State of California, California Medi-Cal 202 Demonstration, Waiver 11-W-00193/9
Global Payment Program (GPP) Final Evaluation Design
Approved by the Centers for Medicare and Medicaid Services on July 26, 2017

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A. Demonstration Initiative Goals/Objectives

As per the Standard Terms and Conditions (STC) 173, 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 (PHCS). As per the STCs, the midpoint evaluation (using 24 months of data) will occur at the midpoint of the demonstration. The second will occur as part of the final evaluation report due at the end of GPP Year (PY) 4.

Background

Experiential and academic literature has demonstrated that it is necessary to improve access to outpatient services in an effort to reduce long –term costs and improve health outcomes. Furthermore, evidence indicates that individuals with mental health issues are at a greater risk for complex physical health problems and on average die 25 years earlier than the general population. A significant proportion of deaths among individuals with mental health issues are due to preventable conditions such as high blood pressure, high cholesterol, diabetes, and heart disease. With more than 3 million uninsured in California and a recognition that uninsured often have limited access to cost- effective preventive care and mental health services, DHCS and the state's PHCS worked together to formulate a new program to improve care to the uninsured. The GPP seek to improve care to the uninsured and transform payments by allocating GPP funds to address the needs of PHCS patients, including expanding preventive services, mental health and patient education, and increasing the use of non-traditional services, such as case managers or nurse advise lines to improve care in more appropriate settings.

GPP Overview

California's GPP is a new pilot program to support 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.

GPP payments will not exceed the established aggregate limit stated in the 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. 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.

B. Research Questions and Hypotheses

The two evaluations will seek to assess whether changing the payment methodology results in more cost-effective and higher-value care as measured by: delivering more services at lower level of care as measured by diagnosis codes, expansion of the use of non-traditional services, reorganization of care teams to include primary care and mental health providers, better use of data collection, improved coordination between mental health and primary care, costs that could have been avoided, and additional investments in infrastructure to improve ambulatory care The midpoint evaluation will examine early trends and describe the infrastructure investments the PHCS has made; the final evaluation will determine whether and to what extent changing the payment methodology resulted in a more patient-centered system of care .

As stated in STC 173 (b) and (c) " the Global Payment Program is testing a new approach to financing care to the remaining uninsured, the two evaluations will monitor the implementation and impact of the demonstration to inform how improvements to the GPP can be made following the expiration of the Demonstrations. Both evaluations will examine the purpose and aggregate impact of the GPP, care provided by the PHCS and patients' experience, with a focus on understanding the benefits and challenges of this innovative payment approach." The qualitative and quantitative data collected will test the following specific research questions with the proposed hypotheses:

Midpoint Evaluation:

1. Research Question: Did the GPP allow PHCS to build or strengthen primary care, data collection and integration, and care coordination to deliver care to the remaining uninsured?
   Hypotheses:

- Since the beginning of the GPP, PHCS built and strengthened primary care, data collection and integration and care coordination to deliver care to the remaining uninsured.
- PHCS are putting a strong foundation in place to deliver care for the remaining uninsured.

2. Research Question: Across the majority of PHCS, did the utilization of non-inpatient, non-emergent services increase?
   Hypothesis:
   - The majority of PHCS improved the utilization of non-inpatient, non-emergent services.

Final Evaluation:

1. Research Question: Was the GPP successful in driving a shift in provision of services from inpatient to outpatient settings (including non-traditional services) over the course of the GPP?
   Hypothesis:
   - Since the beginning of the GPP, PHCS overall increased the use of outpatient services over the course of the GPP.

2. Research Question: Did GPP allow PHCS to leverage investments in primary care, behavioral health, data collection and integration, and care coordination to deliver care to the remaining uninsured?
   Hypotheses:
   - PCHS improved care to the uninsured.
   - GPP promoted allocating resources wisely and is more effectively tailoring care to the appropriate settings.
   - GPP promoted most efficient use of investments in improved care teams, behavioral health integration, robust data tracking and improved care coordination.

3. Research Question: Did the percentage of dollars earned based on non-inpatient, non-emergent services increase across PHCS?
   Hypothesis:
   - The percentage of dollars earned based on non-inpatient, non-emergent services increased across PHCS.

C. Evaluation Design and Approach

The design will be a pre-and-post evaluation using statistical methods to compare early trends at the mid-point evaluation and at final evaluation trend in care delivery. The evaluation will be

summative, aiming to provide an assessment that the program meeting its stated objectives. Both the midpoint and the final evaluations will approach the evaluation in the same manner. The evaluations will use a combination of administrative/quantitative data which will be supplemented by qualitative data derived from interview responses (see: Sections D and E for additional information on Performance Measures and Data Collection/Sources). The survey responses will provide a rich description that will enable the evaluator understand the complexities of service delivery and gain insight into PHCS processes. The methodology for both mid-point and final evaluations will be non-randomized as all participating PHCS will submit data as a condition of participation. It is anticipated that the sample size will be sufficiently robust to derive statistically significant results.

Site Selection and Recruitment

The evaluation contractor will work closely with DHCS to identify PHCS that participate in the GPP. Every PHCS will participate in the evaluation. It is thus anticipated that the large sample size will ensure that the evaluation will be able to detect small program impacts. To ensure optimal participation in the survey, the contractor will:

Step 1: Inform PHCS participating in the GPP of the evaluation to generate support for participation

The contractor will contact the PHCS that are participating in the GPP. The contractor will draft and transmit letters of introduction to the sites. These letters will be sent to a high-level administrator who is likely to have sufficient support to committing the PHCS to the PHCS narrative and subsequent information requests of the evaluation. The letter of introduction will provide a method for ensuring the sites understand the following: the objective of the evaluation and the need of PHCS participating in the GPP to participate in the evaluation as required by the STCs.

Step 2: Conduct teleconferences with PHCS participating in the GPP

The contractor will schedule teleconferences with PHCS that participate in the GPP. During these conference calls, the contractor will provide detailed information to the PHCS about the evaluation's objectives and the requirements of the PHCS. Specifically, the following topics will be discussed:

1) Overview of the evaluation,
2) Key research questions of hypotheses,
3) Design,
4) Requirements for evaluation sites (the need to submit timely reports to DHCS and the need to participate/ensure participation in interviews).

GPP requires public health care systems to restructure their delivery systems to more effectively coordinate care for uninsured patients, improve data collection and tracking, and expand services in the outpatient setting. The midpoint evaluation will identify initial trends

and examine what investments have been made in each PHCS' to reorganize care delivery toward GPP goals and increase non-inpatient and non-emergent utilization. To assess progress to date, health care systems will be required to submit qualitative and quantitative data. The quantitative data will be submitted in the format prescribed by Tables 1 and 2 of this evaluation design and qualitative narratives will be elicited via survey responses and follow-ups. Health system narratives will require each system to provide a comprehensive description of what activities they have undertaken in the following areas: reorganization of care teams, better use of data collection, improved coordination between mental health and primary care, and the expansion of the use of non-traditional services and additional investments in infrastructure to support improvements in care delivery. The qualitative data will categorized and coded by emergent themes. Quantitative data will assess any initial changes in utilization for the first two years of the program, and assess the extent to which PHCS met their GPP targets.

D. Performance Measures

Both evaluations are examining directional trends for quantitative measures. Numerators and denominators will be outlined in the GPP Reporting Manuals or guidance given for the qualitative individual PHCS self-assessment narrative. Directional goals will be established for each performance measure.

Tables 1 and 2 below outline the evaluation hypotheses, associated performance measures, and data sources. Additional detail around data sources is provided in Section E: Data Collection/Sources.

Table 1: Midpoint Evaluation Performance Measures

Hypothesis	Performance Measure(s)	Data Source
Since the beginning of the GPP, PHCS built and strengthened primary care, data collection and integration and care coordination to deliver care to the remaining uninsured.	• Data collection and tracking • Expanded care team as evidenced by increased provision of non-traditional services • Increased coordination with other areas of the delivery system (e.g. primary care, mental health, and substance use) • Expanded care team as evidenced by expanded workforce roles and responsibilities, including description of workforce involvement and the care team and the efforts to transform both. The questions asked will include questions about expansion of roles and responsibility within scope of practice through use of protocols and training; adoption of new staffing ratios in care teams as well as addition of new positions or roles.	Qualitative individual PHCS self-assessment narrative GPP Reports to DHCS

Hypothesis	Performance Measure(s)	Data Source
	• Improvements in care in a manner that avoids or reduces costs and is measured by an assessment I 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 • Improvements in patient care, measured by a description of how each PHCS is 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 • Expanded infrastructure that is being put in place, including improvements within the delivery system or efforts to expand services with contracted providers • Narrative assessment of the overall benefits and challenges of this new payment approach, including care provided by PHCS, patient experience and care delivery transformation	
The majority of PHCS improved the utilization of non-inpatient, non-emergent services.	• Improvements in ambulatory care services as reported from Categories 1, 2 and 3 (excluding behavioral health and emergency services) in Table 3 (e.g. primary and specialty care, nutrition education, group visits), inpatient from Category 4 in Table 3 (e.g. trauma, med surg) and emergency services from Category 1C in Table 3. • Improvements in behavioral health services in Category 1B, 1C and 4A and 4B in Table 3 (particularly in the non-emergent settings, e.g. mental health and substance use outpatient).	GPP reports to DHCS
PHCS are putting a strong foundation in place to deliver care for the remaining uninsured**.**	• Assessment of participating public health care systems use of federal funding o Percent of GPP funding earned by program year • Cost of GPP services vs GPP funding against which cost avoidance will be measured. o Expenditures associated with services provided, both at 100% and 175% • 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%	GPP reports to DHCS Paragraph 14 (P14) Workbook Qualitative individual PHCS

Hypothesis	Performance Measure(s)	Data Source
	• The number of uninsured served within physical health, behavioral health, and through contracted providers • Summary assessment grouped into appropriate categories 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. • Expanded infrastructure that is being put in place, including improvements within the delivery system or efforts to expand services with contracted providers. • Narrative assessment of the overall benefits and challenges of this new payment approach, including care provided by PHCS, patient experience and care delivery transformation.	self-assessment narrative

Table 2: Final Evaluation Performance Measures

Hypothesis	Performance Measure(s)	Data Source
PHCS overall increased the use of outpatient services over the course of the GPP.	• Expanded ambulatory care services, including trends in how many are served in ambulatory care from Categories 1, 2 and 3 (excluding behavioral health and emergency services) in Table 3 (e.g. primary care, specialty care, nutrition education, group visits) inpatient from Category 4 in Table 3 (e.g. trauma, med surg.) and emergent/urgent care from Category 1C in Table 3, mental health and substance use services in Category 1B, 1C and 4A and 4B in Table 3 compared to early trends established in the midpoint evaluation. • Increased utilization in non-traditional services from Categories 1A, 2, 3 and 4A in Table 3, which includes care by other licensed or certified professionals (e.g. nurses, pharmacists) and non-face-to-face visits as compared to the midpoint evaluation. • Increased volume and mix of behavioral health care services in Category 1B, 1C and 4A and 4B in Table 3, with a particular focus on outpatient services (e.g. mental health and substance use outpatient).	GPP reports to DHCS
PHCS improved care to the uninsured.	• Demonstrated improvements in care coordination through PHCS narratives including expanded use of complex care managers, case managers, health educators and health coaches. The categories will result in a description of	Qualitative individual PHCS self-

Hypothesis	Performance Measure(s)	Data Source
	workforce involvement, including team-based care are qualitative measures that will be defined through emergent themes that will emerge in the midpoint evaluation. The questions asked will include questions about expansion of roles and responsibility within scope of practice through use of protocols and training; adoption of new staffing ratios in care teams as well as addition of new positions or roles. The data will be categorized at the midpoint evaluation and at final evaluation and compared to determine if progress has been made. • 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.	assessment narrative
PHCS improved care to the uninsured.	• Compare data from subsequent GPP program years to assess changes in the following categories: o Number of uninsured patients served o Number of types of services provided o Rates of types of services provided per number of uninsured patients served	Qualitative individual PHCS self-assessment narrative GPP reports to DHCS
GPP promoted allocating resources wisely and is more effectively tailoring care to the appropriate settings. The percentage of dollars earned based on non-inpatient, non-emergent services did	▪ Improvements in care to more appropriate settings and resource allocation including: ▪ Assess changes in care to more appropriate settings which could include: o 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 o Changes in the ratio of Emergency Care to Ambulatory Care: ▪ Numerator: Number of ER encounters/year ▪ Denominator: Number of primary care	GPP reports to DHCS Qualitative individual PHCS self-assessment narrative

Hypothesis	Performance Measure(s)	Data Source
increase across PHCS.	and specialty care encounters/year o 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 o 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 o Assessment of use of non-traditional services and expansion of team based care, including expansion of roles and responsibility within scope of practice through use of protocols and training; adoption of new staffing ratios in care teams; and addition of new positions or roles. To determine whether an increase in non-traditional services leads to greater utilization of lower-level primary care services, the following trends over time will be examined: ratio of non-traditional service encounters to primary services and primary care to total services. ▪ Numerator: # Non-Traditional Service Encounters/year ▪ Denominator: # Primary Care services And ▪ Numerator: # Primary Care services ▪ Denominator: #Total services o 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	

Hypothesis	Performance Measure(s)	Data Source
	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	
GPP promoted allocating resources wisely and is more effectively tailoring care to the appropriate settings. GPP promoted most efficient use of investments in improved care teams, behavioral health integration, robust data tracking and improved care coordination.	• Cost of GPP services vs GPP funding (at the individual level) o Expenditures associated with services provided, both at 100% and 175% at baseline and in final evaluation o Expenditures avoided or reduced. Trends over time of: ▪ Volume Acute Care Utilization per uninsured at baseline and at the time of final evaluation: • Numerator: Inpatient uninsured admit/ER uninsured encounters • Denominator: Total # of unduplicated uninsured served through GPP/year ▪ Volume of Acute Mental Care Utilization per uninsured at baseline and at the time of final evaluation • Numerator: Inpatient Mental Health uninsured admissions • Denominator: Total # of unduplicated uninsured o 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	Paragraph 14 (P14) Workbook GPP reports to DHCS
GPP promoted allocating resources wisely and is more effectively tailoring care to the appropriate settings. GPP promoted most efficient use of	• Expansion of non-traditional services and/or expanded use of non-traditional providers • Improvements in coordination with other entities areas of the delivery system (e.g. primary care, mental health, and substance use.) • Improvements in workforce involvement and care team transformation • Improvements in 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 • Expanded infrastructure that has been put in place, including efforts to improve care and quality within the delivery system or with contracted providers	Qualitative individual PHCS self-assessment narrative GPP reports to DHCS

Hypothesis	Performance Measure(s)	Data Source
investments in improved care teams, behavioral health integration, robust data tracking and improved care coordination	• Improvements in patient care, as reported by an assessment of how they allocated GPP funds to address the needs of their patients • 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.	

E. Data Collection/ Sources

The midpoint 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 final evaluation will also utilize applicable available cost data from PHCS as well as qualitative individual system GPP narratives. For purposes of both evaluations, utilization will be defined in terms of units of service as described in Table 3. For many of the components in the midpoint evaluation, PHCS will identify initial trends and describe the infrastructure investments the PHCS has made. The final evaluation will include all data sources from the midpoint evaluation, plus data from GPP encounter reporting that begins in PY2.

Quantitative Data Collection and Analysis

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 the Table 3 of this evaluation design. 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 enable DHCS to identify initial trends in the midpoint evaluation and will provide the necessary service level information to assess trends over time in the final 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.

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.

- 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.

Qualitative Data Collection and Analysis

The individual PHCS will provide a qualitative description that address whether the GPP payment method led to PHCS strengthening primary care, data collection and integration, and care coordination as described in Table 3. The qualitative description will be collected via a structured survey and will be completed independently by all PHCS. Survey responses will be categorized and coded by emergent themes. Follow-up interviews will be conducted to address gaps and questions about the original responses. Interview responses will be added to the survey responses and further coded by themes. Survey responses at midpoint evaluation and final evaluation will be compared to assess what change has occurred.

The quantitative performance measures for this evaluation will be derived from Table 3: GPP Service Types by Category and Tier, with Point Values below. The data from table 3, will be supplemented by self-assessments in response to interviews. The interviews will be administered to PHCS and to patients.

Table 3: GPP Service Types by Category and Tier, with Point Values

Category and description	Tier	Tier description	Service type	Traditional / non-traditional	Initial point value
1: Outpatient in traditional settings	A	Care by Other Licensed or Certified Practitioners	RN-only visit	NT	50
			PharmD visit	NT	75
			Complex care manager	NT	75
	B	Primary, specialty, and other non-emergent care (physicians or other licensed independent practitioners)	Primary/specialty **(benchmark)**	T	100
			Contracted primary/specialty (contracted provider)	T	19
			Mental health outpatient	T	38
			Substance use outpatient	T	11
			Substance use: methadone	T	2
			Dental	T	62
	C	Emergent care	OP ER	T	160
			Contracted ER (contracted provider)	T	70
			Mental health ER / crisis stabilization	T	250
	D	High-intensity outpatient services	OP surgery	T	776
2: Complementary patient support and care services	A	Preventive health, education and patient support services	Wellness	NT	15
			Patient support group	NT	15
			Community health worker	NT	15
			Health coach	NT	15
			Panel management	NT	15
			Health education	NT	25
			Nutrition education	NT	25
			Case management	NT	25
			Oral hygiene	NT	30
	B	Chronic and integrative care services	Group medical visit	NT	50
			Integrative therapy	NT	50
			Palliative care	NT	50
			Pain management	NT	50
	C	Community-based face-to-	Home nursing visit	NT	75
			Paramedic treat and release	NT	75

Category and description	Tier	Tier description	Service type	Traditional / non-traditional	Initial point value
		face encounters	Mobile clinic visit	NT	90
			Physician home visit	NT	125
3: Technology-based outpatient	A	Non-provider care team telehealth	Texting	NT	1
			Video-observed therapy	NT	10
			Nurse advice line	NT	10
			RN e-Visit	NT	10
	B	eVisits	Email consultation with PCP	NT	30
	C	Store and forward telehealth	Telehealth (patient - provider) - Store & Forward	NT	50
			Telehealth (provider - provider) – eConsult / eReferral	NT	50
			Telehealth – Other Store & Forward	NT	65
	D	Real-time telehealth	Telephone consultation with PCP	NT	75
			Telehealth (patient - provider) - real time	NT	90
			Telehealth (provider - provider) - real time	NT	90
4: Inpatient	A	Residential, SNF, and other recuperative services, low intensity	Mental health / substance use residential	T	23
			Sobering center	NT	50
			Recuperative / respite care	NT	85
			SNF	T	141
	B	Acute inpatient, moderate intensity	Medical/surgical	T	634
			Mental health	T	341
	C	Acute inpatient, high intensity	ICU/CCU	T	964
	D	Acute inpatient, critical	Trauma	T	863
			Transplant/burn	T	1,131

Category and description	Tier	Tier description	Service type	Traditional / non-traditional	Initial point value
		community services			

Initial data and GPP Reporting Manual: Midpoint Evaluation

As stated above, initial trends will be collected during the midpoint evaluation and will consist of administrative data collected through Table 3 and reports submitted to DHCS and interviews with PHCS. It is anticipated that Table 3 data will be collected in a timely manner as the PHCS cannot be reimbursed without this data. To facilitate the collection of evaluation data, PHCS will be asked to uniformly collect the following information during the midpoint evaluation.

As described in the table above, the narrative assessments describing 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. These narratives will be grouped into appropriate thematic categories and will be used to produce detailed descriptive analyses. Furthermore, a GPP reporting manual will be created to facilitate the process of collecting encounter data in the PHCS that participate in the GPP. The reporting manual will be administered by DHCS and the data will be shared the selected contractor for analysis. The data collected and stored will be in the format prescribed by Table 3.

The survey narrative information will also be stored and analyzed by the contractor.

Follow-up data collection: Final Evaluation

The final evaluation will collect follow-up data and examine initial trends. All PHCS participating in the GPP will participate in the final evaluation as a condition of the GPP. It is therefore anticipated that the follow-up response rate will be 100%. Quantitative data collection procedures will be identical to the midpoint evaluation in that they will utilize Table 3 data. The narrative will differ in that it will ask PHCS to describe a summary assessment of the various aspects of the program including infrastructure and improvements in care, an overview of the opportunities and challenges of the program and the effects of the GPP on care delivery and cost.

Survey Instrument Development and Administration

To develop the PHCS individual narratives the contractor will utilize a validated survey instrument. However, pilot testing will be required to ensure smooth survey implementation and valid survey results. To that end, the contractor will pilot test the surveys that will be used at the midpoint and final evaluations. Pilot testing informs the evaluation contractor of difficulties in administering the survey (e.g., the wording may be difficult to read or comprehend) as well as difficulties that respondents may have in interpreting and/or

understanding specific questions. More importantly, pilot testing will ensure that the evaluation contractor is obtaining the desired data from the survey questions.

The survey will be administered by the evaluator. The survey at midpoint evaluation will be self-administered survey. Two waves of follow-up measurements will be administered during the final evaluation. Additional interviews will be conducted as needed.

F. Data Analysis Strategy

In order to assess the outcomes of the GPP payment methodology several research methods are proposed to be utilized, including quantitative and qualitative data analysis. A variety of analytical techniques will be applied, including pre- and post-intervention design and thematic grouping of survey responses. Quantitative data will be routinely tracked throughout the implementation of the GPP and a series of surveys and focus groups of patients and providers will be implemented. Table 3 will be utilized as the standardized protocol for ongoing collection and reporting on participating PHCS' organizational data and related quantitative information. Table 3 data will be supplemented by standardized narratives (which will be administered to providers) and which will combine open-ended and quantitative questions. The responses to open ended questions will be grouped into appropriate categories 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. The rating scale questions will be collapsed by theme.

G. Timeline

GPP Year	Step
PY 1 (SFY 15-16)	Q1: GPP begins
PY 2 (SFY 16-17)	Q4: Evaluation design approved
PY 3 (SFY 17-18)	Q1: Evaluator RFP process initiated and completed
PY 3 (SFY 17-18)	Q4: Midpoint evaluation completed (target submission to CMS, 6/30/2018)
PY 4 (SFY 18-19)	Q4: Final evaluation completed (due to CMS 6/30/2019, per STC 173(b))

H. Independent Evaluator

As per the STCs, the State of California shall conduct two evaluations of provider expenditures and activities under the GPP methodology. The midpoint evaluation will occur at the midpoint of the demonstration and the final evaluation will occur as part of the interim evaluation report that will be submitted to CMS at the end of GPP PY 4.

Upon CMS approval of the evaluation design, the State will contract with an independent entity and ensure that the entity is free of conflict of interest to conduct an evaluation of the GPP methodology. The State will contract with an entity that does not have a direct relationship to DHCS. A data use agreement will be included in the contract to allow for the sharing of data with and access to data by the independent entity for purposes of conducing the GPP evaluations. The State will seek application(s) from interested entities that have been identified based on prior experience and expertise in analyzing the experience of the population and working with the data that would be analyzed. Proposals will be scored; if a minimal score is not achieved, the State will seek proposals from additional entities.