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 #: HB 5301 PCB HCB 26-01	**COMPANION BILL:** None
TITLE: Health Care	**LINKED BILLS:** None
SPONSOR(S): Health Care Budget Subcommittee, Andrade	**RELATED BILLS:** None

Committee References

Orig. Comm.: Health Care Budget
12 Y, 0 N

SUMMARY

Effect of the Bill:
The bill conforms statutes to the House proposed General Appropriations Act (GAA) for Fiscal Year 2026-2027, making several changes related to Health Care. Specifically, the bill:

- Eliminates the Health Care Innovation Council and the Revolving Loan Program within the Department of Health.
- Increases the nursing home prospective payment reimbursement methodology for the Quality Incentive Program Payment Pool from 10 percent of non-property funds to 15.2344 percent of non-property funds.
- Creates the Medicaid Eligibility Assistance Program for Persons with Disabilities within the Department of Children and Families.
- Requires funding to follow an individual who voluntarily transfers between the Home and Community-Based Services Waiver program and the Intellectual Developmental Disabilities Pilot Program.
- Requires AHCA to reimburse for long-acting injectable medications administered to Medicaid recipients with severe mental illness in an inpatient hospital setting, at an amount no less than the actual acquisition cost.
- Requires AHCA to re-procure contracts with Medicaid managed care plans every 8 years instead of every 6 years.
- Requires AHCA to establish a quality withhold incentive in each SMMC plan, with the sole metric being infant mortality.

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:

Health Care Innovation Council

The bill eliminates the Health Care Innovation Council, a 15-member council within the Department of Health (DOH), by repealing s. 381.4015, F.S.

Revolving Loan Program

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

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 from 10 percent to 15.2344 percent of the September 2016 non-property related payments of included facilities. (Section 2)

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.

Intellectual Developmental Disabilities Pilot Program

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 Agency for Persons with Disabilities and the Agency for Health Care Administration to reconcile the transfer amount quarterly, and authorizes the agencies to submit a budget amendment to transfer the funds.

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).

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 8 years instead of every 6 years, beginning with the contract procurement process initiated during the 2023 calendar year.

The bill also requires AHCA establish a quality withhold incentive within the current SMMC contracts, with the sole metric of the incentive being infant mortality. The agency is required to withhold two percent of each plans capitated rate each year. The plans will be able to earn a portion or all of the withhold back in the following ways:

- The plan that reduces its rate of infant mortality by the greatest amount compared to other plans shall earn the full two percent withhold.
- The plan that reduces its rate of infant mortality by the greatest number of lives compared to other plans shall earn back the full two percent withhold.
- Each other plan that reduces the rates of infant mortality shall earn back one percent of the withhold.
- For a plan that increases its rate of infant mortality, the agency shall suspend automatic assignment under ss. 409.977, F.S. and 409.98, F.S. for a period of 4 months.

Each plans performance is based on changes compared to the prior two years in the contract term. The agency is required to account for varying plan population sizes in the methodology for measuring performance for the quality withhold incentive, to achieve accurate comparisons of performance.

FISCAL OR ECONOMIC IMPACT:

STATE GOVERNMENT:

The proposed House General Appropriations Act (GAA) includes $82.4 million, of which $36.4 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 15.2344 percent of non-property funds, effective July 1, 2026.

The proposed House General Appropriations Act (GAA) contains provisions which will positively impact the General Revenue Fund due to the saving on the following appropriations:

- $1,000,000 for administering the Health Care Innovation Council.
- $50,000,000 per year over 10 years for the revolving loan fund.

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.

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.[1]

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 Agency for Health Care Administration and educational or clinical training providers in partnership with one of the entities, may apply for a loan.[2] 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.

[1] DOH, *Florida Health Care Innovation Council Annual Report December 1, 2025,* pg. 2, On File with Health Care Budget Subcommittee
[2] The entities licensed, registered, or certified pursuant to s. 408.802, except for subsections (1), (3), (13), (23), and (25) of the sections, are eligible to apply.

Eligibility
Current law authorizes different types of health care entities licensed, registered, or certified by the Agency for Health Care Administration (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 department may not 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, and
- 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. The council anticipates announcing the first loan awards in early 2026, with projects beginning implementation shortly thereafter.[3]

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 department 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.

[3] DOH, *Florida Health Care Innovation Council Annual Report December 1, 2025,* pg. 8, On File with Health Care Budget Subcommittee

Nursing Prospective Payment System

Background

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[4] 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.[5]

The Quality Incentive Payment calculation[6] 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.[7]

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.[8] The change is only valid for the fiscal year, and will revert back to 10 percent on July 1, 2026.

Medicaid Eligibility Assistance 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.

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.

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.

The bill creates section 409.9207, Florida Statutes, establishing the Medicaid Eligibility Assistance for Persons with Disabilities Program within DCF to provide information, referral, and navigation services to assist persons with

[4] 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
[5] R. 59G-6.010(2)(y), F.A.C.
[6] *Id.*
[7] S. 409.908(2)(e), F.S.
[8] Ch. 25-199, Laws of Fla.

disabilities in initiating and completing actions necessary to secure Medicaid eligibility and access other community-based support programs that enable individuals to remain in their homes and communities.

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 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.[9]

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.[10]
- Clinician discomfort with administering injections.[11]
- 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.[12]

LAI are more widely available for treating schizophrenia, with some also available for bipolar disorder or opioid use disorder.[13] However, a 2019 study indicated that only about 10% of patients with schizophrenia were taking LAI's.[14]

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 Agency for Health Care Administration (AHCA) and financed by federal and state funds. AHCA delegates certain functions to other state agencies, including the Department of Children and Families, 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.[15] 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

[9] 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 Feb. 10, 2026).
[10] 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 Feb. 10, 2026).
[11] 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 Feb. 10, 2026).
[12] *Id.*
[13] *Id.*
[14] Schwartz, *supra* note 91.
[15] Title 42 U.S.C. §§ 1396-1396w-5; Title 42 C.F.R. Part 430-456 (§§ 430.0-456.725) (2016).

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.[16] States can add benefits, with federal approval. Florida has added many optional benefits, including prescription drugs, ambulatory surgical center services, and dialysis.[17]

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

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.[18]

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.[19] 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.[20] 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.[21]

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).[22] This established a managed care

[16] S. 409.905, F.S.
[17] S. 409.906, F.S.
[18] 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).
[19] S. 409.964, F.S.
[20] 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).
[21] 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).
[22] AHCA competitively procures plans in the SMMC program by region; there are nine SMMC regions.

model for integrating medical 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.[23]

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 available statewide. Beginning in July 2026, the IDD Pilot Program expands to allow enrollment to all individuals with Developmental Disabilities enrolled in either the individual budget waiver services program (iBudget Waiver) or in the long-term care managed care program.

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.
- 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.

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.

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

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.
- Providing a consultative resource for AHCA in the development of policy for the pilot program.

BILL HISTORY

COMMITTEE REFERENCE	ACTION	DATE	STAFF DIRECTOR/ POLICY CHIEF	ANALYSIS PREPARED BY
Orig. Comm.: Health Care Budget Subcommittee	12 Y, 0 N	2/16/2026	Clark	Day