Putting Quality to Work: Rewarding Plan Performance in Medi-Cal Managed Care

Appendix B

Performance-Based Auto-Assignment in Other States

Background

To initiate our research of assignment practices across the states, we contacted a number of Medicaid managed care experts and state Medicaid agencies to identify states using performance-based auto-assignment processes. While there are not a large number of states currently using this type of approach, many states expressed an interest in learning about other states' performance-based assignment methods, and in potentially exploring such assignment methods in the near future.

A few states we contacted in late 2004 indicated that due to tight budget constraints and difficult rate negotiations, the states have not pursued performance-based assignment as a plan incentive. In these states, the Medicaid agencies indicated that the health plans generally did not view obtaining more Medicaid managed care members as an incentive.

At the same time, in the current tight budget environment that many states continue to experience, other Medicaid agencies are looking for non-financial incentives for plans to improve performance on targeted areas important to the Medicaid managed care population. In these states, the Medicaid agencies believe that a majority of the plans are likely to view increased enrollment as a positive incentive, particularly since most states are not currently expanding Medicaid eligibility. In addition, a number of states now have sufficient experience collecting health plan performance data to inform an incentive strategy. These states are seeking new ways to use the data, beyond public reporting of performance and consumer report cards, in order to improve care for Medicaid managed care members and to reward higher performing plans.

State Pioneers

In the mid-1990s, Massachusetts was the first state to use performance-based auto-assignment in its Medicaid managed care program. At the time, Massachusetts had over 14 health plans contracting with Medicaid across the state and the state was seeking ways to improve health plan performance and to increase enrollment in higher performing plans. Since the early 1990s, the state has negotiated annual quality improvement goals with health plans and reviewed plan performance at semi-annual meetings called Contract Status Meetings. The state was seeking new ways to recognize and reward plans with higher performance, with the goal of improving the quality and access to care for all Medicaid managed care members.

As an incentive for health plans to improve performance, Massachusetts began using a plan's overall performance on annual quality improvement goals to adjust the distribution of default assignments made to plans in each service area of the state. Plans that scored higher on goal achievement relative to other plans in their service area received a greater portion of default assignments. By 2000, Massachusetts Medicaid was contracting with four health plans instead of 14. Two of the four plans were new, without prior performance measurement data to use in comparison with other plans. One of the other plans had recently acquired the Medicaid enrollment of a fifth health plan. At that

point, Massachusetts suspended the use of the performance-based auto-assignment algorithm. The performance-based algorithm has not been reintroduced since that time.

Three other states, Michigan, New Mexico, and New York, have also implemented performance-based assignment algorithms for Medicaid managed care eligibles that do not select a plan. Michigan and New Mexico both started Medicaid managed care performance-based auto-assignment in the late 1990s. New York first implemented performance-based auto-assignment in 2000. These three states' rationales for implementing performance-based auto-assignments appear similar to each other and to that of Massachusetts.

New York has been publicly reporting Medicaid health plan performance on HEDIS measures and state-specific measures of quality since 1994, even though mandatory Medicaid managed care did not begin until 1997. In the late 1990's, with mandatory managed care in upstate New York counties, and the initial counties in New York City, the state was seeking a way to use the performance data to reward and recognize higher-performing plans, as well as to increase enrollment in higher performing plans. According to a state Medicaid official, plans were requesting rewards for improved performance. The plaques and awards the state was giving out were viewed as too little reward for the amount of effort the plans were investing in quality improvement and measurement. New York's goal statement for the assignment policy is "To implement a system that rewards plans that demonstrate higher levels of quality performance through a preference in the auto-assignment methodology."

The responsible state staff in Michigan and New Mexico have changed since these states first implemented performance-based auto-assignments, but the current staff indicated that the initial rationale was to find new ways to focus plans on performance in areas important to Medicaid and to provide incentives for plans to improve performance in these targeted areas.

Recent and Future State Developments

We initially interviewed states in 2004 regarding their use of performance-based auto-assignment in Medicaid. In October 2005, we re-contacted states with current or past performance-based auto-assignment to discuss any recent or proposed changes. Both Massachusetts and New Mexico hope to re-instate performance-based assignment in the future, pending additional discussions between the health plans and the state. Attachment B-1 on page 14 provides state-specific information on auto-assignment approaches. The descriptions of auto-assignment approaches for Massachusetts and New Mexico in Attachment B-1 represent previous auto-assignment algorithms that are not currently in use.

In 2005, Michigan changed its assignment methodologies to eliminate the cost factor from the methodology and replace it with a capacity measure. The state is also moving toward using encounter data to calculate performance measures. The description of the Michigan performance-based auto assignment approach in Attachment B-1 is based on the new measures and approach put in place in 2005.

In 2005, New York aligned the quality measures in the performance-based auto-assignment algorithm with the measures that the state links to financial incentives for Medicaid health plans and its public report card of health plan performance, the Quality Assurance Reporting Requirements (QARR). The description of the New York approach in Attachment B-1 represents the assignment algorithm for 2005.

States that are currently developing performance-based assignment algorithms for Medicaid managed care include Arizona and Texas. Arizona intends to implement performance-based assignment in its Medicaid managed care program for acute care. Arizona's Medicaid HMO contracts indicate that in 2006 the state will consider clinical performance on prenatal care and well-child care when making default assignments. Texas recently awarded contracts for its Medicaid and CHIP managed care program that include the option to implement performance-based assignments beginning in 2007.

Authority for Performance-based Auto-assignments

All four states with experience using performance-based auto-assignments (MA, MI, NM, NY), as well as Arizona and Texas, have some general language in their Medicaid health plan contracts about the state's ability to distribute default enrollments based on plan performance. New York also has legislative authority to adjust default assignments based on a plan's performance in the second year of mandatory Medicaid managed care in the region.[1] New Mexico has regulatory authority to implement performance-based auto-assignments in its Medicaid managed care program.[2] New Mexico's regulation includes a broad list of potential performance measures.

The states with performance-based auto-assignments typically provide plans with additional detail on the assignment measures and algorithms through Medicaid agency directives and memos. These states typically work with contracted health plans and with other stakeholders, such as interested legislators and consumer advocates, to make adjustments to the measures or algorithms over time. Strong general support for the measures and distribution employed in the assignment algorithm was viewed by states and plans as being crucial to the effectiveness of performance-based algorithms.

Performance-based Auto-assignment Approaches

Massachusetts, Michigan, New Mexico, and New York represent different regions of the U.S. and managed care programs of varying scope. For example, the number of health plans in these states ranges from three in New Mexico to 26 in New York. It is not surprising that the types of Medicaid performance-based auto-assignment approaches in these four states vary. This Appendix outlines key components of state assignment algorithms, including the performance measures and benchmarks used, as well as the distribution criteria. Areas of commonality and difference across the state auto-assignment approaches are highlighted in this section of the report. Attachment B-1 offers specific information on each state's approach.

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[1] Legislation passed in 1996 allows New York to use quality and costs as weights in the auto-assignment algorithm according to communications with New York Medicaid staff.

[2] The New Mexico Medicaid regulatory cite is 8.305.5.12 and can be found at www.state.nm.us/hsd/mad/pdf_files/provmanl/prov83055.pdf

Performance Measures Used in Auto-Assignment Algorithms

The number of performance measures used in various states' Medicaid auto-assignment algorithms ranges from one to fifteen. States were sometimes limited in the number of measures they could use by the lack of standardized performance data readily available to the state. For example, other than HEDIS and CAHPS data for which national data collection and reporting standards exist, data submitted by health plans to state Medicaid agencies may not be collected and reported in a standardized way across health plans.

In addition, some states limited the number of performance measures in their auto-assignment algorithms to ensure that each individual measure was important in evaluating plan performance. States noted that if too many measures were included in the algorithm, a plan's performance on any one measure would be less likely to affect the outcome of the assignment algorithm.

The states selected the performance measures based on a number of factors, including:

- relevance to the Medicaid managed care population (e.g., maternal and child health issues);
- availability of standardized health plan performance data;
- the frequency with which such performance data are available;
- performance areas for which clear opportunities for improvement exist;
- areas in which performance varies across plans, and
- relevance to the state's priorities, including those of the state legislature and the state Medicaid agency.

New York changed some of their performance measures recently to better align their performance-based auto assignment approach with the measures the state uses in its quality incentive program that pays plans bonuses for performance above target levels.

States typically have at least one measure designed to assess clinical performance, either through HEDIS-based measures, or through health plan evaluations performed by the state's External Quality Review Organization (EQRO). HEDIS-based measures used by one or more states in performance-based assignment algorithms include:

1. childhood immunizations;
2. well-child visits (15 months, 3-6 yrs., 12-21 yrs);
3. adult access to health care services (ages 20-44);
4. timeliness of prenatal care;
5. post-partum check-ups;
6. cervical cancer screenings;
7. breast cancer screenings;
8. follow-up treatment for patients with inpatient behavioral health admissions;
9. appropriate use of asthma medications (all ages), and
10. diabetes testing (multiple measures).

States review the HEDIS rotation schedule recommended by the National Committee for Quality Assurance (NCQA) and make adjustments to their performance measures, as needed. New York rotates HEDIS measures annually in relation to its performance-based auto-assignment algorithm. New York selects HEDIS measures for the assignment algorithm from among the HEDIS measures that are collected and reported as part of the state's Medicaid health plan report cards.

Other clinical measures that have been used in Medicaid assignment algorithms by one or more states include: risk-adjusted low-birth weight incidence, annual evaluations by the state's EQRO, and plan performance on negotiated quality improvement goals.

New York was the one state that used risk-adjusted low-birth weight incidence as a performance measure in its assignment algorithm. The state has since dropped this measure for a number of reasons, including the lack of variation in performance across plans and the administrative difficulty in obtaining health plan performance information using state vital statistics records.

New Mexico has used EQRO annual evaluations as part of its performance-based algorithm. The EQRO topics have varied annually and have included a review of dental visit rates, EPSDT visit rates, lead screening visit rates, and behavioral health-related topics. The annual variation in the EQRO topics and the state's selection of non-HEDIS indicators has resulted in some operational challenges for the state and the plans. For example, one plan indicated that with the annual changes in the EQRO performance measure topics, the state was not always able to give plans sufficient notice on the targeted performance in time for the plan to affect its performance rates. Both the state and the plan noted operational challenges of using measures for which the collection methods are not as standardized as HEDIS. Doing so requires more work to ensure that plans are reporting the information consistently.

As previously noted, Massachusetts is the one state that has used plan performance on negotiated quality improvement goals in an auto-assignment algorithm. The state scored plans on a four-point scale based on whether the plan exceeded (4 points), met (3 points), partially met (2 points), or did not meet (1 point), each quality improvement goal. Twice a year, average scores were calculated for each plan based on the latest Contract Status Meeting evaluation and these averages were used to assess the relative performance of plans in a given service area in the state.

Non-clinical performance measures used in some state auto-assignment algorithms now and in the past include:

- timeliness of clean claims processing;
- timeliness of encounter data submission;
- annual state site visit of plan compliance with contract requirements;
- Medicaid capitation bid rate;
- ratio of open PCPs to capacity, and
- voluntary selection rate into competing plans in a service area.

The first five measures listed above are from Michigan, the only state to currently include non-clinical performance measures in its performance-based assignment algorithm. Due to a change in the way the state establishes rates with the Medicaid plans, Michigan eliminated the capitation bid rate measure from the assignment algorithm in 2005 and substituted the capacity measure. In its current fiscal year, Michigan also dropped the measure relating to annual site visit of plan compliance with contract requirements.

Massachusetts is the state that has used voluntary selection rates in its assignment algorithm. This could be viewed as a non-clinical performance measure of a plan's attractiveness to potential members, even though it also is affected by the success of a health plan's marketing activities.

Translating Performance into an Assignment Distribution Method

Each state developed an assignment algorithm to translate specific performance results into a point system or ranking system that is then used to distribute the volume of default assignments across competing health plans in a given region. Attachment B-1 provides more details on the distribution method in the specific states included in this report.

HEDIS-based performance measures drive two-thirds of the performance-based assignment algorithm in New York and account for just over one-half of the potential assignment algorithm points in Michigan. In some years, New Mexico has included HEDIS-based measures in its assignment algorithm. These states each use the HEDIS-based measures differently in the assignment algorithm.

Examples of HEDIS benchmark comparisons used in Medicaid assignment algorithms include a plan's performance compared to:

- the regional average;
- the previous 75th percentile of plan performance in the state;
- an NCQA-derived national Medicaid percentile (50th, 75th);
- absolute performance thresholds (e.g., the actual HEDIS rate), and
- Healthy People 2010 goals (criteria for bonus points).

New York compares a health plan's performance on HEDIS-based measures to the 75th percentile of the state performance for the same HEDIS measure two years prior. If a health plan's performance is above the 75th percentile based on statistical significance tests, the health plan receives ten points, if a plan's average is statistically no different than the 75th percentile, the plan gets five points, and if a plan is below the 75th percentile, the plan is awarded no points. A plan receives no points for a specific HEDIS measure if the plan does not submit the required HEDIS data in accordance with the state's timelines.

Michigan uses a similar approach to awarding points, but a plan earns more points by performing at or above NCQA's 75th percentile for Medicaid, compared to at or above the 50th percentile, or below the 50th percentile.

In New Mexico, with only three managed care plans, plans were ranked according to their HEDIS rate relative to the other two plans, assuming a differential of at least 5 percent in the rates between any two plans. If the differential was less than 5 percent, the plans' performance was judged to be equivalent.

New York compares a health plan's performance on CAHPs to the internal state average CAHPS performance. If a health plan's performance is above the state average based on statistical significance tests, the health plan receives ten points, if a plan's average is statistically no different than the state average, the plan gets five points, and if a plan is below the average, the plan is awarded no points. As noted in Attachment B-1, New York makes an attempt to risk-adjust the CAHPs performance results due to historically differences in performance among plans in New York City versus plans that operate elsewhere in the state. Prior to 2005, New York also compared HEDIS performance on a regional basis to account for differences between plan performance in New York City versus other parts of the state.

Common Elements of Performance-based Assignment Algorithms

In the four states with experience using performance-based assignments, the algorithms employed by the states are consistent across different geographic regions. In other words, the same performance measures and point allocation system is used in all regions. In New York, the benchmark (the regional average) varies by region, but the methodology remains consistent.

None of the states using HEDIS measures made adjustment to HEDIS results for plan characteristics, or for different HEDIS collection methods, such as administrative versus hybrid approaches. This is consistent with the way NCQA compares plan performance on HEDIS measures.

In the assignment algorithms, plan performance is typically measured at a point in time, e.g., HEDIS results in a given year. None of the states have used performance measures based on a plan's improvement over more than one year. However, as previously noted, New York's recent changes in the algorithm compare plan HEDIS results to the 75th percentile of the state performance for the same HEDIS measure two years prior. Before 2005, New York also allowed health plans that narrowly missed the performance threshold cutoff to receive auto-assignments to request that the state review the plan's prior year performance. If the plan's combined performance was over the threshold when the prior year was weighted 25 percent and the current year was weighted 75 percent, then the plan was eligible to receive the performance-based assignments.

All states indicated that plans would be shut off from receiving any default assignments due to financial insolvency or if a plan was no longer receiving voluntary enrollment of Medicaid managed care members.

Frequency of Performance-based Assignment Algorithms

New York runs the assignment algorithm annually and New Mexico used a similar approach when doing performance-based auto-assignments. In these cases, the plans' performance is assessed based on annual measures, such as HEDIS results, and the distribution of default assignments remains consistent until the next year.

Massachusetts used to run the Medicaid health plan assignment algorithm twice a year, based on the plans' quality improvement goal performance as assessed through the semi-annual Contract Status Meetings.

Michigan runs the assignment algorithm quarterly to reflect the latest administrative data on the timeliness of claims payment and the timeliness of encounter data submissions. The outcome of these two administrative measures does not typically result in significant changes in the assignment distribution, which is based on plan performance on ten measures. However, since the algorithm is recalculated quarterly, some participants in Michigan believe it increases plans' attention to the performance algorithm and measures throughout the year.

Other Assignment Distribution Criteria

In addition to determining how to allocate points to plans based on performance, state assignment algorithms use specific criteria to distribute default enrollment across competing plans, such as:

- minimum guarantee of some default assignments;
- allowing plans to opt out of assignments;
- some preference to provider-sponsored plans, regardless of performance, and
- exclusion of family/newborn and continuity of care assignments from the performance-based assignment algorithm.

For example, New York provides all plans with a minimum guarantee of some level of default assignment regardless of performance. The performance-based assignment algorithm is used to assign half of all default enrollments in New York. This percentage remains constant over time. The state initially allocated 25 percent of the default assignments to provider-sponsored plans. This percentage has decreased over time in accordance with legislative requirements, and in the future, there will be no preference given to provider-sponsored plans in the auto-assignment process. Assignments that are not allocated according to performance or provider-sponsored status are distributed evenly among participating plans.

Operational Challenges

The states we interviewed did not report experiencing significant operational challenges in implementing performance-based assignments in their Medicaid managed care programs. The most common operational challenge the states faced related to selecting the measures and the data to use in the assignment algorithm. It appears that the more experience a state has with measuring and reporting performance across Medicaid managed care plans, the better prepared the state will be to implement performance-based auto-assignment. States need to identify what performance measures are priorities, what data are available, when the data are available, and the reliability of the data in fairly assessing performance across plans. This is an iterative process, as states cannot use performance measures for which standardized data are not available in a time frame consistent with the implementation of the assignment algorithm.

State Medicaid agencies noted operational challenges related to the lack of standardized data on performance topics of most interest to the agency, particularly during the initial years of an auto-assignment algorithm. For example, when Michigan first began its performance-based auto-assignment process, the state was able to collect cervical cancer screening data from plans more easily and consistently than maternal and child health HEDIS measures. Consequently, the state initially used cervical cancer screening and did not have the range of maternal and child health clinical measures in the algorithm that the state now uses. Similarly, New Mexico used EQRO evaluation scores as one of up to three measures each year. Over time, the state has identified operational challenges with collecting non-standardized measures relating to dental and lead screening visits. The state has had to spend more time being clear about allowable visit codes when using non-HEDIS measures and auditing data reported by the plans.

Specifying the data to be collected and reported can be a complex process. One plan complained that it sometimes seemed as if the state and the plans spent more time figuring out how to measure and report the data each year, than they did in developing and implementing approaches to improve performance. The more states can build upon existing data and reporting requirements, the lesser the administrative burden on states and plans.

In New Mexico, where the performance measures and EQRO evaluation topics vary annually, one plan reported that it was a challenge for the state to establish performance measures early enough for the plans to be able to develop and implement improvement initiatives prior to the measurement of performance. In addition, since the New Mexico cycle for changing the auto-assignment algorithm was related to the beginning of the state fiscal year in July, the state and plans faced operational challenges with using the most recent HEDIS data. One plan indicated that the state required the plans to track and report HEDIS measures for the assignment algorithm in two different cycles, one to coordinate with the assignment algorithm requirements and the other related to the standard HEDIS collection time periods.

The Michigan Medicaid managed care program initially identified some operational issues with distributing and tracking assignments to health plans on a daily basis in areas with few Medicaid managed care members being assigned on a given day. Typically, most states with performance-based assignment algorithms use processes that apply the algorithm with each batch of default assignments. For example, if an enrollment broker system identifies all individuals at the end of a work day that did not select a plan, the assignment algorithm is applied to that group of Medicaid eligibles and distributed according to the algorithm. The next day, all plans start over at zero percent and all assignments for that day are distributed according to the algorithm. This type of daily process does not work well in the less populous regions of Michigan, where fewer people are assigned on any given day. Since Michigan has had a large number of plans in most regions and has assigned members of the same family to the same health plan, restarting the assignment distribution on a daily basis could result in the actual assignment distribution at the end of the month looking much differently than was intended by the algorithm. Consequently, the Michigan enrollment broker now calculates the assignment distribution on a weekly basis, rather than on a daily basis.

New York Medicaid staff indicated that the managed care program staff needed internal support from different parts of the Medicaid agency, as well as support from the contracted enrollment broker, to be able to successfully develop and administer the auto-assignment methodology. The state staff also noted the importance of obtaining support of the auto-assignment approach from health plans and other interested stakeholders in order to be able to achieve the desired outcomes related to improved Medicaid health plan performance.

Effectiveness of Performance-based Auto-assignments: General Findings

States, plan representatives, and the advocacy group we interviewed all reported that each state's performance-based auto-assignment methodology has achieved the state's objective of focusing plan and state attention on targeted measures, and improving performance for most plans and measures.

The effectiveness of the incentive, however, is related to a plan's interest in obtaining more Medicaid members. If Medicaid business becomes financial disadvantageous, then increased enrollments are viewed as a disincentive.

For those plans that are interested in increasing their Medicaid membership, the volume of available Medicaid auto-assignments influences the effectiveness of the incentive. Additionally, the representatives we spoke to noted that performance-based assignment approaches are likely to be most effective when the assignment logic is clearly understood and accepted as valid, and the performance results are visible to plans and other stakeholders.

Effectiveness of Performance-based Auto-assignments: State-specific Findings

New York cited evidence of "improved HEDIS results over time and increased Medicaid enrollment in higher performing plans." Due to the other performance incentives New York employs, such as public reporting of performance and direct financial incentives for specific performance measures, it is difficult to determine the extent to which performance-based assignment independently contributes to improved performance. However, the state did see more improvement on targeted measures after implementation of the auto-assignment system, compared to the use of public reporting alone. In addition, the New York Medicaid agency staff we spoke with emphasized what they believe to be a positive interactive effect of have multiple, complementary incentives for performance.

New Mexico said the performance-based assignment "definitely" worked to improve performance in targeted areas and cited an increase in dental screens as a result of performance-based assignments focusing on dental screening measures. People we spoke to in Michigan noted that some plans have actively invested in improvement initiatives aimed at assignment algorithm measures and have improved their performance in order to obtain a larger share of assignments.

Health plan representatives in MI, NM, and NY, generally reported that assignment volume is an effective incentive for plans, although the intensity of the incentive may vary across plans. A New Mexico plan said performance-based assignments are a powerful incentive. A New York plan said that direct financial incentives are more powerful than assignment incentives. This plan noted that the volume of assignments related to the

performance measures is not large in New York. In Massachusetts and Michigan, assignment volume was a strong incentive for plans that wanted more Medicaid business, but the incentive deteriorated over time for plans as Medicaid capitation rates became less attractive. A Michigan health plan representative indicated that increased volume from auto-assignment was more effective in motivating plans when it was first introduced in Michigan than it was in late 2004, due primarily to a lack of Medicaid capitation rate increases over time.

The consumer advocacy representative we interviewed commented on the effectiveness of performance incentives, like auto-assignment distribution approaches, compared to mandating contractual requirements. From his perspective, state Medicaid agencies have maternal and child health standards in their Medicaid managed care contracts that the health plans are not meeting. State contracts can require plans to provide the full range of EPSDT visits, including lead screening, for example, but this requirement is just one of many contractual requirements and putting it in the contract does not guarantee than it will be achieved. The advocate indicated that his organization was supportive of the performance-based auto-assignment because it was another mechanism for the state to try to achieve better performance on maternal and child health issues from the health plans. The advocate believed the development, implementation, and periodic modification of the assignment algorithm was a productive process for the state, the plans, and the advocates to identify and track performance on key indicators of health plan compliance with contractual requirements. According to this advocate, "Immunizations increased dramatically because it was in the spotlight. We want the state to make maternal and child health issues a priority – however they can do it. "

While he believed the algorithm had a "major impact on the behavior of the health plans," and has been effective at improving performance among those plans interested in Medicaid, the advocate could not say whether the Medicaid consumers have actually benefited from the performance-based assignment algorithm. He noted that consumers were probably better off than if there was no oversight of plan performance in these areas. The advocate emphasized the importance of the state taking action on the performance data it collects, and cited performance-based assignment as one way to take action.

The advocate we interviewed, and the state Medicaid agency representatives we interviewed in MI, NM, and NY, felt that complementary incentives for health plans enhance the power of the auto-assignment incentive. According to the advocate, "It [performance-based auto-assignments] is a good device, but not the only device you need to bring a complex set of plans along." The state agencies noted that performance-based assignments aligned with public reporting and, if possible, direct financial incentives for plans, increases the effectiveness of the performance incentives. Experience in Massachusetts Medicaid in the 1990s was consistent with these states' findings and recommendations regarding auto-assignments as a health plan performance incentive.

Recommendations for California and Other States

Before a state elects to implement performance-based assignment, it is important for the state to assess the extent to which the contracted health plans perceive more Medicaid assignments as a positive incentive. As long as most of the Medicaid plans are interested in increasing their Medicaid enrollment, a performance-based assignment algorithm can

be an important component of a state's overall strategy for generating quality improvement in Medicaid managed care.

Health plan representatives on the CHCF-DHS Stakeholder Advisory Group uniformly indicated an interest in increasing their Medi-Cal enrollment. These plans and other stakeholders, including consumer advocates and provider groups, supported DHS' development of a performance-based auto-assignment algorithm.

We developed the following list of recommendations for California and other states interested in developing performance-based auto-assignments based on recommendations from state Medicaid agencies, health plan representatives, and an advocacy group in one of the states. We also considered our experience at Bailit working with other states, as well as direct experience managing the Massachusetts Medicaid managed care program in the 1990s.

The measures and indicators:

- Focus on available, reliable data.
- Use objective measures that are auditable.
- Focus on quantifiable measures with standardized methodologies, like HEDIS, for which measurement processes can be easily replicated across plans.

The algorithm and performance benchmarks:

- Keep the assignment algorithm simple to communicate and administer.
- Create an assignment algorithm that has credibility with plans and other stakeholders. Without sufficient credibility, the assignment algorithm will not create a meaningful incentive.
- Make sure the assignment distribution reflects the real differences in plan performance. If there is no statistical significance between one plan's performance and another plan's, the distribution of assignment to the two plans should not differ.
- Consider using trends in plan performance, if sufficient multi-year data is available, rather than only performance at a point in time. For example, use plan performance on a HEDIS measure in 2004 and 2006, to capture any change over time.

The timing:

- Just do it – it is important to get started.
- Give plans sufficient advance notice on measures.
- Raise the bar over time. If the standards are never changed, the plans will lose interest and the assignment algorithm will not be as effective.

Operations:

- Test the assignment algorithm to make sure it is working as intended. It is important to track the assignment distribution initially and then periodically to ensure that system or health plan changes have not inadvertently affected the assignment algorithm.

General:

- Use public reporting of plan performance on assignment algorithm measures and other incentives to complement the auto-assignment incentive for selected measures.

Non-financial incentives could include publishing a consumer guide and public awards in front of Medicaid managed care advisory committees or like bodies. Direct financial incentives, such as bonus payments or penalties, should also be considered if possible. Even if the size of the reward is relatively small, communication to the public can help increase the importance of the recognition.

Summary and Conclusions

Prior to 2005, four states, Massachusetts, Michigan, New Mexico, and New York, implemented performance-based assignment algorithms for Medicaid managed care eligibles who not select a plan. These algorithms are all based on assessment of a health plan's performance on a state-selected set of measures at a point in time. The number of measures used by states has varied from one to 15, with some states using composite HEDIS measures or overall EQRO evaluation scores to encompass a broad range of health plan performance.

State Medicaid agency staff with experience using performance-based auto-assignments have found such an assignment approach to be a positive and successful performance incentive for Medicaid health plans. While the power and effectiveness of the incentive varies across plans, states, plans, and advocates report that performance-based auto-assignment has proven to be effective in improving plan performance in targeted measures.

Performance-based auto-assignment for Medicaid managed care plans is a good device for California and other state Medicaid agencies to consider as a performance incentive for contracted health plans. It provides states with a mechanism to use the performance data collected on Medicaid managed care plans, in addition to publicly reporting the data. The performance incentive is more powerful when combined with other incentives for health plans to improve the quality and access to care for Medicaid members.

Attachment B-1
State-Specific Information on Auto-Assignment Approaches

Massachusetts

Number of Medicaid Health Plans: about 14 when initiated, 4 when discontinued
Use of Performance-Based Auto-Assignment: 1995-2000
Number of Performance Measures Used: 2
Measures:

- Voluntary selection rate
- Quality improvement goal scores

Distribution Criteria:
For each service area, the assignment algorithm first considered the voluntary selection rate of each health plan operating in the service area. This baseline distribution rate was then adjusted up or down depending on how a plan scored on negotiated quality improvement goals, following semi-annual Contract Status Meetings, when compared to other plans in the service area.

The state scored plans on a four-point scale based on whether the plan exceeded (four points), met (three points), partially met (two points), or did not meet (one point), each quality improvement goal. Twice a year, average scores were calculated for each plan based on the latest Contract Status Meeting evaluation and these averages were used to assess the relative performance of plans in a given service area in the state.

Plans that scored below a 3.0 on average, (where 3.0 was equivalent to having met all of the goals), were not eligible to receive additional default assignments.

Michigan

Number of Medicaid Health Plans: 15
Use of Performance-based Auto-Assignment: 1999-present
Number of Performance Measures Used: 10 (in 2005)
Measures: 3 categories – clinical performance, administrative performance, and network capacity

- Clinical measures:
    - HEDIS childhood immunization
    - HEDIS well-child visit, first fifteen months of life
    - HEDIS well-child visit, three to six years
    - HEDIS timeliness of prenatal care
    - HEDIS post-partum care
    - HEDIS blood sugar (HbA1c) testing
    - Blood lead screening

- Administrative measures:
    - 90 percent of clean claims paid in 30 days
    - Timeliness and sufficient volume of encounter data submissions
- Capacity measure:
    - Ratio of the number open PCPs to the plan's state-approved capacity

The state will be moving from reliance on HEDIS data to utilization of encounter data and is developing a process for incorporating enrollment saturation into the auto-assignment algorithm. The state continues to meet with health plans and advocates to discuss changes.

Distribution Criteria:
Plans are grouped into three bands, based on combined performance scores in the three categories: clinical performance, administrative performance, and network capacity. Clinical performance measures are worth up to 63 points (9 points x 7 HEDIS measures), the two administrative measures are worth up to 30 points in total, and the network capacity measure is worth up to 28 points, for a combined total of 121 possible points.

Clinical points are awarded based on health plan performance relative to HEDIS percentiles. For each measure that a plan scores at or above the 75th HEDIS percentile established by NCQA, the plan received nine points. For each measure at or above the 50th percentile, the plan receives four points, for each measure less than the 50th percentile, the plan receives no points. For blood lead screening scores, plans receive nine points for scores above 60 percent and four points for scores above 55 percent.

Administrative points for claims payment and encounter data submission are based on the plan's most recent quarterly experience. A plan obtains 15 points if it has met the timeliness of claims payment standard for all three months in the quarter and eight points if it has met the timeliness of claims payment standard for two of the three months in the quarter. A plan obtains 15 points for submitting a sufficient volume of encounter data on time in all three months of the quarter and eight points for submitting a sufficient volume of encounter data on time for two of the three months in the quarter.

Capacity points are based on the ratio of open PCPs to the plan's stated capacity in the county. Plans receive 28 points in counties where the open PCP to capacity ratio is at least 1:500. Plans receive 14 points in counties where the plan's open PCP to capacity ratio is at least 1:750 but not 1:500.

After the plan scores are calculated for each county, the distribution of scores is divided into thirds. Plans in the top third are in Band 1; plans in the middle third are in Band 2, and plans in the bottom third are in Band 3. Plans in Band 1 receive more auto-assignments than plans in Band 2. Plans in Band 3 receive the lowest number of assignments. The state works with its enrollment broker to implement the auto-assignment algorithm.

New Mexico

Number of Medicaid Managed Care Plans: 3
Use of Performance-Based Auto-Assignment: 1998/9 to 2002/3 contract year
Number of Performance Measures Used: 1 to 3 each year

Measures:
- Annual EQRO review (topics varied, but included: EPSDT visits, dental visits, immunizations, behavioral health issues)
- EPSDT screen – actual percentage reported on line 11 of the 416 report for total age groups (1999-2000); percentage based on encounter data submitted in June 2002 for encounters from July to December 2001 (2002-2003).
- HEDIS childhood immunization – Combo 1
- HEDIS well-child visit, three to six years
- HEDIS follow-up within 30 days after hospitalization for mental illness

New Mexico included EQRO annual review scores as a performance measure each year in which performance-based assignments were made. In addition, the state usually included one or two of the other indicators listed above.

Distribution Criteria
Plans were ranked based on performance on 1 to 3 measures. Measures changed annually but often included an EQRO score and a HEDIS measure. The distribution algorithm also changed annually, but was based on plan rank. In 2003, the first place plan received 50 percent of the assignments, the second plan received 30 percent, and the third plan received 20 percent of the assignments. If plans were within 5 percent of each other, the plans would be considered tied and would split the assignments evenly for the associated rankings.

New York

Number of Medicaid Managed Care Plans: 26
Use of Performance-Based Auto-Assignment: 2000-present
Number of Performance Measures Used: up to 15 measures beginning in 2005
Measures:
Each year, New York will use up to ten measures from the state's Quality Assurance Reporting Requirements (QARR) and five from CAHPs to calculate each plan's score for the quality weight in the auto-assignment logic. The list of QARR measures is expected to change annually but will typically encompass women's and children's health, chronic care, and mental health.

For 2005, New York selected the following QARR measures:
- Well-child care 0-15 months
- Well-child care age 3-6
- Adolescent visits
- Breast cancer screening
- Post-partum visits
- Diabetes (poorly controlled)

- Chlamydia screening
- Blood pressure control
- Follow-up after mental health hospitalization

The CAHPS measures are expected to remain consistent and for 2005 include:

- Problem getting needed care
- Received services quickly
- Rating of personal doctor or nurse
- Rating of health plan
- Problem getting service.

Distribution Criteria

New York Department of Health uses plan performance on the selected QARR and CAHPS to calculate a score for both the state's financial incentive for Medicaid health plans as well as to calculate the "Quality Weight" for auto-assignment. A total of up to 150 points are available, normalized to a 100 point scale. New York establishes cut-off points for the various levels of financial incentive available (e.g., 3 percent, 2.25 percent, 1.5 percent, 0.75 percent). Plans receiving no incentive will not be eligible for the Quality Weight in Auto-assignment. QARR data will be updated annually and CAHPS data biennially.

The QARR measures are benchmarked to the 75th percentile from the QARR submission two years prior to the current measurement year. As an example, for 2005 data reported in June 2006, a plan must be at, or better than, the 75th percentile for 2003 QARR in order to receive ten points per measure. For measures where two-years-prior benchmarks are not available, New York will use the 75th percentile score from three-years-prior QARR data. The HEDIS-based measures used in performance-based assignments may change every year, but will typically encompass women's and children's health, chronic care and mental health.

The five CAHPS scores will be compared to statewide averages and are also worth ten points each. A plan will earn ten points if its rate for a measure was above the statewide average and five if it was at the statewide average. In years when we do not conduct a CAHPS, the most recent year's data would be used. New York adjusts CAHPs scores for member age, health status, education, and whether the survey completed was for adult or children. Since New York City plan members have historically rated their plans lower than "rest-of-state" members, New York will risk-adjust CAHPs results to reflect these differences. The state assigns statistical significance after accounting for differences in plans' members.

In 2005, Medicaid plans that do not meet the threshold for obtaining a financial incentive payment are also not eligible for performance-based auto-assignment. Performance-based assignments are equally distributed to all plans above the financial incentive threshold. In 2004, eight of the 26 Medicaid plans did not receive any performance-based auto assignment but the state used a different methodology for determining the threshold below which plans would not receive such auto-assignments in 2004 compared to 2005.

The performance-based assignment algorithm is used to assign a percentage of all default enrollments in New York. This percentage changes over time depending on when mandatory Medicaid managed care was initially instituted in a given county or region. In the first year after mandatory managed care, no assignments were based on plan performance to

quality measures. In the second year, 50 percent of assignments are based on plan performance, in the third year, 55 percent of assignments and based on plan performance. In the forth year after mandatory managed care, and all subsequent years, 75 percent of the assignments are based on plan performance. The remaining 25 percent are randomly distributed to all plans.

In the first years after mandatory managed care, the state allocates a percentage of the default assignments to provider-sponsored plans. This percentage decreases over time from 25 percent to 0 percent in accordance with legislative requirements. Assignments that are not allocated according to performance or provider-sponsored status are distributed evenly among participating plans.