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State of California Medi-Cal Managed Care Directed Payment Programs Annual Evaluation for Program Year 2: State Fiscal Year 2018-2019

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) 2018-2019 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-PY2-Evaluation-Report.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 directs 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) 2 (SFY 2018-2019) Annual Evaluation is 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, 99211-99215, 99381-99385, and 99391-99395. These metrics will be used to compare PY 2 (SFY 2018-2019) to the baseline (PY 1) to determine if the Directed Payment Program met or exceeded program goals for PY 2.

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 metrics for PY 2 (SFY 2018-2019) related to payments made by MCPs to network providers on a FFS basis for inpatient (including long-term care) and non-inpatient services to compare against baseline PY 1 data to determine if the Directed Payment Program met or exceeded program goals for PY 2.

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 PY 2 (SFY

2018-2019) 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 to compare against baseline PY 1 data to determine if the 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 PY 2 metrics will be compared against the baseline PY 1 data to determine if the Directed Payment Program met or exceeded program goals.

Evaluation Design:

The following report involves a comparison of encounter data quality metrics and Inpatient, Outpatient, and Emergency Room service utilization for PY 1 (July 1, 2017 to June 30, 2018) and PY 2 (July 1, 2018, to June 30, 2019). This Annual Evaluation is designed to answer the following questions concerning the four Directed Payment Programs described above:

- Do increased payments, via the PY 2 directed payments, serve to maintain or improve the reasonability and timeliness of encounter data reported by MCPs when compared to PY 1?

- Do increased payments, via the PY 2 directed payments, serve to maintain or change utilization patterns for inpatient, outpatient, and emergency room services for MCP members when compared to PY 1?

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			SFY 2018 - 2019		
	Corrected Encounters	Total Denied Encounters	Percentage of Corrected Encounters per Group	Corrected Encounters	Total Denied Encounters	Percentage of Corrected Encounters per Group
0 to 15 Days	49,532	6,064,978	0.82%	83,261	6,136,928	1.36%
15 to 30 Days	48,966	6,064,978	0.81%	29,947	6,136,928	0.49%
30 to 60 Days	103,246	6,064,978	1.70%	66,094	6,136,928	1.08%
Greater Than 60 Days	5,863,234	6,064,978	96.67%	5,957,626	6,136,928	97.08%

The Denied Encounters Turnaround Time metric indicates that, during PY 2 of the Directed Payment Programs, the percentage of denied encounter files corrected and resubmitted within 15 days of receiving a data file denial notice improved from 0.82% to 1.36%, while the rate of encounter data files resubmitted after 15 days decreased. In addition, when compared to PY 1, the amount of files corrected within 30 to 60 days slightly decreased (1.70% to 1.08%) while the percentage of files corrected after 60 days slightly increased (96.67% to 97.08%) DHCS thus concludes that Denied Encounter Turnaround Time was maintained across program years with changes being balanced between turnaround improving within 0-15 days but worsening in the greater than 60 days category.

- 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			SFY 2018 - 2019		
Total Denied Encounters	Total Encounters	Percent of Denied Encounters per Month	Total Denied Encounters	Total Encounters	Percent of Denied Encounters per Month
6,111,016	118,833,932	5.14%	5,897,086	141,799,344	4.16%

The results show that, while total encounters reported for PY 2 (SFY 2018-2019) increased when compared to PY 1, the percentage of denied encounters decreased. DHCS therefore concludes that the lower rate of denied encounters served to improve the reasonability of encounter data in PY 2.

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			SFY 2018 - 2019		
	Encounters per Lagtime Group	Total Encounters	Percent of Encounters per Lagtime Group	Encounters per Lagtime Group	Total Encounters	Percent of Encounters per Lagtime Group
0 to 90 Days	75,540,158	118,833,932	63.57%	86,415,642	141,799,344	60.94%
90 to 180 Days	19,842,489	118,833,932	16.70%	22,997,964	141,799,344	16.22%
180 to 365 Days	10,754,035	118,833,932	9.05%	17,897,191	141,799,344	12.62%
Greater than 365 Days	12,697,250	118,833,932	10.68%	14,488,547	141,799,344	10.22%

The Lagtime Groups for PY 2, when compared separately against PY 1, indicate a shift toward less timely submissions for those encounters submitted within 180 days and an improvement in timing for those encounters submitted 180 days or more after their applicable Date of Service. However, when Lagtime for PY 2 is compared as an aggregate against Lagtime for PY 1, the results indicate an improvement in the number of encounters submitted within one year of their Date of Service. Specifically, around 89.32% of encounters were submitted within one year in PY 1, while approximately 89.78% of encounters were submitted within one year in PY 2. This, and the corresponding decrease in the number of encounters submitted after one year from the Date of Service, reflects a general improvement in the timeliness of submissions in PY 2.

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	SFY 2018 - 2019
Inpatient Admissions per 1,000 member months	**Inpatient Admissions per 1,000 member months**
16.20	15.40

The results show that the number of reported inpatient admissions decreased during PY 2 (SFY 2018-2019), compared to PY 1 (SFY 2017-2018). DHCS will continue to monitor this metric in future program years.

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	SFY 2018 - 2019
Outpatient Visits per 1,000 member months	**Outpatient Visits per 1,000 member months**
1,098.90	1,107.60

The results indicate that reporting of outpatient visits increased in comparison with PY 1. DHCS will continue to monitor this metric in future PY.

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	SFY 2018 - 2019
Emergency Room Visits per 1,000 member months	**Emergency Room Visits per 1,000 member months**
52.40	50.90

The results indicate that reporting of emergency room visits slightly decreased during the second year of the Directed Payment Programs. DHCS will continue to monitor this metric in future PY.

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 2 of the Directed Payment Programs. While the comparison of this data with the baseline metrics gathered in SFY 2017-2018 does not provide specific insight as to definitive causal relationships, changes in encounter data quality and utilization following the second year of the Directed Payment Programs suggest that the Directed Payment Programs had an impact on the metrics gathered and warrants further exploration in future PY.

DHCS believes this Annual Evaluation accurately reflects the statewide impact of the four Directed Payment Programs in PY 2. 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 2 (SFY 2018-2019) encounter data quality and inpatient, outpatient, and emergency room service utilization during the second year of the Directed Payment Programs and its comparison to PY 1 indicates the following.

1. MCPs took relatively the same amount of time to review, correct, and resubmit encounter data files. Additionally, the rate of denied encounters per month decreased by almost 1 percentage point.

2. There was an improvement in timeliness, with a shift toward more encounters being submitted within one year of their Date of Service.

3. Encounter reporting of total inpatient admissions and emergency room visits per 1,000 Member Months decreased while reporting of total outpatient visits per 1,000 Member Months increased.