California Department of Health Care Services (DHCS)

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

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

Revised Draft Evaluation Design for the Reentry Demonstration Managed Care Plans Transition (MCP)

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CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

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General Background Information

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

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

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

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

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

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

As a result, this Revised Evaluation Design covers the evaluation of three components of the waiver: the Providing Access and Transforming Health (PATH) Initiative, the Global Payment Program (GPP), and the Medi-Cal Matching Plan Policy for Dual Eligible

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

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

Beneficiaries, as well as a new proposed evaluation design for the Reentry Demonstration. More details about these programs and evaluation designs are below.

Acronym Glossary

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

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

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

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

Brief Overview of PATH

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

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

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

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

» **Reentry Capacity Building Program.** PATH is also providing funding to support the implementation of the statewide CalAIM Reentry demonstration. This includes support for implementation of pre-release Medi-Cal enrollment and suspension processes, as well as the delivery of select Medi-Cal services to eligible members in the 90 days prior to release. This includes:

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

PATH Evaluation Questions, Hypotheses, and Measures

The evaluation design for PATH is guided by the driver diagram shown in

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

Figure 1. Driver Diagram for Path Evaluation

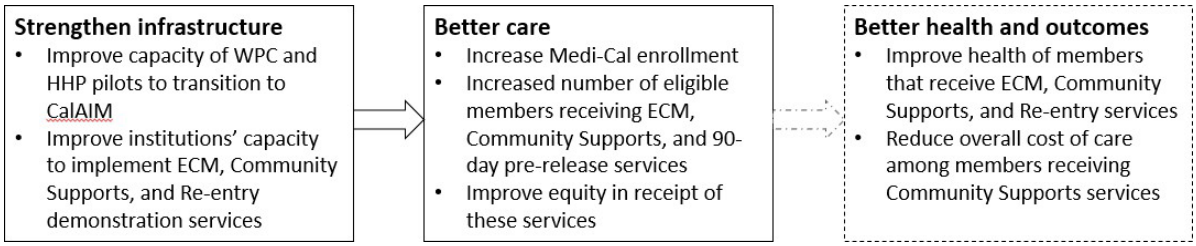

Exhibit 1 shows PATH goals as articulated by DHCS, which are aligned with the CalAIM 1115 Demonstration Special Terms and Conditions (STCs) goals for PATH. The exhibit further includes the evaluation questions (EQs), directional hypotheses (H), and measures developed by DHCS/UCLA to assess whether the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

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

Exhibit 1. PATH Evaluation Questions, Hypotheses, and Measures

Evaluation Questions (EQ) & Hypotheses (H)	Measures
Goal 1. ***Increase the number of ECM and Community Supports community-based providers and consequently increase Medi-Cal member ECM and Community Supports utilization according to community needs.***	
EQ 1: Did the number of community-based providers that contracted with Medicaid managed care plans (MCPs) to provide ECM or Community Supports increase over time? **H1a**: The number of community-based providers contracted with MCPs to provide ECM or Community Supports will increase over time due to provision of PATH funding and resources. **H1b**: The number and proportion of community-based providers located in under-resourced communities will increase over time due to provision of PATH funding and resources.	• Number of providers that were contracted to provide ECM or Community Supports services • Proportion of the total providers contracted to provide ECM or Community Supports that were community-based providers (versus for-profit or MCPs) • Proportion of ECM or Community Supports providers located in under-resourced or rural communities • Number of providers that applied for and received PATH CITED funding; Number that received TA and WPC transition funding. • Number of community-based providers that received PATH CITED funding, TA, or WPC transition funds • Proportion of providers that provided services under WPC or the Medi-Cal Health Homes Program (HHP) and were subsequently contracted to provide ECM and Community Supports
EQ 2: What factors are associated with community-based providers' participation in ECM or Community Supports?	• Characteristics of providers eligible to provide ECM or Community Supports • Eligible providers' self-reported organizational mission, ECM

Exhibit 1. PATH Evaluation Questions, Hypotheses, and Measures

H 2: Community-based providers are more likely to contract with MCPs to provide ECM or Community Supports if they participate in PATH, were contracted with MCPs prior to CalAIM, or had robust data sharing infrastructure in place prior to CalAIM.	populations of focus, and Community Supports services provided, contracts with MCPs, and data sharing infrastructure prior to CalAIM • PATH-participating providers' self-reported reasons for participating in PATH and their perceptions of role PATH's role in helping them successfully contract with MCPs to provide ECM and Community Supports
EQ 3: Did PATH increase utilization of ECM and Community Supports? **H3a**: PATH will increase the number of eligible members that utilize ECM or Community Supports and the number of ECM and Community Supports services used by eligible members. PATH will increase ECM and Community Supports utilization by helping MCPs and providers to: (a) develop cross-sector collaborative relationships and infrastructure needed to implement ECM or Community Supports, and (b) use effective strategies for identifying and engaging eligible members in ECM or Community Supports services. **H3b**: PATH will increase the number of eligible members in	• Proportion of eligible Medi-Cal members that used ECM and Community Supports services • Number and type of ECM and Community Supports services used • Demographic and health characteristics of ECM and Community Supports users and non-users, compared to the population of members eligible for these services (e.g., age, sex, language preference, homelessness status, county or region, vulnerability indices, chronic health conditions, serious mental illness, substance use disorder) • ECM and Community Supports providers' self-reported strategies for identifying and engaging eligible members in ECM and Community Supports • ECM and Community Supports providers' self-reported impact of PATH on their ability to develop

Exhibit 1. PATH Evaluation Questions, Hypotheses, and Measures

under-resourced communities that utilize ECM or Community Supports and the number of ECM and Community Supports services used by eligible members by increasing the number of providers in these communities contracted to provide these services.	collaborative relationships and infrastructure needed to implement ECM or Community Supports and identify and engage eligible members in care.
Goal 2: ***Improve data collection and information sharing infrastructure among ECM and Community Supports providers.***	
EQ 4: Did PATH improve ECM and Community Supports providers' data collection and information sharing infrastructure? **H 4**: PATH will increase the number of ECM and Community Supports providers with data use agreements with MCPs, EHR technology or other electronic care management documentation system, and Medi-Cal billing systems. PATH will increase the number of ECM and Community Supports providers that had shared data with MCPs using these systems.	• ECM and Community Supports providers' self-reported data collection and information sharing infrastructure capabilities over time among providers, stratified by provider type and participation in PATH • Number and proportion of providers with data sharing agreements with MCPs • Number and proportion of providers who have electronic health records (EHR) or other electronic care management documentation system • Number and proportion of Community Supports providers with data sharing agreements with the Homeless Management Information System (of those providing housing-related services) • Number and proportion of providers with Medi-Cal billing systems • ECM and Community Supports providers' self-reported impact of

Exhibit 1. PATH Evaluation Questions, Hypotheses, and Measures

	PATH on their ability to improve data collection and information sharing infrastructure
Goal 3: ***Improve the ability for state prisons, county jails, youth correctional facilities, and their community providers to screen, enroll, change the suspension status, or provide 90-day pre-release services for eligible individuals in Medi-Cal prior to release; and increase the number of eligible individuals screened and enrolled in Medi-Cal prior to release.***	
EQ 5: Did PATH funding improve these institutions' capacity and infrastructure necessary to screen, enroll, and change the suspension status of individuals eligible for Medi-Cal prior to release? **H 5**: PATH funding will improve these institutions' capacity and infrastructure necessary to screen, enroll, and change the suspension status for individuals eligible for Medi-Cal prior to release. PATH will do so by enabling correctional facilities to invest in needed infrastructure and capacity development.	• Self-reported changes to infrastructure, workflow, and policies/regulations made by correctional facilities and other partner institutions in order to screen, enroll, and change the suspension status of individuals eligible for Medi-Cal prior to release, stratified by participation in PATH • Self-reported total amount of funding (PATH and non-PATH) used by these institutions to develop capacity and infrastructure needed to screen, enroll, and change the suspension status of individuals eligible for Medi-Cal prior to release • Perceived role of PATH in promoting these institutions' ability to screen, enroll, and change the suspension status of individuals eligible for Medi-Cal prior to release
EQ 6. Did PATH funding improve these institutions' capacity and infrastructure necessary to provide 90-day pre-release services to eligible individuals?	• Self-reported changes to infrastructure, workflow, and community-based linkages made by correctional facilities, county behavioral health agencies, and other

Exhibit 1. PATH Evaluation Questions, Hypotheses, and Measures

H 6. PATH funding will improve these institutions' capacity and infrastructure to provide pre-release services by providing funding to invest in needed infrastructure and capacity development.	community partners to provide eligible individuals with pre-release services, stratified by participation in PATH. • Self-reported total amount of funding used to develop capacity and infrastructure needed to provide eligible individuals with pre-release services • Perceived role of PATH in promoting these institutions' ability to provide pre-release services
EQ 7: Did the number of eligible individuals screened and enrolled in Medi-Cal prior to release increase over time? **H 7**: The number of eligible individuals screened and enrolled in Medi-Cal prior to release will increase over time.	• Number and proportion of incarcerated individuals that were screened for Medi-Cal eligibility prior to release • Proportion of eligible individuals enrolled in Medi-Cal prior to release • Self-reported impact of PATH on screening and enrollment of eligible individuals in Medi-Cal prior to release

Methods

Data Source

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

urbanicity, social vulnerability, and health inequity. When appropriate, UCLA will also draw on provider data previously collected by UCLA as part of the WPC and HHP evaluations and DHCS records on providers that transitioned to PATH.

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

1. California Department of Health Care Services (DHCS) administrative data on PATH from January 1, 2022, through December 31, 2026, including Medi-Cal eligibility and claims data, ECM and Community Supports provider list and characteristics, PATH CITED applications and awardees (ECM and Community Supports), PATH Reentry funding applications and awardees, materials collected or distributed by the PATH Third Party Administrator (TPA) and facilitators responsible for administering different PATH initiatives, reports submitted by MCPs, ECM, Community Supports, or Reentry providers to DHCS (e.g., PATH implementation plans and readiness reviews), salient data from any DHCS-administered surveys of ECM, Community Supports, and Re-entry stakeholders, and PATH Transition, TA, and CPI participants.

2. Data on community-based providers and their characteristics including Uniform Data System for federally qualified health centers (FQHCs), American Hospital Association (AHA) survey of hospitals, National Center for Charitable Statistics (NCCS) data on human services nonprofit organizations, California Department of Housing and Urban Development (HUD) data on organizations contracted to provide services in the Continuum of Care program, and National Institute for Medical Respite Care on medical respite providers, as feasible. We will follow DHCS' definition of community-based providers as including all providers eligible for PATH funding, such as community-based organizations (CBOs), public hospitals, county agencies, and tribes. These organizations also include federally qualified health centers, medical groups or physician networks, hospitals or healthcare systems, behavioral health providers, and social service organizations.
3. Existing data from Whole Person Care (WPC) and Health Home Program (HHP) on providers of care coordination, care management, and other services similar to ECM and Community Supports. WPC and HHP providers included participating WPC lead entities and their partners and HHP participating MCPs and their contracted community-based care management entities.
4. Publicly available geographic data such as county, rural-urban commuting area codes (RUCAs), Social Vulnerability Index (SVI), or Healthy Places Index (HPI). These indices will be used to identify under-resourced communities (i.e., rural communities), those with high SVI scores, or those in the bottom two HPI quartiles.
5. UCLA surveys of MCPs and community-based providers, administered at 2024 and 2026 to all MCPs, PATH CITED ECM and Community Supports applicants and awardees, PATH ECM and Community Supports participants, and ECM and Community Supports providers. In a subset of counties with particularly high and low proportions of community-based providers contracted to provide ECM and Community Supports, UCLA will also administer an additional survey to community-based providers not participating in ECM and Community Supports. To minimize respondent burden, this survey will be conducted once in SFY 2024-2025 and may be restricted to community-based provider types for which high-quality secondary data on provider characteristics are not available; we will collect data from an estimated maximum of 400 providers.
6. Key informant interviews with the PATH TPA and CPI facilitators. Interviews will occur in 2024 and 2026. At each time point, UCLA will interview the PATH TPA and CPI facilitators. Interviews will address support and other resources provided as part of

PATH, lessons learned in engaging participants and providing these supports, and other topics identified as salient to the evaluation by UCLA and DHCS. The interviews will also be complemented by observations of select TA and CPI sessions.

7. Key informant interviews with MCPs and community-based providers. Interviews will occur in 2024 and 2026 following the UCLA surveys. At each time point, we will interview 24 MCPs and a purposefully selected sample of 40 community-based providers. Community-based providers will be selected to maximize variation in provider types (e.g., FQHCs, behavioral health providers, human services providers) and geographic location (e.g., region and SVI score or HPI quartile in which services are provided). The first round of interviews with MCPs and community-based providers will address topics such as factors affecting MCP selection of ECM or Community Supports providers; factors affecting provider readiness and willingness to participate in ECM or Community Supports; technical assistance and other supports provided by MCPs to ECM or Community Supports providers; use and perceived utility of PATH, including in relation to other funding supports such as the Incentive Payment Program (IPP); and as appropriate, facilitators, barriers, and lessons learned in implementing ECM or Community Supports. The second round of interviews with MCPs and community-based providers will address factors affecting continued participation in ECM or Community Supports over time, perceived business case and sustainability of Community Support services, and other topics identified as salient to the evaluation by the independent evaluator and DHCS.
8. Administrative data obtained by the RAND team, including Medi-Cal screening, enrollment and eligibility for 90-day pre-release services from CDCR and from a sample of county jails and youth correctional facilities in four counties from January 1, 2017, through December 31, 2026.
9. Key informant interviews in coordination with the RAND team with CDCR staff for state prisons and with administrative staff in a purposefully selected sample of county jails and youth correctional facilities in four local counties). Interviews will occur in mid-2025 and will address topics such as systems changes and supports needed to screen, enroll, and change the suspension of individuals eligible for Medi-Cal prior to release; systems changes and community-based linkages needed to identify and engage eligible individuals in pre-release services and to provide these services; the use and perceived utility of PATH; and facilitators, barriers, and lessons learned in implementing the Reentry demonstration. The RAND team will lead interviews with key informants in correctional facilities and the UCLA team will lead

interviews with county social services agencies and other salient community-based implementation partners.

10. UCLA organizational survey of relevant CDCR administrators for state prison facilities and relevant administrators for county jails, and youth correctional facilities, administered in 2025/2026. UCLA and RAND will examine all available administrative data (e.g., PATH implementation plans and readiness reviews, DHCS-administered surveys, etc.) and will assess if gaps exist. If gaps are identified, UCLA will develop survey questions salient to addressing PATH EQs, and will also include survey questions developed by the RAND team. Survey questions will be informed by findings from key informant interviews. The survey will then be administered to relevant administrators in eligible state prisons, county jails, and youth correctional facilities and/or to key implementation partners (e.g., county social service agencies responsible for benefits eligibility determinations).

Analytic methods

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

To answer EQ 1, which asks whether the number of providers contracted to provide ECM or Community Supports increased over time, UCLA will assess change or rate of growth in the related measures noted in Exhibit 1 over time (i.e., from January 1, 2022, to December 31, 2026). To better understand provider retention as indicated in Exhibit 1, UCLA will also (a) assess the transition of WPC and HHP providers to ECM or Community Supports in the early phase of PATH implementation and (b) examine churn in those providers as well as in newly contracted providers of ECM or Community Supports services. Data will be presented using graphical plots, and we will examine the trend and use the appropriate test (e.g., the Mann-Kendall test or regression modeling) to evaluate whether upward or downward trends are statistically significant. To determine whether the number and proportion of community-based providers located in under-resourced communities increases over time (H1), UCLA will stratify results by California county and by under-resourced community indices. When stratifying by county is not feasible due to small numbers, UCLA will stratify results by a regional grouping determined in collaboration with DHCS. To determine whether changes in the number of providers can

be attributed to PATH (H1), UCLA will also stratify results based on PATH participation. PATH participation will be operationalized as a dichotomous variable. As a sensitivity analysis, UCLA will test alternative specifications of the PATH participation variable (e.g., to assess impact of participation in different PATH initiatives or multiple PATH initiatives) and of under-resourced community indices. UCLA will also attempt to account for provider participation in other capacity-building programs such as IPP or learning collaboratives not facilitated by PATH.

To answer EQ 2, UCLA will assess the type of organizations that participated in PATH and the factors that may have contributed to their participation using the related measures noted in Exhibit 1. As feasible, UCLA will identify eligible providers based on DHCS-provided lists of preferred provider types for each ECM population of focus and each Community Support. To test H2, UCLA will use logistic regression analysis to identify factors associated with whether providers contracted to provide ECM or Community Supports. Factors assessed will include provider and community characteristics, such as provider type, participation in PATH, county or region, and community indices such as HPI or SVI score. When available, we will also attempt to control for provider size, ownership (public, private for-profit, private nonprofit or not-for-profit), and other provider characteristics. UCLA will utilize available administrative data to identify providers' participation in PATH and providers that contracted with MCPs prior to CalAIM (in 2020 or 2021). Data on providers' data sharing infrastructure prior to CalAIM will be drawn from UCLA provider-level surveys and when available, administrative data (e.g., provider applications for PATH TA or CITED funding). Due to the volume of ECM and Community Support providers, UCLA will use a survey sampling strategy to be determined following analysis of available administrative data and discussions with DHCS to collect data from a representative subset of these providers. Similar to EQ1, we will conduct sensitivity analyses to test alternative specifications of the PATH participation variable and community indices. We will also test alternative specifications of the outcome variable (e.g., dichotomous variable for any contracting to provide Community Supports vs. count variable representing number of Community Supports provided). UCLA will also thematically analyze qualitative data obtained during key informant interviews to provide further contextual information on factors affecting provider participation in ECM or Community Supports, and whether these factors vary by MCP, provider type or community context.

To answer EQ 3, which assesses whether PATH increased utilization of ECM and Community Supports, UCLA will use Medi-Cal eligibility and claims data to measure rate and patterns of use of ECM and Community Supports during PATH implementation years. UCLA will first examine the rate of use of ECM by population of focus and the rate of use of each Community Support. These analyses will be stratified by California county or region and by under-resourced community indices. UCLA will then use logistic regression analyses to assess characteristics differentiating eligible users and non-users for each ECM Population of Focus (POF) and for each Community Support. Where feasible and applicable, UCLA will also examine member characteristics associated with length of time using services or frequency of service use. Member characteristics examined will include age, gender, race/ethnicity, preferred language, homelessness, California county or region, vulnerability indices, chronic health conditions, severe mental illness, and substance use disorder, among others. UCLA will also use regression analyses to assess differences in patterns of use of ECM and Community Supports by provider characteristics and as feasible, to further examine the potential role of PATH in reducing disparities in access to and use of ECM and Community Supports services by member race/ethnicity and language preference. Sensitivity analyses will entail differing specifications of the PATH participation variable, the Community Supports utilization variable, provider participation in non-PATH capacity development initiatives, and of under-resourced community indices. Regression analyses will be complemented with descriptive analysis of survey data and thematic analysis of interview data to contextualize and explain the findings from the Medi-Cal eligibility and claims data, e.g., by providing data on perceived impact of PATH on providers' ability to develop collaborative relationships and infrastructure needed to implement ECM or Community Supports and to identify and engage eligible members in care.

To answer EQ 4, which examines whether PATH improved ECM and Community Supports providers' data collection and information sharing infrastructure, UCLA will use provider survey responses and available administrative data such as provider PATH applications, meeting notes, and progress reports. To test H4, UCLA will use ANCOVA or appropriate regression analyses to assess change in the related measures noted in Exhibit 1 over time, controlling for provider characteristics, county or region, and under-resourced community indices. Sensitivity analyses will entail testing alternative specifications of the infrastructure variables, salient provider characteristics, and community indices. These analyses will be complemented with analysis of interview data on changes in information sharing infrastructure before and after PATH, how such

infrastructure was developed or improved by providers during PATH, how data was shared with MCPs, and what were the related barriers and challenges to these activities.

To answer EQ 5 and EQ 6, UCLA will collaborate with RAND to analyze surveys, interviews, and salient administrative data to descriptively examine changes in infrastructure, workflows, staffing, and policies/regulations that may have influenced facilities' ability to screen, enroll, and change the suspension status for eligible individuals in Medi-Cal prior to release before and after PATH implementation (H5). When feasible, we will conduct t-test, Chi-squared, or other appropriate statistical tests to determine whether there are significant pre-post changes in infrastructure or staffing. UCLA and RAND will further conduct similar analyses to characterize the delivery of 90-day pre-release services (H6). The analyses will include an assessment of perceptions of the impact of PATH funding, technical assistance, and other supports as well as barriers and challenges to PATH implementation in these institutions.

To answer EQ 7, UCLA will collaborate with RAND to examine administrative data from CDCR, select county jails, and youth correctional facilities. As feasible, UCLA and RAND will attempt to corroborate enrollment using Medi-Cal enrollment data, pending the availability of a reliable flag in these data identifying previously incarcerated individuals or the ability to link administrative data from CDCR and select carceral facilities with Medi-Cal data. Data on the rate of incarcerated individuals that were screened for Medi-Cal eligibility or enrolled in Medi-Cal prior to release will be graphically plotted, and UCLA will use regression analyses to evaluate whether trends are statistically significant. To test H7, results will be stratified by facility type and region. Due to the large number of correctional facilities and associated implementation partners (e.g., county social service agencies) receiving PATH JI funding, and the fact that administrative data on county jails and youth correctional facilities will only be available in four counties, UCLA does not believe it will be feasible to stratify administrative data on screening and eligibility rates by facility receipt of PATH funding. Thus, regression analyses will be complemented with descriptive analysis of survey data and thematic analysis of interview data to contextualize and explain the findings, e.g., by providing data on facilitators and barriers to screening and enrollment, and perceived impact of PATH on institutions' ability to screen and enroll eligible members in Medi-Cal prior to release.

Cost analyses

UCLA proposes to examine all PATH expenditures and resources as well as payments to providers for ECM and Community Supports services. This is not a goal articulated by DHCS in the original evaluation design but is included to address CMS' request to measure cost outcomes of the demonstration.

Data on PATH expenditures will be provided by DHCS and will be used as part of the assessment of whether HRSN expenditures exceed the aggregate spending cap per demonstration year. This analysis will be coordinated with the UCLA Community Supports evaluation team. To determine the expenditures of ECM and Community Supports services, UCLA will ask MCPs to provide an average payment amount for each ECM or Community Supports service identified in Medi-Cal claims data by a HCPCS code. UCLA anticipates that MCPs payments to individual providers may vary for each ECM and Community Supports service identified by a HCPCS code, by region, by population of focus and potentially other factors. However, an average payment for each service may be calculated on a per service/per unit basis. UCLA will use this data to determine average payments and patterns of average payments for each ECM population of focus and for Community Supports services. UCLA will stratify these data by county or region, under-resourced community indices, provider types, and by whether the members were transitioned from WPC or HHP vs. newly enrolled following PATH implementation. These analyses depend on the feasibility of obtaining average payment rates from MCPs. If MCP are unable to estimate average payment amounts, then we will rely on DHCS-provided data pertaining to rates provided to MCPs; the limitation of this approach is that we would then only be able to examine expenditures in aggregate.

UCLA will attempt to assess cost savings by comparing Medi-Cal payments by category of service incurred by members receiving ECM or Community Supports, from providers that participated in PATH to a matched comparison group of eligible members that did not participate in ECM or Community Supports.

Additional analytic considerations

- **Prior participation in similar waiver programs:** For most PATH analyses, UCLA will use a baseline period of 2020-2021. In some counties, ECM and Community Supports are similar to services previously provided as part of California's

Medi-Cal Whole Person Care (WPC) Pilot Program (baseline period 2015-2016 and intervention implemented 2017-2021) or by Medicaid managed care plans that participated in the optional Medicaid Health Homes Program (HHP) benefit (baseline 2016-2017 and intervention implemented 2018-2021). In these counties, UCLA will use data from UCLA's prior evaluation of these programs to assess patterns of service use for Medicaid members that previously received WPC or HHP services and subsequently participated in ECM or Community Supports, as feasible. These analyses may be challenging due to churn in enrollment and selection bias (i.e., members that participate in services for a longer period of time may have a higher level of complexity than those that do not).

- **Potential effects of public health emergencies (PHE):**
  PHEs can impact patterns of health care use and expenditures, and also negatively impact fiscal solvency of many provider organizations. UCLA's previous evaluations of WPC and HHP assessed COVID-19 PHE impact, and did not identify major confounding impacts from the PHE; thus, UCLA also does not believe the COVID-19 PHE will confound PATH evaluation outcomes. However, when appropriate, the UCLA team may include a PHE indicator (e.g. for COVID-19 or other PHE) to determine whether there may be an association with members' subsequent uptake of ECM or Community Supports services.

Limitations

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

utilization of ECM and Community Supports to PATH. Self-reported data on changes in the provider organizations due to PATH and perceived impact of PATH on organization and population served are subject to recall and acquiescence bias. In addition, proposed cost analyses only address costs to Medi-Cal and not to other systems of care. The evaluation will also only include data through the end of the waiver period (December 31, 2026) and thus may not reflect longer-term program impacts. Nevertheless, these data are an important element of mixed-method evaluation design; are crucial in understanding providers' actions and motivation for choosing specific PATH implementation approaches; and essential in contextualizing and explaining quantitative outcomes.

Evaluation Design for the Global Payment Program (GPP)

Brief Overview of Global Payment Program

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

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

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

Exhibit 2. PHCS Participating in the Global Payment Program

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

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

process is summarized below based upon a detailed description in the CalAIM-1115-STC[5].

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

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

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

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

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

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

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

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

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

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

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

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

[6] Appendices K and L from the CalAIM waiver STCs provide details of GPP services stratified by categories, tiers, and services, including point values historically and recently assigned to individual GPP services.

based practices to facilitate improvements in health disparities.

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

A prior evaluation of GPP was conducted through PY 3 (SFY 2017-2018).[7] Briefly, the evaluation found that PHCSs increased the use of outpatient services, increased the number of uninsured patients served, and the percentage of GPP points (and therefore dollars) earned based on percentage of dollars earned for non-inpatient, non-emergent services. This current evaluation design for GPP applies to a renewal of California's section 1115 demonstration. Since the conclusion of the evaluation of GPP conducted through PY 3 (SFY 2017-2018), several changes in the implementation of GPP have occurred. In response, this evaluation will assess changes in the number and composition of uninsured in California, utilization of new additions to GPP services since the beginning of the Medi-Cal 2020 waiver (e.g., doula, peer support, and Equity Enhancing Services), and changes in quality of care for California's uninsured.

In this section, Exhibits 3 and 4 further show GPP goals as described by driver diagrams presented by DHCS in their Initial Evaluation Design.[8] Later in this section, Exhibits 5, 6, and 7 provide additional detail about GPP's current evaluation questions (EQs), directional hypotheses (H), and measures developed by UCLA-RAND evaluators to assess whether the goals of GPP are achieved across the evaluation period. The target population for all measures include individuals for whom the PHCSs submitted points for any GPP service provided by any of the PHCSs participating in the GPP.

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

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

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

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

Exhibit 4. GPP Driver Diagram (GPP Goal 3)

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

Clinical quality measures associated with the first goal, research questions, and hypothesis are chosen to include those systematically collected by PHCS and aligned

with the DHCS Comprehensive Quality Strategy, derived from the Uniform Data System (UDS)[9]. These sources are used since their measures are based on patients seen by the public health clinic/system and also have national benchmarks, while most other standardized and nationally stewarded clinical measures are based on a health plan enrolled or provider-assigned population, which does not exist in GPP.

The Target Population for GPP quality and utilization Health Equity Measures is: "Individuals for whom the PHCS submitted points for any GPP service provided by the PHCS."[10] GPP eligible individuals include those who are uninsured for the service they receive.

Metrics associated with GPP's second goal, research question, and hypothesis are pertinent to utilization of services, and metrics associated with the third goal, research question, and hypothesis pertain to equity. The first four of these measures include those identified by DHCS in 2023 for measurement of both quality of care and health equity.[11] Note that the target population for individual quality metrics is more specific than the cohort of patients eligible for GPP services. The former includes individuals for whom the PHCS submitted points for any GPP service provided. Among these individuals, a subset who meet relevant criteria, are eligible for specific clinical measures.

DHCS proposes continuing to assess utilization as was done in the initial GPP evaluation, which assessed the core program objective of shifting care from inpatient and emergency settings to primary and preventive services, including non-traditional services. While these measures do not have national benchmarks, they help to understand the continued impact of the program in encouraging the use of primary and preventive care. These measures, defined by CPT and ICD-10 codes[12] include changes in

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

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

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

[12] Codes and descriptions, if available for these GPP services, are documented in CalAIM-1115-STC-Technical Corrections, Appendix 2, Table 7, Categories of Service, Pg 204 of 289 pgs. Following Appendix

utilization across multiple GPP service categories.

Evaluation Design Methods

Data sources

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

Primary data collection and analyses

Surveys of GPP Health System Leaders and Teams

Our GPP Evaluation Team developed and fielded respectively in 2018 and 2019, a GPP survey of PHCS leaders to provide a comprehensive description of the activities that each PHCS conducted to support GPP goals. We now intend to field an updated version of this survey to PHCS GPP leaders and their teams in 2024 and 2026. This survey will ask about specific health system improvement actions that PHCSs are pursuing to enhance their responses to the GPP and the types of supports that PHCSs have implemented to enhance the delivery of accessible, proactive quality care. As with prior surveys and interviews, we anticipate that each PHCS will identify a leadership team to participate in the GPP surveys and interviews. We will welcome involvement from the California Association of Public Hospitals and Health Systems (CAPH) to ensure that the survey reflects actual PHCS activities.

Interviews with GPP Health System Leaders and Teams

2, Table 7 shows an extensive set of notes explaining code/definition sources. The source of Updated codes and descriptions will be reflected in reporting guidance provided by DHCS to PHCS.

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

Primary data collection to examine the patient experience

Although prior analyses of the GPP highlighted increasing numbers of uninsured individuals and expanded types of health services used by the uninsured, how GPP impacts quality of care, patient experience, and health status is not known. Furthermore, the mechanisms by which GPP influences the volume, type, and setting of service use is not known. We do not know whether changes in service use or costs relates to the GPP's system for incentivizing higher value care, to increasing access to primary and preventive services, to changes in the health status of uninsured individuals, or to uninsured individuals becoming more familiar with how to access clinical care. We do know that improving clinical care depends upon improvements in access, patient engagement, comprehensive and continuous care. While health system data can report patient demographics, utilization, and costs, only patients can report their experience with care. To better examine the patient experience in our evaluation, we will attempt to gather this information through questions in the PHCS surveys and PHCS interviews described above to learn about how patients use the services provided and paid for through GPP. We will attempt to use existing patient-level Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data collected by DHCS as part of the

state's Medicaid Core Set reporting requirements to understand changes in patient experience over time for GPP service users. After consideration of the pros and cons of interviewing patients, with DHCS, the Evaluation Team has decided upon the alternative methods described above to assess patient experience.

Secondary Data Sources

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

Aggregate Utilization Reports

Each PHCS reports aggregate utilization data using a standard reporting template developed by DHCS that includes each of the 50+ services eligible for points and a field for reporting the number of units of each service provided to the uninsured during the year. Each PHCS is expected to submit an interim year-end summary report by February 15 following the end of each PY and a final, year-end reconciliation summary report by September 30 following the end of each PY. PHCSs are expected to use the applicable STCs in the CalAIM waiver to guide reporting of the utilization data.

Encounter-Level Data

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

P14 Workbook Data

The P14 workbook has served as a California-specific reporting tool that PHCSs have used to claim federal matching payments for both Medi-Cal and uncompensated care to the uninsured. For the purposes of the GPP, these workbooks provide a record of the aggregate cost of services that each PHCS provided to individuals using GPP services and

any payments that these individuals made to that PHCS. These data are expected to be available one year following the end of each fiscal year (June 30). Cost data as reported in the P14 workbook have been available annually since PY 1 (SFY2015-2016). To implement planned pre-post and differences-in-differences analyses, the evaluation team recommends we examine historical P14 workbook data from PY 1 (SFY 2015-2016) through to the present time. This will allow us to develop appropriate analyses across years without and with consideration of the period spanning the COVID Public Health Emergency (PHE).

Medi-Cal Claims, Encounters, and Eligibility Files

Medi-Cal claims and encounter data (hereafter referred to simply as "claims") will supplement GPP encounter data to capture use of GPP services. For example, since the beginning of GPP in SFY 2015-2016, GPP users who were eligible for restricted scope Medi-Cal and who used ED or pregnancy-related services will have documentation of these services in the Medi-Cal claims files. In addition, we will use both claims and eligibility files to identify a comparison group of Medi-Cal members for selected analyses.

Medicaid Core Set Measures

DHCS generates and submits to CMS measures of performance on the quality of care provided to Medi-Cal enrollees on an annual basis. These measures assess performance in domains such as primary care access and preventive care, behavioral health care, maternal and perinatal health, care of acute and chronic conditions, and members' experience of care. We will explore using patient-level data to assess changes in these measures among our comparison group of Medi-Cal members during CalAIM.

Managed Care Accountability Set (MCAS) Measures

Medi-Cal managed care organizations operating in California are required to submit to DHCS measures of performance each year, which are then publicly reported. Measure domains include behavioral health, children's health, chronic disease management, reproductive health, cancer prevention, and utilization. We will explore using patient-level data to assess changes in these performance measures among Medi-Cal members during CalAIM for our comparison groups.

Emergency Department and Hospital Inpatient Encounter Data

The California Department of Health Care Access and Information (HCAI) maintains databases containing all ED and hospital inpatient encounters in the state each year—including encounters for uninsured residents. We will use these files to measure ambulatory care-sensitive utilization measures for GPP service users from 2015 to 2026.

GPP Point Thresholds

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

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

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

GPP Payments

Interim payments to each PHCS for providing services to the uninsured are made on a quarterly basis. Additionally, a final reconciliation payment is then made, which may include payments to PHCSs that exceeded their point thresholds if there is unclaimed funding for hospitals which did not meet their point thresholds. Interim, final reconciliation, and total PY payments to each PHCS are publicly reported on the DHCS website.

Annual Health Equity Report

Completion of this report will first be required to be completed by PHCS for the period covering PY 9, January 1, 2023-December 23. The first PHCS reporting date to DHCS for this *Annual Health Equity Report*was September 30, 2024. All participating PHCSs are required to report on the five GPP Health Equity measures selected by DHCS and GPP service utilization categories, using the specifications outlined by DHCS as required by Attachment M.

Methods: Goals, Questions, Hypotheses, Measures and Analyses

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

GPP Goal 1 Evaluation Design

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

GPP Goal 1. Improve the quality of care among individuals with uninsured services.	
Evaluation Questions and Hypotheses	**Measures**
EQ1: Was the GPP successful in improving quality of care to individuals with uninsured services?	1. Colorectal Cancer Screening[13] 2. Diabetes: HbA1c Poor Control (>9%)[14] 3. Preventive Care and Screening: Screening for Depression and Follow-Up Plan[15] 4. Breast cancer screening[16] 5. Cervical cancer screening[17]

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

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

H1: PHCS improved the quality of care to the uninsured.	Other quality measures that may be included depending on data availability include: Chlamydia Screening in Women, Postpartum Care, Childhood Immunization Status, Immunizations for Adolescents, Developmental Screening in the First Three Years of Life, Lead Screening in Children, and Topical Fluoride for Children.

Analytic methods for GPP Goal 1

1.1. Descriptive Analyses

To evaluate GPP Goal 1 we will begin by conducting descriptive analyses of trends in quality of care for GPP users without the use of comparison groups.

- **Data sources:** The data sources used by PHCSs to generate quality Measures 1-5 listed in Exhibit 5 include administrative data (i.e., claims data) and medical record documentation (e.g., structured and unstructured EHR data, clinical registry data, pharmacy, and lab data). As part of the GPP Health Equity Monitoring Metrics Protocol approved by CMS on December 20, 2023, PHCS will be required to submit stratified performance data on the five clinical quality measures listed above. PHCS submitted the first Health Equity Annual Report containing performance rates for calendar year 2023 on November 29, 2024, and will continue to submit these reports on an annual basis thereafter.
- **Measures**: Quality measures were chosen based on alignment with the DHCS Comprehensive Quality Strategy and were derived from the Uniform Data System (UDS) and Merit-based Incentive Payment System (MIPS).[18] These sources were used since their measures are based on patients seen by the clinic/system and have national benchmarks while most other standardized and nationally stewarded clinical measures are based on a health plan enrolled or provider-assigned population, which does not exist in GPP.
- **Target population:** All individuals receiving GPP services. More specific target populations will be defined by each clinical measure specification. The level of analysis will be at the PHCS level and program level.
- **Comparison group:** None
- **Baseline period:** None
- **Statistical analyses:**

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

    - Model: Longitudinal analysis
    - Analysis period: 2023-2026
    - Estimates of interest: Yearly change in quality for the target population relative to the first year of the analysis period (2023).
- **Stratifications:** Analyses will be stratified by race, ethnicity, preferred language, gender identity, sexual orientation, age group, and area-level deprivation measures, such as the Social Vulnerability Index or the Healthy Places Index. Analyses across all five CalAIM components will seek to align use of area-level deprivation measures where possible and following empirical analysis of their concordance for areas within California.

1.2. Analyses with Comparison Groups

We will also explore conducting analyses that include comparison groups to provide a more rigorous assessment of the effects of GPP on quality of care. For these analyses, we will explore using GPP encounter data to measure quality of care for the target population and Medi-Cal claims data and MCAS and Medicaid Core Set measures to assess quality of care for a comparison group of Medi-Cal members who receive care from the PHCS, or, alternatively Medi-Cal members who live within a PHCS service area but who are not attributed to a PHCS. Measures may include key screening measures (e.g., breast cancer screening, cervical cancer screening), measures of postpartum care, and immunization measures (Exhibit 5). The statistical analysis would use comparative interrupted time series models as there are no data available for the target population prior to the start of GPP. Stratified analyses could be conducted for key patient subgroups defined by race, ethnicity, and area-level deprivation.

GPP Goal 2 Evaluation Design

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

GPP Goal 2. Drive the shift in the provision of services from emergency and select inpatient services to non-emergency outpatient settings among those individuals with uninsured services.	
Evaluation Questions and Hypotheses	**Measures**
EQ2. Was the GPP successful in driving a shift in the provision of services from emergent and select inpatient services to non-emergency outpatient settings, including non-traditional and equity enhancing services? H2. PHCS increased the use of outpatient services, non-traditional services, and equity-enhancing services over the course of the GPP.	***Utilization measures derived from GPP encounter data:***[19] 1. GPP non-behavioral health outpatient non-emergency, emergency, and inpatient med/surg services 2. GPP behavioral health outpatient non-emergency, emergency, and inpatient services 3. GPP non-traditional services 4. GPP equity-enhancing services ***Utilization measures derived from HCAI encounter data:*** 5. Ambulatory care-sensitive Emergency Department (ED) visits 6. Ambulatory care-sensitive hospitalizations 7. 30-day-all-cause-hospital-readmission-rate 8. All-cause ED utilization ***Utilization measures still under consideration:*** 9. Visit Patterns *(Possible measures under consideration include frequency/regularity of ambulatory visits and types of providers seen including generalist or specialist provider MD, NP, PA, RN[20] or other provider type)*

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

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

GPP Goal 2. Drive the shift in the provision of services from emergency and select inpatient services to non-emergency outpatient settings among those individuals with uninsured services.	
Evaluation Questions and Hypotheses	**Measures**
	10. Follow-up care following abnormal clinical findings *(Possible measures under consideration include timely follow up to abnormal mammograms, abnormal fecal occult testing for colorectal cancer screening, or abnormal laboratory values such as elevated hemoglobin A1c or lipid values).* ***Other utilization measures that might be derived from Medicaid claims and/or are available in Medicaid Core Set or Managed Care Accountability Set (MCAS) measure files*** *(Possible measures under consideration include):* 11. *Follow-up after ED visit for individuals at high-risk for multiple chronic conditions, substance use, or mental illness; Follow-up after hospitalization; Continuity of primary and specialty care providers; Readmissions or repeated ED use; and among pregnant women, length of hospital stay, intensive care unit (ICU) use during hospital stay, and prenatal visit rates).*

Analytic methods for GPP Goal 2

2.1. Planned descriptive analyses and analyses with comparison groups

To evaluate GPP Goal 2 we will conduct a series of analyses to compare the utilization of services by GPP users to comparison groups not exposed to GPP.

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

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

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

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

- **Measures**: We will assess changes in utilization of GPP services using approaches analogous to those used in the initial GPP evaluation while also adding several new measures. Measures 1-4 displayed in Exhibit 6 are based on the number of GPP points provided in each service "category" and "tier" as displayed in Attachment L of the STCs. While these measures do not have national benchmarks, they are valuable to understanding the continued impact of the program in encouraging the use of primary and preventive care. The relevant codes and descriptions for these GPP services are documented in *Technical corrections to the California section 1115 Medicaid demonstration, entitled "California Advancing and Innovating Medi-Cal"*

(CalAIM) (Project Number 11-W-00193/9) which was approved on August 23, 2023, under the authority of section 1115(a) of the Social Security Act (the Act) Appendix 2, Table 7, Categories of Service, Page 204 of 289 pages[1,3] Importantly, within this citation and following Appendix 2, Table 7, is an extensive set of notes explaining the source of codes applied to GPP services. The citation indicates that updated codes and descriptions will be reflected in reporting guidance provided by DHCS to PHCS.

Measures 5-8, which are derived from HCAI encounter data, include two measures of ambulatory care-sensitive (ACS) utilization: ACS hospitalizations[21] and ACS ED visits.[22] Both measures will help to assess potential reductions in acute care utilization through improved access to primary and preventive care. Two additional measures, 30-day all-cause hospital readmission[23] and all-cause ED utilization will help to measure improvements in transitional care and efforts by PHCS to avoid repeated ED use, respectively. All four measures can be constructed for both PHCS and a non-PHCS comparison group comprising facilities in non-GPP counties (as discussed below) and allows us to use multiple years of data preceding Cal-AIM.

Metrics 9-11 are still under development, as we continue to work with PHCSs to examine the feasibility of including in the Goal 2 analysis two additional measure types that we anticipate will provide new insights into the mechanisms by which GPP changes clinical care delivery. Metric 9 will examine trends in the patterns of frequency, regularity, and types of providers associated with visits by uninsured individuals to non-emergent ambulatory settings paid for by GPP funds. As GPP progresses, the program is designed to increasingly incentivize a shift to non-emergency ambulatory settings (e.g., by increasing GPP points associated with ambulatory services, while decreasing point values for potentially avoidable, costly inpatient services). We will attempt to examine whether this shift in venue of care is associated with more continuity and coordinated care by measuring the changes in the prevalence of more regular PHCS visit patterns from patients and more timely follow-ups to abnormal clinical findings. These findings could shed light on how GPP may change patient care, especially noting that regular visits with known providers

[21] https://qualityindicators.ahrq.gov/measures/pqi_resources
[22] https://qualityindicators.ahrq.gov/measures/ed_pqi_resources
[23] https://data.chhs.ca.gov/dataset/all-cause-unplanned-30-day-hospital-readmission-rate-california/resource/baa1a00c-d515-454a-ae47-410f8b95c3f3

are associated with fewer ED and hospital days, and that prompt attention to specified abnormal clinical findings can save lives and improve quality of life.[24]

Our exploration of Metric 10 will first assess the availability of PHCS data for assessing whether GPP implementation is associated with changes in the extent to which timely follow-up to select well-specified abnormal findings is occurring. For example, we may explore as the GPP program matures, whether uninsured women receiving an abnormal screening mammogram finding (e.g., an advanced BI-RADS Category) at a PHCS, are more likely to receive timely follow-up to that abnormality. A similar analysis could be done to assess timely follow-up to a positive stool test performed for colorectal cancer screening, or follow-up to a very high blood sugar value (HbA1c value >8). While exploring data quality related to these concerns, we also intend to address these topics during patient interviews and health system leader surveys and interviews. In these ways, our planned mixed methods approach will provide insight how GPP impacts patient care and experiences.
Metric 11 will also explore other utilization measures that might be available including for example, follow-up after ED visits for individuals at high-risk for multiple chronic conditions, substance use, mental illness diagnoses, or following hospitalization.

- **Target population**: All individuals receiving GPP services or the closest proxy available in each data source (e.g., uninsured individuals receiving services at a PHCS).
- **Comparison group:** As described in the statistical analyses below, some analyses will use a comparison group comprising hospitals and EDs in non-GPP counties. Other analyses will not use a comparison group because no comparison group is available for measuring utilization of specific services by the uninsured.
- **Baseline Period and Evaluation Period:** Both periods will vary by analysis as described in the statistical analyses below.
- **Stratifications:** Selected analyses (described below) will be stratified by race, ethnicity, preferred language, gender identity, sexual orientation, and age group.
- **Statistical analysis:** We will use both pre-post analyses as well as differences-in-differences analyses for a subset of measures. Details for specific analyses are included below:

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

- **Analysis 1: Pre-post comparison of utilization measures derived from GPP encounter data [Exhibit 6 Metrics 1-4].** Although this analysis does not allow causal impacts of GPP on measures of utilization, it leverages the rich GPP encounter data to conduct pre-post analyses of changes in specific categories and tiers of services. The analysis would use 2017-2021 as the baseline period and 2022-2026 as the evaluation period and would use an interrupted time-series design to determine whether CalAIM is associated with a statistically significant change in utilization rates for each type of service (i.e., change in slope) between the two waiver periods. In addition, we will explore PHCS-level correlations between changes in utilization of outpatient and non-traditional services with changes in utilization of high-cost services such as ED and hospital stays.
- **Analysis 2: Difference-in-differences analysis of changes in ACS hospitalizations, ACS ED visits, and all-cause ED utilization [Exhibit 6 Metrics 5-8].** This analysis will compare trends in utilization measures for uninsured individuals treated at PHCS relative to non-GPP counties in California. The analysis would use 2015 as the baseline year and would measure ACS utilization on a yearly basis through 2026. This specification allows us to estimate the impact of GPP on utilization during CalAIM relative to the pre-GPP period (2015) as well as differential changes in utilization (i.e., change in slope) between the two waiver periods.
- **Analysis 3: Pre-post subgroup analyses.** We will expand Analysis 1 to measure changes in utilization of GPP services utilization stratified by each of the population characteristics captured in the GPP encounter data (race, ethnicity, preferred language, gender identity, and sexual orientation), and area-level deprivation measures, such as the SVI or the HPI.
- **Analysis 4: Difference-in-differences subgroup analyses.** We will expand Analysis 2 to measure the impact of GPP on utilization for population subgroups defined by race and ethnicity and area-level deprivation measures, such as the Social Vulnerability Index or the Healthy Places Index. which are the only population subgroups available for stratification that can be measured in the HCAI data. We note that the race and ethnicity in HCAI are unlikely to be self-reported, which is a limitation of these analyses.

2.2 Additional analyses under consideration

In addition, we will explore supplementing GPP encounter data with Medi-Cal claims, MCAS measures, and Medicaid Core Set measures to conduct further analyses (Exhibit 6 Metrics 9-11). The analyses would include members who are attributed to one of the 13 PHCS based on analysis of Medi-Cal claims as well as a comparison group of Medi-Cal members who receive care from the PHCS, or, alternatively Medi-Cal members who live within a PHCS service area but who are not attributed to a PHCS. The statistical analysis might use comparative interrupted time series models or comparative trend analyses depending on whether pre-CalAIM data are available for each measure. Stratified analyses could be conducted for key patient subgroups (e.g., race, ethnicity, area-level deprivation).

GPP Goal 3 Evaluation Design

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

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

Analytic methods for GPP Goal 3

- **Data sources:** GPP encounter data submitted by each PHCS on a yearly basis.
- **Measures:** Improvements in data infrastructure will be measured by percent completion of 5 individual level characteristics listed in Exhibit 7.

- Race categories will include American Indian or Alaska Native; Asian; Black or African American; Native Hawaiian or Other Pacific Islander; White; Some Other Race; Two or More Races; No Race Selection and Hispanic or Latino Ethnicity; Asked but No Answer/Unknown.
- Ethnicity categories will include Hispanic or Latino; Not Hispanic or Latino; Asked but No Answer/Unknown.
- Preferred Language Spoken will be coded as specified in GPP guidance consistent with the Department of Health Care Access and Information (HCAI) reporting guidance for Preferred Language Spoken.
- Sexual orientation categories will include Lesbian, gay or homosexual; straight or heterosexual; Bisexual; Other ("Something else, please describe"); Don't Know; Choose not to disclose.
- Gender Identity includes five specific categories, as well as Other ("Additional gender category or other, please specify"), and "Choose not to disclose".

» **Stratifications:** Each measure listed in Exhibit 7 will be stratified by age group (e.g., <18, 18-64, >=65). Stratified reporting by age reflects the fact that willingness to self-report this type of information might vary by age.

» **Target Population:** All individuals receiving GPP services.

» **Comparison Group:** None

» **Baseline Period:** CY 2023 (PY9). This is the first year that PHCSs will be collecting all five stratification variables according to the GPP Health Equity Monitoring Metrics Protocol.

» **Evaluation Period:** CY 2024 (PY 10) through CY 2026 (PY 12)

» **Statistical Analysis:** Measures will be trended annually to assess changes over time during GPP.

GPP qualitative design

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

system to meet the goals of GPP.

The qualitative data will be collected via a structured survey and will be completed independently by all PHCS. Survey responses will be categorized and coded by emergent themes. Follow-up interviews will be conducted to address gaps and questions about the original responses. Interview responses will be added to the survey responses and further coded by themes. All interviews will be recorded and transcribed, while qualitative data from surveys (e.g., free text responses to open-ended questions) will be extracted and organized into a spreadsheet.

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

Analysis of the PHCS Survey

The PHCS survey will again contain mainly ordinal-scale items. We will summarize the responses by reporting means, standard deviations, and sample sizes (not all items will be applicable to all 13 PHCSs). For this evaluation, we will generally query PHCS leader respondents about their views on a topic in the years since the end of the Public Health Emergency. Where survey items are identical with prior survey findings, we will compare responses with those previously obtained in 2015 and 2018. This will yield multiple longitudinal data points for each PHCS for these items. One limitation of drawing conclusions from survey data is that survey responses come from reports by PHCS leaders. Thus, the survey responses may not reflect what is truly happening within a PHCS or what all PHCS staff and leaders believe, but rather the perceptions and opinions of the respondent. However, when supplemented with utilization and quality of care data, the surveys provide context for the trends and patterns observed across PHCSs and experienced by GPP users.

GPP Cost Analyses

We will use P14 workbooks from each PHCS to measure the cost of services provided to the uninsured provided by the PHCS. Audited P14 data will be used in the cost analysis

or the most current unaudited P14 data when audited P14 workbooks are not available. We will then derive per capita cost estimates using unduplicated patient counts from the GPP encounter data. These analyses will support pre-post analyses of per-capita spending from as early as 2015 through the end of GPP. Cost data for a comparison group comprising non-GPP counties could be derived from a combination of hospital and ED encounter-specific charges reported in the HCAI data supplemented with UDS financial cost data reported by FQHCs in the UDS. Although the cost of care for the uninsured may be defined differently for the PHCS and comparison group, these differences should be stable over time and should be netted out in our difference-in-differences analysis. We will ensure alignment of the cost analyses across all other CalAIM components.

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

Limitations

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

While our evaluation team is intensely focused on identifying valid comparison groups that will allow us to draw causal inferences about the effect of the GPP on shifts in service utilization, costs, or perceptions of changes in quality, identifying such comparison groups is difficult since systematic data about use of services among uninsured individuals with characteristics similar to California's uninsured population are limited. We will ensure that any comparison group used in the evaluation is well-matched to the sociodemographic profile of the target population and provides adequate statistical power. We will also compare trends in ambulatory care sensitive

utilization for uninsured individuals treated at PHCSs relative to non-GPP counties in California.

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

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

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

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

Overview of the Evaluation

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

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

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

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

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

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

While the Medi-Cal Matching Plan Policy in its current form was first implemented in 2022, we recommend the analysis comparing the demonstration and the comparison sites include analysis of similarities between the demonstration and comparison sites that begin at least one year prior to the demonstration's launch. Consistent with the difference-in-differences design recommended by DHCS in its draft Evaluation Design,[25] examination of the pre-intervention period (2021 and earlier) will allow us to distinguish whether any difference in outcomes noted during or after the intervention can be meaningfully attributed to the intervention, or alternatively to preexisting differences between the Duals residing in demonstration or comparison counties. The evaluation team recognizes the policy landscape surrounding alignment has been dynamic and varied across counties and over time, and we consequently recognize the necessity of close collaboration with subject matter experts at DHCS to explore possibilities for these analyses and leverage their guidance over the course of the evaluation.

Overview of Medicare Enrollment and MA Plans

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

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

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

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

Exhibit 1: MA Enrollment Among Dual Eligibles in California (October 2023)[26]

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

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

- **Regular MA Plans:** These plans serve both dual eligible and Medicare only members and are not required to have written agreements with state Medicaid agencies, such as DHCS, for benefit and care coordination for dual eligible beneficiaries. This group also includes individuals enrolled in Medi-Cal and Dual Eligible Special Needs Plans (D-SNPs) that do not have a contract with DHCS (out-of-state D-SNPs), likely due to out-of-state zip codes for Medicare enrollment.
- **Medicare Medi-Cal Plans (Medi-Medi Plans or MMPs): Also known as Exclusively Aligned Enrollment (EAE) D-SNPs**, these plans are a type of MA plan that meet integrated D-SNP care coordination requirements, with integrated member materials, and have membership limited to dually eligible individuals who are also enrolled in the Medi-Cal managed care plan affiliated with the D-SNP. Medi-Medi Plans are available in seven counties in 2023: Los

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

Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. In 2024, MCPs in an additional five counties will offer EAE D-SNPs (Fresno, Kings, Madera, Sacramento, and Tulare).

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

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

While the Cal Medi-Connect demonstration was a three-way contract with CMS, DHCS, and each plan, and member enrollment was into a single plan, Medi-Medi Plans are separate D-SNP and MCP contracts, with separate federal and state enrollment transactions. As a result, the Medi-Cal Matching Plan Policy is essential to enrollment

operations for Medi-Medi Plans, for a Dual member to have concurrent enrollment in the same plan organization for both Medicare and Medi-Cal.

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

Medi-Cal Managed Care Delivery System and MCPs

California has a unique county-based managed care delivery system for MCPs that has been implemented across the 58 counties in the state. In more populous counties, MCPs are administered using one of three models: (1) – County Operated Health System (COHS) with a single MCP administered by the county, (2) Two Plan Model (TPM) with one local non-profit MCP and one MCP operated by a commercial entity, and (3) Geographic Managed Care (GMC) with two counties with five or more MCPs operated by commercial entities. Seventeen rural counties are governed according to the Regional Model (covering the central Sierra counties) with two or more commercial MCPs, Imperial Model (covering Imperial County) with two commercial MCPs, and San Benito County which is covered by a single commercial MCP. Fourteen suburban and rural northern counties are covered by a single COHS entity with an additional commercial plan in the more populous counties in this group. Beginning in 2024, there has been a reorganization of these models, with some of the northern counties, San Benito County, and Imperial County moving towards the COHS / single plan model. In addition, Kaiser is expanding its Medi-Cal prime plan participation through a direct contract with DHCS, where eligible members may actively choose to enroll in Kaiser in any county in which Kaiser operates, including GMC, Regional, Two Plan, COHS and Single Plan counties.[27]

To increase member choice, in years prior to 2024, MCPs in certain counties (including Los Angeles, Riverside, San Bernardino, San Mateo, and Santa Clara) sub-contracted to other plans. The MCPs referred to as ***Primary Plans*** have direct contracts with DHCS to

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

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

Medi-Cal Managed Care Enrollment for Dual Eligible Beneficiaries

Medi-Cal has had a county-based policy of mandatory and optional enrollment of Duals into MCPs across the 58 counties in the state. Mandatory MCP enrollment for Duals in certain counties began with the introduction of the Coordinated Care Initiative (CCI) in 2014 in some of the state's more populous counties (Los Angeles, Riverside, San Bernardino, Santa Clara, San Diego Counties) and in COHS counties such as Orange and San Mateo prior to that time. As of January 2022, the policy of mandatory MCP enrollment for Duals was effective in 27 counties[28]. Approximately 70% of California's 1.5 million Duals (~1,050,000) were in a MCP – and most of these were in these 27 counties. Expansion of mandatory MCP enrollment policy to the remaining 31 counties[29] occurred in 2023.

The Medi-Cal Matching Plan Policy

In general, upon receiving Medicaid benefits, most non-Duals in Medi-Cal are assigned to an MCP that operates in their county of residence and the member may request a change in any month after enrollment. DHCS implemented the *Medi-Cal Matching Plan Policy* beginning in January 2022 in twelve of California's 58 counties with an additional five counties in January 2024.[30] For Duals with Medicare Part A and Part B, as of 2022, choice of MCP depends on whether the Dual is enrolled in a MA plan or in Original Medicare and on the county of residence for that Dual.

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

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

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

Under the *Medi-Cal Matching Plan Policy*, if a Dual chooses to enroll in any type of MA plan in these counties, their MCP must *align* with their MA choice if there is a MCP affiliated with the MA plan. The key principle is that Medicare plan choice determines Medi-Cal plan enrollment. Further, aligned enrollment occurs at both the Medi-Cal Primary and Delegated Plan level. The *Medi-Cal Matching Plan Policy* does not change or impact a member's MA plan choice. DHCS also operates an exception policy if needed for immediate MCP disenrollment for urgent/medically necessary Dual member needs. For counties with the *Medi-Cal Matching Plan Policy*, common scenarios are described in Exhibit 1 (next page).

Exhibit 1. General Scenarios for the Medi-Cal Matching Plan Policy

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

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

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

This 1115 demonstration impacts Duals enrolled in an MA plan who reside in one of the matching plan counties. Per DHCS' previous discussion with CMS on January 28, 2022, the state will evaluate programs goals of improving alignment and integration, as primarily assessed by member experience with Medi-Cal plan alignment. Other related impacts of alignment and integration – care coordination, access, quality, and overall cost – are of great interest, but detailed exploration of these is outside the scope of the evaluation of the *Medi-Cal Matching Plan Policy*. Medicare and Medi-Cal integration has been evaluated elsewhere by CMS Medicare-Medicaid Coordination Office (MMCO) through contract with RTI International.[31]

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

Exhibit 2 shows *Medi-Cal Matching Plan Policy* goals articulated by DHCS. DHCS defines a **Medi-Medi Plan** as an integrated EAE D-SNP; an **Aligned Plan** as a MA plan and MCP affiliated with and operated by the same MCO and an **Unaligned Plan** as a MA plan and MCP operated by different MCOs. The exhibit further includes the evaluation questions (EQs), directional hypotheses (H), and measures developed by UCLA and DHCS to assess whether the goals of the policy were achieved as anticipated. The evaluation team will incorporate feedback from DHCS subject matter experts to ensure that directional hypotheses accurately capture policy nuances across comparison groups.

Exhibit 2: Alignment and Integration for Dually Eligible Beneficiaries

G 1: Determine the Epidemiology of Plan Changes among Dually Eligible Beneficiaries Eligible for MA Plans and Relate them to Requested MCP Change Requests.	
Evaluation Questions and Hypotheses	**Measures**
EQ 1a: How many Duals enrolled in a MA plan in the 12 counties with a *Medi-Cal Matching Plan Policy* in 2023 had the policy applied to them?	» Percent of Duals enrolled in a MA plan who change their MCP and who change their MA plan (in counties with the

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

EQ 1b: Of Duals that had the policy applied to them, how many changed their MCP to a non-matching plan within 12 months of enrollment?	*Medi-Cal Matching Plan Policy* compared to counties without the *Policy*) – aligned versus unaligned plans. » Percent of Duals enrolled in Medi-Medi Plans who change to a different Medi-Medi Plan, a different MA plan, or Original Medicare, compared to Duals in Original Medicare, and compared to Duals in other MA types. » Overall MCP enrollment churn rate, with comparisons. » Percent of individuals who change their MMP compared to individuals in unaligned D-SNPs in counties without the *Medi-Cal Matching Plan Policy*.
H 1: Less than 0.1 percent of Duals in mandatory aligned plans in Matching Plan Counties will change their MCP without changing their MA within 12 months of enrollment during the target period.	
H 2: Duals in aligned plans during the target period, are less likely to change their MCP (without changing their MA) than those in unaligned plans during the target period.	
H 3: Duals who change from a mandatory aligned plan are less likely to change their MA plans (and MCP) than Duals who change from unaligned MA plans during the target period.	
H 4: Duals in MMPs will be less likely to change plans than those in other aligned plans that are not MMPs and less likely than those in unaligned D-SNPs	

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

Conceptual Model

The driver diagram (Exhibit 3) shows how the *Medi-Cal Matching Plan Policy* conceptually impacts Duals. Improved education of Duals combined with reduced administrative burden and improved alignment and care coordination for Duals will improve Duals' knowledge of and satisfaction with the policy, particularly for those in Medi-Medi Plans. This will lead to low rates of requests for MCP changes to non-matching MCPs among these with aligned plans in the counties where the policy is in place.

Exhibit 3: Driver Diagram for the Medi-Cal Matching Plan Policy

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

Methods

Data Sources

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

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

In Goal #1, the evaluation will attempt to understand the impact of the *Medi-Cal Matching Plan Policy* on Duals plan enrollment changes in counties where the demonstration has been implemented. The evaluation's primary outcomes of interest among Duals enrolled in an MA are: (1) Duals monthly MA plan / MCP change, (2) Duals MA plan and MCP aligned or unaligned, and (3) Duals enrollment in or out of Medi-Medi Plans. We will account for other possible valid transitions (e.g., MA to Original Medicare) that would impact an MCP assignment and modeling of Duals plan choices.[32] The primary predictor of interest will be the county policy variable – *Medi-Cal Matching Plan Policy*. Secondary predictors will be: Medi-Medi Plan, Duals Baseline MA plan, Duals Baseline MCP, Duals Baseline MCP characteristics (Primary Plan versus Delegate Plan), Duals Baseline Plans aligned / unaligned, Duals characteristics (age, gender, race/ethnicity, preferred language, county), and social need metric by zip code (defined consistently over the CalAIM evaluation components).

In summary, with the Dual Project's goal #1, the UCLA team will describe the epidemiology of plan transitions in the Medi-Cal Duals population pre- and post-policy implementation. Data from goal #1 will allow the evaluation team to define the sampling frame and also assess the magnitude of special circumstances, such as individuals who newly enroll and disenroll from Medi-Cal. In the subgroup analyses, we will break out patterns of changes for newly enrolled individuals as well as individuals who have breaks in enrollment. At present, it is difficult to characterize a priori patterns and characteristics of individuals with breaks in enrollment, which may have a number of antecedent events (e.g. loss of eligibility, moving residences, incarceration, and so on). Furthermore, individuals with two or more changes in MCPs are likely to be relatively uncommon and may be investigated separately given their potential complexity.

The results of Goal #1 will be used to create the sampling frame for the knowledge and satisfaction surveys to be fielded in Goal #2.

Target Population: The target population includes Duals in MA plans (with Duals in Original Medicare as a control) in counties with the *Medi-Cal Matching Plan Policy*

[32] A previous iteration of this evaluation design report suggested we would also be including as a primary outcome, requests from Dual beneficiaries to change MCP to non-matching MCP. However, further review of data available from DHCS revealed no reliable source of Duals requests to change MCP to non-matching MCP. Accordingly, we have withdrawn this variable from the analysis plan.

compared to those in counties without the *Medi-Cal Matching Plan Policy* and also includes Duals in Medi-Medi Plans compared to Duals in other MA plans compared to Duals in Original Medicare.

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

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

Descriptive Analyses

1. Among Duals in MA plans from 2022 (or earlier, if possible) through 2026 (with one year lookback), UCLA will assess the rate and type of MA plan change, MCP change, and MCP alignment, pre- and post- *Medi-Cal Matching Plan Policy* implementation if applicable, comparing Duals in counties with the policy and Duals in counties without (or before) the policy. We will examine the five possible month-to-month Medicare transitions (1) MA – no change, (2) MA – switch to another MA, (3) Original Medicare to MA, (4) MA to Original Medicare, and (5) Original Medicare – no change. MCP choices described in Exhibit 1 follow these Medicare transitions. UCLA will also assess enrollment changes into and out of Medi-Medi Plans.
2. Overall, and stratified by these Medicare transitions, UCLA will examine MCP transitions that follow the MA plan. MCP status will be defined as [MCP change / no change] and [MA plan change (including special case to Original Medicare) / no change and MCP – integrated (MMP) / aligned / not aligned.

   In addition to examining the number of Duals who transition at least once, UCLA will also examine the distribution of the number of transitions that individual Duals make during the target period. Individual persons who frequently switch plans may account for a disproportionate number of switches and may require further examination.
3. UCLA will examine Duals' MCP changes to non-matching MCPs, comparing Duals in counties where the policy is implemented and Duals in counties where the policy is not implemented, who change their MCPs.
4. UCLA will then examine the rates of change within demographic categories of Duals – age, gender, race/ethnicity, preferred language, counties, and quartile measure of social need (of residence zip code). Because numbers of observations

may be quite small for some categories, UCLA may roll up assessments to 12-month periods.

Multiple Variable Regression Analyses

We propose to follow the difference-in-differences (DID) approach described in the original evaluation design and endorsed by CMS to estimate the independent impact of the *Medi-Cal Matching Plan Policy* on Dual's plan choice behavior. We will welcome further input from DHCS subject matter experts to ensure that the DID analyses can be performed as intended. The DID approach applies a pre- / post- /case- / control – design, allowing for greater confidence in the causal impact of the policy. The primary regression outcome will be "Change to non-matching MCP" and the primary regressor will be presence/absence *Medi-Cal Matching Plan Policy* in the Dual's county of residence at the time of the change. Covariates will include Dual's plan status at the time of the change (Original Medicare, Medi-Medi Plan, MA-MCP aligned, MA-MCP not aligned), Delegate plan (versus Primary MCP), Dual's characteristics (age, gender, race/ethnicity, preferred language, county, quartile of social need metric), and time period (likely measured quarterly), plus fixed effect for county of residence. UCLA will test for parallel trends between counties where DHCS has implemented the policy versus counties where DHCS has not implemented the policy.

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

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

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

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

For Goal #2, the UCLA evaluation team will develop and field a survey of the Duals population using a sampling frame derived from the data in Goal #1, including assessing satisfaction in the process of changing plans among Medi-Medi Plan members, other MA members, and Original Medicare members who changed their MCPs. Results from Goal #2 will be used to inform DHCS, MCPs and their members about member experiences with the matching process and to improve Duals' knowledge and experience. Surveys will be performed in 2024 to assess knowledge and satisfaction with the process of changing plans among Duals who change their MCPs.

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

Time Period: CY 2023 to CY 2024.

Sampling Frame: Probability sample of 4,000 Duals (including representatives from MA and Original Medicare) who change their MCP sampled according to: *Medi-Cal Matching Plan Policy* for County of Residence (yes/no), MA Plan change (yes/no), and Baseline Plan Alignment (unaligned/aligned/integrated) with a goal of 400 completed surveys (10 percent response rate) with 25 completed surveys per strata with MA enrollment (300 total) and 50 completed surveys per strata in Original Medicare (100 total divided between counties with and without the *Medi-Cal Matching Plan Policy*).

We will balance the samples by matching Duals within groups on observable characteristics (age category, gender, race/ethnicity, language, county, and quartile social need). There will be oversampling of race/ethnicity and quartile social need (based upon zip code of residence) to account for difficult to reach vulnerable populations. Specifically, we will sample equal numbers from the quartiles of social need and within quartiles we will sample equal numbers from the primary four race/ethnicity categories (non-Hispanic white, non-Hispanic black, Hispanic, and Asian-Pacific Islander).

Assuming equal size and variance, comparing between the primary comparison groups (MA enrollees in counties with and without the policy – with 150 individuals per group), we estimate a standardized effect size of 0.32 with 80 percent power to detect differences. Similarly, comparing within county strata – MA versus Original Medicare enrollees (150 versus 50 individuals), we estimate a standardized effect size of 0.50 with

84 percent power to detect differences.

Survey Fielding: We will sample across the 58 counties in California and will adjust the sampling based upon the results from the secondary data analysis. The sample will be weighted in order to under-sample Los Angeles County – with 1/3 of the Medi-Cal population – which would otherwise dominate the sample. We anticipate a ten percent response rate conditional upon our implementing the multiple strategies described below. Specifically, to maximize the response rate, we propose fielding the survey using a mixed-mode data collection approach that involves fielding the survey as a web and mail survey with phone follow-up to those who fail to complete the survey via the web or by mail. The web and mail versions of the survey will be available in English, Spanish, Mandarin, and Vietnamese.

All 4,000 sampled beneficiaries will receive a letter inviting them to participate in the survey. The letter will be personalized with the member's first and last name and will be printed in English on one side and Spanish on the other. To motivate survey invitees to complete the survey, a one dollar bill will be affixed to the letter. An English version of the survey with a self-addressed, postage-paid envelope that beneficiaries can use to mail back their completed survey will be enclosed with the survey invitation letter. The letter will briefly describe the purpose of the survey, why it's important that each sampled member participate, and the 20 dollars that they will receive if they complete the survey.

In the event they have questions or concerns about the survey or if they would like to complete the survey by phone, the letter will include a toll-free number for the participant to be able to call. In addition, the letter will include the survey URL and a unique PIN as well as a QR code for those who prefer to complete the survey via the web using either a computer, tablet, or smart phone. The survey invitation letter will include a prominent note letting survey invitees know the availability of Spanish, Mandarin, and Vietnamese versions which they can access on the web or by requesting a hard copy in any of these languages by calling the survey's toll-free number or sending an email to a project-specific email.

We anticipate that a significant proportion of the sampled beneficiaries will be primarily Spanish-speaking and therefore have budgeted to mail both an English and a Spanish version of the survey to approximately 25 percent of the sample. We will select the beneficiaries who should receive the two-booklet mailing by identifying those who indicate Spanish language preference in their Medi-Cal files, and according to those

with a Hispanic surname. Among this cohort, we will randomly select 25 percent of the sample frame who will receive with their initial mailing a Spanish language survey booklet in addition to their English language survey booklet.

Approximately two weeks after the first survey mailing, we will send a second survey invitation letter to survey invitees that have not completed the survey. The second survey mailing will again include an English version of the survey booklet for all invitees and additionally include a Spanish version of the survey booklet to another randomly selected 25 percent of the sampled beneficiaries who have expressed Spanish language preference or who have a Hispanic surname.

Approximately two weeks after the second survey mailing, we will mail non-respondents a reminder postcard letting them know that there is still time to complete the survey either via the web, by mail, or by phone. We will simultaneously launch phone follow-up to those who have not completed the survey for whom we were able to obtain either a telephone number (landline) or a cellphone number through a tele matching vendor. Phone follow-up will be conducted in English and Spanish only. Respondents who don't feel they will be able to complete the survey by phone in either English or Spanish will again be offered the option of completing the survey via the web or by mail, in which case we would mail them a copy of the survey in their preferred language (from among the languages we offer). To further maximize response rates, we will allow proxy respondents.

In summary, the survey team is estimating a response rate of 10 percent for this population of Dual-insured individuals with recent plan changes, even with inducement and phone follow-up. Currently, initial mailing is planned to be to 4,000 individuals based upon a target of 400 completed surveys (see below).

The revised survey design of MCP changers has three sets of comparison strata among individuals enrolled in MA plans [(1) resident county has the policy (yes/no); (2) member changes their baseline MA plan (yes/no); (3) baseline MCP is aligned/integrated with MA plan (yes/no)] plus the external comparison to Duals in traditional (fee-for-service) Medicare who reside in counties with and without the alignment policy. There are 12 cells for MA plan enrollees and two cells for traditional Medicare enrollees. We plan to have 25 completed surveys per MA plan enrollee cell and up to 50 completed surveys per traditional Medicare enrollee cell to yield a total goal of 400 completed surveys. These sample sizes ensure statistical stability for unadjusted estimates yet may not be adequately powered to detect underlying differences for comparisons between the

targeted groups. We will oversample on non-White minorities and on individuals residing in zip codes with the lowest quartile SES to balance the sample. Given the shorter time frame required for completing the survey, the evaluation team is balancing ensuring adequate response rates with the survey budget.

Survey Content and Development

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

UCLA additionally recommends supplementing these transition-specific survey items with a small number of items from a standardized tool to enhance case-mix adjustment across surveyed groups and across other components of the overall CalAIM evaluations. Specifically, UCLA recommends drawing validated and standardized items from the 10-item core Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool. This tool is currently being used by CMS to better understand whether finding and dealing with the health-related social needs of Medicare and Medicaid beneficiaries has any effect on their total health care costs and makes their health outcomes better.[OBJ] The tool can help providers find out patients' needs in these five core domains that community services can help with: (1) Housing instability, (2) Food insecurity, (3) Transportation problems, (4) Utility help needs, and (5) Interpersonal safety. We will also use the eight supplemental validated items that measure (1) Financial strain, (2) Employment, (3) Family and community support, (4) Education, (5) Physical activity, (6) Substance use, (7) Mental health, and (8) Disabilities. UCLA also recommends using the Short Form Survey (SF12), a widely used 12-item measure of the impact of overall health on an individual's daily life. UCLA will pilot survey items to allow us to better understand how long the survey takes to complete and which portions may be too unwieldy.

The current survey now includes the following domains.

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

We anticipate the surveys will be translated into Spanish and two additional languages (Mandarin and Vietnamese). These languages have been identified as the most prevalent languages spoken within the state of California among those who do not speak English or Spanish.[33] The survey will be piloted for readability and clarity at UCLA and/or UCLA-training sites among a convenience sample of up to ten Duals in MA plans who are seen as primary care patients. Feedback will be obtained in consultation with DHCS subject matter experts and pilot participants that will be incorporated into the final survey design to minimize burden and optimize utility.

Once the survey design is finalized, the survey will be fielded in 2024 via mail and online with the option of responding via phone. Initial mailing will be followed by reminders. For non-respondents, a second survey will be sent. There will be an incentive (e.g., $20 for a completed survey) to improve response rates. Each survey will be identified by a study ID that will allow for linkage to derived data from routinely collected data, including sampling weights. A crosswalk of study IDs and Medi-Cal client identification numbers will be kept separately from the survey results.

Survey Analysis – Descriptive Analyses

In descriptive analyses, the evaluation team will present results according to raw (unweighted) and weighted results, with survey weights according to the probability sampling and non-response rates. First, the raw respondent characteristics will be compared across the sampling strata to ensure balanced groups. This will include demonstrating that (1) the matching characteristics and (2) survey-elicited characteristics (self-reported health, service use) are similar within strata. Duals' responses on MCP and MA enrollment will be compared to metrics derived from the Medi-Cal and Medicare monthly enrollment files. For bivariate comparisons, a significance test will be performed using logistic regression.

Second, survey weighted responses will be presented overall and stratified by whether

[33] U.S. Census Bureau. (2022). *2018-2022 American Community Survey. [Retrieved from: https://data.census.gov/profile/California?g=040XX00US06]*

an individual resided in a county with the *Medi-Cal Matching Plan Policy* or in a county without the policy. We will stratify individuals by whether their MA plan changed, whether their MCP was aligned or not at baseline and at follow-up, and whether they were in an MCP or Original Medicare (the internal control) at baseline. For bivariate comparisons, significance testing will be performed using logistic regression with sampling weights. If two waves of surveys are fielded, a similar design can be used for pre- and post- comparisons.

Survey Analysis – Multiple Variable Regression with Sampling Weights

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

Power Calculations

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

For the enrollment analyses, the large number of individual observations for MCP changes suggests that we will be able to detect extremely small differences between cases and controls. For example, using a two-year sample (2021 and 2022) with the

original 12 policy counties versus remaining 15 non-policy counties (among counties with mandatory managed care enrollment), the total number of individual observations is the total number of months of enrollment for each group – which would conservatively be on the order of a million for each group. We should have adequate power to detect small differences – such as the original benchmark suggested by DHCS – 0.1 percent requests (either per month or per year).

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

Limitations

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

Dissemination

Results of the evaluation of the *Medi-Cal Matching Plan Policy* will be presented in the formal reports to CMS and in-person presentations will be made to the DHCS Duals

Program and other stakeholders. We expect that the results from Goal #1 through 2024 and for the survey results from the first wave in Goal #2 will be included in the Preliminary CalAIM Demonstration Evaluation Report. Overall results from Goal #1 through 2026 and for both waves of Goal #2 will be included in the Final CalAIM Demonstration Evaluation Report.

Exhibit 4: Evaluation Milestones

Milestone	Target Date
1. Submission of revised evaluation design with responses to CMS internal reviewers	January 2024
2. Obtain existing Medi-Cal and Medicare monthly enrollment files and other existing data sources	June 2024
3. Respond to remaining critiques and questions from the CMS	Summer 2024
4. Goal #1 initial analyses	Summer 2024
5. Duals' knowledge and satisfaction survey design and piloting	August 2024
6. Fielding Duals' knowledge and satisfaction survey	Oct to Dec 2024
7. Goal #2 initial analyses	mid-Aug 2024
8. Conduct post-survey focus groups on analysis findings regarding Duals knowledge and satisfaction on plan alignment and information on changing enrollment	Winter 2025
8. Preliminary CalAIM Demonstration Evaluation Report to CMS	
9. Goal #1 final analyses	June 2026
11. Goal #2 final analyses	Winter 2027
12. Final CalAIM Demonstration Evaluation Report to CMS	June 2028

Evaluation Design for California's Justice-Involved Reentry Initiative

Brief Overview

The California Advancing and Innovating Medi-Cal (CalAIM) REENTRY Evaluation will assess the degree to which incarcerated individuals preparing for reentry to the community who are exposed to the Justice-Involved (JI) Reentry Initiative interventions (i.e., the Reentry Waiver Exposed Group) experience different processes and outcomes than those not exposed (i.e. the Reentry Waiver Comparison Group). Evaluation activities will include assessments of changes over time between exposed and comparison groups in (1) access to medical and behavioral health services for incarcerated individuals eligible for the State's Medicaid Program (Medi-Cal); (2) exposure to systems for effectively enrolling eligible detainees into Medi-Cal prior to release; (3) coordination of transitional care between the pre- and post-release setting; (4) coordination of community-based services through Enhanced care Management, and (5) provision of a supply of medications and durable medical equipment at release.[34]

Reentry's Role within the CalAIM Evaluation

While California received federal authority to implement the CalAIM 1115 Demonstration on December 29, 2021, the approval by the Centers for Medicare & Medicaid Services to provide limited coverage for services to a subset of incarcerated individuals for up to 90 days immediately prior to their expected date of release from the carceral setting was granted on January 26, 2023.[35] Both are expected to be effective through December 31, 2026. Similar to other CalAIM components, the CalAIM JI Reentry Initiative has established a framework to address basic needs of individuals during high-risk periods of life by using Medi-Cal to implement a target set of pre-release services including health care, behavioral health, and reentry services.

[34] Cronin-Furman, Margot, et al. "Breaking Ground: How California is Using Medicaid to Improve the Health of People Leaving Incarceration." (2023).
[35] 11-W-00193/9: "California CalAIM Demonstration". https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-calaim-ca1.pdf

CalAIM's three primary stated goals are to "(1) Identify and managed comprehensive needs through whole person care approaches and social drivers of health; (2) Make Medi-Cal a more consistent and seamless system for enrollees to navigate by reducing complexity and increasing flexibility; and (3) Improve quality outcomes, reduce health disparities, and transform the delivery system through value-based initiatives, modernization, and payment reform."[36] Consistent with these goals, the Special Terms and Conditions (STCs) for the Justice-Involved Reentry Initiative, focused on five milestones: (1) increasing coverage and ensuring continuity of coverage for individuals who are incarcerated; (2) covering and ensuring access to the minimum set of pre-release services for incarcerated individuals to improve care transitions upon return to the community; (3) promoting continuity of care; (4) connecting to services available post-release to meet the need of the reentering population; and (5) ensuring cross-system collaboration. Through the JI Reentry Initiative, California is allowing the state prison system and the fifty-eight California counties the opportunity to bridge the gap between correctional and community health care during a window of time when incarcerated individuals experience an enhanced risk for physical and behavioral health concerns and complications, including higher rates of morbidity and mortality. Key features of CalAIM's JI Reentry Initiative include efforts to improve access to needed health care services during the 90 days prior to release when incarcerated individuals prepare to leave the carceral setting and reenter the community setting. The period around release has been identified as a high-risk window associated with serious morbidity and mortality including higher risk of suicide and opioid overdose and higher rates of preventable adverse outcomes than among the general population.[37]

It is estimated that as many as 80 percent of incarcerated individuals will be eligible for CalAIM JI services.[38] As mandated by state law as of January 2023, counties are developing strategies for expanding Medi-Cal enrollment at intake and California's managed care plans (MCPs) are developing systems to expand post-incarceration

[36] CalAim 1115 Demonstration & 1915(b) Waiver. https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM-1115-and-1915b-Waiver-Renewals.aspx

[37] California Department of Health Care Services. Policy and Operational Guide for Planning and Implementing the CalAim Justice-Involved Initiative. October 2023. Plenary PPT. https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/CalAIM-JI-Policy-and-Operations-Guide-FINAL-October-2023-updated.pdf

[38] Justice System Partners (JSP) and Health and Reentry Project (HARP). Implementing the Medicaid Reentry Waiver in California: Key Policy and Operational Insights From 11 Counties. October 2024.

Enhanced Care Management[39], reduce care gaps, and increase access to Community Supports (e.g., Housing Navigation). Key stakeholders are sharing strategies to enhance coordination of services between county jails, correctional health care, and MCPs with supports from multidisciplinary criminal justice partners including courts, pretrial services, and probation teams.

The Incarcerated Population in California

California incarcerates individuals at both state and county-level facilities with almost 160,000 adults currently in state prison and county jail facilities.[40] In addition, more than 2,200 youth are incarcerated at the county level in juvenile halls, camps and ranches.[41] To facilitate a basic understanding of California's Criminal Justice (CJ) system that is critical for the Reentry component's evaluation design, below we highlight key features of the prison, jail, and juvenile incarcerated populations.

- With respect to the prison population, according to the California Department of Corrections and Rehabilitation's (CDCR) Office of Research, Summary of Offender Data Points:[42] The in-custody adult prison population as of December 2023, was 94,188 with incarcerated individuals housed in 33 prison facilities across the state. The average age was 42.5 years with 96.0% male and by race/ethnicity 46.1% Hispanic, 27.5% Black, 20.0% White (non-Hispanic), and 6.4% other.[43] The average number of individuals released from prison back to communities per month ranged from 2,006 (June 2021) to 2,647 (December 2023). Of the 58 California counties, six -- Los Angeles, San Bernardino, San Diego, Riverside,

[39] ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of Members with the most complex medical and social needs. ECM provides systematic coordination of services and comprehensive care management that is community based, interdisciplinary, high touch and person centered.
https://www.dhcs.ca.gov/CalAIM/ECM/Documents/ECM-Policy-Guide.pdf

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

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

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

[43] Among the general population, the average age in California is 38.2, 49% of the population are male and by race/ ethnicity, 46.4% of the population are Hispanic, 6.5% Black, 34.3% White (non-Hispanic), and 23% other (https://www.census.gov/quickfacts/fact/table/CA/PST045223; https://data.census.gov/profile/California?g=040XX00US06)

Orange and Sacramento -- accounted for almost two-thirds of the released population in 2023.[44]

- With respect to the jail population, as of year-end 2023, almost 60,000 adults were incarcerated in local jails, with the vast majority being held pre-trial.[45] Fewer than a quarter are serving sentences.
- With respect to the juvenile population, until June 30, 2023, California operated the California Department of Juvenile Justice (DJJ), which housed youth who had been adjudicated and incarcerated. As of June 30th, 2023 all state-run juvenile operations ceased at DJJ, and youth custody cases were realigned to the care of counties. County probation chiefs opposed this change and established a transition group to help plan the transition of the approximately 400 youth returning to counties. County probation departments supervise justice-involved youth who are placed in local juvenile halls, camps, and ranches, or supervised in the community.[46] [47]

Reentry: Pre-Release Enrollment and Services

CMS approved California's 1115 Re-entry Demonstration Waiver, which is part of DHCS' overall CalAIM Justice-Involved Reentry Initiative. As a group, incarcerated individuals have generally been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. With the Waiver, California will cover a targeted set of pre-release services for Medi-Cal members who meet specified criteria, as applicable, and are incarcerated in state prisons, county jails and youth correctional facilities to improve re-reentry and their transitions (in particular, transitions of health coverage and care) back to the community. The provision of Medi-Cal pre-release and re-entry transition services, for the 90-days prior to the individual's release, as well as Enhanced Care Management (ECM) upon release, is expected to increase continuity of health coverage, prevent unnecessary disruptions in care, reduce emergency department visits

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

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

[46] https://www.cdcr.ca.gov/ccjbh/wp-content/uploads/sites/172/2020/07/Juvenile-Justice-Factsheet-6.30.2020.pdf.

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

and inpatient hospital admissions; reduce mental health decompensation, suicide-related death, overdose, overdose-related death and all-cause death; and lead to improved health outcomes in general. This targeted set of pre-release services will be available to certain eligible Medicaid and CHIP members who are residing in state prisons, county jails, or youth correctional facilities, for up to 90 days immediately prior to the individual's expected release date (see Special Terms and Conditions (STC) 9.8).[48]

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

All children/youth who are enrolled in Medi-Cal or CHIP and in custody of a participating youth correctional facility are eligible for the targeted set of pre-release services and, as required under section 5121 of the Consolidated Appropriations Act, screening and diagnostic services required under the Early and Periodic Screening, Diagnostic and Treatment benefit. Incarcerated adults must be enrolled in Medi-Cal and meet one or more of the specified criteria.[49] The targeted set of pre-release services approved in the Reentry Demonstration Wavier include reentry case management services; physical and behavioral health clinical consultation services, laboratory and radiology services, medications and medication administration; medication-assisted treatment (MAT) for all Food and Drug Administration (FDA)-approved medication, including coverage for counseling and services provided by community health workers or Peer Support Specialists with lived experience. Qualifying members will also receive

[48] https://www.dhcs.ca.gov/provgovpart/Documents/California-Reentry-Demonstration-Initiative-Amendment-Approval.pdf

[49] Mental illness, Substance Use Disorder (SUD), Chronic Disease/Significant Clinical Condition, Intellectual or Developmental Disability (I/DD), Pregnant/Postpartum.

covered outpatient prescription medication (a minimum 30-day supply, as clinically appropriate, consistent with the Medicaid State Plan) and durable medical equipment (DME) upon release.

The goals for the Justice-Involved Reentry Initiative are to:[50]

1. Increase coverage, continuity of care, and appropriate service uptake through assessment of eligibility and availability of coverage for benefits in carceral settings just prior to release;
2. Improve access to services prior to release and improve transitions and continuity of care into the community upon release;
3. Improve coordination and communication between correctional systems, Medicaid and CHIP systems, managed care plans, and community-based providers;
4. Increase additional investments in health care and related services, aimed at improving the quality of care for beneficiaries in carceral settings, and in the community to maximize successful reentry post-release;
5. Improve connections between carceral settings and community services upon release to address physical health, behavioral health, and health-related social needs;
6. Provide intervention for certain behavioral health conditions and using stabilizing medications like long-acting injectable anti-psychotics and medications for addiction treatment for substance use disorders (SUDs), with the goal of reducing decompensation, suicide-related deaths, overdoses, and overdose-related deaths in the near-term post-release; and
7. Reduce post-release acute care utilization such as emergency department visits, inpatient hospitalizations, and all-cause deaths among recently incarcerated Medicaid beneficiaries and individuals otherwise eligible for CHIP if not for their

[50] We use the term "beneficiaries" here since this term is used by CMS. Goals are outlined under 9.1 in the Special Terms and Conditions for California (see Centers for Medicare & Medicaid Services (CMS) letter dated January 26 2023 to Ms. Jacey Cooper, State Medicaid Director, Chief Deputy Director, Health Care Programs, California Department of Health Care Services (CDHCS) – approval of California's request to amend the section 1115(a) demonstration titled, "California Advancing and Innovating Medi-Cal (CalAIM)" (Project Number 11-W-00193/9).

incarceration status through robust pre-release identification, stabilization, and management of certain serious physical and behavioral health conditions that may respond to ambulatory care and treatment (e.g., diabetes, heart failure, hypertension, schizophrenia, SUDs) as well as increased receipt of preventive and routine physical and behavioral health care.

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

State law and the Waiver allow for a two-year ramp up for all correctional facilities. The UCLA-RAND Reentry Evaluation team's research design will be responsive to the different start dates for facilities; facilities that come onboard later may have less follow-up time for analyses.

Overall Evaluation Strategy

UCLA-RAND Reentry Evaluation Team

The UCLA-RAND Reentry Evaluation team is responsible for the evaluation of the Justice-Involved Reentry Initiative. The team is led by researchers Drs. Lois Davis and Susan Turner from RAND. The team also includes researchers from RAND and UCLA as detailed in the section below titled "Reentry Evaluation Team." The JI Reentry Initiative evaluation period covers October 2024 through December 2026. The UCLA-RAND Reentry evaluation contract period is from December 1, 2023, to May 31, 2029, which includes the development of the evaluation design, its implementation, and completion of all other contract deliverables (i.e. evaluation reports and responses to comments from DHCS and CMS). A detailed project timeline is provided in Table *1*. The total budget for the effort is $2,903,678.39.

Timeline for Data Collection Activities

Table 1 on the next page shows the anticipated timeline for the Reentry Evaluation activities. The table shows the data collection activity, timeframe, and goals associated with each activity.

Table 1. Study Timeline for Reentry Data Collection Activities

Activity	Timeframe	Goals
Revise evaluation research design; submit revisions to address CMS' comments	Fall of 2024	1-7
In consultation with DHCS, select the four focal counties for jail and juvenile populations analyses	2025	1-7
Develop research applications, data use agreements, etc. for CDCR and the four focal counties	2024-2025	1-7
Submit research application to CDCR Research Oversight Committee (ROC) for identification of Waiver comparison cohorts, to obtain data on background characteristics, and pre-release services	2024-2025	1-7
Work with Sheriff's Departments and juvenile authorities in the four focal counties on research approvals & data use agreements; access data to identify Waiver comparison cohorts for jail population and juvenile populations	2025	1-7
Qualitative Data Collection & Analysis		
Recruit and conduct interviews with Waiver participants (who were incarcerated in prisons, jails, & juvenile facilities)	2025	3,4,5
Conduct key stakeholder interviews at state and county levels; analyze data	2025	3,4,5
Analyze Waiver participants' interview data and key stakeholders interview data	2025	3,4,5
Quantitative Data Collection & Analysis		
Identify Waiver comparison cohorts (pre-Waiver)	2025-2026	1,2,6,7
Obtain Data for comparison cohorts (pre-	2025-2026	1,2, 6, 7

Waiver)		
Clean/merge/prepare pre-Waiver analytic data	2025-2026	1,2,6,7
Obtain Data for Waiver cohorts (post-Waiver)	2026	1,2,6,7
Clean/merge/prepare post-Waiver analytic data	2026-2027	1,2,6,7
Final analyses to include all comparison and treatment cohorts; including sensitivity analysis	2027-2028	1,2,6,7

Reentry Waiver Populations and Counties Selected for the UCLA-RAND Reentry Evaluation

The eligible Reentry Waiver populations in California include all 33 state prison facilities, county jails, and youth correctional facilities. The state prison facilities are operated by the California Department of Corrections and Rehabilitation (CDCR) as a single department. Each of California's 58 counties operates its own jails and juvenile correctional facilities individually. Generally, jails are operated by county Sheriff Departments and juvenile facilities by county Probation Departments. In some cases, correctional health care services may be managed by the county public health or health department, which would the targeted entity for obtaining relevant pre-release healthcare information for the evaluation. The UCLA-RAND evaluation team will be working with all involved entities in targeted counties to complete the evaluation tasks.

Qualifying conditions for individuals participating in the Reentry Waiver include adults who are incarcerated who meet one or more of the following criteria listed in STC 9.2[51]:

- Mental illness, defined as confirmed or suspected mental health diagnosis based on specified criteria;
- Substance use disorder, defined as confirmed or suspected diagnoses based on specified criteria;

[51] As defined in the CMS Waiver Authority, Numbers 11-W-00193/9 and 21-W-00077/0, California CalAIM Demonstration document (https://www.dhcs.ca.gov/CalAIM/Documents/BH-CONNECT/CA-CalAIM-STCs.pdf). For the list of the 38 Chronic Conditions or Significant Non-Chronic Clinical Conditions, see Attachment W page 322.

- Chronic condition or significant non-chronic clinical condition, defined as confirmed or suspected diagnoses based on specified criteria;
- Intellectual or developmental disability (I/DD), defined as a disability that begins before an individual has turned 18 years of age and that is expected to continue indefinitely and present a substantial disability;
- Traumatic brain injury or other condition that has caused significant cognitive, behavioral and/or functional impairment;
- Positive test or diagnosis of human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS); or
- Currently pregnant or within a 12-month postpartum period.

All youth under the age of 19 years who are eligible for Medi-Cal or CHIP including children in foster care and former foster care youth; and are in the custody of a county youth correctional facility are eligible for pre-release services.[52]

All California counties are state mandated to implement the Reentry Waiver program no later than October 1, 2026. Correctional facilities must submit to DHCS a readiness review application for approval at least six months prior to the correctional facilities' requested go-live date. The readiness review assessment focuses on five key areas needed to operationalize 90-day pre-release services (e.g., Medi-Cal application process, 90-day pre-release service delivery). Correctional facilities are expected to attest to their ability to meet minimum requirements. Correctional facilities can go live with pre-release services with an approved readiness assessment.[53]

As of October 2024, three California counties—Inyo, Santa Clara, and Yuba—were approved to begin delivering a targeted set of Medi-Cal services to people returning to communities after incarceration.[54] CDCR, including all 33 state prisons, will go live with

[52] Reentry Demonstration Initiative Populations are defined as persons who are enrolled in Medicaid or who would be eligible for CHIP except for their incarcerated status, and who are incarcerated in a state prison, county jail, or youth correctional facility and who meet the eligibility criteria under STC 9.2. See: ca-calaim-dmnstn-aprvl-12192023_0.pdf

[53] California Department of Health Care Services. Policy and Operational Guide for Planning and Implementing the CalAim Justice-Involved Initiative. October 2023. Plenary PPT. https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/CalAIM-JI-Policy-and-Operations-Guide-FINAL-October-2023-updated.pdf

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

pre-release services in February 2025. County correctional facilities will go live on a quarterly basis through September 30, 2026.

The UCLA-RAND Reentry Evaluation research design includes all CDCR prison facilities as well as county jails and youth correctional facilities in four counties: Sacramento, Yuba, San Joaquin and Orange Counties. These four counties were selected in consultation with DHCS based on geography, population size, and timeliness of implementation. Note, it is not feasible to study all 58 counties as each is a separate entity that would require separate permissions and extensive data abstraction efforts at the county-level.

Quantitative Goals 1, 2, 6, and 7

Goals 1, 2, 6, and 7 focus on screening and enrollment, delivery of services and health outcomes of individuals. Research questions relevant to these goals will be addressed by using a difference-in-differences approach that compares individuals after the go-live date for correctional facilities with individuals who are similar to those who participated in the Reentry Waiver but were incarcerated and released before the go-live date.

Identifying Qualifying Conditions for Reentry Waiver Groups

The UCLA-RAND Reentry Evaluation team will work with the California Department of Corrections and Rehabilitation (CDCR) and the counties to develop plans for identification of Reentry Waiver groups for the evaluation, as well as data and other permissions that may be required by the UCLA-RAND Reentry Evaluation team. The plans will address access to the most reliable information on correctional facility eligibility screening and enrollment[55]; information on how correctional facilities developed criteria to identify those with qualifying conditions; selection of the release cohorts for the Reentry Waiver individuals; determination of background demographic characteristics, and health status services data available for creating comparison groups as described in the next paragraph.

Identifying Qualifying Conditions for Comparison Groups

As practicable, Reentry Waiver pre-intervention and post-intervention comparison groups will be identified by applying the Reentry eligibility criteria described above to individuals who had been incarcerated but released prior to the go-live date, as well as for those released after the go-live date. This will allow the UCLA-RAND Reentry

[55] This information may be obtained from the data portal used by correctional facilities.

Evaluation team to create and follow cohorts released around the go-live date to estimate cohort difference-in-difference models (the Methods section discusses this methodological approach in more detail).[56]

For local county jails, the UCLA-RAND Reentry Evaluation team will determine whether the local data systems will allow identification of previously released individuals with qualifying conditions. For juveniles there are no qualifying health conditions. The Reentry evaluation will not restrict the analysis for youth in the same way proposed for prison releasees and will instead use all releases as specified in the STCs for youth (e.g., all children/youth who are enrolled in Medi-Cal or CHIP and in the custody of a county youth correctional facility are eligible for pre-release services). If the UCLA-RAND evaluation team is unable to use state and local health data to identify eligible cohorts based upon the detailed eligibility criteria, UCLA-RAND Reentry Evaluation may need to use full (100%) cohorts of released individuals for both the comparison (i.e., pre-go live) and Reentry Waiver (i.e., post-go live) groups rather than the roughly 80% of these cohorts who are actually eligible for services.

Even if full cohorts rather than Reentry Waiver eligible cohorts are required (for data purposes) it is expected that the majority of the cohort will meet the health services criteria for the Waiver, since the prevalence of SUD and other health issues is high in the JI population. For example, it is estimated that about 85% of CDCR inmates have SUD, which is a conservative estimate.[57] Prevalence rates in jails are harder to obtain, but a recent brief from the Bureau of Justice Statistics indicates that 63 percent of post-adjudication jail inmates have an SUD and there have been increasing numbers of jail deaths from 2000 to 2019, particularly among those who died frum drug related intoxication (BJS, 2022).[58] If full cohorts, rather than Reentry Waiver eligible cohorts are used, the study design would not be able to include case-mix adjustments for an individual's illness.

Data Sources for Waiver and Comparison Groups

The UCLA-RAND Reentry Evaluation team intends to use Medi-Cal and prison/jail/youth correctional facilities databases (as available) for the Reentry Waiver and comparison

[56] In conversations with the CDCR, they have indicated that they should be able to select previously released cohorts of individuals based on the same coding they are doing for current eligibility determination. This should result in similar individuals in both the comparison and Waiver groups.

[57] ISUDT Annual Outcomes Report 2024 (ca.gov)

[58] Managing Substance Withdrawal in Jails: A Legal Brief (ojp.gov)

groups for the evaluation. Cross-referencing CDCR identifiers with Medicaid data has successfully been accomplished in recent work conducted by the Council on Criminal Justice and Behavioral Health in their 2023 Medi-Cal Utilization project.[59] This project matched data from the CDCR to Medi-Cal records from over 35,000 individuals released from CDCR in fiscal year 2019-2020 to analyze enrollment and utilization of Medi-Cal services. The evaluation design relies upon a similar strategy for matching CDCR releases to Medicaid databases; feasibility and protocols for county correctional facility matching of releasees is yet to be determined.

The UCLA-RAND Reentry Evaluation will make use of a cohort difference-in-differences analysis, which will exploit the within year timing of the policy and across year exposure to the policy. More details of the design are in the Methods sections below. As an illustrative example, if one were to assume that the Waiver will be implemented in Month t of 2025, then individuals who are released from Month t through Month t+3 of 2025 will be partially treated as they will not receive the full 90 days of pre-release services (e.g., those individuals released in Month t+1 will only receive up to 30 days of pre-release services), individuals released after Month t+3 in 2025 will be fully treated, and individuals released in 2025 prior to Month t (i.e. Months t-1 to Month t-6) will be untreated. However, it is worth noting that it is expected that that there will exist some people who are partially treated or not treated in all cohorts based on length of stay within the incarceration system (i.e., those individuals who are incarcerated for less than 90 days will be partially treated). Analyses will explore how the magnitude of effect sizes varies dependent on length of treatment (i.e., under 30 days, 30 to 59 days, 60 to 89 days, and those with the full 90 days of pre-release services, separately).

The UCLA-RAND Reentry Evaluation will exploit the month by year variation in Waiver eligibility. Regardless of the date of actual go live, a 12-month window will be identified around the timing of the go-live dates for specific correctional facilities to ensure 6 pre-implementation monthly cohorts, 3 partially treated post-cohorts, and 3 fully treated post-cohorts. The UCLA-RAND Reentry Evaluation team will also explore augmenting models to cover a wider post-treatment period as well as monthly cohorts prior to 2025, given available data. The UCLA-RAND Reentry Evaluation team has selected 2021 as the

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

earliest year for data to provide stability in measurement, but data availability will guide the actual study period.

Testing the 90-day In-reach Period for the Waiver

California selected a 90-day pre-release services period for Waiver implementation. This timeframe was chosen to allow ample time within the carceral setting to conduct eligibility assessments, stabilize an incarcerated individual, prepare a post-release transition plan and allow the pre- and post-release care managers to do a warm hand-off and transition of care with the individual. Variation in full vs. partial treatment (e.g., full 90-day pre-release services vs. <90-day pre-release services) due to the timing of release, relative to go-live date[60] can be used to test how pre-release services period length impacts identified effectiveness. Dynamic models (i.e., event studies- see Methods section for more details) will be able to identify variation in the effect size for those that are partially treated and fully treated (compared to not treated cohorts - i.e., pre-go-live cohorts), separately. This will allow the UCLA-RAND team to identify the effect of the Waiver differentially for those individuals who receive less than 30 days, 30 to 59 days, 60 to 89 days, and those with the full 90 days of pre-release services, separately. Jail stays are often much shorter than 90 days. Although the average time spent in jail is about a month, the majority of released individuals have been incarcerated for a week or less.[61] In state prisons about 30 percent of individuals served less than a year in 2020-2021; almost 60 percent served less than two years.

Outcome Measurement Period

Goals 6 and 7 have defined the numerators and denominators for the outcomes of interest. Each outcome will be measured in the near-term (30 days) after an individual's release into the community as well as longer term (6 and 12 months). Vulnerability to drug overdose and death can occur within the first few weeks after release, thus it is important to include measures soon after release.

Additional Quantitative Evaluation Methods

Analytic methods for addressing the Goals are presented in the sections below. Note that, in addition to the proposed approach in which UCLA-RAND Reentry Evaluation

[60] Actual analyses will take into account whether or not the county or institution is in the pre- or post-period and what amount of the 90-day window the releasee is in.

[61] https://www.chcf.org/wp-content/uploads/2023/07/CalAIMExplainedCaringCaliforniansLeavingIncarceration.pdf

team plans to include fixed effects for facilities and time period, the team will also consider multi-level regression to account for shared variability within institutions.

A crucial assumption underpinning difference-in-differences analysis is the parallel trends assumption. Generally, the parallel trends assumption states that the evolution of the outcomes in the control group (i.e., in the years prior to implementation) accurately reflects how those same outcomes would have evolved in partially or fully treated groups (i.e., in the years post-implementation) had the treatment groups not been treated. The UCLA-RAND Reentry evaluation will make use of both conditional (i.e. models that include controls) and unconditional (i.e. models without controls) event study models (which extend the above difference-in-differences models to include both lead (pre) and lag (post) period effects, identified from lead and lag release cohorts) to visually inspect the likelihood of passing the parallel trends assumption. In addition to the lag periods allowing one to visually inspect the likelihood of passing the parallel trends assumption, the lead periods allow one to identify dynamic effects of the Waiver. Effect sizes across release cohorts will be examined to identify whether a greater period of pre-release services is associated with more positive patient outcomes. The first three release cohorts are "partially treated" as they will not receive the full 90 days of pre-release services, thus differences in effect sizes in the first three lead periods compared to later lead periods would indicate that a greater period of pre-release services is associated with differential effect sizes.

If divergent trends pre-correctional facility Reentry Waiver implementation are present, Goodman-Bacon (2021) "detrended" difference-in-differences specification will be used to identify the size of a credibly causal effect of the Reentry Waiver, even if statistically significant pre-trends exist. Further, the sensitivity of event study models will be tested by implementing Rambachan & Roth's (2023) "honest" differences-in-differences approach which involves constructing confidence intervals that allow deviations from linearity, and in doing so estimates the amount of non-linearity that is allowable, while still rejecting the null hypothesis.[62]

In addition to estimating difference-in-differences models of the form specified above, a donut regression discontinuity design (RDD) will be estimated that exploits the timing of the Reentry Waiver rollout, as an additional sensitivity analysis. The donut-RDD will be used given that the rollout of the Reentry Waiver may result in partially treated releasees (i.e., those individuals who are released within the first 90 days of the policy being

[62] Rambachan, A., & Roth, J. (2023). A more credible approach to parallel trends. *Review of Economic Studies*, *90*(5), 2555-2591.

implemented), which can be excluded in a donut-RDD model. Such models will provide local average treatment effects for those people who were released just after full implementation of (and exposure to) the Reentry Waiver compared to just before the Reentry Waiver was implemented.

The UCLA-RAND Reentry Evaluation team expects to have a large enough sample size to address the proposed research questions. The sample size will be substantially larger than that which other scholars have had when utilizing similar approaches to answer research questions related to the effect of Medicaid waivers for incarcerated populations (Burns & Dague, 2024; Packham & Slusky, 2024), which have involved policies to increase access to Medicaid enrollment post-release.[63] Based on the number of releasees in California per year the sample size should be least 150,000 releasees given that there are around 25,000 individuals released from the state prisons each year. This is far larger than the 38,508 releasees in Burns & Dague (2024). However, depending on design parameters, RDD models may have only one-third the power of a similarly sized randomized control trial (Schochet, 2009).[64] Nonetheless, prior studies utilizing RDD approaches with smaller sample sizes than those expected for the present study have been sufficiently powered to identify effects of increasing access to Medicaid enrollment after release for re-entry populations in other states using RDD approaches (Packham & Slusky, 2024).[65] For example, Packham and Slusky (2024) had a sample size of 14,568 for their analysis with a 6-month window around the RDD, while the UCLA-RAND Reentry Evaluation team expect to have a sample size of around 25,000 for such an analysis, thus they also expect to be well-powered when using the donut RDD approach.

Qualitative Goals 3, 4, and 5

Goals 3, 4 and 5 will require interviews with key stakeholders and with individuals who have been previously incarcerated. The research questions related to these goals will focus on the Reentry Waiver time period (2024 to 2026) as well as the PATH demonstration timeframe.

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[63] Burns, M & Dague, L. (2024). In-Kind Welfare Benefits and Reincarceration Risk: Evidence from Medicaid. *NBER working paper 31394*.
Packham, A & Slusky, D. (2024). Accessing the Safety Net: How Medicaid Affects Health and Recidivism. NBER working paper 31971.

[64] Schochet, P. (2009) "Statistical Power for Regression Discontinuity Designs in Education Evaluations." Journal of Educational and Behavioral Statistics. 34(2) pp. 238—266.

[65] Packham, A & Slusky, D. (2024). Accessing the Safety Net: How Medicaid Affects Health and Recidivism. NBER working paper 31971.

Interviews with Formerly Incarcerated Individuals

The UCLA-RAND Reentry Evaluation team will conduct interviews in 2025 and 2026 of recently released individuals from CDCR, county jails and juvenile facilities in four counties. Within each county, the UCLA-RAND Reentry Evaluation team will identify community-based organizations (CBO), including JI ECM providers, to help identify and recruit respondents for the interviews. The budget includes a $500 payment for each CBO for their assistance in identifying potential interview participants.

Prior to starting recruitment, Reentry Evaluation staff will meet with the designated liaison from the CBO to review recruitment goals, procedures, and materials. CBOs will be provided a flyer in English and Spanish that describes what participation in the interview entails, the eligibility criteria for the interviews, recruitment goals, a recruitment script, and a contact information release form. To be eligible for the interviews, individuals must have been released in the previous 90 days from one of the targeted facilities, enrolled in Medi-Cal, and have one of the conditions that make them eligible for the Reentry Demonstration. If a Waiver participant is interested in taking part in the interview, the CBO will ask the individual to sign a release form that authorizes the CBO to release their name and contact information (telephone number, cell phone number, email address) to the UCLA-RAND Reentry Evaluation team in order to contact them. Individuals will be contacted to verify Reentry Waiver status (e.g. that the individual was recently incarcerated and that their Medi-Cal enrollment was reactivated prior to or at release), provide details about what participation in the interview entails, answer any questions or concerns they may have, and if they are interested and available, schedule an appointment to complete the interview with a trained interviewer, either in person or by phone. If the Reentry Waiver participant is available to do the interview right away, they will be interviewed by phone.

If the CBO is unable to provide staff to help identify and recruit Reentry Waiver participants for the interviews, the UCLA-RAND Reentry Evaluation team will seek their permission to allow an interviewer to visit their office(s) to recruit Reentry Waiver participants onsite, either before or after their appointment with CBO staff. With the CBO's permission, and in collaboration with CBO staff, interviewers will approach CBO clients to provide information about the survey and if they are interested, they will verify eligibility for the interviews and either conduct the interview on site (if possible) or schedule an appointment to do the interview later, either in person or by phone.

For the prison sample, UCLA-RAND Reentry Evaluation team will conduct interviews with 10-15 individuals who were formally incarcerated in prison and are recently released to

one of the four focal counties. This will result in a total of 40-60 interviews with individuals newly released from prison in 2025. It is anticipated that 100 newly released individuals will need to be screened to yield 10-15 interviews per identified focus county per project year.

For the county jail and youth correctional facility populations, 80 to 120 interviews will be conducted in the four focal counties in 2025, half of which will be with Reentry Waiver participants who were recently incarcerated in county jails and the other half will be with youth recently incarcerated in youth correctional facilities who are Reentry Waiver participants. It is estimated that between 100-125 individuals will need to be screened to complete 20-30 interviews per county (10-15 individuals released from jails and 10-15 individuals released from youth correctional facilities). The interviews will be administered by a bilingual interviewer, as a computer administered personal interview (CAPI) using a hand-held tablet. The interview will be conducted in English or Spanish, as applicable, and is estimated to take approximately 60 to 90 minutes. Respondents will be paid, which may be via gift card, for completing the interview.

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

To do qualitative analysis of these interview data, qualitative coding of themes will be conducted using software such as Dedoose, which will provide a systematic way to code and reveal themes in the data. Qualitative analysis will inform the interpretation of Goals 3, 4, and 5 by identifying strategies for improving coordination and connections between correctional systems, Medi-Cal systems, ECM, and community providers to address the physical health, behavioral health, and other health-related social needs of

the JI population. The qualitative analysis will also inform understanding of factors that facilitated or hindered Reentry Waiver participants' access to care pre-release and post-release, and their perceptions of their treatment needs and experiences with pre-release care, case management, and post-release care. Convenience sampling will be used to recruit interviewees. Equity-based populations (e.g., women, persons of color) will be oversampled and analyses will be stratified by demographics (e.g., race/ethnicity, gender, age) to the extent that sample sizes will support stratification.

The UCLA-RAND Reentry Evaluation team will identify CBOs which work specifically with different communities and work with younger individuals as well. The interview samples will be restricted to those individuals who speak English or Spanish as these are the languages that the UCLA-RAND Reentry Evaluation team are able to conduct interviews in.

Interviews with Key Stakeholders

In conjunction with the UCLA-RAND Providing Access and Transforming Health (PATH) Evaluation Team – which is focused on examining infrastructure investment – including Reentry - under the current 1115, interviews will be conducted with key stakeholders involved in the planning and implementation of the Waiver for the JI population. Key stakeholder interviewees will include at the state-level CDCR and California Correctional Health Care Services (CCHCS) staff. At the county-level, administrators of county jails, and youth correctional facilities will be selected with individuals who were involved with the planning and implementation of the Waiver for the JI population.

Table 2 summarizes, for the different interview topic areas, the entities who will be interviewed (including the lead entity), and who the system implementation partners are. Specifically, at the prison-level, evaluation plans are to interview those individuals within CDCR and the CCHCS who were involved in planning for and implementing the Waiver for the incarcerated population in the state's correctional system. Similarly, at the jail and youth correctional facilities, implementation partners listed in Table 2 including county sheriffs, county jail staff and juvenile facility administrators/staff, county probation staff, and state parole staff will be interviewed.

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

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

Table 2. Interview Topic Areas, Lead Entity, and System Implementation Partners

Topics	Lead Entity	System Implementation Partners
Pre-Release Medi-Cal Application Processes in County Correctional Facilities	County Jails and Youth Correctional Facilities	County Sheriff's Offices, County Probation Offices, and County Social Services Departments (SSDs) and other partners responsible for correctional health care services.
Provision of Targeted Set Services 90 Days Prior to Release from Jail or Prison	State Prisons, County Jails, and Youth Correctional Facilities working in partnership with and Community-Based Providers, as appropriate	State Prisons, County Sheriffs, County Probation, County Jails and Youth Correctional Facilities, CA Department of Corrections and Rehabilitation, CA Correctional Health Care Services (CCHCS)

Enhanced Care Management	Medi-Cal Managed Care Plans	County Behavioral Health, Reentry ECM Providers, Support Services Providers (e.g., Housing), County Correctional Facilities, CDCR, Probation and Parole
Community Supports	Medi-Cal Managed Care Plans	County Behavioral Health, Service Providers (e.g., Housing), Probation and Parole

Source: CCJBH "Brief Overview of the Department of Health Care Services (DHCS)' California Advancing and Innovating Medi-Cal (CalAIM) CalAIM Justice-Involved Initiative," Prepared by the Council on Criminal Justice and Behavioral Health (CCJBH) and reviewed by DHCS, March 2023. Note: For ECM, the support services providers will be determined after the UCLA-RAND Evaluation team review their plans.

As noted above, the UCLA-RAND Reentry Evaluation team will coordinate with the UCLA-RAND PATH team on the key stakeholder interviews eliciting that team's input on the development of the interview protocols and will share with them the results of the qualitative analyses. Similar to the interviews with Reentry Waiver participants, qualitative coding of themes for the stakeholder interviews using software such as Dedoose will be used, which will provide a systematic way to code and reveal themes in the data. Qualitative analysis of the stakeholder interviews will inform the interpretation of Goals 3, 4, and 5 by identifying strategies for improving coordination and connections between correctional systems, Medi-Cal systems, ECM, and community providers. The qualitative analysis will also inform understanding of factors that facilitated or hindered implementation of the different components of the Reentry Waiver and stakeholders' suggestions for improving Medi-Cal enrollment processes, pre-release treatment services, and case management, and post-release care.

Evaluation Goals

This section begins with a summary of the seven evaluation goals and the evaluation questions and hypotheses and measures associated with each goal. In the Driver Diagram section that follows the specific aim(s) and primary and secondary drivers are identified. The Methods section describes in detail for each goal and research question the specific methods proposed for analyses.

Goals 1 and 2 and their related hypotheses are designed to satisfy the STCs for a comprehensive analysis of services rendered by type of service over the duration of the

90-day coverage period immediately prior to the expected date of release. The specific methods sections below discuss the analysis of the relationship between service provision and timing and the outcomes in Goals 6 and 7. Ninety days pre-release is used as the time period to align with the allowable time Reentry Waiver services can be provided for California within the carceral setting.

Goals 3, 4, and 5 and their related hypotheses address the extent to which the Waiver coverage timeline facilitated providing more coordinated, efficient and effective reentry planning, enabled pre-release management and stabilization of physical and behavioral health conditions, and helped mitigate any potential operational challenges the state might have otherwise encountered in a more compressed timeline for coverage or pre-release services. These are addressed in a qualitative manner.

This UCLA-RAND Reentry Evaluation design kept the term "beneficiary" in exact language used by CMS; however, in other places the term "members" is used per DHCS guidance. It is worth noting that measures refer to the measured changes that related to evaluation questions and hypotheses, but the underlying measures needed to identify such changes come from underlying individual level data, discussed in more detail in Methods section. For each measure the numerator and denominator are defined. It is worth noting that the UCLA-RAND Reentry Evaluation design uses the full number of releasees within a cohort as the denominator to facilitate the identification of intention-to-treat estimates.

G 1: Increase coverage, continuity of care, and appropriate service uptake through assessment of eligibility and availability of coverage for benefits in carceral settings just prior to release.	
Evaluation Questions and Hypotheses	**Measures**
EQ 1: Did the Waiver increase coverage for eligible Medi-Cal members?	» Medicaid Coverage (numerator = number enrolled in Medicaid; denominator = number of releasees) » Eligibility screening (numerator = number screened for eligibility within 90 days of release; denominator = number of releasees) » Eligibility (numerator = number found eligible for Justice-Involved Reentry
H 1: The Waiver will increase coverage for eligible Medi-Cal members?	

	Initiative services after screening; denominator = number of screened releasees) » Suspended status (numerator = number with suspended status; denominator = number of releasees)
G 2: Improve access to services prior to release and improve transitions and continuity of care into the community upon release	
Evaluation Questions and Hypotheses	**Measures**
EQ 2: Did the Waiver improve access to services prior to release from prison/jail/juvenile hall? Improve transitions and continuity of care upon release for eligible Medi-Cal members?	» Pre-release care management (numerator = number who received pre-release care management during 90-day pre-release period; denominator = number of releasees)
H1: The Waiver will increase access to services prior to release and improve transitions and continuing of care upon release for eligible Medi-Cal members.	» Pre-release medication billing (numerator = number who received any medication billed during the 90-day pre-release period; denominator = number of releasees) » Pre-release MAT treatment (numerator = number who received MAT treatment during the 90-day pre-release period; denominator = number of releasees) » Pre-release prescription fills (numerator = number who had a filled prescription in the 30 days prior to release; denominator = number of releasees) » Post-release prescription fills (numerator = number who had a filled prescription in the 30 days following release; denominator = number of releasees) » Assigned pre-release care manager (numerator = number who had an

	assigned pre-release care manager within 90 days of release; denominator = number of releasees) » Pre-release substance use disorder treatment (numerator = number who received substance use disorder treatment in the 90-day pre-release period; denominator = number of releasees) » Necessary medications (numerator = number of releasees who received all necessary medications (as identified in their health records while incarcerated) for chronic disease in the community prior to completion of previous supply received during incarceration; denominator = number of releasees) » Visit with an ECM provider (numerator = number of releasees who had a visit with their ECM provider within 30 days after release; denominator = number of releasees) » Medicaid services (numerator = number of releasees who received any Medicaid service within 30 days, 90 days and six-months post-release; denominator = number of releasees) » Provider beneficiary rate (numerator = number of providers; denominator = number of releasees) » Wait time (numerator =time from referral to appointment; denominator = all appointments)[66]

[66] This will be included provided reliable data are available for date of referral and date of appointment.

	» Percent of incarcerated individuals found eligible for Justice-Involved Reentry Initiative services after screening - post-Waiver cohorts compared to pre-Waiver cohorts
G 3 Improve coordination and communication between correctional systems, Medicaid and CHIP systems, managed care plans, and community-based providers.	
Evaluation Questions and Hypotheses	**Measures**
EQ 3A: Did the Waiver improve coordination between correctional systems, Medicaid and CHIP systems, managed care plans, and community-based providers? **EQ 3B**: Did the Waiver improve communication between correctional systems, Medicaid and CHIP systems, managed care plans, and community-based providers?	Interviews with individuals released from prison/jail/juvenile facilities could cover: » Challenges/facilitators in transitioning to the community after release (e.g., number of available providers) » Continuity of care from incarceration to community » Effectiveness of case managers Interviews with key stakeholders could cover: » Newly established communication channels between correctional systems and community based-providers, Medicaid/CHIP systems » Data sharing put into place » Handoff protocols between prisons/jails/juvenile facilities and community
H1: The Waiver will improve coordination between correctional systems, Medicaid and CHIP systems, managed care plans, and community-based providers. **H2:** The Waiver will improve communication between correctional systems, Medicaid and CHIP systems, managed care plans, and community-based providers.	
G 4. Increase additional investments in health care and related services, aimed at improving the quality of care for beneficiaries in carceral settings and in the community to maximize successful reentry post-release.	

Evaluation Questions and Hypotheses	Measures
EQ 1: How did the Waiver influence investments in health care and related services in carceral settings aimed at improving quality of care and in the community aimed at maximizing successful reentry post-release?	Interviews with key stakeholders could cover: » How were Waiver funds used? » What were the additional federal, state, and general fund investments for pre-release services, ECM, and PATH?
H1: The Waiver (post-Reentry) will be associated with increased services associated with improved quality of care, such as medication-assisted treatment, care coordination, and enhanced care management.	
G 5. Improve connections between carceral settings and community services upon release to address physical health, behavioral health, and health-related social needs.	
Evaluation Questions and Hypotheses	**Measures**
EQ 1: Did the Waiver Improve connections between carceral settings and community services upon release to address physical health, behavioral health, and health-related social needs?	Interviews with individuals released from prisons/jails/juvenile facilities could cover: » Health care needs of participants » Provision of services during 90-day in-reach period » Transition services provided, including case manager and medications upon release, appointments made in the community » Community supports needed and received » ECM services needed and received Interviews with key stakeholders could cover:
H1: The Waiver will improve connections between carceral settings and community services upon release to address physical health, behavioral health, and health-related social needs.	

	» Coordination of care between carceral settings (prison, jail, youth correctional facilities) and community service providers (behavioral health, medical care, social services) » Type of formal arrangements (e.g., memorandums of understanding, regular meetings, etc.) to facilitate connections between carceral settings and providers » Facilitators and barriers and how these may vary by type of services provided
G 6: Provide intervention for certain behavioral health conditions and use stabilizing medications like long-acting injectable antipsychotics and medications for addiction treatment for SUDs, with the goal of reducing decompensation, suicide-related death, overdose, and overdose-related death in the near-term post-release.	
Evaluation Questions and Hypotheses	**Measures**
EQ 1: Did the Waiver provide intervention for certain behavioral health conditions and use stabilizing medications like long-acting injectable anti-psychotics and medications for addiction treatment for SUDs for eligible Medi-Cal members?	» Post-release substance use disorder treatment (numerator = number of releasees who received substance use disorder treatment within 30 days of release; denominator = number of releasees)Post-release mental health treatment (numerator = number of releasees who received mental health treatment within 30 days of release; denominator = number of releasees) » Post-release MAT (numerator = number of releasees who received MAT within 30 days of release; denominator = number of releasees)
H1: The Waiver will increase access to interventions for behavioral health conditions, access to long-acting injectable anti-psychotics, and access to	

medications for addiction treatment for SUDs for eligible Medi-Cal members. **EQ 2:** Did the Waiver reduce decompensation, suicide-related deaths, overdoses, and overdose-related deaths in the near-term post-release for eligible Medi-Cal members? **H2:** The Waiver will reduce decompensation, suicide-related deaths, overdoses, and overdose-related deaths for eligible Medi-Cal members.	» Post-release necessary medications (numerator = number of releasees who received all necessary medications (as identified in facility records) for chronic disease in the community prior to completion of previous supply received during incarceration; denominator = number of releasees) » Receipt of behavioral health condition interventions (numerator = number of releasees who received behavioral health condition interventions 90 days pre-release and post-release (30 and 90 days); denominator = number of releasees) » Medications for addiction treatment for SUDs (numerator = number of releasees who received medications for addiction treatment for SUDs in the 90 days pre-release and post-release (30 days and 90 days); denominator = number of releasees) » Suicide-related emergency department visits (numerator = number of releasees who had suicide-related emergency department visits post-release (30 days and 90 days; denominator = number of releasees) » Suicide-related inpatient hospitalizations (numerator = number of releasees who had inpatient hospitalizations post-release (30 days and 90 days; denominator = number of releasees) » Suicide-related deaths (numerator = number of releasees who died by suicide

	(30 days and 90 days); denominator = number of releasees) » Emergency department utilization for SUD (numerator = number of releasees who had emergency department utilization for SUD post-release (30 days and 90 days); denominator = number of releasees) » Inpatient stays for SUD (numerator = number of releasees who had inpatient stays for SUD post-release (30 days and 90 days); denominator = number of releasees) » Overdose-related deaths (numerator = number of releasees who had an overdose-related death (30 days and 90 days); denominator = number of releasees) » Decompensation (numerator = number of releasees who had any (and each) post-release decompensation (include psychosis, suicide attempt, depression, anxiety, mania, drug overdose (regardless of intention), drug induced mental disorders, insomnia, social withdrawal, anorexia, aggression, increased substance use) 30 days and 90 days; denominator = number of releasees)
G 7: Reduce post-release acute care utilization such as emergency department visits, inpatient hospitalizations, and all-cause deaths among recently incarcerated Medicaid beneficiaries and individuals otherwise eligible for CHIP if not for their incarceration status through robust pre-release identification, stabilization, and management of certain serious physical and behavioral health conditions that may	

respond to ambulatory care and treatment (e.g., diabetes, heart failure, hypertension, schizophrenia, SUDs) as well as increased receipt of preventive and routine physical and behavioral health care.	
Evaluation Questions and Hypotheses	**Measures**
EQ 1: Did the Waiver reduce post-release emergency department visits, inpatient hospitalizations, and all-cause deaths for eligible Medi-Cal members?	» All-cause deaths (numerator = number of releasees who died (30 days and 90 days); denominator = number of releasees) » All-cause emergency room visits (numerator = number of releasees who had an emergency room visit (30 days and 90 days); denominator = number of releasees) » All-cause inpatient hospitalizations (numerator = number of releasees who had an inpatient hospitalization (30 days and 90 days); denominator = number of releasees)
H1: The Waiver will reduce post-release emergency department visits, inpatient hospitalizations, and all-cause deaths for eligible Medi-Cal members.	

Driver Diagrams

The goals listed in the driver diagrams are taken directly from the Special Terms and Conditions (STCs) number 9.1 for California.[67]

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

Aim	Primary Driver	Secondary Driver
Increase coverage—in terms of individuals now eligible for Medi-Cal benefits—in carceral settings in prison/jail/juvenile hall just prior to release.	Increase the screening rate for Medicaid eligibility. Improve coverage for benefits in carceral settings prior to release.	Increase administration of screening to identify eligible individuals. Conduct outreach to ensure beneficiary and applicant awareness of the policy and assist individuals with Medicaid application, enrollment, and renewal processes. Increase utilization of applicable pre- and post-release services. Increase behavioral health linkages and enhanced care management linkages for health and social services pre- and post-release.

[67] https://www.dhcs.ca.gov/provgovpart/Documents/California-Reentry-Demonstration-Initiative-

		Improve data systems in carceral settings.
← Causality ←		

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

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

		providers have the necessary experience and training, and case managers are knowledgeable about community-based providers.
← Causality ←		

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

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

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

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

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

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

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

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

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

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

Methods

Note, the goals are taken from CMS guidance in the STCS.[68]

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

Research Question 1: Did the Reentry Waiver increase coverage—in terms of individuals now eligible for Medi-Cal benefits—in carceral settings in prison/jail/youth correctional facilities just prior to release?

Hypothesis: The Reentry Waiver will increase coverage.

- Measures:
    - Medicaid coverage
    - Medicaid suspended status
    - Medicaid eligibility screening
    - Medicaid eligibility
- Target Population: People who are eligible Medi-Cal members who met service criteria for the Waiver and then released from carceral settings following the go live of the Waiver (specific to each facility)
- Comparison Population: People who would have met Medi-Cal eligibility released from carceral settings prior to the go live of the Waiver (specific to each facility)
- Individual level data
- Evaluation Period: CY 2021 through CY 2026
- The approach will make use of cohorts of individuals released from facilities in order to select treatment groups and control groups around the timing of when the Waiver goes live. Additional control cohorts will be created from prior to the go live to be able to estimate models that can identify a causal effect. Thus, the UCLA-RAND Reentry Evaluation team will assess the feasibility of constructing control cohorts over the same periods in prior years (e.g., 6 months pre and 6 months post the go live for years around the time of the facility roll-out and the same calendar periods for years prior to the policy rolling out). While in practice the year of the roll-out and one year before could be used to identify these

[68] CENTERS FOR MEDICARE & MEDICAID SERVICES WAIVER AUTHORITY, NUMBERS: 11-W-00193/9 and 21-W-00077/0, TITLE: California CalAIM Demonstration. See: https://www.dhcs.ca.gov/CalAIM/Documents/BH-CONNECT/CA-CalAIM-STCs.pdf

groups (i.e., two cohorts), this may lead to less precise estimates. Such noise could result in the findings indicating that the Reentry Waiver had no impact due to precision rather than a true null effect. Increasing the number of control cohorts (back to 2021 for example) would allow for the identification of more precise estimates. More precision (afforded by these earlier cohorts) will therefore be important to provide precise estimates of the effect of the Reentry Waiver and ensure that the evaluation is powered to identify an effect if one exists.

- Methodological Design: The UCLA-RAND Reentry Evaluation team will use cohort difference-in-differences and event study analyses. The UCLA-RAND Reentry Evaluation team will identify a 12-month cohort of individuals released around the timing of the go live of the Waiver (i.e., groups released 6 months prior to waiver implementation (control) and the first 6 months after Waiver implementation(treated)). The UCLA-RAND Reentry Evaluation team will also explore whether control cohorts can be identified from the same 12-month period, for years prior to Reentry Waiver go live.

  The difference-in-differences models will explore how outcomes vary before and after Reentry Waiver go live compared to associated control cohorts (in earlier years) to identify the causal effect of the Reentry Waiver. Importantly, this approach is able to follow the outcomes of individuals who meet the criteria who transition from carceral settings to community over time, allowing exploration of the dynamic effect in event study models by using monthly data for the outcomes of each individual. Event study models will also allow exploration of whether control and treated cohorts were on parallel trends prior to Reentry Waiver go live (a crucial assumption in difference-in-differences models).

  The Reentry Waiver go live will likely be rolled out in staggered settings across jails/youth correctional facilities. As such, in these cases The UCLA-RAND Reentry Evaluation team will make use of staggered difference-in-differences and event study models that compare the outcomes of the re-entry population that are released after Waiver go live, compared to those released prior to the go live, for jails/youth correctional facilities that go live, compared to those that go live later. Given the staggered nature in these settings the UCLA-RAND Reentry Evaluation team approach will make use of models that deal with biases that may arise in such settings (Roth et al., 2023).

If those released after the Waiver go live, compared to those released prior to the roll-go live, in the treatment cohort compared to associated earlier control cohorts, have higher rates of Medi-Cal enrollment and suspended status then the hypothesis is affirmed.

- Data Sources: Medicaid claims data and correctional agencies' health care utilization data and demographic information (e.g., gender, race/ethnicity, health/behavioral health condition, age, county) as well as release dates.
- Analytic Methods: Descriptive summary and t-tests will be used to provide sample characteristics over time (e.g., gender, race/ethnicity, health/behavioral health condition, age, county). Probit models will be estimated to take consideration of the binary nature of outcomes variables. Difference-in-differences analysis will be used to identify a causal effect. Event study models will be used to test for pre-trends. Analyses will examine the three major populations targeted for Reentry – prisoners, jail inmates, and youth who are incarcerated.

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

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

- Hypothesis: The Waiver will increase access to services prior to release and improve transitions and continuity of care upon release.
- Measures:
    - Pre-release case management
    - Pre-release medication billing
    - Pre-release MAT treatment
    - Pre-release prescription fills
    - Pre-release care manager
    - Pre-release substance-use disorder treatment
    - Medically necessary medications
    - Visits with ECM provider
    - Medicaid services
    - Provider beneficiary rate

- Wait times
- Self-reported access to care based on interviews with individuals newly released from prison/jail/juvenile facilities
    - Interview questions regarding their health care treatment needs and reentry support needs prior to release; their experiences in receiving pre-release services while still incarcerated; their experiences with case management and the transition of their care to community providers; other support they may have received to help facilitate their transition of care to the community

» Target Population: People who are eligible Medi-Cal members who met Waiver service criteria and were enrolled and then released from carceral settings following the go live of the Waiver (specific to each facility)

» Comparison Population: People who would have met Medi-Cal eligibility released from carceral settings prior to the go live of the Waiver (specific to each facility)

» Individual level data

» Evaluation Period: CY 2021 through CY 2026

» Methodological Design: The UCLA-RAND Reentry Evaluation team will use cohort difference-in-differences and event study analyses. A 12-month cohort of individuals released around the timing of the go live of the Waiver (i.e., groups released 6 months prior to Reentry Waiver go live (control) and the first 6 months after Reentry Waiver go live (treated)) will be identified. The UCLA-RAND Reentry Evaluation team will also assess the feasibility of constructing control cohorts from the same 12-month period, for years prior to Reentry Waiver go live. The difference-in-differences models will explore how outcomes vary before and after Waiver go live compared to associated control cohorts (in earlier years) to identify the causal effect of the Reentry Waiver. Importantly, this approach allows one to follow the outcomes of releasees over time, allowing exploration of dynamic effects in event study models by using monthly data for the outcomes of each individual event.

» Event study models will also allow explore whether control and treated cohorts were on parallel trends prior to Reentry Waiver go live (a crucial assumption in difference-in-differences models). The Reentry Waiver will likely go live in staggered settings across jails/youth correctional facilities. As such, in these cases we will make use of staggered difference-in-differences and event study

models that compare the outcomes of the re-entry population in the 90 days prior to release that are released after Reentry Waiver go live compared to those released prior to the go live; for jails/youth correctional facilities that go live earlier compared to those that go live later. Given the staggered nature in these settings the UCLA-RAND Reentry Evaluation team will make use of models that deal with biases that may arise in such settings (Roth et al, 2023).

If post-Reentry Waiver cohorts in the treatment cohort have higher rates of the measures listed above during the 90 days prior to release, compared to pre-Reentry Waiver cohorts, and cohorts from earlier years, then the hypothesis is affirmed.

- Data Sources: Medicaid claims data and correctional agencies' health care utilization and demographic information (e.g., gender, race/ethnicity, health/behavioral health condition, age, county) as well as release dates. State hospital inpatient discharge data, state hospital emergency department visit data, and state death data. Patient discharge and ED visit data will be obtained from HCAI data sources via DHCS.
- Analytic Methods: Descriptive summary and t-tests will be used to provide sample characteristics over time (e.g., gender, race/ethnicity, health/behavioral health condition, age, county). Probit models will be estimated to take consideration of the binary nature of outcomes variables. Difference-in-differences analysis will be used to identify a causal effect. Event study models will be used to test for pre-trends. Analyses will examine the three major populations targeted for Reentry – prisoners, jail inmates, and youth who are incarcerated.

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

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

- Hypotheses:
  - Hypothesis 1: The Waiver will improve coordination between correctional systems, Medicaid and CHIP systems, managed care plans, and community-based providers.
  - Hypothesis 2: The Waiver will improve communication between

correctional systems, Medicaid and CHIP systems, managed care plans, and community-based providers.

- Measures: emergent themes from interviews
- Target Population: key stakeholders in prison, jails, juvenile facilities, Medicaid, CHIP, managed care plans, and community-based providers
- Comparison Population: not applicable
- Individual level data: not applicable
- Evaluation Period: CY 2022 through CY 2026
- Methodological Design: qualitative interview-based design with semi-structured interview protocols that will be conducted via TEAMS or ZOOM once a year starting in Years 1-4. A minimum of 2-3 interviews within each of the stakeholder groups at the state-level will be conducted; interviews with county-level stakeholders will also be conducted within four counties. The interviews will ask about the context before the Reentry Waiver went into effect and during each year of implementation. The interviews will focus on questions related to coordination and communication between relevant stakeholders. For example, the evaluation team will use questions based on validated items from surveys such as CAHPS (e.g. Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often, Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service, Shared Decision Making) to probe interviewees. In addition, interviews will be conducted with Reentry Waiver participants newly released from carceral settings in four counties.
- In the context of regular across project evaluation team meetings, the UCLA-RAND Reentry Evaluation team will regularly review project specific approaches to qualitative instrument development. To date, the Reentry Evaluation team and the UCLA-RAND PATH Evaluation team have already met to agree upon the important interface between the two evaluation components. For example, any administrative data from CDCR or from county jails and youth correctional facilities will be obtained and maintained by the UCLA-RAND Reentry Evaluation team who will run analyses of these data and stratify by whether a carceral facility received PATH funding on UCLA's behalf for inclusion in the PATH section of the report. The PATH team will lead the development of the organizational surveys, with input from the other projects. The Reentry Evaluation team will assist with disseminating the survey to carceral facilities. Similarly, responsibilities for key informant interviews within PATH and Reentry will be distributed with the

UCLA-RAND Reentry Evaluation team leading interviews in carceral settings, while the UCLA-RAND PATH team will lead interviews with carceral facilities' "external" partners (e.g., county social service agencies assisting with eligibility determinations and community-based providers responsible for providing the 90-day pre-release services). Interview data will be jointly analyzed.

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

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

Research Question 1: How did the Waiver influence investments in health care and related services in carceral settings aimed at improving quality of care and in the community aimed at maximizing successful reentry post-release?

- Hypothesis: The Waiver (post-Reentry) will be associated with increased services associated with improved quality of care, such as medication-assisted treatment, care coordination, and enhanced care management..
- Measures: emergent themes from interviews
- Target Population: key stakeholders in prison, jails, juvenile facilities, Medicaid, CHIP, managed care plans, and community-based providers
- Comparison Population: not applicable
- Individual level data: not applicable
- Evaluation Period: CY 2022 through CY 2026

- Methodological Design. The UCLA-RAND Reentry evaluation team will gather expenditure and staffing data post-Waiver. Semi-structured interviews will be conducted via TEAMS or ZOOM with relevant financial personnel at the state prison-level, and at the jail and juvenile facility levels within the four counties. The interviews will focus on questions related to investment strategies in carceral settings as well as out in the community.
- Data Sources: available financial documents from key stakeholder agencies; interviews with stakeholder staff
- Analytic Methods: qualitative discussion of changes in expenditures and investments in health care and related services, aimed at improving the quality of care for members in carceral settings, and in the community to maximize successful reentry post-release. Qualitative coding of themes using software such as Dedoose will be used, which will provide a systematic way to code and reveal themes in the data and will examine the three major populations targeted for Reentry – prisoners, jail inmates, and juveniles who are incarcerated.

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

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

- Hypothesis: The Waiver will improve person-level connections between carceral settings and community services upon release to address physical health, behavioral health, and health-related social needs.
- Measures: emergent themes from interviews
- Target Population: key stakeholders in prison, jails, juvenile facilities, Medicaid, CHIP, managed care plans, and community-based providers
- Comparison Population: not applicable
- Individual level data: not applicable
- Evaluation Period: CY 2022 through CY 2026
- Methodological Design: qualitative interview-based design with semi-structured interview protocols that will be conducted via TEAMS or ZOOM once a year starting in Years 1-4. A minimum of 2-3 interviews within each of the stakeholder

groups at the state-level will be conducted; the UCLA-RAND Evaluation team will also conduct interviews with county-level stakeholders within four counties. The interviews will ask about the context before the Waiver went into effect and during each year of implementation. The interviews will focus on questions related to coordination and communication between relevant stakeholders. In addition, interviews with Reentry Waiver participants will be conducted with newly released from carceral settings in four counties.

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

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

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

- Hypothesis: The Waiver will increase access to interventions for behavioral health conditions, access to long-acting injectable anti-psychotics, and access to medications for addiction treatment for SUDs.
- Measures:
    - Post-release substance use disorder treatment
    - Post-release mental health treatment

    - Post-release MAT
    - Post-release necessary medications
    - Post-release receipt of behavioral health condition interventions
        - Medications for addiction treatment for substance use disorders
- Target Population: People who are eligible Medi-Cal members who met Waiver service criteria and were enrolled and then released from carceral settings following the go live of the Reentry Waiver (specific to each facility)
- Comparison Population: People who would have met Medi-Cal eligibility and Waiver service requirements and were released from carceral settings prior to the go live of the Waiver (specific to each facility)
- Individual level data
- Evaluation Period: CY 2021 through CY 2026
- Methodological Design: Cohort difference-in-differences and event study analyses will be used. The UCLA-RAND Reentry Evaluation team will identify a 12-month cohort of individuals released around the timing of the county go live date (i.e., groups released 6 months prior to Reentry Waiver go live (control) and the first 6 months after Reentry Waiver go live (with the first 3 months being a group of partially treated individuals and the subsequent 3 months being a fully treated sample)). The UCLA-RAND Reentry Evaluation team will also assess the feasibility of constructing control cohorts from the same 12-month period, for years prior to Reentry Waiver go live. The difference-in-differences models will explore how outcomes vary before and after Reentry Waiver go live compared to associated control cohorts (in earlier years) to identify the causal effect of the Reentry Waiver. Importantly, this approach will be able to follow the outcomes of releasees over time, allowing exploration of dynamic effect in event study models by using monthly data for the outcomes of each individual. Event study models will also allow the UCLA-RAND Reentry Evaluation team to explore whether control and treated cohorts were on parallel trends prior to Reentry Waiver go live (a crucial assumption in difference-in-differences models). Event study models will also allow the UCLA-RAND Reentry Evaluation team to explore dynamics in the post-treatment period, allowing exploration of whether changes in outcomes occurred pre-release, post-release, or both.

  The Reentry Waiver go live will likely to be rolled out in staggered setting across jails/youth correctional facilities. As such, in these cases the UCLA-RAND Reentry Evaluation team will make use of staggered difference-in-differences and event

study models that compare the outcomes of the reentry population in the 90 days prior to release, that are released after Reentry Waiver go live, compared to those released prior to the go live, for jails/ youth correctional facilities that go live earlier, compared to those that go live later. Given the staggered nature in these settings the UCLA-RAND Reentry Evaluation team will make use of models that deal with biases that may arise in such settings (Roth et al., 2023).

If post-Waiver cohorts in the treatment cohort have higher rates of receiving behavioral health condition interventions, long-acting injectable anti-psychotic, and medications for addiction treatment for SUDs, during the 90 days prior to release, compared to pre-Waiver cohorts, and cohorts from earlier years then Hypothesis 1 is affirmed.

- Data Sources: Medicaid claims data and correctional agencies' health care utilization and demographic information (e.g., gender, race/ethnicity, health/behavioral health condition, age, county) as well as release dates. State hospital inpatient discharge data, state hospital emergency department visit data, and state death data.
- Analytic Methods: Descriptive summary and t-tests will be used to provide sample characteristics over time (e.g., gender, race/ethnicity, health/behavioral health condition, age, county). Probit models will be estimated to take consideration of the binary nature of outcomes variables. Difference-in-differences analysis will be used to identify a causal effect. Event study models will be used to test for pre-trends. The three major populations targeted for Reentry – prisoners, jail inmates, and juveniles who are incarcerated will be examined. Regression models will be used to determine the impact of specific services received and timing on outcomes for this Research Question.

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

- Hypothesis: The Waiver will reduce decompensation, suicide-related deaths, overdoses, and overdose-related deaths.
- Measures:
  - Suicide related ED visits
  - Suicide related inpatient hospitalizations
  - Suicide related deaths
  - ED utilization for substance use disorders

- Inpatient stays for substance use disorders
- Overdose related deaths
- Decompensation[69]

» Target Population: People who are eligible Medi-Cal members who met Waiver service criteria and were enrolled and then released from carceral settings following the go live of the Waiver (specific to each facility)

» Comparison Population: People who would have met Medi-Cal eligibility and Waiver service criteria and were released from carceral settings prior to the go live of the Waiver (specific to each facility)

» Individual level data

» Evaluation Period: CY 2021 through CY 2026

» Methodological Design: The UCLA-RAND Reentry Evaluation team will use cohort difference-in-differences and event study analyses. The UCLA-RAND Reentry Evaluation team will identify a 12-month cohort of individuals released around the timing of the go live of the Reentry Waiver (i.e., groups released 6 months prior to Waiver go live (control) and the first 6 months after go live (treated)). The UCLA-RAND Reentry Evaluation team will also assess the feasibility of constructing control cohorts from the same 12-month period, for years prior to Reentry Waiver go live. The difference-in-differences models will explore how outcomes vary before and after Waiver go live compared to associated control cohorts (in earlier years) to identify the causal effect of the Reentry Waiver. Importantly, the UCLA-RAND Reentry Evaluation team will be able to follow the outcomes of releasees over time, allowing exploration of dynamic effect in event study models by using monthly data for the outcomes of each individual. Event study models will also allow the UCLA-RAND Reentry Evaluation team to explore whether control and treated cohorts were on parallel trends prior to Waiver go live (a crucial assumption in difference-in-differences models).

The Reentry Waiver will likely go live out in staggered setting across jails/youth correctional facilities. As such, in these cases the UCLA-RAND Reentry Evaluation team will make use of staggered difference-in-differences and event study

[69] Direct objective measures of mental health decompensation will not be available in the absence of an electronic medical record. However, in addition to the listed utilization measures (including ED visits for psychosis), it is possible to examine other indicators that might reflect worsening mental health (decompensation): gaps in receipt of medication OR change in medication; need to check into sober center or long-term inpatient psychiatric facility; increase in use of outpatient mental health services.

models that compare the outcomes of the reentry population that are released after Waiver go live, compared to those released prior to the go live, for jails/ youth correctional facilities that go live earlier, compared to those that go live later. Given the staggered nature in these settings, the UCLA-RAND Reentry Evaluation team will make use of models that deal with biases that may arise in such settings (Roth et al, 2023).

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

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

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

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

- Hypothesis: The Waiver will reduce post-release emergency department visits, inpatient hospitalizations, and all-cause deaths.
- Measures:
  - All-cause deaths post-release (30 days and 90 days)
  - All-cause emergency room visits post-release (30 days and 90 days)
  - All-cause inpatient hospitalizations post-release (30 days and 90 days)
- Target Population: People who are eligible Medi-Cal members who met Waiver service criteria and were enrolled and then released from carceral settings following the go live of the Waiver (specific to each facility)
- Comparison Population: People who would have met Medi-Cal eligibility and Waiver service criteria and then released from carceral settings prior to the go live of the Waiver (specific to each facility)
- Individual level data
- Evaluation Period: CY 2021 through CY 2026
- Methodological Design: The UCLA-RAND Reentry Evaluation team will use cohort difference-in-differences and event study analyses. The UCLA-RAND Reentry Evaluation team will identify a 12-month cohort of individuals released around the timing of go live (i.e., groups released 6 months prior to Reentry Waiver go live (control) and the first 6 months after Reentry Waiver go live (treated)). The UCLA-RAND Reentry Evaluation team will also assess the feasibility of constructing control cohorts from the same 12-month period, for years prior to Waiver go live. The difference-in-differences models will explore how outcomes

vary before and after Waiver go live compared to associated control cohorts (in earlier years) to identify the causal effect of the Waiver. Importantly, the UCLA-RAND Reentry Evaluation team will be able to follow the outcomes of releasees over time, allowing exploration of dynamic effect in event study models by using monthly data for the outcomes of each individual. Event study models will also allow the UCLA-RAND Reentry Evaluation team to explore whether control and treated cohorts were on parallel trends prior to go live (a crucial assumption in difference-in-differences models).

The Reentry Waiver go live is likely to be staggered across jails/youth correctional facilities. As such, in these cases the UCLA-RAND Reentry Evaluation team will make use of staggered difference-in-differences and event study models that compare the outcomes of the reentry population that are released after go live, compared to those released prior to the go live date, for jails/youth correctional facilities that go live earlier, compared to those that go live later. Given the staggered nature in these settings the UCLA-RAND Reentry Evaluation team will make use of models that deal with biases that may arise in such settings (Roth et al., 2023).

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

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

determine the impact of specific services received and timing on outcomes for this Research Question.

Cost

To examine changes in health care utilization and expenditures by the JI population, the UCLA-RAND Reentry Evaluation team will compare utilization of select services post-release and the payments associated with that utilization for Waiver participants that received pre-release services and a matched comparison group. To conduct these analyses, the UCLA-RAND Reentry Evaluation team will need to obtain identifiers from the correctional system (i.e., prisons and jails), which as previously noted, UCLA-RAND will attempt to obtain from CDCR and from correctional facilities in four purposively selected counties.

The cost analysis will be limited to Medi-Cal covered costs post-release. This is because the UCLA-RAND Reentry Evaluation team anticipates that obtaining cost estimates for all services delivered while in prison and jail will not be feasible or practically available.

For services delivered post-release, the UCLA-RAND Reentry Evaluation team will examine utilization of Medi-Cal covered outpatient services, ED visits, hospitalizations, and long-term stays, and associated Medi-Cal payments. In estimating Medi-Cal payments, the UCLA-RAND Reentry Evaluation team will use the methodology developed by the UCLA PATH team to attribute payment amounts to each claim. As detailed in the UCLA PATH Evaluation Design, to determine the expenditures of ECM and Community Supports services, the UCLA PATH team will ask MCPs to provide an average payment amount for each ECM or Community Supports service identified in Medi-Cal claims data by a HCPCS code. UCLA anticipates that MCPs payments to individual providers may vary for each ECM and Community Supports service identified by a HCPCS code, by region, by population of focus and potentially other factors. However, an average payment for each service may be calculated on a per service/per unit basis. UCLA-RAND will use this data to determine average payments and patterns of average payments for each ECM population of focus and for Community Supports services.

UCLA-RAND will stratify these data by county or region, under-resourced community indices, and by provider types. These analyses depend on the feasibility of obtaining average payment rates from MCPs. If MCP are unable to estimate average payment amounts, then the UCLA-RAND Evaluation team will rely on DHCS-provided data

pertaining to rates provided to MCPs. The limitation of this approach is that the UCLA-RAND evaluation team would then only be able to examine expenditures in aggregate.

UCLA-RAND will attempt to assess cost savings by comparing Medi-Cal payments by category of service incurred by members receiving ECM or Community Supports to a matched comparison group of eligible members that did not participate in ECM or Community Supports.

The UCLA-RAND Reentry Evaluation team will examine whether the Reentry Waiver led to a different pattern of health services utilization and associated payments. In other words, the analyses will not only provide estimates of the impact of the Reentry Waiver on use of each category of service or cost but will further demonstrate if there are reductions in acute care services or costs of such services as ED visits and hospitalizations were achieved.

Alternative Research Design Possibilities

The proposed Reentry evaluation design, especially for Goals 1,2, 6, and 7, depends heavily on establishing collaborations with the CDCR and four focal county correctional facilities to provide data on their populations, releases, inmate health status and service utilization. Thus, the UCLA-RAND Reentry Evaluation team may need to modify significantly the methods if securing the specific data sets is not possible. It is anticipated that the most difficult information to obtain will be automated health service utilization data from correctional facilities (that is not reimbursed by Medi-Cal) to help understand the 90-days before release. The UCLA-RAND Reentry Evaluation team might add a small chart review effort for 100 individuals for services received during the 90-day in-reach period before and after the Waiver implementation to understand how the Waiver impacts the 90-day period prior to release. However, a chart review will still require that the UCLA-RAND Evaluation team obtain specific data sets from correctional agencies. The UCLA-RAND Reentry Evaluation team may need to focus heavily on the Medi-Cal-reimbursed services that individuals receive and outcomes *before* and *after* release from prison or jail since that data will be automated and obtained through DHCS.

The UCLA-RAND Reentry Evaluation team might explore the use of contemporaneous comparison groups post-Waiver including those who refused to sign up for the Waiver or for those who received no Waiver services. However, this will require careful control for factors that may be correlated with the decision to enroll or receive services, and that a large enough sample refused to sign up for the Waiver or did not receive waiver

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

Reentry Evaluation Team and Budget

The evaluation contract period is from December 1, 2023, to May 31, 2029. The total budget for the Reentry evaluation component of the project is $2,903,678.39. A detailed project timeline is provided in Table 1 above.

The Reentry Evaluation Team is nested within the larger CalAIM Evaluation Team, led by Dr. Katherine L Kahn and Dr. David Zingmond. The Reentry Evaluation is one component of the larger CalAIM Evaluation.

[Lead Investigator is currently to be determined.]

Dr. Lois Davis, Co-Investigator of the UCLA-RAND Reentry Evaluation team, is a Senior Policy Researcher at RAND Corporation, who has spent over 35 years conducting public health research on justice-involved populations. She has extensive experience in both qualitative and quantitative analysis, program evaluation, and in-depth case studies with stakeholders involved in service provision, policymaking, and the administration of programs. Davis led the multi-year study on Understanding the Public Health Implications of Prisoner Reentry in California: State-of-the-State – a California Assembly Select Committee on Re-entry charged with implementing the study's recommendations for improving reentry and health care services for returning citizens. She currently is leading a three-year evaluation of California's prosecutor-initiated resentencing pilot program.

Dr. Samuel Mann, Associate Economist at RAND, serves as the economist on the UCLA-RAND Reentry Evaluation team. Prior to joining RAND, he was a postdoctoral researcher in the Department of Economics and LGBTQ+ Policy Lab at Vanderbilt University. He brings expertise in health services research, mental health, and quasi-experimental methods to this project. As an economist, he is proficient in the design and use of quasi-experimental methods and has extensive experience in using complex data to identify the causal effects of policies and programs on the outcomes of vulnerable populations.

Louis Mariano, Ph.D., is a Senior Statistician at the RAND Corporation. His research interests include experimental and quasi-experimental design methodology; evaluation of the efficacy of policy programs and reforms; statistical applications to mental

measurement; and labor and personnel policy. Dr. Mariano has served as Principal Investigator, co-PI, or lead statistician for over 50 evaluation projects in public policy, over 30 of which have used quasi-experimental design (QED) to draw causal conclusions of policy impact and efficacy. Dr. Mariano is currently leading the case-level statistical analyses of county-level criminal justice data and state-level prison data for RAND's evaluation of prosecutor-initiated resentencing in CA led by Dr. Davis. Dr. Mariano will consult on the evaluation design for the Justice-Involved Reentry Initiative including the sampling plan and cohort definitions, as well as development of the analytic plan. He will also consult on the analyses of Medicaid and utilization data with the full UCLA-RAND Reentry Evaluation team.

Dr. Nina Harawa, Professor with appointments with the David Geffen School of Medicine at UCLA, UCLA Fielding School of Public Health, and the College of Medicine at Charles R. Drew University of Medicine and Science, specializes in public health and health services epidemiologic and intervention research on HIV, STIs, substance use, and access to related health services. Much of her research has focused on sexual and gender minority populations and people with criminal justice involvement. As Director of the Policy Impact Core for the Center for HIV Identification, Prevention and Treatment Services (CHIPTS) at UCLA, Dr. Harawa leads efforts to help researchers inform decision makers about addressing the U.S. epidemics of HIV, STIs, and hepatitis C. Dr. Harawa will assist with the qualitative analysis proposed above.

RAND's Survey Research Group (SRG) was established in 1972 to provide RAND with an in-house capability for conducting primary data collection. SRG is composed of survey methodologists, behavioral scientists, and specialists in the technical aspects of survey research. These professionals share a common interest and expertise in applying state-of-the-art survey methods to interview, conduct focus groups, and survey special populations such as currently and formerly incarcerated adults and juveniles, welfare recipients, homeless individuals and other difficult to reach populations--the special challenges often encountered in public health and public safety research.

Beverly Weidmer, M.A., SRG Senior Survey Director, will lead the SRG's efforts on the Reentry evaluation. She has over 25 years of experience in both quantitative and qualitative research methods, including all aspects of survey design and management, instrument development, focus groups, cognitive interviews, and usability testing. She has expertise in translation, and in the design and testing of culturally appropriate survey instruments. She specializes in the design and implementation of complex field projects including multi-mode data collection, and surveying difficult to reach populations (immigrants, current and formerly incarcerated populations, low literate

populations, welfare recipients, the elderly, and children and adolescents). Ms. Weidmer has collaborated with Dr. Davis on a number of prisoner reentry studies. She recently collaborated with Drs. Davis and Turner on two national surveys to assess the impact of COVID on prison education programs.

Evaluation Design for the Managed Care Plans Transition

General Background Information

Objective

This Evaluation Plan details the ways in which the State will evaluate the transition to limited choice, county-authorized managed care programs. This transition is an amendment to the section 1115(a) CalAIM demonstration and is subject to the limitations of the demonstration as outlined in the special terms and conditions (STCs).[70] In specific, the STCs require proper monitoring and evaluation of the transition to ensure continuity of care for members, adequate capacity and services, and maintenance of choice in primary care providers.

Background

The California Advancing and Innovating Medi-Cal (CalAIM) 1115 Demonstration, approved by the Centers for Medicare and Medicaid Services (CMS) on December 29, 2021[71], leverages Medi-Cal as a tool to improve coverage and care for California's most vulnerable populations. The CalAIM Demonstration aims to enhance health care access and outcomes and promote health equity for Medi-Cal recipients and other low-income individuals across the state. Through the Demonstration and associated initiatives, including the 1915(b) waiver also approved by CMS on December 29, 2021, the state is strengthening a population health approach that prioritizes prevention and addresses the social determinants of health.

The December 2021 waiver approvals also shifted authority for the State's managed care delivery systems (Medi-Cal Managed Care, Dental Managed Care, Specialty Mental Health Services, and the Drug Medi-Cal Organized Delivery System) from the previous Section 1115 Demonstration to the CalAIM 1915(b) waiver. This transition was aimed at streamlining and aligning the programs, improving oversight, and standardizing benefits and enrollment processes within Medi-Cal.

[70] MCP Transition STCs: https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-ManagedCare-Amendment-Approved.pdf
[71] CMS Extension Approval: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-calaim-ext-appvl-12292021.pdf

Managed Care Plan (MCP) Transition Amendment

California's Medi-Cal Managed Care delivery system comprises several managed care models that differ by county. Prior to the amendment implementation, all 58 counties in California offered one of the following models:

- **County Organized Health System (COHS)** -- one plan operated by the county;
- **Two Plan** -- one local initiative plan operated by the county and one commercial plan;
- **Multiple commercial plans** -- Geographic Managed Care, Regional, or Imperial models; or
- **San Benito Model** -- one commercial plan and a Fee-for-Service option.

In advance of the State's commercial plan procurement process in 2022, counties were given the chance to propose changes to their managed care models, and the California Department of Health Care Services (DHCS) provisionally approved model modifications in 17 counties; of these counties,15 sought to transition to a managed care model with a single plan per county, either by expanding an existing COHS model or by creating a new "Single Plan" model (plans that a MCP operates under contract with DHCS, with the authorization and sponsorship of a county or local authority).[72] DHCS conditionally approved these county model changes in October, and by December 2021 the involved counties submitted network contracting strategies for operationalization, which were further defined and established between Spring 2022 and December 2023.[73]

On November 4, 2022, DHCS requested an amendment to the CalAIM Section 1115 Demonstration to include expenditure authority to limit choice of managed care plans in Metro, Large Metro, and Urban counties operating under the COHS and Single Plan Models. This limit to model choices was intended to simplify and align managed care programs, standardize benefits and enrollment processes, and strengthen oversight of these programs throughout the state. CMS approved the amendment request on August 23, 2023. Through a separate submission, DHCS also received an amendment to the CalAIM 1915(b) waiver to reflect use of the rural area exemption for plan choice in rural counties with existing and/or expanding COHS, and rural counties intending to operate a Single Plan. Collectively, the primary aim of these amendments is to reduce

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

administrative complexity for providers, plans, and members, while streamlining State oversight and improving accountability of plans.

Exhibit 1 shows the change in models by county. Not all Medi-Cal members in these counties transitioned to a new MCP, but close to 1.2 million members have been involved in the transition in 2024. Members transitioning to a new MCP received a 90-day notice from their exiting MCP, 60-day and 30-day notices from DHCS's enrollment broker, and a welcome packet from their receiving MCP in January 2024.

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

Exhibit 1. 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	Anthem Blue Cross Partnership Plan	Contra Costa Health Plan

County ***County Plan Model Type***	**2023 MCP(s)**	**2024 MCP(s)**
Two-Plan model (2023) Single Plan model (2024)	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 Regional model (2023) County-Organized Health System model (2024)	Anthem Blue Cross Partnership Plan	Central California Alliance For Health
	California Health & Wellness	Kaiser Permanente
Nevada Regional model (2023) County-Organized Health System model (2024)	Anthem Blue Cross Partnership Plan	Partnership Health Plan of California
	California Health & Wellness	
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	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	
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 Regional model (2023) County-Organized Health System model (2024)	Anthem Blue Cross Partnership Plan	Partnership Health Plan of California
	California Health & Wellness	Kaiser Permanente
Tehama Regional model (2023) County-Organized Health System model (2024)	Anthem Blue Cross Partnership Plan	Partnership Health Plan of California
	California Health & Wellness	
Yuba Regional model (2023) County-Organized Health System model (2024)	Anthem Blue Cross Partnership Plan	Partnership Health Plan of California
	California Health & Wellness	Kaiser Permanente

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

Also, effective January 1, 2024, DHCS entered a direct contract with Kaiser Permanente (Kaiser) as a Medi-Cal MCP for a five-year contract term. For eligible Medi-Cal members in transition counties in which Kaiser will operate in 2024, Kaiser will be included as a MCP option. In effect, Kaiser will operate in parallel with the single plan or COHS county systems but will not be permitted to enroll new members in these counties unless a member or their family has a history of enrollment with Kaiser. Default member assignment to Kaiser in COHS and Single Plan counties will be limited to plan/family linkage. Beginning in 2026, an Auto-Assignment Incentive Program using quality measures will take effect. Under this program, Kaiser will be auto-assigned enrollees to meet its annual enrollment growth target.[74]

Evaluation Questions and Hypotheses

Implementing expanded COHS and new Single Plan models in select Metro, Large Metro, and Urban counties is consistent with the goals of CalAIM, which include improving quality, access, and accountability. Key drivers in support of this aim are described in **Exhibit 2.** **Exhibit 2. Driver Diagram for the MCP Transition**

Exhibit 2. 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

[74] Department Of Health Care Services, "Auto Assignment Incentive Program Technical Assistance Guide: Program Year 20 CY25" – January 2025.

Aim	Primary Driver	Secondary Driver
		Allow the member to keep their current PCP
		Automatically enroll dual-eligible members in Medi-Cal Matching Plan counties in a Medi-Cal MCP that matches their Medicare Advantage plan
		Allow transitioning members to keep their out-of-network providers for a 12-month period at their Receiving MCP
		Provide clear communications around the transition (e.g. choice packet sent to members with 60-notice, Welcome Packet from new MCP sent in early January 2023
	Maintain or improve quality of care	Ensure a whole-person, interdisciplinary approach for populations with complex health care needs
		Report on and regularly monitor quality of care measures during the transition period
		Strengthen and maintain quality of care for vulnerable populations
	Ensure accountability of MCPs' transition responsibilities	Establish—and provide additional support for existing—Community Advisory Committees
		Provide opportunities to file grievances and appeals, and ensure the State responds within a reasonable period
		Provide transparent information to managed care members by publicly posting MCP and subcontractors' activities (e.g. Population Needs Assessment, CAHPS survey results)
		Expand DHCS oversight responsibilities, including an independent access assessment for network adequacy

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

The evaluation will assess the overall impact of the MCP Transition by analyzing trends prior to and after the implementation of the amendment (i.e., 2021-2023 and 2024-2026). We will also contextualize these changes against the backdrop of the existing CalAIM Demonstration initiatives and other statewide care transformation efforts affecting the managed care model in California overall. **Exhibit 3 Exhibit 3. Summary of MCP Transition Evaluation Design**provides an overview of the high-level evaluation hypotheses and research questions.

Exhibit 3. Summary of MCP Transition Evaluation Design

Research Question	Measures	Population(s)	Data Source(s)	Analytic Methods
Hypothesis 1: The MCP Transition will maintain or improve overall access to and continuity of care.				
1A. How many Medi-Cal members were in the 15 MCP Transition counties? How many Med-Cal members switched plans under the MCP Transition?	» 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[75]	Descriptive analyses
1B. What were the characteristics of Medi-Cal members in MCP Transition counties?	» Sociodemographic characteristics of members in MCP Transition counties	Members in MCP Transition counties	» Enrollment data	Descriptive analyses, pre- post analyses
1C. What was the effect of the Demonstration on access to care?	» Network adequacy (i.e., Provider-to-member ratios; Active providers) » 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
1D. To what extent did access to preventive/ ambulatory health services change under the MCP Transition?	» Adults' access to preventative/ambulatory health services » Well-child visits » Immunizations for adolescents » Timeliness of prenatal and postpartum care	Members in MCP Transition counties	» Medi-Cal claims/encounter data; MCAS data	Descriptive analyses; pre-post analyses *(Paired t-tests; chi-squared tests*)
1E. To what extent did access to behavioral health services change under the Demonstration?	» Follow up after ED visit for mental illness » Follow up after hospitalization for mental illness » Outpatient mental health provider-to-member ratio » Psychiatric provider-to-member ratio	Members in MCP Transition counties	» Medi-Cal claims/encounter data; 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*)
1F. What was the effect of the Demonstration on continuity of care?	» Continuity of care grievances	MCP Transition counties	» DHCS grievance records » Interviews with members	Pre-post analyses *(Paired t-tests; chi-squared tests);* thematic analysis of interviews

[75] NORC will work with DHCS to assess the feasibility of using MCAS rate sheets to construct evaluation measures. For each metric, NORC and DHCS will determine whether the MIS/DSS data or the MCAS data are a more appropriate source.

Research Question	Measures	Population(s)	Data Source(s)	Analytic Methods
Hypothesis 2: The MCP Transition will maintain or improve quality of care.				
2A. What was the impact of the Demonstration on quality of care?	» Colorectal cancer screening » Breast cancer screening » Immunizations for adolescents » Plan all-cause readmissions » PQI #90 Prevention Quality Overall Composite	Members in MCP Transition counties	» Medi-Cal claims/encounter data; MCAS data » Interviews with members	Difference-in-Differences or Comparative Interrupted Time Series; thematic analysis of interviews
Hypothesis 3: The MCP Transition will maintain or improve access to high-quality, continuous care.				
3A. To what extent were historically marginalized and under-resourced populations, who were members living in MCP Transition counties, affected by the transition?	» Sociodemographic characteristics of members in MCP Transition counties	Members in MCP Transition counties by equity relevant sub-populations^	» Enrollment data	Directed content analysis of secondary data; Descriptive analyses; Pre-post analyses
3B. What was the effect of the Demonstration on access to care in historically marginalized and under-resourced populations?	» Network adequacy(e.g. Provider-to-member ratio; Active providers) » 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
3C. To what extent did access to preventive/ ambulatory health services change under the Demonstration among historically marginalized and under-resourced populations?	» Adults' access to preventative/ambulatory health services » Well-child visits » Immunizations for adolescents » Timeliness of prenatal and postpartum care	Members in MCP Transition counties by equity relevant sub-populations^	» Medi-Cal claims/encounter data; MCAS data	Descriptive analyses; Pre-post analyses *(Paired t-tests; chi-squared tests*)
3D. To what extent did access to behavioral health services change under the Demonstration among historically marginalized and under-resourced populations?	» Follow up after ED visit for mental illness » Follow up after hospitalization for mental illness	Members in MCP Transition counties by equity relevant sub-populations^	» Medi-Cal claims/encounter data ; MCAS data	Pre-post analyses *(Paired t-tests; chi-squared tests*)
3E. What was the effect of the	» Continuity of care grievances	Members in MCP Transition counties	» DHCS grievance records	Pre-post analyses *(paired t-tests; chi-*

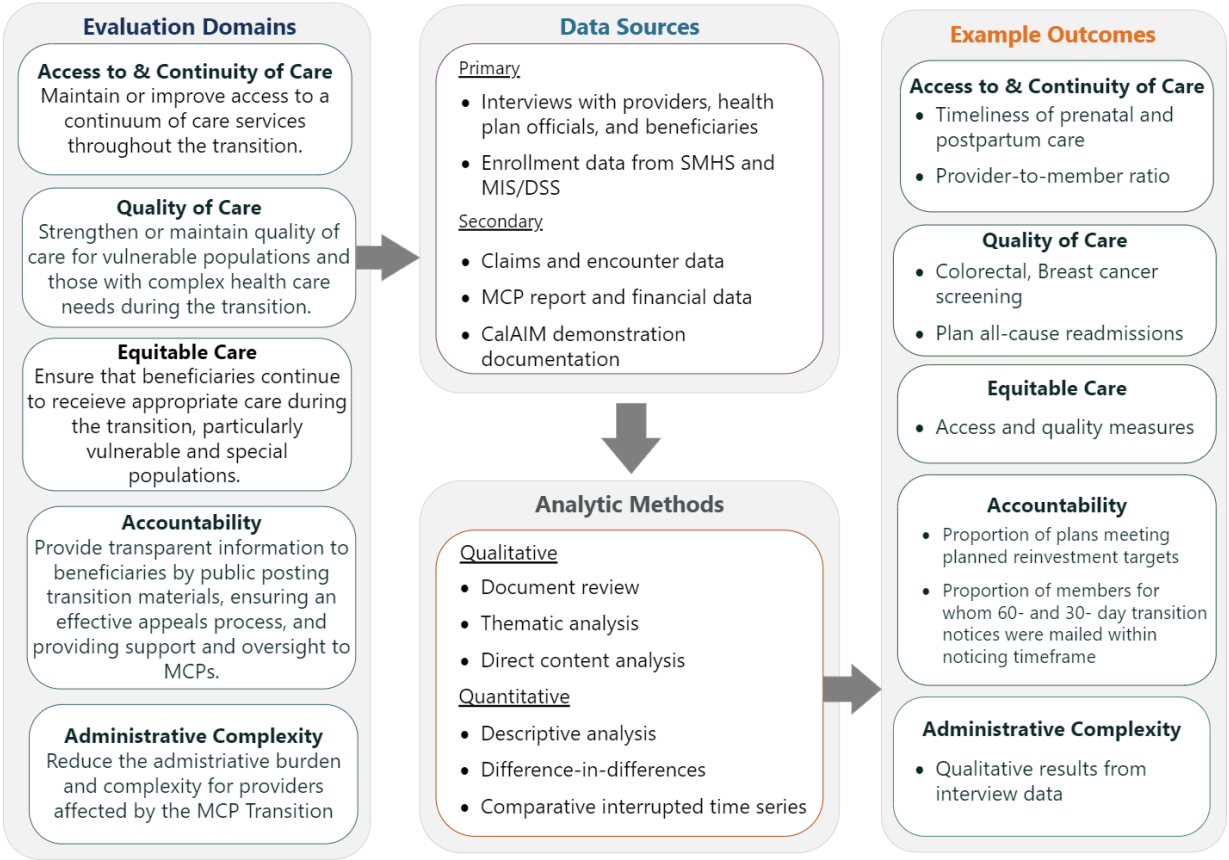
Research Question	Measures	Population(s)	Data Source(s)	Analytic Methods
Demonstration continuity of care among historically marginalized and under-resourced populations?		by equity relevant sub-populations^	» Interviews with members	*squared tests);* Thematic analysis of interviews
3F. What was the effect of the Demonstration on quality of care outcomes for members among historically marginalized and under-resourced populations?	» Colorectal cancer screening » Breast cancer screening » Immunizations for adolescents » Plan all-cause readmissions	Members in MCP Transition counties by equity relevant sub-populations^	» Medi-Cal claims/encounter data; MCAS data	Difference-in-Differences or Comparative Interrupted Time Series
Hypothesis 4: The MCP Transition will reduce administrative complexity for plans.				
4A. To what extent did the MCP Transition impact plan administrative workflows, and how?	» Qualitative data-plan perspectives	Plans in MCP Transition Counties	» Interviews with health plan officials	Thematic analysis of interviews
Hypothesis 5: Plans will maintain accountability and improve transparency under the MCP Transition by adhering to transition requirements.				
5A. To what extent did plans establish and execute their Community Reinvestment Plans, and how?	» Proportion of plans meeting planned reinvestment targets (as defined in Community Reinvestment Plans)^^ » Qualitative data—plan and stakeholder perspectives	Plans in MCP Transition Counties	» Document review of Community Reinvestment Plans, MCP Annual Reports, financial information^^ » Interviews with health plan officials » Focus groups with DHCS Member Stakeholder Committee	Directed content analysis of secondary data, thematic analysis of interviews
5B. To what extent did plans publish required performance and operations documentation as required?	» Proportion of plans developing and making publicly available programmatic and financial documentation (i.e., Community Reinvestment Plans, Population Needs Assessments, MCP Annual Reports, etc.) within required timeframes	MCP Transition Counties	» Websites for plans in MCP transition counties	Web scan with directed content analysis

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

Methodology

This evaluation will employ both quantitative and qualitative methods to assess overall impact of the MCP Transition on members, plans, and providers. The proposed approach reflects the aims that DHCS has identified as priorities for this evaluation, which in turn will guide the framing of hypotheses, data sources, measures, analytic approaches, and findings. The evaluation will use both primary and secondary data. Qualitative analysis will be used to describe the core components and status of transition activities in each county, as well as the experiences of directly affected parties (i.e., members, plan officials, and other interest holders) and their perceptions of the transition's impact on care continuity and access. Quantitative analysis will be used to better understand trends in selected process and outcome measures before and after the transition. **Exhibit 4. Overall Approach to the Evaluation of the MCP Transition**provides a visual overview of the evaluation design.

Exhibit 4. Overall Approach to the Evaluation of the MCP Transition



Evaluation Period

The evaluation period will cover the implementation of the MCP Transition on January 1, 2024, through the end of the amendment approval on December 31st, 2026. Our quantitative impact analysis will use data from 2021-2023 as a baseline period and 2024-2026 as the implementation period. In the Interim Evaluation Report, our quantitative analyses will include all complete claims/encounter data available up to the time of analysis allowing for six months of claims/encounter data runout, and in the Summative Evaluation Report, we will be able to evaluate the entire post-implementation period.

Quantitative Evaluation

The below sections detail our approach to evaluating the MCP Transition, including identification of target and comparison populations, data sources, outcome measures, and statistical analyses.

Target Population: Medi-Cal members in MCP Transition counties. The target population will be all Medi-Cal members enrolled for at least one year residing in the 15 MCP Transition counties (Alameda, Butte, Colusa, Contra Costa, Glenn, Imperial, Mariposa, Nevada, Placer, Plumas, San Benito, Sierra, Sutter, Tehama, and Yuba) over the course of 2021-2026, the baseline and implementation period.[76] Medi-Cal members in these counties who have been enrolled one year or more are included in the target population to assess whether the county-level MCP Transition affected access and quality outcomes for all members in the county (including members whose individual coverage did not change under the MCP Transition). As discussed in more detail below, we will assess the differential effects on members whose coverage changed under the MCP Transition and those whose coverage did not change, if sufficient data permit.

Comparison Population: The Medi-Cal members residing in non-MCP Transition counties that were *eligible to request to participate in the MCP transition but did not make that request* will serve as the pool for selecting a comparison group. Using a propensity score or coarsened exact matching method, we will identify comparison counties based on their similarity to MCP transition counties on key county-level characteristics (e.g. availability of services, county governance structure and delivery system characteristics), working closely with the state to determine the full list of characteristics.

[76] DHCS (December 2023) "Medi-Cal Managed Care Plans By County (As Of 2023 And 2024)" https://www.dhcs.ca.gov/CalAIM/Documents/MCP-County-Table-2023-2024.pdf

Addressing selection bias. Because the MCP transition was implemented non-randomly (i.e., counties requested to implement the MCP transition), there may be systematic differences between Medi-Cal members in the treatment and comparison counties. To obtain unbiased estimates of impacts, we propose addressing selection bias using entropy balancing (EB). Unlike other matching or weighting methods such as propensity scores, ensuring a balance between groups on key covariates is the primary objective of EB[77]. Additionally, unlike matching methods, EB uses all available comparison observations, which retains as much information as possible. The EB models will include member-level demographics and coverage characteristics, member-level clinical characteristics, and area-level community and healthcare delivery system characteristics, which will ensure that the treatment and comparison groups are similar on these key factors.

We will work closely with the state to determine the full set of EB covariates. We anticipate incorporating the following covariate domains in our EB models:

- **Member-level demographics and coverage characteristics**: e.g., age, sex, race/ethnicity, dual eligibility status, type of Medicaid coverage, and months of enrollment in Medicaid.
- **Area-level community characteristics**: e.g., educational attainment, provider density, unemployment rate, and area deprivation index (ADI).

After producing EB weights, we will assess the balance of each covariate by measuring the standardized difference between the treatment and comparison groups. We will consider a characteristic to be adequately balanced if the standardized difference between the groups is within (-0.1, 0.1) and will document this with covariate balance plots. In the event that a suitable comparison group cannot be identified (i.e. balance cannot be achieved on key characteristics), we will select statistical analyses that do not require a comparison group.

Quantitative Data Sources

We will use quantitative data sources to construct evaluation measures assessing access to and quality of care, continuity of care, and equity outcomes in each treatment and comparison county. We propose to use member-level Medi-Cal enrollment and claims/encounter data as well as publicly available community-level data to conduct our analyses. These data sources are summarized in **Exhibit 5.**

[77] Hainmeuller J. (2012). Entropy balancing for causal effects: A multivariate reweighting method to produce balanced samples in observational studies. *Political Analysis* 25(1)1:25-46.

Exhibit 5. Quantitative Data Sources for the MCP Transition Evaluation

Data Source	Proposed Use
Data Provided by DHCS	
Medi-Cal Enrollment Data	Medi-Cal enrollment data contain member-level demographic and coverage information. We will use the enrollment data to identify Medi-Cal members in treatment and comparison groups, and construct member-level covariates that reflect members' demographic and coverage characteristics.
Medi-Cal Claims/Encounter Data	Medi-Cal claims/encounter data contain information on dates of service, services received, and diagnosis and procedure codes for services received by Med-Cal members. We will use the claims/encounter data to construct outcomes on access to, quality, and continuity of care for each member.
Medi-Cal Managed Care Accountability Set (MCAS) including core set rate sheets	Person-level MCAS/Core Set files may be used to analyze trends on MCAS metrics pertaining to access, quality and continuity of care.
MCP Grievances Data	Grievance data contains member level information on grievances from the MCP. Grievances are summarized with the grievance type (e.g., access to care, provider availability), grievance category, benefit type and resolution date and status. We will use the grievance data to assess access to care and continuity of care.
Community-Level Data	
American Community Survey (ACS)	The ACS is a national survey providing area-level data on topics such as demographics, education, employment, income, and housing. We will use ACS data to identify county-level sociodemographic characteristics of counties

Data Source	Proposed Use
	as a basis for selecting comparison counties, conducting entropy balancing, and adjusting regression models.
Area Deprivation Index (ADI), Healthy Places Index (HPI), or similar data measuring community health and resilience	The ADI and HPI are examples of tools that assess a community's characteristics impacting health, , and well-being. The ADI identifies a community's social disadvantage based on factors such as income, education, employment, and housing quality. The HPI assesses social conditions that impact health, such as access to clean air and water, education, and job opportunities. We will work with DHCS to determine the appropriate data source for measuring community health and resiliency, and use this data at the county-level in entropy balancing models and adjusted regression models to control for an individual's environmental characteristics affecting access and equity of care.
Rural-Urban Continuum Codes (RUCCs)^	RUCCs are used to categorize rurality based on a county's level of urbanization and proximity to metropolitan areas. We will use RUCC data to select comparison counties, conduct entropy balancing, and adjust regression models.
COVID-19 Pandemic Vulnerability Index (PVI)	The PVI is a tool that integrates multiple data sources into an overall county-level score derived from key indicators in four domains: current infection rates, baseline population concentration, current interventions, and health and environmental vulnerabilities. The last full year of available data is calendar year 2022—we plan to use this index to adjust for baseline variation in COVID-19 vulnerability scores.

NOTE: ^There are many rural classification systems; NORC will work with DHCS to select the most appropriate definitions and data sources for defining and adjusting for rurality.

Claims-Based Evaluation Measures

The quantitative evaluation measures that will be constructed from DHCS enrollment and claims/encounter data, MCAS data including the person-level MCAS/Core Set files, and provider 274 files are summarized in **Exhibit 6. Quantitative Measures for MCP Transition Evaluation** Measures cover the domains of access to care, behavioral, maternal, and preventive healthcare and are based on CMS Core Set and or NCQA/HEDIS technical specifications. Before inclusion in the IER and/or SER, NORC will work with DHCS to conduct a thorough feasibility assessment for each metric based on data quality, timeliness, and availability. To maximize evaluation resources, we will leverage existing metrics being reported by the state (e.g. MCAS metrics) wherever possible.

Exhibit 6. Quantitative Measures for MCP Transition Evaluation

Measure Name	Description	Numerator	Denominator
Adults' access to preventive / ambulatory health services	The percentage of members 20 years and older who had an ambulatory or preventive care visit.	Number of members in the eligible population with one or more ambulatory or preventive care visits during the measurement year.	Number of members in the eligible population
Child and adolescent well-care visits	Percentage of children ages 3 to 21 who had at least one comprehensive well-care visit with a primary care practitioner (PCP) or an obstetrician/gynecologist (OB/GYN) during the measurement year	Number of members in the eligible population with one or more well-care visits during the measurement year	Number of members in the eligible population
Follow-up after ED visit for mental illness	Percentage of emergency department (ED) visits for members ages 18 and older with a principal diagnosis of mental	Number of eligible follow-up visits within 7 or 30 days of the eligible ED visit including visits	Number of eligible ED visits with a principal diagnosis of mental illness or

Measure Name	Description	Numerator	Denominator
	illness or intentional self-harm and who had a follow-up visit for mental illness within 7/30 days.	that occur on the date of the ED visit	intentional self-harm
Plan all-cause readmissions	For members ages 18 to 64, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.	Number of observed 30-day readmissions	Number of index hospital stays in the eligible population
Well-child visits in the first 30 months of life	Percentage of children who had the appropriate number of well-child visits with a primary care practitioner (PCP) during the last 15 months. Separate rates are reported for children who turned ages 15 and 30 months within the measurement year.	The number children in the eligible population with the appropriate number of well-child visits on different dates of service on or before the 15/30 month birthday.	Number of members in the eligible population
Follow up after hospitalization for mental illness	Percentage of discharges for members ages 18 and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider within 7/30 days.	Number of discharges in the denominator with a follow-up visit with a mental health provider within 7/30 days after discharge.	Number of eligible discharges in the eligible population

Measure Name	Description	Numerator	Denominator
Immunizations for adolescents	Percentage of adolescents aged 13 who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates.	Number of patients in the eligible population that are vaccine compliant	Number of members in the eligible population
Prenatal and postpartum care	• Timeliness of Prenatal Care: Percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment state date or within 42 days of enrollment. • Postpartum Care: Percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery	Prenatal care: A prenatal visit during the required time frame. Postpartum care: A postpartum visit on or between 7 and 84 days after delivery.	Members within the eligible population with a live birth. Members can count multiple times if they have multiple births.
Colorectal cancer screening	Percentage of members ages 45 to 75 who had appropriate screening for colorectal cancer.	Number of members from the denominator that had one or more screenings for colorectal cancer.	Number of members in the eligible population

Measure Name	Description	Numerator	Denominator
Breast cancer screening	Percentage of women ages 50 to 74 who had a mammogram to screen for breast cancer.	Number of members in the eligible population who had one or more mammograms any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year.	Number of members in the eligible population
Outpatient mental health provider-to-member ratio	Number of outpatient mental health (non-psychiatry) providers per beneficiary (shown as # members to 1 provider)	Number of beneficiaries enrolled in plan (have a Short Doyle claim in measurement year)	Number of outpatient mental health (non-psychiatry) providers contracting with plan.
Psychiatric provider-to-member ratio	Number of psychiatric providers per beneficiary (shown as # members to 1 provider)	Number of beneficiaries enrolled in plan (have a Short Doyle claim in measurement year)	Number of psychiatric providers contracting with plan
PQI #90 Prevention Quality Overall Composite	Overall Quality Composite per 100,000 beneficiaries, ages 18 years and older.	Discharges for beneficiaries ages 18 year and older meeting the inclusion/exclusion rules for PQIs related to diabetes, COPD, hypertension, heart	Beneficiaries ages 18 years and older.

Measure Name	Description	Numerator	Denominator
		failure, dehydration, bacterial pneumonia, urinary tract infection, asthma, and angina.	
Provider to member ratio	The ratio of members to active providers.	Number of members	Number of active providers

NOTE: *Measures constructed from enrollment and claims/encounter data; all measures listed except the provider member ratio are endorsed by the National Committee for Quality Assurance (NCQA).*

Statistical Analyses

We will conduct quantitative descriptive and impact analyses for evaluating the MCP Transition, based on data availability and feasibility of assessing outcomes in groups over time, described in more detail below. Before starting analyses, we will conduct evaluability assessments to ensure we are selecting the most appropriate approach for each analysis, that key assumptions are met, and that we have sufficient sample size to estimate impacts.

Descriptive Analyses. Descriptive statistics, including frequency distributions and rates over time, will be calculated to highlight trends over time in member-level characteristics and key outcomes. We will tabulate descriptive statistics in each year (time-series analyses) and pooled in baseline and treatment periods (pre-post analyses) to assess changes over time in the baseline years (January 2021 – December 2023) and years after the MCP Transition (January 2024 – December 2026). We will conduct descriptive analyses for both member-level characteristics, to show changes in member populations over time before and after the MCP transition, as well as for all outcome measures (**Exhibit 6**). We will present the descriptive analyses in tables and exhibits in the Interim Evaluation Report and Summative Evaluation Report.

Pre-Post Analysis. We will use pre-post analyses to report statistically significant changes in outcome measures before and after the transition. These analyses will also inform the development of impact analyses below.

Impact Analysis. If a suitable comparison group is available, we propose using difference-in-differences (DID) or comparative interrupted time series (CITS) analysis as

our primary approach to estimate the impact on access, quality, and continuity of care under the MCP transition.[78] The DID models will compare the changes in means during the baseline (2021-2023) and post-MCP Transition (2024-2026) periods between the treatment and comparison counties, controlling for any time-invariant differences between the groups to estimate the impact of the MCP transition.

The DID model will be specified as:

$$g[E(Y_{itc})] = \beta_0 + \beta_1 MCP_i + \beta_2 Post_t + \beta_3 MCP_i * Post_t + \gamma Member_{itc} + \delta County_{itc} + \rho County * Year_c$$

In this model, *i* indexes an individual member and *t* indexes the time period (baseline or post-MCP transition), and *c* indexes county. *Y* represents the outcome of interest, for an individual, *MCP* is an indicator for treatment or comparison group, and *Post* is an indicator for time period (post-MCP transition). Member-level covariates are included in the model for risk adjustment. To control for time-invariant differences across counties, we will include fixed effects for each county and county-specific time trend.[79] Analyses will be conducted on data pooled across all MCP transition and comparison counties, allowing us to estimate one estimate of impact for the MCP transition overall (i.e., no county-level impacts will be estimated). An additional analysis will compare the counties in which Kaiser has a direct contract with the state to their matched control county. We will compare results with that of the main analysis to determine whether there are meaningful differences.

A key assumption of the DID model is that baseline trends between the treatment and comparison groups are parallel, meaning that any differences in outcomes between the two groups remain constant over time in the absence of the MCP transition. If we empirically observe that this assumption is violated (i.e., that baseline trends between the groups are not parallel), we will be unable to produce unbiased estimates of impact using a DID model. Instead, in these cases we propose assessing the feasibility of using a CITS model; this model is more flexible than the DID model in that it does not require baseline trends to be parallel between the two groups (i.e., it allows for changes in both the level and the rate of change of the outcome in the treatment group relative to the comparison group).

[78] If constructing a suitable comparison group is not feasible, we will instead include pre-post analyses and time-series analyses without a comparison group.

[79] If these fixed effects result in multicollinearity, we will instead control for a set of area-level characteristics.

Covariate Adjustment. We will account for key covariates that affect the relative risks of the study measures through covariate adjustment. We will adjust for member-level covariates such as sex, age, race and ethnicity, and chronic conditions. Potential area-level covariates include socioeconomic characteristics (e.g., median income, education) derived from publicly available datasets like the American Community Survey, the Area Deprivation Index, the Healthy Places Index, and the Rural-Urban Continuum Code data. Finally, to account for potential differential effects of the COVID-19 Public Health Emergency, we will adjust for area-level COVID-related variables, such as Pandemic Vulnerability Index.

Because beneficiary- and market-level characteristics are largely time-invariant, we propose that these covariates be measured at baseline. Because area-level COVID data is not available after the end of the Public Health Emergency in May 2023, COVID-related covariates would also be measured at baseline and included as time-invariant. For all models, we will consider interactions and higher-order terms.

Subgroup Analysis. Recognizing that the impact of the MCP Transition may be heterogeneous across different member populations, we will carry out subgroup analyses to evaluate whether and how program impacts vary. As with the overall analyses, we will conduct evaluability assessments and confirm that all relevant assumptions (e.g., sample size) are met for any proposed statistical analyses within subgroups of interest. We will assess conducting subgroup analysis for both descriptive and impact analyses. We anticipate being able to conduct descriptive analyses for most if not all subgroups; the feasibility of conducting impact analyses for subgroups will be determined empirically based on sample size and outcome distributions.

We will first consider analyses within subgroups defined by member characteristics (e.g., member age, sex, race/ethnicity, preferred language), including all relevant subpopulations (as described previously). We will also explore other subgroups as observed in eligibility (e.g., Medicaid-only, dual) and claims/encounter data (e.g., chronic conditions, substance use disorders, and behavioral health diagnoses) or by belonging to under-resourced communities (defined by deprivation indices such as ADI or HPI). We will also explore subgroups of members who transitioned out of their previous MCPs as compared to members retained by their incumbent plan in the county. Finally, because the MCP Transition in Metro, Large Metro, and Urban counties fall under different waiver authorities than in Rural counties, we will assess whether there were differential outcomes for these two subgroups.

Qualitative Evaluation

In addition to the quantitative assessments described above, we propose collecting and analyzing qualitative data via 1) document review of transition-related documentation and 2) key informant interviews with health plan officials, Community Advisory Committee members, and providers and members in transitioning counties. Collectively, these data will provide a richer understanding of the depth and breadth of transition activities at ground level, as well as how various key groups (implementation partners, providers, and members) experienced the transition and their perspective on changes and impacts they have observed.

Primary data collection and document review will focus primarily on the waiver implementation period. Interviews may include discussion of pre-implementation activities and differences in member experience of care before and after the transition, and document review will similarly consider descriptions of the plan and service landscape before and after the transition occurred. These retrospective, largely open-ended data will enable us to understand waiver implementation and impacts, and can help understand the "pre" and "post" period but should not be considered a true "pre"/"post" assessment as we are not able to systematically gather qualitative data before the transition occurred.

Qualitative Data Sources and Data Collection

Document Review

To better understand the components, context and status of the transition in each participating county, we will review select transition-related documentation generated by MCPs, the State, and other relevant groups including but not limited to Demonstration quarterly reports, and documents that must be developed and made public by each transitioning plan (i.e., Community Investment Plans and related annual reports, Population Needs Assessments, CAHPS survey results, financial information, such as profits and reserves, and third party Memoranda of Understanding (MOUs)[80]). We will prioritize for review documents for which we have comparable data for all transitioning counties. Publicly available data will be collected via web scan and analyzed on an annual basis; additional, non-public documentation will be collected and analyzed on an ongoing basis as it is made available.

[80] 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.

Primary Data Collection

We aim to conduct semi-structured interviews and focus groups with individuals from key groups directly involved in and/or affected by the MCP Transition process in a sample of counties participating. These interviews will provide critical perspective of how the transition was understood and experienced by the individuals who stand to be affected by it (i.e., MCP officials, providers, and members) as well as those advising on its rollout (i.e., DHCS Stakeholder Committee).

Participants and Data Collection Approach

Members: We propose conducting 30-45-minute 1:1 virtual interviews with 2-3 adult (i.e., 18 years or older) members in each MCP Transition county, for a total of up to 45 interviews. Interviews will be conducted in English and Spanish. Participants will be compensated with a gift card incentive (for non-resalable goods or services) in recognition of their time.

- ***Timing:*** Year One (2025), to limit recall bias about the transition.
- ***Sampling:*** We will consider two options for identifying participants, pending availability and quality of contact information in MIS/DSS data.
    - If contact information is available in MIS/DSS, we will draw a random sample of adult members who experienced a transition of plans from each of the 15 counties.
    - If contact information is NOT available in secondary data, we will work with DHCS and the DHCS Stakeholder Committee group and county-specific Community Advisory Committees to identify a convenience sample of adult members from each of the 15 counties.
- ***Recruitment:*** Our recruitment approach will be largely determined based on the type and quality of contact information available; we will work with DHCS to identify the optimal approach (e.g., U.S.-mailed postcard, phone, email) once data availability and quality are determined. Recruitment materials will be translated into and made available in Spanish.
- ***Topics:*** How and when they were notified of the transition and their plan options; barriers/challenges and facilitating factors they encountered during the transition; and any perceived changes or interruptions in care access, quality and continuity

Health plan officials: We propose to conduct 60-minute group interviews with health plan officials from each MCP transition county, for a total of up to 17 group interviews.

- ***Timing:*** Years One and Two, to assess planned and actual transition-related activities and the degree to which activities aligned with plan- and Demonstration-specific objectives regarding care access and continuity.
- ***Sampling:*** Purposeful sample of health plan officials within counties, with a focus on health plan leadership and other key roles associated with the transition.
- ***Recruitment Approach:*** Recruitment via email and/or phone, after securely gathering contact information from DHCS.
- ***Topics:*** Plan's outreach and enrollment strategies; investments in primary care and prevention; efforts to improve the integration of behavioral health care services; Community Reinvestment Plans; and engagement with Community Advisory Committees.

DHCS Stakeholder Advisory Committee Members: NORC will conduct a 90-minute virtual focus group with DHCS Stakeholder Advisory Committee members at two time points (two sessions, up to eight individuals at each session for a total of 16 participants). Participants will be compensated with a gift card incentive (for non-resalable goods or services) in recognition of their time.

- ***Timing:*** Year One and again in Year Three, to assess planned and actual transition-related activities and the degree to which activities aligned with plan- and Demonstration-specific objectives regarding care access and continuity.
- ***Sampling:*** Convenience sample of individuals serving on DHCS Stakeholder Advisory Committee, identified in consultation with DHCS and prioritizing those with active/substantial engagement in transition-focused Committee feedback gathering prior.
- ***Recruitment Approach:*** Recruitment via email and/or phone, after securely gathering contact information from DHCS.
- ***Topics:*** Community awareness/experience of transition, and changes or interruptions in care received and service offerings; implementation and impacts of Community Reinvestment Plans.

Qualitative Analyses

Directed Content Analysis of Secondary Data

Using both a programmatic and direct content analytic approach to document review, we will review, code, and construct measures from plan and DHCS-developed documentation related to the transition, including MCP Annual Reports, Population Needs Assessments, Community Reinvestment Plans, and MOUs. Data will be descriptively analyzed and maintained in a county-level dataset. Where relevant, measures will be linked to interview and focus group data to examine the transition experience of different county subgroups.

Thematic Analysis of Interviews and Focus Groups

We will analyze member, provider, plan and DHCS Stakeholder Advisory Committee interviews using a thematic analytic approach. To this end, we will deductively develop a codebook in alignment with evaluation framework domains and qualitative-driven hypotheses, and inductively refine it based on emergent themes and concurrent findings arising from the document review. To organize program documents and interview transcripts for coding, we will use Dedoose, a cloud-based analytic software. Before coders analyze study data, they will be trained and will complete several rounds of pilot coding exercises to establish robust inter-rater reliability. Whenever possible, coders will have been involved in interview data collection, to leverage their insights gained through first-hand experience.

Methodological Limitations

Evaluations of 1115 demonstrations necessitate a flexible and adaptive approach, and we anticipate that methodological challenges will arise during the evaluation process. **Exhibit 7. Anticipated Methodological Challenges and Proposed Mitigation Approaches**outlines the anticipated challenges along with proposed mitigation strategies.

Exhibit 7. Anticipated Methodological Challenges and Proposed Mitigation Approaches

Challenge	Mitigation Approach
Timeliness and quality of claims/encounter data	» Work closely with DHCS data stewards to receive the most recent data, identify appropriate timeframes for claims run out, and quickly address any data quality issues.

Challenge	Mitigation Approach
	» Create automated reports that identify potential quality issues (e.g., missingness, disallowed values) in data elements used in evaluation analyses, which will be conducted immediately upon receipt of data from DHCS.
Constructing a valid comparison group	» Select comparison counties based on eligibility for the MCP transition as well as key county-level characteristics (e.g., aggregate sociodemographic characteristics, rurality) to ensure we are selecting similar counties as comparators. » Use entropy balancing to weight comparison group members to be similar to members in MCP transition counties on key characteristics in descriptive and impact analyses.
Non-parallel pre-intervention (baseline) trends	» Assess baseline trends in intervention and non-intervention counties; if baseline trends are not parallel, conduct CITS analyses instead of DID analyses.
Insufficient post-intervention cases to establish a trend	» Empirically assess the appropriate level of analysis from available data (e.g., annual, quarterly, monthly) that will establish stable trends while retaining the most granular level of data to feasibility conduct analyses. » Consider reserving DID or CITS analyses until the Summative Evaluation Report, when complete data on outcomes for members in 2024-2026 are available.
Potential bias introduced by primary data collection recruitment approach	» Pending type and quality of contact information available in secondary data, utilize sequential, multi-mode outreach approach (e.g., mail with phone follow-up) to reduce bias that may be introduced by using a single mode alone (i.e., inadvertent exclusion of those with limited or inconsistent access to technology, or with recent changes in residence).
Primary data collection respondent burden	» Thoroughly assess and leverage existing data sources (for example, program documents) before considering primary data collection.

Challenge	Mitigation Approach
	» Conduct primary data collection over videoconferencing rather than in person to be more flexible with respondents' time. » Compensate members and DHCS Stakeholder Committee members for their time.
Primary data collection respondent recall bias	» Provide framing language to remind participants of timeline of transition and transition notification. » Focus interview topics on perceived changes arising during and after the transition occurred, allowing for feedback on changes observed over broader transition period. » Conduct primary data collection in the first half of 2025, to maximize recall.

Independent Evaluator

In June 2024, DHCS selected NORC at the University of Chicago as the Independent Evaluator for the Managed Care Transition 1115 Demonstration via a direct contract process due to Public Contract Code exemption. The evaluation contract was finalized in October 2024. NORC will conduct an evaluation of the Demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. NORC agreed to conduct the Demonstration evaluation in an independent manner in accordance with the CMS-approved, draft Evaluation Design.

In addition to the design, NORC will be responsible for developing draft and final versions of the evaluation design, final measure selection, conducting data collection and analysis, interpreting results, and drafting the Interim and Summative Evaluation Reports.

CONFLICT OF INTEREST COMPLIANCE PROCESS

Overview

NORC has robust policies and procedures for avoiding and mitigating potential conflicts of interest on programs such as this. For this solicitation, ***Evaluation of the California Managed Care Transition 1115 Waiver*** NORC has no known actual or potential conflict of interest. NORC has no known organizational or personal conflicts of interest that might cause biased judgment. NORC does not have access to nonpublic information that will provide an unfair competitive advantage.

Introduction

National Opinion Research Center ("NORC") is a prominent not-for-profit research firm that is well known for its scientific excellence, independence, and integrity. The majority of NORC's business is performed through contracts and grants with the federal government. Given the importance of NORC's reputation for successful business activity and its position as a federal contractor, a robust and well-proven Conflict of Interest ("COI") regime is in place to ensure (1) the prevention of COIs from developing in the first place, and (2) the identification and remediation of any COIs effectively and immediately in the rare cases they do occur. NORC has developed COI procedures described herein to fulfill the requirements set forth in ***Evaluation of the California Managed Care Transition 1115 Waiver*** We provide details on our tailored COI processes in the remainder of this document.

NORC Compliance Officer

NORC Vice President, Bess Welch, serves as NORC's Conflicts Compliance Officer. The Conflicts Compliance Officer reports directly to NORC's Board of Trustees for all compliance and conflicts matters. NORC's Conflicts Compliance Officer reviews and has auditing authority for all business and contractual relationships and activities of NORC.

Independent and Impartial

NORC is an independent 501 (c) 3 not-for-profit organization. NORC has its own Board of Trustees (16). NORC is affiliated with the University of Chicago in that the President of the University can nominate 51% of NORC's Trustees. However, all of NORC's Trustees have a fiduciary responsibility to act in NORC's best interest while making decisions as Trustees of NORC. The University of Chicago has its own independent Board of Trustees which is required to make decisions in the best interest of the University.

Conflicts Policies and Procedures

NORC maintains policies and procedures for organizational conflicts of interest and personal conflicts of interest, each described in turn below. Each item below describes the particular conflicts oversight process including how conflicts are identified and resolved.

1. Organizational Conflicts

All staff are required to identify potential conflicts of interest on an on-going basis. All NORC staff receive annual conflicts and ethics training that include series of self-administered training modules and exams supplemented by regularly conducted training sessions. NORC's Conflicts Compliance Officer reviews all existing and potential new business for NORC and its staff, subcontractors, consultants, and vendors to determine if there are any actual, potential, or apparent conflicts. Any actual, potential, or apparent conflicts are categorized into any or all of the following conflict types: unequal access to information, biased ground rules, or impaired objectivity. If any of the aforementioned conflicts exist as determined by the Conflicts Compliance Officer, the Conflicts Compliance Officer works with the project team and NORC's Contracts department to create a mitigation plan for submission to the cognizant awarding agency's conflicts officer and/or the program's assigned Contracting Officer along with any other information that may be useful in assisting the review of NORC's proposed solution to mitigate or neutralize the conflict.

Additionally, the Conflicts Compliance Officer has full authority to audit all relevant areas of NORC's business and individual projects to determine if staff and management are complying with NORC's conflicts policies and procedures at all times. NORC maintains a reporting hotline where anyone can call in to report an issue. Issues reported to the hotline are resolved by the Conflicts Compliance Officer and Board of Trustees members that participate in NORC's Conflict Transactions Committee. All such reported issues are treated seriously and investigated thoroughly.

2. Personal Financial Conflicts

NORC also adheres to a robust Personal Financial Conflict of Interest (FCOI) Policy. This is a federally mandated policy by certain agencies of the government including HHS. Under this policy all principal investigators, and other staff who can influence the results of an affected government contract, are required to at least annually complete a certificate identifying potential conflicts of interest with the work they are performing on the affected contract (Personal Conflicts disclosures are also completed on per project and/or per proposal basis as required by individual sponsors). These employees are also

required to undergo specific training on how to identify a potential conflict of interest and the requirements to disclose it. FCOI compliance is overseen by the NORC FCOI Committee, of which the Conflicts Compliance Officer is a member. All personal conflict disclosures are evaluated by the Conflicts Compliance Officer. Under the direction of NORC's Conflicts Compliance Officer, the Contracts department administers the annual certifications and trainings required to satisfy the organization's compliance obligations for FCOI. If an FCOI disclosure is identified, it is immediately sent to the FCOI Committee for review, discussion, and further remediation by other cognizant NORC officers, if necessary. The Conflicts Compliance Officer ensures a mitigation plan is created and submitted to the appropriate governing agency for review where any actual, potential, or apparent conflict has been identified. Conflicted and/or potentially conflicted individuals are prohibited from participating in any component of the program or work that gave rise to the conflict until the conflict has been neutralized and cleared by the governing agency.

Authority, Audits and Remediation

NORC's Conflicts Compliance Officer has independent authority to audit all relevant areas of NORC's business and individual projects to determine if staff and management are complying with NORC's conflicts policies and procedures at all times. In coordination with NORC's Contracts department, Accounting and Finance, and other stakeholders within the organization, the Conflicts Compliance Officer conducts regular random audits of project and personnel activities to ensure compliance with NORC's conflicts policies and procedures. Additionally, NORC contracts with an independent external auditor to conduct an independent audit of any mitigation plans as directed. The findings and recommendations of any external audit including any corrective action plan developed by NORC will be shared with our client for review and approval.

NORC maintains a third party administered Hotline for reporting conflicts, fraud, misconduct, and illegal or unethical practices. Staff, contractors, sponsors, or interested parties can anonymously call this third-party administrator and report any suspected wrongdoing including conflict of interest at any time. The third-party administrator reports directly to the Board of Trustees Chairman of the Audit and Finance Committee and NORC's Conflicts Compliance Officer. All such reported issues are treated seriously and investigated thoroughly. In accordance with FAR 52.203-14, the Conflicts Compliance Officer works with NORC's Human Resources and Facilities Departments to ensure these conflicts policies and hotline number are posted in locations that are accessible to all staff including hard copy posters in common areas of office sites and on NORC's intranet. NORC routinely prompts staff to review these policies.

Violation of NORC's conflicts policies and procedures are handled in a manner commensurate to the nature of the violation. Violations may range from corrective action by a supervisor, termination of employment/contractor, referral to authorities, as well as civil and criminal prosecution where warranted or necessitated by law.

11/4/2024

Adil Moiduddin, Senior Vice President, Health Care Evaluation Research

Timeline and Major Milestones

Exhibit 8 shows the projected timeline for evaluation activities and major deliverables. All deliverables in this exhibit (evaluation design, evaluation reports, and summative report) reflect the date the draft version is due to CMS; a final version of those deliverables will be due to CMS 60 days after receiving their comments on the draft version. The due dates for submitting drafts of the major deliverables to CMS are as follows:

- Evaluation Design Draft: February 28, 2025
- Interim Evaluation Report: December 25, 2025
- Summative Evaluation Report: June 27, 2028

Exhibit 8. Evaluation Timeline

Evaluation Activity	Year 1 (9/24-6/25)	Year 2 (7/25-6/26)	Year 3 (7/26-6/27)	Year 4 (7/27-6/28)	Year 5 (7/28-5/29)
Quantitative Data Collection & Analysis					
Qualitative Data Collection & Analysis					
Evaluation Design					
Interim Evaluation Report Draft					
Quarterly Evaluation Reports					
Summative Evaluation Report Draft					

NOTE: *Dark blue indicates a due date for the deliverable; light blue indicates evaluation activities (e.g., primary data collection, measure programming and analysis) related to that deliverable.*