California Advancing and Innovating Medi-Cal Medicaid Section 1115 Demonstration

RESPONSES TO CMS COMMENTS ON THE DRAFT EVALUATION DESIGNS

February 28, 2025

The Centers for Medicare & Medicaid Services (CMS) reviewed California's draft Evaluation Designs for the California Advancing and Innovating Medi-Cal (CalAIM) section 1115 demonstration (Project Number 1-W-00193/9), dated February 7, 2024. CMS approved the extension of the state's section 1115 demonstration on December 29, 2021, for a demonstration period effective from January 1, 2022, through December 31, 2026. On January 26, 2023, CMS approved the "Reentry Demonstration Initiative" amendment for a demonstration period from April 1, 2024, through December 31, 2026. This revised draft Evaluation Design incorporates responses to CMS's comments to the earlier draft Evaluation Design submitted on February 7, 2024 for four demonstration components: (1) Providing Access and Transforming Health ver(PATH) Initiative, (2) the Global Payment Program (GPP), (3) Alignment and Integration for Dually Eligible Beneficiaries, and (4) the Reentry Demonstration Initiative.

CMS assessed California's draft Evaluation Designs against the state's special terms and conditions (STCs)[1], CMS's general evaluation design guidance, and the previous round of CMS feedback that was provided to the state for the PATH, GPP, Dual and Reentry demonstration components.[2] This letter summarizes responses to specific CMS comments on the previously submitted draft Evaluation Designs.

Responses to Recommendations for Strengthening the PATH, GPP, and Dual Evaluation Designs

1. Provide more detail on the methods for the PATH Evaluation Design.

The state should provide more detail on the analytic methods that will be used to address each PATH hypothesis, including the type of statistical analysis, how model assumptions will be tested, and any sensitivity analyses that will be used to test the robustness of the results. In addition, the state should provide additional detail on the proposed methods for carrying out the cost analyses.

Response: *We now provide more detail on analytic methods used to address each PATH hypothesis, including how assumptions will be tested, type of statistical analysis (when applicable), and any sensitivity analyses (see pages 20-24). We also provide additional detail on the proposed methods for carrying out the cost analyses (see pages 24-25).*

[1] Available at https://www.medicaid.gov/sites/default/files/2024-01/ca-calaim-dmnstn-aprvl-attch-M-12202023.pdf
[2] Available at https://www.medicaid.gov/sites/default/files/2020-02/developing-the-evaluation-design.pdf and included as Attachment A in the STCs.

2. Update the Evaluation Designs to include details that were provided in the state's memo in response to CMS's feedback.

The state provided detailed responses to CMS's recommendations for strengthening the Evaluation Designs for the PATH, GPP, and Dual demonstration components. However, not all these details were included in the revised Evaluation Designs. The state should update the Evaluation Designs to include the following information for each demonstration component.

a) For the PATH Evaluation Design, the state should include additional detail on the baseline periods and how the evaluation will account for the potential confounding effects of the COVID-19 PHE.

Response: *For the PATH evaluation design, we now include additional detail on the baseline periods and how the evaluation will account for potential confounding effects of the COVID-19 PHE (see section titled additional analytic considerations section starting on page 25). Briefly, the baseline period is 2020-2021 for most PATH analyses. But for WPC and HHP programs, the baseline will be 2015-2016 and 2018, respectively. As to the confounding effects of PHEs, UCLA also does not anticipate issues based on evidence from WPC and HHP evaluations but will include a PHE indicator in regression models (e.g. for COVID-19 or other PHE) as appropriate.*

b) For the GPP Evaluation Design, the state should provide information on the availability of the GPP Equity Protocol data and details on the indices to identify under-resourced communities.

Response: *PHCS (Public Health Care Systems) participating in GPP submitted their first Health Equity Report containing stratified performance measure data for calendar year 2023 on November 29, 2024, in accordance with the CMS-approved GPP Health Equity Monitoring Metrics Protocol (STC Attachment M). PHCS will submit subsequent Health Equity Reports on an annual basis thereafter. We have added this information to the description of the evaluation design for GPP Goal 1, which focuses on changes in the quality of care during GPP.*

Analyses of changes in quality of care and utilization will be stratified by community-level deprivation measures such as the Social Vulnerability Index (SVI) or the Healthy Places Index. Analyses across all four CalAIM components will seek to align use of area-level deprivation measures where possible and following empirical analysis of their concordance for geographic areas within California. We have added this information to the description of the evaluation design for GPP Goal 1 and Goal 2 which focus on changes in quality and utilization, respectively.

An additional change in the GPP Evaluation Design is the inclusion of additional data sources. At the time the Evaluation Design Report (EDR) draft was last viewed by CMS, the GPP team was still exploring strategies for accessing data to support the analyses we intended. We had not yet confirmed the availability of the Medi-Cal claims, encounters, and eligibility files, and were not yet aware of the option for accessing the Medicaid Core Set Measures, the Managed Care

Accountability Set Measures (MCAS), or the Emergency Department and Hospital Inpatient Encounter Data that will contribute to the GPP comparison cohorts. During recent months we have had several meetings with DHCS data teams and now are confident in our ability to access these files. Our access to these files allows us to supplement pre-post time series analyses, with a more rigorous design including appropriate comparison groups. This will support our implementation of causal models including use of difference-in-differences analyses consistent with recommendations from CMS. We see these edits as useful for a reader understanding the proposed analyses described in the pages that follow.

Furthermore, as the evaluation team has learned more about available data sources, we have been able to provide more specificity to the list of utilization measures shown in Exhibit 6.

c) For the Duals Evaluation Design, the state should include the more detailed description of the members' survey including estimates for the number of cells for major comparisons, an estimate for stability of estimates, and the plan to over-sample for race and ethnicity and individuals from the lowest quartile of the needs metric. In addition, the state should provide more detail on whether subgroup analyses will be performed with regard to certain groups being difficult to understand (e.g., individuals who enroll and disenroll from Medi-Cal).

Response: *For the Duals Evaluation Design, we have added the requested details to the EDR and have added an appendix cataloguing transitions. In goal #1 of the EDR, the UCLA team describes the epidemiology of plan transitions in the Medi-Cal Duals population pre- and post-policy implementation. Data from goal #1 will allow the evaluation team to define the sampling frame and assess the magnitude of special circumstances, such as individuals who newly enroll and disenroll from Medi-Cal. In the subgroup analyses, we will break out patterns of changes for newly enrolled individuals as well as individuals who have breaks in enrollment. At present, it is difficult to characterize a priori patterns and characteristics of individuals with breaks in enrollment, which may have a number of antecedent events (e.g. loss of eligibility, moving residences, incarceration, and so on). Furthermore, individuals with two or more changes in Medicare managed care plans (MCPs) are likely to be relatively uncommon and may be described qualitatively relative to the vast majority of cases.*

In goal #2 of the EDR, the UCLA team will perform a survey of Medi-Cal managed care plan (MCP) changers. Some changes have been incorporated into the survey design due to data availability issues) and a desire to more rapidly field the survey before anticipated changes in CMS policy that may impact Duals' plan choices.

We will sample across the 58 counties in California and will adjust the sampling based upon the results from the secondary data analysis. The sample will be weighted in order to under-sample Los Angeles County – with 1/3 of the Medi-Cal population – which would otherwise dominate the sample. We anticipate a 10 % responses rate. In order to maximize the response rate, we propose fielding the survey using a mixed-mode data collection approach that involves fielding the survey as a web and mail survey with phone follow-up to those who fail to complete the survey via the web or by mail. The web and mail versions of the survey will be available in

English, Spanish, Mandarin, and Vietnamese. All 4,000 sampled beneficiaries will receive a letter inviting them to participate in the survey. Participants will receive $20 upon survey completion.

The survey will include the following domains.

- *Beneficiary knowledge and satisfaction of their recent plan change*
- *Beneficiary report of their usual patterns of health services use*
- *Beneficiary report of their health status*
- *Beneficiary report of health-related social needs*

The revised survey design of MCP changers has three sets of comparison strata among individuals enrolled in Medicare Advantage (MA) plans [(1) resident county has the policy (yes/no); (2) member changes their baseline MA plan (yes/no); (3) baseline MCP is aligned/integrated with MA plan (yes/no)] plus the external comparison to Duals in traditional (fee-for-service) Medicare who reside in counties with and without the alignment policy. We anticipate having adequate sample sizes to ensure statistical stability for unadjusted estimates yet may not be adequately powered to detect underlying differences for comparisons between the targeted groups. We will oversample on non-White minorities and on individuals residing in zip codes with the lowest quartile SES to balance the sample.

Recommendations for Strengthening the Reentry Evaluation Design

3. Clarify how the state will identify the comparison populations and their measures.

The state should clarify how it will identify the comparison population for each facility. STC 9.2 indicates that only people with certain qualifying health conditions are eligible to be in the demonstration population, but the design does not include details on the qualifying conditions and the data that will be used to identify the conditions. It is therefore unclear how the state will identify the comparison group population to ensure it is similar to the demonstration population.

Response: *We have included a new section entitled, "Reentry Waiver Populations and Counties Selected". This section includes a discussion of the qualifying conditions, how we anticipate identifying them and the construction of the comparison cohorts for the study design. More specifically, California has qualifying conditions for adults which include mental illness, substance abuse disorder, chronic disease/significant clinical condition, intellectual or developmental disability, HIV/AIDs and pregnant/postpartum. There are no qualifying conditions for individuals in youth correctional facilities.*

- *For the prison system, we will work with the California Department of Corrections and Rehabilitation (CDCR) to use their data system to identify records of individuals during the pre-Waiver go-live period with documentation of any of the qualifying conditions. As practicable, Waiver comparison groups will be created by using the same qualifying conditions as criteria for simulating Waiver eligibility with cohorts of individuals who were incarcerated but released prior to the go-live date as well as for those released*

following the go-live date. Discussions between the evaluation team and CDCR have indicated that CDCR should be able to select previously released cohorts of individuals based on the same coding they are applying with current eligibility determinations. This will facilitate a meaningful analysis of the comparison versus Waiver groups.

- *For county jails and youth correctional facilities in four counties within California, using the same approach as proposed above for data collection from prisons, analysts from county jails apply the same qualifying conditions across the pre- and post-intervention time periods to identify pre-Waiver comparison cohorts.*
- *For the youth correctional facilities, all incarcerated youth are eligible so all releases prior to the go-live date are eligible. Prisons, local jails, and juvenile correctional facilities keep records on individuals who are admitted and released from their facilities.*

Also, regarding difference-in-differences (DiD) analyses, the state should provide more information about how post-release outcome measures will be measured for comparison populations and describe limitations of available data to measure these outcomes.

For example, for the measure of filled prescriptions in the 30 days following release, the state should indicate what data will be used to construct this measure for comparison populations.

Response: *We discuss the issue of data sources in the new "Overall Evaluation Strategy" section. Our plan is to use Medicaid and prison/jail data to gather information for pre- and post-release measures. For post-release measures, we plan to use Medi-Cal data. The CDCR has previously cross-referenced CDCR records with Medi-Cal data and gathered enrollment and utilization data from 2019-2020 as part of a project conducted by the Council on Criminal Justice and Behavioral Health.[3] We anticipate using the same matching strategy to link our files of released individuals for both the Waiver and comparison cohorts, thus providing consistency for all cohorts.*

The Evaluation Design also includes a new section entitled "Alternative Research Design Possibilities" that discusses options if the evaluation team is unable to secure data sets from the CDCR or local jails and youth correctional facilities. If the latter is the case, the project team may need to focus heavily on the already automated data describing Medi-Cal-reimbursed services that individuals receive and outcomes before and after release from prison or jail.

4. Provide more detail about the measures that will be used to address each hypothesis.

In some cases, the state did not provide details about the measures that will be used. For example, under Goal 1, the state specifies that it will analyze "appropriate service uptake," but the state does not provide a concrete measure for this under Goal 1.

[3] Council on Criminal Justice and Behavioral Health (CCJBH). Medi-Cal Utilization Project: *A Report on the Medi-Cal Enrollment and Behavioral Health Services Utilization for Individuals Released from the California Department of Corrections and Rehabilitation in Fiscal Year 2019-20, October 2023*. https://www.cdcr.ca.gov/ccjbh/wp-content/uploads/sites/172/2024/01/MCUP-FY-2019-2020-October-2023-ADA-1.pdf

The Evaluation Design should include specific measures for each goal and research question, including the intended study populations and measure definitions (i.e., numerator and denominator), as well as provide timeframes for each of the measures.

Response: *In consultation with DHCS, the Evaluation Team has revised Goal 1 to focus on coverage only (removing "continuity of care and appropriate service uptake") to eliminate the overlap between Goals 1 and 2. The revised Goal 1 is shown below.*

- *Goal 1. Increase coverage—in terms of individuals now eligible for Medi-Cal benefits—in carceral settings in prison/jail/juvenile hall just prior to release.*

The Evaluation Design Report uses the term "coverage" to indicate the availability of Medicaid-reimbursed services to support the delivery of needed services for up to 90 days prior to intended release from the prison/jail/ or juvenile hall carceral setting to the community setting. To measure Goal 1, "appropriate service uptake", we will assess the proportion of releasees who receive appropriate services during the 90 days prior to expected release from the carceral setting.

To measure Goal 2, we will use existing service use data from the carceral settings to determine trends in utilization of services during the 90 days prior to release from the prisons, jails, and juvenile settings.

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

Overall, our measures now specify groups being compared within individual measures, the time frame for the exposed and comparison groups, and reports of rate or percent values for outcomes. Timeframes for pre-release measures are generally 90 days; for post-release we use 30- and 90-days post-release, with a few longer-term outcomes of 6 months.

As an example, below Goal 1, Hypothesis 1 states:

> *Goal 1: Increase coverage among individuals now eligible for Medi-Cal benefits in prison/jail/juvenile hall carceral settings just prior to release.*
> *H1. The Waiver will increase coverage for eligible Medi-Cal members.*

Our measures are now defined as follows:

- *Medicaid Coverage (numerator = number enrolled in Medicaid; denominator = number of releasees)*
- *Eligibility screening (numerator = number screened for eligibility within 90 days of release; denominator = number of releasees)*
- *Eligibility (numerator = number found eligible for Reentry initiative services after screening; denominator = number of screened releasees)*

5. Identify which hypotheses satisfy the 90-day pre-release services requirement and provide rationale.

As noted in the STCs:

a) The state must also provide a comprehensive analysis of services rendered by type of service over the duration of the 90-day coverage period immediately prior to the expected date of release—to the extent feasible, and discuss in the evaluation any relationship identified between the provision and timing of particular services with salient post-release outcomes, including utilization of acute care services for chronic and other serious conditions, overdose, and overdose- and suicide-related and all-cause deaths in the period soon after release.

b) In addition, the state is expected to assess the extent to which this coverage timeline facilitated providing more coordinated, efficient and effective reentry planning, enabled pre-release management and stabilization of physical and behavioral health conditions, and helped mitigate any potential operational challenges the state might have otherwise encountered in a more compressed timeline for coverage or pre-release services.

Please explicitly identify the hypotheses that satisfy this requirement and the state's rationale for testing them over a 90-day pre-release timeframe.

Response: *California has chosen a 90-day in-reach period for the Waiver implementation. This timeframe was chosen to allow ample time within the carceral setting to conduct eligibility assessments, stabilize an incarcerated individual, prepare a post-release transition plan and allow the pre- and post-release care managers to do a warm hand-off and transition of care with the individual. The effectiveness of shorter time periods for in-reach services can be tested using natural variation in the data that we expect to see. Using event study models as described in the Methods section of the Evaluation Design Report, we will be able to identify variation in the effect size for incarcerated individuals who are partially vs fully treated.*

Goals 1 and 2 and their related hypotheses address the STC's requirement for a comprehensive analysis of services rendered by type of service during the 90-day coverage period immediately prior to the expected date of release. In the Methods Sections of the revised Evaluation Design, we indicate how we will analyze the relationship between service provision, the timing of service provision, and the outcomes described in the Evaluation Design Report's Goals 6 and 7. We focus on service provision during the 90 days pre-release as the time period for documenting service delivery to align with the 90 pre-release days during which the Waiver will support the delivery of services for Medicaid-eligible individuals within the carceral setting. The following two paragraphs highlight examples from Goals 1,2, 6, and 7.

Hypotheses under Goals 1 and 2 in the Evaluation Design address the comments in paragraph "a" noting the STCs above. Additionally, hypotheses under Goals 3, 4, and 5 in the Evaluation Design address the comments in paragraph "b" above.

We plan to address these in a qualitative fashion, using interviews. We outline more detail on these interviews in the question below requesting more information on themes and who will be interviewed for Goals 3, 4, and 5.

Our Goals focus on the 90 days for pre-release services as that is the timeframe for services for the Waiver implementation in California. We will probe respondents for their perceptions regarding their health care treatment needs, reentry support needs; and their experiences in receiving pre-release services while still incarcerated.

6. Consider alternative quantitative evaluation methods to support a rigorous evaluation. Given the nested nature of the data (beneficiaries within institutions), the state should consider multilevel regression, which will account for more variance in the model and increase statistical power. This approach is commonly employed by education researchers who evaluate student outcomes. Students are nested within schools and multilevel regression accounts for shared variability that otherwise goes unaccounted for. Because reentry beneficiaries are nested within correctional facilities, California's evaluator can use multi-level regression to account for shared variability within facilities, thus increasing the power of statistical analyses.

Also, please include pertinent information on comparison groups where DiD analyses are planned. To the extent that DiD modeling methods are not feasible due to limitations with sample size or issues identifying comparisons groups, the state should consider alternative analytic methods.

Response: *In the new section titled "Additional Quantitative Evaluation Methods", we discuss the use of multi-level regression to account for shared variability within institutions. We will be able to compare this with multi-level regression analyses that use fixed effects for facilities and time-period. We will also include differences-in-differences (DiD) analyses with methods described in detail in the Methods section of the Evaluation Design. We have also included discussion of alternative analytic methods should the difference-in-differences analyses prove problematic. In particular, if we observe that there are divergent trends pre-implementation, we may use a "detrended" difference-in-difference specification. As an additional sensitivity analysis, we will also estimate a donut regression discontinuity design (RDD) that exploits the timing of the rollout.*

7. Add information about the independent evaluator, evaluation budget, and timeline for the evaluation.

The Evaluation Design does not include information covering the independent evaluator, evaluation budget, or timeline for the reentry component of the CalAIM demonstration evaluation. The state should update the Evaluation Design to include this information since these are required sections per the demonstration STCs.

Response: *The Reentry Evaluation Team is nested within the larger CalAIM Evaluation Team, led by Dr. Katherine L Kahn and Dr. David Zingmond. The Reentry Evaluation is one component of the larger CalAIM Evaluation. Within the Reentry Portion of the CalAIM Evaluation Design Report, a section titled, "Study Timeline for Reentry Data Collection Activities" now describes the Reentry staffing and budget.*

8. Update the design for greater clarity and detail.

The state has opportunities to update the Evaluation Design for greater clarity and detail. First, it would be useful to explicitly describe the timeframe for the evaluation.

Response: *In response to these suggestions, the Evaluation Design Report now includes an "Overall Evaluation Strategy" that provides greater clarity and detail, as well as revised measures as noted in earlier responses. This text now also includes a timeline for the evaluation.*

According to the STCs, the state may begin claiming Federal Financial Participation (FFP) for services covered through the reentry initiative, which is expected to begin April 1, 2024, but the design does not include start dates for the evaluation or provide any information on estimated number of facilities that will begin implementation at different points based on expected staggered rollout. The state indicates that it would use data going back to 2017, but there is little detail on the measurement periods and sample timeframe that would be used to identify individuals with qualifying health conditions and have sufficient pre-intervention measures.

Response: *The new Overall Evaluation Strategy section addresses the timeline. As of October 2024, three California counties—Inyo, Santa Clara, and Yuba—were approved to begin delivering a targeted set of Medi-Cal services to individuals returning to communities after incarceration.[4] CDCR, including all 33 state prisons, is expected to go live in February 2025. County correctional facilities will go live on a quarterly basis through September 30, 2026.*

The "Overall Evaluation Strategy" also documents the timeframe for study and comparison cohorts. Specifically, we will make use of a cohort difference-in-difference analysis, which will exploit the within year timing of the policy and across year exposure to the policy. As an illustrative example, if one were to assume that the Waiver will be implemented in Month t of 2025, then individuals who are released from Month t through Month t+3 of 2025 will be partially treated as they will not receive the full 90 days of pre-release services (e.g., those individuals released in Month t+1 will only receive up to 30 days of pre-release services), individuals released after Month t+3 in 2025 will be fully treated, and individuals released in 2025 prior to Month t (i.e. Months t-1 to Month t-6) will be untreated.

We will leverage the month by year variation in Waiver eligibility. Regardless of the date of actual go-live, we will identify a 12-month window around the timing of the go-live dates for specific correctional facilities to ensure that we have 6 pre-implementation monthly cohorts, 3 partially treated post-cohorts, and 3 fully treated post-cohorts. We will also explore augmenting our model to cover a wider post-treatment period as well as monthly cohorts prior to 2025, given available data.

We have indicated 2021 as the earliest year for data to provide stability in measurement and to control for effects due to COVID-19, but data availability will guide the actual study period.

[4] DHCS News Release, October 9, 2024, "For the first time, California to provide Medi-Cal services for people returning home after incarceration."

It also indicates the qualitative information will be collected through calendar year 2028, but it did not provide any further information on the different time periods for the different approaches.

Response: *We have added a timeline to the Reentry Evaluation as part of the newly added Overall Evaluation Strategy (Table 1). This table presents the activities for activities related to data access and permissions and for the qualitative and quantitative tasks. We include the Goals that are associated with each evaluation activity. For example, we expect that activities for Year 2 will focus on selection of the four focal counties, developing research applications and data use agreements with CDCR and the four counties. These activities are relevant to all seven goals for the Reentry component.*

In addition, the state proposes to conduct interviews with key stakeholders involved in the Reentry demonstration to evaluate several of the goals, and with demonstration participants newly released from carceral settings in four counties to evaluate (1) improvement in coordination and connections between correctional systems, Medi-Cal systems, ECM and community providers (Goal 3), and (2) connections between carceral settings and community services (Goal 5). However, there was minimal detail about how these beneficiaries would be recruited, estimated numbers of participants among those newly released, or specific topics for the interviews.

Response: *We have provided more information on the interviews in the new "Overall Evaluation Strategy" section of the Evaluation Design Report. Specifically, related to Goals 3, 4, and 5, the evaluation team will conduct interviews with 80-120 recently released individuals in four focal counties (yet to be selected) representing individuals released from CDCR, county jails and juvenile facilities. The evaluation team plans to work with community-based organizations for the recruitment of individuals who are recently released. For the key stakeholder interviews, we will sample from individuals from county jails and youth correctional facilities, county Probation Departments and County Social Service Departments, CDCR and California Correctional Health Care Services, county behavioral health, support service providers. Descriptions of the sampling plan for interviewees are included qualitative goal 3, 4, and 5 narratives in the Evaluation Design Report.*[5]

The interviews with newly released Waiver participants from prison, jail, or youth correctional facilities will cover the following topics. We will ask about their experiences with enrollment in Medi-Cal (or reinstatement of benefits) during the pre-release period; their perceptions regarding their health care treatment needs and reentry support needs; and their experiences in receiving pre-release services while still incarcerated. We also will ask about their experiences with case management and the transition of their care to community providers; as well as what other support they may have received to help facilitate their transition of care to the community. We will ask for feedback on their experiences in accessing primary care, mental health care, substance use treatment, and care for chronic health conditions post-release from the carceral setting; and perceptions regarding barriers and facilitators to accessing health care pre-release and post-release. For those Waiver participants on prescription medications, we will ask if they

[5] The PATH and Reentry teams will coordinate on conducting these interviews.

were released with a supply of medications and experiences in getting their medications refilled post-release.

In conjunction with the PATH team, we also will conduct interviews with key stakeholders involved in the planning and implementation of the Waiver for the JI population. Key informant interviewees at the state-level will include CDCR and California Correctional Health Care Services (CCHCS) staff. At the county-level (administrators of county jails, and youth correctional facilities will be selected with individuals who were involved with the planning and implementation of the Waiver for the JI population.

Interview topics will include: system changes and supports needed to screen for Medi-Cal eligibility, to enroll, and to re-instate eligibility for those who were suspended during their incarceration; process of identifying individuals eligible individuals for the Waiver, the pre-release Medi-Cal application and enrollment process; planning for and the provision of a targeted set of pre-release services 90- days prior to release from jail/prison/juvenile facilities; planning for and care in the carceral setting, as well as provision of needed medications and durable medical equipment; coordination with enhanced care of care and provision of comprehensive case management (as part of ECM); coordination with benefits in preparation for release to the community supports; and barriers and facilitators to in planning for and implementing each component of the Waiver, the Reentry demonstration initiative, and lessons learned.

The RAND Reentry Evaluation team will lead interviews with key informants within CDCR and CCHCS as well as within county correctional facilities, while the PATH Evaluation team will lead interviews with county social services agencies and other salient community-based implementation partners.

9. Revise the background section of the reentry design.

In the background section, the state should reference the STCs for California's approved demonstration, not the SMDL.

Response: *This has been corrected so that it now refers the STCs for California's approved demonstration.*

10. Consider including additional measures relevant to the goals listed below.

Goal 2 – Access to services

- Rate of providers to beneficiaries –
- Wait times for services –
- Beneficiary-reported access to services –

Goal 7 – Post-acute care utilization

- All cause deaths (30 days and 90 days)
- All cause emergency room visits (30 days and 90 days)
- All cause hospitalization (30 days and 90 days)

Response: *We have revised the measures for Goal 2 to include a new measure of the rate of providers to beneficiaries. We will attempt to measure wait times for services if we are able to obtain data that will allow us to calculate wait time. With respect to beneficiary-reported access to services, this will be part of the interviews with released individuals, which we would consider part of Goal 5.*

For Goal 7, as part of our response to earlier comments, we have included the specific time frames of 30- and 90-days post-release for 1) all-cause deaths, 2) all-cause emergency room visits, and 3) all cause hospitalization.