FLORIDA HOUSE OF REPRESENTATIVES
FINAL BILL ANALYSIS

This bill analysis was prepared by nonpartisan committee staff and does not constitute an official statement of legislative intent.

BILL #: HB 5301E	**COMPANION BILL:** SB 2518-E (Trumbull)
TITLE: Health Care	**LINKED BILLS:** None
SPONSOR(S): Andrade	**RELATED BILLS:** None

FINAL HOUSE FLOOR ACTION: 103 **Y's** 2 **N's** **GOVERNOR'S ACTION:** Pending

SUMMARY

Effect of the Bill:

The bill conforms statutes to the Fiscal Year 2026-2027 General Appropriations Act (GAA). Specifically, the bill:

- Makes various changes to the Department of Health's revolving loan program, new newborn screening testing, infant nutritional needs, and trauma centers.
- Establishes a formula to allocate funds related to the Slots for Doctors Program.
- Requires the re-procurement of contracts with Medicaid managed care plans every 10 years.
- Revises provisions related to approved Behavioral Health Teaching Hospital Grant Program expenditures.
- Requires the Agency for Persons with Disabilities (APD) to continue a monthly reimbursement rate for Life Skills Development Level 3 and Level 4 services.
- Increases foster care room and board rates for foster families.
- Makes the Step into Success Workforce Education and Internship Program permanent.
- Establishes the Foster and Family Support Grant Program.
- Establishes the Eligibility Assistance Program within the Department of Children and Families (DCF) to provide Medicaid eligibility information, referral, and navigation services for individuals with disabilities.
- Establishes statewide qualification standards for child welfare providers, and requires DCF to implement a standardized statewide provider contract for services.
- Authorizes Community Based Care lead agencies to carry forward up to eight percent of unexpended state funds of their annual contract amount instead of the cumulative contract total.

Fiscal or Economic Impact:

The bill will have a significant negative fiscal impact to State expenditures. *See* fiscal impact section.

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ANALYSIS

EFFECT OF THE BILL:

Revolving Loan Program

The bill makes the revolving loan program within the Department of Health (DOH), which provides funding for applicants seeking to implement innovative solutions, as directed by the Health Care Innovation Council, subject to appropriation. (Section 1).

Newborn Screening

The bill requires the DOH to add additional tests for infantile Krabbe disease and metachromatic leukodystrophy. (Section 2).

Neonatal Nutrition

The bill requires the DOH to create an educational pamphlet on the nutritional needs of preterm infants, with information relating to the specific nutritional needs of preterm infants and the options available for best outcomes. The pamphlet may be made available for distribution by hospitals. (Section 3).

Adult Day Training – Life Skills Development Level 3 and Level 4 Services

The bill amends s. 393.066, F.S., requiring the Agency for Persons with Disabilities (APD) to utilize a monthly reimbursement rate for Life Skills Development Level 3 and Level 4 services for clients receiving at least 80 hours of such services during a calendar month. The monthly reimbursement rate must be developed by the Agency for Health Care Administration (AHCA) in consultation with APD. The bill provides that providers serving clients who receive less than 80 hours of Life Skills Development Level 3 or Level 4 services during a calendar month shall continue to be reimbursed using an hourly reimbursement rate. (Section 4).

Trauma Centers

The bill provides that specialty children's hospitals who are certified by the American College of Surgeons must be designated by the DOH as Level I or Level II pediatric trauma centers. (Section 5).

Slots for Doctors Program

The bill revises the funding methodology for the Slots for Doctors Program, providing a formula to calculate participating hospitals' and teaching institutions' funding allocation factor for the Slots for Doctors Graduate Medical Education Program. (Section 6). The bill also eliminates the per-resident funding amount, allowing for the distribution amount to be determined by the funding formula. (Section 13).

Behavioral Health Teaching Hospital Grant

The bill specifies that funds provided through the Behavioral Health Teaching Hospital Grant Program may be used for operational expenses for the delivery of rehabilitative services for behavioral health patients and for fixed capital outlay expenses directly related to the provision of behavioral health services by the hospital or its subcontractor. (Section 7).

Foster Parent Room and Board Rates

The bill amends s. 409.145, F.S., increasing monthly room and board rates, effective July 1, 2026, for foster parents, including relative and nonrelative caregivers who are licensed as level I child-specific foster placements, and for caregivers participating in the Relative Caregiver Program under s. 39.5085, F.S.1. or 2., F.S. (Section 8).

The bill increases monthly room and board rates as follows:

- For children ages 0 through 5, from $517.94 to $663.03.
- For children ages 6 through 12, from $531.21 to $680.01.
- For children ages 13 through 21, from $621.77 to $795.94.

Step into Success Workforce Education and Internship Program

The bill amends s. 409.1455, F.S., removing the Step into Success Workforce Education and Internship Pilot Program's designation as a pilot program and establishing the program as an ongoing statewide program within the Department of Children and Families (DCF) Office of Continuing Care.

The bill requires the office to develop future cohorts of the Step into Success program within DCF's regions and to collaborate with local chambers of commerce to recruit mentors and participating organizations, emphasizing recruitment efforts in Duval, Escambia, Hillsborough, Palm Beach, and Polk counties.

The bill also authorizes the office to connect eligible former foster youth with existing third-party mentorship organizations in which such youth have an interest in participating.

The bill revises mentor training requirements by requiring trauma-informed mentor training to include interactive or experiential components, such as role-playing, scenario discussion, or case studies. Before being matched with a former foster youth, mentors must complete a one-hour training covering core topics that include:

- Understanding trauma and its impacts.
- Recognizing and responding to trauma-related behaviors.
- De-escalation strategies and crisis response.
- Boundaries and mentor self-care.
- Communication skills.

The bill authorizes DCF to offer annual refresher trainings and optional asynchronous online trainings relating to mentorship of special populations and requires the office to inform participating organizations of such training opportunities.

The bill expands mentor eligibility requirements by allowing an employee with at least one year of experience in his or her career field or area, rather than solely with the participating organization, to serve as a mentor.

The bill increases the monthly stipend for participating former foster youth from $1,517 to $1,717, subject to the availability of funds. The bill also removes current law authorizing additional stipend payments to offset reductions in public benefits resulting from receipt of the stipend.

The bill requires DCF to assign experienced staff to serve as program liaisons who are available for mentors to contact whenever mentors need to debrief or have questions concerning a former foster youth. (Section 9).

Foster and Family Support Grant Program

The bill creates s. 409.1475, F.S., establishing the Foster and Family Support Grant Program within DCF to award grants to nonprofit, faith-based organizations to support efforts to recruit and retain foster, adoptive, and kinship families, and other families caring for vulnerable children in underserved and rural communities.

The bill provides that the program must emphasize sustained, community-based support beyond initial licensure or training in order to improve caregiver retention and outcomes for children.

The bill requires grant funds to be used to provide education, training, resources, and technical assistance to eligible faith-based organizations involved in foster care, adoption, and family preservation activities, and to support the development of trauma-informed, community-based support systems for families throughout the caregiving continuum.

Allowable uses of grant funds include, but are not limited to:

- Outreach and recruitment activities to increase the number of licensed foster and adoptive families.
- Training and support for organizations and volunteers assisting foster, adoptive, and kinship families.
- Trauma-informed training, coaching, and counseling services for caregivers, families, and individuals supporting children in out-of-home care or at risk of entering care.
- Program support and other activities to strengthen local capacity to support foster, adoptive, and kinship families.
- Expansion of foster parent training initiatives designed to improve caregiver engagement, retention, and placement stability.
- Development of volunteer-based wraparound support services for families, including kinship caregivers.
- Assistance with essential family needs for families actively fostering, adopting, or pursuing licensure, consistent with federal and state law.
- Ongoing family mentoring and peer support to promote placement stability, permanency, and family well-being.

The bill requires grant recipients to submit annual reports to DCF in a format and at intervals prescribed by the department.

The bill authorizes DCF to adopt rules to implement the program. (Section 10).

Nursing Prospective Payment System

The bill amends s. 409.908, F.S., modifying the parameters governing the nursing home prospective payment methodology for Medicaid provider reimbursement to increase the quality incentive payment pool for Fiscal Year 2026-2027 from 10 percent to 18.1373 percent of the September 2016 non-property related payments of included facilities. (Section 11). Effective July 1, 2027, the quality incentive payment pool percentage for Fiscal Year 2027-2028 and thereafter changes to 16.5482 percent of the September 2016 non-property related payments of included facilities. (Section 12).

Long-Acting Injectables

The bill amends s. 409.912, F.S., requiring AHCA to amend the Medicaid reimbursement protocol to require that a hospital facility administering long-acting injectables (LAI's) for severe mental illness (SMI) shall be reimbursed separately from the diagnosis-related group. The bill specifies that LAI's administered for severe mental illness in an inpatient hospital setting be reimbursed for an amount no less than the Actual Acquisition Cost (AAC). (Section 15).

Additionally, the bill amends s. 409.91195, F.S., authorizing the AHCA to implement a Medicaid therapeutic supplies spending control program, including negotiating manufacturer rebates and participating in multistate purchasing arrangements to reduce program costs. The bill requires the program to include a preferred product list of cost-effective therapeutic supplies recommended by the Medicaid Pharmaceutical and Therapeutics Committee and permits AHCA to publish and update the list on its website without engaging in the rulemaking procedures established in chapter 120, F.S. (Section 14).

Medicaid Eligibility Assistance for Persons with Disabilities

The bill creates s. 409.9207, F.S., to establish the Medicaid Eligibility Assistance Program for Persons with Disabilities. (Section 16).

Medicaid Managed Care

The bill amends s. 409.967, F.S., requiring AHCA to re-procure contracts with managed care plans in the Statewide Medicaid Managed Care (SMMC) program every 10 years instead of every 6 years, beginning with the contract procurement process initiated during the 2023 calendar year. (Section 17).

The bill also requires that any payment refunds recovered by AHCA from managed care plan or any payment withhold balance not paid to a managed care plan pursuant to the terms of its contract, the state share of the funds shall be transferred to the General Revenue Fund, and the federal share shall be deposited into the Medical Care Trust Fund within AHCA, based on the applicable Federal Medical Assistance Percentages. (Section 18).

Adult Day Care Services

The bill authorizes AHCA to establish a fee schedule to reimburse providers of adult day care services. (Section 19).

Pilot Program for Individuals with Developmental Disabilities

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

The bill directs the APD and AHCA to reconcile the transfer amount quarterly, and authorizes the agencies to submit a budget amendment to transfer the funds. (Section 20).

Qualified Provider

The bill amends s. 409.986, F.S., defining the term "qualified provider" for purposes of child welfare services procured under Part V of ch. 409, F.S., defining a qualified provider as an entity that:

- Meets the required regulatory or licensing standards for the service being procured.
- Has not had a contract for the applicable service terminated due to failure to meet contractual requirements.
- Does not have an active formal corrective action plan or performance improvement plan associated with a license or contract for the service being procured. (Section 21).

Community Based Care Lead Agencies

The bill amends s. 409.990, F.S., authorizing community-based care lead agencies to carry forward up to 8 percent of unexpended state funds based on the annual contract amount rather than the cumulative contract amount. (Section 22).

The bill amends s. 409.996, F.S., requiring DCF to establish a standard statewide provider contract for core child welfare services to reduce administrative burden and establish uniform:

- Reporting requirements;
- Accounting requirements;
- Billing requirements; and
- Budgeting requirements.

The bill requires the statewide provider contract to include:

- Standardized terms for the provision of core child welfare services, including case management, foster home licensing, independent living services, and residential group care.
- Standardized attachments based on provider type.
- Provisions relating to provider probation, termination for cause, emergency termination, and provider appeal procedures.

The bill also provides that a provider subject to an emergency termination may not continue providing services while an appeal is pending.

The bill requires DCF to:

- Work with lead agencies and providers of each service type in developing the statewide provider contract;
- Publish the statewide provider contract on its website; and
- Require lead agencies to use the statewide provider contract, at a minimum, for provider contracting purposes.

The bill authorizes lead agencies to establish additional contract terms necessary to address regional needs and circumstances. (Section 23).

Subject to the Governor's veto powers, the effective date of this bill is July 1, 2026, except as otherwise provided. (Section 29).

The Fiscal Year 2026-2027 General Appropriations Act (GAA) includes $173.5 million, of which $76.6 million is from the General Revenue Fund, to increase the quality component of nursing home Medicaid rates from 10 percent of non-property funds to 18.1373 percent of non-property funds, effective July 1, 2026. The percentage decreases to 16.5482 on July 1, 2027, to account for $49.2 million of the funding provided being nonrecurring.

The bill includes $11.1 million, of which $8.0 million is from the General Revenue Fund, for a room and board rate increase for foster caregivers.[1]

The bill includes $5.0 million from the General Revenue Fund for the establishment of the Foster and Family Support Grant Program within DCF to award grants to nonprofit, faith-based organizations to support efforts to recruit and retain foster, adoptive, and kinship families, and other families caring for vulnerable children in underserved and rural communities.[2]

The bill includes $3.4 million from the General Revenue Fund establishing the Step Into Success Workforce and Internship Program as an ongoing statewide program within the DCF Office of Continuing Care.[3]

The bill contains provisions which will positively impact the General Revenue Fund due to potential saving on the Healthcare Innovation Council and Revolving Loan Fund by making it subject to appropriation, from having a recurring funding amount of $50 million.

The provision in the bill relating to Newborn Screening includes $5.2M from the Planning and Evaluation Trust Fund to provide for the additional costs related to implementing the additional newborn screening tests for Krabbe disease and metachromatic leukodystrophy.

The provision of the bill relating to the Medicaid reimbursement cost of LAI's administered to SMI patients would have an indeterminant fiscal impact to the State, to the extent that the additional state share of Medicaid reimbursement cost for administering LAI's is offset by a reduction in costs in other mental health and behavioral health programs.

[1] Fiscal Year 2026-2027 *General Appropriations Act, Specific Appropriations 339 and 369*.
[2] Fiscal Year 2026-2026 *General Appropriations Act, Specific Appropriation 332A*.
[3] Fiscal Year 2026-2027 *General Appropriations Act, Specific Appropriation 339*.

RELEVANT INFORMATION

SUBJECT OVERVIEW:

Health Care Innovation Council

In 2024, s. 381.4015, F.S. created the Health Care Innovation Council, a 15-member council within the Department of Health. The Lieutenant Governor serves as the chair of the council and as an ex officio, nonvoting member. The Secretary of the Agency for Health Care Administration, the Secretary of the Department of Children and Families, the director of the Agency for Persons with Disabilities, the State Surgeon General, and the Secretary of the Department of Elder Affairs all serve as ex officio, nonvoting members. The chair of the Council of Florida Medical School Deans serves as a voting member.

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

The remainder of the council consists of the following appointments by the Governor:

- A licensed physician;
- An employee of a licensed hospital;
- A licensed nurse;
- A Florida resident to represent the interest of health care patients;
- An employee of a health insurer or health maintenance organization; and
- A representative of the long-term care facility industry.

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

Council Duties

The council must facilitate public meetings at which innovators, developers, and implementers of technologies, workforce pathways, service delivery models, and other solutions may present information and lead discussions. The work:

- Must cover concepts that address challenges to the health care system as they develop in real time and concepts that advance the delivery of health care in this state through technology and innovation.
- Must give consideration to how the concepts:
  - Increase efficiency in the health care system in this state;
  - Reduce strain on the state's health care workforce;
  - Improve patient outcomes;
  - Expand public access to health care services in this state; or
  - Reduce costs for patients and the state without reducing the quality of patient care.
- May consider broad community or statewide issues or needs to be addressed.
- May include how concepts can be supported, cross-functional, or scaled to meet the needs of health care consumers, including employers, payers, patients, and the state.
- May include coordination with the Small Business Development Center Network, the Florida Opportunity Fund, the Institute for Commercialization of Florida Technology, and other business

incubators, development organizations, or institutions of higher education to include emerging and early-stage concepts in the discussions.
- May bring information technology technical experts to lead discussions on recommended structures and integrations of information technology products, services, and solutions.

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

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

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

Some key accomplishments of the Council as outlined in the December 1, 2025 Annual Report were:

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

[4] DOH, *Florida Health Care Innovation Council Annual Report December 1, 2025,* pg. 2, on file with the Health Care Budget Subcommittee.

Revolving Loan Program

Current law provides a revolving loan program within the DOH to provide funding for applicants seeking to implement innovative solutions. Certain entities licensed, registered, or certified by the AHCA and educational or clinical training providers in partnership with one of the entities, may apply for a loan.[5] The program made operational progress in 2025, establishing the infrastructure necessary for launch.

DOH is to establish eligibility criteria that:

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

Application Process

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

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

Eligibility

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

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

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

Awards

The amount of each loan must be based upon demonstrated need and availability of funds. The DOH may not

[5] The entities licensed, registered, or certified pursuant to s. 408.802, F.S., except for subsections (1), (3), (13), (23), and (25) of this section, are eligible to apply.

award more than 10 percent of the total allocated funds for the fiscal year to a single loan applicant.

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

The application period was widely publicized to eligible stakeholders including:

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

Applications submitted during this period are currently under review by the council using the approved 100-point scoring framework and tiered review process.

Loan repayment

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

Revolving loan fund

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

Newborn Screening

Newborn screening is a preventive public health service provided in every state to identify, diagnose, and manage newborns at risk for selected disorders that, without detection and treatment, can lead to permanent developmental and physical damage or death. Newborn screening is evidence-based and has been shown to be effective at reducing infant morbidity and mortality.[6] The federal government produces a list of conditions that it recommends every newborn be screened for, but each state determines the conditions newborns are screened for under their respective state's newborn screening program[7].

The Florida Newborn Screening (NBS) program, within the Department of Health (DOH), screens all infants born in the state for metabolic, hereditary, and congenital disorders. The NBS Program does not currently screen for Duchenne Muscular Dystrophy (DMD)[8], Infantile Krabbe Disease (IKD)[9], or Metachromatic Leukodystrophy (MLD).[10]

[6] Yusuf, C., Sontag, M. K., Miller, J., Kellar-Guenther, Y., McKasson, S., Shone, S., Singh, S., & Ojodu, J. (2019). Development of National Newborn Screening Quality Indicators in the United States. International Journal of Neonatal Screening, 5(3), 34. https://doi.org/10.3390/ijns5030034; Watson, S., Lloyd-Puryear, M., & Howell, R. (2022). The Progress and Future of US Newborn Screening. International Journal of Neonatal Screening, 8:41, https://doi.org/10.3390/ijns8030041. (last visited May 28, 2026).

[7] Health Resources & Services Administration, History of the ACHDNC https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/heritable-disorders/hrsa-timeline-interactive.pdf (last visited May 28, 2026).

[8] Centers for Disease Control and Prevention. About Muscular Dystrophy (2025). Available at https://www.cdc.gov/musculardystrophy/about/index.html (last visited May 28, 2026).

[9] American Academy of Pediatrics https://publications.aap.org/pediatrics/article/155/4/e2024069152/201256/Evidence-and-Recommendation-for-Infantile-Krabbe?searchresult=1 (last visited May 28, 2026).

[10] American Academy of Pediatrics https://publications.aap.org/pediatrics/article/doi/10.1542/peds.2025-073188/203176/Evidence-Regarding-Metachromatic-Leukodystrophy?autologincheck=redirected (last visited May 28, 2026).

Neonatal Nutrition

Preterm infants face significant growth challenges due to high metabolic demands, limited nutrient reserves, poor temperature control, and prolonged illness. These challenges are prevalent in all neonatal intensive care units, irrespective of the level of resources available. Preterm infant nutrition risk can be exacerbated by constrained tangible and human resources, making the provision of adequate nutrition even more difficult.[11]

Trauma Centers

Currently, ss. 395.402, F.S. and s. 395.4025, F.S. regulate Trauma Center service areas, location and criteria[12]. To be eligible for approval as a Level I, Level II, or pediatric trauma center, a hospital must complete the applicable application and submit all requested information to the Florida Department of Health's Division of Emergency Preparedness and Community Support, for review. Each hospital approved as a trauma center shall be issued a certificate of approval, which are incorporated by reference and available from the Department, as defined by subsection 64J-2.001(4), F.A.C.

Nursing Prospective Payment System

On October 1, 2018, Florida Medicaid nursing homes transitioned from facility-specific cost based rates to the prospective rate reimbursement methodology, which determines rates in advance of payment. Section 409.908, F.S., provides the methodology[13] and parameters for rate setting including reimbursement rates for direct care, indirect care, and operating costs.

The methodology includes a parameter for a Quality Incentive Payment, in which a provider is awarded points for process, outcome, structural and credentialing measures using most recently reported data on May 31 of the rate period year.[14]

The Quality Incentive Payment calculation[15] is as follows:

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

Payment amounts are limited to a percentage of the September 2016 non-property related payments of included facilities.[16]

Effective July 1, 2025, Senate Bill 2502, the Fiscal Year 2025-2026 Implementing Bill for the General Appropriations Act, amended s. 409.908, F.S., increasing the Quality Incentive Payment percentage from 10 percent to 17.862 percent.[17] The change was only valid for the fiscal year, and will revert back to 10 percent on July 1, 2026.

Long-Acting Injectables

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

[11] Neonatal Nutrition Assessment - https://nutritioncare.org/wp-content/uploads/2025/08/Neonatal-Nutr-Assessment.pdf (last visited May 29, 2026).
[12] Department of Health Trauma Center Standard, DOH pamphlet January 2010 https://www.floridahealth.gov/wp-content/uploads/2025/08/trauma-center-standards-pamphlet.pdf (last visited May 29, 2026).
[13] Nursing Home Prospective Payment System Calculation: (Operating Price + Direct Care Price - Floor Reduction + Indirect Care Price - Floor Reduction + FRVS Rate + Pass Through Payments) * Budget Neutrality Factor + Quality Incentive Payment + Medicaid Share of NFQA + Ventilator Supplemental Payment + High Medicaid Utilization and High Direct Patient Care Add-On)) + Unit Cost Rate Increase.
[14] R. 59G-6.010(2)(y), F.A.C.
[15] *Id.*
[16] S. 409.908(2)(e), F.S.
[17] Ch. 25-199, Laws of Fla.

formulation permits medication to be released into the bloodstream over a longer period of time. This allows injections to be given only every two weeks to six months, depending on the medication and formulation.[18]

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

- Cost of LAIs, particularly newer second generation medications.
- Fear of needles.
- Negative patient attitudes about LAIs or medication generally.[19]
- Clinician discomfort with administering injections.[20]
- Clinician perception that LAIs are more appropriate for nonadherent patients.

Patients typically begin receiving medication orally to identify which medicine is most effective for them before receiving the medication through a LAI. Some patients may receive a LAI while in inpatient care but discontinue use after discharge.[21]

LAI are more widely available for treating schizophrenia, with some also available for bipolar disorder or opioid use disorder.[22] However, a 2019 study indicated that only about 10% of patients with schizophrenia were taking LAI's.[23]

Florida Medicaid Program

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

The structure of each state's Medicaid program varies, but what states must pay for is largely determined by the federal government, as a condition of receiving federal funds.[24] Federal law sets the amount, scope, and duration of services offered in the program, among other requirements. These federal requirements create an entitlement that comes with constitutional due process protections. The entitlement means that two parts of the Medicaid cost equation – people and utilization – are largely predetermined for the states. The federal government sets the minimum mandatory populations to be included in every state Medicaid program. The federal government also sets the minimum mandatory benefits to be covered in every state Medicaid program. These benefits include physician services, hospital services, home health services, and family planning.[25] States can add benefits, with federal approval. Florida has added many optional benefits, including prescription drugs, ambulatory surgical center services, and dialysis.[26]

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

[18] National Alliance on Mental Illness, Long-Acting Injectables (LAIs), https://www.nami.org/about-mental-illness/treatments/mental-health-medications/long-acting-injectables-lais/ (last visited May 28, 2026).
[19] S. Schwartz, et al., *Attitudes and perceptions about the use of long-acting injectable antipsychotics among behavioral health practitioners*, Mental Health Clinician, Aug. 23, 2022, https://mhc.kglmeridian.com/view/journals/mhcl/12/4/article-p232.xml (last visited May 28, 2026).
[20] Lovett, L., *Behavioral Health Business*, Behavioral Providers Turn to Long-acting Injectables to Boost Adherence, Decrease Burden, July 3, 2024, https://bhbusiness.com/2024/07/03/behavioral-providers-turn-to-long-acting-injectables-to-boost-adherence-decrease-burden/ (last visited May 28, 2026).
[21] *Id.*
[22] *Id.*
[23] Schwartz, *supra* note 91.
[24] Title 42 U.S.C. §§ 1396-1396w-5; Title 42 C.F.R. Part 430-456 (§§ 430.0-456.725) (2016).
[25] S. 409.905, F.S.
[26] S. 409.906, F.S.

Medicaid Managed Care

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

States may also ask the federal government to waive federal requirements to expand populations or services, or to try new ways of service delivery. Many states have elected to provide Medicaid benefits through a managed care model. Traditionally, Medicaid services are paid for under a fee-for-service (FFS) reimbursement model. Under the FFS model, the state pays providers directly for each covered service received by a Medicaid beneficiary. Under managed care, the state pays a fee to a managed care plan for each person enrolled in the plan. In turn, the plan pays providers for all of the Medicaid services a beneficiary may require that are included in the plan's contract with the state.[27]

For example, Florida has a Section 1115 waiver to use a comprehensive managed care delivery model for primary and acute care services, the Statewide Medicaid Managed Care (SMMC) Managed Medical Assistance (MMA) program.[28] The MMA program was enacted in 2011 and fully implemented in 2014.

MMA Program

The MMA program provides acute health care services through managed care plans contracted with AHCA in 9 regions across the state.[29] Specialty plans are also available to serve distinct populations, such as the Children's Medical Services Network for children with special health care needs, or those in the child welfare system. Medicaid recipients with HIV/AIDS, serious mental illness, dual enrollment with Medicare, chronic obstructive pulmonary disease, congestive heart failure, or cardiovascular disease may also select from specialized plans. Roughly 80% of Florida's Medicaid population is served through the MMA program, while the remainder of participants are served by traditional FFS Medicaid.[30]

Graduate Medical Education (GME)

The continuum of formal physician education begins with undergraduate medical education in an allopathic or osteopathic medical school. U.S. medical schools confer the M.D. or D.O. degree. U.S. graduates with these degrees combine with some of the graduates of non-U.S. medical schools in competing for residency program slots. Graduate medical education, or GME, is the post-graduate period often called residency training. GME has evolved from an apprenticeship model to a curriculum-based education program. Learning is still predominantly based on resident participation in patient care, under supervision, with increasing independence through the course of training.[31] Most residency programs are sponsored by and take place in large teaching hospitals and academic health centers. However, as health care services are increasingly provided in ambulatory and community-based settings, residency training is beginning to expand to non-hospital sites.[32]

Every U.S. state requires at least one year of residency training to receive an unrestricted license to practice medicine, and some require two or three years. However, most physicians train beyond the minimum licensure requirement in order to become board certified in a "pipeline" specialty (i.e., those that lead to initial board

[27] Medicaid and CHIP Payment and Access Commission (MACPAC), *Provider payment and delivery systems*, https://www.macpac.gov/medicaid-101/provider-payment-and-delivery-systems/ (last accessed Feb. 10, 2026).
[28] S. 409.964, F.S.
[29] Agency for Health Care Administration, *SMMC Region Map*, https://ahca.myflorida.com/var/site/storage/images/5/8/9/2/182985-1-eng-US/a49c585cebfc-regions_Current2025.png, (last accessed Feb. 10, 2026).
[30] Agency for Health Care Administration, presentation by Beth Kidder, Deputy Secretary for Medicaid, to the House Health and Human Services Committee, February 17, 2021, https://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=3085&Session=2021&DocumentType=Meeting%20Packets&FileName=hhs%202-17-21.pdf (last accessed January 6, 2022).
[31] *Graduate Medical Education That Meets the Nation's Health Needs*, Committee on the Governance and Financing of Graduate Medical Education; Board on Health Care Services; Institute of Medicine; Eden J, Berwick D, Wilensky G, editors. Washington (DC): National Academies Press (US); 2014 Sep 30. 1, Introduction. Available from: https://www.ncbi.nlm.nih.gov/books/NBK248032/, (last visited May 28, 2026).
[32] *Id.*

certification). The number of pipeline training positions determines the total number of physicians that the entire continuum can produce. For many years, the number of U.S. residency slots has been larger than the number of U.S. medical graduates, so residency programs were filled in part by graduates of non-U.S. medical schools (including both U.S. and non-U.S. citizens). Now, with growth in the number and size of medical schools, the number of U.S. medical graduates is beginning to more closely approximate the current number of residency slots. In a recent survey conducted by the Association of American Medical Colleges (AAMC), 122 of 130 responding medical school deans reported some concern about the number of post-graduate training opportunities for their students.[33]

Medicare Funding of GME

GME is largely funded through both the Medicare and the Medicaid programs. Until the enactment of the Balanced Budget Act (BBA) of 1997, Medicare support of GME was open-ended. Before the BBA, hospitals had a strong financial incentive to add new residency slots because each new position generated additional Medicare per-resident amount and indirect medical education revenues. In response to concerns about an oversupply of physicians and increasing Medicare costs, the BBA capped the number of Medicare-supported physician training slots.[34]

Hospitals are free to add residents beyond their cap, but these trainees do not generate additional Medicare revenues. The cap on Medicare funding was set at each hospital's resident count in the cost report period ending on or before December 31, 1996. With this step, the geographic distribution of Medicare-supported residencies was essentially frozen in place without regard for future changes in local or regional health workforce priorities or the geography or demography of the U.S. population. As can be seen by the following chart (showing the number of Medicare-funded training positions per 100,000 population), Medicare-supported slots are most highly concentrated in the Northeastern states, as is most of Medicare GME funding.[35]

Medicaid Funding of GME

GME is an approved component of Medicaid inpatient and outpatient hospital services.[36] If a state Medicaid program opts to cover GME costs, the federal government provides matching funds.[37] Florida opts to fund GME through the Statewide Medicaid Residency Program (SMRP).[38] For fiscal year 2023-2024, the SMRP funded 6,176 residents at 83 location.[39]

The SMRP allows both hospitals and Federally Qualified Health Centers (FQHC) that are accredited by the Accreditation Council for Graduate Medical Education (ACGME) to qualify for GME funding. In addition to the SMRP, the Legislature has allocated additional funding to GME through the Startup Bonus Program and the Slots for Doctors Program.

Startup Bonus Program (SBP)[40]

The SBP was established to provide resources for the education and training of physicians in specialties which are in a statewide supply-and-demand deficit. The program allocates a $100,000 startup bonus for each newly created resident position that is authorized by the Accreditation Council for Graduate Medical Education or Osteopathic Postdoctoral Training Institution in an initial or established accredited training program that is in a physician specialty in statewide supply-and-demand deficit. For the purposes of the program, physician specialties in statewide supply-and-demand deficit are identified in the General Appropriations Act (GAA).[41]

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[33] *Id.*
[34] *Id.*
[35] *Id.*
[36] *Id.*
[37] *Id.*
[38] S. 409.909, F.S.
[39] SFY 2023-24 Statewide Medicaid Residency Program Distribution, AHCA, available at https://ahca.myflorida.com/content/download/23217/file/SFY%2023-24%20GME%20SMRP%20Calculation%20Clean.pdf, (last visited May 28, 2026).
[40] S. 409.909(5), F.S.
[41] Ch. 2023-239, Laws of Florida

The Slots for Doctors Program (SDP)

The SDP requires the AHCA to annually allocate $100,000 to hospitals and qualifying institutions for each newly created slot that is first filled on or after June 1, 2023, and remains filled thereafter.[42] The new slot must be accredited by the Accreditation Council for Graduate Medical Education or the Osteopathic Postdoctoral Training Institution in an initial or established accredited training program which is in a physician specialty or subspecialty in a statewide supply-and-demand deficit. The sections specify that the program is designed to generate matching funds under the Medicaid program and distribute those funds to participating hospitals and qualifying institutions and that specialties and sub-specialties are those that are identified in the GAA.

Behavioral Health Teaching Hospitals

To increase the overall supply of behavioral health professionals, some states may choose to act through partnerships with educational institutions and residency programs.[43] These partnerships can encourage students and early career professionals to practice in rural and underserved communities.[44]

Other states may support new and existing behavioral health educational initiatives at behavioral health teaching hospitals with grant funding. For example, Massachusetts pledged at least $20 million for FY 2024 to establish new, or enhance existing, clinical supervision of students pursuing degrees in behavioral health and behavioral health providers-in-training pursing certification or licensure. Massachusetts's clinical supervision incentive program provides grants to clinical supervisors working in community-based settings who also provide unreimbursed supervision to students and clinicians-in-training. Administered by the Executive Office for Health and Human Services, the grant program prioritizes providers of diverse backgrounds and providers who practice in underserved and geographically isolated areas.[45]

In 2024, the legislature passed SB 330 creating the behavioral health teaching hospital program within AHCA for Florida-based hospitals to establish a nationally acclaimed behavioral health system of care and to fund both behavioral health GME and hospital workforce projects.[46] The goal of the program is to increase the size and quality of the state's behavioral health workforce and to close the supply-and-demand gap in the state's behavioral health care sector.

Medicaid Prescribed Drug Benefits – Cost Control

Federal law requires state Medicaid programs to cover every drug for which the federal Department of Health and Human Services (HHS) has negotiated a manufacturer rebate.[47] Florida law requires AHCA to have a spending control program for this benefit, including a state-negotiated supplemental rebate, which is in addition to the federal rebate.[48] AHCA contracts with a pharmacy benefit manager to negotiate those rebates. Revenues generated from the rebates are reinvested in the Medicaid program.

Part of the spending control program is a Medicaid Preferred Drug List (PDL). The PDL is a list of drugs which are the most cost-effective options in each therapeutic class.[49] AHCA establishes the PDL based on the clinical efficacy and safety of the drug, as well as the price of the drug and the price of competing products, taking into account the federal and state rebates.[50] In developing the PDL, AHCA must consider the recommendations of the Medicaid

[42] S. 409.909(6), F.S.
[43] National Conference of State Legislatures, *State Strategies to Recruit and Retain the Behavioral Health Workforce*, (last updated May 20, 2022), https://www.ncsl.org/health/state-strategies-to-recruit-and-retain-the-behavioral-health-workforce (last visited May 28, 2026).
[44] *Id*.
[45] Commonwealth of Massachusetts Session Law 2023-28, Line Item 4000-0054, https://malegislature.gov/Laws/SessionLaws/Acts/2023/Chapter28 (last visited May 28, 2026).
[46] Ch. 2024-12, Laws of Florida
[47] Title 42 U.S.C. § 1396r-8. State Medicaid programs are authorized to cover non-rebated drugs with HHS approval, under certain circumstances.
[48] S. 409.912(5)(a), F.S.
[49] S. 409.912(5)(a), F.S.; Agency for Health Care Administration, *Florida Medicaid Preferred Drug List*, March 8, 2023, available at https://ahca.myflorida.com/medicaid/prescribed_drug/pharm_thera/fmpdl.shtml (last viewed on May 28, 2026).
[50] SS. s. 409.912(5)(a)7, F.S., and 409.91195(7), F.S.

Pharmacy and Therapeutics Committee, a committee of clinicians which reviews drugs for clinical efficacy, safety and cost-effectiveness.[51]

Another component of the spending control program is prior authorization. Current law allows AHCA to condition reimbursement on prior authorization; that is, the prescriber or dispenser must obtain AHCA (or managed care plan) approval prior to dispensing, or Medicaid will not pay for the drug.[52] AHCA may require prior authorization:[53]

- For an indication not approved in labeling;
- To comply with clinical guidelines; or
- If the product has the potential for overuse, misuse, or abuse.

In the prior authorization process, the prescriber may be required to provide the rationale and supporting medical evidence for the use of a drug.[54] For prior authorized PDL drugs, the prior authorization system must guarantee a response within 24 hours, and cover a 72-hour supply of the drug if that time is exceeded.[55]

Pharmacy, Drug Purchasing

Prescribed drugs are a standard benefit of the Florida Medicaid program and part of the reimbursement to providers.[56] Florida Medicaid program reimbursements for medications can be stand-alone payments, bundled into a prospective payment rate, e.g. diagnosis-related group (DRG), or part of the Medicaid capitation payment to health plans in SMMC.[57]

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

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

Generic drugs must be used, unless the prescriber has received an exemption.[58]

Drugs are currently acquired pursuant to a Preferred Drug List (PDL). The PDL is developed, maintained and reviewed by the AHCA's Medicaid Pharmaceutical and Therapeutics Committee.[59] The committee is composed of 11 members appointed by the Governor – four members are allopathic physicians licensed under ch. 458, F.S., one member is an osteopathic physician licensed under ch. 459, F.S., five members are pharmacists, and one member is a consumer. The duties of the committee are to recommend the contents of the PDL to the AHCA and review the contents at least every twelve months.[60] The committee's standards and considerations for determining whether to include or delete a drug are:

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[51] S. 409.91195, F.S. The P&T Committee is comprised of 11 gubernatorial appointees, including four physicians, five pharmacists and a consumer member. It must meet at least quarterly, and must review all drug classes every 12 months. Meetings are open to the public, and the committee is required to receive public testimony from interested parties; however, portions of meetings during which rebates and other trade secrets are discussed are closed, pursuant to s. 409.91196, F.S., and 42 U.S.C. 1396r-8(b)(3)(D).
[52] S. 409.91195(5), F.S.
[53] S. 409.912, (5)(a)12., F.S.
[54] *Id*.
[55] S. 409.912(5)(a), F.S.
[56] S. 409.815(n), F.S. (KidCare); s. 409.905(3), F.S. (Mandatory Coverage, Family Planning Services); s. 409.906(20), F.S. (Optional Coverage, Prescribed Drug Services); and s. 409.906(29), F.S. (Optional Coverage, Bio Marker Testing Services).
[57] In plan year 2024 for MMA plans, $3,229,392,040 was spent by the health plans. Retrieved from AHCA Dashboard, Compare Medicaid Financial Data; available at: https://ahca.myflorida.com/medicaid/agency-dashboards (last visited May 28, 2026).
[58] S. 409.908(14)(a), F.S.
[59] S. 409.91195, F.S.
[60] S. 409.91195(4), F.S.

- Is the drug medically appropriate drug therapy for Medicaid patients?[61]
- Does the drug achieve the cost savings contained in the General Appropriations Act?[62]
- Did the manufacturer agree to supplemental rebates as provided by law?[63]
- Does the drug have the requisite United States Food and Drug Administration (FDA) approval for the particular use?[64]
- Clinical efficacy.[65]
- Safety.[66]
- Cost effectiveness.[67]

The committee may make recommendations as to prior authorization requirements for any recommended drug.[68] The committee is required to allow public testimony before making recommendations to add or delete a drug.[69]

The AHCA must adopt the PDL; however, it does not have to follow the requirements of rulemaking pursuant to ch. 120, F.S. Instead, the AHCA may post the PDL and updates on an internet website.[70] In addition, the list must also comply with the requirement of the Medicaid prescribed-drug spending control program under s. 409.912(5)(a), F.S. The current list is effective as of January 1, 2026, and has been posted.[71]

Federal law gives states the option to provide coverage for prescribed drugs.[72] Florida has elected to do so,[73]as has every other state.[74] To be eligible for the FMAP, the drug must be deemed a covered outpatient drug (COD) by federal CMS. As an additional requirement, the manufacturer of the drug and federal CMS must have entered into a National Drug Rebate Agreement (NDRA).[75] The state FMAP is paid based on this rebate amount and any supplemental rebates achieved by the state.[76, 77]

States may also place limitations of the coverage of drugs, such as preferred drug lists. Federal law provides that a state may exclude or otherwise restrict coverage as to a COD, if it is on a formulary or part of a prior authorization plan.[78]

Medicaid Eligibility Assistance for Persons with Disabilities

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

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

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[61] *Id*.
[62] *Id*.
[63] S. 409.91195(7), F.S.
[64] *Id*.
[65] S. 409.91195(8), F.S.
[66] *Id*.
[67] S. 409.91195(8), F.S.
[68] S. 409.91195(9), F.S.
[69] S. 409.91195(7), F.S.
[70] S. 409.912 (5)(a)1,F.S.
[71] Agency for Health Care Administration, *Florida Medicaid Preferred Drug List, Effective January 1, 2026,* available at: https://ahca.myflorida.com/content/download/22289/file/September%202025%20P%26T%20PDL%201.1.2026.pdf (last visited May 28, 2026).
[72] 42 U.S.C. § 1396r-8.
[73] S. 409.906(20), F.S.
[74] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Report to Congress, Medicaid Services Investment and Accountability Act of 2019 Preventing the Misclassification of Drugs Under the Medicaid Drug Rebate Program, FFY 2024* (August 2025), p. 2; Available at: https://www.medicaid.gov/prescription-drugs/downloads/mdrp-misclassification-rtc.pdf (last visited May 28, 2026).
[75] 42 U.S.C. § 1396r-8(a)(1).
[76] 42 U.S.C. § 1396r-8(b)(1)(B).
[77] S. 409.912(5)(a)1.6. & 7, F.S.
[78] 42 U.S.C. § 1396r-8(d).

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

iBudget Waiver

Under federal law, Medicaid provides coverage for health care services to cure or ameliorate diseases; generally, Medicaid does not cover services that will not cure or mitigate the underlying diagnosis, or social services. However, people with developmental disabilities, while certainly requiring traditional medical services, need other kinds of services to maintain their independence and avoid institutionalization. Home- and community-based services (HCBS) are an alternative to institutionalizing people with developmental disabilities.

To obtain federal Medicaid funding for HCBS, Florida obtained a Medicaid waiver.[79] This allows coverage of non-medical services to avoid institutionalization, and allows the state to limit the scope of the program to the number of enrollees deemed affordable by the state.[80] In this way, the HCBS waiver is not an entitlement; it is a first-come-first-served, slot-limited program.

The HCBS waiver program, called iBudget Florida, serves eligible[81] persons with developmental disabilities. Eligible diagnoses include disorders or syndromes attributable to intellectual disability, cerebral palsy, autism, spina bifida, Down syndrome, Phelan-McDermid syndrome, or Prader-Willi syndrome. The disorder must manifest before the age of 18, and it must constitute a substantial handicap that can reasonably be expected to continue indefinitely.[82]

Unlike other Medicaid waiver programs, which are administered by the AHCA, APD administers the iBudget program. The iBudget program allocates available funding to clients, providing each one with an established budget with the flexibility to choose from the authorized array of services that best meet their individual needs within their community.[83] Individual waiver support coordinators assist each client with determination of his or her unique needs and the coordination of necessary providers to provide those services. Because the iBudget waiver program covers a limited number of people (based on the amount appropriated by the Legislature each year), APD maintains a preenrollment list, or waitlist, of people who would like to enroll in the iBudget waiver.[84]

As of January 5, 2026, there are 36,707 iBudget waiver enrollees.[85]

Adult Day Training

Adult day training (ADT) services support iBudget clients in valued routines of the community, such as volunteering, job exploration, accessing community resources, and self-advocacy. ADT programs take place in a nonresidential setting, separate from the home or facility where a client resides.[86]

ADT services can include meaningful day activities and training in the activities of daily living, adaptive skills, and employment. The training, activities, and routine established by the trainer must be meaningful to the recipient and provide an appropriate level of variation and interest. ADT services generally are offered for individuals age 22 and above, when a recipient is out of the public-school system.

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[79] Florida Developmental Disabilities Individual Budgeting Waiver (0867.R02.00), March 4, 2011, authorized under s. 1915b of the Social Security Act.
[80] The waiver also waives income eligibility requirements for the program, allowing the state to disregard household income and consider each waiver applicant as a 'family of one'.
[81] The HCBS wavier retains the Medicaid requirement that enrollees be low-income, but measures only the developmentally disabled person's income; not the income generated by the whole household.
[82] S. 393.063(11), F.S.
[83] *Id.*
[84] As of December 19, 2025, there were 17,433 individuals on the preenrollment list to receive services. *See* Agency for Persons with Disabilities, *Pre-Enrollment numbers by Priority Category and County, As of 12/19/2025,* available at https://apd.myflorida.com/publications/reports/docs/Preenrollment%20Website%20Reporting%2020251219.pdf (last visited May 28, 2026).
[85] Agency for Persons with Disabilities, *Home and Community Based Services (HCBS) Waiver Monthly Report for Waiver Enrollment Offers FY 2025-26* (January 2026), available at: APD Enrollment Report 2025-01-30.pdf (last visited May 28, 2026).
[86] S. 393.063(1), F.S.

As of February, 2026, there are 320 ADT programs licensed by APD.

Intellectual and Developmental Disabilities (IDD) Pilot Program

In 2023, the Legislature created the IDD Pilot Program in SMMC Region D (Hardee, Highlands, Hillsborough, Manatee and Polk counties) and Region I (Miami-Dade and Monroe counties).[87] This established a managed care model for integrating acute medical care, long-term care, and HCBS for persons with intellectual and developmental disabilities, as an alternative to the iBudget model. To obtain federal Medicaid funding for the IDD Pilot Program, Florida obtained a Medicaid waiver in April 2024.[88] The program is administered by AHCA.

Enrollees are allowed the opportunity to disenroll from the IDD Pilot Program and enroll in any appropriate existing Medicaid waiver program if any of the following conditions occur:

- At any point during the operation of the IDD Pilot Program, an enrollee declares an intent to voluntarily disenroll, provided that he or she has been covered for the entire previous plan year by the IDD Pilot Program;
- AHCA determines the enrollee has good cause to disenroll; or
- The IDD Pilot Program ceases to operate.

Benefits

Current law requires the following benefits for the pilot program, delivered through a single, integrated model of care:

- All the medical care benefits covered in the SMMC program, as described in s. 409.973, F.S., including access to prepaid dental plans;
- All the long-term care benefits covered in the SMMC program, as described in s. 409.98, F.S.; and
- All the HCBS covered in the iBudget program, as described in s. 393.066, F.S.

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

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

Step Into Success Program

The Legislature created the Step into Success Workforce Education and Internship Pilot Program within the DCF's Office of Continuing Care in 2023.[89] The program is intended to help eligible foster youth and former foster youth as they develop professional skills and prepare for an independent and successful future.[90]

Current foster youth who are older than 16 years of age but younger than 18 years of age are currently in licensed care, excluding Level I licensed placements, are eligible for the Step into Success program.[91] Former foster youth

[87] AHCA competitively procures plans in the SMMC program by region; there are nine SMMC regions. Agency for Health Care Administration, *New SMMC Regions*, available at https://ahca.myflorida.com/var/site/storage/images/0/1/0/4/164010-1-eng-US/f96e21c2155c-Florida_Regions_Map.png (last visited May 29, 2026).
[88] Florida Comprehensive Intellectual Developmental Disabilities Managed Care Pilot Program (2346.R00.00), April 1, 2024, authorized under s. 1915b of the Social Security Act.
[89] 2023-255, Laws of Fla.
[90] Florida Department of Children and Families, *Step into Success Pilot Program,* available at: https://www.myflfamilies.com/youth-young-adults (last visited May 28, 2026).
[91] 409.1455(3)(c), F.S.

who are 18 years of age but younger than 26 years of age who are currently in or were in licensed care, excluding Level I licensed placements, for at least 60 days, are also eligible for the program.[92]

To date, there have been three cohorts of the Step into Success Pilot Program, with over 30 eligible former foster youth beginning internships in the Tallahassee and Orlando areas.[93] The DCF engages with former foster youth to ascertain career fields they may be interested in. Subsequently, the DCF pairs the foster youth with a mentor that works in that career field, providing the foster youth with the opportunity to experience the career field they are interested in first-hand.

Eligibility

The Step into Success Pilot Program determines eligibility for the program by involvement in the foster care system. Each level of licensed foster care varies in service levels based on the foster child's needs for the out-of-home placement.

Independent Living Professionalism and Workforce Education Component

During the workforce education component of the Step into Success program, the Office of Continuing Care may provide participants with resources such as workshops, mock interviews, experiential training, and assistance with securing an internship or employment.[94] Such materials must include education on topics that include, but are not limited to, the following:

- Interview skills.
- Professionalism.
- Teamwork.
- Leadership.
- Problem solving.
- Conflict resolution in the workplace.[95]

Onsite Workforce Training Internship Component

Upon completion of the workforce education component of the program, eligible former foster youth may begin the workforce training internship. Participating individuals are paired with a mentor that has worked for the participating organization for at least one year and has completed a minimum of one hour of trauma-informed training to gain critical skills for successfully engaging former foster youth.[96] In the current cohorts, 100 percent of mentors reported they would mentor with the program again. Feedback suggested an increase in training requirements to better equip mentors with trauma-informed strategies for engaging with former foster youth.[97]

Additionally, mentors lead monthly performance reviews of the intern, to review his or her work product, professionalism, time management, communication style, and stress-management strategies. Mentors are eligible to receive a maximum payment of $1,200 per intern per fiscal year, issued as a $100 monthly payment for every month of service as a mentor. Employees may mentor three interns at one time, and may not receive more than $3,600 in compensation per fiscal year.[98]

Participating foster youth are required to intern for 80 hours per month to be eligible to receive the monthly stipend payment of $1,517.99 This stipend is not considered earned income for the purposes of computing eligibility for federal or state benefits; however, if an individual's benefits are reduced or lost due to receipt of such

[92] 409.1455(3)(b), F.S.
[93] December 3, 2025 E-mail from Chancer Teel, Legislative Affairs Director, the DCF (on file with the Senate Committee on Children, Families, and Elder Affairs).
[94] S. 409.1455(5), F.S.
[95] *Id.*
[96] S. 409.1455 (7), F.S.
[97] December 3, 2025 E-mail from Chancer Teel, Legislative Affairs Director, the DCF (on file with the Senate Committee on Children, Families, and Elder Affairs).
[98] *Id.*
[99] S. 409.1455(10), F.S. and Florida Department of Children and Families, *Step into Success Pilot Program,* available at: https://www.myflfamilies.com/youth-young-adults (last visited May 28, 2026).

stipend, the individual may receive an offset by an additional stipend equal to the value of the maximum benefit amount for a single person allowed under the Supplemental Nutrition Assistance Program ($298 monthly per a one-person household).[100] Interns may participate in the internship for no more than one year and receive 12 monthly stipends. A former foster youth may intern with multiple participating organizations, but not at the same time.[101]

Step into Success Program Successes

While a very new program, the Step into Success cohorts have shown positive employment outcomes for former foster youth who participated in the internship component. Through the program, participants have improved their professionalism, communication skills, time management strategies, and workplace adaptability – skills that employers repeatedly identify as essential for success.

In Cohort 1, the participants were able to secure internships with various organizations in fields such as music business, real estate, nursing, public health, culinary arts, graphic design, and law.
Some of the early reported wins are as follows:

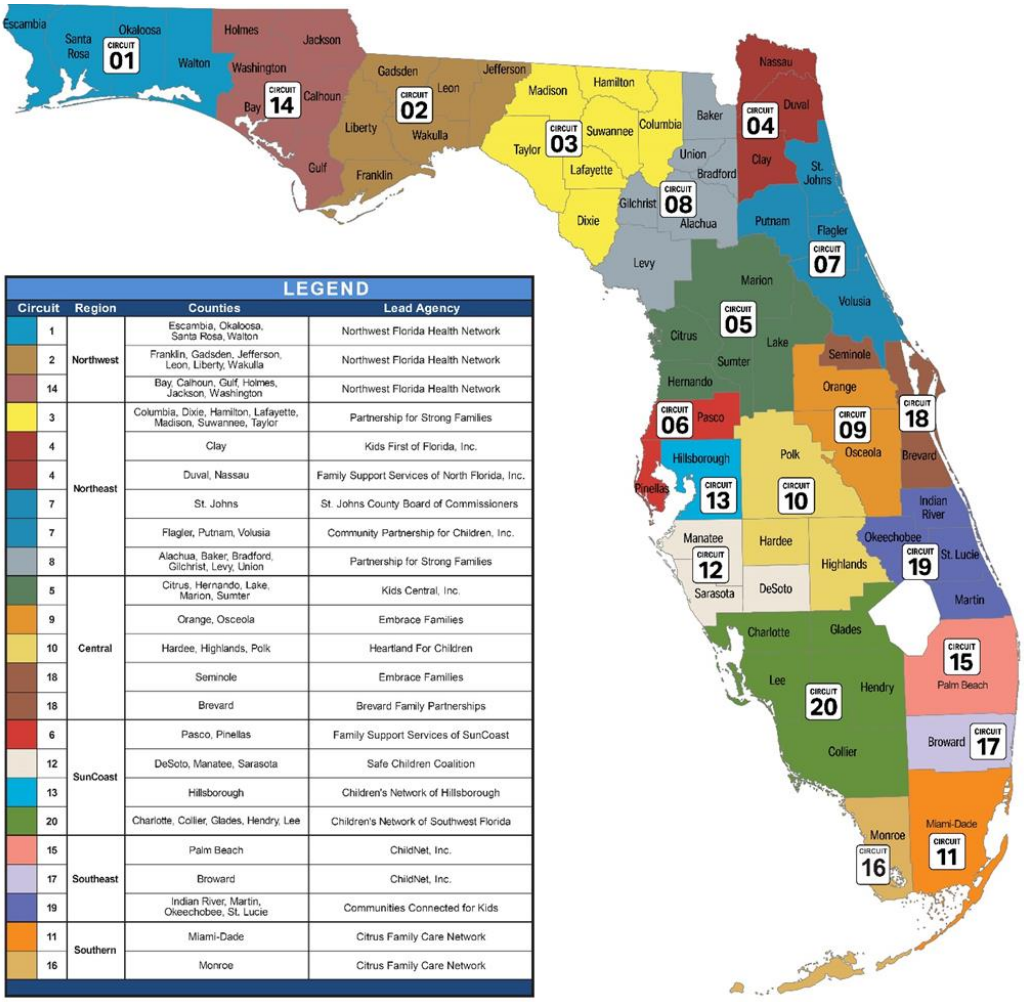
- 73 percent of participants in Cohort 1 completed more than 11 months in the internship;
- 53 percent of participants in Cohort 1 were offered employment at the completion of their internship, with a majority of those with the organization in which they interned;
- 100 percent of Cohort 1 mentors report they would recommend being a mentor to a co-worker or colleague, 67 percent of these mentors were mentoring a youth with child welfare lived experience for the first time;
- Participants have reported increased confidence and experience in the workplace.[102]

Community-Based Care (CBC) Lead Agencies

Florida's model for providing child welfare services is unique in the nation. No other state outsources its child welfare services to private organizations to the extent that Florida does. Accordingly, the performance of those private organizations – community based-care lead agencies (CBCs) – has great impact on the health, safety, and well-being of the thousands of children and families served by Florida's child welfare system. DCF's effective management and oversight of the CBCs is critical to the successful functioning of the child welfare system.

At present, there are 18 CBCs that each cover specific geographic areas within the 20 Judicial Circuits in Florida. The geographic size of the CBCs varies widely. While a few serve only one county, ranging from St. Johns County to Broward County, several CBCs cover multiple counties, with one CBC (Partnership for Strong Families) encompassing 13 rural counties. The following map illustrates DCF Regions, Judicial Circuits, and CBC geographic areas.[103]

[100] S. 409.1455(10)(d), F.S.; USDA Food and Nutrition Service, *SNAP Eligibility,* available at: https://www.fns.usda.gov/snap/recipient/eligibility (last visited May 28, 2026).
[101] S. 409.1455, F.S.
[102] December 3, 2025 E-mail from Chancer Teel, Legislative Affairs Director, the DCF (on file with the Senate Committee on Children, Families, and Elder Affairs).
[103] Florida Department of Children and Families, *A Comprehensive, Multi-Year Review of the Revenues, Expenditures, and Financial Position of All Community-Based Care Lead Agencies with System of Care Analysis*, p. 2 (Dec. 1, 2023) https://www.myflfamilies.com/services/child-family/lmr (last visited May 28, 2026).



LEGEND

Circuit	Region	Counties	Lead Agency
1	Northwest	Escambia, Okaloosa, Santa Rosa, Walton	Northwest Florida Health Network
2		Franklin, Gadsden, Jefferson, Leon, Liberty, Wakulla	Northwest Florida Health Network
14		Bay, Calhoun, Gulf, Holmes, Jackson, Washington	Northwest Florida Health Network
3	Northeast	Columbia, Dixie, Hamilton, Lafayette, Madison, Suwannee, Taylor	Partnership for Strong Families
4		Clay	Kids First of Florida, Inc.
4		Duval, Nassau	Family Support Services of North Florida, Inc.
7		St. Johns	St. Johns County Board of Commissioners
7		Flagler, Putnam, Volusia	Community Partnership for Children, Inc.
8		Alachua, Baker, Bradford, Gilchrist, Levy, Union	Partnership for Strong Families
5	Central	Citrus, Hernando, Lake, Marion, Sumter	Kids Central, Inc.
9		Orange, Osceola	Embrace Families
10		Hardee, Highlands, Polk	Heartland For Children
18		Seminole	Embrace Families
18		Brevard	Brevard Family Partnerships
6	SunCoast	Pasco, Pinellas	Family Support Services of SunCoast
12		DeSoto, Manatee, Sarasota	Safe Children Coalition
13		Hillsborough	Children's Network of Hillsborough
20		Charlotte, Collier, Glades, Hendry, Lee	Children's Network of Southwest Florida
15	Southeast	Palm Beach	ChildNet, Inc.
17		Broward	ChildNet, Inc.
19		Indian River, Martin, Okeechobee, St. Lucie	Communities Connected for Kids
11	Southern	Miami-Dade	Citrus Family Care Network
16		Monroe	Citrus Family Care Network

DCF competitively contracts with CBCs as required by chapters 287 and 409, F.S., to provide child protection and child welfare services. These contracts generally cover case management, out-of-home services, and related services. The outsourced provision of child welfare services is intended to increase local community ownership of service delivery and design. Current law requires the DCF procurement team for each CBC contract to include individuals from that CBC's circuit community alliance.[104] Established by DCF, community alliances catalyze community participation and local governance of community-based child protection and child welfare services.[105] Each community alliance may encompass more than one county when such arrangement is determined to provide for more effective representation.[106]

The CBCs, in turn, contract with a number of subcontractors for case management and direct care services to children and their families. DCF remains responsible for a number of child welfare functions, including operating the central abuse hotline, performing child protective investigations, and providing children's legal services. Ultimately, even with the community alliances, DCF is responsible for program oversight and the overall performance of the child welfare system. [107]

[104] S. 409.987(5), F.S.
[105] S. 20.19(5), F.S. Community alliances are composed of representatives from DCF, the county government, the school district, the county United Way, the county sheriff's office, the circuit court corresponding to the county, the county children's board (if one exists), and a faith-based organization involved in efforts to prevent child maltreatment, strengthen families, and promote adoption. Additional members may include state attorneys, public defenders, their designees, or individuals from funding organizations, community leaders or individuals who have knowledge of community-based service issues.
[106] S. 20.19(5)(a), F.S.
[107] S. 409.996, F.S.

CBCs may carry forward documented unexpended state funds from one fiscal year to the next; however, the cumulative amount carried forward may not exceed eight percent of the total contract. Any unexpended state funds in excess of that percentage must be returned to the DCF.[108]

Funds that are carried forward cannot be used to create ongoing future costs and cannot be used for any program or service that is not already authorized under the existing contract with the DCF. Any spending of carried-forward funds must be reported separately to the department. Any funds that remain unspent at the end of the contract period must be returned to the department. Carried-forward funds may continue to be retained through contract renewals or new procurements, provided the DCF keeps the same lead agency under contract.[109]

The contract periods for CBCs and managing entities are typically for five years. Unlike managing entities which are permitted to carry forward up to eight percent of the annual amount of their contract,[110] CBCs are allowed to carry forward up to eight percent of their total five-year contract amount. If a CBC has a negative balance at the end of a fiscal year, the CBC may take out a loan, or apply for risk pool funds,[111] or request an additional legislative appropriation of general revenue funds to the DCF on the CBC's behalf.

In-Home Preventative Services

If a DCF child protective investigator discovers impending danger[112] or present danger[113] to a child, he or she must implement a specific, sufficient, feasible, and sustainable safety plan.[114] DCF may activate in-home prevention services like parental coaching, family therapy, and cognitive-behavioral interventions to mitigate danger. If these services are successful, DCF prevents a home removal, a disrupted family, and a foster care placement.[115]

Temporary Shelter

At any time during the life of the safety plan, should DCF develop probable cause that a child cannot remain safely at home, current law authorizes DCF to take custody of the child. Within 24 hours of the home removal, DCF must file a petition for a shelter hearing.[116,117] DCF may temporarily shelter the child overnight with a relative or nonrelative or in a licensed home or facility.[118] At the shelter hearing, the court appoints guardian ad litem for the child.[119]

If the presiding judge agrees with the necessity of home removal and that in-home remedial services will not eliminate the necessity of out-of-home care, the judge will continue the child's shelter placement.[120] At the next scheduled hearing (i.e., disposition), the judge orders an out-of-home care placement for the child and, if necessary, the accompanying array of social and rehabilitative services.[121]

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[108] Section 409.990(5), F.S.
[109] *Id.*
[110] Section 394.9082(9)(a), F.S.
[111] Section 409.990(8)(a), F.S.
[112] "Impending danger" means a situation in which family behaviors, attitudes, motives, emotions, or situations pose a threat that may not be currently active but that can be anticipated to become active and to have severe effects on a child at any time. S. 39.01(38), F.S.
[113] "Present danger" means a significant and clearly observable family condition that is occurring at the current moment and is already endangering or threatening to endanger the child. Present danger threats are conspicuous and require that an immediate protective action be taken to ensure the child's safety. S. 39.01(69), F.S.
[114] S. 39.301(9)(a), F.S.
[115] S. 39.01(70), F.S.
[116] "Shelter hearing" means a hearing in which the court determines whether probable cause exists to keep a child in shelter status pending further investigation of the case. S. 39.01(82), F.S.
[117] Ss. 39.401(1), F.S., and 39.401(3), F.S. To establish probable cause, DCF must find evidence of: Past abuse, neglect or abandonment to the child; Present suffering of the child from illness or injury as a result of abuse, neglect, or abandonment; Imminent suffering of the child from illness or injury as a result of abuse, neglect, or abandonment; A material violation of the court's order of protective supervision (Ss. 39.01 (74), F.S. and, 39.521(3), F.S.) or out-of-home placement; The lack of an immediately known or available legal caregiver or kinship caregiver to provide care and supervision for the child.
[118] Ss. 39.01(81), F.S., and, 39.402(8)(a), F.S. DCF must determine the shelter placement according to the same standard as foster care placements – balance the child's best interests (*see* s. 39.01375, F.S.) against the statutory hierarchy of preferred placements (*see* s. 39.4021, F.S.).
[119] S. 39.402(8)(c), F.S.
[120] Ss. 39.402(2), F.S., and, 39.402(8)(h), F.S.
[121] S. 39.521(1)(a), F.S.

Out-of-Home Care Placements

Current law prioritizes out-of-home care placements that are the least restrictive, most family-like settings which are available in close proximity to the child's home and meets the child's needs.[122] Licensed foster care consists of a range of placements for children in out-of-home care that vary in service level. The following chart displays the levels of licensed care.[123]

Licensed Care Placements	
Placement Type	**Description**
Level I: Child-Specific Foster Home	Places a child with relatives or non-relatives who have an existing relationship with the child and are willing and able to provide care for the child.
Level II: Non-Child Specific Foster Home	Places a child with a foster parent without having a prior relationship between the child and foster parent.
Level III: Safe Foster Home for Victims of Human Trafficking	Places a victim of human trafficking in a safe and stable environment.
Level IV: Therapeutic Foster Home	Places a child with a foster parent that has received specialized training to care for children and adolescents that have significant emotional, behavioral, or social needs.
Level V: Medical Foster Home	Places a child with a foster parent with specialized training to care for children and adolescents with chronic medical conditions.
Group Homes	Places a child in a single family or multi-family community with no greater than 14 children to meet the physical, emotional, and social needs of the child.

Across all placement categories, DCF served an average of 14,634 children and young adults in out-of-home care per month in calendar year 2025. In calendar year 2024, the monthly average was 16,979, which means DCF served on average 13% less children and young adults per month in out-of-home care year-over-year.[124]

As of June 2025, DCF records a total bed capacity of license Levels I through V at 14,078. This is a decrease in total bed capacity of 19.4% from 2023 levels, where DCF recorded total bed capacity at 17,470 in January 2023.[125]

Relative and Nonrelative Caregivers

When determining a suitable out-of-home placement for a child, the department identifies that placing a child within his or her own family reduces the trauma of removal, reduces the risk of placement disruption, and enhances prospects for finding a permanent family if the child cannot return home.[126] Placing a child in the home of

[122] Ss. 39.4021, F.S., and, 39.523(1), F.S. The statutory hierarchy of preferred placements for a child, in descending order, is with the nonoffending parent, a relative caregiver, an adoptive parent of the child's sibling, fictive kin with a close existing relationship to the child, a nonrelative caregiver who lacks an existing relationship with the child, licensed foster care, and group or congregate care.
[123] S. 409.175, F.S.; The Department of Children and Families, *Foster Home Licensing,* https://www.myflfamilies.com/services/licensing/foster-care-licensing (last visited May 28, 2026).
[124] Office of Child and Family Well-Being, "Office of Child and Family Well-Being Dashboard: Monthly Trend," *Department of Children and Families*, (last updated Jan. 12, 2026) https://www.myflfamilies.com/ocfw-dashboard (last visited May 28, 2026). Select the box for "Children and Young Adults in Out-of-Home Care". On the next page, click the grid symbol in the upper right-hand corner. On the next page, add up data entries for January 2025 through December 2025 yields 175,614. Divide that figure by 12 to yield monthly average. Repeat for calendar year 2024.
[125] Department of Children and Families, "Placement in Out-of-Home Care Data: Percent and Count of Foster Home Bed Capacity by License Type and CBC Lead Agency," (last updated Jun. 2025) https://www.myflfamilies.com/services/child-family/placement-data (last visited May 28, 2026). Scroll down to "Percent and Count of Foster Home Bed Capacity by License Type and CBC Lead Agency" interactive graph chart. Note that bed capacity is highly concentrated in License Levels I and II.
[126] S. 39.4015, F.S.

a relative or fictive kin[127] is referred to as "kinship care" and is generally praised for improving the outcomes of children in out-of-home care.[128]

The DCF is required to engage in family finding to identify family and other close adults that may care for the child in his or her home, or provide a long-term emotional support network if the adult is not able to care for the child in his or her home.[129] Such family finding efforts must begin as soon as the child is taken into the custody of the department.[130]

As of December 31, 2025, there were 2,801 children and young adults placed with relatives, and 1,115 children and young adults placed with an approved nonrelative.[131]

Financial Support for Caregivers

To support caregivers as they care for children in out-of-home care, the state operates several programs to provide caregivers with financial assistance; the amount of financial assistance a caregiver receives is based on the type of caregiver, licensure, and the dependency status of the child.

Relative Caregiver Program

The Relative Caregiver Program (RCP) was established in 1998 and has been expanded[132] in recent years to recognize the importance of family relationships and provide additional placement options and incentives to help achieve permanency and stability for children who are otherwise at risk for foster care placement.[133]

Generally, the program provides RCP payments to relatives[134] who care full-time for a dependent child (and, in some circumstances, the dependent half-brother or half-sister of the dependent child) in the role of substitute parent as the result of a court's determination of child abuse, neglect, or abandonment, and the subsequent placement with the relative. Additionally, the program provides payments to nonrelatives who are willing to assume custody and care of a dependent child in the role of substitute parent as a result of the court's determination of child abuse, neglect, or abandonment and subsequent placement with the nonrelative caregiver.[135]

Relatives or nonrelatives who care for a child found to be dependent receive a monthly payment equal to the monthly room and board rate pursuant to s. 409.145(3), F.S. from the date the child is found to be dependent or from the date the child is placed with them in out-of-home care, whichever is later, for a period of no more than 6 months or until the child achieves permanency, whichever occurs first.[136]

Those participating in the RCP are not required to meet foster care licensing requirements.[137] However, if a relative or nonrelative has obtained licensure as a Level I foster parent, they receive the monthly room and board rates foster parents receive, even if the child has not been adjudicated dependent.[138] This payment extends from the date

[127] "Fictive kin" refers to a person unrelated by birth, marriage, or adoption who has an emotionally significant relationship, which possesses the characteristics of a family relationship, to a child. See S. 39.01(29), F.S.
[128] See S. 39.5086, F.S.; American Bar Association, Kinship Care is Better for Children and Families, available at: https://www.americanbar.org/groups/public_interest/child_law/resources/child_law_practiceonline/child_law_practice/vol-36/july-aug-2017/kinship-care-is-better-for-children-and-families/ (last visited May 28, 2026)
[129] S.39.4015, F.S.
[130] *Id.*
[131] Florida Department of Children and Families, Office of Child and Family Well-Being Dashboard, available at: https://www.myflfamilies.com/ocfw-dashboard (last visited May 28, 2026)
[132] Ch. 2024-68, Laws of Fla.
[133] Ch. 98-78, Laws of Fla.
[134] Referred to as within the fifth degree by blood or marriage to the parent or stepparent of the child. See S. 39.5085, F.S.
[135] S. 39.5085(2)(a), F.S.
[136] S. 39.5085(2)(d)2., F.S.
[137] S. 39.5085(2)(c), F.S.
[138] S. 39.5085(2)(d)1., F.S

the child is placed in out-of-home care with his or her relative or nonrelative until the child achieves permanency.[139]

Monthly Room and Board Rate

Level II through Level V licensed foster parents are eligible for the monthly room and board rate. Additionally, the room and board rate extends to the following individuals:[140]

- Relative and nonrelative caregivers licensed as a Level I Child-Specific Foster Placement; and
- Relative and nonrelative caregivers receiving RCP payments who:
  - Have a child placed with them in out-of-home care and have obtained licensure as a Child-specific level I foster placement, regardless of whether a court has found the child to be dependent; or
  - Relatives or nonrelatives who have a child found to be dependent placed with them in out-of-home care, regardless of whether the relatives or nonrelatives have obtained a child-specific level I foster license.

The monthly room and board rate is different based upon the age of the child in out-of-home care. All recipients of the room and board rates receive an annual cost of living increase each January, equal to the percentage change in the Consumer Price Index.[141] The following chart displays the room and board rate adjustments since 2022:

Room and Board Rate Increases 2022-2025				
Age Range	2022 Room and Board Rate	2023 Room and Board Rate	2024 Room and Board Rate	2025 Room and Board Rate
Ages 0-5 Years	$ 517.94	$ 551.61	$ 570.36	$ 586.90
Ages 6-12	$ 531.21	$ 565.74	$ 584.98	$ 601.94
Ages 13-21	$ 621.77	$ 622.19	$ 684.70	$ 704.56

[139] *Id.*
[140] S. 409.145(3), F.S.
[141] S. 409.145(3), F.S.