

California Department of Health Care Services (DHCS)

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

Interim Evaluation Report for the Providing Access and Transforming Health (PATH), Global Payment Program (GPP), Medi-Cal Matching Plan Policy for Dually Eligible Beneficiaries, and Justice-Involved Reentry Initiatives, AND Community Supports Authorized under the CalAIM Section 1115(a) Demonstration

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ACRONYM LIST

Acronym	Text
ACS	Ambulatory Care-Sensitive
AHA	American Hospital Association
AHC	Accountable Health Communities
AHRQ	Agency for Healthcare Research and Quality
ALF	Assisted Living Facility
APC	Alignment Policy County
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 & Medicaid Services
COHS	County Operated Health System
CPI	Collaborative Planning and Implementation
CTAC	California Tax Credit Allocation Committee
CY	Calendar Year
DHCS	Department of Health Care Services
DJJ	Department of Juvenile Justice
DPH	Designated Public Hospital
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

Acronym	Text
EE	Equity Enhancing
EHR	Electronic Health Records
EQs	Evaluation Questions
FDA	Food and Drug Administration
FFS	Fee-For-Service
FQHCs	Federally Qualified Health Centers
GMC	Geographic Managed Care
GPP	Global Payment Program
H	Hypotheses
HMIS	Homeless Management Information Systems
HHIP	Housing and Homelessness Incentive Program
HHP	Health Homes Program
HHS	Health and Human Services
HPI	Healthy Places Index
HRSN	Health-Related Social Needs
HUD	Housing and Urban Development
IMDs	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
LIHTC	Low-Income Housing Tax Credit
MA	Medicare Advantage
MAT	Medication Assisted Treatment
MCAS	Managed Core Accountability Set
MCPs	Medi-Cal Managed Care Plan(s)
MIPS	Merit-based Incentive Payment System
MMP	Medicare Medi-Cal Plan
MPPC	Matching Plan Policy County
NCCS	National Center for Charitable Statistics
NCQA	National Committee for Quality Assurance

Acronym	Text
PATH	Providing Access and Transforming Health
PATH JI	PATH Justice-Involved Capacity Building Program
PCP	Primary Care Physician
PHCS	Public Health Care System
PHE	Public Health Emergency
PHM	Population Health Management
POF	Populations of Focus
PQI	Prevention Quality Indicator
PSH	Permanent Supportive Housing
PY	Program Year
QIMR	Quarterly Implementation Monitoring Report
REPL	Race, Ethnicity, Preferred Language
ROC	Research Oversight Committee
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
UDS	Uniform Data System
WPC	Whole Person Care

SECTION 1: CALAIM 1115 INTERIM EVALUATION REPORT BY THE EVALUATION TEAM AT UCLA- RAND



General Background Information

California's Medicaid program, Medi-Cal, the largest state Medicaid program in both total enrollment and budget, provides medical, dental, behavioral health (BH), or social services for over one-third of Californians. Millions of Californians rely upon Medi-Cal for health care.¹ California has also been a long-established program leader and innovator among states as evidenced by its early adoption of Medicaid managed care, receipt of multiple federal waivers and pilot opportunities, early support for the Medicaid Affordable Care Act eligibility expansions, and its recent enhanced supports for home- and community-based services. California's Medi-Cal 2020 Demonstration (effective 12/30/2015-12/31/2020) aimed to transform and improve the quality of care, access, and efficiency of health care services for California's more than 13 million Medi-Cal members. As California's Medi-Cal population increased further, peaking in 2022 with an enrollment of 15 million members, California planned to implement its next waiver immediately following the completion of California's Medi-Cal 2020 1115 Demonstration. The initiation of CalAIM was delayed one year, however, due to the impact of COVID-19.

What is CalAIM?

The California Advancing and Innovating Medi-Cal (CalAIM) 1115 demonstration,^a approved by the Centers for Medicare & Medicaid Services (CMS) on December 29, 2021, reflects CalAIM's leveraging of Medi-Cal to systematically lessen many of the complex challenges facing California's most vulnerable residents. CalAIM has identified and is now testing multi-factorial strategies to address the complex health needs of vulnerable populations including children and adults who are unhoused, have limited access to needed BH care, have multi-system complex medical conditions, are involved with justice-involved (JI) settings, and members of the aging population. Each of these groups experience a higher-than-average degree of complex medical conditions often

^a Section 1115 Medicaid demonstration waivers allow states to test approaches within the Medicaid program that differ from what is required by federal statute if [in the HHS Secretary's view] the approach is likely to promote the objectives of the Medicaid program.

requiring patient involvement with multiple different providers across different health care settings.

The CalAIM demonstration is promoting a person-centered approach to meet the physical, behavioral, developmental, long-term care, oral health, and health-related social needs (HRSN) of all Medi-Cal members. This approach was first authorized by the Medi-Cal 2020 demonstration as Whole Person Care (WPC) pilots that were associated with improved clinical outcomes for patients and fiscal outcomes for the state.² Further, the Medi-Cal 2020 demonstration's Global Payment Program (GPP) for uninsured individuals showed that the GPP incentivized a shift toward value in health care for the uninsured, yielding evidence that regular access to the delivery of primary care and other lower-intensity services was associated with an increase in the use of primary care services and a decrease in the use of emergency department (ED) and inpatient services.³ Some examples of low-intensity, outpatient services include encounters with services delivered by Doctor of Pharmacy (PharmD), nurse-only visits, mobile clinic visits, e-consults, or telehealth. Examples of low-intensity services delivered in the inpatient setting include skilled nursing facility utilization and recuperative/respite care. In contrast, higher-intensity services refer to inpatient medical/surgical admissions including overnight hospital stays.

The CalAIM 1115 demonstration, along with related authorities, including the CalAIM 1915(b)^{4,5} Waiver also approved by CMS on December 29, 2021, are enabling California to execute its larger CalAIM initiative, providing benefits to certain high-need, hard-to-reach populations identified by the Department of Health Care Services (DHCS), with the objective of improving health outcomes for Medi-Cal members and other low-income residents. To achieve these goals, CalAIM is shifting Medi-Cal to a population health approach that prioritizes prevention and addresses social drivers of health. These broad initiatives build upon previous innovations with an expanded focus on the recognition and management of Medi-Cal members' health risks and needs. CalAIM is operationalizing these initiatives through a whole person care approach with consideration of the (a) impacts of social factors that influence health; (b) implementation of strategies to reduce the complexity and increase the flexibility of the Medi-Cal system; and (c) continuance of Medi-Cal's longstanding commitments to improve quality outcomes, reduce health disparities, and drive innovative delivery system transformation through value-based initiatives, systems' modernization, and payment reforms.⁶

In 2023, DHCS launched the Population Health Management (PHM) program, a cornerstone of CalAIM's cross-cutting interventions.⁷ The PHM program 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. With the PHM program, health plans, 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 global 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.

CalAIM and its 1115 and 1915(b) Waivers are part of the larger Medi-Cal Transformation initiative, which includes additional new managed care population health efforts. Examples of these efforts include California's implementation of its new statewide Enhanced Care Management (ECM) program and a new menu of state-approved Community Supports through its managed care contracts. ECM is a benefit under California's CalAIM Medi-Cal Transformation initiative that is designed to provide whole-person, person-centered, and community-based coordination for Medi-Cal members with the most complex medical and social needs. Community Supports (previously called In Lieu of Services (ILOS)) are services available to Medi-Cal managed care plan (MCP) members who meet specific need criteria to address social drivers of health. While 12 of the Community Supports under managed care authority were approved in the CalAIM 1915(b) Waiver, two additional Community Supports – recuperative care and short-term post-hospitalization services – are authorized through the CalAIM 1115 demonstration.

The CalAIM Initiative was designed as a data-driven, transparent and accountable program to aid Medi-Cal members and providers, partners, advocates, and policy teams, to monitor the progress of CalAIM's development and understand its impact on quality and population-based health and well-being. The Initiative was designed to support the

implementation and monitoring of progress across the expansive CalAIM interventions and to understand their impact on California's most vulnerable populations.

The resulting CalAIM initiative can be described as a comprehensive initiative involving hundreds of interventions devoted to improving health outcomes and addressing social needs for Medi-Cal members. This Initiative, however, is not a single program. Instead, it offers a coordinated framework aiming to integrate clinical care, BH integration, housing support and incentive programs to deliver more holistic, person-centered care.

Overall, CalAIM and the broader Medi-Cal Transformation effort address a broad set of initiatives and reforms including domains such as BH, Community Supports, Dental Care, Enhanced care Management, Incentive Payment Program (IPP), Integrated Care for Dual Eligible Members, Population Management, Providing Access and Transforming Health, and Statewide Managed Long-Term Care, Drug Medi-Cal-Organized Delivery System (DMC-ODS) including Contingency Management, Transitional Health Care Practices and more.

1115 Medicaid Demonstration Waivers

CalAIM has been funded in large part with a Section 1115 Medicaid demonstration waiver. These waivers allow states to test approaches within the Medicaid program that differ from existing federal statute requirements conditional on the federal Health and Human Services (HHS) Secretary's view that the proposed demonstration approach is likely to promote the objectives of the Medicaid program. Most states have at least one Section 1115 Waiver allowing individual states to prioritize flexibilities in their program operations. Section 1115 Waivers are usually approved for a five-year period and can be renewed.⁴

California has a history of receiving 1115 Waivers to innovate and improve its Medi-Cal program since the 1990s when it focused on expanding Medi-Cal eligibility, restructuring care delivery models, redirecting funds for indigent care, and simplifying the administration of Medi-Cal. This report fulfills this tradition and also fulfills a requirement by CMS for an evaluation of the CalAIM initiative.

The 1115 Waiver Interim Evaluation Report

Since the initiation of CalAIM, CalAIM interventions, aligned with efforts to understand CalAIM's impact on California's most vulnerable populations have been developed, implemented, and monitored. While CalAIM is not one single program, its initiatives share a focus on improving health outcomes and addressing social needs for Medi-Cal members. Overall, CalAIM offers a coordinated framework to integrate clinical care, BH and social services including care management, BH integration, housing support and incentive programs to deliver more holistic, person-centered care.

The evaluation of large CalAIM initiatives authorized through the 1115 Waiver are included in this Interim Evaluation Report. Five of these have been conducted by the UCLA-RAND Evaluation Team including: (1) Providing Access and Transforming Health (PATH) Initiative, (2) Global Payment Program (GPP), (3) the Medi-Cal Matching Plan Policy for Dual Eligible Beneficiaries (Duals), (4) Reentry Demonstration Initiative (Reentry), and (5) Community Supports. Section 1 of this volume includes the evaluation of the five project components completed by the UCLA-RAND Evaluation Team. Details about these programs and their evaluations comprise the body of this report. The Interim Evaluation of the remaining CalAIM 1115-authorized initiative, the DMC-ODS program including Contingency Management, is included in a separate report.

As an Interim Evaluation Report, this document reports some of the implementation components and qualitative data that have been collected thus far. As expected for an Interim Evaluation Report, other parts, including many quantitative analyses, are not yet complete but will be in the Final Summative Report.

CalAIM sets out to:

- (1) Provide infrastructure support and capacity building in the Medi-Cal delivery system, and introduce new waiver programs – such as ECM and a set of Community Support (CS) services – into sustainable programs in the Medi-Cal managed care setting via PATH, which was first implemented in January 2022, while also building; and to build new capacity in the Medi-Cal delivery system;
- (2) Expand and standardize the provision of services in the state's safety net network of public hospital and health care system providers via the GPPGPP – an ongoing program initiative since 2017 when first initiated as part of the prior Medi-Cal 2020 waiver;

(3) Align Medi-Cal managed care with Medicare Advantage (MA) enrollment through the Medi-Cal Matching Plan Policy for *Dually enrolled individuals* (Duals) that was first initiated in 2022;

(4) Introduce a new initiative for transition services for Medi-Cal eligible incarcerated individuals currently in carceral settings in the period prior to release, the Justice-Involved Reentry Initiative (Reentry);

(5) Establish new Community Supports services effective January 2022 that address members' HRSN and help promote member health, stability, and independence in the community; and

Holistically, PATH has directed a support program that provides managed care organizations, community organizations, and providers with the funds to establish infrastructure for the development and expansion of these initiatives. GPP, Reentry, and Community Supports are program initiatives that expand choices and access to care. The two remaining CalAIM initiatives – Duals and MCP Transition expand or maintain access to managed care choices.

Each project component focuses on a different intervention or cohort to achieve the bold goals of CalAIM to improve the health of all Californians, especially those whose health and social needs have traditionally been under resourced.

The results described in this Interim Evaluation Report document sustained efforts of the State of California to provide efficient and effective health care services to the Medicaid population and to address known leverage points where care is the most difficult to deliver and where the services provided require sustained coordination.

Overview and Orientation to the Interim Evaluation Report

The Special Terms and Conditions (STCs) for 1115 Waivers specify requirements for the preparation of Interim and Summative Evaluation Reports.⁸ These requirements are introduced by acknowledging that both the state and federal governments benefit from rigorous quantitative and qualitative evidence to guide policy decisions. They highlight that the evaluations of new initiatives have and can influence the direction of future Medicaid policy most effectively through the accession and analysis of data. Evaluation teams are encouraged to include findings about project implementation, outcomes, and impacts. These requirements emphasize that CMS-approved Evaluation Designs should serve as a map to guide the report with a focus on demonstration goals, evaluation

questions, and specific hypotheses. This report is large. What follows is an attempt to facilitate readers' experience.

Following this brief introduction, [Exhibit 0.1: Complete Listing of CalAIM Evaluation Goals, Evaluation Questions, Hypotheses, and Evaluation Team Assessments](#), summarizes key elements of the evaluation of each project component. This 10-page exhibit offers a framework for orienting readers to the structure of this report. Following [Exhibit 0.1](#), in advance of the body of this report, readers may review one overall executive summary that includes all five project components evaluated by UCLA-RAND. Across the more technical body of the report, the sequence of presentation of the project components remains the same: (1) PATH, (2) GPP, (3) Duals, (4) Reentry, (5) Community Supports all within Section 1. The Managed Care Plan Transition executive summary and body of the report is presented in [Section 2](#).

Placing [Exhibit 0.1](#) before readers peruse the executive summary and read technical sections of the body of the report introduces readers to the framework guiding the evaluation of the CalAIM initiative, allowing readers to most effectively digest the report.

Explanation of Exhibit 0.1

Within [Exhibit 0.1](#), each project component is sequentially represented with a set of rows that describes the analytic building blocks of the evaluation, expressed as evaluation goals, evaluation questions, or hypotheses. Additionally, the last column of this and similar exhibits include an assessment made by the evaluation team. These assessments are currently mostly descriptive as the evaluation is now approaching only the end of the second of five years of planned data collection and analyses.

As of the writing of this Interim Evaluation Report, investigators were able to provide assessment of progress made regarding many goals, and some evaluation questions and hypotheses. A notation of *Pending Final Report* indicates that, although team investigators have been addressing the topic, all data necessary for a final assessment requires additional time for several analyses. These assessments are reserved until further evaluation occurs. These measures will be reported within the Summative Evaluation Report. Methods and analyses described in the remainder of this report detail how the evaluation team is approaching these assessments. The words selected to describe assessments are used to convey general terms based upon analyses to date. Where evidence supports a more robust assessment, checks have been applied within cells. Three checks (✓✓✓) indicate significant progress made as of the writing of this Interim Evaluation Report; two checks (✓✓) indicate moderate progress has been made,

and a single check (✓) indicates limited progress made as of this Interim Evaluation Report. "TRUE" = adequate evidence to indicate the hypothesis is accepted. "Likely True" = some/limited evidence to indicate that the hypothesis is accepted. Progress in achieving goals and whether hypotheses were true or likely true was assessed based on consideration of all measures examined in the Interim Evaluation Report. Determination was made based on the overall assessment of the findings and not whether every measure was accomplished.

The executive summary that follows describes CalAIM evaluation progress. The body of the report that follows describes progress across each of the five individual evaluation components and the methods used to generate these assessments.

Exhibit 0.1: Goals, Evaluation Questions, Hypotheses and Assessments for Five CalAIM Evaluation Project Components

Evaluation Project 1 of 5: PATH Initiative Goals, Evaluation Questions (EQ), Hypotheses (H), and Assessments (A)	Assessment
<i>Goal 1. Increase the number of ECM and Community Supports community-based providers and consequently increase Medi-Cal member ECM and Community Supports utilization according to community needs.</i>	<i>Progress made (✓✓✓)</i>
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 1a: 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.	TRUE
H 1b: The number and proportion of community-based providers located in under-resourced communities will increase over time due to provision of PATH funding and resources.	TRUE
EQ 2: What factors are associated with community-based providers' participation in ECM or Community Supports?	

Evaluation Project 1 of 5: PATH Initiative Goals, Evaluation Questions (EQ), Hypotheses (H), and Assessments (A)	Assessment
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.	Likely true
EQ 3: Did PATH increase utilization of ECM and Community Supports?	
H 3a: 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.	Likely true
H 3b: PATH will increase the number of eligible members in under-resourced communities that utilize ECM or Community Supports and the number of ECM and Community Supports services used by eligible members by increasing the number of providers in these communities contracted to provide these services.	TRUE
Goal 2: Improve data collection and information sharing infrastructure among ECM and Community Supports providers.	Progress made (✓✓✓)
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, electronic health record (EHR) technology or other electronic care management documentation system, and Medi-Cal billing systems. PATH will increase	Likely true

Evaluation Project 1 of 5: PATH Initiative Goals, Evaluation Questions (EQ), Hypotheses (H), and Assessments (A)	Assessment
the number of ECM and Community Supports providers that had shared data with MCPs using these systems.	
<i>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.</i>	<i>Progress made (✓✓)</i>
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.	TRUE
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.	TRUE
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.	Pending final report
<i>Cost analysis to measure cost outcomes of the demonstration through examination of PATH</i>	<i>Pending final report</i>

Evaluation Project 1 of 5: PATH Initiative Goals, Evaluation Questions (EQ), Hypotheses (H), and Assessments (A)	Assessment
<i>expenditures and resources, payments to providers for ECM and Community Supports services, and the patterns of payments for services used among members</i>	

Evaluation Project 2 of 5: GPP Goals, Evaluation Questions (EQ), Hypotheses (H) and Assessments (A)	Assessments
Goal 1. Improve the quality of care among individuals with uninsured services.	Pending final report
EQ 1: Was the GPP successful in improving quality of care to individuals with uninsured services?	
H 1: Public Health Care Systems (PHCS) improved the quality of care to the uninsured.	Pending final report
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	Progress made (✓)
EQ 2: 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 non-traditional, equity enhancing (EE) services?	
H 2a: PHCS increased the use of outpatient services over the course of the GPP.	Likely true
H 2b: PHCS increased the use of non-traditional services over the course of the GPP.	Likely true
H 2c: PHCS increased the use of equity-enhancing services over the course of the GPP.	Pending final report
Goal 3: Improve PHCS data infrastructure and completeness that are necessary to understand health inequities among GPP utilizers.	Progress made (✓✓)

Evaluation Project 2 of 5: GPP Goals, Evaluation Questions (EQ), Hypotheses (H) and Assessments (A)	Assessments
EQ 3: Was the GPP successful in driving improvements in the data infrastructure necessary to understand health inequities?	
H 3: PHCS improved the data collection, reporting, and analytics infrastructure to identify and act on health inequities.	Likely true
<i>Cost Analysis to measure the cost of services provided by the PHCS to the uninsured through examination of Audited P14 workbooks and compare this to the cost of a comparison group comprising non-GPP counties</i>	<i>Pending final report</i>

Evaluation Project 3 of 5: Dually Eligible Beneficiaries Eligible for MA Plans (Duals) Goals, Evaluation Questions (EQ), Hypotheses (H) and Assessments (A)	Assessments
<i>Goal 1. Determine the epidemiology of plan changes among duals eligible for MA plans and relate them to requested MCP change requests.</i>	<i>Progress made (✓✓✓)</i>
EQ 1a: How many duals enrolled in an MA plan in the 12 counties with a <i>Medi-Cal Matching Plan Policy</i> in 2023 had the policy applied to them?	
EQ 1b: Of duals that had the policy applied to them, how many changed their MCP to a non-matching plan within 12 months of enrollment?	
H1: Less than 0.1% of duals in mandatory aligned plans in Matching Plan Counties will change their MCP without changing their MA within 12 months of enrollment during the target period.	Likely true
H2: Duals in aligned plans during the target period are less likely to change their MCP (without changing their MA) than those in unaligned plans during the target period.	TRUE

Evaluation Project 2 of 5: GPP Goals, Evaluation Questions (EQ), Hypotheses (H) and Assessments (A)	Assessments
H3: Duals who 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.	Likely true
H 4: 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.	Pending final report
<i>Goal 2: Maintain a high degree of satisfaction with changing their Medi-Cal related plans among duals in MA plans that are aligned with MCPs and among duals in MMPs.</i>	<i>Progress made (✓✓✓)</i>
EQ 2: Are duals satisfied with the information and process for mandatory Medi-Cal aligned enrollment when they choose an MA plan?	
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.	Likely true
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 other type of MA.	Pending final report
H 3: Duals in counties with the policy will be more knowledgeable and will be more satisfied with the policy.	Not likely true

Evaluation Project 4 of 5: Justice-Involved Reentry Initiative (REENTRY) Goals, Evaluation Questions (EQ), Hypotheses (H) and Assessments (A)	Assessments
<i>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.</i>	<i>Progress made (✓✓)</i>
EQ 1: Did the Waiver increase coverage for eligible Medi-Cal members?	
H1: The Waiver will increase coverage for eligible Medi-Cal members.	Pending final report
<i>Goal 2: Improve access to services prior to release and improve transitions and continuity of care into the community upon release.</i>	<i>Pending final report</i>
EQ 2: Did the Waiver improve access to services prior to release from prison/jail/youth correctional facilities? Improve transitions and continuity of care upon release for eligible Medi-Cal members?	
H2: The Waiver will increase access to services prior to release and improve transitions and continuing of care upon release for eligible Medi-Cal members.	Pending final report
<i>Goal 3: Improve coordination and communication between correctional systems, Medicaid and Children's Health Insurance Program (CHIP) systems, MCPs, and community-based providers.</i>	<i>Progress made (✓✓)</i>
EQ 3a: Did the Waiver improve <i>coordination</i> between correctional systems, Medicaid and CHIP systems, MCPs, and community-based providers?	
H 3a: The Waiver will improve <i>coordination</i> between correctional systems, Medicaid and CHIP systems, MCPs and community-based providers.	Pending final report
EQ 3b: Did the Waiver improve <i>communication</i> between correctional systems, Medicaid and CHIP systems, MCPs, and community-based providers?	
H 3b: The Waiver will improve <i>communication</i> between correctional systems, Medicaid and CHIP systems,	Pending final report

Evaluation Project 4 of 5: Justice-Involved Reentry Initiative (REENTRY) Goals, Evaluation Questions (EQ), Hypotheses (H) and Assessments (A)	Assessments
managed care plans (MCPs), and community-based providers.	
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.	Pending final report
EQ4: How did the Waiver influence investments in health care and related services in carceral settings aimed at improving quality of care and in the community aimed at maximizing successful reentry post-release?	
H 4: The Waiver will increase services associated with improved quality of care, such as medication-assisted treatment (MAT), care coordination, and enhanced care management.	Pending final report
Goal 5: Improve connections between carceral settings and community services upon release to address physical health, BH, and HRSNs.	Progress made (✓✓)
EQ 5: Did the Waiver improve connections between carceral settings and community services upon release to address physical health, BH, and HRSNs?	
H 5: The Waiver will improve connections between carceral settings and community services upon release to address physical health, BH, and HRSNs.	Pending final report
Goal 6: Provide intervention for certain BH conditions and use stabilizing meds 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.	Pending final report

Evaluation Project 4 of 5: Justice-Involved Reentry Initiative (REENTRY) Goals, Evaluation Questions (EQ), Hypotheses (H) and Assessments (A)	Assessments
EQ 6a: Did the Waiver provide intervention for certain BH conditions and use stabilizing medications like long-acting injectable anti-psychotics and medications for addiction treatment for SUDs for eligible Medi-Cal members?	
EQ 6b: Did the Waiver reduce decompensation, suicide-related deaths, overdoses, and overdose-related deaths in the near-term post-release for eligible Medi-Cal members?	
H 6a: The Waiver will increase access to interventions for BH conditions, access to long-acting injectable anti-psychotics, and access to medications for Substance Use Disorder (SUD) treatment for eligible Medi-Cal members.	Pending final report
H 6b: The Waiver will reduce decompensation, suicide-related deaths, overdoses, and overdose-related deaths for eligible Medi-Cal members.	Pending final report
<i>Goal 7: Reduce post-release acute care utilization (e.g., ED 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 BH 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 BH care.</i>	<i>Pending final report</i>
EQ 7: Did the Waiver reduce post-release ED visits, inpatient hospitalizations, and all-cause deaths for eligible Medi-Cal members?	
H7: The Waiver will reduce post-release ED visits, inpatient hospitalizations, and all-cause deaths for eligible Medi-Cal members.	Pending final report

Evaluation Project 4 of 5: Justice-Involved Reentry Initiative (REENTRY) Goals, Evaluation Questions (EQ), Hypotheses (H) and Assessments (A)	Assessments
<i>COST: To estimate changes in Medi-Cal expenditures on the JI population.</i>	<i>Pending final report</i>
H 8: To estimate changes in Medi-Cal expenditures on the JI population.	Pending final report

Evaluation Project 5 of 5: COMMUNITY SUPPORTS Goals, Evaluation Questions (EQ), Hypotheses (H) and Assessments (A)	Assessments
<i>Goal 1: Increase offering of Community Supports by MCPs.</i>	<i>Progress made (✓✓✓)</i>
EQ 1: Did the number of MCPs offering Community Supports increase over time?	
H1: The number of Community Supports offered by MCPs will increase over time.	TRUE
<i>Goal 2: Increase contracts between providers and MCPs for Community Supports services.</i>	<i>Progress made (✓✓✓)</i>
EQ 2: Did the number and diversity of providers contracted to provide Community Supports increase over time?	
H2: The number and diversity of providers contracted to provide Community Supports will increase over time.	Likely true
EQ 3: What factors influence provider participation in Community Supports?	
H 3: Provider capacity and infrastructure and local service availability and need will influence provider participation in Community Supports.	TRUE
<i>Goal 3: Increase utilization of Community Supports by eligible members.</i>	<i>Progress made (✓✓✓)</i>

Evaluation Project 4 of 5: Justice-Involved Reentry Initiative (REENTRY) Goals, Evaluation Questions (EQ), Hypotheses (H) and Assessments (A)	Assessments
EQ 4: Did the number of members receiving Community Supports increase over time?	
H 4a: The number of members receiving Community Supports will increase over time.	TRUE
H 4b: Members with housing-related needs will receive more than one Community Support to address these needs.	TRUE
EQ 5: What strategies are being used to identify and refer eligible members to Community Supports?	
H 5: Members will primarily be connected to Community Supports via community-based provider referrals.	TRUE
<i>Goal 4: Examine whether and how public investments in housing and other HRSN services change over time in concert with new Medicaid funding for those services.</i>	<i>Progress made (✓✓)</i>
EQ 6: How is new Medicaid funding for Community Supports impacting existing systems of care?	
H 6: Medicaid funding for Community Supports will be perceived as complementing state and local investments in housing and other HRSN services.	TRUE
<i>Goal 5: Increase members' access to outpatient care including BH services and reduce acute care utilization and long-term care admission and stays</i>	<i>Pending final report</i>
EQ 7a. Will Community Supports affect member access to outpatient care?	
H 7a: Members receiving Community Supports will use more outpatient services than members who do not.	Pending final report
EQ 7b. Will Community Supports reduce avoidable acute care utilization or long-term care stays?	
H 7b: Members receiving Community Supports will experience greater reductions in avoidable acute care	Pending final report

Evaluation Project 4 of 5: Justice-Involved Reentry Initiative (REENTRY) Goals, Evaluation Questions (EQ), Hypotheses (H) and Assessments (A)	Assessments
utilization and long-term care stays than members who do not.	
Goal 6: Improve quality and outcomes of care.	Progress made (✓)
EQ 8: Are members satisfied with Community Supports referral processes and services?	
H8a: Members who receive Community Supports will be satisfied with services.	Pending final report
H8 b: Member dissatisfaction with services, as indicated by number of appeals, grievances, and state fair hearings for each Community Supports relative to total service use, will decrease over time.	Pending final report
EQ 9: Following receipt of housing-related Community Supports, are members being transitioned to other appropriate supports when needed?	
H 9: The proportion of members transitioned to appropriate HRSN supports will increase over time.	Likely true
EQ 10: Will Community Supports improve quality and outcomes of health care?	
H 10a: Community Supports will improve member receipt of appropriate care.	Pending final report
H 10b: Community Supports will reduce member receipt of inappropriate care.	Pending final report
H 10c: Community Supports will promote maintenance of member function.	Pending final report
H 10d: Community Supports will reduce cause-specific complications.	Pending final report
Goal 7: Reduce disparities in service utilization, quality of care, and outcomes of care.	Pending final report
EQ 11: Are there disparities in Community Supports utilization based on member demographic	

Evaluation Project 4 of 5: Justice-Involved Reentry Initiative (REENTRY) Goals, Evaluation Questions (EQ), Hypotheses (H) and Assessments (A)	Assessments
characteristics, health conditions, or community characteristics?	
H 11: Community Supports utilization will be higher in urban communities, communities with street medicine programs, and among members with English as preferred language.	Pending final report
EQ 12: Will Community Supports impact disparities in downstream physical or behavioral health service utilization, quality of care, or outcomes of care?	
H 12a: Community Supports will reduce age, sex, racial/ethnic, linguistic, and functional (disability) disparities in downstream physical or behavioral health service utilization, quality of care, and outcomes of care.	Pending final report
H 12b: Community Supports will reduce disparities in physical or behavioral health services utilization and outcomes of care for individuals experiencing homelessness.	Pending final report
<i>Goal 8: Ensure Community Supports are cost-effective alternatives to State Plan services or settings.</i>	<i>Pending final report</i>
EQ13: Will Community Supports impact cost of care?	
H 13: Community Supports are cost-effective alternatives to State Plan services or settings.	Pending final report

Note: ✓✓✓ = significant progress made as of Interim Evaluation Report; ✓✓ = moderate progress made as of Interim Evaluation Report; ✓ = limited progress made as of Interim Evaluation Report. "TRUE" = adequate evidence to indicate the hypothesis is accepted. "Likely True" = some/limited evidence to indicate that the hypothesis is accepted. Progress in achieving goals and whether hypotheses were true or likely true was assessed based on consideration of all measures examined in the Interim Evaluation Report. Determination was made based on the overall assessment of the findings and not whether every measure was accomplished. EQ is Evaluation Question. H is Hypothesis.

Independent Evaluation Team

DHCS selected the Regents of the University of California on behalf of its Los Angeles campus (UCLA) as the Independent Evaluator in October 2023 to assess the impact of

five Evaluation Components of the CalAIM 1115 Demonstration: PATH, GPP, Duals, Reentry, and Community Supports. The evaluation contract was finalized in December 2023. Throughout this Interim Evaluation Report, the independent evaluators are referred to as “UCLA-RAND” or as the “evaluation team,” recognizing the shared effort between UCLA, the contracted organization, and the RAND Corporation, the main subcontractor for this evaluation. UCLA-RAND has agreed to conduct the evaluation in an independent manner and in accordance with the CMS-approved Evaluation Design. The independent evaluation team considers the unique goals of each initiative and the overarching impact on CalAIM and population health. UCLA-RAND’s approach considers structural change, cost of care, quality of care, and access to care, all of which provide a picture of member experience and impact to the state’s administration of the program overall.

UCLA-RAND is responsible for developing the evaluation design and reporting results of the evaluation in this Interim and the subsequent Summative Evaluation Reports for the PATH, GPP, Duals, Reentry, and Community Supports project components.

Projected Timeline

Exhibit 2 shows the planned timeline for important elements of the evaluation as well as the major deliverables. The Interim Evaluation Report, Summative Report, and Reentry Mid-Point Assessment reflect the date the draft version is due to CMS. As stated in STC 17.4 and 9.10, the final versions are due to CMS 60 days after receiving CMS comments. The due dates of the major required CMS deliverables are listed below:

- » Interim Evaluation Report: December 31, 2025
- » Justice-Involved Reentry Demonstration Mid-Point Assessment: September 30, 2027
- » Summative Evaluation Report: June 27, 2028

Exhibit 0.2: UCLA-RAND Projected Evaluation Timeline

Evaluation Activity	Year 1: 12/1/23- 6/30/24				Year 2: 7/1/24 – 6/30/25				Year 3: 7/1/25- 6/30/26				Year 4: 7/1/26- 6/30/27				Year 5: 7/1/27- 6/30/28				Year 6: 7/1/28- 5/31/29			
PATH, GPP, Duals, Reentry Primary Data Collection^b																								
PATH, GPP, Duals, Reentry Existing Data Receipt^c (1) Initial data request / receipt (2) Follow-up data request / receipt				1		1				2				2										
Quantitative Data Collection & Analysis^d																								
Qualitative Data Collection & Analysis^e																								
Evaluation Design																								
Interim Evaluation Report																								
Quarterly Evaluation Reports																								

^b UCLA-RAND will conduct PATH, GPP, Duals, Reentry primary data collection.

^c UCLA-RAND will initiate data requests, receipt, and conduct follow-up as needed.

^d NORC's MCP Transition Evaluation will conduct quantitative data collection and analysis.

^e NORC's MCP Transition Evaluation will conduct qualitative data collection and analysis.

Evaluation Activity	Year 1: 12/1/23- 6/30/24				Year 2: 7/1/24 – 6/30/25				Year 3: 7/1/25- 6/30/26				Year 4: 7/1/26- 6/30/27				Year 5: 7/1/27- 6/30/28				Year 6: 7/1/28- 5/31/29			
Reentry Mid-Point Assessment																								
Summative Evaluation Report Draft																								

Note: Dark blue indicates a due date for the deliverable; light blue indicates evaluation activities related to that deliverable. Grey indicates that no evaluation activities took place, as Year 1 was 6 months in length vs. 12 months in the other project years.

**EXECUTIVE SUMMARY FOR THE CALAIM 1115
EVALUATION COMPONENTS UNDER THE
EVALUATION TEAM AT UCLA-RAND**

California's CalAIM initiative represents one of the most comprehensive efforts in the nation to transform Medicaid delivery systems to provide more equitable, coordinated, and whole-person care. The UCLA-RAND Interim Evaluation Report summarizes early implementation results from five interrelated evaluation components—PATH, GPP, the Medi-Cal Matching Plan Policy for Dually Eligible Beneficiaries (Duals), the JI Reentry Initiative, and Community Supports. Together, these efforts demonstrate the State's progress toward creating a more integrated Medi-Cal system designed to improve health outcomes, strengthen local infrastructure, and address members' social and BH needs.

Across these components, several cross-cutting themes emerged. California has made significant progress in expanding provider networks, increasing participation in new programs, and improving coordination across delivery systems. Data also revealed early improvements in access to care and service integration, along with persistent challenges in data sharing, administrative complexity, and variation in local implementation capacity. These findings reflect both the scale and ambition of CalAIM as a transformative framework for advancing PHM statewide.

The PATH initiative served as a foundation for much of CalAIM's implementation by providing funding and technical assistance (TA) to build the infrastructure needed to operationalize new Medi-Cal benefits such as ECM, Community Supports, and the Justice-Involved Reentry Initiative (Reentry). PATH funding was distributed to community-based organizations (CBOs), local government agencies, and providers—particularly those serving rural and underserved regions—to expand capacity to deliver person-centered, coordinated care. In addition, PATH provided targeted support for correctional facilities and county BH and social service agencies to establish systems for pre-release Medi-Cal applications, suspension processes, and 90-day pre-release services for JI individuals. By the end of 2024, data indicated successful completion of multiple rounds of PATH funding that supported tangible progress in developing local systems for the JI Reentry Initiative and other CalAIM components.

GPP, launched in 2015 and incorporated into CalAIM's framework, continued to enable California's PHCSs to provide high-value, efficient care to uninsured residents. GPP aims to incentivize a shift from hospital-based to preventive and community-based care. Interim findings of five quality measures showed that GPP users received higher quality

care than a comparison group on some preventive measures, including colorectal cancer screening and depression screening, while outcomes were lower for cervical cancer screening and diabetes control. The share of GPP services delivered in lower-intensity settings rose modestly over time, demonstrating incremental progress toward system transformation. However, differences in quality across population subgroups persist, underscoring the importance of sustained focus on reducing these gaps within PHCSs. Participating systems improved the completeness of patient demographic data during the first few years of CalAIM but some data challenges persist, including limited data sharing between PHCSs and county-based behavioral health systems.

The Medi-Cal Matching Plan Policy for Dually Eligible Beneficiaries (matching plan policy) was designed to improve coordination between MCPs and MA plans by aligning enrollees where possible under the same managed care organization. Early analysis of enrollment data indicates the policy has been effective in promoting plan alignment in participating counties. This alignment is expected to simplify administrative processes, enhance communication between providers, and reduce care fragmentation for dual-eligible members. Survey results from late 2024 suggested that members in matching plan policy counties were slightly more satisfied with their plan transition experience compared to those in non-policy counties, with higher rates of perceived ease in the transition process. These findings suggest that, while overall numbers of affected members remain relatively small, the policy is achieving its intended objective of improving coordination and member experience.

Implementation of the JI Reentry Initiative marks a historic expansion of Medi-Cal coverage for incarcerated individuals, enabling eligible populations to receive targeted pre-release services within 90 days of their release. These services, designed to improve continuity of care and reduce post-release health risks, are a cornerstone of CalAIM's broader effort to address social and structural determinants of health. Although implementation is still in its early stages and varies across counties and facility types, the initiative has demonstrated measurable progress. By the fourth quarter of 2024, at least 611 individuals with reentry-related eligibility codes had received pre-release Medi-Cal services. Interviews with plans and correctional administrators highlighted the logistical challenges of enrolling eligible individuals and billing for services within carceral settings, particularly given labor-intensive data entry and delays in claims reporting. Despite these obstacles, the initiative has laid a critical foundation for connecting JI

individuals to health care and support services upon release.

Community Supports, another cornerstone of CalAIM, represent a major innovation in Medi-Cal by allowing managed care plans to offer services addressing members' health-related social needs. Between 2022-2024, there were increases in the number of MCPs offering each Community Support, the number of providers contracted by MCPs to provide Community Supports, and the number of users of each Community Support. Most providers were contracted to provide more than one Community Support. The number of contracted providers for eight Community Supports decreased between 2023-2024: Recuperative Care, Housing Tenancy & Sustaining Services, Day Habilitation, Assisted Living Facility (ALF) Transitions, Community or Home Transition Services, Environmental Accessibility Adaptations, Sobering Centers, and Asthma Remediation. Community Supports utilization was highest for Medically Tailored Meals / Medically Supportive Food and Housing Transition Navigation Services, and lowest for ALF Transitions and Community or Home Transition Services. Impact of receiving Community Supports on health care utilization, outcomes, and costs of care will be measured in the Summative Evaluation Report.

Taken together, interim findings from these five evaluation components illustrate meaningful progress in advancing CalAIM's overarching goals. The initiatives collectively demonstrate California's commitment to integrating medical, behavioral, and social services; strengthening community-based care infrastructure; and promoting equity through targeted investments and policy alignment. The state has successfully expanded participation in new programs, improved the alignment of managed care systems, and piloted innovative approaches to serving high-need populations, including the JI and dually eligible. At the same time, data systems, workforce capacity, and administrative coordination remain key areas for continued development.

As California moves toward the summative evaluation phase, the next stage of analysis will assess the long-term impacts of these efforts on health outcomes, quality, cost, and equity across populations. Collectively, the interim results highlight both the complexity and promise of the CalAIM transformation—illustrating how state-level innovation, paired with local implementation and continuous evaluation, can drive sustainable

improvement in health care delivery.

EVALUATION COMPONENT 1: EVALUATION OF THE PROVIDING ACCESS AND TRANSFORMING HEALTH (PATH) INITIATIVE

Nadereh Pourat, PhD, Brenna O'Masta, MPH, Leigh Ann Haley, MPP, Weihao Zhou, MPH, Stephen Ma, MPH, Farah Severeid, MPH, Nereida Heller, MPP, Chris Rubeo, DrPH, Emmeline Chuang, PhD.



A. PATH Executive Summary

Summary of the PATH Demonstration

PATH is a component of the CalAIM 1115 Medicaid Waiver demonstration approved by CMS for the period of January 1, 2022, to December 31, 2026. PATH is designed to expand the number and capacity of CBOs, providers, and local government entities to contract with Medicaid managed care plans (MCPs) and provide ECM and Community Supports, and to expand the capacity of correctional facilities and their partners to implement the JI Reentry Initiative.

PATH is comprised of five specific programs. Four of these programs are focused on developing provider capacity and infrastructure to implement ECM and Community Supports: Whole Person Care (WPC) Services and Transition to Managed Care Mitigation; TA Marketplace; Collaborative Planning and Implementation (CPI) initiative; and Capacity and Infrastructure Transition, Expansion, and Development (CITED) initiative. PATH also included funding through the Justice-Involved Capacity Building Program (PATH JI) to correctional facilities, partners, and county BH agencies to develop capacity for pre-release Medi-Cal enrollment and suspension processes and to deliver 90-day pre-release services and BH linkages.

ECM is a new case management benefit that MCPs are required to offer to eligible members. ECM implementation rolled out in phases for eight Populations of Focus (POFs), differentiated by age into “children and youth” and “adults.” Implementation began by transitioning members who received services under the WPC and Health Homes Program (HHP) demonstrations into ECM; other POFs were added in phases, with the final POFs implemented in 2024. MCPs also had the option of offering eligible members Community Supports, which are services to address members’ health-related social needs, e.g., for housing. Two Community Supports were authorized under the CalAIM Section 1115 Medicaid Waiver, and 12 were authorized under the CalAIM 1915(b) Medicaid Waiver. An additional Community Support, Transitional Rent, was added in July 2025 as part of California’s Section 1115 BH Community-Based Organized Networks of Equitable Care and Treatment Waiver.

Methodology and Methodological Limitations

The PATH evaluation examines whether PATH achieved its three overarching goals by strengthening the infrastructure to deliver ECM, Community Supports, and the JI Reentry Initiative. UCLA-RAND obtained all available administrative data from DHCS and other relevant sources and gathered primary data through surveys and interviews with MCPs and providers. For the Interim Report, quantitative analyses included preparing data for analysis, merging data as needed, and conducting descriptive analyses of Quarterly Implementation and Monitoring Reports and Medi-Cal eligibility and claims data. Qualitative analyses included coding and developing themes from interviews, narrative reports, and other qualitative data sources.

Key methodological limitations affecting the analyses for the Interim Report included (1) delayed access to Medi-Cal eligibility and claims data, which were not available until the end of May 2025; (2) no information on provider National Provider Identifier(s) was available for Community Supports users in the Quarterly Implementation and Monitoring Reports; and (3) lack of a comprehensive database of community-based providers eligible to offer ECM or Community Supports.

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

Findings indicated:

- » The number of unique participating providers (621 to 2,041) and number of contracts (1,250 to 6,299) increased from 2022 Quarter (Q)1 to 2024 Q3.
- » The proportion of community-based providers as measured by private non-profit (64% to 67%) ownership status increased from 2022 Q1 to 2024 Q1. However, the proportion of providers with public ownership status decreased (20% to 11%) during that time. The proportion of contracts with public (11% to 6%) or private non-profit (56% to 48%) providers also declined at the same time, indicating an increase in contracts with for-profit providers over time.
- » Of the total providers that received PATH CITED or PATH TA, most were community-based (91% and 93%, respectively). Ten WPC lead entities requested WPC Transition funding. Also, 27% of WPC and 86% of HHP providers became ECM and Community Supports providers. ECM and Community Supports participation

was higher among providers that perceived high mission alignment, with prior experience providing similar services or serving similar populations, existing data sharing infrastructure, and those interested in diversifying revenue streams and increasing financial sustainability. Providers perceived PATH as valuable and contributing to their success in contracting with MCPs. But they noted challenges to ECM and Community Supports implementation including inadequate payment rates from MCPs, excessive reporting and documentation, and changes in policy guidance.

- » The total number of users of ECM and/or Community Supports increased per quarter from 82,088 in 2022 Q1 to 256,406 in 2024 Q3, and the total number of members who had ever used these services reached 500,447. The cumulative number of ECM users that used ECM regardless of Community Supports use was 277,077, and the cumulative number of Community Supports users that used Community Supports regardless of ECM use was 297,544. The proportion of ECM users receiving care from private for-profit ECM providers increased from 26% to 40%, resulting in a decline in the proportion of users receiving care from CBOs.
- » Among members reported using ECM and/or Community Supports between 2022 Q1 and 2024 Q1 in QIMRs, a higher proportion of members using both ECM and Community Supports were experiencing homelessness (44%) than ECM only (27%) and Community Supports only (23%). Similarly, compared to users of only ECM and Community Supports, users of both ECM and Community Supports were more likely than users of ECM only or Community Supports only to have had serious mental illness (41% vs. 34% and 23%) and SUDs (35% vs. 27% and 19%) or had ED visits (64% vs. 62% and 52%) and hospitalizations (33% vs. 28% and 21%).
- » PATH CITED funding helped cover providers' operational costs and supported a gradual ramp-up; TA Marketplace vendors provided financial and operational assessments to providers; and PATH CPI facilitators helped build relationships and referral networks with other providers. Provider and CPI facilitator concerns included increased funding to larger for-profit providers, greater administrative burden to smaller providers, and difficulty navigating the TA Marketplace website.

Goal 2. Improve data collection and information sharing infrastructure among ECM and Community Supports providers.

Findings indicated:

- » Providers used PATH CITED, TA Marketplace, and CPI to support data collection and information sharing infrastructure, particularly for submitting claims and billing MCPs. Challenges included differences in MCP portals that required too much staff time and training to use; establishing internal systems or extensively modifying them to meet MCP criteria; or need for more directive from DHCS on use of data exchanges and aggregators and variations in these systems that required time and effort to address before sharing data.
- » In a 2025 survey, most providers who had participated in PATH (i.e., received PATH CITED, received PATH TA, or attended PATH CPI) (65%) reported having established or modified data use agreements with MCPs. 73% of surveyed reported usually received information on clients from MCPs.
- » Most surveyed providers who participated in PATH (70%) also obtained or modified existing electronic health records (EHRs) or care management software to support service delivery of ECM and Community Supports. Therefore, most surveyed providers (68%) usually relied on their own systems to support service delivery vs. other sources such as health information exchange or community information exchange (33%).
- » Some surveyed providers who participated in PATH (21%) reported having established or modified their data sharing agreements with local Continuums of Care or other entities to access data from local Homeless Management Information Systems (HMIS). Many surveyed providers (42%) reported usually receiving client information from HMIS.
- » Most surveyed providers who participated in PATH (63%) reported that they invested in obtaining or modifying existing software or other technology to support billing. Furthermore, 20% of PATH-participating providers reported contracting with or paying organizations to provide specific services needed to participate in ECM or Community Supports. And 46% of these providers contracted with another organization such as a hub or a management support organization to generate claims and submit them. Twelve of 22 MCPs reported that 75% or more of ECM providers submitted claims instead of invoices, and 10 MCPs reported that 75% or more of Community Supports providers submitted claims in a 2024-2025 survey.
- » PATH CPI and TA Marketplace were considered helpful in developing data sharing infrastructure by providing opportunities to learn from providers with successful systems and helping them identify and implement data collection and sharing infrastructure, including EHR systems and data exchange platforms.

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.

Findings indicated:

- » In 2022 and 2023, correctional agencies and their county social service department partners collectively received approximately \$69.84 million (\$4.55 million across 40 applications in PATH JI Round 1 and \$65.29 million across 97 applications in PATH JI Round 2) to implement pre-release Medi-Cal application and suspension processes. This funding was described by correctional facilities, county social service departments, and their partners as essential to their ability to implement pre-release Medi-Cal application and suspension processes.
- » PATH JI Round 1 and 2 funding were most often used to support development of technology and information technology (IT) systems, collaborative planning, infrastructure, and staffing needed to implement pre-release application and suspension processes.
- » JI providers described robust collaborative planning between county sheriff, probation, and local social services departments as essential for effective implementation of pre-release enrollment and suspension processes.
- » In 2023 and 2024, correctional facilities and county BH agencies received approximately \$229 million in PATH JI Round 3 funding to support planning and implementation of 90-day pre-release services and BH linkages; additional PATH JI dollars were awarded but not yet disseminated during this period. PATH JI grants are deliverable-based in 2025.
- » In interviews, correctional facilities, county BH agencies, and other partners described Round 3 funding as essential to support implementation of 90-day pre-release services and BH linkages; however, correctional facilities with large average daily populations noted that the funding was not sufficient to cover infrastructure costs and correctional facilities with smaller average daily populations noted the need for additional TA or other support in learning how to bill Medi-Cal.
- » In 2025 interviews, JI providers identified key implementation challenges related to difficulties experienced with the JI Screening Portal used to validate Medi-Cal

eligibility and apply 90-day pre-release services eligibility timeframes, uncertain release dates for individuals incarcerated in county jails and youth correctional facilities, requirements to provide individuals, in-hand, upon release, a 30-day supply of medications, and billing Medi-Cal given limited vendor capabilities to manage requirements associated with Medi-Cal Fee-For-Service, Short Doyle claims with the Short-Doyle/Medi-Cal program, Medi-Cal Rx, and Medi-Cal managed care.

- » Despite these implementation challenges, the California Department of Corrections and Rehabilitation (CDCR) and nine counties (Inyo, Monterey, San Francisco, San Joaquin, San Mateo, Santa Clara, Siskiyou, Sutter, and Yuba) implemented pre-release services by July 2025; remaining counties with correctional facilities were expected to implement later in 2025 or 2026.
- » Medi-Cal claims data on three counties that implemented in October 2024 (Inyo, Santa Clara, and Yuba) indicated that these counties provided pre-release services to 115 individuals in October 2024, 150 individuals in November 2024, and 198 individuals in December 2024.

Cost Analysis to measure cost outcomes of the demonstration through examination of PATH expenditures and resources, payments to providers for ECM and Community Supports services, and the patterns of payments for services used among members

The analysis will be completed and presented in the Summative Evaluation Report.

Conclusions

The findings of the evaluation indicated that significant progress was made toward PATH Goals 1 and 2 and some progress was made toward Goal 3. In addition, the results provided evidence that all the PATH hypotheses were true or likely true based on the available evidence in the Interim Evaluation Report ([Exhibit 0.1](#)).

The evidence to examine some evaluation measures was not available due to lack of or delays in data. UCLA-RAND anticipates addressing these limitations in the Summative Evaluation Report. This includes an analysis of cost outcomes.

Lessons Learned

- » Funding is crucial to build capacity among small social service community-based providers to deliver ECM and Community Supports. Continued provision of PATH resources, especially PATH CITED funding, is needed to build local provider capacity to deliver ECM and Community Supports. PATH CITED funding is particularly important for developing infrastructure capacity among smaller, community-based, and social service providers with less pre-existing experience in data sharing, submitting claims, or working with MCPs. Additionally, monitoring participation of for-profit providers and the number of users they serve is needed to ensure that public and private non-profit providers can continue to deliver ECM and Community Supports and compete with private for-profit providers.
- » Multiple changes in DHCS policy guidance are disruptive and add to the administrative burden on providers. Obtaining further feedback before policy guidance modifications can help reduce administrative burden and unintended changes in service use.
- » Lack of consistency in MCP referral pathways, authorization denials, variations in MCP portals for sharing client data, and lack of automation for claims submission do not allow providers to conduct their activities and add to their administrative burden. While updates in DHCS policy guidance improved these implementation challenges, further reducing administrative burden on providers by streamlining referral pathways, improving the authorization process, and reducing variation in MCP portals to ease sharing client data is needed.
- » Promoting data sharing through external sources such as data exchanges, local Continuums of Care collaboratives, or HMIS requires more support and standardization. Providing more support and direction to community-based providers in adoption and use of health information exchanges is needed.
- » Low reimbursement for services with high administrative burden reduces participation of providers in ECM and Community Supports. Revising the DHCS non-binding Pricing Guidance and monitoring provider payment policies to prevent attrition of smaller and low-resource providers is needed.
- » Continue providing PATH JI funding to correctional facilities to support implementation of 90-day pre-release services, improve functionality of the JI Portal, and provide support regarding how to bill Medi-Cal for services.

Recommendations to Other States

- » Dedicate time to engage stakeholders, such as MCPs, local providers and CBOs, Counties, and correctional facilities, to gather information on existing capacity to develop policy guidance that addresses program implementation challenges prior to implementation.
- » Allocate funding to build local capacity, particularly among smaller and low-resourced organizations to reach likely users in all communities across the state.
- » Develop guidance prior to implementation on activities such as referrals, authorization process, MCP data sharing infrastructure and payment portals, use of data exchanges and local Continuums of Care, or HMIS.
- » Provide MCPs with non-binding pricing guidance for HRSN services developed with input from MCPs and local providers.
- » Provider participation in Medicaid to address members' HRSNs can be promoted by Community care hubs or management support organizations that centralize administrative functions for providers to contract with or submit claims to MCPs. These approaches should be monitored closely, however, to ensure accountability, quality, and equitable distribution of referrals or resources to providers.

B. Background

Intervention Context

Medicaid members with complex social and behavioral needs utilize significantly more health care and incur significantly higher health care costs than members without these needs.⁹⁻¹¹ To reduce costs and improve member well-being, DHCS used Section 2703 of the 2010 Patient Protection and Affordable Care Act and the Section 1115 Medicaid Waiver mechanism to conduct two demonstrations completed in 2021 called the Medi-Cal HHP and Medi-Cal Whole Person Care (WPC), respectively. These demonstrations illustrated that providing members who have complex medical, behavioral, and/or social needs with care management and other services to address their HRSNs (such as housing navigation or recuperative care) had better health outcomes and lower costs of care than members who did not receive these services.^{2,12} WPC and HHP also illustrated that community-based providers required support in developing data sharing infrastructure and capacity needed to participate in these programs.^{2,13}

Following these demonstrations, DHCS chose to sustain and expand services to provide case management or address members' HRSNs using new ECM and Community Supports services, and through new 90-day pre-release services for incarcerated individuals under the JI Reentry Initiative. ECM is a new Medi-Cal benefit to provide comprehensive care coordination to members with complex medical and social needs, while Community Supports are available through a 1915(b) Medicaid Waiver using the ILOS option available to Medicaid managed care plans (MCPs) and two Section 1115 Medicaid Waivers. Under ILOS, MCPs can voluntarily choose to offer certain services as medically appropriate and cost-effective substitutes for other covered State Plan services and settings. In addition, the JI Reentry Initiative includes provision of reentry care management and other services to members who are incarcerated in state prisons, county jails, or youth correctional facilities for up to 90 days prior to release.

On December 29, 2021, DHCS received approval from the Centers for Medicare and Medicaid Services (CMS) to implement a demonstration called the PATH Initiative using the Section 1115 Medicaid Waiver as part of the CalAIM initiative. PATH is designed to increase the capacity and infrastructure of providers to implement ECM and Community Supports and increase capacity of correctional facilities and other organizations to implement pre-release Medi-Cal application and suspension processes and deliver 90-day pre-release services and BH linkages. PATH is comprised of multiple aligned programs and initiatives ([Exhibit 1.1](#))

Exhibit 1.1. Summary of PATH Programs or Initiatives

Program / Initiative	Brief Description
<i>Support for Implementation of ECM and Community Supports</i>	
WPC Services and Transition to Managed Care Mitigation (WPC Transition) Initiative	Funding for services provided by WPC pilot lead entities until the services transition to managed care coverage under CalAIM, available January 1, 2022, until January 1, 2024.
TA Marketplace	A virtual marketplace that offers vendor-provided technical support and resources to providers to help them establish infrastructure needed to implement ECM and Community Supports, available January 1, 2022, until December 31, 2026.
CPI Initiative	County or regionally facilitated collaboratives to support collaborative planning and implementation of ECM and Community Supports by MCPs, providers, and other entities,

Program / Initiative	Brief Description
	available January 1, 2022, until December 31, 2026.
Capacity and Infrastructure Transition, Expansion, and Development (CITED) Initiative	Direct funding available to providers or other entities contracting with MCPs by application to DHCS to develop capacity needed to deliver ECM or Community Supports. Funding is distributed in multiple, discrete application rounds between January 1, 2022, and December 31, 2026.
<i>Support for Implementation of the JI Reentry Initiative</i>	
PATH JI	Direct funding that state prisons, county jails, youth correctional facilities, or their partners (e.g., county social services departments or county BH agencies) can apply for to support collaborative planning, capacity, and infrastructure development needed to implement new Medi-Cal enrollment and suspension processes, 90-day pre-release services, and BH linkages. Funding distributed in multiple, discrete application rounds between January 1, 2022, and December 31, 2026.

Source: DHCS Providing Access and Transforming Health website.¹⁴

Services Supported by PATH

In this section, we briefly describe ECM, Community Supports, the JI Reentry Initiative, and the specific resources under PATH that are intended to support implementation of these benefits or initiatives.

Enhanced Care Management

ECM is a new Medi-Cal benefit implemented in January 2022 for eligible members with complex needs to receive comprehensive care management and coordination of health and health-related care and services. All MCPs are required to provide ECM to members who meet the eligibility criteria for eight Populations of Focus (POFs), differentiated into “children and youth” and “adults” by age ([Exhibit 1.2](#)). ECM services were rolled out by POFs. MCPs in counties with WPC and HHP demonstrations were the first to offer ECM in January 2022. Other counties rolled out ECM by January 2024.

Exhibit 1.2. Populations of Focus Eligible for ECM and the Implementation Date for each Population of Focus

Age	Populations of Focus	Implementation Date
Children and Youth	Experiencing Homelessness: Homeless Families	July 2023
	Experiencing Homelessness: Unaccompanied Children/Youth Experiencing Homelessness	July 2023
	With Serious Mental Health or Substance Use Disorder (SUD) Needs	July 2023
	At Risk for Avoidable Hospital or Emergency Department (ED) Utilization	July 2023
	Transitioning from Incarceration	January 2024
	Birth Equity	January 2024
	Involved in Child Welfare	July 2023
	Children and Youth Enrolled in California Children's Services (CCS) or CCS Whole Child Model with Additional Needs Beyond the CCS Condition	July 2023
Adults	Experiencing Homelessness: Homeless Families	January 2022 (WPC/HHP counties) July 2022 (All counties)
	Experiencing Homelessness: Adults without Dependent Children/Youth Living with Them Experiencing Homelessness	January 2022 (WPC/HHP counties) July 2022 (All counties)
	With Serious Mental Health or SUD Needs	January 2022 (WPC/HHP counties) July 2022 (All counties)
	At Risk for Avoidable Hospital or ED Utilization	January 2022 (WPC/HHP counties)

Age	Populations of Focus	Implementation Date
		July 2022 (All counties)
	Transitioning from Incarceration	January 2024
	Birth Equity	January 2024
	Living in the Community and at Risk for Long-Term Care Institutionalization	January 2023
	Nursing Facility Residents Transitioning to Community	January 2023

Source: CalAIM Enhanced Care Management Policy Guide, August 2024.¹⁵

Note: WPC is Whole Person Care. HHP is Health Homes Program.

Community Supports

Community Supports are new services focused on addressing eligible members' HRSN. A brief overview of the 15 pre-approved Community Supports and the associated Medicaid Waiver mechanism is provided in [Exhibit 1.3](#). Seven of the 15 Community Supports focus specifically on supporting members experiencing or at-risk of homelessness, while the remaining Community Supports address other HRSN. Except for Transitional Rent, which will become mandatory effective January 1, 2026, Community Supports are optional for MCPs to offer. Per Waiver requirements, Community Supports must supplement and not supplant services received by members through other federal, state, or locally funded programs. Community Supports are also optional for members, meaning MCPs cannot require members to use a Community Support instead of a State Plan service or setting. Eligibility criteria for each Community Support are outlined in the Community Supports Section of the Evaluation Report in [Appendix D](#).

Exhibit 1.3. Approved Community Supports by Waiver Mechanism

Community Supports Services	Brief Description
1115 Waiver	
Recuperative Care* (Medical Respite)	Short-term residential setting for individuals experiencing or at-risk of homelessness with medical needs that would otherwise require institutional care to recover from injury or illness while also obtaining access to primary care, BH, and other supportive social services.
Short-Term Post-Hospitalization Housing* (also known as short-term post-transition housing)	Room and board service for members exiting an institution, experiencing or at-risk of homelessness, and whose ongoing physical or BH needs would otherwise require continued institutional care.
Transitional Rent ^{1*}	Up to six months of rental assistance in interim or permanent settings for members experiencing or at risk of homelessness that meet specific clinical and social risk eligibility criteria to provide support needed to connect to long-term housing supports and needed health care.
1915(b) Waiver	
Housing Transition Navigation Services*	Services to assist members with finding, applying for, and obtaining housing.
Housing Deposits*	Assistance with identifying, coordinating, securing, or funding one-time services, goods, or modifications necessary to establish a basic household.
Housing Tenancy and Sustaining Services*	Services to help a member maintain safe and stable tenancy once housing is secured.
Day Habilitation*	Services to assist members with acquiring, retaining, and improving self-help, socialization, and support daily functioning and skill-building.
Medically Tailored Meals / Medically Supportive Food	Services intended to help address members' nutrition-sensitive conditions, such as medically tailored or medically supportive meals or groceries or nutrition education.
Assisted Living Facility (ALF) Transitions	Services intended to facilitate member transition from nursing facility back into a home-like, community settings

Community Supports Services	Brief Description
(formerly known as Nursing Facility Transition / Diversion to Assisted Living Facilities)	and/or prevent nursing facility admission for members living in the community.
Community or Home Transition Services (formerly known as Community Transition Services / Nursing Facility Transition to Home)	Services intended to facilitate member transition from nursing facility or recuperative care into a private residence or public subsidized housing.
Personal Care and Homemaker Services	Services for individuals who need assistance with Activities of Daily Living or Instrumental Activities of Daily Living to remain in their homes.
Respite Services	In-person, short-term services provided for caregivers of members who live in the community and require intermittent, temporary supervision to avoid institutional placement for which the MCP would be responsible.
Environmental Accessibility Adaptations (Home Modifications)	Necessary physical adaptations to a home to ensure member health, welfare, and safety or avoid institutionalization.
Sobering Centers	Provide members publicly intoxicated (with alcohol and/or drugs) a safe, supportive environment to become sober as an alternative to the emergency room or jail.
Asthma Remediation ²	Supplies and/or physical modifications to a home environment to prevent acute asthma episodes that could result in the need for emergency services and hospitalization.

Source: CalAIM Community Supports Policy Guide Volume 1 and Volume 2, April 2025.^{16,17}

Note:

* Indicates Community Support focused on supporting members experiencing or at risk of homelessness

¹ Transitional rent was authorized under the BH Community-Based Organized Networks of Equitable Care and Treatment Waiver and will be evaluated separately. Because Transitional Rent

was not implemented until July 1, 2025, data on this Community Support will only be included in the Summative Evaluation Report.

² Effective January 1, 2026, in-home environmental trigger assessments and asthma self-management education can only be provided under Asthma Preventive Services (which became a Medi-Cal state plan benefit on July 1, 2022) rather than as part of Asthma Remediation.

PATH Resources for Implementation of ECM and Community Supports

An explicit goal of PATH is to increase contracting of community-based organizations (CBOs), defined by DHCS as “a nonprofit organization, governmental agency, or health care provider that has direct experience with the Medi-Cal populations being served within the county in which they are seeking a contract with a Medi-Cal MCP and is generally embedded in the health care and social services ecosystem in the provider’s county.”

To achieve this, PATH included four supports: (1) WPC Transition funding to help WPC pilot lead entities, who were typically county health or public health agencies, transition services to managed care; (2) PATH CITED, direct funding to help providers develop capacity and infrastructure needed to implement ECM or Community Supports; (3) PATH TA Marketplace, involving access to vendor-provided TA and resources; and (4) PATH CPI, collaboratives to support local or regional collaborative planning and implementation efforts. WPC Transition funding, PATH TA Marketplace, and PATH CPI were available on an ongoing basis, while PATH CITED funding was distributed in four rounds. PATH CITED Round 1 focused on building capacity to expand ECM and Community Supports across POFs and services. More recently, Rounds 3 and 4 have emphasized filling local and statewide gaps, expanding providers in rural areas and for tribal entities, and supporting the rollout of Transitional Rent and newly added POFs.

Each of these PATH initiatives included features intended to promote participation by CBOs. For example, PATH CITED explicitly encouraged applications from CBOs; county, city, or local government agencies; federally qualified health centers; tribal and Indian health care providers; and other health care providers (e.g., hospitals or provider organizations).

PATH is implemented concurrently with numerous other broad-based delivery system, program, and payment reforms that are collectively focused on making Medi-Cal services more person-centered and coordinated and help members maximize their health and life trajectory. These can include new Medi-Cal benefits to provide preventive asthma services or care provided by community health workers or doulas. [Exhibit 1.4](#)

highlights the two new DHCS programs or Medi-Cal benefits that are expected to directly influence PATH implementation.

Exhibit 1.4. Summary of DHCS Programs or Benefits Expected to Influence PATH Implementation

Program / Initiative	Brief Description
IPP	DHCS program (2022 to 2024) to support implementation of Community Supports and other CalAIM initiatives by providing incentives to MCPs to support member engagement and service delivery, infrastructure and capacity development, program quality, and equitable service access for members.
Housing and Homelessness Incentive Program (HHIP)	Home and Community-Based Services initiative (2022 to 2024) that allows MCPs to earn incentive funds for partnering with local Continuums of Care, county BH, public hospitals, and other local stakeholders to invest in and make progress in addressing homelessness.

Source: Incentive Payment Program website;¹⁸ Housing and Homelessness Incentive Program website.¹⁹

PATH Resources for Implementation of the JI Reentry Initiative

Effective January 1, 2023, all counties in California were mandated to implement pre-release Medi-Cal application processes in county jails and youth correctional facilities, suspend Medi-Cal benefits for inmates of public institutions for the duration of their incarceration, and then unsuspend benefits upon release. On January 26, 2023, California also received federal approval for its 1115 Reentry Demonstration Waiver, which provides authority for California to implement the JI Reentry Initiative to offer eligible youth and adults in state prisons, county jails, and youth correctional facilities a targeted set of Medi-Cal services for up to 90 days prior to release (e.g., comprehensive care management with physical and BH clinical consult, provision of covered and prescribed outpatient medications and durable medical equipment upon release, etc.). Additional information about the pre-release services is provided in the [JI Reentry section of the Interim Evaluation Report](#).

State prisons, county jails, and youth correctional facilities vary in when they expect to be ready to implement pre-release services, with dates ranging from October 2024 to

October 2026. [Exhibit 1.5](#) identifies correctional facilities implementing pre-release services in 2024 or 2025.

Exhibit 1.5. Correctional Facilities Implementing Pre-Release Services in 2024, 2025, or 2026

Correctional Facility	Pre-Release Services Implementation Date
CDCR; 33 facilities	February 2025
Inyo County – Sheriff and Probation	October 2024
Kern County – Sheriff and Probation	November 2025
Monterey County – Sheriff	July 2025
Nevada County – Sheriff	November 2025
San Diego County – Probation	October 2025
San Francisco County – Sheriff	April 2025
San Joaquin County - Sheriff	January 2025
San Mateo County – Sheriff	July 2025
San Mateo County – Probation	March 2026
Santa Clara County – Sheriff and Probation	October 2024
Siskiyou County – Sheriff	April 2025
Sutter County – Sheriff	April 2025
Yuba County – Sheriff and Probation	October 2024

Source: DHCS Justice-Involved Reentry Initiative County Readiness Status website.²⁰

Note: A County Sheriff supports county jails, and County Probation supports youth correctional facilities. County jails and youth correctional facilities not shown in this Exhibit are expected to be implemented in 2026.

PATH provided up to \$443 million in funding for collaborative planning and capacity and infrastructure support to correctional agencies, county social service agencies, and other organizations for implementation of pre-release Medi-Cal enrollment and suspension processes, as well as delivery of select Medi-Cal services to eligible members, in the 90 days prior to release.

As of October 2025, four rounds of PATH JI funding have been released. [Exhibit 1.6](#) provides an overview of the purpose of each round of funding and the application due dates.

Exhibit 1.6. Overview of PATH JI Capacity Building Program Funding Rounds

Funding Round	Description	Application Due Date
Round 1	Small planning grants to support collaborative planning between correctional agencies, county social service departments, and other enrollment implementation partners to identify processes, protocols, and IT modifications needed to support implementation of pre-release Medi-Cal enrollment and suspension.	July 2022
Round 2	Application-based grants to support implementation of processes, protocols, and IT system modifications needed to implement pre-release Medi-Cal enrollment and suspension.	March 2023
Round 3	Capacity building funds available to qualified entities to support investments in personnel, capacity, and/or IT systems needed to effectuate pre-release service processes and distributed based on meeting specific performance milestones.	July 2023
Round 4	Additional, application-based funds to support planning and implementation of pre-release Medi-Cal services for eligible individuals in state prisons, county jails, youth correctional facilities, and behavioral health departments.	October 2025

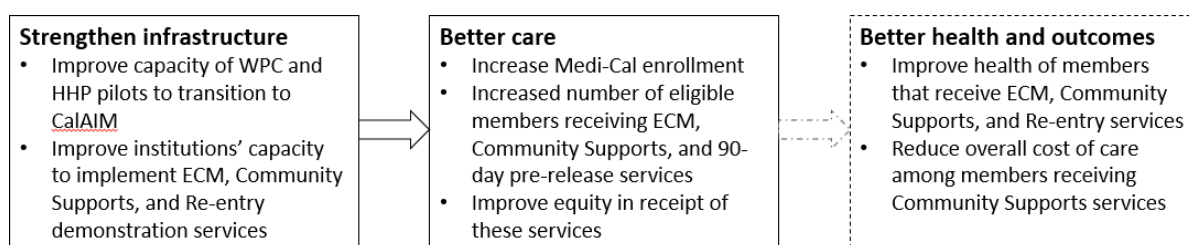
Source: DHCS Justice-Involved Capacity Building Program website.²¹

Note: To facilitate implementation of BH linkages, Rounds 3 and 4 included funding from PATH JI Reentry Initiative grants to support correctional facilities and from AB 133 to support county BH agencies. Qualified entities in Rounds 3 and 4 included CDCR (state prisons), county sheriff (county jails), county probation (youth correctional facilities), and county BH departments (BH linkages).

C. Evaluation Questions and Hypotheses

The PATH evaluation examines whether PATH achieved its overarching goals as noted in the PATH driver diagram ([Exhibit 1.7](#)). The diagram indicates that strengthening the infrastructure to deliver ECM and Community Supports under PATH is expected to lead to better care and subsequently improve the health and outcomes of members who receive these services. However, the dotted arrow indicates that PATH evaluation does not directly measure changes in member health and other outcomes.

Exhibit 1.7. Driver Diagram for the PATH Evaluation



[Exhibit 1.8](#) shows the specific PATH goals and the related evaluation questions, hypotheses, and measures included the [PATH Evaluation Design](#) are indicated in **bold text**. The findings for the remaining evaluation questions and measures will be included in the Summative Evaluation Report. The findings for the remaining evaluation questions and measures will be included in the Summative Evaluation Report.

Exhibit 1.8. PATH Goals and the Related Evaluation Questions, Hypotheses, and Measures

Evaluation Questions (EQs) and Hypotheses (H)	Measures
<i>Goal 1. Increase the number of ECM and Community Supports community-based providers and consequently increase Medi-Cal member ECM and Community Supports utilization according to community needs.</i>	
EQ 1: Did the number of community-based providers that contracted with MCPs to provide ECM or Community Supports increase over time? H 1a: The number of community-based providers contracted with MCPs to provide ECM	1. Number of providers that were contracted to provide ECM or Community Supports services. 2. Proportion of the total providers contracted to provide ECM or Community Supports that were community-based providers (versus for-

Evaluation Questions (EQs) and Hypotheses (H)	Measures
or Community Supports will increase over time due to provision of PATH funding and resources. H1b: The number and proportion of community-based providers located in under-resourced communities will increase over time due to provision of PATH funding and resources.	profit or MCPs). 3. Proportion of ECM or Community Supports providers located in under-resourced or rural communities. 4. Number of providers that applied for and received PATH CITED funding; Number that received TA and WPC Transition funding. 5. Number of community-based providers that received PATH CITED funding, TA, or WPC Transition funds. 6. Proportion of providers that provided services under WPC or HHP and were subsequently contracted to provide ECM and Community Supports.
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.	1. Characteristics of providers eligible to provide ECM or Community Supports. 2. Eligible providers' self-reported organizational mission, ECM POFs, and Community Supports services provided, contracts with MCPs, and data sharing infrastructure prior to CalAIM. 3. PATH-participating providers' self-reported reasons for participating in PATH and their perceptions of PATH's role in helping them successfully contract with MCPs to provide ECM and Community Supports.
EQ 3: Did PATH increase utilization of ECM and Community Supports? H 3a: 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	1. Proportion of eligible Medi-Cal members that used ECM and Community Supports services. 2. Number and type of ECM and Community Supports services used. 3. Demographic and health characteristics of ECM and Community Supports users and non-users compared to the population of members eligible for these services.

Evaluation Questions (EQs) and Hypotheses (H)	Measures
needed to implement ECM or Community Supports and (b) use effective strategies for identifying and engaging eligible members in ECM or Community Supports services. H3b: PATH will increase the number of eligible members in under-resourced communities that utilize ECM or Community Supports and the number of ECM and Community Supports services used by eligible members by increasing the number of providers in these communities contracted to provide these services.	4. ECM and Community Supports providers' self-reported strategies for identifying and engaging eligible members in ECM and Community Supports. 5. 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.
<i>Goal 2: Improve data collection and information sharing infrastructure among ECM and Community Supports providers.</i>	
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, electronic health record 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.	1. 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. 2. Number and proportion of providers with data sharing agreements with MCPs. 3. Number and proportion of providers who have electronic health records or other electronic care management documentation system. 4. Number and proportion of Community Supports providers with data sharing agreements with the Homeless Management Information System (of those providing housing-related services). 5. Number and proportion of providers with Medi-Cal billing systems. 6. ECM and Community Supports providers' self-reported impact of PATH on their ability to improve data collection and information sharing infrastructure.

Evaluation Questions (EQs) and Hypotheses (H)	Measures
<i>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.</i>	
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.	1. 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. 2. 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. 3. 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.
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.	1. 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. 2. Self-reported total amount of funding used to develop capacity and infrastructure needed to provide eligible individuals with pre-release services. 3. Perceived role of PATH in promoting these institutions' ability to provide pre-release services.

Evaluation Questions (EQs) and Hypotheses (H)	Measures
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.	1. Number and proportion of incarcerated individuals that were screened for Medi-Cal eligibility prior to release, stratified by whether the institution received PATH funding. 2. Proportion of eligible individuals enrolled in Medi-Cal prior to release, stratified by whether the institution received PATH funding or other resources.
<i>Cost analysis to measure cost outcomes of the demonstration through examination of PATH expenditures and resources, payments to providers for ECM and Community Supports services, and the patterns of payments for services used among members</i>	
EQ 8: What were PATH expenditures, including payments to providers for ECM and Community Supports services?	1. PATH expenditures. 2. Payments to providers for ECM and Community Supports services. 3. Patterns of payments for services used for members that received WPC and HHP services prior to ECM and Community Supports compared to members that only received ECM and Community Supports.
EQ 9: Did ECM and Community Supports use by members in PATH participating providers result in cost savings to Medi-Cal?	1. Cost savings among ECM and Community Supports members under PATH participating providers.

Note: The goals and evaluation questions and measures examined in the Interim Evaluation Report are indicated in **bold text**.

The assessment of whether infrastructure and capacity building investments under PATH supported delivery of high-quality, high-value, and accessible care to members is aligned with and promotes Title XIX and XXI objectives.

UCLA-RAND considered PATH to have successfully met its goals under the following circumstances:

1. Increase in the number of providers contracted to deliver ECM and Community Supports and in the number of members utilizing services over time.
2. Improvement in data collection and information sharing infrastructure among contracted ECM and Community Supports providers as a result of participating in PATH over time.

3. Improvement in state prison, county jails, youth correctional facilities, or their JI Reentry Initiative partners (county social services, county BH, community-based providers when applicable) ability to implement Medi-Cal application and suspension processes and 90-day pre-release services and BH linkages as a result of PATH JI funding over time.

As required by 1115 Waiver Special Terms and Conditions, UCLA-RAND will present data on cost outcomes by examining PATH expenditures, payments to providers for ECM and Community Supports services, and patterns of payments for services used by members in the Summative Evaluation Report.

D. Methodology

UCLA-RAND used two study designs for the evaluation of PATH. This included cross-sectional study of the implementation approach by MCPs and providers using surveys and interviews and pre-post study of provider participation in PATH and of ECM and Community Supports users. The Summative Evaluation Report will further include quasi experimental design for assessment of PATH impact on ECM and Community Support users, JI Reentry Initiative service users, and of costs.

Data Sources and Methods

UCLA-RAND used multiple qualitative and quantitative data sources to address the PATH evaluation questions in the Interim Evaluation Report. [Exhibit 1.9](#) provides an overview of data sources, time period and related details, and analytic methods.

UCLA-RAND searched for and obtained all available administrative data from DHCS and other relevant secondary data sources to respond to the evaluation questions. As needed, the UCLA-RAND team also gathered primary data to understand the implementation process and perspectives of MCPs, PATH CPI facilitators, PATH TA Marketplace vendors and ECM, Community Supports, and JI providers regarding factors affecting participation in ECM, Community Supports, and JI to identify challenges, solutions, and lessons learned. UCLA-RAND analyzed all data using appropriate qualitative and quantitative methods.

For the Interim Evaluation Report, qualitative analytic methods included coding and thematic analysis of salient documents and MCP, PATH CPI facilitator, PATH TA Marketplace vendor, and ECM and Community Supports provider interview transcripts in the qualitative software NVivo. Quantitative analysis included preparing data for analysis, merging data as needed, and conducting descriptive analyses.

Exhibit 1.9. Data Sources Used by UCLA-RAND and Related Methods for the PATH Interim Evaluation Report

Data Source	Time Period and Related Details	Analytic Methods
<i>Primary Data Collected by UCLA-RAND</i>		
Semi-structured Interviews with MCPs	Conducted from July to September 2024. Interviewed 101 individuals in 23 of 24 MCPs eligible to offering Community Supports in 2024. AIDS Healthcare Foundation was not interviewed as they specialize in care for members with HIV/AIDS in a single county. One MCP that stopped operating as a Medi-Cal MCP in January 2024 was jointly interviewed with the MCP that took over its service area.	Thematic analysis to describe MCP perspectives and lessons learned.
MCP Survey	Cross-sectional survey conducted from November 2024 to January 2025. Survey was distributed to 23 of 24 MCPs eligible to offer Community Supports in 2024. AIDS Healthcare Foundation was not surveyed as they specialize in care for members with HIV/AIDS in a single county. One MCP that fully delegated responsibility for member care to another MCP did not respond to the survey.	Descriptive analysis to describe MCP implementation processes and perspectives.

Data Source	Time Period and Related Details	Analytic Methods
Semi-structured Interviews with ECM and Community Support Providers	Interviewed 129 people in 63 ECM or Community Supports provider organizations from October 2024 to July 2025. Respondents were purposively sampled for diversity in Community Supports provided, MCP(s) contracted with, provider type, and region(s) in which services were offered.	Thematic analysis to describe provider perspectives on PATH and lessons learned in implementing ECM and Community Supports.
Semi-structured Interviews with PATH CPI Facilitators and PATH TA Marketplace Vendors	Interviewed 34 people from ten CPI facilitators and/or TA Marketplace Vendor organizations from January to April 2025. Interviewed all CPI facilitators, six of whom were also TA Marketplace vendors; also interviewed an additional TA Marketplace vendor not involved with PATH CPI.	Thematic analysis of CPI facilitator and TA Marketplace vendor perspectives and lessons learned regarding PATH.
Semi-structured Interviews with JI Providers	Interviewed 63 people in 11 counties between April to July 2025. UCLA-RAND attempted to recruit participants from all sheriff and probation departments that implemented or planned to implement 90-day pre-release in 2024 or 2025, as well as key informants involved with implementing pre-release Medi-Cal enrollment and suspension processes or with BH linkages that were also part of the	Thematic analysis of perspectives and lessons learned in implementing the JI Reentry Initiative.

Data Source	Time Period and Related Details	Analytic Methods
	broader JI Reentry Initiative. UCLA-RAND did not interview CDCR because permissions to contact CDCR staff were not acquired in time for the Interim Evaluation Report. UCLA-RAND will interview CDCR for inclusion in the Summative Evaluation Report.	
ECM and Community Supports Provider Survey	Cross-sectional survey conducted from June to July 2025. Survey was distributed to ECM and Community Supports providers contracted to provide services as of May 2025 (259 respondents). Survey was distributed by DHCS, MCPs, CPI facilitators, and other partners in contact with contracted providers.	Descriptive analysis to describe provider implementation processes and perspectives.
Secondary Data		
National Plan and Provider Enumeration System National Provider Identifier Registry	Publicly available directory of all active National Provider Identifier (NPI) records. NPIs are unique identification numbers for providers that must be used in administrative and financial transactions under the Health Insurance Portability and Accountability Act.	Data were merged with Quarterly Implementation and Monitoring Reports (QIMR) data and with Medi-Cal claims to identify provider names.
GuideStar	2024 database identifying Internal Revenue Service-	Data were merged with QIMR data for descriptive

Data Source	Time Period and Related Details	Analytic Methods
	recognized tax-exempt organizations to identify providers that are private non-profit organizations, supplemented by manual search of provider websites for ownership status data.	analysis of provider ownership status.
Health Resources and Services Administration Rural Areas	2020 database developed by the Federal Office of Rural Health Policy that defines rural areas by ZIP Code.	Data were merged with eligibility data to identify members residing in a rural area. The proportion of members residing in rural areas served by each provider was calculated based on QIMR provider data.
Social Vulnerability Index (SVI)	Publicly available 2022 SVI data, which uses 16 U.S. Census variables from the 5-year American Community Survey to identify communities that may need support before, during, or after disasters, as an indicator of community-level social vulnerability.	Data were merged with Medi-Cal eligibility data to identify members in communities in the top SVI quartile. The proportion of members in top SVI quartile served by each provider was calculated based on QIMR provider data.
Administrative Data Provided by DHCS		
Quarterly Implementation and Monitoring Reports (QIMRs)	Quarterly data submitted by MCPs to DHCS from January 2022 to September 2024. Data included lists of contracted providers, ECM and Community	Data were used for descriptive analysis of provider participation in ECM and Community Supports and were further merged with

Data Source	Time Period and Related Details	Analytic Methods
	Support users, and dates of service.	Medi-Cal eligibility and claims data for descriptive analysis of ECM and Community Support users.
Medi-Cal Eligibility and Claims Data	Data on member enrollment, demographics, and health care utilization from January 2020 to December 2024.	Data were used for descriptive analysis of demographics, health status, and health care utilization of ECM and Community Support users.
ECM and Community Supports Policy Guides	Available in 2021 (ECM only), 2023, 2024, and 2025.	Used to identify changes in ECM and Community Supports eligibility criteria and policies.
PATH CITED Funding Applications and Lists of Awardees	Available for PATH CITED Rounds 1-3 (2022 to 2024).	Data were merged with QIMR data for descriptive analysis of provider descriptives.
PATH TA Marketplace Funding	Data on recipients and vendors who participated in PATH TA Marketplace through Q3 2024.	Data were merged with QIMR data for descriptive analysis of provider descriptives.
PATH WPC Transition Funding	Available in 2022 and 2023 for ten participating counties (of 27).	Data were used to identify dates and counties that received supports.
MCPs' ECM and Community Supports Model of Care Narratives	Submitted by MCPs in 2022 outlining plans for designing, administering, and	Used to inform development of MCP and provider interview protocols, providing

Data Source	Time Period and Related Details	Analytic Methods
	implementing ECM and Community Supports.	background information ahead of qualitative data collection.
WPC and HHP Provider Lists	Data on providers that participated in WPC or HHP from January 2017 to December 2021.	Data used to identify prior participation in WPC and HHP.
Lists of PATH JI Round 1 and 2 Awardees	Data on counties in which correctional facilities or their designated representatives were awarded PATH JI Round 1 or 2 funding.	Data used to identify correctional facilities that received PATH JI Round 1 and 2 funding.
PATH JI Applications and Interim Progress Reports	Data submitted by correctional facilities, county BH agencies, or their designated representatives in applying for or reporting on use of PATH JI funding to support implementation of the JI Reentry Initiative.	Analysis of implementation needs and use of PATH JI funding to develop capacity or infrastructure needed to implement the JI Reentry Initiative.

E. Methodological Limitations

There were several limitations in the Interim Evaluation Report related to program implementation process, content and availability of data, and methodological barriers to analysis, summarized in [Exhibit 1.10](#).

Exhibit 1.10. Summary of Methodological Limitations

Limitation Type	Description
Program Implementation Process	» Findings presented in the Interim Evaluation Report only reflect the first three years of PATH implementation and only contain analyses feasible given availability and content of data during this time and cannot be considered conclusive.

Limitation Type	Description
	» MCPs could elect to offer new Community Supports every six months and to discontinue Community Supports annually. MCPs contracted to serve members in each county could also change annually. As a result, Community Supports were offered by different MCPs in different counties over time, resulting in potential imprecision in analyses of Community Supports providers and users. » DHCS policy guidance around ECM POFs and Community Supports changed each year. Changes in policies such as eligibility criteria and allowable duration of services can contribute to potential imprecision in analyses of trends in ECM and Community Supports use and users. » ECM implementation was phased in by POFs and given county(ies) and MCP prior participation in WPC or HHP. Additional information about this timeline is available in Error! Reference source not found. Therefore, the number of some Community Supports services offered and number of some ECM and Community Supports users were lower than others offered or available from the start of the program.
Content and Availability of Administrative Data Provided by DHCS	» Medi-Cal eligibility and claims data were not available until the end of May 2025. The data was over 2,000 gigabytes and required extensive quality checks and processing. Delays in receipt of these data meant that certain evaluation questions could not be addressed in the Interim Evaluation Report (e.g., health care utilization changes, quality of care, and costs associated with health care utilization). » QIMR data did not include information on provider NPIs per Community Supports user. Thus, UCLA-RAND was not able to use these data to determine which providers were serving which members. For the Summative Evaluation Report, UCLA-RAND will link QIMR data on Community Supports users with Medi-Cal claims data to determine provider NPIs per user. » QIMR data did not include provider names, only provider NPIs. Providers can have multiple NPIs as they may use a unique NPI

Limitation Type	Description
	per facility or location. Therefore, UCLA-RAND was not able to determine the number of unique provider organizations being contracted. UCLA-RAND attempted to use DHCS-provided NPI directory data to link NPI to organizational names, but this process was prone to significant error. » Reliance of some providers on community care hubs, management support organizations, or other centralized administrative entities to contract with MCPs and process Medi-Cal billing and claims could result in under-reporting of the number of providers participating in CalAIM and imprecision in assessment of provider types, as the provider contracted with the MCP might not be the provider actually delivering services to ECM and Community Supports users. » Administrative or secondary data were not available to the UCLA-RAND team to construct a quantitative measure that precisely matched DHCS' definition of a "community-based provider." Data were not available to identify ECM and Community Supports providers that had prior experience serving Medi-Cal populations or were already embedded in local health and social services ecosystems prior to CalAIM. Instead, UCLA-RAND used available quantitative data on provider ownership status and type as a proxy, and perceived impact of prior experience with Medi-Cal population(s) and embeddedness in local service ecosystems were assessed qualitatively.
Content and Availability of Primary Data	» QIMR data did not include provider names or contact information. Thus, UCLA-RAND could not directly contact ECM and Community Supports providers for participation in interviews or the survey and instead needed to rely on MCPs, DHCS, and other sources (e.g., contacts in statewide professional associations or at the California Health Care Foundation) to assist with initial outreach. Particularly for the survey, this could have resulted in some eligible providers not

Limitation Type	Description
	receiving the survey and negatively affected survey response rate and accuracy of calculated survey response rates. » When conducting qualitative interviews, UCLA-RAND purposively sampled ECM and Community Supports providers to ensure variation in type(s) of Community Supports provided, MCP(s) contracted with, counties served, and provider types. Although UCLA-RAND prioritized Section 1115 Waiver-authorized services, achieving saturation in themes, these dimensions resulted in a longer data collection time frame than previously anticipated, with some interviews still being conducted in July 2025. Therefore, information reported from interviews in the Interim Evaluation Report is limited due to lack of time for in-depth analysis and reporting. More information will be included in the Summative Evaluation Report. » The provider survey was purposefully designed to follow up on themes identified in qualitative interviews and was therefore not developed until after most provider interviews were completed, in late April 2025. Additional time needed for review and approval from DHCS meant the survey was not fielded until mid-June 2025. To allow adequate response time, the survey remained open until end of July 2025. This timeline, coupled with lag in release of 2025 Quarter (Q)2 QIMR data, negatively impacted UCLA-RAND's ability to comprehensively analyze all survey data for the Interim Evaluation Report and to link data on provider names to provider NPIs to calculate an accurate response rate. More in-depth analysis and adjusted response rates will be included in the Summative Evaluation Report.
Content and Availability of Secondary Data	» Lack of a database that comprehensively identifies all social services providers or nonprofit CBOs, making it difficult to identify the "universe" of providers that could be eligible to contract with MCPs for Community Supports.

Limitation Type	Description
	» Provider ownership status was constructed in 2024 through a lengthy and highly manual process that is subject to error and is not easily replicable. This process will be repeated after December 2026 when complete data are available for inclusion in the Summative Evaluation Report.
Methodological Barriers	» All interview and survey data used in the Interim Evaluation Report were subject to recall and acquiescence bias. » Provider interview data have high internal validity, but results may not be generalizable. » UCLA-RAND used QIMR data to identify ECM and Community Supports users in Medi-Cal eligibility and claims data rather than Healthcare Common Procedure Coding System codes and associated modifiers. QIMR data allowed for identification of Community Supports services approved and provided, while claims data only included adjudicated claims for services provided, resulting in potential discrepancies in numbers of Community Supports users between the two data sources. Only ECM providers at the member-level were reported in QIMR data. » UCLA-RAND's preliminary assessment of concordance between provider NPIs in the QIMR and Medi-Cal eligibility and claims data in July 2025 revealed significant discordance that needed to be reconciled through further, iterative discussions with DHCS and MCPs for the Summative Evaluation Report. This discordance could result in imprecision in findings on users in the Interim Evaluation Report. » Some measures needed to be modified for the Interim Evaluation Report because originally planned data or methods were not feasible. Modifications are noted in the appropriate results sections, along with justification.

F. Results

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

Goal 1 is evaluated by addressing three Evaluation Questions and analyzing 14 measures articulated in the [Evaluation Questions and Hypotheses](#) section of this report. Data sources used in analyses are articulated for each measure.

Evaluation Question 1: Did the number of community-based providers that contracted with MCPs to provide ECM or Community Supports increase over time?

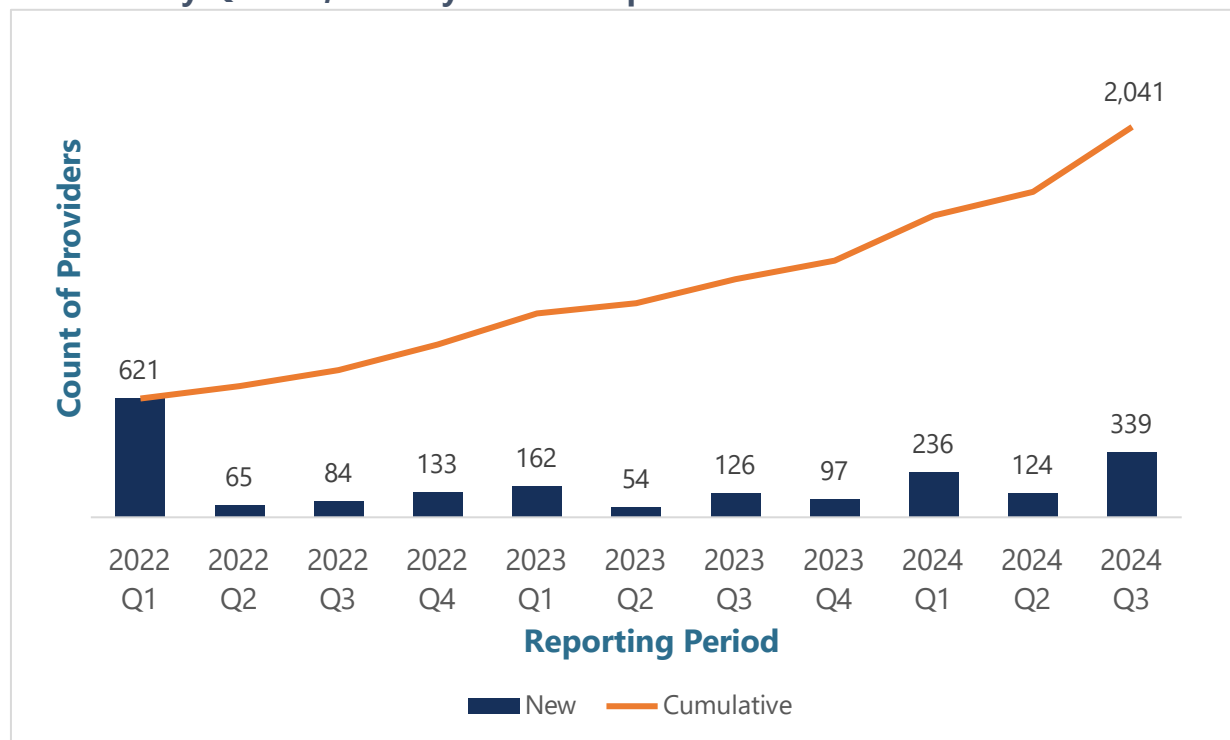
Evaluation Question 1 is addressed by analysis of six measures articulated in the PATH Evaluation Design and displayed in the [Evaluation Questions and Hypotheses](#) section of this report. The data sources used for the analyses are noted for each measure. Further detail on data sources and methods is included in the [Methodology](#) section.

Measure 1. Number of providers that were contracted to provide ECM or Community Supports services

Data source: Quarterly Implementation and Monitoring Reports (QIMRs).

Analysis of QIMR data showed that a total of 2,041 unique providers, based on National Provider Identifiers (NPIs) reported in QIMR data, had ever contracted with one or more Medicaid MCPs to deliver ECM and Community Supports services across one or more California counties by September 2024 ([Exhibit 1.11](#)). The number of new providers per quarter was largest in 2022 Quarter (Q)1 (621 providers), followed by 2024 Q3 (339 providers). Of the 2,041 providers, 53% provided only ECM, 26% provided Community Supports only, and 21% provided both services (data not shown).

Exhibit 1.11. Cumulative and New Count of ECM and Community Supports Providers by Quarter, January 2022 to September 2024

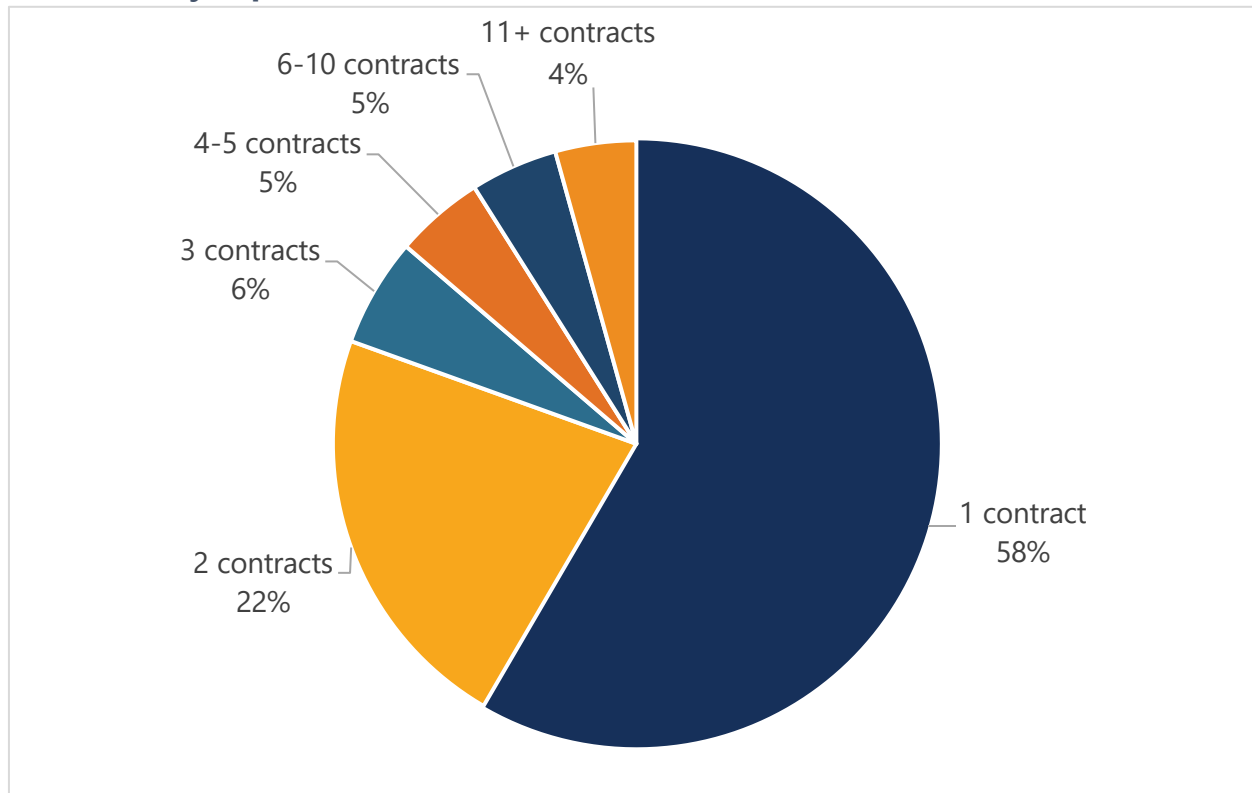


Source: Quarterly Implementation and Monitoring Reports, 2022 Q1 to 2024 Q3.

Note: A total of 2,041 unique providers were identified by unique NPIs. The number of providers may be overestimated because some providers may have multiple NPIs. ECM is Enhanced Care Management.

Of the 2,041 unique providers, 58% contracted with only one MCP in one county, followed by 22% of providers who contracted with two plans (either two MCPs in one county or one MCP in two counties; [Exhibit 1.12](#)). The remaining 20% of providers contracted with three or more plans. The maximum number of contracts per provider was 149 (data not shown).

Exhibit 1.12. Proportion of Unique ECM and Community Supports Providers that Ever Contracted with Managed Care Plans in Specific Counties by the Number of Contracts, by September 2024

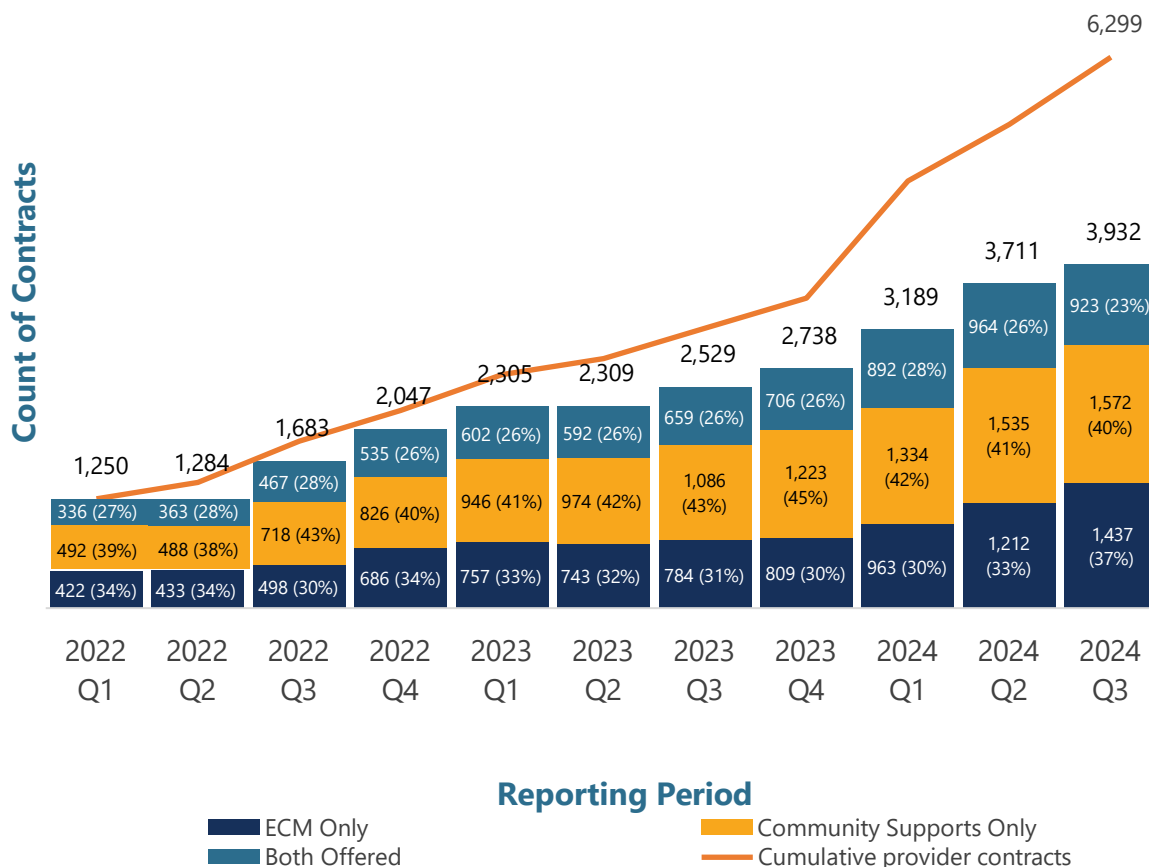


Source: Quarterly Implementation and Monitoring Reports, 2022 Q1 to 2024 Q3.

Note: Contracts were between a given ECM or Community Supports provider and a specific MCP in each county. A total of 2,041 unique providers were identified by unique NPIs. The number of providers may be overestimated because some providers may have multiple NPIs. ECM is Enhanced Care Management.

UCLA-RAND further measured the change in the number of provider contracts over time because providers frequently had more than one contract with MCPs. Analysis indicated that the 2,041 unique providers collectively held 6,299 contracts as of September 2024 ([Exhibit 1.13](#)). The number of provider contracts grew from 1,250 in 2022 Q1 to 3,932 in 2024 Q3. By 2024 Q3, 37% of contracts were for ECM services only, 40% for Community Supports only, and 23% for both services. These proportions remained relatively similar over time.

Exhibit 1.13. Quarterly Change in the Number of Provider Contracts with Managed Care Plans, by Whether the Contract Included ECM, Community Supports, or Both, January 2022 to September 2024

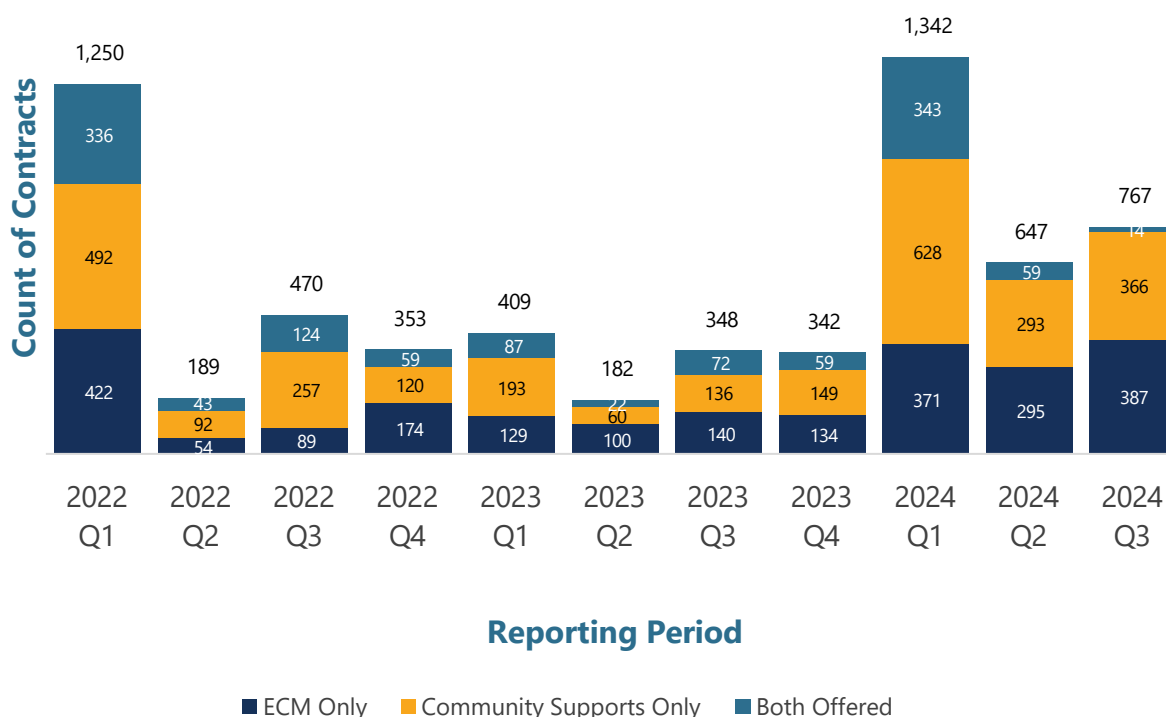


Source: Quarterly Implementation and Monitoring Reports, 2022 Q1 to 2024 Q3.

Note: Data showed the number of provider contracts (contracts were between a given ECM or Community Supports provider and a specific managed care plan in each county). A total of 2,041 unique providers were identified by unique NPIs. The number of providers may be overestimated because some providers may have multiple NPIs. ECM is Enhanced Care Management.

Data further showed that after the beginning of PATH implementation in 2022 Q1, MCPs reported the largest number of new contracts in 2024 Q1 (1,342; [Exhibit 1.14](#)). Changes to the MCPs, including the removal of some plans and addition of new plans serving the Medi-Cal population at the start of 2024 may have explained the observed increase in contracts at the start of 2024. MCPs reported the fewest number of new contracts in 2022 Q2 (189) and 2023 Q2 (182). New contracts were most likely to provide either ECM or Community Supports rather than both services.

Exhibit 1.14. Number of New Provider Contracts Including ECM, Community Supports, or Both Services Per Quarter, January 2022 to September 2024



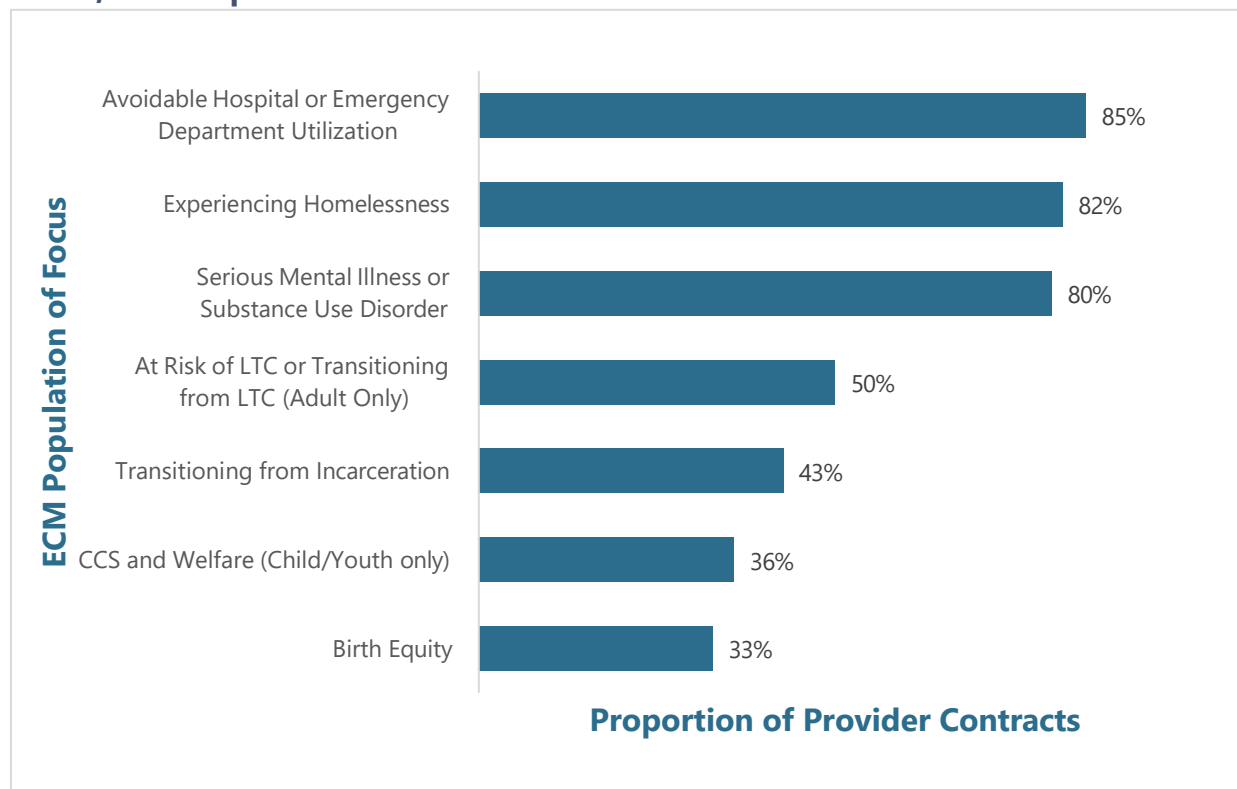
Source: Quarterly Implementation and Monitoring Reports, 2022 Q1 to 2024 Q3.

Note: Data showed the number of provider contracts (contracts were between a given ECM or Community Supports provider and a specific MCP in each county). A total of 2,041 unique providers were identified by unique NPIs. The number of providers may be overestimated because some providers may have multiple NPIs. ECM is Enhanced Care Management. 22 and 14 contracts were with providers offering both ECM and Community Supports in 2023 Q3 and 2023 Q4, respectively.

ECM provider contracts by POF

Of the 6,299 contracts held by all providers, 3,513 contracts offered ECM services as of September 2024 (data not shown). Of these, 183 contracts did not list which POFs they served. Among the rest, 56% served both adult and children and youth POFs, followed by 39% serving adult POFs only, and 5% serving children and youth POFs only (data not shown). The most common POFs served were members At Risk for Avoidable Hospital or ED Utilization (85%), Individuals and Families Experiencing Homelessness (82%), and Individuals with Serious Mental Illness or SUD (80%; [Exhibit 1.15](#)). The least common was Birth Equity (33%), which was partly due to the rollout of this POF in 2023 Q3.

Exhibit 1.15. Proportion of Provider Contracts Offering ECM by Populations of Focus, as of September 2024



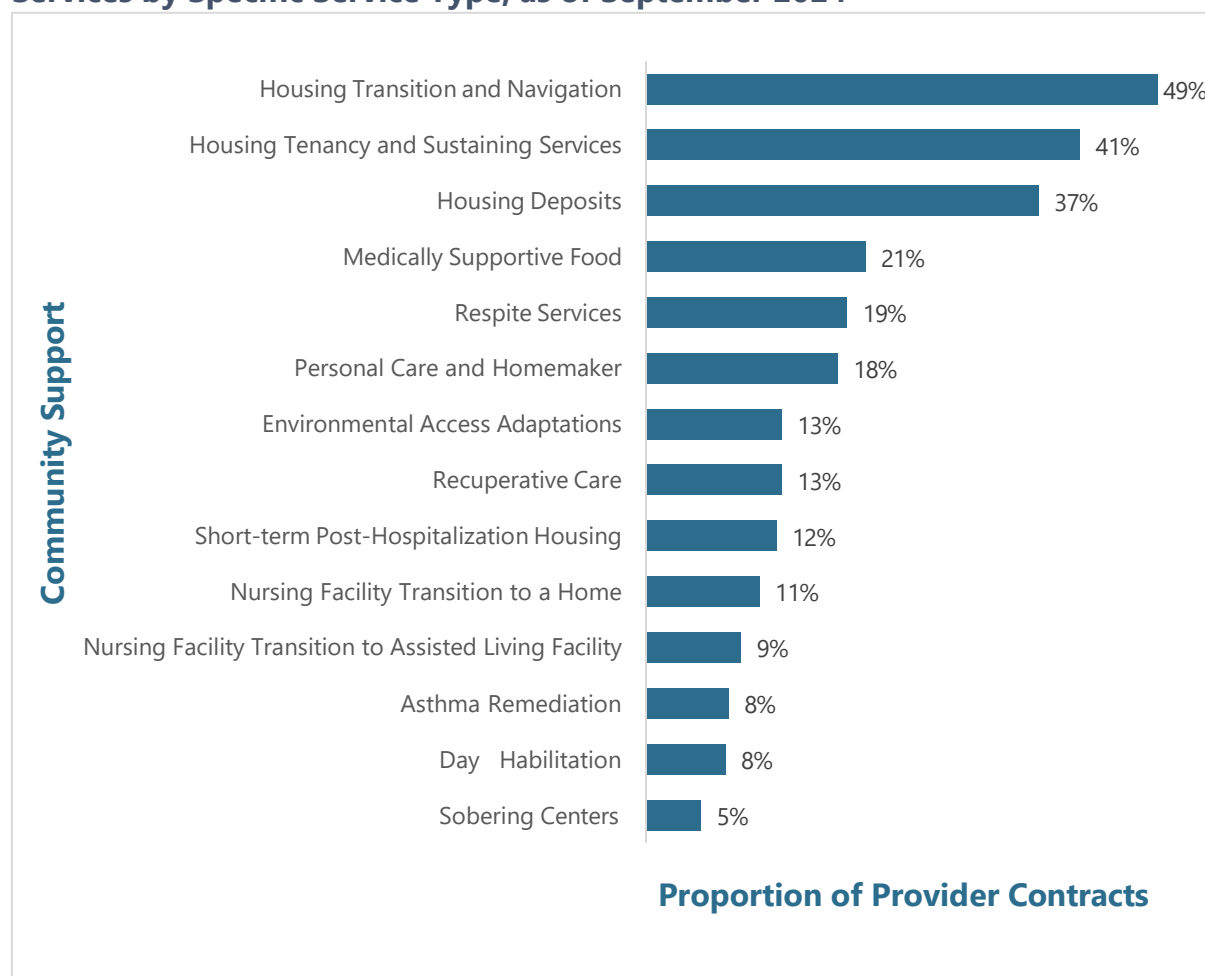
Source: Quarterly Implementation and Monitoring Reports, 2024 Q3.

Note: LTC is long-term care. CCS is California's Children Services. ECM is Enhanced Care Management. Data showed the number of provider contracts (contracts were between a given ECM or Community Supports provider and a specific MCP in each county). A total of 3,513 provider contracts offered ECM. Data excluded 183 ECM provider contracts that were missing information on POFs. Percents do not add to 100% because providers frequently served multiple POFs.

Community Supports Provider Contracts by Type of Community Support

Of the 6,299 contracts held by all providers, 4,004 contracts offered Community Supports services as of September 2024 (data not shown). Of these, 49% offered Housing Transition and Navigation Services, followed by Housing Tenancy and Sustaining Services (41%), and Housing Deposits (39%; [Exhibit 1.16](#)). The least commonly offered Community Supports were Asthma Remediation (8%), Day Habilitation (8%), and Sobering Centers (5%).

Exhibit 1.16. Proportion of Provider Contracts Offering Community Supports Services by Specific Service Type, as of September 2024



Source: Quarterly Implementation and Monitoring Reports, 2024 Q3.

Note: Data showed the number of provider contracts (contracts were between a given ECM or Community Supports provider and a specific MCP in each county). A total of 4,004 provider contracts offered Community Supports. Percents do not add to 100% because providers frequently offered multiple Community Supports.

Measure 2. Proportion of total providers contracted to provide ECM or Community Supports that were community-based providers

Data sources: QIMRs; PATH Capacity and Infrastructure Transition, Expansion, and Development (CITED) applications; GuideStar and organizational websites.

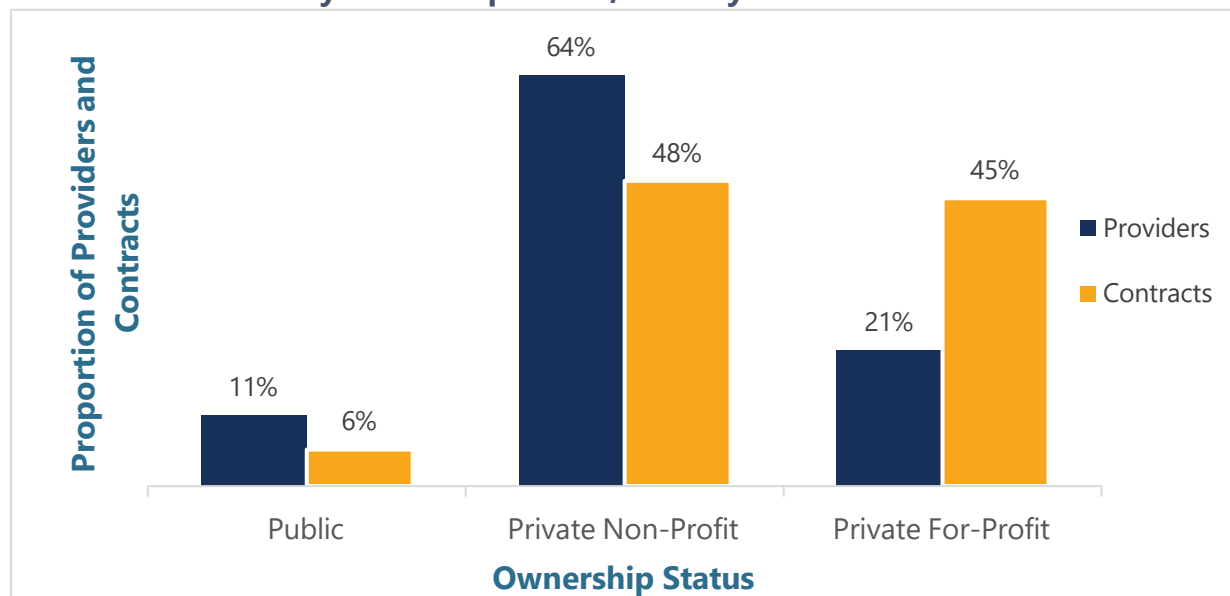
UCLA-RAND was unable to determine community-based providers as defined by DHCS: "a nonprofit organization, governmental agency, or health care provider that has direct experience with the Medi-Cal populations being served within the county in which they

are seeking a contract with a MCP. A community provider is generally embedded in the health care and social services ecosystem in the provider's county." This was because data were not available to determine whether a provider had direct experience with Medi-Cal populations or was embedded in the health care and social services ecosystem of the county. Instead, UCLA-RAND used PATH CITED applications and manually searched GuideStar and organizational websites using provider names from the NPI Registry as of March 2024 to estimate ownership status and attribute for private for-profit, private non-profit, public status to providers. The latter two groups were considered a proxy for CBOs.

A total of 1,566 of the 2,041 unique providers and 4,750 of the 6,299 provider contracts were reported by MCPs as of March 2024. UCLA-RAND could not identify the ownership status of 51 unique providers. Among the rest, data showed that 64% of unique providers were private non-profit, followed by 21% private for-profit, and 11% public ([Exhibit 1.17](#)).

Furthermore, 48% of contracts were to private non-profit providers, followed by 6% to public and 45% to private for-profit providers. The difference in breakdown by ownership status between unique providers and provider contracts is due to the variation in the average number of contracts per unique provider. For example, the average number of contracts for private for-profit providers was 6.4 compared to 1.6 for public providers and 2.3 for private non-profit providers (data not shown).

Exhibit 1.17. Proportion of ECM and Community Supports Unique Providers and Provider Contracts by Ownership Status, January 2022 to March 2024

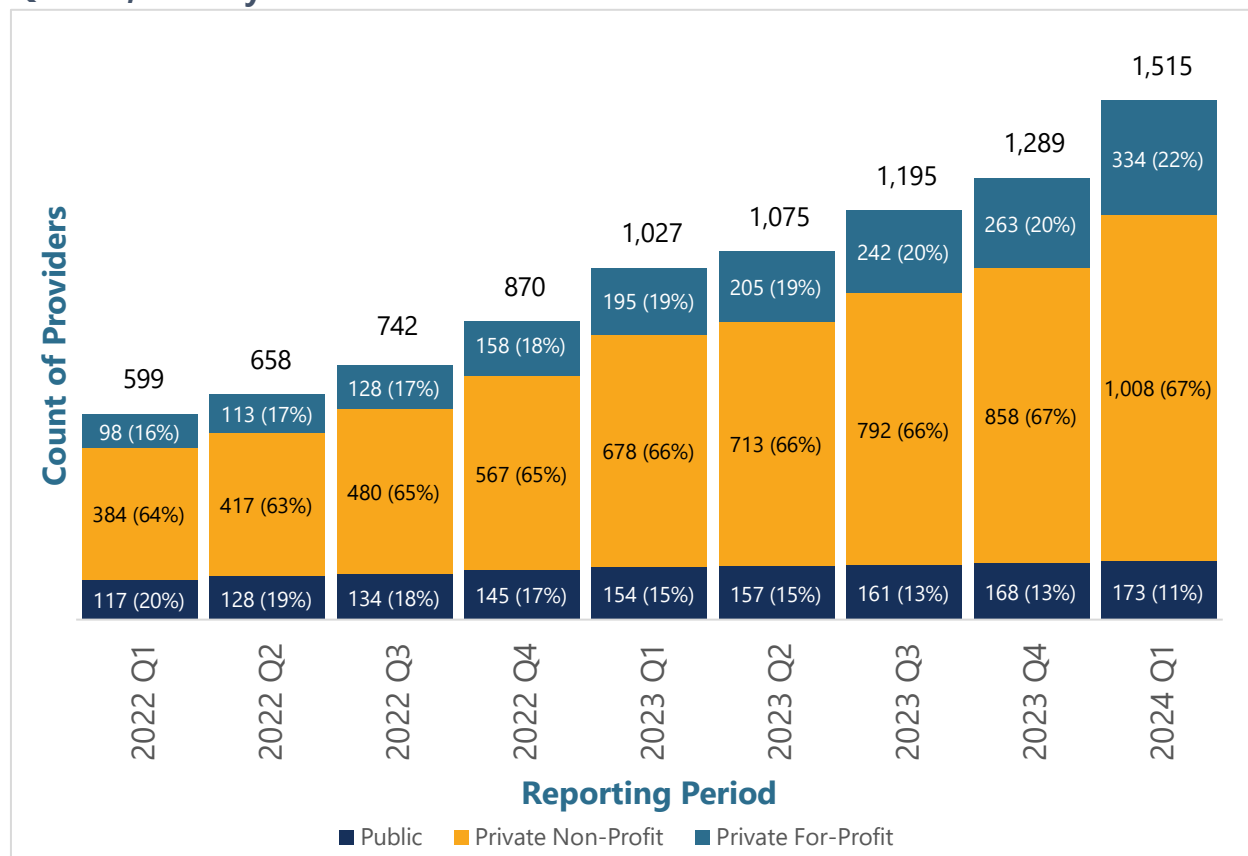


Source: Quarterly Implementation and Monitoring Reports, 2022 Q1 to 2024 Q1.

Note: Data were reported for 1,515 unique providers and 4,684 contracts with known ownership status and excluded 51 providers and 66 contracts with unknown ownership status. Ownership status was determined manually as of March 2024. Data showed the number of unique providers based on NPI and contracts per unique provider and contracted to a specific MCP in each county. The number of providers may be overestimated because some providers may have multiple NPIs. ECM is Enhanced Care Management.

Further examination of ownership status over time showed that the number of providers that were public, private non-profit, and private for-profit had grown over time ([Exhibit 1.18](#)). While the majority of providers were private non-profit, the proportion that were public declined from 20% to 11% and the proportion that were private for-profit providers increased from 16% to 22% from 2022 Q1 to 2024 Q1.

Exhibit 1.18. Number and Proportion of Unique Providers by Ownership Status Per Quarter, January 2022 to March 2024

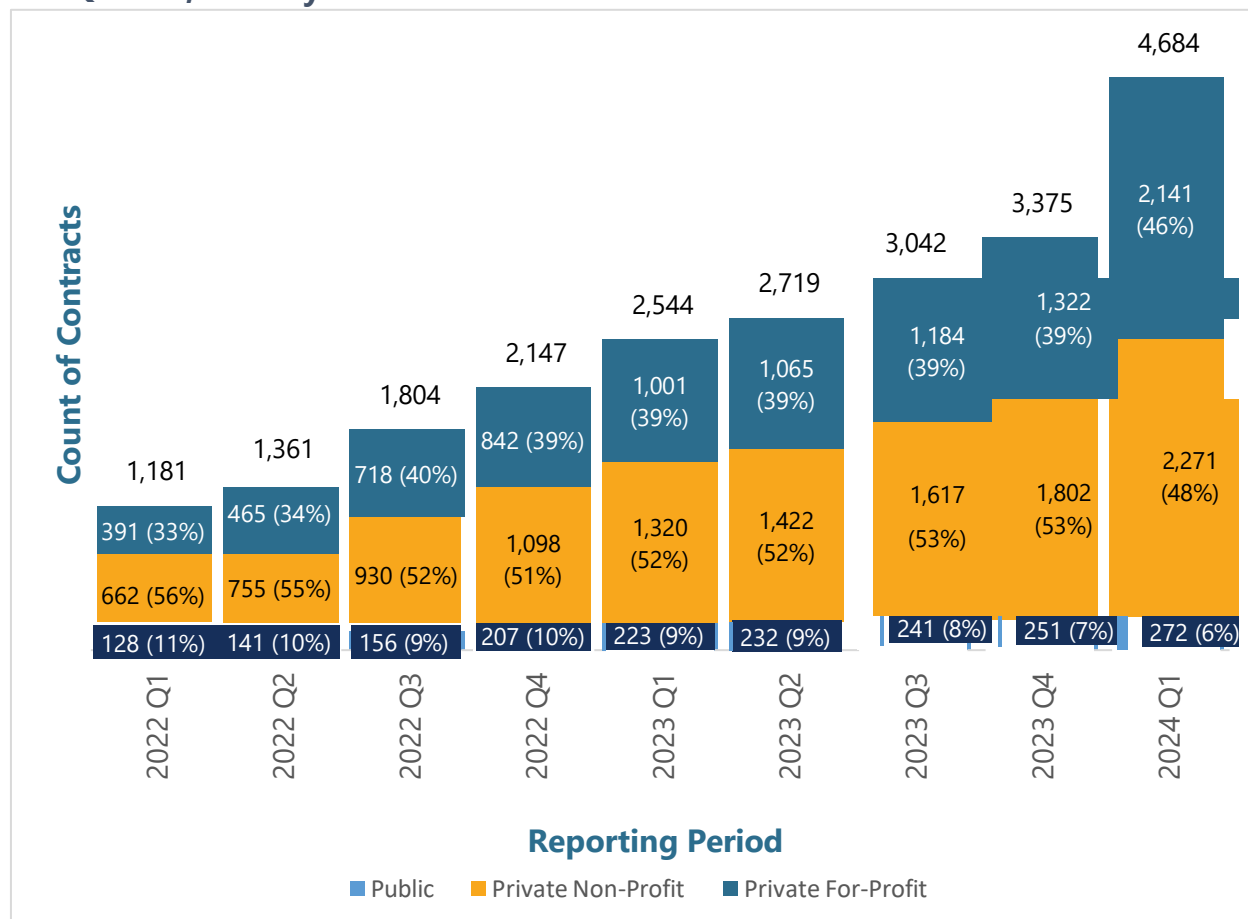


Source: Quarterly Implementation and Monitoring Reports, 2022 Q1 to 2024 Q1.

Note: Data were reported for 1,515 unique providers and 4,684 contracts with known ownership status and excluded 51 providers and 66 contracts with unknown ownership status. Ownership status was determined manually as of March 2024. Data showed the number of unique providers based on NPI and contracts per unique provider and contracted to a specific MCP in each county. The number of providers may be overestimated because some providers may have multiple NPIs.

The number of provider contracts also increased over time but at a greater rate than unique providers ([Exhibit 1.19](#)). These data showed that the proportion of contracts to private non-profit providers and to public providers had declined from 56% to 48% and 11% to 6%, respectively from 2022 Q1 to 2024 Q1. In contrast, the proportion of contracts to private for-profit providers increased from 33% to 46% in the same period.

Exhibit 1.19. Number and Proportion of Provider Contracts by Ownership Status Per Quarter, January 2022 to March 2024



Source: Quarterly Implementation and Monitoring Reports, 2022 Q1 to 2024 Q1.

Note: Data were reported for 1,515 unique providers and 4,684 contracts with known ownership status and excluded 51 providers and 66 contracts with unknown ownership status. Ownership status was determined manually as of March 2024. Data showed the number of unique providers based on NPI and contracts per unique provider and contracted to a specific MCP in each county. The number of providers may be overestimated because some providers may have multiple NPIs.

Measure 3. Proportion of ECM or Community Supports providers located in under-resourced or rural communities

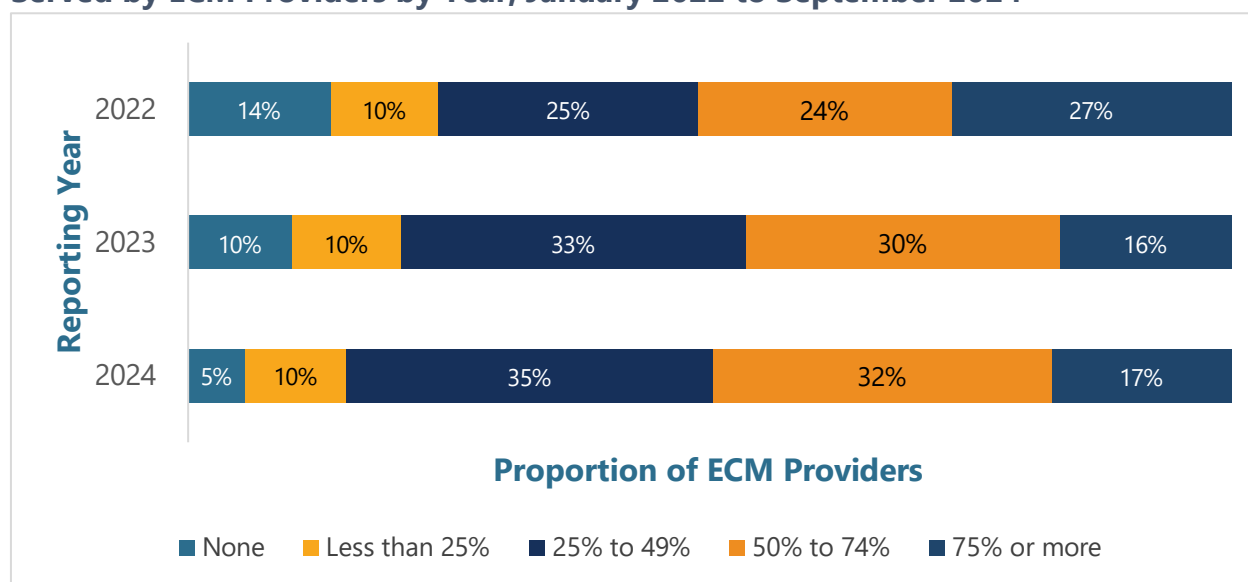
Data sources: QIMRs; Medi-Cal eligibility and claims data; Social Vulnerability Index (SVI).

UCLA-RAND used the ECM providers listed in QIMR data for ECM users, the Medi-Cal eligibility data to identify the ECM users' census tracts through their home addresses, and the 2022 SVI at the census tract level for this measure. UCLA-RAND followed the Centers for Disease Control and Prevention definition of under-resourced status,

defining these as areas in the top quartile of SVI and assigned this status to ECM users as appropriate. UCLA-RAND then determined the proportion of ECM users residing in under-resourced areas per unique ECM provider per year.

[Exhibit 1.20](#) shows that 14% of the ECM providers did not serve any ECM users that resided in under-resourced areas in 2022, but this proportion decreased to 5% in 2024. In turn, the proportion of ECM providers that served 25% to 49% or 50% to 74% of these residents increased in this time frame (25% to 35% and 24% to 32%, respectively).

Exhibit 1.20. Proportion of ECM Users Residing in Under-Resourced Areas and Served by ECM Providers by Year, January 2022 to September 2024

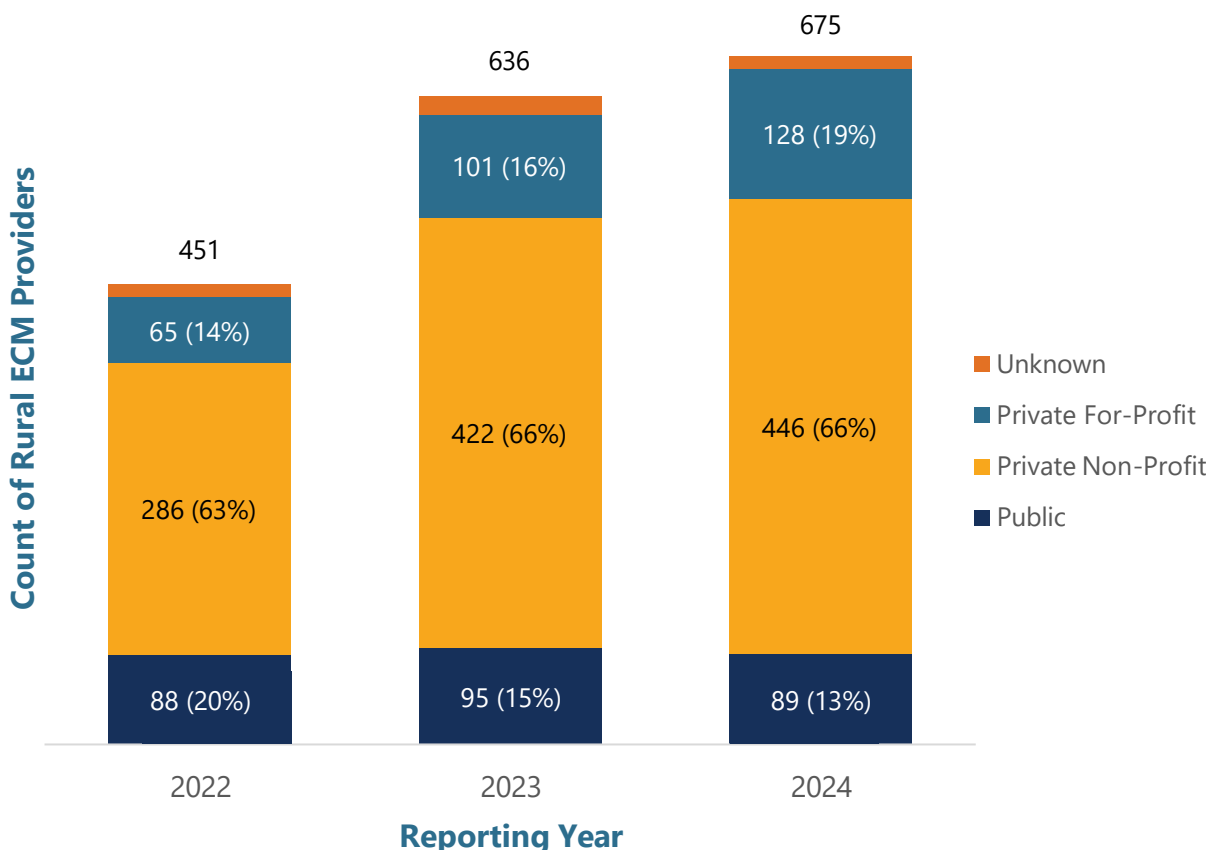


Source: Quarterly Implementation and Monitoring Reports, 2022 Q1 to 2024 Q3; Medi-Cal Eligibility and Claims Data, January 2022 to December 2024; Social Vulnerability Index, 2022.

Note: Data were based on 1,451 unique ECM providers that were reported in QIMRs as member's ECM providers as of September 2024. Residence in an under-resourced area was determined by a member's home address reported to Medi-Cal and included those living in the top quartile of the 2022 Social Vulnerability Index at the census tract level across California. ECM is Enhanced Care Management.

The total number of ECM providers who served at least 25% of ECM users residing in an under-resourced area grew from 451 in 2022 to 675 in 2024 ([Exhibit 1.21](#)). Among these, the proportion that was community-based was measured based on public or private non-profit ownership status. The proportion of these providers that were public declined from 2022 (20%) to 2024 (13%), but the proportion that were non-profit increased from 2022 (63%) to 2024 (66%).

Exhibit 1.21. Number of ECM Providers with 25% or More ECM Residing in Under-Resourced Areas, January 2022 to March 2024



Source: Quarterly Implementation and Monitoring Reports, 2022 Q1 to 2024 Q1; Medi-Cal Eligibility and Claims Data, January 2022 to December 2024; Social Vulnerability Index, 2022.

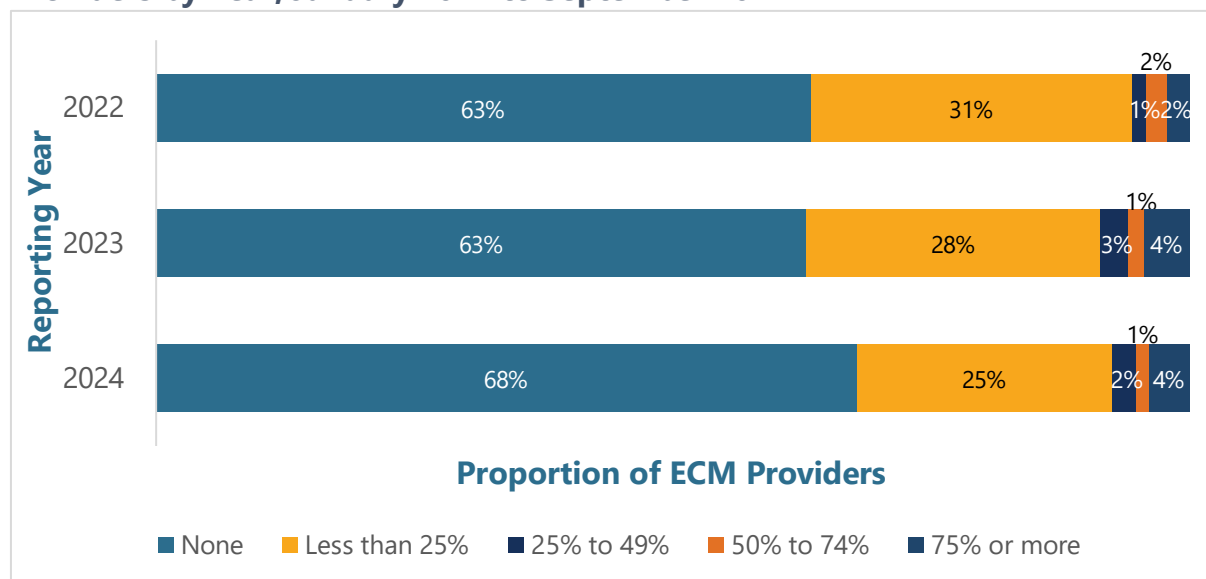
Note: Data were based on 1,017 unique ECM providers that were reported in QIMRs as member's ECM providers as of September 2024 and had been assigned ownership status.

Residence in an under-resourced area was determined by a member's home address reported to Medi-Cal and included those living in the top quartile of the 2022 Social Vulnerability Index at the census tract level across California. Ownership status was determined manually as of March 2024. ECM is Enhanced Care Management.

UCLA-RAND further used the ECM providers listed in QIMR, the Medi-Cal eligibility data, and the rural status of census tracts as defined by the Health Resources and Services Administration to assign 2023 rural status to each ECM user. UCLA-RAND then used these data to determine the proportion of ECM users per unique ECM provider that were rural residents per year. [Exhibit 1.22](#) shows that 63% of ECM providers did not serve any ECM users that were rural residents in 2022, and this proportion increased to 68% in 2024. However, the proportion of ECM providers with less than 25% and greater than 25% rural residents increased in the same period. Specifically, the proportion of

ECM providers with 75% or more rural residents increased from 2% in 2022 to 4% in 2024.

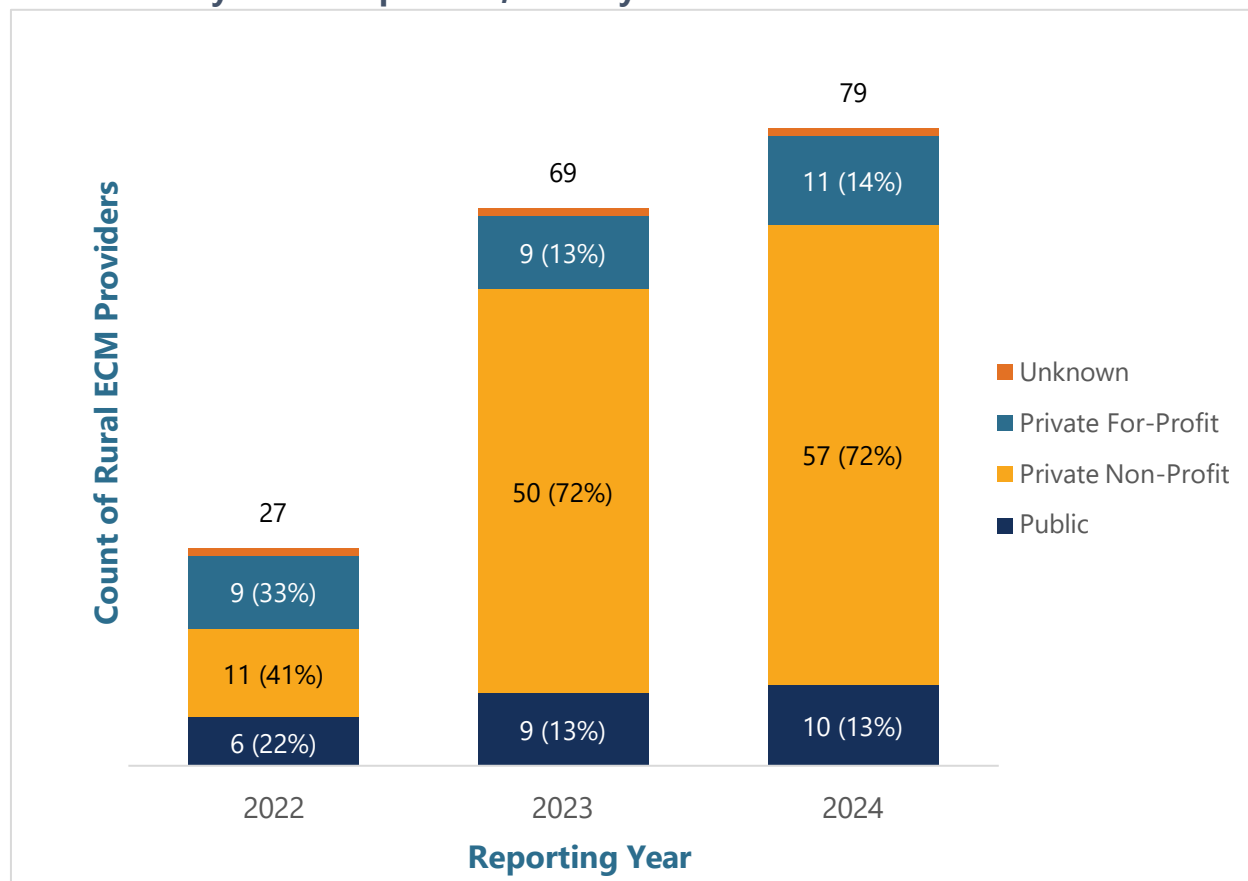
Exhibit 1.22. Proportion of ECM Users Living in Rural Areas Served by ECM Providers by Year, January 2022 to September 2024



Source: Quarterly Implementation and Monitoring Reports, 2022 Q1 to 2024 Q3; Medi-Cal Eligibility and Claims Data, January 2022 to December 2024. ²Note: Data were based on 1,451 unique ECM providers that were reported in QIMRs as member's ECM providers as of September 2024. Rural residence was determined by a member's home address reported to Medi-Cal and was based on the definition of rural defined by the Health Resources and Services Administration using 2023 data.²² ECM is Enhanced Care Management.

The total number of ECM providers who served at least 25% of ECM users residing in rural areas increased from 27 in 2022 to 79 in 2024 ([Exhibit 1.23](#)). Among these, the proportion that was community-based was measured based on public or private non-profit ownership status. The proportion of these providers that were public declined from 22% to 13% and the proportion that were non-profit increased from 41% to 72% from 2022 to 2024.

Exhibit 1.23. Number of ECM Providers with 25% or More ECM Users Residing in Rural Areas by Ownership Status, January 2022 to March 2024



Source: Quarterly Implementation and Monitoring Reports, 2022 Q1 to 2024 Q1; Medi-Cal Eligibility and Claims Data, January 2022 to December 2024.

Note: Data were based on 1,017 unique ECM providers that were reported as member's ECM providers as of March 2024. Ownership status was determined manually as of March 2024. Rural residence was determined by a member's home address reported to Medi-Cal and was based on the definition of rural established by the Health Resources and Services Administration using 2023 data.²² ECM is Enhanced Care Management.

Measures 4 and 5. Number of total providers and community-based providers that applied for and received PATH CITED funding; number of total providers and community-based providers that received Technical Assistance and WPC transition funding; Number of community-based providers that received PATH CITED funding, TA, or WPC transition funds

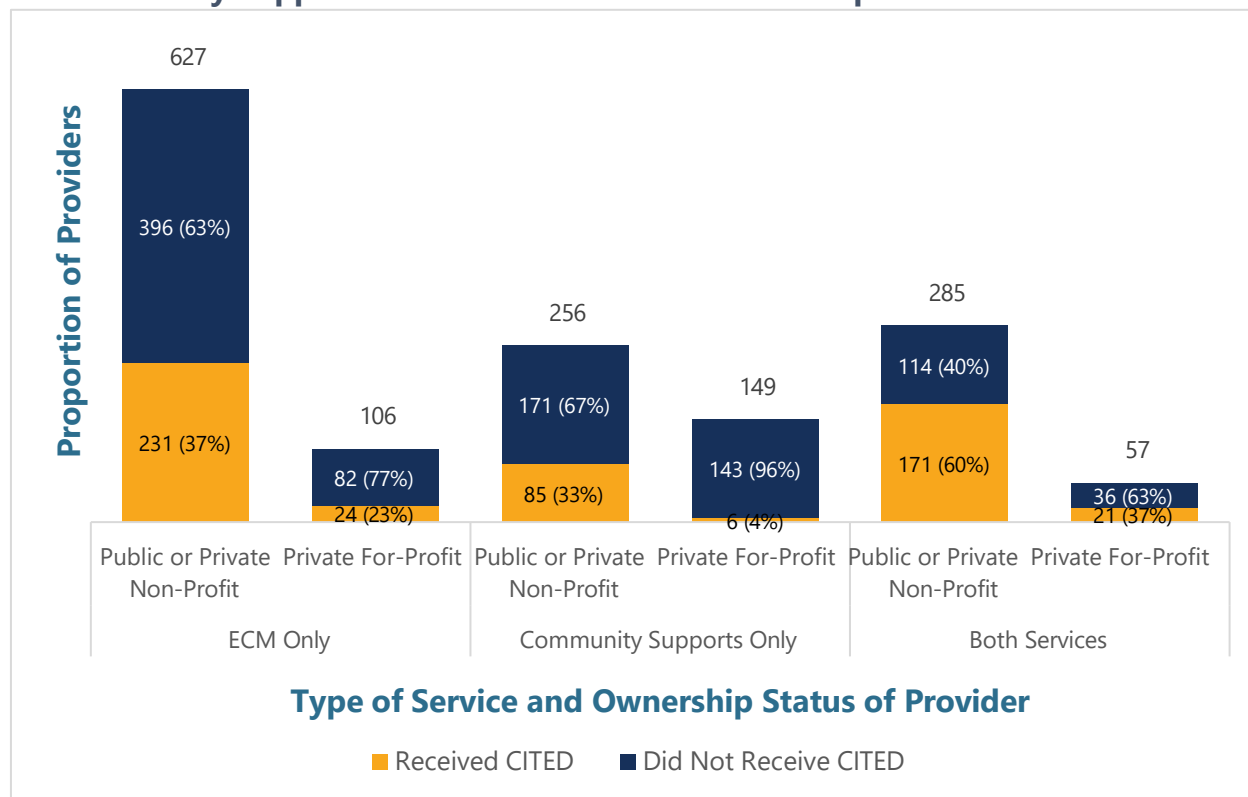
Data source: QIMRs; PATH CITED awardee lists (Rounds 1A, 1B, 2); PATH Technical Assistance (TA) funding awardee lists; 2022 to 2023 Whole Person Care Services and Transition to Managed Care Mitigation (WPC Transition) initiative utilization reports.

UCLA-RAND did not have data on providers that applied for PATH CITED funding. Instead, UCLA-RAND measured the number of contracted providers that had received PATH CITED funding. UCLA-RAND used available data on the first rounds of PATH CITED funding in January 2023 (Round 1A), March 2023 (Round 1B), and October 2023 (Round 2) for this report. Data on Round 3 and Round 4 of PATH CITED funding will be included in the Summative Evaluation Report. UCLA-RAND linked Round 1 and Round 2 awardees with unique providers reported by MCPs, attributed ownership status to providers, and identified the number and proportion of existing contracts that were PATH CITED and TA awardees.

Of the total 1,480 providers with known ownership status as of March 2024, 538 (36%) had received PATH CITED funding. Of those with PATH CITED funding, 487 (91%) were community-based as measured by public or private non-profit ownership status (data not shown).

Among the ECM only providers, 627 were public or private non-profit and 37% of them received PATH CITED funding ([Exhibit 1.24](#)). Among those offering Community Supports only, 256 were public or private non-profit and 33% received PATH CITED funding. Among those offering both ECM and Community Supports, 285 were public or private non-profit and 60% received PATH CITED funding. The proportion of private for-profit ECM and Community Supports providers that received PATH CITED funding was smaller (23%, 4%, and 37% respectively).

Exhibit 1.24. Proportion of Providers that Received PATH CITED Funding by ECM or Community Supports Service Provision and Ownership Status

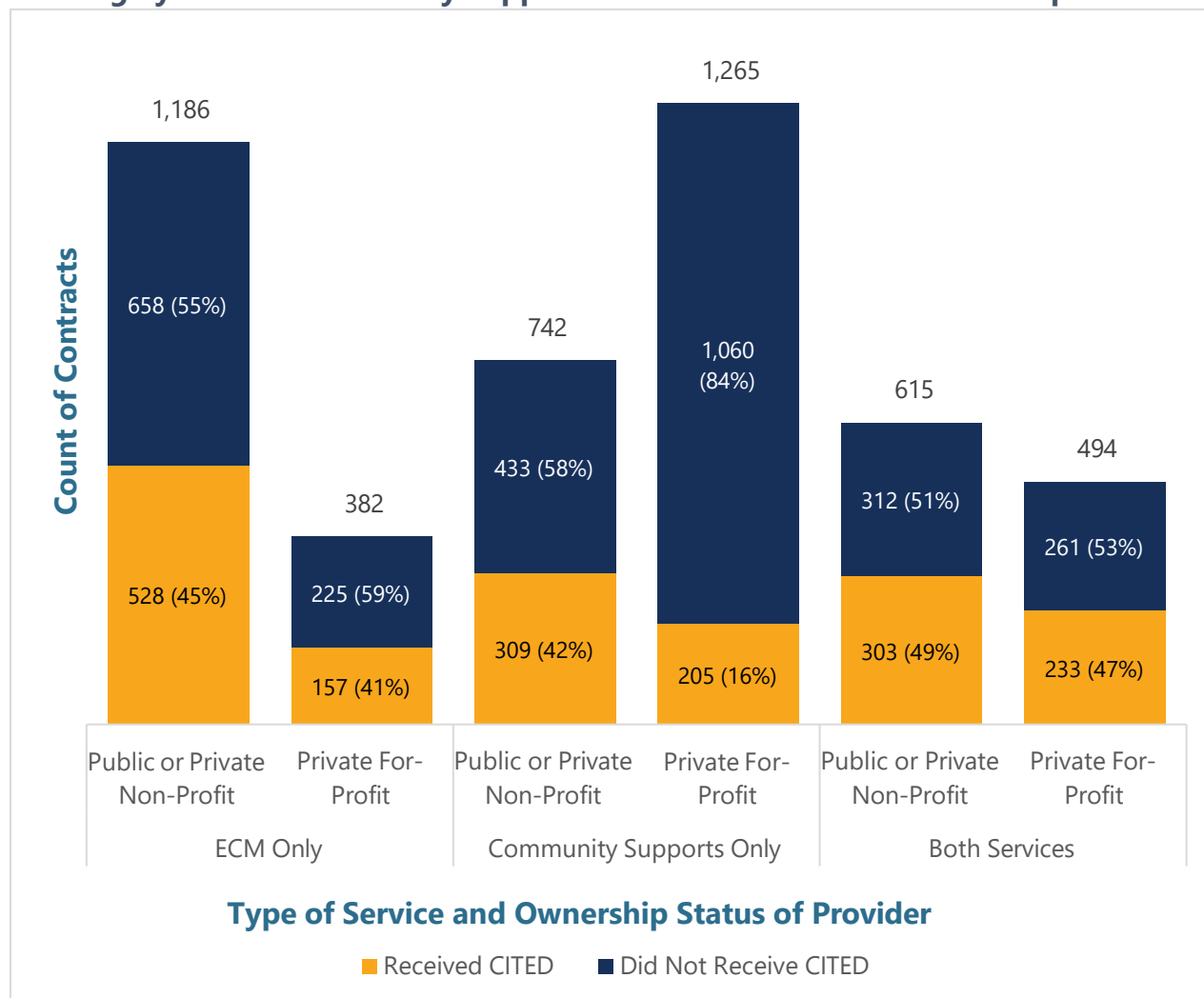


Source: Quarterly Implementation and Monitoring Reports, 2022 Q1 to 2024 Q1; CITED funding was obtained from DHCS website.²³

Note: Data were based on 1,480 providers reported as of March 2024 with known ownership status. Data excluded 51 providers with unknown ownership status. Ownership status was determined manually as of March 2024. Data showed the number of unique providers based on NPI. The number of providers may be overestimated because some providers may have multiple NPIs. Some providers may have delivered both ECM and Community Supports services. ECM is Enhanced Care Management. CITED is Capacity and Infrastructure, Transition, Expansion, and Development. 6 Community Supports providers that were private for-profit received PATH CITED.

MCPs reported a total of 4,750 contracts as of March 2024. Among those offering ECM only or both ECM and Community Supports, the proportion of contracts with providers receiving PATH CITED funding was similar for public or private non-profit providers (45% and 49%, respectively) and private for-profit providers (41% and 47%, respectively; [Exhibit 1.25](#)). Conversely, among contracts offering Community Supports only, 42% of contracts with public or private non-profit providers received PATH CITED funding compared to 16% of contracts with private for-profit providers.

Exhibit 1.25. Proportion of Contracts with Providers that Received PATH CITED Funding by ECM or Community Supports Service Provision and Ownership Status



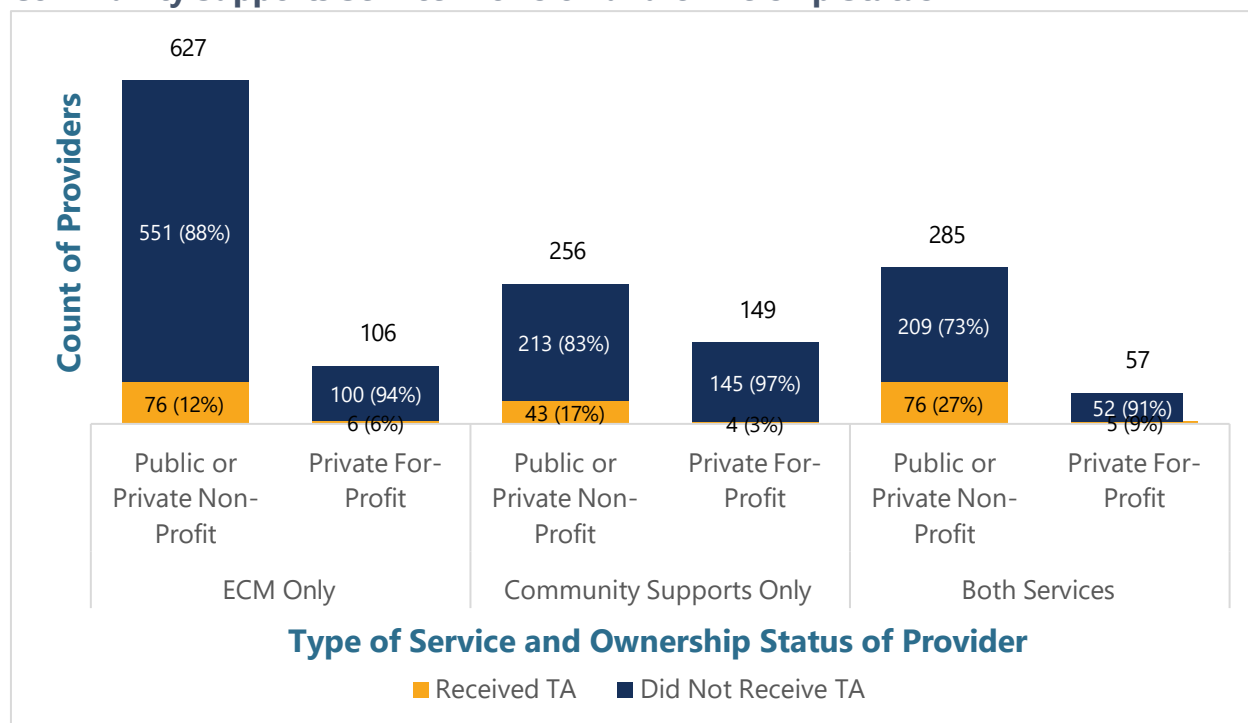
Source: Quarterly Implementation and Monitoring Reports, 2022 Q1 to 2024 Q1; CITED funding was obtained from DHCS website.²³

Note: Data were based on 4,750 contracts as of March 2024 and excluded 66 contracts with unknown provider ownership status. Ownership status was determined manually as of March 2024. Data showed the number of unique providers based on NPI and contracts per unique provider and contracted to a specific MCP in each county. The number of providers may be overestimated because some providers may have multiple NPIs. Some contracts may have included both ECM and Community Supports services. ECM is Enhanced Care Management. CITED is Capacity and Infrastructure, Transition, Expansion, and Development.

Of the total of 1,480 providers with known ownership status as of March 2024, 210 (14%) had received PATH TA. Of those with PATH TA, 195 (93%) were community-based as measured by public or private non-profit ownership status (data not shown).

Among providers offering ECM only that were public or private non-profit, 12% received PATH TA compared to 6% of those that were private for-profit ([Exhibit 1.26](#)). Among those offering Community Supports only that were public or private non-profit, 17% received TA compared to 3% that were private for-profit. Among those offering both services that were public or private non-profit, 27% received TA compared to 9% that were private for-profit.

Exhibit 1.26. Proportion of Providers that Received PATH TA Funding by ECM or Community Supports Service Provision and Ownership Status



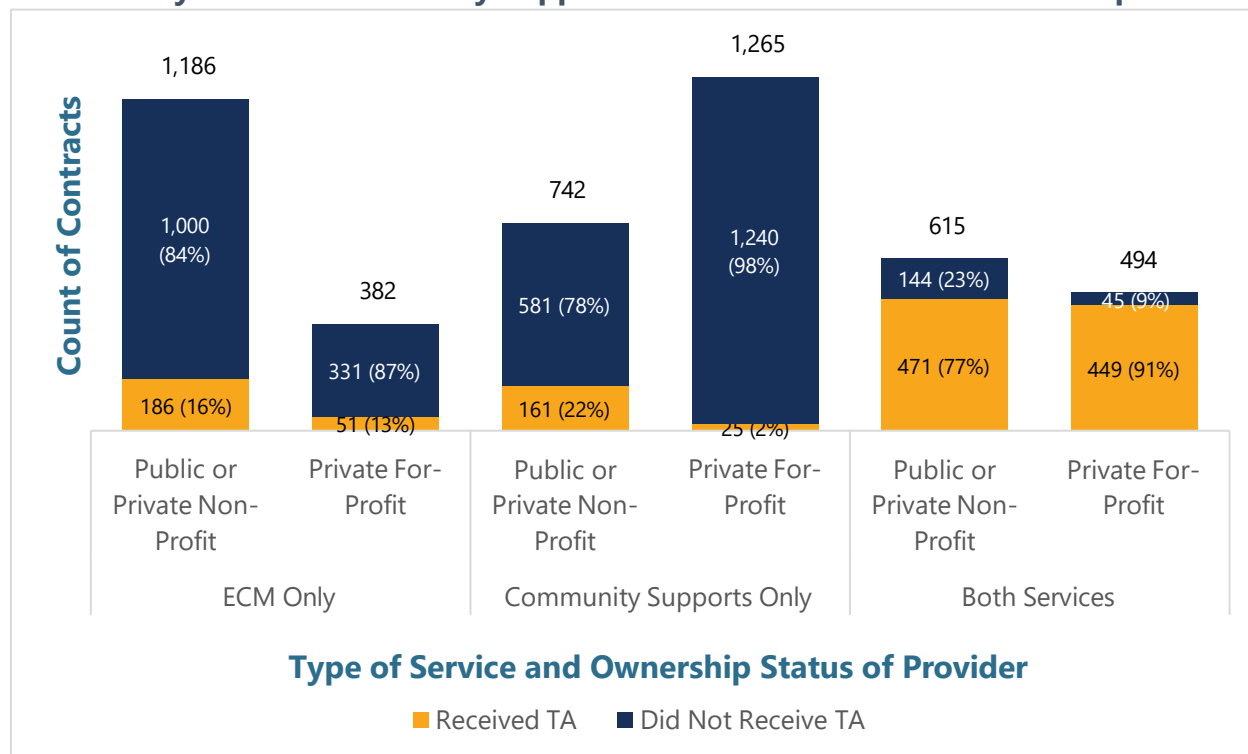
Source: Quarterly Implementation and Monitoring Reports, 2022 Q1 to 2024 Q1; TA funding award announcements were obtained from DHCS.

Note: Data were based on 1,480 providers reported as of March 2024 with known ownership status. Data excluded 51 providers with unknown ownership status. Ownership status was determined manually as of March 2024. Data showed the number of unique providers based on NPI. The number of providers may be overestimated because some providers may have multiple NPIs. Some providers may have delivered both ECM and Community Supports services. ECM is Enhanced Care Management. TA is Technical Assistance. 6, 4, and 5 private for-profit providers that received TA offered ECM only, Community Supports only, or both services, respectively.

Examination of the provider contracts that received PATH TA by provision of ECM or Community Supports services and non-profits or public ownership status showed that similar proportions of provider contracts for ECM only services received PATH TA

whether they had non-profit or public (16%) or for-profit (13%) ownership status ([Exhibit 1.27](#)). Among providers of Community Supports only, contracts with providers that were public or private non-profit were more likely to receive PATH TA compared to contracts with private for-profit providers (22% vs. 2%, respectively). Contracts with providers that provided both ECM and Community Supports were the most likely to receive PATH TA, with 77% of private non-profit or public of contracts receiving PATH TA and 91% of private for-profit receiving PATH TA.

Exhibit 1.27. Proportion of Contracts with Provider Organizations that Received PATH TA by ECM or Community Supports Service Provision and Ownership Status



Source: Quarterly Implementation and Monitoring Reports, 2022 Q1 to 2024 Q1; TA funding award announcements were obtained from DHCS.

Note: Data were reported for 4,750 new contracts as of March 2024 with known ownership status and exclude 51 providers and 66 contracts with unknown ownership status. Ownership status was determined manually as of March 2024. Data showed the number of unique providers based on NPI and contracts per unique provider and contracted to a specific MCP in each county. The number of providers may be overestimated because some providers may have multiple NPIs. Some contracts may have included both ECM and Community Supports services. ECM is Enhanced Care Management. TA is Technical Assistance. 25 private for-profit providers offered Community Supports only.

DHCS promoted the transition of providers from the Whole Person Care (WPC) demonstrations to PATH under the WPC Transition to deliver ECM and Community Supports services. Ten of the 27 WPC lead entities applied for the CalAIM WPC Transition funding to continue providing WPC services following the end of WPC in December 2021 ([Exhibit 1.28](#)). Seven of ten WPC lead entities used the funds in 2022 only despite availability of funds through December 2024.

Exhibit 1.28. Whole Person Care Lead Entities That Received PATH Whole Person Care Transition Funding and the Duration Services Were Provided

County	Timeframe
Alameda	January 2022 to December 2023
Contra Costa	January to June 2022
Kern	October to December 2022
Los Angeles	January 2022 to December 2023
Orange	October to December 2022
Placer	April 2022
Riverside	January to December 2022
San Francisco	January 2022 to December 2023
Santa Clara	January to June 2022
Shasta	January to December 2022

Source: Whole Person Care Services and Transition to Managed Care Mitigation Initiative Utilization Reports, January 2022 to December 2023.

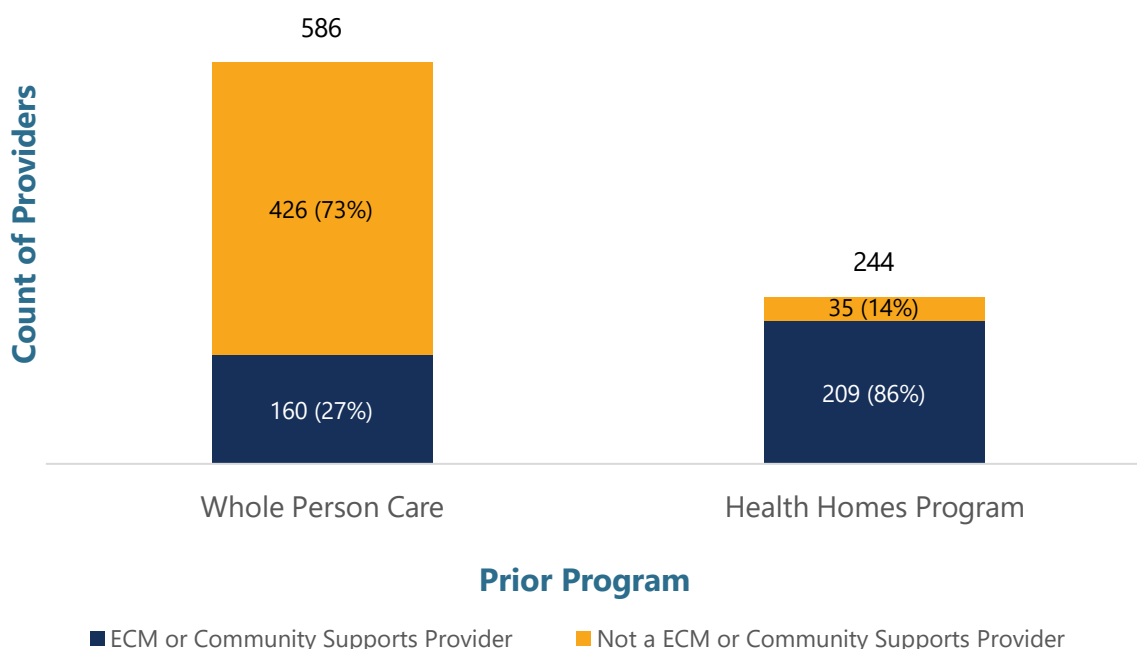
Measure 6. Proportion of providers that provided services under WPC or HHP and were subsequently contracted to provide ECM and Community Supports

Data sources: QIMRs; 2022 WPC evaluation; 2023 Health Homes Program (HHP) evaluation.

WPC was implemented in 27 counties by lead entities, which were typically county health and health services agencies. HHP was operated by MCPs in 12 counties. Data from the evaluations of WPC and HHP along with QIMR data were used to report the proportion of ECM or Community Supports providers that transitioned under CalAIM from WPC or HHP. Of the 586 WPC providers, 27% transitioned to CalAIM by contracting with MCPs to provide ECM or Community Supports services ([Exhibit 1.29](#)). In contrast, of the 244 HHP providers, 86% transitioned to CalAIM. Some of these

providers were providers under both WPC and HHP. Therefore, of the 1,566 providers reported by MCPs in QIMRs through March 2024, 329 or 21% were previously providers under WPC and/or HHP (data not shown).

Exhibit 1.29. Proportion of Whole Person Care and Health Homes Program Providers that Transitioned to ECM or Community Supports Providers as of March 2024



Source: Quarterly Implementation and Monitoring Reports, 2022 2022 Q1 to 2024 Q1; Final Evaluation of California's Whole Person Care (WPC) Program, 2022; Final Evaluation of California's Health Homes Program (HHP), 2023.^{2,12}

Note: WPC data included providers participating as of March 2020 and HHP data included providers participating as of December 2021. ECM is Enhanced Care Management.

Evaluation Question 2: What factors are associated with community-based providers' participation in ECM or Community Supports?

Evaluation Question 2 is addressed by analysis of three measures articulated in the PATH Evaluation Design and displayed in the [Evaluation Questions and Hypotheses](#) section of this report. The data sources used for the analyses are noted for each measure. Further detail on data sources and methods is included in the [Methodology](#) section.

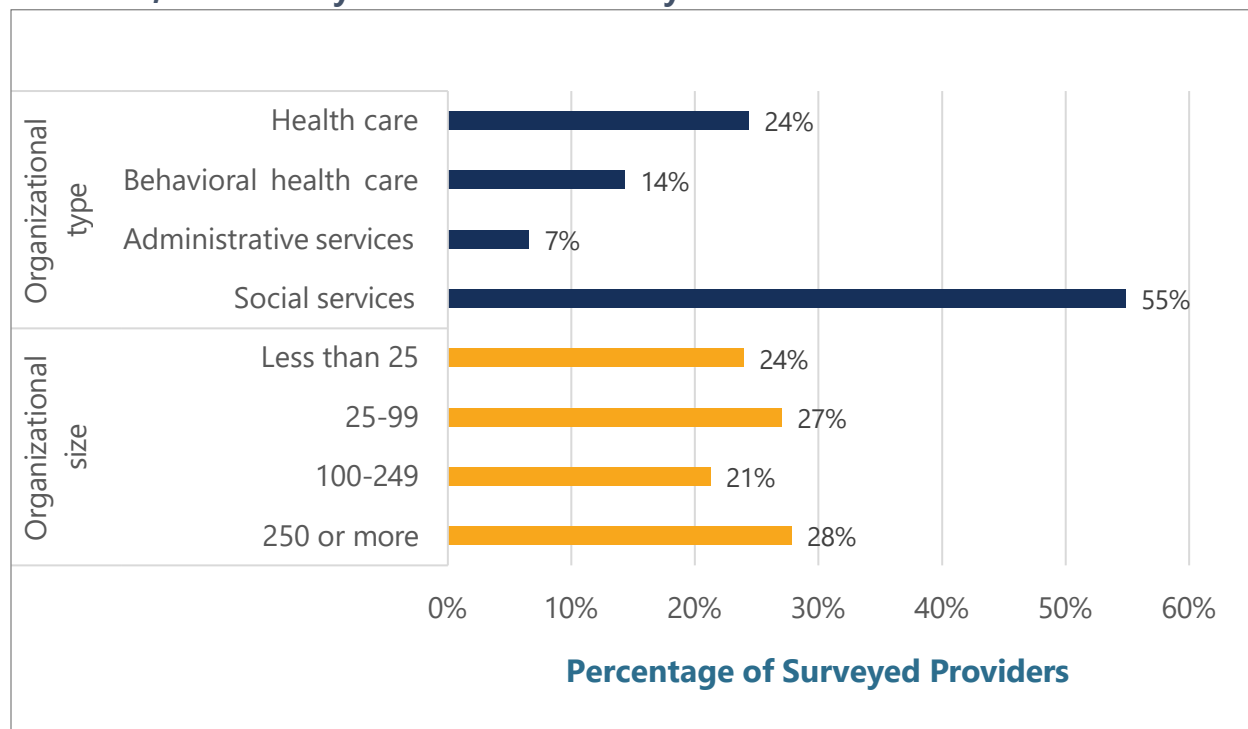
Measure 1. Characteristics of providers eligible to provide ECM or Community Supports

Data source: June to July 2025 provider survey.

UCLA-RAND did not have data on eligible providers that were not contracted for ECM and Community Supports services. However, data on ownership status of providers, provision of ECM vs. Community Supports, provision of ECM by POF, and provision of specific Community Supports are provided in [Evaluation Question 1 Measure 2](#) based on QIMRs. UCLA-RAND included additional information on the type and size of contracted providers from the provider survey for this measure.

[Exhibit 1.30](#) shows that most survey respondents were social services providers (55%), followed by health care (24%) and BH (14%) providers. Provider size was measured by full-time equivalent (FTE) staff and most respondents had 250 or more (28%) and fewest (21%) had 100-249 FTEs.

Exhibit 1.30. Characteristics of ECM and Community Supports Contracted Providers, June to July 2025 Provider Survey



Source: ECM and Community Supports Provider Survey, June to July 2025.

Note: Data were based on 259 unique respondents. Health care providers included hospitals, health care systems, federally qualified health centers, and other health clinics. BH providers included organizations treating mental health and SUDs. Social services providers included CBOs offering social supports, medically tailored meals and food providers, and housing and shelter organizations. Provider size was measured by full-time equivalent (FTE) staff.

Measure 2. 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

Data sources: QIMRs; Uniform Data System data; list of Continuum of Care providers; list of providers that participated in WPC or HHP.

No results were reported for Measure 2 in the Interim Evaluation Report but will be included in the Summative Evaluation Report for a subset of providers. This was because data on eligible providers was not available. See the [Methodological Limitations](#) for further detail.

Measure 3. PATH-participating providers' self-reported reasons for participating in PATH and their perceptions of PATH's role in helping them successfully contract with MCPs to provide ECM and Community Supports

Data sources: October 2024 to July 2025 provider interviews; January to April 2025 PATH Collaborative Planning and Implementation (CPI) Initiative and PATH TA Marketplace vendor facilitator interviews; July to September 2024 MCP interview; June to July 2025 provider survey; November 2024 to January 2025 MCP survey.

Key reasons for provider participation in ECM and Community Supports

Prior experience offering similar services. Providers noted that participation in ECM and Community Supports was a low-risk investment that aligned well with their existing services such as case management services and medically tailored meals. Those previously participating in WPC or HHP viewed ECM and Community Supports as a natural extension of existing work and felt they could leverage existing relationships and infrastructure to ease the transition. In the provider survey, 33% of providers reported prior experience providing ECM and Community Supports services in all counties they were contracted to provide ECM and Community Supports in and for all contracted services, while another 32% had experience in some of the counties they were contracted to provide services in and/or for some of the contracted services (data not shown).

Prior experience contracting with MCPs. Providers noted that lack of prior experience contracting with MCPs was a considerable barrier and providers new to such contracting felt they were held to high and inflexible expectations. Even WPC providers with robust prior relationships with MCPs noted that their transition was smooth when WPC lead entities agreed to serve as administrative hubs to navigate contracting and billing on their behalf. In contrast, HHP providers and medical and BH providers reported fewer challenges contracting with MCPs. Providers described the contracting process taking five to eight months and being administratively burdensome. Some reported poor communication and responsiveness from MCPs that required going through multiple channels just to identify and the problem was compounded by frequent staff turnover at MCPs. Providers also noted additional challenges when contracting with multiple MCPs because they faced different rates, payment models, requirements, and expectations. One provider described it as a "tremendous" amount of work. Smaller providers found this a greater burden because they had fewer resources to dedicate towards MCP communication. These challenges were reported as reasons for fewer contracts or discontinued contracts despite ongoing community need.

Existing data sharing infrastructure. Providers with existing data sharing infrastructure such as federally qualified health centers were often already connected to

local Health Information Exchanges and were familiar with data exchange prior to ECM and Community Supports. In contrast, providers without established infrastructure or electronic systems to support data collection, reporting, and care coordination found it “daunting” and “administratively burdensome” to develop such infrastructure.

Revenue diversification and financial sustainability. In interviews, providers also considered CalAIM as an opportunity to diversify their revenue sources and promote financial sustainability. However, providers weighed the pros and cons of participation. For example, some providers considered the provision of ECM as a lower risk than Community Supports because it was perceived as a permanent benefit. Providers were also concerned about the adequacy of rates given the administrative workload for compliance and reporting. Smaller non-profit providers were more risk-averse because they had to invest in new claim processing and billing infrastructure without knowing if they could recoup those costs through provision of services. Some providers noted that services such as environmental accessibility adaptations and housing deposits did not cover overhead or administrative expenses and, therefore, they discontinued them.

[Exhibit 1.31](#) provides illustrative quotes to further highlight the reasons for ECM and Community Supports participation.

Exhibit 1.31. Factors Influencing Provider Participation in ECM or Community Supports, Illustrative Quotes from Provider Interviews

Factor Affecting Participation	Illustrative Quotes
Prior experience offering similar services	<i>“Organizations see the activities they’re already doing reflected in the services now reimbursable through Medi-Cal.” - CPI facilitator #1</i> <i>“The mission and the people we’re serving [in our ECM POF] ... are already the clientele we’re serving, ... We saw an opportunity to really wrap services around people we were already serving” - Provider #45</i>
Prior experience contracting with MCPs	<i>“We had experience working with health plans [through HHP], but [under ECM] we just moved to directly working with them, and ... dealing with some of the reimbursement challenges, and how to use their system.” - Provider #39</i> <i>“We had some experience ... providing recuperative care and contracting with the health plans ... and doing billing</i>

Factor Affecting Participation	Illustrative Quotes
	<i>with them, which helped us establish the relationships that we would need when CalAIM came out and develop some of the infrastructure and experience” - Provider #2</i>
Existing data sharing infrastructure	<i>“We were lucky to start out because... we'd actually gotten a grant ... [in 2021] to build our own internal database system, ... we were able to pair that pretty quickly with the start of our housing navigation services ... If we didn't have that already up and running to some degree, I don't think we would have been able to do as well as we did early on.” - Provider #9</i>
Revenue diversification and financial sustainability	<i>“I think everyone is feeling the call to think about diverse funding sources and braided funding. I think that a lot of organizations participate because they see value in drawing down state and Medi-Cal dollars to support their existing work.” - CPI facilitator #1</i> <i>“We just knew we were going to roll into ECM... Senior leadership’s big question was “could we afford to?” because the payment model was so different [from WPC]” - Provider #59</i> <i>“We've always known that we just want to get out of the grant game, and we need a long-term source of revenue to kind of operate it as a social enterprise, ... it was always about ... integrating our program into the healthcare sector so that it could be issued as a covered benefit.” - Provider #57</i>

Source: ECM and Community Supports Provider Interviews, October 2024 to July 2025; PATH CPI Facilitator and PATH TA Marketplace Vendor Interviews, January to April 2025.

Note: Data were based on 73 unique respondents.

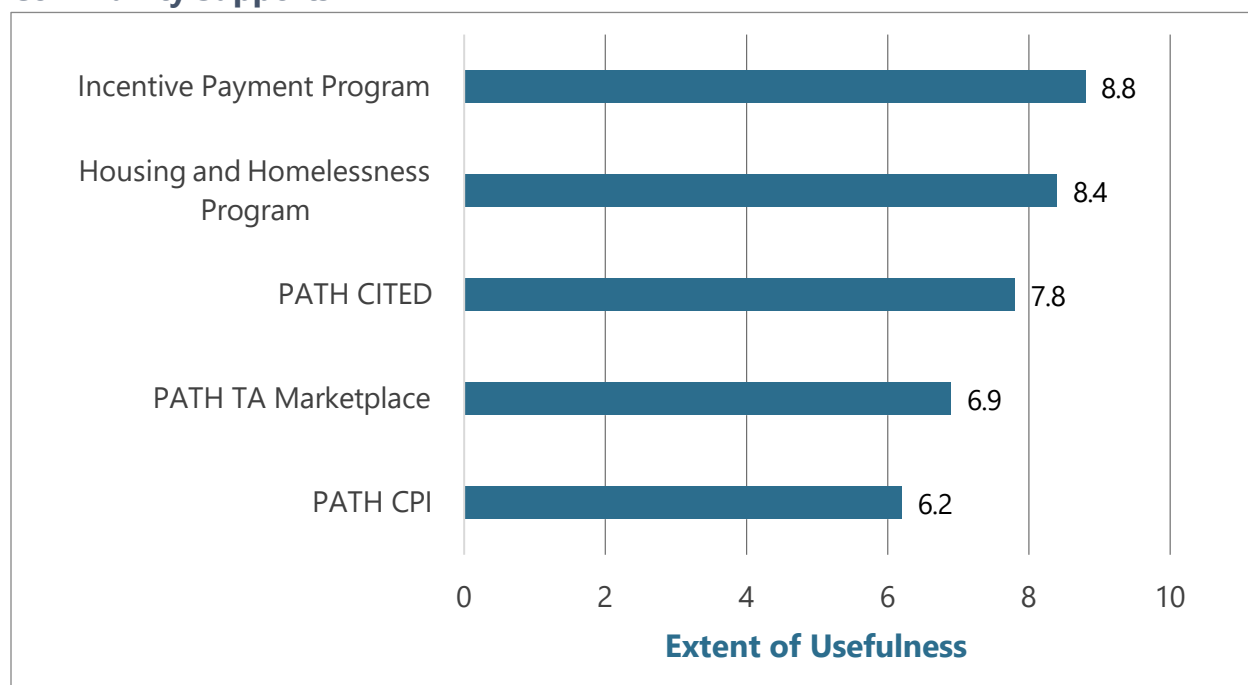
Perceptions of PATH's Role in Contracting with MCPs and Providing ECM and Community Supports

During interviews, providers emphasized the necessity of PATH's financial and technical support to successfully integrate with existing Medi-Cal systems. Several CPI facilitators mentioned that most of their earlier collaborative sessions were spent preparing providers for contracting, introducing CalAIM, and providing various tools and information necessary for contracting. Providers noted the value of dedicated PATH CPI sessions in which providers who had successfully contracted with MCPs presented on their processes and successes, the opportunity to discuss challenges related to MCP communication and responsiveness in early contracting phases and facilitated opportunities for providers to speak face-to-face with MCPs about the contracting process. Providers also noted that PATH CPI assisted them in understanding CalAIM and managed care requirements and effectively and efficiently leveraging of available PATH resources.

Providers further emphasized the importance of PATH CITED funding in building staffing and technology infrastructure and in meeting contracting and implementation criteria. Providers and TA Marketplace vendors also shared that the "off-the-shelf" videos on the PATH TA Marketplace were useful for providers to start the process and find some inspiration; then as providers progress in implementation, they can work with a vendor for individually tailored projects to continue to build out and improve their service and care delivery.

In addition to providers, MCPs rated the contribution of PATH and other initiatives to supporting provider contracting in surveys from not at all useful (0) to extremely useful (10). MCPs average rating was highest for the IPP (8.8) and lowest for PATH CPI (6.2; [Exhibit 1.32](#)).

Exhibit 1.32. Managed Care Plans' Perceived Usefulness of PATH and Managed Care Plan-Administered Resources for Providers' Ability to Contract for ECM and Community Supports



Source: Managed Care Plan Survey, November 2024 to January 2025.

Note: Data were based on 22 unique respondents out of 24 MCPs eligible to offer Community Supports in 2024. One MCP that fully delegated responsibility for member care to another MCP did not respond to the survey. CITED is Capacity and Infrastructure Transition, Expansion and Development. TA is Technical Assistance. CPI is Collaborative Planning and Implementation.

In interviews, MCPs further noted that PATH CITED funding was useful for providers to invest in administrative and data capabilities and to hire new staff to expand service offerings. However, some MCPs shared that it felt counterintuitive to require MCPs to provide a letter of support for PATH CITED applications attesting they intended to contract with a provider since PATH CITED was meant to help providers develop capacity to contract. MCPs also viewed PATH CPI as helpful in developing tools to standardize providers' processes and leveraging shared learning to elevate best practices. However, MCPs noted that information varied across collaboratives and was sometimes discussed prematurely to DHCS finalizing and releasing decisions and guidance, which caused confusion. One MCP perceived that PATH CPI was not particularly helpful in getting new providers to contract for services and more emphasis should be placed on funding (e.g., PATH CITED, IPP) and the PATH TA Marketplace. MCPs also commented that the PATH TA Marketplace was helpful but underutilized largely due to its non-user-friendly interface.

In addition, surveyed providers were asked to rate how challenging it was to implement ECM and Community Supports from not at all challenging (0) to extremely challenging (6) in the survey. Providers were asked to rate payment and reimbursement challenges, administrative burden challenges, and authorization challenges. [Exhibit 1.33](#) shows that, among payment and reimbursement challenges, providers rated inadequate payment rates as most challenging (average rating of 3.7 for ECM and Community Supports) and rated claims denials as less challenging (average rating of 2.6 for ECM and Community Supports). Among administrative burden challenges, providers reported excessive reporting and documentation (3.5 for ECM, 3.2 for Community Supports), variability in MCP requirements (3.4, 3.4), and changes in DHCS policy guidance (3.3, 3.4) as more challenging than avoiding service duplications (2.9, 2.4) and executing or managing contracts with MCPs (2.6, 2.7). Providers rated authorization as less challenging, but ratings were somewhat higher for Community Supports than ECM to get services authorized (3.0 vs. 2.5) or re-authorized (3.0 vs. 2.3).

Exhibit 1.33. Provider Ratings of Challenges Providing ECM and Community Supports



Source: ECM and Community Supports Provider Survey, June to July 2025.

Note: Data were based on 243 unique respondents and excluded 16 respondents who did not answer this question. Providers were categorized as ECM or Community Supports based on whether they reported providing that service, regardless of whether they also provided the other. ECM is Enhanced Care Management. MCP is Managed Care Plan.

Evaluation Question 3: Did PATH increase utilization of ECM and Community Supports?

Evaluation Question 3 is addressed by analysis of five measures articulated in the PATH Evaluation Design and displayed in the [Evaluation Questions and Hypotheses](#) section of

this report. The data sources used for the analyses are noted for each measure. Further detail on data sources and methods is included in the [Methodology](#) section.

Measure 1. Proportion of eligible Medi-Cal members that used ECM and Community Supports services

Data sources: QIMRs; Medi-Cal eligibility and claims data.

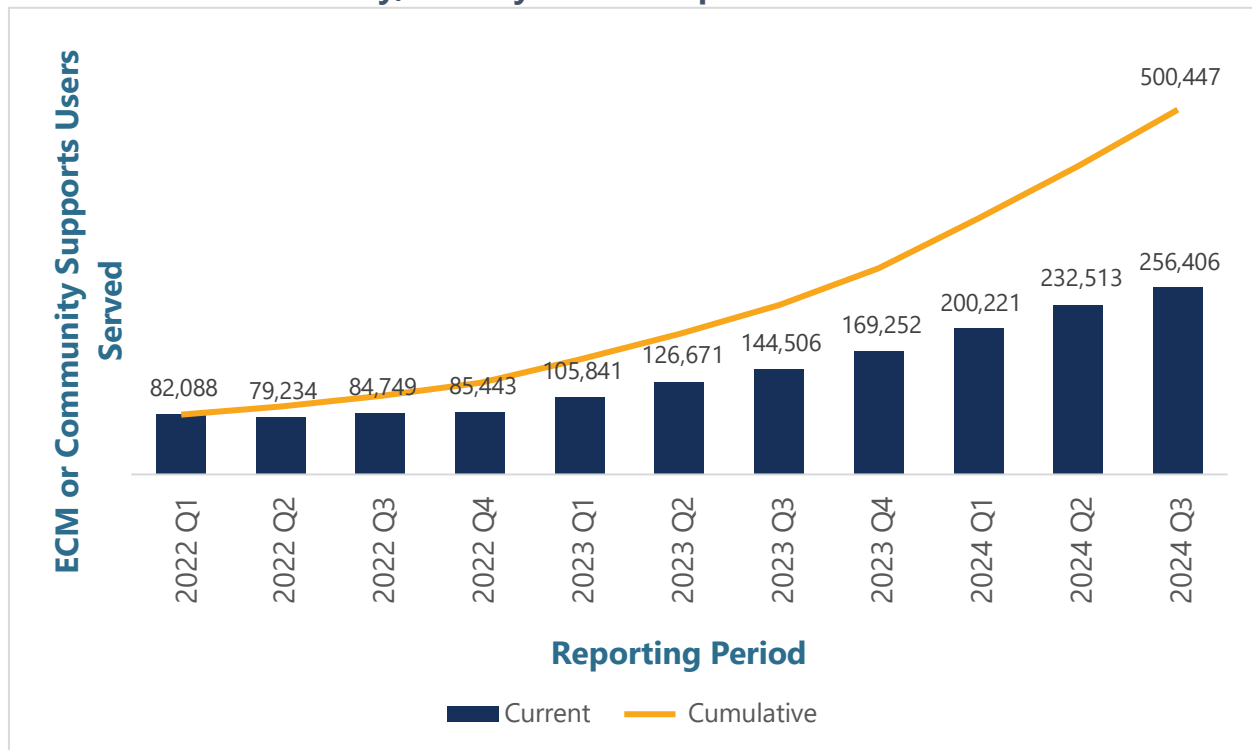
No results were reported for Measure 1 in the Interim Evaluation Report but will be included in the Summative Evaluation Report. This was because of delays in availability of Medi-Cal eligibility and claims data and the additional time that was required to accurately identify ECM and Community Supports eligible members who did not use these services. See the [Methodological Limitations](#) for further detail.

Measure 2. Number and type of ECM and Community Supports services used

Data sources: QIMRs; provider ownership status.

UCLA-RAND used the QIMR data and community-based provider status as measured by public or private non-profit ownership status for this measure. [Exhibit 1.34](#) shows that the number of unique ECM or Community Supports users increased per quarter from 82,088 in 2022 Q1 to 256,406 in 2024 Q3. The total number of ECM or Community Supports users who were ever served under PATH reached 500,447 in 2024 Q3.

Exhibit 1.34. Total Number of Unique ECM and Community Supports Users Per Quarter and Cumulatively, January 2022 to September 2024

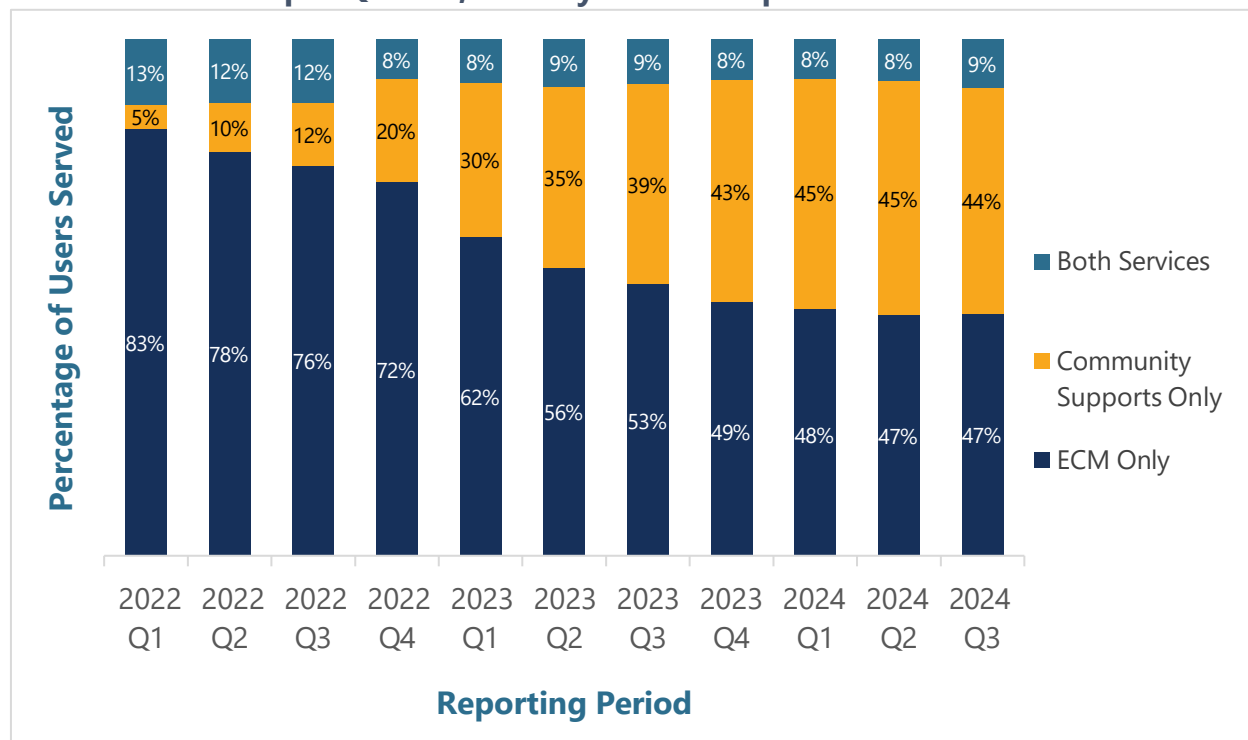


Source: Quarterly Implementation and Monitoring Reports, 2022 Q1 to 2024 Q3.

Note: Data showed the number of unique users. Current shows the total number of ECM or Community Supports users per quarter. Cumulative shows the total number of users who ever received ECM or Community Supports between 2022 Q1 and 2024 Q4. ECM is Enhanced Care Management.

[Exhibit 1.35](#) shows that in 2022 Q1, most users were receiving ECM (83%) services only, followed by both services (13%). By 2024 Q3, 47% of users were receiving ECM only, followed by 44% receiving Community Supports only and 9% receiving both services.

Exhibit 1.35. Proportion of ECM and Community Supports Users by Type of Services Received per Quarter, January 2022 to September 2024



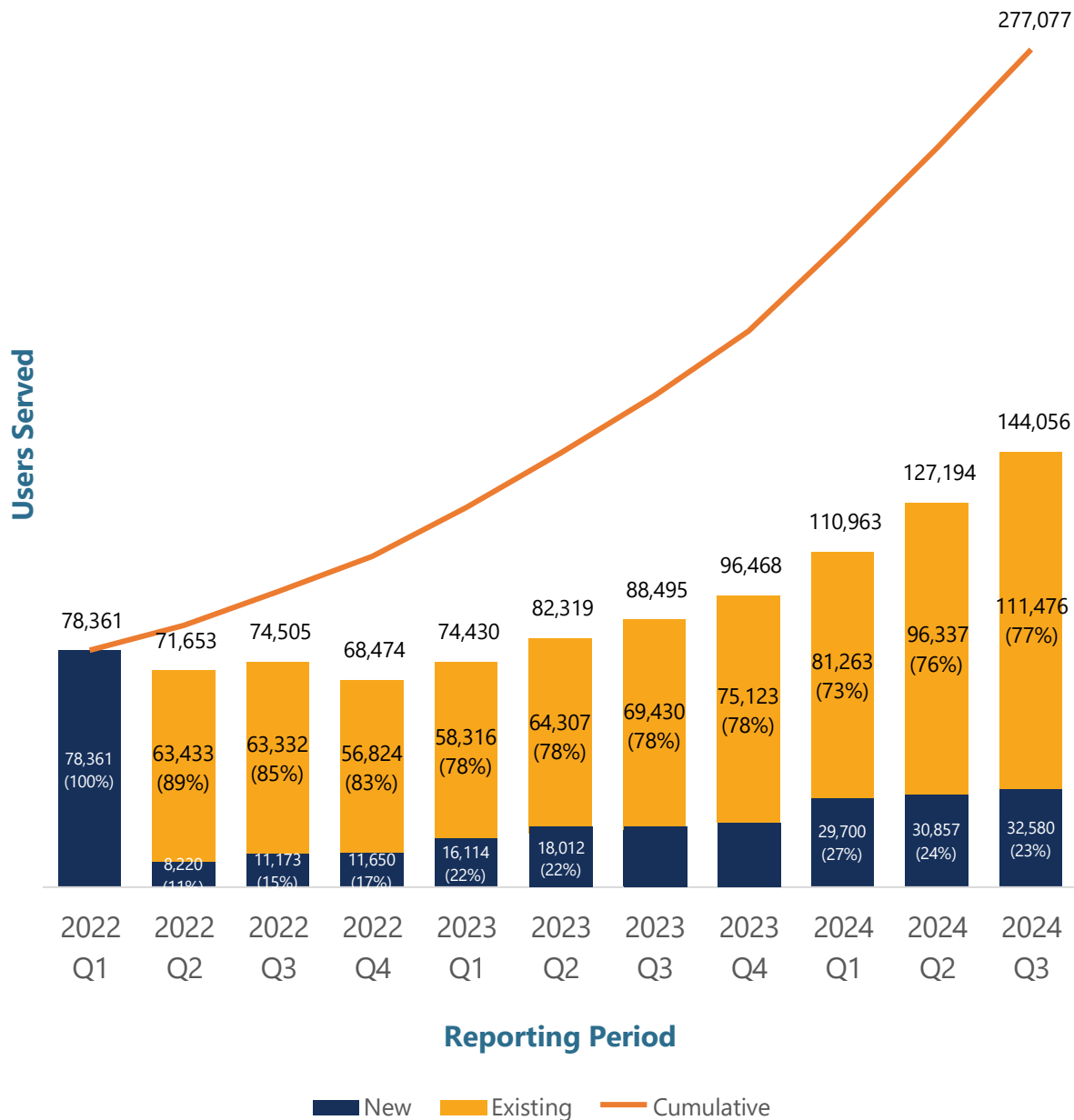
Source: Quarterly Implementation and Monitoring Reports, 2022 Q1 to 2024 Q3.

Note: Data were based on 547,503 unique users. Percents may not add to 100% due to rounding error. ECM is Enhanced Care Management.

ECM Users

[Exhibit 1.36](#) shows that the number of unique ECM users increased from 78,361 in 2022 Q1 to 277,077 in 2024 Q3. Many ECM users transitioned from WPC and HHP at the start of 2022 Q1. Following that transition, the proportion who newly used ECM each quarter increased from 11% in 2022 Q2 to 23% in 2024 Q3. The patterns of new enrollment reflect the phased implementation of ECM by POFs as shown in [Exhibit 1.2](#).

Exhibit 1.36. Current and Cumulative Number of ECM Users by Quarter, January 2022 to September 2024



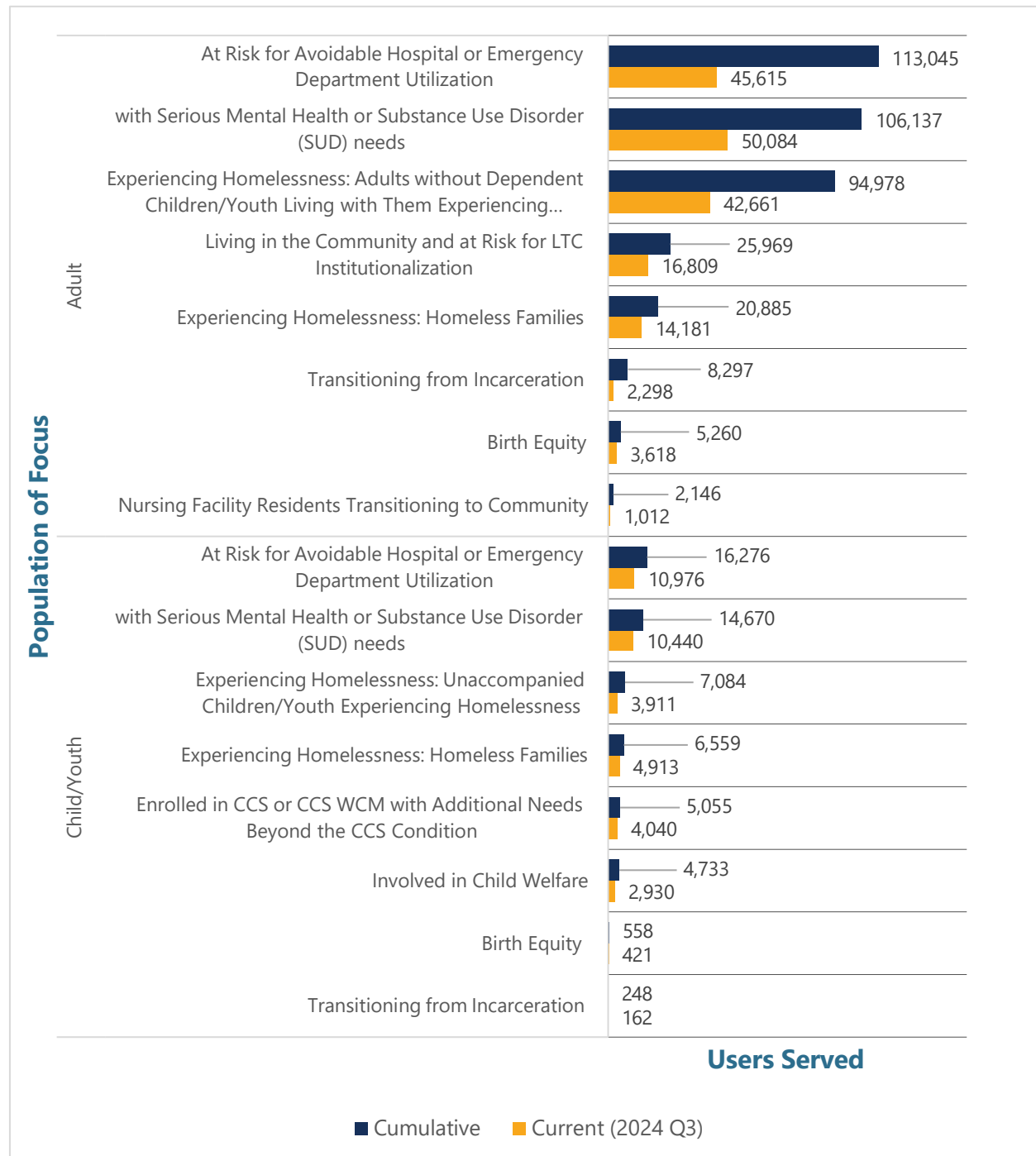
Source: Quarterly Implementation and Monitoring Reports, 2022 Q1 to 2024 Q3.

Note: Data were based on 277,077 unique ECM users. New users were those who began receiving ECM during each quarter and existing users were those who received ECM in a previous quarter and were receiving ECM in the current quarter. Cumulative numbers reflect total users that ever-received ECM. ECM is Enhanced Care Management.

[Exhibit 1.37](#) shows the number of members who ever used ECM and the number of ECM users in 2024 Q3 by POFs. In 2024 Q3, the largest number of ECM users by POFs were Adults With Serious Mental Health or SUD Needs (50,084), followed by Adults At-Risk for Avoidable Hospital or ED Utilization (45,615), and Experiencing Homelessness (adults without dependents; 42,661). These were also the three POFs with the largest cumulative number of ECM users as of 2024 Q3. The Adult POFs with the smallest number of users were Birth Equity and those Transitioning from Incarceration, which is consistent with later implementation in January 2024.

Patterns of ECM use were relatively similar among Children and Youth POFs. The largest numbers in 2024 Q3 were Children and Youth At-Risk for Avoidable Hospital or ED Utilization (10,976), With Serious Mental Health and SUD Needs (10,440), and Experiencing Homelessness (either unaccompanied or with families; 8,824).

Exhibit 1.37. Cumulative and Latest Number of ECM Users by Populations of Focus, January 2022 to September 2024



Source: Quarterly Implementation and Monitoring Reports, 2022 Q1 to 2024 Q3.

Note: Data were based on 277,077 unique ECM users. Current includes number of users reported in 2024 Q3. Cumulative includes number of users that ever-received ECM. POF were reported by the MCPs, and the same members could be in multiple categories. ECM is Enhanced Care Management, LTC is long-term care. CCS is California's Children Services. WCM is Whole

Child Model. ECM was implemented in phases for POF and counties with a WPC or HHP demonstrations were the first to implement.

[Exhibit 1.38](#) shows that members used ECM for an average of 3.7 quarters. The POFs with the longest duration of use were Adults At Risk for Avoidable Hospital or ED Utilization (3.7), With Serious Mental Health or SUD Needs (3.6), and Experiencing Homelessness Without Dependent Children (3.1) and Children and Youth At Risk for Avoidable Hospital or ED Utilization (2.6), With Serious Mental Health or SUD Needs (2.5), and Unaccompanied Experiencing Homelessness (2.3). Adults and Children and Youth in the Birth Equity POF had the shortest duration of use (1.9 and 1.6 quarters, respectively). Examination of median rather than average duration of use indicated a slightly shorter duration overall (3 quarters) and for the largest Adult POFs.

Exhibit 1.38. Duration of use of ECM by Population of Focus, January 2022 to September 2024

Populations of Focus		Average Number of Quarters Using ECM	Median Number of Quarters Using ECM
Overall		3.7	3
Adults	At Risk for Avoidable Hospital or ED Utilization	3.7	3
	With Serious Mental Health or SUD Needs	3.6	3
	Experiencing Homelessness: Adults without Dependent Children/Youth Living with Them Experiencing Homelessness	3.1	3
	Living in the Community and at Risk for Long-Term Care Institutionalization	2.8	2
	Experiencing Homelessness: Homeless Families	1.9	2
	Transitioning from Incarceration	2.9	2
	Birth Equity	1.9	2

Populations of Focus		Average Number of Quarters Using ECM	Median Number of Quarters Using ECM
	Nursing Facility Residents Transitioning to Community	2.5	2
Children and Youth	At Risk for Avoidable Hospital or ED Utilization	2.6	2
	With Serious Mental Health or SUD Needs	2.5	2
	Experiencing Homelessness: Unaccompanied Children and Youth Experiencing Homelessness	2.3	2
	Experiencing Homelessness: Homeless Families	2.0	2
	Enrolled in CCS or CCS WCM with Additional Needs Beyond the CCS Condition	2.4	2
	Involved in Child Welfare	1.7	1
	Birth Equity	1.6	1
	Transitioning from Incarceration	2.0	2

Source: Quarterly Implementation and Monitoring Reports, 2022 Q1 to 2024 Q3.

Note: Data were based on 277,077 unique users that ever-received ECM. POFs were reported by MCPs and the same members could be in multiple categories. ECM is Enhanced Care Management. ED is Emergency Department. SUD is Substance Use Disorder. CCS is California's Children Services. WCM is Whole Child Model. ECM was implemented in phases for POF and counties with a WPC or HHP demonstrations were the first to implemented.

[Exhibit 1.39](#) shows that the proportion of ECM users who received services from community-based ECM providers as measured by public ownership status declined from 28% in 2022 Q1 to 14% in 2024 Q1. The proportion of those who received care from private non-profit ECM providers did not change substantially but the proportion of those who received ECM from private for-profit ECM providers increased from 26% to 40% in this period.

Exhibit 1.39. Proportion of ECM Users by ECM Provider Ownership Status per Quarter, January 2022 to March 2024



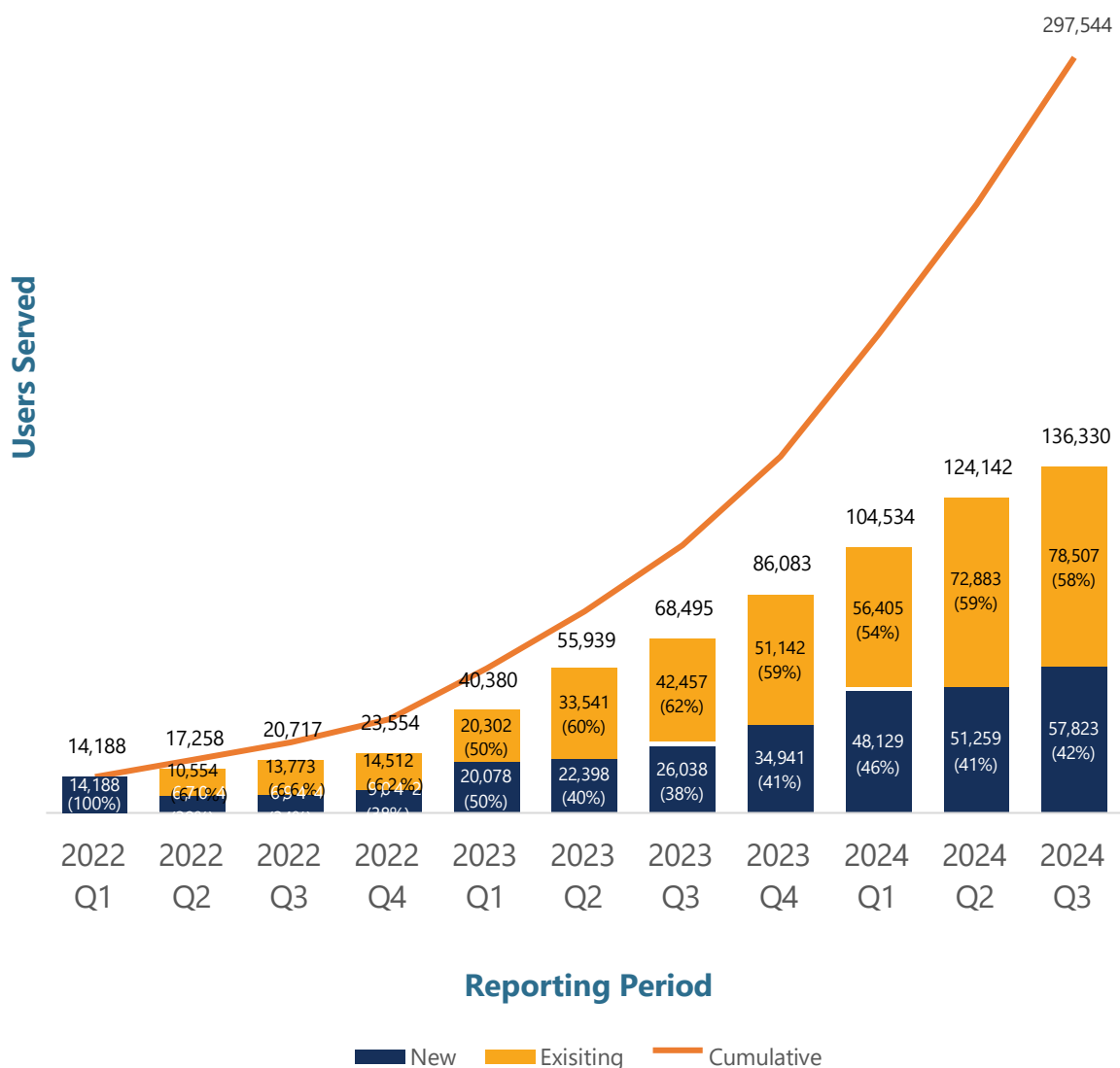
Source: Quarterly Implementation and Monitoring Reports, 2022 Q1 to 2024 Q1; UCLA-RAND determination of ECM provider ownership status.

Note: Ownership data were determined as of 2024 Q1. Ownership status was unknown for 51 providers, resulting in 1% of members being excluded. Another 468 members were excluded because MCPs did not report their ECM provider. The final number of members included in the analysis was 213,640. Percents may not add to 100% due to rounding error. ECM is Enhanced Care Management.

Community Supports Users

[Exhibit 1.40](#) shows that the number of unique Community Supports users increased from 14,188 in 2022 Q1 to 297,544 in 2024 Q3. Many of these users transitioned from WPC and HHP at the start of 2022 Q1. Following that transition, the proportion who newly used Community Supports increased from 39% in 2022 Q2 to 42% in 2024 Q3. Additional information on the use of specific Community Supports can be found in the [Community Supports Section of the Evaluation Report](#).

Exhibit 1.40. Current and Cumulative Counts of Members Receiving Community Supports by Quarter, January 2022 to September 2024



Source: Quarterly Implementation and Monitoring Reports, 2022 Q1 to 2024 Q3.

Note: Data were based on 297,544 unique Community Supports users. New users were those who began receiving Community Supports during each quarter and existing users were those who received Community Supports in a previous quarter and were receiving Community Supports in the current quarter. Cumulative numbers reflect total users that ever-received Community Supports. 10,554, 13,773, and 14,512 users were existing users in 2022 Q2, 2022 Q3, and 2022 Q4, respectively.

Measure 3. Demographic and health characteristics of ECM and Community Supports users and non-users compared to the population of members eligible for these services

Data sources: QIMRs; Medi-Cal eligibility and claims data.

As noted in [Measure 1](#), the population of non-users who were eligible for ECM or Community Supports were not available for the Interim Evaluation Report and will be described in the Summative Evaluation Report. However, data was available to describe characteristics of ECM and Community Supports users. UCLA-RAND used Medi-Cal eligibility and claims data to describe the demographics and health status of users.

[Exhibit 1.41](#) shows demographics of ECM and Community Supports users in the first month of using either service or the type of service used. Data showed that ECM only users were more likely than Community Supports only users to be younger (average age of 43 vs 51), male (44% vs 39%), White (22% vs 19%), and report English as their primary preferred language for communication (74% vs 62%).

Members using both ECM and Community Supports differed from the other two groups in gender, race/ethnicity, language preference, and experiences of homelessness. Specifically, the proportion experiencing homelessness among this group was higher (85%) than ECM only (27%) and Community Supports only (23%) users.

Exhibit 1.41. Demographics of ECM and Community Supports Users as of their First Quarter Using Either Service

	ECM Only	Community Supports Only	Both ECM and Community Supports
Number of Unique Members	202,889	223,351	74,172
Age			
Average	42	49	48
Median	43	51	51
Female	56%	61%	52%
Race/Ethnicity			
White	22%	19%	27%
Black	14%	10%	22%

	ECM Only	Community Supports Only	Both ECM and Community Supports
Hispanic	45%	45%	33%
Asian	4%	9%	2%
American Indians and Alaska Natives	1%	<1%	1%
Native Hawaiian and other Pacific Islander	1%	1%	1%
Some other race	15%	16%	14%
English as preferred language for communication	74%	62%	85%
Experiencing homelessness	27%	23%	44%
Rural residence	6%	6%	6%
Residence in an under-resourced area	48%	52%	51%

Source: Quarterly Implementation and Monitoring Reports, 2022 Q1 to 2024 Q3; Medi-Cal Eligibility and Claims Data; January 2022 to December 2024. Social Vulnerability Index, 2022. Note: Data included 500,447 ECM or Community Supports users between 2022 Q1 to 2024 Q3. Data excluded 35 users that were included in QIMRs but could not be identified in the Medi-Cal eligibility and claims data. Demographics were identified on date of first ECM or Community Supports use. ECM is Enhanced Care Management. Other race/ethnicity includes both "other" and "unknown." Asian race/ethnicity includes Filipino, Amerasian, Chinese, Cambodian, Japanese, Korean, Asian Indian, Laotian, and Vietnamese. Members experiencing homelessness were identified using a previously validated model that uses predictors such as address- and claims-based indicators and county-level homelessness rate.²⁴ Rural residence was determined by a member's home address and definition of rural established by the Health Resources and Services Administration in 2023.²² Residence in an under-resourced area was determined by a member's home address and includes those living in the top quartile of the 2022 Social Vulnerability Index. Percents may not add to 100% due to rounding error.

[Exhibit 1.42](#) shows the health status and service utilization of ECM and Community Supports users at baseline, defined as the two-year period prior to their first ECM enrollment or Community Supports utilization.

ECM only users had higher prevalence of chronic conditions such as asthma, chronic obstructive pulmonary disease, depression or anxiety, mental health conditions, and SUDs than Community Supports only users. ECM only users also had higher utilization of all outpatient and acute categories of service examined than Community Supports only users. The prevalence of chronic conditions and average number of ED visits and hospitalizations, however, were higher among members using both ECM and Community Supports than ECM only users.

Exhibit 1.42. Health Status and Health Care Utilization of ECM and Community Supports Users at Baseline, January 2022 to September 2024

	ECM Only	Community Supports Only	Both ECM and Community Supports
Number of unique members	202,845	222,734	74,062
Health Status			
Asthma	13%	10%	14%
Chronic Kidney Disease	21%	22%	24%
Chronic Obstructive Pulmonary Disease	10%	9%	13%
Diabetes	24%	28%	26%
Hypertension	36%	39%	42%
Depression or Anxiety	42%	30%	45%
Serious Mental Illness	34%	23%	41%
SUD	27%	19%	35%
Utilization			
Any ED visits	62%	52%	64%
Any hospitalizations	28%	21%	33%
Any primary care	83%	77%	76%

	ECM Only	Community Supports Only	Both ECM and Community Supports
Any outpatient specialty care	61%	57%	56%
Average number of ED visits	2.9	1.9	3.5
Average number of hospitalizations	0.7	0.5	0.9
Average number of primary care services	10.1	7.4	9.3
Average number of outpatient specialty services	6.6	5.7	5.9

Source: Quarterly Implementation and Monitoring Reports, 2022 Q1 to 2024 Q3; Medi-Cal Eligibility and Claims Data; January 2022 to December 2024.

Note: Data included 500,447 ECM or Community Supports users between 2022 Q1 to 2024 Q3. Data excluded 803 members that were included in QIMRs but could not be identified in the Medi-Cal eligibility and claims data during the baseline period, defined as two years prior to first ECM or Community Supports service use). Health status indicators were constructed using the Chronic Condition Warehouse.²⁵ Percents may not add up to 100% due to rounding error. ECM is Enhanced Care Management.

Measure 4. ECM and Community Supports providers' self-reported strategies for identifying and engaging eligible members in ECM and Community Supports

Data sources: October 2024 to July 2025 provider interviews; June to July 2025 provider survey.

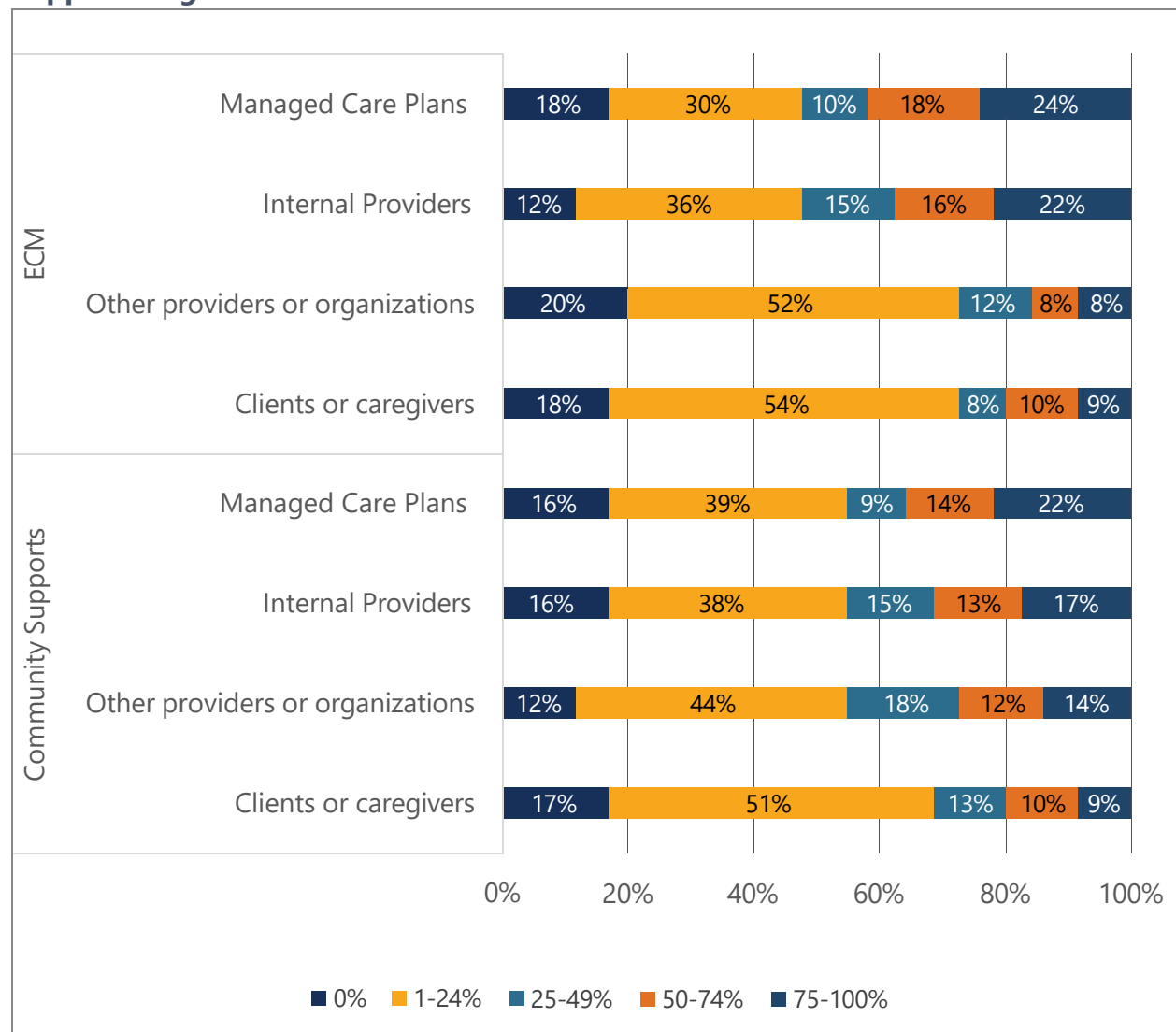
Referral Sources and Strategies

[Exhibit 1.43](#) shows that providers received referrals for ECM and Community Supports from multiple sources. Surveyed providers reported that a larger proportion of ECM referrals were from MCPs and internal providers (i.e., other departments within the same organization) than other organizations or clients and caregivers. For example, 24% of ECM providers reported that 75% to 100% of ECM referrals came from MCPs, and 22% reported the same for internal providers. In contrast, only 8% and 9% reported that 75%

to 100% of ECM referrals came from other organizations or clients and caregivers, respectively.

For Community Supports, surveyed providers also reported a larger proportion of referrals were from MCPs and internal providers. For example, providers selected that 75% to 100% of their referrals were from MCPs (22%), followed by internal providers (17%). Community Supports providers indicated they received more referrals from other providers or organizations than ECM providers, with only 12% of Community Supports providers indicating they received no referrals from other providers or organizations compared to ECM providers' 20% reporting the same.

Exhibit 1.43. Referrals Sources Reported by Providers for ECM and Community Supports Eligible Users



Source: ECM and Community Supports Provider Survey, June to July 2025.

Note: Data were based on 256 unique respondents and excluded three respondents who did not answer this question. Providers were categorized as ECM or Community Supports based on whether they reported providing that service, regardless of whether they also provided the other. ECM is Enhanced Care Management.

In interviews, providers explained that MCPs approached referrals differently for ECM and Community Supports. For ECM, MCPs typically provided a list of ECM eligible members. ECM providers indicated that they were only able to reach a small percentage of these eligible members, with estimates ranging from 0% to 20%. Of those reached, not all members agreed to enroll in ECM. Providers attributed low enrollment of eligible members to outdated or inaccurate contact information, members not recognizing or trusting “cold calls” or unsolicited outreach from ECM providers, or a general lack of interest. Some providers had more successes with outreach if they were known in the community or had a dedicated outreach and enrollment team. One provider emphasized that referral and enrollment success depended heavily on the level of effort the MCP invested in maintaining accurate and updated member information. For Community Supports, providers reported that MCPs did not generate lists of eligible members. Instead, MCPs referred members who were identified as having relevant HRSNs (e.g., through MCP-administered screening or an ECM provider-administered needs assessment) or who self-referred into Community Supports.

In contrast to referrals from MCPs, providers noted that community-based referrals were more likely to result in successful engagement of members. Some providers reported working hard to establish successful referral relationships with local organizations in their community, particularly clinical partners, while larger providers built internal referral pathways from other departments in their own organizations. To cultivate community-based referral networks, providers used a range of strategies, including leveraging pre-existing relationships; using MCP- and PATH CPI-provided directories of ECM and Community Supports providers; participating in local learning collaboratives such as PATH CPI; proactively conducting outreach by presentations sessions in local organizations to increase awareness of CalAIM; and developing or advertising ECM and Community Supports on social media or organizational websites. For Community Supports in particular, providers shared that clients’ willingness to engage in the service was highly dependent on their understanding of the program, so their staff spend time on client education during outreach and enrollment.

Providers noted that another important strategy to improve enrollment and engagement was building trust with eligible members. Some providers prioritized hiring

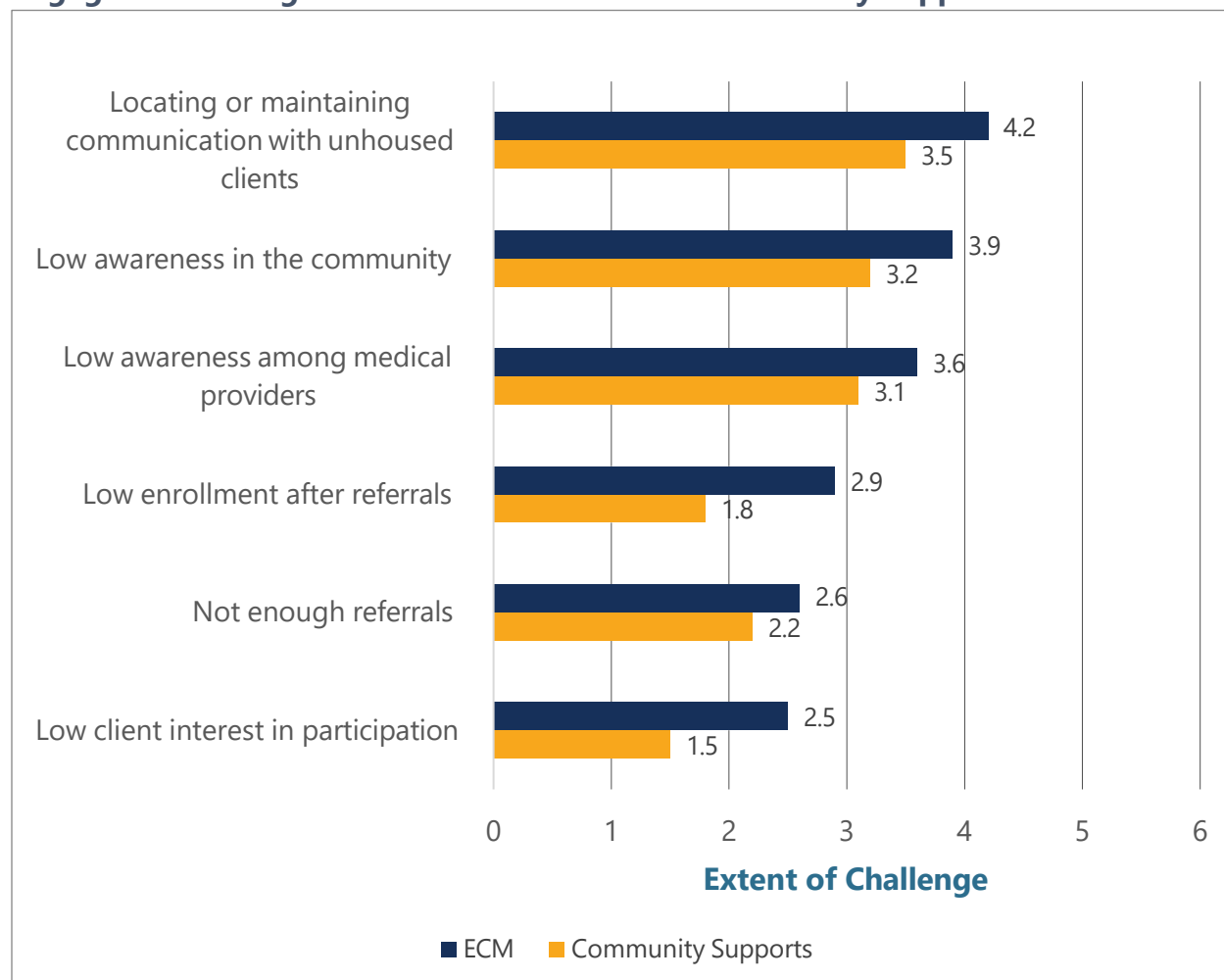
staff with lived experience and focused on retaining staff to maintain continuity and rapport with the members they served.

“We have been here for so long, we have done so much. It’s just having that history and background really helped us solidify the assistance of who we are. It made a trusted partner within the community. And so, it was an easy ask when we go to the clients like, ‘Hey, we referred you over’ and so they’ve already most likely worked with us in some capacity, so it was easy to have the trust and the relationship with clients.” - Provider #3

Challenges and Strategies for Member Identification and Engagement

In the provider survey, providers rated challenges to member identification, referrals, and engagement from not at all (0) to extremely (6) challenging ([Exhibit 1.44](#)). For both ECM and Community Supports, the highest average ratings were for locating or maintaining communication with unhoused clients (4.2 for ECM and 3.5 for Community Supports). The lowest average ratings were low client interest in participation (2.5) and not enough referrals (2.6) for ECM and low client interest in participation (1.5) and low enrollment after referrals (1.8) for Community Supports. ECM providers perceived more challenges related to identification and engagement than Community Supports providers.

Exhibit 1.44. Provider Ratings of Challenges Related to Identification and Engagement of Eligible Members for ECM and Community Supports



Source: ECM and Community Supports Provider Survey, June to July 2025.

Note: Data were based on 236 unique respondents and excluded 23 respondents who did not answer this question. Providers were categorized as ECM or Community Supports based on whether they reported providing that service, regardless of whether they also provided the other. ECM is Enhanced Care Management.

In interviews, some providers identified challenges in converting referrals into enrolled members and in enrolling enough members in services to be financially sustainable. Commonly described challenges in identifying members similarly included lack of knowledge of ECM and Community Supports in the community (both among eligible members and potential referral sources), and difficulty locating or maintaining clients (particularly unhoused clients) due to inaccurate or outdated contact information. One provider shared using trackers (e.g., bracelets) to locate clients. Commonly described challenges in enrolling members in services included inaccurate eligibility or contact

information, delayed delivery of eligible member lists by MCPs, and delays in authorizations by MCPs. Providers were hopeful that the new pre-authorization from MCPs that went into effect in 2025 would increase engagement and timely service delivery. Some providers noted that they had difficulty integrating member identification processes into their existing workflows because of unclear referral processes and lack of standardized guidance related to eligibility. Providers who contracted with multiple MCPs explained that inconsistencies in how referrals were submitted and how eligible member lists were shared were also a problem.

When asked about potential strategies for mitigating these challenges, several providers suggested that DHCS could create and maintain a standardized template for outreach and communication, in part by ensuring that MCPs and potential referral sources in the community have a shared understanding of what these benefits are, their eligibility criteria, and consistent referral pathways. Providers shared that creating a standardized referral form and streamlining referral pathways can help them process and initiate more referrals, leading to more financial sustainability.

Measure 5. 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

Data sources: October 2024 to July 2025 provider interviews; January to April PATH CPI facilitator and TA Marketplace vendor interviews; July to September 2024 MCP interviews.

PATH CITED

Providers noted various ways they used PATH CITED funding to hire staff to support referrals, confirming eligibility, outreach, and enrollment. Providers shared that PATH CITED helped cover their operational costs and supported a gradual ramp-up, since they were not prepared to take on a large volume of referrals right away. Additionally, providers were able to expand staff to provide services, invest in transportation, and expand facility capacity to increase enrollment.

Some providers and CPI facilitators expressed concerns about the amount of PATH CITED funding going to larger for-profit organizations. They perceived this to be misaligned with the goals of PATH. Smaller public or non-profit providers noted that applying for PATH CITED was a greater administrative burden for them than larger organizations. One provider who did not receive PATH CITED funding after applying for multiple rounds shared their frustration with the lack of feedback provided when they

were denied funding, and they were subsequently asked to share their experience with CalAIM implementation after they had invested in an outreach and engagement platform to be linked to their data warehouse and electronic health record system.

PATH TA Marketplace

PATH TA Marketplace connected providers with vendors who offered expertise in cross-sector relationship building as well as with tools and training for effective member outreach, identification, and engagement, especially for difficult-to-reach populations.

One TA Marketplace vendor shared that they commonly helped organizations conduct financial and operational assessments to see how well the organization could identify, engage, and enroll individuals in ECM. One TA Marketplace vendor's project analyzed why certain organizations were more successful in engaging members and they found that for-profit organizations had stronger marketing and outreach teams.

Providers, CPI facilitators, TA Marketplace vendors, and MCPs frequently mentioned that although the PATH TA Marketplace is a great resource, it is overwhelming for providers to navigate due to the volume of projects and vendors, as well as initial functionality and interface issues (e.g., no search bar). A CPI facilitator recommended that the PATH TA Marketplace website should be clearly marketed and advertised as free. Some interviewees also shared that the PATH TA Marketplace was rolled out a little late and still has long wait times for approvals.

PATH CPI

Providers further described PATH CPI as useful for building relationships with other providers of ECM and Community Supports in their community and building a referral network. CPI facilitators shared that they highlighted different providers in each meeting to familiarize others with which providers serve different POFs or provide different Community Supports. They further said that they created and maintained their own provider directory because provider feedback indicated that MCPs' directories were not up to date or user-friendly. Some CPI facilitators mentioned creating referral mapping processes to help streamline and facilitate referral pathways. CPI facilitators helped providers by identifying and documenting the differences between MCPs in referral processes. They shared that this strategy had been successful in driving community-based referrals for ECM and Community Supports services. CPI facilitators noted they had changed their focus over time from general CalAIM education to increasing referrals and engagement as implementation progressed.

I think we are hearing the conversation shift from just knowing who is in the network, ... to organizations wanting a sort of trusted smaller network of folks that are specific orgs that they will refer to ... and trying to figure out how they can develop a closer relationship with other providers in the county that they're serving - CPI facilitator #9

When asked about the perceived impact of participating in PATH CPI, one provider shared that they had anticipated receiving more referrals due to their participation in PATH CPI, but that did not happen. Another provider shared that the way referrals were discussed in PATH CPIs were very broad and mostly focused on networking. They recommended PATH CPIs focus on TA and clear standards for referral forms and required documents.

Goal 2: Improve data collection and information sharing infrastructure among ECM and Community Supports providers

Goal 2 is evaluated by addressing one Evaluation Question and analyzing six measures articulated in the [Evaluation Questions and Hypotheses](#) section of this report. Data sources used in analyses are articulated for each measure section of this report.

Evaluation Question 4: Did PATH improve ECM and Community Supports providers' data collection and information sharing infrastructure?

Evaluation Question 4 is addressed by analysis of six measures articulated in the PATH Evaluation Design and displayed in the [Evaluation Questions and Hypotheses](#) section of this report. The data sources used for the analyses are noted for each measure. Further detail on data sources and methods is included in the [Methodology](#) section.

Measure 1. 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

Data sources: October 2024 to July 2025 provider interviews; January to April 2025 PATH Collaborative Planning and Implementation (CPI) initiative facilitator and PATH Technical Assistance (TA) Marketplace vendor interviews; July to September 2024 Medicaid MCP interviews; June to July 2025 provider survey; November 2024 to January 2025 MCP survey.

Stratification by provider type was not possible in interview data due to small sample sizes.

Providers and MCPs described their approaches to data sharing for client management and for claims submission. MCPs survey data indicated 17 (of 22) MCPs provided their own data portal to facilitate tracking and managing referrals and member information. While providers were not obligated to use those portals according to DHCS guidelines, 13 MCPs with portals reported that 75% to 100% of contracted ECM providers used the portal and nine MCPs reported 75% to 100% of contracted Community Supports providers used it (data not shown). During interviews, some MCP staff shared spending extensive time and resources developing portals.

Providers who contracted with more than one MCP reported challenges with needing to coordinate and train staff on use of multiple MCP portals. Additionally, some social service providers indicated difficulty managing referrals from multiple, different referral management platforms; smaller organizations in particular reported difficulty managing costs and administrative burden of accessing multiple platforms (e.g., paying for access, staff training and management associated with multiple systems, staff management time, and technology needed) and therefore could not access some referrals to their organizations. Providers emphasized the importance of aligning elements of portals across MCPs or using one shared system to ease the burden of multiple processes and platforms and build additional capability to indicate when the referral resulted in service use.

“There's just a tension statewide right around what's standardized and what's tailored to each managed care plan? And I think every organization is sort of figuring out how it makes sense for them to navigate that.” - CPI facilitator #1

Several providers mentioned establishing or modifying their existing electronic health records (EHRs) or other electronic care management systems for participation in PATH. Some smaller social service providers transitioned from using Google Docs and Google Forms to establish and use new client management software or EHR that support service delivery, reporting, and billing. Others mentioned adding additional required fields to their systems to automate reporting, invest in new systems, or transition to more secure systems to meet the Health Insurance Portability and Accountability Act requirements.

“We had to build an EHR because all of the managed care plans wanted different things. So, we wanted to track it all. Then we wanted our own outcome measures as well.” - Provider #10

CPI facilitators noted lacking clarity and directive from DHCS on data governance and exchange options. Some providers such as federally qualified health centers had access to Health Information Exchanges and Qualified Health Information Organizations (QHIOs) and additional trainings to support data sharing. But many smaller CBOs lack such knowledge or capacity and had competing priorities. Some providers commented on their voluntary use of the Data Exchange Framework (DXF).²⁶ They noted that while DXF laid the groundwork and vision for data sharing, there were challenges in adoption and standardization. Those who adopted the DXF faced minimal enforcement and unclear expectations. Furthermore, there was wide variation in functionality and data completeness in QHIOs across counties. A CPI facilitator shared that providers and plans that relied on the QHIO's county data to inform programmatic decisions later realized the data was inaccurate and incomplete and had to reassess the data. Additionally, some clinical and social service providers noted they did not have the same standards.

"There's no teeth to the DXF, and so there's no enforcement mechanism. What the State is now relying on is the plans to enforce through the plan contracts, the ability to drive provider data sharing. And this is hugely problematic. We're not seeing providers share data in the way envisioned by the DXF. What we're seeing is a lot of stopgap measures and a lot of more old school ways of sharing data sharing flat files." - CPI facilitator #6

[Exhibit 1.45](#) outlines challenges related to data collection and information sharing infrastructure around key themes that emerged from interviews.

Exhibit 1.45. Challenges Related to Data Sharing

Theme	Example
Lack of data sharing infrastructure	Some smaller CBOs or organizations that had never worked with MCPs lacked the infrastructure needed to fully participate.
Lack of knowledge about data sharing	Many providers were unfamiliar with coding and lacked the large systems typically used by health plans.
	Although the importance of data exchange was presented to providers in PATH CPIs, they often had competing priorities and do not prioritize data sharing.
Multiple data exchange systems and platforms	The use of multiple, uncoordinated platforms created confusion and challenges for data collection and patient-level care management.

Theme	Example
	A centralized structure for data submission and reporting was lacking from the start, leading to fragmented systems across plans and providers.
Changes in policy guidance	Providers struggled to meet new reporting requirements that did not initially exist. Changes to DHCS guidance caused providers to constantly tweak their data systems.
	MCPs had different interpretations of DHCS guidance, leading different methodologies and pieces of data needed, which resulted in extra work for providers.
	MCPs were expected to independently build their systems from the start, leading to inconsistent infrastructures and later challenges in standardizing processes.
	Providers faced uncertainty about what systems or processes to invest in due to lack of clear guidance. And some providers used funds to invest in infrastructure and later realized it would not work with their needs.
Optional infrastructure	Providers were not required to work within plan-specific portals or sign data exchange agreements, which created barriers for reporting.
	Even if providers did sign the data sharing framework, there was no enforcement mechanism.
Providing Additional Supports	Recommended additional support to continue to support providers in the transition to CalAIM and its data reporting requirements.

Sources: ECM and Community Supports Provider Interviews, October 2024 to July 2025; PATH CPI Facilitator and PATH TA Marketplace Vendor Interviews, January to April 2025; Managed Care Plan Interviews, July to September 2024.

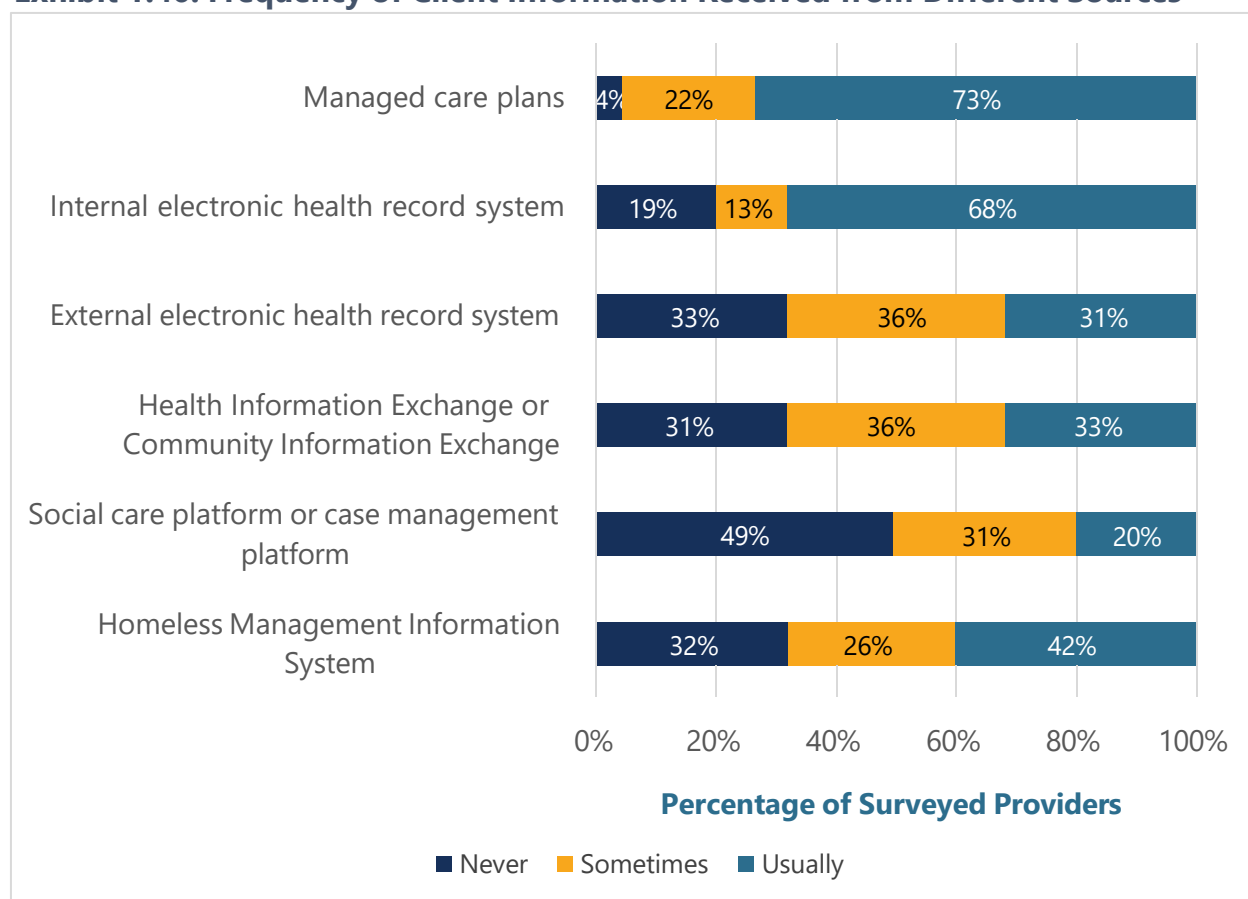
Note: Data were based on 97 unique organizational respondents.

Measures 2-4. Number and proportion of providers with data sharing agreements with MCPs; Number and proportion of providers who have 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)

Data sources: October 2024 to July 2025 provider interviews; July to September 2024 MCP interviews; June to July 2025 provider survey; November 2024 to January 2025 MCP survey.

Among providers surveyed who participated in PATH (i.e., received PATH CITED, received PATH TA, or attended PATH CPI), 65% reported that they had established or modified data use agreements with managed care plans, 70% had obtained or modified existing EHR or other care management software to support service delivery of ECM and Community Supports, and 21% had established or modified their data sharing agreements with local Continuums of Care or other entities to access data from local HMIS (data not shown). All surveyed providers further reported that the most common sources of data on client health and social needs were MCPs (73%) and their own EHR (68%; [Exhibit 1.46](#)), and less frequently from other sources such as HMIS (42%).

Exhibit 1.46. Frequency of Client Information Received from Different Sources



Source: ECM and Community Supports Provider Survey, June to July 2025.

Note: Data were based on 245 unique respondents and excluded 14 respondents who did not answer this question.

During interviews, multiple providers of housing-related Community Supports reported relying on HMIS data to support delivery of Housing Transition Navigation Services, Housing Deposits, or Housing Tenancy and Sustaining Services. Housing navigators at providers with access to HMIS frequently used HMIS to access information on clients' history of homelessness and services used. One provider shared that although their organization was previously registered with HMIS, they only began using it consistently after contracting to provide services under CalAIM. Another provider without an established data exchange system used their current HMIS data and added custom fields (e.g., member identification, diagnosis codes, Healthcare Common Procedure Coding System codes) for required reporting.

In addition to providers, survey data indicated that 82% of MCPs have established data sharing agreements with the local Continuums of Care collaboratives or other entities to access HMIS data (data not shown). In interviews, some MCPs mentioned sharing HMIS data with providers to help with outreach and engagement and that MCPs had

integrated ECM and Community Supports referral forms into the local HMIS. One MCP estimated 20% to 30% of member contact information in HMIS is incorrect.

Measure 5. Number and proportion of providers with Medi-Cal billing systems

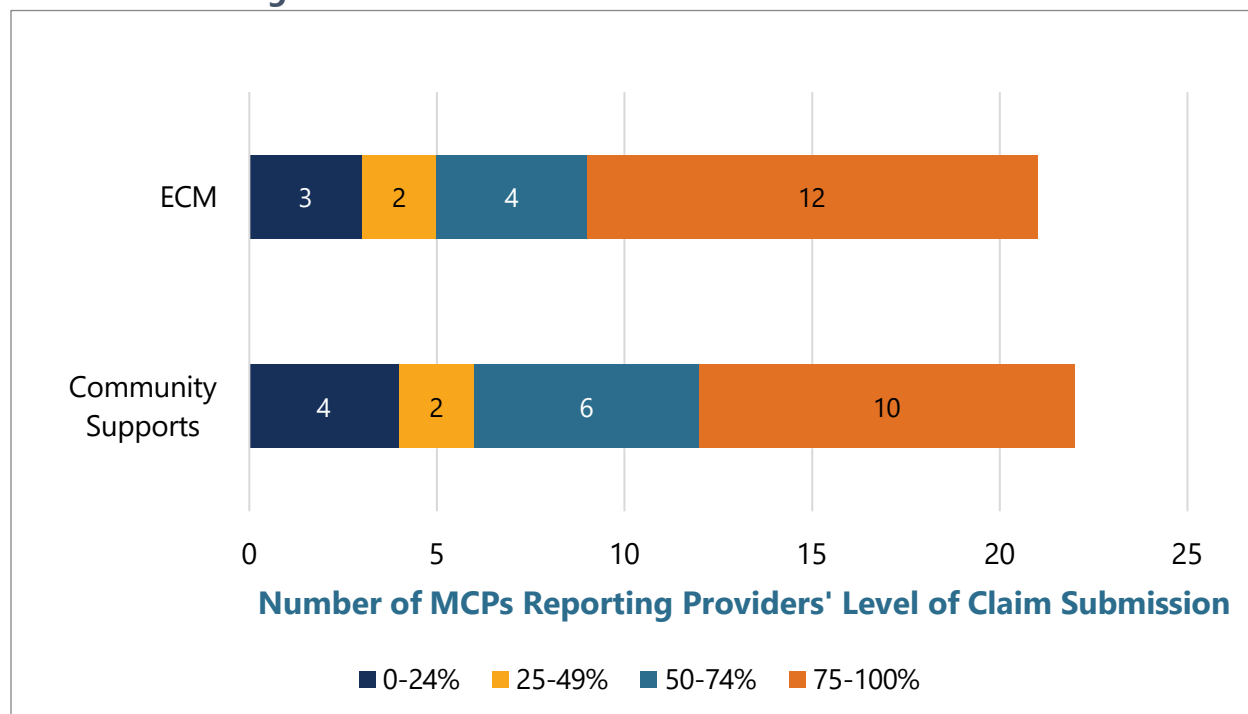
Data sources: June to July 2025 provider survey; November 2024 to January 2025 MCP survey.

In provider surveys, 63% of providers participating in PATH reported that they invested in obtaining or modifying existing software or other technology to support billing and reimbursement. Furthermore, 20% reported contracting with or paying organizations to provide specific services needed to participate in ECM or Community Supports and 46% of these providers are contracted to another organization to generate claims and submit them.

In interviews, some providers highlighted the use of community hubs to streamline operational functions like billing and claims submission. Use of hubs was seen as a benefit in reducing administrative burden, particularly for social and community-based providers who may have lower overhead and operating budgets and who were not as familiar with the Medi-Cal delivery system and requirements. At the same time, some providers elected not to join hubs due to the cost (e.g., percent of CalAIM revenue to the hub), ambiguity of how referrals were distributed to contracted providers, or concerns about financial risk if claims were denied. MCPs also varied in their perceptions of hubs, with some viewing them as an important mechanism for engaging community-based providers that might not otherwise have the administrative capacity to participate in ECM or Community Supports, and others expressing concern about potential delegation of MCPs' monitoring and oversight responsibilities to hubs, indicating it would only be appropriate in certain circumstances. Overall, hubs were viewed as an opportunity to expand community-based provider participation in CalAIM largely because they replaced the need for building internal data and information sharing infrastructure. Hubs varied considerably in their structure and capabilities, however, and further study is warranted.

In the MCP survey, most (12 of 22) MCPs reported that 75% or more of ECM providers were submitting claims and only three MCPs reported that less than 25% of ECM providers were submitting invoices instead ([Exhibit 1.47](#)). Similarly, ten MCPs reported that 75% or more of Community Supports providers submitted claims and four MCPs reported that less than 25% of Community Supports providers were submitting invoices instead.

Exhibit 1.47. Proportion of Contracted Providers that were Submitting Claims vs. Invoices to Managed Care Plans



Source: Managed Care Plan Survey, November 2024 to January 2025.

Note: Data were based on 22 unique respondents out of 24 MCPs eligible to offer Community Supports in 2024. One MCP that fully delegated responsibility for member care to another MCP did not respond to the survey. MCP is Managed Care Plan.

Measure 6. Self-reported impact of PATH on providers' ability to develop needed data collection and information sharing infrastructure

Data source: October 2024 to July 2025 provider interviews; January to April 2025 PATH CPI facilitator and PATH TA Marketplace vendor interviews.

During interviews, providers noted that PATH has helped them develop data and administrative capabilities. Specifically, PATH CITED was used to develop or update referral, reporting, and electronic care management systems. This included investing in and building out EHR systems by paying for it upfront or recouping initial investments. Additionally, PATH CITED has been used to pay for data sharing tools as well as IT consultants and clearing houses to process claims.

PATH CPI facilitators shared that billing was a very large topic of discussion, with sessions and office hours dedicated to helping providers set up or improve their processes. CPI facilitators arranged presentations by providers who were further along in setting up their infrastructure and billing mechanisms to share their approach and foster

peer learning. Providers noted that PATH CPIs have helped define minimum data sets for sharing data and point out inconsistencies across MCPs that providers can refer to when building out their reporting infrastructure. CPI facilitators have elevated the importance of data exchange, and some CPI facilitators have hosted local Health Information Exchanges at meetings to outreach to attending providers. However, some CPI facilitators shared that, aside from coding and billing, providers were less focused on data sharing.

“Progress [on data sharing] has slowed down with the lack of policy alignment across the data exchange framework.... providers [are] trying to figure out which systems they want get connected with. ... different entities, like the State departments, counties, MCPs, and hospital systems, they are still operating in silos. And so, it's making it hard for them to find a system to help them all be connected because everyone's using different platforms.” - CPI facilitator #4

Providers noted that the PATH TA Marketplace has helped them identify and implement data collection and sharing infrastructure, including EHR systems and data exchange platforms tailored to their needs. Providers noted that the TA Marketplace vendors have supported these efforts by advising on data architecture and reviewing billing processes to support sustainability and avoid duplication. One TA Marketplace vendor shared that their “off-the-shelf” billing support video was their highest-viewed video.

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

Goal 3 is evaluated by addressing Evaluation Questions 5, 6, and 7 and analysis of eight measures described in the [Evaluation Questions and Hypotheses](#) section of this report. Data sources used in analyses are articulated for each measure.

Evaluation Question 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?

Evaluation Question 5 is addressed by analysis of three measures articulated in the PATH Evaluation Design and displayed in the [Evaluation Questions and Hypotheses](#) section of this report. The data sources used for the analyses are noted for each measure. Further detail on data sources and methods is included in the [Methodology](#) section.

Measure 1. 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

Data sources: DHCS lists of PATH Justice-Involved Capacity Building Program (PATH JI) Round 1 and 2 awardees; 2023 PATH JI Round 2 interim progress reports; April to July 2025 Justice-Involved (JI) provider interviews.

For this measure, only self-reported changes made by correctional facilities, county social service departments, or other partner institutions that received PATH JI funding are reported. Data could not be stratified by participation in PATH JI because correctional facilities that did not receive PATH JI funding did not report changes to infrastructure, workflow, and policies and regulations needed to screen, enroll, and change the suspension status of individuals eligible for Medi-Cal prior to release.

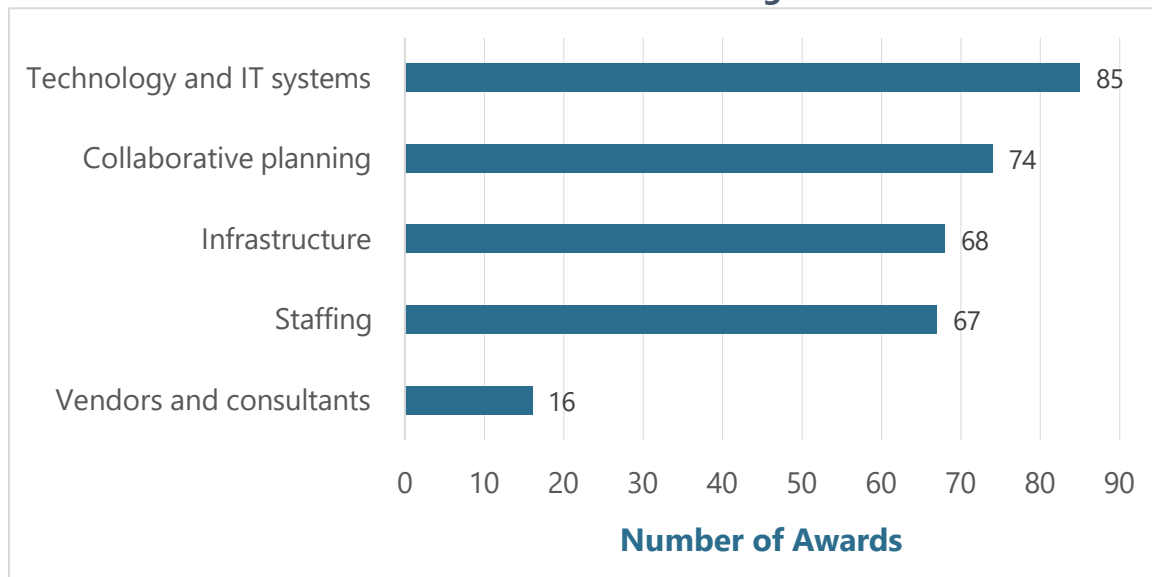
PATH JI Round 1 and 2 funding was intended to support implementation of pre-release Medi-Cal enrollment and suspension processes. Examination of list of awardees showed that the CDCR, which oversees state prison facilities, and correctional agencies and their partner institutions in 44 of 58 California counties received PATH JI Round 1 or 2 funding. Correctional agencies and partner institutions in 14 counties (Alpine, Amador, Humboldt, Kings, Mendocino, Modoc, Mono, Napa, San Joaquin, Shasta, Sierra, Sonoma, Yolo, and Yuba) did not apply for or receive this funding. Four of these counties (Alpine, Sierra, Modoc, and Mono) were the least populated with population ranging from 1,043 to 13,194, and Alpine and Sierra do not directly operate jails and instead contract jail services to neighboring counties.

In interviews, one JI provider indicated that low correctional facility capacity to apply for and manage grant funds prevented some counties from applying.

“We thought it was ideal to go after [PATH] JI funding because the capacity is needed ... but our sheriff and probation were like ‘That’s great, do it, but we don’t have capacity. If you want to write this grant for us, we’ll sign this over, you take care of it ...’, so we applied for [PATH JI] Round 1, Round 2, ... and we got them. But they [sheriff and probation] need [us, as the] administrative organization to help them ... because they’re not a social service provider, they are not understanding some of those things. Their mindset is not about building structure; it’s about keeping people safe.” - JI Provider #3

[Exhibit 1.48](#) shows that PATH JI Round 1 and 2 funding were most often used to support development of technology and IT systems (85) and collaborative planning (74). For example, one county used PATH JI Round 2 funding to implement an electronic Real-Time Eligibility system to automatically verify individuals’ Medi-Cal eligibility and coverage after 24 hours in custody rather than requiring manual verification of each individual’s status in the DHCS Eligibility Verification System. Another county used the funds to embed a public assistance specialist in the jail with full access to systems used to manage Medi-Cal eligibility and enrollment (e.g., California Statewide Automated Welfare System, Medi-Cal Eligibility Data System).

Exhibit 1.48. Use of PATH JI Round 1 and 2 Funding



Source: Lists of PATH JI Round 1 and 2 Awardees; PATH JI Round 2 Interim Progress Reports, 2023.

Note: Data were based on 40 PATH JI Round 1 and 78 PATH JI Round 2 Awardees in 44 counties and CDCR. Infrastructure included infrastructure and processes needed to draw down Medi-Cal Administrative Activities funding, while Technology and IT systems and Staffing focused more on implementation of Medi-Cal application and suspension processes. PATH JI is PATH Justice-Involved Capacity Building Program.

In PATH JI interim progress reports and JI provider interviews, JI providers described collaborative planning between county sheriff's offices, probation, and local social services departments as essential for effective implementation of pre-release enrollment and suspension processes. They emphasized that robust planning was needed given substantial impacts on existing workflows and staffing needs.

For many counties, challenges of implementation of pre-release application and suspension processes were compounded due to simultaneous transition of IT systems used to manage public assistance programs from the California Welfare Information Network to the California Statewide Automated Welfare System between October 2022 to October 2023. Interviewees noted that this added to the implementation burden on local social service department staff and disrupted established data sharing processes with other agencies.

For example, one county noted that under the California Welfare Information Network, correctional facility staff had direct access to the DHCS Eligibility Verification System to verify individuals' Medi-Cal status. However, this access was disrupted following transition to California Statewide Automated Welfare System and local social service department staff had to manually review intake reports, verify individuals' Medi-Cal eligibility status, and send the information back to correctional facility staff.

Interviewees noted that the manual review process of the average daily population (ADP) in California county jails was untenable as it could be as high as 4,506. Therefore, counties with large ADPs focused on automating and streamlining these processes. For example, one county with multiple correctional facilities developed a web-based Application Programming Interface to facilitate cross-referencing and exchange of data between the sheriff's department and the social services agency.

Interviewees described PATH JI Round 1 and 2 funding as essential but not always sufficient for ensuring staff capacity to plan and implement changes needed for implementation.

Measure 2. 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

Data sources: PATH JI Rounds 1 and 2 applications; DHCS lists of PATH JI Round 1 and 2 awardees and funding uses; April to July 2025 JI provider interviews.

In 2022 and 2023, correctional agencies and their social service department partners collectively received approximately \$69.84 million (\$4.55 million across 40 applications

in PATH JI Round 1 and \$65.29 million across 97 applications in PATH JI Round 2) to identify and implement processes, protocols, and/or IT infrastructure needed to implement Medi-Cal pre-release enrollment and suspension processes.

Correctional facilities and their partners did not systematically report on non-PATH funding used to develop capacity and infrastructure needed to screen, enroll, and change the suspension status of individuals eligible for Medi-Cal prior to release. However, in interviews, multiple counties shared that PATH JI funding did not fully cover implementation costs for participating agencies, particularly for county social services agencies, and that county general funds and other funding sources were often needed to support implementation. Several counties expressed concern about long-term sustainability of pre-release enrollment and suspension processes without dedicated funding to support staff time to engage in this work. A couple of counties expressed particular concern about viability of using the County-based Medi-Cal Administrative Activities to cover these costs.

Measure 3. Perceived role of PATH in promoting these individuals' ability to screen, enroll, and change the suspension status of individuals eligible for Medi-Cal prior to release

Data source: April to July 2025 JI provider interviews.

In interviews, correctional facilities, county social service departments, and their partners described PATH JI Round 1 and 2 funding as essential to their ability to implement pre-release Medi-Cal application and suspension processes. As noted above in [Measure 1](#) and [Measure 2](#), however, correctional facilities were described as not always having the awareness of and bandwidth to apply for and meet PATH JI funding reporting requirements without administrative support from other county entities. In addition, available funding was described as necessary but not always sufficient for covering implementation costs, particularly in counties with high jail ADPs.

Evaluation Question 6: Did PATH funding improve these institutions' capacity and infrastructure necessary to provide 90-day pre-release services to eligible individuals?

Evaluation Question 6 is addressed by analysis of three measures articulated in the PATH Evaluation Design and displayed in the [Evaluation Questions and Hypotheses](#) section of this report. The data sources used for the analyses are noted for each measure. Further detail on data sources and methods is included in the [Methodology](#) section.

Measure 1. 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

Data sources: 2023 PATH JI Round 3 implementation plans; April to July 2025 JI provider interviews.

PATH JI Round 3 funding was intended for implementation of 90-day pre-release services. In PATH JI Round 3 implementation plans, correctional facilities and county behavioral health (BH) agencies described changes to infrastructure, workflow, and community-based linkages needed to implement pre-release services and BH linkages. PATH JI Round 4 applications were not available in time for inclusion in the Interim Evaluation Report and will be included in the Summative Evaluation Report.

As shown in [Exhibit 1.49](#), correctional facilities principally used PATH JI funding to develop policies and procedures, staffing, and infrastructure needed to implement pre-release services and BH linkages. In interviews, correctional facilities indicated that implementation required substantial cross-sector collaboration to align workflows and share information across staff in different organizations. JI providers described these efforts as time-consuming and requiring time to ensure buy-in and subsequent alignment.

Exhibit 1.49. Example Uses of PATH JI Round 3 Funding to Support Implementation of Pre-Release Services and Behavioral Health Linkages

Focus Area	Funding Use Examples
90-day pre-release eligibility screening	» Developed policies and procedures for 90-day pre-release eligibility and BH screening processes » Hired or assigned and trained staff needed to perform pre-release screenings » Obtained or modified the electronic health record to identify screening outcomes that qualify individuals for pre-release services
Screening for BH linkages	» Developed workflows for BH intake, screening, and assessment » Physical realignment of space was needed to ensure patient privacy during BH screening

Focus Area	Funding Use Examples
	» Hired staff to perform BH screenings and assessments at intake and in-custody
Medi-Cal billing and provider enrollment	» Submitted application to the Centers for Medicare and Medicaid Services for a National Provider Identifier, and to DHCS to enroll as a facility Exempt from Licensure Clinic » Procured and implemented a Medi-Cal billing solution or worked with existing electronic health record vendors to develop new billing infrastructure
Pre-release care management	» Developed policies, procedures, and data sharing agreements needed for pre-release care management and coordination of care » Procured or enhanced electronic health records, jail management systems, and/or health information exchange needed to ensure Health Insurance Portability and Accountability Act-compliant documentation of release dates, individual eligibility, and care needs
Clinical consultation	» Developed or updated standard operating procedures to support BH clinical consultation services » Developed processes for securing consent from incarcerated individuals or, if applicable, their parents or guardians to share information » Implemented multi-disciplinary team meetings that included health care providers, county BH, and other stakeholders as needed
Virtual / in-person in-reach provider	» Obtained equipment (e.g., laptops, webcams, tablets, WiFi access) needed to facilitate connections between members and in-reach providers for pre- or post-release services » Obtained or modified physical space needed to facilitate connections between members and in-reach providers for pre- or post-release services

Focus Area	Funding Use Examples
Support for medications	» Located pharmacy with Medi-Cal Rx billing capabilities to provide pharmacy benefits » Developed and documented workflows needed to meet medication requirements
Support for medication for addiction treatment	» Expanded medication for addiction treatment services (e.g., beyond opiate and alcohol substance use treatment to treatment for inhalants, stimulants, methamphetamines, and psychedelics) » Expanded SUD services to include a more robust educational and counseling component
Support for prescription upon release	» Contracted with pharmacy vendor for same-day medication delivery to ensure provision of medications upon release » Discussed providing transportation to obtain post-release prescriptions from the pharmacy
Support for durable medical equipment (DME) upon release	» Developed policies and procedures for identifying and meeting members' needs for DME and other Medi-Cal covered assistive devices » Trained staff in policies and procedures needed to ensure this requirement was met
Release date notification	» Developed data sharing agreements needed to share release dates with relevant stakeholders » Procured or modified existing administrative infrastructure needed for electronic notifications of release dates
Case management reentry plan finalization	» Developed policies, procedures, data sharing agreements, and IT infrastructure needed for reentry care planning » Physically modified space for confidential sharing of information needed to develop reentry care plans
Reentry care management warm hand-off	» Developed policies and procedures for warm hand-off between the incarcerated individual, care manager, and post-release provider prior to release or within the first week post-release

Focus Area	Funding Use Examples
	» Expanded or established new linkages with community providers able to provide post-release services
Reentry BH linkage	» Developed policies and procedures for reentry BH linkages and for determining whether an individual's BH needs will be met by county BH or by community-based non-specialty BH services provider » Expanded or established linkages with providers for community-based non-specialty BH services

Source: PATH JI Round 3 Implementation Plans, 2023.

Note: Data were based on 44 unique counties. Focus areas reflected different components of the JI Reentry Initiative and aligned with PATH JI Round 3 implementation plan reporting requirements. Examples provided do not comprehensively address all potential uses of PATH JI Round 3 funding. PATH JI is PATH Justice-Involved Capacity Building Program.

Measure 2. Self-reported total amount of funding used to develop capacity and infrastructure needed to provide eligible individuals with pre-release services

Data sources: 2023 PATH JI Round 3 budgets.

In 2023 and 2024, correctional facilities and county BH agencies in 44 counties received approximately \$443 million in PATH JI Round 3 funding to support planning and implementation of pre-release services and BH linkages. Approximately \$ 347.7 million was awarded to correctional facilities and \$ 80.4 million to county BH agencies.

Measure 3. Perceived role of PATH in promoting these institutions' ability to provide pre-release services

Data source: April to July 2025 JI provider interviews.

In interviews, correctional facilities and county BH agencies noted that PATH JI Round 3 funding was essential to support implementation of pre-release services and BH linkages. However, correctional facilities with large ADPs indicated that funding allocations were insufficient to cover their initial planning and implementation costs. In addition, many interviewees described salary duration caps associated with PATH JI Round 3 funding as a barrier, given the volume of cross-sector collaboration, infrastructure development, and workflow or other systems changes needed for planning and implementation. Based on correctional facilities' input, DHCS later

reversed the direction on salary caps and allowed correctional facilities and county BH agencies to exceed these caps with justification.

[Exhibit 1.50](#) identifies JI provider-reported barriers to implementing pre-release services and BH linkages, along with illustrative quotes. Three barriers were described by all interviewees: (1) uncertainty around release dates; (2) manual data entry required for the JI Screening Portal; and (3) challenges with Medi-Cal billing. Multiple counties also described challenges with meeting 30-day medication in-hand requirements. Several interviewees also reported challenges with inter-county transfers (for people originally residing in one county but incarcerated in another) and with coordinating with CDCR to ensure people released from state prison received appropriate reentry care management, warm hand-offs, and BH linkages.

Exhibit 1.50. JI Provider-Reported Barriers to Implementing 90-day Pre-Release Services

Implementation Barrier	Illustrative Quote
Release date uncertainty	<i>"Most people [coming to our facilities] are pre-adjudicated ... Very few have release dates and even if they have a release date, that's not a concrete date. It is a continuous, fluid date until date of release ... we can't take [the release date] at face value." - JI Provider #7</i>
Manual data entry required for the JI Screening Portal	<i>"You created a system where jails are expected to manually enter data for every person that comes into jail that has Medi-Cal and then expect the jails to try and track what happens in people's criminal histories to try and predict 90-days pre-release. This is untenable ... for the entire jail population ... The staffing is not possible ... [if the JI Screening Portal has] no automation capability ... We anticipate 75% of our population has Medi-Cal ... that means 20,000 times we have to go into the portal to manually enter information. We are a small jail ... We don't have the money or staff needed to manage this ... There will be delays and errors." - JI Provider #1</i> <i>"The portal drives us crazy and is a barrier ... When we developed our implementation plans, the portal didn't exist ... We weren't trained on the portal until three weeks before go</i>

Implementation Barrier	Illustrative Quote
	<i>live ... We built our plans around back billing ... The portal turns on the aid code that allows you to bill for services ... [but] you can only activate the aid code manually one by one through the portal, and you can only activate through the first of the month that someone is in the system. So, if I'm incarcerated on April 15th and we decide I'm ... eligible on May 9th, we can only activate my JI aid code from May 1st and anything that happened in April wouldn't be eligible for reimbursement. When we pictured how this would happen, we thought someone would be released May 9th, incarcerated for 65 days, and we would activate the portal backwards for up to 90 days prior to release ... and that's how we built our billing system." - JI Provider #2</i> <i>"Managing the portal has been a huge job ... a nightmare. Everything has been extremely manual. We hired additional staff before starting but still don't have enough for implementation because of the manual labor in managing the portal." - JI Provider #8</i>
Difficulty billing Medi-Cal	<i>"Go-live counties aren't fully billing because the billing structure is too complicated ... There's technically four different billing streams. Medi-Cal fee for service for the correctional facility for clinical services, reentry care bundles that in-reach providers bill directly, Short Doyle billing for specialty mental health, and the Medi-Cal Prescription billing mechanism ... It's very challenging for ... counties to wrap their minds around it." - JI Provider #10</i> <i>"We have historically never billed for anything ... Larger agencies may have a well-established process for billing Medi-Cal, but it is a hurdle for our jail. We have no current pathways to lean on to bill ... The codes are so new they're not in any pre-made software ... so there aren't any off-the-shelf software for billing bundled rates or for fee-for-service ... We do have a pharmacy actively billing for a few months, but</i>

Implementation Barrier	Illustrative Quote
	<i>we've yet to hear if that's been successful. Finally, billing for ECM [Enhanced Care Management] for post-release hand-off, we've had hurdles with our MCP [Medicaid managed care plan] because MCPs haven't implemented at large scale or consistently so we needed a customized data sharing agreement and contract."</i> - JI Provider #3
30-day medication on-hand requirements (for embedded providers) and inter-county transfers	<i>"Prior to CalAIM, our county's policy was to call in prescriptions as people were being released to a pharmacy of their choice ... And then CalAIM came in and said everyone will walk out with a 30-day supply at release date ... For methadone, our county doesn't have narcotics treatment ... We're a rural county ... To get methadone, we have to transport individuals 1.5 hours away and bring them back!"</i> - JI Provider #6 <i>"Prior to CalAIM, we provided 14 days of psychiatric medication prior to release and then provided [other] prescriptions to outside pharmacies for pick-up if needed. We don't have the capacity to store all the medications required for people to have 30 days in hand upon release ... Even if we work with a retail pharmacy, the medication in hand requirement requires a courier service and a cut-off time with orders submitted by a certain time so the medications can be provided at point of release ... But we have a lot of unplanned releases and can't meet the deadline for the courier service,"</i> - JI Provider #5
Coordination with CDCR for reentry services	<i>"CDCR went partially live as of February 1, 2025 ... [but] their version of a reentry care plan is a random email to adult probation services or county BH saying this person is ready to be released, and their medication list or condition ... [But] we want a warm hand off. Did you tell them about this initiative? Did you give them medicine? Most of the time we are scrambling to find this person... personally call the parole agent ... [and] most of those agents have no idea what I'm talking about."</i> - JI Provider #9

Source Justice-Involved Provider Interviews, April to July 2025.

Note: Data were based on 10 unique counties. UCLA-RAND did not interview CDCR.

Release date uncertainty. All interviewees noted that many people in county jails or youth correctional facilities are pre-adjudicated, meaning they have not yet gone to trial or been sentenced, and thus do not have a known release date. Even when release dates are provided, they can be subject to change based on a wide range of factors. Interviewees described this uncertainty in release dates as making it very challenging to meet certain pre-release service requirements (e.g., 30-days medication and DME in hand at time of release, warm hand-offs to community-based providers, etc.) and to know in advance when to activate, suspend, or terminate the associated aid codes.

Jl Screening Portal. DHCS developed the Jl Screening Portal with the expectation that correctional facilities would use the portal to validate members' eligibility for pre-release services and activate, terminate, pause, reset, or restart the 90-day pre-release services eligibility. Although the portal cannot be used for billing, obtaining prior authorization, or inquiring into other Medi-Cal eligibility, correctional facilities must use the portal to activate an aid code needed to bill. As of July 2025, all interviewees described the portal's limited functionality as a barrier to implementation of pre-release services. For example, the portal was described as not having any automation or batch processing capabilities and therefore requiring extensive manual data entry of member-level information by staff. In addition, staff in one county noted that while the portal is supposed to use "real-time" information from the Medi-Cal Eligibility System, interviewees noted that in practice it only syncs with the system once per day, introducing further delays in workflows. In September 2025, DHCS responded to critiques about the Jl Screening Portal's functionality by launching bulk upload capabilities that allow counties to enter information for up to 100 individuals at a time.

Challenges with Medi-Cal billing. All interviewees, including those in counties that began implementing pre-release services in October 2024, described Medi-Cal billing as a challenge. Multiple interviewees described the absence of a specific, Jl Reentry Initiative billing guide as problematic, particularly given the complexity of the Jl Reentry Initiative and the absence of any existing vendors with knowledge of how to meet the coding and billing requirements for all the different funding streams involved. As of July 2025, multiple interviewees reported challenges with successfully billing and claiming reimbursement for all components of the Jl Reentry Initiative. As of November 2025, DHCS is developing comprehensive Jl Reentry Initiative billing guidance in response to this feedback.

Evaluation Question 7: Did the number of eligible individuals screened and enrolled in Medi-Cal prior to release increase over time?

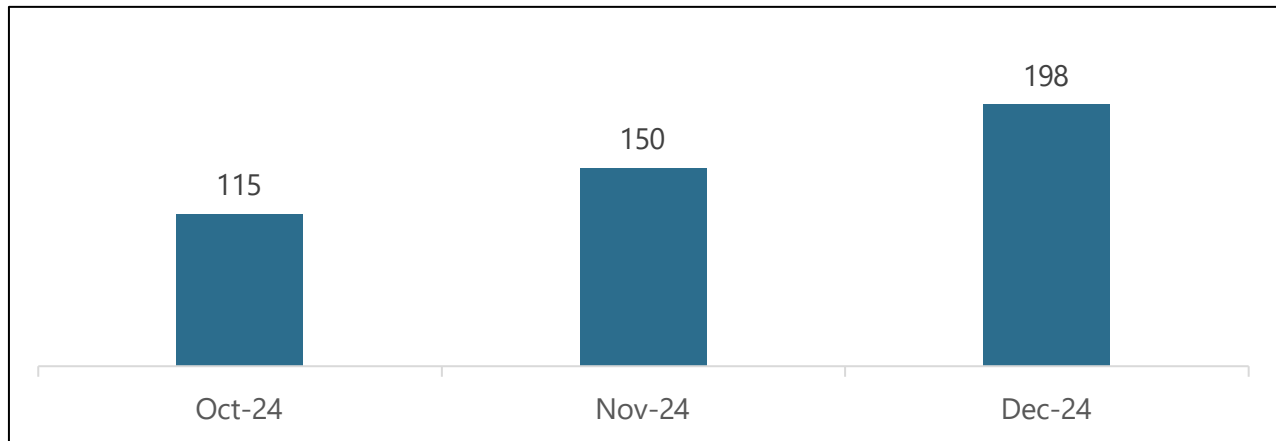
Evaluation Question 7 is addressed by analysis of two measures articulated in the PATH Evaluation Design and displayed in the [Evaluation Questions and Hypotheses](#) section of this report. The data sources used for the analyses are noted for each measure. Further detail on data sources and methods is included in the [Methodology](#) section.

Measure 1. Number and proportion of incarcerated individuals that were screened for Medi-Cal eligibility prior to release, stratified by whether the institution received PATH funding

Data source: October to December 2024 Medi-Cal eligibility and claims data.

Data on the number and proportion of incarcerated individuals screened for Medi-Cal eligibility were not available at the time of the Interim Evaluation Report and the UCLA-RAND PATH Evaluation Team will assess the feasibility of securing this data in four to five select focal counties for inclusion in the Summative Evaluation Report and in collaboration with the UCLA-RAND Reentry evaluation team. Instead, UCLA-RAND used Medi-Cal eligibility and claims data to identify the number of individuals receiving 90-day pre-release services between October 2024 to December 2024 ([Exhibit 1.51](#)).

Exhibit 1.51. Number of Individuals Receiving 90-day Pre-Release Services in Inyo, Santa Clara, and Yuba counties, October 2024 to December 2024



Source: Medi-Cal Eligibility and Claims Data, 2024 Q4.

Note: Individuals receiving 90-day pre-release services were identified using JI-related aid codes. The number of individuals receiving pre-release services may be underestimated because of billing challenges.

Measure 2. Proportion of eligible individuals enrolled in Medi-Cal prior to release, stratified by whether the institution received PATH funding or other resources

Data source: April to July 2025 JI provider interviews.

Administrative data for this measure were not available for the Interim Evaluation Report. UCLA-RAND did not have access to data on the proportion of eligible, incarcerated individuals screened and enrolled in Medi-Cal prior to release. The UCLA-RAND PATH Evaluation Team will collaborate with the UCLA RAND JI Reentry evaluation team to assess feasibility of securing this data in four to five select, focal counties for inclusion in the Summative Evaluation Report.

However, JI providers that were interviewed indicated that the majority of individuals entering county jails and youth correctional facilities were already enrolled in Medi-Cal and that screening, enrollment, and suspension processes were implemented either for all incarcerated individuals or for those incarcerated for at least 48 hours. The most commonly identified barriers to enrolling eligible individuals in Medi-Cal prior to release were member refusal or unwillingness to engage and short lengths of stay in custody.

Cost Analysis to measure cost outcomes of the demonstration through examination of PATH expenditures and resources, payments to providers for ECM and Community Supports services, and the patterns of payments for services used among members

Data needed to address this Evaluation Question and related measures were not available for the Interim Evaluation Report and will be addressed in the Summative Evaluation Report.

G. Conclusions

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

Evaluation data showed significant progress towards this goal as of the Interim Evaluation Report and confirmed that the related hypotheses for this goal were true or likely true. These conclusions were based on evidence of growth in the number of providers contracted to provide ECM and Community Supports; the number of providers contracting with one or more Medicaid managed care plans (MCPs) or in more than one county; the number of providers serving ECM and Community Supports users in rural and under-resourced areas; and the number of ECM and Community Supports users over time.

Provider participation in ECM and Community Supports was in part attributed to PATH resources such as Capacity and Infrastructure, Transition, Expansion, and Development (CITED) funding, TA Marketplace, and Collaborative Planning and implementation (CPI) initiative, which supported providers in building the staffing capacity and technology infrastructure needed to contract with MCPs and deliver ECM and Community Supports. Further evidence showed that PATH funding (CITED, TA) was most often provided to public or private non-profit providers, most of which were small or mid-size social service organizations that did not have prior experience in providing ECM or Community Supports, MCP contracting, data sharing, or billing. Of note were the findings that indicated increases over time in the proportion of MCP contracts with for-profit

providers for both ECM and Community Supports, and in the proportion of ECM members served by private for-profit providers.

Evidence highlighted challenges to implementation including payment adequacy or delays; burden of documentation and variability in MCP requirements and processes, and service authorizations. Impact on ECM and Community Support users experience, access, outcomes, and cost of care are currently unknown but will be assessed in the Summative Evaluation Report.

Goal 2. Improve data collection and information sharing infrastructure among ECM and Community Supports providers.

Evaluation data indicated significant progress towards this goal as of the Interim Evaluation Report and confirmed that the related hypothesis for this goal was likely true. These conclusions were based on qualitative evidence from providers in interviews, surveys, and progress reports that PATH resources, particularly PATH CITED funding, played a critical role in helping them build or modify existing data collection and information sharing infrastructure needed to effectively coordinate the care of clients and report data. Most providers used their own systems rather than other systems such as data exchanges, local Continuums of Care, or local Homeless Management Information. Lack of reliance on other systems was in part due to the time and resource intensive nature of interacting with referral management platforms using different approaches to data sharing and interacting with multiple systems simultaneously. Smaller organizations without existing systems also had barriers to using data exchanges or Qualified Health Information Organizations because of variations in functionality and completeness of data and lack of standardization. Data sharing was further challenged by changes in DHCS policy guidance that required system updates by providers.

MCP-administered supports and PATH helped provide funding and TA to providers to help stand up and build out provider data infrastructure to support CalAIM delivery. Despite this, there were still challenges in data sharing with a lack of a prescribed, centralized system leading to provider apprehension to invest in infrastructure. The successes in improved data sharing infrastructure may have led to more providers submitting claims to MCPs, but evidence indicated that some providers were not fully relying on electronic claims submission and were still submitting invoices. The changes

in MCP and provider progress in building and sharing data will be reexamined in follow-up interviews and presented in the Summative Evaluation Report.

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 data indicated some progress towards this goal as of the Interim Evaluation Report, largely due to delayed implementation of 90-day pre-release services. Available evidence confirmed that two of the three hypotheses for this goal were likely true. However, the evaluation team was only able to access limited quantitative data for the Interim Evaluation Report, limiting our ability to present comprehensive findings. Further information will be provided in the Summative Evaluation Report. In qualitative data, providers indicated that PATH JI funding played a critical role in helping correctional facilities and county social service departments develop capacity and infrastructure needed to screen, enroll, and change the suspension status of Medi-Cal eligible members prior to release. PATH JI funding also played a critical role in helping correctional facilities and county BH agencies develop policies and procedures, staffing, and infrastructure needed to implement 90-day pre-release services and BH linkages.

Findings indicated that as of the Interim Evaluation Report, while essential, PATH JI funding was not sufficient to overcome certain barriers to implementation of 90-day pre-release services, particularly uncertainty around release dates for members in county jails and youth correctional facilities, administrative burden associated with the JI Screening Portal, and challenges with Medi-Cal billing in correctional settings due to lack of vendors with needed billing capabilities and lack of support in helping correctional facilities understand how to bill the different Medi-Cal funding streams. These challenges are being actively addressed by DHCS, e.g., through a September 2025 update to the Justice-Involved Screening Portal to allow batch uploads of information for up to 100 users, and through development of guidance on Medi-Cal billing for the JI Reentry Initiative.

Cost Analysis to measure cost outcomes of the demonstration through examination of PATH expenditures and resources, payments to providers for ECM and Community Supports services, and the patterns of payments for services used among members

This analysis will be completed and presented in the Summative Evaluation Report.

Overall Conclusions

Overall, the findings indicated that significant progress was made towards PATH goals and available evidence in the Interim Evaluation Report indicated that all the PATH hypotheses were true or likely true ([Exhibit 0.1](#)).

The evidence to examine some evaluation measures was not available due to lack of or delays in receipt of administrative data. UCLA-RAND anticipates addressing these limitations in the Summative Evaluation Report, where additional analysis will be conducted to:

- » Identify members who were eligible for but did use ECM or Community Support services.
- » Examine alternative methods of identifying community-based providers that are more closely aligned with DHCS' definition.
- » Calculate cost outcomes for ECM and Community Support users compared to members who were eligible for but did not use these services. Cost analyses will entail using Medi-Cal eligibility and claims data; attributing payment amounts to health services used by both users and eligible non-users; and using difference-in-difference regression models. These models will be used to compare changes in costs for users from before to after the demonstration to changes in costs for non-users in the same period and comparing the difference between these two groups.
- » Reexamine the implementation of PATH near the end of the demonstration by conducting a second round of MCP and provider interviews.
- » Reexamine the characteristics of ECM and Community Supports users during the entire demonstration period.

- » Assess use of PATH JI Round 4 funding to support implementation of 90-day pre-release services and BH linkages.
- » Examine whether the number of eligible individuals screened and enrolled in Medi-Cal prior to release increased over time.

H. Interpretations, Policy Implications, and Interactions with Other State Initiatives

Providers, particularly those without prior experience contracting with Medicaid managed care plans (MCPs) or billing Medi-Cal, require support to develop capacity and infrastructure to implement new services like those offered under ECM, Community Supports, and the JI Reentry Initiative. PATH resources, particularly PATH CITED and JI Capacity Building Program funding, were perceived as critical for supporting providers with initial start-up costs needed for implementation of these three initiatives.

Under the CalAIM Waiver, the PATH implementation co-occurred with implementation of two other capacity and infrastructure development initiatives, the IPP and the HHIP. The IPP, which ran from January 1, 2022, to December 31, 2024, provided targeted incentives to MCPs to develop infrastructure and capacity for ECM and Community Supports; enhance member engagement and service delivery; improve program quality; and ensure equitable member access to ECM and Community Supports services. The HHIP also provided incentives to MCPs to partner with local stakeholders to address homelessness. Funds were used to develop local system capacity and infrastructure needed to effectively address homelessness such as building a street medicine program, flexible housing pools, or engage in partnerships to develop new housing units. These efforts could have impacted implementation of ECM and Community Supports for members experiencing or at-risk of homelessness.

The 2024 MCP Transition could also have influenced PATH and implementation of the associated ECM, Community Supports, and JI Reentry Initiative by impacting which MCPs were contracted to serve members in many California counties.

I. Lessons Learned and Recommendations

Lessons Learned

- » Funding is crucial to build capacity among small social service community-based providers to deliver ECM and Community Supports. Continued provision of PATH resources, especially PATH CITED funding is needed to build local provider capacity to deliver ECM and Community Supports. PATH CITED funding is particularly important for developing infrastructure capacity among smaller, community-based, and social service providers with less pre-existing experience in data sharing, submitting claims, or working with MCPs. Additionally, monitoring participation of for-profit providers and number of users they serve is needed to ensure that public and private non-profit providers can continue to deliver ECM and Community Supports and compete with private for-profit providers.
- » Multiple changes in policy guidance, such as what was experienced in the early years of ECM and Community Supports implementation, are disruptive and can add to administrative burden for providers and MCPs. Initial ECM and Community Supports policy guides were often ambiguously worded; differing MCP interpretations of these policy guides led to differences in eligibility criteria and disparate referrals and authorization processes between MCPs, among other challenges. While subsequent policy guides were intended to standardize and streamline ECM and Community Supports, the frequency of updates caused confusion among providers and implementing associated system and process changes were perceived as imposing considerable additional administrative burden on MCPs and providers. Obtaining further feedback before policy guidance modifications could help reduce administrative burden and unintended changes in service use.
- » Lack of consistency in MCP referral pathways, authorization denials, variations in MCP portals for sharing client data, and lack of automation for claims submission do not allow providers to conduct their activities and add to their administrative burden. Reducing administrative burden on providers by streamlining referral pathways, improving the authorization process, and reducing variation in MCP portals to ease sharing client data is needed.
- » Promoting data sharing through external sources such as data exchanges, local Continuums of Care collaboratives, or local HMIS requires more support and

standardization. Providing more support and direction to community-based providers in adoption and use of health information exchanges is needed.

- » Low reimbursement for services with high administrative burden reduces participation of providers in ECM and Community Supports. Monitoring and revising provider payment policies to prevent attrition of smaller and low resource providers is needed.
- » Provide correctional facilities and their partners with support to facilitate billing for services. Identifying potential vendors with the needed billing capabilities would be helpful to correctional facilities without prior experience with billing Medi-Cal.
- » Providing detailed policy guidance in advance of implementation will facilitate planning efforts, as would working with vendors developing required portals to ensure ability to interface or permit automation with existing systems, rather than requiring manual data entry.

Recommendations to Other States

The interim evaluation data have implications for states that are considering adding ECM and Community Supports as new benefits under Medicaid to address the needs of members who incur high expenditures because they lack access to care management and social services. The findings further have implications for states that are considering bolstering the local providers' capacity to provide these services.

The lessons learned from PATH implementation indicate that states considering implementing PATH or related initiatives should:

- » Allocate funding to build local capacity, particularly among smaller and low-resourced organizations, to reach likely users in all communities across the state.
- » Dedicate time to engage stakeholders and gather information on existing capacity to develop policy guidance that addresses program implementation challenges prior to implementation.
- » Develop guidance prior to implementation on activities such as referrals, authorization process, MCP data sharing infrastructure and payment portals, use of data exchanges and local Continuums of Care, or local HMIS.
- » Provide MCPs with non-binding pricing guidance for HRSN services developed with input from MCPs and providers.
- » Provider participation in Medicaid to address members' HRSNs can be promoted by community care hubs or management support organizations that centralize

administrative functions for providers to contract with or submit claims to MCPs. However, these approaches should be monitored closely to ensure accountability, quality, and equitable distribution of referrals or resources to providers.

- » Develop guidance prior to implementation of Medicaid billing and reporting requirements and payment portals, particularly for participating providers, without prior experience billing Medicaid.
- » When implementing Medicaid pre-release application and suspension processes, consider impacts on correctional facilities and local social service departments and allocate capacity and infrastructure development resources accordingly.
- » Funding is necessary but not sufficient to support implementation in the absence of other supports such as technical assistance.

EVALUATION COMPONENT 2: EVALUATION OF THE GLOBAL PAYMENT PROGRAM (GPP)

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A. Executive Summary

Summary of the GPP Demonstration

History of fragmented and episodic care for the uninsured. California's uninsured population has historically faced significant barriers to accessing continuous, high-quality care in ambulatory and community settings. Residents without health insurance bear a high burden of HRSNs such as unstable housing and employment, face significant financial and logistical challenges accessing health care, and can experience difficulty navigating the health care system due to language or health literacy barriers. This fragmented and episodic access to care is further compounded by safety net health care financing programs, including Medicaid Disproportionate Share Hospital (DSH) funding, that can limit providers' ability to innovate or invest in services that could more effectively meet the needs of uninsured residents. In the absence of flexible funding streams, safety net health systems have historically faced difficulty prioritizing preventive, equity-enhancing, and outpatient care over more reactive high-cost services, such as ED visits.

Introduction of the GPP. GPP was introduced in July 2015 as part of California's Medi-Cal 2020 Section 1115 demonstration waiver, representing a novel approach to funding care for the state's uninsured residents. GPP consolidated two federal and state funding streams for PHCSs into a single, flexible global budget paid to participating PHCSs on a quarterly basis throughout each payment year. Each service eligible for funding through GPP is assigned a unique point value that reflects the relative value of the service provided. PHCSs earn points throughout the year for providing services to patients who are uninsured for the service and each PHCS has its own specific point threshold that it must meet in order to earn its budgeted amount of total GPP funding. A year-end reconciliation process ensures that the percentage of each PHCS's budget earned, matches the percentage of its threshold that it has met. At the same time, PHCSs that earn more points than their thresholds are eligible to receive payments from PHCSs that do not meet their point thresholds. This payment model incentivized PHCSs to shift from a reliance on episodic, high-cost emergency and inpatient services for uninsured individuals toward delivering proactive, patient-centered preventive and outpatient care. By incorporating non-traditional services such as health coaching and group visits, and by implementing its value-based point methodology to claim funding, GPP both

broadened the definition of covered services and encouraged the adoption of more cost-effective and patient-focused care strategies.

GPP's evolution as part of CalAIM. As California advanced payment and delivery system reforms with its CalAIM waiver, the role of GPP has further evolved to focus on PHM and optimizing clinical quality for the uninsured. The introduction of GPP's Health Equity Monitoring Metrics Protocol, requiring PHCSs to stratify performance data by key demographic characteristics, lays the foundation for more targeted efforts to address inequities in health outcomes and access to care. The addition of ECM and nine new Community Supports better aligns the services eligible for GPP funding with those available to Medi-Cal members, expands access to services that can facilitate patient engagement in care, and can help avoid future, costly acute care utilization allowing PHCSs to stretch scarce safety net funding over a larger population of high need patients.

Goals of GPP. The overarching goals of the GPP demonstration are to:

1. Improve the quality of care for uninsured service users in participating PHCSs;
2. Promote a shift from emergency and inpatient services to lower-intensity, higher-value outpatient and non-traditional services; and
3. Strengthen PHCS data systems to help understand and address health inequities.

These priorities shape the demonstration's approach and provide the foundation for the evaluation, which assesses whether GPP improves the quality of care for California's uninsured, catalyzes a shift toward high-value care, and improves data infrastructure that supports efforts to improve equity across the state's PHCSs.

Methods

The evaluation of GPP is structured around research questions and hypotheses designed to determine whether the program achieves its intended goals for uninsured residents served by participating PHCSs. The evaluation questions focus on three core areas:

1. **Quality of Care:** Does the GPP improve the quality of care for uninsured individuals as measured by improvements in at least one out of five clinical quality measures reported by PHCSs between 2023 and 2026, relative to a comparison group? The five measures selected by DHCS and approved by CMS as part of the GPP Health Equity Monitoring Metrics Protocol are Colorectal Cancer Screening, Hemoglobin A1c Control for Patients with Diabetes, Screening

for Depression and Follow-Up Plan, Cervical Cancer Screening, and Breast Cancer Screening.

2. **Shifts in Service Delivery Settings:** Does the GPP incentivize a shift from high-intensity, acute care settings (e.g., EDs and inpatient stays) toward more cost-effective, patient-centered outpatient and non-traditional settings? This is assessed by measuring the change in the share of GPP points for services provided in low-intensity care settings between 2015 and 2026.
3. **Data Infrastructure and Equity:** Has the GPP led to improvements in the completeness and quality of PHCS data systems – specifically, for patient-level data critical to understanding and addressing health disparities among GPP users? This is evaluated through changes in the completeness of data for five key patient characteristics (race, ethnicity, gender, sexual orientation, and preferred spoken language) between 2022 and 2026.

To answer these questions, the evaluation leverages diverse data sources, including:

- » **GPP Encounter-Level Data:** Submitted annually by PHCSs, these data include details about each GPP service provided to uninsured patients, enabling analyses of trends in service utilization and completeness of patient demographic data collection.
- » **GPP Aggregate Utilization Reports:** These provide annual, PHCS-level summary counts for more than 50 covered services, enable overall trend and service mix analyses, and span a longer time period than the encounter-level data.
- » **GPP Health Equity Report:** The annual report submitted by each PHCS documents performance on five quality measures both overall and stratified by key patient characteristics.
- » **Medicaid Core Set and Managed Care Accountability Set (MCAS) Data:** These data are used to derive a Medi-Cal member comparison group for quality-of-care assessments.
- » **Health Resources and Services Administration (HRSA) Uniform Data System:** These data are used to compare trends in quality of care for GPP users relative to a comparison group of federally qualified health center (FQHC) users.

- » **PHCS Survey and Interviews:** These instruments collect information on care delivery strategies used by PHCSs, perceptions of patient care experiences, and data infrastructure-building activities and challenges.

For each Evaluation Question, the design includes both an intervention group comprising GPP users (i.e., uninsured residents receiving a service from one or more participating PHCSs for which GPP points were earned) and, where feasible, a comparison group of Medi-Cal members living in PHCS counties. Depending on data availability, the evaluation uses a combination of descriptive analyses, two-group cross-sectional comparisons, single-group longitudinal analyses, and qualitative assessments.

Principal Results

Evaluation Question 1: Was the GPP successful in improving quality of care to individuals with uninsured services?

Cross-sectional analysis of five quality measures from 2023, the second year of CalAIM, reveals that, for three out of five indicators (colorectal cancer screening, screening for depression, and breast cancer screening), individuals receiving GPP services experienced care that was comparable to or surpassed that of the comparison group. To close quality gaps on the two remaining measures, focused improvements are needed in the rates of cervical cancer screening – particularly among lesbian/gay and bisexual GPP users and individuals across most racial groups – and in achieving better hemoglobin A1c control, with an emphasis on Hispanic or Latino GPP users and most racial groups.

These encouraging results in quality of care for GPP users may be attributed to PHCS initiatives to minimize appointment wait times and to bolster both primary and specialty care physician staffing – strategies prioritized by over two-thirds of PHCSs in the early years of CalAIM. While robust efforts to promote engagement in primary and preventive care through patient-directed reminders are ongoing, additional targeted outreach to individuals overdue for screenings or experiencing poor chronic disease control, as well as expanded implementation of supportive services (such as equity-enhancing Community Supports), may be necessary to drive improvements in outcomes like hemoglobin A1c control. The forthcoming Summative Evaluation Report will incorporate longitudinal trend analyses to assess whether PHCSs' performance on the quality measures have improved over time and whether they are able to close quality gaps relative to the comparison group over the full duration of CalAIM.

Evaluation Question 2: 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 non-traditional and equity-enhancing services?

Since GPP's inception in state fiscal year (SFY) 2015–2016, PHCSs have achieved an overall increase in the provision of non-BH services in outpatient and other low-intensity care settings, with a particularly notable surge following the COVID-19 pandemic. Simultaneously, inpatient medical and surgical stays also rose, though this was primarily confined to 2023, the second year of CalAIM. Utilization patterns were similar for BH care, where outpatient service use grew substantially over the eight-year period, while inpatient BH services saw consistent increases after 2020, the pandemic's initial year. Collectively, these utilization trends, spanning from the state's earlier Medi-Cal 2020 Waiver through the first two years of CalAIM (2015-2023) resulted in a modest 2-percentage point increase in the proportion of total points earned for services delivered in low-intensity settings, with little difference between BH and non-BH services. Among GPP physician service users – used as a proxy for individuals who may consider a PHCS to be their main source of care – the share of points for non-BH services in low-intensity settings increased by 3 percentage points across the duration of the GPP, a finding consistent with GPP Goal 2. On the other hand, the equivalent measure for BH services fell by 7 percentage points—a result inconsistent with GPP Goal 2.

Mirroring these service shifts, PHCSs reported an array of interventions designed to minimize unnecessary ED visits, including ongoing tracking of ED utilization, referring patients with frequent ED use to ECM, and fostering stronger continuity of care in primary care settings. Despite these efforts, uptake of ECM and the expanded suite of 11 Community Supports remained limited among GPP users in 2023, the first full year of their rollout, and PHCSs faced obstacles in systematically identifying patients referred for most Community Supports within their health systems. Meanwhile, during the first two years of CalAIM, utilization of non-traditional GPP services persisted at peak levels first achieved in 2021. Analysis at the PHCS level further revealed considerable variation in the types of non-traditional services offered, suggesting adaptation of services to align with the unique strengths of each PHCS or the needs of their individual patient populations.

Evaluation Question 3: Was the GPP successful in driving improvements in the data infrastructure necessary to understand health inequities?

During the second year of CalAIM, analysis of GPP encounter data from PHCSs showed a high proportion of self-reported demographic information – specifically for four out of the five data elements emphasized by GPP – with completion rates between 83% and 93%. The proportion of records missing information was minimal: 1%-2% for preferred spoken language, race, and ethnicity; 7% for gender; and 28% for sexual orientation. For GPP users who accessed physician services^f, rates of self-reported information were even higher for most data elements, especially sexual orientation. Additionally, PHCSs widely indicated that the accuracy of patient demographic data used for GPP’s health equity reporting was high, and over half reported dedicating a considerable amount of resources toward enhancing data accuracy during the first few years of CalAIM.

Despite these successes, PHCSs reported that collecting and sharing data remained challenging – especially in terms of maintaining efficient clinic workflows. Almost half of PHCSs had invested substantial effort into addressing a variety of data issues, such as establishing consistent unique patient identifiers throughout their systems and improving the exchange of information with county-based BH providers. All PHCSs relied on patient portals to streamline communication and support essential functions like appointment scheduling and prescription refills. Only a minority noted patient barriers to portal use, with few PHCSs reporting challenges due to language accessibility or complex medical terminology.

Discussion and Interpretation

PHCSs are achieving or making notable strides toward all three GPP goals ([Exhibit 0.1](#)). For three out of the five quality measures evaluated, GPP users received care that matched or exceeded levels provided to a comparison group of Medi-Cal members, while ongoing efforts to improve quality for the remaining two measures and address gaps in care for subpopulations of GPP users across all measures will be monitored for three additional measurement years. As for the second goal, PHCSs have increased the proportion of health services delivered in low-intensity care settings, although PHCSs appear to have more difficulty shifting BH services to low-intensity settings. Upcoming analyses in the Summative Evaluation Report will use additional data sources to offer a

^f “Physician services” refers to outpatient primary care and specialty services provided to GPP users by physicians or non-physician clinicians such as nurse practitioners (NPs), physician assistants (PAs), and certified nurse-midwives (CNMs).

more comprehensive picture of emergency and inpatient service utilization and will incorporate additional measures such as ambulatory care-sensitive (ACS) admission rates. To maintain or boost the use of outpatient, residential, and community-based services, greater uptake of ECM and Community Supports for GPP service users may be necessary. With respect to the third goal, progress was demonstrated by high rates of self-reported patient demographic information and minimal missing data across the first two years of CalAIM. Increasing data capture for these data elements and strengthening data sharing related to referrals and the use of ECM and Community Supports could further enhance the ability of PHCSs to provide efficient, high-value care to GPP service users.

Recommendations

Based on preliminary findings from the GPP demonstration, the evaluation team offers several recommendations to DHCS to strengthen GPP's implementation.

- » Consider integrating additional BH quality measures into the GPP Health Equity Monitoring Protocol, including those that specifically track appropriate follow-up care after hospitalizations or ED use for BH conditions.
- » Foster additional integration by exploring global payment arrangements that span both PHCSs and county-based BH systems, supported by combined funding streams and targeted assessments of governance and data exchange models.
- » Enhance encounter-level data by adding service codes for specialist visits or requiring clinician identifiers to permit more precise tracking of specialty care utilization financed by GPP.
- » Consider implementing a unique patient identifier within GPP data that would facilitate linkage of patient data from other sources including Medi-Cal and the California Health Care Payments Data to address challenges in tracking comprehensive service utilization.

For states considering initiatives similar to GPP, the evaluation team offers the following recommendations:

- » Prioritize robust data infrastructure development in conjunction with global payment models to effectively measure changes in health care quality and support health equity efforts.

- » In states with public BH care delivery systems that operate separately from other health care systems, develop integrated funding mechanisms and data flows between these systems to facilitate more effective care delivery and data sharing.
- » Establish data exchange systems prior to program implementation between state agencies and providers – such as systems enabling efficient Medicaid eligibility verification – to accurately identify uninsured patients eligible for services under the payment model.
- » Provide program participants flexibility in the use of program funds, which has proven key to supporting innovative, high-value care models that are tailored to local needs within GPP.
- » Combine multiple data sources to provide a complete picture of service use among uninsured populations in light of the inherent difficulty in capturing comprehensive utilization data in the absence of a single payer.

Attention to these recommendations can help ensure effective program design, accurate evaluation, and improved outcomes in future demonstrations of global payment models for uninsured populations.

B. General Background Information

Purpose of the Program

California's uninsured population faces significant barriers to accessing continuous, high-quality care in ambulatory and community settings. Many of California's 2.4 million uninsured residents lack eligibility for public health insurance programs, find insurance to be unaffordable, or have difficulty navigating enrollment processes, leading to fragmented and episodic access to care. This problem is further compounded by the limited resources of safety net health care providers to innovate or invest in delivery models that effectively address the needs of these residents. In the absence of flexible funding streams, safety net providers have historically faced difficulty prioritizing preventive, equity-enhancing, and outpatient care over more reactive high-cost services, such as ED visits. Addressing these systemic challenges requires a targeted approach that aligns funding mechanisms with high-value care delivery models for uninsured individuals.

DHCS began implementing GPP in July 2015 as part of the state's Medi-Cal 2020 Section 1115 demonstration waiver, representing a novel approach to funding care for

uninsured populations. The program's purpose is to enable PHCSs to deliver care in more cost-efficient, high-value settings and lessen reliance on high-cost care settings, such as EDs and inpatient facilities. GPP seeks to fundamentally shift service delivery by incentivizing primary and preventive care, supportive services, and innovative methods of care delivery, including telehealth and community-based services. DHCS specified three goals for GPP under CalAIM:

1. Improve the quality of care among individuals with uninsured services.
2. Drive the shift in the provision of services from emergency and select inpatient services to non-emergency outpatient settings among individuals with uninsured services.
3. Improve PHCSs data infrastructure and completeness to help understand and address health inequities among GPP users.

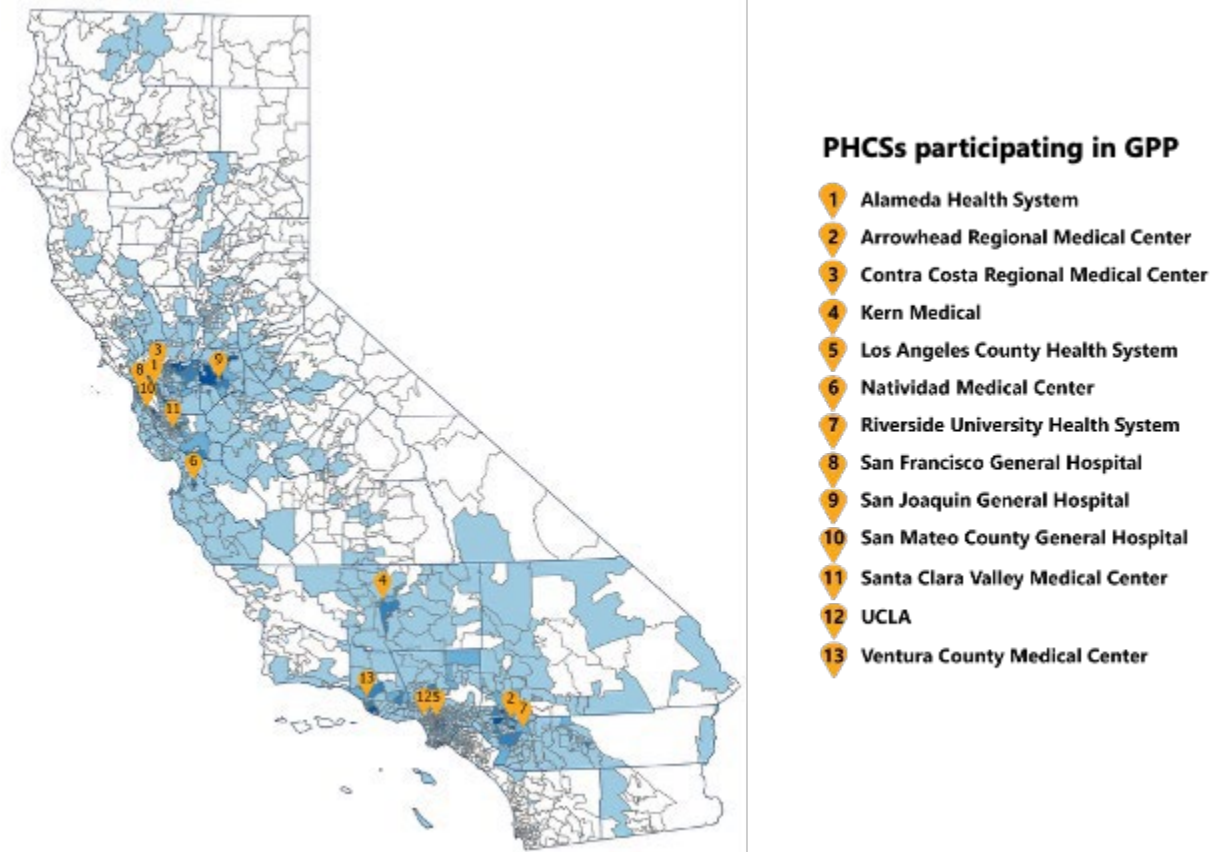
Through its value-based payment structure, GPP aims to improve health equity, access, and outcomes for uninsured individuals while reducing costs and enhancing system efficiency.

Description of the Program

Program Participants

Thirteen PHCSs are implementing GPP across California, including county, city, and University of California (UC)-affiliated medical centers. Participants comprise designated public hospitals (DPHs) and their affiliated and contracted providers, including critical safety net institutions that serve populations with limited or no access to private insurance. These systems partnered with DHCS to deliver GPP services, adhere to quality and utilization reporting requirements, and participate in the evaluation. In 2022, GPP users reported a residence in 57 of California's 58 counties, with a higher concentration of users in the state's more densely populated counties where the PHCSs are located (Exhibit 2.1). While PHCSs serve a high proportion of uninsured residents, it is difficult to determine the percentage of the state's uninsured population that is served by PHCSs as uninsured individuals might seek care from a variety of providers, including both PHCS and non-PHCS providers. For example, there are nearly 200 FQHCs in the state that also serve a high proportion of uninsured residents, separately from PHCSs.

Exhibit 2.1: PHCS Service Areas, 2022



Source: GPP Encounter data (2022).

Note: The intensity of blue shading indicates the relative frequency of encounters by GPP users, by zip code, within each PHCS's service area.

[Exhibit 2.2](#) provides an overview of the characteristics of PHCSs participating in GPP during the CalAIM Waiver. Los Angeles County (LA Co.) Health System is notably the largest participating PHCS in terms of hospital discharges (60,728), and outpatient sites (23), reflecting its significant role in serving one of California's most populous counties. Conversely, smaller systems like San Joaquin General Hospital and Contra Costa Health operate fewer facilities and report substantially lower numbers of discharges. Several systems, including Arrowhead Regional Medical Center and Santa Clara Valley Medical Center, serve critical trauma care needs as Level I trauma centers, while others, such as Contra Costa Health and San Mateo County General Hospital, lack trauma center designation. PHCSs also varied in the level of need of county residents, with Arrowhead Regional Medical Center, Kern Medical Center, and Natividad Medical Center experiencing the highest concentrations of uninsured residents in their counties across all PHCSs (7.8%, 8.2%, and 9.9%, respectively). These differences underscore variation in

PHCS infrastructure and resources and highlight the large population potentially served by GPP. provides an overview of the characteristics of PHCSs participating in GPP during the CalAIM Waiver. Los Angeles County Health System is notably the largest participating PHCS in terms of hospital discharges (60,728), and outpatient sites (23), reflecting its significant role in serving one of California’s most populous counties. Conversely, smaller systems like San Joaquin General Hospital and Contra Costa Health operate fewer facilities and report substantially lower numbers of discharges. Several systems, including Arrowhead Regional Medical Center and Santa Clara Valley Medical Center, serve critical trauma care needs as Level I trauma centers, while others, such as Contra Costa Health and San Mateo County General Hospital, lack trauma center designation. PHCSs also varied in the level of need of county residents, with Arrowhead Regional Medical Center, Kern Medical Center, and Natividad Medical Center experiencing the highest concentrations of uninsured residents in their counties across all PHCSs (7.8%, 8.2%, and 9.9%, respectively). These differences underscore variation in PHCS infrastructure and resources and highlight the large population potentially served by GPP.

Exhibit 2.2: PHCS Characteristics, 2022

PHCS	Hospitals	Hospital Discharges	Outpatient Sites	Trauma Center Status	Staffed Burn Beds	County Uninsured	Global Budget (Millions)
Alameda Health System	4	14,467	4	Level I	No	4.7% 75,000	243
Arrowhead Regional Medical Center	1	17,689	4	Level I	Yes	7.8% 166,000	95
Contra Costa Health	1	6,314	9	None	No	3.1% 35,000	72
Kern Medical Center	1	11,369	11	Level II	No	8.2% 71,000	46
LA Co. Health System	4	60,728	23	Level I	Yes	6.9% 665,000	1,287

PHCS	Hospitals	Hospital Discharges	Outpatient Sites	Trauma Center Status	Staffed Burn Beds	County Uninsured	Global Budget (Millions)
Natividad Medical Center	1	8,252	7	Level II	No	9.9% 41,000	38
Riverside University Health System Medical Center	1	21,502	13	Level I	No	5.4% 129,000	102
San Joaquin General Hospital	1	10,494	5	Level II	No	6.0% 46,000	38
San Mateo County General Hospital	1	2,157	6	None	No	3.6% 27,000	111
Santa Clara Valley Medical Center	3	31,341	12	Level I	Yes	3.7% 70,000	247
University of California Los Angeles Health	3	43,632	14	Level I	Yes	6.9% 665,000	45
Ventura County Medical Center	1	12,479	21	Level II	No	4.0% 33,000	117
Zuckerberg San Francisco General Hospital	2	13,738	14	Level I	No	4.3% 36,000	164

Source: AHRQ Compendium of U.S. Health Systems (2022),²⁷ California Health Interview Survey (2021-2023),²⁸ PHCS websites, and GPP Funding and Annual Limits Report (2022).

Note: Global budgets for 2022 are displayed for all PHCS except for UCLA Health whose 2023 budget is displayed. County uninsured rates were estimated using pooled California Health Interview Survey (CHIS) data from 2021-2023.

Target Population

The target population for GPP includes individuals who are uninsured for one or more services and who receive these services from participating PHCSs. Importantly, eligibility under GPP is specific to the service being provided. Some services, such as emergency care and pregnancy-related services, are already covered under the Medi-Cal program for low-income, uninsured residents, and thus are not eligible for GPP funding since there is no uncompensated care associated with these services. GPP is designed to provide access to care for non-emergency and preventive services that fill critical gaps for uninsured individuals who lack third-party coverage for the specific care needs they seek. GPP's approach to providing access to care for the uninsured ensures that the program complements existing coverage structures and focuses its funding on areas of high need among the uninsured. Individuals are eligible for GPP services regardless of age or residence in a specific county, consistent with GPP's broad and inclusive approach to addressing gaps in health care access.

Program Components

Funding Sources and Amounts. GPP employs a funding structure that combines two primary sources: Medicaid DSH funding and the state's Uncompensated Care Pool funding. Together, these funds form the financial backbone of the program. Under CalAIM, the total computable annual limits for GPP payments amount to approximately \$2.9 billion, composed of the adjusted DSH allotment and an additional \$472 million in Uncompensated Care Pool funding. PHCS-specific budgets were initially calculated based on estimated uninsured services and have been adjusted over time to better align with provision of services to the uninsured. Budgets ranged from \$38 million to just under \$1.3 billion across PHCSs in 2022 (Exhibit 2.2). Participating PHCSs receive quarterly interim payments throughout each program year, calculated as 25% of their global budget.

Points-based Payment Methodology. GPP organizes its 63 reimbursable services into five categories and 18 tiers designed to incentivize care delivery in low-intensity settings and provide funding for both traditional and non-traditional health services (see [Appendix A](#)). Services are grouped into categories that reflect similarities in care setting and modality:

1. Category 1 focuses on outpatient services in traditional settings.
2. Category 2 is comprised of complementary patient support and care services.
3. Category 3 includes technology-mediated outpatient services, such as telehealth and e-consults.
4. Category 4 addresses inpatient and facility-based care, such as hospital stays or residential recuperative services.
5. Category 5, which is a new category of services under CalAIM, comprises “equity-enhancing” services including ECM, Community Supports, and team-based street outreach and engagement.

Each of the five categories is further divided into tiers (A–D) based on the intensity, level of effort, and resource utilization associated with the services. For instance, Tier D services, the most intensive and costly, often require advanced training, certification, or specialized expertise, while Tier A represents lower-intensity services with fewer resource demands. [Exhibit 2.3](#) provides examples of 5 GPP services and their point values in the first year of CalAIM.

Exhibit 2.3: Examples of GPP Services, by Category and Tier

Category	Tier	Service	Point Value in First Year of CalAIM
1. Outpatient in traditional settings	B. Physicians/licensed independent practitioners	Outpatient primary/specialty visit	100
2. Complementary patient support and care services	C. Community-based face-to-face encounters	Mobile clinic visit	90
3. Technology-based outpatient	C. Real-time telehealth	Patient-provider real-time telehealth	100
4. Inpatient	B. Acute inpatient, moderate intensity	Medical/surgical (including acute rehab and stepdown)	613
5. Equity Enhancing	B. Community Supports	Short-term post-hospitalization housing	16/day

Relative point values are assigned to services within tiers using a valuation methodology established by the State and are the same for each PHCS. Traditional services, such as

emergent care and acute inpatient stays, tend to receive lower relative point values over time to discourage reliance on high-cost hospital settings. In contrast, non-traditional services – such as group visits and community outreach – are prioritized with higher point values to encourage use of equity-enhancing and preventive care approaches. The valuation methodology also recognizes the importance of timeliness, convenience, increased access, and resource optimization for favorable patient outcomes. By emphasizing services aligned with early intervention, care coordination, and health promotion, the tier system supports GPP’s broader goals to promote equity and reduce long-term health care costs.

Year-end payment reconciliation. PHCSs earn points throughout the year for providing services to eligible patients up to a PHCS-specific point threshold—equivalent in dollars to the PHCS’s budget. At the end of each program year, the state reconciles global payments with aggregate counts of claimed points for each PHCS to ensure that global payments do not exceed the value of their budgeted point thresholds. The state then redistributes unearned funds from PHCSs that do not meet their point thresholds to those that have exceeded them, incentivizing PHCSs to expand provision of services as appropriate to meet the needs of uninsured residents in their communities.

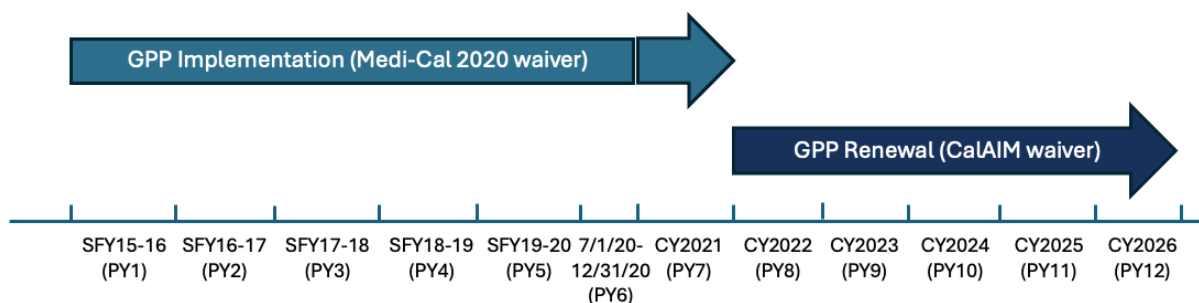
Participation Requirements. PHCSs in GPP are required to meet several reporting and evaluation responsibilities to ensure accountability and the program's success in improving care for uninsured populations. PHCSs must submit aggregate utilization reports on the number of units of eligible GPP services provided and the resulting points earned by these services. Additionally, PHCSs are required to submit encounter-level data annually for all services for which the PHCS claims GPP points, detailing information such as service type, diagnosis and procedure codes, and patient demographics. To support improvements in patient care and outcomes including equity objectives, PHCSs must also provide quality measure data stratified by each of five patient characteristics, including race, ethnicity, gender, sexual orientation, and preferred spoken language, enabling analysis of service accessibility and gaps in care for subpopulations of GPP users. Finally, PHCSs play an active role in the program’s evaluation by engaging in surveys and interviews, and providing the quantitative data sources described above for each program year (PY) that inform the program’s effectiveness and alignment with its goals.

Program Implementation Status

Current Implementation under CalAIM

Initially launched in 2015, CalAIM extended GPP as an integral component of Medicaid reform in the state. The extension preserves the program's essential role in providing care for uninsured individuals while incorporating new services and equity-enhancing strategies. The evaluation focuses on GPP Program Years (PY) 8-12, which correspond to the five-year period spanning from calendar year (CY) 2022 to 2026 ([Exhibit 2.4](#)).

Exhibit 2.4: GPP Implementation Timeline



Note: SFY denotes state fiscal year, PY denotes program year, and CY denotes CY. California's Medi-Cal 2020 waiver extension from December 31, 2020 to December 31, 2021 allowed GPP to continue operating in the year preceding the start of the state's CalAIM waiver.

History of the Program

Medi-Cal 2020 GPP Findings. Under Medi-Cal 2020, RAND's evaluation of the GPP uncovered substantial evidence that the program stimulated changes in care delivery, particularly in outpatient care utilization.³ Across participating PHCSs, outpatient services saw a measurable increase over the course of the GPP. Aggregate utilization data showed consistently rising GPP point totals for non-inpatient, non-emergent services, underscoring shifts in care delivery patterns. For instance, RAND noted that for six out of the 12 PHCSs, the use of outpatient non-BH services increased, illustrating efforts by PHCSs to emphasize care in more cost-effective and patient-centered settings.

Improved access to care was also reflected in increased use of targeted service types, such as preventive care and BH care. BH service utilization showed mixed trends, with increases in outpatient BH for some PHCSs and decreases for others, suggesting localized differences in service use or complete capture of these services within PHCS data systems but aligning overall with the GPP's goals to shift resources to outpatient settings. Surveys and interviews with PHCS leaders further corroborated improvements in care delivery. Providers frequently reported moderate to strong success in enhancing

care team coordination, integrating BH services, and leveraging flexible funding to implement innovative care delivery strategies.

Importantly, the share of points earned by PHCS for non-inpatient, non-emergent services steadily increased across the program years. GPP may have achieved this by incentivizing PHCSs to reallocate resources to higher-value service categories, such as telehealth, patient navigation, and group visits, while de-emphasizing reliance on hospital-based services. RAND's evaluation demonstrated that the percentage of GPP funds earned for non-inpatient services rose progressively, further validating the program's ability to shift care delivery to settings that improve access and reduce cost burdens. By recalibrating the payment structure to reward outpatient and preventive care, GPP laid the groundwork for sustainable delivery system improvements for the uninsured across California's PHCSs.

Changes to the Program Under the Current Waiver. Under the current waiver, GPP incorporated a refined approach to monitoring quality and equity by introducing five clinical quality measures and requiring participating PHCSs to submit stratified data to assess disparities and progress in achieving equity outcomes. The quality measures now included as part of the program are Colorectal Cancer Screening, Hemoglobin A1c Control (less than or equal to 9%) for Patients with Diabetes, Screening for Depression and Follow-Up Plan, Cervical Cancer Screening, and Breast Cancer Screening. These measures were selected due to their alignment with the DHCS Comprehensive Quality Strategy and their relevance to promoting prevention, chronic disease management, and mental health care.^{29,30}

To evaluate progress in equity, PHCSs are required to stratify clinical quality measure data by several patient characteristics, including race, ethnicity, preferred spoken language, gender, and sexual orientation. DHCS and PHCSs use these stratified data to identify gaps in care across specific subgroups and assess whether differences in care are narrowing over time. This equity-focused monitoring approach enables targeted identification and implementation of strategies to enhance care delivery and improve health outcomes for subpopulations of GPP users, ensuring that the program not only improves overall quality but also addresses gaps in care access and outcomes for selected patient groups.

Under the current waiver, GPP places an elevated focus on strengthening data infrastructure as a critical component of Goal 3. Recognizing that incomplete or inadequate patient data can hinder efforts to improve care delivery and address health

disparities, GPP has prioritized the development of comprehensive data collection, reporting, and analytic systems. PHCSs must implement or maintain advanced data management systems to capture robust, encounter-level information that informs PHM and identifies inequities in care. For example, PHCSs are expected to adhere to the Health Equity Monitoring Metrics Protocol,⁸ which requires stratified reporting of clinical quality measures by demographic characteristics described earlier. By enhancing the completeness and accuracy of patient data, systems are better equipped to continuously monitor outcomes, tailor interventions to specific populations, and drive improvements in equity and quality of care in support of GPP's goals.

Changes to the Evaluation Design that Build on Earlier Findings. Under the CalAIM Waiver, the evaluation design has been expanded to build on earlier findings by incorporating more robust comparison groups and leveraging new data sources to strengthen inferences about the impact of GPP. Recognizing the limitations of pre-post designs used in the prior evaluation, the new design integrates comparison groups to assess trends in quality and utilization. These comparison groups were constructed using Medi-Cal claims and eligibility data, allowing the identification of Medi-Cal members who match the characteristics of GPP users and live in PHCS service areas. By comparing quality of care and utilization between GPP participants and these comparison groups, the design strengthens the internal validity of the evaluation's findings.

Additionally, the evaluation now leverages expanded data sources to provide deeper insights into performance. Medi-Cal claims data supplement GPP encounter data to capture utilization trends for services not traditionally reimbursed under GPP, such as ED visits. Managed Care Accountability Set (MCAS) measures, reported annually by Medi-Cal managed care organizations, were used as an additional dataset to evaluate quality and equity outcomes. These measures cover domains such as preventive care, chronic disease management, BH, and maternal health, offering valuable benchmarks to track trends in quality of care. By incorporating these comparison groups and additional data sources, the updated evaluation design provides more detailed analyses of the program's impacts, improving the ability to assess whether GPP has successfully transitioned care to high-value settings and reduced disparities in quality of care.

C. Evaluation Questions and Hypotheses

GPP's Three Evaluation Questions

The interim evaluation addresses three central questions to assess the impact of GPP: whether the GPP has improved quality of care, shifted service provision from emergency and inpatient care to non-emergency outpatient settings, and driven improvements in data infrastructure needed to understand health inequities ([Exhibit 2.5](#)). The three evaluation questions reflect GPP's dual focus on clinical quality and health equity for California's uninsured while promoting use of services in cost-effective care settings.

Exhibit 2.5: GPP Evaluation Questions and Hypotheses

Evaluation Question	Hypothesis
1. Was the GPP successful in improving quality of care to individuals with uninsured services?	PHCSs improved the quality of care to the uninsured.
2. 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 non-traditional and equity-enhancing services?	PHCSs increased the use of outpatient services, non-traditional services, and equity-enhancing services over the course of the GPP.
3. Was the GPP successful in driving improvements in the data infrastructure necessary to understand health inequities?	PHCSs improved the data collection, reporting, and analytics infrastructure to identify and act on health inequities.

GPP's Key Driver Diagram describes how the design of the program will help to achieve these goals ([Exhibit 2.6](#)). The upper part of the diagram centers on improving the quality of clinical care through investment in patient-centered primary and preventive services, utilizing a value-based point methodology that incentivizes a shift from acute care settings (such as emergency and inpatient services) to more cost-effective, patient-centered care, while incorporating non-traditional services like group visits and health coaching. The lower part of the diagram reflects GPP's emphasis on strengthening PHCS data infrastructure to better understand and address health inequities, primarily by incentivizing data collection, reporting, and analytics improvements and requiring PHCSs to submit performance data stratified by key demographic variables according to

the GPP Health Equity Monitoring Metrics Protocol. Together, these drivers are intended to transform care delivery and data systems to advance quality and equity for uninsured populations served by the GPP.

Exhibit 2.6: GPP Key Driver Diagram

Aim	Primary Driver	Secondary Driver
Improve the quality of clinical care (as measured by clinical quality performance rates) for California’s uninsured.	(1) Invest in patient-centered primary and preventive care for the uninsured. (2) Shift care away from less cost-effective acute settings, such as emergency and inpatient settings for the uninsured. (3) 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.
Improve PHCS data infrastructure and completeness that are necessary to understand health inequities among GPP users.	Incentivize PHCS through GPP to improve data collection, reporting, and analytics infrastructure.	(1) Implementation of the Health Equity Monitoring Metrics Protocol. (2) Require PHCS to adhere to the Health Equity Monitoring Metrics Protocol by submitting performance data stratified by demographic data.
← Causality ←		

Alignment with Title XIX and XXI Objectives

All evaluation questions and hypotheses promote the objectives of Title XIX and Title XXI by assessing whether providing high-quality, accessible services to individuals without insurance improves their health outcomes and HRSNs during the demonstration

thereby reducing Medicaid expenditures (including Medicaid DSH funding). In addition, the infrastructure-building goals of CalAIM, including investments in data systems and monitoring protocols, will help to support PHM and optimize clinical care, which will support the delivery of high-quality, high-value care to beneficiaries in line with Title XIX and XXI objectives.

Measuring the Impact of the Program

In evaluating the impact of GPP, the evaluation team will consider GPP to have successfully met its goals under the following circumstances:

1. Improvement in quality of care for GPP service users relative to the comparison group on at least one of the five quality measures reported by PHCSs between 2023 and 2026 and the absence of statistically significant reductions in quality relative to the comparison group on the five measures.
2. Improvement in the share of points for services provided in low-intensity care settings vs. high-intensity care settings between 2017 and 2026.
3. Improvement in data completeness for each of five patient characteristics collected in GPP encounter-level data between 2022 and 2026.

Over the course of GPP, major policy, payment, or public health changes may affect access to care for California’s uninsured population independent of the GPP.

Accordingly, the evaluation team may require adjustments to the evaluation design and the associated criteria for assessing GPP’s impact.

D. Methodology

The evaluation team developed a mixed methods evaluation design that combined quantitative analyses of program data and Medi-Cal claims data, with interviews and surveys of PHCS staff knowledgeable about GPP to assess the program’s impact. This section begins by outlining the data sources used in the evaluation followed by a description of the methodological design and analytic methods used to assess each of the three GPP goals. Detailed tables, one for each Evaluation Question, display the methodological design, target and comparison populations, evaluation period, evaluation measures, and analytic methods. Additional details are provided in the Evaluation Design Report ([Appendix F](#)).

Data Sources for the GPP Evaluation

[Exhibit 2.7](#) outlines the data sources the evaluation team is using in the GPP evaluation. The exhibit shows both secondary data sources and primary data collected by UCLA/RAND. It describes the data sources and how the data were used in the evaluation.

Exhibit 2.7: GPP Evaluation Design Data Sources

Data Source	Description of Data Source	How the Data Source Is Used in the Evaluation
Secondary Data		
GPP Encounter-Level Data	Patient-level encounter data submitted by each PHCS on a yearly basis; includes details on each service provided under GPP, with fields such as patient characteristics (race, ethnicity, preferred spoken language), service type, provider identifier, diagnosis codes, and procedure codes. Data have been submitted by PHCSs since PY 2 (SFY2016-2017), improving in quality and completeness over time. Data from SFY2016-2017 through CY 2023 were used for analyses included in this report.	To describe users of GPP services, evaluate changes in service utilization for GPP users, and assess the impact of improvements in data infrastructure needed to measure and advance health equity.
GPP Aggregate Utilization Reports	PHCS-level aggregate annual counts of GPP services delivered, submitted via a standardized reporting template developed by DHCS (interim and final year-end summary reports, submitted after each PY). Reports include number of services provided to the uninsured for each eligible GPP service. Data from SFY2016-2017 through CY 2023 were used for analyses included in this report.	To supplement encounter-level data for the analysis of trends in service utilization. Data source for points earned for ED services reimbursed through county Maddy EMS Funds. ⁹

⁹ California counties can establish a Maddy Emergency Medical Services (EMS) Fund to reimburse physicians and hospitals operating in the county for the costs of uncompensated emergency care. ED encounters for these services are not included in GPP encounter-level data as they are captured in a parallel reporting system.

Data Source	Description of Data Source	How the Data Source Is Used in the Evaluation
Medicaid Core Set	Annually reported member-level measures of performance on quality and utilization, covering domains such as primary care, BH, maternal health, chronic disease, and utilization. Data are reported by DHCS for each year of CalAIM. Data from CY 2023 were used for analyses included in this report.	To compare trends in quality of care for GPP users relative to a comparison group of Medi-Cal members.
MCAS Measures	Medi-Cal managed care member-level data that includes measures of performance in BH, children's health, chronic disease management, reproductive health, cancer prevention, and utilization. Data are reported on an annual basis by MCPs for each year of CalAIM. Data from CY 2023 were used for analyses included in this report.	To compare trends in quality of care for GPP users relative to a comparison group of Medi-Cal members.
Medi-Cal Claims, Encounters, and Eligibility Files	Statewide Medi-Cal claims and encounter data since GPP inception (SFY2015–2016). Includes claims and encounters for physical, dental, and BH (e.g., Short Doyle claims) for members enrolled in either managed care or fee-for-service. Data from CY 2023 were used for analyses included in this report.	To identify comparison groups and derive additional measures to supplement utilization analyses.
GPP Health Equity Reports	Annual report submitted by PHCSs (required as of PY9, (2023) covering five DHCS-selected clinical quality measures and utilization categories. The data are stratified by demographic categories per Attachment M of the CalAIM special terms and conditions. ⁸ Data from CY 2023 were used for analyses included in this report.	To assess changes in disparities in quality of care for GPP users throughout CalAIM.
Health Resources and Services Administration	Annual data from HRSA Health Center Program awardees and look-alikes that include clinical quality measures. Data from CY 2023 were used for analyses	To compare trends in quality of care for GPP users relative to a comparison group of

Data Source	Description of Data Source	How the Data Source Is Used in the Evaluation
(HRSA) Uniform Data System	included in this report.	FQHC users.
Primary Data Collected by UCLA/RAND		
PHCS Survey	Surveys of PHCS leaders and teams administered twice during the evaluation period (e.g., 2025 and 2026), based on protocols developed by the evaluation team. Includes structured questions on care delivery strategies, implementation challenges, and perceptions of patients' care experiences.	To collect PHCS-specific data on GPP implementation strategies and challenges and provide context for quantitative findings.
PHCS Interviews	Structured interviews (recorded and transcribed) with PHCS leaders and teams conducted twice during the evaluation period (e.g., 2025 and 2026), following up on survey responses and assessing implementation experiences in greater depth.	To explore emergent themes, address survey gaps, and contextualize system responses and barriers.

Methodological Design and Analytic Methods

GPP Goal 1 Evaluation Design

GPP's Goal 1 is to improve the quality of care provided to individuals with uninsured services. Analyses of quality of care measures and PHCS data on care delivery strategies and perceptions of patient experiences inform our approach to evaluating GPP's Goal 1 ([Exhibit 2.8](#)).

Exhibit 2.8: Methodological Design Components for GPP Evaluation Question 1

Evaluation Measures	Evaluation Period	Design/ Analytic Methods	Target Population, Description	Target Population, Data Source	Comparison Group, Description	Comparison Group, Data Source
Included in the Interim Evaluation Report						
Quality measures* » Colorectal Cancer Screening » Hemoglobin A1c Control for Patients with Diabetes » Screening for Depression and Follow-Up Plan » Cervical Cancer Screening » Breast Cancer Screening	2023 (Interim Evaluation Report) 2023-2026 (Summative Evaluation Report)	Two-group comparison; descriptive analysis	GPP service users	GPP Health Equity Reports	Medi-Cal members who have received primary care services FQHCs in California not affiliated with PHCSs	MCAS/ Medicaid Core Set Measures HRSA Uniform Data System
» Strategies to improve access to care, continuity of care, and population health » Timeliness of care for PHCS patients	2025	Single period cross-sectional	Participating PHCSs	PHCS Survey	NA	NA

Evaluation Measures	Evaluation Period	Design/ Analytic Methods	Target Population, Description	Target Population, Data Source	Comparison Group, Description	Comparison Group, Data Source
» Perceptions of patient experiences at PHCS						
Additional analyses to be included in the Summative Evaluation Report						
» Strategies to improve access to care, continuity of care, and population health » Timeliness of care for PHCS patients » Perceptions of patient experiences at PHCS » Impact of state and federal payment and policy changes	2026	Single period cross-sectional	Participating PHCSs	PHCS Survey	NA	NA

*For the five measures reported in the GPP Health Equity Reports, CMS is the measure steward for the Screening for Depression and Follow-up Plan measure. The National Committee for Quality Assurance (NCQA) is the measure steward for the other four quality measures. For the comparison group, four of the five measures were obtained from the MCAS and NCQA is the measure steward for all four measures. For the measure obtained from the HRSA Uniform Data System data, CMS is the measure steward.

GPP Quality Measures. The first set of analyses uses the GPP Health Equity Reports to examine trends in the quality of care PHCSs provide to GPP users. PHCSs started submitting these reports for care provided in 2023 and will continue doing so on an annual basis through the end of CalAIM (2026). The reports included each PHCS's performance on five quality measures, both overall and stratified by patient's self-reported demographic characteristics (ethnicity, race, preferred spoken language, gender, and sexual orientation). The five quality measures included in the GPP Health Equity Reports include⁸:

1. **Colorectal Cancer Screening:** percentage of adults 45-75 years of age who had appropriate screening for colorectal cancer with any of the following: fecal occult blood test during the CY, FIT-DNA (fecal immunochemical test) in the last 3 years, flexible sigmoidoscopy in the last 5 years, computed tomography colonography in the last 5 years, or colonoscopy in the last 10 years. [Measure steward: NCQA].
2. **Hemoglobin A1c Control for Patients with Diabetes:** percentage of individuals 18-75 years of age with diabetes (type 1 and type 2) whose hemoglobin A1c was >9.0% during the measurement year. To facilitate comparisons across measures, results were reverse-coded so that a higher performance rate implies better quality [Measure steward: NCQA].
3. **Screening for Depression and Follow-up Plan:** percentage of patients aged 12 years and older screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and, if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter [Measure steward: CMS].
4. **Breast Cancer Screening:** percentage of women 50-74 years of age who had a mammogram to screen for breast cancer any time on or between October 1 two years prior to the measurement period and the end of the measurement period [Measure steward: NCQA].
5. **Cervical Cancer Screening:** the percentage of women 21-64 years of age who were screened for cervical cancer using (a) cervical cytology performed within the last 3 years (for women 21-64 years of age), (b) high-risk human papillomavirus testing performed within the last 5 years (for women 30-64 years of age), or c)

cervical cytology/high-risk human papillomavirus co-testing within the last 5 years (for women 30-64 years of age) [Measure steward: NCQA].

This Interim Evaluation Report includes data from the first year of reporting (2023). In the Summative Evaluation Report, the evaluation team will examine changes in quality of care and disparities between 2023 and 2026.

For four of the five quality measures, the analysis used a comparison group of Medi-Cal members who live in the same counties as participating PHCSs, have full-scope Medi-Cal coverage, and received at least one primary care service in 2023.^h To identify the comparison group the evaluation used Medi-Cal claims, encounter, and eligibility data, and MCAS data were used to assess quality of care. The MCAS data were reported by MCPs to DHCS reflecting the quality of care received by their Medi-Cal members and include four of the five quality measures comprising the GPP Health Equity Reports. A primary care service was defined by adapting the May 2024 California Office of Health Care Affordability's Draft Primary Care Code Set. Under this definition, a service was defined as a primary care service if it was one of 584 services, was rendered by a provider with one of 30 primary care specialty codes, and was offered in one of 16 places of service.³¹ After identifying the cohort of Medi-Cal members who met inclusion criteria, the evaluation team matched via each member's Client Identification Numberⁱ in the 2023 Medi-Cal eligibility file with the 2023 MCAS data and only included in the analyses those members who appeared in both files.

For the fifth measure, Screening for Depression and Follow-up Plan, a comparable measure is not available in the MCAS data. Instead, the evaluation team relied on the HRSA Uniform Data System (UDS) data, which includes performance data for HRSA Health Center Program awardees and look-alikes for the same measure included in the GPP Health Equity Report data. Using the HRSA UDS data, the evaluation team identified a

^h The evaluation team implemented the utilization requirement for the Medi-Cal comparison group as the performance rates reported by PHCSs for GPP users only includes in the target population those patients for whom the PHCS submitted points and who had a GPP primary care visit with the PHCS. The Depression Screening and Follow-up Plan measure is not included in the MCAS and required use of a different comparison group that is described later in this section.

ⁱ The Client Identification Number is the unique patient identifier used in Medi-Cal claims and eligibility files.

comparison group cohort of FQHCs operating in California, excluding five FQHCs that are affiliated with one of the 13 PHCSs participating in GPP. The team then used FQHC-level performance estimates on the measure and calculated an overall rate for the comparison group, weighting the FQHC-level estimates by the number of patients ages 18 and older that were served by the FQHC.

PHCS Survey. Analyses of the PHCS Survey provided insights into implementation of the strategies of PHCSs to improve quality of care (including access to care, continuity of care, and population health), estimates of timeliness of care provided to patients at the PHCS, and PHCS perceptions of patient experiences.

GPP Goal 2 Evaluation Design

GPP's Goal 2 is to drive the shift in the provision of services from emergency and select inpatient services to non-emergency outpatient settings among individuals with uninsured services. Quantitative analyses of service utilization and analyses of the PHCS Survey were used to inform the approach to GPP's Goal 2 ([Exhibit 2.9](#)). Selected utilization analyses were included in this Interim Evaluation Report while additional analyses are in-progress and will be included in the Summative Evaluation Report. In addition, a second wave of the PHCS Survey and a second set of interviews with staff from each PHCS will be conducted in 2026 and incorporated into the Summative Evaluation Report.

Exhibit 2.9: Methodological Design Components for GPP Evaluation Question 2

Evaluation Measures	Evaluation Period	Design/ Analytic Methods	Target Population, Description	Target Population, Data Source	Comparison Group, Description	Comparison Group, Data Source
Included in the Interim Evaluation Report						
» Utilization (in GPP points), by service category » Share of points in low-intensity settings, overall and stratified by patient demographics	2015-2023 (Interim Evaluation Report) 2015-2026 (Summative Evaluation Report)	Single-group longitudinal analysis	GPP service users	GPP encounter-level data	NA	NA
» Strategies to promote care in cost-effective settings » Availability of Community Supports » Providers of Community Supports within PHCS	2025	Single period cross-sectional	Participating PHCSs	PHCS Survey	NA	NA

Evaluation Measures	Evaluation Period	Design/ Analytic Methods	Target Population, Description	Target Population, Data Source	Comparison Group, Description	Comparison Group, Data Source
» Experiences with referrals for Community Supports						
Additional analyses to be included in the Summative Evaluation Report						
» ECM and Community Supports implementation progress and challenges » Impact of BH delivery changes » Impact of state and federal payment and policy changes	2026	Single period cross-sectional	Participating PHCSs	PHCS Survey, PHCS Interviews	NA	NA
» All-cause ED visit rate » Multiple ED visits/year » ACS ED visits	2015-2023	Pre-post with comparison group	GPP service users attributed to a PHCS	Medi-Cal Claims	Medi-Cal members attributed to a PHCS	Medi-Cal Claims

Evaluation Measures	Evaluation Period	Design/ Analytic Methods	Target Population, Description	Target Population, Data Source	Comparison Group, Description	Comparison Group, Data Source
» ACS hospitalizations	2017-2023	Two-group longitudinal analysis	GPP service users attributed to a PHCS	GPP encounters	Medi-Cal members attributed to a PHCS	Medi-Cal Claims

GPP Service Utilization Trends. The first set of analyses used GPP encounter-level data to examine trends in utilization of GPP services from the program’s inception (state FY 2015-2016) through 2023, which reflected the most current data available. The evaluation team assessed trends in utilization for five categories of non-BH services: outpatient-traditional, outpatient-non-traditional, low-intensity inpatient, inpatient medical/surgical, and emergency. The first three categories reflected services that were typically provided in “low-intensity” settings whereas the latter two categories reflected “high-intensity” settings. The evaluation team then examined four categories of BH services: outpatient and residential, which reflected “low-intensity” settings, and inpatient and emergency, which reflected “high-intensity” settings. Points earned by PHCSs for each service, based on GPP’s valuation methodology (Attachment L of the CalAIM special terms and conditions),⁸ were aggregated within each of these service categories. [Appendix A](#) of the Interim Evaluation Report contains a crosswalk between individual GPP services to categories and contains point values for each service.

Share of Points in Low-intensity Settings. Using the service categories listed above, the evaluation team then examined trends in points earned for all services in low-intensity settings as a share of total points. [Appendix B](#) of the Interim Evaluation Report provides specifications for the numerator and denominator of each point-share measure. These share-of-points measures were examined across all services and stratified by BH and non-BH services. The evaluation team next examined these measures for a cohort of users of physician services^j at the PHCS. This analysis accounted for the fact that PHCSs provided services to all members of their communities regardless of insurance status and that many patients may use primary care services outside of the PHCS, presenting challenges for PHCSs in coordinating services across care settings. This analysis was restricted to seven PHCSs for which the patient identifiers included in the GPP encounter data could reliably track individual patients across inpatient and outpatient settings for services provided by the PHCS.

Impact of GPP on ACS Utilization. While the analyses listed above are descriptive only, two additional sets of analyses featured comparisons of trends in ED and inpatient

^j “Physician services” refers to outpatient primary care and specialty provided to GPP users by physicians or non-physician clinicians such as nurse practitioners (NPs), physician assistants (PAs), and certified nurse-midwives (CNMs).

utilization between GPP service users and a comparison group of Medi-Cal members who use PHCSs as their usual source of primary care and will be included in the Summative Evaluation Report. The ED utilization analyses will assess all-cause ED utilization, repeated ED visits, and ACS ED utilization, and it will include a pre-GPP measurement year^k allowing robust, difference-in-differences analyses that can account for unobservable differences between GPP service users and Medi-Cal members. Medi-Cal claims were the data source for the ED utilization analyses because GPP service users are eligible for restricted-scope Medi-Cal coverage, also known as “Emergency Medicaid,” and Medi-Cal claims were generated for these services. By contrast, our analyses of ACS hospitalizations will rely on GPP encounter-level data for GPP users and will cover the period 2017 to 2026, which reflects the period during which GPP encounter-level data are available.

PHCS Survey. Analyses of the PHCS Survey provided insight into PHCS implementation of strategies to support provision of Community Supports, experiences with referrals for Community Supports, and delivery of services in cost-effective settings.

GPP Goal 3 Evaluation Design

GPP’s Goal 3 is to improve PHCS data infrastructure and completeness necessary to understand health inequities among GPP users. Two distinct analyses informed our approach to GPP’s Goal 3 ([Exhibit 2.10](#)). First, the evaluation team analyzed GPP encounter-level data to assess the extent to which information was reported on five patient characteristics on each encounter record: race, ethnicity, gender, sexual orientation, and preferred spoken language. The team first conducted this analysis including all GPP users and then for the subset of GPP patients who used a PHCS for physician services.

The team also analyzed PHCS Survey questions around data infrastructure, including the accuracy of patient information and priorities for each PHCS in improving data accuracy, challenges with data collection and data sharing, and use of patient portals – a key tool for patient engagement, data collection, and data sharing.

^k Although GPP began in SFY(SFY) 2015-2016 (July 1, 2015-June 30, 2016), program implementation was delayed. The Medi-Cal 2020 Section 1115 waiver was approved in December 2015 and the service valuation methodology and payment mechanics were not finalized until April 2016.

Exhibit 2.10: Methodological Design Components for GPP Evaluation Question 3

Evaluation Measures	Evaluation Period	Design/ Analytic Methods	Target Population, Description	Target Population, Data Source	Comparison Group, Description	Comparison Group, Data Source
Included in the Interim Evaluation Report						
» Completeness of patient race, ethnicity, gender, sexual orientation, and preferred spoken language in GPP Encounter data	2022-2023 (Interim Evaluation Report) 2022-2026 (Summative Evaluation Report)	Single-group longitudinal analysis	Participating PHCSs	GPP encounter-level data	NA	NA
» Accuracy of patient information » Data collection and data sharing challenges » Patient portals	2025	Single period cross-sectional	Participating PHCSs	PHCS Survey	NA	NA
Additional Analyses to be Included in the Summative Evaluation Report						
» Data collection and data sharing challenges	2026	Single period cross-sectional	Participating PHCSs	PHCS Survey, PHCS Interviews	NA	NA

E. Methodological Limitations

In assessing the impact of GPP, the evaluation team encountered a wide range of challenges, including difficulty in identifying a suitable comparison group, incomplete and inconsistent data capture across care settings, lack of data collection directly from patients, and analytic constraints stemming from the COVID-19 pandemic and available data sources at the time of submission of this Interim Evaluation Report.

Study Design Limitations

Comparison Group Constraints: Difficulty constructing a valid comparison group for GPP service users stemmed primarily from the lack of available data sources on uninsured California residents – especially for care received in ambulatory settings. Nearly all California PHCSs participate in GPP, except for five of the six UC-affiliated health systems; however, the evaluation team was unable to secure patient-level data from the non-participating UC systems. Efforts to assemble a comparison group from out-of-state health systems were also infeasible due to limited information on quality and utilization across care settings within comparable systems. Similarly, an FQHC comparison group could not be developed because available quality measures were not stratified by insurance status or relevant patient characteristics – both crucial for exploring GPP’s evaluation questions. Moreover, it remains uncertain whether FQHCs would have mirrored PHCS trends in quality and utilization measures prior to the start of GPP.

The main comparison group identified for analyses in this report, full-scope Medi-Cal members who live in the same counties as participating PHCSs, has several limitations. For example, Medi-Cal members and uninsured members may have differences in care-seeking behavior that are not stable over time. In particular, the uninsured may be more likely to defer care during periods in which use of public resources by uninsured residents receives negative publicity at the local, state, or federal levels. Separately, there is a continuous coverage requirement for the quality measures that rely on the MCAS data as a comparison group. This requirement limits the members that are included in the reporting of the measure to those who have been enrolled in Medi-Cal for a period of time specified by each measure. There are no similar coverage requirements for the GPP cohort. In addition, access to care and quality of care for Medi-Cal members were likely affected by several other CalAIM waiver components (discussed more in Section

H) and therefore may not have similar trajectories in these outcomes as GPP service users in the absence of GPP.

Data Limitations

Comprehensiveness of GPP Data: All GPP data (aggregate utilization reports and encounter-level records) represent only services for which points were earned by PHCSs for GPP funding and may not capture the entirety of services provided to GPP users. Many GPP users might experience periods with and without insurance in the same year and over time, making it difficult to estimate the impact of GPP on utilization using GPP data sources alone. For example, periods of uninsurance might cause individuals to use EDs as their usual source of care or reduce their utilization of primary care during these periods, while using primary care physicians (PCP) in their communities when they are insured. The mix of services provided through GPP could shift more from primary care-focused to acute care-focused as rates of uninsurance decrease in the state.

A related limitation is that GPP data reflect only services delivered by PHCSs and their contracted entities – not the totality of care received by GPP users – which might include FQHCs unaffiliated with the PHCSs. As a result, the analyses may underestimate both quality measure performance and the proportion of points earned in low-intensity settings, particularly if GPP users use PHCSs for ED and hospital care but use non-PHCS clinics for most or all of their ambulatory care. The use of a second exposure cohort that is limited to PHCS physician service users seeks to address this limitation, but it is unlikely to capture all services received by GPP users. Furthermore, since ED services are covered by Medi-Cal (“Emergency Medi-Cal”) for all residents with qualifying incomes, many ED services are not included in GPP data reported by PHCSs. The evaluation will incorporate Medi-Cal claims data for the Summative Evaluation Report to provide a more comprehensive assessment of changes in ED utilization.

Improvements in PHCS data systems for capturing GPP services over the course of the program could also introduce bias by overstating increases in utilization. In particular, data exchange between PHCSs and county-based BH systems is still challenging in many counties depending on the degree of organizational integration. Over time, improvements in data capture – especially for services provided by county-based BH providers and PHCSs that use contracted providers – could improve reporting of utilization by GPP users. However, we anticipate that these improvements would only introduce bias in our low-intensity-point share measures if there were differential

improvements in data capture between inpatient and outpatient settings causing shifts in utilization that are due only to improved data capture rather than actual shifts across settings.

Encounter-Level Identification Issues: Few PHCSs employ a unique patient identifier that spans all care settings within their health systems, hampering efforts to accurately construct utilization and quality measures at the individual level and to track longitudinal changes. This challenge was pronounced for contracted providers and county-based BH systems, especially in PHCSs where BH services were not fully integrated. The evaluation team surveyed PHCSs to understand the consistency of unique identifiers across settings and used this information to define cohorts of physician service users in seven PHCSs that allow linkages between inpatient and outpatient care across behavioral and non-behavioral services. However, in less integrated systems, inconsistencies in linking behavioral and non-behavioral data persist, limiting the evaluation's ability to measure continuity of care, assess follow-up care after acute events, and evaluate changes in physical health and BH integration that might be associated with GPP.

Lack of Encounter Data Specificity: The inability to distinguish primary care from specialist encounters in the GPP encounter-level data stemmed from lack of granularity in service codes (a common code identifies visits with physicians regardless of specialty) and reliance predominantly on organizational provider identifiers instead of clinician-specific identifiers. These limitations rendered any efforts to assess specialty care infeasible even though access to specialists was highlighted as a key challenge in the PHCS Survey. Additionally, encounter-level data were not collected during the first year of GPP (state FY 2015-2016)¹ and were not considered reliable for the following year, requiring analyses to rely on the aggregate utilization reports through June 2017 and encounter-level data thereafter for analyses of trends in utilization.

Limitations of Quality Measure Data: Assessments of GPP's impact on quality of care were constrained by the availability of only five measures, which – although addressing diverse patient populations and including an intermediate outcome (A1c control) – omit important areas like SUD treatment or follow-up care after acute events. Such omissions limit the evaluation's ability to fully assess alignment with GPP goals, especially

¹ Encounter-level reporting was a requirement beginning in GPP's second year (SFY2016-2017).

regarding increased provision of care in low-intensity settings. Moreover, GPP's quality measures were first collected only in 2024, reflecting performance in 2023 (CalAIM's second year), restricting the evaluation's ability to measure GPP's impact over the entire five-year waiver.

PHCS Survey Limitations: The PHCS Survey was limited by the lack of a comparison group, difficulty attributing care improvement strategies undertaken by PHCSs specifically to GPP, and potential respondent bias, as PHCS staff may wish to present GPP progress in a favorable light. Moreover, during cognitive interviews with two PHCSs conducted to develop the PHCS Survey, the evaluation team learned that insurance status at the point of care was often unknown, so PHCS representatives would not be able to provide GPP-user-specific responses, which limits the specificity of survey and interview feedback. The timing of the survey (early 2025) further limits its ability to capture temporal changes.

Patient Experience Gaps: Direct engagement of patients through primary data collection (surveys or interviews) was not possible due to operational and privacy concerns. To partially mitigate this, the evaluation required staff from two primary care clinics within each PHCS to respond to questions about patient experiences. The evaluation team will seek to engage community stakeholders in the future to supplement the survey findings to develop a more comprehensive assessment of care experiences of uninsured residents who may be receiving services from PHCSs.

Limitations of Statistical Analyses

Pandemic-Related Impacts: COVID-19 dramatically affected utilization patterns in 2020, with the impact very likely persisting through the initial years of GPP implementation under CalAIM. While the use of a comparison group in the quality of care assessments provided adjustment for these long-term pandemic impacts, the utilization analyses reported in this report remain sensitive to COVID-19's effects due to the lack of a comparison group. Nevertheless, the utilization analyses included four pre-pandemic years and will expand to cover two full CYs following the end of the public health emergency (PHE) in May 2023 in the Summative Evaluation Report.

Adjusting for Changing Patient Health Needs: Since GPP's introduction, significant changes in patient health status likely occurred among uninsured residents, as deferred care during COVID-19 may have worsened chronic or mental health conditions among GPP users. Although current analyses do not adjust for case mix changes over time,

analyses that will be included in the Summative Evaluation Report will incorporate adjustments for medical complexity and risk using standard tools like the Chronic Illness and Disability Payment System.³²

F. Results

The results section provides a profile of GPP service users, presents interim evaluation findings for each of the three evaluation questions, and discusses future analyses that will build on these interim results and will be included in the Summative Evaluation Report.

Profile of GPP Service Users

To examine the characteristics of GPP users, the evaluation team used GPP Encounter-Level Data from 2023 and summarized the number and percentage of encounters that were provided to subpopulations of users, including across all PHCSs as well as the minimum and maximum percentages at the PHCS-level. In reporting GPP user characteristics in the encounter-level data, PHCSs used guidance provided by DHCS in the Format and File Specification for GPP Encounter Reporting Manual,³³ including how to classify missing and unknown data. In 2023, nearly half of GPP services were provided to adults ages 26–49 (49.4% of all encounters) and ages 50–64 (25.8%) ([Exhibit 2.11](#)). Only 9% of services were provided to children ages 18 and younger. Most services were provided to people who identified as female (51.4%). A quarter of services were provided to White GPP users (25.7%), and a notable proportion to GPP users who identified as Other Race (49.2%), with smaller percentages of services for Black or African American GPP users (3.4%) and Asian GPP users (4.7%). Nearly two-thirds of services were provided to GPP users who identified as Hispanic or Latino (65.3%), while 17.3% were provided to those who identified as not Hispanic or Latino. Regarding GPP users' sexual orientation, the largest proportion of services were provided to those who described themselves as straight or heterosexual (40.3%) although GPP users' self-reported sexual orientation was not available for most encounters (58.5%). Over half of services were provided to GPP users whose preferred spoken language was Spanish (62.4%), followed by English (27.7%), with a small fraction indicating a preference for other languages.

Exhibit 2.11. Demographic Characteristics of GPP Service Users, 2023

	Number of Encounters, All PHCSs	Percent of Encounters, All PHCSs	Minimum PHCS (Percent)	Maximum PHCS (Percent)
Age				
0-12	137,681	4.6	1.3	11.3
13-18	129,303	4.4	1.8	13.8
19-25	138,208	4.7	2.8	9.5
26-49	1,465,551	49.3	38.4	60.6
50-64	766,334	25.8	13.6	31.6
65+	319,405	10.8	3.7	14.7
Value Missing	13,451	0.5	0.0	6.4
Gender				
Female	1,525,235	51.4	24.3	60.5
Male	1,074,503	36.2	21.4	54.3
Other	32,285	1.1	0.0	54.2
Did not disclose	121,707	4.1	0.0	25.1
Value Missing	216,203	7.3	0.0	14.8
Race				
White	759,497	25.6	7.6	89.0
Black or African American	100,615	3.4	1.2	11.2
Asian	129,363	4.4	0.8	9.1
American Indian or Alaska Native	12,260	0.4	0.1	2.4
Native Hawaiian or Other Pacific Islander	16,596	0.6	0.0	4.0
Multiracial	23,307	0.8	0.2	2.1
Other Race*	1,457,203	49.1	3.9	70.4
Declined to Answer	30,741	1.0	0.0	14.3
Unknown	376,655	12.7	0.0	20.6
Value Missing	63,696	2.1	0.0	15.3
Ethnicity				
Not Hispanic or Latino	514,817	17.3	10.2	41.0
Hispanic or Latino	1,938,581	65.3	29.8	80.6
Unknown	470,279	15.8	0.3	42.6
Declined to Answer	4,529	0.2	0.0	0.6
Value Missing	41,727	1.4	0.0	15.4
Sexual Orientation				
Straight or Heterosexual	1,198,056	40.3	10.3	76.6
Lesbian, Gay, or Homosexual	19,946	0.7	0.1	1.8
Bisexual	9,393	0.3	0.0	0.9
Something Else	3,657	0.1	0.0	1.8
Choose Not to Disclose	430,481	14.5	0.6	39.1

	Number of Encounters, All PHCSs	Percent of Encounters, All PHCSs	Minimum PHCS (Percent)	Maximum PHCS (Percent)
Don't know	474,378	16.0	0.1	88.7
Value Missing	834,022	28.1	0.2	57.2
Preferred Spoken Language				
English	822,202	27.7	15.5	64.9
Spanish	1,853,637	62.4	21.3	70.8
All other languages**	92,609	3.1	0.2	6.6
Unknown	176,281	5.9	0.5	44.0
Value Missing	25,204	0.8	0.8	15.4

Source: GPP Encounter Data, 2023.

Note: Each percentage reflects the number of encounters in which each response category was reported on the encounter as a proportion of all encounters analyzed. Encounters across all care settings (i.e., inpatient, outpatient, residential, community) were included in the analysis. CY 2023 was chosen for this analysis because it was the first performance year that included all 13 PHCS following UCLA Health's entry into the program in 2023.

*A GPP user was categorized as "Other Race" when they self-identified with a race not otherwise listed.

**All other languages include a wide range of languages, and most account for fewer than 1 percent of GPP encounters. The most commonly preferred spoken languages other than English and Spanish in 2023 were Portuguese (0.4% of encounters), Mandarin (0.3%), Russian (0.3%), Tagalog (0.2%), Korean (0.2%), Dari (0.2%), and Arabic (0.2%).

Results for GPP Evaluation Question 1

Evaluation Question 1 addresses the extent to which GPP is associated with improvements in quality of care for individuals receiving uninsured services. To answer this question, the evaluation team used PHCS reported data on five measures of the quality of care provided to GPP users in 2023 – the first year that these reports were available following CMS's approval of GPP's Health Equity Monitoring Metrics Protocol. The team compared performance on four of these five measures for GPP service users relative to a comparison group of full-scope Medi-Cal members living in PHCS counties

who had at least one primary care encounter in 2023.^m For the fifth measure (Prevention Care and Screening: Screening for Depression and Follow-Up Plan), the team compared performance for GPP users to that of FQHCs in the state, excluding those FQHCs that are affiliated with a PHCS.

As described in Section D, the evaluation intends to compare trends in quality of care for GPP users relative to full-scope Medi-Cal members and FQHCs between 2023 and 2026 to determine whether GPP achieves improvements in quality or stability in trends relative to the comparison group. [Appendix C](#) includes a table comparing the demographic characteristics of the sample of GPP users and Medi-Cal members that were included in the analyses of the four relevant quality measures that used MCAS data for the comparison group. In addition to analyses assessing quality of care, data were analyzed from the 13 PHCSs responding to our PHCS Survey relating to the strategies they have used to improve the quality of care during the first few years of CalAIM, estimates of the timeliness of care provided to their patients, and perceptions of patient care experiences.

Quality of Care for GPP Users

Exhibits 2.12-2.16 display comparisons of the quality of care provided to GPP users in 2023 with a comparison group of full-scope Medi-Cal members residing in the same county as one of the 13 PHCSs or patients served by FQHCs in the state, depending on the measure. In each exhibit, the bars indicate the quality of care provided to GPP users across all PHCSs while the dashed lines indicate the quality of care provided to the comparison group (either Medi-Cal members or California FQHCs).

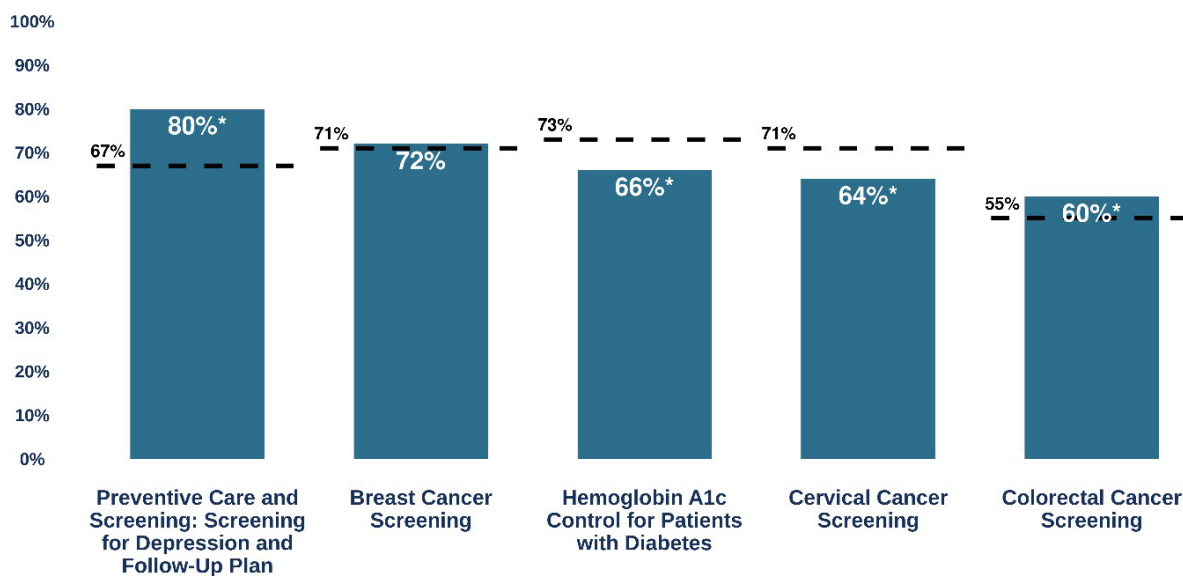
Across the five measures, GPP users received higher quality care than the comparison group on two measures, lower quality on two measures, and similar quality on one measure ([Exhibit 2.12](#)). For the two measures in which GPP outperformed the comparison group, GPP users were 5 percentage points more likely to receive colorectal cancer screenings (60% vs. 55%, $p < 0.001$) and 13 percentage points more likely to undergo screening for depression (80% vs. 67%, $p < 0.001$). By contrast, GPP users were

^m The evaluation team implemented the utilization requirement for the Medi-Cal comparison group because the performance rates reported by PHCSs for GPP users define the target population as all patients for whom the PHCS submitted points and who had a GPP primary care visit with the PHCS.

less likely to achieve hemoglobin A1c control (7 percentage points fewer GPP users achieved hemoglobin A1c control of 9% or less compared to Medi-Cal members; 66% vs. 73%, $p < 0.001$) and cervical cancer screening rates were also 7 percentage points lower (64% vs. 71%, $p < 0.001$). GPP users and Medi-Cal members received breast cancer screenings at similar rates (72% vs. 71%, $p = 0.09$).

To place the quality of care for GPP users within a national context, PHCSs' performance for GPP patients can be compared to nationwide median benchmarks from the NCQA Quality Compass from measurement year 2023. Compared to these national benchmarks, a greater proportion of GPP users received recommended breast cancer screenings (72% vs. 51%), cervical cancer screenings (64% vs. 58%), and hemoglobin A1c control (66% vs. 60%). Two of the five quality measures, however, are not included in the NCQA Quality Compass. For these measures, the evaluation team compared PHCSs to FQHCs nationwide using data from HRSA's UDS.³⁴⁻³⁶ Compared to patients seen at FQHCs nationally, a greater proportion of GPP users received colorectal cancer screenings (60% vs. 41%) and screening for depression with documentation of a follow-up plan (80% vs. 72%).³⁷

Exhibit 2.12. Quality of Care Provided to GPP Users, 2023



Source: GPP Health Equity Reports, 2023; MCAS, 2023; HRSA Uniform Data System, 2023.

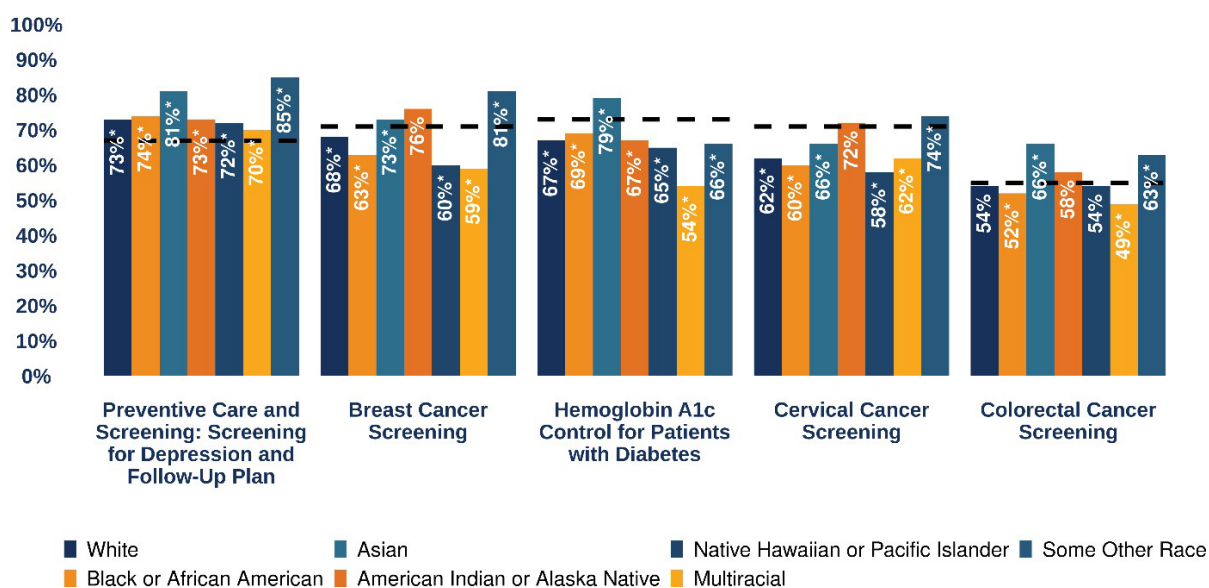
Note: Bars indicate overall performance rate for all PHCSs. Dashed lines indicate performance for the comparison group of Medi-Cal members for all measures except Preventive Care and Screening: Screening for Depression and Follow-Up Plan, which reflects all users of California FQHCs. A higher performance rate implies better quality. Although the Hemoglobin A1c Control

measure used in GPP and included in the MCAS assesses poor control (>9%), the chart shows 1 minus the performance rate such that a higher rate indicates better quality. *Indicates a statistically significant difference between GPP users and the comparison group at the $p \leq 0.05$ level.

Next, the evaluation team examined performance on the five quality measures within population subgroups defined by five patient characteristics.

Differences in quality of care by GPP user race. First, differences in quality across seven racial categories were examined ([Exhibit 2.13](#)). Comparisons between GPP users who self-reported one or more races and the entire Medi-Cal member cohort indicated that GPP users who self-identified as Multiracial were more likely to receive lower quality than the comparison group across the greatest number of measures and the magnitude of the gaps tended to exceed most other racial groups – including a 19-percentage point lower rate of hemoglobin A1c control and a 12-percentage point lower rate of breast cancer screening compared with Medi-Cal members. GPP users who self-identified as Black or African American or Native Hawaiian or Pacific Islander were also less likely to receive screenings than the comparison group, particularly on the cervical cancer screening measure, where Black or African American GPP users were 11 percentage points less likely to receive screenings than Medi-Cal members and GPP users who self-identified as Native Hawaiian or Pacific Islander were 13 percentage points less likely to do so ($p < 0.001$ for all comparisons).

Exhibit 2.13. Quality of Care Provided to GPP Users, by Race, 2023



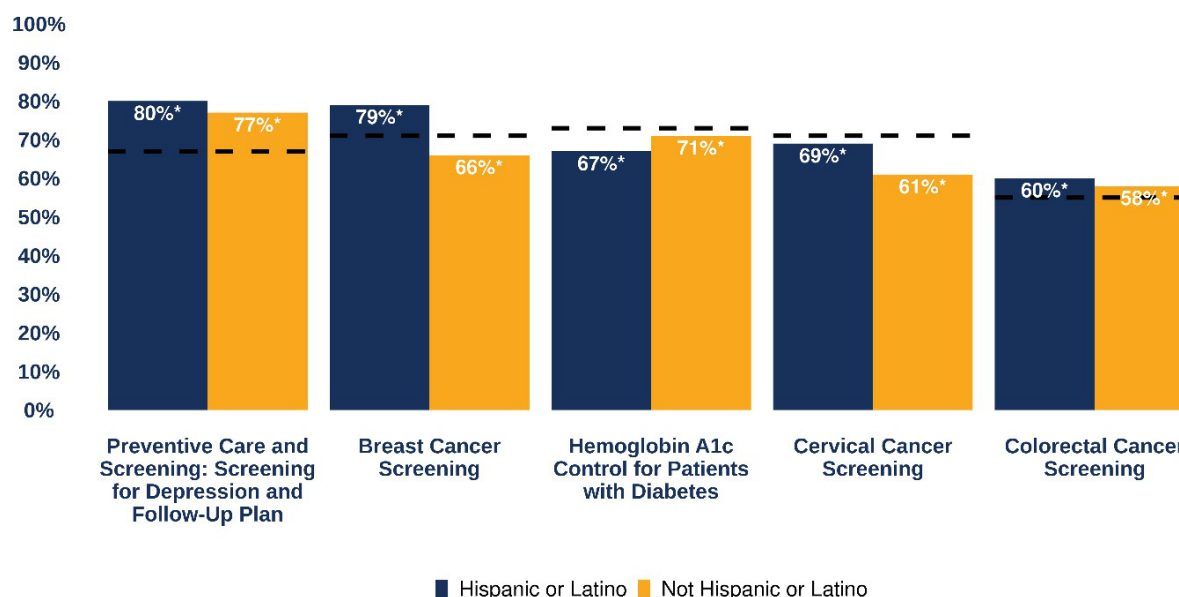
Source: GPP Health Equity Reports, 2023; MCAS, 2023; HRSA Uniform Data System, 2023.

Note: Bars indicate overall performance rate for all PHCSs. Dashed lines indicate performance for the comparison group of Medi-Cal members for all measures except Preventive Care and Screening: Screening for Depression and Follow-Up Plan, which reflects all users of California FQHCs. A higher performance rate implies better quality. Although the Hemoglobin A1c Control measure used in GPP and included in the MCAS assesses poor control (>9%), the chart shows 1 minus the performance rate such that a higher rate indicates better quality. Patient race is self-reported for GPP users and is derived from Medi-Cal eligibility files for the comparison group.

*Indicates a statistically significant difference between a GPP user subgroup and the entire comparison group at the $p \leq 0.05$ level.

Differences in quality of care by GPP user ethnicity. [Exhibit 2.14](#) displays comparisons of quality of care by patient ethnicity. Differences in quality between ethnic groups of GPP users and the entire Medi-Cal member comparison group were most notable for breast cancer screening, for which Hispanic or Latino GPP users were 8 percentage points *more likely* to receive screenings relative to the Medi-Cal comparison group while GPP users who self-identified as not Hispanic or Latino were 5 percentage points *less likely* to do so ($p < 0.001$ for each comparison). For the cervical cancer screening measure, performance gaps relative to the Medi-Cal population existed for both groups but were substantially larger for GPP users who were not Hispanic or Latino users (10 percentage points; $p < 0.001$) than for Hispanic or Latino GPP users (2 percentage points; $p = 0.04$). While the lower overall rate of hemoglobin A1c control for GPP users relative to the Medi-Cal comparison group was observed for both ethnic groups, the differences were small between the two groups.

Exhibit 2.14. Quality of Care Provided to GPP Users, by Ethnicity, 2023



Source: GPP Health Equity Reports, 2023; MCAS, 2023; HRSA Uniform Data System, 2023.

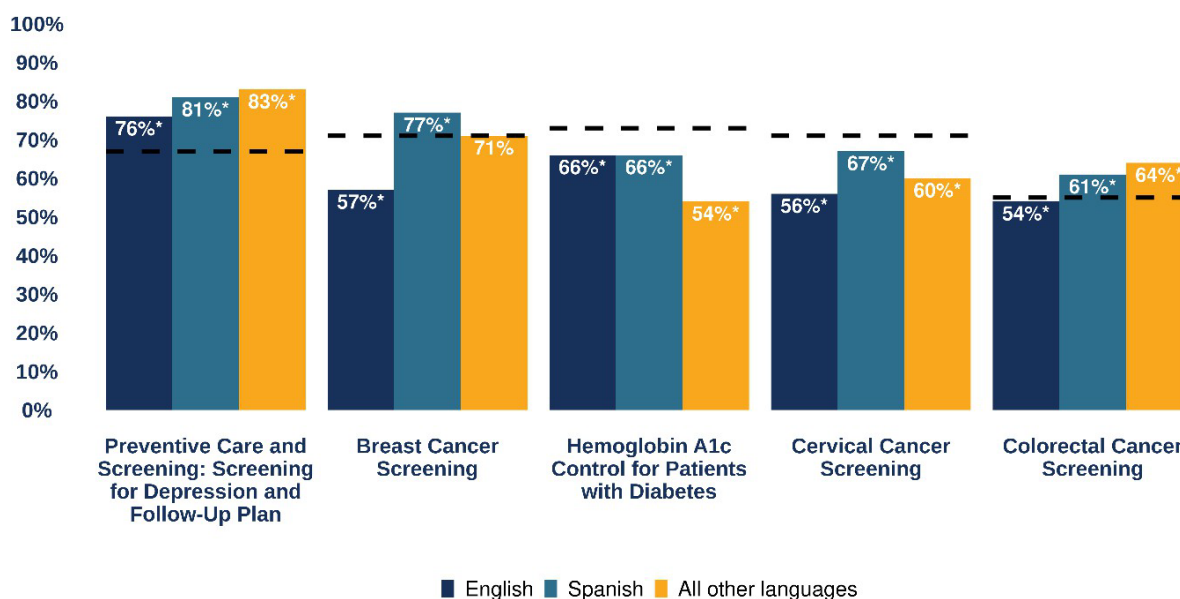
Note: Bars indicate overall performance rate for all PHCSs. Dashed lines indicate performance for the comparison group of Medi-Cal members for all measures except Preventive Care and Screening: Screening for Depression and Follow-Up Plan, which reflects all users of California FQHCs. A higher performance rate implies better quality. Although the Hemoglobin A1c Control measure used in GPP and included in the MCAS assesses poor control (>9%), the chart shows 1 minus the performance rate such that a higher rate indicates better quality. Patient ethnicity is self-reported for GPP users and is derived from Medi-Cal eligibility files for the comparison group. *Indicates a statistically significant difference between a GPP user subgroup and the entire comparison group at the $p \leq 0.05$ level.

Differences in quality of care by GPP user preferred spoken language. We also examined quality of care by patients' preferred spoken language ([Exhibit 2.15](#)). Relative to the entire Medi-Cal comparison group, performance gaps were present for both English-speaking and Spanish-speaking GPP users, but the gaps tended to be larger for English-speakers. For example, cervical cancer screening rates for English-speaking GPP users were 15 percentage points lower than those of Medi-Cal members whereas rates for Spanish-speaking GPP users were only 4 percentage points lower ($p < 0.001$ for each comparison). By contrast, English-speaking GPP users had breast cancer screening rates that were 14 percentage points lower than the comparison group while screening rates among Spanish-speaking GPP users equaled those of the Medi-Cal population. Meanwhile, GPP users whose preferred language was a language other than Spanish or English received as good or better-quality care across all patient groups for three of the

five measures (colorectal cancer screening, Hemoglobin A1c control, and preventive care and screening for depression, $p < 0.001$ for all three measures).

Higher quality of care for Spanish-speaking patients and patients who prefer other languages compared with English-speaking patients could be explained by the use of targeted strategies within PHCSs to address the needs of non-English speaking communities, including bilingual staff, culturally tailored outreach programs, and community partnerships that specifically aim to reduce barriers to preventive and primary care access for non-English speakers. PHCS Survey results included later in this chapter indicate that PHCSs have made concerted efforts to improve language access through interpreter services, but they may also use language-concordant navigation and educational materials, which can lead to increased utilization and adherence to recommended care among patients whose language preference is Spanish or another language compared to English-speaking patients.

Exhibit 2.15. Quality of Care Provided to GPP Users, by Preferred Spoken Language, 2023



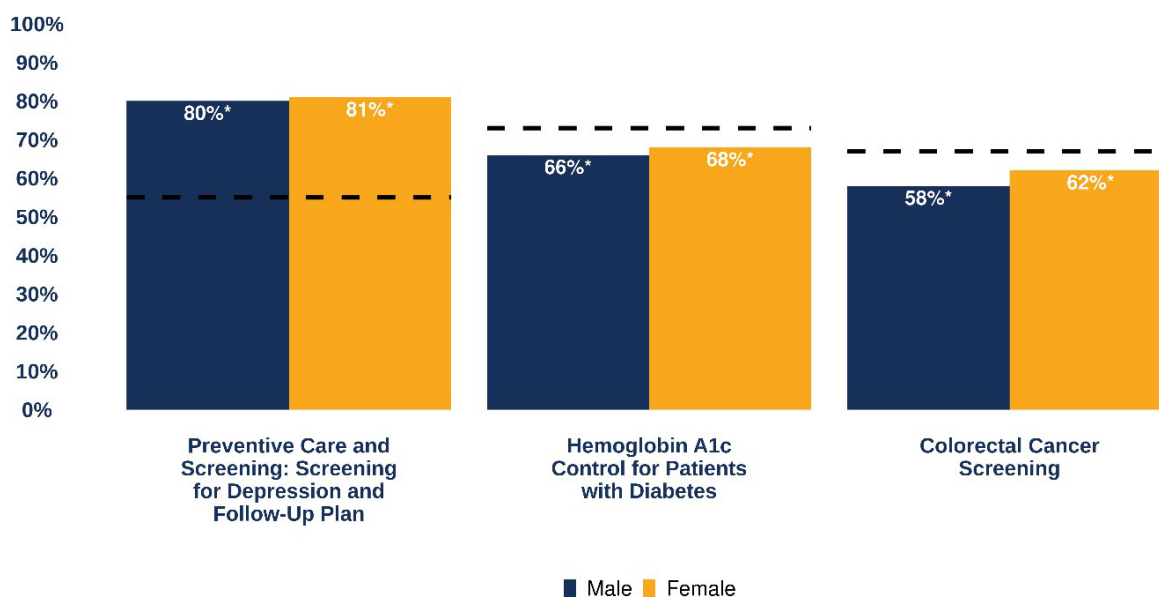
Source: GPP Health Equity Reports, 2023; MCAS, 2023; HRSA Uniform Data System, 2023.

Note: Bars indicate overall performance rate for all PHCSs. Dashed lines indicate performance for the comparison group of Medi-Cal members. A higher performance rate implies better quality. Although the Hemoglobin A1c Control measure used in GPP and included in the MCAS assesses poor control ($>9\%$), the chart shows 1 minus the performance rate such that a higher rate indicates better quality. In 2023, GPP users reporting English preference represented 28% of all encounters; users reporting Spanish preference represented 62% of all encounters, and users with a preference other than these two languages represented 3% of all encounters (See Exhibit

2.11) The category “All other languages” include a wide range of languages, most of which account for less than 1 percent of GPP users individually. *Indicates a statistically significant difference between a GPP user subgroup and the entire comparison group at the $p \leq 0.05$ level.

Differences in quality of care by GPP user gender. Both males and females are included in the eligible population for three of the five measures included in the analysis. For only one of the three measures, hemoglobin A1c control, GPP performance was lower, on average, than the entire Medi-Cal comparison group ([Exhibit 2.16](#)). The differences in performance gaps between genders for this measure were small. Female GPP users had a 5-percentage point lower rate of hemoglobin A1c control than the overall Medi-Cal population (68% vs 73%, $p < 0.001$), while the performance gap for male GPP users was 7 percentage points (66% vs 73%, $p < 0.001$).

Exhibit 2.16. Quality of Care Provided to GPP Users, by Gender, 2023

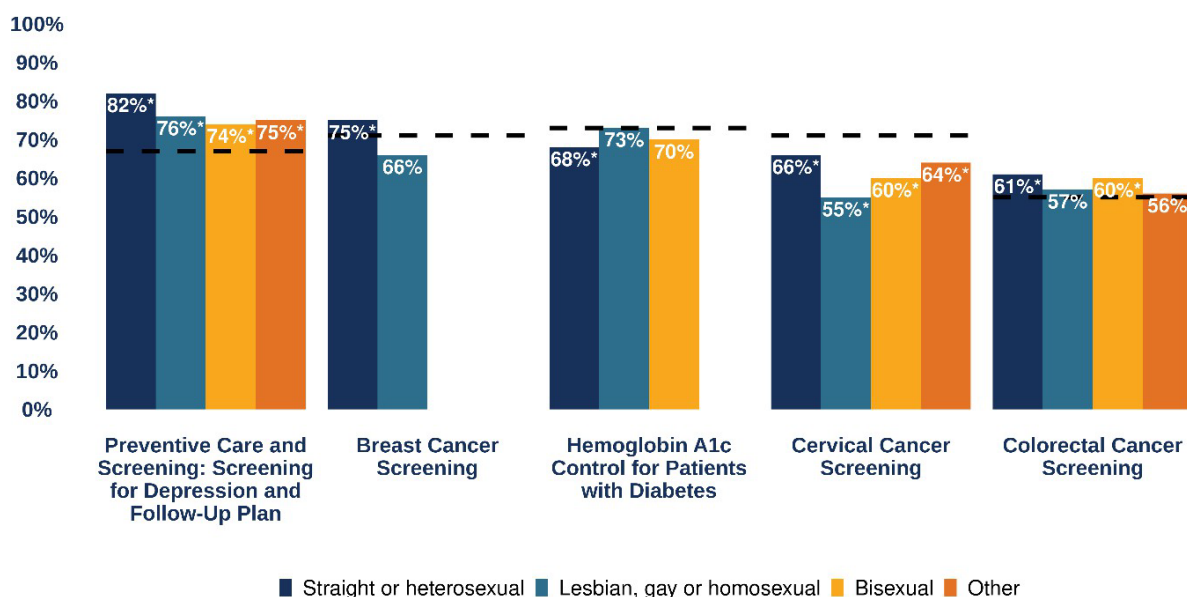


Source: GPP Health Equity Reports, 2023; MCAS, 2023; HRSA Uniform Data System, 2023.

Note: Bars indicate overall performance rate for all PHCSs. Dashed lines indicate performance for the comparison group of Medi-Cal members for all measures except Preventive Care and Screening: Screening for Depression and Follow-Up Plan, which reflects all users of California FQHCs. A higher performance rate implies better quality. Although the Hemoglobin A1c Control measure used in GPP and included in the MCAS assesses poor control ($>9\%$), the exhibit shows 1 minus the performance rate such that a higher rate indicates better quality. *Indicates a statistically significant difference between a GPP user subgroup and the entire comparison group at the $p \leq 0.05$ level.

Differences in quality of care by GPP user sexual orientation. Finally, the evaluation team examined differences in quality according to patients' self-reported sexual orientation ([Exhibit 2.17](#)). Although small sample sizes for certain groups limited the number of comparisons possible for certain measures, gaps in quality relative to the Medi-Cal population were, on average, larger for lesbian, gay, or homosexual GPP users than for straight or heterosexual GPP users. For example, lesbian, gay, or homosexual GPP users had a 16-percentage point lower rate of cervical cancer screening than the comparison group whereas the gap for straight or heterosexual GPP users was only 5 percentage points ($p < 0.001$ for both comparisons). Lesbian, gay, or homosexual GPP users were also 5-percentage points less likely to receive breast cancer screenings than Medi-Cal members. While this difference was not statistically significant, it is important to note that, by contrast, straight or heterosexual GPP users were 4 percentage points more likely than Medi-Cal members to receive breast cancer screenings ($p < 0.001$).

Exhibit 2.17. Quality of Care Provided to GPP Users, by Sexual Orientation, 2023



Source: GPP Health Equity Reports, 2023; MCAS, 2023; HRSA Uniform Data System, 2023.

Note: Bars indicate overall performance rate for all PHCSs. Missing bars indicate that the denominator for the subgroup was below 100. Dashed lines indicate performance for the comparison group of Medi-Cal members for all measures except Preventive Care and Screening: Screening for Depression and Follow-Up Plan, which reflects all users of California FQHCs. The "other" category includes all other reported sexual orientations, including asexual, pansexual, and queer. This number of GPP users in this category is small, with the denominator for the included measures ranging from 170 to 339 GPP users. A higher performance rate implies better quality. Although the Hemoglobin A1c Control measure used in GPP and included in the MCAS

assesses poor control (>9%), the exhibit shows 1 minus the performance rate such that a higher rate indicates better quality. *Indicates a statistically significant difference between a GPP user subgroup and the entire comparison group at the $p \leq 0.05$ level.

Strategies Used by PHCSs to Improve Quality of Care

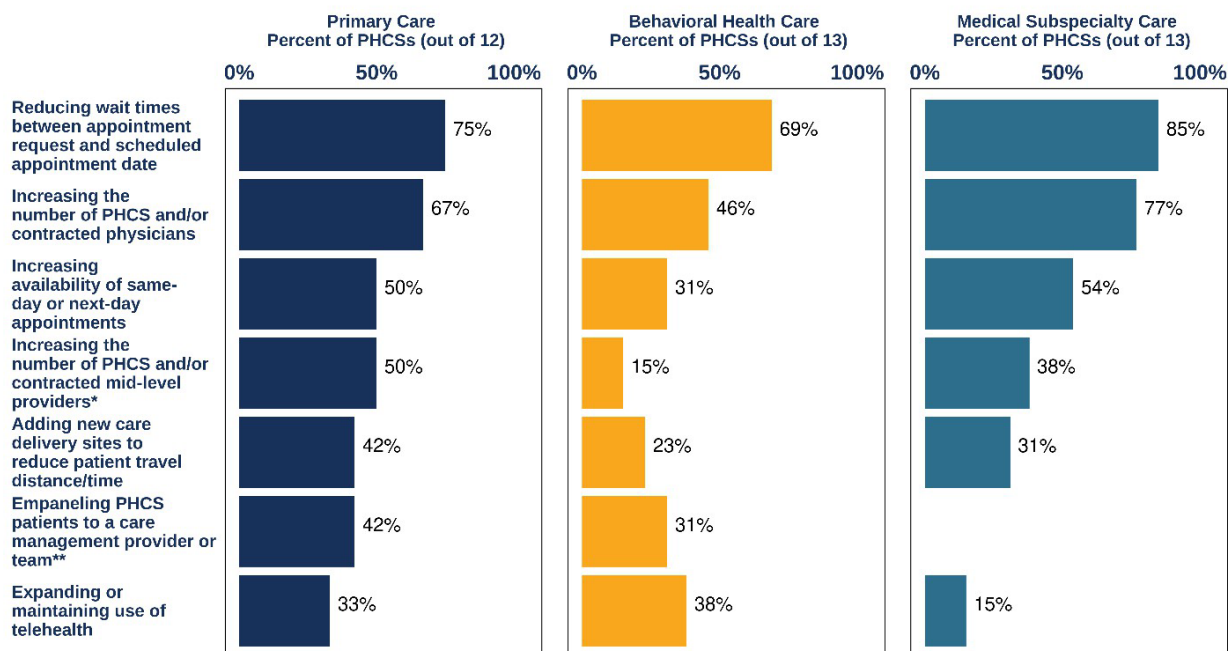
To provide additional context around changes in the quality of care for GPP users during CalAIM, the evaluation team gathered information through surveys of PHCS leaders and staff about the strategies the 13 PHCSs used to improve access to care and continuity of care throughout their health systems over the first few years of CalAIM.

Strategies to Improve Access to Care and Continuity of Care. Most of the 13 PHCSs reported devoting a high or very high level of effort to reducing wait times between requests for an appointment and the scheduled appointment date, especially for appointments with medical subspecialists (85% of PHCSs) and primary care providers (75%) ([Exhibit 2.18](#)). Increasing the number of physicians within the PHCS was the next most widely pursued strategy with 77% of PHCSs reporting substantial efforts to increase the number of medical specialists, 67% reporting this strategy for primary care, and just under half of PHCSs reporting substantial efforts to expand their BH physician workforce. Other strategies pursued intensively, primarily to improve access to primary care, included expanding the availability of same-day or next-day appointments, hiring additional mid-level providers, adding new care delivery sites, and expanding empanelment to providers and/or care teams. On the other hand, only about a third of PHCSs reported devoting effort to expanding or maintaining use of telehealth in the past two years for primary and BH care settings, and even fewer (15%) of PHCSs reported focusing effort on this strategy to improve access for medical subspecialty care. Notably, all strategies were used substantially less for BH than for primary care with the exception of telehealth.

Exhibit 2.18. PHCS Use of Strategies to Improve Access to Care and Continuity of Care

PHCS Strategies for Improving Access and Continuity of Care

Percent of PHCSs devoting high or very high effort in the last two years



Note: *Mid-level providers are defined as nurse practitioners and physician assistants.

**Question not asked regarding medical subspecialty care.

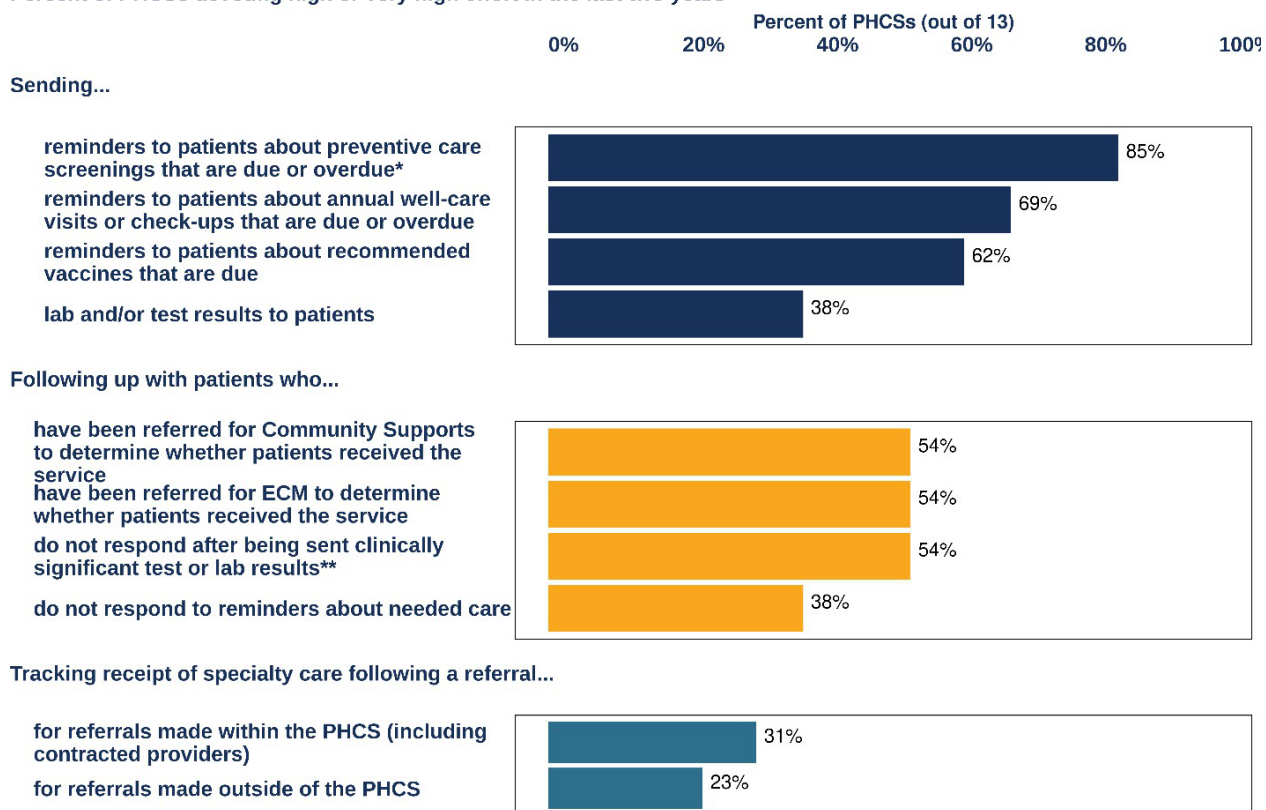
Note: BH services refer to services provided to people with mild to moderate mental health conditions and SUDs. Medical subspecialties include specialties such as cardiology, pulmonology, and gastroenterology. Surgical subspecialties, such as orthopedics, dermatology, and interventional cardiology, are not included in this category.

Strategies to Improve Population Health. PHCSs reported using a wide range of strategies to improve population health during the first few years of CalAIM, including sending reminders to patients about needed care, following up with patients, and tracking referrals ([Exhibit 2.19](#)). More than half of PHCSs reported devoting high or very high effort to sending reminders to patients about preventive care screenings that were due or overdue (85% of PHCSs), annual well-care visits or check-ups that were due or overdue (69%), and recommended vaccines that were due (62%). Just over half of PHCSs reported devoting considerable effort to following up with patients who do not respond after being sent clinically significant tests or lab results and following up with patients who have been referred to ECM or Community Supports to determine if the patient received the service. Fewer than a third of PHCSs reported devoting substantial effort to maintaining systems that track patients' receipt of specialty care following a referral.

Exhibit 2.19. PHCS Use of Strategies to Improve Population Health

PHCS Strategies to Improve Population Health

Percent of PHCSs devoting high or very high effort in the last two years



Note: 13 PHCSs responded to all of the measures included in this figure.

*These include screenings recommended by the U.S. Preventive Services Task Force (USPSTF).

**These might include abnormal fecal immunochemical test (FIT) or Pap smear results.

PHCS Perceptions of Patients' Care Experiences

Since primary data collection from patients was viewed as potentially disruptive to clinic operations, the evaluation team surveyed PHCS primary care clinic leaders to assess their perceptions of care experiences for patients who received care from their clinic. A total of 25 clinic leaders responded to this portion of the PHCS Survey.

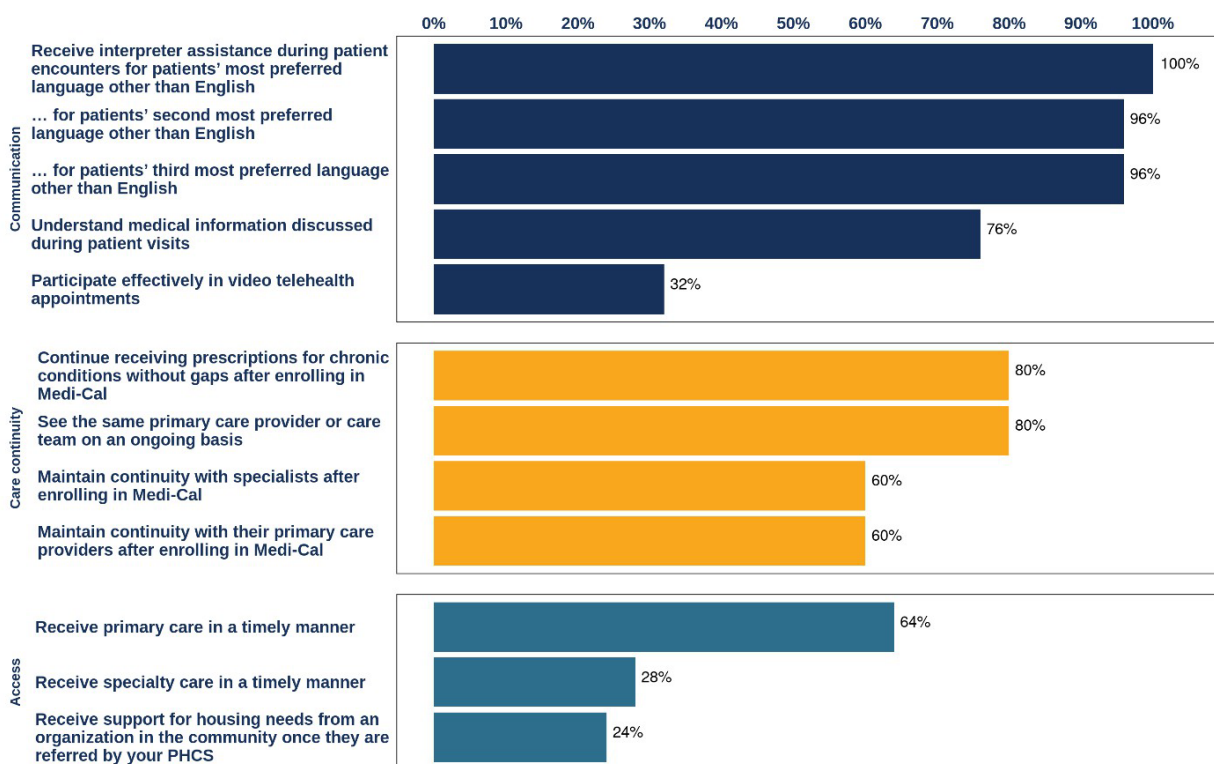
Communication, Care Continuity, and Access. All or nearly all primary care clinic leaders reported that patients were able to easily receive interpreter assistance during their appointments and most reported that it was easy for patients to understand medical information discussed during visits ([Exhibit 2.20](#)). However, only 32% of clinic leaders reported that it was easy for patients to participate effectively in video telehealth appointments. Most primary care clinic leaders felt that patients received high levels of care continuity and reported that their patients were able to easily receive prescriptions

without gaps after enrolling in Medi-Cal and were able to see the same primary care provider or care team on an ongoing basis. Although nearly two-thirds (64%) of primary care clinic leaders reported that it was easy for patients to receive primary care in a timely manner, only 28% of clinic leaders reported that receiving timely specialty care was somewhat or very easy for patients, and only 24% reported that it was easy for patients to receive support for housing needs after being referred by the PHCS.

Exhibit 2.20. PHCS Primary Care Clinic Leaders' Perceptions of Patient Experiences When Seeking Care

Perceptions of Patient Experiences

Percent of PHCS responding somewhat or very easy for patient seeking care to receive help for need



Source: PHCS Survey, 2025.

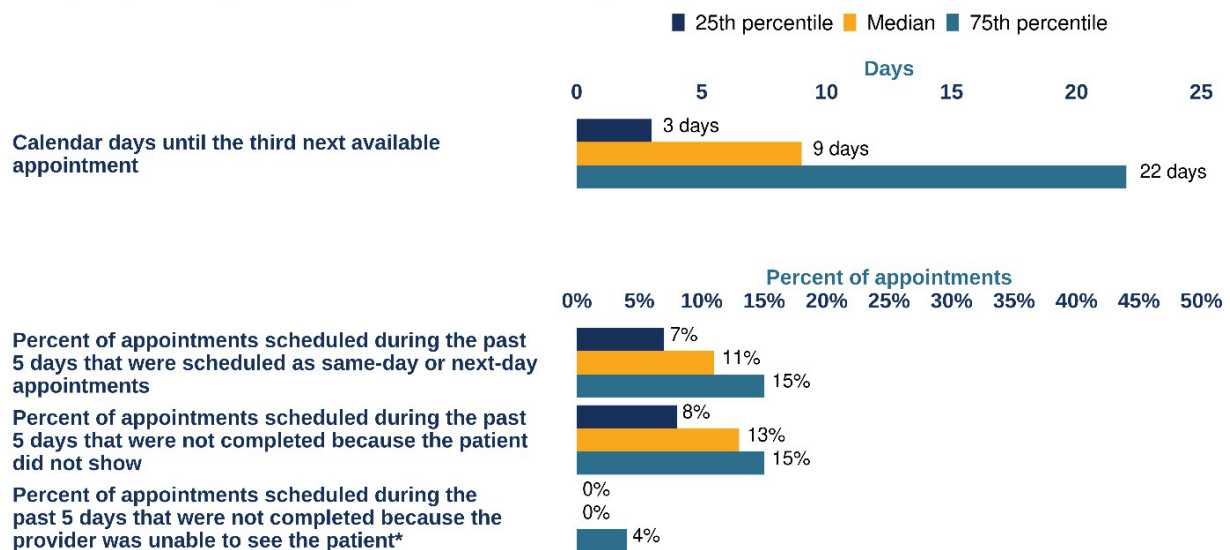
Note: Two primary care sites from each PHCS were asked to respond to the survey. Twenty-five primary care sites across 13 PHCSs responded.

Timeliness of Care. Recognizing the difficulty many patients face accessing timely primary care, and the possible role of wait times as a barrier to receiving primary care and preventive services, the evaluation team asked PHCS primary care clinic leaders to report information about the availability of appointments at their clinics and completion rates for these appointments ([Exhibit 2.21](#)). Analysis of these data indicated that the wait-time for the third-next-available appointment, a common measure of access, was

nine days for the median primary care clinic, which is shorter than the traditional 14-day benchmark and much shorter than recent national estimates of metropolitan areas that ranged from 27 to 44 days.³⁸ All primary care clinic leaders reported allocating at least some appointments for same-day or next-day visits, and the median clinic offered 11% of its total appointments for these types of visits. In terms of visit completion rates, the median clinic reported that 13% of its appointments were not completed during the past five days because patients did not show, which is generally within the range of primary care visit non-completion rates found in the literature (between 3-16%).^{39,40} Although primary care providers might be unable to attend to a patient at the time of an appointment for any number of reasons, including patient care emergencies or staff absences, the median clinic did not report any patient visits that were not completed on account of a provider being unable to see the patient. This suggests that PHCS primary care clinics routinely ensured that other members of the patient's care team or other staff can attend to patients when the patient's scheduled provider was unavailable.

Exhibit 2.21. Timeliness of Care for PHCS Patients

Appointment Availability, Appointment Types, and Appointment Completion in PHCS Primary Care Clinics
Median, 25th percentile, and 75th percentile values for PHCS primary care clinics



Source: PHCS Survey, 2025.

Note: Two primary care sites from each PHCS were asked to respond to the survey. Twenty-five primary care sites across 13 PHCSs responded. *Includes any scheduled appointment that was not completed because the scheduled provider was unable to see the patient for any reason. For example, if a patient showed up for their originally scheduled appointment on a Tuesday and the provider was unable to see the patient until later that week, the originally scheduled appointment was counted as not completed.

Results for GPP Evaluation Question 2

Evaluation Question 2 focuses on shifts in utilization of services by GPP users across care settings. Using encounter-level data submitted by PHCSs participating in GPP, the evaluation team examined utilization trends in selected categories of service over the entire GPP – spanning the state’s earlier Medi-Cal 2020 Waiver through the first two years of CalAIM (2015-2023). The team then examined trends in the share of services provided in low-intensity settings to assess whether GPP facilitated a shift from care in high-intensity settings to low-intensity settings when appropriate.ⁿ Finally, PHCS Survey data were used to understand possible mechanisms underlying these changes in utilization patterns during CalAIM. Future analyses in the Summative Evaluation Report will focus on measures such as ACS utilization in both ED and inpatient settings – using Medi-Cal claims data to provide a more comprehensive data source for ED encounters.

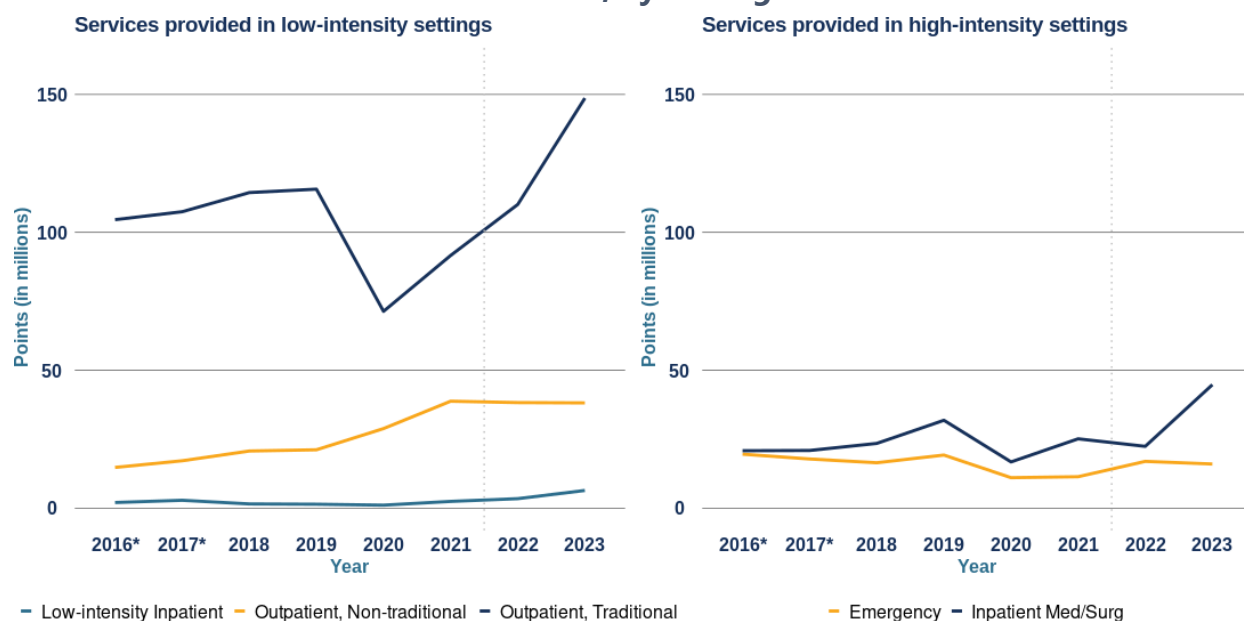
Utilization of Non-BH Services

Utilization in Low-Intensity Settings. Over the first two years of CalAIM, the evaluation team observed a large increase in utilization of outpatient, traditional services, a category that includes encounters with physicians, dental visits, and outpatient surgeries ([Exhibit 2.22](#), panel 1). These increases continued a trend that began after the first CY of the COVID-19 pandemic, reaching a high in 2023 of nearly 149 million points, which resulted in earning approximately \$1.6 billion dollars in GPP global budget expenditures. This growth was driven overwhelmingly by physician services rather than outpatient surgeries. Utilization of non-traditional services, a category that includes 33 eligible services such as PharmD and nurse-only visits, mobile clinic visits, e-consults, and telehealth, grew consistently prior to CalAIM and remained constant during the first two years of CalAIM. The rapid growth in non-traditional services starting in 2020 can be traced to increased use of telehealth by PHCSs during the pandemic, which leveled off starting in 2021. Low-intensity inpatient services were limited to skilled nursing facility utilization and recuperative/respice care and were associated with very few points overall.

ⁿ[Appendix A](#) GPP Services, Service Categories, and Point Values (2015-2023) provides a list of all GPP services eligible for claiming points along with their designation as high-intensity services or low-intensity services.

Utilization in High-Intensity Settings. Since GPP’s inception, far fewer points have been earned for non-BH services provided in high-intensity settings compared to those provided in low-intensity settings ([Exhibit 2.22](#), panel 2). Overall, inpatient medical/surgical admissions increased across both waiver periods, although the increase was largely driven by a substantial increase in points earned for these services between 2022 and 2023. The extent to which this increase may be driven by increases in GPP users’ case mix, as measured by increased comorbidities or increased length of hospital stays, is still being examined. Points earned for emergency services have remained consistently low since GPP’s inception because most uninsured individuals are eligible to enroll in Medi-Cal coverage during these encounters (also known as “Emergency Medicaid”), and PHCSs are not eligible to earn points for these encounters.

Exhibit 2.22. Non-BH Service Utilization, by Setting



Source: GPP Aggregate Utilization Reports (state FY 2015-2016 through CY 2023), GPP Encounter Data (7/1/17 through 12/31/23).

Note: Point values are time-varying. See [Appendix A](#) for point values for each service. GPP’s 11 equity-enhancing services were omitted from the first panel since these services were introduced only in 2023. In 2023 these services accounted for approximately 2.7 million points.

*Encounter-level data were not generated in state FY 2015-2016 and had uncertain quality in the first year of reporting (state FY 2016-2017). Accordingly, the 2016 estimate was based on the state FY 2015-2016 aggregate utilization reports submitted by PHCS, and the 2017 estimate was based on an annualized estimate derived from the state FY 2016-2017 aggregate utilization report and GPP encounter-level data from 7/1/2017-12/31/2017. As a result, the evaluation team was unable to recategorize services with non-BH service codes as BH encounters for dates of service before 7/1/2017.

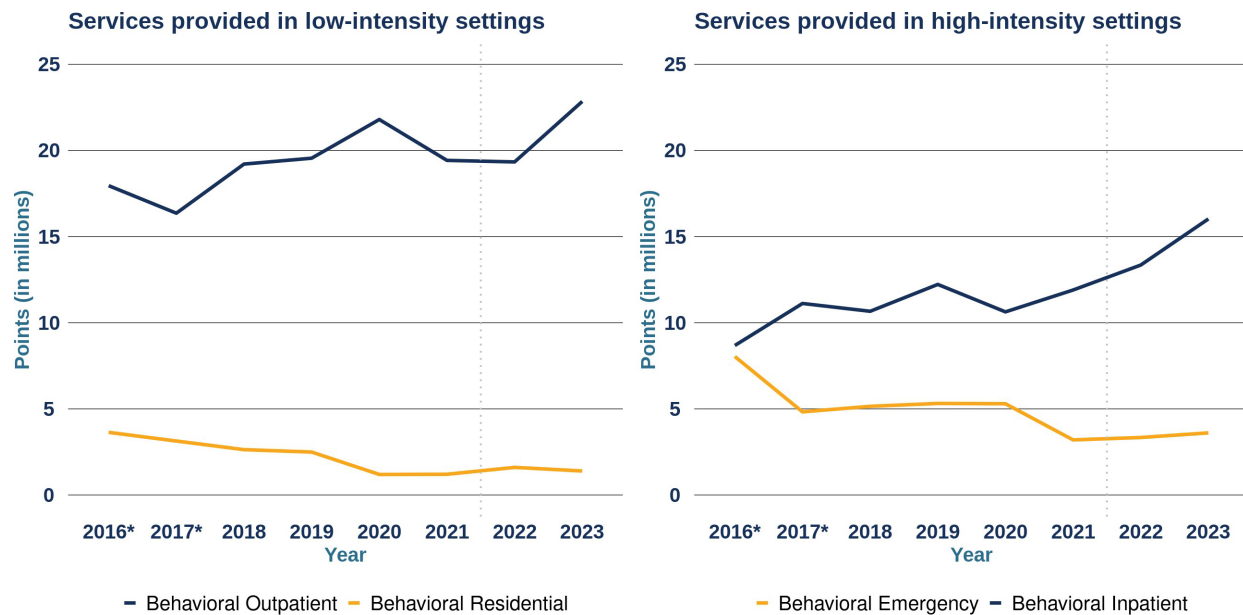
Utilization of BH Services^o

Utilization in Low-Intensity Settings. Utilization of BH outpatient visits, which includes encounters with mental health and substance use providers, methadone treatment, and non-traditional services such as telehealth, increased substantially since the beginning of GPP ([Exhibit 2.23](#), panel 1). Utilization of these services also increased over the first two years of GPP under the CalAIM Waiver, although this increase was limited to the second year of the waiver. Meanwhile, use of BH residential services decreased during the COVID-19 pandemic and remained steady during the first two years of CalAIM. Residential services include stays in mental health and substance use facilities, which can span multiple days, as well as encounters at sobering centers, which are typically limited to stays less than one day, and only four PHCSs earned points for sobering center utilization since GPP's inception. Increased demand and prioritization of BH services along with improved data sharing between county PHCSs and BH systems could explain the observed increases in outpatient services, while the slight decline in use of residential facilities may reflect limited capacity. The evaluation team continues to explore both factors in interviews with PHCS leaders.

Utilization in High-Intensity Settings. BH inpatient services increased steadily over the first two years of CalAIM, continuing an upward trend observed during much of the prior waiver ([Exhibit 2.23](#), panel 2). This increase could be the result of lack of access to beds in residential facilities or greater emphasis on expanding access to care, which is consistent with the increased trend observed in outpatient care for BH conditions. Meanwhile, emergency BH service utilization did not increase meaningfully during the first two years of CalAIM, suggesting that it is unlikely that the increases in inpatient utilization were due to unmanaged BH conditions in outpatient and community settings.

^o The GPP identifies specific services as mental health services, substance use disorder services, or BH services. To ensure that analyses of BH services encompass all encounters for these conditions regardless of their categorization, however, the evaluation team re-categorized any service associated with a non-BH service code as a BH service if the principal diagnosis on the encounter was a BH condition identified by an ICD-10 CM diagnosis code beginning with "F", which includes both mental health conditions (such as mood disorders) and substance use conditions (such as opioid use disorder). These methods were implemented for encounters with dates of service beginning 7/1/2017 based on the evaluation team's assessment of encounter-level data quality.

Exhibit 2.23. BH Service Utilization



Source: GPP Aggregate Utilization Reports (state FY 2015-2016 through CY 2023), GPP Encounter Data (7/1/17 through 12/31/23).

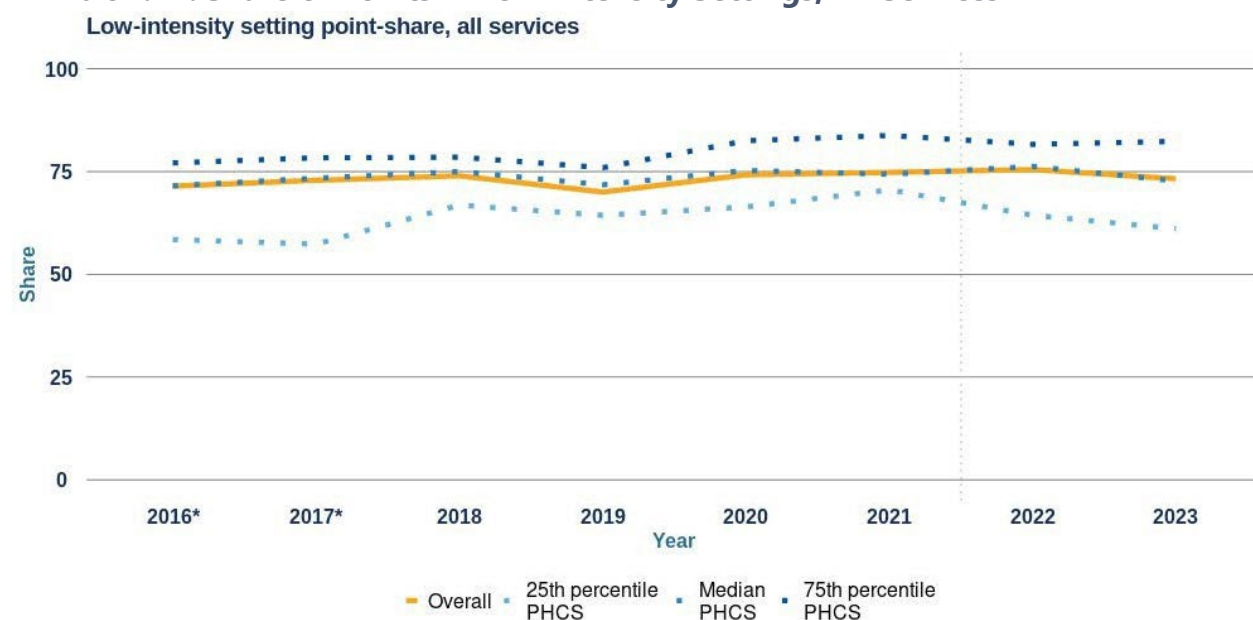
Note: Point values are time-varying. See [Appendix A](#) for point values for each service.

*Exhibit 2.22 notes describe the methods used to derive these estimates.

Changes in Utilization in Low-Intensity Settings Versus High-Intensity Settings

Share of Points in Low-intensity Settings, All Services. Overall, just under three-quarters of all points earned by PHCS were for services in low-intensity settings, and, consistent with GPP Goal 2, this percentage increased slightly from 71% to 73% since GPP's inception ([Exhibit 2.24](#)). The evaluation team also examined the share of points in low-intensity settings at the PHCS level to understand how the distribution of this percentage changed over time across the 13 PHCSs participating in GPP. Some variation was observed across PHCSs, including several PHCSs that were able to increase their share of points in low-intensity settings over time although the PHCS representing the 25th percentile of the share of points in low-intensity settings was essentially unchanged between 2016 and 2023.

Exhibit 2.24. Share of Points in Low-intensity Settings, All Services



Source: GPP Aggregate Utilization Reports (state FY 2015-2016 through CY 2023), GPP Encounter Data (7/1/17 through 12/31/23).

Note: GPP services excluded from this analysis include ICU/CCU, trauma, transplant, and burn care services, which are considered essential community services. Percentiles were computed in each CY and may refer to different PHCSs in each CY

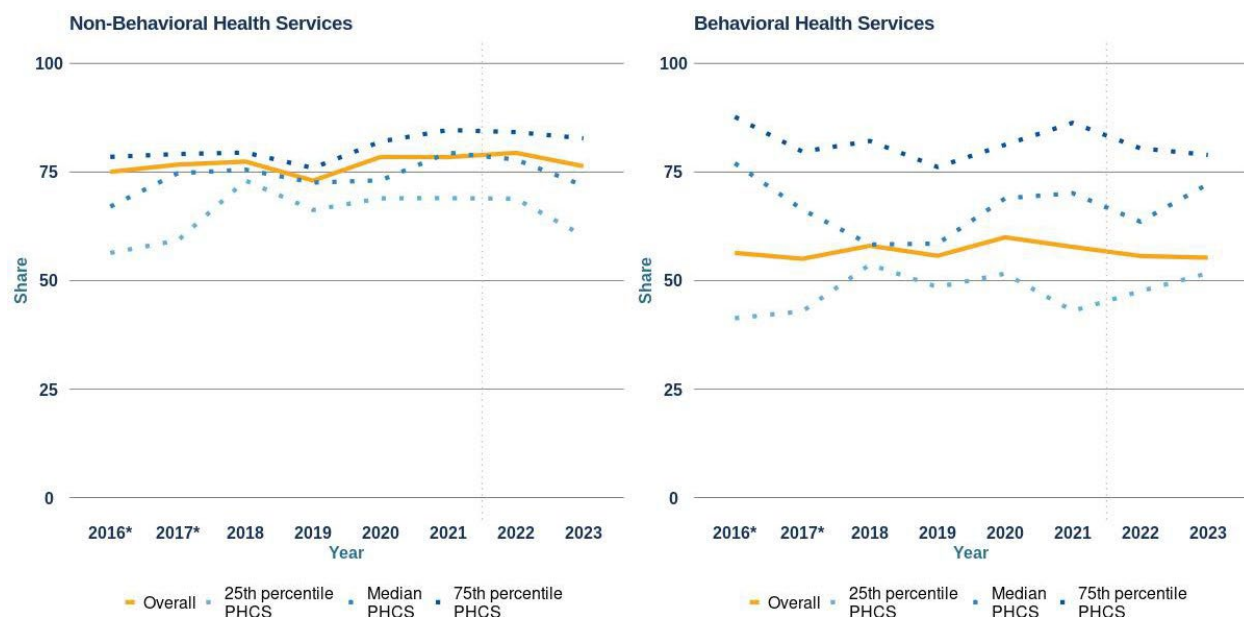
*The Exhibit 2.22 notes describe the methods used to derive these estimates.

Share of Points in Low-intensity Settings, Non-BH Services. When examining non-BH services only, the evaluation team found the share of points in low-intensity settings decreased slightly during the first two years of CalAIM despite a gradual increase since the beginning of GPP ([Exhibit 2.25](#), panel 1). This change appears to be driven by the sharp increase in inpatient medical/surgical encounters between 2022 and 2023. Overall, since GPP's inception the share of points in low-intensity settings increased slightly from 75% to 76%, which is consistent with GPP Goal 2.

Share of Points in Low-Intensity Settings, BH Services. For BH services, the share of points in low-intensity settings declined slightly over the first two years of CalAIM ([Exhibit 2.25](#), panel 2). These findings indicate that the increases in BH outpatient services were not large enough to offset increases in inpatient utilization during this period. The decrease in the share of points in low-intensity settings during CalAIM is consistent with the slight overall decline in the percentage since GPP's inception, which

decreased from 56% to 55% over the 8-year period, which is inconsistent with GPP Goal 2.

Exhibit 2.25. Share of Points in Low-intensity Settings for Behavioral and Non-behavioral Services

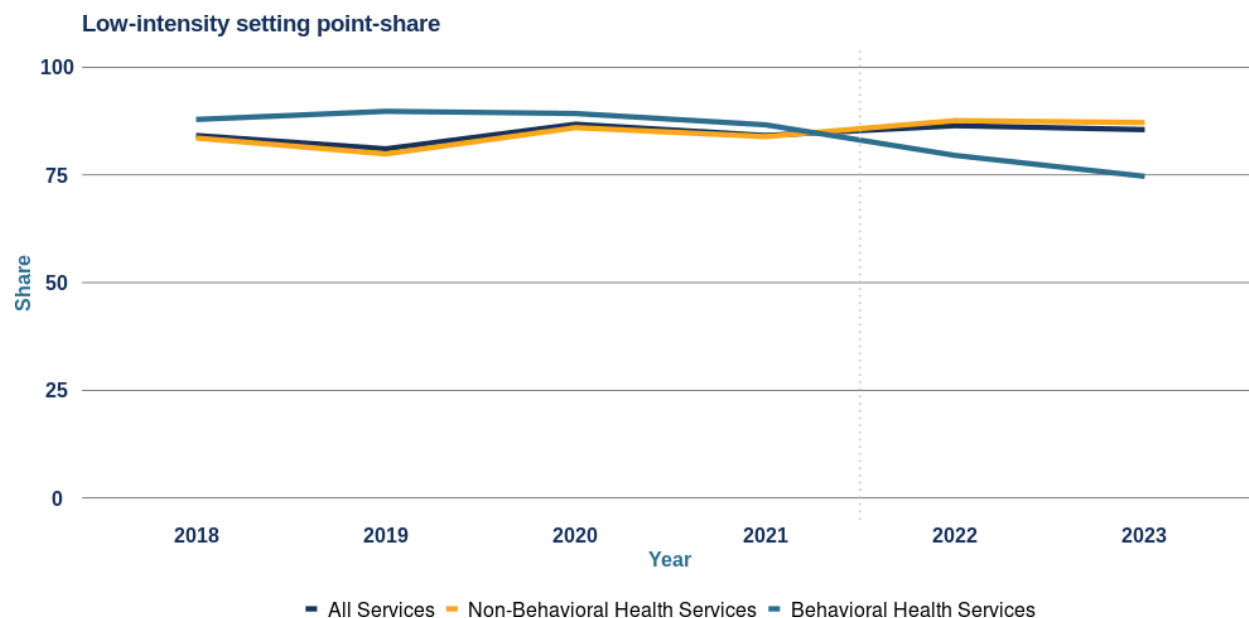


Source: GPP Aggregate Utilization Reports (state FY 2015-2016 through CY 2023), GPP Encounter Data (7/1/17 through 12/31/23).

*Encounter-level data did not exist or had variable quality in 2016 and 2017; accordingly, these estimates are based on aggregate utilization reports submitted by PHCS from state FY 2015-2016 and state FY 2016-2017, respectively.

Share of Points in Low-intensity Settings, GPP Physician Service Users. The evaluation team next examined the cohort of GPP service users who had one or more visits with physicians during a calendar year ([Exhibit 2.26](#)). Results showed the share of points in low-intensity settings increased over time for all services (84% in 2018 to 86% in 2023) as well as for non-BH services (84% to 87% over the same period). Consistent with prior analyses focusing on BH services only, the team observed a decrease in the share of points in low-intensity settings for these services, which decreased from 88% in 2018 to 75% in 2023.

Exhibit 2.26. Share of Points in Low-intensity Settings for GPP Physician Service Users



Source: GPP Encounter Data (2018-2023), GPP Aggregate Utilization Reports (state FY 2017-2018 through CY 2023).

Notes: This analysis used encounters from patients who had at least one physician encounter for which the PHCS earned GPP points. The sample was defined within each year; GPP users may not be included in all years. The analysis used data beginning in 2018 because encounter-level data are required to identify the cohort of physician service users and the encounter data from CY 2018 onward were determined to be high quality.

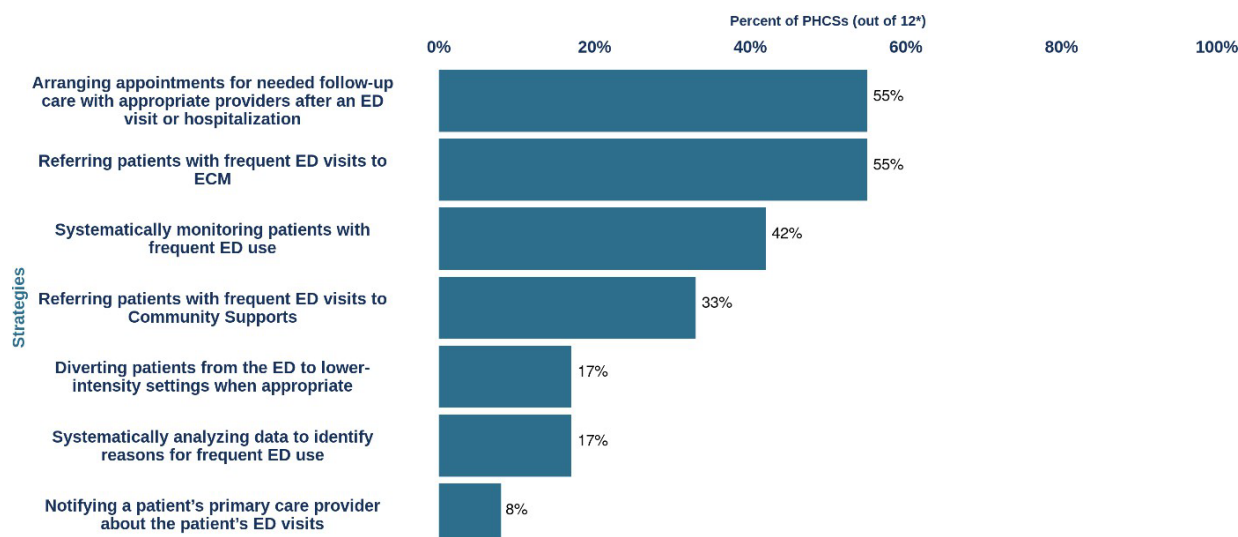
PHCS Strategies to Shift Utilization to Low-Intensity Settings

PHCSs were surveyed in early PY11 (2025) to better understand the extent to which PHCSs were using seven possible strategies to minimize utilization in high-intensity settings where appropriate. PHCSs reported devoting a high or very high level of effort to several strategies ([Exhibit 2.27](#)). More than half of PHCSs reported devoting substantial effort to arranging appointments for needed follow-up care after ED visits or hospitalizations to enhance continuity of care. Over half of PHCSs also focused on referrals to ECM for people who frequently use the ED, while a third of PHCSs prioritized referrals for Community Supports, both of which are described in more detail in the next section.

Exhibit 2.27. PHCS Use of Strategies to Promote Care in Cost-effective Settings

PHCS Strategies for Reducing Avoidable ED Visits

Percent of PHCSs devoting high or very high effort in the last two years



Source: PHCS Survey, 2025.

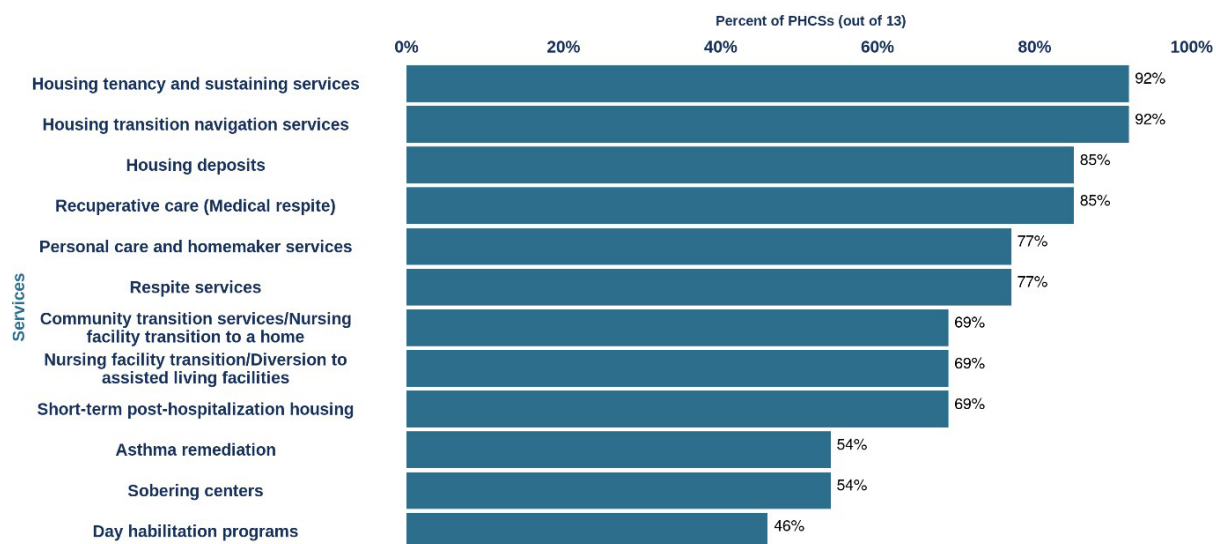
Note: *Only 11 PHCS responded to the questions about arranging appointments for needed follow-up care with appropriate providers after an ED visit or hospitalization and referring patients with frequent ED visits to ECM. ED=Emergency Department.

ECM and Community Supports

Availability of Community Supports. To align the services available to California residents through GPP with those newly available to Medi-Cal members under CalAIM, DHCS added nine new Community Supports to GPP along with ECM. Since the provision of Community Supports to GPP users might depend on the extent to which Community Supports are available to the PHCS's Medi-Cal patients (which are, in turn, determined by the MCPs with which the PHCS contracts), the evaluation team asked PHCSs to identify which Community Supports were available through the MCPs with which they contracted ([Exhibit 2.28](#)). Most PHCSs (85%-92%) reported that at least one MCP provided housing transition navigation services, housing tenancy and sustaining services, and housing deposits. An equally high proportion of PHCSs reported that their MCPs offered recuperative care/medical respite services. Notably, around half or fewer than half of PHCSs reported that MCPs offered asthma remediation, sobering center services, or day habilitation services. These offer rates for Community Supports generally aligned with statewide averages as assessed by UCLA/RAND in its evaluation of Community Supports appearing later in this report.

Exhibit 2.28. Availability of Community Supports through Medi-Cal MCPs

Community Supports Offered by Managed Care Plans that Contract with PHCSs
Percent of PHCSs reporting that at least one MCP offers the Community Support



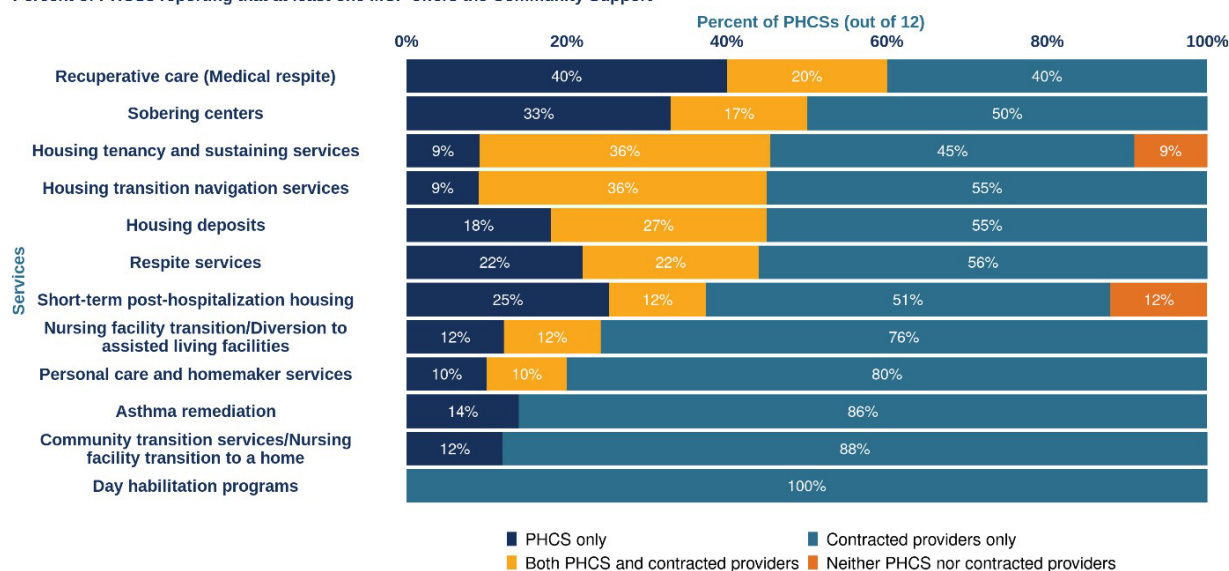
Source: PHCS Survey, 2025.

Providers of Community Supports. PHCSs might choose to provide Community Supports directly or contract with providers in their communities who have experience with these services. However, the more that PHCSs rely on contracted organizations, the more difficult it might be for PHCSs to know which patients were referred for these services, because CBOs can initiate referrals to MCPs. PHCSs might also be less likely to know which patients ultimately received the services and whether or how to ensure that the PHCS provides optimal follow-up care. As of early 2025, many PHCSs contracted exclusively with service providers outside of the PHCS, although the extent to which this occurs varied by service ([Exhibit 2.29](#)). For example, recuperative care was provided directly by 60% of PHCSs (sometimes supplemented by contracted providers), whereas day habilitation services were provided to PHCS patients entirely by contracted providers. The services with the highest rates of direct provision were medical respite and sobering centers, which may reflect the historical inclusion of these two Community Supports in GPP since the program's inception. In addition, PHCSs were more likely to provide housing-related Community Supports directly, potentially reflecting the priority given to these services and the strength of the association between access to these services and patient health and well-being.

Exhibit 2.29. Providers of Community Supports within PHCSs

Community Supports Offered by Managed Care Plans that Contract with PHCSs

Percent of PHCSs reporting that at least one MCP offers the Community Support



Source: PHCS Survey, 2025.

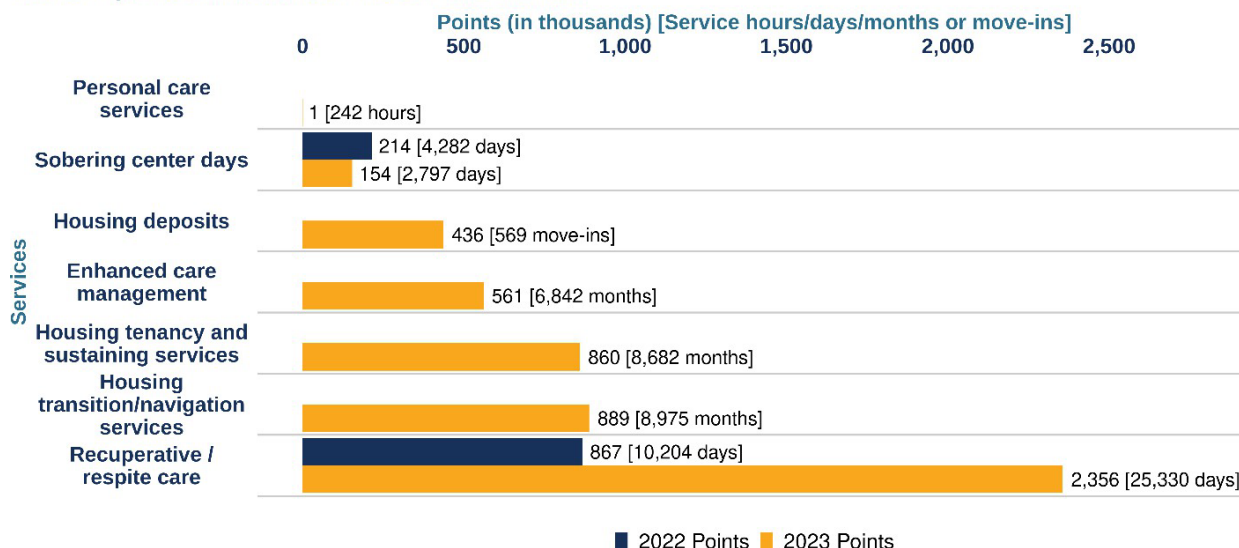
Note: Only asked of those PHCSs that contracted with at least one MCP that offered the Community Support (denominator ranges from 5 to 11 PHCSs).

Utilization of Community Supports and ECM. During the first two years of CalAIM, PHCSs earned points for a limited number of Community Supports ([Exhibit 2.30](#)). In PY8 (2022), only two Community Supports were available, and PHCSs earned substantially more points for recuperative care than sobering center services. In PY9 (2023) a total of 11 Community Supports were available through GPP for which PHCSs earned points for seven services. By far, PHCSs earned points for recuperative care (approximately 45% of all points earned for Community Supports in 2023). In addition, PHCSs earned points for housing transition/navigation services and housing tenancy and sustaining services, collectively providing over 17,000 months of services to GPP users, as well as housing deposits that supported nearly 600 move-ins. Nearly 7,000 months of ECM services were provided to GPP users in 2023. Whereas six individual PHCSs provided GPP's two long-standing Community Supports in 2023, only five individual PHCSs earned points for any of the nine Community Supports that were newly added to GPP in 2023.

Exhibit 2.30. Utilization of Community Supports and ECM by GPP Service Users

Community Supports and Enhanced Care Management use by PHCSs

Total GPP points claimed across PHCSs in 2022 and 2023



Source: GPP encounter-level data, 2022-2023

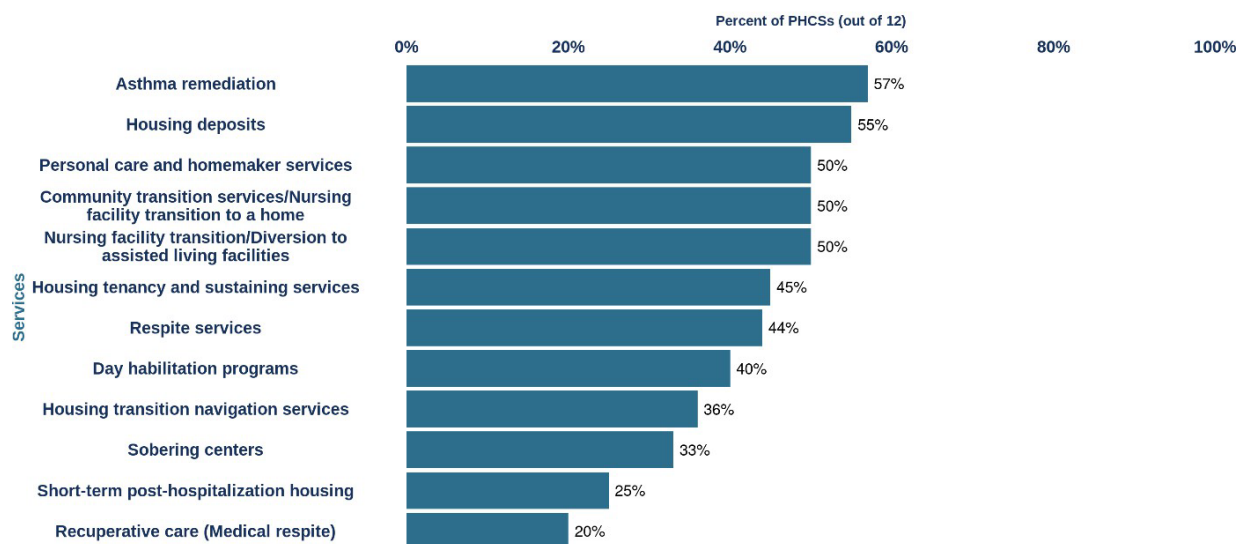
Note: The length of each bar reflects the total number of GPP points earned by all PHCSs. The total units of service provided by all PHCSs are also indicated.

Experiences with Referrals for Community Supports. Successful implementation of the nine additional Community Supports within GPP requires PHCSs to develop new workflows and data infrastructure. In particular, new systems that document initiation of referrals for Community Supports are needed to support follow-up to ensure that eligible patients receive each service and PHCSs can earn points for each service. The evaluation team surveyed PHCSs to better understand their ability to track referrals for Community Supports initiated by PHCS providers. PHCSs reported that, as of 2025, it remained somewhat or very difficult to track referrals for all Community Supports ([Exhibit 2.31](#)). PHCSs most frequently reported asthma remediation as the service for which referrals were most difficult to track, followed closely by housing deposits. By contrast, PHCSs reported far less difficulty in tracking referrals for Community Supports that have historically been a part of GPP.

Exhibit 2.31. PHCS Referral Experiences for Community Supports

Difficulty Identifying Patients Referred for Community Supports

Percent of PHCSs responding somewhat or very difficult to identify all patients the PHCS refers



Source: PHCS Survey, 2025.

Note: Only asked of those PHCSs that contracted with at least one MCP that offered the Community Support (denominator ranges from 5 to 11 PHCSs).

Non-Traditional Services Provided to GPP Service Users

Under the GPP points system, PHCSs can earn points for 33 individual, non-traditional services beyond ECM and Community Supports. These services include non-physician visits; preventive health, education, and support services; chronic and integrative care services; community-based encounters; and multiple forms of telehealth, including “store and forward” services, e-Consults, and real-time audio and/or video telehealth visits between patients and providers. Analyses of utilization data from 2023 indicate that each PHCS provided a unique mix of non-traditional services, which may reflect tailoring to meet the unique needs of GPP service users or the capabilities of each PHCS.

To illustrate the variation in use of non-traditional services, the evaluation team examined the nine most commonly used non-traditional services across all PHCSs and the relative use of these nine services for each of the 13 PHCS ([Exhibit 2.32](#)). Overall, PHCSs earned the most non-traditional points for real-time telehealth services^P (51% of all non-traditional points) followed by nurse-only visits (17% of all non-traditional points). For individual PHCSs, these two services were among the most commonly

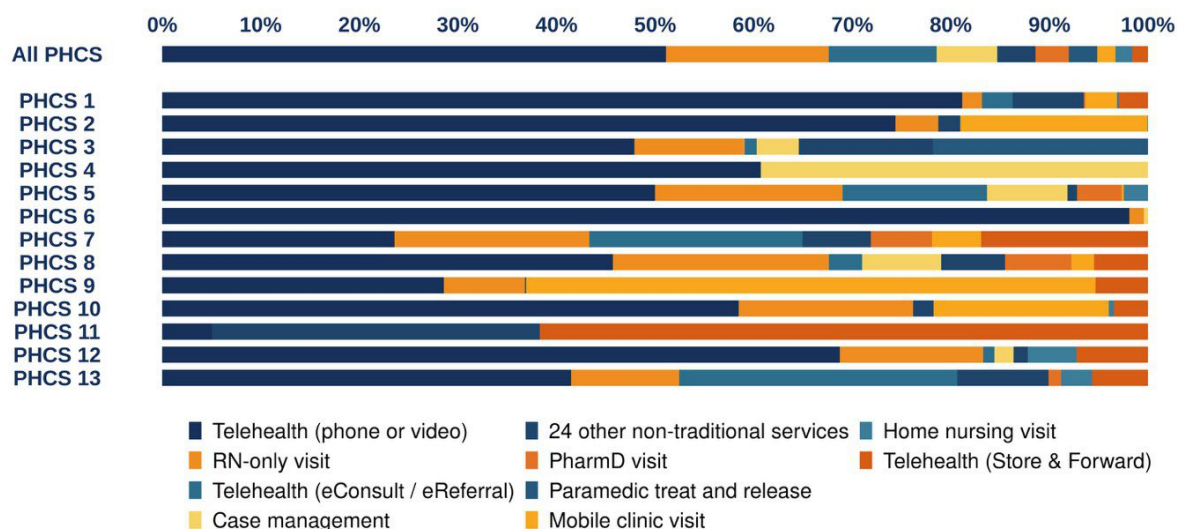
^P Real-time telehealth involves synchronous telehealth communication in which providers and patients communicate directly with each other using audio or video.

provided. However, [Exhibit 2.32](#) also indicates that selected PHCSs prioritized specific non-traditional services. For example, use of case management ranged from 0% to 39% of all non-traditional points across PHCSs, mobile clinic visits ranged from 0% to 58%, and e-Consults ranged from 0% to 28%.

Exhibit 2.32. Utilization of Non-Traditional GPP Services

Non-Traditional Services Most Frequently Provided to GPP Service Users

Percentage of Non-Traditional Points Claimed for Each of the Nine Most Common Non-Traditional Services, CY2023



Source: GPP encounter-level data, 2023

Note: Denominators for each row in the figure correspond to the total number of points earned for nontraditional services earned by all PHCSs (first row) or by each individual PHCS (next 13 rows).

Results for GPP Evaluation Question 3

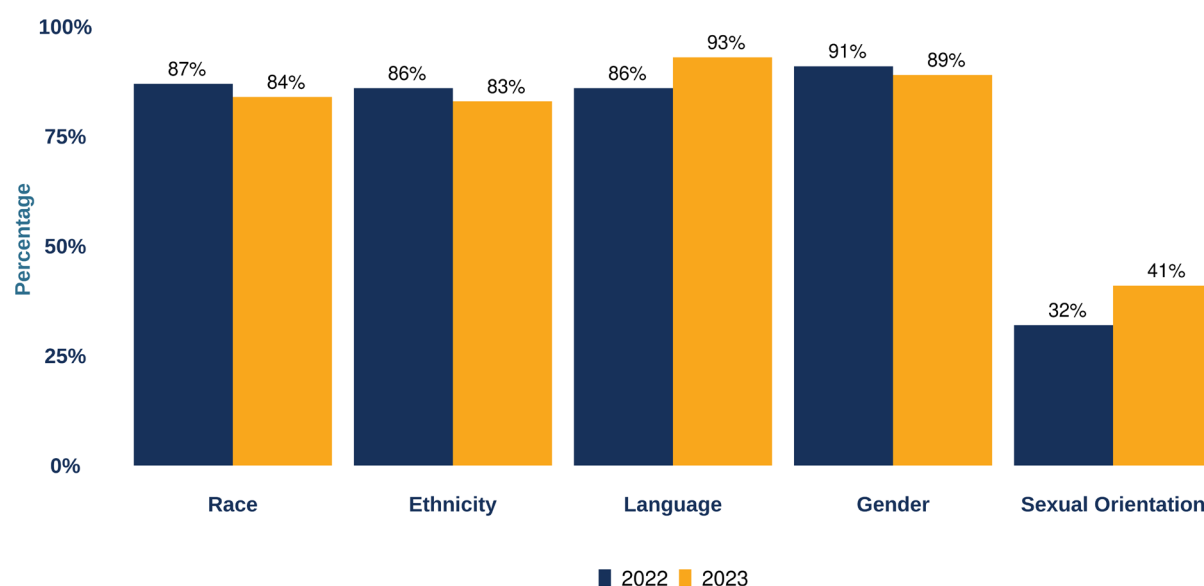
Evaluation Question 3 focuses on the extent to which GPP induces improvements in data infrastructure that can help PHCSs measure and reduce disparities in care. Using encounter-level data submitted by the 13 PHCSs, the evaluation team examined trends in the completeness of key patient information reported on encounter records that PHCSs used to support the claiming of points during the first two years of CalAIM. Analyses examined completeness of these data elements both overall and for a cohort of physician service users for whom PHCSs were expected to have more opportunities to collect information from patients. Finally, survey data were used to better understand the challenges PHCSs faced collecting and sharing patient data, including an in-depth analysis of PHCS patient portals, which are a potentially important tool for communicating with patients and exchanging key patient information.

Completeness and Accuracy of Patient information

Completeness of Patient Information, all GPP Users. Overall, rates of reported patient information were high across four of the five patient characteristics prioritized by DHCS in the design of GPP’s Health Equity Monitoring Metrics Protocol – ranging from 83% to 93% complete for ethnicity, gender, language, and race ([Exhibit 2.33](#)). The lone exception was sexual orientation, which was only complete for 41% of encounters in 2023. Aggregating rates of reported information across the five measures, the evaluation team observed an increase in overall completion from 76% to 78% between 2022 and 2023.

Among encounters for which patient information was not reported, GPP users might decline to provide the information or report “unknown.” Alternatively, PHCSs that do not ask patients for this information report “missing” on the encounter record. Rates of missing data were low in 2023 – ranging from 1%-2% for language, race, and ethnicity, 7% for gender, and 28% for sexual orientation.

Exhibit 2.33. Percentage of GPP Encounters with Reported Patient Information, 2022-2023

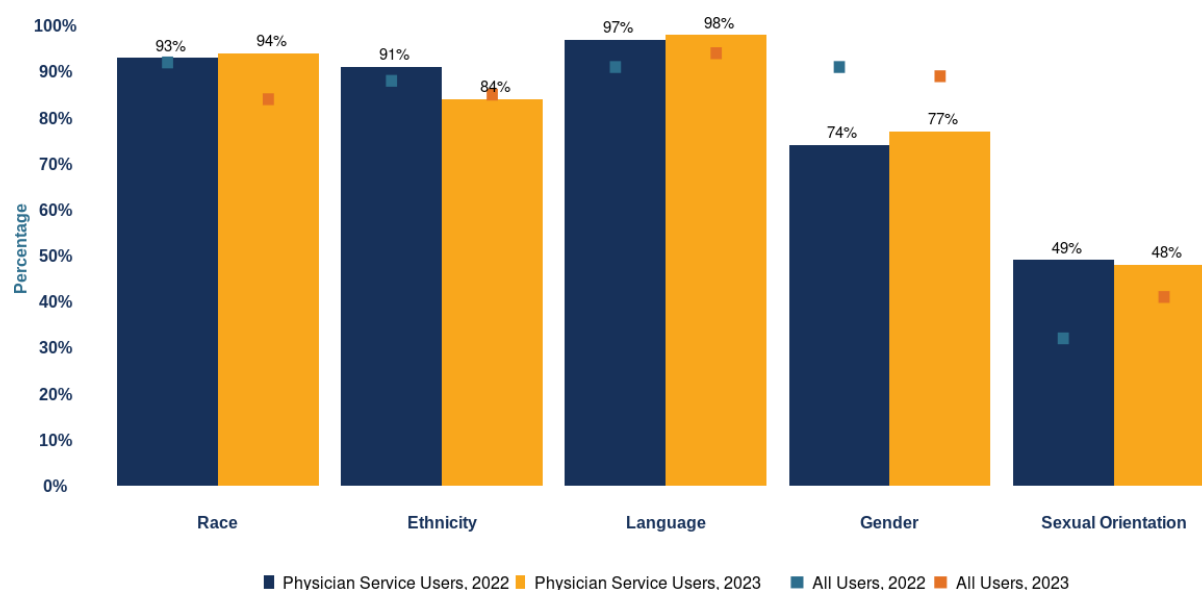


Source: GPP Encounter Data, 2022-2023.

Completeness of Patient Information, Physician Service Users. Because GPP service users include individuals who receive primary care regularly within the PHCS as well as those who obtain services exclusively through the ED or who are referred to the PHCS

for hospital care, the number of opportunities and feasibility of collecting patient information varies widely across individual GPP users. Thus, the evaluation team examined all encounters for a subgroup of GPP users with at least one physician visit in ambulatory settings in seven PHCSs that reported using a consistent, unique patient identifier across time. This analysis confirmed that patient information tended to be much more complete for GPP users of physician services compared to the overall GPP cohort ([Exhibit 2.34](#)). The exception was information about gender, which was less likely to be reported for users of physician services compared with the overall cohort.

Exhibit 2.34. Percentage of GPP Encounters with Reported Patient Information for Users of Physician Services, 2022-2023



Source: GPP Encounter Data, 2022-2023.

Note: The PHCS cohort used in the analysis was limited to seven PHCSs that used a consistent, unique patient identifier across all years. Each bar indicates the percentage of encounters with reported information among GPP physician service users in these 7 PHCSs. Each square represents the corresponding percentage for all GPP users in these 7 PHCSs.

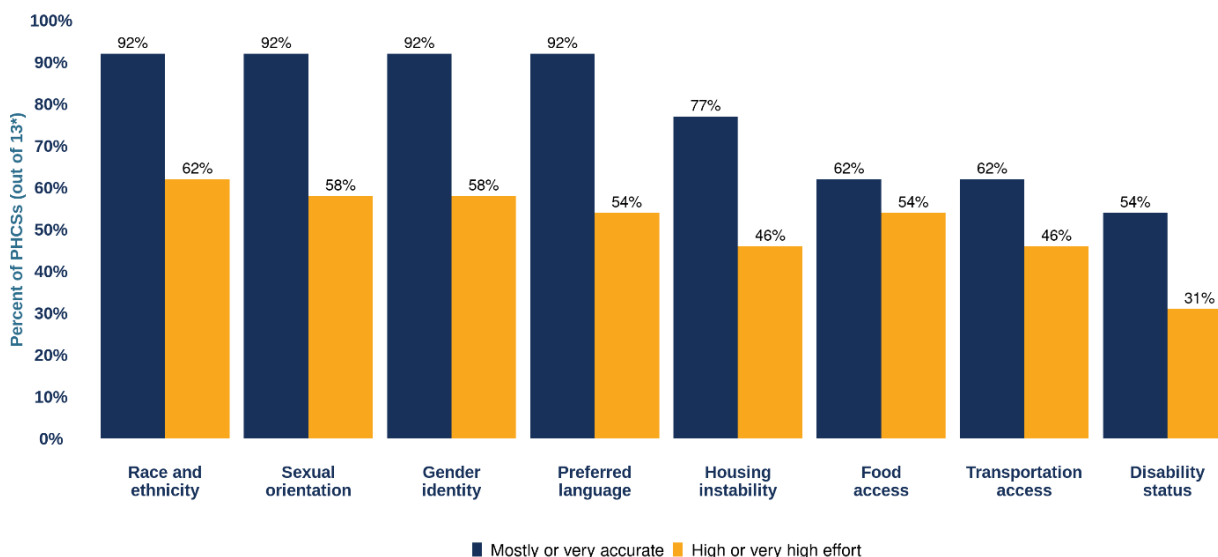
Accuracy of Patient Information. When queried about the accuracy of their patient information, PHCSs overwhelmingly reported high accuracy for patient demographic information required to generate the GPP Health Equity Report ([Exhibit 2.35](#)). By contrast, the reported level of accuracy was lower for health-related social needs, such as food access, transportation access, and housing instability, which are more dynamic than demographic characteristics and require more frequent data collection to ensure

their accuracy. PHCSs also reported spending a high or very high level of effort on improving data accuracy for the patient information included in the health equity monitoring protocol, and they were somewhat less likely to report substantial effort for other patient information—particularly patients’ disability status, although proxy indicators of disability, such as current medical conditions, are also readily available in PHCS electronic health records.

Exhibit 2.35. PHCS Ratings of Accuracy of Patient Information and Efforts to Improve Accuracy

Accuracy of Patient Information and Level of Effort to Improve Accuracy

Percent of PHCSs reporting mostly or very accurate information and high or very high effort to improve accuracy



Source: PHCS Survey, 2025.

Note: Accuracy refers to the degree to which patient-specific information is both valid and current. *Only 12 PHCS responded to the questions about gender and sexual orientation. High or very high effort refers to efforts to improve data accuracy.

Data Collection and Data Sharing Challenges

Despite the importance of having valid patient information, PHCSs reported substantial challenges collecting these data. PHCS Survey respondents indicated that the biggest challenges were the impact of data collection on clinic flow, difficulty obtaining data outside of clinic visits, and concern about overburdening patients ([Exhibit 2.36](#)).

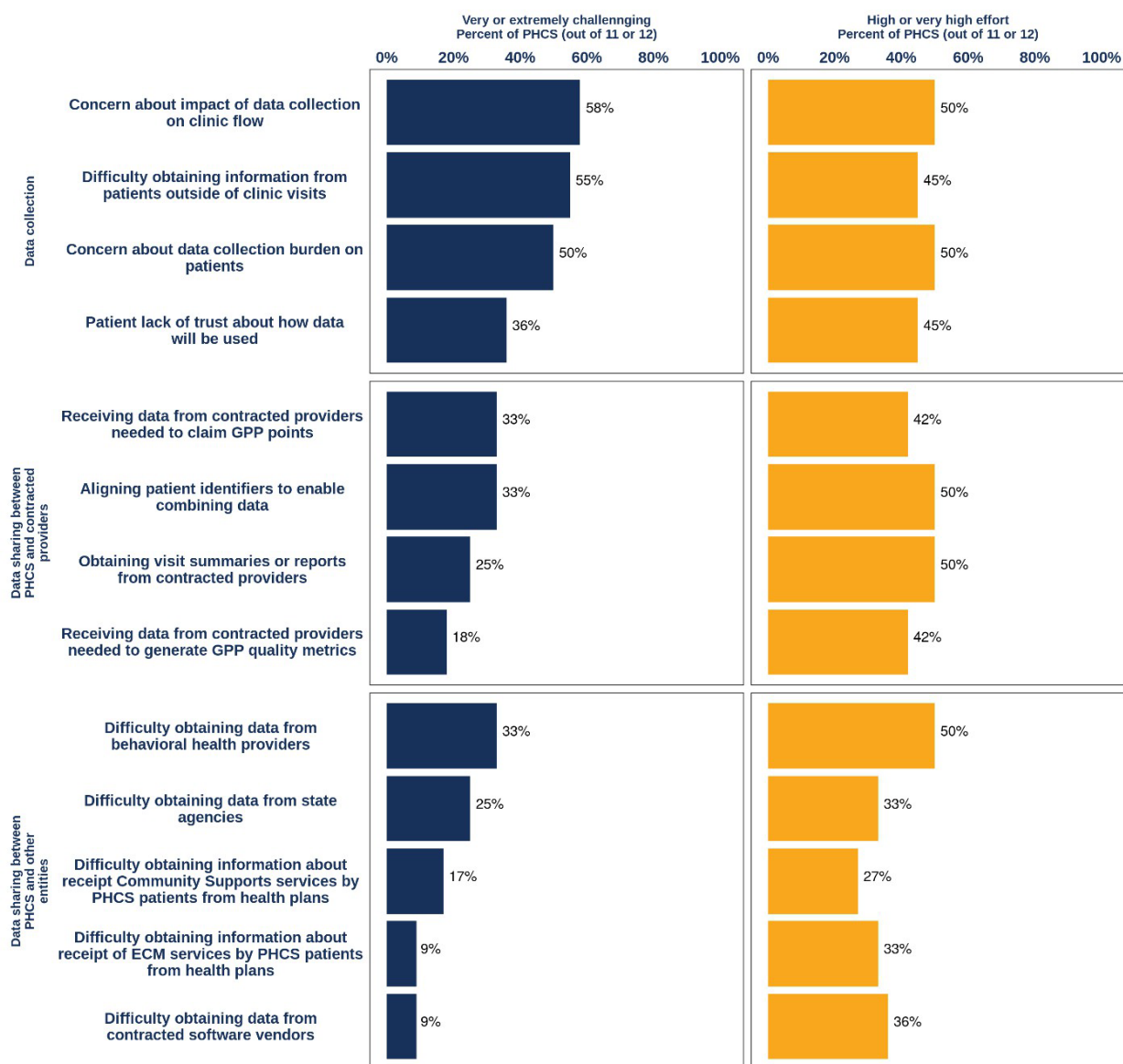
By comparison, data sharing challenges between PHCSs and contracted providers and between PHCSs and other entities were rated as less challenging, which may be related to the fact that GPP had already operated for over six years prior to CalAIM’s implementation. The most widely reported data sharing challenges were receiving data from contracted providers and aligning patient identifiers with contracted providers to

enable linking of encounters for the same patient. In addition, PHCSs reported difficulty receiving data from BH providers that operate under a separate, county-based authority in most counties in California. Half of PHCSs who reported these challenges also reported devoting substantial effort to address each of these data sharing challenges.

Exhibit 2.36. PHCS Challenges with Collecting and Sharing Patient Information

PHCS Challenges with Collecting and Sharing Patient Information

Percent of PHCSs reporting that each issue is very or extremely challenging during the last two years (panel 1) and Percent of PHCSs reporting that they devoted high or very high effort to the challenge during the last two years (panel 2).



Source: PHCS Survey, 2025.

Note: *Contracted providers refer to providers who are neither employed nor affiliated with the PHCS but who are contracted by the PHCS to provide GPP services.

Patient Portals

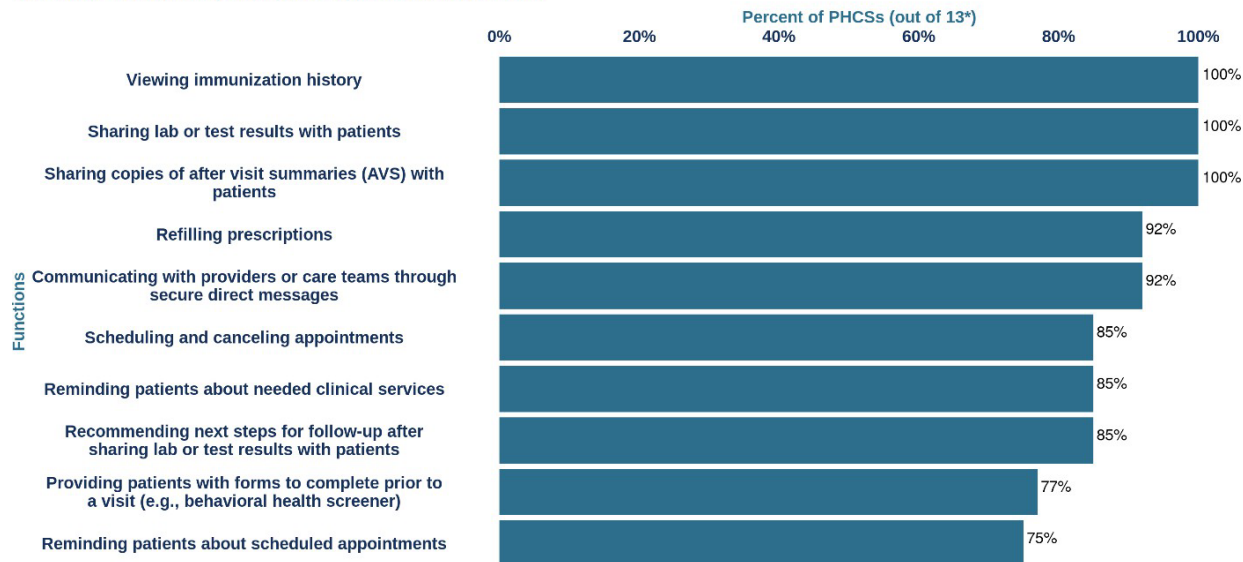
Large health systems across the country frequently use patient portals to centralize communications, share information with patients, and support patient efforts to manage their health. All 13 PHCSs reported using a patient portal as of 2025. The evaluation team surveyed PHCSs about specific functions of their patient portals that could support GPP's three goals as well as challenges associated with the use of portals.

Patient Portal Functions. The overwhelming majority of PHCSs reported that their patient portals supported each of the ten functions included in the PHCS Survey ([Exhibit 2.37](#)). All PHCSs reported that their portals enabled sharing of lab and test results with patients and copies of after visit summaries and allowed patients to view their immunization history. Nearly all patient portals enabled a range of functions related to appointments, including the ability for patients to schedule and cancel appointments (85% of PHCSs), receive reminders about scheduled appointments (75%), and communicate with PHCS staff through secure direct messaging outside of appointments (92%).

Exhibit 2.37. Functions of PHCS Patient Portals

Functions of PHCS Patient Portals

Percent of PHCSs whose patient portal supports the listed function



Source: PHCS Survey, 2025.

Note: *Only 12 PHCSs responded to the questions about reminding patients about scheduled appointments.

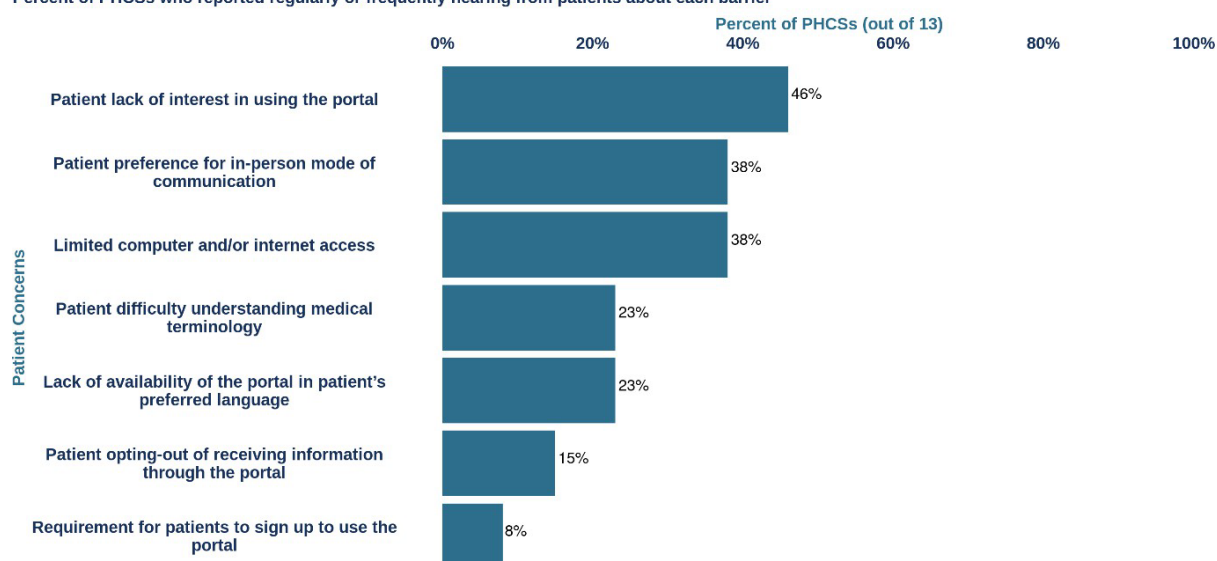
Barriers to Patient Use of Portals. GPP users may face greater barriers accessing health care services than other PHCS patients because they might have lower incomes,

limited English proficiency, or other reasons. These same factors could limit the effectiveness of patient portals as a tool to help GPP users meaningfully engage in their care. The evaluation team surveyed PHCSs about the extent to which patients have expressed seven different concerns regarding use of the PHCS's patient portal to better understand the impact of patient portals on patient care experiences and the degree to which PHCS portals take into account the needs of GPP users ([Exhibit 2.38](#)). Patient lack of interest in using portals was the most prevalent barrier – reported by just under half of PHCSs. Meanwhile, only 23% of PHCSs reported language barriers (because portals did not allow patients to engage with the portal in their preferred language), and only 23% of PHCSs reported that patient difficulty understanding medical terminology in the portal was a major challenge.

Exhibit 2.38. Barriers to Patient Use of Portals

Patient Concerns Regarding Use of Portals

Percent of PHCSs who reported regularly or frequently hearing from patients about each barrier



Source: PHCS Survey, 2025

G. Conclusions

GPP Evaluation Question 1: Improvements in Quality of Care for Individuals with Uninsured Services. Cross-sectional analyses of five quality indicators during the second year of CalAIM indicate that GPP users received equivalent or better care than the comparison group on three of the five measures examined. Reducing quality gaps for the remaining two measures will require efforts to improve cervical cancer screening rates – especially among lesbian, gay, or homosexual and bisexual GPP users and

individuals across most racial groups – and improvements in hemoglobin A1c control especially among Hispanic or Latino patients and most racial groups.

The positive performance of PHCSs in providing high-quality care to GPP users may reflect efforts to reduce wait times and expand both primary care and specialist physician workforces that more than two-thirds of PHCSs prioritized during the first few years of CalAIM. While PHCSs reported aggressively pursuing PHM strategies through reminders to engage users in use of preventive services, more intensive follow-up to users who continue to remain overdue for these services or maintain poor control of chronic conditions may be needed along with greater use of services to support lifestyle or improved treatment to achieve hemoglobin A1c control, such as GPP's non-traditional services. Longitudinal analyses that will be included in the Summative Evaluation Report will determine whether PHCSs are able to improve quality overall and reduce quality gaps for subpopulations of GPP users relative to Medi-Cal members over the last four years of CalAIM.

GPP Evaluation Question 2: Shifts from Emergent and Inpatient Care to Outpatient and Equity-Enhancing Services. Utilization of non-BH services provided in outpatient and other low-intensity settings has increased since GPP's inception including a dramatic increase after the COVID-19 pandemic. At the same time, use of inpatient medical/surgical services also increased although the increase was almost entirely limited to the second year of CalAIM. BH services followed similar trends with services in outpatient settings increasing substantially since the beginning of GPP and inpatient services increasing steadily after the first full year of the pandemic. The net impact of these trends was a modest 2-percentage point increase in the share of total points earned for services in low-intensity settings with little difference between BH and non-BH services. When examining these results for GPP physician service users specifically, our proxy for use of a PHCS as an individual's usual source of care, the share of points in low-intensity settings increased by 3 percentage points over the most recent six years of GPP for non-BH services and decreased by 7 percentage points for BH services, a trend at odds with GPP Goal 2.

Consistent with these findings, PHCSs reported substantial effort to reduce avoidable ED utilization, including monitoring ED use, referral to ECM and Community Supports, and promoting continuity with primary care. Use of ECM and Community Supports remained low for GPP service users in 2023 – the first year of implementation for the broader set of 11 Community Supports. Some implementation challenges for these new services

emerged, including difficulty identifying referred patients for most Community Supports. Meanwhile, use of non-traditional services largely maintained its seven-year high (first reached in 2021) and PHCS-level analyses documented heterogeneity in the types of non-traditional services used suggesting extensive tailoring of services to PHCS strengths or patient needs.

GPP Evaluation Question 3: Advancements in Data Infrastructure to Understand Health Inequities. In the second year of CalAIM, GPP encounter data generated by PHCSs reflected high rates of self-reported demographic information on the order of 83% to 93% across four of the five characteristics prioritized for GPP, and very low rates of missing data, ranging from 1%-2% for language preference, race, and ethnicity, 7% for gender, and 28% for sexual orientation. Among GPP physician service users, rates of reported information were higher for most characteristics, including sexual orientation. Moreover, PHCSs overwhelmingly reported high accuracy for patient demographic information required to generate the GPP Health Equity Report, and over half of PHCSs reported spending a high or very high level of effort on improving data accuracy.

Many PHCSs reported experiencing challenges with data collection and sharing, most importantly, its impact on clinic flow, although nearly half of PHCSs reported devoting substantial effort to a wide range of data challenges including unique identifier alignment across the system and improving data exchange with county-based BH systems. All PHCSs use patient portals to improve communication with patients and perform functions efficiently, including scheduling appointments and refilling prescriptions, and few PHCSs reported patient difficulty with use of portals such as language barriers or difficulty with medical terminology.

Overall assessment. Overall, PHCSs demonstrated either success or progress on all three of GPP's goals. PHCSs provided to GPP users similar or better quality relative to a Medi-Cal comparison group on three of five measures assessed; progress on closing quality gaps for the other two measures will be assessed using longitudinal data spanning four measurement years. The Summative Evaluation Report will also assess changes in quality overall and for subpopulations of GPP users between 2023 and 2026. PHCSs showed progress on Goal 2 by improving the share of points earned for services provided in low-intensity settings, greater priority to expanding outpatient BH services may be needed to reverse the negative trend we observed in the share of points earned for BH services in low-intensity settings. Additionally, more intensive use of ECM and Community Supports for GPP users may be needed to sustain or improve levels of use

of care in outpatient residential and community settings. Analyses that will be included in the Summative Evaluation Report will examine additional utilization measures using an expanded set of data sources that can provide a more complete assessment of utilization in ED and inpatient settings, including an assessment of ACS utilization. Progress meeting GPP's Goal 3 is reflected in high rates of reported patient information over the first two years of GPP and very low levels of missing data. Expanding data capture on sexual orientation and improving data exchange regarding referral and receipt of ECM and Community Supports could further enhance PHCS's ability to provide GPP users with high-value care that can ensure efficient use of GPP funding.

H. Interpretations, Policy Implications, and Interactions with Other State Initiatives

Under the CalAIM Waiver, GPP's implementation has occurred alongside several other demonstration components that interact with the program in ways that could enhance PHCSs' ability to achieve GPP's goals. PHCSs have been receiving funding through the PATH program to support their ability to provide ECM and Community Supports to eligible Medi-Cal members. To the extent that PATH funding strengthens the capacity of PHCSs and their community partners to develop information and billing systems, hire staff, meet credentialing requirements, and expand provision of these services, GPP users could experience larger improvements in quality of care and avoid utilization in high-intensity settings over the remainder of the evaluation period. Early positive feedback on the effectiveness and cost-effectiveness of Community Supports could also incentivize MCPs to expand their offering of these services, which could further expand provider supply, accelerate PHCS efforts to develop referral and data sharing systems, and encourage PHCSs to allocate a larger share of GPP funding toward Community Supports.

CalAIM's Drug Medi-Cal Organized Delivery System (DMC-ODS), a component of the waiver that focuses on improving SUD treatment for Medi-Cal members, could also reinforce GPP's goals of strengthening the delivery of BH services in low-intensity settings. One unique feature of DMC-ODS is county oversight of its implementation, which could support the development of integrated care models between PHCS and county-based providers of SUD services.

Other ongoing programs include the Quality Incentive Pool (QIP), a Medi-Cal managed care incentive program focused on public hospitals and health systems that allocates performance-based payments annually based on a set of 20 required measures. Notably, the measure list has expanded recently to include counts of Medi-Cal members served by the hospital who are enrolled in ECM and the number and types of Community Supports received by Medi-Cal members. Linking these specific measures to incentive payments in the future could help strengthen incentives further for PHCSs to invest in these services.

Given that the findings presented earlier in this chapter include data from only the first two years of CalAIM, we defer discussion of the broader implications of these findings to the Summative Evaluation Report. However, we note that the ability of other states to implement similar programs may be time-limited as Medicaid DSH funding reductions are expected to begin in January 2026. States might consider adopting many of the same features of the GPP to accelerate program implementation.

I. Lessons Learned and Recommendations

Lessons Learned from the GPP Demonstration

The GPP demonstration has highlighted several important lessons pertinent to serving uninsured individuals in California's safety net health systems. Below, the evaluation team lists these lessons, and, where appropriate, provides recommendations to DHCS to support PHCS efforts to achieve GPP's goals.

- » The BH needs of California's uninsured are substantial and include patients with SUDs and those with low and moderate severity as well as serious mental illness. Incorporating quality measures that specifically track receipt of appropriate follow-up care after hospitalizations or ED use for BH conditions could further support PHCSs in effectively managing these conditions within outpatient and other low-intensity care settings.
- » BH delivery systems in California generally operate separately from PHCSs, except in rare instances. This structural separation creates barriers for integrating care and data across systems. Global payment arrangements spanning both PHCSs and county-based BH systems, with combined funding streams, could foster incentives for integrated care models and facilitate improved data sharing between systems. DHCS could conduct an in-depth assessment of counties

simultaneously implementing GPP and BH-CONNECT to identify governance models and data exchange systems that are particularly effective.

- » Ensuring access to specialists may be equally important to avoiding care in high-intensity settings as improving access to primary care and care continuity. PHCSs reported difficulty with wait times to see specialists and difficulty expanding specialty physician staffing. At the same time, GPP encounter-level data do not allow assessments of specialty care utilization because of the lack of clinician identifiers in the data, making it difficult to assess changes in access to specialty care. DHCS might consider adding a separate service code for visits with specialists in the GPP encounter data or require reporting of clinician-level identifiers to improve assessments of specialty care utilization.
- » Developing a comprehensive view of service utilization for GPP users requires access to multiple data sources, given the lack of a single payer for uninsured care and the reality that uninsured patients often seek services from various organizations. While many PHCSs have made substantial investments in data systems to support quality measurement and advance health equity, others lag behind, resulting in uneven capacity to capture and report on service use. To support data integration DHCS could incorporate Medi-Cal Client Index Numbers into GPP encounter-level data reporting to facilitate data linkage for GPP service users who also have periods of enrollment in Medi-Cal.
- » Accurately determining whether a service can be counted under GPP as an uninsured service is also a labor-intensive process for PHCSs. The demonstration underscores the importance of establishing robust data flows between the state and providers before program implementation to streamline administrative processes and ensure accurate point-claiming.
- » Utilization patterns among GPP users are highly heterogeneous; some individuals engage regularly with primary care, while others use PHCSs only for acute care needs. Evaluation methods must account for these distinct subpopulations to ensure that assessments of quality and utilization accurately reflect the diverse needs and experiences of the uninsured population served by PHCSs. DHCS could strengthen evaluation efforts by supporting PHCS efforts to use a single cross-system patient identifier spanning all care settings, including those of PHCS, contracted, and affiliated providers.

Recommendations to Other States

Based on initial findings from the GPP demonstration, a preliminary list of recommendations can be made for states considering similar initiatives:

- » One key requirement for successful implementation is the need to provide PHCSs with flexibility in using program funds, as this approach allowed GPP to support over 50 different services and continuously incorporate high-value options. States interested in adopting a similar payment model should work collaboratively with local hospitals and health systems to develop a detailed list of eligible services and establish point values that reflect state and community priorities.
- » Robust encounter-level data infrastructure is also critical; states should ensure their systems capture all services delivered to uninsured individuals, including services not directly linked to the claiming of points, to enable comprehensive monitoring of quality and utilization trends over time. These data systems should also include provider-specific identifiers and detailed patient characteristics, facilitating assessment of care patterns across primary and specialty care settings and allowing for meaningful equity analyses.
- » For evaluation purposes, states should identify and develop comparison groups of health systems with similar characteristics to those participating in the demonstration, which supports high-quality, rigorous analyses of program outcomes.
- » Consideration should be given to phased-in implementation strategies, such as a step-wedge design, in which the program is sequentially introduced to different groups at different time points, allowing all groups to eventually receive the intervention while enabling comparison between intervention and control periods. If feasible, leveraging comparable systems from other states, given adequate data on uninsured care, could also strengthen the evaluation.
- » Collecting baseline data prior to implementation is essential, as it enables more effective selection of a comparison group and allows for robust estimation of program impacts through longitudinal evaluation approaches.

EVALUATION COMPONENT 3: EVALUATION OF THE MEDI-CAL MATCHING PLAN POLICY FOR DUALY ELIGIBLE BENEFICIARIES (DUALS)

Li-Jung Liang, PhD, Elizabeth Bromley, MD, PhD, Emily Shamban,
MPH, Abbey Shirley, and Katherine L. Kahn, MD.



A. Executive Summary

Summary of Demonstration

Managed care has become the predominant model of care delivery for Medi-Cal members in California. As dually enrolled individuals also make use of MA plans, there has been an increased need to facilitate aligned managed care delivery for services covered by Medicare and Medi-Cal. The Medi-Cal Matching Plan Policy for Dually Eligible Beneficiaries (duals) was designed to ensure that, where possible, Medi-Cal managed care members would be assigned to MCPs offered by the same parent organization that administer their MA choices to reduce administrative burden and improve the coordination of care. The policy was operational in 12 counties in 2023, followed by an additional five counties in 2024. In 2023, a significant number of duals were enrolled in MCPs and the matching plan policy was applied to these members newly enrolled in Medi-Cal managed care. The department will expand the matching plan policy to the remaining counties in 2026.

The first goal of the evaluation was to assess the epidemiology of Medi-Cal managed care enrollment and changes in enrollment among duals enrolled in Medi-Cal managed care. The evaluation team used monthly enrollment data for duals enrolled between January 2021 to May 2024 (with a minimum one-year lookback period) to assess enrollment and changes in enrollment in Medi-Cal and Medicare and how managed care enrollment and changes in enrollment conformed with the policy. The second goal of the evaluation was to understand members' knowledge and satisfaction of the process to change their plan enrollment. To achieve this, in fall 2024, the evaluation team surveyed Medi-Cal members who changed their MCPs between December 2023 and May 2024.

Methods and Limitations

For the Interim Evaluation Report, the evaluation measure of alignment in the past two years.

There has been a steady increase in MA enrollment with concurrent increases in alignment between MA plans and MCPs. The new Medi-Medi Plans are one component of this. MCP enrollment at the beginning of the CY follows the Medicare open enrollment period, which occurs each fall. Increased MCP changes in January reflect to

some extent, the choice of members to enroll in the Medi-Medi Plans in the fall. This is supported by the concurrent change (e.g., MCPs and MA plans changing in the same period). In contrast, enrollment changes due to the policy (aligning each MCP member with his MA choice) should follow the MA enrollment change. The actual number of individuals impacted by the policy appears to be small. In contrast, individuals already enrolled in MCPs (and primarily Original Medicare) primarily enrolled in Medi-Medi Plans or, less often, in aligned MA plans (e.g. MA plans offered by the same parent managed care organization but which are not Medi-Medi Plans).

The member survey conducted in October-December of 2024 of MCP changers provided additional context for this process. In the descriptive analyses, our survey data indicated that many individuals were unaware that their MCPs had changed. For individuals who changed their plans, an equal proportion reported experiencing difficulties and no difficulties. In addition, individuals from matching plan policy counties were more likely to find information on changing their MCPs more helpful prior to the change. This may reflect the greater expectations and efforts by DHCS in policy counties where there are more managed care options to choose from and where choosing between options may be complicated.

Interpretations

Initial results of the matching plan policy highlight the expansion of duals enrollment in D-SNPs (e.g., Medi-Medi Plans) across the state and the alignment of MCP enrollment with MA plan enrollment. The results of the descriptive analyses completed at this time suggest that members are choosing to enroll in a MA plan that aligns with their MCP rather than choosing to enroll in a MA plan and subsequently being required to change their MCP to match their MA plan. Changes in MCP options which occurred in January 2024 likely created additional opportunities for members to make MA enrollment changes. The increased integration of managed care services across Medicare and Medi-Cal should result in more seamless delivery of services and create further incentives for members to remain enrolled in their Medi-Medi Plans and aligned MA plans. The evaluation cannot answer whether individuals found changing their MCP harder and thus settled on aligning their MA plans, where possible, because they perceived MA enrollment was more straightforward.

From its inception and announcement to members, the alignment policy was presented as the MCP follows the MA plan. It appears that the policy is infrequently driving such

changes and that individuals are choosing MA plans that align with their MCPs, especially among individuals moving from Original Medicare to MA plans. It thus appears that Managed Care Organizations (MCOs) that are the parent organizations for managed care plans are inviting MCP members who are not yet enrolled in MA plans to enroll in MA plans that are aligned or integrated with MCPs. The process in which this might be occurring has not been explored.

Results of the survey suggest that members who changed their MCPs were generally satisfied with the process. However, the survey cannot answer whether non-changers are satisfied or knowledgeable about the process of changing plans or the alignment policy, which may be a separate driver of change in the Medi-Cal program. From a policy perspective, transparency on changing plans might generate greater change.

Lessons Learned

Based on this experience, at this point in the evaluation, there are some lessons learned regarding the implementation and recommendations to other states that choose to implement these policies.

1. The matching plan policy was developed to ensure alignment of MCPs with MA plan enrollment, but few (less than two thousand overall) individuals were identified as subject to the policy. Limitations to member choice are not a major impact of this policy.
2. Clear guidance to members regarding the Medi-Cal Matching Plan Policy is important.
3. Assessing enrollment changes were complicated by subcontracted (delegated) plan enrollment not directly reported to DHCS.

Recommendations

In light of the current findings, the evaluation team recommends the following:

1. Advanced notice of policy implementation – in addition to standard information on the DHCS website regarding Medicare open enrollment, this might include providing members with an email or robocall to remind them to check changes to the DHCS website or to remind them that their Medicare managed care enrollment may impact their Medi-Cal MCP enrollment.

2. Timely announcement of plan availability in affected service areas. For example, if a MCP has possible aligned MA plans, these MA plans should be easily identifiable. Integrated plans are identifiable, but not aligned plans.
3. Attempt to track member enrollment in delegated plans to improve understanding of plan alignment.
4. Consider ways to improve information on MCP and MA plan in a member's county of residence. For example, a drop-down menu of available MCPs in the member's county of residence and then a link to the CMS website with directions on what to look for regarding MA plans. This sharing of information is the biggest challenge because DHCS does not control MA plan availability or how CMS presents this information.

In the future, with greater stability in MCP offerings, tracking the matching plan policy and its impact will be less affected by these external factors. For the final report, the evaluation will assess the impact of the alignment policy over the longer term, attempt to include all geographic areas for assessment, and identify observable factors which influence MCP changes and plan alignment among members.

B. General Background Information

The Matching Plan Policy for Dually Eligible Beneficiaries

As Medi-Cal managed care enrollment has expanded and become mandatory, California is addressing the separate 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 the matching plan policy for Dually Eligible Beneficiaries, which is aimed at improving the experiences of duals with Medicare Parts A and B who choose to enroll in a MA plan by aligning their Medi-Cal MCP with their MA choice. This alignment has been accentuated with the introduction of Dual Eligible Special Needs Plans (D-SNPs), in particular, fully integrated plans – Medicare Medi-Cal Plans (Medi-Medi Plans) (see below for more detail).

Federal rules dictate freedom of MA choice for Medicare beneficiaries. In the course of introducing mandatory managed care assignment for Medi-Cal enrollees, Medi-Cal originally allowed enrollees to have full discretion regarding choice of MCPs offered in their county of residence, where more than one plan was available. The Alignment Policy

reduces Medi-Cal MCP choice, and the overarching goal of the 1115 Waiver evaluation is to understand the impact of the policy.

The matching plan policy was operational in 12 counties in California in 2023, with five counties added in 2024, and the remainder planned for inclusion in 2026. The matching plan policy was designed to ensure that, where possible, Medi-Cal managed care members would be assigned to managed care plans (MCP) that match their MA choices to reduce administrative burden and improve the coordination of care. Managed care plans are required to offer specific services, have contracted allied health professionals and institutions to provide these services, and define benefits consistent with Medicare and Medi-Cal. Different MCPs are not required to align contracted providers or services with plans offered by other managed care organizations. This can create administrative delays and reduced choice for managed care members where the members are coordinating between plans offered by different managed care organizations. For example, a hospitalized individual may be transferred to a post-acute care facility within their MA plan but will need to transfer to a different facility for long term care, while an aligned plan might be able to find a facility that can provide both sets of services and is contracted across the aligned plans.

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. 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 (Fee-For-Service [FFS]) Medicare.

For purposes of this evaluation, MA options include Regular MA plans; Exclusively Aligned Enrollment (EAE) D-SNPs, also known as Medi-Medi Plans; non-EAE D-SNPs; Chronic Condition Special Needs Plans (C-SNPs); Institutional Special Needs Plans (I-SNPs); SCAN Fully Integrated Special Needs Plan (FIDE-SNP); and Program of All-Inclusive Care for the Elderly (PACE) organizations. Definitions for each plan type are provided below:

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.

Medicare Medi-Cal Plans (Medi-Medi Plans): 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 MCP affiliated with the D-SNP. Medi-Medi Plans were 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 offered 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 duals. 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 and (2) plans that do not have an affiliated Medi-Cal plan (e.g., that are offered by MCOs that do not have an MCP in that county). For contract year 2025, and ongoing, DHCS is limiting new enrollment in D-SNPs to only those D-SNPs that are affiliated with a Medi-Cal plan. D-SNPs without an affiliated Medi-Cal plan will no longer be able to enroll new members, but existing members may remain with their plan. As of contract year 2026, all Medi-Cal MCPs are required to operate an EAE D-SNP.

Other Special Needs Plans (SNPs): The Other SNP 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.

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 duals. 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 ages 55 and older who meet the criteria for needing a nursing facility level of care, most of whom are duals. 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 grew

to over 290,000 by January 2024.

In contrast to the Cal Medi-Connect demonstration – where there was a three-way contract between CMS, DHCS, and each plan, and member enrollment was into a single plan – Medi-Medi Plans are more complex. They have separate State Medicaid Agency Contracts (SMACs) and MCP contracts with DHCS as well as MA contracts with CMS, as well as separate federal and state enrollment transactions. As a result, the 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.

From the standpoint of the alignment policy, DHCS defines a **Medi-Medi Plan** as an integrated EAE D-SNP, an **Aligned Plan** as an MA plan and MCP affiliated with and operated by the same MCO, and an **Unaligned Plan** as an MA plan and MCP operated by different MCOs.

Federal rules dictate freedom of MA choice for Medicare beneficiaries. In the course of introducing mandatory managed care assignment for Medi-Cal enrollees, Medi-Cal originally allowed enrollees to have full discretion regarding choice of MCPs offered in their county of residence, where more than one plan was available. The Alignment Policy reduces Medi-Cal MCP choice and the overarching goal of the 1115 Waiver evaluation is to understand the impact of the policy.

Medi-Cal Managed Care Delivery System and MCPs⁴¹

California has had a unique county-based managed care delivery system for MCPs that has been implemented across the 58 counties in the state, which has implications for the matching plan policy. MCPs were 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 which each have four MCPs operated by commercial entities. Seventeen rural counties were 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 was covered by a single commercial MCP. Fourteen suburban and rural northern counties were covered by a single COHS entity with an additional commercial plan in the more populous counties in this group.

As described in detail [in a separate evaluation](#), beginning in 2024, there has been a

reorganization of these models, with some of the rural counties –San Benito County and Imperial County – moving towards the COHS or single plan model. In addition, Kaiser Permanente expanded its Medi-Cal prime plan participation through a direct contract with DHCS, where eligible members may actively choose to enroll in Kaiser Permanente in any county in which it operates, including GMC, Regional, Two Plan, COHS, and Single Plan counties.⁴²

To increase member choice, in years prior to the 2024 reorganization, MCPs in certain counties (including Los Angeles, Riverside, San Bernardino, San Mateo, and Santa Clara) sub-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 2023 in LA Co., Kaiser Permanente, Blue Shield, and Anthem Blue Cross were Delegated Plans to LA Care, the Primary Plan. As of 2024, Anthem Blue Cross, Blue Shield, and Molina Healthcare were Delegated Plans to LA Care and Kaiser Permanente became a Primary Plan.

Medi-Cal Managed Care Enrollment for Dual Eligible Beneficiaries

Medi-Cal has had a county-based policy of mandatory and voluntary 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.⁹ Approximately 70% of California’s 1.5 million duals (~1,050,000) were in an MCP – and most of these were in these 27

⁹ 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

counties. Expansion of mandatory MCP enrollment policy to the remaining 31 counties^r occurred in 2023.

The Program: The Matching Plan Policy

In general, upon receiving Medicaid benefits, if non-duals don't specify an MCP within 30 days of enrollment, most are assigned to an MCP that operates in their county of residence, and the member may request a change in any month after enrollment. The matching plan policy was operational in January 2023 in 12 of California's 58 counties with an additional five counties in January 2024.^s

Under the matching plan policy, if a Dual with both Medicare Part A and Medicare Part B 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 their MA plan (in other words, operated by the parent Managed Care Organization – MCO). 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 matching plan policy does not change or impact a member'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 matching plan policy, common scenarios are described in [Exhibit 3.1](#).

Exhibit 3.1. General Scenarios for the Matching Plan Policy

Circumstance when Duals ^t 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.

^r 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

^s 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.

^t Medicare Part A and Part B are required to enroll in an MA Plan.

Circumstance when Duals^t Consider or Request a Change in their MCP	Description
2. Request to change from an aligned MCP	If a dual is currently enrolled in an MCP that matches their MA but wants to change their MCP to one that does not match their MA, the enrollment is not allowed. 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. 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 is enrolled in an MA plan, and there is a MCP that matches with that MA plan, the 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 \(ca.gov\)](#)⁴³

This 1115 demonstration impacts duals enrolled in an MA plan who reside in one of the matching plan counties. Per the CMS approved evaluation design, the state will evaluate program goals of improving alignment and integration, as primarily assessed by member experience with Medi-Cal plan alignment. Other aspects of MCP alignment and integration – care coordination, access, and quality – were examined in the context of how these interact with member experience with changing their managed care plans (as described in the member survey). Medicare and Medi-Cal integration has been evaluated by the CMS Medicare-Medicaid Coordination Office (MMCO) through a contract with RTI International.⁴⁴⁻⁴⁶

C. Evaluation Questions and Hypotheses

Evaluation Questions, Hypotheses, and Measures

[Exhibit 3.2](#) shows *matching plan* policy goals articulated by DHCS. Exhibit 3.2 further includes the evaluation questions (EQs), directional hypotheses (H), and measures developed by UCLA-RAND and DHCS to assess whether the goals of the policy were achieved as anticipated.

Exhibit 3.2: 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 an MA plan in the 12 counties with a <i>matching plan policy</i> in 2023 had the policy applied to them?	1. Percent of duals enrolled in an MA plan who change their MCP and who change their MA plan (in counties with the <i>matching plan policy</i> compared to counties without the Policy) – aligned versus unaligned plans.
EQ 1b: Of duals that had the policy applied to them, how many changed their MCP to a non-matching plan within 12 months of enrollment?	1. 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 Original Medicare and compared to duals in other MA types. 2. Overall MCP enrollment churn (or temporary loss of coverage) rate,
H 1: Less than 0.1% of duals in mandatory aligned plans in Matching Plan Counties will change their MCP without changing their MA within 12 months of enrollment during the target period.	

Goal 1: Determine the Epidemiology of Plan Changes among Dually Eligible Beneficiaries Eligible for MA Plans and Relate Them to Requested MCP Change Requests.

H 2: Duals in aligned plans during the target period are less likely to change their MCP (without changing their MA) than those in unaligned plans during the target period.	with comparisons. 3. Percent of individuals who change their MMP compared to individuals in unaligned D-SNPs in counties without the <i>matching plan policy</i>.
H 3: Duals who 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.	
H 4: 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.	

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 an MA plan?	1. Knowledge of the MCP enrollment process among duals enrolled in MA plans in <i>matching plan policy</i> counties versus those in Medi- Medi Plans versus other types of MA in counties without the policy. 2. Satisfaction of the MCP enrollment process among duals enrolled in MA plans in <i>matching plan policy</i> counties versus those in Medi- Medi Plans versus other types of MA in counties without the policy as measured by a 5-point Likert Scale. 3. 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 with the policy.	

Conceptual Model

The driver diagram ([Exhibit 3.3](#)) shows how the 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 3.3: Driver Diagram for the Matching Plan Policy

Aim	Primary Drivers	Secondary Drivers
Achieve less than 0.1% monthly rate of duals changing their MCP to non-matching MCP for those who enroll in MA plans AND who are in counties where the <i>Medi-Cal Matching Plan Policy</i> 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 about 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 ←		

D. Methodology

Data Sources

For the Interim Evaluation Report, the matching plan policy evaluation team obtained monthly Medi-Cal enrollment data (2021 baseline to present with one year lookback) and monthly MA enrollment data (2021 baseline to present with one year lookback) from DHCS. Delegated Plan assignment – which represent internal MCP subcontracting and no data routinely collected by DHCS – has not yet been available for the evaluation. Public use data included complete MA and MCP plan lists for this period, MA and MCP plan descriptions, list of Medi-Medi plans, and licensed D-SNPs nationally. For Goal #2, UCLA-RAND developed and fielded a knowledge and satisfaction survey for MCP changers across the state in 2024.

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 attempted 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 monthly MA plan or MCP change, (2) duals MA plan and MCP aligned or unaligned, and (3) duals enrollment in or out of Medi-Medi Plans. We have also characterized 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 is the county policy variable – matching plan policy. Secondary predictors are Medi-Medi Plan; duals Baseline MA plan, duals Baseline MCP; duals Baseline Plans aligned or unaligned, or both; duals characteristics (age, gender, race-ethnicity, preferred language, county); and social need metric by ZIP code (defined consistently over the CalAIM evaluation components).

As described in the background section, the matching plan policy is being implemented in three waves – the initial 12 counties (2023), five additional counties (2024), and the remaining 41 counties (2026). Descriptive results are presented overall and by each set of counties.

For the Interim Evaluation Report, the evaluation focuses on descriptive analyses of the matching plan policy including the creation of the sampling frame for the member

survey. Because the evaluation team experienced a delay in receipt of enrollment information for when duals were not fully eligible for Medicare (which may occur before, during, or after fully eligible period), some subgroup analyses regarding special circumstances – individuals who newly enroll and disenroll from Medi-Cal is not included in the Interim Evaluation Report, but will appear in the Summative Evaluation Report.

Finally, individuals who changed their MCPs were identified from the last six months of available enrollment data (December 2023 through May 2024) to create the sampling frame for the knowledge and satisfaction surveys fielded for Goal #2.

The Target Population includes duals in MA plans (with duals in Original Medicare Part A and Part B as a control) in counties with the matching plan policy compared to those in counties without the matching plan policy and duals in Medi-Medi Plans compared to duals in other MA plans compared to duals in Original Medicare (Part A and Part B).

The Time Period is January 2022 to May 2024 compared to CY 2021. For the Summative Final Report, enrollment data will extend to CY 2027 (one year after the end of the Waiver).

The Sampling Frame for the Interim Report was defined as all duals in California enrolled in Medi-Cal between 2021 and May 2024 with one year lookback to characterize enrollment prior to any plan changes.

Descriptive Analyses

For the Interim Report, the evaluation team present unadjusted descriptive results without statistical testing for significance as a compromise while data issues – incorporating periods where individuals were not in Medicare Part A or Part B or when individuals were in delegated plans – are being addressed.

1. Among duals in MA plans from 2021 to present (with one year lookback), UCLA-RAND assessed the rate and type of MA plan change, MCP change, and MCP alignment, pre- and post-*matching plan policy* implementation, comparing duals in counties with the policy and duals in counties without (or before) the policy. We examined the five possible month-to-month Medicare transitions: (1) MA – no change, (2) MA – switch to another MA, (2) Original Medicare to MA, (4) MA to Original Medicare, and (5) Original Medicare – no change. Assessment of enrollment in D-SNPs and transitions from D-SNPs is included. However, assessment of

enrollment changes into and out of Medi-Medi Plans (EAE D-SNPs) was deferred to the Summative Evaluation Report because these were not explicitly identified as such by the Centers for Medicare and Medicaid (CMS) and must be separately verified.

2. *Overall, and stratified by Medicare transitions, UCLA-RAND examined MCP transitions that follow the MA plan.* MCP status and its relationship to MA status are defined as follows:

- » MCP change vs no change,
- » MA plan change (including the special case of Original Medicare) versus no change, and
- » MCP and MA alignment: not aligned, aligned, or integrated (Medi-Medi Plans).

UCLA-RAND also assessed the distribution of the number of transitions that individual duals make during the target period. Individuals who frequently switched plans require further examination. Because this pattern of enrollment was more complicated and occurs in a small number of individuals, this analysis was deferred to the Summative Evaluation Report.

3. Descriptive analyses of MCP changes, comparing patterns of enrollment of duals in counties where the policy was implemented with duals in counties where the policy has yet to be implemented.
4. Descriptive analyses of demographics of duals changers within demographic categories of duals – age, gender, race or ethnicity, preferred language, counties, and quartile measure of social need (of residence ZIP code). A more complete analysis examining likelihood of changing a plan over time will be deferred to the Summative Evaluation Report given unresolved data issues.

Multiple Variable Regression Analyses

Proposed regression analyses from the Evaluation Design Report to examine “Change to non-matching MCP” and “Change of MCP” is deferred to the Summative Evaluation Report given unresolved data issues that would affect these results.

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.

For Goal #2, the UCLA-RAND evaluation team developed and fielded a survey of the duals population using a sampling frame derived from the final six months of data in Goal #1, including assessing satisfaction in the process of changing plans among Medi-Cal members, other MA members, and Original Medicare members who changed their MCPs. Results from Goal #2 may be used to inform DHCS, MCPs, and their members about experiences with the matching process and to improve duals' knowledge and experience. Surveys to assess knowledge and satisfaction with the process of changing plans among duals who change their MCPs were completed in the last quarter of CY 2024.

The Target Population for the Duals Survey was duals in MA plans (with Duals in Original Medicare as a control) who change their MCPs in counties with the *matching plan policy* compared to those in counties without the *matching plan policy*.

The Time Period covered individuals who changed MCPs between December 2023 to May 2024.

The Sampling Frame was restricted to duals (whether enrolled in MA or Original Medicare) who definitely changed their MCP (see further discussion below). Individuals were sampled according to the following strata: (1) whether the county of residence had the *matching plan policy* (yes or no) and (2) whether they changed their MA Plan enrollment (yes or no), and Baseline Plan Alignment (unaligned, aligned, or integrated). The target sample size was 4,000 with a goal of 400 completed surveys (10% response rate) with 25 completed surveys per strata with MA enrollment (300 total) and 50 completed surveys per strata in Original Medicare (100 total divided between counties with and without the matching plan policy). Within the defined strata, the evaluation team attempted to match on gender and race-ethnicity with oversampling for underrepresented minorities to ensure adequate power to examine differences between these groups. Because the population of MCP changers was much smaller in the counties without the *Medi-Cal matching plan policy*, oversampling meant that within certain strata a full census of minority members was included.

The evaluation team categorized MCP changers into five categories, reflecting the MCP

reorganization and existence of delegated plans where the evaluation team does not yet have enrollment data. For purposes of the survey, the evaluation only considered individuals who were in counties with more than one MCP to choose from, whose plan change reflected more than a plan code change, and who were not enrolled in an MCP that had delegated plans. This ensured a sample of MCP changers who would have been able to make a choice and that this choice (change) could be identified by the evaluation team.

Finally, the team restricted the universe of MCP changers to community dwelling individuals with valid contact information. The following were excluded:

- » Individuals without a residence address and without a phone number;
- » Individuals with addresses that corresponded to institutional settings; (assisted living, skilled nursing facilities, other health care settings, or carceral settings); and
- » Individuals who reported being homeless.

Survey Fielding: To maximize the response rate, the survey was fielded using a mixed-mode data collection approach that involved fielding the survey as both an online and mail survey. All sampled beneficiaries received a letter inviting them to participate in the survey. The letter was personalized with the member's first and last name and were printed in English on one side and Spanish on the other. To motivate survey invitees to complete the survey, a one-dollar bill was affixed to the letter. An English version of the survey with a self-addressed, postage-paid envelope that beneficiaries could use to mail back their completed survey was enclosed with the invitation letter. The letter briefly described the purpose of the survey, why it is important that each sampled member participate, and the \$20 dollars that they will receive if they complete the survey.

In the event they had questions or concerns about the survey, or if they preferred to complete the survey by phone, the letter included a toll-free number. In addition, the letter included the survey URL and a unique PIN as well as a QR code for those who preferred to complete the survey online using either a computer, tablet, or smart phone. The survey invitation letter included a prominent note letting survey invitees know the availability of Spanish, Mandarin, and Vietnamese versions, which they could access online by requesting a hard copy in any of these languages, by calling the survey's toll-free number, or by an email to a project-specific email. These languages were selected based on the most common preferred non-English languages reported among Medi-Cal

members.

Approximately two weeks after the first survey mailing, a second survey invitation letter was sent to survey invitees that had not completed the survey. The second survey mailing again included an English version of the survey booklet for all invitees and additionally included a Spanish version of the survey booklet to another randomly selected 25% of the sampled beneficiaries who expressed Spanish language preference or who had a Hispanic surname.

Approximately two weeks after the second survey mailing, we mailed non-respondents a reminder postcard letting them know that there was still time to complete the survey online, by mail, or by phone. We planned to simultaneously launch telephone follow-up to those who had not completed the survey for whom we were able to obtain either a telephone number (landline) or a cellphone number through a tele matching vendor. However, because of higher-than-expected response rates, phone follow-up was shifted to those individuals who began the survey online but did not complete it.

Phone follow-up was conducted in English and Spanish only. Respondents who did not feel they would be able to complete the survey by phone in either English or Spanish were again offered the option of completing the survey via the web or by mail, in which case the team mailed them a copy of the survey in their preferred language (from among the languages offered). To further maximize response rates, the survey allowed proxy respondents.

Survey Content and Development

The short “Duals Survey” of knowledge and satisfaction of the matching plan policy was developed by UCLA-RAND with input from DHCS and external stakeholders. The survey included a short introductory description of the 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, ability and circumstances regarding the process of changing their MCP, satisfaction with MCP, (or Medi- Medi Plan), use of health care services in the past year (for case-mix adjustment), whether the participants had changed their MCP in the prior year, and if their current MCP was aligned or not with their MA plan (to assess participant self-knowledge on their own enrollment).

In addition, the survey included elements to assess self-reported health and health care needs. Specifically, UCLA-RAND included validated and standardized items from the 10-item core Accountable Health Communities (AHC) HRSN Screening Tool.⁴⁷ This tool is

currently being used by CMS to better understand whether identification and addressing the HRSNs of Medicare and Medicaid beneficiaries has any effect on their total health care costs and their health outcomes. The tool can help providers find out patients' needs in these five 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. The team also used the eight 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-RAND included the Short Form Survey (SF12), a widely used 12-item measure of the impact of overall health on an individual's daily life.

Survey Analysis – Descriptive Analyses

In descriptive analyses, the evaluation team present unadjusted, unweighted results. The respondent characteristics were compared across the sampling strata to ensure balanced groups. This included comparing (1) enrollment-data reported characteristics and (2) survey-elicited characteristics (self-reported health, service use) across strata. Duals' responses on MCP and MA enrollment were compared to metrics derived from the Medi-Cal and Medicare monthly enrollment files. For bivariate comparisons, a significance test was performed using logistic regression. Due to the large number of possible comparisons, for the Interim Report, bivariate comparisons were restricted to the primary strata of interest – whether an individual resided in a county with the matching plan policy or in a county without the policy and whether the member responded in English or another language. The team also stratified individuals by whether their MA plan changed, whether their MCP was aligned or not at baseline and at follow-up, and whether they were in an MCP or Original Medicare (the internal control) at baseline.

Survey Analysis – Multiple Variable Regression

Finally, to estimate the impact of the policy on MCP changers' knowledge and satisfaction with the process of changing their plans, UCLA-RAND performed multiple variable regression with the primary predictor being matching plan policy in county of residence, with the following covariates: plan aligned (baseline); Medi-Medi Plan enrollment; duals' characteristics derived from enrollment data (age, gender, race/ethnicity, English/Non-English, county, quartile social needs metric); and duals' self-reported characteristics (health status, level of education, recent health care

utilization).

E. Methodological Limitations

This evaluation is subject to a number of limitations. The assessment was retrospective in nature, limiting interpretation of changes as causal. Alignment of plans was based on available data. This likely undercounts alignment in the circumstances where members were enrolled in delegated plans or where their delegated plan status was not revealed in the monthly enrollment data. This may also lead to overcounts if a delegated plan is not identified, but the primary MCP appears to align with an MA plan. It is planned that more complete enrollment data for members in delegated plans will be available for inclusion in the Summative Evaluation Report. Other data issues identified (such as what appears to be incorrect classification of some members being in traditional Medi-Cal in January and February) have not yet been adjudicated.

The creation of the survey sampling frame required the exclusion of a large number of MCP changers. This may have biased the final sample of individuals who received the survey. The overarching rule for the sampling frame was to identify MCP changers whose MCP change occurred in a situation where there was a choice (more than one) of new MCPs, even if their prior MCP had been canceled and that evaluators could distinguish the new MCP from the old MCP. This meant that the team excluded individuals who changed to an MCP that had previously been a delegated plan, as it could not be assessed whether this was an actual change or simply a coding change. Thus, if the experience of MCP changing was different for these individuals, the survey would not reveal these experiences. The team also could not identify individuals who actively sought information on changing their MCPs (e.g., via contacting DHCS or their MCPs).

For the survey, selection bias was a concern. The evaluation team had limited information on MCP changers prior to the invitation to participate in the survey. Thus, respondents may be different than non-responders in unknown ways. Recall bias was a second major challenge as individuals were surveyed up to a year after their MCP change. A high percentage (56%) of respondents stated that they were unaware that their MCP had changed or that their plans had not changed (Exhibit 3.13), raising concerns regarding the validity of the remaining responses in the survey. However, these limitations were counterbalanced by the large number of responses that may have correctly known that their health insurance changed in some way but could not match

their knowledge with the way the survey questions were posed, including how they think of their insurance plans. The team recognizes that the similarities in names of *Medi-Cal plan* and *Medicare plan* can be challenging to individuals of any age and educational background. Notably, the team relied upon secondary data as the source of information for analyses regarding plan changes. There was a single survey item that included both the terms *Medi-Cal plan* and *Medicare plan* within a single survey question that was included in the survey to assess respondent understanding of terms frequently used in oral and written conversation with dually insured individuals. The remainder of survey items focused on respondent experiences of changing their plan and respondent descriptions of their health status and determinants of health.

F. Results

Goal 1: Determine the epidemiology of plan changes among Dually Eligible Beneficiaries eligible for MA plans and relate them to requested MCP change requests duals enrollment in managed care, January 2021 to May 2024.

The characteristics of the Medi-Cal duals members across the different cohorts are shown in [Exhibit 3.4](#). Members from the seventeen counties in the 2023 and 2024 counties differ primarily in the greater representation of Blacks in the 2023 counties and Asian-Pacific Islanders in the 2024 counties. This is also reflected in the difference in languages spoken – where Vietnamese is seen (14%) in members from the 2024 counties. In contrast, members from the 2026 counties have a greater proportion of non-Hispanic whites and fewer Asian-Pacific Islanders than members from the other counties. Spoken language reflects this as well with 74% of members reporting English as their preference among members from the 2026 counties.

Exhibit 3.4: Descriptive Summary Table for Target Population Studied

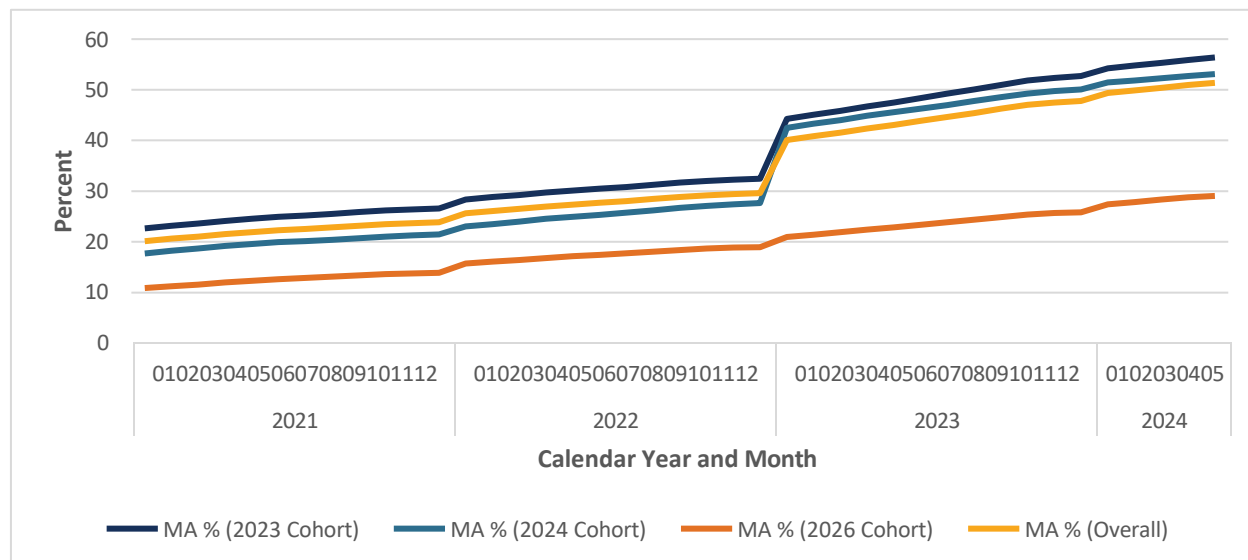
	2023 Counties		2024 Counties		2026 Counties		All Counties	
	N	%	N	%	N	%	N	%
Overall	1,517,428		227,332		366,283		2,111,043	
Age (Years)								
< 65	290,252	19	36,680	16	94,522	26	421,454	20
65 to 84	967,152	64	146,916	65	221,086	60	1,335,154	63
85+	260,024	17	43,736	19	50,675	14	354,435	17
Race/Ethnicity								
non-Hispanic White	344,713	23	48,684	21	158,597	43	551,994	26
Black	138,557	9	4,406	2	13,675	4	156,638	7
Hispanic	543,471	36	71,863	32	112,082	31	727,416	34
Asian-Pacific Islander	295,613	19	68,587	30	26,163	7	390,363	18
Native American	3,766	0	539	0	3,628	1	7,933	0
Other	45,942	3	9,295	4	9,146	2	64,383	3
Unknown	145,366	10	23,958	11	42,992	12	212,316	10

	2023 Counties		2024 Counties		2026 Counties		All Counties	
	N	%	N	%	N	%	N	%
Sex								
Female	846,564	56	127,659	56	200,464	55	1,174,687	56
Male	670,864	44	99,673	44	165,819	45	936,356	44
Language								
English	841,380	55	117,805	52	269,299	74	1,228,484	58
Spanish	382,856	25	50,275	22	78,493	21	511,624	24
Chinese	94,505	6	5,586	2	1,423	0	101,514	5
Tagalog	16,839	1	2,457	1	2,564	1	21,860	1
Vietnamese	42,925	3	32,821	14	1,585	0	77,331	4
Other or Unknown	138,923	9	18,388	8	12,919	4	170,230	8

In order to contextualize the timing and potential impact of the matching plan policy, it is important to understand the current trends of MA plan enrollment that make the matching plan policy relevant. Across California, overall monthly enrollment of fully eligible (Medicare A & B) duals (referred to simply as duals) was 1,400,518 in January 2021, peaked at 1,593,721 in June 2023, and was 1,559,300 in May 2024. When broken out by *matching plan policy* counties (by year of policy adoption), 72% of duals were in the first (2023) 12 policy counties, 11% were in the second (2024) five policy counties, and the remaining 17% were in the 41 counties that did not yet have the *matching plan policy*. These proportions were essentially unchanged between 2021 and 2024. Because the vast majority of MCP members reside in the first counties to have the policy, overall results tend to track with these counties. Breakouts by county cohorts highlight important distinctions in managed care enrollment and plan changes.

Among duals, MA enrollment was 20% in January 2021 and steadily increased to 51% in May 2024. ([Exhibit 3.5](#)). When broken out by county cohort, among the first 12 counties with the policy, MA enrollment was 23% of duals in January 2021 and 56% by May 2024. In the five counties with the policy implemented in 2024, MA enrollment was 18% in 2021 and increased to 53% of duals in these counties by 2024. For these 17 counties that have the policy, MA enrollment increased steadily, punctuated by a substantial increase in January 2023. For the remaining counties, MA enrollment steadily increased from 11% of duals in January 2021 to 29% of duals in May 2024. To address the evaluation question, it was necessary to understand the adoption of D-SNPs, which require joint enrollment in Medicare and Medicaid, which differs from alignment of a member's Medicare and Medicaid MCPs. First, one must separate the regular MA plans from the D-SNPs. D-SNP enrollment has evolved over time. An examination of duals' D-SNP enrollment during the current waiver period shows that duals were enrolled for at least one month in 722 D-SNP plans. The 80 California-based D-SNP plans accounted for 99% of D-SNP enrollment, while the remaining 1% of D-SNP enrolled California duals were enrolled in 642 non-California-based-D-SNP plans. Enrollment broken down by managed care contract is detailed in [Appendix H](#) Exhibits 6, 7, and 8 with the details regarding California D-SNP availability and enrollment in [Appendix H](#) Exhibits 10A, 10B, and 10C.

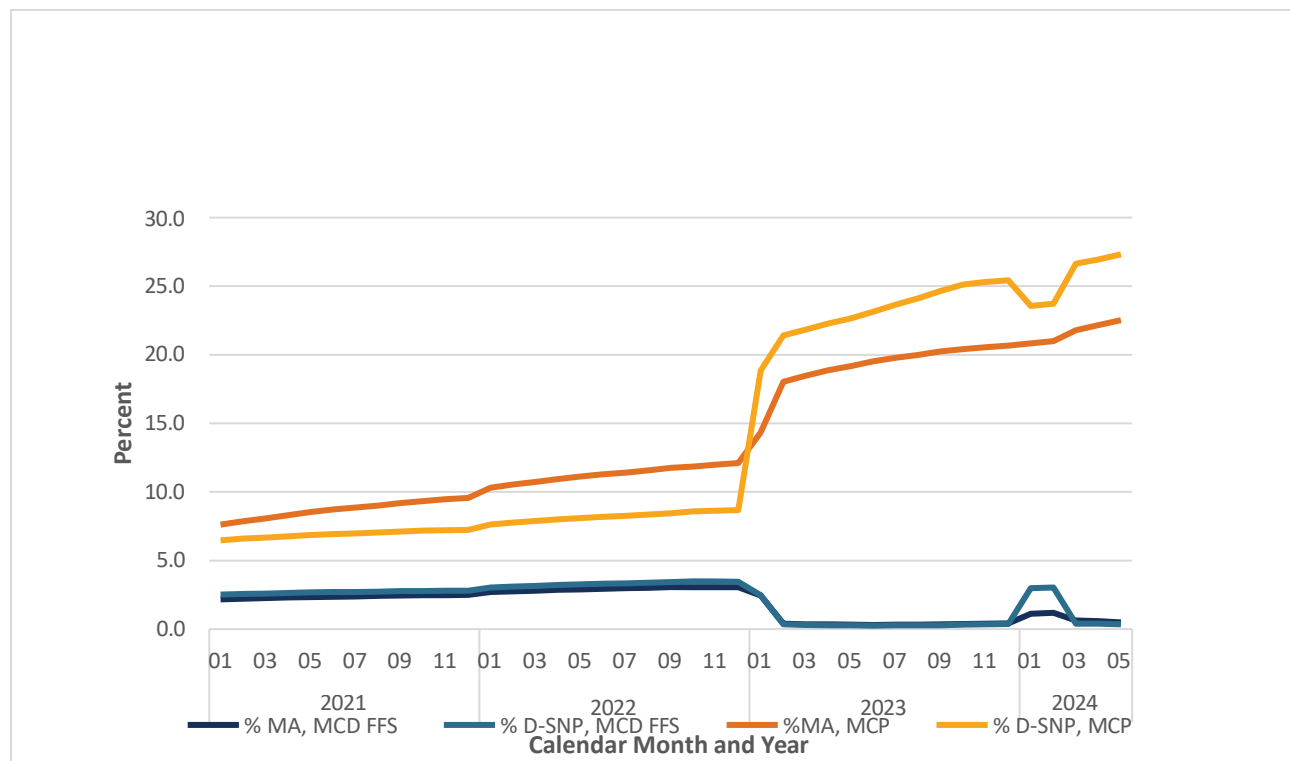
Exhibit 3.5: Percent MA Enrollment Among Duals by County Matching Plan Policy Cohort and Overall



MA – Medicare Advantage; MA1 => MA2 – MA change from one month to the next; FFS – Fee-for-service (traditional), Breakout by MCP enrollment and alignment not shown.

D-SNP enrollment has increased substantially since January 2021 ([Exhibit 3.6](#)). Overall, in January 2021, D-SNP enrollment was 9%. By May 2024, aligned D-SNP enrollment was 28% with 0.3% showing D-SNP enrollment and enrollment in FFS Medi-Cal. Changes in D-SNP in MCP and D-SNP Medi-Cal FFS mirror each other between December 2023 and March 2024. The overall pattern was associated with enrollment in the counties starting with the matching plan policy in 2023 (see Appendix Figures). In the 12 counties where the policy was first introduced, D-SNP rates increased from 10% to 31%. In the second group of five counties, these increased from 5% to 25% of MA enrollees. Among members in counties that do not yet have the policy, the D-SNP rate increased from 6% to 16% of MA enrollees. Furthermore, in January and February 2024, it appears that there was an anomalous increase in Medi-Cal FFS reported enrollment, which appears to reflect non-attribution to managed care. These data have not yet been revised to reflect managed care enrollment.

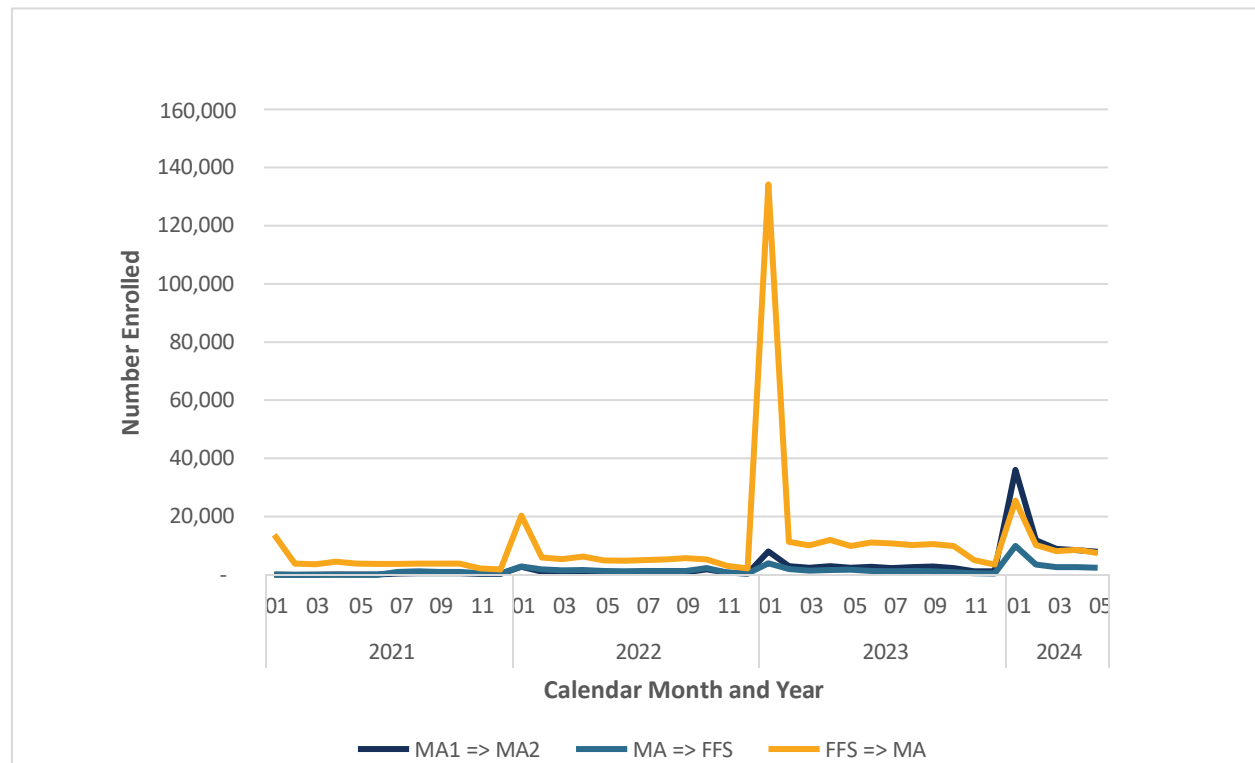
Exhibit 3.6. Percent Managed Care Adoption Over Time (Overall) for Duals by Medicare and Medi-Cal Participation



MA – Medicare Advantage; Medi-Cal FFS – Traditional (Fee-for-service) Medi-Cal; MCP – Medi-Cal managed care plan; D-SNP – Duals special needs plan; Not shown – Duals enrolled in FFS

Changes in enrollment over time demonstrated that the vast majority of newly enrolled duals in MA plans are among those moving from Original (fee-for-service) Medicare to an MA plan ([Exhibit 3.7](#), FFS=> MA). A much smaller number of individuals entered MA plans from other MA plans (MA1=>MA2). Finally, the number of individuals leaving an MA plan for Original Medicare (MA1=>FFS) is much lower than these two other groups. Of note, most changes occurred around Medicare open enrollment. The large spikes corresponded to the availability of new MA products (such as Medi-Medi Plans) and other aligned products that members formerly in Medicare FFS chose. Not shown in the exhibit are the majority of members who do not change their MA plans or who remain in Original Medicare.

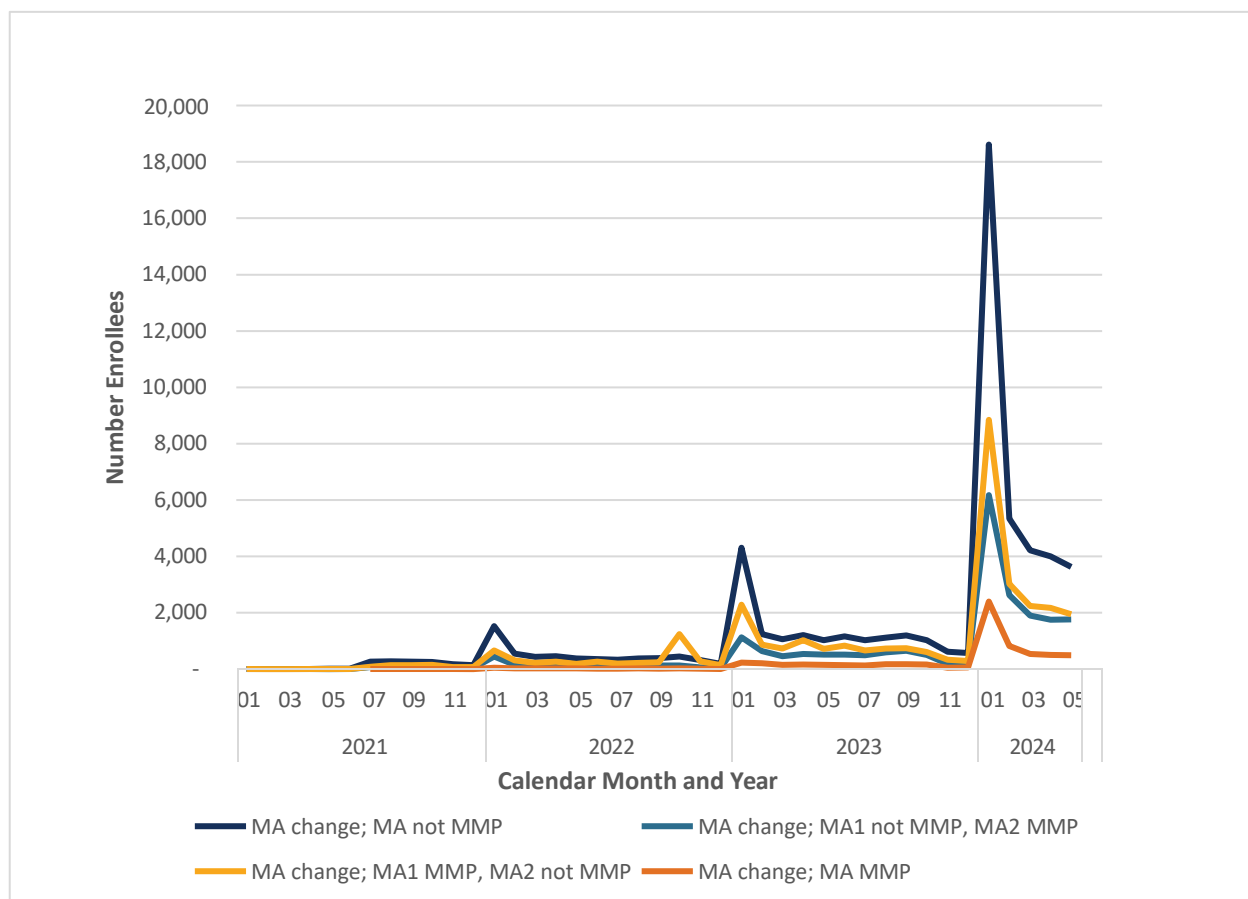
Exhibit 3.7: Duals Managed Care and Original Medicare Enrollment Transitions, Overall



Note: Graph tracks Duals' Medicare Advantage (MA) enrollment changes. MA1 & MA2 – MA Plans across two consecutive months; MMP – MCP Matching Plan – an MA plan that has a matching MCP

Member enrollment in MA plans that are MCP matching plans (MMPs) drive the alignment policy, e.g. MCP enrollment follows enrollment in an MMP. When a member chooses an MA plan that is an MMP, their MCP must match that MA plan. If a member chooses an MA plan that is not an MMP, they may choose any MCP offered in their area. As shown, in ([Exhibit 3.8](#)), we track among Medi-Cal members the type of MA plan (e.g. MMP) that members choose when they switch MA plans. The possibilities include MA change where (1) both the old and new MA plans chosen are MMP, (2) the old MA plan was an MMP, but the new MA plan is not an MMP, (3) the old MA plan was not an MMP, but the new MA plan is an MMP, and (4) neither the old or new MA plan is an MMP. In the figure, the two highest curves are associated with members moving from a non-MMP to a non-MMP and members moving from an MMP to a non-MMP. These changes are independent of members changing their MCP enrollment.

Exhibit 3.8: Magnitude of MA (Matching Plan or not) Enrollment Change, Matching Plan Policy Overall



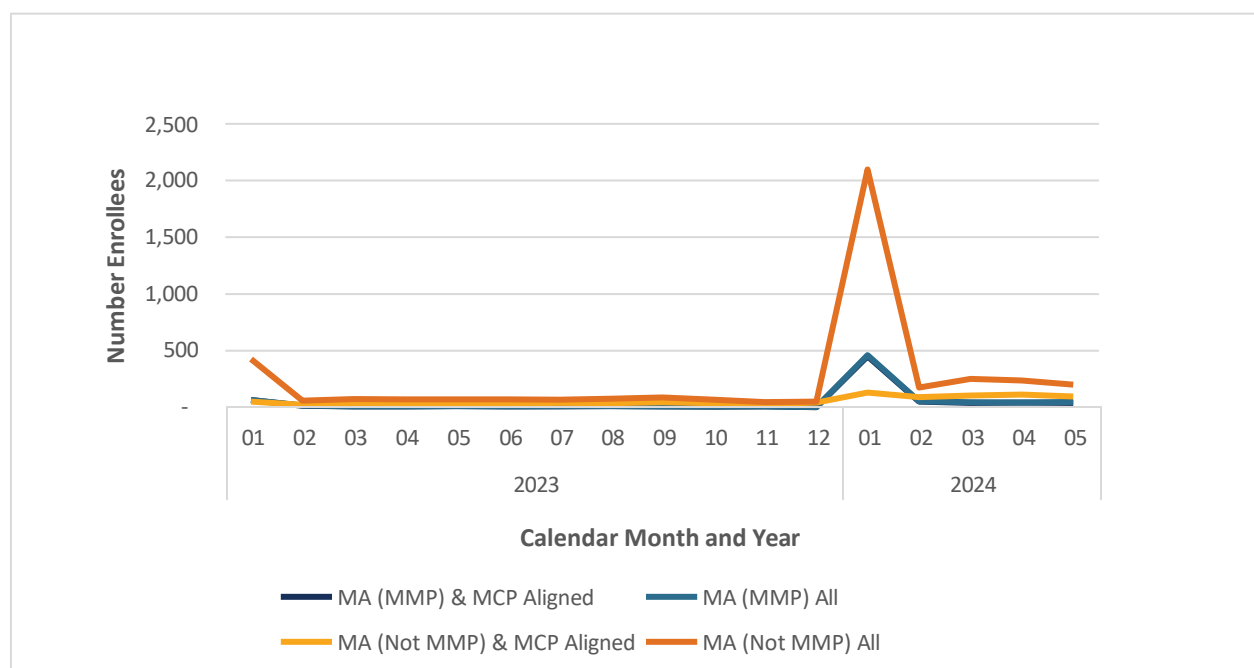
MCP – Medi-Cal Managed Care Plan; MA – Medicare Advantage; MMP – Medi-Cal Matching Plan - (member should have MCP matched to this MA plan); Aligned – MCP and MA are from the same managed care organization. For example, “MA change; MA not MMP” is the number of MCP members where a member changes their MA plan and neither their first or second MA plan is an MMP.

Evaluation Question 1A: How many Duals enrolled in an MA plan in the 12 counties with a matching plan policy in 2023 had the policy applied to them?

Breaking out individuals who change their MA plans and their MCPs, the number of individuals affected is small – these early analyses identify only 421 cases in 2023 in the

12 original counties and an additional 531 cases in 2024 ([Exhibit 3.9](#)). Alignment between the MA and MCP plans are 92% and 95% for these changers in 2023 and 2024. In contrast, 1,162 (across 2023) and 2,958 (across 2024) individuals changed into MA plans that are not explicitly affected by the policy, but for whom an MCP change also occurred. Alignment for this group is 36% and 18% respectively. The group of MAs that are not part of the Medi-Cal matching plans are primarily a combination of (1) enrollment in MCPs with delegated plans (i.e., alignment between the MA plan and the delegated plan) and (2) plans that require dual enrollment but are not subject to the policy.

Exhibit 3.9: Number of Duals with Change in MA and MCP, 2023 Matching Plan Policy Counties



MCP – Medi-Cal Managed Care Plan; MA – Medicare Advantage; MMP – Medi-Cal Matching Plan (member should have MCP matched to this MA plan); Aligned – MCP and MA are from the same managed care organization.

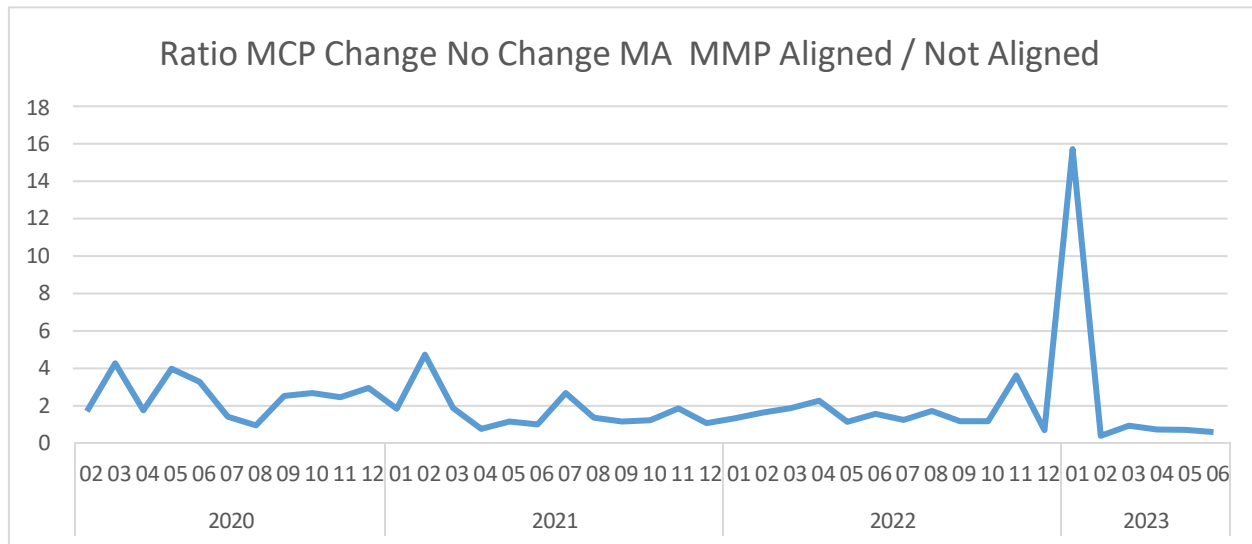
H1: Less than 0.1% of Duals in mandatory aligned plans in matching plan counties will change their MCP without changing their MA within 12 months.

At the time of this writing, a full analysis of 12-month patterns of changes has not been completed. Nevertheless, monthly changes across the 12-month period are roughly analogous since most individuals do not appear to change their plans. Compared to the total of individuals in mandatory aligned plans, few individuals change their MCPs without also changing their MA plans. Relative to the total number of individuals in mandatorily aligned plans, this is less than 0.1% on a monthly basis, except in January 2024, where the monthly basis was 2.4% (See Appendix Tables). Based on these data, the hypothesis is likely true.

H2: Duals in aligned plans during the target period are less likely to change their MCP (without changing their MA) than those in unaligned plans during the target period.

As defined, the team compared the ratio of those who change their MCP and do not change their MA versus those who change their MCP and do not change their MA between individuals whose MA and MCP are aligned versus those whose MA and MCP are not aligned ([Exhibit 3.10](#)). A ratio of less than one means that MCP change for aligned plans is lower in that period than changes in plans for unaligned plans. The team also examined changes among those in plans that would not be subject to a matching policy whether aligned or not. Based on these data, the hypothesis is rejected.

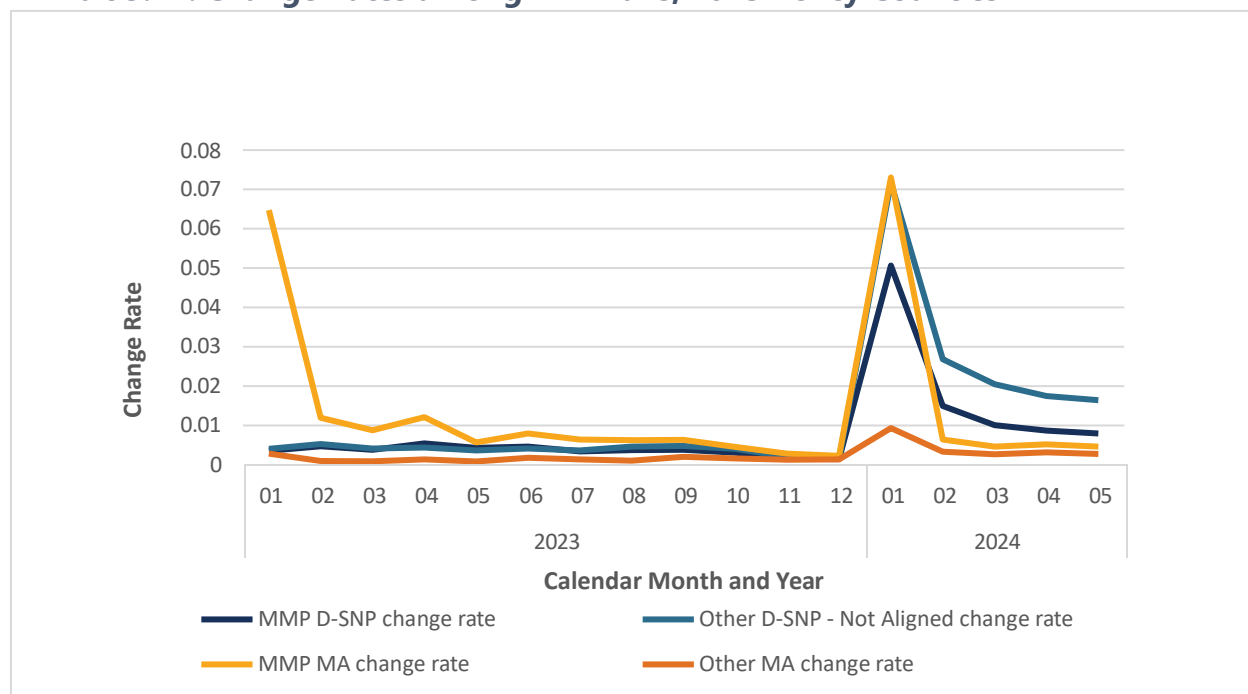
Exhibit 3.10: Ratio of MCP Change to No Change in MA that is an MMP - Aligned versus Not Aligned in 2023 Policy Counties



H3: Duals who 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.

Based on current results, the hypothesis appears partially true ([Exhibits 3.9](#) and [3.11](#)). The hypothesis appears supported for D-SNPs but less clear for other MA plans. Members in delegated plans are difficult to identify and thus their behavior may affect these results.

Exhibit 3.11: Change Rates among MA Plans, 2023 Policy Counties



MCP – Medi-Cal Managed Care Plan; DSNP – Duals Special Needs (MA) Plan; MA – Medicare Advantage Plan; MMP – Medi-Cal Matching Plan (member should have MCP matched to this MA plan); Aligned – MCP and MA are from the same managed care organization.

H4: Duals in Medi-Medi Plans will be less likely to change plans than those in other aligned plans that are not Medi-Medi plans and less likely than those in unaligned D-SNPs.

Among the 12 counties where mandatory matching occurred in 2023, hypothesis four appears not to be true on a month-to-month basis ([Exhibit 3.11](#)). Testing for year-over-year has not yet been completed. Of note, examining the ratio of rates of change do not reveal dramatic differences between MMP D-SNPs and other, unaligned D-SNPs.

Evaluation Question 1B: Of Duals that had the policy applied to them, how many changed their MCP to a non-matching plan within 12 months of enrollment?

There has been insufficient time to address EQ1B for the Interim Evaluation Report. As currently defined, however, the number of individuals affected by the policy over a full twelve month period must be small given the already small numbers identified in EQ1A.

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.

As described above, the evaluation team identified all individuals with at least one MCP change in the last six months of the available data. Individuals considered for invitation to the survey had to be in a county where there was more than one MCP and where the MCP change observed did not occur due to cancellation of the MCP that they had been enrolled in, thus reflecting a group of members who potentially made a more deliberative decision. Finally, individuals enrolled in primary plans that had delegated plans were excluded due to the inability to fully distinguish MCP changes versus reassignment to a delegated plan that had become a primary plan. A total of 35,728 members with verifiable MCP change were identified – 32,881 in matching plan policy counties and 2,847 in non-matching plan policy counties ([Exhibit 3.12](#)). After sampling, the final invited members consisted of a total of 4,319 individuals – 2,945 in matching plan policy counties and 1,374 in non-matching plan policy counties. A total of 926 members responded with 877 surveys completed – 620 from matching plan policy counties and 257 from non-matching plan policy counties. Overall completion response was 20.0% and 21% in matching plan policy counties and 19% in non-matching plan policy counties. These exceeded our anticipated 10% response rate, primarily via web-based surveys.

Exhibit 3.12. Dual Survey Response Rates among Members Who Changed their MCPs between December 2023 and May 2024

	Matching Plan Policy County		
	All	Yes	No
N (column %)	35,728	32,881	2,847
California Duals Identified from Enrollment File	4,319	2,945	1,374
California Duals Invited to Participate to Survey	926	657	269
California Duals Completing the Survey	877	620	257
Survey Completion Rate	20%	21%	19%

Note: There were a total of 1,677,565 unique individuals enrolled with at least one month of Dual enrollment with 1,390,573 in Yes – resident of an matching plan policy county and 286,992 in No, not a resident of an matching plan policy county.

Because of the much smaller sample and the greater rate of Original Medicare enrollees in the non-matching plan policy counties, it was not possible to exactly match the characteristics of survey invitees from the two sets of counties. In general, MCP changers from matching plan policy counties tend to be older; self-identify as black, Hispanic, or Asian-Pacific Islander; and non-English speakers. The invited survey sample and respondents oversampled minorities and non-English speakers.

Evaluation Question 2: Are Duals satisfied with the information and process for mandatory Medi-Cal aligned?

A single question^u was asked regarding knowledge of their MCP and MA plan assignment and plan changes ([Exhibit 3.13](#)). When comparing knowledge of plan changes, many survey respondents did not know that their plans had changed.

^u According to our records, your Medi-Cal plan changed in the last 12 months. You may have also changed your Medicare plan. Which of your health plans changed?

Approximately, 40% of respondents indicate they “do not know,” “are not sure,” or marked “missing” responses. Dual survey responses suggest respondents may not be familiar with the names of their health plans or those that changed, with little difference between the two groups. When asked about the circumstances of their MCP change, 58% indicated that they did not know the circumstances of the change or did not know that it had changed, without a difference between the two groups.

Exhibit 3.13: Knowledge of Changes to Health Plan

	Matching Plan Policy County					
	All		Yes		No	
	N	%	N	%	N	%
Total	877		620		257	
My Medi-Cal plan only	130	14.8	76	12.3	54	21.0*
My Medicare plan only	66	7.5	58	9.4	8	3.1
Both my Medi-Cal and Medicare plans changed recently	182	20.8	139	22.4*	43	16.7
Neither my Medi-Cal, nor my Medicare plans changed recently	147	16.8	105	16.9	42	16.3
I don’t know or I’m not sure	339	38.7	230	37.1	109	42.4
Missing (NA)	13	1.5	12	1.9	1	0.4

In contrast, survey responses describing other behaviors, decision making, information seeking, and satisfaction include more specific responses ([Exhibit 3.14](#)). For example, respondents used multiple sources to look for information about changing their health plans, but there was little difference by policy and non-policy counties. More than half did not look for information about changing their health plans.

Exhibit 3.14: Information Sources for Changing Managed Care Plans

Where did you look for information about changing your health plan? (marked all that applied)	All Counties		Yes Aligned Counties		Not Aligned Counties	
	N	%	N	%	N	%
Online Websites	116	13	87	14	29	11
My insurance or health plan documents	91	10	65	11	26	10
My friends, family, or workplace colleagues	85	10	70	11	15	6
A doctor or other healthcare providers	59	7	49	8	10	4
A case manager or care coordinator	59	7	45	7	14	5
A state or county government agency that provides my health insurance	68	8	47	8	21	8
A health insurance broker	82	9	67	11	15	6
Other	66	8	47	8	19	7
I did not look for plan information about changing my Medi-Cal health plan	456	52	307	50	149	58

When asked about the difficulty of finding information on changing plans, there was a fairly even distribution in responses with 39% stating that they did not know or refused to answer ([Exhibit 3.15](#)). There was little difference between survey respondents from policy and non-policy counties although, on balance, survey respondents from policy counties felt that it was slightly easier to get information than respondents from non-policy counties.

Three questions were fielded to assess how MCP members felt about the receipt of information from others regarding changing their plans. These included: did anyone recommend changing their plan; who helped change their plan; and who was most helpful in providing information about selecting available MCPs? Overall, 63% of individuals answered that no one recommended changing their plan; 53% said

answered that no one helped change their plan; and 43% answered that no one, or they did not know, if anyone was most helpful.

Exhibit 3.15: Overall, how difficult or easy was finding information about changing your Medi-Cal

Response	All Counties		Yes Aligned Counties		Not Aligned Counties	
	N	%	N	%	N	%
	877		620		257	
Very difficult	74	10	57	9	27	11
Somewhat difficult	127	15	86	14	41	16
Neither difficult nor easy	137	16	110	18	27	11
Somewhat easy	98	11	71	12	27	11
Very easy	91	10	68	11	23	9
Don't know, not sure	290	33	196	32	94	37
Missing / refused	50	6	32	5	18	7

H1: Duals who request to change their MCP and who change their plans will be satisfied with the process of doing so during the target period.

The evaluation team asked six questions regarding satisfaction with the process of changing their health care plans, covering ease, information availability, and care coordination between MCPs and Medicare ([Exhibit 3.16](#)). Of the six questions asked, only one question (Q15) regarding information received before a final decision on a new MCP differed between respondents in policy and non-policy counties with regard to being very satisfied or somewhat satisfied (50% versus 39%). Based on survey responses, MCP members who changed their MCPs were generally satisfied with the process of changing their plans. *Based on these data, the hypothesis is likely true.*

Exhibit 3.16: Satisfaction with Plan Alignment and Changing Plans

	Before your health plan(s) changed		Before your health plan(s) changed		Looking back on the time before your Medi-Cal Plan Changed		At the time your Medi-Cal plan was changing		Overall		Overall	
How satisfied were you with ...												
	How Medicare and Medi-Cal plans worked together?		How Medicare and Medi-Cal plans worked together to provide you the care you needed?		The information you received before a final decision was made to change to a new Medi-Cal health plan?		The new Medi-Cal Health plan choices offered to you?		The process of changing your Medi-Cal plan?		The choices you had in the Med-Cal health plans available to you?	
	MPPC (%)	Not MPPC (%)	MPPC (%)	Not MPPC (%)	MPPC (%)	Not MPPC (%)	MPPC (%)	Not MPPC (%)	MPPC (%)	Not MPPC(%)	MPPC (%)	Not MPPC (%)
Very or Somewhat Satisfied	62	63	65	66	50	39	50	51	44	40	53	47
Neither	8	9	11	7	12	13	10	9	13	13	10	11
Very or Somewhat Dissatisfied	11	9	9	8	9	12	9	11	12	14	10	13
Don't know; Not sure; Refused; or	19	19	16	19	29	37	31	29	31	34	27	29

	Before your health plan(s) changed		Before your health plan(s) changed		Looking back on the time before your Medi-Cal Plan Changed		At the time your Medi-Cal plan was changing		Overall		Overall	
Missing												

H2: 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 other type of MA plans.

This hypothesis was not yet tested for inclusion in the Interim Evaluation Report. It will be included in the final Summative Evaluation Report.

H3: Duals in counties with the policy will be more knowledgeable and will be more satisfied with the policy.

Referring back to Exhibits [3.13](#) and [3.16](#), there are slight differences between duals in counties with the alignment policy versus those without the alignment policy, which suggests that those in the matching plan policy counties are somewhat more knowledgeable and satisfied with the policy. However, initial unadjusted comparisons did not demonstrate that these differences were statistically significant. Based on these data, the hypothesis is not likely true.

Important Factors Affecting Decision Making and overall Difficulty with Changing MCPs

The drivers for selecting a new plan differed somewhat between respondents in policy and non-policy counties ([Exhibit 3.17](#)). Of note, respondents from policy counties were more likely to respond that they were not able to see a provider that they wanted to see with their prior plan (24% versus 16%). In contrast, respondents from non-policy counties were more likely to state that it was not their decision to change their MCP compared to those in policy counties (47% versus 40%).

Exhibit 3.17: Important Factors in the Decision Change to Your Medi-Cal Plan

	All Counties		Yes Aligned Counties		Not Aligned Counties	
	N	%	N	%	N	%
	877		620		257	
I could not see the doctors or healthcare providers I wanted to see.	190	22	148	24	42	16
I was not treated with respect by the health plan representatives I encountered.	63	7	50	8	13	5
I could not get the medicines, equipment or treatment I needed covered by the plan.	113	13	80	13	33	13
My waiting times were too long.	103	12	80	13	23	9
I was not able to receive the right kind of care for my condition.	100	11	71	12	29	11
My plan required too much paperwork.	50	6	34	6	16	6
Other (please specify)	137	16	98	16	39	15
I was not my decision to change my health plan.	371	42	250	40	121	47

Importantly, when asked to rate the overall difficulty of changing their MCP, 36% of all survey respondents stated that it was very easy or somewhat easy to change their MCPs ([Exhibit 3.18](#)). When separated by county of residence, however, respondents living in policy counties on average felt that it was easier to change their MCP than respondents living in non-policy counties with 39% of those in policy counties responding that it was easy or very easy versus 30% for those in non-policy counties. In addition, respondents from policy counties were less likely to have missing, don't know, or refused responses (11% versus 15%). Based on survey responses, Medi-Cal members in policy counties found it easier to change their MCPs in policy counties than in non-policy counties.

Exhibit 3.18: Overall Difficulty Changing Managed Care Plan

	All Counties		Yes Aligned Counties		Not Aligned Counties	
	N	%	N	%	N	%
	877		620		257	
Very difficult	83	10	56	9	27	11
Somewhat difficult	83	10	57	9	26	10
Neither difficult nor easy	283	32	196	32	87	34
Somewhat easy	175	20	141	23	34	13
Very easy	139	16	96	16	43	17
Missing	81	9	52	8	29	11
Don't know	20	2	14	2	6	2
Refused	13	2	8	1	5	2

G. Conclusions

To date, the matching plan policy for Medi-Cal MCP members dually enrolled in MA plans has been quite effective at aligning Medi-Cal MCP members with their MA plans. Notably, this occurred during a time of rapid growth in MA plan membership among duals in California. In 2021, MA enrollment and alignment with MCPs was much higher among members in the original 12 counties with the matching plan policy. Consistent with the expansion of mandatory MCP enrollment for duals starting in January 2023; since January 2023, MA enrollment and MCP alignment has jumped in the remaining counties. Medi-Medi Plans grew rapidly as well and are significant drivers of alignment in the past two years. Enrollment in 2023 as well as in 2024 surged in the cohort where the policy was implemented.

The alignment policy appeared to have had the desired effect, and the introduction of Medi-Medi Plans incentivized duals to enroll in these plans. Because Medi-Medi Plans followed the Medicare open enrollment period, spikes in MCP changes in January reflect the choice of members to enroll in the Medi-Medi Plans. This is supported by the concurrent change (e.g., MCPs and MA plans changing in the same time period). In contrast, the policy (aligning MCP members) should follow MA enrollment changes – and this is what the results show with a change occurring soon after the MA change. The actual number of individuals impacted by the policy was small – the number of individuals changing MA plans concurrent or followed by a MCP change was small. In contrast, individuals already enrolled in MCPs (and primarily Original Medicare) were primarily enrolling in Medi-Medi Plans or, less often, in aligned MA plans (e.g. MA plans offered by the same parent managed care organization, but which are not Medi-Medi Plans).

From its inception and presentation to members, the alignment policy was presented as the MCP follows the MA plan. A concern was that the policy might limit choice as members might want to move away from a specific plan choice. In reality, it appears the policy is infrequently driving such changes and that individuals are choosing MA plans that align with their MCPs, especially among individuals moving from Original Medicare to MA plans. It thus appears that MCOs are inviting MCP members who are not yet in MA plans into MA plans that are aligned with the MCPs. The process in which this might be occurring has not been explored.

In comparison to individuals in MA plans, duals who remained in Original Medicare had overall lower rates of MCP changes in the policy counties. This is consistent with a lack of incentives to change their MCP. For duals, Medicare serves as the primary payer for most acute care services. Under these circumstances, for individuals remaining in Original Medicare, changes in MCP are uncommon. A more complete analysis estimating the impact of the policy on enrollment will be presented in the Summative Evaluation Report, but it is unlikely to alter the general impression from these descriptive results.

The member survey of MCP changers provided additional context for this process. Descriptive analyses presented in the Interim Report showed that, overall, many individuals were unaware that their MCPs had changed. Where individuals acknowledged changing their plans, there was a distribution of responses regarding difficulty obtaining information to change their MCPs. Individuals from policy counties

were more likely to find information on changing their MCPs more helpful before their change – which may trigger speculation regarding greater expectations and efforts in these counties where the alignment policy and managed care choices are greater and more complicated – but which were not directly addressed in this evaluation.

H. Interpretations, Policy Implications, and Interactions with Other State Initiatives

Initial results of the matching plan policy highlight the expansion of dual enrollment in D-SNPs (e.g., Medi-Medi Plans) across the state and the alignment of MCPs with MA plans. The results of the descriptive analyses in this report suggest that members are choosing MA plans that match their MCPs rather than choosing MA plans and subsequently being required to change their MCPs to match their MA plans. The managed care realignment that occurred in January 2024 likely created additional opportunities for members to make MA changes. The evaluation cannot answer whether individuals found changing their MCP harder and thus settled on aligning their MA plans where possible because MA enrollment was more straightforward. The increased integration of managed care services across Medicare and Medi-Cal should result in more seamless delivery of services and likely create further incentives for members to remain in their Medi-Medi Plans.

Results of the survey suggest that members who changed their MCPs were generally satisfied with the process. However, the survey cannot answer whether non-changers are satisfied or knowledgeable about the process of changing plans or the alignment policy, which may be a separate driver of change in the Medi-Cal program. From a policy perspective, greater transparency on changing plans – including easily identifiable plan availability in a central site – might lead to greater member satisfaction and ability to change plans, if desired.

I. Lessons Learned and Recommendations

I.1 Lessons Learned from the matching plan policy

The *matching plan policy* is a commonsense attempt to simplify the delivery of managed care in the Medicare and Medicaid space. Some elements are unique to California due to the way that managed care has been implemented in the state. For example, it is a county-by-county offering of a limited number of contracted managed care plans.

Historically, this has led to the use of delegated plans as a mechanism for diversifying care to different managed care plans. These plans provide greater diversity but are not directly contracted by Medi-Cal and thus harder to track in terms of plan alignment and service delivery. Finally, the concentration of the state's population in just a few counties is counter-balanced by the extremely large geographic size of the counties in what is the third largest state in the United States. Urban areas were impacted by the policy, while more rural counties were not. In some ways, this may make county implementation of the policy more comparable to statewide implementations in many other states.

Based on this experience, at this point in the evaluation, there are some lessons learned regarding the implementation and recommendations to other states that choose to implement these policies.

1. The *matching plan policy* was developed to ensure alignment of MCPs with MA plan enrollment, but few (less than two thousand overall) individuals (compared to the 130,000 individuals who changed MA plans overall and the additional 150,000+ members who enrolled in MA plans from traditional Medicare) were identified as subject to the policy.
2. Clear guidance to members regarding the policy is important both in terms of plan choices, timing, and ensuring that members are aware of changes in MCP enrollment and why. For example, if a member is reassigned because they are in an MMP and their MCP does not match the MA plan, then their reassignment should be accompanied by that explanation. Survey results suggested that members were often unaware of changes.
3. Assessing enrollment changes were complicated by subcontracted (delegated) plan enrollment not directly reported to DHCS.

I.2 Recommendations for Other States

In light of the current findings, the evaluation team recommends the following for other states considering adopting the alignment policy:

1. Advanced notice of policy implementation – in addition to standard information on the DHCS website regarding Medicare open enrollment, this might include providing members with an email or robocall to remind them to check changes to the DHCS website or to remind them that their Medicare managed care enrollment may impact their Medi-Cal MCP enrollment.

2. Timely announcement of plan availability in affected service areas. For example, if a MCP has aligned MA plans, these MA plans should be easily identifiable. Integrated plans are identifiable but not aligned plans.
3. Active tracking of requests for information to change MCPs and enroll in MA plans by members to better assess members' attempts to engage with the process of changing their plans – whether they ultimately change their enrollment or not.
4. Comprehensive tracking of enrollment of members in all aspects of MCPs, including enrollment in delegated plans because the impact of the policy cannot be fully assessed using enrollment in Primary plans.
5. Consider ways to improve information on MCP and MA plan in a member's county of residence. For example, a drop-down menu of available MCPs in the member's county of residence and then a link to the CMS website with directions on what to look for regarding MA plans. This sharing of information is the biggest challenge because DHCS does not control MA plan availability or how CMS presents this information.

In the future, with greater stability in MCP offerings, tracking the matching plan policy and its impact will be less affected by these external factors. For the final report, the evaluation will assess the impact of the alignment policy over the longer term, attempt to include all geographic areas for assessment, and identify observable factors which influence MCP changes and plan alignment among members.

EVALUATION COMPONENT 4: EVALUATION OF THE JUSTICE-INVOLVED REENTRY INITIATIVE

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A. Executive Summary

Summary of Initiative

The UCLA-RAND Reentry Evaluation is designed to assess California's implementation of the JI Reentry Initiative under the state's 1115 Medicaid Waiver (henceforth referred to as the Waiver), which extends select Medi-Cal benefits to eligible individuals immediately prior to and following release from correctional facilities. The intervention fosters connections between carceral and community health care, expands pre-release and post-release services and aims to improve care continuity, address behavioral and physical health needs, and reduce adverse outcomes for JI populations. The evaluation focuses on implementation barriers and facilitators, quality of care, care transitions, coordination among systems, and impact on health care investments in both carceral and community contexts.

Methods and Limitations

Methods

The evaluation utilizes a mixed methods approach:

Quantitative Analysis: The evaluation employs a cohort difference-in-differences design to compare outcomes for intervention (post-Waiver) and comparison (pre-Waiver) groups using comprehensive data sources, including Medi-Cal eligibility and claims, correctional agency health data, prescription fills, and mortality records.

Qualitative Analysis: Structured and semi-structured interviews began in Fall 2025 with key stakeholders, including county stakeholders involved in the implementation of the JI Initiative. Results from those interviews are presented in this report. Coding software (e.g., Dedoose) will be used to analyze interview data and identify themes related to coordination, care transitions, and barriers and facilitators.

Cost Analysis: Development of methods are underway to evaluate the financial implications and investments made under the Waiver.

Results

Preliminary Insights:

- » The initiative has catalyzed new collaborations and workflows across correctional, Medi-Cal, managed care, and community organizations, requiring significant effort needed to align these disparate systems.
- » During interviews, stakeholders, such as key informants from Probation, Sheriff's Office, Correctional Health, Social Services/Human Services, Health & Human Services, Public Health, Behavioral Health (BH), and contracted in-reach services providers, emphasized the need for enhanced communication, education, and well-defined handoff protocols to ensure seamless care transitions.
- » The JI Screening Portal, intended as a communication and documentation tool, has presented usability challenges, requiring manual data entry and improvements to better support cross-system coordination. DHCS made changes to the user interface (i.e., allowing bulk uploads to reduce administrative burdens for correctional facilities) and additional improvements are forthcoming as DHCS continues to optimize the Portal to enhance the user experience and to address some of the challenges identified by the counties.
- » Early investments are focused on infrastructure, staffing, and service expansion, but counties are still in the early stages of full program implementation and service delivery.
- » Fragmentation and duplication in reentry planning persist; stakeholders highlight the importance of person-centered care plans to prevent conflicting guidance for individuals upon release.

Conclusions

At this time, the UCLA-RAND Reentry evaluation team has not yet received quantitative data; qualitative data collection is still in its early phases, limiting the ability to present comprehensive findings. The team is actively collaborating with DHCS, CDCR, and county facilities to finalize data requests and secure the quantitative and qualitative data. The UCLA-RAND Reentry evaluation team expects to receive the quantitative data in early 2026 and has begun collecting qualitative data. The team will be submitting a Mid-Point Assessment report to CMS in early 2027 that will include a description of the progress of the evaluation, as well as include qualitative and quantitative findings derived from the data collection activities in 2026.

Preliminary insights drawn from PATH interviews, along with ongoing work to refine the cost analysis, evaluation approach, and county selection, inform this report. Although current results are limited and findings are too preliminary to assess demonstration outcomes or effectiveness, the team remains on track to deliver more extensive analyses and recommendations in the Mid-Point Assessment report. The Mid-Point Assessment will include findings from the qualitative interviews with stakeholders from the state and counties, as well as interviews with formerly incarcerated individuals. The mid-point assessment will also provide a description of utilizers between September 2024 and September 2025, using DHCS and CDCR data. This data will allow us to address the evaluation questions in more detail.

B. General Background Information

The CalAIM Reentry Evaluation assesses the degree to which incarcerated individuals preparing for reentry to the community who participate in the JI Reentry Initiative interventions (i.e., the Reentry Waiver Exposed Group) experience different processes and outcomes than those not exposed (i.e., the Reentry Waiver Comparison Group). Evaluation activities include assessments of changes over time between exposed and comparison groups in (1) access to medical and BH services for incarcerated individuals eligible for the state's Medicaid Program (Medi-Cal), (2) use of systems for effectively enrolling eligible detainees into Medi-Cal prior to release, (3) coordination of transitional care between the pre- and post-release setting, (4) coordination of community-based services through ECM, and (5) provision of a 30-day supply of medications and durable medical equipment (DME) at release.

Purpose of the Program

As a group, incarcerated individuals have generally been historically underserved, marginalized, and adversely affected by persistent poverty. With the Waiver, California covers 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 reentry and their transitions (in particular, transitions of health coverage and care) back to the community. The provision of Medi-Cal pre-release and reentry 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 care coverage; prevent unnecessary disruptions in care; reduce ED visits and inpatient hospital admissions; reduce

mental health decompensation, suicide-related death, overdose, overdose-related death, and all-cause death; and lead to improved health outcomes. The objective of this component of the demonstration is to facilitate members' access to certain health care services, including case management services, to facilitate reentry planning and care transitions.

The goals of the JI Reentry Initiative include the following:

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.
2. Improve access to services prior to release and improve transitions and continuity of care into the community upon release.
3. Improve coordination and communication between correctional systems, Medicaid and Children's Health Insurance Program (CHIP) systems, MCPs, and community-based providers.
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, BH, and health related social needs (HRSN).
6. Provide intervention for certain BH conditions and using stabilizing medications like long-acting injectable anti-psychotics and medications for addiction treatment for SUDs, with the goal of reducing decompensation, suicide-related deaths, overdoses, and overdose-related deaths in the near-term post-release.
7. Reduce post-release acute care utilization such as ED visits, inpatient hospitalizations, and all-cause deaths among recently incarcerated Medicaid beneficiaries and individuals otherwise eligible for CHIP if not for their incarceration status. Reduce use of acute care through robust pre-release identification, stabilization, and management of certain serious physical and BH conditions that may respond to ambulatory care and treatment (e.g., diabetes, heart failure, hypertension, schizophrenia, or SUDs). In addition, increase receipt of preventive and routine physical and BH care.

History of the Program

Recognizing the multitude of factors influencing health outcomes, health agencies and systems have increasingly focused on whole-person care, a comprehensive approach that considers health and well-being across various domains (e.g., physical, mental, social). This approach is particularly relevant for JI individuals who have been historically underserved and marginalized.⁴⁸⁻⁵² JI individuals have higher rates of chronic conditions and infectious diseases, as well as a high prevalence of mental and BH concerns and are disproportionately lower income than the general U.S. population.

The federal “inmate exclusion” policy has long prohibited Medicaid’s coverage of health care services provided in carceral settings. Accordingly, coverage of health care services in carceral settings has been historically limited, and many JI individuals did not previously receive the care they required. For instance, a study of proposals to provide contracted health care services in jails across some states by the PEW Charitable Trusts found that many jails did not have medical or nursing staff 24 hours a day to address high-acuity health care needs upon booking.⁵³ JI individuals also experience limited care continuity upon reentry given potential changes in their Medicaid enrollment prior to, during, and after incarceration.

The Affordable Care Act (ACA) provisions provided a pathway for improved health care coverage and access among many population segments, including JI individuals, as well as better care coordination between incarceration and reentry.^{54,55} Yet, the 2020 PHE demonstrated that disproportionate differences persisted for JI individuals, particularly those incarcerated at that time.⁵⁶

California has pioneered initiatives to improve health care services for JI individuals over the past decade. Through a Section 1115 Medicaid Waiver (“Medi-Cal 2020”) from January 2016 to December 2021, California implemented the Whole Person Care (WPC) program for “high-risk, high-utilizing enrollees who have a complex profile and are high need.”⁵⁷ This program focused on the coordination of physical health, BH, and social services, where pilots across the state were required to target at least one of six key populations including “individuals recently released from institutions, including jail or prison (JI).” Lessons learned from this program directly informed the inclusion of ECM and Community Supports benefits within the CalAIM initiative, which launched in January 2022. ECM and Community Supports extend services beyond traditional health care services to address other needs and improve comprehensive care management and

coordination. Community Supports, for instance, can include housing supports, a WPC program benefit utilized most by JI enrollees in the program.^{58,31}

Through CalAIM, JI populations in WPC pilot counties received continuity of ECM supports.⁵⁹ PATH program's JI Capacity Building program funding, which also launched in 2022, was intended to "provide funding to support collaborative planning, as well as [IT] system modifications necessary to implement pre-release Medi-Cal application and suspension processes" for JI individuals."²¹ Through the first two rounds of funding over 2022 and 2023, PATH enabled the design and implementation of pre-release Medi-Cal enrollment and suspension processes for youth and adults, thus extending the WPC program aims for JI individuals.

As described earlier, in 2023, California became the first state to be approved for offering specific Medi-Cal services to youth and select adults in carceral settings for up to 90 days prior to release, referred to as the JI Reentry Initiative. Additional rounds of PATH funding are intended to support these efforts, which will be implemented statewide by October 2026.

In addition to California, numerous other states have pursued Section 1115 Medicaid Waivers to improve the health of JI individuals. In total, 27 states have submitted a related waiver: 19 are approved and eight are pending (Washington D.C. is also pending). The approved states are Arizona, California, Colorado, Hawaii, Illinois, Kentucky, Maryland, Massachusetts, Michigan, Montana, New Hampshire, New Mexico, North Carolina, Oregon, Pennsylvania, Utah, Vermont, Washington, and West Virginia. The Kaiser Family Foundation's analysis of Medicaid.gov Waiver documentation (as of July 1, 2025) demonstrates similarities and differences across states with approved waivers for JI individuals prior to reentry:⁶⁰

- » Five state waivers do not cover youth correctional facilities and/or have age cutoffs (18 or 19 years of age).
- » Six states include Tribal correctional facilities in their covered populations.
- » States most frequently intend to provide services 90 days prior to release (16 of 19), but three respectively use 30-, 45-, and 60-day cutoffs.
- » California offers the most comprehensive eligibility criteria, referenced above.
 - Pennsylvania has the next most comprehensive eligibility criteria: "One or more high-risk criteria: SUD/serious mental illnesses (SMI), one or more

chronic conditions, pregnant or postpartum, autism spectrum disorder, HCBS Waiver eligible.”

- The other four states with eligibility criteria focus largely on individuals with SUDs and/or SMIs.
- » All states provide case management and medication-assisted treatment (MAT), and all but one provides MAT-related counseling.
- » All states provide at least 30 days of medication upon release.
- » States vary greatly in other health care services currently offered or planned (e.g., office visits, and DME provision).

Description of the Program

The eligible Reentry Waiver populations in California include all 31 state prison facilities, approximately 120 county jails, and over 100 youth correctional facilities. The state prison facilities are operated by the CDCR as a single department. Each of California’s 58 counties operates its own jails and juvenile correctional facilities. Generally, jails are operated by County Sheriff Departments and juvenile facilities by County Probation Departments. In some cases, correctional health care services may be managed by the county public health or health department, which would be the lead entity for obtaining relevant pre-release health care information for the evaluation.

Population of Focus

Under California’s JI Reentry Initiative, people in state prisons, county jails, and county youth correctional facilities can receive a targeted package of Medi-Cal “pre-release” services during the 90 days before release if they meet eligibility criteria. Eligibility criteria include all youth and adults if they meet at least one health-need criterion (listed below). As part of the JI Reentry Initiative prisons and jails will screen adults for these health need criteria, and services will be offered to releasees if they meet the required criteria.

Utilization of the services is voluntary. Qualifying conditions for individuals participating in the Reentry Waiver include adults who are incarcerated and who meet one or more of the following criteria listed in Special Terms and Conditions (STCs) 9.251:

- » Mental illness, defined as confirmed or suspected mental health diagnosis based on specified criteria
- » SUD, defined as confirmed or suspected diagnoses based on specified criteria

- » Chronic condition or significant non-chronic clinical condition, defined as confirmed or suspected diagnoses based on specified criteria
- » Intellectual or developmental disability (I/DD), defined as a disability that begins before an individual has turned 18 years of age and that is expected to continue indefinitely and present a substantial disability
- » Traumatic brain injury or other condition that has caused significant cognitive, behavioral and/or functional impairment
- » Positive test or diagnosis of human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS)
- » Currently pregnant or within a 12-month postpartum period
- » All youth under the age of 19 years who are eligible for Medi-Cal or CHIP including children in foster care and former foster care youth and are in the custody of a county youth correctional facility are eligible for pre-release services.

Program Components

While California received federal authority to implement the CalAIM 1115 demonstration on December 29, 2021, approval was granted on January 26, 2023, by CMS to provide coverage for services (including reentry care management, physical/BH clinical consultation (in-person or telehealth), laboratory and radiology, medications and medication administration, MAT for SUD, and a minimum 30-day supply of outpatient prescription/over-the-counter (OTC) meds at release) to a subset of incarcerated individuals for up to 90 days immediately prior to their expected date of release from the carceral setting. To provide these services Medi-Cal reimburses JI pre-release services provided during custody by eligible providers (including correctional health staff (if enrolled/contracted), facility-contracted providers, or community “in-reach” providers who deliver services on site).

Similar to other CalAIM components, the CalAIM JI Reentry Initiative has established a framework to address basic needs of individuals during high-risk periods of life by using Medi-Cal to implement a target set of pre-release services including health care, BH, and reentry services. CalAIM’s three primary stated goals are to “(1) Identify and manage comprehensive needs through WPC approaches and social drivers of health; (2) Make Medi-Cal a more consistent and seamless system for enrollees to navigate by reducing complexity and increasing flexibility; and (3) Improve quality outcomes, reduce health

disparities, and transform the delivery system through value-based initiatives, modernization, and payment reform.”

Consistent with these goals, the STCs 9.1. for the JI Reentry Initiative focused on five goals: (1) increasing coverage and ensuring continuity of coverage for individuals who are incarcerated, (2) covering and ensuring access to the minimum set of pre-release services for incarcerated individuals to improve care transitions upon return to the community, (3) promoting continuity of care, (4) connecting to services available post-release to meet the need of the reentering population, and (5) ensuring cross-system collaboration.

To deliver on these goals, correctional facilities are expected to complete a range of activities to better connect releasees to the health care system during and post-release. Prior to release, facilities begin the pre-release Medi-Cal workflow by initiating the application process before the expected release date and activating the limited pre-release benefit at 90 days pre-release, while ensuring any previously suspended Medi-Cal is unsuspended at release so coverage continues without a gap. Facilities then screen for DHCS-defined health needs and assign a pre-release care manager (embedded or in-reach) who coordinates services inside the facility and plans the handoff to post-release ECM. During the 90-day window prior to an individual’s release from the carceral facility, the program delivers a defined, billable set of pre-release services in the carceral setting and reimbursed via Medi-Cal Fee-For-Service under the 1115 Reentry authority. As release approaches, MCP auto-assignment will occur at the time of pre-release service activation and will be based on the county of residence to which the individual will return, as listed in the Medi-Cal Eligibility Data System (MEDS). After their release, members will be provided a choice period and an opportunity to change plans, consistent with DHCS managed care enrollment policy. Depending on the care management model selected by the correctional facilities, either the facility or the post-release ECM provider, schedules post-release primary care and BH/SUD appointments, arrange transportation, and transmit release packets and authorizations to MCP/ECM providers. Individuals receive at least a 30-day supply of maintenance medications on the day of release and a care manager ensures a warm handoff to community ECM, which then continues services for a minimum period unless reassessed, supporting continuity of medical, BH, and social care. Through the JI Reentry Initiative, California is mandating the state prison system and the 58 California counties to bridge the gap between correctional and community health care during a window of time when incarcerated individuals experience an enhanced risk for physical and BH concerns and complications, including higher rates of morbidity and

mortality. Key features of CalAIM's JI Reentry Initiative include efforts to improve access to needed health care services during the 90 days prior to release when incarcerated individuals prepare to leave the carceral setting and reenter the community setting. The period around release has been identified as a high-risk window associated with serious morbidity and mortality including higher risk of suicide and opioid overdose and higher rates of preventable adverse outcomes than among the general population.

Program Implementation Status

CDCR went live on February 8, 2025. [Exhibit 4.1](#) provides information about the county-level rollout (from the publicly posted tracker as of August 4, 2025). Ten counties went live with the initiative by July 2025 and three additional counties went live in October/November 2025. By statute, county correctional facilities have until October 2026 to go live. DHCS held a learning collaborative series in 2024 that was well attended and provided a deep dive into the waiver requirements. The Medi-Cal Learning Portal includes a course catalog focused specifically on Medi-Cal billing, the portal, and other key information. In addition, Public Consulting Group has conducted numerous trainings and office hours for the PATH JI program.

Many counties are still in the process of developing their readiness assessments. Implementation delays are not currently affecting the evaluation timeline.

Exhibit 4.1: County Requested “Go Live” Dates

County	Requested Go-Live Data	Number of Adults In-Custody (June 2025)	Number of Juveniles In-Custody (March 2025)
Alameda	Sheriff - 07/01/2026 Probation - 04/01/2026	2082	62
Alpine	To be determined	0	N/A
Amador	Sheriff - 10/01/2026 Probation - To be determined	126	N/A
Butte	Sheriff - 10/01/2026 Probation - To be determined	795	22
Calaveras	Sheriff - 03/31/2026 Probation - 10/01/2026	60	N/A
Colusa	Sheriff - 04/01/2026 Probation - to be determined	57	N/A
Contra Costa	10/01/2026	1451	72
Del Norte	Sheriff - 10/01/2026 Probation - To be determined	117	0
El Dorado	Sheriff - 10/01/2026 Probation - 07/01/2026	345	15
Fresno	10/01/2026	3188	258
Glenn	10/01/2026	65	N/A

County	Requested Go-Live Data	Number of Adults In-Custody (June 2025)	Number of Juveniles In-Custody (March 2025)
Humboldt	Probation - 09/30/2026 Sheriff - 10/01/2026	347	14
Imperial	Sheriff - 03/01/2026 Probation - 07/01/2026	279	14
Inyo	10/01/2024	27	4
Kern	11/01/2025	3540	203
Kings	10/01/2026	808	31
Lake	Sheriff – 08/01/2026 Probation – 10/01/2026	218	N/A
Lassen	Sheriff – 07/01/2026 Probation – 10/01/2026	133	N/A
L.A.	04/01/2026	26473	671
Madera	Sheriff - 10/01/2026 Probation - 10/01/2026	542	47
Marin	10/01/2026	168	14
Mariposa	04/01/2026	46	0
Mendocino	Sheriff - 01/01/2026 Probation - 02/01/2026	289	10
Merced	10/01/2026	722	34

County	Requested Go-Live Data	Number of Adults In-Custody (June 2025)	Number of Juveniles In-Custody (March 2025)
Modoc	To be determined	19	N/A
Mono	To be determined	21	N/A
Monterey	Sheriff - 07/01/2025 Probation - 10/01/2026	1419	0
Napa	10/01/2026	263	15
Nevada	Sheriff – 10/01/2025 Probation - 10/01/2026	112	N/A
Orange	04/01/2026	3949	180
Placer	7/1/2026	705	23
Plumas	Sheriff - 04/01/2026 Probation - To be determined	30	N/A
Riverside	To be determined	7683	157
Sacramento	Probation - 10/01/2026 Sheriff – 10 /01/2026	4669	135
San Benito	10/01/2026	90	6
San Bernardino	Sheriff - 10/01/2026 Probation - 07/01/2026	5576	170
San Diego	Probation - 10/01/2025	6687	301

County	Requested Go-Live Data	Number of Adults In-Custody (June 2025)	Number of Juveniles In-Custody (March 2025)
	Sheriff - 01/01/2026		
San Francisco	Probation - 04/01/2025 Sheriff – 04/01/2026	461	73
San Joaquin	Sheriff - 01/31/2025 Probation – 07/01/2026	2159	75
San Luis Obispo	Sheriff - 01/01/2026 Probation- 02/01/2026	568	20
San Mateo	Probation - 03/01/2026 Sheriff – 07/01/2025	825	50
Santa Barbara	Sheriff - 10/01/2026 Probation – 04/01/2026	975	53
Santa Clara	10/01/2024	2815	231
Santa Cruz	10/01/2026	395	31
Shasta	07/01/2026	985	42
Sierra	To be determined	Missing	N/A
Siskiyou	Sheriff - 04/01/2025 Probation - Not applicable	209	N/A
Solano	10/01/2026	697	21

County	Requested Go-Live Data	Number of Adults In-Custody (June 2025)	Number of Juveniles In-Custody (March 2025)
Sonoma	Sheriff - 09/01/2026 Probation - 10/01/2026	707	58
Stanislaus	Sheriff - 07/01/2026 Probation - 10/01/2026	1592	86
Sutter	Sheriff - 04/01/2025 Probation - To be determined	228	N/A
Tehama	10/01/2026	311	18
Trinity	Sheriff - 3/1/2026 Probation - To be determined	46	N/A
Tulare	07/01/2026	1843	125
Tuolumne	10/01/2026	262	19
Ventura	Sheriff - 10/01/2026 Probation - 04/01/2026	1324	68
Yolo	Sheriff - 10/01/2026 Probation - 07/01/2026	412	21
Yuba	10/01/2024	467	30
Notes: Data come from the DHCS county tracker , CDCR population data points , and the Juvenile Detention Profile Dashboard and are correct as of 09/29/2025. For the number of juveniles in-custody, "N/A" indicates that there were no youth facilities located in a given county.			

Status of Evaluation Sites

The UCLA-RAND Reentry Evaluation research design, for both the interim and final evaluation, includes all CDCR prison facilities as well as county jails and youth correctional facilities in five focal counties: San Joaquin, Yuba, San Francisco, Santa Clara, and San Diego (youth only for San Diego). These sites were finalized on June 13, 2025.

C. Evaluation Questions and Hypotheses

The provision of Medi-Cal pre-release and reentry 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 ED visits and inpatient hospital admission; mitigate mental health decompensation, suicide-related death, overdose, overdose-related death and all-cause death; and lead to improved health outcomes. Evaluation questions (EQ) and hypotheses (H) have been developed that allow the UCLA-RAND Reentry evaluation team to assess whether the state's hypotheses are met.

This section outlines the evaluation questions and hypotheses associated with each goal. Overall, goals 1 and 2 and their related hypotheses are designed to satisfy the STCs 9.1 for a comprehensive analysis of services rendered by type of service over the duration of the 90-day coverage period immediately prior to the expected date of release. The specific methods sections below discuss the analysis of the relationship between service provision and timing and the outcomes in Goals 6 and 7. Goals 3, 4, and 5 and their related hypotheses address the extent to which the Waiver coverage timeline facilitated providing more coordinated, efficient, and effective reentry planning, enabled pre-release management and stabilization of physical and BH conditions, and helped mitigate any potential operational challenges the state might have otherwise encountered in a more compressed timeline for coverage or pre-release services. These are addressed using a qualitative approach.

The evaluation questions and hypotheses directly correspond to the associated goals of the JI Reentry Waiver.

- EQ1. Did the Waiver increase coverage for eligible Medi-Cal members?
 - H1. The Waiver will increase coverage for eligible Medi-Cal members.
- EQ2. Did the Waiver improve access to services prior to release from prison/jail/youth correctional facilities and improve transitions and continuity of care upon release for eligible Medi-Cal members?

- H2. The Waiver will increase access to services prior to release and improve transitions and continuity of care upon release for eligible Medi-Cal members.
- EQ3a. Did the Waiver improve coordination between correctional systems, Medicaid and CHIP systems, managed care plans, and community-based providers?
 - H3a. The Waiver will improve coordination between correctional systems, Medicaid and CHIP systems, managed care plans, and community-based providers.
- EQ3b. Did the Waiver improve communication between correctional systems, Medicaid and CHIP systems, managed care plans, and community-based providers?
 - H3b. The Waiver will improve communication between correctional systems, Medicaid and CHIP systems, managed care plans, and community-based providers.
- EQ4. How did the Waiver influence investments in health care and related services in carceral settings aimed at improving quality of care and in the community to maximize successful Reentry post-release?
 - H4. The Waiver will increase services associated with improved quality of care, such as medication-assisted treatment, care coordination, and ECM.
- EQ5. Did the Waiver Improve connections between carceral settings and community services upon release to address physical health, BH, and HRSNs?
 - H5. The Waiver will improve connections between carceral settings and community services upon release to address physical health, BH, and HRSNs.
- EQ6a. Did the Waiver provide intervention for certain BH conditions and use stabilizing medications like long-acting injectable anti-psychotics and medications for addiction treatment for SUDs for eligible Medi-Cal members?
 - H6a. The Waiver will increase access to interventions for BH conditions, access to long-acting injectable anti-psychotics, and access to medications for addiction treatment for SUDs for eligible Medi-Cal members.
- EQ6b. Did the Waiver reduce decompensation, suicide-related deaths, overdoses, and overdose-related deaths in the near-term post-release for eligible Medi-Cal

members?

- H6b. The Waiver will reduce decompensation, suicide-related deaths, overdoses, and overdose-related deaths for eligible Medi-Cal members.
- EQ7. Did the Waiver reduce post-release ED visits, inpatient hospitalizations, and all-cause deaths for eligible Medi-Cal members?
 - H7. The Waiver will reduce post-release ED visits, inpatient hospitalizations, and all-cause deaths for eligible Medi-Cal members.

Alignment with California's approved Medicaid State Plan (Title XIX) and California's CHIP State Plan (Title XXI)

The evaluation goals and hypotheses promote the objectives of Titles XIX (California's State Plan) and The Children's Health Insurance Program State Plan (Title XXI).

The Reentry 1115 demonstration's research agenda advances the core aims in California's Medicaid State Plan: continuous coverage, timely access, cost-effective utilization, improved outcomes, and cross-system coordination. First, to evaluate whether JI individuals remain enrolled from 90 days pre-release through a full year post-release, the evaluation operationalizes the State Plan's eligibility and continuity requirements (§3-C). It then measures whether enrollees secure primary- and behavioral-care within 30 days of release, an empirical check on the access standards and EPSDT/behavioral-health provisions (§4.26, §4.43). Utilization-control objectives (§7.1) are addressed through hypotheses that potentially avoidable ED visits and inpatient stays will decrease. Finally, interview measures will test the care coordination expectations of §4.44, and mortality/overdose outcomes directly, assessing the State Plan's overarching goal to improve health for low-income Californians.

Although the demonstration focuses on adults, its hypotheses also inform CHIP objectives around coverage stability, network adequacy, quality, and program coordination. Continuous coverage metrics for JI individuals, particularly those aging out of juvenile facilities, offer evidence for future CHIP State Plan Amendments aimed at minimizing

recidivism among older adolescents. Assessing 30-day follow-up care, especially BH visits, generates actionable data on whether pediatric and adolescent networks meet CHIP's access and quality benchmarks (§8). Analyses of potentially avoidable ED use and substance-related admissions supply indicators that can be folded into CHIP's quality-improvement targets for high-risk youth. Findings on overdose prevention (e.g., initiation of Medications for Opioid Use Disorder, or MOUD) and cross-system data sharing will help the state craft State Plan Amendments (SPA) that strengthen coordination between juvenile-justice health systems and CHIP administrators, satisfying the program-administration and "supplement-not-supplant" financing provisions (§9) while ultimately advancing CHIP's goal of better health and wellness for eligible children and youth.

Measuring the Impact of the Program

The state's demonstration goals were translated into quantifiable indicators of impact. Below, evidence on how the UCLA-RAND Reentry evaluation team will identify the effects of the Waiver on the achievements of such targets is presented.

» Goal 1:

- Statistically significant increases in Medicaid enrollment, Medicaid eligibility screening, and Medicaid eligibility, and statistically significant reductions in Medicaid suspension status within the last 90 days of incarceration prior to release for those released post-Waiver rollout relative to those released prior to the rollout.

» Goal 2:

- Statistically significant increases in the proportion of releasees that received pre-release case management, medication billing, MAT treatment, prescription fills, a care manager, SUD treatment, medically necessary medications, visits with an ECM provider, and Medicaid services for those released post-Waiver rollout relative to those released prior to the rollout.
- Statistically significant increases in the provider beneficiary rate in the period following the Waiver rollout relative to prior to the rollout.
- Statistically significant reductions in health care appointment wait times for those released post-Waiver rollout relative to those released prior to the rollout.

- Positive perceptions among stakeholders, including staff at county jails and juvenile facilities and CDCR, and formerly incarcerated individuals regarding self-reported access to care, reentry support needs prior to release; experiences in receiving pre-release services while still incarcerated; and experiences with case management and the transition of care to community providers.
- » **Goal 3:**
 - Positive perceptions among stakeholders regarding coordination and communication between correctional systems, Medicaid and CHIP systems, managed care plans, and community-based providers.
- » **Goal 4:**
 - Positive perceptions among stakeholders regarding additional investments in health care and related services aimed at improving the quality of care for beneficiaries in carceral settings and the community to maximize successful reentry post-release.
- » **Goal 5:**
 - Positive perceptions among stakeholders and formerly incarcerated individuals regarding connections between carceral settings and community services upon release to address physical health, BH, and HRSN.
- » **Goal 6:**
 - Statistically significant increases in the receipt of post-release SUD treatment, post-release mental health treatment, post-release MAT, post-release necessary medications, and post-release BH condition interventions among those released post-Waiver rollout, relative to those released prior to the rollout.
 - Statistically significant reductions in suicide-related ED visits, suicide-related inpatient hospitalizations, suicide-related deaths, ED utilization for SUDs, inpatient stays for SUDs, overdose-related deaths, and decompensation²²

²² Direct objective measures of mental health decompensation will not be available in the absence of an electronic medical record. However, in addition to the listed utilization measures (including ED visits for

among those released post-Waiver rollout relative to those released prior to the rollout.

» **Goal 7**

- Statistically significant reductions in all-cause deaths post-release (30 days and 90 days), all-cause emergency room visits post-release (30 days and 90 days), and all-cause inpatient hospitalizations post-release (30 days and 90 days) among those released post-Waiver rollout relative to those released prior to the rollout.

Driver Diagrams

The goals listed in the driver diagrams are taken directly from the STCs 9.1 for California.⁶¹

Goal 1: Increase coverage – in terms of individuals now eligible for Medi-Cal benefits – in carceral settings in prison/jail/youth correctional facilities just prior to release.

Aim	Primary Driver	Secondary Driver
Increase coverage – in terms of individuals now eligible for Medi-Cal benefits – in carceral settings in prison/jail/youth correctional facilities just prior to release.	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.

psychosis), it is possible to examine other indicators that might reflect worsening mental health (decompensation): gaps in receipt of medication OR change in medication, the need to check into sober center or long-term inpatient psychiatric facility, or an increase in use of outpatient mental health services.

Aim	Primary Driver	Secondary Driver
		Increase BH linkages and ECM linkages for health and social services pre- and post-release. Improve data systems in carceral settings.
Causality		

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 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 tailored care 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		

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		

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 Re-Entry 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 infrastructure, data, and staffing needs. Identify service gaps. Develop mechanisms to capture funding requirements and track expenditures.
Causality		

Goal 5: Improve connections between carceral settings and community services upon release to address physical health, BH, and HRSNs.

Aim	Primary Driver	Secondary Driver
Improve person-level connections between carceral settings and community services upon release to address physical health, BH, and HRSN.	Increase service provision for physical health, BH, 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 personally tailored plan for coordination of their care post-release.
	← Causality ←	

Goal 6: Provide interventions for certain BH conditions and use stabilizing medications like long-acting injectable anti-psychotics 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 BH 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 BH 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 BH 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		

Goal 7: Reduce post-release acute care utilization such as ED 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 BH 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 BH care.

Aim	Primary Driver	Secondary Driver
Reduce post-release acute care utilization such as ED 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 BH conditions. Increase receipt of preventive and routine physical and BH 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 BH care.
Causality		

D. Methodology

The section that follows discusses the methodology used to evaluate the effects of the Waiver.

Overall, Goals 1, 2, 6, and 7 focus on screening and enrollment, delivery of services, and health outcomes of individuals. Research questions relevant to these goals are addressed by accessing data from CDCR, county facilities and DHCS and using a difference-in-differences approach that compares individuals after the go-live date for correctional facilities with individuals who are similar to those who participated in the Reentry Waiver but were incarcerated and released before the go-live date. It is important to note that the UCLA-RAND Reentry team has yet to access data as the Waiver only recently rolled

out (February 2025). The evaluation team continues to work closely with DHCS and CDCR to implement the proposed methodological strategy. The UCLA-RAND Reentry evaluation team is also working closely with DHCS to evaluate the feasibility for matching county correctional facility releasees to DHCS data.

Goals 3, 4, and 5 focus on the perceptions of coordination and communication between correctional systems, Medicaid and CHIP systems, managed care plans, and community-based providers, additional investments in health care and related services, and connections between carceral settings and community services upon release. The evaluation team is employing qualitative methods, including interviews with stakeholders and with formerly incarcerated individuals, to answer the related research questions. Protocols have been approved by the UCLA Institutional Review Board (IRB). RAND Human Subjects Protection Committee defers to the UCLA IRB. As of September 2025, county outreach is occurring.

The full Evaluation Design Report is available in [Appendix F](#).

Methodological Design

Quantitative Design and Methods

Once the UCLA-RAND Reentry Evaluation team have gained access to the necessary data, they will employ a cohort difference-in-differences analysis, which will exploit the within-year timing of the policy and across year exposure to the policy. As an illustrative example, if one were to assume that the Waiver will be implemented in Month t of 2025, then individuals who are released from Month t through Month $t+3$ of 2025 will be partially treated as they will not receive the full 90 days of pre-release services (e.g., those individuals released in Month $t+1$ will only receive up to 30 days of pre-release services), individuals released after Month $t+3$ in 2025 will be fully treated, and individuals released in 2025 (or prior years) prior to Month t (i.e. Months $t-1$ to Month $t-6$) will be untreated. However, it is expected there will exist some people who are partially treated or not treated in all post-Waiver cohorts based on length of stay within the incarceration system (i.e., those individuals who are incarcerated for less than 90 days will be partially treated). Analyses will explore how the magnitude of effect size varies dependent on length of treatment (i.e., under 30 days, 30 to 59 days, 60 to 89 days, and those with the full 90 days of pre-release services, separately).

The UCLA-RAND Reentry Evaluation will exploit the month by year variation in Waiver eligibility. A 12-month window around February 8, 2025, for CDCR will be identified. For

jails, a 12-month window around the timing of the go-live dates will be identified to ensure six pre-implementation monthly cohorts, three partially treated post-cohorts, and three fully treated post-cohorts. The UCLA-RAND Reentry Evaluation team will also explore augmenting models to cover a wider post-treatment period as well as monthly cohorts prior to 2025, given available data. The UCLA-RAND Reentry Evaluation team has selected 2021 as the earliest year for data to provide stability in measurement, but data availability will guide the final study period.

Event study specifications of the above models will allow exploration of whether control and treated cohorts were on parallel trends prior to the Reentry Waiver going live (a crucial assumption in difference-in-differences models). We will test the parallel trends assumption by identifying whether there are statistically insignificant (based on t-tests) differences between treatment and control groups in the months running up to the Waiver implementation. We will test whether there are effects of the Waiver using t-tests to identify whether there are statistically significant differences between the treatment and control cohorts in the months post-Waiver implementation. If the parallel trends assumption is met, statistical differences in the post-implementation period can be assumed reliable and valid.

The Reentry Waiver go live is rolling out in staggered settings across jails/youth correctional facilities. As such, in these cases the UCLA-RAND Reentry Evaluation team will make use of staggered difference-in-differences and event study models that compare the outcomes of the reentry population that are released after Waiver go live to those released prior to the go live and for jails/youth correctional facilities that go live compared to those that go live later. Given the staggered nature in these settings, the UCLA-RAND Reentry Evaluation team will make use of models that deal with biases that may arise in such settings.

The evaluation design builds on existing work that has used quasi-experimental methods such as difference-in-difference designs to identify the effects of Medicaid for JI populations and Medicaid Waivers on the outcomes of enrollees.⁶²⁻⁶⁵

The UCLA-RAND Reentry evaluation team is in the process of developing data requests for both DHCS and CDCR and continues to work closely with DHCS to identify the feasibility of matching county jail release cohorts to DHCS data.

Intervention and Comparison Groups

Intervention Group: The UCLA-RAND Reentry Evaluation team is working with the CDCR and counties to develop plans for identification of Reentry Waiver groups for the evaluation as well as data and other permissions that may be required for the evaluation. Plans address access to the most reliable information on correctional facility eligibility screening and enrollment, information on how correctional facilities developed criteria to identify those with qualifying conditions, selection of the release cohorts for the Reentry Waiver individuals, determination of background demographic characteristics, and health status services data available for creating comparison groups as described in the next paragraph.

As practicable, the evaluation team will identify Reentry Waiver pre-intervention and post-intervention treatment groups by applying the Reentry eligibility criteria described above to individuals who had been incarcerated. This allows the evaluation team to create and follow cohorts released around the go-live date to estimate cohort difference-in-difference models for those individuals that would be impacted by the policy due to eligibility. The UCLA-RAND Reentry Evaluation team expects that the JI Reentry Waiver may increase screening for eligibility. If that is the case then the UCLA-RAND Reentry Evaluation team will utilize data from the full population of releasees (regardless of eligibility) to identify reduced form, intention-to-treat effects. Such models will account for selection bias that would arise from changing screening practices. For local county jails, the UCLA-RAND Reentry Evaluation team are in the process of determining whether local data systems will allow identification of previously released individuals with qualifying conditions. For juveniles, there are no qualifying health conditions. The Reentry evaluation will not restrict the analysis for youth in the same way proposed for prison releasees and instead plans to use all releases as specified in the STCs for youth (e.g., all children/youth who are enrolled in Medi-Cal or CHIP and in the custody of a county youth correctional facility are eligible for pre-release services). If the team is unable to use state and local health data to identify eligible cohorts based upon the detailed eligibility criteria, analyses may need to use full (100%) cohorts of released individuals for both the comparison (i.e., pre-post calendar months for the go-live dates in the years preceding 2025) and Reentry Waiver (i.e., pre-post calendar months for the go-live dates in 2025) groups rather than the roughly 80% of these cohorts who are actually eligible for services. Even if full cohorts rather than Reentry Waiver eligible cohorts are required (for data purposes), the UCLA-RAND JI Reentry team expect that the majority of the cohort will meet the health services criteria for the Waiver since the prevalence of SUD and other

health issues is high in the JI population. For example, it is estimated that about 85% of CDCR inmates have an SUD, which is a conservative estimate.⁶⁶ Prevalence rates in jails are harder to obtain, but a recent brief from the Bureau of Justice Statistics indicates that 63% of post-adjudication jail inmates have an SUD, and there have been increasing numbers of jail deaths from 2000 to 2019, particularly among those who died from drug-related intoxication.⁶⁷ If full cohorts are used, rather than Reentry Waiver eligible cohorts, the study design would not be able to include case mix adjustments for an individual's illness. The evaluation team will continue to work closely with DHCS and CDCR to identify eligibility cohorts.

In all cases, the treatment group will include releasees that were eligible for services but did not receive them (either due to self-selecting to not receive services or not being offered services – i.e., we will estimate intention-to-treat effects). Such an approach allows the UCLA-RAND Reentry evaluation team to overcome bias that arises from selection into treatment.

Comparison Group: As practicable, the evaluation team will identify Reentry Waiver pre-intervention and post-intervention comparison groups by applying the Reentry eligibility criteria described above to individuals who had been incarcerated. This will allow the evaluation team to create and follow cohorts released around the go-live date to estimate cohort difference-in-difference models for those individuals that would not be impacted by the policy due to eligibility. The UCLA-RAND Reentry Evaluation team expects that the JI Reentry Waiver may increase screening for eligibility. If that is the case then the UCLA-RAND Reentry Evaluation team will utilize data from the full population of releasees (regardless of eligibility) to identify reduced form, intention-to-treat effects. Such models will account for selection bias that would arise from changing screening practices. UCLA-RAND will take the same approach as that described above for treatment groups to identify control groups for county jails and youth. In each case, we will select control groups by identifying 12-month windows around the go-live month for the years preceding 2025 and treatment groups for the 12-month window around the go-live month in 2025.

Data sources

Quantitative: The evaluation team will use Medi-Cal and prison/jail/youth correctional facilities databases (as available) for the Reentry Waiver and comparison groups for the evaluation. Cross-referencing CDCR identifiers with Medicaid data has successfully been accomplished in recent work conducted by the Council on Criminal Justice (CJ) and BH in

their 2023 Medi-Cal Utilization project.⁶⁸ This project matched data from the CDCR to Medi-Cal records from over 35,000 individuals released from CDCR in fiscal year 2019-2020 to analyze enrollment and utilization of Medi-Cal services. The evaluation design relies on a similar strategy for matching CDCR releases to Medicaid databases.

The evaluation team continues to work closely with DHCS and CDCR to implement this strategy and is working closely with DHCS to evaluate the feasibility of matching county correctional facility releasees to DHCS data. Data will cover the period 2021 to 2025. Data for the treatment group will cover the 2025 post-waiver implementation period. Data for the comparison group will cover the 2021-2025 pre-waiver implementation period.

Alternative datasets were considered. Numerous studies use data from publicly available surveys such as the American Community Survey to study the effects of changes in Medicaid policy on the Medicaid enrollment of individuals. However, such data do not include information about release date from prisons/ jails, which is critically needed to evaluate the effects of the Waiver on those individuals impacted by the Waiver. The UCLA-RAND team also considered sources such as the California Health Interview Survey, but sample sizes would be too small for the recently JI population, which would limit precision. The proposed data were chosen based on large sample sizes, high levels of linkability between unique data sources, and objective measures.

This approach is not without limitations. The approach means that the UCLA-RAND JI Reentry evaluation team can only identify individuals that have been enrolled in Medicaid at some point in time. That is, individuals with no Medicaid enrollment, including releasees that remain uninsured or immediately acquire private insurance, will not be identifiable within the health care data. Nonetheless, there is evidence that matching CDCR to Medicaid records captures the vast majority of the population. Previous efforts to link releasees to DHCS data (using the same matching approach that the UCLA-RAND JI Reentry Evaluation team plan to apply) was successful in matching >75% of CDCR releasees to Medicaid records.⁶⁸ As such, the UCLA-RAND JI Reentry evaluation team expect the magnitude of bias arising from unsuccessful matching and non-Medicaid enrollment to be minimal given the high success of the matching algorithm and the high Medicaid penetration rates for the JI population.

Qualitative: Goals 3, 4 and 5 requires interviews with key stakeholders and with individuals who have been previously incarcerated.

Analytic Methods

In line with the evaluation design, descriptive summary and t-tests will be used to provide sample characteristics and trends, once the evaluation team is able to access the needed data. Event study and difference-in-difference models will use regression models (Ordinary Least Squares for continuous variables, Probit for binary variables, and Poisson for count variables) to estimate the effects of the program. Difference-in-difference analysis will be used to identify a causal effect. Event study models will be used to test for pre-trends. Once data are secured, the UCLA-RAND team will finalize analytic methods and report any changes in the final summative report.

Qualitative Design and Methods

The qualitative design includes interviews with recently released individuals from CDCR, county jails, and juvenile facilities in the five focal counties, all implementing the waiver. All protocols have been approved. The Evaluation team is working with DHCS to identify CBOs, including JI ECM providers, to help identify and recruit respondents for the interviews. We will pay each CBO \$500 for their assistance in identifying potential interview participants.

Prior to starting recruitment, Reentry Evaluation staff will meet with the designated liaison from the CBOs to review recruitment goals, procedures, and materials. CBOs will be provided a flyer in English and Spanish that describes what participation in the interview entails, the eligibility criteria for the interviews, recruitment goals, a recruitment script, and a contact information release form. To be eligible for the interviews, individuals must have been released in the previous 90 days from one of the targeted facilities, enrolled in Medi-Cal, and have one of the conditions that make them eligible for the Reentry Demonstration. If a Waiver participant is interested in taking part in the interview, the CBOs will ask the individual to sign a release form that authorizes the CBO to release their name and contact information (telephone number, cell phone number, email address) to the UCLA-RAND Reentry Evaluation team. Individuals will be contacted to verify Reentry Waiver status (e.g. that the individual was recently incarcerated and that their Medi-Cal enrollment was reactivated prior to or at release), provide details about what participation in the interview entails, answer any questions or concerns they may have and, if they are interested and available, schedule an appointment to complete the interview with a trained interviewer, either in-person or by phone, in Spanish or English. If the Reentry Waiver participant is available to do the interview right away, they will be interviewed by phone.

If the CBO is unable to provide staff to help identify and recruit Reentry Waiver participants for the interviews, the UCLA-RAND Reentry Evaluation team will seek their permission to allow an interviewer to visit their office(s) to recruit Reentry Waiver participants on-site, either before or after their appointment with CBO staff. With the CBO's permission, and in collaboration with CBO staff, interviewers will approach CBO clients to provide information about the survey and, if they are interested, they will verify eligibility for the interviews and either conduct the interview on-site (if possible) or schedule an appointment to do the interview later, either in-person or by phone. For the prison sample, the UCLA-RAND Reentry Evaluation team will conduct interviews with 10–15 individuals who were formally incarcerated in prison and are recently released to 95 one of the five focal counties. This will result in a total of 40–60 interviews with individuals newly released from prison in 2025. It is anticipated that 100 newly released individuals will need to be screened to yield 10–15 interviews per identified focus county per project year. For the county jail and youth correctional facility populations, 80 to 120 interviews will be conducted in the five focal counties in 2025, half of which will be with Reentry Waiver participants who were recently incarcerated in county jails and the other half will be with youth recently incarcerated in youth correctional facilities who are Reentry Waiver participants. It is estimated that between 100–125 individuals will need to be screened to complete 20–30 interviews per county (10–15 individuals released from jails and 10–15 individuals released from youth correctional facilities).

The interviews will be administered by a bilingual interviewer as a computer-administered personal interview (CAPI) using a hand-held tablet. The interview will be conducted in English or Spanish, as applicable, and is estimated to take approximately 60 to 90 minutes. Respondents will be paid, which may be via gift card, for completing the interview. The interviews with newly released Reentry Waiver participants from prison, jail, or youth correctional facilities will ask about:

- » Experiences with enrollment in Medi-Cal (or reinstatement of benefits) during the pre-release period;
- » Perceptions regarding their health care treatment needs and Reentry support needs;
- » Experiences in receiving pre-release services while still incarcerated;
- » Experiences with case management and the transition of their care to community providers as well as what other support they may have received to help facilitate their transition of care to the community;

- » Feedback on their experiences, as applicable, in accessing primary care, mental health care, substance use treatment, and care for chronic health conditions post-release from the carceral setting;
- » Perceptions regarding barriers and facilitators to accessing health care pre-release and post-release; and
- » Whether they were released with a supply of medications and experiences in getting their medications refilled post-release.

To do qualitative analysis of these interview data, qualitative coding of themes will be conducted 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 EQs 3, 4, and 5 by identifying strategies for improving coordination and connections between correctional systems, Medi-Cal systems, ECM, and community providers to address the physical health, BH, and other HRSN of the JI population. The qualitative analysis will also inform understanding of factors that facilitated or hindered Reentry Waiver participants' access to care pre-release and post-release and their perceptions of their treatment needs and experiences with pre-release care, case management, and post-release care.

Convenience sampling will be used to recruit interviewees. We will oversample women, older adults, and people of color to ensure sample sizes support stratification by demographics (e.g., race/ethnicity, gender, age). The UCLA-RAND Reentry Evaluation team will identify CBOs that work specifically with different communities and with younger individuals as well. The interview samples will be restricted to those individuals who speak English or Spanish as these are the languages that the UCLA-RAND Reentry Evaluation team members are fluent in.

Interviews will also be conducted with key stakeholders involved in the planning and implementation of the Waiver for the JI population in the five focal counties (e.g., representatives from Probation, Sheriff's offices, correctional facilities, Correctional Health, and county healthcare services and providers). The team is assembling a list of key stakeholders to invite for interviews. Interviews are expected to begin in the Fall 2025 and continue through mid-2026.

Key stakeholder interviewees will include a state-level CDCR and California Correctional Health Care Services (CCHCS) staff. At the county-level, administrators of county jails and

youth correctional facilities will be selected with a focus on individuals who were involved with the planning and implementation of the Waiver for the JI population.

At the prison-level, evaluation plans are to interview those individuals within CDCR and the CCHCS who were involved in planning for and implementing the Waiver for the incarcerated population in the state's correctional system. Similarly, at the jail and youth correctional facilities, implementation partners will include county sheriffs, county jail staff and juvenile facility administrators/staff, county probation staff, and state parole staff. The UCLA-RAND Reentry Evaluation team will lead interviews with key informants within CDCR and CCHCS as well as in county correctional facilities.

Interview topics will include:

- » System changes and supports needed to screen for Medi-Cal eligibility to enroll, and to re-instate eligibility, for those who were suspended during their incarceration;
- » The process of identifying eligible individuals for the Waiver;
- » The pre-release Medi-Cal application and enrollment process;
- » Planning for and the provision of the targeted set of pre-release services 90 days prior to release from jail/prison/juvenile facilities;
- » Planning for and care in the carceral setting, as well as provision of needed medications and DME;
- » Coordination with enhanced care and provision of comprehensive case management (as part of ECM); coordination with benefits in preparation for release to the community supports; and
- » Barriers and facilitators in planning for and implementing each component of the Waiver, the JI Reentry Initiative, and lessons learned.

Similar to the interviews with Reentry Waiver participants, qualitative coding of themes for the stakeholder interviews using software such as Dedoose will be used, which will provide a systematic way to code and reveal themes in the data. Qualitative analysis of the stakeholder interviews will inform the interpretation of Goals 3, 4, and 5 by identifying strategies for improving coordination and connections between correctional systems, Medi-Cal systems, ECM, and community providers. The qualitative analysis will also inform understanding of factors that facilitated or hindered implementation of the different

components of the Reentry Waiver and stakeholders' suggestions for improving Medi-Cal enrollment processes, pre-release treatment services, case management, and post-release care.

In conjunction with the UCLA-RAND PATH Evaluation Team – which is focused on examining infrastructure investment – evaluators are conducting interviews with county providers about JI and PATH initiatives (e.g., Probation, Sheriff's Office, Correctional Health, Social Services/Human Services, Health & Human Services, Public Health, BH, and contracted in-reach services providers). These interviews are across California counties, not limited to the focal counties. Three interviews have been completed, and six interviews are scheduled with additional counties in July 2025.

[Exhibit 4.2](#) provides additional details regarding the design components of the evaluation.

Exhibit 4.2: Reentry Evaluation Design Components*

Intervention Group					Comparison Group		
Evaluation Measures (Measure Steward)²³		Evaluation Period	Design	Description	Data Source	Description	Data Source
EQ1	» Medicaid Coverage	2021-2026	Cohort Difference-in-differences	Reentry population post-Waiver Implementation (post February 2025 – February 2026)	Medi-Cal eligibility and claims data, DHCS Master file: eligibility file, CDCR, Correctional agencies health care utilization data	Reentry population pre-Waiver Implementation (February 2021-February 2025)	Medi-Cal eligibility and claims data, DHCS Master file: eligibility file, CDCR, Correctional agencies health care utilization data
	» Medicaid Suspended Status						
	» Medicaid eligibility screening						
	» Medicaid eligibility						
EQ2	» Pre-release case management	2021-2026	Cohort Difference-in-differences	Reentry population post-Waiver Implementation (post February 2025 – February 2026)	Medi-Cal eligibility and claims data, CDCR, Correctional agencies health care utilization data	Reentry population pre-Waiver Implementation (February 2021-February 2025)	Medi-Cal eligibility and claims data, CDCR, Correctional agencies health care utilization data
	» Pre-release medication billing						
	» Pre-release MAT treatment						

²³ The RAND-UCLA Reentry Evaluation Team selected and operationalized measures that addressed the evaluation questions and hypotheses.

<u>Intervention Group</u>					<u>Comparison Group</u>	
Evaluation Measures (Measure Steward) ²³	Evaluation Period	Design	Description	Data Source	Description	Data Source
» Pre-release prescription fills » Pre-release care manager » Pre-release SUD treatment » Medically necessary medications » Visits with ECM provider » Medicaid services » Provider beneficiary rate » Wait times						
EQ3 Individuals: » Transition barriers and facilitators » Continuity of care	2025-2026	Structured interview guide, semi-structured	Individuals released from prison/jail/juvenile facilities, Key stakeholders	Interviews	N/A	N/A

<u>Intervention Group</u>				<u>Comparison Group</u>			
Evaluation Measures (Measure Steward) ²³		Evaluation Period	Design	Description	Data Source	Description	Data Source
	» Effectiveness of case managers Stakeholders – Types, processes, and perceived effectiveness of: » Established communication channels » Data sharing process » Handoff protocols		interview guide				
EQ4	» How Waiver funds are used » Use of additional investments	2025	Semi-structured interview guide	Key stakeholders	Interviews	N/A	N/A
EQ5	Individuals: » Health care needs of participants	2025-2026	Structured interview guide, semi-structured	Individuals released from prison/jail/juvenile facilities, Key stakeholders	Interviews	N/A	N/A

<u>Intervention Group</u>				<u>Comparison Group</u>		
Evaluation Measures (Measure Steward) ²³	Evaluation Period	Design	Description	Data Source	Description	Data Source
» Provision of services during 90-day in-reach period » Transition services provided » Community supports needed and received » ECM services needed and received Stakeholders: » Coordination of care » Type of formal arrangements to facilitate transition » Barriers and facilitators by		interview guide				

<u>Intervention Group</u>				<u>Comparison Group</u>			
Evaluation Measures (Measure Steward) ²³		Evaluation Period	Design	Description	Data Source	Description	Data Source
	type of services provided						
EQ6	» Post-release SUD treatment » Post-release mental health treatment » Post-release MAT » Post-release necessary medications » Post-release receipt of BH condition interventions » Suicide-related ED visits » Suicide-related inpatient hospitalizations	2021-2026	Cohort Difference-in-differences	Reentry population post-Waiver Implementation (post February 2025 – February 2026)	Medi-Cal eligibility and claims data, pharmacy data, ADP (SUD) file, State hospital inpatient discharge data, state hospital ED visit data, HCAI data sources, multiple cause of death files	Reentry population pre-Waiver Implementation (February 2021-February 2025)	Medi-Cal eligibility and claims data, pharmacy data, ADP (SUD) file, State hospital inpatient discharge data, state hospital ED visit data, HCAI data sources, multiple cause of death files

<u>Intervention Group</u>				<u>Comparison Group</u>			
Evaluation Measures (Measure Steward) ²³		Evaluation Period	Design	Description	Data Source	Description	Data Source
	» Suicide-related deaths » ED utilization for SUDs » Inpatient stays for SUDs » Overdose-related deaths » Other Mental Health Decomensation Measures						
EQ7	» All-cause deaths post-release (30 days and 90 days) » All-cause ED visits post-release (30 days and 90 days) » All-cause inpatient hospitalizations	2021-2026	Cohort Difference-in-differences	Reentry population post-Waiver Implementation (post February 2025 – February 2026)	Medi-Cal claims data, hospital inpatient discharge data, state hospital ED visit data, HCAI data sources, multiple cause of death files	Reentry population pre-Waiver Implementation (February 2021-February 2025)	Medi-Cal claims data, hospital inpatient discharge data, state hospital ED visit data, HCAI data sources, multiple cause of death files

<u>Intervention Group</u>					<u>Comparison Group</u>		
Evaluation Measures (Measure Steward) ²³		Evaluation Period	Design	Description	Data Source	Description	Data Source
	post-release (30 days and 90 days)						

*A complete description of the evaluation design is included in the Evaluation Design Report (Appendix X).

Cost Methodology Description

Producing a reliable estimate of the cost impact of the JI Reentry Waiver is essential for California policymakers as they consider whether and how to continue and refine the program and allocate sufficient financial resources for it. To calculate costs, the UCLA-RAND Reentry Evaluation team will follow the same approach being used by the other evaluation components. Namely, UCLA-RAND will use the methodology developed under the WPC and The Public Hospital Redesign and Incentives in Medi-Cal (PRIME) evaluations (in consultation with Mercer and DHCS) to attribute estimated payments to claims, to quantify costs for the JI population. This step is necessary because payment amounts for managed care encounters are not accurate or reliable. Briefly, this methodology includes identifying detailed and unduplicated categories of outpatient service, identifying the appropriate and available Medi-Cal fee schedules for each type of service, and attributing that amount to a claim. For ED visits, all claims on the day of the ED visit will be aggregated and counted as part of the visit. For hospitalization, all claims during the length of stay other than visits with primary care providers on the first or last day of the stay will be aggregated as part of the same stay. Payments for hospitalizations will be estimated using publicly available prices in DHCS's All Patient Refined-Diagnosis Related Group (APR-DRG) Pricing Calculator to calculate payments for each DRG. For long-term stays, institutional fees billed by a facility will be calculated at the per diem rate, which is inclusive of supplies, drugs, equipment, and services such as therapy. For pre-release services, the study team will estimate Medi-Cal spending based on the reimbursement amounts for the direct pre-release health care services received in the FFS claims data. We will calculate total costs for the first-year post-release for treatment and control cohort individuals, separately.

UCLA-RAND will then use the cohort difference-in-difference multivariate regression models described earlier in Section D to assess the impact of the JI Reentry Waiver on the costs of care for the treatment group, relative to the control group, pre-post the passage of the JI Reentry Waiver.

E. Methodological Limitations

The evaluation of the reentry component of the 1115 Waiver includes both strengths and limitations. The primary strength of the evaluation are the design and plans for data collection and analyses, which are strategically planned to produce the highest quality results with all sources and approaches considered. These plans and rationale are

discussed in the methodology section. Along with this design and protocol, a strength of the evaluation plan is its flexible and adaptive approach, designed to meet methodological challenges that are likely to arise.

Limitations are presented in [Exhibit 4.3](#), which illustrates our adaptive approach by outlining the anticipated challenges and proposed mitigation strategies.

Exhibit 4.3: Challenges and Proposed Mitigation Strategies

Challenge	Mitigation Approach
Timeliness and Quality of CDCR and County Facility Data	» Work closely with CDCR and county facilities to receive comprehensive data on release cohorts and work quickly to address any data quality issues or missing data.
Timeliness and Quality of DHCS data	» Work closely with DHCS to receive data and work quickly to address any data quality issues or missing data.
County and CDCR DHCS Data Linkages	» Work closely with CDCR data stewards to identify the most appropriate way to link CDCR release cohorts to DHCS data. Identify data stewards previously involved in the Medi-Cal utilization project to replicate approach. » Work closely with DHCS and county facility data stewards to identify whether DHCS data can be linked to county facility release cohorts. » Complete a small chart review if necessary for county facilities.
Constructing a Valid Comparison Group	» Work closely with CDCR to identify whether high-quality Waiver eligibility data prior to the rollout exists. » Work closely with county facilities to identify whether high-quality Waiver eligibility data prior to the rollout exists. » Implement a full cohort rather than eligibility cohort approach if necessary.
Non-Parallel Trends	» Work quickly to identify whether the unconditional or conditional parallel trends assumption is met.

Challenge	Mitigation Approach
	» If the assumption is not met, implement a synthetic weighting approach to improve the similarity in baseline differences between groups. » If the assumption remains unmet, utilize a regression discontinuity design approach.
County Implementation Delays	» Closely track the readiness and implementation among county facilities. » Reconsider county selection based on the timing of implementation, if necessary.
Recruitment of formerly incarcerated individuals for interviews	» Garner support from CBOs to help with recruitment. » Explore other options for recruitment, if needed.

F. Results

The UCLA-RAND Reentry evaluation team is continuing to collaborate with DHCS, CDCR, and county facilities to gather the necessary data. As of September 2025, all qualitative instruments have been approved by the IRB and recruitment has commenced. The team has also participated in PATH interviews with county stakeholders, and the information presented below, that directly addresses the evaluation questions, is based on those findings. These findings are preliminary and qualitative. Additionally, the UCLA-RAND JI Reentry evaluation team presents some preliminary data using information on claims filed using the JI eligibility codes. Given the limited nature of the data (i.e. covers October 2024 – December 2024, for the period when only a few counties had implemented) it was not appropriate to utilize statistical tests. Instead, descriptive trends in enrollment are presented.

Profile of 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.^{69,70} In addition, more than 2,200 youth are incarcerated at the county level in youth correctional facilities camps, and ranches.⁷¹ The UCLA-RAND Reentry evaluation team is in the process of working with county facilities, CDCR, and DHCS to gain access to data on the population while they

continue to implement the Waiver. However, to facilitate a basic understanding of California's CJ system that is critical for the Reentry component's evaluation design, key features of the prison, jail, and juvenile incarcerated populations are highlight below.

- » With respect to the prison population, according to the CDCR Office of Research, Summary of Offender Data Points⁷² the in-custody adult prison population as of May 2025, was 90,747 with incarcerated individuals housed in 33 prison facilities across the state. The average age was 43 years with 96.0% male and by race/ethnicity, 36.1% Hispanic, 27.3% Black, 19.5% White (non-Hispanic), 10.4% Mexican, and 3.6% other.⁷² The average number of individuals released from prison back to communities per month between May 2023 and May 2025 ranged from 2,771 (May 2023) to 2,408 (February 2025). Among releasees, the average sentence length over the period May 2023 to May 2025 was 81.93 months. Los Angeles accounted for a quarter of the released population in May 2025.
- » Recent estimates from the 2019–20 Medi-Cal Utilization project indicate that over three-quarters of releasees had an identified BH need at the time of their release and 52.5% had an identified SUD need with 19% utilizing a SUD service. Approximately 76% of individuals transitioning from CDCR facilities were enrolled into Medi-Cal within one year of release.⁶⁸
- » In 2025, the average daily jail population in California was 58,968.⁷³ Fewer than a quarter are serving sentences.
- » With respect to the juvenile population, until June 30, 2023, California operated the California Department of Juvenile Justice (DJJ), which housed youth who had been adjudicated and incarcerated. As of June 30th, 2023, all state-run juvenile operations ceased at DJJ, and youth custody cases were realigned to the care of counties. County probation chiefs opposed this change and established a transition group to help plan the transition of the approximately 400 youth returning to counties. County probation departments supervise JI youth who are placed in local youth correctional facilities, camps, and ranches or supervised in the community.⁷⁴ In 2025 (up to May), there was an average of 2,637 juveniles in facilities.⁷⁵

Evaluation Question 1: Did the Waiver increase coverage for eligible Medi-Cal members?

- » The UCLA-RAND Reentry evaluation team continues to work with DHCS, CDCR, and county facilities to collect the needed data to evaluate whether the Waiver increased coverage for eligible Medi-Cal members. The Waiver went live at CDCR

in February 2025 and is still rolling out across county facilities; at the time of writing, it is too early to evaluate the effectiveness of the policy, as data systems continue to be updated.

- » The UCLA-RAND Reentry evaluation team hypothesize that the Waiver will increase coverage for eligible Medi-Cal members, driven by increases in the screening rate for Medicaid eligibility, improved coverage for benefits in carceral settings prior to release, and increased administration of screening to identify eligible individuals. Before going live, counties and CDCR must provide readiness assessments. As part of these assessments, facilities had to indicate whether they have processes in place to screen and enroll individuals into Medi-Cal, provide application support, and unsuspend and activate benefits; if they do not have such processes in place, TA will be provided. This provision of processes is expected to increase enrollment.

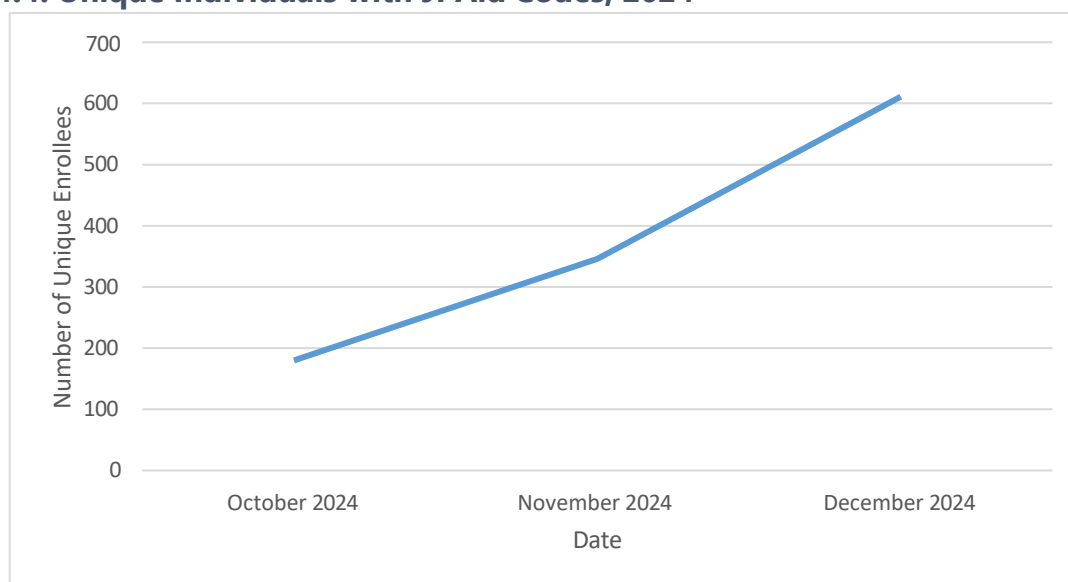
Evaluation Question 2: Did the Waiver improve access to services prior to release from prison/jail/youth correctional facilities? Did it improve transitions and continuity of care upon release for eligible Medi-Cal members?

- » The UCLA-RAND Reentry evaluation team continues to work with DHCS, CDCR, and county facilities to collect the needed data to evaluate whether the Waiver improved access to services prior to release from prison/ jail/ juvenile facilities and whether the Waiver improved transitions and continuity of care upon release for eligible Medi-Cal members. The Waiver went live at CDCR in February 2025 and is still rolling out across county facilities; at the time of writing, it is too early to evaluate the effectiveness of the policy, as data systems continue to be updated and data access and matching is agreed upon.
- » The UCLA-RAND Reentry evaluation team hypothesize that the Waiver will improve access to services prior to release from prison/ jail/ juvenile facilities and that the Waiver will improve transitions and continuity of care upon release for eligible Medi-Cal members. Readiness assessments require facilities to indicate whether they have processes in place to screen for pre-release services and BH links; ensure the provision of pre-release services, care management, medications, and SUD medications; the provision of post-release medication upon release and DME upon release; and processes in place to provide Reentry care management warm handoff's and BH links. If they do not have such processes in place, TA will

be provided. These provisions are expected to improve access to services prior to release and improve transitions and continuity of care upon release.

- » Preliminary qualitative interviews conducted in the fall 2025 with key informants from Probation, Sheriff's Office, Correctional Health, Social Services/Human Services, Health & Human Services, Public Health, BH, and contracted in-reach services providers indicate that some pre-release medical services that will be paid for via CalAIM are already offered by most jail facilities. In addition, some pre-release non-medical services and supports were not universally available. It is not yet clear whether the ability to be reimbursed for these services via CalAIM will result in more individuals having their need for these services met prior to release. Provision of 30-day post-release supply of outpatient prescribed medication if clinically appropriate does appear likely for those individuals who have a jail stay greater than 3–4 days as this service did not exist or was only offered for a very limited number of medications prior to CalAIM. However, for individuals with very short jail stays, interviewees indicated it was not possible to meet this requirement.
- » The UCLA-RAND Reentry evaluation team has been able to access a limited DHCS Medi-Cal JI dataset, covering the period October 2024 - December 2024. The claims and enrollment data (data pulled 18th March 2025) allow us to filter by JI aid codes. [Exhibit 4.4](#) reports unique individuals (that have had a claim or encounter) enrolled in the JI aid codes in DHCS data. Aid codes refer to indicators that indicate eligibility category (e.g., JI), funding stream (e.g., Title XIX, state-funded only) and benefit level (e.g., full-scope vs. restricted benefits). Each aid Code corresponds to a specific Medi-Cal eligibility group. The JI Reentry Waiver has new specific codes to refer to individuals that receive benefits based on eligibility due to their inclusion in the JI component of the Waiver. By December 2024, three counties had gone live. In total, there were 180, 346, and 611 unique individuals that had a claim or encounter with a JI aid code in October, November, and December of 2024, respectively. These findings indicate that in counties that have gone live there is an increasing number of people utilizing services prior to release – suggestive evidence that the Waiver is increasing utilization of Medi-Cal services.

Exhibit 4.4: Unique Individuals with JI Aid Codes, 2024



Evaluation Question 3a. Did the Waiver improve coordination between correctional systems, Medicaid and CHIP systems, managed care plans, and community-based providers?

- » The UCLA-RAND Reentry evaluation team was approved for the qualitative interviews that will ask stakeholders and formerly incarcerated individuals their perceptions of coordination in September 2025. Recruitment has begun. Findings will be available in the Mid-Point Assessment that will be submitted in early 2027. Below are preliminary findings from the PATH interviews conducted in Fall 2025 with key informants from Probation, Sheriff's Office, Correctional Health, Social Services/Human Services, Health & Human Services, Public Health, BH, and contracted in-reach services providers.

Results

- » Overall, interviewees believed that CalAIM has the potential to be beneficial by enabling them to create a network of care for the vulnerable JI population. Increasing access to services and building stronger community partnerships to provide healthier reentry were also cited as important goals.
- » Stakeholders recognized the need for close communication, education, and well-defined protocols as had been anticipated by the reentry program. The bringing together of relevant stakeholders unfamiliar with each other's policies and procedures required a lengthy coordination process. To facilitate coordination, some counties assigned dedicated social workers or a CalAIM manager and

established steering committees of correctional and health systems and health providers to work together.

- » Working in the jail is new to the health plans.
- » In one county, the leadership within the Sheriff's Department changed, which meant that agreements for implementing CalAIM that had been negotiated earlier had to be reworked.
- » As stakeholders experience the fragmentation and duplication associated with the introduction of the Reentry's proposed approaches for California's justice system, they emphasize the importance of person-centered care plans. Numerous reentry plans need to be coordinated.

Discussion of Results

- » Sheriffs and probation department interviewees commented that they lacked the expertise and staff to drive this initiative forward and found that having a dedicated CalAIM manager and/or social workers as well as the ECM/Community Supports was helpful.
- » Bringing together relevant stakeholders underscored that significant education, restructuring, and development of workflows were needed to get corrections and health officials and staff on the same page. For example:
 - In one county, the Sheriff and BH differed in how they saw CalAIM working: "To facilitate conversations, we need Wellpath, BH, probation, social services, and jail staff all at the table. Jail has specific criteria to be met – people need to be supervised in jail, you can't be left alone with an inmate. If BH brings people in, will they pay for that supervision?" Interviewees felt a workshop was needed with the Sheriff and BH to say, 'Here are some ways you can work through that,' or 'Here are the best practices, laws, and regulations to do these things.'"
 - Many of the health plans lack experience working with the jails. One interviewee felt it was naïve to think that some MCP ECM providers will have the ability to do in-reach and release planning.
 - A consistently raised issue was that, unlike the prison system, jails do not know in advance the release dates of individuals in their care. For example, one site indicated that fewer than 10% of the people in their jail facilities have set release dates. Interviewees repeatedly raised this as a challenge to

meeting the requirements and objectives of CalAIM. While this was especially true of release medications, it caused issues with other aspects of ensuring coverage for and continuity of services as well.

- Numerous entities are making reentry plans that will need to be coordinated. On the health side, sites have added reentry services under CalAIM. In addition, if someone goes to a mental health court, they will have a reentry plan that is mental health-based. Rehabilitative officers within the Sheriff's Department and probation officers also do reentry planning. The public defender's office may try to support and solidify reentry planning as well. Thus, all these entities may be doing reentry planning for a single individual that requires coordination, with some to be billed under Medi-Cal and others not. Further, in California, pre-trial diversion means some people get out of custody under supervision of a pre-trial monitoring program – these individuals already have someone assigned to work with them and to monitor that they show up to court – and part of that is linkage to care.

Evaluation Question 3b. Did the Waiver improve communication between correctional systems, Medicaid and CHIP systems, managed care plans, and community-based providers?

- » The UCLA-RAND Reentry evaluation team was approved for the qualitative interviews that will ask stakeholders and formerly incarcerated individuals their perceptions of communication in September 2025. Recruitment has begun. Findings will be available in the Mid-Point Assessment.

Evaluation Question 4. How did the Waiver influence investments in health care and related services in carceral settings aimed at improving quality of care and in the community aimed at maximizing successful Reentry post-release?

- » The UCLA-RAND Reentry evaluation team was approved for the qualitative interviews that will ask stakeholders and formerly incarcerated individuals their perceptions of investments in health care and related services in September 2025. Recruitment has begun. Findings will be available in the Mid-Point Assessment.
- » Counties are still in the very early stages of implementing CalAIM, including utilizing the JI Screening Portal and payment. Interviews will capture the

investments in health care services as the counties move forward with providing services.

Evaluation Question 5. Did the Waiver improve connections between carceral settings and community services upon release to address physical health, BH, and health-related social needs?

- » The UCLA-RAND Reentry evaluation team was approved for the qualitative interviews that will ask stakeholders and formerly incarcerated individuals their perceptions of connectedness in September 2025. Recruitment has begun. Findings will be available in the Mid-Point Assessment. Below are preliminary findings from the PATH interviews.

Results

- » The JI Screening Portal is used by correctional facilities to manage member JI 90-day, pre-release services timeframes. The JI Screening Portal validates Medi-Cal eligibility as well as applies JI 90-day, pre-release services eligibility timeframes. The system stores this information and uses it for reporting screening data to CMS. The JI Screening Portal is not designed for billing, obtaining prior authorization, or inquiring into other Medi-Cal eligibility. Instead, it is for activating, terminating, pausing, resetting, or restarting JI 90-day, pre-release services eligibility.
- » The transition from conceptualizing a project to implementation has challenges as illustrated by the JI Screening Portal. The JI Screening Portal was seen as deeply problematic by all of the counties interviewed, requiring manual data entry and not geared toward rapidly shifting jail populations. DHCS recognizes the challenges identified below and recently addressed these issues, for both CDCR and jails.
 - Technology issues also included the need for a new security system in one county.
 - Also cited were interoperability issues with multiple existing reporting systems that do not “talk” to one another.

Discussion of Results

- » The JI Screening Portal has six main features: (1) Activate JI 90-day, pre-release services for a member; (2) Deny JI 90-day, pre-release services for a member; (3) Pause JI 90-day, pre-release services for a member (e.g., temporary stoppage of

90-day, pre-release services because of a qualifying event such as hospitalization within the same episode of incarceration); (4) Reset JI 90-day, pre-release services for a member (i.e., a new set of 90-day, pre-release services after a pause or termination within the same episode of incarceration); (5) Restart JI 90-day, pre-release services for a member (a restart of the remaining days within the same episode of incarceration); and (6) Terminate JI 90-day, pre-release services for a member.

- » The JI Screening Portal was cited as a challenge by all the counties interviewed. Its set up and ongoing use required putting into place the staff and technology to support a laborious, manual process of data entry that required a large amount of staff time and a significant investment to update their electronic health record interfaces.
- » All counties interviewed felt the JI Screening Portal was geared more toward prisons where release dates are known. However, the 90-days pre-release rule does not match the reality for the jail population or youth correctional population where one might not know the release date until the day of release. To address this, one county indicated that if someone is going to stay, for example, 5 days or longer in jail, they activate the JI code a.s.a.p. to make sure that individual has a JI code and not wait for the 90-day release date. "If we know someone is going to stay 5 days or longer, we focus on those individuals to make sure they have a JI code and implement it. We can only go back to reactivate the JI code at the beginning of the month. If we don't catch it in time, we don't get reimbursement. There is no way to retroactively activate a JI code – which is a big deal because then there is no possibility for any kind of billing."
- » Further, the process for inputting a case into the JI Screening Portal to bill for services can be cumbersome as explained below.
 - "The [JI Screening] Portal is used to turn on the JI aid code that allows you to bill for the services that are in the benefit package of the pre-release services. You can't bill for that if the JI aid code is not active during the date and time of service. You can only activate the JI aid code manually, one by one, through the portal, and when you activate it, you can only activate it for up to the 1st of that month that you're actively in the system."
- » Several counties felt that they learned about the JI Screening Portal only after they had already made plans to implement CalAIM. In one case, the county had already

hired additional staff but did not learn from DHCS until later that there are enrollment requirements for staff providing services.

- » Another county was an early implementor and built their implementation plans before the JI Screening Portal existed, assuming it would be an automatic process, but instead learned later on that it required manual data entry.
- » Other technology issues cited included the need for a new security system for one jail system, which CalAIM would help build but with delays. “We’re being required to provide in-reach through BH. We have a small jail with no capacity and outdated capacity. We got approved through the implementation grant a whole new security system for the jail. When we told DHCS, they said, spend \$700,000 on a security system to get people safely in and out of jail for rendering services. Building capacity in our region is time-consuming.”
- » In addition, not surprisingly counties are facing interoperability issues with multiple reporting systems that do not “talk” to one another: “The Sheriff’s Department is mandated to report into one system. BH is required to enter into another system that’s HIPAA compliant. To work together, we need yet another system. Either the current systems need to be modified for what’s mandated or a universal system to take on that communication for all is needed. Interoperability is huge, and data exchange framework is happening but that also takes money and resources.”

Evaluation Question 6a. Did the Waiver provide intervention for certain BH conditions and use stabilizing medications like long-acting injectable anti-psychotics and medications for addiction treatment for SUDs for eligible Medi-Cal members?

- » The UCLA-RAND Reentry evaluation team continue to work with DHCS, CDCR, and county facilities to collect the needed data to evaluate whether the Waiver increased the provision of interventions for certain BH conditions and used stabilizing medications like long-acting injectable anti-psychotics and medications for addiction treatment for SUDs for eligible Medi-Cal members. The Waiver went live at CDCR in February 2025 and is still rolling out across county facilities; at the time of writing, it is too early to evaluate the effectiveness of the policy as data agreements are set up, data access is agreed upon, and enough eligible members have been released to provide early estimates.
- » The UCLA-RAND Reentry evaluation team hypothesize that the Waiver will increase the provision of interventions for certain BH conditions and stabilizing

medications like long-acting injectable anti-psychotics and medications for addiction treatment for SUDs for eligible Medi-Cal members. Readiness assessments require facilities to indicate whether they have processes in place to provide training to incarcerated individuals and staff and education related to both interventions for BH conditions and stabilizing medications such as Medication Assisted Treatment (MAT). We expect that such training and education provision should increase utilization by providers and releasees, and warm hand offs will result in the continued provision of such interventions.

Evaluation Question 6b. Did the Waiver reduce decompensation, suicide-related deaths, overdoses, and overdose-related deaths in the near-term post-release for eligible Medi-Cal members?

- » The UCLA-RAND Reentry evaluation team continue to work with DHCS, CDCR, and county facilities to collect the needed data to evaluate whether the Waiver reduced decompensation, suicide-related deaths, overdoses, and overdose-related deaths in the near-term post-release for eligible Medi-Cal members. The Waiver went live at CDCR in February 2025 and is still rolling out across county facilities; at the time of writing, it is too early to evaluate the effectiveness of the policy as data agreements continue to be set up, data access is agreed upon, and enough eligible members have been released to provide early estimates.
- » The UCLA-RAND Reentry evaluation team hypothesize that the Waiver will reduce decompensation, suicide-related deaths, overdoses, and overdose-related deaths in the near-term post-release for eligible Medi-Cal members. The Waiver is expected to increase health care access and utilization, including substance use-related and BH care treatment. In turn, numerous studies indicate that the utilization of such services is associated with reductions in decompensation, suicide-related deaths, overdoses, and overdose-related deaths⁷⁶⁻⁸⁰.

Evaluation Question 7. Did the Waiver reduce post-release ED visits, inpatient hospitalizations, and all-cause deaths for eligible Medi-Cal members?

- » The UCLA-RAND Reentry evaluation team continue to work with DHCS, CDCR, and county facilities to collect the needed data to evaluate whether the Waiver reduced post-release ED visits, inpatient hospitalizations, and all-cause deaths for eligible Medi-Cal members. The Waiver went live at CDCR in February 2025 and is still rolling out across county facilities; at the time of writing, it is too early to evaluate the effectiveness of the policy as data agreements continue to be set up,

data access is agreed upon, and enough eligible members have been released to provide early estimates.

- » The UCLA-RAND Reentry evaluation team hypothesize that the Waiver will reduce post-release ED visits, inpatient hospitalizations, and all-cause deaths for eligible Medi-Cal members. The Waiver is expected to increase healthcare access and utilization, including substance use-related and BH care treatment. Numerous studies indicate that healthcare access and utilization are associated with reductions in ED visits, inpatient hospitalizations, and all-cause deaths.

G. Conclusion

At the time this Interim Evaluation Report is being prepared, the evaluation team has not yet received quantitative data, nor have they begun conducting qualitative interviews. The qualitative information provided in this Interim Evaluation Report is based on interviews with county stakeholders conducted in collaboration with the PATH team. The data collection process is still in its early stages, and as such, UCLA-RAND's ability to present comprehensive findings is currently very limited. The UCLA-RAND Reentry evaluation team remains actively engaged in ongoing collaboration with DHCS, the CDCR, as well as various county facilities to ensure that all necessary data are gathered in a timely and systematic manner. The Reentry evaluation team expects to secure both quantitative and qualitative data in 2026, which will provide ample time to provide preliminary findings to evaluation research questions in the Mid-Point Assessment report.

The UCLA-RAND Reentry evaluation team is presently in the process of finalizing data requests for both DHCS and CDCR. Once these sites have been confirmed, the UCLA-RAND Reentry evaluation team will move forward with initiating data collection activities in partnership with the selected counties. Recruitment of study participants for qualitative interviews began in September 2025.

In the interim, while awaiting the start of primary data collection, the evaluation team has been involved in PATH interviews. The preliminary insights and information presented in the sections above are drawn from these PATH interviews, providing an initial understanding based on available qualitative data. These findings are intended to inform future phases of the evaluation as more comprehensive data become available. Further, the UCLA-RAND team has worked to develop and refine the cost analysis, worked with subject matter experts to refine the proposed evaluation approach and select the counties

for inclusion in the analysis, and developed and drafted data requests for both DHCS and CDCR.

While the results in this report are limited, the UCLA-RAND team is on track to provide more extensive findings in the Mid-Point Assessment report.

At this point, findings are too preliminary to discuss the outcomes and impacts of the demonstration or determine the effectiveness of the demonstration. Future reports will discuss the outcomes and effectiveness and provide recommendations to better enable such an effort to more fully achieve stated purposes, aims, objectives, and goals.

H. Interpretations, and Policy Implications and Interactions with Other State Initiatives

The Reentry component of the Waiver aligns with the core agenda of Medi-Cal by providing a continuity of eligibility from carceral setting to community. The eligibility determination starts in the pre-release period, then we assign them to a managed care and set up post-release appointments via ECM.. In doing so, the demonstration operationalizes key sections of the State Plan – continuous coverage (§3-C), network access (§4.26), and care coordination (§4.44) – for JI Californians.

The Reentry demonstration is tightly woven into a web of complementary Medicaid initiatives that together advance CalAIM’s vision. First, it acts as an early “on-ramp” to the existing ECM and Community Supports benefits, enrolling JI individuals in care-coordination and other services before they leave prisons/ jails/ juvenile facilities. Second, it is powered by PATH Capacity & Infrastructure grants, which finance electronic data interfaces, care manager staffing, and TA inside prisons, jails, and CBOs. These resources make real-time handoffs technically feasible. These interlocking demonstrations and federal awards create a coherent policy in which the Reentry component can achieve greater coverage, smoother care transitions, and better health outcomes than it could in isolation, while simultaneously generating evidence to inform nationwide Medicaid strategy for carceral transitions.

Several federal grant streams reinforce and will help contextualize the evaluation of the Reentry demonstration. Most directly, SAMHSA’s State Opioid Response (SOR) grants are financing additional community slots for Medication for Opioid Use Disorder (MOUD); managed care plans can draw on this capacity once beneficiaries’ Medi-Cal coverage is unsuspended. At the same time, recent HRSA Health Center Program awards have

expanded FQHCs in underserved areas, creating natural “bridge-appointment” sites that align with ECM pathways. Together, these complementary federal investments amplify the demonstration’s reach and supply critical context for interpreting its impact on access, utilization, and mortality.

While the UCLA-RAND team is yet to access the data needed to assess the effects of the Waiver, the demonstration’s driver diagrams and hypothesized effects point to several likely gains. First, by replacing the old terminate-and-re-enroll approach with an automatic suspension–unsuspension workflow, the Waiver is projected to cut coverage and eligibility gaps. Second, existing studies across health policy, health economics, and health services research consistently demonstrate that Medicaid enrollment leads to substantial improvements in health outcomes. In line with this, it is expected that such improvements will be evident in this context. Finally, several counties as well as CDCR have now “gone live” indicating high levels of readiness and the ability for the UCLA-RAND Reentry evaluation team to access data in a timely manner to evaluate the effects of the Waiver in the near future.

Looking ahead, the evaluation findings will have major implications for California’s longer-term Medicaid strategy. First, if the utilization and outcome metrics confirm the anticipated gains, then continued implementation of reentry services and supports could result in significant improvements in the health and longevity of Californians and improved outcomes of JI populations. Second, cost analyses will identify whether the Waiver is cost-neutral or produces net savings; such analyses could impact decisions regarding “JI” risk-adjustment factors to managed care capitation rates. Third, positive outcomes could justify extending PATH infrastructure grants and codifying care coordination as a permanent network-adequacy requirement, thereby locking in the cross-system data interfaces and workforce investments that have made the demonstration feasible.

Finally, the findings of the evaluation will have significant national impact. In addition to California, 19 states have approved and eight have pending JI Waivers (Washington D.C. also has a pending waiver). Importantly, California is one of the earliest states to implement, and unlike several others, includes juvenile facilities, has varied pre-release service periods, and has differing eligibility criteria. The results from the California evaluation will provide critical context to other states regarding *what works*. The proposed analysis will test whether shorter reentry service periods are as effective, identify whether specific eligible populations benefit more, explore effects for juvenile facilities, and

quantify which eligible populations were most impacted. In doing so, the results of the Waiver will provide a blueprint for which elements are most effective, providing critical context to states with ongoing Waivers, as well as future states that apply for such Waivers from CMS.

I. Lessons Learned and Recommendations

Data are not yet available to evaluate the Waiver (given the CDCR did not go live until February 2025, and numerous counties are yet to go live at the time of writing), making it difficult to provide lessons that have been learned from the evaluation of the Waiver.

Moving forward, the evaluation is set to be able to provide critical lessons learned regarding who is most impacted and when, critical for the development of future demonstrations in other states.

To provide such lessons learned it is critical that county and state entities continue to monitor and support implementation by closely tracking readiness and county-level progress and providing targeted TA to counties experiencing delays or operational barriers. DHCS continues to work with counties to ensure readiness and to provide support where needed. As implementation matures, it is critical that the state prioritizes timely reporting and adaptation based on emerging qualitative and quantitative evidence. The mid-point assessment will provide important insights that can be translated into clear recommendations for ways to improve implementation. While data access is currently limited, the evaluation team was able to utilize early findings from PATH interviews. These interviews indicated that dedicated social workers or CalAIM managers were helpful in establishing steering committees of correctional and health systems and health providers to work together. These collaborative relationships will be critical to the successful implementation of the Waiver and thus dedicated implementation facilitators show promise in ensuring the smooth implementation of the Waiver. Dedicated staff (who are familiar with correctional and health systems) will also assist with the facilitation of hand-offs, having potential impacts on the ability of correctional facilities to facilitate continuity of care at reentry. Finally, early data from PATH interviews provide suggestive evidence that there are some technical issues with the JI Screening Portal, which may result in delays in data sharing. Enhancing data systems such as the JI Screening Portal will ensure smoother transitions for counties as they continue to rollout, and enhanced automation in these systems would limit error.

EVALUATION COMPONENT 5: EVALUATION OF COMMUNITY SUPPORTS

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A. Executive Summary

Background

Community Supports are new services that address eligible Medi-Cal managed care members' HRSNs and include 15 distinct services expected to improve member health and well-being and reduce avoidable ED use, hospitalization, or nursing facility care. Except for Transitional Rent, which will become a mandatory benefit effective January 1, 2026, Community Supports are optional for Medicaid managed care plans (MCPs) to offer, and voluntary for eligible members to receive. Seven of the 15 Community Supports are designed for members experiencing or at risk of homelessness (e.g., Recuperative Care, Housing Transition Navigation Services), while the remaining Community Supports address other HRSN (e.g., Medically Tailored Meals / Medically Supportive Food, Sobering Centers, Asthma Remediation, and ALF Transitions).

Two Community Supports are authorized under California's CalAIM Section 1115 Medicaid Waiver for the period of January 1, 2022, to December 31, 2026, and 12 Community Supports are covered under In Lieu of Services, under managed care plan regulatory authority. An additional Community Support, Transitional Rent, was added in July 2025, authorized under the state's Section 1115 BH Community-Based Organized Networks of Equitable Care and Treatment Waiver (BH-CONNECT).

Evaluation Questions

The Community Supports evaluation examines eight goals, five of which are assessed in this Interim Evaluation Report, related to whether MCP and provider offering of Community Supports and member utilization increased over time and whether receipt of Community Supports resulted in better care and lower costs for members who received them compared to members who did not.

Methodology and Methodological Limitations

UCLA-RAND obtained all available administrative data from DHCS and other relevant sources and gathered primary data through surveys and interviews with MCPs and providers. For the Interim Evaluation Report, quantitative analyses included preparing data for analysis, merging data as needed, and conducting descriptive analyses of Community Supports Quarterly Implementation and Monitoring Reports (QIMRs) and

Medi-Cal eligibility and claims data. Qualitative analyses included coding and developing themes from interviews, narrative reports, and other qualitative data sources.

Key methodological limitations affecting the analyses for the Interim Evaluation Report included delayed access to Medi-Cal eligibility and claims data, which were not available until the end of May 2025; no information in the QIMRs on provider National Provider Identifier(s) for Community Supports users; and lack of a comprehensive database of community-based providers eligible to offer Community Supports.

Results

The Interim Evaluation Report includes preliminary results for Goals 1, 2, 3, 4, and 6, addressed through eight associated evaluation questions and 28 associated measures for the 14 Community Supports included in the Community Supports evaluation.

Goal 1: Increase offering of Community Supports by MCPs

The number of MCPs offering each Community Support and the number of counties in which Community Supports were offered increased between 2022 and 2025. In 2025, six Community Supports were offered by at least one MCP in all 58 California counties (Housing Transition Navigation Services, Housing Deposits, Housing Tenancy and Sustaining Services, Medically Tailored Meals / Medically Supportive Food, Respite Services, and Personal Care and Homemaker Services). The least frequently offered Community Support was Sobering Centers, which was only available in 29 counties.

In 2024 interviews, MCPs described four reasons for offering Community Supports: prior experience offering similar programs or services; MCP and local providers' capacity and readiness; perceived importance of the Community Support in addressing member needs; and perceived cost-effectiveness or financial sustainability of the Community Support. In a 2024 to 2025 MCP survey, the Community Supports rated most highly in terms of perceived value for member health or well-being were Housing Deposits, Recuperative Care, Housing Transition Navigation Services, and Housing Tenancy and Sustaining Services. The Community Supports rated most highly in terms of perceived cost effectiveness were ALF Transitions, Environmental Accessibility Adaptations, Community or Home Transition Services, and Short-Term Post-Hospitalization Housing. ED visits (8.3 visits) followed by Recuperative Care users (5.9 visits), while Medically Tailored Meals / Medically Supportive Food users had the lowest (1.7 visits).

Analyses of co-occurring Community Supports utilization indicated that users of housing-related Community Supports most frequently used other housing-related Community Supports or Medically Tailored Meals / Medically Supportive Food.

In interviews with providers, major factors perceived to affect member utilization included MCP authorization and communication processes, providers' approach to member engagement and service delivery, and members' desire for housing. Presumptive authorization was identified as important to ensure timely access to certain Community Supports (e.g., Sobering Centers, Recuperative Care).

When asked about processes for identifying and referring eligible members for Community Supports, MCPs reported relying primarily on contracted providers. Providers' processes varied by Community Support, with some providers choosing to offer select Community Supports only to prior clients, and others relying on a range of different referral sources in the community. Recuperative Care providers described receiving the majority of referrals from local hospitals or health care systems, while Short-Term Post-Hospitalization Housing providers reported receiving referrals from a wider range of sources (e.g., Recuperative Care providers, local hospitals, MCPs, and other providers).

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

Public investments in housing generally increased between 2015 and 2024. The number of people experiencing homelessness in California grew from 564,708 people in 2015 to approximately 771,500 in 2024. During the same period, U.S. Department of Housing and Urban Development (HUD) funding to local Continuums of Care in California increased from \$337 million to \$683 million, and the total number of recorded Continuums of Care housing program beds for people experiencing homelessness in California increased from 105,107 to 208,794. In addition, properties representing a cumulative total of 193,515 Low-Income Housing Tax Credit (LIHTC) units were awarded tax credits between 2015 and 2024. The proportion of new or preserved LIHTC units allocated for households with incomes less than 30% of the area median income increased from 7% of units in 2015 to 29% in 2024.

In 2024-2025 interviews, MCPs and providers described new Medicaid funding for housing-related Community Supports and from programs like HHIP as helping to improve

integration of care within local communities and supporting rapid development of new, needed services infrastructure in many communities. HHIP funding in particular was used to address upstream housing needs within communities. However, both MCPs and providers indicated that lack of affordable housing remained a problem in many communities. Although providers of housing-related Community Supports described new Medicaid funding as important for supplementing and addressing gaps in existing systems of care, they also described new Medicaid funding as resulting in increased competition between providers and increased administrative burden, and of the need for sufficient volume of members to offset costs of participating in Community Supports.

Goal 6: Improve quality of care and outcomes of care

Limited data were available to address this goal as of the Interim Evaluation Report. Analyses of January 2022 to December 2024 MCP appeals and grievances data as an indicator of member satisfaction indicated that the two Community Supports with the highest number of users, Medically Tailored Meals / Medically Supportive Food and Housing Transition Navigation Services, also had the largest number of appeals and grievances. The three most common reasons for any Community Supports-related grievances were provider or staff attitude, MCP customer service, and timely access to Community Supports.

When asked to rate perceived positive impact of each Community Support on member health and well-being, MCPs rated Housing Deposits the highest (average rating 9.0 out of 10.0) and Day Habilitation the lowest (average rating of 6.6 out of 10.0). Providers rated Community Supports as most effective at improving member access to social services (average rating 4.9 out of 6.0) and as least effective at earlier identification of member needs (average rating 4.4 out of 6.0).

Finally, in assessing the extent to which members receiving housing-related Community Supports were transitioned to other supports, analyses of QIMR data revealed that from January 2022 to September 2024, 35% of Recuperative Care users also received Housing Transition Navigation Services, and that 9% subsequently transitioned to Short-Term Post-Hospitalization Housing. Data also showed that 63% of Short-Term Post-Hospitalization Housing users also received Housing Transition Navigation Services.

Conclusions

Evaluation findings indicated that significant progress was made towards Community Supports Goals 1, 2, and 3, moderate progress towards Goal 4, and some progress towards Goal 6. In addition, results provided evidence that all except one of the Community Supports hypotheses examined were true or likely true based on data available for inclusion in the Interim Evaluation Report ([Exhibit 0.1](#)). For H8b, UCLA-RAND was able to present data on the total number of appeals, grievances, and state fair hearings between 2022 to 2024, but could not assess whether the number of appeals and grievances relative to total Community Supports use decreased over time.

Evidence to examine other evaluation questions and measures was not available for the Interim Evaluation Report due to lack of or delays in access to data. UCLA-RAND anticipates addressing these limitations in the Summative Evaluation Report.

Lessons Learned

- » Community Supports were generally perceived by MCPs and providers as addressing important gaps in care within communities and as supplementing existing systems of care and should be sustained if proven cost-effective.
- » MCPs without prior experience offering services to address members' HRSN required support in how to identify and contract with high-quality service providers and appropriately monitor service quality.
- » MCPs varied in the extent to which they voluntarily contract with community-based providers for HRSN services. If MCPs contracting with community-based providers is a priority, MCPs should be provided with additional incentives or support to do so.
- » Non-local providers were less likely than local providers to report combining Community Supports with other resources or to offer Community Supports as part of a broader continuum of care. Further data collection is needed to understand how this may impact quality and outcomes of care for members. If integration of Community Supports within a broader continuum of care is a priority, this should be clearly communicated to providers and monitored.
- » Low reimbursement rates and high administrative burden within Medicaid were challenging for MCPs and providers and served as a barrier to provider participation and perceived financial sustainability of Community Supports. Adequate funding levels and efforts to reduce administrative burden should be considered.

- » Funding support for provider capacity was critical as it enabled community-based providers to develop the infrastructure and workflows needed to adapt to rapidly changing policy guidance on Community Supports and to meet Medi-Cal billing, compliance, and reporting requirements. Continuing to provide funding through PATH Capacity and Infrastructure, Transition, Expansion, and Development, IPP, or HHIP will be important to providers' ability to implement any major policy changes in the future.
- » Efforts to improve awareness of Community Supports in certain communities and with certain referral partners will be important for increasing utilization of certain Community Supports.
- » Housing Deposits would be more feasible for providers to offer if implemented as part of a flexible housing subsidy pool or if the service included an administrative fee for providers rather than operating on a strict cost reimbursement basis.
- » New Medicaid funding has resulted in rapid growth in Recuperative Care but was also perceived as increasing competition as well as increased referrals of members with more acute or complex care needs. Recuperative Care providers therefore reported less capacity to serve members with less acute needs. Recuperative Care providers also continued to report difficulty serving members who required support with Activities of Daily Living or Instrumental Activities of Daily Living.
- » Clear policy guidance is needed to help MCPs and providers differentiate Medically Tailored Meals / Medically Supportive Food from interventions to address food insecurity. Monitoring the type and quality of intervention being provided to members is also important to assess impact on member health and outcomes.

Recommendations for Other States

Interim Evaluation Report findings have implications for other states implementing or considering implementation of Community Supports as Medicaid benefits to address members' HRSN. Specific recommendations include:

- » Assess whether MCPs have prior experience offering similar benefits. MCPs without prior experience may require preliminary support with pricing guidance, developing provider networks, and with how to assess quality of services to address members' HRSN.
- » Allocate funding to develop provider capacity and infrastructure, particularly if engagement of community-based providers without prior experience billing

Medicaid is important to member engagement or to ensure Community Supports are integrated within existing systems of care.

- » Dedicate time to engage relevant stakeholders and develop clear policy guidance on eligibility criteria, allowable duration or frequency of service use (when applicable), referral processes, authorization, claims submission, and reporting requirements prior to program implementation.
- » Reduce administrative burden on providers where possible.
- » Dedicate resources to increase awareness of these new benefits and their eligibility criteria among providers expected to refer eligible members for services. Certain referral providers, such as skilled nursing facilities and assisted living facilities, may require support in completing referral paperwork once eligible members are identified.
- » Encourage MCPs to allow presumptive authorization for time-sensitive benefits, while ensuring providers are aware of associated financial risks.
- » Implementation of Community Supports to address housing as an HRSN should be accompanied with upstream investment in increasing the supply of affordable housing available.
- » Offering Housing Deposits and other housing-related benefits involving large sums of money should be implemented as part of a flexible housing subsidy pool or include administrative fee for providers rather than operate on a strict cost reimbursement basis.

B. General Background Information

Intervention Context

Medicaid members with complex social and behavioral needs utilize significantly more health care and incur significantly higher health care costs than members without these needs.^{9-11,81} To reduce costs and improve member well-being, DHCS used Section 2703 of the 2010 Patient Protection and Affordable Care Act and the Section 1115 Medicaid Waiver mechanism to conduct two demonstrations completed in 2021 called the Medi-Cal HHP and Medi-Cal Whole Person Care, respectively. These demonstrations illustrated that providing members who have complex medical, behavioral, and/or social needs with care management and other services to address their HRSNs (such as housing navigation or recuperative care) had better health outcomes and lower costs of care than members who did not receive these services.^{2,12}

Following these demonstrations, DHCS chose to sustain and expand services that address members' HRSN using the ILOS option available to Medicaid managed care plans (MCPs) as well as two new Section 1115 Medicaid Waivers. Under ILOS, MCPs can voluntarily choose to offer certain services as medically appropriate and cost-effective substitutes for other covered State Plan services and settings. On December 29, 2021, DHCS received approval from the Centers for Medicare and Medicaid Services to include 12 HRSN services under ILOS as part of the state's CalAIM 1915(b) Medicaid Waiver, for the period of January 1, 2022, to December 31, 2026, and two additional HRSN services under the state's CalAIM Section 1115 Waiver. A 15th service called Transitional Rent was approved as part of the state's BH Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) demonstration under the Section 1115 Medicaid Waiver for the period of January 1, 2025, to December 31, 2029. These 15 services, collectively known as Community Supports under CalAIM, are intended to be broadly available to members, given that approximately 95% of Medi-Cal members are enrolled in managed care.

Community Supports services are expected to improve the health and well-being of MCP members by helping them live healthier lives and avoid higher, costlier levels of care such as ED use, hospitalization, or nursing facility care. Community Supports are being implemented in conjunction with other broad-based delivery system, program, and payment reforms under the CalAIM and BH-CONNECT Section 1115 and 1915(b) Medicaid Waivers and through other initiatives that are collectively focused on making Medi-Cal services more person-centered and coordinated and help members maximize

their health and life trajectory. Other new DHCS programs or Medi-Cal benefits expected to influence Community Supports implementation are summarized in [Exhibit 5.](#)

Exhibit 5.1. Summary of DHCS Programs or Benefits Expected to Influence Community Supports Implementation

Program / Initiative	Brief Description
Providing Access and Transforming Health	\$1.85 billion CalAIM Section 1115 Waiver program (2022-2026) to build the capacity and infrastructure of providers to participate in Community Supports and other CalAIM initiatives. Additional information can be found in the PATH Section of the Evaluation Design (see Section 3).
IPP	\$1.5 billion DHCS program (2022-2024) to support implementation of Community Supports and other CalAIM initiatives by providing incentives to MCPs to support member engagement and service delivery, infrastructure and capacity development, program quality, and equitable service access for members.
HHIP	\$1.2 billion Medicaid Home and Community-Based Services initiative (2022-2024) that allowed MCPs to earn incentive funds for partnering with local Continuums of Care, county BH, public hospitals, and other local stakeholders to invest in addressing homelessness.
Enhanced Care Management	New Medi-Cal benefit implemented within the Managed Care delivery system in January 1, 2022, for eligible members with complex needs to receive comprehensive care management and coordination of health and health-related care services.
Asthma Preventive Services	New Medi-Cal benefit implemented July 1, 2022, for eligible members to receive clinic-based asthma self-management education, home-based asthma self-management education, and in-home environmental trigger assessments.
Community Health Worker benefit	New Medi-Cal benefit implemented July 1, 2022, for eligible members to receive preventive health services, such as prevention and control of chronic conditions and BH, from non-licensed public health workers.
Jl Reentry initiative	New Medi-Cal pre-release and suspension processes, 90-day pre-release services, and BH linkages provided to eligible members who are incarcerated in state prisons, county jails, and

Program / Initiative	Brief Description
	youth correctional facilities to improve continuity of care and access to needed physical, behavioral, and HRSN services upon release.
MCP Transition	2024 changes to MCP models implemented as part of California's CalAIM Section 1115 and 1915(b) Waivers resulted in changes to MCPs contracted to serve members in many California counties. This transition affected which MCPs were eligible to offer Community Supports, which could in turn have impacted Community Supports implementation.

A brief overview of the pre-approved Community Supports and the Medicaid waiver mechanism they are covered under is provided in [Exhibit 5.2](#). Seven of the 15 Community Supports focus specifically on supporting members experiencing or at-risk of homelessness, while the remaining Community Supports address other HRSNs. All of the Community Supports except one are optional for MCPs to offer. Per waiver requirements, Community Supports must supplement and not supplant services received by members through other federal, state, or locally funded programs. Community Supports are also optional for members, meaning MCPs cannot require members to use a Community Support instead of a State Plan service or setting. Detailed eligibility criteria for each Community Support and when applicable, allowable duration or frequency of use, are outlined in [Appendix D](#).

Exhibit 5.2. Approved Community Supports by Waiver Mechanism

Community Support	Brief Description
1115 Waiver	
Recuperative Care* (Medical Respite)	Short-term residential setting for individuals experiencing or at-risk of homelessness with medical needs that would otherwise require institutional care to recover from injury or illness while also obtaining access to primary care, BH, and other supportive social services.
Short-Term Post-Hospitalization Housing* (also known as short-term post-transition housing)	Room and board service for members exiting an institution, experiencing or at-risk of homelessness, and whose ongoing physical or BH needs would otherwise require continued institutional care.

Community Support	Brief Description
Transitional Rent ^{1*}	Up to six months of rental assistance in interim or permanent settings for members experiencing or at risk of homelessness that meet specific clinical and social risk eligibility criteria to provide support needed to connect to long-term housing supports and needed health care.
1915(b) Waiver	
Housing Transition Navigation Services*	Services to assist members with finding, applying for, and obtaining housing.
Housing Deposits*	Assistance with identifying, coordinating, securing, or funding one-time services, goods, or modifications necessary to establish a basic household.
Housing Tenancy and Sustaining Services*	Services to help a member maintain safe and stable tenancy once housing is secured.
Day Habilitation*	Services to assist members with acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in a natural environment.
Medically Tailored Meals / Medically Supportive Food	Services intended to help address members' nutrition-sensitive conditions, such as medically tailored or medically supportive meals or groceries or nutrition education.
Respite Services	In-person, short-term services provided for caregivers of members who live in the community and require intermittent, temporary supervision to avoid institutional placement for which the MCP would be responsible.
Assisted Living Facility (ALF) Transitions (formerly known as nursing facility transition / diversion to assisted living facilities)	Services intended to facilitate member transition from nursing facility back into a home-like, community setting and/or prevent nursing facility admission for members living in the community.
Community or Home Transition Services (formerly known as community transition services / nursing facility transition to home)	Services intended to facilitate member transition from nursing facility or Recuperative Care into a private residence or public subsidized housing.

Community Support	Brief Description
Personal Care and Homemaker Services	Services for individuals who need assistance with Activities of Daily Living or Instrumental Activities of Daily Living to remain in their homes.
Environmental Accessibility Adaptations (Home Modifications)	Physical adaptations to a home necessary to ensure member health, welfare, and safety or avoid institutionalization.
Sobering Centers	Provide members publicly intoxicated (with alcohol and/or drugs) a safe, supportive environment to become sober as an alternative to the emergency room or jail.
Asthma Remediation ²	Supplies and/or physical modifications to a home environment to prevent acute asthma episodes that could result in the need for emergency services and hospitalization.

Source: CalAIM Community Supports Policy Guide Volume 1 and Volume 2, April 2025.^{16,17}

Note: * Indicates Community Support focused on supporting members experiencing or at risk of homelessness.

¹ Transitional Rent was authorized under the BH-CONNECT 1115 Waiver but will be evaluated in the Community Supports Summative Evaluation Report. Because Transitional Rent was not implemented until July 1, 2025, data on this Community Support is not included in this Interim Evaluation Report.

² Effective January 1, 2026, in-home environmental trigger assessments and asthma self-management education can only be provided under Asthma Preventive Services (which became a Medi-Cal state plan benefit on July 1, 2022) rather than as part of Asthma Remediation.

C. Evaluation Questions and Hypotheses

The Community Supports Evaluation examines whether Community Supports achieved its overarching goals as noted in the driver diagram in [Exhibit 5.3](#). The diagram indicates that provision and use of Community Supports will lead to receipt of better care, which will in turn improve member health outcomes and lower costs.

Exhibit 5.3. Driver Diagram for the Community Supports Evaluation

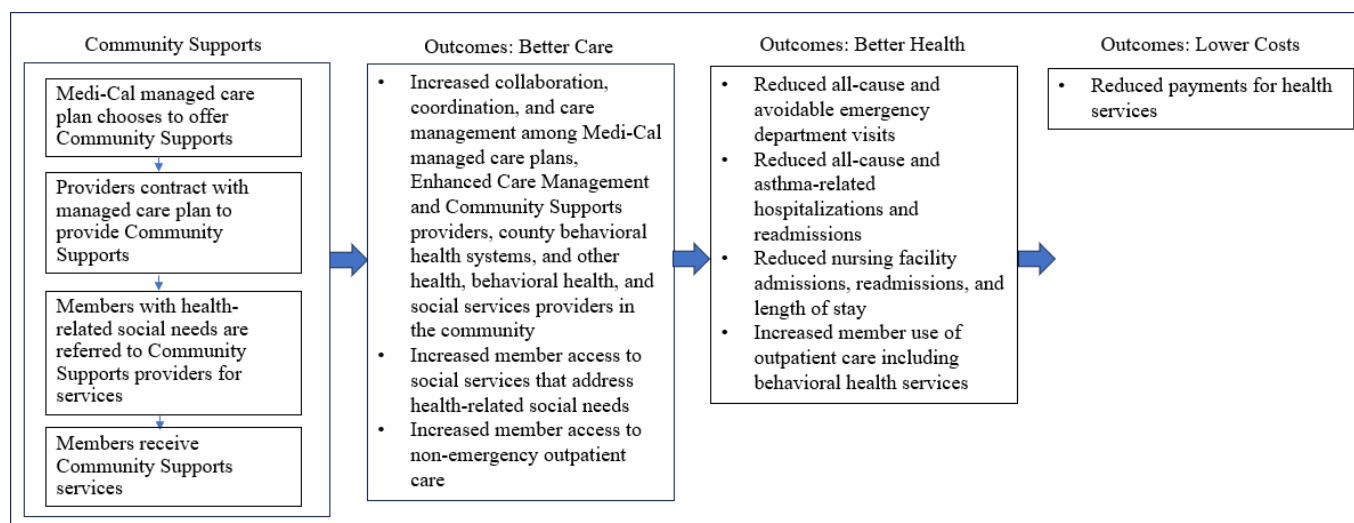


Exhibit 5.4 shows the specific Community Supports program goals and the related evaluation questions, hypotheses, and measures included in the Community Supports Evaluation Design (Section 3). Goals, evaluation questions, and measures addressed in the Interim Evaluation Report are indicated in **bold text**. Results for the remaining goals, evaluation questions, and measures will be included in the Summative Evaluation Report.

Exhibit 5.4. Community Supports Goals and Related Evaluation Questions, Hypotheses, and Measures

Evaluation Questions (EQ) and Hypotheses (H)	Measures
Goal 1: Increase offering of Community Supports by MCPs	
EQ 1. Did the number of MCPs offering Community Supports increase over time? H1: The number of Community Supports offered by MCPs will increase over time.	1. Number of MCPs offering each Community Support 2. Proportion of counties in which each Community Support is offered 3. Proportion of MCPs in each county offering each Community Support 4. MCPs' self-reported reasons for offering or not offering Community Supports

Evaluation Questions (EQ) and Hypotheses (H)	Measures
<i>Goal 2: Increase contracts between providers and MCPs for Community Supports services</i>	
EQ2: Did the number and diversity of providers contracted to provide Community Supports increase over time? H2: The number and diversity of providers contracted to provide Community Supports will increase over time	1. Number of providers contracted to provide each Community Support 2. Number of providers providing multiple Community Supports 3. Ownership and types of providers contracted to provide each Community Support
EQ3: What factors influence provider participation in Community Supports? H3: Provider capacity and infrastructure and local service availability and need will influence provider participation in Community Supports	1. Providers' self-reported reasons for contracting or not contracting with MCPs to provide Community Supports - MCPs and providers' perceptions of whether the number of eligible and contracted providers are sufficient to meet service need
<i>Goal 3: Increase utilization of Community Supports by eligible members</i>	
EQ4: Did the number of members receiving Community Supports increase over time? H4a: The number of members receiving Community Supports will increase over time. H4b: Members with housing-related needs will receive more than one Community Support to address these needs.	1. Proportion of eligible members that are authorized for and subsequently utilize Community Supports 2. Number and types of Community Supports used 3. Frequency* and duration of Community Supports use - Number and proportion of eligible members that used each Community Support 5. Demographic and health characteristics of Community Supports users compared to the population of non-users eligible for services 6. Proportion of members with housing

Evaluation Questions (EQ) and Hypotheses (H)	Measures
	needs that receive more than one Community Support simultaneously 7. Most frequently co-occurring Community Supports 8. Demographic and health characteristics of members receiving more than one Community Support, relative to members receiving only one Community Support 9. MCPs and providers' perceptions of factors affecting member utilization of Community Supports
EQ5: What strategies are being used to identify and refer eligible members to Community Supports? H5: Members will primarily be connected to Community Supports via community-based provider referrals	1. MCPs and providers' self-reported processes for identifying members eligible for Community Supports and connecting them to services 2. Member self-reports of mechanisms for learning about how their Community Supports needs can be recognized and addressed: family, community organizations, primary care provider, specialty care** 3. Member self-report of who, how, and when MCP or provider offered information about options for managing their needs and/or how Community Supports might address their needs** 4. Member self-reports of number, types, and timing of exposure to and use of different types of Community Supports**
<i>Goal 4: Examine whether and how public investments in housing and other HRSN services change over time in concert with new Medicaid funding for those services</i>	
EQ6: How is new Medicaid funding for Community Supports impacting existing systems of care? H6: Medicaid funding for Community	1. Number of people experiencing homelessness in California, 2015-2024 2. U.S. Department of Housing and Urban Development funding to Continuums of Care in California, 2015-2024

Evaluation Questions (EQ) and Hypotheses (H)	Measures
Supports will be perceived as complementing state and local investments in housing and other HRSN services	3. Continuum of Care Homeless Assistance Program Housing Inventory, California, 2015-2024 4. Low-Income Housing Tax Credit housing units, California, 2015-2024 5. MCP and provider perceptions of how new Medicaid funding for Community Supports has impacted existing systems of care, including non-Medicaid funding for similar supports or services 6. MCP and provider descriptions of how they are using new Medicaid funding in concert with state and local investments in housing or other social services to address member needs
<i>Goal 5: Increase members' access to outpatient care including BH services and reduce acute care utilization and long-term care admission and stays</i>	
EQ7a. Will Community Supports affect member access to outpatient care? H7a: Members receiving Community Supports will use more outpatient services than members who do not	1. Primary care visits 2. Specialty care visits 3. Mental health services 4. Substance use disorder services 5. Member self-report of downstream impact of receiving Community Supports (e.g., on finances and access to needed health care)**
EQ7b. Will Community Supports reduce avoidable acute care utilization or long-term care stays? H7b: Members receiving Community Supports will experience greater reductions in avoidable acute care utilization and long-term care stays than members who do not	1. Emergency department visits (total; needed, preventable, primary care treatable, non-emergent; mental health-related, alcohol-related or substance-use related) 2. Hospitalizations (total, from emergency department, potentially avoidable) 3. Long-term care stays 4. Housing stability (as feasible)

Evaluation Questions (EQ) and Hypotheses (H)	Measures
Goal 6: Improve quality and outcomes of care	
EQ8: Are members satisfied with Community Supports referral processes and services? H8a: Members who receive Community Supports will be satisfied with services H8b: Member dissatisfaction with services, as indicated by number of appeals and grievances for each Community Supports relative to total service use, will decrease over time	1. Volume of appeals and grievances for each Community Support 2. Reasons and resolution status for appeals and grievances 3. MCPs' self-reported perception of Community Supports' effectiveness at addressing members' identified HRSN 4. Providers' self-reported perception of Community Supports' effectiveness at addressing members' identified HRSN 5. Members' self-reported knowledge and satisfaction with anticipated and actual Community Supports received**
EQ9: Following receipt of housing-related Community Supports, are members being transitioned to other appropriate supports, when needed? H9: The proportion of members transitioned to appropriate HRSN supports will increase over time	1. Proportion of members receiving Recuperative Care that transition to Short-Term Post-Hospitalization Housing 2. Proportion of members receiving Recuperative Care or Short-Term Post-Hospitalization Housing that receive housing transition navigation supports 3. Proportion of members receiving housing navigation, Housing Deposits, Recuperative Care, or Short-Term Post-Hospitalization Housing that subsequently receive other public housing assistance
EQ10: Will Community Supports improve quality and outcomes of health care? H10a: Community Supports will improve member receipt of appropriate care	1. Initiation and engagement of alcohol and other drug dependence treatment 2. Follow-up after emergency department visit for alcohol and other drug abuse or dependence 3. Health Equity and Quality Measure Set and Healthcare Effectiveness Data and Information Set measures not already in

Evaluation Questions (EQ) and Hypotheses (H)	Measures
H10b: Community Supports will reduce member receipt of avoidable care H10c: Community Supports will promote maintenance of member function H10d: Community Supports will reduce cause-specific complications	the Health Equity and Quality Measure data set, e.g., A1C control for patients with diabetes and blood pressure control for those with a history of high blood pressure or high risk of coronary artery disease 4. Receipt of medications / adherence to recommended medications (based on medication fill rates for chronic conditions) 5. Overall summary quality metric(s) based upon the full set of measured quality metrics 6. Maintenance of function 7. Mortality 8. Cause-specific complications 9. Provider and member self-report of appropriate care processes (as needed and feasible)
<i>Goal 7: Reduce disparities in service utilization, quality of care, and outcomes of care</i>	
EQ11: Are there disparities in Community Supports utilization based on member demographic characteristics, health conditions, or community characteristics? H11: Community Supports utilization will be higher in urban communities, communities with street medicine programs, and among members with English as preferred language	1. Number and type of Community Supports used, stratified by member housing status, demographic and health characteristics, and geographic indicators 2. Proportion of eligible members that used Community Supports, stratified by member housing status, demographic and health characteristics, and geographic indicators
EQ12: Will Community Supports impact disparities in downstream physical or behavioral health service utilization, quality of care, or outcomes of care?	1. Select measures from Goals 5-6, stratified by member demographic and health characteristics and geographic indicators 2. MCPs and providers' self-reported participation in health equity initiatives or

Evaluation Questions (EQ) and Hypotheses (H)	Measures
H12a: Community Supports will reduce age, sex, racial/ethnic, linguistic, and functional (disability) disparities in downstream physical or behavioral health service utilization, quality of care, and outcomes of care H12b: Community Supports will reduce disparities in physical or behavioral health services utilization and outcomes of care for individuals experiencing homelessness	other efforts to improve health equity (as feasible) 3. Member self-report of discrimination or disparities**
Goal 8: Ensure Community Supports are cost-effective alternatives to State Plan services or settings	
EQ13: Will Community Supports impact cost of care? H13: Community Supports are cost-effective alternatives to State Plan services or settings	1. Estimated change in Medi-Cal payments for services such as emergency department visits, hospitalizations, and long-term care stays for members utilizing Community Supports

Note: * Frequency will only be assessed for services that can be offered more than once per demonstration or lifetime. **Member surveys will only assess Section 1115 Medicaid Waiver-authorized Community Supports. Goals, evaluation questions, and measures addressed in the Interim Evaluation Report are indicated in **bold text**.

Evaluation questions and hypotheses promote the objectives of Title XIX and Title XXI by assessing whether addressing members' HRSNs improved their health outcomes and was cost-effective. In evaluating the impact of Community Supports, UCLA-RAND will consider Community Supports to have successfully met its goals under the following circumstances:

- » Increased member utilization of Community Supports
- » Increased Community Supports users' access to outpatient care including BH services and reduced member utilization of avoidable acute care or long-term care admissions and stays relative to the comparison group

- » Improvement in at least some indicators of quality or outcomes of care for Community Supports users relative to the comparison group
- » Reduced utilization of health care and associated payments for Community Supports users relative to eligible non-users

D. Methodology

For the Interim Evaluation Report, UCLA-RAND conducted cross-sectional studies of Community Supports implementation approaches used by Medicaid managed care plans (MCPs) and providers and trend analyses of MCP and provider participation in Community Supports, of Community Supports users, and of whether and how public investments in housing change over time in concert with new Medicaid funding for these services. For the Summative Evaluation Report, UCLA-RAND will also conduct a cross-sectional study of member satisfaction and experiences with the two 1115 Community Supports and will utilize quasi-experimental approaches to assess Community Supports' impact on users' utilization of care, quality and outcomes of care, and cost.

Data Sources and Methods

UCLA-RAND used multiple qualitative and quantitative data sources to address the Community Supports evaluation questions in this Interim Evaluation Report. [Exhibit 5.5](#) provides an overview of data sources, time period, and analytic methods.

UCLA-RAND searched for and obtained all available administrative data from DHCS and other relevant secondary data sources to respond to the evaluation questions. As needed, UCLA-RAND also gathered primary data to understand the implementation process and perspectives of MCPs and Community Supports providers regarding factors affecting participation in Community Supports and to identify challenges, solutions, and lessons learned. UCLA-RAND analyzed all data using appropriate qualitative and quantitative methods. For the Interim Evaluation Report, qualitative analytic methods included coding and thematic analysis of salient documents and MCP and provider interview transcripts in the qualitative software NVivo. Quantitative analysis included preparing data for analysis, merging data as needed, and conducting descriptive analyses.

Exhibit 5.5. Data Sources and Related Methods for the Community Supports Interim Evaluation Report

Data Source	Time Period and Related Details	Analytic Methods
Primary Data Collected by UCLA-RAND		
Semi-structured Interviews with MCPs	Conducted from July to September 2024. Interviewed 101 individuals in 23 of 24 MCPs eligible to offer Community Supports in 2024. AIDS Healthcare Foundation was not interviewed. One MCP that stopped operating as a Medi-Cal MCP in January 2024 was jointly interviewed with the MCP that took over its service area.	Thematic analysis to describe MCP perspectives and lessons learned.
MCP Survey	Cross-sectional survey conducted from November 2024 to January 2025. Survey was distributed to 23 of 24 MCPs eligible to offer Community Supports in 2024. AIDS Healthcare Foundation was not surveyed. One MCP that fully delegated responsibility for member care to another MCP did not respond to the survey.	Descriptive analysis to describe MCP implementation processes and perspectives.
Semi-structured Interviews with ECM and Community Support Providers	Interviewed 128 people in 60 Community Supports provider organizations from October 2024 to July 2025. Provider organizations were purposively sampled for diversity in type(s) of Community Supports provided, MCP(s) contracted with, provider type, and region(s) in which services were offered.	Thematic analysis to describe provider perspectives and lessons learned in implementing Community Supports.
Semi-structured Interviews with PATH Collaborative Planning and	Conducted 10 interviews with 34 people in CPI facilitators and/or TA Marketplace Vendor	Thematic analysis of perspectives and lessons learned regarding PATH

Data Source	Time Period and Related Details	Analytic Methods
Implementation (CPI) initiative Facilitators and PATH TA Marketplace Vendors	organizations from January to April 2025. Interviewed all CPI facilitators, six of whom were also TA Marketplace vendors; also interviewed an additional TA Marketplace vendor not involved with PATH CPI.	and Community Supports implementation.
ECM and Community Supports Provider Survey	Cross-sectional survey conducted from June to July 2025. Survey was distributed to ECM and Community Supports providers contracted to provide services as of May 2025 (206 respondents who provide Community Supports as of 07/31/25). Survey was distributed by DHCS, MCPs, CPI facilitators, and other partners in contact with contracted providers.	Descriptive analysis to describe provider implementation processes and perspectives.
<i>Secondary Data</i>		
National Plan and Provider Enumeration System National Provider Identifier (NPI) Registry	Publicly available directory of all active NPI records. NPIs are unique identification numbers for providers that must be used in administrative and financial transactions under the Health Insurance Portability and Accountability Act.	Data were merged with Quarterly Implementation and Monitoring Reports (QIMR) data and with Medi-Cal claims to identify provider names.
GuideStar	2024 database identifying Internal Revenue Service-recognized tax-exempt organizations to identify providers that are private non-profit organizations, supplemented by manual search of provider websites for ownership status data.	Data were merged with QIMR data for descriptive analysis of provider ownership status.

Data Source	Time Period and Related Details	Analytic Methods
U.S. Department of HUD data	Continuum of Care Homelessness Point in Time counts; Homeless Assistance Program Housing Inventory; and awards (2015 to 2024).	Descriptive analysis of homelessness in California and use of U.S. Department of HUD funds.
California Tax Credit Allocation Committee (CTAC) data	LIHTC data (2015 to 2024) used to identify the number of new or preserved units allocated for affordable housing, overall and for households with incomes less than 30% of Area Median Income (AMI) ²⁴ . The latter units principally serve people at risk of or experiencing homelessness or seniors on fixed incomes. ⁸²	Descriptive analysis of LIHTC units in California.

24 LIHTC data provides two levels of federal tax credits (9% and 4%) to investors, reducing their federal tax bill, in exchange for equity that can be used to build or preserve affordable housing. This equity reduces the amount of money a developer has to borrow to construct or acquire and rehab the property, which in turn reduces rent levels. LIHTC regulations require that rents are set at levels affordable to households earning between 50% to 60% of Area Median Income (AMI), but developers commonly layer in other subsidy sources that allow them to lower the rents even further.⁸² Kneebone E, Reid C. *The Complexity of Financing Low-Income Housing Tax Credit Housing in the United States*. 2021.

<https://ternercenter.berkeley.edu/wp-content/uploads/2021/04/LIHTC-Complexity-Final.pdf>

Tax credits are awarded through a competitive process, with the state setting its housing policy priorities through a Qualified Allocation Plan that determines which tax credit applications will be prioritized for funding. In recent years, California has prioritized the development of PSH within its LIHTC program. State investments in programs such as No Place Like Home and the Veterans Housing and Homelessness Prevention Program, as well as local bond measures such as Los Angeles's Measure HHH, have also provided deeper subsidies, allowing developers to include PSH units in their developments.⁸³ Reid C. *Permanent Supportive Housing as a Solution to Homelessness: The Critical Role of Long-Term Operating Subsidies*. 2023. <https://ternercenter.berkeley.edu/wp-content/uploads/2023/06/PSH-Paper-June-2023-Final.pdf>

Data Source	Time Period and Related Details	Analytic Methods
Administrative Data Provided by DHCS		
Quarterly Implementation and Monitoring Reports	Quarterly data submitted by MCPs to DHCS from January 2022 to September 2024. Data include lists of contracted providers, Community Support users, and dates of service.	Data were used for descriptive analysis of provider participation in Community Supports and were further merged with Medi-Cal eligibility and claims data for descriptive analysis of Community Support users.
Medi-Cal Eligibility and Claims Data	Data on member enrollment, demographics, and health care utilization from January 2020 to December 2024.	Data were used for descriptive analysis of demographics, health conditions, and health care utilization of Community Support users.
MCP Community Supports Elections	Data on MCPs electing to offer each Community Support in each county in 2022 and 2025.	Data were used for descriptive analysis of MCP participation in Community Supports.
Community Supports Policy Guides	Available in 2023, 2024, and 2025.	Used to identify changes in Community Supports eligibility criteria and policies.
PATH CITED (Capacity and Infrastructure Transition, Expansion, and Development) funding applications and list of awardees	Available for PATH CITED Rounds 1-3 (2022 to 2024).	Data were merged with QIMR data for descriptive analysis of provider ownership.
HHIP Investment Plans	Data on HHIP investment plans submitted in 2022.	Document analysis of how MCPs planned to work with local Continuums of Care and other stakeholders in the community to make investments and progress

Data Source	Time Period and Related Details	Analytic Methods
		in addressing homelessness and in keeping people housed.

E. Methodological Limitations

There were several limitations related to program implementation process, content and availability of data, and methodological barriers to analysis, summarized in [Exhibit 5.6](#).

Exhibit 5.6. Summary of Methodological Limitations

Limitation Type	Description
Program Implementation Process	» Findings presented in the Interim Evaluation Report only reflect the first three years of Community Supports implementation and only contain analyses feasible given availability and content of data during this time and cannot be considered conclusive. » Medical managed care plans (MCPs) could elect to offer new Community Supports every six months and to discontinue Community Supports annually. MCPs contracted to serve members in each county could also change annually. As a result, Community Supports were offered by different MCPs in different counties over time, resulting in potential imprecision in analyses of Community Supports providers and users. » DHCS policy guidance around Community Supports changed each year. Changes in policies such as eligibility criteria and allowable duration of services can contribute to potential imprecision in analyses of trends in ECM and Community Supports use and users. » ECM implementation was phased in by POF and by county and MCP prior participation in Whole Person Care or Medi-Cal Health Homes Program. Additional information about this timeline is available in the PATH Interim Evaluation Report. Timing of ECM implementation could have influenced timing

Limitation Type	Description
	of Community Supports implementation and thus number of users over time.
Content and Availability of Administrative Data Provided by DHCS	» Medi-Cal eligibility and claims data were not available until the end of May 2025. The data were quite large and required extensive quality checks and processing. Delays in receipt of these data meant that certain evaluation questions could not be addressed in the Interim Evaluation Report (e.g., health care utilization changes, quality of care, and costs associated with health care utilization). » Quarterly Implementation and Monitoring Reports (QIMR) data did not include information on provider National Provider Identifiers (NPIs) per Community Supports user. Thus, UCLA-RAND was not able to use these data to determine which providers were serving which members. For the Summative Evaluation Report, UCLA-RAND will link QIMR data on Community Supports users with Medi-Cal claims data to determine provider NPIs per user. » QIMR data did not include provider names, only provider NPIs. Providers can have multiple NPIs as they may use a unique NPI per facility or location. Therefore, UCLA-RAND was not able to determine the number of unique provider organizations being contracted. UCLA-RAND attempted to use DHCS-provided NPI directory data to link NPI to organizational names, but this process was prone to significant error. NPIs that could not be identified in the NPI Registry were shared with DHCS and are expected to be reconciled for the Summative Evaluation Report. » Reliance of some providers on community care hubs, management support organizations, or other centralized administrative entities to contract with MCPs and process Medi-Cal billing and claims could result in under-reporting of the number of providers participating in CalAIM and imprecision in assessment of provider types, as the provider

Limitation Type	Description
	contracted with the MCP might not be the provider actually delivering services to Community Supports users. » Administrative or secondary data were not available to UCLA-RAND team to construct a quantitative measure that precisely matched DHCS' definition of a "community-based provider." Data were not available to identify Community Supports providers that had prior experience serving Medi-Cal populations or were already embedded in local health and social services ecosystems prior to CalAIM. Instead, UCLA-RAND used available quantitative data on provider ownership status and type as a proxy, and perceived impact of prior experience with Medi-Cal population(s) and embeddedness in local service ecosystems were assessed qualitatively. » There were discrepancies in provider types and categories reported by MCPs in the QIMRs and provider type self-reported in PATH Capacity and Infrastructure, Transition, Expansion, and Development applications and identified using other DHCS-provided administrative data that could not be reconciled in time to include in the Interim Evaluation Report.
Content and Availability of Primary Data	» QIMR data did not include provider names or contact information. Thus, UCLA-RAND could not directly contact Community Supports providers for participation in interviews or the survey and instead needed to rely on MCPs, DHCS, and other sources (e.g., contacts in statewide professional associations or at the California Health Care Foundation) to assist with initial outreach. Particularly for the survey, this could have resulted in some eligible providers not receiving the survey and negatively affected survey response rate and accuracy of calculated survey response rates. » When conducting qualitative interviews, UCLA-RAND purposively sampled Community Supports providers to ensure variation in type(s) of Community Supports provided, MCP(s) contracted with, county(ies) served, and provider types. Although UCLA-RAND prioritized Section 1115 Waiver-

Limitation Type	Description
	authorized services, achieving saturation in themes, these dimensions resulted in a longer data collection time frame than previously anticipated, with some interviews still being conducted in July 2025. Therefore, information reported from interviews in the Interim Evaluation Report is limited due to lack of time for in-depth analysis and reporting. More information will be included in the Summative Evaluation Report. » The provider survey was purposefully designed to follow up on themes identified in qualitative interviews and was therefore not developed until after most provider interviews were completed, in late April 2025. Additional time needed for review and approval from DHCS meant the survey was not fielded until mid-June 2025. To allow adequate response time, the survey remained open until end of July 2025. This timeline, coupled with lag in release of 2025 Quarter 2 QIMR data, negatively impacted UCLA-RAND's ability to comprehensively analyze all survey data for the Interim Evaluation Report and to link data on provider names to provider NPIs to calculate an accurate response rate. More in-depth analysis and adjusted response rates will be included in the Summative Evaluation Report.
Content and Availability of Secondary Data	» Homeless Point-in-Time Count data used to track trends in people experiencing homelessness in California were not available in 2021 due to pandemic-related disruptions and were omitted from relevant Exhibits. These data are also subject to certain limitations,⁷ such as variability across local Continuums of Care in how counts are conducted and only counting individuals at a specific point in time and may not accurately reflect all people experiencing homelessness. UCLA-RAND will utilize other approaches for identifying members experiencing homelessness in the Summative Evaluation Report. » Continuums of Care Homeless Assistance Program Housing Inventory are the best available source of data on housing

Limitation Type	Description
	available to people experiencing homelessness in a specified geographic area but may not comprehensively reflect all homeless support services and housing resources available. » California Tax Allocation Credit Committee data on Low Income Housing Tax Credit units do not reflect all affordable housing within California. » There is no database that comprehensively identifies all social services providers or nonprofit CBO, making it difficult to identify the “universe” of providers that could be eligible to contract with MCPs for Community Supports. For the Summative Evaluation Report, we will rely on multiple data sources (e.g., UDS on federally qualified health centers, National Center for Charitable Statistics (NCCS) data on nonprofit organizations, California Department of Health Care Access and Information facility data, and California Homeless Data Integration System data on homeless support providers) to identify a potential universe of providers eligible to contract for Community Supports. This process will be highly manual and subject to error, and it will only be conducted after December 2026 when complete data are available for the inclusion in the Summative Evaluation Report. » Provider ownership status was constructed in 2024 through a lengthy and highly manual process that is subject to error and is not easily replicable. This process will be repeated after December 2026 when complete data are available for inclusion in the Summative Evaluation Report.
Methodological Barriers	» All interview and survey data used in the Interim Evaluation Report are subject to recall and acquiescence bias. » Provider interview data have high internal validity, but results may not be generalizable. » UCLA-RAND used QIMR data to identify ECM and Community Supports users in Medi-Cal eligibility and claims data rather than Healthcare Common Procedure Coding System codes and associated modifiers. QIMR data allow for identification of

Limitation Type	Description
	Community Supports services approved and provided, while claims data only include adjudicated claims for provided, resulting in potential discrepancies in numbers Community Supports users between the two data sources. » UCLA-RAND’s preliminary assessment of concordance between provider NPIs in the QIMRs and Medi-Cal eligibility and claims data in June and July 2025 revealed significant discordance that needed to be reconciled through further, iterative discussions with DHCS and MCPs for the Summative Evaluation Report. This discordance could result in imprecision in findings on users in the Interim Evaluation Report. » Some measures needed to be modified for the Interim Evaluation Report because originally planned data or methods were not feasible. Modifications are noted in the appropriate results sections, along with justification.

F. Results

Goal 1: Increase offering of Community Supports by MCPs

Goal 1 is addressed with one Evaluation Question and four measures articulated in the [Evaluation Questions and Hypotheses](#) sections of this report. Data sources used in analyses are articulated for each measure.

Evaluation Question 1: Did the number of MCPs offering Community Supports increase over time?

Measure 1. Number of MCPs offering each Community Support

Data sources: July 2022 and January 2025 Community Supports elections by Medicaid managed care plans (MCPs).

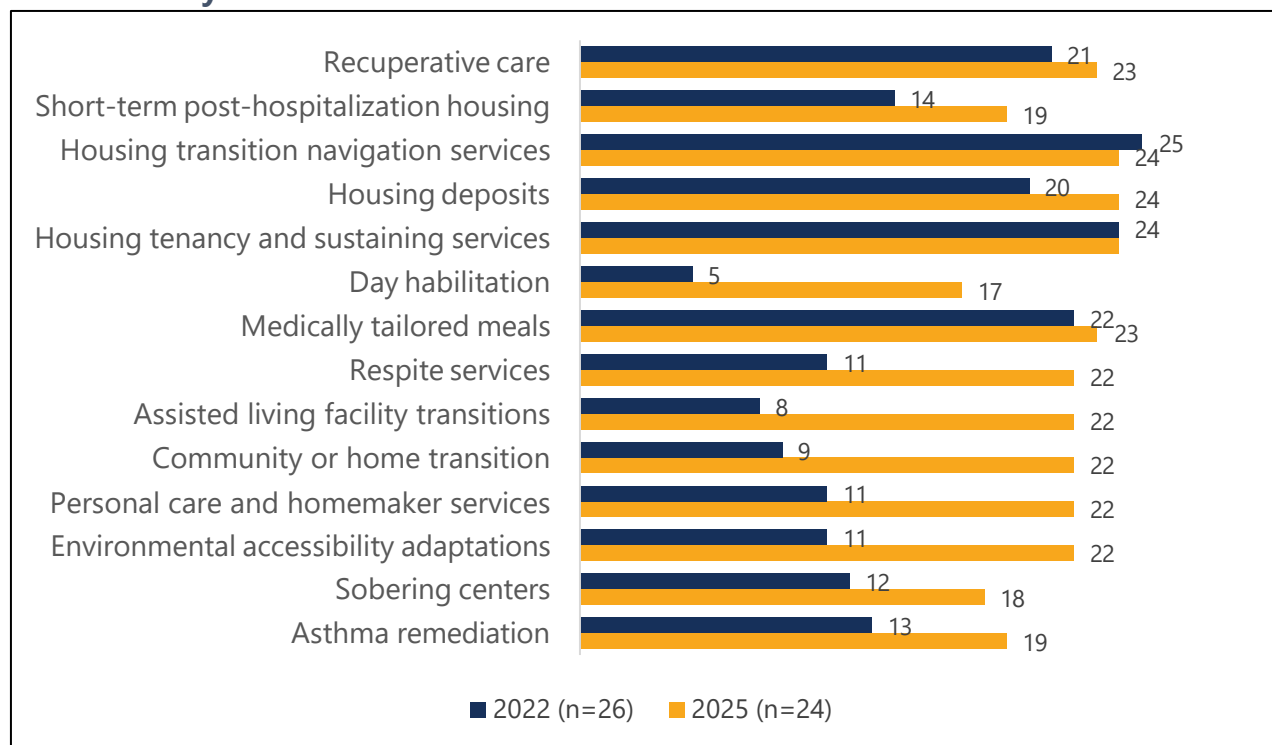
As noted in the [Background](#) section of this report, MCPs can choose whether to offer Community Supports. Goal 1 assesses the extent to which MCPs have elected to offer Community Supports, and in which counties, over time. California has a county-based

managed care system, which means the MCPs contracted by DHCS to serve Medi-Cal members can vary by county (see [Appendix E](#) for additional information).

[Exhibit 5.7](#) shows the number of MCPs in July 2022 and January 2025 that offered each Community Support in at least one county they operated in. In 2022, most of California’s 26 MCPs offered Recuperative Care (21), Housing Transition Navigation Services (25), Housing Tenancy and Sustaining Services (24), and Medically Tailored Meals / Medically Supportive Food (22). However, very few MCPs offered Day Habilitation (5), ALF Transitions (8), and Community or Home Transition Services (9). By 2025, most of California’s 24 MCPs were offering Community Supports in at least one county they operated in; the least frequently offered Community Supports were Day Habilitation (18) and Sobering Centers (19).

Additional analysis (data not shown) indicated that the average number of Community Supports offered by each MCP increased from 7.6 Community Supports in 2022 to 12.0 Community Supports in 2025.

Exhibit 5.7. Number of Managed Care Plans Offering Community Supports, July 2022 and July 2025



Source: Community Supports Elections by Managed Care Plans, July 2022 and January 2025.

Note: MCPs can offer new Community Supports every 6 months in January and July and can stop offering any Community Support annually. MCPs contracted to provide services in each county can change annually. In 2022 there were 26 MCPs and in 2025 there were 24 MCPs. Additional information about California's county-based managed care system is available in [Appendix E](#). Recuperative Care and Short-Term Post-Hospitalization Housing were offered under a 1115 Waiver and the remaining Community Supports in this Exhibit were offered under a 1915(b) Waiver. Medically tailored meals = Medically Tailored Meals / Medically Supportive Food.

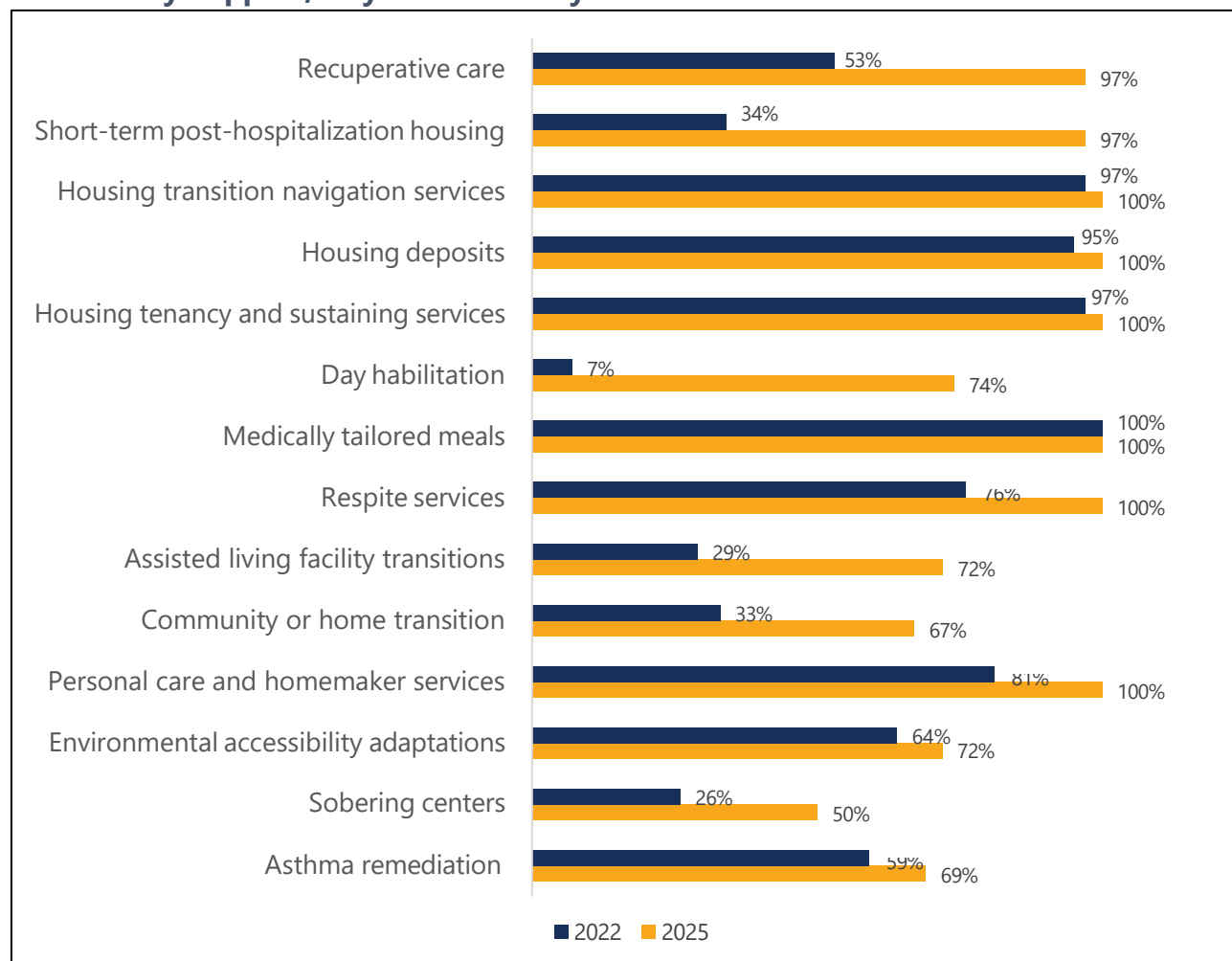
Measure 2. Proportion of counties with MCPs offering each Community Support

Data sources: July 2022 and January 2025 Community Supports elections by MCPs.

[Exhibit 5.8](#) shows the proportion of all 58 California counties where specific Community Supports were offered by at least one MCP in the county. In 2022, the Community Supports offered by the highest proportion of counties were Housing Transition Navigation Services, Housing Deposits, Housing Tenancy and Sustaining Services, and Medically Tailored Meals / Medically Supportive Food (95% to 100%). Approximately 53% of counties offered Recuperative Care and 34% offered Short-Term Post-Hospitalization Housing. The least frequently offered Community Support was Day Habilitation, which was only available in 7% of counties.

The proportion of counties in which at least one MCP offered each Community Support increased in 2025. In 2025, 97% of counties had at least one MCP offering Recuperative Care and Short-Term Post-Hospitalization Housing. The least frequently offered Community Support in 2025 was Sobering Centers (offered by at least one MCP in 50% of counties).

Exhibit 5.8. Proportion of Counties with Managed Care Plans Offering Each Community Support, July 2022 and July 2025



Source: Community Supports Elections by Managed Care Plans, July 2022 and July 2025.

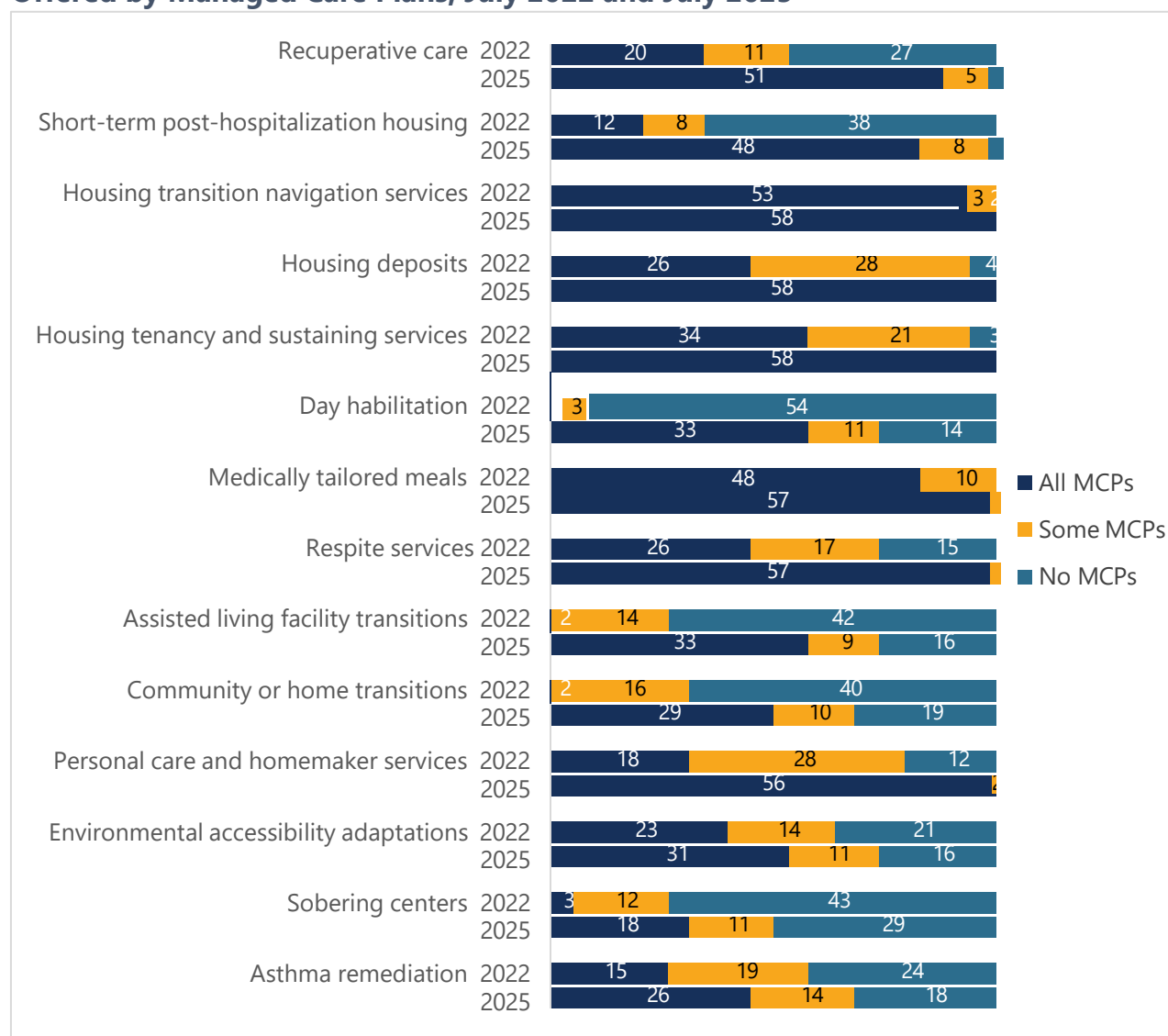
Note: MCPs can offer new Community Supports every six months in January and July and can stop offering any Community Support annually. MCPs contracted to provide services in each county can change annually. In 2022 there were 26 MCPs and in 2025 there were 24 MCPs. Additional information about California's county-based managed care system is available in [Appendix E](#). In 2024, ten of 24 MCPs in California operated in two or more counties. Recuperative Care and Short-Term Post-Hospitalization Housing are offered under a 1115 Waiver and the remaining Community Supports in this Exhibit are offered under a 1915(b) Waiver. Medically tailored meals = Medically Tailored Meals / Medically Supportive Food.

Measure 3. Proportion of MCPs in each county offering each Community Support

Data sources: July 2022 and January 2025 Community Supports elections by MCPs.

[Exhibit 5.9](#) illustrates the number of counties in which all, some, or no MCPs offered specific Community Supports in 2022 and 2025. Data showed that the proportion of counties where all operating MCPs offered specific Community Supports increased from 2022 to 2025. For example, the number of counties where Recuperative Care was offered by all MCPs increased from 20 counties in 2022 to 51 counties in 2025, while the number of counties in which all MCPs offered Short-Term Post-Hospitalization Housing increased from 12 counties in 2022 to 48 counties in 2025.

Exhibit 5.9. Number of Counties Where All, Some, or No Community Supports Were Offered by Managed Care Plans, July 2022 and July 2025



Source: Community Supports Elections by Managed Care Plans, July 2022 and July 2025.

Note: MCPs can offer new Community Supports every six months in January and July and can stop offering any Community Support annually. MCPs contracted to provide services in each county can change annually. In 2022 there were 26 MCPs and in 2025 there were 24 MCPs. Additional information about California's county-based managed care system is available in [Appendix E](#). In 2024, ten of 24 MCPs in California operated in two or more counties. Recuperative Care and Short-Term Post-Hospitalization Housing are offered under a 1115 Waiver and the remaining Community Supports in this Exhibit are offered under a 1915(b) Waiver. Medically tailored meals = Medically Tailored Meals / Medically Supportive Food.

Measure 4. MCPs’ self-reported reasons for offering or not offering Community Supports

Data sources: July to September 2024 MCP interviews; November 2024 to January 2025 MCP survey.

MCPs were asked to report on factors influencing their decisions about whether to offer Community Supports and rate perceived implementation difficulty, impact on member health and well-being, and perceived cost-effectiveness of each Community Support.

Factors influencing MCP decisions about whether to offer Community Supports

In interviews, MCPs identified four reasons for offering Community Supports. [Exhibit 5.10](#) identifies these reasons, the proportion of MCPs that mentioned them, and illustrative quotes.

Exhibit 5.10. Managed Care Plan Reasons for Offering or Not Offering Community Supports

Reason for Offering Community Supports	% of MCPs Reporting	Illustrative Quotes
MCPs’ prior experience offering similar programs or services	45%	<i>“We really prioritized standing up Community Supports services in counties that were Whole Person Care or Health Homes ... and then for other counties, it really depended on availability of capacity and infrastructure. Like, for some services or in some counties we needed to take time to invest in infrastructure using Incentive Payment Program or PATH funding to support our local providers [first].” - MCP #13</i> <i>“We had a pilot through Whole Person Care to cover Recuperative Care ... but it was not successful. We didn’t bring it to scale over the 2-year pilot ... We could not fill beds on a routine, regular basis ... because members being referred didn’t have the ability to be stable and ambulatory ... and there wasn’t behavioral health support for members... and so we chose ... not to proceed with Recuperative Care ... [as a Community Support].” - MCP #8</i>

Reason for Offering Community Supports	% of MCPs Reporting	Illustrative Quotes
MCP and local provider capacity and readiness	32%	<i>"When we look at the sequencing of which Community Supports to launch, we look at what our members need, and then we balance that with what our community collectively is prioritizing ... We also look at provider network capacity, the readiness of our providers. And we look at our internal staff capacity as well." - MCP #5</i> <i>"We needed to phase our rollout because it is a heavy operational lift to build new networks and build the internal operations. That's the reason why we didn't turn on all [the Community Supports] at the same time ... [despite] how important these programs are to our broader membership." - MCP #10</i> <i>"Those facility-based services have been the last for us to implement ... For example, it has taken us almost a year and a half to finally get a property to stand up a Recuperative Care site [in one county] ...each county could have their own challenge [in standing up facility-based services]. It could be that the land is expensive. It could be ... in our rural areas that there's just no providers and such small membership. Like, how do you keep a business open and viable when in [one small county] you may only have 200 Medi-Cal members? Those are just some of the challenges." - MCP #7</i>
Perceived importance of Community Supports in addressing member needs	32%	<i>"We looked at our membership and pain points in terms of clinical need. For example, we have a number of difficult discharges for members in the hospital that need to transition home but need additional support, so that really pushed us to offer Personal Care and Homemaker Services. Similarly, medical respite was really high on our list for support with those difficult clinical discharges. So that was an aspect of how we chose our Community Support</i>

Reason for Offering Community Supports	% of MCPs Reporting	Illustrative Quotes
		<i>services. Is there an impact in one area of our clinical world that could be assisted by offering them?"</i> - MCP #17 <i>"The external community really influenced what our local provider network looks like ... Providers would start speaking about Community Supports that would be really beneficial for members in terms of the gaps or what is preventing them to be successful ... And that really helped us to develop our strategy for what's already in the community that we could bring into the CalAIM model."</i> - MCP #5
Perceived cost-effectiveness or financial sustainability	41%	<i>"From a financial perspective, we're measuring the cost. As these Community Supports grow, our costs are significantly growing as well ... One of the things we're trying to measure is, "are we actually seeing any savings?" ... As costs grow, if we don't see the savings we expect, at some point there's going to have to be a decision made about whether or not to continue some of these services."</i> - MCP #21 <i>"You might be able to come out of pocket a little bit initially ... [then] when the member becomes healthy, we avoid all these episodic issues where they end up utilizing other services that are most costly. So, we are ... gathering data to determine cost-effectiveness ... cost of benefit when we look at what we get from the state and what we're paying for members. Is there an actual benefit in the back end?"</i> - MCP #9

Source: Managed Care Plan Interviews, July to September 2024.

Note: Data were based on 23 unique organizational respondents out of 24 MCPs eligible to offer Community Supports in 2024. One MCP that stopped operating as a Medi-Cal MCP beginning January 1, 2024, was jointly interviewed with another MCP that took over its service area. One MCP specializing in care for members with HIV/AIDS in a single county was not interviewed. Illustrative quotes were selected to represent key themes and highlight heterogeneity in factors affecting MCP decisions. The same MCPs may have reported more than one reason.

Further examination of MCP interview responses showed that 80% of MCPs serving Medi-Cal members in 2024 had **prior experience addressing members' HRSNs** through participation in Medi-Cal Whole Person Care, Health Homes Program, or other programs funded either by the MCP or through external grants. For these MCPs, the presence of pre-existing provider relationships and services made it much easier to offer certain Community Supports quickly.

In some cases, MCPs also cited prior experience with other programs as affecting their decision to *not* offer certain Community Supports. For example, one MCP described a previous negative experience with a sobering center as affecting the decision to *not* offer as a Community Support.

In addition, while the decision to offer Community Supports depended on **MCP and local provider capacity and readiness**, it did not differ based on whether the MCP operated in one or multiple counties. However, MCPs noted they were more likely to offer certain Community Supports earlier if the Community Support was aligned with state-mandated implementation of ECM to specific POF. Conversely, MCPs were less likely to offer Community Supports early if it required developing new services in a community. Facility-based services such as Recuperative Care, Short-Term Post-Hospitalization Housing, and Sobering Centers were viewed as particularly challenging to offer and as resulting in delayed implementation if infrastructure to deliver these services was not already present within a given community.

MCPs also described carefully reviewing data on **member needs** in deciding which Community Supports to offer. Some MCPs focused on clinical needs and the potential of certain Community Supports to reduce high acute care utilization, while others emphasized potential for services to improve members' quality of life and other outcomes.

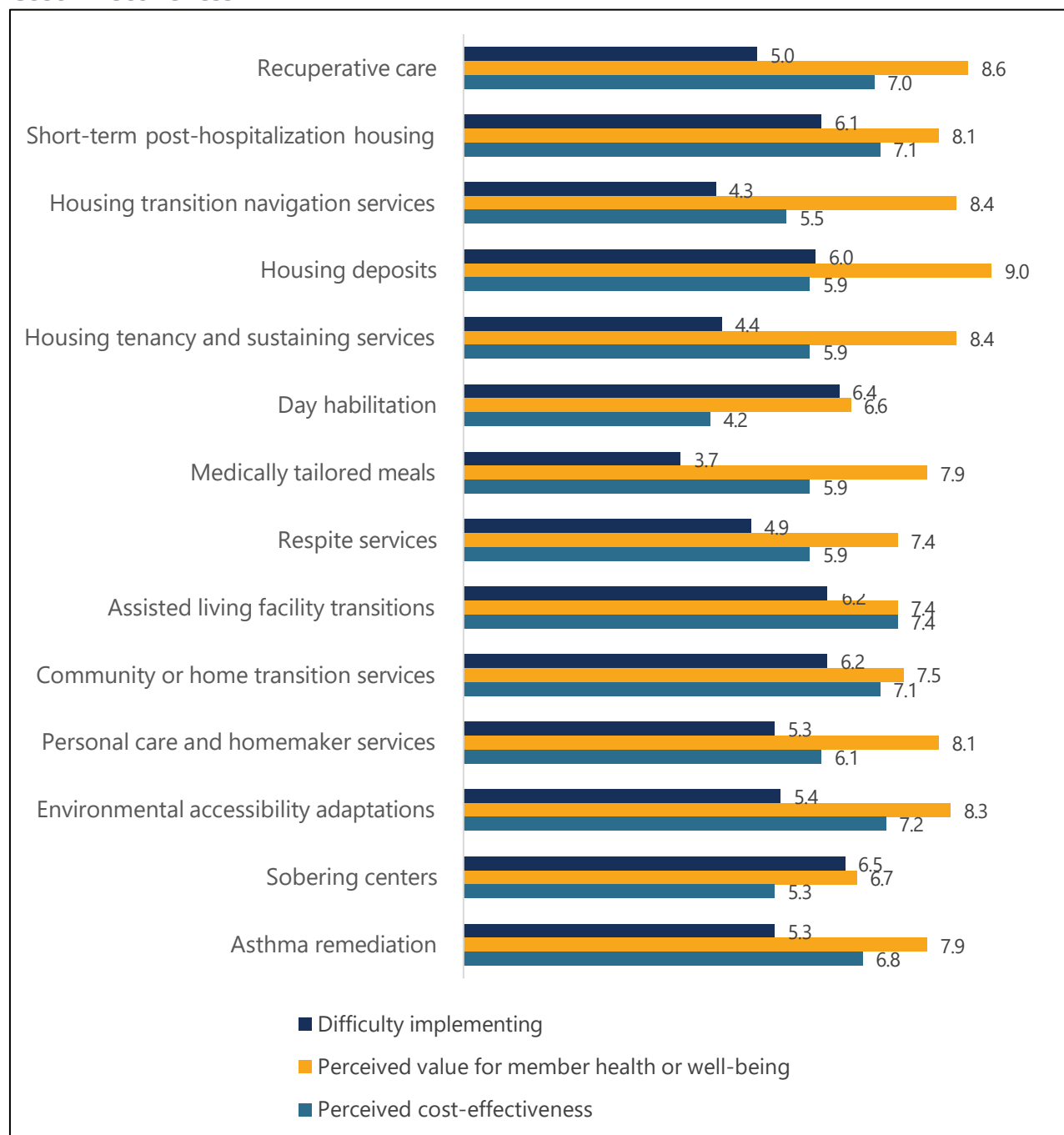
Finally, multiple MCPs emphasized the **cost-effectiveness and financial sustainability** as important to decisions about whether to offer Community Supports. For example, one MCP described needing to close a Sobering Center in one county due to the center not being able to serve enough members needed to support the program. Another MCP cited rising costs and the need to carefully determine whether the MCP was realizing any savings to decide whether to continue offering Community Supports in the future.

Implementation difficulty, perceived impact on member health, and perceived cost-effectiveness

In a survey, MCPs were asked to rate the difficulty of implementing each Community Support, perceived positive impact on member health or well-being, and perceived cost-effectiveness on a scale of 0 (extremely low) to 10 (extremely high). [Exhibit 5.11](#) shows that average MCP ratings of implementation difficulty ranged from 3.7 for Medically Tailored Meals / Medically Supportive Food to 6.5 for Sobering Centers. Average MCP ratings of perceived positive impact on member health or well-being ranged from 6.6 for Day Habilitation to 9.0 for Housing Deposits. The perceived cost-effectiveness of each Community Support ranged from 4.2 for Day Habilitation to 7.2 for Environmental Accessibility Adaptations.

In open-ended responses, MCPs indicated that ratings of implementation difficulty were driven by factors such as insufficient provider networks (e.g., low reimbursement rates making it difficult to identify providers willing to contract for certain services), unclear or rapidly changing eligibility criteria and procedural requirements provided by DHCS, limited facility bed space, and difficulty maintaining contact with members experiencing homelessness. Multiple MCPs also indicated they felt it was either too early in implementation or service utilization was too low to determine cost-effectiveness yet. One MCP also noted that whether cost savings could be achieved varied by Community Supports provider, with *“not all providers created equal.”*

Exhibit 5.11. Managed Care Plan Ratings of Community Supports: Difficulty of Implementation, Perceived Value for Member Health and Well-being, and Perceived Cost-Effectiveness



Source: Managed Care Plan Survey, November 2024 to January 2025.

Note: Data were based on 22 unique respondents out of 24 MCPs eligible to offer Community Supports in 2024. One MCP that fully delegated responsibility for member care to another MCP did not respond to the survey. One MCP specializing in care for members with HIV/AIDS in a single county was not interviewed. Recuperative Care and Short-Term Post-Hospitalization

Housing are offered under a 1115 Waiver and the remaining Community Supports in this Exhibit are offered under a 1915(b) Waiver. Medically tailored meals = Medically Tailored Meals / Medically Supportive Food.

Goal 2: Increase contracts between providers and MCPs for Community Supports services

Goal 2 is addressed with two Evaluation Questions and five measures articulated in the [Evaluation Questions and Hypotheses](#) section of this report. Data sources used in analyses are noted for each measure.

Evaluation Question 2: Did the number and diversity of contracted providers increase over time?

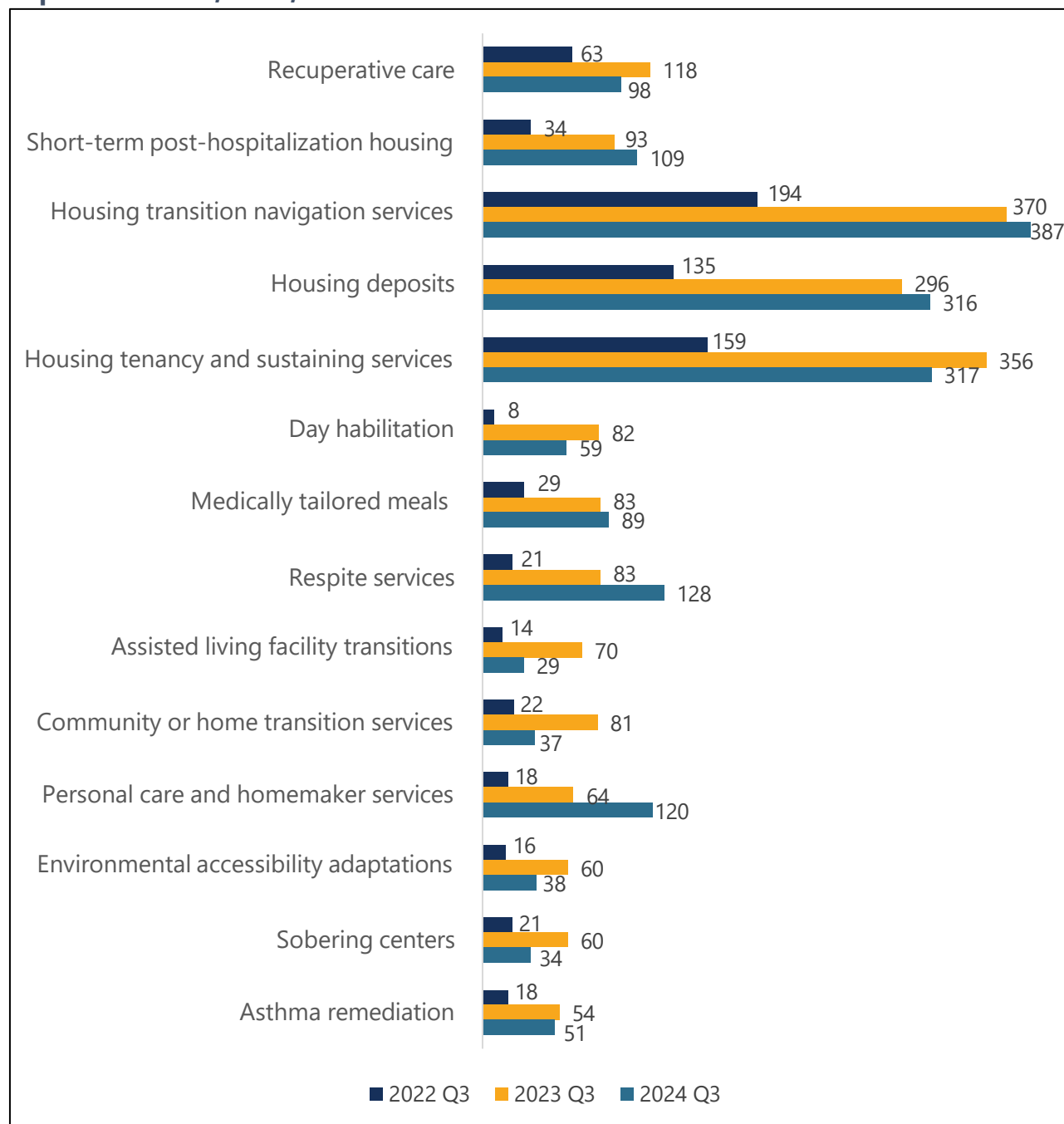
Measure 1. Number of providers contracted to provide each Community Support

Data source: Quarterly Implementation and Monitoring Reports (QIMRs).

The number of unique National Provider Identifiers (NPIs) in the QIMR data were used to represent the number of providers; use of NPIs will over-represent the number of providers because larger providers often have multiple NPIs for different locations or facilities where services are provided. The number of contracts per NPI were also included because Medicaid managed care plans (MCPs) contract with providers in each county.

[Exhibit 5.12](#) shows large increases in the number of contracted Community Supports providers from 2022 Quarter (Q)3 to 2023 Q3. The number of contracted providers increased between 2023 Q3 and 2024 Q3 for six Community Supports but declined for eight. The largest increase in contracted Community Supports providers from 2023 Q3 to 2024 Q4 were for Respite Services (83 to 128) and Personal Care and Homemaker Services (64 to 120). The largest decreases were for ALF Transitions (70 to 29) and Community or Home Transition Services (81 to 37). During this time period, the number of contracted providers also decreased for three of the six housing-related Community Supports included in the Interim Evaluation Report: Recuperative Care (118 to 98), Housing Tenancy and Sustaining Services (356 to 317), and Day Habilitation (82 to 59).

Exhibit 5.12. Number of Unique Community Supports Providers Contracted, July to September 2022, 2023, and 2024

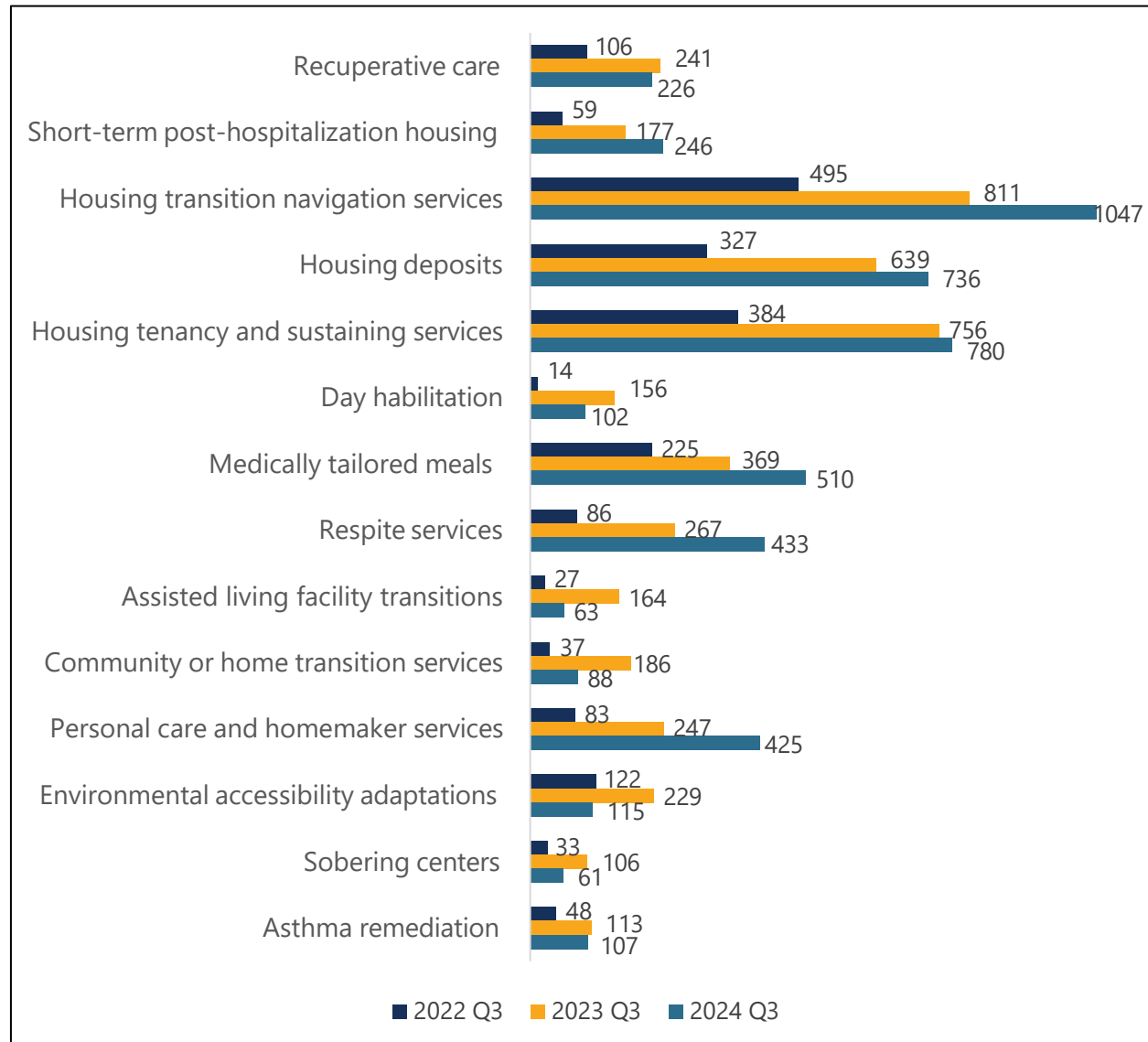


Source: Quarterly Implementation and Monitoring Reports, 2022 Q3 to 2024 Q3.

Note: Data were based on 855 providers identified by unique NPIs reported in selected quarters. The number of providers may be overestimated because some providers may have multiple NPIs. Recuperative Care and Short-Term Post-Hospitalization Housing are offered under a 1115 Waiver and the remaining Community Supports are offered under a 1915(b) Waiver. Medically tailored meals = Medically Tailored Meals / Medically Supportive Food.

[Exhibit 5.13](#) shows that between 2023 Q3 and 2024 Q3, the total number of contracts for each Community Support increased for seven Community Supports and decreased for the other seven Community Supports. With the exception of contracts for Housing Tenancy and Sustaining Services, trends in the total number of contracts mirrored trends in the number of providers contracted for each Community Support.

Exhibit 5.13. Number of Contracts for Each Community Support, July to September 2022, 2023, and 2024



Source: Quarterly Implementation and Monitoring Reports, 2022 Q3 to 2024 Q4.

Note: Data were based on 3,281 contracts reported during the three selected quarters. Contracts are between a provider identified by unique NPI and a specific MCP in each county. The number of providers may be overestimated because some providers have multiple NPIs. Recuperative Care and Short-Term Post-Hospitalization Housing are offered under a 1115 Waiver and the remaining

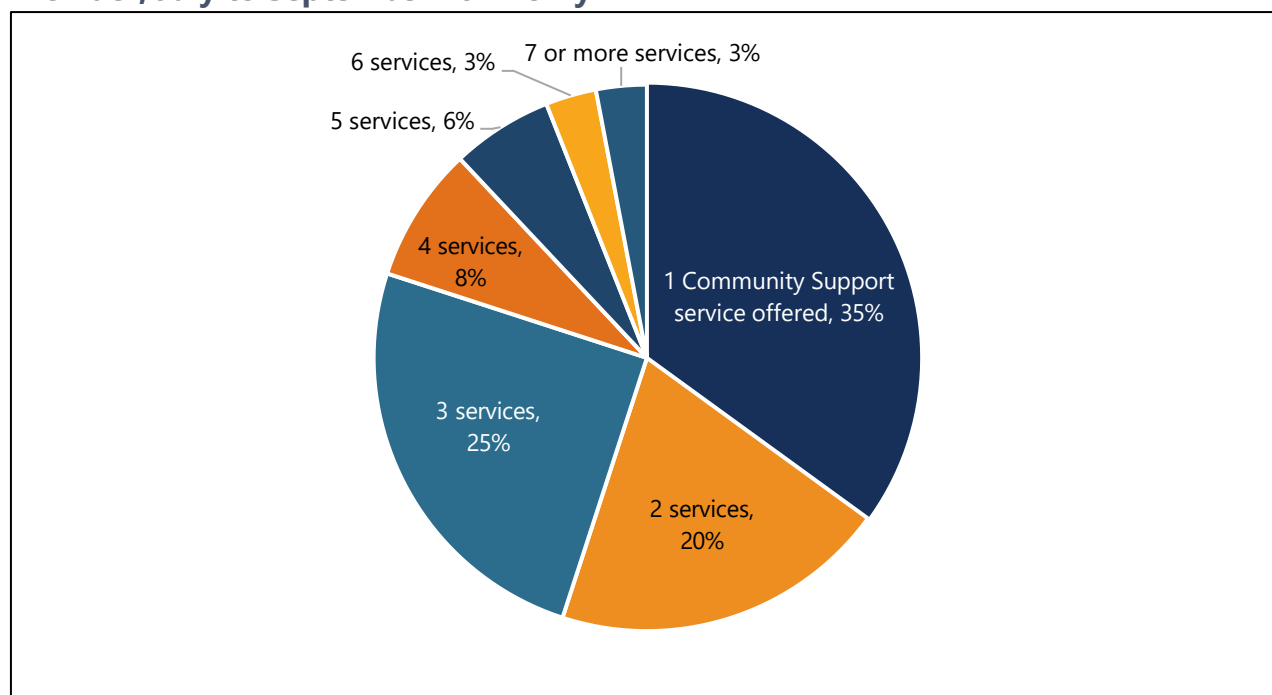
Community Supports are offered under a 1915(b) Waiver. Medically tailored meals = Medically Tailored Meals / Medically Supportive Food.

Measure 2. Number of providers providing multiple Community Supports

Data source: QIMRs.

Data are only shown for 2024 Q3 because the types of Community Supports offered by providers can change over time. As shown in [Exhibit 5.14](#), between July to September 2024, 35% of providers contracted to provide a single type of Community Support, 20% of providers provided two types, 25% of providers provided three types, and 30% provided four or more.

Exhibit 5.14. Average Number of Different Community Supports Offered per Provider, July to September 2024 Only



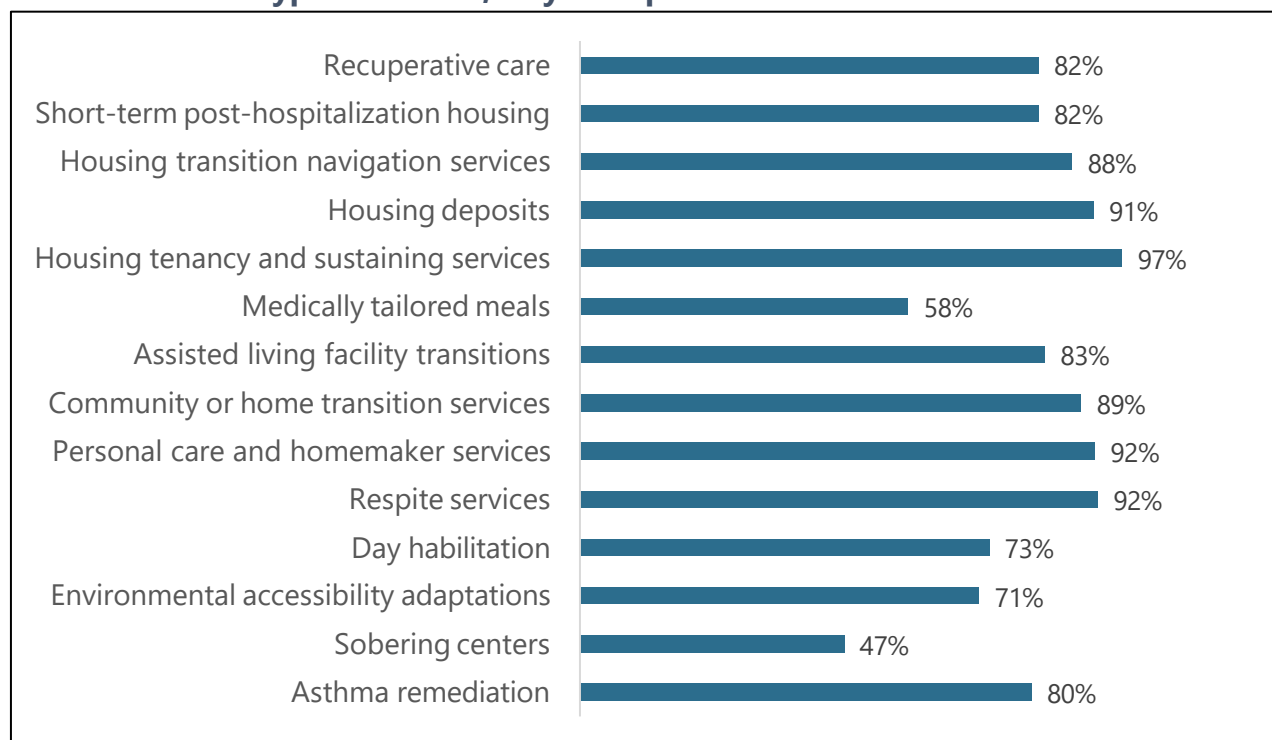
Source: Quarterly Implementation and Monitoring Reports, Q3 2024.

Note: Data were based on 709 unique provider NPIs. The number of providers may be overestimated because some providers have multiple NPIs.

[Exhibit 5.15](#) displays the proportion of each type of Community Supports for providers offering more than one service. For example, 82% of Recuperative Care providers contracted to provide additional Community Supports, but only 47% of Sobering Center providers and only 58% of Medically Tailored Meals / Medically Supportive Food

providers contracted to provide additional Community Supports. Data on the most frequently co-occurring Community Supports is provided in [Evaluation Question 4 Measure 7](#).

Exhibit 5.15. Proportion of Each Type of Community Supports Provider Offering More Than One Type of Service, July to September 2024



Source: Quarterly Implementation and Monitoring Report, Q3 2024.

Note: Data were based on 709 providers identified by unique NPIs reported during the selected quarter. The number of providers may be overestimated because some providers have multiple NPIs. Change over time will be assessed in the final evaluation report. Recuperative Care and Short-Term Post-Hospitalization Housing are offered under a 1115 Waiver and the remaining Community Supports are offered under a 1915(b) Waiver. Medically tailored meals = Medically Tailored Meals / Medically Supportive Food.

Measure 3. Ownership and type of providers contracted to provide each Community Support

Data sources: QIMRs; October 2024 to July 2025 provider interviews; June to July 2025 provider survey; NPI Registry; 2022 and 2023 Providing Access and Transforming Health (PATH) Capacity and Infrastructure Transition, Expansion, and Development (CITED) applications; provider ownership data from GuideStar and organizational websites.

DHCS recommended but did not require MCPs to contract with community-based providers, defined as a *"nonprofit organization, governmental agency, or health care provider that has direct experience with the Medi-Cal population(s) being served within the county in which they are seeking a contract with a Medi-Cal MCP... and is generally embedded in the health care and social services ecosystem in the provider's county."*

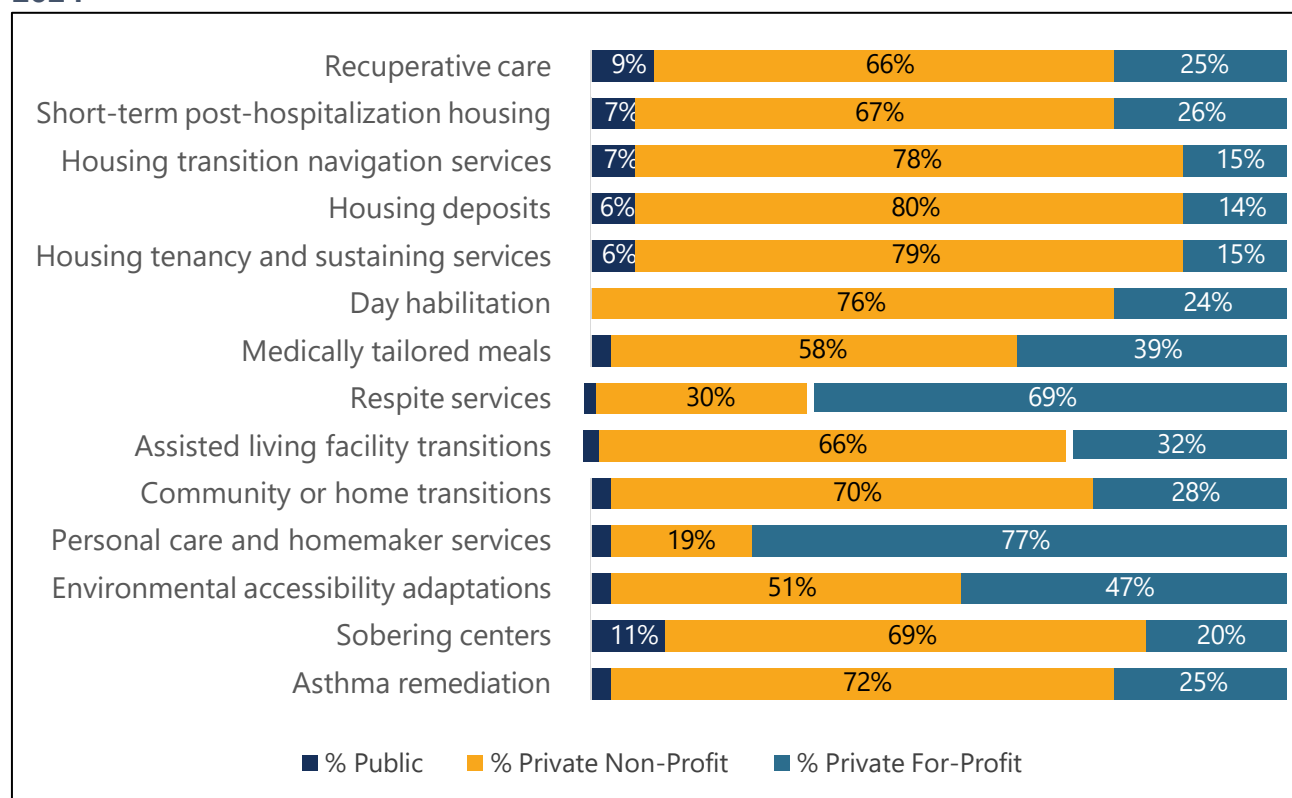
Administrative data on whether providers had direct experience with Medi-Cal populations or were embedded in local health and social services ecosystems were not available. Instead, in this measure, the proportion of Community Supports providers with public or private non-profit ownership status were reported as a proxy for being a community-based organization. To determine ownership status, UCLA-RAND matched provider names from the NPI Registry as of March 2024 to provider-reported ownership status from PATH CITED applications, GuideStar, and organizational websites.

Data on provider type were not available but will be included in the Summative Evaluation Report. Data on providers' prior experience with Medi-Cal population(s) and if they were embedded in local health and social service ecosystems were assessed in provider interviews and surveys.

Provider Ownership

[Exhibit 5.16](#) shows that the majority of Community Supports providers were community-based, as measured by public or private non-profit ownership. The exceptions were Respite Services and Personal Care and Homemaker Services, which were predominantly offered by private for-profit providers (69% and 77%, respectively).

Exhibit 5.16. Ownership Status of Community Supports Providers, January to March 2024

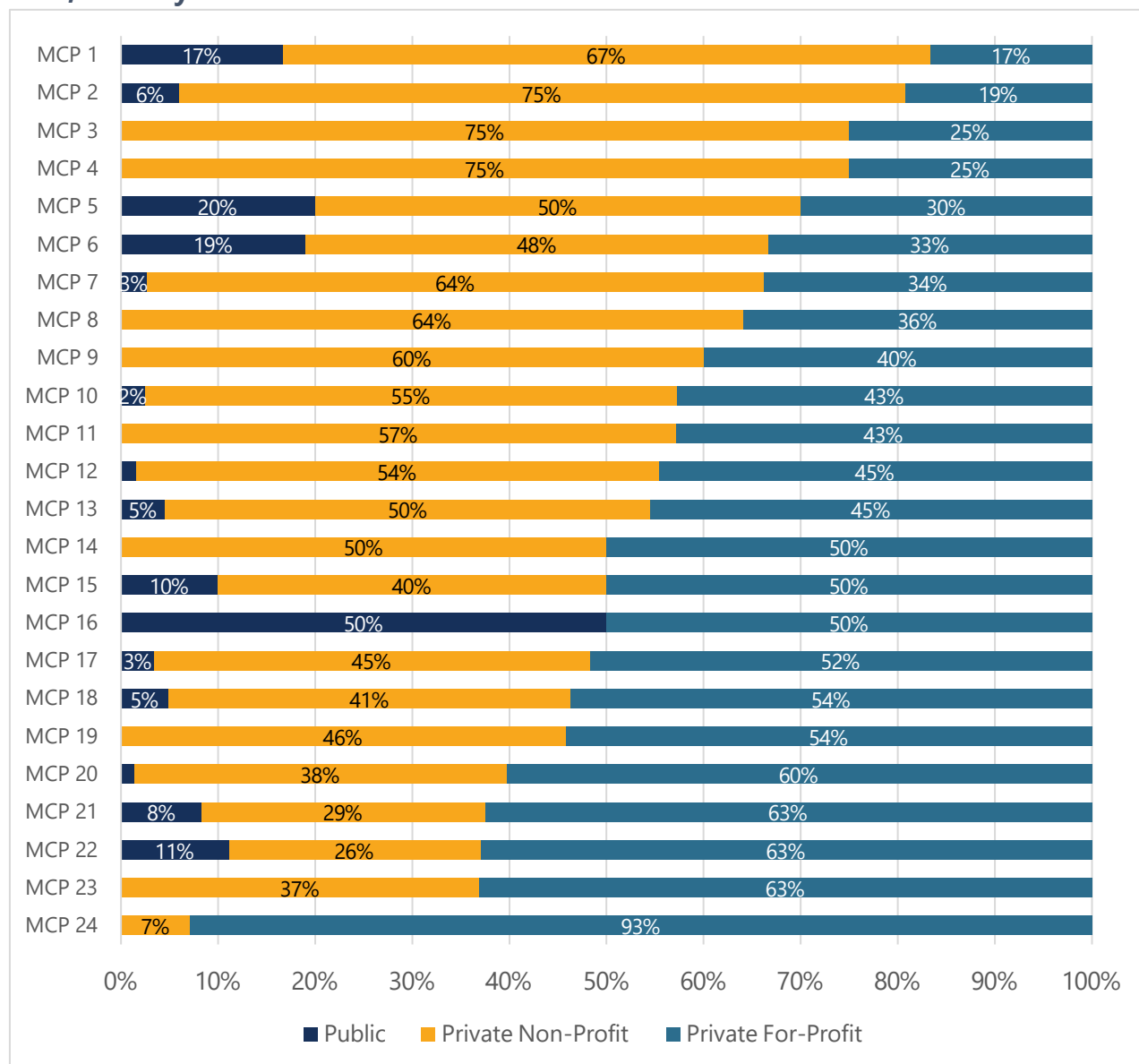


Source: Quarterly Implementation and Monitoring Reports, January to March 2024; Data on provider ownership obtained from 2022-2023 PATH CITED applications, GuideStar, and organizational websites using provider names from the NPI Registry.

Note: Data were based on 583 unique provider NPIs. The number of providers may be overestimated because some providers have multiple NPIs. Between 1% to 9% of providers per Community Support were excluded due to unknown ownership status. Recuperative Care and Short-Term Post-Hospitalization Housing are offered under a 1115 Waiver and the remaining Community Supports are offered under a 1915(b) Waiver. Medically tailored meals = Medically Tailored Meals / Medically Supportive Food.

[Exhibit 5.17](#) shows that MCPs varied in the proportion of Community Supports contracts with private non-profit or public providers, ranging from a high of 83% (67% private non-profit and 17% public) by MCP #3 to a low of 7% (7% private non-profit and 0% public) by MCP #24.

Exhibit 5.17. Ownership Status of Community Supports Providers by Managed Care Plan, January to March 2024



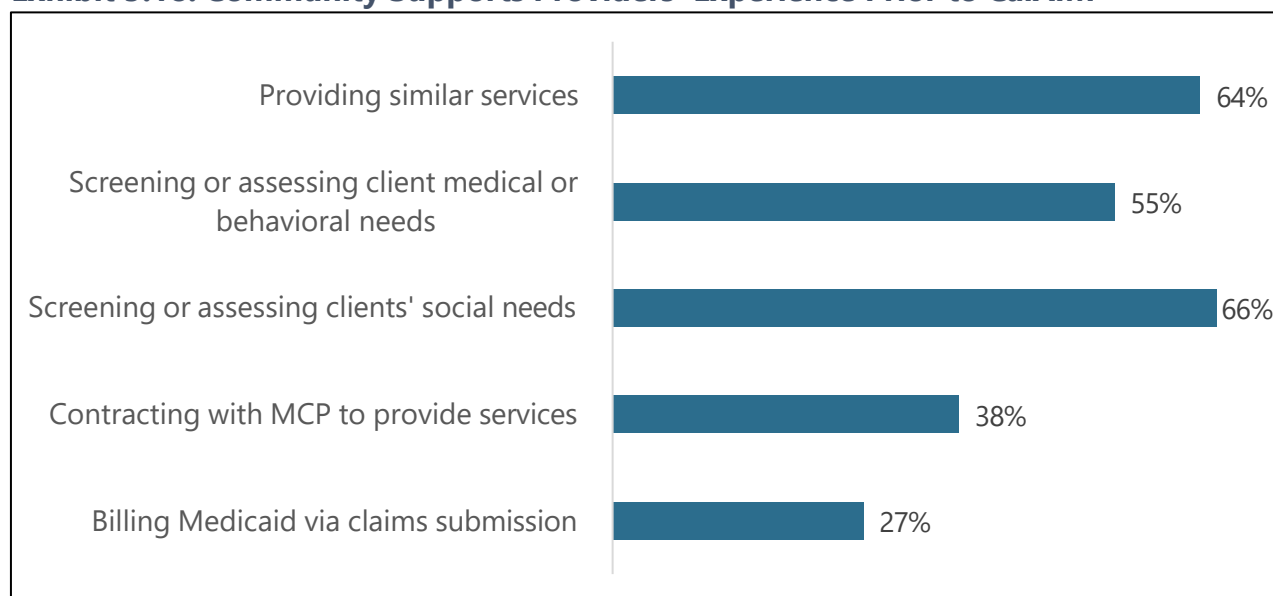
Source: Quarterly Implementation and Monitoring Report, 2024 Q1; Data on provider ownership from PATH CITED applications, GuideStar and organizational websites using provider names from the NPI Registry.

Note: Data were based on 583 unique provider NPIs. The number of providers may be overestimated because some providers have multiple NPIs. Between 0% to 8% of providers per MCP were excluded due to unknown ownership status.

Prior Experience with Medi-Cal

Surveyed providers were asked about their prior experience providing services similar to Community Supports, contracting with MCPs, or with submitting claims. As shown in [Exhibit 5.18](#), most providers had prior experience delivering similar services (64%) as well as screening or assessing clients' social (66%) or medical or behavioral needs (55%). Fewer providers had prior experience contracting with MCPs (38%) and submitting claims (27%).

Exhibit 5.18. Community Supports Providers' Experience Prior to CalAIM



Source: Enhanced Care Management and Community Supports Provider Survey, June to July 2025.

Note: Data were based on 205 unique respondents who offered Community Supports and excluded one respondent who did not answer the question.

In surveys and interviews, providers expanded on the benefits of prior contracting and claims experience, as shown in [Exhibit 5.19](#). Providers indicated that lack of prior experience contracting with MCPs led to greater difficulty successfully negotiating contracts and rates. Similarly, lack of prior experience with claims submission meant providers had to make tremendous infrastructure investments. In particular, housing and homeless services providers frequently discussed the challenge of needing to develop new administrative infrastructure and operational workflows specifically for billing Medi-Cal. Many of these providers reported associated costs of developing this infrastructure as resulting in considerably longer periods of time before financial sustainability of Community Supports could be determined.

Exhibit 5.19. Community Supports Providers’ Perceptions of the Benefits of Prior Experience with Managed Care Plan Contracts and Claims

Key Themes	Illustrative Quotes
Prior contracts with MCPs made it easier to contract for Community Supports and negotiate rates	<i>“The contracts [with MCPs] weren’t too different from what we were already doing in prior projects ... The biggest difference is just the negotiation because we had to negotiate under [the guidelines] DHCS provided ... We created our own ... fee schedule and presented it the MCPs ... and they took our options sound ... They knew we’re the experts in this type of work. We knew exactly the cost of it.” - Provider #26 [Prior experience contracting with MCP(s)]</i> <i>“We’re a robust company. We [already] had contracts with the MCPs, so really contacting them and wanting to [contract for Community Supports] was a very smooth transition for our organization.” - Provider #5 [Prior experience contracting]</i> <i>“I didn’t – because I didn’t know how all of this works, I didn’t know you could negotiate the price [of the service]. I thought it was pretty much, ‘Hey this is what we’re willing to pay ... and you either accept it or you don’t.’” - Provider #30 [No prior experience contracting]</i>
Prior experience with claims reduces costs associated with Medi-Cal billing and reduces percentage of denied claims	<i>“We’ve, for the last 15 years, billed the private insurance side marketplace. This [Community Supports] is the same. This is just commercial payers ... It was just [like] adding another commercial payer to the setup.” - Provider #55 [Prior experience with claims]</i> <i>“Health Homes [HHP] was a huge learning curve for us as an FQHC... [but as part of HHP] we worked out how to provide services to patients and non-patients ... We had our EHR [electronic health record], the clinical part, and [now] we have the social determinants of health path that allows us to put in both our patients and our non-patients [for ECM and Community Supports].” - Provider #23 [Prior experience with claims]</i> <i>“Billing is different from cost-reimbursement ... I spent hours figuring out our billing. I have entered more medical claims and corrected billing pages than I ever dreamed I would. I wanted to be therapist, not a medical biller! But that’s what it</i>

Key Themes	Illustrative Quotes
	<i>took for us to be successful ... [even though] it's been challenging in every aspect you could ever imagine." - Provider #28 [No prior experience with claims]</i>

Source: Enhanced Care Management and Community Supports Provider Interviews, October 2024 to July 2025.

Note: Data were based on 60 unique organizational respondents who offered Community Supports. Providers were purposively sampled for variation in MCPs contracted with, Community Supports provided, geographic region, and provider type. Illustrative quotes were selected to represent key themes and maximize heterogeneity in provider perspectives represented.

Embeddedness in Local Systems of Care

In surveys and interviews, providers described how their organizations “fit” in the broader system of services in the communities they served. Of the 60 Community Supports providers interviewed, 55 (92%) were community-based, or already embedded in local systems of care or serving Medi-Cal populations prior to CalAIM implementation in 2022. [Exhibit 5.20](#) shows key themes related to providers’ perceptions of the benefits of being embedded in local systems of care.

Providers embedded in local systems of care described pre-established relationships with members as helpful for facilitating member identification and engagement in services, referrals to appropriate care, and care coordination. Large providers offering diverse medical, BH, and/or social services indicated that providing members with direct access to a broader continuum of care was also helpful for member engagement and continuity of care. Finally, providers embedded in local systems of care described non-local providers positively when perceived as filling needed gaps in care within a community, but they described them as unwelcome competition when non-local providers did not provide “brick and mortar” services, when lack of knowledge of the community led to more work for local providers, or when MCPs were perceived as not providing sufficient monitoring and oversight to ensure service quality.

Embedded providers viewed non-local, out-of-state providers of Medically Tailored Meals / Medically Supportive Food as particularly detrimental to community-based providers due to certain MCPs’ contracting and referral practices resulting in large numbers of eligible members being served by these providers, undercutting community-based providers’ ability to achieve economies of scale needed to make service provision financially sustainable for their organizations and removing funds from local economies.

One non-local provider contracted to offer Community Supports in multiple counties throughout California acknowledged being perceived as competition by community-based providers in some communities, and they noted that the strong hostility encountered from Continuum of Care providers in one community resulted in a focus on building relationships with local landlords rather than trying to work with the Homeless Management Information System when providing Housing Transition Navigation Services to members.

Exhibit 5.20. Community Supports Providers’ Perceptions of the Benefits of Being Embedded in Local Health or Social Service Ecosystems

Key Themes	Illustrative Quotes
Established trust and relationships with members and other providers in the community	<i>“We have been here so long. We have done so much. Having that history and that background helped ... make us a trusted partner in the community ... When we go to the clients like, ‘Hey you know you were referred over’ they’ve most likely already worked with us in some capacity, so it was easy to have the trust and the relationship with clients.”</i> - Provider #3 <i>“[Compared to non-local providers] We have developed stronger relationships, we’re more aware of resources ... if you’re new to this, if you don’t have that background coming in, and you’re just like ‘Oh, I can do housing transition navigation, and ... boom! You’re housed’ ... we’re like, no, we have a 2% vacancy rate in our community... [non-local] people are not taking that environmental perspective into consideration when they’re implementing.”</i> - Provider #38 <i>“[In my role in the local Continuum of Care] I’ve had a view and perspective of all the agencies involved [in our community]. We’ve had large companies come in and try to flex their muscles. One in particular came in and got a large contract ... and it didn’t go well ... Part of the problem was they didn’t have those relationships ... there wasn’t the level of trust [with other agencies and the county].”</i> - Provider #51
Community Supports	<i>“We do everything in the [substance use treatment]</i>

Key Themes	Illustrative Quotes
can be offered as part of a broader continuum of care	<i>continuum of care ... we have withdrawal management, detox, outpatient, intensive outpatient, residential, we have two narcotic treatment clinics, three recovery residences, two to three sober living environments, a DUI [Driving Under the Influence] program ... [in addition to] our Sobering Center.” - Provider #55</i> <i>“We layer so much value for the community ... 78% of our adult volunteers improve their eating habits after getting involved ... We reached almost 1,000 kids last year with nutrition education, and information out of an internship program that was about training teens and building skills ... We buy locally ... we’re part of the ecosystem in the community ... we’re leading community-based food network projects, we’re the emergency meal provider for the county.” - Provider #43</i> <i>“Our Coordinated Entry system is now engaged ... and is able to make those connections, so they can look into our HMIS [Homeless Management Information System] because we can show if somebody is authorized [for Community Supports] or not ... When they’re looking at people for an emergency housing voucher or other voucher programs that don’t have that layer of support, then they can make those referrals ... it’s really benefited...” - Provider #33</i>
Concern about non-local providers’ service quality, motive for providing care, and burden on local providers	<i>“There used to be only real medically tailored meal providers in the community. Whomever you chose, there were maybe about five of us, you would know the quality is at least in the right direction. Now that venture capital-funded, out of state, newer companies come along, they take the services and ... edit them ... without any oversight or money ... [but] clients don’t get better, and it’s a waste of millions of dollars.” - Provider survey open-ended response</i> <i>“A pain point with having providers that are not part of [our county] is ... [not] understanding the landscape and nuances with landlords ... It creates challenges if the people or the</i>

Key Themes	Illustrative Quotes
	<i>agencies providing Community Supports don't have an understanding of the community they're serving." - Provider #33</i> <i>"There are a lot of Community Supports providers from out of county that are taking clients away from local providers. It would not be an issue if local providers were not considered a resource for those out of county providers. Half the time they tell their clients to contact local providers while they are getting paid to hold the authorization. Then, the clients have to fight to get their authorization transferred to a local provider with boots on the ground to help them. Sometimes this process takes months while the member is not being helped by insurance and is paying for services not being rendered." - Provider survey open-ended response</i>

Source: Enhanced Care Management and Community Supports Provider Interviews, October 2024 to July 2025; Enhanced Care Management and Community Supports Provider Survey, June to July 2025.

Note: Interview data were based on 60 unique organizational respondents who offered Community Supports and survey data were based on 206 unique organizational respondents who offered Community Supports. Interviewed providers were purposively sampled for variation in MCPs contracted with, Community Supports provided, geographic region, and provider type. Illustrative quotes were selected to represent key themes and maximize heterogeneity in provider perspectives represented.

Evaluation Question 3: What factors influence provider participation in Community Supports?

Measure 1: Providers' reasons for contracting or not contracting with MCPs to provide Community Supports

Data sources: October 2024 to July 2025 provider interviews; January to April 2025 PATH Collaborative and Implementation (CPI) facilitator and PATH Technical Assistance (TA) Marketplace vendor interviews; June to July 2025 provider survey.

Providers and CPI facilitators noted providers' reasons for contracting or not contracting with MCPs to offer Community Supports, which are summarized in [Exhibit 5.21](#), along with illustrative quotes.

When discussing reasons for contracting, Community Supports providers highlighted mission alignment, community needs, and interest in new revenue sources as major reasons. Multiple BH and homeless services providers perceived Community Supports as an opportunity to diversify their revenue streams and build relationships with MCPs, given changes to state funding for these services. Affordable housing developers operating permanent supportive housing (PSH) units were interested in the potential of ECM or Community Supports to help offset costs of supportive services to eligible members living in their PSH units.

Inadequate payment rates and administrative burden of Medi-Cal billing, compliance, and reporting were described as contributing to financial risk to their organizations. Providers further noted disparate policies, payment rates, and payment models across MCPs as an additional administrative challenge, which could influence their decision to contract with certain MCPs over others. Perceived financial risks were further exacerbated by ambiguous and/or rapidly changing policy guidance around Community Supports service definitions and eligibility criteria, which were described as challenging to navigate for providers trying to develop and implement new service programs. Providers, particularly those asked to develop facility-based services such as Recuperative Care, Short-Term Post-Hospitalization Housing, or Sobering Centers, also cited costs of renovating or developing new facilities as cost-prohibitive if IPP, HHIP, or PATH funding were not available to assist.

Finally, providers noted increases in MCP refusal to contract with new providers over time or increased termination of contracts. While some providers did not know the reasons for this behavior, others cited reasons such as (1) preferences of MCPs operating in multiple counties to contract with large, non-local private for-profits over local non-profit providers; (2) MCPs affiliated with integrated health systems bringing services “in-house”; and (3) MCP concerns with financial sustainability of certain Community Supports.

Exhibit 5.21. Provider Reasons for Contracting or Not Contracting for Community Supports

Key Themes	Illustrative Quotes
<i>Reasons for Contracting for Community Supports</i>	
Alignment with the organization’s mission	<i>“What we do as an agency is see if it fits in our scope ... Does this fall in line with our mission? Is it something we know how to do and that we can lift up and be successful with?” - Provider</i>

Key Themes	Illustrative Quotes
	#3 <i>"We wanted to do the most good for the most amount of people while being financially responsible." - Provider #4</i> <i>"Health and homelessness intersect in a very large X, and it's knowing if somebody can maintain their health, they're more likely to maintain their housing, their job, their well-being ... And we really wanted to support that." - Provider #25</i>
Address service gap or need in the community	<i>"We took this on because of the need in the community"- Provider #6</i> <i>"There was a deficit of Recuperative Care beds in [the community], which is why we elected to start that particular service." -Provider #21</i> <i>"We were on the ground level ... we saw the benefit in tailoring food to the needs of chronically sick clients, initially just with congestive heart failure but then all these other conditions that could be impacted by proper nutrition ... The impact we could have was very visible and very meaningful, and there was no hesitation that we would want to contract with our MCPs through CalAIM [to do this]."</i> - Provider #31
New revenue source or opportunity for revenue diversification	<i>"We realized a lot of our funding was dependent upon [the county], and we set an intention to diversify some of that funding... for Housing Transition Navigation Services and Housing Tenancy and Sustaining Services, because it essentially was what we were already doing." - Provider #9</i> <i>"The mental health world is changing ... we wanted to diversify the kinds of contract our organization has so as not to solely rely on our contracts with mental health." - Provider #12</i> <i>"All these organizations are solely reliant on DMC-ODS [the</i>

Key Themes	Illustrative Quotes
	<i>Drug Medi-Cal Organized Delivery System] dollars, and we're about 64% reliant, which felt like a lot to me. So, I'm already working on diversification again."</i> - Provider #55
Alignment with services already being provided and/or with clients being served	<i>"We were already good at [providing the service], we knew CalAIM was coming. It seemed like a slam dunk for us to contract with the MCP, to increase the amount of services we could provide, and expand our services."</i> - Provider #7 <i>"From the client standpoint, these are already our clients ... so [Community Supports] could help us improve the services we are providing, expand the services we were doing."</i> - Provider #17 <i>"We were a lead entity for Whole Person Care and many of our programs exploded during the pilot ... That pipelined into the decision to pursue Community Supports, so those programs could continue be funded, and supported and expand."</i> - Provider #19 <i>"We integrated CalAIM into our shelter systems that were funded, but not to the levels where you need ... so, having [Community Supports] as gap funding, filler funding, has enabled us to have more robust services, and direct pathways from our hospitals and health systems, and difference dialogues. Now we're fully integrated."</i> - Provider #33
Reasons for Not Contracting for Community Supports	
Inadequate rates	<i>"In the beginning, we were up to the level of contracting with two MCPs in our county and we declined to sign a contract because the rate was significantly less [and wouldn't allow us to maintain the quality of our service model]."</i> - Provider #34 <i>"The rates, are they viable? Are they going to cover our costs? ... Disparate payment models for some of these programs ... [also] create a number of administrative challenges. Are you PMPM [per member per month]? Are you trying to force fee-for-service? ... These are all things we have to consider."</i> - Provider

Key Themes	Illustrative Quotes
	#24 <i>"All of this had this idea that CalAIM was the answer for our funding to make this [program] systemic and integrated ... [But] as we got into negotiations and contracting, we realized it didn't solve everything ... One the rates were too low, and two, there continued to be a cutting of eligibility [criteria] and services." - Provider #49</i>
Administrative burden or administrative complexity resulting in excessive financial risk	<i>"The housing fund that we used to provide was a very complicated administrative service to provide to staff and to provide to clients. We had to have an extra administrator ... We had to have someone monitor the checks ... We had to collect W9s ... [but] the deposit service itself doesn't provide for administrative support, no easy way for us to recoup the administrative fees for the service." - Provider #32</i> <i>"We were [concerned about] delay in authorization approvals ... loss of contact, even when authorizations were approved... denials that we were seeing [in the community] ... I can't risk that financial burden." - Provider #62</i> <i>"Providers are concerned whether rates ... will be sufficient to cover the cost of delivering services, given the administrative workload for [billing] and for required compliance and reporting." - CPI facilitator #4</i>
Lack of clarity in policy guidance around what certain services would "look like"	<i>"We considered Day Habilitation ... it sounds like something we're already doing ... but truthfully there still isn't much clarity on exactly what it looks like ... We haven't received clarification from the MCP on how or what a model for Day Habilitation should look like ... so we've talked about it, but we haven't committed to anything." - Provider #6</i> <i>"There's a lot of new policies coming out. And Community Supports definition updates that are being phased out, and even</i>

Key Themes	Illustrative Quotes
	<i>though they're being phased out, there's a ramp up period for providers to catch up and understand what's going on... And that's not how CBOs function ... They need more time to adjust."</i> - CPI facilitator #7 <i>"One concern is about the Community Supports in and of itself ... The state is going to change [the policies]. It's hard when you're trying to build programs in one direction to have to pivot again to meet the state's new requirements ... That's why we're waiting to see what the state announces [before contracting for this service]."</i> - Provider #12
Cost of developing new services, particularly facility-based services	<i>"Some of this requires brick and mortar investment not available to most [CalAIM providers]. If you don't have a facility, you aren't going to have a Sobering Center."</i> - CPI facilitator #3 <i>"[These two Community Supports] would have required us to have a residential facility ... and we are not 24/7."</i> - Provider #22
MCP refusal to contract, termination of contract, or refusal to authorize any services	<i>"We asked to get paid for hundreds of ... services that were pre-approved by the plan but later rejected after the fact. Many of these rejected were referred to us from the MCP... When we brought this up to the MCP, instead of addressing the issue, they retaliated and... cancelled our contract... Now the same services are being provided by out of state providers using out of state farmers rather than our local farming program."</i> - Provider survey open-ended response <i>"At first, MCPs were just contracting with everybody... and I think beginning in 2024, they hit their max of what they can pay for and what they're willing to pay for. So, I think new contracting [for some MCPs] has stopped ... And for some folks, the MCPs just weren't authorizing their referrals. There have been providers that have canceled contracts with MCPs that contract but then refuse to authorize [any] referrals ... And some MCPs are just pulling out of their contracts completely with certain programs."</i> - Provider #1

Key Themes	Illustrative Quotes
	<i>"Currently, if you want to take a contract with [the MCP], they're closed ... Even if you know you can do more for the community, you cannot because they're closed. They're not contracting with anyone else." - Provider #58</i>

Source: Enhanced Care Management and Community Supports Provider Interviews, October 2024 to July 2025; PATH CPI Facilitator and TA Marketplace Vendor Interviews, January to April 2025; Enhanced Care Management and Community Supports Provider Survey, June to July 2025.

Note: Interview data were based on 70 unique organizational respondents (either Community Supports providers, PATH CPI facilitators, or PATH TA Marketplace vendors) and survey data were based on 206 unique respondents who offered Community Supports. Providers were purposively sampled for variation in MCPs contracted with, Community Supports provided, geographic region, and provider type. Illustrative quotes were selected to represent key themes and maximize heterogeneity in provider perspectives represented.

Measure 2: Perceptions of whether number of eligible and contracted providers are sufficient to meet need

Data sources: MCP interviews.

Data on Measure 5 were not available for the Interim Evaluation Report. Data on perceptions of whether eligible and contracted providers are sufficient to meet need will be collected in additional surveys and interviews and included in the Summative Evaluation Report.

Goal 3: Increase utilization of Community Supports by eligible members

Goal 3 is addressed with two Evaluation Questions and 13 measures articulated in the [Evaluation Questions and Hypotheses](#) section of this report. Data sources used in analyses are noted for each measure.

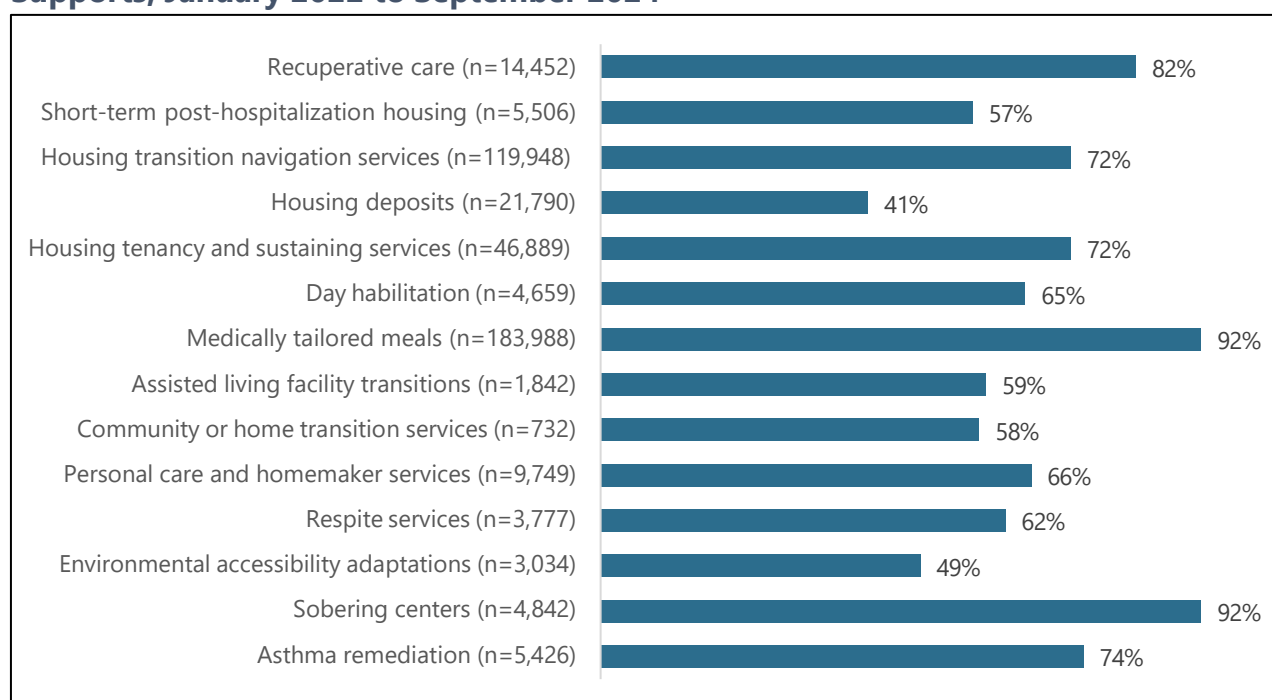
Evaluation Question 4: Did the number of members receiving Community Supports increase over time?

Measure 1. Proportion of members authorized for and subsequently utilize Community Supports

Data source: Quarterly Implementation and Monitoring Reports (QIMRs).

Exhibit 5.22 shows that the proportion of members authorized for and subsequently used Community Supports was highest for Medically Tailored Meals / Medically Supportive Foods (92%), Sobering Centers (92%), and Recuperative Care (82%) and lowest for Housing Deposits (41%) and Environmental Accessibility Adaptations (49%).

Exhibit 5.22. Proportion of Members Authorized and Subsequently Used Community Supports, January 2022 to September 2024



Source: Quarterly Implementation and Monitoring Reports, 2022 Q1 to 2024 Q3.

Note: In the QIMR data, between 1% and 14% of members used a Community Support without prior authorization; these members are not shown in this Exhibit. Recuperative Care and Short-Term Post-Hospitalization Housing are offered under a 1115 Waiver, and the remaining Community Supports are offered under a 1915(b) Waiver. Medically tailored meals = Medically Tailored Meals / Medically Supportive Food.

Measure 2. Number and types of Community Supports used by members (over time)

Data source: QIMRs.

[Exhibit 5.23](#) shows that between 2022 Q1 and 2024 Q3 the number of users increased for all Community Supports. The number of users increased the most for Medically Tailored Meals / Medically Supportive Food (443 to 176,001 users) and Housing Transition Navigation Services (4,026 to 89,094 users). The number of users increased the least for Community or Home Transition Services (14 to 442 users) and ALF Transitions (146 to 1,159 users).

Exhibit 5.23. Number of Community Supports Users in January to March 2022 and July to September 2024

Community Support	January to March 2022	July to September 2024
Recuperative Care	762	12,119
Short-Term Post-Hospitalization Housing	Less than 11	3,170
Housing Transition Navigation Services	4,026	89,094
Housing Deposits	112	9,379
Housing Tenancy and Sustaining Services	9,489	35,176
Day Habilitation	Less than 11	3,510
Medically Tailored Meals / Medically Supportive Food	443	176,001
Respite Services	Less than 11	2,367
ALF Transitions	146	1,159
Community or Home Transition Services	14	442
Personal Care and Homemaker Services	Less than 11	6,569
Environmental Accessibility Adaptations	Less than 11	1,677
Sobering Centers	39	4,601
Asthma Remediation	27	4,115

Source: Quarterly Implementation and Monitoring Reports, 2022 Q1 to 2024 Q3.

Note: Data showed number of users in 2022 Q1 and 2024 Q3. Recuperative Care and Short-Term Post-Hospitalization Housing are offered under a 1115 Waiver, and the remaining Community Supports are offered under a 1915(b) Waiver.

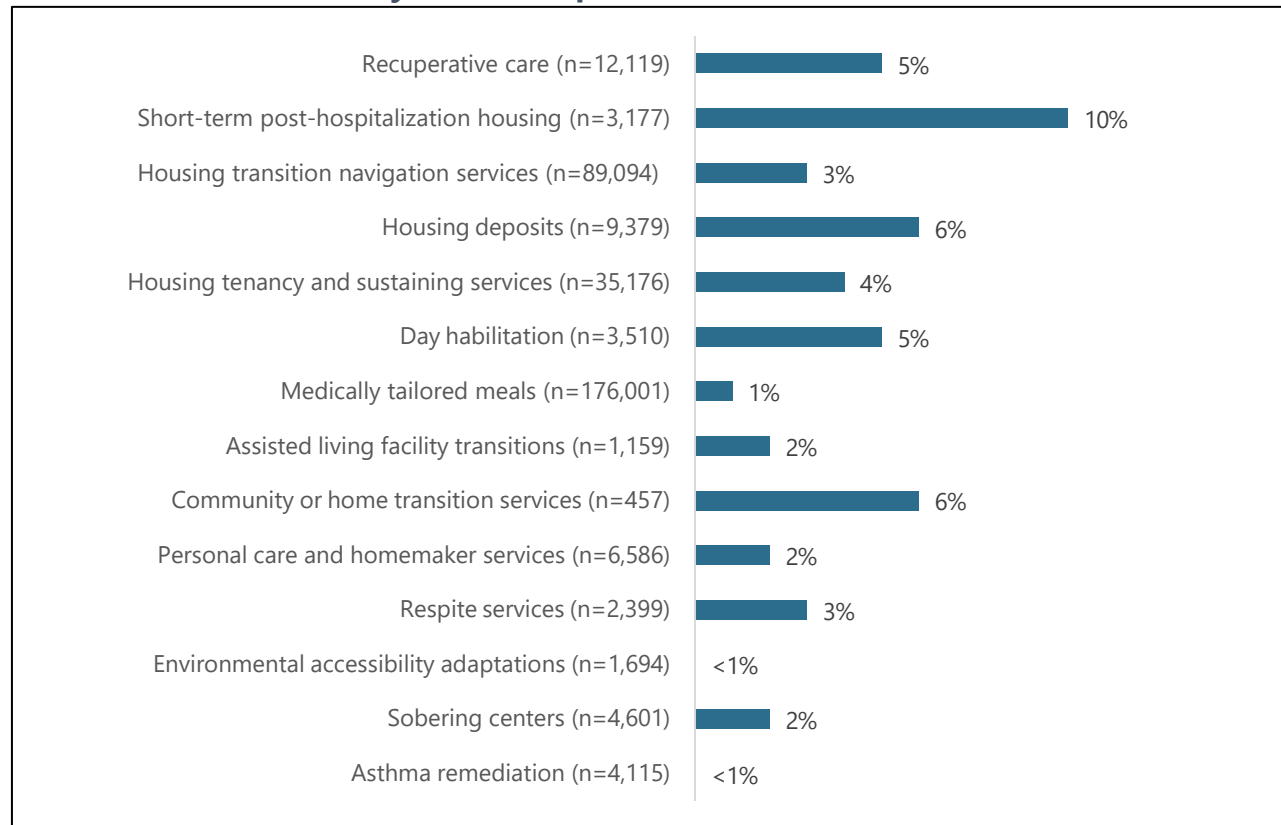
Measure 3. Frequency and duration of Community Supports use

Data source: QIMRs.

QIMR data only indicated whether a member used Community Supports in each quarter rather than actual dates of service. Therefore, analyses for this measure underestimate frequency of use if members used a Community Support more than once per quarter and overestimate duration if members used a Community Support for less than three months. More precise estimates of the frequency and duration of Community Supports use will be reported using Medi-Cal eligibility and claims data in the Summative Evaluation Report.

[Exhibit 5.24](#) shows the proportion of members that received each Community Support in multiple quarters. The proportion of members using Community Supports in multiple quarters ranged from a high of 10% for Short-Term Post-Hospitalization Housing to less than 1% for Medically Tailored Meals / Medically Supportive Food, Environmental Accessibility Adaptations, and Asthma Remediation.

Exhibit 5.24. Proportion of Members Receiving Each Community Support More Than Once, in Quarters, January 2022 to September 2024

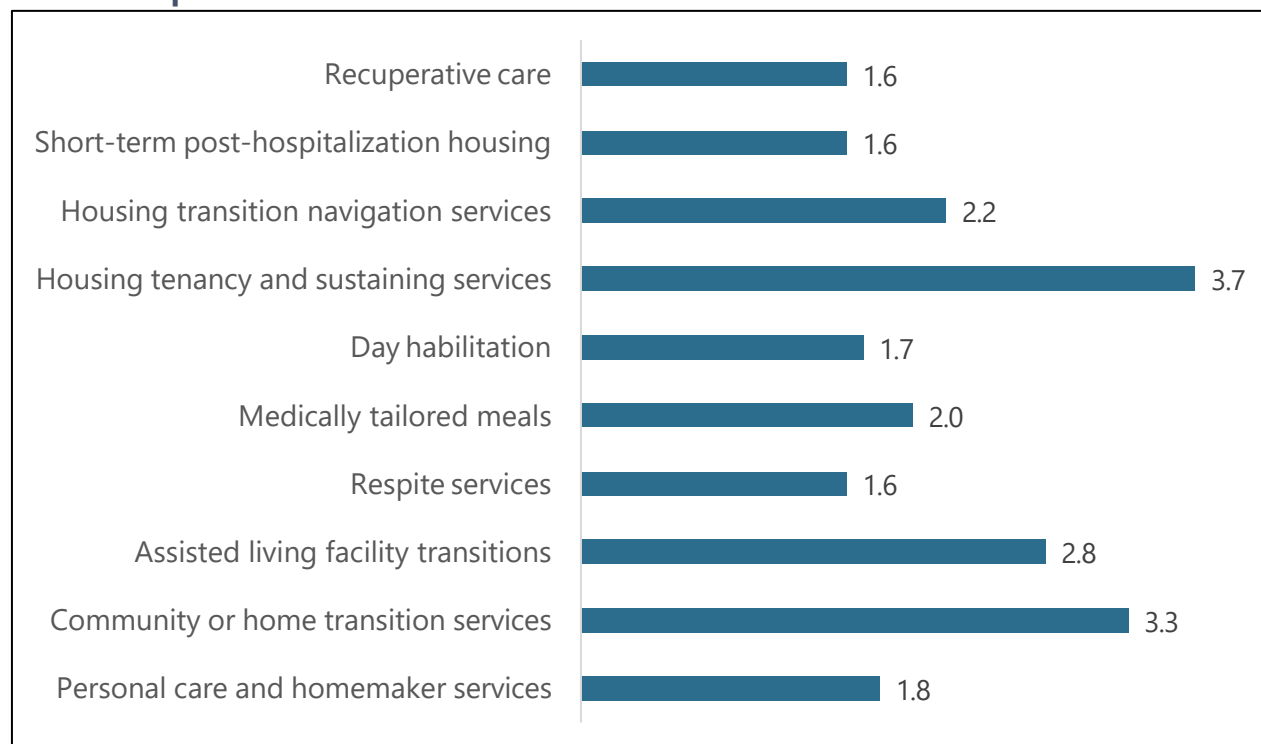


Source: Quarterly Implementation and Monitoring Reports, 2022 Q1 to 2024 Q3.

Note: QIMR data will underestimate frequency of use for Community Supports such as Medically Tailored Meals / Medically Supportive Food and Sobering Centers. An overview of Community Supports eligibility criteria and restrictions or limitations on allowable use is provided in [Appendix D](#). Recuperative Care and Short-Term Post-Hospitalization Housing are offered under a 1115 Waiver and the remaining Community Supports are offered under a 1915(b) Waiver. Medically tailored meals = Medically Tailored Meals / Medically Supportive Food.

[Exhibit 5.25](#) shows the average number of quarters Community Supports were used was highest for Housing Tenancy and Sustaining Services at 3.7 quarters and lowest for Asthma Remediation at 1.1 quarters.

Exhibit 5.25. Average Duration of Community Supports Use, in Quarters, January 2022 to September 2024



Source: Quarterly Implementation and Monitoring Reports, 2022 Q1 to 2024 Q3.

Note: Community Supports addressing one-time services or costs (e.g., Housing Deposits, Environmental Accessibility Adaptations) or covered for less than 24 hours duration (e.g., Sobering Centers) were omitted from this Exhibit. QIMRs only include data on whether members are receiving Community Supports in three-month intervals. Service duration will be overestimated for members receiving services for less than three months and may be underestimated for members that started receiving services in Q2 or Q3 2024 due to the Quarter 3 2024 cut-off. More precise data on service utilization using Medi-Cal claims will be provided in the Summative Evaluation Report. Recuperative Care and Short-Term Post-Hospitalization Housing are offered under a 1115 Waiver, and the remaining Community Supports are offered under a 1915(b) Waiver. Medically tailored meals = Medically Tailored Meals / Medically Supportive Food.

Measure 4. Number and proportion of eligible Medi-Cal members that used each Community Support

Data sources: QIMRs; Medi-Cal eligibility and claims data.

Data on members eligible for each Community Support were not available for the Interim Evaluation Report. This measure will be analyzed in the Summative Evaluation Report.

Measure 5. Demographic and health characteristics of Community Supports users compared to the population of non-users eligible for these services

Data sources: QIMRs; Medi-Cal eligibility and claims data.

Data on the non-users eligible for these services were not available for the Interim Evaluation Report and will be analyzed in the Summative Evaluation Report. Only data on demographic and health characteristics of Community Supports users are reported below. Community Supports users reported in the QIMRs were identified in Medi-Cal eligibility and claims data. Demographic characteristics were reported using Medi-Cal eligibility data based on the first month of service receipt. Health conditions and health care utilization were based on Medi-Cal claims data. The Chronic Conditions Warehouse were used to categorize members' chronic conditions.

Demographic Characteristics of Community Supports Users

[Exhibit 5.26](#) shows that the median age of housing-related Community Supports users ranged from 43 years for Housing Deposits to 52 years for Recuperative Care. The percentage of female Community Supports users was much lower for Recuperative Care and Short-Term Post-Hospitalization Housing than for the other housing-related Community Supports (27% and 31% respectively compared to 40% for Day Habilitation and 63% for Housing Deposits). Conversely, the percentage of Community Supports users experiencing homelessness was much higher for Recuperative Care and Short-Term Post-Hospitalization Housing than for the other housing-related Community Supports (71% and 73% respectively compared to 47% for Housing Tenancy and Sustaining Services and 66% for Day Habilitation).

In addition, the percentage of Community Supports users who were White was much higher for Short-Term Post-Hospitalization Housing (48%) than for the other housing-related Community Supports (25% to 36%), while the percentage of Community Supports users who were Black or African-American was much lower for Day Habilitation and Short-Term Post-Hospitalization Housing than for other housing-related Community Supports (8% and 12% respectively compared to 23% to 34% for the other Community Supports).

Exhibit 5.26. Demographics of Housing-Related Community Supports Users, January 2022 to September 2024

Demographics	Recuperative Care	Short-Term Post-Hospitalization Housing	Housing Transition Navigation Services	Housing Deposits	Housing Tenancy and Sustaining Services	Day Habilitation
Number of users	10,900	2,868	76,314	9,922	33,269	2,816
Age at enrollment (Average / median)	50 / 52	49 / 51	45 / 46	44 / 43	48 / 50	47 / 48
Female	27%	31%	53%	63%	49%	40%
Race and ethnicity						
White	32%	48%	28%	26%	25%	36%
Hispanic	28%	21%	30%	29%	26%	33%
Black	23%	12%	24%	26%	34%	8%
Asian	2%	1%	1%	1%	1%	2%
American Indian/Alaska Native	1%	1%	1%	1%	1%	1%
Native Hawaiian and other Pacific Islander	1%	1%	1%	1%	1%	1%
Other or unknown	14%	15%	15%	17%	12%	20%
English as preferred language	92%	95%	90%	89%	91%	93%
Experiencing homelessness	71%	73%	56%	50%	47%	66%

Source: Quarterly Implementation and Monitoring Reports, 2022 Q1 to 2024 Q3. Medi-Cal eligibility and claims data.

Note: Data included 297,544 unique Community Supports users between 2022 Q1 to 2024 Q3. Data excluded 21 users that were included in the QIMRs but could not be identified in the Medi-Cal eligibility data. Members experiencing homelessness were identified using a previously validated model that uses predictors such as address- and claims-based indicators and county-level homelessness rate.²⁴ Recuperative Care and Short-Term Post-Hospitalization Housing are offered under a 1115 Waiver and the remaining Community Supports are offered under a 1915(b) Waiver. Asian includes Filipino, Amerasian, Chinese, Cambodian, Japanese, Korean, Asian Indian, Laotian, and Vietnamese.

[Exhibit 5.27](#) shows that demographic characteristics of users of the remaining Community Supports varied by age, sex, and race/ethnicity. For example, the median age of users ranged from 16 years for Asthma Remediation to 70 years for ALF Transitions. Also, 96% of Sobering Center users had English as a preferred language compared to 53% of Medically Tailored Meals / Medically Supportive Food users.

Exhibit 5.27. Demographics of Other Community Supports Users, January 2022 to September 2024

Demographics	MTM / MSF	Respite Services	ALF Transitions	CHTS	PCHS	EAA	Sobering Center	Asthma Remediation
Number of users	144,513	1,912	1,023	377	5,224	1,152	3,830	3,772
Age at enrollment (Average / median)	51 / 54	62 / 69	70 / 70	68 / 68	63 / 65	67 / 68	41 / 39	26 / 16
Female	65%	60%	48%	50%	59%	60%	29%	57%
Race and ethnicity								
White	17%	24%	41%	31%	28%	36%	34%	11%
Hispanic	50%	35%	14%	18%	34%	29%	28%	65%
Black	5%	9%	11%	8%	10%	10%	10%	10%
Asian	12%	17%	4%	8%	13%	9%	1%	2%
American Indian and Alaska Native	0%	0%	0%	0%	0%	0%	1%	0%
Native Hawaiian and other Pacific Islander	1%	2%	2%	5%	2%	2%	1%	0%
Other or unknown	15%	13%	27%	31%	13%	14%	25%	12%
English as preferred	53%	62%	90%	82%	65%	57%	96%	64%

Demographics	MTM / MSF	Respite Services	ALF Transitions	CHTS	PCHS	EAA	Sobering Center	Asthma Remediation
language								
Experiencing homelessness	14%	10%	23%	23%	13%	16%	68%	9%

Source: Quarterly Implementation and Monitoring Reports, 2022 Q1 to 2024 Q3. Medi-Cal eligibility and claims data.

Note: Data included 297,544 unique users between 2022 Q1 and 2024 Q3. Data excluded 21 users included in QIMRs but not identified in the Medi-Cal eligibility data. Members experiencing homelessness were identified using a previously validated model that uses predictors such as address- and claims-based indicators and county-level homelessness rate.²⁴ Asian includes Filipino, Amerasian, Chinese, Cambodian, Japanese, Korean, Asian Indian, Laotian, and Vietnamese. MTM/MSF = Medically Tailored Meals / Medically Supportive Food; ALF = ALF; CHTS = Community or Home Transition Services; PCHS = Personal Care and Homemaker Services; EAA = Environmental Accessibility Adaptations.

Health Conditions and Health Care Utilization of Community Supports Users

[Exhibit 5.28](#) shows the health conditions and health care utilization of housing-related Community Supports users at baseline, defined as the 2-year period prior to first use of that Community Support. Data shows that the prevalence of chronic conditions varied by housing-related Community Support. For example, users of Short-Term Post-Hospitalization Housing and Housing Tenancy and Sustaining Services had the highest prevalence of serious mental illness (28%) while users of Housing Deposits had the lowest (17%). Health care utilization also varied by housing-related Community Support. For example, Recuperative Care users had the highest average number of ED visits (5.9 visits) while users of Housing Tenancy and Sustaining Services had the lowest (2.5 visits).

[Exhibit 5.29](#) shows that prevalence of chronic conditions at baseline, i.e., the 2-year period prior to first Community Supports use, also varied across users of the remaining Community Supports. For example, prevalence of serious mental illness was highest among users of ALF Transitions (25%) and lowest among users of Medically Tailored Meals / Medically Supportive Food (6%). Sobering Center users had the highest average number of ED visits at baseline (8.3 visits) while users of Medically Tailored Meals / Medically Supportive Food had the lowest (1.7 visits).

Exhibit 5.28. Health Conditions and Health Care Utilization of Housing-Related Community Supports Users, January 2022 to September 2024

Health Characteristics	Recuperative Care	Short-Term Post-Hospitalization Housing	Housing Transition Navigation Services	Housing Deposits	Housing Tenancy and Sustaining Services	Day Habilitation
Number of users	10,900	2,868	76,314	9,922	33,269	2,816
Health conditions						
Asthma	5%	6%	7%	6%	7%	5%
Chronic kidney disease	16%	17%	11%	8%	10%	9%
COPD	9%	10%	6%	5%	7%	5%
Diabetes	14%	15%	11%	9%	11%	9%
Hypertension	26%	27%	20%	16%	21%	18%
Depression or anxiety	23%	31%	24%	20%	27%	22%
Serious mental illness	23%	28%	22%	17%	28%	20%
SUD	27%	37%	20%	16%	18%	23%
Health care utilization: (Any / Average number)						
ED visits	74% / 5.9	76% / 4.7	67% / 3.5	65% / 3.1	54% / 2.5	66% / 3.4
Hospitalizations	55% / 2.4	47% / 1.8	29% / 0.8	24% / 0.6	23% / 0.6	30% / 1.1
Primary care	77% / 8.0	80% / 7.9	79% / 8.2	80% / 8.3	71% / 7.1	71% / 6.2

Health Characteristics	Recuperative Care	Short-Term Post-Hospitalization Housing	Housing Transition Navigation Services	Housing Deposits	Housing Tenancy and Sustaining Services	Day Habilitation
Outpatient specialty care	51% / 3.7	51% / 3.7	54% / 4.9	56% / 5.0	47% / 3.9	43% / 3.0

Source: Quarterly Implementation and Monitoring Reports, 2022 Q1 to 2024 Q3. Medi-Cal eligibility and claims data.

Note: Data included 297,544 unique users between 2022 Q1 to 2024 Q3. Data excluded 727 members in the QIMRs that could not be identified in the Medi-Cal claims data in the two years prior to first Community Supports use. Health condition indicators were constructed using the Chronic Condition Warehouse. Percents may not add to 100% due to rounding. Recuperative Care and Short-Term Post-Hospitalization Housing are offered under a 1115 Waiver and the remaining Community Supports are offered under a 1915(b) Waiver. COPD = Chronic Obstructive Pulmonary Disease. SUD is Substance Use Disorder. ED is Emergency Department.

Exhibit 5.29. Health Conditions and Health Care Utilization of Other Community Supports Users, January 2022 to September 2024

Health Characteristics	MTM / MSF	Respite Services	ALF Transitions	CHTS	PCHS	EAA	Sobering Center	Asthma Remediation
Number of users	144,513	1,912	1,023	377	5,224	1,152	3,830	3,772
Health conditions								
Asthma	3%	4%	5%	4%	4%	5%	3%	14%
Chronic kidney disease	6%	10%	21%	24%	11%	17%	5%	5%
COPD	2%	5%	9%	10%	5%	8%	3%	5%
Diabetes	7%	11%	19%	24%	11%	20%	4%	6%
Hypertension	8%	15%	35%	36%	16%	33%	11%	9%
Depression or anxiety	7%	11%	23%	23%	13%	21%	17%	11%
Serious mental illness	6%	9%	25%	23%	11%	16%	17%	9%
SUD	4%	6%	16%	18%	8%	9%	21%	5%
Health care utilization: (Any / Average number)								
ED visits	51% / 1.7	53% / 1.9	47% / 2.3	49% / 2.3	58% / 2.4	53% / 2.1	83% / 8.3	67% / 2.5
Hospitalizations	22% / 0.5	36% / 1.1	41% / 1.5	56% / 3.2	44% / 1.5	39% / 1.2	41% / 1.2	17% / 0.3
Primary care	81% / 9.5	79% / 11.0	65% / 9.7	76% / 14.1	79% / 11.1	75% / 11.2	75% / 6.5	97% / 14.9
Outpatient specialty care	66% / 7.9	70% / 9.8	54% / 5.4	68% / 7.8	72% / 10.7	75% / 12.4	44% / 2.4	64% / 7.2

Source: Quarterly Implementation and Monitoring Reports, 2022 Q1 to 2024 Q3. Medi-Cal eligibility and claims data.

Note: Data included 297,544 unique users between 2022 Q1 to 2024 Q3. Data excluded 727 members included in QIMRs but not identified in the Medi-Cal claims in the two-year period prior to first Community Supports use. Health condition indicators were constructed using the Chronic Condition Warehouse. Percents may not add to 100% due to rounding error. MTM/MSF = Medically Tailored Meals / Medically Supportive Food; ALF = ALF; CHTS = Community or Home Transition Services; PCHS = Personal Care and Homemaker Services; EAA = Environmental Accessibility Adaptations; COPD = Chronic Obstructive Pulmonary Disease. SUD is Substance Use Disorder. ED is Emergency Department.

Measure 6. Proportion of members with housing needs that received more than one Community Support simultaneously

Data source: QIMRs.

[Exhibit 5.26](#) and [Exhibit 5.27](#) ([Evaluation Question 4 Measure 5](#)) showed that between 9% to 73% of Community Supports users experienced homelessness in the 2-year period prior to first service use. In addition, UCLA-RAND assessed the proportion of housing-related Community Supports users that received another housing-related Community Support in the same quarter as a proxy for simultaneous use ([Exhibit 5.30](#)). Data showed that 91% of housing deposit users and 67% of Short-Term Post-Hospitalization Housing users also used another Community Support in the same quarter. However, only 15% of Housing Transition Navigation Services users and 30% of Housing Tenancy and Sustaining Services users received another Community Support in the same quarter.

Exhibit 5.30. Proportion of Housing-related Community Supports Users that Received Another Community Support in the Same Quarter, July 2024 to September 2024

Community Support	Number of Members Receiving	Proportion of Members that Received Another Housing-related Community Support
Recuperative Care	3,746	35%
Short-Term Post-Hospitalization Housing	1,570	67%
Housing Transition Navigation Services	36,968	15%
Housing Deposits	3,027	91%
Housing Tenancy and Sustaining Services	9,093	30%
Day Habilitation	1,836	60%

Source: Quarterly Implementation and Monitoring Reports, 2024 Q3.

Note: Data were reported for use of Community Supports in the same quarter. More precise data on service utilization using Medi-Cal claims data will be included in the Summative Evaluation Report. Recuperative Care and Short-Term Post-Hospitalization Housing are offered under a 1115 Waiver and the remaining Community Supports are offered under a 1915(b) Waiver.

Measure 7. Most frequently co-occurring Community Supports

Data source: QIMRs.

[Exhibit 5.31](#) shows the three most frequent Community Supports received in the same quarter by users of specific Community Supports in 2024 Q3. Data shows that users of housing-related Community Supports most frequently used other housing-related Community Supports or Medically Tailored Meals / Medically Supportive Food in the same quarter. For example, Housing Transition Navigation Services users most frequently received Housing Deposits (6%), Housing Tenancy and Sustaining Services (5%), or Medically Tailored Meals / Medically Supportive Food (5%) in the same quarter.

Exhibit 5.31. Community Supports Most Frequently Used in the Same Quarter, July to September 2024

Community Support	Top Three Community Supports Most Frequently Used in the Same Quarter		
Recuperative Care	HTNS (31%)	STPHH (7%)	Day Habilitation (6%)
Short-Term Post-Hospitalization Housing	HTNS (60%)	Recuperative Care (17%)	Day Habilitation (7%)
Housing Transition Navigation Services	Housing Deposits (6%)	HTSS (5%)	MTM / MSF (5%)
Housing Deposits	HTNS (76%)	HTSS (42%)	MTM / MSF (6%)
Housing Tenancy and Sustaining Services	HTNS (21%)	Housing Deposits (14%)	MTM / MSF (9%)
Day Habilitation	HTNS (34%)	HTSS (20%)	Recuperative Care (11%)
Medically Tailored Meals / Medically Supportive Food	HTNS (2%)	HTSS (1%)	PCHS (1%)
Respite Services	PCHS (34%)	MTM / MSF (8%)	EAA (3%)
ALF Transitions	Community or Home Transition Services (19%)	HTNS (3%)	PCHS (2%)
Community or Home Transition Services	ALF Transitions (44%)	HTNS (4%)	PCHS (3%)
Personal Care and Homemaker Services	Respite Services (14%)	MTM / MSF (13%)	EAA (3%)
Environmental Accessibility Adaptations	MTM / MSF (17%)	PCHS (12%)	HTSS (3%)
Sobering Centers	HTNS (11%)	Day Habilitation (5%)	Recuperative Care (5%)

Community Support	Top Three Community Supports Most Frequently Used in the Same Quarter		
Asthma Remediation	MTM / MSF (4%)	Respite Services (2%)	PCHS (2%)

Source: Quarterly Implementation and Monitoring Report, 2024 Q3.

Note: Data were reported for use of Community Supports in a given quarter. More precise data using Medi-Cal claims data will be provided in the Summative Evaluation Report. Recuperative Care and Short-Term Post-Hospitalization Housing are offered under a 1115 Waiver and the remaining Community Supports are offered under a 1915(b) Waiver. HTNS = Housing Transition Navigation Services; HTSS = Housing Tenancy and Sustaining Services; STPHH = Short-Term Post-Hospitalization Housing; MTM / MSF = Medically Tailored Meals / Medically Supportive Food; PCHS = Personal Care and Homemaker Services; EAA = Environmental Accessibility Adaptations; ALF = ALF.

Measure 8. Demographic and health characteristics of members receiving more than one Community Support, relative to members receiving only one Community Support

Data sources: QIMRs; Medi-Cal eligibility and claims data.

Data on this measure were not available for the Interim Evaluation Report and will be included in the Summative Evaluation Report.

Measure 9. MCP and provider perceptions of factors affecting member use of Community Supports

Data sources: October 2024 to July 2025 provider interviews; July to September 2024 Medicaid managed care plan (MCP) interviews.

In interviews, multiple MCPs described efforts to contract with at least some providers that were “experts in serving the community” and that could meet members’ different cultural and linguistic needs. MCPs considered this approach important for engaging members in Community Supports.

In interviews, providers identified four factors affecting member use of Community Supports ([Exhibit 5.32](#)).

Exhibit 5.32. Community Supports Providers’ Perceptions of Factors Affecting Member Utilization

Factors Affecting Member Use of Community Supports	Illustrative Quotes
Providers’ ability to build rapport with new members	<i>“Clients come in defensive from different [prior] experiences ... and we have to build rapport to get them to open up ... create an environment for people to feel like we’re here for them.”</i> - Provider #7 <i>“You will have a lot of clients that will judge you based on your first [contact] and after that likely will never engage again or will continue services for a long time ... You want to ... lead with what they need.”</i> - Provider #8 <i>“Uptake for some of our providers is from people who</i>

Factors Affecting Member Use of Community Supports	Illustrative Quotes
	<i>already receive other services from there ... 'Oh I was able to add on this service we already provide, because they already knew us'."</i> - Provider #41
Providers' approach to member engagement and service delivery	<i>"A lot of our members are high touch, high need, and at times, in-person visits are more personable ... especially when it is a homeless individual." - Provider #5</i> <i>"It's rare you will find a client in our office because we're going to go to the shelter. We're going to meet you at the park. We're going to go to where you are ... because we get more results that way ... And at our housing sites, we're on site."</i> - Provider #9
MCPs' authorization and communication processes	<i>"We have MCPs that do give us pre-authorized members, which I love." - Provider #20</i> <i>"Presumptive eligibility is huge, because authorizations ... every time they're delayed, makes it harder on the member engagement." - Provider #12</i> <i>"The other issue is once [the Community Support services] were approved by the MCP, the approvals weren't being communicated to the provider." - Provider #47</i>
Clients' desire for housing (for housing-related Community Supports only)	<i>"Even when we enroll somebody ... they'll say 'Well, really, I just need housing. I don't want anything else.' And that becomes our biggest thing." - Provider #4</i> <i>"Clients' willingness to engage is also dependent on their understanding ... because a lot of times they just hear 'housing' and they're like yes, I want it, and they think they're going to get housed tonight, get a voucher, think we're Section 8 ... so it's important for us when we</i>

Factors Affecting Member Use of Community Supports	Illustrative Quotes
	<i>outreach to let them know these are case management services.” - Provider #6</i>

Source: Enhanced Care Management and Community Supports Provider Interviews, October 2024 to July 2025.

Note: Data were based on 60 unique organizational respondents who offered Community Supports. Providers were purposively sampled for variation in MCPs contracted with, Community Supports provided, geographic region, and provider type. Illustrative quotes were selected to represent key themes and maximize heterogeneity in provider perspectives represented.

Providers shared that members are often suspicious or resistant to services if the provider was not previously known to them. Factors perceived as helpful to building rapport include already having previously served the member in another capacity, and having the Community Supports provider contact the member already knowing a little bit about the member’s history and service need so they do not have to *“retell their story again.”* Providers of Housing Transition Navigation Services also noted benefits of providing other services to allow the member to get other tangible needs met (e.g., shower, meal, clinical care, detox) before trying to discuss care plan goals.

Providers identified outreach and service modality as critical to member engagement, with most providers describing the importance of being person-centered and trying to go to the member and *“meet them where they’re at”* rather than relying exclusively on telephonic or text-based outreach or expecting the member to show up at a clinic or other facility. This was described as particularly important when serving members experiencing homelessness. A few providers in more rural or geographically distributed locations highlighted transportation-related barriers as motivating the decision to rely principally on telehealth or telephonic service delivery. Medically Tailored Meals / Medically Supportive Food providers reported the most heterogeneity in approaches to member identification and outreach, but not in service delivery. Some concern was expressed about the potential for inappropriate referrals for Medically Tailored Meals / Medically Supportive Food when certain community-based approaches for outreaching to members were taken (e.g., advertisement on social media platforms or recruiting members in community-based settings like grocery stores) and when MCPs had not yet set up appropriate monitoring requirements to differentiate members being referred for food insecurity as opposed to nutrition-sensitive health conditions.

Providers also described how MCP authorization processes could facilitate or impede members' use of Community Supports. Specifically, delays in authorization could negatively impact members' ability to receive Community Supports, particularly services affecting transitions from acute or long-term care settings to lower levels of care (e.g., Recuperative Care, Short-Term Post-Hospitalization Housing, ALF Transitions, Community or Home Transition Services). Providers also noted that poor communication related to MCP authorizations could also be problematic, e.g., if providers were not aware that another provider was already authorized to provide a service or were not notified that an authorization had been approved.

Finally, multiple providers noted that although housing needs were a strong motivator for members to engage with housing-related Community Supports, providers needed to carefully manage members' understanding and expectations of what the housing-related Community Supports addressed and did not include, and over what duration.

Evaluation Question 5: What strategies are being used to identify and refer eligible members to Community Supports?

Measure 1. MCPs and providers' self-reported processes for identifying members eligible for Community Supports and connecting them to services

Data sources: October 2024 to July 2025 provider interviews; July to September 2024 MCP interviews; and June to July 2025 provider survey.

MCPs reported two main processes for identifying members eligible for Community Supports ([Exhibit 5.33](#)). All MCPs reported relying on contracted providers to identify members eligible for Community Supports and connect them to services. Approximately 39% of MCPs also described more proactive efforts to identify and refer members, e.g., by cultivating "referral partners" in the community or less commonly, through direct member outreach. For example, one MCP described setting up a meeting between local hospital discharge planners and Medically Tailored Meals / Medically Supportive Food providers to help make hospital discharge planners aware of the service.

Exhibit 5.33. MCP Processes for Identifying Members Eligible for Community Supports and Connecting Them to Services

MCP Process	% of MCPs Reporting	Illustrative Quotes
Rely on contracted providers to generate referrals	100%	<i>"We are a referral-based service. We don't pre-identify members eligible for Community Supports." - MCP #22</i> <i>"Most if not all of our Community Supports referrals are bottom up ... It is contracted providers who are identifying and referring." - MCP #3</i> <i>"We didn't anticipate the amount of outreach that our contracted vendors would conduct in the community ... in the first year, our numbers were staggeringly high." - MCP #5</i>
Proactively identify and refer	35%	<i>"DHCS didn't want us to rely on ... data mining to identify members that may be eligible ... so we engaged providers in the community ... sources that don't want to be Community Supports providers but can identify and refer." - MCP #4</i> <i>"We launched a countywide program for street medicine and tried to ensure providers were incented to refer to housing transition navigation." - MCP #18</i> <i>"We are proactive in asking questions about housing insecurity in our member health risk assessment so we can be proactive and identify these members. We also contract with the local housing authority for data sharing... and educate our primary care providers and medical groups." - MCP #23</i> <i>"We sent out newsletters to our members and coordinated with our local 211 to help with referrals." - MCP #9</i>

Source: Managed Care Plan Interviews, July to September 2024.

Note: Data were based on 23 unique organizational respondents out of 24 MCPs eligible to offer Community Supports in 2024. One MCP that stopped operating as a Medi-Cal MCP beginning January 1, 2024, was jointly interviewed with another MCP that took over its service area. One MCP specializing in care for members with HIV/AIDS in a single county was not interviewed. Illustrative quotes were selected to represent key themes and highlight heterogeneity in processes for identifying eligible members. The same MCPs may have reported more than one process.

Providers varied in processes used to identify and refer members to Community Supports ([Exhibit 5.34](#)). Two Community Supports, Housing Deposits and Day Habilitation, were described as very rarely provided to members not already receiving other services from the same organization. Certain providers, typically affordable housing developers, also elected to provide Housing Tenancy and Sustaining Services only to clients already being served by their organization rather than accepting external referrals. For the remaining Community Supports, providers reported relying heavily on a range of referral sources.

Exhibit 5.34. Providers’ Processes for Identifying Members Eligible for Each Community Support and Connecting Them to Services

Community Support	Referral Sources	Illustrative Quotes
Recuperative Care	» Hospitals » MCPs » Street medicine » MH/SUD providers » SNFs or ALFs	<i>“Hospitals are a big partner.” - Provider #1</i> <i>“Our primary referral source is street medicine, the second is hospital referrals.” - Provider #38</i>
Short-Term Post-Hospitalization Housing	» Recuperative Care » Hospitals » MCPs » Street medicine » MH/SUD providers » SNFs or ALFs	<i>“We partner with the hospital. We receive folks from the ER who may be frequent fliers, and we do Short-Term Post-Hospitalization Housing and Housing Transition Navigation ... braided together.” - Provider #60</i>

Community Support	Referral Sources	Illustrative Quotes
Housing Transition Navigation Services	» Street outreach » Coordinated entry system » Other providers in the same organization » Other providers in the community » MCPs	<i>"We also operate the Coordinated Entry System ... We will ask if clients have managed care ... and if they're not currently receiving service, we will request an authorization ... We also have people coming into our shelter." - Provider #3</i> <i>"The majority of our referrals are in-house." - Provider #6</i>
Housing Deposits	» Housing Transition Navigation Services » Other providers in the same organization	<i>"Housing Deposits [can be] cost-prohibitive ... A lot of providers of Housing Deposits don't take outside referrals. They only provide deposits to people they're already providing [other] services to." - Provider #11</i>
Housing Tenancy and Sustaining Services	» Housing Transition Navigation Services » Coordinated entry system » Other providers in the same organization » PSH providers	<i>"We work with the housing authority for set-aside vouchers ... and on landlord navigation ... Once somebody has secured a unit, they get transferred to Housing Tenancy and Sustaining Services." - Provider #17</i> <i>"As a large nonprofit affordable housing developer and manager, we focus on Housing Tenancy and Sustaining Services for residents in our PSH ... We don't accept outside referrals." - Provider #61</i>
Day Habilitation	» Other providers in the same organization » Recuperative Care	<i>"[Once clients are with us] We'll tell them about our Day Habilitation program, and we'll have staff go into all our [Recuperative Care] facilities and provide group programming on different</i>

Community Support	Referral Sources	Illustrative Quotes
	» Short-Term Post-Hospitalization Housing	<i>independent living skills.” - Provider #2</i>
Medically Tailored Meals / Medically Supportive Food	» Direct outreach to members » Advertisements » Primary care clinics » Other providers in the community » Other providers in the same organization » MCPs	<i>“Our dietician is out in the community [at dialysis centers and other locations] eliciting trust. You send your referral, your client to us, we’re going to help them.” - Provider #30</i> <i>“We... have gotten less than five referrals from the MCP itself.” - Provider #29</i>
Respite Services	» MCPs » Direct outreach in the community	<i>“We started doing senior wellness fairs in different counties ... bringing in different providers ... and had seniors and their families come to get resources.” - Provider #16</i>
ALF Transitions	» Direct outreach to SNFs » MCPs » Other providers in the community	<i>“The majority of referrals we have gotten is because we generated them.” - Provider #11</i>
Community or Home Transition Services	» Direct outreach to SNFs » MCPs » Other providers in the community	<i>“The referrals for the two nursing facility transitions are so underutilized ... We have been doing this work for a long time with our hospital partners ... but the amount of referrals we get is miniscule ... it hasn’t been tapped to get the word out to social services directors at SNFs that this is available” - Provider #34</i>

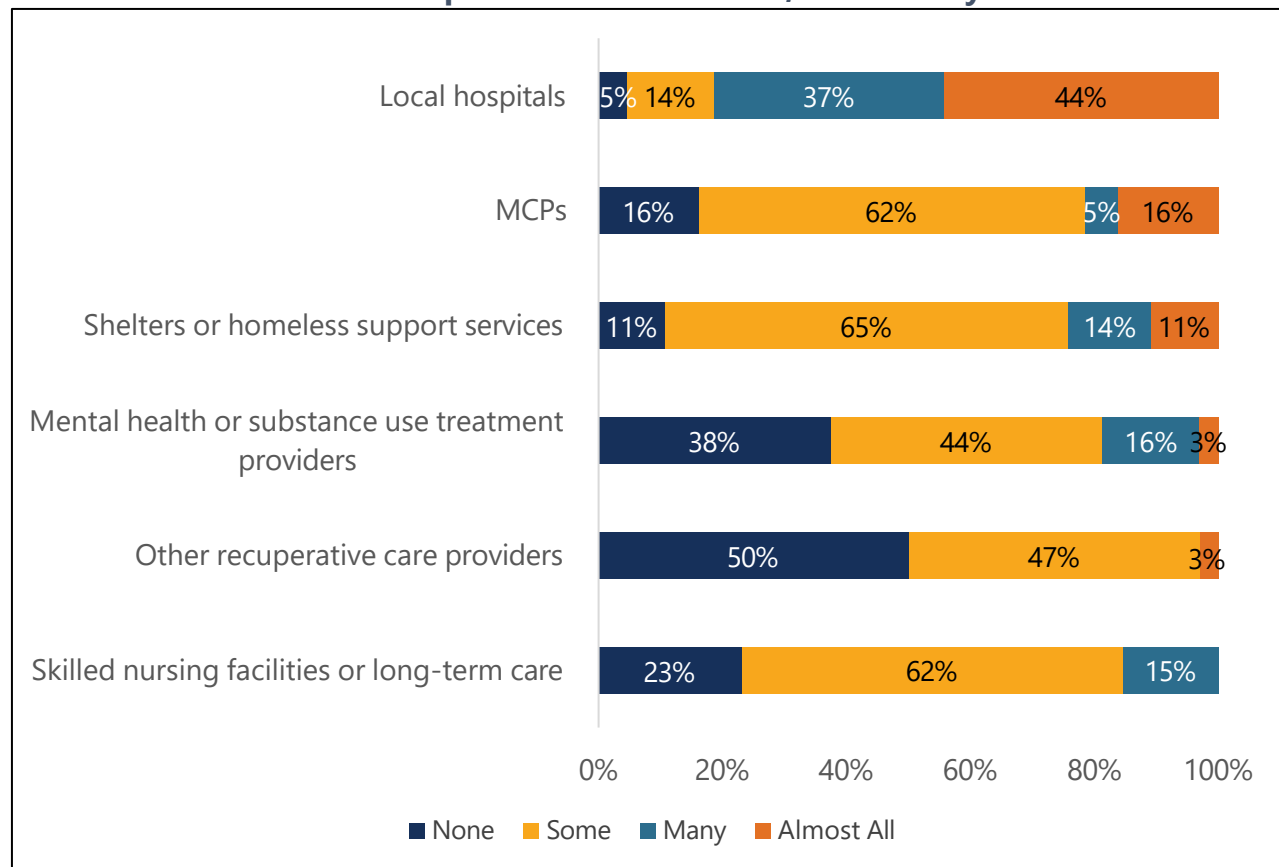
Community Support	Referral Sources	Illustrative Quotes
Personal Care and Homemaker Services	» MCPs » Recuperative Care » Direct outreach in the community	<i>"The MCP sends me referrals on a weekly basis, a thick packet of clients' information and their medical conditions ... Before the MCP would show the member approved for so many hours per week. Now, they want me to [conduct an assessment and] determine the hours." - Provider #18</i>
Environmental Accessibility Adaptations	» MCPs	<i>"There's been an eagerness with some MCPs to implement ... while others there are very few referrals or zero communication about referrals." - Provider #15</i>
Sobering Centers	» Police and law enforcement » Emergency medical services » Street outreach » Medical providers	<i>"Referrals vary by [which] Sobering Center. Clients may come from police, emergency medical services, street outreach teams, or ambulatory clinics." - Provider #36</i> <i>"We have a 10-bed facility in front of the jail ... the sheriff and law enforcement drop people off." - Provider #55</i>
Asthma Remediation	» MCPs » Other providers in the same organization » Other providers in the community » Direct outreach in the community	<i>"We have been pushing MCPs to help us identify members through utilization, using asthma medication ratios ... We also have done presentations at certain clinics." - Provider #26</i> <i>"Some providers end up contracting with allergists or other providers [to meet the provider order requirement] ... because of the roadblock of getting members' providers to answer our call and sign a form." - Provider #48</i>

Source: Enhanced Care Management and Community Supports Provider Interviews, October 2024 to July 2025.

Note: Data were based on 60 unique organizational respondents who offered Community Supports. Providers were purposively sampled for variation in MCPs contracted with, Community Supports provided, geographic region, and provider type. Illustrative quotes were selected to represent key themes and maximize heterogeneity in provider perspectives represented. MCP = Managed Care Plans; MH/SUD = Mental Health or Substance Use Disorder; SNFs = Skilled Nursing Facilities; ALFs = Assisted Living Facilities.

Surveyed providers of the two 1115 Community Supports (Recuperative Care and Short-Term Post-Hospitalization Housing) were asked to estimate the percentage of their referrals from different sources. [Exhibit 5.35](#) shows the percentage of providers reporting none, some, most, or almost all of their Recuperative Care referrals from different sources. Over 70% of Recuperative Care providers reported receiving many or almost all of their referrals from local hospitals, though some also reported relying on MCPs, shelters or homeless support services, or mental health or substance use treatment providers for referrals.

Exhibit 5.35. Sources of Recuperative Care Referrals, June to July 2025

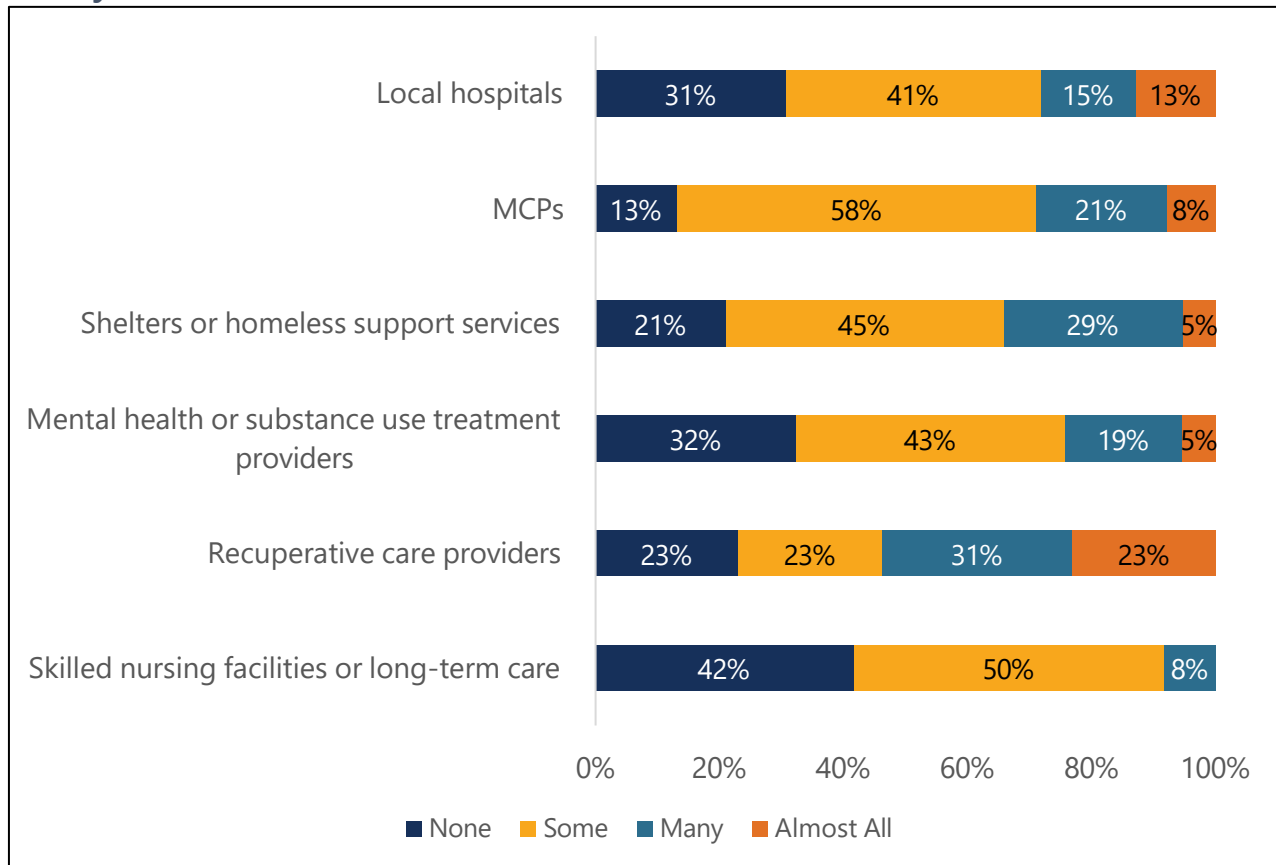


Source: Enhanced Care Management and Community Supports Provider Survey, June to July 2025.

Note: Data were based on 43 of the 49 unique respondents who provided Recuperative Care. None is no referrals, Some is 1%-24% of referrals, Many is 25%-74% of referrals, Almost All is 75%-100% of referrals from a given source. MCPs = Managed Care Plans.

[Exhibit 5.36](#) shows the percentage of providers reporting none, some, most, or almost all of their Short-Term Post-Hospitalization Housing referrals from different sources. Just over half (54%) of providers reported receiving many or almost all of their referrals from Recuperative Care providers. However, providers also received referrals from hospitals, MCPs, shelters or homeless support services, and mental health or substance use treatment providers as well.

Exhibit 5.36. Sources of Short-Term Post-Hospitalization Housing Referrals, June to July 2025



Source: Enhanced Care Management and Community Supports Provider Survey, June to July 2025.

Note: Data were based on 43 unique respondents of the 53 who provided Short-Term Post-Hospitalization Housing. None is no referrals, Some is 1%-24% of referrals, Many is 25%-74% of referrals, Almost All is 75%-100% of referrals from a given source. MCPs = Managed Care Plans.

Measure 2. Member self-reports of mechanisms for learning about how their Community Supports needs can be recognized and addressed

Data sources: Member survey.

Data for this measure were not available for the Interim Evaluation Report and will be addressed in the Summative Evaluation Report.

Measure 3. Member self-reports of who, how, and when MCP or provider offered information about options for managing their needs or how Community Supports might address their needs

Data source: Member survey.

Data for this measure were not available for the Interim Evaluation Report and will be addressed in the Summative Evaluation Report.

Measure 4. Member self-reports of number, types, and timing of exposure to and use of different types of Community Supports

Data source: Member survey.

Data for this measure were not available for the Interim Evaluation Report and will be addressed in the Summative Evaluation Report.

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

Goal 4 is addressed with one Evaluation Question and six measures articulated in the [Evaluation Questions and Hypotheses](#) sections of this report. Data sources used in analyses are articulated for each measure and focus specifically on impact of new Medicaid funding for housing-related Community Supports.

Evaluation Question 6: How is new Medicaid funding for Community Supports impacting existing systems of care?

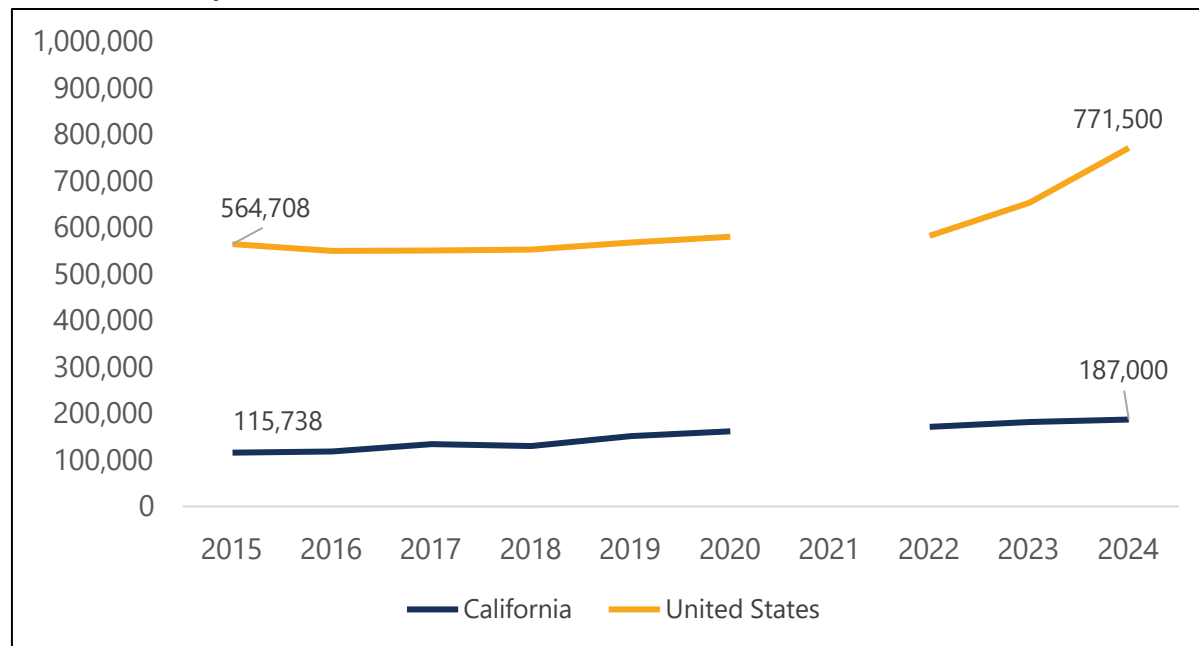
Measure 1. Number of people experiencing homelessness in California

Data source: 2015 to 2024 U.S. Department of Housing and Urban Development (HUD) Annual Point-in-Time counts of people experiencing homelessness.

[Exhibit 5.37](#) shows the number of people experiencing homelessness in California and in the United States between 2015 and 2024. The number of people experiencing homelessness in the United States remained relatively stable from 2015 to 2022 but increased from 582,462 people in 2022 to 771,500 people in 2024. The number of people experiencing homelessness in California did not increase as rapidly between

2022 and 2024 compared to the rest of the United States but close to a quarter (24%) of people experiencing homelessness in the United States live in California.

Exhibit 5.37. Number of People Experiencing Homelessness in California and in the United States, 2015 to 2024

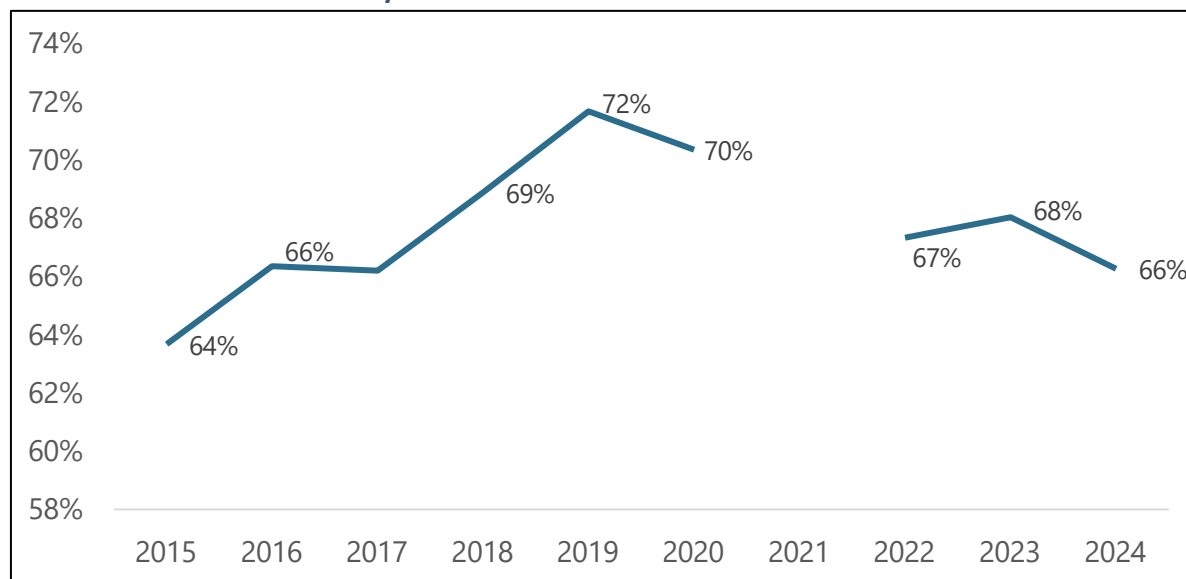


Source: U.S. Department of Housing and Urban Development Annual Point in Time Counts, 2015 to 2024.

Note: Data were not available in 2021 due to pandemic-related disruptions to counts.

[Exhibit 5.38](#) shows the percentage of people experiencing homelessness that were unsheltered or living in streets, vehicles, or other places not meant for human habitation in California. Data show an increase from 2015 (64%) to 2019 (72%). By 2024, 66% of people experiencing homelessness in California were unsheltered, compared to only 36% in the rest of the United States.

Exhibit 5.38. Percentage of People Experiencing Homelessness who were Unsheltered in California, 2015 to 2024



Source: U.S. Department of Housing and Urban Development Annual Point in Time counts, 2015 to 2024.

Note: Data were not available in 2021 due to pandemic-related disruptions to counts.

Unsheltered refers to living in streets, vehicles, or other places not meant for human habitation.

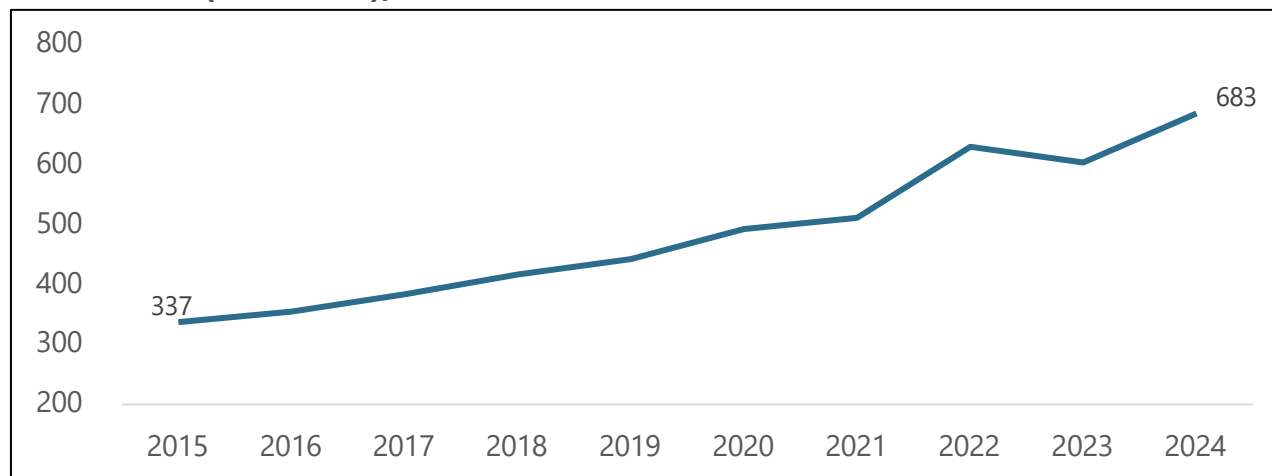
Measure 2. U.S. Department of HUD funding to Continuums of Care in California

Data source: 2015 to 2024 HUD Continuum of Care (CoC) Program Competition and Funding Reports.

CoCs are planning bodies developed for the purpose of coordinating housing and homeless services for people experiencing homelessness in the regions or localities they serve. In California, there were 44 CoCs in 2025. HUD provides federal funding for homeless services and housing programs through grants to local CoCs. These funds are awarded through the CoC planning process and allocated as part of an annual funding competition that takes into consideration a range of factors, such as a community's need for funding based on factors such as poverty and overcrowding. Increased levels of HUD CoC funding indicate a broader array of resources for programs that provide supportive services, transitional housing, permanent housing, and homelessness prevention. HUD CoC funding also supports the implementation of local HMIS, which is used to collect data on provision of housing and services to individuals and families at risk of or experiencing homelessness.

As shown in [Exhibit 5.39](#), HUD funding to CoCs in California increased from \$337 million in 2015 to \$683 million in 2024. Funding is contingent on the HUD budget and increases after 2020 were in part due to temporary funding increases in response to the COVID-19 pandemic.

Exhibit 5.39. Amount of U.S. Department of HUD funding to Continuums of Care in California (in millions), 2015 to 2024



Source: U.S. Department of Housing and Urban Development Continuum of Care Program Competition and Funding Reports, 2015 to 2024.

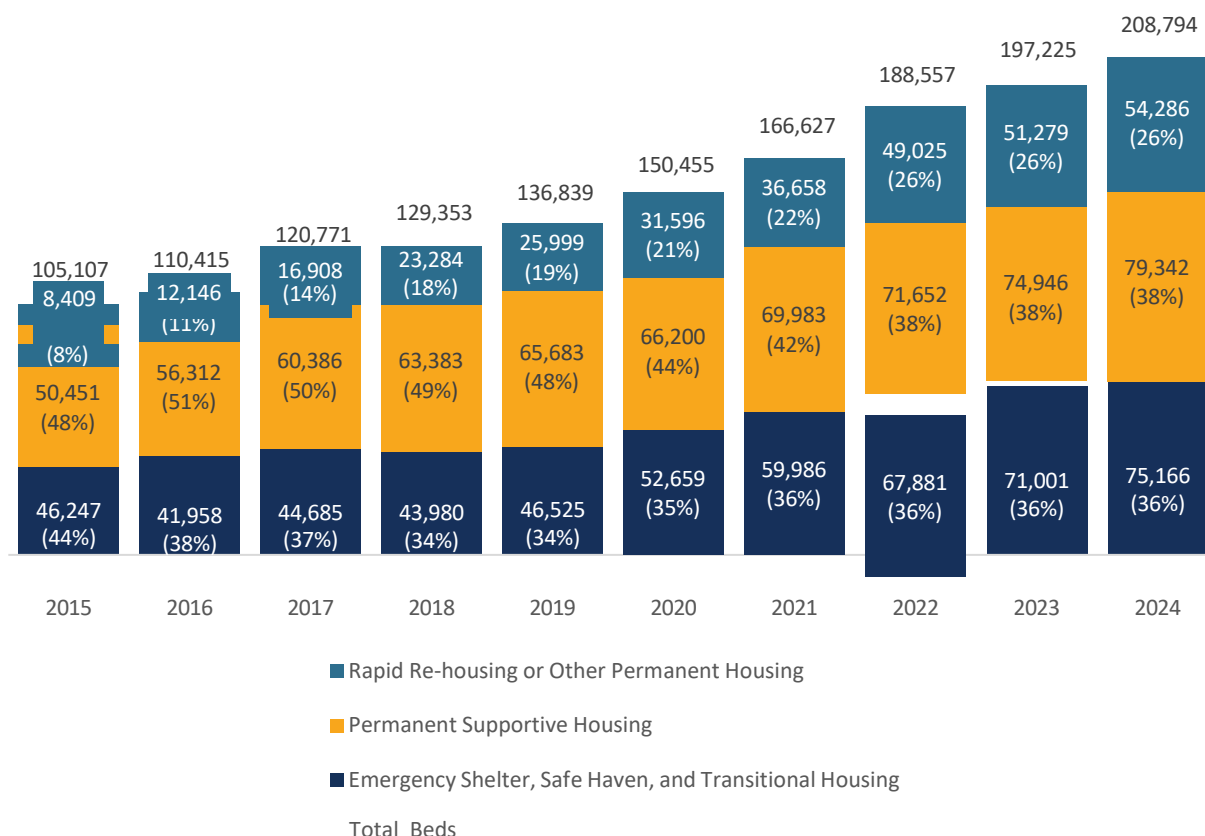
Measure 3. Continuum of Care Homeless Assistance Programs Housing Inventory in California

Data source: 2015 to 2024 HUD CoC Homeless Assistance Programs Housing Inventory.

The Homeless Assistance Program Housing Inventory is an annual point-in-time inventory of housing program beds dedicated to serving people experiencing homelessness within each CoC. These data serve as an indicator of the housing resources available within the homeless assistance system and can also be used to differentiate housing resources by program type. The total number of recorded CoC housing program beds in California almost doubled between 2015 and 2024, from 105,107 to 208,794 ([Exhibit 5.40](#)). The proportion of these beds allocated for rapid re-housing or other permanent housing increased from 8% to 26% in this period, but the proportion allocated for PSH declined from 48% to 38%. The former provides short-term rental assistance and services, typically lasting less than six months, while the latter combines permanent housing with indefinite leasing or rental assistance and on-site

support services tailored to address barriers to housing stability, such as physical and mental health diagnoses or co-occurring substance use issues.

Exhibit 5.40. Continuum of Care Homeless Assistance Programs Housing Inventory, California, 2015 to 2024



Source: U.S. Department of Housing and Urban Development Continuum of Care Homeless Assistance Programs Housing Inventory, 2015 to 2024.

Note: Y-axis indicates the total number of beds available per year.

Measure 4. LIHTC Housing Units in California

Data source: 2015 to 2024 California Tax Credit Allocation Committee data.

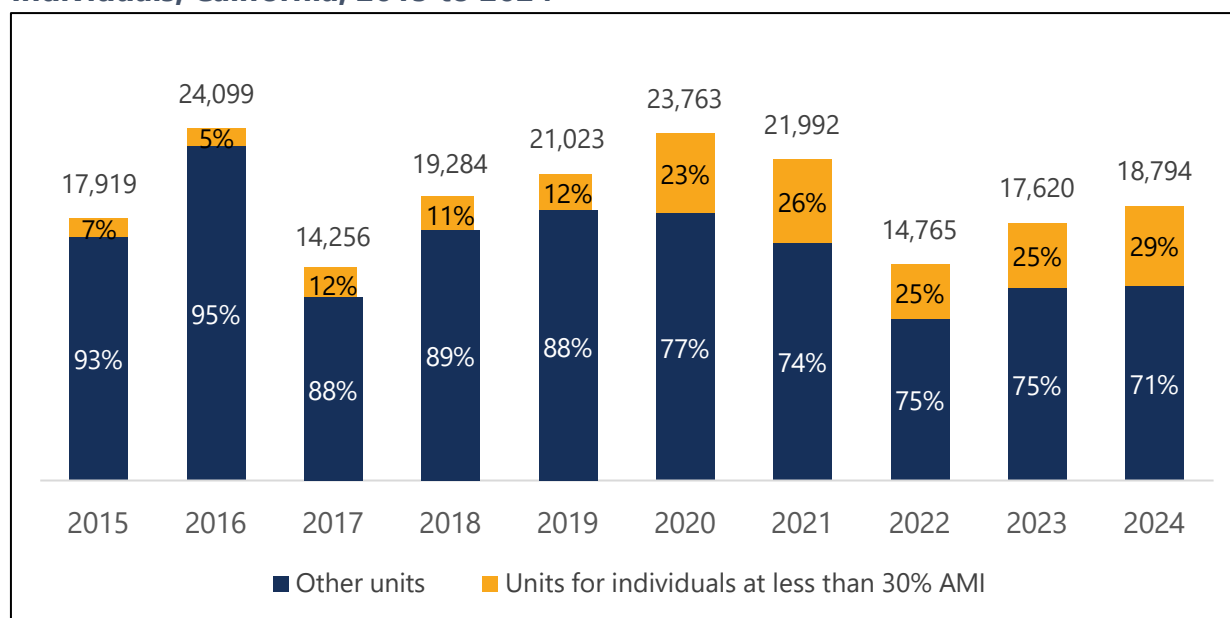
The LIHTC Housing Units program is the most important source of funding for the construction, rehabilitation, and preservation of housing affordable to lower-income households.^{82,83} The California's Tax Credit Allocation Committee does not publicly release the share of PSH units within LIHTC projects, but it does report on the share of

LIHTC units that targeted at households earning less than 30% of AMI. These units

mostly serve people who are at risk of or experiencing homelessness, or seniors on fixed incomes who meet the less than 30% of AMI threshold for household income.

The total number of new or preserved LIHTC units fluctuates by year due to the availability of credits or gaps in funding. However, a cumulative total of 193,515 LIHTC units were awarded tax credits in California between 2015 to 2024, ranging from 14,256 to 24,099 per year. As shown in [Exhibit 5.41](#), the proportion of new or preserved LIHTC units allocated for households with incomes less than 30% AMI has increased from 7% to 29%.

Exhibit 5.41. LIHTC Housing Units and Proportion Allocated to Low-Income Individuals, California, 2015 to 2024



Source: California Tax Credit Allocation Committee data.

Note: Y-axis reflects the total number of units in projects awarded LIHTC each year, but these properties may not yet be placed in service. AMI=Area Median Income; data include units <30% AMI and <20% AMI.

Measure 5: MCP and provider perceptions of how new Medicaid funding for Community Supports has impacted existing systems of care

Data sources: October 2024 to July 2025 provider interviews; July to September 2024 Medicaid managed care plan (MCP) interviews; November 2024 to January 2025 MCP survey.

MCPs described two types of positive impacts of the new Medicaid funding and a continued concern. In terms of positive impacts, [Exhibit 5.42](#) shows that seven MCPs

described new Medicaid funding as **strengthening relationships** between MCPs and housing providers in the community and between CBOs and clinical providers. Thirteen MCPs also described new Medicaid funding as **improving service infrastructure** such as the development of new Recuperative Care and Short-Term Post-Hospitalization Housing facilities, investment in street medicine programs to improve identification and engagement of members in Community Supports, and access to primary care.

Positive perceptions of CalAIM impact were tempered by concern regarding **insufficient housing**, which was cited by nine MCPs as an ongoing challenge in implementation of housing-related Community Supports. MCPs highlighted the importance of continued investment in affordable housing in California to fully address housing as a health-related social need.

Exhibit 5.42. MCP Perceptions of How New Medicaid Funding for Housing-Related Community Supports Has Impacted Existing Systems of Care

MCP Perceptions	Number of MCPs Reporting	Illustrative Quotes
Strengthened relationships in the community	7	<i>"We are collaborating with agencies that wouldn't typically be in our network ... to set up permanent housing, shelters, or other types of homeless support services that we [MCPs] can't cover but these are services our members might need to access." - MCP #16</i> <i>"Increased collaboration between CBOs and primary care providers helps enhance care coordination that addresses clinical and social determinants of health elements." - MCP survey open-ended response</i>
Improved service infrastructure within communities	13	<i>"All of the MCPs in our community are collaboratively funding the purchase of an old motel to turn it into a facility for people exiting incarceration to be able to go to instead of being homeless." - MCP #19</i> <i>"We worked with a local FQHC [federally qualified health center] to fund a street medicine program [using HHIP funds] that would serve three different regions." - MCP #9</i>

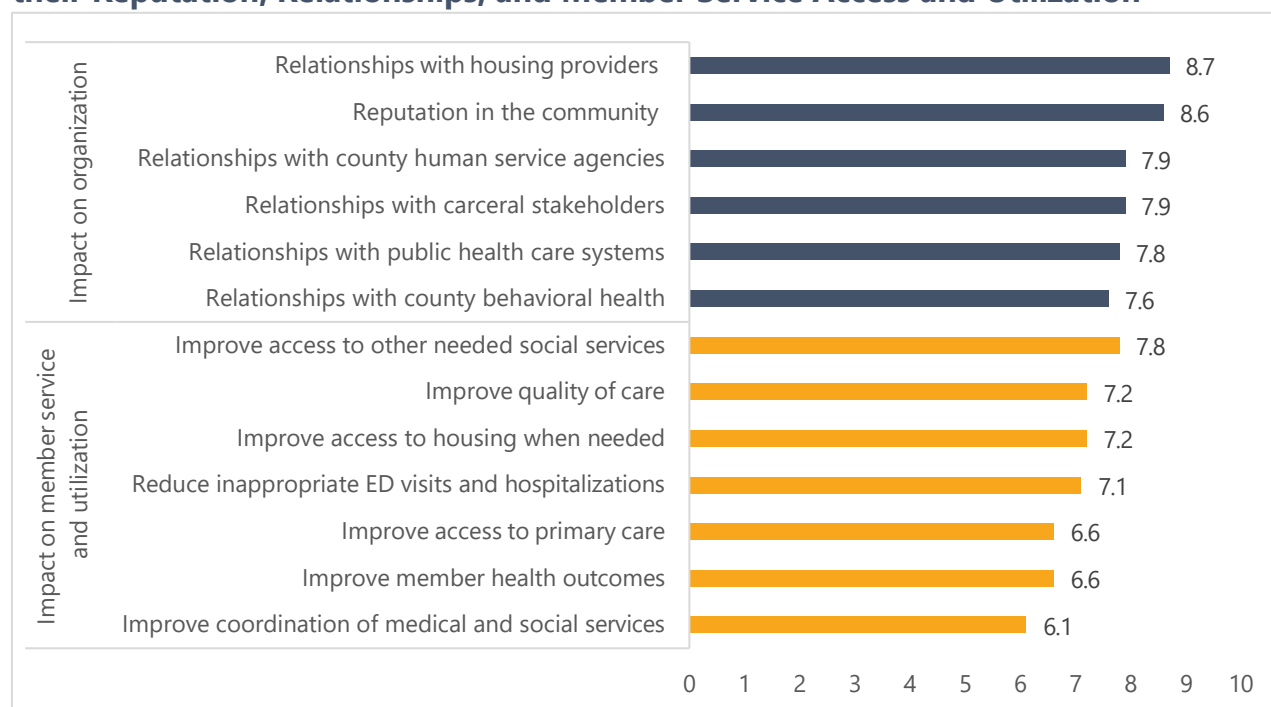
MCP Perceptions	Number of MCPs Reporting	Illustrative Quotes
Continued concern regarding insufficient affordable housing	9	<i>"There is a lot of capacity growth [still] needed ... CalAIM is a good idea if there's enough housing stock, but we need ... to figure out how to improve or increase the housing available to members." - MCP #8</i>

Source: Managed Care Plan Interviews, July to September 2024; Managed Care Plan Survey, November 2024 to January 2025.

Note: Interview data were based on 23 unique organizational respondents and survey data were based on 22 unique organizational respondents. There were 24 MCPs eligible to offer Community Supports in 2024. One MCP that stopped operating as a Medi-Cal MCP beginning January 1, 2024, was jointly interviewed with another MCP that took over its service area. One MCP specializing in care for members with HIV/AIDS in a single county was not interviewed or surveyed. One MCP that fully delegated responsibility for member care to another MCP did not respond to the survey. Illustrative quotes were selected to represent key themes and highlight heterogeneity in perceptions.

In a survey, MCPs rated perceived impact of participating in Community Supports on their reputation, relationships, and member service access and service utilization on a scale from 0 (not at all or not effective) to 10 (very or very effective). [Exhibit 5.43](#) shows that average MCP ratings were highest for impact of Community Supports on relationships with housing providers (8.7) and MCP reputation in the community (8.6) and lowest for improved coordination of care between medical and social services providers (6.1).

Exhibit 5.43. MCP Ratings of How Participating in Community Supports Impacted their Reputation, Relationships, and Member Service Access and Utilization



Source: Managed Care Plan Survey, November 2024 to January 2025.

Note: Data were based on 22 unique respondents out of 24 MCPs eligible to offer Community Supports in 2024. One MCP that fully delegated responsibility for member care to another MCP did not respond to the survey. One MCP specializing in care for members with HIV/AIDS in a single county was not surveyed. MCP ratings are based on a scale of 0 (not at all or not effective) to 10 (very or very effective). Housing providers included the local Continuum of Care, local housing authority, and other housing and homeless services providers. ED = Emergency Department.

In interviews, providers reflected on the perceived impacts of new Medicaid funding for Community Supports on existing systems of care. [Exhibit 5.44](#) shows that providers noted three benefits such as improved care integration and greater supply of services and four challenges such as increased competition and administrative burden.

Exhibit 5.44. Provider Perceptions of How Medicaid Funding for Housing-Related Community Supports Has Affected their Organizations and Communities

Perceived Impact	Illustrative Quotes
Benefits	
Improved integration of care through strengthened cross-sector relationships and awareness of resources in the community	<i>"CalAIM has been beneficial for the community. It is bringing resources some families didn't have access to if they weren't literally homeless ... A lot of the families we're serving now wouldn't qualify for anything through the homeless response system and then would end up being homeless, so this is a good tool for prevention." - Provider #3</i> <i>"Community Supports is transformative to Medi-Cal. Medi-Cal has never authorized services like this before ... [but despite challenges] ... it's really transformed the way we work with our members." - Provider #6</i> <i>"I could talk about positives all day long ... There's a lot more resources now and help in our community. A lot more people being housed, people getting off the streets ... So many more happy, healthy families ... if it were stripped away ... it would decimate a lot of organizations and resources out here." - Provider #50</i>
Growth in services, particularly for Recuperative Care providers in urban areas	<i>"Five years ago, I don't even think there was a Recuperative Care landscape ... it was an emerging practice ... Now there has been such rapid growth, which is wonderful." - Provider #1</i> <i>"Since CalAIM started, we've gotten more referrals ... we used to only have the one facility in the county, and then we opened another 36-bed facility ... and we're able to keep that facility full as well." - Provider #7</i>
City and county interest in encouraging providers to draw on multiple, separate	<i>"We have seen RFPs [request for proposals] released on the homeless services side that have scoring criteria that privilege providers that are also able to leverage CalAIM as a supplement." - Provider #2</i>

Perceived Impact	Illustrative Quotes
sources of funding (including Medi-Cal) to support a program or service	<i>"We recently lifted up a new interim shelter program ... and in the RFQ [request for qualification] that was put out as part of the application process, it asked if we were currently under an MOU [memorandum of understanding with an MCP] and what Community Supports we were providing, and if not, if we were open to contracting within the next year with an MCP ... We don't anticipate CalAIM will fully fund, but we will be braiding funds for flow with our short-term post-hospitalization program ... But it is interesting [that the funder was asking]."</i> - Provider #33
Challenges	
Increased competition between providers for contracts and members	<i>"I'm seeing competition from providers, many from outside the area ... for contracts and for members."</i> - Provider #17 <i>"We blend funding in our existing shelters and operations ... in the long term we've got to have some conversations about yielding service provision to the shelter or provider on-site versus keeping services with an external ... because it complicates our budgets. Like we know we have a 60-bed shelter. We assume 75% have Medi-Cal, and we assume 60% we can bill for. But when that 60% becomes 30 to 40% because many have a different provider, now you're short on budget."</i> - Provider #28
Increased member complexity and acuity and members experiencing difficulties with Activities of Daily Living (Recuperative Care only)	<i>"[In Recuperative Care] We're find a lot more complex chronic health conditions, an older population, a lot more on the fence on their ability to handle their Activities of Daily Living."</i> - Provider #2 <i>"Members complexity and level of need has increased tremendously. It's not just one need, it is multiple needs ... some of it is that we have so many people aging on</i>

Perceived Impact	Illustrative Quotes
	<i>the streets ... we're seeing older adults becoming homeless more and their ability to weather [that] is different." - Provider #39</i> <i>"We're seeing changes in the population of medical needs coming into our Recuperative Care program ... It used to be more wounds and wound care ... now maybe half the people have congestive heart failure due to substance use ... we have a lot of cancer patients ... we get people with significant psychiatric illnesses." - Provider #54</i>
Pressure to increase caseloads from some MCPs (Housing Transition and Navigation Services and Housing Tenancy and Sustaining Services only)	<i>"Our MCP wants a high caseload and quick turnaround. But for us in the housing realm, it is best practice to have a lower caseload and keep clients on and meet weekly so they can be successful in housing placement and sustain housing ... We went from a caseload of 30-40 to 75." - Provider #3</i> <i>"Our MCP set a cap of 50 to 1 but we try to keep it lower than that ... we feel anything higher is not doable." - Provider #10</i>
Increased administrative burden for providers	<i>"We had to develop an entire billing platform, a billing platform, and integrate it into our existing workflow." - Provider #2</i> <i>"I have had to bring staff on to handle claims, make sure we're reconciling our claims and getting paid." - Provider #3</i> <i>"We needed to hire a medical biller, because now we have a ton of claims that need to go out constantly ... and initially we weren't getting a lot of our claims paid and it was constant problems." - Provider #7</i>

Source: Enhanced Care Management and Community Supports Provider Interviews, October 2024 to July 2025.

Note: Data were based on 60 unique organizational respondents who offered Community Supports. Providers were purposively sampled for heterogeneity in MCPs contracted with, Community Supports provided, geographic region, and provider type. Illustrative quotes were selected to represent key themes and maximize heterogeneity in provider perspectives represented. Not all themes apply to all Community Supports providers or to all types of Community Supports.

Measure 6: MCP and provider descriptions of how they are using new Medicaid funding in concert with state and local investments in housing or other social services to address member needs

Data sources: October 2024 to July 2025 provider interviews; July to September 2024 MCP interviews; MCP HHIP Investment Plans.

In interviews, MCPs described leveraging funding from HHIP to address upstream housing needs within the community ([Exhibit 5.45](#)). Under HHIP, participating MCPs were required to partner with CoC providers and other community stakeholders to conduct a housing and services gaps and needs assessment, map out resources available within the local housing continuum (e.g., prevention, interim housing, rapid-rehousing, or PSH) and then indicate how funds would align with existing plans to address unmet needs in the community. MCPs were permitted to allocate funds towards a range of initiatives and investment activities guided by three priority areas established by DHCS. [Exhibit 5.45](#) provides examples of HHIP investments made by MCPs, organized by priority area.

Exhibit 5.45. MCP HHIP Investments

HHIP Priority Area	Example HHIP Investments and Illustrative Quotes
#1: Partnerships and capacity to support referrals for services	» Coordinated Entry System: 20 MCPs strengthened local Coordinated Entry Systems by funding staff roles to facilitate member connections, increasing access points at hospitals, federally qualified health centers, and ECM provider sites, and improving HMIS integration to allow for member tracking and referrals (e.g., data dashboards of housing placements and service access). » Homeless Point-in-Time Counts: 15 MCPs collaborated with CoCs to improve accuracy of

HHIP Priority Area	Example HHIP Investments and Illustrative Quotes
	data on homelessness, providing incentives to ensure comprehensive geographic coverage within certain communities or software enhancements and technical support to streamline the count process.
#2: Infrastructure to coordinate and meet member housing needs	» Street medicine: 21 MCPs developed or expanded on existing street medicine outreach, services, and infrastructure. Several MCPs also developed mobile clinics. » HMIS enhancements: 21 MCPs invested in expanding and strengthening existing HMIS infrastructure to improve data sharing, reporting, and service coordination. For example, some MCPs covered costs of licensing, training, and supporting their staff and/or ECM or Community Supports providers to access HMIS systems or on allowing for data exchange between HMIS and other systems (e.g., electronic health records). <i>"We used our HHIP funding to ensure each of our ECM and Community Supports providers could get 5 users [equipment and training needed to] access the HMIS system." - MCP #13</i>
#3: Delivery of Services and Member Engagement	» Flexible funding investments: 23 MCPs braided HHIP with other funds to help reduce barriers to addressing members' housing-related needs. For example, several MCPs used funds towards flexible housing pools that would relieve financial burden on Community Supports providers for covering upfront housing deposit costs out of pocket, or support members with credit rebuilding or housing-related costs not covered under Community Supports. Other MCPs braided HHIP funds with other funds to increase shelter or facility-based services and placements available within the community.

HHIP Priority Area	Example HHIP Investments and Illustrative Quotes
	<i>"We partnered with United Way [in our community] to provide the Whatever It Takes program. This paired with Community Supports, so if someone receiving housing transition navigation exhausted their housing deposit benefit or found there was something they needed but couldn't get covered under the benefit, this program would kick in to cover outstanding costs. For example, if someone needed their car repaired so they could commute between their job and their home." - MCP #5</i>

Source: Managed Care Plan Housing and Homelessness Incentive Program Investment Plans, 2022; Managed Care Plan Interviews, July to September 2024.

Note: Investment Plan Data were based on 23 MCPs; one MCP did not participate. Interview data were based on 23 unique organizational respondents. There were 24 MCPs eligible to offer Community Supports in 2024. One MCP that stopped operating as a Medi-Cal MCP beginning January 1, 2024, was jointly interviewed with another MCP that took over its service area. One MCP specializing in care for members with HIV/AIDS in a single county was not interviewed.

In interviews, many community-based providers of housing-related Community Supports described using new Medicaid funding (HHIP, PATH, and reimbursement for Community Supports) in concert with other funds to further expand service or bed capacity within their communities or to increase the continuum of services available to more comprehensively meet member needs.

[Exhibit 5.46](#) provides illustrative examples of how community-based providers used Medicaid funds in concert with other investments in housing or social services to help address member needs. These community-based providers viewed braided funding, in which Medicaid funds were used in conjunction with other, separate funding sources to support programs or more comprehensively address member needs, as essential to sustainability and to help address gaps in existing systems of care.

In addition to Community Supports, providers described PATH Capacity and Infrastructure, Transition, Expansion, and Development (CITED) funding and IPP as important for helping them develop infrastructure needed to meet member needs. PATH CITED funding is described in the [PATH Section of the Evaluation Report](#). IPP provided performance-based incentive payments to MCPs that they could use to strengthen quality of care and capacity in the delivery system. MCPs often allocated IPP

funds to help ECM and Community Supports providers obtain or upgrade IT systems or EHRs needed for care management, invoicing and claims submission capabilities, or to meet reporting requirements. However, funds could also be used in conjunction with non-Medicaid funds to support physical infrastructure investments, such as purchase or renovation of buildings needed to provide facility-based services such as Recuperative Care, Short-Term Post-Hospitalization Housing, or Sobering Centers.

Exhibit 5.46. Examples of How Providers Used Medicaid Funds in Concert with Other Investments to Address Member Needs

Housing-Related Community Support	Illustrative Examples
Recuperative Care	<i>"Braided funding, of hospital payments [for people not eligible for Community Supports] with Community Supports funding is really the way to go ... as long as hospitals don't stop making direct payments to programs because of CalAIM." - Provider #1</i>
Short-Term Post-Hospitalization Housing	<i>"We scouted out new properties, these single-family homes, and purchased them mostly with support from PATH CITED funding; to create new Recuperative Care and Short-Term Post-Hospitalization Housing beds ... and we braid other funding to sustain the program and integrate [other services] ... For example, we have people on a SAMHSA [Substance Abuse and Mental Health Services Administration] grant go out and provide SUD counseling ... and other services we couldn't do if we were didn't [braid the funds]." - Provider #35</i> <i>"The struggle for us was always pressure to free up beds before people were healed or stable enough to meaningfully move into housing ... One of the ways we, as an organization, assess how we're doing is how many program exits lead to permanent housing, and our Short-Term Post-Hospitalization Housing [through CalAIM] helps with that... because the funds allowed us to expand and have new extra beds." - Provider #54</i>
Housing Transition Navigation Services	<i>"People coming to us via referrals from our health system often don't have access to very limited resources in the Coordinated Entry System. What the funding has done is let us take on caseloads of people we have never been able to support before and feed it into our other direct services. We've integrated</i>

Housing-Related Community Support	Illustrative Examples
	<i>Community Supports funding into our shelter systems, which were already funded, but not to the levels we needed them. Having gap funding, filler funding [like Community Supports] has enabled us to have more robust services and allowed us to have direct pathways from our hospital and health systems ... We were working in siloes side by side, and now we're integrated, which has been the beauty of this work."</i> - Provider #33 <i>"CalAIM provides for [some of] our program services ... but we also have grants, federal and local, and large donor base and partnerships with county entities to provide our campus, food, showers [for people experiencing homelessness at our shelter]."</i> - Provider #37
Housing Deposits	<i>"Housing Deposits has been new ... and a huge upgrade for our system to be able to cover security deposits and move in costs for people moving into permanent housing."</i> - Provider #19
Housing Tenancy and Sustaining Services	<i>"PSH is underfunded and difficult to develop. Our MCP has invested in a local pilot to make Housing Tenancy and Sustaining Services a permanent benefit for anyone residing in PSH to help enhance the supportive services component of PSH ... really address unmet needs of the system with these newly available services."</i> - Provider #60 <i>"We have a 7-unit PSH and have been using Housing Tenancy and Sustaining Services to help with housing retention."</i> - Provider #54
Day Habilitation	<i>"Day Habilitation consistently runs in the red for us ... I'm not sure there's a way to run it the way that we want that will be cost-effective. But we've accepted we may lose a bit of money on Day Habilitation, but we look at the intangible benefits we believe it brings to our facilities ... and it also frees up our case manager's time to work on things beyond life skills and provides enrichment activities ... that's made it worth it to operate in the red a little bit on it."</i> -Provider #2

Housing-Related Community Support	Illustrative Examples
	<i>"We operate a day center with a very captive population, a real varied population of people, and Day Habilitation has been developed to benefit those that want to participate in it." - Provider #37</i>

Source: Enhanced Care Management and Community Supports Provider Interviews, October 2024 to July 2025.

Note: Data were based on 60 unique organizational respondents who offered Community Supports. Providers were purposively sampled for heterogeneity in MCPs contracted with, Community Supports provided, geographic region, and provider type. Illustrative quotes were selected to represent key themes and maximize heterogeneity in provider perspectives represented. Not all themes apply to all Community Supports providers or to all types of Community Supports.

Goal 5: Increase members' access to outpatient care, including behavioral health services, and reduce acute care utilization and long-term care admission and stays

Goal 5 will be evaluated by addressing Evaluation Questions 7a and 7b and analysis of nine related measures articulated in the [Evaluation Questions and Hypotheses](#) sections of this report. Data to address Goal 5 were not available for the Interim Evaluation Report and will be addressed in the Summative Evaluation Report.

Evaluation Question 7a: Will Community Supports affect member access to non-emergency outpatient care?

Data sources: Medi-Cal eligibility and claims data.

Data needed to address this Evaluation Question and related measures were not available for the Interim Evaluation Report and will be addressed in the Summative Evaluation Report.

Evaluation Question 7b: Will Community Supports reduce avoidable acute care utilization or long-term care stays?

Data sources: Medi-Cal eligibility and claims data.

Data needed to address this Evaluation Question and related measures were not available for the Interim Evaluation Report and will be addressed in the Summative Evaluation Report.

Goal 6: Improve quality of care and outcomes of care

Goal 6 is addressed with three Evaluation Questions and 17 associated measures articulated in the [Evaluation Questions and Hypotheses](#) sections of this report. Data sources used in analyses are articulated for each measure.

Evaluation Question 8: Are members satisfied with Community Supports referral processes and services?

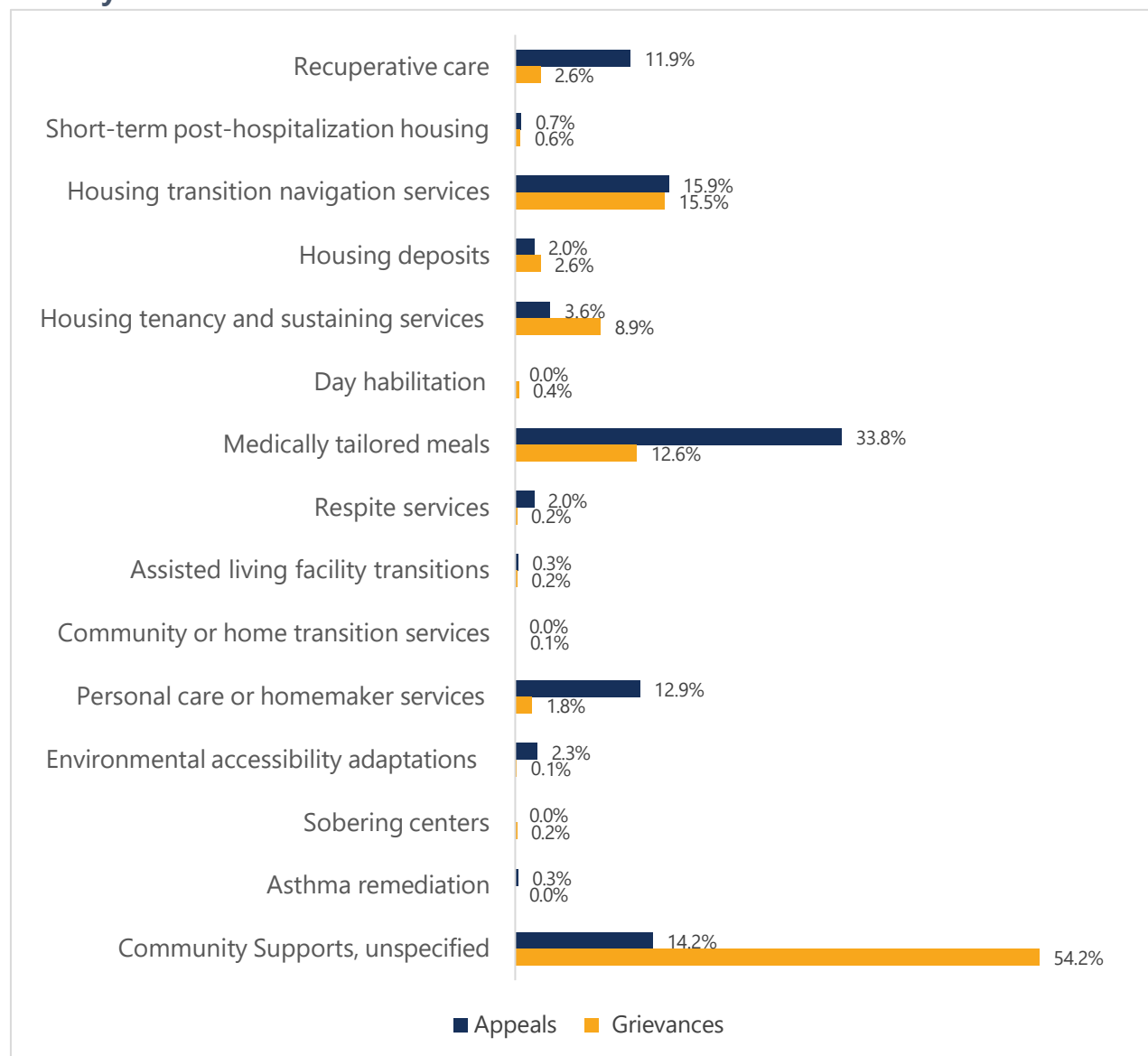
Measure 1. Appeals and grievances for each Community Support

Data source: January 2022 to December 2024 Medicaid managed care plan (MCP) appeals and grievances data.

Appeals included request to an MCP to review an adverse benefit determination, such as denial or limited authorization of a requested service; reduction, suspension, or termination of a previously authorized service; denial in whole or in part of payment for a service for any reason other than not being a clean claim, i.e., containing necessary information, free of errors, and ready for processing and payment; or failure to provide services in a timely manner. Appeals also included denials of requests to obtain services outside of network for members in rural areas with only one MCP. Grievances include any member expression of dissatisfaction about a topic other than an adverse benefit determination such as quality of care or services provided, interpersonal behavior of a provider or staff, or facility adequacy.⁸⁴ Appeals or grievances can be filed at any time either orally or in writing by members, providers acting on behalf of members, or an authorized representative and, in California, must be resolved by the MCP within 30 calendar days of filing.

[Exhibit 5.47](#) shows that there was a total of 302 appeals and 2,095 grievances filed between January 2022 to December 2024. Medically Tailored Meals / Medically Supportive Food constituted the greatest proportion of appeals (33.8%) followed by Housing Transition Navigation Services (15.9%). In contrast, the majority of grievances were not linked to a specific Community Support (54.2%).

Exhibit 5.47. Proportion of Appeals and Grievances by Community Support, January 2022 to December 2024



Source: DHCS Managed Care Plan Community Supports Appeals and Grievances Data, January 1, 2022, to December 10, 2024.

Note: Data included 302 appeals and 2,095 grievances for Community Supports.

Measure 2. Reasons and resolution status for appeals and grievances

Data source: January 2022 to December 2024 MCP appeals and grievances data.

Appeals are related to specific adverse benefit determinations and therefore do not require additional categorization. [Exhibit 5.48](#) shows the most common reasons for grievances to be filed for Community Supports between January 2022 to December

2024 were provider / staff attitude (499), MCP customer service (344), and timely access to services (216).

Exhibit 5.48. Most Common Reasons for Community Supports Grievances, January 2022 to December 2024

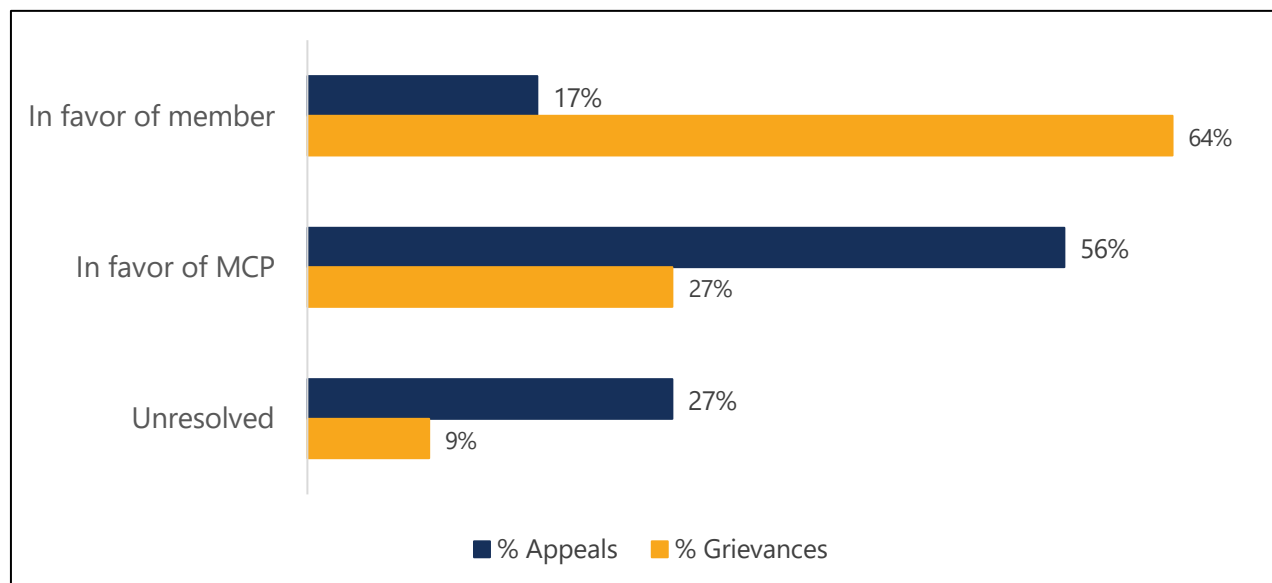


Source: DHCS Managed Care Plan Community Supports Grievances Data, January 1, 2022, to December 10, 2024.

Note: Grievances were categorized based on reason type (37 total available). Grievances for low frequency categories such as abuse / neglect / exploitation, assault / harassment, disability discrimination, enrollment, language access, and scheduling are not shown.

[Exhibit 5.49](#) shows that more than half of appeals (56%) were resolved in favor of MCPs, but the majority of grievances (64%) were resolved in favor of members.

Exhibit 5.49. Resolution Status of Appeals and Grievances, January 2022 to December 2024



Source: Community Supports Appeals and Grievances Data, January 1, 2022, to December 10, 2024.

Note: MCP = Managed Care Plan.

Measure 3. MCPs' self-reported perception of Community Supports' effectiveness at addressing members' HRSN

This measure is addressed in [Goal 1 Evaluation Question 1 Measure 4 Exhibit 5.12](#), which indicated that MCPs perceived a positive impact on member health and well-being with average ratings that ranged from 6.6 for Day Habilitation to 9.0 for Housing Deposits (on a scale of very low (0) to very high (10)). Additional information was provided in [Goal 4 Evaluation Question 6 Measure 5 Exhibit 5.43](#), which showed that MCPs rated the perceived effectiveness of Community Supports at addressing members' HRSNs as 8.3 out of 10.

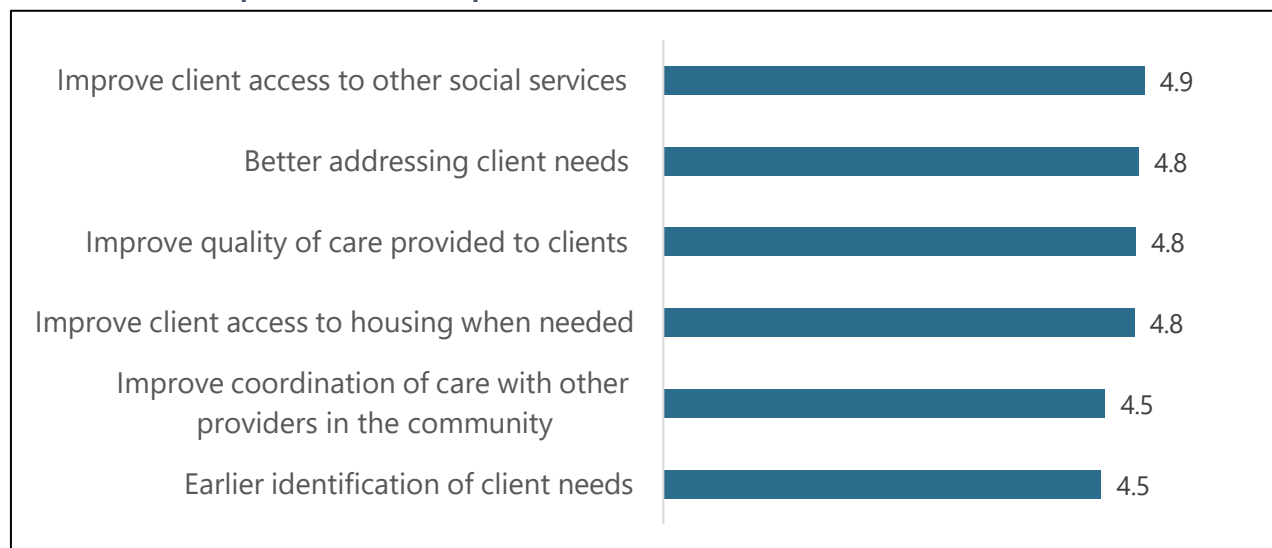
Measure 4. Providers' self-reported perception of Community Supports' effectiveness at addressing members' HRSN

Data source: June to July 2025 provider survey.

Surveyed providers were asked to rate how effective Community Supports were at addressing member needs, improving coordination of care, and increasing member service access and utilization on a scale from not at all effective (0) to extremely effective

(6). [Exhibit 5.50](#) shows that, on average, providers perceived Community Supports as most effective at improving client access to other social services (4.9), at better addressing client needs (4.8), improving quality of care provided to clients (4.8), and improving client access to housing when needed (4.8) and least effective at earlier identification of client needs (4.5) and improving care coordination with other providers (4.5).

Exhibit 5.50. Provider Ratings of Community Supports' Effectiveness at Addressing Member Needs, Service Access, and Service Utilization



Source: Enhanced Care Management and Community Supports Provider Survey, June to July 2025.

Note: Data were based on 177 unique respondents who offered Community Supports and excluded 29 respondents who did not answer the question.

Measure 5. Members' self-reported knowledge and satisfaction with anticipated and actual Community Supports received

Data sources: Member survey.

Data for this measure were not available for the Interim Evaluation Report and will be addressed in the Summative Evaluation Report.

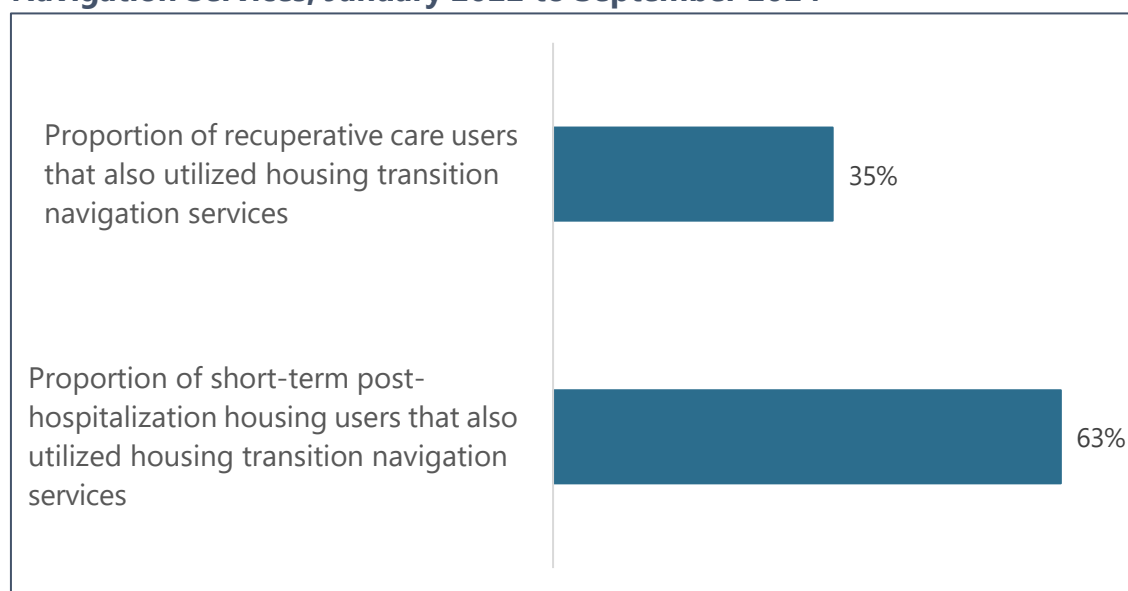
Evaluation Question 9: Following receipt of housing-related Community Supports, are members being transitioned to other appropriate supports when needed?

Data source: Quarterly Implementation and Monitoring Reports (QIMRs).

Data on the proportion of housing-related Community Supports users that were subsequently housed were not available and will be addressed in the Summative Evaluation Report. Instead, data on use of Housing Transition Navigation Services were examined as the most expedient next step following Recuperative Care or Short-Term Post-Hospitalization Housing.

[Exhibit 5.51](#) shows that 35% of Recuperative Care users utilized Housing Transition Navigation Services during the same quarter, as a proxy for simultaneous use or in the following quarters without an interruption as a proxy sequential use. Also, 63% of Short-Term Post-Hospitalization Housing users also utilized Housing Transition Navigation Services simultaneously or sequentially. Additional analyses found that 9% of Recuperative Care users subsequently transitioned to Short-Term Post-Hospitalization Housing (data not shown).

Exhibit 5.51. Proportion of Recuperative Care or Short-Term Post-Hospitalization Housing Users that Simultaneously or Sequentially Utilized Housing Transition Navigation Services, January 2022 to September 2024



Source: Quarterly Implementation and Monitoring Reports, 2022 Q1 to 2024 Q3.

Note: QIMRs assessed service utilization in three-month intervals. Members were counted as simultaneously receiving Community Supports if utilization occurred in the same quarter and as sequentially receiving if utilization occurred in the following quarter.

Evaluation Question 10: Will Community Supports improve quality and outcomes of health care?

Data needed to address this Evaluation Question and related measures were not available for the Interim Evaluation Report and will be addressed in the Summative Evaluation Report.

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

Goal 7 is addressed with two Evaluation Questions and five associated measures articulated in the [Evaluation Questions and Hypotheses](#) sections of this report. Data sources were not available in time for inclusion in the Interim Evaluation Report and will be addressed in the Summative Evaluation Report.

Evaluation Question 11: Are there disparities in Community Supports uptake based on member demographic characteristics, health conditions or community characteristics?

Data sources: Quarterly Implementation and Monitoring Reports (QIMRs); Medi-Cal eligibility and claims data.

Data needed to address this Evaluation Question and related measures were not available for the Interim Evaluation Report and will be addressed in the Summative Evaluation Report.

Evaluation Question 12: Will Community Supports impact disparities in downstream physical or behavioral health services utilization, quality of care, or outcomes of care?

Data sources: QIMRs; Medi-Cal eligibility and claims data.

Data needed to address this Evaluation Question and related measures were not available for the Interim Evaluation Report and will be addressed in the Summative Evaluation Report.

Goal 8: Ensure Community Supports are cost-effective alternatives to state plan services or settings

Goal 8 is addressed with one Evaluation Question and one associated measure articulated in the [Evaluation Questions and Hypotheses](#) sections of this report. Data sources needed to address Goal 8 were not available in time for inclusion in the Interim Evaluation Report and will be addressed in the Summative Evaluation Report.

Evaluation Question 13: Will Community Supports impact cost of care?

Data sources: Medi-Cal eligibility and claims data.

Data to address this Evaluation Question and related measures were not available for the Interim Evaluation Report and will be addressed in the Summative Evaluation Report. Additional information regarding planned analyses is available in [Section 3](#).

G. Conclusions

Goal 1: Increase offering of Community Supports by MCPs

Evaluation data indicate significant progress towards this goal as of the Interim Evaluation Report and suggested that the related hypothesis for this goal was true. This conclusion was based on evidence that the number of Medicaid managed care plans (MCPs) offering each Community Support and the proportion of California counties in which at least one MCP offered each Community Support all increased over time. MCPs described local capacity and readiness, perceived importance of the Community Supports in addressing member needs, and perceived cost-effectiveness and financial sustainability of the Community Supports as important to the decision of whether and when to offer the service. In 2024 and 2025, MCPs were only beginning to transition from initial implementation to more robust monitoring and quality improvement; the Summative Evaluation Report will assess whether MCP perceptions of cost-effectiveness and financial sustainability of each Community Support changed over time, and whether MCPs discontinued any Community Supports and why.

Goal 2: Increase contracts between providers and MCPs for Community Supports services

Evaluation data indicated significant progress towards this goal as of the Interim Evaluation Report, with related hypotheses for this goal either true or likely true. This conclusion was based on evidence that the number of contracted providers and the number of contracts per provider increased between 2022 and 2024. Because MCPs were required to develop county-specific contracts, the number of contracted providers and the number of contracts per providers were both important indicators of how provider networks for Community Supports may be changing over time.

The number of contracted providers and the number of contracts per provider increased for all Community Supports between 2022 and 2024. However, evaluation data indicated decreases in the number of contracted providers and the number of contracts per provider for seven Community Supports between 2023 and 2024 for Recuperative Care, Day Habilitation, ALF Transitions, Community or Home Transition Services, Environmental Accessibility Adaptations, Sobering Centers, and Asthma Remediation. These decreases could reflect adjustments based on local service need, consolidation of contracts with a smaller number of high-quality, high-volume providers, or could be indicative of decreased availability of Community Supports in certain communities, for example, if MCPs or providers did not find contracting for a Community Support financially sustainable. In addition, findings also indicated a decrease between 2023 and 2024 in the number of contracted providers coupled with an increase in the number of contracts for Housing Tenancy and Sustaining Services, likely reflecting a shift in contracting practices in which a smaller set of providers were contracting with more MCPs and/or providing services in more counties. Trends in the number of contracted providers and the number of contracts for each Community Support will continue to be monitored in the Summative Evaluation Report, along with additional data collection and analyses to explain observed trends and assess their potential impact on member utilization of Community Supports.

Finally, although DHCS did not require MCPs to contract with specific types of providers, DHCS recommended that MCPs contract with community-based providers when possible. Assessing the types of providers contracted to provide Community Supports services was important because community-based providers were hypothesized to be more successful in identifying and engaging eligible members in services, and in

ensuring that Community Supports were coordinated with and supplement other services already being provided in the community. As of the Interim Evaluation Report, the majority of Community Supports providers were community-based, as measured by public or private non-profit ownership. The exceptions were providers of Respite Services and Personal Care and Homemaker Services, who were primarily private for-profit providers. However, these markets were predominantly comprised of private for-profit providers prior to implementation of Community Supports. The proportion of contracts with private for-profit providers also varied considerably across MCPs. Trends in the proportion of MCP contracts with private for-profit providers for each Community Support will be further assessed in the Summative Evaluation Report, along with alternative measures of whether a provider is community-based aligned with DHCS's definition.

Goal 3: Increase utilization of Community Supports by eligible members

Evaluation data indicated significant progress towards this goal and confirmed that related hypotheses for this goal were true as of the Interim Evaluation Report. These conclusions were based primarily on evidence of substantial growth in the number of Community Supports users between 2022 and 2024. Community Supports services are voluntary for members, and prior evidence suggests that identifying members' HRSNs and engaging them in services can be challenging.⁸¹ Member utilization of Community Supports over time was therefore a critical indicator of improvement (or lack thereof) in members' access to and engagement in these services. Although the number of users increased for all Community Supports, the total number of users of certain Community Supports such as Community or Home Transition Services and ALF Transitions remained fairly low. Providers that successfully delivered these Community Supports indicated the importance of proactive outreach to nursing facilities and of helping nursing facilities complete required referral paperwork once eligible members were identified. In the Summative Evaluation Report, UCLA-RAND will assess the proportion of eligible Medi-Cal members that used each Community Support as an additional, important indicator of program reach.

Of additional note were findings that showed the proportion of members who were authorized and subsequently used Community Supports was relatively low for certain Community Supports including Short-Term Post-Hospitalization Housing, Housing

Deposits, ALF Transitions, Community or Home Transition Services, and Environmental Accessibility Adaptations. The lower rates may have been due to delays between when services were requested and provided, which could have negatively impacted use. Any delays in authorization of these Community Supports could have prevented housing placement or placement in a home or community-based setting. To avoid delays, MCPs were able to permit presumptive authorization that allows qualified providers to deliver Community Supports prior to receiving authorization. However, MCPs could still deny authorization and payment. Thus, not all providers chose to take advantage of this option due to its financial risk. This issue alongside potential impacts on member outcomes will be further examined in the Summative Evaluation Report.

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

Evaluation data indicated moderate progress towards this goal as of the Interim Evaluation Report, with the related hypothesis confirmed as true. This conclusion was principally based on evidence of increased public investment in homeless support and housing programs in concert with new Medicaid funding for those services. The conclusion was also based on qualitative data from community-based providers' descriptions of how they used new Medicaid funding, particularly from the HHIP and Community Supports, to supplement other public investments and services and address gaps in care for members experiencing or at-risk of homelessness.

In terms of public investments in housing, the number of permanent housing beds was used as a meaningful indicator of impact on housing stability, both because it reflects housing stability directly⁸⁵ and because the high potential overlap with eligibility for permanent housing and for housing-related Community Supports (e.g., Housing Tenancy and Sustaining Services). Similarly, the number of LIHTC units was used as an important indicator of efforts to build and preserve affordable housing within a community, with the percentage of units serving households at or below 30% the area median income serving as a specific indicator of the share of these homes available for people at risk of homelessness or for people previously unhoused. Data available for both of these measures as of the Interim Evaluation Report indicated substantial growth over the last decade in the number of permanent housing beds and the number of

LIHTC units in California, including between 2022 and 2024, when new Medicaid funding to address members' housing-related social needs became available.

Despite growth over time in these indicators, most MCPs and providers indicated that insufficient housing remained problematic in most communities. Insufficient housing was attributed in part to increased cost of living and increases in the number of people experiencing homelessness in California and similar to the United States as a whole. MCPs and providers described new Medicaid funding as critical for helping to address gaps in existing systems of care, and in improving integration of care for members experiencing homelessness or at-risk of homelessness and with significant physical or BH needs. At the same time, many community-based providers described availability of new Medicaid funding as resulting in increased competition due to emergence of new for-profit providers in their communities and as increasing administrative burden, raising concerns for some providers about financial sustainability over time. Perceived impacts of new Medicaid funding on existing systems of care will be further examined in the Summative Evaluation Report, along with analyses of impact on Community Supports provider or user outcomes.

Goal 6: Improve quality of care and outcomes of care

Evaluation data indicated limited progress towards this goal as of the Interim Evaluation Report, largely due to delays in receipt of data. Based on available data, only one hypothesis was confirmed as likely true indicating that the proportion of members transitioned to appropriate HRSNs supports would increase. Specifically, findings indicated that a substantial proportion of Recuperative Care users and Short-Term Post-Hospitalization users either simultaneously or sequentially used Housing Transition Navigation Services. Aggregate data on Community Supports-related appeals, grievances, and resolution status were included as an indicator of member satisfaction but could not be assessed over time in relation to total Community Supports use for the Interim Evaluation Report. Other analyses needed to assess progress towards this goal and related hypotheses will be completed and presented in the Summative Evaluation Report.

Overall Conclusions

Overall, findings indicate significant progress towards four Community Supports goals, and available evidence in the Interim Evaluation Report indicated that all hypotheses associated with these four goals were true or likely true ([Exhibit 0.1](#)).

Inability to determine progress for the remaining goals could be attributed to lack of available data as of the Interim Evaluation Report, rather than failure to achieve the goals. UCLA-RAND anticipates addressing these limitations in the Summative Evaluation Report, where additional analyses will be conducted to:

- » Examine alternative or additional methods of identifying community-based providers in alignment with DHCS' definition.
- » Assess MCPs and providers' perceptions of whether the number of eligible and contracted providers were sufficient to meet service needs.
- » Identify members that were eligible for but did not use Community Supports.
- » Compare demographic and health characteristics of Community Supports users to eligible non-users.
- » Compare demographic and health characteristics of members using multiple Community Supports to those using only one.
- » Examine member self-reported mechanisms for learning about Community Supports, satisfaction with Community Supports received, and downstream impact of receiving Community Supports on their health and well-being.
- » Impact of Community Supports use on member access to outpatient care, acute care utilization, and long-term care admission and stays relative to eligible non-users.
- » Impact of Community Supports use on member quality and outcomes of care, relative to eligible non-users.
- » Impact of housing-related Community Supports use on housing stability, if feasible.
- » As appropriate, re-examine measures already analyzed for the Interim Evaluation Report using updated data.

H. Interpretations, and Policy Implications and Interactions with Other State Initiatives

Community Supports were implemented with the intent of improving the health and well-being of eligible Medi-Cal members by helping them live healthier lives and avoid higher, costlier levels of care such as ED use, hospitalization, or nursing facility care.^{2,12} Community Supports were implemented in conjunction with other broad-based delivery system, program, and payment reforms under the CalAIM and BH Community-Based Organized Networks of Equitable Care and Treatment Section 1115 and 1915(b) Medicaid Waivers and through other initiatives collectively focused on making Medi-Cal services more person-centered and coordinated and help members maximize their health and life trajectory. Other programs and initiatives expected to influence implementation of Community Supports were previously summarized in [Exhibit 5](#). Hypothesized impacts of these programs or initiatives on Community Supports are described below:

- » **ECM:** This new Medi-Cal benefit to provide eligible members with comprehensive care management and coordination of care is expected to improve member identification and engagement in Community Supports, as well as outcomes of care.
- » **JI Reentry initiative:** This initiative, which includes pre-release Medi-Cal enrollment strategies, 90-day pre-release services, and BH linkages to improve continuity of care and access to needed for care for eligible members upon release from state prison, county jails, and youth correctional facilities, is expected to increase the number of members eligible for and referred to Community Supports.
- » **Providing Access and Transforming Health:** This 2022 to 2026 CalAIM Section 1115 Waiver program is expected to improve provider capacity and infrastructure to participate in Community Supports and other CalAIM initiatives.
- » **IPP:** This 2022 to 2024 DHCS program is expected to improve provider participation in Community Supports as well as access and quality of care for Community Supports users by providing incentives to Medicaid managed care plans (MCPs) to support member engagement and service delivery, infrastructure and capacity development, program quality, and service access for ECM and Community Supports.

- » **HHIP:** This 2022 to 2024 Medicaid Home and Community-Based Services initiative is expected to influence Community Supports implementation and outcomes by improving local infrastructure and capacity to address homelessness, e.g., by helping MCPs partner with other stakeholders in the community to develop street or field medicine programs, Recuperative Care, Short-Term Post-Hospitalization Housing, Sobering Center facilities, or temporary or permanent housing.
- » **Asthma Preventive Services benefit:** This new Medi-Cal state plan benefit is expected to complement the Asthma Remediation Community Support by covering asthma self-management education and in-home environmental trigger assessments that may also be needed to treat eligible members with poorly controlled asthma.
- » **Community Health Worker benefit:** This new Medi-Cal state plan benefit is expected to complement Community Supports through provision of preventive health services, such as prevention and control of chronic conditions and BH, by non-licensed public health workers, to members not eligible for ECM that could benefit from this support.
- » **MCP Transition:** In 2024, the MCP Transition implemented as part of California's CalAIM 1115 and 1915(b) Waivers and DHCS' new five-year direct contract with Kaiser Permanente resulted in changes to the Medi-Cal MCPs contracted to serve members in many California counties. This transition could have affected Community Supports implementation through its impact on which MCPs were eligible to offer Community Supports, and on these MCPs' provider networks.

I. Lessons Learned and Recommendations

Lessons Learned

Overall

- » Community Supports are generally perceived by Medicaid managed care plans (MCPs) and providers as addressing important gaps in care within communities and as supplementing existing systems of care and should be sustained if proven cost-effective.
- » MCPs without prior experience offering services to address members' HRSNs require support in how to identify and contract with high-quality service providers and appropriately monitor service quality.

- » MCPs vary in the extent to which they voluntarily contract with community-based providers for HRSN services. If MCPs contracting with community-based providers is a priority, MCPs should be provided with additional incentives or support to do so.
- » Non-local providers may be less likely than local providers to combine Community Supports with other resources and offer Community Supports as part of a broader continuum of care. Further data collection is needed to understand how this may impact quality and outcomes of care for members. If integration of Community Supports within a broader continuum of care is a priority, this should be clearly communicated to providers and monitored.
- » Low reimbursement rates and high administrative burden within Medicaid were challenging for MCPs and providers and can be a barrier to provider participation and perceived financial sustainability of Community Supports. Adequate funding levels and efforts to reduce administrative burden should be considered.
- » Funding the development of capacity among providers are critical as they enable community-based providers to develop the infrastructure and workflows needed to adapt to rapidly changing policy guidance on Community Supports and to meet Medi-Cal billing, compliance, and reporting requirements. Continuing to provide PATH funding, IPP, or HHIP will be important to providers' ability to implement any major policy changes in the future.
- » Efforts to improve awareness of Community Supports in certain communities and with certain referral partners will be important for increasing utilization of certain Community Supports.

Specific Community Supports

- » Offering Housing Deposits would be more feasible for providers if it is implemented as part of a flexible housing subsidy pool or include administrative fee for providers rather than operate on a strict cost reimbursement basis.
- » New Medicaid funding has resulted in rapid growth in Recuperative Care but is also perceived as increasing competition as well as increased referrals of members with more acute or complex care needs. Recuperative Care providers therefore report less capacity to serve members with less acute needs. Recuperative Care providers also continue to report difficulty serving members who require support with Activities of Daily Living or Instrumental Activities of Daily Living.

- » Clear policy guidance is needed to help MCPs and providers differentiate Medically Tailored Meals / Medically Supportive Food from interventions to address food insecurity. Monitoring the type and quality of intervention being provided to members is also important to assess impact on member health and outcomes.

Recommendations to Other States

Interim Evaluation Report findings have implications for other states implementing or considering implementation of Community Supports as a Medicaid benefits to address members' health-related social needs. Specific recommendations include:

- » Assess whether MCPs have prior experience offering similar benefits. MCPs without prior experience may require preliminary support with pricing guidance, developing provider networks, and with how to assess quality of services to address members' HRSN.
- » Allocate funding to develop provider capacity and infrastructure, particularly if engagement of community-based providers without prior experience billing Medicaid is important to member engagement or to ensure Community Supports are integrated within existing systems of care.
- » Dedicate time to engage relevant stakeholders and develop clear policy guidance on eligibility criteria, allowable duration or frequency of service use (when applicable), referral processes, authorization, claims submission, and reporting requirements prior to program implementation.
- » Reduce administrative burden on providers where possible.
- » Dedicate resources to increase awareness of these new benefits and their eligibility criteria among providers expected to refer eligible members for services. Certain referral providers, such as skilled nursing facilities and assisted living facilities, may require support in completing referral paperwork once eligible members are identified.
- » Encourage MCPs to allow presumptive authorization for time-sensitive benefits, while ensuring providers are aware of associated financial risks.
- » Implementation of Community Supports to address housing as an HRSN should be accompanied with upstream investment in increasing the supply of affordable housing available.

Offering Housing Deposits and other housing-related benefits involving large sums of money should be implemented as part of a flexible housing subsidy pool or include administrative fee for providers rather than operate on a strict cost reimbursement basis

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SECTION 2: PLACEHOLDER FOR NORC



SECTION 3: APPENDICES



Appendix A. GPP Services, Service Categories, and Point Values (2015-2023)

The table below provides a list of services that were used in analyses conducted to answer GPP Evaluation Question 2. The arrows that appear alongside selected point values indicate increases or decreases in point values in the PY relative to the prior program year. "N/A" indicates that the service was not eligible for earning points in the program year.

Code	GPP Service Description	Service Category*	PY1 Point Values	PY2 Point Values	PY3 Point Values	PY4-5 Point Values	PY6-7 Point Values	PY8 Point Values	PY9-12 Point Values
1B04	Dental	1. Outpatient, traditional	62	62	62	62	62	62	68↑
1B05	Outpatient Primary/Specialty	1. Outpatient, traditional	100	100	100	100	100	100	110↑
1B06	Contracted Primary/Specialty	1. Outpatient, traditional	19	19	19	19	19	19	21↑
1D13	Outpatient Surgery	1. Outpatient, traditional	776	776	776	776	776	776	850↑
1A01	Registered nurse-only visit	2. Outpatient, non-traditional	50	50	50	50	50	50	55↑
1A02	PharmD visit	2. Outpatient, non-traditional	75	75	75	75	75	75	82↑
1A03	Complex care manager	2. Outpatient, non-traditional	75	75	75	75	75	75	82↑
2A14	Wellness	2. Outpatient, non-traditional	15	15	15	15	15	15	16↑
2A15	Patient support group	2. Outpatient, non-traditional	15	15	15	15	15	15	16↑
2A16	Community health worker	2. Outpatient, non-traditional	15	15	15	15	15	15	16↑
2A17	Health coach	2. Outpatient, non-traditional	15	15	15	15	15	15	16↑
2A18	Panel management	2. Outpatient, non-traditional	15	15	15	15	15	15	16↑
2A19	Health education	2. Outpatient, non-traditional	25	25	25	25	25	25	27↑
2A20	Nutrition education	2. Outpatient, non-traditional	25	25	25	25	25	25	27↑
2A21	Case management	2. Outpatient, non-traditional	25	25	25	25	25	25	27↑
2A22	Oral hygiene	2. Outpatient, non-traditional	30	30	30	30	30	30	33↑

Code	GPP Service Description	Service Category*	PY1 Point Values	PY2 Point Values	PY3 Point Values	PY4-5 Point Values	PY6-7 Point Values	PY8 Point Values	PY9-12 Point Values
2A51	Doula service (prenatal or postnatal)	2. Outpatient, non-traditional	N/A	N/A	N/A	N/A	N/A	60	66↑
2A52	Peer support	2. Outpatient, non-traditional	N/A	N/A	N/A	N/A	N/A	25	27↑
2B23	Group medical visit	2. Outpatient, non-traditional	50	50	50	50	50	50	55↑
2B24	Integrative therapy	2. Outpatient, non-traditional	50	50	50	50	50	50	55↑
2B25	Palliative care	2. Outpatient, non-traditional	50	50	50	50	50	50	55↑
2B26	Pain management	2. Outpatient, non-traditional	50	50	50	50	50	50	55↑
2C27	Home nursing visit	2. Outpatient, non-traditional	75	75	75	75	75	75	82↑
2C28	Paramedic treat and release	2. Outpatient, non-traditional	75	75	75	75	75	75	82↑
2C29	Mobile clinic visit	2. Outpatient, non-traditional	90	90	90	90	90	90	99↑
2C30	Physician home visit	2. Outpatient, non-traditional	125	125	125	125	125	125	137↑
3A31	Texting	2. Outpatient, non-traditional	1	1	1	1	1	1	1
3A32	Video-observed therapy	2. Outpatient, non-traditional	10	10	10	10	10	10	11↑
3A33	Nurse advice line	2. Outpatient, non-traditional	10	10	10	10	10	10	11↑
3A34	Registered nurse e-visit	2. Outpatient, non-traditional	10	10	10	10	10	10	11↑
3B35	Email consultation with PCP	2. Outpatient, non-traditional	30	30	30	30	30	30	33↑
3C36	Telehealth (patient - provider) - Store & Forward	2. Outpatient, non-traditional	50	50	50	50	50	100↑	110↑
3C37	Telehealth (provider - provider) – e-Consult / e-Referral	2. Outpatient, non-traditional	50	50	50	50	50	50	55↑
3C38	Telehealth – Other Store & Forward	2. Outpatient, non-traditional	50	65↑	65	65	65	100↑	110↑
3D39	Telephone consultation with PCP	2. Outpatient, non-traditional	75	75	75	75	75	100↑	110↑
3D40	Telehealth (patient - provider) - real time	2. Outpatient, non-traditional	90	90	90	90	90	100↑	110↑
3D41	Telehealth (provider - provider) - real time	2. Outpatient, non-traditional	90	90	90	90	90	90	99↑

Code	GPP Service Description	Service Category*	PY1 Point Values	PY2 Point Values	PY3 Point Values	PY4-5 Point Values	PY6-7 Point Values	PY8 Point Values	PY9-12 Point Values
4A44	Recuperative / respite care days	3. Low-intensity inpatient	85	85	85	85	85	85	93↑
4A45	Skilled nursing facility	3. Low-intensity inpatient	141	141	141	141	141	141	154↑
4B46	Med/surg, etc. (acute rehab, stepdown)	4. Inpatient Medical/Surgical	634	630.2↓	624.5↓	615.0↓	613.1↓	613.1	665↑
1C10	Outpatient emergency room	5. Emergency	160	158.4↓	156.0↓	152↓	151.2↓	151.2	164↑
1C11	Contracted emergency room (All other)	5. Emergency	70	69.3↓	68.3↓	66.5↓	66.2↓	66.2	72↑
1CMD	Contracted emergency room (Calculated from Maddy funds)	5. Emergency	70	69.3↓	68.3↓	66.5↓	66.2↓	66.2	72↑
1B07	Mental health outpatient	6. BH outpatient	38	38	38	38	38	38	42↑
1B08	Substance use outpatient	6. BH outpatient	11	11	11	11	11	11	12↑
1B09	Substance use methadone	6. BH outpatient	2	2	2	2	2	2	2
4A42	Mental health/substance use residential	7. BH residential	23	23	23	23	23	23	25↑
4A43	Sobering center days	7. BH residential	50	50	50	50	50	50	55↑
4B47	Mental health inpatient	8. BH inpatient	341	339.0↓	335.9↓	330.8↓	329.8↓	329.8	357↑
1C12	Mental health emergency room/crisis stabilization	9. BH emergency	250	247.5↓	243.8↓	237.5↓	236.3↓	236.3	256↑
5A53	Enhanced Care Management	10. Equity Enhancing	N/A	N/A	N/A	N/A	N/A	N/A	82 PUPM
5B54	Asthma remediation	10. Equity Enhancing	N/A	N/A	N/A	N/A	N/A	N/A	88/case
5B55	Community transition: Nursing facility to home	10. Equity Enhancing	N/A	N/A	N/A	N/A	N/A	N/A	241 PUPM
5B56	Day habilitation	10. Equity Enhancing	N/A	N/A	N/A	N/A	N/A	N/A	3.30/hour
5B57	Housing deposits	10. Equity Enhancing	N/A	N/A	N/A	N/A	N/A	N/A	767/move-in
5B58	Housing tenancy and sustaining services	10. Equity Enhancing	N/A	N/A	N/A	N/A	N/A	N/A	99 PUPM
5B59	Housing transition/navigation services	10. Equity Enhancing	N/A	N/A	N/A	N/A	N/A	N/A	99 PUPM
5B60	Nursing facility transition/diversion to ALF	10. Equity Enhancing	N/A	N/A	N/A	N/A	N/A	N/A	13/day

Code	GPP Service Description	Service Category*	PY1 Point Values	PY2 Point Values	PY3 Point Values	PY4-5 Point Values	PY6-7 Point Values	PY8 Point Values	PY9-12 Point Values
5B61	Personal care services	10. Equity Enhancing	N/A	N/A	N/A	N/A	N/A	N/A	4.4/hour
5B62	Short-term post-hospitalization housing	10. Equity Enhancing	N/A	N/A	N/A	N/A	N/A	N/A	16/day
5C63	Team-based street outreach and engagement	10. Equity Enhancing	N/A	N/A	N/A	N/A	N/A	N/A	164/visit

*Services in Categories 4, 5, 8, and 9 are those that are provided in "high-intensity" settings.

Note. PUPM=per user per month.

Appendix B. Specifications for Share of Points in Low-Intensity Setting Measures

Measure	Numerator	Denominator
Share of points in low-intensity settings, all services	Sum of points for: • Outpatient-traditional • Outpatient non-traditional • Low-intensity Inpatient • BH outpatient • BH residential • Equity-enhancing	Sum of points for all services included in the numerator plus: • Emergency • Inpatient Medical/Surgical • BH inpatient • BH emergency
Share of points in low-intensity settings, non-BH services	Sum of points for: • Outpatient-traditional • Outpatient non-traditional • Low-intensity Inpatient • Equity-enhancing	Sum of points for all services included in the numerator plus: • Emergency • Inpatient Medical/Surgical
Share of points in low-intensity settings, BH services	Sum of points for: • BH outpatient • BH residential	Sum of points for all services included in the numerator plus: • BH inpatient • BH emergency

Appendix C. Characteristics of GPP Service Users and Medi-Cal Comparison Group for Quality Measures

The table below compares the demographic characteristics of the cohort of GPP users and Medi-Cal members that were included in the analyses for GPP Evaluation Question 1, comparing the quality of care between GPP users and Medi-Cal members. The sample sizes for some of the analyses using MCAS data are at times smaller than that of GPP due to the requirement that health plans using the hybrid method to provide data on their members are only required to submit information on a random sample of 411 members. Overall, there are substantial differences across the samples in terms of patient race, ethnicity, and preferred spoken language. Some of these differences may in part be due to differential definitions for these terms, including how to classify individuals with missing or unknown information or who decline to provide the requested information to health systems or DHCS. Others, however, may reflect real differences between the two samples. For example, the comparison sample of Medi-Cal members has a much higher proportion of patients whose preferred spoken language is English compared to the GPP user population. As more data become available, the evaluation team will continue to refine the sample of comparison Medi-Cal members to be more comparable to the GPP user population.

	Colorectal Cancer Screening, GPP	Colorectal Cancer Screening, Medi-Cal	Hemoglobin A1c Control for Patients with Diabetes, GPP	Hemoglobin A1c Control for Patients with Diabetes, Medi-Cal	Cervical Cancer Screening, GPP	Cervical Cancer Screening, Medi-Cal	Breast Cancer Screening, GPP	Breast Cancer Screening, Medi-Cal
Total (n)	110,009	481,351	55,174	4,782	107,795	4,184	48,513	213,610
Race (%)								
American Indian or Alaska Native	0.5	0.5	0.5	0.9	0.5	0.8	0.5	0.5

	Colorectal Cancer Screening, GPP	Colorectal Cancer Screening, Medi-Cal	Hemoglobin A1c Control for Patients with Diabetes, GPP	Hemoglobin A1c Control for Patients with Diabetes, Medi-Cal	Cervical Cancer Screening GPP	Cervical Cancer Screening, Medi-Cal	Breast Cancer Screening, GPP	Breast Cancer Screening, Medi-Cal
Asian	7.0	16.8	5.6	17.2	4.3	13.7	8.7	18.0
Black or African American	3.6	11.1	3.0	11.3	2.7	9.0	4.0	10.2
Native Hawaiian or Pacific Islander	0.4	0.7	0.5	0.8	0.3	0.6	0.5	0.7
White	25.0	34.1	26.0	31.3	30.5	35.1	25.4	34.0
Some Other Race	56.6	15.6	59.8	17.5	49.7	15.7	51.9	15.7
Multiracial	1.2	2.0	1.0	3.7	1.5	3.3	1.1	2.0
Ethnicity (%)								
Hispanic or Latino	70.1	40.2	77.3	41.0	68.4	41.9	65.3	42.3
Not Hispanic or Latino	19.0	25.9	14.5	36.5	14.5	34.3	21.6	24.5
Preferred Spoken Language (%)								
English	22.3	63.7	20.6	71.1	25.4	76.3	23.3	57.0
Spanish	71.6	23.2	75.3	18.6	69.4	16.0	68.5	28.3
All others	5.0	13.0	3.4	10.4	4.1	7.7	6.6	14.7
Gender (%)								
Male	36.2	39.2	39.0	44.2	0.0	0.0	0.0	0.0
Female	53.4	60.8	51.3	55.8	100.0	100.0	100.0	100.0
Sexual Orientation (%)								
Straight or heterosexual	78.1	N/A	79.8	N/A	77.0	N/A	79.5	N/A
Lesbian, gay, or homosexual	1.0	N/A	0.8	N/A	0.5	N/A	0.4	N/A

	Colorectal Cancer Screening, GPP	Colorectal Cancer Screening, Medi-Cal	Hemoglobin A1c Control for Patients with Diabetes, GPP	Hemoglobin A1c Control for Patients with Diabetes, Medi-Cal	Cervical Cancer Screening, GPP	Cervical Cancer Screening, Medi-Cal	Breast Cancer Screening, GPP	Breast Cancer Screening, Medi-Cal
Bisexual	0.3	N/A	0.3	N/A	0.5	N/A	0.0	N/A
Other	0.2	N/A	0.0	N/A	0.2	N/A	0.0	N/A

Source: GPP Health Equity Report, 2023; MCAS, 2023.

Appendix D. Community Supports Eligibility Criteria and Allowable Duration or Frequency of Use

Exhibit 5.52. Community Supports Eligibility Criteria, Effective April 2025

Community Support	Eligibility Criteria
Recuperative Care (Medical Respite)	Individuals who meet <u>all</u> of the following criteria: • Individuals requiring recovery in order to heal from an injury or illness; • Experiencing or at risk of homelessness.
Short-Term Post-Hospitalization Housing (also known as short-term post-transition housing)	Individuals who meet <u>all</u> of the following criteria: • Individuals who are exiting an institution, which includes recuperative care facilities (including facilities covered under Community Support Recuperative Care or other facilities outside of Medi-Cal), inpatient hospitals (either acute or psychiatric or Chemical Dependency and Recovery hospital), residential SUD or mental health treatment facility, correctional facility, or nursing facility; • Experiencing or at risk of homelessness; • Meet one of the following criteria: ○ Are receiving Enhanced Care Management; ○ Have one or more serious chronic conditions; ○ Have serious mental illness; ○ Are at risk of institutionalization or requiring residential services as a result of a SUD. • Have ongoing physical or BH needs as determined by a qualified health professional that would otherwise require continued institutional care if not for receipt of Short-Term Post-Hospitalization Housing.
Transitional Rent	Individuals who meet <u>all</u> of the following criteria: • Social Risk Factor Requirement: Experiencing or at risk of homelessness.

Community Support	Eligibility Criteria
	• Clinical Risk Factor Requirement: Must have one or more of the following qualifying clinical risk factors: ○ Meets the access criteria for Medi-Cal Specialty Mental Health Services (SMHS); ○ Meets the access criteria for Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS); ○ One or more serious chronic physical health conditions; ○ One or more physical, intellectual, or developmental disabilities; ○ Individuals who are pregnant up through 12-months postpartum. • Individual must meet one of the following requirements: ○ Transitioning Population Requirement: Must be included within one of the following transitioning populations; ▪ Transitioning out of an institutional or congregate residential setting: Individuals transitioning out of an institutional or congregate residential setting, including but not limited to an inpatient hospital stay, an inpatient or residential SUD treatment facility, an inpatient or residential mental health facility, or nursing facility. ▪ Transitioning out of a carceral setting: Individuals transitioning out of a state prison, county jail, youth correctional facility, or other state, local, or federal penal setting where they have been in custody and held involuntarily through operation of law enforcement authorities. ▪ Transitioning out of interim housing: Individuals transitioning out of transitional housing, rapid rehousing, a domestic violence shelter or domestic violence housing, a homeless shelter, or other interim housing, whether funded or administered by U.S. Department of Housing and Urban Development, or at the State or local level. ▪ Transitioning out of recuperative care or short-term posthospitalization housing: Individuals transitioning out of short-term post-hospitalization housing or recuperative care, whether the stay was covered by Medi-Cal

Community Support	Eligibility Criteria
	managed care, or another source. ▪ Transitioning out of foster care: Individuals having aged out of foster care up to age 26 (having been in foster care on or after their 18th birthday) either in California or in another state. ○ Experiencing unsheltered homelessness: Individuals or families with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground; ○ Eligible for Full-Service Partnership (FSP): a comprehensive BH program for individuals living with significant mental health and/or co-occurring substance use conditions that have demonstrated a need for intensive wraparound services.
Housing Transition Navigation Services	Individuals who meet <u>one</u> of the following criteria: • Individuals who meet the following social and clinical risk factor requirements; ○ Social Risk Factor Requirement: Experiencing or at risk of homelessness. ○ Clinical Risk Factor Requirement: Must have one or more of the following qualifying clinical risk factors: ▪ Meets the access criteria for SMHS; ▪ Meets the access criteria for DMC or DMC-ODS; ▪ One or more serious chronic physical health conditions; ▪ One or more physical, intellectual, or developmental disabilities; ▪ Individuals who are pregnant up through 12-months postpartum. • Individuals who are determined eligible for Transitional Rent. • Individuals who are prioritized for a PSH unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services because of a SUD and/or is exiting incarceration.

Community Support	Eligibility Criteria
Housing Deposits	Individuals who meet <u>one</u> of the following criteria: - Individuals who meet the following social and clinical risk factor requirements: - Social Risk Factor Requirement: Experiencing or at risk of homelessness. - Clinical Risk Factor Requirement: Must have one or more of the following qualifying clinical risk factors: - Meets the access criteria for SMHS; - Meets the access criteria for DMC or DMC-ODS; - One or more serious chronic physical health conditions; - One or more physical, intellectual, or developmental disabilities; - Individuals who are pregnant up through 12-months postpartum. - Individuals who are determined eligible for Transitional Rent. - Individuals who are prioritized for a PSH unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services because of a SUD and/or is exiting incarceration.
Housing Tenancy and Sustaining Services	Individuals who meet <u>one</u> of the following criteria: - Individuals who meet the following social and clinical risk factor requirements: - Social Risk Factor Requirement: Experiencing or at risk of homelessness. - Clinical Risk Factor Requirement: Must have one or more of the following qualifying clinical risk factors: - Meets the access criteria for SMHS; - Meets the access criteria for DMC or DMC-ODS; - One or more serious chronic physical health conditions; - One or more physical, intellectual, or developmental disabilities;

Community Support	Eligibility Criteria
	▪ Individuals who are pregnant up through 12-months postpartum. • Individuals who are determined eligible for Transitional Rent. • Individuals who are prioritized for a PSH unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services because of a SUD and/or is exiting incarceration.
Day Habilitation	Individuals who meet one of the following criteria: • Experiencing homelessness. • Exited homelessness and entered housing in the last 24 months. • At risk of homelessness or institutionalization whose housing stability could be improved through participation in a Day Habilitation Program.
Medically Tailored Meals / Medically Supportive Food	Individuals who have chronic or other serious health conditions that are nutrition sensitive, such as (but not limited to): cancer(s), cardiovascular disorders, chronic kidney disease, chronic lung disorders or other pulmonary conditions (e.g., asthma/chronic obstructive pulmonary disease), heart failure, diabetes or other metabolic conditions, elevated lead levels, end-stage renal disease, high cholesterol, human immunodeficiency virus, hypertension, liver disease, dyslipidemia, fatty liver, malnutrition, obesity, stroke, gastrointestinal disorders, gestational diabetes, high risk perinatal conditions, and chronic or disabling mental/BH disorders.
ALF Transitions (formerly known as Nursing Facility Transition / Diversion to Assisted Living Facilities)	Members residing in a nursing facility who meet <u>all</u> of the following criteria: • Have resided 60+ days in a nursing facility; • Are willing to live in an assisted living setting as an alternative to a nursing facility; • Are able to reside safely in an ALF (ALF). Members residing in the Community who meet <u>all</u> of the following criteria: • Are interested in remaining in the community;

Community Support	Eligibility Criteria
	• Are willing and able to reside safely in an ALF; • Meet the minimum criteria to receive nursing facility Level of Care (LOC) services and, in lieu of going into a facility, choose to remain in the community and continue to receive medically necessary nursing facility LOC services at an ALF.
Community or Home Transition Services (formerly known as Community Transition Services / Nursing Facility Transition to Home)	Individuals who meet <u>all</u> of the following criteria: • Are currently receiving medically necessary nursing facility LOC services and in lieu of remaining in the nursing facility or Recuperative Care setting are choosing to transition home and continue to receive medically necessary nursing facility LOC services; • Have lived 60+ days in a nursing home and/or Recuperative Care setting; • Are interested in moving back to the community; • Are able to reside safely in the community with appropriate and cost-effective supports and services.
Personal Care and Homemaker Services	Individuals who meet <u>one</u> of the following criteria: • Individuals at risk for hospitalization, or institutionalization in a nursing facility; • Individuals with functional deficits and no other adequate support system; • Individuals approved for In-Home Supportive Services.
Respite Services	Individuals who live in the community and are compromised in their ADLs and are therefore dependent upon a qualified caregiver who provides most of their support, and who require caregiver relief to avoid institutional placement. Other subsets may include children who previously were covered for Respite Services under the Pediatrics Palliative Care Waiver, foster care program beneficiaries, Members enrolled in either California Children's Services or the Genetically Handicapped Persons Program, and Members with Complex Care Needs.
Environmental Accessibility Adaptations (Home Modifications)	Individuals at risk for institutionalization in a nursing facility.

Community Support	Eligibility Criteria
Sobering Centers	Individuals ages 18 and older who are intoxicated but conscious, cooperative, able to walk, nonviolent, free from any medical distress (including life threatening withdrawal symptoms or apparent underlying symptoms), and who would otherwise be transported to the ED or a jail or who presented at an ED and are appropriate to be diverted to a Sobering Center.
Asthma Remediation	Members with a completed in-home environmental trigger assessment within the last 12 months through the Asthma Preventive Services benefit that identifies medically appropriate Asthma Remediations and specifies how the interventions meet the needs of the Member. Effective January 1, 2026, MCPs must cover in-home environmental trigger assessments through the Asthma Preventive Services benefit, as described above.

Source: DHCS Community Supports Policy Guide, Volumes 1 and 2, April 2025.

Note: Transitional Rent will be evaluated separately in the BH-CONNECT 1115 Waiver Evaluation and is not examined in the Community Supports Evaluation.

Exhibit 5.53. Community Supports Allowable Use or Duration, Effective April 2025

Community Support	Allowable Use or Duration
Recuperative Care (Medical Respite)	Cannot exceed a duration of six months per rolling 12-month period and is subject to the six-month global cap on Room and Board services.
Short-Term Post-Hospitalization Housing (also known as short-term post-transition housing)	Cannot exceed a duration of six months per rolling 12-month period and is subject to the six-month global cap on Room and Board services.
Transitional Rent	Cannot exceed a duration of six months per rolling 12-month period and is subject to the six-month global cap on Room and Board services.
Housing Transition Navigation Services	As long as necessary; no limit on number of times a member can be authorized for this service.
Housing Deposits	Available once per demonstration and can be approved one additional time with documentation as to what conditions have changed to demonstrate why providing this benefit will be more successful on the second attempt.
Housing Tenancy and Sustaining Services	As long as necessary; no limit on number of times a member can be authorized for this service.
Day Habilitation	As long as necessary; no limit on number of times a member can be authorized for this service.
Medically Tailored Meals / Medically Supportive Food	Covers up to two meals or meal packages per day using a combination of interventions and can be authorized for up to 12 weeks and re-authorized thereafter as medically necessary.
Assisted Living Facility Transitions (formerly known	Transition services and expenses are expected to be time-limited and ongoing assisted living services may continue as long as necessary but do not include room and board expenses.

Community Support	Allowable Use or Duration
as Nursing Facility Transition / Diversion to Assisted Living Facilities)	
Community or Home Transition Services (formerly known as Community Transition Services / Nursing Facility Transition to Home)	Non-recurring set-up expenses are payable up to a total lifetime maximum amount of \$7,500. Transitional coordination costs are not included in this total.
Personal Care and Homemaker Services	Cannot be utilized in lieu of In-Home Supportive Services.
Respite Services	May not exceed 24 hours per day or 336 hours per calendar year, inclusive of all in-home and in-facility services. Exceptions to the calendar year limit can be made, with Medi-Cal MCP authorization, when the caregiver experiences an episode that leaves a Medicaid member without their caregiver (e.g., medical treatment and hospitalization).
Environmental Accessibility Adaptations (Home Modifications)	Payable up to a lifetime maximum of \$7,500 for modifications needed for direct medical or remedial benefit to the member. The only exception is if a member's place of residence changes or the member's condition has changed so significantly that additional modifications are needed to ensure member health, welfare, and safety.
Sobering Centers	Covered for a duration of less than 24 hours but can be repeated as many times as necessary.
Asthma Remediation	Payable up to a lifetime maximum of \$7,500, unless the member's condition has changed so significantly that additional modifications are necessary to ensure member health, welfare, and safety or are necessary to enable the member to function with greater independence in the home and avoid institutionalization or hospitalization.

Source: DHCS Community Supports Policy Guide, Volumes 1 and 2, April 2025.

Appendix E. California's County-Based Managed Care System

In California, the majority of Medi-Cal members are enrolled in managed care. The managed care delivery system is county-based, and the specific model of managed care in place within a given county can vary.

Effective January 1, 2024, DHCS made changes to the Medicaid managed care plans (MCPs) available to Medi-Cal members in order to meet new requirements related to quality, equity, accessibility, and accountability. Changes in the MCP marketplace in turn influenced which MCPs were eligible to offer Community Supports. Major changes to the Medi-Cal MCP marketplace effective January 1, 2024, are further described in the [Managed Care Transition Interim Report](#) and also briefly summarized below.

Changes to the Medi-Cal Managed Care Marketplace

The main models of managed care used in California include:

- **County organized health system (COHS) or Single Plan:** A single local MCP in the county manages care for all members. COHS are established by a county's Board of Supervisors, governed by an independent commission, and exempt from state Knox-Keene Act licensure requirements, while Single Plans operate under authorization and sponsorship of a county or local authority and are licensed under the Knox-Keene Act.
- **Two Plan model:** There are two MCPs within the county, a local MCP and a commercial MCP, offering members a choice.
- **Geographic managed care (GMC):** Multiple commercial MCPs operate in the county, offering more options for residents.
- In rural counties where fewer providers are available, California may adopt a **regional model** in which an MCP is contracted to serve two or more contiguous rural counties (i.e., a region).

[Exhibit 5.54](#) shows that the number of counties operating under a COHS or Single Plan model of managed care increased from 22 counties in 2023 to 37 counties in 2024, while the number of counties operating under Regional, GMC, or another county-specific model decreased from 22 counties in 2023 to seven counties in 2024. Overall, 45 of 58 counties experienced changes in the MCPs available to members between 2023 and 2024.

Exhibit 5.54. Number of Counties Operating Under Different MCP Models, 2023 and 2024

	Number of Counties in 2023	Number of Counties in 2024
COHS or Single Plan	22	37
Two Plan	14	14
Regional, GMC, or other county-specific model	22	7

Source: DHCS Medi-Cal Managed Care Plans by County, December 2023.

Note: Effective January 1, 2024, Kaiser Permanente became an additional, commercial MCP choice for certain members in 32 counties operating under COHS, Single Plan, and Two Plan MCP models. Two commercial MCPs, Aetna and United, stopped serving Medi-Cal members, and a third MCP, California Health and Wellness, ceased operating as a separate MCP and began operating as part of Health Net Community Solutions. In 2023, two counties (Imperial and San Benito) were operating under county-specific managed care models; these counties transitioned to other MCP models in 2024.

MCPs offering Community Supports

Except for Kaiser Permanente, which is required to offer all Community Supports per the terms of their Memorandum of Understanding with DHCS⁸⁶ (effective May 30, 2023, to December 31, 2028), 14 of the 15 Community Supports are voluntary for MCPs to offer. Transitional Rent, which was not implemented until July 1, 2025, and will be evaluated separately as part of the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment 1115 Waiver evaluation, will become the first mandatory Community Support effective January 1, 2026.

[Exhibit 5.55](#) shows that in 2022, there were 26 MCPs eligible to offer Community Supports and in 2024, following changes to the Medi-Cal managed care marketplace, there were 24 MCPs eligible to offer Community Supports.

Exhibit 5.55. Managed Care Plans Eligible to Offer Community Supports, 2022 and 2025

MCP	2022	2025
Aetna	Yes	No
AIDS Healthcare Foundation	Yes	Yes
Alameda Alliance for Health	Yes	Yes
Anthem Blue Cross	Yes	Yes

MCP	2022	2025
Blue Shield Promise	Yes	Yes
California Health and Wellness	Yes	No
CalOptima	Yes	Yes
CalViva	Yes	Yes
CenCal Health (formerly Santa Barbara Health Authority)	Yes	Yes
Central California Alliance for Health	Yes	Yes
Community Health Group	Yes	Yes
Community Health Plan of Imperial Valley	No	Yes
Contra Costa Health Plan	Yes	Yes
Gold Coast Health Plan	Yes	Yes
Health Net Community Solutions	Yes	Yes
Health Plan of San Mateo	Yes	Yes
Inland Empire Health Plan	Yes	Yes
Kaiser Permanente	Yes	Yes
Kern Family Health Care (formerly Kern Health Systems)	Yes	Yes
L.A. Care	Yes	Yes
Molina Healthcare of California Partner Plan	Yes	Yes
Mountain Valley Health Plan (formerly Health Plan of San Joaquin)	Yes	Yes
Partnership Health Plan	Yes	Yes
Santa Clara Family Health Plan	Yes	Yes
San Francisco Health Plan	Yes	Yes
SCAN Health Plan	Yes	Yes
United Healthcare	Yes	No

Source: Community Supports Elections by Managed Care Plans, July 2022 and January 2025;
Manual search of MCP ownership status.

Note: Although Kaiser Permanente's health plan is structured as a not-for-profit, the affiliated Permanente Medical Groups are all structured as for-profit entities. SCAN Health Plan is a MA plan that has elected to offer certain Community Supports to members dually eligible for Medicaid. AIDS Healthcare Foundation only serves eligible members living with HIV/AIDS in Los Angeles County, California.

Appendix F. Revised Evaluation Designs for Providing Access and Transforming Health (PATH), Global Payment Program (GPP), Medi-Cal Matching Plan Policy for Dually Eligible Beneficiaries, Reentry Demonstration Initiative, and Managed Care Plans Transition (MCP)

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), Global Payment Program (GPP),
Medi-Cal Matching Plan Policy for Dually Eligible Beneficiaries,
Reentry Demonstration Initiative, and Managed Care Plans
Transition (MCP)**

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July 23, 2025

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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 members 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 members.

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 members 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.²⁵ 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, 2023.²⁶

As a result, this Revised Evaluation Design covers the evaluation of five components of the waiver: the Providing Access and Transforming Health (PATH) Initiative, the Global Payment Program (GPP), the Medi-Cal Matching Plan Policy for Dual Eligible Beneficiaries,

²⁵ CalAIM Population Health Management Initiative:

<https://www.dhcs.ca.gov/CalAIM/Pages/PopulationHealthManagement.aspx>

²⁶ <https://www.dhcs.ca.gov/Documents/CA-SUD-CM-Evaluation-Design.pdf>

Reentry Demonstration Initiative, and Managed Care Plan Transition. More details about these programs and evaluation designs are below.

Independent Evaluation Team

DHCS selected the Regents of the University of California on behalf of its Los Angeles campus (UCLA) as the Independent Evaluator in October 2023 to assess the impact of five Evaluation Components of the CalAIM 1115 Demonstration: PATH, GPP, DUALS, Reentry, and MCP. The evaluation contract was finalized in December 2023. Throughout this evaluation design, the independent evaluators are referred to as “UCLA-RAND”, recognizing the shared effort between UCLA, the contracted organization, and the RAND Corporation, the main subcontractor for this evaluation. UCLA-RAND has agreed to conduct the evaluation in an independent manner and in accordance with the CMS-approved Evaluation Design. The independent evaluation team considers the unique goals of each initiative and the overarching impact on CalAIM and population health. UCLA-RAND’s approach considers structural change, cost of care, quality of care, and access to care, all of which provide a picture of member experience and impact to the state’s administration of the program overall. UCLA-RAND is responsible for developing the evaluation design and reporting results of the evaluation in the Interim and Summative Evaluation Reports.

Projected Timeline

[Exhibit 1](#) shows the planned timeline for important elements of the evaluation as well as the major deliverables. The interim report, summative report, and Reentry mid-point assessment reflect the date that the draft version is due to CMS. As stated in STC 17.4 and 9.10, the final versions are due to CMS 60-days after receiving CMS comments. The due dates of the major required CMS deliverables are listed below:

- » Final Evaluation Design: July 29, 2025
- » Interim Evaluation Report: December 29, 2025
- » Justice-Involved Reentry Demonstration Mid-Point Assessment: September 30, 2027
- » Summative Evaluation Report: June 27, 2028

Exhibit 1. Projected Evaluation Timeline

Evaluation Activity	Year 1: 12/1/23- 6/30/24				Year 2: 7/1/24 – 6/30/25				Year 3: 7/1/25- 6/30/26				Year 4: 7/1/26- 6/30/27				Year 5: 7/1/27- 6/30/28				Year 6: 7/1/28- 5/31/29			
PATH, GPP, Duals, Reentry Primary Data Collection ²⁷	NEA	NEA			EA	EA	EA	EA	EA	EA	EA	EA	EA	EA	EA	EA	EA							
PATH, GPP, Duals, Reentry Existing Data Receipt ²⁸ (1) Initial data request / receipt (2) Follow-up data request / receipt	NEA	NEA	EA	EA 1	EA	EA	EA 1	EA	EA	EA	EA	EA	EA	EA	EA	EA								
Quantitative Data Collection & Analysis ²⁹	NEA	NEA	EA	EA	EA	EA	EA	EA	EA	EA	EA	DD	EA	EA	EA	DD	EA	EA	EA	DD				
Qualitative Data Collection & Analysis ³⁰	NEA	NEA						EA	EA	EA	EA	EA	EA	EA	EA	EA								
Evaluation Design	NEA	NEA			DD		DD		DD															
Interim Evaluation Report	NEA	NEA				EA	EA	EA	EA	DD														
Quarterly Evaluation Reports	NEA	NEA	DD	DD	DD	DD	DD	DD	DD	DD	DD	DD	DD	DD	DD	DD	DD	DD	DD	DD	DD	DD	DD	
Reentry Mid-Point Assessment	NEA	NEA												EA	EA	EA	DD							
Summative Evaluation Report Draft	NEA	NEA															EA	EA	EA	DD				

NOTE: Dark blue indicates a due date for the deliverable; light blue indicates evaluation activities related to that deliverable. Grey indicates that no evaluation activities took place, as Year 1 was 6 months in length vs. 12 months in the other project years.

Due Date	DD
Evaluation Activities	EA
No Evaluation Activities	NEA

²⁷ UCLA-RAND will conduct PATH, GPP, Duals, Reentry primary data collection

²⁸ UCLA-RAND will initiate data requests, receipt and conduct follow up as needed

²⁹ NORC will conduct Quantitative Data Collection & Analysis

³⁰ NORC will conduct Qualitative Data Collection & Analysis

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

Acronym	Text
EE	Equity Enhancing
EQs	Evaluation Questions
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
PCP	Primary Care Physician
PHE	Public Health Emergency
PHM	Population Health Management
PQI	Prevention Quality Indicator
PY	Program Year

Acronym	Text
QIMR	Quarterly Implementation Monitoring Report
REPL	Race, Ethnicity, Preferred Language
ROC	Research Oversight Committee
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
SDI	Social Deprivation Index
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)

General Background Information

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 Indian health care providers, 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:

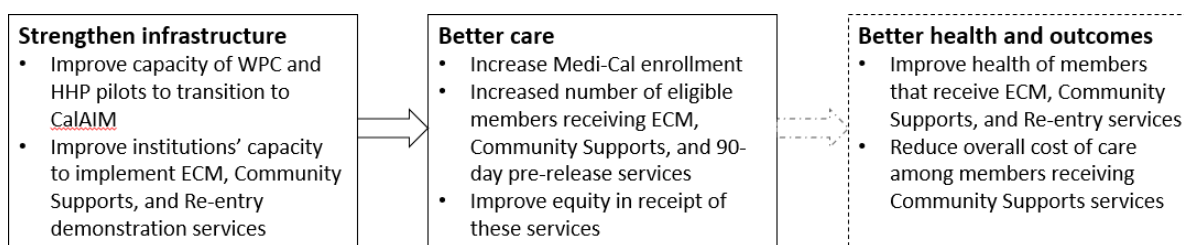
- » **Support for Implementation of Enhanced Care Management and Community Supports.** PATH is supporting the expansion of community-based provider capacity and infrastructure needed to implement ECM and Community Supports, and increase eligible members' access to these services statewide through four 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 transition to managed care coverage under CalAIM.

- **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 Indian health care providers, 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 Indian health care providers, 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.

Evaluation Questions and Hypotheses

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.³¹

Figure 1. Driver Diagram for Path Evaluation



[Exhibit 2](#) 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.

³¹ 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 2. PATH Evaluation Questions, Hypotheses, and Measures

Evaluation Questions (EQ) & Hypotheses (H)	Measures
Goal 1. Increase the number of ECM and Community Supports community-based providers and consequently increase Medi-Cal member ECM and Community Supports utilization according to community needs.	
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? H1a: 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. H1b: The number and proportion of community-based providers located in under-resourced communities will increase over time due to provision of PATH funding and resources.	» 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
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

Evaluation Questions (EQ) & Hypotheses (H)	Measures
Goal 1. Increase the number of ECM and Community Supports community-based providers and consequently increase Medi-Cal member ECM and Community Supports utilization according to community needs.	
EQ 3: Did PATH increase utilization of ECM and Community Supports? H3a: 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. H3b: PATH will increase the number of eligible members in under-resourced communities that utilize ECM or Community Supports and the number of ECM and Community Supports services used by eligible members by increasing the number of providers in these communities contracted to provide these 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 (e.g., age, sex, language preference, homelessness status, county or region, vulnerability indices, chronic health conditions, serious mental illness, substance use disorder) » 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.

Evaluation Questions (EQ) & Hypotheses (H)	Measures
Goal 2: <i>Improve data collection and information sharing infrastructure among ECM and Community Supports providers.</i>	
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

Evaluation Questions (EQ) & Hypotheses (H)	Measures
Goal 3: <i>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.</i>	
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
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

Evaluation Questions (EQ) & Hypotheses (H)	Measures
Goal 3: <i>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.</i>	
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 » Proportion of eligible individuals enrolled in Medi-Cal prior to release » Self-reported impact of PATH on screening and enrollment of eligible individuals in Medi-Cal prior to release

Methodology

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. UCLA will request Medi-Cal eligibility and claims data going back two years prior to the start of CalAIM (January 2020 to December 2021) in order to include a two-year baseline period in relevant analyses as indicated in the methodology section below. 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 baseline organization characteristics and infrastructure (i.e., prior to CalAIM), 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 from January 1, 2020, 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), Social Deprivation Index (SDI), Healthy Places Index (HPI), or a comparable index. These indices will be used to identify under-resourced communities (i.e., rural communities), those with high SDI/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 SDI/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 (IPP); 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 obtained by the RAND team, including Medi-Cal screening, enrollment and eligibility for 90-day pre-release services from CDCR and from a sample of county jails and youth correctional facilities in four counties from January 1, 2017, through December 31, 2026.
9. Key informant interviews in coordination with the RAND team with CDCR staff for state prisons and with administrative staff in a purposefully selected sample of county jails and youth correctional facilities in four local counties). Interviews will occur in mid-2025 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; the use and perceived utility of PATH; and facilitators, barriers, and lessons learned in implementing the Reentry demonstration. The RAND team will lead

interviews with key informants in correctional facilities and the UCLA team will lead interviews with county social services agencies and other salient community-based implementation partners.

10. UCLA organizational survey of relevant CDCR administrators for state prison facilities and relevant administrators for county jails, and youth correctional facilities, administered in 2025/2026. UCLA and RAND will examine all available administrative data (e.g., PATH implementation plans and readiness reviews, DHCS-administered surveys, etc.) and will assess if gaps exist. If gaps are identified, UCLA will develop survey questions salient to addressing PATH EQs and will also include survey questions developed by the RAND team. Survey questions will be informed by findings from key informant interviews. The survey will then be administered to relevant administrators in eligible state prisons, county jails, and youth correctional facilities and/or to key implementation partners (e.g., county social service agencies responsible for benefits eligibility determinations).

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, which asks whether the number of providers contracted to provide ECM or Community Supports increased over time, UCLA will assess change or rate of growth in the related measures noted in [Exhibit 2](#) over time (i.e., from January 1, 2022, to December 31, 2026). For these measures, we will examine growth over the course of the program and therefore will not include a baseline period. To better understand provider retention as indicated in [Exhibit 2](#), UCLA will also (a) assess the transition of WPC and HHP providers to ECM or Community Supports in the early phase of PATH implementation and (b) examine churn in those providers as well as in newly contracted providers of ECM or Community Supports services. Data will be presented using graphical plots, and we will examine the trend and use the appropriate test (e.g., the Mann-Kendall test or regression modeling) to evaluate whether upward or downward trends are statistically significant. To determine whether the number and proportion of community-based providers located in under-resourced communities increases over time (H1), UCLA will stratify results by California county and by under-resourced

community indices. When stratifying by county is not feasible due to small numbers, UCLA will stratify results by a regional grouping determined in collaboration with DHCS. To determine whether changes in the number of providers can be attributed to PATH (H1), UCLA will also stratify results based on PATH participation. PATH participation will be operationalized as a dichotomous variable. As a sensitivity analysis, UCLA will test alternative specifications of the PATH participation variable (e.g., to assess impact of participation in different PATH initiatives or multiple PATH initiatives) and of under-resourced community indices. UCLA will also attempt to account for provider participation in other capacity-building programs such as IPP or learning collaboratives not facilitated by 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 2](#). As feasible, UCLA will identify eligible providers based on DHCS-provided lists of preferred provider types for each ECM population of focus and each Community Support. To test H2, UCLA will use logistic regression analysis to identify factors associated with whether providers contracted to provide ECM or Community Supports. Factors assessed will include provider and community characteristics, such as provider type, participation in PATH, county or region, and community indices such as HPI or SDI/SVI score (or comparable index). When available, we will also attempt to control for provider size, ownership (public, private for-profit, private nonprofit or not-for-profit), and other provider characteristics. UCLA will utilize available administrative data to identify providers' participation in PATH and providers that contracted with MCPs prior to CalAIM during the baseline period (2020 to 2021). Data on providers' data sharing infrastructure prior to CalAIM will be drawn from UCLA provider-level surveys and when available, administrative data (e.g., provider applications for PATH TA or CITED funding). Due to the volume of ECM and Community Support providers, UCLA will use a survey sampling strategy to be determined following analysis of available administrative data and discussions with DHCS to collect data from a representative subset of these providers. Similar to EQ1, we will conduct sensitivity analyses to test alternative specifications of the PATH participation variable and community indices. We will also test alternative specifications of the outcome variable (e.g., dichotomous variable for any contracting to provide Community Supports vs. count variable representing number of Community Supports provided). UCLA will also thematically analyze qualitative data obtained during key informant interviews to

provide further contextual information on factors affecting provider participation in ECM or Community Supports, and whether these factors vary by MCP, provider type or community context.

To answer EQ 3, which assesses whether PATH increased utilization of ECM and Community Supports, 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 first examine the rate of use of ECM by population of focus and the rate of use of each Community Support. These analyses will be stratified by California county or region and by under-resourced community indices. UCLA will then use logistic regression analyses to assess characteristics differentiating eligible users and non-users for each ECM Population of Focus (POF) and for each Community Support. Where feasible and applicable, UCLA will also examine member characteristics associated with length of time using services or frequency of service use. Member characteristics examined will include age, gender, race/ethnicity, preferred language, homelessness, California county or region, vulnerability indices, chronic health conditions, severe mental illness, substance use disorder, and baseline service utilization (2 years prior to enrollment in ECM or receipt of Community Support services), among others. UCLA will also use regression analyses to assess differences in patterns of use of ECM and Community Supports by provider characteristics and as feasible, to 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 language preference, and baseline service use. Sensitivity analyses will entail differing specifications of the PATH participation variable, the Community Supports utilization variable, provider participation in non-PATH capacity development initiatives, and of under-resourced community indices. Regression analyses will be complemented with descriptive analysis of survey data and thematic analysis of interview data to contextualize and explain the findings from the Medi-Cal eligibility and claims data, e.g., by providing data on perceived impact of PATH on providers' ability to develop collaborative relationships and infrastructure needed to implement ECM or Community Supports and to identify and engage eligible members in care.

To answer EQ 4, which examines whether PATH improved ECM and Community Supports providers' data collection and information sharing infrastructure, UCLA will use provider survey or interview responses on what infrastructure they have in place prior to and after CalAIM, and available administrative data such as provider PATH applications,

meeting notes, and progress reports. To test H4, UCLA will use ANCOVA or appropriate regression analyses to assess change in the related measures noted in [Exhibit 2](#) over time, controlling for provider characteristics, county or region, and under-resourced community indices. Sensitivity analyses will entail testing alternative specifications of the infrastructure variables, salient provider characteristics, and community indices. These analyses will be complemented with analysis of 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 descriptively examine 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 (H5). When feasible, we will conduct t-test, Chi-squared, or other appropriate statistical tests to determine whether there are significant pre-post changes in infrastructure or staffing before and after CalAIM. UCLA and RAND will further conduct similar analyses to characterize the delivery of 90-day pre-release services (H6). 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 administrative data from CDCR, select county jails, and youth correctional facilities. As feasible, UCLA and RAND will attempt to corroborate enrollment using Medi-Cal enrollment data, pending the availability of a reliable flag in these data identifying previously incarcerated individuals or the ability to link administrative data from CDCR and select carceral facilities with Medi-Cal data. Data on the rate of incarcerated individuals that were screened for Medi-Cal eligibility or enrolled in Medi-Cal prior to release will be graphically plotted, and UCLA will use regression analyses to evaluate whether trends are statistically significant. For these measures, we will examine growth over the course of the program and therefore will not include a baseline period. To test H7, results will be stratified by facility type and region. Due to the large number of correctional facilities and associated implementation partners (e.g., county social service agencies) receiving PATH JI funding, and the fact that administrative data on county jails and youth correctional facilities will

only be available in four counties, UCLA does not believe it will be feasible to stratify administrative data on screening and eligibility rates by facility receipt of PATH funding. Thus, regression analyses will be complemented with descriptive analysis of survey data and thematic analysis of interview data to contextualize and explain the findings, e.g., by providing data on facilitators and barriers to screening and enrollment, and perceived impact of PATH on institutions' ability to screen and enroll eligible members in Medi-Cal prior to release.

Cost Analyses

UCLA proposes to examine all PATH expenditures and resources as well as payments to providers for ECM and Community Supports 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.

Data on PATH expenditures will be provided by DHCS and will be used as part of the assessment of whether HRSN expenditures exceed the aggregate spending cap per demonstration year. This analysis will be coordinated with the UCLA Community Supports evaluation team. To determine the expenditures of ECM and Community Supports services, UCLA will ask MCPs to provide an average payment amount for each ECM or Community Supports service identified in Medi-Cal claims data by a HCPCS code. UCLA anticipates that MCPs payments to individual providers may vary for each ECM and Community Supports service identified by a HCPCS code, by region, by population of focus and potentially other factors. However, an average payment for each service may be calculated on a per service/per unit basis. UCLA will use this data to determine average payments and patterns of average payments for each ECM population of focus and for Community Supports services. UCLA will stratify these data by county or region, under-resourced community indices, provider types, and by whether the members were transitioned from WPC or HHP vs. newly enrolled following PATH implementation. These analyses depend on the feasibility of obtaining average payment rates from MCPs. If MCP are unable to estimate average payment amounts, then we will rely on DHCS-provided data pertaining to rates provided to MCPs; the limitation of this approach is that we would then only be able to examine expenditures in aggregate.

UCLA will attempt to assess cost savings by comparing Medi-Cal payments by category of service incurred by members receiving ECM or Community Supports, from providers

that participated in PATH to a matched comparison group of eligible members that did not participate in ECM or Community Supports.

Additional analytic considerations

- » **Prior participation in similar waiver programs:** For most PATH analyses, UCLA will use a baseline period of 2020-2021. In some counties, ECM and Community Supports are similar to services previously provided as part of California's Medi-Cal Whole Person Care (WPC) Pilot Program (baseline period 2015-2016 and intervention implemented 2017-2021) or by Medicaid managed care plans that participated in the optional Medicaid Health Homes Program (HHP) benefit (baseline 2016-2017 and intervention implemented 2018-2021). In these counties, UCLA will use data from UCLA's prior evaluation of these programs to assess patterns of service use for Medicaid members that previously received WPC or HHP services and subsequently participated in ECM or Community Supports, as feasible. These analyses may be challenging due to churn in enrollment and selection bias (i.e., members that participate in services for a longer period of time may have a higher level of complexity than those that do not).
- » **Potential effects of public health emergencies (PHE):** PHEs can impact patterns of health care use and expenditures, and also negatively impact fiscal solvency of many provider organizations. UCLA's previous evaluations of WPC and HHP assessed COVID-19 PHE impact, and did not identify major confounding impacts from the PHE; thus, UCLA also does not believe the COVID-19 PHE will confound PATH evaluation outcomes. However, when appropriate, the UCLA team may include a PHE indicator (e.g. for COVID-19 or other PHE) to determine whether there may be an association with members' subsequent uptake of ECM or Community Supports services.

Methodological 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, 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, 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)

General Background Information

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 assist public health care systems (PHCS) in their key role of 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 emergency departments (EDs) 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 members under other 1115 Medicaid waivers. With the approval of California's CalAIM 1115 waiver,³² GPP will continue through 2026, its twelfth program 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 outcomes. 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 3](#) below. Twelve of the PHCSs listed below began participating in GPP on July 1, 2015 (Program Year 1 (PY1)). UCLA began participating in GPP beginning with PY 9, January 1,

³² 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>.

2023.

Exhibit 3. 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
 - c. UCLA West Valley Medical Center

The total amount of annual funding available for the GPP across its planned 12 PYs, 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. The valuation process is summarized below based upon a detailed description in the CalAIM-1115-STC³³.

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 more appropriate settings are valued relatively higher than care given in less appropriate 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 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 or exceed its threshold for a given GPP PY, the PHCS's GPP payments equal the PHCS's global budget diminished by the proportion by which it fell short of its threshold.

³³ 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>

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 ED, 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 primary care physician (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 with 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 details on non-traditional services, including codes where available and descriptions, are in STC Attachments K and L.³⁴

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 revaluations 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 inpatient mental health 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 support service to supplement the original 50 GPP services. California's GPP has also now added, a fifth category, *Equity-Enhancing Services*, which spans three tiers: "Enhanced Care Management"; "Community Supports", and "Other Equity Enhancing Services". From the list of fourteen Community Supports included as part of CalAIM's initial provision of CSs,

³⁴ Attachments K and L from the CalAIM waiver STCs provide details of GPP services stratified by categories, tiers, and services, including point values historically and recently assigned to individual GPP services.

- » Two Community Support services were included in the original list of 50 GPP services including Recuperative Care (Medical Respite) and Sobering Centers.
- » Nine Community Support services, included in GPP's fifth category, Equity Enhancing services, are now included as a GPP service including: 1) Housing Transition Services; 2) Housing Deposits; 3) Housing Tenancy and Sustaining Services; 4) Short-Term Post-Hospitalization Housing; 5) Day Habitation Programs; 6) Nursing Facility Transition/ Diversion to Assisted Living Facilities; 7) Community Transition Services/ Nursing Facility Transition to a Home; 8) Personal Care and Homemaker Services; and 9) Asthma Remediation.³⁵
- » Three remaining Community Support services, Respite Care (for caregivers), Environmental Accessibility Adaptations (Home Modifications) and Medically Tailored Meals are currently not included as GPP services.
- » The inclusion of the nine Community Supports not previously included as a GPP service, supplements the two Community Supports already included in the original GPP services. This assures that 11 current CalAIM Community Supports are now covered services under GPP. Currently, GPP lists Team-based street outreach and engagement as the only currently approved "Other Equity-Enhancing Service".

These new services are intended to align GPP service offerings with those available to Medicaid beneficiaries and utilize evidence-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 health care landscape for the uninsured population who receive GPP services in California and help inform meaningful care improvement strategies.

³⁵ Within CalAIM's Waiver's STCs, Attachment L, Table 1 of the Program Valuation text (page 18 of Attachment L), the components of the GPP services included in the new GPP Equity Enhancing Services are listed.

A prior evaluation of GPP was conducted through PY 3 (SFY 2017-2018).³⁶ 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. 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 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, utilization of new additions to GPP services since the beginning of the Medi-Cal 2020 waiver (e.g., doula, peer support, and Equity Enhancing Services), and changes in quality of care for California's uninsured.

Evaluation Questions and Hypotheses

This section introduces GPP goals with [Exhibits 4](#) and [5](#) using driver diagrams, initially presented by DHCS in their Initial Evaluation Design.³⁷ The discussion of goals is followed later in this section with [Exhibits 6](#), [7](#), and [8](#) that provide additional detail about GPP's current evaluation questions (EQs), directional hypotheses (H), and measures developed by UCLA-RAND evaluators to assess whether the goals of GPP are achieved across the evaluation period. The target population for all measures includes individuals for whom the PHCSs submitted points for any GPP service provided by any of the PHCSs participating in the GPP.

³⁶ 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.

³⁷ California Department of Health Care Services (DHCS) California Advancing and Innovating Medi-Cal (CalAIM) Section 1115(a) Demonstration. Draft Evaluation Design for PATH, GPP, Duals. June 27, 2022.

Exhibit 4. 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	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
	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	
Causality		

Exhibit 5. 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	Implementation of the Health Equity Monitoring Metrics Protocol Require PHCS to adhere to Health Equity Monitoring Metrics Protocol by submitting performance data stratified by demographic data
 Causality		

To assess the extent to which these goals were met, the GPP Evaluation Team will pursue the following three Evaluation Research Questions and Hypotheses.

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.

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 non- 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.

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.

Methodology

Overview of Approach to Evaluation Questions and Hypotheses including Building Blocks for Analyses

The Evaluation Team will use descriptive, qualitative and quantitative analyses to address the three GPP goals, research questions, and hypotheses. An overview of the building blocks of the GPP Evaluation Teams' qualitative, descriptive, and quantitative approaches to planned analyses is shown below.

For the quantitative design discussed in more detail below, the evaluator proposes conducting 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 PHCSs. Survey responses will be described, 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 meeting the goals of GPP and adapting its operations and care delivery during GPP implementation. Topics will also include reports of barriers to adaptation including external factors, such as the COVID pandemic, and how systems are improving the data infrastructure to track and address gaps in care for different population groups. The first survey and interview should take place once the evaluator is onboarded and prepared to conduct interviews. The second survey and interview should take place after data for PY 12 (CY 2026) is submitted. The qualitative data that will address all three GPP goals and provide contextual background for interpreting quantitative analyses. Accordingly, building blocks that characterize the qualitative analyses above will be similar to those described in the paragraphs that follow. Details of both the qualitative and quantitative analyses are described throughout the remainder of this Methodology Section.

GPP's first research goal, question and hypothesis. Clinical quality measures associated with the first goal, research questions, 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)³⁸. 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."³⁹ GPP eligible individuals include those who are uninsured for the service they receive.

GPP's second and third research goals, questions and hypotheses. 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 pertain to equity. The first four of these measures include those identified by DHCS in

³⁸ 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>

³⁹ Global Payment Program (GPP) Health Equity Reporting Specifications. Program Year (PY) 9 Reporting Manual, Measurement Period January 1, 2023-December 31, 2023. Page 7.

2023 for measurement of both quality of care and health equity.⁴⁰ 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 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 codes⁴¹ include changes in utilization across multiple GPP service categories.

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 quantitative 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. For example, 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. The text below respectively describes GPP's primary and secondary data sources.

⁴⁰ 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.

⁴¹ 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 provided by DHCS to PHCS.

Primary Data Sources for Planned 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 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 accessible, 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 high-quality care in 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 to examine the patient experience

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 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 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. To better examine the patient experience in our evaluation, we will attempt to gather this information through questions in the PHCS surveys and PHCS interviews described above to learn about how patients use the services provided and paid for through GPP. We will attempt to use existing patient-level Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data collected by DHCS as part of the state's Medicaid Core Set reporting requirements to understand changes in patient experience over time for GPP service users. After consideration of the pros and cons of interviewing patients, with DHCS, the Evaluation Team has decided upon the alternative methods described above to assess patient experience.

Secondary Data Sources for Planned Secondary Analyses

The interim and final evaluations will 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 by February 15 following the end of each PY and a final, year-end reconciliation summary report by September 30 following the end of each PY. PHCSs are expected to use the applicable STCs in the CalAIM waiver 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 over 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 and 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 PY 1 (SFY2015-2016). To implement planned pre-post and differences-in-differences analyses, the evaluation team recommends we examine historical P14 workbook data from PY 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).

Medi-Cal Claims, Encounters, and Eligibility Files

Medi-Cal claims and encounter data (hereafter referred to simply as “claims”) will supplement GPP encounter data to capture use of GPP services. For example, since the beginning of GPP in SFY 2015-2016, GPP users who were eligible for restricted scope Medi-Cal and who used ED or pregnancy-related services will have documentation of these services in the Medi-Cal claims files. In addition, we will use both claims and eligibility files to identify a comparison group of Medi-Cal members for selected analyses.

Medicaid Core Set Measures

DHCS generates and submits to CMS measures of performance on the quality of care provided to Medi-Cal enrollees on an annual basis. These measures assess performance in domains such as primary care access and preventive care, behavioral health care, maternal and perinatal health, care of acute and chronic conditions, and members' experience of care. We will explore using patient-level data to assess changes in these measures among our comparison group of Medi-Cal members during CalAIM.

Managed Care Accountability Set (MCAS) Measures

Medi-Cal managed care organizations operating in California are required to submit to DHCS measures of performance each year, which are then publicly reported. Measure domains include behavioral health, children's health, chronic disease management, reproductive health, cancer prevention, and utilization. We will explore using patient-level data to assess changes in these performance measures among Medi-Cal members during CalAIM for our comparison groups.

Emergency Department and Hospital Inpatient Encounter Data

The California Department of Health Care Access and Information (HCAI) maintains databases containing all ED and hospital inpatient encounters in the state each year—including encounters for uninsured residents. We will use these files to measure ambulatory care-sensitive utilization measures for GPP service users from 2015 to 2026.

GPP Point Thresholds

Point thresholds represent the total number of points each PHCS was expected to earn in each PY based on past experience. Specifically, point thresholds for PY 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 PY. 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. Additionally, a final reconciliation payment is then made, which may include payments to PHCSs that exceeded their point thresholds if there is unclaimed funding for hospitals which did not meet their point thresholds. Interim, final reconciliation, and total PY payments to each PHCS are publicly reported on the DHCS website.

Annual Health Equity Report

Completion of this report will first be required to be completed by PHCS for the period covering PY 9, January 1, 2023–December 23. The first PHCS reporting date to DHCS for this *Annual Health Equity Report* was September 30, 2024. All participating PHCSs are required to report on the five GPP Health Equity measures selected by DHCS and GPP service utilization categories, using the specifications outlined by DHCS as required by Attachment M.

Analysis Approach

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 individuals who receive 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 and interrupted time series analyses with suitable comparison groups will be included where feasible.

GPP Goal 1 Evaluation Design

The first GPP goal is the improvement of quality of care among individuals with uninsured services.

Exhibit 6. 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 Screening⁴² 2. Diabetes: HbA1c Poor Control (>9%)⁴³ 3. Preventive Care and Screening: Screening for Depression and Follow-Up Plan⁴⁴ 4. Breast cancer screening⁴⁵ 5. Cervical cancer screening⁴⁶ Other quality measures that may be included depending on data availability include: Chlamydia Screening in Women, Postpartum Care, Childhood Immunization Status, Immunizations for Adolescents, Developmental Screening in the First Three Years of Life, Lead Screening in Children, and Topical Fluoride for Children.

Analytic methods for GPP Goal 1

1.1. Descriptive Analyses

To evaluate GPP Goal 1 we will begin by conducting descriptive analyses of trends in quality of care for GPP users without the use of comparison groups.

- » **Data sources:** The data sources used by PHCSs to generate quality Measures 1-5 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, pharmacy, and lab data). As part of the GPP Health Equity Monitoring Metrics Protocol approved by CMS on December 20, 2023, PHCS will be required to

⁴² Measure specification: [CMS130v10](#). UDS benchmark available. NCQA stewarded.

⁴³ Measure specification: [CMS122v10](#). UDS benchmark available. NCQA stewarded.

⁴⁴ Measure specification: [CMS2v11](#). UDS benchmark available. CMS stewarded.

⁴⁵ Measure specification: [CMS125v11](#). UDS benchmark; NCQA stewarded.

⁴⁶ Measure specification: [CMS124v10](#). UDS benchmark available. NCQA stewarded.

submit stratified performance data on the five clinical quality measures listed above. PHCS submitted the first Health Equity Annual Report containing performance rates for calendar year 2023 on November 29, 2024, and will continue to submit these reports on an annual basis thereafter.

- » **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).⁴⁷ 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:** All individuals receiving GPP services. More specific target populations will be defined by each clinical measure specification. The level of analysis will be at the PHCS level and program level.
- » **Comparison group:** None
- » **Baseline period:** None
- » **Statistical analyses:**
 - Model: Longitudinal analysis
 - Analysis period: 2023–2026
 - Estimates of interest: Yearly change in quality for the target population relative to the first year of the analysis period (2023).
- » **Stratifications:** Data available for analyses will be stratified by race, ethnicity, preferred language, gender identity, sexual orientation, age group, and area-level deprivation measures, such as the Social Vulnerability Index, Social Deprivation Index, the Healthy Places Index, or a comparable index. Analyses across all five CalAIM components will seek to align use of area-level deprivation measures where possible and following empirical analysis of their concordance for areas within California.

1.2. Analyses with Comparison Groups

We will also explore conducting analyses that include comparison groups to provide a more rigorous assessment of the effects of GPP on quality of care. For these analyses, we will explore using GPP encounter data to measure quality of care for the target

⁴⁷ <https://bphc.hrsa.gov/sites/default/files/bphc/data-reporting/uds-clinical-measures-handout.pdf>

population and Medi-Cal claims data and MCAS and Medicaid Core Set measures to assess quality of care for a comparison group of Medi-Cal members who receive care from the PHCS, or, alternatively Medi-Cal members who live within a PHCS service area but who are not attributed to a PHCS. Measures may include key screening measures (e.g., breast cancer screening, cervical cancer screening), measures of postpartum care, and immunization measures ([Exhibit 6](#)). The statistical analysis would use comparative interrupted time series models as there are no data available for the target population prior to the start of GPP. Stratified analyses could be conducted for key patient subgroups defined by race, ethnicity, and area-level deprivation.

1.3. PHCS Survey and Qualitative Interviews Analyses for Goal 1

As part of our analyses to assess GPP Goal 1, we will also examine PHCS responses to PHCS Survey questions on PHCS' strategies to improve access to and continuity of care, timeliness of care for PHCS patients, and perceptions of patient experiences of care at the PHCS. We will summarize the responses by reporting means, standard deviations, and sample sizes (not all items will be applicable to all 13 PHCSs). We will also conduct follow-up interviews with the PHCS to discuss their responses to the survey and gain more contextual information about some of their decision-making around the strategies they do and do not employ to improve access to and continuity of care, their perceptions of patient experiences, and the challenges and successes around providing timely care to PHCS patients.

GPP Goal 2 Evaluation Design

The second GPP goal is to shift the provision of services from emergency and select inpatient settings to non-emergency outpatient settings among those individuals with uninsured services.

Exhibit 7: 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 non-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.	<u>Utilization measures derived from GPP encounter data:</u>⁴⁸ 1. GPP <u>non-behavioral health</u> outpatient non-emergency, emergency, and inpatient med/surg services 2. GPP <u>behavioral health</u> outpatient non-emergency, emergency, and inpatient services 3. GPP non-traditional services 4. GPP equity-enhancing services <u>Utilization measures derived from HCAI encounter data:</u> 5. Ambulatory care-sensitive Emergency Department (ED) visits 6. Ambulatory care-sensitive hospitalizations 7. 30-day-all-cause-hospital-readmission-rate 8. All-cause ED utilization <u>Utilization measures still under consideration:</u> 9. Visit Patterns (<i>Possible measures under consideration include frequency/regularity of ambulatory visits and</i>

⁴⁸ 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 7](#) 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/>)

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
	<i>types of providers seen including generalist or specialist provider MD, NP, PA, RN⁴⁹ or other provider type)</i> 10. Follow-up care following abnormal clinical findings <i>(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).</i> <u>Other utilization measures that might be derived from Medicaid claims and/or are available in Medicaid Core Set or Managed Care Accountability Set (MCAS) measure files</u> <i>(Possible measures under consideration include):</i> 11. Follow-up after ED visit for individuals at high-risk for multiple chronic conditions, substance use, or mental illness; Follow-up after hospitalization; Continuity of primary and specialty care providers; Readmissions or repeated ED use; and among pregnant women, length of hospital stay, intensive care unit (ICU) use during hospital stay, and prenatal visit rates).

⁴⁹ Example categories of provider type include MD (physician), NP (nurse practitioner), PA (physician's assistant), RN (registered nurse).

Analytic methods for GPP Goal 2

2.1. Planned descriptive analyses and analyses with comparison groups

To evaluate GPP Goal 2, we will conduct analyses to compare the utilization of services by GPP users to comparison groups not exposed to GPP.

- » **Data sources:** 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 PY 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.

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 7](#) 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 provided by DHCS to PHCS.

Measures 5-8, which are derived from HCAI encounter data, include two measures of ambulatory care-sensitive (ACS) utilization: ACS hospitalizations⁵⁰ and ACS ED visits.⁵¹ 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 readmission⁵² 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 9-11 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 9 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

⁵⁰ https://qualityindicators.ahrq.gov/measures/pqi_resources

⁵¹ https://qualityindicators.ahrq.gov/measures/ed_pqi_resources

⁵² <https://data.chhs.ca.gov/dataset/all-cause-unplanned-30-day-hospital-readmission-rate-california/resource/baa1a00c-d515-454a-ae47-410f8b95c3f3>

may change patient care, especially noting that regular visits with known providers are associated with fewer ED and hospital days, and that prompt attention to specified abnormal clinical findings can save lives and improve quality of life.⁵³

Our exploration of Metric 10 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 as the GPP program matures, whether uninsured women receiving an abnormal screening mammogram finding (e.g., an advanced BI-RADS Category) at a PHCS, are 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 experiences.

Metric 11 will also explore other utilization measures that might be available including for example, follow-up after ED visits for individuals at high-risk for multiple chronic conditions, substance use, mental illness diagnoses, or following hospitalization.

- » **Target population:** All individuals receiving GPP services or the closest proxy available in each data source (e.g., uninsured individuals receiving services at a PHCS).
 - » **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.

⁵³ 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>

- » **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 the four proposed specific analyses are included below:
- **Analysis 1: Pre-post comparison of utilization measures derived from GPP encounter data [Exhibit 6 Metrics 1-4].** 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 2017-2021 as the baseline period and 2022-2026 as the evaluation period and would use an interrupted time-series design to determine whether CalAIM 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: Difference-in-differences analysis of changes in ACS hospitalizations, ACS ED visits, and all-cause ED utilization [Exhibit 6 Metrics 5-8].** This analysis will compare trends in utilization measures 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 utilization during CalAIM relative to the pre-GPP period (2015) as well as differential changes in utilization (i.e., change in slope) between the two waiver periods.
- **Analysis 3: Pre-post subgroup analyses.** We will expand Analysis 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), and area-level deprivation measures, such as the SDI/SVI, HPI, or comparable index.

- **Analysis 4: Difference-in-differences subgroup analyses.** We will expand Analysis 2 to measure the impact of GPP on utilization for population subgroups defined by race and ethnicity and area-level deprivation measures, such as the SDI/SVI, HPI, or a comparable index, which are the only population subgroups available for stratification 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.

2.2 Additional analyses under consideration

In addition, we will explore supplementing GPP encounter data with Medi-Cal claims, MCAS measures, and Medicaid Core Set measures to conduct further analyses ([Exhibit 6 Metrics 9-11](#)). The analyses would include members who are attributed to one of the 13 PHCS based on analysis of Medi-Cal claims as well as a comparison group of Medi-Cal members who receive care from the PHCS, or, alternatively Medi-Cal members who live within a PHCS service area but who are not attributed to a PHCS. The statistical analysis might use comparative interrupted time series models or comparative trend analyses depending on whether pre-CalAIM data are available for each measure. Stratified analyses could be conducted for key patient subgroups (e.g., race, ethnicity, area-level deprivation).

2.3. PHCS Survey and Qualitative Interview Analyses for Goal 2

As part of our analyses to assess GPP Goal 2, we will also examine PHCS responses to PHCS Survey questions on PHCS' strategies to promote care in cost-effective settings, provision of non-traditional services, and Enhanced Care Management and Community Supports. We will summarize the responses by reporting means, standard deviations, and sample sizes (not all items will be applicable to all 13 PHCSs). We will also conduct follow-up interviews with the PHCS to discuss their responses to the survey and gain more contextual information about some of their decision-making around the strategies they do and do not employ to promote care in cost-effective settings and their provision of non-traditional services, Enhanced Care Management, and Community Supports.

GPP Goal 3 Evaluation Design

To evaluate GPP Goal 3 we will conduct analyses to assess possible improvements in PHCS data infrastructure and completeness that are necessary to understand health inequities among GPP utilizers.

Exhibit 8. 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

3.1. Descriptive Analyses

- » **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 8](#).
 - 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; No Race Selection and Hispanic or Latino Ethnicity; 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 8](#) 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.

3.2. PHCS Survey and Qualitative Interview Analyses for Goal 3

As part of our analyses to assess GPP Goal 3, we will also examine PHCS responses to PHCS Survey questions around data infrastructure, patient portals, use of data, and data challenges. We will summarize the responses by reporting means, standard deviations, and sample sizes (not all items will be applicable to all 13 PHCSs). We will also conduct follow-up interviews with the PHCS to discuss their responses to the survey and gain more contextual information about their data infrastructure, patient portals, use of data, and data challenges.

GPP Cost Analyses

We will use P14 workbooks from each PHCS to measure the cost of services provided to the uninsured provided by the PHCS. Audited P14 data will be used in the cost analysis or the most current unaudited P14 data when audited P14 workbooks are not available. 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 CalAIM components.

Payment data from PY 1 (SFY 2015–2016) and PY 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.

Methodological 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. One limitation of drawing conclusions from survey data is that survey responses come from reports by PHCS leaders. Thus, the survey responses will reflect the perceptions and opinions of the respondents, which may not align with actual utilization and quality of care trends within a PHCS or be what all PHCS staff and leaders believe. However, when supplemented with utilization and quality of care data, the surveys provide context for the trends and patterns observed across PHCSs and experienced by GPP users. 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 comparison groups is difficult since systematic data about use of services among uninsured individuals with characteristics similar to California’s uninsured population are limited. 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 PYs 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 PHE 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 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 state's most vulnerable populations.

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

General Background Information

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,⁵⁴ 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

⁵⁴ California Department of Health Care Services (DHCS) California Advancing and Innovating Medi-Cal (CalAIM) Section 1115(a) Demonstration. Draft Evaluation Design for PATH, GPP, Duals. June 27, 2022

Needs Plans (C-SNPs); Institutional Special Needs Plans (I-SNPs); SCAN Fully Integrated 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 9](#)).

Exhibit 9: MA Enrollment Among Dual Eligibles in California (October 2023)⁵⁵

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

⁵⁵ DHCS, California Dual Eligible Member Enrollment in Medicare Advantage Programs, as of October 2023. Table 1. <https://www.dhcs.ca.gov/provgovpart/Documents/October-2023-MA-Enrollment-Report.pdf>.

- individuals who are also enrolled in the Medi-Cal managed care plan affiliated 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.⁵⁶

⁵⁶ 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>

To increase member choice, in years prior to 2024, MCPs in certain counties (including Los Angeles, Riverside, San Bernardino, San Mateo, and Santa Clara) sub-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 counties⁵⁷. 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 counties⁵⁸ 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 member 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

⁵⁷ 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

⁵⁸ 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

five counties in January 2024.⁵⁹ For Duals with Medicare Part A and Part B, as of 2022, 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 member'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 10](#).

Exhibit 10. 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.

⁵⁹ 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.

Circumstance when Duals ¹ consider or request a change in their MCP	Description
	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 \(ca.gov\)](https://www.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 member 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 Medicare-Medicaid Coordination Office (MMCO) through contract with RTI International.⁶⁰

⁶⁰ 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*

Evaluation Questions and Hypotheses

[Exhibit 11](#) 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.

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 11: Alignment and Integration for Dually Eligible Beneficiaries

G 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 <i>Medi-Cal Matching Plan Policy</i> in 2023 had the policy applied to them?	» Percent of Duals enrolled in a MA plan who change their MCP and who change their MA plan (in counties with the <i>Medi-Cal Matching Plan Policy</i> compared to counties without the <i>Policy</i>) – 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 Original Medicare, and compared to Duals in other MA types. » Overall MCP enrollment churn rate, with comparisons. » Percent of individuals who change their MMP compared to individuals in unaligned D-SNPs in counties without the <i>Medi-Cal Matching Plan Policy</i>.
EQ 1b: Of Duals that had the policy applied to them, how many changed 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 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 change their MCP (without changing their MA) than those in unaligned plans during the target period.	
H 3: Duals who 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.	
H 4: 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	

G 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

G 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.

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.	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 <i>Medi-Cal Matching Plan Policy</i> 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 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 with the policy.	

Conceptual Model

The driver diagram ([Exhibit 12](#)) 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 12: Driver Diagram for the Medi-Cal Matching Plan Policy

Aim	Primary Drivers	Secondary Drivers
Achieve less than 0.1% monthly rate of Duals changing their MCP to non-matching MCP for those who enroll in MA plans AND who are in counties where the <i>Medi-Cal Matching Plan Policy</i> 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		

Methodology

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. For Goal #2, UCLA will perform the Duals knowledge and satisfaction surveys in 2024.

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 monthly MA plan / MCP change, (2) Duals MA plan and MCP aligned or unaligned, and (3) 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.⁶¹ 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).

In summary, with the Dual Project's [Goal #1](#), the UCLA team will describe the epidemiology of plan transitions in the Medi-Cal Duals population pre- and post-policy implementation. Data from [Goal #1](#) will allow the evaluation team to define the sampling frame and also assess the magnitude of special circumstances, such as individuals who newly enroll and disenroll from Medi-Cal. In the subgroup analyses, we will break out patterns of changes for newly enrolled individuals as well as individuals who have breaks in enrollment. At present, it is difficult to characterize a priori patterns and characteristics of individuals with breaks in enrollment, which may have antecedent events (e.g. loss of eligibility, moving residences, incarceration, and so on). Furthermore, individuals with two or more changes in MCPs are likely to be relatively uncommon and may be investigated separately given their potential complexity.

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](#).

⁶¹ A previous iteration of this evaluation design report suggested we would also be including as a primary outcome, requests from Dual beneficiaries to change MCP to non-matching MCP. However, further review of data available from DHCS revealed no reliable source of Duals requests to change MCP to non-matching MCP. Accordingly, we have withdrawn this variable from the analysis plan.

Target Population: The target population includes 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* and also includes 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 13](#) 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' MCP changes 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.

Multiple Variable Regression Analyses

We propose to follow the difference-in-differences (DID) 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 “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 change. Covariates will include Dual's plan status at the time of the change (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 “MCP change”, Dual's plan status before change (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 develop and field a survey of the Duals population using a sampling frame derived from the data in Goal #1, including assessing satisfaction in the process of changing plans among Medi-Medi Plan members, other MA members, and Original Medicare members who changed their MCPs. Results from Goal #2 will be used to inform DHCS, MCPs and their members about member experiences with the matching process and to improve Duals' knowledge and experience. Surveys will be performed in 2024 to assess knowledge and satisfaction with the process of changing plans among Duals who change their MCPs.

Target Population: Duals in MA plans (with Duals in Original Medicare as a control) who change their MCPs 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 2024.

Sampling Frame: Probability sample of 4,000 Duals (including representatives from MA and Original Medicare) who change their MCP sampled according to: *Medi-Cal Matching Plan Policy* for County of Residence (yes/no), MA Plan change (yes/no), and Baseline Plan Alignment (unaligned/aligned/integrated) with a goal of 400 completed surveys (10 percent response rate) with 25 completed surveys per strata with MA enrollment (300 total) and 50 completed surveys per strata in Original Medicare (100 total divided between counties with and without the *Medi-Cal Matching Plan Policy*).

We will 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 race/ethnicity and quartile social need (based upon zip code of residence) to account for difficult to reach vulnerable populations. Specifically, we will sample equal numbers from the quartiles of social need and within quartiles we will sample equal numbers from the primary four race/ethnicity categories (non-Hispanic white, non-Hispanic black, Hispanic, and Asian-Pacific Islander).

Assuming equal size and variance, comparing between the primary comparison groups (MA enrollees in counties with and without the policy – with 150 individuals per group), we estimate a standardized effect size of 0.32 with 80 percent power to detect differences. Similarly, comparing within county strata – MA versus Original Medicare

enrollees (150 versus 50 individuals), we estimate a standardized effect size of 0.50 with 84 percent power to detect differences.

Survey Fielding: We will sample across the 58 counties in California and will adjust the sampling based upon the results from the secondary data analysis. The sample will be weighted in order to under-sample Los Angeles County – with 1/3 of the Medi-Cal population – which would otherwise dominate the sample. We anticipate a ten percent response rate conditional upon our implementing the multiple strategies described below. Specifically, to maximize the response rate, we propose fielding the survey using a mixed-mode data collection approach that involves fielding the survey as a web and mail survey with phone follow-up to those who fail to complete the survey via the web or by mail. The web and mail versions of the survey will be available in English, Spanish, Mandarin, and Vietnamese.

All 4,000 sampled beneficiaries will receive a letter inviting them to participate in the survey. The letter will be personalized with the member's first and last name and will be printed in English on one side and Spanish on the other. To motivate survey invitees to complete the survey, a one-dollar bill will be affixed to the letter. An English version of the survey with a self-addressed, postage-paid envelope that beneficiaries can use to mail back their completed survey will be enclosed with the survey invitation letter. The letter will briefly describe the purpose of the survey, why it's important that each sampled member participate, and the 20 dollars that they will receive if they complete the survey.

In the event they have questions or concerns about the survey or if they would like to complete the survey by phone, the letter will include a toll-free number for the participant to be able to call. In addition, the letter will include the survey URL and a unique PIN as well as a QR code for those who prefer to complete the survey via the web using either a computer, tablet, or smart phone. The survey invitation letter will include a prominent note letting survey invitees know the availability of Spanish, Mandarin, and Vietnamese versions which they can access on the web or by requesting a hard copy in any of these languages by calling the survey's toll-free number or sending an email to a project-specific email.

We anticipate that a significant proportion of the sampled beneficiaries will be primarily Spanish-speaking and therefore have budgeted to mail both an English and a Spanish version of the survey to approximately 25 percent of the sample. We will select the

beneficiaries who should receive the two-booklet mailing by identifying those who indicate Spanish language preference in their Medi-Cal files, and according to those with a Hispanic surname. Among this cohort, we will randomly select 25 percent of the sample frame who will receive with their initial mailing a Spanish language survey booklet in addition to their English language survey booklet.

Approximately two weeks after the first survey mailing, we will send a second survey invitation letter to survey invitees that have not completed the survey. The second survey mailing will again include an English version of the survey booklet for all invitees and additionally include a Spanish version of the survey booklet to another randomly selected 25 percent of the sampled beneficiaries who have expressed Spanish language preference or who have a Hispanic surname.

Approximately two weeks after the second survey mailing, we will mail non-respondents a reminder postcard letting them know that there is still time to complete the survey either via the web, by mail, or by phone. We will simultaneously launch phone follow-up to those who have not completed the survey for whom we were able to obtain either a telephone number (landline) or a cellphone number through a tele matching vendor. Phone follow-up will be conducted in English and Spanish only. Respondents who don't feel they will be able to complete the survey by phone in either English or Spanish will again be offered the option of completing the survey via the web or by mail, in which case we would mail them a copy of the survey in their preferred language (from among the languages we offer). To further maximize response rates, we will allow proxy respondents.

In summary, the survey team is estimating a response rate of 10 percent for this population of Dual-insured individuals with recent plan changes, even with inducement and phone follow-up. Currently, initial mailing is planned to be to 4,000 individuals based upon a target of 400 completed surveys (see below).

The revised survey design of MCP changers has three sets of comparison strata among individuals enrolled in MA plans [(1) resident county has the policy (yes/no); (2) member changes their baseline MA plan (yes/no); (3) baseline MCP is aligned/integrated with MA plan (yes/no)] plus the external comparison to Duals in traditional (fee-for-service) Medicare who reside in counties with and without the alignment policy. There are 12 cells for MA plan enrollees and two cells for traditional Medicare enrollees. We plan to have 25 completed surveys per MA plan enrollee cell and up to 50 completed surveys

per traditional Medicare enrollee cell to yield a total goal of 400 completed surveys. These sample sizes ensure statistical stability for unadjusted estimates yet may not be adequately powered to detect underlying differences for comparisons between the targeted groups. We will oversample on non-White minorities and on individuals residing in zip codes with the lowest quartile SES to balance the sample. Given the shorter time frame required for completing the survey, the evaluation team is balancing ensuring adequate response rates with the survey budget.

Survey Content and Development

The short “Duals Survey” of knowledge and satisfaction of the *Medi-Cal Matching Plan Policy* will be developed at UCLA with input from DHCS and external stakeholders. Because of time constraints prior to fielding the survey, UCLA will convene post-survey focus group(s) to explore in depth themes and questions raised by the survey results. 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, questions on participant 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 changed their MCP in the prior year and if 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.^[OB] The tool can help providers find out patients’ needs in these five 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 eight 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 also recommends using the Short Form Survey (SF12), a widely used 12-item measure of the

impact of overall health on an individual's daily life. 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 current survey now includes the following domains.

- » Member knowledge and satisfaction of their recent plan change
- » Member report of their usual patterns of health services use
- » Member report of their health status
- » Member report of health-related social needs

We anticipate the surveys will be translated into Spanish and two additional languages (Mandarin and Vietnamese). These languages have been identified as the most prevalent languages spoken within the state of California among those who do not speak English or Spanish.⁶² The survey will be piloted for readability and clarity at UCLA and/or UCLA-training sites among a convenience sample of up to ten 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 via mail and online with the option of responding via phone. Initial mailing will be followed by reminders. For non-respondents, a second survey will be sent. There will be an incentive (e.g., \$20 for a completed survey) 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.

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

⁶² U.S. Census Bureau. (2022). *2018-2022 American Community Survey*. [Retrieved from: <https://data.census.gov/profile/California?g=040XX00US06>]

(self-reported health, service use) are similar within strata. 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 resided in a county with the *Medi-Cal Matching Plan Policy* or in a county without the policy. We will stratify individuals by whether their MA plan changed, whether their MCP was aligned or not at baseline and at follow-up, and whether they were in an MCP or Original Medicare (the internal control) at baseline. 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 speaking/Non-English speaking, 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 percent of dual eligible member MA enrollees switched MA plans and an additional 0.74 percent exited MA plans. An additional 2.4 percent entered MA plans from Original Medicare. In April, there were 734,746 Duals MA plan enrollees. Between April and May 2023, another 1.2 percent of dually eligible member MA enrollees switched MA plans and 0.66 percent exited MA plans. An additional 2 percent 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 percent 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 percent confidence interval and 80 percent power for the main comparison (satisfaction – five-point scale). Here we assume a mean of three and a standard deviation of 1.4.

Methodological 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. Evaluation milestones are displayed in [Exhibit 13](#) below.

Exhibit 13: 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	June 2024
3. Respond to remaining critiques and questions from the CMS	Summer 2024
4. Goal #1 initial analyses	Summer 2024
5. Duals' knowledge and satisfaction survey design and piloting	August 2024
6. Fielding Duals' knowledge and satisfaction survey	Oct to Dec 2024
7. Goal #2 initial analyses	Mid-Aug 2024
8. Conduct post-survey focus groups on analysis findings regarding Duals knowledge and satisfaction on plan alignment and information on changing enrollment 8. Preliminary CalAIM Demonstration Evaluation Report to CMS	Winter 2025
9. Goal #1 final analyses	June 2026
11. Goal #2 final analyses	Winter 2027
12. Final CalAIM Demonstration Evaluation Report to CMS	June 2028

Evaluation Design for California's Justice-Involved Reentry Initiative (Reentry)

General Background Information

The California Advancing and Innovating Medi-Cal (CalAIM) REENTRY Evaluation will assess the degree to which incarcerated individuals preparing for reentry to the community who are exposed to the Justice-Involved (JI) Reentry Initiative interventions (i.e., the Reentry Waiver Exposed Group) experience different processes and outcomes than those not exposed (i.e. the Reentry Waiver Comparison Group). Evaluation activities will include assessments of changes over time between exposed and comparison groups in (1) access to medical and behavioral health services for incarcerated individuals eligible for the State's Medicaid Program (Medi-Cal); (2) exposure to systems for effectively enrolling eligible detainees into Medi-Cal prior to release; (3) coordination of transitional care between the pre- and post-release setting; (4) coordination of community-based services through Enhanced care Management, and (5) provision of a supply of medications and durable medical equipment at release.⁶³

Reentry's Role within the CalAIM Evaluation

While California received federal authority to implement the CalAIM 1115 Demonstration on December 29, 2021, the approval by the Centers for Medicare & Medicaid Services to provide limited coverage for services to a subset of incarcerated individuals for up to 90 days immediately prior to their expected date of release from the carceral setting was granted on January 26, 2023.⁶⁴ Both are expected to be effective through December 31, 2026. Similar to other CalAIM components, the CalAIM JI Reentry Initiative has established a framework to address basic needs of individuals during high-risk periods of life by using Medi-Cal to implement a target set of pre-release services including health care, behavioral health, and reentry services.

⁶³ Cronin-Furman, Margot, et al. "Breaking Ground: How California is Using Medicaid to Improve the Health of People Leaving Incarceration." (2023).

⁶⁴ 11-W-00193/9: "California CalAIM Demonstration". <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-calaim-ca1.pdf>

CalAIM's three primary stated goals are to "(1) Identify and managed comprehensive needs through whole person care approaches and social drivers of health; (2) Make Medi-Cal a more consistent and seamless system for enrollees to navigate by reducing complexity and increasing flexibility; and (3) Improve quality outcomes, reduce health disparities, and transform the delivery system through value-based initiatives, modernization, and payment reform."⁶⁵ Consistent with these goals, the Special Terms and Conditions (STCs) for the Justice-Involved Reentry Initiative, focused on five milestones: (1) increasing coverage and ensuring continuity of coverage for individuals who are incarcerated; (2) covering and ensuring access to the minimum set of pre-release services for incarcerated individuals to improve care transitions upon return to the community; (3) promoting continuity of care; (4) connecting to services available post-release to meet the need of the reentering population; and (5) ensuring cross-system collaboration. Through the JI Reentry Initiative, California is allowing the state prison system and the fifty-eight California counties the opportunity to bridge the gap between correctional and community health care during a window of time when incarcerated individuals experience an enhanced risk for physical and behavioral health concerns and complications, including higher rates of morbidity and mortality. Key features of CalAIM's JI Reentry Initiative include efforts to improve access to needed health care services during the 90 days prior to release when incarcerated individuals prepare to leave the carceral setting and reenter the community setting. The period around release has been identified as a high-risk window associated with serious morbidity and mortality including higher risk of suicide and opioid overdose and higher rates of preventable adverse outcomes than among the general population.⁶⁶

It is estimated that as many as 80 percent of incarcerated individuals will be eligible for CalAIM JI services.⁶⁷ As mandated by state law as of January 2023, counties are developing strategies for expanding Medi-Cal enrollment at intake and California's

⁶⁵ CalAim 1115 Demonstration & 1915(b) Waiver. <https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM-1115-and-1915b-Waiver-Renewals.aspx>

⁶⁶ California Department of Health Care Services. Policy and Operational Guide for Planning and Implementing the CalAim Justice-Involved Initiative. October 2023. Plenary PPT. <https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/CalAIM-JI-Policy-and-Operations-Guide-FINAL-October-2023-updated.pdf>

⁶⁷ Justice System Partners (JSP) and Health and Reentry Project (HARP). Implementing the Medicaid Reentry Waiver in California: Key Policy and Operational Insights From 11 Counties. October 2024.

managed care plans (MCPs) are developing systems to expand post-incarceration Enhanced Care Management⁶⁸, reduce care gaps, and increase access to Community Supports (e.g., Housing Navigation). Key stakeholders are sharing strategies to enhance coordination of services between county jails, correctional health care, and MCPs with supports from multidisciplinary criminal justice partners including courts, pretrial services, and probation teams.

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.⁶⁹ In addition, more than 2,200 youth are incarcerated at the county level in juvenile halls, camps and ranches.⁷⁰ 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:⁷¹ 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 46.1% Hispanic, 27.5% Black, 20.0% White (non-Hispanic), and 6.4% other.⁷² The average number of individuals released from prison back to communities per month

⁶⁸ ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of Members with the most complex medical and social needs.

ECM provides systematic coordination of services and comprehensive care management that is community based, interdisciplinary, high touch and person centered. <https://www.dhcs.ca.gov/CalAIM/ECM/Documents/ECM-Policy-Guide.pdf>

⁶⁹ <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

⁷⁰ 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.

⁷¹ 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

⁷² Among the general population, the average age in California is 38.2, 49% of the population are male and by race/ ethnicity, 46.4% of the population are Hispanic, 6.5% Black, 34.3% White (non-Hispanic), and 23% other (<https://www.census.gov/quickfacts/fact/table/CA/PST045223>; <https://data.census.gov/profile/California?g=040XX00US06>)

ranged from 2,006 (June 2021) to 2,647 (December 2023). Of the 58 California counties, six -- Los Angeles, San Bernardino, San Diego, Riverside, Orange and Sacramento -- accounted for almost two-thirds of the released population in 2023.⁷³

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.⁷⁴ Fewer than a quarter are serving sentences.

With respect to the juvenile population, until June 30, 2023, California operated the California Department of Juvenile Justice (DJJ), which housed youth who had been adjudicated and incarcerated. As of June 30th, 2023 all state-run juvenile operations ceased at DJJ, and youth custody cases were realigned to the care of counties. County probation chiefs opposed this change and established a 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, and ranches, or supervised in the community.^{75 76}

Reentry: Pre-Release Enrollment and Services

CMS approved California's 1115 Re-entry Demonstration Waiver, which is part of DHCS' overall CalAIM Justice-Involved Reentry 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 Enhanced

⁷³ <https://public.tableau.com/app/profile/cdcr.or/viz/OffenderDataPoints/SummaryInCustodyandParole>, accessed January 14, 2024

⁷⁴ https://www.bscc.ca.gov/wp-content/uploads/Jail-Pop-Trends-Through-Q3_2023.pdf, accessed January 14, 2024.

⁷⁵ <https://www.cdcr.ca.gov/ccjbh/wp-content/uploads/sites/172/2020/07/Juvenile-Justice-Factsheet-6.30.2020.pdf>.

⁷⁶ 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: see https://www.bscc.ca.gov/wp-content/uploads/JDPS-1Q2002-1Q2023_Trends_6.20.23.pdf, accessed January 14, 2024.

Care Management (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 mental health 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 (see Special Terms and Conditions (STC) 9.8).⁷⁷

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 Justice-Involved Reentry 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.

All children/youth who are enrolled in Medi-Cal or CHIP and in custody of a participating youth correctional facility are eligible for the targeted set of pre-release services and, as required under section 5121 of the Consolidated Appropriations Act, screening and diagnostic services required under the Early and Periodic Screening, Diagnostic and Treatment benefit. Incarcerated adults must be enrolled in Medi-Cal and meet one or more of the specified criteria.⁷⁸ The targeted set of pre-release services approved in the Reentry Demonstration Waiver include reentry case management services; physical and behavioral health clinical consultation services, laboratory and radiology services, medications and medication administration; medication-assisted

⁷⁷ <https://www.dhcs.ca.gov/provgovpart/Documents/California-Reentry-Demonstration-Initiative-Amendment-Approval.pdf>

⁷⁸ Mental illness, Substance Use Disorder (SUD), Chronic Disease/Significant Clinical Condition, Intellectual or Developmental Disability (I/DD), Pregnant/Postpartum.

treatment (MAT) for all Food and Drug Administration (FDA)-approved medication, including coverage for counseling and services provided by community health workers or Peer Support Specialists with lived experience. Qualifying members will also receive covered outpatient prescription medication (a minimum 30-day supply, as clinically appropriate, consistent with the Medicaid State Plan) and durable medical equipment (DME) upon release.

The goals for the Justice-Involved Reentry Initiative are to:⁷⁹

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;
2. Improve access to services prior to release and improve transitions and continuity of care into the community upon release;
3. Improve coordination and communication between correctional systems, Medicaid and CHIP systems, managed care plans, and community-based providers;
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 utilization such as emergency department visits, inpatient hospitalizations, and all-cause deaths among recently incarcerated

⁷⁹ We use the term “beneficiaries” here since this term is used by CMS. Goals are outlined under 9.1 in the Special Terms and Conditions for California (see Centers for Medicare & Medicaid Services (CMS) letter dated January 26 2023 to Ms. Jacey Cooper, State Medicaid Director, Chief Deputy Director, Health Care Programs, California Department of Health Care Services (CDHCS) – approval of California’s request to amend the section 1115(a) demonstration titled, “California Advancing and Innovating Medi-Cal (CalAIM)” (Project Number 11-W-00193/9).

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 Justice-Involved Reentry 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. The UCLA-RAND Reentry Evaluation team's 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.

Overall Evaluation Strategy

UCLA-RAND Reentry Evaluation Team

The UCLA-RAND Reentry Evaluation team is responsible for the evaluation of the Justice-Involved Reentry Initiative. The team is led by researchers Drs. Lois Davis and Susan Turner from RAND. The team also includes researchers from RAND and UCLA as detailed in the section below titled "Reentry Evaluation Team." The JI Reentry Initiative evaluation period covers October 2024 through December 2026. The UCLA-RAND Reentry evaluation contract period is from December 1, 2023, to May 31, 2029, which includes the development of the evaluation design, its implementation, and completion of all other contract deliverables (i.e. evaluation reports and responses to comments from DHCS and CMS). A detailed project timeline is provided in [Exhibit 14](#). The total budget for the effort is \$2,903,678.39.

Timeline for Data Collection Activities

[Exhibit 14](#) on the next page shows the anticipated timeline for the Reentry Evaluation activities. The table shows the data collection activity, timeframe, and goals associated with each activity.

Exhibit 14. Study Timeline for Reentry Data Collection Activities

Activity	Timeframe	Goals
Revise evaluation research design; submit revisions to address CMS' comments	Fall of 2024	1-7
In consultation with DHCS, select the four focal counties for jail and juvenile populations analyses	2025	1-7
Develop research applications, data use agreements, etc. for CDCR and the four focal counties	2024-2025	1-7
Submit research application to CDCR Research Oversight Committee (ROC) for identification of Waiver comparison cohorts, to obtain data on background characteristics, and pre-release services	2024-2025	1-7
Work with Sheriff's Departments and juvenile authorities in the four focal counties on research approvals & data use agreements; access data to identify Waiver comparison cohorts for jail population and juvenile populations	2025	1-7
Qualitative Data Collection & Analysis		
Recruit and conduct interviews with Waiver participants (who were incarcerated in prisons, jails, & juvenile facilities)	2025	3,4,5
Conduct key stakeholder interviews at state and county levels; analyze data	2025	3,4,5
Analyze Waiver participants' interview data and key stakeholders interview data	2025	3,4,5
Quantitative Data Collection & Analysis		
Identify Waiver comparison cohorts (pre-Waiver)	2025-2026	1,2,6,7
Obtain Data for comparison cohorts (pre-Waiver)	2025-2026	1,2, 6, 7

Activity	Timeframe	Goals
Clean/merge/prepare pre-Waiver analytic data	2025-2026	1,2,6,7
Obtain Data for Waiver cohorts (post-Waiver)	2026	1,2,6,7
Clean/merge/prepare post-Waiver analytic data	2026-2027	1,2,6,7
Final analyses to include all comparison and treatment cohorts; including sensitivity analysis	2027-2028	1,2,6,7

Reentry Waiver Populations and Counties Selected for the UCLA-RAND Reentry Evaluation

The eligible Reentry Waiver populations in California include all 33 state prison facilities, county jails, and youth correctional facilities. The state prison facilities are operated by the California Department of Corrections and Rehabilitation (CDCR) as a single department. Each of California's 58 counties operates its own jails and juvenile correctional facilities individually. Generally, jails are operated by county Sheriff Departments and juvenile facilities by county Probation Departments. In some cases, correctional health care services may be managed by the county public health or health department, which would be the targeted entity for obtaining relevant pre-release healthcare information for the evaluation. The UCLA-RAND evaluation team will be working with all involved entities in targeted counties to complete the evaluation tasks.

Qualifying conditions for individuals participating in the Reentry Waiver include adults who are incarcerated who meet one or more of the following criteria listed in STC 9.2⁸⁰:

- Mental illness, defined as confirmed or suspected mental health diagnosis based on specified criteria;

- Substance use disorder, defined as confirmed or suspected diagnoses based on specified criteria;

⁸⁰ As defined in the CMS Waiver Authority, Numbers 11-W-00193/9 and 21-W-00077/0, California CalAIM Demonstration document (<https://www.dhcs.ca.gov/CalAIM/Documents/BH-CONNECT/CA-CalAIM-STCs.pdf>). For the list of the 38 Chronic Conditions or Significant Non-Chronic Clinical Conditions, see Attachment W page 322.

Chronic condition or significant non-chronic clinical condition, defined as confirmed or suspected diagnoses based on specified criteria;
Intellectual or developmental disability (I/DD), defined as a disability that begins before an individual has turned 18 years of age and that is expected to continue indefinitely and present a substantial disability;
Traumatic brain injury or other condition that has caused significant cognitive, behavioral and/or functional impairment;
Positive test or diagnosis of human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS); or
Currently pregnant or within a 12-month postpartum period.

All youth under the age of 19 years who are eligible for Medi-Cal or CHIP including children in foster care and former foster care youth; and are in the custody of a county youth correctional facility are eligible for pre-release services.⁸¹

All California counties are state mandated to implement the Reentry Waiver program no later than October 1, 2026. Correctional facilities must submit to DHCS a readiness review application for approval at least six months prior to the correctional facilities' requested go-live date. The readiness review assessment focuses on five key areas needed to operationalize 90-day pre-release services (e.g., Medi-Cal application process, 90-day pre-release service delivery). Correctional facilities are expected to attest to their ability to meet minimum requirements. Correctional facilities can go live with pre-release services with an approved readiness assessment.⁸²

As of October 2024, three California counties—Inyo, Santa Clara, and Yuba—were approved to begin delivering a targeted set of Medi-Cal services to people returning to communities after incarceration.⁸³ CDCR, including all 33 state prisons, will go live with

⁸¹ Reentry Demonstration Initiative Populations are defined as persons who are enrolled in Medicaid or who would be eligible for CHIP except for their incarcerated status, and who are incarcerated in a state prison, county jail, or youth correctional facility and who meet the eligibility criteria under STC 9.2. See: [ca-calaim-dmnstn-aprvl-12192023_0.pdf](https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/CalAIM-JI-Policy-and-Operations-Guide-FINAL-October-2023-updated.pdf)

⁸² California Department of Health Care Services. Policy and Operational Guide for Planning and Implementing the CalAIM Justice-Involved Initiative. October 2023. Plenary PPT. <https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/CalAIM-JI-Policy-and-Operations-Guide-FINAL-October-2023-updated.pdf>

⁸³ DHCS News Release, October 9, 2024, "For the first time, California to provide Medi-Cal services for people returning home after incarceration."

pre-release services in February 2025. County correctional facilities will go live on a quarterly basis through September 30, 2026.

The UCLA-RAND Reentry Evaluation research design includes all CDCR prison facilities as well as county jails and youth correctional facilities in four counties: Sacramento, Yuba, San Joaquin and Orange Counties. These four counties were selected in consultation with DHCS based on geography, population size, and timeliness of implementation. Note, it is not feasible to study all 58 counties as each is a separate entity that would require separate permissions and extensive data abstraction efforts at the county-level.

Quantitative Goals 1, 2, 6, and 7

Goals 1, 2, 6, and 7 focus on screening and enrollment, delivery of services and health outcomes of individuals. Research questions relevant to these goals will be addressed by using a difference-in-differences approach that compares individuals after the go-live date for correctional facilities with individuals who are similar to those who participated in the Reentry Waiver but were incarcerated and released before the go-live date.

Identifying Qualifying Conditions for Reentry Waiver Groups

The UCLA-RAND Reentry Evaluation team will work with the California Department of Corrections and Rehabilitation (CDCR) and the counties to develop plans for identification of Reentry Waiver groups for the evaluation, as well as data and other permissions that may be required by the UCLA-RAND Reentry Evaluation team. The plans will address access to the most reliable information on correctional facility eligibility screening and enrollment⁸⁴; information on how correctional facilities developed criteria to identify those with qualifying conditions; selection of the release cohorts for the Reentry Waiver individuals; determination of background demographic characteristics, and health status services data available for creating comparison groups as described in the next paragraph.

Identifying Qualifying Conditions for Comparison Groups

As practicable, Reentry Waiver pre-intervention and post-intervention comparison groups will be identified by applying the Reentry eligibility criteria described above to

⁸⁴ This information may be obtained from the data portal used by correctional facilities.

individuals who had been incarcerated but released prior to the go-live date, as well as for those released after the go-live date. This will allow the UCLA-RAND Reentry Evaluation team to create and follow cohorts released around the go-live date to estimate cohort difference-in-difference models (the Methods section discusses this methodological approach in more detail).⁸⁵

For local county jails, the UCLA-RAND Reentry Evaluation team will determine whether the local data systems will allow identification of previously released individuals with qualifying conditions. For juveniles there are no qualifying health conditions. The Reentry evaluation will not restrict the analysis for youth in the same way proposed for prison releasees and will instead use all releases as specified in the STCs for youth (e.g., all children/youth who are enrolled in Medi-Cal or CHIP and in the custody of a county youth correctional facility are eligible for pre-release services). If the UCLA-RAND evaluation team is unable to use state and local health data to identify eligible cohorts based upon the detailed eligibility criteria, UCLA-RAND Reentry Evaluation may need to use full (100%) cohorts of released individuals for both the comparison (i.e., pre-go live) and Reentry Waiver (i.e., post-go live) groups rather than the roughly 80% of these cohorts who are actually eligible for services.

Even if full cohorts rather than Reentry Waiver eligible cohorts are required (for data purposes) it is expected that the majority of the cohort will meet the health services criteria for the Waiver, since the prevalence of SUD and other health issues is high in the JI population. For example, it is estimated that about 85% of CDCR inmates have SUD, which is a conservative estimate.⁸⁶ Prevalence rates in jails are harder to obtain, but a recent brief from the Bureau of Justice Statistics indicates that 63 percent of post-adjudication jail inmates have an SUD and there have been increasing numbers of jail deaths from 2000 to 2019, particularly among those who died from drug related intoxication (BJS, 2022).⁸⁷ If full cohorts, rather than Reentry Waiver eligible cohorts are used, the study design would not be able to include case-mix adjustments for an individual's illness.

⁸⁵ In conversations with the CDCR, they have indicated that they should be able to select previously released cohorts of individuals based on the same coding they are doing for current eligibility determination. This should result in similar individuals in both the comparison and Waiver groups.

⁸⁶ [ISUDT Annual Outcomes Report 2024 \(ca.gov\)](#)

⁸⁷ [Managing Substance Withdrawal in Jails: A Legal Brief \(ojp.gov\)](#)

Data Sources for Waiver and Comparison Groups

The UCLA-RAND Reentry Evaluation team intends to use Medi-Cal and prison/jail/youth correctional facilities databases (as available) for the Reentry Waiver and comparison groups for the evaluation. Cross-referencing CDCR identifiers with Medicaid data has successfully been accomplished in recent work conducted by the Council on Criminal Justice and Behavioral Health in their 2023 Medi-Cal Utilization project.⁸⁸ This project matched data from the CDCR to Medi-Cal records from over 35,000 individuals released from CDCR in fiscal year 2019-2020 to analyze enrollment and utilization of Medi-Cal services. The evaluation design relies upon a similar strategy for matching CDCR releases to Medicaid databases; feasibility and protocols for county correctional facility matching of releasees is yet to be determined.

The UCLA-RAND Reentry Evaluation will make use of a cohort difference-in-differences analysis, which will exploit the within year timing of the policy and across year exposure to the policy. More details of the design are in the Methods sections below. As an illustrative example, if one were to assume that the Waiver will be implemented in Month t of 2025, then individuals who are released from Month t through Month $t+3$ of 2025 will be partially treated as they will not receive the full 90 days of pre-release services (e.g., those individuals released in Month $t+1$ will only receive up to 30 days of pre-release services), individuals released after Month $t+3$ in 2025 will be fully treated, and individuals released in 2025 prior to Month t (i.e. Months $t-1$ to Month $t-6$) will be untreated. However, it is worth noting that it is expected that there will exist some people who are partially treated or not treated in all cohorts based on length of stay within the incarceration system (i.e., those individuals who are incarcerated for less than 90 days will be partially treated). Analyses will explore how the magnitude of effect sizes varies dependent on length of treatment (i.e., under 30 days, 30 to 59 days, 60 to 89 days, and those with the full 90 days of pre-release services, separately).

The UCLA-RAND Reentry Evaluation will exploit the month by year variation in Waiver eligibility. Regardless of the date of actual go live, a 12-month window will be identified

⁸⁸ Council on Criminal Justice and Behavioral Health (CCJBH). Medi-Cal Utilization Project: A Report on the Medi-Cal Enrollment and Behavioral Health Services Utilization for Individuals Released from the California Department of Corrections and Rehabilitation in Fiscal Year 2019-20, October 2023. <https://www.cdcr.ca.gov/ccjbh/wp-content/uploads/sites/172/2024/01/MCUP-FY-2019-2020-October-2023-ADA-1.pdf>

around the timing of the go-live dates for specific correctional facilities to ensure 6 pre-implementation monthly cohorts, 3 partially treated post-cohorts, and 3 fully treated post-cohorts. The UCLA-RAND Reentry Evaluation team will also explore augmenting models to cover a wider post-treatment period as well as monthly cohorts prior to 2025, given available data. The UCLA-RAND Reentry Evaluation team has selected 2021 as the earliest year for data to provide stability in measurement, but data availability will guide the actual study period.

Testing the 90-day In-Reach Period for the Waiver

California selected a 90-day pre-release services period for Waiver implementation. This timeframe was chosen to allow ample time within the carceral setting to conduct eligibility assessments, stabilize an incarcerated individual, prepare a post-release transition plan and allow the pre- and post-release care managers to do a warm hand-off and transition of care with the individual. Variation in full vs. partial treatment (e.g., full 90-day pre-release services vs. <90-day pre-release services) due to the timing of release, relative to go-live date⁸⁹ can be used to test how pre-release services period length impacts identified effectiveness. Dynamic models (i.e., event studies- see Methods section for more details) will be able to identify variation in the effect size for those that are partially treated and fully treated (compared to not treated cohorts - i.e., pre-go-live cohorts), separately. This will allow the UCLA-RAND team to identify the effect of the Waiver differentially for those individuals who receive less than 30 days, 30 to 59 days, 60 to 89 days, and those with the full 90 days of pre-release services, separately. Jail stays are often much shorter than 90 days. Although the average time spent in jail is about a month, the majority of released individuals have been incarcerated for a week or less.⁹⁰ In state prisons about 30 percent of individuals served less than a year in 2020-2021; almost 60 percent served less than two years.

Outcome Measurement Period

Goals 6 and 7 have defined the numerators and denominators for the outcomes of interest. Each outcome will be measured in the near-term (30 days) after an individual's release into the community as well as longer term (6 and 12 months). Vulnerability to

⁸⁹ Actual analyses will take into account whether or not the county or institution is in the pre- or post-period and what amount of the 90-day window the releasee is in.

⁹⁰ <https://www.chcf.org/wp-content/uploads/2023/07/CalAIMEExplainedCaringCaliforniansLeavingIncarceration.pdf>

drug overdose and death can occur within the first few weeks after release, thus it is important to include measures soon after release.

Additional Quantitative Evaluation Methods

Analytic methods for addressing the Goals are presented in the sections below. Note that, in addition to the proposed approach in which UCLA-RAND Reentry Evaluation team plans to include fixed effects for facilities and time period, the team will also consider multi-level regression to account for shared variability within institutions.

A crucial assumption underpinning difference-in-differences analysis is the parallel trends assumption. Generally, the parallel trends assumption states that the evolution of the outcomes in the control group (i.e., in the years prior to implementation) accurately reflects how those same outcomes would have evolved in partially or fully treated groups (i.e., in the years post-implementation) had the treatment groups not been treated. The UCLA-RAND Reentry evaluation will make use of both conditional (i.e. models that include controls) and unconditional (i.e. models without controls) event study models (which extend the above difference-in-differences models to include both lead (pre) and lag (post) period effects, identified from lead and lag release cohorts) to visually inspect the likelihood of passing the parallel trends assumption. In addition to the lag periods allowing one to visually inspect the likelihood of passing the parallel trends assumption, the lead periods allow one to identify dynamic effects of the Waiver. Effect sizes across release cohorts will be examined to identify whether a greater period of pre-release services is associated with more positive patient outcomes. The first three release cohorts are “partially treated” as they will not receive the full 90 days of pre-release services, thus differences in effect sizes in the first three lead periods compared to later lead periods would indicate that a greater period of pre-release services is associated with differential effect sizes.

If divergent trends pre-correctional facility Reentry Waiver implementation are present, Goodman-Bacon (2021) “detrended” difference-in-differences specification will be used to identify the size of a credibly causal effect of the Reentry Waiver, even if statistically significant pre-trends exist. Further, the sensitivity of event study models will be tested by implementing Rambachan & Roth’s (2023) “honest” differences-in-differences approach which involves constructing confidence intervals that allow deviations from

linearity, and in doing so estimates the amount of non-linearity that is allowable, while still rejecting the null hypothesis.⁹¹

In addition to estimating difference-in-differences models of the form specified above, a donut regression discontinuity design (RDD) will be estimated that exploits the timing of the Reentry Waiver rollout, as an additional sensitivity analysis. The donut-RDD will be used given that the rollout of the Reentry Waiver may result in partially treated releasees (i.e., those individuals who are released within the first 90 days of the policy being implemented), which can be excluded in a donut-RDD model. Such models will provide local average treatment effects for those people who were released just after full implementation of (and exposure to) the Reentry Waiver compared to just before the Reentry Waiver was implemented.

The UCLA-RAND Reentry Evaluation team expects to have a large enough sample size to address the proposed research questions. The sample size will be substantially larger than that which other scholars have had when utilizing similar approaches to answer research questions related to the effect of Medicaid waivers for incarcerated populations (Burns & Dague, 2024; Packham & Slusky, 2024), which have involved policies to increase access to Medicaid enrollment post-release.⁹² Based on the number of releasees in California per year the sample size should be at least 150,000 releasees given that there are around 25,000 individuals released from the state prisons each year. This is far larger than the 38,508 releasees in Burns & Dague (2024). However, depending on design parameters, RDD models may have only one-third the power of a similarly sized randomized control trial (Schochet, 2009).⁹³ Nonetheless, prior studies utilizing RDD approaches with smaller sample sizes than those expected for the present study have been sufficiently powered to identify effects of increasing access to Medicaid enrollment after release for re-entry populations in other states using RDD approaches (Packham & Slusky, 2024).⁹⁴ For example, Packham and Slusky (2024) had a sample size of 14,568 for

⁹¹ Rambachan, A., & Roth, J. (2023). A more credible approach to parallel trends. *Review of Economic Studies*, 90(5), 2555-2591.

⁹² Burns, M & Dague, L. (2024). In-Kind Welfare Benefits and Reincarceration Risk: Evidence from Medicaid. *NBER working paper 31394*.

Packham, A & Slusky, D. (2024). Accessing the Safety Net: How Medicaid Affects Health and Recidivism. *NBER working paper 31971*.

⁹³ Schochet, P. (2009) "Statistical Power for Regression Discontinuity Designs in Education Evaluations." *Journal of Educational and Behavioral Statistics*. 34(2) pp. 238—266.

⁹⁴ Packham, A & Slusky, D. (2024). Accessing the Safety Net: How Medicaid Affects Health and Recidivism. *NBER working paper 31971*.

their analysis with a 6-month window around the RDD, while the UCLA-RAND Reentry Evaluation team expect to have a sample size of around 25,000 for such an analysis, thus they also expect to be well-powered when using the donut RDD approach.

Qualitative Goals 3, 4, and 5

Goals 3, 4 and 5 will require interviews with key stakeholders and with individuals who have been previously incarcerated. The research questions related to these goals will focus on the Reentry Waiver time period (2024 to 2026) as well as the PATH demonstration timeframe.

Interviews with Formerly Incarcerated Individuals

The UCLA-RAND Reentry Evaluation team will conduct interviews in 2025 and 2026 of recently released individuals from CDCR, county jails and juvenile facilities in four counties. Within each county, the UCLA-RAND Reentry Evaluation team will identify community-based organizations (CBO), including JI ECM providers, to help identify and recruit respondents for the interviews. The budget includes a \$500 payment for each CBO for their assistance in identifying potential interview participants.

Prior to starting recruitment, Reentry Evaluation staff will meet with the designated liaison from the CBO to review recruitment goals, procedures, and materials. CBOs will be provided a flyer in English and Spanish that describes what participation in the interview entails, the eligibility criteria for the interviews, recruitment goals, a recruitment script, and a contact information release form. To be eligible for the interviews, individuals must have been released in the previous 90 days from one of the targeted facilities, enrolled in Medi-Cal, and have one of the conditions that make them eligible for the Reentry Demonstration. If a Waiver participant is interested in taking part in the interview, the CBO will ask the individual to sign a release form that authorizes the CBO to release their name and contact information (telephone number, cell phone number, email address) to the UCLA-RAND Reentry Evaluation team in order to contact them. Individuals will be contacted to verify Reentry Waiver status (e.g. that the individual was recently incarcerated and that their Medi-Cal enrollment was reactivated prior to or at release), provide details about what participation in the interview entails, answer any questions or concerns they may have, and if they are interested and available, schedule an appointment to complete the interview with a trained interviewer, either in person or by phone. If the Reentry Waiver participant is available to do the interview right away, they will be interviewed by phone.

If the CBO is unable to provide staff to help identify and recruit Reentry Waiver participants for the interviews, the UCLA-RAND Reentry Evaluation team will seek their permission to allow an interviewer to visit their office(s) to recruit Reentry Waiver participants onsite, either before or after their appointment with CBO staff. With the CBO's permission, and in collaboration with CBO staff, interviewers will approach CBO clients to provide information about the survey and if they are interested, they will verify eligibility for the interviews and either conduct the interview on site (if possible) or schedule an appointment to do the interview later, either in person or by phone.

For the prison sample, UCLA-RAND Reentry Evaluation team will conduct interviews with 10-15 individuals who were formally incarcerated in prison and are recently released to one of the four focal counties. This will result in a total of 40-60 interviews with individuals newly released from prison in 2025. It is anticipated that 100 newly released individuals will need to be screened to yield 10-15 interviews per identified focus county per project year.

For the county jail and youth correctional facility populations, 80 to 120 interviews will be conducted in the four focal counties in 2025, half of which will be with Reentry Waiver participants who were recently incarcerated in county jails and the other half will be with youth recently incarcerated in youth correctional facilities who are Reentry Waiver participants. It is estimated that between 100-125 individuals will need to be screened to complete 20-30 interviews per county (10-15 individuals released from jails and 10-15 individuals released from youth correctional facilities). The interviews will be administered by a bilingual interviewer, as a computer administered personal interview (CAPI) using a hand-held tablet. The interview will be conducted in English or Spanish, as applicable, and is estimated to take approximately 60 to 90 minutes. Respondents will be paid, which may be via gift card, for completing the interview.

The interviews with newly released Reentry Waiver participants from prison, jail, or youth correctional facilities will ask about their experiences with enrollment in Medi-Cal (or reinstatement of benefits) during the pre-release period; their perceptions regarding their health care treatment needs and reentry support needs; and their experiences in receiving pre-release services while still incarcerated. Questions will also ask about their experiences with case management and the transition of their care to community providers; as well as what other support they may have received to help facilitate their transition of care to the community. Items will ask for feedback on their experiences, as applicable, in accessing primary care, mental health care, substance use treatment, and

care for chronic health conditions post-release from the carceral setting; and perceptions regarding barriers and facilitators to accessing health care pre-release and post-release. Reentry Waiver participants on prescription medications will be asked if they were released with a supply of medications and experiences in getting their medications refilled post-release.

To do qualitative analysis of these interview data, qualitative coding of themes will be conducted 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 coordination and connections between correctional systems, Medi-Cal systems, ECM, and community providers to address the physical health, behavioral health, and other health-related social needs of the JI population. The qualitative analysis will also inform understanding of factors that facilitated or hindered Reentry Waiver participants' access to care pre-release and post-release, and their perceptions of their treatment needs and experiences with pre-release care, case management, and post-release care. Convenience sampling will be used to recruit interviewees. Equity-based populations (e.g., women, persons of color) will be oversampled and analyses will be stratified by demographics (e.g., race/ethnicity, gender, age) to the extent that sample sizes will support stratification.

The UCLA-RAND Reentry Evaluation team will identify CBOs which work specifically with different communities and work with younger individuals as well. The interview samples will be restricted to those individuals who speak English or Spanish as these are the languages that the UCLA-RAND Reentry Evaluation team are able to conduct interviews in.

Interviews with Key Stakeholders

In conjunction with the UCLA-RAND PATH Evaluation Team – which is focused on examining infrastructure investment – including Reentry - under the current 1115, interviews will be conducted with key stakeholders involved in the planning and implementation of the Waiver for the JI population. Key stakeholder interviewees will include at the state-level CDCR and California Correctional Health Care Services (CCHCS) staff. At the county-level, administrators of county jails, and youth correctional facilities will be selected with individuals who were involved with the planning and implementation of the Waiver for the JI population.

[Exhibit 15](#) summarizes, for the different interview topic areas, the entities who will be interviewed (including the lead entity), and who the system implementation partners

are. Specifically, at the prison-level, evaluation plans are to interview those individuals within CDCR and the CCHCS who were involved in planning for and implementing the Waiver for the incarcerated population in the state’s correctional system. Similarly, at the jail and youth correctional facilities, implementation partners listed in [Exhibit 15](#) including county sheriffs, county jail staff and juvenile facility administrators/staff, county probation staff, and state parole staff will be interviewed.

The RAND Reentry Evaluation team will lead interviews with key informants within CDCR and CCHCS as well as in county correctional facilities, while the UCLA-PATH team will lead interviews with county social services agencies and other salient community-based implementation partners.

Interview topics will include: system changes and supports needed to screen for Medi-Cal eligibility, to enroll, and to re-instate eligibility for those who were suspended during their incarceration; process of identifying eligible individuals for the Waiver, the pre-release Medi-Cal application and enrollment process; planning for and the provision of the targeted set of pre-release services 90- days prior to release from jail/prison/juvenile facilities; planning for and care in the carceral setting, as well as provision of needed medications and durable medical equipment; coordination with enhanced care and provision of comprehensive case management (as part of ECM); coordination with benefits in preparation for release to the community supports; and barriers and facilitators in planning for and implementing each component of the Waiver, the Justice-Involved Reentry Initiative and lessons learned.

Exhibit 15. Interview Topic Areas, Lead Entity, and System Implementation Partners

Topics	Lead Entity	System Implementation Partners
Pre-Release Medi-Cal Application Processes in County Correctional Facilities	County Jails and Youth Correctional Facilities	County Sheriff’s Offices, County Probation Offices, and County Social Services Departments (SSDs) and other partners responsible for correctional health care services.

Topics	Lead Entity	System Implementation Partners
Provision of Targeted Set Services 90 Days Prior to Release from Jail or Prison	State Prisons, County Jails, and Youth Correctional Facilities working in partnership with and Community-Based Providers, as appropriate	State Prisons, County Sheriffs, County Probation, County Jails and Youth Correctional Facilities, CA Department of Corrections and Rehabilitation, CA Correctional Health Care Services (CCHCS)
Enhanced Care Management	Medi-Cal Managed Care Plans	County Behavioral Health, Reentry ECM Providers, Support Services Providers (e.g., Housing), County Correctional Facilities, CDCR, Probation and Parole
Community Supports	Medi-Cal Managed Care Plans	County Behavioral Health, Service Providers (e.g., Housing), Probation and Parole

Source: CCJBH "Brief Overview of the Department of Health Care Services (DHCS)' California Advancing and Innovating Medi-Cal (CalAIM) CalAIM Justice-Involved Initiative," Prepared by the Council on Criminal Justice and Behavioral Health (CCJBH) and reviewed by DHCS, March 2023. Note: For ECM, the support services providers will be determined after the UCLA-RAND Evaluation team review their plans.

As noted above, the UCLA-RAND Reentry Evaluation team will coordinate with the UCLA-RAND PATH team on the key stakeholder interviews eliciting that team's input on the development of the interview protocols and will share with them the results of the qualitative analyses. Similar to the interviews with Reentry Waiver participants, qualitative coding of themes for the stakeholder interviews using software such as Dedoose will be used, which will provide a systematic way to code and reveal themes in the data. Qualitative analysis of the stakeholder interviews will inform the interpretation of Goals 3, 4, and 5 by identifying strategies for improving coordination and connections between correctional systems, Medi-Cal systems, ECM, and community providers. The qualitative analysis will also inform understanding of factors that facilitated or hindered implementation of the different components of the Reentry Waiver and stakeholders' suggestions for improving Medi-Cal enrollment processes, pre-release treatment services, and case management, and post-release care.

Evaluation Questions and Hypotheses

This section begins with a summary of the seven evaluation goals and the evaluation questions and hypotheses and measures associated with each goal. In the Driver Diagram section that follows the specific aim(s) and primary and secondary drivers are identified. The Methods section describes in detail for each goal and research question the specific methods proposed for analyses.

Goals 1 and 2 and their related hypotheses are designed to satisfy the STCs for a comprehensive analysis of services rendered by type of service over the duration of the 90-day coverage period immediately prior to the expected date of release. The specific methods sections below discuss the analysis of the relationship between service provision and timing and the outcomes in Goals 6 and 7. Ninety days pre-release is used as the time period to align with the allowable time Reentry Waiver services can be provided for California within the carceral setting.

Goals 3, 4, and 5 and their related hypotheses address the extent to which the Waiver coverage timeline facilitated providing more coordinated, efficient and effective reentry planning, enabled pre-release management and stabilization of physical and behavioral health conditions, and helped mitigate any potential operational challenges the state might have otherwise encountered in a more compressed timeline for coverage or pre-release services. These are addressed in a qualitative manner.

This UCLA-RAND Reentry Evaluation design kept the term “beneficiary” in exact language used by CMS; however, in other places the term “members” is used per DHCS guidance. It is worth noting that measures refer to the measured changes that related to evaluation questions and hypotheses, but the underlying measures needed to identify such changes come from underlying individual level data, discussed in more detail in Methods section. For each measure the numerator and denominator are defined. It is worth noting that the UCLA-RAND Reentry Evaluation design uses the full number of releasees within a cohort as the denominator to facilitate the identification of intention-to-treat estimates.

[Exhibit 16](#) describes Goals, Evaluation Questions and Hypotheses, and Measures for the Reentry Evaluation.

Exhibit 16. Goals, Evaluation Questions, Hypotheses, and Measures

G 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.	
Evaluation Questions and Hypotheses	Measures
EQ 1: Did the Waiver increase coverage for eligible Medi-Cal members?	Medicaid Coverage (numerator = number enrolled in Medicaid; denominator = number of releasees)
H 1: The Waiver will increase coverage for eligible Medi-Cal members?	Eligibility screening (numerator = number screened for eligibility within 90 days of release; denominator = number of releasees) Eligibility (numerator = number found eligible for Justice-Involved Reentry Initiative services after screening; denominator = number of screened releasees) Suspended status (numerator = number with suspended status; denominator = number of releasees)

G 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?	Pre-release care management (numerator = number who received pre-release care management during 90-day pre-release period; denominator = number of releasees)
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.	Pre-release medication billing (numerator = number who received any medication billed during the 90-day pre-release period; denominator = number of releasees) Pre-release MAT treatment (numerator = number who received MAT treatment during the 90-day pre-release period; denominator = number of releasees) Pre-release prescription fills (numerator = number who had a filled prescription in the 30 days prior to release; denominator = number of releasees) Post-release prescription fills (numerator = number who had a filled prescription in the 30 days following release; denominator = number of releasees) Assigned pre-release care manager (numerator = number who had an assigned pre-release care manager within 90 days of release; denominator = number of releasees) Pre-release substance use disorder treatment (numerator = number who received substance use disorder treatment in the 90-day pre-release period; denominator = number of releasees)

G 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
	Necessary medications (numerator = number of releasees who received all necessary medications (as identified in their health records while incarcerated) for chronic disease in the community prior to completion of previous supply received during incarceration; denominator = number of releasees) Visit with an ECM provider (numerator = number of releasees who had a visit with their ECM provider within 30 days after release; denominator = number of releasees) Medicaid services (numerator = number of releasees who received any Medicaid service within 30 days, 90 days and six-months post-release; denominator = number of releasees) Provider beneficiary rate (numerator = number of providers; denominator = number of releasees) Wait time (numerator = time from referral to appointment; denominator = all appointments)⁹⁵ Percent of incarcerated individuals found eligible for Justice-Involved Reentry Initiative services after screening - post-Waiver cohorts compared to pre-Waiver cohorts

⁹⁵ This will be included provided reliable data are available for date of referral and date of appointment.

G 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?	Interviews with individuals released from prison/jail/juvenile facilities could cover: - Challenges/facilitators in transitioning to the community after release (e.g., number of available providers) - Continuity of care from incarceration to community - Effectiveness of case managers
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.	Interviews with key stakeholders could cover: - Newly established communication channels between correctional systems and community based-providers, Medicaid/CHIP systems - Data sharing put into place - Handoff protocols between prisons/jails/juvenile facilities and community

G 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: How did the Waiver influence investments in health care and related services in carceral settings aimed at improving quality of care and in the community aimed at maximizing successful reentry post-release?	Interviews with key stakeholders could cover: How were Waiver funds used? What were the additional federal, state, and general fund investments for pre-release services, ECM, and PATH?
H1: The Waiver (post-Reentry) will be associated with increased services associated with improved quality of care, such as medication-assisted treatment, care coordination, and enhanced care management.	

G 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?	Interviews with individuals released from prisons/jails/juvenile facilities could cover: - Health care needs of participants - Provision of services during 90-day in-reach period
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.	Transition services provided, including case manager and medications upon release, appointments made in the community Community supports needed and received ECM services needed and received Interviews with key stakeholders could cover: - Coordination of care between carceral settings (prison, jail, youth correctional facilities) and community service providers (behavioral health, medical care, social services) - Type of formal arrangements (e.g., memorandums of understanding, regular meetings, etc.) to facilitate connections between carceral settings and providers - Facilitators and barriers and how these may vary by type of services provided

G 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?	Post-release substance use disorder treatment (numerator = number of releasees who received substance use disorder treatment within 30 days of release; denominator = number of releasees) Post-release mental health treatment (numerator = number of releasees who received mental health treatment within 30 days of release; denominator = number of releasees) Post-release MAT (numerator = number of releasees who received MAT within 30 days of release; denominator = number of releasees)
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.	Post-release necessary medications (numerator = number of releasees who received all necessary medications (as identified in facility records) for chronic disease in the community prior to completion of previous supply received during incarceration; denominator = number of releasees)
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?	Receipt of behavioral health condition interventions (numerator = number of releasees who received behavioral health condition interventions 90 days pre-release and post-release (30 and 90 days); denominator = number of releasees)
H2: The Waiver will reduce decompensation, suicide-related deaths, overdoses, and overdose-related deaths for eligible Medi-Cal members.	

G 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
	Medications for addiction treatment for SUDs (numerator = number of releasees who received medications for addiction treatment for SUDs in the 90 days pre-release and post-release (30 days and 90 days); denominator = number of releasees) Suicide-related emergency department visits (numerator = number of releasees who had suicide-related emergency department visits post-release (30 days and 90 days); denominator = number of releasees) Suicide-related inpatient hospitalizations (numerator = number of releasees who had inpatient hospitalizations post-release (30 days and 90 days); denominator = number of releasees) Suicide-related deaths (numerator = number of releasees who died by suicide (30 days and 90 days); denominator = number of releasees) Emergency department utilization for SUD (numerator = number of releasees who had emergency department utilization for SUD post-release (30 days and 90 days); denominator = number of releasees)

G 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
	Inpatient stays for SUD (numerator = number of releasees who had inpatient stays for SUD post-release (30 days and 90 days); denominator = number of releasees) Overdose-related deaths (numerator = number of releasees who had an overdose-related death (30 days and 90 days); denominator = number of releasees) Decompensation (numerator = number of releasees who had any (and each) post-release decompensation (include psychosis, suicide attempt, depression, anxiety, mania, drug overdose (regardless of intention), drug induced mental disorders, insomnia, social withdrawal, anorexia, aggression, increased substance use) 30 days and 90 days; denominator = number of releasees)

G 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.

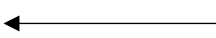
Evaluation Questions and Hypotheses	Measures
EQ 1: Did the Waiver reduce post-release emergency department visits, inpatient hospitalizations, and all-cause deaths for eligible Medi-Cal members?	All-cause deaths (numerator = number of releasees who died (30 days and 90 days); denominator = number of releasees)
H1: The Waiver will reduce post-release emergency department visits, inpatient hospitalizations, and all-cause deaths for eligible Medi-Cal members.	All-cause emergency room visits (numerator = number of releasees who had an emergency room visit (30 days and 90 days); denominator = number of releasees) All-cause inpatient hospitalizations (numerator = number of releasees who had an inpatient hospitalization (30 days and 90 days); denominator = number of releasees)

Driver Diagrams

The goals listed in the driver diagrams shown in [Exhibit 17](#) are taken directly from the Special Terms and Conditions (STCs) number 9.1 for California.⁹⁶

Exhibit 17. Goals listed in the driver diagrams

Goal 1: Increase coverage—in terms of individuals now eligible for Medi-Cal benefits—in carceral settings in prison/jail/juvenile hall just prior to release.

Aim	Primary Driver	Secondary Driver
Increase coverage—in terms of individuals now eligible for Medi-Cal benefits—in carceral settings in prison/jail/juvenile hall just prior to release.	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 		

⁹⁶ <https://www.dhcs.ca.gov/provgovpart/Documents/California-Reentry-Demonstration-Initiative-Amendment-Approval.pdf>

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 ←		

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		

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 infrastructure, data, and staffing needs. Identify service gaps. Develop mechanisms to capture funding requirements and track expenditures.
Causality		

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 ←		

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 antipsychotics, 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 antipsychotics; 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 antipsychotics. Increased education of providers and incarcerated persons on availability of medications for addiction treatment for SUDs.
← Causality ←		

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		

Methodology

Note, the goals are taken from CMS guidance in the STCS.⁹⁷

Goal 1: Increase coverage—in terms of individuals now eligible for Medi-Cal benefits—in carceral settings in prison/jail/juvenile hall just prior to release.

Research Question 1: Did the Reentry Waiver increase coverage—in terms of individuals now eligible for Medi-Cal benefits—in carceral settings in prison/jail/youth correctional facilities just prior to release?

Hypothesis: The Reentry Waiver will increase coverage.

Measures:

- Medicaid coverage
- Medicaid suspended status
- Medicaid eligibility screening
- Medicaid eligibility

Target Population: People who are eligible Medi-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 2021 through CY 2026

The approach will make use of cohorts of individuals released from facilities in order to select treatment groups and control groups around the timing of when the Waiver goes live. Additional control cohorts will be created from prior to the go live to be able to estimate models that can identify a causal effect. Thus, the UCLA-RAND Reentry Evaluation team 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

⁹⁷ CENTERS FOR MEDICARE & MEDICAID SERVICES WAIVER AUTHORITY, NUMBERS: 11-W-00193/9 and 21-W-00077/0, TITLE: California CalAIM Demonstration. See: <https://www.dhcs.ca.gov/CalAIM/Documents/BH-CONNECT/CA-CalAIM-STCs.pdf>

the year of the roll-out and one year before could be used to identify these groups (i.e., two cohorts), this may lead to less precise estimates. Such noise could result in the findings indicating that the Reentry Waiver had no impact due to precision rather than a true null effect. Increasing the number of control cohorts (back to 2021 for example) would allow for the identification of more precise estimates. More precision (afforded by these earlier cohorts) will therefore be important to provide precise estimates of the effect of the Reentry Waiver and ensure that the evaluation is powered to identify an effect if one exists.

Methodological Design: The UCLA-RAND Reentry Evaluation team will use cohort difference-in-differences and event study analyses. The UCLA-RAND Reentry Evaluation team 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)). The UCLA-RAND Reentry Evaluation team will also explore whether control cohorts can be identified from the same 12-month period, for years prior to Reentry Waiver go live.

The difference-in-differences models will explore how outcomes vary before and after Reentry Waiver go live compared to associated control cohorts (in earlier years) to identify the causal effect of the Reentry Waiver. Importantly, this approach is able to follow the outcomes of individuals who meet the criteria who transition from carceral settings to community over time, allowing exploration of the dynamic effect in event study models by using monthly data for the outcomes of each individual. Event study models will also allow exploration of whether control and treated cohorts were on parallel trends prior to Reentry Waiver go live (a crucial assumption in difference-in-differences models).

The Reentry Waiver go live will likely be rolled out in staggered settings across jails/youth correctional facilities. As such, in these cases The UCLA-RAND Reentry Evaluation team will make use of staggered difference-in-differences and event study models that compare the outcomes of the re-entry population that are released after Waiver go live, compared to those released prior to the go live, for jails/youth correctional facilities that go live, compared to those that go live later. Given the staggered nature in these settings the UCLA-RAND Reentry Evaluation team approach 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 go live, compared to those released prior to the roll-go live, in the treatment cohort compared to associated earlier control cohorts, have higher rates of Medi-Cal enrollment and suspended status then the hypothesis is affirmed.

Data Sources: Medicaid claims data and correctional agencies' health care utilization data and demographic information (e.g., gender, race/ethnicity, health/behavioral health condition, age, county) as well as release dates.

Analytic Methods: Descriptive summary and t-tests will be used to provide sample characteristics over time (e.g., gender, race/ethnicity, health/behavioral health condition, age, county). Probit models will be estimated to take consideration of the binary nature of outcomes variables. Difference-in-differences analysis will be used to identify a causal effect. Event study models will be used to test for pre-trends. Analyses will examine the three major populations targeted for Reentry – prisoners, jail inmates, and youth 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 improve transitions and continuity of care upon release.

Measures:

- Pre-release case management
- Pre-release medication billing
- Pre-release MAT treatment
- Pre-release prescription fills
- Pre-release care manager
- Pre-release substance-use disorder treatment
- Medically necessary medications
- Visits with ECM provider
- Medicaid services
- Provider beneficiary rate
- Wait times

- Self-reported access to care based on interviews with individuals newly released from prison/jail/juvenile facilities
 - Interview questions regarding their health care treatment needs and reentry support needs prior to release; their experiences in receiving pre-release services while still incarcerated; their experiences with case management and the transition of their care to community providers; other support they may have received to help facilitate their transition of care to the community

Target Population: People who are eligible Medi-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 2021 through CY 2026

Methodological Design: The UCLA-RAND Reentry Evaluation team will use cohort difference-in-differences and event study analyses. 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 Reentry Waiver go live (control) and the first 6 months after Reentry Waiver go live (treated)) will be identified. The UCLA-RAND Reentry Evaluation team will also assess the feasibility of constructing control cohorts from the same 12-month period, for years prior to Reentry Waiver go live. The difference-in-differences models will explore how outcomes vary before and after Waiver go live compared to associated control cohorts (in earlier years) to identify the causal effect of the Reentry Waiver. Importantly, this approach allows one to follow the outcomes of releasees over time, allowing exploration of dynamic effects in event study models by using monthly data for the outcomes of each individual event.

Event study models will also allow explore whether control and treated cohorts were on parallel trends prior to Reentry Waiver go live (a crucial assumption in difference-in-differences models). The Reentry Waiver will likely go live in staggered settings across jails/youth correctional facilities. As such, in these cases we will make use of staggered difference-in-differences and event study models that compare the outcomes of the re-entry population in the 90 days prior to

release that are released after Reentry Waiver go live compared to those released prior to the go live; for jails/youth correctional facilities that go live earlier compared to those that go live later. Given the staggered nature in these settings the UCLA-RAND Reentry Evaluation team will make use of models that deal with biases that may arise in such settings (Roth et al, 2023).

If post-Reentry Waiver cohorts in the treatment cohort have higher rates of the measures listed above during the 90 days prior to release, compared to pre-Reentry Waiver cohorts, and cohorts from earlier years, then the hypothesis is affirmed.

Data Sources: Medicaid claims data and correctional agencies' health care utilization and demographic information (e.g., gender, race/ethnicity, health/behavioral health condition, age, county) as well as release dates. State hospital inpatient discharge data, state hospital emergency department visit data, and state death data. Patient discharge and ED visit data will be obtained from HCAI data sources via DHCS.

Analytic Methods: Descriptive summary and t-tests will be used to provide sample characteristics over time (e.g., gender, race/ethnicity, health/behavioral health condition, age, county). Probit models will be estimated to take consideration of the binary nature of outcomes variables. Difference-in-differences analysis will be used to identify a causal effect. Event study models will be used to test for pre-trends. Analyses will examine the three major populations targeted for Reentry – prisoners, jail inmates, and youth 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 2022 through CY 2026

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 each of the stakeholder groups at the state-level will be conducted; interviews with county-level stakeholders will also be conducted within four counties. The interviews will ask about the context before the Reentry Waiver went into effect and during each year of implementation. The interviews will focus on questions related to coordination and communication between relevant stakeholders. For example, the evaluation team will use questions based on validated items from surveys such as CAHPS (e.g. Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often, Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service, Shared Decision Making) to probe interviewees. In addition, interviews will be conducted with Reentry Waiver participants newly released from carceral settings in four counties.

In the context of regular across project evaluation team meetings, the UCLA-RAND Reentry Evaluation team will regularly review project specific approaches to qualitative instrument development. To date, the Reentry Evaluation team and the UCLA-RAND PATH Evaluation team have already met to agree upon the important interface between the two evaluation components. For example, any administrative data from CDCR or from county jails and youth correctional facilities will be obtained and maintained by the UCLA-RAND Reentry Evaluation team who will run analyses of these data and stratify by whether a 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 Evaluation 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 Evaluation team leading interviews 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 Reentry 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, qualitative coding of themes using software such as Dedoose will be used, 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. Analyses will examine the three major populations targeted for Reentry – prisoners, jail inmates, and youth 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: How did the Waiver influence investments in health care and related services in carceral settings aimed at improving quality of care and in the community aimed at maximizing successful reentry post-release?

Hypothesis: The Waiver (post-Reentry) will be associated with increased services associated with improved quality of care, such as medication-assisted treatment, care coordination, and enhanced care management.

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 2026

Methodological Design: The UCLA-RAND Reentry evaluation team will gather expenditure and staffing data post-Waiver. Semi-structured interviews will be

conducted via TEAMS or ZOOM with relevant financial personnel at the state prison-level, and at the jail and juvenile facility levels within the four counties. 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. Qualitative coding of themes using software such as Dedoose will be used, 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.

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 2026

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 each of the stakeholder groups at the state-level will be conducted; the UCLA-RAND Evaluation team will also conduct interviews with county-level stakeholders within four 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, interviews with Reentry Waiver participants will be conducted with newly released from carceral settings in four counties.

Data Sources: individual stakeholder interviews will be led by 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. The three major populations targeted for Reentry – prisoners, jail inmates, and juveniles who are incarcerated will be examined.

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:

- Post-release substance use disorder treatment
- Post-release mental health treatment
- Post-release MAT
- Post-release necessary medications

- Post-release receipt of behavioral health condition interventions
 - Medications for addiction treatment for substance use disorders

Target Population: People who are eligible Medi-Cal members who met Waiver service criteria and were enrolled and then released from carceral settings following the go live of the Reentry 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 2021 through CY 2026

Methodological Design: Cohort difference-in-differences and event study analyses will be used. The UCLA-RAND Reentry Evaluation team will identify a 12-month cohort of individuals released around the timing of the county go live date (i.e., groups released 6 months prior to Reentry Waiver go live (control) and the first 6 months after Reentry Waiver go live (with the first 3 months being a group of partially treated individuals and the subsequent 3 months being a fully treated sample)). The UCLA-RAND Reentry Evaluation team will also assess the feasibility of constructing control cohorts from the same 12-month period, for years prior to Reentry Waiver go live. The difference-in-differences models will explore how outcomes vary before and after Reentry Waiver go live compared to associated control cohorts (in earlier years) to identify the causal effect of the Reentry Waiver. Importantly, this approach will be able to follow the outcomes of releasees over time, allowing exploration of dynamic effect in event study models by using monthly data for the outcomes of each individual. Event study models will also allow the UCLA-RAND Reentry Evaluation team to explore whether control and treated cohorts were on parallel trends prior to Reentry Waiver go live (a crucial assumption in difference-in-differences models). Event study models will also allow the UCLA-RAND Reentry Evaluation team to explore dynamics in the post-treatment period, allowing exploration of whether changes in outcomes occurred pre-release, post-release, or both.

The Reentry Waiver go live will likely to be rolled out in staggered setting across jails/youth correctional facilities. As such, in these cases the UCLA-RAND Reentry Evaluation team will make use of staggered difference-in-differences and event study models that compare the outcomes of the reentry population in the 90 days prior to release, that are released after Reentry Waiver go live, compared to

those released prior to the go live, for jails/ youth correctional facilities that go live earlier, compared to those that go live later. Given the staggered nature in these settings the UCLA-RAND Reentry Evaluation team 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 Hypothesis 1 is affirmed.

Data Sources: Medicaid claims data and correctional agencies' health care utilization and demographic information (e.g., gender, race/ethnicity, health/behavioral health condition, age, county) as well as release dates. 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 over time (e.g., gender, race/ethnicity, health/behavioral health condition, age, county). Probit models will be estimated to take consideration of the binary nature of outcomes variables. Difference-in-differences analysis will be used to identify a causal effect. Event study models will be used to test for pre-trends. The three major populations targeted for Reentry – prisoners, jail inmates, and juveniles who are incarcerated will be examined. Regression models will be used to determine the impact of specific services received and timing on outcomes for this Research Question.

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:

- Suicide related ED visits
- Suicide related inpatient hospitalizations
- Suicide related deaths
- ED utilization for substance use disorders
- Inpatient stays for substance use disorders
- Overdose related deaths

- Decompensation⁹⁸

Target Population: People who are eligible Medi-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 2021 through CY 2026

Methodological Design: The UCLA-RAND Reentry Evaluation team will use cohort difference-in-differences and event study analyses. The UCLA-RAND Reentry Evaluation team will identify a 12-month cohort of individuals released around the timing of the go live of the Reentry Waiver (i.e., groups released 6 months prior to Waiver go live (control) and the first 6 months after go live (treated)). The UCLA-RAND Reentry Evaluation team will also assess the feasibility of constructing control cohorts from the same 12-month period, for years prior to Reentry Waiver go live. The difference-in-differences models will explore how outcomes vary before and after Waiver go live compared to associated control cohorts (in earlier years) to identify the causal effect of the Reentry Waiver. Importantly, the UCLA-RAND Reentry Evaluation team will be able to follow the outcomes of releasees over time, allowing exploration of dynamic effect in event study models by using monthly data for the outcomes of each individual. Event study models will also allow the UCLA-RAND Reentry Evaluation team to explore whether control and treated cohorts were on parallel trends prior to Waiver go live (a crucial assumption in difference-in-differences models).

The Reentry Waiver will likely go live out in staggered setting across jails/youth correctional facilities. As such, in these cases the UCLA-RAND Reentry Evaluation team will make use of staggered difference-in-differences and event study models that compare the outcomes of the reentry population that are released

⁹⁸ Direct objective measures of mental health decompensation will not be available in the absence of an electronic medical record. However, in addition to the listed utilization measures (including ED visits for psychosis), it is possible to examine other indicators that might reflect worsening mental health (decompensation): gaps in receipt of medication OR change in medication; need to check into sober center or long-term inpatient psychiatric facility; increase in use of outpatient mental health services.

after Waiver go live, compared to those released prior to the go live, for jails/ youth correctional facilities that go live earlier, compared to those that go live later. Given the staggered nature in these settings, the UCLA-RAND Reentry Evaluation team will make use of models that deal with biases that may arise in such settings (Roth et al, 2023).

If those released after the Reentry Waiver go live, compared to those released prior to the Reentry Waiver go live, 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 correctional agencies' health care utilization and demographic information (e.g., gender, race/ethnicity, health/behavioral health condition, age, county) as well as release dates. 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 UCLA-RAND Reentry Evaluation team will work with CDCR, and 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, the UCLA-RAND Reentry Evaluation team 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 over time (e.g., gender, race/ethnicity, health/behavioral health condition, age, county). Probit models will be estimated to take consideration of the binary nature of outcomes variables. Difference-in-differences 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. Regression models will be used to determine the impact of specific services received and outcomes for this Research Question.

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 post-release (30 days and 90 days)
- All-cause emergency room visits post-release (30 days and 90 days)
- All-cause inpatient hospitalizations post-release (30 days and 90 days)

Target Population: People who are eligible Medi-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 2021 through CY 2026

Methodological Design: The UCLA-RAND Reentry Evaluation team will use cohort difference-in-differences and event study analyses. The UCLA-RAND Reentry Evaluation team will identify a 12-month cohort of individuals released around the timing of go live (i.e., groups released 6 months prior to Reentry Waiver go live (control) and the first 6 months after Reentry Waiver go live (treated)). The UCLA-RAND Reentry Evaluation team will also assess the feasibility of constructing control cohorts from the same 12-month period, for years prior to Waiver go live. The difference-in-differences models will explore how outcomes vary before and after Waiver go live compared to associated control cohorts (in earlier years) to identify the causal effect of the Waiver. Importantly, the UCLA-

RAND Reentry Evaluation team will be able to follow the outcomes of releasees over time, allowing exploration of dynamic effect in event study models by using monthly data for the outcomes of each individual. Event study models will also allow the UCLA-RAND Reentry Evaluation team to explore whether control and treated cohorts were on parallel trends prior to go live (a crucial assumption in difference-in-differences models).

The Reentry Waiver go live is likely to be staggered across jails/youth correctional facilities. As such, in these cases the UCLA-RAND Reentry Evaluation team will make use of staggered difference-in-differences and event study models that compare the outcomes of the reentry population that are released after go live, compared to those released prior to the go live date, for jails/youth correctional facilities that go live earlier, compared to those that go live later. Given the staggered nature in these settings the UCLA-RAND Reentry Evaluation team will make use of models that deal with biases that may arise in such settings (Roth et al., 2023).

If those released after the Reentry Waiver go live, compared to those released prior to the Waiver go live, 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 over time (e.g., gender, race/ethnicity, health/behavioral health condition, age, county). Probit models will be estimated to take consideration of the binary nature of outcomes variables. Difference-in-differences analysis will be used to identify a causal effect. Event study models will be used to test for pre-trends. UCLA-RAND Reentry Evaluation team will examine the three major populations targeted for Reentry – prisoners, jail inmates, and juveniles who are incarcerated. Regression models will be used to determine the impact of specific services received and timing on outcomes for this Research Question.

Cost

To examine changes in health care utilization and expenditures by the JI population, the UCLA-RAND Reentry Evaluation team will compare utilization of select services post-release and the payments associated with that utilization for Waiver participants that received pre-release services and a matched comparison group. To conduct these analyses, the UCLA-RAND Reentry Evaluation team will need to obtain identifiers from the correctional system (i.e., prisons and jails), which as previously noted, UCLA-RAND will attempt to obtain from CDCR and from correctional facilities in four purposively selected counties.

The cost analysis will be limited to Medi-Cal covered costs post-release. This is because the UCLA-RAND Reentry Evaluation team anticipates that obtaining cost estimates for all services delivered while in prison and jail will not be feasible or practically available.

For services delivered post-release, the UCLA-RAND Reentry Evaluation team will examine utilization of Medi-Cal covered outpatient services, ED visits, hospitalizations, and long-term stays, and associated Medi-Cal payments. In estimating Medi-Cal payments, the UCLA-RAND Reentry Evaluation team will use the methodology developed by the UCLA PATH team to attribute payment amounts to each claim. As detailed in the UCLA PATH Evaluation Design, to determine the expenditures of ECM and Community Supports services, the UCLA PATH team will ask MCPs to provide an average payment amount for each ECM or Community Supports service identified in Medi-Cal claims data by a HCPCS code. UCLA anticipates that MCPs payments to individual providers may vary for each ECM and Community Supports service identified by a HCPCS code, by region, by population of focus and potentially other factors. However, an average payment for each service may be calculated on a per service/per unit basis. UCLA-RAND will use this data to determine average payments and patterns of average payments for each ECM population of focus and for Community Supports services.

UCLA-RAND will stratify these data by county or region, under-resourced community indices, and by provider types. These analyses depend on the feasibility of obtaining average payment rates from MCPs. If MCP are unable to estimate average payment amounts, then the UCLA-RAND Evaluation team will rely on DHCS-provided data pertaining to rates provided to MCPs. The limitation of this approach is that the UCLA-RAND evaluation team would then only be able to examine expenditures in aggregate.

UCLA-RAND will attempt to assess cost savings by comparing Medi-Cal payments by category of service incurred by members receiving ECM or Community Supports to a matched comparison group of eligible members that did not participate in ECM or Community Supports.

The UCLA-RAND Reentry Evaluation team will examine whether the Reentry Waiver led to a different pattern of health services utilization and associated payments. In other words, the analyses will not only provide estimates of the impact of the Reentry Waiver on use of each category of service or cost but will further demonstrate if there are reductions in acute care services or costs of such services as ED visits and hospitalizations were achieved.

Alternative Research Design Possibilities

The proposed Reentry evaluation design, especially for Goals 1,2, 6, and 7, depends heavily on establishing collaborations with the CDCR and four focal county correctional facilities to provide data on their populations, releases, inmate health status and service utilization. Thus, the UCLA-RAND Reentry Evaluation team may need to modify significantly the methods if securing the specific data sets is not possible. It is anticipated that the most difficult information to obtain will be automated health service utilization data from correctional facilities (that is not reimbursed by Medi-Cal) to help understand the 90-days before release. The UCLA-RAND Reentry Evaluation team might add a small chart review effort for 100 individuals for services received during the 90-day in-reach period before and after the Waiver implementation to understand how the Waiver impacts the 90-day period prior to release. However, a chart review will still require that the UCLA-RAND Evaluation team obtain specific data sets from correctional agencies. The UCLA-RAND Reentry Evaluation team may need to focus heavily on the Medi-Cal-reimbursed services that individuals receive and outcomes *before* and *after* release from prison or jail since that data will be automated and obtained through DHCS.

The UCLA-RAND Reentry Evaluation team might explore the use of contemporaneous comparison groups post-Waiver including those who refused to sign up for the Waiver or for those who received no Waiver services. However, this will require careful control for factors that may be correlated with the decision to enroll or receive services, and that a large enough sample refused to sign up for the Waiver or did not receive waiver services to be able to draw inferences. 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 Justice-Involved Reentry Initiative. Any delays will impact the evaluation timeline.

Methodological Limitations

As described in the evaluation design, the Reentry cohort is identified through specific eligibility criteria. Identifying these criteria may not be available for incarcerated individuals in the period prior to the Reentry program going live. Because most released individuals qualify for Reentry, even an intention to treat approach and including all released individuals will be a reasonable alternative approach for evaluation and will likely generate conservative estimates of the impact of the intervention.

To the extent possible, we will be assessing data completeness and validity through concordant validity checks with other routinely collected data. Aspects of care within the carceral setting in window of time of eligibility for Reentry for care that should be covered by Reentry may have gold standard comparisons. For example, individuals who are hospitalized or seen in an emergency department will be captured by the carceral setting and by the state hospital discharge and emergency department encounter data sets. Because Reentry covered services should appear in the Medi-Cal data, these data will potentially be comparable to care captured by the carceral setting electronic health record (EHR), such as outpatient visits and prescriptions. Because individuals will be moving directly into managed care after release, post-release services should be more reliably identifiable across all periods.

Despite these potential limitations, the evaluation team will have multiple remedial approaches – as described – to answer the evaluation questions and to ensure a robust assessment of the Reentry Program.

Evaluation Design for the Managed Care Plans Transition (MCP)

General Background Information

Objective

This Evaluation Plan details the ways in which the State will evaluate the transition to limited choice, county-authorized managed care programs. This transition is an amendment to the section 1115(a) CalAIM demonstration and is subject to the limitations of the demonstration as outlined in the special terms and conditions (STCs).⁹⁹ In specific, the STCs require proper monitoring and evaluation of the transition to ensure continuity of care for members, adequate capacity and services, and maintenance of choice in primary care providers.

Background

The California Advancing and Innovating Medi-Cal (CalAIM) 1115 Demonstration, approved by the Centers for Medicare and Medicaid Services (CMS) on December 29, 2021,¹⁰⁰ leverages Medi-Cal as a tool to improve coverage and care for California's most vulnerable populations. The CalAIM Demonstration aims to enhance health care access and outcomes and promote health equity for Medi-Cal recipients and other low-income individuals across the state. Through the Demonstration and associated initiatives, including the 1915(b) waiver also approved by CMS on December 29, 2021, the state is strengthening a population health approach that prioritizes prevention and addresses the social determinants of health.

The December 2021 waiver approvals also shifted authority for the State's managed care delivery systems (Medi-Cal Managed Care, Dental Managed Care, Specialty Mental Health Services, and the Drug Medi-Cal Organized Delivery System) from the previous Section 1115 Demonstration to the CalAIM 1915(b) waiver. This transition was aimed at

⁹⁹ MCP Transition STCs: <https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-ManagedCare-Amendment-Approved.pdf>

¹⁰⁰ CMS Extension Approval: <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-calaim-ext-appvl-12292021.pdf>

streamlining and aligning the programs, improving oversight, and standardizing benefits and enrollment processes within Medi-Cal.

Managed Care Plan (MCP) Transition Amendment

California's Medi-Cal Managed Care delivery system comprises several managed care models that differ by county. Prior to the amendment implementation, all 58 counties in California offered one of the following models:

County Organized Health System (COHS) -- one plan operated by the county;

Two Plan -- one local initiative plan operated by the county and one commercial plan;

Multiple commercial plans -- Geographic Managed Care, Regional, or Imperial models; or

San Benito Model -- one commercial plan and a Fee-for-Service option.

In advance of the State's commercial plan procurement process in 2022, counties were given the chance to propose changes to their managed care models, and the California Department of Health Care Services (DHCS) provisionally approved model modifications in 17 counties; of these counties, 15 sought to transition to a managed care model with a single plan per county, either by expanding an existing COHS model or by creating a new "Single Plan" model (plans that a MCP operates under contract with DHCS, with the authorization and sponsorship of a county or local authority).¹⁰¹ DHCS conditionally approved these county model changes in October, and by December 2021 the involved counties submitted network contracting strategies for operationalization, which were further defined and established between Spring 2022 and December 2023.¹⁰²

On November 4, 2022, DHCS requested an amendment to the CalAIM Section 1115 Demonstration to include expenditure authority to limit choice of managed care plans in Metro, Large Metro, and Urban counties operating under the COHS and Single Plan Models. This limit to model choices was intended to simplify and align managed care programs, standardize benefits and enrollment processes, and strengthen oversight of

¹⁰¹ Medi-Cal Managed Care Plan Model Fact Sheets:

<https://www.dhcs.ca.gov/services/Documents/MMCD/MMCD-Model-Fact-Sheet.pdf>.

¹⁰² [County Plan Model Change Public Timeline](#):

<https://pan.dhcs.ca.gov/services/Documents/MMCD/County-Plan-Model-Change-Public-Timeline.pdf>

these programs throughout the state. CMS approved the amendment request on August 23, 2023. Through a separate submission, DHCS also received an amendment to the CalAIM 1915(b) waiver to reflect use of the rural area exemption for plan choice in rural counties with existing and/or expanding COHS, and rural counties intending to operate a Single Plan. Collectively, the primary aim of these amendments is to reduce administrative complexity for providers, plans, and members, while streamlining State oversight and improving accountability of plans.

Exhibit 18 shows the change in models by county. Not all Medi-Cal members in these counties transitioned to a new MCP, but close to 1.2 million members have been involved in the transition in 2024. Members transitioning to a new MCP received a 90-day notice from their exiting MCP, 60-day and 30-day notices from DHCS’s enrollment broker, and a welcome packet from their receiving MCP in January 2024.

During the MCP Transition (“the Demonstration”), DHCS aimed to minimize service interruptions for members, and particularly for under-resourced groups; provide adequate communications, including outreach and education, to members, providers, and MCPs; and effectively measure and ensure accountability of MCP’s transition responsibilities.

Exhibit 18. Counties Transitioning to a County-Organized Health System (COHS) Model or Single Plan Model under the MCP Transition Amendment

County <i>County Plan Model Type</i>	2023 MCP(s)	2024 MCP(s)
Alameda Two-Plan model (2023) Single Plan model (2024)	Anthem Blue Cross Partnership Plan	Alameda Alliance for Health
	Alameda Alliance for Health	Kaiser Permanente
Butte Regional model (2023) County-Organized Health System model (2024)	Anthem Blue Cross Partnership Plan	Partnership Health Plan of California
	California Health & Wellness	

County County Plan Model Type	2023 MCP(s)	2024 MCP(s)
Colusa Regional model (2023) County-Organized Health System model (2024)	Anthem Blue Cross Partnership Plan	Partnership Health Plan of California
	California Health & Wellness	Partnership Health Plan of California
Contra Costa Two-Plan model (2023) Single Plan model (2024)	Anthem Blue Cross Partnership Plan	Contra Costa Health Plan
	Contra Costa Health Plan	Kaiser Permanente
Glenn Regional model (2023) County-Organized Health System model (2024)	Anthem Blue Cross Partnership Plan	Partnership Health Plan of California
	California Health & Wellness	Partnership Health Plan of California
Imperial Imperial model (2023) Single Plan model (2024)	California Health & Wellness	Community Health Plan of Imperial Valley
	Molina Healthcare of California	Kaiser Permanente
Mariposa Regional model (2023) County-Organized Health System model (2024)	Anthem Blue Cross Partnership Plan	Central California Alliance For Health
	California Health & Wellness	Kaiser Permanente
Nevada Regional model (2023) County-Organized Health System model (2024)	Anthem Blue Cross Partnership Plan	Partnership Health Plan of California
	California Health & Wellness	Partnership Health Plan of California
Placer Regional model (2023) County-Organized Health System model (2024)	Anthem Blue Cross Partnership Plan	Partnership Health Plan of California
	California Health & Wellness	Partnership Health Plan of California
	Kaiser Permanente	Partnership Health Plan of California

County County Plan Model Type	2023 MCP(s)	2024 MCP(s)
Plumas Regional model (2023) County-Organized Health System model (2024)	Anthem Blue Cross Partnership Plan	Partnership Health Plan of California
	California Health & Wellness	Partnership Health Plan of California
San Benito San Benito model (2023) County-Organized Health System model (2024)	Anthem Blue Cross Partnership Plan	Central California Alliance For Health
	Medi-Cal Fee-For-Service	Central California Alliance For Health
Sierra Regional model (2023) County-Organized Health System model (2024)	Anthem Blue Cross Partnership Plan	Partnership Health Plan of California
	California Health & Wellness	Partnership Health Plan of California
Sutter Regional model (2023) County-Organized Health System model (2024)	Anthem Blue Cross Partnership Plan	Partnership Health Plan of California
	California Health & Wellness	Kaiser Permanente
Tehama Regional model (2023) County-Organized Health System model (2024)	Anthem Blue Cross Partnership Plan	Partnership Health Plan of California
	California Health & Wellness	Partnership Health Plan of California
Yuba Regional model (2023) County-Organized Health System model (2024)	Anthem Blue Cross Partnership Plan	Partnership Health Plan of California
	California Health & Wellness	Kaiser Permanente

SOURCE: DHCS Medi-Cal Managed Care Plans by County,
<https://www.dhcs.ca.gov/CalAIM/Documents/MCP-County-Table-2023-2024.pdf>

Also, effective January 1, 2024, DHCS entered a direct contract with Kaiser Permanente (Kaiser) as a Medi-Cal MCP for a five-year contract term. For eligible Medi-Cal members in transition counties in which Kaiser will operate in 2024, Kaiser is included as a MCP option. In effect, Kaiser will operate in parallel with the single plan or COHS county systems Kaiser has committed to growth of new Medi-Cal members of 25 percent from July 1, 2024, (after the end of the PHE unwinding redetermination period and excluding

any population growth resulting from the 2024 default enrollment requirements between January 1, 2024, and June 30, 2024) to the end of the contract term, or December 31, 2028. Kaiser enrollment growth will come from geographic expansion, foster care youth and former foster care youth who elect to enroll in Kaiser, and members dually eligible for Medi-Cal and Medicare residing in Kaiser's geographic service areas, as well as annual enrollment growth through default enrollments in specific counties. There is no enrollment limit for the number of children in foster care, members dually eligible for Medi-Cal and Medicare, and other enrollment resulting from continuity of care rights.

Evaluation Questions and Hypotheses

Implementing expanded COHS and new Single Plan models in select Metro, Large Metro, and Urban counties is consistent with the goals of CalAIM, which include improving quality, access, and accountability. Key drivers in support of this aim are described in [Exhibit 19](#).

Exhibit 19. Driver Diagram for the MCP Transition

Aim	Primary Driver	Secondary Driver
Maintain or improve quality, access to care, and accountability	Maintain or improve access to care	Enhanced protections, included extended eligibility period for out-of-network provider use at the Receiving MCP, for special populations^
		Monitor MCPs' implementation of transition responsibilities
	Ensure continuity of care	Continue medically necessary services for members in an ongoing course of treatment without any form of prior approval and without regard to whether such services are provided by in-network or out-of-network providers
		Allow the member to keep their current PCP
		Automatically enroll dual-eligible members in Medi-Cal Matching Plan counties in a Medi-Cal MCP that matches their Medicare Advantage plan
		Allow transitioning members to keep their out-of-network providers for a 12-month period at their Receiving MCP
		Provide clear communications around the transition (e.g. choice packet sent to members with 60-notice, Welcome Packet from new MCP sent in early January 2023)
	Maintain or improve quality of care	Ensure a whole-person, interdisciplinary approach for populations with complex health care needs
		Report on and regularly monitor quality of care measures during the transition period
		Strengthen and maintain quality of care for vulnerable populations

Aim	Primary Driver	Secondary Driver
	Ensure accountability of MCPs' transition responsibilities	Establish—and provide additional support for existing—Community Advisory Committees
		Provide opportunities to file grievances and appeals, and ensure the State responds within a reasonable period
		Provide transparent information to managed care members by publicly posting MCP and subcontractors' activities (e.g. Population Needs Assessment, CAHPS survey results)
		Expand DHCS oversight responsibilities, including an independent access assessment for network adequacy

NOTE: ^See [DHCS 2024 Medi-Cal Managed Care Plan Transition Policy Guide](#) for definitions.

The evaluation will assess the overall impact of the MCP Transition by analyzing trends prior to and after the implementation of the amendment (i.e., 2021-2023 and 2024-2026). We will also contextualize these changes against the backdrop of the existing CalAIM Demonstration initiatives and other statewide care transformation efforts affecting the managed care model in California overall. [Exhibit 20](#) **Exhibit 20. Summary of MCP Transition Evaluation Design** provides an overview of the high-level evaluation hypotheses and evaluation questions as they relate to the goals of the MCP Transition.

Exhibit 20. Summary of MCP Transition Evaluation Design

Goal 1: Maintain or improve overall access to and continuity of care.				
Evaluation Questions & Hypotheses	Measures	Population(s)	Data Source(s)	Analytic Methods
EQ1A. How many Medi-Cal members were in the 15 MCP Transition counties? How many Med-Cal members switched plans under the MCP Transition? H1A. N/A (descriptive)	» Medi-Cal members residing in MCP Transition counties » Medi-Cal members required to switch MCPs under the MCP Transition	Members in MCP Transition counties; members who switched MCPs under the transition	» Enrollment data	Descriptive analyses
EQ1B. What were the characteristics of Medi-Cal members in MCP Transition counties? H1B. N/A (descriptive)	» Sociodemographic characteristics of members in MCP Transition counties	Members in MCP Transition counties	» Enrollment data	Descriptive analyses, pre-post analyses
EQ1C. What was the effect of the Demonstration on access to care? H1C. The Demonstration will maintain or improve access to care: network adequacy will stay the same or increase, and access to care grievances will stay the same or decrease.	» Network adequacy (i.e., member-to-provider ratios) » Access to care grievances	MCP Transition counties	» Interviews with members » DHCS grievance data » DHCS Network Adequacy Monitoring data (i.e., 274 Provider File and MIS/DSS enrollment data)	Descriptive analyses; thematic analysis of interviews
EQ1D. To what extent did access to preventive/ ambulatory health services change under the MCP Transition? H1D. The Demonstration will maintain or improve access to preventive/ ambulatory health services: rates of well-child visits, immunizations for adolescents, and timeliness of prenatal and postpartum care will stay the same or increase.	» Well-child visits » Immunizations for adolescents » Timeliness of prenatal and postpartum care	Members in MCP Transition counties	» MCAS data; Core Set data	Descriptive analyses; pre-post analyses (<i>Paired t-tests; chi-squared tests</i>)
EQ1E. To what extent did access to behavioral health services change under the Demonstration? H1E. The Demonstration will maintain or improve access to behavioral health services: rates of follow up after ED visit for mental illness and non-specialty mental health member-to-provider ratios will stay the same or increase.	» Follow up after ED visit for mental illness » Non-Specialty outpatient mental health member-to-provider ratio	Members in MCP Transition counties	» MCAS data; DHCS Network Adequacy Monitoring data (i.e., 274 Provider File and MIS/DSS enrollment data)	Pre-post analyses (<i>Paired t-tests; chi-squared tests</i>)
EQ1F. What was the effect of the Demonstration on continuity of care? H1F. The Demonstration will maintain or improve continuity of care: continuity of care grievances will stay the same or decrease.	» Continuity of care grievances	MCP Transition counties	» DHCS grievance records » Interviews with members	Pre-post analyses (<i>Paired t-tests; chi-squared tests</i>); thematic analysis of interviews

Goal 2: Maintain or improve quality of care.				
Evaluation Questions & Hypotheses	Measures	Population(s)	Data Source(s)	Analytic Methods
EQ2A. What was the impact of the Demonstration on quality of care? H2A. The Demonstration will maintain or improve quality of care: rates of breast cancer screening and immunizations for adolescents will stay the same or increase, and all-cause readmissions will stay the same or decrease.	» Breast cancer screening » Immunizations for adolescents » Plan all-cause readmissions	Members in MCP Transition counties	» MCAS data; Core Set data » Interviews with members	Difference-in-Differences or Comparative Interrupted Time Series; thematic analysis of interviews

Goal 3: Maintain or improve access to high-quality, continuous care among historically marginalized and under-resourced populations.				
Evaluation Questions & Hypotheses	Measures	Population(s)	Data Source(s)	Analytic Methods
EQ3A. To what extent were historically marginalized and under-resourced populations, who were members living in MCP Transition counties, enrolled in the Demonstration? H3A. N/A (descriptive)	» Sociodemographic characteristics of members in MCP Transition counties	Members in MCP Transition counties by equity relevant sub-populations^	» Enrollment data	Directed content analysis of secondary data; Descriptive analyses; Pre-post analyses
EQ3B. What was the effect of the Demonstration on access to care among historically marginalized and under-resourced populations? H3B. The Demonstration will maintain or improve access to care among historically marginalized and under-resourced populations: network adequacy will stay the same or increase, and access to care grievances will stay the same or decrease, within subgroups of such populations.	» Network adequacy (e.g. member-to-provider ratio) » Access to care grievances	Members in MCP Transition counties by equity relevant sub-populations^	» Interviews with members » DHCS grievance data » DHCS Network Adequacy Monitoring data (i.e., 274 Provider File and MIS/DSS enrollment data)	Descriptive analyses; thematic analysis of interviews
EQ3C. To what extent did access to preventive/ ambulatory health services change under the Demonstration among historically marginalized and under-resourced populations? H3C. The Demonstration will maintain or improve access to preventive/ ambulatory health services among historically marginalized and under-resourced populations: rates of well-child visits, immunizations for adolescents, and timeliness of prenatal and postpartum care will stay the same or increase within subgroups of such populations.	» Well-child visits » Immunizations for adolescents » Timeliness of prenatal and postpartum care	Members in MCP Transition counties by equity relevant sub-populations^	» MCAS data; Core Set data	Descriptive analyses; Pre-post analyses (<i>Paired t-tests; chi-squared tests</i>)
EQ3D. To what extent did access to behavioral health services change under the Demonstration among historically marginalized and under-resourced populations? H3D. The Demonstration will maintain or improve access to behavioral health services among historically marginalized and under-resourced populations: rates of follow-up after ED visits for mental illness will stay the same or increase within subgroups of such populations.	» Follow up after ED visit for mental illness	Members in MCP Transition counties by equity relevant sub-populations^	» MCAS data	Pre-post analyses (<i>Paired t-tests; chi-squared tests</i>)
EQ3E. What was the effect of the Demonstration on continuity of care among historically marginalized and under-resourced populations? H3E. The Demonstration will maintain or improve continuity of care among historically marginalized and under-resourced populations: continuity of care	» Continuity of care grievances	Members in MCP Transition counties by equity relevant sub-populations^	» DHCS grievance records » Interviews with members	Pre-post analyses (<i>paired t-tests; chi-squared tests</i>); Thematic analysis of interviews

Goal 3: Maintain or improve access to high-quality, continuous care among historically marginalized and under-resourced populations.				
Evaluation Questions & Hypotheses	Measures	Population(s)	Data Source(s)	Analytic Methods
grievances will stay the same or decrease within subgroups of such populations.				
EQ3F. What was the effect of the Demonstration on quality of care outcomes for members among historically marginalized and under-resourced populations? H3F. The Demonstration will maintain or improve quality of care outcomes among historically marginalized and under-resourced populations: rates of breast cancer screening and immunizations for adolescents will stay the same or increase, and all-cause readmissions will stay the same or decrease, within subgroups of such populations.	» Breast cancer screening » Immunizations for adolescents » Plan all-cause readmissions	Members in MCP Transition counties by equity relevant sub-populations^	» MCAS data; Core Set data	Difference-in-Differences or Comparative Interrupted Time Series

Goal 4: Reduce administrative complexity for plans.				
Evaluation Questions & Hypotheses	Measures	Population(s)	Data Source(s)	Analytic Methods
EQ4A. To what extent did the MCP Transition impact plan administrative workflows, and how? H4A. The Demonstration will reduce administrative complexity for plans.	» Qualitative data- plan perspectives	Plans in MCP Transition Counties	» Interviews with health plan officials	Thematic analysis of interviews

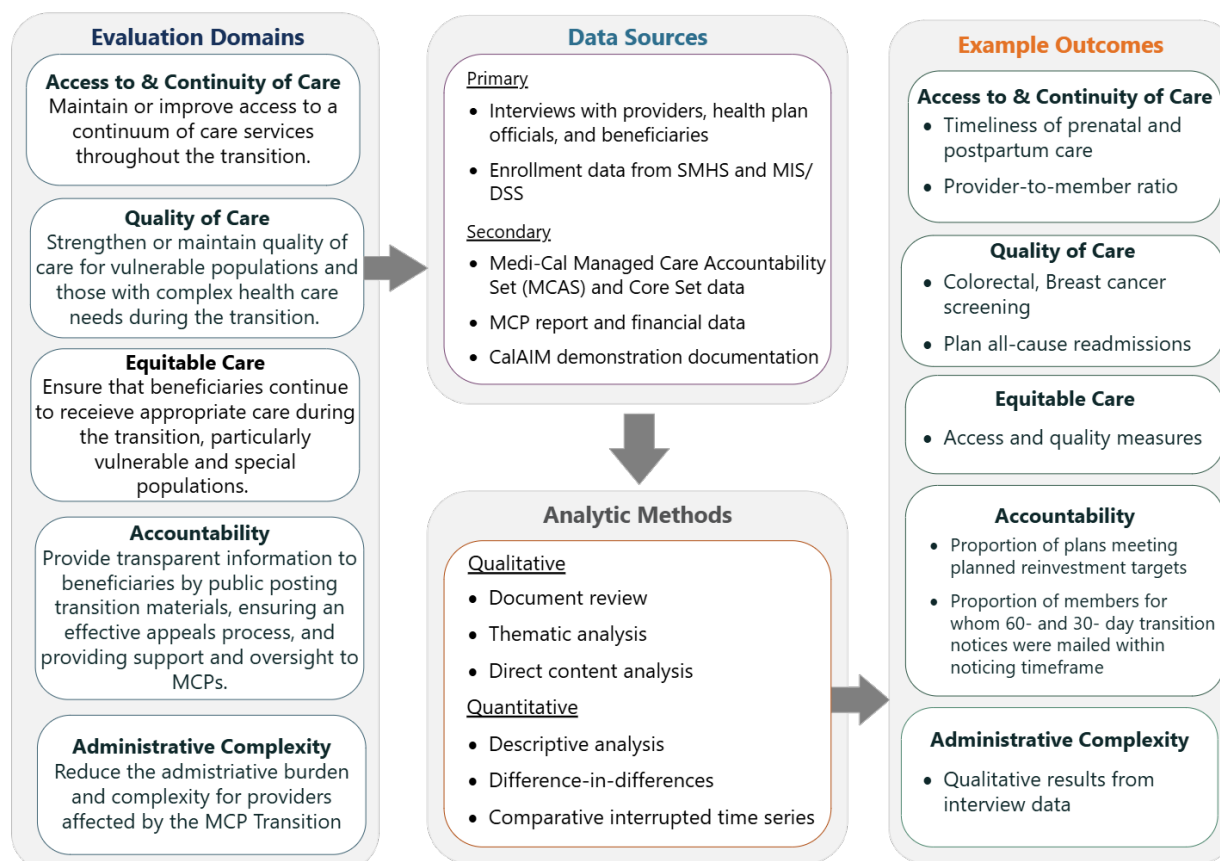
Goal 5: Maintain plan accountability and improve transparency.				
Evaluation Questions & Hypotheses	Measures	Population(s)	Data Source(s)	Analytic Methods
EQ5A. To what extent did plans establish and execute their Community Reinvestment Plans, and how? H5A. Plans will adhere to transition requirements and execute Community Reinvestment plans.	» Proportion of plans meeting planned reinvestment targets (as defined in Community Reinvestment Plans)^ » Qualitative data—plan and stakeholder perspectives	Plans in MCP Transition Counties	» Document review of Community Reinvestment Plans, MCP Annual Reports, financial information^^ » Interviews with health plan officials » Focus groups with DHCS Member Stakeholder Committee	Directed content analysis of secondary data, thematic analysis of interviews
EQ5B. To what extent did plans publish required performance and operations documentation as required? H5B. Plans will adhere to transition requirements and publish required performance and operations documentation.	» Proportion of plans developing and making publicly available programmatic and financial documentation (i.e., Community Reinvestment Plans, Population Needs Assessments, MCP Annual Reports, etc.) within required timeframes	MCP Transition Counties	» Websites for plans in MCP transition counties	Web scan with directed content analysis

NOTES: ^ Equity relevant subgroups include race/ethnicity, age, sex, and preferred language. For additional information on equity relevant subgroups, see the “Identifying Target and Comparison Populations” subsection. ^^Data content and availability permitting; to be included in Summative Evaluation Report only.

Methodology

This evaluation will employ both quantitative and qualitative methods to assess overall impact of the MCP Transition on members, plans, and providers. The proposed approach reflects the aims that DHCS has identified as priorities for this evaluation, which in turn will guide the framing of hypotheses, data sources, measures, analytic approaches, and findings. The evaluation will use both primary and secondary data. Qualitative analysis will be used to describe the core components and status of transition activities in each county, as well as the experiences of directly affected parties (i.e., members, plan officials, and other interest holders) and their perceptions of the transition's impact on care continuity and access. Quantitative analysis will be used to better understand trends in selected process and outcome measures before and after the transition. [Exhibit 21](#) provides a visual overview of the evaluation design.

Exhibit 21. Overall Approach to the Evaluation of the MCP Transition



Evaluation Period

The evaluation period will cover the implementation of the MCP Transition on January 1, 2024, through the end of the amendment approval on December 31st, 2026. Our quantitative impact analysis will use data from 2021-2023 as a baseline period and 2024-2026 as the implementation period. In the Interim Evaluation Report, our quantitative analyses will include all outcome data available up to the time of analysis, and in the Summative Evaluation Report, we will be able to evaluate the entire post-implementation period.

Quantitative Evaluation

The below sections detail our approach to evaluating the MCP Transition, including identification of target and comparison populations, data sources, outcome measures, and statistical analyses.

Target Population: Medi-Cal members in MCP Transition counties. The target population will be all Medi-Cal members enrolled for at least one year residing in the 15 MCP Transition counties (Alameda, Butte, Colusa, Contra Costa, Glenn, Imperial, Mariposa, Nevada, Placer, Plumas, San Benito, Sierra, Sutter, Tehama, and Yuba) over the course of 2021-2026, the baseline and implementation period.¹⁰³ Medi-Cal members in these counties who have been enrolled one year or more are included in the target population to assess whether the county-level MCP Transition affected access and quality outcomes for all members in the county (including members whose individual coverage did not change under the MCP Transition). As discussed in more detail below, we will assess the differential effects on members whose coverage changed under the MCP Transition and those whose coverage did not change, if sufficient data permit.

Comparison Population: The Medi-Cal members residing in non-MCP Transition counties that were *eligible to request to participate in the MCP transition but did not make that request* will serve as the pool for selecting a comparison group. Using a propensity score or coarsened exact matching method, we will identify comparison counties based on their similarity to MCP transition counties on key county-level characteristics (e.g. availability of services, county governance structure and delivery

¹⁰³ DHCS (December 2023) "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>

system characteristics), working closely with the state to determine the full list of characteristics.

Addressing selection bias. Because the MCP transition was implemented non-randomly (i.e., counties requested to implement the MCP transition), there may be systematic differences between Medi-Cal members in the treatment and comparison counties. To obtain unbiased estimates of impacts, we propose addressing selection bias using entropy balancing (EB). Unlike other matching or weighting methods such as propensity scores, ensuring a balance between groups on key covariates is the primary objective of EB¹⁰⁴. Additionally, unlike matching methods, EB uses all available comparison observations, which retains as much information as possible. The EB models will include member-level demographics and coverage characteristics, member-level clinical characteristics, and area-level community and healthcare delivery system characteristics, which will ensure that the treatment and comparison groups are similar on these key factors.

We will work closely with the state to determine the full set of EB covariates. We anticipate incorporating the following covariate domains in our EB models:

- » **Member-level demographics and coverage characteristics:** e.g., age, sex, race/ethnicity, dual eligibility status, type of Medicaid coverage, and months of enrollment in Medicaid.
- » **Area-level community characteristics:** e.g., educational attainment, provider density, unemployment rate, area deprivation index (ADI), HPI, SDI/SVI, or comparable index.

After producing EB weights, we will assess the balance of each covariate by measuring the standardized difference between the treatment and comparison groups. We will consider a characteristic to be adequately balanced if the standardized difference between the groups is within (-0.1, 0.1) and will document this with covariate balance plots. In the event that a suitable comparison group cannot be identified (i.e. balance cannot be achieved on key characteristics), we will select statistical analyses that do not require a comparison group.

¹⁰⁴ Hainmeuller J. (2012). Entropy balancing for causal effects: A multivariate reweighting method to produce balanced samples in observational studies. *Political Analysis* 25(1) 1:25-46.

Quantitative Data Sources

We will use quantitative data sources to construct evaluation measures assessing access to and quality of care, continuity of care, and equity outcomes in each treatment and comparison county. We propose using member-level Medi-Cal enrollment data, member-level Medi-Cal Managed Care Accountability Set (MCAS) data and Medicaid and CHIP Core Sets of Health Care Quality measures data,¹⁰⁵ and publicly available community-level data to conduct our analyses. These data sources are summarized in [Exhibit 22](#).

¹⁰⁵ Based on the limitations associated with NORC reconstructing outcome measures using claims data and the desire to leverage existing metrics already being reported by the state, we will use the person-level pre-calculated values from the MCAS and Core Set data for outcome metrics.

Exhibit 22. Quantitative Data Sources for the MCP Transition Evaluation

Data Source	Proposed Use
Data Provided by DHCS	
Medi-Cal Enrollment Data	Medi-Cal enrollment data contain member-level demographic and coverage information. We will use the enrollment data to identify Medi-Cal members in treatment and comparison groups, and construct member-level covariates that reflect members' demographic and coverage characteristics.
Medi-Cal Managed Care Accountability Set (MCAS) and Medicaid and CHIP Core Sets of Health Care Quality	These files represent datasets of standardized health care quality measures that states must submit to CMS annually. Person-level MCAS and Core Set files in each year will be used to construct outcome measures on access to, quality, and continuity of care for each member.
MCP Grievances Data	Grievance data contains member level information on grievances from the MCP. Grievances are summarized with the grievance type (e.g., access to care, provider availability), grievance category, benefit type and resolution date and status. We will use the grievance data to assess access to care and continuity of care.
Community-Level Data	
American Community Survey (ACS)	The ACS is a national survey providing area-level data on topics such as demographics, education, employment, income, and housing. We will use ACS data to identify county-level sociodemographic characteristics of counties as a basis for selecting comparison counties, conducting entropy balancing, and adjusting regression models.

Data Source	Proposed Use
Area Deprivation Index (ADI), Healthy Places Index (HPI), Social Deprivation Index (SDI), Social Vulnerability Index (SVI), or similar data measuring community health and resilience	The ADI, HPI, and SDI/SVI are examples of tools that assess a community's characteristics impacting health, and well-being. We will work with DHCS to determine the appropriate data source for measuring community health and resiliency, and use this data at the county-level in entropy balancing models and adjusted regression models to control for an individual's environmental characteristics affecting access and equity of care.
Rural-Urban Continuum Codes (RUCCs) [^]	RUCCs are used to categorize rurality based on a county's level of urbanization and proximity to metropolitan areas. We will use RUCC data to select comparison counties, conduct entropy balancing, and adjust regression models.
COVID-19 Pandemic Vulnerability Index (PVI)	The PVI is a tool that integrates multiple data sources into an overall county-level score derived from key indicators in four domains: current infection rates, baseline population concentration, current interventions, and health and environmental vulnerabilities. The last full year of available data is calendar year 2022—we plan to use this index to adjust for baseline variation in COVID-19 vulnerability scores.

NOTE: [^]There are many rural classification systems; NORC will work with DHCS to select the most appropriate definitions and data sources for defining and adjusting for rurality.

Quantitative Evaluation Measures

The quantitative evaluation measures that will be constructed from the person-level MCAS and Core Set files and provider 274 files are summarized in [Exhibit 23](#). Measures cover the domains of access to care, behavioral, maternal, and preventive healthcare and are based on CMS Core Set and or NCQA/HEDIS technical specifications. Before inclusion in the IER and/or SER, NORC will work with DHCS to conduct a thorough feasibility assessment for each metric based on data quality, timeliness, and availability.

In particular, NORC and DHCS will determine whether the MCAS or Core Set data are a more appropriate source for each metric.

Exhibit 23. Quantitative Measures for MCP Transition Evaluation

Measure Name	Description	Numerator	Denominator
Child and adolescent well-care visits	Percentage of children ages 3 to 21 who had at least one comprehensive well-care visit with a primary care practitioner (PCP) or an obstetrician/gynecologist (OB/GYN) during the measurement year	Number of members in the eligible population with one or more well-care visits during the measurement year	Number of members in the eligible population
Follow-up after ED visit for mental illness	Percentage of emergency department (ED) visits for members ages 18 and older with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness within 7/30 days.	Number of eligible follow-up visits within 7 or 30 days of the eligible ED visit including visits that occur on the date of the ED visit	Number of eligible ED visits with a principal diagnosis of mental illness or intentional self-harm
Plan all-cause readmissions	For members ages 18 to 64, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.	Number of observed 30-day readmissions	Number of index hospital stays in the eligible population

Measure Name	Description	Numerator	Denominator
Well-child visits in the first 30 months of life	Percentage of children who had the appropriate number of well-child visits with a primary care practitioner (PCP) during the last 15 months. Separate rates are reported for children who turned ages 15 and 30 months within the measurement year.	The number children in the eligible population with the appropriate number of well-child visits on different dates of service on or before the 15/30 month birthday.	Number of members in the eligible population
Immunizations for adolescents	Percentage of adolescents aged 13 who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates.	Number of patients in the eligible population that are vaccine compliant	Number of members in the eligible population

Measure Name	Description	Numerator	Denominator
Prenatal and postpartum care	• Timeliness of Prenatal Care: Percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment state date or within 42 days of enrollment. • Postpartum Care: Percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery	Prenatal care: A prenatal visit during the required time frame. Postpartum care: A postpartum visit on or between 7 and 84 days after delivery.	Members within the eligible population with a live birth. Members can count multiple times if they have multiple births.
Breast cancer screening	Percentage of women ages 50 to 74 who had a mammogram to screen for breast cancer.	Number of members in the eligible population who had one or more mammograms any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year.	Number of members in the eligible population

Measure Name	Description	Numerator	Denominator
Non-Specialty outpatient mental health member-to-provider ratio	Number of members per outpatient mental health (non-psychiatry) provider (shown as # members to 1 provider)	Number of members enrolled in plan	Number of outpatient mental health (non-psychiatry) providers contracting with plan
Member-to-provider ratio	The ratio of members to providers.	Number of members enrolled in plan	Number of providers contracting with plan

NOTE: Measures constructed from enrollment and claims/encounter data; all measures listed except the provider member ratio are endorsed by the National Committee for Quality Assurance (NCQA).

Statistical Analyses

We will conduct quantitative descriptive and impact analyses for evaluating the MCP Transition, based on data availability and feasibility of assessing outcomes in groups over time, described in more detail below. Before starting analyses, we will conduct evaluability assessments to ensure we are selecting the most appropriate approach for each analysis, that key assumptions are met, and that we have sufficient sample size to estimate impacts.

Descriptive Analyses. Descriptive statistics, including frequency distributions and rates over time, will be calculated to highlight trends over time in member-level characteristics and key outcomes. We will tabulate descriptive statistics in each year (time-series analyses) and pooled in baseline and treatment periods (pre-post analyses) to assess changes over time in the baseline years (January 2021 – December 2023) and years after the MCP Transition (January 2024 – December 2026). We will conduct descriptive analyses for both member-level characteristics, to show changes in member populations over time before and after the MCP transition, as well as for all outcome measures ([Exhibit 23](#)). We will present the descriptive analyses in tables and exhibits in the Interim Evaluation Report and Summative Evaluation Report.

Pre-Post Analysis. We will use pre-post analyses to report statistically significant changes in outcome measures before and after the transition. These analyses will also inform the development of impact analyses below.

Impact Analysis. If a suitable comparison group is available, we propose using difference-in-differences (DID) or comparative interrupted time series (CITS) analysis as our primary approach to estimate the impact on access, quality, and continuity of care under the MCP transition.¹⁰⁶ The DID models will compare the changes in means during the baseline (2021-2023) and post-MCP Transition (2024-2026) periods between the treatment and comparison counties, controlling for any time-invariant differences between the groups to estimate the impact of the MCP transition.

The DID model will be specified as:

$$gg[EE(Y_{itct})] = \beta_0 + \beta_1 MMMMM_{it} + \beta_2 MMPPPP_{it} + \beta_3 MMMMM_{it} * MMPPPP_{it} + \gamma_1 MMYYYY_{itct} + \delta_1 MMPP\delta\delta\delta\delta_{itct} + \rho_1 MMPP\delta\delta\delta\delta * YYYY_{itct}$$

In this model, i indexes an individual member and t indexes the time period (baseline or post-MCP transition), and c indexes county. Y represents the outcome of interest, for an individual, MCP is an indicator for treatment or comparison group, and $Post$ is an indicator for time period (post-MCP transition). Member-level covariates are included in the model for risk adjustment. To control for time-invariant differences across counties, we will include fixed effects for each county and county-specific time trend.¹⁰⁷ Analyses will be conducted on data pooled across all MCP transition and comparison counties, allowing us to estimate one estimate of impact for the MCP transition overall (i.e., no county-level impacts will be estimated). An additional analysis will compare the counties in which Kaiser has a direct contract with the state to their matched control county. We will compare results with that of the main analysis to determine whether there are meaningful differences.

A key assumption of the DID model is that baseline trends between the treatment and comparison groups are parallel, meaning that any differences in outcomes between the two groups remain constant over time in the absence of the MCP transition. If we empirically observe that this assumption is violated (i.e., that baseline trends between the groups are not parallel), we will be unable to produce unbiased estimates of impact using a DID model. Instead, in these cases we propose assessing the feasibility of using a CITS model; this model is more flexible than the DID model in that it does not require baseline trends to be parallel between the two groups (i.e., it allows for changes in both

¹⁰⁶ If constructing a suitable comparison group is not feasible, we will instead include pre-post analyses and time-series analyses without a comparison group.

¹⁰⁷ If these fixed effects result in multicollinearity, we will instead control for a set of area-level characteristics.

the level and the rate of change of the outcome in the treatment group relative to the comparison group).

Covariate Adjustment. We will account for key covariates that affect the relative risks of the study measures through covariate adjustment. We will adjust for member-level covariates such as sex, age, race and ethnicity, and chronic conditions. Potential area-level covariates include socioeconomic characteristics (e.g., median income, education) derived from publicly available datasets like the American Community Survey, the ADI, HPI, SDI/SVI, or a comparable index, and the Rural-Urban Continuum Code data. Finally, to account for potential differential effects of the COVID-19 Public Health Emergency, we will adjust for area-level COVID-related variables, such as Pandemic Vulnerability Index.

Because beneficiary- and market-level characteristics are largely time-invariant, we propose that these covariates be measured at baseline. Because area-level COVID data is not available after the end of the Public Health Emergency in May 2023, COVID-related covariates would also be measured at baseline and included as time-invariant. For all models, we will consider interactions and higher-order terms.

Subgroup Analysis. Recognizing that the impact of the MCP Transition may be heterogeneous across different member populations, we will carry out subgroup analyses to evaluate whether and how program impacts vary. As with the overall analyses, we will conduct evaluability assessments and confirm that all relevant assumptions (e.g., sample size) are met for any proposed statistical analyses within subgroups of interest. We will assess conducting subgroup analysis for both descriptive and impact analyses. We anticipate being able to conduct descriptive analyses for most if not all subgroups; the feasibility of conducting impact analyses for subgroups will be determined empirically based on sample size and outcome distributions.

We will first consider analyses within subgroups defined by member characteristics (e.g., member age, sex, race/ethnicity, preferred language), including all relevant subpopulations (as described previously). We will also explore other subgroups as observed in eligibility data (e.g., Medicaid-only, dual) or by belonging to under-resourced communities (defined by deprivation indices such as ADI, HPI, SDI/SVI, or a comparable index). We will also explore subgroups of members who transitioned out of their previous MCPs as compared to members retained by their incumbent plan in the county. Finally, because the MCP Transition in Metro, Large Metro, and Urban counties fall under different waiver authorities than in Rural counties, we will assess whether there were differential outcomes for these two subgroups.

Qualitative Evaluation

In addition to the quantitative assessments described above, we propose collecting and analyzing qualitative data via 1) document review of transition-related documentation and 2) key informant interviews with health plan officials, Community Advisory Committee members, and providers and members in transitioning counties. Collectively, these data will provide a richer understanding of the depth and breadth of transition activities at ground level, as well as how various key groups (implementation partners, providers, and members) experienced the transition and their perspective on changes and impacts they have observed.

Primary data collection and document review will focus primarily on the waiver implementation period. Interviews may include discussion of pre-implementation activities and differences in member experience of care before and after the transition, and document review will similarly consider descriptions of the plan and service landscape before and after the transition occurred. These retrospective, largely open-ended data will enable us to understand waiver implementation and impacts, and can help understand the “pre” and “post” period but should not be considered a true “pre”/“post” assessment as we are not able to systematically gather qualitative data before the transition occurred.

Qualitative Data Sources and Data Collection

Document Review

To better understand the components, context and status of the transition in each participating county, we will review select transition-related documentation generated by MCPs, the State, and other relevant groups including but not limited to Demonstration quarterly reports, and documents that must be developed and made public by each transitioning plan (i.e., Community Investment Plans and related annual reports, Population Needs Assessments, CAHPS survey results, financial information, such as profits and reserves, and third party Memoranda of Understanding (MOUs)¹⁰⁸). We will prioritize for review documents for which we have comparable data for all transitioning counties. Publicly available data will be collected via web scan and

¹⁰⁸ DHCS (2023). *Understanding the 2024 Medi-Cal Managed Care Plan (MCP) Transition*. Prepared by the California Primary Care Association. December 12, 2023. Available at: <https://www.dhcs.ca.gov/MCP-Transition/Documents/CPCA-MCP-Transition-Webinar-December-2023.pdf>.

analyzed on an annual basis; additional, non-public documentation will be collected and analyzed on an ongoing basis as it is made available.

Primary Data Collection

We aim to conduct semi-structured interviews and focus groups with individuals from key groups directly involved in and/or affected by the MCP Transition process in a sample of counties participating. These interviews will provide critical perspective of how the transition was understood and experienced by the individuals who stand to be affected by it (i.e., MCP officials, providers, and members) as well as those advising on its rollout (i.e., DHCS Stakeholder Committee).

Participants and Data Collection Approach

Members: We propose conducting 30-45-minute 1:1 virtual interviews with 2-3 adult (i.e., 18 years or older) members in each MCP Transition county, for a total of up to 45 interviews. Interviews will be conducted in English and Spanish. Participants will be compensated with a gift card incentive (for non-resalable goods or services) in recognition of their time.

- » **Timing:** Year One (2025), to limit recall bias about the transition.
- » **Sampling:** We will consider two options for identifying participants, pending availability and quality of contact information in MIS/DSS data.
 - If contact information is available in MIS/DSS, we will draw a random sample of adult members who experienced a transition of plans from each of the 15 counties.
 - If contact information is NOT available in secondary data, we will work with DHCS and the DHCS Stakeholder Committee group and county-specific Community Advisory Committees to identify a convenience sample of adult members from each of the 15 counties.
- » **Recruitment:** Our recruitment approach will be largely determined based on the type and quality of contact information available; we will work with DHCS to identify the optimal approach (e.g., U.S.-mailed postcard, phone, email) once data availability and quality are determined. Recruitment materials will be translated into and made available in Spanish.

- » **Topics:** How and when they were notified of the transition and their plan options; barriers/challenges and facilitating factors they encountered during the transition; and any perceived changes or interruptions in care access, quality and continuity

Health plan officials: We propose to conduct 60-minute group interviews with health plan officials from each MCP transition county, for a total of up to 17 group interviews.

- » **Timing:** Years One and Two, to assess planned and actual transition-related activities and the degree to which activities aligned with plan- and Demonstration-specific objectives regarding care access and continuity.
- » **Sampling:** Purposeful sample of health plan officials within counties, with a focus on health plan leadership and other key roles associated with the transition.
- » **Recruitment Approach:** Recruitment via email and/or phone, after securely gathering contact information from DHCS.
- » **Topics:** Plan's outreach and enrollment strategies; investments in primary care and prevention; efforts to improve the integration of behavioral health care services; Community Reinvestment Plans; and engagement with Community Advisory Committees.

DHCS Stakeholder Advisory Committee Members: NORC will conduct a 90-minute virtual focus group with DHCS Stakeholder Advisory Committee members at two time points (two sessions, up to eight individuals at each session for a total of 16 participants). Participants will be compensated with a gift card incentive (for non-resalable goods or services) in recognition of their time.

- » **Timing:** Year One and again in Year Three, to assess planned and actual transition-related activities and the degree to which activities aligned with plan- and Demonstration-specific objectives regarding care access and continuity.
- » **Sampling:** Convenience sample of individuals serving on DHCS Stakeholder Advisory Committee, identified in consultation with DHCS and prioritizing those with active/substantial engagement in transition-focused Committee feedback gathering prior.
- » **Recruitment Approach:** Recruitment via email and/or phone, after securely gathering contact information from DHCS.

- » **Topics:** Community awareness/experience of transition, and changes or interruptions in care received and service offerings; implementation and impacts of Community Reinvestment Plans.

Qualitative Analyses

Directed Content Analysis of Secondary Data

Using both a programmatic and direct content analytic approach to document review, we will review, code, and construct measures from plan and DHCS-developed documentation related to the transition, including MCP Annual Reports, Population Needs Assessments, Community Reinvestment Plans, and MOUs. Data will be descriptively analyzed and maintained in a county-level dataset. Where relevant, measures will be linked to interview and focus group data to examine the transition experience of different county subgroups.

Thematic Analysis of Interviews and Focus Groups

We will analyze member, provider, plan and DHCS Stakeholder Advisory Committee interviews using a thematic analytic approach. To this end, we will deductively develop a codebook in alignment with evaluation framework domains and qualitative-driven hypotheses, and inductively refine it based on emergent themes and concurrent findings arising from the document review. To organize program documents and interview transcripts for coding, we will use Dedoose, a cloud-based analytic software. Before coders analyze study data, they will be trained and will complete several rounds of pilot coding exercises to establish robust inter-rater reliability. Whenever possible, coders will have been involved in interview data collection, to leverage their insights gained through first-hand experience.

Methodological Limitations

Evaluations of 1115 demonstrations necessitate a flexible and adaptive approach, and we anticipate that methodological challenges will arise during the evaluation process. [Exhibit 24](#) outlines the anticipated challenges along with proposed mitigation strategies.

Exhibit 24. Anticipated Methodological Challenges and Proposed Mitigation Approaches

Challenge	Mitigation Approach
Timeliness and quality of MCAS and Core Set data	» Work closely with DHCS data stewards to receive the most recent data, identify appropriate timeframes for run out, and quickly address any data quality issues. » Create automated reports that identify potential quality issues (e.g., missingness, disallowed values) in data elements used in evaluation analyses, which will be conducted immediately upon receipt of data from DHCS.
Constructing a valid comparison group	» Select comparison counties based on eligibility for the MCP transition as well as key county-level characteristics (e.g., aggregate sociodemographic characteristics, rurality) to ensure we are selecting similar counties as comparators. » Use entropy balancing to weight comparison group members to be similar to members in MCP transition counties on key characteristics in descriptive and impact analyses.
Non-parallel pre-intervention (baseline) trends	» Assess baseline trends in intervention and non-intervention counties; if baseline trends are not parallel, conduct CITS analyses instead of DID analyses.
Insufficient post-intervention cases to establish a trend	» Empirically assess the appropriate level of analysis from available data (e.g., annual, quarterly, monthly) that will establish stable trends while retaining the most granular level of data to feasibility conduct analyses. » Consider reserving DID or CITS analyses until the Summative Evaluation Report, when complete data on outcomes for members in 2024-2026 are available.
Potential bias introduced by primary data collection recruitment approach	» Pending type and quality of contact information available in secondary data, utilize sequential, multi-mode outreach approach (e.g., mail with phone follow-up) to reduce bias that may be introduced by using a single mode alone (i.e., inadvertent exclusion of those with limited or inconsistent access to technology, or with recent changes in residence).

Challenge	Mitigation Approach
Primary data collection respondent burden	» Thoroughly assess and leverage existing data sources (for example, program documents) before considering primary data collection. » Conduct primary data collection over videoconferencing rather than in person to be more flexible with respondents' time. » Compensate members and DHCS Stakeholder Committee members for their time.
Primary data collection respondent recall bias	» Provide framing language to remind participants of timeline of transition and transition notification. » Focus interview topics on perceived changes arising during and after the transition occurred, allowing for feedback on changes observed over broader transition period. » Conduct primary data collection in the first half of 2025, to maximize recall.

Independent Evaluator

In June 2024, DHCS selected NORC at the University of Chicago as the Independent Evaluator for the Managed Care Transition 1115 Demonstration via a direct contract process due to Public Contract Code exemption. The evaluation contract was finalized in October 2024. NORC will conduct an evaluation of the Demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. NORC agreed to conduct the Demonstration evaluation in an independent manner in accordance with the CMS-approved, draft Evaluation Design.

In addition to the design, NORC will be responsible for developing draft and final versions of the evaluation design, final measure selection, conducting data collection and analysis, interpreting results, and drafting the Interim and Summative Evaluation Reports.

Conflict of Interest Compliance Process

Overview

NORC has robust policies and procedures for avoiding and mitigating potential conflicts of interest on programs such as this. For this solicitation, ***Evaluation of the California Managed Care Transition 1115 Waiver*** NORC has no known actual or potential conflict of interest. NORC has no known organizational or personal conflicts of interest that might cause biased judgment. NORC does not have access to nonpublic information that will provide an unfair competitive advantage.

Introduction

National Opinion Research Center (“NORC”) is a prominent not-for-profit research firm that is well known for its scientific excellence, independence, and integrity. The majority of NORC’s business is performed through contracts and grants with the federal government. Given the importance of NORC’s reputation for successful business activity and its position as a federal contractor, a robust and well-proven Conflict of Interest (“COI”) regime is in place to ensure (1) the prevention of COIs from developing in the first place, and (2) the identification and remediation of any COIs effectively and immediately in the rare cases they do occur. NORC has developed COI procedures described herein to fulfill the requirements set forth in ***Evaluation of the California Managed Care Transition 1115 Waiver*** We provide details on our tailored COI processes in the remainder of this document.

NORC Compliance Officer

NORC Vice President, Bess Welch, serves as NORC’s Conflicts Compliance Officer. The Conflicts Compliance Officer reports directly to NORC’s Board of Trustees for all compliance and conflicts matters. NORC’s Conflicts Compliance Officer reviews and has auditing authority for all business and contractual relationships and activities of NORC.

Independent and Impartial

NORC is an independent 501 (c) 3 not-for-profit organization. NORC has its own Board of Trustees (16). NORC is affiliated with the University of Chicago in that the President of the University can nominate 51% of NORC’s Trustees. However, all of NORC’s Trustees have a fiduciary responsibility to act in NORC’s best interest while making decisions as Trustees of NORC. The University of Chicago has its own independent Board of Trustees which is required to make decisions in the best interest of the University.

Conflicts Policies and Procedures

NORC maintains policies and procedures for organizational conflicts of interest and personal conflicts of interest, each described in turn below. Each item below describes the particular conflicts oversight process including how conflicts are identified and resolved.

1. Organizational Conflicts

All staff are required to identify potential conflicts of interest on an on-going basis. All NORC staff receive annual conflicts and ethics training that include series of self-administered training modules and exams supplemented by regularly conducted training sessions. NORC's Conflicts Compliance Officer reviews all existing and potential new business for NORC and its staff, subcontractors, consultants, and vendors to determine if there are any actual, potential, or apparent conflicts. Any actual, potential, or apparent conflicts are categorized into any or all of the following conflict types: unequal access to information, biased ground rules, or impaired objectivity. If any of the aforementioned conflicts exist as determined by the Conflicts Compliance Officer, the Conflicts Compliance Officer works with the project team and NORC's Contracts department to create a mitigation plan for submission to the cognizant awarding agency's conflicts officer and/or the program's assigned Contracting Officer along with any other information that may be useful in assisting the review of NORC's proposed solution to mitigate or neutralize the conflict.

Additionally, the Conflicts Compliance Officer has full authority to audit all relevant areas of NORC's business and individual projects to determine if staff and management are complying with NORC's conflicts policies and procedures at all times. NORC maintains a reporting hotline where anyone can call in to report an issue. Issues reported to the hotline are resolved by the Conflicts Compliance Officer and Board of Trustees members that participate in NORC's Conflict Transactions Committee. All such reported issues are treated seriously and investigated thoroughly.

2. Personal Financial Conflicts

NORC also adheres to a robust Personal Financial Conflict of Interest (FCOI) Policy. This is a federally mandated policy by certain agencies of the government including HHS. Under this policy all principal investigators, and other staff who can influence the results of an affected government contract, are required to at least annually complete a certificate identifying potential conflicts of interest with the work they are performing on

the affected contract (Personal Conflicts disclosures are also completed on per project and/or per proposal basis as required by individual sponsors). These employees are also required to undergo specific training on how to identify a potential conflict of interest and the requirements to disclose it. FCOI compliance is overseen by the NORC FCOI Committee, of which the Conflicts Compliance Officer is a member. All personal conflict disclosures are evaluated by the Conflicts Compliance Officer. Under the direction of NORC's Conflicts Compliance Officer, the Contracts department administers the annual certifications and trainings required to satisfy the organization's compliance obligations for FCOI. If an FCOI disclosure is identified, it is immediately sent to the FCOI Committee for review, discussion, and further remediation by other cognizant NORC officers, if necessary. The Conflicts Compliance Officer ensures a mitigation plan is created and submitted to the appropriate governing agency for review where any actual, potential, or apparent conflict has been identified. Conflicted and/or potentially conflicted individuals are prohibited from participating in any component of the program or work that gave rise to the conflict until the conflict has been neutralized and cleared by the governing agency.

Authority, Audits and Remediation

NORC's Conflicts Compliance Officer has independent authority to audit all relevant areas of NORC's business and individual projects to determine if staff and management are complying with NORC's conflicts policies and procedures at all times. In coordination with NORC's Contracts department, Accounting and Finance, and other stakeholders within the organization, the Conflicts Compliance Officer conducts regular random audits of project and personnel activities to ensure compliance with NORC's conflicts policies and procedures. Additionally, NORC contracts with an independent external auditor to conduct an independent audit of any mitigation plans as directed. The findings and recommendations of any external audit including any corrective action plan developed by NORC will be shared with our client for review and approval.

NORC maintains a third party administered Hotline for reporting conflicts, fraud, misconduct, and illegal or unethical practices. Staff, contractors, sponsors, or interested parties can anonymously call this third-party administrator and report any suspected wrongdoing including conflict of interest at any time. The third-party administrator reports directly to the Board of Trustees Chairman of the Audit and Finance Committee and NORC's Conflicts Compliance Officer. All such reported issues are treated seriously and investigated thoroughly. In accordance with FAR 52.203-14, the Conflicts

Compliance Officer works with NORC's Human Resources and Facilities Departments to ensure these conflicts policies and hotline number are posted in locations that are accessible to all staff including hard copy posters in common areas of office sites and on NORC's intranet. NORC routinely prompts staff to review these policies.

Violation of NORC's conflicts policies and procedures are handled in a manner commensurate to the nature of the violation. Violations may range from corrective action by a supervisor, termination of employment/contractor, referral to authorities, as well as civil and criminal prosecution where warranted or necessitated by law.



11/4/2024

Adil Moiduddin, Senior Vice President, Health Care Evaluation
Research

Appendix A: UCLA-RAND Projected Budget for PATH, GPP, Duals and Reentry Evaluation Components

COSTS	Year 1: 12/1/23- 6/30/24	Year 2: 7/1/24 – 6/30/25	Year 3: 7/1/25- 6/30/26	Year 4: 7/1/26- 6/30/27	Year 5: 7/1/27- 6/30/28	Year 6: 7/1/28- 5/31/29	Total
Personnel (including fringe benefits)	1,321,479	2,653,368	2,793,107	2,596,758	2,618,758	1,091,227	13,074,697
Other Direct Costs (Rent, TIF, etc.)	58,031	103,768	108,370	112,586	113,012	67,686	563,453
UCLA Department of Medicine Statistics Core (DOMSTAT) - data cleaning, analysis, programming, etc.	79,688	121,570	124,467	127,491	130,525	108,027	691,768
Survey non-personnel costs (e.g. translation, printing, mailing, incentives)	0	200,000	0	75,000	75,000	0	350,000
Interview or focus group costs (e.g. interpretation, incentives)	7,500	37,500	7,500	17,500	0	0	70,000
Indirect Costs (F&A)	230,992	385,785	410,835	412,873	406,197	254,400	2,101,082
Other (e.g. materials, supplies, software)	9,000	8,000	8,000	8,000	8,000	8,000	49,000
TOTAL							16,900,000

More information about these costs is as follows:

Personnel. This includes all staff time to complete the evaluation plan and deliverables. Staff roles include research scientists, project managers, research analysts, research associates, and statisticians, and data programmers. Their work covers all oversight and planning, design, data collection, analysis, reporting, coordination, and all other tasks related to the successful completion of the evaluation plan and deliverables. The personnel budget line includes fringe benefits.

Other direct costs. This includes office rent, Technology Infrastructure Fees (TIF), and General and Employment Liabilities (GAEL).

Department of Medicine Statistics Core (DOMSTAT). DOMSTAT consists of a team of experienced faculty and staff biostatisticians, data managers, and research assistants. They provide investigators at UCLA with state-of-the-art statistical support and advise on study design, data management and statistical analyses.

Survey non-personnel costs. This includes all survey costs including subcontractor costs, translation, printing, and mailing. Compensation for survey respondents is also included in this budget line.

Interview or focus groups. Cost associated with interviews and/or focus groups include subcontractor costs, incentives, translation of materials, verbal translation services, and transcription fees.

Indirect costs. This includes Facilities and Administrative rate (F&A). The University of California F&A rate (base: modified total direct costs) pertains to this California State-Funded off-campus project.

Other. Other costs include software, materials, supplies, etc.

Appendix B: NORC Projected Evaluation Budget for the MCP Transition

Activity	Y1	Y2	Y3	Y4	Y5	Total
Quantitative Data Collection & Analysis	\$42,069	\$293,991	\$185,938	\$263,490	\$46,573	\$832,060
Qualitative Data Collection & Analysis	\$21,034	\$251,992	\$123,959	\$105,396	\$46,573	\$548,954
Evaluation Design	\$189,310	-	-	-	-	\$189,310
Interim Evaluation Report Draft	\$105,172	\$251,992	-	-	-	\$357,164
Quarterly Evaluation Reports	\$63,103	\$41,999	\$41,320	\$52,698	\$23,286	\$222,406
Summative Evaluation Report Draft	-	-	\$61,979	\$105,396	\$116,432	\$283,807
Total	\$420,689	\$839,974	\$413,195	\$526,980	\$232,863	\$2,433,701

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

**California Department of Health Care Services (DHCS)
California Advancing and Innovating Medi-Cal (CalAIM)
Section 1115(a) Demonstration**

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

**Submitted by the UCLA-RAND Community Supports
Evaluation Design Leadership Team:**

Emmeline Chuang, PhD, Nadereh Pourat, PhD

Katherine L Kahn, MD & David Zingmond, MD, PhD

August 4, 2025

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General Background Information

On December 29, 2021, CMS approved the California Advancing & Innovating Medi-Cal (CalAIM) 1115 demonstration and 1915(b) waiver. Community Supports, launched in 2022, are foundational components of CalAIM's transformational focus on breaking down the traditional walls of health care by more holistically addressing member needs and introducing better strategies for care coordination and person-centered care. Community Supports focus on addressing health-related social needs (HRSNs), e.g., for food or housing, of Medi-Cal members. Addressing members' HRSNs is expected to help improve member function, health, and access to care, and reduce avoidable utilization of higher, costlier levels of care. Community Supports supplement a suite of other broad-based delivery system, program, and payment reforms across CalAIM to make Medi-Cal more coordinated and person-centered to help people maximize their health and life trajectory.¹⁰⁹

A key goal of Community Supports is to allow members to obtain services in the least restrictive setting possible and to keep them in the community as medically appropriate. Building on California's prior experience with Home and Community-Based Services (HCBS) Waivers, the Whole Person Care (WPC) Pilots, Medi-Cal Health Homes Program (HHP), stakeholder input, and experiences elsewhere in the nation, the Department of Health Care Services (DHCS) has approved a list of 14 Community Supports that managed care plans (MCPs) are strongly encouraged to offer, such as, housing transition navigation services, medically tailored meals or medically supportive food and nutrition, asthma remediation, recuperative care, and short-term post-hospitalization housing. A 15th Community Support, transitional rent, was approved in 2025. Community Supports are designed to substitute for covered Medi-Cal services or settings as cost-effective alternatives, decreasing the need for avoidable hospital care, nursing facility care, and emergency department (ED) use. In California, over 90 percent of Medi-Cal members are enrolled in Medicaid managed care. Medicaid managed care plans can choose to offer any or all of the approved Community Supports to members that meet DHCS eligibility criteria for receipt of these services.

¹⁰⁹ CalAIM 1115 Demonstration & 1915(b) Waiver; <https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM-1115-and-1915b-Waiver-Renewals.aspx>

Exhibit 1 provides a brief overview of the Community Supports, their eligibility criteria / target population(s), and allowable service durations, while Exhibit 2 shows additional policy guidance related to the Community Supports initiative. Additional information about Community Supports is available in the CalAIM Community Supports Policy Guide.^{110, 111} These Community Supports are intended to be integrated with enhanced care management for eligible members and are intended to serve as cost-effective and medically appropriate substitutes for State Plan services or settings.

The evaluation of Community Supports will cover the five-year approval of the demonstration, from December 29, 2021 to December 31, 2026. This evaluation design starts with the presentation of three Exhibits that orient the reader to the key foundations of the evaluation of Community Supports. Exhibit 1 on the next page summarizes data for member eligibility for use of any of the 14 Community Supports described above as documented in the DHCS Community Supports Policy Guide (July 2023).

¹¹⁰ CalAIM Community Supports Policy Guide, Vol. 1; <https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide.pdf>

¹¹¹ CalAIM Community Supports Policy Guide, Vol. 2; <https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide-Volume-2.pdf>

Exhibit 1: Community Services Eligibility Criteria															
	Housing transition navigation	Housing deposits	Housing tenancy and sustaining	Recuperative care	Short-term post-hospitalization housing	Caregiver respite	Day habilitation	Assisted Living facility transitions	Community or home transition services	Personal care and homemaker services	Environmental accessibility adaptations	MTM/MSF&N	Sobering centers	Asthma remediation	Transitional rent
Eligibility criteria															
1. Homeless*	•	•	•	•	•		•								•
2. At-risk of homelessness**	•	•	•	•	•		•								•
3. Eligible for transitional rent	•	•	•												
4. At-risk of hospitalization or post-hospitalization				•											
5. Living alone with no formal supports				•											
6. Housing insecurity ***				•											
7. Exiting recuperative care					•										
8. Discharged inpatient hospital or nursing facility				•	•							•			•
9. Discharged from residential or correctional facility				•	•										•
10. Chronic conditions	•											•			
11. Qualifying clinical risk factor	•	•	•												•
12. Living in community, compromised in ADLs, and require relief to avoid institutional placement						•									
13. Resided 60+ days in nursing facility and willing and able to live in assisted living								•							
14. Living in community, willing and able to live in assisted living, and meet medically necessary nursing LOC								•							
15. Resided 60+ days in nursing facility or medical respite, willing and able to reside safely in community, and meet medically necessary nursing LOC									•						
16. Interested in moving back to the community and can reside safely in the community with appropriate and cost-effective supports and services.									•						
17. At-risk for hospitalization										•					
18. At-risk for institutionalization in a nursing facility										•	•				
19. Approved for IHSS										•					
20. Functional deficits and no other adequate support										•					
21. Adults who are intoxicated and would otherwise be transported to ED or jail****													•		
22. Individuals with poorly controlled asthma and provider documentation														•	
23. Complete in-home environmental trigger assessment within last 12 months														•	

Exhibit 1: Community Services Eligibility Criteria

	Housing transition navigation	Housing deposits	Housing tenancy and sustaining	Recuperative care	Short-term post-hospitalization housing	Caregiver respite	Day habilitation	Assisted Living facility transitions	Community or home transition services	Personal care and homemaker services	Environmental accessibility adaptations	MTM/MSF&N	Sobering centers	Asthma remediation	Transitional rent
24. Transitioning***** or eligible for FSP															•
Individuals with extensive care coordination needs												•			
Service duration*****															
Once per demonstration period		•													
Maximum duration allowed	N/A	N/A	N/A	6mo per rolling 12mo period	6mo per rolling 12mo period	336 hr/yr			\$7.5k max		\$7.5k max	12 wks	24hr/st ay	\$7.5k max	6mo per rolling 12mo period

Exhibit 1 Table Notes:

Community Supports are only available to Medi-Cal members enrolled in Medicaid managed care whose plan chose to offer the Community Support, and who meet DHCS eligibility criteria for receipt of the service. Specific target population(s) for each Community Support are reflected in the DHCS-specified eligibility criteria above.

+Within each column of Exhibit 1, individual Community Supports are shown as column headings. Rows display potential DHCS eligibility criteria for the specific Community Service displayed as column headings. For each row, a bullet within a column indicates that the row-specific eligibility criteria are pertinent to the Community Service that heads the column. Members may need to meet more than one of these criteria in order to be eligible for a given Community Supports (e.g., clinical risk factor requirement and a social risk factor requirement).

Note: Transitional rent is not included in this table because even though it is a Community Support, it is being implemented under the BH-CONNECT 1115 waiver.

MTM/MSF&N = Medically tailored meals / medically supportive food & nutrition; ADL = Activities of Daily Living; HUD = Housing and Urban Development; LOC = level of care; FSP = Full-Service Partnership

* HUD definition of homeless

** HUD definition of at-risk of homelessness with qualifying health or behavioral health conditions OR children or youth that qualify as homeless under other provisions

***Housing insecurity or housing that could jeopardize member health and safety without modification

**** Must also be conscious, cooperative, able to walk, nonviolent, and free from medical distress

***** Transitioning out of institutional, congregate residential, or carceral setting; interim housing; recuperative or short-term post-hospitalization housing; or foster care,

***** This table does not include allowable exceptions, e.g., circumstances under which the Community Support can be provided more than once in a lifetime or for longer than the maximum duration

Data Source: Medi-Cal Community Supports Policy Guide, Volumes 1 and 2 [April 2025](#); requirements subject to change as the Community Supports policy guide is updated and will be revised accordingly.

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

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

1. A key goal of Community Supports is to allow members to obtain care in the least restrictive setting possible and to keep them in the community as medically appropriate.

2. Community Supports are designed to substitute for, and decrease avoidable utilization of, a range of covered Medi-Cal benefits, such as hospital care, nursing facility care, and emergency department (ED) use.¹¹² Federal regulation allows states to offer ILOS as an option to MCPs and members.
3. DHCS has determined the 12 approved Community Supports covered under the CalAIM 1915(b) waiver to be cost-effective and medically appropriate substitutes for covered Medi-Cal services or settings. The remaining three Community Supports (recuperative care, short-term post-hospitalization housing, and transitional rent) are considered room and board services, are subject to a global cap, and must meet requirements in 1115 waiver STCs. DHCS selected these 15 services based on prior experience with the Medi-Cal Whole Person Care and Health Home Pilots and evidence that these services can be medically appropriate substitutes for Medi-Cal covered services that are more costly.
Starting on January 1, 2022, MCPs in all counties have been strongly encouraged to offer one or more of 14 approved Community Supports covered under the CalAIM 1115 and 1915(b) waivers. Effective January 1, 2026 MCPs in all counties will be required to offer transitional rent, which is covered under the BH-CONNECT 1115 waiver. as a contractually covered service.
4. MCPs must report to DHCS which Community Supports are offered in which county.
5. MCPs must also report on data regarding the utilization and cost of Community Supports for the purposes of rate setting but do not need to actively reassess cost-effectiveness for Community Supports at the MCP or individual level for the purposes of compliance with federal requirements. MCPs may apply utilization management techniques as applicable and as permitted by federal managed care regulations and as required to ensure appropriate monitoring and oversight of Community Supports services from a program integrity perspective and to adhere to service definitions and eligibility criteria.
6. DHCS is conducting further statewide aggregate analyses of the cost-effectiveness of each of the approved Community Supports services in the 1915(b) waiver. The evaluation team will also conduct cost or cost-effectiveness analyses as required in the 1115 and 1915(b) waiver STCs.

Community Supports Evaluation Requirements

Exhibit 3 highlights common and unique themes in the Special Terms and Conditions (STCs) for evaluation of the CalAIM 1115 and the 1915(b) waivers that authorize delivery of Community Supports under Medi-Cal. Two Community Supports are authorized under the CalAIM 1115 waiver (short-term post-hospitalization services and recuperative care; hereafter referred to as 1115 waiver Community Supports). An additional Community Support, transitional rent, is authorized under the BH-CONNECT 1115 waiver and will also

¹¹² DHCS CalAIM Enhanced Care Management (ECM) and Community Supports (ILOS), Contract Template Provisions. <https://www.dhcs.ca.gov/Documents/MCQMD/MCP-ECM-and-ILOS-Contract-Template-Provisions.pdf>

be considered an 1115 waiver Community Support. The remaining 12 Community Supports are authorized under the 1915(b) Managed Care waiver (hereafter referred to as 1915(b) waiver Community Supports). This Evaluation Design has been developed to cover the evaluation requirements of both waivers.

While the specific language used to describe the 1115 and 1915(b) waivers varies by waiver type as shown in the respective columns of Exhibit 3, the respective STCs address similar issues or themes. For example, both 1115 and 1915(b) waivers include STCs that focus on the impact of receiving Community Supports on health care utilization, associated costs, and member health outcomes.

Both waivers also include STCs that focus on whether Community Supports were effective at addressing member needs, with the 1915(b) STCs also requiring measurement of cost-effectiveness.¹¹³ Both waivers also include STCs focused on assessing member experiences, with the

Exhibit 3: Special Terms and Conditions for the Evaluation of Community Supports Authorized in the CalAIM 1115 Waiver and in the 1915(b) Waiver		
Common evaluation themes across 1115 and 1915(b) STCs	STC 17 for 1115 Waiver Community Supports (2)	STC 21 for 1915(b) Waiver Community Supports (12)
Impact of Community Supports on utilization of health care, associated costs,	Focus on assessing how the initiatives affect utilization of preventive and routine care, utilization of and costs associated with potentially avoidable, high acuity health care, and member physical and behavioral health outcomes.	Impact each Community Support had on utilization of state plan-covered services or settings, including the associated cost savings, trends in MCPs and enrollee use of each Community

¹¹³ It is important to distinguish between the traditional definition of cost-effectiveness and the way that this is stated in the STCs. Per CMS, cost-effectiveness analysis is a way to examine both the costs and health outcomes of one or more interventions. It compares an intervention to another intervention (or the status quo) by estimating how much it costs to gain a unit of a health.

Cite: <https://www.cdc.gov/policy/polaris/economics/cost-effectiveness/index.html#:~:text=Cost%2Deffectiveness%20analysis%20is%20a,gained%20or%20a%20death%20prevented.>

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

Exhibit 3: Special Terms and Conditions for the Evaluation of Community Supports Authorized in the CalAIM 1115 Waiver and in the 1915(b) Waiver

Common evaluation themes across 1115 and 1915(b) STCs	STC 17 for 1115 Waiver Community Supports (2)	STC 21 for 1915(b) Waiver Community Supports (12)
and health outcomes		Supports, and impact of each Community Supports on quality of care.
Effectiveness of Community Supports for addressing member needs	Focus on the effectiveness of Community Supports services in mitigating identified needs of members.	Evaluation of whether encounter data supports the state's determination that each Community Supports is a medically appropriate and cost-effective substitute for identified covered services and settings under the state plan.
Member experiences	If the data system is unable to capture necessary data for a quantitative evaluation, then must conduct a qualitative assessment leveraging suitable primary data collections efforts (e.g., member surveys).	Appeals, grievances, and state fair hearings data, reported separately and for each Community Support, including volume, reason, resolution status, and trends.
Health equity	Focus on understanding the impact of Community Supports initiatives on advancing health quality, including through the reduction of health disparities.	Impact each Community Support had on health equity initiatives and efforts undertaken by the state to mitigate health disparities.
Measuring contextual changes in HRSN	Examine whether and how state and local investments in housing and any other type of allowable HRSN change over time in concert with new Medicaid funding toward those services.	
Measuring costs of providing Community Supports	Include, in alignment with the evaluation required in the state's 1915(b)(1)/(4) Waiver for California Advancing and Innovating Medi-Cal (CalAIM) special terms and conditions for other similar services, a cost analysis to support developing comprehensive and accurate cost estimates of covering such services.	Evaluate whether the 1915(b) Community Supports are medically appropriate and cost-effective substitutes for the services and settings covered under the state plan.

Exhibit 3: Special Terms and Conditions for the Evaluation of Community Supports Authorized in the CalAIM 1115 Waiver and in the 1915(b) Waiver		
Common evaluation themes across 1115 and 1915(b) STCs	STC 17 for 1115 Waiver Community Supports (2)	STC 21 for 1915(b) Waiver Community Supports (12)
Assessment of downstream impacts of Community Support	Include a robust assessment of potential improvements in the efficiency, quality, and effectiveness of downstream services that can be provided under the state plan authority, and associated cost implications related to the provision of upstream Community Supports services.	

1115 Waiver noting direct collection of data from members if required, and the 1915(b) Waiver examining existing appeals and grievances. Finally, both waivers focus on health equity, with the 1115 Waiver assessing whether Community Supports improve health equity for members, and the 1915(b) Waiver focused on assessing the impact of Community Supports on broader, statewide health equity initiatives and efforts.

The 1115 Waiver further focuses on examining trends in state and local investments in Community Supports observed over time; a cost analysis to support developing comprehensive and accurate cost estimates associated with covering Community Support services, and an analysis of potential impacts on quality, health outcomes, and delivery and cost offsets associated with Medi-Cal covered services.

Evaluation Questions and Hypotheses

Community Supports evaluation requirements and research questions are informed by the CalAIM demonstration Special Terms and Conditions (STCs) goals and requirements, including STCs 8.1-8.15, 15.4-15.5, 16.5, 17.6, 17.10, 18.8-18.9, and Attachment U. The questions are further informed by the Donabedian model described in the overall CalAIM evaluation design, conceptual framework for how addressing health-related social needs may affect health outcomes in Figure 1, and the Community Supports evaluation-specific driver diagram shown in Figure 2.

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

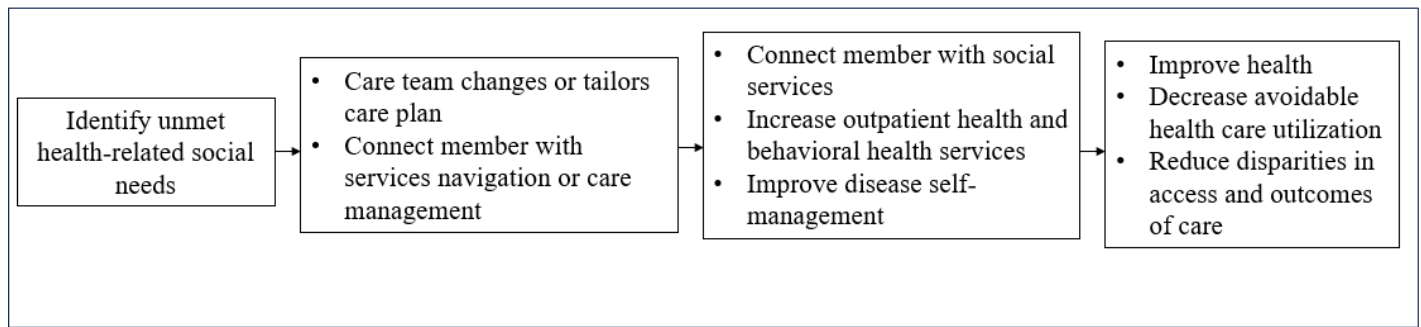
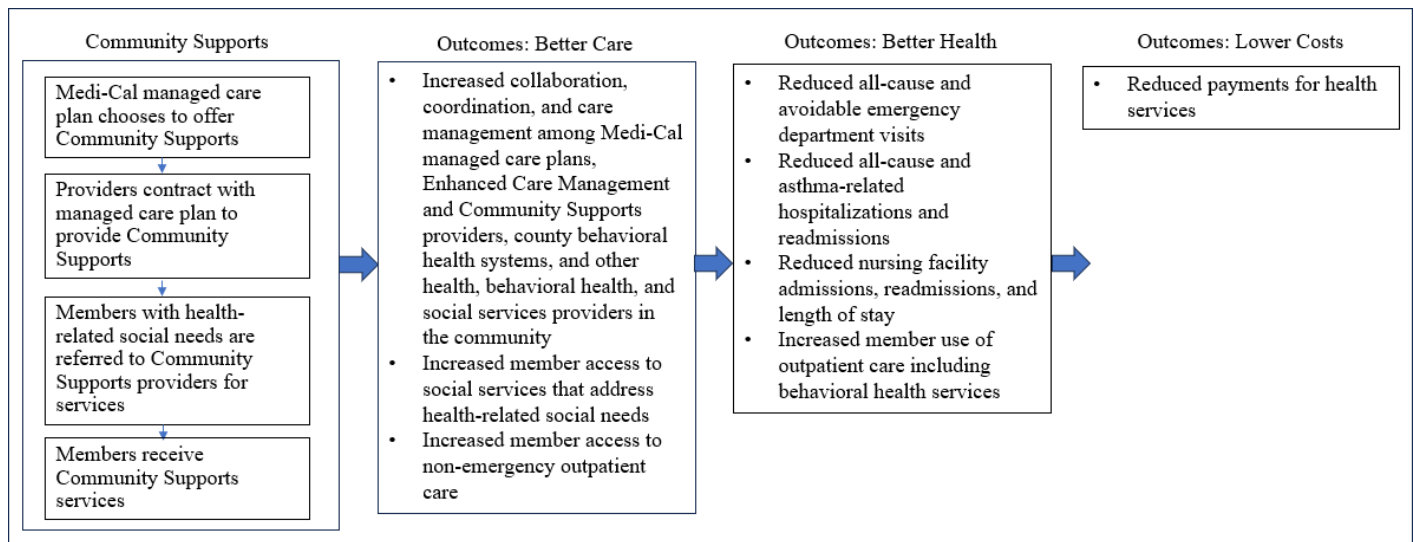


Figure 2. Driver diagram for Community Supports evaluation



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

First Order Goals

1. Increase offering of Community Supports by MCPs
2. Increase contracts between providers and MCPs for Community Supports services.
3. Increase utilization of Community Supports by eligible members

Additional Goals

4. Examine whether and how public investments in housing and other HRSN services change over time in concert with new Medicaid funding
5. Increase members' access to outpatient care including behavioral health services and reduce acute care utilization and long-term care admissions and stays
6. Improve quality and outcomes of care for eligible members
7. Reduce disparities in service utilization, quality, and outcomes of care for eligible members
8. Ensure Community Supports are cost-effective alternatives to State Plan services and settings.

To evaluate the Community Supports program goals, UCLA-RAND developed related evaluation questions and measures to determine whether the goals were achieved as

anticipated. Program goals and related evaluation questions and measures are described in Exhibit 4 on the following pages.

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

Evaluation Questions (EQ) & Hypotheses (H)	Measures
Goal 1: Increase offering of Community Supports by MCPs	
EQ 1: Did the number of MCPs offering Community Supports increase over time? H1: The number of Community Supports offered by MCPs will increase over time.	• Number of MCPs offering each Community Support • Proportion of counties in which each Community Support is offered • Proportion of MCPs in each county offering each Community Support • MCPs' self-reported reasons for offering or not offering Community Supports
Goal 2: Increase contracts between providers and MCPs for Community Supports services	
EQ2: Did the number and diversity of providers contracted to provide Community Supports increase over time? H2: The number and diversity of providers contracted to provide Community Supports will increase over time	• Number of providers contracted to provide each Community Supports • Number of providers providing multiple Community Supports • Ownership and types of providers contracted to provide each Community Supports
EQ3: What factors influence provider participation in Community Supports? H3: Provider capacity and infrastructure and local service availability and need will influence provider participation in Community Supports.	• Providers' self-reported reasons for contracting or not contracting with MCPs to provide Community Supports • MCPs and providers' perceptions of whether the number of eligible and contracted providers are sufficient to meet service need
Goal 3: Increase utilization of Community Supports by eligible members	
EQ4: Did the number of members receiving Community Supports increase over time? H4: The number of members receiving Community Supports will increase over time	• Proportion of eligible members that are authorized for and subsequently utilize Community Supports • Number and types of Community Supports used • Frequency¹¹⁴ and duration of Community Supports use

¹¹⁴ Frequency will only be assessed for Community Supports that can be offered more than once in a lifetime.

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

Evaluation Questions (EQ) & Hypotheses (H)	Measures
H4b: Members with housing-related needs will receive more than one Community Supports to address these needs	• Number and proportion of eligible Medi-Cal members that used each Community Supports • Demographic and health characteristics of Community Supports users, compared to the population of non-users eligible for these services • Proportion of members with housing needs that receive more than one Community Support simultaneously • Most frequently co-occurring Community Supports • Demographic and health characteristics of members receiving more than one Community Support, relative to members only receiving one Community Support • MCPs and providers' perceptions of factors affecting member utilization of Community Supports
EQ5: What strategies are being used to identify and refer eligible members to Community Supports? H5: Members will primarily be connected to Community Supports via community-based provider referrals	• MCPs and providers' self-reported processes for identifying members eligible for Community Supports and connecting them to services • Member self-reports of mechanisms for learning about how their Community Supports needs can be recognized and addressed: family, community orgs, PCP, specialty care • Member self-report of who, how, and when MCP or provider offered information about options for managing their need and/or how Community Supports might address their need • Member self-reports of number, types, and timing of exposure to and use of different types of Community Supports
Goal 4: Examine whether and how public investments in housing and other HRSN services change over time in concert with new Medicaid funding for those services	

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

Evaluation Questions (EQ) & Hypotheses (H)	Measures
EQ6: How is new Medicaid funding for Community Supports impacting existing systems of care? H6: Medicaid funding for Community Supports will be perceived as complementing state and local investments in housing and other HRSN services.	• Number of people experiencing homelessness in California, 2015-2024 • U.S. Department of Housing and Urban Development (HUD) funding to Continuums of Care (CoCs) in California, 2015-2024 • CoC Homeless Assistance Programs Housing Inventory, California, 2015-2024 • Low-Income Housing Tax Credit (LIHTC) housing units, California, 2015-2024 • MCPs and providers' perceptions of how new Medicaid funding for Community Supports has impacted existing systems of care, including non-Medicaid funding for similar supports or services • MCP and provider descriptions of how they are using new Medicaid funding in concert with state and local investments in housing or other social services to address member needs.
Goal 5: Increase members' access to outpatient care including behavioral health services and reduce acute care utilization and long-term care admission and stays	
EQ7a: Will Community Supports affect access to outpatient care? H7a: Members receiving Community Supports will use more outpatient services than members who do not	• Primary care visits • Specialty care visits • Mental health services • Substance use disorder services • Member self-report of downstream impacts of receiving Community Supports (e.g., on finances and access to needed health care)
EQ7b: Will Community Supports reduce avoidable acute care utilization or long-term care stays? H7b: Members receiving Community Supports will experience greater reductions in avoidable acute care utilization and long-term care stays than members who do not	• Emergency department visits (total; needed, preventable, primary care treatable, non-emergent; mental health-related, alcohol-related or substance use related) • Hospitalizations (total; from ED; potentially avoidable) • Long-term care stays

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

Evaluation Questions (EQ) & Hypotheses (H)	Measures
	Housing stability (as feasible)
Goal 6: Improve quality of care and outcomes of care	
EQ8: Are members satisfied with Community Supports referral processes and services? H8a: Members who receive Community Supports will be satisfied with services H8b: Member dissatisfaction with services, as indicated by appeals and grievances for each Community Supports relative to total service use, will decrease over time.	- Volume of appeals and grievances for each Community Supports - Reasons and resolution status for appeals and grievances. - Members' self-reported knowledge and satisfaction with anticipated and actual Community Supports received - Providers' self-reported perception of Community Supports' effectiveness at addressing members' identified HRSN - MCPs' self-reported perception of Community Supports' effectiveness at addressing members' identified HRSN
EQ9: Following receipt of housing-related Community Services, are members being transitioned to other appropriate supports, when needed? H9: The proportion of members transitioned to appropriate HRSN supports will increase over time	- Proportion of members receiving recuperative care that transition to short-term post-hospitalization housing - Proportion of members receiving recuperative care or short-term post-hospitalization housing that receive housing transition navigation supports - Proportion of members receiving housing navigation, housing deposits, recuperative care, or short-term post-hospitalization housing that subsequently receive other public housing assistance
EQ10: Will Community Services improve quality and outcomes of health care? H10a: Community Supports will improve member receipt of appropriate care H10b: Community Supports will reduce member receipt of avoidable care	- Initiation and engagement of alcohol and other drug dependence treatment - Follow-up after ED visit for alcohol and other drug abuse or dependence - Health Equity and Quality Measure set (HEQMS) and Healthcare Effectiveness Data and Information Set (HEDIS) measures not already in the HEQMS data set, e.g., A1C control for patients with diabetes and blood pressure

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

Evaluation Questions (EQ) & Hypotheses (H)	Measures
H10c: Community Supports will promote maintenance of member function H10d: Community Supports will reduce cause-specific complications	control for those with a history of high blood pressure or high risk of coronary artery disease. • Receipt of medications / adherence to recommended medications (based on medication fill rates for chronic conditions) • Overall summary quality metric(s) based upon the full set of measured quality metrics • Maintenance of function • Mortality • Cause-specific complications • Provider and member self-report of appropriate care processes (as needed and feasible)
Goal 7: Reduce disparities in service utilization, quality of care, and outcomes of care	
EQ11: Are there disparities in Community Supports utilization based on member demographic characteristics or health conditions or community characteristics? H11: Community Supports utilization will be higher in urban communities, communities with street medicine programs, and among members with English as preferred language	• Number and type of Community Supports used, stratified by member housing status, demographic and health characteristics, and geographic indicators • Proportion of eligible members that used Community Supports, stratified by member housing status, demographic and health characteristics, and geographic indicators
EQ12: Will Community Supports impact disparities in downstream physical or behavioral health service utilization, quality of care, and outcomes of care? H12a: Community Supports will reduce age, sex, racial/ethnic, linguistic, and functional (disability) disparities in downstream physical or behavioral health service utilization, quality of care, and outcomes of care H12b: Community Supports will reduce disparities in physical or behavioral health service	• Select measures from Goals 5-6, stratified by member demographic and health characteristics and geographic indicators • MCPs and providers' self-reported participation in health equity initiatives or other efforts to reduce health disparities • Member self-report of discrimination or disparities

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

Evaluation Questions (EQ) & Hypotheses (H)	Measures
utilization and outcomes of care for individuals experiencing homelessness	
Goal 8: Ensure Community Supports are cost-effective alternatives to State Plan services or settings	
EQ13: Will Community Supports impact cost of care? H13: Community Supports are cost-effective alternatives to State Plan services and settings.	Estimated change in Medi-Cal payments for services such as ED visits, hospitalizations, and long-term care stays for members utilizing Community Supports

Methodology

Data Sources

UCLA-RAND will use multiple data sources for the Community Supports evaluation. To improve cost-efficiencies and consistency across the CalAIM evaluation as well as enhance the evaluation's understanding of potential differential Community Supports' impact on subpopulations of Medi-Cal members, UCLA-RAND will use relevant data already obtained for the PATH, GPP, Duals, and Reentry evaluations when possible. UCLA-RAND has already submitted a consolidated data request for the four initial components of the CalAIM Evaluation to facilitate efficiencies in data accession. The Community Supports' evaluation will also request new administrative data sources from DHCS as needed to address Community Supports' evaluation questions. The UCLA-RAND Evaluation will further obtain available external secondary data on community-based providers and their characteristics, as well as on geographic indicators such as urbanicity, social vulnerability, and health inequity. When appropriate, UCLA-RAND will also draw on data previously collected by UCLA-RAND as part of prior 1115 Waivers or other evaluations (e.g., for GPP, WPC, or HHP). Exhibit 5 lists the data sources that UCLA-RAND plans to use as part of the evaluation, along with the baseline period, follow-up period and/or collection date(s) for each data sources. Periods/dates may change based on data availability and level of effort for data collection as noted below.

Exhibit 5. List of Data Sources for Community Supports Evaluation with Baseline Period, Follow-Up Period, or Collection Date(s)¹¹⁵

Data Source	Baseline Period	Follow-Up Period or Collection Date(s)
Primary Data		
Managed Care Plan Semi-Structured Interviews and Surveys	Prior to Community Support implementation – select measures	Q2/Q3 2024 and Q2/Q3 2026 (two collection dates)
Community Support Provider Semi-Structured Interviews and Surveys	Prior to Community Support implementation – select measures	Q4 2024-Q3 2025 and Q2/Q3 2026 (two collection dates)
Member Survey	n/a	2026 (one collection date)
DHCS Administrative Data		

¹¹⁵ Prospective data collection (member surveys, focus groups, interviews, and chart abstraction) are only for the two 1115 Waiver CS services.

Data Source	Baseline Period	Follow-Up Period or Collection Date(s)
Quarterly Implementation and Monitoring Reports	n/a	January 1, 2022 – December 31, 2026
Medi-Cal Eligibility and Claims Data	January 1, 2020 – December 31, 2021	January 1, 2022 – December 31, 2026
Data on Appeals, Grievances, and State Fair Hearings for Community Supports	n/a	January 1-2022-December 31, 2026
Other documents (e.g., Community Supports Policy Guides, MCP-Submitted Model of Care Templates, Reports on HRSN Capacity Building and Infrastructure Efforts)	n/a	January 1, 2022 – December 31, 2026 or As Available/Collected
Other Member-Level Data		
California Interagency Council on Homelessness (CalICH)'s Homeless Data Integration System (HDIS)	January 1, 2020 – December 31, 2021	January 1, 2022 – December 31, 2026
California Department of Health Care Access and Information (HCAI) Hospital Discharge and Emergency Department Visit Data	January 1, 2020 – December 31, 2021	January 1, 2022 – December 31, 2026
In Home Support Services (IHSS) Annual Functional Evaluation	January 1, 2020 – December 31, 2021	January 1, 2022 – December 31, 2026
State Death Statistical Master File	January 1, 2020 – December 31, 2021	January 1, 2022 – December 31, 2026
State Cancer Registry	January 1, 2020 – December 31, 2021	January 1, 2022 – December 31, 2026
State Vaccine Registry	January 1, 2020 – December 31, 2021	January 1, 2022 – December 31, 2026
MCAS measures	January 1, 2020 – December 31, 2021	January 1, 2022 – December 31, 2026
Medicaid Core Set Measures	January 1, 2020 – December 31, 2021	January 1, 2022 – December 31, 2026
Minimum Data Set (MDS) of Long-Term Care Assessments	January 1, 2020 – December 31, 2021	January 1, 2022 – December 31, 2026
Outcome and Assessment Information Set (OASIS) Home Care Assessments	January 1, 2020 – December 31, 2021	January 1, 2022 – December 31, 2026
Hospital Chart Abstraction Period during which Members were hospitalized	n/a	Select individuals hospitalized between July 2025 through December 2026
Secondary Data		
National Institute for Medical Respite Care Directory	January 1, 2020 – December 31, 2021	January 1, 2022 – December 31, 2026
Continuum of Care Providers	January 1, 2020 – December 31, 2021	January 1, 2022 – December 31, 2026
Uniform Data System	January 1, 2020 – December 31, 2021	January 1, 2022 – December 31, 2026

Data Source	Baseline Period	Follow-Up Period or Collection Date(s)
Lists of PATH CITED and TAM recipients	n/a	January 1, 2022 – December 31, 2026
Enrollment and utilization data on WPC and HHP users	January 2017 to December 2021	
Publicly Available Geographic Data (e.g., Health Places Index)	January 1, 2020 – December 31, 2021	January 1, 2022 – December 31, 2026

Notes: The CalAIM waiver was authorized for the time period January 1, 2022 – December 31, 2026. Baseline period refers to the time frame prior to CalAIM implementation that will be used to help evaluate impact of Community Supports. Follow-up period refers to the time frame after CalAIM implementation used to evaluate impact of Community Supports. Baseline and follow-up periods and collection dates are subject to change based on data availability. Member survey and hospital chart extraction will only be used for evaluation of the two CalAIM 1115 waiver Community Supports, recuperative care and short-term post-hospitalization housing.

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

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

1. The California Interagency Council on Homelessness (CalICH)'s Homeless Data Integration System (HDIS), which integrates local Homeless Management Information System data from all the Continuums of Care (CoC) in California and links this data with Medi-Cal eligibility and claims data on members eligible for Community Supports. If UCLA is unable to obtain the CalICH HDIS data, then UCLA-RAND will, with input and support from DHCS, determine whether to secure data on member receipt of housing assistance from a purposefully selected sample of local CoCs or from the Los Angeles County Enterprise Linkages Project 2.0. UCLA-RAND will also attempt to procure and link data on people living in Low-Income Housing Tax Credit (LIHTC) and Housing and Urban Development (HUD)-subsidized housing in a small sample of purposefully selected jurisdictions because data on HUD assistance represents only a small component of the overall housing assistance members may receive.

2. Data on social needs screening and results from select community resource referral platforms, health plans, or provider electronic health records. Additionally, UCLA-RAND will survey a purposeful sample of members eligible for the 1115 Waiver Community Supports to obtain member reports of perceived needs for Community Supports, their experiences accessing Community Supports, how their receipt of Community Supports were associated with changes in perceived needs, and any unintended consequences of Community Supports participation.
3. The Minimum Data Set of Long-Term Care database for California nursing home (NH) residents, which will provide comprehensive data on NH resident functional status, cognitive status, active illnesses, adverse events, supportive care, and advanced care preferences – elements that are key to understanding Community Supports measures linked to transitioning NH residents to assisted living or independent living in the community. UCLA-RAND will also attempt to obtain annual In-Home Supportive Services (IHSS) assessments, which provide standardized functional assessments that can be used to track the maintenance of function for a substantial subset of members over time.
4. Medicare managed care encounter data for Duals who are eligible to receive Community Supports services. There is one MCP offering Community Supports that is a fully integrated dual eligible special needs plan; other Duals may also be receiving Community Supports from other MCPs.

Hospital chart abstraction (post-hospitalization transitional housing) to measure (1) severity of illness, (2) instability at discharge, (3) discharge location, and (4) discharge treatment plan. Hospital chart abstraction will focus on the initial and final aspects of hospitalization (focused on admission notes, discharge summaries, discharge notes, and advanced care planning documentation). Chart abstraction will focus on up to 1000 completed charts – 500 individuals who received post-hospitalization transitional housing and 500 matched individuals (based on demographics, location, diagnosis at admission, and severity of illness based upon administrative data-based secondary diagnoses). More detailed information about chart abstractions is provided in Appendix 1. If chart abstraction is not feasible, UCLA-RAND will determine, with input from DHCS, whether the member survey or other data could be used to obtain some of this information instead.

Should the chart abstraction design described above not be feasible for the sample size described above, an alternative strategy for assessing member experience would involve a more intense mixed methods approach engaging a smaller study cohort (30-50 individuals). Specifically, UCLA-RAND will conduct a mixed method,

focused, short-term (e.g., nine-month) longitudinal assessment of members eligible for use of the short-term post-hospitalization housing 1115 Community Supports. Participants would be invited to sign informed consent for review of medical records and participation in the program. Analysis of this cohort would provide clinically and socially relevant information about how member's lives are changed (or not) with exposure (or not) to a 1115 Community Support. This type of analysis would be focused on individuals meeting eligibility criteria for either the post-hospital short-term housing Community Supports and/or medical respite condition on the individual (1) providing consent to participate in twice monthly video or phone calls, (2) signing medical record consents for access to their medical records, and (3) meeting specific clinical criteria associated with one of the three clinical conditions we anticipate studying.

When administrative or secondary data are not available to address evaluation research questions, UCLA-RAND will address these gaps with primary data collection (e.g., surveys and/or interviews). Any surveys or interviews conducted with MCPs, or providers will be coordinated with other CalAIM evaluation components (e.g., PATH, Re-entry) as appropriate. More specific details of data sources planned for the Community Supports evaluation are provided below.

1. DHCS administrative data on Community Supports from January 1, 2022 through December 31, 2026, including Medi-Cal eligibility and claims data, Quarterly Implementation Monitoring Reports and JavaScript Object Notation Data on ECM and Community Supports, Community Supports policy guides, PATH CITED applications and awardees for Community Supports, Housing and Homelessness Incentive Program (HHIP) and Incentive Payment Program (IPP) reports, reports submitted by MCPs or Community Supports providers to DHCS (e.g., Model of Care templates, implementation plans), data on appeals, grievances, and state fair hearings for each Community Support, and salient data from any DHCS-administered surveys of MCPs or Community Supports providers.
2. Existing data on previous WPC and HHP users. WPC was implemented in 2017-2021. HHP implementation was staggered, but the program was implemented in 2018-2021.
3. Data on community-based providers and their characteristics, focusing on providers identified by DHCS as "preferred partners" for providing each Community Support (e.g., National Institute for Medical Respite Care directory of medical respite providers in California).

4. Publicly available geographic data such as county, rural-urban commuting area codes (RUCAs), Social Vulnerability Index (SVI), Healthy Places Index (HPI), or Social Deprivation Index (SDI) used to identify members' county of residence, region, rural communities, those with high SVI or SDI scores, or those in the bottom two HPI quartiles.
5. Semi-structured interviews with MCPs and a purposive sample of providers contracted to provide Community Supports, conducted in 2024 and 2026. At each time, we will interview MCPs and a purposefully selected sample of 40-45 community-based providers. Community-based providers will be selected to maximize variation in eligible provider types, Community Support provided, and geographic location, and will be identified based on UCLA-RAND review of provider data as well as MCP recommendation. Interview questions will assess topics such as: (a) factors affecting provider and member uptake of Community Supports, (b) processes for identifying members eligible for Community Supports and connecting them to services, (c) how respondents may be using Community Supports funding in conjunction with other resources to address member needs; (d) approaches for coordinating with other stakeholders to identify and address members' other health, behavioral health, and social needs, (e) perceived effectiveness of Community Supports at addressing members' HRSN, and (f) perceived impacts of Community Supports and other new Medicaid funding on existing systems of care. As appropriate, UCLA-RAND may interview up to 15 additional key informants (e.g., from county human service agencies, public behavioral health, Continuums of Care) in select counties to address (c) and (f). These key informants would only be interviewed at a single point in time. To minimize respondent burden, all interviews will be conducted in coordination with the PATH evaluation; any interviews with key informants from carceral settings will be coordinated with the Reentry evaluation.
6. UCLA-RAND surveys of MCPs and Community Supports providers, administered in 2024 and 2026 to MCPs and Community Supports providers. To minimize respondent burden, surveys will be conducted in coordination with the PATH evaluation. Surveys will collect structured information on Community Supports implementation policies and practices and other topics identified as salient in key informant interviews.
7. UCLA-RAND Member Surveys for a sample of members participating in the two 1115 Waiver Community Supports. Per STC 15.4, UCLA-RAND will attempt, with support from DHCS, to sample members participating in the Post-Hospitalization Transitional Housing Support and a different sample of those participating in the

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

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

the study of conditions for which preexisting measurement tools are documented, appropriate for use in this population, and can support repeat measures across nine months.

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

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

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

Measures

Exhibit 6 on the next page summarizes the data sources and associated data elements that UCLA-RAND anticipates accessing to address Community Supports evaluation goals. Data that UCLA-RAND anticipates using for the evaluation are listed in each column, and measurement domains pertinent to the Community Supports evaluation are listed in each row. Check marks within cells illustrate our expectation of measures available in each data source.

Exhibit 6: Data Sources and Data Elements (Abbreviations and notes are shown at the bottom of the table)

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

Exhibit 6: Data Sources and Data Elements (Abbreviations and notes are shown at the bottom of the table)

Member Functional Status

Activities of Daily Living			.	.										
Cognitive Status				.						.				

Enrollment Characteristics

Eligibility Status	.													
Duration Enrolled	.													
Medicare Status	.													

Access to Care

Ease receiving needed care									.					
Distance to Closest Service Provider	.	.										.	.	
Distance to Closest High Volume Service Provider	.	.										.	.	

Outcomes: Utilization Measures

Hospitalization (All cause, cause-specific, preventable)		.				.								
ED Visit without Hospitalization (All cause, cause-specific, preventable)		.				.								

Exhibit 6: Data Sources and Data Elements (Abbreviations and notes are shown at the bottom of the table)

Ambulatory Care Visits (All cause)		.											
In-Home Supportive Service Hours		.											
Nursing Home Stays		.		.				.					

Outcomes: Cost of Care

Overall Estimated Costs	.	.					.			.			

Outcomes: Quality of Care

HEDIS Measures (Claims-based)		.											
Medicaid Core Measures (Claims- based)		.											
Other Valid Measures (Claims-based)		.											

Outcomes: Clinical Outcomes

Mortality	.			.	.	.							.
Functional Decline			.		.			.					
Illness Resolution								.					

Non-Clinical Outcomes

Housing stability							.	.					
Satisfaction with Assistance								.					

Exhibit 7 illustrates data elements that UCLA-RAND anticipates using to evaluate each of the 14 pre-approved Community Supports. Within each listed column (all of which represent a unique Community Support), we have included a check mark within cells to illustrate our expectation for data that will be available for analysis of the Community Support named in the associated column.

Exhibit 7: Measures and Community Supports														
	1115 services		1915(b) services											
	Short-term post-hospitalization housing	Recuperative care (medical respite)	Housing transition / navigation services	Housing tenancy and sustaining services	Housing deposits	Respite care	Day habilitation programs	Nursing facility transition/diversion to assisted living facility	Community transition services/nursing facility transition to home	Personal care and homemaker services	Environmental accessibility adaptations (home modifications)	Medically tailored meals / medically supportive foods	Sobering centers	Asthma remediation
Member Demographics														
Age	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Sex	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Race	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Preferred Language	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Marital Status	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Social Need (self-report)	•	•												
Social Need (neighborhood)	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Service Need	•	•						•	•					•
Homelessness	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Member Case-Mix Severity and Related Selection Criteria														
Reported Diagnoses	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Active Illnesses								•	•					
Severity at Admission	•													
Illness Burden at Discharge	•													
Duration in Hospital*	•													
Duration in Nursing Home*								•	•					
Member Functional Status														
Activities of Daily Living								•	•	•				
Cognitive Status								•	•					
Enrollment Characteristics														
Eligibility Status	•	•	•	•	•	•	•	•	•	•	•	•	•	•

Exhibit 7 illustrates data elements that UCLA-RAND anticipates using to evaluate each of the 14 pre-approved Community Supports. Within each listed column (all of which represent a unique Community Support), we have included a check mark within cells to illustrate our expectation for data that will be available for analysis of the Community Support named in the associated column.

Exhibit 7: Measures and Community Supports														
	1115 services		1915(b) services											
	Short-term post-hospitalization housing	Re recuperative care (medical respite)	Housing transition / navigation services	Housing tenancy and sustaining services	Housing deposits	Respite care	Day habilitation programs	Nursing facility transition/diversion to assisted living facility	Community transition services/nursing facility transition to home	Personal care and homemaker services	Environmental accessibility adaptations (home modifications)	Medically tailored meals / medically supportive foods	Sobering centers	Asthma remediation
Duration Enrolled	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Medicare Status	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Access to Care														
Ease of receiving timely necessary care (self-reported access to care)	•	•												
Distance to Closest Service Provider	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Distance to Closest High Volume Service Provider	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Outcomes														
Utilization Measures														
Hospitalization (All cause, cause-specific, preventable)	•	•	•	•	•	•	•	•	•	•	•	•	•	•
ED Visit without Hospitalization (All cause, cause-specific, preventable)	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Ambulatory Care Visits (All cause)	•	•	•	•	•	•	•	•	•	•	•	•	•	•
In-Home Supportive Service Hours										•	•			
Nursing home Stays	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Cost of Care														
Overall Estimated Costs	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Quality of Care														
HEDIS Measures (Claims-based)	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Medicaid Core Measures (Claims-based)	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Other Valid Measures (Claims-based)	•	•	•	•	•	•	•	•	•	•	•	•	•	•

Exhibit 7 illustrates data elements that UCLA-RAND anticipates using to evaluate each of the 14 pre-approved Community Supports. Within each listed column (all of which represent a unique Community Support), we have included a check mark within cells to illustrate our expectation for data that will be available for analysis of the Community Support named in the associated column.

Exhibit 7: Measures and Community Supports														
	1115 services		1915(b) services											
	Short-term post-hospitalization housing	Re recuperative care (medical respite)	Housing transition / navigation services	Housing tenancy and sustaining services	Housing deposits	Respite care	Day habilitation programs	Nursing facility transition/diversion to assisted living facility	Community transition services/nursing facility transition to home	Personal care and homemaker services	Environmental accessibility adaptations (home modifications)	Medically tailored meals / medically supportive foods	Sobering centers	Asthma remediation
Clinical Outcomes														
Mortality	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Functional Decline								•	•	•				
Illness resolution	•	•												
non-Clinical Outcomes														
Housing stability (derived)	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Housing stability (self-report)	•	•												
Satisfaction with Assistance	•	•												

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

Data Cleaning and Validation

This section outlines data cleaning and validation processes that the evaluation team expects to follow based on the team's prior collective experience working with data. Certain aspects of these processes are expected to change based upon data availability and reporting. For the Community Supports evaluation, the evaluation team will rely upon a combination of routinely collected person-level, provider-level, and plan-level data based primarily on data from the state Medicaid program. These data will be supplemented by other routinely collected state and federal data as described in the Data Sources section above as well as by prospectively collected data from Medi-Cal members (surveys), service providers (interviews, possible chart abstraction, and other data), and Medi-Cal managed care plans (surveys and interviews).

For person-level analyses, state Medi-Cal data will provide the overarching source for demographic, geographic, and case-mix severity. Data will be assembled to create longitudinal descriptions of utilization, quality, and outcomes as described in more detail elsewhere. Where possible, we will employ concordant validity across distinct data sources to determine accuracy and completeness of reporting.

For Community Supports, the California Department of Health Care Services has provided guidance to MCPs regarding which codes to use for each Community Support. The accuracy and completeness of codes is unknown at this time. The evaluation team will rely upon concordant and face validity to determine completeness of reporting. For example, data provided in QIMRs will be compared to data available in claims regarding the number of members served and the number of Community Supports services provided. Patient self-report and chart abstraction are independent sources of gold standard information that may be used to validate some of the Community Supports services.

For utilization, key aspects of care can be compared across distinct data sources, contingent on data availability and access. For example, hospitalizations and ED visits within state reported by MCPs can be compared to the gold standard of hospitalization discharge and ED visit abstracts reported to the state by hospitals. Similarly, care delivered by home health care and within registered nursing homes can be compared between the Medi-Cal data and the reporting from the gold standard of Outcome and Assessment Information Set (OASIS) and the Minimum Data Set (MDS) data sets, which also have additional information on demographics, indications for care, comorbidities, physical function, cognitive function, and care delivery in these settings.

Demographics will be drawn from the Medi-Cal eligibility / enrollment file. Data on unhoused individuals or individuals at-risk of being unhoused will be based upon a prior validated approach, e.g., by using residence information from the eligibility file

supplemented by the International Classification of Diseases (ICD)-10-z-codes. This approach is known to be specific, but not sensitive. Certain providers may be able to provide the evaluation team prospectively identified individuals who are unhoused or at-risk of being unhoused, which can be as gold standard validation for existing data. Comorbidities based upon consensus coding (e.g. Elixhauser assigned codes) and a minimum of two separate outpatient or one inpatient code for each condition with consistent observation periods for all individuals provide valid and reliable measures.

As currently conceived, the evaluation team will perform prospective data collection from members receiving Community Supports and from potentially matched members that did not receive Community Supports. The evaluation team's member survey may be used to help assess accuracy, completeness, and reliability of demographics, comorbidities, and service receipt in Medicaid data with self-report. Patient survey will allow the evaluation team to compare service receipt to recorded service delivery. Chart abstraction in the hospital (if feasible) will provide an additional source of gold standard information.

In summary, the evaluation team has a number of strategies that could be employed in cleaning and validating the data. Nevertheless, the evaluation team is aware that there are likely to be issues with accuracy and completeness of reporting of new Community Supports services, particularly when delivered in new settings or by providers without prior experience with Medi-Cal billing and claims. The evaluation team plans to use primary data and ancillary external data to reduce potential threats to validity of the data and our work.

Analyses

UCLA-RAND will respond to the evaluation questions using appropriate qualitative and/or quantitative analytic methods, consistent with the CalAIM evaluation's mixed methods approach. Qualitative analysis will be conducted using thematic analysis or comparative case analysis, as appropriate. Quantitative analysis will include descriptive analyses using t-tests and Chi-square tests, regression models, and difference-in-difference regression models as appropriate. Target populations used in analyses of each Community Support will vary based on DHCS-identified eligibility criteria for that Community Support (high-level overview of which was provided in Exhibit 1). When relevant, baseline periods for each data source are identified in Exhibit 5. Unless otherwise indicated below, the baseline period for difference-in-difference regression models will be January 1, 2020 to December 31, 2021.

Goal 1: Increase uptake of Community Supports by MCPs

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

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

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

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

Goal 3: Increase uptake of Community Supports by eligible members

To answer EQ4, which assesses whether the number of members utilizing Community Supports increased over time, UCLA-RAND will use Quarterly Implementation Monitoring

Reports and JavaScript Object Notation Data on Community Supports to measure rate and patterns of use of Community Supports over time. UCLA-RAND will use logistic regression analyses to assess what member characteristics (age, sex, race, preferred language, marital status, social need via self-report and neighborhood characteristic, service need, and homelessness) differentiate eligible users and non-users for each Community Support. No baseline period will be included because Community Supports was not offered prior to the evaluation period. Member characteristics examined include age, sex, race/ethnicity, preferred language, homelessness, California county or region, chronic health conditions, vulnerability indices, severe mental illness, substance use disorder, and Medi-Cal state-funded status, among others. For individuals receiving care in nursing homes, physical function, cognitive status, Resource Utilization Group (RUG) scores, adverse outcomes, and care receipt may be available from the MDS. Individuals receiving IHSS services will have a physical function available from annual IHSS functional assessments. An example equation for logistic regression models is provided below:

$$\log\left(\frac{P(Y_i = 1)}{P(Y_i = 0)}\right) = \beta^0 + \beta^1 \cdot Sex_i + \beta^2 \cdot Race_i + \beta^3 \cdot Language_i + \beta^4 \cdot MaritalStatus_i + \beta^5 \cdot SocialNeedSelf_i + \beta^6 \cdot SocialNeedNeighborhood_i + \beta^7 \cdot ServiceNeed_i + \beta^8 \cdot Homeless_i$$

Y_i : $Y_i = 1$ means the member **used Community Supports**, and $Y_i = 0$ means they **did not**.

i : index of *individual*

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

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

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

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

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

To address EQ6, which assesses how new Medicaid funding for Community Supports impacts existing systems of care, UCLA-RAND will assess the feasibility of procuring data on California public housing expenditures from federal and state sources from 2018-2026. As necessary, UCLA-RAND may also attempt to secure local public housing expenditure data in 2-3 purposefully selected counties over the same period. As feasible, these data will be analyzed to assess changes in state and local investments in housing over time, using descriptive statistics and ANCOVA or regression analyses as appropriate. To better understand MCP and provider perceptions of how new Medicaid funding for Community Supports has impacted existing systems of care, UCLA will thematically analyze data from semi-structured interviews with MCPs, providers contracted to provide Community Supports, and other key informants in county human service agencies, public behavioral health, local CoCs, or carceral settings. Interview questions will address relevant topics noted in Exhibit 1.

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

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

UCLA-RAND will use difference-in-difference (DD) multivariate regression models to compare changes in health care utilization of members who received Community Supports to a comparison group of members who were eligible for but did not receive Community Supports. An example equation for the difference-in-difference (DD) regression model is provided below:

$$Y_{it} = \beta^0 + \beta^1 \cdot Post_t + \beta^2 \cdot Treat_i + \beta^3 \cdot (Post_t \times Treat_i) + \beta^4 \cdot Demo_{it} + u_i + \varepsilon_{it}$$

Y_{it} : Health care utilization outcome and associated payment for individual i at time t (e.g., ED visits, inpatient stays)

$Post_t$: Indicator for post-treatment period (1 = post receipt of specific Community Support, 0 = pre)

$Treat_i$: Indicator for treatment group (1 = received Community Supports, 0 = did not)

$Post_t \times Treat_i$: Interaction term for the **Difference in Difference estimator**

$Demo_{it}$: Vector of member-level covariates (age, sex, race, etc.)

u_i : patient-level **random intercept**

ε_{it} : Residual error term

UCLA-RAND anticipates that identifying a single comparison group across Community Supports will be challenging because there are differences in eligibility criteria for each Community Support, in delivery systems and population characteristics in California counties, in MCP implementation approaches, and in the availability of Community Supports within each community over time. One important challenge is UCLA-RAND's incomplete access to complete lists of members who MCPs determine to be service-eligible and lists of the subset of these members who are meaningfully offered services. Furthermore, noting that Community Supports' participation by members is voluntary, UCLA-RAND anticipates that some members who are offered services will decline. Nevertheless, opportunities for selecting a comparison group include selection from: 1) members who had a similar risk profile and were authorized for services but did not participate, and 2) members who were eligible but were not selected, perhaps because of a lower risk profile or because Community Supports were not available in their area or from their MCP. UCLA-RAND will examine the characteristics of members who were eligible and not receiving Community Support(s) before determining the best strategy to identify the comparison group. UCLA-RAND will also consider developing targeted comparison groups based upon patterns of Community Support use to be identified prior to the cohort matching process. For certain Community Supports, such as for the NH transition Community Supports services and individuals receiving IHSS, a more targeted comparison group may be more appropriate. To account for the possibility of clustered data (e.g., repeated measures over time or nesting of members by provider), UCLA-RAND will use methods such as repeated measures ANOVA, ANCOVA, or generalized linear mixed-effects models as appropriate.

Although UCLA-RAND anticipates that targeted comparison groups will be necessary, UCLA-RAND will also examine the possibility of developing a single comparison group rather than creating separate comparison groups for each Community Support to allow for assessment of the overall impact of Community Supports on member health care use. This approach would avoid the anticipated difficulty of identifying an adequate number of members in the comparison group per MCP or Community Support. Because the

comparison group population profile will be designed with the collective population in mind, further assessment is required to determine to what extent the comparison group can be used as a benchmark to assess variation in impact on specific populations (e.g., members experiencing homelessness, members at-risk of institutionalization, etc.) or on MCP-level variation in impact of Community Supports. If needed and feasible, multiple comparison groups may be included allowing for comparison of the results for each group to gain a better understanding of the impact of Community Supports on member health care use.

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

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

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

UCLA-RAND will run multilevel models with an individual random intercept and an interaction term that allows for potentially different pre-trends in baseline years between members receiving Community Supports and matched comparison group. As feasible, UCLA-RAND will also run sensitivity analyses to assess potential differential impacts of Community Supports on health services use of different populations (e.g., members who are unhoused and remain unhoused; members who are unhoused and subsequently housed; members with SMI/SUD; Justice Involved (JI); duals; etc.).

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

Goal 6: Improve quality and outcomes of care

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

To address EQ9, which assesses whether members are being transitioned to appropriate, needed supports following receipt of Community Supports, UCLA-RAND will draw on data

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

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

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

Using the approach outlined in Goal 5 in addressing EQs 7a/7b, UCLA-RAND will then use difference-in-difference multivariate regression models to assess the impact of Community Supports on the quality of care for members, relative to a matched comparison group. As feasible, UCLA-RAND will also run sensitivity analyses to assess potential differential impacts of Community Supports on quality and outcomes of care for different populations (e.g., members who are unhoused and remain unhoused, members who are unhoused and subsequently housed, members with SMI/SUD, members with diabetes receiving MTM, etc.).

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

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

To address EQ11, which assesses whether there are disparities in Community Supports uptake by member demographic characteristics or health conditions, or by community characteristics, UCLA will use data on Medi-Cal eligibility and claims data, Quarterly Implementation Monitoring Reports and JavaScript Object Notation data on Community Supports, and publicly available geographic data identified in Data Sources. These data will be used to examine number and type of Community Supports used, relevant measures identified in Exhibit 1, stratified by member housing status; demographic characteristics such as race/ethnicity, sex, language preference; health status indicators (baseline acute care utilization, baseline Chronic Illness and Disability Payment System risk scores, specific chronic conditions, total count of chronic conditions, behavioral health needs), and geographic indicators (e.g., county of residence, RUCA, HPI quartile). For NH populations, it is possible to obtain physical function, cognitive status, RUG scores, complications, and active conditions. For IHSS recipients, it is possible to obtain physical function scores, which can be used to assess the maintenance of function over time for a subset of members. Disparities will be assessed using appropriate statistical tests, e.g., t-test, MANOVA, chi-square test, etc. These analyses will be supplemented with thematic analysis of interview data regarding factors perceived as affecting Community Supports uptake and for the two 1115 Waiver Community Supports, analysis of member survey data to assess whether there are disparities in measures previously identified in EQs 4-9.

To address EQ12, which examines whether receipt of Community Supports impacts disparities in downstream health care use, quality of care and outcomes of care, UCLA-RAND will examine select measures identified in Goals 5-6, stratified by select member demographic characteristics, health status, and geographic indicators. Specific measures will be selected following review of Goals 5-6 analyses, member characteristics, and with input from DHCS. Analyses will be conducted using the same approach outlined in Goal 5 for EQs 7a/7b, e.g., difference-in-difference models. These analyses will be supplemented with thematic analysis of interview data, e.g., regarding MCP or provider participation in health equity initiatives, efforts to address health disparities, or factors perceived as affecting health equity. Member survey data will be used to examine differences in

perceived health, access to care, and receipt of recommended care between recipients and controls for the 1115 Waiver Community Supports.

Goal 8: Ensure Community Supports are cost-effective alternatives to State Plan services and settings

To address EQ13, which assesses whether the cost of each Community Support is offset by reductions in the costs of State Plan services and settings, UCLA-RAND will also examine categories of costs, including outpatient services, ED visits, hospitalizations, and long-term stays. Examination of these categories of service and costs will help illustrate whether receipt of Community Supports led to a different pattern of health services utilization and associated costs. In other words, the analyses will not only provide estimates of the impact on use of each category of service or cost but will further demonstrate if reductions in acute care services or costs of such services as ED visits and hospitalizations were achieved by provision of Community Supports or different types of outpatient care and associated costs.

UCLA-RAND will use the methodology developed under the WPC and the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) evaluations (in consultation with Mercer and DHCS) to attribute estimated payments to claims. This step is necessary because payment amounts for managed care encounters are not accurate or reliable. Briefly, this methodology includes identifying detailed and unduplicated categories of outpatient service, identifying the appropriate and available Medi-Cal fee schedules for each type of service, and attributing that amount to a claim. For ED visits, all claims on the day of the ED visit will be aggregated and counted as part of the visit. For hospitalization, all claims during the length of stay other than visits with primary care providers on the first or last day of the stay will be aggregated as part of the same stay. Payments for hospitalizations will be estimated using publicly available prices in DHCS's All Patient Refined-Diagnosis Related Group (APR-DRG) Pricing Calculator to calculate payments for each DRG. For long-term stays, institutional fees billed by a facility will be calculated at the per diem rate, which is inclusive of supplies, drugs, equipment, and services such as therapy. Using the approach outlined in Goal 5 for EQs 7a/7b, UCLA-RAND will then use separate difference-in-difference multivariate regression models to assess the impact of each Community Support on the costs of care for members relative to a matched comparison group. As feasible, UCLA will also run sensitivity analyses to assess potential differential impacts of Community Supports on costs of care for different populations (e.g., members who are unhoused and remain unhoused, members who are unhoused and subsequently housed, members with SMI/SUD, etc.).

Additional analytic considerations

- **Overlap in Community Supports received:** Prior to conducting analyses for Goals 5-8, UCLA-RAND will determine if any Community Supports should be examined together. As shown in Table 1, Community Supports differ in service type, eligibility criteria, preferred provider types, and allowable frequency and duration. Nevertheless, some Community Supports are focused on specific populations and are similar in intent. For example, housing transition/navigation, housing deposits, housing tenancy and sustaining services, recuperative care, short-term post-hospitalization housing, and transitional rent (if approved) are all focused on addressing housing-related needs for members experiencing or at-risk of homelessness with varying levels of clinical needs and are likely to be offered sequentially or in conjunction with one another. Similarly, personal care and homemaker services and environmental accessibility adaptations are targeted to members at risk of institutionalization and are designed to prolong and support community living. Therefore, certain populations are likely to receive more than one Community Support, making it difficult to attribute impact on service utilization, costs, or other outcomes of care to a single Community Support. Furthermore, analysis of the impact of receipt of a single Community Support overlooks the possibility of the cumulative impact of other Community Supports that are used in tandem. Therefore, UCLA-RAND will examine the patterns of use of Community Supports before conducting analyses related to Goals 5-8. If the data indicate significant overlap in receipt of Community Supports, UCLA will identify categories of Community Supports that are better analyzed together and will develop analytic models accordingly. For example, UCLA-RAND may develop an analytic model to measure the impact of receiving housing-focused Community Supports on members experiencing homelessness. This model would include indicators for receipt of each Community Support to account for variation in services provided. UCLA will further measure the impact of receipt of different mixes of services and the cumulative impact of multiple services, as feasible. This analytic approach will increase efficiency and improve the usability of the findings. For Community Supports with limited or no overlap, UCLA-RAND will develop separate analytic models.
- **Changing program requirements:** DHCS is continually refining Community Supports requirements in response to feedback from MCPs, contracted providers, and other stakeholders. These changes are typically reflected in annual updates to the DHCS Community Supports policy guide, which are used by MCPs and providers to inform implementation. UCLA-RAND will document these changes and the timeline over

which they occurred as part of UCLA-RAND's evaluation of Community Supports implementation and impact. As appropriate, UCLA-RAND will also adjust or otherwise account for changes in eligibility criteria and other requirements in analyses, e.g., by incorporating into the selection of comparison groups or in planned subgroup analyses.

- **Prior participation in similar waiver programs:** For most analyses, UCLA-RAND will use a baseline period of 2020-2021. In some counties, Community Supports are similar to services previously provided as part of California's Medi-Cal WPC Pilot Program (baseline period 2015-2016 and intervention implemented 2017-2021) or by Medicaid MCPs that participated in the optional Medicaid HHP benefit (baseline 2016-2017 and intervention implemented 2018-2021). In these counties, UCLA will use data from UCLA's prior evaluation of these programs to assess patterns of service use for Medicaid members who previously received WPC or HHP services and subsequently participated in Community Supports, as feasible. These analyses may be challenging due to churn in enrollment and also selection bias (i.e., members who participate in services for a longer period of time may have a higher level of complexity than those who do not).
- **Potential confounding effects of COVID-19 public health emergency (PHE):** Nationally, the PHE impacted patterns of health care use and expenditures, and also negatively impacted the fiscal solvency of many provider organizations. The baseline period (2020-2021) for the Community Supports evaluation is impacted by the PHE. However, UCLA's previous evaluations of WPC and HHP assessed PHE impact. In these prior evaluations, UCLA found that the PHE temporarily increased services use for Medicaid members with COVID-19; for all other members, there was a sharp decrease in all service use between March – June 2020, followed by a nearly complete recovery in the number of outpatient services (due to use of telehealth) and a less than complete recovery of ED visits and hospitalizations, which continued into December 2021. UCLA's examination of COVID-19 related service use showed high rates of hospitalizations and primary care visits, moderate use of ED visits, and low use of specialty, laboratory services, and long-term care stays. These rates were similar to those for the control population. In these evaluations, UCLA used a COVID-19 indicator (i.e., members with a COVID-19 diagnosis in any claims) in selecting a control group and in difference-in-difference models to ensure that parallel trends assumptions of these models would hold and did not identify major confounding impacts from the PHE. Therefore, while UCLA acknowledges the potential confounding effects of the

COVID-19 PHE on health care use and expenditures, UCLA does not believe the PHE will confound Community Supports evaluation outcomes.

- **Sensitivity Analyses:** (1) Clarify differences in claims/encounters and service delivery, including better understanding the gap in reporting between contracted services and billing encounters, which may occur between MCPs that have different contracting arrangements for specific services. (2) Description of patient need (appropriateness) – examine how to identify which individuals are eligible for care and which receive care based on the different data resources available to UCLA-RAND. (3) Selection effects (unmeasured severity of illness is associated with the choice of intervention leading to biased results) – examination of different approaches and data sources for impact on the robustness of estimates. (4) Weakness of relying upon administrative data for determining need / appropriateness. In particular, disease severity and care plan cannot be determined from (2) and (3). We will attempt to assess gaps by comparing survey results and chart abstraction with administrative data-based results.
- **Additional data:** The Urban Institute’s analysis of preventable hospitalizations used publicly available claims-based algorithms provided by the Agency for Healthcare Research and Quality. States could use this software to examine preventable hospitalizations across other characteristics available directly in their Medicaid data, or by linking to other datasets within the state that may shed light on a wider range of factors contributing to health inequities. For example, linking Medicaid data with data on access to social services outside the health care system or exposure to environmental pollutants could identify shortcomings in other resources and possible root causes of disparities such as housing instability, food insecurity, or poor air quality. Addressing these social needs may help people avoid hospitalizations and other poor health outcomes.
- **Aligning the Community Supports Evaluation with other Components of the CalAIM Evaluation**

The Community Supports evaluation represents an important opportunity to assess the implementation of Community Supports and associated concerns regarding capacity. It supplements four other components: PATH, GPP, DUALs, and REENTRY. While each of these components will generate its own unique evaluation, the interim and final reports will integrate these. In preparation for this, the evaluation team will continue to align the designs of the five components.

Community Supports Evaluation Timeline

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

1. August 1, 2024: Evaluator selection and contracting
2. October 1, 2024: Initiate the process for receipt of Medi-Cal data
3. November 1, 2024: Begin first round of primary data collection from MCPs and providers and analysis of MCP and administrative documents (e.g., Community Supports Model of Care templates, updated Community Supports policy guide, etc.)
4. January 2025: Receipt of person-level data from DHCS
5. January 1, 2025: Begin analyses of Medi-Cal data for interim report
6. September 2025 to December 2025: Develop and pilot test member survey
7. September 16, 2025: Interim report draft submitted to DHCS; only includes data on the 1115 Community Supports
8. December 31, 2025: Interim report submitted to CMS
9. January 2026 to December 2026: Field and analyze member surveys
10. January 2026 to June 2026: Develop and pilot test medical record accession and abstraction protocol
11. May 1, 2026: Begin final round of primary data collection from MCPs and providers
12. July 2026 to June 2027: If feasible, abstract and analyze medical records re post-hospital transitions
13. June 2026: If feasible, follow-up surveys of Community Supports recipients
14. July 2026 to December 2026: Chart abstraction of post-hospitalization transitions
15. June 2027: Receipt of enrollment and claims data from DHCS
16. June 1, 2027: Begin analyses of Medi-Cal data for final report

17. August to October 2027: If feasible, among Community Support recipients who received services in 2026, conduct a second set of cross-section surveys for a new cohort of CS-recipients
18. December 2028: Submit Final Community Support Evaluation submitted to CMS, including all 14 Community Supports and including meeting 1115 and 1915(b) waiver Community Supports evaluations requirements

Methodological Limitations

Attributing outcomes to Community Supports may be challenging due to the simultaneous implementation of other initiatives also intended to improve member health services access, quality of care, and outcomes (e.g., street medicine expansion, community health worker benefit, etc.). In addition, the proposed cost analyses only address costs to Medi-Cal and not to other systems of care and will not include measurements of cost per life year added, or any similar ratio. The evaluation will also only include data through the end of the waiver period (December 31, 2026) and thus may not reflect longer-term program impacts. UCLA's ability to conduct certain analyses is also contingent on the ability to secure access to appropriate data (e.g., Cal ICH HDIS data, the Minimum Data Set, IHSS assessments, Medicare claims/encounters, and Reentry Program eligibility codes). Finally, while UCLA-RAND will attempt to control for member participation in ECM or other care management/case management programs that might moderate the impact of Community Supports on member health care use, quality of care, and other outcomes, UCLA-RAND may not have complete data on all other services members may be engaged with in addition to Community Supports, particularly services not provided by Medi-Cal. Complete information about members fulfilling or not fulfilling specified eligibility criteria for services may not be available. This will affect the identification of appropriate comparison groups. Furthermore, and related to this is the likelihood of selection bias by members, providers, and MCPs. In other words, there is concern that providers or MCPs may be more likely to refer members with higher (unmeasured) severity for Community Supports, and that these members may also be more likely to opt-in to receive Community Supports). The extent to which we can devise adequate analytic approaches to account for selection effects is a limitation of this evaluation. The inclusion of a medical record abstraction for a cohort of individuals using the 1115 Waivers, can enhance our understanding of a member's chronic and current burden of illness. This information can help to assess the degree of selection bias for those who use Community Supports compared with those eligible but not using and for those whose eligibility was not assessed.

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

may reflect the impact of the interventions we are evaluating or merely changes associated with new data systems.

Attachments

Appendix 1. Member Surveys and Medical Chart Abstraction Additional Information

Member Surveys

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

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

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

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

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

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

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

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

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

the Member Survey Fielding protocol and survey content, in collaboration with DHCS. UCLA-RAND anticipates fielding the survey during 2025.

Chart Abstraction

We will aim to complete a targeted chart abstraction for up to 500 individuals receiving 1115-authorized Community Supports services and a matched comparison group of 500 individuals (as described above). Informed consent would explicitly be obtained for survey respondents. If possible, implicit consent will be devised for this retrospective quality improvement evaluation effort. We will supplement the explicit consent chart abstractions with a sample of Community Supports recipients and matching Community Supports non-recipients clustered within hospitals. In this case, with the consent of the plans, we will ask for voluntary chart abstraction from the hospitals via the mechanism of the plans performing quality assessment. We believe that this is a feasible approach for a focused chart abstraction of the initial and final portions of hospital-based care.

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

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

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

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

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

	• The quality and completeness of information about member's: ○ Potential eligibility for any Community Supports ○ Likelihood of receiving any Community Supports ○ Likely benefits and risks of Community Supports for relieving their need(s)
Goal 3: Improve collaboration between MCPs, medical providers, and social services providers to address members' physical health, behavioral health, and HRSN	<i>Member Engagement in Information Sharing and Decision Making Regarding Possible Participation in Community Supports</i> • Information shared with member about options for addressing their physical health, behavioral health, and health-related social needs • Type of provider who shared information and opportunities for ○ Relieving member's medical, social, and financial needs ○ Guiding member about how Community Supports might address member's medical, social, and financial ○ Sharing member-specific information about member's eligibility for Community Supports ○ Guiding member to prepare materials they would have to provide to be considered for Community Supports • Member satisfaction with: ○ Type and adequacy of information shared about their eligibility for Community Supports use, how to improve their eligibility, the information needed to apply for Community Supports use ○ Their perception of how their MCP, medical provider, and social service providers worked together to address their physical, behavioral health and HRSN ○ How their MCP, medical provider, and social service providers heard and incorporated the member's voice and concerns as decisions about Community Supports eligibility were considered and finalized
Goal 4: Examine whether and how public investments in housing and other HRSN services change over	<i>Member's reports of changes over time in how their MCP, medical providers, and social service providers recognized challenges associated with housing and other HRSN services</i>

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

time in concert with new Medicaid funding for those services	Duration of needing and wanting assistance with housing Prior experiences learning about housing options Helpful and unsatisfactory prior experiences with housing options Duration of time from learning of Community Supports housing options and final decision about their eligibility for housing Community Supports Duration of time from learning about Community Supports housing options and actual receipt of support Other Medicaid/state-funded services member is using
Goal 5: Increase members' access to non-emergency outpatient care and reduce acute care utilization and long-term care stays	<i>Member opportunities for and use of Non-Emergency vs Emergency use of Specific Types of Services</i> • Characterize typical use of Primary, Specialty, Mental Health, and Substance Use Disorder Services ○ Emergent vs. Non-emergent Setting ○ Typical frequency of use ○ Satisfaction with access and quality ○ Specific barriers to access and quality • Characterize most recent ED use ○ Reason for most recent ED visit ○ Satisfaction with health or social service visits preceding most recent ED visits ○ Satisfaction with health or social service visits following most recent ED visits ○ Did the recent ED visit intensify or diminish the member's highest priority need? <i>Member use of Acute and Long-Term Care Stays</i> Did recent acute care or long-term care stay intensify or diminish the member's highest priority need? <i>Members' perceived impact on service access and use</i> • Awareness of duration and future availability of services • Participation with long-term care and/or other community services • Changes since using Community Supports in ED and non-emergency visits and services

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

Goal 6: Improve quality of care and outcomes of care	<i>Member overall report of access, quality of care, and outcomes now</i> • Member overall reports of changes in fulfillment of their priority need during the last six months • Has access, quality, and outcomes changed since member has learned about Community Supports and since they have participated in Community Supports, or learned they will soon initiate Community Supports, or are not eligible for Community Supports
Goal 7: Reduce disparities in service utilization, quality of care, and outcomes of care	<i>Member report of disparities experienced in relation to opportunities to:</i> • have their priority need recognized as a concern by MCP, medical provider, and social providers • receive optimal quality of care for managing their needs • have Community Supports information shared in a spoken and written language they can understand • learn about Community Support and eligibility requirements for Community Support in a timely manner • gather and share information about their history that could support their eligibility for Community Support Community Support • receive their priority Community Support Community Support • receive an additional Community Supports beyond the one they already have <i>Member characterization of specific types of disparity that they have experienced</i> • Looking downstream • Member reports of concerns that progress in addressing needs will be undone once access to Community Supports is terminated
Goal 8: Ensure HRSN expenditures do not exceed aggregate spending caps and Community Supports are cost-effective alternatives to State Plan services and settings	N/A

Appendix 2. Community Supports Quality Metrics

Community Supports	Candidate Measures – Health Condition Specific	Candidate Measures – Not Health Condition Specific	Notes
1115 Community Supports			
Recuperative care		AMB-ED - ED Utilizaion AHU - Acute Hospitl Utilization AAP - Adults' Acces to Preventive/ Ambulry Health Services Housing Stability SNF Admission an LOS – Admission to skilled sing facility and length o stay	Housing stability measured by member survey and available data.
Short-term post-hospitalization housing		AMB-ED - ED Utilizaion AHU - Acute Hospitl Utilization AAP - Adults' Acces to Preventive/ Ambulry Health Services PCR – Plan All Caus Readmissions Housing Stability SNF Admission an LOS – Admission to skilled sing facility and length o stay	Housing stability measured by member survey and available data.
1915(b) Community Supports			
Housing transition / navigation		AMB-ED - ED Utilizaion AHU - Acute Hospitl Utilization Housing Stability SNF Admissions SNF LOS	Housing stability measured by available data.

Community Supports	Candidate Measures – Health Condition Specific	Candidate Measures – Not Health Condition Specific	Notes
Housing deposits		AMB-ED - ED Utilization AHU - Acute Hospital Utilization Housing Stability SNF Admissions SNF LOS	Housing stability measured by available data.
Housing tenancy and sustaining		AMB-ED - ED Utilization AHU - Acute Hospital Utilization Housing Stability SNF Admissions SNF LOS	Housing stability measured by available data.
Day habilitation		Housing Stability Transition to SNF or Assisted Living. SNF Admissions SNF LOS	Housing stability measured by available data.
Caregiver respite		Housing Stability Transition to SNF or Assisted Living. SNF Admissions SNF LOS	Housing stability measured by available data.
Nursing Facility transition / diversion to Assisted Living Facility	Return to Skilled Nursing Facility within 6 Months	HFS - Hospitalization Following Discharge from a Skilled Nursing Facility Referrals to or enrollment in Assisted Living Waiver (ALW) SNF Readmissions SNF LOS	No specific consensus metrics. Failure may lead to returning to SNF.
Community transition / Nursing Facility to home	Return to Skilled Nursing Facility within 6 Months	HFS - Hospitalization Following Discharge from a Skilled Nursing Facility	No specific consensus metrics.

Community Supports	Candidate Measures – Health Condition Specific	Candidate Measures – Not Health Condition Specific	Notes
		Referrals to or enrollment in Assisted Living Waiver (ALW) SNF Readmissions SNF LOS	Failure may lead to returning to SNF.
Personal care and homemaker		Housing Stability Transition to Assisted Living or SNF. SNF Admissions SNF LOS	Housing stability measured by available data.
Medically Tailored Meals	CBP - Controlling High Blood Pressure HBD - Hemoglobin HbA1c Control for Patients with Diabetes – Poor Control (HbA1c > 9%) EDH - Emergency Department Visits for Hypoglycemia in Older Adults with Diabetes	AMB-ED - ED Utilization AHU - Acute Hospital Utilization (any and LOS) Transition to SNF or Assisted Living (and SNF LOS)	Weight loss / malnutrition is not measurable
Sobering centers	FUA - Follow-Up After ED Visit for Substance Use—30 days ETOH-specific ED visits	AMB-ED - ED Utilization AHU - Acute Hospital Utilization AAP - Adults' Access to Preventive/ Ambulatory Health Services	
Environmentally Accessible Adaptations	Falls resulting in fracture	AMB-ED - ED Utilization AHU - Acute Hospital Utilization AAP - Adults' Access to Preventive/ Ambulatory Health Services	No specific /consensus measures.

Community Supports	Candidate Measures – Health Condition Specific	Candidate Measures – Not Health Condition Specific	Notes
		Transition to SNF or Assisted Living.	
Asthma remediation	AMR – Asthma Medication Management: Continuation Phase Treatment Asthma-specific ED visits Use of Oral Steroids	AMB-ED - ED Utilization AHU - Acute Hospital Utilization AAP - Adults' Access to Preventive/ Ambulatory Health Services	Metrics reflect overuse of rescue medications OR need for rescue visit to ED.

Note:

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

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

For most CS services, specific chronic care management measures from MCAS and HEDIS (such as receipt of appropriate recommended care, e.g. receipt of colonoscopy, testing for diabetics, testing for hyperlipidemia, and care follow-up) would be relevant for interventions promoting housing stability, given that individuals with stable housing are more likely to be able to accomplish these tasks but are not listed above for space considerations.

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

Appendix 3. Projected Budget and Independent Evaluators

Projected Budget

Exhibit A2. Community Supports Evaluation Estimated Budget

COSTS	Year 1: N/A*	Year 2: 7/1/24 – 6/30/25	Year 3: 7/1/25- 6/30/26	Year 4: 7/1/26- 6/30/27	Year 5: 7/1/27- 6/30/28	Year 6: 7/1/28- 5/31/29	TOTAL
Personnel (including fringe benefits)	-	530,249	605,871	563,695	581,354	541,762	2,822,931
Other Direct Costs (Rent, TIF, etc.)	-	13,364	14,259	13,978	14,354	13,788	69,743
Chart Abstraction	-	0	100,000	100,000	0	0	200,000
Survey – Post-Hospitalization Transitional Housing	-	50,000	50,000	50,000	50,000	0	200,000
Survey – Recuperative Care	-	0	100,000	100,000	100,000	0	300,000
Survey – Transitional Rent	-	0	200,000	0	0	0	200,000
Data & Statistical Support (DOMSTAT)	-	17,118	17,632	18,160	18,705	16,605	88,220
Indirect Costs (F&A)	-	131,433	245,239	186,347	165,053	124,450	852,522
TOTAL COSTS							4,733,416

*The CS Evaluation was not implemented until Year 2 of the CalAIM1115 Evaluation.

More information about these costs is as follows:

Personnel. This includes all staff time to complete the evaluation plan. Staff roles include research scientists, project managers, research analysts, research associates, and statisticians, and data programmers. Their work covers all oversight and planning, design, data collection, analysis, reporting, coordination, and all other tasks related to the successful completion of the evaluation plan. The personnel budget line includes fringe benefits.

Other Direct Costs. This includes office rent, Technology Infrastructure Fees (TIF), and General and Employment Liabilities (GAEL).

Chart Abstraction. Hospital chart abstraction (post-hospitalization transitional housing) will focus on the initial and final aspects of hospitalization to measure (1) severity of illness, (2) instability at discharge, (3) discharge location, and (4) discharge treatment plan. Chart abstraction will focus on up to 1,000 completed charts – 500 individuals who received post-hospitalization transitional housing and 500 matched individuals. Costs include personnel costs, implementation and set up, quality assurance and error correction, and IT and overhead costs.

Survey – Post-Hospitalization Transitional Housing. This includes all survey costs including subcontractor costs, translation, printing, and mailing. Compensation for survey respondents is also included in this budget line.

Survey – Recuperative Care. This includes all survey costs including subcontractor costs, translation, printing, and mailing. Compensation for survey respondents is also included in this budget line.

Survey – Transitional Rent. This includes all survey costs including subcontractor costs, translation, printing, and mailing. Compensation for survey respondents is also included in this budget line.

Data and Statistical Support (DOMSTAT). The UCLA Department of Medicine Statistics Core (DOMSTAT) provides investigators at UCLA with state-of-the-art statistical support and supports study design, data management, and statistical analysis.

Indirect Costs. This includes Facilities and Administrative rate (F&A). The University of California F&A rate (base: modified total direct costs) pertains to this California State-Funded off-campus project.

Other. Other costs include software, materials, supplies, etc. and is included within the Core budget.

Independent Evaluation Team

DHCS selected the Regents of the University of California on behalf of its Los Angeles campus (UCLA) as the Independent Evaluator to perform the Independent Evaluation of Community Supports. The contract includes two subcontractors – the

RAND Corporation, and the University of California (UC) at Berkeley. UCLA, RAND and UC Berkeley agreed to conduct the evaluation in an independent manner in accordance with the draft Evaluation Design. The independent evaluators consider the unique goals of Community Supports and the overarching impact on CalAIM and population health. The Independent Evaluator's approaches consider structural changes, cost of care, quality of care, and access to care, all of which provide a picture of the beneficiary's experience and impact to the state's administration of the program overall. Furthermore, UCLA-RAND is responsible for developing the evaluation design, as well as reporting results of the evaluation in the Interim and Summative Evaluation Report.

Appendix H. Duals Medi-Cal Plan Alignment Policy Evaluation

(Placeholder – see separate PDF file)