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OVERVIEW OF MEDICAID MANAGED CARE PROGRAMS IN FLORIDA

Statement of the Issue

Florida Medicaid beneficiaries receive services through several different delivery systems, including a number of managed care systems, each with a different level of care coordination and parameters. In the Florida Medicaid program, over 66 percent of beneficiaries are currently enrolled in some form of managed care program for primary and acute care services. Florida has authorized at least 15 different managed care models, including primary care case management (PCCM), provider service networks (PSNs), health maintenance organizations (HMOs), minority physician networks (MPNs), prepaid behavioral health plans (PBHPs), prepaid dental plans (PDHPs), the nursing home diversion (NHD) waiver, and pediatric emergency room (ER) diversion programs. Some managed care models are designed to deliver comprehensive care while others are limited to specialty care. Florida operates several of its Medicaid managed care programs through a section 1915(b) waiver obtained from the federal Centers for Medicare and Medicaid Services in 1991. The Medicaid Reform demonstration project operates under a federal section 1115 waiver. Florida's Agency for Health Care Administration (Agency) is responsible for administering these managed care programs, sometimes in conjunction with other state agencies.

Discussion

Background

Managed care in the state Medicaid program began in 1982 when the Palm Beach County Public Health Unit began operating the first Medicaid managed care plan. In 1984 Florida was selected as one of five states to receive a 1915(b) waiver from what is now the federal Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), to implement a program to create a statewide, mandatory managed care system to provide for more efficient and effective service delivery that would enhance quality of care in parts of the state for certain eligibility groups.

Managed Care Eligibility

Currently, about 76 percent of Florida Medicaid beneficiaries statewide are required to choose some form of managed care for primary and acute care services within 30 days of becoming Medicaid eligible. Such beneficiaries are commonly known as "mandatories." Certain Florida Medicaid beneficiaries are not eligible for managed care by state and/or federal law, such as patients receiving care in institutional settings, patients enrolled in the Medically Needy program, and patients receiving hospice care, and are commonly known as "excluded." Other Medicaid beneficiaries are not required to enroll in managed care but may voluntarily choose managed care, such as certain pregnant women and individuals eligible for both Medicare and Medicaid, and are commonly known as "voluntaries."

As of October 1, 2010, 10.4 percent of the state's total Medicaid population consisted of beneficiaries who were required to enroll in managed care but were within their first 30 days of eligibility and had yet to choose a managed care option.

Managed Care Payment Methods

Florida Medicaid uses two main methods of payment within managed care. When services are delivered to beneficiaries and billed to the state on an individual or itemized basis, payment is made via "fee-for-service" (FFS), i.e. payment is made for each service after the service has been rendered and the state has been billed. Conversely, the state also contracts to make payments on a prepaid basis, which results in a fixed, lump-sum payment per beneficiary, typically

made on a monthly basis, designed to cover services needed in the aggregate for any given month in a 12-month period. Such a fixed, prepayment is known as a “capitation.” Managed care plans that provide for services on a prepaid, capitated basis agree to accept the capitation payment and assume financial risk for delivering all covered services, regardless of whether the capitation fully covers the cost for all services that need to be provided. Capitated entities sometimes assume full risk, i.e. the coverage is comprehensive with no mitigation factors for the risk assumed, and others assume partial risk, i.e. the coverage is limited as opposed to comprehensive and/or the risk may be mitigated by loss prevention or shared-savings arrangements. Capitation is designed to provide the state with less risk and more predictability for Medicaid spending and to incent the capitated entities to manage the provision of services in a cost-effective manner.

The Agency is charged by statute with developing capitation rates for managed care plans by administrative rule.¹ The rule is designed to represent a discount from what the state would otherwise pay for the same services provided to comparable populations on a fee-for-service basis. Capitation rates must be certified as actuarially sound by a third-party actuary in compliance with federal guidelines.

MediPass

The Medicaid Provider Access System (MediPass)² is a managed care program consisting of a primary care case management (PCCM) system established in 1991. MediPass is available statewide to all beneficiaries who are eligible for managed care except for most beneficiaries in Medicaid Reform counties.³ MediPass was designed to provide Medicaid beneficiaries with coordinated primary care while decreasing the inappropriate utilization of medical services. The state contracts with a health care provider – usually the beneficiary’s primary care physician (PCP) – to provide basic care and to coordinate any needed specialty care or other services furnished by other physicians or providers. The MediPass PCP is paid a case management fee per person per month, and the PCP’s services, as well as services from other providers, are paid for by the state on a fee-for-service basis. The PCPs are expected to monitor the appropriateness of health care provided to their patients. MediPass is managed care but is administered at the individual provider level, not by a managed care organization or managed care plan.

The Agency has contracted with disease management organizations to provide disease management services to MediPass-enrolled beneficiaries living with certain diseases.⁴

All of the following services must be made available to enrolled MediPass beneficiaries, either through the MediPass PCP or by referral to another Medicaid provider:

- Physician services (includes services rendered by a licensed physician, advanced registered nurse practitioner, physician assistant, podiatrist, chiropractor, ambulatory surgical center, rural health clinic, federally qualified health center, birthing center, and county health department clinic.)
- Child health check-up services
- Durable medical equipment and medical supplies
- Home health services
- Hospital inpatient services
- Hospital outpatient services
- Laboratory services
- Licensed midwife services
- Prescribed drug services
- X-ray services including portable x-rays services
- Therapy services (occupational, physical, speech, respiratory)

As of October 1, 2010, there were 594,409 Medicaid beneficiaries enrolled in the MediPass program, representing 20.9 percent of the total Medicaid program.⁵

¹ See s. 409.9124, F.S.

² See s. 409.9121, F.S.

³ The Medicaid Reform pilot project, authorized under s. 409.91211, F.S., is currently in operation in Broward, Duval, Nassau, Baker, and Clay counties.

⁴ See <http://ahca.myflorida.com/Medicaid/Disease_Management/>, (Last visited on November 12, 2010).

Provider Service Networks

A provider service network (PSN) in the Medicaid program is a managed care plan that is majority-owned and operated by Florida health care providers, such as hospitals, physician groups, and/or federally qualified health centers. The PSN program began in 1997 when the Legislature authorized the Florida Medicaid program to establish a Medicaid PSN demonstration project to capitalize on high-volume Medicaid providers and their ability to manage the medical care of Medicaid beneficiaries they serve. The first Medicaid PSN became operational by 2000.

The initial PSN contract was awarded by competitive bid. The Agency currently awards PSN contracts based on an open application process, meaning the Agency will offer a PSN contract to every applicant that applies for and meets the state's standards for a Medicaid PSN contract. There are currently six Medicaid PSNs statewide,⁶ operating in 12 counties. The Agency is authorized to pay PSNs a capitation if the PSN chooses to assume financial risk, or services rendered to PSN members may be paid on a fee-for-service basis. Fee-for-service PSNs are paid monthly primary care case management fees, as well as administrative allocations per member. Florida Statutes direct the Agency to conduct periodic financial reconciliations to determine cost-savings. PSNs in the Medicaid program are required to demonstrate cost effectiveness.⁷ If cost savings do not occur, the PSN may be required to refund a portion of the payment it receives through its monthly administrative allocations.

As of October 1, 2010, 180,859 Medicaid beneficiaries were enrolled in PSNs statewide and represented 6.36 percent of the total Medicaid program. Of the total Medicaid beneficiaries served by PSNs, 56,737 were members of capitated PSNs while 124,122 PSN members were covered via fee-for-service.⁸

Health Maintenance Organizations

The Agency is authorized to contract with health maintenance organizations (HMOs) for the provision of services to Medicaid beneficiaries. Medicaid HMOs are required to be licensed by the Office of Insurance Regulation (OIR) under ch. 641, F.S.⁹ The Agency typically contracts with HMOs in an open application process for the provision of comprehensive health coverage to Medicaid beneficiaries who become HMO members. HMOs are paid a fixed capitation to assume full financial risk for delivering a set of comprehensive primary and acute care services. HMOs are expected to employ managed care principles in order to achieve cost effectiveness and to eliminate overutilization, fraud, and abuse, while providing for all covered, medically necessary services. Like commercial HMOs, Medicaid HMOs are subject to regulations and solvency standards required by OIR for HMO licensure.

Medicaid HMOs contracted for comprehensive care must provide the following services:

- Physician services (includes services rendered by a licensed physician, psychiatrist, advanced registered nurse practitioner, physician assistant, podiatrist, chiropractor, ambulatory surgical center, rural health clinic, federally qualified health center, birthing center, and county health department clinic)
- Hospital services (inpatient, outpatient, and emergency services)
- Prescribed drug services
- Child Health check-up services
- Dialysis services in a freestanding center
- Durable medical equipment and medical supplies
- Family planning services
- Hearing services
- Home health services
- Laboratory services, including independent laboratory services

⁵ Medicaid Enrollment by Program Type, as of October 1, 2010, published by the Agency, available at: <http://ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/med_data.shtml>, (Last visited on November 12, 2010).

⁶ List of Florida Medicaid Provider Services Networks, as of July 12, 2010, published by the Agency, available at: <http://ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/docs/MCAID/LIST_MEDICAID_PSNs.pdf>, (Last visited on November 12, 2010).

⁷ See s. 409.912(44), F.S.

⁸ Ibid, 5.

⁹ See s. 409.912(3), F.S.

- Community mental health and behavioral targeted case management services
- Therapy services
- Vision services
- X-ray services

Quality Enhancement programs include, but are not limited to, the following:

- Children's Programs Domestic Violence
- Pregnancy Prevention
- Prenatal/Postpartum Pregnancy Programs
- Smoking Cessation
- Substance Abuse

There are currently 18 full-risk Medicaid HMOs¹⁰ operating in 33 counties. As of October 1, 2010, these HMOs served 1,076,567 Medicaid beneficiaries statewide and represented 37.85 percent of the total Medicaid program.¹¹

Minority Physician Networks

In 2003, the Agency established agreements with two physician-owned minority physician networks (MPNs)¹² composed mostly of physicians representing racial minorities. MPNs provide primary care case management services. In addition, the MPNs are responsible for supporting the primary care case managers by providing administrative and utilization management services as a means of containing cost and enhancing the quality of care. The MPN financial structure is fee-for-service, based upon a shared-savings arrangement with an advanced monthly case management fee of \$12. MPNs are eligible to receive a portion of savings that are achieved, but a percentage of the administrative fee is required to be returned to the Agency if no savings are achieved.

As of October 1, 2010, 29,458 Medicaid beneficiaries were enrolled in MPNs and represented 1.04 percent of the total Medicaid program.¹³ Both of Florida's MPNs have recently been acquired or have entered into acquisition agreements with two health maintenance organizations. MPN enrollees have been transitioning into HMO membership during 2009 and 2010, and the target date for the transition to be complete is November 30, 2010.

Pediatric Emergency Room Diversion

In 2002, the Agency established agreements with pediatric ER diversion programs as an alternative managed care option in Broward County. In subsequent years ER diversion programs expanded to a few counties in Central and North Florida but were primarily focused in South Florida. These PCCM programs were designed to manage patient care and ensure adequate access to primary care, reduce inappropriate utilization of emergency services, control program costs, and improve health outcomes. ER diversion primary care providers are paid a monthly fee for case management services while the Medicaid program pays for health care services on a fee-for-service basis. In addition, ER diversion programs are eligible to receive a portion of shared savings. No ER diversion program has operated in the Florida Medicaid program since January 2009.

Children's Medical Services Networks

The Florida Children's Medical Services (CMS)¹⁴ program provides a family-centered, PCCM system of care for children with special health care needs. Children with special health care needs are those children younger than 21 years of age whose chronic physical or developmental conditions require extensive preventive and maintenance care beyond that required by typically healthy children. Roughly 60 percent of children covered by CMS networks are Medicaid eligible.

¹⁰ Florida Medicaid Health Maintenance Organizations, as of July 19, 2010, published by the Agency, available at: <http://ahca.myflorida.com/MCHO/Managed_Health_Care/MHMO/docs/MCAID/LIST_MEDICAID_HMOs.pdf>, (Last visited on November 12, 2010).

¹¹ Ibid, 5.

¹² See s. 409.912(49), F.S.

¹³ Ibid, 5.

¹⁴ Not to be confused with the federal Centers for Medicare and Medicaid Services, also known as CMS.

CMS networks offer a full range of care that includes prevention and early intervention services, primary and specialty care, as well as long-term care for medically-complex, fragile children. Most services are provided at or coordinated through CMS offices in local communities throughout the state. When necessary, children are referred to CMS-affiliated medical centers. These centers provide many specialty programs with follow-up care provided at local CMS offices. Families may enroll their Medicaid children with special health care needs in CMS networks. The CMS program is administered by the Florida Department of Health and partly funded with Medicaid dollars on a fee-for-service basis. As of October 1, 2010, 48,371 Medicaid beneficiaries were enrolled in CMS networks and represented 1.7 percent of the total Medicaid program.

Exclusive Provider Organizations

The Agency is authorized to contract for Medicaid services with exclusive provider organizations (EPOs), which are individual providers or groups of providers who have entered into written agreements with a licensed health insurer to provide health care services to EPO members.¹⁵ There are currently no EPOs operating within Florida Medicaid.

Prepaid Limited Health Service Organizations

The Agency employs prepaid limited health service organizations, commonly known as prepaid limited health plans or prepaid limited plans, to provide a number of limited or specialized services to certain Medicaid beneficiaries. Prepaid limited plans are partial risk-bearing entities regulated by OIR under ch. 636, F.S., and, in return for a fixed capitation, provide for limited types of health services to enrollees through an exclusive panel of providers. Prepaid limited plans are typically engaged by the Agency as prepaid behavioral health plans or prepaid dental health plans.

Prepaid Behavioral Health Plans

In 1996, Florida began contracting with prepaid behavioral health plans (PBHPs)¹⁶ to provide behavioral health services in a cost-effective manner to eligible beneficiaries. The PBHPs are selected through competitive procurement¹⁷ to provide, on a limited, prepaid basis, the following mental health services:

- Community mental health
- Behavioral health targeted case management
- Inpatient psychiatric hospitalization (emergency and non-emergency)
- Outpatient psychiatric hospitalization (behavioral health and physician services)

PBHPs assume risk for the limited set of services they provide. Medicaid beneficiaries who receive services via PBHPs are typically in MediPass or unmanaged fee-for-service for primary and acute care, except that most Medicaid-eligible children statewide who are receiving child welfare services from the Department of Children and Families, including those enrolled in managed care plans, are provided enhanced PBHP services via a specialty PBHP operated by community-based lead agencies.¹⁸

Prepaid Dental Health Plans

In July 2004, the Agency contracted with a prepaid dental health plan (PDHP) to provide dental services on a limited, prepaid basis to Medicaid-eligible children under the age of 21 in Miami-Dade County who are not enrolled in a managed care plan that provides its own dental services.¹⁹ Currently there are two PDHPs in Miami-Dade County providing dental care for approximately 247,000 Medicaid beneficiaries. PDHPs are paid a capitated rate for providing all covered dental services.

Nursing Home Diversion

The nursing home diversion (NHD) waiver program was originally implemented in December 1998 in the Orlando and Palm Beach areas and currently offers services in 37 counties.²⁰ The Department of Elder Affairs operates the program

¹⁵ See s. 409.912(8), F.S.

¹⁶ Also known as prepaid mental health plans, or PMHPs.

¹⁷ See s. 409.912(4)(b), F.S.

¹⁸ See s. 409.912(4)(b)8., F.S.

¹⁹ See s. 409.912(43), F.S.

²⁰ The approved coverage area is 60 counties. NHD providers have been engaged to provide services in 37 counties. See

in conjunction with the Agency. The primary objective of the program is to provide frail elders who meet eligibility criteria with an alternative to nursing home placement. Under this voluntary managed care program, enrollees can choose to continue living in their own homes or a community setting such as an assisted living facility. The program makes this option possible by offering coordinated acute care, long-term care, and case management services to frail elders in a community setting. All participants select a case manager and a NHD provider. NHD service providers are NHD managed care organizations that are approved for each county and are reimbursed at a monthly capitated rate for each plan member.

The case manager develops an individualized care plan used in coordinating medically necessary acute and long-term care services. Long-term care services include adult companion, adult day health, assisted living, case management, chore services, consumable medical supplies, environmental accessibility and adaptation, escort services, family training, financial assessment and risk reduction, home delivered meals, homemaker, nutritional assessment and risk reduction, personal care, personal emergency response systems, respite care, occupational, physical and speech therapies, home health, and nursing facility services. Acute care services include community mental health services, dental, hearing and visual services, independent laboratory and X-ray, hospice, inpatient hospital and outpatient hospital/ emergency, physicians, prescribed drugs, and transportation (optional) services.

The NHD program is operated under a unique federal waiver and offers home and community based services that other managed care models do not. As of October 1, 2010, 20,085 Medicaid beneficiaries were enrolled in the NHD program and represented less than one percent of the total Medicaid program.²¹

Enrollment Numbers for Florida Medicaid: Statewide (including Reform and non-Reform counties)

Statewide Medicaid, Type of Coverage	Oct 2010 Enrollees	Percent of Total	Monthly Growth		Sept 2010 Enrollees	Percent of Total	Monthly Growth
FFS (non-managed care)	942,959	33.15%	4.52%		902,152	32.19%	4.50%
FFS MediPass	594,409	20.90%	0.22%		593,090	21.16%	1.80%
FFS PSN	124,122	4.36%	-0.47%		124,702	4.45%	0.06%
FFS MPN	29,458	1.04%	-7.19%		31,741	1.13%	-20.84%
Total Fee-for-Service	1,690,948	59.45%	2.38%		1,651,685	58.93%	2.55%
Capitated HMO	1,076,567	37.85%	0.18%		1,074,685	38.34%	0.94%
Capitated PSN	56,737	1.99%	1.03%		56,160	2.00%	2.81%
Capitated NHD	20,085	0.71%	-0.44%		20,173	0.72%	1.01%
Total Capitated	1,153,389	40.55%	0.21%		1,151,018	41.07%	1.03%
TOTAL STATEWIDE	2,844,337		1.49%		2,802,703		1.92%
Total Managed Care	1,901,378	66.85%	0.04%		1,900,551	67.81%	0.74%

Florida Medicaid Reform

In 2005, Florida was approved to implement a five-year Medicaid experimental demonstration pilot project (Medicaid Reform) under a section 1115 waiver.²² Medicaid Reform was initially implemented in 2006 in Broward and Duval counties and then expanded to Nassau, Baker, and Clay counties in 2007. The demonstration pilot project requires mandatory participation in managed care plans for specified Medicaid populations, offering customized benefit

<http://ahca.myflorida.com/Medicaid/pdf/files/SS_10_100501_SOS_ver2.4_1164_1011_FINAL2.pdf>, (Last visited on November 12, 2010) (page 108).

²¹ Ibid, 5.

²² Florida Medicaid Reform Extension Request, submitted to CMS on June 30, 2010 by the Agency, available at: <http://ahca.myflorida.com/Medicaid/medicaid_reform/pdf/fl_1115_research_and_demonstration_waiver_extension_request_06-30-2010.pdf>, (Last visited on November 12, 2010).

packages that may vary in amount, duration, and scope. Beneficiaries who are employed and who have access to employer-sponsored insurance, have the ability to opt-out of Medicaid services and use Medicaid funding to pay their share of their employers' private health insurance premium.

Key managed care components of the Medicaid Reform pilot include:

- Comprehensive choice counseling
- Customized benefit packages
- Enhanced benefits resulting from participation in healthy behaviors
- Risk-adjusted capitations for prepaid managed care plans, based on enrollee health status
- An optional "catastrophic component" of the capitation, i.e. state reinsurance to encourage development of managed care plans in rural and underserved areas of the state
- Managed care plans participating in the Reform pilot may include health insurers, EPOs, PSNs, HMOs, and CMS networks. MPNs that formerly participated in Reform were classified as PSNs, and CMS networks in Reform are classified as specialty PSNs for children with chronic conditions.

Each managed care plan participating in Medicaid Reform must cover all mandatory services as outlined in federal law. Unique to Reform is that plans may vary the coverage level and offer more or less coverage to adults than is typically covered by Medicaid for the following services: prescribed drugs, hospital outpatient services (excluding emergency care), durable medical equipment (DME) and supplies, home health services, chiropractic, podiatric, physical and respiratory therapy, vision, dental, and hearing. Any limits imposed by Reform managed care plans that are more restrictive than non-Reform coverage do not apply to pregnant women or children. The state must pre-approve all benefit packages to ensure they are sufficient to meet the needs of the enrolled population.

The state pays HMOs participating in Reform a capitation that is subject to a risk-adjustment methodology, designed specifically for the Reform pilot, to help ensure that capitations reflect the health status of each managed care plan's membership as much as possible. PSNs participating in Reform have the option to be paid via risk-adjusted capitation or to be paid case management fees and administrative allocations while health care services for their members are paid on a fee-for-service basis.²³

As of October 1, 2010, eight HMOs were participating in the Reform pilot on a capitated basis with a membership of 150,747 while four PSNs were participating on a fee-for-service basis with a membership of 115,586.²⁴ No PSNs in the Reform pilot have opted to be paid via capitation. Under current law, all Reform PSNs must be paid via capitation no later than the beginning of the Reform pilot's final year of operation under a waiver extension, if an extension is granted.

Medicaid Reform Waiver Extension

On April 30, 2010, the Florida Legislature passed legislation directing the Agency to seek federal approval of a three-year waiver extension in order to maintain and continue operation of the section 1115 waiver.²⁵ The Agency submitted the extension request on June 30, 2010.²⁶ On August 17, 2010, the federal CMS advised the Agency that it would review and process the state's request to renew the Reform Demonstration under section 1115(a) authority, rather than under section 1115(e) authority as originally requested by the state. This authority would allow the federal CMS to request changes to the terms and conditions of the waiver. Under section 1115(a), there is no prescribed timeframe by which the federal CMS must process a waiver request. The Agency has indicated that at this point, the state does not anticipate that a review under the section 1115(a) authority would impact waiver operations and the original waiver does not expire until June 30, 2011. Furthermore, the Agency notes that while there is no formal processing timeframe, the state will work with the federal CMS to facilitate timely review.

²³ See s. 409.91211(3)(e), F.S.

²⁴ Ibid, 5.

²⁵ See ch. 2010-144, LOF.

²⁶ Ibid, 22.

Enrollment Numbers for Florida Medicaid: Medicaid Reform Counties²⁷

Medicaid Reform Counties, Type of Coverage	Oct 2010 Enrollees	Percent of Total	Monthly Growth		Sept 2010 Enrollees	Percent of Total	Monthly Growth
FFS (non-managed care)	133,832	32.66%	5.45%		126,910	31.46%	5.89%
FFS MediPass	5,545	1.35%	-0.40%		5,567	1.38%	4.25%
FFS PSN	115,586	28.21%	-0.50%		116,166	28.80%	0.14%
FFS MPN (non-Reform)	169	0.04%	1.20%		167	0.04%	-14.36%
Total Fee-for-Service	255,132	62.27%	2.54%		248,810	61.68%	3.07%
Capitated HMO	150,747	36.79%	0.05%		150,673	37.35%	-0.16%
Capitated HMO (non-Reform)	991	0.24%	-2.75%		1,019	0.25%	-2.95%
Capitated PSN	0	0.00%			0	0.00%	
Capitated NHD	2,874	0.70%	-0.38%		2,885	0.72%	-0.31%
Total Capitated	154,612	37.73%	0.02%		154,577	38.32%	-0.18%
TOTAL IN REFORM COUNTIES	409,744		1.58%		403,387		1.80%
Total Managed Care	275,912	67.34%	-0.20%		276,477	68.54%	0.03%
Total Reform Enrollees	266,333	65.00%	-0.19%		266,839	66.15%	-0.03%
Total Non-Reform Enrollees	143,411	35.00%	5.03%		136,548	33.85%	5.58%

Federal Health Reform

The Patient Protection and Affordable Care Act²⁸ (Affordable Care Act) was enacted by the federal government in March 2010. This comprehensive legislation contains a wide range of measures to reform the nation's health insurance system. The Congressional Budget Office (CBO) estimates that the law will reduce the number of uninsured nationally by 32 million in 2019 at a net cost of \$938 billion over ten years. Further, the CBO projects that 24 million individuals will obtain coverage in the yet-to-be-created state health insurance exchanges and that 16 million individuals will enroll in state Medicaid and Children's Health Insurance (Kidcare) programs by virtue of the Affordable Care Act.

The caseload for Florida's Medicaid program is projected to be 2.97 million individuals for the 2010-11 fiscal year²⁹ at a cost of \$20.2 billion,³⁰ and, according to the 2008 Census Bureau statistics, the state has approximately 3.6 million uninsured individuals. Preliminary estimates regarding the impact of the Affordable Care Act to Florida's Medicaid and Kidcare programs, project that the caseload will increase by approximately 1.2 million individuals in fiscal year 2014-15. This represents a 29.3 percent increase in the state's Medicaid caseload at a total cost of \$6.1 billion (state share of \$641.2 million). By fiscal year 2018-19, the caseload is projected to increase by an additional 1.9 million individuals, representing a 38.93 percent increase in the state's Medicaid caseload at a total cost of \$8.9 billion (state share of \$1.4 billion).

The Affordable Care Act does not specifically mandate how states must deliver services to Medicaid beneficiaries, whether through any particular managed care model, a combination of managed care models, or by using managed care at all.

²⁷ Ibid, 3.

²⁸ The Patient Protection and Affordable Care Act (H.R. 3590, Public Law 111-148) as amended by the Health Care Education Reconciliation Act of 2010 (H.R. 4872, Public Law 111-152).

²⁹ Based on projections issued by the August 2010 Social Services Estimating Conference.

³⁰ Fiscal Year 2010-2011 General Appropriations Act.