California HealthCare Foundation

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

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*Prepared for*

California HealthCare Foundation

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## About the Foundation

The **California HealthCare Foundation**, based in Oakland, is an independent philanthropy committed to improving California's health care delivery and financing systems. Formed in 1996, our goal is to ensure that all Californians have access to affordable, quality health care. For more information about CHCF, visit us online at **www.chcf.org**.

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# I. Executive Summary

## Background

In 2003, the California Department of Health Services (DHS) expressed interest in creating a performance incentive to improve the quality of care in its Medi-Cal managed care program. The state's fiscal crisis removed the possibility of providing a new financial incentive to participating health plans. Instead, DHS wanted to explore the option of applying a set of performance indicators to the process of differentially assigning default enrollments—that is, the automatic assignment of beneficiaries who are required to enroll in managed care but did not choose a health plan for themselves. The California HealthCare Foundation offered to provide DHS with technical assistance to design this strategy and facilitate a process for soliciting feedback from interested parties. CHCF hired Bailit Health Purchasing, LLC to provide the assistance.

Performance-based auto assignment has been adopted by a small number of other state Medicaid programs, including those in Massachusetts, Michigan, New Mexico, and New York. To design the new algorithm, DHS drew upon the experience of these states, as well as the expertise of a stakeholder advisory group consisting of executives from Medi-Cal health plans, consumer advocates, and provider association representatives.

The algorithm was designed to operate in 14 counties in California, which account for nearly 3 million Medi-Cal managed care enrollees. Twelve of these counties operate under the Two-Plan Model, in which DHS generally contracts with a county-developed health plan called a Local Initiative and with one commercial plan. The remaining two counties operate under the Geographic Managed Care (GMC) Model, in which DHS allows many different health plans to operate within a designated county, similar to most other states' Medicaid managed care programs.

## The New Algorithm

Working with the advisory group, DHS developed several goals for the new performance-based auto-assignment algorithm by 2005. Specifically, the algorithm would:

- Recognize health plans with superior performance relative to other health plan(s) in the county;
- Create an incentive among all plans for quality improvement by assigning more members to higher performing plans than to comparatively lower performing plans in a county, and
- Support preservation of the safety net.

Supporting preservation of the safety net was an element advocated by some of the advisory group members. It reflects the Two-Plan model's origins and, specifically, its design to support traditional safety-net providers.

DHS ultimately elected to incorporate seven performance measures as the basis for determining auto-assignment distribution in each Two-Plan and GMC county. These included five HEDIS measures that focus on the care of children and adolescents, prenatal care, and people with asthma. DHS and its stakeholders also worked together to design, test, and adopt two new measures of safety-net support: the percent of hospital discharges at Disproportionate Share Hospital (DSH) facilities for Medi-Cal managed care members residing within the county, and the percent of members assigned to safety-net primary care providers (PCPs).

DHS also decided to make two additional important changes to its auto-assignment procedures: exclude continuity of care assignments in the count of auto-assignments, and eliminate assured minimum enrollment levels for Local Initiative health plans. Finally, DHS and the stakeholder advisory group agreed to explore the addition of measures in the second year which would reflect improvement of health plan performance over time, so that the plans would have an incentive to improve regardless of how their results compared with those of their competitors.

## Impact of the New Algorithm

The new performance-based auto-assignment algorithm was implemented in December 2005.

The new algorithm discernibly changed the allocation of auto-assignments, with even modest differences in performance yielding significant changes in the distribution of default enrollment. The impact of these changes was muted to some degree by a DHS decision to cap the change in auto-assignments during the first year at 10 percent of the default enrollees in a county. The cap was applied in six of ten Two-Plan counties, and in one of two GMC counties. In all but one of these counties, the difference in HEDIS scores alone created the need to apply the cap.

In most counties there was a statistically significant difference among competing plans on only one of five HEDIS measures. Where differences were significant, they were between 5 percent and 10 percent in absolute terms. When there was a statistical difference in Two-Plan counties, the Local Initiative most often was the superior performer.

Differences occurred a higher percentage of the time with the safety-net provider support measures, most often with the PCP measure, and most often with the Local Initiative the superior performer in Two-Plan counties. Significant differences in Two-Plan counties were larger in absolute terms than they were for the HEDIS measures, ranging between 6 percent and 12 percent for the DSH measure, and 11 percent and 43 percent for the PCP measure.

The projected annual net impact for the first year on plans in Two-Plan counties is an addition or subtraction of between 7 percent and 14 percent of the total auto-assignment volume (including continuity of care assignment volume) that any given plan had been receiving prior to the introduction of the new algorithm. Projecting net impact in the GMC counties is more difficult due to the added effect of plans leaving and entering these two counties.

As a result of the new performance-based auto-assignment algorithm, 17,000 Medi-Cal managed care enrollees in Two-Plan counties will be assigned in the first year to a better health plan, as assessed by the seven performance indicators, than they would have been assigned otherwise. The long-term impact will be that 2.7 million enrollees in the 14 counties and the safety-net should benefit from all health plans in the 14 counties striving to improve their performance on the measures contained within the algorithm.

This project has demonstrated that available measures exist to implement a performance-based auto-assignment algorithm in a manner that does not unduly tax a state agency's administrative resources. The project also showed that stakeholders are generally supportive of performance-based auto-assignment, provided that the measures are objective, the algorithm is fair, and the implementation impact on health plans is not traumatic.

# II. Background

State Medicaid programs across the United States have slowly been adopting the principles of "value-based purchasing" over the past decade. Value-based purchasing represents a purchaser strategy to explicitly define and measure performance against prioritized performance expectations, and then apply incentives or disincentives with contractors based on measured results.

The California Department of Health Services (DHS) and its Medicaid (known as "Medi-Cal") Managed Care program has been a participant in this national movement. With support from the California HealthCare Foundation (CHCF), DHS has adopted a set of performance indicators to track key attributes of managed care organization contractor performance. It has also developed a Medi-Cal managed care consumer guide for distribution to beneficiaries.

In 2003 DHS expressed interest in creating a performance incentive for contracted health plans. The state's fiscal crisis removed the possibility of providing a new financial incentive. Instead, DHS expressed an interest in creating incentives for Medi-Cal managed care organizations to improve their performance by differentially assigning default enrollments based on a set of performance indicators. A default enrollment, or "auto-assignment," occurs when a Medi-Cal beneficiary who is required to participate in managed care does not select a plan within 30 days of notification. In California, as in most Medicaid managed care programs across the country, some beneficiaries do not select a health plan and must be assigned to a health plan in order to receive coverage.

In any given month, DHS uses a default assignment process to enroll between 18 and 23 percent of newly eligible Medi-Cal beneficiaries to a health plan in counties where beneficiaries have a choice of health plans in which to enroll. Health care use and the cost of caring for these beneficiaries reportedly tends to be below average as compared to other plan-enrolled Medi-Cal beneficiaries, so managed care programs generally view default enrollment as financially desirable.

From the perspective of purchasers and consumers, performance-based auto-assignment has two benefits. First, it results in a greater number of beneficiaries in higher quality health plans. Second, it encourages improvements in quality that benefit all managed care enrollees.

Performance-based auto assignment has been adopted by a small number of other state Medicaid programs in the past, including those in Massachusetts, Michigan, New Mexico, and New York. The California HealthCare Foundation offered to provide DHS with technical assistance to design this strategy and facilitate a process for soliciting feedback from interested parties. CHCF hired Bailit Health Purchasing, LLC to provide the assistance.

At the outset of the project, DHS set forth the following parameters. First, the performance-based auto-assignment algorithm would be applied by DHS in the 14 counties where there are two or more managed care organizations serving the Medi-Cal population. Second, the algorithm would be used by DHS as an incentive for health plans to improve their performance in targeted areas by recognizing and rewarding health plans with superior performance relative to other plans in a county.

This report describes:

- Medi-Cal managed care and the prior auto-assignment methodology;
- The experience of other states with performance-based auto-assignment;
- The process followed by DHS to develop its own performance-based auto-assignment process;
- The final auto-assignment algorithm selected by DHS; and
- The results of the new performance-based auto-assignment algorithm and their impact on contracted health plans.

## Overview of Medi-Cal Managed Care

The California Department of Health Services has a Medicaid managed care system that includes three different organizing models: Two-Plan, Geographic Managed Care (GMC), and County-organized Health System (COHS). In each Medi-Cal managed care county, or multi-county region, DHS contracts with one health plan in the COHS Model, two health plans in the Two-Plan Model, and multiple health plans in the GMC Model. Since the COHS Model includes only one plan in each county, this model was not included is the performance-based assignment process.[1]

- Under the Two-Plan Model, DHS generally contracts with a county-developed health plan called a Local Initiative (LI) and one commercial plan. The Two-Plan Model operates in California counties with a high concentration of Medi-Cal beneficiaries. The intended design of the Local Initiative, a public entity, was to preserve the role of traditional providers of Medi-Cal beneficiaries in the transition to mandatory Medi-Cal managed care. Eleven health plans participate in the Two-Plan Model, which operates in 12 counties: Alameda, Contra Costs, Fresno, Kern, Los Angeles, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare. Some health plans participate in more than one county within the Two-Plan Model.
- The GMC Model allows many different health plans to operate within a designated county, similar to most other states' Medicaid managed care programs. There are two GMC counties, Sacramento and San Diego. Six Medicaid managed care plans participate in Sacramento County and six plans participate in San Diego County. Five plans (Blue Cross, Care First, HealthNet, Kaiser, and Molina) participate in both GMC regions.

As of July 2005, 2.7 million Medi-Cal beneficiaries were enrolled in health plans in the 14 counties with the Two-Plan or GMC Model. A listing of health plans by county is provided in Appendix A, published separately on the CHCF Web site at www.chcf.org/topics/medi-cal/index.cfm?itemID=121098.

## Prior Auto-Assignment Processes

Prior to the development of the performance-based auto-assignment algorithm, DHS maintained similar auto-assignment processes in Two-Plan and GMC Model counties when an individual did not voluntarily select a health plan. Prior to making general default enrollment assignments, DHS' enrollment broker determined if the eligible individual had previously been enrolled in a Medi-Cal plan or had family members who were enrolled in a Medi-Cal plan. In each of these circumstances, DHS specific auto-assignment processes came into play. These processes were referred to as continuity of care assignments and were designed to ensure individuals previously enrolled in a plan were automatically re-enrolled into the same plan and that individuals in the same family were enrolled in a common Medi-Cal plan.

In general, after all health plans were operational, total default assignments, including continuity of care assignments, were distributed evenly across participating health plans in a region, unless a health plan was not eligible to receive assignments. To reduce the effects of continuity of care assignments an equal number of non-continuity of care default assignments were awarded to the competing plan in the Two-Plan Model to achieve an even distribution of total assignments.

A health plan could be ineligible to receive assignments for a number of reasons. First, a health plan could elect to limit the number of default assignments it received. Second, in the Two-Plan Model, a commercial plan would be ineligible to receive default assignments if the Local Initiative had not yet reached its minimum enrollment level or dropped back below that level after initially attaining minimum enrollment. All default assignments (excluding continuity of care assignments) would go to the LI until it reached its minimum enrollment level. At that time the default algorithm would revert to an even distribution.

Third, also in the Two-Plan Model, a commercial plan would not receive default assignments if the plan had reached its maximum enrollment limit.

The 2004 annual volume of auto-assignments in the 14 affected counties[2], excluding continuity of care assignments, was approximately 192,000. The volume varied from a monthly average of about 380 auto-assignments per month in San Francisco City and County to a high of about 7,100 auto-assignments per month in Los Angeles County.[3]

When continuity of care assignments were included in the calculations, as had been DHS' practice, the actual distribution of total assignments to each managed care organization in Two-Plan counties was between 49 and 51 percent in 2004. This equal distribution of total assignments was mirrored in the GMC counties, except to the extent that individual plans might have refused to accept assignments.

# III. Developing a New Algorithm

## Stakeholder Interviews

BAILIT BEGAN THE PROJECT BY INTERVIEWING California health plan executives, professional association representatives, and consumer advocates to understand their perspectives, hopes, and concerns regarding the development of a performance-based auto-assignment algorithm. These individuals uniformly expressed support for the concept, although some stated reservations. The reservations centered around four main issues:

- The appropriateness of the measures and comparisons incorporated into the methodology;
- The ability of DHS to implement and operate the algorithm following a period of significant agency downsizing;
- The extent to which the algorithm would support the safety net, and hence, safety-net plans (LIs); and
- To what extent the initiative would gain DHS senior management support and see fruition given staff resource limitations.

The interview process was also used to ask about any concerns individuals had about the existing auto-assignment algorithm. The most frequently cited concern was that DHS considered continuity of care assignments to be a component of the default assignment count. Many argued that continuity of care assignments should be considered choice enrollments and excluded from the assignment algorithm. However, health plans with smaller Medi-Cal enrollments argued against this change, as they felt that it favored plans with higher enrollment.

## Examination of Other States' Practices

Bailit studied the experience of four other states with current or previously operating performance-based auto-assignment algorithms. Appendix B, published separately on the CHCF Web site at www.chcf.org/topics/medi-cal/index.cfm?itemID=121098, provides a comprehensive description of the experience of these other states. The most pertinent lessons learned were as follows:

### Measures:

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

### Algorithm and performance benchmarks:

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

### 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.

### Broader context for performance-based auto-assignment:

- 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 publicly presenting awards to high performing plans. 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, public communication can help increase the importance of the recognition.

## Stakeholder Advisory Group

To assist DHS and Bailit with the design of the new performance-based auto-assignment algorithm, CHCF assembled an advisory group consisting of executives from health plans in GMC and Two-Plan counties, consumer advocates, and provider association representatives. A list of the advisory group members can be found in Appendix C, published separately on the CHCF Web site at www.chcf.org/topics/medi-cal/index.cfm?itemID=121098. The advisory group meetings also included participants from DHS and CHCF, and were facilitated by Bailit.

At the initial meeting CHCF explained that the role of the group was to provide input to DHS for a new auto-assignment algorithm to be implemented in September 2005. While consensus among the members was viewed as desirable, it was not required. DHS explained that the department would make the final determination of the specifics of the performance-based auto-assignment policy.

Significant discussion occurred at the first two advisory group meetings on the issue of whether, and to what extent, the new algorithm should be explicitly designed to support the safety net, with several members advocating this position. Some advisory group members recounted that an original purpose of the Two-Plan Model was for safety-net protection, and also that the existing algorithm, with its enrollment minimums for local initiative plans, provided some protection for safety-net providers. There was general consensus that the algorithm should not harm the safety net.

Informed by this conversation, and in response to stakeholder request, DHS developed a goal statement for the project.

DHS' goal for the auto-assignment algorithm project is to create and implement an assignment algorithm by 2005 that:

- Recognizes health plans with superior performance relative to other health plan(s) in the county;
- Creates an incentive among all plans for quality improvement by assigning more members to higher-performing plans than to comparatively lower-performing plans in a county, and
- Supports preservation of the safety net.

Another early conversation among the advisory group members concerned the extent to which new incentives for managed care organizations to compete on quality might discourage plans from collaborating on quality improvement initiatives in the future. Several members of the advisory group felt that this was a real risk. Still, the group's prevailing sentiment was that the benefit of creating clear incentives for plans to improve quality of care outweighed the potential risk of diminished future collaboration.

The stakeholders participating on the advisory group provided invaluable information as basic parameters for the algorithm were reviewed, and they generously gave of their time throughout the project. Their willingness to collaborate with DHS and with one another was crucial to the success of the project.

## Development of the Algorithm

The algorithm development process was primarily conducted over the initial 12 months of the process, with testing and development following during the spring and summer of 2005. Major milestones in the development process are described below.

## Selecting Measures

Bailit worked with DHS to identify available DHS data that could be used in a performance-based algorithm. Concurrently, Bailit also reviewed options with advisory group members. This process allowed for the easy identification of a short list of potential measures. This process was aided by the fact that (a) DHS collected a limited number of quality measures from its contracted plans, and (b) the stakeholders were generally of one mind—both with one another, DHS, and Bailit—as to which of the available measures would be most appropriate for algorithm use.

The selection of safety-net provider support measures, however, generated significant discussion. DHS was unable to produce a valid and reliable measure in the short-term using its encounter data, so alternative approaches needed to be considered. Bailit worked with a subgroup of the stakeholder advisory group to design, test, and populate new measures of safety-net provider support. Operational definitions were developed to support the new measures, and they were then tested. Following testing, Bailit and DHS worked together with each of the Two-Plan and GMC county plans to collect needed data to generate the plan-specific rates.

## Making Comparisons

Decisions regarding the process for comparing plans were, generally speaking, easier than those regarding measure selection, and DHS and its stakeholders were usually in agreement. Only the question of how to make statistical comparisons of competing plans' performance presented a number of choices requiring deliberation. The potential business implications of this policy decision gave rise to considerable care when reviewing available options.

## Identifying Algorithm Options

After reviewing the experience of other states, available DHS data, and potential measures and methods for comparison, Bailit began developing draft algorithms. The algorithms adhered to the guiding principles Bailit developed working with the advisory group and DHS staff. Some of the most important principles were as follows:

- Measurement and comparisons should be county-specific;
- Statistical significance tests should be used to evaluate differences in performance;
- Performance should be assessed at both a point-in-time and over time in order to recognize both excellence in performance and performance improvement, and to provide a motivation for all health plans to improve, regardless of their current performance standing relative to the competition;
- Auto-assignment algorithm calculations should be performed as soon as possible following the receipt of updated performance information, and should be updated annually;
- Health plan support of the safety net should be assessed and recognized within the algorithm;
- The implementation of the performance-based auto-assignment algorithm should not provide major disruption for health plans at its outset, and
- Should a plan elect to not receive default assignments in a GMC county, the algorithm should consider performance data for all county managed care organizations but redistribute enrollments proportionately to plans that do wish to accept assignments.

# IV. The New Auto-Assignment Algorithm

## The Measures

DHS elected to incorporate seven performance measures as the basis for determining auto-assignment distribution in each Two-Plan and GMC county.

DHS chose to employ five HEDIS measures. The measures reflect national standards for clinical care and for measurement, they are audited, reflect meaningful assessments of quality of care, and they are currently available to DHS. No other quality-related performance measures currently available to DHS met these criteria.

- Childhood immunization status: Combo 2
- Well-child visits: 3rd through 6th years of life
- Adolescent well-care visits
- Timeliness of prenatal care
- Use of appropriate medications for people with asthma

As discussed previously, there were no existing measures of safety-net support, and data to support such measures were not collected by DHS. Upon the recommendation of a subgroup of the stakeholder advisory group, DHS and the full advisory group endorsed the following measures:

- The percentage of hospital discharges at Disproportionate Share Hospital (DSH) facilities for Medi-Cal managed care members residing within the county; and
- The percentage of Medi-Cal managed care members assigned to safety-net provider primary care providers (PCPs).

"Safety-net provider PCPs" were defined as primary care clinicians practicing in any of the following settings:

- Federally Qualified Health Center (FQHC);
- Rural Health Center (RHC);
- Indian or Tribal Clinic;

- Nonprofit community or free clinic licensed as a primary clinic by the state, including any satellite/intermittent sites of the clinic if the site serves as a location of plan PCPs; and
- Clinic affiliated with publicly owned DSH facilities.

Each plan in a county developed a list of the PCPs with which they contracted and which met these criteria. These lists were shared among plans in the county, and the plans and DHS agreed upon a final list for each county. PCP sites that could not be verified by DHS as meeting DHS criteria or which were located in bordering counties were not included in the rate calculation. The process was, with rare exception, neither difficult nor controversial.

DHS was able to obtain required data to generate the DSH measure from the Office of Statewide Health Planning and Development (OSHPD) within the California Health and Human Services Agency. The data for the PCP measure were generated by the plans, and DHS performed a desk audit. Plans that failed the audit were to receive zero points for the measure. No plan failed the audit.

## Measurement Period

The measurement period for the seven algorithm measures varied as shown in Table 1:

DHS anticipates using these same five measures for the first three years the new algorithm is in place and will convey any changes to these measures to the plans with advance notice. DHS decided that the measures will not change frequently, in order to give plans a greater incentive to invest in performance improvement efforts in the targeted performance areas.

Beginning in the second year, DHS will also assess whether each managed care organization showed statistically significant improvement for each of the algorithm measures. Thus, DHS will be assessing contractors on both a point-in-time comparison to the competitor plan(s) and also on an over-time comparison of performance improvement.

## Other Changes to Old Algorithm

After reviewing the historical algorithm used by DHS, Bailit recommended three changes. The first recommendation was to exclude continuity of care assignments in the count of auto-assignments. In the course of reviewing the historical algorithm it became clear that continuity of care assignments were not, and should not be considered, true default assignments for the purposes of a performance-based algorithm. The advisory group had mixed perspectives on this recommendation, but the majority voiced support for it. DHS elected to make this change.

**Table 1. Algorithm Measurement Period, by Measure**

| Measure | Measured Time Period |
|---|---|
| All HEDIS measures | Prior calendar year |
| Safety-net provider support: PCP | Point in time selected by DHS each summer, but sometime within the four months immediately preceding the request |
| Safety-net provider support: DSH | The most recently available calendar year for the OSHPD hospital discharge data set |

Second, Bailit recommended that DHS limit the "look back" period to two years. The look back period refers to the extent to which DHS traces the history of a previously enrolled member's prior Medi-Cal health plan affiliation and re-assigns the member to that health plan. Bailit observed that DHS had no limit in place for how far back it would search for a prior enrollment as long as there was at least one family member active in a plan. DHS elected not to make this change because of the operational resource implications, time constraints and the perceived low impact that the change would have on members.

Finally, Bailit and then the advisory group recommended, and DHS adopted, a decision to eliminate health plan enrollment minimums.

## Phase-in Period

A majority of advisory group members recommended, and DHS agreed, that the impact of the new algorithm should be limited in the first few years in order to avoid a disruptive transition to the new methodology. For the first year, the assignment percentage received by a plan will not change more than 10 percent in either direction (e.g., from 50 percent to 60 percent), and by another 10 percent in the second year. After the second year, the cap will be removed. The cap is assessed against the percentage of assignments a plan has been receiving on average over the preceding six months, excluding continuity of care assignments[4].

## The Algorithm: Two-Plan Counties

1. For each of the HEDIS measures, the rates of the two plans are compared for each of the designated measures using a two-tailed test for statistical significance and a 95 percent confidence level. For each of the HEDIS measures, a plan is assigned 2 points if it is statistically superior to the competitor plan, 1 point if the two plans are statistically equivalent, and 0 points if it is statistically inferior.

2. For each of the two safety-net provider support measures, the plans are compared and points allocated in the following fashion:

   a. If the rates of the two plans are within 5 percentage points of one another, each plan will be assigned 0 points.[5]

   b. If one plan's rate is greater than or equal to 5 percentage points but less than 10 percentage points greater than the other plan, the plan with the higher rate is be awarded 1 point.

   c. If one plan's rate is greater than or equal to 10 percentage points but less than 15 percentage points greater than the other plan, the plan with the higher rate is awarded 1.25 points.

   d. If one plan's rate is greater than or equal to 15 percentage points but less than 20 percentage points greater than the other plan, the plan with the higher rate is awarded 1.5 points.

   e. If one plan's rate is greater than or equal to 20 percentage points but less than 25 percentage points greater than the other plan, the plan with the higher rate is awarded 1.75 points.

   f. If one plan's rate is at least 25 percentage points greater than the other plan, the plan with the higher rate is awarded 2 points.

This approach moderates the impact of the points being assigned to one plan for greater safety-net support—a source of concern to some stakeholders.

3. The points earned by each plan are summed and the percentage of the total points earned by a health plan equals the percentage of auto-assignments the organization receives for the following 12-month time period.

4. Beginning in Year 2, for each of the measures (HEDIS and safety net), the rates for each plan will also be compared to the plan's prior year rates for the same measures using a two-tailed test for statistical significance and a 95 percent confidence level. A plan will be assigned 0 points if its performance has not changed, 1 point if its performance has improved, and -1 point if its performance has deteriorated. The points earned by each plan will then be summed and the percentage of the total points earned by a health plan will equal the percentage of auto-assignments the organization will receive for the following 12-month time period.

Those plans judged by DHS to have exceptionally strong performance on HEDIS measures will automatically earn a point and not be required to demonstrate statistically significant improvement. DHS intends to define "exceptionally strong performance" prior to Year 2, and anticipates that the definition will in some manner incorporate reference to national Medicaid HEDIS benchmark data. DHS has not yet decided if, and if so how, the exceptionally strong performance designation should be applied to the safety-net provider support measures.

5. Following these steps, the total assignments are calculated, then recalculated after capping the change in the percentage of assignments from Year 1 at 10 percent.

## The Algorithm: GMC Counties

Because the GMC counties have more than two plans competing within them, it was necessary to modify the methodology and utilize different statistical tests. Instead of comparing one plan to another, for each of the HEDIS and safety-net provider support measures for which there is no standardized denominator size, the rates of the plans are compared to the harmonic mean for each of the county's Medi-Cal managed care organizations, using a two-tailed test for statistical significance and a 95 percent confidence level. Otherwise, the county arithmetic mean is used.

"Harmonic means" is a statistical technique sometimes used instead of the traditional arithmetic mean when there are only a few comparators and there is variation in denominator size. Using the harmonic mean avoids having one of the values "drive"the mean. The DHS advisory group voiced its support for the use of this technique in GMC counties for those measures without standardized denominator size. The formula and a sample calculation of a harmonic mean are presented in Appendix D, published separately on the CHCF Web site at www.chcf.org/topics/medi-cal/index.cfm?itemID=121098.

In addition, in GMC counties it is possible for the auto-assignment algorithm to result in allocations greater or less than 100 percent. This is because the change in a plan's year-over-year allocation is limited to an absolute change of 10 percent up or down and there are more than two plans competing for assignments. To adjust for this potential statistical phenomenon, the allocation is normalized so that the final allocation equals 100 percent.

When a new plan enters a county it receives the percentage of allocations it would receive if its performance equaled the county mean. To adjust for the new plan, plans already in the county are allocated auto-assignments and normalized as above. The new plan is then assigned its fixed allocation and the other plans are adjusted in relation to the new plan so that the total allocation across all plans equals 100 percent.

Otherwise, the algorithm follows the same steps described above for the Two-Plan counties.

## Plan Changes

The Medi-Cal managed care program is dynamic. Plans may enter and depart the program in individual counties. In addition, plans are acquired, merge, and buy and sell lines of business to one another.

DHS decided that the most appropriate method for managing these changes would be to treat a wholly new health plan in the county as performing the same as its competitor (Two-Plan county) or as the county average (GMC county) until such time as it can produce its own performance rates. However, should a plan newly enter a county through the acquisition of another health plan's Medi-Cal business, that new plan will be assessed using existing performance data for the acquired plan in that county.

## Plan Refusal to Accept Assignments

It has been DHS' experience that on occasion health plans may elect to not accept auto-assignments for any reason other than continuity of care. DHS decided that under such circumstances, it will apply the algorithm as if the plan was accepting assignments, and then will distribute that organization's performance-based auto-assignments to the other plan(s). In a GMC County, this would entail a pro rata distribution based on the points earned by the competitor plans in the county. In a Two-Plan County, all of the assignments would be allocated to the competitor plan.

# V. Selected Ideas That Were Considered but Not Adopted

Several ideas were considered during the course of the project, but not adopted. Some of the most notable ideas, and the rationale for their exclusion, follow below.

- ***Allotment of bonus points:*** Some advisory group members felt it desirable to include a provision for "bonus points" for health plans with demonstrated performance that is superior to that of the competition by a predetermined amount, or that, alternatively, meets the 90th percentile for Medicaid managed care plans nationally.

This approach, in either form, has considerable merit, as it recognizes performance that is far superior and not only statistically significantly higher than the performance of the competition. It is also a concept that has been incorporated into the algorithm's treatment of the two safety-net provider support measures, albeit in yet another modified form.

Nonetheless, the approach was not incorporated into the recommended algorithm or into any of the identified options for the simple reason that it adds additional complexity. The concept of bonus points may be given consideration again for Year 2.

- ***Use of consumer-centric performance measures:*** The adopted algorithm fails to make use of any consumer-focused performance measures. This results not from an explicit decision to exclude them, but rather, from the failure to identify any currently available valid measures.

The Consumer Assessment of Health Plans Survey (CAHPS) was considered and rejected due to the fact that data are collected only biannually, and health plans felt that the results were not meaningful for a number of reasons.

Consideration of the voluntary disenrollment rate was stymied because DHS' contractor, Maximus, does not collect data on the volume of truly voluntary disenrollments from managed care. DHS needs to address the current use of the disenrollment reason codes with its contractor so that such a measure might be considered for inclusion in the future.

- ***Use of DHS-developed measures:*** DHS staff recommended two additional measures for inclusion: (a) ER visits as a percentage of all outpatient visits (a measure of primary care access), and (b) outpatient visits per 1000 (a measure of encounter data completeness and also of access to care).

Bailit concluded, and DHS agreed, that these two measures, while thoughtfully conceived, should not be included in the algorithm at the outset. The rationale was as follows.

First, there are seven measures considered in the algorithm. Bailit's experience has shown that managed care organizations are realistically unable to respond to more than several performance incentives at one time. To add more measures would risk significantly diluting the effectiveness of the strategy. Second, the use of non-standardized measures creates many hazards and concerns. Non-standardized measures have often not been subject to the extensive testing and verification that standardized measures have undergone. They also may suffer from less-developed specifications since their testing and application has not yet revealed potential shortcomings, and as a result they may generate results that suffer from methodological errors. Finally, non-standardized measures may lack the credibility of standardized measures with key stakeholders.

- ***Definition of safety-net outpatient provider:*** One GMC county-based managed care program argued that DHS should also include community practices serving high volumes of the uninsured and of Medi-Cal recipients in DHS' outpatient safety-net provider support measure, particularly in those counties where there is a paucity of traditional safety-net providers. Data resource limitations prevented consideration of this option.

# VI. The New Algorithm's Results and Impact

THE NEW PERFORMANCE-BASED AUTO-ASSIGNment algorithm was successfully implemented in December 2005 by DHS. An analysis of health plan performance relative to the algorithm and its component measures revealed the following:

## Overall Impact

The new algorithm discernibly changed the allocation of auto-assignments. The impact of these changes was muted to some degree by the decision to limit the extent to which allocation percentages would change in the first year. The cap on the annual change in the percentage of auto-assignments was applied in six of ten Two-Plan counties, and in one of two GMC counties. In all but one of these counties, the difference in HEDIS scores alone created the need to apply the cap.

Generally speaking, plan performance did not vary significantly on the selected HEDIS measures. In most counties there was a statistically significant difference among competing plans on only one of five HEDIS measures. Where differences were significant, they were between 5 percent and 10 percent in absolute terms. When there was a statistical difference in Two-Plan counties, the Local Initiative most often was the superior performer.

Differences occurred a higher percentage of the time on the safety-net provider support measures, most often on the PCP measure, and most often with the Local Initiative the superior performer in Two-Plan counties. Significant differences in Two-Plan counties were larger in absolute terms that they were for the HEDIS measures, ranging between 6 percent and 12 percent for the DSH measure, and 11 percent and 43 percent for the PCP measure.

The projected annual net impact for the first year on plans in Two-Plan counties is an addition or subtraction of between 7 percent and 14 percent of the total auto-assignment volume (inclusive of continuity of care assignment volume) that any given plan had been receiving prior to the introduction of the new algorithm. Projecting net impact in the GMC counties is more difficult due to the added effect of plans leaving and entering these two counties.

If the caps were not applied in the six Two-Plan counties, the impact on assignment volume would be greater. The net percent of total assignment volume reassigned to or from an individual plan would range between 17 percent and almost 70 percent in these counties.

As a result of the new performance-based auto-assignment algorithm, 17,000 Medi-Cal managed care enrollees in Two-Plan counties will be assigned in the first year to a better health plan, as assessed by the seven performance indicators, than they would have been assigned otherwise. The long-term impact will be that 2.7 million enrollees in the 14 counties and the safety net should benefit from all health plans in these counties striving to improve their performance on the measures contained within the algorithm.

A more detailed assessment of the algorithm's impact follows below.

## Two-Plan Counties

Analysis revealed that superior performance on HEDIS measures generally correlated with superior performance on safety-net provider measures.

- While it would be inappropriate to infer causation, a plan with superior HEDIS performance also tended to do better relative to its competitor on the safety-net provider support measures.
- In no instance did a plan have superior performance on HEDIS measures and inferior performance on safety-net provider support measures.

Plan performance on the selected indicators was statistically equivalent in most instances. In addition, there was no measure for which the Local Initiatives or the commercial plans consistently outperformed the other. There were only two measures for which either the LIs or the commercial plans were superior in at least three instances:[6]

- LIs were superior on the HEDIS appropriate medication for people with asthma measure in three (of nine) instances, and
- LIs were superior on use of outpatient safety-net providers as PCPs in four (of 10) instances.

Despite the lack of statistically significant difference on most measures in most counties, LIs performed better than their commercial plan competitors in seven of 10 Two-Plan counties.

- LIs performed slightly better on HEDIS measures. (LIs were better in five counties, worse in three counties, and the same as the commercial plan in one county.) "Better" performance often meant that the plans were equivalent on four HEDIS measures but differed on one, and that the LI was statistically superior on the one measure where the difference was significant.
- LIs performed slightly better on safety-net provider support measures. (LIs were better in four counties, worse in three counties, and the same as commercial plans in three counties.)

## GMC Counties

Performance patterns in the two GMC counties were quite distinct. There was significant variation in HEDIS performance in Sacramento, whereas the plans generally performed at the same level in San Diego. Superior performance on HEDIS measures did not appear to parallel superior performance on safety-net provider measures in these two counties, as it did in the Two-Plan Model counties. However, similar to the Two-Plan counties, safety-net provider-based plans generally performed better than other plans in both counties on the two safety-net provider support measures.

The GMC counties had some distinctive characteristics:

- One Sacramento plan (Blue Cross) exceeded the county average on four of five HEDIS measures.
- One plan (Kaiser) had noticeably lower safety-net provider support measure rates because the plan, by policy, relies primarily upon its own, non-safety-net providers. The effect of this phenomenon was to pull down the county mean and generate points for the other plans, particularly in San Diego County.
- Because of the effect of having more than two plans in each county and the resulting broader distribution of points, the 10 percent change cap had limited application.
- San Diego and Sacramento both added new plans. These plans were allocated points as if their performance was equivalent to the county mean.

An example of the complete detailed algorithm calculations for a Two-Plan county can be found in Appendix E. The performance of each health plan on the algorithm measures by county can be found in Appendix F. Both documents are published separately on the CHCF Web site at www.chcf.org/topics/medi-cal/index.cfm?itemID=121098.

To determine the final net impact on each health plan, it is necessary to add in the percentage of assignments due to continuity of care considerations. Unlike in the past, these assignments are no longer considered to be part of the assignment algorithm, but are now made before the algorithm is applied. Table 2 provides the projected annual impact of the revised auto-assignment system on Medi-Cal managed care plans in Two-Plan counties, and Table 3 provides the same information for plans in GMC counties.

## Table 2. Projected Impact in Two-Plan Counties

| Health Plan | Annual Auto-Assign Volume | Annual Continuity of Care Assign Volume | Total Annual Assign Volume | Percentage of Auto-Assign Volume | Percentage of Continuity of Care Volume | Percentage of Total Annual Assign Volume |
|---|---|---|---|---|---|---|
| **Alameda County** | | | | | | |
| **Old Algorithm** | | | | | | |
| Alameda Alliance | 4,078 | 2,710 | 6,788 | 44% | 65% | 51% |
| Blue Cross | 5,216 | 1,434 | 6,650 | 56% | 35% | 49% |
| Total | 9,294 | 4,144 | 13,438 | | | |
| **New Algorithm** | | | | | | |
| Alameda Alliance | 5,019 | 2,710 | 7,729 | 54% | 65% | 58% |
| Blue Cross | 4,275 | 1,434 | 5,709 | 46% | 35% | 42% |
| Total | 9,294 | 4,144 | 13,438 | | | |
| **Year 1 Net Impact** | | | | | | |
| Alameda Alliance | 941 | – | 941 | 10% | 0% | 7% |
| Blue Cross | (941) | – | (941) | -10% | 0% | -7% |
| **Contra Costa County** | | | | | | |
| **Old Algorithm** | | | | | | |
| Contra Costa HP | 2,178 | 1,904 | 4,082 | 40% | 72% | 51% |
| Blue Cross | 3,210 | 732 | 3,942 | 60% | 28% | 49% |
| Total | 5,388 | 2,636 | 8,024 | | | |
| **New Algorithm** | | | | | | |
| Contra Costa HP | 2,694 | 1,904 | 4,598 | 50% | 72% | 57% |
| Blue Cross | 2,694 | 732 | 3,426 | 50% | 28% | 43% |
| Total | 5,388 | 2,636 | 8,024 | | | |
| **Year 1 Net Impact** | | | | | | |
| Contra Costa HP | 516 | – | 516 | 10% | 0% | 6% |
| Blue Cross | (516) | – | (516) | -10% | 0% | -6% |

| Health Plan | Annual Auto-Assign Volume | Annual Continuity of Care Assign Volume | Total Annual Assign Volume | Percentage of Auto-Assign Volume | Percentage of Continuity of Care Volume | Percentage of Total Annual Assign Volume |
|---|---|---|---|---|---|---|
| **Fresno County** | | | | | | |
| **Old Algorithm** | | | | | | |
| Health Net | 8,512 | 2,568 | 11,080 | 71% | 25% | 50% |
| Blue Cross | 3,504 | 7,678 | 11,182 | 29% | 75% | 50% |
| Total | 12,016 | 10,246 | 22,262 | | | |
| **New Algorithm** | | | | | | |
| Health Net | 7,690 | 2,568 | 10,258 | 64% | 25% | 46% |
| Blue Cross | 4,326 | 7,678 | 12,004 | 36% | 75% | 54% |
| Total | 12,016 | 10,246 | 22,262 | | | |
| **Year 1 Net Impact** | | | | | | |
| Health Net | (822) | – | (822) | -7% | 0% | -4% |
| Blue Cross | 822 | – | 822 | 7% | 0% | 4% |
| **Los Angeles County** | | | | | | |
| **Old Algorithm** | | | | | | |
| LA Care Health Plan | 42,950 | 37,118 | 80,068 | 45% | 56% | 50% |
| Health Net | 51,498 | 28,622 | 80,120 | 55% | 44% | 50% |
| Total | 94,448 | 65,740 | 160,188 | | | |
| **New Algorithm** | | | | | | |
| LA Care Health Plan | 51,946 | 37,118 | 89,064 | 55% | 56% | 56% |
| Health Net | 42,502 | 28,622 | 71,124 | 45% | 44% | 44% |
| Total | 94,448 | 65,740 | 160,188 | | | |
| **Year 1 Net Impact** | | | | | | |
| LA Care Health Plan | 8,996 | – | 8,996 | 10% | 0% | 6% |
| Health Net | (8,996) | – | (8,996) | -10% | 0% | -6% |

| Health Plan | Annual Auto-Assign Volume | Annual Continuity of Care Assign Volume | Total Annual Assign Volume | Percentage of Auto-Assign Volume | Percentage of Continuity of Care Volume | Percentage of Total Annual Assign Volume |
|---|---|---|---|---|---|---|
| **Riverside County** | | | | | | |
| **Old Algorithm** | | | | | | |
| Inland Empire HP | 9,332 | 6,676 | 16,008 | 42% | 67% | 50% |
| Molina Healthcare | 12,700 | 3,234 | 15,934 | 58% | 33% | 50% |
| Total | 22,032 | 9,910 | 31,942 | | | |
| **New Algorithm** | | | | | | |
| Inland Empire HP | 11,457 | 6,676 | 18,133 | 52% | 67% | 57% |
| Molina Healthcare | 10,575 | 3,234 | 13,809 | 48% | 33% | 43% |
| Total | 22,032 | 9,910 | 31,942 | | | |
| **Year 1 Net Impact** | | | | | | |
| Inland Empire HP | 2,125 | – | 2,125 | 10% | 0% | 7% |
| Molina Healthcare | (2,125) | – | (2,125) | -10% | 0% | -7% |
| **San Bernardino County** | | | | | | |
| **Old Algorithm** | | | | | | |
| Inland Empire HP | 12,368 | 8,796 | 21,164 | 44% | 62% | 50% |
| Molina Healthcare | 15,598 | 5,324 | 20,922 | 56% | 38% | 50% |
| Total | 27,966 | 14,120 | 42,086 | | | |
| **New Algorithm** | | | | | | |
| Inland Empire HP | 15,102 | 8,796 | 23,898 | 54% | 62% | 57% |
| Molina Healthcare | 12,864 | 5,324 | 18,188 | 46% | 38% | 43% |
| Total | 27,966 | 14,120 | 42,086 | | | |
| **Year 1 Net Impact** | | | | | | |
| Inland Empire HP | 2,734 | – | 2,734 | 10% | 0% | 6% |
| Molina Healthcare | (2,734) | – | (2,734) | -10% | 0% | -6% |

| Health Plan | Annual Auto-Assign Volume | Annual Continuity of Care Assign Volume | Total Annual Assign Volume | Percentage of Auto-Assign Volume | Percentage of Continuity of Care Volume | Percentage of Total Annual Assign Volume |
|---|---|---|---|---|---|---|
| **San Francisco County** | | | | | | |
| **Old Algorithm** | | | | | | |
| SF Health Plan | 2,200 | 1,246 | 3,446 | 61% | 70% | 64% |
| Blue Cross | 1,396 | 532 | 1,928 | 39% | 30% | 36% |
| Total | 3,596 | 1,778 | 5,374 | | | |
| **New Algorithm** | | | | | | |
| SF Health Plan | 2,517 | 1,246 | 3,763 | 70% | 70% | 70% |
| Blue Cross | 1,079 | 532 | 1,611 | 30% | 30% | 30% |
| Total | 3,596 | 1,778 | 5,374 | | | |
| **Year 1 Net Impact** | | | | | | |
| SF Health Plan | 317 | – | 317 | 9% | 0% | 6% |
| Blue Cross | (317) | – | (317) | -9% | 0% | -6% |
| **San Joaquin County** | | | | | | |
| **Old Algorithm** | | | | | | |
| HP of San Joaquin | 2,556 | 2,950 | 5,506 | 43% | 62% | 51% |
| Blue Cross | 3,458 | 1,780 | 5,238 | 57% | 38% | 49% |
| Total | 6,014 | 4,730 | 10,744 | | | |
| **New Algorithm** | | | | | | |
| HP of San Joaquin | 2,165 | 2,950 | 5,115 | 36% | 62% | 48% |
| Blue Cross | 3,849 | 1,780 | 5,629 | 64% | 38% | 52% |
| Total | 6,014 | 4,730 | 10,744 | | | |
| **Year 1 Net Impact** | | | | | | |
| HP of San Joaquin | (391) | – | (391) | -7% | 0% | -4% |
| Blue Cross | 391 | – | 391 | 7% | 0% | 4% |

| Health Plan | Annual Auto-Assign Volume | Annual Continuity of Care Assign Volume | Total Annual Assign Volume | Percentage of Auto-Assign Volume | Percentage of Continuity of Care Volume | Percentage of Total Annual Assign Volume |
|---|---|---|---|---|---|---|
| **Santa Clara County** | | | | | | |
| **Old Algorithm** | | | | | | |
| Santa Clara Family | 4,794 | 3,242 | 8,036 | 44% | 68% | 51% |
| Blue Cross | 6,114 | 1,558 | 7,672 | 56% | 32% | 49% |
| Total | 10,908 | 4,800 | 15,708 | | | |
| **New Algorithm** | | | | | | |
| Santa Clara Family | 5,890 | 3,242 | 9,132 | 54% | 68% | 58% |
| Blue Cross | 5,018 | 1,558 | 6,576 | 46% | 32% | 42% |
| Total | 10,908 | 4,800 | 15,708 | | | |
| **Year 1 Net Impact** | | | | | | |
| Santa Clara Family | 1,096 | – | 1,096 | 10% | 0% | 7% |
| Blue Cross | (1,096) | – | (1,096) | -10% | 0% | -7% |
| **Tulare County** | | | | | | |
| **Old Algorithm** | | | | | | |
| Blue Cross | 2,818 | 3,792 | 6,610 | 36% | 73% | 51% |
| Health Net | 4,988 | 1,404 | 6,392 | 64% | 27% | 49% |
| Total | 7,806 | 5,196 | 13,002 | | | |
| **New Algorithm** | | | | | | |
| Blue Cross | 2,654 | 3,792 | 6,446 | 34% | 73% | 50% |
| Health Net | 5,152 | 1,404 | 6,556 | 66% | 27% | 50% |
| Total | 7,806 | 5,196 | 13,002 | | | |
| **Year 1 Net Impact** | | | | | | |
| Blue Cross | (164) | – | (164) | -2% | 0% | -1% |
| Health Net | 164 | – | 164 | 2% | 0% | 1% |

## Table 3. Projected Impact in GMC Counties

| Health Plan | Annual Auto-Assign Volume | Annual Continuity of Care Assign Volume | Total Annual Assign Volume | Percentage of Auto-Assign Volume | Percentage of Continuity of Care Volume | Percentage of Total Annual Assign Volume |
|---|---|---|---|---|---|---|
| **Sacramento County** | | | | | | |
| **Old Algorithm** | | | | | | |
| Molina Healthcare | 3,824 | 1,220 | 5,044 | 26% | 17% | 23% |
| Western Health Adv | 2,278 | 744 | 3,022 | 15% | 10% | 14% |
| Health Net | 3,510 | 1,520 | 5,030 | 24% | 21% | 23% |
| Blue Cross | 2,102 | 3,012 | 5,114 | 14% | 42% | 23% |
| Kaiser Foundation | 4 | 572 | 576 | 0% | 8% | 3% |
| Other | 3,106 | 186 | 3,292 | 21% | 3% | 15% |
| Total | 14,824 | 7,254 | 22,078 | | | |
| **New Algorithm** | | | | | | |
| Molina Healthcare | 2,402 | 1,220 | 3,622 | 16% | 17% | 16% |
| Western Health Adv | 2,402 | 744 | 3,146 | 16% | 11% | 14% |
| Health Net | 2,402 | 1,520 | 3,922 | 16% | 22% | 18% |
| Blue Cross | 3,602 | 3,012 | 6,614 | 24% | 43% | 30% |
| Kaiser Foundation | 1,651 | 572 | 2,223 | 11% | 8% | 10% |
| Care First | 2,552 | – | 2,552 | 17% | N/A | 12% |
| Total | 15,010 | 7,068 | 22,078 | | | |
| **Year 1 Net Impact** | | | | | | |
| Molina Healthcare | (1,422) | – | (1,422) | -10% | 0% | -6% |
| Western Health Adv | 124 | – | 124 | 1% | 0% | 1% |
| Health Net | (1,108) | – | (1,108) | -8% | 1% | -5% |
| Blue Cross | 1,500 | – | 1,500 | 10% | 1% | 7% |
| Kaiser Foundation | 1,647 | – | 1,647 | 11% | 0% | 7% |
| Care First | (554) | (186) | (740) | -4% | N/A | N/A |

| Health Plan | Annual Auto-Assign Volume | Annual Continuity of Care Assign Volume | Total Annual Assign Volume | Percentage of Auto-Assign Volume | Percentage of Continuity of Care Volume | Percentage of Total Annual Assign Volume |
|---|---|---|---|---|---|---|
| **San Diego County** | | | | | | |
| **Old Algorithm** | | | | | | |
| Other | 3,224 | 1,742 | 4,966 | 19% | 27% | 22% |
| Comm Health Group | 3,024 | 2,258 | 5,282 | 18% | 34% | 23% |
| Blue Cross | 3,992 | 1,206 | 5,198 | 24% | 18% | 23% |
| Health Net | 4,296 | 736 | 5,032 | 26% | 11% | 22% |
| Kaiser Foundation | 2,008 | 606 | 2,614 | 12% | 9% | 11% |
| Total | 16,544 | 6,548 | 23,092 | | | |
| **New Algorithm** | | | | | | |
| Molina Healthcare | 3,109 | N/A | 3,109 | 17% | N/A | 13% |
| Comm Hlth Group | 3,291 | 2,258 | 5,549 | 18% | 47% | 24% |
| Blue Cross | 3,474 | 1,206 | 4,680 | 19% | 25% | 20% |
| Health Net | 3,657 | 736 | 4,393 | 20% | 15% | 19% |
| Kaiser Foundation | 1,646 | 606 | 2,252 | 9% | 13% | 10% |
| Care First | 3,109 | N/A | 3,109 | 17% | N/A | 13% |
| Total | 18,286 | 4,806 | 23,092 | | | |
| **Year 1 Net Impact** | | | | | | |
| Molina Healthcare | 3,109 | N/A | 3,109 | 17% | N/A | N/A |
| Comm Hlth Group | 267 | – | 267 | 0% | 12% | 1% |
| Blue Cross | (518) | – | (518) | -5% | 7% | -2% |
| Health Net | (639) | – | (639) | -6% | 4% | -3% |
| Kaiser Foundation | (362) | – | (362) | -3% | 3% | -2% |
| Care First | 3,109 | N/A | 3,109 | 17% | N/A | N/A |

Note: The individuals represented by "other" under the Old Algorithm for both Sacramento and San Diego Counties were moved into the auto-assignment pool in the New Algorithm table. These individuals were re-assigned into new plans, as their old plan has left the county. This has the effect of making it appear that there is a percentage gain in the allocation of continuity of care for plans. In fact, each plan receives the same number of individuals for continuity of care under both algorithms.

The performance-based auto-assignment algorithm will need to be regularly monitored regarding its intended and unintended impact. Modifications will be both desirable and necessary over time. DHS intends to utilize the same advisory group to reconvene in the spring of 2006 to assess the implementation of the algorithm and discuss any modifications for Year 2. DHS will need to use this group, or another body with representation from health plans and other interested parties to assess algorithm impact and review and recommend potential changes on a periodic basis.

# VII. Conclusion

DHS HAS MADE A COMMITMENT TO EXPAND its efforts to integrate value-based purchasing principles into its Medi-Cal managed care contracting activity. The implementation of a performance-based auto-assignment algorithm does just that.

In the first year of the new performance-based auto-assignment algorithm, 17,000 Medi-Cal managed care enrollees in Two-Plan counties will be assigned to a better health plan, as assessed by the seven performance indicators, than they would have been assigned otherwise. An additional number will be assigned to superior plans in the GMC counties. Beyond this, 2.7 million enrollees in the 14 counties and the safety net should benefit from all health plans in these counties striving to improve their performance.

This project has revealed that available measures exist to implement such an algorithm in a manner that does not unduly tax the agency's limited administrative resources.

The project has also revealed that stakeholders are generally supportive of such an approach, provided that the measures are objective, the algorithm is fair, and the implementation impact on health plans is not traumatic. The contributions of stakeholders in the design process proved invaluable.

In the end, the project underlined one of the lessons learned by other states that have previously implemented performance-based auto-assignment—"just do it." DHS and its stakeholders were committed to doing so, and because of that commitment and an ability to work openly and respectfully with one another, they succeeded.

# Endnotes

1. Additional information about Medi-Cal managed care is available on the DHS web site (www.dhs.ca.gov/mcs/default.htm) and the CHCF web site (www.chcf.org).
2. Excluding Stanislaus County, which had only one managed care organization during that year resulting in one plan receiving all enrollments.
3. DHS/Maximus MSC-B-M02 Monthly Enrollment Summary reports for 2004
4. Toward the end of the algorithm development process, there was some controversy as to whether or not the agreed-upon cap included continuity of care assignments. One reason DHS decided, after much discussion, to exclude continuity of care assignments from the cap is that if continuity of care assignments were included, a plan could outperform its competitor and yet see its share of auto-assignments drop.
5. For example, 70 percent is exactly 3 percentage points higher than 67 percent.
6. Because plans in Riverside and San Bernardino Counties submitted combined data for those counties, we compared nine sets of rates for HEDIS measures, but ten sets of rates for the safety-net provider support measures.