

**Medi-Cal Managed Care Division:
AUTO ASSIGNMENT INCENTIVE PROGRAM OVERVIEW**

As of 6/10/13

The Auto Assignment Incentive Program was implemented in the Medi-Cal Managed Care Program in December 2005 (Year 1) in the GMC and Two-Plan Model counties. Initially five HEDIS measures and two safety net measures were used to develop quality scores for plans in each county to determine which plans would receive a greater percentage of default enrollment. Additional HEDIS measures were added in Year 3 (effective Dec 2007) and Year 6 (effective Jan 2011), and the Use of Appropriate Medications for People with Asthma HEDIS measure was dropped for Year 6 (effective Jan 2011). The effective date range was also changed for Year 6 to begin in January 2011 and for Year 7 to begin in February 2012.

Current HEDIS Measures Used in Auto Assignment Program to be used through Year 8 (to be effective February 2013 to January 2014)

- Adolescent Well-Care Visits (AWC)
- Cervical Cancer Screening (CCS)
- Childhood Immunization Status – Combination 3 (CIS-3)
- Prenatal and Postpartum Care – Timeliness of Prenatal Care (PPC-Pre)
- Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life (W34)
- Comprehensive Diabetes Care: HbA1c Testing

Since the Adolescent Well-Care Visits measure will not be reported by the plans for HEDIS 2013, Year 9 (effective February 2014 to January 2015) will only use the remaining five measures above.

Scoring of HEDIS Results

Points are assigned to each plan's HEDIS rate for each measure – “current year” points and “improvement” points.

- For current year points, plans are compared to each other (2-plan counties) or to the county's harmonic mean” (GMC counties) and awarded points based on whether the plan's score for each measure is statistically superior to the other (2-plan) or to the harmonic mean (GMC), statistically equivalent or statistically inferior.
- An improvement point is awarded if a plan's performance has improved over the previous year or in the case of “exceptionally strong performance” (at or above NCQA's national 90th percentile for Medicaid managed care and better than 70% overall). No point is awarded if the plan's performance is unchanged from the previous year, and a point is removed if the plan's performance has deteriorated from the previous year.

Safety Net Measures

Two safety net measures are used in the Auto Assignment Incentive Program:

- Percentage of hospital discharges at DSH facilities for members residing within the county (based on OSHPD hospital discharge data)

- Percentage of members assigned to PCPs who are safety net providers (based on rates provided by the plans after safety net provider lists have been validated by MMCD and validation of a sample of screen prints verifying PCP assignments)

“Safety net providers” are defined as: FQHCs, Rural Health Centers, Indian or Tribal Clinics, non-profit community or free clinic licenses by state as primary care clinic, or clinics affiliated with DSH facilities.

For each safety net measure, plans are compared to each other (2-plan) or to the county’s harmonic mean (GMC) and earn points based on their score in relation to the other plan or the mean. Improvement points also are awarded based on the how much a plan’s scores improved or decreased over the previous year’s scores.

Cap on Percentage of Total Assignments

For the first three years, the allowed percentage change in total assignments to a plan was “capped” at 10 percent to avoid disruptive transition to new methodology for assigning defaults. The cap was changed to 20 percent for Year 4 (effective Dec 2008), which effectively eliminated the cap for that year since no plan had a change in assigned defaults greater than 20 percent. The cap may be eliminated completely at some point, but currently remains at 20 percent.

New Plans Entering a County

When new plan enters a county, generally it receives the percentage of allocations it would receive if its performance equaled the county mean – until such time it can produce its own performance rates – usually within two years. However, defaults for new plans may be handled differently for an initial period as determined appropriate by program management.

Shift of 5% for Lowest Cost Plan

Starting with Year 8, pursuant to 2012 Trailer Bill Language (TBL), the Department of Health Care Services is adding a cost factor to the default algorithm for the Two-Plan and Geographic Managed Care (GMC) plan counties. This factor will be in addition to the currently used quality of care and safety net population factors and is applicable to beneficiaries in the Family or SPD mandatory aid categories. The default algorithm will be adjusted to increase defaults to low cost plans by 5 percent and lower defaults to highest cost plans by 5 percent.

Since cost per plan is determined by aid code category, separate rates will be determined for Seniors and People with Disabilities (SPD) and Non-SPD members.

Auto Assignment website address:

<http://www.dhcs.ca.gov/provgovpart/Pages/MMCDAAPerfIncentive.aspx>

MMCD Program Data and Performance Measurement Section
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