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 #: CS/CS/HB 1103	**COMPANION BILL:** None
TITLE: Services for Individuals with Developmental Disabilities	**LINKED BILLS:** None
SPONSOR(S): Kincart Jonsson	**RELATED BILLS:** CS/CS/SB 1050 (Bradley)

FINAL HOUSE FLOOR ACTION: 110 **Y's** 0 **N's** **GOVERNOR'S ACTION:** Approved

SUMMARY

Effect of the Bill:

CS/CS/HB 1103 expands the Intellectual Developmental Disabilities (IDD) Pilot Program in three phases. It requires individuals eligible for the IDD Pilot Program to make an affirmative choice before being enrolled and it prohibits the Agency for Health Care Administration (AHCA) from automatically enrolling them. The bill clarifies the roles of the Agency for Persons with Disabilities (APD) and AHCA in the IDD Pilot Program, emphasizing that AHCA is responsible for managing the program.

The bill also revises various AHCA and APD functions, including:

- Requiring individuals eligible to participate in the Statewide Medicaid Managed Care program to make an affirmative choice before being enrolled, and prohibiting AHCA from automatically enrolling them.
- Requiring APD to contract for a study of its iBudget allocation algorithm and submit a report by November 15, 2025.
- Requiring APD to publish reconciliation reports and the iBudget preenrollment list online.
- Mandating APD participation in transition planning activities with the Department of Children and Families for young adults with developmental disabilities who are also in the child welfare system.
- Establishing the Statewide Family Care Council to coordinate with existing Local Family Care Councils.

Fiscal or Economic Impact:

The bill has a significant recurring negative fiscal impact on AHCA to expand the IDD Pilot Program, and an insignificant fiscal impact on APD for administrative support of the new Statewide Family Care Council. See Fiscal or Economic Impact section.

JUMP TO SUMMARY ANALYSIS RELEVANT INFORMATION

ANALYSIS

EFFECT OF THE BILL:

Services for Persons with Developmental Disabilities

The bill expands the Intellectual Developmental Disabilities (IDD) Pilot Program in three phases. It also makes changes to Agency for Persons with Disabilities (APD) and Agency for Health Care Administration (AHCA) functions related to services for developmentally disabled individuals, including the iBudget Medicaid waiver program and the Statewide Medicaid Managed Care (SMMC) Program.

Statewide Medicaid Managed Care Program

The bill requires individuals on the iBudget waiver or who reside in an APD-licensed group home, who are eligible for voluntary enrollment into the Statewide Medicaid Managed Care (SMMC) program, to make an affirmative

choice before being enrolled. The bill also affirmatively prohibits AHCA from automatically enrolling them into the SMMC program. This provision also applies to other populations in the statutory voluntary enrollment list.[1]

Intellectual Developmental Disabilities Pilot Program

The IDD Pilot Program voluntary managed care initiative delivers comprehensive medical and home- and community-based services for up to 600 individuals on the APD preenrollment list living in one of two Medicaid regions. The bill expands the IDD Pilot Program in three phases:

1. To all individuals on the APD preenrollment list residing in Statewide Medicaid Managed Care Regions D or I immediately, eliminating the 600-member cap.
2. To all individuals on the APD preenrollment list, statewide, on October 1, 2025.
3. To all individuals with developmental disabilities enrolled in a Medicaid waiver program (iBudget or Medicaid Long-Term Care) on July 1, 2026.

The bill makes clear that enrollment into the IDD pilot is voluntary by requiring an individual to make an affirmative choice before being enrolled into the pilot program and prohibiting AHCA from automatically enrolling them.

The bill clarifies that AHCA in charge of managing the IDD Pilot Program, reducing unnecessary delays tied to APD's involvement, so that individuals and families who are interested in enrolling into the IDD Pilot Program may be enrolled more quickly. The bill requires APD to transmit weekly client data files of clients who are eligible for enrollment to AHCA. It requires AHCA to provide a call center to assist prospective enrollees and their families to learn about and enroll into the IDD Pilot Program and requires AHCA to coordinate with APD and DCF to develop partnerships with community-based organizations to disseminate information about the IDD Pilot Program to providers and potential enrollees. (Section 4)

iBudget Waiver

Funding Algorithm

The bill requires APD to contract for a study to review, evaluate, and identify recommendations regarding the algorithm used to determine the amount of funding each iBudget enrollee receives and report its findings and recommendations to the Governor and Legislature by November 15, 2025.

Developmental Disability Data Transparency

Currently, APD oversees home and community-based services (HCBS) for individuals with developmental disabilities, including the iBudget waiver program. Transparency in funding reconciliation and waitlist prioritization is limited.

The bill requires APD to publish its quarterly reconciliation reports on its website within five days of submitting the reports to the Governor and Legislature, and the current and total number of individuals in each preenrollment priority category, by county of residence, on its website, to be updated every five days. (Sections 1, 2)

Child Welfare Coordination

[1] These other groups are:
- Medicaid recipients who have other creditable health care coverage, excluding Medicare.
- Medicaid recipients residing in residential commitment facilities operated through the Department of Juvenile Justice or a treatment facility as defined in s. 394.455, F.S.
- Persons eligible for refugee assistance.
- Medicaid recipients who are residents of a developmental disability center, including Sunland Center in Marianna and Tacachale in Gainesville.
- Children receiving services in a prescribed pediatric extended care center.

Some developmentally disabled children are in the child welfare system. Current law requires the Department of Children and Families (DCF) and the Community-Based Care Lead Agencies (CBCs) to conduct transition plan and multi-disciplinary staffings for children who need both waiver and extended foster care services. APD is not currently required to participate in those meetings, resulting in the absence of a crucial coordination component.

The bill requires APD participation in DCF's transition planning for young adults with developmental disabilities in extended foster care or transitioning from the child welfare system to ensure that have access to all of the services they need. (Section 2)

Statewide and Local Family Care Councils

Local family care councils (FCCs) are councils located throughout the state that were created to educate and empower individuals with developmental disabilities and their families. The Local FCCs have existed since 1993, but lack a unified state level structure.

The bill establishes the Statewide Family Care Council (Statewide FCC) to connect local FCCs and facilitate direct communication between the local FCCs and APD. It directs the Statewide FCC to:

- Review policy proposals and program recommendations from the local FCCs.
- Advise APD on statewide policies, programs, and service delivery improvements based on the collective recommendations of the local councils.
- Identify systemic barriers to the delivery of services and recommend solutions to address those barriers.
- Foster collaboration and the sharing of best practices and resources among the local FCCs.
- Submit an annual report to the Governor, Legislature, and APD by December 1 of each year, which includes a summary of local FCC findings, recommendations, and an assessment of APD's actions in response to previous recommendations from the local FCCs.

The bill also makes changes to the existing local FCCs by tasking them to:

- Assist in providing information and coordinate outreach to individuals with developmental disabilities and their families.
- Convene family listening sessions to gather input on local service delivery challenges.
- Hold public forums every 6 months to solicit feedback on actions the local FCCs have taken.
- Share information with other local FCCs.
- Identify policy issues relevant to the community and family support system in the region.
- Submit annual reports to the Statewide FCC detailing proposed policy changes, program recommendations, and identified service delivery challenges with their region, by September 1 of each year.

The bill requires the Governor to make appointments to the Statewide FCC and local FCCs within 45 days of receiving a recommendation. If the Governor does not make an appointment to the Statewide FCC within 45 days, the bill allows the chair of the local council to appoint a member to act as the statewide council representative for that local FCC until the Governor makes the appointment. Similarly, if the Governor does not make an appointment to the local FCC within 45 days, the bill allows the local FCC, by majority vote, to select an interim appointment for each vacancy from the panel of candidates recommended by the family-led nominating committee.

To ensure that recommendations made by the local FCCs are addressed by APD, the bill requires APD to provide a written response to the Statewide FCC's annual report, including an action plan outlining steps taken or planned to address the local FCCs' recommendations. (Section 3)

The bill was approved by the Governor on June 9, 2025, ch. 2025-130, L.O.F., and will become effective on July 1, 2025. (Section 7)

FISCAL OR ECONOMIC IMPACT:

STATE GOVERNMENT:

The General Appropriations Act (GAA) for Fiscal Year 2025-2026 provides an increase in funding for the IDD Pilot Program to cover the cost of the increased enrollment authorized by the bill: $44,167,794 in recurring funds ($18,960,805 in state General Revenue and $22,206,989 in federal funds).[2] The average annual capitation payment per enrollee in the pilot program is $55,000, so this appropriation can fund approximately 806 additional enrollees in the pilot program. Additionally, the GAA provides $360,000 ($180,000 in General Revenue and $180,000 in federal funds) for AHCA to contract for the evaluation of the pilot program required by the bill.[3]

The GAA provides $500,000 from the General Revenue Fund and $500,000 from the Operations and Maintenance Trust Fund for APD to update the iBudget allocation algorithm. The GAA makes these funds contingent upon the passage of HB 1103, or similar legislation, becoming law.[4]

Providing administrative support for the new Statewide Family Care Council and participating in child welfare transition planning will have an insignificant fiscal impact on APD, absorbable within existing resources.

RELEVANT INFORMATION

SUBJECT OVERVIEW:

Agency for Persons with Disabilities

The Agency for Persons with Disabilities (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.[5]

Family Care Councils

In 1993, the Legislature established fifteen Family Care Councils (FCCs) which represent each service area of the Agency for Persons with Disabilities to advise the agency on the needs of self-advocates and their families. The primary functions of the local FCCs are to:

- Assist in providing information and outreach to families;
- Review the effectiveness of service programs and make recommendations with respect to program implementation;
- Advise the agency with respect to policy issues relevant to the community and family support system in the local area; and
- Meet and share information with other local family care councils.[6]

Each local FCC must have between 10 and 15 members. Members of each FCC must be recommended by a majority vote of the local FCC and then appointed by the Governor.[7]

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

[2] Conference Report on SB 2500, General Appropriations Act, Specific Appropriation 218 (2025).
[3] *Id*. at Specific Appropriation 190.
[4] *Id*. at Specific Appropriation 241.
[5] Agency for Persons with Disabilities, *About Us*, https://apd.myflorida.com/about/ (last visited March 24, 2025).
[6] S. 393.502(7), F.S.
[7] S. 393.502(2)(a), F.S.

by the Agency for Health Care Administration (AHCA) and financed by federal and state funds. AHCA delegates certain functions to other state agencies, including DCF, the Department of Health, APD, and the Department of Elderly Affairs.

The structure of each state's Medicaid program varies and what states must pay for is largely determined by the federal government, as a condition of receiving federal funds.[8] Federal law sets the amount, scope, and duration of services offered in the program, among other requirements. 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.[9] States can add benefits, with federal approval. Florida has added many optional benefits, including prescription drugs, adult dental services, and dialysis.[10]

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 (HHS) 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." Section 1115 of the Social Security Act allows states to implement demonstrations of innovative service delivery systems that improve care, increase efficiency, and reduce costs. These laws allow HHS to waive federal requirements to expand populations or services, or to try new ways of service delivery.

Florida operates under 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.[11] Florida also has a waiver under Sections 1915(b) and (c) of the Social Security Act to operate the SMMC Long-Term Care (LTC) program to provide long-term care services, including nursing facility and home and community-based services, to individuals age 65 and over and individuals age 18 and over who have a disability.[12]

The Florida Medicaid program covers over 4 million low-income individuals.

Statewide Medicaid Managed Care (SMMC) Program

Florida delivers medical assistance to most Medicaid recipients using a comprehensive managed care model, the SMMC program. The SMMC program was intended to provide comprehensive, coordinated benefits coverage to the Medicaid population, leveraging economic incentives to ensure provider participation and quality performance impossible under the former, federally prescribed, fee-for-service delivery model.

The SMMC program has three components: the integrated Managed Medical Assistance (MMA) program that provides primary care, acute care and behavioral health care services; the Long-Term Care (LTC) program[13] that provides long-term care services, including nursing facility and home and community-based services; and the dental component.

- MMA: provides Medicaid covered medical services like doctor visits, hospital care, prescribed drugs, mental health care, and transportation to these services.[14]
- LTC: provides Medicaid LTC services like care in a nursing facility, assisted living, or at home. To get LTC you must be at least 18 years old and meet nursing home level of care (or meet hospital level of care if you have Cystic Fibrosis).[15]

[8] Title 42 U.S.C. §§ 1396-1396w-5; Title 42 C.F.R. Part 430-456 (§§ 430.0-456.725) (2016).
[9] S. 409.905, F.S.
[10] S. 409.906, F.S.
[11] S. 409.964, F.S.
[12] *Id*.
[13] The LTC program provides services in two settings: nursing facilities or home and community-based services (HCBS) provided in a recipient's home, an assisted living facility, or an adult family care home. Enrollment in the LTC program is based on a clinical priority system and includes a wait list. The state is approved for 62,000 recipients in the HCBS portion of LTC. In order to be eligible for the program, a recipient must be both clinically eligible under s. 409.979, F.S., and financially eligible for Medicaid under s. 409.904, F.S.
[14] Agency for Health Care Administration, *Statewide Medicaid Managed Care, Health Plans and Programs*, available at https://flmedicaidmanagedcare.com/health/comparehealthplans (last visited Mar. 10, 2025).
[15] *Id*.

- Dental: provides all Medicaid dental services for children and adults. All individuals on Medicaid must enroll in a dental plan.[16]

Services in SMMC are delivered by two types of managed care plans: traditional managed care organizations and provider service networks (PSNs). Traditional managed care organizations, such as HMOs, are reimbursed as prepaid plans – they are risk-bearing entities that are paid capitated rates (prospective, per-member, per-month payments) by AHCA. PSNs are managed care plans controlled by health care providers, such as physician groups or hospitals. Because health care practitioners and facilities did not previously operate managed care plans or use capitated payment arrangements, SMMC allowed an alternative risk-bearing arrangement for PSNs.

AHCA contracts with managed care plans on a statewide and regional basis, in sufficient numbers to ensure choice. The cyclical Medicaid procurement process ensures plans offer competitive benefit designs and prices. In addition, plans compete for consumer choice: while Medicaid requires a basic benefit package, and regulates the adequacy of plans' provider networks, plans can add to their benefit packages and offer provider networks attractive to Medicaid recipients when choosing a plan.

The SMMC program includes extensive statutory and contract requirements for plan accountability, including network adequacy standards, financial accountability, provider compensation and prompt payment requirements, encounter data, program integrity, transparency, and performance metrics.[17]

Current law makes enrollment into the SMMC program voluntary for certain populations,[18] including developmentally disabled Medicaid recipients enrolled in the APD iBudget waiver or living in a group home licensed by APD. Those who do not choose to enroll in SMMC are served by the fee-for-service Medicaid delivery model.

However, beginning in early 2025, AHCA changed its policy and automatically enrolled APD clients into SMMC. Those individuals were permitted to "opt out" of managed care by contacting AHCA and expressing their desire to disenroll.[19]

Long-Term Care – Home and Community-Based Services

Federal Medicaid law establishes coverage for institutional care, such as nursing home care and residential institutions for people with developmental disabilities, but does not allow federal dollars to be spent on alternatives to such care. Those alternatives include home-based and community-based services designed to keep people in their homes and communities instead of going into an institution when they need higher levels of care. This federal spending limitation creates a bias toward institutional care, and toward acute care, rather than allowing the non-acute supports that prevent institutionalization.

Florida obtained a federal waiver to allow the state Medicaid program to cover other kinds of long-term care services for elders and people with disabilities, to prevent admission into a nursing home. Those non-institutional, often non-acute, long-term care benefits are listed below.

SMMC Long-Term Care Mandatory Benefits	
Services provided in an ALF	Physical therapy
Hospice services	Intermittent and skilled nursing
Adult day care	Medication administration
Personal care	Medication management

[16] *Id.*
[17] *See,* ss. 409.967, 409.975, 409.982, F.S.
[18] S. 409.972(1), F.S.
[19] *See* Florida Agency for Health Care Administration, *A Snapshot of Statewide Medicaid Managed Care 3.0*, available at https://ahca.myflorida.com/content/download/25049/file/SMMC_Snapshot.pdf (last visited Apr. 15, 2025); Florida Agency for Health Care Administration, *Statewide Medicaid Managed Care (SMMC) New Program Highlight: The Individual Budgeting (iBudget) Waiver*, available at https://ahca.myflorida.com/content/download/25042/file/SMMC%203.0_iBudget%20Program%20Highlight_09172024.pdf (last visited Apr. 15, 2025).

SMMC Long-Term Care Mandatory Benefits	
Home accessibility adaption	Medical equipment and supplies
Behavior management	Caregiver training
Home-delivered meals	Respite care
Case management	Personal emergency response system
Occupational therapy	Transportation
Speech therapy	Nutritional assessment and risk reduction
Respiratory therapy	

iBudget Home- and Community-Based Waiver for Persons with Developmental Disabilities

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.[20] 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.[21] 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[22] 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.[23]

Unlike other Medicaid waiver programs, which are administered by 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.[24] 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.

The waiver services are delivered through a fee-for-service delivery model, which means that providers are enrolled and reimbursed for services directly by the state agency, not a managed care plan. While providers and individual waiver support coordinators each have a role in helping the iBudget enrollee assess and coordinate their care, the program essentially operates with no comprehensive care management in the traditional sense. The HCBS services are not integrated with acute medical services or behavioral health services, which are administered separately by AHCA.

As of December 1, 2024, 35,640 individuals were enrolled in the iBudget waiver program.[25]

iBudget Allocation Algorithm

[20] Florida Developmental Disabilities Individual Budgeting Waiver (0867.R02.00), March 4, 2011, authorized under s. 1915b of the Social Security Act.
[21] 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'.
[22] The HCBS wavier retain 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.
[23] S. 393.063(11), F.S.
[24] *Id.*
[25] Agency for Persons with Disabilities, *Quarterly Report on Agency Services to Floridians with Developmental Disabilities and Their Costs, Second Quarter Fiscal Year 2024-25 (October, November, December)*, on file with the Human Services Subcommittee.

Each client's established budget is determined by application of the allocation algorithm, the mathematical formula based upon statistically validated relationships between individual characteristics (variables) and the client's level of need for services provided through the iBudget waiver.[26]

A client can request supplemental funding, in addition to that allocated through the algorithm, that if not provided would place the health and safety needs of the client, the client's caregiver, or public in serious jeopardy.[27] This supplemental funding, known as "Significant Additional Need" (SAN), is categorized as an extraordinary need, a significant need for one time or temporary support or services, or a significant increase in the need for services after the beginning of the service plan year, or a significant need for transportation services.[28]

APD may authorize additional funding based on one or more significant additional needs that cannot be accommodated within the funding determined by the algorithm and having no other resources, supports, or services available to meet the needs so long as the waiver support coordinator has documented the availability of all nonwaiver resources.[29] The process for approval of a SAN can take anywhere from 30 days to more than 60 days, if APD determines that it needs additional documentation to reach a decision.

The last time the algorithm was evaluated and updated was in 2015.[30]

iBudget Waiver Benefits

The iBudget Waiver provides the following home and community-based benefits:[31]

iBudget Home and Community-Based Benefits	
Adult day training services	Social services
Family care services	Specialized therapies
Guardian advocate referral services	Supported employment
Parent training	Supported living
Personal care services	Training, including behavioral analysis services
Recreation	Transportation
Residential facility services	Other habilitative and rehabilitative services as needed
Respite services	

iBudget waiver benefits also include Medicaid coverage for medical, non-HCBS services, administered by AHCA. The vast majority of Medicaid recipients receive services through the SMMC managed care model, in which the recipient can choose from different health plans – including HMOs and PSNs – to provide their care. However, under current law, using the managed care model is an option for iBudget enrollees; not a requirement. iBudget participants can opt to use the traditional fee-for-service model of service delivery.[32]

Because clinical services and home- and community-based services are provided by two different programs in two different state agencies, these services are not integrated or managed as a whole service for the individual.

iBudget Waiver Preenrollment List

[26] R. 65G-4.0213(1), F.A.C.
[27] S. 393.0662(1), F.S.
[28] R. 65G-4.0213(26), F.A.C.
[29] S. 393.0662(1)(b), F.S.
[30] *See* Florida Department of Financial Services, *Florida Accountability Contract Tracking System*, Agency for Persons with Disabilities, Purchase Order Title: FSU iBudget Statistics Consultation, available at https://facts.fldfs.com/Search/PurchaseOrderDetails.aspx?AgencyId=670000&PONo=AB56EF&Tab=1 (last visited April 28, 2025); *see also* Rule 65G-4-.0214, F.A.C.
[31] S. 393.066, F.S.
[32] S. 409.972(1)(e), F.S. AHCA policy is to enroll iBudget participants in managed care; enrollees may then choose to opt out.

Because the 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 waiver. As of December 1, 2024, 21,471 individuals were on the preenrollment list to receive services.[33]

As people leave the program or as new funding becomes available, APD is expected to enroll people from the preenrollment list in a statutory order of priority in seven categories, described below.[34]

Category	Description
1	Crisis, as defined by APD.

2	Individuals:
	• From the child welfare system with an open case who are either:
	  ○ Transitioning out of the child welfare system at the finalization of an adoption, a reunification with family members, a permanent placement with a relative, or a guardianship with a nonrelative; or
	  ○ At least 18 years but not yet 22 years of age and who need both waiver services and extended foster care services; or
	• 18-21 years old who chose not to remain in extended foster care.

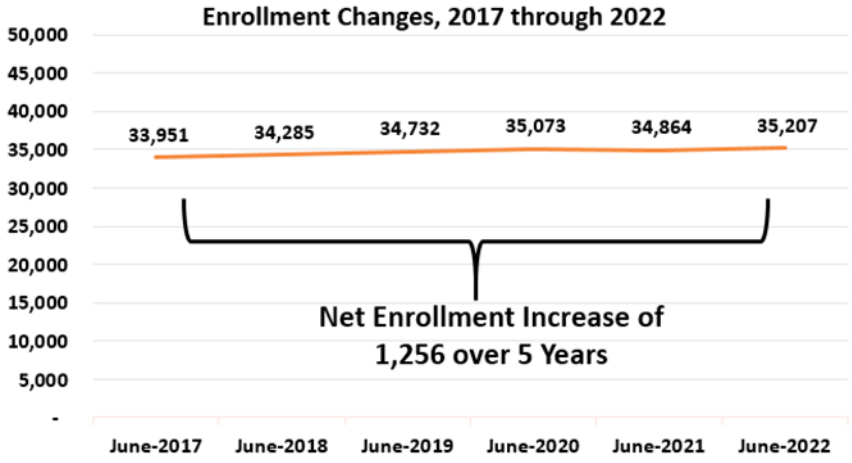
3	Individuals: • Whose caregiver has a documented condition that is expected to render the caregiver unable to provide care within the next 12 months and for whom a caregiver is required but no alternate caregiver is available; • At substantial risk of incarceration or court commitment without supports; • Whose documented behaviors or physical needs place them or their caregiver at risk of serious harm and other supports are not currently available to alleviate the situation; or • Who are identified as ready for discharge within the next year from a state mental health hospital or skilled nursing facility and who require a caregiver but for whom no caregiver is available or whose caregiver is unable to provide the care needed.
4	Individuals whose caregivers are 60 years of age or older and for whom a caregiver is required but no alternate caregiver is available.
5	Individuals expected to graduate from high school within the next 12 months who need support to obtain a meaningful day activity, maintain competitive employment, or attend postsecondary education.
6	Individuals age 21 or older who do not meet the criteria for Categories 1-5.
7	Individuals under age 21 who do not meet the criteria for Categories 1-4.

iBudget Waiver Enrollment Trends

Historically, despite the utilization management tools authorized in law and the entitlement flexibilities provided by the federal waiver, and despite legislative funding increases, APD has frequently been unable to manage the waiver program within the budget appropriated by the legislature, resulting in significant deficit spending. For example, the legislature made retroactive appropriations to address APD deficits that occurred in FY 17-18 ($56,895,137), FY 18-19 ($107,848,988), and FY 19-20 ($133,505,542). See Sections 30, 30, and 29, respectively, of the respective General Appropriations Acts in those years.

Despite this deficit spending, the legislature maintained its commitment to pulling people off the waitlist and appropriated additional funding for that purpose totaling $217,302,620 from 2017-2022. In that time, and despite deficit spending, there was only a minor increase in net enrollment, as indicated by the chart below.[35]

[33] Agency for Persons with Disabilities, *Quarterly Report on Agency Services to Floridians with Developmental Disabilities and Their Costs, Second Quarter Fiscal Year 2024-25 (October, November, December)*, on file with the Human Services Subcommittee.
[34] S. 393.065(5), F.S.
[35] Florida Community Care, presentation to the House Health and Human Services Subcommittee, February 11, 2025.

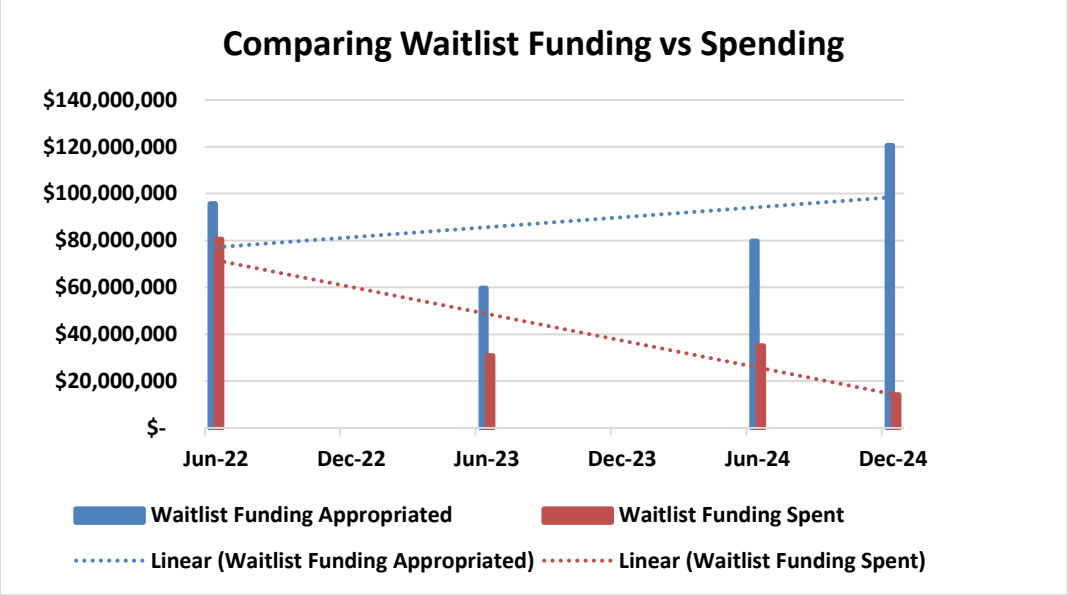


Conversely, in recent years APD moved to the other extreme. Now, APD stays within its annual appropriation but fails to spend significant amounts of its budget, even when directed by the legislature to enroll more people and reduce the preenrollment list. Instead, APD has been reverting appropriations back to the state, as indicated by the table below.

APD General Revenue Reversions FY 2019-20 – FY 2023-24	
Fiscal Year	**Amount Reverted (GR)**
2019-2020	$-11,287,781
2020-2021	$-983,836
2021-2022	$-39,567,230
2022-2023	$-59,135,133
2023-2024	$-73,676,927
TOTAL	$-184,650,907 GR $-246,877,270 Fed **$-431,528,177**

As noted above, APD is not spending the appropriations made by the legislature for pulling people off the preenrollment list and enrolling them in iBudget. The chart below compares recent funding increases to APD spending.[36]

[36] Data extracted from APD HCBS Surplus-Deficits Reports for this time period.



Specifically, in 2024 the legislature directed APD to enroll all the people on the preenrollment list from Categories 3, 4, and 5 – 400 people – and appropriated an additional $38.8 million for this purpose.[37] As of February 2025, APD has only enrolled 56 of those people, as illustrated by the following table. Some of those people went into crisis status before being enrolled.

Implementation of Directive to Enroll Categories 3-5 in Fiscal Year 2024-2025

	Status of Enrollment Group (7/1/24 – 2/1/25)	Category 3: Intensive Needs	Category 4: Caregiver over 60	Category 5: Transition from School	TOTALS
Row 1	**Individuals in Waitlist Categories 3-5 (June 2024)**	**198**	**158**	**44**	**400**
Row 2	Row 1 # Moved into iBudget	5	28	23	56
Row 3	Row 1 # APD Sent to AHCA for IDD Pilot Enrollment	0	0	0	0
Row 4	Row 1 # No Longer APD Clients	28	9	1	38
Row 5	Row 1 # No Longer on Waitlist (Crisis Enrollment, ICF Admission, Other)	3	13	9	25
Row 6	Row 1 # Still on the Waitlist	162	108	11	281

Current projections indicate APD will revert $ $32,676,653 (GR) of its FY 2024-25 appropriation.[38]

Preenrollment List Data and Quarterly Reconciliation Reports

In the past, APD published data on its preenrollment list, including numbers by category and region or county, on its website and updated it regularly. APD no longer posts this data on its website.

[37] Categories 1 and 2 are already prioritized by APD.
[38] APD HCBS Waiver Monthly Surplus-Deficit Report for Waiver Program Expenditures FY 2024-25, Feb. 2025, on file with the Human Services Subcommittee.

Section 393.0662 requires APD, in consultation with AHCA, to provide a quarterly reconciliation report of all home and community-based services waiver expenditures from AHCA's claims management system with service utilization from APD's Allocation, Budget and Contract Control system to the Governor and Legislature. APD does not post this report on its website.

Current law does not require APD to post any data concerning the preenrollment list or the quarterly reconciliation reports on its website.

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).[39] 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.[40] The program is administered by AHCA.

Eligibility

The IDD Pilot Program is available to individuals who:

- Are Medicaid-eligible and 18 years of age or older;
- Have been assigned to categories 1 through 6 on the iBudget preenrollment list; and
- Reside in a pilot program region.

The IDD Pilot is only available to people on the iBudget preenrollment list, not iBudget enrollees; and is not available statewide. This is a voluntary option for people in the pilot regions; there is no requirement to enroll in the pilot program.

Currently, enrollment is capped at 600 participants.

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.

[39] 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 March 24, 2025).
[40] Florida Comprehensive Intellectual Developmental Disabilities Managed Care Pilot Program (2346.R00.00), April 1, 2024, authorized under s. 1915b of the Social Security Act.

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.

Administration

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

Under the IDD Pilot Program, AHCA is responsible for:

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

Under the IDD Pilot Program, APD is responsible for:

- Approving a needs assessment methodology to determine functional, behavioral, and physical needs of prospective enrollees; and
- Providing a consultative resource for AHCA in the development of policy for the pilot program.

Implementation

In November 2023, AHCA issued an Invitation to Negotiate for each region participating in the IDD Pilot Program and awarded a contract to Florida Community Care (FCC), a SMMC Long-Term Care plan, in February 2024. In August 2024, APD began identifying individuals potentially eligible for enrollment.

Enrollment has increased, but slowly and irregularly. This appears to be due in part to the fact that communication regarding the program to people on the preenrollment list and their families is exclusively performed by APD, rather than AHCA or FCC. APD issued one mailing effort in August 2024 advising families of the new pilot option.[41] Families were required to fill out and mail back an interest form to APD; neither APD or AHCA provided an online method of expressing interest. APD then engaged in a process to contact the interested person to verify eligibility, obtain another federal form, and conduct an assessment of the person's needs. Only at that point would APD send AHCA information on the interested person; then AHCA sent FCC the enrollment file.[42]

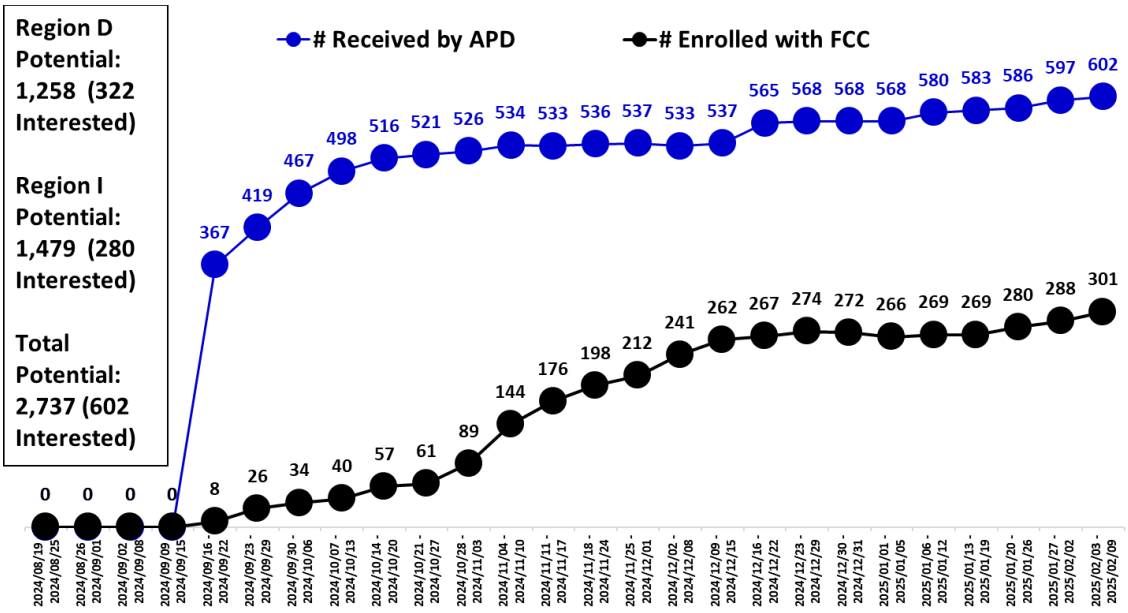
It appears that at no time did the person or their family receive one-on-one, specific information on the program or how it worked until FCC received the enrollment file. In addition, it appears that APD's August letter of interest form was the only point of initial communication; there is no periodic or repeated communication to eligible

[41] This correspondence also included information on the option to enroll in iBudget pursuant to the legislature's funding increase that year, which may have generated confusion.
[42] Florida Community Care, presentation to the House Health and Human Services Subcommittee, February 11, 2025.

persons about this option.[43] This is in contrast to the current method of enrollment in SMMC plans, which involves extensive online and mailed information, in addition to a call center.[44]

The assessment APD conducts for the prospective enrollee is the "Questionnaire for Situational Information" (QSI) authorized by s. 393.0662, F.S. APD conducts this assessment for iBudget enrollees based on its obligation to do so within the federal terms and conditions of the iBudget waiver approval.[45] However, the terms of the iBudget waiver do not govern the waiver for the IDD Pilot program. Under AHCA's contract with the plan, the assessment is to be done by the plan, and must be conducted within 5 days of enrollment. APD does not have a similar deadline, and it appears that waiting for APD to conduct the QSI has contributed to delays in enrollment.

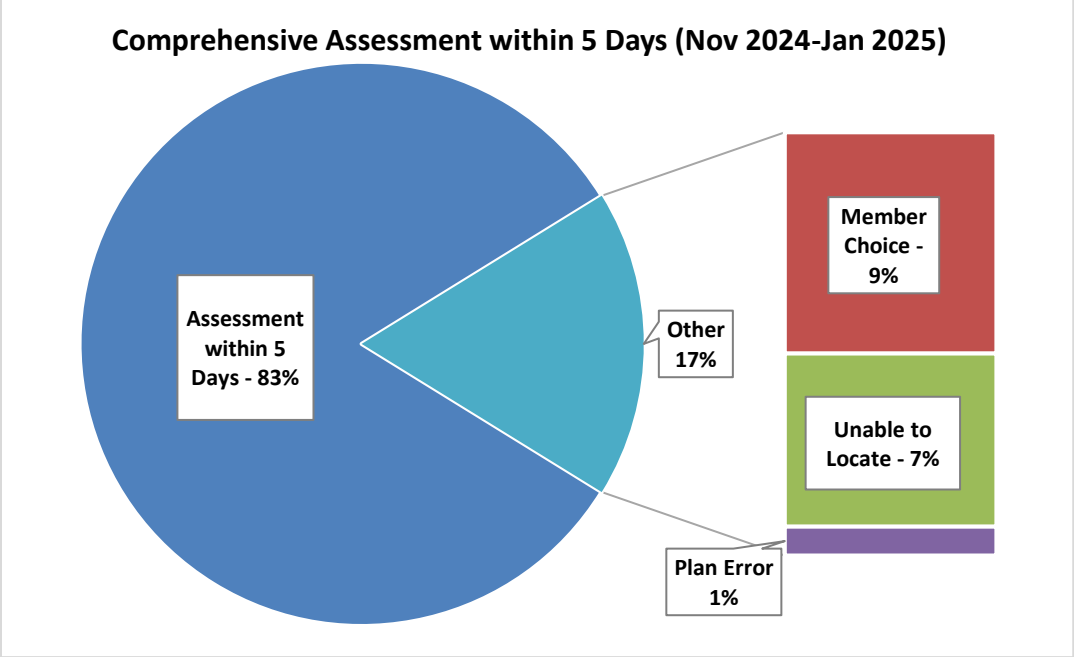
Since October, over 600 people have expressed interest in the pilot program; however, APD had sent files to AHCA on half that number by early February, as indicated by the graph below.[46]



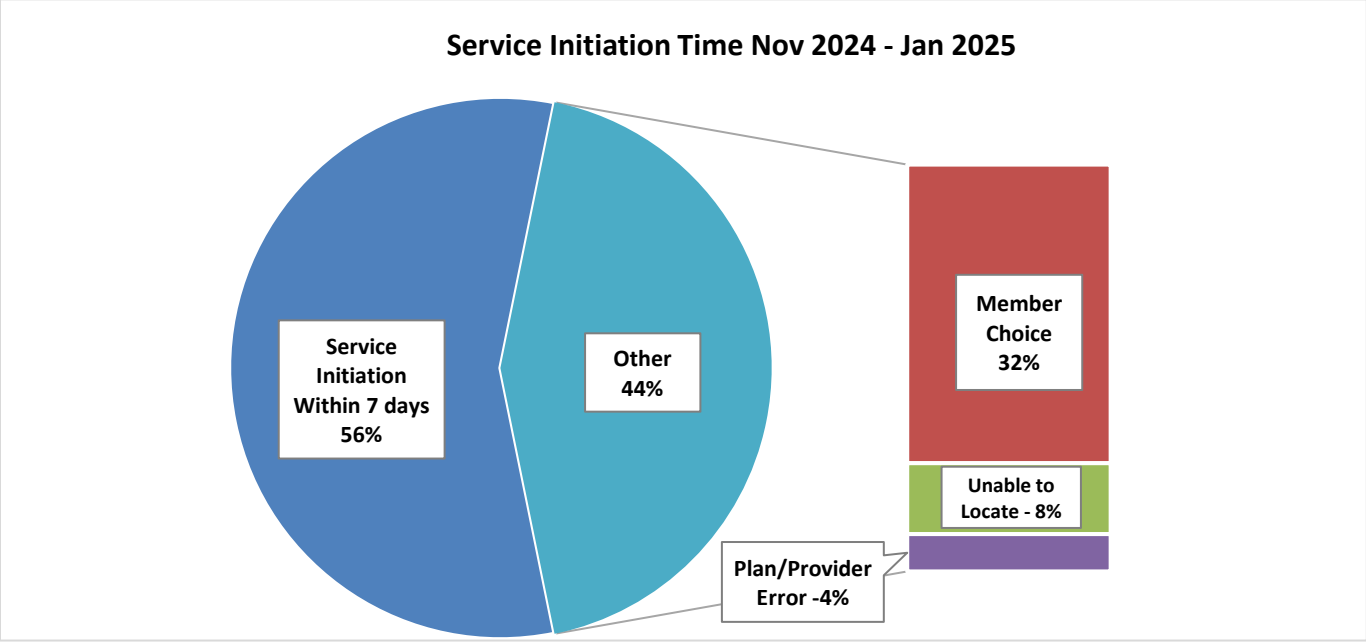
As of March 15, 2025, 364 individuals have enrolled in the IDD Pilot Program.

Once the individual is enrolled, FCC then conducts the comprehensive assessment required by its contract with AHCA and the federal terms and conditions for the pilot waiver approval. FCC data indicates 83 percent of enrollees receive this assessment within five days of enrollment, as indicated by the chart below.

[43] *Id.*
[44] *See, e.g.,* Agency for Health Care Administration, "Enrolling in A Health Plan", https://www.flmedicaidmanagedcare.com/health/enroll (last viewed March 24, 2025).
[45] Email from APD staff, March 10, 2025, on file with the Human Services Subcommittee.
[46] Florida Community Care, presentation to the House Health and Human Services Subcommittee, February 11, 2025.



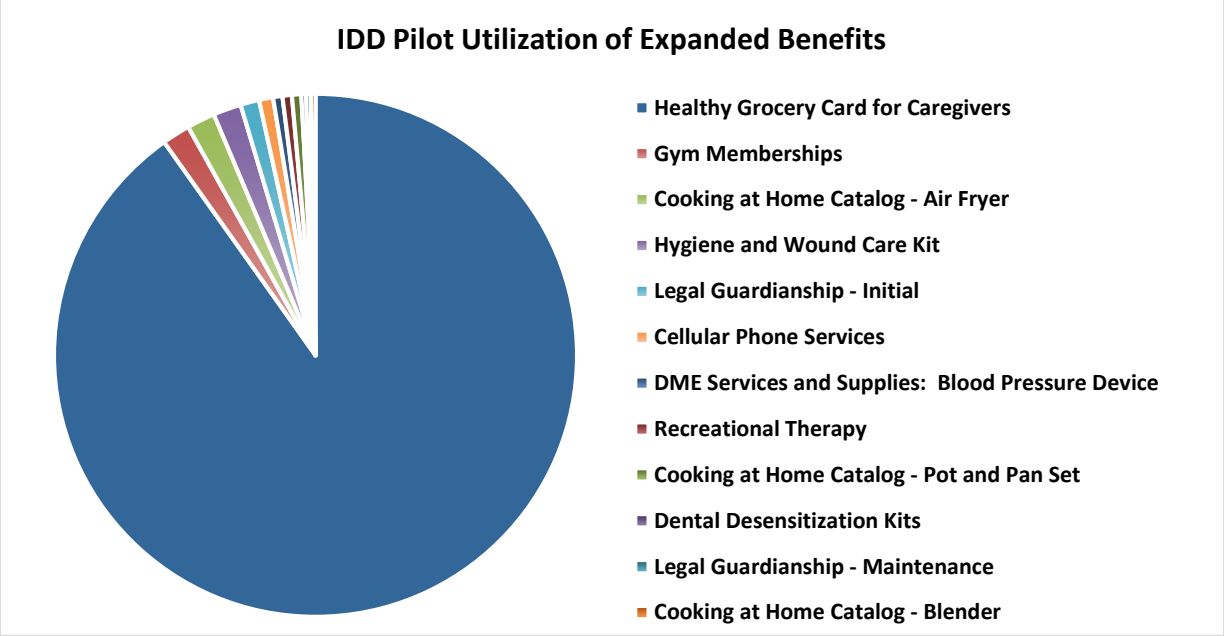
Once the assessment is complete, the plan can initiate services. FCC data indicates the plan initiates services for the enrollee within seven days of enrollment for 56 percent of enrollees. Notably, for both assessment and service initiation purposes, FCC is unable to locate the enrollee in seven percent of cases. This may point to flawed or out-of-date data transferred from APD.



Expanded Benefits

AHCA negotiated a significant array of expanded benefits in the pilot program, not offered under the iBudget waiver. In the time since enrollment began, FCC tracked expanded benefit use and provided data on the most commonly-used expanded benefits, as noted in the chart below.[47]

[47] FCC data on expanded benefits utilization, March 14, 2025.



Child Welfare Coordination

Transition Plans

Some children in out-of-home care do not receive a permanent placement and age out of the child welfare system. Current law requires DCF and the appropriate community-based care lead agency (CBC) to assist an older foster youth to develop a transition plan during the year after his or her 16th birthday. A transition plan targets the state's independent living programs to help older foster youth access housing, health insurance, financial literacy, a driver's license, workforce support, and employment services.[48] DCF must regularly review the transition plan, and the court must approve it before the youth's 18th birthday.[49]

Extended Foster Care

The permanency goal for a young adult who chooses to remain in care past his or her 18th birthday is to transition to independence. To this end, current law gives these young adults the option to remain in DCF care under judicial supervision as long as they participate in a qualifying self-sufficiency activity (e.g., pursuing a high school diploma, GED, postsecondary education, vocational education, workforce development programs, or maintaining employment for at least 80 hours a month). However, the young adult may be excused from the self-sufficiency activities if the young adult documents a physical, intellectual, emotional, or a psychiatric condition that limits the young adult's full-time participation.[50]

As long as the young adult remains in extended foster care, the CBC must provide regular case management reviews, which includes at least monthly face-to-face meetings with the case manager.[51] In addition, current law requires DCF or the appropriate CBC to convene a multidisciplinary staffing to discuss one or more important life decisions in a child's life which are so complex that they believe a multidisciplinary staffing is necessary to ensure the best interests of the child.[52]

Judicial Review of Extended Foster Care

[48] Ss. 39.6035, 409.14515, F.S.
[49] S. 39.6035(3)-(4), F.S.
[50] S. 39.6251(2)(e), F.S.
[51] S. 39.6251(7), F.S.
[52] S. 39.4022(5)(a), F.S. A multidisciplinary team is an integrated group of individuals which meet to collaboratively develop and attempt to reach a consensus decision on the most suitable out-of-home placement, educational placement, or other specified important life decision that is in the best interest of the child. s. 39.4022(2)(c), F.S.

While the young adult is in extended foster care, the dependency court retains jurisdiction over the young adult's case. The presiding judge must ensure that DCF and the CBC provide services and must coordinate with other agencies who are involved with implementing the young adult's case plan, individual education plan, and transition plan.[53] The court must review the status of the young adult at least every 6 months with a permanency review hearing at least annually.[54]

For each review hearing, DCF and the CBC must prepare and submit a case plan progress report to the judge and propose modifications to the court as necessary.[55] If the presiding judge believes that the young adult is entitled to additional services to achieve his or her case plan goals, the judge may order DCF to arrange for the provision of any identified services.[56]

For a young adult with developmental disabilities, extended foster care ends on his or her 22nd birthday, when the young adult achieves permanency, or when the young adult knowingly and voluntarily withdraws consent to participate in extended foster care.[57] However, DCF may not close the dependency case, and the dependency court may not terminate jurisdiction, until the young adult attends the final hearing (or offers informed written consent to waive right of personal appearance).[58]

RECENT LEGISLATION:

YEAR	BILL #	HOUSE SPONSOR(S)	SENATE SPONSOR	OTHER INFORMATION
2023	SB 2510	Appropriations	Appropriations	Became law on July 1, 2023.

[53] S. 39.6251(8), F.S.
[54] S. 39.6251(8), F.S., s. 39.701(4), F.S.
[55] S. 39.701(4)(a), F.S.
[56] S. 39.701(4)(d), F.S.
[57] S. 39.6251(5), F.S.
[58] S. 39.701(e), F.S.