

Medicaid Health Plan Enrollment Auto-Assignment Algorithm

(FY2012 Appropriation Bill - Public Act 63 of 2011)

March 1, 2012

Section 1853: The department shall form a workgroup composed of representatives from the Medicaid HMOs and the Michigan association of health plans to develop revisions to the process of automatically assigning new Medicaid recipients to HMOs if they do not choose an HMO upon enrollment. The department shall report on the results of the workgroup's findings to the senate and house appropriations subcommittees on community health and the senate and house fiscal agencies by March 1 of the current fiscal year.

*Michigan Department
of Community Health*



**Rick Snyder, Governor
Olga Dazzo, Director**

Medicaid Health Plan Enrollment Auto-Assignment Algorithm

Report to the Senate and House Appropriations Subcommittees on
Community Health and the Senate and House Fiscal Agencies pursuant to
Section 1853 of Public Act 63 of 2011

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Department of Community Health

Purpose

Section 1853 of Public Act 63 of 2011 required the Department of Community Health to form a workgroup to develop revisions to the process used to automatically enroll Medicaid beneficiaries into Medicaid Health Plans (MHPs).

Background

Approximately 70% of Michigan's 1.8 million Medicaid beneficiaries are enrolled in a Medicaid Health Plan (MHP) for the purposes of obtaining Medicaid-covered services. The Department of Human Services (DHS) reviews and approves individuals' application for Medicaid. When DHS determines that an individual is eligible for Medicaid, the individual is contacted by the Department of Community Health's (DCH) enrollment broker, MI Enrolls, to choose an MHP in which to enroll. If the individual does not choose an MHP within 27 days, MI Enrolls automatically assigns the individual to an MHP based on the DCH auto-assignment algorithm. The purpose of the auto-assignment algorithm is to assign beneficiaries to MHPs using performance-based criteria that are reliable and valid, multidimensional, and based on an equitable methodology.

Historical Development of Auto-Assignment Algorithm

At the inception of Medicaid managed care (1997/1998), DCH utilized price to bid and award the MHP contract. DCH then utilized the bid price as the major component in the auto-assignment of individuals into MHPs. Basically, the lower the bid rate, the higher an MHP's score and the more auto-assignments the MHP received. At this time, DCH adjusted the auto-assignment scores annually.

Since 2000, DCH has included quality and administrative components as well as band placement in the auto assignment methodology. Band placement determines the percentage of auto-assignments each MHP receives. Higher band placement leads to a greater percentage of auto-assignments. The components of the auto-assignment algorithm were as follows:

- Cervical cancer and breast cancer screening HEDIS (Healthcare Effectiveness Data and Information Set) scores; HEDIS is a set of standardized performance measures used by managed care organizations
- Administrative: reporting timeliness
- Financial: Bid rate by region

DCH adjusted the auto-assignment scores annually.

In 2004, rates were no longer part of the bid, so the band placement calculation became entirely performance based. Since 2004, DCH utilizes three performance categories: clinical, administrative and access to care. Also in 2004, DCH moved to a quarterly revision of the auto-assignment algorithm to account for changes in plans' status across time. Finally, in 2005, DCH changed the weight of the performance categories to place more emphasis on the clinical components.

Current Auto-Assignment Algorithm

The current measures for each component are as follows:

- Clinical: HEDIS measures that rotate each quarter and blood lead testing scores
- Administrative: Encounter data submissions, provider file accuracy, and claims processing performance
- Access to Care: Ratio of open primary care providers to MHP capacity

Each quarter, the Department determines the regional score for each MHP in each of 10 regions. Based on the relative score, the MHPs are placed into “Bands”:

- MHPs above the 66th percentile are in Band 1
- MHPs between the 33rd and 66th percentile are in Band 2
- MHPs below the 33rd percentile are in Band 3

DCH provides the regional quarterly band placement to MI Enrolls. Based on a mathematical algorithm taking into account number of plans in each of the three bands, MI Enrolls auto-assigns enrollees into plans utilizing the following structure:

- Plans in Band 1 always receive more auto-assignments than plans in Band 2 and plans in Band 2 always receive more auto-assignments than plans in Band 3
- All individuals on the same case are auto-assigned to the same plan

Work group

On January 24, 2012, the Department convened a work group with Department staff as well as representatives from the MHPs and the Michigan Association of Health Plans. The work group reviewed the background and history of the auto-assignment algorithm and evaluated the current auto-assignment algorithm structure. The following aspects of the auto-assignment algorithm process were evaluated:

- Components
- Component Weights
- Measures
- Score Calculation
- Band Development

Components

The current components are clinical, administrative and access to care. The workgroup discussed adding a new component to measure financial health and stability. Medical Loss Ratio and Risk Based Capital were proposed as appropriate measures to include in the auto-assignment algorithm as part of the financial component.

Component Weights

The current component weights are Clinical (48%), Administrative (34%), and Access to Care (18%). The work group discussed changing the relative weights among the components. Specifically, some work group members proposed that Access to Care should have a relatively equal weight to the clinical and/or administrative components.

New Measures

In addition to the new financial component, the work group also discussed new measures under existing components. New measures were proposed for the Administrative and Access to Care components. Under the Access to Care component, the group discussed both hospital contracts and contracts with Federally Qualified Health Centers (FQHCs). Work group members expressed both pro and con views on including a hospital contract measure in the auto-assignment algorithm. Some members of the work group proposed that having a hospital contract in the region provides greater access to and coordination of care. Other members of the workgroup suggested that network contracts with hospitals is not an accurate measure of Access to Care because most hospitals in the State have signed the Hospital Access Agreement which allows members of non-contracted MHPs to seek services at out-of-network hospitals. Some work group members thought that hospital contracts as part of the auto-assignment algorithm created an unfair advantage for those MHPs that are affiliated with the

hospital in the region, and allowed hospitals to influence which MHPs receive more auto-assigned members in the region

Under administrative measures, work group members suggested four new measures:

- Timely submission of accurate summary reports for the Encounter Data Quality Initiative
- Percentage of passing scores on the annual compliance review results
- Number of beneficiary complaints from the Beneficiary Helpline quarterly report
- Timely submission PCP information to Medicaid Information System
- Timely submission of accurate provider file information to MI Enrolls

Score Calculation

In general, work group members expressed satisfaction with the current method of score calculation. However, two suggestions were offered. One work group member suggested that DCH should consider using improvement in HEDIS scores from the previous year in addition to the actual HEDIS score as part of the clinical components. Several work group members suggested that the blood lead measure under clinical components be limited to a single quarter rather than included in all four quarters.

Band Development

Finally, the work group discussed how the scores were grouped and placed into bands that determine how many auto-assignments each MHP receives in each region. Discussion centered around five proposals:

- Apply a normalization calculation to the scores to ensure that the scores are normally distributed prior to using the 33rd and 66th percentiles to create the bands
- Change the percentiles used to develop the bands to perhaps 80% for band 1 and 50% for band 2
- If an MHP's regional score is below a certain percentile or significantly different from all other MHPs in the region, then that MHP should not receive any auto-assignments in that region
- Set minimum thresholds for the quality and access scores. Failure to achieve the minimum score would disqualify the plan from receiving auto assignments for the applicable quarter.
- Currently, if an MHP is above the 50th percentile in both quality and percent of regional enrollment, the MHP is "bumped" up one band. Work group members suggested that this part of the process be removed and that percent of regional enrollment should not be utilized for any aspect of the auto-assignment algorithm

Summary

The current algorithm methodology auto-assigns individuals to MHPs with high quality scores, demonstrated administrative performance, and adequate capacity. The work group discussed several promising revisions to strengthen the link between high performance and number of auto-assignments an MHP receives. DCH will evaluate all proposed revisions and make a final determination of revisions to the auto-assignment methodology for FY 2013.