



State of California—Health and Human Services Agency  
Department of Health Care Services



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September 19, 2016

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**CALIFORNIA CHILDREN'S SERVICES, DENTAL TRANSFORMATION INITIATIVE,  
GLOBAL PAYMENT PROGRAM, AND SENIORS AND PERSONS WITH  
DISABILITIES DRAFT EVALUATION DESIGNS FOR THE CALIFORNIA MEDI-CAL  
2020 DEMONSTRATION (11-W-00193/9)**

Dear Mr. Fishman, Ms. Rashid, and Ms. Sam-Louie:

Enclosed are the California Children's Services (CCS), Dental Transformation Initiative (DTI), Global Payment Program (GPP), and Seniors and Persons with Disabilities (SPD) Program Draft Evaluation Design Reports for submission per Special Terms and Conditions (STCs) Item 211 of California's Section 1115 Waiver *Medi-Cal 2020 Demonstration* (11-W-00193/9). The State will submit the Final Evaluation Design, per STCs Item 214, within 60 days after necessary revisions are made in response to CMS comments on the reports. The State will provide updates on the programs' evaluation implementation to CMS in each of the quarterly and annual progress reports.

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If you or your staff have any questions or need additional information regarding these reports, please contact Angeli Lee at [Angeli.Lee@dhcs.ca.gov](mailto:Angeli.Lee@dhcs.ca.gov). Thank you!

Sincerely,



Sarah Brooks  
Deputy Director

Enclosures:

CCS Draft Evaluation Design  
DTI Draft Evaluation Design  
GPP Draft Evaluation Design  
SPD Draft Evaluation Design

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**Medi-Cal 2020 Demonstration  
California Children's Services  
Draft Evaluation Design**

**Introduction**

The California Children's Services (CCS) Program provides health care services including diagnostic, treatment, medical case management, and Medical Therapy Program services to children from birth up to 21 years of age with CCS-eligible medical conditions. Examples of CCS-eligible conditions include, but are not limited to, chronic medical conditions such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, hearing loss, and traumatic injuries.

The CCS Program is administered as a partnership between local CCS county programs and the Department of Health Care Services (DHCS). Throughout California, CCS authorizes services for approximately 185,000 children served by a network of CCS-paneled specialty and subspecialty providers, and CCS-approved hospitals and special care centers. Historically, CCS only funds and manages the care of the CCS conditions, and not the primary care or care of non-CCS eligible health conditions, leading to fragmentation of health care.

Under the 1115 Waiver, the State of California will pilot up to two models of care for children enrolled in the CCS program. By testing these models of care, California believes it will be able to create health care delivery systems that respond to the unique needs of regions and populations throughout the state. The pilots will also help inform best practices, through a comprehensive evaluation component, so that at the end of the five-year demonstration period decisions can be made on permanent restructuring of the CCS program design and delivery systems. This draft outlines the evaluation component of the Section 1115 waiver for the CCS Demonstration Projects.

**Goal and Objectives**

The overarching goal of the CCS pilot project is for the State to test two integrated delivery models for the CCS population that results in achieving the desired outcomes related to timely access to care, improved coordination of care, promotion of community-based services, improved satisfaction with care, improved health outcomes and greater cost-effectiveness. The two models of care delivery include a provider-based Accountable Care Organization (ACO) and an existing Medi-Cal Managed Care Plan (MCP).

The objective of the evaluation is to demonstrate the effectiveness of an integrated delivery model for the CCS population by:

1. Ensuring that the CCS population has access to timely and appropriate, high quality and well-coordinated medical and supportive services that are likely to maintain and enhance their health and functioning and meet their developmental needs.

2. Increasing patient and family satisfaction with the delivery of services provided through the CCS program.
3. Increasing satisfaction with both the delivery of and the reimbursement of services.
4. The State's ability to measure and assess those strategies that are most and least effective in improving the cost-effectiveness of delivering high-quality, well-coordinated medical and supportive services to the CCS population.
5. Increasing the use of community-based services as an alternative to inpatient care and emergency room use.
6. Reducing the annual rate of growth of expenditures for the CCS population.

### **Evaluation Design and Methods**

The CCS pilot evaluation design incorporates quantitative and/or qualitative process and/or outcome measures that adequately assess the effectiveness of the demonstration in terms of cost of services and total costs of care, improved health outcomes and system transformation including better care, better quality, and enhanced value, change in delivery of care from inpatient to outpatient, and quality improvement under managed care.

The evaluation will meet the standards of leading academic institutions and academic journals. Data will be reported at the beneficiary, provider, health plan, and statewide levels. Significant attention will be given to ensuring use of the best available data and the cleanliness of it when utilized. When necessary, the data will be adjusted and/or controls will be put into place to maximize the use of it. Should there be data limitations, the data will be modified as needed and only used appropriately so as not to misinterpret it. Any modifications and changes will be reported in the final evaluation report. The final evaluation report will also consider how the findings from the evaluation may or may not be generalized.

The evaluation will compare pre- and post-pilot implementation data whenever possible. Research has shown that it can take up to two years for beneficiaries to become adjusted to a change in delivery system. Therefore, for the two pilot programs, an analysis will be conducted of the experience of CCS children 24 months prior to the pilot and 24 months post implementation of the pilot. Furthermore, the evaluation shall also evaluate the managed care plans or ACO participating in the pilot as compared to the CCS program in selected counties where CCS services are not incorporated into managed care or an ACO.

Because additional data are available for the post- pilot implementation population and only certain assessed requirements exist for the post pilot implementation, additional metrics and data may only be available for the post pilot implementation period of time. All measures will be benchmarked against available state and national standards and benchmarks. For example, NCQA Medicaid benchmarks

for performance will be utilized when possible.

### **Evaluation Measures**

The evaluation shall provide a general beneficiary profile of each model including, age, gender, race and ethnicity, primary language spoken at home and CCS diagnoses. The evaluation shall look at the following enrollment measures:

#### **Measure 1: Percent of newly enrollment**

- Numerator: Number of unique children under age 21 with CCS-eligible medical conditions, deemed newly eligible during the reporting period
- Denominator: All unique children under age 21 with CCS-eligible medical conditions, during the reporting period
- Data will be stratified by source of eligibility referral such as managed care plan, provider, etc. and monitor trends over time
- Baseline value: TBD
- Data Sources: CMSNet Eligibility Data

#### **Measure 2: Average length of enrollment**

- Definition: The average length of time from original enrollment date of program to disenrollment rate
- Data will indicate percent of continuous enrollment
- Baseline value: TBD
- Data Sources: CMSNet Eligibility Data

Furthermore, the evaluation shall measure the following domains: access to care, client satisfaction, provider satisfaction, quality of care, care coordination and total cost of care. Each domain of the evaluation will respond to a fundamental evaluation question and hypotheses.

### **Access to Care**

Evaluation Question: What is the impact of the pilots on children's access to CCS services?

Hypotheses: An integrated delivery system ensures access to timely and appropriate, high quality and well-coordinated medical and supportive services that maintain and enhance the health for the CCS population.

To demonstrate access to timely and appropriate primary, specialty and behavioral health care, DHCS shall measure the following:

1. Percent of children and young adults 12 months–20 years of age who had a visit with a PCP.
2. Referral of a Child to Special Care Center (SCC)
3. Screening for Clinical Depression and Follow-Up Plan

#### **Measure 1: Percent of children and young adults 12 months–20 years of age who had a visit with a PCP**

Access to primary care is important for the health and well-being of children and adolescents.

- Definition: The measure reports on four separate percentages:
  - CCS Children 12–24 months who had a visit with a PCP during the reporting period.
  - CCS Children 25 months–6 years who had a visit with a PCP during the reporting period.
  - CCS Children 7–11 years who had a visit with a PCP during the measure year or the year prior to the reporting period.
  - CCS Adolescents 12–20 years who had a visit with a PCP during the measurement year or the year prior to the reporting period.
- Numerator Number of unique children, within defined age, with CCS-eligible medical conditions who had a visit with a PCP during the reporting period
- Denominator: All unique children within defined age, with CCS-eligible medical conditions, during the reporting period
- Standard: HEDIS<sup>1</sup>
- Evaluation Type: 1) Pre-and-post pilot implementation; and 2) Non-MCP/ACO CCS comparison to MCP/ACO pilot
- Data Sources: FFS claims data and MCP/ACO encounter data

### **Measure 2: Referral of a Child to Special Care Center (SCC)**

CCS has oversight of a system of SCCs that provide comprehensive, coordinated specialty health care to CCS clients with complex, physically handicapping medical conditions. SCCs consist of multi-disciplinary, multi-specialty teams that evaluate the child's/adult's medical condition and develop a comprehensive, family centered plan of health care that facilitates the provision of timely, coordinated treatment.

- Definition: This measure is based on the CCS requirement that certain CCS eligible medical conditions require a referral to a CCS Special Care Center for ongoing coordination of services.
- Numerator: Number of children in CCS, with medical conditions in the categories as listed in Numbered Letter 01-0108 requiring a Special Care Center Authorization, who actually received an authorization for services.
- Denominator: Number of children in CCS, with medical conditions in the categories as listed in Numbered Letter 01-0108 requiring a Special Care Center Authorization.
- Standard/Source of Measure: CCS Performance Measures from the FY 13-14 Plan and Fiscal Guidelines <sup>2</sup>
- Evaluation Type: 1) Pre-and-post pilot implementation; and 2) Non-MCP/ACO CCS comparison to MCP/ACO pilot
- Data Sources: FFS claims/authorization data and MCP/ACO eligibility, authorization and encounter data

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<sup>1</sup> <http://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality/2015-table-of-contents/children-and-adolescents-access#sthash.iHAtdQCX.dpuf>

<sup>2</sup> <http://www.dhcs.ca.gov/formsandpubs/publications/Documents/CMS/PFG/1314/Section03.pdf>

### **Measure 3: Screening for Clinical Depression and Follow-Up Plan**

Depression causes suffering, decreases quality of life, and causes impairment in social and occupational functioning. It is associated with increased health care costs as well as with higher rates of many chronic medical conditions<sup>3</sup>.

- Definition: Screening for Clinical Depression and Follow-Up Plan  
Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.
- Numerator: CCS patients screened for clinical depression on the date of the encounter using an age appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen
- Denominator: Number of unique children aged 12 years and older with CCS-eligible medical conditions
- Standard/ Source of Measure: NQF 0418<sup>4</sup>
- Sampling methodology: As determined by NQF 0418
- Evaluation Type: Non-MCP/ACO CCS comparison to MCP/ACO pilot
- Data Sources: MCP/ACO chart review

### **Client Satisfaction**

Evaluation Question: What is the impact of the pilots on clients' satisfaction?

Hypotheses: An integrated delivery system will improve patient and family satisfaction with the delivery of services provided through the delivery model.

To demonstrate client satisfaction, DHCS shall measure the following:

1. Satisfaction with both primary care and subspecialty care access and quality of services.
2. Grievance and appeals.

### **Measure 1: Surveys of families related to satisfaction with participation CCS Pilot including both primary care and subspecialty care access and quality of services.**

- Definition: CAHPS Health Plan Survey 5.0H Child Version, Children With Chronic Conditions (Commercial and Medicaid)
- Standard/Source of Measure: HEDIS<sup>5</sup>
- Evaluation Type: 1) Non-MCP/ACO CCS comparison to MCP/ACO pilot; and 2) Pre and Post ACO
- Data Source: CAHPS data

### **Measure 2: Grievance and Appeals**

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<sup>3</sup> The World Health Organization (WHO), as seen in Pratt & Brody (2008)

<sup>4</sup> [http://www.aana.com/resources2/quality-reimbursement/Documents/2016\\_PQRS\\_Measure\\_134\\_11\\_17\\_2015.pdf](http://www.aana.com/resources2/quality-reimbursement/Documents/2016_PQRS_Measure_134_11_17_2015.pdf)

<sup>5</sup> <http://www.ncqa.org/hedis-quality-measurement/certified-survey-vendors-auditors-software-vendors/hedis-survey-vendor-certification/cahps-5-0h-survey#sthash.WmiaDmrZ.dpuf>

- Description: Number of ACO or MCP reported grievances and/or appeals for CCS children
  - a. Grievances by age and gender
  - b. Grievances by ethnicity
  - c. Grievances by type
  - d. Grievances by resolution
  - e. Appeals by age and gender
  - f. Appeals by ethnicity
  - g. Appeals by type
  - h. Appeals by resolution
- Standard/Source of Measure: Medi-Cal Managed Care Quality Dashboard
- Evaluation Type: MCP/ACO pilot, no comparison group identified due to non-comparable data prior to pilot or in non- MCP/ACO CCS cohort
- Data Sources: ACO or MCP grievance and appeals data

**Provider Satisfaction**

Evaluation Question: What is the impact of the pilots on providers' satisfaction with the delivery of and the reimbursement of services?

Hypotheses: An integrated delivery system will improve provider satisfaction with both the delivery of and the reimbursement of services.

To demonstrate provider satisfaction, DHCS shall measure physician, hospital/clinic, in-home pharmacy and DME providers for satisfaction, including changes in reimbursement.

**Measure 1: Surveys of physicians, hospitals/clinics, in-home pharmacy and DME providers for satisfaction, including changes in reimbursement under the CCS Pilot.**

- Description: ACO or MCP provider satisfaction survey
- Standard/Source of Measure: N/A
- Sampling methodology: Sample size shall vary based on provider network
- Evaluation Type: 1) Non-MCP/ACO CCS comparison to MCP/ACO pilot; and 2) Pre and Post ACO
- Data Sources: CCS, ACO or MCP satisfaction survey data

**Quality of Care**

Evaluation Question: What is the impact of the pilots on the quality of care?

Hypotheses: An integrated delivery system is a cost-effective means of delivering high-quality, well-coordinated medical and supportive services to the CCS population.

To demonstrate quality of care, DHCS shall measure the following:

1. Childhood immunizations
2. Subspecialty care for Diabetes - HbA1c Testing
3. Lung Function for Cystic Fibrosis patients



### **Measure 1: Childhood Immunization Status**

Childhood vaccines protect children from a number of serious and potentially life-threatening diseases such as diphtheria, measles, meningitis, polio, tetanus and whooping cough, at a time in their lives when they are most vulnerable to disease. Approximately 300 children in the United States die each year from vaccine-preventable diseases.<sup>6</sup>

- Description: The percentage of children 2 years of age who had appropriate childhood immunizations.
- Numerator: The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. This measure calculates a rate for each vaccine and nine separate combination rates.
- Denominator: Number of unique children 2 years of age with CCS-eligible medical condition(s)
- Standard/Source of Measure: HEDIS
- Evaluation Type: 1) Pre-and-post pilot implementation; and 2) Non-MCP/ACO CCS comparison to MCP/ACO pilot
- Data Sources: FFS claims data and MCP/ACO encounter data

### **Measure 2: Subspecialty care for Diabetes - HbA1c Testing**

Blood sugar control is critical to reducing the development and progression of diabetes microvascular complications. Studies have shown that reducing A1c levels by just 1% can reduce the risk of developing eye, kidney, and nerve disease by 40%.<sup>7</sup>

- Description: Percentage of patients with type 1 or type 2 diabetes mellitus who had a most recent hemoglobin A1c (HbA1c) greater than 9 percent
- Numerator: Number of patients from the denominator whose most recent hemoglobin A1c level during the measurement year is greater than 9 percent
- Denominator: Number of unique children under age 21 with CCS-eligible medical conditions with a diagnosis of type 1 or type 2 diabetes mellitus during the measurement year
- Standard/Source of Measure: NCQA / NQF/ PQRI/ PCPI<sup>8</sup>
- Evaluation Type: Non-MCP/ACO CCS comparison to MCP/ACO pilot
- Data Sources: MCP/ACO encounter data and chart review

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<sup>6</sup> <http://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality/2015-table-of-contents/childhood-immunization-status>

<sup>7</sup> National Institute of Diabetes and Digestive and Kidney Diseases. National diabetes statistics. Available at: <http://diabetes.niddk.nih.gov/dm/pubs/statistics/index.htm>. Accessed March 14, 2005. - See more at: <http://www.ncqa.org/publications-products/other-products/quality-profiles/focus-on-diabetes/what-is-the-current-state-of-quality-of-care#sthash.GsTyVudl.dpuf>

<sup>8</sup> <http://www.ncqa.org/publications-products/other-products/quality-profiles/focus-on-diabetes/what-is-the-current-state-of-quality-of-care>

### **Measure 3: Lung Function for Cystic Fibrosis patients**

Forced Expiratory Volume or FEV<sub>1</sub>, measures one's capacity to breathe and access oxygen normally. Healthy people will have a FEV<sub>1</sub> range from 85 percent to 115 percent. Children with cystic fibrosis on average lose about 2 percent to 4 percent of their lung function each year, making it important to continuously monitor lung function and seek ways to improve this outcome<sup>9</sup>.

- Description: Percentage of patients with cystic fibrosis who had a recent FEV<sub>1</sub> greater than the national average lung function for Cystic Fibrosis patients.
- Numerator: Number of unique children with diagnoses with cystic fibrosis, with CCS-eligible medical conditions, who had a recent FEV<sub>1</sub> equal to or greater than the national benchmark for FEV<sub>1</sub> in cystic fibrosis children
- Denominator: Total number of unique children with diagnoses with cystic fibrosis, with CCS-eligible medical conditions, during the reporting period
- Standard/Source of Measure: Cystic Fibrosis Foundation<sup>10</sup>
- Evaluation Type: 1) Pre-and-post pilot implementation; and 2) Non-MCP/ACO CCS comparison to MCP/ACO pilot
- Data Sources: FFS claims data and MCP/ACO encounter data

### **Care Coordination**

Evaluation Question: What is the impact of the pilots on care coordination?

Hypotheses: An integrated delivery system increased the use of community-based services as an alternative to inpatient care and emergency room use.

To demonstrate care coordination, DHCS shall measure the following:

1. Family Experiences with Care Coordination (FECC)
2. Utilization of ER, IP, OP, Pharmacy and Mild/Moderate Mental Health Services

### **Measure 1: Family Experiences with Care Coordination (FECC) Survey**

Comprehensive, well-coordinated care has shown to improve patient and family experiences of care and patient medical outcomes. Care coordination interventions for medically complex children have also been associated with decreased unmet specialty care needs, decreased hospitalizations, and lower costs. Improving care coordination for children with medical complexity is likely to improve many aspects of care received by these children and families.<sup>11</sup>

- Definition: FECC Survey
- Numerator: The FECC Survey is composed of 10<sup>12</sup> separate and independent quality indicators related to care coordination for children with medical complexity. Each indicator's numerator is determined by caregiver

<sup>9</sup> <https://www.cincinnatichildrens.org/service/c/cystic-fibrosis/quality>

<sup>10</sup> [https://www.cff.org/2013\\_CFF\\_Annual\\_Data\\_Report\\_to\\_the\\_Center\\_Directors.pdf](https://www.cff.org/2013_CFF_Annual_Data_Report_to_the_Center_Directors.pdf)

<sup>11</sup> [http://www.ahrq.gov/sites/default/files/wysiwyg/policymakers/chipra/factsheets/chipra\\_15-p002-ef.pdf](http://www.ahrq.gov/sites/default/files/wysiwyg/policymakers/chipra/factsheets/chipra_15-p002-ef.pdf)

<sup>12</sup> file:///C:/Users/jcooper/Downloads/pediatric\_measure\_worksheets.pdf

response to specific questions, as described in the detailed measure specifications.

- Denominator: All unique children, with CCS-eligible medical condition
- Standard/Source of Measure: Center of Excellence on Quality of Care Measures for Children with Complex Needs (COE4CCN)
- Sampling methodology: Based on COE4CCN specifications
- Evaluation Type: 1) Non-MCP/ACO CCS comparison to MCP/ACO pilot; and 2) Pre and Post ACO
- Data Sources: CCS, ACO or MCP FECC survey data

## **Measure 2: Utilization of ER, IP, OP, Pharmacy and Mild/Moderate Mental Health Services for CCS children**

- ER Visits per 1,000 Member Months
- ER Visits with an IP Admission per 1,000 Member Months
- IP Admission per 1,000 Member Months
- OP Visits per 1,000 Member Months
- Prescriptions per 1,000 Member Months
- Mild to Moderate Mental Health Visits per 1,000 Member Months
- Description
  - **Emergency Room (ER) Visits:** This measure captures the number of ER visits per month. A visit consists of a provider, member and date of service. This measure is displayed per 1,000 member months.
  - **Emergency Room (ER) Visits with an Inpatient (IP) Admission:** This measure captures the number of ER visits that resulted in an inpatient admission per month. An admission consists of a member and date of admission to a facility. This measure is displayed per 1,000 member months.
  - **Inpatient (IP) Admissions:** This measure captures the number of Inpatient Admissions per month. An admission consists of a member and date of admission to a facility. This measure is displayed per 1,000 member months.
  - **Outpatient (OP) Visits:** This measure captures the number of OP visits per month. A visit consists of a provider, member and date of service. This measure is displayed per 1,000 member months.
  - **Prescriptions:** This measure captures the number of prescriptions per month. A prescription consists of a National Drug Code, member, and date of service. This measure is displayed per 1,000 member months.
  - **Mild to Moderate Mental Health Visits:** This measure captures the number of visits per month related to selected Psychotherapy Services and Diagnostic Evaluations. The selected procedure codes aim to capture mild to moderate mental health visits. A visit consists of a provider, member and date of service. This measure is displayed per 1,000 member months.
- Standard: Medi-Cal Managed Care Performance Dashboard Indicators

- Evaluation Type: 1) Pre-and-post pilot implementation; and 2) Non-MCP/ACO CCS comparison to MCP/ACO pilot
- Data Sources: FFS claims data and MCP/ACO encounter data

### **Total Cost of Care**

Evaluation Question: What is the impact of the pilots on amounts expended on CCS services, and the total cost of care?

Hypotheses: An integrated delivery system reduces the annual rate of growth of expenditures for the CCS population.

### **Measure 1: Total cost of care**

- Description: This measure is used to assess the total cost of care for children, with CCS-eligible medical conditions. The total cost of care includes all costs associated with treating members including professional, facility inpatient and outpatient, pharmacy, lab, radiology, ancillary and behavioral health services. DHCS would work with the independent evaluator on the most appropriate total cost of care measure based on the data available through Medi-Cal, CCS and the pilots.
- Potential Standard/Source of Measure: AHRQ<sup>13</sup> or IHA<sup>14</sup>
- Evaluation Type: 1) Pre-and-post pilot implementation; and 2) Non-MCP/ACO CCS comparison to MCP/ACO pilot
- Data Sources: FFS claims data and MCP/ACO encounter data; for (including professional, facility inpatient and outpatient, pharmacy, lab, radiology, ancillary and behavioral health services); the evaluation shall not include supplemental payments
- Considerations: If either demonstration pilot are paying capitation for this population, DHCS would either need to find a similar total cost of care measure or require that the MCP/ACO provide claims data to complete evaluation

### **Evaluator Selection**

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 CCS Demonstration Projects. The State will contract with an entity that does not have a direct relationship to the State of California, Department of Health Care Services (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 conducting the CCS Demonstration Projects evaluation. 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.

<sup>13</sup> <https://www.qualitymeasures.ahrq.gov/summaries/summary/38363/Cost-of-care-total-cost-of-care-populationbased-per-member-per-month-PMPM-index>

<sup>14</sup> [http://www.iha.org/sites/default/files/resources/my\\_2016\\_value\\_based\\_p4p\\_manual.pdf](http://www.iha.org/sites/default/files/resources/my_2016_value_based_p4p_manual.pdf)

### **Evaluation Timeline**

California shall submit the draft Evaluation Plan for the CCS Demonstration Pilot on September 19, 2016. CMS shall provide comments on the draft design and the draft evaluation strategy within 60 days of receipt, and California shall submit a final design within 60 days of receipt of CMS' comments. The state must implement the evaluation design, and describe progress relating to the evaluation design in each of the quarterly and annual progress reports.

The draft Evaluation Plan will be posted on the DHCS webpage for stakeholder review and comment upon submission to CMS. The final design will include a summary of stakeholder comments and questions and a description of any changes made to the final design based upon stakeholder input.

# **Medi-Cal 2020 Waiver Evaluation**

## **DRAFT Evaluation Plan for the Dental Transformation Initiative**

### **I. Introduction**

Within the Medi-Cal 2020 Waiver, the Dental Transformation Initiative (DTI) represents a critical strategy to improve dental health for eligible Medi-Cal children by focusing on high-value care, improved access, and utilization of performance measures to drive delivery system reform. More specifically, this initiative aims to increase the use of preventive dental services for children, prevent and treat more early childhood caries, and increase continuity of care for children. Given the importance of oral health to the overall health of an individual, California views improvements in dental care as critical to achieving better health outcomes overall for Medi-Cal children.

The DTI covers 4 areas or Domains:

#### Domain 1

This domain aims to increase statewide the number of Medi-Cal children ages 1 through 20 that receive preventive dental services by at least 10 percentage points over a five-year period.

#### Domain 2

Under this domain, dental providers in selected pilot counties will be eligible to receive incentive payments for performing pre-defined caries risk assessments (CRAs), develop treatment plans, provide nutritional and motivational counseling for Medi-Cal children ages 6 and under based upon the child's risk. This domain seeks to prevent and mitigate oral disease through the delivery of preventive services in lieu of more invasive and costly procedures (restorative services).

#### Domain 3

This domain seeks to make available incentive payments to dental service office locations in select pilot counties who have maintained continuity of care through providing recall examinations to their enrolled Medi-Cal children ages 20 and under. This domain seeks to increase continuity of care for the targeted population over 2, 3, 4, 5, and 6 continuous year periods.

#### Domain 4

Local Dental Pilot Projects (LDPPs) will address the above-described domains through pilot programs aimed at increasing preventive services, CRAs and disease management and continuity of care. The Department of Health Care Services (DHCS) will solicit proposals and shall review, approve, and make payments to LDPPs in accordance with the requirements stipulated in the Medi-Cal 2020 Waiver. There is the potential to fund up to 15 LDPPs.

# **Medi-Cal 2020 Waiver Evaluation**

## **DRAFT Evaluation Plan for the Dental Transformation Initiative**

### **II. Goals and Objectives**

The primary goals of the DTI are to improve dental health for eligible Medi-Cal children by focusing on high-value care, improved access, and utilization of performance measures to drive delivery system reform. More specifically, this initiative aims to increase the use of preventive dental services, prevent and treat more early childhood caries, and increase continuity of care for children. The evaluation will examine each of these goals.

The aim of the evaluation is to determine the causal impacts of the DTI Demonstration on how incentive payments influence:

- Increased statewide numbers of Medi-Cal children ages 1 through 20 that receive preventive dental services by at least 10 percentage points over a five-year period;
- Diagnoses of early childhood caries for targeted children 6 and under by utilizing a predefined CRA tool and treatment planning for managing this condition as a chronic disease based on the beneficiary's risk assessment in lieu of more invasive and costly procedures and restorative treatment; and Improved continuity of care for targeted children under the age of 21 through regular examinations with their established dental provider.

### **A. Hypotheses**

Evaluation hypotheses are as follows:

1. Provider incentive payments are an effective method to encourage dental service office locations to provide preventive dental services to targeted Medi-Cal children.
2. Provider incentive payments are an effective method for increasing Medi-Cal provider participation, which could improve access to care for children.
3. Provider incentive payments are effective in encouraging providers to perform CRA for the targeted population and ensure completion of appropriate treatment modalities for the management of early childhood caries.
4. Utilization of emergency room visits for dental issues among the targeted populations will decline.
5. Utilization and expenditures for dental related general anesthesia for targeted populations will decline.
6. Incentive payments are an effective method of promoting continuity of care for targeted children.
7. The provider incentive payments for preventive services and continuity of care provide a more favorable cost benefit ratio than that of CRA.

### **B. Design**

Determination of the best approach to evaluate the causal effects of the DTI demonstration is challenging. When considering alternative evaluation designs, the implementation of some DTI Domains in select counties versus statewide, uncertainty regarding participation of dental providers and yet to be determined as LDPP awardees must be taken into account. All dental providers in a select county and/or LDPPs may

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not be ready to participate in the Domains immediately. It is likely that Domain implementation will not be tightly tied to stated implementation dates. As a result, the start dates used in data collection or analyses will in some instances be based on an individual dental provider's implementation start dates, rather than California's stated implementation dates.

The proposed evaluation will use an interrupted time series design that, under a multiple baseline design, allows implementation of the respective Domains at multiple points staggered over time with a hypothetical outcome of measurement of treatment access or quality of care. Changes in outcomes following Domain implementation, coupled with the absence of changes in other counties that were not selected for the Domain may suggest that the change observed resulted from the implementation of the demonstration. A multiple baseline design can be used to study the changes created by the demonstration.

To determine whether incentive payments have been effective in meeting the goals of the DTI demonstration, the evaluation will examine the availability of services along the full continuum of dental care, dental services provided to eligible Medi-Cal children and target populations, performance metrics for each of the Domains and any health care cost offsets resulting from appropriate use of dental services using a logic model.

To determine the cost benefits of the DTI, a cost-benefit analysis of the DTI and each of the Domains, as well as any health care cost offset resulting from the appropriate use of dental services will be conducted.

### **III. Methodology**

The proposed methods can be divided into three broad areas: Access, Quality, and Cost. The measures proposed for each of the areas are described below. The data sources included in this section are described in greater detail in the Data section that follows.

#### **A. Access Measures**

Hypotheses:

1. Provider incentive payments are an effective method to encourage dental service office locations to provide preventive dental services to targeted Medi-Cal children. Progress will be measured across all Domains by conducting a comparative analysis of the before and after utilization measures. This will entail the measurement of provider participation figures for actual number of providers, as well as number of claims received in the fee for service and managed care delivery systems. Utilization will also be measured by age stratifications consistent with CMS 416 methodology to gauge the extent of success within each Domain. Comparative analysis for proximate counties prior to the demonstration with similar population and/or utilization that were not selected for participation will be conducted and as provided in Appendix 1, Evaluation Methodology Models.



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2. Provider incentive payments are an effective method for increasing Medi-Cal provider participation, which could improve access to care for children. Progress will be measured across all Domains by conducting a comparative analysis of the before and after utilization measures. This will entail the measurement of provider participation figures for actual number of providers, as well as number of claims received in the fee for service and managed care delivery systems. Utilization will also be measured by age stratifications consistent with the CMS 416 methodology to gauge the extent of success within each Domain. Comparative analysis for proximate counties prior to the demonstration with similar population and/or utilization that were not selected for participation will be conducted and as provided in Appendix 1, Evaluation Methodology Models.
3. Provider incentive payments are effective in encouraging providers to perform CRA for the targeted population and ensure completion of appropriate treatment for the management of early childhood caries. Progress will be measured by conducting a comparative analysis by distinguishing the CDTs that are utilized within this Domain and assessing whether the risk level associated with the child also affects the provider's ability to complete the CRA treatment plan and assessments. As CRA is not a covered benefit statewide, there are specific challenges imposed in this Domain as there is not a control county in which to compare. Rather, a study of the progress through all counties will be conducted. Stratifications again consistent with the CMS 416 methodology will be utilized as provided in Appendix 1, Evaluation Methodology Models.
4. Utilization of emergency room visits for dental issues among the targeted children will decline. Utilization of emergency room visits will be measured across all of the pilot counties for Domain 2 and compared against similarly situated and in close geographic proximity to assess if the number of emergency room visits declines. Further analysis will also be performed to trend if counties in which there is a higher rate of completion of appropriate treatment for the management of childhood caries affects the ratio or restorative to preventive services as well as has a residual effect resulting in the decline of emergency room services. Comparative analysis Statewide will be conducted and as provided in Appendix 1, Evaluation Methodology Models.
5. Utilization and expenditures for dental related general anesthesia for target children will decline. Utilization of general anesthesia will be measured across all of the pilot counties for Domain 2 and compared against similarly situated and in close geographic proximity to assess if the number of general anesthesia declines. Further analysis will also be performed to trend if counties in which there is a higher rate of completion of appropriate treatment for the management of childhood caries affects the ratio or restorative to preventive services and if there is a residual effect resulting in the decline of emergency room services.

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Comparative analysis Statewide will be conducted and as provided in Appendix 1, Evaluation Methodology Models.

6. Provider incentive payments are an effective method of promoting continuity of care for targeted children. Progress will be measured across all Domains by conducting a comparative analysis of the before and after percentage measures in a year by year comparison for continuity of care. This will entail the measurement of total number beneficiaries in comparison to the number of beneficiaries that continued to see the same provider on an annual basis. Utilization will also be measured by age stratifications consistent with the CMS 416 methodology to gauge the extent of success within this Domain. Comparative analysis for proximate counties prior to the demonstration with similar population and/or utilization that were not selected for participation will be conducted. Comparative analysis for proximate counties prior to the demonstration with similar population and/or utilization that were not selected for participation will be conducted and as provided in Appendix 1, Evaluation Methodology Models.
7. Promising practices will be identified with the implementation of CRA and disease management and LDPPs. Comparative analysis for proximate counties prior to the demonstration with similar population and/or utilization that were not selected for participation will be conducted and as provided in Appendix 1, Evaluation Methodology Models.

Access will be evaluated using the following measures:

- Provider enrollment, beneficiary eligibility, encounter data, and claims data will be used to evaluate access to preventive services, continuity of care, emergency services, general anesthesia utilization, and provider enrollment for periods prior to the implementation of the demonstration pilots and subsequent to implementation of the pilots.
- Claims data will be analyzed to examine changes in access and whether the frequency of preventive services, CRA and treatment, and continuity of care have increased, remained the same, or decreased for the target populations. Claims data will be examined to determine changes in utilization of emergency room visits for dental services and utilization for dental related general anesthesia utilization to determine whether emergency room visits for dental services or utilization of dental related general anesthesia have declined, remained the same, or increased for the target populations.
- Medi-Cal beneficiary and dental provider surveys regarding access to care will be used to measure perceptions of access to care.

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**B. Quality Measures**

Hypotheses:

1. Promising practices will be identified with the implementation of CRA and disease management and LDPPs. Progress will be measured by conducting a comparative analysis by distinguishing the CDTs that are utilized within this Domain and assessing whether the risk level associated with the child also affects the provider's ability to complete the CRA treatment plan and assessments and assessing if the increased number of CRAs has a correlation to the improvement of care by decreasing the number of childhood caries within the targeted population.

Quality will be evaluated using the following measures:

- Provider enrollment, beneficiary eligibility and claims data will be used to evaluate preventive services, continuity of care, emergency services, general anesthesia, and provider enrollment for periods prior to the implementation of the demonstration project and subsequent to implementation of the pilots.
- Medi-Cal beneficiary and dental provider surveys will be used to measure perceptions of quality of care.
- Grievance reports and provider audits will be leveraged to track the type of concerns received by beneficiaries and providers.

**C. Cost Measures**

Hypotheses:

1. Utilization of emergency room visits for dental issues among the targeted children will decline.
2. Utilization and expenditures for dental related general anesthesia utilization for target children will decline.
3. The provider incentive payments for preventive services and continuity of care provide a more favorable cost benefit ratio than that of CRA.

Costs will be evaluated using Medi-Cal claims data and the actual dollar amounts paid for dental services and DTI incentive payments for calendar time periods pre and post implementation on a quarterly basis. The following measures will be examined:

- Change in overall average costs for Medi-Cal children who receive preventive services, CRA and disease management, and/or continuity of care.
- Change in emergency room utilization for dental services to assess if there is a decrease in the cost of emergency room utilization based on increased utilization of preventive care services.
- Change in utilization and expenditures for dental related general anesthesia utilization.

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- Change in preventive services utilization and costs.
- Differences in costs among Medi-Cal children that received DTI services and beneficiaries that did not, analyzed to the extent possible by geographic location, delivery system, and type of service.

#### **IV. Data Sources**

##### **A. Administrative Data Sources**

1. Medi-Cal Eligibility Data System (MEDS): MEDS contains data on all Medi-Cal beneficiaries statewide, including demographic information and residential addresses.
2. Medi-Cal Claims and Encounter Data (DHCS data warehouse): The DHCS data warehouse, known as the Medi-Cal Management Information System/Decision Support System (MIS/DSS) contains data for Medicaid claims, which provides identifying information on Medi-Cal eligible beneficiaries that can be linked to other datasets.
3. Medi-Cal Provider Master File (PMF): The PMF contains data for enrolled Medi-Cal dental providers and safety net clinic providers, including service office locations, pay-to addresses and delivery system details.
4. Surveillance Utilization Review System (SURS): Suspicious claim activity is tracked through SURS to prevent fraud, waste, and abuse.

In addition to the above datasets, data from any other dataset that may become available during the evaluation will be assessed to determine whether the data would add substantially to the planned analyses. If so, these datasets will be incorporated into the evaluation to the extent possible.

##### **B. New Data Collection Activities**

1. Stakeholder Surveys: Stakeholder surveys will address multiple needs. For example, Medi-Cal beneficiary and dental provider surveys may include questions on access to care, quality of care, and/or whether provider incentive payments are an effective method to encourage service office locations to provide preventive dental services and continuity of care to more Medi-Cal children or enroll as a Medi-Cal dental provider.
2. Chart Review: Beneficiary dental records at dental provider service office locations may be reviewed to inform evaluation activities.
3. Document Review: The evaluation may consider other relevant data points such as enrollment data, provider audits or grievance reports, in order to inform evaluation activities. These activities will complement but not duplicate planned review processes, which are intended to ensure that baseline requirements from the STCs are met.

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## **V. Analysis Plan**

### **A. Statistical Data Analysis**

Administrative data and survey data will be collected and analyzed across the State and different Domains, pre-implementation and throughout the demonstration years to account for implementation periods and comparisons among participating and non-participating Medi-Cal dental providers. A variety of models may be used to analyze DTI statistical data. These analyses will be used to assist DHCS in answering the stated research questions.

For annual longitudinal quantitative data, a generalized linear model will be used to identify changes over time. These mixed effects models are similar to a multivariate regression model. Mixed effects regression models can account for the correlation seen between years within the same county. For example, one county may implement a Domain quicker than another county, which will influence the next year's measurement within that county. Generalized linear models are helpful in accounting for differences at a county level, such as multiple delivery systems while other counties may not have these. An analogous set of analyses can be conducted using a logistic mixed model to account for binary outcomes over time.

Where data is sufficient, a multiple baseline approach may be applied to account for different implementation periods and comparisons among two county types, for example, looking at data pre-implementation, partial implementation when some counties have implemented a Domain and some have not, and post-implementation, using a separate mixed effects model for each piece of the data.

Multivariate regression models using indicator variables for opt-in status (e.g. Domain 2) along with other possible confounding factors may be used to control for differences based on characteristics such as Medi-Cal enrollment, age, or race. It is also possible to test for interactions between confounding variables and opt-in status and when looking at binary outcomes, it is possible to account for differences using logistic regression.

Data may be insufficient for the analyses models described. In these cases, repeated measure methods may be used to compare baseline to any specific later observation or composite of later observations.

For surveys of beneficiaries or dental providers, statistical significance is a consideration since surveys will be conducted on sample sizes. The number of surveys may be adjusted up or down based on resource availability and the numbers of beneficiaries or providers participating in a Domain will be critical to the ability to detect an effective size in estimating the pre-and-post change of a continuous outcome.

### **B. Qualitative Analysis**

Data collected will be analyzed separately as well as across the Domains and different groups, by implementation and over time to identify themes and patterns. Detailed

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information will provide an understanding of experiences, which will be used to supplement and expand on the data sets to answer the research questions.

The evaluation work will be inclusive of results from both qualitative and quantitative data sets, consider how they contribute to answering the research questions in the relevant Domains, and examine whether and where the results from the data sets converge, complement one another, and/or expand on another.

## **VI. Evaluation Implementation**

### **A. Independent Evaluation**

California will use a procurement process to identify applicants and contract with a qualified independent entity to perform the DTI evaluation and to ensure no conflict of interest.

### **B. Evaluation Timeline**

California shall submit the draft Evaluation Plan for the DTI on September 19, 2016. CMS shall provide comments on the draft design and the draft evaluation strategy within 60 days of receipt, and California shall submit a final design within 60 days of receipt of CMS' comments. The state must implement the evaluation design, and describe progress relating to the evaluation design in each of the quarterly and annual progress reports.

The draft Evaluation Plan will be posted on the DHCS DTI webpage for stakeholder review and comment upon submission to CMS. A webinar will be scheduled to review the draft with stakeholders and respond to questions. Stakeholders will also be able to submit comments and questions regarding the draft via the DTI email box. The final design will include a summary of stakeholder comments and questions and a description of any changes made to the final design based upon stakeholder input.

Consistent with 42 CFR 431.424(d), the state must submit to CMS an interim evaluation report in conjunction with its request to extend the demonstration, or any portion thereof. California must submit to CMS a draft of the evaluation final report by December 31, 2021.

Appendix 1: Evaluation Methodology Models

Evaluation Hypothesis	Domain	Type of Measure	Measure Steward	Eligibility Measure	Delivery System	County Comparative Analysis Methodology	Past Performance Measure	Age Stratifications	Baseline Figures	Numerator	Denominator
1. Provider incentive payments are an effective method to encourage dental service office locations to provide preventive dental services to targeted Medi-Cal children.	Overview	Access									
1.1 Domain 1 -Beneficiary Utilization	1	Access	DHCS	90 Day Continuous	Comparative analysis of DMC, SNC, and FFS models.	Comparative analysis of counties Statewide	Yes	<1, 1-2, 3-5, 6-9, 10-14, 15-18, 19-20	CY 2014 Baseline using the same numerator and denominator methodology.	Number of unduplicated beneficiaries ages one (1) through twenty (20) enrolled in Medi-Cal for at least ninety (90) continuous days who received any Medi-Cal covered preventive dental service in the measurement period	Number of all unduplicated children ages one (1) through twenty (20) enrolled in Medi-Cal for at least ninety (90) continuous days during the measurement period
1.2 Domain 2 -Beneficiary Utilization	2	Access	DHCS	90 Day Continuous	Comparative analysis of DMC, SNC, and FFS models.	Comparative analysis of counties with similar population and provider participation history, utilization of preventive services to restorative services, and geographic proximity.	Yes	<1, 1-2, 3-4, 5-6	CY 2014 Baseline using the same numerator and denominator methodology.	Number of unduplicated beneficiaries who received any restorative service and a separate measure of a restorative service in the measurement period	Total county population of unduplicated beneficiaries within the provided age range.
1.2 Domain 2 -Beneficiary Utilization w/CRA	2	Access	DHCS	90 Day Continuous	Comparative analysis of DMC, SNC, and FFS models.	Comparative analysis of counties with similar population and provider participation history, utilization of preventive services to restorative services, and geographic proximity.	Yes	<1, 1-2, 3-4, 5-6	CY 2014 Baseline using the same numerator and denominator methodology.	Number of unduplicated beneficiaries who received any restorative service in the measurement period and additional services provided in Domain 2.	Total county population of unduplicated beneficiaries within the provided age range.
1.3 Domain 3 -Beneficiary Utilization	3	Access	DHCS	90 Day Continuous	Comparative analysis of FFS and SNC models.	Comparative analysis of counties with similar population and provider participation history, utilization of preventive services to restorative services, and geographic proximity.	Yes	1-2, 3-5, 6-9, 10-14, 15-18, 19-20	CY 2015 Baseline using the same numerator and denominator methodology.	Claims data to determine the number of unduplicated beneficiaries who received services by the same provider for two, three, four, five, and six continuous year periods.	Total county population of unduplicated beneficiaries within the provided age range.
1.4 Domain 4	4	Access	TBD	90 Day Continuous	Subject to selection	Comparative analysis of counties with similar population and provider participation history, utilization of preventive services to restorative services, and geographic proximity.	Potentially	<1, 1-2, 3-5, 6-9, 10-14, 15-18, 19-20	Subject to selection	Dependant on the selection of LDPPs	Dependant on the selection of LDPPs
2. Provider incentive payments are an effective method for increasing Medi-Cal provider participation, which could improve access to care for children.	Overview	Access		90 Day Continuous	Comparative analysis of DMC, SNC, and FFS models.						
2.1 Domain 1	1	Access	DHCS	90 Day Continuous	Comparative analysis of DMC, SNC, and FFS models.	Comparative analysis of counties with similar population and provider participation history, utilization of preventive services to restorative services, and geographic proximity.	Yes	<1, 1-2, 3-5, 6-9, 10-14, 15-18, 19-20	CY 2014 Baseline using the same numerator and denominator methodology.	Claims data to determine the number of providers that are providing preventive dental services to Medi-Cal beneficiaries under 20, compared to the number of these locations in the measurement period.	The total number of enrolled providers by county
2.2 Domain 2	2	Access	DHCS	90 Day Continuous	Comparative analysis of DMC, SNC, and FFS models.	Comparative analysis of counties with similar population and provider participation history, utilization of preventive services to restorative services, and geographic proximity.	Yes	<1, 1-2, 3-4, 5-6	CY 2014 Baseline using the same numerator and denominator methodology.	Claims data to determine the number of providers in each county that have opted in for participation.	The total number of enrolled providers by county
2.3 Domain 3 (Notably very similar to NQF 2517)	3	Access	DHCS	90 Day Continuous	Comparative analysis of FFS and SNC models.	Comparative analysis of counties with similar population and provider participation history, utilization of preventive services to restorative services, and geographic proximity.	Yes	1-2, 3-5, 6-9, 10-14, 15-18, 19-20	CY 2015 Baseline using the same numerator and denominator methodology.	Claims data to determine the number of unduplicated beneficiaries who received services by the same provider for two, three, four, five, and six continuous year periods.	The total number of enrolled providers by county
2.4 Domain 4	4	Access	TBD	91 Day Continuous	Subject to selection	Comparative analysis of counties with similar population and provider participation history, utilization of preventive services to restorative services, and geographic proximity.	Potentially	<1, 1-2, 3-5, 6-9, 10-14, 15-18, 19-20	Subject to selection	Dependant on the selection of LDPPs	Dependant on the selection of LDPPs
3. Provider incentive payments are effective in encouraging providers to perform CRA for the targeted population and ensure completion of appropriate treatment modalities for the management of early childhood caries.	Overview	Access	DHCS	90 Day Continuous	Comparative analysis of DMC, SNC, and FFS models.	Comparative analysis of counties with similar population and provider participation history, utilization of preventive services to restorative services, and geographic proximity.	Limited in that CRA bundled services were never historically rendered.	<1, 1-2, 3-4, 5-6	N/A	Number of unduplicated beneficiaries who received any restorative service and a separate measure of a restorative service in the measurement period stratified by the level of risk and number of CRAs received in a twelve month period.	Total county population of unduplicated beneficiaries within the provided age range.
3.1 Domain 4	4	Access	TBD	90 Day Continuous	Subject to selection	Comparative analysis of counties with similar population and provider participation history, utilization of preventive services to restorative services, and geographic proximity.	Potentially	<1, 1-2, 3-5, 6-9, 10-14, 15-18, 19-20	Subject to selection	Dependant on the selection of LDPPs	Dependant on the selection of LDPPs
4. Utilization of emergency room visits for dental issues among the targeted populations will decline.	Overview	Access	DHCS	90 Day Continuous	Comparative analysis of DMC and FFS models.	Comparative analysis of counties with similar population and provider participation history, utilization of preventive services to restorative services, and geographic proximity.	Yes	<1, 1-2, 3-5, 6-9, 10-14, 15-18, 19-20	CY 2014 Baseline using the same numerator and denominator methodology.	Number of unduplicated beneficiaries who received any emergency related dental service in the measurement period	Total county population of unduplicated beneficiaries within the provided age range.
4.1 Domain 4	4	Access	TBD	90 Day Continuous	Subject to selection	Comparative analysis of counties with similar population and provider participation history, utilization of preventive services to restorative services, and geographic proximity.	Potentially	<1, 1-2, 3-5, 6-9, 10-14, 15-18, 19-20	Subject to selection	Dependant on the selection of LDPPs	Dependant on the selection of LDPPs
5. Utilization and expenditures for dental related general anesthesia for targeted populations will decline.	Overview	Access	DHCS	90 Day Continuous	Comparative analysis of DMC and FFS models.	Comparative analysis of counties with similar population and provider participation history, utilization of preventive services to restorative services, and geographic proximity.	Yes	<1, 1-2, 3-5, 6-9, 10-14, 15-18, 19-20	CY 2014 Baseline using the same numerator and denominator methodology.	Total number of beneficiaries require gnep	Total county population of unduplicated beneficiaries within the provided age range.
5.1 Domain 4	4	Access	TBD	90 Day Continuous	Subject to selection	Comparative analysis of counties with similar population and provider participation history, utilization of preventive services to restorative services, and geographic proximity.	Potentially	<1, 1-2, 3-5, 6-9, 10-14, 15-18, 19-20	Subject to selection	Dependant on the selection of LDPPs	Dependant on the selection of LDPPs
6. Incentive payments are an effective method of promoting continuity of care for targeted children.	Overview	Access	DHCS	90 Day Continuous	Comparative analysis of SNC and FFS models.	Comparative analysis of counties with similar population and provider participation history, utilization of preventive services to restorative services, and geographic proximity.	Yes	1-2, 3-5, 6-9, 10-14, 15-18, 19-20	CY 2014 Baseline using the same numerator and denominator methodology.	Claims data to determine the number of unduplicated beneficiaries who received services by the same provider for two, three, four, five, and six continuous year periods.	The total number of enrolled providers by county
6.1 Domain 4	4	Access	TBD	90 Day Continuous	Subject to selection	Comparative analysis of counties with similar population and provider participation history, utilization of preventive services to restorative services, and geographic proximity.	Potentially	<1, 1-2, 3-5, 6-9, 10-14, 15-18, 19-20	Subject to selection	Dependant on the selection of LDPPs	Dependant on the selection of LDPPs
7. Promising practices will be identified with the implementation of CRA and disease management and LDPPs.	Overview	Quality	DHCS	90 Day Continuous	Comparative analysis of DMC, SNC and FFS models.	Comparative analysis of counties with similar population and provider participation history, utilization of preventive services to restorative services, and geographic proximity.	Limited in that CRA bundled services were never historically rendered.	<1, 1-2, 3-4, 5-6	CY 2014 Baseline using the same numerator and denominator methodology.		
7.1 Domain 4	Four	Quality	TBD	90 Day Continuous	Subject to selection	Comparative analysis of counties with similar population and provider participation history, utilization of preventive services to restorative services, and geographic proximity.	Potentially	<1, 1-2, 3-5, 6-9, 10-14, 15-18, 19-20	Subject to selection		
8. The provider incentive payments for preventive services and continuity of care provide a more favorable cost benefit ratio than that of CRA.	Overview	Cost	DHCS	90 Day Continuous	Comparative analysis of DMC, SNC and FFS models.	Comparative analysis of counties with similar population and provider participation history, utilization of preventive services to restorative services, and geographic proximity.	Limited in that CRA bundled services were never historically rendered.	<1, 1-2, 3-4, 5-6	CY 2014 Baseline using the same numerator and denominator methodology.	Cost comparison of the Domain 1 and 3 Incentive Payments compared to the incentive payments within domain 2.	Total overall program expenditures by county and comparison of results for dental outcomes.
8.1 Domain 4	4	Cost	TBD	90 Day Continuous	Subject to selection	Comparative analysis of counties with similar population and provider participation history, utilization of preventive services to restorative services, and geographic proximity.	Potentially	<1, 1-2, 3-5, 6-9, 10-14, 15-18, 19-20	Subject to selection	Dependant on the selection of LDPPs	Dependant on the selection of LDPPs
9. (4) Utilization of emergency room visits for dental issues among the targeted children will decline.	Overview	Cost	DHCS	90 Day Continuous	Comparative analysis of DMC, SNC and FFS models.	Comparative analysis of counties with similar population and provider participation history, utilization of preventive services to restorative services, and geographic proximity.	Yes	<1, 1-2, 3-5, 6-9, 10-14, 15-18, 19-20	CY 2014 Baseline using the same numerator and denominator methodology.	Annual expenditures for emergency room visits for dental related issues or the targeted outreach population. Divided by denominator.	Total county population of unduplicated beneficiaries within the provided age range.
9.1 Domain 4	4	Cost	TBD	90 Day Continuous	Subject to selection	Comparative analysis of counties with similar population and provider participation history, utilization of preventive services to restorative services, and geographic proximity.	Potentially	<1, 1-2, 3-5, 6-9, 10-14, 15-18, 19-20	Subject to selection	Dependant on the selection of LDPPs	Dependant on the selection of LDPPs
10. (5) Utilization and expenditures for dental related general anesthesia utilization for target children will decline.	Overview	Cost	DHCS	90 Day Continuous	Comparative analysis of DMC, SNC and FFS models.	Comparative analysis of counties with similar population and provider participation history, utilization of preventive services to restorative services, and geographic proximity.	Yes	<1, 1-2, 3-5, 6-9, 10-14, 15-18, 19-20	Subject to selection	Annual expenditures for dental anesthesia for the targeted outreach population. Divided by denominator.	Total county population of unduplicated beneficiaries within the provided age range.
10.1 Domain 4	4	Cost	TBD	90 Day Continuous	Subject to selection	Comparative analysis of counties with similar population and provider participation history, utilization of preventive services to restorative services, and geographic proximity.	Potentially	<1, 1-2, 3-5, 6-9, 10-14, 15-18, 19-20	Subject to selection	Dependant on the selection of LDPPs	Dependant on the selection of LDPPs

## **Global Payment Program Draft 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. 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.

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.

### **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

### **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 have to evaluate changes compared to the pre-GPP baseline, which is the SFY 2014-15 reporting period utilized to establish the initial thresholds. 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 Table 1 of Attachment FF. 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 inform summary and system level information for the GPP 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.

Please refer to Table 1 in Attachment FF for the list of all services that will be captured under the GPP.

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. This is consistent with the methodology used in the 2010 Bridge to Reform waiver.
- 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.

### **Proposed Evaluation Design**

#### **First GPP Evaluation**

- I. Executive Summary**
  - a. The goals of the GPP program
  - b. Key findings, including whether and to what extent GPP achieved the goals of the first evaluation
- II. Introduction**
  - a. Include a description of the GPP program objectives and data sources that will be used

### III. Evaluation Outline

#### 1. Demonstrate that public health care systems are putting a strong foundation in place to improve care to the uninsured

- A. Individual public health care system self-assessment narrative that will include the following key elements:
  - a. Narrative on what changes they are making to their 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. Improvements in workforce involvement and care team transformation
    - v. Describe 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 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
    - 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. Based on the reported services specified in Table 1 in Attachment FF, compare baseline SFY 2014-15 data 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, compare baseline SFY 2014-15 data with subsequent GPP program years to analyze 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
    - 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 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. Executive Summary**

- a. The goals of the GPP program
- b. Key findings, including whether and to what extent GPP facilitated improvements in care for uninsured patients in public health care systems

### **II. Introduction**

- a. Include a description of the GPP program objectives and data sources that will be used

### **III. Evaluation Design**

1. Demonstrate that public health care systems have improved care to the uninsured
  - A. Across all participating GPP health care systems, 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 reported data as required under Table 1 in Attachment FF and assess the following areas:

- 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 Table 1 of Attachment FF (e.g. primary care, specialty care, nutrition education, group visits) inpatient from Category 4 in Table 1 of Attachment FF (e.g. trauma, med surg) and emergent/urgent care from Category 1C in Table 1 of Attachment FF, mental health and substance use services in Category 1B, 1C and 4A and 4B in Table 1 of Attachment FF compared to prior years from baseline and during the GPP as compared to the first evaluation
- Trends in utilization in non-traditional services from Categories 1A, 2, 3 and 4A in Table 1 of Attachment FF during the GPP, 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 Table 1 of Attachment FF, with a particular focus on outpatient services (e.g. mental health and substance use outpatient)
- PHCS-self assessment narrative in care coordination activities, which could include expanded use of complex care managers, case managers, health educators and health coaches
- 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. The GPP is allocating resources wisely and is more effectively tailoring care to the appropriate settings

- A. Across all participating GPP systems, compare SFY 2014-15 baseline data 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
    - 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

- Cost of GPP services vs GPP funding (at the individual level)
  - Expenditures associated with services provided, both at 100% and 175%
  - Expenditures avoided or reduced
  - 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. From a PHCS perspective, provide an assessment of the successes and challenges of the GPP

- A. PHCS 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, substance use, etc.)
  - 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.



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**Seniors and Persons with Disabilities  
Evaluation Design  
September 2016**

**Background**

Under the authority of California's Section 1115 Medicaid Waiver, Bridge to Reform, California transitioned its Seniors and Persons with Disabilities (SPDs) population from the Medi-Cal fee-for-service (FFS) delivery system into the managed care delivery system (i.e., enrolled into Medi-Cal managed care health plans (MCPs)) between June 2011 and May 2012. Specifically, the Special Terms and Conditions (STCs) of the Bridge to Reform Waiver included requirements about information and communication strategies that address the unique needs of SPDs, approaches to assignment and opportunities for changes in MCPs, participant rights, safeguards and contractual provisions regarding care coordination and linkages to other service delivery systems, person-centered approaches to service planning and delivery, and physical and geographic accessibility of service providers. The transition occurred in Two-Plan and Geographic Managed Care (GMC) plan model counties, 16 counties in total, located across California. Mandatory enrollment of SPDs in managed care and the aforementioned requirements were continued under the State's Section 1115 Medicaid Waiver renewal, Medi-Cal 2020.

**Evaluation Objectives**

The Medi-Cal 2020 STCs require the State to complete an assessment, using pre-mandatory enrollment as a baseline, of the impact on mandatory managed care on the SPD population, including all significant and notable findings based on all of the data accumulated through the quarterly progress report. The evaluation must address three areas: access to care; quality of care; and cost of coverage.

The below description sets forth the State's design for the SPD transition evaluation. This design approach was selected because it considers cost of care, quality of care, and access to care, all of which provide a picture of the beneficiary's experience and impact to the State's administration of the program overall. The measures selected were chosen because they provide indicators of the beneficiary's experience and resultant health outcomes when accessing care through a delivery system. They are tied to the specific health care needs of SPDs and their specific care needs due to diagnosis and the existence of, at times, multiple complex conditions.

**Evaluator Selection**

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 SPD transition to the Medi-Cal managed care delivery system. The State will contract with an entity that does not have a direct relationship to the State of California, Department of Health Care Services (DHCS). A data use agreement will be included in the contract to

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allow for the sharing of data with and access to data by the independent entity for purposes of conducting the SPD transition evaluation. 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.

## **Evaluation Methods**

### ***General Approach***

The evaluation will meet the standards of leading academic institutions and academic journals. Data will be reported at the beneficiary, provider, health plan, and statewide levels. Significant attention will be given to ensuring use of the best available data and the cleanliness of it when utilized. When necessary, the data will be adjusted and/or controls will be put into place to maximize the use of the it. Should there be data limitations, the data will be modified as needed and only used appropriately so as not to misinterpret it. Any modifications and changes will be reported in the final evaluation report. The final evaluation report will also consider how the findings from the evaluation may or may not be generalized.

The evaluation will compare pre- and post-transition data whenever possible. Research has shown that it can take up to two years for beneficiaries to become adjusted to a change in delivery system. Therefore, for the 16 transition counties, an analysis will be conducted of the experience of SPDs in FFS 24 months prior to the transition and 24 months post-transition.

For both pre- and post- transition analyses, socioeconomic and demographic factors will be considered including race/ethnicity, gender, age, geographic area, diagnosis, language, and other factors (as identified through a public comment process). Data from the California Department of Public Health will be utilized to overlay these demographic factors with applicable health disparity considerations such as average income, tobacco utilization, and crime rates. A menu of the same metrics will be used and compared for both the pre- and post-transition populations. Because additional data are available for the post-transition population and only certain assessed requirements exist for the post-transition managed care delivery system, additional metrics and data are available for it. All measures will be benchmarked against available state and national standards and benchmarks. For example, NCQA Medicaid benchmarks for performance will be utilized when possible.

State vital statistics databases will be also used to report on the number of deaths by diagnosis. This information will be presented as a comparison across transition counties and non-transition counties.

### ***Data Sources and Types***

Qualitative and quantitative data available to DHCS both from data collected directly or collected in partnership with the State will be utilized. The evaluation will consider: process and outcomes measures (MCP encounter data, FFS claims, HEDIS) (pre- and post- transition); beneficiary satisfaction (Ombudsman, call center, grievances and appeals, beneficiary surveys) (post-transition); and administrative functions (beneficiary surveys) (post-transition).

## ***Baseline Data and Pre-Transition Evaluation***

Baseline data that will be utilized to assess the pre-transition population will include FFS claims data, qualitative interviews including with beneficiaries, and HEDIS rates. The pre-transition analysis will review the beneficiary's experience 24 months prior to the transition beginning.

The pre-transition evaluation will review access to care metrics which will provide an indication of the beneficiaries' ability to access primary care providers within a close proximity to their residence while in FFS. In addition, the pre-transition evaluation will utilize HEDIS metrics to determine access to services. They will be calculated administratively using FFS claims data for the pre-transition period. Costs associated with average annual costs and avoidable costs will be considered as well. All of the aforementioned factors will provide a baseline understanding of the SPD beneficiary's overall experience when care was received through the FFS delivery system.

The data measures and sources that will be used to measure the pre-transition experience consists of, but are not limited to:

- a. Access to Care
  - i. Network Access
    - 1. Time and distance - average number of miles to primary care provider from beneficiary residence
    - 2. Type of available specialists

Data Sources: California provider enrollment data
  - ii. HEDIS rates (see quality of care metrics below)
- b. Quality of Care (for beneficiaries transitioned to managed care)
  - i. HEDIS/EAS rates stratified measures by SPD/Non-SPD (see attached for NCQA measure specifications)
    - 1. All-Cause Readmissions – NCQA
      - a. Ambulatory Care - NCQA
        - i. Outpatient visits
        - ii. Emergency department visits
    - 2. Annual Monitoring for Patients on Persistent Medications - NCQA
    - 3. Comprehensive Diabetes Care (8 indicators) – NCQA
    - 4. Rate of post-discharge follow-up after hospitalization or ED visit - NCQA

Data Sources: The State will use FFS claims data to calculate performance rates for these measures.
- c. Cost of Coverage (for beneficiaries enrolled in the delivery system for a minimum of ten months and transitioned to managed care)
  - i. Average annual cost for Medi-Cal covered health<sup>1</sup> services per beneficiary
  - ii. Avoidable institutionalization costs:
    - 1. Ratio per 10,000 beneficiaries of and average cost per beneficiary for length of stays greater than ten days in an acute care hospital

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<sup>1</sup> California is in the process of determining whether or not county mental health and SUD costs will be included for purposes of this analysis.

2. Ratio per 10,000 beneficiaries of and average cost per beneficiary stay for length of stays less than 60 days in a Skilled Nursing Facility (SNF)
3. Ratio per 10,000 beneficiaries of and average cost per beneficiary stay for length of stays less than 90 days in an acute hospital stay plus SNF
- iii. Average annual pharmacy costs per beneficiary
- iv. Ratio per 10,000 beneficiaries of and average emergency room costs for non-emergency visits (as defined by NCQA)

Data Source(s): FFS claims and pharmacy data

### ***Post-Transition Evaluation***

Different types of data will be used to analyze the post-transition beneficiary experience. The data will support analysis of the same metrics utilized in FFS as described above as well as additional data sets that are accessible through the managed care delivery system and an independent External Quality Review Organization (EQRO). HEDIS rates will be calculated utilizing MCP encounter data for hybrid measures; and audited EQRO data will be utilized for admin measures. This will allow for an equal comparison of the measures across the FFS and managed care delivery systems.

Additionally, data collected by Carrie Graham, University of California at Berkeley, during a qualitative study will be utilized to gauge beneficiary satisfaction including care coordination (see attachment for additional information about the questions and findings from the study).

Lastly, MCP network data which the State collects monthly, as well as MCP network certifications for the SPD transition, will also be utilized to support analysis of provider data and access. Moreover, other data sources will be utilized, such as calls to the Ombudsman, State Fair Hearing and Independent Medical Review (IMT) information, and grievances and appeals data. The State reports these data in the quarterly progress reports to CMS and serves as indicators regarding beneficiary experience. The combination of all of the aforementioned data sources will allow the State to analyze the beneficiary's experience post-transition in a comprehensive way.

The data and measures that will be used to for post-transition include, but are not limited to, the following:

- i. Access to Care
  - a. Network Access
    - i. Time to primary care provider from place of residence
    - ii. Type of available specialists in network
    - iii. Out of network referrals and access
      1. Frequency of out-of-network referrals per 10,000 beneficiaries
        - a. Compared to non-SPD population
    - iv. Ease of getting appointments with primary care doctor – Likert scale
    - v. Ease of getting appointments with specialist – Likert scale
    - vi. Disability access
      1. Provider understanding of how to care for a person with specific health condition or disability – Likert scale

2. Access to equipment or services for individuals with a specific health condition or disability – Likert scale

Data Sources: MCP network certifications; MCP network provider files; Carrie Graham - beneficiary surveys

b. Beneficiary Satisfaction

- i. Beneficiary satisfaction with managed care benefits - Likert scale
- ii. Beneficiary satisfaction with quality of care – Likert scale
- iii. Benefit differences from FFS to managed care – Likert scale
  1. Prescription medications
  2. Specialty care
  3. Medical equipment and supplies
  4. Primary care

Data Sources: Carrie Graham - beneficiary surveys

b. Care Coordination

i. Plan navigation

1. Do you know how to: - Yes or No
  - a. Get a prescription filled
  - b. Make an apt with a PCP
  - c. Get tests you need
  - d. Get health advice over the phone
  - e. Find a doctor
  - f. Get medical equipment and supplies
  - g. Make an apt with a specials
  - h. Know that you can switch doctors at any time
  - i. Know about the continuity of care policies

ii. Member services

1. Were you called by your plan to discuss your health needs? – Yes or No
2. Experience with member services – Likert scale
3. Help finding doctors and getting the services needed – Likert scale

Data Sources: Carrie Graham - beneficiary surveys

iv. SPD Specific Complaints – rate per 10,000 beneficiaries

1. Grievances and appeals
2. State Fair Hearings
3. Independent Medical Reviews
4. Calls to Ombudsman

Data Sources: Quarterly MCP grievances and appeals data; State Fair Hearings; Independent Medical Reviews; Quarterly progress report data

ii. Quality of Care

- a. HEDIS/EAS rates stratified measures by SPD/Non-SPD (see attached for NCQA measure specifications)
  - i. All-Cause Readmissions – NCQA
  - ii. Ambulatory Care - NCQA

1. Outpatient visits
2. Emergency department visits
- iii. Annual Monitoring for Patients on Persistent Medications - NCQA
- iv. Comprehensive Diabetes Care (8 indicators) – NCQA
- v. Rate of post-discharge follow-up after hospitalization or ED visit - NCQA

Data Sources: MCP encounter data; audited EQRO HEDIS rates

- iii. Cost of Coverage (for beneficiaries enrolled in the delivery system for a minimum of ten months)
  - iii. Average annual cost for Medi-Cal covered health services per beneficiary (note: costs will be a combination of FFS and capitation both to MCPs and from MCPs to delegated entities)
  - iv. Avoidable institutionalization costs:
    1. Ratio per 10,000 beneficiaries of and average cost per beneficiary for length of stays greater than ten days in an acute care hospital
    2. Ratio per 10,000 beneficiaries of and average cost per beneficiary stay for length of stays less than 60 days in a Skilled Nursing Facility (SNF)
    3. Ratio per 10,000 beneficiaries of and average cost per beneficiary stay for length of stays less than 90 days in an acute hospital stay plus SNF
  - v. Average annual pharmacy costs per beneficiary
  - vi. Ratio per 10,000 beneficiaries of and average emergency room costs for non-emergency visits (as defined by NCQA)

Data Sources: MCP encounters; Rate Development Template (RDT/Mercer; FFS claims and encounter; audited EQRO HEDIS

### **Communication of Findings**

The evaluation will provide a general analysis and description of the population, including a report of enrollment numbers and analysis by demographic factor. The evaluation will also contain both performance metrics and a narrative description in order to present the full experience of SPDs during the transition.

Upon submission of the draft SPD evaluation design to the Centers for Medicare and Medicaid Services (CMS) it will be shared publically. The document will be distributed via email to the State's stakeholder waiver distribution list and posted on the State's website for public comment. Specifically, the State will request comment on the evaluation approach and questions that the evaluation should address. It will also be presented and discussed at the State's Waiver Stakeholder Advisory Committee (SAC) and Managed Care Advisory Group (MCAG). Updates to the design will be made based on stakeholder comment received during these meetings or in writing. The design will be finalized in conjunction with the independent entity and submitted to CMS for final approval.

Based on the methodology used to assess the pre- and post-transition population, the evaluation will provide recommendations for programmatic changes relating to access to and quality of care as well as

overall cost implications for the SPD population. The final evaluation report is due December 31, 2021 at the completion of the Medi-Cal 2020 Waiver. The findings from the assessment will allow DHCS to evaluate the experience of SPDs in the managed care delivery system as well as inform DHCS as to best practices and lessons learned.