Global Payment Program Draft Evaluation Design

Purpose

As part of the Medi-Cal 2020 waiver, the California Department of Health Care Services is required to conduct two evaluations of the Global Payment Program (GPP) to assess the degree to which the program achieved the intended goals and improved care for uninsured patients accessing care in California's public health care systems.

Introduction

California's GPP is a new pilot program to support public health care systems (PHCS) efforts to provide services to California's remaining uninsured, and to promote the delivery of more cost-effective and higher-value care. The GPP establishes a new payment structure that will reward the provision of care in more appropriate venues, rather than primarily through the emergency department or through inpatient hospital settings. Under the GPP, public health care systems will receive GPP payments that will be calculated using a value-based point methodology that incorporates factors designed to incentivize a shift in the overall delivery of services for the uninsured to more appropriate settings, and reinforce structural changes to the care delivery system that will improve the options for treating uninsured patients. The intent of the GPP framework is to provide flexibility in the provision of services while encouraging a broad shift to more cost-effective care that is person-centered.

GPP payments will not exceed the established aggregate limit stated in the Standard Terms and Conditions (STC) but may be less if PHCS do not provide the required level of services and the established point thresholds are not achieved. The total amount available for the GPP funding is a combination of portion the state's Medicaid Disproportionate Share Hospital (DSH) allotment that would otherwise be allocated to the PHCS, and the state's Safety Net Care Uncompensated Care Pool.

Evaluation Requirements

The STCs require two GPP evaluations. The first evaluation will occur at the midpoint of the GPP program, and the second evaluation is due at the end of program year 4. The evaluations are intended to take a snapshot of early of GPP implementation and assess the impact of the program, including the care provided by the public health care system, the benefits and challenges of this new innovative payment approach, and the potential for broader application for future waivers.

The STCs require the following elements to be included in the GPP evaluations:

- Required for the first and second evaluation:
    - Assess the GPP goals of promoting value, not volume by each individual PHCS:

        - Number of uninsured individuals served
        - Number and type of services provided
        - Expenditures associated with the services provided, both at 100% and 175% uncompensated care cost (UCC) levels
        - Expenditures that were avoided or reduced due to the GPP
        - An assessment of the effects of the GPP on care delivery and costs
    - Individual PHCS self-assessment of the successes and challenges of the GPP
- For the second evaluation only:
    - Examine the extent to which the GPP encouraged or improved:
        - Care in more appropriate settings, to ensure right care in the right place at the right time
        - Changes in resource allocation
        - Improvements in workforce involvement and care team transformation under the demonstration

Data Collection

The first GPP evaluation will use the most complete data available for State fiscal years (SFY) 2015-16 and 2016-17 and will rely primarily on aggregate data by service type for all participating GPP systems. Encounter level data for GPP services (e.g. diagnosis and procedure codes) will be collected for service dates beginning in the second year of the GPP program. The evaluation will also utilize applicable available cost data from PHCS as well as qualitative individual system GPP narratives. For purposes of the evaluations, utilization will be defined in terms of units of service as described in Table 5, Attachment FF. For many of the components in the first evaluation, PHCS will have to evaluate changes compared to the pre-GPP baseline, which is the SFY 2014-15 reporting period utilized to establish the initial thresholds. The second evaluation will include all data sources from the first evaluation, plus data from GPP encounter reporting that begins in PY2.

Each year, PHCS will submit an interim- year-end summary report and a final year-end summary report that will include data for all services provided in Categories 1-4 in Table 1 of Attachment FF. The interim and final year-end summary reports will include all GPP utilization information that will specify the provision and volume of services at each PHCS. Data obtained from these reports will inform summary and system level information for the GPP evaluation, and will provide the necessary service level information to assess trends over time in the second evaluation. Furthermore, beginning in GPP PY2, all PHCS will also submit encounter level data in conjunction with their final year and summary GPP reports that will offer additional details on the scope of services provided to uninsured patients within in their systems. The source of data for the summary reports and encounter data will include services provided internally at the PHCS, contracted providers as well as local mental health and substance use providers.

Please refer to Table 1 in Attachment FF for the list of all services that will be captured under the GPP.

With respect to the cost data required under the calculation, PHCS will utilize different sources and methodologies for the various types of services being provided under the GPP as follows:

- For traditional hospital inpatient, outpatient, and professional services provided internally by PHCS, the most recently available "Interim Hospital Payment Rate Workbooks" (referred to as the "P14 reports") will be the primary data sources, with key cost elements matching those in the 2552 Medi-Cal hospital cost reports which will also be available. This is consistent with the methodology used in the 2010 Bridge to Reform waiver.
- For the various contracted uninsured services which may earn GPP points (e.g., hospital, physician, and behavioral health), PHCS will rely on all claims/invoices paid to the contracted providers, with the negotiated paid amount equivalent to the "costs".
- For mental health services provided internally by PHCS, PHCS will continue to report costs using the same sources and methodologies under the 2010 waiver with the P14s. Sources of data will include the Short Doyle Medi-Cal cost reports (SD/MC cost report) and mental health databases which are utilized for determining number of uninsured mental health units of service.
- For substance abuse services provided internally by PHCS, PHCS will rely on the SUD cost reports as well as internal records to identify the number of uninsured units of service and associated costs.

For non-traditional services, to determine costs, PHCS will look to various data sources to estimate costs which shall include general ledger for direct costs, internal records, logs and stats, time studies and invoices for contracted services. In estimating the costs incurred for these non-traditional services, PHCS will utilize all these sources to identify direct costs where applicable and for other costs, will apportion the time spent by the provider and intensity of services to calculate a cost per service.

Proposed Evaluation Design

First GPP Evaluation

I. Executive Summary

a. The goals of the GPP program
b. Key findings, including whether and to what extent GPP achieved the goals of the first evaluation

II. Introduction

a. Include a description of the GPP program objectives and data sources that will be used

III. Evaluation Outline

1. Demonstrate that public health care systems are putting a strong foundation in place to improve care to the uninsured
    A. Individual public health care system self-assessment narrative that will include the following key elements:
        a. Narrative on what changes they are making to their care delivery systems, including areas such as:
            i. Data collection and tracking
            ii. Inclusion of non-traditional services
            iii. Coordination with other areas of the delivery system (e.g. primary care, mental health, and substance use)
            iv. Improvements in workforce involvement and care team transformation
            v. Describe efforts underway to improve care in a manner that avoids or reduces costs, including an assessment of the effects of the GPP on care delivery and costs and efforts to provide care in more appropriate settings and resource allocation, to include the number and type of non-traditional services provided
            vi. Assessment, including a description of PHCS efforts to transform care, describing how they are allocating GPP funds to address the needs of their patients, which could include efforts to improve patient education, expanded clinic hours or use of non-traditional services, such as increased use of case managers or nurse advise lines to improve care in more appropriate settings
            vii. Additional infrastructure that is being put in place, including improvements within the delivery system or efforts to expand services with contracted providers
            viii. Overall benefits and challenges of this new payment approach, including care provided by PHCS, patient experience and care delivery transformation
    B. Based on the reported services specified in Table 1 in Attachment FF, compare baseline SFY 2014-15 data with data from subsequent GPP program years to analyze the GPP trends and utilization for each PHCS in the following categories:
        - Ambulatory care services from Categories 1, 2 and 3 (excluding behavioral health and emergency services) in Table 1 of Attachment

FF (e.g. primary and specialty care, nutrition education, group visits), inpatient from Category 4 in Table 1 of Attachment FF (e.g. trauma, med surg) and emergency services from Category 1C in Table 1 of Attachment FF

- Behavioral health services in Category 1B, 1C and 4A and 4B in Table 1 of Attachment FF (particularly in the non-emergent settings, e.g. mental health and substance use outpatient)

C. Using data sources specified above, compare baseline SFY 2014-15 data with subsequent GPP program years to analyze how GPP resources are being allocated
   a. Participating public health care systems use of federal funding
      i. Percent of GPP funding earned by program year
   b. Cost of GPP services vs GPP funding
      i. Expenditures associated with services provided, both at 100% and 175%
   c. Comparison of: (a) ratio of GPP funding to uninsured uncompensated costs to (b) ratio of SFY 14-15 SNCP and DSH to uncompensated costs, both at 100% and 175%
   d. The number of uninsured served within physical health, behavioral health, and through contracted providers
   e. Summary assessment of individual system narratives that describes the effects of the GPP on care delivery and cost, including what changes GPP systems are making to improve care and how they are allocating resources more efficiently.

Second GPP Evaluation

I. Executive Summary
   a. The goals of the GPP program
   b. Key findings, including whether and to what extent GPP facilitated improvements in care for uninsured patients in public health care systems

II. Introduction
   a. Include a description of the GPP program objectives and data sources that will be used

III. Evaluation Design

1. <u>Demonstrate that public health care systems have improved care to the uninsured</u>
   A. Across all participating GPP health care systems, compare baseline service level data with subsequent GPP program years to analyze trends in care provided to the uninsured, measuring changes in utilization and number of people served.

Specifically, the evaluation will use reported data as required under Table 1 in Attachment FF and assess the following areas:

- Trends in traditional services, including how many are served in ambulatory care from Categories 1,2 and 3 (excluding behavioral health and emergency services) in Table 1 of Attachment FF (e.g. primary care, specialty care, nutrition education, group visits) inpatient from Category 4 in Table 1 of Attachment FF (e.g. trauma, med surg) and emergent/urgent care from Category 1C in Table 1 of Attachment FF, mental health and substance use services in Category 1B, 1C and 4A and 4B in Table 1 of Attachment FF compared to prior years from baseline and during the GPP as compared to the first evaluation
- Trends in utilization in non-traditional services from Categories 1A, 2, 3 and 4A in Table 1 of Attachment FF during the GPP, which includes care by other licensed or certified professionals (e.g. nurses, pharmacists) and non-face-to-face visits as compared to the first evaluation
- Volume and mix of behavioral health care services in Category 1B, 1C and 4A and 4B in Table 1 of Attachment FF, with a particular focus on outpatient services (e.g. mental health and substance use outpatient)
- PHCS-self assessment narrative in care coordination activities, which could include expanded use of complex care managers, case managers, health educators and health coaches
- Patient experience: PHCS self-assessment narrative that describes how they are working to improve patient experience for patients, including increased translation services, expanded hours for certain clinical services, increased use of community health workers/promotoras, surveys or patient outreach efforts specifically targeting the uninsured patients.

B. At the individual public health care system level demonstrate improvements in services provided.

- Compare baseline data with data from subsequent GPP program years to assess changes in the following categories:
    - Number of uninsured patients served
    - Number of types of services provided
    - Rates of types of services provided per number of uninsured patients served

2. <u>The GPP is allocating resources wisely and is more effectively tailoring care to the appropriate settings</u>

A. Across all participating GPP systems, compare SFY 2014-15 baseline data with subsequent GPP years to analyze how GPP resources are being allocated and if care is being provided in more appropriate settings, including the movement from emergency/urgent to ambulatory care.
    - Care in more appropriate settings and resource allocation
        - Assess changes in care to more appropriate settings which could include:
            - Changes in the ratio of Inpatient Care to Ambulatory Care:
                - Numerator: Number of inpatient Med/surg days/year
                - Denominator: Number of primary care and specialty encounters/year
            - Changes in the ratio of Emergency Care to Ambulatory Care:
                - Numerator: Number of ER encounters/year
                - Denominator: Number of primary care and specialty care encounters/year
            - Changes in the ratio of Inpatient Behavioral Health Services to outpatient non-emergent services
                - Numerator: Number of mental health and substance days/year
                - Denominator: Number of primary and specialty care encounters/year
            - Changes in the ratio of low-acuity ER visits
                - Numerator: Number of low-acuity ER visits/year
                - Denominator: Number of uninsured served/year
    - Improvements in workforce involvement
        - Assessment of use of non-traditional services and expansion of team based care, including expansion of roles and responsibility within scope of practice
    - Participating public health care systems use of federal funding (at the individual level)
        - Percent of GPP funding earned by program year
        - Narrative of health care system self-assessment describing how they are allocating GPP funds to address the needs of their patients, which could include efforts to improve patient education, expanded clinic hours or use of non-traditional

services, such as increased use of case managers or nurse advise lines to improve care in more appropriate settings

- Cost of GPP services vs GPP funding (at the individual level)
  - Expenditures associated with services provided, both at 100% and 175%
  - Expenditures avoided or reduced
  - Comparison of: (a) ratio of GPP funding to uninsured uncompensated costs both at 100% and 175% to (b) ratio of SFY 14-15 SNCP and DSH to uncompensated costs

3. <u>From a PHCS perspective, provide an assessment of the successes and challenges of the GPP</u>
   A. PHCS self-assessment narrative that describes the changes each system made throughout the program to improve care to the uninsured in their system such as:
      - Expansion of non-traditional services and/or expanded use of non-traditional providers
      - Coordination with other entities areas of the delivery system (e.g. primary care, mental health, substance use, etc.)
      - Improvements in workforce involvement and care team transformation
      - Efforts underway to improve care in a manner that avoids or reduces costs, including an assessment of the effects of the GPP on care delivery and costs, efforts to improve patient education
      - Description of additional infrastructure that has been put in place, including efforts to improve care and quality within the delivery system or with contracted providers
      - Assessment of how they allocated GPP funds to address the needs of their patients
   B. Overall summary of the major opportunities and challenges provided by the GPP.
      4. Summary assessment of individual system narratives that describes the effects of the GPP on care delivery and cost, including how GPP systems improved care to the uninsured and how they are allocating resources more efficiently.