# PRIVATE HOSPITAL DIRECTED PAYMENTS (SFY 2018-19)
## Section 438.6(c) Preprint

Section 438.6(c) provides States with the flexibility to implement delivery system and provider payment initiatives under MCO, PIHP, or PAHP Medicaid managed care contracts. Section 438.6(c)(1) describes types of payment arrangements that States may use to direct expenditures under the managed care contract – paragraph (c)(1)(i) provides that States may specify in the contract that managed care plans adopt value-based purchasing models for provider reimbursement; paragraph (c)(1)(ii) provides that States have the flexibility to require managed care plan participation in broad-ranging delivery system reform or performance improvement initiatives; and paragraph (c)(1)(iii) provides that States may require certain payment levels for MCOs, PIHPs, and PAHPs to support State practices critical to ensuring timely access to high-quality care.

Under section 438.6(c)(2), contract arrangements that direct the MCO's, PIHP's, or PAHP's expenditures under paragraphs (c)(1)(i) through (iii) must have written approval from CMS prior to implementation and before approval of the corresponding managed care contract(s) and rate certification(s). This preprint implements the prior approval process and must be completed, submitted, and approved by CMS before implementing any of the specific payment arrangements described in section 438.6(c)(1)(i) through (iii).

### Standard Questions for All Payment Arrangements

*In accordance with §438.6(c)(2)(i), the following questions must be completed.*

### DATE AND TIMING INFORMATION:

1. Identify the State's managed care contract rating period for which this payment arrangement will apply (for example, July 1, 2017 through June 30, 2018):

| |
|---|
| Program Year 2: July 1, 2018 through June 30, 2019 |

2. Identify the State's requested start date for this payment arrangement (for example, January 1, 2018):

| |
|---|
| July 1, 2018 |

3. Identify the State's expected duration for this payment arrangement (for example, 1 year, 3 years, or 5 years):

| |
|---|
| Program Year 1 (SFY 2017-18) through Program Year 5 (SFY 2021-22) |

## STATE DIRECTED VALUE-BASED PURCHASING:

*4.* In accordance with §438.6(c)(1)(i) and (ii), the State is requiring the MCO, PIHP, or PAHP to implement value-based purchasing models for provider reimbursement, such as alternative payment models (APMs), pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services; or the State is requiring the MCO, PIHP, or PAHP to participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative. *Check all that apply; if none are checked, proceed to Question 6.*

Not Applicable

☐ Quality Payments / Pay for Performance (Category 2 APM, or similar)
☐ Bundled Payments / Episode-Based Payments (Category 3 APM, or similar )
☐ Population-Based Payments / Accountable Care Organization (ACO) (Category 4 APM, or similar)
☐ Multi-Payer Delivery System Reform
☐ Medicaid-Specific Delivery System Reform
☐ Performance Improvement Initiative
☐ Other Value-Based Purchasing Model

5. Provide a brief summary or description of the required payment arrangement selected above and describe how the payment arrangement intends to recognize value or outcomes over volume of services (the State may also provide an attachment). If "other" was checked above, identify the payment model. If this payment arrangement is designed to be a multi-year effort, describe how this application's payment arrangement fits into the larger multi-year effort. If this is a multi-year effort, identify which year of the effort is addressed in this application.

Not Applicable

## STATE DIRECTED FEE SCHEDULES:

*6.* In accordance with §438.6(c)(1)(iii), the State is requiring the MCO, PIHP, or PAHP to adopt a minimum or maximum fee schedule for network providers that provide a particular service under the contract; or the State is requiring the MCO, PIHP, or PAHP to provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract. *Check all that apply; if none are checked, proceed to Question 10.*

☐ Minimum Fee Schedule
☐ Maximum Fee Schedule
☒ Uniform Dollar or Percentage Increase

7. Use the checkboxes below to identify whether the State is proposing to use §438.6(c)(1)(iii) to establish any of the following fee schedules:

☐ The State is proposing to use an approved State plan fee schedule
☐ The State is proposing to use a Medicare fee schedule
☒ The State is proposing to use an alternative fee schedule established by the State

8. If the State is proposing to use an alternative fee schedule established by the State, provide a brief summary or description of the required fee schedule and describe how the fee schedule was developed, including why the fee schedule is appropriate for network providers that provide a particular service under the contract (the State may also provide an attachment).

The State does not concur with the characterization that this payment arrangement constitutes a fee schedule. Nonetheless, the state is providing an answer to this question based on the assumption that CMS is requiring an answer for question 8 for uniform dollar increments under $438.6(c)(1)(iii)(B).

The directed payment structure will not change the Medi-Cal Managed Care Plans (MCPs) existing base reimbursement amounts for these providers. The directed payment proposal will replace an existing supplemental payment program (California's Hospital Quality Assurance Fee (HQAF) Program/waiver, see CA Welfare & Institutions Code §14169.50, et. seq.)), that has been an integral part of our managed care program since 2010. As proposed, the directed payment proposal will continue to support our hospitals that provide critical services to our Medi-Cal managed care members.

The State will establish two sub-pools from which the total uniform increment payments for each provider class will be made. For PY 2 (SFY 2018-19), the two sub-pools will consist of total amounts for:

1) contracted inpatient services, and
2) select contracted non-inpatient services.

This proposal will direct MCPs to pay uniform dollar amount add-on payments to eligible network "private hospitals" (as the term is defined W&I Code §14169.51(ap)) based on actual network utilization.

A weighted pro rata redistribution of a particular sub-pool (1 or 2) may occur if necessary to fairly distribute a pool over all actual utilization. For example, if the number of inpatient claims/encounters would exhaust the sub pool (1), the state will ensure that all claims in the rate year receive a weighted pro rata portion of the pool, rather than simply paying those claims that occur first in time.

9. If using a maximum fee schedule, use the checkbox below to make the following assurance:

Not Applicable

☐ In accordance with §438.6(c)(1)(iii)(C), the State has determined that the MCO, PIHP, or PAHP has retained the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.

## APPROVAL CRITERIA FOR ALL PAYMENT ARRANGEMENTS:

10. In accordance with §438.6(c)(2)(i)(A), describe in detail how the payment arrangement is based on the utilization and delivery of services for enrollees covered under the contract (the State may also provide an attachment).

MCPs will be directed to pay a uniform dollar amount add-ons payment for every adjudicated claim for the class of network private hospitals identified below in Question 11. Total funding available for these enhanced contracted payments will be limited to a predetermined amount (pool). The pool funding and projected utilization will be assumed in the development of prospective actuarial sound rates.

Upon determination of actual utilization, the State will direct the MCPs to make enhanced payments for contracted services utilized within the class of network private hospitals, via all-plan letter or similar instruction. The State may calculate directed payment amounts based on actual utilization for two distinct periods within PY 2 and direct MCP payments accordingly. Following the issuance of all enhanced payments, the State will notify CMS of the updated actual per-member-per-month (PMPM) increment adjusted for actual utilization.

11. In accordance with §438.6(c)(2)(i)(B), identify the class or classes of providers that will participate in this payment arrangement.

| Class of Hospitals | PY 2 (SFY18-19) Total IP and OP Pool Size |
|---|---|
| 1) Private hospitals as defined in CA W&I Code §14169.51(ap) | $2.33 billion |

12. In accordance with §438.6(c)(2)(i)(B), describe how the payment arrangement directs expenditures equally, using the same terms of performance, for the class or classes of providers (identified above) providing the service under the contract (the State may also provide an attachment).

| Class of Hospitals | Payment Arrangement |
|---|---|
| 1) Private hospitals as defined in CA W&I Code §14169.51(ap) | Uniform Dollar Increments TBD |

## QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS:

13. Use the checkbox below to make the following assurance (and complete the following additional questions):

☒ In accordance with §438.6(c)(2)(i)(C), the State expects this payment arrangement to advance at least one of the goals and objectives in the quality strategy required per §438.340.

a. Hyperlink to State's quality strategy (consistent with §438.340(d), States must post the final quality strategy online beginning July 1, 2018; if a hyperlink is not available, please attach the State's quality strategy):

http://www.dhcs.ca.gov/formsandpubs/Documents/ManagedCareQSR062918.pdf

b. Date of quality strategy (month, year):

July 2018

c. In the table below, identify the goal(s) and objective(s) (including page number references) this payment arrangement is expected to advance:

| **Table 13(c): Payment Arrangement Quality Strategy Goals and Objectives** | | |
|---|---|---|
| **Goal(s)** | **Objective(s)** | **Quality strategy page** |
| Enhance quality, including the patient care experience, in all DHCS programs | Deliver effective, efficient, affordable care | Medi-Cal Managed Care Quality Strategy Report, Page 6 |
| | | |
| | | |
| If additional rows are required, please attach. | | |
| | | |

d. Describe how this payment arrangement is expected to advance the goal(s) and objective(s) identified in Question 13(c). If this is part of a multi-year effort, describe this both in terms of this year's payment arrangement and that of the multi-year payment arrangement.

The State will direct MCPs to make the directed payments to the class of private hospitals, identified in our response to Question 11, based on their utilization of contracted services for network providers. These directed payments are expected to enhance quality, including the patient care experience by ensuring that essential hospital providers in California receive adequate payment to deliver effective, efficient, affordable care, including primary, specialty, and inpatient (both tertiary and quaternary) care. Access to care is the first step in realizing quality, health, and improved outcomes. This program will support the critical goals of promoting access and increasing credibility and accuracy of encounter reporting by the private hospitals, which deliver care to millions of Medi-Cal beneficiaries each year.

The directed payment proposal creates a robust data monitoring and reporting mechanism with strong incentives for quality data—especially, since this proposal links payments to actual reported encounters. This information will enable dependable data-driven analysis, issue spotting and solution design.

14. Use the checkbox below to make the following assurance (and complete the following additional questions):

☒ In accordance with §438.6(c)(2)(i)(D), the State has an evaluation plan which measures the degree to which the payment arrangement advances at least one of the goal(s) and objective(s) in the quality strategy required per §438.340.

a. Describe how and when the State will review progress on the advancement of the State's goal(s) and objective(s) in the quality strategy identified in Question 13(c). If this is any year other than year 1 of a multi-year effort, describe prior year(s) evaluation findings and the payment arrangement's impact on the goal(s) and objective(s) in the State's quality strategy. If the State has an evaluation plan or design for this payment arrangement, or evaluation findings or reports, please attach.

Please see Attachment 1 for additional details.

b. Indicate if the payment arrangement targets all enrollees or a specific subset of enrollees. If the payment arrangement targets a specific population, provide a brief description of the payment arrangement's target population (for example, demographic information such as age and gender; clinical information such as most prevalent health conditions; enrollment size in each of the managed care plans; attribution to each provider; etc.).

California is proposing to implement these enhanced directed payments for certain managed care categories of aid. Subsets of enrollees or categories of aid may be excluded from the enhanced contracted payment arrangement as necessary for actuarial or other reasons.

c. Describe any planned data or measure stratifications (for example, age, race, or ethnicity) that will be used to evaluate the payment arrangement.

| |
|---|
| Not applicable |

d. Provide additional criteria (if any) that will be used to measure the success of the payment arrangement.

| |
|---|
| Not applicable |

**REQUIRED ASSURANCES FOR ALL PAYMENT ARRANGEMENTS:**

15. Use the checkboxes below to make the following assurances:

☒ In accordance with §438.6(c)(2)(i)(E), the payment arrangement does not condition network provider participation on the network provider entering into or adhering to intergovernmental transfer agreements.

☒ In accordance with §438.6(c)(2)(i)(F), the payment arrangement is not renewed automatically.

☒ In accordance with §438.6(c)(2)(i), the State assures that all expenditures for this payment arrangement under this section are developed in accordance with §438.4, the standards specified in §438.5, and generally accepted actuarial principles and practices.

## Additional Questions for Value-Based Payment Arrangements

*In accordance with §438.6(c)(2)(ii), if a checkbox has been marked for Question 4, the following questions must also be completed.*

### APPROVAL CRITERIA FOR VALUE-BASED PAYMENT ARRANGEMENTS:

16. In accordance with §438.6(c)(2)(ii)(A), describe how the payment arrangement makes participation in the value-based purchasing initiative, delivery system reform, or performance improvement initiative available, using the same terms of performance, to the class or classes of providers (identified above) providing services under the contract related to the reform or improvement initiative (the State may also provide an attachment).

| |
|---|
| Not applicable |

### QUALITY CRITERIA AND FRAMEWORK FOR VALUE-BASED PAYMENT ARRANGEMENTS:

17. Use the checkbox below to make the following assurance (and complete the following additional questions):

Not applicable

☐ In accordance with §438.6(c)(2)(ii)(B), the payment arrangement makes use of a common set of performance measures across all of the payers and providers.

a. In the table below, identify the measure(s) that the State will tie to provider performance under this payment arrangement (provider performance measures). To the extent practicable, CMS encourages States to utilize existing validated performance measures to evaluate the payment arrangement.

| **TABLE 17(a): Payment Arrangement Provider Performance Measures** | | | | | |
|---|---|---|---|---|---|
| **Provider Performance Measure Number** | **Measure Name and NQF #** (if applicable) | **Measure Steward/ Developer** (if State-developed measure, list State name) | **State Baseline** (if available) | **VBP Reporting Years*** | **Notes**** |
| 1 | | | | | |
| 2 | | | | | |
| 3 | | | | | |
| 4 | | | | | |
| 5 | | | | | |
| 6 | | | | | |
| If additional rows are required, please attach. | | | | | |

*If this is planned to be a multi-year payment arrangement, indicate which year(s) of the payment arrangement the measure will be collected in.
**If the State will deviate from the measure specification, please describe here. Additionally, if a State-specific measure will be used, please define the numerator and denominator here.

b. Describe the methodology used by the State to set performance targets for each of the provider performance measures identified in Question 17(a).

| |
|---|
| Not applicable |

**REQUIRED ASSURANCES FOR VALUE-BASED PAYMENT ARRANGEMENTS:**

18. Use the checkboxes below to make the following assurances:

Not applicable

☐ In accordance with §438.6(c)(2)(ii)(C), the payment arrangement does not set the amount or frequency of the expenditures.

Not applicable

☐ In accordance with §438.6(c)(2)(ii)(D), the payment arrangement does not allow the State to recoup any unspent funds allocated for these arrangements from the MCO, PIHP, or PAHP.

# ATTACHMENT 1

## California 438.6(c) Proposal C – Uniform Increase for Private Hospital Services
## Private Hospital Directed Payment (PHDP) Evaluation Plan
## Program Year 2: July 1, 2018 – June 30, 2019

### Evaluation Purpose

The purpose of this evaluation is to determine if the proposed directed payments made through the California Department of Health Care Services' (DHCS) Medi-Cal managed care health plans (MCPs) to network provider private hospitals for eligible contract services results in preserving or improving access to and services for all MCP members.

### Stakeholders

- MCPs
- California Hospital Association (CHA)
- California Association of Health Plans (CAHP)
- Local Health Plans of California (LHPC)
- Medi-Cal Managed Care Advisory Group (MCAG)

### Evaluation Questions

This evaluation is designed to answer the following questions:

1. Do higher private hospital payments, via the proposed PY 2 directed payments, serve to maintain or improve the reasonability and timeliness of encounter data reported for MCP members?

2. Do higher private hospital payments, via the proposed PY 2 directed payments, serve to maintain or change utilization patterns for inpatient, outpatient, and emergency services for MCP members?

### Evaluation Design

**Encounter Data:**

The state will conduct encounter data quality assessments focusing on reasonability and timeliness of encounter data. All encounter data quality measures will have a baseline determined from data submitted in state fiscal year (SFY) July 1, 2017 – June 30, 2018. Each subsequent program year will be compared to the baseline to determine if any changes have occurred in the encounter data with the target of maintaining or increasing the baseline during the measurement year. This directed payment program was specifically designed so that payments to DPHs are determined based on actual utilization data as demonstrated from the encounter data submitted received by DHCS from the MCPs. This design has the intended consequence of encouraging increased collaboration among DPHs and MCPs to ensure that the encounter data received by DHCS accurately reflects the actual utilization that has taken place in the given time period. This is extremely likely to result in a substantial increase in encounter reporting for all service categories starting in PY1 and continuing to improve over

time. To that end, the results of any of the evaluation assessments stated below need to be adjusted for the material increase to the volume of encounter data submissions.

- Reasonability:
  - Denied Encounters Turnaround Time – this measure addresses how quickly encounters denied for quality are corrected and resubmitted.

The target is to maintain the baseline (SFY 2017-18) or to demonstrate 50% or more denied encounter turnaround within 60 days, whichever is higher.

  - Denied Encounters as a Percent of Total - this measure reports the percentage of total encounters that are denied for quality each month of submission.

The target is to maintain the baseline (SFY 2017-18) or demonstrate 5% or less denied encounters as a percentage of total, whichever is lower.

- Timeliness:
  - Lagtime - This measure reports the lagtime for submitting encounter data. Lagtime is the time, in days, between the Date of Services and the Submission Date to DHCS.

The target is to maintain the baseline (SFY 2017-18) or demonstrate timeliness in accordance with the lagtime categories below, whichever is higher.

| File type | 0-90 days | 0-180 days | 0-364 days |
|---|---|---|---|
| Professional | 65% | 80% | 95% |
| Institutional | 60% | 80% | 95% |

**Inpatient Utilization:**

Inpatient Admissions per 1000 Member Months: From the MCP encounter data, DHCS staff will calculate the number of MCP Inpatient Admissions per 1000 Member Months. Data for participating plans will be aggregated at a statewide level. An admission consists of a unique combination between member and date of admission to a facility. The first measurement year will be for PY 2 (July 1, 2018-June 30, 2019). The baseline year will be SFY July 1, 2017 – June 30, 2018. DHCS will compare the first measurement year to the baseline year to identify any changes in utilization patterns, with the target of maintaining or decreasing the baseline number of Inpatient Admissions per 1000 Member Months during the measurement year, as adjusted for changes to volume of encounter data submission by MCPs and providers, in response to the design of the directed payment program.

The target is to maintain the baseline (SFY 2017-18) or demonstrate higher utilization as an indicator of improved encounter data completeness.

**Outpatient Utilization:**

Outpatient Visits per 1000 Member Months: From the MCP encounter data, DHCS staff will calculate the number of MCP Outpatient Visits per 1000 Member Months. Data for participating plans will be aggregated at a statewide level. A visits consists of a unique combination between provider, member, and date of service. The first measurement year will be for PY 2 (July 1,

2018-June 30, 2019). The baseline year will be SFY July 1, 2017 – June 30, 2018. DHCS will compare the first measurement year to the baseline year to identify any changes in utilization patterns, with the target of maintaining or increasing the baseline number of Outpatient Visits per 1000 Member Months during the measurement year, as adjusted for changes to volume of encounter data submission by MCPs and providers, in response to the design of the directed payment program.

The target is to maintain the baseline (SFY 2017-18) or demonstrate higher utilization as an indicator of improved encounter data completeness.

**Emergency Room Utilization:**

Emergency Room Visits per 1000 Member Months: From the MCP encounter data, DHCS staff will calculate the number of MCP Emergency Room Visits per 1000 Member Months. Data for participating plans will be aggregated at a statewide level. A visits consists of a unique combination between provider, member, and date of service. The first measurement year will be SFY July 1, 2018-June 30, 2019. The baseline year will be for SFY July 1, 2017 – June 30, 2018. DHCS will compare the first measurement year to the baseline year to identify any changes in utilization patterns, with the target of maintaining or decreasing the baseline number of Emergency Room Visits per 1000 Member Months during the measurement year, as adjusted for changes to volume of encounter data submission by MCPs and providers, in response to the design of the directed payment program.

The target is to maintain the baseline (SFY 2017-18) or demonstrate higher utilization as an indicator of improved encounter data completeness.

**Stratification:**

DHCS will stratify Inpatient Admissions, Outpatient Visits, and Emergency Room Visits per 1000 Member Months by the following categories:

- Gender
- Age
- Ethnicity
- Eligible population groups: Duals[1], Medi-Cal Only Affordable Care Act (ACA)[2], Medi-Cal Only Optional Targeted Low Income Children (OTLIC)[3], Medi-Cal Only Seniors and Persons with Disabilities (SPD)[4], and Medi-Cal Only Other[5]

## Data Collection Methods

[1] Dual population consists of any Medi-Cal eligible member who has active Medicare coverage. Active Medicare coverage means one or more of the following Medicare portions are active: Part A, B, or D. Dual members are not identified by an aid code.
[2] ACA population consists of the following Adult Expansion aid codes: M1, M2, L1, and 7U.
[3] OTLIC population consists of the following OTLIC aid codes: 2P, 2R, 2S, 2T, 2U, 5C, 5D, E2, E5, E6, E7, H1, H2, H3, H4, H5, M5, T0, T1, T2, T3, T4, T5, T6, T7, T8, and T9.
[4] SPD population consists of the following SPD aid codes: 10, 13, 14, 16, 17, 1E, 1H, 20, 23, 24, 26, 27, 2E, 2H, 36, 60, 63, 64, 66, 67, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6R, 6V, 6W, 6X, 6Y, C1, C2, C3, C4, C7, C8, D2, D3, D4, D5, D6, and D7.
[5] The Other population consists of all aid codes not categorized under ACA, OTLIC, or SPD.

All data necessary for encounter data quality measurement will be extracted from DHCS' Post-Adjudicated Claims and Encounters System (PACES) and Management Information System/Decision Support System (MIS/DSS).

To measure the number of Inpatient Admissions, Outpatient Visits, and Emergency Room Visits per 1000 Member Months, DHCS will rely on encounter data submitted by MCPs. DHCS will conduct its analysis on 100% of the data received.

### Timeline

All data necessary for encounter data quality measurement will be extracted after a sufficient lag period post-Program Year. A sufficient lag period should be no less than six.

The encounter data will be pulled no sooner than 6 months after the close of the measurement year to allow for sufficient lag period, with a report being completed within 6 months of the data pull. For PY 2 (July 1, 2018-June 30, 2019), the data will be pulled no sooner than January 1, 2020 and a report produced by June 30, 2020.

### Communication and Reporting

The results will be shared with the stakeholders listed above and a report will be shared with CMS. Annual reports will also be posted on the State's directed payment website.