AUTO ASSIGNMENT INCENTIVE PROGRAM TECHNICAL ASSISTANCE GUIDE: PROGRAM YEAR 20 CY25

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, the vast majority of 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

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

independently assessed and monitored by the program and are not factored into the methodology (unless a plan 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 PY20. Stakeholders had the opportunity to provide their feedback and ask questions at various meetings in 2024 (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 their areas of concerns with an initial proposal from DHCS. The Department reviewed and accepted proposals submitted by stakeholders, provided they aligned with the goals and criteria that included: a head-to-head comparison of MCPs using MY23 audited data and national HEDIS Medicaid benchmarks, the proposal included a nationally recognized methodology or validated approach, and the proposal did not include components of the historic methodology. As a result of this collaboration, DHCS was able to provide the stakeholders with five updated proposed methodologies that were developed based on the stakeholder feedback received. Each of these methodologies were deemed appropriate for AAIP by DHCS. Some of the changes that DHCS incorporated into these proposed methodologies based on stakeholder feedback included the following:

- Avoiding mathematical extrapolation of benchmarks when the National Committee on Quality Assurance (NCQA) do not provide benchmarks in the Quality Compass
- Exploring a larger point scale than 10 points to provide more granularity in comparing MCPs
- Even width of bands between low performance and high-performance levels
- Reducing the cap in swing for PY20 to reduce unintended operational impacts

MCPs were then given an opportunity to submit their binding vote on their preferred proposal to DHCS for PY20; each MCP was given the opportunity to rank vote the five proposed methodologies. DHCS then chose the final methodology to implement in

[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.

PY20 based on this vote. In order to accommodate an extended stakeholder engagement process, DHCS delayed implementation of the PY20 AAIP to February 1, 2025 (instead of January 1, 2025). DHCS intends to resume its normal calendar year schedule for the AAIP in PY21.

METHODOLOGY

Scoring of Quality Measure

AAIP leverages data on eleven quality measures from the Managed Care Accountability Sets (MCAS) for Measurement Year (MY) 2023. Points are assigned to each MCP's rate for each individual quality measure. MCPs' final audited quality measure rates are compared against 2024 NCQA National Medicaid Benchmarks for the latest measurement year available 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 against 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 against 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 AL Final 18 Level Benchmark-Based Aggregate Score. 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.

Cap on Year-Over-Year Allocation Rate Changes

The maximum change from year to year in the default allocation rate for any one plan is "capped" at 5% for PY20 (which will increase in PY 20 and subsequently return to the 20% cap baseline). This will protect for large fluctuations in rates that may be the result

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

of external factors that require a closer examination for the variation. This approach also prevents unintended operational impacts of large swings in default allocations rates.

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

The AB-85 policy states that, if a 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 a 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 MCP's 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.

New MCPs Entering a County

In cases where an MCP newly enters a service area, an equal assignment split will be applied to all MCPs within that county since there is no comparable quality measure data for new MCPs entering a county. In these cases, the default rate will be set the same for all applicable MCPs (for example, if there are two MCPs, the allocation rates will be 50% and 50%). This even split will continue until quality measure rates can be assessed for the new MCP.

Kaiser Foundation Health Plan Inc. Allocation

In 2025, Kaiser Foundation Health Plan Inc. (KFHP) will have a set default assignment ceiling of 5,919 members as agreed upon in Deliverable KP.MOU-01 Projected Default Enrollment Report. KFHP is only receiving assignment of members in certain counties. To allow for this expansion, Table 1 shows total assignment, by relevant counties, spread over nine months (April to December). In these counties, the non-KFHP MCPs' default assignment rate will be paused while KFHP is assigned members up to the total amount per month per county. Once the total ceiling is achieved by county by month, the non-KFHP MCPs' default AAIP rate will resume as calculated through the methodology above, and KFHP will receive no further assignment through the end of that month.

Table 1: Assignment to Kaiser by County and by Month

County	2025- Auto Spread Assignment (Default) New Members	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
Los Angeles	3,663	0	0	0	407	407	407	407	407	407	407	407	407
Kern	470	0	0	0	53	53	52	52	52	52	52	52	52
San Bernardino	564	0	0	0	63	63	63	63	63	63	63	62	62
Riverside	108	0	0	0	12	12	12	12	12	12	12	12	12
San Diego	1,114	0	0	0	124	124	124	124	124	124	124	123	123
Total	5,919	0	0	0	659	659	658	658	658	658	657	656	656

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. HBD-H9: Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control (HBD-H9)* (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 plans to DHCS through the external quality review organization (EQRO). The MY 2023 MCAS audited rates were submitted to DHCS on September 12, 2024, and the rates were released publicly to all MCPs on September 27, 2023.

Counties Impacted by Methodology

Counties Impacted

1. Two Plan: Fresno, Kings, Los Angeles, Madera, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, Tulare
2. GMC: Sacramento, San Diego
3. Region 2: Amador, Calaveras, Inyo, Mono, Tuolumne

Counties Not Impacted

Alpine, El Dorado, and Kern counties will receive a 50/50 split.

Counties No Longer in AAIP

As of January 1, 2024, Imperial County only has one MCP other than Kaiser Foundation Health Plan Inc. Thus, Imperial County is not participating in AAIP for PY20.

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 2023 MCAS performance, and (2) NCQA Medicaid 2024 (based on MY23 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 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
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 PY19). 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 PY20.

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