DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

October 8, 2021

Jacey Cooper
Chief Deputy Director, Health Care Programs
California Department of Health Care Services
1501 Capitol Avenue, 6th Floor, MS 0000
Sacramento, CA 95814

Dear Ms. Cooper:

In accordance with 42 CFR 438.6(c), the Centers for Medicare & Medicaid Services (CMS) has reviewed and is approving California's submission of a proposal for delivery system and provider payment initiatives under Medicaid managed care plan contracts. The proposal was received by CMS on December 31, 2020 and has a control name of CA Proposal H 2021.

Specifically, the following proposal for delivery system and provider payment initiatives (i.e. state directed payment) is approved:

- Uniform dollar increase for inpatient and outpatient services provided by private hospitals as defined in CA Welfare & Institutions Code § 14169.51(ap) for the rating period covering January 1, 2021 through December 31, 2021.

This approval letter does not constitute approval of any Medicaid managed care plan contracts or rate certifications for the aforementioned rating period, or any specific Medicaid financing mechanism used to support the provider payment arrangement. All other federal laws and regulations apply. This approval letter only satisfies the regulatory requirement pursuant to 42 CFR 438.6(c)(2) for written approval prior to implementation of any payment arrangement described in 42 CFR 438.6(c)(1). Approval of the corresponding Medicaid managed care plan contracts and rate certifications is still required.

The state is always required to submit a contract action(s) to incorporate the contractual obligation for the state directed payment and related capitation rates that include this payment arrangement.

Note that this payment arrangement and all state directed payments must be addressed in the applicable rate certifications. Documentation of all state directed payments must be included in the initial rate certification as outlined in Section I, Item 4 of the Medicaid Managed Care Rate Development Guide. The state and its actuary must ensure all documentation outlined in the Medicaid Managed Care Rate Development Guide is included in the initial rate certification. Failure to provide all required documentation in the rate certification may cause delays in CMS review. CMS is happy to provide technical assistance to states and their actuaries.

As part of the preprint, the state indicated that this state directed payment will be incorporated into the state's rate certification through a separate payment term. As the payment arrangement is addressed through a separate payment term, CMS has several requirements related to this payment arrangement, including but not limited to the requirement that the state's actuary must certify the aggregate amount of the separate payment term and an estimate of the magnitude of the payment

on a per member per month (PMPM) basis for each rate cell. Failure to provide all required documentation in the rate certification may cause delays in CMS review. As the PMPM magnitude is an estimate in the initial rate certification, no later than 12 months after the rating period is complete, the state must submit documentation to CMS that incorporates the total amount of the state directed payment into the rate certification's rate cells consistent with the distribution methodology described in the initial rate certification, as if the payment information (e.g., providers receiving the payment, amount of the payment, utilization that occurred, enrollees seen, etc.) had been known when the rates were initially developed. Please submit this documentation to statedirectedpayment@cms.hhs.gov and include the control name listed for this review along with the rating period.

Additionally, if the total amount of the state directed payment or distribution methodology is changed from the initial rate certification, CMS requires the state to submit both a state directed payment preprint amendment and an amendment to the rate certification(s) for the rating period, and clearly describe the magnitude of and the reason for the change.

CMS is able to approve this state directed payment proposal with a requirement that the state provide baseline data as well as Year 1 and Year 2 evaluation findings with the state's CY 2022 preprint submission for prior approval under 42 CFR 438.6(c).

Lastly, please note that CMS will continue to work with the state on the underlying managed care rate certification issues related to inclusion of the unsatisfactory immigration status (UIS) beneficiary population.

If you have questions concerning this approval or state directed payments in general, please contact Alex Loizias, Division of Managed Care Policy, at (410) 786-2425, alexandra.loizias@cms.hhs.gov.

Sincerely,

John Giles

Digitally signed by John Giles
Date: 2021.10.08 11:22:18 -04'00'

John Giles, MPA
Director, Division of Managed Care Policy
Center for Medicaid and CHIP Services

PRIVATE HOSPITAL DIRECTED PAYMENTS (PY 4, CY 2021)
Section 438.6(c) Preprint

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

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

Standard Questions for All Payment Arrangements

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

DATE AND TIMING INFORMATION:

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

Calendar Year (CY) 2021: January 1, 2021 through December 31, 2021

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

January 1, 2021

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

Program Year 1 (PY 1, SFY 2017-18) through PY 5 (CY 2022). This preprint addresses the 12-month period from January 1, 2021 through December 31, 2021.

STATE DIRECTED VALUE-BASED PURCHASING:

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

   Not Applicable

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

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

Not Applicable

STATE DIRECTED FEE SCHEDULES:

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

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

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

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

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

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

The State will direct Medi-Cal managed care health plans (MCPs) to pay uniform dollar amount add-on payments to eligible network "private hospitals", as defined in Welfare & Institutions Code §14169.51(ap), based on actual network utilization. The directed payment structure will not change the MCPs' existing base reimbursement amounts for these providers. The directed payment arrangement will replace a pre-existing supplemental payment program (California's Hospital Quality Assurance Fee (HQAF) Program/waiver, see Welfare & Institutions Code §14169.50, et. seq.), that has been an integral part of California's managed care program since 2010. The directed payment arrangement will continue to support hospitals that provide critical services to Medi-Cal managed care members.

The State will establish two pools from which the total uniform increment payments for each provider class will be made. For PY 4 (CY 2021), the two pools will consist of total amounts for:

1) contracted inpatient services, and
2) select contracted non-inpatient services (outpatient/emergency room services).

A weighted pro rata redistribution of a particular pool (1 or 2) shall be used to distribute a pool based on actual utilization. For example, if the number of inpatient claims/encounters exceeds what was initially projected in the rate development, the State will ensure that all eligible claims in the rate year receive a weighted pro rata portion of the pool.

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

Not Applicable

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

APPROVAL CRITERIA FOR ALL PAYMENT ARRANGEMENTS:

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

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

Upon determination of actual utilization, the State will direct the MCPs to make enhanced payments for contracted services utilized within the class of network private hospitals, via All Plan Letter or similar instruction. The State may calculate directed payment amounts based on actual utilization for two distinct periods within PY 4 (CY 2021) and direct MCP payments accordingly. Following the issuance of all enhanced payments, the State will notify CMS of the updated actual per-member-per-month (PMPM) increments adjusted for actual utilization.

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

Class of Hospitals	Total IP and OP Pool Size
1) Private hospitals as defined in Welfare & Institutions Code §14169.51	$3.528 billion

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

Class of Hospitals	Payment Arrangement
1) Private hospitals as defined in Welfare & Institutions Code §14169.51(ap)	Uniform Dollar Increments TBD

QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS:

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

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

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

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

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

June 2018

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

Table 13(c): Payment Arrangement Quality Strategy Goals and Objectives

Goal(s)	Objective(s)	Quality strategy page
Enhance quality, including the patient care experience, in all DHCS programs	Deliver effective, efficient, affordable care	Medi-Cal Managed Care Quality Strategy Report, Page 6

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

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

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

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

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

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

See Attachment 1

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

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

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

Not Applicable

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

Not Applicable

REQUIRED ASSURANCES FOR ALL PAYMENT ARRANGEMENTS:

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

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

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

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

Additional Questions for Value-Based Payment Arrangements

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

APPROVAL CRITERIA FOR VALUE-BASED PAYMENT ARRANGEMENTS:

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

Not Applicable

QUALITY CRITERIA AND FRAMEWORK FOR VALUE-BASED PAYMENT ARRANGEMENTS:

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

Not Applicable

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

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

TABLE 17(a): Payment Arrangement Provider Performance Measures

Provider Performance Measure Number	**Measure Name and NQF #** (if applicable)	**Measure Steward/ Developer** (if State-developed measure, list State name)	**State Baseline** (if available)	**VBP Reporting Years***	**Notes****
1					
2					
3					
4					

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

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

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

Not Applicable

REQUIRED ASSURANCES FOR VALUE-BASED PAYMENT ARRANGEMENTS:

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

Not Applicable

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

Not Applicable

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

ATTACHMENT 1

438.6(c) Proposal – Uniform Dollar Increase for Private Hospital Services
Evaluation Plan
Program Year 4 (PY 4): January 1, 2021 – December 31, 2021

Evaluation Purpose

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

Stakeholders

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

Evaluation Questions

This evaluation is designed to answer the following questions:

1. Do higher private hospital payments, via the proposed PY 4 directed payments, serve to maintain or improve the timeliness and completeness of encounter data reported for MCP members?

2. Do higher private hospital payments, via the proposed PY 4 directed payments, serve to maintain or change utilization patterns for inpatient, outpatient, and emergency services for MCP members?

Evaluation Design

Encounter Data:

The state will conduct encounter data quality assessments focusing on timeliness and completeness of encounter data. All encounter data quality measures will have a baseline determined from data submitted in state fiscal year (SFY) 2017-18, July 1, 2017 – June 30, 2018. Each subsequent program year will be compared to the baseline to determine if any changes have occurred in the encounter data with the target of maintaining or increasing the baseline during the measurement year. This directed payment program was specifically designed so that payments to private hospitals are determined based on actual utilization data as demonstrated from the encounter data received by DHCS from the MCPs. This design has the intended consequence of encouraging increased collaboration among private hospitals and MCPs to ensure that the encounter data received by DHCS accurately reflects the actual utilization that has taken place in the given time period. This is likely to result in a substantial increase in encounter reporting for all service categories starting in PY 1 and continuing to

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

- Timeliness:
    - Lagtime – This measure reports the lagtime for submitting encounter data. Lagtime is the time, in days, between the Date of Services and the Submission Date to DHCS.The target is to maintain the baseline (SFY 2017-18) or demonstrate timeliness in accordance with the lagtime categories below, whichever is higher.

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

- Completeness:
    - Completeness – This measure will be evaluated through the following Transformed Medicaid Statistical Information System (T-MSIS) related measures:
        - Inpatient Encounters will be evaluated to determine if either the "Discharge Date" or "Still a Patient" field is populated.
        - Outpatient/Emergency Room Encounters will be evaluated to determine if the "Rendering Provider" field is populated with a Type 1 National Provider Identifier.

Inpatient Utilization:

Inpatient Admissions per 1000 Member Months: From the MCP encounter data, DHCS staff will calculate the number of MCP Inpatient Admissions per 1000 Member Months. Data for participating MCPs will be aggregated at a statewide level. An admission consists of a unique combination between member and date of admission to a facility. The third measurement period will be PY 4 (January 1, 2021 - December 31, 2021). The baseline year will be SFY 2017-18. DHCS will compare the third measurement period (PY 4) to the second measurement period (PY 3) and the baseline year to identify any changes in utilization patterns, with the target of maintaining or decreasing the baseline number of Inpatient Admissions per 1000 Member Months during the measurement year, as adjusted for changes to volume of encounter data submission by MCPs and providers, in response to the design of the directed payment program. The target is to maintain the baseline (SFY 2017-18) or demonstrate higher utilization as an indicator of improved encounter data completeness.

Outpatient Utilization:

Outpatient Visits per 1000 Member Months: From the MCP encounter data, DHCS staff will calculate the number of MCP Outpatient Visits per 1000 Member Months. Data for participating MCPs will be aggregated at a statewide level. A visit consists of a unique combination between provider, member, and date of service. The third measurement period will be PY 4 (January 1, 2021 - December 31, 2021). The baseline year will be SFY 2017-18. DHCS will compare the third measurement period (PY 4) to the second measurement period (PY 3) and the baseline year to identify any changes in utilization patterns, with the target of maintaining or increasing the baseline number of Outpatient Visits per 1000 Member Months during the measurement year, as adjusted for changes to volume of encounter data submission by MCPs and providers,

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

Emergency Room Utilization:

Emergency Room Visits per 1000 Member Months: From the MCP encounter data, DHCS staff will calculate the number of MCP Emergency Room Visits per 1000 Member Months. Data for participating MCPs will be aggregated at a statewide level. A visit consists of a unique combination between provider, member, and date of service. The third measurement period will be PY 4 (January 1, 2021 - December 31, 2021). The baseline year will be SFY 2017-18. DHCS will compare the third measurement period (PY 4) to the second measurement period (PY 3) and the baseline year to identify any changes in utilization patterns, with the target of maintaining or decreasing the baseline number of Emergency Room Visits per 1000 Member Months during the measurement year, as adjusted for changes to volume of encounter data submission by MCPs and providers, in response to the design of the directed payment program. The target is to maintain the baseline (SFY 2017-18) or demonstrate higher utilization as an indicator of improved encounter data completeness.

Stratification:

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

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

Data Collection Methods

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

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

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

Timeline

All data necessary for encounter data quality measurement will be extracted after a sufficient lag period post-Program Year. The encounter data will be pulled no sooner than 12 months after the close of the measurement period to allow for sufficient lag period, with a report being completed within 6 months of the data pull.

Communication and Reporting

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