DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

State Demonstrations Group

July 26, 2017

Ms. Mari Cantwell
Chief Deputy Director
Department of Health Care Services
Director's Office, MS 0000
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Ms. Cantwell:

This letter is to inform you that the Centers for Medicare and Medicaid Services (CMS) has reviewed the proposed evaluation design for Global Payment Program (GPP) authorized under the section 1115(a) demonstration entitled "Medi-Cal 2020" (11-W-00193/9). CMS finds the evaluation design for the GPP program to be in accordance with the special terms and conditions and approve the evaluation for the demonstration, and has no further questions or comments on them at this time.

We look forward to continuing to work with you and your staff on the California Medi-Cal 2020 Demonstration. If you have any questions, please contact your project officer, Mrs. Heather Ross, at either 410-786-3666, or by email at Heather.Ross@cms.hhs.gov.

We appreciate your cooperation throughout the review process.

Sincerely,

/s/

Angela D. Garner
Director
Division of System Reform Demonstrations

Enclosures

cc: Henrietta Sam-Louie, ARA Region IX

Global Payment Program Final Evaluation Design

Purpose

As part of the Medi-Cal 2020 waiver, 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.

Introduction

California's GPP is a new pilot program to support public health care systems (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 Standard Terms and Conditions (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.

Research Question

The two evaluations will examine 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 and a reduction of individuals who are in crisis, 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 have been avoided, and additional investments in infrastructure. The first evaluation will establish a baseline and describe the infrastructure investments the PHCS has made; the second evaluation will determine whether and to what

extent changing the payment methodology resulted in a more patient-centered system of care.

Evaluation Requirements

The STCs require two GPP evaluations. The first evaluation will occur at the midpoint of the GPP program, and the second evaluation is due at the end of program year 4. The evaluations are intended to take a snapshot of early of GPP implementation and assess the impact of the program, including the care provided by the public health care system, the benefits and challenges of this new innovative payment approach, and the potential for broader application for future waivers.

The STCs require the following elements to be included in the GPP evaluations:

- Required for the first and second evaluation:
  - Assess the GPP goals of promoting value, not volume by each individual PHCS:
  - Number of uninsured individuals served
  - Number and type of services provided
  - Expenditures associated with the services provided, both at 100% and 175% uncompensated care cost (UCC) levels
  - Expenditures that were avoided or reduced due to the GPP
  - An assessment of the effects of the GPP on care delivery and costs
  - Individual PHCS self-assessment of the successes and challenges of the GPP
- For the second evaluation only:
  - Examine the extent to which the GPP encouraged or improved:
    - Care in more appropriate settings, to ensure right care in the right place at the right time
    - Changes in resource allocation
    - Improvements in workforce involvement and care team transformation under the demonstration

These elements required in the STCs have been incorporated in the evaluation design as indicators assessing the GPP program's progress related to the evaluation hypotheses.

Data Collection

The first GPP 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 evaluation will also utilize applicable available cost data from PHCS as well as qualitative individual system GPP narratives. For purposes of the evaluations, utilization will be defined in

terms of units of service as described in Table 5, Attachment FF. For many of the components in the first evaluation, PHCS will establish a baseline and describe the infrastructure investments the PHCS has made. The second evaluation will include all data sources from the first evaluation, plus data from GPP encounter reporting that begins in PY2.

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 1 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 establish a baseline in the first evaluation and will provide the necessary service level information to assess trends over time in the second 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.

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 Evaluation Outline II.1.A below. 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 baseline and second evaluation will be compared to assess what change has occurred.

Proposed Evaluation Design

The design will be a pre- and post- evaluation using statistical methods to compare changes in baseline (first evaluation at the mid-point evaluation) and post-GPP (second evaluation) trend in care delivery.

First GPP Evaluation at the Mid-point

I. Evaluating the extent to which PHCS established a strong foundation to improve care to the uninsured

The Global Payment Program (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 first evaluation will establish a baseline 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 Attachment 1 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. The qualitative and quantitative data is to be used to test the following hypotheses:

A. 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?
B. Across the majority of PHCS, did the utilization of non-inpatient, non-emergent services increase compared to baseline?

These hypotheses will be used to answer the research question as to 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 and a reduction of individuals who are in crisis, 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 have been avoided, and additional investments in infrastructure. The first evaluation will set the baseline. The second evaluation will measure the extent to which the GPP programs resulted in a greater shift of services from the inpatient to outpatient setting for the uninsured.

II. Evaluation Elements

1. <u>Demonstrate that public health care systems are putting a strong foundation in place to improve care to the uninsured</u>
    A. This data will be gathered via a qualitative individual PHCS self-assessment narrative that will include the following key elements:
        a. Narrative on what changes each PHCS making to its care delivery systems, including areas such as:
            i. Data collection and tracking
            ii. Inclusion of non-traditional services
            iii. Coordination with other areas of the delivery system (e.g. primary care, mental health, and substance use)
            iv. 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.
            v. Description of efforts underway to improve care in a manner that avoids or reduces costs, including an assessment 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

vi. Assessment, including a description of PHCS efforts to transform care, describing 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

vii. Additional infrastructure that is being put in place, including improvements within the delivery system or efforts to expand services with contracted providers

viii. Overall benefits and challenges of this new payment approach, including care provided by PHCS, patient experience and care delivery transformation

B. Quantitative data will be based on the reported services specified in Table 1 in Attachment FF which is included as an attachment to this design and will be used compare baseline data gathered in the first evaluation with data from subsequent GPP program years to analyze the GPP trends and utilization for each PHCS in the following categories:

- Ambulatory care services from Categories 1, 2 and 3 (excluding behavioral health and emergency services) in Table 1 of Attachment FF (e.g. primary and specialty care, nutrition education, group visits), inpatient from Category 4 in Table 1 of Attachment FF (e.g. trauma, med surg) and emergency services from Category 1C in Table 1 of Attachment FF
- Behavioral health services in Category 1B, 1C and 4A and 4B in Table 1 of Attachment FF (particularly in the non-emergent settings, e.g. mental health and substance use outpatient)

C. Using data sources specified above, the first evaluation will establish a baseline using SFY 2014-15 data and assessing any initial change with subsequent year data. The baseline will determine how GPP resources are being allocated

a. Participating public health care systems use of federal funding

i. Percent of GPP funding earned by program year

b. Cost of GPP services vs GPP funding to establish baseline against which cost avoidance will be measured.

i. Expenditures associated with services provided, both at

100% and 175%

c. 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%
d. The number of uninsured served within physical health, behavioral health, and through contracted providers
e. 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.

Second GPP Evaluation

I. Evaluating the progress that PHCS made improving care to the uninsured

The second evaluation will build on the mid-point evaluation by demonstrating the impact of investments made in each PHCS' to reorganize care delivery toward GPP goals and maximize available GPP funding. To assess progress to date, health care systems will be required to submit quantitative data, via the biannual GPP reports to DHCS, and qualitative data, via a self-assessment description of what activities, and specifically what changes since the mid-year evaluation, PHCS have undertaken in the areas of care teams, data collection, improved care coordination, and the expansion of non-traditional services expanding care delivery. This SFY 2015-16 an SFY 2016-17 data will be compared to the data at baseline (SFY 2014-15 data) to test the following hypotheses:

A. 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?
B. 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?
C. Did the percentage of dollars earned based on non-inpatient, non-emergent services increase across PHCS?

The second evaluation builds upon the first, synthesizing progress and determining the GPP's overall impact. The first evaluation will have established a baseline against which the second evaluation will be measuring progress. The research question will, however, remain the same: whether changing the payment methodology resulted in more cost-effective and higher-value care as measured by: delivering more services at lower level of care as measured by diagnosis codes and a reduction of individuals who are in crisis, 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 have been avoided, and additional investments in infrastructure.

I. Evaluation Elements

1. Demonstrate that public health care systems have improved care to the uninsured

   A. Across all participating GPP health care systems, the second evaluation will compare baseline service level data with subsequent GPP program years to analyze trends in care provided to the uninsured, measuring changes in utilization and number of people served. Specifically, the evaluation will use quantitative data as reported using reports that are standardized in Attachment 1 to assess the following:

   - Trends in traditional services, including how many are served in ambulatory care from Categories 1, 2 and 3 (excluding behavioral health and emergency services) in Attachment 1 (e.g. primary care, specialty care, nutrition education, group visits) inpatient from Category 4 in Attachment 1 (e.g. trauma, med surg) and emergent/urgent care from Category 1C in Attachment 1, mental health and substance use services in Category 1B, 1C and 4A and 4B in Attachment 1 compared to baseline established in the first evaluation
   - Trends in utilization in non-traditional services from Categories 1A, 2, 3 and 4A in Attachment 1, which includes care by other licensed or certified professionals (e.g. nurses, pharmacists) and non-face-to-face visits as compared to the first evaluation.
   - Volume and mix of behavioral health care services in Category 1B, 1C and 4A and 4B in Attachment 1, with a particular focus on outpatient services (e.g. mental health and substance use outpatient)

   The evaluation will also include qualitative data gathered from self-assessments in response to interview questions and which will include:

   - PHCS-self assessment narrative in care coordination activities, to include expanded use of complex care managers, case managers, health educators and health coaches. The categories will result in a description of workforce involvement, including team-based care are qualitative measures that will be defined through emergent themes that will emerge in the first 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 baseline and at second 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.

B. At the individual public health care system level demonstrate improvements in services provided:
   - Compare baseline data with data from subsequent GPP program years to assess changes in the following categories:
     - Number of uninsured patients served
     - Number of types of services provided
     - Rates of types of services provided per number of uninsured patients served

2. <u>The GPP is allocating resources wisely and is more effectively tailoring care to the appropriate settings</u>
   A. Across all participating GPP systems, compare baseline data established in the first report with subsequent GPP years to analyze how GPP resources are being allocated and if care is being provided in more appropriate settings, including the movement from emergency/urgent to ambulatory care.
      - Care in more appropriate settings and resource allocation
        - Assess changes in care to more appropriate settings which could include:
          - 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
          - Changes in the ratio of Emergency Care to Ambulatory Care:
            - Numerator: Number of ER encounters/year
            - Denominator: Number of primary care and specialty care encounters/year
          - 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
    - 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
    - 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
- 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 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

The evaluation will compare the costs that were using the baseline evaluation as a starting point. To do so, it will examine:

- Cost of GPP services vs GPP funding (at the individual level)
    - Expenditures associated with services provided, both at 100% and 175% at baseline and in second evaluation
    - Expenditures avoided or reduced. Trends over time of:

- Volume Acute Care Utilization per uninsured at baseline and at the time of second 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 second evaluation
  - Numerator: Inpatient Mental Health uninsured admissions
  - Denominator: Total # of unduplicated uninsured

▪ 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

3. <u>From a PHCS perspective, provide an assessment of the successes and challenges of the GPP</u>

A. PHCS qualitative self-assessment narrative that describes the changes each system made throughout the program to improve care to the uninsured in their system such as:

- Expansion of non-traditional services and/or expanded use of non-traditional providers
- 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
- Efforts underway to improve 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
- Description of additional infrastructure that has been put in place, including efforts to improve care and quality within the delivery system or with contracted providers
- Assessment of how they allocated GPP funds to address the needs of their patients

B. Overall summary of the major opportunities and challenges provided by the GPP.

4. 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.

4. <u>GPP Evaluation Timeline and Evaluation Selection Criteria</u>

As per the Standard Terms and Conditions, the State of California shall conduct two evaluations of provider expenditures and activities under the GPP methodology. The first evaluation will occur at the midpoint of the demonstration and the second report will occur as part of the interim evaluation report that will be submitted to CMS at the end of GPP's fourth Program Year.

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.

Attachment 1: 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	A	Preventive health, education and	Wellness	NT	15
			Patient support group	NT	15

and care services		patient support services	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-face encounters	Home nursing visit	NT	75
			Paramedic treat and release	NT	75
			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
	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
4: Inpatient	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 community services	Trauma	T	863
			Transplant/burn	T	1,131