INNOVATION OHIO EDUCATION FUND

THE COMING REASSIGNMENT

Millions of Ohio Medicaid Recipients Are About To Face A Change In Healthcare Plans If They Do Not Act

Innovation Ohio Education Fund
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Executive Summary

Nearly 3.3 million Ohioans receive healthcare coverage through a plan. A new policy set to take effect in the coming months could result in negative consequences for current members.

Bottom Line

- 2.9 million Ohioans could be dropped from their Medicaid managed care plan and reassigned to another as a result of a new administration policy, few details about which have been released.
- Managed care members will be notified in spring 2022 that they must choose a managed care plan and, if they fail to act, would be subject to reassignment to a new plan selected by computer algorithm.
- Between 15 and 60 percent of members might be expected to actively select a plan, with the rest - anywhere from 1 to 2.4 million Ohioans - subject to reassignment.
- These individuals are disproportionately Black, female and younger than the Ohio population overall.
- A change in healthcare plan could mean a subscriber's providers are no longer in network and services are no longer covered; changes to provider networks could, in turn, pose transportation challenges.
- While emphasizing consumer choice, the move appears to be aimed at ensuring profitability of managed care plans by redistributing current members among them.

Background

Today, Medicaid covers the healthcare costs of nearly 3.3 million Ohioans.

The program is open to Ohio residents who are low-income, very young, very old or living with disabilities. As of September 2021, managed care organizations were responsible for the healthcare coverage of over 2.9 million Ohioans, or 88% of all individuals enrolled in Medicaid. [1]

Managed care is an arrangement by which an insurance carrier contracted by the Ohio Department of Medicaid (ODM) offers care to members through a network of medical providers. Five companies currently operate in Ohio as Managed Care Organizations (MCOs) for Medicaid.[2] The state recently completed a procurement process to re-bid these contracts and announced that seven companies will be operating as MCOs beginning in 2022. Of the five current participating plans, four were selected to continue. Three new plans will join the four incumbents in providing care beginning in mid-2022.[3]

[1]Ohio Department of Medicaid. 2021. "Workbook: Medicaid Demographic and Expenditure." https://analytics.das.ohio.gov/t/ODMPUB/views/MedicaidDemographicandExpenditure/WhoWeServe.
[2]Incumbent plans are: Buckeye Health Plan, CareSource, Molina Healthcare, Paramount Advantage and UnitedHealthcare Community Plan.
[3]In 2022, Buckeye, UnitedHealthcare, Molina and CareSource will continue to provide service (Paramount was not selected for contract renewal), along with three new plans: Humana Health Plan of Ohio, AmeriHealth Caritas Ohio and Anthem Blue Cross and Blue Shield.

The Coming Reassignment

In 2022, as part of a major overhaul of the administration of Medicaid managed care in Ohio, the DeWine administration is set to enact one major change that could disrupt care for millions of Ohio existing subscribers.

Plan Selection Today

Ohio requires the vast majority of Medicaid enrollees to participate in managed care. While participation is required, not all members make an active choice about which plan to sign up for.

If a new member takes no action upon enrollment to select a managed care plan, they are automatically assigned to one by ODM using a mathematical algorithm to determine the best plan for that individual.

ODM describes the auto-assignment process as "a hierarchy of multiple steps with the goal of assigning individuals to the managed care plan that best matches their needs and preserves the existing provider patient relationships, including relationships that may exist for persons with special health care needs." It looks at prior enrollment, existing provider relationships, claims history, and which plans the subscriber's relatives belong to, with the goal of assigning members to plans they have experience with and who cover the providers and services they are most likely to utilize.[4]

Once assigned, an individual remains with their plan unless they actively make a new plan selection during their first 90 days or in the annual open enrollment period.

Proposed Changes to Plan Selection

Beginning in 2022, the 2.9 million members already enrolled in managed care will be asked to make an active choice to remain with their current plan, select another plan, or risk being automatically assigned to one of six other plans. The automatic selection of a new plan for current subscribers who do not choose one will be made by a computer

[4]In a 2018 filing with the Centers for Medicare & Medicaid Service, Ohio's Department of Medicaid (ODM) characterized the current auto-assignment algorithm for newly-enrolled members as follows: " If a member has been enrolled in the previous six months, he or she is enrolled into the same plan. If a member has a family member in the same Medicaid case that is currently enrolled, he or she is enrolled in the same plan as the rest of his or her family. For members who do not have enrollment history, an assignment is attempted based on the Medicaid fee-for-service providers the member has utilized in the last 12 months and matching those providers to each of the managed care plans' provider networks. If the Medicaid recipient does not have an existing relationship with a Medicaid fee-for-service provider, the managed care assignment is based on quarterly quality assessments of the managed care plans in five key health related performance standards. ODM weights the percentages of assignments to each individual managed care plan (MCP) based on the results of the quality assessments. Assignments are also based on the MCP's member enrollment and provider network capacity in each county. If a MCP's ratio of member enrollment to provider network capacity is too high in a particular county, assignments will be blocked for that MCP in that county for the entire month. Enrollees have up to 90 days from enrollment to change plans."
[https://medicaid.ohio.gov/static/Stakeholders%2C+Partners/MedicaidStatePlan/Sections/SGP/3.1-F.pdf]

algorithm. Members, in other words, will be automatically unenrolled from the plan they are enrolled in and forced to choose to keep it or face potential reassignment. The process has been termed "Member Transition Enrollment" and is set to occur in the spring of 2022, when members will "be able to select from the next generation plans." Coverage will be effective in July.[5]

According to the Department, sometime in the spring, all members will be asked to select from the next generation plans during Member Transition Enrollment. No specifics have been provided as to how this communication with members will work. According to the Department's website, "[a]dditional communications will be sent to members to provide directions on how to select from the new and continuing plans."

Changing plans could mean transportation challenges and disruptions in receiving care as members find that their preferred medical providers are no longer in the network and services they are receiving are no longer covered.

Origins of the Reassignment Proposal

It's hard to know where this proposal is coming from. The decision to subject existing members to plan reassignment was not a subject of an extensive public-input process conducted over the past two years leading up to the rebidding of managed care contracts.

As the Department of Medicaid began efforts to redesign the managed care program, it issued two separate Requests for Information (RFIs) in 2019 and 2020 to solicit feedback from providers, industry groups and individuals. Despite prompting for input about dozens of aspects of the program, neither solicitation asked for feedback on having members re-confirm their plan selection during open enrollment or face reassignment. In the February 2020 RFI, ODM asked for input on how to allocate members who didn't affirmatively select a plan equitably across plans.[6]

But in doing so, the Department did not indicate they intended to reassign existing members, but rather appeared to be looking for ways to avoid sending too many or too few members to any single plan.

[5]Ohio Department of Medicaid, "Managed Care Procurement: Individuals." Accessed October 19, 2021. https://managedcare.medicaid.ohio.gov/wps/portal/gov/manc/help-center/individual.

[6]The exact wording of the statement soliciting feedback was: "ODM intends to redistribute individuals who do not affirmatively select an MCO across all MCOs using an automatic assignment algorithm." source: Ohio Department of Medicaid, "Ohio Medicaid Managed Care Program RFI #2." https://procure.ohio.gov/PDF/ODMR20210019242020852490DMR20210019.pdf

Further, the final solicitation of bids from MCOs for a portion of the state's annual $20 billion expenditure on managed care did not mention the plan to drop members from their current plans. In September 2020, when the Department opened up the bidding for carrier plans to be awarded a contract, the Department stated its intent to use an algorithm to auto-assign enrollees to plans if they did not affirmatively select one," but nowhere indicated they planned to force existing members to repeat the plan selection process."[7]

By May of 2021, however, it had become clear that the Department intended to subject existing members to actively affirm their selection of plans, or face reassignment. Lawmakers serving on the Joint Medicaid Oversight Committee (JMOC) raised concerns in questions to ODM Director Maureen Corcoran at a May 20 hearing.[8] In an August response to news coverage and a series of op-eds by policy advocates, Director Corcoran reiterated the Department's intent to subject all managed care participants to the new selection process with many members reassigned if they did not make an affirmative choice.[9] In a statement to the Columbus Dispatch, the Director explained the intent was to "try to help everyone make a choice" and to "educate and provide information about available services, so that we could improve the overall health literacy of everyone on the program, rather than sort of default."[10]

Outside of Department responses to media inquiries and questions in committee hearing rooms, the only public acknowledgement of this proposed policy change is found deep on the Medicaid Department's website, explaining how current members will need to choose a new plan (or affirmatively request to stay with their current plan) in early 2022.

This begs obvious questions about how subscribers are going to be notified and reminded of their responsibility to make a new choice of plans. Further, it leaves even more unanswered questions about how this change will affect those who fail to respond.

How It Will Work

Much is unknown at this time, but according to the Ohio Department of Medicaid's website, in the spring of 2022, members will be required to respond to communication from the Department in order to elect their plan for the coming year. The ODM website says that all current members will be required to choose a new plan or be automatically assigned to one. No information is provided about how members will be notified, other than the promise that "[a]dditional communications will be sent to members to

[7]Ohio Department of Medicaid. "REQUEST FOR APPLICATIONS Ohio Medicaid Managed Care Organizations." https://procure.ohio.gov/PDF/ODMR20210024930202011535 5ODMR20210024.pdf.
[8]Gongwer News Service, "Lawmakers Scrutinize Medicaid Managed Care." May 20, 2021. https://www.gongwer-oh.com/news/?article_ID=900980202.
[9]Gongwer News Service,. "New Medicaid Managed Care System To Start In July." August 25, 2021. https://www.gongwer-oh.com/news/?article_ID=901650203.
[10]Wu, Titus, "Will enrollment changes hurt Ohioans on Medicaid?" Columbus Dispatch, August 16, 2021. https://www.dispatch.com/story/news/healthcare/2021/08/16/enrollment-changes-hurt-ohioans-medicaid-poc-ohio-barriers-access-low-income-health-plan/5473761001/.

provide directions on how to select from the new and continuing plans."[11]

The only additional information we have about the mode of contact is that, in testimony before lawmakers, Medicaid Director Corcoran agreed that mail alone would be insufficient, stating that the Department was "working on plans about how we go about this in a way that not only acknowledges that - I don't know about you but I don't open my mail, so that's not going to cut it - but also all the difficulties of keeping people's addresses, we're looking at every possible option so people don't get missed."[12]

Beyond those comments, Corcoran had very few details to share about how the process would work, stating: "I would prefer to come back and talk about that when we have a more -- the current process is one thing, how we'll use it going forward is part of our design."[13]

For some current members, this process is unavoidable. One plan that currently provides managed care -- Paramount -- was not selected in the 2021 contract awards, so remaining in the Paramount MCO will not be an option moving into 2022. Obviously the approximately 250,000 members in that plan will need to be reassigned -- either by selecting a new plan or having one assigned to them. But members of the four other incumbent plans -- all of whom were selected to continue under the new contract -- are also being dropped from their plans and expected to go through this selection and reassignment process.

It is also unclear whether members will be able to switch back to their old plan once reassigned. Today, a new Medicaid enrollee has up to 90 days to request a change of plans after being automatically assigned to one.[14] The Department has not yet stated if existing members who are reassigned for failing to make an active selection to stay with their plan will also have 90 days to switch back.

"I don't know about you but I don't open my mail."

- Ohio Department of Medicaid Director, **Maureen Corcoran**

The Department has released no information about how Medicaid enrollees, many of whom have unstable housing and internet access, will be asked to take action to keep their current plan

[11]Ohio Department of Medicaid, "MC Procurement / Help Center / Individual," https://managedcare.medicaid.ohio.gov/wps/portal/gov/manc/help-center/individual, Last Accessed 12/6/2021.
[12]Ohio Department of Medicaid Director Maureen Corcoran. May 20, 2021. "Testimony to Joint Medicaid Oversight Committee." https://ohiochannel.org/video/ohio-joint-medicaid-oversight-committee-5-20-2021.
[13]ibid
[14]Ohio Department of Medicaid, "Managed Care." https://medicaid.ohio.gov/wps/portal/gov/medicaid/families-and-individuals/mcare/managed+care

Winners and Losers

Who Could be Hurt?

Around a million Medicaid subscribers can reasonably be expected not to take action to affirmatively remain in their current plan and may be forced into a different plan. That's because, according to Department estimates, 40% of subscribers do not affirmatively select a plan and are automatically assigned to one by the Department. A 2016 analysis by Milliman, commissioned by ODM, found that between 29.4 and 48.9% of Medicaid recipients voluntarily selected their MCO. The rest were assigned to or automatically enrolled in a plan.[15]

If this behavior of failing to make an active selection holds up for re-enrollment, **as many as 1 million Ohioans** (40% of 2.9 million current members) **could find themselves assigned to a new healthcare plan** thanks to no action on their part, even if their current plan is still offering coverage.

The actual number could be far higher, however. People can be expected to play a more active role in selecting a healthcare plan when they are in the process of seeking care - either by enrolling in Medicaid or seeking health-related services. Conversely, once

[15]Millman. 2016. "Self-Select Analysis: Medicaid Managed Care Program." JMOC archived testimony. https://jmoc.state.oh.us/Assets/documents/reports/Self-Selection%20ODM%20Study%202016.dotx.pdf.

an individual is already enrolled in a plan, it may not be unreasonable to expect them to pay less attention to communications about plan selection, given no action is typically required on their part to continue with the same place.

Distractions created by a tough job climate and ongoing pandemic may contribute to the lack of active involvement by plan members. ODM Director Corcoran touched on this herself when she explained relatively low rates of new enrollment to the Medicaid program during the pandemic as follows: "With an economic downturn, an individual or family's primary concerns likely focus on food and other basic living essentials. Despite being eligible for Medicaid, many individual and families may not apply for coverage until they need medications or medical care."[16] It's not unreasonable, therefore, to expect that similar distractions may result in current members failing to heed warnings about plan reassignment.

Few details have been revealed about how ODM will reach out to current members about selecting a plan for 2022, but it seems plausible that far fewer existing members -- who aren't actively engaged in thinking about healthcare coverage -- might be expected to make an active choice of plans than the 60% of people who do so when initially enrolling in Medicaid.

Indeed, in North Carolina, a recent shift from fee-for-service to managed care plans that required current Medicaid recipients to choose a managed care plan, only 14.7% plan participants actively did so, despite being given a 60-day period in which to make a selection.[17,18] If Ohio saw the same percentage of its Medicaid members fail to make an active selection, fully 2.4 million (approximately 85% of 2.9 million members) could see a change in their healthcare plan.

> **"With an economic downturn, an individual or family's primary concerns likely focus on food and other basic living essentials. Despite being eligible for Medicaid, many individual and families may not apply for coverage until they need medications or medical care."**
>
> - Ohio Department of Medicaid Director,
> **Maureen Corcoran**

[16]Ohio Department of Medicaid Director Maureen Corcoran. May 5, 2021. "Testimony to Ohio Senate Health Committee." https://search-prod.lis.state.oh.us/cm_pub_api/api/unwrap/chamber/134th_ga/ready_for_publication/committee_docs/cmte_s_health_1/testimony/cmte_s_health_1_2021-05-05-0900_453/corcoran_medicaid_testimony.pdf.

[17]https://www.northcarolinahealthnews.org/2021/06/04/almost-1-5-million-consumers-have-been-moved-to-nc-medicaids-managed-care-now-what/

[18]https://files.nc.gov/ncdma/documents/Providers/playbook/NCMT-Provider-FactSheet-Beneficiary-Enrollment-and-Timelines-20210422-DRAFT.pdf

Beyond the top-line number of people reassigned, it's also important to note that this change will impact certain groups disproportionately. **Medicaid managed care participants are more likely to be female, young, and non-white than the typical Ohioan.** Fully 43.7% of the members in Medicaid managed care plans are under 18 (compared to just 22% of Ohio).

The process the department will use to notify members is also important and has not yet been shared with stakeholders. Low-income people, often living in rental or other temporary living situations, can change residences frequently and might not have updated their addresses with ODM. This could lead to them failing to receive notifications about the upcoming change, thus failing to make an active plan selection as a result. If they are automatically reassigned to another plan, the lack of current address on file could mean they will not receive their insurance card to access benefits or updated information about their new plan.

The potential consequences of abrupt plan changes - transportation challenges, providers no longer in-network, and services no longer covered - can therefore be expected to acutely impact a million or more Ohioans, primarily young people, people of color, and women, particularly those with transient or unstable living arrangements.

The process the department will use to notify members matters because of the circumstances many Medicaid recipients find themselves in. Low-income people, often living in rental or other temporary living situations, can change residences frequently and may not inform the Department immediately if their contact information changes. This could lead to them failing to receive notifications about the upcoming change, thus failing to make an active plan selection as a result. If they are automatically reassigned to another plan, the lack of current address on file could mean they will not receive their insurance card to access benefits or updated information about their new plan.

The potential consequences of abrupt plan changes - transportation challenges, providers no longer in-network, and services

Demographics of Medicaid Managed Care

	Ohio	Medicaid Managed Care
Black	13.1%	29.5%
Female	51.0%	54.6%
Under 5	5.9%	14.6%
Under 18	22%	43.7%

Sources: Ohio Department of Medicaid and US Census QuickFacts[19,20]

[19] Ohio Department of Medicaid. 2021. "Workbook: Medicaid Demographic and Expenditure." https://analytics.das.ohio.gov/t/ODMPUB/views/MedicaidDemographicandExpenditure/WhoWeServe.

[20] U.S. Census. 2019. "QuickFacts Ohio." https://www.census.gov/quickfacts.

Current Managed Care Membership By Plan

CareSource	1,396,808
Buckeye Community Health Plan	429,625
United Healthcare Community Plan of Ohio	355,506
Molina Healthcare of Ohio	330,202
Paramount Advantage	252,895

Source: ODM Medicaid Demographic and Expenditure Dashboard, Sept. 2021

no longer covered - can therefore be expected to acutely impact a million or more Ohioans, primarily young people, people of color, and women, particularly those with transient or unstable living arrangements.

Who benefits?

It's become clear that the Department's goal was to be mindful of the need for each of the managed care plans to each have enough members to spread the risk and ensure each makes a profit.

In her May testimony to JMOC, Director Corcoran admitted that part of the Department's thinking behind the forced reassignment proposal was the need to rebalance plan membership among the soon-to-be seven plans. The four current plans retained by the Department cover 2.6 out of 2.9 million total managed care subscribers. Nearly 1.5 million of those are covered by one company -- CareSource of Dayton.

Fewer than 253,000 current customers are enrolled in Paramount Advantage, the one incumbent plan that will not remain as part of re-procurement. But rather than reassign just those customers and rely on new subscribers to round out membership in the new plans, the Department is subjecting all 2.9 million members to potential reassignment if they fail to act with an eye toward plan profitability.

Director Corcoran has insisted that the Department's focus on "person-centered care" means maximizing personal engagement in the selection process. "That has to be the #1 principle to honor people's choice from the very beginning," stated Corcoran. But she did so while acknowledging that making sure each managed care plan has enough of the right mix of customers to be profitable was another key consideration: "we will be looking at, over time, what is minimally necessary for a plan to be financially stable and managing that transition process. So I'm not going to say that the assignment process is disconnected from that, but there are a variety of things that have to be looked at in terms of both the assignment and the different kinds of sickness and morbidity within different populations and how the assignment plays out -- that affects all of the rate-setting."[21]

[21] Op. cit. Corcoran testimony to JMOC

A "Drastic" Experiment

As far as we can tell, Ohio is the only state proposing to force all current members through a plan selection and reassignment process.

To be clear, auto-assignment is, in itself, not particularly controversial. It's allowed within federal guidelines, as long as members are first given the choice of at least two plans and fail to select one. Currently, 39 states automatically assign members to plans in the absence of an affirmative selection by the enrolled individual. Auto-assignment, by definition, means that a member played a less than active role in choosing their healthcare plan, but that is preferable to not being enrolled in any specific plan due to lack of action.

Obviously, in instances where a plan exits the market or is not selected for contract renewal, members must choose a new plan or have one selected for them. But to force over 2.6 million subscribers covered by the four incumbent plans retained by ODM to either choose a new plan or face reassignment is not common practice, and some believe it could have unforeseen negative consequences.[22]

Forcing current members to be dropped from their plans and assigned to another plan is the aspect of the proposed process that is somewhat novel, and it seems extreme and out of step with best practices in auto-assignment. One expert in auto-assignment best practices that we contacted said that Ohio's approach seemed more "drastic" than the typical re-procurement process of shifting members from a non-renewed old plan to a newly-contracted plan. He suggested that Ohio should ensure a lengthy grace period after the auto-assignment in which customers are allowed to switch back without consequence.[23]

[22]Proposed Medicaid changes are terrible idea." Columbus Dispatch, July 26, 2021

[23]Email correspondence with Chima Ndumele, Yale School of Public Health, October 12, 2021.

Best Practices in Auto-Assignment

To be clear, using an auto-assignment algorithm to balance enrollment between plans is not bad in itself. Indeed, it's very common.

According to research by the Kaiser Family Foundation (KFF), "over half (23) of MCO states reported that their auto-enrollment algorithms were designed to balance enrollments among plans."[24]

However, auto-assignment is normally only used to enroll new members, not to reassign already-subscribed members to other plans. Re-procurement of managed care plans by state Medicaid programs is not unique either. Other states have rebid their managed care contracts without causing widespread shifts in coverage for individuals enrolled in plans that have their managed care contracts renewed.

One example of this is **Florida**, where the program **re-bid its managed care contracts in 2013-2014, but specifically avoided re-assigning members whose plans were selected to remain as managed care providers, unless the individual specifically asked to change plans.**

For consumers whose current plans were not selected to remain and were exiting the program, the agency sent customers a letter with a brochure comparing benefits under each remaining plan, information about which plan they would be auto-assigned to if they took no action, and notification that they had 120 days to choose a different plan.[25]

Generally, when approaching auto-enrollment for new Medicaid subscribers, there is a fairly common set of priorities used by Medicaid programs across the country for deciding which plan to assign members to. According to a recent report to Congress by the US General Accounting Office in which they examined the auto-assignment processes of eight representative state Medicaid programs, the primary consideration used by states is typically maintaining consistency for the beneficiary.[26]

In one such example, Louisiana's Medicaid program assigns new members to plans by looking at whether an individual was previously enrolled in a medicaid managed care plan, whether they have a past primary care provider or claims history, or have family members in a particular plan. Tennessee automatically assigns members to the plan they participated in before if they were

[24] Henry Kaiser Foundation and National Association of Medicaid Directors, "Implementing Coverage and Payment Initiatives: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2016 and 2017," October 2016, https://files.kff.org/attachment/Report-Implementing-Coverage-and-Payment-Initiatives.

[25] "Florida Medicaid Managed Care Auto-Assignment Methodology," Report to the Florida Legislature. 2019. https://ahca.myflorida.com/Medicaid/recent_presentations/2019/Auto-Assignment_Report_100119_Final.pdf

[26] https://www.gao.gov/assets/gao-16-77.pdf

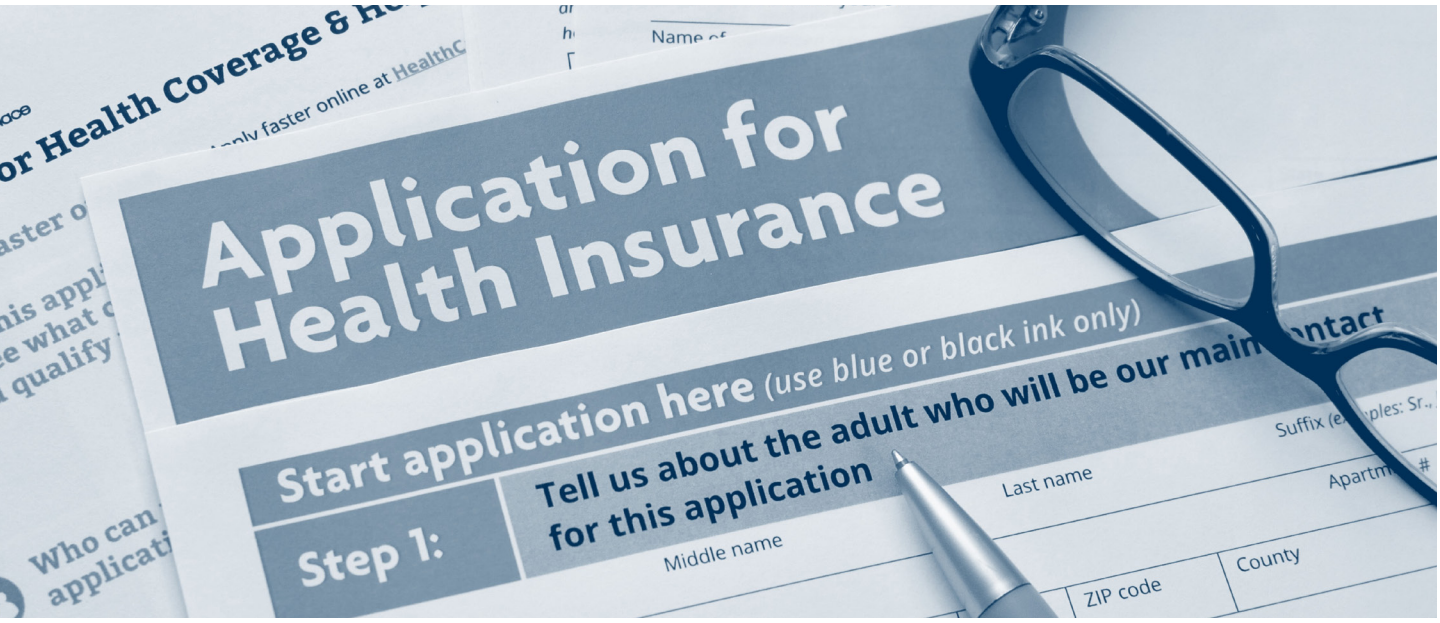
previously on Medicaid and re-enrolled. Washington and Tennessee aim to sign members up for plans that cover members of their family. The other four states consider factors such as plan performance, but only after considering the enrollment, claims and provider history of the patient. All eight states factored in overall program goals such as ensuring no plan had too few or too many subscribers -- but only after considering an individual's medical history and/or plan performance.

A separate analysis conducted by the Kaiser Family Foundation and the National Association of Medicaid Directors found that, in general, state auto-assignment algorithms typically "take into consideration previous plan or provider relationships, geographic location of the beneficiary, and/or plan enrollments of other family members."[27]

In short, when automatically assigning members to plans, states typically first attempt to preserve consistency by matching recipients with plans they've had in the past or that line up with primary care providers with whom they have a relationship. If Ohio was to use this approach for re-procurement, no one would be assigned to a new plan unless that plan was discontinued or no longer serving the program. In 2022, this applies to only one healthcare plan - Paramount Advantage, whose 253,000 current subscribers will need to be reassigned to one of the 7 plans selected to serve as MCOs in 2022.

Ohio's plan to reassign a million or more individuals to plans other than the one in which they are currently enrolled goes against the beneficiary-first approach used by nearly every other state Medicaid program. Re-assigning up to 40 percent of the covered population rather than the 253,000 losing a plan under re-procurement doesn't put the individual first.

[27] Op cit, Henry Kaiser Foundation and National Association of Medical Directors



Alternatives to Consider

Provide Hands-On Assistance to Members

In a May presentation to the Joint Medicaid Oversight Committee, Director Corcoran indicated that feedback and suggestions that the Department received from subscribers about managed care said that better functionality for "plan comparison" was needed.[28]

At the same meeting, Senators Cecil Thomas and Nicki Antonio asked Director Corcoran about the option of providing assistance in the form of counseling akin to the "navigators" who were deployed to help individuals choose healthcare plans on the federal Affordable Care Act exchanges. Director Corcoran responded that no such plans were being contemplated by the Department. But such an approach would not be novel - many states offer such assistance to members to help them select the best plan for themselves and their families.

This would not be out of step with how other states assist clients enrolling in Medicaid to navigate plan options. According to MACPAC, a "a non-partisan legislative branch agency that provides policy and data analysis and makes recommendations to Congress," many states use independent brokers to help enrollees select among plan options. They note that states are additionally permitted to use community-based organizations to help navigate the enrollment process.[29]

Give Members More Time to Choose and Change Plans

Another alternative could be for Ohio to give members one month to choose a plan or face having one automatically assigned to them. Other states provide a two to three month window.

After a plan has been automatically assigned to a new Medicaid member, the members have 90 days to make a change. It has not yet been made clear if the 2022 reassignment process will similarly provide a 90-day corrective window for individuals to switch back to their former (or another) plan.

In North Carolina, which recently transitioned its fee-for-service members to managed care, participants were given nearly four months to make a change to the plan that was assigned to them. As part of the process, North Carolina is also allowing members to keep seeing their old providers, even if they are out of network in their new plans, for up to a few weeks after the switch is effective to minimize disruptions in care.[30]

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[28] ODM Presentation: "Developing the ODM Procurement," 5/20/21, https://jmoc.state.oh.us/assets/meetings/JMOC%20Developing%20the%20ODM%20Procurement%205.20.21%20-%20FINAL.pdf

[29] Medicaid and CHIP Payment and Access Commission, "Enrollment process for Medicaid managed care," https://www.macpac.gov/subtopic/enrollment-process-for-medicaid-managed-care/.

[30] NC Department of Health and Human Services, "NC Medicaid Managed Care Health Plan Assignments Completed for Beneficiaries," May 26, 2021, https://www.ncdhhs.gov/news/press-releases/2021/05/26/nc-medicaid-managed-care-health-plan-assignments-completed-beneficiaries

Conclusion

Next spring, all of Ohio's 2.9 million Medicaid managed care enrollees will be forced to choose whether to stay with their existing healthcare plan or face reassignment to a new plan.

Based on current behavior and observations in other states, as many as 2.4 million members could be reassigned thanks to no action on their part. That number may be far lower, but few details have emerged from the Department of Medicaid about how members will be notified and what type of assistance they will be provided to select a plan or keep the one they already have. Stakeholders should continue to monitor this proposal and hold the administration accountable for prioritizing the quality and predictability of healthcare coverage over the profits of managed care companies.

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