California Department of Health Care Services (DHCS)

California Advancing and Innovating Medi-Cal (CalAIM) Section 1115(a) Demonstration

Evaluation Design for Community Supports authorized through the CalAIM Section 1115 and 1915(b) Waivers

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Evaluation Design for Community Supports

Community Supports launched in 2022 are foundational components of California's Advancing and Innovating Medi-Cal's (CalAIM's) transformational focus on breaking down the traditional walls of health care by more holistically addressing member needs and introducing better strategies for care coordination, person-centered and equitable care. These Community Supports, also known as In Lieu of Services (ILOS), focus on addressing health-related social needs (HRSNs), e.g., for food or housing, of Medi-Cal members. Addressing members' HRSNs is expected to help improve member function, health, and access to care, reduce avoidable utilization of higher, costlier levels of care, and improve health equity. Community Supports supplement a suite of other broad-based delivery system, program, and payment reforms across CalAIM to make Medi-Cal more equitable, coordinated, and person-centered to help people maximize their health and life trajectory.[1]

Community Supports are services that help address Medi-Cal members' HRSNs to facilitate their living healthier lives and avoiding higher, costlier levels of care. Community Supports are medically appropriate and cost-effective alternatives to services or settings covered under the State Plan. A key goal of Community Supports is to allow members to obtain services in the least restrictive setting possible and to keep them in the community as medically appropriate. Building on California's prior experience with Home and Community-Based Services (HCBS) Waivers, the Whole Person Care (WPC) Pilots, Medi-Cal Health Homes program (HHP), stakeholder input, and experiences elsewhere in the nation, the Department of Health Care Services (DHCS) has preapproved a list of 14 Community Supports that managed care plans (MCPs) are strongly encouraged to offer. Exhibit 1 provides a brief overview of the Community Supports, their eligibility criteria, and maximum duration, while Exhibit 2 shows additional policy guidance related to the Community Supports initiative. Additional information about Community Supports is available in the CalAIM Community Supports Policy Guide. These Community Supports are expected to be integrated with care management for vulnerable members and are intended to serve as cost-effective and medically appropriate substitutes for State Plan services or settings.

This evaluation design starts with the presentation of three Exhibits that orient the reader to the key foundations of the evaluation of Community Supports. Exhibit 1 on the next page summarizes data for member eligibility for use of any of the 14 Community Supports described above as documented in the DHCS Community Supports Policy Guide (July 2023).

[1] CalAIM 1115 Demonstration & 1915(b) Waiver; https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM-1115-and-1915b-Waiver-Renewals.aspx

Exhibit 1: Community Services Eligibility Criteria

	Housing transition / navigation	Housing deposits	Housing tenancy and sustaining	Recuperate care	Short-term post-hospitalization housing	Caregiver respite	Day habilitation	Nursing facility transition / diversion	Community transition	Personal care and homemaker services	Environmental accessibility adaptations	Medically tailored meals	Sobering centers	Asthma remediation
Eligibility criteria														
1. Homeless*	•	•	•	•	•		•							
2. At-risk of homelessness**	•	•	•	•	•		•							
3. Receiving or received housing transition / navigation		•	•		•									
4. At-risk of hospitalization or post-hospitalization				•										
5. Living alone with no formal supports				•										
6. Housing insecurity ***				•										
7. Exiting recuperative care					•									
8. Discharged inpatient hospital or nursing facility				•	•							•		
9. Discharged from residential facility or correctional facility				•	•									
10. Chronic conditions												•		
11. Living in community, compromised in ADLs, and require relief to avoid institutional placement						•								
12. Resided 60+ days in nursing facility and willing and able to live in assisted living								•						
13. Living in community, willing and able to live in assisted living, and meet medically necessary nursing LOC								•						
14. Resided 60+ days in nursing facility or medical respite, willing and able to reside safely in community, and meet medically necessary nursing LOC									•					
15. At-risk for hospitalization										•				
16. At-risk for institutionalization in a nursing facility										•	•			
17. Approved for IHSS										•				
18. Functional deficits and no other adequate support										•				
19. Adults who are intoxicated and would otherwise be transported to ED or jail****													•	
20. Individuals with poorly controlled asthma and provider documentation														•
21. Complete in-home environmental trigger assessment within last 12 months														•
Individuals with extensive care coordination needs												•		
Service duration***														
Once in a lifetime			•		•				•		•			•
Maximum duration allowed	N/A	N/A	N/A	90d con't	6mo	336 hr/yr			$7.5k max		$7.5k max	12 wks	24hr/stay	$7.5k max

Note: Exhibit 1 Table Notes follow on the next page.

Exhibit 1 Table Notes:

+Within each column of Exhibit 1, 14 individual Community Supports are shown as column headings. Rows display potential eligibility criteria for the specific Community Service displayed as column headings. For each row, a bullet within a column indicates that the row-specific eligibility criteria are pertinent to the Community Service that heads the column.
Note: Transitional rent is not included in this table because it has not yet been approved and policy guidance is unavailable
ADL = Activities of Daily Living; HUD = Housing and Urban Development; LOC = level of care
* HUD definition of homeless
** HUD definition of at-risk of homelessness with qualifying health or behavioral health conditions OR children or youth that qualify as homeless under other provisions
***Housing insecurity or housing that could jeopardize member health and safety without modification
**** Must also be conscious, cooperative, able to walk, nonviolent, and free from medical distress
***** This table does not include allowable exceptions, e.g., circumstances under which Community Service can be provided more than once in a lifetime or for longer than the maximum duration
Data Source: Medi-Cal Community Supports Policy Guide, September 2024 Draft; requirements subject to change as the Community Supports policy guide is updated and will be revised accordingly.

Exhibit 2 summarizes key principles from CMS and DHCS related to the goals and implementation of the Community Supports Initiative.

Exhibit 2: Key principles from CMS and DHCS related to the Community Supports Initiative

1. A key goal of Community Supports is to allow members to obtain care in the least restrictive setting possible and to keep them in the community as medically appropriate.
2. Community Supports can substitute for, and potentially decrease utilization of, a range of covered Medi-Cal benefits, such as hospital care, nursing facility care, and emergency department (ED) use.[2] Federal regulation allows states to offer Community Supports as an option to members.
3. Starting on January 1, 2022, MCPs in all counties have been strongly encouraged to offer one or more of the following 14 pre-approved Community Supports.
4. Consistent with federal regulations, DHCS has determined the preapproved Community Supports to be cost-effective and medically appropriate substitutes for covered Medi-Cal services or settings. MCPs must report data regarding the utilization and cost of Community Supports for the purposes of rate setting but do not need to actively reassess cost-effectiveness for Community Supports at the MCP or individual level for the purposes of compliance with federal requirements. Furthermore, nothing shall prohibit MCPs from using utilization management techniques as applicable and as permitted by federal managed care regulations. DHCS is conducting statewide aggregate analyses of the cost-effectiveness of each of the approved Community Supports services. All MCPs are encouraged to offer as many of the 14 pre-approved Community Supports as are offered in the Medi-Cal member's county. Although the provision of Community Supports is optional, MCPs are strongly encouraged to elect to offer some or all of these services. MCPs can choose to offer different Community Supports in different counties and can add or remove services at defined intervals (e.g., six months for addition of services, annually for removal). MCPs in all counties in California were permitted to offer pre-approved Community Supports beginning January 1, 2022. Provision

[2] DHCS CalAIM Enhanced Care Management (ECM) and Community Supports (ILOS), Contract Template Provisions. https://www.dhcs.ca.gov/Documents/MCQMD/MCP-ECM-and-ILOS-Contract-Template-Provisions.pdf

5. of Community Supports was intended to help smooth the transition of WPC pilots into Medi-Cal managed care and support CalAIM goals of improving service access, quality, and equity for eligible members.

Community Supports Evaluation Requirements

Exhibit 3 highlights common and unique themes in the Special Terms and Conditions (STCs) for evaluation of the CalAIM 1115 and the 1915(b) Waivers that authorize delivery of 14 Community Supports under Medi-Cal. Two Community Supports are authorized under the CalAIM 1115 Waiver (short-term post-hospitalization services and recuperative care; hereafter referred to as 1115 Waiver Community Supports). The remaining 12 Community Supports are authorized under the 1915(b) Managed Care Waiver (hereafter referred to as 1915(b) Waiver Community Supports). This Evaluation Design has been developed to cover the evaluation requirements of both waivers.

Exhibit 3: Special Terms and Conditions for the Evaluation of Community Supports Authorized in the 1115 Waiver and in the 1915(b) Waiver: Common evaluation themes across 1115 and 1915(b) STCs

Exhibit 3: Special Terms and Conditions for the Evaluation of Community Supports Authorized in the 1115 Waiver and in the 1915(b) Waiver: Common evaluation themes across 1115 and 1915(b) STCs	
STC 16.5 for 1115 Waiver Community Supports (2)	**STC 21 for 1915(b) Waiver Community Supports (12)**

Impact of Community Supports on utilization of health care, associated costs, and health outcomes: Focus on assessing how the initiatives affect utilization of preventive and routine care, utilization of and costs associated with potentially avoidable, high acuity health care, and member physical and behavioral health outcomes.	**Impact of Community Supports on utilization of health care, associated costs, and health outcomes:** Impact each Community Support had on utilization of state plan-covered services or settings, including the associated cost savings, trends in MCPs and enrollee use of each Community Supports, and impact of each Community Supports on quality of care.
Effectiveness of Community Supports for addressing member needs: Focus on the effectiveness of Community Supports services in mitigating identified needs of members. **Member experiences:** If the data system is unable to capture necessary data for a quantitative evaluation, then must conduct a qualitative assessment leveraging suitable primary data collections efforts (e.g., member surveys).	**Effectiveness of Community Supports for addressing member needs:** Evaluation of whether encounter data supports the state's determination that each Community Supports is a medically appropriate and cost-effective substitute for identified covered services and settings under the state plan. **Member experiences:** Appeals, grievances, and state fair hearings data, reported separately and for each Community Support, including volume, reason, resolution status, and trends.
Health equity: Focus on understanding the impact of Community Supports initiatives on advancing health quality, including through the reduction of health disparities.	**Health equity:** Impact each Community Support had on health equity initiatives and efforts undertaken by the state to mitigate health disparities.
Measuring contextual changes in HRSN: Examine whether and how state and local investments in housing and any other type of allowable HRSN change over time in concert with new Medicaid funding toward those services.	

Measuring costs of providing Community Supports: Include, in alignment with the evaluation required in the state's 1915(b)(1)/(4) Waiver for California Advancing and Innovating Medi-Cal (CalAIM) special terms and conditions for other similar services, a cost analysis to support developing comprehensive and accurate cost estimates of covering such services.	
Assessment of downstream impacts of Community Support: Include a robust assessment of potential improvements in the efficiency, quality, and effectiveness of downstream services that can be provided under the state plan authority, and associated cost implications related to the provision of upstream Community Supports services.	

STC 16.5 for 1115 Waiver Community Supports (2)	STC 21 for 1915(b) Waiver Community Supports (12)
Impact of Community Supports on utilization of health care, associated costs, and health outcomes: Focus on assessing how the initiatives affect utilization of preventive and routine care, utilization of and costs associated with potentially avoidable, high acuity health care, and member physical and behavioral health outcomes.	**Impact of Community Supports on utilization of health care, associated costs, and health outcomes:** Impact each Community Support had on utilization of state plan-covered services or settings, including the associated cost savings, trends in MCPs and enrollee use of each Community Supports, and impact of each Community Supports on quality of care.
Effectiveness of Community Supports for addressing member needs: Focus on the effectiveness of Community Supports services in mitigating identified needs of members.	**Effectiveness of Community Supports for addressing member needs:** Evaluation of whether encounter data supports the state's determination that each Community Supports is a medically appropriate and cost-effective substitute for identified covered services and settings under the state plan.
Member experiences: If the data system is unable to capture necessary data for a quantitative evaluation, then must conduct a qualitative assessment leveraging suitable primary data collections efforts (e.g., member surveys).	**Member experiences:** Appeals, grievances, and state fair hearings data, reported separately and for each Community Support, including volume, reason, resolution status, and trends.
Health equity: Focus on understanding the impact of Community Supports initiatives on advancing health quality, including through the reduction of health disparities.	**Health equity:** Impact each Community Support had on health equity initiatives and efforts undertaken by the state to mitigate health disparities.
Measuring contextual changes in HRSN: Examine whether and how state and local investments in housing and any other type of allowable HRSN change over time in concert with new Medicaid funding toward those services.	
Measuring costs of providing Community Supports: Include, in alignment with the evaluation required in the state's 1915(b)(1)/(4) Waiver for California Advancing and Innovating Medi-Cal (CalAIM) special terms and conditions for other similar services, a cost analysis to support developing comprehensive and accurate cost estimates of covering such services.	

STC 16.5 for 1115 Waiver Community Supports (2)	STC 21 for 1915(b) Waiver Community Supports (12)
Assessment of downstream impacts of Community Support: Include a robust assessment of potential improvements in the efficiency, quality, and effectiveness of downstream services that can be provided under the state plan authority, and associated cost implications related to the provision of upstream Community Supports services.	

While the specific language used to describe the 1115 and 1915(b) Waivers varies by waiver type as shown in the respective columns of Exhibit 3, the respective STCs address similar issues or themes. For example, both waivers include STCs that focus on the impact of receiving Community Supports on health care utilization, associated costs, and member health outcomes. Both waivers also include STCs that focus on whether Community Supports were effective at addressing member needs, with the 1915(b) STCs also requiring measurement of cost-effectiveness.[3] Both waivers also include STCs focused on assessing member experiences, with the 1115 Waiver noting direct collection of data from members if required, and the 1915(b) Waiver examining existing appeals and grievances. Finally, both waivers focus on health equity, with the 1115 Waiver assessing whether Community Supports improve health equity for members, and the 1915(b) Waiver focused on assessing the impact of Community Supports on broader, statewide health equity initiatives and efforts.

The 1115 Waiver further focuses on examining trends in state and local investments in Community Supports observed over time; a cost analysis to support developing comprehensive and accurate cost estimates of covering services, and an analysis of potential improvements in efficiency, quality, and effectiveness of downstream health services and associated cost implications related to the delivery of Community Supports.

[3] It is important to distinguish between the traditional definition of cost-effectiveness and the way that this is stated in the STCs. Per CMS, cost-effectiveness analysis is a way to examine both the costs and health outcomes of one or more interventions. It compares an intervention to another intervention (or the status quo) by estimating how much it costs to gain a unit of a health.
Cite: https://www.cdc.gov/policy/polaris/economics/cost-effectiveness/index.html#:~:text=Cost%2Deffectiveness%20analysis%20is%20a,gained%20or%20a%20death%20prevented.

To be eligible for inclusion in the 1115 and 1915(b) Waivers, prior research has already established medical appropriateness and cost-effectiveness of the 14 Community Supports. Thus, per STC 8.6 in the 1115 Waiver, cost-effectiveness in the context of the UCLA-RAND evaluation is focused on ensuring that aggregate costs of providing Community Supports do not exceed aggregate costs of providing other services, particularly the institutional care and other services that the Community Supports are expected to substitute for.

Community Supports Evaluation Research Questions

Community Supports evaluation requirements and research questions are informed by the CalAIM demonstration Special Terms and Conditions (STCs) goals and requirements, including STCs 8.1-8.15, 15.4-15.5, 16.5, 17.6, 17.10, 18.8-18.9, and Attachment U. The questions are further informed by the Donabedian model described in the overall CalAIM evaluation design and the social care logic model shown in Figure 1.

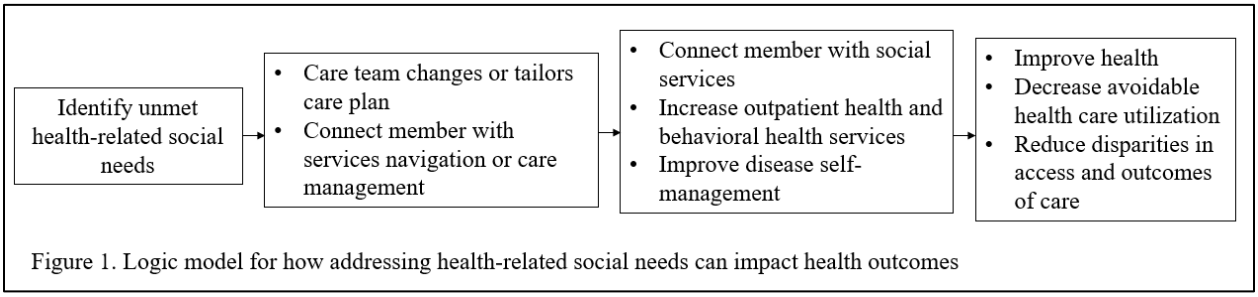

Figure 1. Logic model for how addressing health-related social needs can impact health outcomes

Program Goals

A list of specific first order and additional program goals is shown below. First order program goals refer to service goals that must be met before additional goals can be achieved.

First Order Goals

- 1. Increase uptake of Community Supports by MCPs
- 2. Increase awareness and offering of Community Supports by providers. Increase uptake of Community Supports by eligible members

Additional Goals

- 4: Increase uptake of Community Supports by MCPs
- 5: Increase members' access to non-emergency outpatient care and reduce acute care utilization and long-term care admissions and stays
- 6. Improve quality and outcomes of care for eligible members
- 7. Reduce disparities in service utilization, quality, and outcomes of care for eligible members
- 8. Ensure HRSN expenditures do not exceed aggregate spending caps and Community Supports are cost-effective alternatives to State Plan services and settings

To evaluate the Community Supports program goals, UCLA-RAND developed related evaluation questions and measures to determine whether the goals were achieved as anticipated. Program goals and related evaluation questions and measures are described in Exhibit 4 on the following pages.

Exhibit 4. Community Supports program goals and related evaluation questions, hypotheses, and measures

Evaluation Questions (EQ) & Hypotheses (H)	Measures
Goal 1: Increase uptake of Community Supports by MCPs EQ 1: Did the number of MCPs offering Community Supports increase over time? H1: The number of Community Supports offered by MCPs will increase over time.	• Number of MCPs offering each Community Support • Proportion of counties in which each Community Support is offered • Proportion of MCPs in each county offering each Community Support • MCPs' self-reported reasons for offering or not offering Community Supports
Goal 2: Increase awareness and uptake of Community Supports by providers EQ2: Did the number and diversity of providers contracted to provide Community Supports increase over time? H2: The number and diversity of providers contracted to provide Community Supports will increase over time	• Number of providers contracted to provide each Community Supports • Number of providers providing multiple Community Supports • Ownership and types of providers contracted to provide each Community Supports
Goal 2: Increase awareness and uptake of Community Supports by providers EQ3: What factors influence provider participation in Community Supports? H3: Provider capacity and infrastructure and local service availability and need will influence provider participation in Community Supports.	• Providers' self-reported reasons for contracting or not contracting with MCPs to provide Community Supports • MCPs and providers' perceptions of whether the number of eligible and contracted providers are sufficient to meet service need
Goal 3: Increase uptake of Community Supports by eligible members EQ4: Did the number of members receiving Community Supports increase over time?	• Proportion of eligible members that are authorized for and subsequently utilize Community Supports • Number and types of Community Supports used

Evaluation Questions (EQ) & Hypotheses (H)	Measures
H4: The number of members receiving Community Supports will increase over time H4b: Members with housing-related needs will receive more than one Community Supports to address these needs	• Frequency[4] and duration of Community Supports use • Number and proportion of eligible Medi-Cal members that used each Community Supports • Demographic and health characteristics of Community Supports users and non-users, compared to the population of members eligible for these services • MCPs and providers' perceptions of factors affecting member uptake of Community Supports • Proportion of members with housing needs that receive more than one Community Supports Community Supports, either simultaneously or sequentially • Demographic and health characteristics of members receiving more than one Community Supports, relative to members only receiving one Community Supports • Most frequently co-occurring Community Supports
Goal 3: Increase uptake of Community Supports by eligible members EQ5: What strategies are being used to identify and refer eligible members to Community Supports? H5: Members will primarily be connected to Community Supports via community-based provider referrals	• MCPs and providers' self-reported processes for identifying members eligible for Community Supports and connecting them to services • Member self-reports of mechanisms for learning about how their Community Supports needs can be recognized and addressed: family, community orgs, PCP, specialty care • Member self-report of who, how, and when MCP or provider offered information about options for managing their need and/or how Community Supports might address their need

[4] Frequency will only be assessed for Community Supports that can be offered more than once in a lifetime.

Evaluation Questions (EQ) & Hypotheses (H)	Measures
	• Member self-reports of number, types, and timing of exposure to and use of different types of Community Supports
Goal 4: Examine whether and how public investments in housing and other HRSN services change over time in concert with new Medicaid funding for those services EQ6: How is new Medicaid funding for Community Supports impacting existing systems of care? H6: Medicaid funding for Community Supports will be perceived as complementing state and local investments in housing and other HRSN services.	• California public housing expenditures from federal and state sources, 2018-2026 • MCPs and providers' perceptions of how new Medicaid funding for Community Supports has impacted existing systems of care, including non-Medicaid funding for similar supports or services • MCP and provider descriptions of how they are using new Medicaid funding in concert with state and local investments in housing or other social services to address member needs. •
Goal 5: Increase members' access to non-emergency outpatient care and reduce acute care utilization and long-term care admission and stays EQ7: Will Community Supports affect access to non-emergency outpatient care? H7: Members receiving Community Supports will use more non-emergency outpatient services than members who do not	• Primary care visits • Specialty care visits • Mental health services • Substance use disorder services Member self-report of downstream impacts of receiving Community Supports (e.g., on finances and access to needed health care)
Goal 5: Increase members' access to non-emergency outpatient care and reduce acute care utilization and long-term care admission and stays EQ7: Will Community Supports reduce avoidable acute care utilization or long-term care stays?	• Emergency department visits (total; needed, preventable, primary care treatable, non-emergent; mental health-related, alcohol-related or substance use related) • Hospitalizations (total; from ED; potentially avoidable) • Long-term care stays • Housing stability (as feasible)

Evaluation Questions (EQ) & Hypotheses (H)	Measures
H7: Members receiving Community Services will experience greater reductions in avoidable acute care utilization and long-term care stays than members who do not	
Goal 6: Improve quality of care and outcomes of care EQ8: Are members satisfied with Community Supports referral processes and services? H8a: Members who are referred and receive Community Supports will be satisfied with services H8b: Member dissatisfaction with services, as indicated by appeals, grievances, and state fair hearings for each Community Supports relative to total service use, will decrease over time	• Volume of appeals, grievances, and state fair hearings for each Community Supports • Reason for appeals, grievances, and state fair hearings for each Community Supports • Resolution status of appeals, grievances, and state fair hearings for each Community Supports • Members' self-reported knowledge and satisfaction with anticipated and actual Community Supports received • Providers' self-reported perception of Community Supports' effectiveness at addressing members' identified HRSN • MCPs' self-reported perception of Community Supports' effectiveness at addressing members' identified HRSN
Goal 6: Improve quality of care and outcomes of care EQ9: Following receipt of housing-related Community Services, are members being transitioned to other appropriate supports, when needed? H9: The proportion of members transitioned to appropriate HRSN supports will increase over time	• Proportion of members receiving recuperative care that transition to short-term post-hospitalization housing • Proportion of members receiving short-term post-hospitalization housing that receive housing transition navigation supports • Proportion of members receiving housing navigation, housing deposits, recuperative care, or short-term post-hospitalization housing that subsequently receive other public housing assistance
EQ10: Will Community Services improve quality and outcomes of health care? H10a: Community Supports will improve member receipt of appropriate care	• Initiation and engagement of alcohol and other drug dependence treatment • Follow-up after ED visit for alcohol and other drug abuse or dependence

Evaluation Questions (EQ) & Hypotheses (H)	Measures
H10b: Community Supports will reduce member receipt of inappropriate care H10c: Community Supports will promote maintenance of member function H10d: Community Supports will reduce cause-specific complications	• Health Equity and Quality Measure set (HEQMS) and Healthcare Effectiveness Data and Information Set (HEDIS) measures not already in the HEQMS data set, e.g., A1C control for patients with diabetes and blood pressure control for those with a history of high blood pressure or high risk of coronary artery disease. • Receipt of medications / adherence to recommended medications (based on medication fill rates for chronic conditions) • Overall summary quality metric(s) based upon the full set of measured quality metrics • Maintenance of function • Mortality • Cause-specific complications • Provider and member self-report of appropriate care processes (as needed)
Goal 7: Reduce disparities in service utilization, quality of care, and outcomes of care EQ11: Are there disparities in Community Supports uptake based on member demographic characteristics or health conditions or community characteristics? H11: Community Supports uptake will be higher in urban communities, communities with street medicine programs, and among members with English as preferred language	• Number and type of Community Supports used, stratified by member housing status, demographic and health characteristics, and geographic indicators • Proportion of eligible members that used Community Supports, stratified by member housing status, demographic and health characteristics, and geographic indicators
Goal 7: Reduce disparities in service utilization, quality of care, and outcomes of care EQ12: Will Community Supports impact disparities in downstream physical or	• Select measures from Goals 5-6, stratified by member demographic and health characteristics and geographic indicators

Evaluation Questions (EQ) & Hypotheses (H)	Measures
behavioral health service utilization, quality of care, and outcomes of care? H12a: Community Supports will reduce age, sex, racial/ethnic, linguistic, and functional (disability) disparities in downstream physical or behavioral health service utilization, quality of care, and outcomes of care H12b: Community Supports will reduce disparities in physical or behavioral health service utilization and outcomes of care for individuals experiencing homelessness	• MCPs and providers' self-reported participation in health equity initiatives or other efforts to improve health equity • Member self-report of discrimination or disparities
Goal 8: Ensure HRSN expenditures do not exceed aggregate spending caps and Community Supports are cost-effective alternatives to State Plan services or settings EQ13: Will HRSN expenditures exceed the aggregate spending cap per demonstration year? H13: HRSN expenditures will not exceed the aggregate spending cap.	• Total expenditures on HRSN services and infrastructure, per demonstration year • % Medicaid budget expended on HRSN services and infrastructure, per demonstration year
Goal 8: Ensure HRSN expenditures do not exceed aggregate spending caps and Community Supports are cost-effective alternatives to State Plan services or settings EQ14: Will Community Supports impact cost of care? H14: Community Supports are cost-effective alternatives to State Plan services and settings.	• Estimated Medi-Cal payments for services such as ED visits, hospitalizations, and long-term care stays

Methods
Data Sources

UCLA-RAND will use multiple data sources for the Community Supports evaluation. To improve cost-efficiencies and consistency across the CalAIM evaluation as well as enhance the evaluation's understanding of potential differential Community Supports' impact on subpopulations of Medi-Cal members, UCLA-RAND will use relevant data already obtained for the PATH, GPP, Duals, and Reentry evaluations when possible. UCLA-RAND has already submitted a consolidated data request for the four initial components of the CalAIM Evaluation to facilitate efficiencies in data accession. The Community Supports' evaluation will also request new administrative data sources from DHCS as needed to address Community Supports' evaluation questions. The UCLA-RAND Evaluation will further obtain available external secondary data on community-based providers and their characteristics, as well as on geographic indicators such as urbanicity, social vulnerability, and health inequity. When appropriate, UCLA-RAND will also draw on data previously collected by UCLA-RAND as part of prior 1115 Waivers or other evaluations (e.g., for GPP, WPC, or HHP).

Per STC 15.4, UCLA-RAND will attempt, with support from DHCS, to access several databases necessary to characterize our exposed population and comparison groups, as well as member reports of utilization of services and receipt of recommended care services, and data elements describing key structures related to homelessness and other social needs. In all instances, we emphasize the importance of seeking support from DHCS as their support will be critically important in our securing timely and comprehensive data as requested.

Below we provide several examples of specific data requests with associated potential alternatives that could be performed if the primary data request is unsuccessful.

1. The California Interagency Council on Homelessness (CalICH)'s Homeless Data Integration System (HDIS), which integrates local Homeless Management Information System data from all the Continuums of Care (CoC) in California and links this data with Medi-Cal eligibility and claims data on members eligible for Community Supports. If UCLA is unable to obtain the CalICH HDIS data, then UCLA-RAND will, with input and support from DHCS, determine whether to secure data on member receipt of housing assistance from a purposefully selected sample of local CoCs or from the Los Angeles County Enterprise Linkages Project 2.0. UCLA-RAND will also attempt to procure and link data on people living in Low-Income Housing Tax Credit (LIHTC) and Housing and Urban Development (HUD)-subsidized housing in a small sample of purposefully selected jurisdictions because data on HUD assistance represents only a small component of the overall housing assistance members may receive.
2. Data on social needs screening and results from select community resource referral platforms, health plans, or provider electronic health records. Additionally, UCLA-RAND will survey a purposeful sample of members eligible for the 1115 Waiver Community Supports to obtain member reports of perceived needs for Community Supports, their experiences accessing Community Supports, how their receipt of Community Supports were associated with changes in perceived needs, and any unintended consequences of Community Supports participation.

3. The Minimum Data Set of Long-Term Care database for California nursing home (NH) residents, which will provide comprehensive data on NH resident functional status, cognitive status, active illnesses, adverse events, supportive care, and advanced care preferences – elements that are key to understanding Community Supports measures linked to transitioning NH residents to assisted living or independent living in the community. UCLA-RAND will also attempt to obtain annual In-Home Supportive Services (IHSS) assessments, which provide standardized functional assessments that can be used to track the maintenance of function for a substantial subset of members over time.
4. Medicare managed care encounter data for Duals who are eligible to receive Community Supports services. Duals represent a sub-population that is likely to be substantially represented among recipients of Community Supports services targeted at maintenance of function and independence while living outside of NHs.
5. Hospital chart abstraction (post-hospitalization transitional housing) to measure (1) severity of illness, (2) instability at discharge, (3) discharge location, and (4) discharge treatment plan. Hospital chart abstraction will focus on the initial and final aspects of hospitalization (focused on admission notes, discharge summaries, discharge notes, and advanced care planning documentation). Chart abstraction will focus on up to 1000 completed charts – 500 individuals who received post-hospitalization transitional housing and 500 matched individuals (based on demographics, location, diagnosis at admission, and severity of illness based upon administrative data-based secondary diagnoses). More detailed information about chart abstractions is provided in Appendix 1. If chart abstraction is not feasible, UCLA-RAND will determine, with input from DHCS, whether the member survey or other data could be used to obtain some of this information instead. Noting that abstractions would occur conditional on member consent, there may be value in reviewing reasons for avoiding this potentially useful methodology.

   Should the chart abstraction design described above not be feasible for the sample size described above, an alternative strategy for assessing member experience would involve a more intense mixed methods approach engaging a smaller study cohort (30-50 individuals). Specifically, UCLA-RAND will conduct a mixed method, focused, short-term (e.g., nine-month) longitudinal assessment of members eligible for use of the short-term post-hospitalization housing 1115 Community Supports. Participants would be invited to sign informed consent for review of medical records and participation in the program. Analysis of this cohort would provide clinically and socially relevant information about how member's lives are changed (or not) with exposure (or not) to a 1115 Community Support. This type of analysis would be focused on individuals meeting eligibility criteria for either the post-hospital short-term housing Community Supports and/or medical respite condition on the individual (1) providing consent to participate in twice monthly video or phone calls, (2) signing medical record consents for access to their medical records, and (3) meeting specific clinical criteria associated with one of the three clinical conditions we anticipate studying.

When administrative or secondary data are not available to address evaluation research questions, UCLA-RAND will address these gaps with primary data collection (e.g., surveys and/or interviews). Any surveys or interviews conducted with MCPs, or providers will be coordinated with other CalAIM

evaluation components (e.g., PATH, Re-entry) as appropriate. More specific details of data sources planned for the Community Supports evaluation are provided below.

1. DHCS administrative data on Community Supports from January 1, 2022 through December 31, 2026, including Medi-Cal eligibility and claims data, Quarterly Implementation Monitoring Reports and JavaScript Object Notation Data on ECM and Community Supports, Community Supports policy guides, PATH CITED applications and awardees for Community Supports, Housing and Homelessness Incentive Program (HHIP) and Incentive Payment Program (IPP) reports, reports submitted by MCPs or Community Supports providers to DHCS (e.g., Model of Care templates, implementation plans), data on appeals, grievances, and state fair hearings for each Community Support, and salient data from any DHCS-administered surveys of MCPs or Community Supports providers.
2. Existing data from WPC and HHP on providers of care coordination, care management, and other services similar to Community Supports and on members that received these services. WPC was implemented in 2017-2021. HHP implementation was staggered, but the program was implemented in 2018-2021.
3. Data on community-based providers and their characteristics, focusing on providers identified by DHCS as "preferred partners" for providing each Community Support (e.g., National Institute for Medical Respite Care directory of medical respite providers in California).
4. Publicly available geographic data such as county, rural-urban commuting area codes (RUCAs), Social Vulnerability Index (SVI), Healthy Places Index (HPI), or Social Deprivation Index (SDI) used to identify members' county of residence, region, rural communities, those with high SVI or SDI scores, or those in the bottom two HPI quartiles.
5. Semi-structured interviews with MCPs and a purposive sample of providers contracted to provide Community Supports, conducted in 2024 and 2026. At each time, we will interview MCPs and a purposefully selected sample of 40-45 community-based providers. Community-based providers will be selected to maximize variation in eligible provider types, Community Support provided, and geographic location, and will be identified based on UCLA-RAND review of provider data as well as MCP recommendation. Interview questions will assess topics such as: (a) factors affecting provider and member uptake of Community Supports, (b) processes for identifying members eligible for Community Supports and connecting them to services, (c) how respondents may be using Community Supports funding in conjunction with other resources to address member needs; (d) approaches for coordinating with other stakeholders to identify and address members' other health, behavioral health, and social needs, (e) perceived effectiveness of Community Supports at addressing members' HRSN, and (f) perceived impacts of Community Supports and other new Medicaid funding on existing systems of care. As appropriate, UCLA-RAND may interview up to 15 additional key informants (e.g., from county human service agencies, public behavioral health, Continuums of Care) in select counties to address (c) and (f). These key informants would only be interviewed at a single point in time. To minimize respondent burden, all interviews will be conducted in coordination with the PATH evaluation; any interviews with key informants from carceral settings will be coordinated with the Reentry evaluation.
6. UCLA-RAND surveys of MCPs and Community Supports providers, administered in 2024 and 2026 to MCPs and Community Supports providers. To minimize respondent burden, surveys

will be conducted in coordination with the PATH evaluation. Surveys will collect structured information on Community Supports implementation policies and practices and other topics identified as salient in key informant interviews.

7. UCLA-RAND Member Surveys for a sample of members participating in the two 1115 Waiver Community Supports. Per STC 15.4, UCLA-RAND will attempt, with support from DHCS, to sample members participating in the Post-Hospitalization Transitional Housing Support and a different sample of those participating in the Recuperative Care Support. UCLA-RAND will aim for 200 completed surveys for each of these two 1115 Community Supports with an estimated survey response rate of 10%. Survey recipients will receive an inducement ($20 gift card) for completed surveys. We anticipate survey completion will take approximately 20 minutes. Surveys will be available in English and Spanish and may be translated to additional languages as needed. Questions will focus on member-reported health and social needs, housing instability, health instability, self-reported health, satisfaction, post-intervention housing outcomes, and access to and use of other types of social services. Since *need* can be understood by members through clinical, social, and/or economic lenses, survey items will be specifically designed to understand how members identify and characterize their need(s). Where possible, UCLA-RAND will aim to assess concordance between member reports of their need for specific components of the Community Support bundle they may have anticipated receiving and those they report receiving. The survey will query members about how receipt of Community Supports impacted their health and well-being. If members report not using the approved service, they will be queried about the reason the service was not used. Ideally, a matched set of members not receiving Community Supports will also be identified and surveyed. More detailed information about the member surveys is provided in Appendix 1.

   Among members eligible for a 1115 Community Supports, individuals eligible to participate in this evaluation component would include members known to have claim/encounter evidence for one of three clinical conditions noted to be prevalent among those eligible for a 1115 Community Supports. Applying this restriction will allow our measurement tools to collect focused clinical-condition specific measures regarding changes in burden of illness, processes, and outcomes, including member report of function and quality of life. For example, if we use active leg ulcers as a diagnosis at the time of hospital discharge, we would be able to include during our proposed nine-month follow-up period, measures describing how the leg ulcer is managed and healing, in addition to measuring member's function and well-being. Conditions likely to be prevalent among members eligible for a 1115 Community Supports include chronic conditions such as diabetes, hypertension, and chronic kidney disease with an acute exacerbation (e.g., with leg ulcer) prompting a recent hospital stay. UCLA-RAND will use empirical analyses of the distribution of diagnoses among those eligible for 1115 Community Supports to assess prevalent conditions. Among prevalent conditions, UCLA-RAND will prioritize the study of conditions for which preexisting measurement tools are documented, appropriate for use in this population, and can support repeat measures across nine months.

If feasible, available data would come from focused medical record review, phone/video visits, member-reported survey data, and claims/ encounter data. Utilization, quality, and quality of life data will be measured.

While this mixed methods approach uses case identification strategies similar to those described above for survey and medical record abstraction, the number of members studied will be fewer than described above with the member survey abstraction analysis. The added value of this focused mixed method approach is somewhat more intense with multiple complementary data elements being available to describe and evaluate stability of hospital discharge, processes, and outcomes, including member experience of their transition to and from a 1115 Community Supports opportunity.

Analyses of this mixed method cohort will be largely descriptive combining thematic analyses and comparative case analysis with quantitative analyses describing utilization and quality for those participating in this mixed methods approach. The analysis will address the member's experience of transitioning to 1115 Community Supports with the description being formed by multiple complementary data sources that are likely to provide answers to the important question of the member's experience participating in a 1115 Community Supports.

Measures

Exhibit 5 on the next page summarizes the data sources and associated data elements that UCLA-RAND anticipates accessing to address Community Supports evaluation goals. Data that UCLA-RAND anticipates using for the evaluation are listed in each column, and measurement domains pertinent to the Community Supports evaluation are listed in each row. Check marks within cells illustrate our expectation of measures available in each data source.

Exhibit 5: Data Sources and Data Elements (Abbreviations and notes are shown at the bottom of the table)

	DHCS	Claims	IHSS	MDS	DSMF	HCAI	House	M Survey	Chart	Fee Sch	Prov	OSurveys	Qual
Age	•												
Sex	•												
Race/Ethnicity	•												
Preferred Language	•												
Marital Status				•	•			•					
Social Need (self-report)								•					
Social Need (neighborhood)	•												
Service Need		•						•				•	
Homelessness	•					•	•	•					
Reported Diagnoses		•				•							
Active Illnesses				•									
Severity at Admission									•				
Illness Burden at Discharge									•				
Duration in Hospital*		•				•			•				
Duration in Nursing Home*		•		•									

Exhibit 5: Data Sources and Data Elements (Abbreviations and notes are shown at the bottom of the table)

	DHCS	Claims	IHSS	MDS	DSMF	HCAI	House	M Survey	Chart	Fee Sch	Prov	OSurveys	Qual
Activities of Daily Living			•	•									
Cognitive Status				•					•				
Eligibility Status	•												
Duration Enrolled	•												
Medicare Status	•												
Ease receiving needed care								•					
Distance to Closest Service Provider	•	•									•	•	
Distance to Closest High Volume Service Provider	•	•									•	•	

Exhibit 5: Data Sources and Data Elements (Abbreviations and notes are shown at the bottom of the table)

	DHCS	Claims	IHSS	MDS	DSMF	HCAI	House	M Survey	Chart	Fee Sch	Prov	OSurveys	Qual
Hospitalization (All cause, cause-specific, preventable)		•				•							
ED Visit without Hospitalization (All cause, cause-specific, preventable)		•				•							
Ambulatory Care Visits (All cause)		•											
In-Home Supportive Service Hours		•											
Nursing Home Stays		•		•				•					
Overall Estimated Costs	•	•					•			•			
HEDIS Measures (Claims-based)		•											
Medicaid Core Measures (Claims-based)		•											
Other Valid Measures (Claims-based)		•											

Exhibit 5: Data Sources and Data Elements (Abbreviations and notes are shown at the bottom of the table)

	DHCS	Claims	IHSS	MDS	DSMF	HCAI	House	M Survey	Chart	Fee Sch	Prov	OSurveys	Qual
Mortality	•			•	•	•							•
Functional Decline			•		•			•					
Illness Resolution								•					
Housing stability							•	•					
Satisfaction with Assistance								•					
Provider Surveys													•

Note: **DHCS –** DHCS enrollment file; **Claims –** service managed care encounters and paid claims; **IHSS –** In Home Service Support annual evaluations; **MDS –** Minimum Data Set for Long Term Care; **DSMF –** California Death Statistical Master File; **HCAI –** California Health Care Access and Information hospital discharge and ED encounter abstracts; **House –** Public Housing Assistance Data; **MSurvey –** Member Surveys; **Chart –** Hospital Chart Abstraction (Post-Hospitalization Transitional Housing); **Fee Sch –** Fee Schedules; **Prov –** Provider Databases; **OSurveys –** Other Surveys (Plans, Providers, etc.); **Qual** – Qualitative Data.

Exhibit 6 illustrates data elements that UCLA-RAND anticipates using to evaluate each of the 14 pre-approved Community Supports. Within each listed column (all of which represent a unique Community Support), we have included a check mark within cells to illustrate our expectation for data that will be available for analysis of the Community Support named in the associated column.

Exhibit 6: Measures and Community Supports

	1115 services		1915(b) services											
	Short-term post-hospitalization housing	Recuperative care (medical respite)	Housing transition / navigation services	Housing tenancy and sustaining services	Housing deposits	Respite care	Day habilitation programs	Nursing facility transition/diversion to assisted living facility	Community transition services/nursing facility transition to home	Personal care and homemaker services	Environmental accessibility adaptations (home modifications)	Medically tailored meals / medically supportive foods	Sobering centers	Asthma remediation
Age	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Sex	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Race	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Preferred Language	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Marital Status	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Social Need (self-report)	•	•												
Social Need (neighborhood)	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Service Need	•	•						•	•					•
Homelessness	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Reported Diagnoses	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Active Illnesses								•	•					
Severity at Admission	•													
Illness Burden at Discharge	•													
Duration in Hospital*	•													
Duration in Nursing Home*								•	•					
Activities of Daily Living								•	•	•				
Cognitive Status								•	•					
Eligibility Status	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Duration Enrolled	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Medicare Status	•	•	•	•	•	•	•	•	•	•	•	•	•	•

Exhibit 6 (Cont): Measures and Community Supports

	1115 services		1915(b) services											
	Short-term post-hospitalization housing	Recuperative care (medical respite)	Housing transition / navigation services	Housing tenancy and sustaining services	Housing deposits	Respite care	Day habilitation programs	Nursing facility transition/diversion to assisted living facility	Community transition services/nursing facility transition to home	Personal care and homemaker services	Environmental accessibility adaptations (home modifications)	Medically tailored meals / medically supportive foods	Sobering centers	Asthma remediation
Ease of receiving timely necessary care (self-reported access to care)	•	•												
Distance to Closest Service Provider	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Distance to Closest High Volume Service Provider	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Hospitalization (All cause, cause-specific, preventable)	•	•	•	•	•	•	•	•	•	•	•	•	•	•
ED Visit without Hospitalization (All cause, cause-specific, preventable)	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Ambulatory Care Visits (All cause)	•	•	•	•	•	•	•	•	•	•	•	•	•	•
In-Home Supportive Service Hours										•	•			
Nursing home Stays	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Overall Estimated Costs	•	•	•	•	•	•	•	•	•	•	•	•	•	•
HEDIS Measures (Claims-based)	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Medicaid Core Measures (Claims-based)	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Other Valid Measures (Claims-based)	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Mortality	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Functional Decline								•	•	•				
Illness resolution	•	•												

Exhibit 6 (Cont): Measures and Community Supports

	1115 services		1915(b) services										
	Short-term post-hospitalization housing	Recuperative care (medical respite)	Housing transition / navigation services	Housing tenancy and sustaining services	Housing deposits	Respite care	Day habilitation programs	Nursing facility transition/diversion to assisted living facility	Community transition services/nursing facility transition to home	Personal care and homemaker services	Environmental accessibility adaptations (home modifications)	Medically tailored meals / medically supportive foods	Sobering centers	Asthma remediation
Housing stability (derived)	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Housing stability (self-report)	•	•												
Satisfaction with Assistance	•	•												

Note: Measures that are universally available across all Community Supports would be based upon in-common routinely collected data (enrollment, claims/encounters, hospital ED and discharge data, death certificate data, housing data, and provider data).

Analyses

UCLA-RAND will respond to the evaluation questions using appropriate qualitative and/or quantitative analytic methods, consistent with the CalAIM evaluation's mixed methods approach. Qualitative analysis will be conducted using thematic analysis or comparative case analysis, as appropriate. Quantitative analysis will include descriptive analyses using t-tests and Chi-square tests, regression models, and difference-in-difference regression models as appropriate.

Goal 1: Increase uptake of Community Supports by MCPs

To address EQ1, which asks whether the number of MCPs offering Community Supports increase over time, UCLA-RAND will assess change or rate of growth in the related measures noted in Exhibit 1 over time (i.e., from January 1, 2022, to December 31, 2026). Data will be presented using graphical plots, and changes in trends will be measured with appropriate tests (e.g., Mann-Kendall test or regression modeling) to determine whether upward or downward trends are statistically significant. Where appropriate, these analyses will be complemented with descriptive analysis of survey data and thematic analysis of interview data, e.g., to provide insight into factors affecting MCPs' decision to offer Community Supports.

Goal 2: Increase awareness and uptake of Community Supports by providers

To answer EQ2, which examines whether the number of providers contracted to provide Community Supports increases over time, UCLA-RAND will assess change or rate of growth in the related measures noted in Exhibit 1 over time (i.e., from January 1, 2022, to December 31, 2026). To better understand provider retention, UCLA-RAND will also assess provider churn over time. Data will be presented using graphic plots, and changes in trends will be measured with appropriate tests (e.g., Mann-Kendall test or regression modeling) to determine whether upward or downward trends are statistically significant. Where appropriate, these analyses will be complemented with descriptive analysis of survey data and thematic analysis of interview data, e.g., to provide insight into factors affecting providers' decision to contract for Community Supports. UCLA-RAND will also analyze Community Supports Model of Care documents submitted by MCPs to obtain information on MCP processes for vetting providers and any minimum qualifications required of providers. As appropriate, UCLA-RAND will build on the PATH analysis, which examines whether the number and proportion of community-based providers located in under-resourced communities increased over time and the extent of provider participation in capacity-building programs such as PATH, HHIP, and IPP.

To answer EQ3, which assesses factors affecting provider participation in Community Supports, UCLA-RAND will descriptively analyze provider survey data and thematically analyze provider interview data. Because provider participation is also contingent on MCPs being willing to contract with providers, UCLA-RAND will also analyze MCP survey data and MCP interview data for MCP perspective on this topic.

Goal 3: Increase uptake of Community Supports by eligible members

To answer EQ4, which assesses whether the number of members utilizing Community Supports increased over time, UCLA-RAND will use Quarterly Implementation Monitoring Reports and JavaScript Object Notation Data on Community Supports to measure rate and patterns of use of Community Supports over time. UCLA-RAND will use logistic regression analyses to assess what

member characteristics differentiate eligible users and non-users for each Community Support. Member characteristics examined include age, sex, race/ethnicity, preferred language, homelessness, California county or region, chronic health conditions, vulnerability indices, severe mental illness, substance use disorder, and Medi-Cal state-funded status, among others. For individuals receiving care in nursing homes, physical function, cognitive status, Resource Utilization Group (RUG) scores, adverse outcomes, and care receipt may be available from the MDS. Individuals receiving IHSS services will have a physical function available from annual IHSS functional assessments.

When feasible, UCLA-RAND will also assess frequency and duration of Community Supports use and member characteristics associated with the frequency and duration of Community Supports use. UCLA-RAND will also assess the feasibility of applying a UCLA-developed algorithm to improve identification of individuals experiencing homelessness or residing in NHs, assisted living, board and care (also known as senior assisted living), or other group living arrangements. UCLA-RAND will also assess member use of multiple Community Supports and the extent to which Community Supports use coincides with the use of Enhanced Care Management. Regression analyses will be complemented with descriptive analysis of survey data and thematic analysis of interview data to contextualize and explain the findings from administrative data analysis. For example, interviews and survey data can illustrate whether other unmeasured characteristics or systemic barriers affected member use of Community Supports.

For the two 1115 Waiver Community Supports, member survey data will provide additional insight into members' characterization of priority needs, previously experienced barriers to resolving these needs, and extent to which they perceive these Community Supports as helping to address some or all these needs.

To address EQ5, which assesses strategies being used to identify and refer members to Community Supports, UCLA-RAND will analyze Community Supports Model of Care documents submitted by MCPs, which provide information on policies and procedures for how Community Supports are provided, including processes for identifying eligible members, authorizing Community Supports, referring members to authorized Community Supports, and monitoring utilization and/or outcomes resulting from the provision of Community Supports. Document analyses of Model of Care documents will be complemented with a thematic analysis of interview data, which will provide deeper insight into the rationale for developing certain processes and the perceived strengths and weaknesses of different approaches for identifying and referring members to Community Supports.

For the two 1115 Waiver Community Supports, member survey data will be used to characterize number, types, timing of member exposure to information about Community Supports, and member satisfaction with information shared about their Community Supports eligibility, availability, and applicability to their needs.

Goal 4: **Examine whether and how public investments in housing and other HRSN services change over time in concert with new Medicaid funding for those services**

To address EQ6, which assesses how new Medicaid funding for Community Supports impacts existing systems of care, UCLA-RAND will assess the feasibility of procuring data on California public

housing expenditures from federal and state sources from 2018-2026. As necessary, UCLA-RAND may also attempt to secure local public housing expenditure data in 2-3 purposefully selected counties over the same period. As feasible, these data will be analyzed to assess changes in state and local investments in housing over time, using descriptive statistics and ANCOVA or regression analyses as appropriate. To better understand MCP and provider perceptions of how new Medicaid funding for Community Supports has impacted existing systems of care, UCLA will thematically analyze data from semi-structured interviews with MCPs, providers contracted to provide Community Supports, and other key informants in county human service agencies, public behavioral health, local CoCs, or carceral settings. Interview questions will address relevant topics noted in Exhibit 1.

Goal 5: Increase members' access to non-emergency outpatient care and reduce acute care utilization and long-term care stays

To address EQs 7-8, which address the impact of Community Supports on members' health care use, UCLA-RAND will analyze the Medi-Cal eligibility and claims data and Quarterly Implementation Monitoring Reports and JavaScript Object Notation data on Community Supports supplemented by MDSS, IHSS annual evaluations, HCAI hospital discharge abstracts, and Medicare claims and managed care encounters to compare health care use of members who received and members who were eligible but did not receive Community Supports before and during program implementation. UCLA-RAND will examine utilization of major categories of services including ambulatory medical care (primary and specialty care), mental health care, substance use disorder treatment, ED visits, hospitalizations, and long-term care stays. Specific measures examined may vary by Community Support and will be finalized with input from DHCS. To measure ED visit type, UCLA-RAND will apply the New York University (NYU) algorithm for differentiating ED types based on diagnosis codes, e.g., as (1) needed, not preventable or avoidable, (2) emergent or primary care treatable, (3) non-emergent; (4) mental health-, alcohol-related, or substance use-related, (5) injury-related, etc.

UCLA-RAND will use difference-in-difference (DD) multivariate regression models to compare changes in health care utilization of members who received Community Supports to a comparison group of members who were eligible for but did not receive Community Supports. UCLA-RAND anticipates that identifying a single comparison group across Community Supports will be challenging because there are differences in eligibility criteria for each Community Support, in delivery systems and population characteristics in California counties, in MCP implementation approaches, and in the availability of Community Supports within each community over time. Participation in Community Supports is also voluntary for members and lists of members who MCPs determine to be eligible and/or who are offered services but decline to participate are not available to UCLA-RAND. Therefore, a comparison group could be selected from: 1) members who had a similar risk profile and were authorized for services but did not participate, and 2) members who were eligible but were not selected, perhaps because of a lower risk profile or because Community Supports were not available in their area or from their MCP. UCLA-RAND will examine the characteristics of members who were eligible and not receiving Community Support before determining the best strategy to identify the comparison group. UCLA-RAND will also consider developing targeted comparison groups based upon patterns of Community Supports use to be identified prior to the cohort matching process. For certain Community Support, such as for the NH transition Community Supports services and individuals receiving IHSS, a more targeted comparison group may be more appropriate. To account

for the possibility of clustered data (e.g., repeated measures over time or nesting of members by provider), UCLA-RAND will use methods such as repeated measures ANOVA, ANCOVA, or generalized linear mixed-effects models as appropriate.

Although UCLA-RAND anticipates that targeted comparison groups will be necessary, UCLA-RAND will also examine the possibility of developing a single comparison group rather than creating separate comparison groups for each Community Support to allow for assessment of the overall impact of Community Supports on member health care use. This approach would avoid the anticipated difficulty of identifying an adequate number of members in the comparison group per MCP or Community Support. Because the comparison group population profile will be designed with the collective population in mind, further assessment is required to determine to what extent the comparison group can be used as a benchmark to assess variation in impact on specific populations (e.g., members experiencing homelessness, members at-risk of institutionalization, etc.) or on MCP-level variation in impact of Community Supports. If needed and feasible, multiple comparison groups may be included allowing for comparison of the results for each group to gain a better understanding of the impact of Community Supports on member health care use.

If the above strategies do not lead to the selection of a reasonable comparison group, UCLA-RAND will develop a model to predict the counterfactual outcomes of interest after Community Supports implementation, or as if Community Supports were not implemented. The observed outcomes will then be compared to the counterfactual predicted outcome. UCLA-RAND will examine all the above methodologies to identify a comparison group to be used in the analyses of the quantitative data.

A key assumption of the DD design is the parallel trends assumption; that is, in the absence of Community Supports, health- and social services use and other outcomes (e.g., health-related quality of life) for enrollees and the comparison group would have been similar with parallel trends. In addition to the approaches described above, UCLA will also use propensity score matching to strengthen the validity of this parallel trends assumption. Specifically, UCLA-RAND will develop a propensity model that includes demographic characteristics, health status, service utilization, county of residence, and cost variables constructed from the Medi-Cal eligibility and claims data. UCLA-RAND will then use the subsequent propensity score in the DD models to “match” members receiving Community Supports to similar members who were eligible for but did not receive services. The models will further include the number of full-scope Medi-Cal enrollment months, indicators for a COVID-19 diagnosis, and participation in ECM.

UCLA will subsequently use multilevel, generalized linear regression models to assess the impact of Community Supports on health services utilization per Medi-Cal member month. Model type will vary based on the nature of the dependent variable. For example, UCLA-RAND anticipates using Poisson or zero-inflated Poisson distribution to assess utilization. Models will control for member demographics, program characteristics, baseline utilization, health status indicators, and other factors identified as important in predicting utilization. The exposure option within a Generalized Linear Model (GLM) will be used to adjust for different number of months of Medi-Cal enrollment and the subsequent different lengths of receipt of Community Supports. To test the parallel trends assumption, UCLA-RAND will run multilevel models with an individual random intercept and an interaction term that allows for potentially different pre-trends in baseline years between members

receiving Community Supports and matched comparison group. As feasible, UCLA-RAND will also run sensitivity analyses to assess potential differential impacts of Community Supports on health services use of different populations (e.g., members who are unhoused and remain unhoused; members who are unhoused and subsequently housed; members with SMI/SUD; Justice Involved (JI); duals; etc.).

Where appropriate, the DD analyses described above will be complemented with descriptive analysis of survey data or thematic analysis of interview data, e.g., to provide insight into factors perceived as affecting members' health care use. For the two 1115 Waiver Community Supports, UCLA-RAND will assess the feasibility of conducting a highly focused medical chart abstraction to provide clinically detailed information about member's prehospital burden of illness, a brief summary of reasons for recent hospitalization that preceded 1115 Community Supports use, and plan of care specified at the time of hospital discharge. This information, combined with member reports of their health status, will provide context for interpreting utilization patterns observed with secondary data analyses and MCP and provider.

Goal 6: Improve quality and outcomes of care

To address EQ8, which assesses member satisfaction with Community Supports referral processes and services, UCLA-RAND will analyze data on appeals, grievances, and state fair hearings for each Community Supports. Specifically, UCLA-RAND will track the number of appeals, grievances, and state fair hearings for each Community Supports over time, relative to Community Supports use, and summarize stated reasons and resolution status for these appeals, grievances, and state fair hearings. UCLA-RAND will also analyze data from MCP and provider-level surveys and interviews regarding perceived effectiveness of Community Supports at addressing members' identified HRSN, when applicable, factors perceived as contributing to any increases in appeals, grievances, and state fair hearings for Community Supports, and opportunities for improvement. For the two 1115 Waiver Community Supports, member surveys will assess member satisfaction with services, ease of accessing services, route of referral, related supportive care, and success in obtaining permanent housing.

To address EQ9, which assesses whether members are being transitioned to appropriate, needed supports following receipt of Community Supports, UCLA-RAND will draw on data from Medi-Cal eligibility and claims data, Quarterly Implementation Monitoring Reports and JavaScript Object Notation Data on Community Supports utilization, and HDIS or other data on members' receipt of public housing assistance to assess change in the related measures identified in Exhibit 1. Where appropriate, these analyses will be accompanied with thematic analysis of interview data, e.g., to provide information on factors affecting the transition of members to appropriate supports and on lessons learned in implementation. For individuals transitioning from NHs back to the community (home or assisted living), NH assessments will allow for the matching of NH admissions and discharges of individuals with similar profiles of need to assess referral to post-NH stays.

For the two 1115 Waiver Community Supports, member surveys will allow for member report of their general health, well-being, access and quality of care, and the extent to which they perceive the need that prompted their Community Support(s) use is being met.

To address EQ10, which examines the impact of Community Supports on the quality and outcomes of health care, UCLA will use related measures identified in Exhibit 1 from the Health Equity and Quality Measure set (HEQMS) supplemented by items from HEDIS and other consensus measures to create greater granularity for individual and summary quality assessment approaches. In particular, we anticipate assessing individual and overall quality performance. Overall quality assessment has the advantages of expanding the eligible target population for assessment while also increasing the granularity of outcomes by allowing for individuals to be eligible for multiple quality metrics. Quality outcomes of interest – receipt of recommended care or avoidance of non-recommended care – can be succinctly present in terms of both overall "pass" rates or normalized to account for underlying differences in achieving recommended care as measured by individual quality metrics. As with Goal 5, specific quality and outcome measures examined will vary by Community Support and will be selected with input from DHCS.

Using the approach outlined in Goal 5, UCLA-RAND will then use difference-in-difference multivariate regression models to assess the impact of Community Supports on the quality of care for members, relative to a matched comparison group. As feasible, UCLA-RAND will also run sensitivity analyses to assess potential differential impacts of Community Supports on quality and outcomes of care for different populations (e.g., members who are unhoused and remain unhoused, members who are unhoused and subsequently housed, members with SMI/SUD, members with diabetes receiving MTM, etc.).

For the two 1115 Waiver Community Supports, UCLA-RAND will assess the feasibility of medical chart abstraction to provide insight into member's chronic and acute medical burden of illness and its association with quality and outcomes. Member surveys will provide additional insight into member-reported access, utilization, quality of care, and health outcomes following receipt of Community Supports.

Goal 7: Reduce disparities in service utilization, quality of care, and outcomes of care

To address EQ11, which assesses whether there are disparities in Community Supports uptake by member demographic characteristics or health conditions, or by community characteristics, UCLA will use data on Medi-Cal eligibility and claims data, Quarterly Implementation Monitoring Reports and JavaScript Object Notation data on Community Supports, and publicly available geographic data identified in Data Sources. These data will be used to examine number and type of Community Supports used, relevant measures identified in Exhibit 1, stratified by member housing status; demographic characteristics such as race/ethnicity, sex, language preference; health status indicators (baseline acute care utilization, baseline Chronic Illness and Disability Payment System risk scores, specific chronic conditions, total count of chronic conditions, behavioral health needs), and geographic indicators (e.g., county of residence, RUCA, HPI quartile). For NH populations, it is possible to obtain physical function, cognitive status, RUG scores, complications, and active conditions. For IHSS recipients, it is possible to obtain physical function scores, which can be used to assess the maintenance of function over time for a subset of members. Disparities will be assessed using appropriate statistical tests, e.g., t-test, MANOVA, chi-square test, etc. These analyses will be supplemented with thematic analysis of interview data regarding factors perceived as affecting

Community Supports uptake and for the two 1115 Waiver Community Supports, analysis of member survey data to assess whether there are disparities in measures previously identified in EQs 4-9.

To address EQ12, which examines whether receipt of Community Supports impacts disparities in downstream health care use, quality of care and outcomes of care, UCLA-RAND will examine select measures identified in Goals 5-6, stratified by select member demographic characteristics, health status, and geographic indicators. Specific measures will be selected following review of Goals 5-6 analyses, member characteristics, and with input from DHCS. Analyses will be conducted using the same approach outlined in Goal 5, e.g., difference-in-difference models. These analyses will be supplemented with thematic analysis of interview data, e.g., regarding MCP or provider participation in health equity initiatives, efforts to address health disparities, or factors perceived as affecting health equity. Member survey data will be used to examine differences in perceived health, access to care, and receipt of recommended care between recipients and controls for the 1115 Waiver Community Supports.

Goal 8: *Ensure HRSN expenditures do not exceed aggregate spending caps and Community Supports are cost-effective alternatives to State Plan services and settings*

Per CMS guidance on 1115 Waivers, HRSN expenditures are considered “capped hypothetical” expenditures that do not need to be offset by demonstration savings, cannot produce demonstration savings, and are eligible for federal financial participation up to an aggregate spending cap per demonstration year. Specifically, HRSN services and infrastructure cannot exceed 3% of total annual Medicaid spending and HRSN infrastructure cannot account for more than 15% of the state’s total HRSN expenditure authority. Unspent HRSN expenditure authority under the cap for each demonstration year can be carried, shifted, or transferred across future years. Federal regulations require that the costs of Community Supports be taken into account in the development of capitation rates for MCPs that provide Community Supports.

To address EQ13, which assesses whether HRSN expenditures exceed the aggregate spending cap per demonstration year, UCLA-RAND will draw on Medi-Cal eligibility and claims data, Quarterly Implementation Monitoring Reports and JavaScript Object Notation data on Community Supports, and other data provided by DHCS (e.g., on IPP and HHIP expenditures) to assess related measures identified in Exhibit 1. As appropriate, UCLA-RAND may also use MCP survey data (e.g., on average cost per HCPS code) to assess HRSN expenditures.

To address EQ14, which assesses whether the cost of each Community Support is offset by reductions in the costs of State Plan services and settings, UCLA-RAND will also examine categories of costs, including outpatient services, ED visits, hospitalizations, and long-term stays. Examination of these categories of service and costs will help illustrate whether receipt of Community Supports led to a different pattern of health services utilization and associated costs. In other words, the analyses will not only provide estimates of the impact on use of each category of service or cost but will further demonstrate if reductions in acute care services or costs of such services as ED visits and hospitalizations were achieved by provision of Community Supports or different types of outpatient care and associated costs.

UCLA-RAND will use the methodology developed under the WPC and The Public Hospital Redesign and Incentives in Medi-Cal (PRIME) evaluations (in consultation with Mercer and DHCS) to attribute estimated payments to claims. This step is necessary because payment amounts for managed care encounters are not accurate or reliable. Briefly, this methodology includes identifying detailed and unduplicated categories of outpatient service, identifying the appropriate and available Medi-Cal fee schedules for each type of service, and attributing that amount to a claim. For ED visits, all claims on the day of the ED visit will be aggregated and counted as part of the visit. For hospitalization, all claims during the length of stay other than visits with primary care providers on the first or last day of the stay will be aggregated as part of the same stay. Payments for hospitalizations will be estimated using publicly available prices in DHCS's All Patient Refined-Diagnosis Related Group (APR-DRG) Pricing Calculator to calculate payments for each DRG. For long-term stays, institutional fees billed by a facility will be calculated at the per diem rate, which is inclusive of supplies, drugs, equipment, and services such as therapy. Using the approach outlined in Goal 5, UCLA-RAND will then use difference-in-difference multivariate regression models to assess the impact of Community Supports on the costs of care for members relative to a matched comparison group. As feasible, UCLA will also run sensitivity analyses to assess potential differential impacts of Community Supports on costs of care for different populations (e.g., members who are unhoused and remain unhoused, members who are unhoused and subsequently housed, members with SMI/SUD, etc.).

Additional analytic considerations

- **Overlap in Community Supports received:** Prior to conducting analyses for Goals 5-8, UCLA-RAND will determine if any Community Supports should be examined together. As shown in Table 1, Community Supports differ in service type, eligibility criteria, preferred provider types, and allowable frequency and duration. Nevertheless, some Community Supports are focused on specific populations and are similar in intent. For example, housing transition/navigation, housing deposits, housing tenancy and sustaining services, recuperative care, short-term post-hospitalization housing, and transitional rent (if approved) are all focused on addressing housing-related needs for members experiencing or at-risk of homelessness with varying levels of clinical needs and are likely to be offered sequentially or in conjunction with one another. Similarly, personal care and homemaker services and environmental accessibility adaptations are targeted to members at risk of institutionalization and are designed to prolong and support community living. Therefore, certain populations are likely to receive more than one Community Support, making it difficult to attribute impact on service utilization, costs, or other outcomes of care to a single Community Support. Furthermore, analysis of the impact of receipt of a single Community Support overlooks the possibility of the cumulative impact of other Community Supports that are used in tandem. Therefore, UCLA-RAND will examine the patterns of use of Community Supports before conducting analyses related to Goals 5-8. If the data indicate significant overlap in receipt of Community Supports, UCLA will identify categories of Community Supports that are better analyzed together and will develop analytic models accordingly. For example, UCLA-RAND may develop an analytic model to measure the impact of receiving housing-focused Community Supports on members experiencing homelessness. This model would include indicators for receipt of each Community Support to account for variation in services provided. UCLA will further measure the impact of receipt of different mixes of services and the cumulative impact of multiple

services, as feasible. This analytic approach will increase efficiency and improve the usability of the findings. For Community Supports with limited or no overlap, UCLA-RAND will develop separate analytic models.

- **Changing program requirements**: DHCS is continually refining Community Supports requirements in response to feedback from MCPs, contracted providers, and other stakeholders. These changes are typically reflected in annual updates to the DHCS Community Supports policy guide, which are used by MCPs and providers to inform implementation. UCLA-RAND will document these changes and the timeline over which they occurred as part of UCLA-RAND's evaluation of Community Supports implementation and impact. As appropriate, UCLA-RAND will also adjust or otherwise account for changes in eligibility criteria and other requirements in analyses, e.g., by incorporating into the selection of comparison groups or in planned subgroup analyses.
- **Prior participation in similar waiver programs:** For most analyses, UCLA-RAND will use a baseline period of 2020-2021. In some counties, Community Supports are similar to services previously provided as part of California's Medi-Cal WPC Pilot Program (baseline period 2015-2016 and intervention implemented 2017-2021) or by Medicaid MCPs that participated in the optional Medicaid HHP benefit (baseline 2016-2017 and intervention implemented 2018-2021). In these counties, UCLA will use data from UCLA's prior evaluation of these programs to assess patterns of service use for Medicaid members who previously received WPC or HHP services and subsequently participated in Community Supports, as feasible. These analyses may be challenging due to churn in enrollment and also selection bias (i.e., members who participate in services for a longer period of time may have a higher level of complexity than those who do not).
- **Potential confounding effects of COVID-19 public health emergency (PHE):** Nationally, the PHE impacted patterns of health care use and expenditures, and also negatively impacted the fiscal solvency of many provider organizations. The baseline period (2020-2021) for the Community Supports evaluation is impacted by the PHE. However, UCLA's previous evaluations of WPC and HHP assessed PHE impact. In these prior evaluations, UCLA found that the PHE temporarily increased services use for Medicaid members with COVID-19; for all other members, there was a sharp decrease in all service use between March – June 2020, followed by a nearly complete recovery in the number of outpatient services (due to use of telehealth) and a less than complete recovery of ED visits and hospitalizations, which continued into December 2021. UCLA's examination of COVID-19 related service use showed high rates of hospitalizations and primary care visits, moderate use of ED visits, and low use of specialty, laboratory services, and long-term care stays. These rates were similar to those for the control population. In these evaluations, UCLA used a COVID-19 indicator (i.e., members with a COVID-19 diagnosis in any claims) in selecting a control group and in difference-in-difference models to ensure that parallel trends assumptions of these models would hold and did not identify major confounding impacts from the PHE. Therefore, while UCLA acknowledges the potential confounding effects of the COVID-19 PHE on health care use and expenditures, UCLA does not believe the PHE will confound Community Supports evaluation outcomes.
- **Sensitivity Analyses:** (1) Clarify differences in claims/encounters and service delivery, including better understanding the gap in reporting between contracted services and billing encounters, which may occur between MCPs that have different contracting arrangements for specific

services. (2) Description of patient need (appropriateness) – examine how to identify which individuals are eligible for care and which receive care based on the different data resources available to UCLA-RAND. (3) Selection effects (unmeasured severity of illness is associated with the choice of intervention leading to biased results) – examination of different approaches and data sources for impact on the robustness of estimates. (4) Weakness of relying upon administrative data for determining need / appropriateness. In particular, disease severity and care plan cannot be determined from (2) and (3). We will attempt to assess gaps by comparing survey results and chart abstraction with administrative data-based results.

- **Additional data:** The Urban Institute's analysis of preventable hospitalizations used publicly available claims-based algorithms provided by the Agency for Healthcare Research and Quality. States could use this software to examine preventable hospitalizations across other characteristics available directly in their Medicaid data, or by linking to other datasets within the state that may shed light on a wider range of factors contributing to health inequities. For example, linking Medicaid data with data on access to social services outside the health care system or exposure to environmental pollutants could identify shortcomings in other resources and possible root causes of disparities such as housing instability, food insecurity, or poor air quality. Addressing these social needs may help people avoid hospitalizations and other poor health outcomes.
- **Aligning the Community Supports Evaluation with other Components of the CalAIM Evaluation**
  The Community Supports evaluation represents an important opportunity to assess the implementation of Community Supports and associated concerns regarding capacity. It supplements four other components: PATH, GPP, DUALs, and REENTRY. While each of these components will generate its own unique evaluation, the interim and final reports will integrate these. In preparation for this, the evaluation team will continue to align the designs of the five components.

Limitations

Attributing outcomes to Community Supports may be challenging due to the simultaneous implementation of other initiatives also intended to improve member health services access, quality of care, and outcomes (e.g., street medicine expansion, community health worker benefit, etc.). In addition, the proposed cost analyses only address costs to Medi-Cal and not to other systems of care and will not include measurements of cost per life year added, or any similar ratio. The evaluation will also only include data through the end of the waiver period (December 31, 2026) and thus may not reflect longer-term program impacts. UCLA's ability to conduct certain analyses is also contingent on the ability to secure access to appropriate data (e.g., Cal ICH HDIS data, the Minimum Data Set, IHSS assessments, Medicare claims/encounters, and Reentry Program eligibility codes). Finally, while UCLA-RAND will attempt to control for member participation in ECM or other care management/case management programs that might moderate the impact of Community Supports on member health care use, quality of care, and other outcomes, UCLA-RAND may not have complete data on all other services members may be engaged with in addition to Community Supports, particularly services not provided by Medi-Cal. Complete information about members

fulfilling or not fulfilling specified eligibility criteria for services may not be available. This will affect the identification of appropriate comparison groups. Furthermore, and related to this is the likelihood of selection bias by members, providers, and MCPs. In other words, there is concern that providers or MCPs may be more likely to refer members with higher (unmeasured) severity for Community Supports, and that these members may also be more likely to opt-in to receive Community Supports). The extent to which we can devise adequate analytic approaches to account for selection effects is a limitation of this evaluation. The inclusion of a medical record abstraction for a cohort of individuals using the 1115 Waivers, can enhance our understanding of a member's chronic and current burden of illness. This information can help to assess the degree of selection bias for those who use Community Supports compared with those eligible but not using and for those whose eligibility was not assessed.

An additional limitation relates to our anticipation that the recording of quality measures is likely to become more digitalized during the tenure of both the 1115 and 1915(b) Waivers. While we are enthusiastic about this advancement, this will present challenges assessing the extent to which changes in quality metric numerators and denominators may reflect the impact of the interventions we are evaluating or merely changes associated with new data systems.

Community Supports Evaluation Timeline

Per STC 16.7, an Interim Evaluation Report for the two 1115 Community Supports is due to CMS December 31, 2025. A final report that evaluates all 14 Community Supports (1115 and 1915(b)) is due to CMS December 31, 2028. To meet these deadlines, the proposed timeline for the Community Supports evaluation is presented below, which identifies the proposed start dates of major evaluation activities. Data collection will be ongoing across the evaluation period.

- August 1, 2024: Evaluator selection and contracting
- October 1, 2024: Initiate the process for receipt of Medi-Cal data
- November 1, 2024: Begin first round of primary data collection from MCPs and providers and analysis of MCP and administrative documents (e.g., Community Supports Model of Care templates, updated Community Supports policy guide, etc.)
- January 2025: Receipt of person-level data from DHCS
- January 1, 2025: Begin analyses of Medi-Cal data for interim report
- February to March 2025: Identify cohorts for cross-section surveys of 1115 Waiver CS-recipients and matched comparisons and for the chart abstraction of post-hospitalization transitional housing.
- June to August 2025: Cross-section surveys of 1115 CS-recipients
- July to December 2025: chart abstraction of post-hospitalization transitional housing September 2, 2025: Interim report draft submitted to DHCS; only includes data on the 1115 Community Supports
- December 31, 2025: Interim report submitted to CMS
- May 1, 2026: Begin final round of primary data collection from MCPs and providers
- June 2026: If feasible, follow-up surveys of CS recipients

- June 2027: Receipt of enrollment and claims data from DHCS
- June 1, 2027: Begin analyses of Medi-Cal data for final report
- August to October 2027: If feasible, second set of cross-section surveys for CS-recipients (new cohort)
- December 2028: Final 1115 and 1915(b) Waiver Reports submitted to CMS

Appendix 1. Additional Information regarding Member Surveys and Medical Chart Abstraction

Member Surveys

As described above, UCLA-RAND will survey members referred for 1115 Community Supports about the type and duration of needs they perceive that could be addressed by Community Supports and their experiences using Community Supports if they did use them. In the latter instance, the survey will address member experiences even if they were unable to use them. For each 1115 Community Supports [(i.e., the Short-Term Post-Hospitalization Housing Community Supports or the Recuperative Care (Medical Respite)], we will field a targeted survey for this Community Support. Members invited to participate in the survey will include potentially three cohorts who were referred for the specific Community Support:

1. The Community Supports - Approved USER cohort will include individuals referred for either 1115 Community Support who have been approved for participation after meeting Community Support eligible criteria. These individuals agree to participate, and initiate use of the Community Support. These individuals may be identified through service encounters provided from DHCS or from the plans.
2. The Community Supports - Approved USER non-responder cohort will include individuals approved for participation with either of the 1115 Community Supports after meeting eligibility criteria. These individuals either declined to participate or have not yet initiated use of the Community Support. These individuals would be identified solely by plans and reported to UCLA-RAND.
3. The Community Supports - Not Approved cohort will include individuals referred for a 1115 Community Supports but who were considered not eligible after review of the Community Supports criteria. These individuals would be identified solely by plans and reported to UCLA-RAND.

In addition to these three cohorts who will have been referred for 1115 Community Supports and been evaluated for eligibility, UCLA-RAND recognizes other individuals who might benefit from a Community Support but were not referred for Community Support.

4. The Community Supports - Eligibility Unknown cohort will be derived from a cohort of members matched to Community Supports Approved Users (Groups 1 and 2) based upon member's MCP, demographics, ICD-10 diagnoses, available information about HRSNs, and utilization patterns.

This formulation is possible with member data only available from MCPs. If these data are not available, then using data only from DHCS we would compare Group 1 to a cohort of members matched to Group 1. This revised Group 4 (Group 4*), would thus potentially include individuals who would have been explicitly included previously in Groups 2 and 3.

Ideally, the survey will be fielded to members from all four cohorts. Group 2 (approved but not received Community Supports) is likely to be the smallest group, while Group 4 (or Group 4*) is drawn from a large pool of individuals. Actual numbers will be driven by a review of available data.

Individuals will be contacted in a stepwise manner via email, mail, and phone call. We will offer an incentive ($20) for a completed survey. For both Community Supports surveys, we will include a consent to participate in the survey and an invitation to participate in a small, focused follow-up of a small number of Community Supports and non-Community Supports participants. When applicable, we will include a consent for chart abstraction.

For simplicity, consider a sample of 400 surveys with equal numbers of individuals for Groups 1 and 4* (where the UCLA-RAND evaluation team is only able to receive data from DHCS and not from the plans). Assuming equal standard deviations (SD) for satisfaction for receipt of care in the two populations. This sample would be able to detect a difference of 0.28 (using a normalized measure with SD = 1) between means with an alpha = 0.05 and a power (beta) of 0.80. In the more complicated circumstance with three groups (e.g. Groups 1, 3, and 4) with 133 individuals in each group, this would be able to detect a difference of 0.345 between means with an alpha = 0.05 and a power (beta) of 0.80. Power to detect overall difference would be calculated using ANOVA, but given the lack of data, this is too speculative at this point.

Information about the contribution of the Member Survey to addressing Evaluation Goals is provided in the Evaluation Design Analyses section and also summarized in more detail in Exhibit A1. As UCLA-RAND reviews empirical data that is emerging from DHCS and MCPs about Community Supports utilization, and the four initial CalAIM Evaluation components (PATH, GPP, Duals, Reentry) to collect data about California's vulnerable individuals and their use of services, UCLA-RAND will use this information to further refine the Member Survey Fielding protocol and survey content, in collaboration with DHCS. UCLA-RAND anticipates fielding the survey during 2025.

Chart Abstraction

We will aim to complete a targeted chart abstraction for up to 500 individuals receiving Community Supports services and a matched comparison group of 500 individuals (as described above). Informed consent would explicitly be obtained for survey respondents. If possible, implicit consent will be devised for this retrospective quality improvement evaluation effort. We will supplement the explicit consent chart abstractions with a sample of Community Supports recipients and matching Community Supports non-recipients clustered within hospitals. In this case, with the consent of the plans, we will ask for voluntary chart abstraction from the hospitals via the mechanism of the plans performing quality assessment. We believe that this is a feasible approach for a focused chart abstraction of the initial and final portions of hospital-based care.

Chart Abstractions will target patient admission and discharge diagnoses, chronic conditions, instability at discharge, advanced care preferences, and care plans at discharge. These data can be used alone and in combination with the member survey results to generate a comprehensive evaluation that considers documented care plans and post-discharge care, patient experience, and other outcomes (utilization, quality, and costs).

Because ICD-10 codes do not capture either severity of disease, extent of disease, or instability of illness nor do they capture treatment plan AND because the 1115 Community Supports sites differ in level of care, reporting of care, and licensure, such information will allow the UCLA-RAND evaluation team to better account for significant selection effects and differences in reporting between sites. These data will allow the team to not only achieve a better understanding of the receipt and impact of Community Supports services, but they will also be an important validation of the overarching administrative data-based analyses for the 1115 Community Supports services and the parallel analyses to be performed for the 1915(b) Waiver Community Supports services.

Exhibit A1. Member Survey Domains Used to Address each Community Supports Program Goal

Goal 1: Increase uptake of Community Supports by MCPs, providers, and members	***Member characterization of their priority need(s) that they perceive could be addressed by Community Supports*** Type of need Duration of need Impact of unfulfilled need on function and health-related quality of life ***Previously experienced barriers to resolution of priority needs*** Clinical challenges Social challenges Financial challenges Equity challenges ***Member report of how specific Community Supports might address some or all of their need(s)***
Goal 2: Address members' opportunities for accessing Community Supports	***Member report of Information Shared about Community Supports*** • Characterize the number, types, and timing of exposure to information about Community Supports use • Characterize member interest in and priorities for receiving Community Supports initiation and continuation of different Community Supports types ***Member Awareness of Community Supports Opportunities*** • How did they learn about these? • Who first advised them about these? • Who was most helpful in guiding member about Community Supports opportunities? • When did they learn about these? • Did member experience barriers in learning about Community Supports opportunities? ***Member Satisfaction with Information Shared About Community Supports Eligibility, Availability, and How Community Supports May Address Their Needs***

	• Understanding of their options for addressing their needs
	• Awareness of a Community Supports program that could address their need
	• The quality and completeness of information about member's:
	  o Potential eligibility for any Community Supports
	  o Likelihood of receiving any Community Supports
	  o
	Likely benefits and risks of Community Supports for relieving their need(s)

Goal 3: Improve collaboration between MCPs, medical providers, and social services providers to address members' physical health, behavioral health, and HRSN	***Member Engagement in Information Sharing and Decision Making Regarding Possible Participation in Community Supports***
	
	• Information shared with member about options for addressing their physical health, behavioral health, and health-related social needs
	
	• Type of provider who shared information and opportunities for
	  o Relieving member's medical, social, and financial needs
	  o Guiding member about how Community Supports might address member's medical, social, and financial
	  o Sharing member-specific information about member's eligibility for Community Supports
	  o Guiding member to prepare materials they would have to provide to be considered for Community Supports
	
	• Member satisfaction with:
	  o Type and adequacy of information shared about their eligibility for Community Supports use, how to improve their eligibility, the information needed to apply for Community Supports use
	  o Their perception of how their MCP, medical provider, and social service providers worked together to address their physical, behavioral health and HRSN

	○ How their MCP, medical provider, and social service providers heard and incorporated the member's voice and concerns as decisions about Community Supports eligibility were considered and finalized
Goal 4: Examine whether and how public investments in housing and other HRSN services change over time in concert with new Medicaid funding for those services	***Member's reports of changes over time in how their MCP, medical providers, and social service providers recognized challenges associated with housing and other HRSN services*** Duration of needing and wanting assistance with housing Prior experiences learning about housing options Helpful and unsatisfactory prior experiences with housing options Duration of time from learning of Community Supports housing options and final decision about their eligibility for housing Community Supports Duration of time from learning about Community Supports housing options and actual receipt of support Other Medicaid/state-funded services member is using
Goal 5: Increase members' access to non-emergency outpatient care and reduce acute care utilization and long-term care stays	***Member opportunities for and use of Non-Emergency vs Emergency use of Specific Types of Services*** • Characterize typical use of Primary, Specialty, Mental Health, and Substance Use Disorder Services ○ Emergent vs. Non-emergent Setting ○ Typical frequency of use ○ Satisfaction with access and quality ○ Specific barriers to access and quality • Characterize most recent ED use ○ Reason for most recent ED visit ○ Satisfaction with health or social service visits preceding most recent ED visits ○ Satisfaction with health or social service visits following most recent ED visits ○ Did the recent ED visit intensify or diminish the member's highest priority need? ***Member use of Acute and Long-Term Care Stays*** Did recent acute care or long-term care stay intensify or diminish the member's highest priority need?

	Members' perceived impact on service access and use • Awareness of duration and future availability of services • Participation with long-term care and/or other community services • Changes since using Community Supports in ED and non-emergency visits and services
Goal 6: Improve quality of care and outcomes of care	***Member overall report of access, quality of care, and outcomes now*** • Member overall reports of changes in fulfillment of their priority need during the last six months • Has access, quality, and outcomes changed since member has learned about Community Supports and since they have participated in Community Supports, or learned they will soon initiate Community Supports, or are not eligible for Community Supports
Goal 7: Reduce disparities in service utilization, quality of care, and outcomes of care	***Member report of disparities experienced in relation to opportunities to:*** • have their priority need recognized as a concern by MCP, medical provider, and social providers • receive optimal quality of care for managing their needs • have Community Supports information shared in a spoken and written language they can understand • learn about Community Support and eligibility requirements for Community Support in a timely manner • gather and share information about their history that could support their eligibility for Community Support Community Support • receive their priority Community Support Community Support • receive an additional Community Supports beyond the one they already have ***Member characterization of specific types of disparity that they have experienced*** • Looking downstream

	• Member reports of concerns that progress in addressing needs will be undone once access to Community Supports is terminated
Goal 8: Ensure HRSN expenditures do not exceed aggregate spending caps and Community Supports are cost-effective alternatives to State Plan services and settings	N/A

Appendix 2. Community Supports Quality Metrics

Community Supports	Candidate Measures – Health Condition Specific	Candidate Measures – Not Health Condition Specific	Notes
Recuperative care (***1115 CS)***		**AMB-ED** - ED Utilization **AHU** - Acute Hospital Utilization **AAP -** Adults' Access to Preventive/ Ambulatory Health Services **Housing Stability** **SNF Admission and LOS –** Admission to skilled nursing facility and length of stay	Housing stability measured by member survey and available data.
Short-term post-hospitalization housing (***1115 CS)***		**AMB-ED** - ED Utilization **AHU** - Acute Hospital Utilization **AAP -** Adults' Access to Preventive/ Ambulatory Health Services **PCR** – Plan All Cause Readmissions **Housing Stability** **SNF Admission and LOS –** Admission to skilled nursing facility and length of stay	Housing stability measured by member survey and available data.
Housing transition / navigation (***1915(b) CS)***		**AMB-ED** - ED Utilization **AHU** - Acute Hospital Utilization **Housing Stability** **SNF Admissions** **SNF LOS**	Housing stability measured by available data.
Housing deposits (***1915(b) CS)***		**AMB-ED** - ED Utilization **AHU** - Acute Hospital Utilization **Housing Stability** **SNF Admissions** **SNF LOS**	Housing stability measured by available data.
Housing tenancy and sustaining (***1915(b) CS)***		**AMB-ED** - ED Utilization **AHU** - Acute Hospital Utilization **Housing Stability** **SNF Admissions** **SNF LOS**	Housing stability measured by available data.

Community Supports	Candidate Measures – Health Condition Specific	Candidate Measures – Not Health Condition Specific	Notes
Day habilitation (***1915(b) CS)***		**Housing Stability Transition to SNF or Assisted Living.** **SNF Admissions** **SNF LOS**	Housing stability measured by available data.
Caregiver respite (***1915(b) CS)***		**Housing Stability Transition to SNF or Assisted Living.** **SNF Admissions** **SNF LOS**	Housing stability measured by available data.
Nursing Facility transition / diversion to Assisted Living Facility (***1915(b) CS)***	**Return to Skilled Nursing Facility within 6 Months**	**HFS - H**ospitalization **F**ollowing Discharge from a **S**killed Nursing Facility **Referrals to or enrollment in Assisted Living Waiver (ALW)** **SNF Readmissions** **SNF LOS**	No specific consensus metrics. Failure may lead to returning to SNF.
Community transition / Nursing Facility to home (***1915(b) CS)***	**Return to Skilled Nursing Facility within 6 Months**	**HFS - H**ospitalization **F**ollowing Discharge from a **S**killed Nursing Facility **Referrals to or enrollment in Assisted Living Waiver (ALW)** **SNF Readmissions** **SNF LOS**	No specific consensus metrics. Failure may lead to returning to SNF.
Personal care and homemaker (***1915(b) CS)***		**Housing Stability Transition to Assisted Living or SNF.** **SNF Admissions** **SNF LOS**	Housing stability measured by available data.

Community Supports	Candidate Measures – Health Condition Specific	Candidate Measures – Not Health Condition Specific	Notes
Medically Tailored Meals (***1915(b) CS)***	**CBP** - Controlling High Blood Pressure **HBD** - Hemoglobin HbA1c Control for Patients with Diabetes – Poor Control (HbAIc > 9%) **EDH** - Emergency Department Visits for Hypoglycemia in Older Adults with Diabetes	**AMB-ED** - ED Utilization **AHU** - Acute Hospital Utilization (any and LOS) **Transition to SNF or Assisted Living (and SNF LOS)**	Weight loss / malnutrition is not measurable
Sobering centers (***1915(b) CS)***	**FUA - Follow-Up After ED Visit for Substance Use—30 days** **ETOH-specific ED visits**	**AMB-ED** - ED Utilization **AHU** - Acute Hospital Utilization **AAP -** Adults' Access to Preventive/ Ambulatory Health Services	
Environmentally Accessible Adaptations (***1915(b) CS)***	**Falls resulting in fracture**	**AMB-ED** - ED Utilization **AHU** - Acute Hospital Utilization **AAP -** Adults' Access to Preventive/ Ambulatory Health Services **Transition to SNF or Assisted Living.**	No specific /consensus measures.
Asthma remediation (***1915(b) CS)***	**AMR** – Asthma Medication Management: Continuation Phase Treatment **Asthma-specific ED visits** **Use of Oral Steroids**	**AMB-ED** - ED Utilization **AHU** - Acute Hospital Utilization **AAP -** Adults' Access to Preventive/ Ambulatory Health Services	Metrics reflect overuse of rescue medications OR need for rescue visit to ED.

Note:

Primary data sources for metrics are available administrative data (including routine assessments that may be available to DHCS and the evaluation team) and member surveys specific to the evaluation.

Not every CS may have an expert consensus quality metric that can be assigned. In this case, we can create alternative metrics with face validity using available data.

For most CS services, specific chronic care management measures from MCAS and HEDIS (such as receipt of appropriate recommended care, e.g. receipt of colonoscopy, testing for diabetics, testing for hyperlipidemia, and care follow-up) would be relevant for interventions promoting

housing stability, given that individuals with stable housing are more likely to be able to accomplish these tasks but are not listed above for space considerations.

SNS-E (Social Need Screening and Intervention) HEDIS measure is quite relevant to the current work, but this measure is a clinical records system-based metric and is not reported to MCAS.