California Department of Health Care Services (DHCS)

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

Interim Evaluation Report for the Managed Care Plans Transition under the CalAIM Section 1115(a) Demonstration

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EXECUTIVE SUMMARY

The CalAIM Section 1115 Demonstration, approved by CMS in December 2021, advances California's commitment to improving care delivery and equity for Medi-Cal members. A central feature—the Managed Care Plan (MCP) Transition Amendment—streamlined managed care models across 15 counties, transitioning approximately 1.2 million members to either a County Organized Health System (COHS) or Single Plan model. This restructuring aims to simplify administration, enhance oversight, and promote consistent access to services statewide.

This Interim Evaluation Report presents baseline findings from the early phase of the transition (January 2021 – December 2023), focusing on member demographics, access and quality indicators, and stakeholder perspectives. While full impact analyses are forthcoming in the Summative Evaluation Report, initial results offer critical insights into the transition's implementation and lay the groundwork for assessing its long-term effects on care continuity, equity, and accountability.

Methods

This evaluation draws on:

- **Descriptive quantitative analysis** of member demographics, care quality and access indicators, and provider-to-member ratios across 15 transition counties and comparison counties during the pre-transition baseline period.[1]
- **Qualitative interviews** with MCP officials and a DHCS Stakeholder Advisory Committee (SAC)[2] member to assess implementation experiences, challenges, and promising practices.

[1] Due to data acquisition timelines, results in this report are limited to the baseline period and do not contain information on quality and access metrics after the MCP Transition. The Summative Evaluation Report will assess the full implementation period for the MCP Transition (January 2024 to December 2026).

[2]DHCS Stakeholder Advisory Committee
https://www.dhcs.ca.gov/Pages/DHCSStakeholderAdvisoryCommittee.aspx

Key Results

Goal 1: Maintain or improve overall access to and continuity of care

- The members enrolled in the 15 MCP Transition counties were predominantly 19 to 44 years old (39.9%) of the transition county member population) and 0 to 18 years old (27.3 %). A slight majority of members were female (52.8%), and Hispanic members made up the largest racial and ethnic group (33.6%). A total of 67.4 percent of members reported English as their primary language, and 11.5 percent of members were dually eligible for Medicare and Medicaid for at least one month during the baseline period.
- During the baseline period, the 15 counties included in the MCP Transition performed better than the counties not included in the transition on certain care access metrics, including well-child visits at 15- and 30-months, prenatal and postpartum care, and 7-day and 30-day follow-up rates after emergency department visits for mental illness.
- Transition counties performed equally as well as non-transition counties for child and adolescent well-care visits during the baseline period.
- Transition counties had lower meningococcal and tetanus, diphtheria toxoids and acellular pertussis (TDAP) vaccine rates, compared to non-transition counties, but the two groups had comparable rates of human papillomavirus (HPV) vaccinations.
- Member-to-provider ratios varied across MCP Transition counties during the baseline period, with urban counties generally reporting greater access. The urban counties of Placer, Contra Costa, and Alameda reported greatest access to overall physicians, primary care practitioners (PCPs), and specialists, while the rural counties Colusa, Tehama, and San Benito counties reported lower access.

Goal 2: Maintain or improve quality of care

- During the baseline period, MCP Transition counties performed slightly better than non-MCP Transition counties on all-cause readmission rates.
- However, transition counties had slightly lower breast cancer screening rates than non-transition counties.

Goal 3: Maintain or improve access to high-quality, continuous care among historically marginalized and under-resourced populations

- During the baseline period, there was some evidence of disparities between urban and rural counties, with the urban transition counties outperforming their rural counterparts on child and adolescent well-care visits, prenatal and postpartum care, and follow-up after ED visits for mental illness.
- However, rural counties had lower rates of all-cause readmissions than urban counties. In addition, urban counties had higher well-child visit rates during the first 15 months, but the difference had largely reduced to zero for children turning 30 months. While urban counties had higher vaccination rates for meningococcus and HPV, rates for TDAP were comparable between urban and rural counties.
- Counties with higher proportions of Hispanic and non-English-speaking members may face unique access challenges. In response, MCPs have launched targeted efforts to expand access for historically underserved groups, strengthen member engagement, and ensure care delivery is culturally responsive.

Goal 4: Reduce administrative complexity for MCPs

- MCPs reported significant upfront administrative burden including staffing and infrastructure investments. These demands required rapid scaling of internal operations and reallocation of resources to meet transition timelines.
- Coordination with exiting MCPs and county stakeholders was critical but challenging. Differences in systems, priorities, and communication protocols often introduced challenges to effective member identification, engagement and care continuity needs assessment.
- Infrastructure investments (e.g., staffing, data systems) were made to support transition. These investments were essential to ensure continuity of care and minimize disruption for members and providers.

Goal 5: Maintain MCP accountability and improve transparency

- Document review showed variability in public reporting and stakeholder engagement. Some MCPs provided detailed, timely updates and maintained open channels for stakeholder input, while others lacked clear reporting mechanisms or regular engagement opportunities.
- Stakeholder interviews revealed gaps in DHCS communication and MCP understanding of responsibilities. These gaps contributed to confusion around care

coordination roles and limited awareness of the transition among members and providers.

Lessons Learned

- Early and clear communication from MCPs with stakeholders is essential to minimize confusion and service disruption.
- Data quality and timely access are critical for evaluation and implementation.
- MCPs need support in navigating behavioral health integration and culturally competent care.
- Culturally and linguistically appropriate care must be prioritized especially in counties with high proportions of non-English-speaking populations.
- Administrative complexity remains a challenge, despite efforts to streamline workflows. MCPs are still iterating on protocols and infrastructure.

Recommendations

- Strengthen oversight and interdepartmental coordination to ensure consistent implementation
- Improve protocols for and ensure sufficient lead time ahead of data sharing between exiting and receiving MCPs to support continuity of care.
- Support MCPs with technical assistance on behavioral health integration and culturally competent care.
- Monitor equity impacts through stratified analyses and targeted outreach to historically marginalized populations.
- Work collaboratively across counties and MCPs to standardize transition protocols, timelines, data formats, and administrative procedures.

Next Steps

The Summative Evaluation Report will expand on these findings using:

- Full implementation-period data (January 2024–December 2026)
- Interviews with 45 members from transition counties
- A second round of stakeholder interviews

This data will support deeper analysis of the MCP Transition's impact on care access, quality, and equity, and will be contextualized by member experiences and additional stakeholder perspectives.

GENERAL BACKGROUND INFORMATION

Background

The California Advancing and Innovating Medi-Cal (CalAIM) 1115 Demonstration, approved by the Centers for Medicare & Medicaid Services (CMS) on December 29, 2021,[3] uses Medi-Cal as a strategic platform to expand coverage and improve care for California's most vulnerable residents. Its goals include enhancing access to health services, improving health outcomes, and advancing health equity for Medi-Cal members and other low-income populations statewide. Through CalAIM and related efforts—such as the 1915(b) waiver approved on the same date—the state is reinforcing a population health framework that emphasizes prevention and addresses social determinants of health.

The December 2021 approvals also marked a shift in oversight for California's managed care systems—including Medi-Cal Managed Care, Dental Managed Care, Specialty Mental Health Services, and the Drug Medi-Cal Organized Delivery System—from the previous Demonstration to the CalAIM Demonstration. This transition was designed to streamline program administration, enhance oversight, and standardize benefits and enrollment processes across Medi-Cal.

Managed Care Plan (MCP) Transition Amendment

- California's Medi-Cal Managed Care system includes several models that vary by county. Before county MCP model changes that were effective 1/1/2024, each of the state's 58 counties operated under one of the following arrangements:
- **County Organized Health System (COHS**): A single MCP managed by the county.
- **Two-Plan Model**: One county-run local initiative and one commercial plan.
- **Multiple Commercial Plans**: Includes Geographic Managed Care, Regional, or Imperial models.
- **San Benito Model:** One commercial plan alongside a Fee-for-Service option.

Ahead of the state's 2022 commercial plan procurement, counties were invited to propose changes to their managed care models. The California Department of Health

[3] CMS Extension Approval: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-calaim-ext-appvl-12292021.pdf

Care Services (DHCS) gave provisional approval to model changes in 17 counties. Of these, 15 aimed to adopt a single-plan model—either by expanding an existing COHS or establishing a new "Single Plan" model, where a managed care plan contracts with DHCS under county or local authority sponsorship **Exhibit 1**.[4] DHCS supported the MCP Transition through activities that promoted coordinated and culturally competent care, integration of physical and behavioral health, and investments in primary care and local infrastructure.

The state convened a Community Advisory Committee (CAC) and implemented transparency initiatives to improve member understanding. These efforts reinforced the broader goals of the CalAIM Demonstration and helped ensure a smoother transition for Medi-Cal members. DHCS gave conditional approval to county proposals in October 2021, and by December 2021, counties submitted MCPs for network contracting.[5] On November 4, 2022, DHCS submitted a request to amend the CalAIM Section 1115 Demonstration, seeking federal approval to limit managed care plan choices in Metro, Large Metro, and Urban counties using the COHS and Single Plan models. The goal of this limitation was to streamline and align managed care programs, create consistency in benefits and enrollment, and enhance program oversight statewide. CMS approved the amendment on August 23, 2023.

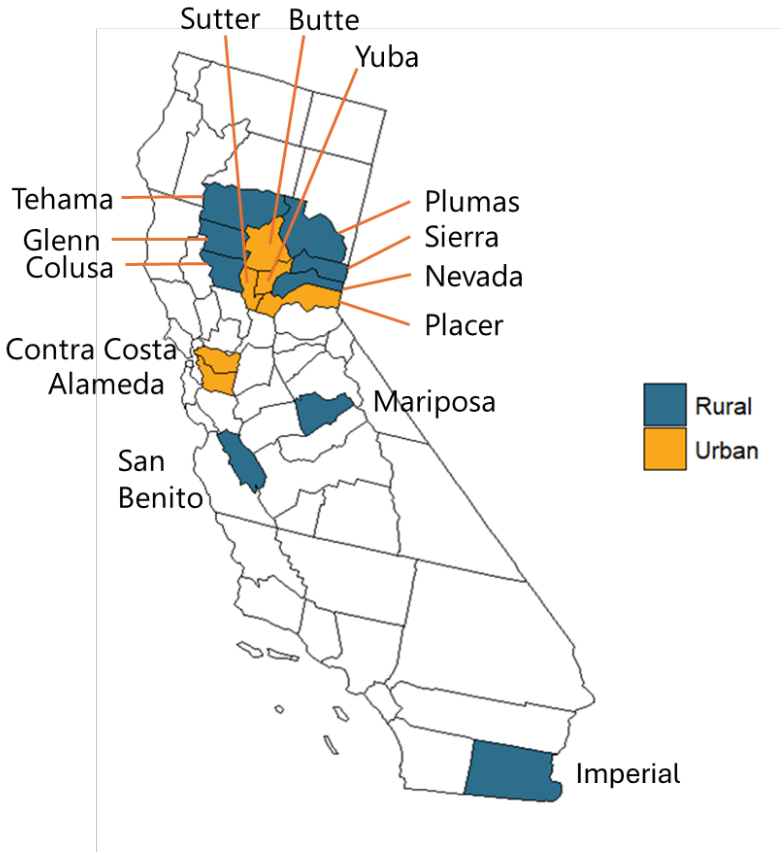
Separately, DHCS also received approval to amend the CalAIM 1915(b) waiver, allowing the use of a rural area exemption for MCP choice in counties with existing or planned COHS or Single Plan models. Together, these amendments aimed to simplify administration for providers, MCPs, and members, while improving state oversight and accountability.

Exhibit 1 shows the 15 counties included in the Transition, by urban (1115 authority) and rural (1915 authority) status, and **Exhibit 2** shows the change in models by county. Not all Medi-Cal members in these counties transitioned to a new MCP, but close to 1.2 million members have been involved in the transition in 2024. Members transitioning to a new MCP received a 90-day notice from their exiting MCP, 60-day and 30-day notices

[4] Medi-Cal Managed Care Plan Model Fact Sheets: https://www.dhcs.ca.gov/services/Documents/MMCD/MMCD-Model-Fact-Sheet.pdf
[5] County Plan Model Change Public Timeline: https://pan.dhcs.ca.gov/services/Documents/MMCD/County-Plan-Model-Change-Public-Timeline.pdf

from DHCS's enrollment broker, and a welcome packet from their receiving MCP in January 2024.

Exhibit 1. Fifteen counties were included in the MCP Transition.



During the MCP Transition ("the Demonstration"), DHCS aimed to minimize service interruptions for members, and particularly for under-resourced groups; provide adequate communications, including outreach and education, to members, providers, and MCPs; and effectively measure and ensure accountability of MCP's transition responsibilities.

Exhibit 2. Counties Transitioning to a County-Organized Health System (COHS) Model or Single Plan Model under the MCP Transition Amendment

County ***County Plan Model Type***	**2023 MCP(s)**	**2024 MCP(s)**
Alameda* Two-Plan model (2023) Single Plan model (2024)	Anthem Blue Cross Partnership Plan	Alameda Alliance for Health
	Alameda Alliance for Health	Kaiser Permanente
Butte* Regional model (2023) County-Organized Health System model (2024)	Anthem Blue Cross Partnership Plan	Partnership Health Plan of California
	California Health & Wellness	
Colusa Regional model (2023) County-Organized Health System model (2024)	Anthem Blue Cross Partnership Plan	Partnership Health Plan of California
	California Health & Wellness	
Contra Costa* Two-Plan model (2023) Single Plan model (2024)	Anthem Blue Cross Partnership Plan	Contra Costa Health Plan
	Contra Costa Health Plan	Kaiser Permanente
Glenn Regional model (2023) County-Organized Health System model (2024)	Anthem Blue Cross Partnership Plan	Partnership Health Plan of California
	California Health & Wellness	
Imperial Imperial model (2023) Single Plan model (2024)	California Health & Wellness	Community Health Plan of Imperial Valley
	Molina Healthcare of California	Kaiser Permanente
Mariposa	Anthem Blue Cross Partnership Plan	Central California Alliance For Health

County ***County Plan Model Type***	**2023 MCP(s)**	**2024 MCP(s)**
Regional model (2023) County-Organized Health System model (2024)	California Health & Wellness	Kaiser Permanente
Nevada Regional model (2023) County-Organized Health System model (2024)	Anthem Blue Cross Partnership Plan	Partnership Health Plan of California
	California Health & Wellness	
Placer* Regional model (2023) County-Organized Health System model (2024)	Anthem Blue Cross Partnership Plan	Partnership Health Plan of California
	California Health & Wellness	
	Kaiser Permanente	
Plumas Regional model (2023) County-Organized Health System model (2024)	Anthem Blue Cross Partnership Plan	Partnership Health Plan of California
	California Health & Wellness	
San Benito San Benito model (2023) County-Organized Health System model (2024)	Anthem Blue Cross Partnership Plan	Central California Alliance For Health
	Medi-Cal Fee-For-Service	
Sierra Regional model (2023) County-Organized Health System model (2024)	Anthem Blue Cross Partnership Plan	Partnership Health Plan of California
	California Health & Wellness	
Sutter*	Anthem Blue Cross Partnership Plan	Partnership Health Plan of California

County ***County Plan Model Type***	**2023 MCP(s)**	**2024 MCP(s)**
Regional model (2023) County-Organized Health System model (2024)	California Health & Wellness	Kaiser Permanente
Tehama Regional model (2023) County-Organized Health System model (2024)	Anthem Blue Cross Partnership Plan	Partnership Health Plan of California
	California Health & Wellness	
Yuba* Regional model (2023) County-Organized Health System model (2024)	Anthem Blue Cross Partnership Plan	Partnership Health Plan of California
	California Health & Wellness	Kaiser Permanente
Starred counties (*) are Metro, Large Metro, and Urban counties		

SOURCE: DHCS Medi-Cal Managed Care Plans by County, https://www.dhcs.ca.gov/CalAIM/Documents/MCP-County-Table-2023-2024.pdf

Also, effective January 1, 2024, DHCS entered a direct contract with Kaiser Permanente (Kaiser) as a Medi-Cal MCP for a five-year contract term. For eligible Medi-Cal members in transition counties in which Kaiser will operate in 2024, Kaiser is included as a MCP option. In effect, Kaiser will operate in parallel with the single MCP or COHS county systems. Kaiser has committed to increasing its new Medi-Cal membership by 25 percent between July 1, 2024, and December 31, 2028. This growth target applies after the conclusion of the Public Health Emergency (PHE) unwinding redetermination period and excludes any membership increases resulting from the enrollment requirements that were in effect from January 1 to June 30, 2024. Kaiser enrollment growth will come from foster care youth and former foster care youth who elect to enroll in Kaiser, and members dually eligible for Medi-Cal and Medicare residing in Kaiser's geographic service areas, as well as annual enrollment growth through default enrollments in specific counties. There is no enrollment limit for the number of children in foster care, members dually eligible for Medi-Cal and Medicare, and other enrollment resulting from continuity of care rights.

In alignment with the 1115 evaluation timeline, DHCS contracted with NORC at the University of Chicago ("NORC") to serve as the independent evaluator for the MCP Transition in the fall of 2024. This Interim Evaluation Report presents NORC's initial findings and analysis conducted during the contracted phase of the evaluation period.

EVALUATION QUESTIONS AND HYPOTHESES

The MCP Transition Amendment under California's CalAIM Section 1115 Demonstration was designed to improve access, quality, and accountability in Medi-Cal managed care delivery. To evaluate the effectiveness of this transition, the state's goals were translated into quantifiable targets for improvement, enabling performance measurement across key domains. These targets were operationalized through a structured set of hypotheses and evaluation questions, which are grounded in a conceptual framework illustrated by the Driver Diagram **Exhibit 3**.

The Driver Diagram is a visual representation of the demonstration's theory of change. It outlines the causal pathways between the demonstration's features and its intended outcomes, with the overarching aim of maintaining or improving quality, access to care, and accountability. Primary drivers include maintaining access to care, ensuring continuity of care, improving quality of care, and strengthening MCP accountability. Each primary driver is supported by secondary drivers that reflect specific policy mechanisms, such as extended eligibility periods for out-of-network provider use, automatic enrollment for dual-eligible members, and expanded oversight responsibilities for DHCS. These drivers informed the development of evaluation measures and guided both the quantitative and qualitative components of the analysis.

The state hypothesized that the MCP Transition would maintain or improve access to and continuity of care, enhance quality of care, promote equitable outcomes for historically marginalized and under-resourced populations, reduce administrative complexity for MCPs, and improve transparency and accountability through adherence to transition requirements. These hypotheses are directly aligned with the evaluation questions, which assess outcomes such as provider-to-member ratios, access to preventive services, behavioral health utilization, grievance rates, and MCP compliance with transition protocols. The evaluation design also includes subgroup analyses to explore differential impacts across equity-relevant populations.

This Interim Evaluation Report provides a targeted assessment of managed care restructuring in 15 counties. It incorporates lessons learned from prior waiver transitions, including the importance of continuity protections, stakeholder engagement, and transparent communication strategies.

Finally, the evaluation promotes the objectives of Titles XIX and XXI by supporting continuity of coverage and care for low-income populations, enhancing access to preventive and behavioral health services, and strengthening oversight mechanisms for managed care plans. Through rigorous analysis and stakeholder-informed inquiry, this

report contributes to the evidence base for Medicaid innovation and informs future policy decisions at both the state and federal levels.

Exhibit 3. Driver Diagram for the MCP Transition

Aim	Primary Driver	Secondary Driver
Maintain or improve quality, access to care, and accountability	Maintain or improve access to care	Enhanced protections, included extended eligibility period for out-of-network provider use at the Receiving MCP, for special populations^
		Monitor MCPs' implementation of transition responsibilities
	Ensure continuity of care	Continue medically necessary services for members in an ongoing course of treatment without any form of prior approval and without regard to whether such services are provided by in-network or out-of-network providers
		Allow the member to keep their current PCP
		Automatically enroll dual-eligible members in Medi-Cal Matching Plan counties in a Medi-Cal MCP that matches their Medicare Advantage plan
		Allow transitioning members to keep their out-of-network providers for a 12-month period at their Receiving MCP
		Provide clear communications around the transition (e.g. choice packet sent to members with 60-notice, Welcome Packet from new MCP sent in early January 2023
	Maintain or improve quality of care	Ensure a whole-person, interdisciplinary approach for populations with complex health care needs

Aim	Primary Driver	Secondary Driver
		Report on and regularly monitor quality of care measures during the transition period
		Strengthen and maintain quality of care for vulnerable populations
	Ensure accountability of MCPs' transition responsibilities	Establish—and provide additional support for existing—Community Advisory Committees
		Provide opportunities to file grievances and appeals, and ensure the State responds within a reasonable period
		Provide transparent information to managed care members by publicly posting MCP and subcontractors' activities (e.g. Population Needs Assessment, CAHPS survey results)
		Expand DHCS oversight responsibilities, including an independent access assessment for network adequacy

NOTE: ^See DHCS 2024 Medi-Cal Managed Care Plan Transition Policy Guide for definitions.

To evaluate the impact of the MCP Transition Amendment, this report examines how the transition affected access to care, quality of care, and continuity of care for Medi-Cal members in the 15 participating counties. The evaluation uses both quantitative and qualitative methods, drawing on enrollment data, MCAS metrics, grievance records, and stakeholder interviews to assess baseline conditions and early implementation experiences. **Exhibit 4** summarizes the evaluation hypotheses, research questions, and associated measures.

Exhibit 4. Summary of MCP Transition Evaluation Design

Goal 1: Maintain or improve overall access to and continuity of care.				
Evaluation Questions & Hypotheses	**Measures**	**Population(s)**	**Data Source(s)**	**Analytic Methods**
EQ1A. How many Medi-Cal members were in the 15 MCP Transition counties? How many Med-Cal members switched MCPs under the MCP Transition? **H1A.** N/A (descriptive)	» Medi-Cal members residing in MCP Transition counties » Medi-Cal members required to switch MCPs under the MCP Transition	Members in MCP Transition counties; members who switched MCPs under the transition	» Enrollment data	Descriptive analyses
EQ1B. What were the characteristics of Medi-Cal members in MCP Transition counties? **H1B.** N/A (descriptive)	» Sociodemographic characteristics of members in MCP Transition counties	Members in MCP Transition counties	» Enrollment data	Descriptive analyses, pre- post analyses

Goal 1: Maintain or improve overall access to and continuity of care.				
Evaluation Questions & Hypotheses	**Measures**	**Population(s)**	**Data Source(s)**	**Analytic Methods**
EQ1C. What was the effect of the Demonstration on access to care? **H1C.** The Demonstration will maintain or improve access to care: network adequacy will stay the same or increase, and access to care grievances will stay the same or decrease.	» Network adequacy (i.e., member-to-provider ratios) » Access to care grievances	MCP Transition counties	» Interviews with members » DHCS grievance data » DHCS Network Adequacy Monitoring data (i.e., 274 Provider File and MIS/DSS enrollment data)	Descriptive analyses; thematic analysis of interviews
EQ1D. To what extent did access to preventive/ ambulatory health services change under the MCP Transition? **H1D.** The Demonstration will maintain or improve access to preventive/ ambulatory health services: rates of well-child visits, immunizations for adolescents, and timeliness of prenatal and postpartum care will stay the same or increase.	» Well-child visits » Immunizations for adolescents » Timeliness of prenatal and postpartum care	Members in MCP Transition counties	MCAS data; Core Set data	Descriptive analyses; pre-post analyses *(Paired t-tests; chi-squared tests*)

Goal 1: Maintain or improve overall access to and continuity of care.				
Evaluation Questions & Hypotheses	**Measures**	**Population(s)**	**Data Source(s)**	**Analytic Methods**
EQ1E. To what extent did access to behavioral health services change under the Demonstration? **H1E.** The Demonstration will maintain or improve access to behavioral health services: rates of follow up after ED visit for mental illness and non-specialty mental health member-to-provider ratios will stay the same or increase.	» Follow up after ED visit for mental illness » Non-Specialty outpatient mental health member-to-provider ratio	Members in MCP Transition counties	» MCAS data; DHCS Network Adequacy Monitoring data (i.e., 274 Provider File and MIS/DSS enrollment data)	Pre-post analyses (Paired t-tests; chi-squared tests)
EQ1F. What was the effect of the Demonstration on continuity of care? **H1F.** The Demonstration will maintain or improve continuity of care: continuity of care grievances will stay the same or decrease.	» Continuity of care grievances	MCP Transition counties	» DHCS grievance data » Interviews with members	Pre-post analyses *(Paired t-tests; chi-squared tests);* thematic analysis of interviews

Goal 2: Maintain or improve quality of care.				
Evaluation Questions & Hypotheses	**Measures**	**Population(s)**	**Data Source(s)**	**Analytic Methods**
EQ2A. What was the impact of the Demonstration on quality of care? **H2A.** The Demonstration will maintain or improve quality of care: rates of breast cancer screening will stay the same or increase, and all-cause readmissions will stay the same or decrease.	» Breast cancer screening » MCP all-cause readmissions	Members in MCP Transition counties	» MCAS data; Core Set data » Interviews with members	Difference-in-Differences or Comparative Interrupted Time Series; thematic analysis of interviews

Goal 3: Maintain or improve access to high-quality, continuous care among historically marginalized and under-resourced populations.				
Evaluation Questions & Hypotheses	**Measures**	**Population(s)**	**Data Source(s)**	**Analytic Methods**
EQ3A. To what extent were historically marginalized and under-resourced populations, who were members living in MCP Transition counties, enrolled in the Demonstration?	» Sociodemographic characteristics of members in MCP Transition counties	Members in MCP Transition counties by equity	» Enrollment data	Directed content analysis of secondary data;

Goal 3: Maintain or improve access to high-quality, continuous care among historically marginalized and under-resourced populations.				
Evaluation Questions & Hypotheses	**Measures**	**Population(s)**	**Data Source(s)**	**Analytic Methods**
H3A. N/A (descriptive)		relevant sub-populations^		Descriptive analyses; Pre-post analyses
EQ3B. What was the effect of the Demonstration on access to care among historically marginalized and under-resourced populations? **H3B.** The Demonstration will maintain or improve access to care among historically marginalized and under-resourced populations: network adequacy will stay the same or increase, and access to care grievances will stay the same or decrease, within subgroups of such populations.	» Network adequacy (e.g. member-to-provider ratio) » Access to care grievances	Members in MCP Transition counties by equity relevant sub-populations^	» Interviews with members » DHCS grievance data » DHCS Network Adequacy Monitoring data (i.e., 274 Provider File and MIS/DSS enrollment data)	Descriptive analyses; thematic analysis of interviews
EQ3C. To what extent did access to preventive/ ambulatory health services change under the Demonstration among historically	» Well-child visits » Immunizations for adolescents	Members in MCP Transition counties by	» MCAS data; Core Set data	Descriptive analyses; Pre-post analyses

Goal 3: Maintain or improve access to high-quality, continuous care among historically marginalized and under-resourced populations.				
Evaluation Questions & Hypotheses	**Measures**	**Population(s)**	**Data Source(s)**	**Analytic Methods**
marginalized and under-resourced populations? **H3C.** The Demonstration will maintain or improve access to preventive/ ambulatory health services among historically marginalized and under-resourced populations: rates of well-child visits, immunizations for adolescents, and timeliness of prenatal and postpartum care will stay the same or increase within subgroups of such populations.	» Timeliness of prenatal and postpartum care	equity relevant sub-populations^		*(Paired t-tests; chi-squared tests*)
EQ3D. To what extent did access to behavioral health services change under the Demonstration among historically marginalized and under-resourced populations? **H3D.** The Demonstration will maintain or improve access to behavioral health services among	» Follow up after ED visit for mental illness	Members in MCP Transition counties by equity relevant sub-populations^	» MCAS data	Pre-post analyses *(Paired t-tests; chi-squared tests*)

Goal 3: Maintain or improve access to high-quality, continuous care among historically marginalized and under-resourced populations.				
Evaluation Questions & Hypotheses	**Measures**	**Population(s)**	**Data Source(s)**	**Analytic Methods**
historically marginalized and under-resourced populations: rates of follow-up after ED visits for mental illness will stay the same or increase within subgroups of such populations.				
EQ3E. What was the effect of the Demonstration on continuity of care among historically marginalized and under-resourced populations? **H3E.** The Demonstration will maintain or improve continuity of care among historically marginalized and under-resourced populations: continuity of care grievances will stay the same or decrease within subgroups of such populations.	» Continuity of care grievances	Members in MCP Transition counties by equity relevant sub-populations^	» DHCS grievance data » Interviews with members	Pre-post analyses *(Paired t-tests; chi-squared tests);* Thematic analysis of interviews

Goal 3: Maintain or improve access to high-quality, continuous care among historically marginalized and under-resourced populations.				
Evaluation Questions & Hypotheses	**Measures**	**Population(s)**	**Data Source(s)**	**Analytic Methods**
EQ3F. What was the effect of the Demonstration on quality of care outcomes for members among historically marginalized and under-resourced populations? **H3F.** The Demonstration will maintain or improve quality of care outcomes among historically marginalized and under-resourced populations: rates of breast cancer screening and immunizations for adolescents will stay the same or increase, and all-cause readmissions will stay the same or decrease, within subgroups of such populations.	» Breast cancer screening » Immunizations for adolescents » MCP all-cause readmissions	Members in MCP Transition counties by equity relevant sub-populations^	» MCAS data; Core Set data	Difference-in-Differences or Comparative Interrupted Time Series

Goal 4: Reduce administrative complexity for MCPs.				
Evaluation Questions & Hypotheses	**Measures**	**Population(s)**	**Data Source(s)**	**Analytic Methods**
EQ4A. To what extent did the MCP Transition impact MCP administrative workflows, and how? **H4A.** The Demonstration will reduce administrative complexity for MCPs.	» Qualitative data- MCP perspectives	MCPs in MCP Transition Counties	» Interviews with MCP officials	Thematic analysis of interviews

Goal 5: Maintain MCP accountability and improve transparency.				
Evaluation Questions & Hypotheses	**Measures**	**Population(s)**	**Data Source(s)**	**Analytic Methods**
EQ5A. To what extent did MCPs establish and execute their Community Reinvestment Plans, and how? **H5A.** MCPs will adhere to transition requirements and execute Community Reinvestment plans.	» Proportion of MCPs meeting planned reinvestment targets (as defined in Community Reinvestment Plans) » Qualitative data—MCP and stakeholder perspectives	MCPs in MCP Transition Counties	» Document review of Community Reinvestment Plans, MCP Annual Reports, financial information^^ » Interviews with MCP officials » Focus groups or interviews with DHCS Member Stakeholder	Directed content analysis of secondary data, thematic analysis of interviews

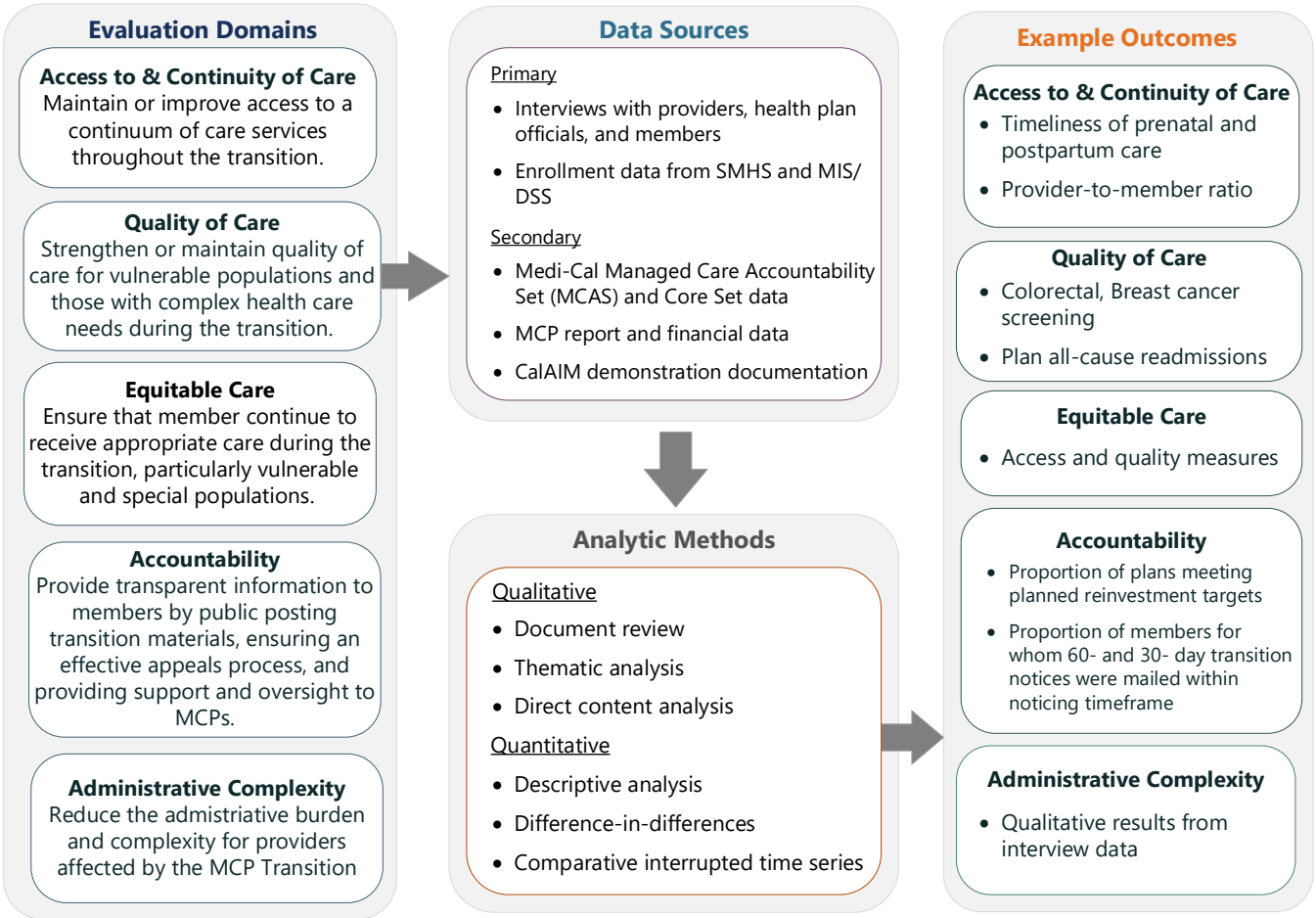
Goal 5: Maintain MCP accountability and improve transparency.				
Evaluation Questions & Hypotheses	**Measures**	**Population(s)**	**Data Source(s)**	**Analytic Methods**
			Committee members	
EQ5B. To what extent did MCPs publish required performance and operations documentation as required? **H5B.** MCPs will adhere to transition requirements and publish required performance and operations documentation.	» Proportion of MCPs developing and making publicly available programmatic and financial documentation (i.e., Community Reinvestment Plans, Population Needs Assessments, MCP Annual Reports, etc.) within required timeframes	MCP Transition Counties	» Websites for MCPs in MCP Transition counties	Web scan with directed content analysis

NOTES: ^ Equity relevant subgroups include race/ethnicity, age, sex, and preferred language. For additional information on equity relevant subgroups, see the "Identifying Target and Comparison Populations" subsection. ^^Data content and availability permitting; to be included in Summative Evaluation Report only.

METHODOLOGY

This evaluation employed both quantitative and qualitative methods to assess the overall impact of the MCP Transition on members, MCPs, and providers. This approach reflects the priorities that DHCS identified for this evaluation, which in turn guided the framing of hypotheses, data sources, measures, analytic approaches, and findings. The evaluation used both primary and secondary data. Qualitative analysis was used to describe the core components and current status of transition activities in each county, as well as the experiences of members, MCP officials, and the DHCS Stakeholder Advisory Committee, and their perceptions of the transition's impact on care continuity and access. Quantitative analysis was used to better understand trends in selected process and outcome measures before and after the transition. **Exhibit 5** provides a visual overview of the evaluation design.

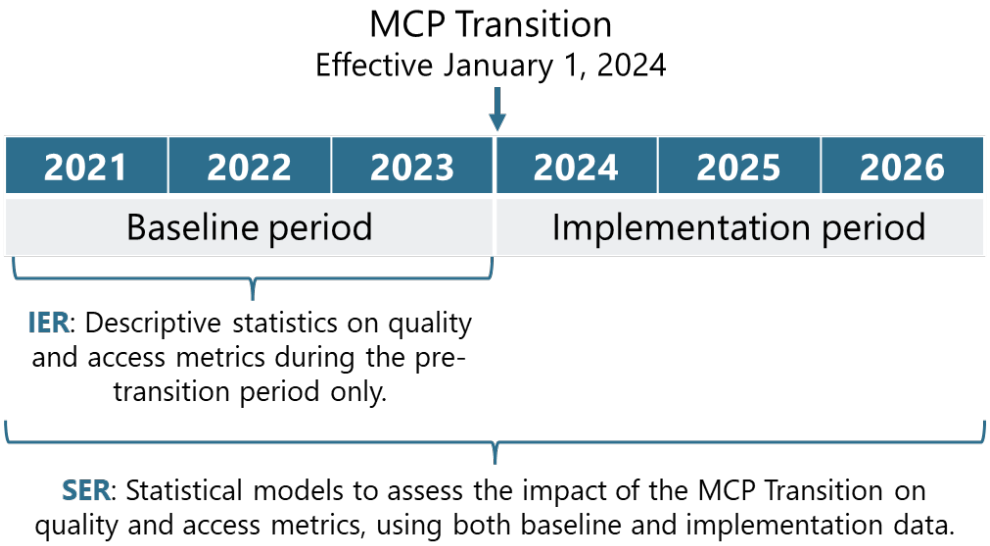
Exhibit 5. Overall Approach to the Evaluation of the MCP Transition



Evaluation Period

Due to data acquisition timelines, quantitative analysis in this report was limited to data reflecting quality and access metrics observed during the evaluation's baseline period from January 1, 2021 to December 31, 2023. The Summative Evaluation Report will assess the full implementation period for the MCP Transition (January 1, 2024 to December 31, 2026) in addition to the baseline period**. Exhibit 6** provides an overview of the years included in the evaluation of the MCP Transition.

Exhibit 6. Time Period Covered in the MCP Transition Evaluation



Quantitative Evaluation Methods

The below sections detail NORC's quantitative approach to evaluating the MCP Transition in the Interim Evaluation Report , including data sources, statistical analyses, and associated measures.

Data Sources

NORC used four secondary data sources to examine member demographic data and construct evaluation measures assessing access to and quality of care, continuity of care, and equity in the treated group. These data sources and their use are summarized in **Exhibit 7**.

Member demographic information was taken from **MIS/DSS – Medi-Cal Enrollment** datasets. Metrics were derived from person-level, pre-calculated values available through the **Medi-Cal**

Managed Care Accountability Set (MCAS) and the **Medicaid and CHIP Core Sets of Health Care Quality measures (Core Set).** MCAS datasets comprise measures of performance that Medi-Cal managed care organizations operating in California are required to calculate and submit to DHCS each year. Core Set datasets comprise measures of performance and quality of care that DHCS generates and submits to CMS each year. Measure domains in both datasets include primary care access and preventive care, children's health, behavioral health, maternal and perinatal health, and care of acute and chronic conditions. Finally, data on provider network adequacy includes pre-calculated member-to-provider ratios derived from the **Provider 274 files**. The Provider 274 files are used to report provider network information, including provider coverage and network adequacy to DHCS by managed care plans.

Since person-level MCAS and Core Set datasets for 2024 were not available at the time of analysis, the Interim Evaluation Report includes data solely on measures from the baseline period of January 2021 through December 2023. In addition, because Provider 274 files report information monthly, this analysis uses the data reported in December of each reporting year as representative for that year. For example, the member-to-provider ratios reported for 2023 are based specifically on the December 2023 submission. The decision to use December as a representative month for the whole year was made in collaboration with the state, as DHCS does not anticipate large changes in these data on a short-term basis. If in future data transfers, NORC finds evidence of large month-to-month changes, NORC will explore the possibility of using the more granular monthly data for the Summative Evaluation Report. Provider 274 files were also only available in 2022 and 2023, as the data was not reported previously. Finally, NORC could not receive data for both transition and non-transition counties from every data source, due to limitations in data availability and accessibility; thus, **Exhibit 7** also notes the geographic specification for each data source.

Exhibit 7. Quantitative Data Sources for the MCP Transition Evaluation

Data Source	Geographic Availability	Use
Data Provided by DHCS		
Medi-Cal Enrollment Data	Transition counties only	Medi-Cal enrollment data contain member-level demographic and coverage information and were used to assess trends in member demographics and other characteristics.

Data Source	Geographic Availability	Use
Medi-Cal Managed Care Accountability Set (MCAS)	Transition and non-transition counties	Person-level MCAS files were used to analyze trends on outcomes pertaining to access, quality and continuity of care.
Medicaid and CHIP Core Sets of Health Care Quality measures (Core Set)	Transition and non-transition counties	Person-level Core Set files were used to analyze trends on outcomes pertaining to access, quality and continuity of care.
Provider 274 files	Transition counties only	Provider 274 files were used to assess network adequacy via member-to-provider ratios.

Target and Comparison Populations

Target Population: The target population consists of members enrolled for at least one month during the baseline period (January 2021 – December 2023) in the following 15 MCP Transition counties: Alameda, Butte, Colusa, Contra Costa, Glenn, Imperial, Mariposa, Nevada, Placer, Plumas, San Benito, Sierra, Sutter, Tehama, and Yuba. Due to data availability, the Interim Evaluation Report includes descriptive statistics for Medi-Cal members residing in the MCP Transition counties only.

Comparison Population: For the Summative Evaluation Report, NORC will explore the feasibility of constructing an appropriate comparison population comprised of Medi-Cal members from non-MCP Transition counties, with which to conduct impact analyses of the effect of the MCP transition. Throughout the process, NORC will work closely with the state to determine the full list of appropriate county-level, area-level, and member-level characteristics that will need to be considered to construct an appropriate comparison group.

Evaluation Measures

The quantitative evaluation measures were developed using data from the person-level MCAS and Core Set files, along with Provider 274 files. These measures are summarized in **Exhibit 8** and encompass key domains such as access to care, continuity of care, behavioral health,

maternal health, and preventive care. The construction of the numerator and denominator for each measure was based on technical specifications provided by CMS and/or NCQA/HEDIS.

Exhibit 8. Quantitative Measures for MCP Transition Evaluation

Measure Name	Data Set	Description	Numerator	Denominator
Well-child visits in the first 30 months of life	MCAS	Percentage of children who had the appropriate number of well-child visits with a PCP during the last 15 months. Separate rates are reported for children who turned ages 15 and 30 months within the measurement year.	The number of children in the eligible population with the appropriate number of well-child visits on different dates of service on or before the 15/30 month birthday.	Number of members in the eligible population.
Child and adolescent well-care visits	MCAS	Percentage of children ages 3 to 21 who had at least one comprehensive well-care visit with a PCP or an obstetrician/gynecologist (OB/GYN) during the measurement year.	Number of members in the eligible population with one or more well-care visits during the measurement year.	Number of members in the eligible population.

Measure Name	Data Set	Description	Numerator	Denominator
Prenatal and postpartum care	MCAS	• Timeliness of Prenatal Care: Percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment state date or within 42 days of enrollment. • Postpartum Care: Percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.	Prenatal care: A prenatal visit during the required time frame. Postpartum care: A postpartum visit on or between 7 and 84 days after delivery.	Members within the eligible population with a live birth. Members can count multiple times if they have multiple births.
Follow-up after ED visit for mental illness	MCAS	Percentage of emergency department (ED) visits for members ages 18 and older with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness within 7/30 days.	Number of eligible follow-up visits within 7 or 30 days of the eligible ED visit including visits that occur on the date of the ED visit.	Number of eligible ED visits with a principal diagnosis of mental illness or intentional self-harm.
MCP all-cause readmissions	MCAS	For members ages 18 to 64, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.	Number of observed 30-day readmissions.	Number of index hospital stays in the eligible population.

Measure Name	Data Set	Description	Numerator	Denominator
Immunizations for adolescents	Core Set	Percentage of adolescents aged 13 who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates.	Number of patients in the eligible population that are vaccine compliant.	Number of members in the eligible population.
Breast cancer screening	Core Set	Percentage of women ages 50 to 74 who had a mammogram to screen for breast cancer.	Number of members in the eligible population who had one or more mammograms any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year.	Number of members in the eligible population.
Member to provider ratio	Provider 274 files	The ratio of members to all active providers.	Number of members.	Number of all active providers.

Measure Name	Data Set	Description	Numerator	Denominator
PCP member to provider ratio	Provider 274 files	The ratio of members to active PCPs.	Number of members.	Number of active PCPs.
Specialist member to provider ratio	Provider 274 files	The ratio of members to active specialist providers.	Number of members.	Number of active specialists.
Outpatient mental health member to provider ratio	Provider 274 files	The ratio of members to active outpatient mental health providers (non-psychiatry: psychologists, LCSWs and LMFTs).	Number of members.	Number of outpatient mental health (non-psychiatry) providers contracting with MCP.

Statistical Analyses

Due to data availability, NORC restricted Interim Evaluation Report findings to quantitative descriptive analyses for the baseline period (January 2021 – December 2023), examining trends over time and pooled over baseline in member demographics and quality and access measures for the target population. For the Summative Evaluation Report, NORC will conduct impact analyses with a comparison group (if feasible), which will assess changes between the baseline and post-MCP transition periods across the target and comparison populations.

Descriptive Analyses. Descriptive statistics, including frequency distributions and rates over time, were calculated to highlight trends over time in member-level characteristics and quality and access measures. NORC conducted descriptive analyses for both member-level characteristics, to show changes in member populations over time within the target population, as well as for all measures (**Exhibit 6**). NORC conducted time-series analyses, tabulating data for each of the three years in the baseline period to assess changes over time. The time-series analyses were conducted for the MCP Transition counties in aggregate as well as separately for each of the 15 counties. Finally, in addition to annual trends, NORC pooled data across the entire baseline period to capture broader patterns and differences by county. For the Summative Evaluation Report, NORC will present the descriptive analyses across the implementation period.

Additional Analyses for the Summative Evaluation Report. The Summative Evaluation Report will include pre-post analyses to assess changes in outcomes before and after the MCP transition. Where feasible, it will also incorporate impact analyses using a difference-in-differences (DID) or comparative interrupted time series (CITS) design, pending the identification of a suitable comparison group. These models will estimate the effect of the MCP transition on access, quality, and continuity of care.

Subgroup Analysis. Recognizing that the impact of the MCP Transition may be heterogeneous across different member populations, in the Summative Evaluation Report, NORC will conduct subgroup analyses (where feasible) to evaluate whether and how program impacts vary, pending available data to construct appropriate subgroups. NORC will conduct subgroup evaluability assessments for the Summative Evaluation Report and confirm that all relevant assumptions (e.g., sample size) are met for any proposed statistical analyses within subgroups of interest. NORC will explore conducting subgroup analysis for both descriptive and impact analyses. NORC anticipates being able to conduct descriptive analyses for most if not all subgroups (pending available data for constructing relevant subgroups) by stratifying outcome frequencies by individual-level subgroup characteristics. However, the feasibility of conducting impact analyses by subgroups will be determined empirically based on sample size and outcome distributions.

Qualitative Evaluation Methods

In addition to the quantitative assessments described above, this Interim Evaluation Report presents data gathered from qualitative data collection and analysis of:

1. Document review of transition-related documentation; and
2. Key informant interviews with MCP officials and members of the DHCS SAC.

Analysis of interviews for Medi-Cal members within the 15 transition counties will be included in the Summative Evaluation Report.

Together, these qualitative data sources provide a deeper understanding of the scope and implementation of transition activities at the local level. They also offer valuable insight into how key stakeholder groups, including implementation partners, providers, and members, experienced the transition and perceived its effects on care access, quality, and continuity.

Primary data collection and document review focused on the MCP Transition implementation period (January 1, 2024 to December 31, 2026). Interview protocols included questions about pre-implementation activities and changes in member experiences before and after the transition. Similarly, the document review examined how MCPs and services were structured

both prior to and following the transition. While these retrospective, open-ended data offer important context for understanding the transition's implementation and early impacts, they do not constitute a formal pre/post assessment, as no qualitative data was collected prior to the transition.

Data Sources

MCP Transition-Related Documents

To better understand the components, context and status of the transition in each participating county, NORC reviewed select transition-related documentation generated by MCPs, the State, and other relevant groups, including Demonstration quarterly reports and documents that must be developed and made public by each transitioning MCP. These included Community Health Needs Assessments, Community Investment Plans, Community Health Improvement Plans, annual data reports, Population Needs Assessments, Quality Improvement Health Equity Workplans and Evaluations, CAHPS survey results, Transition Notifications, and third-party Memoranda of Understanding (MOUs)[6].

Priority was given to documents that provided comparable data across all transitioning counties. Publicly available materials were identified and collected through a structured web scan. This Interim Evaluation Report reflects the first round of document data collection and analysis. NORC will conduct further rounds of document review on an annual basis and collect and analyze additional, non-public documentation (e.g., Community Reinvestment Plans) on an ongoing basis as it is made available. Future analyses will be included in the Summative Evaluation Report.

Key Informant Interviews

NORC conducted semi-structured interviews with individuals from key groups directly involved in and/or affected by the MCP Transition process (i.e., MCP officials, providers, and members) as well as those advising on its rollout (i.e., DHCS SAC members).

These activities were designed to capture firsthand experiences and insights related to the transition, with a particular focus on care access, quality, and continuity.

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[6] DHCS (2023). *Understanding the 2024 Medi-Cal Managed Care Plan (MCP) Transition.* Prepared by the California Primary Care Association. December 12, 2023. Available at: https://www.dhcs.ca.gov/MCP-Transition/Documents/CPCA-MCP-Transition-Webinar-December-2023.pdf.

MCP Official Interviews

NORC conducted 60-minute group interviews with MCP officials in each MCP Transition county. In summer 2025, NORC contacted six MCPs for a voluntary interview and ultimately conducted interviews with three MCPs. These interviews assessed both the planned and actual transition-related activities, and to understand how these activities aligned with the objectives of the MCP Demonstration, particularly regarding care access and continuity.

Participants were selected through purposeful sampling, focusing on MCP leadership and other key roles involved in the transition. Recruitment was conducted via email using contact information securely obtained from DHCS. Interview discussions covered a range of topics, including outreach and enrollment strategies, investments in primary care and prevention, efforts to integrate behavioral health services, implementation of Community Reinvestment Plans, and engagement with Community Advisory Committees.

A second round of outreach will take place for interviews with MCPs during Year Two (i.e., summer 2026).

DHCS Stakeholder Advisory Committee Member Interviews

To further enrich the evaluation, NORC additionally aimed to conduct virtual interviews with members of the DHCS SAC. In Year One, NORC contacted sixteen stakeholders for voluntary interviews or group discussions. Several stakeholders declined or were unresponsive to outreach, and NORC was ultimately able to conduct one 1:1 interview. Potential participants were selected for outreach in consultation with DHCS, prioritizing those who have been actively engaged in transition-related SAC activities. Recruitment was conducted by email. The interview protocol explored community awareness and experiences of the transition, changes or interruptions in care and services, and the implementation and impact of Community Reinvestment Plans.

A second round of interviews with DHCS SAC members will be conducted in Year Three (i.e., summer 2027).

Qualitative Analysis

Directed Content Analysis of Secondary Data

NORC employed a direct content analytic approach to review and analyze documentation related to the transition. All available documentation was reviewed and coded, and relevant measures were constructed to support descriptive analysis. The resulting data were compiled into a county-level dataset designed to align with the evaluation's research questions and to inform the development of interview protocols. This analysis provides a summary of the transition's components, context, and status in each participating county, including how

members and providers were notified, provider recruitment strategies, county-level demographic profiles, priority health needs, and the presence of MOUs.

Rapid Thematic Analysis of Interviews

NORC conducted a thematic analysis of qualitative data collected through interviews with MCP representatives and DHCS SAC participants. The analytic process began with the development of a deductive codebook, grounded in the evaluation framework domains and qualitative hypotheses. This codebook was then refined inductively to incorporate emergent themes and insights that surfaced during the concurrent review of program documents.

To facilitate systematic coding and organization of both program documents and interview transcripts, NORC utilized Dedoose, a secure, cloud-based qualitative analysis platform. Coders who participated in interview data collection were also involved in the coding process, allowing them to apply contextual knowledge gained through direct engagement with participants.

METHODOLOGICAL LIMITATIONS

Evaluations of 1115 demonstrations require a flexible and adaptive approach, and NORC has encountered some limitations that may impact the interpretation of NORC's findings. First, NORC was limited in the availability of quality and access data. Due to data acquisition timelines, quantitative analyses in this report are limited to data reflecting the pre-transition baseline period (January 1, 2021 to December 31, 2023). The Summative Evaluation Report will assess the full implementation period for the MCP Transition (January 1, 2024 to December 31, 2026). Additionally, Provider 274 files were not available in the 2021 baseline year, impacting NORC's ability to fully capture baseline trends in these provider network measures. NORC were also not able to obtain data for both transition and non-transition counties for all analyses. Finally, NORC used pre-calculated person-level MCAS and Core Set data provided by DHCS to ensure alignment with the state's existing outcome measures and other published analyses. Due to differences in data availability across the MCAS and Core Set datasets, measures were derived from either dataset based on data quality and availability.).

In addition, efforts to resolve discrepancies in the data are still ongoing at the time of this reporting, including instances of partial or total duplicates in the MCAS data. NORC analyzed annual person-level MCAS data with values for measures that were summarized for each member for the year. A relatively small portion of individuals appeared in the dataset(s) multiple times within the same year, sometimes with different values in their summarized measure variables (it should be noted that event level data does go through a PMV audit process[7]). NORC suspects that some of these duplicates may be due to members switching MCPs, while others are potential data processing errors. The dataset did not contain an MCP identifier, therefore NORC was unable to ascertain the source of these duplicate records at this time. The duplicates make up 7.6 percent of the total quality and access data from the transition counties and affect 8.8 percent of unique individuals residing in the transition counties. However, analyses showed that baseline rates in quality and access metrics were very similar whether analyses excluded duplicates entirely or just used the earliest instance of the duplicate. Thus, for the Interim Evaluation Report, NORC removed all members with partial or

[7] As part of the PMV audit process, auditors assess for members being duplicated in the data when they should not be. For measures such as follow-up after ED visit for mental illness, members could be included more than once since those measures count events, and a member could qualify more than one time for the measured event (i.e., the ED visit).

total duplicate data from the analysis within each year. NORC will continue to work with DHCS to investigate data quality issues for the Summative Evaluation Report, including the proper deduplication of the summarized data. An additional limitation with the MCAS dataset is that MCAS data is reported by the MCPs, and, therefore, requires members to be continuously enrolled in the MCP to be included in the data. This requirement for continuous enrollment may exclude some members who changed MCPs, but who are still continuously enrolled in Medi-Cal.

Further, feedback gathered and analytic findings arising from interviews with MCPs and stakeholders reflect the input of those willing and able to participate within the timeframe allotted. Participation in these qualitative data collection activities was voluntary for both MCPs and stakeholders, and data collection was limited to late July through mid-September 2025. As a result, several stakeholders and some MCPs contacted did not respond or declined to participate.

NORC anticipates further methodological challenges will arise during the subsequent evaluation process for the Summative Evaluation Report. **Exhibit 9** outlines the anticipated challenges along with proposed mitigation strategies.

Exhibit 9. Anticipated Methodological Challenges and Proposed Mitigation Approaches

Challenge	Mitigation Approach
Timeliness and quality of enrollment and quantitative outcome data	» Work closely with DHCS data stewards to identify appropriate datasets for each measure and establish timelines for receiving the most recent data, keeping in mind additional time needed for administrative approval. » Schedule regular meetings with DHCS data stewards to quickly address and resolve any data quality issues.
Constructing a valid comparison group	» Assess data for available county-level, area-level, and member-level variables that would allow for the proper creation of a comparison group. » Select comparison counties based on eligibility for the MCP transition as well as key county-level characteristics (e.g., aggregate sociodemographic characteristics, rurality) to ensure NORC is selecting similar counties as comparators.

Challenge	Mitigation Approach
	» Use entropy balancing to weight comparison group members to be similar to members in MCP Transition counties on key characteristics in descriptive and impact analyses.
Non-parallel pre-intervention (baseline) trends, or insufficient data to establish a trend	» Assess baseline trends in transition and non-transition counties; if baseline trends are not parallel, conduct CITS analyses instead of DID analyses. » Decide on the appropriate level of analysis from available data (e.g., annual, quarterly, monthly) that will establish stable trends while retaining the most granular level of data to feasibly conduct analyses.
Potential bias introduced by primary data collection recruitment approach	» Employ multi-lingual outreach approach in English and Spanish for members. » Tailor data collection to allow interested individuals to participate by web or phone, offering technological support as needed with data collection platform (i.e., Zoom), including option to be called at time of interview. » Offer outside of business hours scheduling to accommodate participation outside of business/working hours. » For group interviews, offer participants the option of 1:1 conversations as needed to accommodate preferences and schedules.
Primary data collection respondent burden	» Thoroughly assess and leverage existing data sources (for example, program documents) before considering primary data collection. » Conduct primary data collection over videoconferencing rather than in person to be more flexible with respondents' time. » Compensate members for their time.
Primary data collection respondent recall bias	» Provide framing language to remind participants of timeline of transition and transition notification. » Focus interview topics on perceived changes arising during and after the transition occurred, allowing for feedback on changes observed over broader transition period.

Challenge	Mitigation Approach
	» Conduct primary data collection in the first half of 2025, to maximize recall.
Voluntary participation in qualitative data collection limits generalizability of insights to those willing and able to participate	» Develop and provide supplementary information about the evaluation (e.g., FAQ sheets, snapshot summaries of goals and objectives) in outreach communications to ensure participants are aware of evaluation goals, timelines, expectations from them as a participant, and data privacy and confidentiality protocols in place. » Offer flexibility in scheduling dates and times for focus groups and interviews; allow individuals expressing interest in focus group participant to provide feedback via 1:1 interview instead, if/where requested. » Send detailed scheduling correspondence and follow-up and reminder emails to boost participation.

RESULTS

The results presented in this report are derived from quantitative and qualitative data and presented by Demonstration goal. Trends in quality and access measures are provided for the baseline period of the MCP Transition (January 2021 – December 2023), and data from interviews with MCP officials and DHCS SAC members present the early implementation experience of transition counties.

Goal 1: Maintain or improve overall access to and continuity of care

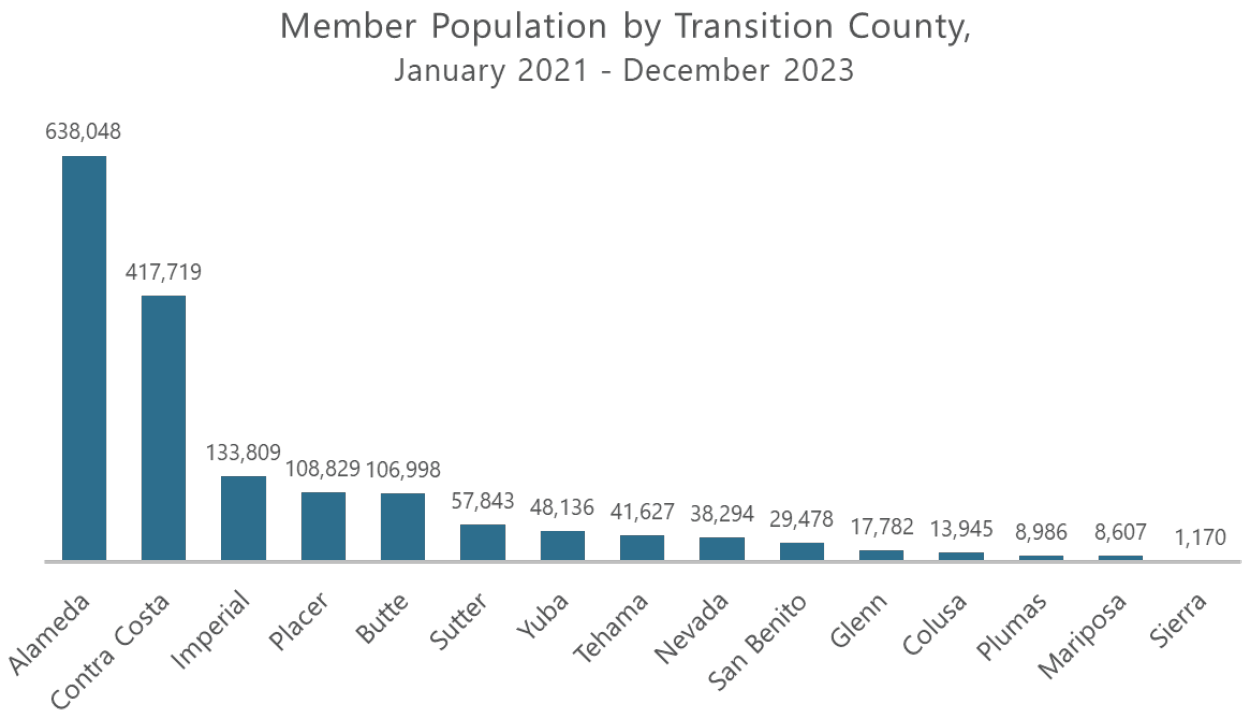
This section presents results on access and continuity of care experienced by transition county members. NORC first shows the demographic characteristics of members residing in the transition counties during the baseline period, then present quality and access metrics over the baseline period and member perceptions of access to preventative and ambulatory health services, behavioral health services, and continuity of care.

Member Demographics

NORC began the evaluation of the MCP Transition by examining the demographic characteristics of members residing in the transition counties. In this section, NORC presents information on member characteristics during the baseline period, and in the Summative Evaluation Report, NORC will contrast the demographic distributions during the baseline period to those observed during the implementation period. Due to data availability, the Interim Evaluation Report includes demographic data for the transition counties only; differences between transition and non-transition counties will be examined in the Summative Evaluation Report.

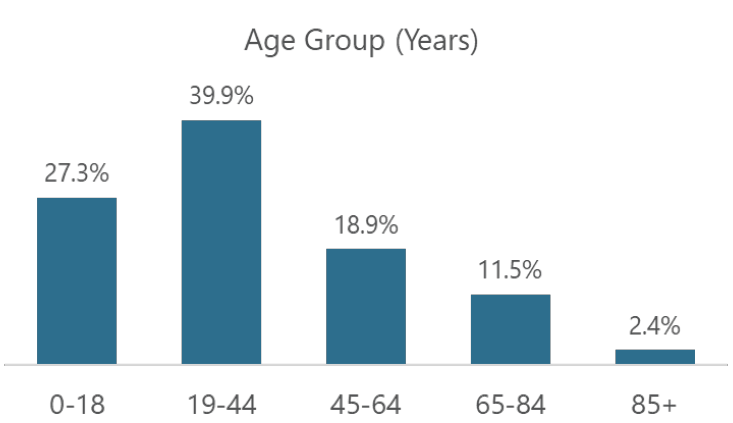
Overall there were 1,671, 271 unique members who resided within the MCP Transition counties and were enrolled in Medi-Cal for at least one month during the baseline period (**Exhibit 10**).

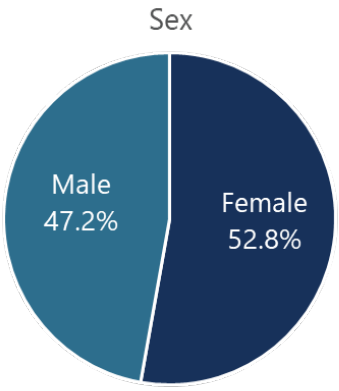
Exhibit 10. Member populations were highest in Alameda, Contra Costa, and Imperial counties, and lowest in Plumas, Mariposa, and Sierra counties.

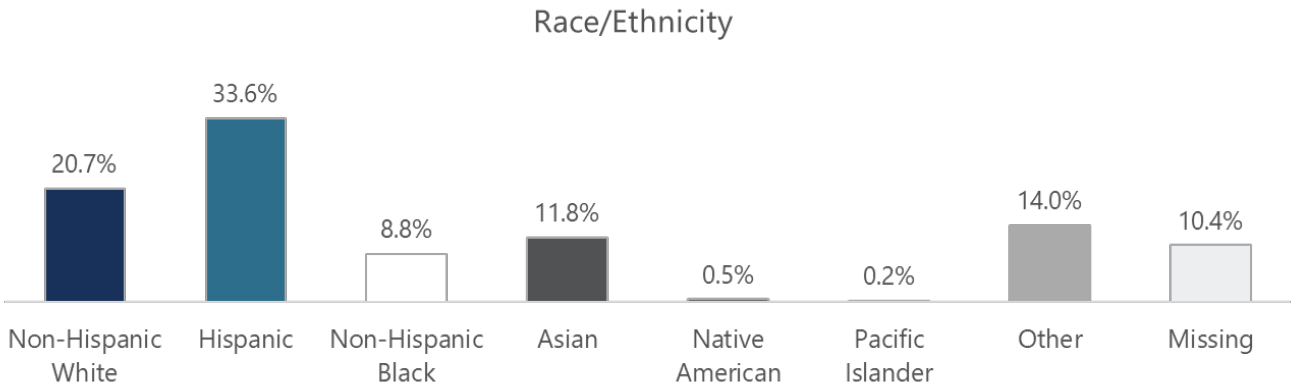


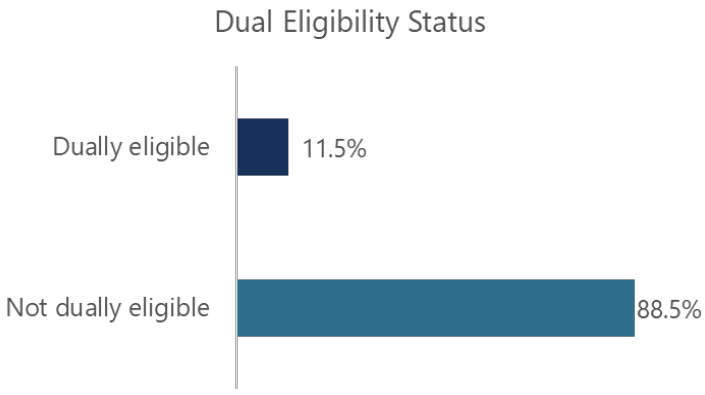
Pooled across the three years of the baseline period, the majority of members were 19 to 44 years old (39.9 percent of the member population), and 0 to 18 years old (27.3 percent). NORC observed a slight majority of female members at 52.8 percent, with male members comprising 47.2 percent. Hispanic members made up the largest racial and ethnic group at 33.6 percent, while non-Hispanic White and Asian members represented 20.7 percent and 11.8 percent of all members, respectively. A total of 67.4 percent of members reported English as their primary language. Additionally, 11.5 percent of members were dually eligible for both Medicare and Medicaid for at least one month during the baseline period. Member demographics were stable year over year in the baseline period across the transition counties (see **Appendix A.**), with the largest change being a slight decrease in the percent of non-Hispanic White members (from 21.6 in 2021 to 19.7 percent in 2023) and a corresponding increase in the percent of Hispanic members (34.2 percent in 2021 to 36.6 percent in 2023). **Exhibit 11** presents a summary of member demographics across the transition counties for the baseline period.

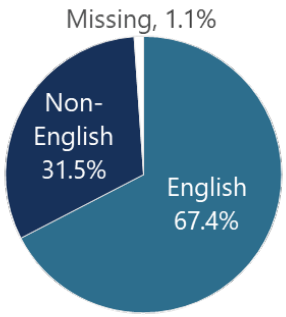
Exhibit 11. Members across the transition counties during the baseline period (January 2021 – December 2023) were predominantly 19-44 years old, Hispanic, and not dually eligible for Medicare and Medicaid.











County Level Demographic Characteristics

At baseline, NORC identified notable variations in member demographics by transition county.

Age Group. The 19–44 yr. age group comprised the largest proportion of members in nearly all transition counties, accounting for between 33 percent (in Sierra County) and 41 percent (Butte County) of the total population. Butte, San Benito, and Nevada Counties had the largest proportion of this age group (41.3, 40.6, and 40.5 percent, respectively). Colusa, Glenn, and Yuba Counties reported the highest percentage of members from 0-18 years old (35.0, 33.9, and 32.9 percent, respectively). In contrast, there was more variability in the proportion of members in the 65–84 yr. age group across counties. Sierra County (17.6 percent) and Plumas County (13.5 percent) reported higher proportions of older members, while in contrast, San Benito (7.8 percent) and Placer (9.9 percent) showed comparatively lower proportions of seniors.

Sex. Female members comprised a slight majority across all transition counties, ranging from 50.4 percent in Mariposa County to 53.8 percent in Imperial County. Counties with the next highest proportions of female members were Contra Costa (53.6 percent) and Colusa (53.3 percent) Counties.

Race/Ethnicity. Hispanic members constituted the largest racial/ethnic group in several counties, with particularly high representation in Imperial (82.5 percent), Colusa (67.7 percent), San Benito (68.4 percent), and Glenn (51.0 percent) Counties. Non-Hispanic White members represented the majority in Sierra (70.8 percent), Plumas (68.8 percent), Nevada (67.8 percent), and Mariposa (66.5 percent) Counties.

Dual Eligibility Status. Less than 25 percent of members across all transition counties were dually eligible for Medicare and Medicaid for at least one month during the baseline period, with percentages ranging from 8.6 percent in San Benito County to 21.4 percent in Sierra County. In addition to Sierra County, Plumas, Mariposa, and Imperial Couties also reported relatively high proportions of dually eligible members (15.6, 14.1, and 13.9 percent, respectively).

Primary Language. Across all but one transition county, English was the predominant language among members. Mariposa, Plumas, Nevada, and Sierra Counties reported the highest proportions of English-speaking members (95.0, 94.5 92.6 and 93.0 percent, respectively). In contrast, Imperial County was the only county with majority non-English speakers, where 56.7 percent of members spoke Spanish (75,833 out of 133,809 total members). The counties with the next highest percentages of non-English speakers were Colusa, San Benito, and Alameda (at 46.7, 38.0, and 36.6 percent non-English speakers and 46.5 [6,478 out of 13,945], 37.5 [11,042 out of 29,478], and 23.1 [147,530 out of 638,048] percent Spanish speakers, respectively).

County Priority Health Needs

In reviewing publicly available documentation (i.e., Community Health Improvement Plans, Community Health Needs Assessments, and Population Needs Assessments), NORC was able to identify self-reported priority health needs for 15 transition counties. This information is summarized in **Exhibit 12** below.

Exhibit 12. Transition Counties and Corresponding Priority Health Needs Reported in Publicly Available Documentation

County	2024 MCP(s)	Priority Health Needs Identified
Alameda	Alameda Alliance for Health Kaiser Permanente	Access to care, behavioral health, community safety, employment, and housing.[8]
Butte	Partnership Health Plan of California	Access to care, behavioral health, community safety, food security, housing, employment, and income security.[9]
Colusa	Partnership Health Plan of California	Access to care, behavioral health (e.g., ACEs prevention and response), economic opportunity and sustainability, and environmental health risks.[10]
Contra Costa	Contra Costa Health Plan Kaiser Permanente	Behavioral health, and chronic disease management (i.e., asthma, diabetes, cardiovascular disease, obesity).[11]
Glenn	Partnership Health Plan of California	Access to care, behavioral health (e.g., ACEs), community safety, income security, medical provider shortages, and transportation.[12]

[8] https://acphd-web-media.s3-us-west-2.amazonaws.com/media/programs-services/chip/docs/community-health-improvement-plan-2023-25.pdf
[9] https://www.buttecounty.net/DocumentCenter/View/12035/Butte-County-Community-Health-Assessment-Revised-on-April-20-2024-PDF?bidId=
[10] https://acrobat.adobe.com/id/urn:aaid:sc:va6c2:786755c1-f220-46c6-ac69-bcbf0175a14a
[11] https://www.cchealth.org/home/showpublisheddocument/32241/638911007644870000
[12] https://www.canva.com/design/DAGJdHCipAA/k754x3-yUGFlDeQGt6qqlQ/view?utm_content=DAGJdHCipAA&utm_campaign=designshare&utm_medium=link&utm_source=editor#1

County	2024 MCP(s)	Priority Health Needs Identified
Imperial	Community Health Plan of Imperial Valley Kaiser Permanente	Access to care, behavioral health, child and family health[13], chronic disease management (e.g., diabetes)[14], and community safety.[15]
Mariposa	Central California Alliance For Health Kaiser Permanente	Access to care, behavioral health, chronic disease management, child and family health, housing and homelessness, health equity and SDOH, and maternal health.[16]
Nevada	Partnership Health Plan of California	Child and family health (e.g., vaccinations), comprehensive healthcare and social services, and affordable early learning and care programs.[17]
Placer	Partnership Health Plan of California	Aging and older adult health, built environment, and lifestyle and preventative health concerns.[18]
Plumas	Partnership Health Plan of California	Access to care, behavioral health (e.g., substance use and overdose, and suicide), chronic disease management (e.g., cancer, diabetes, heart disease, and kidney disease), environmental health (e.g., air quality), community safety (e.g., accidents and injuries), and food insecurity and hunger.[19]
San Benito	Central California Alliance for Health Partnership Health Plan of California	Access to care, behavioral health (e.g., mental health and substance use services, stigma reduction, and integrated care), early childhood development, and parenting supports across health and service sectors.[20]

[13] https://chpiv.org/wp-content/uploads/2024/03/QIHEC-Agenda-4.10.24.FULL_.pdf
[14] https://chpiv.org/wp-content/uploads/2024/03/QIHEC-Agenda-4.10.24.FULL_.pdf
[15] https://www.icphd.org/assets/CHACHIP/Reports/CHIP/2024-27-Imperial-County-Community-Health-Improvement-Plan.pdf
[16] https://www.mariposacounty.org/2163/Community-Health-Assessment-CHA
[17] https://www.nevadacountyca.gov/DocumentCenter/View/55580/Nevada-County-Community-Health-Improvement-Plan-2025-2027
[18] https://www.placerdashboard.org/content/sites/placer/Placer_County_Community_2024-2029_Health_Improvement_Plan_v2.pdf
[19] https://www.plumascounty.us/DocumentCenter/View/47101/Plumas-County-CHIP-2023-Final?bidId=
[20] https://hhsa.cosb.us/wp-content/uploads/2024/10/SBC_CHIP.pdf

County	2024 MCP(s)	Priority Health Needs Identified
Sierra	Partnership Health Plan of California	Access to care, behavioral health (e.g., tobacco use and vaping), community supports (e.g., recreational activity), and food and nutrition access.[21]
Sutter	Partnership Health Plan of California Kaiser Permanente	Behavioral health (e.g., ACEs), food and nutrition access, community resilience, housing and homelessness, and reducing STIs.[22]
Tehama	Partnership Health Plan of California	Access to care, behavioral health (e.g., mental health and substance abuse prevention), and food and nutrition access.[23]
Yuba	Partnership Health Plan of California Kaiser Permanente	Access to care, behavioral health, the built environment, and community safety.[24]

Access to Care

As measures of access to care, NORC examined member-to-provider ratios for all physicians as well as for PCP and specialists (**Exhibit 13**). Due to data limitations, NORC was only able to include data for 2022 and 2023, as this data was not collected in 2021. In the Interim Evaluation Report, NORC is presenting data only for the transition counties, but in the Summative Evaluation Report NORC will compare ratios for transition versus non-transition counties. The ratio of members to physicians overall across the transition counties increased from 21.2 in 2022 to 24.1 in 2023. Across counties, there was wide variation in this ratio, which when averaged across the baseline period, ranged from 17.4 in Contra Costa County and 17.9 in Placer County to 250.2 in San Benito County and 312.0 in Tehama County (see **Appendix B.**).

[21] https://sierracounty.ca.gov/DocumentCenter/View/9346/Community-Health-Assessment-CHA-2023
[22] https://www.suttercounty.org/home/showpublisheddocument/6770/638339306743730000
[23] https://www.tehamacohealthservices.net/wp-content/uploads/2025/07/Tehama-CHIP.pdf
[24] https://cms7files.revize.com/yubaca/Yuba%20County%20CHIP%20-%20FINAL.pdf

Exhibit 13. The ratio of members to total physicians and to specialists increased from 2022 to 2023, but the ratio of members to PCPs decreased over the two years.

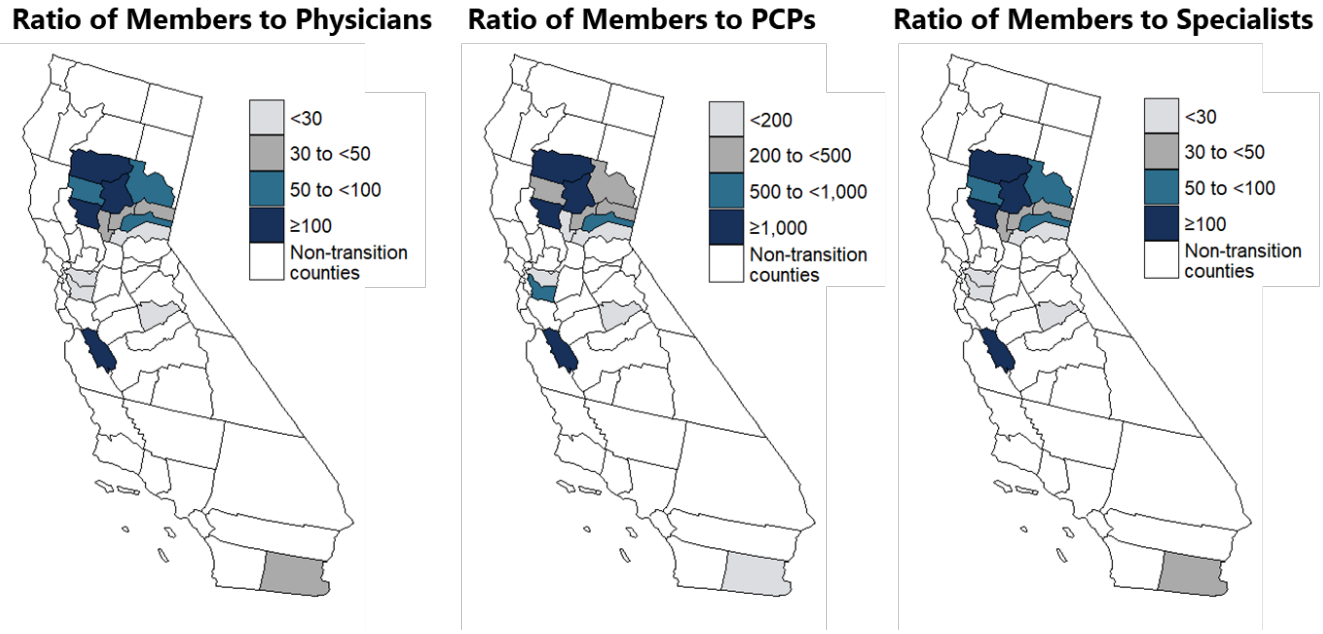
Year	Total Number of Members	All Physicians		PCPs		Specialists	
		Total FTE Physicians	Ratio of Members to Physicians	Total FTE PCPs	Ratio of Members to PCPs	Total FTE Specialists	Ratio of Members to Specialists
2022	976,990	46,112.0	21.2	2,835.1	344.6	36,716.7	26.6
2023	1,049,760	43,542.4	24.1	5,690.4	184.5	36,183.1	29.0
Pooled baseline	2,026,750	89,654.4	22.6	8,525.5	237.7	72,899.8	27.8

NOTE: The total number of members/providers refers to the total number of members/providers across all MCP Transition counties. Ratios for the pooled baseline represent averages of the yearly ratios, weighted by the number of physicians, PCPs, or specialists. FTE=full-time equivalent.

Ratio of members to PCPs showed wide variation between the two baseline years as well as between county. The counties with the highest PCP access (i.e., lowest baseline ratios of members to PCPs) were Mariposa (45.9), Placer (69.8), and Imperial (142.1) Counties, while the counties with the lowest access (highest ratios) were Tehama (1,252.4), Colusa (1,399.8), San Benito (1,850.2), and Butte Counties (2,199.9). Overall, across counties, the ratio of members to PCPs decreased from 344.6 in 2022 to 184.5 in 2023. The ratio of members to specialists showed a similar pattern by county.

Overall, NORC saw similar patterns across transition counties regarding access to physicians, PCPs, and specialists (**Exhibit 14**). Access fell roughly along urban and rural divides, with urban counties generally reporting greater access, with some exceptions. Alameda, Contra Costa, Placer, and Mariposa all reported greater provider access, but Mariposa was the only rural county of that group. Of the counties reporting lower access (Colusa, Butte, San Benito, and Tehama), Butte was the only urban county.

Exhibit 14. Member to provider ratios varied between MCP Transition counties but showed similar patterns by county across the three ratio measures.



Qualitative rapid analysis of managed care plan interviews underscored that MCPs believed the transition would improve overall access to care for members in effected counties, citing ease of authorization processes and lower denial rates among COHS and Single Plan Counties.

> *"Ultimately, it's better for the health of Californians to have less people in commercial insurance. [Now] all of the dollars that come into our community go directly back to our community through our county infrastructure, and it's going to providers."* – Health Plan Interview

Preventative and Ambulatory Health Services

This section describes rates in preventive and ambulatory health services during the baseline period. The measures derived from MCAS and Core Set datasets are the only ones for which NORC has data for transition and non-transition counties, so NORC presents results for both groups of counties, as well as the state overall. For additional details on baseline rates for each transition county, please see **Appendix C**. The Summative Evaluation Report will include member perceptions of their access to such services. NORC hypothesized that the Demonstration will maintain or improve access to preventive/ ambulatory health services, including rates of well-child visits, immunizations for adolescents, and timeliness of prenatal and postpartum care.

Well-Child Visits

Well-child visits at 15 and 30 months (**Exhibit 15**) both increased over the baseline period, for transition as well as non-transition counties. The percentage of children with 6 or more well-child visits at 15 months increased from 48.1 percent in 2021 to 59.6 percent in 2023 in transition counties, and the percentage with 2 or more well-child visits at 30 months increased from 63.6 percent in 2021 to 70.1 percent in 2023 in transition counties. During the baseline period, the percentage of children with appropriate well-child visits at both 15 and 30 months in the transition counties were higher than the corresponding percentages in the non-transition counties.

Exhibit 15. Rates of well-child visits at 15- and 30-months increased over the baseline period and were higher in transition versus non-transition counties.

Year	Transition Counties			Non-Transition Counties			Statewide		
15 months									
	Members turning 15 months during the MY	Had 6 or more well-child visits in MY	%	Members turning 15 months during the MY	Had 6 or more well-child visits in MY	%	Members turning 15 months during the MY	Had 6 or more well-child visits in MY	%
2021	5,977	2,877	48.1	89,943	35,755	39.8	95,920	38,632	40.3
2022	6,016	3,245	53.9	87,294	43,030	49.3	93,310	46,275	49.6
2023	6,011	3,583	59.6	85,205	45,325	53.2	91,216	48,908	53.6
Pooled baseline	18,004	9,705	53.9	262,442	124,110	47.3	280,446	133,815	47.7
30 months									

	Members turning 30 months during the MY	Had 2 or more well-child visits in MY	%	Members turning 30 months during the MY	Had 2 or more well-child visits	%	Members turning 30 months during the MY	Had 2 or more well-child visits in MY	%
2021	14,220	9,048	63.6	170,760	102,472	60.0	184,980	111,520	60.3
2022	14,287	9,740	68.2	169,868	108,827	64.1	184,155	118,567	64.4
2023	13,586	9,522	70.1	162,240	107,779	66.4	175,826	117,301	66.7
Pooled baseline	42,093	28,310	67.3	502,868	319,078	63.5	544,961	347,388	63.7

NOTES: Values for the pooled baseline indicate the total number of infants in the eligible population that received well child visits over the entire baseline period. MY=measurement year.

Across the transition counties, seven of the fifteen had baseline rates of 15-month well-child visits (pooled over the entire period) between 50 and 60 percent, while only Mariposa County was below 30 percent (17.9 percent). Two counties (Contra Costa and Sutter) achieved rates greater than 60 percent. For 30-month well-child visits, most counties fell within the 50–70 percent range, with three counties exceeding 70 percent (Colusa, Tehama, and Sutter, the latter of which also achieved high 15-month well-child visit rates). Two counties, Plumas and Mariposa, were below 50 percent for 30-month well-child visit rates.

Child and Adolescent Well-Care Visits

Rates of child and adolescent well-care visits were relatively stable year over year during the baseline period and were also similar between the transition and non-transition counties. Over the entire baseline period, child and adolescent well-care visit rates were 48.2 percent in transition counties, and 48.0 percent in non-transition counties and statewide (**Exhibit 16**).

Exhibit 16. Rates of child and adolescent well-care visits were stable during the baseline period.

Year	Transition Counties			Non-Transition Counties			Statewide		
	Members ages 3-21 in the MY	Had at least one well-care visit during MY	%	Members ages 3-21 in the MY	Had at least one well-care visit during MY	%	Members ages 3-21 in the MY	Had at least one well-care visit during MY	%
2021	322,105	155,296	48.2	3,876,769	1,839,376	47.4	4,198,874	1,994,672	47.5
2022	338,653	160,339	47.3	4,019,096	1,888,436	47.0	4,357,749	2,048,775	47.0
2023	323,292	158,394	49.0	3,946,627	1,954,821	49.5	4,269,919	2,113,215	49.5
Pooled baseline	984,050	474,029	48.2	11,842,492	5,682,633	48.0	12,826,542	6,156,662	48.0

NOTES: Numerator and denominator values for the pooled baseline represent person-years, not the number of unique members, since members could count in the numerator and denominator multiple times over the 3-year baseline period. Thus, the pooled baseline represents the total number of person-years with a well-child visit out of the total number of person-years eligible for screening. MY=measurement year.

Of the fifteen transition counties, only Colusa exceeded 60 percent for child and adolescent well-care visits, while two neighboring counties, Alameda and Contra Costa, achieved rates between 50–60 percent. Most (eight) counties were in the 40–50 percent range, while Plumas and Sierra Counties had the lowest rates at 23.7 and 25.4 percent, respectively.

Immunizations for Adolescents

Immunization rates (**Exhibit 17**) for the meningococcal vaccine were relatively stable from 2021-2022, but dropped in 2023 for both transition and non-transition counties (70.5 percent in 2021 to 61.7 percent in 2023 for transition counties), and were slightly lower for transition compared to non-transition counties for all baseline years. Immunization rates for tetanus, diphtheria toxoids and acellular pertussis (TDAP) were relatively high at around 81

percent, remained stable throughout the baseline period, and were comparable between transition and non-transition counties. Immunization for human papillomavirus (HPV) began at about 36 percent for transition and non-transition counties in 2021 and increased to 39.6 percent for transition counties and 38.6 percent in non-transition counties by 2023. Vaccine rates for Combination 1 (comprising meningococcal and TDAP vaccines) were only available for 2023 and were 59.8 percent in transition counties and 63.1 percent in non-transition counties. Vaccine rates for Combination 2 (comprising meningococcal, TDAP, and HPV vaccines) remained at around 34 percent for both the transition and non-transition counties and over each year of the baseline period.

Exhibit 17. Immunization rates for adolescents were generally stable over the baseline period and between transition and non-transition counties.

Year	Transition Counties			Non-Transition Counties			Statewide		
	Adolescents who turned 13 during MY	Had the given vaccine	Rate	Adolescents who turned 13 during MY	Had the given vaccine	Rate	Adolescents who turned 13 during MY	Had the given vaccine	Rate
Meningococcal Vaccine									
2021	18,074	12,744	70.5	212,237	153,368	72.3	230,311	166,112	72.1
2022	22,391	15,892	71.0	252,408	182,711	72.4	274,799	198,603	72.3
2023	22,352	13,783	61.7	250,657	163,276	65.1	273,009	177,059	64.9
Pooled baseline	62,817	42,419	67.5	715,302	499,355	69.8	778,119	541,774	69.6
TDAP									
2021	18,074	14,175	78.4	212,237	168,485	79.4	230,311	182,660	79.3
2022	22,391	18,346	81.9	252,408	208,946	82.8	274,799	227,292	82.7
2023	22,352	18,215	81.5	250,657	208,720	83.3	273,009	226,935	83.1

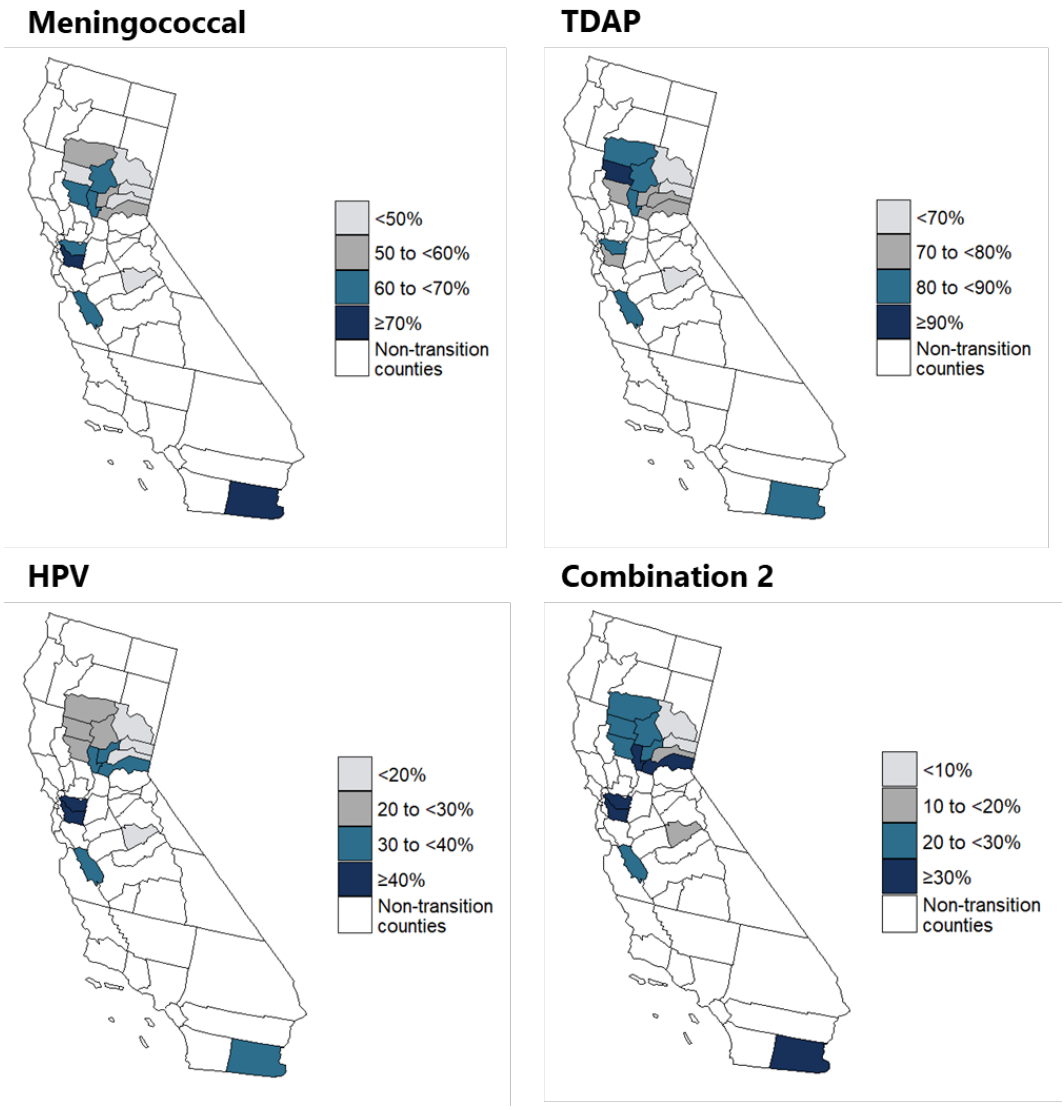
Year	Transition Counties			Non-Transition Counties			Statewide		
	Adolescents who turned 13 during MY	Had the given vaccine	Rate	Adolescents who turned 13 during MY	Had the given vaccine	Rate	Adolescents who turned 13 during MY	Had the given vaccine	Rate
Pooled baseline	62,817	50,736	80.8	715,302	586,151	81.9	778,119	636,887	81.8
HPV									
2021	18,074	6,500	36.0	212,237	76,844	36.2	230,311	83,344	36.2
2022	22,391	8,806	39.3	252,408	92,810	36.8	274,799	101,616	37.0
2023	22,352	8,844	39.6	250,657	96,779	38.6	273,009	105,623	38.7
Pooled baseline	62,817	24,150	38.4	715,302	266,433	37.2	778,119	290,583	37.3
Combination 1									
2023	22,352	13,362	59.8	250,657	158,150	63.1	273,009	171,512	62.8
Combination 2									
2021	18,074	5,851	32.4	212,237	71,069	33.5	230,311	76,920	33.4
2022	22,391	8,168	36.5	252,408	86,712	34.4	274,799	94,880	34.5
2023	22,352	7,660	34.3	250,657	85,418	34.1	273,009	93,078	34.1
Pooled baseline	62,817	21,679	34.5	715,302	243,199	34.0	778,119	264,878	34.0

NOTES: The meningococcal vaccine indicates receiving at least one meningococcal serogroups A, C, W, Y vaccine with a date of service on or between the adolescent's 11th and 13th birthdays. TDAP indicates receiving at least one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine with a date of service on or between the adolescent's 10th and 13th birthdays. HPV indicates receiving at least two HPV vaccines on or between the child's 9th and 13th birthdays and with dates of service at least 146 days

apart, *or* at least three HPV vaccines with different dates of service on or between the adolescent's 9th and 13th birthdays. Combination 1 comprises the meningococcal and TDAP vaccines, and data was only available for 2023. Combination 2 comprises the meningococcal, TDAP, and HPV vaccines. Values for the pooled baseline indicate the total number of members receiving vaccines out of the total number eligible for a vaccine. HPV=human papillomavirus; MY=measurement year; TDAP=tetanus, diphtheria toxoids and acellular pertussis.

Exhibit 18 shows the aggregate baseline rates for meningococcal, TDAP, HPV, and Combination 2 vaccination among eligible adolescents by county. Of the fifteen transition counties, only two (Alameda and Imperial) achieved rates greater than 70 percent for meningococcal vaccine. Five counties achieved rates of 60-70 percent, including a cluster of 3 neighboring counties (Colusa, Sutter, Butte). Sutter and Butte also achieved high TDAP vaccination rates. Glenn County was the only county that exceeded 90 percent for TDAP vaccination, despite having relatively low vaccination rates for the other conditions. Sutter, Alameda, and Contra Costa had the highest rates of HPV and Combination 2 vaccinations among transition counties. Sierra, Plumas, and Mariposa Counties consistently had the lowest vaccination rates for all three individual conditions and Combination 2.

Exhibit 18. Vaccination rates at baseline varied by transition county, with Sierra, Plumas, and Mariposa Counties having the lowest vaccination rates.



NOTES: The meningococcal vaccine indicates receiving at least one meningococcal serogroups A, C, W, Y vaccine with a date of service on or between the adolescent's 11th and 13th birthdays. TDAP indicates receiving at least one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine with a date of service on or between the adolescent's 10th and 13th birthdays. HPV indicates receiving at least two HPV vaccines on or between the child's 9th and 13th birthdays and with dates of service at least 146 days apart, *or* at least three HPV vaccines with different dates of service on or between the adolescent's 9th and 13th birthdays. Combination 2 comprises the meningococcal, TDAP, and HPV vaccines. HPV=human papillomavirus; TDAP=tetanus, diphtheria toxoids and acellular pertussis.

Timeliness of Prenatal and Postpartum Care

Rates of receiving prenatal care in the first trimester (**Exhibit 19**) were high at about 87 percent for both transition and non-transition counties, although they did drop slightly in 2023 (to 85.9 percent in transition counties and 85.2 percent in non-transition counties). Rates of postpartum care were stable throughout the baseline period and slightly higher for transition versus non-transition counties (83.1 versus 80.3 percent, respectively, pooled over the baseline period).

Exhibit 19. Rates of prenatal care were slightly higher than rates of postpartum care, but both rates were stable during the baseline period for transition and non-transition counties.

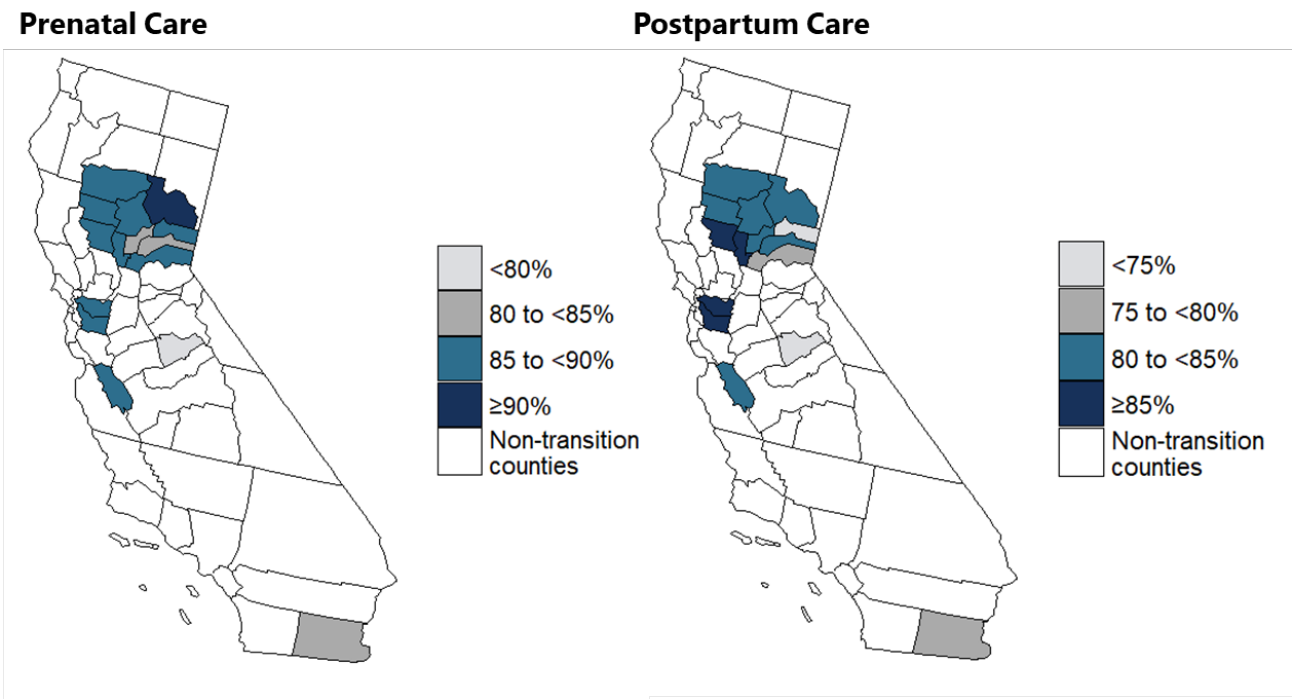
Year	Transition Counties			Non-Transition Counties			Statewide		
Prenatal Care During the First Trimester									
	Live births	Had a prenatal visit in first trimester	%	Live births	Had a prenatal visit in first trimester	%	Live births	Had a prenatal visit in first trimester	%
2021	2,467	2,180	88.4	14,234	12,419	87.2	16,701	14,599	87.4
2022	2,125	1,863	87.7	14,721	12,810	87.0	16,846	14,673	87.1
2023	2,090	1,796	85.9	18,182	15,497	85.2	20,272	17,293	85.3
Pooled baseline	6,682	5,839	87.4	47,137	40,726	86.4	53,819	46,565	86.5
Postpartum Care									
	Live births	Had a postpartum visit	%	Live births	Had a postpartum visit	%	Live births	Had a postpartum visit	%
2021	2,467	2,028	82.2	14,234	11,470	80.6	16,701	13,498	80.8
2022	2,125	1,778	83.7	14,721	11,825	80.3	16,846	13,603	80.7

Year	Transition Counties			Non-Transition Counties			Statewide		
2023	2,090	1,745	83.5	18,182	14,557	80.1	20,272	16,302	80.4
Pooled baseline	6,682	5,551	83.1	47,137	37,852	80.3	53,819	43,403	80.6

NOTES: Postpartum visits had to occur on or between 7 and 84 days after delivery. Values for the pooled baseline indicate the total number of live births receiving prenatal and postpartum visits out of the total number of live births eligible for these visits.

Across transition counties, all fifteen counties generally had high rates of prenatal visits in the first trimester, ranging from 77.8% in Mariposa County to 94.5% in Plumas County, with most counties achieving between 85-90%. However, two counties with relatively high prenatal visit rates (Placer, 89.6%, and Glenn, 89.6%) also had relatively lower postpartum visit rates (Placer, 77.2% and Glenn, 81.3%). Postpartum visit rates by county varied from Sierra at 62.5% to Alameda at 87.0%, with most counties achieving between 75-85% (**Exhibit 20**).

Exhibit 20. Most counties achieved between 85-90% prenatal visit rates during the first trimester, and between 75-85% postpartum visit rates.



NOTE: Postpartum visits had to occur on or between 7 and 84 days after delivery.

Behavioral Health Services

This section describes baseline access to behavioral health services and the MCPs' strategies for behavioral health coordination. From the qualitative interviews, NORC learned that MCPs established and expanded communication channels with county behavioral health departments and specialty mental health providers. Key strategies included monthly meetings, closed-loop referral tracking, and shared health information exchanges. NORC hypothesize that the Demonstration will maintain or improve access to behavioral health services, including rates of follow up after ED visit for mental illness and non-specialty mental health member-to-provider ratios.

Follow up After Emergency Department Visits for Mental Illness

Follow-up rates within 7 days of an ED visit for mental illness (**Exhibit 21**) varied over the baseline years and were generally higher in transition counties than non-transition counties. In the transition counties, 7-day follow-up rates increased from 24.1 percent in 2021 to 39.9 percent in 2022, but dropped to 32.1 percent in 2023. Follow-up rates within 30 days showed the same increase in 2022 for both transition and non-transition counties, and were also generally higher for transition counties than non-transition counties.

Exhibit 21. Follow-up rates after an ED visit for mental illness showed an increase in 2022 and were generally higher for transition counties than non-transition counties.

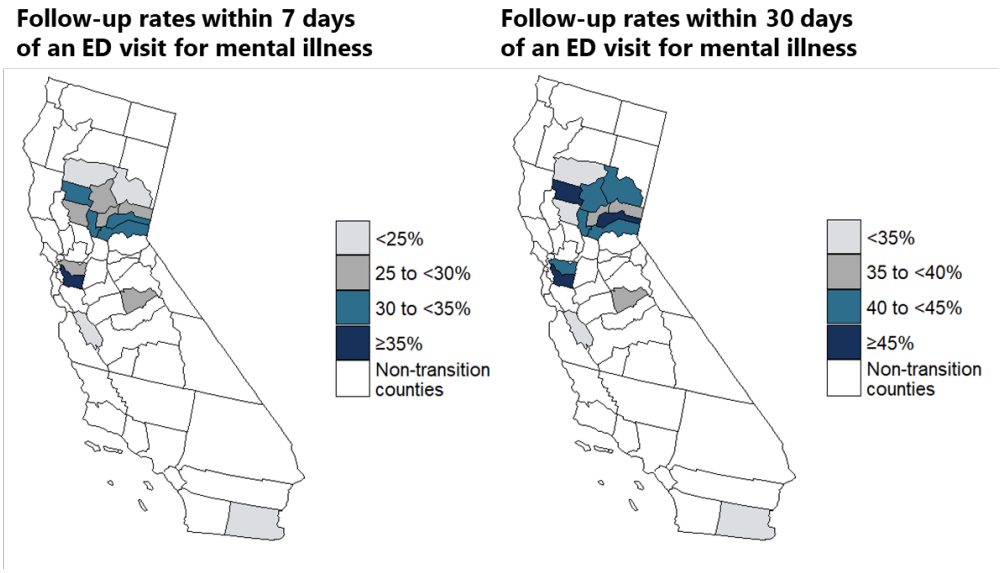
Year	Transition Counties			Non-Transition Counties			Statewide		
	Number of ED visits	Number of visits with follow-up	%	Number of ED visits	Number of visits with follow-up	%	Number of ED visits	Number of visits with follow-up	%
Within 7 Days									
2021	4,585	1,107	24.1	46,049	10,659	23.1	50,634	11,766	23.2
2022	4,698	1,873	39.9	49,077	16,344	33.3	53,775	18,217	33.9
2023	4,895	1,572	32.1	53,806	13,380	24.9	58,701	14,952	25.5

Year	Transition Counties			Non-Transition Counties			Statewide		
	Number of ED visits	Number of visits with follow-up	%	Number of ED visits	Number of visits with follow-up	%	Number of ED visits	Number of visits with follow-up	%
Pooled baseline	14,178	4,552	32.1	148,932	40,383	27.1	163,110	44,935	27.5
Within 30 Days									
2021	4,585	1,565	34.1	46,049	16,085	34.9	50,634	17,650	34.9
2022	4,698	2,420	51.5	49,077	22,940	46.7	53,775	25,360	47.2
2023	4,895	2,245	45.9	53,806	20,222	37.6	58,701	22,467	38.3
Pooled baseline	14,178	6,230	43.9	148,932	59,247	39.8	163,110	65,477	40.1

NOTES: The eligible population is defined as members age 18 and older. ED visits in the denominator have a principal diagnosis of mental illness or self-harm. Values for the pooled baseline indicate the total number of mental health ED visits that occurred during the baseline period that received follow-up.

Exhibit 22 shows the variation by county in the follow-up rates within 7 days and 30 days of an ED visit for mental illness. For follow-up within 7 days, six of the fifteen transition counties fell within the 25–30 percent range. A smaller number of counties achieved slightly higher rates, between 30–35 percent, with one county (Alameda) exceeding 35 percent. Four counties with higher 7-day follow-up rates (between 30-35 percent), were geographically clustered: Glenn, Nevada, Placer, and Sutter. Regarding 30-day follow-up rates, most counties fell within the 35 to 45 percent range, with three counties achieving rates above 45 percent (Alameda, Nevada, and Glenn – all three of which also had high 7-day follow-up rates). Tehama, San Benito, and Imperial reported the lowest rates of both 7-day and 30-day follow-up. Rates of 30-day follow-up exceeded rates of 7-day follow-up by 7 percent in Mariposa to 22 percent in Plumas.

Exhibit 22. Most transition counties had 7-day follow-up rates after a mental health ED visit between 20 and 30 percent, and 30-day follow-up rates between 35 and 45 percent.



Non-Specialty Outpatient Mental Health Member-to-Provider Ratio

Network adequacy measures show that the ratio of total members to non-specialty outpatient mental health providers decreased very slightly from 99.9 in 2022 to 96.4 in 2023 (**Exhibit 23**). The aggregate baseline member-to-provider ratio showed wide variation by transition county, ranging from 29.2 in Placer County and 73.9 in Contra Costa County to 1,966.4 in Imperial County and 4,545.7 in San Benito County (See **Appendix B**).

Exhibit 23. The ratio of members to non-specialty outpatient mental health providers decreased slightly from 2022 to 2023.

Year	Total Number of Members	Total FTE Non-Specialty Outpatient Mental Health Providers	Ratio of Members to Providers
2022	976,990	9,782.5	99.9
2023	1,049,760	10,894.3	96.4
Pooled baseline	2,026,750	20,676.9	98.0

NOTES: Non-specialty outpatient mental health providers comprise Psychologists, Licensed Clinical Social Workers, and Licensed Marriage and Family Therapists. Ratios for the pooled baseline represent averages of the yearly ratios, weighted by the number of providers. Data was not available for 2021 as it was not collected at that time. FTE=full-time equivalent.

Continuity of Care

Qualitative interviews with MCPs and stakeholders revealed some challenges in the administrative preparation and data transfer processes, which MCPs felt introduced barriers to maintaining continuity of care for members. This included receiving late or incomplete data from transitioning MCPs, leading to the reinforming of care authorization to members who had already received authorization approvals, and in some cases, had already had the authorized procedure the previous year. This led to member confusion regarding the notification of authorization, resulting in a far higher than average call volume to member assistance lines. Continuity of care will be analyzed quantitatively using continuity of care grievances data from DHCS. Due to data acquisition timelines, this analysis will be presented in the Summative Evaluation Report.

> *"If we had some input into others going through similar sorts of activity, it would be trying to make sure that… rates and certainly the data sharing that's required for seamless patient care… [are] put into [a] 3-month window instead of the last 30 day window and certainly the last, you know, three to five days. It was a terrible scramble to try to get all of that [data] pulled across. We had our IT folks up 24/7 working on projects… and unfortunately, it wasn't that we weren't preparing for it, it was that, when we finally got the information that we needed to get… it was a scramble at that point to try to make things happen."* -Health Plan Interview

Goal 2: Maintain or improve quality of care

This section describes metrics relating to quality of care during the baseline period. In the Summative Evaluation Report, NORC will add information on member perceptions of care quality. NORC hypothesized that the Demonstration will maintain or improve quality of care, including rates of breast cancer screening and all-cause readmissions. For additional details on baseline rates for each transition county, please see **Appendix C**.

Breast Cancer Screening

Rates of breast cancer screening (**Exhibit 24**) were relatively stable over the baseline period, except for a slight dip in 2022 for both transition and non-transition counties (from 57.0 percent in 2021 to 55.5 percent in 2022 for transition counties), and were slightly higher for non-transition versus transition counties.

Exhibit 24. Rates of breast cancer screening were stable over the baseline period and slightly higher non-transition versus transition counties.

Year	Transition Counties			Non-Transition Counties			Statewide		
	Women ages 50 to 74	Had a mammogram	Rate	Women ages 50 to 74	Had a mammogram	Rate	Women ages 50 to 74	Had a mammogram	Rate
2021	54,377	30,993	57.0	529,884	310,120	58.5	584,261	341,113	58.4
2022	60,725	33,678	55.5	594,059	335,284	56.4	654,784	368,962	56.3
2023	61,357	35,436	57.8	595,261	349,578	58.7	656,618	385,014	58.6
Pooled baseline	176,459	100,107	56.7	1,719,204	994,982	57.9	1,895,663	1,095,089	57.8

NOTES: Numerator and denominator values for the pooled baseline represent person-years, not the number of unique members, since members could count in the numerator and denominator multiple times over the 3-year baseline period. Thus, values for the pooled baseline indicate the total number of person-years receiving a mammogram screening out of the total number of person-years eligible for screening.

Of the fifteen transition counties, only one (Contra Costa) exceeded 60 percent for aggregate baseline mammogram screening rates, while three other counties were in the 55 to 60 percent range: Alameda, San Benito, and Imperial. Most counties fell between 45-60 percent. Two counties (Yuba and Plumas) had screening rates below 45 percent.

MCP All-Cause Readmissions

All-cause readmissions were evaluated by calculating the ratio of the number of observed readmissions to the number of expected readmissions, given the hospitalized member's general health. Expected readmissions are risk-adjusted estimates based on the presence of an observation stay status at discharge, any surgeries performed during the hospitalization, and the member's discharge condition, comorbidities, age, and sex. Thus, lower ratios are more favorable as they signal fewer actual readmissions compared to what was expected. Statewide,

the ratio of observed-to-expected all-cause 30-day readmissions was below 1 (0.95-0.96) for all baseline years. The observed-to-expected ratio was similar in transition counties, dropping slightly over time to 0.93 in 2022 and 0.92 in 2023 (**Exhibit 25**).

There was some variation in the ratio of observed-to-expected all-cause readmissions by transition county. Ratios ranged from a low of 0.71 in Colusa County to a high of 2.17 in Sierra County (**Exhibit 26**). Three other counties had ratios above 1.0: San Benito, Alameda, and Mariposa. Most counties had ratios falling between 0.80 and 1.0.

Exhibit 25. Observed-to-expected ratios for all-cause readmissions were between 0.80-1.0 for most transition counties.

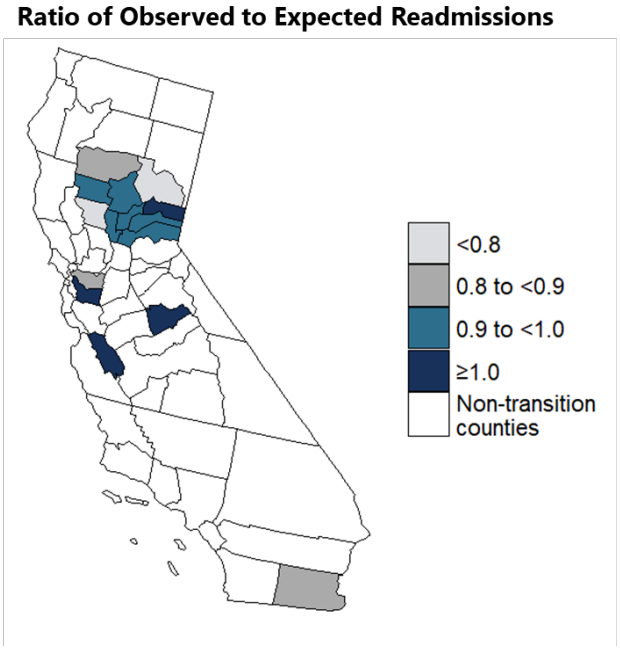


Exhibit 26. Ratios of observed-to-expected all-cause readmissions were below 1 in transition and non-transition counties.

Year	Transition Counties				Non-Transition Counties				Statewide			
	Index hospital stays	Observed 30-day R-adms	Expected 30-day R-adms	Ratio of observed to expected	Index hospital stays	Observed 30-day R-adms	Expected 30-day R-adms	Ratio of observed to expected	Index hospital stays	Observed 30-day R-adms	Expected 30-day R-adms	Ratio of obsered to expeced
2021	19,337	1,814	1,892	0.96	213,798	19,455	20,324	0.96	233,135	21,269	22,216	0.96
2022	21,264	1,932	2,072	0.93	222,010	19,966	20,937	0.95	243,274	21,898	23,008	0.95
2023	21,817	1,953	2,114	0.92	227,306	20,837	21,588	0.97	249,123	22,790	23,702	0.96
Pooled baseline	62,418	5,699	6,077	0.94	663,114	60,258	62,849	0.96	725,532	65,957	68,926	0.96

NOTES: The eligible population is defined as members ages 18 to 64. The expected number of readmissions is a risk-adjusted estimate based on presence of observation stay status at discharge, surgeries, discharge condition, comorbidity, age, and sex. Values for the pooled baseline indicate the total number of index admissions with a readmission over the entire baseline period. R-adms=readmissions

In qualitative analyses of managed care plan interviews, improvement of quality of care remained a priority. Some methods for improvement included a focus on patient outreach and care coordination for preventative services, while others analyzed contracts among transitioning MCPs' provider networks for quality and efficiency.

> *"[The transition] has really helped shape the way that we outreach members and making sure that we have strict protocols that define the attempts to outreach members… via phone, via letters, secure messaging, [etc.]."* -Health Plan Interview

Goal 3: Maintain or improve access to high-quality, continuous care among historically marginalized and under-resourced populations

In this section, NORC describes the strategies that MCPs took to expand services and engage members to improve equity of care. NORC hypothesize that the Demonstration will maintain or improve care access, quality, and continuity among historically marginalized and under-resourced populations. As with Goal 2, the Summative Evaluation Report will incorporate member perceptions of access to and quality of care. NORC first began with a descriptive assessment of potential health disparities in the baseline period, then described the approaches that MCPs implemented to address these disparities.

For the Interim Evaluation Report, NORC was only able to conduct descriptive analyses for quality and access metrics by subgroups of counties stratified by urban (falling under 1115 waiver authority) versus rural (falling under 1915 waiver authority) status. For the Summative Evaluation Report, NORC will conduct a more thorough analysis of impacts, including all equity-relevant subgroups of race/ethnicity, age, sex, and preferred language.

During the baseline period, urban transition counties had more favorable rates across several metrics. For example, 55.3% of children in urban counties received six or more well-child visits by 15 months, compared to 48.3% in rural counties. However, the disparity between the urban and rural setting had narrowed considerably for the 30-month well-child metric, a trend that was reflected in each individual year of the baseline period (see additional details in **Appendix C**). In 2023, 61.2% of children in urban counties received six or more visits in the first 15 months, compared to 53.3% in rural areas, a difference of 7.9 percentage points. For the first 30 months, the percentage

of children with two or more visits was 70.6% in urban areas and 68.2% in rural areas, reducing the gap to just 2.4 percentage points.

Adolescent vaccination rates were generally higher in urban counties versus rural, particularly for the HPV vaccine (41.1% vs. 28.3%) and the Combination 2 vaccine (36.8% vs. 25.7%), although rates of TDAP vaccination were comparable between urban and rural counties at about 80%. Maternal health measures favored urban versus rural counties, with higher rates of prenatal (88.7% vs. 84.7%) and postpartum visits (84.1% vs. 80.9%). Behavioral health follow-up after emergency department visits was also more frequent in urban counties, with 33.1% receiving follow-up within 7 days compared to 26.0% in rural areas (with the disparity persisting for follow-up within 30 days). However, quality of care indicators were mixed, with urban areas having a slightly higher mammogram rate (57.0% vs. 55.5% in rural counties), but rural areas having a more favorable readmission ratio (0.89 vs. 0.95 in urban counties).

Exhibit 27. Urban transition counties tended to have more favorable results for quality and access metrics over the whole baseline period, compared to rural transition counties.

	Urban	Rural
Preventative and Ambulatory Health Services		
Percent with 6 or more well-child visits in the MY for children turning 15 months	55.3	48.3
Percent with 2 or more well-child visits in the MY for children turning 30 months	67.6	66.0
Children and adolescents with at least one well-care visit during the MY	49.0	45.2
Rate for Meningococcal Vaccine for adolescents	68.7	62.9
Rate for TDAP for adolescents	80.8	80.5
Rate for HPV for adolescents	41.1	28.3
Rate for Combination 1 Vaccine for adolescents[1]	60.3	57.8
Rate for Combination 2 Vaccine for adolescents	36.8	25.7
Percent of live births with a prenatal visit in the first trimester	88.7	84.7
Percent of live births with a postpartum visit on or between 7-84 days after delivery	84.1	80.9

	Urban	Rural
Behavioral Health Services		
Percent of ED visits for mental illness with follow-up with 7 days	33.1	26.0
Percent of ED visits for mental illness with follow-up with 30 days	45.0	37.3
Quality of Care		
Rate of mammograms among women ages 50-74	57.0	55.5
Ratio of observed to expected all-cause readmissions	0.95	0.89

NOTES: Rates are shown pooled over the 3-year baseline period for all urban versus rural counties. [1] Rates for Combination 1 vaccination reflect rates during 2023, as that was the only year of available data for this vaccine.

Overall trends between urban and rural counties were reflected in each individual year of the baseline period, with one exception. In both rural and urban counties, follow-up rates for ED visits for mental illness in 2022 were considerably higher than in 2021 or 2023, and in 2022 rural counties achieved higher follow-up rates than urban counties (for 7-day follow-up, 43.8% and 39.2% for rural and urban, respectively, and for 30-day follow-up, 52.9% and 51.3%).

In interviews, MCPs described undertaking several efforts to expand access to historically under-resourced populations, better engage members to coordinate services, and deliver culturally inclusive care.

- *Access for rural and under-resourced populations.* One MCP operating in largely rural regions expanded telehealth services and non-emergency medical transportation to improve access to specialty care. These investments were particularly impactful in areas with limited provider availability, helping assist with gaps in care delivery.
- *Multilingual outreach and member engagement.* MCPs implemented multilingual outreach strategies to ensure members received timely and culturally appropriate information about the transition and their benefits. Outreach efforts began well in advance of the January 2024 transition date, including phone calls and written notices. Communications were tailored to members' preferred written languages and interpreter services were available for real-time phone support.
- *Behavioral health integration and coordination.* Efforts to improve behavioral health access included the implementation of closed-loop referral systems. One MCP established referral trackers with all county behavioral health departments in its service area to confirm appointment scheduling and attendance. These systems

supported continuity of care and strengthened coordination between managed care and specialty behavioral health services.

- *Culturally inclusive services.* MCPs emphasized the importance of culturally and linguistically appropriate care across all points of service. Member-facing materials were translated into languages identified by the state. Interpreter services were available at all levels of care, including in-person and telehealth visits. Internal and contracted providers received training on cultural competency and diversity, equity, and inclusion practices.

> *"Interpreter services are offered at all points of contact to ensure continuity and appropriateness of care."*
>
> – Health Plan Interview

Goal 4: Reduce administrative complexity for MCPs

This section describes activities undertaken by MCPs and stakeholder groups to reduce administrative complexity. NORC hypothesized that the transition will reduce administrative complexity by centralizing and streamlining workflows and provider and member outreach and engagement activities.

Qualitative interviews revealed the transition introduced significant operational demands for participating MCPs. While the transition aimed to streamline member experience and improve care coordination, MCPs reported navigating substantial administrative complexity, particularly in the prep and post-launch phases. This summary synthesizes insights from three participating MCPs and one stakeholder organization to inform DHCS's ongoing efforts to reduce administrative burden and improve future transitions. As with prior Goals, the Summative Evaluation Report will incorporate member perspectives on system complexity, and service navigation.

Pre-Launch Activities

MCPs devoted considerable time and resources to pre-launch activities, including:

- *Stakeholder engagement.* Multiple MCPs reported conducting listening sessions and outreach with county officials, behavioral health departments, providers, and community-based organizations. These efforts helped build trust and clarify expectations, especially in counties unfamiliar with the incoming MCP.
- *Data acquisition from existing MCPs.* MCPs described challenges in obtaining timely, accurate member data from exiting MCPs. Data quality issues created confusion and delayed continuity of care efforts, including outdated provider assignments, incomplete utilization and authorization histories, and inconsistent formatting.
- *Staffing and infrastructure expansion.* To anticipate the needs of the transition, MCPs added new roles to their staff, including county-level coordinators, member services leads, and data analysts. They also built internal systems to process member files, assess prior utilization, and generate automatic authorizations when possible.

> *"I think what was the actual case was a lot of the data that was coming over from [health plan] was extremely poor-quality data, which had a lot of poor information... People were assigned to PCPs that were five hours away from us in [county].*" – Health Plan Interview

Workflow Changes During and After Launch

Post-launch, MCPs implemented several workflow adaptations to maintain continuity and reduce disruption, including:

- *Behavioral health coordination.* MCPs established and expanded communication channels with county behavioral health departments and specialty mental health providers. Key strategies included monthly meetings, closed-loop referral tracking, and shared health information exchanges.
- *Rapid data review and member assignment.* MCPs developed internal algorithms to match members to PCPs based on prior care history, geographic proximity, and panel availability. However, poor data quality sometimes resulted in inaccurate connections, including assignments to providers located far from members.
- *Cross MCP collaboration.* In counties in which Kaiser Permanente was also operating as a MCP option, , MCPs coordinated messaging, member outreach, and transition checklists to ensure consistency and reduce confusion.

Goal 5: Maintain MCP accountability and improve transparency

This section describes activities undertaken by MCPs to maintain or improve MCP accountability and improve transparency during the transition process, including developing and publishing required performance and operations documentation and required Community Reinvestment Plans. NORC hypothesized that the MCPs will adhere to transition requirements and publish required performance and operations documentation, and develop and execute their Community Reinvestment Plans.

In qualitative interviews, MCPs reported undertaking steps to maintain MCP accountability and improve transparency before and after transition launch, though they and stakeholders interviewed noted continued challenges navigating roles and responsibilities of care entities (e.g., behavioral health providers) within transition counties and limited awareness about the transition among members and direct care providers.

Use of DHCS Transition Policy Guide

MCPs identified the DHCS Transition Policy Guide as a valuable resource that supported transparency and clarity during the 2024 managed care transition. The guide set

expectations and requirements in a single document which facilitated internal planning and coordination.

Defining Entity Roles and Responsibilities

Confusion around the responsibilities between managed care plans and specialty behavioral health providers was a recurring theme. Some expressed concern that MCPs lacked clarity on their obligations, particularly in distinguishing between specialty and non-specialty care. The process by which MCPs could and should establish financing agreements, Memoranda of Understanding (MOUs) and other contractual arrangements with counties was at times similarly unclear; in at least one instance, a MCP created documentation that led to confusion and strained relationships with counties. The document proposed financial arrangements that diverged from state guidance, leading to delays in executing Memoranda of Understanding (MOUs) and concerns about fairness and transparency. Others described the administrative complexity of coordinating care across counties, each with different intake criteria, referral processes, and expectations. To address these challenges, some MCPs emphasized the importance of sustained relationship-building and monthly meetings with county partners to clarify roles and improve collaboration.

> *"Providers were, by and large, completely blindsided by this transition, not knowing what it meant, not knowing the implications, not knowing who to reach out to."* - Health Plan Interview

Assessing Provider and Member Awareness

Across counties and MCPs, all providers could access the DHCS Managed Care Plan Transition Page for Providers, which directs providers to the Members page and a searchable database of areas impacted. In reviewing publicly available documents, NORC was able to identify additional provider notifications and newsletters covering three different MCPs in four counties. Additional details on provider outreach and notification efforts are in **Exhibit 28**.

Exhibit 28. Provider Outreach and Notification Efforts as Reported on MCP Websites

County	2024 MCP(s)	How Providers Were Informed
Alameda	Alameda Alliance for Health	In December 2023, providers were notified about the transition to a single MCP via Alameda Alliance for Health's "Provider Updates" section and a downloadable information sheet that informed providers on what changes to expect, such as increase in membership and guidance on continuity of care.[25]
Contra Costa	Contra Costa Health Plan	In 2023, providers were made aware of the transition via CCHP's "Provider Network News" Winter letter, that they would now be the primary managed care plan in CC county. It incorporated "need to know" bullets at the bottom about upcoming changes or areas of potential concern.[26]
Mariposa, San Benito	Central California Alliance For Health	Providers were notified about the transition of the MCP through official communications - including the December 2023 Provider Bulletin and the Provider Digest (Issue 39).[27,28]

Similarly, members across all counties and MCPs were informed of the MCP transition via the DHCS MCP transition overview page and materials. The materials are available in both English and Spanish. At the county-specific level, the DHCS searchable database included every county's specific notice to members, and resources were available in English and Spanish. Additionally, the team was able to identify additional webpage or news updates on four different MCP and health center websites covering fourteen counties clarifying that members impacted by MCP transitions were informed via mail and should have received additional clarifying information from their new MCPs. Details on MCP-specific informational notices to members were relatively sparse, but available information is summarized in the table below.

[25] https://alamedaalliance.org/providers/provider-updates/
[26] https://www.cchealth.org/home/showpublisheddocument/29683/638447330039270000
[27] https://thealliance.health/wp-content/uploads/CCAH-Provider-December2023-high-res.pdf
[28] https://thealliance.health/provider-digest-issue-39/

Exhibit 29. Member Outreach and Notification Efforts as Reported on MCP Websites

County	2024 MCP(s)	How Members Were Informed
Alameda	Alameda Alliance for Health	Members impacted by the MCP transition were sent a letter by mail from their current health insurance MCPs with details and next steps.[29] ***Transition Material Languages:*** English
Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Yuba	Partnership Health Plan of California	Partnership Health Plan of California produced an informational notice with frequently asked questions and answers about the MCP transition, reminders, and contact information.[30] ***Transition Material Languages:*** English
Imperial	Community Health Plan of Imperial Valley	California Health & Wellness website indicated that members in Imperial County were informed that they had been auto-enrolled in Community Health Plan of Imperial Valley.[31] ***Transition Material Languages:*** English, Spanish
Mariposa, San Benito	Central California Alliance for Health	MCP website included new updates about expanded services and the transition process.[32] ***Transition Material Languages:*** English, Spanish, Hmong, Punjabi, Vietnamese, Arabic, Chinese, Portuguese, Russian, Tagalog, Korean, Persian

[29] https://chcnetwork.org/
[30] https://www.countyofcolusaca.gov/DocumentCenter/View/16920/MediCal-Members_6030day_FINAL
[31] https://www.cahealthwellness.com/members/chw-medi-cal-change-2024.html
[32] https://thealliance.health/mariposa-and-san-benito-counties-have-a-new-medi-cal-health-plan/

In spite of these efforts, MCPs noted gaps in awareness among Medi-Cal members and providers regarding benefit changes and MCP administrative and operational responsibilities were and remained extensive in the early months of the transition process. Stakeholders similarly observed that many members were initially unaware of the transition and providers lacked clarity on new contractual and quality requirements. Some strategies implemented by the managed care MCPs to improve member awareness of the change included increased member outreach, conducting community engagement events, and increasing awareness of member support options for information assistance.

> *"We had a 48% increase in inbound calls in the month of January 2024… A typical January, we 're hovering around 7,500-7,600 and we got 11,300 calls in that month."* – Health Plan Interview

Providing Documentation of Prior Authorization Requirements

NORC's review of publicly available information on MCP websites, conducted from July through September 2025, revealed all MCPs posted information about the prior authorization process for patients, providers, or both. In most cases, websites contain patient-facing information and details about the prior authorization process, including offering lists of specific services that require prior authorization. Some MCPs also have publicly accessible patient handbooks which include information on services that require prior authorization. In the case of two of the MCPs operating in three counties, NORC was only able to identify information on prior authorization that was targeted towards providers. Further details are shared in the table below.

Exhibit 30. Summary of Prior Authorization Materials as Reported on MCP Websites

County	2024 MCP(s)	Prior Authorization Materials
Alameda	Alameda Alliance for Health	The MCP website contains both patient- and provider-facing information discussing the prior authorization process, including context on prior authorization, lists of services that will always require prior authorization, and instructions for prior authorization form submission, denials, and appeals.[33,34]
Alameda, Contra Costa, Imperial, Mariposa, Sutter, Yuba	Kaiser Permanente	The MCP website contains patient-facing information about the utilization management process, including detailing the prior authorization process, including a list of services that require prior authorization.[35]

[33] https://alamedaalliance.org/members/group-care/benefits-and-covered-services/
[34] Authorization Management – Alameda Alliance for Health

[35] https://healthy.kaiserpermanente.org/content/dam/kporg/final/documents/health-plan-documents/notice/utilization-management-process-ca.pdf

County	2024 MCP(s)	Prior Authorization Materials
Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Yuba	Partnership Health Plan of California	The MCP website offers information to members in the form of handbooks, pamphlets and other online information that offers insight into what is available to them under Medi-Cal, including specialist visits and other services requiring prior authorization.[36] [37] The MCP website contains a patient-facing webpage describing the prior authorization process and lists services that always require prior authorization.[38]
Contra Costa	Contra Costa Health Plan	CCHP has an "Authorization and Referral" department which providers can call and see which services need authorization and referrals. The MCP website also includes a CPT Tool that providers can use to see if a service needs authorization by inputting the 5-digit code, keyword or description of service.[39,40]
Imperial	Community Health Plan of Imperial Valley	The MCP website and member handbook include description of the prior authorization process and list services that require prior authorization.[41] [42]

[36] https://www.partnershiphp.org/Members/Medi-Cal/Pages/default.aspx
[37] https://www.partnershiphp.org/Members/Medi-Cal/Pages/Benefits.aspx
[38] https://www.partnershiphp.org/Members/Medi-Cal/Pages/Prior-Authorization.aspx
[39] https://www.cchealth.org/health-insurance/my-contra-costa-health-plan/authorization-and-referrals-department
[40] https://hsdmobile.cchealth.org/CPTcodesearch
[41] https://chpiv.org/member-resources/
[42] https://chpiv.org/wp-content/uploads/2025/05/HN_1-25-CHPIV-Handbook-FINAL_English-1.pdf

County	2024 MCP(s)	Prior Authorization Materials
Mariposa, San Benito	Central California Alliance For Health	CCAH maintains a dedicated Referrals and Authorizations page where providers can access: lists of services requiring prior authorization; Instructions for submitting Authorization Requests (AR) via the Provider Portal, fax, or mail; Utilization Management policies and criteria.[43]

[43] https://thealliance.health/for-providers/manage-care/clinical-resources/referrals-and-authorizations/

CONCLUSIONS

This section summarizes key findings from the baseline period of the MCP Transition evaluation, organized by the five primary goals guiding the initiative. Drawing on quantitative data and qualitative interviews with MCPs and stakeholders, NORC identified early successes, persistent challenges, and areas for further investigation. These insights will inform the next phase of evaluation, including member interviews and implementation-period data analysis, to assess the full impact of the transition on access, quality, and equity in care.

- **GOAL 1: Maintain or improve overall access to and continuity of care**.

From an implementation perspective, challenges in administrative readiness and data transfer processes were identified as key barriers to ensuring continuity of care during MCP transitions. MCPs reported that delays and incomplete data from outgoing MCPs often resulted in duplicated care authorization communications, even for services that had already been approved or completed. These findings underscore the importance of strengthening administrative coordination and data-sharing protocols during MCP transitions. Additionally, enhanced communication strategies and member support systems may be needed to manage increased inquiries and ensure a smoother transition experience for members.

- **GOAL 2: Maintain or improve quality of care.**

During the pre-transition baseline period, the 15 MCP Transition counties outperformed non-transition counties and the state as a whole on many of the metrics examined related to care access and quality: well-child visits at 15- and 30-months, prenatal and postpartum care, follow-up rates after ED visits for mental illness, both for 7-days and 30-days, and observed-to-expected all-cause readmissions (particularly for 2022 and 2023). Transition counties performed equally as well as non-transition counties for child and adolescent well-care visits. However, transition counties had slightly lower breast cancer screening rates than non-transition counties. Transition counties also had lower meningococcal and TDAP vaccine rates, but were comparable to non-transition counties and the state overall on rates of HPV and Combination 2 vaccinations.

Member-to-provider ratios varied considerably across MCP Transition counties, with urban counties (Placer, Contra Costa, and Alameda) generally reporting greater access to overall physicians, PCPs, and specialists, while rural counties (Colusa, Tehama, and San Benito) generally reported lower access.

MCPs have made substantial investments in workflows and infrastructure to maintain this quality of care seen during the baseline period for transitioning members, as well as to preserve continuity of care. NORC will have a more robust sense of members' experiences with and perceptions of the effectiveness of these efforts when member interviews are completed, set for inclusion in the Summative Evaluation Report. The Summative Evaluation Report will also include implementation period data to evaluate the impact of the transition on these care access and quality metrics for members.

- **GOAL 3: Maintain or improve access to high-quality, continuous care among historically marginalized and under-resourced populations.**

MCPs suggested they are making efforts to expand access to under-resourced subpopulations in transition counties, improve care management and behavioral health integration, and provide culturally inclusive care. During the baseline period, NORC saw some evidence of disparities between urban and rural counties, with the urban transition counties outperforming their rural counterparts on child and adolescent well-care visits, prenatal and postpartum care, and follow-up after ED visits for mental illness. However, rural counties had lower observed-to-expected all-cause readmissions than urban counties, and urban versus rural differences in well-child visits and vaccination rates were mixed. While urban counties had higher well-child visit rates during the first 15 months, that difference had largely reduced to zero for children turning 30 months. In addition, while urban counties had higher vaccination rates for meningococcus, HPV, and Combination 2, vaccination rates for TDAP were comparable between urban and rural counties. In the Summative Evaluation Report, NORC will examine whether these disparities persist into the implementation period, as well as whether disparities by other member characteristics exist or were impacted by the transition. NORC will have a better understanding of the degree to which MCPs' efforts to close any gaps in care have been effective after completing and analyzing data from interviews with members.

- **GOAL 4: Reduce administrative complexity for MCPs.**

MCPs have devoted substantial time and effort to creating and/or enhancing infrastructure that would allow for streamlining of administrative processes, but are still iterating with stakeholders, other MCPs, and DHCS to refine protocols. In the Summative Evaluation Report, NORC will engage and incorporate feedback from members across transition counties to assess their experience with MCP and service system navigation and any administrative barriers or facilitating factors they encountered during and after the transition process.

- **GOAL 5: Maintain MCP accountability and improve transparency.**

MCPs have undertaken substantial effort to engage and orient affected members, providers and community-based organizations, and develop and publish transition-related resource materials. Further, they invested time and workforce to provide ongoing consult to and collaboration with community leaders and adjacent county-level agencies in transition counties, though the timing and intensity of these engagements varied by county and MCP. MCPs noted they had begun planning and pre-work to develop their Community Reinvestment Plans, though those MCPs remain in progress. As with Goal 4, the Summative Evaluation Report will incorporate feedback from member interviews which will shed light on members' understanding of the transition and ability to access and interpret transition-related resources.

Looking ahead to the summative evaluation:

In addition to the analyses included in this Interim Evaluation Report, the Summative Evaluation Report will include:

- Data on member demographic and other characteristics, quality and access measures, and member-to-provider ratios for both transition and non-transition counties, for the baseline period and the full implementation period (January 2024 – December 2026)
- Data from interviews with a total of 45 members residing in transition counties, as well as additional data from a second round of interviews with MCP officials and DHCS SAC members (to be conducted in Year Three).
- With this additional data, NORC will conduct quantitative analyses to understand the impact of the MCP Transition on access to, quality, and continuity of care for members residing in the transition counties relative to comparable members living in similar counties. NORC will also be able to contextualize quantitative findings with direct member experiences and perceptions of the MCP Transition on their health care, as well as additional feedback from MCP officials and DHCS Advisory Committee members on further implementation progress, challenges and successes.

INTERPRETATIONS, POLICY IMPLICATIONS AND INTERACTIONS WITH OTHER STATE INITIATIVES

The CalAIM Section 1115 Demonstration MCP Transition amendment provides federal authority for California to limit managed care plan choices in Metro, Large Metro, Urban, and rural[44] counties through the adoption of County Organized Health Systems (COHS) and Single Plan models. The primary goal of this amendment is to streamline and align managed care programs, create consistency in benefits and enrollment, and strengthen program oversight statewide.

While the Demonstration authority is narrowly focused on enabling COHS and Single Plan models to limit MCP choice in affected counties, the broader MCP Transition encompasses a suite of reforms aimed at improving care quality, access, equity, and transparency. These reforms include:

- Enhanced care coordination and integration of physical and behavioral health services
- Culturally competent service delivery
- Increased investment in primary care
- Mandated community reinvestment by MCPs
- Strengthened stakeholder engagement and accountability
- Emphasis on minimizing service disruptions and preserving member choice and provider continuity

As one initiative within the CalAIM Section 1115(a) Demonstration, the MCP Transition is also positioned to **complement and reinforce other CalAIM initiatives** that share the overarching goals of building a more coordinated, person-centered, and equitable health system.

For example:

- The **Medi-Cal Matching Plan Policy for Dual Eligible Members** addresses fragmentation in care delivery by enrolling dually eligible individuals into fully integrated MCPs. These MCPs are designed to improve care coordination and chronic condition management. Like the MCP Transition, this policy aims to

[44] Rural counties are authorized through the 1915(b) Waiver

simplify managed care structures and standardize benefits, contributing to greater efficiency and effectiveness in care delivery.

- The **Providing Access and Transforming Health (PATH) Initiative** supports infrastructure and capacity-building among community-based providers to deliver Enhanced Care Management (ECM) and Community Supports. PATH's focus on readiness and provider strengthening is particularly relevant for ensuring that the MCP Transition does not inadvertently disrupt access to care—especially for historically marginalized populations with complex needs, such as justice-involved individuals.
- The **Incentive Payment Program (IPP)** provided targeted funding to MCPs to accelerate the implementation of Enhanced Care Management (ECM), Community Supports, and other delivery system reforms. By incentivizing MCPs to build infrastructure, expand provider networks, and improve service quality, IPP played a foundational role in preparing plans for the MCP Transition. Its emphasis on measurable progress and equitable access for CalAIM Populations of Focus—including those newly eligible for services—helped ensure that MCPs were better equipped to meet the needs of diverse and high-need populations. As MCPs take on expanded responsibilities under the transition, the systems and capacities developed through IPP will be critical to sustaining momentum and minimizing disruptions in care delivery.

Together, these initiatives form a cohesive policy framework that seeks to modernize Medi-Cal managed care, reduce fragmentation, and improve outcomes for members across the state. The MCP Transition is not only a structural shift in MCP models but also a strategic opportunity to advance CalAIM's broader goals of equity, integration, and member-centered care.

LESSONS LEARNED AND RECOMMENDATIONS

Through qualitative data collection activities conducted for this report, NORC identified a handful of early lessons learned and recommendations. These takeaways reflect the findings above.

- Consistent timelines, roles and responsibilities and data acquisition and review workflows for transitioning MCPs (both those entering and exiting a county) are critical to ensure both entities are prepared to rapidly assemble, quality review and reconcile transition member enrollment and historic utilization data (including prior authorizations). MCPs reported their substantial investments in workforce, training, and ongoing member and provider education helped them navigate the early months of the transition, but worked best when those involved were engaged early and expectations and workflows were clear.
- Early and ongoing engagement with county behavioral health departments and specialty behavioral health providers can help strengthen needed partnerships, establish necessary documentation (e.g., MOUs, contracts), and align behavioral health care coordination workflows. MCPs and stakeholders noted that, where efforts were undertaken to proactively engage and establish ongoing communication channels with county behavioral health departments and specialty behavioral health providers, all parties involved (i.e., members, providers, MCPs, and counties) were better prepared to coordinate care.
- Provider and member awareness of transition processes may be limited, despite outreach and engagement; reserving time for MCP staff at all levels (e.g., member service and benefits teams, community engagement leads, behavioral health coordinators) and developing resource materials to orient providers and members in real-time proved beneficial. MCPs reported challenges with ongoing confusion from members and providers about the transition process, and found they needed to adapt quickly to provide resources (including both staff and written materials) to individuals reaching out with questions.

TECHNICAL APPENDICES

Appendix A. Additional Data on Member Demographic Characteristics

Appendix A 1. Member demographic characteristics overall across the Transition counties and pooled across the baseline period.

	N (Total N = 1,671,271)	Percent
Age group		
0-18	456,541	27.3
19-44	667,086	39.9
45-64	316,464	18.9
65-84	191,528	11.5
85+	39,652	2.4
Gender		
Female	883,083	52.8
Male	788,188	47.2
Race/Ethnicity		
Non-Hispanic White	346,666	20.7
Hispanic	561,904	33.6
Non-Hispanic Black	146,885	8.8
Asian	197,438	11.8
Native American	7,859	0.5
Pacific Islander	3,868	0.2
Other	233,222	14.0
Missing	173,429	10.4
Primary Language		

	N (Total N = 1,671,271)	Percent
English	1,126,768	67.4
Non-English	526,467	31.5
Missing	18,036	1.1
Dual Eligibility Status		
Not Dually Eligible	1,478,838	88.5
Dually Eligible	192,433	11.5

Appendix A 2. Member demographic characteristics by baseline year across the Transition counties.

	2021		2022		2023	
	N	Percent	N	Percent	N	Percent
Age group						
0-18	347,803	26.47	380,078	27.10	418,982	27.80
19-44	519,391	39.52	554,335	39.52	597,917	39.67
45-64	252,025	19.18	269,519	19.22	288,447	19.14
65-84	160,256	12.19	166,116	11.84	171,306	11.37
85+	34,717	2.64	32,580	2.32	30,515	2.02
Gender						
Female	700,613	53.31	744,602	53.09	796,542	52.85
Male	613,579	46.69	658,026	46.91	710,625	47.15
Race/Ethnicity						
Non-Hispanic White	283,847	21.60	289,498	20.64	297,501	19.74
Hispanic	449,463	34.20	482,130	34.37	550,990	36.56

	2021		2022		2023	
	N	Percent	N	Percent	N	Percent
Non-Hispanic Black	125,337	9.54	127,109	9.06	124,395	8.25
Asian	160,921	12.24	165,937	11.83	174,492	11.58
Native American	6,582	0.50	6,698	0.48	6,741	0.45
Pacific Islander	3,147	0.24	3,233	0.23	2,985	0.20
Other	196,054	14.92	213,522	15.22	95,630	6.35
Missing	88,841	6.76	114,501	8.16	254,433	16.88
Primary Language						
English	890,831	67.79	948,185	67.60	1,037,517	68.84
Non-English	413,610	31.47	444,288	31.68	456,775	30.31
Missing	9,751	0.74	10,155	0.72	12,875	0.85
Dual Eligibility Status						
Not Dually Eligible	1,162,483	88.46	1,243,045	88.62	1,338,788	88.83
Dually Eligible	151,709	11.54	159,583	11.38	168,379	11.17

Appendix A 3. Member demographic characteristics by Transition county, pooled across the baseline years. Age Group.

County	Age Group	N	Percent
Alameda	0-18	154,061	24.15
Alameda	19-44	258,267	40.48
Alameda	45-64	125,075	19.60
Alameda	65-84	82,021	12.85
Alameda	85+	18,624	2.92
Butte	0-18	28,701	26.82

County	Age Group	N	Percent
Butte	19-44	44,221	41.33
Butte	45-64	20,993	19.62
Butte	65-84	11,325	10.58
Butte	85+	1,758	1.64
Colusa	0-18	4,875	34.96
Colusa	19-44	5,232	37.52
Colusa	45-64	2,249	16.13
Colusa	65-84	1,347	9.66
Colusa	85+	242	1.74
Contra Costa	0-18	116,323	27.85
Contra Costa	19-44	169,195	40.50
Contra Costa	45-64	78,870	18.88
Contra Costa	65-84	44,112	10.56
Contra Costa	85+	9,219	2.21
Glenn	0-18	6,019	33.85
Glenn	19-44	6,724	37.81
Glenn	45-64	3,026	17.02
Glenn	65-84	1,695	9.53
Glenn	85+	318	1.79
Imperial	0-18	42,450	31.72
Imperial	19-44	48,913	36.55
Imperial	45-64	22,195	16.59
Imperial	65-84	16,741	12.51
Imperial	85+	3,510	2.62

County	Age Group	N	Percent
Mariposa	0-18	2,251	26.15
Mariposa	19-44	3,285	38.17
Mariposa	45-64	1,855	21.55
Mariposa	65-84	1,053	12.23
Mariposa	85+	163	1.89
Nevada	0-18	9,753	25.47
Nevada	19-44	15,511	40.51
Nevada	45-64	8,247	21.54
Nevada	65-84	4,149	10.83
Nevada	85+	634	1.66
Placer	0-18	32,230	29.62
Placer	19-44	43,635	40.10
Placer	45-64	20,070	18.44
Placer	65-84	10,777	9.90
Placer	85+	2,117	1.95
Plumas	0-18	2,361	26.27
Plumas	19-44	3,408	37.93
Plumas	45-64	1,868	20.79
Plumas	65-84	1,210	13.47
Plumas	85+	139	1.55
San Benito	0-18	9,620	32.63
San Benito	19-44	11,952	40.55
San Benito	45-64	5,067	17.19
San Benito	65-84	2,284	7.75

County	Age Group	N	Percent
San Benito	85+	555	1.88
Sierra	0-18	286	24.44
Sierra	19-44	383	32.74
Sierra	45-64	254	21.71
Sierra	65-84	206	17.61
Sierra	85+	41	3.50
Sutter	0-18	18,510	32.00
Sutter	19-44	22,043	38.11
Sutter	45-64	10,172	17.59
Sutter	65-84	5,954	10.29
Sutter	85+	1,164	2.01
Tehama	0-18	13,254	31.84
Tehama	19-44	15,811	37.98
Tehama	45-64	7,726	18.56
Tehama	65-84	4,240	10.19
Tehama	85+	596	1.43
Yuba	0-18	15,847	32.92
Yuba	19-44	18,506	38.45
Yuba	45-64	8,797	18.28
Yuba	65-84	4,414	9.17
Yuba	85+	572	1.19

Appendix A 4. Member demographic characteristics by Transition county, pooled across the baseline years. Gender.

County	Gender	N	Percent
Alameda	Female	336,280	52.70
Alameda	Male	301,768	47.30
Butte	Female	54,814	51.23
Butte	Male	52,184	48.77
Colusa	Female	7,427	53.26
Colusa	Male	6,518	46.74
Contra Costa	Female	223,996	53.62
Contra Costa	Male	193,723	46.38
Glenn	Female	9,422	52.99
Glenn	Male	8,360	47.01
Imperial	Female	72,027	53.83
Imperial	Male	61,782	46.17
Mariposa	Female	4,336	50.38
Mariposa	Male	4,271	49.62
Nevada	Female	19,479	50.87
Nevada	Male	18,815	49.13
Placer	Female	57,208	52.57
Placer	Male	51,621	47.43
Plumas	Female	4,731	52.65
Plumas	Male	4,255	47.35
San Benito	Female	15,751	53.43
San Benito	Male	13,727	46.57
Sierra	Female	595	50.85
Sierra	Male	575	49.15

County	Gender	N	Percent
Sutter	Female	30,278	52.35
Sutter	Male	27,565	47.65
Tehama	Female	21,688	52.10
Tehama	Male	19,939	47.90
Yuba	Female	25,051	52.04
Yuba	Male	23,085	47.96

Appendix A 5. Member demographic characteristics by Transition county, pooled across the baseline years. Race/Ethnicity.

County	Race/Ethnicity	N	Percent
Alameda	White	61,842	9.69
Alameda	Hispanic	180,881	28.35
Alameda	Black	86,441	13.55
Alameda	Asian	124,021	19.44
Alameda	Native American	1,371	0.21
Alameda	Pacific Islander	1,981	0.31
Alameda	Other	124,072	19.45
Alameda	Missing	57,439	9.00
Butte	White	57,675	53.90
Butte	Hispanic	21,467	20.06
Butte	Black	2,879	2.69
Butte	Asian	6,013	5.62
Butte	Native American	1,713	1.60
Butte	Pacific Islander	168	0.16

County	Race/Ethnicity	N	Percent
Butte	Other	2,340	2.19
Butte	Missing	14,743	13.78
Colusa	White	2,284	16.38
Colusa	Hispanic	9,435	67.66
Colusa	Black	103	0.74
Colusa	Asian	169	1.21
Colusa	Native American	126	0.90
Colusa	Pacific Islander	11	0.08
Colusa	Other	129	0.93
Colusa	Missing	1,688	12.10
Contra Costa	White	62,638	15.00
Contra Costa	Hispanic	135,275	32.38
Contra Costa	Black	49,177	11.77
Contra Costa	Asian	42,055	10.07
Contra Costa	Native American	948	0.23
Contra Costa	Pacific Islander	1,156	0.28
Contra Costa	Other	86,142	20.62
Contra Costa	Missing	40,328	9.65
Glenn	White	5,920	33.29
Glenn	Hispanic	9,061	50.96
Glenn	Black	*	*
Glenn	Asian	546	3.07
Glenn	Native American	307	1.73
Glenn	Pacific Islander	*	*

County	Race/Ethnicity	N	Percent
Glenn	Other	158	0.89
Glenn	Missing	1,652	9.29
Imperial	White	6,745	5.04
Imperial	Hispanic	110,358	82.47
Imperial	Black	1,294	0.97
Imperial	Asian	600	0.45
Imperial	Native American	849	0.63
Imperial	Pacific Islander	20	0.01
Imperial	Other	861	0.64
Imperial	Missing	13,082	9.78
Mariposa	White	5,723	66.49
Mariposa	Hispanic	1,474	17.13
Mariposa	Black	*	*
Mariposa	Asian	92	1.07
Mariposa	Native American	186	2.16
Mariposa	Pacific Islander	*	*
Mariposa	Other	125	1.45
Mariposa	Missing	918	10.67
Nevada	White	25,947	67.76
Nevada	Hispanic	4,875	12.73
Nevada	Black	257	0.67
Nevada	Asian	431	1.13
Nevada	Native American	231	0.60
Nevada	Pacific Islander	46	0.12

County	Race/Ethnicity	N	Percent
Nevada	Other	726	1.90
Nevada	Missing	5,781	15.10
Placer	White	48,873	44.91
Placer	Hispanic	17,715	16.28
Placer	Black	2,783	2.56
Placer	Asian	7,120	6.54
Placer	Native American	718	0.66
Placer	Pacific Islander	188	0.17
Placer	Other	15,616	14.35
Placer	Missing	15,816	14.53
Plumas	White	6,180	68.77
Plumas	Hispanic	1,137	12.65
Plumas	Black	125	1.39
Plumas	Asian	*	*
Plumas	Native American	213	2.37
Plumas	Pacific Islander	*	*
Plumas	Other	112	1.25
Plumas	Missing	1,132	12.60
San Benito	White	4,029	13.67
San Benito	Hispanic	20,175	68.44
San Benito	Black	146	0.50
San Benito	Asian	566	1.92
San Benito	Native American	*	*
San Benito	Pacific Islander	19	0.06

County	Race/Ethnicity	N	Percent
San Benito	Other	400	1.36
San Benito	Missing	4,094	13.89
Sierra	White	828	70.77
Sierra	Hispanic	123	10.51
Sierra	Black	*	*
Sierra	Asian	*	*
Sierra	Native American	*	*
Sierra	Pacific Islander	*	*
Sierra	Other	15	1.28
Sierra	Missing	186	15.90
Sutter	White	16,840	29.11
Sutter	Hispanic	22,115	38.23
Sutter	Black	1,326	2.29
Sutter	Asian	12,106	20.93
Sutter	Native American	267	0.46
Sutter	Pacific Islander	78	0.13
Sutter	Other	1,014	1.75
Sutter	Missing	4,097	7.08
Tehama	White	20,848	50.08
Tehama	Hispanic	13,232	31.79
Tehama	Black	336	0.81
Tehama	Asian	537	1.29
Tehama	Native American	424	1.02
Tehama	Pacific Islander	37	0.09

County	Race/Ethnicity	N	Percent
Tehama	Other	344	0.83
Tehama	Missing	5,869	14.10
Yuba	White	20,294	42.16
Yuba	Hispanic	14,581	30.29
Yuba	Black	1,800	3.74
Yuba	Asian	3,098	6.44
Yuba	Native American	451	0.94
Yuba	Pacific Islander	140	0.29
Yuba	Other	1,168	2.43
Yuba	Missing	6,604	13.72

NOTE: The symbol * indicates suppression or complementary suppression for cells with values less than 11.

Appendix A 6. Member demographic characteristics by Transition county, pooled across the baseline years. Dual Eligibility.

County	Dual Eligibility Status	N	Percent
Alameda	Not dually eligible	563,321	88.29
Alameda	Dually eligible	74,727	11.71
Butte	Not dually eligible	92,745	86.68
Butte	Dually eligible	14,253	13.32
Colusa	Not dually eligible	12,444	89.24
Colusa	Dually eligible	1,501	10.76
Contra Costa	Not dually eligible	375,352	89.86
Contra Costa	Dually eligible	42,367	10.14
Glenn	Not dually eligible	15,669	88.12

County	Dual Eligibility Status	N	Percent
Glenn	Dually eligible	2,113	11.88
Imperial	Not dually eligible	115,245	86.13
Imperial	Dually eligible	18,564	13.87
Mariposa	Not dually eligible	7,396	85.93
Mariposa	Dually eligible	1,211	14.07
Nevada	Not dually eligible	33,363	87.12
Nevada	Dually eligible	4,931	12.88
Placer	Not dually eligible	97,108	89.23
Placer	Dually eligible	11,721	10.77
Plumas	Not dually eligible	7,585	84.41
Plumas	Dually eligible	1,401	15.59
San Benito	Not dually eligible	26,950	91.42
San Benito	Dually eligible	2,528	8.58
Sierra	Not dually eligible	920	78.63
Sierra	Dually eligible	250	21.37
Sutter	Not dually eligible	51,482	89.00
Sutter	Dually eligible	6,361	11.00
Tehama	Not dually eligible	36,262	87.11
Tehama	Dually eligible	5,365	12.89
Yuba	Not dually eligible	42,996	89.32
Yuba	Dually eligible	5,140	10.68

Appendix A 7. Member demographic characteristics by Transition county, pooled across the baseline years. Primary Language.

County	Primary Language	N	Percent
Alameda	English	396,501	62.14
Alameda	Non-English	233,371	36.58
Alameda	Missing	8,176	1.28
Butte	English	95,958	89.68
Butte	Non-English	10,577	9.89
Butte	Missing	463	0.43
Colusa	English	7,361	52.79
Colusa	Non-English	6,515	46.72
Colusa	Missing	69	0.49
Contra Costa	English	279,926	67.01
Contra Costa	Non-English	131,155	31.40
Contra Costa	Missing	6,638	1.59
Glenn	English	12,434	69.92
Glenn	Non-English	5,291	29.75
Glenn	Missing	*	*
Imperial	English	56,883	42.51
Imperial	Non-English	76,136	56.90
Imperial	Missing	790	0.59
Mariposa	English	8,178	95.02
Mariposa	Non-English	*	*
Mariposa	Missing	65	0.76
Nevada	English	35,470	92.63
Nevada	Non-English	2,622	6.85
Nevada	Missing	202	0.53

County	Primary Language	N	Percent
Placer	English	91,592	84.16
Placer	Non-English	16,605	15.26
Placer	Missing	632	0.58
Plumas	English	8,490	94.48
Plumas	Non-English	411	4.57
Plumas	Missing	85	0.95
San Benito	English	18,098	61.39
San Benito	Non-English	11,206	38.01
San Benito	Missing	174	0.59
Sierra	English	1,088	92.99
Sierra	Non-English	*	*
Sierra	Missing	*	*
Sutter	English	41,422	71.61
Sutter	Non-English	16,231	28.06
Sutter	Missing	190	0.33
Tehama	English	33,370	80.16
Tehama	Non-English	7,957	19.11
Tehama	Missing	300	0.72
Yuba	English	39,997	83.09
Yuba	Non-English	7,953	16.52
Yuba	Missing	186	0.39

NOTE: The symbol * indicates suppression or complementary suppression for cells with values less than 11.

Appendix B. Additional Data on Member-to-Provider Ratios

Appendix B 1. Member to provider ratios, by county and baseline year – All Physicians.

County	Year	Total Number of Members	Total FTE Physicians	Ratio of Members to Physicians
Alameda	2022	403,065	20,869.1	19.3
Alameda	2023	433,308	18,276.1	23.7
Alameda	Pooled baseline	836,373	39,145.2	21.4
Butte	2022	25,043	193.6	129.4
Butte	2023	26,777	135.4	197.7
Butte	Pooled baseline	51,820	329.0	157.5
Colusa	2022	5,470	32.8	166.9
Colusa	2023	5,465	19.0	288.4
Colusa	Pooled baseline	10,935	51.7	211.4
Contra Costa	2022	279,045	17,171.5	16.3
Contra Costa	2023	303,827	16,232.9	18.7
Contra Costa	Pooled baseline	582,872	33,404.5	17.4
Glenn	2022	2,913	37.2	78.4
Glenn	2023	2,979	24.0	123.9
Glenn	Pooled baseline	5,892	61.2	96.3
Imperial	2022	92,044	2,863.8	32.1
Imperial	2023	99,411	3,497.1	28.4
Imperial	Pooled baseline	191,455	6,360.9	30.1

County	Year	Total Number of Members	Total FTE Physicians	Ratio of Members to Physicians
Mariposa	2022	5,252	474.8	11.1
Mariposa	2023	5,332	45.0	118.6
Mariposa	Pooled baseline	10,584	519.8	20.4
Nevada	2022	14,799	189.8	78.0
Nevada	2023	15,706	128.6	122.1
Nevada	Pooled baseline	30,505	318.4	95.8
Placer	2022	51,901	2,965.7	17.5
Placer	2023	54,906	3,017.0	18.2
Placer	Pooled baseline	106,807	5,982.7	17.9
Plumas	2022	3,013	60.3	50.0
Plumas	2023	3,018	29.7	101.6
Plumas	Pooled baseline	6,031	90.0	67.0
San Benito	2022	11,260	58.9	191.2
San Benito	2023	12,073	34.4	351.5
San Benito	Pooled baseline	23,333	93.2	250.2
Sierra	2022	383	9.9	38.8
Sierra	2023	409	12.9	31.6
Sierra	Pooled baseline	792	22.8	34.8
Sutter	2022	39,124	617.9	63.3
Sutter	2023	40,628	1,122.0	36.2

County	Year	Total Number of Members	Total FTE Physicians	Ratio of Members to Physicians
Sutter	Pooled baseline	79,752	1,739.9	45.8
Tehama	2022	11,154	39.3	283.5
Tehama	2023	11,993	34.8	344.2
Tehama	Pooled baseline	23,147	74.2	312.0
Yuba	2022	32,524	527.4	61.7
Yuba	2023	33,928	933.5	36.3
Yuba	Pooled baseline	66,452	1,460.9	45.5

NOTE: Ratios for the pooled baseline represent averages of the yearly ratios, weighted by the number of providers. FTE=full-time equivalent.

Appendix B 2. Member to provider ratios, by county and baseline year – Primary Care Practitioners (PCPs).

County	Year	Total Number of Members	Total FTE PCPs	Ratio of Members to PCPs
Alameda	2022	403,065	632.3	637.4
Alameda	2023	433,308	472.7	916.7
Alameda	Pooled baseline	836,373	1,105.0	756.9
Butte	2022	25,043	15.3	1,634.5
Butte	2023	26,777	8.2	3,252.0
Butte	Pooled baseline	51,820	23.6	2,199.9
Colusa	2022	5,470	5.5	990.4
Colusa	2023	5,465	2.3	2,387.2
Colusa	Pooled baseline	10,935	7.8	1,399.8
Contra Costa	2022	279,045	417.9	667.7
Contra Costa	2023	303,827	3,034.9	100.1
Contra Costa	Pooled baseline	582,872	3,452.8	168.8
Glenn	2022	2,913	10.0	292.2
Glenn	2023	2,979	6.3	470.0
Glenn	Pooled baseline	5,892	16.3	361.3
Imperial	2022	92,044	591.0	155.7
Imperial	2023	99,411	756.7	131.4
Imperial	Pooled baseline	191,455	1,347.7	142.1
Mariposa	2022	5,252	116.5	45.1

County	Year	Total Number of Members	Total FTE PCPs	Ratio of Members to PCPs
Mariposa	2023	5,332	114.3	46.6
Mariposa	Pooled baseline	10,584	230.8	45.9
Nevada	2022	14,799	21.4	692.8
Nevada	2023	15,706	9.7	1,616.0
Nevada	Pooled baseline	30,505	31.1	981.5
Placer	2022	51,901	764.4	67.9
Placer	2023	54,906	766.1	71.7
Placer	Pooled baseline	106,807	1,530.5	69.8
Plumas	2022	3,013	11.7	257.2
Plumas	2023	3,018	3.5	871.0
Plumas	Pooled baseline	6,031	15.2	397.3
San Benito	2022	11,260	8.6	1,317.0
San Benito	2023	12,073	4.1	2,972.8
San Benito	Pooled baseline	23,333	12.6	1,850.2
Sierra	2022	383	1.7	219.7
Sierra	2023	409	0.2	2,045.0
Sierra	Pooled baseline	792	1.9	407.6
Sutter	2022	39,124	133.9	292.2
Sutter	2023	40,628	297.3	136.7
Sutter	Pooled baseline	79,752	431.2	184.9

County	Year	Total Number of Members	Total FTE PCPs	Ratio of Members to PCPs
Tehama	2022	11,154	9.9	1,126.4
Tehama	2023	11,993	8.6	1,397.8
Tehama	Pooled baseline	23,147	18.5	1,252.4
Yuba	2022	32,524	95.0	342.5
Yuba	2023	33,928	205.5	165.1
Yuba	Pooled baseline	66,452	300.4	221.2

NOTE: Ratios for the pooled baseline represent averages of the yearly ratios, weighted by the number of providers. FTE=full-time equivalent.

Appendix B 3. Member to provider ratios, by county and baseline year – Specialists.

County	Year	Total Number of Members	Total FTE Specialists	Ratio of Members to Specialists
Alameda	2022	403,065	15,717.2	25.6
Alameda	2023	433,308	13,915.0	31.1
Alameda	Pooled baseline	836,373	29,632.2	28.2
Butte	2022	25,043	180.1	139.0
Butte	2023	26,777	219.5	122.0
Butte	Pooled baseline	51,820	399.6	129.7
Colusa	2022	5,470	27.5	199.0
Colusa	2023	5,465	27.7	197.1
Colusa	Pooled baseline	10,935	55.2	198.1
Contra Costa	2022	279,045	13,718.7	20.3
Contra Costa	2023	303,827	13,368.0	22.7
Contra Costa	Pooled baseline	582,872	27,086.7	21.5
Glenn	2022	2,913	28.9	100.9
Glenn	2023	2,979	33.2	89.6
Glenn	Pooled baseline	5,892	62.1	94.9
Imperial	2022	92,044	2,842.0	32.4
Imperial	2023	99,411	3,492.6	28.5
Imperial	Pooled baseline	191,455	6,334.6	30.2

County	Year	Total Number of Members	Total FTE Specialists	Ratio of Members to Specialists
Mariposa	2022	5,252	471.7	11.1
Mariposa	2023	5,332	65.7	81.2
Mariposa	Pooled baseline	10,584	537.3	19.7
Nevada	2022	14,799	169.7	87.2
Nevada	2023	15,706	183.7	85.5
Nevada	Pooled baseline	30,505	353.3	86.3
Placer	2022	51,901	2,302.2	22.5
Placer	2023	54,906	2,492.3	22.0
Placer	Pooled baseline	106,807	4,794.5	22.3
Plumas	2022	3,013	52.9	57.0
Plumas	2023	3,018	37.9	79.6
Plumas	Pooled baseline	6,031	90.8	66.4
San Benito	2022	11,260	53.9	208.9
San Benito	2023	12,073	34.9	345.9
San Benito	Pooled baseline	23,333	88.8	262.8
Sierra	2022	383	8.1	47.5
Sierra	2023	409	17.5	23.4
Sierra	Pooled baseline	792	25.6	31.0
Sutter	2022	39,124	602.8	64.9
Sutter	2023	40,628	1,223.5	33.2

County	Year	Total Number of Members	Total FTE Specialists	Ratio of Members to Specialists
Sutter	Pooled baseline	79,752	1,826.3	43.7
Tehama	2022	11,154	29.4	379.0
Tehama	2023	11,993	49.8	241.0
Tehama	Pooled baseline	23,147	79.2	292.3
Yuba	2022	32,524	511.8	63.5
Yuba	2023	33,928	1,021.8	33.2
Yuba	Pooled baseline	66,452	1,533.6	43.3

NOTE: Ratios for the pooled baseline represent averages of the yearly ratios, weighted by the number of providers. FTE=full-time equivalent.

Appendix B 4. Member to provider ratios, by county and baseline year – Non-Specialty Outpatient Mental Health Providers.

County	Year	Total Number of Members	Total FTE Non-Specialty Outpatient Mental Health Providers	Ratio of Members to Providers
Alameda	2022	403,065	4,517.4	89.2
Alameda	2023	433,308	4,021.8	107.7
Alameda	Pooled baseline	836,373	8,539.2	97.9
Butte	2022	25,043	56.0	447.4
Butte	2023	26,777	21.0	1,276.4
Butte	Pooled baseline	51,820	77.0	673.4
Colusa	2022	5,470	6.9	789.4
Colusa	2023	5,465	2.0	2,740.6
Colusa	Pooled baseline	10,935	8.9	1,225.4
Contra Costa	2022	279,045	3,913.3	71.3
Contra Costa	2023	303,827	3,974.2	76.4
Contra Costa	Pooled baseline	582,872	7,887.5	73.9

County	Year	Total Number of Members	Total FTE Non-Specialty Outpatient Mental Health Providers	Ratio of Members to Providers
Glenn	2022	2,913	6.9	420.4
Glenn	2023	2,979	2.8	1,066.3
Glenn	Pooled baseline	5,892	9.7	606.0
Imperial	2022	92,044	46.9	1,963.1
Imperial	2023	99,411	50.5	1,969.5
Imperial	Pooled baseline	191,455	97.4	1,966.4
Mariposa	2022	5,252	30.6	171.6
Mariposa	2023	5,332	5.6	953.2
Mariposa	Pooled baseline	10,584	36.2	292.4
Nevada	2022	14,799	37.6	393.9
Nevada	2023	15,706	9.2	1,714.9
Nevada	Pooled baseline	30,505	46.7	652.8
Placer	2022	51,901	976.5	53.2
Placer	2023	54,906	2,679.6	20.5
Placer	Pooled baseline	106,807	3,656.1	29.2

County	Year	Total Number of Members	Total FTE Non-Specialty Outpatient Mental Health Providers	Ratio of Members to Providers
Plumas	2022	3,013	8.8	343.9
Plumas	2023	3,018	2.2	1,381.6
Plumas	Pooled baseline	6,031	10.9	550.9
San Benito	2022	11,260	5.1	2,193.6
San Benito	2023	12,073	0.0	
San Benito	Pooled baseline	23,333	5.1	4,545.7
Sierra	2022	383	1.3	287.3
Sierra	2023	409	0.5	858.9
Sierra	Pooled baseline	792	1.8	437.7
Sutter	2022	39,124	91.3	428.6
Sutter	2023	40,628	63.1	643.5
Sutter	Pooled baseline	79,752	154.4	516.4
Tehama	2022	11,154	7.8	1,437.1
Tehama	2023	11,993	4.7	2,536.9
Tehama	Pooled baseline	23,147	12.5	1,853.4

County	Year	Total Number of Members	Total FTE Non-Specialty Outpatient Mental Health Providers	Ratio of Members to Providers
Yuba	2022	32,524	76.2	426.9
Yuba	2023	33,928	57.2	593.1
Yuba	Pooled baseline	66,452	133.4	498.2

NOTES: Non-specialty outpatient mental health providers comprise Psychologists, Licensed Clinical Social Workers, and Licensed Marriage and Family Therapists. Ratios for the pooled baseline represent averages of the yearly ratios, weighted by the number of providers. Data was not available for 2021 as it was not collected at that time. FTE=full-time equivalent.

Appendix C. Additional Data on Quality and Access Measures

Appendix C 1. Rates of well-child visits at 15 and 30 months by county and baseline year.

County	Year	Members turning 15 months during the MY	Had 6 or more well-child visits in MY	Percent (15 months)	Members turning 30 months during the MY	Had 2 or more well-child visits in MY	Percent (30 months)
Alameda	2021	1,677	749	44.7	4,852	3,054	62.9
Alameda	2022	1,679	808	48.1	4,768	3,275	68.7
Alameda	2023	1,686	984	58.4	4,147	2,976	71.8
Alameda	Pooled Baseline	5,042	2,541	50.4	13,767	9,305	67.6
Butte	2021	661	304	46.0	1,075	661	61.5
Butte	2022	697	325	46.6	1,049	660	62.9
Butte	2023	553	248	44.8	1,074	660	61.5
Butte	Pooled Baseline	1,911	877	45.9	3,198	1,981	61.9
Colusa	2021	58	19	32.8	169	131	77.5
Colusa	2022	63	28	44.4	164	122	74.4
Colusa	2023	41	20	48.8	166	138	83.1
Colusa	Pooled Baseline	162	67	41.4	499	391	78.4
Contra Costa	2021	1,424	749	52.6	3,157	2,004	63.5
Contra Costa	2022	1,556	1,006	64.7	3,458	2,497	72.2
Contra Costa	2023	1,604	1,145	71.4	3,303	2,440	73.9
Contra Costa	Pooled Baseline	4,584	2,900	63.3	9,918	6,941	70.0
Glenn	2021	150	55	36.7	243	185	76.1
Glenn	2022	133	71	53.4	199	130	65.3
Glenn	2023	145	92	63.4	199	131	65.8
Glenn	Pooled Baseline	428	218	50.9	641	446	69.6

County	Year	Members turning 15 months during the MY	Had 6 or more well-child visits in MY	Percent (15 months)	Members turning 30 months during the MY	Had 2 or more well-child visits in MY	Percent (30 months)
Imperial	2021	616	267	43.3	1,594	1,021	64.1
Imperial	2022	519	278	53.6	1,475	969	65.7
Imperial	2023	666	378	56.8	1,447	1,021	70.6
Imperial	Pooled Baseline	1,801	923	51.2	4,516	3,011	66.7
Mariposa	2021	*	*	*	*	*	*
Mariposa	2022	*	*	*	*	*	*
Mariposa	2023	*	*	*	*	*	*
Mariposa	Pooled Baseline	*	*	*	208	66	31.7
Nevada	2021	95	39	41.1	342	206	60.2
Nevada	2022	*	*	*	328	196	59.8
Nevada	2023	*	*	*	349	206	59.0
Nevada	Pooled Baseline	238	91	38.2	1,019	608	59.7
Placer	2021	362	198	54.7	821	481	58.6
Placer	2022	360	218	60.6	821	517	63.0
Placer	2023	386	229	59.3	890	564	63.4
Placer	Pooled Baseline	1,108	645	58.2	2,532	1,562	61.7
Plumas	2021	*	*	*	77	24	31.2
Plumas	2022	47	15	31.9	67	28	41.8
Plumas	2023	*	*	*	78	33	42.3
Plumas	Pooled Baseline	107	37	34.6	222	85	38.3
San Benito	2021	116	70	60.3	223	142	63.7
San Benito	2022	118	67	56.8	246	170	69.1
San Benito	2023	95	37	38.9	229	147	64.2

County	Year	Members turning 15 months during the MY	Had 6 or more well-child visits in MY	Percent (15 months)	Members turning 30 months during the MY	Had 2 or more well-child visits in MY	Percent (30 months)
San Benito	Pooled Baseline	329	174	52.9	698	459	65.8
Sierra	2021	*	*	*	*	*	*
Sierra	2022	*	*	*	*	*	*
Sierra	2023	*	*	*	*	*	*
Sierra	Pooled Baseline	*	*	*	22	11	50.0
Sutter	2021	326	210	64.4	635	486	76.5
Sutter	2022	302	181	59.9	690	503	72.9
Sutter	2023	336	213	63.4	648	491	75.8
Sutter	Pooled Baseline	964	604	62.7	1,973	1,480	75.0
Tehama	2021	186	73	39.2	434	312	71.9
Tehama	2022	172	96	55.8	421	300	71.3
Tehama	2023	146	71	48.6	461	346	75.1
Tehama	Pooled Baseline	504	240	47.6	1,316	958	72.8
Yuba	2021	244	128	52.5	521	318	61.0
Yuba	2022	237	114	48.1	532	351	66.0
Yuba	2023	252	128	50.8	511	337	65.9
Yuba	Pooled Baseline	733	370	50.5	1,564	1,006	64.3

NOTES: Values for the pooled baseline indicate the total number of infants in the eligible population that received well child visits over the entire baseline period. MY=measurement year. The symbol * indicates suppression or complementary suppression for cells with values less than 11.

Appendix C 2. Rates of child and adolescent well-care visits by county and baseline year.

County	Year	Members ages 3-21 in the MY	Had at least one well-care visit during MY	Percent
Alameda	2021	114,775	57,999	50.5
Alameda	2022	120,940	58,924	48.7
Alameda	2023	104,624	55,427	53.0
Alameda	Pooled baseline	340,339	172,350	50.6
Butte	2021	22,099	8,777	39.7
Butte	2022	23,080	8,938	38.7
Butte	2023	23,807	8,334	35.0
Butte	Pooled baseline	68,986	26,049	37.8
Colusa	2021	4,311	2,518	58.4
Colusa	2022	4,259	2,693	63.2
Colusa	2023	4,183	2,640	63.1
Colusa	Pooled baseline	12,753	7,851	61.6
Contra Costa	2021	75,073	40,276	53.6
Contra Costa	2022	80,256	41,504	51.7
Contra Costa	2023	78,508	42,272	53.8
Contra Costa	Pooled baseline	233,837	124,052	53.1
Glenn	2021	4,823	2,458	51.0
Glenn	2022	5,011	2,372	47.3
Glenn	2023	4,776	2,300	48.2
Glenn	Pooled baseline	14,610	7,130	48.8
Imperial	2021	33,112	14,498	43.8
Imperial	2022	34,538	15,450	44.7
Imperial	2023	33,267	15,787	47.5
Imperial	Pooled baseline	100,917	45,735	45.3
Mariposa	2021	1,362	377	27.7
Mariposa	2022	1,420	456	32.1
Mariposa	2023	1,460	510	34.9
Mariposa	Pooled baseline	4,242	1,343	31.7
Nevada	2021	7,080	2,450	34.6
Nevada	2022	7,354	2,793	38.0
Nevada	2023	7,905	2,717	34.4
Nevada	Pooled baseline	22,339	7,960	35.6

County	Year	Members ages 3-21 in the MY	Had at least one well-care visit during MY	Percent
Placer	2021	19,007	8,328	43.8
Placer	2022	20,279	8,287	40.9
Placer	2023	21,674	8,588	39.6
Placer	Pooled baseline	60,960	25,203	41.3
Plumas	2021	1,789	382	21.4
Plumas	2022	1,668	354	21.2
Plumas	2023	1,679	480	28.6
Plumas	Pooled baseline	5,136	1,216	23.7
San Benito	2021	3,965	1,898	47.9
San Benito	2022	4,059	1,955	48.2
San Benito	2023	4,507	2,026	45.0
San Benito	Pooled baseline	12,531	5,879	46.9
Sierra	2021	182	32	17.6
Sierra	2022	184	43	23.4
Sierra	2023	193	67	34.7
Sierra	Pooled baseline	559	142	25.4
Sutter	2021	13,918	6,563	47.2
Sutter	2022	14,109	6,899	48.9
Sutter	2023	14,272	7,310	51.2
Sutter	Pooled baseline	42,299	20,772	49.1
Tehama	2021	9,668	4,491	46.5
Tehama	2022	10,033	4,962	49.5
Tehama	2023	10,473	5,106	48.8
Tehama	Pooled baseline	30,174	14,559	48.3
Yuba	2021	10,941	4,249	38.8
Yuba	2022	11,463	4,709	41.1
Yuba	2023	11,964	4,830	40.4
Yuba	Pooled baseline	34,368	13,788	40.1

Note: Numerator and denominator values for the pooled baseline represent person-years, not the number of unique members, since members could count in the numerator and denominator multiple times over the 3-year baseline period. Thus, the pooled baseline represents the total number of person-years with a well-child visit out of the total number of person-years eligible for screening. MY=measurement year.

Appendix C 3. Immunization rates for adolescents by county and baseline year, Meningococcal Vaccine.

County	Year	Adolescents who turned 13 during the MY	Had the meningococcal vaccine	Rate
Alameda	2021	6,156	4,567	74.2
Alameda	2022	7,524	5,759	76.5
Alameda	2023	7,362	4,996	67.9
Alameda	Pooled baseline	21,042	15,322	72.8
Butte	2021	1,147	797	69.5
Butte	2022	1,408	891	63.3
Butte	2023	1,519	812	53.5
Butte	Pooled baseline	4,074	2,500	61.4
Colusa	2021	197	137	69.5
Colusa	2022	295	201	68.1
Colusa	2023	284	193	68
Colusa	Pooled baseline	776	531	68.4
Contra Costa	2021	4,567	3,339	73.1
Contra Costa	2022	5,710	4,235	74.2
Contra Costa	2023	5,690	3,587	63
Contra Costa	Pooled baseline	15,967	11,161	69.9
Glenn	2021	265	140	52.8
Glenn	2022	336	186	55.4
Glenn	2023	322	116	36
Glenn	Pooled baseline	923	442	47.9
Imperial	2021	1,775	1,279	72.1
Imperial	2022	2,176	1,627	74.8
Imperial	2023	2,120	1,486	70.1
Imperial	Pooled baseline	6,071	4,392	72.3
Mariposa	2021	*	*	*
Mariposa	2022	*	*	*
Mariposa	2023	*	*	*

County	Year	Adolescents who turned 13 during the MY	Had the meningococcal vaccine	Rate
Mariposa	Pooled baseline	*	*	*
Nevada	2021	365	188	51.5
Nevada	2022	496	252	50.8
Nevada	2023	476	220	46.2
Nevada	Pooled baseline	1,337	660	49.4
Placer	2021	1,095	704	64.3
Placer	2022	1,433	888	62
Placer	2023	1,517	787	51.9
Placer	Pooled baseline	4,045	2,379	58.8
Plumas	2021	108	34	31.5
Plumas	2022	116	41	35.3
Plumas	2023	96	25	26
Plumas	Pooled baseline	320	100	31.3
San Benito	2021	352	238	67.6
San Benito	2022	425	292	68.7
San Benito	2023	426	244	57.3
San Benito	Pooled baseline	1,203	774	64.3
Sierra	2021	*	*	*
Sierra	2022	*	*	*
Sierra	2023	*	*	*
Sierra	Pooled baseline	*	*	*
Sutter	2021	749	549	73.3
Sutter	2022	928	643	69.3
Sutter	2023	929	485	52.2
Sutter	Pooled baseline	2,606	1,677	64.4
Tehama	2021	562	340	60.5
Tehama	2022	680	381	56
Tehama	2023	667	361	54.1

County	Year	Adolescents who turned 13 during the MY	Had the meningococcal vaccine	Rate
Tehama	Pooled baseline	1,909	1,082	56.7
Yuba	2021	636	409	64.3
Yuba	2022	756	448	59.3
Yuba	2023	832	430	51.7
Yuba	Pooled baseline	2,224	1,287	57.9

NOTES: The meningococcal vaccine indicates receiving at least one meningococcal serogroups A, C, W, Y vaccine with a date of service on or between the adolescent's 11th and 13th birthdays. Values for the pooled baseline indicate the total number of members receiving vaccines out of the total number eligible for a vaccine. The symbol * indicates suppression or complementary suppression for cells with values less than 11. MY=measurement year.

Appendix C 4. Immunization rates for adolescents by county and baseline year, TDAP vaccine.

County	Year	Adolescents who turned 13 during the MY	Had the TDAP vaccine	Rate
Alameda	2021	6,156	4,568	74.2
Alameda	2022	7,524	5,993	79.7
Alameda	2023	7,362	5,864	79.7
Alameda	Pooled baseline	21,042	16,425	78.1
Butte	2021	1,147	963	84
Butte	2022	1,408	1,195	84.9
Butte	2023	1,519	1,277	84.1
Butte	Pooled baseline	4,074	3,435	84.3
Colusa	2021	197	155	78.7
Colusa	2022	295	229	77.6
Colusa	2023	284	212	74.6
Colusa	Pooled baseline	776	596	76.8
Contra Costa	2021	4,567	3,766	82.5
Contra Costa	2022	5,710	4,867	85.2

County	Year	Adolescents who turned 13 during the MY	Had the TDAP vaccine	Rate
Contra Costa	2023	5,690	4,794	84.3
Contra Costa	Pooled baseline	15,967	13,427	84.1
Glenn	2021	265	241	90.9
Glenn	2022	336	300	89.3
Glenn	2023	322	291	90.4
Glenn	Pooled baseline	923	832	90.1
Imperial	2021	1,775	1,355	76.3
Imperial	2022	2,176	1,804	82.9
Imperial	2023	2,120	1,751	82.6
Imperial	Pooled baseline	6,071	4,910	80.9
Mariposa	2021	*	*	*
Mariposa	2022	*	*	*
Mariposa	2023	*	*	*
Mariposa	Pooled baseline	*	*	*
Nevada	2021	365	263	72.1
Nevada	2022	496	386	77.8
Nevada	2023	476	360	75.6
Nevada	Pooled baseline	1,337	1,009	75.5
Placer	2021	1,095	890	81.3
Placer	2022	1,433	1,110	77.5
Placer	2023	1,517	1,156	76.2
Placer	Pooled baseline	4,045	3,156	78
Plumas	2021	108	70	64.8
Plumas	2022	116	81	69.8
Plumas	2023	96	63	65.6
Plumas	Pooled baseline	320	214	66.9
San Benito	2021	352	271	77
San Benito	2022	425	355	83.5
San Benito	2023	426	358	84

County	Year	Adolescents who turned 13 during the MY	Had the TDAP vaccine	Rate
San Benito	Pooled baseline	1,203	984	81.8
Sierra	2021	*	*	*
Sierra	2022	*	*	*
Sierra	2023	*	*	*
Sierra	Pooled baseline	*	*	*
Sutter	2021	749	630	84.1
Sutter	2022	928	787	84.8
Sutter	2023	929	777	83.6
Sutter	Pooled baseline	2,606	2,194	84.2
Tehama	2021	562	466	82.9
Tehama	2022	680	576	84.7
Tehama	2023	667	565	84.7
Tehama	Pooled baseline	1,909	1,607	84.2
Yuba	2021	636	494	77.7
Yuba	2022	756	581	76.9
Yuba	2023	832	670	80.5
Yuba	Pooled baseline	2,224	1,745	78.5

NOTES: TDAP indicates receiving at least one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine with a date of service on or between the adolescent's 10th and 13th birthdays. Values for the pooled baseline indicate the total number of members receiving vaccines out of the total number eligible for a vaccine. The symbol * indicates suppression or complementary suppression for cells with values less than 11. MY=measurement year; TDAP=tetanus, diphtheria toxoids and acellular pertussis.

Appendix C 5. Immunization rates for adolescents by county and baseline year, HPV vaccine.

County	Year	Adolescents who turned 13 during the MY	Had the HPV vaccine	Rate
Alameda	2021	6,156	2,557	41.5
Alameda	2022	7,524	3,397	45.1

County	Year	Adolescents who turned 13 during the MY	Had the HPV vaccine	Rate
Alameda	2023	7,362	3,320	45.1
Alameda	Pooled baseline	21,042	9,274	44.1
Butte	2021	1,147	298	26
Butte	2022	1,408	365	25.9
Butte	2023	1,519	393	25.9
Butte	Pooled baseline	4,074	1,056	25.9
Colusa	2021	197	55	27.9
Colusa	2022	295	86	29.2
Colusa	2023	284	89	31.3
Colusa	Pooled baseline	776	230	29.6
Contra Costa	2021	4,567	1,755	38.4
Contra Costa	2022	5,710	2,628	46
Contra Costa	2023	5,690	2,627	46.2
Contra Costa	Pooled baseline	15,967	7,010	43.9
Glenn	2021	265	61	23
Glenn	2022	336	92	27.4
Glenn	2023	322	75	23.3
Glenn	Pooled baseline	923	228	24.7
Imperial	2021	1,775	552	31.1
Imperial	2022	2,176	700	32.2
Imperial	2023	2,120	756	35.7
Imperial	Pooled baseline	6,071	2,008	33.1
Mariposa	2021	*	*	*
Mariposa	2022	*	*	*
Mariposa	2023	*	*	*
Mariposa	Pooled baseline	276	37	13.4
Nevada	2021	365	67	18.4
Nevada	2022	496	78	15.7
Nevada	2023	476	79	16.6
Nevada	Pooled baseline	1,337	224	16.8
Placer	2021	1,095	390	35.6
Placer	2022	1,433	494	34.5
Placer	2023	1,517	461	30.4
Placer	Pooled baseline	4,045	1,345	33.3
Plumas	2021	*	*	*
Plumas	2022	*	*	*
Plumas	2023	*	*	*
Plumas	Pooled baseline	*	*	*
San Benito	2021	352	98	27.8
San Benito	2022	425	144	33.9

County	Year	Adolescents who turned 13 during the MY	Had the HPV vaccine	Rate
San Benito	2023	426	159	37.3
San Benito	Pooled baseline	1,203	401	33.3
Sierra	2021	*	*	*
Sierra	2022	*	*	0
Sierra	2023	*	*	*
Sierra	Pooled baseline	*	*	*
Sutter	2021	749	286	38.2
Sutter	2022	928	349	37.6
Sutter	2023	929	353	38
Sutter	Pooled baseline	2,606	988	37.9
Tehama	2021	562	125	22.2
Tehama	2022	680	169	24.9
Tehama	2023	667	180	27
Tehama	Pooled baseline	1,909	474	24.8
Yuba	2021	636	230	36.2
Yuba	2022	756	271	35.8
Yuba	2023	832	335	40.3
Yuba	Pooled baseline	2,224	836	37.6

NOTES: HPV indicates receiving at least two HPV vaccines on or between the child's 9th and 13th birthdays and with dates of service at least 146 days apart, *or* at least three HPV vaccines with different dates of service on or between the adolescent's 9th and 13th birthdays. Values for the pooled baseline indicate the total number of members receiving vaccines out of the total number eligible for a vaccine. The symbol * indicates suppression or complementary suppression for cells with values less than 11. MY=measurement year; HPV=human papillomavirus.

Appendix C 6. Immunization rates for adolescents by county for 2023, Combination 1 vaccine.

County	Year	Adolescents who turned 13 during the MY	Had the Combination 1 vaccine	Rate
Alameda	2023	7,362	4,808	65.3
Butte	2023	1,519	794	52.3
Colusa	2023	284	150	52.8
Contra Costa	2023	5,690	3,511	61.7
Glenn	2023	322	116	36.0
Imperial	2023	2,120	1,465	69.1
Mariposa	2023	98	33	33.7
Nevada	2023	476	217	45.6
Placer	2023	1,517	763	50.3
Plumas	2023	*	*	*
San Benito	2023	426	236	55.4

County	Year	Adolescents who turned 13 during the MY	Had the Combination 1 vaccine	Rate
Sierra	2023	*	*	*
Sutter	2023	929	472	50.8
Tehama	2023	667	355	53.2
Yuba	2023	832	413	49.6

NOTES: Combination 1 comprises the meningococcal and TDAP vaccines, and data was only available for 2023. The symbol * indicates suppression or complementary suppression for cells with values less than 11. MY=measurement year.

Appendix C 7. Immunization rates for adolescents by county and baseline year, Combination 2 vaccine.

County	Year	Adolescents who turned 13 during the MY	Had the Combination 2 vaccine	Rate
Alameda	2021	6,156	2,234	36.3
Alameda	2022	7,524	3,117	41.4
Alameda	2023	7,362	2,967	40.3
Alameda	Pooled baseline	21,042	8,318	39.5
Butte	2021	1,147	279	24.3
Butte	2022	1,408	349	24.8
Butte	2023	1,519	361	23.8
Butte	Pooled baseline	4,074	989	24.3
Colusa	2021	197	50	25.4
Colusa	2022	295	77	26.1
Colusa	2023	284	69	24.3
Colusa	Pooled baseline	776	196	25.3
Contra Costa	2021	4,567	1,644	36.0
Contra Costa	2022	5,710	2,478	43.4
Contra Costa	2023	5,690	2,213	38.9
Contra Costa	Pooled baseline	15,967	6,335	39.7
Glenn	2021	265	58	21.9
Glenn	2022	336	89	26.5
Glenn	2023	322	58	18.0
Glenn	Pooled baseline	923	205	22.2
Imperial	2021	1,775	520	29.3
Imperial	2022	2,176	679	31.2
Imperial	2023	2,120	695	32.8
Imperial	Pooled baseline	6,071	1,894	31.2
Mariposa	2021	*	*	*
Mariposa	2022	93	16	17.2
Mariposa	2023	*	*	*
Mariposa	Pooled baseline	276	33	12.0
Nevada	2021	365	61	16.7
Nevada	2022	496	76	15.3
Nevada	2023	476	71	14.9
Nevada	Pooled baseline	1,337	208	15.6
Placer	2021	1,095	368	33.6
Placer	2022	1,433	475	33.1
Placer	2023	1,517	422	27.8
Placer	Pooled baseline	4,045	1,265	31.3
Plumas	2021	*	*	*

County	Year	Adolescents who turned 13 during the MY	Had the Combination 2 vaccine	Rate
Plumas	2022	116	12	10.3
Plumas	2023	*	*	*
Plumas	Pooled baseline	*	*	*
San Benito	2021	352	73	20.7
San Benito	2022	425	125	29.4
San Benito	2023	426	119	27.9
San Benito	Pooled baseline	1,203	317	26.4
Sierra	2021	*	*	*
Sierra	2022	15	0	0.0
Sierra	2023	14	0	0.0
Sierra	Pooled baseline	*	*	*
Sutter	2021	749	260	34.7
Sutter	2022	928	308	33.2
Sutter	2023	929	266	28.6
Sutter	Pooled baseline	2,606	834	32.0
Tehama	2021	562	108	19.2
Tehama	2022	680	151	22.2
Tehama	2023	667	165	24.7
Tehama	Pooled baseline	1,909	424	22.2
Yuba	2021	636	177	27.8
Yuba	2022	756	216	28.6
Yuba	2023	832	240	28.8
Yuba	Pooled baseline	2,224	633	28.5

NOTES: Combination 2 comprises the meningococcal, TDAP, and HPV vaccines. Values for the pooled baseline indicate the total number of members receiving vaccines out of the total number eligible for a vaccine. The symbol * indicates suppression or complementary suppression for cells with values less than 11. MY=measurement year.

Appendix C 8. Rates of prenatal and postpartum care by county and baseline year.

County	Year	Live births	Had a prenatal visit in first trimester	Percent (prenatal)	Had a postpartum visit on or between 7 and 84 days after delivery	Percent (post-partum)
Alameda	2021	512	463	90.4	440	85.9

County	Year	Live births	Had a prenatal visit in first trimester	Percent (prenatal)	Had a postpartum visit on or between 7 and 84 days after delivery	Percent (post-partum)
Alameda	2022	432	380	88.0	373	86.3
Alameda	2023	408	357	87.5	363	89.0
Alameda	Pooled baseline	1,352	1,200	88.8	1,176	87.0
Butte	2021	203	179	88.2	172	84.7
Butte	2022	150	137	91.3	125	83.3
Butte	2023	157	137	87.3	128	81.5
Butte	Pooled baseline	510	453	88.8	425	83.3
Colusa	2021	42	37	88.1	35	83.3
Colusa	2022	36	33	91.7	31	86.1
Colusa	2023	27	24	88.9	24	88.9
Colusa	Pooled baseline	105	94	89.5	90	85.7
Contra Costa	2021	343	311	90.7	295	86.0
Contra Costa	2022	327	294	89.9	282	86.2
Contra Costa	2023	383	339	88.5	334	87.2
Contra Costa	Pooled baseline	1,053	944	89.6	911	86.5
Glenn	2021	37	34	91.9	31	83.8
Glenn	2022	25	21	84.0	21	84.0
Glenn	2023	34	31	91.2	26	76.5
Glenn	Pooled baseline	96	86	89.6	78	81.3
Imperial	2021	454	364	80.2	348	76.7
Imperial	2022	277	230	83.0	233	84.1
Imperial	2023	255	198	77.6	194	76.1

County	Year	Live births	Had a prenatal visit in first trimester	Percent (prenatal)	Had a postpartum visit on or between 7 and 84 days after delivery	Percent (post-partum)
Imperial	Pooled baseline	986	792	80.3	775	78.6
Mariposa	2021	*	*	*	*	*
Mariposa	2022	*	*	*	*	*
Mariposa	2023	*	*	*	*	*
Mariposa	Pooled baseline	*	*	*	*	*
Nevada	2021	55	45	81.8	47	85.5
Nevada	2022	60	49	81.7	48	80.0
Nevada	2023	68	61	89.7	58	85.3
Nevada	Pooled baseline	183	155	84.7	153	83.6
Placer	2021	235	220	93.6	180	76.6
Placer	2022	258	228	88.4	197	76.4
Placer	2023	273	238	87.2	214	78.4
Placer	Pooled baseline	766	686	89.6	591	77.2
Plumas	2021	30	30	100.0	27	90.0
Plumas	2022	*	*	*	*	*
Plumas	2023	*	*	*	*	*
Plumas	Pooled baseline	*	*	*	*	*
San Benito	2021	129	117	90.7	109	84.5
San Benito	2022	166	150	90.4	135	81.3
San Benito	2023	139	121	87.1	117	84.2
San Benito	Pooled baseline	434	388	89.4	361	83.2
Sierra	2021	*	*	*	*	*

County	Year	Live births	Had a prenatal visit in first trimester	Percent (prenatal)	Had a postpartum visit on or between 7 and 84 days after delivery	Percent (post-partum)
Sierra	2022	*	*	*	*	*
Sierra	2023	*	*	*	*	*
Sierra	Pooled baseline	*	*	*	*	*
Sutter	2021	192	175	91.1	156	81.3
Sutter	2022	145	132	91.0	130	89.7
Sutter	2023	124	105	84.7	106	85.5
Sutter	Pooled baseline	461	412	89.4	392	85.0
Tehama	2021	104	92	88.5	85	81.7
Tehama	2022	76	69	90.8	63	82.9
Tehama	2023	73	64	87.7	63	86.3
Tehama	Pooled baseline	253	225	88.9	211	83.4
Yuba	2021	109	94	86.2	83	76.1
Yuba	2022	137	111	81.0	114	83.2
Yuba	2023	120	98	81.7	101	84.2
Yuba	Pooled baseline	366	303	82.8	298	81.4

NOTES: Postpartum visits had to occur on or between 7 and 84 days after delivery. Values for the pooled baseline indicate the total number of live births receiving prenatal and postpartum visits out of the total number of live births eligible for these visits. The symbol * indicates suppression or complementary suppression for cells with values less than 11.

Appendix C 9. Follow up after emergency department visits for mental illness by county and baseline year.

County	Year	Number of ED visits	Number of visits with follow-up within 7-days	Percent (7-days)	Number of visits with follow-up within 30 days	Percent (30 days)
Alameda	2021	1,998	760	38.0	953	47.7
Alameda	2022	2,094	776	37.1	1,000	47.8
Alameda	2023	2,270	817	36.0	1,089	48.0
Alameda	Pooled baseline	6,362	2,353	37.0	3,042	47.8
Butte	2021	328	63	19.2	104	31.7
Butte	2022	306	136	44.4	170	55.6
Butte	2023	327	78	23.9	129	39.4
Butte	Pooled baseline	961	277	28.8	403	41.9
Colusa	2021	*	*	*	*	*
Colusa	2022	*	*	*	*	*
Colusa	2023	*	*	*	*	*
Colusa	Pooled baseline	*	*	*	*	*
Contra Costa	2021	881	141	16.0	218	24.7
Contra Costa	2022	804	236	29.4	381	47.4
Contra Costa	2023	926	348	37.6	497	53.7
Contra Costa	Pooled baseline	2,611	725	27.8	1,096	42.0
Glenn	2021	*	*	*	*	*
Glenn	2022	33	19	57.6	22	66.7
Glenn	2023	*	*	*	*	*
Glenn	Pooled baseline	86	30	34.9	40	46.5
Imperial	2021	223	*	*	20	9.0
Imperial	2022	230	102	44.3	120	52.2

County	Year	Number of ED visits	Number of visits with follow-up within 7-days	Percent (7-days)	Number of visits with follow-up within 30 days	Percent (30 days)
Imperial	2023	192	*	*	65	33.9
Imperial	Pooled baseline	645	148	22.9	205	31.8
Mariposa	2021	*	*	*	*	*
Mariposa	2022	*	*	*	*	*
Mariposa	2023	*	*	*	*	*
Mariposa	Pooled baseline	69	20	29.0	25	36.2
Nevada	2021	189	33	17.5	57	30.2
Nevada	2022	159	96	60.4	107	67.3
Nevada	2023	176	47	26.7	80	45.5
Nevada	Pooled baseline	524	176	33.6	244	46.6
Placer	2021	394	37	9.4	83	21.1
Placer	2022	483	255	52.8	310	64.2
Placer	2023	440	119	27.0	185	42.0
Placer	Pooled baseline	1,317	411	31.2	578	43.9
Plumas	2021	*	*	*	*	*
Plumas	2022	*	*	*	*	*
Plumas	2023	*	*	*	*	*
Plumas	Pooled baseline	97	20	20.6	41	42.3
San Benito	2021	*	*	*	*	*
San Benito	2022	*	*	*	*	*
San Benito	2023	73	20	27.4	28	38.4
San Benito	Pooled baseline	186	41	22.0	58	31.2
Sierra	2021	*	*	0.0	*	*
Sierra	2022	*	*	*	*	*

County	Year	Number of ED visits	Number of visits with follow-up within 7-days	Percent (7-days)	Number of visits with follow-up within 30 days	Percent (30 days)
Sierra	2023	*	*	*	*	*
Sierra	Pooled baseline	*	*	*	*	*
Sutter	2021	134	14	10.4	34	25.4
Sutter	2022	159	81	50.9	97	61.0
Sutter	2023	127	35	27.6	48	37.8
Sutter	Pooled baseline	420	130	31.0	179	42.6
Tehama	2021	*	*	*	*	*
Tehama	2022	105	34	32.4	42	40.0
Tehama	2023	*	*	*	*	*
Tehama	Pooled baseline	298	61	20.5	98	32.9
Yuba	2021	175	15	8.6	35	20.0
Yuba	2022	188	98	52.1	111	59.0
Yuba	2023	182	32	17.6	55	30.2
Yuba	Pooled baseline	545	145	26.6	201	36.9

NOTES: The eligible population is defined as members age 18 and older. ED visits in the denominator have a principal diagnosis of mental illness or self-harm. Values for the pooled baseline indicate the total number of mental health ED visits that occurred during the baseline period that received follow-up. The symbol * indicates suppression or complementary suppression for cells with values less than 11.

Appendix C 10. Rates of breast cancer screening by county and baseline year.

County	Year	Women ages 50 to 74	Had a mammogram	Rate
Alameda	2021	21,936	12,503	57.0
Alameda	2022	24,312	13,430	55.2
Alameda	2023	24,276	14,075	58.0
Alameda	Pooled baseline	70,524	40,008	56.7

County	Year	Women ages 50 to 74	Had a mammogram	Rate
Butte	2021	3,572	1,779	49.8
Butte	2022	3,846	1,852	48.2
Butte	2023	3,926	1,917	48.8
Butte	Pooled baseline	11,344	5,548	48.9
Colusa	2021	351	157	44.7
Colusa	2022	393	193	49.1
Colusa	2023	413	228	55.2
Colusa	Pooled baseline	1,157	578	50.0
Contra Costa	2021	13,547	8,538	63.0
Contra Costa	2022	15,334	9,406	61.3
Contra Costa	2023	15,888	10,107	63.6
Contra Costa	Pooled baseline	44,769	28,051	62.7
Glenn	2021	450	241	53.6
Glenn	2022	489	272	55.6
Glenn	2023	502	271	54.0
Glenn	Pooled baseline	1,441	784	54.4
Imperial	2021	4,502	2,668	59.3
Imperial	2022	4,989	2,922	58.6
Imperial	2023	4,887	2,980	61.0
Imperial	Pooled baseline	14,378	8,570	59.6
Mariposa	2021	314	149	47.5
Mariposa	2022	351	160	45.6
Mariposa	2023	335	158	47.2
Mariposa	Pooled baseline	1,000	467	46.7
Nevada	2021	1,239	655	52.9
Nevada	2022	1,395	709	50.8
Nevada	2023	1,426	722	50.6
Nevada	Pooled baseline	4,060	2,086	51.4
Placer	2021	2,989	1,577	52.8
Placer	2022	3,450	1,763	51.1

County	Year	Women ages 50 to 74	Had a mammogram	Rate
Placer	2023	3,465	1,858	53.6
Placer	Pooled baseline	9,904	5,198	52.5
Plumas	2021	361	154	42.7
Plumas	2022	358	153	42.7
Plumas	2023	315	130	41.3
Plumas	Pooled baseline	1,034	437	42.3
San Benito	2021	705	400	56.7
San Benito	2022	825	482	58.4
San Benito	2023	888	558	62.8
San Benito	Pooled baseline	2,418	1,440	59.6
Sierra	2021	46	22	47.8
Sierra	2022	46	23	50.0
Sierra	2023	43	26	60.5
Sierra	Pooled baseline	135	71	52.6
Sutter	2021	1,806	907	50.2
Sutter	2022	2,062	1,004	48.7
Sutter	2023	2,069	1,095	52.9
Sutter	Pooled baseline	5,937	3,006	50.6
Tehama	2021	1,081	566	52.4
Tehama	2022	1,251	605	48.4
Tehama	2023	1,296	621	47.9
Tehama	Pooled baseline	3,628	1,792	49.4
Yuba	2021	1,478	677	45.8
Yuba	2022	1,624	704	43.3
Yuba	2023	1,628	690	42.4
Yuba	Pooled baseline	4,730	2,071	43.8

NOTE: Numerator and denominator values for the pooled baseline represent person-years, not the number of unique members, since members could count in the numerator and denominator multiple times over the 3-year baseline period. Thus, values for the pooled baseline indicate the total number of person-years receiving a mammogram screening out of the total number of person-years eligible for screening.

Appendix C 11. Observed, expected, and ratio of observed to expected all-cause readmissions by county and baseline year.

County	Year	Number of Index hospital stays	Observed 30-day readmissions	Expected 30-day readmissions	Ratio of observed to expected readmissions
Alameda	2021	6,592	693	660	1.05
Alameda	2022	7,181	712	710	1.00
Alameda	2023	7,179	760	709	1.07
Alameda	Pooled baseline	20,952	2,165	2,079	1.04
Butte	2021	2,652	237	267	0.89
Butte	2022	2,579	245	261	0.94
Butte	2023	2,675	227	261	0.87
Butte	Pooled baseline	7,906	709	789	0.90
Colusa	2021	*	*	*	*
Colusa	2022	*	*	*	*
Colusa	2023	135	11	12	0.90
Colusa	Pooled baseline	*	*	*	*
Contra Costa	2021	4,055	344	396	0.87
Contra Costa	2022	5,471	457	539	0.85
Contra Costa	2023	5,543	450	539	0.84
Contra Costa	Pooled baseline	15,069	1,251	1,474	0.85
Glenn	2021	233	24	23	1.03
Glenn	2022	207	14	18	0.76
Glenn	2023	221	20	20	1.00
Glenn	Pooled baseline	661	58	62	0.94
Imperial	2021	1,415	118	128	0.93
Imperial	2022	1,460	100	126	0.79
Imperial	2023	1,388	101	127	0.80

County	Year	Number of Index hospital stays	Observed 30-day readmissions	Expected 30-day readmissions	Ratio of observed to expected readmissions
Imperial	Pooled baseline	4,263	319	380	0.84
Mariposa	2021	124	17	13	1.32
Mariposa	2022	124	13	12	1.06
Mariposa	2023	162	15	16	0.94
Mariposa	Pooled baseline	410	45	41	1.09
Nevada	2021	575	51	55	0.93
Nevada	2022	551	63	52	1.20
Nevada	2023	561	43	53	0.81
Nevada	Pooled baseline	1,687	157	160	0.98
Placer	2021	1,198	95	113	0.84
Placer	2022	1,287	113	122	0.92
Placer	2023	1,494	136	141	0.97
Placer	Pooled baseline	3,979	344	376	0.91
Plumas	2021	139	13	13	1.00
Plumas	2022	*	*	*	*
Plumas	2023	*	*	*	*
Plumas	Pooled baseline	430	32	41	0.79
San Benito	2021	139	13	12	1.09
San Benito	2022	193	20	17	1.17
San Benito	2023	173	13	15	0.85
San Benito	Pooled baseline	505	46	44	1.04
Sierra	2021	*	*	*	*
Sierra	2022	*	*	*	*
Sierra	2023	*	*	*	*
Sierra	Pooled baseline	*	*	*	*
Sutter	2021	716	68	68	1.00
Sutter	2022	656	62	64	0.97

County	Year	Number of Index hospital stays	Observed 30-day readmissions	Expected 30-day readmissions	Ratio of observed to expected readmissions
Sutter	2023	781	65	75	0.87
Sutter	Pooled baseline	2,153	195	207	0.94
Tehama	2021	507	46	50	0.93
Tehama	2022	542	39	52	0.75
Tehama	2023	538	42	53	0.80
Tehama	Pooled baseline	1,587	127	154	0.83
Yuba	2021	845	84	81	1.04
Yuba	2022	757	76	74	1.02
Yuba	2023	791	58	77	0.75
Yuba	Pooled baseline	2,393	218	232	0.94

NOTES: The eligible population is defined as members ages 18 to 64. The expected number of readmissions is a risk-adjusted estimate based on presence of observation stay status at discharge, surgeries, discharge condition, comorbidity, age, and sex. Values for the pooled baseline indicate the total number of index admissions with a readmission over the entire baseline period. The symbol * indicates suppression or complementary suppression for cells with values less than 11.

Appendix C 12. Rates of well-child visits at 15 and 30 months by baseline year, stratified by urban versus rural Transition counties.

Year	Urbanicity	Members turning 15 months during the MY	Had 6 or more well-child visits in MY	Percent (15 months)	Members turning 30 months during the MY	Had 2 or more well-child visits in MY	Percent (30 months)
2021	Rural	1,283	539	42.0	3,159	2,044	64.7
2021	Urban	4,694	2,338	49.8	11,061	7,004	63.3
2022	Rural	1,185	593	50.0	2,969	1,937	65.2
2022	Urban	4,831	2,652	54.9	11,318	7,803	68.9

Year	Urbanicity	Members turning 15 months during the MY	Had 6 or more well-child visits in MY	Percent (15 months)	Members turning 30 months during the MY	Had 2 or more well-child visits in MY	Percent (30 months)
2023	Rural	1,194	636	53.3	3,013	2,054	68.2
2023	Urban	4,817	2,947	61.2	10,573	7,468	70.6
Pooled baseline	Rural	3,662	1,768	48.3	9,141	6,035	66.0
Pooled baseline	Urban	14,342	7,937	55.3	32,952	22,275	67.6

NOTES: Values for the pooled baseline indicate the total number of infants in the eligible population that received well child visits over the entire baseline period. MY=measurement year.

Appendix C 13. Rates of child and adolescent well-care visits by baseline year, stratified by urban versus rural Transition counties.

Year	Urbanicity	Members ages 3-21 in the MY	Had at least one well-care visit during MY	Percent
2021	Rural	66,292	29,104	43.9
2021	Urban	255,813	126,192	49.3
2022	Rural	68,526	31,078	45.4
2022	Urban	270,127	129,261	47.9
2023	Rural	68,443	31,633	46.2
2023	Urban	254,849	126,761	49.7
Pooled baseline	Rural	203,261	91,815	45.2
Pooled baseline	Urban	780,789	382,214	49.0

Note: Numerator and denominator values for the pooled baseline represent person-years, not the number of unique members, since members could count in the numerator and denominator multiple times over the 3-year baseline period. Thus, the pooled baseline represents the total number of person-years with a well-child visit out of the total number of person-years eligible for screening. MY=measurement year.

Appendix C 14. Rates of immunizations by baseline year, stratified by urban versus rural Transition counties.

Year	Urbanicity	Adole-scents who turned 13 during the MY	Had meningo-coccal vaccine	Rate meningo-coccal vaccine	Had TDAP vaccine	Rate TDAP vaccine	Had HPV vaccine	Rate HPV vaccine	Had Combin-ation 1	Rate Combin-ation 1	Had Combin-ation 2	Rate Combin-ation 2
2021	Rural	3,724	2,379	63.9	2,864	76.9	984	26.4	--	--	889	23.9
2021	Urban	14,350	10,365	72.2	11,311	78.8	5,516	38.4	--	--	4,962	34.6
2022	Rural	4,632	3,028	65.4	3,813	82.3	1,302	28.1	--	--	1,225	26.4
2022	Urban	17,759	12,864	72.4	14,533	81.8	7,504	42.3	--	--	6,943	39.1
2023	Rural	4,503	2,686	59.6	3,677	81.7	1,355	30.1	2,601	57.8	1,191	26.4
2023	Urban	17,849	11,097	62.2	14,538	81.4	7,489	42.0	10,761	60.3	6,469	36.2
Pooled baseline	Rural	12,859	8,093	62.9	10,354	80.5	3,641	28.3	2,601	20.2	3,305	25.7
Pooled baseline	Urban	49,958	34,326	68.7	40,382	80.8	20,509	41.1	10,761	21.5	18,374	36.8

NOTES: The meningococcal vaccine indicates receiving at least one meningococcal serogroups A, C, W, Y vaccine with a date of service on or between the adolescent's 11th and 13th birthdays. TDAP indicates receiving at least one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine with a date of service on or between the adolescent's 10th and 13th birthdays. HPV indicates receiving at least two HPV vaccines on or between the child's 9th and 13th birthdays and with dates of service at least 146 days apart, *or* at least three HPV vaccines with different dates of service on or between the adolescent's 9th and 13th birthdays. Combination 1 comprises the meningococcal and TDAP vaccines, and data was only available for 2023. Combination 2 comprises the meningococcal, TDAP, and HPV vaccines. Values for the pooled baseline indicate the total number of members receiving vaccines out of the total number eligible for a vaccine. MY=measurement year; TDAP=tetanus, diphtheria toxoids and acellular pertussis; HPV=human papillomavirus.

Appendix C 15. Rates of prenatal and postpartum care by baseline year, stratified by urban versus rural Transition counties.

Year	Urbanicity	Live births	Had a prenatal visit in first trimester	Percent (prenatal)	Had a postpartum visit on or between 7 and 84 days after delivery	Percent (postpartum)
2021	Rural	873	738	84.5	702	80.4
2021	Urban	1,594	1,442	90.5	1,326	83.2
2022	Rural	676	581	85.9	557	82.4
2022	Urban	1,449	1,282	88.5	1,221	84.3
2023	Rural	625	522	83.5	499	79.8
2023	Urban	1,465	1,274	87.0	1,246	85.1
Pooled baseline	Rural	2,174	1,841	84.7	1,758	80.9
Pooled baseline	Urban	4,508	3,998	88.7	3,793	84.1

NOTES: Postpartum visits had to occur on or between 7 and 84 days after delivery. Values for the pooled baseline indicate the total number of live births receiving prenatal and postpartum visits out of the total number of live births eligible for these visits.

Appendix C 16. Rates of follow-up after emergency department visits for mental illness by baseline year, stratified by urban versus rural Transition counties.

Year	Urbanicity	Number of ED visits	Number of visits with follow-up within 7 days	Percent (7 days)	Number of visits with follow-up within 30 days	Percent (30 days)
2021	Rural	675	77	11.4	138	20.4
2021	Urban	3,910	1,030	26.3	1,427	36.5
2022	Rural	664	291	43.8	351	52.9
2022	Urban	4,034	1,582	39.2	2,069	51.3
2023	Rural	623	143	23.0	242	38.8
2023	Urban	4,272	1,429	33.5	2,003	46.9
Pooled	Rural	1,962	511	26.0	731	37.3

Year	Urbanicity	Number of ED visits	Number of visits with follow-up within 7 days	Percent (7 days)	Number of visits with follow-up within 30 days	Percent (30 days)
baseline						
Pooled baseline	Urban	12,216	4,041	33.1	5,499	45.0

NOTES: The eligible population is defined as members age 18 and older. ED visits in the denominator have a principal diagnosis of mental illness or self-harm. Values for the pooled baseline indicate the total number of mental health ED visits that occurred during the baseline period that received follow-up.

Appendix C 17. Rates of breast cancer screening by baseline year, stratified by urban versus rural Transition counties.

Year	Urbanicity	Women ages 50 to 74	Had a mammogram	Rate
2021	Rural	9,049	5,012	55.4
2021	Urban	45,328	25,981	57.3
2022	Rural	10,097	5,519	54.7
2022	Urban	50,628	28,159	55.6
2023	Rural	10,105	5,694	56.3
2023	Urban	51,252	29,742	58.0
Pooled baseline	Rural	29,251	16,225	55.5
Pooled baseline	Urban	147,208	83,882	57.0

NOTE: Numerator and denominator values for the pooled baseline represent person-years, not the number of unique members, since members could count in the numerator and denominator multiple times over the 3-year baseline period. Thus, values for the pooled baseline indicate the total number of person-years receiving a mammogram screening out of the total number of person-years eligible for screening.

Appendix C 18. Observed, expected, and ratio of observed to expected all-cause readmissions by baseline year, stratified by urban versus rural Transition counties.

Year	Urbanicity	Number of index hospital stays	Observed 30-day readmissions	Expected 30-day readmissions	Ratio of observed to expected readmissions
2021	Rural	3,279	293	306	0.96
2021	Urban	16,058	1,521	1,585	0.96
2022	Rural	3,333	267	301	0.89
2022	Urban	17,931	1,665	1,770	0.94
2023	Rural	3,354	257	312	0.82
2023	Urban	18,463	1,696	1,802	0.94
Pooled baseline	Rural	9,966	817	920	0.89
Pooled baseline	Urban	52,452	4,882	5,158	0.95

NOTES: The eligible population is defined as members ages 18 to 64. The expected number of readmissions is a risk-adjusted estimate based on presence of observation stay status at discharge, surgeries, discharge condition, comorbidity, age, and sex. Values for the pooled baseline indicate the total number of index admissions with a readmission over the entire baseline period.

Appendix D 1. Managed Care Plan Transition – Member – Interview Guide

Consent

Hello, thank you very much for your time today. I am [NAME] from NORC at the University of Chicago, a nonprofit research organization contracted by the California Department of Health Care Services (DHCS) to conduct an evaluation of the Medi-Cal Managed Care Plan Transition which happened in 2024. As part of the evaluation, we are speaking with Medi-Cal members in each transition county to discuss how the Medi-Cal Managed Care Plan transition process was understood and experienced from their perspective. Your interview will be used to help DHCS better understand the implementation and impact of the Medi-Cal Managed Care Plan transition on the access, continuity, and quality of health care for Californians.

A few things before we get started:

- The interview will take around 30-45 minutes, and each question is designed to be answered in 1-2 minutes, however, I may follow up briefly on key topics of interest.
- The goals of the interview are to better understand:
  - How you were initially engaged by your new plan and providers after the transition.
  - Any barriers, challenges, and facilitating factors you encountered during the transition.
  - Any perceived helpful changes or interruptions you have noticed in care access, quality, and continuity.
- Your participation is completely voluntary. There are no right or wrong answers. If you do not want to participate, need to end the interview at any point, or do not want to answer a particular question, please let us know.
- We are conducting multiple interviews and focus groups with members, health plan officials, and DHCS's Stakeholder Advisory Committee Members across the state.
- Your input will remain anonymous and will not be linked to you or your specific health plan. If we include a quote from your interview, we will not include your name or any other identifying information tied to you or your specific health plan.

- We would like to record the interview for our note-taking purposes, to ensure we capture everything accurately. The recordings will not be shared outside of the NORC research team. If you choose not to be recorded, we can still conduct the interview and will rely on our notes alone.
- With that in mind:
  - Do you consent to participate? [GET Y/N]
  - Do you consent to being recorded? [GET Y/N]

Thank you. Do you have any questions before we proceed?

Our first few questions focus on how you were initially engaged by your new plan and/or healthcare providers after the transition.

Enrollment Strategies

1. At the time you changed plans, did you have an existing PCP?

i. **If no, go to Q2.**

ii. **If yes, go to Q3.**

2. Did your new plan help you connect to a PCP?

a. **If yes:**

i. How did they help you find one?

ii. What and how many, if any, options were you given?

b. **If no:**

i. Have you since found a PCP on your own?

ii. How did you determine your options and select a provider?

iii. How long did it take you to find the provider?

3. Was your PCP available under your new plan?

a. What information were you given about your options for maintaining that PCP or choosing a new one?

b. Were you able to choose your preferred PCP?

4. Did your PCP or any of your other healthcare providers reach out to provide information or discuss the plan change with you?

5. What has worked well about this transition process so far?

6. What information or communications have been the most helpful to you as a plan member to understand:

a. What the transition means to you as a Medi-Cal member in terms of your health care options?

b. What (if anything) you need to do as a new plan member?

7. Have you experienced any delays or interruptions in care while changing plans? If so, how long was the delay or interruption you experienced (e.g., days, weeks, months)?

8. What, if any, other challenges or barriers have you encountered while changing plans as part of the transition?

Post-Implementation Experience with Primary Care and Prevention Services

Our next few questions focus on the care you have received since you transitioned plans.

9. Has your plan helped you determine who among your existing providers were within or outside of their network?

a. **If yes:** How did they help you? What kinds of information were you given?

10. Has your plan reached out to provide you with information about preventive health strategies (like nutrition, exercise, stress management/wellness)?

a. **If yes:** How did they contact you? What kinds of information were you given?

11. Has your plan offered you information about behavioral health services they offer and providers they work with?

a. **If yes:** How did they contact you? What kinds of information were you given?

12. Has your plan reached out to notify you about upcoming or over-due services (like screenings, check-ups, or immunizations) to be scheduled?

a. **If yes**: How did they contact you? What kinds of information were you given?

13. What, if any, changes have you noticed in getting insurance coverage for needed healthcare services?

a. What, if any, services have required PCP referrals or prior authorizations that did not require previously?

14. What, if any, changes have you noticed in the healthcare services you receive?

a. How, if at all, have your healthcare service options (like the types of services, providers, and locations you have available to you) changed?

b. How, if at all, have your wait times for healthcare services changed?

c. How, if at all, have your healthcare costs/co-pays changed?

15. Thinking about your plan now, to what extent are you able to receive services:

a. From the provider of your choice?

b. In your preferred language?

c. At a time that works for you?

d. In a location that is easy for you to get to?

i. Has your plan provided you with transportation services for healthcare appointments?

e. With respect for your race/ethnicity, sexual orientation and gender identity, age, immigration documentation status, or other identities?

16. To what extent are you able to reach out to your new plan for further questions or concerns about your care when you need to?

Closing

Our final few questions ask for your perspective on how things are going now – what is working well with your plan, areas for improvement, and other general feedback you may have.

17. Was there something that you feel your plan did particularly well during and/or after the transition process?

18. Do you feel there are any ways in which the options they offer and/or the administrative processes they use could still be improved?

19. Is there anything else you would like to share about your experience?

Those are all the questions we have for the interview. Thank you so much for your time and the information you provided. We are incredibly grateful to you for sharing your insights. Your feedback, along with the feedback of other Medi-Cal members, will be reviewed together and used to evaluate the transition and inform recommendations for program improvement. As a reminder, your input will remain anonymous and will not be linked to you or your specific health plan. Do you have any remaining comments or questions?

We will follow up with you over email with your electronic gift card in the next two days. If you have questions or additional comments for us, please feel free to reach out to the NORC team at CAMCPTransitionEvaluation@norc.org.

Appendix E 1. Managed Care Plan Transition – Health Plan – Interview Guide

Consent

Hello, my name is [NAME]. Thank you very much for your time today. I am working with NORC at the University of Chicago, a nonprofit research organization contracted by the California Department of Health Care Services (DHCS), to conduct an evaluation of the overall impact of the Medi-Cal Managed Care Plan (MCP) Transition. The purpose of the evaluation is to better understand the implementation and impact of the MCP transition on access to care, continuity of care, quality of care, administrative complexity, and plan accountability. These interviews will provide a critical perspective of how the transition was understood and experienced by the individuals involved and those who stand to be affected by it.

A few things before we get started:

- The group interview will take around 60 minutes, and each question is designed to be answered in 1-2 minutes, however, I may follow up briefly on key topics of interest.
- The goals of this group interview are to better understand how the MCP Transition impacted health plan administrative workflows, and the processes that the MCPs are taking to establish and execute their Community Reinvestment Plans. Other topic areas will include: outreach and enrollment strategies, post-implementation care and services experience of the MCP Transition, and integration of behavioral health care services.
- Your participation is completely voluntary. There are no right or wrong answers. If you do not want to participate, need to leave the group interview at any point, or do not want to answer a particular question, please let us know.
- We are conducting multiple interviews and focus groups with members, health plan officials, and DHCS's Stakeholder Advisory Committee Members across the state.
- Your input will remain anonymous and will not be linked to you or your specific health plan. We will develop a broad summary and report based on what we hear from everyone we interview. If we do include a quote from you, we will not include your name or any other identifying information tied to you or your specific health plan in our report.

- We would like to record the interview for our note-taking purposes, to ensure we capture everything accurately. The recordings will not be shared outside of the NORC research team. If you choose not to be recorded, this entire meeting will not be recorded and we can still conduct the interview and will rely on our notes alone.
- With that in mind:
  - Do you consent to participate? [GET Y/N]
  - And do you consent to being recorded? [GET Y/N]

Thank you. Do you have any questions before we proceed?

Background, Admin and Introductions

1. Can you [each] briefly describe your current role at your MCP, including how long you have been working with the MCP.
2. How, if at all, were you involved in the administration of the MCP transition in [COUNTY/COUNTIES]?

Outreach & Enrollment Strategies

3. How was your MCP involved in notification and outreach to current Medi-Cal members transitioning to your health plan?

a. When did the outreach begin once the transition was announced?

b. What did the outreach process to transitioning members entail?

c. **For plans operating in multiple counties:** How, if at all, did this process vary among the transitioning counties you operate in?

4. Thinking through the enrollment process for new Medi-Cal members transitioning into your plan:

a. How were new members assigned to a PCP?

b. How, if at all, were plan PCPs and other providers notified they had a new member?

5. What has worked well about these transition processes so far?
6. What challenges or barriers has your MCP encountered when trying to execute these processes?

a. How, if at all, has the transition otherwise changed the way that your plan conducts outreach to members?

Investments in Primary Care and Prevention

7. Can you please walk us through the approval process that your plan conducts to assess medical necessity for services prescribed by primary care providers?

a. How has the transition affected this approval/denial process?

i. Does the transition particularly impact any specific type of services?

8. How does your plan conduct outreach to inform your members about preventative health practices at home, and the importance of seeking preventative health services?

9. How, at all, does your MCP send reminders or notification to members who have upcoming or over-due services to be scheduled?

a. What, if any, guidance does your MCP provide to plan providers to send similar reminders or notifications to members?

10. What practices does your plan currently use to recruit Medi-Cal providers into your organization?

11. What practices does your plan currently use to enhance provision of culturally and linguistically appropriate care?

12. Are there any initiatives you want to highlight which demonstrate your plan's investment into primary care and prevention?

Efforts to Improve Integration of Behavioral Health Care Services

13. How does your MCP connect & coordinate member services with non-specialty (NSMHS) OR specialty mental health (SMHS) care providers?

14. What processes does your MCP take to ensure continuity of care for members receiving NSMHS, SMHS or Substance Use Disorder [SUD] services with approved Medi-Cal providers outside of your network?

15. How [if at all] have these administrative workflows regarding behavioral health care services changed or been affected by the county plan transition?

16. What steps is your MCP taking to increase the number of NSMH providers in your network?

a. *[For clarity] Non-Specialty Mental Health Services refer to those which an MCP must provide as determined by Medical Necessity, and are provided by either PCPs or licensed mental health Network Providers. Services include: mental health*

evaluation and treatment including psychotherapy, outpatient services, psychiatric consultations, etc.

Administrative Workflows

17. How, if at all, has your MCP made changes to other administrative or referral processes and workflows as part of the transition?

Community Reinvestment Plans & Engagement with Community Advisory Committees

18. Can you please describe the administrative process your MCP has taken to develop your annual Community Reinvestment Plan as part of the MCP Transition reporting requirements?

a. *Probing topics: Who is involved? Who makes decisions? How are decisions made? How do you engage with subcontractors*?

19. How did your MCP make decisions regarding topics of focus for your Community Reinvestment Plan with respect to:

a. Reducing existing health disparities for historically marginalized and under-resourced populations?

b. Promoting improved health outcomes for Medi-Cal populations, per CalAIM requirements?

20. How has your MCP engaged community members (e.g., Community Advisory Committees (CACs) with the Community Reinvestment Plan development process?

21. Does your MCP engage with any additional, interested community stakeholders outside of those represented via the Community Advisory Committee?

Closing

22. Was there something that you feel your MCP did particularly well to facilitate the administration of the transition?

23. Do you feel there are any ways in which administrative processes can improve post-transition?

a. *Any lessons learned?*

24. Is there anything else you would like to share regarding how your plan operates in the counties that participated in the transition?

Those are all the questions we have for the interview. Thank you so much for your time and the information you provided. We are very grateful to you for sharing your insights and recommendations. As a reminder, your responses will not be attributed to you personally and will be incorporated into a high-level summary that will help policymakers understand best practices and lessons learned from the MCP transition process. For any further questions on this interview, or if you have any follow-up questions or additional comments, please reach out to the NORC evaluation team at **CAMCPTransitionEvaluation@norc.org**.

Appendix F 1.1 Managed Care Plan Transition – Stakeholder [INTERVIEW] Guide

Consent

Hello, my name is [NAME]. Thank you very much for your time today. I am working with NORC at the University of Chicago, a nonprofit research organization contracted by the California Department of Health Care Services (DHCS) to conduct an evaluation of the overall impact of the Medi-Cal Managed Care Plan (MCP) Transition. The purpose of the evaluation is to better understand the implementation and impact of the MCP transition on access to care, continuity of care, quality of care, administrative complexity, and plan accountability. These interviews will provide a critical perspective of how the transition was understood and experienced by the individuals involved and those who stand to be affected by it. A few things before we get started:

- The [DISCUSSION] will take around [50] minutes.
- We are interested in hearing about your experiences and perspectives as members of the DHCS Stakeholder Advisory Committee and from your individual perspectives working in the California healthcare system. The goals of this [DISCUSSION] are to better understand the community awareness and experience of the transition, impacts of the transition on care received and service offerings, and community reinvestment plans. Your responses will help policymakers understand best practices and lessons learned from the MCP transition process.
- Your participation is voluntary. There are no right or wrong answers. If you do not want to participate, need to leave the [INTERVIEW] at any point, or do not want to answer any question, please let us know. To the extent they are applicable, we would love to hear your perspectives both from your role within your organization where you work and as a member of the DHCS Stakeholder Advisory Committee.
- We are conducting multiple interviews with members, health plan officials, and DHCS Stakeholder Advisory Committee Members across the state.
- We will not attribute anything you say as coming from you personally. We will develop a high-level summary and report based on what we hear from everyone we interview. While our public reports will not contain the names of individuals nor organizations who participated in our study, we may attribute findings to the DHCS Stakeholder Advisory Committee. There is a potential risk that some

findings may be linked back to yourself or your organization due to the public nature of the Committee. As we prepare these reports, we aim to mitigate this risk to the best of our abilities.

- We would like to record the [DISCUSSION] for our note-taking purposes, to ensure we capture everything accurately. The recordings will not be shared outside of the NORC research team. If [YOU] choose not to be recorded, we can still conduct the [INTERVIEW] and will rely on our notes alone for analysis.
- With that in mind:
  - Do you consent to participate? [GET Y/N]
  - Do you consent to being recorded? [GET Y/N]

Background, Admin and Introductions

1. Please briefly introduce yourself, your organization, your role within your organization, and how long you have been on the Stakeholder Advisory Committee.

a. When did you start with the Stakeholder Advisory Committee?

2. How have you been involved with Medi-Cal Managed Care Plan (MCP) Transition in your role on the Stakeholder Advisory Committee and within your organization?

a. If you were involved with the MCP transition at the organizational level, what kind of role did you play?

Community Awareness and Experience of Transition

3. In general, how would you describe awareness of the MCP transition throughout the state?

a. Among relevant Medi-Cal members?

b. Among health plans?

c. Among providers?

d. Among other organizations serving the Medi-Cal population?

4. How would you describe the information that Medi-Cal members in your community received regarding changes to their coverage and the MCP transition? For example, what kind of notification and outreach did members receive? Where did that information come from?

a. What kind of notification and outreach did members receive from their health plans regarding the transition?

b. What kind of notification and outreach did members receive from the state regarding the transition?

c. Did your organization conduct any additional outreach or education efforts to members regarding the transition?

5. Did you observe any member groups or communities in particular that reached out for additional information on the transition? Any groups in particular that did not reach out?

a. For example, were there any gaps in outreach among members that are blind, deaf, or who cannot read or understand the English language?

6. Did you observe any member groups or communities in particular that were most aware of the transition? Groups least aware of the transition?

a. For example, were there any gaps in awareness among members that are blind, deaf, or who cannot read or understand the English language?

7. How has the transition changed the way that your organization conducts outreach to members [if your organization is involved in conducting outreach]?

8. What kinds of challenges did you observe or encounter regarding educating and spreading awareness of the MCP transition?

a. To members?

b. To health plans?

c. To providers?

d. To other stakeholder groups / organizations serving the Medi-Cal population?

9. What, if any, gaps in awareness did you observe among different member groups or communities?

a. For example, were there any gaps in awareness among members that are blind, deaf, or who cannot read or understand the English language?

10. What were members' greatest concerns regarding the transition to new MCPs?

11. How did health plans respond to the MCP Transition Policy Guide?

a. In your opinion, were any areas of information or policy direction missing from the Policy Guide?

b. Did you receive any feedback from health plans on missing areas of information or policy direction?

Changes or Interruptions in Care Received and Service Offerings

12. What impacts were there, if any, on access to care among members that your organization serves? Any improvements? Any interruptions?

a. For example, access to behavioral health services, primary care utilization decreases, hospitalization/ED increases, etc.

b. For example, were there any gaps in access to care among members that are blind, deaf, or who cannot read or understand the English language?

c. What might be some of the reasons for these improvements or interruptions in access to care?

13. What impacts were there, if any, on the care received by members following the MCP transition?

a. Were there any areas of particular concern around continuity of care among members?

b. What impacts were there on quality of care (i.e., cancer screenings, immunizations, readmissions, etc.)?

14. What impacts were there, if any, on access to specific service offerings among members that your organization serves?

a. What services, if any, were less available to members following the transition? More available?

b. How did members respond to changes in access to specific service offerings?

15. How did members respond to changes in networks after the MCP transition?

Implementation and Impacts of Community Reinvestment Plans

16. How, if at all, was your organization consulted in plans' development of their Community Reinvestment Plans?

a. For example, identifying areas of focus or soliciting community feedback

17. To what extent do you think Community Reinvestment Plans reflect community priorities?

Closing

18. In your opinion, what are some important lessons learned from your experiences with the MCP transition, both from your organizational perspective and from your role on the DHCS Stakeholder Advisory Committee?
19. What suggestions do you have for the state for future MCP transition processes?

a. What areas of the transition (e.g. education, awareness, etc.) presented the most challenges for members? For health plans? For other organizations?
b. What areas of the transition do you think would benefit from additional guidance in the future?
c. Are there any entities or entity types that you feel should be more involved in future MCP transition processes?

20. What are some successful aspects of the MCP transition to note for future MCP transition processes? What are some potential areas of improvement?
21. Is there anything else we did not discuss today that you would like to share about you or your organization's experiences with the MCP transition?

Thank you so much for taking the time to meet with us today. We greatly appreciate your willingness to share your experiences and hope that the information we collect will be helpful to DHCS. As a reminder, your responses will not be attributed to you personally and will be incorporated into a high-level summary that will help policymakers understand best practices and lessons learned from the MCP transition process. For any further questions on this [INTERVIEW], or if you have any follow-up questions or additional comments, please reach out to the NORC evaluation team at ***CAMCPTransitionEvaluation@norc.org***