop uniform data reporting  
134 requirements for loan recipients to evaluate the performance of  
135 the implemented proposals. Such data must be shared with the  
136 council.

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137 3. If requested, the department shall provide technical  
138 assistance to loan recipients under the program.

139 (f) Loan repayment.—Loans become due and payable in  
140 accordance with the terms of the written agreement. All  
141 repayments of principal received by the department in a fiscal  
142 year shall be returned to the revolving loan fund and made  
143 available for loans to other applicants.

144 (g) Revolving loan fund.—The department shall create and  
145 maintain a separate account in the Grants and Donations Trust  
146 Fund within the department as a fund for the program. All  
147 repayments of principal must be returned to the revolving loan  
148 fund and made available as provided in this section.  
149 Notwithstanding s. 216.301, funds appropriated for the revolving  
150 loan program are not subject to reversion. The department may  
151 contract with a third-party administrator to administer the  
152 program, including loan servicing, and manage the revolving loan  
153 fund. A contract for a third-party administrator which includes  
154 management of the revolving loan fund must, at a minimum,  
155 require maintenance of the revolving loan fund to ensure that  
156 the program may operate in a revolving manner.

157 **Section 2. Paragraph (a) of subsection (2) of section**  
158 **383.14, Florida Statutes, is amended to read:**

159 383.14 Screening for metabolic disorders, other hereditary  
160 and congenital disorders, and environmental risk factors.—

161 (2) RULES.—

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

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

167 2. Be tested for any condition included on the federal  
168 Recommended Uniform Screening Panel which the council advises  
169 the department should be included under the state's screening  
170 program. After the council recommends that a condition be  
171 included, the department shall submit a legislative budget  
172 request to seek an appropriation to add testing of the condition  
173 to the newborn screening program. The department shall expand  
174 statewide screening of newborns to include screening for such  
175 conditions within 18 months after the council renders such  
176 advice, if a test approved by the United States Food and Drug  
177 Administration or a test offered by an alternative vendor is  
178 available. If such a test is not available within 18 months  
179 after the council makes its recommendation, the department shall  
180 implement such screening as soon as a test offered by the United  
181 States Food and Drug Administration or by an alternative vendor  
182 is available;

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

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186 4. ~~Subject to legislative appropriation,~~ Beginning January  
187 1, 2027, be screened for all of the following:

188 a. Duchenne muscular dystrophy.

189 b. Infantile Krabbe disease.

190 c. Metachromatic leukodystrophy.

191 **Section 3. Section 383.1401, Florida Statutes, is created**  
192 **to read:**

193 383.1401 Neonatal Nutrition.—The Department of Health  
194 shall create an evidence-based, educational pamphlet on the  
195 nutritional needs of preterm infants. By January 1, 2027, the  
196 department shall make the pamphlet available electronically to  
197 hospitals licensed under chapter 395 to provide neonatal  
198 intensive care services. Such hospitals may provide the pamphlet  
199 to parents and guardians of infants receiving care in a neonatal  
200 intensive care unit. The pamphlet must include, but need not be  
201 limited to, information on preterm infants relating to all of  
202 the following:

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

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

206 (3) Different nutritional sources for infants, including  
207 maternal breast milk, pasteurized human donor milk, infant  
208 formula, human-milk-derived fortifiers, and bovine-milk-derived  
209 fortifiers, and the recommended uses for each type of  
210 nutritional source;

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211 (4) The importance of maternal breast milk for meeting the  
212 nutritional and developmental needs of infants, and the  
213 alternative of pasteurized human donor milk if maternal breast  
214 milk is not available;

215 (5) The importance of having a physician discuss with  
216 family members the risks and benefits of all nutritional sources  
217 available, based on the preterm infant's individual situation;  
218 and

219 (6) Necrotizing enterocolitis, the risk factors for  
220 necrotizing enterocolitis, and the potential for a human-milk-  
221 based diet, including maternal and pasteurized donor breast  
222 milk, to reduce the risk of necrotizing enterocolitis.

223 **Section 4. Subsection (9) of section 393.066, Florida**  
224 **Statutes, is renumbered as subsection (10), and a new subsection**  
225 **(9) is added to that section to read:**

226 393.066 Community services and treatment.—

227 (9) The agency shall utilize a monthly reimbursement rate,  
228 developed by the Agency for Health Care Administration in  
229 consultation with the agency, for Life Skills Development Level  
230 3 and Level 4 services. The monthly reimbursement rate shall  
231 apply to services for clients who receive at least 80 hours of  
232 such services during a calendar month. For clients who receive  
233 less than 80 hours of services during a calendar month,  
234 providers shall be reimbursed using an hourly reimbursement  
235 rate.

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236           **Section 5. Paragraph (g) of subsection (16) of section**  
237 **395.4025, Florida Statutes, is redesignated as paragraph (h),**  
238 **and a new paragraph (g) is added to that subsection to read:**

239           395.4025 Trauma centers; selection; quality assurance;  
240 records.—

241           (16)

242           (g) Notwithstanding the statutory capacity limits  
243 established in s. 395.402(1), the provisions of subsection (8),  
244 or any other provision of this part, specialty licensed  
245 children's hospitals licensed by the agency shall be designated  
246 by the department as a Level I or Level II pediatric trauma  
247 center based on documentation of a valid certification of trauma  
248 center verification by the American College of Surgeons.

249           **Section 6. Subsection (6) of section 395.902, Florida**  
250 **Statutes, is amended to read:**

251           395.902 Behavioral health teaching hospitals.—

252           (6) Upon designating a behavioral health teaching hospital  
253 under this section, the agency shall award the hospital funds as  
254 follows:

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

259           (b) Through the Training, Education, and Clinicals in  
260 Health Funding Program established in s. 409.91256 to offset a

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261 portion of the costs of maintaining integrated workforce  
262 development programs.

263 **Section 7. Section 395.903, Florida Statutes, is amended**  
264 **to read:**

265 395.903 Behavioral Health Teaching Hospital grant  
266 program.—

267 (1) There is established within the agency a grant program  
268 for the purpose of funding designated behavioral health teaching  
269 hospitals, subject to legislative appropriation. Grant funding  
270 may be used for operational expenses for the delivery of  
271 comprehensive wrap-around rehabilitative services for behavioral  
272 health patients ~~operations and expenses~~ and for fixed capital  
273 outlay expenses that are directly related to the provision of  
274 behavioral health services by the behavioral health teaching  
275 hospital or its subcontracted behavioral health care provider,  
276 including, but not limited to: r

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

278 1. Establish new beds for patients requiring behavioral  
279 health services; or

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

282 (b) Establishing new or increasing the capacity of  
283 existing behavioral health services provided by the behavioral  
284 health teaching hospital or its subcontracted behavioral health  
285 care provider; and

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

288 (2)(a)1. For the 2024-2025 fiscal year, the agency shall  
289 hold a 30-day, open application period beginning November 1,  
290 2024, to accept applications from the behavioral health teaching  
291 hospitals designated under s. 395.902(4), in a manner determined  
292 by the agency. Applicants must include a detailed spending plan  
293 with the application.

294 (b)2. For the 2025-2026 and 2026-2027 fiscal years, the  
295 agency shall hold a 30-day, open application period beginning  
296 October 1 of each year to accept applications from behavioral  
297 health teaching hospitals designated under s. 395.902, in a  
298 manner determined by the agency. Applicants must include a  
299 detailed spending plan with the application. On or before  
300 January 1, 2025, and January 1, 2026, hospitals desiring to  
301 apply for designation in the next fiscal year shall submit  
302 letters of intent to the agency.

303 (3)(b) The agency, in consultation with the department,  
304 shall evaluate and rank grant applications based on compliance  
305 with s. 395.902(2) and the quality of the plan submitted under  
306 s. 395.902(2)(e) or plan implementation, as applicable, related  
307 to achieving the purposes of the behavioral health teaching  
308 hospital program. The agency, in consultation with the  
309 department, shall make recommendations for grant awards and  
310 distribution of available funding for such awards. The agency

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311 shall submit the evaluation and grant award recommendations to  
312 the President of the Senate and the Speaker of the House of  
313 Representatives within 90 days after the open application period  
314 closes.

315 ~~(4)(e)~~ Notwithstanding ss. 216.181 and 216.292, the agency  
316 may submit budget amendments, subject to the notice, review, and  
317 objection procedures under s. 216.177, requesting the release of  
318 the funds to make awards. The agency is authorized to submit  
319 budget amendments relating to expenses under this subsection  
320 under the grant program only within the 90 days after the open  
321 application period closes.

322 ~~(5)(2)~~ Notwithstanding s. 216.301 and pursuant to s.  
323 216.351, the balance of any appropriation from the General  
324 Revenue Fund for the program which is not disbursed but which is  
325 obligated pursuant to contract or committed to be expended by  
326 June 30 of the fiscal year for which the funds are appropriated  
327 may be carried forward for up to 8 years after the effective  
328 date of the original appropriation.

329 ~~(6)(3)~~ The agency may adopt rules necessary to implement  
330 this section.

331 **Section 8. Subsection (3) of section 409.145, Florida**  
332 **Statutes, is amended to read:**

333 409.145 Care of children; "reasonable and prudent parent"  
334 standard.—The child welfare system of the department shall  
335 operate as a coordinated community-based system of care which

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336 empowers all caregivers for children in foster care to provide  
337 quality parenting, including approving or disapproving a child's  
338 participation in activities based on the caregiver's assessment  
339 using the "reasonable and prudent parent" standard.

340 (3) ROOM AND BOARD RATES.—

341 (a) Effective July 1, 2026 ~~2022~~, room and board rates  
342 shall be paid to foster parents, including relative and  
343 nonrelative caregivers who are licensed as a level I child-  
344 specific foster placement, and to relative and nonrelative  
345 caregivers who are participating in the Relative Caregiver  
346 Program and receiving payments pursuant to s. 39.5085(2)(d)1. or  
347 2., as follows:

348 Monthly Room and Board Rate

349	0-5 Years	6-12 Years	13-21 Years
	Age	Age	Age
350	<u>\$663.03</u> <del>\$517.94</del>	<u>\$680.01</u> <del>\$531.21</del>	<u>\$795.94</u> <del>\$621.77</del>

351  
352 (b) Each January, foster parents, including relative and  
353 nonrelative caregivers who are licensed as a level I child-  
354 specific foster placement and relative and nonrelative  
355 caregivers who are participating in the Relative Caregiver  
356 Program and receiving payments pursuant to s. 39.5085(2)(d)1. or

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357 2., shall receive an annual cost of living increase. The  
358 department shall calculate the new room and board rate increase  
359 equal to the percentage change in the Consumer Price Index for  
360 All Urban Consumers, U.S. City Average, All Items, not  
361 seasonally adjusted, or successor reports, for the preceding  
362 December compared to the prior December as initially reported by  
363 the United States Department of Labor, Bureau of Labor  
364 Statistics. The department shall make available the adjusted  
365 room and board rates annually.

366 (c) The amount of the monthly room and board rate may be  
367 increased upon agreement among the department, the community-  
368 based care lead agency, and the foster parent.

369 (d) Effective July 1, 2022, community-based care lead  
370 agencies providing care under contract with the department shall  
371 pay a supplemental room and board payment to foster parents,  
372 including relative and nonrelative caregivers who are licensed  
373 as a level I child-specific foster placement and relative and  
374 nonrelative caregivers who are participating in the Relative  
375 Caregiver Program and receiving payments pursuant to s.  
376 39.5085(2) (d)1. or 2., on a per-child basis, for providing  
377 independent life skills and normalcy supports to children who  
378 are 13 through 17 years of age placed in their care. The  
379 supplemental payment must be paid monthly in addition to the  
380 current monthly room and board rate payment. The supplemental  
381 monthly payment shall be based on 10 percent of the monthly room

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382 and board rate for children 13 through 21 years of age as  
383 provided under this section and adjusted annually.

384 **Section 9. Section 409.1455, Florida Statutes, is amended**  
385 **to read:**

386 409.1455 Step into Success Workforce Education and  
387 Internship ~~Pilot~~ Program for foster youth and former foster  
388 youth.—

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

391 (2) CREATION.—The department shall establish the ~~3-year~~  
392 Step into Success Workforce Education and Internship ~~Pilot~~  
393 Program to give eligible foster youth and former foster youth an  
394 opportunity to learn and develop essential workforce and  
395 professional skills, to transition from the custody of the  
396 department to independent living, and to become better prepared  
397 for an independent and successful future. The ~~pilot~~ program must  
398 consist of an independent living professionalism and workforce  
399 education component and, for youth who complete that component,  
400 an onsite workforce training internship component. In  
401 consultation with subject-matter experts and the community-based  
402 care lead agencies, the office shall develop and administer the  
403 ~~pilot~~ program for interested foster youth and former foster  
404 youth; however, the department may contract with entities that  
405 have demonstrable subject-matter expertise in the transition to  
406 adulthood for foster youth, workforce training and preparedness,

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407 professional skills, and related subjects to collaborate with  
408 the office in the development and administration of the ~~pilot~~  
409 program. The independent living professionalism and workforce  
410 education component of the program must culminate in a  
411 certificate that allows a former foster youth to participate in  
412 the onsite workforce training internship.

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

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

416 (b) "Former foster youth" means an individual 18 years of  
417 age or older but younger than 26 years of age who is currently  
418 or was previously placed in licensed care, excluding Level I  
419 licensed placements pursuant to s. 409.175(5)(a)1., for at least  
420 60 days within this state.

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

425 (d) "Office" means the department's Office of Continuing  
426 Care.

427 (e) "Participating organization" means a state agency, a  
428 corporation under chapter 607 or chapter 617, or another  
429 relevant entity that has agreed to collaborate with the office  
430 in the development and implementation of a trauma-informed

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431 onsite workforce training internship program pursuant to  
432 subsections (6) and (7).

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

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

439 (b) Collaborate with local chambers of commerce and  
440 recruit mentors and organizations within the department's  
441 regions, emphasizing recruitment of mentors and organizations in  
442 the following counties:

443 1. Duval.

444 2. Escambia.

445 3. Hillsborough.

446 4. Palm Beach.

447 5. Polk.

448 (c) Provide eligible former foster youth with a variety of  
449 internship placement opportunities, including by connecting  
450 existing third-party mentorship organizations that focus on  
451 former foster youth with eligible former foster youth who have  
452 an interest in such organizations' programs ~~The pilot program~~  
453 ~~must be administered as part of an eligible foster youth's~~  
454 ~~regular transition planning under s. 39.6035 or as a post-~~  
455 ~~transition service for eligible former foster youth. The office~~

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456 ~~must begin the professionalism and workforce education component~~  
457 ~~of the program on or before January 1, 2024, and the onsite~~  
458 ~~workforce training internship component of the program on or~~  
459 ~~before July 1, 2024.~~

460 (5) INDEPENDENT LIVING PROFESSIONALISM AND WORKFORCE  
461 EDUCATION COMPONENT REQUIREMENTS.—The office shall do all of the  
462 following in connection with the independent living  
463 professionalism and workforce education component for eligible  
464 foster youth and former foster youth:

465 (a) Designate and ensure that the number of qualified  
466 staff is sufficient to implement and administer the component,  
467 which may be part of a larger independent living or life skills  
468 training program if the larger program meets the requirements of  
469 this subsection.

470 (b) Develop all workshops, presentations, and curricula  
471 for the component, including, but not limited to, all written  
472 educational and training materials for foster youth and former  
473 foster youth. Resources may include, but are not limited to,  
474 workshops and materials to assist with preparing résumés, mock  
475 interviews, experiential training, and assistance with securing  
476 an internship or employment. The office must review and update  
477 these materials as necessary. The training materials must  
478 address, but are not limited to, the following:

- 479 1. Interview skills;
- 480 2. Professionalism;

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- 481           3. Teamwork;  
482           4. Leadership;  
483           5. Problem solving; and  
484           6. Conflict resolution in the workplace.

485           (c) Require that the training provided be in addition to  
486 any other life skills or employment training required by law.  
487 The training may be developed or administered by the department,  
488 community-based care lead agencies, or the lead agencies'  
489 subcontracted providers, or in collaboration with colleges or  
490 universities or other nonprofit organizations in the community  
491 with workforce education and training resources.

492           (d) Provide relevant written materials from the component  
493 and any relevant tools developed to ensure participants'  
494 successful transition to internships to all participating  
495 organizations that offer workforce training internship  
496 opportunities.

497           (e) Provide materials to inform eligible foster youth and  
498 former foster youth of the program, the requirements for  
499 participation, and contact information for enrollment. The  
500 community-based care lead agencies shall ensure that any  
501 subcontracted providers that directly serve youth receive this  
502 information.

503           (f) Advertise and promote the availability of the  
504 education and internship program to engage as many eligible  
505 foster youth and former foster youth as possible.

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506 (g) Assess the career interests of each eligible foster  
507 youth and former foster youth who expresses interest in  
508 participating in the program and determine the most appropriate  
509 internship and post-internship opportunities for that youth  
510 based on his or her expressed interests.

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

515 (a) Develop processes and procedures to implement a  
516 trauma-informed onsite workforce training internship component.  
517 The processes and procedures of the internship component must be  
518 designed so that they can be replicated and scaled to meet  
519 various organizational structures and sizes. The component must  
520 include:

- 521 1. Recruitment of agencies, corporations, and other  
522 entities to host interns as participating organizations;
- 523 2. Assisting participating organizations with mentor  
524 recruitment, training, and matching;
- 525 3. Mentor-led performance reviews, including a review of  
526 the intern's work product, professionalism, time management,  
527 communication style, and stress-management strategies;
- 528 4. Daily mentorship and coaching on topics such as:
  - 529 a. Professionalism;
  - 530 b. Teamwork;

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531 c. Leadership;

532 d. Problem solving; and

533 e. Conflict resolution in the workplace;

534 5. Development of opportunities for interns to become  
535 employees of the participating organization; and

536 6. Reporting requirements specified in subsection (11).

537 (b) Develop a ~~minimum of 1 hour of~~ required trauma-  
538 informed training for mentors to satisfy the requirements of  
539 sub-subparagraph (7) (b) 1.e. Such training must include  
540 interactive or experiential components, such as role-playing,  
541 scenario discussion, or case studies. The office may provide at  
542 least four additional 1-hour trainings on mentorship of special  
543 populations as optional training opportunities, which must be  
544 asynchronous and accessible to mentors online at their  
545 convenience, and must inform participating organizations of  
546 these optional training opportunities ~~teach the skills necessary~~  
547 ~~to engage with participating eligible former foster youth.~~

548 (c) Provide assistance to eligible foster youth and former  
549 foster youth interested in participating in the internship  
550 component, including, but not limited to, identifying and  
551 monitoring internship opportunities, being knowledgeable of the  
552 training and skills needed to match eligible foster youth and  
553 former foster youth with appropriate internships, and assisting  
554 eligible foster youth and former foster youth with applying for  
555 post-internship employment opportunities.

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

559 (e) Provide a participating former foster youth with  
560 financial assistance in the amount of \$1,717 ~~\$1,517~~ monthly and  
561 develop a process and schedule for the distribution of payments  
562 to former foster youth participating in the component, subject  
563 to the availability of funds.

564 (f) Distribute funds appropriated for the compensation of  
565 mentors who are participating in the component as provided in  
566 paragraph (7) (b).

567 (g) By May 1, 2024, provide to the Board of Governors and  
568 the State Board of Education all relevant internship information  
569 necessary to support the award of postsecondary credit or career  
570 education clock hours for internship positions held by former  
571 foster youth participating in the onsite workforce training  
572 internship component.

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

574 1. Former foster youth within 3 months after their  
575 internship start date to ensure successful transition into the  
576 work environment and to gather feedback on how to improve the  
577 experience for future participants.

578 2. Mentors assigned to participating former foster youth.  
579 Such data must be collected by October 1, 2024, and by October 1

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580 annually thereafter, for inclusion in the independent living  
581 services annual report.

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

584 (i) Assign experienced staff to serve as program liaisons  
585 who are available for mentors to contact whenever the mentors  
586 need to debrief or have questions concerning a former foster  
587 youth.

588 (7) REQUIREMENTS FOR PARTICIPATING ORGANIZATIONS.—Each  
589 organization participating in the onsite workforce training  
590 internship component shall:

591 (a) Collaborate with the office to implement a trauma-  
592 informed approach to mentoring and training former foster youth.

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

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

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

598 b. Have experience relevant to the job and task  
599 responsibilities of the intern;

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

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

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

610 (I) Understanding trauma and its impacts.

611 (II) Recognizing and responding to trauma-related  
612 behaviors.

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

614 (IV) Boundaries and mentor self-care.

615 (V) Communication skills.

616  
617 The department may offer a 1-hour training to review topics  
618 covered by the training required under this sub-subparagraph  
619 every subsequent year that the employee chooses to serve as a  
620 mentor.

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

626 3. An employee may serve as a mentor for a maximum of  
627 three interns at one time and may not receive more than \$3,600  
628 in compensation per fiscal year for serving as a mentor. Any  
629 time spent serving as a mentor to an intern under this section

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630 counts toward the minimum service required for eligibility for  
631 payments pursuant to subparagraph 2. and this subparagraph.

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

635 (c) When necessary, have a discussion with an intern's  
636 assigned mentor, the participating organization's internship  
637 program liaison, and the office about the creation of a  
638 corrective action plan to address issues related to the intern's  
639 professionalism, work product, or performance and, if  
640 applicable, after giving the intern a reasonable opportunity to  
641 comply with the corrective action plan, document the intern's  
642 failure to do so before discharging him or her.

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

645 (e) Collaborate with the department to provide any  
646 requested information necessary to prepare the annual report  
647 required under subsection (11).

648 (8) TIME LIMITATIONS FOR PARTICIPATION.—A former foster  
649 youth who obtains an internship with a participating  
650 organization may participate in the internship component for no  
651 more than 1 year, calculated as 12 monthly stipend periods. The  
652 year begins on his or her start date with a participating  
653 organization. A former foster youth may intern under the  
654 internship program with more than one participating

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655 organization, but may not intern with more than one  
656 participating organization at the same time. A participating  
657 organization may hire the intern as an employee, but the hiring  
658 of a former foster youth may not be for an internship under this  
659 section.

660 (9) AWARD OF POSTSECONDARY CREDIT.—The Board of Governors  
661 and the State Board of Education shall adopt regulations and  
662 rules, respectively, to award postsecondary credit or career  
663 education clock hours for eligible former foster youth  
664 participating in the internship component pursuant to subsection  
665 (4). The regulations and rules must include procedures for the  
666 award of postsecondary credit or career education clock hours,  
667 including, but not limited to, equivalency and alignment of the  
668 internship component with appropriate postsecondary courses and  
669 course descriptions.

670 (10) CONDITIONS OF PARTICIPATION IN THE INTERNSHIP  
671 COMPONENT.—

672 (a) To become a participant in the internship component of  
673 the program, the applicant must be a foster youth or a former  
674 foster youth as those terms are defined in subsection (3) at the  
675 time such youth applies for an internship position with a  
676 participating organization. A foster youth or former foster  
677 youth who has completed the training component with the  
678 department may apply for a position with a participating

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679 organization but may not begin an internship until attaining the  
680 age of 18 years.

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

684 (c) A former foster youth must spend any stipend funds  
685 specified for clothing on clothing that is in compliance with  
686 the dress code requirements of the participating organization  
687 with which the former foster youth is interning. Notwithstanding  
688 any limitation on funds provided to purchase clothing, the  
689 former foster youth must comply with any dress code requirements  
690 of the participating organization with which he or she is  
691 interning.

692 (d) Stipend money earned pursuant to the internship  
693 component may not be considered earned income for purposes of  
694 computing eligibility for federal or state benefits, including,  
695 but not limited to, the Supplemental Nutrition Assistance  
696 Program, a housing choice assistance voucher program, the  
697 Temporary Cash Assistance Program, the Medicaid program, or the  
698 school readiness program. ~~Notwithstanding this paragraph, any  
699 reduction in the amount of benefits or loss of benefits due to  
700 receipt of the Step into Success stipend may be offset by an  
701 additional stipend payment equal to the value of the maximum  
702 benefit amount for a single person allowed under the  
703 Supplemental Nutrition Assistance Program.~~

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704 (e) A former foster youth may, at the discretion of a  
705 postsecondary educational institution within this state in which  
706 such youth is enrolled, earn postsecondary credit or career  
707 education clock hours for work performed as an intern under the  
708 internship component. Postsecondary credit and career education  
709 clock hours earned for work performed under the internship  
710 component may be in addition to any compensation earned for the  
711 same work performed under the internship component and may be  
712 awarded for completion of all or any part of the internship  
713 component. Participating organizations shall cooperate with  
714 postsecondary educational institutions to provide any  
715 information about internship positions which is necessary to  
716 enable the institutions to determine whether to grant the  
717 participating former foster youth postsecondary credit or career  
718 education clock hours toward his or her degree.

719 (f) A former foster youth who accepts an internship with a  
720 participating organization pursuant to this section may only be  
721 discharged from the internship component after the participating  
722 organization engages the intern's assigned mentor and the  
723 participating organization's internship program staff to assist  
724 the intern in performing the duties of the internship. Before  
725 discharging the former foster youth, the participating  
726 organization must also document the intern's failure to comply  
727 with a corrective action plan after being given a reasonable  
728 opportunity to do so.

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

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

736 (b) A list of participating organizations and the number  
737 of interns.

738 (c) A summary of recruitment efforts to increase the  
739 number of participating organizations.

740 (d) A summary of the feedback and surveys received  
741 pursuant to paragraph (6)(h) from participating former foster  
742 youth, mentors, and others who have participated in the ~~pilot~~  
743 program.

744 (e) Recommendations, if any, for actions necessary to  
745 improve the quality, effectiveness, and outcomes of the ~~pilot~~  
746 program.

747 (f) Employment outcomes of former foster youth who  
748 participated in the ~~pilot~~ program, including employment status  
749 after completion of the program, whether he or she is employed  
750 by the participating organization in which he or she interned or  
751 by another entity, and job description and salary information,  
752 if available.

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753 (12) RULEMAKING.—The department shall adopt rules to  
754 implement this section.

755 **Section 10. Section 409.1475, Florida Statutes, is created**  
756 **to read:**

757 409.1475 Foster and Family Support Grant Program.—

758 (1) The Legislature recognizes that children and families  
759 thrive when caregivers are engaged, supported, and equipped to  
760 meet their responsibilities. It is the intent of the Legislature  
761 to strengthen community-based support that promotes stable  
762 caregiving relationships, responsible parenting, and improved  
763 outcomes for vulnerable children. Therefore, the Foster and  
764 Family Support Grant Program is created within the department.

765 (2) The department shall award grants to not-for-profit,  
766 faith-based organizations to support their efforts in the  
767 recruitment of foster and adoptive families through faith-based  
768 organizations and strengthening local capacity to support  
769 foster, adoptive, and kinship families and families caring for  
770 vulnerable children in underserved and rural communities. The  
771 program shall emphasize sustained, community-based support  
772 beyond initial licensure or training in order to improve  
773 caregiver retention and outcomes for children.

774 (3) Awarded grant funds must be used to provide education,  
775 resources, training, and technical assistance to eligible faith-  
776 based organizations involved in foster care, adoption, and  
777 family preservation activities and to support the development of

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778 trauma-informed, community-based support systems for families  
779 throughout the caregiving continuum. Allowable uses of funds  
780 include, but are not limited to:

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

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

785 (c) Trauma-informed training, coaching, and counseling  
786 services for caregivers, families, and individuals involved in  
787 supporting children in out-of-home care or at risk of entry into  
788 care;

789 (d) Program support and other activities to strengthen  
790 local capacities to support foster, adoptive, and kinship  
791 families and families;

792 (e) Expansion of foster parent training initiatives  
793 designed to improve caregiver engagement, retention, and  
794 placement stability;

795 (f) Development of volunteer-based wrap-around support  
796 services for foster and adoptive families, including kinship  
797 caregivers;

798 (g) Assistance with essential family needs for families  
799 actively fostering, adopting, or pursuing licensure, consistent  
800 with federal and state law; and

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

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

806 (5) The department may adopt rules to implement this  
807 section.

808 **Section 11. Upon the expiration and reversion of the**  
809 **amendments made to s. 409.908, Florida Statutes, pursuant to**  
810 **section 26 of chapter 2025-199, Laws of Florida, paragraph (b)**  
811 **of subsection (2) of section 409.908, Florida Statutes, is**  
812 **amended to read:**

813 409.908 Reimbursement of Medicaid providers.—Subject to  
814 specific appropriations, the agency shall reimburse Medicaid  
815 providers, in accordance with state and federal law, according  
816 to methodologies set forth in the rules of the agency and in  
817 policy manuals and handbooks incorporated by reference therein.  
818 These methodologies may include fee schedules, reimbursement  
819 methods based on cost reporting, negotiated fees, competitive  
820 bidding pursuant to s. 287.057, and other mechanisms the agency  
821 considers efficient and effective for purchasing services or  
822 goods on behalf of recipients. If a provider is reimbursed based  
823 on cost reporting and submits a cost report late and that cost  
824 report would have been used to set a lower reimbursement rate  
825 for a rate semester, then the provider's rate for that semester  
826 shall be retroactively calculated using the new cost report, and  
827 full payment at the recalculated rate shall be effected

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828 retroactively. Medicare-granted extensions for filing cost  
829 reports, if applicable, shall also apply to Medicaid cost  
830 reports. Payment for Medicaid compensable services made on  
831 behalf of Medicaid-eligible persons is subject to the  
832 availability of moneys and any limitations or directions  
833 provided for in the General Appropriations Act or chapter 216.  
834 Further, nothing in this section shall be construed to prevent  
835 or limit the agency from adjusting fees, reimbursement rates,  
836 lengths of stay, number of visits, or number of services, or  
837 making any other adjustments necessary to comply with the  
838 availability of moneys and any limitations or directions  
839 provided for in the General Appropriations Act, provided the  
840 adjustment is consistent with legislative intent.

841 (2)

842 (b) Subject to any limitations or directions in the  
843 General Appropriations Act, the agency shall establish and  
844 implement a state Title XIX Long-Term Care Reimbursement Plan  
845 for nursing home care in order to provide care and services in  
846 conformance with the applicable state and federal laws, rules,  
847 regulations, and quality and safety standards and to ensure that  
848 individuals eligible for medical assistance have reasonable  
849 geographic access to such care.

850 1. The agency shall amend the long-term care reimbursement  
851 plan and cost reporting system to create direct care and  
852 indirect care subcomponents of the patient care component of the

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853 per diem rate. These two subcomponents together shall equal the  
 854 patient care component of the per diem rate. Separate prices  
 855 shall be calculated for each patient care subcomponent,  
 856 initially based on the September 2016 rate setting cost reports  
 857 and subsequently based on the most recently audited cost report  
 858 used during a rebasing year. The direct care subcomponent of the  
 859 per diem rate for any providers still being reimbursed on a cost  
 860 basis shall be limited by the cost-based class ceiling, and the  
 861 indirect care subcomponent may be limited by the lower of the  
 862 cost-based class ceiling, the target rate class ceiling, or the  
 863 individual provider target. The ceilings and targets apply only  
 864 to providers being reimbursed on a cost-based system. Effective  
 865 October 1, 2018, a prospective payment methodology shall be  
 866 implemented for rate setting purposes with the following  
 867 parameters:

- 868 a. Peer Groups, including:
  - 869 (I) North-SMMC Regions 1-9, less Palm Beach and Okeechobee
  - 870 Counties; and
  - 871 (II) South-SMMC Regions 10-11, plus Palm Beach and
  - 872 Okeechobee Counties.
- 873 b. Percentage of Median Costs based on the cost reports  
 874 used for September 2016 rate setting:
  - 875 (I) Direct Care Costs.....100 percent.
  - 876 (II) Indirect Care Costs.....92 percent.
  - 877 (III) Operating Costs.....86 percent.

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- 878 c. Floors:
- 879 (I) Direct Care Component.....95 percent.
- 880 (II) Indirect Care Component.....92.5 percent.
- 881 (III) Operating Component.....None.
- 882 d. Pass-through Payments.....Real Estate and
- 883 Personal Property
- 884 Taxes and Property Insurance.
- 885 e. Quality Incentive Program Payment
- 886 Pool 18.1373 ~~10~~ percent of September
- 887 2016 non-property related
- 888 payments of included facilities.
- 889 f. Quality Score Threshold to Qualify for Quality
- 890 Incentive Payment.....33
- 891 percent of all available points in
- 892 the Medicaid Quality Incentive Program ~~20th~~
- 893 ~~percentile of included facilities.~~
- 894 g. Fair Rental Value System Payment Parameters:
- 895 (I) Building Value per Square Foot based on 2018 RS Means.
- 896 (II) Land Valuation.....10 percent of Gross Building value.
- 897 (III) Facility Square Footage.....Actual Square Footage.
- 898 (IV) Movable Equipment Allowance.....\$8,000 per bed.
- 899 (V) Obsolescence Factor.....1.5 percent.
- 900 (VI) Fair Rental Rate of Return.....8 percent.
- 901 (VII) Minimum Occupancy.....90 percent.
- 902 (VIII) Maximum Facility Age.....40 years.

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- 903 (IX) Minimum Square Footage per Bed.....350.
- 904 (X) Maximum Square Footage for Bed.....500.
- 905 (XI) Minimum Cost of a renovation/replacements\$500 per bed.
- 906 h. Ventilator Supplemental payment of \$200 per Medicaid
- 907 day of 40,000 ventilator Medicaid days per fiscal year.
- 908 2. The agency shall revise its methodology for calculating
- 909 Quality Incentive Program payments to:
- 910 a. Include the results of consumer satisfaction surveys
- 911 conducted pursuant to s. 400.0225 as a measure of nursing home
- 912 quality. The agency shall so revise the methodology after the
- 913 surveys have been in effect for an amount of time the agency
- 914 deems sufficient for statistical and scientific validity as a
- 915 meaningful quality measure that may be incorporated into the
- 916 methodology.
- 917 b. During the next rebasing for the Quality Incentive
- 918 Program, consider implementing the recommendations proposed in
- 919 sections 3.1.1-3.1.5 of the Study of Nursing Home Quality
- 920 Incentive Programs Final Report pursuant to section 20 of
- 921 chapter 2025-204, Laws of Florida, and presented to the agency
- 922 on December 22, 2025.
- 923 c. Delay the effective date of any change made to its
- 924 methodology or scoring due to rebasing for 1 year after any
- 925 recalculations have been completed and the scores have been made
- 926 available to the public.

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

937           4. All other patient care costs shall be included in the  
938 indirect care cost subcomponent of the patient care per diem  
939 rate, including complex medical equipment, medical supplies, and  
940 other allowable ancillary costs. Costs may not be allocated  
941 directly or indirectly to the direct care subcomponent from a  
942 home office or management company.

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

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

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952 7. A direct care supplemental payment may be made to  
953 providers whose direct care hours per patient day are above the  
954 80th percentile and who provide Medicaid services to a larger  
955 percentage of Medicaid patients than the state average.

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

964 9. By October 1, 2025, and each year thereafter, the  
965 agency shall submit to the Governor, the President of the  
966 Senate, and the Speaker of the House of Representatives a report  
967 on each Quality Incentive Program payment made pursuant to sub-  
968 subparagraph 1.e. The report must, at a minimum, include all of  
969 the following information:

970 a. The name of each facility that received a Quality  
971 Incentive Program payment and the dollar amount of such payment  
972 each facility received.

973 b. The total number of quality incentive metric points  
974 awarded by the agency to each facility and the number of points  
975 awarded by the agency for each individual quality metric  
976 measured.

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977 c. An examination of any trends in the improvement of the  
978 quality of care provided to nursing home residents which may be  
979 attributable to incentive payments received under the Quality  
980 Incentive Program. The agency shall include examination of  
981 trends both for the program as a whole as well as for each  
982 individual quality metric used by the agency to award program  
983 payments.

984  
985 It is the intent of the Legislature that the reimbursement plan  
986 achieve the goal of providing access to health care for nursing  
987 home residents who require large amounts of care while  
988 encouraging diversion services as an alternative to nursing home  
989 care for residents who can be served within the community. The  
990 agency shall base the establishment of any maximum rate of  
991 payment, whether overall or component, on the available moneys  
992 as provided for in the General Appropriations Act. The agency  
993 may base the maximum rate of payment on the results of  
994 scientifically valid analysis and conclusions derived from  
995 objective statistical data pertinent to the particular maximum  
996 rate of payment. The agency shall base the rates of payments in  
997 accordance with the minimum wage requirements as provided in the  
998 General Appropriations Act.

999 **Section 12. Effective July 1, 2027, paragraph (b) of**  
1000 **subsection (2) of section 409.908, Florida Statutes, as amended**  
1001 **by this act, is amended to read:**

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1002           409.908 Reimbursement of Medicaid providers.—Subject to  
1003 specific appropriations, the agency shall reimburse Medicaid  
1004 providers, in accordance with state and federal law, according  
1005 to methodologies set forth in the rules of the agency and in  
1006 policy manuals and handbooks incorporated by reference therein.  
1007 These methodologies may include fee schedules, reimbursement  
1008 methods based on cost reporting, negotiated fees, competitive  
1009 bidding pursuant to s. 287.057, and other mechanisms the agency  
1010 considers efficient and effective for purchasing services or  
1011 goods on behalf of recipients. If a provider is reimbursed based  
1012 on cost reporting and submits a cost report late and that cost  
1013 report would have been used to set a lower reimbursement rate  
1014 for a rate semester, then the provider's rate for that semester  
1015 shall be retroactively calculated using the new cost report, and  
1016 full payment at the recalculated rate shall be effected  
1017 retroactively. Medicare-granted extensions for filing cost  
1018 reports, if applicable, shall also apply to Medicaid cost  
1019 reports. Payment for Medicaid compensable services made on  
1020 behalf of Medicaid-eligible persons is subject to the  
1021 availability of moneys and any limitations or directions  
1022 provided for in the General Appropriations Act or chapter 216.  
1023 Further, nothing in this section shall be construed to prevent  
1024 or limit the agency from adjusting fees, reimbursement rates,  
1025 lengths of stay, number of visits, or number of services, or  
1026 making any other adjustments necessary to comply with the

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1027 availability of moneys and any limitations or directions  
1028 provided for in the General Appropriations Act, provided the  
1029 adjustment is consistent with legislative intent.

1030 (2)

1031 (b) Subject to any limitations or directions in the  
1032 General Appropriations Act, the agency shall establish and  
1033 implement a state Title XIX Long-Term Care Reimbursement Plan  
1034 for nursing home care in order to provide care and services in  
1035 conformance with the applicable state and federal laws, rules,  
1036 regulations, and quality and safety standards and to ensure that  
1037 individuals eligible for medical assistance have reasonable  
1038 geographic access to such care.

1039 1. The agency shall amend the long-term care reimbursement  
1040 plan and cost reporting system to create direct care and  
1041 indirect care subcomponents of the patient care component of the  
1042 per diem rate. These two subcomponents together shall equal the  
1043 patient care component of the per diem rate. Separate prices  
1044 shall be calculated for each patient care subcomponent,  
1045 initially based on the September 2016 rate setting cost reports  
1046 and subsequently based on the most recently audited cost report  
1047 used during a rebasing year. The direct care subcomponent of the  
1048 per diem rate for any providers still being reimbursed on a cost  
1049 basis shall be limited by the cost-based class ceiling, and the  
1050 indirect care subcomponent may be limited by the lower of the  
1051 cost-based class ceiling, the target rate class ceiling, or the

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1052 individual provider target. The ceilings and targets apply only  
 1053 to providers being reimbursed on a cost-based system. Effective  
 1054 October 1, 2018, a prospective payment methodology shall be  
 1055 implemented for rate setting purposes with the following  
 1056 parameters:

1057       a. Peer Groups, including:

1058           (I) North-SMMC Regions 1-9, less Palm Beach and Okeechobee  
 1059 Counties; and

1060           (II) South-SMMC Regions 10-11, plus Palm Beach and  
 1061 Okeechobee Counties.

1062       b. Percentage of Median Costs based on the cost reports  
 1063 used for September 2016 rate setting:

1064           (I) Direct Care Costs.....100 percent.  
 1065           (II) Indirect Care Costs.....92 percent.  
 1066           (III) Operating Costs.....86 percent.

1067       c. Floors:

1068           (I) Direct Care Component.....95 percent.  
 1069           (II) Indirect Care Component.....92.5 percent.  
 1070           (III) Operating Component.....None.

1071       d. Pass-through Payments.....Real Estate and  
 1072 Personal Property  
 1073 Taxes and Property Insurance.

1074       e. Quality Incentive Program Payment  
 1075 Pool 16.5482 ~~18.1373~~ percent of September

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1076 2016 non-property related  
1077 payments of included facilities.  
1078 f. Quality Score Threshold to Qualify for Quality  
1079 Incentive Payment.....33  
1080 percent of all available points in  
1081 the Medicaid Quality Incentive Program.  
1082 g. Fair Rental Value System Payment Parameters:  
1083 (I) Building Value per Square Foot based on 2018 RS Means.  
1084 (II) Land Valuation.....10 percent of Gross Building value.  
1085 (III) Facility Square Footage.....Actual Square Footage.  
1086 (IV) Movable Equipment Allowance.....\$8,000 per bed.  
1087 (V) Obsolescence Factor.....1.5 percent.  
1088 (VI) Fair Rental Rate of Return.....8 percent.  
1089 (VII) Minimum Occupancy.....90 percent.  
1090 (VIII) Maximum Facility Age.....40 years.  
1091 (IX) Minimum Square Footage per Bed.....350.  
1092 (X) Maximum Square Footage for Bed.....500.  
1093 (XI) Minimum Cost of a renovation/replacements\$500 per bed.  
1094 h. Ventilator Supplemental payment of \$200 per Medicaid  
1095 day of 40,000 ventilator Medicaid days per fiscal year.  
1096 2. The agency shall revise its methodology for calculating  
1097 Quality Incentive Program payments to:  
1098 a. Include the results of consumer satisfaction surveys  
1099 conducted pursuant to s. 400.0225 as a measure of nursing home  
1100 quality. The agency shall so revise the methodology after the

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1101 surveys have been in effect for an amount of time the agency  
1102 deems sufficient for statistical and scientific validity as a  
1103 meaningful quality measure that may be incorporated into the  
1104 methodology.

1105       b. During the next rebasing for the Quality Incentive  
1106 Program, consider implementing the recommendations proposed in  
1107 sections 3.1.1-3.1.5 of the Study of Nursing Home Quality  
1108 Incentive Programs Final Report pursuant to section 20 of  
1109 chapter 2025-204, Laws of Florida, and presented to the agency  
1110 on December 22, 2025.

1111       c. Delay the effective date of any change made to its  
1112 methodology or scoring due to rebasing for 1 year after any  
1113 recalculations have been completed and the scores have been made  
1114 available to the public.

1115       3. The direct care subcomponent shall include salaries and  
1116 benefits of direct care staff providing nursing services  
1117 including registered nurses, licensed practical nurses, and  
1118 certified nursing assistants who deliver care directly to  
1119 residents in the nursing home facility, allowable therapy costs,  
1120 and dietary costs. This excludes nursing administration, staff  
1121 development, the staffing coordinator, and the administrative  
1122 portion of the minimum data set and care plan coordinators. The  
1123 direct care subcomponent also includes medically necessary  
1124 dental care, vision care, hearing care, and podiatric care.

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1125 4. All other patient care costs shall be included in the  
1126 indirect care cost subcomponent of the patient care per diem  
1127 rate, including complex medical equipment, medical supplies, and  
1128 other allowable ancillary costs. Costs may not be allocated  
1129 directly or indirectly to the direct care subcomponent from a  
1130 home office or management company.

1131 5. On July 1 of each year, the agency shall report to the  
1132 Legislature direct and indirect care costs, including average  
1133 direct and indirect care costs per resident per facility and  
1134 direct care and indirect care salaries and benefits per category  
1135 of staff member per facility.

1136 6. Every fourth year, the agency shall rebase nursing home  
1137 prospective payment rates to reflect changes in cost based on  
1138 the most recently audited cost report for each participating  
1139 provider.

1140 7. A direct care supplemental payment may be made to  
1141 providers whose direct care hours per patient day are above the  
1142 80th percentile and who provide Medicaid services to a larger  
1143 percentage of Medicaid patients than the state average.

1144 8. Pediatric, Florida Department of Veterans Affairs, and  
1145 government-owned facilities are exempt from the pricing model  
1146 established in this subsection and shall remain on a cost-based  
1147 prospective payment system. Effective October 1, 2018, the  
1148 agency shall set rates for all facilities remaining on a cost-  
1149 based prospective payment system using each facility's most

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1150 recently audited cost report, eliminating retroactive  
1151 settlements.

1152 9. By October 1, 2025, and each year thereafter, the  
1153 agency shall submit to the Governor, the President of the  
1154 Senate, and the Speaker of the House of Representatives a report  
1155 on each Quality Incentive Program payment made pursuant to sub-  
1156 subparagraph 1.e. The report must, at a minimum, include all of  
1157 the following information:

1158 a. The name of each facility that received a Quality  
1159 Incentive Program payment and the dollar amount of such payment  
1160 each facility received.

1161 b. The total number of quality incentive metric points  
1162 awarded by the agency to each facility and the number of points  
1163 awarded by the agency for each individual quality metric  
1164 measured.

1165 c. An examination of any trends in the improvement of the  
1166 quality of care provided to nursing home residents which may be  
1167 attributable to incentive payments received under the Quality  
1168 Incentive Program. The agency shall include examination of  
1169 trends both for the program as a whole as well as for each  
1170 individual quality metric used by the agency to award program  
1171 payments.

1172  
1173 It is the intent of the Legislature that the reimbursement plan  
1174 achieve the goal of providing access to health care for nursing

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1175 home residents who require large amounts of care while  
1176 encouraging diversion services as an alternative to nursing home  
1177 care for residents who can be served within the community. The  
1178 agency shall base the establishment of any maximum rate of  
1179 payment, whether overall or component, on the available moneys  
1180 as provided for in the General Appropriations Act. The agency  
1181 may base the maximum rate of payment on the results of  
1182 scientifically valid analysis and conclusions derived from  
1183 objective statistical data pertinent to the particular maximum  
1184 rate of payment. The agency shall base the rates of payments in  
1185 accordance with the minimum wage requirements as provided in the  
1186 General Appropriations Act.

1187 **Section 13. Subsection (6) of section 409.909, Florida**  
1188 **Statutes, is amended to read:**

1189 409.909 Statewide Medicaid Residency Program.—

1190 (6) The Slots for Doctors Program is established to  
1191 address the physician workforce shortage by increasing the  
1192 supply of highly trained physicians through the creation of new  
1193 resident positions, which will increase access to care and  
1194 improve health outcomes for Medicaid recipients.

1195 (a)1. Notwithstanding subsection (4), the agency shall  
1196 annually allocate funding ~~\$100,000~~ to hospitals, qualifying  
1197 institutions, and behavioral health teaching hospitals  
1198 designated under s. 395.902 for each newly created resident  
1199 position that is first filled on or after June 1, 2023, and

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1200 filled thereafter, and that is accredited by the Accreditation  
1201 Council for Graduate Medical Education or the Osteopathic  
1202 Postdoctoral Training Institution in an initial or established  
1203 accredited training program which is in a physician specialty or  
1204 subspecialty in a statewide supply-and-demand deficit.

1205 a. Beginning in the 2024-2025 fiscal year, for purposes of  
1206 distributing funds appropriated in the General Appropriations  
1207 Act, the agency shall use exclusively the following formula to  
1208 calculate every participating hospital's and qualifying  
1209 institution's allocation factor for the funding allocated for  
1210 the enumerated statewide specialties and subspecialties as  
1211 provided in paragraph (c) and separately calculate every  
1212 participating behavioral health teaching hospital's allocation  
1213 fraction for the funding allocated for those hospitals  
1214 designated under s. 395.902:

1215  $HAF = [0.9 \times (HP/TP)] + [0.1 \times (HMP/TMP)]$

1216 Where:

1217 HAF = A hospital's and qualifying institution's or  
1218 behavioral health teaching hospital's allocation fraction.

1219 HP = A hospital's and qualifying institution's or  
1220 behavioral health teaching hospital's total number of positions.

1221 TP = The total positions for all participating hospitals  
1222 and qualifying institutions or behavioral health teaching  
1223 hospitals.

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1224 HMP = A hospital's and qualifying institution's or  
1225 behavioral health teaching hospital's Medicaid payments.

1226 TMP = The total Medicaid payments for all participating  
1227 hospitals and qualifying institutions or behavioral health  
1228 teaching hospitals.

1229  
1230 As used in this sub-subparagraph, "Medicaid payments" means the  
1231 estimated total payments for reimbursing a hospital and  
1232 qualifying institutions or behavioral health teaching hospitals  
1233 for direct inpatient and outpatient services for the fiscal year  
1234 in which the allocation fraction is calculated based on the  
1235 hospital inpatient appropriation and outpatient appropriation  
1236 and the parameters for the inpatient diagnosis-related group  
1237 base rate and the parameters for the outpatient enhanced  
1238 ambulatory payment group rate, including applicable  
1239 intergovernmental transfers, specified in the General  
1240 Appropriations Act, as determined by the agency.

1241 b. A hospital's and qualifying institution's or behavioral  
1242 health teaching hospital's annual allocation shall be calculated  
1243 by multiplying the funds appropriated for the Slots for Doctors  
1244 Program in the General Appropriations Act by that hospital's and  
1245 qualifying institution's or behavioral health teaching  
1246 hospital's allocation fraction. If the calculation results in an  
1247 annual allocation that exceeds two times the average per-  
1248 position amount for all hospitals and qualifying institutions or

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1249 behavioral health teaching hospitals, the hospital's and  
1250 qualifying institution's or behavioral health teaching  
1251 hospital's annual allocation shall be reduced to a sum equaling  
1252 no more than two times the average per position. The funds  
1253 calculated for that hospital and qualifying institution or  
1254 behavioral health teaching hospital in excess of two times the  
1255 average per position amount for all hospitals and qualifying  
1256 institutions or behavioral health teaching hospitals shall be  
1257 redistributed to participating hospitals and qualifying  
1258 institutions; or

1259 2. Notwithstanding the requirement that a new resident  
1260 position be created to receive funding under this subsection,  
1261 the agency may allocate funding ~~\$100,000~~ to hospitals and  
1262 qualifying institutions, pursuant to subparagraph 1., for up to  
1263 100 resident positions that existed before July 1, 2023, if such  
1264 resident position:

1265 a. Is in a physician specialty or subspecialty  
1266 experiencing a statewide supply-and-demand deficit;

1267 b. Has been unfilled for a period of 3 or more years;

1268 c. Is subsequently filled on or after June 1, 2024, and  
1269 remains filled thereafter; and

1270 d. Is accredited by the Accreditation Council for Graduate  
1271 Medical Education or the Osteopathic Postdoctoral Training  
1272 Institution in an initial or established accredited training  
1273 program.

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1274 3. If applications for resident positions under this  
1275 paragraph exceed the number of authorized resident positions or  
1276 the available funding allocated, the agency shall prioritize  
1277 applications for resident positions that are in a primary care  
1278 specialty as specified in paragraph (2) (a).

1279 (b) This program is designed to generate matching funds  
1280 under Medicaid and distribute such funds to participating  
1281 hospitals, qualifying institutions, and behavioral health  
1282 teaching hospitals designated under s. 395.902, on a quarterly  
1283 basis in each fiscal year for which an appropriation is made.  
1284 Resident positions created under this subsection are not  
1285 eligible for concurrent funding pursuant to subsection (1).

1286 (c) For purposes of this subsection, physician specialties  
1287 and subspecialties, both adult and pediatric, in statewide  
1288 supply-and-demand deficit are those identified as such in the  
1289 General Appropriations Act.

1290 (d) Funds allocated pursuant to this subsection may not be  
1291 used for resident positions that have previously received  
1292 funding pursuant to subsection (1).

1293 **Section 14. Section 409.91195, Florida Statutes, is**  
1294 **amended to read:**

1295 409.91195 Medicaid Pharmaceutical and Therapeutics  
1296 Committee.—There is created a Medicaid Pharmaceutical and  
1297 Therapeutics Committee within the agency for the purpose of

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1298 developing a Medicaid preferred drug list and a preferred  
1299 product list.

1300 (1) The committee shall be composed of 11 members  
1301 appointed by the Governor. Four members shall be physicians,  
1302 licensed under chapter 458; one member licensed under chapter  
1303 459; five members shall be pharmacists licensed under chapter  
1304 465; and one member shall be a consumer representative. The  
1305 members shall be appointed to serve for terms of 2 years from  
1306 the date of their appointment. Members may be appointed to more  
1307 than one term. The agency shall serve as staff for the committee  
1308 and assist them with all ministerial duties. The Governor shall  
1309 ensure that at least some of the members of the committee  
1310 represent Medicaid participating physicians and pharmacies  
1311 serving all segments and diversity of the Medicaid population,  
1312 and have experience in either developing or practicing under a  
1313 preferred drug list. At least one of the members shall represent  
1314 the interests of pharmaceutical manufacturers.

1315 (2) Committee members shall select a chairperson and a  
1316 vice chairperson each year from the committee membership.

1317 (3) The committee shall meet at least quarterly and may  
1318 meet at other times at the discretion of the chairperson and  
1319 members. The committee shall comply with rules adopted by the  
1320 agency, including notice of any meeting of the committee  
1321 pursuant to the requirements of the Administrative Procedure  
1322 Act.

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1323 (4) Upon recommendation of the committee, the agency shall  
1324 adopt a preferred drug list as described in s. 409.912(5) and a  
1325 preferred product list as described in s. 409.912(14). To the  
1326 extent feasible, the committee shall review all drug and product  
1327 classes included on the preferred drug list or preferred product  
1328 list every 12 months, and may recommend additions to and  
1329 deletions from the lists ~~preferred drug list~~, such that the  
1330 preferred drug list provides for medically appropriate drug  
1331 therapies and products for Medicaid patients which achieve cost  
1332 savings contained in the General Appropriations Act.

1333 (5) Except for antiretroviral drugs, reimbursement of  
1334 drugs or products not included on the preferred drug list or  
1335 preferred product list are ~~is~~ subject to prior authorization.

1336 (6) The agency shall publish and disseminate the preferred  
1337 drug list and the preferred product list to all Medicaid  
1338 providers in the state by Internet posting on the agency's  
1339 website or in other media.

1340 (7) The committee shall ensure that interested parties,  
1341 including pharmaceutical manufacturers agreeing to provide a  
1342 supplemental rebate as outlined in this chapter, have an  
1343 opportunity to present public testimony to the committee with  
1344 information or evidence supporting inclusion of a product on the  
1345 preferred drug list or preferred product list. Such public  
1346 testimony shall occur before ~~prior to~~ any recommendations made  
1347 by the committee for inclusion or exclusion from the preferred

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1348 drug list. Upon timely notice, the agency shall ensure that any  
1349 drug that has been approved or had any of its particular uses  
1350 approved by the United States Food and Drug Administration under  
1351 a priority review classification will be reviewed by the  
1352 committee at the next regularly scheduled meeting following 3  
1353 months of distribution of the drug to the general public.

1354 (8) The committee shall develop its preferred drug list  
1355 and preferred product list recommendations by considering the  
1356 clinical efficacy, safety, and cost-effectiveness of a product.

1357 (9) The Medicaid Pharmaceutical and Therapeutics Committee  
1358 may also make recommendations to the agency regarding the prior  
1359 authorization of any prescribed drug covered by Medicaid.

1360 (10) Medicaid recipients may appeal agency preferred drug  
1361 formulary decisions using the Medicaid fair hearing process  
1362 administered by the Agency for Health Care Administration.

1363 **Section 15. Paragraph (a) of subsection (5) of section**  
1364 **409.912, Florida Statutes, is amended, and subsection (14) is**  
1365 **added to that section, to read:**

1366 409.912 Cost-effective purchasing of health care.—The  
1367 agency shall purchase goods and services for Medicaid recipients  
1368 in the most cost-effective manner consistent with the delivery  
1369 of quality medical care. To ensure that medical services are  
1370 effectively utilized, the agency may, in any case, require a  
1371 confirmation or second physician's opinion of the correct  
1372 diagnosis for purposes of authorizing future services under the

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1373 Medicaid program. This section does not restrict access to  
1374 emergency services or poststabilization care services as defined  
1375 in 42 C.F.R. s. 438.114. Such confirmation or second opinion  
1376 shall be rendered in a manner approved by the agency. The agency  
1377 shall maximize the use of prepaid per capita and prepaid  
1378 aggregate fixed-sum basis services when appropriate and other  
1379 alternative service delivery and reimbursement methodologies,  
1380 including competitive bidding pursuant to s. 287.057, designed  
1381 to facilitate the cost-effective purchase of a case-managed  
1382 continuum of care. The agency shall also require providers to  
1383 minimize the exposure of recipients to the need for acute  
1384 inpatient, custodial, and other institutional care and the  
1385 inappropriate or unnecessary use of high-cost services. The  
1386 agency shall contract with a vendor to monitor and evaluate the  
1387 clinical practice patterns of providers in order to identify  
1388 trends that are outside the normal practice patterns of a  
1389 provider's professional peers or the national guidelines of a  
1390 provider's professional association. The vendor must be able to  
1391 provide information and counseling to a provider whose practice  
1392 patterns are outside the norms, in consultation with the agency,  
1393 to improve patient care and reduce inappropriate utilization.  
1394 The agency may mandate prior authorization, drug therapy  
1395 management, or disease management participation for certain  
1396 populations of Medicaid beneficiaries, certain drug classes, or  
1397 particular drugs to prevent fraud, abuse, overuse, and possible

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1398 dangerous drug interactions. The Pharmaceutical and Therapeutics  
1399 Committee shall make recommendations to the agency on drugs for  
1400 which prior authorization is required. The agency shall inform  
1401 the Pharmaceutical and Therapeutics Committee of its decisions  
1402 regarding drugs subject to prior authorization. The agency is  
1403 authorized to limit the entities it contracts with or enrolls as  
1404 Medicaid providers by developing a provider network through  
1405 provider credentialing. The agency may competitively bid single-  
1406 source-provider contracts if procurement of goods or services  
1407 results in demonstrated cost savings to the state without  
1408 limiting access to care. The agency may limit its network based  
1409 on the assessment of beneficiary access to care, provider  
1410 availability, provider quality standards, time and distance  
1411 standards for access to care, the cultural competence of the  
1412 provider network, demographic characteristics of Medicaid  
1413 beneficiaries, practice and provider-to-beneficiary standards,  
1414 appointment wait times, beneficiary use of services, provider  
1415 turnover, provider profiling, provider licensure history,  
1416 previous program integrity investigations and findings, peer  
1417 review, provider Medicaid policy and billing compliance records,  
1418 clinical and medical record audits, and other factors. Providers  
1419 are not entitled to enrollment in the Medicaid provider network.  
1420 The agency shall determine instances in which allowing Medicaid  
1421 beneficiaries to purchase durable medical equipment and other  
1422 goods is less expensive to the Medicaid program than long-term

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1423 rental of the equipment or goods. The agency may establish rules  
1424 to facilitate purchases in lieu of long-term rentals in order to  
1425 protect against fraud and abuse in the Medicaid program as  
1426 defined in s. 409.913. The agency may seek federal waivers  
1427 necessary to administer these policies.

1428 (5) (a) The agency shall implement a Medicaid prescribed-  
1429 drug spending-control program that includes the following  
1430 components:

1431 1. A Medicaid preferred drug list, which shall be a  
1432 listing of cost-effective therapeutic options recommended by the  
1433 Medicaid Pharmacy and Therapeutics Committee established  
1434 pursuant to s. 409.91195 and adopted by the agency for each  
1435 therapeutic class on the preferred drug list. At the discretion  
1436 of the committee, and when feasible, the preferred drug list  
1437 should include at least two products in a therapeutic class. The  
1438 agency may post the preferred drug list and updates to the list  
1439 on an Internet website without following the rulemaking  
1440 procedures of chapter 120. Antiretroviral agents are excluded  
1441 from the preferred drug list. The agency shall also limit the  
1442 amount of a prescribed drug dispensed to no more than a 34-day  
1443 supply unless the drug products' smallest marketed package is  
1444 greater than a 34-day supply, or the drug is determined by the  
1445 agency to be a maintenance drug in which case a 100-day maximum  
1446 supply may be authorized. The agency may seek any federal  
1447 waivers necessary to implement these cost-control programs and

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1448 to continue participation in the federal Medicaid rebate  
1449 program, or alternatively to negotiate state-only manufacturer  
1450 rebates. The agency may adopt rules to administer this  
1451 subparagraph. The agency shall continue to provide unlimited  
1452 contraceptive drugs and items. The agency must establish  
1453 procedures to ensure that:

1454 a. There is a response to a request for prior  
1455 authorization by telephone or other telecommunication device  
1456 within 24 hours after receipt of a request for prior  
1457 authorization; and

1458 b. A 72-hour supply of the drug prescribed is provided in  
1459 an emergency or when the agency does not provide a response  
1460 within 24 hours as required by sub-subparagraph a.

1461 2. A provider of prescribed drugs is reimbursed in an  
1462 amount not to exceed the lesser of the actual acquisition cost  
1463 based on the Centers for Medicare and Medicaid Services National  
1464 Average Drug Acquisition Cost pricing files plus a professional  
1465 dispensing fee, the wholesale acquisition cost plus a  
1466 professional dispensing fee, the state maximum allowable cost  
1467 plus a professional dispensing fee, or the usual and customary  
1468 charge billed by the provider.

1469 3. The agency shall develop and implement a process for  
1470 managing the drug therapies of Medicaid recipients who are using  
1471 significant numbers of prescribed drugs each month. The  
1472 management process may include, but is not limited to,

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1473 comprehensive, physician-directed medical-record reviews, claims  
1474 analyses, and case evaluations to determine the medical  
1475 necessity and appropriateness of a patient's treatment plan and  
1476 drug therapies. The agency may contract with a private  
1477 organization to provide drug-program-management services. The  
1478 Medicaid drug benefit management program shall include  
1479 initiatives to manage drug therapies for HIV/AIDS patients,  
1480 patients using 20 or more unique prescriptions in a 180-day  
1481 period, and the top 1,000 patients in annual spending. The  
1482 agency shall enroll any Medicaid recipient in the drug benefit  
1483 management program if he or she meets the specifications of this  
1484 provision and is not enrolled in a Medicaid health maintenance  
1485 organization.

1486 4. The agency may limit the size of its pharmacy network  
1487 based on need, competitive bidding, price negotiations,  
1488 credentialing, or similar criteria. The agency shall give  
1489 special consideration to rural areas in determining the size and  
1490 location of pharmacies included in the Medicaid pharmacy  
1491 network. A pharmacy credentialing process may include criteria  
1492 such as a pharmacy's full-service status, location, size,  
1493 patient educational programs, patient consultation, disease  
1494 management services, and other characteristics. The agency may  
1495 impose a moratorium on Medicaid pharmacy enrollment if it is  
1496 determined that it has a sufficient number of Medicaid-  
1497 participating providers. The agency must allow dispensing

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1498 practitioners to participate as a part of the Medicaid pharmacy  
1499 network regardless of the practitioner's proximity to any other  
1500 entity that is dispensing prescription drugs under the Medicaid  
1501 program. A dispensing practitioner must meet all credentialing  
1502 requirements applicable to his or her practice, as determined by  
1503 the agency.

1504 5. A hospital facility administering long-acting  
1505 injectables for severe mental illness shall be reimbursed  
1506 separately from the diagnosis-related group. Long-acting  
1507 injectables administered for severe mental illness in a hospital  
1508 facility setting shall be reimbursed at no less than the actual  
1509 acquisition cost of the drug.

1510 ~~6.5.~~ The agency shall develop and implement a program that  
1511 requires Medicaid practitioners who issue written prescriptions  
1512 for medicinal drugs to use a counterfeit-proof prescription pad  
1513 for Medicaid prescriptions. The agency shall require the use of  
1514 standardized counterfeit-proof prescription pads by prescribers  
1515 who issue written prescriptions for Medicaid recipients. The  
1516 agency may implement the program in targeted geographic areas or  
1517 statewide.

1518 ~~7.6.~~ The agency may enter into arrangements that require  
1519 manufacturers of generic drugs prescribed to Medicaid recipients  
1520 to provide rebates of at least 15.1 percent of the average  
1521 manufacturer price for the manufacturer's generic products.  
1522 These arrangements shall require that if a generic-drug

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1523 manufacturer pays federal rebates for Medicaid-reimbursed drugs  
1524 at a level below 15.1 percent, the manufacturer must provide a  
1525 supplemental rebate to the state in an amount necessary to  
1526 achieve a 15.1-percent rebate level.

1527 ~~8.7.~~ The agency may establish a preferred drug list as  
1528 described in this subsection, and, pursuant to the establishment  
1529 of such preferred drug list, negotiate supplemental rebates from  
1530 manufacturers that are in addition to those required by Title  
1531 XIX of the Social Security Act and at no less than 14 percent of  
1532 the average manufacturer price as defined in 42 U.S.C. s. 1936  
1533 on the last day of a quarter unless the federal or supplemental  
1534 rebate, or both, equals or exceeds 29 percent. There is no upper  
1535 limit on the supplemental rebates the agency may negotiate. The  
1536 agency may determine that specific products, brand-name or  
1537 generic, are competitive at lower rebate percentages. Agreement  
1538 to pay the minimum supplemental rebate percentage guarantees a  
1539 manufacturer that the Medicaid Pharmaceutical and Therapeutics  
1540 Committee will consider a product for inclusion on the preferred  
1541 drug list. However, a pharmaceutical manufacturer is not  
1542 guaranteed placement on the preferred drug list by simply paying  
1543 the minimum supplemental rebate. Agency decisions will be made  
1544 on the clinical efficacy of a drug and recommendations of the  
1545 Medicaid Pharmaceutical and Therapeutics Committee, as well as  
1546 the price of competing products minus federal and state rebates.  
1547 The agency may contract with an outside agency or contractor to

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1548 conduct negotiations for supplemental rebates. For the purposes  
1549 of this section, the term "supplemental rebates" means cash  
1550 rebates. Value-added programs as a substitution for supplemental  
1551 rebates are prohibited. The agency may seek any federal waivers  
1552 to implement this initiative.

1553 ~~9.a.8.a.~~ The agency may implement a Medicaid behavioral  
1554 drug management system. The agency may contract with a vendor  
1555 that has experience in operating behavioral drug management  
1556 systems to implement this program. The agency may seek federal  
1557 waivers to implement this program.

1558 b. The agency, in conjunction with the Department of  
1559 Children and Families, may implement the Medicaid behavioral  
1560 drug management system that is designed to improve the quality  
1561 of care and behavioral health prescribing practices based on  
1562 best practice guidelines, improve patient adherence to  
1563 medication plans, reduce clinical risk, and lower prescribed  
1564 drug costs and the rate of inappropriate spending on Medicaid  
1565 behavioral drugs. The program may include the following  
1566 elements:

1567 (I) Provide for the development and adoption of best  
1568 practice guidelines for behavioral health-related drugs such as  
1569 antipsychotics, antidepressants, and medications for treating  
1570 bipolar disorders and other behavioral conditions; translate  
1571 them into practice; review behavioral health prescribers and  
1572 compare their prescribing patterns to a number of indicators

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1573 that are based on national standards; and determine deviations  
1574 from best practice guidelines.

1575 (II) Implement processes for providing feedback to and  
1576 educating prescribers using best practice educational materials  
1577 and peer-to-peer consultation.

1578 (III) Assess Medicaid beneficiaries who are outliers in  
1579 their use of behavioral health drugs with regard to the numbers  
1580 and types of drugs taken, drug dosages, combination drug  
1581 therapies, and other indicators of improper use of behavioral  
1582 health drugs.

1583 (IV) Alert prescribers to patients who fail to refill  
1584 prescriptions in a timely fashion, are prescribed multiple same-  
1585 class behavioral health drugs, and may have other potential  
1586 medication problems.

1587 (V) Track spending trends for behavioral health drugs and  
1588 deviation from best practice guidelines.

1589 (VI) Use educational and technological approaches to  
1590 promote best practices, educate consumers, and train prescribers  
1591 in the use of practice guidelines.

1592 (VII) Disseminate electronic and published materials.

1593 (VIII) Hold statewide and regional conferences.

1594 (IX) Implement a disease management program with a model  
1595 quality-based medication component for severely mentally ill  
1596 individuals and emotionally disturbed children who are high  
1597 users of care.

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1598        ~~10.9.~~ The agency shall implement a Medicaid prescription  
1599 drug management system.

1600            a. The agency may contract with a vendor that has  
1601 experience in operating prescription drug management systems in  
1602 order to implement this system. Any management system that is  
1603 implemented in accordance with this subparagraph must rely on  
1604 cooperation between physicians and pharmacists to determine  
1605 appropriate practice patterns and clinical guidelines to improve  
1606 the prescribing, dispensing, and use of drugs in the Medicaid  
1607 program. The agency may seek federal waivers to implement this  
1608 program.

1609            b. The drug management system must be designed to improve  
1610 the quality of care and prescribing practices based on best  
1611 practice guidelines, improve patient adherence to medication  
1612 plans, reduce clinical risk, and lower prescribed drug costs and  
1613 the rate of inappropriate spending on Medicaid prescription  
1614 drugs. The program must:

1615            (I) Provide for the adoption of best practice guidelines  
1616 for the prescribing and use of drugs in the Medicaid program,  
1617 including translating best practice guidelines into practice;  
1618 reviewing prescriber patterns and comparing them to indicators  
1619 that are based on national standards and practice patterns of  
1620 clinical peers in their community, statewide, and nationally;  
1621 and determine deviations from best practice guidelines.

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1622 (II) Implement processes for providing feedback to and  
1623 educating prescribers using best practice educational materials  
1624 and peer-to-peer consultation.

1625 (III) Assess Medicaid recipients who are outliers in their  
1626 use of a single or multiple prescription drugs with regard to  
1627 the numbers and types of drugs taken, drug dosages, combination  
1628 drug therapies, and other indicators of improper use of  
1629 prescription drugs.

1630 (IV) Alert prescribers to recipients who fail to refill  
1631 prescriptions in a timely fashion, are prescribed multiple drugs  
1632 that may be redundant or contraindicated, or may have other  
1633 potential medication problems.

1634 ~~11.10.~~ The agency may contract for drug rebate  
1635 administration, including, but not limited to, calculating  
1636 rebate amounts, invoicing manufacturers, negotiating disputes  
1637 with manufacturers, and maintaining a database of rebate  
1638 collections.

1639 ~~12.11.~~ The agency may specify the preferred daily dosing  
1640 form or strength for the purpose of promoting best practices  
1641 with regard to the prescribing of certain drugs as specified in  
1642 the General Appropriations Act and ensuring cost-effective  
1643 prescribing practices.

1644 ~~13.12.~~ The agency may require prior authorization for  
1645 Medicaid-covered prescribed drugs. The agency may prior-  
1646 authorize the use of a product:

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- 1647 a. For an indication not approved in labeling;  
1648 b. To comply with certain clinical guidelines; or  
1649 c. If the product has the potential for overuse, misuse,  
1650 or abuse.

1651  
1652 The agency may require the prescribing professional to provide  
1653 information about the rationale and supporting medical evidence  
1654 for the use of a drug. The agency shall post prior  
1655 authorization, step-edit criteria and protocol, and updates to  
1656 the list of drugs that are subject to prior authorization on the  
1657 agency's Internet website within 21 days after the prior  
1658 authorization and step-edit criteria and protocol and updates  
1659 are approved by the agency. For purposes of this subparagraph,  
1660 the term "step-edit" means an automatic electronic review of  
1661 certain medications subject to prior authorization.

1662 ~~14.13.~~ The agency, in conjunction with the Pharmaceutical  
1663 and Therapeutics Committee, may require age-related prior  
1664 authorizations for certain prescribed drugs. The agency may  
1665 preauthorize the use of a drug for a recipient who may not meet  
1666 the age requirement or may exceed the length of therapy for use  
1667 of this product as recommended by the manufacturer and approved  
1668 by the Food and Drug Administration. Prior authorization may  
1669 require the prescribing professional to provide information  
1670 about the rationale and supporting medical evidence for the use  
1671 of a drug.

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1672        ~~15.14.~~ The agency shall implement a step-therapy prior  
1673 authorization approval process for medications excluded from the  
1674 preferred drug list. Medications listed on the preferred drug  
1675 list must be used within the previous 12 months before the  
1676 alternative medications that are not listed. The step-therapy  
1677 prior authorization may require the prescriber to use the  
1678 medications of a similar drug class or for a similar medical  
1679 indication unless contraindicated in the Food and Drug  
1680 Administration labeling. The trial period between the specified  
1681 steps may vary according to the medical indication. The step-  
1682 therapy approval process shall be developed in accordance with  
1683 the committee as stated in s. 409.91195(7) and (8). A drug  
1684 product may be approved without meeting the step-therapy prior  
1685 authorization criteria if the prescribing physician provides the  
1686 agency with additional written medical or clinical documentation  
1687 that the product is medically necessary because:

1688        a. There is not a drug on the preferred drug list to treat  
1689 the disease or medical condition which is an acceptable clinical  
1690 alternative;

1691        b. The alternatives have been ineffective in the treatment  
1692 of the beneficiary's disease;

1693        c. The drug product or medication of a similar drug class  
1694 is prescribed for the treatment of schizophrenia or schizotypal  
1695 or delusional disorders; prior authorization has been granted

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1696 | previously for the prescribed drug; and the medication was  
1697 | dispensed to the patient during the previous 12 months; or

1698 |       d. Based on historical evidence and known characteristics  
1699 | of the patient and the drug, the drug is likely to be  
1700 | ineffective, or the number of doses have been ineffective.

1701 |  
1702 | The agency shall work with the physician to determine the best  
1703 | alternative for the patient. The agency may adopt rules waiving  
1704 | the requirements for written clinical documentation for specific  
1705 | drugs in limited clinical situations.

1706 |       ~~16.15.~~ The agency shall implement a return and reuse  
1707 | program for drugs dispensed by pharmacies to institutional  
1708 | recipients, which includes payment of a \$5 restocking fee for  
1709 | the implementation and operation of the program. The return and  
1710 | reuse program shall be implemented electronically and in a  
1711 | manner that promotes efficiency. The program must permit a  
1712 | pharmacy to exclude drugs from the program if it is not  
1713 | practical or cost-effective for the drug to be included and must  
1714 | provide for the return to inventory of drugs that cannot be  
1715 | credited or returned in a cost-effective manner. The agency  
1716 | shall determine if the program has reduced the amount of  
1717 | Medicaid prescription drugs which are destroyed on an annual  
1718 | basis and if there are additional ways to ensure more  
1719 | prescription drugs are not destroyed which could safely be  
1720 | reused.

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1721 (14) The agency shall implement a Medicaid therapeutic  
1722 supplies spending control program. The agency may negotiate and  
1723 enter into arrangements with supplies manufacturers which  
1724 require manufacturers to provide rebates and may participate in  
1725 multistate organizations negotiating for such rebates. The  
1726 spending control program shall include a preferred product list,  
1727 which shall be a listing of cost-effective therapeutic supplies  
1728 recommended by the Medicaid Pharmaceutical and Therapeutics  
1729 Committee established pursuant to s. 409.91195 and adopted by  
1730 the agency for each product class listed on the preferred  
1731 product list. The agency may publish the preferred product list  
1732 and updates to the list on the agency website without following  
1733 the rulemaking procedures of chapter 120.

1734 **Section 16. Section 409.9207, Florida Statutes, is created**  
1735 **to read:**

1736 409.9207 Medicaid eligibility assistance for persons with  
1737 disabilities.—

1738 (1) LEGISLATIVE INTENT.—It is the intent of the  
1739 Legislature to create a program that supports and enables  
1740 persons with disabilities to become Medicaid eligible. The  
1741 Department of Children and Families shall be responsible for  
1742 this program; however, all agencies with any duties related to  
1743 Medicaid are responsible for collaborating with the department  
1744 and the independent contractor selected to implement the  
1745 program.

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1746 (2) DEFINITIONS.—As used in this section, unless otherwise  
1747 specified, the term:

1748 (a) "Agency" means any state or local governmental entity.

1749 (b) "Independent contractor" means a nonprofit  
1750 organization with experience operating an information and  
1751 referral program that includes person-centered services to  
1752 successfully navigate eligibility procedures for state and  
1753 federal assistance.

1754 (c) "Person with disabilities" means any person who has  
1755 one or more permanent physical or mental limitations which  
1756 restrict his or her ability to perform the normal activities of  
1757 daily living and impede his or her capacity to live  
1758 independently with relatives or friends without the provision of  
1759 community-based services.

1760 (3) ELIGIBILITY ASSISTANCE PROGRAM.—

1761 (a) The Eligibility Assistance Program is created within  
1762 the Department of Children and Families to offer information,  
1763 referral, and navigation services to persons with disabilities  
1764 to initiate and successfully complete the actions required to  
1765 secure eligibility for Medicaid and other community-based  
1766 services enabling such persons to remain in their homes and  
1767 communities.

1768 (b) The program shall be operated by an independent  
1769 contractor selected based on the following criteria:

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1770 1. A tax-exempt organization incorporated in this state  
1771 and in good standing with the Division of Corporations of the  
1772 Department of State.

1773 2. At least 20 years' experience operating local or  
1774 regional programs that provide services for persons with  
1775 disabilities.

1776 3. Capability to operate call center and online access  
1777 points.

1778 **Section 17. Subsection (1) and paragraph (f) of subsection**  
1779 **(2) of section 409.967, Florida Statutes, are amended to read:**

1780 409.967 Managed care plan accountability.—

1781 (1) ~~Beginning with the contract procurement process~~  
1782 ~~initiated during the 2023 calendar year,~~ The agency shall  
1783 establish a 10-year ~~6-year~~ contract with each managed care plan  
1784 selected through the procurement process described in s.  
1785 409.966. A plan contract may not be renewed; however, the agency  
1786 may extend the term of a plan contract to cover any delays  
1787 during the transition to a new plan. The agency shall extend  
1788 until January 31, 2035 ~~December 31, 2024~~, the term of existing  
1789 plan contracts awarded pursuant to the invitations ~~invitation~~ to  
1790 negotiate published in 2023 ~~July 2017~~.

1791 (2) The agency shall establish such contract requirements  
1792 as are necessary for the operation of the statewide managed care  
1793 program. In addition to any other provisions the agency may deem  
1794 necessary, the contract must require:

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1795 (f) Continuous improvement.—The agency shall establish  
1796 specific performance standards and expected milestones or  
1797 timelines for improving performance over the term of the  
1798 contract.

1799 1. Each managed care plan shall establish an internal  
1800 health care quality improvement system, including enrollee  
1801 satisfaction and disenrollment surveys. The quality improvement  
1802 system must include incentives and disincentives for network  
1803 providers.

1804 2. Each managed care plan must collect and report the  
1805 Healthcare Effectiveness Data and Information Set (HEDIS)  
1806 measures, the federal Core Set of Children's Health Care Quality  
1807 measures, and the federal Core Set of Adult Health Care Quality  
1808 Measures, as specified by the agency. Each plan must collect and  
1809 report the Adult Core Set behavioral health measures beginning  
1810 with data reports for the 2025 calendar year. Each plan must  
1811 stratify reported measures by age, sex, race, ethnicity, primary  
1812 language, and whether the enrollee received a Social Security  
1813 Administration determination of disability for purposes of  
1814 Supplemental Security Income beginning with data reports for the  
1815 2026 calendar year. A plan's performance on these measures must  
1816 be published on the plan's website in a manner that allows  
1817 recipients to reliably compare the performance of plans. The  
1818 agency shall use the measures as a tool to monitor plan  
1819 performance.

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1820 3. Each managed care plan must be accredited by the  
1821 National Committee for Quality Assurance, the Joint Commission,  
1822 or another nationally recognized accrediting body, or have  
1823 initiated the accreditation process, within 1 year after the  
1824 contract is executed. For any plan not accredited within 18  
1825 months after executing the contract, the agency shall suspend  
1826 automatic assignment under ss. 409.977 and 409.984.

1827 4. The agency shall develop a coordinated statewide  
1828 initiative of value-based strategies to drive cost-effective  
1829 service delivery and improved health outcomes by directing  
1830 managed care plans to implement a coordinated program of  
1831 rewarding providers who deliver patient-centered, high-quality  
1832 services. The initiative shall be predicated on a strategic  
1833 plan, submitted to the President of the Senate and the Speaker  
1834 of the House of Representatives by December 15, 2026, and  
1835 implemented over a multiyear period that begins when the plan is  
1836 approved by the Legislature.

1837 a. The strategic plan must set measurable goals, establish  
1838 action plans and timelines, and define evaluation methods. The  
1839 strategic plan must include procedures for making implementation  
1840 adjustments necessary due to changing conditions. The agency  
1841 shall review value-based payment models in other states with  
1842 well-developed programs and incorporate best practices and  
1843 elements which contribute to the success of those programs.

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1844 b. The initiative will consist of the following focus area  
1845 phases:

1846 (I) Year 1 will focus on perinatal health.

1847 (II) Year 2 will add a focus on behavioral health to the  
1848 Year 1 initiatives.

1849 (III) Year 3 will add a focus on management of chronic  
1850 conditions to the Year 1 and Year 2 initiatives.

1851 c. The agency shall augment staff expertise for planning  
1852 and implementation of this initiative with consultants who  
1853 specialize in value-based payment. The agency must ensure active  
1854 engagement of both providers and plans in developing the  
1855 strategic plan and in implementation of the initiative, in a  
1856 manner which fosters collaborative effort and mutual commitment  
1857 to achieving goals in each focus area.

1858 d. Upon legislative approval of the strategic plan, the  
1859 agency shall replace all other contractual requirements for  
1860 value-based payment set by the agency with those developed  
1861 through this initiative.

1862 **Section 18. Subsection (1) of section 409.968, Florida**  
1863 **Statutes, is amended to read:**

1864 409.968 Managed care plan payments.—

1865 (1)(a) Prepaid plans shall receive per-member, per-month  
1866 payments negotiated pursuant to the procurements described in s.  
1867 409.966. Payments shall be risk-adjusted rates based on  
1868 historical utilization and spending data, projected forward, and

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1869 adjusted to reflect the eligibility category, geographic area,  
1870 and clinical risk profile of the recipients.

1871 (b) In negotiating rates with the plans, the agency shall  
1872 consider any adjustments necessary to encourage plans to use the  
1873 most cost-effective modalities for treatment of chronic disease  
1874 such as peritoneal dialysis.

1875 (c) Per-member, per-month payments made to any managed  
1876 care plan contracted under this part or part III that are  
1877 subsequently refunded to or recovered by the agency, or  
1878 initially withheld by the agency prior to payment and not later  
1879 paid to a managed care plan pursuant to the terms of its  
1880 contract, shall be adjusted for the Federal Medical Assistance  
1881 Percentages. The state share shall be transferred to the General  
1882 Revenue Fund, unallocated, and the federal share shall be  
1883 transferred to the Medical Care Trust Fund, unallocated.

1884 **Section 19. Subsection (5) of section 409.982, Florida**  
1885 **Statutes, is amended to read:**

1886 409.982 Long-term care managed care plan accountability.-  
1887 In addition to the requirements of s. 409.967, plans and  
1888 providers participating in the long-term care managed care  
1889 program must comply with the requirements of this section.

1890 (5) PROVIDER PAYMENT.-Managed care plans and providers  
1891 shall negotiate mutually acceptable rates, methods, and terms of  
1892 payment.

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1893        (a) Plans shall pay nursing homes an amount equal to the  
1894 nursing facility-specific payment rates set by the agency;  
1895 however, mutually acceptable higher rates may be negotiated for  
1896 medically complex care.

1897        (b) Plans shall pay hospice providers through a  
1898 prospective system for each enrollee an amount equal to the per  
1899 diem rate set by the agency. For recipients residing in a  
1900 nursing facility and receiving hospice services, the plan shall  
1901 pay the hospice provider the per diem rate set by the agency  
1902 minus the nursing facility component and shall pay the nursing  
1903 facility the applicable state rate.

1904        (c) Plans must ensure that electronic nursing home and  
1905 hospice claims that contain sufficient information for  
1906 processing are paid within 10 business days after receipt.

1907        (d) The agency may establish a fee schedule to reimburse  
1908 providers for adult day care services.

1909        **Section 20. Subsection (8) is added to section 409.9855,**  
1910 **Florida Statutes, to read:**

1911        409.9855 Pilot program for individuals with developmental  
1912 disabilities.—

1913        (8) WAIVER TRANSFER FUNDING.—

1914        (a) For individuals enrolled in the Medicaid home and  
1915 community-based services waiver program under chapter 393 who  
1916 choose to enroll in the pilot program, funding associated with  
1917 the individual shall be transferred from the Agency for Persons

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1918 with Disabilities to the Agency for Health Care Administration.  
1919 The funding shall be equivalent to the total state share cost of  
1920 the individual for the remaining months in the fiscal year based  
1921 on the pilot program's managed care plan monthly rate.

1922 (b) For individuals enrolled in the pilot program who  
1923 choose to enroll in the Medicaid home and community-based  
1924 services waiver program under chapter 393, funding associated  
1925 with the individual shall be transferred from the Agency for  
1926 Health Care Administration to the Agency for Persons with  
1927 Disabilities. The funding shall be equivalent to the total state  
1928 share cost of the individual for the remaining months in the  
1929 fiscal year based on the pilot program's managed care plan  
1930 monthly rate.

1931 (c) The Agency for Persons with Disabilities and the  
1932 Agency for Health Care Administration shall reconcile the  
1933 amounts on a quarterly basis. The Agency for Health Care  
1934 Administration may submit a budget amendment pursuant to chapter  
1935 216 to transfer the funds between the agencies.

1936 **Section 21. Paragraph (e) of subsection (3) of section**  
1937 **409.986, Florida Statutes, is redesignated as paragraph (f), and**  
1938 **a new paragraph (e) is added to that subsection to read:**

1939 409.986 Legislative findings and intent; child protection  
1940 and child welfare outcomes; definitions.—

1941 (3) DEFINITIONS.—As used in this part, except as otherwise  
1942 provided, the term:

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1943           (e) "Qualified provider" means an entity that meets the  
1944 required regulatory or licensing standards for the service being  
1945 procured, that has not had a contract for that service  
1946 terminated due to a failure to meet contractual requirements,  
1947 and that does not have any active formal corrective action plan  
1948 or performance improvement plan associated with a license or  
1949 contract for the service being procured.

1950           **Section 22. Subsection (5) of section 409.990, Florida**  
1951 **Statutes, is amended to read:**

1952           409.990 Funding for lead agencies.—A contract established  
1953 between the department and a lead agency must be funded by a  
1954 grant of general revenue, other applicable state funds, or  
1955 applicable federal funding sources.

1956           (5) A lead agency may carry forward documented unexpended  
1957 state funds from one fiscal year to the next; however, the  
1958 cumulative amount carried forward may not exceed 8 percent of  
1959 the annual amount of the ~~total~~ contract. Any unexpended state  
1960 funds in excess of that percentage must be returned to the  
1961 department.

1962           (a) The funds carried forward may not be used in any way  
1963 that would create increased recurring future obligations, and  
1964 such funds may not be used for any type of program or service  
1965 that is not currently authorized by the existing contract with  
1966 the department.

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1967 (b) Expenditures of funds carried forward must be  
1968 separately reported to the department.

1969 (c) Any unexpended funds that remain at the end of the  
1970 contract period shall be returned to the department.

1971 (d) Funds carried forward may be retained through any  
1972 contract renewals and any new procurements as long as the same  
1973 lead agency is retained by the department.

1974 **Section 23. Subsection (2) of section 409.996, Florida**  
1975 **Statutes, is amended to read:**

1976 409.996 Duties of the Department of Children and  
1977 Families.—The department shall contract for the delivery,  
1978 administration, or management of care for children in the child  
1979 protection and child welfare system. In doing so, the department  
1980 retains responsibility for the quality of contracted services  
1981 and programs and shall ensure that, at a minimum, services are  
1982 delivered in accordance with applicable federal and state  
1983 statutes and regulations and the performance standards and  
1984 metrics specified in the strategic plan created under s.  
1985 20.19(1).

1986 (2) (a) The department must adopt written policies and  
1987 procedures for monitoring the contract for delivery of services  
1988 by lead agencies which must be published on the department's  
1989 website. These policies and procedures must, at a minimum,  
1990 address the evaluation of fiscal accountability and program  
1991 operations, including provider achievement of performance

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1992 standards, provider monitoring of subcontractors, and timely  
1993 followup of corrective actions for significant monitoring  
1994 findings related to providers and subcontractors. These policies  
1995 and procedures must also include provisions for reducing the  
1996 duplication of the department's program monitoring activities  
1997 both internally and with other agencies, to the extent possible.  
1998 The department's written procedures must ensure that the written  
1999 findings, conclusions, and recommendations from monitoring the  
2000 contract for services of lead agencies are communicated to the  
2001 director of the provider agency and the community alliance as  
2002 expeditiously as possible.

2003 (b) The department shall establish a standard statewide  
2004 provider contract to reduce administrative burden and expense by  
2005 establishing uniform reporting, accounting, billing, and  
2006 budgeting requirements. The contract shall establish terms for  
2007 the provision of core child welfare services, including case  
2008 management, foster home licensing, independent living, and  
2009 residential group care, with standardized attachments by  
2010 provider type. The standard statewide provider contract shall  
2011 include provisions for provider probation, termination for  
2012 cause, and emergency termination for actions or inactions of a  
2013 provider that pose an immediate and serious danger to the  
2014 health, safety, or welfare of children, and shall include  
2015 provider appeal procedures for these actions. During the  
2016 pendency of an appeal of an emergency termination, the provider

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2017 may not continue to provide services. In developing the  
2018 statewide provider contract, the department shall work directly  
2019 with both lead agencies and providers of each service type. The  
2020 department shall publish the standard statewide provider  
2021 contract on its website and require lead agencies to use the  
2022 contract, at a minimum, for provider contracting. Lead agencies  
2023 may establish additional contract terms to respond to particular  
2024 regional needs and circumstances.

2025 **Section 24. Subsection (5) of section 414.56, Florida**  
2026 **Statutes, is amended to read:**

2027 414.56 Office of Continuing Care.—The department shall  
2028 establish an Office of Continuing Care to ensure young adults  
2029 who age out of the foster care system between 18 and 21 years of  
2030 age, or 22 years of age with a documented disability, have a  
2031 point of contact until the young adult reaches the age of 26 in  
2032 order to receive ongoing support and care coordination needed to  
2033 achieve self-sufficiency. Duties of the office include, but are  
2034 not limited to:

2035 (5) Developing and administering the Step into Success  
2036 Workforce Education and Internship ~~Pilot~~ Program for foster  
2037 youth and former foster youth as required under s. 409.1455.

2038 **Section 25. For the purpose of incorporating the amendment**  
2039 **made by this act to section 409.968, Florida Statutes, in a**  
2040 **reference thereto, subsection (2) of section 409.978, Florida**  
2041 **Statutes, is reenacted to read:**

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2042 409.978 Long-term care managed care program.—

2043 (2) The agency shall make payments for long-term care,  
2044 including home and community-based services, using a managed  
2045 care model. Unless otherwise specified, ss. 409.961-409.969  
2046 apply to the long-term care managed care program.

2047 **Section 26. For the purpose of incorporating the amendment**  
2048 **made by this act to section 409.968, Florida Statutes, in a**  
2049 **reference thereto, paragraph (b) of subsection (1) of section**  
2050 **409.9855, Florida Statutes, is reenacted to read:**

2051 409.9855 Pilot program for individuals with developmental  
2052 disabilities.—

2053 (1) PILOT PROGRAM IMPLEMENTATION.—

2054 (b) The agency shall administer the pilot program pursuant  
2055 to s. 409.963 and as a component of the Statewide Medicaid  
2056 Managed Care model established by this part. Unless otherwise  
2057 specified, ss. 409.961-409.969 apply to the pilot program. For  
2058 purposes of the pilot program, compliance with s. 409.966 is  
2059 deemed satisfied by the competitive procurement procedures  
2060 conducted for contracts effective on February 1, 2025.

2061 **Section 27. Subsection (1) of section 409.91196, Florida**  
2062 **Statutes, is amended to read:**

2063 409.91196 Supplemental rebate agreements; public records  
2064 and public meetings exemption.—

2065 (1) The rebate amount, percent of rebate, manufacturer's  
2066 pricing, and supplemental rebate, and other trade secrets as

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2067 defined in s. 688.002 that the agency has identified for use in  
2068 negotiations, held by the Agency for Health Care Administration  
2069 under s. 409.912(5)(a)8. ~~s. 409.912(5)(a)7.~~ are confidential and  
2070 exempt from s. 119.07(1) and s. 24(a), Art. I of the State  
2071 Constitution.

2072 **Section 28. Paragraph (b) of subsection (5) of section**  
2073 **393.065, Florida Statutes, is amended to read:**

2074 393.065 Application and eligibility determination.—

2075 (5) Except as provided in subsections (6) and (7), if a  
2076 client seeking enrollment in the developmental disabilities home  
2077 and community-based services Medicaid waiver program meets the  
2078 level of care requirement for an intermediate care facility for  
2079 individuals with intellectual disabilities pursuant to 42 C.F.R.  
2080 ss. 435.217(b)(1) and 440.150, the agency must assign the client  
2081 to an appropriate preenrollment category pursuant to this  
2082 subsection and must provide priority to clients waiting for  
2083 waiver services in the following order:

2084 (b) Category 2, which includes clients in the  
2085 preenrollment categories who are:

2086 1. From the child welfare system with an open case in the  
2087 Department of Children and Families' statewide automated child  
2088 welfare information system and who are either:

2089 a. Transitioning out of the child welfare system into  
2090 permanency; or

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2091 b. At least 18 years but not yet 22 years of age and who  
2092 need both waiver services and extended foster care services; or

2093 2. At least 18 years but not yet 22 years of age and who  
2094 withdrew consent pursuant to s. 39.6251(5)(c) to remain in the  
2095 extended foster care system.

2096  
2097 For individuals who are at least 18 years but not yet 22 years  
2098 of age and who are eligible under sub-subparagraph 1.b., the  
2099 agency must provide waiver services, including residential  
2100 habilitation, and must actively participate in transition  
2101 planning activities, including, but not limited to,  
2102 individualized service coordination, case management support,  
2103 and ensuring continuity of care pursuant to s. 39.6035. The  
2104 community-based care lead agency must fund room and board at the  
2105 rate established in s. 409.145(3) and provide case management  
2106 and related services as defined in s. 409.986(3)(f) ~~s.~~  
2107 ~~409.986(3)(e)~~. Individuals may receive both waiver services and  
2108 services under s. 39.6251. Services may not duplicate services  
2109 available through the Medicaid state plan.

2110  
2111 Within preenrollment categories 3, 4, 5, 6, and 7, the agency  
2112 shall prioritize clients in the order of the date that the  
2113 client is determined eligible for waiver services.

2114 **Section 29.** Except as otherwise provided in this act, this  
2115 act shall take effect July 1, 2026.

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**T I T L E   A M E N D M E N T**

Remove everything before the enacting clause and insert:

A bill to be entitled

An act relating to health care; amending s. 381.4015, F.S.; providing that a specified loan program administered by the Department of Health is subject to appropriation; amending s. 383.14, F.S.; providing that, beginning on a specified date, the department must require newborns to be screened for infantile Krabbe disease and metachromatic leukodystrophy; creating s. 383.1401, F.S.; authorizing the department to create an educational pamphlet on the nutritional needs of preterm infants; requiring the department to provide the pamphlet electronically by a specified date; providing requirements for such pamphlet; amending s. 393.066, F.S.; requiring the Agency for Persons with Disabilities to reimburse certain providers using monthly and hourly rates for certain recipients; amending s. 395.4025, F.S.; providing requirements for specified designation of certain specialty licensed children's hospitals; amending s. 395.902, F.S.; removing a specified allocation for specified positions at behavioral health teaching

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2141 hospitals; amending s. 395.903, F.S.; revising uses  
2142 for certain grant funding for behavioral health  
2143 teaching hospitals; amending s. 409.145, F.S.;  
2144 revising the monthly room and board rates the  
2145 department is required to pay to certain foster  
2146 parents and caregivers; amending s. 409.1455, F.S.;  
2147 renaming the Step into Success Workforce Education and  
2148 Internship Pilot Program as the Step into Success  
2149 Workforce Education and Internship Program; removing a  
2150 provision limiting the duration of the program;  
2151 requiring the Office of Continuing Care within the  
2152 Department of Children and Families to develop certain  
2153 cohorts within specified regions, to collaborate with  
2154 certain organizations to recruit mentors and  
2155 organizations, and to provide eligible former foster  
2156 youth with internship placement opportunities;  
2157 removing a provision requiring that the program be  
2158 administered in a certain manner; requiring the office  
2159 to develop trauma-informed training for mentors of  
2160 certain former foster youth; providing requirements  
2161 for the training; authorizing the office to provide  
2162 certain additional trainings on mentorship of special  
2163 populations; revising the amount of monthly financial  
2164 assistance that the office provides to participating  
2165 former foster youth; requiring the office to assign

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2166 | experienced staff to serve as program liaisons for a  
2167 | specified purpose; revising qualifications to serve as  
2168 | a mentor; authorizing the department to offer certain  
2169 | training to mentors; authorizing an employee who  
2170 | serves as a mentor to participate in certain  
2171 | additional trainings; removing a provision authorizing  
2172 | the offset of a reduction in or loss of certain  
2173 | benefits due to receipt of a Step into Success stipend  
2174 | by an additional stipend payment; creating s.  
2175 | 409.1475, F.S.; providing legislative findings and  
2176 | intent; creating the Foster and Family Support Grant  
2177 | Program within the department; requiring the  
2178 | department to award grants to not-for-profit, faith-  
2179 | based organizations for specified purposes; requiring  
2180 | that the program emphasize certain support; specifying  
2181 | authorized uses for awarded grant funds; requiring  
2182 | grant recipients to submit reports to the department  
2183 | in a format and at intervals prescribed by the  
2184 | department; authorizing the department to adopt rules;  
2185 | amending s. 409.908, F.S.; revising specified rate  
2186 | setting parameters for a specified reimbursement  
2187 | payment methodology; amending s. 409.909, F.S.;  
2188 | revising and providing allocation requirements for the  
2189 | Slots for Doctors Program; defining the term "Medicaid  
2190 | payments"; amending s. 409.91195, F.S.; revising the

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2191 purpose of the Medicaid Pharmaceutical and  
2192 Therapeutics Committee to include creation of a  
2193 Medicaid preferred product list; requiring the Agency  
2194 for Health Care Administration to adopt such list upon  
2195 recommendation of the committee; specifying the  
2196 frequency with which the committee must review such  
2197 list for certain recommendations; specifying  
2198 parameters for such recommendations; providing that  
2199 reimbursement for products not included on such list  
2200 is subject to prior authorization; requiring the  
2201 agency to publish and disseminate such list to all  
2202 Medicaid providers in the state by posting on the  
2203 agency's website or in other media; providing  
2204 requirements for public testimony relating to proposed  
2205 inclusions on or exclusions from such list; amending  
2206 s. 409.912, F.S.; revising Medicaid preferred drug  
2207 coverage guidelines; requiring the agency to implement  
2208 a Medicaid therapeutic supplies spending-control  
2209 program; authorizing the agency to negotiate with  
2210 manufacturers for rebates and participate in  
2211 multistate organizations negotiating for such rebates;  
2212 requiring the agency to establish a preferred product  
2213 list; providing requirements for such list; exempting  
2214 the agency from the rulemaking procedures of ch. 120,  
2215 F.S., when publishing such lists and updates; creating

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2216 s. 409.9207, F.S.; providing legislative intent;  
2217 providing definitions; creating the Eligibility  
2218 Assistance Program within the department; providing  
2219 program requirements; requiring the department to be  
2220 operated by an independent contractor that shall be  
2221 selected based on specified criteria; amending s.  
2222 409.967, F.S.; revising the maximum term for Medicaid  
2223 managed care contracts; requiring the agency to  
2224 establish by contract a quality withhold incentive for  
2225 certain purposes; providing requirements for such  
2226 incentive; amending s. 409.968, F.S.; providing  
2227 adjustment requirements for specified payments made to  
2228 managed care plans; amending s. 409.982, F.S.;  
2229 authorizing the agency to establish a provider  
2230 reimbursement fee schedule for certain purposes;  
2231 amending s. 409.9855, F.S.; providing waiver transfer  
2232 funding requirements for specified individuals;  
2233 amending s. 409.986, F.S.; defining the term  
2234 "qualified provider"; amending s. 409.990, F.S.;  
2235 revising the amount of documented unexpended state  
2236 funds a lead agency may carry forward; amending s.  
2237 409.996, F.S.; authorizing the department to establish  
2238 a standard statewide provider contract for certain  
2239 purposes; providing contract requirements; requiring  
2240 the department to publish such contract on its

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2241 website; authorizing lead agencies to establish  
2242 additional contract terms under certain circumstances;  
2243 amending s. 414.56, F.S.; conforming a provision to  
2244 changes made by the act; reenacting ss. 409.978(2) and  
2245 409.9855(1)(b), F.S., relating to the long-term care  
2246 managed care program and the pilot program for  
2247 individuals with developmental disabilities,  
2248 respectively; amending ss. 409.91196 and 393.065,  
2249 F.S.; conforming cross-references; providing effective  
2250 dates.

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