California Department of Health Care Services (DHCS)

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

Revised Evaluation Designs for Providing Access and Transforming Health (PATH) Initiative, Global Payment Program (GPP), and the Medi-Cal Matching Plan Policy for Dually Eligible Beneficiaries
AND
Draft Evaluation Design for the Reentry Demonstration

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General Background Information

The California Advancing and Innovating Medi-Cal (CalAIM) 1115 demonstration, approved by the Centers for Medicare and Medicaid Services (CMS) on December 29, 2021, leverages Medi-Cal as a tool to help address many of the complex challenges facing California's most vulnerable residents, such as the health needs of the homeless, behavioral health care access, children with complex medical conditions, the growing number of justice-involved (JI) populations who have significant clinical needs, and the growing aging population. This demonstration aims to assist the state in improving health outcomes and advancing health equity for Medi-Cal beneficiaries and other low- income people in the state. The demonstration – in combination with other innovations the state is undertaking through its managed care delivery system – is focusing on a person-centered approach, first authorized as Whole Person Care (WPC) pilots by the Medi-Cal 2020 demonstration, to meet the physical, behavioral, developmental, long-term care, oral health, and health-related social needs of all beneficiaries.

The CalAIM demonstration, along with related authorities, including the 1915(b) waiver also approved by CMS on December 29, 2021, is enabling California to fully execute its larger CalAIM initiative, providing benefits to certain high-need, hard-to-reach populations identified by DHCS, with the objective of improving health outcomes for Medi-Cal beneficiaries and other low-income residents. CalAIM is shifting Medi-Cal to a population health approach that prioritizes prevention and addresses social drivers of health. Alongside this demonstration and the 1915(b) waiver, California is also launching statewide a new Enhanced Care Management (ECM) program and a new menu of state-approved Community Supports through its managed care contracts.

While 12 of the Community Supports under managed care authority known as "in lieu of services" (ILOS) were approved in the renewal of the 1915(b) waiver, two additional Community Supports – recuperative care and short-term post-hospitalization services – are authorized through this 1115 demonstration. In alignment with the 1915(b) STCs, California will submit a separate independent evaluation of these 12 ILOS, which will also include an evaluation of the two Community Supports authorized through this 1115 waiver, to CMS in the agreed upon timeline.

In 2023, DHCS launched the Population Health Management (PHM) program, a cornerstone of CalAIM.[1] PHM is establishing a cohesive, statewide approach that ensures Medi-Cal members have access to a comprehensive program intended to lead to longer, healthier and happier lives, improved health outcomes, and health equity. Under PHM, plans and their networks and partners are required to:

- Build trust and meaningfully engage with members;
- Gather, share, and assess timely and accurate data on member preferences and needs to identify efficient and effective opportunities for intervention through data-driven risk stratification processes, predictive analytics, identification of gaps in care, and standardized assessment processes;
- Focus on upstream approaches that link to public health and social services and support members staying healthy through wellness and prevention services;
- Provide care management, care coordination and care transitions across delivery systems, settings, and life circumstances; and
- Identify and mitigate social drivers of health to reduce disparities.

The CalAIM 1115 demonstration activities encompassed in this evaluation design are intended to fit within this larger population health management framework. Please note that this 1115 demonstration continues to provide expenditure authority to allow federal reimbursement for Medi-Cal services provided to short-term residents of Institutions for Mental Diseases (IMDs) receiving DMC-ODS services, and also authorizes contingency management, an evidence-based behavioral health treatment that the state will pilot in conjunction with a comprehensive outpatient treatment program for psycho-stimulant use disorders, in DMC-ODS counties that elect and are approved by DHCS to implement. As agreed with the Centers for Medicare and Medicaid Services (CMS), the Department of Health Care Services (DHCS) submitted a single unified design for these two components of the waiver on July 28, 2023.[2]

As a result, this Revised Evaluation Design covers the evaluation of three components of the waiver: the Providing Access and Transforming Health (PATH) Initiative, the Global Payment Program (GPP), and the Medi-Cal Matching Plan Policy for Dual Eligible Beneficiaries, as well as a new proposed evaluation design for the Reentry Demonstration. More details about these programs and evaluation designs are below.

[1] CalAIM Population Health Management Initiative: https://www.dhcs.ca.gov/CalAIM/Pages/PopulationHealthManagement.aspx

[2] https://www.dhcs.ca.gov/Documents/CA-SUD-CM-Evaluation-Design.pdf

Acronym Glossary

Acronym	Text
ACS	Ambulatory Care-Sensitive
AHA	American Hospital Association
AHC	Accountable Health Communities
AHRQ	Agency for Healthcare Research and Quality
Base SFY	State Fiscal Year
BH	Behavioral Health
BRFSS	Behavioral Risk Factor Surveillance System
CalAIM	California Advancing and Innovating Medi-Cal
CAPH	California Association of Public Hospitals
CBOs	Community-Based Organizations
CCI	Coordinated Care Initiative
CDCR	California Department of Corrections and Rehabilitation
CHIP	Children's Health Insurance Program
CHIS	California Health Interview Survey
CITED	Capacity and Infrastructure Transition, Expansion and Development
CJ	Criminal Justice
CMS	Centers for Medicare and Medicaid Services
COHS	County Operated Health System
CPI	Collaborative Planning and Implementation
CS	Community Supports
CY	Calendar Year
DHCS	Department of Health Care Services
DJJ	Department of Juvenile Justice
DSH	Disproportionate Share Hospital
D-SNP	Duals Special Needs Plan
DUALs	Dually Eligible Beneficiaries
EAE	Exclusively Aligned Enrollment
ECM	Enhanced Care Management
ED	Emergency Department
EE	Equity Enhancing
EQs	Evaluation Questions

Acronym	Text
FDA	Food and Drug Administration
FFS	Fee-For-Service
FQHCs	Federally Qualified Health Centers
GMC	Geographic Managed Care
GPP	Global Payment Program
H	Hypotheses
HER	Electronic Health Records
HHIP	Housing and Homelessness Incentive Program
HHP	Health Homes Program
HPI	Healthy Places Index
HRSN	Health-Related Social Needs
HUD	Housing and Urban Development
IDMs	Institutions for Mental Diseases
ILOS	In Lieu Of Services
IPP	Incentive Payment Program
IRB	Institutional Review Board
JI	Justice Involved
JSON	JavaScript Object Notation
LA Co.	Los Angeles County
MA	Medicare Advantage
MAT	Medication Assisted Treatment
MCPs	Medicaid managed care plan(s)
MIPS	Merit-based Incentive Payment System
MMP	Medicare Medi-Cal Plan
NCCS	National Center for Charitable Statistics
PATH	Providing Access and Transforming Health
PHE	Public Health Emergency
PHM	Population Health Management
PQI	Prevention Quality Indicator
PY	Program Year
QIMR	Quarterly Implementation Monitoring Report
REPL	Race, Ethnicity, Preferred Language
ROC	Research Oversight Committee

Acronym	Text
RUCAs	Rural-Urban Commuting Area
SFY	State Fiscal Year
SO/GI	Sexual Orientation, and Gender Identity
SRG	Survey Research Group
STC	Special Terms and Conditions
SUD	Substance Use Disorder
SVI	Social Vulnerability Index
TA	Technical Assistance
TPA	Third Party Administrator
TPM	Two Plan Model
UC	Uncompensated Care
UC Pool	Uncompensated Care Pool
UDS	Uniform Data System
WPC	Whole Person Care

Evaluation Design for Providing Access and Transforming Health Initiative (PATH)

Brief Overview of PATH

PATH is a five-year, $1.85 billion (total computable) expenditure authority that provides funding to build up the capacity and infrastructure of on-the-ground partners, such as community-based organizations (CBOs), providers, public hospitals, county agencies, tribes, and others, to successfully participate in the Medi-Cal delivery system as California widely implements Enhanced Care Management (ECM) and Community Supports services and the Reentry demonstration under CalAIM. Drawing upon the success and lessons learned from the Whole Person Care and Health Homes Pilots, PATH funding is expected to help address gaps in local organizational capacity and infrastructure that exist statewide, enabling these local partners to scale up the services they provide to eligible Medi-Cal members. Resources funded by PATH - such as additional staff, billing systems, and data exchange capabilities - are expected to help community partners successfully contract with managed care plans, bringing their wealth of expertise in community needs to the Medi-Cal delivery system. As PATH funds serve to strengthen capacity statewide, particularly among providers and CBOs that have historically been under-resourced, the initiative is expected to help California advance health equity, address social drivers of health, and move towards a more equitable, coordinated, and accessible Medi-Cal system.

Authorized under California's Section 1115 waiver, PATH refers to the following aligned programs and initiatives:

- **Support for Implementation of Enhanced Care Management and Community Supports.** PATH is supporting the expansion of community-based provider capacity and infrastructure needed to implement ECM and Community Supports, and increase eligible members' access to these services statewide through four integrated initiatives:
    - **Whole Person Care (WPC) Services and Transition to Managed Care Mitigation (Transition) Initiative:** PATH funded services provided by former

Whole Person Care Pilot Lead Entities until these services transitioned to managed care coverage under CalAIM. This funding ended January 1, 2024.

  - **Technical Assistance (TA) Initiative:** PATH is providing a virtual "marketplace" that offers hands-on technical support and off-the-shelf resources from vendors to help community-based providers establish the infrastructure needed to implement ECM and Community Supports.
  - **Collaborative Planning and Implementation (CPI) Initiative:** PATH is funding regional collaborative planning and implementation efforts among managed care plans, providers, CBOs, county agencies, public hospitals, tribes, and others to promote readiness for ECM and Community Supports.
  - **Capacity and Infrastructure Transition, Expansion and Development (CITED) Initiative:** PATH provides direct funding to support the delivery of ECM and Community Supports services. Entities, such as providers, CBOs, county agencies, public hospitals, tribes, and other providers that are contracted or plan to contract with a managed care plan can apply to receive funding for specific capacity needs to support the transition, expansion, and development of these specific services.

- **Reentry Capacity Building Program.** PATH is also providing funding to support the implementation of the statewide CalAIM Reentry demonstration. This includes support for implementation of pre-release Medi-Cal enrollment and suspension processes, as well as the delivery of select Medi-Cal services to eligible members in the 90 days prior to release. This includes:
  - **Collaborative planning:** PATH provides direct funding to support correctional agencies, county social services departments, county behavioral health agencies, managed care plans, and others so they can jointly design, modify, and launch new processes aimed at increasing enrollment in Medi-Cal and continuous access to care for justice-involved youths and adults.
  - **Capacity and Infrastructure:** PATH provides direct funding to support correctional agencies, institutions, and other justice-involved stakeholders as they implement pre-release Medi-Cal enrollment and suspension processes and deliver select Medi-Cal services to eligible members in the 90 days prior to release.

PATH Evaluation Questions, Hypotheses, and Measures

The evaluation design for PATH is guided by the driver diagram shown in Figure 1. The diagram highlights PATH as an intervention to develop systemwide infrastructure and capacity for delivery of ECM and Community Supports services and implementation of the Reentry demonstration in California. Development of this infrastructure is expected to improve eligible Medi-Cal members' access to ECM, Community Supports, and Re-entry demonstration services. Receipt of ECM, Community Supports, and Reentry demonstration services are in turn expected to improve the health of members who receive these services; Community Supports may also reduce costs associated with avoidable acute care utilization for members that receive these services.[3]

Figure 1. Driver Diagram for Path Evaluation

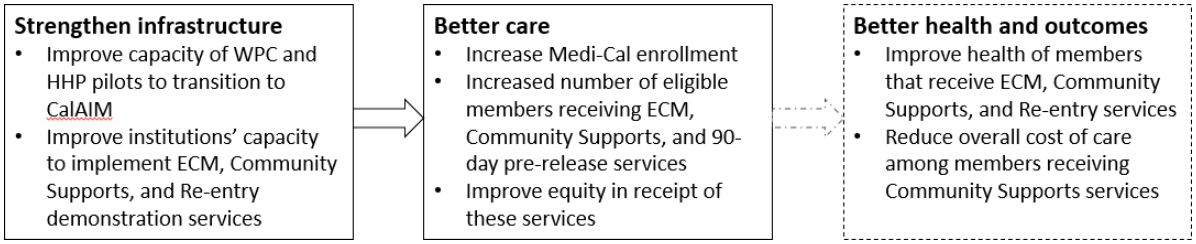

Exhibit 1 shows PATH goals as articulated by DHCS, which are aligned with the CalAIM 1115 Demonstration Special Terms and Conditions (STCs) goals for PATH. The exhibit further includes the evaluation questions (EQs), directional hypotheses (H), and measures developed by DHCS/UCLA to assess whether the goals of PATH were achieved as anticipated. Data sources used to address the EQs and develop measures are identified in the methods section below.

[3] Impact of Community Supports and Re-entry services on member health and costs will be addressed in the ILOS and Re-entry demonstration evaluations; the PATH evaluation will focus on assessing PATH impact on system capacity and infrastructure, and on use of ECM, Community Supports, and Re-entry demonstration services.

Exhibit 1. PATH Evaluation Questions, Hypotheses, and Measures

Goal 1. ***Increase the number of ECM and Community Supports community- based providers and consequently increase Medi-Cal beneficiary ECM and Community Supports utilization according to community needs.***

Evaluation Questions (EQ) & Hypotheses (H)	Measures
EQ 1: Did the number of community-based providers that contracted with Medicaid managed care plans (MCPs) to provide ECM or Community Supports increase over time? **H 1**: The number of community-based providers contracted with MCPs to provide ECM or Community Supports will increase over time due to provision of PATH funding and resources. The number and proportion of community-based providers located in under-resourced communities will increase over time.	• Number of providers that were contracted to provide ECM or Community Supports services • Proportion of the total providers contracted to provide ECM or Community Supports that were community-based providers (versus for-profit or MCPs) • Proportion of ECM or Community Supports providers located in under-resourced or rural communities • Number of providers that applied for and received PATH CITED funding; Number that received TA and WPC transition funding. • Number of community-based providers that received PATH CITED funding, TA, or WPC transition funds • Proportion of providers that provided services under WPC or the Medi-Cal Health Homes Program (HHP) and were subsequently contracted to provide ECM and Community Supports

Exhibit 1. PATH Evaluation Questions, Hypotheses, and Measures (Cont)

Goal 1. ***Increase the number of ECM and Community Supports community- based providers and consequently increase Medi-Cal beneficiary ECM and Community Supports utilization according to community needs.***	
Evaluation Questions (EQ) & Hypotheses (H)	**Measures**
EQ 2: What factors are associated with community-based providers' participation in ECM or Community Supports? **H 2**: Community-based providers are more likely to contract with MCPs to provide ECM or Community Supports if they participate in PATH, were contracted with MCPs prior to CalAIM, or had robust data sharing infrastructure in place prior to CalAIM.	• Characteristics of providers eligible to provide ECM or Community Supports • Eligible providers' self-reported organizational mission, ECM populations of focus, and Community Supports services provided, contracts with MCPs, and data sharing infrastructure prior to CalAIM PATH-participating providers' self- reported reasons for participating in PATH and their perceptions of role PATH's role in helping them successfully contract with MCPs to provide ECM and Community Supports

Exhibit 1. PATH Evaluation Questions, Hypotheses, and Measures (Cont)

Goal 1. ***Increase the number of ECM and Community Supports community- based providers and consequently increase Medi-Cal beneficiary ECM and Community Supports utilization according to community needs.***	
Evaluation Questions (EQ) & Hypotheses (H)	**Measures**
EQ 3: Did PATH increase utilization of ECM and Community Supports? **H 3**: PATH will increase the number of eligible members that utilize ECM or Community Supports and the number of ECM and Community Supports services used by eligible members. PATH will increase ECM and Community Supports utilization by helping MCPs and providers to: (a) develop cross-sector collaborative relationships and infrastructure needed to implement ECM or Community Supports, and (b) use effective strategies for identifying and engaging eligible members in ECM or Community Supports services.	• Proportion of eligible Medi-Cal members that used ECM and Community Supports services • Number and type of ECM and Community Supports services used • Demographic and health characteristics of ECM and Community Supports users and non-users, compared to the population of members eligible for these services • ECM and Community Supports providers' self-reported strategies for identifying and engaging eligible members in ECM and Community Supports • ECM and Community Supports providers' self-reported impact of PATH on their ability to develop collaborative relationships and infrastructure needed to implement ECM or Community Supports and identify and engage eligible members in care.

Exhibit 1. PATH Evaluation Questions, Hypotheses, and Measures (Cont)

Goal 2: *Improve data collection and information sharing infrastructure among ECM and Community Supports providers.*	
Evaluation Questions (EQ) & Hypotheses (H)	**Measures**
EQ 4: Did PATH improve ECM and Community Supports providers' data collection and information sharing infrastructure? **H 4**: PATH will increase the number of ECM and Community Supports providers with data use agreements with MCPs, EHR technology or other electronic care management documentation system, and Medi-Cal billing systems. PATH will increase the number of ECM and Community Supports providers that had shared data with MCPs using these systems.	• ECM and Community Supports providers' self-reported data collection and information sharing infrastructure capabilities over time among providers, stratified by provider type and participation in PATH • Number and proportion of providers with data sharing agreements with MCPs • Number and proportion of providers who have electronic health records (EHR) or other electronic care management documentation system • Number and proportion of Community Supports providers with data sharing agreements with the Homeless Management Information System (of those providing housing-related services) • Number and proportion of providers with Medi-Cal billing systems • ECM and Community Supports providers' self-reported impact of PATH on their ability to improve data collection and information sharing infrastructure

Exhibit 1. PATH Evaluation Questions, Hypotheses, and Measures (Cont)

Goal 3: ***Improve the ability for state prisons, county jails, youth correctional facilities, and their community providers to screen, enroll, change the suspension status, or provide 90-day pre-release services for eligible individuals in Medi-Cal prior to release; and increase the number of eligible individuals screened and enrolled in Medi-Cal prior to release.***	
Evaluation Questions (EQ) & Hypotheses (H)	**Measures**
EQ 5: Did PATH funding improve these institutions' capacity and infrastructure necessary to screen, enroll, and change the suspension status of individuals eligible for Medi-Cal prior to release? **H 5**: PATH funding will improve these institutions' capacity and infrastructure necessary to screen, enroll, and change the suspension status for individuals eligible for Medi-Cal prior to release. PATH will do so by enabling correctional facilities to invest in needed infrastructure and capacity development.	• Self-reported changes to infrastructure, workflow, and policies/regulations made by correctional facilities and other partner institutions in order to screen, enroll, and change the suspension status of individuals eligible for Medi-Cal prior to release, stratified by participation in PATH • Self-reported total amount of funding (PATH and non-PATH) used by these institutions to develop capacity and infrastructure needed to screen, enroll, and change the suspension status of individuals eligible for Medi-Cal prior to release • Perceived role of PATH in promoting these institutions' ability to screen, enroll, and change the suspension status of individuals eligible for Medi-Cal prior to release

Exhibit 1. PATH Evaluation Questions, Hypotheses, and Measures (Cont)

Goal 3: ***Improve the ability for state prisons, county jails, youth correctional facilities, and their community providers to screen, enroll, change the suspension status, or provide 90-day pre-release services for eligible individuals in Medi-Cal prior to release; and increase the number of eligible individuals screened and enrolled in Medi-Cal prior to release.***	
Evaluation Questions (EQ) & Hypotheses (H)	**Measures**
EQ 6. Did PATH funding improve these institutions' capacity and infrastructure necessary to provide 90-day pre-release services to eligible individuals? **H 6**. PATH funding will improve these institutions' capacity and infrastructure to provide pre-release services by providing funding to invest in needed infrastructure and capacity development.	• Self-reported changes to infrastructure, workflow, and community-based linkages made by correctional facilities, county behavioral health agencies, and other community partners to provide eligible individuals with pre-release services, stratified by participation in PATH. Self-reported total amount of funding used to develop capacity and infrastructure needed to provide eligible individuals with pre-release services • Perceived role of PATH in promoting these institutions' ability to provide pre-release services
EQ 7: Did the number of eligible individuals screened and enrolled in Medi-Cal prior to release increase over time? **H 7**: The number of eligible individuals screened and enrolled in Medi-Cal prior to release will increase over time.	• Number and proportion of incarcerated individuals that were screened for Medi-Cal eligibility prior to release, stratified by whether the institution received PATH funding • Proportion of eligible individuals enrolled in Medi-Cal prior to release, stratified by whether the institution received PATH funding or other resources

Methods

Data Source

UCLA will use the following data sources for the PATH evaluation as feasible. UCLA will request all administrative data sources available to DHCS. These include PATH applications, reports and invoices (e.g., Quarterly Implementation Monitoring Reports and JavaScript Object Notation data on ECM and Community Supports membership, utilization, outreach, referral, and provider capacity; PATH implementation plans, and readiness reviews submitted by stakeholders participating in the Reentry demonstration), ECM and Community Supports provider databases, and Medi-Cal eligibility and claims data. To evaluate PATH Supports for ECM and Community Supports, UCLA will further obtain available external secondary data on community-based providers and their characteristics as well as on community context, such as urbanicity, social vulnerability, and health inequity. When appropriate, UCLA will also draw on provider data previously collected by UCLA as part of the WPC and HHP evaluations and DHCS records on providers that transitioned to PATH.

UCLA anticipates that secondary data on community-based providers and their characteristics will not always be readily available and will address gaps in data by surveying these organizations. These surveys will also be used to obtain information on providers' contracts with MCPs, changes in infrastructure and other capabilities over time, implementation of PATH, and self-reported impact of PATH on their ability to participate in ECM or Community Supports. As appropriate, these surveys will be complemented with key informant interviews and observations of select CPI and TA sessions to better understand the context for PATH implementation, perceptions of PATH resources and their impact on the organizations' ability to contract for and provide ECM and Community Supports to eligible enrollees, and to identify challenges, successes, and lessons learned in contracting with MCPs and implementing ECM or Community Supports. To evaluate PATH Supports for Justice-Involved Capacity Building, UCLA will coordinate with the RAND Reentry evaluation team on obtaining any additional, salient administrative data needed from DHCS, the California Department of Corrections and Rehabilitation (CDCR) and select county jails or youth correctional facilities. To address any gaps in data, UCLA also proposes to survey these facilities and conduct key informant interviews, as feasible. Any surveys and interviews conducted in state prisons, county jails, and youth correctional facilities will be coordinated with the RAND Reentry evaluation team. More specific details of data sources planned for the PATH evaluation are provided below.

1. California Department of Health Care Services (DHCS) administrative data on PATH from January 1, 2022 through December 31, 2026, including Medi-Cal eligibility and claims data, ECM and Community Supports provider list and characteristics, PATH CITED applications and awardees (ECM and Community Supports), PATH Reentry funding applications and awardees, materials collected or distributed by the PATH Third Party Administrator (TPA) and facilitators responsible for administering different PATH initiatives, reports submitted by MCPs, ECM, Community Supports, or Reentry providers to DHCS (e.g., PATH implementation plans and readiness reviews), salient data from any DHCS-administered surveys of ECM, Community Supports, and Re-entry stakeholders, and PATH Transition, TA, and CPI participants.
2. Data on community-based providers and their characteristics including Uniform Data System for federally qualified health centers (FQHCs), American Hospital Association (AHA) survey of hospitals, National Center for Charitable Statistics (NCCS) data on human services nonprofit organizations, California Department of Housing and Urban Development (HUD) data on organizations contracted to provide services in the Continuum of Care program, and National Institute for Medical Respite Care on medical respite providers, as feasible. We will follow DHCS' definition of community- based providers as including all providers eligible for PATH funding, such as community-based organizations (CBOs), public hospitals, county agencies, and tribes. These organizations also include federally qualified health centers, medical groups or physician networks, hospitals or healthcare systems, behavioral health providers, and social service organizations.
3. Existing data from Whole Person Care (WPC) and Health Home Program (HHP) on providers of care coordination, care management, and other services similar to ECM and Community Supports. WPC and HHP providers included participating WPC lead entities and their partners and HHP participating MCPs and their contracted community-based care management entities.
4. Publicly available geographic data such as county, rural-urban commuting area codes (RUCAs), Social Vulnerability Index (SVI), or Healthy Places Index (HPI). These indices will be used to identify under-resourced communities (i.e., rural communities), those with high SVI scores, or those in the bottom two HPI quartiles.
5. UCLA surveys of MCPs and community-based providers, administered at 2024 and 2026 to all MCPs, PATH CITED ECM and Community Supports applicants and awardees, PATH ECM and Community Supports participants, and ECM and Community Supports providers. In a subset of counties with particularly high and low proportions of community-based providers contracted to provide ECM and Community Supports, UCLA will also administer an additional survey to community-

based providers not participating in ECM and Community Supports. To minimize respondent burden, this survey will be conducted once in SFY 2024-2025 and may be restricted to community-based provider types for which high-quality secondary data on provider characteristics are not available; we will collect data from an estimated maximum of 400 providers.

6. Key informant interviews with the PATH TPA and CPI facilitators. Interviews will occur in 2024 and 2026. At each time point, UCLA will interview the PATH TPA and CPI facilitators. Interviews will address support and other resources provided as part of PATH, lessons learned in engaging participants and providing these supports, and other topics identified as salient to the evaluation by UCLA and DHCS. The interviews will also be complemented by observations of select TA and CPI sessions.
7. Key informant interviews with MCPs and community-based providers. Interviews will occur in 2024 and 2026 following the UCLA surveys. At each time point, we will interview 24 MCPs and a purposefully selected sample of 40 community-based providers. Community-based providers will be selected to maximize variation in provider types (e.g., FQHCs, behavioral health providers, human services providers) and geographic location (e.g., region and SVI score or HPI quartile in which services are provided). The first round of interviews with MCPs and community-based providers will address topics such as factors affecting MCP selection of ECM or Community Supports providers; factors affecting provider readiness and willingness to participate in ECM or Community Supports; technical assistance and other supports provided by MCPs to ECM or Community Supports providers; use and perceived utility of PATH, including in relation to other funding supports such as the Incentive Payment Program; and as appropriate, facilitators, barriers, and lessons learned in implementing ECM or Community Supports. The second round of interviews with MCPs and community-based providers will address factors affecting continued participation in ECM or Community Supports over time, perceived business case and sustainability of Community Support services, and other topics identified as salient to the evaluation by the independent evaluator and DHCS.
8. Administrative data from CDCR obtained by the RAND team including Medi-Cal screening and enrollment and eligibility for 90-day pre-release services from a sample of county jails and youth correctional facilities from January 1, 2017 through December 31, 2026.
9. The RAND team's organizational survey of state prisons, county jails, and youth correctional facilities, administered in 2025/2026. The team will attempt to administer the survey to all 195 eligible facilities in the state (four state prisons, 114 county jails, and 47 youth correctional facilities). The PATH evaluation team will develop survey questions salient to addressing PATH EQs. The survey will only be

administered if gaps in available administrative data (e.g., PATH implementation plans and readiness reviews, DHCS-administered surveys, etc.) are identified.

10. Key informant interviews in coordination with the RAND team in a purposefully selected sample of 32 state prisons, county jails, and youth correctional facilities (12 state-level stakeholders and 20 others in four-to-five focal counties). Interviews will occur in 2024 and 2026 and will address topics such as systems changes and supports needed to screen, enroll, and change the suspension of individuals eligible for Medi-Cal prior to release; systems changes and community-based linkages needed to identify and engage eligible individuals in pre-release services and to provide these services; use and perceived utility of PATH; and facilitators, barriers, and lessons learned in implementing the Reentry demonstration.

Analytic methods

UCLA will respond to the evaluation questions using appropriate qualitative and quantitative analytic methods. Qualitative analysis will be conducted using thematic analysis, comparative case analysis, or coincidence analysis, as appropriate. Quantitative analysis will include descriptive analysis using t-tests and Chi-square tests, regression, and difference-in-difference regression models as appropriate.

To answer EQ 1, UCLA will assess change or rate of growth in the related measures noted in Exhibit 1 during PATH over time (i.e., from January 1, 2022, to December 31, 2026) and by California regions and under-resourced community indices. UCLA will also assess the transition of WPC and HHP providers to PATH providers in the early phase of PATH implementation as well as churn in providers newly contracted to provide ECM or Community Supports services during PATH to better understand retention of WPC, HHP, and additional providers under PATH.

To answer EQ 2, UCLA will assess the type of organizations that participated in PATH and the factors that may have contributed to their participation using the related measures noted in Exhibit 1. UCLA will assess the provider survey responses by whether organizations applied to or contracted with MCPs and whether they received PATH CITED funding or other PATH supports. UCLA will further analyze the qualitative data obtained during interviews to provide further contextual information and barriers and challenges obtained during interviews by the providers groups described above as feasible. UCLA will also analyze the available administrative data from PATH CITED applications, materials collected by or distributed by the TPA or CPI facilitators responsible for administering different PATH initiatives, and other salient materials

submitted by MCPs or ECM and Community Supports providers to answer this EQ.

To answer EQ 3, UCLA will use Medi-Cal eligibility and claims data to measure rate and patterns of use of ECM and Community Supports during PATH implementation years. UCLA will further assess the rate and patterns of use by salient characteristics of users and non-users. Salient characteristics will include age, gender, race/ethnicity, preferred language, homelessness, California region, vulnerability indices, severe mental illness, and substance use disorder, among others. UCLA will further examine the types of ECM and Community Supports services used by salient enrollee characteristic to further demonstrate the concordance between enrollee needs, regional differences in provider availability, and service use as feasible. UCLA will assess differences in rates and patterns of use of ECM and Community Supports by provider characteristics, by California regions and under-resourced community indices. As feasible, UCLA will further examine the potential role of PATH in reducing disparities in access to and use of ECM and Community Supports services by member race/ethnicity and language preference, using regression models. These analyses will be complemented with analysis of survey and interview data to contextualize and explain the findings from the Medi-Cal eligibility and claims data.

To answer EQ 4, UCLA will use provider survey responses and available administrative data such as MCP and provider reports to assess change in the related measures noted in Exhibit 1 during PATH over time and by provider characteristics and by California regions and under-resourced community indices. These analyses will be complemented with analysis of survey and interview data on changes in information sharing infrastructure before and after PATH, how such infrastructure was developed or improved by providers during PATH, how data was shared with MCPs, and what were the related barriers and challenges to these activities.

To answer EQ 5 and EQ 6, UCLA will collaborate with RAND to analyze surveys, interviews, and salient administrative data to assess changes in infrastructure, workflows, staffing, and policies/regulations that may have influenced facilities' ability to screen, enroll, and change the suspension status for eligible individuals in Medi-Cal prior to release before and after PATH implementation. UCLA and RAND will further conduct similar analyses to characterize the delivery of 90-day pre-release services. The analyses will include an assessment of perceptions of the impact of PATH funding, technical assistance, and other supports as well as barriers and challenges to PATH

implementation in these institutions.

To answer EQ 7, UCLA will collaborate with RAND to examine CDCR administrative data and administrative data in select county jails and youth correctional facilities to measure the rate of incarcerated individuals that were screened for Medi-Cal eligibility and whether those found eligible were enrolled in Medi-Cal prior to release, stratified by facility type, region, and whether the institution received PATH funding or resources. As feasible, UCLA and RAND will attempt to corroborate enrollment using Medi-Cal enrollment data, assuming the availability of a flag in these data identifying previously incarcerated individuals.

Cost analyses

The PATH team proposes to examine all PATH expenditures and resources as well as payments to providers for ECM/CS services. This is not a goal articulated by DHCS in the original evaluation design but is included to address CMS request to measure cost outcomes of the demonstration. The PATH team will further examine the patterns of payments for services used for beneficiaries that received WPC and HHP services and subsequently received ECM/CS as well as beneficiaries that received ECM/CS services for the first-time following PATH implementation, stratified by provider type, region, and whether the provider received PATH funding or resources.

Limitations

Attributing outcomes to PATH implementation are challenging because WPC entities and HHP MCPs in most California counties transitioned to PATH by January 2022 and the PATH initiatives were implemented statewide. Furthermore, DHCS has simultaneously implemented other funding initiatives to develop provider infrastructure and capacity such as the CalAIM Incentive Payment Program (IPP), which provided MCPs with $1.5 billion in additional funding to support provider infrastructure and capacity development and member engagement for ECM, Community Supports, and the Housing and Homelessness Incentive Program (HHIP), which allowed MCPs to earn incentive payments for investments and progress in addressing homelessness as a social driver of health. Providers that applied for PATH may have been denied funding if they received IPP or HHIP funds and their applications were deemed duplicative. Therefore, it is not feasible to construct a comparison group of counties or geographic areas without a PATH intervention or to fully attribute changes in provider capacity and infrastructure or utilization of ECM and Community Supports to PATH. Self-reported data on changes

in the provider organizations due to PATH and perceived impact of PATH on organization and population served are subject to recall and acquiescence bias. In addition, proposed cost analyses only address costs to Medi-Cal and not to other systems of care. 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. Nevertheless, these data are an important element of mixed-method evaluation design; are crucial in understanding providers' actions and motivation for choosing specific PATH implementation approaches; and essential in contextualizing and explaining quantitative outcomes.

Evaluation Design for the Global Payment Program (GPP)

Brief Overview of Global Payment Program

The Global Payment Program (GPP), launched in July 2015 as part of California's Section 1115 Medi-Cal 2020 waiver, established a statewide pool of funding for the uninsured by combining federal disproportionate share hospital (DSH) and uncompensated care (UC) funding to operate its GPP to assist public health care systems (PHCS) in their key role providing health care for the uninsured. The GPP's value-based payment structure uses a value-based point methodology to incentivize a shift in the overall delivery of services to more patient-centered and cost-effective care settings and strategies. By incentivizing a shift in the provision of GPP services from avoidable, costly, low-value care to primary and preventive high-value care in more appropriate venues, non-emergency care delivery can substitute for care provided through the emergency department or inpatient hospital settings. To enhance access, utilization, and equity among California's uninsured, GPP also incorporates services that are otherwise available to the state's Medi-Cal beneficiaries under other 1115 Medicaid waivers. With the approval of California's CalAIM 1115 waiver,[4] GPP will continue through 2026, its twelfth project year (PY). California will continue to test and assess this approach to assist PHCSs to strengthen data infrastructure and completeness necessary to describe and improve health care utilization, quality of care and cost inequities. This evaluation of the GPP will examine key program features to identify areas that can be improved and those that can be emulated as California strives to strengthen GPP performance and effectiveness for potentially broader application.

PHCSs that participate in the GPP are comprised of designated public hospitals and their affiliated and contracted providers. PHCSs participating in the GPP are shown in Exhibit 2 below. Twelve of the PHCSs listed below began participating in GPP on July 1, 2015 (GPP Program Year 1 (PY1). UCLA began participating in GPP beginning with PY 9, January 1, 2023.

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[4] Medical STCs: Technical corrections to the California section 1115 Medicaid demonstration, entitled "California Advancing and Innovating Medi-Cal" (CalAIM) (Project Number 11-W-00193/9) which was approved on August 23, 2023, under the authority of section 1115(a) of the Social Security Act (the Act). https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-1115-STC-Technical-Corrections.pdf.

Exhibit 2. PHCS Participating in the Global Payment Program

1. Los Angeles County (LA Co.) health system
    a. LA Co. Harbor/UCLA Medical Center
    b. LA Co. Olive View Medical Center
    c. LA Co. Rancho Los Amigos National Rehabilitation Center
    d. LA Co. University of Southern California Medical Center
2. Alameda Health System
    a. Highland Hospital (including the Fairmont and John George Psychiatric facilities)
    b. Alameda Hospital
    c. San Leandro Hospital
3. Arrowhead Regional Medical Center
4. Contra Costa Regional Medical Center
5. Kern Medical Center
6. Natividad Medical Center
7. Riverside University Health System - Medical Center
8. San Francisco General Hospital
9. San Joaquin General Hospital
10. San Mateo County General Hospital
11. Santa Clara Valley Medical Center
12. Ventura County Medical Center
13. University of California Los Angeles
    a. UC Los Angeles Medical Center
    b. Santa Monica UCLA Medical Center

The total amount of annual funding available for the GPP across its planned 12 program years, historically has been a combination of a portion of the state's DSH allotment that would otherwise be allocated to the PHCS, and the amount associated with the historical Safety Net Care Uncompensated Care Pool (UC Pool) that existed before the GPP. Details

of the Valuation process are summarized below based upon a detailed description in the CalAIM-1115-STC[5]

PHCSs participating with GPP continue receiving GPP payments that are calculated using a value-based point methodology that incorporates factors that shift the overall delivery of services for the uninsured to more appropriate settings and reinforces structural changes to the care delivery system that can improve the options for treating both Medicaid and uninsured patients. The methodology for setting GPP service values incorporates measures of value for the patient in conjunction with the recognition of costs to the health care system. Care being received in appropriate settings are valued relatively higher than care given in inappropriate care settings for the type of illness.

Each PHCS is required to prove a threshold amount of care, measured in points, to earn their entire annual GPP budget amount. The threshold amounts for each PHCS were initially constructed using the volume and cost of services incurred by participating providers and used the most recent complete state fiscal year (SFY) data (Base SFY). DHCS established GPP PY 1-point thresholds for each PHCS by collecting utilization data for all traditional uninsured services (by each traditional table 1 category) provided in SFY 2014-15, and then multiplying those GPP service counts by corresponding initial point values.

Point values for each GPP service remain consistent across all providers. Points are assigned after considering measures of value for patients and contribution to other program goals.

Interim GPP payments are made to PHCSs on a quarterly basis calculated as 25 percent of the PHCS's annual global budget. Within nine months following the end of each GPP PY, the state reconciles interim payments to the amount each PHCS reported to DHCS as having earned by delivering GPP-related services to uninsured individuals. Annually, PHCSs receive as payment the full amount of a PHCS global budget if it meets or exceeds its designated threshold for a specific GPP PY. When a PHCS does not achieve

[5] Medical STCs: Technical corrections to the California section 1115 Medicaid demonstration, entitled "California Advancing and Innovating Medi-Cal" (CalAIM) (Project Number 11-W-00193/9) which was approved on August 23, 2023, under the authority of section 1115(a) of the Social Security Act (the Act). Attachment L. Global Payment Program Valuation. Pages 187-220/264. CalAIM - https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-1115-STC-Technical-Corrections.pdf

or exceed its threshold for a given GPP PY, the PHCS' GPP payments equal the PHCS's global budget diminished by the proportion by which it fell short of its threshold.

GPP services are grouped into categories and tiers with the intent of providing a flexible framework to provide services while encouraging a broad shift to more cost-effective and patient-centered care. Categories reflect the intensity and location of service delivery. Four categories initially defined GPP services: (1) Traditional Outpatient services provided by a public hospital system facility; (2) Non-Traditional Outpatient includes non-traditional outpatient encounters, where care is provided by non-traditional providers or in non-traditional settings; (3) Technology-Based Outpatient includes outpatient encounters that rely mainly on technology to provide care; and (4) Inpatient and Facility Stays include traditional inpatient and facility stays by patients. In 2022, California added a fifth category for equity-enhancing services.

Within each category, services are grouped into tiers of similar service intensity generally based upon the training/certification of the individual providing the service, time or other resources spent providing the service, and the modality of service (in-person, electronic, etc.). Each service is assigned GPP points. Generally, the services whose values are expected to decline over time under the GPP include most service types in the emergent outpatient category and the inpatient medical/surgical and mental health categories. Initially, these services were identified as higher-cost and judged as the most likely to be reducible through efforts at coordination, earlier intervention, and increased access to appropriate care. All traditional services are assigned point values based on their relative cost compared to an outpatient primary and specialty visit, which serves as the benchmark traditional service. The non-traditional services provide value to the delivery of health care to the uninsured population by enhancing the efficiency and effectiveness of traditional services, and by improving uninsured individuals' access to the right care, at the right time, in the right place. For example, instead of needing to go to the emergency department, an uninsured individual could have telephone access to his or her care team, which would both help address and treat the presenting condition, as well as help connect the patient back to the entire breadth of primary care services. Likewise, a PHCS deploying eReferral/eConsult services would be able to better prioritize which uninsured individuals need early access to face-to-face specialty care expertise, or which can benefit from receipt of specialty care expertise via electronic collaboration between their PCP and a specialist. This collaboration between primary and specialty care enhances the PCPs' capacity to provide high-quality, patient-centered care, and

allows the individual receiving that care to avoid specialty care wait times and the challenges of travelling to an additional appointment to a specialist who may be located far from where they live. It is anticipated that this increased ability to provide timely access to specialty expertise will result in earlier treatment of complex conditions and help uninsured individuals avoid the need to seek emergent or acute care for untreated or partially treated sub-acute and chronic conditions. More detail on non-traditional services, including codes where available and descriptions, is in STC Attachments K and L.[6]

Point values for services are modified over the course of the GPP, from being linked primarily to cost to being linked to both cost and value. The provision of general medical/surgical acute inpatient services and emergent services receive fewer points over time. The changing point structure is designed to incentivize PHCSs to provide care in the most appropriate and cost-effective setting feasible. Point revaluation continue to be calibrated so that the overall impact will not lead to any PHCS receiving additional total points in any given GPP PY if utilization and the mix of services provided remained constant. Specifically, for any PHCS, if its utilization and mix of services does not change from the baseline year of SFY 2014-15, it will not earn any more points in GPP PY 1 than it earned under the baseline year, and in subsequent GPP PYs shall earn fewer points.

As points for certain services are revalued over the course of the GPP, PHCSs are incentivized to provide more of certain valued services and less of certain more costly and avoidable services. This revaluation has been phased in over time to enable PHCSs to adapt to incentive changes. With time, point values have diminished by 5.5% for outpatient ER and mental health ER/crisis services and by 3.3% for inpatient med/surg and in-patient mental services.

Significantly, although non-traditional services were not billable in Medi-Cal when GPP was initiated, California included non-traditional services (such as group visits and health coaching) in GPP so that PHCSs could invest in offering these services to the uninsured. With the CalAIM 1115 waiver renewal, California has already added a new doula and a new peer review service to supplement the original 50 GPP services, in addition to a new category of Equity Enhancement services. These new services are intended to align GPP service offerings with those available to Medicaid beneficiaries and utilize evidence-

[6] Appendices K and L from MediCal STC, provide details of GPP services stratified by categories, tiers, and services, including point values historically and recently assigned to individual GPP services. https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-1115-STC-Technical-Corrections.pdf

based practices to facilitate improvements in health disparities.

As part of the CalAIM waiver, California has begun to track and monitor health disparities in a more robust fashion for individuals receiving services under GPP, with data reported by a range of population characteristics such as race, ethnicity, preferred language, and sexual orientation and gender identity. The state has also outlined metrics focused on access, utilization, quality of care, or health outcomes, as well as population stratifications of interest. This evaluation of the GPP will incorporate the state's systematic measurement and reporting of these metrics to facilitate understanding of the landscape of health inequities among the uninsured population who receive GPP services in California and help inform meaningful future mitigation strategies.

A prior evaluation of GPP was conducted through Program Year (PY) 3 (SFY 2017-2018).[7] Briefly, the evaluation found that PHCSs increased the use of outpatient services, increased the number of uninsured patients served, and the percentage of GPP points (and therefore dollars) earned based on percentage of dollars earned for non- inpatient, non-emergent services increased over time.

This current evaluation design for GPP applies to a renewal of California's section 1115 demonstration. Since the conclusion of the evaluation of GPP conducted through Program Year (PY) 3 (SFY 2017-2018), several changes in the implementation of GPP have occurred. In response, this evaluation will assess changes in the number and composition of uninsured in California, additions to GPP services since the beginning of the Medi-Cal 2020 waiver (e.g., doula, peer support, and Equity Enhancing Services), changes in quality of care for California's uninsured, and changes in inequities among GPP utilizers.

Figure 1 of this report introduces a conceptual framework spanning all four projects that comprise the CalAIM Evaluation. In this section, Exhibits 3 and 4 further show GPP goals as described by driver diagrams presented by DHCS in their Initial Evaluation Design.[8] Later in this section, Exhibits 5, 6, and 7 provide additional detail about GPP's current evaluation questions (EQs), directional hypotheses (H), and measures developed by UCLA-

[7] Timbie, JW., DeYoreo M, Liu JL, Quigley DD, Baseman L , Slaughter ME, Palimaru AI, and Kahn KL, Evaluation of California's Global Payment Program: Final Report. Santa Monica, CA: RAND Corporation, 2019. https://www.rand.org/pubs/research_reports/RR3080.html.

[8] California Department of Health Care Services (DHCS) California Advancing and Innovating Medi-Cal (CalAIM) Section 1115(a) Demonstration. Draft Evaluation Design for Providing Access and Transforming Health (PATH) Initiative, Global Payment program (GPP), and Dually Eligible Beneficiary Satisfaction in the Medi-Cal Matching Process. June 27, 2022.

RAND evaluators to assess whether the goals of GPP are achieved across the evaluation period. The target population for all measures include individuals for whom the PHCSs submitted points for any GPP service provided by any of the PHCSs participating in the GPP.

Exhibit 3. Driver Diagram (GPP Goals 1 and 2)

Aim	Primary Driver	Secondary Driver
Improve the quality of clinical care (as measured by clinical quality performance rates) for California's uninsured	• Invest in patient-centered primary and preventive care for the uninsured • Shift care away from less cost-effective acute settings, such as emergency and inpatient settings for the uninsured • Incorporate non- traditional services such as group visits and health coaching for the uninsured	Administration of a value-based point methodology that incorporates factors to incentivize a shift in the overall delivery of services to more patient-centered and cost-effective settings
← Causality ←		

Exhibit 4. GPP Driver Diagram (GPP Goal 3)

Aim	Primary Driver	Secondary Driver
Improve PHCS data infrastructure and completeness that are necessary to understand health inequities among GPP utilizers.	Incentivize PHCS through GPP to improve data collection, reporting and analytics infrastructure	Develop Health Equity Monitoring Metrics Protocol Require PHCS to adhere to Health Equity Monitoring Metrics Protocol by submitting performance data stratified by demographic data
← Causality ←		

Clinical quality measures associated with the first goal, research question, and hypothesis are chosen to include those systematically collected by PHCS and aligned with the DHCS Comprehensive Quality Strategy, derived from the Uniform Data System (UDS)[9]. These sources are used since their measures are based on patients seen by the public health clinic/system and also have national benchmarks while most other standardized and nationally stewarded clinical measures are based on a health plan enrolled or provider-assigned population, which does not exist in GPP.

The Target Population for GPP quality and utilization Health Equity Measures is: "Individuals for whom the PHCS submitted points for any GPP service provided by the PHCS.[10] GPP eligible individuals include those with no insurance coverage and individuals who have commercial or Medicare coverage, but the specific GPP service provided by the PHCS is not covered by that insurance. Individuals with state-only Medi-Cal who have already received any acute GPP-eligible service (e.g., emergency department (ED) and inpatient stabilization, are not eligible for GPP points as there is already federal funding for these services)."[11] Metrics associated with GPP's second goal, research question, and hypothesis are pertinent to utilization of services, and metrics associated with the third goal, research question, and hypothesis pertains to equity. The first four of these measures include those identified by DHCS in 2023 for measurement of both quality of care and health equity.[12] Note that the target population for individual quality metrics is more specific than the cohort of patients eligible for GPP services. The former includes individuals for whom the PHCS submitted points for any GPP service

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[9] Uniform Data System. 2023 Manual. Health Center Data Reporting Requirements. HRSA Health Center Program. Bureau of Primary Care. https://bphc.hrsa.gov/sites/default/files/bphc/data-reporting/2023-uds-manual.pdf

[10] Global Payment Program (GPP) Health Equity Reporting Specifications. Program Year (PY) 9 Reporting Manual, Measurement Period January 1, 2023-December 31, 2023. Page 7.

[11] Appendix M ,GPP Health Equity Monitoring Metric Appendices K and L from MediCal STC, provide details of GPP services stratified by categories, tiers, and services, including point values historically and recently assigned to individual GPP services. https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-1115-STC-Technical-Corrections.pdf

[12] One additional measure proposed in the CalAIM evaluation design, Coronary Artery Disease: ACE/ARB Therapy - Diabetes or LVSD (LVEF < 40%) (Measure specification: QPP #118 MIPS CQM 2021) (MIPS benchmark; American Heart Association/American Society of Anesthesiologists stewarded) requires clinical information not commonly found in administrative data and may be too burdensome for PHCS to collect efficiently.

provided. Among these individuals, a subset who meet relevant criteria, are eligible for specific clinical measures.

DHCS proposes continuing to assess utilization as was done in the initial GPP evaluation, which assessed the core program objective of shifting care from inpatient and emergency settings to primary and preventive services, including non-traditional services. While these measures do not have national benchmarks, they help to understand the continued impact of the program in encouraging the use of primary and preventive care. These measures, defined by CPT and ICD-10 codes[13] include changes in utilization multiple GPP categories.

Evaluation Design Methods

Data sources

GPP's evaluation will conduct analyses of primary and secondary data sources including survey, interview, aggregate utilization, encounter, and cost data to assess the GPP's implementation and impact. We will apply mixed methods analyses including both difference-in-differences and pre–post analyses to assess the magnitude and direction of changes in *utilization of services, payments and/or costs* associated with California's PHCSs as well as qualitative inputs from key stakeholders. Specifically, we will develop and field an interview protocol, a midpoint, and a final survey to the GPP team leaders and their team members who participate in GPP implementation. These surveys will allow us to describe the infrastructure investments that PHCSs have made and to assess factors that are perceived as impactful in determining how GPP meets its goals.

Primary data collection and analyses

Surveys of GPP Health System Leaders and Teams

Our GPP Evaluation Team developed and fielded respectively in 2018 and 2019, a GPP survey of PHCS leaders to provide a comprehensive description of the activities that

[13]Codes and descriptions, if available for these GPP services, are documented in CalAIM-1115-STC-Technical Corrections, Appendix 2, Table 7, Categories of Service, Pg 204 of 289 pgs. Following Appendix 2, Table 7 shows an extensive set of notes explaining code/definition sources. The source of Updated codes and descriptions will be reflected in reporting guidance provider by DHCS to PHCS.

each PHCS conducted to support GPP goals. We now intend to field an updated version of this survey to PHCS GPP leaders and their teams in 2024 and 2026. This survey will ask about specific health system improvement actions that PHCSs are pursuing to enhance their responses to the GPP and the types of supports that PHCSs have implemented to enhance the delivery of equitable, proactive quality care. As with prior surveys and interviews, we anticipate that each PHCS will identify a leadership team to participate in the GPP surveys and interviews. We will welcome involvement from the California Association of Public Hospitals and Health Systems (CAPH) to ensure that the survey reflects actual PHCS activities.

Interviews with GPP Health System Leaders and Teams

Using interview protocols similar to those developed and fielded by our GPP evaluation team in 2018 and 2019 but updated to the current period, the Evaluation Team anticipates conducting group interviews with PHCS leaders and key team members, as identified by the PHCS leader, during 2024 and 2026. Interview guides will be informed by findings from our prior GPP leader surveys, from analyses of utilization data from GPP PY 1-8, existing literature and reports on the GPP, and from our team's prior interview guides. Interviews will focus on strategies employed by each PHCS to change utilization patterns and ensure delivery of care in more equitable manners and more-appropriate settings. Interviews will be conducted through a video conferencing platform that allows video conference meetings, webinars, and live and private chat. Participants will be briefed about the purpose of the interviews and asked to provide informed consent for audiotaping the interview process. Evaluation team members will serve as note-takers as needed. We anticipate the interviews to last 60 minutes. Interviews will be audio-recorded, transcribed verbatim, coded and used for data analyses. We anticipate using a mix of both inductive and deductive approaches to identify themes from interview content. Analyses will present dominant themes related to the GPP experience as well as variations from PHCS-specific experiences.

Primary data collection allowing inclusion of the patient voice

To include the patient voice in our evaluation, we have considered the feasibility, internal and external validity and sample sizes relevant to three types of data collection activities, focus groups, patient surveys, and patient interviews. After receiving feedback from PHCSs and their representatives, we believe individual patient interviews will be the

most feasible strategy for interviewing a diverse and representative sample of uninsured individuals who use services paid for with GPP funds at PHCSs who participate in GPP.

Although prior analyses of the GPP highlighted increasing numbers of uninsured individuals and expanded types of health services used by the uninsured, how GPP impacts quality of care, patient experience, and health status is not known. Furthermore, the mechanisms by which GPP influences the volume, type, and setting of service use is not known. We do not know whether changes in service use or costs relates to the GPP's novel system for incentivizing higher value care, to increasing access to primary and preventive services, to changes in the health status of uninsured individuals, or to remaining uninsured individuals becoming more familiar with how to access clinical care. We do know that improving clinical care depends upon improvements in access, patient engagement, comprehensive and continuous care. While health system data can report patient demographics, utilization, and costs, only patients can report their experience with care. Interviews will query uninsured patients receiving services paid for with GPP funds. We propose to interview a representative cohort of these patients about their access to GPP service categories and individual services. Our interview questions will prompt interviewees to share their experiences accessing care for primary, preventive, urgent, and/or emergent concerns.

Including the patient's voice in the evaluation of GPP can provide insights into features of the program that impact patients' burden of illness, use of services, trust in providers, and outcomes. For example, the structure of GPP is organized around the delivery of discrete services. This contrasts sharply with payment systems that are primarily dedicated to the delivery of patient-centered care, or continuous and coordinated care. While care delivered in PHCS's may be patient centered and attentive to the delivery of continuous and coordinated care, the GPP's focus on the delivery of individual services may not consistently prompt care coordination within and across providers as is characteristic of some care delivery models. This is an example of a topic that could be particularly salient to individuals with a history of unsatisfactory insurance status. Our proposed methods for conducting interviews with GPP-utilizing patients is presented in the Qualitative Analysis section at the end of this GPP text.

Secondary Data Sources

The midpoint and final evaluations will also make use of the following secondary data sources.

Aggregate Utilization Reports

Each PHCS reports aggregate utilization data using a standard reporting template developed by DHCS that includes each of the 50+ services eligible for points and a field for reporting the number of units of each service provided to the uninsured during the year. Each PHCS is expected to submit an interim year-end summary report in August following the end of each program year and a final, year-end reconciliation summary report by March 30 following the end of each program year. PHCSs are expected to use the applicable STCs in the Medi-Cal 2020 waiver (CMS, 2018) updated in 2023 to guide reporting of the utilization data.

Encounter-Level Data

In addition to submission of aggregate reports during the early years of GPP, participating PHCSs submitted encounter-level data for the first time on March 31, 2018, and on an annual basis thereafter with some irregularities during the Covid Public Health Emergency (PHE). Each encounter record reflects a unique service provided by a participating PHCS including information on the date of service, type of service, diagnosis and procedure codes, demographic information, and an indicator for which of the 50+ GPP services was provided during the encounter. Specifications for the submission of encounter data have been provided by DHCS. These annual encounter data will be used to support GPP analyses of utilization of services, quality of care, and equity of services overall, over time, and stratified by PHCS.

P14 Workbook Data

The P14 workbook has served as a California-specific reporting tool that PHCSs have used to claim federal matching payments for both Medi-Cal and uncompensated care to the uninsured. For the purposes of the GPP, these workbooks provide a record of the aggregate cost of services that each PHCS provided to individuals using GPP services and any payments that these individuals made to that PHCS. These data are expected to be available one year following the end of each fiscal year (June 30). Cost data as reported in the P14 workbook have been available annually since program year 1 (SFY 2015–2016). To implement planned pre-post and differences-in-differences analyses, the evaluation team recommends we examine historical P14 workbook data from program year 1 (SFY 2015-2016) through to the present time. This will allow us to develop

appropriate analyses across years without and with consideration of the period spanning the Covid Public Health Emergency (PHE).

GPP Point Thresholds

Point thresholds represent the total number of points each PHCS was expected to earn in each program year based on past experience. Specifically, point thresholds for program year 1 were calculated for each PHCS as the number of units per service in the year prior to the GPP (SFY 2014–2015) multiplied by the point value for each service, which were then summed across all services. Thresholds were set in the starting year and are adjusted up or down in future years to the extent that additional or lesser GPP funds are available in each program year. Only PHCSs that exceeded their point thresholds are eligible to earn additional funding related to those PHCSs that were unable to meet their thresholds. These additional payments are made available each year using funds available from PHCSs that did not reach their thresholds.

Disproportionate Share Hospital (DSH) and Safety Net Uncompensated Care Pool (UC Pool) Payments

Prior to the GPP, all PHCSs received federal matching payments for providing uncompensated care from two sources: the Medicaid DSH program and the UC Pool. As previously implemented, we anticipate DHCS will provide the Evaluation Team with data that includes PHCS-level payments from the year prior to the start of the GPP (SFY 2014–2015). These payments are adjusted annually depending upon the performance of individual PHCSs in relation to their baseline provision of services to uninsured individuals.

GPP Payments

Interim payments to each PHCS for providing services to the uninsured are made on a quarterly basis and publicly reported on the DHCS website (DHCS, 2016a). A final year-end reconciliation payment is then made, which includes supplemental payments to PHCSs that exceeded their budgets. Final year-end payments are publicly reported one year following the end of each fiscal year (June 30).

Annual Health Equity Report

Completion of this report will first be required to be completed by PHCS for the period covering Program Year (PY) 9, January 1, 2023-December 23. The first PHCS reporting

date to DHCS for this *Annual Health Equity Report* is September 30, 2024. All participating PHCSs are required to report on the five GPP Health Equity measures selected by DHCS, using the specifications outlined by DHCS.

Methods: Goals, Questions, Hypotheses, Measures and Analyses

The following section describes our proposed methods for evaluating progress on each of the three GPP goals. Overall, the analyses will include descriptive analyses of uninsured individuals receiving services paid for with GPP funds at participating PHCSs. Analyses will be stratified by demographic factors, and include longitudinal analyses of quality, utilization, and equity metrics. As noted below, difference-in-differences analyses with suitable comparison groups will be included where feasible.

GPP Goal 1 Evaluation Design

Exhibit 5. GPP Goal 1 Evaluation Questions, Hypotheses, and Measures

GPP Goal 1: Improve the quality of care among individuals with uninsured services.	
Evaluation Questions and Hypotheses	**Measures**
EQ1: Was the GPP successful in improving quality of care to individuals with uninsured services? H1: PHCS improved the quality of care to the uninsured.	1. Colorectal Cancer Screening[14] 2. Diabetes: HbA1c Poor Control (>9%)[15] 3. Preventive Care and Screening: Screening for Depression and Follow-Up Plan[16] 4. Breast cancer screening[17] 5. Cervical cancer screening[18]

Analytic methods for GPP Goal 1

- **Data sources**: The data sources required to generate the quality measures listed in Exhibit 5 include administrative data (i.e., claims data) and medical record documentation (e.g., structured and unstructured EHR data, clinical registry data,

[14] Measure specification: CMS130v10. UDS benchmark available. NCQA stewarded.
[15] Measure specification: CMS122v10. UDS benchmark available. NCQA stewarded.
[16] Measure specification: CMS2v11. UDS benchmark available. CMS stewarded.
[17] Measure specification: CMS125v11. UDS benchmark; NCQA stewarded.
[18] Measure specification: CMS124v10. UDS benchmark available. NCQA stewarded.

pharmacy, and lab data). As part of the GPP Health Equity Monitoring Metrics Protocol, PHCS will be required to submit stratified performance data on five clinical quality measures, and we will align the measures to evaluate GPP Goal 1 with the final set of measures to be used for health equity monitoring. PHCS will submit performance rates on an annual basis for the five quality measures following the end of each program year.

- **Measures**: Quality measures were chosen based on alignment with the DHCS Comprehensive Quality Strategy and were derived from the Uniform Data System (UDS) and Merit-based Incentive Payment System (MIPS).[19] These sources were used since their measures are based on patients seen by the clinic/system and have national benchmarks while most other standardized and nationally stewarded clinical measures are based on a health plan enrolled or provider-assigned population, which does not exist in GPP.
- **Target population**: Uninsured individuals receiving GPP services, with more specific target populations defined by each clinical measure specification. The level of analysis will be at the PHCS level and program level.
- **Comparison group:** Constructing a valid comparison group is extremely challenging given the lack of available data on the quality of care provided to the uninsured—either within or outside of California. Early in the evaluation we will construct and rigorously test two potential comparison groups. First, we will explore an FQHC comparison group by aggregating facility-level data from HRSA's Uniform Data System (UDS) in states that have not yet expanded Medicaid. FQHCs in these states have a much larger percentage of uninsured patients than FQHCs in expansion states, and we will consider using the subset of FQHCs with the highest percentage of uninsured residents in these states. Second, we will explore using population surveys (particularly the Behavioral Risk Factor Surveillance System, BRFSS[20]), which captures screenings for three of the five quality measures on an annual basis (colorectal cancer screening, breast cancer screening, and cervical cancer screening). We will ensure that any comparison group used in the evaluation is well-matched to the sociodemographic profile of the target population and provides adequate statistical power. If we determine that comparison groups are not sufficiently robust for the analysis, we will conduct pre-post analyses as described below.

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[19] https://bphc.hrsa.gov/sites/default/files/bphc/data-reporting/uds-clinical-measures-handout.pdf

[20] Behavioral Risk Factor Surveillance System (BRFSS), Center for Disease Control and Prevention. https://www.cdc.gov/brfss/index.html

- **Baseline period:** The number of years of pre-CalAIM data available for the analysis will depend on the ability of PHCS to generate quality data before 2022. We anticipate that some PHCS may be able to contribute a variable number of years of pre-CalAIM quality data, and we can accommodate this heterogeneity in the analysis. Comparison group data are available for all measures from the UDS from 2021 onward and from BRFSS from 2015 onward. We anticipate that all quality measures will continue to be gathered via the UDS and BRFSS through 2026. Because the Public Health Emergency (PHE) occurred primarily during the pre-CalAIM period and may introduce bias in the measurement of baseline quality, we will prefer to use a multi-year baseline period along with year fixed effects to account for year-specific shocks such as the PHE. To ensure robustness of our results we will also conduct a sensitivity analysis in which we exclude 2020 and 2021 from the baseline period.
- **Stratifications:** Selected analyses (described below) will be stratified by race, ethnicity, preferred language, gender identity, sexual orientation, and age group.
- **Statistical analyses:** Analyses will be conducted at the facility level or individual level depending on the data source for the comparison group (if used). All analyses will be conducted using linear models to facilitate interpretation of regression estimates and will include calendar year fixed effects. Details for specific analyses are included below:
    - **Analysis 1.1 Pre-post analysis:** We will conduct pre/post comparisons to assess changes in each measure over time during GPP. Improvement will be measured by gap closure from each measure's baseline rates to each measure's national 90^{th} percentile benchmark.
    - **Analysis 1.2: Difference-in-differences analysis:** We will use a conventional two-way fixed effects difference-in-differences methodology to estimate the impact of GPP on each quality measure. This analysis will compare trends in quality for PHCS relative to comparison facilities or individuals.
    - **Analysis 1.3: Dynamic difference-in-differences analysis:** We will use this approach, otherwise known as an "event study" analysis to estimate the impact of GPP on quality of care in each individual waiver year.
    - **Analysis 1.4: Parallel trends assessment:** We will estimate differences in quality between PHCS and the comparison group for all pre-CalAIM years, test the statistical significance of any differences, and document the

consistency of any trends. We will use Rambachan and Roth's (2023)[21] "relative magnitude bounding" method to assess the robustness of all statistically significant results from Analyses 1.2 and 1.3 to violations of parallel trends. This approach assesses the largest violation of parallel trends (measured as a multiple of the maximum pre-GPP violation) that would cause the observed result to lose statistical significance.

- **Analysis 1.5: Difference-in-differences subgroup analyses:** We will expand Analysis 1.2 to examine impacts of GPP on population subgroups. For the UDS comparison group, only a single quality measure listed above (Diabetes: HbA1c Poor Control (>9%) is available stratified by patient characteristics (race and ethnicity, separately). BRFSS allows stratification of quality data by race, ethnicity, sexual orientation, and gender identity. To test whether GPP has reduced disparities for these subgroups, we will include interactions for the patient characteristics of interest.
- **Analysis 1.6: Pre-post subgroup analyses:** Since comparison group quality measures are not available for all population subgroups of interest, we will conduct pre-post analyses within PHCSs to estimate trends in quality measures for subgroups defined by: race, ethnicity, preferred language, sexual orientation, and gender identity. To test whether GPP is reducing disparities within participating PHCS, we will include interactions in all regression analyses to estimate differential trends between population subgroups.

[21] Rambachan A, Roth J, A More Credible Approach to Parallel Trends. Review of Economic Studies (2023)90, 2555-2591

GPP Goal 2 Evaluation Design

Exhibit 6: GPP Goal 2 Evaluation Questions, Hypotheses, and Measures

GPP Goal 2. Drive the shift in the provision of services from emergency and select inpatient services to non-emergency outpatient settings among those individuals with uninsured services.	
Evaluation Questions and Hypotheses	**Measures**
EQ2. Was the GPP successful in driving a shift in the provision of services from emergent and select inpatient services to non-emergency outpatient settings, including on-traditional and equity enhancing services? H2. PHCS increased the use of outpatient services, non-traditional services, and equity-enhancing services over the course of the GPP.	*Utilization measures derived from GPP encounter data*:[22] 1. GPP non-behavioral health outpatient non-emergency, emergency, and inpatient med/surg services 2. GPP behavioral health outpatient non-emergency, emergency, and inpatient services 3. GPP non-traditional services 4. GPP equity-enhancing services 5. Follow-up care after ED visits for individuals with high-risk multiple chronic conditions *Utilization measures derived from HCAI encounter data*: 6. Ambulatory care-sensitive Emergency Department (ED) visits 7. Ambulatory care-sensitive hospitalizations 8. 30-day-all-cause-hospital-readmission-rateAll-cause ED utilization 9. All-cause ED utilization

[22] GPP service utilization measures are based on number of GPP points provided in each tier and category, defined in Attachment L of the STCs. Non-traditional services and equity-enhancing services are identified in the GPP STCs. The exception is Metric 5 in Exhibit 6 which will be derived based on HEDIS Technical Specifications (https://www.ncqa.org/hedis/measures/follow-up-after-emergency-department-visit-for-people-with-high-risk-multiple-chronic-conditions/)

Exhibit 6: GPP Goal 2 Evaluation Questions, Hypotheses, and Measures (Cont)

GPP Goal 2. Drive the shift in the provision of services from emergency and select inpatient services to non-emergency outpatient settings among those individuals with uninsured services.	
Evaluation Questions and Hypotheses	**Measures**
	<u>*Utilization measures still under consideration*</u>*:* 10. Visit Patterns *(Possible measures under consideration include frequency/regularity of ambulatory visits and types of providers seen including generalist or specialist provider MD, NP, PA, RN[23] or other provider type)* 11. Follow-up care following abnormal clinical findings *(Possible measures under consideration include timely follow up to abnormal mammograms, abnormal fecal occult testing for colorectal cancer screening, or abnormal laboratory values such as elevated hemoglobin A1c or lipid values).*

Analytic methods for GPP Goal 2

- **<u>Data sources:</u>** Data sources that will be used to measure changes in utilization in different settings during GPP are described below.

  First, we will leverage encounter level and aggregated GPP service utilization data, which include services provided by the PHCS, contracted providers, and local behavioral health providers. Each PHCS compiles and submits both encounter-level and aggregated data nine months after the end of each program year using a well-established reporting process. Each PHCS has submitted encounter data reports since PY 2, and the quality and completeness of data have improved over time.

  Second, we will use HCAI Patient Discharge Data (PDD) and ED Data, which includes all discharges from inpatient and ED settings within the state regardless of insurance status. The HCAI data will allow us to construct comparison groups for selected utilization measures as described below and imposes no additional data collection burden on GPP participating PHCSs or other participants.

[23] Example categories of provider type include MD (physician), NP (nurse practitioner), PA (physician's assistant), RN (registered nurse)

Additionally, we are exploring with both DHCS and PHCSs the opportunity to use encounter level and aggregated GPP service utilization to assess shifts over time in the types of providers who deliver GPP services, the frequency and regularity of GPP encounters, and timely follow-up to abnormal clinical findings. Since the National Provider Identifier (NPI) is a field in the GPP encounter data, we anticipate being able to link individual encounters with both provider identity and specialty type.

- **Measures**: We will assess changes in utilization of GPP services using approaches analogous to those used in the initial GPP evaluation while also adding several new measures. Measures 1-4 displayed in Exhibit 6 are based on the number of GPP points provided in each service "category" and "tier" as displayed in Attachment L of the STCs. While these measures do not have national benchmarks, they are valuable to understanding the continued impact of the program in encouraging the use of primary and preventive care. The relevant codes and descriptions for these GPP services are documented in *Technical corrections to the California section 1115 Medicaid demonstration, entitled "California Advancing and Innovating Medi-Cal" (CalAIM) (Project Number 11-W-00193/9) which was approved on August 23, 2023, under the authority of section 1115(a) of the Social Security Act (the Act)* Appendix 2, Table 7, Categories of Service, Page 204 of 289 pages[1,3] Importantly, within this citation and following Appendix 2, Table 7, is an extensive set of notes explaining the source of codes applied to GPP services. The citation indicates that updated codes and descriptions will be reflected in reporting guidance provider by DHCS to PHCS. We supplement these measures with the HEDIS measure *Follow-Up After Emergency Department Visit for People with High-Risk Multiple Chronic Conditions*[24] (Measure 5) to assess efforts by PHCS to shift care from ED and inpatient settings to ambulatory care settings.

  Measures 6-9, which are derived from HCAI encounter data, include two measures of ambulatory care-sensitive (ACS) utilization: ACS hospitalizations[25] and ACS ED visits.[26] Both measures will help to assess potential reductions in acute care utilization through improved access to primary and preventive care. Two additional measures, 30-day all-cause hospital readmission[27] and all-cause ED utilization will help to measure improvements in transitional care and efforts by PHCS to avoid repeated ED use, respectively. All four measures can be constructed for both PHCS and a non-PHCS comparison group comprising facilities in non-GPP counties (as discussed below) and allows us to use multiple years of data preceding Cal-AIM.

  Metrics 10-11 are still under development, as we continue to work with PHCSs to

examine the feasibility of including in the Goal 2 analysis two additional measure types that we anticipate will provide new insights into the mechanisms by which GPP changes clinical care delivery. Metric 10 will examine trends in the patterns of frequency, regularity, and types of providers associated with visits by uninsured individuals to non-emergent ambulatory settings paid for by GPP funds. As GPP progresses, the program is designed to increasingly incentivize a shift to non-emergency ambulatory settings (e.g., by increasing GPP points associated with ambulatory services, while decreasing point values for potentially avoidable, costly inpatient services). We will attempt to examine whether this shift in venue of care is associated with more continuity and coordinated care by measuring the changes in the prevalence of more regular PHCS visit patterns from patients and more timely follow-ups to abnormal clinical findings. These findings could shed light on how GPP may change patient care, especially noting that regular visits with known providers are associated with fewer emergency department and hospital days, and that prompt attention to specified abnormal clinical findings can save lives and improve quality of life.[28]

Our exploration of Metric 11 will first assess the availability of PHCS data for assessing whether GPP implementation is associated with changes in the extent to which timely follow-up to select well-specified abnormal findings is occurring. For example, we may explore whether as the GPP program matures, whether uninsured women receiving an abnormal screening mammogram finding (e.g., an advanced BI-RADS Category) at a PHCS, is more likely to receive timely follow-up to that abnormality. A similar analysis could be done to assess timely follow-up to a positive stool test performed for colorectal cancer screening, or follow-up to a very high blood sugar value (HbA1c value >8). While exploring data quality related to these concerns, we also intend to address these topics during patient interviews and health system leader surveys and interviews. In these ways, our planned mixed methods approach will provide insight how GPP impacts patient care and

[24] https://www.ncqa.org/hedis/measures/follow-up-after-emergency-department-visit-for-people-with-high-risk-multiple-chronic-conditions/
[25] https://qualityindicators.ahrq.gov/measures/pqi_resources
[26] https://qualityindicators.ahrq.gov/measures/ed_pqi_resources
[27] https://data.chhs.ca.gov/dataset/all-cause-unplanned-30-day-hospital-readmission-rate-california/resource/baa1a00c-d515-454a-ae47-410f8b95c3f3

[28] Rose, A.J., Timbie, J.W., Setodji, C. *et al.* Primary Care Visit Regularity and Patient Outcomes: an Observational Study. *J Gen Intern Med* **34**, 82–89 (2019). https://doi.org/10.1007/s11606-018-4718-x

experiences.

- **Target population**: Uninsured individuals receiving GPP services
- **Comparison group:** As described in the statistical analyses below, some analyses will use a comparison group comprising hospitals and EDs in non-GPP counties. Other analyses will not use a comparison group because no comparison group is available for measuring utilization of specific services by the uninsured.
- **Baseline Period and Evaluation Period:** Both periods will vary by analysis as described in the statistical analyses below.
- **Stratifications:** Selected analyses (described below) will be stratified by race, ethnicity, preferred language, gender identity, sexual orientation, and age group.
- **Statistical analysis:** We will use both pre-post analyses as well as differences-in-differences analyses for a subset of measures. Details for specific analyses are included below:
    - **Analysis 2.1: Pre-post comparison of utilization measures derived from GPP encounter data.** Although this analysis does not allow causal impacts of GPP on measures of utilization, it leverages the rich GPP encounter data to conduct pre-post analyses of changes in specific categories and tiers of services. The analysis would use 2016-2021 as the baseline period and 2022- 2026 as the evaluation period and would use an interrupted time-series design to determine whether Cal-AIM is associated with a statistically significant change in utilization rates for each type of service (i.e., change in slope) between the two waiver periods. In addition, we will explore PHCS-level correlations between changes in utilization of outpatient and non-traditional services with changes in utilization of high-cost services such as ED and hospital stays.
    - **Analysis 2.2: Difference-in-differences analysis of changes in ACS hospitalizations and ACS ED visits.** This analysis will compare trends in ACS utilization for uninsured individuals treated at PHCS relative to non-GPP counties in California. The analysis would use 2015 as the baseline year and would measure ACS utilization on a yearly basis through 2026. This specification allows us to estimate the impact of GPP on ACS utilization during Cal-AIM relative to the pre-GPP period (2015) as well as differential changes in rates of ACS utilization (i.e., change in slope) between the two waiver periods.
    - **Analysis 2.3: Pre-post subgroup analyses.** We will expand Analysis 2.1 to

measure changes in utilization of GPP services utilization stratified by each of the population characteristics captured in the GPP encounter data (race, ethnicity, preferred language, gender identity, and sexual orientation).

- **Analysis 2.4: Difference-in-differences subgroup analyses.** We will expand Analysis 2.2 to measure the impact of GPP on ACS utilization for population subgroups defined by race and ethnicity, which are the only population subgroups available for health equity monitoring that can be measured in the HCAI data. We note that the race and ethnicity in HCAI are unlikely to be self-reported, which is a limitation of these analyses.

GPP Goal 3 Evaluation Design

Exhibit 7. GPP Goal 3 Evaluation Questions, Hypotheses, and Measures

GPP Goal 3. Improve PHCS data infrastructure and completeness that are necessary to understand health inequities among GPP utilizers.	
Evaluation Questions and Hypotheses	**Measures**
EQ3. Was the GPP successful in driving improvements in the data infrastructure necessary to understand health inequities? H3. PHCS improved the data collection, reporting and analytics infrastructure to identify and act on health inequities.	Percent completion of GPP encounter data fields for the following patient characteristics: 1. Race 2. Ethnicity 3. Preferred language 4. Sexual orientation 5. Gender identity

Analytic methods for GPP Goal 3

- **Data sources:** GPP encounter data submitted by each PHCS on a yearly basis.
- **Measures:** Improvements in data infrastructure will be measured by percent completion of 5 individual level characteristics listed in Exhibit 7.
    - Race categories will include American Indian or Alaska Native; Asian; Black or African American; Native Hawaiian or Other Pacific Islander; White; Some Other Race; Two or More Races; Asked but No Answer; Unknown.
    - Ethnicity categories will include Hispanic or Latino; Not Hispanic or Latino; Asked

but No Answer; Unknown.

  - Preferred Language Spoken will be coded as specified in GPP guidance consistent with the Department of Health Care Access and Information (HCAI) reporting guidance for Preferred Language Spoken.
  - Sexual orientation categories will include Lesbian, gay or homosexual; straight or heterosexual; Bisexual; Other ("Something else, please describe"); Don't Know; Choose not to disclose.
  - Gender Identity includes five specific categories, as well as Other ("Additional gender category or other, please specify"), and "Choose not to disclose".

- **Stratifications:** Each measure listed in Exhibit 7 will be stratified by age group (e.g., <18, 18-64, ≥65). Stratified reporting by age reflects the fact that willingness to self-report this type of information might vary by age.
- **Target Population:** All individuals receiving GPP services.
- **Comparison Group:** None
- **Baseline Period:** CY 2023 (PY9). This is the first year that PHCSs will be collecting all five stratification variables according to the GPP Health Equity Monitoring Metrics Protocol.
- **Evaluation Period:** CY 2024 (PY 10) through CY 2026 (PY 12)
- **Statistical Analysis:** Measures will be trended annually to assess changes over time during GPP.

GPP qualitative design

In addition to the quantitative design above, the evaluator proposes having the independent evaluator conduct a survey and interview with each of the PHCSs at the beginning and end of the evaluation period. Such qualitative data was collected in the first GPP evaluation and proved to be a highly valuable source of information to contextualize the quantitative data and to understand the efforts of each health care system to meet the goals of GPP.

The qualitative data will be collected via a structured survey and will be completed independently by all PHCS. Survey responses will be categorized and coded by emergent themes. Follow-up interviews will be conducted to address gaps and questions about the original responses. Interview responses will be added to the survey responses and further coded by themes. All interviews will be recorded and transcribed,

while qualitative data from surveys (e.g., free text responses to open-ended questions) will be extracted and organized into a spreadsheet.

Survey and interview topics will include but are not limited to how the system is responding to meet the goals of GPP; examples of how the system has adapted operations and care delivery and its recovery; barriers to adaptation including external factors, such as the COVID pandemic; and how systems are improving the data infrastructure to track and act on health inequities. The first survey and interview should take place once the evaluator is on boarded and prepared to conduct interviews. The second survey and interview should take place after data for PY 12 (CY 2026) is submitted.

Analysis of the PHCS Survey

The PHCS survey will again contain mainly ordinal-scale items. We will summarize the responses by reporting means, standard deviations, and sample sizes (not all items will be applicable to all 12 PHCSs). For this evaluation, we will generally query PHCS leader respondents about their views on a topic in the years since the end of the Public Health Emergency, and separately query them about interim and lasting impacts of the PHE on the GPP program. Where survey items are identical with prior survey findings, we will compare responses with those previously obtained in 2015 and 2018. This will yield multiple longitudinal data points for each PHCS for these items. One limitation of drawing conclusions from survey data is that survey responses come from reports by PHCS leaders. Thus, the survey responses may not reflect what is truly happening within a PHCS or what all PHCS staff and leaders believe, but rather the perceptions and opinions of the respondent. However, when supplemented with utilization and quality of care data, the surveys provide context for the trends and patterns observed across PHCSs.

Interviews with Uninsured Individuals who Receive GPP Services

The GPP Evaluation Team proposes conducting interviews with uninsured residents who have used GPP services to better understand PHCS care processes and experiences from the perspective of users of GPP services.

We will use the PHCS leader survey questions as the starting point for the development of the patient interview protocol, and we will prioritize topics that can help us understand the degree to which PHCSs have used GPP funds to develop, maintain, and expand advanced primary models. For example, topics might include team-based care, appointment scheduling protocols, procedures for obtaining services after hours,

follow-up care after acute events, and unmet health care needs that may not be addressed through GPP services.

- Timing: 2024 (first wave) and 2026 (second wave)
- Sampling: We propose to conduct 5 interviews for each of the 13 PHCS, for a total of 65 interviews per wave. For each PHCS, we would identify unique patients in the GPP encounter data who exhibit selected utilization patterns. For example, we might identify patients who only use primary care or only use ED or inpatient care, as well as patients who use care across multiple settings. We might also sample patients who use specific types of non-traditional or equity-enhancing services. We would develop a sampling frame for these individuals, provide the unique IDs for these patients to the PHCS, and work with the PHCS to develop a recruitment plan that would preserve patients' privacy and provide patients with the right to refuse participation in an interview. For each of the 13 PHCSs, we will conduct interviews during each wave in at least English or Spanish as appropriate for the sampled patients. We will further explore the feasibility of interviewing in multiple languages as we refine the feasibility of interview protocols with PHCSs.
- Mode: Interviews will be conducted by telephone or videoconference. We will encourage participants to conduct the interview via videoconference (e.g., on their smartphones if available) to allow us to develop rapport with patients.
- Analyses: Will include both inductive and deductive approaches to theme derivation from the interview contents. Team meetings will explore emerging topics and codes, identify discrepancies, and iteratively refine concepts and codes.

Analyses of Existing CHIS Items

The GPP Evaluation team also supports using existing CHIS items to try to examine changes in care experience for insured in California's GPP counties vs non-GPP counties. Several items measuring access and coordination exist prior to 2020, including questions about the use of telehealth, communicating with doctors, and delays accessing care or filling prescriptions. We are also exploring the possibility of using any new California Health Interview Survey (CHIS) to capture member experience data for the uninsured and analyze these data to look at trends over the demonstration period.

GPP Cost Analyses

We will use audited P14 workbooks from each PHCS to measure the cost of services provided to the uninsured provided by the PHCS. We will then derive per capita cost estimates using unduplicated patient counts from the GPP encounter data. These analyses will support pre-post analyses of per-capita spending from as early as 2015

through the end of GPP. Cost data for a comparison group comprising non-GPP counties could be derived from a combination of hospital and ED encounter-specific charges reported in the HCAI data supplemented with UDS financial cost data reported by FQHCs in the UDS. Although the cost of care for the uninsured may be defined differently for the PHCS and comparison group, these differences should be stable over time and should be netted out in our difference-in-differences analysis. We will ensure alignment of the cost analyses across all other Cal-AIM components.

Payment data from program year 1 (SFY 2015–2016) and program year 2 (SFY 2016–2017) were included in the preparation of the Evaluation Team's final evaluation report published in June 2019 but will be extended during the planned 2025 midpoint and 2028 final reports.

Limitations

This evaluation has several limitations. The small sample size of 13 PHCSs makes it difficult to rule out the possibility that changes observed in analyses of aggregate utilization data are not due to random variation. Data limitations include utilization data quality issues, the lack of detailed patient self-reported measures and only limited access to clinically detailed measures of patient's need for service utilization. Potential biases in survey responses of PHCS leaders and of patients may occur. While CalAIM and PHCSs have been implementing programs to enhance trust by uninsured individuals in PHCSs, circumstances persist such that some remaining uninsured are hesitant to fully participate in available access to care opportunities.

While our evaluation team is intensely focused on identifying valid comparison groups that will allow us to draw causal inferences about the effect of the GPP on shifts in service utilization, costs, or perceptions of changes in quality, identifying such a comparison site is difficult since systematic data about use of services among uninsured individuals with characteristics similar to California's uninsured population are limited. In several instances we believe we will identify suitable comparison sites. To do so, we will construct and rigorously test an FQHC comparison group by aggregating facility-level data from HRSA's Uniform Data System (UDS) in states that have not yet expanded Medicaid. Second, we will explore using population surveys (particularly the Behavioral Risk Factor Surveillance System, BRFSS), which captures screenings for three of the five quality measures on an annual basis (colorectal cancer screening, breast cancer screening, and cervical cancer screening). We will ensure that any comparison group used in the evaluation is well-matched to the

sociodemographic profile of the target population and provides adequate statistical power. We will also compare trends in ambulatory care sensitive utilization for uninsured individuals treated at PHCSs relative to non-GPP counties in California.

If we determine that comparison groups are not sufficiently robust for the analysis, we will conduct pre-post analyses. However, the early years of the GPP program years beginning in July 2015 overlapped with the early years of ACA implementation, during which the composition of the uninsured population may have been changing. Subsequently, the Public Health Emergency has disrupted usual patterns of how patients access services, and how health systems manage data. Although the overall level of the uninsured population may have been constant during GPP implementation, changes in the composition of the uninsured and those uninsured for a particular service may contribute to observed changes in utilization and payments. A related challenge is the ability of individual PHCSs to reliably link unique patient IDs with their utilization of services. Historically, this has been less reliable across mental health services than physical health services.

Despite these limitations, the GPP is providing an important service for remaining uninsured individuals and doing so using a novel payment mechanism designed to incentivize improvements in high value care and reductions in low-value care. The duration of the program, the increasing quality of data, and the introduction of quality and equity metrics will allow important new insights about care utilization by remaining uninsured in California. We are optimistic that suitable comparison groups can be identified for some planned analyses.

Furthermore, across the twelve years of its planned program, the GPP provides an opportunity to assess how state level policy can influence the structure, processes, and outcomes of care for remaining uninsured individuals. While remaining mindful of the limitations described above, if desired outcomes emerge from the GPP, then aspects of the program can be expanded. If desired outcomes do not emerge or if adverse outcomes are noted, then this too can prompt learnings that can refine future efforts to improve the well-being of one of the states' most vulnerable populations.

Evaluation Design for the Medi-Cal Matching Plan Policy for Dually Eligible Beneficiaries

Overview of the Evaluation

As Medi-Cal managed care enrollment has expanded and become mandatory, California is addressing the bifurcated Medicare and Medi-Cal managed care delivery systems that make integrated and coordinated care challenging for dually eligible beneficiaries, who are among the highest need and highest cost groups in both programs. This evaluation addresses dually eligible beneficiaries (Duals) with Medicare Parts A and B, which are required for enrollment in any type of Medicare Advantage (MA) plan, including Dual Eligible Special Needs Plans (D-SNPs), in particular, fully integrated plans – Medicare Medi-Cal Plans (Medi-Medi Plans or MMPs). The *Medi-Cal Matching Plan Policy* is aimed at improving the experiences of Duals in managed care in twelve counties in California starting in 2022, an additional five counties starting in 2024, and additional counties in 2026.

In the evaluation, we will study the impact of the *Medi-Cal Matching Plan Policy* on Duals Medi-Cal plan changing and Duals' knowledge and satisfaction with the policy. The revised evaluation design builds upon the original evaluation design. The overall evaluation goals are:

1. Determine the epidemiology of plan changes among dually eligible beneficiaries eligible for MA Plans and relate them to requested MCP change requests.
2. Maintain a high degree of satisfaction with changing their Medi-Cal related plans among dually eligible beneficiaries enrolled in MA plans that are aligned with MCPs and among dually eligible beneficiaries enrolled in MMPs.

The *Medi-Cal Matching Plan Policy* is highly complex, as is the nature of data available to DHCS. Further technical edits and corrections may be needed throughout the evaluation period.

In Goal #1 of the proposed evaluation, the evaluation team will examine Medi-Cal managed care plan (MCP) enrollment behavior between 2021 (or earlier if feasible) and 2026 among Duals in counties with the *Medi-Cal Matching Plan Policy* compared to counties that have not had the policy in place. Goal #2 will address both plan alignment and Medi-Medi Plans – integrated managed care plans. In Goal #2, the evaluation team

will field a survey to assess knowledge and satisfaction with the plan changing process in place. Data from Goal #1 will provide the sampling frame for the primary data collection from Duals in Goal #2 – a knowledge and satisfaction survey of Duals who request and do not request MCP changes in counties with and without the *Medi-Cal Matching Plan Policy*.

While the Medi-Cal Matching Plan Policy in its current form was first implemented in 2022, we recommend the analysis comparing the demonstration and the comparison sites include analysis of similarities between the demonstration and comparison sites that begin at least one year prior to the demonstration's launch. Consistent with the difference-in-differences design recommended by DHCS in its draft Evaluation Design,[29] examination of the pre-intervention period (2021 and earlier) will allow us to distinguish whether any difference in outcomes noted during or after the intervention can be meaningfully attributed to the intervention, or alternatively to preexisting differences between the Duals residing in demonstration or comparison counties. The evaluation team recognizes the policy landscape surrounding alignment has been dynamic and varied across counties and over time, and we consequently recognize the necessity of close collaboration with subject matter experts at DHCS to explore possibilities for these analyses and leverage their guidance over the course of the evaluation.

Overview of Medicare Enrollment and MA Plans

Medicare beneficiaries may choose to enroll in MA plans upon receipt of Medicare Part A and Part B benefits or may switch into, out of, or between MA plans during annual open enrollment periods or special enrollment periods (effectively once per quarter). Close to half of Duals statewide in California with Medicare Parts A and B have opted to enroll in some type of MA, although the percent of overall MA enrollment varies significantly by county. Those not enrolled in MA are in Original Medicare.

For purposes of this evaluation, Medicare Advantage options include: standard MA plans (not Special Needs Plans or PACE organizations); Exclusively Aligned Enrollment (EAE) D-SNPs, also known as Medi-Medi Plans (which replaced the Cal MediConnect demonstration effective January 1, 2023); non-EAE D-SNPs; Chronic Condition Special Needs Plans (C-SNPs); Institutional Special Needs Plans (I-SNPs); SCAN Fully Integrated

[29] California Department of Health Care Services (DHCS) California Advancing and Innovating Medi-Cal (CalAIM) Section 1115(a) Demonstration. Draft Evaluation Design for Providing Access and Transforming Health (PATH) Initiative, Global Payment program (GPP), and Dually Eligible Beneficiary Satisfaction in the Medi-Cal Matching Process. June 27, 2022

Special Needs Plan (FIDE-SNP); and PACE organizations. October 2023 Duals enrollment for each type of MA is provided in this DHCS report: October 2023 MA Enrollment Report (ca.gov). A significant proportion of Duals have opted to enroll in MA plans. As of October 2023, there were 788,869 Duals who were MA enrollees (Exhibit 1).

Exhibit 1: MA Enrollment Among Dual Eligibles in California (October 2023)[30]

MA Plan Type	Age Under 65	Age 65+	Total
Regular MA	52,371	259,020	311,391
Medi-Medi Plan	46,817	198,258	245,075
Non-EAE D-SNP	35,014	125,467	160,481
Other SNP	4,453	26,677	31,130
SCAN FIDE-SNP	0	20,995	20,995
PACE	4,349	15,448	19,797
Total Any Type of MA Enrollment	**143,004**	**645,865**	**788,869**

As defined in the October report, the MA categories are:

- **Regular MA Plans:** These plans serve both dual eligible and Medicare only members and are not required to have written agreements with state Medicaid agencies, such as DHCS, for benefit and care coordination for dual eligible beneficiaries. This group also includes individuals enrolled in Medi-Cal and Dual Eligible Special Needs Plans (D-SNPs) that do not have a contract with DHCS (out-of-state D-SNPs), likely due to out-of-state zip codes for Medicare enrollment.
- **Medicare Medi-Cal Plans (Medi-Medi Plans or MMPs): Also known as Exclusively Aligned Enrollment (EAE) D-SNPs**, these plans are a type of MA plan that meet integrated D-SNP care coordination requirements, with integrated member materials, and have membership limited to dually eligible individuals who are also enrolled in the Medi-Cal managed care plan affiliated

[30] DHCS, California Dual Eligible Beneficiary Enrollment in Medicare Advantage Programs, as of October 2023. Table 1. https://www.dhcs.ca.gov/provgovpart/Documents/October-2023-MA-Enrollment-Report.pdf.

with the D-SNP. Medi-Medi Plans are available in seven counties in 2023: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. In 2024, MCPs in an additional five counties will offer EAE D-SNPs (Fresno, Kings, Madera, Sacramento, and Tulare).

- **Non-EAE D-SNPs:** D-SNPs are a type of MA plan that provide specialized care and wrap-around services for dual eligible beneficiaries. Non-EAE D-SNPs include two types of plans: 1) Those that have an affiliated Medi-Cal plan but are not yet transitioned to EAE D-SNPs; 2) Plans that do not have an affiliated Medi-Cal plan.
- **Other Special Needs Plans (SNPs):** The Other SNPs category includes Chronic Conditions Special Needs Plans (C-SNPs) and Institutional Special Needs Plans (I-SNPs). Many members reflected in the Other SNPs category are enrolled in C-SNPs, with a small number of members enrolled in I-SNPs. Note, these enrollment counts may include individuals who have out-of-state zip codes for Medicare and/or are enrolled in other SNPs that are not licensed by the Department of Managed Health Care (Knox Keene plans).
- **Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP):** California has one FIDE-SNP, SCAN Connections and SCAN Connections at Home, that provides integrated Medicare and Medi-Cal benefits to dually eligible beneficiaries. The SCAN FIDE-SNP only operates in Los Angeles, Riverside, San Bernardino, and San Diego counties. Scan enrollees are 65+ years old.
- **Program of All-Inclusive Care for the Elderly (PACE):** PACE is an integrated care model that provides medical and long-term services and supports to individuals age 55 and older who meet the criteria for needing a nursing facility level of care, most of whom are dually eligible individuals. California has a number of PACE organizations. PACE members can be Medi-Cal only, full duals with Part A and Part B, or have Part B only.

Medi-Medi Plans are Applicable Integrated Plans (AIPs) per federal regulations and include care coordination across all Medicare and Medi-Cal benefits, integrated member materials, and integrated appeals and grievances. Enrollment in Medi-Medi Plans has grown to over 290,000 as of January 2024.

While the Cal Medi-Connect demonstration was a three-way contract with CMS, DHCS, and each plan, and member enrollment was into a single plan, Medi-Medi Plans are separate D-SNP and MCP contracts, with separate federal and state enrollment

transactions. As a result, the Medi-Cal Matching Plan Policy is essential to enrollment operations for Medi-Medi Plans, for a Dual member to have concurrent enrollment in the same plan organization for both Medicare and Medi-Cal.

As we describe in more detail below, the *Medi-Cal Matching Plan Policy* follows whether a Dual is in FFS Medicare or an MA plan and which MA plan the Dual chooses. These dynamics suggest that there will be adequate numbers to detect even small differences in the impact of the *Medi-Cal Matching Plan Policy* in counties where the policy is in affect versus counties without the policy.

Medi-Cal Managed Care Delivery System and MCPs

California has a unique county-based managed care delivery system for MCPs that has been implemented across the 58 counties in the state. In more populous counties, MCPs are administered using one of three models: (1) – County Operated Health System (COHS) with a single MCP administered by the county, (2) Two Plan Model (TPM) with one local non-profit MCP and one MCP operated by a commercial entity, and (3) Geographic Managed Care (GMC) with two counties with five or more MCPs operated by commercial entities. Seventeen rural counties are governed according to the Regional Model (covering the central Sierra counties) with two or more commercial MCPs, Imperial Model (covering Imperial County) with two commercial MCPs, and San Benito County which is covered by a single commercial MCP. Fourteen suburban and rural northern counties are covered by a single COHS entity with an additional commercial plan in the more populous counties in this group. Beginning in 2024, there has been a reorganization of these models, with some of the northern counties, San Benito County, and Imperial County moving towards the COHS / single plan model. In addition, Kaiser is expanding its Medi-Cal prime plan participation through a direct contract with DHCS, where eligible members may actively choose to enroll in Kaiser in any county in which Kaiser operates, including GMC, Regional, Two Plan, COHS and Single Plan counties.[31]

To increase beneficiary choice, in years prior to 2024, MCPs in certain counties (including Los Angeles, Riverside, San Bernardino, San Mateo, and Santa Clara) sub-

[31] UCLA has examined the presentation: https://www.dhcs.ca.gov/MCP-Transition/Documents/CAADS-2024-MCP-Transition-Webinar-09222023.pdf for specifics on these updated county plan models. Presumably, in LA County, Kaiser will go from being a Delegate Plan to a Primary Plan. Also see: Medi-Cal Managed Care Plans by County (as of 2023 and 2024): https://www.dhcs.ca.gov/CalAIM/Documents/MCP-County-Table-2023-2024.pdf

contracted to other plans. The MCPs referred to as ***Primary Plans*** have direct contracts with DHCS to provide Medi-Cal services. Primary Plans are responsible for ensuring that delegate health plans and provider groups are, and continue to be, in compliance with all applicable Medi-Cal, State and federal laws, and contractual requirements. Each Primary Plan is responsible for enrolling beneficiaries into ***Delegated Plans*** (sub-contracted plans). For example, in Los Angeles County in 2023, Kaiser, Blue Shield and Anthem Blue Cross are Delegated Plans to LA Care, the Primary Plan. As of 2024, Delegated Plans occur only in Los Angeles County, and Kaiser is a Primary Plan.

Medi-Cal Managed Care Enrollment for Dual Eligible Beneficiaries

Medi-Cal has had a county-based policy of mandatory and optional enrollment of Duals into MCPs across the 58 counties in the state. Mandatory MCP enrollment for Duals in certain counties began with the introduction of the Coordinated Care Initiative (CCI) in 2014 in some of the state's more populous counties (Los Angeles, Riverside, San Bernardino, Santa Clara, San Diego Counties) and in COHS counties such as Orange and San Mateo prior to that time. As of January 2022, the policy of mandatory MCP enrollment for Duals was effective in 27 counties[32]. Approximately 70% of California's 1.5 million Duals (~1,050,000) were in a MCP – and most of these were in these 27 counties. Expansion of mandatory MCP enrollment policy to the remaining 31 counties[33] occurred in 2023.

The Medi-Cal Matching Plan Policy

In general, upon receiving Medicaid benefits, most non-Duals in Medi-Cal are assigned to an MCP that operates in their county of residence and the beneficiary may request a change in any month after enrollment. DHCS implemented the *Medi-Cal Matching Plan Policy* beginning in January 2022 in twelve of California's 58 counties with an additional five counties in January 2024.[34] For Duals with Medicare Part A and Part B, as of 2022,

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[32] Del Norte, Humboldt, Lake, Lassen, Los Angeles, Marin, Mendocino, Merced, Modoc, Monterey, Napa, Orange, Riverside, San Bernardino, San Diego, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Trinity, Ventura, and Yolo counties

[33] Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, El Dorado, Fresno, Glenn, Imperial, Inyo, Kern, Kings, Madera, Mariposa, Mono, Nevada, Placer, Plumas, Sacramento, San Benito, San Francisco, San Joaquin, Sierra, Stanislaus, Sutter, Tehama, Tuolumne, Tulare, and Yuba counties

[34] The twelve original counties are Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, Santa Clara, and Stanislaus. The five counties added in January 2024 are Kings, Madera, Orange, San Mateo and Tulare.

choice of MCP depends on whether the Dual is enrolled in a MA plan or in Original Medicare and on the county of residence for that Dual.

Under the *Medi-Cal Matching Plan Policy*, if a Dual chooses to enroll in any type of MA plan in these counties, their MCP must *align* with their MA choice if there is a MCP affiliated with the MA plan. The key principle is that Medicare plan choice determines Medi-Cal plan enrollment. Further, aligned enrollment occurs at both the Medi-Cal Primary and Delegated Plan level. The *Medi-Cal Matching Plan Policy* does not change or impact a beneficiary's MA plan choice. DHCS also operates an exception policy if needed for immediate MCP disenrollment for urgent/medically necessary Dual member needs. For counties with the *Medi-Cal Matching Plan Policy*, common scenarios are described in Exhibit 2 (next page).

Exhibit 2. General Scenarios for the Medi-Cal Matching Plan Policy

Circumstance when Duals[1] consider or request a change in their MCP	Description
1. Original Medicare and Any MCP	When a Dual is in Original Medicare, they can choose any MCP.
2. Request to change from an aligned MCP	If a Dual is currently enrolled in a MCP that matches their MA but wants to change their MCP to one that does not match their MA, the enrollment is not allowed. A refusal letter is generated by the MCO. The Dual must change the MA plan first.
3. Request to Change MA Plan	A Dual changes MA plans and the new MA plan no longer aligns with the MCP.
	1. If there is a matching MCP to the MA plan, then the Dual will be automatically enrolled into the matching MCP. The Dual will receive a letter from MCO explaining matching MCP enrollment.
	2. OR If there is no matching MCP to the MA plan, the Dual is allowed to be in mis-aligned MA plan and MCP.
4. Medicare Beneficiaries Newly Eligible for Medi-Cal	When a Dual enrolled in an MA plan, there is a MCP that matches with that MA plan, the Dual is automatically enrolled in that MCP.
	Dual is automatically enrolled into the matching Medi-Cal MCP.
5. Medi-Cal-only Beneficiaries Newly Eligible for Medicare	The Dual may choose Original Medicare or an MA Plan. If they choose Original Medicare, then they may choose any MCP (as in case #1). If they choose an MA plan, then their MCP will follow (as in case #3).

Adapted from: 2023 Matching Plan Policy Scenarios (ca.gov)

[1] Medicare Part A and Part B are required to enroll in an MA Plan.

This 1115 demonstration impacts Duals enrolled in an MA plan who reside in one of the matching plan counties. Per DHCS' previous discussion with CMS on January 28, 2022, the state will evaluate programs goals of improving alignment and integration, as primarily assessed by beneficiary experience with Medi-Cal plan alignment. Other related impacts of alignment and integration – care coordination, access, quality, and overall cost – are of great interest, but detailed exploration of these is outside the scope of the evaluation of the *Medi-Cal Matching Plan Policy*. Medicare and Medi-Cal integration has been evaluated elsewhere by CMS MMCO through contract with RTI International.[35]

Medi-Cal Matching Plan Policy Evaluation Questions, Hypotheses, and Measures

Exhibit 3 shows *Medi-Cal Matching Plan Policy* goals articulated by DHCS. DHCS defines a **Medi-Medi Plan** as an integrated EAE D-SNP; an **Aligned Plan** as a MA plan and MCP affiliated with and operated by the same MCO and an **Unaligned Plan** as a MA plan and MCP operated by different MCOs. The exhibit further includes the evaluation questions (EQs), directional hypotheses (H), and measures developed by UCLA and DHCS to assess whether the goals of the policy were achieved as anticipated. The evaluation team will incorporate feedback from DHCS subject matter experts to ensure that directional hypotheses accurately capture policy nuances across comparison groups.

[35] For example, see: Clark, W., Lehman, D., & Walsh, E. G. (2016). Measurement, Monitoring, and Evaluation of State Demonstrations to Integrate Care for Dual Eligible Individuals; Walsh, E., Greene, A. M., Hoover, S., Khatutsky, G., Layton, C., & Richter, E. (2003). Case studies of managed care arrangements for dually eligible beneficiaries. *RTI International report to the Centers for Medicare and Medicaid Services*; Graham, C. L., Stewart, H. C., Kurtovich, E., & Liu, P. J. (2018). Integration of Medicare and Medicaid for dually eligible beneficiaries: A focus group study examining beneficiaries' early experiences in California's dual financial alignment demonstration. *Disability and health journal*, *11*(1), 130-138.

Exhibit 3: Alignment and Integration for Dually Eligible Beneficiaries

Goal 1: Determine the Epidemiology of Plan Changes among Dually Eligible Beneficiaries Eligible for MA Plans and Relate them to Requested MCP Change Requests.	
Evaluation Questions and Hypotheses	**Measures**
EQ 1a: How many Duals enrolled in a MA plan in the 12 counties with a *Medi-Cal Matching Plan Policy* in 2023 had the policy applied to them?	• Percent of Duals enrolled in a MA plan who request to change their MCP (in counties with the *Medi-Cal Matching Plan Policy* compared to Duals who change their MCP to a non-matching plan in counties without the *Medi-Cal Matching Plan Policy*) • Percent of Duals enrolled in a MA plan who request to change their MCP and who change their MA plan and MCP (in counties with the *Medi-Cal Matching Plan Policy* compared to counties without the *Policy*) – aligned versus unaligned plans. • Percent of Duals enrolled in Medi-Medi Plans who change to a different Medi-Medi Plan, a different MA plan, or Original Medicare, compared to Duals in
EQ 1b: Of Duals that had the policy applied to them, how many requested to change their MCP to a non-matching plan within 12 months of enrollment?	
H 1: Less than 0.1 percent of Duals in mandatory aligned plans in Matching Plan Counties will request to change their MCP without changing their MA within 12 months of enrollment during the target period.	
H 2: Duals in aligned plans during the target period, are less likely to request to change their MCP (without changing their MA) than those in unaligned plans during the target period.	
H 3: Duals who request a change from a mandatory aligned plan are less likely to change their MA plans (and MCP) than Duals who change from unaligned MA plans during the target period.	
H4: Duals in MMPs will be less likely to change plans than those in other aligned plans that are not MMPs and less likely than those in unaligned D-SNPs	

Exhibit 3: Alignment and Integration for Dually Eligible Beneficiaries (Cont)

Goal 2: Maintain a high degree of satisfaction with changing their Medi-Cal related plans among dually eligible beneficiaries in MA plans that are aligned with MCPs and among dually eligible beneficiaries in MMPs.	
Evaluation Questions and Hypotheses	**Measures**
EQ 2: Are Duals satisfied with the information and process for mandatory Medi-Cal aligned enrollment when they choose a MA plan?	• Knowledge of the MCP enrollment process among Duals enrolled in MA plans in *Medi-Cal Matching Plan Policy* counties versus those in Medi- Medi Plans versus other types of MA in counties without the policy. • Satisfaction of the MCP enrollment process among Duals enrolled in MA plans in *Medi-Cal Matching Plan Policy* counties versus those in Medi- Medi Plans versus other types of MA in counties without the policy as measured by a five- point Likert Scale. • Reason(s) for changing MCP at time of Duals survey.
H 1: Duals who request to change their MCP and who change their plans will be satisfied with the process for doing so during the target period.	
H 2: Duals in Medi-Medi Plans will be more satisfied with the mandatory alignment of their MCP to their MA plan choice compared to Duals who are in in other type of MA plans.	
H 3: Duals in counties with the policy will be more knowledgeable and will be more satisfied as the policy matures.	

Conceptual Model

The driver diagram (Exhibit 4) shows how the *Medi-Cal Matching Plan Policy* conceptually impacts Duals. Improved education of Duals combined with reduced administrative burden and improved alignment and care coordination for Duals will improve Duals' knowledge of and satisfaction with the policy, particularly for those in Medi-Medi Plans. This will lead to low rates of requests for MCP changes to non-matching MCPs among these with aligned plans in the counties where the policy is in place.

Exhibit 4: Driver Diagram for the Medi-Cal Matching Plan Policy

Aim	Primary Drivers	Secondary Drivers
Achieve less than 0.1% monthly rate of Duals requesting to change their MCP to non-matching MCP for those who enroll in MA plans AND who are in counties where the *Medi-Cal Matching Plan Policy* is in effect during the target period.	• Improve Duals' satisfaction with mandatory MCP aligned enrollment to their MA plan. • Improve Duals' knowledge of mandatory MCP aligned enrollment to their MA plan	• Educate Duals and their caregivers benefits behind MCP and MA plan alignment via consistent documentation on the DHCS and contracted MCP websites. • Reduce administrative burden on Duals when enrolling for an aligned MCP. • Improve care coordination between aligned MCP and MA plans
← Causality ←		

Methods

Data Sources

The *Medi-Cal Matching Plan Policy* evaluation will use monthly Medi-Cal enrollment data (2021 baseline - or earlier as feasible - to present with one year look back), monthly Medicare Advantage enrollment data (2021 baseline – or earlier as feasible – to present with one year lookback), complete MA and MCP plan lists for this period, other available routinely collected data as feasible (e.g. delegate plan assignments if not within the DHCS data silo), MA and MCP plan descriptions (routinely available data and possible supplemental information from plan representatives), and Duals survey data. For Goal #1, DHCS will provide to the UCLA evaluation team the monthly enrollment data supplemented by data on MCP change requests for non-matching MCPs. For Goal #2, UCLA will perform the Duals knowledge and satisfaction surveys in 2024 through early 2025.

Goal #1: Determine the Epidemiology of Plan Changes with the Medi-Cal Matching Process and Relate Them to Requested MCP Change Requests

In Goal #1, the evaluation will attempt to understand the impact of the *Medi-Cal Matching Plan Policy* on Duals plan enrollment changes in counties where the demonstration has been implemented. The evaluation's primary outcomes of interest among Duals enrolled in an MA are: (1) Duals request to change MCP to non-matching MCP, (2) Duals monthly MA plan / MCP change, (3) Duals MA plan and MCP aligned or unaligned, and (4) Duals enrollment in or out of Medi-Medi Plans. We will account for other possible valid transitions (e.g., MA to Original Medicare) that would impact an MCP assignment and modeling of Duals plan choices. The primary predictor of interest will be the county policy variable – *Medi-Cal Matching Plan Policy*. Secondary predictors will be: Medi-Medi Plan, Duals Baseline MA plan, Duals Baseline MCP, Duals Baseline MCP characteristics (Primary Plan versus Delegate Plan), Duals Baseline Plans aligned / unaligned, Duals characteristics (age, gender, race/ethnicity, preferred language, county), and social need metric by zip code (defined consistently over the CalAIM evaluation components). The results of Goal #1 will be used to create the sampling frame for the knowledge and satisfaction surveys to be fielded in Goal #2.

Target Population: Duals in MA plans (with Duals in Original Medicare as a control) in counties with the *Medi-Cal Matching Plan Policy* compared to those in counties without the *Medi-Cal Matching Plan Policy*. Also, Duals in Medi-Medi Plans compared to Duals in other MA plans compared to Duals in Original Medicare.

Time Period: CY 2022 to CY 2026 compared to CY 2021 and earlier.

Sampling Frame: All Duals in California enrolled in Medi-Cal between 2021 and 2026 with one year lookback to determine one year enrollment inclusion criteria definition.

Descriptive Analyses

1. Among Duals in MA plans from 2022 (or earlier, if possible) through 2026 (with one year lookback), UCLA will assess the rate and type of MA plan change, MCP change, and MCP alignment, pre- and post- *Medi-Cal Matching Plan Policy* implementation if applicable, comparing Duals in counties with the policy and Duals in counties without (or before) the policy. We will examine the five possible month-to-month Medicare transitions (1) MA – no change, (2) MA – switch to another MA, (3) Original Medicare to MA, (4) MA to Original Medicare, and (5) Original Medicare – no change. MCP choices described in Exhibit 1 follow these

Medicare transitions. UCLA will also assess enrollment changes into and out of Medi-Medi Plans.

2. Overall, and stratified by these Medicare transitions, UCLA will examine MCP transitions that follow the MA plan. MCP status will be defined as MCP change / no change and MA plan change (including special case to Original Medicare) / no change and MCP – integrated (MMP) / aligned / not aligned.

   In addition to examining the number of Duals who transition at least once, UCLA will also examine the distribution of the number of transitions that individual Duals make during the target period. Individual persons who frequently switch plans may account for a disproportionate number of switches and may require further examination.

3. UCLA will examine Duals' requests for MCP change to non-matching MCPs, comparing Duals in counties where the policy is implemented and Duals in counties where the policy is not implemented, who change their MCPs.

4. UCLA will then examine the rates of change within demographic categories of Duals – age, gender, race/ethnicity, preferred language, counties, and quartile measure of social need (of residence zip code). Because numbers of observations may be quite small for some categories, UCLA may roll up assessments to 12-month periods.

5. UCLA will examine available documented reasons and circumstances for MCP change at the time of MCP change, where available and pending assessment of completeness. If data are more than sporadically reported, UCLA will assess frequency and distribution of reasons for requesting a change of MCPs overall and compared to (1) county *Medi-Cal Matching Plan Policy* (yes/no), (2) MA plan /MCP alignment (yes/no), and (3) Duals' demographics.

Multiple Variable Regression Analyses

We propose to follow the difference-in-differences approach described in the original evaluation design and endorsed by CMS to estimate the independent impact of the *Medi-Cal Matching Plan Policy* on Dual's plan choice behavior. We will welcome further input from DHCS subject matter experts to ensure that the DID analyses can be performed as intended. The DID approach applies a pre- / post- /case- / control – design, allowing for greater confidence in the causal impact of the policy. The primary

regression outcome will be "Request for MCP change to non-matching MCP" and the primary regressor will be presence/absence *Medi-Cal Matching Plan Policy* in the Dual's county of residence at the time of the request. Covariates will include Dual's plan status at the time of the request (Original Medicare, Medi-Medi Plan, MA-MCP aligned, MA-MCP not aligned), Delegate plan (versus Primary MCP), Dual's characteristics (age, gender, race/ethnicity, preferred language, county, quartile of social need metric), and time period (likely measured quarterly), plus fixed effect for county of residence. UCLA will test for parallel trends between counties where DHCS has implemented the policy versus counties where DHCS has not implemented the policy.

The secondary regression outcome will be "MCP change" and the primary regressor will be presence/absence *Medi-Cal Matching Plan Policy* in the Dual's county of residence at the time of the change. Covariates will include lagged "Request for MCP change", Dual's plan status at the time of the request (FFS, MMP, MA-MCP aligned, MA-MCP not aligned), Dual's characteristics (age, gender, race/ethnicity, preferred language, quartile of social need metric), and time period (likely measured quarterly), plus fixed effect for county of residence.

In addition, the mandatory managed care transition for Duals in 31 counties beginning in January 2023 was a change in policy that impacted enrollment. In regression analyses, UCLA will include a flag to denote mandatory managed care participation by county by time period.

Further, Medi-Medi Plans were available in five additional counties in 2024, and the analysis will consider the impact of that change.

Goal #2: Maintain a high degree of satisfaction with the Medi-Cal matching process among Duals in MA plans who are matched.

For Goal #2, the UCLA evaluation team will field a knowledge and satisfaction survey of MCP changes in the Duals population using a sampling frame derived from the data in Goal #1, including comparison of satisfaction among Medi-Medi Plan members, other MA members, and Original Medicare members. Results from Goal #2 will be used to inform DHCS, MCPs and their members to improve Duals' knowledge and experience. Surveys will be performed in 2024 and early 2025 to assess knowledge and satisfaction. UCLA will consider a second wave in 2026 to capture expanded introduction of the policy into additional counties.

Target Population: Duals in MA plans (with Duals in Original Medicare as a control) in counties with the *Medi-Cal Matching Plan Policy* compared to those in counties without

the *Medi-Cal Matching Plan Policy*.

Time Period: CY 2023 to CY 2026.

Sampling Frame: Probability sample of up to 2,000 Duals (including representatives from MA and Original Medicare) sampled according to: MCP change request (100% sample), MCP change, Medi-Medi Plan enrollment, plan alignment (baseline), plan alignment (follow-up), and *Medi-Cal Matching Plan Policy* in the Dual's county of residence. We will attempt to balance the samples by matching Duals within groups on observable characteristics (age category, gender, race/ethnicity, language, county, and quartile social need). There will be oversampling of non-requesters and non-MCP changers because of the challenges in assessing and matching on unobservable severity, especially if requesting an MCP change or achieving an MCP change (through MA plan change without requesting an MCP change) is correlated with unmeasured severity.

Survey Content and Development

The short knowledge and satisfaction survey of the *Medi-Cal Matching Plan Policy* will be developed at UCLA with input from DHCS and external stakeholders. UCLA will convene focus group(s) to inform the development of themes and questions for the survey. The survey will include a short introductory description of the *Medi-Cal Matching Plan Policy* followed by a series of questions on knowledge and satisfaction of the policy and their MCP assignment and MCP alignment with the MA plan and questions on participant self-perceived health, preferred language, satisfaction with MCP (or Medi-Medi Plan) and use of healthcare services in the past year (for case-mix adjustment), and whether the participants had requested or changed their MCP in the prior year and whether their current MCP was aligned or not with their MA plan (to assess participant self-knowledge on their own enrollment).

UCLA additionally recommends supplementing these transition-specific survey items with a small number of items from a standardized tool to enhance case-mix adjustment across surveyed groups and across other components of the overall CalAIM evaluations. Specifically, UCLA recommends drawing validated and standardized items from the 10-item core Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool. This tool is currently being used by CMS to better understand whether finding and dealing with the health-related social needs of Medicare and Medicaid

beneficiaries has any effect on their total health care costs and makes their health outcomes better.[36] The tool can help providers find out patients' needs in these 5 core domains that community services can help with (1) Housing instability, (2) Food insecurity, (3) Transportation problems, (4) Utility help needs, and (5) Interpersonal safety. We will also use the 8 supplemental validated items that measure (1) Financial strain, (2) Employment, (3) Family and community support, (4) Education, (5) Physical activity, (6) Substance use, (7) Mental health, and (8) Disabilities. UCLA will pilot survey items to allow us to better understand how long the survey takes to complete and which portions may be too unwieldy.

The survey will be translated into Spanish and potentially other languages (Mandarin, Cantonese, and Vietnamese). The survey will be piloted for readability and clarity at UCLA and/or UCLA-training sites among a convenience sample of up to 50 Duals in MA plans who are seen as primary care patients. Feedback will be obtained in consultation with DHCS subject matter experts and pilot participants that will be incorporated into the final survey design to minimize burden and optimize utility.

Once the survey design is finalized, the survey will be fielded in 2024 into early 2025 via mail and phone with the option for responding on-line using a unique participant code and password. Initial mailing will be followed by reminders. For non-respondents, a second survey will be sent. There will be an incentive (e.g., gift card or activation code for Amazon) to improve response rates. Each survey will be identified by a study ID that will allow for linkage to derived data from routinely collected data, including sampling weights. A crosswalk of study IDs and Medi-Cal client identification numbers will be kept separately from the survey results. If feasible, a second wave of the survey will be fielded in late 2026, which would allow for a pre- / post- comparison of the late policy adopters compared to the early adopters.

Survey Analysis – Descriptive Analyses

In descriptive analyses, the evaluation team will present results according to raw (unweighted) and weighted results, with survey weights according to the probability sampling and non-response rates. First, the raw respondent characteristics will be compared across the sampling strata to ensure balanced groups. This will include demonstrating that (1) the matching characteristics and (2) survey-elicited characteristics

[36] See: https://www.cms.gov/priorities/innovation/files/worksheets/ahcm-screeningtool.pdf

(self-reported health, service use) are similar within strata and when comparing Duals' characteristics across MCP change request (yes/no) and MCP change strata (yes/no). Duals' responses on MCP and MA enrollment will be compared to metrics derived from the Medi-Cal and Medicare monthly enrollment files. For bivariate comparisons, a significance test will be performed using logistic regression.

Second, survey weighted responses will be presented overall and stratified by whether an individual changed their MCP (or not). Among individuals that changed their MCP, we will stratify individuals by whether their MCP was aligned or not at baseline and at follow-up. For bivariate comparisons, significance testing will be performed using logistic regression with sampling weights. If two waves of surveys are fielded, a similar design can be used for pre- and post- comparisons.

Survey Analysis – Multiple Variable Regression with Sampling Weights

Finally, UCLA will attempt to estimate Duals' knowledge and Duals' satisfaction with the *Medi-Cal Matching Plan Policy* using multiple variable regression with sampling weights (accounting for probability sample and non-response) with the primary predictor being "MCP change in the past twelve months" with covariates: plan aligned (baseline), *Medi-Cal Matching Plan Policy* in county of residence, Medi-Medi Plan enrollment, Duals' characteristics derived from enrollment data (age, gender, race/ethnicity, English/Non-English, county, quartile social needs metric), Duals' self-reported characteristics (health status, level of education, recent healthcare utilization).

Power Calculations

Churn rates in Medicare program choices for Duals suggest significant activity related for Duals' MCP choices in general and the *Medi-Cal Matching Plan Policy* impact on choice specifically. For example, in March 2023, there were 722,676 Duals MA plan enrollees. Based upon preliminary data provided by DHCS to the independent evaluation team, between March and April 2023, 1.6% of dual eligible beneficiary MA enrollees switched MA plans and an additional 0.74% exited MA plans. An additional 2.4% entered MA plans from Original Medicare. In April, there were 734,746 Duals MA plan enrollees. Between April and May 2023, another 1.2% of dually eligible beneficiary MA enrollees switched MA plans and 0.66% exited MA plans. An additional 2% entered MA plans from Original Medicare. Annualized numbers are likely lower than these estimates due to lower churn outside of open enrollment months. Nevertheless, this gives confidence that there will be sufficient activity to evaluate as described.

For the enrollment analyses, the large number of individual observations for MCP changes suggests that we will be able to detect extremely small differences between cases and controls. For example, using a two-year sample (2021 and 2022) with the original 12 policy counties versus remaining 15 non-policy counties (among counties with mandatory managed care enrollment), the total number of individual observations is the total number of months of enrollment for each group – which would conservatively be on the order of a million for each group. We should have adequate power to detect small differences – such as the original benchmark suggested by DHCS – 0.1% requests (either per month or per year).

For the survey, using a two-way difference in means and equal standard deviations, a survey of 1500 individuals can detect a difference of 0.2 with 95% confidence interval and 80% power for the main comparison (satisfaction – five-point scale). Here we assume a mean of 3 and a SD of 1.4.

Limitations

There are a number of limitations with the design approach for the evaluation. For Goal #1, which is focused primarily on understanding enrollment and disenrollment behavior among Duals in California, overlapping policy changes and secular events may make inference with regards to timing of the *Medi-Cal Matching Plan Policy* harder. Although the evaluation can account for certain elements of case-mix (e.g., matching demographics), it is not possible to account for selection effects (unmeasured severity correlated with the behavior of interest) that bias estimates in Goal #1 and the survey sample in Goal #2. Plan switching behavior is complex and requested changes (or not) and MCP changes (or not) may not be valid measures of MCP or *Medi-Cal Matching Plan Policy* satisfaction. Other areas of interest with regards to plan alignment – efficiency, cost effectiveness, improved access to care – which might add context and validate measures are outside of the scope of the evaluation of the *Medi-Cal Matching Plan Policy*. Nevertheless, the proposed evaluation design will provide valuable metrics for determining the success and maturation of the *Medi-Cal Matching Plan Policy* and the maintenance of Duals' plan choice. With the expectation that policies associated with alignment between Medicare and Medicaid plans are likely to mature with time, the findings from this evaluation are likely to inform future efforts design and implementation efforts by CMS and DHCS. Findings will also be of interest to Medicare and Medicaid health plans.

Dissemination

Results of the evaluation of the *Medi-Cal Matching Plan Policy* will be presented in the formal reports to CMS and in-person presentations will be made to the DHCS Duals Program and other stakeholders. We expect that the results from Goal #1 through 2024 and for the survey results from the first wave in Goal #2 will be included in the Preliminary CalAIM Demonstration Evaluation Report. Overall results from Goal #1 through 2026 and for both waves of Goal #2 will be included in the Final CalAIM Demonstration Evaluation Report.

Exhibit 5: Evaluation Milestones

Milestone	Target Date
1. Submission of revised evaluation design with responses to CMS internal reviewers	January 2024
2. Obtain existing Medi-Cal and Medicare monthly enrollment files and other existing data sources	July 2024
3. Focus groups on Duals knowledge and satisfaction on plan alignment and information on changing enrollment	No Later than July 2024
3. Respond to remaining critiques and questions from the CMS	mid-2024
4. Goal #1 initial analyses	
5. Duals' knowledge and satisfaction survey design and piloting	August 2024
6. Duals' knowledge and satisfaction survey	Oct 2024 to Dec 2024
7. Goal #2 initial analyses	May 2025
8. Preliminary CalAIM Demonstration Evaluation Report to CMS	June 2025
9. Goal #1 final analyses	June 2026
10. Duals' knowledge and satisfaction survey – possible second wave	June 2026
11. Goal #2 final analyses	January 2027
12. Final CalAIM Demonstration Evaluation Report to CMS	May 2027

Evaluation Design for the Reentry Demonstration Initiative

The Incarcerated Population in California

California incarcerates individuals at both state and county-level facilities with almost 160,000 adults currently in state prison and county jail facilities.[37] In addition, more than 2,200 youth are incarcerated at the county level in juvenile halls, camps and ranches.[38] To facilitate a basic understanding of California's Criminal Justice (CJ) system that is critical for the Reentry component's evaluation design, below we highlight key features of the prison, jail, and juvenile incarcerated populations.

- With respect to the prison population, according to the California Department of Corrections and Rehabilitation's (CDCR) Office of Research, Summary of Offender Data Points:[39] the in-custody adult prison population as of December 2023, was 94,188 with incarcerated individuals housed in 33 prison facilities across the state. The average age was 42.5 years with 96.0% male and by race/ethnicity 46.09% Hispanic, 27.5% Black, 20.0% White, and 6.4% other. The average number of individuals released from prison back to communities per month ranged from 2,006 (June 2021) to 2,647(December 2023). Of the 58 California counties, six accounted for almost two-thirds of the released population in 2023.[40]
- With respect to the jail population, as of year-end 2023, almost 60,000 adults were incarcerated in local jails, with the vast majority being held pre-trial.[41] Fewer than a quarter are serving sentences.

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[37] https://www.cdcr.ca.gov/research/wp-content/uploads/sites/174/2024/01/Tpop1d2312.pdf; https://www.bscc.ca.gov/wp-content/uploads/Jail-Pop-Trends-Through-Q3_2023.pdf, accessed January 14, 2024

[38] https://www.bscc.ca.gov/wp-content/uploads/JDPS-1Q2002-3Q2023_Trends_12.21.23.pdf. Numbers vary in the report between approximately 2200 and 2700 in the state for average daily population, accessed January 14, 2024.

[39] Obtained from California Department of Corrections Office of Research Offender Summary of Data Points website: https://public.tableau.com/app/profile/cdcr.or/viz/OffenderDataPoints/SummaryInCustodyandParole, accessed January 14, 2024

[40] https://public.tableau.com/app/profile/cdcr.or/viz/OffenderDataPoints/SummaryInCustodyandParole, accessed January 14, 2024

[41] https://www.bscc.ca.gov/wp-content/uploads/Jail-Pop-Trends-Through-Q3_2023.pdf,accessed January 14, 2024.

- With respect to the juvenile population, until June 30, 2023, California operated the California Department of Juvenile Justice (DJJ), which housed the most serious youth at state-run facilities. As of June 30th, all juvenile operations ceased at DJJ and youth were realigned to the care of counties. County probation chiefs opposed this change and established a controversial transition group to help plan the transition of the approximately 400 youth returning to counties. County probation departments supervise justice-involved youth who are placed in local juvenile halls, camps, or supervised in the community.[42]

Reentry: Pre-Release Enrollment and Services

The following summary is based directly on the January 26, 2023, CMS guidance in the SMDL - SMD 23-003 - Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated (medicaid.gov). CMS approved California's 1115 Re-entry Demonstration waiver, which is part of DHCS' overall CalAIM Justice-Involved Initiative. As a group, incarcerated individuals have generally been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. With the Waiver, California will cover a targeted set of pre-release services for Medi-Cal members who meet specified criteria, as applicable, and are incarcerated in state prisons, county jails and youth correctional facilities to improve re-reentry and their transitions (in particular, transitions of health coverage and care) back to the community. The provision of Medi-Cal pre-release and re-entry transition services, for the 90-days prior to the individual's release, as well as ECM upon release, is expected to increase continuity of health coverage, prevent unnecessary disruptions in care, reduce emergency department visits and inpatient hospital admissions; reduce decompensation, suicide-related death, overdose, overdose-related death and all-cause death; and lead to improved health outcomes in general. This targeted set of pre-release services will be available to certain eligible Medicaid and CHIP members who are residing in state prisons, county jails, or youth correctional facilities, for up to 90 days immediately prior to the individual's expected release date.

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[42] https://www.cdcr.ca.gov/ccjbh/wp-content/uploads/sites/172/2020/07/Juvenile-Justice-Factsheet-6.30.2020.pdf.The most recent jail survey from the Bureau of State and Community Corrections (BSCC) lists almost 1700 youth in halls and 600 in camps across the state, but the data are not complete: https://www.bscc.ca.gov/wp-content/uploads/JDPS-1Q2002-1Q2023_Trends_6.20.23.pdf, accessed January 14, 2024.

The objective of this component of the demonstration is to facilitate members' access to certain healthcare services, including case management services to facilitate reentry planning and care transitions. These services will be provided by Medicaid enrolled providers, CHIP participating providers, or by correctional facilities enrolled as an exempt from licensure clinic, while members are incarcerated and allow them to establish relationships with community-based providers from whom they can receive services upon reentry to communities. This bridge to coverage begins prior to release and is expected to promote continuity of care and improve health outcomes for these individuals. The purpose of this reentry demonstration initiative is to provide Medicaid enrollment assistance and pre-release coverage for certain services to facilitate successful care transitions, as well as improve the identification and treatment of certain chronic and other serious illnesses.

The targeted set of pre-release services approved in the Reentry Demonstration wavier include reentry case management services; physical and behavioral health clinical consultation services, laboratory and radiology services, medications and medication administration; medication-assisted treatment (MAT) for all Food and Drug Administration (FDA)-approved medication, including coverage for counseling and services provided by community health workers with lived experience. Qualifying members will also receive covered outpatient prescribed medication and durable medical equipment upon release.

The goals for the Reentry Demonstration Initiative are to[43]:

1. Increase coverage, continuity of coverage, and appropriate service uptake through assessment of eligibility and availability of coverage for benefits in carceral settings in prison/jail/juvenile hall just prior to release;
2. Improve access to services prior to release from prison/jail/juvenile hall and improve transitions and continuity of care into the community upon release from prison/jail/juvenile hall;
3. Improve coordination and communication between correctional systems, Medicaid and CHIP systems, managed care plans, and community-based providers;

[43] We use the term "beneficiaries" here since these goals are verbatim language from CMS.

4. Increase additional investments in health care and related services, aimed at improving the quality of care for beneficiaries in carceral settings and in the community to maximize successful reentry post-release;
5. Improve connections between carceral settings and community services upon release to address physical health, behavioral health, and health-related social needs;
6. Provide intervention for certain behavioral health conditions and using stabilizing medications like long-acting injectable anti-psychotics and medications for addiction treatment for substance use disorders (SUDs), with the goal of reducing decompensation, suicide-related deaths, overdoses, and overdose-related deaths in the near-term post-release; and
7. Reduce post-release acute care utilizations such as emergency department (ED) visits and inpatient hospitalizations and all-cause deaths among recently incarcerated Medicaid beneficiaries and individuals otherwise eligible for CHIP if not for their incarceration status through robust pre-release identification, stabilization, and management of certain serious physical and behavioral health conditions that may respond to ambulatory care and treatment (e.g., diabetes, heart failure, hypertension, schizophrenia, SUDs) as well as increased receipt of preventive and routine physical and behavioral health care.

To assess the Reentry Demonstration Initiative, DHCS and its independent evaluation team will engage in a comprehensive evaluation using mixed-methods to assess the impact and success of the demonstration, including detailed analysis of person-level routinely collected data and interviews.

State law and the Waiver allow for a two-year ramp up for all correctional facilities. Our research design will be responsive to the different start dates for facilities; facilities that come onboard later may have less follow-up time for analyses. In our methods, we tag pre- and post-Waiver events at the individual facility-level. Our target and comparison groups will then be defined for each facility separately. This is noted in each research question.

Evaluation Goals

The following evaluation goals are taken verbatim from the CMS guidance in the SMDL - SMD 23-003 - Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated

(medicaid.gov). We have kept the term "beneficiary" in exact language used by CMS; however, in other places we use the term "members" per DHCS guidance.

Exhibit 1: Evaluation Goals for Reentry

<table>
<tr><td colspan="2">Goal 1: Increase coverage, continuity of care, and appropriate service uptake through assessment of eligibility and availability of coverage for benefits in carceral settings just prior to release.</td></tr>
<tr><th>Evaluation Questions and Hypotheses</th><th>Measures</th></tr>
<tr><td>EQ 1: Did the Waiver increase coverage, continuity of care, and appropriate service uptake for eligible Medi-Cal members?</td><td rowspan="2">New individuals enrolled in Medicaid relative to the number of Medicaid individuals who have Medicaid at the time of entry to the facility
New individuals with a suspended status relative to the number of Medicaid-enrolled individuals who are in a suspended status due to incarceration
Number of Reentry Initiative enrollees who received pre-release care management during pre-release period
Receipt of services appropriate for existing conditions</td></tr>
<tr><td>H 1: The Waiver will increase coverage, continuity of care, and appropriate service uptake for eligible Medi-Cal members?</td></tr>
</table>

Exhibit 1: Evaluation Goals for Reentry (Cont)

Goal 2: Improve access to services prior to release and improve transitions and continuity of care into the community upon release.	
Evaluation Questions and Hypotheses	**Measures**
EQ 2: Did the Waiver improve access to services prior to release from prison/jail/juvenile hall? Improve transitions and continuity of care upon release for eligible Medi-Cal members? **H1:** The Waiver will increase access to services prior to release and improve transitions and continuing of care upon release for eligible Medi-Cal members.	• Number of Reentry Initiative enrollees who had a visit with their ECM provider within 30 days after release. Receipt of physical and behavioral health clinical consultation services pre-release • Receipt of radiology services pre-release • Number of Reentry Initiative enrollees who received any medication billed during the pre-release period • Number of Reentry Initiative enrollees who had a filled prescription in the 30 days prior to release • Receipt of medications for substance-abuse disorder during the pre-release period • Number of Reentry Initiative enrollees who had a filled prescription in the 30 days following release • Number of Reentry Initiative enrollees who received SUD treatment within 30 days post-release Number of Reentry Initiative enrollees who received any Medicaid service within six months post-release

Exhibit 1: Evaluation Goals for Reentry (Cont)

Goal 3: Improve coordination and communication between correctional systems, Medicaid and CHIP systems, managed care plans, and community-based providers.	
Evaluation Questions and Hypotheses	**Measures**
EQ 3A: Did the Waiver improve coordination between correctional systems, Medicaid and CHIP systems, managed care plans, and community-based providers? **EQ 3B**: Did the Waiver improve communication between correctional systems, Medicaid and CHIP systems, managed care plans, and community-based providers? **H1:** The Waiver will improve coordination between correctional systems, Medicaid and CHIP systems, managed care plans, and community-based providers. **H2:** The Waiver will improve communication between correctional systems, Medicaid and CHIP systems, managed care plans, and community-based providers.	• Emergent themes from interviews

Exhibit 1: Evaluation Goals for Reentry (Cont)

Goal 4: Increase additional investments in health care and related services, aimed at improving the quality of care for beneficiaries in carceral settings and in the community to maximize successful reentry post-release.	
Evaluation Questions and Hypotheses	**Measures**
EQ 1: Did the Waiver Increase additional investments in health care and related services, aimed at improving the quality of care for beneficiaries in carceral settings and in the community to maximize successful reentry post-release?	• Emergent themes from interviews
H1: The Waiver will increase additional investments in health care and related services	
Goal 5: Improve connections between carceral settings and community services upon release to address physical health, behavioral health, and health-related social needs.	
Evaluation Questions and Hypotheses	**Measures**
EQ 1: Did the Waiver Improve connections between carceral settings and community services upon release to address physical health, behavioral health, and health-related social needs?	• Emergent themes from interviews
H1: The Waiver will improve connections between carceral settings and community services upon release to address physical health, behavioral health, and health-related social needs	

Exhibit 1: Evaluation Goals for Reentry (Cont)

Goal 6: Provide intervention for certain behavioral health conditions and use stabilizing medications like long-acting injectable antipsychotics and medications for addiction treatment for SUDs, with the goal of reducing decompensation, suicide-related death, overdose, and overdose-related death in the near-term post-release.	
Evaluation Questions and Hypotheses	**Measures**
EQ 1: Did the Waiver provide intervention for certain behavioral health conditions and use stabilizing medications like long-acting injectable anti-psychotics and medications for addiction treatment for SUDs for eligible Medi-Cal members?	• Number of Reentry Initiative enrollees who received substance use disorder treatment within 30 days post-release • Number of Reentry Initiative enrollees who received any mental health treatment within 30 days post-release • Number of Reentry Initiative enrollees who received MAT within 30 days post-release • Number of Reentry Initiative enrollees who received all necessary medications for chronic disease in the community prior to completion of previous supply received during incarceration. [note possible need to specify hypertension, diabetes, or other common chronic conditions] • Receipt of behavioral health condition interventions pre- and post-release • Receipt of long-acting injectable anti-psychotics pre- and post-release • Receipt of medications for addiction treatment for SUDs pre- and post-release • Suicide-related emergency department visits post-release
H1: The Waiver will increase access to interventions for behavioral health conditions, access to long-acting injectable anti-psychotics, and access to medications for addiction treatment for SUDs for eligible Medi-Cal members	

Exhibit 1: Evaluation Goals for Reentry (Cont)

Goal 6: Provide intervention for certain behavioral health conditions and use stabilizing medications like long-acting injectable antipsychotics and medications for addiction treatment for SUDs, with the goal of reducing decompensation, suicide-related death, overdose, and overdose-related death in the near-term post-release.	
Evaluation Questions and Hypotheses	**Measures**
EQ 2: Did the Waiver reduce decompensation, suicide-related deaths, overdoses, and overdose-related deaths in the near-term post-release for eligible Medi-Cal members? **H2:** The Waiver will reduce decompensation, suicide-related deaths, overdoses, and overdose-related deaths for eligible Medi-Cal members?	Indicators of decompensation can include: • Psychosis • Suicide attempt • Depression • Anxiety • Mania • Drug overdose (regardless of intention) • Drug-induced mental disorders • Insomnia • Social withdrawal • Anorexia • Aggression Increases substance use

Exhibit 1: Evaluation Goals for Reentry (Cont)

<table>
<tr><td colspan="2">Goal 7: Reduce post-release acute care utilization such as emergency department visits, inpatient hospitalizations, and all-cause deaths among recently incarcerated Medicaid beneficiaries and individuals otherwise eligible for CHIP if not for their incarceration status through robust pre-release identification, stabilization, and management of certain serious physical and behavioral health conditions that may respond to ambulatory care and treatment (e.g., diabetes, heart failure, hypertension, schizophrenia, SUDs) as well as increased receipt of preventive and routine physical and behavioral health care.</td></tr>
<tr><th>Evaluation Questions and Hypotheses</th><th>Measures</th></tr>
<tr><td>EQ 1: Did the Waiver reduce post-release emergency department visits, inpatient hospitalizations, and all-cause deaths for eligible Medi-Cal members?</td><td rowspan="2">All-cause deaths (count and rate) post-release
All-cause emergency room visits post-release
All-cause inpatient hospitalizations post-release</td></tr>
<tr><td>H1: The Waiver will reduce post-release emergency department visits, inpatient hospitalizations, and all-cause deaths for eligible Medi-Cal members?</td></tr>
</table>

Driver Diagrams

The goals listed in the driver diagrams are taken directly from CMS guidance in the SMDL - SMD 23-003 - Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated (medicaid.gov).

Exhibit 2 - Driver Diagram for Goal 1: Increase coverage, continuity of care, and appropriate service uptake through assessment of eligibility and availability of coverage for benefits in carceral settings just prior to release

Aim	Primary Driver	Secondary Driver
Increase coverage, continuity of care and appropriate service uptake	Increase the screening rate for Medicaid eligibility Improve coverage for benefits in carceral settings prior to release	• Increase administration of screening to identify eligible individuals • Conduct outreach to ensure beneficiary and applicant awareness of the policy and assist individuals with Medicaid application, enrollment, and renewal processes. • Increase utilization of applicable pre- and post-release services • Increase behavioral health linkages and enhanced care management linkages for health and social services pre- and post-release • Improve data systems in carceral settings
← Causality ←		

Exhibit 3 - Driver Diagram for Goal 2: Improve access to services prior to release and improve transitions and continuity of care into the community upon release.

Aim	Primary Driver	Secondary Driver
Improve access to services prior to release and improve transitions and continuity of care into the community upon release.	Increase Medicaid coverage and MCP plan assignment. Improve care coordination between carceral and community providers. Increase utilization of applicable pre- and post-release services	• Implement screening process to identify individuals who qualify for pre-release services. • Increase availability of pre-release services. • Increase transition services. • Increase referrals for health and social services pre- and post-release. • As part of case management assessment, ensure all members receive a person- centered plan for coordination of their care post-release. • Implement processes to ensure that all pre-release service providers have the necessary experience and training, and case managers are knowledgeable about community-based providers.
← Causality ←		

Exhibit 4 - Driver Diagram for Goal 3: Improve coordination and communication between correctional systems, Medicaid and CHIP systems, managed care plans, and community-based providers

Aim	Primary Driver	Secondary Driver
Improve system-level coordination and communication between correctional systems, Medicaid and CHIP systems, managed care plans, and community-based providers	Increase contacts and information-sharing between correctional systems, Medicaid and CHIP systems, managed care plans, and community-based providers. Correctional facilities facilitate access to incarcerated members for community health care providers, including case managers, either in person or via telehealth.	Develop data exchange and data sharing agreements. Develop and share strategies to improve awareness about Medicaid coverage and access. Create plans for establishing communication and engagement between systems.
← Causality ←		

Exhibit 5 - Driver Diagram for Goal 4: Increase additional investments in health care and related services, aimed at improving the quality of care for beneficiaries in carceral settings and in the community to maximize successful reentry post-release

Aim	Primary Driver	Secondary Driver
Increase additional investments in health care and related services, aimed at improving the quality of care for members in carceral settings and in the community to maximize successful reentry post-release	Increase funding. Increase staff. Broaden available services.	• Identify additional staffing needs. • Identify service gaps. • Develop mechanisms to capture funding requirements and track expenditures.
← Causality ←		

Exhibit 6 - Driver Diagram for Goal 5: Improve connections between carceral settings and community services upon release to address physical health, behavioral health, and health-related social needs

Aim	Primary Driver	Secondary Driver
Improve person-level connections between carceral settings and community services upon release to address physical health, behavioral health, and health-related social needs;	Increase service provision for physical health, behavioral health, and person-level, health-related needs. Increase contact with transition team and community providers to facilitate coordination of care.	• Implement screening process to identify individuals who qualify for pre-release services. • Increase availability of pre-release services. • Increase transition services. • Increase referrals for health and social services pre- and post- release. • As part of case management assessment, ensure all members receive a person-centered plan for coordination of their care post-release.
← Causality ←		

Exhibit 7 - Driver Diagram for Goal 6: Provide interventions for certain behavioral health conditions and use stabilizing medications like long-acting injectable antipsychotics and medications for addiction treatment for SUDs, with the goal of reducing decompensation, suicide-related death, overdose, and overdose-related death in the near-term post-release

Aim	Primary Driver	Secondary Driver
Increase access to interventions for behavioral health conditions, access to long-acting injectable anti-psychotics, and access to medications for addiction treatment for SUDs. Reduce decompensation, suicide-related deaths, overdose, and overdose-related deaths in the near-term post-release	Increased utilization of interventions for behavioral health conditions. Increased utilization of long-acting injectable anti-psychotics; increased utilization of medications for addiction treatment for SUDs.	• Increased education of providers and incarcerated persons on the availability of interventions for behavioral health conditions. • Increased education of providers and incarcerated persons on availability of long- acting injectable anti-psychotics • Increased education of providers and incarcerated persons on availability of medications for addiction treatment for SUDs.
← Causality ←		

Exhibit 8 - Driver Diagram for Goal 7: Reduce post-release acute care utilization such as emergency department visits, inpatient hospitalizations, and all-cause deaths among recently incarcerated Medicaid beneficiaries and individuals otherwise eligible for CHIP if not for their incarceration status through robust pre-release identification, stabilization, and management of certain serious physical and behavioral health conditions that may respond to ambulatory care and treatment (e.g., diabetes, heart failure, hypertension, schizophrenia, SUDs) as well as increased receipt of preventive and routine physical and behavioral health care

Aim	Primary Driver	Secondary Driver
Reduce post-release acute care utilization such as emergency department visits, inpatient hospitalizations, and all-cause deaths among recently incarcerated Medicaid members and individuals	Increase appropriate utilization of outpatient and inpatient services. Increase robust pre-release identification, stabilization, and management of certain serious physical and behavioral health conditions. Increase receipt of preventive and routine physical and behavioral health care	• Increase availability of pre-release services • Increase pre-release assessments of service need. • Increase transition services. • Increase referrals for health and social services pre- and post- release. • Increase the availability of preventive and routine physical and behavioral health care
← Causality ←		

Methods

Note, the goals are taken directly from CMS guidance in the SMDL - SMD 23-003 - Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated (medicaid.gov).

Goal 1: Increase coverage, continuity of care, and appropriate service uptake through assessment of eligibility and availability of coverage for benefits in carceral settings just prior to release.

Research Question 1: Did the Waiver increase coverage, continuity of care, and appropriate service uptake?

- Hypothesis: The Waiver will increase coverage, continuity of care, and appropriate service uptake
- Measures:
    - New individuals enrolled in Medicaid relative to the number of Medicaid individuals who have Medicaid at the time of entry to the facility.
    - New individuals enrolled in Medicaid relative to the number of Medicaid-enrolled individuals who are in a suspended status due to incarceration.
    - Number of Reentry Initiative enrollees who received pre-release care
    - Receipt of services appropriate for existing conditions pre-release
- Target Population: People who are eligible Medical-Cal members who met service criteria for the Waiver and then released from carceral settings following the go-live of the Waiver (specific to each facility)
- Comparison Population: People who would have met Medi-Cal eligibility released from carceral settings prior to the go-live of the Waiver (specific to each facility)
- Individual level data
- Evaluation Period: CY 2017 through CY 2026.
- Our approach will make use of cohorts of individuals released from facilities so that we are able to select treatment groups and control groups around the timing of the go live. UCLA will also identify additional control cohorts from prior to the go-live to be able to estimate models that can identify a causal effect.

Thus, UCLA will assess the feasibility of constructing control cohorts over the same periods in prior years (e.g., 6 months pre and 6 months post the go-live for years around the time of the facility roll-out and the same calendar periods for years prior to the policy rolling out). While in practice the year of the roll-out and one year before could be used to identify these groups (i.e., 2 cohorts), this may lead to noisy estimates. Such noise could result in the findings indicating that the Waiver had no impact due to noise rather than a true null effect. Increasing the number of control cohorts (back to 2017 for example) would allow for the identification of more precise estimates. More precision (afforded by these earlier cohorts) will therefore be important in allowing UCLA to provide precise estimates of the effect of the Waiver and ensure that the evaluation is powered to identify an effect if one exists.

- Methodological Design: UCLA will use cohort difference-in-difference and event study analyses. UCLA will identify a 12-month cohort of individuals released around the timing of the go-live of the Waiver (i.e., groups released 6 months prior to waiver implementation (control) and the first 6 months after Waiver implementation(treated)). UCLA will also identify control cohorts from the same 12-month period, for years prior to Waiver roll-out.

  Our difference-in-difference models will explore how outcomes vary before and after Waiver roll-out compared to associated control cohorts (in earlier years) to identify the causal effect of the Waiver. Importantly, UCLA will be able to follow the outcomes of individuals who meet the criteria who transition from carceral settings to community over time, allowing us to explore dynamic effect in event study models by using monthly data for the outcomes of each individual. Event study models will also allow UCLA to explore whether control and treated cohorts were on parallel trends prior to Waiver implementation (a crucial assumption in difference-in-difference models). For adults in prison and jails, given that only certain people are eligible based on pre-existing conditions, UCLA will also use this variation to conduct difference-in-difference models with alternative control groups (which compare the outcomes of eligible people to those of non-eligible people, pre-post the Waiver). Since all youth are eligible for the Waiver, analyses with alternative control groups will not be conducted for juveniles.

  Further, UCLA will combine both the cohort and eligibility variation to conduct triple difference models. The Waiver is likely to be rolled out in staggered settings

across jails/juvenile halls. As such, in these cases UCLA will make use of staggered difference-in-difference and event study models that compare the outcomes of the re-entry population that are released after Waiver rollout, compared to those released prior to the roll-out, for jails/ juvenile halls that rollout the Waiver earlier, compared to those that rollout the Waiver later. Given the staggered nature in these settings UCLA will make use of models that deal with biases that may arise in such settings (Roth et al., 2023).

If those released after the Waiver roll-out, compared to those released prior to the roll-out, in the treatment cohort compared to associated earlier control cohorts, have higher rates of Medi-Cal enrollment, care utilization, and receipt of services appropriate for existing conditions then the hypothesis is affirmed.

- Data Sources: Medicaid claims data and correctional agencies' health care utilization data and background information on inmates/releasees. State hospital inpatient discharge data, state hospital emergency department visit data, and state death data.
- Analytic Methods: Descriptive summary and t-tests will be used to provide sample characteristics and trends. Probit models will be estimated to take consideration of the binary nature of outcomes variables. Difference-in-difference analysis will be used to identify a causal effect. Event study models will be used to test for pre-trends. UCLA will examine the three major populations targeted for Reentry – prisoners, jail inmates, and juveniles who are incarcerated.

Goal 2: Improve access to services prior to release and improve transitions and continuity of care into the community upon release.

Research Question 1: Did the Waiver improve access to services prior to release from prison/jail/juvenile correctional facilities and improve transitions and continuing of care upon release?

- Hypothesis: The Waiver will increase access to services prior to release and after
- Measures:
    - Receipt of physical and behavioral health clinical consultation services pre-release
    - Receipt of radiology services pre-release
    - Number of Reentry Initiative enrollees who received any medication billed

during the pre-release period
    - Number of Reentry Initiative enrollees who had a filled prescription in the 30 days prior to release
    - Receipt of Medication Assisted Treatment (MAT) for all types of SUD during pre-release period
    - Number of Reentry Initiative enrollees who had a visit with their ECM provider within 30 days after release
    - Number of Reentry Initiative enrollees who had a filled prescription in the 30 days following release
    - Number of Reentry Initiative enrollees who received SUD treatment within 30 days post release
    - Number of Reentry Initiative enrollees who received any Medicaid service within six months post-release

- Target Population: People who are eligible Medical-Cal members who met Waiver service criteria and were enrolled and then released from carceral settings following the go-live of the Waiver (specific to each facility)
- Comparison Population: People who would have met Medi-Cal eligibility released from carceral settings prior to the go-live of the Waiver (specific to each facility)
- Individual level data
- Evaluation Period: CY 2017 through CY 2026.
- Methodological Design: UCLA will use cohort difference-in-difference and event study analyses. UCLA will identify a 12-month cohort of individuals released around the timing of the go-live of the Waiver (i.e., groups released 6 months prior to Waiver implementation (control) and the first 6 months after Waiver implementation (treated)). UCLA will also assess the feasibility of constructing control cohorts from the same 12-month period, for years prior to Waiver go-live. Our difference-in-difference models will explore how outcomes vary before and after Waiver roll-out compared to associated control cohorts (in earlier years) to identify the causal effect of the Waiver. Importantly, UCLA will be able to follow the outcomes of releasees over time, allowing us to explore dynamic effects in event study models by using monthly data for the outcomes of each individual.

Event study models will also allow us to explore whether control and treated cohorts were on parallel trends prior to Waiver roll-out (a crucial assumption in difference-in-difference models). The Waiver is likely to be rolled out in staggered settings across jails/juvenile halls. As such, in these cases UCLA will make use of staggered difference-in-difference and event study models that compare the outcomes of the re-entry population in the 90 days prior to release that are released after Waiver rollout compared to those released prior to the roll-out; for jails/ juvenile halls that rollout the Waiver earlier compared to those that rollout the Waiver later. Given the staggered nature in these settings UCLA will make use of models that deal with biases that may arise in such settings (Roth et al, 2023).

If post-Waiver cohorts in the treatment cohort have higher rates of health risk assessment, physical and behavioral health clinical consultation services, radiology services, MAT for all types of SUD, and any Medi-Cal services, during the 90 days prior to release, compared to pre-Waiver cohorts, and cohorts from earlier years then the hypothesis is affirmed. If treatment cohorts have Medicaid services within six-months of release, SUD treatment within 30 days and filled prescriptions within 30 days after release, the hypothesis is confirmed.

- Data Sources: Medicaid claims data and correctional agencies' health care utilization data and background information on inmates/releasees. State hospital inpatient discharge data, state hospital emergency department visit data, and state death data.
- Analytic Methods: Descriptive summary and t-tests will be used to provide sample characteristics and trends. Probit models will be estimated to take consideration of the binary nature of outcomes variables. Difference-in-difference analysis will be used to identify a causal effect. Event study models will be used to test for pre-trends. UCLA will examine the three major populations targeted for Reentry – prisoners, jail inmates, and juveniles who are incarcerated.

Goal 3: Improve coordination and communication between correctional systems, Medicaid and CHIP systems, managed care plans, and community-based providers.

Research Question 1: Did the Waiver improve system-level coordination and communication between correctional systems, Medicaid and CHIP systems, managed care plans, and community-based providers?

- Hypotheses:
    - Hypothesis 1: The Waiver will improve coordination between correctional systems, Medicaid and CHIP systems, managed care plans, and community-based providers.
    - Hypothesis 2: The Waiver will improve communication between correctional systems, Medicaid and CHIP systems, managed care plans, and community-based providers.
- Measures: emergent themes from interviews
- Target Population: key stakeholders in prison, jails, juvenile facilities, Medicaid, CHIP, managed care plans, and community-based providers
- Comparison Population: not applicable
- Individual level data: not applicable
- Evaluation Period: CY 2024 through CY 2028
- Methodological Design: qualitative interview-based design with semi-structured interview protocols that will be conducted via TEAMS or ZOOM once a year starting in Years 1-4. A minimum of 2-3 interviews within in each of the stakeholder groups at the state-level will be conducted; UCLA will conduct interviews also with county-level stakeholders within 4 counties. The interviews will ask about the context before the Waiver went into effect and during each year of implementation. The interviews will focus on questions related to coordination and communication between relevant stakeholders. In addition, we plan to conduct interviews with Waiver participants newly released from carceral settings in 4 counties.
- In the context of our regular across project evaluation team meetings, UCLA will regularly review project specific approaches to qualitative instrument development. To date, the Reentry and PATH teams have already met to agree upon the important interface between our two evaluation components. For example, we have agreed that any administrative data from CDCR or from county jails and youth correctional facilities will be obtained and maintained by the Reentry team who will run analyses of these data and stratify by whether carceral facility received PATH funding on UCLA's behalf for inclusion in the PATH section of the report. The PATH team will lead the development of

the organizational surveys, with input from the other projects. The Reentry team will assist with disseminating the survey to carceral facilities. Similarly, responsibilities for key informant interviews within PATH and Reentry will be distributed with the UCLA-RAND Reentry team leading interviews and focus groups in carceral settings, while the UCLA-RAND PATH team will lead interviews with carceral facilities' "external" partners (e.g., county social service agencies assisting with eligibility determinations and community-based providers responsible for providing the 90-day pre-release services). Interview data will be jointly analyzed.

- Data Sources: individual stakeholder interviews will be led by RAND project staff; interviews with Waiver participants will be conducted by RAND's Survey Research Group (SRG); other data sources include any publicly available documentation and materials that the agencies can provide.
- Analytic Methods: To do qualitative analysis of the interview data, UCLA will utilize qualitative coding of themes using software such as Depose, which will provide a systematic way to code and reveal themes in the data. Qualitative analysis will inform the interpretation of Goals 3, 4, and 5 by identifying strategies for improving communication and coordination and factors that facilitated or hindered, in addition to approaches for addressing identified barriers. UCLA will examine the three major populations targeted for Reentry – prisoners, jail inmates, and juveniles who are incarcerated.

Goal 4: Increase additional investments in health care and related services, aimed at improving the quality of care for beneficiaries in carceral settings and in the community to maximize successful reentry post-release.

Research Question 1: Did the Waiver increase additional investments in health care and related services, aimed at improving the quality of care for members in carceral settings and in the community to maximize successful reentry post-release?

- Hypothesis: The Waiver will increase additional investments in health care and related services
- Measures: emergent themes from interviews
- Target Population: key stakeholders in prison, jails, juvenile facilities, Medicaid, CHIP, managed care plans, and community-based providers Comparison Population: not applicable
- Individual level data: not applicable
- Evaluation Period: CY 2022 through CY 2028

- Methodological Design. UCLA will gather expenditure and staffing data pre and post Waiver. UCLA also will conduct semi-structured interviews via TEAMS or ZOOM with relevant financial personnel at the state prison-level, and at the jail and juvenile facility levels within the 4 counties. The interviews will ask about the context before the Waiver went into effect and during each year of implementation. The interviews will focus on questions related to investment strategies in carceral settings as well as out in the community.
- Data Sources: available financial documents from key stakeholder agencies; interviews with stakeholder staff
- Analytic Methods: qualitative discussion of changes in expenditures and investments in health care and related services, aimed at improving the quality of care for members in carceral settings, and in the community to maximize successful reentry post-release. As we describe in earlier goals, UCLA will utilize qualitative coding of themes using software such as Dedoose, which will provide a systematic way to code and reveal themes in the data and will examine the three major populations targeted for Reentry – prisoners, jail inmates, and juveniles who are incarcerated.

Goal 5: Improve connections between carceral settings and community services upon release to address physical health, behavioral health, and health-related social needs.

Research Question 1: Did the Waiver Improve connections between carceral settings and community services upon release to address physical health, behavioral health, and health-related social needs?

- Hypothesis: The Waiver will improve person-level connections between carceral settings and community services upon release to address physical health, behavioral health, and health-related social needs
- Comparison Population: not applicable
- Individual level data: not applicable
- Evaluation Period: CY 2024 through CY 2028
- Methodological Design: qualitative interview-based design with semi-structured interview protocols that will be conducted via TEAMS or ZOOM once a year starting in Years 1-4. A minimum of 2-3 interviews within in each of the stakeholder groups at the state-level will be conducted; UCLA will conduct interviews also with county-

level stakeholders within 4 counties. The interviews will ask about the context before the Waiver went into effect and during each year of implementation. The interviews will focus on questions related to coordination and communication between relevant stakeholders. In addition, UCLA plans to conduct interviews with Waiver participants newly released from carceral settings in 4 counties.

- Data Sources: individual stakeholder interviews will be led by RAND project staff; interviews with Waiver participants will be conducted by RAND's Survey Research Group (SRG); other data sources include any publicly available documentation and materials that the agencies can provide.
- Analytic Methods: To do qualitative analysis of the interview data, UCLA will utilize qualitative coding of themes using software such as Dedoose, which will provide a systematic way to code and reveal themes in the data. Qualitative analysis will inform the interpretation of Goals 3, 4, and 5 by identifying strategies for improving connections between physical health, behavioral health, and health-related social needs and factors that facilitated or hindered those connections and approaches to address identified barriers. UCLA will examine the three major populations targeted for Reentry – prisoners, jail inmates, and juveniles who are incarcerated.

Goal 6: Provide intervention for certain behavioral health conditions and use stabilizing medications like long-acting injectable antipsychotics and medications for addiction treatment for SUDs, with the goal of reducing decompensation, suicide-related death, overdose, and overdose-related death in the near-term post-release.

Research Question 1: Did the Waiver provide intervention for certain behavioral health conditions and use stabilizing medications like long-acting injectable anti-psychotics and medications for addiction treatment for SUDs?

Hypothesis: The Waiver will increase access to interventions for behavioral health conditions, access to long-acting injectable anti-psychotics, and access to medications for addiction treatment for SUDs

- Measures:
    - Number of Reentry Initiative enrollees who received substance use disorder treatment within 30 days post-release
    - Number of Reentry Initiative enrollees who received any mental health treatment within 30 days post-release

    - Number of Reentry Initiative enrollees who received MAT within 30 days post-release
    - Number of Reentry Initiative enrollees who received all necessary medications for chronic disease in the community prior to completion of previous supply received during incarceration. [note possible need to specify hypertension, diabetes, or other common chronic conditions]
    - Receipt of behavioral health condition interventions pre- and post-release
    - Receipt of long-acting injectable anti-psychotics pre- and post-release
    - Receipt of medications for addiction treatment for SUDs pre- and post-release
    - Suicide-related emergency department visits post-release
    - Suicide-related inpatient hospitalizations post-release
    - Suicide-related deaths post-release
    - Overdose-related emergency department visits post-release
    - Overdose-related inpatient hospitalizations post-release
    - Overdose-related deaths post-release

- Target Population: People who are eligible Medical-Cal members who met Waiver service criteria and were enrolled and then released from carceral settings following the go-live of the Waiver (specific to each facility)
- Comparison Population: People who would have met Medi-Cal eligibility and Waiver service requirements and were released from carceral settings prior to the go-live of the Waiver (specific to each facility)
- Individual level data
- Evaluation Period: CY 2017 through CY 2026
- Methodological Design: UCLA will use cohort difference-in-difference and event study analyses. UCLA will identify a 12-month cohort of individuals released around the timing of the rollout of the Waiver (i.e., groups released 6 months prior to Waiver implementation (control) and the first 6 months after Waiver implementation(treated)). UCLA will also assess the feasibility of constructing control cohorts from the same 12-month period, for years prior to Waiver implementation. Our difference-in-difference models will explore how outcomes vary before and after Waiver roll-out compared to associated control cohorts (in earlier years) to identify the causal effect of the Waiver. Importantly, UCLA will be able to follow the outcomes of releasees over time, allowing us to explore

dynamic effect in event study models by using monthly data for the outcomes of each individual. Event study models will also allow us to explore whether control and treated cohorts were on parallel trends prior to Waiver implementation (a crucial assumption in difference-in-difference models). Event study models will also allow us to explore dynamics in the post-treatment period, allowing us to explore whether changes in outcomes occurred pre-release, post-release, or both.

The Waiver is likely to be rolled out in staggered setting across jails/juvenile halls. As such, in these cases UCLA will make use of staggered difference-in-difference and event study models that compare the outcomes of the reentry population in the 90 days prior to release, that are released after Waiver rollout, compared to those released prior to the roll-out, for jails/ juvenile halls that rollout the Waiver earlier, compared to those that rollout the Waiver later. Given the staggered nature in these settings UCLA will make use of models that deal with biases that may arise in such settings (Roth et al., 2023).

If post-Waiver cohorts in the treatment cohort have higher rates of receiving behavioral health condition interventions, long-acting injectable anti-psychotic, and medications for addiction treatment for SUDs, during the 90 days prior to release, compared to pre-Waiver cohorts, and cohorts from earlier years then the Hypothesis 1 is affirmed Data Sources: Medicaid claims data and corrections agencies' health care utilization data and background information on inmates/releasees. State hospital inpatient discharge data, state hospital emergency department visit data, and state death data.

- Analytic Methods: Descriptive summary and t-tests will be used to provide sample characteristics and trends. Probit models will be estimated to take consideration of the binary nature of outcomes variables. Difference-in-difference analysis will be used to identify a causal effect. Event study models will be used to test for pre-trends. UCLA will examine the three major populations targeted for Reentry – prisoners, jail inmates, and juveniles who are incarcerated.

Research Question 2: Did the Waiver reduce decompensation, suicide-related deaths, overdoses, and overdose-related deaths in the near-term post-release?

- Hypothesis: The Waiver will reduce decompensation, suicide-related deaths, overdoses, and overdose-related deaths.
- Measures:

    - Decompensation
        - Indicators of decompensation include:
            - Psychosis
            - Suicide attempt
            - Major Depression with Suicidal Ideation
            - Drug overdose (regardless of intention)
            - Drug induced mania/delirium
    - Suicide related deaths
    - Overdose-related deaths
    - Non-fatal overdose hospitalizations
- Target Population: People who are eligible Medical-Cal members who met Waiver service criteria and were enrolled and then released from carceral settings following the go-live of the Waiver (specific to each facility)
- Comparison Population: People who would have met Medi-Cal eligibility and Waiver service criteria and were released from carceral settings prior to the go-live of the Waiver (specific to each facility)
- Individual level data
- Evaluation Period: CY 2017 through CY 2026.
- Methodological Design: UCLA will use cohort difference-in-difference and event study analyses. UCLA will identify a 12-month cohort of individuals released around the timing of the rollout of the Waiver (i.e., groups released 6 months prior to Waiver implementation (control) and the first 6 months after Waiver implementation (treated)). UCLA will also assess the feasibility of constructing control cohorts from the same 12-month period, for years prior to Waiver implementation. Our difference-in-difference models will explore how outcomes vary before and after Waiver implementation compared to associated control cohorts (in earlier years) to identify the causal effect of the Waiver. Importantly, UCLA will be able to follow the outcomes of releasees over time, allowing us to explore dynamic effect in event study models by using monthly data for the outcomes of each individual. Event study models will also allow us to explore whether control and treated cohorts were on parallel trends prior to Waiver implementation (a crucial assumption in difference-in-difference models).

  The Waiver is likely to be rolled out in staggered setting across jails/juvenile halls. As such, in these cases UCLA will make use of staggered difference-in-difference and event study models that compare the outcomes of the reentry population

that are released after Waiver rollout, compared to those released prior to the roll-out, for jails/ juvenile halls that rollout the Waiver earlier, compared to those that rollout the Waiver later. Given the staggered nature in these settings UCLA will make use of models that deal with biases that may arise in such settings (Roth et al, 2023).

If those released after the Waiver, compared to those released prior to the Waiver, in the treatment cohort compared to associated earlier control cohorts, have lower rates of decompensation, suicide-related deaths, non-fatal overdose hospitalizations, and overdose-related deaths then the hypothesis is affirmed.

- Data Sources: Medicaid claims data and corrections agencies' health care utilization data and background information on inmates/releasees. State hospital inpatient discharge data, state hospital emergency department visit data, and state death data. UCLA will work with other project teams who will also be accessing claims data. The Reentry staff will work with CDCR, and up to four county jail and juvenile incarceration facilities to gain access and obtain required data. This will involve setting up data sharing agreements for each source. RAND's contract staff will assist in creating the data sharing agreements, as they have experience in drafting these for other projects. As for linking, UCLA will have to explore matching methods for Medicaid claims data with corrections' agency health care utilization data. Corrections agency data typically has name, DOB, gender, and SSN (although reliability is sometimes an issue).
- Analytic Methods: Descriptive summary and t-tests will be used to provide sample characteristics and trends. Probit models will be estimated to take consideration of the binary nature of outcomes variables. Difference-in-difference analyses will be used to identify a causal effect. Event study models will be used to test for pre-trends. UCLA will examine the three major populations targeted for Reentry – prisoners, jail inmates, and juveniles who are incarcerated.

Goal 7: Reduce post-release acute care utilization such as emergency department visits, inpatient hospitalizations, and all-cause deaths among recently incarcerated Medicaid beneficiaries and individuals otherwise eligible for CHIP if not for their incarceration status through robust pre-release identification, stabilization, and management of certain serious physical and behavioral health conditions that may respond to ambulatory care and treatment (e.g., diabetes, heart failure, hypertension, schizophrenia, SUDs) as well as increased receipt of preventive and routine physical and behavioral health care.

Research Question 1: Did the Waiver reduce post-release emergency department visits, inpatient hospitalizations, and all-cause deaths?

- Hypothesis: The Waiver will reduce post-release emergency department visits, inpatient hospitalizations, and all-cause deaths
- Measures:
    - All-cause deaths (count and rate)
    - All-cause emergency room visits
    - All-cause inpatient hospitalizations
- Target Population: People who are eligible Medical-Cal members who met Waiver service criteria and were enrolled and then released from carceral settings following the go-live of the Waiver (specific to each facility)
- Comparison Population: People who would have met Medi-Cal eligibility and Waiver service criteria and then released from carceral settings prior to the go-live of the Waiver (specific to each facility)
- Individual level data
- Evaluation Period: CY 2017 through CY 2026.
- Methodological Design: UCLA will use cohort difference-in-difference and event study analyses. UCLA will identify a 12-month cohort of individuals released around the timing of the rollout of the Waiver (i.e., groups released 6 months prior to Waiver roll-out (control) and the first 6 months after Waiver roll-out (treated)). UCLA will also assess the feasibility of constructing control cohorts from the same 12-month period, for years prior to Waiver implementation. Our difference-in-difference models will explore how outcomes vary before and after Waiver implementation compared to associated control cohorts (in earlier years) to identify the causal effect of the Waiver. Importantly, UCLA will be able to follow the outcomes of releasees over time, allowing us to explore dynamic effect in event study models by using monthly data for the outcomes of each individual. Event study models will also allow UCLA to explore whether control and treated cohorts were on parallel trends prior to Waiver implementation (a crucial assumption in difference-in-difference models).

  The Waiver is likely to be rolled out in staggered setting across jails/juvenile halls. As such, in these cases UCLA will make use of staggered difference-in-difference and event study models that compare the outcomes of the reentry population that are released after Waiver rollout, compared to those released prior to the

roll-out, for jails/ juvenile halls that rollout the Waiver earlier, compared to those that rollout the Waiver later. Given the staggered nature in these settings UCLA will make use of models that deal with biases that may arise in such settings (Roth et al., 2023).

If those released after the Waiver, compared to those released prior to the Waiver, in the treatment cohort compared to associated earlier control cohorts, have lower rates of post-release emergency department visits, inpatient hospitalizations, and all-cause deaths then the hypothesis is affirmed.

- Data Sources: Medicaid claims data and corrections agencies' health care utilization data and background information on inmates/releasees. State hospital inpatient discharge data, state hospital emergency department visit data, and state death data.
- Analytic Methods: Descriptive summary and t-tests will be used to provide sample characteristics and trends. Probit models will be estimated to take consideration of the binary nature of outcomes variables. Difference-in-difference analysis will be used to identify a causal effect. Event study models will be used to test for pre-trends. UCLA will examine the three major populations targeted for Reentry – prisoners, jail inmates, and juveniles who are incarcerated.

Cost

UCLA will attempt to perform a cost analysis for the Reentry Demonstration pre- and post-implementation using health care expenditures data from the correctional system, the monthly Medi-Cal enrollment, plan capitation rates, and service claims, and monthly estimates for public healthcare costs for uninsured individuals. Costs of implementation (infrastructure dollars from PATH for Reentry) will be included in the year-over-year cost estimates. UCLA will not be able to assess whether an individual has commercial health insurance (through a spouse or as a dependent).

Limitations

The Reentry Evaluation poses a number of challenges that will need to be addressed during the design of the evaluation. For example, CDCR and jail systems often use their own unique identifiers; the evaluation team will need to work with carceral institutions to assure that identifiers they record will allow us to match data across the health care utilization data. Although the adult prison system has a unified record keeping system, each county jail and juvenile halls and camps have their own unique systems. The recent closure of the state's DJJ and placement of the most serious CJI youth is still in flux – we

need to determine where the most serious youth will now be housed. Complex IRB and access issues will need to be addressed and likely will require a longer length of time to put into place all of the IRB and research approval permissions. Specifically, any research projects conducted within CDCR must go through their rigorous Research Oversight Committee for approval; the evaluation also will need to go through the state's IRB process as well. In addition, jails may require individual county approval and creation of data use agreements; access to juveniles often requires permission from the presiding judge overseeing juveniles. Most importantly, the Reentry Component has not previously prepared the evaluation plan. Thus, the evaluation plan for this component will be newly developed and will likely require more time to finalize than the other components of the Waiver evaluation.

Lastly, the delivery of pre-release services is to be implemented using a phased-in approach; with all participating state prisons, county jails, and youth correctional facilities needing to demonstrate readiness prior to participating in the Reentry Demonstration Initiative. Any delays will impact the evaluation timeline.