AUTO ASSIGNMENT INCENTIVE PROGRAM TECHNICAL ASSISTANCE GUIDE: 2026

AUTO ASSIGNMENT INCENTIVE PROGRAM OVERVIEW

The Auto-Assignment Incentive Program (AAIP) is a DHCS Incentive Program designed to reward MCPs with higher performance on select quality measures with additional Medi-Cal membership by assigning more members to better-performing MCPs. AAIP only applies to members who are not assigned to an MCP based on member choice, prior plan affiliation, family connection, or alignment per the "Matching Plan Policy" for dual eligible members. In an ideal state, most members would actively choose an MCP as aligned with DHCS vision to have members engaged in decisions related to their health and healthcare. Members should be supported in this active engagement through ongoing and customized outreach based on Health Care Options (HCO) and MCPs' outreach and engagement. This intended future state would mean that less members would be assigned to an MCP in AAIP (based on Health Care Options (HCO) and MCPs' outreach and engagement) and thus not be assigned to an MCP in AAIP. DHCS seeks to have members engaged in decisions related to their health and healthcare.

The Auto-Assignment Incentive Program (AAIP) was initially implemented in the Medi-Cal managed care program in December 2005 (Year 1) in the Geographic Managed Care (GMC) and Two-MCP Model (2-Plan) counties. Methodology shown in this document is applicable for participating Medi-Cal Managed Care Plans (MCPs) in AAIP for 2025 (Program Year [PY] 20). Performance on specific measures is used to determine how default enrollments are split between MCPs in each county.

Historically, Safety Net Primary Care Provider (PCP) Assignment as detailed in AB 85[1] and Encounter Data Quality were part of AAIP. Going forward however, they are independently assessed and monitored by the program and are not factored into the methodology (unless an MCP is out of compliance with AB 85 in which case the AAIP program will be adjusted per AB 85 requirements).[2]

STAKEHOLDER ENGAGEMENT

DHCS engaged MCP stakeholders in discussions about policy changes for 2026 (i.e., Program Year 21 [PY21]). Stakeholders had the opportunity to provide their feedback and ask questions at various meetings in 2025 (both AAIP workgroup meetings and in other meetings with DHCS) and via written feedback. MCPs also had the opportunity to submit their own proposals for methodology to address implementing an Aggregate Performance Comparison (APC) for AAIP. The Department reviewed and accepted a proposal submitted by Local Health Plans of California (LHPC) that introduced an APC methodology that will adjust default assignment rates based on the number of the 11 AAIP quality measures on which an MCP outperforms its competing MCP(s). MCPs were then given an opportunity to submit their feedback and pulse check regarding the APC proposal to DHCS for 2026. The majority of responding MCP stakeholders favored the APC proposal, and DHCS has agreed to implement the proposal in 2026 based on this feedback.

The goal for this adjustment is to ensure that Medi-Cal members are more often assigned to higher-performing MCPs, incentivizing broader quality improvement across all measures. The adjustments are applied after 18-Level Benchmark-Based Aggregate Scores are calculated.

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[1] AB 85: http://www.leginfo.ca.gov/pub/13-14/bill/asm/ab_0051-0100/ab_85_bill_20130627_chaptered.pdf

[2] Encounter Data Validation grades will be assessed separately from the Auto-Assignment Algorithm prioritizing enforcement action for lower performing MCPs demonstrating opportunities for improvement.

Scoring of Quality Measure

AAIP leverages data on eleven quality measures from the Managed Care Accountability Sets (MCAS) for Measurement Year (MY) 2024. Points are assigned to each MCP's rate for each individual quality measure. MCPs' final audited quality measure rates are compared against MY2024 NCQA National Medicaid Benchmarks (released in the 2025 Quality Compass) to evaluate performance for each individual quality measure. The performance for each quality measure rate is scored on a 0 to 17 whole-number point scale (for 18 total levels). The minimum threshold for earning one point is the 10th percentile, and 17 points are awarded at or above the 90th percentile. Two through 16 points are then evenly awarded between the 10th and 90th (i.e., for meeting or exceeding the 15th, 20th, 25th, etc. benchmarks). Performance across the selected measures as compared to these benchmarks is aggregated. The points aggregated across all selected measures for the MCP result in an 18-Level Based Aggregate Score. This score, compared to the score achieved by other MCPs in the county, determines the initial rate for a given MCP (before caps are applied). This methodology is called the 18-Level Benchmark-Based Aggregate Score. This methodology is described in more depth in *Appendix A: Final 18-Level Benchmark-Based Aggregate Score Methodology*. This methodology is derived from the CMS Hospital Value-Based Purchasing program scoring methodology,[3] which assigns points mathematically spread between rates representing low- and high-performance benchmarks.

Aggregate Performance Comparison Adjustment

In September 2025, DHCS accepted the proposal for an "Aggregate Performance Comparison Adjustment" (APC) submitted by the Local Health Plans of California (LHPC). The proposal includes an adjustment to AAIP to further reward MCPs that demonstrate higher quality performance on a majority of measures. It introduces an "Aggregate Performance Comparison" methodology that adjusts default assignment rates based on how many of the 11 AAIP quality measures an MCP outperforms its competitors on. The goal is to ensure that Medi-Cal members are more likely to be assigned to higher-performing MCPs, incentivizing broader high performance across all measures. The adjustment is applied after the standard 18-Level Benchmark-Based Aggregate Score is calculated. After calculating the proposed allocation rate using the CY25 methodology, an over-the-top performance adjustment is applied. MCPs outperforming others on a majority of the 11 quality measures would receive additional adjustment. Additional

[3] Federal Register / Vol. 76, No. 9 / Thursday, January 13, 2011 / Proposed Rules

points are added based on how many measures on which an MCP outperforms others. A maximum of +7% can be awarded to an MCP.

In counties with three MCPs (GMC counties), the methodology includes a negative adjustment to impact the lowest performing MCP. In the example illustrated in Table 3, MCP B performed better than the next best performing MCP on a majority of measures (e.g., 8 out of 11 measures) and, as a result, receives a positive 4% adjustment. A head-to-head comparison of the two lower-performing MCPs is then conducted. In the example, MCP A outperforms MCP C on the 7 out of 11 measures. As a result, MCP A would receive their base allocation rates, and MCP C receives the 4% negative adjustment.

Table 1: Aggregate Performance Comparison Adjustment

Measures Outperformed	Percentage Adjustment
6 out of 11	+2%
7 out of 11	+3%
8 out of 11	+4%
9 out of 11	+5%
10 out of 11	+6%
11 out of 11	+7%

Table 2: Example of Aggregate Performance Comparison Adjustment in Non-GMC Counties

MCP Name	Final Proposed Allocation Rate	Number of Measures Outperformed	Aggregate Performance Comparison Adjustment	Initial Allocation Rate	Final Allocation Rate
MCP A	41.00	--	-4%	41.00	37.00
MCP B	59.00	8/11	+4%	59.00	63.00
Total	100			100	100

Table 3: Example of Aggregate Performance Comparison Adjustment in GMC Counties

MCP Name	Final Proposed Allocation Rate	Number of Measures Outperformed	Aggregate Performance Comparison Adjustment	FINAL Auto Assignment Allocation Rate
MCP A	34.00	7/11*	--	34.00
MCP B	37.00	8/11	+4%	42.00
MCP C	29.00	--	-4%	25.00
Total	100			100

*Comparing MCP A and MCP C, MCP A outperformed MCP C on 6 of 11 measures

Maximum Year-Over-Year Allocation Rate Changes

The maximum change from year to year in the default allocation rate for any one MCP is "capped" at 10% for 2026, before the application of the Aggregate Performance Comparison. This cap will increase in PY 21 and subsequently return to the 20% cap baseline. This prevents large fluctuations in rates, which may cause unintended operational impacts.

AB-85 25% Reduction for Inadequate Safety Net PCP Assignment

The AB-85 policy states that, if an MCP does not assign the required amount of its members, who do not choose a PCP, to an identified Safety Net provider, their net default allocation may be reduced by 25%. If an MCP would otherwise already receive 25% or less, the MCP may not receive any defaults. If the MCP was unable to meet the requirements of AB-85 due to provider panel closures or time and distance requirements, the adjustment should not be made to their default allocation.

Historically, DHCS had found that MCPs did assign as required, so there were no 25% reductions due to non-allocation. In PY20, all MCPs in AAIP were found to be AB-85 compliant, so no action was taken.

Kaiser Foundation Health Plan Inc. Allocation

In 2026, Kaiser Foundation Health Plan Inc. (KFHP) will have a set default assignment ceiling of zero members as agreed upon by KFHP and DHCS.

Per the Memorandum of Understanding (MOU), Kaiser is required to annually provide to DHCS the maximum number of beneficiaries, by applicable counties or geographic regions as determined by Kaiser's projected capacity, who can be enrolled in Kaiser through default enrollment. This is referred to as the annual default enrollment ceiling and will consider Kaiser's projected capacity and growth. The MOU also indicates the goal of a 25% growth target over the initial term of the Primary Contract. Based on Kaisers enrollment growth to date, which is approximately 19.8% as of September 2025, it has been determined that for 2026, Kaiser will not have default enrollments assigned to them.

Regardless of the growth rate, Kaiser will continue to be required to allow any foster care child or youth or dual eligible to enroll in Kaiser regardless of prior "linkage" to Kaiser. Kaiser will be required to allow enrollment of any member who has "family linkage" to Kaiser or who were members of Kaiser at any time during the 12 months preceding the effective date of their Medi-Cal eligibility.

APPENDIX A: FINAL 18-LEVEL BENCHMARK-BASED AGGREGATE SCORE METHODOLOGY

Quality Measures

DHCS selected a subset of Managed Care Accountability Set (MCAS) quality measures for the Auto-Assignment Incentive Program (AAIP).

The eleven (11) measures are:

1. Well Child Visits in the first 30 Months of life-Well-Child Visits in the first 15 months (W30-6)
2. Well Child Visits in the first 30 Months of life-Well-Child Visits for age 15 months-30 months (W30-2)
3. Child and Adolescent Well-Care Visits (WCV)
4. Childhood Immunization Status – Combination 10 (CIS-10)
5. Immunizations for Adolescents: Combination 2 (IMA-2)
6. Glycemic Status Assessment for Patients with Diabetes (GSD-AD) (Lower rate indicates better performance)
7. Controlling High Blood Pressure (CBP)
8. Follow-Up After Emergency Department Visit for Mental Illness (FUM-30)
9. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-30)
10. Prenatal and Postpartum Care: Postpartum Care (PPC-Pst)
11. Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-Pre)

Sourcing Data for Quality Measures

The rates for the quality measures are those provided by MCPs to DHCS.

Technical Methodology

Importing and Preparing Data

First, the required data to determine Auto Assignment Incentive Program Rates for a given program year needs to be acquired, which includes: (1) final quality rate sheets for MCPs' measurement year 2024 MCAS performance, and (2) NCQA Medicaid 2025 (based on MY24 data) benchmark percentiles for relevant quality measures, every percentile by 5th percentiles intervals (from 10th to 90th percentiles).

MCPs that should be excluded from a default rate calculation are flagged for their county or reporting unit of operation. Examples include Kaiser Permanente, reporting units with a new MCP entering with no prior baseline data, or reporting units where an MCP is exiting in the program year.

Calculating Allocation Rates

An initial allocation rate is determined based on the *18-Level Benchmark-Based Aggregate Score*, and then that initial allocation rate is adjusted based on policy considerations (maximum cap in year-to-year change and AB 85 safety net provider criteria adjustments), before arriving at the final proposed allocation rate for the program year.

Scoring Measures by NCQA Benchmark Percentiles

For each MCP, each MCAS-reported quality measure is compared against their respective NCQA Medicaid benchmark percentiles. For most quality measures, a higher rate indicates better performance. For quality measures where a lower rate is considered better, such as *Hemoglobin A1c Control for Patients with Diabetes - Poor HbA1c Control* (HBD-H9), MCP rates and NCQA benchmark percentiles are appropriately inversed so that more points are awarded for a lower rate.

Points Awarded	NCQA Benchmark Percentiles
0	< 10th Percentile
1	10th to < 15th Percentile
2	15th to < 20th Percentile
3	20th to < 25th Percentile
4	25th to < 30th Percentile
5	30th to < 35th Percentile
6	35th to < 40th Percentile
7	40th to < 45th Percentile
8	45th to < 50th Percentile
9	50th to < 55th Percentile
10	55th to < 60th Percentile
11	60th to < 65th Percentile

Points Awarded	NCQA Benchmark Percentiles
12	65th to < 70th Percentile
13	70th to < 75th Percentile
14	75th to < 80th Percentile
15	80th to < 85th Percentile
16	85th to < 90th Percentile
17	90th Percentile or above

Calculating the 18-Level Benchmark-Based Aggregate Score Points in the Reporting Unit or County

An 18-Level Benchmark-Based Aggregate Score point total for an entire reporting unit or county is calculated as the sum of 18-Level Benchmark-Based Aggregate Score points across each MCP in the reporting unit or county.

$$Points_{county} = \sum_{i=MCP}^{n} Points_i$$

Calculating Initial Allocation Rates for the Program Year

The initial allocation rate is obtained from an individual MCP's 18-Level Benchmark-Based Aggregate Score points, divided by the sum of the 18-Level Benchmark-Based Aggregate Score points for all MCPs in the county or reporting unit.

$$Initial\ Allocation\ Rate\ (\%) = \frac{Points_{MCP}}{Points_{county}}$$

Calculating Adjusted and Final Allocations Rates

An adjusted allocation rate is only calculated if there is more than a 5% difference between the current year allocation rate and the previous year allocation rate (which refers to the final rate used in PY20). In cases where an adjustment is made, the adjusted allocation rate is equal to the initial allocation rate plus or minus the maximum allowed difference in rates from year to year.

$$Difference_{year-to-year} = Previous\ Year\ Allocation\ Rate\ -\ Initial\ Allocation\ Rate$$

$$Adjusted\ Allocation\ Rate\ (\%) = Initial\ Allocation\ Rate\ \pm Difference_{year-to-year}$$

In all cases, the final allocation rate for the Program Year is adjusted with any safety net provider criteria adjustments. There were no safety net provider criteria adjustments for 2026.

$$Final\ Allocation\ Rate\ (\%) = Adjusted\ Allocation\ Rate \pm Safety\ Net\ Provider\ Adjustment\ (\%)$$