FLORIDA HOUSE OF REPRESENTATIVES
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 1227	**COMPANION BILL:** None
TITLE: Medicaid Enrollment for Permanently Disabled Individuals	**LINKED BILLS:** None
SPONSOR(S): Tramont	**RELATED BILLS:** SB 7032

Committee References

Health Care Facilities & Systems	Health Care Budget	Health & Human Services
15 Y, 0 N, As CS	13 Y, 0 N	23 Y, 0 N, As CS

SUMMARY

Effect of the Bill:

The bill requires the Agency for Health Care Administration (AHCA) to seek federal approval to provide lifelong eligibility for Medicaid and other forms of public assistance for permanently disabled individuals receiving Medicaid covered institutional care services, hospice services, or home and community-based services through the iBudget Waiver program, or the Long-Term Care Waiver program. The bill requires such a permanently disabled Medicaid enrollee to notify AHCA and the Department of Children and Families (DCF) of any material change in disability or economic status that may result in Medicaid ineligibility. The bill authorizes DCF, upon such a notice, to conduct a redetermination of the individual's eligibility. The bill requires DCF to notify the individual prior to commencing a redetermination and to provide the results to the individual upon conclusion of a redetermination.

Fiscal or Economic Impact:

The bill will have a negative fiscal impact on DCF and AHCA.
(See Fiscal Impact on State Government Section)

JUMP TO SUMMARY ANALYSIS RELEVANT INFORMATION BILL HISTORY

ANALYSIS

EFFECT OF THE BILL:

Under current Florida laws and regulations governing the Florida Medicaid program, Medicaid recipients must undergo a Medicaid eligibility redetermination every 12 months, including permanently disabled recipients. Few members of this population ever become disqualified for exceeding income and asset limits because their permanent disability prevents them from receiving sufficient income through gainful employment.

The bill requires the Agency for Health Care Administration (AHCA) to seek federal approval, by October 1, 2025, to provide lifelong eligibility for permanently disabled Medicaid-qualified individuals receiving Medicaid covered:

- Institutional care services;
- Hospice services; or
- Home and community-based services in the iBudget waiver for persons with developmental disabilities or in the Long-Term Care (LTC) managed care program. (Section 1)

To qualify for lifelong eligibility the bill requires a permanently disabled individual to:

- Have an income at or below 88 percent of the federal poverty level and assets below established limitations;
- Be ineligible for Medicare, or if eligible for Medicare, also be eligible for and receiving Medicaid-covered institutional care services, hospice services, or home and community-based services; and
- Have their qualifying disability certified as being permanent by a licensed physician.

The bill requires an individual who is permanently disabled and presumed eligible for Medicaid to notify AHCA and the Department of Children and Families (DCF) of any material change in their disability or economic status that may result in their ineligibility from Medicaid. The bill authorizes DCF to conduct a redetermination of the individual's eligibility status. The bill requires DCF to notify the individual prior to commencing a redetermination and to provide the results to the individual upon conclusion of a redetermination. The bill requires AHCA and DCF to develop a process to facilitate such notification. (Section 1)

The bill provides an effective date of July 1, 2025. (Section 2)

FISCAL OR ECONOMIC IMPACT:

STATE GOVERNMENT:

The bill is expected to have a negative fiscal impact of $708,000 on DCF resulting from costs associated with updating their online Medicaid application platform.[1] Based on an analysis of the unreserved cash in DCF's trust funds, the costs to the department can be absorbed within existing resources.

AHCA will also have costs to make procedural and system updates, but they can be absorbed with existing resources. Additionally, AHCA expects the bill to have an indeterminate negative fiscal impact for the cost of coverage for any enrollees who would have been identified as ineligible, but for the bill's provisions.[2]

RELEVANT INFORMATION

SUBJECT OVERVIEW:

Florida Medicaid

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 AHCA and financed by federal and state funds.[3] AHCA delegates certain functions to other state agencies, including DCF, the Agency for Persons with Disabilities (APD), the Department of Health (DOH), and the Department of Elderly Affairs (DOEA).

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. 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.[4] States can add benefits, with federal approval. Florida has added many optional benefits, including prescription drugs, adult dental services, and dialysis.[5]

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.

[1] DCF, Agency Analysis of HB 1227 (March 17, 2025).
[2] AHCA, Agency Analysis of HB 1227 (March 4, 2025).
[3] Title 42 U.S.C. §§ 1396-1396w-5; Title 42 C.F.R. Part 430-456 (§§ 430.0-456.725) (2016).
[4] S. 409.905, F.S.
[5] S. 409.906, F.S.

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. Florida also has waivers under Sections 1915(b) and (c) of the Social Security Act to operate the SMMC Long-Term Care (LTC) program and the Development Disabilities Individual Budgeting (iBudget) Waiver.[6]

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- and community-based services (HCBS) 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.

Long-Term Care Home and Community-Based Services Program

Florida obtained a federal waiver to allow the state Medicaid program to cover HCBS long-term care services for elders and people with disabilities,[7] to prevent admission into a nursing home.

iBudget Home and Community-Based Services Waiver Program

AHCA oversees the Medicaid HCBS program for individuals with specified developmental disabilities through a federal waiver administered by APD, known as iBudget, the purpose of the waiver is to:[8]

- Promote and maintain the health and welfare of individuals with developmental disabilities;
- Provide medically necessary supports and services to delay or prevent institutionalization; and
- Foster the principles of self-determination as a foundation for services and supports.

The iBudget provides HCBS to eligible persons with developmental disabilities living at home or in a home-like setting. 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.[9]

The iBudget program allocates available funding to clients through an algorithm, providing each one an established budget with the flexibility to choose from the authorized array of services that best meet their individual needs within their community.[10]

Medicaid Eligibility

Medicaid eligibility in Florida is determined either by DCF or the Social Security Administration (SSA) for Supplemental Security Income (SSI) recipients. Since Medicaid is designed for low-income individuals, Medicaid eligibility is based on an evaluation of the individual's income and assets.

Section 1614(3) of the Social Security Act provides that an individual shall be considered to be disabled if they are unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months. Further, an individual under the age of 18 shall be considered disabled if that individual has a medically determinable physical or mental impairment, which results in marked and severe functional limitations, and which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.

---

[6] S. 409.964, F.S.
[7] S. 409.979, F.S. Individuals 65 years of age or older and in need of nursing facility level of care; or 18 years of age or older and eligible for Medicaid by reason of a disability and in need of nursing facility level of care.
[8] Florida Medicaid Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook, AHCA (May 2023), available at https://apd.myflorida.com/ibudget/docs/iBudget%20Handbook%20with%20ADT%20Redesign%20Final.pdf (last visited April 4, 2025).
[9] S. 393.063(11), F.S.
[10] S. 393.0662(1), F.S.

Under Florida's Medicaid State Plan, permanent and total disability is a physical or mental condition of major significance which is expected to continue throughout the lifetime of an individual and is not expected to be removed or substantially improved by medical treatment. It is expected to continue for a prolonged period of disability and the eventual prognosis may be indefinite. Total disability exists when the permanent impairment, or combination of permanent impairments, substantially precludes the individual from engaging in a useful occupation.

DCF uses the same criteria that the SSA uses to determine disability for benefits. If SSA determines an individual is disabled, DCF adopts their disability decision. If an individual does not have a disability decision from SSA, then DCF must obtain a disability determination based on the individual's circumstances.[11]

DOEA is responsible for conducting clinical level of care evaluations under the LTC Waiver, while APD is responsible for conducting clinical level of care evaluations under the iBudget Waiver. To be eligible for Medicaid under 1915(c) waivers, the individual must be determined to need the level of care provided by a hospital, nursing home, or intermediate care facility for the developmentally disabled.[12] The clinical level of care is determined during an initial evaluation and the individual must be reevaluated at least annually.[13]

Federal regulations require DCF make a redetermination of eligibility without requiring information from the individual if it is possible to make a redetermination based on reliable information contained in the individual's account or obtained from another state agency or federal agency.[14] If DCF is unable to verify the individual's eligibility, they send the recipient a renewal notice, electronically and by mail, requesting the required information to make an eligibility determination.[15]

Between April 2023 and February 2025, approximately 534 disabled individuals lost their Medicaid coverage[16] because they failed to provide information requested by DCF to make an eligibility determination.[17] The number of those individuals that would have still been eligible for Medicaid if they would have sent the requested information to DCF is unknown. Over that same period of time, approximately 3,357 disabled individuals lost their Medicaid coverage because they did not meet the income and asset eligibility requirements.[18]

[11] *Supra* note 1.
[12] 42 C.F.R., § 441.301(b).
[13] 42 C.F.R., § 441.302(c).
[14] 42 C.F.R., § 435.916.
[15] *Supra* note 1.
[16] Includes the following categories of Medicaid that cover disabled populations: Family Related Medicaid; Long-term Care Medicaid; HCBS Waiver Medicaid; Community Hospice Medicaid; and Medicaid for Aged and Disabled (MEDS-AD).
[17] *Supra* note 1.
[18] *Id.*

BILL HISTORY

COMMITTEE REFERENCE	ACTION	DATE	STAFF DIRECTOR/ POLICY CHIEF	ANALYSIS PREPARED BY
Health Care Facilities & Systems Subcommittee	15 Y, 0 N, As CS	3/27/2025	Calamas	Guzzo
THE CHANGES ADOPTED BY THE COMMITTEE:	• Specified that the bill applies to Medicaid recipients enrolled in a home and community-based services waiver program or the Long-Term Care managed care program. • Removed the 5-year limit on continuous enrollment for disabled individuals, making it a lifetime term of continuous enrollment. • Made the continuous enrollment apply unless information becomes available that conclusively documents a change in the person's disability or economic status that would affect eligibility.			
Health Care Budget Subcommittee	13 Y, 0 N	4/9/2025	Clark	Smith
Health & Human Services Committee	23 Y, 0 N, As CS	4/15/2025	Calamas	Guzzo
THE CHANGES ADOPTED BY THE COMMITTEE:	• Required an individual who is permanently disabled and presumed eligible for Medicaid to notify AHCA and DCF of any material change in their disability or economic status that may result in their ineligibility from Medicaid, and authorizes DCF to conduct a redetermination of the individual's eligibility and notify the individual of the results of the redetermination. • Provided a definition of "permanently disabled". • Required AHCA to seek federal approval by October 1, 2025, to exempt permanently disabled Medicaid recipients from annual redeterminations.			

THIS BILL ANALYSIS HAS BEEN UPDATED TO INCORPORATE ALL OF THE CHANGES DESCRIBED ABOVE.
