DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
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State of California Medi-Cal Managed Care Physician Services Directed Payment Program Evaluation for the Bridge Period (July 1, 2019 – December 31, 2020)

Background

In accordance with Title 42 of the Code of Federal Regulations (CFR), Section 438.6(c)(2)(ii)(D), the California Department of Health Care Services (DHCS) is required to submit an evaluation plan that measures the degree to which the directed payment arrangement advances at least one of the goals and objectives in the quality strategy. This evaluation plan will assess the performance and results of the Proposition 56 (Prop 56) Physician Services Directed Payment Program implementation during the Bridge Period (July 1, 2019 through December 31, 2020).

The Prop 56 Physician Services Directed Payment Program directs Medi-Cal managed care health plans (MCPs) to make uniform dollar add-on payments for specific outpatient services. This directed payment program supports network providers to provide critical services to Medi-Cal managed care members.

Evaluation Purpose and Questions

The Prop 56 Physician Services Directed Payment Program is expected to enhance the quality of care and improve encounter data submissions by providers to better target those areas where improved performance will have the greatest effect on health outcomes. The CMS-approved evaluation design features two evaluation questions:

1. Do higher physician directed payments, serve to maintain or improve the timeliness and completeness of encounter data when compared to the Baseline period)?

2. Do higher physician directed payments, serve to maintain or change utilization pattern of outpatient physician services for members when compared to the Baseline period?

EVALUATION DATA SOURCES AND MEASURES

This evaluation addresses these questions mainly through quantitative analyses of encounter data extracted from the DHCS Management Information System/Decision Support System (MIS/DSS), spanning service dates State Fiscal Year (SFY) 2016-2017 (Baseline), and the Bridge Period. Previous evaluations utilized SFY 2017-18 as the baseline, however CMS recommended that baselines for evaluations be prior to the start of the program if possible. Therefore the baseline for this evaluation will be SFY 2016-17.

To measure data quality improvement in encounter claim submission, denied encounters, denied encounter turnaround time, and timeliness in submission were assessed using the Post-Adjudicated Claims and Encounters System (PACES) data extracted via MIS/DSS.

To measure changes in utilization pattern, number of outpatient visits per 1,000 member months were assessed using encounter claims extracted from MIS/DSS.

EVALUATION RESULTS

Encounter Data Quality

1. Denied Claims and Turnaround Time:

    a. 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 2016 – 2017 (Baseline)			Jul 1, 2019 – Dec 31, 2020 (Bridge Period)		
	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	85,880	803,309	11%	60,320	271,477	22%

16 to 30 Days	3,623	803,309	0%	9,133	271,477	3%
31 to 60 Days	253,531	803,309	32%	17,965	271,477	7%
Greater Than 60 Days	460,275	803,309	57%	184,059	271,477	68%

- 22% of denied encounters were corrected and resubmitted within 15 days from denial notice for the Bridge Period compared to 11% for the Baseline Period.

- 3% of denied encounters were corrected and resubmitted between 16 to 30 days from denial notice for the Bridge Period compared to 0% for the Baseline Period.

- 7% of denied encounters were corrected and resubmitted between 31 to 60 days from denial notice for the Bridge Period compared to 32% for the Baseline Period.

- 68% of denied encounters were corrected and resubmitted in greater than 60 days from denial notice for the Bridge Period compared to 57% for the Baseline Period

b. Total Denied Encounters

SFY 2016 – 2017 (Baseline)			**Jul 1, 2019 – Dec 31, 2020 (Bridge Period)**		
Total Denied Encounters	**Total Encounters**	**Percent of Denied Encounters per Month**	**Total Denied Encounters**	**Total Encounters**	**Percent of Denied Encounters per Month**
2,305,885	15,278,848	15%	1,383,685	20,743,933	7%

- The results showed that total denied encounters per month reported for the Bridge Period was approximately 7%, compared to 15% for the Baseline Period.

2. Timeliness (lagtime): This measure reports the time it takes for MCPs to submit encounter data files. Lag time is the time, in days, between the Date of Services and the Submission date to DHCS.

Lag time	SFY 2016 – 2017 (Baseline)			Jul 1, 2019 – Dec 31, 2020 (Bridge Period)		
	Encounters per Lag time Group	Total Encounters	Percent of Encounters per Lag time Group*	Encounters per Lag time Group	Total Encounters	Percent of Encounters per Lag time Group
0 to 90 days	8,561,682	15,278,848	56%	14,195,721	20,743,933	68%
91 to 180 days	2,279,541	15,278,848	15%	3,049,251	20,743,933	15%
181 to 365 days	1,911,035	15,278,848	13%	1,902,318	20,743,933	9%
More than 365 days	2,526,590	15,278,848	17%	1,596,643	20,743,933	8%

* Total percentages may not sum up to 100% due to rounding in each group

- Approximately 83% of encounters were submitted within 180 days from applicable dates of service for the Bridge Period compared to 71% for the Baseline Period.

Service Utilization

Outpatient Utilization: Physician Visits per 1,000 Member Months – DHCS calculated the number of MCP physician visits per 1,000 member months at a statewide level from MCP encounter data. A “visit” refers to a unique combination of provider, member, and date of service.

SFY 2016 – 2017 (Baseline)	Jul 1, 2019 – Dec 31, 2020 (Bridge Period)
Physician Visits per 1,000 member months	Physician Visits per 1,000 member months

176.41	195.12

- The number of outpatient visits was 195.12 per 1,000 member months for the Bridge Period compared to 176.41 for the Baseline Period.
- DHCS will continue to monitor this metric in future program years (PY).

Limitations of Evaluation:

The results presented here suggest that the directed payment program may have had positive impacts on encounter data quality. Both percentage of denied claims and timeliness of claim submission showed positive improvement. Outpatient physician services also increased substantially during the Bridge Period.

However, we cannot separate changes attributable to the directed payment program from other secular changes, such as technology advancements occurring across the health system, provider supply, or other factors.

Conclusions:

DHCS' examination of the Baseline Period and the Bridge Period encounter data quality and outpatient service utilization for the Prop 56 Physician Services Directed Payment Program indicates the following:

1. The percent of denied encounters that took longer than 30 days to review, correct and resubmit during the Bridge Period decreased to 75 percent of denied encounters, relative to 89 percent for the Baseline period.

2. The percent of denied encounters declined to 7 percent per month in the Bridge Period from to 15 percent during the Baseline period.

3. The percent of encounter files that were submitted within 180 days of the date of service increased to 83 percent relative to 71 percent in the Baseline period.

4. Increased visits for physician services in the Bridge Period compared to the Baseline Period may be partially driven by the payment enhancements.