Project Report

JOSHUA BRESLAU, MARCELA HORVITZ-LENNON, RACHEL M. BURNS, ELIZABETH MARSOLAIS, AMY L. SHEARER

Evaluation Plan

Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT)

PR-A4162-1
July 2026
Prepared for the California Department of Health Care Services

PR-A4162-1

About This Evaluation Plan

RAND will conduct the evaluation of the California Department of Health Care Services' (DHCS) Section 1115 demonstration focusing on services for Medi-Cal members with significant behavioral health (BH) needs. The demonstration, known as the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT), was approved by the Centers for Medicare & Medicaid Services (CMS) on December 16, 2024. BH-CONNECT is comprised of a coordinated series of reforms and investments that collectively aim to improve access to care, quality of care, and health outcomes for individuals with significant BH needs. This draft evaluation plan provides the background for BH-CONNECT and an overview of the proposed evaluation design. It subsequently describes each of the five demonstration programs and the methods and data that will be used to evaluate them.

This research was funded by the California Department of Health Care Services and carried out within the Access and Delivery Program in RAND Health Care.

RAND Health Care, a division of RAND, promotes healthier societies by improving health care systems in the United States and other countries. We do this by providing health care decisionmakers, practitioners, and consumers with actionable, rigorous, objective evidence to support their most complex decisions. For more information, see www.rand.org/health-care, or contact

RAND Health Care Communications
1776 Main Street
P.O. Box 2138
Santa Monica, CA 90407-2138
(310) 393-0411, ext. 7775
RAND_Health-Care@rand.org

Statement of Objectivity

This evaluation is being conducted independently and objectively by RAND. The authors have no conflicts of interest to disclose.

Acknowledgments

We thank the California Department of Health Care Services for its support of this evaluation plan and sharing their knowledge of the planned implementation of the BH-CONNECT waiver, particularly Tina Flores and Ye Ji Kim. We are also grateful to Chandra Garber for improving the clarity of this draft evaluation plan.

Contents

Figures and Tables

Figures

Tables

Chapter 1. General Background Information

This document describes the design for RAND's evaluation of the California Department of Health Care Services' (DHCS) Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) demonstration focusing on services for Medi-Cal members with significant behavioral health (BH) needs. The BH-CONNECT demonstration was approved by the Centers for Medicare & Medicaid Services (CMS) on December 16, 2024, under a Serious Mental Illness Section 1115 demonstration opportunity (CMS, undated) that allows states to receive federal financial participation (FFP) for qualifying short-term care provided in institutions for mental disease (IMDs), conditional on improvements in quality of IMD care and in access to community-based BH services. BH-CONNECT is comprised of a coordinated series of reforms and investments that collectively aim to improve access to care (including expanded coverage for of evidence-based practices (EBPs) for adults and clarified coverage for EBPs for children), quality of care, and health outcomes for individuals with significant BH needs. This initial chapter provides the background for BH-CONNECT and an overview of the proposed evaluation design. In subsequent chapters, we describe each of the five demonstration programs and the methods and data that will be used to evaluate them.

Specific Goals of the BH-CONNECT Demonstration

The "Special Terms and Conditions" (STCs) governing the demonstration authorized waivers and expenditure authorities to "test the effectiveness of innovative practices aimed at strengthening the continuum of community-based behavioral health services," and thus achieve the CMS-approved goals. These goals are central to the evaluation because they comprise the primary long-term goals against which the demonstration should be evaluated. As documented in the STCs, which specify requirements for the demonstration, CMS has approved the following goals for BH-CONNECT:

- Expand the continuum of community-based BH services and evidence-based practices (EBPs) available through Medi-Cal
- Strengthen family-based services and supports for children and youth living with significant BH needs, including children and youth involved in the child welfare system
- Invest in statewide practice transformations to better enable county BH delivery systems and providers to support Medi-Cal members living with significant BH needs
- Strengthen the workforce needed to deliver community-based BH services and EBPs to Medi-Cal members
- Reduce the risk of individuals entering or re-entering the criminal justice system due to untreated or under-treated mental illness

- Reduce use of institutional care by those individuals most significantly affected by significant BH needs
- Shorten lengths of stay in institutional settings and support successful transitions to community-based care settings and community reintegration
- Promote improved health outcomes, community integration, treatment and recovery for individuals who are homeless or at risk of homelessness and experiencing critical transitions.

BH-CONNECT Programs

To address BH-CONNECT's specific goals, CMS authorized the state to implement the following five demonstration programs, which this evaluation design will address:

- Access, Reform, and Outcomes Incentive Program (IP): A financial incentive program that encourages county BH delivery systems to improve access to BH services; improve outcomes among Medi-Cal members living with significant BH needs; and make targeted BH delivery system reforms.
- Workforce Initiatives Program (WIP): A series of five initiatives supporting recruitment and retention to increase the availability of behavioral health providers working in Medi-Cal safety-net settings that provide BH services to Medi-Cal members and uninsured populations living with BH needs.
- Activity Funds Initiative: A program that provides flexible funding to cover the cost of activities and items that support improved behavioral health outcomes for children and youth with behavioral health conditions that are involved in the child welfare system.
- SMI Program: Permits behavioral health plans (BHPs) that administer specialty mental health services (SMHS) to receive federal financial participation (FFP) for mental health services provided to adult Medi-Cal members ages 21-64 years during short-term stays in IMDs, as defined by CMS. Counties that opt into the SMI program must also meet several CMS requirements, including requirements related to community-based services.
- Community Transition In-Reach Services: A program that provides transitional care management services to support members with significant behavioral health needs who are returning to the community after extended stays in inpatient, subacute, and residential facilities.
- Short Term Rental Assistance Program (i.e., Transitional Rent[1]): Provides time-limited housing assistance to Medi-Cal members who are homeless or at risk of becoming homeless to improve physical and behavioral health and functioning.

Table 1.1 shows which of the demonstration goals are addressed by each of the above BH-CONNECT programs, according to the evaluation team. The evaluation designs for each program, which are presented in subsequent chapters of this document, focus on the goals indicated for that program in the table. Each chapter provides a logic model which shows how the program components are expected to impact long- and short-term outcomes and lists

[1] Under the BH-CONNECT waiver, CMS refers to this service as Short-Term Rental Assistance. DHCS will continue to use the service name, Transitional Rent, throughout this document and subsequent evaluation reports.

potential confounding and moderating factors. Specific evaluation questions, hypotheses, and the data sources that will be used to examine the evaluation questions are detailed in subsequent chapter sections.

Table 1.1. Potential Association between BH-CONNECT Programs and BH-CONNECT Goals

Demonstration Goals	Incentive Program	Workforce Initiatives Program	Activity Funds Initiative	SMI Program	In-Reach Services Program	Transitional Rent
Expand the continuum of community-based BH services and EBPs available through Medi-Cal.	Associated	Not associated	Not associated	Associated	Not associated	Not associated
Strengthen family-based services and supports for children and youth living with significant BH needs, including children and youth involved in child welfare.	Associated	Not associated	Associated	Not associated	Not associated	Not associated
Invest in statewide practice transformations to better enable county BH delivery systems and providers to support Medi-Cal members living with significant BH needs.	Associated	Not associated	Not associated	Associated	Not associated	Not associated
Strengthen the workforce needed to deliver community-based BH services to Medi-Cal members.	Not associated	Associated	Not associated	Not associated	Not associated	Not associated
Reduce the risk of individuals entering or re-entering the criminal justice system due to untreated or under-treated mental illness.	Associated	Not associated	Not associated	Associated	Not associated	Associated
Reduce use of institutional care by those individuals most significantly affected by significant BH needs.	Associated	Not associated	Associated	Associated	Associated	Not Associated
Shorten lengths of stay in institutional settings and support successful transitions to community-based care settings and community reintegration.	Not associated	Not associated	Not associated	Associated	Associated	Associated
Promote improved health outcomes, community integration, treatment and recovery for individuals who are homeless or at risk of homelessness and experiencing critical transitions.	Associated	Not associated	Not associated	Associated	Associated	Associated

BH-CONNECT Evaluation Overview

As recommended by CMS (2020), the evaluation will use mixed qualitative and quantitative methods to examine implementation of the BH-CONNECT programs and their impacts. Implementation will be assessed using a combination of document reviews, key informant interviews, analyses of administrative data, and surveys of providers and participants. The implementation assessments will provide detailed information from multiple perspectives on what was done under the program, barriers to implementation, and potential unintended consequences. Impacts of the demonstration programs will be assessed primarily through analyses of administrative data. The impact analyses will use methods permitting causal inferences with observational data that will be selected based on their ability to ensure the most robust answers to the evaluation questions. The evaluation design suggests analytic approaches to address the evaluation questions, with the understanding that these analytic approaches may need to be adjusted based on data availability and preliminary data analyses.

The evaluation design takes account of the decentralized structure of California's specialty BH delivery systems for Medi-Cal members and the uninsured living with a serious mental illness (SMI) or serious emotional disturbance (SED), or a substance use disorder (SUD). Medi-Cal behavioral health services are "carved-out" from other Medi-Cal services and managed at the county level through Prepaid Inpatient Health Plans, which the STCs refer to as behavioral health plans (BHPs).[2] The IP, SMI Program, and the In-Reach Services Program are all implemented by county mental health plans (MHPs). Because of this decentralized structure, the evaluation focuses primarily on tracking implementation and impact at the county level. In contrast, the Workforce Initiatives and the Activity Funds Initiative administered by DHCS on a statewide basis. For these programs, the evaluation will take a state-level view, with attention to regional variations in need, implementation, and outcomes.

Deliverables and Timeline

CMS approved the demonstration for a five-year period beginning on January 1, 2025. However, implementation timelines will vary across the programs and across participating counties. The program-specific timelines are described in each of the chapters below. Here we summarize the timeline for the evaluation deliverables (see Table 1.2).

[2] In most counties, specialty mental health services for Medi-Cal beneficiaries and the uninsured with significant mental health needs are managed through a Mental Health Plan, while substance use disorders (SUD) are managed through the Drug Medi-Cal Organized Delivery System. There are some exceptions where SUD services are provided through an older Drug Medi-Cal program that is not a PIHP, or where both mental health and SUD services are provided through an integrated behavioral health plan. At present all PIHPs and Drug Medi-Cal programs are administered by counties.

The evaluation will have five deliverables:

- Evaluation Design: Describes a detailed plan for the independent evaluation of the demonstration program. Final approved version of the current document.
- Rapid Cycle Assessment: Describes preliminary qualitative and quantitative findings on the first year of implementation of the Community Transition In-Reach Services initiative. The Rapid Cycle Assessment will report on initial implementation data, utilization of In-Reach services, and preliminary findings on health outcomes among participants.
- SMI Mid-Point Assessment: Reports on evaluation results covering approximately the first two-and-a-half years of the demonstration based on input from key stakeholders and analysis of administrative data, including performance measures as approved in the monitoring protocol (described in Table 5.2 below). The objective of the Mid-Point Assessment is to examine progress toward achieving the goals of the program, including meeting the milestones within the approved time frames; determine factors that may have hindered progress; and determine factors that may affect future progress.
- Interim Evaluation Report: Describes findings of the evaluation, as per the approved evaluation design, covering completed years of the demonstration.
- Summative Evaluation Report: Describes the findings of the independent evaluation of the demonstration program for all years of the demonstration.

The timeline for submitting these five deliverables is presented in Table 1.2. For each deliverable, a Final Revision will be submitted 60 days after receipt of CMS' comments. Thirty days after CMS approves the deliverable, a final version of the deliverable that is compliant with the Americans with Disabilities Act will be publicly posted to the DHCS website.

Table 1.2. Timeline of Deliverables

Deliverable	Initial Draft to CMS
Evaluation Design	08/08/2025
Rapid Cycle Assessment	One and a half years after implementation of Community Transition In-Reach Services
Mid-Point Assessment	02/14/2028
Interim Evaluation Report	12/31/2028
Summative Evaluation Report	06/30/2031

Data Sources and Methods

The evaluation will use a wide range of existing administrative, clinical, and survey data, supplemented by strategic collection of new data designed to minimize burden on participants. Sources of existing data will include but are not limited to Medi-Cal claims, encounter, and other administrative data (hereinafter referred to as "Medi-Cal data"); data collected as part of the STCs, state licensure data; and data from the Department of Health Care Access and Information

(HCAI) on the workforce initiatives. An exhaustive list of data sources to be used or considered for use is in Appendix A. The individual chapters provide more details on the data sources that will be used to address each evaluation question and hypothesis.

County Profiles

RAND will compile profiles of county BH delivery systems (hereinafter referred to as "county profiles") and update these profiles over the course of the evaluation to assess changes. The county profiles will draw as much as possible on existing data to minimize the need to collect new data from counties. The data sources will include RAND's Mental Health and Addiction Treatment Tracking Repository (MATTR) data system, which includes records of all mental health and substance use treatment facilities listed in the treatment finder maintained by the Substance Abuse and Mental Health Services Administration (SAMHSA). In addition, we will develop an automated data pipeline to draw data from the DHCS Licensing and Certification Division databases and other data sources to track the BH workforce and capacity in psychiatric hospitals and other BH services. These existing data will be supplemented by data collected directly from counties using an online portal through which surveys or reports can be submitted to the evaluation team. To reduce the burden of data collection, counties will have the option of completing structured reports or providing the relevant information in other existing documents, such as the Annual Availability Assessment of Mental Health Services; three-year Integrated Plan, budget reports and Behavioral Health Outcomes, Accountability, and Transparency Reports (BHOATRs) required by the Behavioral Health Services Act (BHSA); or self-assessments using the National Committee on Quality Assurance (NCQA) Managed Behavioral Health Organization assessment tool. Information submitted through documents will be abstracted by the RAND team to complete the county profiles. The county profiles will be used to track change in service capacity across levels of community-based care, including provision of evidence-based practices, community engagement efforts, and health information technology (HIT) systems used in county BH care.

Semi-Structured Interviews

Semi-structured interviews will be used in the evaluation of all demonstration components, providing details on implementation that will inform interpretation of the quantitative assessments of impact and suggest additional hypotheses or sub-group analyses. The types of interviewees will vary across the components but will include state officials, county officials, providers, and Medi-Cal members. State and county officials, including BHP personnel, will be asked about the strategies they have pursued to implement the demonstration programs, the reasoning behind those strategies, barriers to implementation, and how implementation challenges have been addressed. These interviews may also be used to collect information on state or county actions or policies, clarify questions arising from document review or analysis of survey or administrative data, and to help with recruitment of additional interviewees.

Interviews with providers, who may be in administrative or direct care roles, will focus on how the strategies employed by policymakers have affected their practices. We will ask about whether the anticipated impacts of the policy changes have occurred in practice and whether there are groups that may be less well served than others. The interviews will then explore providers' perspectives on why these changes have or have not occurred, what barriers were experienced, and how implementation challenges were met. Interviews with Medi-Cal members will be used in contexts where a small, targeted sample can provide valuable information that could not be better collected through a Medi-Cal member survey. For instance, qualitative interviews will be conducted with Medi-Cal members receiving In-Reach Transition services to ask about their perceptions of that program. Interviews with Medi-Cal members will be offered in English and Spanish.

To ensure the quality of the interview data, all interviewers will undergo a standard training on California's BH system and specific training to understand each type of interview respondent and the specific evaluation questions of interest. We will develop interview guides with input from the DHCS and other stakeholders to ensure that all relevant topics are covered. With interviewee permission, interviews will be recorded and transcribed for analysis. RAND will take several steps to reduce the burden of data collection on participants. First, where possible, we will use fully structured report forms that can be completed independently by staff members prior to interviews. This ensures that detailed factual data, such as numbers of programs of different types, do not need to be collected during qualitative interviews. Second, the interviews will be informed by the county profiles, which will be compiled primarily from document review. Interviewers will review the county profiles prior to the interview so that they can ask informed questions. In addition, questions related to all the components of the evaluation will be combined into a single interview protocol for each interviewee. Third, each year, we will interview a sample of counties, rotating the sample so that all counties will eventually be included. This reduces the number of interviews each county will be asked to complete over the course of the evaluation.

Interview protocols will be developed by the RAND team for each qualitative data collection effort described in subsequent chapters. RAND will initially develop a set of content domains that will be covered in the interview and seek input on the domains from DHCS and other stakeholders. For domains for which there is a published literature, RAND will review measurement approaches to ensure that domains regularly covered in structured instruments are covered in our semi-structured interview protocols. Interview questions for each domain will be developed by the RAND team and shared with stakeholders for input prior to beginning data collection.

Interview data will be analyzed with thematic analysis (Guest, MacQueen, and Namey, 2012), using Dedoose, a cloud-based platform designed for mixed-methods research. The analysis will combine a deductive approach—applying a structured coding scheme based on pre-specified themes derived from the literature and our logic model—with an inductive approach to

identify emergent themes that arise organically from the data. Coders will apply both types of codes to transcripts, enabling the identification of patterns across interviews while remaining open to unanticipated insights. Dedoose facilitates this process through features that support team coding, code co-occurrence analysis, and data visualization.

Survey Data

The evaluation will use survey data for evaluation of three of the demonstration components: the IP, the workforce initiatives, and the activity funds initiative. For the IP, the evaluation will analyze data from the Medi-Cal member survey on quality of life that will be conducted by DHCS. For the workforce initiative, RAND will survey awardees of workforce funds, which will include individual trainees and clinical programs that receive funds for recruitment and retention. For the activity funds initiative, RAND will survey adult participants and family members of child participants. Surveys conducted by RAND will be online and will offer participants a small incentive for participation. Details on the surveys are in the relevant chapters that follow.

Quantitative Methods

Following CMS guidance, including best practices for causal inference (Contreary, Bradley, and Chao, 2018), we will strive to address the evaluation questions and hypotheses with robust quasi-experimental methods enabling a rigorous evaluation of demonstration impacts. Although quasi-experimental methods may be subject to biases, we will interrogate the assumptions needed to justify causal inferences through indirect quantitative assessments, and targeted sensitivity analyses and robustness checks (see below).

Method selection will be grounded in the understanding that the method's robustness depends on its ability to address variation of outcomes and risk factors over time due to secular trends, potential heterogeneity in program implementation effects, and the effects of concurrent initiatives or unobserved factors. Comparison groups in general and in this setting strengthen the premise for drawing causal inferences, so we will take advantage of such comparisons when they are available. Because we will have pre-intervention data available on both intervention and comparison groups and because we believe there are likely to be unobserved differences between intervention and comparison groups, we will use a difference-in-differences (DD) approach to analysis in these cases because of its robustness to certain types of unobserved confounding. In the DD approach, the comparison group controls for background secular trends so that significant differences that remain between intervention and control groups may be validly attributable to the impacts of program implementation. A valid DD analysis must be principled, i.e., the characteristics of the target population, the intervention, and the context in which it is implemented should credibly support the plausibility of observing true effects, and it must address related methodological concerns: violations of the parallel trends (or common shocks) assumption. We will assess the plausibility of parallel trends by estimating differences in pre-program trends in the outcome between program participants and non-participants and will

propose sensitivity analyses to account for potential departures from parallel trends (Rambachan, Ashesh, and Roth, 2023). We will address the possibility that shocks may differentially impact the intervention and control groups through robustness checks, for example, by excluding from analyses the counties that are subject to known major shocks during the demonstration period. An additional methodological concern pertains to serial correlation in outcomes over time, which we will address by calculating empirical standard errors adjusted for clustering.

If the test for parallel trends is not satisfied, the model will be adapted to accommodate diverging trends in a different quasi-experimental approach—a Comparative Interrupted Time Series (CITS) model. The CITS model explicitly accounts for diverging pre-period trends in participants and non-participants when estimating program effects, at the expense of stronger assumptions about how the pre-period relates to the post-period.

Ideal comparison groups are contemporaneous groups of individuals who are not exposed to the program and who have similar characteristics to exposed individuals prior to the implementation of the program, permitting comparison of pre-post differences in outcomes between exposed and unexposed individuals. Such comparison groups may result, for example, from implementation of BH-CONNECT programs at different time points. If no within-state comparison groups can be identified, we may consider valid out-of-state comparison groups. When valid comparison groups are not available, we will implement Interrupted Time Series (ITS), the most robust among the quasi-experimental methods that permit assessing hypotheses without a comparison group by minimizing the confounding effect of other potential drivers of observed effects. ITS assesses risk-adjusted changes in the level and trend in the outcome measures from the baseline to the post-implementation period and uses the estimates to test hypotheses about program impacts.

Because counties can opt in and out of some of the BH-CONNECT programs at their discretion (SMI Program, Community Transition In-Reach Services Program), planned analyses will need to account for differential timing of county participation in these programs. Traditional methods, such as two-way fixed effect models, can incur bias in these settings if the effect of the intervention changes over time because the estimated effect may be influenced by comparisons between counties implementing the program at different times during the study period. We will use recently developed methods that handle staggered adoption to ensure that these types of comparisons do not occur (Callaway and Sant'Anna, 2021; Wing, Coady, Freedman, and Hollingsworth, 2024).

For selected evaluation questions and hypotheses where stratified descriptive analyses suggest that BH-CONNECT Program effects are moderated by key Medi-Cal member characteristics, and if feasible depending on sample sizes, we will estimate difference-in-difference-in-differences (DDD) models. These models, also referred to as triple D models, will permit examination of outcome disparities by sex, age, race and ethnicity, English language proficiency, primary language, disability status, geographic location, and other variables of interest.

Integration of Qualitative and Quantitative Analyses

The mixed-methods approach will be sequential and iterative, with qualitative findings informing subsequent quantitative analyses and quantitative results informing subsequent qualitative methods. Initially, sampling for qualitative interviews will be informed in part by administrative data collected as part of the county profiles and basic implementation information provided by DHCS (e.g. which counties are participating in which programs, contact information for county officials). The initial round of qualitative interviews will precede the quantitative assessments of program impacts. We use this design because of the time lag involved in gaining access to the main sources of quantitative data (Medi-Cal data) and because the qualitative data that we collect on program implementation will inform some of the impact analyses. For instance, qualitative findings on variation in implementation across counties or inclusion of providers who speak languages other than English may suggest quantitative investigations of heterogeneity in treatment effect across groups of counties or English language proficiency.

Qualitative interviews may also suggest factors that may confound the quantitative analysis that should be adjusted for in statistical models. Initial quantitative analysis results will then inform questions for later rounds of qualitative data collection. For instance, if we find that the IP impacts a quality of care measure in some counties and not others, we will add questions to our interview guides to investigate implementation issues in both types of counties, thus highlighting differences that may have led to differences in outcomes. Our approach to combining qualitative and quantitative methods for the interim and summative reports will be integrative, combining qualitative and quantitative information, triangulating findings to identify points of convergence, complementarity and divergence.

Evaluation Timeline

This section summarizes the planned activities for each year of the evaluation period. The evaluation team will streamline data collection efforts of the BH-CONNECT initiatives, to the extent possible, to minimize the burden for initiative administrators and participants.

Evaluation Year 1: 2025

RAND will draft the evaluation design and begin to track implementation of the BH-CONNECT initiatives as they are launched by the State of California.

Evaluation Year 2: 2026

RAND will finalize the evaluation design and begin significant data collection efforts in 2026, including administering surveys developing county profiles, and assessing health IT. RAND will also begin conducting interviews with state officials, county officials, program participants, and other stakeholders. Depending upon the implementation start date for the Community Transition In-Reach Services Program, RAND may begin or continue work on the Rapid Cycle Assessment. RAND will begin analysis of Medicaid and other secondary

data, including performance data, Timely Access Data Tool (TADT), and survey data. RAND will also begin analyses of program administrative data to the extent that such data are made available.

Evaluation Year 3: 2027

RAND will continue the data collection efforts and data analyses described as part of Evaluation Year 2 (2026), as program implementation continues. Depending upon the implementation start date for the Community Transition In-Reach Services Program, RAND may complete and submit the Rapid Cycle Assessment. RAND will draft the Mid-Point Assessment of the SMI program.

Evaluation Year 4: 2028

RAND will continue data collection and analysis efforts previously described. The Mid-Point Assessment will be submitted to CMS, and RAND will revise the Mid-Point Assessment in response to CMS comments. RAND will develop, complete, and submit the Interim Evaluation Report.

Evaluation Year 5: 2029

RAND will continue data collection and analysis efforts that, at this stage of the demonstration, are expected to provide valuable insights into a more mature implementation of the various BH-CONNECT programs. RAND will begin drafting the final summative report.

Evaluation Year 6: 2030

RAND will complete analyses of all secondary data sources including program administrative data and Medicaid data and complete the analysis of surveys fielded by RAND. RAND will finalize and submit the final summative report by June 30, 2031.

Limitations

The evaluation design has several limitations that are important to note. First, the evaluation design is based on estimates of county, provider, and/or individual participation in the various programs. The planned evaluation strategies may need to be updated if the actual participation rates diverge from expected levels. Similarly, delays in the implementation timeline may require that the evaluation design be adjusted to ensure adequate coverage of participants. Of particular concern in this regard is the Activity Funds Initiative, where there is a potential for small sample sizes. Second, depending on the availability of data (including delays in county reporting and missing data), our ability to access data, and preliminary analyses, there is a possibility that the proposed quantitative analytic approaches will need to be revised. For instance, there may be limited access to data preceding the demonstration, which would prevent the evaluation team from using a DD approach. Third, the evaluation will not have access to direct measures of

participant health status, although access to mortality data would mitigate this limitation to some extent. Where possible, we will use proxy measures, such as use of acute care. Fourth, recruitment of individuals for surveys and semi-structured interviews is likely to be challenging. RAND will work with stakeholders to develop the most effective recruitment strategies and offer incentives to participants for completing interviews. However, recruiting providers who have busy schedules and patients with complex health conditions who may be poorly connected to care will be challenging.

Chapter 2. Evaluation Design for Access, Reform, and Outcomes Incentive Program

Brief overview of the Access, Reform, and Outcomes Incentive Program

The Access, Reform, and Outcomes Incentive Program (IP) is a pay-for-performance payment arrangement. BHPs that opt-in will be eligible for additional payments based on their performance on pre-specified metrics of the quality of care provided to Medi-Cal members. The IP allows BHPs to earn additional payments for positive performance, but participation does not put them at risk of losing incentive funds if they fail to meet the measure thresholds. BHPs that receive incentive payments must use those funds to support and expand Medi-Cal services that improve Medi-Cal members' service in the BH delivery system. The state is at risk of forfeiture of a portion of the total federal funding for incentive programs if the BHPs as a group fail to demonstrate progress on a select group of accountability measures on an annual basis starting in demonstration year 3. In this section, we describe the IP goals and approach, and the plan for evaluating its implementation and impact.

According to the approved STCs, the IP has the following overall goals:

- Reward BHPs for improving access to high-quality, timely BH services
- Support BHPs in establishing coverage of and implementing key EBPs with fidelity
- Reward improved health outcomes among Medi-Cal members living with significant mental health conditions and SUDs
- Reduce BHP-specific gaps in BH quality improvement capabilities
- Support improved integration and care coordination across the BH and managed care delivery systems.

At the time of this writing, 45 counties had completed the prerequisites to participate in the IP. Some counties will be eligible to earn incentive payments related to mental health services only; most counties will be eligible to earn incentives payments related to both mental health and substance use disorder (SUD) treatment services. Within each county, the intended target population of the program is the entire population of Medi-Cal members who receive specialty BH services.

To achieve its goals, the IP specifies three focus areas for BHP efforts:

1. Improved Access to BH Services: BHPs can earn performance payments for improving access to specialty mental health services (SMHSs) and the Drug Medi-Cal Organized Delivery System (DMC-ODS). Access is measured in several ways, such as improving penetration and retention in behavioral health services and the ability of members to receive SMHS and DMC-ODS services in a timely manner. The IP focuses specifically on increasing access to certain specified BH services: Assertive Community Treatment (ACT), Forensic ACT (FACT), Coordinated Specialty Care (CSC) for First Episode

Psychosis (FEP), Supported Employment, Peer Support Specialists, Enhanced Community Health Worker (CHW) Services, Clubhouse Services, Multisystemic Therapy, Functional Family Therapy, Parent Child Interaction Therapy, High Fidelity Wraparound, and Enhanced Care Management (ECM).

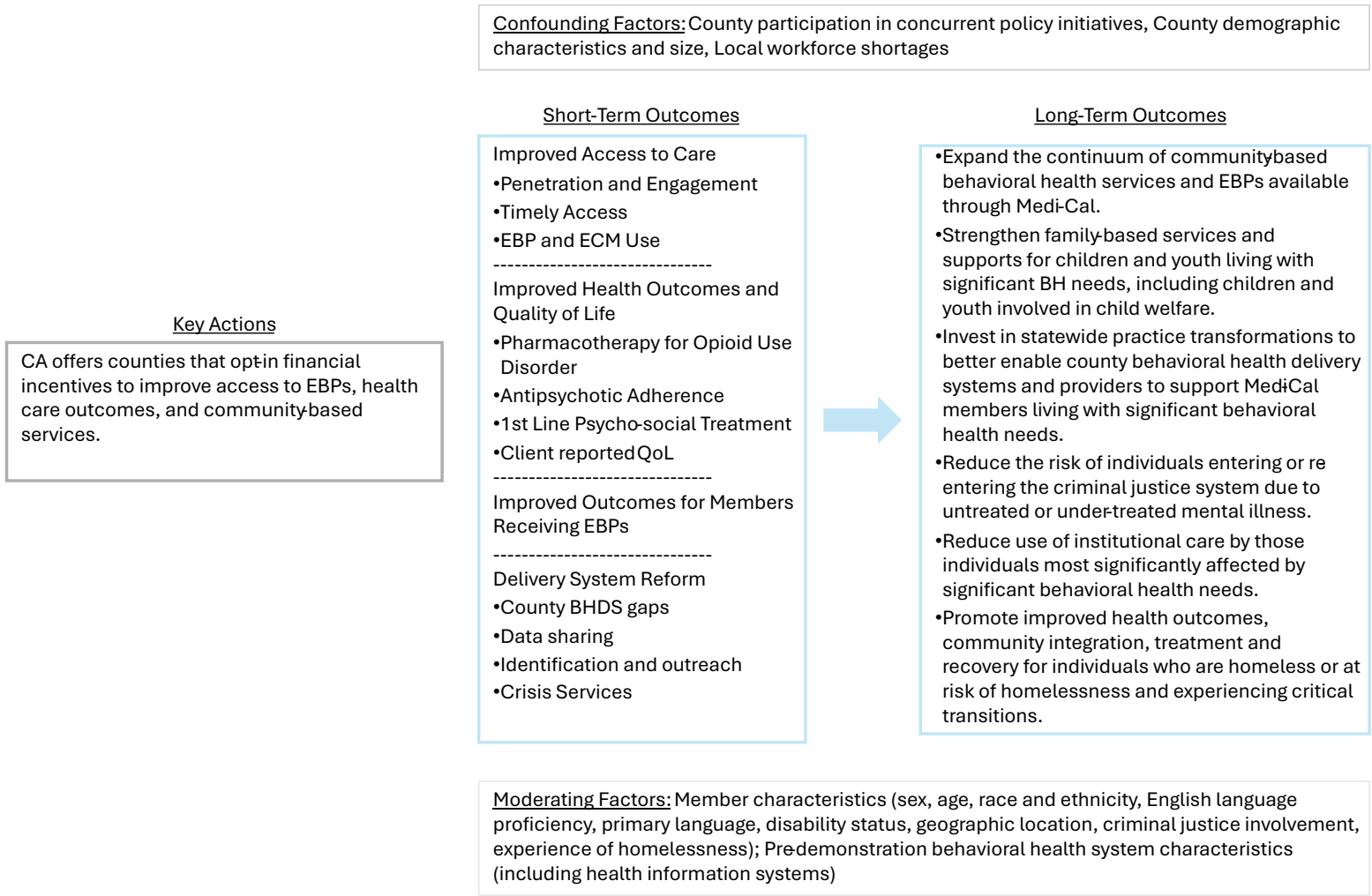
2. Improved Health Outcomes and Quality of Life (QoL): Performance payments can be earned by demonstrating improved health (measured via quality measures) and QoL outcomes for Medi-Cal members living with significant BH needs. There are specific measures for members receiving key evidence-based practices (EBPs). Measures in this focus area are derived from claims data, enrollment data, and/or patient surveys.
3. Targeted BH Delivery System Reforms: Performance payments can be earned through four delivery system reforms that BHPs can implement: 1) reducing BHP-specific gaps in quality improvement capabilities; 2) enhancing data sharing capabilities; 3) improving outreach and engagement to Medi-Cal members with BH needs who are not receiving services; and 4) increasing capacity to deliver crisis services. Where applicable, tracking of BHP performance on delivery system reforms will follow accreditation standards for managed BH organizations developed by the NCQA.

IP Evaluation Overview

The IP evaluation design is guided by the logic model in Figure 2.1. The program is driven by the financial incentives that the IP creates. In response to these incentives, BHPs are expected to make changes to county BH delivery systems across the three focus areas: improvements to access to behavioral health care, improved member health outcomes and quality of life, and targeted BH delivery system reform. Changes in each of these domains, which represent the short-term outcomes of IP, are assessed by the measure domains shown in the figure. Impacts of the IP on the short-term outcomes have impacts on the long-term outcomes, which correspond to the goals of the IP as described in the STCs (Table 1.1).[3] For instance, the model theorizes that improvements in access to behavioral health care will reduce the risk of individuals entering or re-entering the criminal justice system due to untreated or under-treated mental illness and reduce use of institutional care.

[3] To avoid duplication, we refer in the model to the focus areas and the overall demonstration goals in the logic model, noting that the goals for the IP discussed in the STCs that are quoted above are subsumed under those goals.

Figure 2.1. Access, Reform, and Outcomes Incentive Program Logic Model



It is important to note that the IP does not prescribe specific reforms under the delivery system reform focus area. Rather, it enables counties to make locally strategic reforms, based on their current system needs as identified in their self-assessment, in order to meet the IP performance metrics. This means that counties may differ in the specific services they add or reforms that they introduce, whether those are specific EBPs, investments in HIT infrastructure, expansion of ECM, or other investment in community-based services. The evaluation will therefore need to assess these changes on a county-by-county basis.

To enable tracking of IP implementation, the evaluation will use two main strategies, county profiles and qualitative interviews. As described above, the county profiles will track changes made to specialty BH delivery systems, including changes in system capacity (i.e., number of people who can be treated at each level of care or with each service) across the continuum of community-based care and changes to health information sharing systems. Information on county systems will be updated using reports from counties and other documentation on at least a twice-yearly basis.

IP impacts will be examined primarily with Medi-Cal data, supplemented by additional administrative data. Our preferred analytic strategy will be a DD approach, in which trends over time in IP participating counties will be compared with concurrent trends in non-participating counties (see Chapter 1, Quantitative methods). Model assumptions, such as 'parallel trends' and 'common shocks' will be examined in preliminary analyses, as described in Chapter 1. For the IP, concurrent policies implemented in some counties may be shocks that differentially affect participating and non-participating counties. If we find that the DD approach is not appropriate we will consider alternative approaches, such as focusing on a select set of counties (participating and non-participating) that appear to meet model assumptions. Detailed county system reform profiles can help inform the study design by identifying strategic comparisons. Analyses by subgroups listed as moderators in Figure 2.1 will be conducted to examine heterogeneity of impacts and potential impacts of the demonstration on disparities in care.

Finally, we will also monitor how the IP payments, including those paid through the high-performance pool, are made—how many of the participating counties meet the criteria for the payments, how that changes over time, the size of the payments, and how the payments are used. This is important for assessing the IP because of the potential to have a design with thresholds that are too high (few or no counties meeting criteria) or too low (most or all counties meeting criteria) to effectively incentivize delivery system reforms. In addition, counties may perceive the incentive amounts to be not worth the effort required to meet the criteria and they might see the criteria as misaligned with county policy priorities. Information on the functioning of the IP will be drawn from information on payments to counties by the state and interviews with state and county officials.

Table 2.1 presents the evaluation questions (EQs), hypotheses and data sources that will be used to test the hypotheses for each of the three IP goals.

Table 2.1. Evaluation Questions, Hypotheses, and Data Sources: Access, Reform, and Outcomes Incentive Program

Goal	Evaluation Question	Hypotheses	Data Sources
1. Improve access to BH services	1. Will participating counties improve penetration and engagement with specialty BH services?	• Proportion of beneficiaries using SMHS services will increase. • Proportion of beneficiaries with 5 or more SMHS encounters will increase. • Initiation of and engagement in SUD treatment services (Drug Medi-Cal Organized Delivery System [DMC-ODS]) will improve.	• County profiles • Qualitative interviews • Medi-Cal data • SMHS Performance Dashboards
	2. Will participating counties improve timely access to services?	• Identification of Medi-Cal members with BH needs and referral to BH services will increase. • The proportion of clients meeting timely access standards for SMHS and DMC-ODS services will increase.	• County profiles • Qualitative interviews • CA Timely Access Data Tool (TADT)
	3. Will participating counties increase use of EBPs by adults and children?	• Capacity for providing EBPs to adults and children will increase. • Utilization of EBPs by adults and children will increase.	• County profiles • Qualitative interviews • Medi-Cal data
	4. Will participating counties increase use of ECM?	• Capacity to refer to and coordinate with ECM will increase. • Utilization of ECM will increase.	• County profiles • Qualitative interviews • Claims
	5. Will participating counties reduce the risk of Medi-Cal members entering or re-entering the criminal justice system due to untreated or under-treated mental illness?	• Access to BHP-covered outpatient services by Medi-Cal members with criminal justice involvement will increase.	• Medi-Cal data • Automated Criminal History System (ACHS) data
	6. Will participating counties reduce use of institutional care by Medi-Cal members with the most significant BH needs?	• Admission to institutional care by Medi-Cal members with mental illness will decrease. • Medicaid expenditure (total and per-member and per-month) for acute BH care will decrease relative to expenditure for community based BH care, resulting overall reduction of total Medi-Cal BH expenditure.	• Medi-Cal data • HCAI Patient Discharge Data • National Substance Use and Mental Health Services Survey

Goal	Evaluation Question	Hypotheses	Data Sources
2. Improve health outcomes and quality of life (QoL)	1. Will participating counties increase the capacity of provide pharmacotherapy for opioid use disorder (OUD)?	• Capacity for providing pharmacotherapy for OUD will increase. • Utilization of pharmacotherapy for people with OUD will increase.	• County profiles • Qualitative interviews • Quality measure reports • Medi-Cal data
	2. Will counties improve on adherence to antipsychotic medication?	• Patient-centered care for Medi-Cal members prescribed antipsychotics will improve. • Performance on antipsychotic medication adherence will improve.	• County profiles • Qualitative interviews • Quality measure reports • Medi-Cal data
	3. Will counties improve first line use of psychosocial care for children and adolescents on antipsychotics?	• Patient-centered care for child and adolescent Medi-Cal members on antipsychotics will improve. • Counties will improve access to psychosocial care for children and adolescents. • Performance on use of first-line psychosocial care for children and adolescents on antipsychotics will improve.	• County profiles • Qualitative interviews • Quality measure reports • Medi-Cal data
	4. Will counties improve member quality of life?	• Counties will field a QoL survey to Medi-Cal members receiving BH services. • QoL of Medi-Cal members receiving BH services will improve.	• Client surveys • Qualitative interviews
	5. Will counties improve health outcomes among Medi-Cal members receiving intensive community-based services?	• The number of Medi-Cal members with frequent ED visits for BH conditions (> = 4 per year) will decrease. • ED visits for BH conditions will decrease for Medi-Cal members using specified EBPs, including those who are experiencing homelessness, justice involved, receiving CSC for FEP or supported employment.	• Qualitative interviews • Medi-Cal data • Homelessness Data Integration System • Automated Criminal History System (ACHS) data

Goal	Evaluation Question	Hypotheses	Data Sources
3. Implement reforms to the BH delivery system	1. Will participating counties strengthen their quality improvement capabilities?	• Counties' capacity for quality improvement data collection and reporting will expand. • Counties' ability to use data to inform quality improvement efforts and policy change will improv.	• County profiles • Qualitative interviews
	2. Will participating counties improve their data sharing capabilities?	• HIT systems used by community-based providers will be improved. • Capacity for data sharing among BH providers, social services providers, primary care providers, government agencies, and acute care providers (EDs and inpatient facilities) will increase. • Participation in Regional Health Information Exchanges or Health Information Organizations will increase.	• County profiles • HIT assessment • Qualitative interviews • DxF Signatory List • DxF system data
	3. Will participating counties improve identification of and outreach to individuals in need of BH services who are not receiving services?	• Counties will use transparent data-informed methods to guide outreach and engagement efforts. • Counties will use community-based strategies, including community engagement plans and culturally and linguistically appropriate services (CLAS) to identify and address barriers to care. • Investments in outreach efforts addressing unmet needs for BH services in Medi-Cal members not receiving services will increase.	• County profiles • Qualitative interviews

Goal	Evaluation Question	Hypotheses	Data Sources
	4. Will participating counties improve community-based crisis services?	• Capacity of crisis services across the continuum of crisis services will increase. • Timeliness of access to crisis services will improve. • Coordination of crisis services with local law enforcement and community services agencies will improve. • Utilization of crisis services will increase. • Data sharing systems for crisis services will improve.	• County profiles • Qualitative interviews • Medi-Cal data • HIT assessments • 988/911 data

Evaluation Methods

Study Population

The study population will include Medi-Cal members who are exposed to the SMI Program—that is, those living in counties that have opted-in to the IP, and unexposed members living in non-participating or "control" counties. The counties that will opt-in have not been determined as of this writing. A total of 40 counties have met initial eligibility criteria for participation but final decisions have not been made. The STCs specify that up to 80% of counties (which would be 43 counties) can participate. Furthermore, counties may opt-in to the IP at different points in time during the demonstration. We do not anticipate that counties will opt-out of the IP because there is no cost to participate once quality measurement infrastructure is in place. If counties opt-out they will be treated as counties that have entered the IP and failed to meet criteria for a financial incentive.

Analytic Approaches

Quantitative Methods

Descriptive Statistics

Initial analyses will describe characteristics of the Medi-Cal member population (overall and those who use specialty BH services), variation in characteristics across participating and non-participating counties and over time. Differences will be examined using statistical testing and graphical illustrations. Results from the descriptive analyses will inform decisions about the design of quasi-experimental methods.

Quasi-Experimental Methods

The overall approach to use of quasi-experimental methods, such as DD, CITS, and ITS, to assess impacts of the demonstration is described in Chapter 1. For the IP, the analyses will examine whether the outcomes of interest (Table 2.1) differ over time in the counties participating in the IP relative to non-participating counties. Where there is interest in heterogeneity of impact and we have adequate sample size, DDD models will be used to test whether IP impacts are similar across groups (e.g., age, race and ethnicity, English language proficiency, or region). We anticipate having adequate sample size from both participating and non-participating counties for DD models, but ITS models will be considered as options. In the event that counties enter the IP program at different times, methods for staggered adoption, as described in Chapter 1, will be used. To address potential confounding by concurrent policies we will include time varying adjustments for policies associated with participation in the IP and likely to have an impact on IP outcomes. Other strategies, such as restricting the analyses to counties that do not differ with respect to concurrent policies, will also be considered.

Qualitative Methods

Semi-structured interviews will be conducted with state officials, county officials, representatives of provider agencies (including clinicians), and Medi-Cal members.

- State officials: Interviews with state officials will cover the design of the overall program, perception of implementation challenges across the counties, functioning of monitoring processes at the county and state levels, and any notable unintended or unanticipated consequences of the program. Questions about the IP will be included in interviews with state officials during each year of the demonstration.
- County officials: Interviews will aim to understand the process by which counties decide on delivery system reform(s), implementation strategies, and the factors that have aided or hindered implementation as planned. Interviews will cover how decisions related to implementation of BH-CONNECT intersect with other county policy issues, such as full-service partnerships implemented under the Behavioral Health Services Act. To reduce the burden on individual counties, we will conduct interviews with half of the participating counties in the first and third year of the demonstration and the other half in the second and fourth years of the demonstration.

  Counties will be selected to represent all regions of the state in both years. This strategy will provide data on counties at different stages of implementation, while minimizing the number of interviews that county officials are asked to participate in. In addition, we will conduct interviews with a sample of non-participating counties to understand their reasons for non-participating in the IP. While the number of non-participating counties that we can interview may be limited by their willingness to participate, we will aim to select a sample that is diverse with respect to region and size.
- Providers: We will interview program directors, individuals who have supervisory or management roles in organizations responsible for direct service delivery, and clinicians in programs impacted by the IP. Based on an initial analysis of how programs are being implemented across counties, the provider interviews will be staggered across years. For instance, we may focus on enhanced care management programs in Year 1 and specific EBP programs in Year 2. Details of the sampling will be based on initial data from counties on implementation plans.
- Medi-Cal Members: Interviews with members, their family members, or caregivers will be conducted in selected cases where changes in county BH delivery systems impact a well-defined group of BH service users who can be identified and recruited for interviews. The interviews will cover the members' perspectives on the changes, focusing on the burden of seeking care, ability to access the care they want, satisfaction with care, improvement in behavioral health and co-occurring health conditions, and the extent to which the care meets their needs. To allow for time for the changes to impact care, we will conduct Medi-Cal member interviews at least two years following the beginning of the IP.

Focus Area 1: Access to Care

EQ1: Penetration and Engagement in specialty BH services

We expect that both penetration and engagement in SMHS and DMC-ODS services will increase as BHPs increase service capacity across the continuum of care, defined as the number of available services per Medi-Cal member with SMI in the county. Increases in capacity can increase both the number of people who receive services (penetration) and the average number of services received by each service user (engagement). In addition, improvement in the continuum of care within a county in response to the IP can be expected to provide additional opportunities for service users, increasing the likelihood that services will meet actual needs and increase engagement. County-level changes in system capacity will be tracked using the county profiles described above. Outcome measures for assessing penetration and engagement are shown in Table 2.2. The penetration and engagement measures include measures specific to SUD services and SMHS to assess maintenance of continuity of care over time. Criteria for initiation and engagement with SUD treatment will be specified to match the corresponding Healthcare Effectiveness Data and Information Set (HEDIS) measure (*Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment*, IET) to maximize comparability. Qualitative interviews with state and county officials will add information on barriers and facilitators to expanding system capacity. Variation in penetration and engagement with respect to race/ethnicity, age, sex, county or region, or other potential modifiers identified in the qualitative interviews will also be investigated.

EQ2: Timely Access to Specialty BH Services

We expect that timely access to BH services will improve as BHPs increase service capacity and functioning. Qualitative interviews and county BH services profiles will be used to identify changes to BH services systems most likely to impact timely access. Interviews with provider agencies will be informative with respect to how agencies have been directly impacted by changes to referral systems. Quantitative assessments of change in timely access will draw on data from the Timely Access Data Tool (TADT), which includes standardized information on the number of referrals by referral source, the timing of the first appointment offered to new patients, and whether and when appointments were kept.

EQ3: EBP Launch and Scaling

We expect an increase in the number of Medi-Cal members receiving EBP services and in the proportion of BH service users who receive EBPs. Information on service provision will be collected in the county profiles, and qualitative interviews with county officials and EBP providers will provide information on how policy changes have or have not impacted practice. Claims based measures of utilization of EBPs will be used to quantitatively assess impacts of the IP.

EQ4: Utilization of ECM

We expect an increase in the number of Medi-Cal members using ECM. We will track county funded ECM services in our county profiles and ask about implementation of ECM in qualitative interviews with county officials and ECM providers. Claims data on ECM use will be used to examine impacts of the IP on the number of Medi-Cal members using ECM and the average number of ECM services per ECM user.

EQ5: Criminal Justice System Involvement

We expect an increase in the proportion of people with a history of criminal justice system involvement who receive specialty behavioral health services and a decrease in re-entry into the criminal justice system by people with a history of treatment in the specialty behavioral health system. To assess these hypotheses, we will link data from the Automatic Criminal History System (ACHS) with Medi-Cal claims and enrollment data.

EQ6: Reducing Institutional Care

We expect admissions to institutional care among people with serious mental illness to decrease. We also expect that Medi-Cal BH expenditures, measured as total Medi-Cal BH costs and as per-member per-month (PMPM) BH costs, will decrease for acute BH care, i.e. hospitalizations and emergency department visits, and increase for community based BH care. Medi-Cal claims data will be used to identify admission to institutional care and to calculate expenditures.

Table 2.2. Measures for Access Outcomes

Evaluation Question	Measure Domain	Measure Descriptions	Data Source
EQ1.1	Penetration	Proportion of Medi-Cal members who access SMHS services; proportion of past-year users of SMHS services who use services in the current year	Claims
	Engagement (5 or more claims)	Proportion of Medi-Cal Enrollees with 5 or more claims for SMHS services within a 12-month period; proportion of Medi-Cal enrollees with SMHS services on 5 or more days within 12-month period	Claims
	Initiation of SUD treatment	Proportion of Medi-Cal members with one or more claims for SUD treatment in a 12-month period; proportion of Medi-Cal members with a newly identified SUD who have one or more claims for SUD treatment	Claims
	Engagement in SUD Treatment	Proportion of members who initiate SUD treatment who meet criteria for treatment engagement	Claims
EQ1.2	Referrals to BH services	Number of referrals to SMHS services and SUD services, by referral source	TADT
	Timely Access to Care	Proportion of new contacts with care that are offered an initial appointment within 10 days; average and median time to first offered appointment; average and median time to first completed appointment; Proportion of new contacts with care with a kept appointment	TADT
EQ1.3	EBP Launch (Adults/Children)	Number of adult/child members with one or more claims for specified EBPs within a 12-month period	Claims
	EBP Scaling (Adults/Children)	Proportion of adult/child BH services users with one or more claims for specified EBPs within a 12-month period	Claims
EQ1.4	ECM Utilization (Adults/Children)	Number and proportion of adult/child BH services users who access ECM; number of ECM services received by ECM users	Claims
EQ1.5	Criminal Justice System Involvement	Number and proportion of adult/child BH services users who have contact with the criminal justice system	ACHS
EQ1.6	Institutional Care	Admissions to hospitals for BH conditions	Medi-Cal data; HCAI Hospital Data
	Medi-Cal Costs	Costs to Medi-Cal for BH services as reflected in paid Medi-Cal claims	Medi-Cal Data

Focus Area 2: Health Outcomes and Quality of Life

EQ2.1: Pharmacotherapy for OUD

We expect that improvements made to the BH services delivery system will result in an increase in the use of pharmacotherapy for OUD. We will track county-level change in pathways to pharmacotherapy for OUD and ask questions about access to these services in qualitative

interviews with county officials and providers. In quantitative analysis of impacts, we will examine the number of Medi-Cal members with a diagnosis of OUD who receive pharmacotherapy as measured by the HEDIS measure *Pharmacotherapy for Opioid Use Disorder* (POD).

EQ2.2: Adherence to Antipsychotic Medications for Individuals with Schizophrenia

We expect adherence to antipsychotic medications for individuals with schizophrenia to improve. In qualitative interviews with county officials, we will ask questions about how delivery system reforms were designed to improve this outcome. In interviews with providers, we will ask about how these changes have affected care in practice, focusing on care plans. Principles from the Person-Centered Care Planning Assessment Measure will be used to guide development of interview questions. In interviews with Medi-Cal members who receive BH services in participating counties and are prescribed antipsychotic medications, we will ask about how changes to the delivery system have impacted the care they receive. Using claims data, we will examine the number of adults with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period as a proportion of the total number of adults with schizophrenia or schizoaffective disorder who were dispensed an antipsychotic medication.

EQ2.3: Psychosocial Care for Children and Adolescents on Antipsychotic Medication

We expect that changes to the delivery system for children will result in more children receiving frontline psychosocial care prior to being prescribed antipsychotic medications. In qualitative interviews with county officials, we will ask about how delivery system reforms were designed to improve access to psychosocial care for children with BH needs, and, in qualitative interviews with child services providers, we will ask questions about how these changes have affected services in practice. Impacts of the IP will be examined through analyses of claims-based HEDIS measure of receipt of psychosocial care prior to receipt of antipsychotic medication. If this measure is available or definable using claims for the pre-demonstration period we will use DD models for this analysis. If pre-demonstration data are not available for the HEDIS measure are not available, we will explore the possibility of defining a closely related claims-based measure for which pre-demonstration data are available.

EQ2.4: Quality of Life

We expect that quality of life of Medi-Cal members using BH services will improve. Qualitative interviews with county officials and providers will focus on how delivery system reforms have improved quality of life by, for instance, addressing social determinants of health. Quantitative assessment of the impact of the IP will use data from the required client survey to assess change in quality of life among all Medi-Cal members using BH services and, where possible, change over time for the same individuals who complete multiple surveys.

EQ2.5: Improve Health Outcomes

We expect overall ED visits for BH conditions and the proportion of Medi-Cal members with frequent ED visits to decrease due to improved access to community-based services. Qualitative interviews with county officials will ask about efforts to prevent unnecessary reliance on acute care, especially among clients with high needs. The primary outcomes will be measures of high use of ED and inpatient services for any reason and for BH conditions, in particular. Measures of ED use will include the number of Medi-Cal members with one or more ED visits (for any reason or for a BH condition) as a proportion of all Medi-Cal members and the number of Medi-Cal members with four or more ED visits (for any reason or for a BH condition) as a proportion of all Medi-Cal members. Similar measures will be defined for inpatient stays, in addition to a measure of the number of Medi-Cal members who have a total number of inpatient days (potentially across multiple hospitalizations) of 30 or more in a 12-month period. Subgroup analyses will examine these outcomes among members receiving EBPs.

Table 2.3. Measures for Health Outcomes and Quality of Life

Evaluation Question	Measure Domain	Measure Descriptions	Data Source
EQ2.1	Pharmacotherapy for OUD	Proportion of BH services users with OUD who receive pharmacotherapy among BH services users with OUD Continuity of pharmacotherapy for Medi-Cal members with OUD	Claims
EQ2.2	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Proportion of BH services users who were prescribed antipsychotics who remain on antipsychotic medication for at least 80% of the treatment period	Claims
EQ2.3	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	Proportion of child BH services users treated with an antipsychotic medication who received psychosocial care as a first-line treatment	Claims
EQ2.4	Quality of Life	Average QoL among BH services users; improvement in QoL over time among BH services users	Client Survey
EQ2.5	ED Visits	Number of Medi-Cal members with frequent ED use for BH condition (>=4 visits within 12 months)	Claims
	Hospitalizations	Number of Medi-Cal members with frequent hospitalization for BH condition (>=3 stays or 30 days within 12 months)	Claims

Focus Area 3: Delivery System Reform

EQ3.1 Quality Improvement Capabilities

We expect quality improvement capabilities of county BH services system to improve. Assessment of improvement will involve qualitative interviews with county officials and providers. RAND will develop a structured assessment of quality improvement capabilities based on a literature review and consultation with stakeholders. The assessment will measure changes in capabilities related to quality measure data collection and analysis, data sharing, measure selection, iteration of improvement efforts across measurement cycles and systematic follow-up assessments (e.g., implementation of Plan-Do-Study-Act Cycles).

EQ3.2 Data Sharing Capabilities

We expect data sharing capabilities to improve. Qualitative interviews with county officials will ask about changes made to health information technology across the BH services and in capacity for health data sharing. Qualitative interviews with providers will examine how these changes have impacted providing quality care in practice. Improvement in data sharing capabilities will be assessed systematically using information from the Data Exchange Framework, which includes information on county BHP participation in data exchanges.

EQ3.3 Outreach to Medi-Cal Members with BH Needs

We expect that counties will expand their outreach to Medi-Cal members with BH needs through a range of community-based efforts. Qualitative interviews with county officials will ask about community outreach activities. After an initial round of data collection about planned outreach activities and discussions with DHCS, we will select a sample of efforts for close observation and evaluation. Methods will need to be tailored to the selected events. For instance, if there are specific events in which individual participants can be identified and surveyed, we can use pre-post on-site surveys, as has been done in prior assessments of anti-stigma campaigns. For larger campaigns, we will consider county-level population surveys.

EQ3.4 Crisis Services

We expect that counties will improve their crisis services in ways that increase capacity, timely access, and utilization and improve integration with other medical and non-medical services (including law enforcement). We will track county expansions of crisis services and include questions about crisis services in interviews with county officials. Questions about crisis services will be developed to address the ACCESS TO HELP framework for quality crisis services created by the National Council for Mental Well-Being (Hopper et al., 2024). In addition, we will include questions about interactions with crisis services in interviews with providers. The evaluation team will explore data available on 988 and 911 utilization. If feasible, we will use these data sets to examine how 988 and 911 lines are interacting with crisis services. Finally, analyses of claims data will be used to assess the impact of IP on utilization of crisis services.

Chapter 3. Evaluation Design for Workforce Initiatives

Brief Overview of Workforce Initiatives

The BH-CONNECT Workforce Initiatives Program (WIP) consists of a set of five initiatives intended to increase the BH workforce that serves Medi-Cal members and uninsured individuals with significant BH needs. All five initiatives will be administered by HCAI under the direction of DHCS. The five initiatives, as described in the approval letter, are:

- Medi-Cal Behavioral Health Student Loan Repayment Program (MBH-SLRP): Provides up to $240,000 in loan repayment for eligible behavioral health professionals, including those with prescribing privileges, individuals in training to become licensed prescribing practitioners, non-prescribing licensed or associate-level pre-licensure practitioners, and other non-prescribing providers serving Medi-Cal members in exchange for completing up to four years of service in a safety net setting. The maximum amount of loan repayment and the required period of service commitment depends on the practitioner's provider type. Loan repayment funds will be paid directly to loan services.
- Medi-Cal Behavioral Health Scholarship Program (MBH-SP): Provides up to $240,000 in scholarship payments for future BH practitioners in exchange for completing up to four years of service in a safety net setting after graduation. The maximum scholarship amount and required service commitment period depend on the type of behavioral health degree or certification a participant is pursuing, which must lead to their ability to provide behavioral health services to Medi-Cal members. The participant must be pursuing education to become a licensed practitioner with prescribing privileges, non-prescribing licensed or associate-level pre-licensure practitioner roles, and other non-prescribing providers serving Medi-Cal members. Scholarship funds will be paid directly to educational institutions.
- Medi-Cal Behavioral Health Recruitment and Retention Program (MBH-RRP): Provides funds for a range of recruitment and retention bonuses, supervision support for pre-licensure and pre-certification practitioners, and certification/licensure and training aiming to recruit and retain behavioral health practitioners to serve the Medi-Cal population. Recruitment and Retention funds are paid *to Medi-Cal safety net provider organizations* to distribute the funds to eligible BH practitioners. BH practitioners are required to complete up to four years of service in a safety net setting depending on the awarded amount. Bonuses and other activities funded through the recruitment and retention program are listed below:
    - Up to $20,000 per practitioner in recruitment bonuses
    - Up to $4,000 per practitioner in retention bonuses
    - Up to $50,000 per practitioner in recruitment bonuses that support a practitioner's last year of study
    - Up to $1,500 per practitioner for gaining or maintaining licensure or certification
    - Up to $35,000 per safety net setting provider organization per year to support pre-licensure and/or pre-certification supervision requirements
    - Up to $750 per day to backfill BH practitioners who attend specific trainings. The maximum backfill amount is determined by the BH practitioner type.

There are restrictions in place restricting the award of multiple bonuses to an individual provider. For example, individuals may not receive retention bonuses until they fulfill the service obligations for any recruitment bonuses they received. These limitations are in addition to the maximum funding amount available for each individual practitioner.

- Medi-Cal Behavioral Health Community-Based Provider Training Program (MBH-CBPTP: Provides up to $10,000 in funding to support training to become an Alcohol or Other Drug Counselor, Community Health Worker, or Peer Support Specialist. Participating practitioners must complete three years of service in a Medi-Cal safety-net setting. Awards will be paid directly to the training program.
- Medi-Cal Behavioral Health Residency Training Program (MBH-RTP): Provides up to $250,000 per residency or fellowship slot per year to safety net settings for certain specialties. Three residency and fellowship programs are eligible: Psychiatry Residency, Child Psychiatry Fellowship, and Addiction Psychiatry/Addiction Medicine Fellowship. The funds to support the residency or fellowship will be paid to the certified or accredited professional training programs. Residents and fellows will automatically be enrolled in the MBH-SLRP and will be required to complete a four-year service commitment in an eligible Medi-Cal safety net setting post-residency or fellowship.

While all initiatives involve financial support for BH practitioners, the funds are disbursed differently depending on the initiative, to a mix of individual and institutional awardees. The MBH-SLRP and scholarship initiatives provide funding directly to loan services or educational institutions on behalf of the awarded individual practitioners. In exchange, individual awardees are required to complete a term of service working in a Medi-Cal safety net setting, defined and described in the approval letter as Federally Qualified Health Centers (FQHC), Community Mental Health Centers, Rural Health Clinics, or other behavioral health clinical settings with a high proportion of Medi-Cal members or uninsured individuals in their patient population. The recruitment and retention initiative provides funds to Medi-Cal safety net settings that provide BH care to Medi-Cal members and uninsured individuals. The training initiatives target practitioner types for which there are known BH workforce shortages, including community-based providers, and psychiatrists or physicians focused on addiction and/or children and adolescents. These funds are dispersed directly to the clinical training programs that provide the training. In contrast with the other demonstration programs, the WIP is targeted directly at individual awardees, behavioral health clinical care providers, and training programs, rather than BHPs.

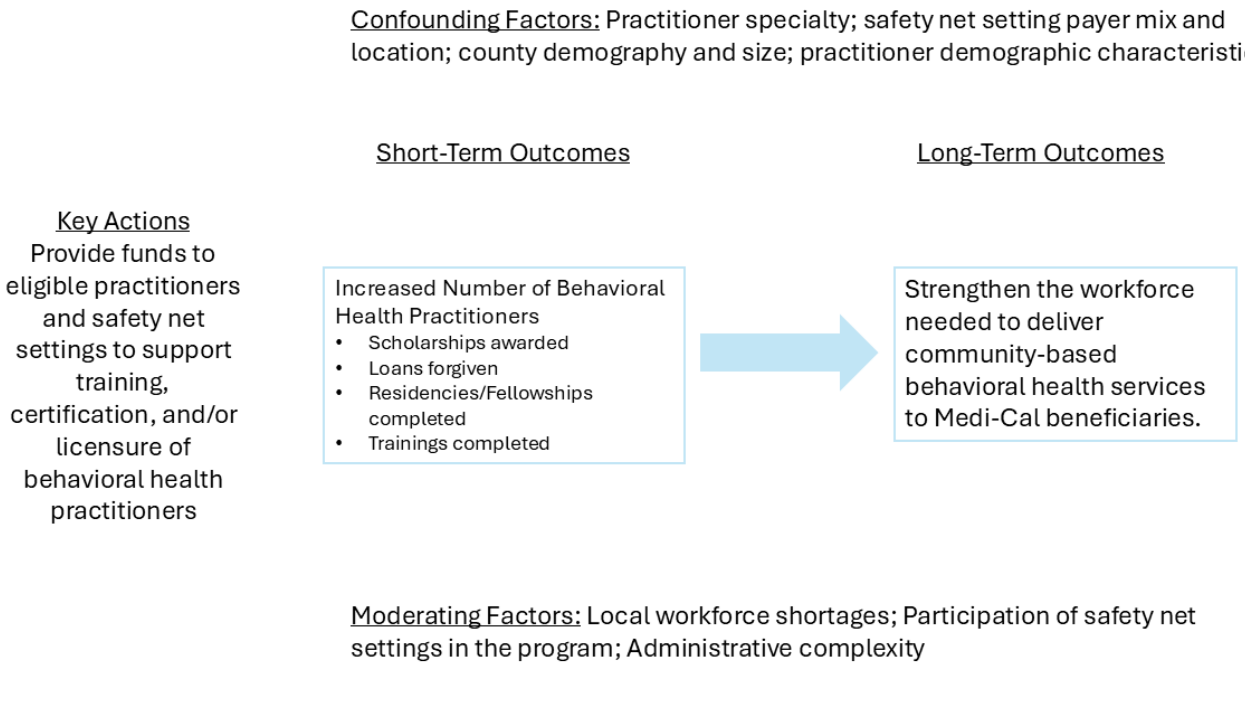
The MBH-SLRP and the MBH-RTP are scheduled to launch in July of 2025, the scholarship and community-based provider initiatives in the first quarter of 2026, and the recruitment and retention initiative in summer 2026.

Workforce Initiatives Program Evaluation Overview

The design of the evaluation of the WIP is guided by the logic model in Figure 3.1. The WIP makes direct investments in BH care workforce development through the five programs

described above. In the short term, these initiatives are expected to increase the initiatives of BH practitioners being trained, recruited into, and retained as BH staff within the safety net care system that serves Medi-Cal members and the uninsured. In addition, by reducing the costs of training in BH clinical certifications, the WIP may also incentivize awardees to work in Medi-Cal safety net clinical settings. In the long term and mediated by these short-term outcomes, the five initiatives are expected to strengthen the system's overall capacity to provide community-based BH services. Several factors may confound or modify the impacts of the WIP. Contextual factors include the characteristics of the safety net provider (size, academic, payer-mix) and its location (severity of shortages, cost of living, urbanicity), the availability of training sites and applicants at or near the safety net setting, and the administrative complexity of the WIPs, which could deter participation; other factors that might influence long-term outcomes include the specialties for which practitioners and safety net settings seek training resources and the characteristics of the practitioners (age, prior training).

Figure 3.1. Workforce Initiatives Logic Model



The evaluation will use a mixed methods approach to track implementation of the initiatives and, to the extent possible, assess the impact of the WIP and its constitutive initiatives on BH workforce capacity. We will track implementation by leveraging administrative data collected by HCAI that will describe, for instance, the number and types of practitioners who have received support through the WIP, the types of safety net providers that have benefitted from the WIP, and the setting types of places in which the WIP individual and institutional awardees are located. In addition, we will collect data through surveys and qualitative interviews of WIP awardees and institutional awardees to assess the perceived impacts of the WIP as well as facilitators and barriers to impact. Assessments of the impact of the initiatives will go beyond description of the activities to estimating longer term contributions to the workforce providing BH services in safety net settings. These analyses will use survey results and other administrative data to assess change in service capacity over time.

We plan two surveys of workforce initiative awardees, an initial survey of early awardees and a later survey of all awardees. We anticipate fielding the later survey during the second half of the waiver period. The administration timing of the final survey may vary based upon a range of factors across all WIPs including, but not limited to: WIP implementation start date, when the institutional and/or individual awardee has completed accruing initiative benefits (e.g., all scholarship payments made), and when the institutional and/or individual awardee is expected to complete WIP requirements (e.g., expected length of service period). Estimating the number of awardees based on the total dollar amounts allocated for the WIP in each year and the ranges of individual awards, the sampling frames for these surveys are anticipated to be approximately 12,500 and 33,500 awardees respectively. For each survey, we plan to field a simple random sample of 6,400 awardees. Assuming a 25 percent response rate (i.e., 1,600 responses), these samples would be sufficient to produce margins of error (MOE) of ±2.5 percentage points (i.e., confidence intervals spanning five percentage points) on survey items with binary responses.[4]

Table 3.1 below presents the evaluation questions, hypotheses, and measures that will be used to evaluate the WIP.

[4] The MOE of ±2.5 percentage points is conservative in two ways. (i) It relies on a worst-case scenario based on 50 percent endorsing each category. The MOEs will reduce as the proportion selecting one of the binary responses moves toward zero or one. For example, at 75% endorsing one category, the MOE reduces to ±2.1 percentage points. (ii) A finite population correction would slightly further reduce the MOE.

Table 3.1. Evaluation Questions, Hypotheses, and Data Sources: Workforce Initiatives

Goal	Evaluation Question	Hypotheses	Data Sources
1. Increase BH workforce recruitment and retention	1. What will be the uptake of the WIP initiatives among different types of eligible practitioners and safety net providers?	• Applications for WIP funds will exceed the available funds. • All available WIP funds will be dispersed. • Resources will be dispersed in areas of identified need based on objective criteria.	• HCAI workforce program data • Area Health Resource Files (AHRF), MH-HPSA data • Awardee Survey
	2. How many practitioners will complete their training (e.g., graduated, received a license, etc.) or employment term and complete their term of service?	• A majority of WIP participants will complete the required service commitment.	• HCAI workforce initiatives data • Qualitative interviews
2. Increased availability of BH practitioners serving Medi-Cal members and uninsured individuals	1. Will participating safety net settings strengthen their ability to serve Medi-Cal members and uninsured individuals?	• Participating safety net settings will have an increased number of BH practitioners. • Participating safety net settings will increase capacity to provide BH services.	• HCAI workforce initiatives data • Qualitative interviews • Mental Health Plan (MHP) Dashboards • Network Adequacy Certification Data • Awardee survey
	2. To what extent do the new practitioners address the pre-existing practitioner shortages at participating safety net settings?	• Participating safety net settings' recruitment of practitioners will mitigate their local shortages. • Participating safety net settings' recruitment of practitioners will increase their capacity to provide BH care.	• HCAI workforce initiatives data • Qualitative interviews • Licensure data • MHP Dashboards • Awardee survey
	3. To what extent does the geographic distribution of participating safety net settings and providers align with pre-existing state-level provider shortages?	• Participating practitioners will be more likely to work in safety net settings as a result of their award. • Practitioners will work in areas with pre-existing provider shortages.	• HCAI workforce initiatives data • Qualitative interviews • Awardee survey • AHRF, MH-HPSA data

Evaluation Methods

Study Population

The study population will include a range of individuals and entities, including practitioners receiving funds through the WIP, safety net settings receiving funds through the WIP, and Medi-Cal members receiving treatment from those practitioners and settings. As of this writing, no awards have been made for any of the WIPs. The initial grant cycles for the Medi-Cal Behavioral Health Student Loan Repayment Program and the Medi-Cal Behavioral Health Residency Training Program closed on August 15, 2025. While it is expected that the number of participating practitioners and safety net settings will increase over time, it is also possible that participation will be low. As a result, in any given year of the demonstration, there may be different sets of WIPs, participating practitioners, and participating safety net settings.

Time Frame for the Evaluation

The evaluation will include a pre-implementation period, or baseline, of a minimum of two years, to the extent that data is available, and a post-implementation period, or post-period. The post-period will span the time between the date of implementation of each individual WIP initiative and the date of either awardee drop-out or the end of the five-year demonstration period, whichever comes first. The staggered start dates for the funding rounds of the five WIP initiatives and ability of awardees to drop out prior to completing their service requirements, as described above, will lead to varying start and end dates for the different WIP initiatives for participating practitioners and safety net settings and for variable durations for post-periods.

Analytic Approaches

We will address each of the evaluation questions using a mixed methods approach of both qualitative and quantitative methods as necessary and feasible. The planned analytic approaches are described below.

Qualitative Methods

Qualitative methods (interviews or focus groups with key stakeholders) will be used to provide context for and augment the quantitative findings, and address evaluation questions for which quantitative data are not available.

We will seek out stakeholders with ‘on the ground’ experience with the implementation of the WIP initiatives, including state officials, HCAI WIP initiative administrators, officials at safety-net settings, practitioners, and affected Medi-Cal members or their families/caregivers. The focus of the qualitative component of the evaluation will be to identify WIP initiative activities or their components or characteristics thought to be most effective in achieving the

goals of the WIP initiatives (facilitators), factors thought to hinder their effectiveness (barriers), and program-driven changes to data sharing systems, processes, or policies.

Semi-structured interview (or focus group) guides and document review abstraction forms will be developed in close consultation with DHCS. The guides will be brief and targeted, consisting of questions and probes, but flexible enough to permit follow-up questions that are responsive to interviewees' comments. The qualitative data will be analyzed with principled methods that emphasize inductive codes emerging directly from the data (Bradley, Curry, and Devers, 2007).

Quantitative Methods

Methods that may be to characterize workforce populations and trends and, whenever possible, validly quantify the impacts of the WIP initiatives include descriptive statistics, geospatial analysis, and quasi-experimental methods.

Descriptive Statistics

Descriptive statistics will be used to describe the populations of participating providers, participating safety-net settings, and Medi-Cal members served by participating providers and/or safety-net settings. The descriptive statistics will be presented overall and stratified by key characteristics (e.g. language proficiency, race/ethnicity), year-to-year, and examine trends over time, as well as regional and initiative-specific patterns. For categorical variables, a chi-square test or a McNemar's test will be used as appropriate; for continuous variables, the Analysis of Variance test or paired t-test will be used as appropriate. For selected outcomes, we will complement the presentation of results with graphical illustrations.

Geospatial Analysis

The WIP initiatives differ from the other BH-CONNECT programs in that the geographic reach of participating practitioners and safety-net settings is not necessarily a county. To the extent that data is available, we will use geospatial analysis to examine the service area of participating practitioners and safety-net settings, as well as examine the extent to which these service areas align with geographic areas experiencing workforce shortages during the baseline period.

Quasi-Experimental Methods

As described in detail in Chapter 1 (Quantitative Methods), BH-CONNECT program outcomes will be examined using quasi-experimental methods that support valid causal inferences, including DD, the most robust of these methods, CITS, and ITS. Whenever quasi-experimental methods are preferred, we will aim to implement a DD approach to examine how the difference in the outcome pre- and post- WIP initiative implementation vary by exposure to a WIP initiative. We will adjust for confounder imbalance between exposed and unexposed Medi-Cal members living in participating and non-participating counties by implementing multivariable DD regression models.

We believe it will be possible to implement a DD approach because, as of July 2025, it appears that there is significant interest in applying for the first funding round of the LRP as evidenced by a completely booked HCAI informational webinar on the initiative. The differential timing of WIP initiative implementation and funding rounds will be addressed with methods that can handle the expected staggered adoption of the program; see Chapter 1 (*Quantitative Methods*).

We will address the possibility that concurrent policies and other initiatives may affect estimates of program impacts by examining the timing of other initiatives relative to the implementation of the BH-CONNECT programs and including controls for concurrent initiatives in the causal models.

Limitations

Our ability to evaluate the long-term impacts of the WIP is limited by the duration of the waiver demonstration period in comparison to the length of the WIP initiative service requirements. Depending on when a participant begins participating in a WIP initiative and the amount of funding they are awarded, they may not complete their service requirement within the demonstration period. This limited availability of post-service requirement data on post-WIP initiative career choices and workforce characteristics may limit our ability to use quantitative methods to examine the impacts of the WIP. Mitigation strategies include identifying related evaluation questions/hypotheses that may be addressed with the available data or informing these analyses with qualitative data, such as interviews with participants about their future career plans while they are still completing their service requirements.

For planned analyses employing quantitative methods, we may be limited by incomplete person-level secondary data (missing Medi-Cal member information, missing years) or lack of the necessary data to construct the required variables. Mitigation strategies include using data imputation methods (if feasible), switching to descriptive analyses, or identifying related evaluation questions/hypotheses that may be addressed with available data.

For quasi-experimental analyses for which a DD approach had been planned, potential limitations are the finding of non-parallel trends, and for system-level outcomes assessed at the county level, the possibility that during the demonstration, most or all regions of the state will have implemented a WIP initiative. We will mitigate these limitations by implementing a CITS model and an ITS, respectively; see Chapter 1 (*Quantitative Methods*).

EQ 1.1 Increase Behavioral Health Workforce Recruitment and Retention

The evaluation team will use administrative data from HCAI to track applications and awards for all the WIP initiatives. Specifically, we will track the numbers and types of applications, the number and types of awards made, characteristics of the applicants and individual awardees and institutional awardees (e.g., age, prior training, professional qualifications, location in the state, language proficiency), characteristics of the safety net settings (e.g., type of facility, size,

academic setting, payer mix, location), and total award amounts. To assess the extent to which the initiative is addressing specific workforce needs, we will crosswalk the awardee characteristics with county-reported workforce shortages. To assess the specific effects of the retention initiatives, we will examine the extent to which individual awardees continue serving in safety-net settings throughout the wavier period, to the extent that data is available on individual awardee's career changes after completing their service requirements. We may be able to access this data from initiative implementation data or by administering a survey to initiative graduates. However, this specific aspect of the evaluation may be limited, as there may be a small number of individual awardees who have completed the service requirements within the waiver period.

EQ 1.2 Completion of Training Programs and Service Requirements

Administrative data from HCAI will be used to track awardees' activities in the initiatives after the initial award is made. Specifically, we will track the completion of the training initiatives, completion of the service requirements, and total payments made. Surveys and qualitative interviews with awardees (individuals or safety net providers as appropriate) will ask about experiences participating in the WIP, the influence of any financial incentives on practitioners' career choices, and whether the initiatives enabled the participant to work in a setting or capacity in which they would otherwise have been unable to work. To assess the extent to which the WIP is addressing specific workforce needs, we will crosswalk the individual awardee and participating provider characteristics with county-reported workforce shortages.

EQ 2.1 Strengthening the BH Workforce

We will examine the impact of the WIP and its constituent programs on the workforce providing BH care to Medi-Cal members using initiative data from HCAI, survey results, and Medi-Cal data. First, using HCAI administrative data we will be able to track the number of practitioners and years of workforce participation covered by the award and the service requirements. Second, drawing on participants' observations about the impact of the awards on the amount of time they spend working in safety net settings, including but not limited to completion of the service requirement, we will estimate the total contribution of the programs to service capacity. Third, using Medi-Cal data we will track the volume of services provided to Medi-Cal members, testing whether predicted increases in capacity are reflected in increases in the number of services provided.

EQ 2.2 and 2.3 Addressing Shortages of Specific Practitioner Types and in Specific Geographic Regions

We will extend the analyses under EQ 2.1 to address impacts of the WIP on specific practitioner types and in specific geographic regions that are identified as areas of shortage. For instance, we will examine whether the WIP initiatives contributed to increasing workforce capacity in mental health provider shortage areas (MH-HPSAs). For example, we will use data from

California Mental Health Services Authority (CalMHSA) on peer support specialty certifications to assess whether the awards initiative has increased the peer support workforce overall and in areas that have historically had lower numbers of peers per Medi-Cal BH service user.

Chapter 4. Evaluation Design for Activity Funds Initiative

Brief Overview of Activity Funds Initiative

The activity funds initiative provides support to Medi-Cal members who are involved in the child welfare system and are diagnosed or are at risk of being diagnosed with BH conditions. This support allows them to engage in activities that facilitate their inclusion in the community and promote improved BH outcomes. To qualify as involved in the child welfare system a Medi-Cal member must meet one of the following four criteria: 1) under age 21 and received care through the child welfare system in California or another state within the past year; 2) under age 26 and aged out of the child welfare system in California or another state; 3) under age 18 and participating in or eligible for California's Adoption Assistance Program; or 4) under 18 and received services from California's Family Maintenance program in the past year. Behavioral health criteria require either a diagnosed BH condition or high risk for a BH condition with a service need, as determined by a licensed BH professional through a clinical assessment. Activity funds payments, which will be administered by DHCS through a contractor, will be paid on behalf of the participant directly to the activity provider.

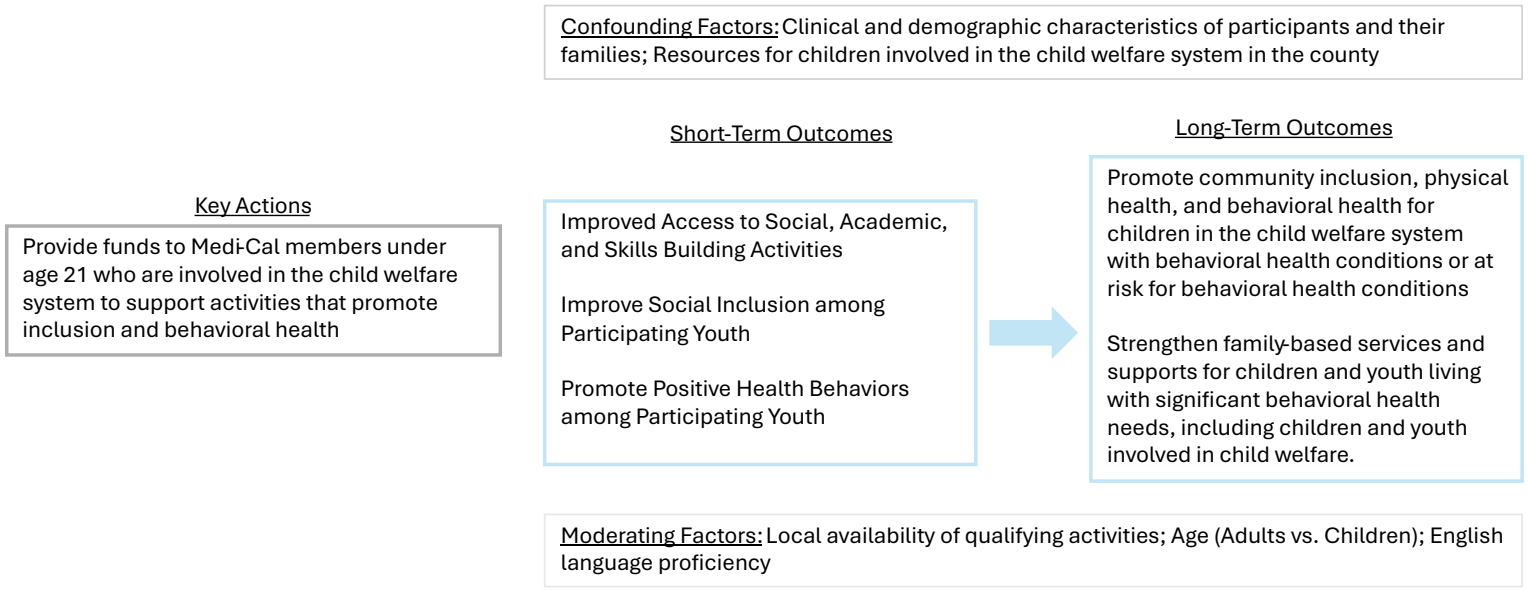
Activity funds can be used on behalf of eligible members to support purchase of goods or services that 1) promote inclusion in the community, 2) increase the member's safety in their home environment, or 3) facilitate participation or autonomy in making decisions that improve physical or BH outcomes. The purchased goods or services must be linked to a specific need documented in the member's clinical record, unavailable through other means, and non-duplicative of goods or services available through the Medicaid State Plan. Decisions about use of the funds, provided they follow these rules, are to be made by eligible members, their families, or caregivers (hereafter, families for simplicity). Examples of potential uses of activity funds include physical wellness activities, such as gym memberships or exercise gear and safety equipment, and strengths-developing activities, such as music lessons or therapeutic summer camps. Activity funds cannot be used for entertainment or recreational activities, tobacco or alcohol purchases, and multiple items of the same type for the same individual without a documented change in need.

Activity Funds Initiative Evaluation Overview

Evaluation of the activity funds initiative will examine implementation of the program through analysis of program documentation and qualitative interviews with participants, families, and activity providers, as well as outcomes of the program using program records, participant surveys, and semi-structured interviews.

The evaluation of the Activity Funds will be informed by the logic model in Figure 4.1. The key actions are the funds that are made available to support activities. The short-term outcomes are the resulting access to activities and the improvement in social inclusion and health behaviors among participants that is theorized to occur as a result. The long-term outcomes are improved inclusion in the community, improved physical health and BH outcomes, and the strengthening of family-based supports for youth involved in the child welfare system. The program is family-based in the sense that participants' families will be directly involved in decision making about use of the funds, though this may vary by the age of the participant. Notable modifying factors include the region in which a participant lives, which is likely to impact the availability of activities, whether the participant is a child or an adult, and the preferred language of the participant or their caregiver. Factors that may confound the impact of the program include clinical and demographic characteristics of participants and their families, and the availability of other types of supports services to which the participant has access.

Figure 4.1. Activity Funds Initiative Logic Model



The evaluation will involve two main components, one tracking implementation of the program and one assessing its impacts on participants and their families. Tracking implementation use administrative data on program participation, document reviews, and interviews with county officials directly administering the program. To assess the program's impact, we will conduct a survey of program participants who are 18 years of age or older and adult family members of participants who are under age 18. The surveys will address interactions with the program, motivations for using the program, and perceived benefits for the participants with respect to connectedness, social participation, social support, health and health behaviors. Follow-up semi-structured interviews with selected survey participants will be conducted to explore interactions with the program and impacts on participants in more depth. Given uncertainty about the numbers of participants, the difficulty in identifying a comparison group, and the long time frame required for detecting outcomes, we do not anticipate a controlled assessment of the impact of the program.

Table 4.1 presents the evaluation questions (EQs), hypotheses and data sources that will be used to evaluate the Activity Funds Initiative. We do not include specific EQs related to strengthening family-based supports since this goal is subsumed under Goal 1.

Table 4.1. Evaluation Questions, Hypotheses, and Data Sources: Activity Funds Initiative

Goal	Evaluation Question	Hypotheses	Data Sources
1. Promote community inclusion, physical health, and BH for children in the child welfare system with BH conditions or at risk for BH conditions.	1. Will the activity funds program engage eligible youth in activities that they would not otherwise have had access to?	• Participating youth will access desired activities that they would not have been able to access without activity funds.	• Qualitative interviews • Participant survey • Program records
	2. Will the activities supported by the program improve social inclusion among participating youth?	• Activities that participants access through the activity funds program will promote a wide range of strategies for social inclusion. • Participants will report positive influences of the activities on connectedness, social participation, and social support.	• Qualitative interviews • Participant survey
	3. Will the activities supported by the program promote positive health behavior among participating youth?	• Activities that participants access through the activity funds program will promote a wide range of strategies for social inclusion. • Participants will report positive influences of the activities on connectedness, social participation, and social support.	• Qualitative interviews • Participant survey

Evaluation Methods

Study Population

The study population will include Medi-Cal members who participate in the Activity Funds Initiative and the family members of participants who are under 18 years of age. Given that information to assess the eligibility criteria is not available for non-participants, we will not attempt to sample a control group for this component of the evaluation. In addition to participants, the evaluation will also collect data from programs that provide services supported by the Activity Funds.

Time Frame for the Evaluation

The evaluation timeline will be based on the actual rollout of the program. We anticipate conducting participant-level data collection (interviews or surveys) between 90 days and six months from the participants' initiation of program-supported activities.

Quantitative Methods

In presenting the survey results we will present detailed information on the characteristics of the sample, response rate, and any weighting that is conducted to correct for non-response. Survey results will be presented as weighted proportions. Comparisons of survey responses across sample sub-groups (e.g., by age group) will be conducted using weighted chi-square tests.

Tracking Implementation

The evaluation team will collect data directly from counties on how activity funds programs are structured and how they are used through review of documents (e.g., instructions for participants and families), information from the third-party entity administering the program, and interviews with county personnel involved in decision-making about awards and oversight of the program. We do not know whether information on participants, such as individual participant demographic characteristics, clinical conditions, preferred activities, and payment amounts, will be available in standardized formats across counties, though we anticipate that detailed information will be collected by DHCS for oversight and reporting purposes. The evaluation team will work with counties, the third-party administrator, and DHCS to collect detailed data on program participants and the activities supported by the program in a format that minimizes burden on counties. In addition, the evaluation team will work with counties and DHCS to apply eligibility criteria to the enrolled Medi-Cal population to characterize the population eligible for the activity funds initiative. Qualitative interviews conducted with samples of counties in years 2 and 3 of the program will examine implementation facilitators and barriers.

Family and Participant Perspectives on Impact

Provided that the contact information can be accessed, we will field a survey to collect information on program participation. The survey sample will include participants aged 18 or older and family members or caregivers of participants who are under age 18. Based on estimates of the number of program participants, we anticipate approximately 500 participants ages 18 to 21 and 1500 participants under age 18. Given these relatively small numbers, we intend to survey all recipients of activity funds. Assuming a 25 percent response rate and employing a finite population correction, these samples would be sufficient to produce margins of error of ± 7.6 percentage points for the adult survey and ± 4.4 percentage points for the parent/caregiver survey. These calculations will be updated as the number of participants becomes clear.

The survey will ask about how difficult or easy it was to participate in the program, the perceived value of the program to the participant, and the impact of the program on participants' BH, health care service use, social engagement, social support, and social connectedness. Survey participants will be given the opportunity to provide direct contact information for a follow-up semi-structured interview that will examine program participation in greater detail, including questions about the decision to participate, use of the funds, quality of interactions with BHPs and program providers, and impacts of the program on participants. Qualitative interviews will also ask about barriers to program participation and potential improvements that could be made. RAND will explore the possibility of conducting interviews with eligible Medi-Cal members who indicated an interest in the program but did not receive activity funds to provide an additional perspective on barriers to participation.

EQ1: Engaging Youth

The evaluation team will track overall participation numbers and the proportions of eligible Medi-Cal members who participate by county over time. Working with the available data, we will develop a measure of program retention, designed to reflect long-term engagement in the selected activity, as opposed to brief episodes of participation that are unlikely to have lasting impacts. In the survey and qualitative interviews, we will ask questions about whether the program enabled participation in activities that would otherwise have been inaccessible. Analyses will examine potential barriers to participation that may impact specific subgroups, such as challenges of managing the program for participants whose preferred language is not English and participants in areas with limited access to qualifying activities.

EQ2: Promoting Social Inclusion

Survey data on the perceived impacts of the activities supported by the program will be used to assess the extent to which it is contributing to improving social inclusion of participants. Social inclusion will be measured through a combination of objective and subjective measures. Objective measures will focus on changes in time spent in social

activities, including but not limited to those directly related to the supported activity. Aspects of social inclusion in work, school, and other settings will also be assessed. We will consider including a validated measure of social inclusion, such as the Filia Social Inclusion Measure (Filia et al., 2022) or the Social Exclusion Scale for Children (Karakaya, Özsavran, and Kurt, 2024). Subjective measures will focus on perception of inclusion in meaningful activities and perceived value of participation in the supported activities. Qualitative data on these topics will provide narrative case studies to illustrate the findings and describe how the supported activities have (or have not) impacted participants.

EQ3: Promoting Positive Health Behavior

Surveys and qualitative interviews will ask about the impact of the supported activities on health behaviors, primarily sleep, physical activity, diet, and health care utilization (BH and general health care). Surveys will use validated measures where possible and feasible. Qualitative interviews will be designed to parallel content covered in validated measures.

Chapter 5. Evaluation Design for Serious Mental Illness Program

Brief Overview of SMI Program

The SMI program seeks to strengthen the BH delivery system by leveraging the SMI Section 1115 demonstration opportunity to enhance the continuum of community-based specialty mental health services and increase opportunities for early intervention for Medi-Cal members with SMI/SED. Medi-Cal members with SMI will have access to a full range of services ranging in intensity from short-term acute care in psychiatric hospitals and residential settings to ongoing care for SMI in cost-effective community-based settings.

Under BH-CONNECT's SMI program, federal financial participation (FFP) for IMD services provided to Medi-Cal members age 21 and over with SMI[5] is available to BHPs[6] that have received DHCS approval and have agreed to the following conditions:

- Cover the following EBPs under State Plan authority on a timeline specified by DHCS: ACT; FACT; CSC for FEP;[7] Individual Placement and Supports (IPS) Supported Employment; Enhanced CHW services; and Peer Support services, including a forensic specialization. Counties that have opted into the program will be required to implement these EBPs during the demonstration period on a rolling basis as follows:
  - Prior to claiming FFP for IMD Stays: Begin providing Enhanced CHW services
  - Within one year of claiming FFP for IMD Stays: Fully Implementing ACT
  - Within two years of claiming FFP for IMD Stays: Begin providing FACT and CSC for FEP
  - Within three years of claiming FFP for IMD Stays, go-live: Begin providing IPS Supported Employment
- Reinvest FFP received for IMD services[8] to support services and activities that benefit Medi-Cal members served by the BHP.

Additionally, the state will work to improve care coordination and care for co-occurring physical and BH conditions.

[5] FFP will be available under this program only for IMD services provided to Medi-Cal members 21 years of age and older.

[6] All California BHPs are eligible for participation.

[7] Available in over half of counties funded in part through SAMHSA block grants and with training and technical assistance offered through UC Davis. The state plan amendment will cover CSC for FEP as a new bundled service at county option.

[8] The state must achieve a statewide average length of IMD stay of no more than 30 days.

The goals of the SMI Program are aligned with those of the SMI Demonstration Opportunity and will facilitate accomplishing several goals of the BH-CONNECT demonstration (See Table 1.1). They include:

- Reduced utilization and lengths of stay in EDs while Medi-Cal members await mental health treatment in specialized settings
- Reduced preventable readmissions to acute care hospitals and residential settings
- Improved availability of crisis stabilization services delivered in various settings.9
- Improved access to community-based services to address Medi-Cal members' chronic mental health care needs, including through increased integration of primary and BH care
- Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

To accomplish the SMI program goals, the state has committed to undertake several actions captured in the following milestones:

- Ensure quality of care in psychiatric hospitals and residential settings that primarily provide mental health treatment to Medi-Cal members with SMI, hereafter also referred to as *participating psychiatric settings*
- Improving care coordination and transitions to community-based care
- Increasing access to continuum of care including crisis stabilization services
- Earlier identification and engagement in treatment including through increased integration.

The state already received approval for an "SMI Implementation Plan" describing actions already undertaken or planned in order to achieve these milestones, and timelines for state action on milestones not yet achieved (typically within 3–24 months of CMS approval).[10] As detailed in the STCs, the activities and their status are as follows:

- 1. Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings
    - 1.a. Assurance that participating psychiatric settings (Mental Health Rehabilitation Centers, Psychiatric Health Facilities, Freestanding Acute Psychiatric Hospitals) are licensed or otherwise authorized by the state primarily to provide mental health treatment; and that residential treatment facilities are accredited by a nationally recognized accreditation entity prior to participating in Medi-Cal (Partially Achieved).

[9] These include Crisis Outreach and Response services (Call Centers, Mobile Crisis Units, Crisis Observation/Assessment Centers, and Coordinated Community Crisis Response Teams involving collaboration with trained law enforcement and other first responders); Intensive Outpatient and Partial Hospitalization services; and Crisis Stabilization services provided during acute short-term stays in public and private psychiatric hospitals, residential treatment facilities, general hospital psychiatric units, and community-based settings (residential crisis stabilization programs, small inpatient units in community mental health centers, peer-run crisis respite programs, and others).

[10] The state also received approval for a Health IT Plan ("HIT Plan") describing the state's ability to leverage HIT, advance health information exchange(s), and ensure HIT interoperability in support of the demonstration's goals.

  - 1.b. Oversight process to ensure that participating psychiatric settings meet state's licensing or certification and accreditation requirements (Achieved).
  - 1.c. Use of a utilization review process to ensure Medi-Cal members have access to the appropriate levels and types of care and to provide oversight on lengths of stay (Achieved).
  - 1.d. Compliance with program integrity requirements and state compliance assurance process (Achieved).
  - 1.e. State requirement that participating psychiatric settings screen Medi-Cal members for co-morbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions, e.g., with on-site staff, telemedicine, or partnerships with local providers (co-morbid physical health conditions) (Partially Achieved).
  - 1.f. Other state requirements/policies to ensure good quality of care in participating psychiatric settings, including: revisions to the informed consent requirement for antipsychotic medications to permit verbal consent; requirement that SUD recovery or treatment facilities offer medications for addiction treatment (MAT) or have effective referral processes for this purpose; establishment of Psychiatric Residential Treatment Facilities, a new category of DHCS-licensed residential health facilities for individuals under 21 (the state is utilizing interim licensing regulations-final regulations expected by December 2027); and improved quality standards for certain residential psychiatric settings serving children and youth (Achieved).

- 2. Improving Care Coordination and Transitions to Community-Based Care
  - 2.a. Actions to ensure participating psychiatric settings carry out intensive pre-discharge planning and include community-based providers in care transitions (Partially Achieved).
  - 2.b. Actions to ensure participating psychiatric settings assess Medi-Cal members' housing situations and coordinate with housing services providers when needed and available (Partially Achieved).
  - 2.c. State requirement to ensure psychiatric hospitals and residential settings contact Medi-Cal members and community-based providers through the most effective means possible, e.g., email, text, or phone call within 72 hours post discharge (Partially Achieved).
  - 2.d. Strategies to prevent or decrease lengths of stay in EDs among Medi-Cal members with SMI prior to admission (Achieved).
  - 2.e. Other State requirements/policies to improve care coordination and connections to community-based care (Achieved).

- 3. Increasing Access to Continuum of Care Including Crisis Stabilization Services
  - 3.a. Establishment of a process to annually assess the availability of mental health services throughout the state, particularly crisis stabilization services, and updates on steps taken to increase availability (Achieved).
  - 3.b. Commitment to implementation of the SMI financing plan (Achieved).

  - 3.c. Strategies to improve the state tracking of the availability of inpatient and crisis stabilization beds to help connect individuals in need with that level of care as soon as possible (Not Achieved).
  - 3.d. State requirement that providers use a widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay (Not Achieved).
  - 3.e. Other state requirements/policies to improve access to a full continuum of care including crisis stabilization (Achieved).

- 4. Earlier Identification and Engagement in Treatment and Increased Integration
  - 4.a. Strategies for identifying and engaging Medi-Cal members with or at risk of SMI in treatment sooner, particularly adolescents and young adults (Achieved).
  - 4.b. Plan for increasing integration of BH care in non-specialty settings, including schools and primary care practices, to improve early identification of SMI conditions and improve awareness of and linkages to specialty treatment providers (Achieved).
  - 4.c. Establishment of specialized settings and services, including crisis stabilization services, focused on the needs of young people experiencing SMI (Achieved).
  - 4.d. Other state strategies to increase earlier identification/engagement, integration, and specialized programs for young people (Achieved).

Evaluation Overview

The SMI Program evaluation will use a mixed-methods approach to examine the state's success at improving member- and system-level outcomes and achieving the program goals.

Following CMS guidance, we have proposed a logic model (Figure 5.1) that identifies connections between the actions that will be undertaken as part of the SMI Program and their expected short-term and long-term outcomes. While some of the long-term outcomes are specific to the SMI Program's five (5) goals, others are specific to the BH-CONNECT reform's goals, with some goals having overlapping domains. We have proposed additional long-term goals of high public health and policy significance. Additionally, the logic model identifies member characteristics and contextual variables that may modify or confound program impacts.

Each of the goals of the SMI Program will be addressed with evaluation questions of relevance to Medi-Cal members with SMI as well as policymakers, along with testable hypotheses. The evaluation questions include, but are not limited to, the primary and subsidiary research questions listed in CMS's SMI/SED and SUD Evaluation Design Guidance: Appendix A (CMS, 2018). See Table 5.1 for evaluation questions and hypotheses, as well as data sources.

In what follows, we describe the data sources, study population, time frame, outcomes and outcome measures, other key variables, and our analytic approach to the evaluation. Measures specific to the Mid-Point Assessment are also noted.

Figure 5.1. SMI Program Logic Model

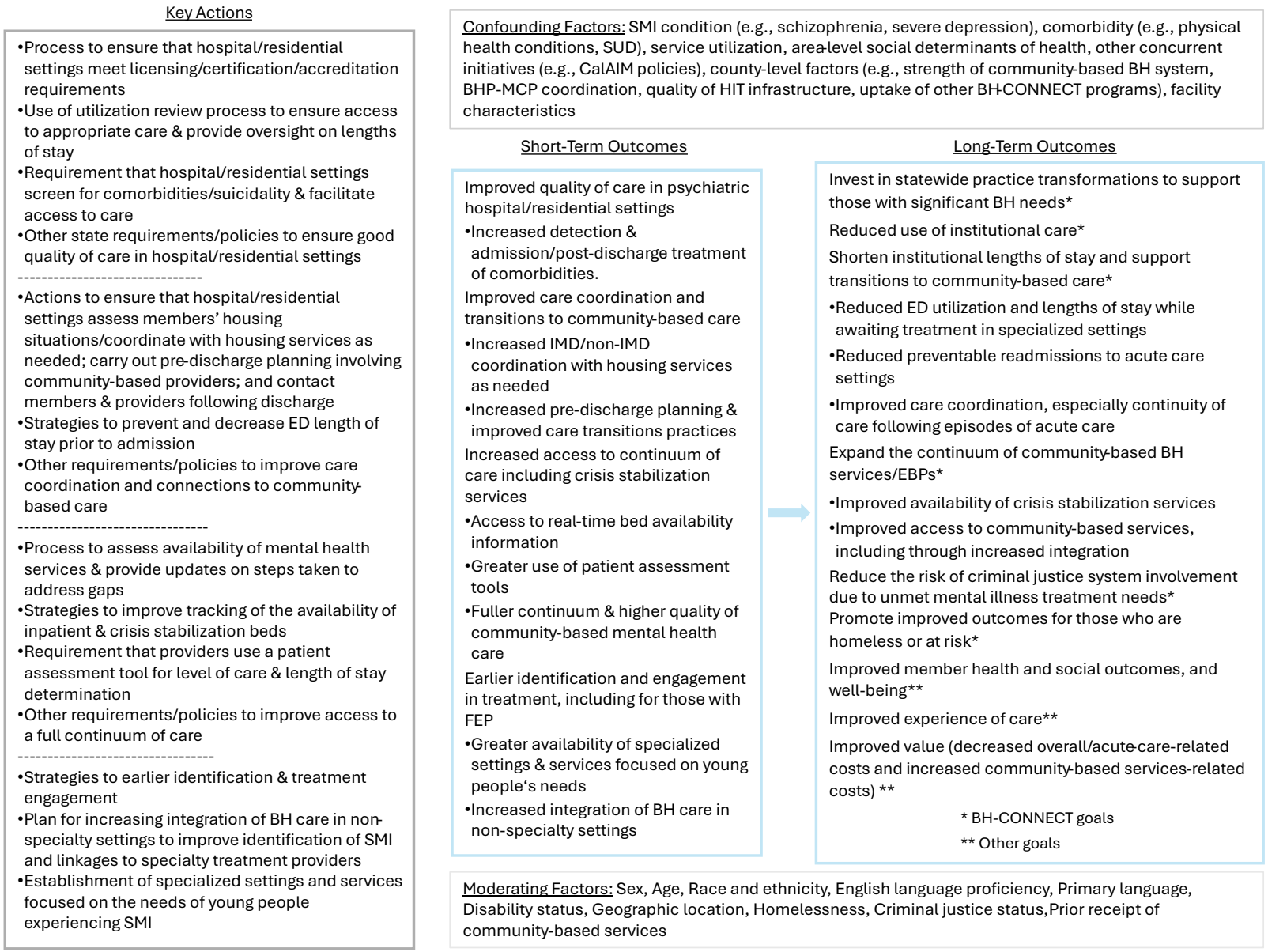


Table 5.1. Evaluation Questions, Hypotheses, and Data Sources: SMI Program

Goal	Evaluation Question	Hypotheses	Data Sources
1. Reduced utilization and lengths of stay in Emergency Departments (EDs) while Medi-Cal members await mental health treatment in specialized settings.	1. Is the SMI Program associated with reductions in ED utilization among Medi-Cal members with SMI? Are member characteristics* and prior receipt of community-based services associated with ED reduced utilization?	• All-Cause ED utilization among Medi-Cal members with SMI will be reduced under the SMI Program. • All-Cause ED utilization will be lower among Medi-Cal members with SMI receiving community-based services. • All-Cause ED utilization reductions may vary across relevant subgroups of Medi-Cal members with SMI (e.g., age groups, rural vs. urban populations). • All-Cause ED utilization and costs (PMPM/total) among Medi-Cal members with SMI will be reduced under the SMI Program. • ED utilization for mental health conditions among Medi-Cal members with SMI will be reduced under the SMI Program.	• Medi-Cal data
	2. Is the SMI Program associated with reductions in ED lengths of stay among Medi-Cal members with SMI awaiting mental health treatment in specialized settings?	• ED lengths of stay among Medi-Cal members with SMI awaiting mental health treatment in specialized settings will be reduced under the SMI Program.	• Medi-Cal data • HCAI Patient-Level Administrative Data • County BH EHR data
	3. What is the association between the activities undertaken under the SMI Program's four (4) milestones^ and the achievement of this Goal?	• Changes made to systems, processes, or policies and other activities undertaken under the SMI Program will be associated with the achievement of this goal.	• Medi-Cal data • HCAI Patient-Level Administrative Data • County BH EHR data • Qualitative data
2. Reduced preventable readmissions to acute care hospitals and residential settings.	1. Is the SMI Program associated with reductions in preventable readmissions of Medi-Cal members with SMI to acute care hospitals and residential settings (IMDs and non-IMDs)? Do observed reductions vary by member characteristics* and prior receipt of community-based services?	• All-cause unplanned readmissions following acute psychiatric hospitalizations will be reduced under the SMI Program. • Reductions in all-cause unplanned readmissions may vary across relevant subgroups of Medi-Cal members with SMI (e.g., age groups, rural vs. urban populations). • All-cause unplanned readmissions following acute care hospital/residential stays for any diagnosis will be reduced for Medi-Cal members with SMI under the SMI Program.	• Medi-Cal data • HCAI Patient-Level Administrative Data • HPD

Goal	Evaluation Question	Hypotheses	Data Sources
	2. Is the SMI Program associated with increased screening and intervention for comorbid SUD and physical health conditions during acute care psychiatric inpatient and residential stays and increased treatment for such conditions after discharge?	• Screening and intervention for comorbid SUD and physical health conditions during acute care psychiatric inpatient/residential stays will increase for Medi-Cal members with SMI under the SMI Program. • Timely post-discharge treatment for comorbid SUD and physical health conditions identified during acute care psychiatric inpatient/residential stays will increase for Medi-Cal members with SMI under the SMI Program. • Care of diabetes for Medi-Cal members with SMI admitted to psychiatric inpatient/residential facilities will improve under the SMI Program as evidenced by fewer individuals whose most recent HbA1c level was ≥9.0% or had a missing result or test.	• Medi-Cal data • County BH EHR data • IPFQR data
	3. What is the association between the activities undertaken under the SMI Program's four (4) milestones^ and the achievement of this Goal?	• Under the SMI Program, fewer all-cause unplanned readmissions for Medi-Cal members with SMI will have no evidence of receipt of timely community-based services following discharge from psychiatric hospitalizations. • The length of stay of psychiatric hospitalizations will be reduced under the SMI Program. • The activities undertaken under the SMI program will be associated with a reduction of preventable readmissions to acute care hospitals and residential settings.	• Medi-Cal data • HCAI Patient-Level Administrative Data • HPD • Qualitative data
3. Improved availability of crisis stabilization services throughout the state.	1. Is the SMI Program associated with improved availability of Crisis Outreach and Response services?	• The availability of Crisis Outreach and Response services will improve for Medi-Cal members with SMI under the SMI Program.	• County Profiles • Other (BHCIP, N-MHSS/N-SUMHSS)
	2. Is the SMI Program associated with improved availability of Intensive Outpatient and Partial Hospitalization?	• The availability of Intensive Outpatient and Partial Hospitalization services will improve for Medi-Cal members with SMI under the SMI Program.	• County Profiles • Other (BHCIP, N-MHSS/N-SUMHSS, AHRF)
	3. Is the SMI Program associated with improved availability of acute short-term crisis stabilization services?	• The availability of acute short-term crisis stabilization services will improve for Medi-Cal members with SMI under the SMI Program.	• County Profiles • Bed Tracking Tool • Other (BHCIP, N-MHSS/N-SUMHSS, AHRF)

Goal	Evaluation Question	Hypotheses	Data Sources
4. Improved access to community-based services to address Medi-Cal members' chronic mental health care needs, including through increased integration of primary and BH care.	1. Is the SMI Program associated with improved access of Medi-Cal members with SMI to community-based services to address their chronic mental health care needs? Do observed improvements vary by member characteristics*?	• Access to (1) outpatient, rehabilitation, and targeted case management services, (2) home and community-based services, and (3) long-term services and supports will increase for Medi-Cal members with SMI under the SMI program. • Improvements in access to community-based services may vary across relevant subgroups of Medi-Cal members with SMI (e.g., age groups, rural vs. urban populations). • Improved access to community-based mental health services for Medi-Cal members with SMI under the SMI program will be associated with increased costs associated with mental health-related community-based services and reduced mental health-related inpatient/residential and overall costs. • Ease and timeliness of access to community-based mental health services will improve for Medi-Cal members with SMI under the SMI program.	• Medi-Cal data • TADT
	2. Is the SMI Program associated with improved availability of community-based services needed to comprehensively address the chronic mental health needs of Medi-Cal members with SMI?	• The availability of community-based mental health services for Medi-Cal members with SMI will improve under the SMI program.	• County Profiles • Other (BHCIP)
	3. To what extent is the SMI Program associated with improved access of SMI Medi-Cal members to specific types of community-based services? Is quality/experience of care improved under the SMI Program? Do observed improvements vary by member characteristics*?	• Access to specific types of evidence-based community mental health practices will improve for SMI Medi-Cal members under the SMI program. • Quality/experience of care will improve for SMI Medi-Cal members under the SMI program. • Quality/experience of care improvements under the SMI Program may vary across relevant subgroups of Medi-Cal members with SMI (e.g., age groups, rural vs. urban populations).	• Medi-Cal data • Performance data • Other (URS)
	4. To what extent does improved access to community-based services under the SMI Program vary by geographic area or member characteristics?	• While access to community-based mental health services for Medi-Cal members with SMI will improve under the SMI Program, improvements may vary across geographic areas and member characteristics including age and language needs.	• County Profiles • Other (N-MHSS/N-SUMHSS)

Goal	Evaluation Question	Hypotheses	Data Sources
	5. To what extent is the SMI Program associated with improved integration of primary and behavioral health care to address the chronic mental health care needs of Medi-Cal members with SMI? Do observed improvements vary by member characteristics*?	• Integration of primary and behavioral health care for Medi-Cal members with SMI will improve under the SMI Program. • The SMI program will be associated with improved efforts to identify need for mental health care among Medi-Cal members with SMI. • The SMI program will be associated with increased access to primary/preventive and chronic medical illness care for Medi-Cal members with SMI. • The SMI program will be associated with an increase in the rate of Medi-Cal members with SMI accessing SMHSs following primary care referrals. • Improvements in integration of primary and behavioral health care under the SMI Program may vary across relevant subgroups of Medi-Cal members with SMI (e.g., age groups, rural vs. urban populations).	• Medi-Cal and HPD/CA Medicare FFS data • County Profiles • Performance data • TADT • Other (Medi-Cal & EHR data: Child and Adult Core Set, hybrid measure)
	6. To what extent is the SMI Program associated with improved patient outcomes? Do observed improvements vary by beneficiary characteristics*?	• H6a.Health and social outcomes and well-being will improve for Medi-Cal members with SMI under the SMI Program. • Improvements in health and social outcomes and well-being under the SMI Program may vary across relevant subgroups of Medi-Cal members with SMI (e.g., age groups, rural vs. urban populations).	• Medi-Cal data • Other (State data, Quality of life survey)
5. Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.	1. Is the SMI Program associated with improved care coordination for Medi-Cal members with SMI? Do observed improvements vary by member characteristics*?	• The SMI program will be associated with improved care coordination for Medi-Cal members with SMI. • Improvements in care coordination under the SMI Program may vary across relevant subgroups of Medi-Cal members with SMI (e.g., age groups, rural vs. urban populations). • The SMI program will be associated with improved data sharing systems, processes, or policies aimed at improving care coordination.	• Medi-Cal data • Performance data • County BH EHR data • IPFQR data • Qualitative data

Goal	Evaluation Question	Hypotheses	Data Sources
	2. Is the SMI Program associated with improved continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities among Medi-Cal members with SMI? Do observed improvements vary by member characteristics*?	• The SMI program will be associated with improved continuity of care in the community for Medi-Cal members with SMI following acute care episodes. • Improvements in continuity of care in the community following acute care episodes under the SMI Program may vary across relevant subgroups of Medi-Cal members with SMI (e.g., age groups, rural vs. urban populations).	• Medi-Cal data • HCAI Patient-Level Administrative Data • HPD • Performance data
	3. To what extent is the SMI Program associated with improved discharge planning and outcomes regarding housing for Medi-Cal members with SMI who are transitioning out of acute psychiatric care in hospitals and residential treatment facilities?	• The SMI program will be associated with improved discharge planning and outcomes regarding housing for Medi-Cal members with SMI who are transitioning out of acute psychiatric care.	• Facility administrative data
	4. What is the association between the activities undertaken under the SMI Program's four (4) milestones^ and improvements in the continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities?	• The activities undertaken under the SMI program will be associated with improved continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.	• Qualitative data

NOTE: ^ Milestones: (1) Ensuring quality of care in IMDs; (2) Improving care coordination and transitions to community-based care; (3) Increasing access to continuum of care including crisis stabilization services; (4) Earlier identification and engagement in treatment including through increased integration.of care including crisis stabilization services; (4) Earlier identification and engagement in treatment including through increased integration.

Evaluation Methods

Data Sources

The data sources for the evaluation of the SMI Program, including the SMI Mid-Point Assessment, will include qualitative data collected during the demonstration through key informant interviews or focus groups and a variety of member- and provider-level secondary data collected by DHCS and other state agencies, as well as publicly available area-level data collected by federal agencies.

Person-level secondary data include (i) health care administrative data, e.g., DHCS's Medi-Cal Claims and Eligibility data and HCAI's Health Care Payments Data (HPD, CA's All Payer Claims Database), both of which provide information on Medi-Cal member demographics, mechanism for Medicaid eligibility, diagnosed BH and physical health conditions, and service utilization including filled prescriptions drugs; HCAI Patient-Level Administrative Data which provides information related to inpatient discharges from CA-licensed hospitals, ED encounters, and ambulatory surgery encounters, including a homelessness indicator; and CA TADT, which provides information on the number of hours/days between a new patient's first contact with BHP-financed care and the offered appointment date, also capturing the source of the referral, final disposition and other information; (ii) other state administrative data, e.g., CA Homeless Data Integration System (HDIS), which provides information on individuals who have experienced homelessness, and ACHS and Juvenile Court Probation Statistical System (JCPSS), which provides information on individuals with criminal justice system involvement; (iii) performance data, e.g., data from the DHCS Mental Health CMS Core Set Measures Dashboard, which provides information on quality measures, and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) data, which provides survey-based information on patient experience of care; (iv) other state data, e.g., CA Department of Public Health vital statistics data, which provides mortality information; (v) clinical operations data, e.g., Electronic Health Record (EHR) data from county BHPs; and (vi) other survey data, namely, the survey that will be deployed to collect information on self-reported quality of life as part of the BH-CONNECT Incentive Program.

Other secondary data include (vii) provider-level capacity/workforce data compiled into the County Profiles (described in Chapter 1) and Behavioral Health Continuum Infrastructure Program (BHCIP) data, which provide information on availability of providers or treatments; (viii) provider-level performance data, e.g., CMS's Inpatient Psychiatric Facility Quality Reporting (IPFQR); and (ix) publicly available area-level data sources, e.g., Area Health Resources File (AHRF), which provide county-level information on social determinants of health, including sociodemographic and health care infrastructure characteristics. See Tables 5.1

and 5.2 for potential data sources for the evaluation of the SMI Program and Appendix A for details on all available data sources.

Study Population

The study population will include Medi-Cal members meeting MHP/BHP criteria for SMI/SED who are exposed to the SMI Program—that is, those living in participating counties (counties that expressed interest in participating, received DHCS approval, and implemented the SMI Program, hereafter also referred to as implementer, opt-in, or "intervention" counties), and unexposed Medi-Cal members living in non-participating or "control" counties.

As of July 2025, in a non-binding survey DHCS released in early 2025, 15 counties expressed interest in implementing the SMI Program. While it is expected that the number of participating counties will grow over the course of the demonstration, it is also possible although unlikely, that some participating counties may opt out before the end of the demonstration (historically counties have rarely opted out of programs that were already launched). As a result, in any given year of the demonstration, there may be different sets of intervention and control counties. Counties that opt out of the SMI Program will not be allowed to serve as control counties; therefore, control counties will only include those that never participate in the SMI Program or are yet to opt in.

Time Frame for the Evaluation

The evaluation period will include a pre-implementation period, hereafter pre-period or baseline, of a minimum duration of two years, and a post-implementation period, hereafter post-period. The post-period will span the time between the date of implementation of the SMI Program (start date) and the date of opt-out or end of the five-year demonstration (end date), whichever comes first. The opt-in and opt-out flexibility afforded to counties, described above, may lead to variable start and end dates for participating counties and variable durations of post-implementation periods.

CMS Outcomes and Outcome Measures

A range of outcomes will be assessed as part of the evaluation. Medi-Cal member-level outcomes include hospital/residential, ED, and outpatient utilization; access to care; quality of BH and physical health care assessed with Core Set and other measures (see Appendix B for an inventory of routinely collected quality and service utilization measures); patient experience with care; and member outcomes, including health outcomes (suicidal behavior, death), social outcomes (homelessness, criminal justice system involvement), and well-being (self-reported quality of life). System-level outcomes include availability of specialized mental health services, i.e., treatment capacity; Medi-Cal costs; and value of Medi-Cal-financed care. We define value as decreasing overall costs over the course of the demonstration, with costs associated with mental health inpatient/residential services also decreasing, and costs associated with mental

health community-based services increasing (we will assess both per-member-per-month (PMPM) and total costs). Other system outcomes include the extent of changes to critical systems, processes, or policies, and barriers to and facilitators of the effectiveness of actions undertaken under the SMI program's four (4) milestones.

Outcomes will be assessed with measures selected based on their relevance to the specific evaluation question and hypothesis being tested, as well as their validity and feasibility. Outcome measures will include but will not be limited to the monitoring metrics required by the Section 1115 SMI/SED Demonstration (CMS, 2019), hereafter CMS monitoring metrics, as well as any recommended metrics that may be feasibly constructed (see Table 5.2 for details on outcome measures, including the monitoring metrics required for the Mid-Point Assessment).

Other Key Variables

We will address the potential confounding effects of relevant member characteristics and contextual factors with variables that will be assessed at baseline. Member characteristics include sex, age, race and ethnicity, English language proficiency, primary language, dual Medicaid-Medicare eligibility, Medicaid eligibility based on disability, geographic location (e.g., ZIP code, rurality), criminal justice status, homelessness, physical health comorbidity, SUD comorbidity, SMI diagnosis (e.g., schizophrenia, bipolar I disorder, severe major depressive disorder), and service utilization (including use of EBPs). Contextual factors include area-level social determinants of health such as household income and quality of housing stock; county-level factors such as strength of the community-based BH system, quality of coordination between BHPs and Medi-Cal managed care plans MCP, quality of the HIT infrastructure, and uptake of other BH-CONNECT programs; ownership and other characteristics of IMDs and other acute care (hospital/residential) facilities; and concurrent multicounty, state, or federal initiatives with the potential to impact outcomes, e.g., CalAIM programs (see Appendix C for a list of multicounty and state-level initiatives). Several of these variables, including those describing contextual factors, may modify program effects and lead to outcome disparities. In keeping with the STCs, we will pay particular attention to outcome moderation by key member characteristics including sex, age, race and ethnicity, English language proficiency, primary language, disability status, geographic location, homelessness, criminal justice status, and prior receipt of community-based services (see Figure 5.1, SMI Program Logic Model and Table 5.2).

Analytic Approaches

We will address each of the evaluation questions using quantitative and qualitative methods as necessary and feasible. See Table 5.2 for planned analytic approaches.

Quantitative Methods

Methods that may be used to characterize populations and trends and, whenever possible, validly quantify the impacts of the SMI Program include:

- Descriptive statistical analyses
- Quasi-experimental methods.

Descriptive Statistics

This method will be used to describe the Medi-Cal member population, overall and stratified by key member characteristics, year-to-year, and examine trends over time as well as regional patterns. For categorical variables, a chi-square test or a McNemar's test will be used as appropriate; for continuous variables, the Analysis of Variance test or paired t-test will be used as appropriate. For selected outcomes, we will complement the presentation of results with graphical illustrations.

Quasi-Experimental Methods

As described in detail in Chapter 1 (*Quantitative Methods*), BH-CONNECT program outcomes will be examined using quasi-experimental methods that support valid causal inferences, including DD, the most robust of these methods, CITS, and ITS.

As described in Chapter 1, whenever quasi-experimental methods are preferred, we will aim to implement a DD approach to examine how the difference in the outcomes pre- and post-SMI Program implementation vary by exposure to the SMI Program. We will adjust for confounder imbalance between exposed and unexposed Medi-Cal members living in participating and non-participating counties by implementing multivariable DD regression models. Additionally, following stratified descriptive analyses to examine potential outcome differences across Medi-Cal member subpopulations defined by key member characteristics (see Other Key Variables), we will implement a DDD approach to assess for effect moderation and identify outcome disparities as described in Chapter 1.

We believe it will be possible to implement a DD approach because, as of July 2025, it appears that there will be an adequate number of participating and non-participating counties providing adequate samples of contemporaneous exposed and unexposed Medi-Cal members with SMI throughout the demonstration (see Study Population).

The flexibility afforded to counties regarding the timing for opting in and the rare eventuality that counties may opt out (see Study Population and Time Frame for the Evaluation) sets up several scenarios for analysis, with the first two (2) thought to be most likely:

- Counties that implemented the SMI Program at the start of the BH-CONNECT demonstration and remained in the SMI Program throughout the demonstration
- Counties that implemented the SMI Program at a later date and remained in the SMI Program throughout the demonstration
- Counties that implemented the SMI Program at the start of the demonstration and opted out before the end of the demonstration
- Counties that implemented the SMI Program at a later date and opted out before the end of the demonstration.

The differential timing of county participation in the SMI Program will be addressed with methods that can handle the expected staggered adoption of the program as described in Chapter 1.

We will address the possibility that concurrent policies and other initiatives may affect estimates of program impacts by examining the timing of other initiatives relative to the implementation of the BH-CONNECT programs and including controls for concurrent initiatives in the causal models.

Qualitative Methods

The focus of the qualitative component of the evaluation will be to identify SMI Program activities or their components or characteristics thought to be most effective in achieving the goals of the SMI Program (facilitators), factors thought to hinder their effectiveness (barriers), and program-driven changes to data sharing systems, processes, or policies. Semi-structured interviews will be conducted with individuals who have 'on the ground' experience with the implementation of the SMI Program, including state and county officials, MCP officials, IMD/other provider administrators, direct care providers (ED, hospital/residential, and outpatient provider staff), and affected Medi-Cal members or their families/caregivers.

Table 5.2. SMI Program: Evaluation Questions, Data Sources, Outcome Measures, and Analytic Approach, by Goal

Goal 1: Reduced utilization and lengths of stay in EDs) while Medi-Cal members await mental health treatment in specialized settings. MM=SMI/SED Monitoring Metric (MM21/MM22: monthly/annual counts, Medi-Cal members with SMI)

Evaluation Question	Data Source	Outcome Measure	Analytic Approach
1. Is the SMI Program associated with reductions in ED utilization among Medi-Cal members with SMI? Are member characteristics* and prior receipt of community-based services associated with ED reduced utilization?	• Medi-Cal Data	• *All-cause ED utilization rate for Medi-Cal members with SMI who may benefit from integrated physical and BH care* **(MM3@)**: • Count (N) of all-cause ED visits per 1,000 member-months for Medi-Cal members with SMI aged ≥18,& all and by prior receipt of community-based services, by annual period • Percentage of Medi-Cal members with SMI who use ED services for mental health **(MM16@)** or any condition, by annual period • Mean all-cause ED utilization and costs (PMPM and total), Medi-Cal members with SMI, by annual period	• Analyses over pre-period (≥2 years) and post-period • Unadjusted Analyses • Adjusted analyses (DD models) • Adjusted analyses to assess effect modification by selected member characteristics (DDD models)
2. Is the SMI Program associated with reductions in ED lengths of stay among Medi-Cal members with SMI awaiting mental health treatment in specialized settings?	• Medi-Cal data • HCAI • Other (EHR data, ED/ inpatient facility administrative data)	• Time from ED arrival to ED departure for patients discharged from ED (NQF-0496-adapted): Median time (minutes) from ED arrival to ED departure for Medi-Cal members with SMI who are admitted or transferred from an ED to inpatient psychiatric treatment, by annual period	• Analyses over pre-period (≥2 years) and post-period • Unadjusted Analyses • Adjusted analyses (DD models)

Evaluation Question	Data Source	Outcome Measure	Analytic Approach
3. What is the association between the activities undertaken under the SMI Program's four (4) milestones^ and the achievement of this Goal?	• Medi-Cal data • Other (ED/inpatient facility administrative data)	• Percentage of Medi-Cal members with SMI with housing instability and prior ED use for mental health/any condition who use enhanced Community Supports, by annual period • Percentage of psychiatric inpatient/residential facilities utilizing the Bed Tracking Tool, by annual period • Number of acute psychiatric admissions following ED visits per 1,000 member-months (with SMI) for which a Patient Assessment Tool was used to determine appropriate level of care and length of stay, by annual period	• Descriptive quantitative analysis of trends over time during the post-period, implementer counties only
	• Qualitative data (interviews or focus groups with ED/county demonstration staff; interviews or focus groups with Medi-Cal members or significant others)	• Barriers/facilitators of the effectiveness of SMI Program activities • Barriers/facilitators of the effectiveness of efforts to track psychiatric beds in real time • Changes made to systems, processes, or policies related to real-time psychiatric bed-tracking	• Qualitative methods

NOTE:
@ Monitoring Metric used for Mid-Point Assessment.
& For selected Evaluation Questions using CMS monitoring metrics focused on specific age groups, metrics may be adapted for use with additional age groups.
* Member characteristics of interest include age, SUD or physical health comorbidity, race and ethnicity, geographic location, and others.
^ Milestones: (1) Ensuring quality of care in IMDs; (2) Improving care coordination and transitions to community-based care; (3) Increasing access to continuum of care including crisis stabilization services; (4) Earlier identification and engagement in treatment including through increased integration.

Goal 2: Reduced preventable readmissions to acute care hospitals and residential settings. MM=SMI/SED Monitoring Metric (MM21/MM22: monthly/annual counts, beneficiaries with SMI)

Evaluation Question	Data Source	Outcome Measure	Analytic Approach
1. Is the SMI Program associated with reductions in preventable readmissions of Medi-Cal members with SMI to acute care hospitals and residential settings (IMDs and non-IMDs)? Do observed reductions vary by member characteristics* and prior receipt of community-based services?	• Medi-Cal Data • HCAI Patient-Level Administrative Data • HPD	• Thirty-day all-cause unplanned readmissions following psychiatric hospitalization (NQF-2860-adapted) **(MM4@)**: Percentage of acute psychiatric hospitalizations for Medi-Cal members with SMI with an unplanned acute readmission for any diagnosis within 30 days after discharge, all and by receipt of community-based services in the 7 and 30 days prior to readmission, by annual period • *Plan All-Cause Readmission*: Percentage of acute care inpatient/ residential and observation stays followed by an unplanned acute readmission for any diagnosis within 30 days after discharge, Medi-Cal members with SMI aged ≥18 years, by annual period	• Analyses over pre-period (≥2 years) and post-period • Unadjusted Analyses • Adjusted analyses (DD models) • Adjusted analyses to assess effect modification by selected member characteristics (DDD models)
2. Is the SMI Program associated with increased screening and intervention for comorbid SUD and physical health conditions during acute care psychiatric inpatient and residential stays and increased treatment for such conditions after discharge?	• Other (EHR data, IPFQR)	• *SUD Screening & Brief Intervention Provided or Offered* (NQF-1663-adapted): Percentage of Medi-Cal members with SMI admitted to psychiatric inpatient/ residential facilities who are screened for SUDs and, if indicated, offered an intervention during the hospital stay **(MM1@)**, by county and annual period	• Descriptive quantitative analysis of trends over time during the evaluation period (pre-period and post-period), implementer and non-implementer counties
	• Other (EHR data)	• Percentage of Medi-Cal members with SMI admitted to psychiatric inpatient/residential facilities who are screened for comorbid physical health conditions and, if indicated, offered an intervention during the hospital stay, by annual period	• Descriptive quantitative analysis for two periods during the post-period: • Between start date and mid-point • Between start and end dates

Evaluation Question	Data Source	Outcome Measure	Analytic Approach
	• Medi-Cal & EHR data	• *Diabetes Care for Patients with SMI: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)*: Percentage of Medi-Cal members with SMI admitted to psychiatric inpatient/residential facilities whose most recent HbA1c level was ≥9.0% or had a missing result or test **(MM23@)**, by annual period	• Descriptive quantitative analysis for two periods during the post-period: • Between start date and mid-point • Between the start and end dates
	• Medi-Cal data	• Percentage of Medi-Cal members who receive outpatient treatment for SUDs and physical health conditions within 30 days of discharge from a psychiatric inpatient/residential facility, by annual period	• Analyses over pre-period (≥2 years) and post-period • Unadjusted Analyses • Adjusted analyses (DD models)
3. What is the association between the activities undertaken under the SMI Program's four (4) milestones^ and the achievement of this Goal?	• Medi-Cal data • HCAI Patient-Level Administrative Data • HPD	• Percentage of Medi-Cal members with SMI with 30-day, all-cause unplanned readmissions following psychiatric hospitalization who received community-based services in the 7 and 30 days prior to readmission, by annual period • Mean length of stay per psychiatric hospitalization **(MM19a@, MM19b)** and annualized **(MM13@)**, Medi-Cal members with SMI, by annual period	• Analyses over pre-period (≥2 years) and post-period • Unadjusted Analyses • Adjusted analyses (DD models)
	• Qualitative data (interviews or focus groups with inpatient/ residential staff and community-based service providers; interviews or focus groups with Medi-Cal members or significant others)	• Barriers/facilitators of the effectiveness of SMI Program activities	• Qualitative methods

NOTE:
@ Monitoring Metric used for Mid-Point Assessment.
* Member characteristics of interest include age, SUD or physical health comorbidity, race and ethnicity, geographic location, and others.
^ Milestones: (1) Ensuring quality of care in IMDs; (2) Improving care coordination and transitions to community-based care; (3) Increasing access to continuum of care including crisis stabilization services; (4) Earlier identification and engagement in treatment including through increased integration.

Goal 3: Improved availability of crisis stabilization services throughout the state. MM=SMI/SED Monitoring Metric (MM21/MM22: monthly/annual counts, Medi-Cal members with SMI).

Evaluation Question	Data Source	Outcome Measure	Analytic Approach
1. Is the SMI Program associated with improved availability of Crisis Outreach and Response services?	• County Profiles	• Count (N) of providers, by county and annual period: • Crisis Call Centers • Mobile Crisis Units • Crisis Observation /Assessment Centers • Coordinated Community Crisis Response Teams	• Descriptive quantitative analysis of trends over time during the post-period, implementer and non-implementer counties
	• County Profiles	• Ratio of Medi-Cal members with SMI to count (N) of providers, by county and annual period: • Crisis Call Centers • Mobile Crisis Units • Crisis Observation/Assessment Centers • Coordinated Community Crisis Response Teams	• State map depicting the outcome measures each year of the SMI Program (between the start and end dates)
	• County Profiles • Other (BHCIP, N-MHSS/N-SUMHSS)	• Count (N) of mental health facilities that accept Medi-Cal and offer a crisis intervention team that handles acute mental health issues, by county and annual period	• Descriptive quantitative analysis of trends over time during the evaluation period (pre-period and post-period), comparing implementer vs. non-implementer counties
2. Is the SMI Program associated with improved availability of Intensive Outpatient and Partial Hospitalization?	• County Profiles	• Count (N) of Medi-Cal-enrolled Intensive Outpatient and Partial Hospitalization providers, by county and annual period	• Descriptive quantitative analysis of trends over time during the post-period, implementer and non-implementer counties
	• County Profiles	• Ratio of Medi-Cal members with SMI to Medi-Cal-enrolled intensive outpatient/partial hospitalization providers, by county and annual period	• State map depicting the outcome measure each year of the SMI Program (between the start and end dates)
	• County Profiles • Other (BHCIP, N-MHSS/N-SUMHSS, AHRF)	• Count (N) of mental health facilities that accept Medi-Cal and offer partial hospitalization/day treatment, by county and annual period • Count (N) of hospitals with psychiatric partial hospitalization programs, by county and annual period	• Descriptive quantitative analysis of trends over time during the evaluation period (pre-period and post-period), comparing implementer vs. non- implementer counties

Evaluation Question	Data Source	Outcome Measure	Analytic Approach
3. Is the SMI Program associated with improved availability of acute short-term crisis stabilization services	• County Profiles • Other (Bed Tracking Tool)	• Count (N) of psychiatric hospitals, by county and annual period • Total count (N) of residential mental health treatment facilities and beds (adults), by county and annual period • Count (N) of Medi-Cal-enrolled psychiatric residential treatment facilities and beds (child), by county and annual period • Count (N) of Medi-Cal-enrolled general hospital psychiatric units (acute care/critical access hospitals), by county and annual period • Count (N) of licensed psychiatric hospitals and psychiatric unit beds, by county and annual period • Count (N) of crisis stabilization units (e.g., residential crisis stabilization programs, small inpatient units in community mental health centers, peer-run crisis respite programs), by county and annual period	• Descriptive quantitative analysis of trends over time during the post-period, implementer and non-implementer counties
	• County Profiles • Other (Bed Tracking Tool)	• Ratio of Medi-Cal members with SMI to count (N) of providers, by county and annual period: • Psychiatric hospitals • Medi-Cal-enrolled psychiatric units in acute care and critical access hospitals • Licensed psychiatric hospital and psychiatric unit beds • Crisis stabilization units • Ratio of Medi-Cal members with SMI to count (N) of Medi-Cal-enrolled providers, by county and annual period: • Residential mental health treatment facilities and beds (adult) • Psychiatric residential mental health treatment facilities and beds (child)	• State map depicting the outcome measures each year of the SMI Program (between the start and end dates)

Evaluation Question	Data Source	Outcome Measure	Analytic Approach
	• County Profiles • Other (BHCIP, N-MHSS/N-SUMHSS, AHRF)	• Count (N) of mental health facilities offering 24-hour inpatient/residential treatment, by county and annual period: • Total • Public psychiatric hospital • Private psychiatric hospital • Residential treatment facility • General hospital psychiatric unit • Community-based inpatient setting	• Descriptive quantitative analysis of trends over time during the evaluation period (pre-period and post-period), comparing implementer vs. non- implementer counties
	• County Profiles • Bed Tracking Tool • Other (AHRF)	• Count (N) of inpatient beds, by county and annual period: • Total • Public psychiatric hospital • Private psychiatric hospital • Residential treatment facility (adult) • Psychiatric residential treatment facility (child) • General hospital psychiatric unit • Crisis stabilization units or other community-based inpatient setting	• Descriptive quantitative analysis of trends over time during the evaluation period (pre-period and post-period), implementer and non-implementer counties
	• County Profiles • Other (BHCIP, N-MHSS/N-SUMHSS, AHRF)	• Count (N) of mental health facilities offering 24-hour inpatient/residential treatment, by county and annual period: • By age groups accepted for treatment (children, adolescents, young adults, adults, seniors) • By whether mental health services are available in languages other than English	• Descriptive quantitative analysis of trends over time during the evaluation period (pre-period and post-period), comparing implementer vs. non- implementer counties

Goal 4: Improved access to community-based services to address Medi-Cal members' chronic mental health care needs, including through increased integration of primary and BH care. MM=SMI/SED Monitoring Metric (MM21/MM22: monthly/annual counts, Medi-Cal members with SMI).

Evaluation Question	Data Source	Outcome Measure	Analytic Approach
1. Is the SMI Program associated with improved access of Medi-Cal members with SMI to community-based services to address their chronic mental health care needs? Do observed improvements vary by member characteristics*?	• Medi-Cal data	• Percentage of Medi-Cal members with SMI who use mental health-related (1) outpatient, rehabilitation, and targeted case management services, (2) home and community-based services, and (3) long-term services and supports (MM15@), by annual period • Percentage of Medi-Cal members with SMI with ≥1 mental health-related outpatient visits per quarter, by annual period • Percentage of Medi-Cal members with SMI who use mental telehealth services (MM17@), by annual period • Amount of mental health–related (1) outpatient, rehabilitation, and targeted case management services, (2) home and community-based services, and (3) long-term services and supports used by Medi-Cal members with SMI, by annual period • Ratio of non-inpatient/non-residential costs (PMPM and total) associated with mental health services for Medi-Cal members with SMI (MM32, MM34) to inpatient/residential costs for the same (MM33, MM35, MM39, MM40), by annual period • Ratio of non-inpatient/non-residential costs (PMPM and total) associated with mental health services for Medi-Cal members with SMI (MM32, MM34) to overall costs for the same, by annual period	• Analyses over pre-period (≥2 years) and post-period • Unadjusted Analyses • Adjusted analyses (DD models) • Adjusted analyses to assess effect modification by selected member characteristics (DDD models)
	• TADT	• Percentage of Medi-Cal members with SMI whose SMHS appointment met DHCS timely access standards, by county and annual period	• Descriptive quantitative analysis of trends over time during the post-period, implementer and non- implementer counties

Evaluation Question	Data Source	Outcome Measure	Analytic Approach
2. Is the SMI Program associated with improved availability of community-based services needed to comprehensively address the chronic mental health needs of Medi-Cal members with SMI?	• County Profiles	• Number of Medi-Cal-enrolled providers, by county and annual period: – Community mental health centers – Psychiatrists and other mental health practitioners authorized to prescribe – Mental health practitioners (other than psychiatrists) who are certified and licensed by the state to independently treat mental illness	• Descriptive quantitative analysis of trends over time during the post-period, implementer and non-implementer counties
	• County Profiles	• Number of mental health facilities that offer outpatient mental health treatment and accept Medicaid, by county and annual period	• Descriptive quantitative analysis of trends over time during the evaluation period (pre-period and post-period), implementer and non-implementer counties
	• County Profiles	• Number of community mental health centers, outpatient mental health facilities, and multi-setting mental health facilities that accept Medicaid and offer specific types of mental health treatment approaches, services, and practices, by county and annual period	• Descriptive quantitative analysis of trends over time during the evaluation period (pre-period and post-period), implementer and non-implementer counties
	• County Profiles	• Ratio of Medi-Cal members with SMI to count (N) of Medi-Cal-enrolled outpatient mental health professionals, by type (psychologists, social workers, psychiatrists & other prescribers, counselors, others), by county and annual period	• Descriptive quantitative analysis during the post-period, comparing the start year with each post-period year, implementer and non-implementer counties
	• County Profiles Other (BHCIP)	• Number and capacity of CCBHCs, by annual period	• Descriptive quantitative analysis for two periods during the post-period: • Between start date and mid-point • Between the start and end dates
3. To what extent is the SMI Program associated with improved access of SMI Medi-Cal members to specific types of community-based services?	• Medi-Cal data • Other (URS)	• Percentage of Medi-Cal members with SMI with ≥1 visit to specific services listed by CMS by county and annual period:	• Descriptive quantitative analysis of trends over time during the evaluation period (pre-period and post-period), implementer and non-implementer counties

Evaluation Question	Data Source	Outcome Measure	Analytic Approach
Is quality and experience of care improved under the SMI Program? Do observed quality or experience of care improvements vary by member characteristics*?	• Medi-Cal data • Performance data (Child and Adult Core Set)	• *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics*: Percentage of children and adolescents aged 1-17 with SMI who had a new prescription for antipsychotic medication and had documentation of psychosocial care as first-line treatment **(MM2@)**, by annual period • *Use of Multiple Concurrent Antipsychotics in Children and Adolescents:* Percentage of children and adolescents who were on ≥2 concurrent antipsychotic medications for an extended period during the year, by annual period • *Metabolic Monitoring for Children and Adolescents on Antipsychotics:* Percentage of children and adolescents aged 1-17 with SMI who ≥2 antipsychotic prescriptions and had metabolic monitoring **(MM29@)**, by annual period • *Adherence to Antipsychotic Medications for Individuals with Schizophrenia:* Percentage of Medi-Cal members with SMI aged ≥18 years with schizophrenia or schizoaffective disorder who were dispensed and remained on antipsychotic medication for ≥80% of their treatment period, by annual period • *Follow-up Care for Beneficiaries who are Newly Prescribed an Antipsychotic Medication* (NQF-3313): Percentage of new antipsychotic prescriptions for Medi-Cal members with SMI aged ≥18 years who have completed a follow-up visit with a provider with prescribing authority within four (4) weeks of prescription of an antipsychotic **(MM30@)**, by annual period • *Antidepressant Medication Management:* Percentage of Medi-Cal members with SMI aged ≥18 years with a diagnosis of major depression who were newly treated with antidepressant medication and remained on their antidepressant medications	• Analyses over pre-period (≥2 years) and post-period • Unadjusted Analyses • Adjusted analyses (DD models) • Adjusted analyses to assess effect modification by selected member characteristics (DDD models)

Evaluation Question	Data Source	Outcome Measure	Analytic Approach
	• Performance data (CAHPS)	• Percentage of Medi-Cal members with SMI aged ≥18 years who self-report overall satisfaction with mental health care, by annual period	• Descriptive quantitative analysis of trends over time during the evaluation period (pre-period and post-period), implementer and non-implementer counties
4. To what extent does improved access to community-based services under the SMI Program vary by geographic area or member characteristics?	• County Profiles	• Ratio of Medi-Cal members with SMI to Medi-Cal-enrolled providers, by county and annual period: • Community mental health centers • Psychiatrists and other mental health practitioners authorized to prescribe • Mental health practitioners (other than psychiatrists) who are certified and licensed by the state to independently treat mental illness • Ratio of Medi-Cal members with SMI to count (N) of Medi-Cal-enrolled outpatient mental health professionals, by type (psychologists, social workers, psychiatrists & other prescribers, counselors, others), by county and annual period	• State map depicting the outcome measures each year of the SMI Program (between the start and end dates)
	• County Profiles • Other (N-MHSS/N-SUMHSS)	• Count (N) of mental health facilities that provide outpatient mental health treatment, accept Medicaid, and (1) serve children, adolescents, or geriatric populations or (2) provide mental health services in languages other than English	• Descriptive quantitative analysis of trends over time during the evaluation period (pre-period and post-period), implementer and non-implementer counties
5. To what extent is the SMI Program associated with improved integration of primary and behavioral health care to address the chronic mental health care needs of Medi-Cal members with SMI? Do observed improvements vary by member characteristics*?	• County Profiles	• Count (N) of FQHCs that offer BH services, by annual period • Ratio of Medi-Cal members with SMI to FQHCs that offer BH services, by county and annual period	• Descriptive quantitative analysis of trends over time during the post-period, implementer and non- implementer counties • State map depicting the outcome measure each year of the SMI Program (between the start and end dates)
	• Medi-Cal data# • HPD/CA Medicare FFS data#	• Count (N) and percentage of Medicare FFS or Medicaid providers providing BH integration services	• Analyses over pre-period (≥2 years) and post-period • Unadjusted Analyses • Adjusted analyses (DD models)
	• TADT	• Percentage of Medi-Cal members with SMI whose first contact with SMHSs resulted from a primary care referral, by county and annual period	• Descriptive quantitative analysis of trends over time during the post-period, implementer and non- implementer counties

Evaluation Question	Data Source	Outcome Measure	Analytic Approach
	• Medi-Cal & EHR data (Child and Adult Core Set, hybrid measure)	• *Depression Screening and Follow-up*: Percentage of Medi-Cal members with SMI screened for clinical depression on the date of the encounter using an age-appropriate standardized depression screening tool AND, if positive, a follow-up plan is documented on the date of the positive screen, by age group (6-17 years, ≥18) **(MM24, MM25)**, by annual period	• Analyses over pre-period (≥2 years) and post-period • Unadjusted Analyses • Adjusted analyses (DD models) • Adjusted analyses to assess effect modification by selected member characteristics (DDD models)
	• Performance data (Adult Core Set)	• *Adults' Access to Preventive/Ambulatory Health Services:* Percentage of Medi-Cal members with SMI aged ≥20 years who had an ambulatory or preventive care visit **(MM26@)**, by annual period • *Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia*: Percentage of Medi-Cal members with SMI aged 18–64 years with schizophrenia or schizoaffective disorder and cardiovascular disease, who had an LDL-C test during the measurement year, by annual period • *Diabetes Monitoring for People with Diabetes and Schizophrenia:* Percentage of Medi-Cal members with SMI aged 18–64 years with schizophrenia or schizoaffective disorder and diabetes, who had both an LDL-C test and an HbA1c test during the measurement year, by annual period.	• Analyses over pre-period (≥2 years) and post-period • Unadjusted Analyses • Adjusted analyses (DD models) • Adjusted analyses to assess effect modification by selected member characteristics (DDD models)
6. To what extent is the SMI Program associated with improved patient outcomes? Do observed improvements vary by member characteristics*?	• Medi-Cal data • Other (state data)	• Percentage of Medi-Cal members with SMI aged ≥18 years who experience poor outcomes: (a) require mental health care for suicidal behavior, (b) are newly diagnosed with Type 2 Diabetes or Cardiovascular Disease (c) die, (d) become homeless, or (e) become involved with the criminal justice system, by annual period	• Analyses over pre-period (≥2 years) and post-period • Unadjusted Analyses • Adjusted analyses (DD models) • Adjusted analyses to assess effect modification by selected member characteristics (DDD models)
	• Other (quality of life survey)	• Percentage of Medi-Cal members with SMI aged ≥18 years who self-reported good quality of life, by annual period	• Descriptive quantitative analysis of trends over time during the post-period, implementer and non- implementer counties

NOTE:
@ Monitoring Metric used for Mid-Point Assessment,
* Member characteristics of interest include age, SUD or physical health comorbidity, race and ethnicity, geographic location, and others.
# Procedure codes for BH integration services

Goal 5: Improved coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities. MM=SMI/SED Monitoring Metric (MM21/MM22: monthly/annual counts, Medi-Cal members with SMI).

Evaluation Question	Data Source	Outcome Measure	Analytic Approach
1. Is the SMI Program associated with improved care coordination for Medi-Cal members with SMI? Do observed improvements vary by member characteristics*?	• Medi-Cal data • Performance data (Child and Adult Core Set)	• *Alcohol Screening and Follow-up for People with SMI* (NQF-2152-adapted): Percentage of Medi-Cal members with SMI aged ≥18 years who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user **(MM28)**, by annual period • *Follow-Up After Emergency Department Visit for Substance Use:* Percentage of Medi-Cal members with SMI aged ≥18 years with follow-up after ED visit for alcohol and other drug abuse **(MM9@)**, by annual period • *Follow-Up After Emergency Department Visit for Mental Illness:* Percentage of Medi-Cal members with SMI aged ≥18 years with follow-up after ED visit for mental illness **(MM10@)**, by annual period	• Analyses over pre-period (≥2 years) and post-period • Unadjusted Analyses • Adjusted analyses (DD models) • Adjusted analyses to assess effect modification by selected member characteristics (DDD models)
	• EHR data	• *Medication Reconciliation on Admission* (NQF-3317) **(MM5)**: Percentage of Medi-Cal members with SMI for whom a designated prior to admission (PTA) medication list was generated by referencing one or more external sources of PTA medications and for which all PTA medications have a documented reconciliation action by the end of Day 2 of the hospitalization, by annual period	• Descriptive quantitative analysis for two periods during the post-period: • Between start date and mid-point • Between start and end dates
	• EHR data • Other (IPFQR)	• *Timely Transmission of Transition Record* (NQF-0648): • Percentage of discharges of Medi-Cal members with SMI (any age) from an inpatient facility to home or other site of care for whom a transition record was transmitted within 24 hours of discharge to the facility or primary physician or other health care professional designated for follow-up care, by annual period • *Transition Record with Specified Elements Received by Discharged Patients* (NQF-0649): Percentage of Medi-Cal members with SMI (any age) discharged from an inpatient facility to home or other site of care, or their caregivers, who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all the specified elements, by annual period	• Analyses over pre-period (≥2 years) and post-period • Unadjusted Analyses • Adjusted analyses (DD models)

Evaluation Question	Data Source	Outcome Measure	Analytic Approach
	• Qualitative data (interviews or focus groups with county demonstration staff, and/or inpatient/ residential and outpatient provider staff)	• Barriers/facilitators regarding data sharing systems, processes, or policies that staff identify as most effective for improving care coordination • Changes made to data sharing systems, processes, or policies to improve care coordination	• Qualitative methods
2. Is the SMI Program associated with improved continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities among Medi-Cal members with SMI? Do observed improvements vary by member characteristics*?	• Medi-Cal data • HCAI Patient-Level Administrative Data • HPD • Performance data (Child and Adult Core Set)	• *Medication continuation following inpatient psychiatric discharge* (NQF-3205) **(MM6)**: Percentage of biennial discharges from inpatient psychiatric facilities for Medi-Cal members with SMI (or schizophrenia, bipolar disorder, or major depressive disorder) for which a prescription for evidence-based medication was filled within 2 days prior to and 30 days post-discharge, by period • *Follow-Up After Hospitalization for Mental Illness (children):* Percentage of Medi-Cal members with SMI aged 6-17 years with follow-up after hospitalization for mental illness **(MM7@)**, by annual period • *Follow-Up After Hospitalization for Mental Illness (adults):* Percentage of Medi-Cal members with SMI aged ≥18 years with follow-up after hospitalization for mental illness **(MM8@)**, by annual period • Amount of mental health–related (1) outpatient, rehabilitation, and targeted case management services, (2) home and community-based services, and (3) long-term services and supports used by Medi-Cal members with SMI within 30 days after discharge from a psychiatric inpatient/residential facility, by annual period	• Analyses over pre-period (≥2 years) and post-period • Unadjusted Analyses • Adjusted analyses (DD models) • Adjusted analyses to assess effect modification by selected member characteristics (DDD models)

Evaluation Question	Data Source	Outcome Measure	Analytic Approach
3. To what extent is the SMI Program associated with improved discharge planning and outcomes regarding housing for Medi-Cal members with SMI who are transitioning out of acute psychiatric care in hospitals and residential treatment facilities?	• Facility administrative data	• Among Medi-Cal members with SMI transitioning out of acute psychiatric care in inpatient/ residential facilities, percentage who are screened for housing needs, by annual period • Among Medi-Cal members with SMI receiving acute psychiatric care in inpatient/residential facilities who lack housing, percentage who meet with housing services agencies/providers before discharge, by annual period • Percentage of Medi-Cal members with SMI who are released from acute psychiatric care in inpatient/residential facilities to a homeless shelter or no fixed address, by annual period • Among Medi-Cal members with SMI who are released from acute psychiatric care in inpatient/ residential facilities to a homeless shelter or no fixed address, percentage who before discharge had an appointment scheduled with a housing services agency/ provider for within 7 or 30 days after discharge	• Descriptive quantitative analysis for two periods during the post-period: • Between start date and mid-point • Between start and end dates
4. What is the association between the activities undertaken under the SMI Program's four (4) milestones^ and improvements in the continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities?	• Qualitative data (interviews or focus groups with county demonstration staff, and/or inpatient/ residential and outpatient provider staff; interviews or focus groups with Medi-Cal members or significant others)	• Barriers/facilitators of the effectiveness of SMI Program continuity-of-care-related activities	• Qualitative methods

NOTE:
@ Monitoring Metric used for Mid-Point Assessment
* Member characteristics of interest include age, SUD or physical health comorbidity, race and ethnicity, geographic location, and others.
^ Milestones: (1) Ensuring quality of care in IMDs; (2) Improving care coordination and transitions to community-based care; (3) Increasing access to continuum of care including crisis stabilization services; (4) Earlier identification and engagement in treatment including through increased integration.

Chapter 6. Evaluation Design for Community Transition In-Reach Services

Brief Overview of Community Transition In-Reach Services

Community Transition In-Reach Services are transitional care management services to support Medi-Cal members age 21 year or older (or emancipated minors) with significant behavioral health needs who are returning to the community after extended stays in inpatient, subacute, and residential facilities, including in facilities that meet the definition of an Institution for Mental Diseases (IMD). Members who are experiencing or at risk of experiencing lengths of stay of 120 days or more are eligible to receive In-Reach Services, for up to 180 days prior to discharge. In-Reach Services are additive to services offered in inpatient, subacute, or residential settings, and are provided by community-based multi-disciplinary teams, not the inpatient, subacute, or residential settings themselves, to improve connections to community-based services and providers.[11]

BHPs may opt in to provide Community Transition In-Reach Services at any point during the demonstration.

The goal of this program is to improve care coordination and facilitate transitions to community-based care for Medi-Cal members with the most complex and significant behavioral health needs. The state envisions Community Transition In-Reach Services as a critical intervention in the pursuit of improved access to high-quality community-based treatments for Medi-Cal members living with significant behavioral health needs.

Specific objectives include:

1. Reducing extended stays in institutional settings
2. Supporting individuals to establish connections with community-based providers
3. Addressing barriers such as housing instability, particularly those due to disparities
4. Promoting continuity of care and reducing readmissions to acute care settings
5. Providing comprehensive pre-discharge planning and transitional care management.

Transition services aimed at addressing both clinical and social barriers to community reintegration can be initiated up to 180 days prior to discharge from qualifying facilities. Services include comprehensive assessments, individualized care planning, referrals to needed services, and monitoring to ensure care plans are implemented effectively, and identifying and addressing other system barriers, including social and financial issues, and facilitating linkages to social supports necessary to support successful reintegration of members into their communities.

[11] BH-CONNECT Section 1115(a) Demonstration Special Terms and Conditions, (STC 9.1 p.40).

Transition services are delivered by community-based multidisciplinary teams, which include at a minimum:

1. a licensed mental health professional as team lead,
2. a certified peer support specialist or other SMHS practitioner with lived experience,
3. an occupational therapist, unless the BHP meets criteria for exemption,
4. at least one additional mental health specialty practitioner, and
5. access to a medical prescriber (included on the team or linked externally), such as a psychiatrist, psychiatric nurse practitioner, or physician) to manage any medications during the discharge process and community reintegration.

In addition to establishing the multidisciplinary care transition teams described above and financing services for Medi-Cal members, BHPs that participate in the Community Transition In-Reach Services program must meet the following criteria:

- BHPs must submit a plan to the DHCS detailing how they will assess the availability of mental health and/or SUD services and housing options within the county. The plan must include a process for assessing the BH continuum of care and outline action steps to address identified gaps.
- BHPs must track and regularly report data to DHCS on trends in the number and utilization of beds across inpatient, subacute, and residential facilities, including IMDs, in which the county places Medi-Cal members.
- BHPs are required to monitor the compliance of facilities delivering Community Transition In-Reach Services.

Community Transition In-Reach Services Evaluation Methods Overview

The evaluation of the Community Transition In-Reach Services program will have two components: a rapid-cycle assessment to provide timely feedback to counties, the state, and CMS on how the program is functioning, and an overall evaluation that is integrated into the evaluation of the other demonstration components. Both the rapid-cycle assessment and the overall evaluation will use a mixed-methods approach. The rapid-cycle assessment will cover implementation of the program, data on utilization of the services, and preliminary data on health-related outcomes, such as discharges from residential services and readmissions. The overall evaluation, guided by the logic model depicted in Figure 6.1, will analyze the impact of the program on the short-term program outcomes and the long-term demonstration outcomes. Table 6.1 below presents the evaluation questions (EQs), hypotheses, and data sources that will be used in the comprehensive evaluation.

Figure 6.1. Community Transitions In-Reach Services Logic Model

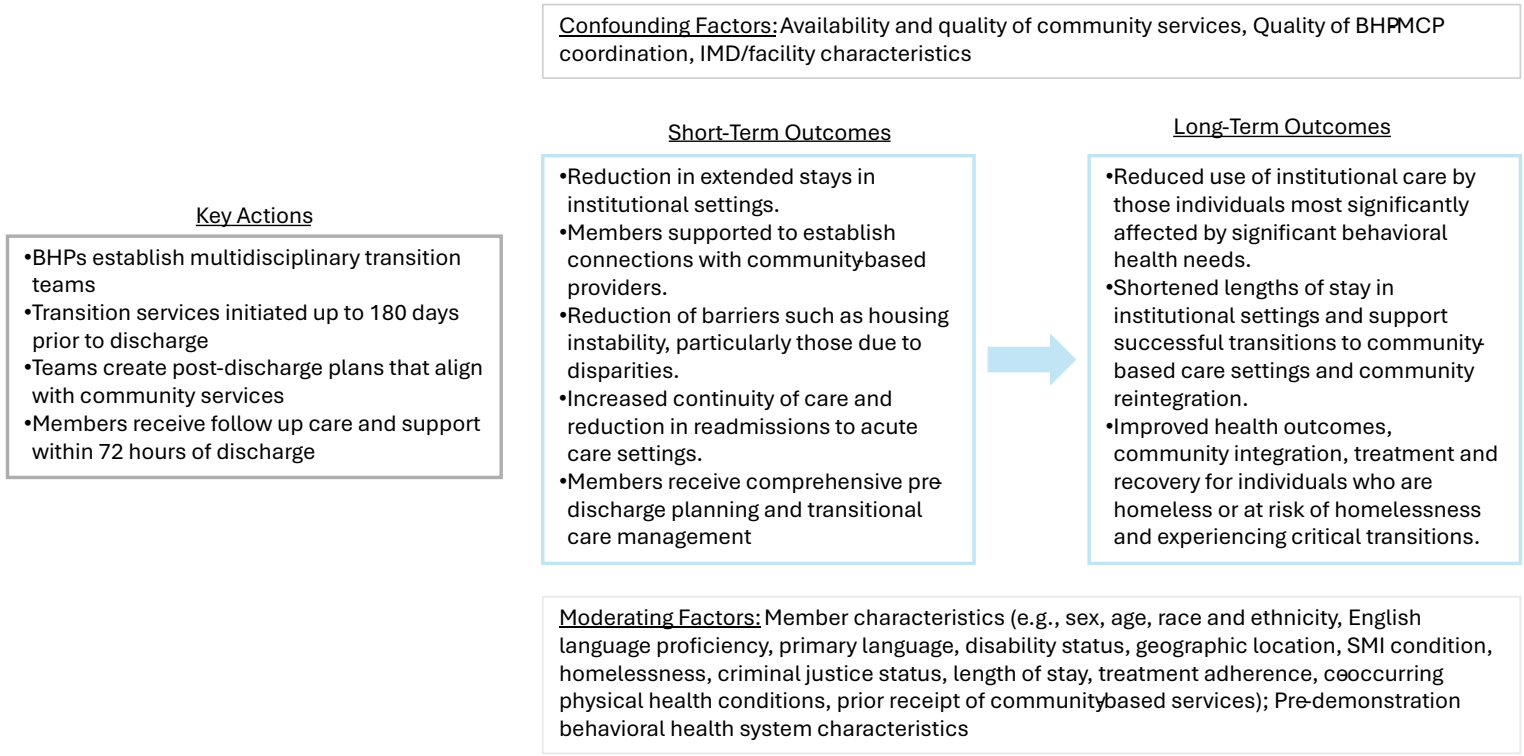


Table 6.1. Evaluation Questions, Hypotheses, and Data Sources: Community Transition In-Reach Services (CTIRS)

Goals	Evaluation Questions	Hypotheses	Potential Data Sources
1. Reduce extended stays in institutional settings	Is CTIRS associated with reduced extended stays in institutional settings?	• CTIRS will be associated with reduced length of stay and extended stays in institutional settings.	• County BH EHR Data • HCAI Patient-Level Administrative Data • Medi-Cal Claims and Eligibility data
2. Support individuals to establish connections with community-based providers	Is CTIRS associated with improved connections to community-based care among discharging Medi-Cal members?	• CTIRS will be associated with increased referrals to community-based providers within 72 hours of discharge. • CTIRS will be associated with greater awareness of and plans to access community treatment and service options. • CTIRS will be associated with increased use of behavioral health and primary care services (at follow up timepoints).	• County Behavioral Health EHR data; Medi-Cal data; HCAI HPD • Referral data from CTIRS team • Medi-Cal member interviews
3. Address barriers to health care access particularly those due to disparities (e.g. housing instability)?	Does CTIRS reduce barriers to health care access, particularly those due to disparities (e.g. housing instability)?	• Medi-Cal members will report a reduction in perceived barriers to care.[12] • CTIRS will be targeted to individuals experiencing or at risk of experiencing stays of 120 days or more in institutional settings and other characteristics that can be barriers to successful community tenure such as diagnosis of SMI, poor treatment adherence, homelessness, and/or co-occurring physical health conditions.	• County Behavioral Health EHR data; Medi-Cal data; HPD claims; • Medi-Cal member interviews

[12] Rapid cycle evaluation and comprehensive evaluation. All other hypotheses pertain to comprehensive evaluation only.

Goals	Evaluation Questions	Hypotheses	Potential Data Sources
4. Promote continuity of care and reduce readmissions to acute care settings	Is CTIRS associated with increased continuity of care and reduced readmissions to acute care settings?	• CTIRS will be associated with reduced readmissions to institutional settings. • CTIRS will be associated with increased continuity of care. • CTIRS will be associated with increased implementation of strategies to enhance data sharing and interoperability among providers.	• HCAI Patient-Level Administrative Data; County BH EHR Data; Medi-Cal data; HCAI HPD • Provider interviews
5. Provide comprehensive pre-discharge planning and transitional care management	Is CTIRS associated high quality, comprehensive pre-discharge planning and transitional care management?	• Medi-Cal members will be satisfied with the quality and comprehensiveness of their pre-discharge planning and transitional care management. [1312] • Transition teams will adhere to best practice strategies for community transitions.[12] • CTIRS will be associated with reduction in discharges homelessness, including discharges to unstable or unsuitable housing. • CTIRS will be associated with a reduction in days spent experiencing homelessness.	• HCAI inpatient discharge data; HMIS data; • Provider and Medi-Cal member interviews • Document review

Evaluation Methods

Rapid Cycle Evaluation

The rapid-cycle evaluation will focus on understanding implementation factors (such as fidelity and satisfaction), as well as preliminary information about outcomes where available. We will use guidance from implementation science frameworks, such as the Consolidated Framework for Implementation Research 2.0 (CFIR) (Damschroder, Reardon, Widerquist and Lowery, 2022), to develop qualitative interview protocols and analysis plans. CFIR provides a structured approach to understanding the multilevel factors that influence implementation, including intervention characteristics, organizational context, external influences, individuals involved in implementation, and the implementation process itself.

Overall Evaluation

The overall evaluation of CTIRS will include quantitative analyses of administrative data and an additional wave of interviews with stakeholders to serve as a follow-up to the interviews included in the rapid cycle evaluation. Qualitative and quantitative analyses will follow procedures outlined in Chapter 1. Data sources and methods are described below as they pertain to each evaluation question.

Study Population

The study population will include Medi-Cal members meeting MHP/BHP criteria for SMI/SED who are exposed to the CTIRS program—that is, those living in participating counties (counties that expressed interest in participating, received DHCS approval, and implemented the program, hereafter also referred to as "intervention" counties), and unexposed Medi-Cal members living in non-participating or "control" counties. The rapid cycle evaluation will include data from the intervention counties only, and the overall evaluation will include both the intervention and control counties.

As with the SMI program, while it is expected that the number of participating counties may increase over the course of the demonstration, it is also possible that some participating counties may opt out before the end of the demonstration; therefore there may be different sets of intervention and control counties during different years of the demonstration. The overall evaluation will include data from all participating counties, as well as corresponding data from selected comparison counties.

Time Frame for the Evaluation

The time frame for the overall evaluation will include a baseline period prior to implementation of a minimum duration of two years and a post-implementation period. The post-

implementation period will span the time between the date of implementation of the CTIRS program (start date) and the date of opt out or end of the five-year demonstration (end date), whichever comes first. As with the SMI program, the opt-in and opt-out flexibility afforded to counties will likely lead to variable start and end dates for participating counties and variable durations of post-implementation periods.

The rapid cycle evaluation will employ two waves of data collection, in Q1 of 2026 and Q1 of 2027. This will enable us to compare earlier and later stages of implementation to understand how the process and outcomes changed over time.

Qualitative Methods

To capture implementation experiences, we will conduct multiple waves of structured interviews with key program stakeholders, including Medi-Cal members, transition team staff (e.g., clinicians, peer specialists), county BH leads, and community-based service providers. These conversations with transition team members and community-based providers will explore barriers to and facilitators of implementation, fidelity to program design, workforce challenges, cross-system coordination and data sharing practices, and strategies for engaging individuals in transition. Member interviews will cover topics such as barriers and facilitators to accessing care, and satisfaction with quality and comprehensiveness of pre-discharge and transition planning.

Table 6.2. In-Reach Transition Services Rapid Cycle Assessment Qualitative Interviews

Informant Type	Estimated number of Interviews	Topics
Transition Team Members	2–5 per county	Barriers and facilitators to implementation, adherence to best practices (fidelity), workforce challenges, data sharing practices, strengths and weaknesses of cross system coordination, strategies used to engage individuals in transition, use of best practices in transition planning (e.g. peer support)
Community Based Providers	2–5 per county	Workforce challenges, data sharing practices, strengths and weaknesses of cross system coordination, strategies used to engage individuals in transition
Participants	2–5 per county	Barriers to and facilitators of care, perceived quality and comprehensiveness of services

Quantitative Methods

RAND will use data reported by the programs to assess patterns of service utilization, such as the volume and timing of in-reach engagement, characteristics of individuals served, duration of services, and initial outcomes such as hospital readmissions, emergency department (ED) visits, and post-discharge community tenure. These data will also be used to examine variation across participating counties and identify emerging trends in program reach and intensity. Where data allow, we will construct and analyze patient pathways, mapping individual trajectories from

institutional settings into community-based services. As described in Chapter 1, we will explore the relationship between outcome variables and potential moderators, including factors such as length of stay, diagnosis, treatment adherence, co-occurring physical health conditions, and/or homelessness. More details about proposed data sources and methods are included in the descriptions by evaluation question, below.

Where possible, preliminary findings from these sources will be included in the rapid cycle evaluation. The results will provide DHCS and CMS with early insights into program performance, inform continuous quality improvement, and meet federal requirements for a rapid-cycle evaluation that incorporates both qualitative and quantitative analysis of implementation progress, service utilization, and preliminary outcomes (CMS, 2024).

EQ1: Reduction in Extended Stays in Institutional Settings

To test the hypothesis that CTIRS is associated with a reduction in extended stays in institutional settings, we will analyze HCAI Patient Level Administrative Data to examine trends in length of stay in the institutional settings served by In-Reach teams and institutional care settings without In-Reach teams. Outcomes will be length of stay, measured in days, and stays of over 120 days, measured as a yes/no outcome. Preliminary analyses will examine trends in outcomes using pre-demonstration data to establish baselines and compare trends. Tests of the impact of In-Reach services will use ITS or DD models, depending on the outcomes of the preliminary analyses, as described in Chapter 1. Information from qualitative interviews on program implementation, community integration outcomes, and perception of program effectiveness from clinicians and participants will assist in interpreting the quantitative results.

EQ2: Improved Connections to Community-Based care.

To assess the impact of CTIRS on connections to community-based care we will use a combination of quality measure and claims data to compare post-discharge service use prior to the demonstration with post-discharge service use during the demonstration in the counties that have transition teams. In addition, we will also compare trends in these outcomes between the counties with and without transition teams. The major outcomes will be follow-up after hospitalization at 30 and 90 days and frequency of outpatient behavioral health care visits following discharge. Additional measures of service utilization will include:

- Structured clinical interventions within step-down care
- Appointments with primary care or other medical follow-up
- Arranged access to prescriptions
- Family and support system engagement
- Psychoeducation
- Peer support engagement
- Vocational or education support
- Crisis response and safety planning

- Suitable, stable housing.

These analyses will be supplemented by semi-structured qualitative interviews with participants discharging from institutional settings to assess their awareness of services, plans to access community-based care, and any follow-up received. In qualitative interviews with transition team members, we will ask about barriers and facilitators to successfully establishing and maintaining connections to community-based care. Qualitative data may help guide selection of quantitative variables and inform subgroup comparisons and moderators. Data will be integrated using the methods described in Chapter 1.

EQ3: Reduction in Barriers to Health Care Access.

We will analyze HCAI inpatient discharge data, County Behavioral Health EHRs, and claims data to assess whether CTIRS mitigates barriers to care—particularly disparities related to housing instability, geography, race/ethnicity, and income. The evaluation will investigate whether the program contributes to more equitable outcomes and access to services across diverse populations, and the extent to which CTIRS has been targeted towards individuals with relatively long lengths of stay in institutional settings and other characteristics that can be barriers to successful community tenure such as diagnosis of SMI, poor treatment adherence, homelessness, and/or co-occurring physical health conditions. To the extent possible, as sample sizes allow, we will investigate the extent to which the impact of CTIRS on health outcomes varies by these factors. We will also interview Medi-Cal members to understand self-reported barriers to care and the impact of CTIRS on them; information from the interviews will be used to inform both the rapid cycle evaluation and the overall evaluation.

EQ4: Increased Continuity of Care and Reduced Readmissions to Acute Care Settings

To test that hypotheses that CTIRS will be associated with increased continuity of care and decreased readmissions to acute care, we will analyze HCAI inpatient discharge data, County Behavioral Health EHRs, and Medi-Cal and HPD claims data. Readmissions to acute care will be defined as visits to an ED for a mental health condition or an inpatient stay for a mental health condition. We will examine use of acute services in the 90 days immediately following discharge as well as frequency of use of acute services. Continuity of care will be defined using information on outpatient services. Measures of continuity, such as number of months in which a person has a visit in the 12 months following discharge, will be developed based on preliminary data analyses. Qualitative interviews with In-Reach team members, community-based clinicians, and participants will provide information on the perceived effectiveness of community-based support services in reducing the need for acute care.

Results from the analysis of the impact of the In-Reach services on acute care utilization will also be used in cost analyses. We will use Medi-Cal claims and encounter data to estimate the

costs of the program to Medi-Cal, the costs saved by Medi-Cal through reduction in acute care utilization, and total cost offsets from the expenditure on In-Reach services.

To understand whether CTIRS has resulted in increased interoperability among providers, we will conduct interviews with acute care and community-based care providers; information from these interviews will be used to inform both the rapid cycle evaluation and the overall evaluation.

EQ5: Increased Comprehensive Pre-Discharge Planning and Transitional Care Management

This question pertains to both the rapid cycle evaluation and the overall evaluation. To determine whether Medi-Cal members receive high quality, comprehensive pre-discharge planning and transitional care management, we will use qualitative interviews with participants and providers. Perceived quality will include perceptions of effectiveness, timeliness, clarity, coordination, respectfulness, and client-centeredness of the pre-discharge and transition process. Perceived comprehensiveness will assess the extent to which all relevant needs were considered in the plan. These methods will explore both the fidelity of transition teams to best practices and Medi-Cal member satisfaction with the process, providing information about the consistency and perceived quality of CTIRS-supported transition processes. We will also investigate the extent to which CTIRS is associated with a reduction in discharges to homelessness, using available HCAI discharge data, and whether it is associated with a reduction in days spent experiencing homelessness following discharge, using data from HDIS and/or HMIS.

RAND will develop a fidelity assessment semi-structured interview protocol to assess fidelity to best practices for transition planning as established in the literature, including early discharge planning (NASMHPD, 2016), comprehensive and strengths-based planning (SAMHSA, 2014), rapid and consistent follow-up (NCQA, n.d.), warm hand-offs (NCBH, 2016; NRI 2012), secure housing (USICH, 2019), and medication planning prior to discharge (Bazelon Center for Mental Health Law, 2020), among others. We will interview members of the transition team to complete the fidelity assessment protocol.

Chapter 7. Evaluation Design for Transitional Rent Program

Brief overview of the Transitional Rent program

The Transitional Rent program, also described as the short-term rental assistance program, is designed to address the impact of housing, as a health related social need, on health by providing up to six months of rental assistance or temporary housing for Medi-Cal members who are experiencing or at risk of homelessness at key points of transition and meet specific clinical and social eligibility criteria. By creating a bridge from homelessness or institutional care to stable, permanent housing, the program aims to improve access to health care, reduce costly use of acute health care services and improve members health and well-being. The Transitional Rent program is one of six programs of the BH-CONNECT waiver, but DHCS implemented it as a Community Supports Service as part of the broader CalAIM initiative.

The Transitional Rent program's delivery model relies on Medi-Cal Managed Care Plans (MCPs), which are required to contract with a network of transitional rent providers. These providers may include county behavioral health agencies, affordable or supportive housing providers, Continuum of Care (CoC) entities, social service agencies, public housing authorities, or other organizations serving people experiencing homelessness. Transitional rent providers are responsible for issuing payments to landlords or property owners or, in some cases, directly providing housing. MCPs must ensure that members have an individualized housing support plan before authorizing transitional rent. The individualized housing support plan outlines the members' permanent housing strategy, identifies necessary supports to sustain tenancy, and must be culturally appropriate, trauma-informed, and responsive to the member's preferences and needs.

Eligibility for transitional rent is based on meeting all of the following three sets of criteria:

1. Inclusion in one of the following 7 'transitioning populations':
    a. transitioning out of institutional or congregate residential settings
    b. transitioning out of carceral settings
    c. transitioning out of interim housing
    d. transitioning out of recuperative care
    e. transitioning out of foster care
    f. unsheltered homeless
    g. eligible for Full Service Partnership (FSP).

AND

1. One or more qualifying clinical risk factor related to behavioral health (qualifying for Medi-Cal Specialty Mental Health Services (SMHS), Drug Medi-Cal (DMC), or the Drug Medi-Cal Organized Delivery System (DMC-ODS); or physical health (having one

or more serious chronic physical health conditions; having a physical, intellectual, or developmental disability; or being pregnant or up to twelve months postpartum)

AND

2. Homelessness or risk of homelessness, as defined by the U.S. Department of Housing and Urban Development (HUD) with certain modifications.[13]

Beginning in January 2026, coverage of Transitional Rent is required for Medi-Cal members who meet the Behavioral Health Population of Focus criteria. Coverage will be required for members with physical health risk factors no earlier than January 2027. A member is eligible for up to six months of Transitional Rent total under the BH-CONNECT waiver, though they may receive room and board services from multiple community supports programs, provided they do not exceed six months of coverage for these services in a single year.

Transitional rent covers both permanent and interim housing settings. Permanent settings include apartments, single-family homes, multi-family homes, shared housing, accessory dwelling units, housing in mobile home communities, project-based or scattered site permanent supportive housing, and supportive housing, while interim settings may include hotels, motels, tiny homes, or transitional recovery housing. MCPs must not exclude any allowable setting type and are expected to prioritize placements that lead to long-term housing stability. The Department of Health Care Services (DHCS) will reimburse MCPs for the actual cost of rent or temporary housing paid to landlords or property owners, up to a specified reimbursable ceiling based on a percentage of the U.S. Department of Housing and Urban Development's Small Area Fair Market Rents (SAFMR), which vary by ZIP code and unit size.

In addition to rent or housing costs, DHCS will pay MCPs an administrative fee to cover the reasonable costs associated with delivering the Transitional Rent service. This fee supports activities such as confirming appropriate housing units, ensuring habitability, assisting members with lease agreements, structuring rent payment arrangements, issuing timely payments, and coordinating with supportive service providers. The administrative fee structure includes two components: a standard monthly fee and a higher one-time fee for the first month a member is placed in a permanent setting, reflecting the additional effort required to secure long-term housing.

---

[13] Members must meet the U.S. Housing and Urban Development (HUD) definition of homeless or at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (CFR), with the following three modifications:

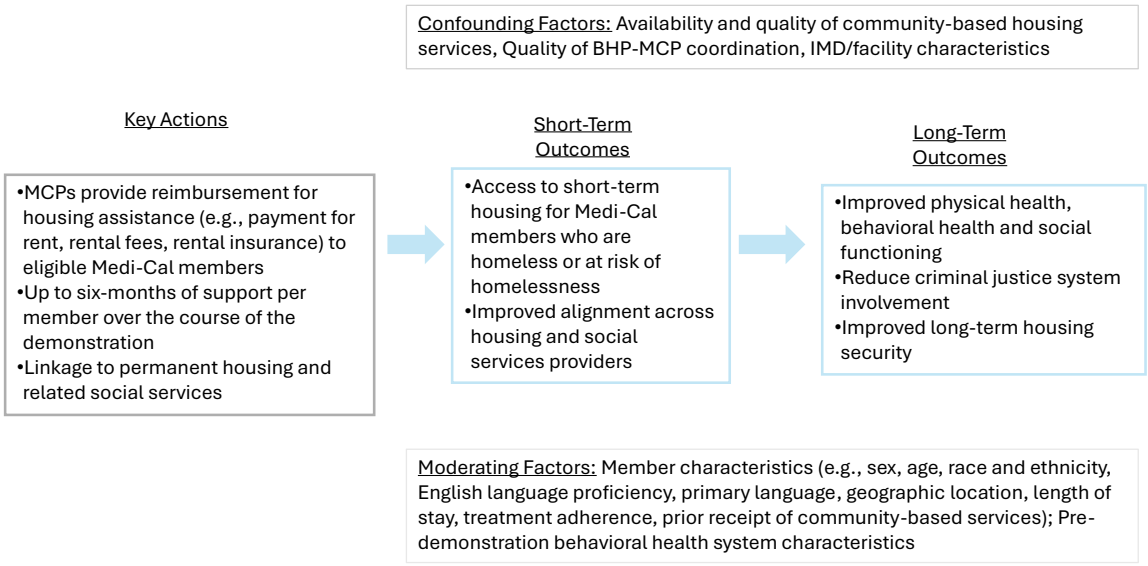
- » If exiting an institution, individuals are considered homeless if they were homeless immediately prior to entering that institutional stay or become homeless during that stay, regardless of the length of the institutionalization; and
- » The timeframe for an individual or family who will imminently lose housing is extended from 14 days for individuals considered homeless and 21 days for individuals considered at risk of homelessness under the current HUD definition to 30 days; and
- » For the at risk of homelessness definition at 24 CFR section 91.5, the requirement to have an annual income below 30 percent of median family income for the area, as determined by HUD, will not apply.

The Transitional Rent program also promotes coordinated partnerships between Medi-Cal Managed Care Plans (MCPs) and a diverse network of local entities that address housing and social needs. MCPs are expected to establish formal agreements with Transitional Rent Providers—including county behavioral health agencies, Continuums of Care (CoCs), public housing authorities, affordable and supportive housing providers, and community-based organizations—to ensure that members receive timely and appropriate housing assistance. These partnerships must extend beyond contracting to include shared operational protocols, referral pathways, and data exchange mechanisms that support coordinated care. MCPs are required to develop or leverage secure information technology systems that enable real-time communication and data sharing among partners while maintaining compliance with HIPAA and state privacy regulations. This includes the use of shared care management platforms, data dashboards, and standardized reporting templates to track member eligibility, housing placements, and service utilization.

Transitional Rent Program Evaluation Overview

The evaluation of the Transitional Rent program will use a mixed-methods approach guided by the logic model in Figure 7.1. The key actions of the program are payments from MCPs to Transitional Rent providers for up to six months of housing services for eligible Medi-Cal members. The payments are supplemented by requirements for individualized housing support plans, which describe a pathway to permanent housing, and linkage to related housing and social services. The evaluation will examine how the Transitional Rent program impacts two short-term and three long-term outcomes. In the short term, the program aims to provide interim housing that addresses the immediate needs of people in the transitioning population and improve integration and coordination among health care, housing and social services agencies serving this population. The system improvements include alignment across health, social services, and housing sectors through development of data sharing systems to support coordinated health and housing services. The long-term goals of the program are to improve the health and well-being of Transitional Rent recipients, reduce their likelihood of criminal justice involvement, and improve their housing security beyond the six-month assistance period.

Figure 7.1. Transitional Rent Program Logic Model



The Transitional Rent program is centered on MCPs, which not only provide reimbursement for services to members, but must also assemble a network of Transitional Rent providers that is adequate to meet the needs of their Medi-Cal populations and submit encounter data to the state through existing reporting mechanisms. In addition, MCPs are required to ensure that the Transitional Rent services are provided with fidelity, and to report on implementation of Transitional Rent services to DHCS on a quarterly basis. It is also important to note that the Transitional Rent services are designed to fit into a complex existing web of medical, housing, and social services without duplication of efforts. The existing web of services provides a wealth of resources, including behavioral health care and support for permanent housing. These additional services strengthen the Transitional Rent program's role as a bridge to permanent housing, and also require significant effort from Transitional Rent providers to coordinate with diverse partner agencies and support robust data sharing.

The evaluation of the Transitional Rent program will make use of the quarterly reports submitted and encounter data by MCPs, along with Medi-Cal data, Transitional Rent participant data reported by DHCS, and additional state-level data on criminal justice involvement, crisis services, and mortality. Our quantitative analyses will utilize these data to provide a description of the Transitional Rent program, its participants, reach into the target population, coordination activities, and outcomes. Because of the simultaneous state-wide rollout of the program, we anticipate that we will not be able to identify an 'unexposed' comparison group. Consequently, our analyses will focus on pre-post comparisons, matching on time of year, clinical, and demographic information. Medi-Cal encounter data will be used to supplement the MCP utilization data. Quantitative analyses will be accompanied by qualitative interviews with MCPs as well as program participants. The specific hypotheses and research questions are presented in Table 7.1.

Table 7.1. Evaluation Questions, Hypotheses, and Data Sources: Transitional Rent Program

BH CONNECT Goals	Evaluation Questions	Hypotheses	Data Sources
Promote improved health outcomes, community integration, treatment and recovery for individuals who are homeless or at risk of homelessness and experiencing critical transitions.	EQ1: Does the Transitional Rent program provide short-term housing support to the intended target population?	MCPs will provide Transitional Rent program, including individualized housing support plans, to eligible Medi-Cal members.	• MCP Quarterly Reporting • Medi-Cal Data • Homeless Data Integration System • DHCS Public Reporting • Qualitative Interviews with Transitional Rent providers and participants
	EQ2: Does the Transitional Rent program improve alignment of MCPs with medical and housing services provider agencies?	MCPs will improve integration between medical services, specialty behavioral health care and a variety of housing services, including Transitional Rent providers, ECM providers, Community Supports providers, Continuums of Care and Public Housing Authorities	• MCP Quarterly Reporting • Qualitative Interviews with County Officials, Transitional Rent providers, and participants
	EQ3: Does the Transitional Rent program Improve health and wellbeing outcomes?	Transitional Rent participants will show increased engagement in services, increased engagement in meaningful activities, and improved self-reported health and wellbeing outcomes during and after participation compared to their pre-period and, where feasible, compared to eligible non-participants	• Medi-Cal Data • Qualitative Interviews with Transitional Rent participants
Reduce the risk of individuals entering or re-entering the criminal justice system due to untreated or under-treated mental illness.	EQ4: Does the Transitional Rent program reduce use of crisis services and justice-system involvement?	Transitional Rent participants will have reduced incarceration and other justice-system involvement during and after participation compared to their pre-period and, where feasible, compared to eligible non-participants.	• Medi-Cal Data • Automated Criminal History System (ACHS) • Juvenile Court Probation Statistical System (JCPSS)
Shorten lengths of stay in institutional settings and support successful transitions to community-based care settings and community reintegration.	EQ5: Does the Transitional Rent program Serve as a bridge to permanent housing?	Transitional Rent participants will be more likely to exit institutional settings into stable housing and remain connected to services.	• MCP Quarterly Reporting • Qualitative Interviews with Transitional Rent providers and participants

Evaluation Methods

Study Population

Since the Transitional Rent program is mandatory for MCPs, the study population includes all MCP-enrolled Medi-Cal members who would meet the eligibility criteria described above. The criteria change slightly over time. In calendar year 2026, the study population will be restricted to members meeting eligibility through the behavioral health risk factors. Starting as early as January 2027, the study population will expand to include members meeting the physical health risk factors. However, it is not possible to identify all members meeting criteria independently of their entry into the Transitional Rent program. Some subsets of the study population, such as Medi-Cal members currently identified as homeless in the Homeless Management Information System, may be identifiable for analysis. We will explore the possibility of using these data to define a population that is eligible for Transitional Rent services that can be followed prospectively or compared across time. For most analyses, however, we will focus on the population that is found to be eligible for Transitional Rent services through the MCP eligibility assessment process.

Time Frame for the Evaluation

The time frame for the Transitional Rent program evaluation will include a baseline period prior to the start of the program in January 2026 of a minimum duration of two years and a post-implementation period. For the interim report, the post-implementation period will span the time between January 2026 and December 2027. The post-implementation period will extend through the end of the waiver period in the final summative report. The baseline, pre-implementation, period will be described using Medi-Cal claims and encounter data, while the implementation period will be described using MCP and DHCS reports as described below.

Data Sources

The Transitional Rent evaluation will make use of available data sources used in other components of the evaluation, including Medi-Cal claims and encounter data, the Homeless Data Integration System, Criminal Justice System Involvement data, and mortality data. In addition, the Transitional Rent evaluation will use some data sources that are unique to this program, including:

MCP Quarterly Reports: MCPs will be required to submit quarterly reports on the Transitional Rent program to DHCS, using the format and procedures already in place for ECM and Community Supports. These reports will include information on referrals to the program, eligibility among enrolled members, numbers of Transitional Rent recipients, linkage to

permanent housing, Transitional Rent denials, grievances and appeals, Transitional Rent provider networks data, and connections to state and federal housing assistance programs.

DHCS Public Reports: DHCS is required by state law to publish an annual report on utilization of ECM and Community Supports that will apply to the Transitional Rent program. The required reporting includes information on demographics of the members served by the program.

Quantitative Methods

As noted above, the simultaneous statewide implementation of the Transitional Rent program and the complex eligibility criteria will make identification of a contemporaneous control group difficult and limit our analytic options to pre-post comparisons. Where we are able to identify comparable groups who would have been eligible for the Transitional Rent program in the pre-implementation period, i.e. prior to January 2026, we will apply ITS methods to Medi-Cal claims and encounter data as described in Chapter 1. However, given the difficulty in identifying these members in the available data, we may be further restricted to pre-post comparisons among Transitional Rent recipients and descriptive analyses of outcomes among Transitional Rent recipients. Analyses based on the MCP and DHCS reports on the Transitional Rent program will necessarily be limited to the implementation period.

The descriptive analyses will provide valuable information for understanding implementation of the program. For instance, we can compare information on program utilization with estimates of the size of the eligible population at the county level. This will allow us to estimate the reach of the program, i.e. the proportion of the eligible population that has received services. Similarly, we can compare costs of the Transitional Rent services, calculated from encounter data, with publicly reported costs of housing people at risk for homelessness in other settings. Results will be presented for the state as a whole and, where possible, separately for each of the five types of MCP in California (Two-Plan Model, County Organized Health Systems, Geographic Managed Care, Regional Model, and Single-Plan Model).

Qualitative Methods

We will conduct semi-structured interviews with participating MCP staff and providers, and Medi-Cal members receiving transitional rent services. MCP interviews will focus on understanding barriers and facilitators to implementation, including reaching the target audience and serving as a bridge to permanent housing, and program outcomes, including participant health, wellbeing, and service utilization outcomes. Interviews with members will explore perceived impacts of the program on outcomes such as permanent housing and health and wellbeing outcomes.

We will use purposive, maximum-variation sampling to recruit semi-structured interview participants across three groups: participating MCP staff, service delivery providers and partners, and Medi-Cal members receiving Transitional Rent Services. Sampling will be informed by the

county profiles we are developing and will be structured to maximize variability across California geography and urbanicity, county housing-system context, and MCP characteristics as well as implementation maturity and service volume. MCP and provider participants will be recruited through MCP points of contact, and members will be recruited through provider participants. Providers will provide informational flyers to interested members advertising the interviews and offering a phone number and/or email address to contact the study team. We will offer flexible interview modalities offered in English and Spanish, with recruitment designed to include participants at different points in the service trajectory and with a range of housing and health/wellbeing experiences. Members who complete the interview with us will be asked for their consent to be contacted for follow up interviews. Participating members will receive a gift card for their participation in the interview, with increasing amounts for each follow up interview to encourage participant retention.

EQ1: Does the Transitional Rent Program Provide Short-Term Housing Support to the Intended Target Population?

To address EQ1 we will use MCP quarterly reports, DHCS data, and Medi-Cal data to examine the extent to which the Transitional Rent program is reaching the intended population and providing effective housing support services. Specifically, we will examine data on the numbers of people referred to the program or determined to be eligible by the MCPs and the proportions of these who are assessed for eligibility, found to be eligible, offered Transitional Rent services, received Transitional Rent services (i.e. moved into a short-term housing situation using Transitional Rent), had individualized housing support plans, and were in stable or permanent housing at discharge. To the extent that data on specific eligibility criteria are available, we will examine the proportions of each category of eligible members who receive services (e.g., unsheltered homeless, FSP-eligible). To focus on the members who are homeless, we will use data from the Homeless Management Information System to independently examine the proportion of homeless Medi-Cal members receiving Transitional Rent services. Medi-Cal encounter and claims data will be used to corroborate MCP reports and estimate per person costs of Transitional Rent to the Medicaid program. Variations across MCPs, regions, and demographic characteristics will be examined. Interviews with MCP providers will explore barriers and facilitators to reaching the intended target populations. Interviews with Transitional Rent recipients will explore the process of accessing services, benefits of participation, and challenges faced while using the program.

EQ2: Does the Transitional Rent Program Improve Alignment of Mcps with Medical and Housing Services Provider Agencies?

As mentioned, the Transitional Rent program requires integration of health care and housing services through the Transitional Rent provider network as well as integration with a broader range of services that contribute to successful long-term housing tenure, such as specialty

behavioral health services and other social services that address health related social needs. Through analyses of quarterly report data and interviews with MCPs and Transitional Rent providers, we will examine integration, including data sharing and adequacy of information technology, of MCPs with:

- The Transitional Rent provider network
- County Behavioral Health Systems
- ECM providers
- Other health and social services providers
- Continuums of Care
- Public Housing Authorities

The Transitional Rent program explicitly requires MCPs to develop information technology infrastructure to collect and share information on closed loop referrals and to effectively collect data from Transitional Rent providers to submit encounter data to the state. These information systems will be examined as part of the assessment of alignment with provider agencies.

EQ3: Does the Transitional Rent Program Improve Health and Wellbeing Outcomes?

To test the hypothesis that Transitional Rent is associated with improved health and wellbeing outcomes, we will examine changes in three outcome areas as a result of program participation, using interviews with Transitional Rent recipients and Medi-Cal data. We will also examine variation in outcomes across the five types of MCP in California.

1. Engagement in services (physical, behavioral, substance use). We will use Medi-Cal claims to measure engagement in physical health, behavioral health, and substance use services. Outcomes will include service utilization and measures of quality of care (for example, outpatient visits, follow-up after acute events, adherence with psychiatric medication, and ongoing treatment engagement) assessed in defined pre- and post-enrollment windows.
2. Engagement in meaningful activities (employment, school, family, community). We will assess engagement in meaningful activities primarily through participant self-report during semi-structured qualitative interviews. Interviews will examine experiences related to job-seeking and attainment, school or training participation, family and caregiving experiences (such as reconnection), and community involvement. These interviews will be repeated during the study period to examine how self-reported outcomes may change as housing stabilizes.
3. Suicidality and mortality. We will use Medi-Cal healthcare utilization data to identify use of acute care related to suicide attempts and CA Department of Public Health vital statistics data to examine all-cause mortality.

EQ4: Does the Transitional Rent Program Reduce Use of Crisis Services and Justice-System Involvement?

To test the hypothesis that Transitional Rent program is associated with reduced avoidable use of crisis services and justice-system involvement, we will analyze Medi-Cal claims and other

available administrative data to examine changes in high-acuity utilization before, during, and after receipt of Transitional Rent, and compare trends to a group of eligible non-participants where feasible. Outcomes will include incarceration, emergency department utilization, IMD inpatient stays, and other crisis response services. Analyses will use pre-enrollment periods to establish baselines and assess existing trends; impact analyses will use ITS or DD models, depending on data availability and the feasibility of constructing an appropriate comparison group. Outcomes will be examined for the state as a whole and separately by type of MCP.

EQ5: Does the Transitional Rent program Serve as a bridge to permanent housing?

To test the hypothesis that Transitional Rent functions as a bridge to stable, longer-term housing, we will analyze program and housing outcomes data to examine member trajectories during and after the assistance period. Outcomes will include (1) housing stability during the subsidy period, (2) transitions to permanent housing or longer-term housing subsidies or placements by a defined follow-up point after assistance ends, and (3) rates of returns to homelessness or housing instability. Preliminary analyses will use pre-enrollment periods to establish baselines and compare trends over time; impact analyses will use pre-post comparisons, depending on data availability and comparison group feasibility. Qualitative interviews with members and providers will inform interpretation of quantitative results by describing how Transitional Rent impacts housing stability, and barriers and facilitators to successful transitions to permanent housing.

Appendix A. Secondary Data Sources

Person-Level Data Sources

Medi-Cal Data

DHCS will provide Medi-Cal claims and eligibility files, which include information about encounters with the health care system that were billed to Medi-Cal, such as demographic information (age, sex, race/ethnicity), service date, place of service, type of service, units of service provided, primary and secondary diagnosis code, procedure code, aid codes, provider type, provider specialty, prescription information, and billing information. Data elements for inpatient stays include date of admission, date of discharge, length of stay, admission necessity code, and discharge status. Eligibility files are available monthly and include demographic information (age, sex, race/ethnicity, language), county code, aid code, eligibility status code, other coverage code, and share of cost amount.

HCAI Health Care Payments Data (HPD)

HCAI's Health Care Payments Data (HPD) is California's All Payer Claims Database, which contains administrative data for health care encounters and claims submitted to California payers by providers. The data come from DHCS (Medi-Cal), CMS (Medicare fee-for service plans), and health plans for employer-based, individual, or Medicare Advantage coverage, as well as private, self-insured companies that voluntarily submit their data. The HPD contains information on eligibility, medical, pharmacy, and dental claims as well as provider information. Non-public data are available to researchers whose application has been approved.

HCAI Patient-Level Administrative Data

HCAI collects abstracted health care data from individual patient records for inpatient discharges from California-licensed hospitals, ED encounters, and ambulatory surgery encounters. Patient Discharge Data (inpatient) include information on patient location, facility type and location, birth date, preferred language, race, ethnicity, homelessness indicator, sex, type of admission, patient disposition, admission source, route of admission, age at admission, admission and discharge dates, length of stay, diagnoses, procedures, total charges, and expected sources of payment. ED encounter data and ambulatory surgery data include information on patient location, facility type and location, birth date, preferred language, race, ethnicity, homelessness indicator, sex, patient disposition, service date, diagnoses, procedures, total charges, and expected sources of payment. Non-public data are available to researchers whose application has been approved by the Committee for the Protection of Human Subjects (CPHS).

County Behavioral Health EHR records

County BH plans maintain electronic health records for patient encounters that include information about patient diagnoses, procedures, services provided, and billing information. These data may provide more insight into the types of services and treatments provided than claims data; however, variation in the structure and quality of the data across counties may complicate comparisons.

California Outcomes Measurement System Treatment

DHCS collects data from SUD treatment providers who receive funding from DHCS, including data on new admissions, discharges, and annual updates for patients who have been in treatment for longer than 12 months. Reportable services and modalities include outpatient, intensive outpatient, partial hospitalization, additional MAT, opioid treatment program/narcotic treatment program, withdrawal management or detox, and all levels of residential services (non-reportable services and modalities include recovery residence, recovery services, psychiatric services, screening and referral, and DWI/DUI programs). The data collected include information on patient demographics, facility location, level of care, type of service, disability, Proposition 36 participation, Medi-Cal eligibility, other funding programs (such as drug court), field-based services, personal responsibility assessment, alcohol and drug use data, employment data, criminal justice data, medications, recent medical history, Naloxone use/education, communicable diseases, mental health, social support, living arrangements, family and children, dates of admission and discharge, discharge status, level of care referred/transferred to, and services used during treatment. These data are submitted to DHCS monthly.

California Homeless Data Integration System

The Homeless Data Integration System (HDIS) is a collection of data from 44 individual local homelessness response systems in California, or continuums of care (COCs). These 44 COCs each maintain local homeless management information systems (HMIS) that feed data to the statewide HDIS. The individual entities follow common federal standards for data collection established by the U.S. Department of Housing and Urban Development and include elements such as demographics, disabling conditions, dates of program participation, destination, family structure, housing move in dates, prior living situation, income and sources, health insurance, disability, chronic health conditions, mental health conditions, substance use disorder, domestic violence, current living situation, dates of engagement in services, bed nights in night-by-night shelters, and coordinated entry activity. The data contain social security numbers (SSN) and name and can be linked to Medi-Cal data.

Automated Criminal History System (ACHS) and Juvenile Court Probation Statistical System (JCPSS)

The California Department of Justice, per Penal Code 13202, maintains the Automated Criminal History System (ACHS), a repository of Criminal Offender Record Information data, and makes it available for research purposes. These data, compiled by criminal justice agencies to identify people who have had contact with the criminal justice system, include information about arrests, pretrial proceedings, criminal charges, sentencing, incarceration, rehabilitation, and release. The California Department of Justice also maintains the Juvenile Court Probation Statistical System (JCPSS), which is similar to the Automated Criminal History System but includes criminal justice information for juveniles. The data contain name and date of birth and can be linked to Medi-Cal data.

California Department of Public Health Vital Statistics Death Data

The California Department of Public Health Vital Statistics provides the California Comprehensive Master Death File to approved researchers. These data contain information about deaths occurring in California as well as deaths of California residents that occur outside of California. The data are available ten months after the end of the calendar year, starting in 2014. Data elements include name, date of birth, date of death, place of death, and cause of death.

Provider-Level Capacity/Workforce Data

California Department of Public Health (CDPH), Center for Health Care Quality, Licensing and Certification (L&C) Program Data

The California Department of Public Health maintains a data system of licenses and certifications for more than 30 different types of health care facilities. These data include information on facility type, location, bed type, and bed capacity (Center for Health Care Quality, California Department of Public Health, 2018) and services associated with those facilities (Center for Health Care Quality, California Department of Public Health, 2025-b). These data are updated monthly. A crosswalk is available to link records in the CDPH L&C data to identification numbers to records that use the HCAI facility identification numbers (Center for Health Care Quality, California Department of Public Health, 2025-a).

DHCS Licensing and Certification Division Data

The DHCS Licensing and Certification Division (LCD) maintains a database of license and location information for several types of facilities, including the following facilities that are relevant to this evaluation.

Licensed Mental Health Rehabilitation Centers and Psychiatric Health Facilities

This data set is maintained by DHCS and includes license and location information for all Mental Health Rehabilitation Centers and Psychiatric Health Facilities for all California counties, as well as information about the target population and client/patient capacity (Center for Health Care Quality, California Department of Public Health, 2025-c). These data are updated monthly.

DHCS SUD Recovery Treatment Facilities

This data set is maintained by the DHCS Substance Use Disorder Compliance division Licensing and Certification Branch and includes license and location information for all non-medical alcoholism and drug abuse recovery or treatment facilities, as well as information about the facilities' resident capacities, total occupancy, and target populations (Center for Health Care Quality, California Department of Public Health, 2025-d). This dataset was created in May 2025 and is updated on an irregular basis.

DHCS Institution for Mental Diseases List

DHCS publishes a list of Institution for Mental Disease (IMD) facilities on a quarterly basis (Center for Health Care Quality, California Department of Public Health, undated). The list includes information on the facility location, program type, number of licensed beds, number of special treatment program beds, and dates of license effectiveness/expiration. DHCS notes that this list is not exhaustive.

Certified and Approved Residential Mental Health Programs

DHCS Community Services Division maintains a database of Mental Health Short-Term Residential Therapeutic Programs, Social Rehabilitation Programs, Community Treatment Facilities, and Special Treatment Programs in California (Center for Health Care Quality, California Department of Public Health, 2025-e). The data include information about the program location, program type, bed capacity, certificate number, and expiration date. This table is updated quarterly.

DHCS Subacute Contracting Unit Adult Medi-Cal Provider List

DHCS published a table of 120 subacute facilities by county that contains the location, facility type, and number of contracted beds for each adult facility (Center for Health Care Quality, California Department of Public Health, 2021).

California Department of Social Services (CDSS) Facility Data

CDSS maintains a database of information about facilities licensed by the Community Care Licensing Division, including foster family agencies and sub-agencies, 24-hour residential care for children, adult residential and day care, elderly assisted living, childcare, home care organizations, and adoption agencies (California Department of Social Services, undated). These

data include information about facility type, location, capacity, status (licensed or closed), inspections and complaints. The data are updated weekly.

California Department of State Hospitals Data

The California Department of State Hospitals website contains information on the state hospital facilities in California (California Department of State Hospitals, undated), including patient demographics through 2020 (California Department of State Hospitals, 2024-a) and counts of patients by reason for admission (forensic or civil commitments) through 2023 (California Department of State Hospitals, 2024-b).

National Substance Use and Mental Health Services Survey (N-SUMHSS)

The Substance Abuse and Mental Health Services Administration (SAMHSA) conducts the National Substance Use and Mental Health Services Survey (N-SUMHSS), an annual survey of substance use disorder and mental health treatment facilities in the United States to understand the availability of these facilities, what services are provided, operation of the facility, facility ownership status, client counts by service type, number of beds, payment options, licensure, certification, and accreditation of the facilities. Information about mental health treatment and substance use disorder treatment were previously collected separately via the National Mental Health Services Survey (N-MHSS) and the National Survey of Substance Abuse Treatment Services, respectively.

CCBHC Locator

The National Council for Mental Wellbeing maintains a list of CCBHCs that includes 22 facilities in California. The data were most recently updated in January 2024.

Behavioral Health Continuum Infrastructure Program (BHCIP) Data Dashboards

DHCS has implemented the Behavioral Health Continuum Infrastructure Program (BHCIP) that awards competitive grants to qualified entities expand the community continuum of BH treatment resources by constructing, acquiring, and rehabilitating real estate assets or investing in mobile crisis infrastructure. Advocates for Human Potential, Inc. is administering BHCIP on behalf of DHCS and maintains a data dashboard for the grants program that contains preliminary, grantee-reported estimates of beds, individuals served annually, and type and location of facility (California Department of Health Care Services, 2025). The data dashboards are updated monthly, and the data are available for download.

Medi-Cal Network Adequacy Certification Tool

DHCS is required to report to CMS on network adequacy for specialty mental health plans, Medi-Cal managed care plans, DMC-ODS, and dental managed care plans pertaining to provider

to member ratios, mandatory provider types, and Time or Distance standard requirements (California Department of Health Care Services, undated), which are monitored for compliance. The tool includes data about the size and composition of California's county BH safety net workforce. The data have been collected since 2018; the most recent data are from 2023.

National Center for Education Statistics Integrated Postsecondary Education Data System

The National Center for Education Statistics collects data for the Integrated Postsecondary Education Data System, which is a survey of academic institutions with an agreement with the Office of Federal Student Aid. The data include information about admissions, completions, enrollment, graduation rates, and outcome measures for postsecondary education programs, which can be used to monitor trends in the number of graduates from programs educating BH professionals.

Data Exchange Framework

The California Health and Human Services Agency (CalHHS) Center for Data Insights and Innovation publishes a list of facilities and county behavioral health plans that have agreed to participate in the Data Exchange Framework (DxF).

Transitional Rent Quarterly Reports

Managed Care Plans are required to submit quarterly reports to DHCS on implementation of the Transitional Rent program. The reports will include information on the Transitional Rent provider network, the numbers referred to, assessed, and provided Transitional Rent services, and numbers referred to federal and state programs for permanent housing options.

DHCS Community Supports Public Reporting

DHCS is required to report on the demographic characteristics of Transitional Rent recipients.

Performance Data

Annual Availability Assessment of Mental Health Services

As part of the section 1115 demonstration, CMS requires collection of information such as the number of beneficiaries (adult, children, and total), the number of psychiatrists or other practitioners authorized to prescribe (overall, Medicaid-enrolled, Medicaid-enrolled and accepting new patients), the number of other practitioners certified and licensed to independently treat mental illness (overall, Medicaid-enrolled, Medicaid-enrolled and accepting new patients), the number of community mental health centers, the number of intensive outpatient or partial hospitalization providers, the number of residential mental health treatment facilities, the number of inpatient

psychiatric units, the number of inpatient psychiatric beds, the number of IMDs (residential facilities or psychiatric hospitals), the number of crisis stabilization services (crisis call centers, mobile crisis units, crisis observation/assessment centers, crisis stabilization units, community crisis response teams), and the number of FQHCs that offer behavioral health services. This information will be collected by CMS annually throughout the demonstration period.

BHSA Required Reports and Data

The BHSA requires counties to submit three-year Integrated Plans for Behavioral Health Services and Outcomes. These reports include information on planned activities and projected expenditures for Medi-Cal behavioral health programs, federal block grants, BHSA funds, and other funding for county behavioral health department services. The report template will include information on County Demographics and Behavioral Health Needs, Plan Goals and Objectives, Community Planning Process, Comment Period and Public Hearing, County Behavioral Health Care Continuum Capacity, Services by Total Funding Source, Behavioral Health Services Fund Programs, Workforce Strategy, and Budget and Prudent Reserve. The first submission is due June 2026, and updates are required annually and intermittently as needed.

Counties are also required to submit BHOATRs to DHCS annually, with the first report covering FY 2026-27 due January 30, 2029. These reports will contain information similar to what is included in the Integrated Plans.

Katie A. Specialty Mental Health Datasets

DHCS collects and publishes data on utilization of services used by children and youth (under 21) who are Katie A. Subclass members[14] or use Katie A. SMHS, which include Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care. Service utilization measures for each of the services include the number of members receiving the service, the number of days, hours, or minutes of service utilization, and the cost of service delivery in dollars. Data are reported monthly at the state level and bimonthly at the county level, starting in 2018. The most recent data are from April 2025.

Inpatient Psychiatric Facility Quality Measure Data - by Facility

CMS publishes hospital-level data for the Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program as part of Care Compare and Hospital Quality Initiative Public Reporting

[14] As a result of the December 2011 Katie A. court settlement, county MHPs are required to provide Intensive Care Coordination and Intensive Home Based Services to Katie A. subclass members, defined as children 1. Under age 21 with full-scope Medi-Cal eligibility, 2. Meet medical necessity criteria, 3. Have an open child welfare case, and 4. Are either a. in or considered for wraparound services, therapeutic foster care, therapeutic behavioral services, crisis stabilization, crisis intervention, or assigned a specialized care rate, or b. are currently in or being considered for a foster care group home, a psychiatric hospital, 24-hour mental health treatment facility, or experienced third placement within 24 months due to behavioral health needs.

initiatives. Snapshot data are available quarterly starting in 2018; the most recent snapshot is from April 2025.

Timely Access Data Tool

To assist in monitoring network adequacy for managed care plans, DHCS requires BHPs to report standardized data on timely access to care through the TADT. The TADT captures data on the number of days or hours between a new patient's first contact with care and the earliest time at which an appointment is offered. Counties report the proportion of new patients who are offered an appointment within ten days of first contact. The system also captures data on the source of the referral, the type of appointment offered, whether the appointment was kept, referrals made, and final disposition (closure reason).

DHCS Specialty Mental Health Services (SMHS) Performance Dashboards

The DHCS Behavioral Health Reporting website contains data for several reporting efforts. This includes the Specialty Mental Health Services Performance Dashboard data, which contains counts of Medi-Cal members utilizing and eligible for SMHS and penetration rates by state fiscal year (overall and by age group, race group, and sex). From 2014 through 2022, DHCS collected state- and county-level data on children and youth receiving Medi-Cal Specialty Mental Health Services (California Department of Health Care Services, 2024-a), children and youth in foster care (California Department of Health Care Services, 2024-b), children and youth with an open child welfare case (California Department of Health Care Services, 2024-c), and adults receiving Medi-Cal Specialty Mental Health Services (California Department of Health Care Services, 2024-d). For each of these groups, DHCS publishes a dataset that includes counts of patients discharged from inpatient care without stepdown service; counts of patients discharged from inpatient care and followed by a stepdown service within seven days, between eight and 30 days, and more than 30 days; counts of unique Medi-Cal members; and mean, minimum, maximum, and median number of days for stepdown service. Another includes state- and county-level utilization service counts of Medi-Cal members; the total number of days, hours, or minutes of service utilization; and the total cost of service delivery in dollars. The performance dashboard data also includes county- and state-level data with unique counts of Medi-Cal members receiving Medi-Cal Specialty mental health services (arrivals, exits, or receipt of continuous service), overall and by age group, sex, and race.

The DHCS Behavioral Health Reporting Data Hub also contains data for the AB470 Dashboards for Adults and Children/Youth. The AB470 Dashboards display counts of eligible Medi-Cal members, Medi-Cal members with one or more visits, Medi-Cal members with five or more visits, and the penetration rate for individuals by health care delivery system (mental health plan, fee for service, or managed care), health plan, mental health type (mental health services, SMHS), demographic category and group (age group, race group, sex, written language), and fiscal year (2019-2022). There are separate dashboards for adults and children/youth. From 2014 to

2022, DHCS also published service utilization and time from inpatient discharge to step down care data by age group, sex, and race for adults (California Department of Health Care Services, 2024-e) and children from 2014 to 2022 (California Department of Health Care Services, 2024-f).

Mental Health Plan Dashboard

The Mental Health Plan Dashboard contains measures of access (capacity and composition, time and distance), timeliness of appointment, and translation/interpretation (language capacity) by MHP, fiscal year (2022–2024), Medi-Cal member age group (adult, children/youth), and SMHS type (outpatient, psychiatric).

Substance Use Disorder Drug Medi-Cal and Drug Medi-Cal Organized Delivery System Penetration Rate Dashboard

This dashboard, maintained by DHCS, displays the percentage of Medi-Cal members who are eligible for services and actively utilize SUD treatment relative to the total number of eligible Medi-Cal members, by state and by county, during the FY 2022–2023 timeframe.

Mental Health CMS Core Set Measures Dashboard

The Mental Health CMS Core Set Measures Dashboard contains data on five quality metrics (AMM-AD, APP-CH, FUH-AD, FUH-CH, and SAA-AD) by county, measurement year (2020–2021), measure denominator (MHP, MCP, and Core Set), as well as Core Set Measure subcategory (e.g., 7 day or 30 day).

Medi-Cal Managed Care Performance Dashboard

The Medi-Cal Managed Care Performance Dashboard is produced by DHCS Managed Care Quality and Monitoring Division and includes data on enrollment, health care utilization, appeals and grievances, network adequacy and quality of care (HEDIS Aggregated Quality Factor Score). The data are available quarterly from March 2016 through April 2024.

From 2014 through 2021, DHCS collected state- and county-level data on children and youth receiving Medi-Cal Specialty Mental Health Services (California Department of Health Care Services, 2024-a), children and youth in foster care (California Department of Health Care Services, 2024-b), children and youth with an open child welfare case (California Department of Health Care Services, 2024-c), and adults receiving Medi-Cal Specialty Mental Health Services (California Department of Health Care Services, 2024-d). For each of these groups, DHCS published a dataset that includes counts of patients discharged from inpatient care without stepdown service; counts of patients discharged from inpatient care and followed by a stepdown service within seven days, between eight and 30 days, and more than 30 days; counts of unique Medi-Cal members; and mean, minimum, maximum, and median number of days for stepdown service. Another includes state- and county-level utilization service counts of Medi-Cal

members; the total number of days, hours, or minutes of service utilization; and the total cost of service delivery in dollars. The performance dashboard data also included county- and state-level data with unique counts of Medi-Cal members receiving Medi-Cal Specialty mental health services, overall and by age group, sex, and race. From 2014 to 2018, DHCS also published service utilization and time from inpatient discharge to step down care data by age group, sex, and race for adults (California Department of Health Care Services, 2024-e) and children from 2014 to 2020 (California Department of Health Care Services, 2024-f). These data were collected annually, but this data collection effort has been discontinued.

Dual-Eligible Special Needs Plan and Cal MediConnect Enrollment Dashboard

The Dual Eligible Special Needs Plan (D-SNP) Dashboard displays data pertaining to dually eligible members receiving both Medicare and Medi-Cal benefits. Information displayed includes enrollment (Exclusively Aligned Enrollment and Non-Exclusively Aligned Enrollment), enrollment by plan, enrollment by demographics (race/ethnicity, age group, language, gender), percent of members with a health risk assessment completed within 90 days of enrollment by plan, percent of members unable to be located within 90 days to complete a health risk assessment by plan, percent of members with an individualized care plan completed within 90 days by plan, percent of members unable to be located to complete an individualized care plan by plan, community-based adult services member referrals per 100 members by plan, Multipurpose Senior Services Program referrals by plan, members residing in long term care per 100 members by plan, members referred to county for in-home supportive services by plan, statewide percentage of members willing to participate and who the plan was able to locate with an assessment completed within 90 days of enrollment, and percentage of D-SNP members with documented discussions of care goals. Dashboard information is available from 2018–2024.

California Children's Services Whole Child Model Dashboards

DHCS maintains data dashboards to show trends in enrollment in California Children's Services (CCS) among CCS Whole Child Model (WCM) and Classic counties. The dashboard includes information about CCS-eligible and Medical Therapy Program beneficiaries. The current version of the dashboard contains information about demographics and enrollment (by age, sex, race/ethnicity, population density, county status, health places index quartile, delivery system, and foster care). The dashboard also has information about enrollment by county by month and health plan. Data are available from July 2023–June 2024. Future iterations of the dashboard will contain quality measures.

Previous versions of the dashboard include quality of care metrics for the CCS and WCM populations (childhood immunization status, ED visits per 1000 member months, COVID-19 vaccination rate), and utilization metrics (outpatient visits per 1000 member months, inpatient admissions per 1000 member months, ER visits per 1000 member months, prescriptions per 1000 member months, non-specialty mental health visits per 1000 member months, etc).

Managed Care WCM Dashboards are available for September 2020, April 2021, and June 2021. Integrated CCS/WCM dashboards are available for 2022–2024.

Dental Fee for Service and Managed Care Utilization and Performance

DHCS monitors performance of Medi-Cal Dental Fee for Service (FFS) and Dental Managed Care (DMC) through reporting of annual dental visits, preventive dental services, and use of sealants for children and adults. Data are reported by plan from June 2022 through March 2025. Statewide data and data for FFS and DMC are available from 2016 through 2022. Statewide utilization data and performance measures are available for Medi-Cal Dental FFS and DMC (geographic managed care and prepaid health plans) from 2014–2024 by age group.

Medi-Cal Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey Data

DHCS reports on perceptions and experiences of members of Medi-Cal managed care plans, fee-for-service programs, or population-specific plans using the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey. DHCS reports on survey results, including global ratings (rating of health plan, rating of all health care, rating of personal doctor, rating of specialist seen most often) and composite measures (getting needed care, getting care quickly, how well doctors communicate, customer service, advising smokers and tobacco users to quit, discussing cessation medications, discussing cessation strategies). Scores are reported by health plan for 2021, 2023, and 2024.

Area-Level Data

Area Health Resource Files (AHRF)

The Area Health Resource Files (AHRF) contain state- and county-level information from several sources on health facilities, health care professions, measures of resource scarcity, health status, economic activity, health training programs, and socioeconomic and environmental characteristics. These publicly available data are maintained by HRSA, Bureau of Health Workforce, National Center for Health Workforce Analysis.

Health Professional Shortage Areas in California

The Health Resources and Services Administration (HRSA) maintains national data for identification of geographic regions that meet the federal designations for shortage areas in primary care, mental health, and dental health. HCAI maintains a California specific subset of these data, and the most recent version was updated on August 28, 2024 (California Department of Health Care Services, 2024-g).

Other Data

SAMHSA Uniform Reporting System (URS)

The Uniform Reporting System is part of SAMHSA's Community Mental Health Services Block Grant and is used by State Mental Health Agencies to report annual data used in decision support and planning for public mental health systems. The state-level data include utilization measures, demographics of clients served by the states, outcomes of care, use of evidence-based practices (ACT, Supported Housing, Supported Employment, Family Psychoeducation, Integrated Treatment for Co-occurring Disorders, Illness Self-Management and Recovery, Medications Management, Therapeutic Foster Care, Multisystemic Therapy, and Functional Family Therapy), consumer assessments of care, information on insurance status, living situation, employment, and readmission to state psychiatric hospitals within 30 and 180 days. URS output tables for California are available from 2010 to 2023.

911/988 Data

If available, we would analyze utilization data from 911/988 systems for behavioral health calls.

Appendix B. Existing Quality and Service Utilization Measures

Table B.1. Availability of Existing Quality and Service Utilization Measures

Measures	Measure Steward	Geographic Unit (Years Available)
Behavioral Health Accountability Set		
County MHP Priority Measures		
Follow-Up After Emergency Department Visit for Mental Illness—30 days	NCQA	State (2017-2026), County (2020-2021)
Follow-Up After Emergency Department Visit for Mental Illness: Ages 6 to 17	NCQA	State (2022-2026)
Follow-Up After Hospitalization for Mental Illness—30 days (FUH-AD)	NCQA	State (2013-2026), County (2020-2021)
Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17 (FUH-CH)	NCQA	State (2010-2026), County (2020-2021)
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	NCQA	State (2017-2026), County (2020-2021)
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA-AD)	NCQA	State (2013-2026), County (2020-2021)
DMC-ODS Priority Measures		
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—30 days	NCQA	State (2017-2026)
Follow-Up After Emergency Department Visit for Substance Use: Ages 13 to 17	NCQA	State (2022-2026)
Pharmacotherapy for Opioid Use Disorder (POD)	HEDIS	County (2024-2026)
Use of Pharmacotherapy for Opioid Use Disorder (OUD)	CMS/SAMHSA	State (2020-2026)
Initiation and Engagement of Substance Use Disorder Treatment (IET-AD)	NCQA	State (2013-2026)
Medi-Cal Managed Care Accountability Set For Health Care Delivery Systems		
Children's Health Domain Measures		
Child and Adolescent Well-Care Visits	NCQA	State (2010-2026)
Childhood Immunization Status	NCQA	State (2010-2026)
Chronic Disease Management Domain Measures		
Asthma Medication Ratio: Ages 5 to 18	NCQA	State (2018-2026)
Controlling High Blood Pressure	NCQA	State (2013-2026)
Glycemic Status Assessment for Patients with Diabetes	NCQA	State (2025-2026)
Reproductive Health Domain Measures		
Chlamydia Screening	NCQA	State (2013-2026)

Measures	Measure Steward	Geographic Unit (Years Available)
Prenatal and Postpartum Care: Postpartum Care	NCQA	State (2013-2026)
Prenatal and Postpartum Care: Timeliness of Prenatal Care	NCQA	State (2013-2026)
Cancer Prevention Domain Measures		
Breast Cancer Screening	NCQA	State (2013-2026)
Cervical Cancer Screening	NCQA	State (2013-2026)
Report Only Measures to DHCS		
Adults' Access to Preventive/Ambulatory Health Services	NCQA	To be determined
Colorectal Cancer Screening	NCQA	State (2022-2026)
Depression Remission or Response for Adolescents and Adults	NCQA	To be determined
Depression Screening and Follow-up for Adolescents and Adults	NCQA	To be determined
Low-Risk Cesarean Delivery	CMS	To be determined
Plan All-Cause Readmissions	NCQA	State (2013-2026)
Postpartum Depression Screening and Follow Up	NCQA	To be determined
Prenatal Depression Screening and Follow Up	NCQA	To be determined
Prenatal Immunization Status	NCQA	To be determined
Mandatory Adult Core Set Measures for Medicaid		
Antidepressant Medication Management (AMM-AD)	NCQA	State (2013-2025), County (2020-2021)
Diabetes Care for People with Serious Mental Illness: Glycemic Status > 9.0%	NCQA	State (2017-2026)
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)	NCQA	State (2017-2025)
Medical Assistance with Smoking and Tobacco Use Cessation	NCQA	State (2013-2026)
Screening for Depression and Follow-Up Plan: Age 18 and Older	CMS	State (2013-2026)
Voluntary Adult Core Set Measures for Medicaid		
Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate	AHRQ	State (2013-2026)
Concurrent Use of Opioids and Benzodiazepines	PQA	State (2018-2026)
Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.1H, Adult Version (Medicaid)	AHRQ	State (2013-2026)
Diabetes Short-Term Complications Admission Rate	AHRQ	State (2013-2026)

Measures	Measure Steward	Geographic Unit (Years Available)
Mandatory Child Core Set Measures for Medicaid		
Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.1H – Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items	NCQA	State (2010-2026)
Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder Medication	NCQA	State (2010-2026)
Immunizations for Adolescents	NCQA	State (2010-2026)
Metabolic Monitoring for Children and Adolescents on Antipsychotics	NCQA	State (2020-2026)
Screening for Depression and Follow-Up Plan: Ages 12-17	CMS	State (2018-2026)
Use of Multiple Concurrent Antipsychotics in Children and Adolescents	NCQA	State (2016-2019)
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	NCQA	State (2010-2026)
Medi-Cal Specialty Mental Health Services (SMHS) Performance Dashboard		
Children and Youth in Foster Care	DHCS	State/County (2014-2022)
Children and Youth with an Open Child Welfare Case	DHCS	State/County (2014-2022)
Time to Step Down (Children and Youth in Foster Care)	DHCS	State/County (2014-2022)
Time to Step Down (Children and Youth with an Open Child Welfare Case)	DHCS	State/County (2014-2022)
Utilization of SMHS (Children and Youth in Foster Care)	DHCS	State/County (2014-2022)
Utilization of SMHS (Children and Youth with an Open Child Welfare Case)	DHCS	State/County (2014-2022)
Behavioral Health Reporting Data Hub		
Median Time Adult Residential Treatment Services Utilized (Adults)	DHCS	State/County (2015-2021)
Median Time Case Management/Brokerage Utilized (Adults)	DHCS	State/County (2015-2021)
Median Time Crisis Intervention Utilized	DHCS	State/County (2015-2021)
Median Time Crisis Residential Treatment Services Utilized	DHCS	State/County (2015-2021)
Median Time Crisis Stabilization Utilized	DHCS	State/County (2015-2021)
Median Time FFS Inpatient Utilized	DHCS	State/County (2015-2021)
Median Time Full-Day Rehabilitation Utilized	DHCS	State/County (2015-2021)
Median Time Full-Day Treatment Intensive Utilized	DHCS	State/County (2015-2021)
Median Time Inpatient Administrative Utilized	DHCS	State/County (2015-2021)
Median Time Intensive Care Coordination Utilized	DHCS	State/County (2015-2021)
Median Time Intensive Home-Based Services Utilized	DHCS	State/County (2015-2021)
Median Time Medication Support Services Utilized	DHCS	State/County (2015-2021)

Measures	Measure Steward	Geographic Unit (Years Available)
Median Time Mental Health Services Utilized	DHCS	State/County (2015-2021)
Median Time Psychiatric Health Facility Utilized	DHCS	State/County (2015-2021)
Median time Short-Doyle/Medi-Cal Hospital Inpatient Utilized	DHCS	State/County (2015-2021)
Median Time Therapeutic Behavioral Services Utilized	DHCS	State/County (2015-2021)
Penetration in SMHS	DHCS	State/County (2015-2022)
Engagement in SMHS	DHCS	State/County (2015-2022)
Received one or more SMHS visits: proportion of beneficiaries eligible for SMHS who received one or more SMHS visits	DHCS	State/County (2015-2022)
Time between Inpatient Discharge and Step Down Service	DHCS	State/County (2015-2022)
MHP Dashboard Measures (Network adequacy)		
Identifies whether the County Mental Health Plan met the requirement to provide language assistance services, such as interpretation, translation, American Sign Language, and hearing impaired 24 hours a day/seven days a week.	DHCS	County MHP (2018-2023)
Measures whether the county Mental Health Plan (MHP) has a sufficient number of providers to serve Medi-Cal beneficiaries.	DHCS	County MHP (2018-2023)
Measures whether the county Mental Health Plan (MHP) has providers located within time and distance standards for Medi-Cal beneficiaries.	DHCS	County MHP (2018-2023)
Provides the percentage of appointment requests a county Mental Health Plan receives that results in a first offered appointment within timely access standards.	DHCS	County MHP (2018-2023)
Timely Access Data Tool		
Proportion of new patients offered an appointment within 10 days of first contact with BHP	DHCS	County BHP (unknown)
Dual-Eligible Special Needs Plan Measures		
Percent of beneficiaries referred to county for in-home supportive services	DHCS	State/Plan (2014-2024)
Percent of beneficiaries residing in long term care	DHCS	State/Plan (2014-2024)
Percent of beneficiaries with a health risk assessment completed within 90 days of enrollment	DHCS	State/Plan (2014-2024)
Percent of beneficiaries with an individualized care plan completed within 90 days of enrollment	DHCS	State/Plan (2014-2024)
Percent of beneficiaries with documented discussions of care goals	DHCS	State/Plan (2014-2024)
Katie A. Specialty Mental Health Reports		
Utilization of Intensive Care Coordination	DHCS	State/County (2018-2025)
Utilization of Intensive Home-Based Services	DHCS	State/County (2018-2025)
Utilization of Therapeutic Foster Care	DHCS	State/County (2018-2025)

Measures	Measure Steward	Geographic Unit (Years Available)
Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program Measures		
Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and the subset, Alcohol and Other Drug Use Disorder Treatment at Discharge	CMS	Facility, State (2018-2025)
Alcohol Use Brief Intervention Provided or Offered and the subset, Alcohol Use Brief Intervention	CMS	Facility, State (2018-2025)
Facility Commitment to Health Equity	CMS	Facility, State (2018-2025)
Follow-Up After Psychiatric Hospitalization	CMS	Facility, State (2018-2025)
Hours of Physical Restraint Use	CMS	Facility, State (2018-2025)
Hours of Seclusion Use	CMS	Facility, State (2018-2025)
Influenza Immunization	CMS	Facility, State (2018-2025)
Medication Continuation Following Inpatient Psychiatric Discharge	CMS	Facility, State (2018-2025)
Modified COVID-19 Vaccination Coverage Among Healthcare Personnel	CMS	Facility, State (2018-2025)
Screen Positive Rate for Social Drivers of Health* (Screen Positive)	CMS	Facility, State (2018-2025)
Screening for Metabolic Disorders	CMS	Facility, State (2018-2025)
Screening for Social Drivers of Health*	CMS	Facility, State (2018-2025)
Thirty-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility	CMS	Facility, State (2018-2025)
Tobacco Use Treatment Provided or Offered at Discharge and the subset, Tobacco Use Treatment at Discharge	CMS	Facility, State (2018-2025)
Transition Record with Specified Elements Received by Discharged Patients	CMS	Facility, State (2018-2025)
Medi-Cal Dental Measures		
Annual Dental Visit	DHCS	State/Plan (2014-2024)
Continuity of care	DHCS	State/Plan (2014-2024)
Count of Fluoride Varnishes	DHCS	State/Plan (2014-2024)
Count of Sealants	DHCS	State/Plan (2014-2024)
Exams/Oral Health Evaluations	DHCS	State/Plan (2014-2024)
Overall Utilization of Dental Services	DHCS	State/Plan (2014-2024)
Preventive Services to Fillings	DHCS	State/Plan (2014-2024)
Treatment/Prevention of Caries	DHCS	State/Plan (2014-2024)
Use of Dental Treatment Services	DHCS	State/Plan (2014-2024)
Use of Diagnostic Services	DHCS	State/Plan (2014-2024)
Use of Preventive Services for Adults Ages 21+	DHCS	State/Plan (2014-2024)
Use of Preventive Services for Children Ages 1 – 20	DHCS	State/Plan (2014-2024)
Use of Sealants	DHCS	State/Plan (2014-2024)

Measures	Measure Steward	Geographic Unit (Years Available)
Usual source of care	DHCS	State/Plan (2014-2024)
Section 1115 SUD Demonstration Metrics		
Metric 3: The number of Medicaid Beneficiaries with SUD diagnosis	CMS	State (2023)
Metric 6: Number of beneficiaries enrolled in the measurement period receiving any SUD treatment service, facility claim, or pharmacy claim during the measurement period.	CMS	State (2023)
Metric 7: Number of beneficiaries who used early intervention services.	CMS	State (2023)
Metric 8: Total Beneficiaries that received Outpatient Services.	CMS	State (2023)
Metric 9: Total Beneficiaries receiving Intensive Outpatient and Partial Hospitalization Services.	CMS	State (2023)
Metric 10: Total Beneficiaries who use residential and/or inpatient services for SUD.	CMS	State (2023)
Metric 11: Total Beneficiaries who use withdrawal services.	CMS	State (2023)
Metric 12: Number of beneficiaries who have a claim for Medication-Assisted Treatment (MAT) for SUD during the measurement period.	CMS	State (2023)
Metric 23: Total number of ED visits for SUD per 1,000 beneficiaries in the measurement period.	CMS	State (2023)
Metric 24: Inpatient stays for SUD per 1,000 Medicaid Beneficiaries.	CMS	State (2023)
Metric #15: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)	NCQA	State (2023)
Metric #17(1): Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD)	NCQA	State (2023)
Metric #17(2): Follow-Up After Emergency Department Visit for Mental Illness	NCQA	State (2023)
Metric #18: Use of Opioids at High Dosage in Persons Without Cancer	NCQA	State (2023)
Metric #21: Concurrent Use of Opioids and Benzodiazepines	NCQA	State (2023)
Metric #22: Continuity of Pharmacotherapy for Opioid Use Disorder	NCQA	State (2023)
Metric #32: Access to Preventive/Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD	HEDIS	State (2023)

Appendix C. Description of Other Initiatives

Table C.1. Other CA/Medi-Cal Programs

Program	Reference	Time Frame	Description
Behavioral Health Bridge Housing	Assembly Bill 179	2022 through June 2027	Funds county behavioral health agencies and Tribal entities to operate bridge housing settings to address the immediate housing needs of people experiencing homelessness who have serious behavioral health conditions.
Behavioral Health Quality Improvement Program	BHIN 24-006	FY2021 through FY2023	Incentivized county BH delivery systems to improve data exchange capabilities to improve quality and coordination of care. Participating entities directly shared data with MCPs (signed the California Health and Human Services Data Exchange Framework Data Sharing Agreement) and/or onboarded to a Health Information Exchange (signed the California Data Use and Reciprocal Support Agreement and California Trusted Exchange Network).
Behavioral Health Continuum Infrastructure Program (BHCIP)	WIC Section 5960	2021-2027	Awards competitive grants to qualified entities to construct, acquire and rehabilitate real estate assets, or to invest in mobile crisis.
Behavioral Health Integration Incentives Program	Proposition 56	2020-2022	Incentivized improvement of physical and behavioral health outcomes, care delivery efficiency, and patient experience by establishing or expanding fully integrated care in a Medi-Cal managed health care plan's (MCP) network.
Behavioral Health Virtual Services Platform	WIC Section 5961	Jan 2024-	Part of the CYBHI - supports the delivery of equitable, appropriate, and timely behavioral health services from prevention to treatment to recovery, provides support and resources, such as interactive digital education, self- monitoring tools, application-based games, and mindfulness exercises, and offers access to free, on-demand one-on- one coaching and counseling supports.
CA Bridge Program	Budget Act of 2019, American Rescue Plan Act of 2021	2018-fall 2027	Trains staff to screen for OUD & other SUD, start MAT and MH care in the ED, and facilitate access/referrals to community-based providers for follow-up care.
CalAIM Justice-Involved Initiative	BHIN 23-059	Oct 2024-	Requires coordination of BHPs and MCPs with correctional facilities to support reentry for Medi-Cal members transitioning from incarceration to the community and managed care setting.
CalAIM No Wrong Door Policy	BHIN 22-011	July 2022-	Allows Medi-Cal members to receive MH services regardless of delivery system where they seek care (SMHS, MCP, FFS).
CalAIM Behavioral Health Payment Reform	BHIN 23-036	July 2022-	Moves counties away from cost-based reimbursement to enable value-based reimbursement structures that reward better care and quality of life for Medi-Cal members.

Program	Reference	Time Frame	Description
CalAIM Screening and Transition of Care Tools for Medi-Cal Mental Health Services	BHIN 22-065	Jan 2023-	Supports BHPs and MCPs in determining the most appropriate MH delivery system referral for Medi-Cal members who are not currently receiving MH services and ensure that Medi-Cal members receive timely and coordinated care when transitioning to/adding a service from other delivery system to their existing MH treatment.
California's Contingency Management Program (Recovery Incentives)	BHIN 22-056	2023-	Complements SUD treatment services and other evidence-based practices for stimulant use disorders with structured 24-week outpatient contingency management service and six months or more of additional treatment and recovery support services without incentives.
California Youth Behavioral Health Initiative (CYBHI)	WIC Section 5961	2021-	Provides school-linked partnership and capacity grants to county offices of education, local education agencies and institutions for higher education to support institutional readiness and promote utilization of the CYBHI statewide all-payer fee schedule for school-linked BH services including screening and assessment.
Care Coordination	BHIN 23-056	2023-	BHPs are contractually required to conduct care coordination (audited by DHCS for compliance)
Community Assistance, Recovery and Empowerment (CARE) Act	BHIN 25-012	2023-	Uses a civil court process (voluntary engagement, approved CARE agreement, or 24-month maximum court-ordered CARE plan) to connect people with untreated schizophrenia/other psychotic spectrum disorders to county BH treatment services which can include medication, a housing plan, and supportive services (eligibility: people at risk of relapse or deterioration that would be likely to result in grave disability or serious harm).
Community-Based Mobile Crisis Intervention Services	BHIN 23-025	April 2022-March 2027	Addresses MH, SED, SUD crises in the community, mitigating the need for ED visits.
Community Health Worker (CHW) Services	TN No. 22-0001	July 2022-	Development and training of CHWs.
Community Supports Services	A.B. 133 14184.206(e), Cal Assembly, 2021 Reg. Sess. (CA 2021)	2022-	Addresses Medi-Cal members' health-related social needs through housing transition navigation services, housing deposits, housing tenancy and sustaining services, short-term post-hospitalization housing and recuperative care.
Complex Care Capacity Building	BHIN 21-055	Oct 2021-	Supports counties with establishing a high-quality continuum of care designed to support foster children and nonminor dependents (NMDs) in the least restrictive setting, consistent with the child/NMD's permanency plan.
Comprehensive Quality Strategy	42 CFR 438.340	Feb 2022-	Requires BHPs and MCPs to meet minimum performance levels
DMC-ODS SUD service expansion	MHSUDS IN 19-032	2019	Participating counties offer all levels of care along American Society of Addiction Medicine criteria.
Dyadic Care Services	WIC Section 5961	Jan 2023-	Part of CYBHI - New Medi-Cal preventive benefit targeting family well-being as a mechanism to support healthy child development and mental health in a dyad with the child's caregiver.

Program	Reference	Time Frame	Description
Earlier Identification and Engagement in Treatment	BHIN 21-073	Jan 2022-	For members under 21 meeting certain eligibility requirements, SMHS criteria do not require a diagnosed MH health disorder (criteria for children and youth are different than for adults). Qualifying criteria: if at high risk for a MH disorder due to the experience of trauma, e.g., being child-welfare involved, juvenile-justice involved, or experiencing homelessness (ACL 24-35 released July 2024 requires that child welfare and juvenile probation submit SMHS referrals within 3 business days of opening a case), or if they have a need for SMHS prior to a formal diagnosis being established).
Early Psychosis Intervention	WIC Section 5961	2018 -	Part of the CYBHI – supports provision of high-quality early psychosis care.
Enhanced Care Management (ECM)	CalAIM DHCS ECM Policy Guide	Jan 2022-	Addresses clinical and nonclinical needs through intensive coordination of health and health-related services, including providing connections to housing and other resources.
Family Urgent Response System	BHIN 21-013	March 2021-	Coordinated statewide, regional, and county-level system designed to provide collaborative and timely response during situations of instability for current and former foster youth and their caregivers.
Full Service Partnership programs	WIC Section 5600.3	1990s-	Provides wraparound or “whatever it takes” services to unserved or underserved people who may be homeless or at risk of homelessness.
Housing and Homelessness Incentive Program	APL 24-005	2022-	Allows MCPs to earn incentive funds for making investments and progress in addressing homelessness and keeping people housed.
MAT Expansion Program	BHIN 21-024	Dec 2021-	Increases MAT access/reduces opioid OD-related deaths through prevention, harm reduction, treatment, and recovery activities.
MOU Guidance for Serving Children and Youth in Foster Care	BHIN 19-053	2020-	Requirement for each county to develop and implement a MOU outlining the roles and responsibilities of local entities that serve children and youth in foster care to establish a more comprehensive Children and Youth System of Care.
Peer Support Services	BHIN 25-010	2021-	Service provided by peer support specialists to prevent relapse, empower beneficiaries through strength-based coaching, support linkages to community resources, and educate beneficiaries and their families about their conditions and the process of recovery.
Semi-Statewide Electronic Health Record (EHR) System	CalMHSA initiative	2023	Encourages counties to implement new semi-statewide EHR that allows for tracking of referrals to non-BH agencies and services and encourages follow-up care.
Statewide e-consult platform	WIC Section 5961	Jan 2024-	Part of the CYBHI - offers provider access to remote and real-time consultation support with behavioral health professionals.
Student Behavioral Health Incentive Program	WIC Section 5961	Jan 2022-	Part of the CYBHI - supports partnerships between Medi-Cal managed care plans and schools to increase access to preventative behavioral health services.

Program	Reference	Time Frame	Description
Suicide and Crisis Lifeline (988)	AB 988	2022-	988 hotline for people seeking help during a BH crisis.
Targeted Case Management	BHIN 24-023	2023-	BHP requirement to provide TCM for people at risk of institutionalization or negative health or psycho-social outcomes, including beneficiaries with SMI; includes coordination of all medically necessary services.
Transitional Care Services	DHCS Transitional Care Services Technical Assistance Resource	August 2023-	Set of requirements for beneficiaries transferring from one setting/LOC to another that include (i) enforcing Admissions, Discharge, and Transfer (ADT) notifications and (ii) discharge planning for benes in acute care hospitals, EDs, and skilled nursing facilities, until benes have been successfully connected to all needed services and supports.

Table C.2. Initiatives to Address Housing Needs

Program	Time Frame	Description
Senate Bill 1152 (Chapter 981, Statutes of 2018)		Requires acute psychiatric hospitals to comply with discharge planning requirements for homeless patients.
Assembly Bill 531 (Chapter 789, Statues of 2023)		Provide additional resources to care for and house people with the most severe MH needs and SUD, including through a bond to fund new beds and supportive housing settings and updates to the Mental Health Services Act (MHSA) to expand resources for housing and workforce and increase accountability for community-based services for prevention and early intervention services.
Bills enacting Prop 1	March 2024	Require counties to allocate BH funding for housing interventions for beneficiaries of all ages with significant BH needs who are experiencing or at risk of homelessness. This funding can be used for rental subsidies, operating subsidies, shared housing, project-based housing assistance, other housing supports, and capital development projects, including affordable housing.

Abbreviations

ACHS	Automated Criminal History System
ACT	Assertive Community Treatment
AHRF	Area Health Resources File
AMM-AD	Antidepressant Medication Management
APP-CH	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
BH	behavioral health
BHCIP	Behavioral Health Continuum Infrastructure Program
BH-CONNECT	Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment
BHOATR	Behavioral Health Outcomes, Accountability, and Transparency Report
BHP	behavioral health plan
BHSA	Behavioral Health Services Act
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CalAIM	California Advancing and Innovating Medi-Cal
CalHHS	California Health and Human Services Agency
CalMHSA	California Mental Health Services Authority
CARE	Community Assistance, Recovery and Empowerment
CCBHC	Certified Community Behavioral Health Clinic
CCS	California Children's Services
CDPH	California Department of Public Health
CDSS	California Department of Social Services
CFIR	Consolidated Framework for Implementation Research
CHW	community health worker
CITS	comparative interrupted time series
CMS	Centers for Medicare & Medicaid Services
COC	continuum of care
CPHS	Committee for the Protection of Human Subjects
CSC	Coordinated Specialty Care
CTIRS	Community Transition In-Reach Services
CYBHI	California Youth Behavioral Health Initiative
DD	difference-in-differences
DDD	difference-in-difference-in-differences
DHCS	Department of Health Care Services
DMC	Dental Managed Care

DMC-ODS	Drug Medi-Cal Organized Delivery System
DSHP	Designated State Health Programs
D-SNP	Dual Eligible Special Needs Plan
DxF	Data Exchange Framework
EBP	evidence-based practices
ECM	Enhanced Care Management
ED	emergency department
EHR	electronic health record
EQ	evaluation question
FACT	Forensic Assertive Community Treatment
FEP	First Episode Psychosis
FFP	Federal Financial Participation
FFS	fee-for-service
FQHC	Federally Qualified Health Centers
FSP	Full Service Partnership
FUH-AD	Follow-Up After Hospitalization for Mental Illness—30 days
FUH-CH	Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17
FY	fiscal year
HBA1c	hemoglobin A1c
HCAI	Department of Health Care Access and Information
HDIS	Homeless Data Integration System
HEDIS	Healthcare Effectiveness Data and Information Set
HIT	health information technology
HMIS	Homeless Management Information System
HPD	Health Care Payments Data
HRSA	Health Resources and Services Administration
IET-AD	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
IMD	Institution for Mental Diseases
IP	Access, Reform and Outcomes Incentive Program
IPFQR	Inpatient Psychiatric Facility Quality Reporting
ITS	interrupted time series
JCPSS	Juvenile Court Probation Statistical System
L&C	licensing and certification
LRP	Medi-Cal Behavioral Health Student Loan Repayment Program
MAT	Medications for Addiction Treatment
MATTR	Mental Health and Addiction Treatment Tracking Repository
MCP	managed care plans
MH-HPSA	Mental Health Provider Shortage Area

MHP	mental health plan
MHSA	Mental Health Services Act
MOE	margin of error
NCQA	National Committee on Quality Assurance
NMD	nonminor dependent
N-MHSS	National Mental Health Services Survey
N-SUMHSS	National Substance Use and Mental Health Services Survey
OUD	opioid use disorder
PMPM	per-member-per-month
POD	Pharmacotherapy for Opioid Use Disorder
PTA	prior to admission
QoL	quality of life
SAA-AD	Adherence to Antipsychotic Medications for Individuals with Schizophrenia
SAMHSA	Substance Abuse and Mental Health Services Administration
SED	serious emotional disturbance
SMHS	Specialty Mental Health Service
SMI	serious mental illness
SSD-AD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
STCs	Special Terms and Conditions
SUD	substance use disorder
TADT	Timely Access Data Tool
URS	Uniform Reporting System
WCM	Whole Child Model
WIP	Workforce Initiatives Program

References

Bazelon Center for Mental Health Law, *Improving Outcomes for People with Serious Mental Illness Involved in the Criminal Justice System*, Bazelon Center, 2020. https://www.bazelon.org/wp-content/uploads/2020/09/Bazelon-Decarceration-Report.pdf.

Bradley, Elizabeth H., Leslie A. Curry, and Kelly J. Devers, "Qualitative Data Analysis for Health Services Research: Developing Taxonomy, Themes, and Theory," *Health Services Research*, Vol. 42, No. 4, 2007. As of July 6, 2025: https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1475-6773.2006.00684.x

California Department of Health Care Services, "Adult Population – Performance Dashboard," webpage, August 28, 2024-d. As of July 6, 2025: https://data.chhs.ca.gov/dataset/adult-population-performance-dashboard

California Department of Health Care Services, "Children and Youth Under the Age of 21 Performance Dashboard," webpage, August 28, 2024-a. As of July 6, 2025: https://data.chhs.ca.gov/dataset/early-and-periodic-screening-diagnosis-and-treatment-of-children-and-youth-performance-dashboard

California Department of Health Care Services, "Data Dashboards," webpage, May 1, 2025. As of July 6, 2025: https://www.infrastructure.buildingcalhhs.com/bhcip-data-dashboards/

California Department of Health Care Services, "Health Professional Shortage Areas in California," webpage, August 28, 2024-g. As of July 6, 2024: https://data.chhs.ca.gov/dataset/health-professional-shortage-areas-in-california

California Department of Health Care Services, "MHS Dashboard Adult Demographic Datasets," webpage, August 28, 2024-e. As of July 6, 2025: https://data.chhs.ca.gov/dataset/adult-ab470-datasets

California Department of Health Care Services, "MHS Dashboard Children and Youth Demographic Datasets," webpage, August 28, 2024-f. As of July 6, 2025: https://data.chhs.ca.gov/dataset/child-youth-ab470-datasets

California Department of Health Care Services, "Network Adequacy," webpage, undated. As of July 6, 2025: https://www.dhcs.ca.gov/formsandpubs/Pages/NetworkAdequacy.aspx

California Department of Health Care Services, "Performance Dashboard Children and Youth in Foster Care," webpage, August 28, 2024-b. As of July 6, 2025: https://data.chhs.ca.gov/dataset/performance-dashboard-children-and-youth-in-foster-care

California Department of Health Care Services, “Performance Dashboard Children and Youth with an Open Child Welfare Case,” webpage, August 28, 2024-c. As of July 6, 2025: https://data.chhs.ca.gov/dataset/performance-dashboard-children-and-youth-with-an-open-child-welfare-case

California Department of Social Services, “Social Services Community Care Facility Search,” webpage, undated. As of July 6, 2025: https://www.ccld.dss.ca.gov/carefacilitysearch/

California Department of State Hospitals, “Forensic vs. Civil Commitment Population,” webpage, September 9, 2024. As of July 6, 2025: https://data.chhs.ca.gov/dataset/department-of-state-hospitals-forensic-vs-civil-commitment-population

California Department of State Hospitals, “Patient Demographics,” webpage, August 28, 2024. As of July 6, 2025: https://data.chhs.ca.gov/dataset/patient-demographics

California Department of State Hospitals, “State Hospitals,” webpage, undated. As of July 6, 2025: https://www.dsh.ca.gov/Hospitals/

Callaway, Brantly, and Pedro H. C. Sant'Anna, “Difference-in-Differences with Multiple Time Periods,” *Journal of Econometrics*, Vol. 225, No. 2, December 1, 2021.

Center for Health Care Quality, California Department of Public Health, “Licensed and Certified Healthcare Facility Bed Types and Counts: Healthcare Facilities California,” September 5, last updated June 18, 2018. As of July 6, 2025: https://data.chhs.ca.gov/dataset/healthcare-facility-bed-types-and-counts

Center for Health Care Quality, California Department of Public Health, “Subacute Contracting Unit (SCU) Adult Medi-Cal Provider List,” January 14, 2021. As of July 6, 2025: https://www.dhcs.ca.gov/provgovpart/Documents/Adult-Subacute-Medi-Cal-Provider-List-1-14-21.pdf

Center for Health Care Quality, California Department of Public Health, “California Open Data Portal: Licensed and Certified Healthcare Facility Services,” webpage, June 18, 2025. As of July 6 ,2025: https://data.ca.gov/dataset/licensed-and-certified-healthcare-facility-services

Center for Health Care Quality, California Department of Public Health, “California Open Data Portal: Licensed Mental Health Rehabilitation Centers (MHRC) and Psychiatric Health Facilities (PHF),” webpage, July 5 2025, 2025. As of July 6, 2025: https://data.ca.gov/dataset/licensed-mental-health-rehabilitation-centers-mhrc-and-psychiatric-health-facilities-phf

Center for Health Care Quality, California Department of Public Health, "Certified and Approved Residential Mental Health Programs," webpage, July 2, 2025. As of July 6, 2025: https://data.chhs.ca.gov/dataset/certified-and-approved-residential-mental-health-programs

Center for Health Care Quality, California Department of Public Health, "Licensed and Certified Healthcare Facility Crosswalk," webpage, January 3, 2025. As of July 6, 2025: https://data.chhs.ca.gov/dataset/licensed-facility-crosswalk

Center for Health Care Quality, California Department of Public Health, "SUD Recovery Treatment Facilities," webpage, 2025. As of July 6, 2025: https://data.ca.gov/dataset/sud-recovery-treatment-facilities

Center for Health Care Quality, California Department of Public Health, "Institution for Mental Diseases List," webpage, undated. As of July 6, 2025: https://www.dhcs.ca.gov/services/MH/Pages/IMD-List.aspx

Chuang, Emmeline, Nadereh Pourat, Katherine L Kahn, and David Zingmond, "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," October 17, 2024. As of February 4, 2026: https://www.dhcs.ca.gov/provgovpart/Documents/20241017-Community-Supports-HRSN-Evaluation-Design.pdf

CMS, "Appendix A: Goals, Research Questions, and Analytic Approaches for Evaluating Section 1115 Serious Mental Illness/Serious Emotional Disturbance Demonstrations," *SMI/SED and SUD Evaluation Design Guidance*, Centers for Medicare and Medicaid Services, 2018. As of July 6, 2025: https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/smi-sed-eval-guide-appendix-a.pdf

CMS, "Monitoring Metrics for Section 1115 Demonstrations with SMI/SED Policies," 2019. As of July 6, 2025: https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/smi-monitoring-metrics.pdf

CMS, "Section 1115 Demonstrations Developing Evaluation Design," 2020. As of July 6, 2025: https://www.medicaid.gov/sites/default/files/2020-02/developing-the-evaluation-design.pdf

CMS, "Serious Mental Illness Section 1115 Demonstration Opportunity," webpage, undated. As of July 6, 2025: https://www.medicaid.gov/medicaid/section-1115-demonstrations/serious-mental-illness-section-1115-demonstration-opportunity

CMS, *California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Demonstration Approval*, December 16, 2024. As of July 6, 2025: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-bh-connect-ca-12162024.pdf

Contreary, Kara, Katharine Bradley, and Sandra Chao, "Best practices in causal inference for evaluations of Section 1115 eligibility and coverage demonstrations," *Mathematic Policy Research*, June, 2018.

Damschroder, Laura J., Caitlin M. Reardon, Marilla A. Opra Widerquist, and Julie Lowery, "The updated Consolidated Framework for Implementation Research based on user feedback," *Implementation Science*, Vol. 17, No. 1, 2022.

Filia, Kate, Caroline X. Gao, Henry J. Jackson, Jana Menssink, Amity Watson, Andrew Gardner, Sue M. Cotton, and Eoin Killackey, "Psychometric properties of a brief, self-report measure of social inclusion: the F-SIM16," *Epidemiology and Psychiatric Sciences*, Vol. 31, January 21, 2022.

Guest, Greg, Kathleen M. MacQueen, and Emily E. Namey. *Applied Thematic Analysis*. SAGE Publications, November 9, 2011.

Hopper, Ken, Angela Pinheiro, Sosunmolu Shoyinka, Joe Parks, Kenneth Minkoff, Billina Shaw, Matthew L. Goldman, and Margaret E. Balfour. "Multidimensional approaches to quality measurement and performance improvement in the ideal crisis system." *The Psychiatric Clinics of North America,* Vol. 47, No. 3, September, 2024.

Karakaya, Cihangir, Musa Özsavran, and Aylin Kurt, "The Social Exclusion Scale for Children (SESC): A Validity and Reliability Study in Turkish," *Journal of Social Service Research*, Vol. 50, No. 5, September 2, 2024.

National Association of State Mental Health Program Directors (NASMHPD). 2016. *Best Practices in Discharge Planning: A Report Prepared by NASMHPD for SAMHSA*, 2016.

National Association of State Mental Health Program Directors Research Institute (NRI), *Best Practices for Reducing Hospital Readmissions for Individuals with Mental Health Conditions*, NRI, 2012.

National Committee for Quality Assurance (NCQA), *State of Health Care Quality Report*, undated. As of July 6, 2025: https://www.ncqa.org/hedis/measures/follow-up-after-hospitalization-for-mental-illness/

National Council for Behavioral Health, *Transitions of Care: Behavioral Health Services and the Safety Net*, National Council., 2016.

Rambachan, Ashesh, and Jonathan Roth. "A more credible approach to parallel trends." *Review of Economic Studies* Vol. 90, No.5, October, 2023.

SAMHSA, *TIP 57: Trauma-Informed Care in Behavioral Health Services*, HHS Publication No. SMA14-4816, 2014. As of July 6, 2025: https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816

U.S. Interagency Council on Homelessness (USICH), "Fact Sheet: Behavioral Health Services for People Experiencing Homelessness," 2019.

Wing, Coady, Seth M. Freedman, and Alex Hollingsworth, "Stacked Difference-in-Differences," *Working Paper, National Bureau of Economic Research*, No. 32054, January 2024.