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**State of California Medi-Cal Managed Care Directed Payment Programs
Annual Evaluation for Program Year 1: State Fiscal Year 2017-2018**

This Directed Payment Programs Annual Evaluation conveys the results of the Annual Evaluation Plans originally submitted by California Department of Health Care Services (DHCS) in accordance with Title 42 of the Code of Federal Regulations (CFR), section 438.6(c)(2)(ii)(D). Specifically, this Annual Evaluation concerns four of the State's Directed Payment Programs that were in effect during the State Fiscal Year (SFY) 2017-2018, and were approved by CMS pursuant to 42 CFR section 438.6(c)(1). The Annual Evaluation for the Proposition 56 Dental Services Directed Payment Program will be submitted separately. The Annual Evaluation for the Designated Public Hospital Quality Incentive Pool is available at https://www.dhcs.ca.gov/services/Documents/QIP-Evaluation-Baseline-Report-PY1.pdf.

Directed Payment Programs Being Evaluated:

Proposition 56 Physician Services Directed Payment Program.
This directed payment arrangement requires Medi-Cal Managed Care Plans (MCPs) to make uniform and fixed dollar amount add-on payments to eligible network providers based on the utilization and delivery of qualifying services. This directed payment arrangement was developed in accordance with the California Healthcare, Research, and Prevention Tobacco Tax Act of 2016 (Proposition 56), a ballot proposition to increase the excise tax rate on cigarettes and other tobacco products for the purpose of funding certain State expenditures including health care programs administered by DHCS.

Designated Public Hospital Directed Payment Program (Fee-For-Service).
This directed payment program requires MCPs to make fixed dollar amount add-on payments to contracted Designated Public Hospitals (DPHs) (as defined in Welfare and Institutions Code section 14166.1(d)) reimbursed on a primarily fee-for-service (FFS) basis. This directed payment structure applies to contracted DPHs that provide critical inpatient (including long-term care) and non-inpatient services to Medi-Cal managed care members.

Designated Public Hospital Directed Payment Program (Capitated).
This directed payment program requires MCPs to make fixed dollar amount and fixed percentage increase add-on payments to contracted DPHs reimbursed on a primarily capitated payment basis. Specifically, uniform increases in payments are directed in the form of uniform percent increases to payments for capitated contractual arrangements and uniform dollar amount payments for FFS contractual arrangements for inpatient (including long-term care) and non-inpatient services. This directed payment program

supports DPH systems' delivery of critical services to Medi-Cal managed care members.

Private Hospital Directed Payment Program.
This directed payment program requires MCPs to make fixed dollar amount add-on payments to eligible network private hospitals (as defined in Welfare and Institutions Code section 14169.51(ap)) based on utilization and delivery of contracted inpatient and select contracted outpatient services. This program supports private hospitals' delivery of essential care to Medi-Cal managed care members.

Annual Evaluation Purposes and Related Questions:

Proposition 56 Physician Services Directed Payment Program.
Access to primary care physicians is a vital step in providing care in the appropriate setting, aiding the State's goals to improve care quality and health outcomes in addition to curbing the higher costs associated with the utilization of emergency departments. The purpose of the Program Year (PY) 1 (SFY 2017-2018) Annual Evaluation is to establish benchmark metrics to measure encounter data quality and service utilization corresponding to directed payments made by MCPs to network provider physicians for contracted outpatient services billed under Current Procedural Terminology (CPT) codes 90791-90792, 90863, 99201-99205, and 99211-99215. These metrics will be used as a baseline measurement period by which to compare subsequent program years.

Designated Public Hospital Directed Payment (FFS) Program.
These payments are expected to enhance the quality of primary, specialty, and inpatient (both tertiary and quaternary) care by improving encounter data submissions by DPHs to better target those areas where improved performance will have the greatest effect on health outcomes. The purpose of this Annual Evaluation is to gather baseline metrics for PY 1 (SFY 2017-2018) related to payments made by MCPs to network providers on a FFS basis for inpatient (including long-term care) and non-inpatient services. Future PY data will then be compared to these metrics to determine if the Directed Payment Program met or exceeded program goals.

Designated Public Hospital Directed Payment (Capitated) Program.
These payments are expected to enhance the quality of primary, specialty, and inpatient (both tertiary and quaternary) care by improving encounter data submissions by DPHs to better target those areas where improved performance will have the greatest effect on health outcomes. The purpose of this Annual Evaluation is to gather baseline metrics related to uniform percentage or dollar amount payments for capitated contractual arrangements and for FFS contractual arrangements for inpatient (including long-term care) and non-inpatient services. Future program year data will then be compared to these metrics to determine if this Directed Payment Program met or exceeded program goals.

Private Hospital Directed Payment (PHDP) Program.
These directed payments are expected to enhance quality, including the patient care experience, by supporting essential hospital providers in California to deliver effective, efficient, and affordable care including primary, specialty, and inpatient (both tertiary and quaternary) care. This proposal creates a robust data monitoring and reporting mechanism with strong incentives for quality data as this proposal links payments to actual reported encounters. This information will enable dependable, data-driven analysis, issue spotting and solution design. Additionally, these metrics will serve as a baseline to compare against future program year data and to determine if the Directed Payment Program met or exceeded program goals.

Evaluation Design:

The following report establishes the benchmark measurements for encounter data quality during PY 1 (July 1, 2017 – June 30, 2018) of the four Directed Payment Programs detailed above. Encounter data quality has been measured across several domains including reasonability, timeliness, and actual utilization of specified services.

Data Sources:

The data utilized for this report was derived from aggregate statewide provider encounter data. Encounter data is submitted to DHCS through the Post-Adjudicated Claims and Encounters System (PACES), and contains detailed information about services provided to Medi-Cal beneficiaries. Data was then extracted from PACES via the Management Information System/Decision Support System (MIS/DSS).

The following measures concerning the reasonability and timeliness of encounter data submissions align with DHCS' Quality Measures for Encounter Data (QMED) version 1.1, published on August 8, 2018. DHCS developed QMED with the intention of using metrics to drive data quality improvement efforts and to establish a statewide standard by which encounter data quality is to be measured. To measure actual utilization, DHCS used encounter data files submitted by MCPs to assess the number of inpatient admissions, outpatient visits, and emergency room visits per 1000 Member Months.

Annual Evaluation Results:

Encounter Data Quality.

1. Reasonability:

   ▪ Denied Encounters Turnaround Time – This measure addresses how quickly denied encounter data files are corrected and resubmitted by MCPs. Turnaround time is the time, in days, between an encounter data file denial date and the date of resubmission to DHCS.

Turnaround Time	SFY 2017 - 2018		
	Corrected Encounters	Total Denied Encounters	Percentage of Corrected Encounters per Group
0 to 15 Days	49,532	6,064,978	0.82%
15 to 30 Days	48,966	6,064,978	0.81%
30 to 60 Days	103,246	6,064,978	1.70%
Greater Than 60 Days	5,863,234	6,064,978	96.67%

The Denied Encounters Turnaround Time metric shows that during PY 1 of the Directed Payment Programs, approximately 0.82% of encounter data files were corrected and resubmitted within 15 days of receiving a data file denial notice. Approximately 0.81% of files were corrected and resubmitted within 15 to 30 days and 1.70% of files were resubmitted within 30 to 60 days. Lastly, the majority of encounter data files (96.67%) were corrected and resubmitted at least 60 days after receiving notice of the encounter data file submission being denied.

▪ Denied Encounters as a Percent of Total – This measure reports the average percentage of total encounters that are denied each month of submission.

SFY 2017 - 2018		
Total Denied Encounters	Total Encounters	Percent of Denied Encounters per Month
6,111,016	118,833,932	5.14%

The Denied Encounters as a Percent of Total metric indicates that, on average, approximately 5.14% of total encounters were denied on a monthly basis during the first year of the Directed Payment Programs.

2. Timeliness:

▪ Lagtime – This measure reports the time it takes for MCPs to submit encounter data. Lagtime is the time, in days, between the encounter's Date of Service and its Submission Date to DHCS.

Lagtime	SFY 2017 - 2018		
	Encounters per Lagtime Group	Total Encounters	Percent of Encounters per Lagtime Group
0 to 90 Days	75,540,158	118,833,932	63.57%
90 to 180 Days	19,842,489	118,833,932	16.70%
180 to 365 Days	10,754,035	118,833,932	9.05%
Greater than 365 Days	12,697,250	118,833,932	10.68%

These results show that during the first year of the Directed Payment Programs, the majority of encounters (63.57%) were submitted within 90 days of the Date of Service. In addition, approximately 16.70% of encounters were submitted within 90 to 180 days, 9.05% were submitted within 180 days to one year of the Date of Service, and around 10.68% of encounters were submitted after one year.

Services Utilization.

1. Inpatient Utilization

- Inpatient Admissions per 1,000 Member Months – DHCS calculated the number of MCP inpatient admissions per 1,000 Member Months at a statewide level from MCP encounter data. An "admission" refers to a unique combination between member and date of admission to a facility.

SFY 2017 - 2018
Inpatient Admissions per 1,000 Member Months
16.20

The results show that there were approximately 16.20 inpatient admissions per 1,000 Member Months during PY 1 (SFY 2017-2018) of the Directed Payment Programs.

2. Outpatient Utilization

- Outpatient Visits per 1,000 Member Months – DHCS calculated the number of MCP outpatient visits per 1,000 Member Months at a statewide level from MCP encounter data. A "visit" refers to a unique combination between provider, member, and date of service.

SFY 2017 - 2018
Outpatient Visits per 1,000 Member Months
1,098.90

The results show that there were approximately 1,098.90 outpatient visits per 1,000 Member Months during PY 1 of the Directed Payment Programs.

3. Emergency Room Utilization

- Emergency Room Visits per 1,000 Member Months – DHCS calculated the number of MCP emergency room visits per 1,000 Member Months at a statewide level from the MCP encounter data. A "visit" refers to a unique combination between provider, member, and date of service.

SFY 2017 - 2018
Emergency Room Visits per 1,000 Member Months
52.40

The results show that there were approximately 52.40 emergency room visits per 1,000 Member Months during PY 1 of the Directed Payment Programs.

Limitations of Annual Evaluation:

These metrics were used to determine the quality of encounter data submissions and utilization of inpatient, outpatient, and emergency room services during PY 1 of the Directed Payment Programs. As a baseline, these measures do not provide a comprehensive overview of the efficacy of the four Directed Payment Programs detailed in this report. However, these metrics will serve as a useful benchmark to compare against future program data to assess changes in encounter data quality and service utilization following the implementation of the Direct Payment Programs.

DHCS believes this Annual Evaluation accurately reflects the initial statewide impact of the four Directed Payment Programs each year. However, technical limitations associated with the encounter database may have compromised DHCS' ability to reliably subset the data at the proper level of granularity. DHCS will continue to collect data concerning these metrics and strives to improve the reliability of Directed Payment Program Annual Evaluations in the future.

Conclusions:

DHCS' examination of PY 1 (SFY 2017-2018) encounter data quality and inpatient, outpatient, and emergency room service utilization during the first year of the Directed Payment Programs indicates the following.

1. On average, MCPs took approximately 60 or more days to adequately correct and resubmit denied encounter data files, and around 5.14% of total encounters were denied per month.

2. Most encounters were submitted within 90 days from their applicable Date of Service.

3. MCPs reported an average of approximately 16.20 inpatient admissions, 1,098.90 outpatient visits, and 52.40 emergency room visits per 1,000 Member Months during PY 1 of the Directed Payment Programs.