Florida Medicaid Managed Care Auto-Assignment Methodology

Report to the Florida Legislature
October 1, 2019

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Executive Summary

During the 2019 legislative session, language in the General Appropriations Act directed the Agency for Health Care Administration (Agency) to develop an alternative automatic assignment methodology for Medicaid recipients enrolled in the Statewide Medicaid Managed Care program.

> *The Agency for Health Care Administration is directed to develop an alternative automatic assignment methodology for Medicaid recipients enrolled in the Medicaid Managed Care program, pursuant to s.409.969(1), Florida Statutes. The alternative auto assignment methodology shall ensure that all managed care organizations in the Managed Medical Assistance program and the Long Term Care Managed Care program receive equitable treatment in the automatic assignments of new and reassigned enrollees. Equitable treatment means the number of assignments does not systematically prevent new plans from establishing successful operations within the program. The agency shall submit a report describing current automatic enrollment procedures and criteria, assessing the effects of those policies and procedures, evaluating options for modifying current practices, and recommending a new methodology. The report is to be submitted to the President of the Senate and Speaker of the House of Representatives no later than October 1, 2019. Implementation of the redesign is contingent on legislative approval.*

The Agency has historically assigned Medicaid recipients into managed care plans based on:

1. The individual's choice of plan
2. Statutory mandates on assignment to plans
3. The principle that individuals' continuity of care is of paramount importance

This report explains how plan assignments are made using person-centered principles both when Statewide Medicaid Managed Care plans are re-procured and on an ongoing basis and the impact of the different steps on the number of individuals available to be assigned to plans.

The Agency issued a Request for Information (RFI) to solicit feedback on this report. The respondents were all Medicaid plans. When the Agency asked how the auto-assignment methodology should be designed to ensure an equitable distribution of enrollees, there were two themes that emerged; Open Competition and Guaranteed Enrollment.

This report provides those two options for consideration when designing a methodology for the auto-assignment algorithm for both future procurements and day-to-day operations. The options can be supplemented with a variety of considerations, such as aligning Medicare enrollment and assigning to a specialty plan where applicable.

Purpose of the Report

This report fulfills a requirement from the 2019 legislative session when language in the General Appropriations Act directed the Agency for Health Care Administration (Agency) to develop an alternative automatic assignment methodology for Medicaid recipients enrolled in the Statewide Medicaid Managed Care program. Specifically:

> *The Agency for Health Care Administration is directed to develop an alternative automatic assignment methodology for Medicaid recipients enrolled in the Medicaid Managed Care program, pursuant to s.409.969(1), Florida Statutes. The alternative auto assignment methodology shall ensure that all managed care organizations in the Managed Medical Assistance program and the Long Term Care Managed Care program receive equitable treatment in the automatic assignments of new and reassigned enrollees. Equitable treatment means the number of assignments does not systematically prevent new plans from establishing successful operations within the program. The agency shall submit a report describing current automatic enrollment procedures and criteria, assessing the effects of those policies and procedures, evaluating options for modifying current practices, and recommending a new methodology. The report is to be submitted to the President of the Senate and Speaker of the House of Representatives no later than October 1, 2019. Implementation of the redesign is contingent on legislative approval.*

Section I: Statutory Basis for Enrollment

In 2013 and 2014, the Agency implemented a Statewide Medicaid Managed Care (SMMC) program pursuant to Chapter 409, Part IV, Florida Statutes. In accordance with the statute, contracts were recently re-procured, resulting in contracts awarded for the period of 2018-2023. The SMMC program consists of two main components, the Managed Medical Assistance component and the Long-Term Care component, and a stand-alone Dental component. The vast majority of full-benefit Medicaid recipients are required to enroll in the MMA component of the program. Nearly 3 million of the 3.8 million Florida Medicaid recipients are enrolled, with most of those not enrolled consisting of limited benefit groups such as those who only qualify for Medicaid to pay Medicare cost-sharing; medically needy who qualify on a month-to-month basis; and those with other insurance coverage. All recipients seeking to receive long-term care services from the Florida Medicaid program must enroll in the Long-Term Care component of the SMMC program, with the exception of those in certain institutions and those enrolled in a different 1915(c) home and community-based services waiver.

Florida Statute provides direction to the Agency on how to enroll people into the health plans participating in the program. Specifically, 409.977, F.S. and 409.984, F.S., direct the Agency to "automatically enroll into a managed care plan those Medicaid recipients who do not voluntarily choose a plan pursuant to s. 409.969." Enrollees are guaranteed a choice of plans and, if no choice is made, are assigned based on an algorithm which takes into consideration statutory requirements for a preference for Specialty plans and Medicare plans. Details of the statutory provisions are in the chart below.

Specific Statutory Direction Regarding How to Enroll a Recipient Into a Health Plan			
		The Managed Medical Assistance Component (409.977 (1) & (2)	**The Long-Term Care Component (409.984 (1) & (2)**
Main		409.977 (1): The agency shall automatically enroll into a managed care plan those Medicaid recipients who do not voluntarily choose a plan pursuant to s. 409.969.	409.984 (1): (1) The agency shall automatically enroll into a long-term care managed care plan those Medicaid recipients who do not voluntarily choose a plan pursuant to s. 409.969.
Special Considerations	Provider network sufficiency and georgraphic	(2) When automatically enrolling recipients in managed care plans, the agency shall automatically enroll based on the following criteria: (a) Whether the plan has sufficient network capacity to meet the needs of the recipients. (b) Whether the recipient has previously received services from one of the plan's primary care providers. (c) Whether primary care providers in one plan are more geographically accessible to the recipient's residence than those in other plans.	(2) When automatically enrolling recipients in plans, the agency shall take into account the following criteria: (a) Whether the plan has sufficient network capacity to meet the needs of the recipients. (b) Whether the recipient has previously received services from one of the plan's home and community-based service providers. (c) Whether the home and community-based providers in one plan are more geographically accessible to the recipient's residence than those in other plans.
Special Considerations	Specialty Plan and condition	When a specialty plan is available to accommodate a specific condition or diagnosis of a recipient, the agency shall assign the recipient to that plan.	If a recipient is deemed dually eligible for Medicaid and Medicare services and is currently receiving Medicare services from an entity qualified under 42 C.F.R. part 422 as a Medicare Advantage Preferred Provider Organization, Medicare Advantage Provider-sponsored Organization, or Medicare Advantage Special Needs Plan, the agency shall automatically enroll the recipient in such plan for Medicaid services if the plan is currently participating in the long-term care managed care program.
Special Considerations	Quality and Performance	The agency shall automatically enroll recipients in plans that meet or exceed the performance or quality standards established pursuant to s. 409.967	The agency shall automatically enroll recipients in plans that meet or exceed the performance or quality standards established pursuant to s. 409.967
Prohibitions	Poor Quality and Performance	The agency . . may not automatically enroll recipients in a plan that is deficient in those performance or quality standards [s. 409.967].	The agency . . may not automatically enroll recipients in a plan that is deficient in those performance or quality standards [s. 409.967].
Prohibitions	No other plan perference allowed	Except as otherwise provided in this part, the agency may not engage in practices that are designed to favor one managed care plan over another.	Except as otherwise provided in this part, the agency may not engage in practices that are designed to favor one managed care plan over another.

Section II: Enrollment Process Overview

The enrollment algorithm employed by the Agency is based on these statutory provisions and the core principle that the continuity of care for the Medicaid recipient should always be of primary consideration. This person-centered approach includes enrolling recipients into plans as family groups, when possible, and re-enrolling individuals into plans with which they had a previous enrollment.

When individuals apply for Medicaid, the Department of Children and Families (DCF) sends a nightly application file to the Florida Medicaid Management Information System (FMMIS), which in turn sends the file to the Agency's enrollment broker's system to create records for each individual applicant. (Some individual are eligible for Medicaid due to their federal Supplemental Security Income (SSI) eligibility. For these SSI eligible individuals, the federal State Data Exchange sends a nightly file to the FMMIS, which is transmitted to the Agency's enrollment broker's system for the creation of an individual record for each eligible individual.)

At the time of application to DCF, individuals may choose an SMMC plan immediately following the completion of the application through the Statewide Medicaid Managed Care website. If no plan choice is made at that time, individuals may later make a plan choice through the Agency's enrollment broker either through the on-line member portal or by calling and speaking with a choice counselor. Once an individual is determined eligible, DCF sends an eligibility update file to the FMMIS for processing. After processing is complete, FMMIS sends an eligibility update file to the enrollment broker system for managed care enrollment. The enrollment broker determines whether the individual has made a choice of plans and, if not, runs the auto-assignment process to select a health plan for the person. It then generates a letter that tells the person the plan they have chosen or been assigned to and mails a "welcome packet" that includes the letter, information about other plans available in the person's region, and how to choose a different plan if desired. The letter informs them that if they are satisfied with the plan assignment, no action is needed, and provides information on the actions needed in order to select a different plan.

SMMC enrollment and assignment consists of the following processes. The enrollment system looks at each of these in this order:

1. **Reinstatement:** Reinstatement is applicable to recipients enrolled in managed care who lose Medicaid eligibility for less than 180 days and then regain it. Recipients eligible for reinstatement are enrolled in the last plan in which they were enrolled. (Specialty plans have specific eligibility requirements such as age; if recipients no longer meet those requirements, they will not be enrolled in their prior plan.)
2. **Recipient Choice**: If the recipient is not eligible for reinstatement, the system evaluates if the recipient has made a choice of plans. If the recipient chose a plan, they are enrolled with that plan.
3. **Auto Assignment:** If the recipient is not eligible for reinstatement and did not make a choice of plan, the recipient is assigned to a plan by the auto-assignment process. Enrollment occurs after each step of the auto assignment process in which the recipient meets the criteria of that step. If auto assignment occurs, the recipient will receive a letter outlining their plan assignment and how to choose a different plan, if they wish.
    a. **Newborn:** Parents who are enrolled in Medicaid may select a plan for a newborn prior to the child being born. Recipients who are born without a plan

choice on file are assigned to their mother's plan if they are eligible to enroll in that plan. If not, they are assigned based on the auto-assignment algorithm.

This report focuses only on the third enrollment process outlined above, the auto-assignment process. The other enrollment processes listed are not included in this report.

Section III: 2018-2023 SMMC Health Plan Re-Procurement

During Fiscal Year 2018-19 the Agency re-procured the SMMC health plans for the next 5-year period (2018-2023). There are a number of factors specific to the procurement that impacted how recipients were distributed across plans. Many of these factors are specified in Florida law, and others are based on decisions made by the Agency based on person-centered principles. This section details those factors that impact enrollment into plans.

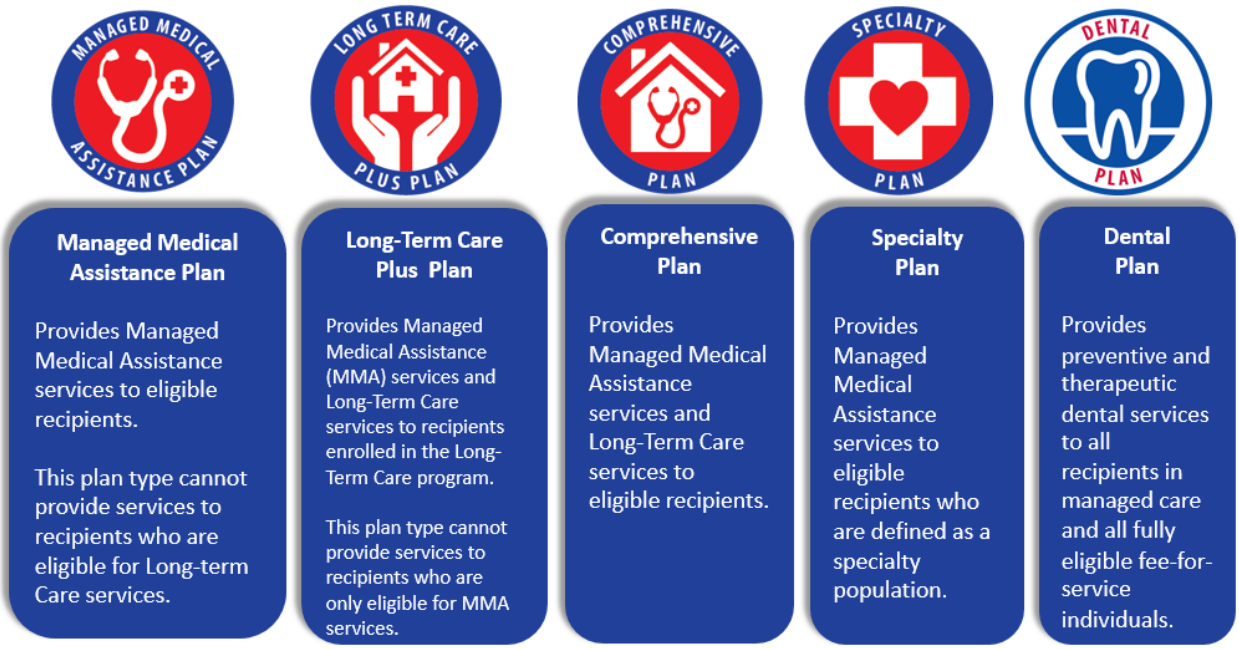
Individuals Were Assigned to the Plan They Were In

Pursuant to the terms of the Invitation to Negotiate used to procure the new SMMC contracts, and in alignment with the core principle of continuity of care, most recipients enrolled in existing plans were automatically assigned to those plans if those plans were awarded a new contract. If a recipient has previously made a choice/ been enrolled with a plan and was satisfied with that plan, no action should have to be taken on the recipient's part to continue with that plan. Recipients who had previously enrolled in two separate plans for their MMA and LTC services were assigned to one Comprehensive or LTC Plus plan for those services, and therefore may have experienced a plan change.

Combining Managed Medical Assistance and Long-Term Care (LTC) Plans

For the original SMMC program procurement, the Agency was required to first procure plans for the LTC program component and then to subsequently procure plans for the MMA program component. The Agency therefore conducted two separate procurements, one for each program component. This resulted in most recipients who needed both MMA and LTC services being enrolled in separate MMA and LTC plans. In the new contract period, the LTC and MMA program components were procured simultaneously, and, as a result, any enrollee who requires both LTC and MMA services receives all of their Medicaid services from one SMMC plan. The chart below displays the different plan types that were awarded a contract in 2018.

SMMC Plan Types



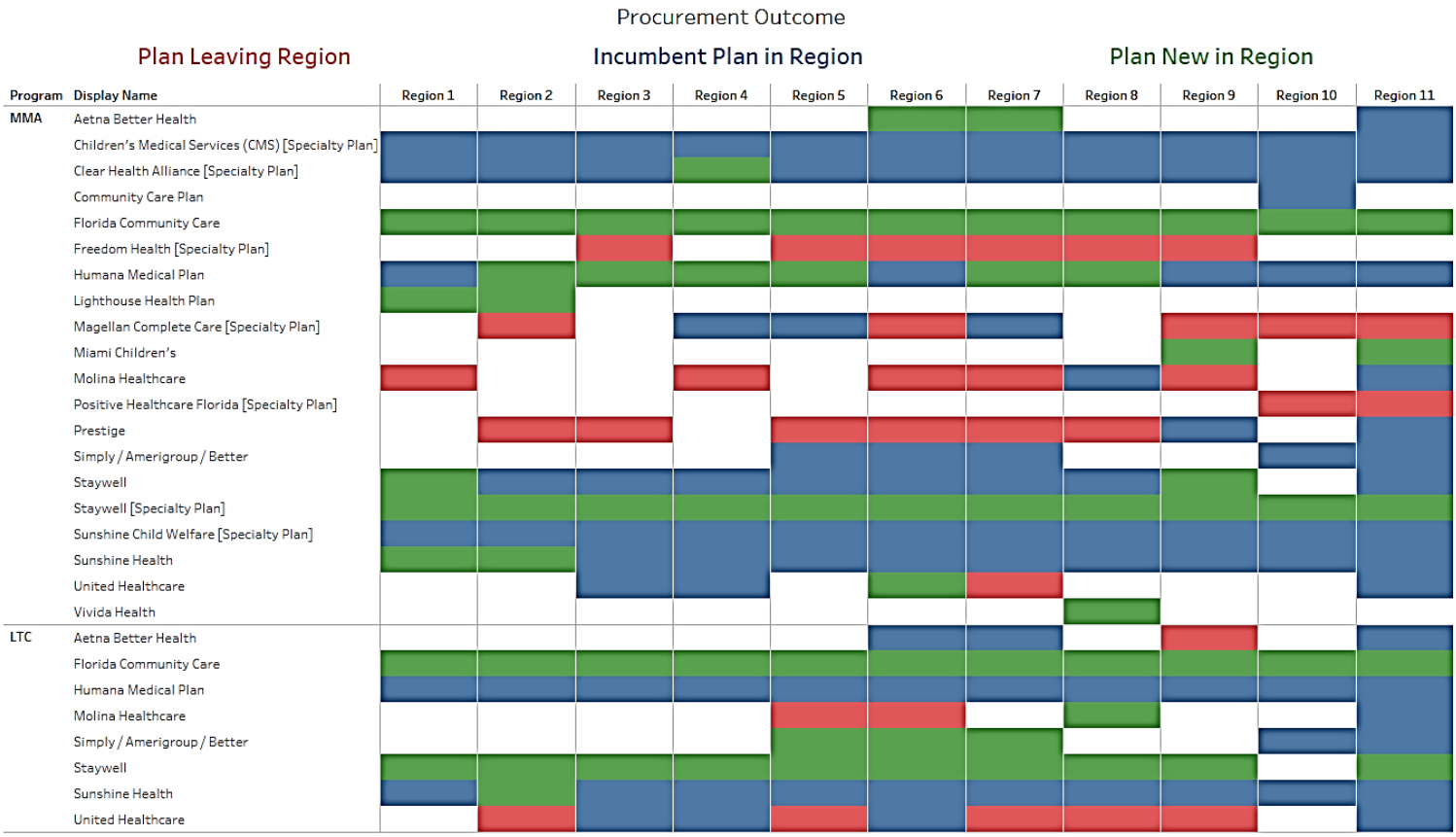
Minimum and Maximum Plans in Regional Procurement

Florida law requires that SMMC plans be procured by the 11 Agency regions. This impacts the number of plans that are awarded contracts and therefore the number of members per plan. Florida Statutes outline the minimum and maximum number of plans the Agency can award in the SMMC procurement process. The Agency awarded the maximum number of health plan contracts allowed per ss. 409.974 and 409.981, F.S., in each region.

In the original SMMC program there were a total of 17 health plans throughout the state. There were two health plans that participated in the original SMMC program that were not awarded any regional contracts in the new SMMC program, and there were four brand new plans that were awarded contracts to participate in the Medicaid program for the first time. Several plans participating in the original SMMC program either won or lost contracts in certain Regions. In every Region there were changes to the plans that participate. This included:

- Plans **exiting** the Region because they were not awarded a contract, or
- Plans **new** to a Region because they were:
    1. Brand new plans that had not participated in SMMC during the initial five-year contract period, or,
    2. Plans that had participated during the initial five-year contact period, but in a different Region.

The chart below details the plans that left regions, stayed in regions, or were brand-new to a region.



The Agency awarded contracts to at least some of the incumbents in each region. A limited number of plans exited the regions. In some cases, no MMA (non-Specialty) plans or LTC plans exited a region.

An additional factor affecting the number of plans was a merger of three different health plans during the procurement of the new contracts. Anthem d/b/a Amerigroup purchased two health plans, Better Health and Simply, and bid as one consolidated entity for the new contract. The Agency awarded new SMMC contracts in regions where the consolidation of Amerigroup, Better and Simply opened up room for a new plan award when all of the incumbent plans and the surviving entity were awarded a contract.

In a situation where the Agency awarded new plan contracts where there were no exiting plans, the result was that there were no recipients to distribute to new plans because none of the recipients in the region were enrolled in an exiting plan.

Some regions had a significant number of plans that were awarded new contracts, and this reduced the pool of recipients available to be assigned to new plans entering the region. In some cases, most recipients were enrolled in continuing plans, and therefore the recipient pool available for assignment was small.

The chart below demonstrates the number of recipients by region who were enrolled in exiting plans and therefore were in the pool of recipients who could be assigned through the auto assignment process. In MMA, Region 10 had the lowest number of individuals in exiting plans at 7,371, and Region 7 had the largest number at 112,836. Even in Region 7, however, this represented only 28 percent of the total MMA enrollee population for the region. In LTC, Regions 1, 3, 4, 10, and 11 did not have any individuals in exiting plans. (Note: The numbers were run at a point in time during implementation and as enrollment fluctuates each day, the numbers could vary if rerun today.)

Program	Display Name	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	Region 10	Region 11
MMA	Freedom Health [Specialty Plan]			35		20	26	8	8	4		
	Magellan Complete Care [Specialty Plan]		4,374				12,808			7,843	7,371	14,416
	Molina Healthcare	46,831			66,801		27,042	25,619		68,605		
	Prestige		50,235	53,031		20,853	31,120	36,346	44,645			
	United Healthcare							50,863				
	Total Leaving	*46,831*	*54,609*	*53,066*	*66,801*	*20,873*	*70,996*	*112,836*	*44,653*	*76,452*	*7,371*	*14,416*
	Total Region Population	105,147	112,405	263,636	316,224	185,921	429,185	405,603	203,081	267,676	257,982	487,759
	Percent of Population	44.54%	48.58%	20.13%	21.12%	11.23%	16.54%	27.82%	22.99%	28.56%	2.86%	2.96%
LTC	Aetna Better Health									1,333		
	Molina Healthcare					1,332	1,655					
	United Healthcare		2,257			1,678		1,930	943	1,170		
	Total Leaving		*2,257*			*3,010*	*1,655*	*1,930*	*943*	*2,503*		
	Total Population	3,253	3,674	7,728	9,353	10,624	12,120	9,576	6,541	9,942	8,890	25,812
	Percent of Population	0%	61.43%	0%	0%	28.33%	13.66%	20.15%	14.42%	25.18%	0%	0%
Grand Total		46,831	56,866	53,066	66,801	23,883	72,651	114,766	45,596	78,955	7,371	14,416
	Percent of Total SMMC Population	1.54%	1.87%	1.75%	2.20%	0.79%	2.39%	3.78%	1.50%	2.60%	0.24%	0.48%

Section IV: Implementation of the 2018-2023 SMMC Contracts

The Agency transitioned to the new contracts by splitting the state into three geographical areas and implementing one area per month from December 2018 through February 2019. The process for recipient enrollment into awarded health plans was outlined in the SMMC Health Plan Procurement. The Agency did not receive any protests related to this specification from any plan in any region as part of the SMMC procurement process. The goal of the 2018-2023 SMMC Plan Procurement Implementation was that Medicaid recipients would continue to receive their services from their current providers if possible. This goal shaped the implementation and enrollment processes the Agency followed.

Agency priorities during implementation included ensuring Medicaid recipients had the opportunity to enroll in the plan of their choice:

1. Recipients were sent a letter with a brochure that included all the available health plans in the region, including extra benefits each plan offered, 15-45 days in advance of their region go-live. The letter included the plan assignment and effective date for each recipient and their family members if they did not take action and choose a different plan.
2. Recipients were given 120 days after enrollment to choose the plan of their choice.

The Agency used an auto-assignment methodology that can be grouped into five high level components for assessing each recipient for assignment into a Medicaid health plan. The high-level components include:

1. Recipient Existing Plan Relationship- Recipients who had additional insurance coverage from a related plan, such as Medicare Advantage, or who were already enrolled with an incumbent Medicaid health plan. This included recipients who were in different Long-Term Care and Managed Medical Assistance plans that needed to be aligned to one plan for all of their Medicaid services.

2. Specialty Plan Eligibility (MMA only)- Recipients eligible for a Specialty plan based on age, diagnosis, or condition were assigned to the appropriate Specialty plan. This is a requirement of Florida Statutes.

3. Family Member Already in a Medicaid Plan- If a family member was already enrolled with an incumbent Medicaid health plan, individuals were enrolled in that plan.

4. New Plan Base Enrollment (MMA only)- If a Region had exiting plans, the Agency assigned 20%-30% of the exiting plan recipients to new plans before the remainder of the exiting plan population was distributed in the Round Robin step.

5. Round Robin Distribution- If a recipient was not assigned based on the groups above, they were distributed by family group in turn to each plan in each Region.

Analysis of the Implementation Enrollment Process

The following chart displays the outcome of the auto-assignment methodology described above at a statewide level. It shows that during the implementation about 83% of MMA recipients and 93% of LTC recipients were assigned to their plan because of their relationship with their incumbent Medicaid plan.

Reprocurement Transition Steps (December 2018 - February 2019)

Program	AA Step Grouping	Percent	Requests
Long Term Care	Recipient Existing Plan Relationship	93.28%	103,968
	Family Existing Plan Relationship	0.03%	31
	Round Robin Distribution	6.69%	7,455
	Total	**100.00%**	**111,454**
Managed Medical Assistance	Recipient Existing Plan Relationship	82.67%	2,543,848
	Specialty Plan Eligible	2.06%	63,446
	Family Existing Plan Relationship	1.53%	46,940
	New Plan Base Enrollment	4.02%	123,615
	Round Robin Distribution	9.72%	299,181
	Total	**100.00%**	**3,077,030**

Unique LTC Enrollment Considerations

Some LTC recipients whose plan was exiting a region were assigned to the Medicare Plan they were already enrolled with based on statutory direction. This requirement drove LTC enrollment into Medicaid plans that were also Medicare plans in the state.

In the original SMMC program, recipients who received LTC services could be enrolled in two different plans for LTC services and MMA services. During the implementation of the new contracts, if a recipient who was enrolled in an LTC plan that was exiting was also enrolled in a MMA plan that was awarded a new contract, the Agency assigned them to their MMA plan for both LTC and MMA services for the new contract period. This is in line with person-centered principles that the recipient should not have to change plans unnecessarily.

While the person-centered approach to aligning all services for Medicaid recipients in one health plan was the right thing to do for the recipient, the impact to the new LTC+ plan was significant. Instead of a statewide pool of 12,298 recipients available for distribution to Comprehensive plans and the LTC+ plan in the round robin step, the available statewide pool of recipients was 7,455.

Summary of Implementation Enrollment Impact

In order to support the Agency's goal for the 2018-2023 SMMC Health Plan Implementation of respecting Medicaid recipient's health care choices and ensuring that they could seamlessly continue to receive their services, the enrollment process for the new contracts was designed to ensure that most recipients had continued access to their current providers, as required by s. 409.977(2), F.S. and s.409.984(2), F.S. Without knowing how many new plans by plan type would be awarded a contract, what the impact of the Anthem/ Simply acquisition would be, and how many incumbent plans would bid for a comprehensive contract and win, the Agency could not have predicted the impact of the enrollment process on new plans.

A regional market-share comparison of the Medicaid plans enrollment before and after the SMMC contract implementation is attached in Appendix I.

Section V: SMMC Auto-Assignment Post Procurement (Standard Operating Protocol)

When a person applies for Medicaid eligibility they are given the opportunity to choose which Medicaid health plan they would like to enroll in if they are determined eligible for Medicaid. If they are determined eligible the Agency will enroll them into the health plan they initially chose during the application process. If they do not have a health plan choice on file, the Agency runs them through the daily auto-assignment process. After they are enrolled into a Medicaid health plan, they have 120 days to pick another plan. After the 120 days passes, the recipient is locked into their health plan until their next open enrollment period, unless they meet a good cause reason to change plans, as detailed in 59G-8.600, Florida Administrative Code.

During the open enrollment period each year all recipients have a choice of every Medicaid plan in their region for which they qualify. The open enrollment period lasts 60 days. The Agency sends letters and brochures that contain plan specific information to each recipient 30 days before their open enrollment period.

When recipients do not choose a plan, the Agency uses an auto-assignment methodology that can be grouped into four high level components when assessing each person for assignment into a Medicaid health plan. The high-level components include:

1. Recipient Existing Plan Relationship- Recipients who had additional insurance coverage from a related plan, such as Medicare Advantage, or who were already enrolled with an incumbent Medicaid health plan.

2. Specialty Plan Eligibility (MMA only)- Recipients eligible for a Specialty plan based on age, diagnosis, or condition were assigned to the appropriate Specialty plan. This is a requirement of Florida Statutes.

3. Family Member Already in a Medicaid Plan- If a family member was already enrolled with an incumbent Medicaid health plan, individuals were enrolled in that plan.

4. Round Robin Distribution- If a recipient was not assigned based on the groups above they were distributed by family group in turn to each plan in each Region.

Analysis of the Post-Procurement Auto-Assignment Methodology

The chart below displays the statewide auto-assignment enrollment data for distribution to LTC and MMA plans using the 4 components noted above from March 2019- August 2019 (after SMMC Health Plan Procurement Implementation). A regional breakout that includes each region and health plan is attached in Appendix II.

Auto Assignment Standard Operations Steps (March 2019 - August 2019)

Program	AA Step Grouping	Percent	Requests
Long Term Care	Recipient Existing Plan Relationship	48.38%	14,518
	Family Existing Plan Relationship	0.63%	188
	Round Robin Distribution	51.00%	15,305
	Total	**100.00%**	**30,011**
Managed Medical Assistance	Recipient Existing Plan Relationship	15.76%	79,655
	Specialty Plan Eligible	9.02%	45,578
	Family Existing Plan Relationship	22.24%	112,414
	Round Robin Distribution	52.99%	267,886
	Total	**100.00%**	**505,533**

About half of the auto-assignment enrollments for both MMA and LTC occur in components 1-3 and about half are distributed through the fourth component, Round Robin.

Section VI: Stakeholder Feedback on the Auto-Assignment Methodology

The Agency issued a Request For Information (RFI) to gather input from stakeholders for this report. There were nine responses to the RFI, all from Florida Medicaid plans. Of the nine responses, four were from plans newly awarded contracts and five from plans that had Florida Medicaid contracts in the both the first and second five years of SMMC. The Agency asked for input on the following topics:

1. If we should define a "new plan" as a plan new to a Region or a plan new to the Medicaid program.
2. How to define successful operations for a new plan, including the enrollment threshold that must be met to ensure the opportunity for a new plan to achieve successful operations.
3. Important Principles when Creating an Auto-Assignment methodology. The Agency provided the following principles for an auto-assignment methodology and asked if these were the most important principles to consider or if there were others that were more important.

    a. Rewards high performing plans with extra enrollment

    b. Supports alignment with the Medicare delivery system

    c. Supports a competitive environment

    d. Minimizes the risk of service disruption

    e. Does not require enrollee action to remain in their current plan

    f. Supports enrollment of recipients into one plan for all Medicaid services

    g. Keeps families together

RFI Responses Respondents did not consistently define a "new" plan. Some plans responded that new plans are only those plans that are completely new to Florida Medicaid. Some plans responded that new plans consist of any plan that is new to a Region, regardless of whether they were a Medicaid plan in another part of the state.

Plans that responded to the RFI did not have a consistent way of defining successful operations. Some plans stated that successful operations did not mean achieving a specific enrollment threshold but could be influenced by key factors such as, product mix, affiliations with larger health system entities, or affiliations with national health plans. There was not consistency in the responses regarding the enrollment threshold that needs to be achieved to ensure successful operations are achieved.

While most plans agreed that most of the principles cited in the RFI are important, there was some push back on the principle that the enrollment process should not require people to make a choice in order to stay in their plan. Some plans felt that the plans' contract with the Agency has sufficient provider network protections in place to secure access and contractual continuity of care provisions to ensure recipients do not have a gap in care if they change plans. For example, health plans honor any ongoing treatment that was authorized prior to the recipient's

enrollment into the plan including prescriptions, and providers must be paid promptly, and at the rate previously received, for care provided during the continuity of care period.

Plans responding to the RFI had several different recommendations for changing the auto-assignment algorithm:

1. Keep the auto-assignment process as is
2. Amend the auto-assignment process to award high-performing plans with extra recipients
3. Auto-assign recipients to only new plans for a period of 18– 24 months after new contract implementation or until all plans in the region achieve a certain percentage of the market share
4. Ensure all plans have at least 25,000 enrollees in their plan as a result of contract implementation. If they do not, auto-enroll recipients to plans with under 25,000 members until they reach 25,000 members

Section VII: Auto-Assignment Methodology Options

There are a number of changes that are possible to the current auto-assignment methodology. Some would require statutory changes; others could be made within existing authority. They could be implemented now, or after the next re-procurement of Medicaid health plans. At their core, however, there are two fundamentally different options:

- Open competitive: Assign all individuals using a round robin method
- Guaranteed enrollment: Assign in a manner that ensures that each plan receives a guaranteed minimum enrollment

The following section explores these two options and several possible variations on them.

Open Competitive

Free market principles underpin the Open Competitive model. All, or most, individuals who do not make a choice of plans are in the pool to be assigned. This option requires plans to compete in areas such as the expanded benefits they offer, the quality of their customer service, and on including sought-after providers in their networks. They will seek to build the loyalty of members who have been previously enrolled by providing them high quality care and an overall good experience so the member will choose them during open enrollment, and they will publicize their plan's track record and benefits to gain new members and retain newly assigned members.

The advantage of this option is that it gives plans a strong incentive to develop positive connections with their members and design and deliver meaningful benefits. A disadvantage is that it requires individuals who are satisfied with their plan to take action to keep that plan. Individuals on Medicaid have significant daily challenges due to their low income, which can cause them to be focused on meeting basic needs rather than choosing a health plan. They can be difficult to reach through conventional means, such as mailed letters, so this could cause an individual to miss the opportunity to stay in their current plan, even if they are satisfied with their care.

Guaranteed Enrollment

The Guaranteed Enrollment approach is based on the principle of leveling the playing field for plans and ensuring they have sufficient membership to be sustainable. This option would assign members to plans until they reach a predefined threshold of enrollment. This could be applied only for plans that are new to Medicaid, or it could be applied to any plan that is under the defined enrollment threshold.

The advantage of this model is that new plans, which were found to be qualified through the procurement, will receive a baseline amount of membership sufficient to sustain their operations and cover the overhead of operating a plan contract. A disadvantage of this model is that it reduces some of the incentive to compete for members, potentially lowering overall quality. If this option is applied on an ongoing basis, it could prop up plans that are failing to attract or retain members that otherwise would not continue in the program.

A consideration of this model is how to determine the guaranteed threshold of enrollment. There are many factors besides number of enrolled members that affect a plan's financial viability, including, but not limited to, administrative efficiency, how well it coordinates care for members with complex conditions, how closely its provider contracts align with market rates, and how large a geographic area it covers. These differences make it difficult to determine the appropriate level of guaranteed enrollment.

Variations

There are a number of variations that could be applied in either the Open Competitive or Guaranteed Enrollment options. These could also be applied after a re-procurement and/or on an ongoing basis.

- **Reinstatement After Regaining Eligibility:** The current algorithm assigns an individual to the plan they were previously in if they regain eligibility within 180 days. This reinstatement approach could be eliminated or the reinstatement period shortened. Individuals would have the opportunity to choose a new plan upon re-application for Medicaid, at which point they would could select their prior plan if desired.

- **Aligning with Medicare:** Individuals dually eligible for Medicare and Medicaid usually have significant needs due to their age and/or disability combined with their low income. A goal of the current algorithm has been to simplify their care by assigning them to the Medicaid plan that corresponds to their Medicare plan, if available. If this were eliminated, individuals could still choose the plan that corresponds to their Medicare plan during the choice process. This would require a change to statute for individuals in the Long-Term Care program.

- **Specialty Plan**: Current law allows for plans to bid as a specialty plan serving a targeted population. If specialty plans are awarded a contract, the law specifies that individuals must be assigned to that plan if they meet the criteria for the plan. If this requirement were eliminated, individuals who meet the criteria for a plan would be notified of the addition specialty plan option during their plan choice period. This would require a change to statute.

Neither of the options for a future auto-assignment methodology provided in this report will prevent new plans from reaching successful operations. The Guaranteed Enrollment option ensures there will be enough enrollment assigned to a new plan to be viable in the market but enrollment alone does not guarantee a new plan will achieve successful operations.

Section VIII: Conclusion

The Agency has carefully reviewed the auto-assignment process at two critical phases in the plan auto-assignment process, during the most recent SMMC plan procurement and during day-to-day operations. Stakeholder input was requested to ensure that every important aspect was examined during the review. After review, the Agency has provided two options to consider that could be implemented in either a procurement or in day-to-day operations. The Open Competitive option focuses on free market principles and requires plans to design their plan benefits, provider networks and customer service to be attractive on the front end and then retain the membership they enroll. The Guaranteed Enrollment option focuses on ensuring all plans can sustain the administrative and operational requirements of running a plan in the Medicaid program and requires the Agency to continue to assign recipients until a minimum enrollment threshold is met. Both options can be supplemented with considerations for more person-centered principles, such as aligning recipients to their Medicare plan or enrolling them into a Medicaid Specialty plan.

Appendix I

Market Share Comparison - Pre and Post Transition - Phase 1

		Region 9				Region 10				Region 11			
		Pre Transition		Post Transition		Pre Transition		Post Transition		Pre Transition		Post Transition	
Program	Display Name	Recipients	Percent	Recipients	Percent	Recipients	Percent	Recipients	Percent	Recipients	Percent	Recipients	Percent
MMA	Aetna Better Health									48,545	9.95%	48,507	10.17%
	Children's Medical Services (CMS) [..	4,481	1.67%	4,399	1.69%	5,818	2.26%	5,710	2.26%	9,835	2.02%	9,813	2.06%
	Clear Health Alliance [Specialty Plan]	1,265	0.47%	1,208	0.47%	1,043	0.40%	917	0.36%	2,291	0.47%	1,925	0.40%
	Community Care Plan					40,396	15.66%	39,054	15.43%				
	Florida Community Care			600	0.23%			97	0.04%			625	0.13%
	Freedom Health [Specialty Plan]	4	0.00%										
	Humana Medical Plan	62,501	23.35%	71,694	27.60%	65,602	25.43%	65,321	25.81%	69,484	14.25%	69,716	14.61%
	Magellan Complete Care [Specialty ..	7,843	2.93%			7,371	2.86%			14,416	2.96%		
	Miami Children's			13,309	5.12%							299	0.06%
	Molina Healthcare	68,605	25.63%							54,491	11.17%	54,293	11.38%
	Positive Healthcare Florida [Special..					757	0.29%	638	0.25%	1,152	0.24%	917	0.19%
	Prestige	50,677	18.93%	61,459	23.66%					17,899	3.67%	17,245	3.61%
	Simply / Amerigroup / Better					70,413	27.29%	70,716	27.94%	114,675	23.51%	110,999	23.26%
	Staywell			18,040	6.94%					56,598	11.60%	56,328	11.80%
	Staywell [Specialty Plan]			6,347	2.44%			4,876	1.93%			8,280	1.74%
	Sunshine Child Welfare [Specialty Pl..	2,992	1.12%	3,416	1.31%	2,936	1.14%	3,059	1.21%	2,764	0.57%	2,846	0.60%
	Sunshine Health	69,308	25.89%	79,310	30.53%	63,646	24.67%	62,673	24.77%	27,891	5.72%	29,467	6.18%
	United Healthcare									67,718	13.88%	65,905	13.81%
LTC	Aetna Better Health	1,333	13.41%							1,912	7.41%	1,723	6.68%
	Florida Community Care			693	7.05%			131	1.47%			822	3.19%
	Humana Medical Plan	2,340	23.54%	2,736	27.82%	2,930	32.96%	2,894	32.47%	5,396	20.91%	5,141	19.93%
	Molina Healthcare									3,116	12.07%	2,946	11.42%
	Simply / Amerigroup / Better					2,581	29.03%	2,579	28.94%	3,420	13.25%	3,424	13.27%
	Staywell			769	7.82%							122	0.47%
	Sunshine Health	5,099	51.29%	5,635	57.31%	3,379	38.01%	3,308	37.12%	6,486	25.13%	6,311	24.46%
	United Healthcare	1,170	11.77%							5,482	21.24%	5,308	20.58%

Market Share Comparison - Pre and Post Transition - Phase 2

		Region 5				Region 6				Region 7				Region 8			
		Pre Transition		Post Transition		Pre Transition		Post Transition		Pre Transition		Post Transition		Pre Transition		Post Transition	
Program	Display Name	Recipients	Percent	Recipients	Percent	Recipients	Percent	Recipients	Percent	Recipients	Percent	Recipients	Percent	Recipients	Percent	Recipients	Percent
MMA	Aetna Better Health							13,056	3.15%			24,049	6.21%				
	Children's Medical Services (CMS) [..	3,789	2.04%	3,730	2.07%	7,332	1.71%	7,212	1.74%	7,458	1.84%	7,328	1.89%	3,213	1.58%	3,142	1.60%
	Clear Health Alliance [Specialty Plan]	701	0.38%	636	0.35%	973	0.23%	988	0.24%	1,108	0.27%	1,191	0.31%	432	0.21%	462	0.24%
	Florida Community Care			352	0.20%			184	0.04%			240	0.06%			87	0.04%
	Freedom Health [Specialty Plan]	20	0.01%			26	0.01%			8	0.00%			8	0.00%		
	Humana Medical Plan			10,279	5.71%	41,439	9.66%	48,093	11.59%			26,793	6.92%			10,288	5.24%
	Magellan Complete Care [Specialty ..	8,946	4.81%	6,375	3.54%	12,808	2.98%			12,957	3.19%	11,846	3.06%				
	Molina Healthcare					27,042	6.30%			25,619	6.32%			39,086	19.25%	41,605	21.19%
	Prestige	20,853	11.22%			31,120	7.25%			36,346	8.96%			44,645	21.98%		
	Simply / Amerigroup / Better	66,678	35.86%	66,009	36.67%	135,406	31.55%	134,725	32.47%	75,258	18.55%	85,984	22.20%				
	Staywell	49,729	26.75%	52,893	29.38%	112,955	26.32%	119,514	28.80%	130,429	32.16%	148,326	38.29%	79,521	39.16%	84,601	43.09%
	Staywell [Specialty Plan]			968	0.54%			12,664	3.05%			2,636	0.68%			7,317	3.73%
	Sunshine Child Welfare [Specialty Pl..	2,451	1.32%	2,873	1.60%	5,450	1.27%	5,895	1.42%	3,922	0.97%	4,502	1.16%	2,650	1.30%	2,978	1.52%
	Sunshine Health	32,754	17.62%	35,915	19.95%	54,634	12.73%	58,335	14.06%	61,635	15.20%	74,449	19.22%	33,526	16.51%	37,382	19.04%
	United Healthcare							14,314	3.45%	50,863	12.54%						
	Vivida Health															8,479	4.32%
LTC	Aetna Better Health					1,040	8.58%	1,156	9.59%	1,037	10.83%	1,110	11.61%				
	Florida Community Care			431	4.10%			203	1.68%			278	2.91%			107	1.64%
	Humana Medical Plan	2,191	20.62%	2,423	23.02%	1,842	15.20%	2,045	16.97%	1,944	20.30%	2,274	23.78%	985	15.06%	1,102	16.88%
	Molina Healthcare	1,332	12.54%			1,655	13.66%									156	2.39%
	Simply / Amerigroup / Better			310	2.95%			185	1.54%			244	2.55%				
	Staywell			1,060	10.07%			582	4.83%			687	7.18%			252	3.86%
	Sunshine Health	5,423	51.04%	6,301	59.87%	5,677	46.84%	5,910	49.04%	4,665	48.72%	4,969	51.97%	4,613	70.52%	4,912	75.23%
	United Healthcare	1,678	15.79%			1,906	15.73%	1,970	16.35%	1,930	20.15%			943	14.42%		

Market Share Comparison - Pre and Post Transition - Phase 3

		Region 1				Region 2				Region 3				Region 4			
		Pre Transition		Post Transition		Pre Transition		Post Transition		Pre Transition		Post Transition		Pre Transition		Post Transition	
Program	Display Name	Recipients	Percent	Recipients	Percent	Recipients	Percent	Recipients	Percent	Recipients	Percent	Recipients	Percent	Recipients	Percent	Recipients	Percent
MMA	Children's Medical Services (CMS) [Specialty Plan]	1,381	1.31%	1,340	1.32%	3,410	3.03%	3,323	3.08%	4,799	1.82%	4,781	1.86%	3,963	1.25%	3,895	1.27%
	Clear Health Alliance [Specialty Plan]	228	0.22%	246	0.24%	268	0.24%	303	0.28%	595	0.23%	608	0.24%			1,032	0.34%
	Florida Community Care			6	0.01%			348	0.32%			14	0.01%			24	0.01%
	Freedom Health [Specialty Plan]									35	0.01%						
	Humana Medical Plan	55,501	52.78%	57,770	56.96%			13,269	12.32%			20,642	8.02%			25,340	8.24%
	Lighthouse Health Plan			13,572	13.38%			11,367	10.55%								
	Magellan Complete Care [Specialty Plan]					4,374	3.89%							12,223	3.87%	9,746	3.17%
	Molina Healthcare	46,831	44.54%											66,801	21.12%		
	Prestige					50,235	44.69%			53,031	20.12%						
	Staywell			11,565	11.40%	53,063	47.21%	62,006	57.56%	87,359	33.14%	96,351	37.43%	66,702	21.09%	81,259	26.41%
	Staywell [Specialty Plan]			4,320	4.26%			5,227	4.85%			13,234	5.14%			1,224	0.40%
	Sunshine Child Welfare [Specialty Plan]	1,206	1.15%	1,732	1.71%	1,055	0.94%	1,471	1.37%	4,243	1.61%	3,935	1.53%	5,397	1.71%	5,284	1.72%
	Sunshine Health			10,879	10.73%			10,418	9.67%	55,718	21.13%	54,953	21.35%	82,716	26.16%	89,701	29.15%
	United Healthcare									57,856	21.95%	62,899	24.43%	78,422	24.80%	90,186	29.31%
LTC	Florida Community Care			11	0.33%			425	11.66%			17	0.22%			29	0.31%
	Humana Medical Plan	1,491	45.83%	1,540	46.67%	1,417	38.57%	1,488	40.83%	1,165	15.08%	1,359	17.24%	3,080	32.93%	3,052	32.37%
	Staywell			32	0.97%			1,175	32.24%			105	1.33%			103	1.09%
	Sunshine Health	1,762	54.17%	1,717	52.03%			556	15.26%	4,721	61.09%	4,535	57.51%	4,140	44.26%	4,038	42.83%
	United Healthcare					2,257	61.43%			1,842	23.84%	1,869	23.70%	2,133	22.81%	2,207	23.41%

Appendix II

Health Plans by Region (2018-2023)

REGION	AETNA BETTER HEALTH	COMMUNITY CARE PLAN	FLORIDA COMMUNITY CARE	HUMANA MEDICAL PLAN	LIGHTHOUSE HEALTH PLAN	MIAMI CHILDREN'S	MOLINA HEALTHCARE	PRESTIGE	SIMPLY HEALTHCARE	STAYWELL	SUNSHINE HEALTH	UNITEDHEALTHCARE	VIVIDA HEALTH
1			FLORIDA COMMUNITY CARE LTC+	HUMANA MEDICAL PLAN COMP	LIGHTHOUSE HEALTH PLAN MMA					STAYWELL COMP	SUNSHINE HEALTH COMP		
2			FLORIDA COMMUNITY CARE LTC+	HUMANA MEDICAL PLAN COMP	LIGHTHOUSE HEALTH PLAN MMA					STAYWELL COMP	SUNSHINE HEALTH COMP		
3			FLORIDA COMMUNITY CARE LTC+	HUMANA MEDICAL PLAN COMP						STAYWELL COMP	SUNSHINE HEALTH COMP	UNITEDHEALTHCARE COMP	
4			FLORIDA COMMUNITY CARE LTC+	HUMANA MEDICAL PLAN COMP						STAYWELL COMP	SUNSHINE HEALTH COMP	UNITEDHEALTHCARE COMP	
5			FLORIDA COMMUNITY CARE LTC+	HUMANA MEDICAL PLAN COMP					SIMPLY HEALTHCARE COMP	STAYWELL COMP	SUNSHINE HEALTH COMP		
6	AETNA BETTER HEALTH COMP		FLORIDA COMMUNITY CARE LTC+	HUMANA MEDICAL PLAN COMP					SIMPLY HEALTHCARE COMP	STAYWELL COMP	SUNSHINE HEALTH COMP	UNITEDHEALTHCARE COMP	
7	AETNA BETTER HEALTH COMP		FLORIDA COMMUNITY CARE LTC+	HUMANA MEDICAL PLAN COMP					SIMPLY HEALTHCARE COMP	STAYWELL COMP	SUNSHINE HEALTH COMP		
8			FLORIDA COMMUNITY CARE LTC+	HUMANA MEDICAL PLAN COMP			MOLINA HEALTHCARE COMP			STAYWELL COMP	SUNSHINE HEALTH COMP		VIVIDA HEALTH MMA
9			FLORIDA COMMUNITY CARE LTC+	HUMANA MEDICAL PLAN COMP		MIAMI CHILDREN'S MMA		PRESTIGE MMA		STAYWELL COMP	SUNSHINE HEALTH COMP		
10		COMMUNITY CARE PLAN MMA	FLORIDA COMMUNITY CARE LTC+	HUMANA MEDICAL PLAN COMP					SIMPLY HEALTHCARE COMP		SUNSHINE HEALTH COMP		
11	AETNA BETTER HEALTH COMP		FLORIDA COMMUNITY CARE LTC+	HUMANA MEDICAL PLAN COMP		MIAMI CHILDREN'S MMA	MOLINA HEALTHCARE COMP	PRESTIGE MMA	SIMPLY HEALTHCARE COMP	STAYWELL COMP	SUNSHINE HEALTH COMP	UNITEDHEALTHCARE COMP	

Specialty Plans

Dental Plans

REGION	CHILDREN'S MEDICAL SERVICES PLAN – CHILDREN WITH CHRONIC CONDITIONS	CLEAR HEALTH ALLIANCE – HIV/AIDS	MAGELLAN COMPLETE CARE – SERIOUS MENTAL ILLNESS (SMI)	STAYWELL – SERIOUS MENTAL ILLNESS (SMI)	SUNSHINE HEALTH – CHILD WELFARE	DENTAQUEST	LIBERTY	MCNA DENTAL
1	CHILDREN'S MEDICAL SERVICES PLAN SPEC	CLEAR HEALTH ALLIANCE SPEC		STAYWELL SPEC	SUNSHINE HEALTH SPEC	DENTAQUEST DEN	LIBERTY DEN	MCNA DENTAL DEN
2	CHILDREN'S MEDICAL SERVICES PLAN SPEC	CLEAR HEALTH ALLIANCE SPEC		STAYWELL SPEC	SUNSHINE HEALTH SPEC	DENTAQUEST DEN	LIBERTY DEN	MCNA DENTAL DEN
3	CHILDREN'S MEDICAL SERVICES PLAN SPEC	CLEAR HEALTH ALLIANCE SPEC		STAYWELL SPEC	SUNSHINE HEALTH SPEC	DENTAQUEST DEN	LIBERTY DEN	MCNA DENTAL DEN
4	CHILDREN'S MEDICAL SERVICES PLAN SPEC	CLEAR HEALTH ALLIANCE SPEC	MAGELLAN COMPLETE CARE SPEC	STAYWELL SPEC	SUNSHINE HEALTH SPEC	DENTAQUEST DEN	LIBERTY DEN	MCNA DENTAL DEN
5	CHILDREN'S MEDICAL SERVICES PLAN SPEC	CLEAR HEALTH ALLIANCE SPEC	MAGELLAN COMPLETE CARE SPEC	STAYWELL SPEC	SUNSHINE HEALTH SPEC	DENTAQUEST DEN	LIBERTY DEN	MCNA DENTAL DEN
6	CHILDREN'S MEDICAL SERVICES PLAN SPEC	CLEAR HEALTH ALLIANCE SPEC		STAYWELL SPEC	SUNSHINE HEALTH SPEC	DENTAQUEST DEN	LIBERTY DEN	MCNA DENTAL DEN
7	CHILDREN'S MEDICAL SERVICES PLAN SPEC	CLEAR HEALTH ALLIANCE SPEC	MAGELLAN COMPLETE CARE SPEC	STAYWELL SPEC	SUNSHINE HEALTH SPEC	DENTAQUEST DEN	LIBERTY DEN	MCNA DENTAL DEN
8	CHILDREN'S MEDICAL SERVICES PLAN SPEC	CLEAR HEALTH ALLIANCE SPEC		STAYWELL SPEC	SUNSHINE HEALTH SPEC	DENTAQUEST DEN	LIBERTY DEN	MCNA DENTAL DEN
9	CHILDREN'S MEDICAL SERVICES PLAN SPEC	CLEAR HEALTH ALLIANCE SPEC		STAYWELL SPEC	SUNSHINE HEALTH SPEC	DENTAQUEST DEN	LIBERTY DEN	MCNA DENTAL DEN
10	CHILDREN'S MEDICAL SERVICES PLAN SPEC	CLEAR HEALTH ALLIANCE SPEC		STAYWELL SPEC	SUNSHINE HEALTH SPEC	DENTAQUEST DEN	LIBERTY DEN	MCNA DENTAL DEN