



State of California—Health and Human Services Agency
Department of Health Care Services



GAVIN NEWSOM
GOVERNOR

December 3, 2020

Ms. Erika Contreras
Secretary of the Senate
State Capitol, Room 3044
Sacramento, CA 95814

Ms. Sue Parker
Chief Clerk of the Assembly
State Capitol, Room 3196
Sacramento, CA 95814

Dear Ms. Contreras and Ms. Parker:

Section 14197.4(k) of the Welfare and Institutions Code (WIC § 14197.4(k)) requires the Department of Health Care Services (DHCS) to satisfy two legislative reporting obligations:

- “The department, in consultation with the designated public hospital systems and the Medi-Cal managed care plans, shall provide the Legislature with the federally approved evaluation plan required in Section 438.6(c)(2)(i)(D) of Title 42 of the Code of Federal Regulations to measure the degree to which the payments authorized under this section advance at least one of the goals and objectives of the department’s managed care quality strategy.”
- “The department, in consultation with the designated public hospital systems and the Medi-Cal managed care plans, shall report to the Legislature the results of this evaluation once the department determines that the evaluation is finalized and complete according to the terms of any applicable federal approval and no earlier than January 1, 2021.”

In response to the first reporting requirement, DHCS is hereby providing to the Legislature the following federally approved evaluation plans required for the directed payments authorized under WIC § 14197.4(b) and (c) pertaining to the designated public hospitals (DPHs) Enhanced Payment Program (EPP) and the Quality Incentive Pool (QIP) :

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- For Capitated EPP Payments and Fee for Service EPP Payments pursuant to WIC § 14197.4(b) for the state fiscal year (SFY), 2017–18, as federally approved on April 2, 2018. These reports can be found on the DHCS website at:
 - https://www.dhcs.ca.gov/services/Documents/DirectedPymts/SFY17-18_DP_DPH_CAP_only.pdf
 - https://www.dhcs.ca.gov/services/Documents/DirectedPymts/SFY17-18_DP_DPH_FFS_only.pdf

- For Capitated EPP Payments and Fee for Service EPP Payments pursuant to WIC § 14197.4(b) for SFY 2018–19, as federally approved on December 17, 2018. These reports can be found on the DHCS website at:
 - <https://www.dhcs.ca.gov/services/Documents/DirectedPymts/SFY-18-19-DPH-EPP-Cap-Preprint-Final.pdf>
 - <https://www.dhcs.ca.gov/services/Documents/DirectedPymts/SFY-18-19-DPH-EPP-FFS-Preprint-Final.pdf>

- For SFY 2017-18 QIP Payments and SFY 2018-19 QIP Payments pursuant to WIC § 14197.4(c), as federally approved on December 17, 2018.
 - https://www.dhcs.ca.gov/services/Documents/DirectedPymts/SFY17-18_DP_DPH_QIP.pdf
 - <https://www.dhcs.ca.gov/services/Documents/DirectedPymts/2018-2021-DPH-QIP-Preprint-Final.pdf>

The enclosed document provides a summary of each of the above evaluation plans as submitted for federal approval.

The second reporting requirement under this statute is effective no earlier than January 1, 2021, and therefore is not addressed within this letter.

Sincerely,

Original signed by

Will Lightbourne
Director

Enclosures

Background

Welfare and Institutions Code, Section 14197.4 (WIC § 14197.4), requires the DHCS to implement new directed payments, commencing with SFY 2017–18, to DPHs in compliance with federal requirements relating to Medicaid managed care.

Specifically:

(b) Commencing with the 2017–18 state fiscal year, and for each state fiscal year thereafter, and notwithstanding any other law, the department shall require each Medi-Cal managed care plan to increase contract services payments to the designated public hospital systems by amounts determined under a directed payment methodology that meets federal requirements and as described in this subdivision. The directed payments may be determined and applied as distributions from directed payment pools, as a uniform percentage increase, or other basis, and may incorporate acuity adjustments or other factors.

and

(c) Commencing with the 2017–18 state fiscal year, and for each state fiscal year thereafter, the department, in consultation with the designated public hospital systems and applicable Medi-Cal managed care plans, shall establish a program under which a designated public hospital system may earn performance-based quality incentive payments from the Medi-Cal managed care plan they contract with in accordance with this subdivision.

Commencing with SFY 2017–18, DHCS has implemented the DPH EPP in accordance with WIC § 14197.4(b) and the DPH QIP in accordance with WIC § 14197.4(c). Each directed payment arrangement is subject to review and approval by the federal Centers for Medicare and Medicaid Services, and has an evaluation plan in accordance with Section 438.6(c)(2)(i)(D) of Title 42 of the Code of Federal Regulations. The evaluation plans provide the standards and criteria for measuring the degree to which the DPH EPP and DPH QIP directed payments advance at least one of the goals and objectives of DHCS' managed care quality strategy.

Evaluation Plan for SFY 2017–18 DPH EPP Directed Payments – WIC § 14197.4(b)

For year one, DHCS proposes to establish benchmark metrics to measure encounter data quality. Encounter data quality would be measured through several different domains, including:

- Reasonability:
 - Denied Encounters Turnaround Time – this measure addresses how quickly denied encounters are corrected and resubmitted.
 - Denied Encounters as a Percent of Total – this measure reports the percentage of total encounters that are denied each month of submission.
 - Review of Rendering Provider Identifier – this measure reports the percentage of providers with a valid rendering provider ID.

- Timeliness:
 - Lagtime – This measure reports the lagtime for submitting Institutional, Professional, or Pharmacy encounter data. Lagtime is the time, in days, between the Date of Services and the Submission Date to DHCS. The benchmark for lagtime is as follows:

Lagtime	Lag of 0 to 90 Days	Lag of 0 to 180 Days	Lag of 0 to 365 Days	Lag > 365 Days
Institutional	60%	80%	95%	5%
Professional	65%	80%	95%	5%
Pharmacy	80%	95%	99%	1%

- Accuracy:
 - Encounter Data Validation Study – the Encounter Data Validation study is to examine the completeness and accuracy of the professional encounter data submitted to DHCS by MCPs through a review of medical records. By performing a comparative analysis between the encounter data in the DHCS data warehouse and the data in the medical records, DHCS can validate whether specific data elements match within data found in both the medical records and DHCS encounter data.

For years two through five, DHCS proposes to establish quality benchmarks that prioritize improved health outcomes and/or other goals or objectives contained in the yet-to-be-finalized Managed Care Quality Strategy pursuant to 42 CFR §438.340.

As the quality of encounter data submitted to DHCS improves, DHCS believes that this will lead to improvements in its quality performance metrics, known as its External Accountability Set or EAS. DHCS’ EAS is composed primarily of Health Effectiveness

Data and Information Set (HEDIS) measures from the National Committee for Quality Assurance (NCQA). In its Annual Managed Care Quality Strategy, DHCS sets goals for quality metric performance. As the MCPs and DHCS have more reliable data on which to base their assessments, DHCS and MCPs will be better able to target those areas where improved performance will have the greatest effect on health outcomes.

Upon finalizing the Managed Care Quality Strategy for use in contract periods on or after July 1, 2018, DHCS will submit proposed revisions to this Evaluation Plan as necessary to establish and refine goals and objectives to be measured in years 2-5 of this directed payment initiative.

Evaluation Plan for SFY 2018–19 DPH EPP Directed Payments – WIC § 14197.4(b)

**California 438.6(c) Proposal – Uniform Increase for DPH Services
Designated Public Hospital Directed Payment Evaluation Plan
Program Year 2: July 1, 2018 – June 30, 2019**

Evaluation Purpose

The purpose of this evaluation is to determine if the proposed directed payments made through DHCS MCPs to network provider DPHs, which are intended to increase provider capitation rates at a fixed percentage and to increase payment for eligible contract services at a fixed dollar amount, result in preserving or improving access to services for all MCP members.

Stakeholders

- MCPs
- California Association of Public Hospitals (CAPH)
- California Association of Health Plans (CAHP)
- Local Health Plans of California (LHPC)
- Medi-Cal Managed Care Advisory Group (MCAG)

Evaluation Questions

This evaluation is designed to answer the following questions:

1. Do higher DPH payments, via the proposed Payment Year (PY) 2 directed payments, serve to maintain or improve the reasonability and timeliness of encounter data reported for MCP members?
2. Do higher DPH payments, via the proposed PY 2 directed payments, serve to maintain or change utilization patterns for inpatient, outpatient, and emergency services for MCP members?

Evaluation Design

Encounter Data

The state will conduct encounter data quality assessments focusing on reasonability and timeliness of encounter data. All encounter data quality measures will have a baseline determined from data submitted in state fiscal year (SFY) July 1, 2017 – June 30, 2018. Each subsequent program year will be compared to the baseline to determine if any changes have occurred in the encounter data with the target of maintaining or increasing the baseline during the measurement year. This directed payment program was specifically designed so that payments to DPHs are determined based on actual

utilization data as demonstrated from the encounter data submitted received by DHCS from the MCPs. This design has the intended consequence of encouraging increased collaboration among DPHs and MCPs to ensure that the encounter data received by DHCS accurately reflects the actual utilization that has taken place in the given time period. This is extremely likely to result in a substantial increase in encounter reporting for all service categories starting in PY 1 and continuing to improve over time. To that end, the results of any of the evaluation assessments stated below need to be adjusted for the material increase to the volume of encounter data submissions.

- Reasonability:

- Denied Encounters Turnaround Time – this measure addresses how quickly encounters denied for quality are corrected and resubmitted.

The target is to maintain the baseline (SFY 2017-18) or to demonstrate 50 percent or more denied encounter turnaround within 60 days, whichever is higher.

- Denied Encounters as a Percent of Total – this measure reports the percentage of total encounters that are denied for quality each month of submission.

The target is to maintain the baseline (SFY 2017-18) or demonstrate five percent or less denied encounters as a percentage of total, whichever is lower.

- Timeliness:

- Lagtime – This measure reports the lagtime for submitting encounter data. Lagtime is the time, in days, between the Date of Services and the Submission Date to DHCS.

The target is to maintain the baseline (SFY 2017-18) or demonstrate timeliness in accordance with the lagtime categories below, whichever is higher.

File type	0-90 days	0-180 days	0-364 days
Professional	65%	80%	95%
Institutional	60%	80%	95%

Inpatient Utilization:

Inpatient Admissions per 1000 Member Months: From the MCP encounter data, DHCS staff will calculate the number of MCP Inpatient Admissions per 1000 Member Months. Data for participating plans will be aggregated at a statewide level. An admission

consists of a unique combination between member and date of admission to a facility. The first measurement year will be for PY 2 (July 1, 2018-June 30, 2019). The baseline year will be SFY July 1, 2017 – June 30, 2018. DHCS will compare the first measurement year to the baseline year to identify any changes in utilization patterns, with the target of maintaining or decreasing the baseline number of Inpatient Admissions per 1000 Member Months during the measurement year, as adjusted for changes to volume of encounter data submission by MCPs and providers, in response to the design of the directed payment program.

The target is to maintain the baseline (SFY 2017-18) or demonstrate higher utilization as an indicator of improved encounter data completeness.

Outpatient Utilization:

Outpatient Visits per 1000 Member Months: From the MCP encounter data, DHCS staff will calculate the number of MCP Outpatient Visits per 1000 Member Months. Data for participating plans will be aggregated at a statewide level. A visit consists of a unique combination between provider, member, and date of service. The first measurement year will be for PY 2 (July 1, 2018-June 30, 2019). The baseline year will be SFY July 1, 2017 – June 30, 2018. DHCS will compare the first measurement year to the baseline year to identify any changes in utilization patterns, with the target of maintaining or increasing the baseline number of Outpatient Visits per 1000 Member Months during the measurement year, as adjusted for changes to volume of encounter data submission by MCPs and providers, in response to the design of the directed payment program.

The target is to maintain the baseline (SFY 2017-18) or demonstrate higher utilization as an indicator of improved encounter data completeness.

Emergency Room Utilization:

Emergency Room Visits per 1000 Member Months: From the MCP encounter data, DHCS staff will calculate the number of MCP Emergency Room Visits per 1000 Member Months. Data for participating plans will be aggregated at a statewide level. A visit consists of a unique combination between provider, member, and date of service. The first measurement year will be SFY July 1, 2018-June 30, 2019. The baseline year will be for SFY July 1, 2017 – June 30, 2018. DHCS will compare the first measurement year to the baseline year to identify any changes in utilization patterns, with the target of maintaining or decreasing the baseline number of Emergency Room Visits per 1000 Member Months during the measurement year, as adjusted for changes to volume of encounter data submission by MCPs and providers, in response to the design of the directed payment program.

The target is to maintain the baseline (SFY 2017-18) or demonstrate higher utilization as an indicator of improved encounter data completeness.

Stratification:

DHCS will stratify Inpatient Admissions, Outpatient Visits, and Emergency Room Visits per 1000 Member Months by the following categories:

- Gender
- Age
- Ethnicity
- Eligible population groups: Duals, Medi-Cal Only Affordable Care Act (ACA), Medi-Cal Only Optional Targeted Low Income Children (OTLIC), Medi-Cal Only Seniors and Persons with Disabilities (SPD), and Medi-Cal Only Other

Data Collection Methods

All data necessary for encounter data quality measurement will be extracted from DHCS' Post-Adjudicated Claims and Encounters System (PACES) and Management Information System/Decision Support System (MIS/DSS).

To measure the number of Inpatient Admissions, Outpatient Visits, and Emergency Room Visits per 1000 Member Months, DHCS will rely on encounter data submitted by MCPs. DHCS will conduct its analysis on 100 percent of the data received.

Timeline

All data necessary for encounter data quality measurement will be extracted after a sufficient lag period post-Program Year. A sufficient lag period should be no less than six months.

The encounter data will be pulled no sooner than six months after the close of the measurement year to allow for sufficient lag period, with a report being completed within six months of the data pull. For PY 2 (July 1, 2018-June 30, 2019), the data will be pulled no sooner than January 1, 2020, and a report produced by June 30, 2020.

Communication and Reporting

The results will be shared with the stakeholders listed above and a report will be shared with CMS. Annual reports will also be posted on the state's [directed payment website](#).

Evaluation Plan for DPH QIP Directed Payments – WIC § 14197.4(c)

**California 438.6(c) Proposal F - Designated Public Hospital (DPH) Quality
Incentive Pool (QIP)
Program Years 1-4 Evaluation Plan
July 1, 2017 – June 30, 2021**

Evaluation Purpose

The purpose of this evaluation is to determine if the proposed directed payments made through California Department of Health Care Services (DHCS) contracts with the Medi-Cal Managed Care Plan (MCP) contracts to network provider Designated Public Hospitals (DPHs) result in improving the current quality of inpatient and outpatient services for Medi-Cal members assigned to DPHs, which serve approximately 30 percent of Medi-Cal members.

Background

During this four-year program, DHCS will direct MCPs to make performance-based quality incentive payments to 17 participating DPH systems based on their performance on at least 20 of 26 specified quality measures that address primary, specialty, and inpatient care, including measures of appropriate resource utilization. The QIP will advance the state's Quality Strategy goal of enhancing quality in DHCS programs by supporting DPHs to deliver effective, efficient, and affordable care. In order to receive QIP payments, DPHs must achieve specified improvement targets, measured for all Medi-Cal beneficiaries utilizing services at the DPH.

The first PY, from July 1, 2017 to June 30, 2018, will consist of baseline reporting. All subsequent PYs will consist of pay-for-performance (P4P) only. The first PY was [approved by CMS](#) on March 6, 2018. The three-year extension of the DPH QIP (PY 2 – PY 4) is still pending CMS approval.

Stakeholders

- Designated Public Hospitals
- California Association of Public Hospitals (CAPH) and Safety Net Institute (SNI)
- California Association of Health Plans (CAHP)
- Local Health Plans of California (LHPC)
- MCPs

Evaluation Questions

This evaluation is designed to answer the following questions:

1. Do performance-based quality incentive payments to DPHs through the MCPs improve the quality of inpatient and outpatient services for Medi-Cal members?

Evaluation Design

The state will use hospital system aggregate data reported to DHCS pertaining to the performance measures listed in Table 1. Each DPH is required to pick 20 out of the 26 measures to report to DHCS.

Table 1: Performance Measures

MEASURE NAME
Primary Care (EAS+): These measures were selected to align with health plan efforts and promote higher quality care in the ambulatory care setting.
Comprehensive Diabetes Care: Eye exam (CDC-E) (NQF 0055, Quality ID 117)
Comprehensive Diabetes Care: Blood Pressure Control (CDC-BP)
Comprehensive Diabetes Care: A1C Control (CDC-H8)
Asthma Medication Ratio (AMR)
Children and Adolescent access to PCP* (CAP)
Medication reconciliation Post Discharge (MRP)
Immunization for Adolescents (IMA) Combination 2* (NQF 1407, Quality ID 394)
Childhood Immunizations (CIS) Combination 3*(NQF 0038, Quality ID 240)
7-Day Post-Discharge Follow-Up Encounter for High Risk Beneficiaries
Specialty Care (CVD): These measures align with the state's quality strategy in promoting high quality care and improving overall health.
Coronary Artery Disease (CAD): Antiplatelet Therapy (NQF 0067, Quality ID 006)
Coronary Artery Disease (CAD): ACE Inhibitor or ARB Therapy - Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%) (NQF 0066, Quality ID 118)
Coronary Artery Disease (CAD): Beta-Blocker Therapy-Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%) (NQF 0070, Quality ID #007, eMeasure ID CMS145v6)
Heart Failure (HF): ACE Inhibitor or ARB Therapy for Left Ventricular Systolic Dysfunction (LVSD) (NQF: 0081, Quality ID 005) (eMeasure ID: CMS135v6, eMeasure NQF: 2907)
Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD) (NQF 0083, Quality ID #008) (eMeasure ID CMS144v6, eMeasure NQF 2908)
Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy (NQF 1525, Quality ID 326)

Inpatient: These high value patient safety measures align with work already underway in public health care systems that began in DSRIP but are not part of PRIME.
Surgical Site Infections (SSI)
Perioperative Care: Selection of Prophylactic Antibiotic - First OR Second Generation Cephalosporin (NQF 268, Quality ID 21)
Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (NQF 239, Quality ID 23)
Prevention of Central Venous Catheter (CVC) - Related Bloodstream Infections (Quality ID 76)
Appropriate Treatment of Methicillin-Sensitive Staphylococcus Aureus (MSSA) Bacteremia (Quality ID 407)
Stroke and Stroke Rehabilitation: Discharged on Antithrombotic (TJC STK-2, eMeasure ID: CMS104v6)
Resource Utilization: These measures reflect an opportunity to reduce unnecessary utilization and improve quality of care.
Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patient 18 years and Older (Quality ID 415)
Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 2 to 17 years old* (Quality ID 416)
Unplanned Reoperation within 30 Day Postoperative Period (Quality ID 355)
Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Preoperative Evaluation in Low Risk Surgery Patients (Quality ID 322)
Concurrent Use of Opioids and Benzodiazepines

*Pediatric measures

In PY 1 (July 1, 2017 to June 30, 2018), DHCS will use aggregated data submitted by DPHs to DHCS to determine:

- The number of measures each hospital reported
- The percentage of hospitals that reported on each measure

Annually in PY 2 through PY 4, DHCS will use aggregated data, submitted by DPHs to DHCS, to determine:

- For each measure, of public hospitals reporting on that measure, what percentage met their quality improvement goal
- For each measure, the aggregate improvement seen across all DPHs who reported on the measure.
- For each public hospital, the percentage of measures for which they meet their quality improvement goal

Data Collection Methods

- DPHs will report aggregated data on each measure to DHCS.

- Depending on the specific measure and DPH capabilities, DPHs will collect aggregated data utilizing Electronic Health Records and/or claims and registry databases.
- DPHs will submit encrypted aggregated data collected in accordance with the QIP Reporting Manual to DHCS, in the manner required by DHCS. For PY 1, DPHs will submit encrypted data using an Excel data template.
- The state will conduct its analysis on 100% of the data received.

Timeline

Example for PY1, with similar timeline for subsequent PYs:

- PY: July 1, 2017 to June 30, 2018
- Dec. 15, 2018 –Deadline for DPHs to submit data to DHCS
- Dec. 16, 2018 to May 30, 2019 – DHCS review of DPH reports
- June 2019 – Final approved data submitted to DHCS Capitated Rates Development Division for payment to DPHs
- June to July 2019 – DHCS will develop the annual QIP evaluation report
- July 2019 – Draft annual QIP evaluation report reviewed by stakeholders
- August to September 2019 – Stakeholder comments incorporated into annual QIP evaluation report
- October 2019 – Annual QIP evaluation report posted on public DHCS website and shared with CMS

Communication and Reporting

The results will be shared with the stakeholders listed above and a report will be shared with CMS. Annual reports will also be posted on the state's [QIP website](#).