DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850

September 25, 2026

Tyler Sadwith
State Medicaid Director
California Department of Health Care Services
P.O. Box 997313, MS 0000
Sacramento, CA 95899-7413

Dear Director Sadwith:

The Centers for Medicare & Medicaid Services (CMS) is clarifying the applicability of recent changes to Medicaid and Children's Health Insurance Program (CHIP) statutes and related regulation and policy for California's "California Advancing and Innovating Medi-Cal (CalAIM)" section 1115 demonstration, (Project Numbers 11-W-00193/9 and 21-W-00077/9).

Public Law 119-21, which CMS refers to as the Working Families Tax Cut (WFTC) legislation, made changes to the Medicaid and CHIP provisions of the Social Security Act (the Act), including eligibility and financing changes. CMS has issued regulations and guidance implementing and interpreting many of the Medicaid and CHIP provisions of the WFTC legislation. Some of these statutory and related regulatory changes will affect this demonstration. Therefore, in this action, CMS is clarifying the applicability of certain of these new requirements to the CalAIM section 1115 demonstration during this demonstration period.

Specifically, in this action:

- We are clarifying the applicability of section 1903(v)(5) of the Act (added by section 71109 of the WFTC legislation) and guidance related to those sections of the Act; this change is effective October 1, 2026, through December 31, 2026.

Unless renewed or otherwise amended, all authorities granted to operate this demonstration will expire on December 31, 2026.

The clarifications are authorized under STC 3.2, which specifies that all requirements of the Medicaid and CHIP programs, expressed in federal law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents, apply to the demonstration.

CMS has determined that this action for the CalAIM demonstration is likely to assist in promoting the objectives of the Medicaid and CHIP statutes by aligning this section 1115 demonstration with new statutory requirements applicable to the Medicaid and CHIP programs and with how CMS has interpreted and implemented those requirements in regulations and

guidance. The effective date of this action is intended to align with the implementation timeline of this new statutory requirement.

Program Integrity

As part of this action, CMS would like to remind the state about program integrity obligations. States are responsible for following all applicable federal law and regulations when they claim and use federal Medicaid funds and must fully comply with all applicable Medicaid and CHIP laws and regulations under a section 1115 demonstration, except where specific provisions have been expressly waived or identified as not applicable for that demonstration. This obligation includes all requirements in Title XIX and Title XXI of the Act and implementing regulations governing provider screening and enrollment activities, pre- and post-payment review claiming, payment methodologies and rate-setting, utilization controls, and program integrity, including processes to identify, investigate, and refer suspected fraud and methods to receive complaints and identify questionable practices. States must maintain effective systems and safeguards to prevent, detect, and address any fraud, waste, or abuse (FWA) in the delivery of and payment for Medicaid and CHIP services, including referrals to law enforcement, when appropriate.

States should have heightened monitoring and oversight mechanisms in place featuring robust internal controls to identify and remediate all vulnerabilities (including, but not limited to, FWA and beneficiary access issues) inherent in service areas approved as part of a demonstration. At any time, CMS may request that the state provide a plan detailing the state's systems and safeguards to prevent, detect, and address any FWA relative to this demonstration. Failure to meet program integrity obligations under federal statutes and regulations or under the terms and conditions of this demonstration approval may result in compliance actions or other enforcement measures that could include requirements to develop and implement corrective action plans, withholdings, deferrals, disallowances, and termination of demonstration authority.

Extent and Scope of Changes

Section 71109 – Alien Medicaid eligibility

Beginning October 1, 2026, sections 1903(v)(5) and 2107(e)(1)(R) of the Act, as added and amended, respectively, by section 71109 of the WFTC legislation, generally limit federal financial participation (FFP) for medical assistance (Medicaid) and child or pregnancy-related health assistance (CHIP), with limited exceptions, to U.S. citizens and U.S. nationals, lawful permanent residents (LPRs), Cuban/Haitian entrants, and Compact of Free Association (COFA) migrants.

Section 1903(v)(5) of the Act describes three exceptions to these FFP limitations: (1) care and services necessary for the treatment of an emergency medical condition as described in section 1903(v)(3) of the Act, (often referred to as "emergency Medicaid"), per section 1903(v)(2) of the Act; (2) full Medicaid and CHIP coverage provided to lawfully residing children and pregnant women under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) 214 option, per section 1903(v)(4) of the Act, applicable to CHIP through a cross reference at section 2107(e)(1)(Q) of the Act; and (3) Health Services Initiatives (HSIs), which are programs

that are designed to improve the health of low-income children, authorized under section 2105(a)(1)(D)(ii) of the Act. California elected the CHIPRA 214 option for Medicaid coverage of lawfully residing children and pregnant women and CHIP coverage of lawfully residing children.

On April 8, 2026, CMS issued State Health Official (SHO) letter #26-001, which provides policy and operational guidance to states related to implementation of the changes made by section 71109 of the WFTC legislation.[1] On August 17, 2026, CMS issued a letter to California describing CMS's determination that continuing previously approved policies in section 1115 demonstrations that authorize federal matching funds for expenditures for services furnished to individuals who will be subject to the FFP limitations in sections 1903(v)(5) and 2107(e)(1)(R) of the Act would not be likely to promote the objectives of the Medicaid or CHIP statutes, as applicable and as modified by the WFTC legislation.[2] In this action, CMS is clarifying the applicability of sections 1903(v)(5) and 2107(e)(1)(R) of the Act to the STCs of the demonstration. This clarification, which is further described below, is expected to protect program integrity and ensure proper claiming of FFP.

Aligning Designated State Health Programs authority with section 71109 changes

CMS has approved several demonstrations under the authority of section 1115(a) of the Act that provide federal matching funds for state expenditures for Designated State Health Programs (DSHP). On April 10, 2025, CMS sent states a letter explaining that CMS does not anticipate approving new state proposals or renewing existing expenditure authority for section 1115 demonstration expenditure authority for DSHP.[3] In this letter, CMS is clarifying that the time-limited authority in the CalAIM demonstration for DSHP must align with new statutory limitations for FFP in section 1903(v)(5) of the Act that apply beginning October 1, 2026. This includes ensuring that DSHP expenditures are restricted to expenditures for individuals who are U.S. citizens and U.S. nationals, LPRs, Cuban/Haitian entrants, and COFA migrants, unless a limited exception applies such as expenditures for lawfully residing children or pregnant women in accordance with the state's election of the CHIPRA 214 option as described in the state plan.

This letter is clarifying required compliance with the WFTC legislation and does not change current CMS guidance that section 1115 demonstration expenditure authority for DSHP in the CalAIM demonstration is not expected to be extended beyond the currently approved demonstration period.

Budget Neutrality

There are no changes to budget neutrality or allotment neutrality for this action.

[1] https://www.medicaid.gov/federal-policy-guidance/downloads/sho26001.pdf
[2] https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-calaim-cms-ltr-08172026.pdf
[3] https://www.medicaid.gov/resources-for-states/downloads/dshp-dsip.pdf

Monitoring and Evaluation

The state is required to conduct systematic monitoring and evaluation in accordance with the demonstration STCs and to incorporate, as appropriate, the clarification specified in this letter into these activities. Monitoring and evaluation should identify and describe any observed changes in metrics or outcome measures, including relevant context, as well as associated operational updates. In addition to other required content, these activities—including required deliverables and monitoring calls—should address any anticipated or actual challenges, risks, and program integrity considerations related to implementation of the clarification in this letter.

Other Information

This action for the demonstration project is conditioned upon compliance with the previously approved waivers, expenditure authorities, and STCs which set forth in detail the nature, character and extent of anticipated federal involvement in the project. Your project officer is Julie Sharp, who is available to answer any questions concerning your section 1115 demonstration. Ms. Sharp's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, MD 21244-1850
Email: Juliana.Sharp@cms.hhs.gov

If you have questions regarding this action, please contact Sarah Aker, Acting Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at Sarah.Aker@cms.hhs.gov.

Sincerely,

[redacted]

Dan Brillman
Deputy Administrator, CMS
Director, Center for Medicaid and CHIP Services

cc: Nicole Lemmon, State Lead, Medicaid and CHIP Operations Group

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER AUTHORITY

NUMBERS: **11-W-00193/9 and 21-W-00077/0**

TITLE: **California CalAIM Demonstration**

AWARDEE: **California Health and Human Services Agency**

All requirements of the Medicaid program and Children's Health Insurance Program (CHIP) expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to the Demonstration from the approval date, through December 31, 2026, unless otherwise specified.

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers shall enable California to implement the CalAIM Demonstration.

1. **Freedom of Choice** **Section 1902(a)(23)(A)**

   To enable the State to require participants to receive benefits through certain providers and to permit the State to require that individuals receive benefits through managed care providers who could not otherwise be required to enroll in managed care. These authorities sunset on December 31, 2021.

   To enable the State to require that individuals who elect to receive Health Home Program (HHP) services (under the state plan) are restricted to the Medi-Cal Managed Care Plan offered by the HHP provider to receive covered services other than family planning services. These authorities sunset on December 31, 2021.

   No waiver of freedom of choice is authorized for family planning providers.

2. **Disproportionate Share Hospital (DSH) requirements**
   Section 1902(a)(13)(A) (insofar as it incorporates Section 1923)

   To exempt the State from making DSH payments, in accordance with Section 1923, to a hospital which qualifies as a disproportionate share hospital during any year for which the Public Health Care System with which the disproportionate share hospital is affiliated receives payment pursuant to the Global Payment Program.

3. **Statewideness** **Section 1902(a)(1)**

   To enable the State to operate the demonstration on a county-by-county basis.

   To enable the State to provide CBAS services on a geographically limited basis.

To enable the State to provide DMC-ODS services to short-term residents on a geographically limited basis.

To enable the state to provide contingency management services to qualifying DMC-ODS beneficiaries only in participating DMC-ODS counties that elect and are approved by DHCS to provide contingency management.

To enable the State to authorize sustaining services under PATH to individuals on a geographically limited basis.

To enable the State to provide peer support specialist services within electing Drug Medi-Cal State Plan counties to individuals on a geographically limited basis, no sooner than July 1, 2022.

To enable the state to provide short-term recuperative care and short-term post-transition housing services only in certain geographic areas where Medi-Cal managed care plans elect to offer these services.

4. **Amount, Duration, and Scope of Services and Comparability Section 1902(a)(10)(B) and 1902(a)(17)**

To enable the State to provide different benefits for low-income pregnant women between 109 percent up to and including 138 percent of the Federal Poverty Level, as compared to other pregnant women in the same eligibility group. This authority will sunset on December 31, 2021.

To enable the State to provide DMC-ODS treatment and withdrawal management services for substance use disorder, for short term residents, in facilities that meet the definition of an Institution for Mental Diseases (IMD) that are not otherwise available to all beneficiaries in the same eligibility group.

To enable the state to provide contingency management in approved DMC-ODS counties, to eligible individuals with substance use disorders under the DMC-ODS program that are not otherwise available to all beneficiaries in the same eligibility group.

To enable the State to provide peer support specialist services within electing Drug Medi-Cal State Plan counties to individuals on a geographically limited basis, no sooner than July 1, 2022.

To enable the state to provide sustaining services under PATH that are not otherwise available to all beneficiaries in the same eligibility group.

To enable the state to provide health-related social needs services, specifically short-term recuperative care and short-term post-transition housing services, that are not otherwise available to all beneficiaries in the same eligibility group.

To enable the state to provide CBAS services that are not otherwise available to all beneficiaries in the same eligibility group.

To enable the state to (1) apply targeted resource disregards of $130,000 for a single individual and an additional $65,000 per household member, up to a maximum of 10 household members as of July 1, 2022 and (2) effective January 1, 2024 no longer apply income and resource financial methodologies to the following populations, which is in a manner that is not applied consistently to all eligibility groups in the state:

i. The Pickle Group under section 1939(a)(5)(E) of the Act and 42 CFR 435.135;
ii. The Disabled Adult Child group under sections 1634(c) and 1939(a)(2)(D) of the Act; and
iii. The Disabled Widow/Widower group under sections 1634(d), 1939(a)(2)(C), and 1939(a)(2)(E) of the Act and 42 CFR 435.137-138.

5. **Coverage of Certain Screening, Diagnostic, and Targeted Case Management Services for Eligible Juveniles in the 30 Days Prior to Release Section 1902(a)(84)(D)**

To enable the state not to provide coverage of the screening, diagnostic, and targeted case management services identified in section 1902(a)(84)(D) of the Act for eligible juveniles described in section 1902(nn)(2) of the Act as a state plan benefit in the 30 days prior to the release of such eligible juveniles from a public institution, to the extent and for the period that the state instead provides such coverage to such eligible juveniles under the approved expenditure authorities under this demonstration. The state will provide coverage to eligible juveniles described in section 1902(nn)(2) in alignment with section 1902(a)(84)(D) of the Act at a level equal to or greater than would be required under the state plan.

Title XXI Waiver Authorities

All requirements of the CHIP program expressed in law, regulation and policy statement, not expressly waived or identified as not applicable in accompanying expenditure authorities and/or these STCs, shall apply to the demonstration project through December 31, 2026. In addition, these waivers may only be implemented consistent with the approved STCs. Waivers associated with the CalAIM Demonstration are approved through December 31, 2026.

Under the authority of section 1115(a)(1) of the Act, the following waiver of state plan requirements contained in section 2102 of the Act are granted for the CalAIM Demonstration, subject to these STCs.

6. **Coverage of Certain Screening, Diagnostic, and Targeted Case Management Services for Low-Income Children in the 30 Days Prior to Release Section 2102(d)(2)**

To enable the state not to provide coverage of the screening, diagnostic, and case management services identified in section 2102(d)(2) of the Act for targeted low-income children as a state plan benefit in the 30 days prior to the release of such targeted low-income children from a public institution, to the extent and for the period that the state instead provides such coverage to such targeted low-income children under the approved expenditure authorities under this demonstration. The state will provide coverage to targeted low-income children in alignment with section 2102(d)(2) of the Act at a level equal to or greater than would be required under the state plan.

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBERS: **11-W-00193/9 and 21-W-00077/0**

TITLE: **California CalAIM Demonstration**

AWARDEE: **California Health and Human Services Agency**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period of this demonstration, be regarded as expenditures under the state's Medicaid title XIX and XXI plan. The expenditure authority period of this demonstration is from the effective date identified in the demonstration approval letter, or as otherwise indicated herein or in the Special Terms and Conditions (STCs), through December 31, 2026.

The following expenditure authorities shall enable California to implement the CalAIM Demonstration. All Medicaid requirements apply to expenditure authority 3, 4, 5, 7, 8, 9, 10, 11 13, 14, and 15 (except as inconsistent with those authorities or except as provided herein or as set forth in the STCs).

1. **Global Payments Program for Public Health Care Systems**. Expenditures for payments to eligible Public Health Care Systems, subject to the annual expenditure limits set forth in the STCs, to support participating Public Health Care systems providers that incur costs for uninsured care under the value-based global budget structure set forth in the STCs.

2. **Chiropractic Services Provided by Indian Health Service (IHS) and Tribal Facilities.** Expenditures for chiropractic services for which Medi-Cal coverage was eliminated by SPA 09-001 that are furnished by IHS/tribal providers to individuals enrolled in the Medi-Cal program.

3. **Expenditures Related to Community Based Adult Services (CBAS).** Expenditures for CBAS services furnished to individuals who meet the level of care or other qualifying criteria.

4. **Expenditures Related to Low Income Pregnant Women.** Expenditures to provide post-partum benefits for pregnant women with incomes between 109 percent up to and including 138 percent of the Federal Poverty Level (FPL), that includes all benefits that would otherwise be covered for women with incomes below 109 percent of the FPL. This authority will sunset on December 31, 2021.

5. **Expenditures Related to the Drug Medi-Cal Organized Delivery System (DMC- ODS) for Residential and Inpatient Treatment for Individuals with Substance Use Disorder (SUD).** Expenditures for otherwise covered Medicaid services furnished to qualified DMC-ODS beneficiaries who are primarily receiving treatment and withdrawal management services for

substance use disorder as short-term residents in facilities that meet the definition of an Institution for Mental Diseases (IMD).

6. **Expenditures Related to Providing Access and Transforming Health (PATH).** Expenditures for payments to Qualified Applicants approved under one or more PATH initiatives. Such expenditures may include payments for allowable administrative costs, services, supports, transitional non-service expenditures, infrastructure and interventions, which may not be recognized as medical assistance under Section 1905(a) or may not otherwise be reimbursable under Section 1903, to the extent such activities are authorized as part of an approved PATH program.

7. **Expenditures Related to Contingency Management.** Expenditures for Contingency Management services provided to qualifying DMC-ODS beneficiaries who reside in a DMC-ODS county that elects and is approved by DHCS to pilot the Contingency Management benefit, beginning July 1, 2022 through December 31, 2026.

8. **Expenditures Related to Health-Related Social Needs (HRSN) Services Short-Term Recuperative Care and Short-Term Post-Transition Housing Community Supports.** Expenditures for HRSN services, specifically short-term recuperative care and short-term post-transition housing services, as detailed in the service description in the STCs, for Medi-Cal managed care enrollees who meet the eligibility criteria specified in the STCs and any related requirements.

9. **Expenditures Related to Dually Eligible Enrollees in Medi-Cal Managed Care.** Expenditures under contracts with Medicaid plans that do not meet the requirements under section 1903(m)(2)(A)(vi) of the Act insofar as that provision requires compliance with requirements in section 1932(a)(4)(A)(ii)(I) of the Act and 42 CFR 438.56(c)(2)(i) to the extent necessary to allow the state to keep a beneficiary in an affiliated Medicaid plan once the beneficiary has selected a Medicare Advantage plan unless and until the beneficiary changes Medicare Advantage plans or selects Original Medicare. Beneficiaries impacted by this expenditure authority until December 31, 2024 will be able to change Medicaid plans by picking a new Medicare Advantage Plan or Original Medicare once a quarter between January through September pursuant to 42 CFR 423.38(c)(4)(i) and following the annual coordination election period from October through December pursuant to 42 CFR 423.38(b)(3). Beneficiaries impacted by this expenditure authority starting January 1, 2025 will be able to change Medicaid plans either: 1) once a month pursuant to 42 CFR 423.38(c)(4)(i) and (c)(35)(i) if picking a new Medicare Advantage Plan that is an exclusively aligned enrollment Dual Eligible Special Needs Plan, known as an applicable integrated plan as defined in 42 CFR 422.561, or Original Medicare, or 2) during the annual coordination election period from October through December pursuant to 42 CFR 423.38(b)(3) if picking any Medicare Advantage Plan. A dually eligible beneficiary's Medicaid plan will be aligned with the new Medicare Advantage Plan, to the extent the Medicare Advantage Plan has an affiliated Medicaid plan. Pursuant to 42 CFR 438.56(e)(1) which requires a state to approve disenrollment no later than the first day of the second month following the month in which the enrollee requests disenrollment, the state will be allowed to align approval of disenrollment from a Medicaid plan with disenrollment from a Medicare Advantage plan.

10. **Expenditures Related to Out-of-State Former Foster Care Youth.** Expenditures to extend eligibility for full Medicaid State Plan benefits to former foster care youth who are under age 26, were in foster care under the responsibility of another state or tribe in such state on the date of attaining 18 years of age or such higher age as the state has elected, and were enrolled in Medicaid on that date.

11. **Expenditures for Deemed SSI Populations.** Expenditures to extend eligibility for individuals in the following Deemed SSI populations who are eligible based on (1) applying a targeted asset disregard of $130,000 for a single individual and an additional $65,000 per household member, up to a maximum of 10 household members as of July 1, 2022, and (2) no longer applying the asset test as of January 1, 2024:

    i. The Pickle Group under section 1939(a)(5)(E) of the Act and 42 CFR 435.135;
    ii. The Disabled Adult Child group under sections 1634(c) and 1939(a)(2)(D) of the Act; and
    iii. The Disabled Widow/Widower group under sections 1634(d), 1939(a)(2)(C), and 1939(a)(2)(E) of the Act and 42 CFR 435.137-138.

12. **Designated State Health Programs (DSHP).** Expenditures for designated state health programs, identified in these STCs, which are otherwise fully state-funded, and not otherwise eligible for Medicaid matching funds. These expenditures are subject to the terms and limitations and not to exceed specified amounts as set forth in these STCs.

13. **Expenditures Related to Pre-Release Services.** Expenditures for pre-release services, as described in these STCs, provided to qualifying Medicaid beneficiaries and beneficiaries who would be eligible for the Children's Health Insurance Program (CHIP) if not for their incarceration status, for up to 90 days immediately prior to the expected date of release from a participating state prison, county jail, or youth correctional facility.

14. **Expenditures Related to Managed Care Plans.** Expenditures under contracts with managed care entities that do not meet the requirements in 1903(m)(2)(A)(vi) and 1932(a)(3) of the Act in so far as implemented at 42 CFR 438.52(a) to the extent necessary to allow the state to limit the choice of managed care plans in Metro, Large Metro, and Urban counties in California as provided under STC 12 and to allow counties to participate or continue participating in County Organized Health System (COHS) and Single Plan managed care models.

15. **Traditional Health Care Practices.** Expenditures for traditional health care practices received through Indian Health Service facilities, facilities operated by Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act, or facilities operated by urban Indian organizations under Title V of the Indian Health Care Improvement Act, by Medicaid beneficiaries who are able to receive services delivered by or through these facilities.

Title XXI Expenditure Authority:

16. **Expenditures Related to Health-Related Social Needs (HRSN) Services Short-Term Recuperative Care and Short-Term Post-Transition Housing Community Supports.** Expenditures for HRSN services, specifically short-term recuperative care and short-term post transition housing services, as detailed in the service description in the STCs, for CHIP enrollees who meet the eligibility criteria specified in the STCs and any related requirements.

17. **Expenditures Related to Pre-Release Services.** Expenditures for pre-release services, as described in these STCs, provided to qualifying demonstration beneficiaries who would be eligible for CHIP if not for their incarceration status, for up to 90 days immediately prior to the expected date of release from a participating state prison, county jail, or youth correctional facility.

18. **Traditional Health Care Practices.** Expenditures for traditional health care practices received through Indian Health Service facilities, facilities operated by Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act, or facilities operated by urban Indian organizations under Title V of the Indian Health Care Improvement Act by Children's Health Insurance Program beneficiaries who are able to receive services delivered by or through these facilities.

Medicaid Requirements Not Applicable to these Medicaid Expenditure Authorities

1. **Statewideness** **Section 1902(a)(1)**

To enable the state to provide pre-release services, as authorized under this demonstration, to qualifying beneficiaries on a geographically limited basis, in accordance with the Reentry Demonstration Initiative Implementation Plan.

2. **Amount, Duration, and Scope of Services and Comparability**
Section 1902(a)(10)(B) and 1902(a)(17)

To enable the state to provide only a limited set of pre-release services, as specified in these STCs, to qualifying beneficiaries that is different than the services available to all other beneficiaries outside of carceral settings in the same eligibility groups authorized under the state plan or the demonstration.

3. **Freedom of Choice** **Section 1902(a)(23)(A)**

To enable the state to require qualifying beneficiaries to receive pre-release services, as authorized under this demonstration, through only certain providers.

4. **Requirements for Providers under the State Plan**

Section 1902(a)(27) and 1902(a)(78)

To enable the state to not require carceral providers to enroll in Medi-Cal, in order to provide, order, refer, or prescribe pre-release services as authorized under this demonstration.

5. **Comparability; Freedom of Choice; Statewideness Section 1902(a)(10)(B), 1902(a)(23), and 1902(a)(1)**

   To the extent necessary to allow the state to offer the coverage described in Expenditure Authority 15 only if the covered traditional health care practices are received through Indian Health Service facilities, facilities operated by Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act, or facilities operated by urban Indian organizations under Title V of the Indian Health Care Improvement Act by Medicaid beneficiaries who are able to receive services delivered by or through these facilities. These sections of the Act are also not applicable to the extent necessary to allow the state to phase in implementation of the coverage described in Expenditure Authority 15 to subsets of beneficiaries otherwise eligible for that coverage in limited regions of the state.

Title XXI Requirements Not Applicable to the Title XXI Expenditure Authority Above

1. **Requirements for Providers under the State Plan Section 2107(e)(1)(D)**

To enable the state to not require carceral providers to enroll in Medi-Cal, in order to provide, order, refer, or prescribe pre-release services as authorized under this demonstration.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBERS: **11-W-00193/9 and 21-W-00077/0**

TITLE: **California CalAIM Demonstration**

AWARDEE: **California Health and Human Services Agency**

1. PREFACE

The following are the Special Terms and Conditions (STCs) for California's CalAIM, formerly Medi-Cal 2020, section 1115(a) Medicaid Demonstration (hereinafter "Demonstration"), to enable the California Health and Human Services Agency (State) to operate this Demonstration, The Centers for Medicare & Medicaid Services (CMS) has granted waivers of statutory Medicaid requirements permitting deviation from the approved State Medicaid plan, and expenditure authorities authorizing expenditures for costs not otherwise matchable. These waivers and expenditure authorities are separately enumerated. These STCs set forth conditions and limitations on those waivers and expenditure authorities, and describe in detail the nature, character, and extent of Federal involvement in the Demonstration and the State's obligations to CMS during the life of the Demonstration.

The periods for each Demonstration Year (DY) will be as follows:

- DY 18 January 1, 2022 through December 31, 2022
- DY 19 January 1, 2023 through December 31, 2023
- DY 20 January 1, 2024 through December 31, 2024
- DY 21 January 1, 2025 through December 31, 2025
- DY 22 January 1, 2026 through December 31, 2026

The STCs related to the programs for those State Plan and Demonstration Populations affected by the Demonstration are effective from the date identified in the CMS Demonstration approval letter through December 31, 2026.

The STCs have been arranged into the following subject areas:

1. Preface
2. Program Description and Historical Context
3. General Program Requirements
4. State Plan and Demonstration Populations Affected by the Demonstration
5. Demonstration Programs
   a. Community Based Adult Services
   b. PATH
   c. Duals
6. Drug Medi-Cal Organized Delivery System
7. Contingency Management
8. Community Supports

9. Reentry Demonstration Initiative
10. Designated State Health Programs
11. Provider Payment Rate Increase Requirement
12. Managed Care Entities
13. Traditional Health Care Practices
14. Negative Balance
15. Global Payment Program
16. General Reporting Requirements
17. Evaluation of the Demonstration
18. General Financial Requirements
19. Monitoring Budget Neutrality for the Demonstration
20. Monitoring Allotment Neutrality

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

Attachment A: Developing the Evaluation Design
Attachment B: Preparing the Interim and Summative Evaluation Reports
Attachment C: Global Payment Program Participating Public Health Care Systems
Attachment D: Funding and Reimbursement Protocol for IHS
Attachment E: SUD Health IT Plan
Attachment F: Accounting Procedures
Attachment G: Demonstration and Program Years
Attachment H: Community-Based Adult Services (CBAS) Provider Standards of Participation
Attachment I: Drug Medi-Cal Organized Delivery System (DMC-ODS) County Certified Public Expenditures (CPE) Protocol
Attachment J: SUD Monitoring Protocol
Attachment K: Global Payment Program Funding and Mechanics Protocol
Attachment L: Global Payment Program Valuation Methodology Protocol
Attachment M: Global Payment Program Health Equity Monitoring Metrics Protocol
Attachment N: Providing Access and Transforming Health (PATH) Funding and Mechanics Protocol
Attachment O: Providing Access and Transforming Health (PATH) Operational and Monitoring Protocol
Attachment P: Historical Information-Budget Neutrality Test (Reserved)
Attachment Q: DSH Coordination Methodology
Attachment R: Negative Balance Payment Schedule (Reserved)
Attachment S: CBAS Program Integrity
Attachment T: Evaluation Design (Reserved)
Attachment U: Community Supports Appendix
Attachment V: Contingency Management Procedures and Protocols
Attachment W: Reentry Demonstration Initiative Qualifying Conditions and Services
Attachment X: Health-Related Social Needs (HRSN) Community Supports Protocol (Reserved)
Attachment Y: Approved Designated State Health Program (DSHP) List
Attachment Z: Designated State Health Program (DSHP) Claiming Protocol

Attachment AA: Designated State Health Program (DSHP) Sustainability Plan (Reserved)
Attachment BB: Designated State Health Program (DSHP) Related Provider Payment Increase Assessment Attestation Table
Attachment CC: Reentry Demonstration Initiative Implementation Plan
Attachment DD: Monitoring Protocol (Reserved)
Attachment EE: Reentry Demonstration Initiative Reinvestment Plan
Attachment FF: Time-limited Expenditure Authority and Associated Requirements for the COVID-19 Public Health Emergency (PHE) Demonstration Amendment
Attachment GG: Attachment K – Emergency Preparedness and Response; Lump Sum Incentive Payments

2. PROGRAM DESCRIPTION AND HISTORICAL CONTEXT

In November 2010, the Federal government approved California's five-year Medicaid section 1115 Bridge to Reform demonstration, through which the state received the necessary authority and corresponding Federal support to invest in its health care delivery system and prepare for the full implementation of the Affordable Care Act. The Bridge to Reform demonstration achieved the goals of simultaneously implementing an historic coverage expansion, beginning the process of transforming the health care delivery system, and reinforcing California's safety net to meet the needs of the uninsured.

In December 2015, the Federal government approved the Medi-Cal 2020 demonstration embodying the shared commitment between the state and the Federal government to support the successful realization of some of the most critical objectives for improving our health care delivery system. Bridge to Reform waiver initiatives such as the managed care delivery system for Seniors and Persons with Disabilities (SPDs) and the state's Coordinated Care Initiative (CCI) were continued in Medi-Cal 2020, and with the foundation of the successes of the Bridge to Reform Demonstration, Medi-Cal 2020 initiatives continued to improve the quality and value of care provided to California's Medi-Cal beneficiaries.

Medi-Cal 2020 initiatives included:

1. A Public Hospital Redesign and Incentives in Medi-Cal program (PRIME), which aimed to improve the quality and value of care provided by California's safety net hospitals and hospital systems;

2. A Global Payment Program (GPP) that aimed to streamline funding sources for care for California's remaining uninsured population and create a value-based mechanism to increase incentives to provide primary and preventive care services and other high-value services;

3. A Whole Person Care (WPC) Pilot program that aimed to support local and regional efforts to integrate the systems and improve the care provided to Medi-Cal's most high-risk beneficiaries; and

4. A Dental Transformation Initiative (DTI) aimed to improve access to dental care and reduce preventable dental conditions for Medi-Cal beneficiaries.

On June 15, 2016, California submitted an amendment to the Demonstration to expand the

definition of a WPC Pilot lead entity to include federally recognized tribes and tribal health programs operated under a Public Law 93-638 contract with the Federal Indian Health Services. CMS approved this amendment on December 8, 2016.

On August 15, 2016, the state submitted an amendment to the demonstration to revise the methodology for determining the baseline metrics for purposes of receiving incentive payments for new and existing dental service office locations under the DTI. California also sought authority to provide incentive payments for specified dental services delivered at provider service office locations at two levels: a 37.5 percent above the state's Schedule of Maximum Allowances (SMA) incentive payment for service office locations that meet at least a 1 percentage point increase in number of children receiving a preventive dental service, on an annual basis, above the pre-determined baseline number of children served in the previous year with a preventive dental service; and a 75 percent above the state's SMA incentive payment for service office locations that meet or exceed a 2 percentage point increase in number of children receiving a preventive dental service, on an annual basis, above the pre-determined baseline number of children receiving a preventive dental service in the previous year. CMS approved this amendment on January 6, 2017.

On August 17, 2017, CMS approved the state's request to amend the demonstration to provide coverage to former foster care youth under age 26 who were in foster care under the responsibility of another state or tribe from any state when they "aged out" of foster at age 18 (or a higher age as elected by the state) and were enrolled at Medi-Cal at the time.

California submitted an amendment on November 10, 2016, as a companion to the Health Homes Program (HHP) State Plan Amendment (SPA) 16-007, to request a waiver of freedom of choice in the non- county organized health system (COHS) counties in order to provide the HHP services through the Medi-Cal managed care delivery system to beneficiaries enrolled in managed care. Managed care plans (MCPs) will be responsible for the overall administration of the HHP, which will be structured as a HHP network with members functioning as a team to provide care coordination. Fee-For-Service (FFS) members who meet the eligibility criteria for HHP may choose to voluntarily enroll in a MCP to receive HHP services along with other state plan services provided through MCPs. HHP services will not be provided through a FFS delivery system; therefore, beneficiaries in FFS in non-COHS counties will have to enroll in a MCP to receive HHP services. CMS approved this request on December 19, 2017.

On August 3, 2020, California received CMS approval to permit the GPP to continue from July 1, 2020 to December 31, 2020 and to permit eligible Medi-Cal beneficiaries in Orange County to elect to disenroll from CalOptima (a COHS including CalOptima Program of All-Inclusive Care for the Elderly (PACE)), to be enrolled in a PACE organization not affiliated with CalOptima.

On December 30, 2020, CMS approved a temporary extension of the state's section 1115 demonstration, in order to allow the state and CMS to continue working together on approval of a longer-term renewal of this demonstration by December 31, 2021. This temporary extension continued most elements of the Medi-Cal 2020 Section 1115 demonstration unchanged pending a full renewal and included an additional authorization for the GPP program. The extension included the removal of the authority for the State's Designated State Health Programs (DSHP).

On December 29, 2021, CMS approved the California Advancing & Innovating Medi-Cal (CalAIM) demonstration. This demonstration authorized a five-year renewal of components of

the Medi-Cal 2020 section 1115 demonstration, including new authorities, to continue advancing the state's goal of improving health outcomes and reducing health disparities for Medicaid and other low-income populations in the State. Building on the successes of the Medi-Cal 2020 demonstration, California has moved to implement whole person care strategies statewide through the State's CalAIM 1915(b) managed care delivery system and is moving other aspects of the Medi-Cal 2020 demonstration into the Medi-Cal State Plan. The CalAIM section 1115 demonstration initiatives include:

- Renewing the GPP to streamline funding sources for care for California's remaining uninsured population with a renewed focus on addressing social needs and responding to the impacts of systemic racism and inequities on the uninsured populations served by California's public hospitals.
- Authorizing Community Supports services: recuperative care and short-term post-hospitalization housing.
- Authorizing the Providing Access and Transforming Health (PATH) Supports expenditure authority to (1) sustain, transition, and expand the successful WPC Pilot and HHP services initially authorized under the Medi-Cal 2020 demonstration as they transition to become Enhanced Care Management (ECM) and Community Supports, and (2) sustain reentry pre-release and post-release services provided through existing WPC pilots and support Medi-Cal pre-release application planning and IT investments.
- Continuing short-term residential treatment services to eligible individuals with a substance use disorder (SUD) in the Drug Medi-Cal Organized Delivery System (DMC-ODS).
- Authorizing Contingency Management as a DMC-ODS benefit, to offer Medi-Cal beneficiaries this evidence-based, cost-effective treatment for substance use disorder that combines motivational incentives with behavioral health treatments.

On June 29, 2022, CMS approved an amendment to the demonstration to provide parity with the asset disregard policy for populations covered under SPA 21-0053. This amendment increases the asset limit and subsequently eliminates the asset test for the populations not able to be covered under state plan authority. The resources disregard will be $130,000 for a single individual and an additional $65,000 per household member, up to a maximum of 10 household members. This disregard is effective as of July 1, 2022. The elimination of the asset test for the populations covered under the demonstration will be effective January 1, 2024.

On January 26, 2023, CMS approved an amendment to the CalAIM demonstration to allow the state to provide a targeted set of pre-release services to individuals who are Medicaid eligible or individuals who would be eligible for CHIP except for their incarceration status and who are incarcerated in state prisons, county jails, or youth correctional facilities. This set of services would be provided for up to 90 days immediately prior to the expected date of release to improve transitions (in particular, transitions of health coverage and care) back to the community and for other purposes, including to reduce emergency department visits and inpatient hospital admissions; reduce decompensation, suicide-related death, overdose, overdose-related death, and all-cause death; and lead to improved health outcomes in general. CMS also is approving the authority for Designated State Health Programs (DSHP), which California will use to support portions of the PATH program that was approved in the December 29, 2021 extension of CalAIM. CMS is approving additional PATH funding for planning and implementation of the reentry demonstration initiative. Lastly, in this amendment CMS is approving an adjustment to

the budget neutrality methodology for two previously approved community supports, short-term post-hospitalization services and recuperative care, that address Health-Related Social Needs (HRSN), consistent with current CMS policy. Since these services are considered HRSN, CMS is adjusting the state's budget neutrality calculations to conform to current CMS policy for demonstrations that address HRSN, and will be treating these two services as "capped hypothetical expenditures."

On October 16, 2024, CMS approved an amendment to provide expenditure authority for coverage of traditional health care practices received through Indian Health Service facilities, facilities operated by Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act, or facilities operated by urban Indian organizations under Title V of the Indian Health Care Improvement Act by Medicaid and CHIP beneficiaries who are able to receive services delivered by or through these facilities. California will provide this coverage only to Medicaid and CHIP beneficiaries eligible to participate in the Drug Medi-Cal Organized Delivery System (DMC-ODS). However, with this approval, California will have the authority to expand coverage to all remaining Medicaid and CHIP beneficiaries who are able to receive services delivered by an IHS, Tribal, or urban Indian organization facility, subject to STC 3.7 and 13.2(c).

On December 16, 2024, CMS approved an amendment to this demonstration to add waiver authority related to the reentry demonstration initiative as it concerns section 5121 of the Consolidated Appropriations Act of 2023 (CAA, 2023), an update to the HRSN STCs in alignment with CMS's housing duration and frequency policy, and other technical changes.

3. GENERAL PROGRAM REQUIREMENTS

3.1. **Compliance with Federal Non-Discrimination Laws**. The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and Section 1557 of the Affordable Care Act (Section 1557). Such compliance includes providing reasonable modifications to individuals with disabilities under the ADA, Section 504, and Section 1557 with eligibility and documentation requirements, understanding program rules and notices, to ensure they understand program rules and notices, as well as meeting other program requirements necessary to obtain and maintain benefits.

3.2. **Compliance with Medicaid and CHIP Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs, expressed in federal law, regulation, and written policy, not expressly waived in the waiver document (of which these terms and conditions are part), apply to the demonstration.

3.3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. Nothing in this demonstration absolves California from being subject to future guidance on contingency management and the state

would otherwise need to come into compliance with such guidance. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 3.6. CMS will notify the state 30 days in advance of the expected approval date of the amended STCs to allow the state to discuss the language changes necessary to ensure compliance with Law, Regulation, and Policy. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing within 30 calendar days of receipt.

3.4. **Coordination with the Medicare Program.** The state must have processes in place to coordinate with the Medicare program for Medicare-Medicaid beneficiaries, including:

a. The state must provide contact information to Medicare-Medicaid beneficiaries on how they can obtain assistance with their Medicare coverage at any point of enrollment or disenrollment from Medi-Cal managed care or upon request by the beneficiary.

b. The state must provide accurate reports to CMS of the eligibility and enrollment of Medicare-Medicaid beneficiaries in the demonstration.

c. The state must comply with requirements for Medicaid payment of Medicare cost-sharing for Medicare-Medicaid enrollees, including ensuring any organization delegated with that responsibility adheres with the requirements.

d. The state must provide CMS with requested financial information and other demonstration aspects that have a specific impact on the Medicare-Medicaid population. Requests for information will include a reasonable timeframe for responses as agreed to by CMS and the state.

3.5. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change. Further, the state may seek an amendment to the demonstration (as per STC 3.8 of this section) as a result of the change in FFP.

b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.

3.6. **State Plan Amendments.** The state will not be required to submit title XIX or title XXI state plan amendments for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs. In all such cases, the Medicaid state plan governs.

3.7. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. Changes that expand eligibility for the coverage described in Expenditure Authority 15 and 17 and STC 13 beyond the DMC-ODS group to which the state initially intends to provide that coverage up to the full range of beneficiaries described in STC 13.2 will not require submission of an amendment but must comply with public notice processes as specified under 42 CFR 431.408. Documentation of the state's public notice processes and tribal consultation requirements outlined in STC 3.13 must be submitted to CMS at least 60 days in advance of implementation. Any reduction in the population eligible for the coverage described in Expenditure Authority 15 and 17 below the most recently approved population will require submission of a formal amendment, as described in STC 3.8. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or service-based expenditures, will be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 3.8, except as provided in STC 3.3.

3.8. **Amendment Process**. Requests to amend the demonstration must be submitted to CMS prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required elements of a viable amendment request as found in this STC, and failure by the state to submit required reports and other deliverables according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:

a. An explanation of the public process used by the state, consistent with the requirements of STC 3.13. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;

b. A detailed description of the amendment including impact on beneficiaries, with sufficient supporting documentation;

c. A data analysis worksheet which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detail projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

d. An up-to-date CHIP allotment worksheet, if necessary; and

e. The state must provide updates to existing demonstration reporting, quality and evaluation plans. This includes a description of how the evaluation design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

3.9. **Extension of the Demonstration.** States that intend to request an extension of the demonstration must submit an application to CMS from the Governor or Chief Executive Officer of the state in accordance with the requirements of 42 Code of Federal Regulations (CFR) 431.412(c). States that do not intend to request an extension of the demonstration beyond the period authorized in these STCs, must submit a transition and phase-out plan consistent with the requirements of STC 3.10.

3.10. **Demonstration Phase-Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements:

a. Notification of Suspension or Termination. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 3.13, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into the revised transition and phase-out plan.

b. Transition and Phase-out Plan Requirements. The state must include, at a minimum, in its transition and phase-out plan, the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for those beneficiaries whether currently enrolled or determined to be eligible individuals, as well as any community outreach activities, including community resources that are available.

c. Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than fourteen (14) calendar days after CMS approval of the transition and phase-out plan.

d. Transition and Phase-out Procedures. The state must comply with all notice requirements found in 42 CFR 431.206, 431.210, 431.211, and 431.213. In addition, the state must assure all applicable appeal and hearing rights afforded to demonstration beneficiaries as outlined in 42 CFR 431.220 and 431.221. If a demonstration

beneficiary requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to termination as discussed in October 1, 2010, State Health Official Letter #10-008 and as required under 42 CFR 435.916(f)(1). For individuals determined ineligible for Medicaid, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e).

e. Exemption from Public Notice Procedures, 42 CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).

f. Enrollment Limitation during Demonstration Phase-Out. If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.

g. Federal Financial Participation (FFP). FFP will be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

3.11. **Withdrawal of Waiver or Expenditure Authority.** CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX or title XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued services or benefits as a result of beneficiary appeals, and administrative costs of disenrolling participants.

3.12. **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; payment and reporting systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

3.13. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the state notice procedures as required in 42 CFR 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the Public Notice

Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

The state must also comply with tribal and Indian Health Program/Urban Indian Health Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 3.8 or extension, are proposed by the state.

3.14. **Federal Financial Participation.** No federal matching for expenditures for this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

3.15. **Federal Financial Participation (FFP) for Indian Health Services.** Supplemental payments to participating Indian Health Services and tribal facilities are limited to the costs incurred by the certifying entity in providing chiropractic services.

3.16. **Administrative Authority.** When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated demonstration functions to operating agencies, managed care organizations (MCOs), and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.

3.17. **Common Rule Exemption.** The state shall ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid program – including procedures for obtaining Medicaid benefits or services, possible changes in or alternatives to Medicaid programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. The Secretary has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.101(b)(5)

4. STATE PLAN AND DEMONSTRATION POPULATIONS AFFECTED BY THE DEMONSTRATION

4.1. **Eligibility.** Certain state plan eligibles are affected by the Demonstration, as described below.

State plan eligibles derive their eligibility through the Medicaid or CHIP state plans and are subject to all applicable Medicaid and CHIP laws and regulations in accordance with the Medicaid or CHIP state plans, except as expressly waived or made inapplicable and as described in these STCs. Any Medicaid State Plan Amendments to the eligibility standards and methodologies for these eligibility groups, including the conversion to a modified adjusted gross income standard January 1, 2014, will apply to this demonstration.

The following population groups are affected by the Demonstration:

a. Out-of-State Former Foster Care Youth, defined as youth under age 26, who were in foster care under the responsibility of a state other than California or a tribe in such other state when they turned age 18 or such higher age as the state elected for termination of federal foster care assistance under title IV-E of the Act, were enrolled in Medicaid at that time; and are now applying for Medicaid in California. Out-of-state former foster care youth will receive the same Medicaid State Plan benefits and be subject to the same cost-sharing requirements effectuated by the state for the mandatory Title IV-E foster care youth eligibility category enacted by the Adoption Assistance and Child Welfare Act of 1980 (Pub. L. 96-272).

b. Community Based Adult Services (CBAS) Populations are persons who are age 18 or older and meet CBAS eligibility under STC 5.1(a) and (d).

c. DMC-ODS populations are persons receiving residential services pursuant to DMC-ODS, regardless of the length of stay, as described in STC 6.1 and individuals receiving contingency management services, as described in STC 7.1.

d. Deemed SSI Populations.

i. The resource disregard described in section (ii) below, will be applied in determining eligibility for the following groups, subject to section (iii) below:

1. The Pickle Group under section 1939(a)(5)(E) of the Act and 42 CFR 435.135;

2. The Disabled Adult Child group under sections 1634(c) and 1939(a)(2)(D) of the Act; and

3. The Disabled Widow/Widower group under sections 1634(d), 1939(a)(2)(C), and 1939(a)(2)(E) of the Act and 42 CFR 435.137-138.

ii. The resource disregard to be applied to individuals described in section (i) above will be as follows:

1. Effective July 1, 2022, the resource disregard will be $130,000 for each individual and an additional $65,000 for each additional household member of the individual, up to a maximum of 10 household members; and
2. Effective January 1, 2024, all resources will be disregarded for each individual.

iii. The resource disregard described in section (ii) above, will not apply to the following individuals who are otherwise eligible under the state plan in:

1. A categorically needy eligibility group to which there is available:

a. The minimum mandatory medical assistance described in section 1902(a)(10)(A) of the Act, as implemented at 42 CFR § 441.210; or

b. Benchmark benefits described in section 1937 of the Act, as implemented at 42 CFR § 440.300 et seq; or

2. A medically needy group covered under the state plan without a

spenddown.

e. 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.

5. DEMONSTRATION PROGRAMS

A. Community-Based Adult Services (CBAS) for Medi-Cal State Plan Populations

5.1. **CBAS Eligibility and Delivery System.** CBAS is an outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, care coordination, and transportation to eligible State Plan beneficiaries.

a. CBAS Recipients are those persons who:

i. Are age 18 years and older;

ii. Derive their Medicaid eligibility from the State Plan and are either aged, blind, or disabled; including those who are recipients of Medicare;

iii. Are Medi-Cal managed care plan members or are exempt from enrollment in Medi-Cal managed care; and

iv. Reside within a geographic services area in which the CBAS benefit was available as of April 1, 2012, as more fully described in STC 5.1(b), or are determined eligible for the CBAS benefit by managed care plans that contract with CBAS providers pursuant to STC 5.1(d) and STC 5.1(e).

b. Delivery System.

i. CBAS is a Medi-Cal managed care benefit in counties where CBAS existed on April 1, 2012. To the extent that the provision of CBAS is determined by DHCS to be both cost-effective and necessary to prevent avoidable institutionalization of plan enrollees within a plan's service area in which CBAS was not available as of April 1, 2012, CBAS may be a Medi-Cal managed care benefit pursuant to STC 5.1(a) available to that plan's enrollees at the discretion of the plan when it contracts with a CBAS provider that has been certified as such by DHCS. A Medi-Cal managed care plan shall ensure that every CBAS provider within their service area, that has been approved by the California Department of Aging as a CBAS provider, is included in the plan's network, to the extent that the CBAS provider remains licensed as an Adult Day Health Care Center, certified and enrolled as a Medi-Cal provider, and is willing to enter into a network provider agreement with the plan on mutually agreeable terms and meets the plan's credentialing and quality standards.

ii. CBAS shall be available as a Medi-Cal fee-for-service benefit delivered through licensed Adult Day Health Care Centers approved by the California Department of Aging as a CBAS provider, that are certified and enrolled as a Medi-Cal provider, for individuals who do not qualify for, or are exempt from enrollment in, Medi-Cal managed care as long as the individual resides within the geographic service area where CBAS is provided.

iii. If there is insufficient CBAS Center capacity due to Center closure(s) to satisfy demand in counties where CBAS centers existed as of April 1, 2012, the Department of Health Care Services must assure that eligible CBAS beneficiaries that had received CBAS at the closed Center(s) have access to unbundled CBAS as needed for continuity of care and subject to the following general procedures:

    i. Managed care beneficiaries: For managed care beneficiaries who are eligible for CBAS and there is a 5% change from County capacity as of April 1, 2012, in the area, the Medi-Cal managed care plan will authorize unbundled services and facilitate utilization through care coordination.

    ii. Fee-for-Service beneficiaries: For FFS beneficiaries who are eligible for CBAS and there a 5% change from County capacity as of April 1, 2012, in the area, the following procedures will apply:

        a. DHCS will work with the local CBAS Center network and beneficiary's physician to identify other available CBAS Centers, and the type, scope and duration of the CBAS benefits that are medically necessary for the beneficiary.

        b. DHCS will work with the beneficiary's physician to arrange for needed nursing services, or referral to, or reassessment of, In-Home Supportive Services (IHSS) as needed for personal care services (or authorization of waiver personal care services needed in excess of the IHSS cap).

        c. If the beneficiary needs therapeutic services, DHCS will work with the beneficiary's physician to coordinate the authorization of needed services.

        d. If the beneficiary needs mental health and/or substance use disorder services, DHCS will work with the beneficiary's physician to refer the beneficiary to the local behavioral health services department or appropriate behavioral health professionals or services.

iv. In the event of a negative change in capacity of 5% or greater in any county for any reason, DHCS shall identify in the quarterly report for the same quarter as the negative change the provider capacity in that county for providing all core and additional CBAS services (as listed in STCs 5.1(a) and 5.1(b)) on an unbundled basis.

c. Home and Community-Based Settings. The state must ensure that home and community-based settings have all of the qualities required by 42 CFR 441.301(c)(4), and other such qualities as the secretary determines to be appropriate based on the needs of the individual as indicated in their person-centered plan. In a provider owned or controlled setting, the additional qualities required by CFR 441.301(c)(4)(vi) must be met. The state engaged in a CBAS stakeholder process to amend the HCB settings statewide transition plan to ensure that all home and community-based settings found in the 1115 Demonstration have all of the qualities required by 42 CFR 441.301(c)(4). The state will amend the statewide transition plan to include all HCBS settings used by individuals in the section 1115 demonstration, to ensure complete compliance with HCBS settings by March 17, 2023.

d. CBAS Program Eligibility Criteria. The CBAS benefit shall be available to all beneficiaries who meet the requirements of STC 5.1(a) and for whom CBAS is available based on STC 5.1(b) who meet medical necessity criteria as established in state law and who qualify based on at least one of the medical criteria in (i) through (v) below:

    i. Meet or exceed the "Nursing Facility Level of Care A" (NF-A) criteria as set forth in the California Code of Regulations; OR

    ii. Have a diagnosed organic, acquired or traumatic brain injury, and/or chronic mental disorder. "Chronic mental disorder" means the enrollee shall have one or more of the following diagnoses or its successor diagnoses included in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association: (a) Pervasive Developmental Disorders, (b) Attention Deficit and Disruptive Behavior Disorders, (c) Feeding and Eating Disorder of Infancy, Childhood, or Adolescence, (d) Elimination Disorders, (e) Schizophrenia and Other Psychiatric Disorders, (f) Mood Disorders, (g) Anxiety Disorders, (h) Somatoform Disorders, (i) Factitious Disorders, (j) Dissociative Disorders, (k) Paraphilia, (l) Eating Disorders, (m) Impulse Control Disorders Not Elsewhere Classified, (n) Adjustment Disorders, (o) Personality Disorders, or (p) Medication-Induced Movement Disorders. In addition to the presence of a chronic mental disorder or acquired, organic, or traumatic brain injury, the enrollee shall need assistance or supervision with either:

        i. Two of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, or hygiene; or

        ii. One need from the above list and one of the following: money management; accessing community and health resources; meal preparation, or transportation; or

        iii. Have moderate to severe Alzheimer's disease or other dementia characterized by the descriptors of, or equivalent to, Stages 5, 6, or 7 Alzheimer's disease; or

iv. Have a mild cognitive impairment including Alzheimer's disease or other dementias, characterized by the descriptors of, or equivalent to, Stage 4 Alzheimer's disease, defined as mild or early-stage Alzheimer's disease AND need assistance or supervision with two of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, or hygiene; or

v. Have a developmental disability. "Developmental disability" means a disability, which originates before the individual attains age 18, continues, or can be expected to continue indefinitely, and constitutes a substantial disability for that individual as defined in the California Code of Regulations.

e. CBAS Eligibility Determination. Eligibility determinations for the CBAS benefit will be performed as follows:

i. The initial eligibility determination for the CBAS benefit will be performed through a face-to-face review by a registered nurse with level of care determination experience, using a standardized tool and protocol approved by the Department of Health Care Services unless criteria under STC 5.1(e)(ii) are met. The eligibility determination shall be performed by the beneficiary's managed care plan, or by the Department of Health Care Services or its contractor(s) for beneficiaries exempt from managed care.

ii. An initial face-to-face review is not required when a managed care plan or the Department of Health Care Services or its contractor(s) determine that an individual is eligible to receive CBAS and that the receipt of CBAS is clinically appropriate based on information that the plan possesses.

iii. Eligibility for ongoing receipt of CBAS is determined at least every six months through the reauthorization process or up to every twelve months for individuals determined by the managed care plan to be clinically appropriate.

f. Grievances and Appeals

i. A beneficiary who receives a written notice of action has the right to file an appeal and/or grievance under State and Federal Law.

ii. A CBAS participant may file a grievance with their Medi-Cal managed care plan as a written or oral complaint. The participant or their authorized representative may file a grievance with the participant's Medi-Cal managed care plan at any time they experience dissatisfaction with the services or quality of care provided to them, and as further instructed by the plan.

5.2. **CBAS Benefit and Individual Plan of Care (IPC).**

a. Core Services: Professional nursing care, personal care and/ or social services, therapeutic activities, and a meal shall be provided to all eligible CBAS beneficiaries on each day of service as follows. CBAS benefits include the following:

i. Professional nursing services provided by an RN or LVN, which includes one or more of the following, consistent with scope of practice: observation, assessment, and monitoring of the beneficiary's general health status; monitoring and assessment of the participant's medication regimen; communication with the beneficiary's personal health care provider; supervision of personal care services; and provision of skilled nursing care and interventions.

ii. Personal care services provided primarily by program aides which include one or more of the following: supervision or assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs); protective group supervision and interventions to assure participant safety and to minimize risk of injury, accident, inappropriate behavior, or wandering.

iii. Social services provided by social work staff, which include one or more of the following: observation, assessment, and monitoring of the participant's psychosocial status; group work to address psychosocial issues; care coordination.

iv. Therapeutic activities organized by the CBAS center activity coordinator, which include group or individual activities to enhance social, physical, or cognitive functioning; facilitated participation in group or individual activities for CBAS beneficiaries whose physical frailty or cognitive function precludes them from independent participation in activities. The CBAS physical therapy and occupational therapy maintenance programs are considered part of Therapeutic Activities.

v. A meal offered each day of attendance that is balanced, safe, and appetizing, and meets the nutritional needs of the individual, including a beverage and/or other hydration. Special meals will be provided when prescribed by the participant's personal health care provider.

b. Additional Services. The following additional services shall be provided to all eligible CBAS beneficiaries as needed and as specified on the person's IPC:

i. Restorative physical therapy provided by a licensed, certified, or recognized physical therapist within his/her scope of practice. Pursuant to Section 1570.7(n) of the Health and Safety Code (H&S Code), physical therapy "may also be provided by an assistant or aide under the appropriate supervision of a licensed therapist, as determined by the licensed therapist. The therapy and services are provided to restore function when there is an expectation that the condition will improve significantly in a reasonable period of time, as determined by the multidisciplinary assessment team.

ii. Restorative occupational therapy provided by a licensed, certified, or recognized occupational therapist within his/her scope of practice. Pursuant to Section 1570.7(n) of the H&S Code, occupational therapy "may also be provided by an assistant or aide under the appropriate supervision of a licensed therapist, as determined by the licensed therapist. The therapy and services are

provided to restore function, when there is an expectation that the condition will improve significantly in a reasonable period of time, as determined by the multidisciplinary assessment team.

iii. Speech therapy provided by a licensed, certified, or recognized speech therapist or speech therapy assistant within their scope of practice to restore function when there is an expectation that the participant's condition will improve significantly in a reasonable period of time as determined by the multidisciplinary assessment team.

iv. Behavioral health services for treatment or stabilization of a diagnosed mental disorder provided by a licensed, certified, or recognized mental health professional within his/her scope of practice. Individuals experiencing symptoms that are particularly severe or whose symptoms result in marked impairment in social functioning shall be referred by CBAS staff to the identified managed care plan, County Mental Health programs, or appropriate behavioral health professionals or services.

v. Registered dietician services provided by a registered dietician for the purpose of assisting the CBAS beneficiary and caregivers with proper nutrition and good nutritional habits, nutrition assessment, and dietary counseling and education if needed.

vi. Transportation, provided or arranged, to and from the CBAS beneficiary's place of residence and the CBAS center, when needed.

c. Individual Plan of Care (IPC).

The IPC is a written plan designed to provide the CBAS beneficiary with appropriate treatment in accordance with the assessed needs of the individual, as determined by the CBAS center and as specified in State law. The IPC is submitted as supporting documentation for level of service determination with the treatment authorization request.

The planning process and the development and review of the IPC will comply with the requirements at 42 CFR 441.301(c)(1) through (3) including specifying: 1) How the IPC will identify each enrollee's preferences, choices and abilities and the strategies to address those preferences, choices and abilities; 2) How the IPC will allow the enrollee to participate fully in any treatment or service planning discussion or meeting, including the opportunity to involve family, friends and professionals of the enrollee's choosing; 3) How the IPC will ensure that the enrollee has informed choices about treatment and service decisions; and 4) How the IPC process will be collaborative, recurring and involve an ongoing commitment to the enrollee.

The IPC is prepared by the CBAS center's multidisciplinary team based on the team's assessment of the beneficiary's medical, functional, and psychosocial status, and includes standardized components approved by the Department of Health Care Services.

Development of the IPC is based on principles of Person-Centered Planning, which is an individualized and ongoing process to develop individualized care plans that focus on a person's abilities and preferences for the delivery of services and supports.

Person- Centered Planning includes consideration of the current and unique bio-psycho-social- cultural and medical needs and history of the individual, as well as the person's functional level, support systems, and continuum of care needs. CBAS center staff, the beneficiary, and his/her support team shall review and update the beneficiary's IPC at least every six months or when there is a change in circumstance that may require a change in benefits. Such review and updates must include an evaluation of progress toward treatment goals and objectives, and reflect changes in the beneficiary's status or needs. The IPC shall include at a minimum:

i. Medical diagnoses
ii. Prescribed medications.
iii. Scheduled days at the CBAS center.
iv. Specific type, number of service units, and frequency of individual services to be rendered on a monthly basis.
v. Elements of the services that need to be linked to individual objectives, therapeutic goals, and duration of service(s).
vi. An individualized activity plan designed to meet the needs of the enrollee for social and therapeutic recreational activities.
vii. Participation in specific group activities.
viii. Transportation needs, provided or arranged, to and from CBAS participants' place of residence and the CBAS center, when needed, including special transportation.
ix. Special diet requirements, dietary counseling and education, if needed.
x. A plan for any other necessary services that the CBAS center will coordinate.
xi. IPCs will be reviewed and updated no less than every six months by the CBAS staff, the enrollee, and his/her support team. Such review must include a review of the participant's progress, goals, and objectives, as well as the IPC itself.

5.3. **Remote CBAS Services- Emergency Remote Services (ERS).** Under certain unique circumstances, CBAS ERS may be provided in response to the individual's person-centered needs. CBAS ERS (i.e., professional nursing care; personal care services; social services; behavioral health services; speech therapy; therapeutic activities; registered dietician-nutrition counseling; physical therapy; occupational therapy; meals) shall be provided in alternative service locations (e.g., community setting or participant's home) and/or, as appropriate, telephonically, via telehealth, live virtual video conferencing, as clinically appropriate.

a. These unique circumstances are limited to the following:

    i. Qualified emergencies - state or local disasters such as wildfires and power outages (to allow for services prior to the official declaration of a formal public health emergency (PHE)) as determined by the Department of Health Care Services or its contractor(s)); and,

    ii. Personal emergencies - time-limited illness/injury, crises, or care transitions that temporarily, on a time-limited basis, prevent or restrict enrolled CBAS participants from receiving services, in-person, at the CBAS center (subject to approval by the beneficiary's managed care plan, or by the Department of Health Care Services or its contractor(s) for beneficiaries exempt from managed care).

b. These special circumstances are time-limited and vary based on the unique circumstances and identified needs of the participant as documented in the participant's individual care plan. Participants will be assessed at least every three months as part of the reauthorization of the individual's care plan and a review for a continued need for remote/telehealth delivery of CBAS services.

5.4. **CBAS Provider Specifications.** CBAS center staff shall include licensed and registered nurses; licensed physical, occupational, and speech therapists; licensed behavioral health specialists; registered dieticians; social workers; activity coordinators; and a variety of other non-licensed staff such as program aides who assist in providing services.

a. Licensed, registered, certified, or recognized staff under California State scope of practice statutes shall provide services within their individual scope of practice and receive supervision required under their scope of practice laws.

b. All staff shall have necessary experience and receive appropriate on-site orientation and training prior to performing assigned duties. All staff will be supervised by CBAS center or administrative staff.

c. The Department of Health Care Services maintains Standards of Participation for all CBAS providers which are found in Attachment H to these STCs. These Standards of Participation are hereby incorporated by reference and can be found on the Department of Health Care Services and California Department of Aging (CDA) websites. Any changes in the CBAS Provider Standards of Participation must be approved by CMS.

d. CBAS providers approved for provision of CBAS Emergency Remote Services must:

    i. Maintain regular communication with the participant via phone, email, other electronic device, or in-person visits in order to assess need related to known health status and conditions, as well as emerging needs that the participant or caregiver is reporting.

    ii. Maintain phone and email access for participant and family support, to be staffed a minimum of six hours daily, during provider-defined hours of services, Monday through Friday.

iii. Assess participants' and caregivers' current needs related to known health status and conditions, as well as emerging needs that the participant or caregiver is reporting.

iv. Respond to needs and outcomes through targeted interventions and evaluate outcomes.

v. Communicate and coordinate with participants' networks of care supports based on identified and assessed need.

vi. CBAS providers will work with individual participants to ensure they have the proper support they need in the event of equipment/technology failure including, but not limited to, arranging for alternative tools/equipment, evaluation of the existence or availability of back-up power sources, alarms, additional person(s) to assist, etc.

vii. The CBAS provider will be required to identify back-up telehealth modality service delivery options or in-person/in-home visits in the instance that equipment/technology failure prevents the provision of services through telehealth.

viii. Arrange for delivery or deliver supplies based on assessed need, including, but not limited to, food items, hygiene products, and medical supplies. If needs cannot be addressed, staff will document efforts and reasons why needs could not be addressed. Note: Meals are limited to no more than two meals per day.

e. Medi-Cal certification requires that a CBAS provider adhere to federal and state laws and regulations regarding the confidentiality, security, and unauthorized disclosure of protected health information. The role of the provider in remote service delivery is to:

i. Explain privacy requirements and appropriately document in the individual's clinical records that the individual and/or the legal representative, when appropriate, has consented to receive CBAS services via telehealth.

ii. Confirm that the provider and the individual will use two-way, real-time communication technology that meets the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and that the equipment is adequately suited for the individual's needs in order for remote service delivery.

5.5. **Responsibilities of Managed Care Plans for CBAS Benefits.** The responsibilities of managed care plans for the CBAS benefit shall be consistent with each individual managed care plan's contract with DHCS and with these STCs and shall include that plans do the following.

a. Contract Requirements for Managed Care Plans:

i. Contract with sufficient available CBAS providers in the managed care plans covered geographic service areas to address in a timely way the needs of their members who meet the CBAS eligibility criteria in STC 5.1(d). Sufficient means: providers that are adequate in number to meet the expected utilization

of the enrolled population without a waitlist; geographically located within one hour's transportation time and appropriate for and proficient in addressing enrollees' specialized health needs and acuity, communication, cultural and language needs and preferences.

ii. Plans may, but are not obligated to, contract for CBAS with providers licensed as ADHCs and authorized by the Department to provide CBAS on or after April 1, 2012. Plans are not obligated to develop new CBAS networks or capacity in geographical areas where CBAS capacity is limited or where ADHC was not available prior to April 1, 2012:

iii. Plans must ensure that telehealth delivery of the service will meet HIPAA requirements and the methodology is accepted by the HIPAA compliance officer.

iv. Where there is insufficient or non-existent CBAS capacity in the plan's covered geographic service area and ADHC had been available prior to April 1, 2012, the plan shall arrange for the delivery of appropriate plan-covered benefits and coordinate with community resources to assist members, who have similar clinical conditions as CBAS recipients, to remain in the community.

v. Confirm that every contracted CBAS provider is licensed, certified, enrolled in Medi-Cal, operating, and meets the managed care plan's credentialing and quality standards, including required Medi-Cal enrollment of staff.

i. The managed care plan may exclude any CBAS provider, to the extent that the managed care plan and CBAS provider cannot agree to terms, the CBAS provider does not meet the plan's credentialing, Medi-Cal enrollment, or quality standards, is terminated pursuant to the terms of the CBAS provider's contract with the managed care plan, or otherwise ceases its operations as a CBAS provider.

ii. The managed care plan shall provide the Department of Health Care Services a list of its contracted CBAS providers and its CBAS accessibility standards on an annual basis.

b. Eligibility and Authorization: Develop and implement policies and procedures for CBAS eligibility determination and authorization that address the eligibility criteria set forth in STC 5.1, the processes and timelines in State law, and all of the following:

i. Face-to-face eligibility determination (F2F) review requirements: the minimum standard is that the managed care plan will conduct an F2F eligibility determination for those beneficiaries who have not previously received CBAS through the plan, provided that the managed care plan has not already determined through another process that the member is clinically eligible for CBAS and in need for the start of CBAS to be expedited.

ii. Timeline for eligibility determination: the plan shall complete the F2F eligibility determination using the standard State-approved tool, as soon as

feasible but no more than 30 calendar days from the initial eligibility inquiry request.

iii. The plan shall send approval or denial of eligibility for CBAS to the CBAS provider within one business day of the decision and notify the member in writing of his/her CBAS eligibility determination within two business days of the decision.

iv. Timeline for service authorization: After the CBAS eligibility determination and upon receipt of the CBAS treatment authorization request and individual plan of care (IPC), the plan shall:

i. Approve, modify or deny the authorization request within five business days of receipt of the authorization request, in accordance with State law.

ii. Determine level of service authorization (i.e., days per week authorized) based on the plan's review of the IPC submitted by the CBAS provider, consideration of the days per week recommended by the CBAS multidisciplinary team, and the medical necessity of the member.

iii. Notify the provider within one business day of the authorization decision. Notify the member within two business days of the authorization decision, including informing the member of his/her right to appeal and grievance processes in accordance with STC 5.1(f).

v. Timeline, process, and criteria for expedited eligibility determination and authorization for CBAS such that an F2F will not be performed. At a minimum, expedited authorization shall occur within 72 hours of receipt of a CBAS authorization request for individuals in a hospital or nursing facility whose discharge plan includes CBAS, or when the individual faces imminent and serious threat to his or her health.

vi. Written notices to the beneficiary shall include procedures and contacts for grievances and appeals.

vii. Guidelines for level of service authorization, including for the number of days per week and duration of authorization up to 12 months.

viii. Continuity of care: The managed care plan shall ensure continuity of care when members switch health plans and/or transfer from one CBAS center to another.

c. Coordination with CBAS Providers: Coordinate member care with CBAS providers to ensure the following:

i. CBAS IPCs are consistent with members' overall care plans and goals developed by the managed care plan.

ii. Exchange of participant discharge plan information, reports of incidents that threaten the welfare, health and safety of the participant, and significant

changes in participant condition are conducted in a timely manner and facilitate care coordination.

iii. Clear communication pathways to appropriate plan personnel having responsibility for member eligibility determination, authorization, care planning, including identification of the lead care coordinator for members who have a care team, and utilization management.

iv. Written notification of plan policy and procedure changes, and a process to provide education and training for providers regarding any substantive changes that may be implemented, prior to the policy and procedure changes taking effect.

5.6. **CBAS Center Provider Oversight, Monitoring, and Reporting.** The state shall maintain a plan for oversight and monitoring of CBAS providers to ensure compliance and corrective action with provider standards, access, and delivery of quality care and services. Reporting of activity associated with the plan must be consistent with the Quarterly and Annual Progress Reports as set forth in this Waiver, Section XI, General Reporting Requirements and reported to CMS on a quarterly basis. Such oversight, monitoring and reporting shall include all of the following:

a. Enrollment Information: to include the number of CBAS FFS and managed care beneficiaries in each county, the capacity of each county, total determined eligible and ineligible beneficiaries per county quarterly, and explanation of probable cause of any negative change from quarter to quarter of more than five percent and description of any steps taken to address such variances.

b. The quarterly CBAS provider-reported data submitted to the CDA, identifying participant statistics, average daily attendance utilization at Centers, and capacity data.

c. Summary of operational/policy development/issues, including complaints, grievances and appeals. The State shall also include any trends discovered, the resolution of complaints and any actions taken or to be taken to prevent such issues, as appropriate.

d. Summary of all quality assurance/monitoring activity undertaken in compliance with STC 5.9, inclusive of all amendments.

e. CBAS FFS and Managed Care Access Monitoring. The Department of Health Care Services will assure sufficient CBAS access/capacity, through the mechanisms listed below, in every county where CBAS existed as of April 1, 2012.

i. Review the total number of individuals receiving a new assessment for CBAS vs. the total number of individuals obtaining ongoing CBAS and the number of participants obtaining unbundled services. CMS requires the State to report and review these metrics quarterly and upon a negative change from quarter to quarter of more than 5%, the State must provide a probable cause for the negative change as well as an analysis that addresses such variances.

ii. Review of overall utilization of CBAS, including newly opened or closed Centers. CMS requires the State to report and review these metrics quarterly and upon a negative change from quarter to quarter of more than 5%, the State must provide a probable cause for the negative change as well as an analysis that addresses such variances.

iii. Review of FFS and managed care grievances and appeals by CBAS enrollees for areas including but not limited to: appeals related to requesting services and not able to receive services or receiving more limited services than requested, excessive drive/ride times to access CBAS, grievances around CBAS providers, grievances around FFS or managed care plan staff in assessment, any reports pertaining to health and welfare of individuals utilizing CBAS, and any reports pertaining to requesting a particular CBAS provider and unable to access that provider. CMS requires the State to report and review these metrics quarterly and upon a negative change from quarter to quarter of more than 5%, the State must provide a probable cause for the negative change as well as a corrective action plan that addresses such variances.

iv. A review of any other beneficiary or provider call center/line for complaints surrounding the provision of CBAS benefits through FFS or the managed care plans.

v. CMS requires the state to report and review these metrics quarterly and upon a negative change from quarter to quarter of more than 5%, the State must provide a probable cause for the negative change as well as a corrective action plan that addresses such variances.

vi. Review the CBAS provider capacity per county vs. the total number of beneficiaries enrolled for CBAS each quarter. CMS requires the State to report and review these metrics quarterly and upon a negative change from quarter to quarter of more than 5%, the State must provide a probable cause for the negative change as well as an analysis that addresses such variances. Evidence of sufficient access monitoring and a corrective action plan must be provided to the regional office annually and at any other time a significant impact to the Medi-Cal managed care plan's operations are administered.

vii. If it is found that the State did not meet the monitoring mechanisms listed above, CMS reserves the right to withhold a portion or all of FFP related to CBAS until which time the State provides adequate documentation assuring sufficient access.

5.7. **HCBS Electronic Visit Verification System**. For any in-home services provided to CBAS beneficiaries under the CBAS Emergency Remote Services, the state will demonstrate compliance with the Electronic Visit Verification System (EVV) requirements for personal care services (PCS) and home health services in accordance with section 12006 of the 21st Century CURES Act.

5.8. **Quality Improvement Strategy for 1915(c) or 1915(i) Approvable HCBS Services:** For services that could have been authorized to individuals under a 1915(c) waiver or under a

1915(i) HCBS State plan, the state's Quality Assessment and Performance Improvement Plan must encompass long-term services and supports (LTSS) specific measures set forth in the federal managed care rule at 42 CFR 438.330 and should also reflect how the state will assess and improve performance to demonstrate compliance with applicable federal waiver assurances set forth in 42 CFR 441.301 and 441.302. The state will work on establishing the performance measures with CMS to ensure there is no duplication of effort and will report on the initial series within one year of finalization and from that point will report annually. The performance measures shall include the following components:

a. Administrative Authority: A performance measure should be developed and tracked for any authority that the Department of Healthcare Services delegates to another agency, unless already captured in another performance measure.

b. Level of Care or Eligibility based on 1115 Requirements: Performance measures are required for the following: applicants with a reasonable likelihood of needing services receive a level of care determination or an evaluation for HCBS eligibility, and the processes for determining level of care or eligibility for HCBS are followed as documented. While a performance measure for annual levels of care/eligibility is not required to be reported, the state is expected to be sure that annual levels of care/eligibility are determined.

c. Qualified Providers: The state must have performance measures that track that providers meet licensure/certification standards, that non-certified providers are monitored to assure adherence to demonstration requirements, and that the state verifies that training is given to providers in accordance with the demonstration.

d. Service Plan: The state must demonstrate it has designed and implemented an effective system for reviewing the adequacy of service plans for HCBS participants. Performance measures are required for choice of waiver services and providers, service plans address all assessed needs and personal goals, and services are delivered in accordance with the service plan including the type, scope, amount, duration, and frequency specified in the service plan.

e. Health and Welfare: The state must demonstrate it has designed and implemented an effective system for assuring HCBS participants health and welfare. The state must have performance measures that track that on an ongoing basis it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death; that an incident management system is in place that effectively resolves incidents and prevents further singular incidents to the extent possible; that state policies and procedures for the use or prohibition of restrictive interventions are followed; and, that the state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved demonstration.

f. Financial Accountability: The state must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the HCBS program. The state must demonstrate actuarial soundness on an annual basis pursuant to 42 CFR 438.

5.9. **Monitoring and Reporting of HCBS Quality Assurance:** The state will submit a report to CMS which includes evidence on the status of the HCBS quality assurances and measures that adheres to the requirements outlined in the March 12, 2014, CMS Informational Bulletin, Modifications to Quality Measures and Reporting in 1915(c) Home and Community-Based Waivers as an attachment to its Annual Monitoring Report described in STC 14.5.

The state must report, as an attachment to its Annual Monitoring Reports (refer to STC 14.5) identified issues and gaps found during the oversight and monitoring of the HCBS demonstration assurances, an explanation of how these deficiencies have been or are being corrected, as well as the steps that have been taken to ensure that these deficiencies do not reoccur. The state must also report on the number of substantiated instances of abuse, neglect, exploitation and/or death, the actions taken regarding the incidents and how they were resolved. The state will work on establishing the performance measures with CMS to ensure there is no duplication of effort and will report on the initial series within one year of finalization and from that point will report annually.

5.10. **Beneficiary Protections**:

a. Person-centered planning. The state assures there is a person-centered service plan for each individual determined to be eligible for HCBS. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR 441.301(c)(1) (1915(c)) or 42 CFR 441.725(c) (1915(i)), and the written person-centered service plan meets federal requirements at 42 CFR 441.301(c)(2) (1915(c)) or 42 CFR 441.725(b) (1915(i)). The person-centered service plan is reviewed and revised upon reassessment of functional need as required by 42 CFR 441.301(c)(3) or 42 CFR 441.365(e), at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.

b. Conflict of Interest. The state agrees that the entity that authorizes the services is external to the agency or agencies that provide the HCB services. The state also agrees that appropriate separation of assessment, treatment planning and service provision functions are incorporated into the state's conflict of interest policies.

c. Each beneficiary eligible for long term services and supports will have informed choice on their option to self-direct LTSS, have a designated representative direct LTSS on their behalf, or select traditional agency-based service delivery. Both level of care assessment and person-centered service planning personnel will receive training on these options (for use in MLTSS programs with self-direction).

d. The state, either directly or through its managed care plan contracts, must ensure that participants' engagement and community participation is supported to the fullest extent desired by each participant.

5.11. **CBAS Provider Reimbursement**.

a. DHCS shall reimburse CBAS providers serving eligible Medi-Cal beneficiaries who are not enrolled in Medi-Cal managed care at an all-inclusive rate per day of attendance per beneficiary. DHCS shall publish such rates.

b. Managed care plans shall reimburse contracted CBAS providers pursuant to a reimbursement structure that shall include an all-inclusive rate per day of attendance per plan beneficiary, or be otherwise reflective of the acuity and/or level of care of the plan beneficiary population served by the CBAS providers. Per Welfare and Institutions Code section 14184.201(d)(4), managed care plans shall reimburse contracted CBAS providers at the rate the CBAS provider would have been paid by DHCS for CBAS services under the fee-for-service delivery system (described in 19(b)(iii) above), unless the plan and contracted CBAS provider mutually agree to a different reimbursement amount. Managed care plans may include incentive payment adjustments and performance and/or quality standards in their reimbursement structure in paying CBAS providers.

5.12. **CBAS Program Integrity.**

a. Following a determination that a credible allegation of fraud exists involving a CBAS provider, the state shall notify managed care plans promptly of the finding. The state must require managed care plans to report, in a timeframe and manner as specified by the state, but no less frequently than quarterly, to the state all payments made to the applicable CBAS provider for CBAS services provided after the date of notification; the state must disclose this information to CMS beginning with payments made on or after April 1, 2016.

b. If the credible allegation of fraud is proven:

i. For purposes of claiming FFP, the state must adjust its claiming associated with payments to a managed care plan to account for an amount equal to what the managed care plan has paid to an applicable CBAS provider for dates of services occurring after the state has notified the managed care plan that the CBAS provider has been referred for investigation. The state shall refund the federal share associated with such payments in accordance with Attachment S.

ii. The state may recoup from its payment to a managed care plan an amount equal to what the managed care plan has paid to the applicable CBAS provider for dates of service after the state has notified the managed care plan that the CBAS provider has been referred for investigation.

iii. Additional specifications pertaining to these requirements including information about how payments and claiming will be adjusted and MCPs will be notified are set forth in Attachment S in accordance with the Medicaid Managed Care rule at 80 FR 31097 or the finalized 42 CFR 438

B. Providing Access and Transforming Health

5.13. **Providing Access and Transforming Health (PATH) Overview.** The state is authorized up to $1.85 billion (total computable) in expenditure authority for PATH, subject to the provisions in STC 5.16. PATH is one-time transitional funding that will support the state's efforts to maintain, build, and scale the capacity necessary to transition the Whole Person Care (WPC) and Health Home Pilots approved in the Medi-Cal 2020 demonstration to the CalAIM initiative.

PATH funding will ensure Medi-Cal beneficiaries have continuous access to benefits and services previously covered by WPC Pilots as these activities are integrated into Medi-Cal managed care plans (MCPs). It will also support planning and information technology (IT) investments for pre-release services and reentry activities. Examples of pre-release services and reentry activities include pre-release application and suspension/unsuspension processes, assessment of qualification for reentry demonstration initiative services, the provision of pre-release services for up to 90 days immediately prior to the expected date of release, and care coordination to support reentry planning. Unless otherwise specified, this expenditure authority is authorized over the five years of the demonstration from January 1, 2022 through December 31, 2026. This funding will be administered by DHCS or a Third Party Administrator (TPA). All of PATH funding, except for sustaining services below, will be considered an administrative cost and will be paid at the 50 percent regular administrative expenditure matching rate. Funding for Sustaining Services Through the Transition to Managed Care will be matched at the medical assistance payment (MAP) matching rate.

a. The state shall select Qualified Applicants, described in STC 5.19, to receive payments under PATH, as outlined in STC 5.13(d) below, to support counties, providers, and MCPs as they sustain, transition, and expand WPC and Health Home Pilot services and interventions initially authorized under the Medi-Cal 2020 demonstration to statewide services available through the Medi-Cal managed care delivery system. PATH funding will support the development of capacity, transitional non-service expenditures, infrastructure, and systems across the state, including in those counties that did not participate in WPC.

b. The state and Qualified Applicants as defined in STC 5.19 will be subject to requirements around eligibility for funding, program integrity, and evaluation, as outlined in the PATH STCs, PATH Monitoring Protocol, CalAIM demonstration reporting, and the CalAIM demonstration evaluation approach in STC 15.4.

c. A former "WPC Lead Entity" refers to the cities, county agencies, designated public hospitals, district municipal public hospitals, or federally recognized tribes and tribal health programs that participated in the Whole Person Care Pilots as authorized and defined under the Medi-Cal 2020 demonstration.

d. For applicable initiatives, Qualified Applicants must provide DHCS or the TPA with a specific request and justification as part of an application for funding. DHCS will determine a target amount of funding to be allocated within each county as part of the Ensuring Access to Services During Transition and Delivery System and Innovation Program to promote appropriate distribution of funding across the state. Target funding amounts will likely be adjusted over time to meet varying demand and will be determined based on a combination of factors including, for example, enrollment, access/affordability and other indicators.

e. PATH funding must not supplant funding provided by other Federal, state or local funding sources. The PATH payments do not offset payment amounts otherwise payable to and by MCPs for Medi-Cal beneficiaries, or replace provider payments from MCPs. The PATH funding must not supplant funding provided for the state's

Department of Corrections (DOC) for the purchase of technology for state prisons, county jails, and youth correction facilities.

5.14. **PATH Programs Description**. Ensuring Access to Services During Transition and Delivery System Transformation and Innovation Program, which is comprised of five initiatives:

a. **Support for Sustaining Services Through the Transition to Managed Care.** PATH funding is available for the Support for Sustaining Services Through the Transition to Managed Care Initiative for former WPC Pilot Lead Entities to sustain existing WPC Pilot services that will continue under CalAIM as Community Supports, as defined in Section VIII and the 1915(b) waiver. This funding is intended to ensure continuity of services for individuals when a Community Support is not adopted by the MCP on January 1, 2022, but there is a commitment from the MCP that it will elect to offer the Community Support before January 1, 2024. Funding for services will be matched at MAP for these specific services under PATH expenditures. Allowable Services may assist in the continuity of access to WPC services that are transitioning to CalAIM and may not be covered on "day one." For example:

i. Housing transition navigation services, housing tenancy and sustaining services, or asthma remediation;

ii. Sobering center services;

iii. Recuperative care services.

b. **The funding may not be used to initiate new services.** WPC services and infrastructure that will not continue under CalAIM (i.e., where there is no corresponding CalAIM Community Support) would not be eligible for this funding. Funding may not be used to fund WPC services indefinitely and may only be used to continue services until the services are picked up by MCPs no later than January 1, 2024. The payments do not offset payment amounts otherwise payable to and by MCPs for Medi-Cal beneficiaries, or supplant provider payments from MCPs.

c. **Support for Sustaining Reentry Demonstration Initiative Services Through the Transition to Managed Care.** PATH will make funding available to former WPC Pilot Lead Entities to maintain reentry services currently provided through former WPC Pilots that do not transition to managed care until January 1, 2023, or later. Direct funding is available for WPC Pilot Lead Entities, as well as ECM / Community Supports providers which work with jails, prisons, and youth correctional facilities to sustain existing WPC Pilot pre-release and reentry services that map to required ECM and MCP-offered Community Supports. Funding may be used only to pay former WPC Lead Entities for services provided. Some WPC services will not be covered by MCPs until mid-2022 or 2023; this funding may be used to sustain these services until they are transitioned to and paid for by MCPs. This funding will be matched at ADM for these specific PATH expenditures. The funding may not be used to initiate new services, sustain services that were provided in WPC but are not transitioning to CalAIM, or sustain services indefinitely without a plan to transition them to the

consolidated CalAIM Section 1915(b) waiver delivery system and other related authorities.

d. **Technical Assistance Marketplace.** PATH will make funding available for the provision of technical assistance (TA) to Qualified Applicants that are contracted with or that intend to contract with one or more MCPs as an ECM or Community Supports provider. This funding will be matched at ADM for these specific PATH expenditures. Qualified Applicants, as described in STC 5.19, can apply to the TPA for TA support. Allowable expenditures include, but are not limited to, the following, and once finalized will be included as an Operational Protocol at Attachment O within the STCs:

    i. Workforce training to support expansion of services to newly eligible populations or vulnerable populations (e.g., individuals who are experiencing homeless);

    ii. Technical assistance (e.g., through trainings, one-on-one consultations) mining EHR data to identify individuals newly eligible for ECM/Community Support (ILOS) services;

    iii. Developing and distributing in-depth guidance for implementing data sharing processes between providers and housing services organizations to connect members to housing community support services;

    iv. Providing specific training to support the development, coordination, and implementation for regional learning collaboratives/learning networks; and

    v. Detailed training on how to connect justice-involved individuals to housing services.

e. **Collaborative Planning and Implementation for ECM and Community Supports.** Expenditure authority will make funding available to establish and facilitate regional collaborative planning efforts to support readiness for CalAIM implementation. Regional collaborative planning efforts will be organized and facilitated by a TPA or Vendor, and should include at a minimum: MCPs, city, county, and other government agencies, county and community-based providers (including but not limited to public hospitals), CBOs, and Medi-Cal Tribal and Designees of Indian Health Programs contracted with or that intend to contract with MCPs as ECM or Community Supports providers. As the implementers of ECM and Community Supports, MCPs will not be eligible to receive funding through this initiative but are expected to participate in Collaborative Planning and Implementation initiatives ongoing in their service areas. This funding will be matched at ADM for these specific PATH expenditures. Allowable expenditures include, but are not limited to, the following, and once finalized, will be included as an Operational Protocol at Attachment O in the STCs.

    i. Support collaborative planning between MCPs and local stakeholders to identify and address gaps that may hinder implementation of ECM / Community Support services;

ii. Development of implementation plans to operationalize CalAIM and address ECM/Community Support service gaps using PATH funding;

iii. Identify and resolve ongoing ECM/Community Supports service delivery challenges through regular meetings and collaboration throughout the five-year CalAIM demonstration period; and

iv. Support development, coordination and implementation of virtual or in-person meetings to support ECM/Community Supports quality improvement efforts to ensure the delivery of high-quality services.

f. **Support for Expanding Access to Services.** Expenditure authority will make funding available to enable the transition, expansion and development of capacity and infrastructure necessary for city, county, and other government agencies, county and community-based providers (including but not limited to public hospitals), CBOs, and Medi-Cal Tribal and designees of Indian Health Programs contracted with or that intend to contract with MCPs as ECM or Community Supports providers. Allowable expenditures include, but are not limited to:

i. Hiring staff that will have a direct role in the execution and expansion of ECM/Community Supports services to boost capacity to assure access to these services;

ii. Supporting implementation of a closed-loop referral system to ensure individuals referred to needed services were able to access those services;

iii. Purchasing billing systems for newly available services; and

iv. Providing up front funding needed by providers/community-based organizations to deliver ECM/Community Supports services (e.g., purchasing infrastructure that refrigerates fresh food).

g. Eligible entities include, at a minimum, city, county and other government agencies, county and community-based providers (including but not limited to public hospitals), CBOs, and Medi-Cal Tribal and designees of Indian Health Programs.

a. Qualified Applicants must provide the TPA with a specific request and justification as part of an application for funding. DHCS will determine a target amount of funding to be allocated within each county as part of the Ensuring Access to Services During Transition and Delivery System Transformation and Innovation PATH Program to promote equitable distribution of funding across the state. Target funding amounts will likely be adjusted over time to meet varying demand and will be determined based on a combination of factors including, for example: MCP revenue, enrollment, access/affordability and other indicators.

5.15. **The PATH Reentry Demonstration Initiative Planning and Implementation Program** will provide expenditure authority to fund supports needed for Medi-Cal pre-release application and suspension/unsuspension planning and purchase of certified electronic health record technology to support Medi-Cal pre-release applications. PATH reentry demonstration initiative planning and implementation funds will also provide funding over the remaining four years of the

demonstration (beginning January 26, 2023) to support planning and IT investments that will enable implementation of the reentry demonstration initiative services covered in a period for up to 90 days immediately prior to the expected date of release, and for care coordination to support reentry. These investments will support collaboration and planning between DHCS, carceral facilities participating in the reentry demonstration initiative (e.g., state prisons, county jails, youth correctional facilities), county behavioral health agencies, community-based providers, probation offices, community health workers, managed care plans, sheriff's offices, local county social services departments, and others. The specific use of this funding will be proposed by the Qualified Applicant submitting the application, as the extent of approved funding will be determined according to the needs of the entity. Allowable expenditures are limited to only those that support Medicaid-related expenditures and/or demonstration-related expenditures (and not other activities or staff in the carceral facility) and must be properly cost-allocated to Medicaid or CHIP, as necessary, and once finalized will be included in the PATH Operational and Monitoring Protocol at Attachment O within the STCs. These allowable expenditures may include the following:

a. **Technology and IT Services.** Expenditures for the purchase of technology for Qualified Applicants which are to be used for assisting the reentry demonstration initiative population with Medicaid and CHIP application and enrollment for demonstration coverage (e.g., for inmates who would be eligible for CHIP but for their incarceration status) and coordinating pre-release and post-release services for enrollees. This includes the development of electronic interfaces for prisons, jails, and youth correctional facilities to communicate with Medicaid IT systems to support Medicaid enrollment and suspension/unsuspension and modifications. This also includes support to modify and enhance existing IT systems to create and improve data exchange and linkages with correctional facilities, local county social services departments, county behavioral health agencies, and others, such as managed care plans and community-based providers, in order to support the provision of pre-release services delivered in the period up to 90 days immediately prior to the expected date of release and reentry planning.

b. **Hiring of Staff and Training.** Expenditures for Qualified Applicants to recruit, hire, onboard, and train additional and newly assigned staff to assist with the coordination of Medi-Cal enrollment and suspension/unsuspension, as well as the provision of pre-release services in a period for up to 90 days immediately prior to the expected date of release and for care coordination to support reentry for justice-involved individuals. Qualified Applicants may also require training for staff focused on working effectively and appropriately with justice-involved individuals.

c. **Adoption of Certified Electronic Health Record Technology.** Expenditures for providers' purchase or necessary upgrades of certified electronic health record (EHR) technology and training for the staff that will use the EHR.

d. **Purchase of Billing Systems.** Expenditures for the purchase of billing systems for Qualified Applicants.

e. **Development of Protocols and Procedures.** Expenditures to support the specification of steps to be taken in preparation for and execution of the Medi-Cal enrollment process and suspension/unsuspension process for eligible individuals and coordination of a period for up to 90 days immediately prior to the expected date of release and reentry planning services for individuals qualifying for reentry demonstration initiative services.

f. **Additional Activities to Promote Collaboration.** Expenditures for additional activities that will advance collaboration between California's correctional institutions (county jails, youth correctional facilities, and state prisons), correctional agencies (e.g., California Department of Corrections and Rehabilitation, Sheriff's Offices, Probation Offices, etc.), local county social services departments, county behavioral health agencies, managed care plans, community-based providers and others involved in supporting and planning for the reentry demonstration initiative. This may include conferences and meetings convened with the agencies, organizations, and stakeholders involved in the initiative.

g. **Planning.** Expenditures for planning to focus on developing processes and information sharing protocols to: (1) identifying uninsured who are potentially eligible for Medi-Cal; (2) assisting with the completion of an application; (3) submitting an application to the county social services department or coordinating suspension/unsuspension; (4) screening for eligibility for pre-release services and reentry planning in a period for up to 90 days immediately prior to the expected date of release; (5) delivering necessary services to eligible individuals in a period for up to 90 days immediately prior to the expected date of release and care coordination to support reentry; and (6) establishing on-going oversight and monitoring process upon implementation.

h. **Other activities to support a milieu appropriate for provision of pre-release services.** Expenditures to provide a milieu appropriate for pre-release services in a period for up to 90 days immediately prior to the expected date of release, including accommodations for private space such as movable screen walls, desks, and chairs, to conduct assessments and interviews within correctional institutions, and support for installation of audio-visual equipment or other technology to support provision of pre-release services delivered via telehealth in a period for up to 90 days immediately prior to the expected date of release and care coordination to support reentry.

5.16. **PATH Funding Amounts.** PATH will be funded at the amounts described in the table below for each of the five (5) years of the CalAIM demonstration renewal, with funding phasing down over time as the CalAIM delivery system matures, totaling a maximum of $1.85 billion over five years. To the extent any of the funds associated with PATH are not fully expended or fully allocated in a given demonstration year, PATH funds may be reallocated across other PATH initiatives or years, subject to overall PATH expenditure limits. DHCS will detail within quarterly and annual reports when it reallocates PATH funding to a future DY and/or from one PATH initiative to another.

Table 1. Annual Total Computable PATH Funding by Initiative (Amounts in Millions)

Program	PY 1 (2022)	PY 2 (2023)	PY 3 (2024)	PY 4 (2025)	PY 5 (2026)	Total
Ensuring Access to Services During Transition and Delivery System Transformation and Innovation	$554	$430	$230	$70	$5	$1,289
Reentry Demonstration Initiative Planning and Implementation	$10	$350	$201	$0	$0	$561
Total	**$564**	**$780**	**$431**	**$70**	**$5**	**$1,850**

5.17. **PATH Funding Administration.** Subject to the funding limits in Table 1, DHCS will review, approve, and make payments for PATH funding in accordance with the requirements in these PATH STCs. DHCS will make payments directly to awarded Qualified Applicants or via the TPA to Qualified Applicants. DHCS will monitor payments to ensure compliance with PATH program requirements, applicable statutory and regulatory requirements, and to prevent fraud, waste and abuse. DHCS will ensure that it has appropriate mechanisms and methodologies in place to ensure the appropriate amount of FFP is claimed for each PATH program and initiative.

5.18. **Payment to Qualified Applicants and the TPA is limited to the overall PATH funding limit stipulated in Table 1.** Qualified Applicants and the TPA must attest to DHCS that they have appropriate funds controls between PATH funding and billing for Medi-Cal applicable state plan covered services.

a. DHCS will approve applicants, and administer and monitor funds for the Support for Sustaining Services Through the Transition to Managed Care, and Support for Sustaining Reentry Services Through the Transition to Managed Care initiatives. A TPA may administer and oversee funding for the other PATH initiatives, including the Reentry Demonstration Initiative Planning and Implementation Program.

b. For the Technical Assistance Marketplace, Collaborative Planning and Implementation of ECM and Community Supports, and Support for Expanding Access to Services initiatives, the TPA will be responsible for monitoring PATH payments to identify duplicate funding received by Qualified Applicants for covered Medi-Cal services or other payment programs, such as incentives. The TPA may also administer the Reentry Demonstration Initiative Planning and Implementation Program.

c. To the extent that the intensity of needs shift, PATH funds may be reallocated across PATH initiatives or future demonstration years, subject to overall PATH expenditure limits.

5.19. **Qualified Applicants.** Criteria for Qualified Applicants will vary by PATH initiative.

a. Qualified Applicants for the PATH Ensuring Access to Services During Transition and Delivery System Transformation and Innovation Program will also vary by initiative.

i. For the Support for Sustaining Services Through the Transition to Managed Care Initiative, former WPC Lead Entities, as defined under the Medi-Cal 2020

demonstration, will be eligible to become a Qualified Applicant to receive Support for Sustaining Services Through the Transition to Managed Care Initiative funding. Qualified Applicants may use funding from this initiative to sustain allowable WPC services until they transition to CalAIM.

ii. For the Support for Sustaining Reentry Services Through the Transition to Managed Care Initiative, former WPC Lead Entities, as defined under the Medi-Cal 2020 demonstration that have previously offered pre-release services as part of the WPC Pilots will be eligible to become a Qualified Applicant. Qualified Applicants may use funding from this initiative to sustain previously offered pre-release services until they transition to CalAIM.

iii. For the Technical Assistance Marketplace Initiative, Collaborative Planning and Implementation of ECM and Community Supports Initiative and Support for Expanding Access to Services, the following entities, at a minimum, will be eligible to become a Qualified Applicant to receive TA support: city, county, and other government agencies; county and community-based providers including but not limited to public hospitals, CBOs, and Medi-Cal Tribal and designees of Indian Health Programs contracted with or that intend to contract with MCPs as ECM or Community Supports providers; and other entities as approved by DHCS or the TPA.

b. Qualified Applicants for the Reentry Demonstration Initiative Planning and Implementation Program will include correctional institutions (county jails, youth correctional facilities, and state prisons), the California Department of Corrections and Rehabilitation, Probation Offices, Sheriff's Offices, county behavioral health agencies, county departments of social services, county departments of public health, and other entities as relevant to the needs of justice-involved individuals as approved by DHCS.

5.20. **Invoice and Application Process for Qualified Applicants**. Qualified Applicants will be required to submit invoices and/or applications, to be processed and evaluated by DHCS or the TPA, in order to receive PATH dollars. Funding will vary by initiative and by Qualified Applicant. If a selected applicant fails to substantially comply with any of the terms of the approved application, DHCS will take corrective action and may terminate agreement and redirect applicable funds to other selected applicants who qualify for additional PATH funds or to other Qualified Applicants whose programs were not previously selected for funding, in that same demonstration year or a future demonstration year, as applicable.

a. The invoice and/or application process for Qualified Applicants under the PATH "Ensuring Access to Services During Transition and Delivery System Transformation and Innovation" program will vary by initiative.

i. For the Support for Sustaining Services Through the Transition to Managed Care Initiative, Qualified Applicants must submit a standardized invoice for spending on permissible services.

ii. For the Support for Sustaining Reentry Services Through the Transition to Managed Care Initiative, Qualified Applicants must submit a standardized invoice for spending on permissible services.

iii. For the Technical Assistance Marketplace Initiative, Qualified Applicants must submit a standardized application to the TPA that outlines the request for TA or supporting resources, and other relevant information to be determined by DHCS.

iv. For the Collaborative Planning and Implementation Initiative, Qualified Applicants must submit a standardized application to the TPA outlining their interest and intent to establish and support local collaborative planning in the region and in collaboration with other entities, along with other relevant information to be determined by DHCS.

v. For the Support for Expanding Access to Services Initiative, the Qualified Applicant must submit a standardized application to the TPA outlining the intended purpose of the PATH funds, along with other relevant information to be determined by DHCS.

b. For the Reentry Demonstration Initiative Planning and Implementation Program, Qualified Applicants must submit a standardized application for participation and/or invoices in the format specified by DHCS for spending on permissible activities.

5.21. **Treatment of PATH Funds.** PATH payments are available to Qualified Applicants. PATH Payments shall not be considered direct reimbursement for expenditures or payments for new services. PATH payments are intended to support transitional non-service expenditures, interventions and non-Medicaid covered transitional services that support the transition from WPC Pilots and Health Home Program to CalAIM, expand access to needed services, and enable community-based providers to provide Community Supports.

PATH payments are not direct reimbursement for expenditures incurred by participating entities. PATH payments shall not be considered payments for services otherwise reimbursable under the Medi-Cal program, and therefore providers may continue to bill Medi-Cal and/or the Medi-Cal managed care plan for all applicable state plan covered services. PATH payments are not reimbursement for health care services that are recognized under these STCs or under the state plan. PATH payments should not be considered patient care revenue and should not be offset against the certified public expenditures incurred by government-operated health care systems and their affiliated government entity providers for health care services, disproportionate share hospital payments or administrative activities as defined under these STCs and/or under the state plan. The payments do not offset payment amounts otherwise payable to and by MCPs for Medi-Cal beneficiaries, or supplant provider payments from MCPs.

5.22. **PATH Progress Reports.** Qualified Applicants and the TPA receiving PATH funding shall submit progress reports in a manner and frequency specified by DHCS. Progress reports will include reporting on performance metrics that are standardized by PATH program and initiative. The state will work with the TPA to develop such performance metrics across PATH programs and initiatives. Qualified Applicants will also be responsible for determining entity-specific

milestones related to their need for and use of PATH funding. These proposed milestones may be reviewed and approved by the state or the TPA, as appropriate, as a condition of funding receipt. In these cases, the Qualified Applicant will be expected to provide narrative reports in a frequency and manner established by the state and the TPA. Ongoing funding may be based on progress towards or achievement of those milestones and performance metrics, as determined by the state. Failure to adequately meet or report on milestones and performance metrics may preclude a Qualified Applicant from receiving future PATH funding.

Wherever possible, with respect to the two Support for Sustaining Services Initiatives, progress reports will seek to collect information that may be used to understand race, ethnicity, geographic location, and other characteristics of individuals who receive services associated with these two initiatives. For other PATH initiatives, the state will work to prioritize support for Qualified Applicants that have been historically underutilized and/or under-resourced, and/or that serve the diverse needs of the state's population.

5.23. **PATH Funding and Mechanics Protocol.** Within one hundred and twenty (120) days of CMS approval of the terms and conditions for the CalAIM renewal, CMS and the state will develop and finalize a PATH Funding and Mechanics Protocol that will outline additional detail on the milestones and award criteria for the Qualified Applicants. As needed, the PATH Funding and Mechanics Protocol will be updated within 180 days following approval of the reentry demonstration and DSHP initiatives to address these components outlined in these STCs.

5.24. **PATH Program Integrity.** DHCS will ensure that all PATH payments are made consistent with these STCs. Within one hundred and twenty (120) days of CMS approval of the STCs for the CalAIM renewal, CMS and the state will develop and finalize a PATH Operational and Monitoring Protocol that will outline DHCS' approach to PATH program integrity, oversight, monitoring, and performance metrics, including any required reporting to CMS. As needed, the PATH Operational and Monitoring Protocol will be updated within 180 days following approval of the reentry and DSHP initiatives to address these components outlined in these STCs. The state will ensure that PATH funding is subject to program integrity standards. Program integrity activities will include, at a minimum:

a. **Completing progress reporting on PATH-funded activities.** All PATH funding recipients will be expected to submit progress reports that document PATH-funded activities. Recipients will be required to attest to non-duplication of funding with other federal, state and local funds. The state or its contracted TPA will monitor for funding irregularities and potential duplication across all PATH programs and initiatives.

b. **Participating in audit processes.** The state or its contracted TPA will conduct spot-audits to ensure that PATH funds are being spent on permissible uses and are being documented and reported on appropriately.

c. **Ensuring action is taken to address noncompliance.** The state or its contracted TPA will ensure that action is taken to address any identified non-compliance with PATH funding parameters. If the state determines that a funding recipient has failed to demonstrate appropriate performance, DHCS may impose corrective actions which

may include caps on funding, recoupment of funding, or discontinuation of PATH funding. The state may also impose corrective actions for a Qualified Applicant if it is determined that it is out of compliance with requirements as set forth in the STCs and attachments, the agreement between the Qualified Applicant and the state, and/or policy letters or guidance set forth by the state. Prior to initiating any corrective action on Qualified Applicants, the state shall provide the Qualified Applicants notice and an opportunity to comment regarding the identified area of non-compliance. CMS reserves the right to require DHCS to return FFP associated with recoupment of funding for Qualified Applicant and TPA noncompliance.

5.25. **Sources of Non-Federal Share Funding for PATH Expenditures.** The state must have permissible sources for the non-federal share of all PATH expenditures, which may include, as applicable to a specific PATH initiative or program, permissible intergovernmental transfers (IGTs) from qualifying governmental entities, or state funds. Sources of non-federal share funding shall not include impermissible provider taxes or non-bona fide provider-related donations under Section 1903(w), impermissible IGTs from providers, or federal funds received from federal programs other than Medicaid (unless expressly authorized by federal law to be used for claiming purposes, and the federal Medicaid funding is credited to the other federal funding source). For this purpose, federal funds do not include GPP payments, PATH payments, or patient care revenue received as payment for services rendered under programs such as Medicare or Medicaid.

For PATH expenditures derived from IGTs, the qualified funding entity shall certify that the funds transferred qualify for federal financial participation pursuant to 42 CFR part 433, subpart B, and not derived from the impermissible sources listed above.

C. Dually Eligible Enrollees in Medi-Cal Managed Care

5.26. Under the expenditure authority for the Duals Eligible Program, the state will align a dually eligible beneficiary's Medicaid plan with their Medicare Advantage (MA) Plan choice, to the extent the Medicare Advantage plan has an affiliated Medicaid plan. In counties where the state is authorizing exclusively aligned enrollment Dual Eligible Special Needs Plans (D-SNPs), the state will limit enrollment into D-SNPs without Medicaid managed care plans, further simplifying the health plan market for dually eligible individuals. The state is committed to implementing valuable aspects of integration, including integrated appeals and grievances, continuation of Medicare benefits pending appeal, integrated member materials, and care coordination that extends across Medicare and Medicaid benefits in counties where the state is authorizing the exclusively aligned enrollment D-SNP model. Aligned Medicare/Medicaid plans may also reduce inappropriate billing, improve alignment of Medicare and Medicaid networks, and improve access to care. This will include:

a. The state will develop a process by which the enrollment broker can directly facilitate immediate Medicaid plan disenrollment should the beneficiary need be urgent/medically necessary, particularly during the last quarter of the calendar year. In addition, the Cal MediConnect Ombudsman, and any successor program, can make a warm handoff to the enrollment broker to facilitate immediate Medicaid plan disenrollment in the circumstances described above.

b. With the consultation of stakeholders through the Duals & LTSS Workgroup, the state will implement continuity of care requirements to support beneficiary access to prior providers until, at a minimum, the beneficiary has the opportunity to change Medicaid plans.

c. The state will ensure that beneficiary communications from the state and from plans in counties with exclusively aligned enrollment D-SNPs explain the benefits of enrollment in integrated care, and in all counties with Medicaid plan and MA alignment the beneficiary communications explain the opportunities, process, and timing for changing Medicaid plans. Beneficiary communications will include contact information for Health Insurance Counseling and Advisory Program (HICAP) and ombudsman services.

d. DHCS will develop and implement the necessary system changes to effectuate exclusively aligned enrollment for D-SNPs aligned with the Medicaid managed care plans. The state will work collaboratively with advocates, health plans, and CMS to develop and implement a long-term system.

6. DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM

6.1. **Drug Medi-Cal Organized Delivery System.** The Drug Medi-Cal Organized Delivery System (DMC-ODS) is a program for the organized delivery of substance use disorder (SUD) services to Medi-Cal-eligible individuals with SUD that reside in a county that elects to participate in the DMC-ODS (previously and hereafter referred to as DMC-ODS beneficiaries). Since the DMC-ODS pilot program began in 2015, all California counties had the option to participate in the program to provide their resident Medi-Cal beneficiaries with a range of evidence-based SUD treatment services in addition to those available under the Medi-Cal State Plan. Originally authorized by the Medi-Cal 2020 demonstration, most components of DMC-ODS are authorized under California's Section 1915(b) waiver (for service delivery within a regional managed care environment) and California's Medicaid State Plan (for benefits coverage), as of January 1, 2022. This CalAIM demonstration will continue to provide the state with authority to claim federal financial participation (FFP) for high quality, clinically appropriate SUD treatment services for DMC-ODS beneficiaries who are short-term residents in residential and inpatient treatment settings that qualify as an IMD. The CalAIM demonstration will continue to test whether this authority will increase access to evidence-based treatment services and improve overall health and long-term outcomes for those with SUD when a full continuum of care is provided. Critical elements of the DMC-ODS Program continue to include providing a continuum of care and patient assessment and placement tools modeled after the American Society of Addiction Medicine (ASAM) Criteria.

During the demonstration period, the state seeks to continue achieving the following goals:

a. Increased rates of identification, initiation, and engagement in treatment;

b. Increased adherence to and retention in treatment;

c. Reductions in overdose deaths, particularly those due to opioids;

d. Reduced utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;

e. Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate; and

f. Improved access to care for physical health conditions among beneficiaries.

DMC-ODS Program. Under this demonstration, DMC-ODS beneficiaries will continue to have access to high-quality, evidence-based SUD treatment services including services provided in residential and inpatient treatment settings that qualify as an IMD, which are not otherwise reimbursable expenditures under section 1903 of the Act in the absence of the expenditure authority granted herein. The state will continue to be eligible to receive FFP for DMC-ODS beneficiaries residing in IMDs under the terms of this demonstration for coverage of medical assistance, including SUD benefits that would otherwise be reimbursable if the beneficiary were not residing in an IMD. California will continue to aim for a statewide average length of stay of 30 days or less in residential treatment settings, to be monitored pursuant to the SUD Monitoring Protocol as outlined in STC 6.5 below. The ASAM Criteria assessment shall continue to be used for all DMC-ODS beneficiaries to determine placement into the appropriate level of care.

In counties that do not opt into the DMC-ODS Program, beneficiaries receive only the "Substance Use Disorder Treatment Services" covered under California's Medicaid State Plan, they are not eligible to receive the "Expanded SUD Treatment Services" covered under the State Plan which are limited to beneficiaries residing in DMC-ODS counties.

Beneficiaries under the age of 21 are eligible to receive coverable Medicaid services pursuant to the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. Under the EPSDT mandate, beneficiaries under the age of 21 are eligible to receive all appropriate and medically necessary services needed to correct and ameliorate health conditions that are coverable under section 1905(a) of the Act. Nothing in the DMC-ODS overrides any EPSDT requirements. Counties remain responsible for the provision of medically necessary DMC-ODS services pursuant to the EPSDT mandate.

As outlined in Table 2 below, DMC-ODS benefits reflect a continuum of care that ensures that beneficiaries can enter SUD treatment at a level appropriate to their needs and step up or down to a different intensity of treatment based on their responses. The ASAM Criteria Assessment shall be used for all beneficiaries to determine placement into the appropriate level of care. DMC-ODS counties must provide independent review for residential services within 24 hours of the submission of the request by the provider. Room and board costs are not considered allowable costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

Table 2: ASAM Criteria Continuum of Care Services and the DMC-ODS System		
Benefit	**Medicaid authorities**	**Required or Optional for DMC-ODS Counties**
Screening, Assessment, Brief Intervention, and Referral to Treatment (SABIRT) and Early Intervention	State plan (individual services covered) SABIRT is delivered through fee-for-service (FFS) and Managed Care Plan (MCPs) delivery systems for beneficiaries aged 11 years and older Early intervention services (excluding to SABIRT) are available in DMC-ODS and Drug Medi-Cal for beneficiaries under age 21	Required • Coordination with SABIRT delivered through FFS/MCPs • Additional early intervention services for beneficiaries under age 21
Outpatient services (also known as Outpatient Drug Free)	State plan (individual services covered)	Required
Intensive outpatient services	State plan (individual services covered) 1115 expenditure authority for services provided to individuals in IMDs	Required
Partial hospitalization services	State plan (individual services covered) 1115 expenditure authority for services provided to individuals in IMDs	Optional
Residential/inpatient services	State plan (individual services covered) 1115 expenditure authority for services provided to individuals in IMDs	Required • At least one ASAM level of care initially • ASAM Levels 3.5 available within two years • ASAM Levels 3.1 and 3.3 available within three years • Coordination with ASAM Levels 3.7 and

Table 2: ASAM Criteria Continuum of Care Services and the DMC-ODS System		
Benefit	**Medicaid authorities**	**Required or Optional for DMC-ODS Counties**
		4.0 delivered through FFS/MCPs Optional • ASAM Levels 3.7 and 4.0
Withdrawal management services	State plan (individual services covered) 1115 expenditure authority for services provided to individuals in IMDs	Required • Coordination with ASAM Levels 3.7-WM and 4.0-WM delivered through FFS/MCPs • At least one level of withdrawal management (ASAM Levels 1-WM, 2-WM, 3.2-WM, 3.7-WM, or 4-WM) Optional • Additional levels of withdrawal management
Narcotic Treatment Program services	State plan (individual services covered) 1115 expenditure authority for services provided to individuals in IMDs	Required
Medications for Addiction Treatment for Alcohol Use Disorders and Other Non-Opioid Substance Use Disorders	State plan (individual services covered) 1115 expenditure authority for services provided to individuals in IMDs	Required
Medications for Addiction Treatment for Opioid Use Disorders	State plan (individual services covered)	Required

Table 2: ASAM Criteria Continuum of Care Services and the DMC-ODS System		
Benefit	**Medicaid authorities**	**Required or Optional for DMC-ODS Counties**
	1115 expenditure authorityfor services provided to individuals in IMDs	
Recovery Services	State plan (individual services covered) 1115 expenditure authority for services provided to individuals in IMDs	Required
Peer Support Services	State plan (individual services covered) 1115 expenditure authority for services provided to individuals in IMDs	Optional
Contingency management services	1115 expenditure authority (individual services covered)	Optional
Care Coordination services	State plan 1115 expenditure authority for services provided to individuals in IMDs	Required
Clinician consultation services	State plan (reimbursable activity; not a distinct service) 1115 expenditure authority for services provided to individuals in IMDs	Required
Traditional health care practices	1115 expenditure authority (individual services covered)	Required

6.2. **DMC-ODS County Requirements.** The following requirements apply to counties that participated in DMC-ODS as part of the Medi-Cal 2020 demonstration and new DMC-ODS counties as outlined in their approved County Implementation Plan and managed care contract.

a. **Access to Critical Levels of Care.** DMC-ODS counties are required to cover all mandatory DMC-ODS benefits and optional DMC-ODS it has elected to provide, as outlined in Table 2 above.

b. **Use of Evidence-based SUD-specific Patient Placement Criteria.** DMC-ODS counties are required to ensure the ASAM Criteria is used for all beneficiaries to determine placement into the appropriate level of care.

c. **Patient Placement.** DMC-ODS counties are required to implement a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings.

d. **Use of Nationally Recognized SUD-specific Program Standards to set Provider Qualifications for Residential Treatment Facilities.** DMC-ODS counties are required to contract with residential SUD treatment providers that are licensed by DHCS, the California Department of Social Services (CDSS), or the California Department of Public Health (CDPH), as applicable. Residential providers licensed by DHCS offering ASAM levels 3.1, 3.3, 3.5, and 3.2-WM must also have a DHCS Level of Care (LOC) Designation and/or an ASAM LOC Certification that indicates that the program is capable of delivering care consistent with the ASAM criteria. Residential providers are issued licenses and a DHCS LOC Designation for a two-year period that may be extended for subsequent two-year periods. During the licensure and designation period, DHCS shall conduct at least one onsite program visit for compliance and may conduct announced or unannounced site visits throughout the period. Residential providers must furnish MAT directly or facilitate access to MAT offsite. Residential providers licensed by CDPH or CDSS offering ASAM Levels of Care 3.1, 3.3, or 3.5 without a DHCS Level of Care Designation will be required to obtain an ASAM LOC Certification by January 1, 2024.

e. **Sufficient Provider Capacity.** DMC-ODS counties are required to maintain and monitor a network of contracted, DMC-certified providers and that is sufficient to provide adequate access to all covered DMC-ODS services. Access for this purpose is defined as timeliness to care as specified below. In establishing and monitoring the network, each DMC-ODS county must consider the following:

    i. Require its providers to meet State Department standards for timely access to care and services as specified in the county implementation plan and state-county intergovernmental agreements (managed care contracts per federal definition). Medical attention for emergency and crisis medical conditions must be provided immediately.

    ii. The anticipated number of Medi-Cal eligible beneficiaries.

    iii. The expected utilization of services, taking into account the characteristics and substance use disorder needs of beneficiaries.

    iv. The expected number and types of providers in terms of training and experience needed to meet expected utilization.

    v. The number of network providers who are not accepting new beneficiaries.

vi. The geographic location of providers and their accessibility to beneficiaries, considering distance, travel time, means of transportation ordinarily used by Medi-Cal beneficiaries, and physical access for beneficiaries with disabilities

f. **Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and SUD/OUD.** To the extent applicable, DMC-ODS counties are required to comply with opioid prescribing guidelines, overdose prevention initiative, and other interventions to prevent prescription drug misuse and coverage of and access to naloxone for overdose reversal, including but not limited to those developed by DHCS and CDPH.

g. **Improved Care Coordination and Transitions Between Levels of Care.** DMC-ODS counties are required to implement a care coordination plan to ensure that beneficiaries successfully transition between levels of SUD care (i.e. withdrawal management, residential, outpatient) without disruptions to services. In addition to specifying how beneficiaries will transition across levels of acute and short-term SUD care without gaps in treatment, DMC-ODS counties will describe how beneficiaries will access recovery supports and services immediately after discharge or upon completion of an acute care stay, with the goal of sustained engagement and long-term retention in SUD and behavioral health treatment.

h. **SUD Health IT Plan.** Implementation of the milestones and Metrics as detailed in STC 6.3 or Attachment E.

6.3. **SUD Health Information Technology Plan ("Health IT Plan").** The Health IT Plan applies to all states where the Health IT functionalities are expected to impact beneficiaries within the demonstration. As outlined in SMDL #18-011 and #17-003, respectively, states must submit to CMS the applicable Health IT Plan, to be included as Attachment E to the STCs, to develop infrastructure and capabilities consistent with the requirements outlined in the SUD demonstration-type.

The Health IT Plan must detail the necessary health IT capabilities in place to support beneficiary health outcomes to address the SUD goals of the demonstration. The plan will also be used to identify areas of health IT ecosystem improvement. The plan must include implementation milestones and projected dates for achieving them (see Attachment E), and must be aligned with the state's broader State Medicaid Health IT Plan (SMHP) and, if applicable, the state's Behavioral Health (BH) IT Health Plan.

a. The state must include in its Monitoring Protocol an approach to monitoring its SUD Health IT Plan which will include performance metrics to be approved in advance by CMS.

b. The state must monitor progress, each DY, on the implementation of its SUD Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS in in an addendum to its Annual Report.

c. As applicable, the state should advance the standards identified in the 'Interoperability Standards Advisory—Best Available Standards and Implementation Specifications'

(ISA) in developing and implementing the state's SUD Health IT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.

d. Where there are opportunities at the state- and provider-level (up to and including usage in MCO or ACO participation agreements) to leverage federal funds associated with a standard referenced in 45 CFR 170 Subpart B, the state should use the federally-recognized standards, barring another compelling state interest.

e. Where there are opportunities at the state- and provider-level to leverage federal funds associated with a standard not already referenced in 45 CFR 170 but included in the ISA, the state should use the federally-recognized ISA standards, barring no other compelling state interest.

f. Components of the Health IT Plan include:

    i. The Health IT Plan must describe the state's goals, each DY, to enhance the state's prescription drug monitoring program (PDMP).

    ii. The Health IT Plan must address how the state's PDMP will enhance ease of use for prescribers and other state and federal stakeholders. · This must also include plans to include PDMP interoperability with a statewide, regional or local Health Information Exchange. Additionally, the SUD Health IT Plan must describe ways in which the state will support clinicians in consulting the PDMP prior to prescribing a controlled substance—and reviewing the patients' history of controlled substance prescriptions—prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription.

    iii. The Health IT Plan will, as applicable, describe the state's capabilities to leverage a master patient index (or master data management service, etc.) in support of SUD care delivery. Additionally, the Health IT Plan must describe current and future capabilities regarding PDMP queries—and the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP. The state will also indicate current efforts or plans to develop and/or utilize current patient index capability that supports the programmatic objectives of the demonstration.

    iv. The Health IT Plan will describe how the activities described in (i), (ii) and (iii) above will support broader state and federal efforts to diminish the likelihood of long-term opioid use directly correlated to clinician prescribing patterns.

    v. The Health IT Plan will describe the state's current and future capabilities to support providers implementing or expanding Health IT functionality in the following areas: 1) Referrals, 2) Electronic care plans and medical records, 3) Consent, 4) Interoperability, 5) Telehealth, 6) Alerting/analytics, and 7) Identity management.

    vi. In developing the Health IT Plan, states should use the following resources:

i. States may use federal resources available on Health IT.Gov (https://www.healthit.gov/topic/behavioral-health) including but not limited to "Behavioral Health and Physical Health Integration" and "Section 34: Opioid Epidemic and Health IT" (https://www.healthit.gov/playbook/health-information-exchange/).

ii. States may also use the CMS 1115 Health IT resources available on "Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability" at https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html. States should review the "1115 Health IT Toolkit" for health IT considerations in conducting an assessment and developing their Health IT Plans.

iii. States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to PDMP interoperability, electronic care plan sharing, care coordination, and behavioral health-physical health integration, to meet the goals of the demonstration.

6.4. **DMC-ODS Financing.** For claiming federal financial participation (FFP), Counties will certify the total allowable expenditures incurred in providing the DMC-ODS waiver services provided either through county-operated providers (based on actual costs, consistent with a cost allocation methodology if warranted), contracted fee-for-service providers or contracted managed care plans (based on actual expenditures). For contracted FFS providers, counties will propose county-specific rates except for the NTP/OTP modality and the State will approve or disapprove those rates. NTP/OTP reimbursement shall be set pursuant to the process set forth in Welfare and Institutions Code Section 14021.51. All NTP/OTP providers contracting with counties shall provide the state with financial data on an annual basis in a form and manner specified by the State. This data is to be collected for the purpose of setting the rates for NTP services. The provision in the Welfare and Institutions Code, Section 14124.24(h)) remains in effect and NTPs/OTPs will not be required to submit cost reports to the counties for the purpose of cost settlement.

a. If during the State review process, the State denies the proposed rates, the county will be provided the opportunity to adjust the rates and resubmit to the State. The State will retain all approval of the rates in order to assess that the rates are sufficient to ensure access to available DMC-ODS waiver services. Rates will be set in the State and County intergovernmental agreement. For contracted managed care plans, counties will reimburse the managed care organizations the contracted capitation rate. A CMS-approved CPE protocol, based on actual allowable costs, is required before FFP associated with waiver services is made available to the state. This approved CPE protocol (Attachment I) must explain the process the state will use to determine costs incurred by the counties under this demonstration.

b. Only state plan DMC services will be provided prior to the DHCS approval of the State/County intergovernmental agreement (managed care contract per federal definition) and executed by the County Board of Supervisors. State plan DMC services

will be reimbursed pursuant to the state plan reimbursement methodologies until a county is approved to begin DMC- ODS services.

c. SB 1020 (Statutes of 2012) created the permanent structure for 2011 Realignment. It codified the Behavioral Health Subaccount which funds programs including Drug Medi-Cal. Allocations of Realignment funds run on a fiscal year of October 1-September 30. The monthly allocations are dispersed to counties from the State Controller's Office. The Department of Finance develops schedules, in consultation with appropriate state agencies and the California State Association of Counties (CSAC), for the allocation of Behavioral Health Subaccount funds to the counties. The base has not yet been set, as the State assesses the expenditures by county for these programs. The state will continue to monitor the BH subaccount and counties to ensure that SUD is not artificially underspent.

d. Subject to the participation standards and process to be established by the State, counties may also pilot an alternative reimbursement structure for a DMC-ODS modality if both the provider of that modality and the county mutually and contractually agree to participate. This may include use of case rates. The State and CMS will have the final approval of any alternative reimbursement structure pilot proposed by the county, and such pilot structure must continue to meet the terms and conditions expressed herein, including but not limited to, the rate approval process described above.

e. This STC will remain operative until the effective date for the State's implementation of behavioral health payment reform no sooner than July 1, 2023, which will include a shift from the CPE-based framework to a prospective reimbursement rate methodology. The state will provide CMS with at least 30 days written notice prior to the effective date for behavioral health payment reform and the sunset of CPE-based payments for DMC-ODS, but the State will not be required to seek a formal demonstration amendment.

6.5. **SUD Monitoring Protocol.** The state must submit a Monitoring Protocol for the SUD programs authorized by this demonstration within one hundred fifty (150) calendar days after approval of the demonstration. The Monitoring Protocol must be developed in cooperation with CMS and is subject to CMS approval. The state must submit a revised Monitoring Protocol within sixty (60) calendar days after receipt of CMS's comments. Once approved, the SUD Monitoring Protocol will be incorporated into the STCs, as Attachment J. Progress on the performance measures identified in the Monitoring Protocol must be reported via the Quarterly and Annual Monitoring Reports. Components of the Monitoring Protocol include:

a. An assurance of the state's commitment and ability to report information relevant to each of the program implementation areas listed in these STCs;

b. A description of the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the General Reporting Requirements described in Section XII of the demonstration; and

c. A description of baselines and targets to be achieved by the end of the demonstration. Where possible, baselines will be informed by state data, and targets will be benchmarked against performance in best practice settings.

6.6. **SUD Mid-Point Assessment.** The state must conduct an independent Mid-Point Assessment by December 31, 2024. This timeline will allow for the Mid-Point Assessment Report to capture approximately the first two-and-a-half years of program data during the CalAIM approval period, accounting for data run-out and data completeness. In the design, planning and conduction of the Mid-Point Assessment, the state will require that the independent assessor consult with key stakeholders including, but not limited to: representatives of DMC-ODS counties, SUD treatment providers, beneficiaries, and other key partners.

The state must require that the assessor provide a Mid-Point Assessment Report to the state that includes the methodologies used for examining progress and assessing risks, the limitations of the methodologies, its determinations and any recommendations. The state must provide a copy of the Mid-Point Assessment Report to CMS no later than sixty (60) days after December 31, 2024 and the state must brief CMS on the report, if requested. The state must submit a revised Mid-Point Assessment Report within sixty (60) calendar days after receipt of CMS's comments, if any.

Elements of the Mid-Point Assessment Report include:

a. A brief overview of how the state met each milestone outlined in the State Medicaid Director letter, SMD # 17-003 RE: Strategies to Address the Opioid Epidemic, dated November 1, 2017, through the implementation of California's DMC-ODC program under the Medi-Cal 2020 demonstration approval period, including any lessons learned for best practices and challenges in achieving the milestones. In addition, the Assessment must include an examination of progress toward meeting the targets for performance measures as approved in the SUD Monitoring Protocol;

b. A determination of factors that affected progress in achieving desired targets and goals in performance measures, to date;

c. A determination of factors likely to affect future performance on measure targets not yet met and an assessment about the risk of possibly missing those performance targets;

a. For measure targets at medium to high risk of not being met, recommendations for adjustments to the state's DMC-ODS implementation and operational approaches or to pertinent factors that the state can influence that will help ameliorate those risks and support improvement; and

d. An assessment of whether the state is on track to meet the budget neutrality requirements.

6.7. **Deferral of Federal Financial Participation (FFP) from IMD Claiming for Insufficient Progress Toward Performance Measure Targets and Failure to Report Measurement Data.** Up to $5,000,000 in FFP for DMC-ODS services in IMDs may be deferred if the state is

not making adequate progress in the required performance measures in the Monitoring Protocol agreed upon by the state and CMS. Once CMS determines the state has not made adequate progress, up to $5,000,000 will be deferred in the next calendar quarter and each calendar quarter thereafter until CMS has determined sufficient progress has been made.

7. CONTINGENCY MANAGEMENT SERVICES

7.1. Contingency Management Overview

a. Beginning no earlier than July 1, 2022, DHCS will implement a new contingency management benefit for eligible DMC-ODS beneficiaries with a substance use disorder in DMC-ODS counties that elect and are approved by DHCS to pilot the benefit. The pilots will allow California to evaluate and assess the effectiveness of a contingency management benefit before determining whether it should be available statewide.

b. Under the pilot, the contingency management benefit will be available in participating DMC-ODS counties, that opt and are approved by DHCS to provide this benefit, to qualified beneficiaries who meet the eligibility requirements described below and receive services from a non-residential DMC-ODS provider.

7.2. **Eligibility.** To qualify for the contingency management benefit, a Medi-Cal beneficiary must meet the following conditions:

a. Be enrolled in a comprehensive treatment program that offers other services (e.g., group or individual therapy) delivered in person or via telehealth;

b. Be assessed and determined to have a substance use disorder for which the contingency management benefit is medically necessary and appropriate based on the fidelity of treatment to the evidence-based practice. The presence of additional substance use disorders and/or diagnoses does not disqualify an individual from receiving the contingency management benefit;

c. Reside in a participating DMC-ODS county that elects and is approved by DHCS to pilot the Contingency Management benefit;

a. Not be enrolled in another contingency management program for substance use disorder;

d. Receive services from a non-residential DMC-ODS provider that offers the contingency management benefit in accordance with DHCS policies and procedures; and

e. Contingency management should never be used in place of medication treatment for addiction treatment (e.g., for opioid use disorder or alcohol use).

7.3. Service Description

a. The contingency management benefit consists of a series of motivational incentives for meeting treatment goals. The motivational incentives may consist of cash or cash equivalents, e.g., gift cards of low retail value, consistent with evidence-based clinical research for treating a substance use disorder and as described below. These motivational incentives are central to contingency management, based on the best available scientific evidence for treating a substance use disorder and not as an inducement to use other medical services.

b. The contingency management benefit utilizes an evidence-based approach that recognizes and reinforces individual positive behavior change consistent with substance non-use or treatment/medication adherence. The contingency management benefit provides motivational incentives for treatment/medication adherence or non-use of substances as evidenced by, for example, negative drug tests.

c. Contingency management is offered along with other therapeutic interventions, such as cognitive behavioral therapy, that meet the definition of rehabilitative services as defined by 1905(a) of the Social Security Act and 42 CFR 440.130(d).

d. For purposes of this demonstration, these motivational incentives are considered a Medicaid-covered item or service and are used to reinforce objectively verified, recovery behaviors using a clinically appropriate contingency management protocol consistent with evidence-based research. Consequently, neither the Federal anti-kickback statute (42 U.S.C. § 1320a-7b(b), "AKS") nor the civil monetary penalty provision prohibiting inducements to beneficiaries (42 U.S.C. 1320a-7a(a)(5), "Beneficiary Inducements CMP") would be implicated.

e. The contingency management benefit consists of a set of modest motivational incentives available for beneficiaries that meet treatment goals. Under the benefit, a beneficiary will be limited in motivational incentives during the course of a contingency management treatment episode as detailed in in the Procedures and Protocols in Attachment V, which will be submitted to CMS for review and approval before the program can be implemented.

    i. To qualify for a contingency management motivational incentive, a beneficiary must demonstrate treatment/medication adherence or non-use of substances.

    ii. The size, nature and distribution of all contingency management motivational incentives shall be determined in strict accordance with DHCS procedures and protocols, listed in Attachment V. These procedures and protocols will be based on established clinical research for contingency management. The following guardrails shall ensure the integrity of the contingency management benefit and mitigate the risk of fraud, waste or abuse associated with the motivational incentive:

        i. Providers have no discretion to determine the size or distribution of motivational incentives which will be determined by DHCS.

        ii. Motivational incentives may be managed and disbursed through a mobile or web-based incentive management software program that

includes strict safeguards against fraud and abuse that will be detailed in DHCS guidance and listed in the Procedures and Protocols Attachment V (as listed above).

iii. To calculate and generate the motivational incentives in accordance with the schedule in Attachment V, providers shall enter the evidence of the Medi-Cal beneficiary receiving the contingency management benefit into a mobile or web-based incentive management software program.

7.4. **DMC-ODS County Participation.** To participate in the contingency management pilot, a county must participate in DMC-ODS, submit an application, and be selected by DHCS.

a. The application process shall identify counties that meet at least the following standards:

i. Participating counties shall establish a network of providers that can provide contingency management in accordance with DHCS requirements.

ii. Participating counties shall monitor the ongoing performance, including fidelity of treatment to the evidence-based practice, of contingency management providers and work with DHCS to identify and support providers requiring further training or technical assistance in accordance with DHCS set standards, to be outlined in DHCS guidance.

b. DHCS will provide training, technical assistance and monitoring to counties throughout the implementation process. The training and technical assistance will be provided through a qualified contractor designated by DHCS, and will include staff training, provider readiness reviews, and ongoing technical assistance during the first phase of the pilot.

c. Participating counties and providers shall comply with any billing and data reporting requirements established by DHCS to support research, evaluation, and performance monitoring efforts, including but not limited to satisfactory claims submission, data and quality reporting, and survey participation.

7.5. **Eligible Contingency Management Providers**

a. The contingency management benefit will be delivered by DMC-ODS providers that meet specified programmatic standards and agree to deliver the contingency management benefit in strict accordance with standardized procedures and protocols that will be detailed in DHCS guidance and listed in the Procedures and Protocols Attachment V (as listed above).

b. To be eligible to offer the contingency management benefit, a provider shall offer the benefit in strict accordance with DHCS standards that will be outlined in DHCS guidance included in Attachment V and shall meet the following requirements:

i. Must serve beneficiaries residing in DMC-ODS counties that have been approved by DHCS for participation in the contingency management pilot;

ii. Must be enrolled in Medi-Cal, and certified to provide Medi-Cal and DMC-ODS services, and offer outpatient, intensive outpatient, narcotic treatment program, and/or partial hospitalization services;

iii. Require the staff providing or overseeing the contingency management benefit to participate in contingency management-specific training developed and offered by a qualified contractor designated by DHCS;

iv. Undergo a readiness review by DHCS and a qualified contractor designated by DHCS to ensure that they are capable to offer the contingency management benefit in accordance with DHCS standards that will be detailed in DHCS guidance; and

v. Participate in ongoing training and technical assistance as requested or identified by DMC-ODS counties or DHCS through ongoing monitoring to meet DHCS standards.

c. The following practitioners delivering care at qualified DMC-ODS providers can deliver the contingency management benefit through activities, such as administering point-of-care urine drug tests, informing beneficiaries of the results of the evidence/urine drug test, entering the results into the mobile or web-based application, providing educational information, and distributing motivational incentives, as part of the contingency management benefit:

i. Licensed Practitioner of the Healing Arts (LPHAs);

ii. SUD counselors that are either certified or registered by an organization that is recognized by DHCS and accredited with the National Commission for Certifying Agencies;

iii. Certified peer support specialists; and

iv. Other trained staff under supervision of an LPHA.

d. SUD providers will be required to offer accompanying DMC-ODS SUD treatment services and evidence-based practices for a substance use disorder and any other co-occurring substance use disorder in addition to contingency management services. These services may include individual, group and/or family counseling using a range of applicable evidence-based modalities and techniques, including but not limited to cognitive behavioral therapy, community reinforcement, motivational interviewing, care coordination, peer support services, medications for addiction treatment, recovery supports, withdrawal management, medication services, and patient education.

e. Pilot Evaluation. In alignment with the CalAIM demonstration evaluation requirements outlined in Section XII of these STCs, CA will conduct an evaluation of the effectiveness of the Contingency Management program to assess its overall effectiveness, including cost-effectiveness of these services, and its effects on beneficiary health and recovery outcomes. To the extent feasible, the state will conduct the evaluation to support assessment stratified by stimulant use disorder and other types of SUD.

8. COMMUNITY SUPPORTS

8.1. Community Supports Overview.

The state is authorized to use expenditure authority to provide Health-Related Social Needs (HRSN) services, specifically short-term recuperative care and short-term post-transition housing, through electing Medi-Cal managed care plans as part of an array of evidence-based, health-related "Community Supports" under the California Advancing and Innovating Medi-Cal (CalAIM) initiative. Under this section 1115 demonstration, short-term recuperative care and short-term post-transition housing will be referred to as "Community Supports." The remaining other twelve (12) Community Supports are authorized, subject to the conditions enumerated in the 1915(b) waiver, via the Medi-Cal managed care plan contracts as in lieu of services (ILOS) pursuant to 42 CFR 438.3(e)(2) as part of CMS's review and consideration for approval of the managed care plan contracts for federal financial participation. By authorizing short-term recuperative care and short-term post-transition housing under the CalAIM demonstration, the state will be subject to the requirements detailed in the 1115 demonstration, outlined below, and will include such requirements in contracts between the state and managed care plans, as the operational construct for these two services. HRSN services must be clinically appropriate for the beneficiary and based on medical appropriateness using clinical and other health-related social needs criteria. The state is required to align clinical and social risk criteria across services and with other non-Medicaid social support agencies, to the extent possible.

Short-term recuperative care and short-term post-transition housing authorized under the CalAIM demonstration must be administered in a manner that is: (1) medically appropriate; (2) voluntary for the Medi-Cal managed care plans to offer and the beneficiary to use; and (3) offered exclusively through managed care plans and incorporated into the development of capitation rates for electing managed care plans. These services will be consistent with STCs 8.6, 8.7, and STC 8.8, as demonstration-authorized services regarded as qualifying for Title XIX and Title XXI matching funds for populations who meet the eligibility criteria described in STC 8.5 and Attachment U.

8.2. **Service Delivery.** Consistent with the Medi-Cal managed care contract and DHCS guidance applicable to all Community Supports:

a. Short-term recuperative care and short-term post-transition housing services authorized under the CalAIM demonstration will only be available from electing Medi-Cal managed care plans.

b. Medi-Cal managed care plans have the option to provide one or both Community Supports authorized under this demonstration on a voluntary basis through contracted network providers, as further described in STC 8.3.

c. Medi-Cal managed care plans that elect to offer these demonstration-based Community Supports do not need to offer the services or settings statewide or in all counties in which the Medi-Cal managed care plan operates.

d. The state must require that each Medi-Cal managed care plan must report to DHCS the counties in which it intends to offer the Community Supports and any sub-county limitations on the availability of the service. Managed care plans must receive state approval and provide public notice of any such limitations on each Community Support, including specifying such limitations in the enrollee handbook.

e. Medi-Cal managed care plans will have the option to newly offer these services or change their election to offer these services every six (6) months.

f. Medi-Cal managed care plans may discontinue offering Community Supports annually with notice to DHCS and beneficiaries, as described in the Medi-Cal managed care plan contract.

8.3. **Contracted Providers.** Consistent with the Medi-Cal managed care contract and DHCS guidance and applicable to all Community Supports:

a. Electing Medi-Cal plans will contract with Community Supports providers ("Contracted Providers") to deliver the elected Community Supports authorized under the demonstration.

b. Electing Medi-Cal plans must establish a network of providers and ensure the Contracted Providers have sufficient experience and training in the provision of the Community Supports being offered. Contracted Providers do not need to be licensed, however, staff offering services through Contracted Providers must be licensed when appropriate and applicable.

c. The Medi-Cal managed care plan and Contracted Provider must agree to a rate for the provision of applicable Community Supports, consistent with DHCS guidance for these services, and in compliance with all related federal requirements.

d. Eligible settings for short-term recuperative care and short-term post-transition housing must have appropriate clinicians who can provide medical and/or behavioral health care. The facility cannot be primarily used for room and board without the necessary additional recuperative support services. For example, a hotel room in a commercial hotel, where there are no medical or behavioral health supports provided onsite appropriate to the level of need, would not be considered an appropriate setting, but if a hotel had been converted to a recuperative care facility with appropriate clinical supports, then it would be an eligible setting.

8.4. **Provider Network Capacity.** Electing Medi-Cal managed care plans must ensure the two Community Supports authorized under the demonstration are provided to eligible beneficiaries in a timely manner, and shall develop policies and procedures outlining its approach to managing provider shortages or other barriers to timely provision of the Community Supports, in accordance with the Medi-Cal managed care plan contracts and other DHCS guidance.

8.5. **Eligibility Criteria for Community Supports.** In accordance with the Medi-Cal managed care plan contracts and DHCS guidance, these Community Supports services are available to people experiencing homelessness or who are at risk of homelessness, and who have been determined

by a provider (at the plan or network level) to have medical needs significant enough to result in emergency department visits, hospital admissions or other institutional care.

a. For this purpose, California is using the U.S. Department of Housing and Urban Development's (HUD) current definition of homeless and individuals who are at-risk of homelessness as codified at 24 CFR 91.5, with three modifications: (1) if exiting an institution, individuals are considered homeless if they were homeless immediately prior to entering that institutional stay, regardless of the length of the institutionalization, (2) the timeframe for an individual or family who will imminently lose housing is extended from fourteen (14) days for individuals considered homeless and 21 days for individuals considered at-risk of homelessness under the HUD definition to thirty (30) days, and (3) the state will omit 24 CFR 91.5 (1)(i) from the HUD at-risk of homelessness definition for this eligibility assessment. Additional detail on eligibility for these services are outlined in Attachment U.

b. An electing Medi-Cal managed care plan will identify enrollees who may benefit from the Community Supports authorized under the demonstration, who meet these eligibility criteria, and for whom the Community Supports services will be medically appropriate as determined by a provider (at the plan or network level) and allow an individual to avoid institutionalization.

c. Medi-Cal managed care plans must accept requests and referrals for the Community Supports from enrollees and on behalf of enrollees from providers and organizations that serve them, including community-based organizations.

d. Community Supports shall supplement and not supplant services received by the Medi-Cal enrollee through other state, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

8.6. **Allowable HRSN Services and Definitions.** The state may cover the following HRSN services:

a. Housing Interventions, including:

i. Episodic interventions with clinical services, with room and board limited to:

i. Short-term recuperative care (also referred to as medical respite) where integrated, clinically oriented recuperative or rehabilitative services and supports (e.g., physical, psychosocial, behavioral) are provided for individuals who require ongoing monitoring and continuous access to medical care.

ii. Short-term post-transition housing (also referred to as post-hospitalization housing), where integrated, clinically oriented rehabilitative services and supports (e.g., physical, psychosocial, behavioral) are provided, but ongoing monitoring of the individual's condition by clinicians is not required.

8.7. **Housing Intervention Duration and Frequency.**

a. Subject to STC 8.7.b., housing interventions that are classified as episodic interventions, as described in STC 8.6 may be covered for a qualifying beneficiary, as medically appropriate, up to a combined 6 months per rolling year. For purposes of this demonstration, rolling year is defined as a continuous 12-month period with the start date beginning when the beneficiary begins receiving the service.

b. Multiple HRSN housing interventions can be covered for qualifying beneficiaries across all of California's section 1115(a) demonstrations; provided however that CMS will apply a total combined cap of 6 months for all HRSN housing interventions that include room and board supports, per beneficiary, in any rolling 12-month period.

    i. The state may only offer episodic interventions with room and board supports to beneficiaries who qualify for other HRSN housing interventions if they have not reached the 6-month global cap, within any rolling 12-month period, for HRSN housing interventions that include room and board supports across all of California's section 1115(a) demonstrations.

    ii. If the beneficiary received additional HRSN housing interventions providing room and board supports under another one of California's section 1115(a) demonstrations, the state may only provide the remaining balance of month(s) under the 6-month global cap for HRSN housing interventions that include room and board supports within any rolling 12-month period.

8.8. **Excluded HRSN Services.** Excluded items, services, and activities that are not covered as HRSN services include, but are not limited to:

a. Construction costs (including building modification and building rehabilitation);

b. Capital investments;

c. Room and board, except as described in STC 8.6 and Attachment U;

d. Research grants and expenditures not related to monitoring and evaluation;

e. Costs for services in prisons, correctional facilities or services for people who are civilly committed and unable to leave an institutional setting;

f. Services provided to individuals who are not lawfully present in the United States or are undocumented;

g. Expenditures that supplant services and activities funded by other state and federal governmental entities;

h. School-based programs for children that supplant Medicaid state plan programs;

i. General workforce activities, not specifically linked to Medicaid or Medicaid beneficiaries; and

j. Any other projects or activities not specifically approved by CMS as qualifying for coverage as HRSN services under this demonstration.

8.9. **General Guardrails and Reporting Requirements for Short-Term Recuperative Care and Short-Term Post-Transition Housing Community Supports.** While short-term recuperative care and short-term post-transition housing services are not ILOS authorized under the 1915(b) waiver authority, to reduce administrative burden, the state may coordinate reporting, monitoring, and evaluation efforts of the HRSN services, short-term recuperative care and short-term post-transition housing services, in alignment with corresponding expectations stipulated in California's 1915(b)(1)/(4) CalAIM waiver, while also recognizing that there are additional expectations for monitoring and evaluation for short-term recuperative care and short-term post-transition housing services as provided in these STCs that must also be met. To the extent appropriate, the state and CMS will work collaboratively to assure there is no redundancy in reporting efforts under the section 1115 and 1915(b) authorities.

8.10. **Compliance with Federal Requirements.** The state shall ensure short-term recuperative care and short-term post-transition housing Community Supports are delivered in accordance with all applicable federal statute, regulation or guidance.

8.11. **HRSN Community Supports Protocol.** The state must submit, for CMS review and approval, the HRSN Community Supports Protocol covering the HRSN services authorized in this demonstration. Once approved, the Protocol will be affixed as Attachment X to these STCs. The state may stagger the submission of this Protocol, with the Maintenance of Effort (MOE; see STC 8.15) information submitted no later than 90 days after the inclusion of this STC in the demonstration approval. The remaining content of the Protocol must be submitted to CMS no later than nine months after this STC is effective.

a. A description of the process for identifying beneficiaries with HRSN, including outlining beneficiary qualification criteria for services.

b. A description of the process by which clinical criteria will be applied, including a description of the documented process wherein a provider, using their professional judgment and based on clinical and social risk factors, as applicable, may deem the service to be medically appropriate.

c. A description of the process for developing care plans based on assessment of need that is also culturally responsive and trauma informed.

d. A plan for establishing and/or improving information technology (IT) infrastructure, data sharing and partnerships with an array of health system and social services stakeholders, to the extent those entities are vital, to provide needed administrative and HRSN-related data on beneficiary characteristics, eligibility, screenings, referrals, and provision of services, which are critical for understanding program implementation and conducting demonstration monitoring and evaluation.

e. A plan for tracking and improving the share of Medicaid beneficiaries who are eligible for the Supplemental Nutrition Assistance Program (SNAP) who are enrolled in that program, the Special Supplemental Nutrition Program for Women, Infants and

Children (WIC), and federal and state housing assistance programs, relative to the number of total eligible beneficiaries, including establishing a timeline for reporting.

f. Information as required per STC 8.15 (MOE).

g. Information as required per STC 8.16 (Partnerships with State and Local Entities).

8.12. **Conflict of Interest**. The state shall ensure appropriate protections against conflicts of interest in the service planning and delivery of HRSN services. The state also agrees that appropriate separation of service planning and service provision functions are incorporated into the state's conflict of interest policies.

8.13. **CMS Approval of Managed Care Contracts.**

a. As part of the state's submission of associated Medicaid managed care plan contracts to implement CalAIM, the state must provide documentation including, but not limited to:

i. Beneficiary and plan protections, including but not limited to:

i. Short-Term Recuperative Care and Short-Term Post-Transition Housing Community Supports must not be used to reduce, discourage, or jeopardize Medicaid beneficiaries' access to Medicaid state plan covered services.

ii. Medicaid beneficiaries always retain their right to receive the Medicaid state plan covered service on the same terms as would apply if Short-Term Recuperative Care and Short-Term Post-Transition Housing Community Supports were not an option.

iii. Medicaid beneficiaries always retain the right to file appeals and/or grievances if they request Short-Term Recuperative Care and Short-Term Post-TransitionHousing Community Supports offered by their Medicaid managed care plan, but were not authorized to receive the requested Short-Term Recuperative Care and Short-Term Post-Transition Housing Community Supports services because of a determination that it was not medically appropriate.

iv. Managed care plans are not permitted to deny a beneficiary a medically appropriate Medicaid covered service on the basis that they are currently receiving Short-Term Recuperative Care and Short-Term Post-Transition Housing Community Supports or have received these services in the past.

v. Managed care plans are prohibited from requiring a beneficiary to utilize Short-Term Recuperative Care and Short-Term Post-Transition Housing Community Supports.

vi. Managed care plans must timely submit any related data requested by the state or CMS, including, but not limited to:

a. Data to evaluate the utilization and effectiveness of the Short-Term Recuperative Care and Short-Term Post-Transition Housing Community Supports.

b. Any data necessary to monitor health outcomes and quality metrics at the local and aggregate level through encounter data and supplemental reporting on health outcomes and equity of care. When possible, metrics must be stratified by age, sex, race, ethnicity, and language spoken to inform health equity efforts and efforts to mitigate health disparities.

c. Any data necessary to monitor appeals and grievances for beneficiaries.

   i. Documentation to ensure appropriate clinical support for the medical appropriateness of Short-Term Recuperative Care and Short-Term Post-Transition Housing Community Supports, including but not limited to:

      1. A documented process to authorize Short-Term Recuperative Care and Short-Term Post-Transition Housing Community Supports for beneficiaries for whom there is an assessed risk of a need for other Medicaid state plan services, such as inpatient hospitalizations or emergency department visits. This process must document that a provider using their professional judgment has determined it to be medically appropriate for the specific beneficiary as provision of the Short-Term Recuperative Care and Short-Term Post-Transition Housing Community Supports is likely to reduce or prevent the need for acute care or other Medicaid services. This documentation could be included in a care plan developed for the beneficiary. In addition to this clinical documentation requirement, states may also impose additional provider qualifications or other limitations and protocols and these must be documented within the managed care plan contracts.

      2. Any data determined necessary by the state or CMS to monitor and oversee the Short-Term Recuperative Care and Short-Term Post-Transition Housing Community Supports.

   ii. All data and related documentation necessary to monitor and evaluate Short-Term Recuperative Care and Short-Term Post-Transition Housing Community Supports, including cost assessment,, to include but not limited to:

      1. The managed care plans must submit timely and accurate encounter data to the state on Short-Term Recuperative Care and Short-Term Post-Transition Housing Community Supports provided to members. The state must seek CMS approval on what is considered and appropriate and reasonable timeframe for plan submission of encounter data. This encounter data must include data necessary for the state to stratify services by age, sex, race, ethnicity, and language spoken to inform health equity efforts and efforts to mitigate health disparities undertaken by the state.

2. Any additional information requested by CMS, the state or oversight body to aid in on-going evaluation of the Short-Term Recuperative Care and Short-Term Post-Transition Housing Community Supports or any independent assessment or analysis conducted by the state, CMS, or an independent entity.

iii. Any additional information determined reasonable, appropriate and necessary by CMS.

8.14. **Rate Methodologies.** All new or modified payment rates, methodologies and/or associated data for authorized HRSN services outlined in these STCs must be submitted to CMS for review and approval following the normal managed care rate setting process, including via standard managed care rate certifications and, when applicable, through the state directed payments submission process and in accordance with 42 CFR 438.6(c).

8.15. **Maintenance of Effort (MOE).** The state must maintain a baseline level of state funding, which the state will submit to CMS for CMS approval, for ongoing social services related to housing transition supports for the duration of the demonstration, not including one time or non-recurring funding. Within 90 days of the approval of the demonstration amendment to integrate the community supports in the HRSN framework, as part of the HRSN Community Supports Protocol, the state will submit a plan to CMS for CMS approval that specifies how the state will determine baseline spending on these services. The annual MOE will be reported and monitored as part of the Annual Monitoring Report described in STC 14.5, with any justifications, including declines in available state resources, necessary to describe the findings.

8.16. **Partnerships with State and Local Entities.** The state must have in place partnerships with other state and local entities (e.g., HUD Continuum of Care Program, local housing authority, SNAP state agency) to assist beneficiaries in obtaining non-Medicaid funded housing and nutrition supports, if available, upon the conclusion of temporary Medicaid payment for such supports, in alignment with beneficiary needs identified in the person-centered plans as appropriate. The state will submit a plan to CMS as part of the HRSN Community Supports Protocol that outlines how it will put into place the necessary arrangements with other state and local entities and also work with those entities to assist beneficiaries in obtaining available non-Medicaid funded housing upon conclusion of temporary Medicaid payment, as stated above. The plan must provide a timeline for the activities outlined. As part of the Quarterly and Annual Monitoring Reports described in STC 14.5, the state will provide the status of the state's fulfillment of its plan and progress relative to the timeline, and whether and to what extent the non-Medicaid funded supports are being accessed by beneficiaries as planned. Once the state's plan is fully implemented, the state may conclude its status updates in the Quarterly and Annual Monitoring Reports.

9. REENTRY DEMONSTRATION INITIATIVE

9.1. **Overview of Pre-Release Services and Program Objectives.** This component of the demonstration will provide for pre-release services up to 90 days immediately prior to the expected date of release to qualifying Medi-Cal beneficiaries and demonstration beneficiaries who would be eligible for CHIP except for their incarceration status, who are residing in state prisons, county jails, or youth correctional facilities, as specified by the implementation timeline

in STC 9.8 and the implementation plan in STC 9.9. The objective of this component of the demonstration is to facilitate beneficiaries' access to certain healthcare services and case management, provided by Medicaid participating providers, CHIP participating providers, or by carceral providers who are not participating in Medicaid or CHIP, while beneficiaries 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 justice-involved individuals. Further, coverage beyond 30 days (for up to 90 days immediately before the expected date of release) is expected to provide a longer runway for enrollees to identify and begin to receive needed services, contribute to a reduction in post-release acute care utilization, and lead to a reduction in health crises, overdoses, and overdose-related deaths. The purpose of this reentry demonstration initiative is to provide short-term 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 conditions to reduce acute care utilization in the period soon after release, and test whether it improves uptake and continuity of medication-assisted treatment (MAT) and other SUD and behavioral health treatment, as appropriate for the individual, to reduce decompensation, suicide-related death, overdose, overdose-related death, and all-cause death in the near-term post-release.

During the demonstration, the state seeks to achieve the following goals:

a. 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;

b. Improve access to services prior to release and improve transitions and continuity of care into the community upon release;

c. Improve coordination and communication between correctional systems, Medicaid and CHIP systems, managed care plans, and community-based providers;

d. 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;

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

f. 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; and

g. 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.

9.2. **Qualifying Criteria for Pre-Release Services.** In order to qualify to receive services under this component of the demonstration, a beneficiary must meet the following qualifying criteria:

a. Meet the definition of an inmate of a public institution, as specified in 42 CFR 435.1010, and be incarcerated in a state prison, county jail, or youth correctional facility as defined in STC 9.4;

b. Have been determined eligible for Medicaid and CHIP if not for their incarceration status;

c. Have an expected release date within 90 days and

d. Meet one of the following requirements:

i. Is an individual residing in a state prison or county jail who meets at least one of the health-related criteria described below and further defined in Attachment W. Meeting such health-related criteria may be indicated by a beneficiary, found at an initial screening conducted by the correctional facility upon intake, determined during a beneficiary's incarceration, or found during assessment in the process of pre-release planning.

a. Mental illness, defined as confirmed or suspected mental health diagnosis based on specified criteria as defined in Attachment W;

b. Substance use disorder, defined as confirmed or suspected diagnoses based on specified criteria as defined in Attachment W;

c. Chronic condition or significant non-chronic clinical condition, defined as confirmed or suspected diagnoses based on specified criteria as defined in Attachment W;

d. 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 as defined in Attachment W;

e. Traumatic brain injury or other condition that has caused significant cognitive, behavioral and/or functional impairment;

f. Positive test or diagnosis of human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS); or

g. Currently pregnant or within a 12-month postpartum period, as defined in Attachment W.

ii. Is an individual incarcerated in a youth correctional facility.

a. Has been identified as expected to be released in the next 90 days and identified for participation in the demonstration.

iii. Is an individual under the age of 21 or former foster care youth, regardless of the type of facility in which an individual is incarcerated.

a. Has been identified as expected to be released in the next 90 days and identified for participation in the demonstration.

9.3. **Scope of Pre-Release Services**. The pre-release services authorized under the reentry demonstration initiative include the following services currently covered under the California Medicaid and CHIP State Plans, and further described in Attachment W.

a. The pre-release services are:

i. Reentry case management services;

ii. Physical and behavioral health clinical consultation services provided through telehealth or in-person, as needed, to diagnose health conditions, provide treatment, as appropriate, and support pre-release case managers' development of a post-release treatment plan and discharge planning;

iii. Laboratory and radiology services;

iv. Medications and medication administration;

v. MAT, for all Food and Drug Administration-approved medications, including coverage for counseling; and

vi. Services provided by community health workers with lived experience.

b. In addition to the pre-release services specified in STC 9.3(a), qualifying beneficiaries will also receive covered outpatient prescribed medications and over-the-counter drugs (a minimum 30-day supply as clinically appropriate, consistent with the approved Medicaid State Plan) and durable medical equipment (DME) upon release, consistent with approved state plan coverage authority and policy.

c. The expenditure authority for pre-release services through this initiative comprises a limited exception to the federal claiming prohibition for medical assistance furnished to inmates of a public institution at clause (A) following section 1905(a) of the Act ("inmate exclusion rule"). Benefits and services for inmates of a public institution that are not approved in the reentry demonstration initiative as described in these STCs and accompanying protocols, and not otherwise covered under the inpatient exception to the inmate exclusion rule, remain subject to the inmate exclusion rule. Accordingly, other benefits and services covered under the California Medicaid or CHIP State Plans,

as relevant, that are not included in the above-described pre-release services (e.g., EPSDT treatment services) are not available to qualifying beneficiaries through the reentry demonstration initiative.

9.4. **Participating Facilities**. The pre-release services will be provided at state prisons, county jails, and youth correctional facilities, or outside of the correctional facility with appropriate transportation and security oversight provided by the carceral facility, subject to DHCS approval of a facility's readiness, according to the phase-in schedule described in STC 9.8. States must be mindful of and ensure the policies, procedures, and processes developed to support implementation of these provisions do not effectuate a delay of an individual's release or lead to increased involvement in the juvenile and adult justice systems. Correctional facilities that are also institutions for mental diseases (IMDs) are not allowed to participate in the reentry demonstration initiative.

9.5. **Participating Providers**.

a. Licensed, registered, certified, or otherwise appropriately credentialed or recognized practitioners under California state scope of practice statutes shall provide services within their individual scope of practice and, as applicable, receive supervision required under their scope of practice laws.

b. Participating providers eligible to deliver services under the reentry demonstration initiative may be either community-based or correctional-facility based providers.

c. All participating providers and provider staff, including carceral providers, shall have necessary experience and receive appropriate training, as applicable to a given carceral facility, prior to furnishing demonstration-covered pre-release services under the reentry demonstration initiative.

d. Participating providers of reentry case management services may be community-based or carceral providers who have expertise working with justice-involved individuals.

9.6. **Suspension of Coverage**. Upon entry of a Medicaid beneficiary into a participating correctional facility, DHCS must not terminate and generally shall suspend their Medicaid coverage, as described in the Reentry Demonstration Initiative Implementation Plan.

a. If an individual is not enrolled in Medicaid when entering a correctional facility, the state must ensure that such an individual receives assistance with completing an application for Medi-Cal and with submitting an application to the county departments of social services, unless the individual declines such assistance or wants to decline enrollment.

9.7. **Coverage of Individuals Otherwise Eligible for CHIP During Incarceration.** If an individual who is incarcerated would be eligible for CHIP if not for their incarceration status, and they qualify to receive pre-release services per STC 9.2, pre-release services will be covered under this demonstration's expenditure authority.

9.8. **Reentry Demonstration Initiative Implementation Timeline**. Delivery of pre-release services under this demonstration will be implemented on a phased-in approach, as described below. All participating state prisons, county jails, and youth correctional facilities must demonstrate readiness, as specified below, prior to participating in this initiative (FFP will not be available in expenditures for services furnished to qualifying beneficiaries who are inmates in a facility before the facility meets the below readiness criteria for participation in this initiative). DHCS will determine that each applicable facility is ready to participate in the reentry demonstration initiative under this demonstration based on a facility-submitted assessment (and appropriate supporting documentation) of the facility's readiness to implement:

a. Pre-release Medi-Cal and CHIP application and enrollment processes for individuals who are not enrolled in Medi-Cal or CHIP prior to incarceration and who do not otherwise become enrolled during incarceration;

b. The screening process to determine a beneficiary's qualification for pre-release services;

c. The provision or facilitation of pre-release services for a period of up to 90 days immediately prior to the expected date of release, including the facility's ability to support the delivery of services furnished by providers in the community that are delivered via telehealth. If a facility is not equipped to provide or facilitate the full set of the pre-release services, as listed in STC 9.3, the facility must provide a timeline of when it will be equipped to do so, including concrete steps and their anticipated completion dates that will be necessary to ensure that qualifying beneficiaries are able to receive timely any needed pre-release services;

d. Coordination amongst partners with a role in furnishing health care and HRSN services to beneficiaries, including, but not limited to, social service departments, managed care plans, county behavioral health agencies, county departments of health, and community-based providers;

e. Appropriate reentry planning, pre-release care management, and assistance with care transitions to the community, including connecting beneficiaries to physical and behavioral health providers and their managed care plan, and making referrals to care management and community supports providers that take place throughout the 90-day pre-release period, and providing beneficiaries with covered outpatient prescribed medications and over-the-counter drugs (a minimum 30-day supply as clinically appropriate, consistent with approved Medicaid State Plan) and DME upon release, consistent with approved state plan coverage authority and policy;

f. Operational approaches related to implementing certain Medicaid and CHIP requirements, including but not limited to applications, suspensions, notices, fair hearings, reasonable promptness for coverage of services, and any other requirements specific to receipt of pre-release services by qualifying individuals under the reentry demonstration initiative;

g. A data exchange process to support the care coordination and transition activities described in (d) and (e) of this subsection;

h. Reporting of requested data from DHCS to support program monitoring, evaluation, and oversight; and

i. A staffing and project management approach for supporting all aspects of the facility's participation in the reentry demonstration initiative, including information on qualifications of the providers that the correctional facilities will partner with for the provision of pre-release services.

9.9. **Reentry Demonstration Initiative Implementation Plan**. The state is required to submit a Reentry Demonstration Initiative Implementation Plan to describe, at a minimum, the state's approach to implementing the reentry demonstration initiative, including timelines for meeting critical implementation stages or milestones, as applicable, to support successful implementation. The state must submit the draft Implementation Plan to CMS for review no later than 120 calendar days after approval of the reentry demonstration initiative. The state must submit any required clarifications or revisions to their draft Implementation Plan no later than 60 calendar days after receipt of CMS feedback. The finalized Implementation Plan will be incorporated into the STCs as Attachment CC.

In the Implementation Plan, the state is expected only to provide additional details regarding the implementation of the reentry demonstration initiative that are not already captured in the STCs (including any other attachments). CMS will provide the state with a template to support developing the Implementation Plan.

The Reentry Demonstration Initiative Implementation Plan must describe the implementation settings, the time period that pre-release services are available, and phase-in approach to implementation, as applicable. Other than providing such contextual information, the core requirement of the Implementation Plan is for the state to describe the specific processes, including timelines and programmatic content where applicable, for meeting the below milestones, such as to remain on track to achieve the key goals and objectives of the program. For each milestone—and specifically for any associated actions that are integral aspects for attaining the milestone—the Implementation Plan must document the current state of affairs, the intended end state to meet the milestone, the date by which the milestone is expected to be achieved, and the activities that must be executed by that date for the milestone to be achieved. Furthermore, for each milestone, the Implementation Plan must identify the main anticipated implementation challenges and the state's specific plans to address these challenges. The Implementation Plan is also required to document the state's strategies to drive positive changes in health care quality for all beneficiaries, thereby reducing disparities and improving health equity. The state will be required to provide the following information related to, but not limited to, the following milestones and actions.

a. **Milestone 1: Increasing coverage and ensuring continuity of coverage for individuals who are incarcerated**. The state must describe its plans to fully effectuate, no later than two years from approval of the expenditure authority, a state policy to identify Medicaid eligible individuals or individuals who would be eligible

for CHIP, except for their incarceration status, and suspend a beneficiary's eligibility or benefits during incarceration. It must describe its processes to undertake robust outreach to ensure beneficiary and applicant awareness of the policy and assist individuals with Medicaid application, enrollment, and renewal processes. Other aspects to be included in the Implementation Plan related to this milestone include the state's plan to make available a Medicaid and/or managed care plan identification number or card to an individual, as applicable, upon release; and establish processes to allow and assist all individuals who are incarcerated at a participating facility to access and complete a Medicaid application, including providing information about where to complete the Medicaid application for another state, e.g., relevant state Medicaid agency website, if the individual will be moving to a different state upon release.

b. **Milestone 2: Covering and ensuring access to the expected minimum set of pre-release services for individuals who are incarcerated, to improve care transitions upon return to the community.** The state must describe its plan to implement a screening process to identify individuals who qualify for pre-release services, consistent with the qualifying criteria outlined in these STCs. The state must detail how the facilities will ensure that beneficiaries can access the demonstration benefit package, as clinically appropriate. The state must describe its approach and plans for implementing processes to assure that all pre-release service providers, as appropriate for the provider type, have the necessary experience and training, and case managers have knowledge of (or means to obtain information about) community-based providers in the communities where individuals will be returning upon release. Further, as applicable, the state must establish state requirements for carceral health providers who are not participating in Medicaid or CHIP that are similar to Medicaid provider standards, as well as program integrity standards to ensure appropriate billing.

c. **Milestone 3: Promoting continuity of care.** The state must describe its process to ensure that beneficiaries receive a person-centered plan for coordination post-release to address health needs, as well as HRSN and LTSS, as applicable. The state must detail its plans and timeline for implementing state policies to provide or facilitate timely access to post-release medical supplies, equipment, medication, additional exams, or other post-release services to address the physical and behavioral health care needs identified during the case management assessment and the development of the person-centered care plan. The state must describe its processes for promoting and ensuring collaboration between case managers, providers of pre-release services and providers of post-release services, to ensure that appropriate care coordination is taking place. As applicable, the state must also describe the planning or projected activities to ensure that Medicaid managed care plan and county behavioral health plan contracts include requirements and processes for transfer of relevant health information from the carceral facility, community-based providers, and/or state Medicaid agency to the managed care plan to support continuity and coordination of care post-release.

d. **Milestone 4: Connecting to services available post-release to meet the needs of the reentering population.** The state must describe how it will develop and implement a system to monitor the delivery of post-release services and ensure that such services

are delivered within the appropriate timeframe, per the guidelines in the forthcoming SMDL. The Implementation Plan must also capture how the state will monitor and adjust, as needed, ongoing post-release case management and describe its process to help ensure the scheduling and receipt of needed services, as well as other services needed to address HRSN and LTSS. Additionally, the state must describe how they will ensure that case managers are able to effectively serve demonstration beneficiaries transitioning into the community and recently released beneficiaries who are no longer demonstration beneficiaries.

e. **Milestone 5: Ensuring cross-system collaboration.** The state must describe how correctional facilities will facilitate access to incarcerated beneficiaries for community health care providers, including case managers, either in person or via telehealth. The state must also document its plans for establishing communication and engagement between corrections systems, community supervision entities, health care organizations, the state Medicaid agency, and supported employment and housing organizations. The state must also develop a system (for example, a data exchange, with requisite data-sharing agreements) and establish processes to monitor individuals' health care needs, HRSN, and their access to and receipt of health care services pre- and post-release, and identify anticipated challenges and potential solutions. Further, the state must develop and share its strategies to improve awareness about Medicaid coverage and access among stakeholders, including those who are incarcerated.

9.10. **Reentry Demonstration Initiative Mid-Point Assessment.** The state must contract with an independent entity to conduct a mid-point assessment of the reentry demonstration initiative and complete a Reentry Demonstration Initiative Mid-Point Assessment Report.

The Mid-Point Assessment Report must integrate all applicable implementation and performance data from the first 2.5 years of implementation of the reentry demonstration initiative. The report must be completed by the end of the third year of demonstration implementation. In the event that the reentry demonstration initiative is implemented at a timeline within the demonstration approval period, such as not to provide adequate implementation period to contribute toward a meaningful mid-point assessment, the report may be completed during a future extension of the demonstration, assuming it would also extend the authority for the reentry demonstration initiative. In the event that CMS and the state do not extend the reentry demonstration initiative beyond the demonstration's approval period ending in December 31, 2026, the mid-point assessment must be completed and the report submitted to CMS no later than when the demonstration's Summative Evaluation Report is due to CMS, which is 18 months after the end of the demonstration approval period (STC 17.8). If requested, the state must brief CMS on the report. The state must submit a revised Mid-Point Assessment Report within 60 calendar days after receipt of CMS's comments, if any.

The state must require the independent assessor to provide a draft of the Mid-Point Assessment Report to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies used, the findings on demonstration progress and performance, including identifying any risks of not meeting milestones and other operational vulnerabilities, and recommendations for overcoming those challenges and vulnerabilities. In the design, planning, and execution of the mid-point assessment, the state must require that the

independent assessor consult with key stakeholders including, but not limited to: pre- and post-release providers participating in the state's reentry demonstration initiative, eligible and participating beneficiaries, and other key partners in carceral and community settings.

For milestones and measure targets at medium to high risk of not being achieved, the state must submit to CMS modifications to the Reentry Demonstration Initiative Implementation Plan and the Monitoring Protocol for ameliorating these risks subject to CMS approval.

Elements of the Mid-Point Assessment Report must include, but not be limited to:

a. An examination of progress toward meeting each milestone and timeframe approved in the Reentry Demonstration Initiative Implementation Plan and toward meeting the targets for performance metrics as approved in the Monitoring Protocol;

b. A determination of factors that affected achievement on the milestones and progress toward performance metrics targets to date;

c. A determination of factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets;

d. For milestones or targets at medium to high risk of not being met, recommendations for adjustments in the state's Reentry Demonstration Initiative Implementation Plan or to pertinent factors that the state can influence that will support improvement.

CMS will provide additional guidance for developing the state's Reentry Initiative Mid-Point Assessment Report.

9.11. **Reentry Initiative Reinvestment Plan**. To the extent that the reentry demonstration initiative covers services that are the responsibility of and were previously provided or paid by the carceral facility or carceral authority with custody of qualifying beneficiaries, the state must reinvest all new federal dollars, equivalent to the amount of FFP projected to be expended for such services, as further defined in the Reentry Demonstration Initiative Reinvestment Plan. The Reinvestment Plan will define the amount of reinvestment required over the term of the demonstration, based on an assessment of the amount of projected expenditures for which reinvestment is required pursuant to this STC. FFP projected to be expended for new services covered under the reentry demonstration initiative, defined as services not previously provided or paid by the carceral facility or carceral authority with custody of qualifying beneficiaries prior to the individual facility's implementation of the reentry demonstration initiative (including services that are expanded, augmented, or enhanced to meet the requirements of the reentry demonstration initiative, with respect to the relevant increase in expenditures, as described in the Reentry Demonstration Initiative Reinvestment Plan), is not required to be reinvested pursuant to this STC.

a. Reinvestments in the form of non-federal expenditures totaling the amount of new federal dollars, as described above, must be made over the course of the CalAIM demonstration period. Allowable reinvestments include, but are not limited to:

i. The state share of funding associated with new services covered under the reentry demonstration initiative, as specified in this STC;

ii. Improved access to behavioral and physical community-based health care services and capacity focused on meeting the health care needs and addressing the HRSN of individuals who are incarcerated (including those who are soon-to-be released), those who have recently been released, and those who may be at higher risk of criminal justice involvement, particularly due to untreated behavioral health conditions;

iii. Improved access to and/or quality of carceral health care services, including by covering new, enhanced, or expanded pre-release services authorized via the reentry demonstration initiative opportunity;

iv. Improved health information technology and data sharing;

v. Increased community-based provider capacity that is particularly attuned to the specific needs of, and able to serve, justice-involved individuals or individuals at risk of justice involvement;

vi. Expanded or enhanced community-based services and supports, including services and supports to meet the HRSN of the justice-involved population and,

vii. Any other investments that aim to support reentry, smooth transitions into the community, divert individuals from incarceration or re-incarceration, or better the health of the justice-involved population, including investments that are aimed at interventions occurring both prior to and following release from incarceration into the community.

b. Within one hundred and twenty (120) days of approval, the state will submit a Reentry Demonstration Initiative Reinvestment Plan as part of the implementation plan referred to in STC 9.9 for CMS approval that memorializes the state's reinvestment approach. The Reinvestment Plan will also identify the types of expected reinvestments that will be made over the demonstration period. Actual reinvestments will be reported to CMS in Attachment EE.

10. DESIGNATED STATE HEALTH PROGRAMS

10.1. **Designated State Health Programs (DSHP).** The state may claim FFP for designated state health programs subject to the limits described below. This DSHP authority will allow the state to support DSHP-funded initiatives, as described in STC 10.3. This DSHP authority will be available from DY19 - DY22.

a. The DSHP will have an established limit in the amount of $1,292,850,000 total computable expenditures, in aggregate, for DY19 - DY22.

b. The state may claim FFP for up to the annual amounts outlined in Table 3, plus any unspent amounts from prior years. In the event that the state does not claim the full amount of FFP for a given demonstration year, the unspent amounts will roll over to one or more demonstration years not to exceed this demonstration period, and the state

may claim the remaining amount in a subsequent demonstration year. The total amount of DSHP FFP that the state may claim in DY 19 through 22 combined may not exceed the non-federal share of amounts actually expended by the state for the DSHP-funded initiatives

Table 3. Annual Limits in Total Computable Expenditures for DSHP.

	DY19	DY20	DY21	DY22
Total Computable Expenditures	**$323,212,500**	**$323,212,500**	**$323,212,500**	**$323,212,500**

c. The state must contribute $114,075,000 in original, non-freed up DSHP funds, over the 5-year demonstration period towards its initiatives described in STC 5(b). These funds may only derive from other allowable sources of non-federal share and must otherwise meet all applicable requirements of these STCs and the Medicaid statute and regulations.

d. The state attests, as a condition of receipt of FFP under the DSHP expenditure authority, that all non-federal share for the DSHP is allowable under all applicable statutory and regulatory requirements, including section 1903(w) of the Act and its implementing regulations. The state acknowledges that approval of the DSHP expenditure authority does not constitute approval of the underlying sources of non-federal share, which may be subject to CMS financial review.

e. As a post-approval protocol, the state shall submit an Approved DSHP List identifying the specific state programs for which FFP in expenditures can be claimed within 90 days of the amendment approval date. The Approved DSHP List will be subject to CMS approval and will be limited to programs that are population- or public heath-focused, aligned with the objectives of the Medicaid program with no likelihood that the program will frustrate or impede the primary objective of Medicaid to provide coverage for services for low-income and vulnerable populations, and serve a community largely made up of low-income individuals. The state is not eligible to claim FFP for DSHP expenditures until the list is approved by CMS, and upon approval, the state may only claim FFP for DSHP retrospectively to the effective date of the demonstration amendment that added this STC. The Approved DSHP List will be appended to the STCs as Attachment Y and thereafter may be changed or updated only with CMS approval.

10.2. **Prohibited DSHP Expenditures.**

a. Allowable DSHP expenditures do not include any expenditures that are funded by federal grants or other federal sources (for example, American Rescue Plan Act funding, grants from the Health Resources and Services Administration, the Centers for Disease Control and Prevention, etc.) or that are included as part of any maintenance of effort or non-federal share expenditure requirements of any federal grant.

b. Additionally, allowable DSHP expenditures do not include expenditures associated with the provision of non-emergency care to individuals who do not meet citizenship or immigration status requirements to be eligible for Medicaid. To implement this limitation, 5 percent of total provider expenditures or claims through DSHP identified as described in STC 10.1 will be treated as expended for non-emergency care to individuals who do not meet citizenship or immigration status requirements, and thus not matchable. This adjustment is reflected in the total computable amounts of DSHP described in STC 10.1.

c. The following types of expenditures are not permissible DSHP expenditures: expenditures that are already eligible for federal Medicaid matching funds or other sources of federal funding, that are generally part of normal operating costs that would be included in provider payment rates, that are not likely to promote the objectives of Medicaid, or are otherwise prohibited by federal law. Exclusions that have historically fallen into these categories include, but are not limited to:

   i. Bricks and mortar;

   ii. Shelters, vaccines, and medications for animals;

   iii. Coverage/services specifically for individuals who are not lawfully present or are undocumented;

   iv. Revolving capital funds; and

   v. Non-specific projects for which CMS lacks sufficient information to ascertain the nature and character of the project and whether it is consistent with these STCs.

10.3. **DSHP-Funded Initiatives.**

a. **Definition.** DSHP-funded initiatives are Medicaid or CHIP section 1115 demonstration activities supported by DSHPs.

b. **Requirements.** Expenditures for DSHP-funded initiatives are limited to costs not otherwise matchable under the state plan. CMS will only approve those DSHP-funded initiatives that it determines to be consistent with the objectives of the Medicaid statute; specifically, to expand coverage (e.g., new eligibility groups or benefits), improve access to covered services including home- and community-based services and behavioral health services, improve quality by reducing health disparities, or increase the efficiency and quality of care. DSHP-funded initiatives specifically associated with transitional non-service expenditures start-up costs for new initiatives is time limited to the current demonstration period and will not be renewed.

c. **Approved DSHP-Funded Initiatives.** The initiatives listed below are approved DSHP-funded initiatives for this demonstration. Any new DSHP-funded initiative requires approval from CMS via an amendment to the demonstration that meets the applicable transparency requirements.

i. All PATH initiatives and programs described in STC 5.14 and 5.15, excluding expenditures on Support for Sustaining Services Through the Transition to Managed Care, as described in STC 5.14.a.

10.4. **DSHP Claiming Protocol.** The state will develop and submit to CMS within 150 calendar days of the approval of this amendment, a DSHP Claiming Protocol subject to CMS approval with which the state will be required to comply in order to receive FFP in DSHP expenditures. State expenditures for the DSHP must be documented in accordance with the protocol. The state is not eligible to claim FFP for DSHP expenditures until the protocol is approved by CMS, and upon approval, the state may only claim FFP for DSHP retrospectively to the effective date of the demonstration amendment that added this STC. Once approved by CMS, the protocol becomes Attachment Z to these STCs, and thereafter may be changed or updated only with CMS approval. Changes and updates are to be applied prospectively. In order to claim FFP for DSHP expenditures, the state will provide CMS a summary worksheet that identifies DSHP expenditures by program each quarter.

a. For all eligible DSHP expenditures, the state will maintain and make available to CMS upon request:

i. Certification or attestation of expenditures.

ii. Actual expenditure data from state financial information system or state client sub-system. The Claiming Protocol will describe the procedures used that ensure that FFP is not claimed for the non-permissible expenditures listed in STC 10.2.

b. The state will claim FFP for DSHP quarterly based on actual expenditures.

10.5. **DSHP Claiming Process.** Documentation of all DSHP expenditures must be clearly outlined in the state's supporting work papers and be made available to CMS. Federal funds must be claimed within two years after the calendar quarter in which the state disburses expenditures for the DSHPs.

a. Sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable implementing regulations. To the extent that DSHPs receive federal funds from any other federal programs, such funds shall not be used as a source of non-federal share to support expenditures for DSHPs or DSHP-funded initiatives under this demonstration.

b. The administrative costs associated with DSHPs (that are not generally part of normal operating costs for service delivery) shall not be included in any way as demonstration and/or other Medicaid expenditures.

c. DSHP will be claimed at the administrative matching rate of 50 percent.

d. Expenditures will be claimed in accordance with the CMS-approved DSHP Claiming Protocol in Attachment Z.

10.6. **Sustainability Plan.** The DSHP Sustainability Plan will describe the scope of DSHP-funded initiatives the state wants to maintain and the strategy to secure resources to maintain these initiatives beyond the current approval period. The state shall submit the DSHP Sustainability Plan to CMS no later than the end of December 31, 2024, after the approval of this authority. Upon CMS approval, the plan will become Attachment AA to these STCs. Any future modifications for the DSHP Sustainability Plan will require CMS approval.

11. Provider Rate Increase Requirement

11.1. The provider payment rate increase requirements, in California, described hereafter, are a condition for expenditure authorities as referenced in Expenditure Authority 12.

11.2. As a condition of approval and ongoing provision of FFP for DSHP and related expenditures over this demonstration period of performance, DY 19 through DY 22, the state will in accordance with these STCs increase and (at least) subsequently sustain, through DY 22, Medicaid fee-for-service provider base rates, and require any relevant Medicaid managed care plan to increase for DY 20 and (at least) subsequently sustain through DY 22, network provider payment rates by at least two percentage points in the ratio of Medicaid to Medicare provider rates for each of the services that comprise the state's definition of primary care, behavioral health care, or obstetric care, as relevant, if the average Medicaid to Medicare provider payment rate ratio, as determined by STC 11.5 for a representative sample of these services for any of these three categories of services, is below 80 percent. The state will further increase the rate for these same services in service categories in the delivery systems with ratios below 80 percent. The total annual state cost for these rate increases for all categories of service combined shall be no less than $21.76 million. If the average Medicaid to Medicare provider rate ratio for a representative sample of these services under each of the state's Medicaid fee-for-service program and Medicaid managed care delivery system for any of these three categories of services is below 80 percent, the state shall only be required to increase provider payments for the delivery system for that category of service for which the ratio is below 80 percent.

11.3. State funds available as a result of receiving FFP in DSHP expenditures cannot be used to finance provider rate increases required under this section. Additionally, the state may not decrease provider payment rates for other Medicaid- or demonstration-covered services for the purpose of making state funds available to finance provider rate increases required under this section (i.e., cost-shifting).

11.4. The state will, for the purposes of complying with these requirements to derive the Medicaid to Medicare provider payment rate ratio and to apply the rate increase as may be required under this section, identify the applicable service codes and provider types for each of the primary care, behavioral health, and obstetric care services, as relevant, in a manner consistent with other state and federal Medicaid program requirements, except that inpatient behavioral health services may be excluded from the state's definition of behavioral health services.

11.5. Within 90 days of the approval of the demonstration amendment, and if the state makes fee-for-service payments, the state must establish and report to CMS the state's average Medicaid to

Medicare fee-for-service provider rate ratio for each of the three service categories – primary care, behavioral health and obstetric care, using either of the methodologies below:

a. Provide to CMS the average Medicaid to Medicare provider rate ratios if applicable for each of the three categories of services as these ratios are calculated for the state and service category as noted in the following sources:

    i. For primary care and obstetric care services, in Zuckerman, et al. 2021. "Medicaid Physician Fees Remained Substantially Below Fees Paid by Medicare in 2019." *Health Affairs* 40(2): 343–348 (Exhibit 3); and

    ii. For behavioral health services, the category called, 'Psychotherapy' in Clemans-Cope, et al. 2022. "Medicaid Professional Fees for Treatment of Opioid Use Disorder Varied Widely Across States and Were Substantially Below Fees Paid by Medicare in 2021." *Substance Abuse Treatment, Prevention, and Policy* (2022) 17:49 (Table 3); OR

b. Provide to CMS for approval for any of the three service categories the average ratio, as well as the code sets, code level Medicaid utilization, Medicaid and Medicare rates, and other data used to calculate the ratio, and the methodology for the calculation of the ratio under this alternative approach as specified below:

    i. Service codes must be representative of each service category as defined in STC 11.4;

    ii. Medicaid and Medicare data must be from the same year and not older than 2019; and

    iii. The state's methodology for determining the year of data, the Medicaid code-level utilization, the service codes within the category, the geographic rate differentials for Medicaid and/or Medicare services and their incorporation into the determination of the category average rate, the selection of the same or similar Medicare service codes for comparison, and the timeframes of data and how alignment is ensured should be comprehensively discussed in the methodology as provided to CMS for approval.

11.6. To establish the state's ratio for each service category identified in STC 11.4 as it pertains to managed care plans' provider payment rates in the state, the state must provide to CMS either:

a. The average fee-for-service ratio as provided in STC 11.5(a), if the state and CMS determine it to be a reasonable and appropriate estimate of, or proxy for, the average provider rates paid by managed care plans (e.g., where managed care plans in the state pay providers based on state plan fee-for-service payment rate schedules); or

b. The data and methodology for any or all of the service categories as provided in STC 11.5(b) using Medicaid managed care provider payment rate and utilization data.

11.7. In determining the ratios required under STC 11.5 and 11.6, the state may not incorporate fee-for-service supplemental payments that the state made or plans to make to providers, with the

exception of any state plan payments made using revenue derived by The California Healthcare, Research, and Prevention Tobacco Tax Act (Proposition 56, 2016), and may not incorporate Medicaid managed care pass-through payments in accordance with 42 CFR 438.6(a), and 438.6(d).

11.8. If the state is required to increase provider payment rates for managed care plans per STC 11.2 and 11.6, the state must:

a. Comply with the requirements for state-directed payments in accordance with 42 CFR 438.6(c), as applicable; and

b. Ensure that the entirety of the percentage increase applied to the provider payment rates in the service category whose Medicaid to Medicare average payment rate ratio is below 80 percent is paid to providers, and none of such payment rate increase is retained by managed care plans.

11.9. For the entirety of DY 20 through DY 22, the provider payment rate increase for each service in a service category and delivery system for which the average ratio is less than 80 percent will be an amount necessary so that the Medicaid to Medicare ratio increases by two percentage points over the highest rate for each service in DY 19, and such rate will be in effect on the first day of DY 20. A required payment rate increase for a delivery system shall apply to all services in a service category as defined under STC 11.4.

11.10. If the state uses a managed care delivery system for any of the service categories defined in STC 11.4, for the beginning of the first rating period as defined in 42 CFR 438.2(a) that starts in each demonstration year from DY 20 through DY 22, the managed care plans' provider payment rate increase for each service in the affected categories will be no lower than the highest rate in DY 19 plus an amount necessary so that the Medicaid to Medicare ratio for that service increases by two percentage points. The payment rate increase shall apply to all services in a service category as defined under STC 11.4.

11.11. The state will provide the information to document the payment rate ratio required under STC 11.5 and 11.6, via submission to the Performance Metrics Database and Analytics (PMDA) portal for CMS review and approval.

11.12. For demonstration years following the first year of provider payment rate increases, the state will provide an annual attestation within the state's annual demonstration monitoring report that the provider payment rate increases subject to these STCs were at least sustained from, if not higher than, the previous year.

11.13. Within 90 days of the approval of the demonstration amendment, the state will provide to CMS the following information and Attestation Table signed by the State Medicaid Director, or by the Director's Chief Financial Officer (or equivalent position), to PMDA, along with a description of the state's methodology and the state's supporting data for establishing ratios for each of the three service categories in accordance with STC 11.5 and 11.6 for CMS review and approval, at which time the Attestation Table will be appended to the STCs as Attachment BB:

California DSHP Related Provider Payment Increase Assessment – Attestation Table		
The reported data and attestations pertain to DSHP related provider payment increase requirements for the demonstration period of performance DY 19 thru DY 22		
Category of Service	**Medicaid Fee-for-Service to Medicare Fee-for-service Ratio**	**Medicaid Managed Care to Medicare Fee-for-service Ratio**
Primary Care Services	[*insert percent, or N/A if state does not make Medicaid fee-for-service payments*]	[*insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for applicable covered service categories*]
	[*insert approach, either ratio derived under STC 11.5(a) or STC 11.5(b)*	[*insert approach, either ratio derived under STC 11.6(a) or STC 11.6(b) insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio*]
Obstetric Care Services	[*insert percent, or N/A if state does not make fee-for-service payments*]	[*insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for providers for covered service categories*]
	[*insert approach, either ratio derived under STC 11.5(a) or STC 11.5(b)*	[*insert approach, either ratio derived under STC 11.6(a) or STC 11.6(b) insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio*]
Behavioral Health Services	[*insert percent, or N/A if state does not make fee-for-service payments*]	[*insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for applicable covered service categories]*
	[*insert approach, either ratio derived under STC 11.5(a) or STC 11.5(b)*	[*insert approach, either ratio derived under STC 11.6(a) or STC 11.6(b); insert data source and time period (e.g., applicable 12-month rating*

		period) for each of Medicaid and Medicare to derive the ratio]

In accordance with STCs 11.1 through 11.12, including that the Medicaid provider payment rates used to establish the ratios do not reflect fee-for-service supplemental payments, with the exception of any state plan payments made using revenue derived by The California Healthcare, Research, and Prevention Tobacco Tax Act (Proposition 56, 2016), and do not incorporate Medicaid managed care pass-through payments in accordance with 42 CFR § 438.6(a) and 438.6(d), I attest that at least a two percentage point payment increase will be applied to all the services in each of the three categories in each of the fee-for-service or managed care delivery systems with a ratio below 80 percent if these systems apply to the state's Medicaid program listed herein. Such provider payment increases for each service will be effective beginning on [*insert date*] and will not be lower than the highest rate for that service code in DY 19 plus at least a two percentage point increase relative to the rate for the same or similar Medicare billing code through at least [*insert date*], in the total amount of state expenditure of at least $21.76 million across affected delivery systems.

For the purpose of deriving the Medicaid to Medicare provider payment rate ratio, and to apply the rate increase as may be required under a fee-for-service delivery system and under a managed care delivery system, the state agrees to define primary care, behavioral health and obstetric care, including identify applicable service codes and providers types for each of primary care, behavioral health and obstetric care in a manner consistent with other state and federal Medicaid program requirements, except that inpatient behavioral health services may be excluded.

The services that comprise each service category to which the rate increase must be applied will include all service codes that fit under the state's definition of the category, except the behavioral health codes do not have to include inpatient care services.

For provider payment rates paid under managed care delivery system, the data and methodology for any one of the service categories as provided in STC 11.6(b) will be based on Medicaid managed care provider payment rate and utilization data.

The effective date of the rate increases is the first day of DY 20 and will be at least sustained, if not higher, through DY 22.

The additional payment increases required under STC 11.2 will also be made in the total amount of state expenditure of at least $21.76 million across the affected delivery systems.

California [*insert does or does not*] make Medicaid state plan fee-for-service payments for the following categories of service for at least some populations: primary care, behavioral health, and / or obstetric care.

For any such payments, as necessary to comply with the DSHP STCs, I agree to submit by no later than [*insert date*] for CMS review and approval the Medicaid state plan fee-for-service payment increase methodology, including the Medicaid code set to which the payment rate increases are to be applied, code level utilization, Medicaid and Medicare rates for the same or similar Medicare billing codes, and other data used to calculate the ratio, and the methodology, as well as other documents and supporting information (e.g., state responses to Medicaid

funding questions) as required by statutes, regulations and CMS policy, through the submission of a new state plan amendment, following the normal SPA process including publishing timely tribal and public notice and submitting to CMS all required SPA forms (e.g., SPA transmittal letter, CMS-179, Attachment 4.19-B pages from the state), by no later than [*insert date*]. The state will also provide similar documentation for the additional payment increases required under STC 11.2.
California [*insert does or does not*] include the following service categories within a Medicaid managed care delivery system for which the managed care plans make payments to applicable providers for at least some populations: primary care, behavioral health, and or obstetric care. For any such payments, I agree to submit the Medicaid managed care plans' provider payment increase methodology, including the information listed in STC 11.7 through the state directed payments submission process and in accordance with 42 CFR 438.6(c), as applicable, by no later than *[insert date*]. The state will also provide similar documentation for the additional payment increases required under STC 11.2.
If the state utilizes a managed care delivery system for the applicable service categories, then in accordance with STC 11.8, I attest that necessary arrangements will be made to assure that 100 percent of the amount necessary, so that the Medicaid to Medicare ratio increases by two percentage points, will be paid by managed care plans to the providers of those service categories and none of this payment rate increase is retained by the managed care plans. The state will also assure that 100 percent of the additional payment increases under STC 11.2 will be paid to providers of the applicable services.
California agrees not to use DSHP funding to finance any provider payment rate increase required under Section 11. California further agrees not to decrease provider payment rates for other Medicaid- or demonstration-covered services to make state funds available to finance provider rate increases required under STC 11.
I, *[insert name of SMD or CFO (or equivalent position)*] [*insert title*], attest that the above information is complete and accurate. [*Provide signature*_____] *[Provide printed name of signatory* _____] [*Provide date*_____]

12. Managed Care Entities

12.1 **Managed Care Readiness.** The state must assess readiness pursuant to 438.66(d). Assignment into an MCO may only begin when each MCO has been determined by the state to meet certain readiness and network requirements.

12.2 **Continuity of Care during the Transition Period for Managed Care Plans impacted by this demonstration.**

a. The state's contracts with all managed care plans must require a transition of care protocol to ensure continuity of care for members. In the 12 counties which will expand Whole Child Model no sooner than January 1, 2025, this protocol must include a plan to identify child members served by the California Children's Services (CCS) program and to assure they receive enhanced care coordination in accordance with state statute.
b. Managed care plans must 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 with a single case or letter of agreement for at least six months, unless the member/family has opted to discontinue such services or selects a provider that is in network. To ensure continuity of care and allow the member to keep their current primary care provider (PCP), if the managed care plan does not have a member's PCP in its network on the date when the member is assigned a PCP prior to the launch of the managed care program, the managed care plan is required to offer to execute a contract or a single case or letter of agreement to that PCP upon request.
c. Upon County Organized Health System (COHS) expansion and Single Plan models launch and monthly for six months following the expansion of the COHS model and launch of the Single Plan model, the state must submit a report detailing the total percentage of members who experienced a disruption in primary care across all primary care providers, meaning that their historical primary care provider is not in-network for their COHS and Single Plan models. If the total percentage of members with PCP member disruption is greater than 10%, CMS will request the state submit a corrective action plan. In addition, CMS reserves the right to extend the transition of care protocol by an additional six months if the initial report, and subsequent reports, show there is not adequate access for members. Any notice of extension of transition of care protocols shall be communicated no less than 60 days prior to anticipated expiration of the protocols.

12.3 **Assurances of Adequate Capacity and Services for Managed Care Plans impacted by this demonstration.** For all managed care plans that furnish services to Medicaid members enrolled in Medi-Cal managed care and impacted by this section 1115(a) demonstration, the state must submit the Assurance of Compliance detailed in 42 CFR § 438.207(d) using the Access Reporting Template provided by CMS. Before implementation, each managed care plan expanding its COHS model or launching the Single Plan model must provide adequate assurances that it has sufficient capacity to serve the expected enrollment in its service area and offers an adequate range of preventive, primary, specialty, and acute services for the anticipated number of enrollees in the service area. The state must verify these assurances by

reviewing demographic, utilization and enrollment data for members enrolled in the managed care plans participating in the COHS expansion and Single Plan county model changes as well as:

a. The number and types of preventive, primary, specialty, and acute providers available to provide covered services to members enrolled in the managed care plans participating in the COHS expansion and Single Plan county model changes;

b. The number of providers accepting members enrolled in the managed care plans participating in the COHS expansion and Single Plan county model changes; and

c. The geographic location of providers, as shown through GeoAccess or similar software;

d. The state must respond to, and cooperate with, any CMS requests during an audit.

12.4 **Timing of Submission of Assurances of Adequate Capacity and Services.** The state must begin submitting the Access Reporting Templates for all managed care plans that furnish services to Medicaid members enrolled in Medi-Cal managed care and impacted by this section1115(a) demonstration by January 1, 2024. For the initial submissions in DY 20, the state must tailor Access Reporting Template submissions based on operational readiness and data availability. For submissions in DY 21, the state must provide the complete set of data outlined in the Access Reporting Template for all managed care plans that furnish services to Medicaid members enrolled in Medi-Cal managed care and impacted by this section 1115(a) demonstration. The state must publish these reports on its public website. To the extent appropriate, the state and CMS will work collaboratively to assure there is no redundancy in reporting efforts under the section 1115 and 1915(b) authorities.

12.5 **Quarterly Appeals and Grievance Report for Managed Care Plans.** CMS reserves the right to request quarterly appeals and grievance data for all programs authorized under this section 1115(a) demonstration. The state must submit 60 days after of the end of each quarter, appeals and grievance data for all managed care plans that furnish services to Medicaid members enrolled in Medi-Cal managed care and impacted by this section 1115(a) demonstration launching on or after January 1, 2024. Submissions must include a subgroup analysis of child members served by the CCS program in the 12 counties expanding Whole Child Model in 2025.

The state must submit the data for four quarters. If additional data is needed after that period, CMS shall provide the state with at least 60-days' notice of the extension of the reporting. In effectuating this requirement, the state must utilize the Appeals and Grievance Reporting Template provided by CMS. To the extent appropriate, the state and CMS will work collaboratively to assure there is no redundancy in reporting efforts under the section 1115 and 1915(b) authorities.

12.6 **Choice of Primary Care Physician (PCP).** Managed care plans are required to assure that members have a choice of PCPs. Specifically, members will have a choice of at least two

primary care providers, and may request change of primary care provider at least at the times described in 42 CFR 438.56(c).

13. Traditional Health Care Practices

13.1. **Traditional Health Care Practices Program Overview.** This component of the demonstration will provide federal financial participation (FFP) for state expenditures on traditional health care practices received through Indian Health Service (IHS) facilities, facilities operated by Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA) (here called Tribal facilities), and facilities operated by urban Indian organizations under Title V of the Indian Health Care Improvement Act (IHCIA) (here called urban Indian organization or UIO facilities) by Medicaid and CHIP beneficiaries who are able to receive services by or through those facilities. Because some of the traditional health care practices covered under this demonstration may be considered religious or may contain elements of religious or spiritual practices, the state must attest, as a condition of receiving federal matching funds for its expenditures under Expenditure Authority 15 and 17, to: 1) providing adequate access to secular alternatives, including but not limited to preventive services, primary care, pharmacy services, mental health and substance use disorder services, as approved in its state plan, 1115 demonstration(s), or 1915 waiver(s), and in compliance with federal laws and regulations; 2) for any condition(s) addressed by and through covered traditional health care practices, ensuring beneficiaries have a genuine, independent choice to use other Medicaid- and CHIP-covered services; and 3) assuring that traditional health care practices may not be used to reduce, discourage, or jeopardize a beneficiary's access to services or settings covered under the state plan, 1115 demonstration(s), or 1915 waiver(s) and that the state will not deny access to services or settings on the basis that the beneficiary has been offered, is currently receiving, or has previously utilized traditional health care practices. Provided that all other applicable requirements for claiming FFP have been met, the state may begin claiming FFP for its expenditures on traditional health care practices only after submitting this attestation to CMS. The state must notify beneficiaries of their rights to file grievances, complaints, and appeals related to this attestation and take any needed actions or monitoring, consistent with federal laws and regulations regarding grievances, complaints, and appeals. As per STC 16.5b, the state must report any such grievances, complaints, and appeals to CMS in Monitoring Reports. CMS will review all reports and will follow up on credible concerns in those reports, as well as any credible concerns raised by members of the public. If the state is found to be out of compliance with the attestation and related STCs, CMS may: 1) require the state to submit a corrective action plan, 2) issue a deferral, or 3) withdraw authority for traditional health care practices.

13.2. **Criteria for Receiving Coverage for Traditional Health Care Practices.** To receive coverage for traditional health care practices under this component of the demonstration, a beneficiary must meet the following criteria:

a. Is a Medicaid or CHIP beneficiary;

b. Is able to receive services delivered by or through IHS, Tribal or UIO facilities, as determined by the facility; and[1]

c. Is in a group for which the state has opted to phase-in implementation of this coverage.

13.3. **Scope of Traditional Health Care Practices**. The state may claim FFP for its expenditures on any traditional health care practice that is delivered by or through an IHS, Tribal, or UIO facility to a beneficiary meeting the criteria in STC 13.2.

a. The state will be required to report traditional health care practices provided and utilization in the Annual Monitoring Report.

b. Consistent with CMS's longstanding interpretation of section 1905(b) of the Act, the state will receive a 100 percent federal medical assistance percentage (FMAP) for its expenditures on the services for which coverage is authorized under Expenditure Authority 15 when those services are received through IHS and Tribal facilities by Medicaid beneficiaries who are American Indians or Alaska Natives.[2] State expenditures for these services when delivered to Medicaid beneficiaries by UIO facilities, state expenditures for these services when delivered by or through qualifying facilities to CHIP beneficiaries, and state expenditures on these services when provided by or through qualifying facilities to Medicaid beneficiaries who are not American Indians or Alaska Natives will be federally matched at the otherwise applicable state service match.

c. Excluded items, services, and activities that are not covered as part of the scope of traditional health care practices include, but are not limited to:

i. Construction costs (including building modification and building rehabilitation);

ii. Room and board;

iii. Costs for services in prisons or correctional facilities, or services for people who are civilly committed and unable to leave an institutional setting, except as described in Expenditure Authority 13;

iv. Services provided to individuals who are not lawfully present in the United States or are undocumented;

v. Capital investments; and

[1] Under IHS authorities, IHS and Tribal facilities serve Medicaid and CHIP beneficiaries who are eligible to receive services from the facility under IHS regulations at 42 CFR part 136, and also may serve other Medicaid and CHIP beneficiaries under 25 U.S.C. 1680c. Under IHS authorities, UIO facilities that receive funding from IHS are authorized to use the IHS funding to serve urban Indians (as defined in 25 U.S.C. 1603(28)), residing in the urban centers (as defined in 25 U.S.C. 1603(27)) in which such organizations are situated, including Medicaid and CHIP beneficiaries who also meet those definitions. UIO facilities may also serve other Medicaid and CHIP beneficiaries with non-IHS funds.

[2] Section 1905(b) of the Social Security Act (third sentence).

vi. Research grants and expenditures not related to monitoring and evaluation.

13.4. **Participating Facilities**. Traditional health care practices are covered only when received through IHS, Tribal, or UIO facilities.

13.5. **Participating Providers**. Practitioners or providers of traditional health care practices must be employed by or contracted with IHS, Tribal, or UIO facilities, which could include an urban Indian organization contracted with an IHS or Tribal facility. The qualifying facility is expected to make the following determinations and to provide documentation of these determinations to the state, upon request. Each qualifying facility is responsible for determining that each practitioner, provider, or provider staff member employed by or contracted with the qualifying facility to provide traditional health care practices 1) is qualified to provide traditional health care practices to the qualifying facility's patients; and 2) has the necessary experience and appropriate training. The qualifying facility also is expected to: 1) establish its methods for determining whether its employees or contractors are qualified to provide traditional health care practices, 2) bill Medicaid or CHIP for traditional health care practices furnished only by employees or contractors who are qualified to provide them, and 3) provide documentation to the state about these activities upon request. The state must make any documentation it receives from qualifying facilities about these activities and determinations available to CMS upon request.

13.6. **Payment Methodology.** The state must comply with the payment rate-setting requirements in 42 CFR Part 447, Subpart B, as though a state plan amendment were required, to establish a payment rate or methodology for traditional health care practices as approved through demonstration Expenditure Authority 15 and 17. The state must conduct state-level public notice under 42 CFR 447.205 prior to using the applicable payment methodologies to pay for traditional health care practices and must maintain documentation of the payment methodologies on its website described in 42 CFR 447.203. The state is encouraged to engage with CMS on the development of all new or modified fee-for-service or non-risk rate contract payment methodologies if the state is not using the IHS All-Inclusive Rate (AIR)[3] when paying for traditional health care practices. Provided that all other requirements for claiming FFP have been met (including submission of the attestation described in STC 13.1), the state may draw FFP for traditional health care practices after using the payment methodologies to pay providers (and can use them to pay providers only subsequent to conducting notice under 42 CFR 447.205, as described above). The DMC-ODS counties will pay participating facilities delivering traditional health care practices at the rates or methodologies established by the state.

14. Negative Balance

14.1. **Repayment of Payment Management System (PMS) Negative Account Balances:** As of November 6, 2021, California has negative account balances in some of its Medicaid PMS accounts. In order to bring the accounts into balance, the state shall do the following:

[3] See https://www.ihs.gov/businessoffice/reimbursement-rates/.

a. **Issue Resolution**. CMS and the state shall work collaboratively to resolve outstanding financial issues:

   i. Delayed certified public expenditure reconciliations – The state should review all approved payment methodologies that require a final reconciliation and ensure that clear time frames are incorporated within the approved methodology. For any methodology not containing a clear timeline for completion of the final reconciliation, the state must submit a proposed revised methodology no later than December 31, 2022.

   ii. Open deferrals – The state must immediately submit decreasing adjustments for any remaining placeholder claims after December 31, 2021. For all other open deferrals currently beyond the regulatory 120-day response period, the state must submit a timeline for resolving the deferral. This proposed timeline needs to be submitted no later than March 31, 2022. CMS will work collaboratively with the state to resolve each outstanding issue.

b. **Repayment Process.**

   i. Negative Account Balances – For any negative account balances unresolved as of June 30, 2022, CMS will issue a demand letter to the state identifying the final negative account balance amount and the state's right to appeal. The state may request a repayment schedule in Attachment R that ensures repayment of any remaining amount of the negative account balances identified through Federal Fiscal Year 2020 through regular quarterly installments, plus interest, by the end of the waiver period (12/31/2020) or in three years or less from CMS' approval of the repayment schedule. Interest will begin on the date of the demand notice and end when the debt is paid in full. Additional repayment requirements are identified in section c through h below.

   ii. Deferred Claims – For any deferred claims 1) not paid by CMS by June 30, 2022, 2) for which the state has drawn FFP from its PMS account, and 3) for which the state has not returned all drawn FFP to its PMS account by June 30, 2022, CMS shall proceed by disallowance in accordance with 42 CFR 430 Subpart C. The state may request a repayment schedule in accordance with 42 CFR 430 Subpart C. This repayment is not subject to the provisions of subsection (c) through (h) below.

c. **Repayment Period Interest**. Interest will accrue on the final unresolved negative account balance amount; at the Current Value of Funds Rate (CVFR) published by the U.S. Department of Treasury, beginning on the date of the demand letter issued by CMS pursuant to STC 12.1(b)(i) until the entire principle amount is repaid in full. Each payment will be applied first to accrued interest and then to principal. After each payment, interest will continue to accrue on the remaining principal balance until the debt is paid in full or otherwise resolved by CMS. CMS will adjust the repayment schedule to reflect any changes to the CVFR during the repayment schedule.

d. Each payment will be applied first to accrued interest and then to principal. After each payment, interest will continue to accrue on the remaining principal balance until the debt is paid in full or otherwise resolved by CMS. CMS will adjust the repayment schedule to reflect any changes to the CVFR during the repayment schedule.

e. **Source of Repayment Funds.** The funding source of repayment cannot be derived from federal funds, including any Medicaid or CHIP funds available to the state in FY 2014 or later PMS accounts.

f. **Mechanism of Repayment.** The quarter payment amount due or payment in full may be sent via FedWire (preferred), Automated Clearing House (ACH), or check – specific instructions for FedWire or ACH may be obtained from your state's Division of Payment Management representative. The quarter payment amount due or in payment full via check should be made payable to: "The Department of Health and Human Services" and sent to the following address:

HHS Program Support Center
P.O. Box 979132
St. Louis, MO 63197

Please include your PMS account number and a brief description explaining the nature of the return. Please include a copy of this STC along with your payment.

g. **PMS Draws for Deferred FFP.** When CMS issues a deferral of claims for FFP to the state in accordance with the timelines set forth in 42 CFR 430.40, the state must immediately return the deferred FFP to the applicable PMS subaccount while the deferral is being resolved. After CMS reviews the deferred claims, CMS will determine the allowability of the claims. If CMS determines that a deferred claims are allowable under federal requirements, CMS will release the deferred funds to the appropriate PMS subaccount and will notify California that the funds are available for draw.

h. **Adjustments to Repayment Schedule.** The state may request a recalculation of the repayment schedule from CMS if the state decides to make accelerated repayment installments. CMS will work with the state to recalculate based on any existing positive amounts that may be available in the PMS subaccount(s) and/or any positive Medicaid grant awards issued that may reduce the outstanding negative PMS subaccount(s) balances. CMS will reissue the repayment schedule to reflect adjustments, if any.

i. **Cash Management Improvement Act (CMIA) Agreement.** The Repayment of Payment Management System (PMS) Negative Account Balances section of these STCs does not preclude action by other federal agencies, including the United States Department of Treasury resulting from a violation of the CMIA agreement between the State of California and the United States Department of Treasury.

15. Global Payment Program

15.1. California will operate a global payment program (GPP) to assist public health care systems (PHCS) that provide health care for the uninsured. The GPP is meant to focus on value, rather than volume, of care provided. The purpose is to support PHCS for their key role in providing services to California's remaining uninsured and to promote the delivery of more cost-effective and higher-value care to the uninsured. Promoting more cost-effective and higher value care means that the payment structure will reward the provision of care in more appropriate venues, rather than through the emergency department or through inpatient hospital settings. In addition to providing value-based care, the GPP will incorporate services that are otherwise available to the state's Medi-Cal beneficiaries under different Medicaid authorities with the aim of enhancing access and utilization among the uninsured, and thereby advancing health equity in the state. The state will continue to test and assess this approach to assist PHCS, and will strengthen the GPP performance and effectiveness for potentially broader application.

15.2. Under the GPP, participating PHCS will continue receiving GPP payments that will be 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 reinforce structural changes to the care delivery system that will improve the options for treating both Medicaid and uninsured patients. The methodology for setting service values will incorporate measures of value for the patient in conjunction with the recognition of costs to the health care system. Care being received in appropriate settings will be valued relatively higher than care given in inappropriate care settings for the type of illness.

15.3. Payments will not exceed the limits in Attachment K (GPP Funding and Mechanics Protocol), but may be less if the thresholds are not achieved. Services will be grouped into categories that reflect where care is being provided. Within each category services will be grouped into tiers of similar service intensity. This will assist in modifying relative values of services, so that their long-term value is incorporated and no longer an externality. Service tiers across categories that aim to provide the same end result would have relative values of generally equivalent care. The intent of this framework is to provide flexibility in provision of services while encouraging a broad shift to more cost-effective care that is person-centered.

15.4. The total amount of annual funding available for the GPP in PY1-12 is 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.

15.5. **Entities Eligible to Receive Global Payments.** Payments under the GPP are available for PHCS that are comprised of a designated public hospital (DPH) identified in Attachment C that agrees to participate in the GPP and that DPH's affiliated and contracted providers (collectively, for purposes of the GPP only, Public Health Care System or "PHCS"). For purposes of the GPP, multiple DPHs and their affiliated and contracted providers may comprise a single PHCS in accordance with criteria established and set forth in Attachment K (GPP Funding and Mechanics Protocol). DHCS shall identify to CMS all PHCS that will participate in the GPP.

15.6. **General Overview of Global Payments**

a. Global payments shall be available based on a GPP program year ("GPP PY"). The first GPP PY is for the period July 1, 2015 through June 30, 2016. GPP PY 6 aligned with the six-month period of July 1, 2020 through December 31, 2020. GPP PY7 aligned with the period of January 1, 2021 through December 31, 2021. GPP PYs 8 through 12 will continue to align with CY periods, beginning with GPP PY 8 aligning with the CY period of January 1, 2022 through December 31, 2022.

b. An annual GPP budget for each participating PHCS shall be established in accordance with the parameters set forth in Attachment K (GPP Funding and Mechanics Protocol). For the purposes of GPP PY 6, the annual GPP budget shall be established for a six-month period; for GPP PY7 and all future PYs, the global budget shall be established for a full calendar year. The aggregate GPP budget among participating PHCS shall not exceed the total computable amount of GPP funds available in a given GPP PY, as established by the limits set forth in STC 13.10(e).

c. PHCS shall be required to provide a threshold amount of care, measured in points, to earn their entire annual GPP budget amount. Points for services will be assigned in a manner that incorporates measures of value for the patient and that achieves other programmatic goals, as set forth in Attachment L (GPP Valuation Methodology Protocol).

d. Each PHCS annual threshold point amount is determined through a baseline analysis, accounting for factors such as its historical and projected volume, cost and mix of services to the uninsured and estimated need, determined in accordance with Attachment L (GPP Valuation Methodology Protocol). These thresholds will ensure that PHCS only receive full GPP payments if the PHCS provides levels of services to the uninsured population necessary to meet its threshold that has been set based on the level of services that would otherwise have been provided to the uninsured. For purposes of the GPP, care will be considered uninsured for individuals for whom there is no source of third-party coverage for the specific service furnished by the PHCS. Furthermore, an individual will not be considered uninsured with regard to a non-traditional service (as identified in Attachment L, GPP Valuation Methodology Protocol) he or she receives from the PHCS if the individual has a source of third party coverage for the category of service for which the non-traditional service is being used as a substitute.

e. Interim GPP payments shall be made to PHCS on a quarterly basis, calculated as 25 percent of the PHCS's annual global budget, or, with respect to GPP PY 6, 50 percent of the PHCS's annual budget. Within nine months following the end of each GPP PY, the state shall reconcile interim payments to the amount earned for services as established by the reports submitted in accordance with f. below.

f. Attachment K (GPP Funding and Mechanics Protocol) sets forth a reporting schedule by which each PHCS will report its actual services provided under the GPP and the corresponding points valuation to be used by DHCS to determine the payments due. The report shall at least include the GPP-related services furnished by the PHCS during the applicable year, reported by category, tier, and type, and shall serve as the

basis for reconciling interim GPP payments with final amounts due. As payments for services under the GPP are based on point value, no cost reconciliation protocol will apply. PHCS shall not be subject to the reporting requirements of 42 C.F.R. Section 447.299.

g. The full amount of a PHCS global budget shall be payable to the PHCS if it meets or exceeds its designated threshold for a given GPP PY. In the event a PHCS does not achieve or exceed its threshold for a given GPP PY, the PHCS's GPP payment shall equal its global budget as reduced by the proportion by which it fell short of its threshold.

h. The state, in accordance with procedures set forth in Attachment K (GPP Funding and Mechanics Protocol), shall redistribute unearned GPP funds that were available in a given GPP PY amongst other PHCS that have exceeded their respective threshold for that year.

i. The non-federal federal share of GPP payments will be provided by PHCS through intergovernmental transfers (IGT), subject to the requirements of STC 15.10 (Sources of Non-Federal Share) below. Upon receipt of the IGTs, DHCS will draw the federal funding and pay both the non-federal and federal shares of the applicable GPP payments in accordance with the requirements and schedules described herein and in Attachment K (GPP Funding and Mechanics Protocol). In the event GPP payments are recouped upon reconciliation, DHCS will repay the corresponding federal share to CMS in accordance with federal regulations at 42 CFR 430.30, et seq.

j. GPP payments determined annually for each eligible PHCS, after accounting for finalization of the applicable DSH allotment and subparagraphs (g) and (h) as applicable, represent the final amounts available for that GPP PY.

15.7. **Valuation of Service**

a. Services under the GPP shall be valued in accordance with the methodology set forth in Attachment L (GPP Valuation Methodology Protocol). The valuation methodology allows for the continuation of services provided by Public Health Care Systems that were reimbursed under the DSH and SNCP structure that existed for PHCS prior to the GPP, while encouraging more cost-effective and innovative care where appropriate. Point values shall also be developed for those innovative or alternative services where there is currently little to no reimbursement. The valuation methodology reflects the following programmatic goals:

i. Facilitate a shift away from the previous cost-based payment that was restricted to mostly hospital settings and subject to prolonged periods of cost reconciliation;

ii. Broaden the settings in which Public Health Care Systems receive payment for services furnished to the uninsured, and encourages Public Health Care Systems to provide greater primary and preventive services, as well as to create

access to alternative modalities such as telehealth, group visits and health coaching;

iii. Emphasize coordinated care and alternative modalities by recognizing the higher value of access to primary care, ambulatory care, and other core components of care management, as compared to the higher cost of avoidable emergency room visits and acute care hospital stays;

iv. Recognize the value of services that typically are not directly or separately reimbursed by Medicaid or other payors ("non-traditional" services), and that substitute or complement services for which payment is typically available upon provision of the service ("traditional" services).

v. Make GPP a potentially equity-enhancing program through valuation of additional services otherwise available for the state's Medicaid beneficiaries such that the program can incentivize provision of such services to the uninsured population, potentially to begin addressing health inequities among populations these hospital systems serve.

b. All services eligible for points under the GPP are grouped into the four categories described below in STC 13.11:

c. Services within the categories are further stratified into tiers based on similar service intensity, activity and/or effort. Relative point values are assigned to tiers for purposes of reporting and generating payments.

d. The valuation methodology incorporates a phased approach in which traditional services, over the course of the demonstration approval period, reflect reduced point values. High intensity services will continue to be recognized for their value and importance, including recognition in the point system that emergency room visits and inpatient stays may be necessary and appropriate.

e. Relative point values will be initially set based on cost and then adjusted to a limited degree based on other measures of value, in order to assist in maintaining accountability for the amount of services provided compared to the funding PHCS receive. Higher relative value points may be assigned to services, including non-traditional services that help promote one or more of the objectives from the list below; however, the relative point value of services, except for those services for which cost information is not readily available, such as non- traditional services, may not vary from their initial cost-based amounts by more than 40 percent at any time during the GPP.

i. Timeliness and convenience of service to patient;

ii. Increased access to care;

iii. Earlier intervention;

iv. Appropriate resource use for a given outcome;

v. Health and wellness services that result in improved patient; decisions and overall health status;

vi. Potential to mitigate future costs;

vii. Preventative services;

viii. Likelihood of bringing a patient into an organized system of care; and

ix. Additional criteria, to be designed by the state.

f. In GPP PYs in which point revaluation has occurred, point revaluation must be calibrated so that the overall impact would not lead to any PHCS receiving additional total points in any given GPP PY if its utilization and the mix of services provided remained the same as in the baseline period used to determine the designated threshold. When DHCS develops for approval point values for additional services intended to increase health equity, this subparagraph shall not be interpreted to necessarily require revaluation of other existing services' values. However, the state must provide valuation for any additional services, as further described.

g. The exact methodology for assigning points to the services is reflected in Attachment L (GPP Valuation Methodology Protocol), as approved by CMS on March 21, 2016. This Protocol remains in effect until the state introduces additional services to the GPP. Any updates to Attachment L, including introduction of additional services, and any modifications to the valuation methodology, will be subject to CMS approval, and will require CMS approval before it can be implemented. If the state proposes to change point valuations or add new services, it must obtain CMS approval before they may be implemented in the program.

h. PHCS are not required to provide every service identified on Attachment LFF (GPP Valuation Methodology Protocol), but are allowed the flexibility to provide any combination of services, through their global payments budgets and service-related point thresholds, to address local needs.

15.8. **Global Payment Program Funding and Mechanics Protocol and Global Payment Program Service Valuation Methodology Protocol.** The GPP Funding and Mechanics Protocol (Attachment K) and the GPP Valuation Methodology Protocol (Attachment L) set forth in detail the parameters and procedures related to the operation of the GPP.

a. **Global Payment Program Valuation Methodology Protocol** includes the following:

i. The master list of services and activities for which points apply under the GPP and their associated point values, including the placement of services within the categories and tiers and how point values will change over the course of the demonstration.

ii. Methodology for calculating and modifying the PHCS thresholds.

b. **The Global Payment Program Funding and Mechanics Protocol specifies the following:**

i. How PHCS may be defined, including criteria for when multiple DPHs may comprise a single Public Health Care System.

ii. Methodology for establishing and modifying annual global budgets for each PHCS.

iii. Technical guidance on how eligible services to the uninsured are defined, accounted for and reported.

iv. Reporting schedule for PHCS to report services provided under the GPP.

v. IGT, interim payment and final payment reconciliation mechanics and schedules.

vi. Methods for redistributing unused portions of annual global budgets among PHCS that exceeded their point threshold.

Within 90 calendar days of CMS approval of the CalAIM demonstration, the state will submit an updated version of the GPP Funding and Mechanics Protocol (Attachment K) and the GPP Valuation Methodology Protocol (Attachment L). Updates to both protocols must accommodate, among other things, inclusion of additional services available to Medi-Cal beneficiaries that the state will introduce in the GPP services with the aim of supporting health equity considerations in the state. For both the deliverables, the state must submit a revised Protocol within sixty (60) calendar days after receipt of CMS's comments, if any. Once the updated Protocols are finalized and approved, these will replace any previous CMS-approved versions, and the updated versions will be incorporated into the STCs as Attachments K and L, respectively.

15.9. **Global Payment Program Health Equity Monitoring Metrics Protocol:** No later than ninety (90) calendar days after the approval of the CalAIM demonstration extension, the state will submit to CMS a GPP Health Equity Monitoring Metrics Protocol outlining a set of metrics focused on access to, utilization of, and quality of health care and/or health outcomes that the state will systematically calculate and report for understanding existing health inequities among the state's uninsured population who receive GPP services, and thereafter, for tracking progress in bridging any such inequities. The metrics will, to the extent possible, leverage the national established quality measures, including but not limited to, Medicaid Adult, Child, and Maternity Core Sets, and will in general be reported annually once available. The state can also propose other nationally recognized measures or appropriate metrics that are aligned with its demonstration goals pertinent to the GPP, the uncompensated care pool, and its health equity considerations.

The state will work collaboratively with CMS through iterations of the Protocol to finalize an approvable set of health equity metrics and prioritize collection of data on race, ethnicity, language, disability status and other factors to the extent feasible, and using the data to identify disparities in access, health outcomes and quality and experiences of care. The Health Equity Monitoring Metrics Protocol will outline for each of the selected metrics the reporting timeline, which might be impacted by the state's data systems readiness, the baseline reporting period, and the reporting frequency. The state will report the progress and metrics data through its Quarterly and/or Annual Monitoring Reports, per the reporting schedule that will be established

in the Protocol. To the extent the state will require ramp-up time to set up data systems to be able to begin reporting the various metrics data overall or for any of the key subpopulations of interest, the state should provide regular updates to CMS on progress with data systems readiness via the Monitoring Reports.

Once approved, the Health Equity Monitoring Metrics Protocol will be appended to these STCs as Attachment M.

15.10. **Funding and Annual Limits.**

a. Under the GPP, a portion of the state's DSH funding and funding from the UC Pool are combined to make payments to participating PHCS that incur costs for services to the remaining uninsured. During each GPP PY, FFP will be available for such GPP payment expenditures up to the amount equal to the state's entire DSH allotment as set forth in section 1923(f) of the Act, adjusted as described in subparagraphs of this STC b and c below ("Adjusted DSH"), combined with the additional Demonstration UC funding amounts as set forth in subparagraph d below. For the purposes of GPP PY 6, only the Adjusted DSH shall be reduced by 50 percent. In order to align federal fiscal year DSH allotment amounts with the conversion to calendar year GPP PYs, GPP PYs 7 through 12 will be funded 50 percent of the Adjusted DSH for the FFY beginning prior to the first GPP PY, and 50 percent of the Adjusted DSH for the FFY beginning during the GPP PY.

b. A portion of California's DSH allotment shall be set aside for those California DSH facilities that do not participate in the GPP. The amount set aside shall be identified in Attachment Q DSH Coordination Methodology.

c. In any year to which reductions to California's DSH allotment are required by section 1923(f)(7) of the Social Security Act, the amount of the DSH allotment attributable to GPP in a given GPP PY shall be reduced consistent with CMS guidelines.

d. The total computable amount available for the UC component shall equal $472 million in GPP PY1. For GPP PYs two through five, the UC component was determined by CMS based upon the information contained in the Independent Report on Uncompensated Care. As approved by CMS on July 14, 2016, the total computable amounts available for the UC component shall equal $472 million for each of GPP PYs two through five. For GPP PY 6 the total computable amount available for the UC component shall equal $236 million. For GPP PY 7 through 12, the total computable amount available for the UC component shall equal $472 million annually.

e. Taken together, the total computable annual limits for GPP payments will not exceed the limits set forth below:

GPP PY 1 (SFY 15-16) – Adjusted DSH + $472 million = approximately $2.9 billion
GPP PY 2 (SFY 16-17) – Adjusted DSH + $472 million = approximately $2.9 billion
GPP PY 3 (SFY 17-18) – Adjusted DSH + $472 million = approximately $2.9 billion
GPP PY 4 (SFY 18-19) – Adjusted DSH + $472 million = approximately $2.9 billion
GPP PY 5 (SFY 19-20) – Adjusted DSH + $472 million = approximately $2.9 billion

GPP PY 6 (July 1, 2020 – December 31, 2020) – Adjusted DSH at 50% + $236 million = approximately $1.45 billion
GPP PY 7 (CY 2021)- Adjusted DSH + $472 million= approximately $2.9 billion
GPP PY 8 (CY 2022) – Adjusted DSH + $472 million = approximately $2.9 billion
GPP PY 9 (CY 2023) – Adjusted DSH + $472 million = approximately $2.9 billion
GPP PY 10 (CY 2024) – Adjusted DSH + $472 million = approximately $2.9 billion
GPP PY 11 (CY 2025) – Adjusted DSH + $472 million = approximately $2.9 billion
GPP PY 12 (CY 2026) – Adjusted DSH + $472 million = approximately $2.9 billion

f. The non-federal share of payments under the GPP shall be funded by voluntary intergovernmental transfers made by PHCS, or governmental agencies affiliated with PHCS. The funding entity shall certify that the funds transferred qualify for federal financial participation pursuant to 42 CFR part 433 subpart B, and are not derived from impermissible sources such as recycled Medicaid payments, federal money excluded from use as state match, impermissible taxes, and non- bona fide provider-related donations. The State must have permissible sources for the non-federal share of GPP expenditures, which may include permissible IGTs from government-operated entities and state funds. Sources of non-federal funding shall not include provider taxes or donations impermissible under section 1903(w), impermissible intergovernmental transfers from providers, or federal funds received from federal programs other than Medicaid or Medicare (unless expressly authorized by federal statute to be used for claiming purposes, and the federal Medicaid funding is credited to the other federal funding source). For this purpose, federal funds do not include GPP payments, PATH payments, or patient care revenue received as payment for services rendered under programs such as Medicare or Medicaid.

g. The state will ensure that any lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of Medicaid services available under the state plan or this demonstration. The preceding sentence is not intended to preclude the state from modifying the Medicaid benefit through the state plan amendment process.

15.11. **Categories.** Each service will be assigned into a category by the state that best reflects its characteristics of intensity and area delivered. These categories will assist in determining the point values of individual services. The categories listed below are intended to provide a broad overview of the categories and services. In addition to the categories below, the state will create a new category to include those services intended to address health equity; this new category will be in effect beginning in PY9. The full description of categories are included in Attachment M and shall be updated to reflect any additional services intended to address health equity.

a. **Category 1:** Traditional Outpatient – This category includes traditional outpatient services provided by a public hospital system facility:

i. Non-physician practitioner;

ii. Traditional, provider-based primary care or specialty care visit;

iii. Mental health visit;

iv. Dental;

v. Public health visit;

vi. Post-hospital discharge;

vii. Emergency room/Urgent Care; and

viii. Outpatient procedures/surgery, provider performed diagnostic procedures.

b. **Category 2:** Non-Traditional Outpatient – This category includes non-traditional outpatient encounters, where care is provided by non-traditional providers or in non-traditional settings

i. Community health worker encounters;

ii. Health coach encounters;

iii. Care navigation; and

iv. Health education & community wellness encounters.

c. **Category 3:** Technology-Based Outpatient – This category includes technology- based outpatient encounters that rely mainly on technology to provide care:

i. Call line encounters;

ii. Texting;

iii. Telephone and email consultations between provider and patient;

iv. Provider-to-provider eConsults for specialty care; and

v. Telemedicine;

d. **Category 4:** Inpatient and Facility Stays – This category includes traditional inpatient and facility stays by patients:

i. Recuperative/respite care days;

ii. Sober center days;

iii. Sub-acute care days; and

iv. Skilled nursing facility days;

15.12. **Service Threshold.** The threshold amounts for each PHCS will initially be constructed using the volume and cost of services occurring in participating providers, and will use the most recent complete state fiscal year data (Base SFY). Point values for each service will be consistent across all providers. The threshold amounts shall be determined in accordance with the methodology set forth in Attachment K (GPP Funding and Mechanics Protocol), which takes into account the following requirements and factors:

a. Historic point values for each service category on a per unit of service basis across all Public Health Care Systems, taking into account at a minimum, the varying methods for identifying units and categories of services, cost per unit, cost trends and service mix;

b. Base SFY utilization for each Public Health Care System; and

c. Adjustments to account for changes in uninsured service needs since Base SFY, including the coverage expansions resulting from ACA implementation; and,

d. Adjustments to account for public health emergencies or other state of emergency situations that impact the delivery of GPP services by a Public Health Care System.

e. This threshold will require approval by CMS before it can be finalized.

f. Thresholds for GPP PY2-PY12 will decline in proportion to reductions in annual limits.

15.13. **Coordination with DSH**

a. To maintain budget neutrality, the state will not make state plan-based DSH payments and uncompensated care payments to hospitals participating in the GPP.

b. Hospitals that meet DSH eligibility criteria and which are not participating within a PHCS may receive DSH payments under the applicable provisions of Attachment 4.19-A of the state plan, as modified pursuant to Attachment Q (DSH Coordination Methodology).

15.14. **Discontinuation of GPP**

DHCS may, in consultation with the participating PHCS, discontinue the GPP in any subsequent state fiscal year(s) for the remainder of the Demonstration and revert to financing uncompensated care costs for Medicaid and uninsured patients under the DSH program pursuant to the state plan. DHCS shall notify CMS no later than 30 calendar days prior to the start of the initial state fiscal year for which the GPP will be discontinued. DHCS will follow the appropriate processes as is necessary to facilitate DSH payments to affected PHCS under the State plan.

15.15. **DSH Payments and FFY**

The state is not authorized to make a DSH payment under the Medicaid state plan for any hospital for any federal fiscal year (FFY) in which that hospital is eligible for a GPP payment for a GPP PY or portion thereof that is within that FFY. A DSH payment is considered to be made for a FFY if the payment would count against the DSH allotment for that FFY. In the event that the GPP is not authorized for a full PY, the state is prohibited from making duplicate GPP and DSH payments to GPP-eligible hospitals and must submit, subject to CMS approval, a method for allocating GPP and DSH payments to avoid duplication during the affected period.

16. GENERAL REPORTING REQUIREMENTS

16.1. **Deferral for Failure to Submit Timely Demonstration Deliverables.** CMS may issue deferrals in accordance with 42 CFR part 430 subpart C, in the amount of $5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs) (hereafter singly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or are found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the current demonstration period. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

The following process will be used: 1) thirty (30) days after the deliverable was due if the state has not submitted a written request to CMS for approval of an extension as described in subsection (b) below; or 2) thirty days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements:

a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverable(s).

b. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay and the state's anticipated date of submission. Should CMS agree to the state's request, a corresponding extension of the deferral process can be provided. CMS may agree to a corrective action plan submitted by the state as an interim step before applying the deferral, if the state proposes a corrective action plan in the state's written extension request.

c. If CMS agrees to an interim corrective plan in accordance with subsection (b), and the state fails to comply with the corrective action plan or, despite the corrective action plan, still fails to submit the overdue deliverable(s) with all required contents in satisfaction of the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.

d. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement with respect to required deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the requirements specified in these STCs, the deferral(s) will be released.

As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

16.2. **Submission of Post-approval Deliverables.** The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs, unless CMS and the state mutually agree to another timeline.

16.3. **Compliance with Federal Systems Updates.** As federal systems continue to evolve and incorporate additional 1115 demonstration reporting and analytics functions, the state will work with CMS to:

a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;

b. Ensure all 1115, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and

c. Submit deliverables to the appropriate system as directed by CMS.

16.4. **Monitoring Protocol.** The state must submit to CMS a Monitoring Protocol no later than 150 calendar days after the approval of the demonstration. The state must submit a revised Monitoring Protocol within 60 calendar days after receipt of CMS's comments. Once approved, the Monitoring Protocol will be incorporated in the STCs as Attachment DD. In addition, the state must submit an updated or a separate Monitoring Protocol for any amendments to the demonstration no later than 150 calendar days after the approval of the amendment. Such amendment Monitoring Protocols are subject to the same requirement of revisions and CMS approval, as described above.

At a minimum, the Monitoring Protocol must affirm the state's commitment to conduct Quarterly and Annual Monitoring Reports in accordance with CMS's guidance and technical assistance and using CMS-provided reporting templates, as applicable and relevant for different policies. Any proposed deviations from CMS's guidance should be documented in the Monitoring Protocol. The Monitoring Protocol must describe the quantitative and qualitative elements on which the state will report through Quarterly and Annual Monitoring Reports. For the overall demonstration as well as specific policies where CMS provides states with a suite of quantitative monitoring metrics (e.g., those described under the performance metrics section in STC 16.5), the state is required to calculate and report such metrics leveraging the technical specifications provided by CMS. The Monitoring Protocol must specify the methods of data collection and timeframes for reporting on the demonstration's progress as part of the Quarterly and Annual Monitoring Reports. In alignment with CMS guidance, the Monitoring Protocol must additionally specify the state's plans and timeline on reporting metrics data stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography) and demonstration component.

For the HRSN and reentry services, authorized through this demonstration, the Monitoring Protocol requires specifying a selection of quality of care and health outcomes metrics and population stratifications based on CMS's upcoming guidance on the Health Equity Measure Slate, and outlining the corresponding data sources and reporting timelines, as applicable to the demonstration initiatives and populations. If needed, the state may submit an amendment to the

Monitoring Protocol within 150 days after the receipt of the final Health Equity Measure Slate from CMS. This slate of measures represents a critical set of equity-focused metrics known to be important for closing key equity gaps in Medicaid/CHIP (e.g. the National Quality Forum (NQF) "disparities-sensitive" measures) and prioritizes key outcome measures and their clinical and non-clinical (i.e. social) drivers. The Monitoring Protocol must also outline the state's planned approaches and parameters to track implementation progress and performance relative to the goals and milestones including relevant transitional, non-service expenditures investments, as captured in these STCs, or other applicable implementation and operations protocols.

The state will also be expected to set up its HRSN service delivery system to allow screening of beneficiaries for identified needs, and develop appropriate closed-loop referral system or other feedback loop to ensure beneficiaries receive service referrals and provisions, and provide any applicable update on this process via the Monitoring Reports, in alignment with information provided in the HRSN Community Supports Protocol (STC 8.10(d)).

In addition, the state must describe in the Monitoring Protocol methods and timeline to collect and analyze non-Medicaid administrative data to help calculate applicable monitoring metrics. These sources may include, but are not limited to (1) community resource referral platforms, (2) records of social services receipt from other agencies (such as SNAP or TANF benefits, or HUD assistance), (3) other data from social services organizations linked to beneficiaries (such as, services rendered, resolution of identified need, etc., as applicable), (4) social needs screening results from electronic health records, health plans, or other partner agencies, and (5) data related to carceral status Medicaid eligibility, and the health care needs of individuals who are incarcerated and returning to the community. Across data sources, the state must make efforts and consult with relevant non-Medicaid social service agencies to collect data in ways that support analyses of data on beneficiary subgroups.

To the extent applicable, the state's selection and reporting of monitoring metrics for the HRSN services is expected to align with the monitoring required by the state's 1915(b)(1)/(4) Waiver for California Advancing & Innovating Medi-Cal (CalAIM) special terms and conditions for other similar services.

In addition, the state must describe in the Monitoring Protocol methods and a timeline for collecting and analyzing non-Medicaid administrative data necessary to conduct comprehensive monitoring and evaluation of traditional health care practices. These sources may include but are not limited to data related to traditional health care practices provided by IHS, Tribal, or UIO facilities. Across data sources, in consultation with IHS, Tribal, and UIO facilities, the state must make efforts to collect data in ways that support subgroup analyses as appropriate.

For the qualitative elements (e.g., operational updates as described in STC 16.5 below), CMS will provide the state with guidance on narrative and descriptive information, which will supplement the quantitative metrics on key aspects of the demonstration policies. The quantitative and qualitative elements will comprise the state's Quarterly and Annual Monitoring Reports.

16.5. **Monitoring Reports.** The state must submit three (3) Quarterly Monitoring Reports and one (1) Annual Monitoring Report each DY. The fourth quarter information that would ordinarily be provided in a separate report should be reported as distinct information within the Annual Monitoring Report. The Quarterly Monitoring Reports are due no later than sixty (60) calendar days following the end of each demonstration quarter. The Annual Monitoring Report is due no later than ninety (90) calendar days following the end of the DY. The state must submit a revised Monitoring Report within sixty (60) calendar days after receipt of CMS's comments, if any. The reports will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Monitoring Reports must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve, and be provided in a structured manner that supports federal tracking and analysis.

a. Operational Updates. Per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports shall provide sufficient information to document key challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. The Monitoring Report should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

b. Performance Metrics. The demonstration's monitoring activities through quantitative data and narrative information must support tracking the state's progress toward meeting the applicable program-specific goals and milestones—including relative to their projected timelines—of the demonstration's program and policy implementation and infrastructure investments and transitional non-service expenditures, as applicable. Specifically, the state must undertake standardized reporting on categories of metrics including, but not limited to: beneficiary participation in demonstration components, number of primary and specialist provider participation, utilization of services, quality of care, and health outcomes. The reporting of metrics focused on quality of care and health outcomes must be aligned with the demonstration's policies and objectives, as applicable for all key demonstration initiatives and populations. Such reporting must also be stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography), and by demonstration components, to the extent feasible. Subpopulation reporting will support identifying any existing shortcomings or disparities in quality of care and health outcomes and help track whether the demonstration's initiatives help improve outcomes for the state's Medicaid population, including the narrowing of any identified disparities. To that end, CMS underscores the importance of reporting metrics data on quality of care and health outcomes that are known to be important for closing key equity gaps in Medicaid and CHIP (e.g. the National Quality Forum (NQF) "disparities sensitive" measures) and prioritizing key outcome measures and their clinical and non-clinical (i.e. social) drivers of health. In

coordination with CMS, the state is expected to select such measures for reporting in alignment with a critical set of equity-focused measures CMS is finalizing as part of its upcoming guidance on the Health Equity Measure Slate, as applicable to the demonstration initiatives and populations. If needed, the State may submit an amendment to its monitoring plan no more than 150 days after receiving the final Health Equity Measure Slate from CMS to incorporate these measures.

Additionally, per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as outcomes of care, quality and cost of care, and access to care. This may also include the results of beneficiary satisfaction surveys, if conducted, and grievances and appeals. For the traditional health care practices demonstration component, Monitoring Reports must also include beneficiary grievances, complaints, and appeals related to the attestation described in STC 13.1.

For the approved HRSN initiatives, i.e., short-term post-transition services and short-term recuperative care, in addition to reporting on the metrics described above, the state may align with monitoring required in the state's 1915(b)(1)/(4) Waiver for California Advancing & Innovating Medi-Cal (CalAIM) special terms and conditions for other similar services, as may be applicable. The state must track beneficiary participation in applicable services over time, as well as narratively report annually on the adoption of information technology infrastructure to support data sharing between the state or partner entities assisting in the administration of the demonstration and contracted providers of applicable services (e.g., managed care plan and their contracted HRSN providers). Furthermore, the state's enrollment and renewal metrics must also capture baseline data and track progress via Monitoring Reports for the percent of Medicaid renewals completed ex-parte (administratively), as well as the percentage of Medicaid beneficiaries enrolled in other public benefit programs (such as, Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)) for which they are eligible.

The state's selection and reporting of quality of care and health outcomes metrics outlined above must also accommodate the newly approved reentry demonstration initiative. In addition, the state is required to report on metrics aligned with tracking progress with implementation and toward meeting the milestones of the reentry demonstration initiative. CMS expects such metrics to include, but not be limited to: administration of screenings to identify individuals who qualify for pre-release services, utilization of applicable pre-release and post-release services (e.g., case management, MAT, clinical/behavioral health assessment pre-release and primary and behavioral health services post-release), provision of health or social service referral pre-release, participants who received case management pre-release and were enrolled in case management post-release, and take-up of data system enhancements among participating carceral settings. In addition, the state is expected to monitor the number of beneficiaries served and types of services rendered under the demonstration Also, in alignment with the state's Reentry Initiative Implementation Plan, the state must also provide in its Monitoring Reports narrative details outlining its progress with

implementing the initiative, including any challenges encountered and plans for addressing them. This information must also capture the transitional, non-service expenditures, including enhancements in the data infrastructure and information technology.

For the amendment allowing counties to participate or continue participating in COHS and Single Plan managed care models, as applicable, the state must provide monitoring data for managed care plan performance – including related to member access to care – in alignment and as required by the CalAIM Section 1915(b) waiver's STCs. This report may include, but not limited to, information on primary care provider disruption for the time period applicable, changes in access to care, and appeals and grievances. The state must also provide in its Monitoring Reports narrative details outlining its progress with implementing the amendment, including any challenges encountered and plans for addressing them.

In addition, the state must demonstrate through its Annual Monitoring Reports to CMS improvements in Medicaid fee-for-service base provider payment rates and payment rates for providers enrolled in managed care to the extent required by the DSHP-related STCs. As applicable, the state must also track the number and characteristics of contracted or participating organizations, specifically under the demonstration's HRSN and reentry initiatives, and corresponding payment-related metrics.

The state's selection and reporting of metrics for traditional health care practices are expected to include, but not be limited to: the number of facilities and providers providing traditional health care practices under the demonstration, the number of each type of traditional health care practice provided under the demonstration, and the number of individuals receiving traditional health care practices under the demonstration.

The required monitoring and performance metrics must be included in the Monitoring Reports, and will follow the framework provided by CMS to support federal tracking and analysis.

c. Budget Neutrality and Financial Reporting Requirements. Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs for this demonstration should be reported separately on the CMS-64.

d. Evaluation Activities and Interim Findings. Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of

evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

16.6. **Corrective Action Plan Related to Demonstration Monitoring.** If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. This may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.11. CMS will withdraw an authority, as described in STC 3.11, when metrics indicate substantial, sustained directional change, inconsistent with state targets and goals, as applicable, and the state has not implemented corrective action. CMS would further have the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

16.7. **Close-Out Report.** Within one hundred twenty (120) calendar days after the expiration of the demonstration, the state must submit a draft Close-Out Report to CMS for comments.

a. The draft Close-Out Report must comply with the most current guidance from CMS.

b. In consultation with CMS, and per guidance from CMS, the state shall include an evaluation of the demonstration (or demonstration components) that are to phase out or expire without extension along with the Close-Out Report. Depending on the timeline of the phase-out during the demonstration approval period, in agreement with CMS, the evaluation requirement may be satisfied through the Interim and/or Summative Evaluation Reports stipulated in STCs 21.22 and 21.23, respectively.

c. The state must present to and participate in a discussion with CMS on the Close-Out report.

d. The state must take into consideration CMS's comments for incorporation into the final Close-Out report.

e. The revised Close-Out report is due to CMS no later than thirty (30) calendar days after receipt of CMS's comments.

f. A delay in submitting the draft or final version of the Close-Out report may subject the state to penalties described in STC 20.16.

16.8. **Monitoring Calls.** CMS will convene periodic conference calls with the state.

a. The purpose of these calls is to discuss ongoing demonstration operation, to include (but not limited to) any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, enrollment and access, budget neutrality, and progress on evaluation activities.

b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.

c. The state and CMS will jointly develop the agenda for the calls.

16.9. **Post Award Forum.** Pursuant to 42 CFR 431.420(c), within six (6) months of the demonstration's implementation, and annually thereafter, the state must afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least thirty (30) days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state must also post the most recent annual report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments in the Monitoring Report associated with the quarter in which the forum was held, as well as in its compiled Annual Monitoring Report.

17. EVALUATION OF THE DEMONSTRATION

17.1. **Cooperation with Federal Evaluators and Learning Collaborative.** As required under 42 CFR 431.420(f), the state shall cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they shall make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. This may also include the state's participation—including, as applicable and in consultation and collaboration with the state, representation from the state's independent evaluators, and organizations associated with the demonstration operations—in a federal learning collaborative aimed at cross-state technical assistance, and identification of lessons learned and best practices for demonstration measurement, data development, implementation, monitoring and evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 20.16.

17.2. **Independent Evaluator**. The state must use an independent party to 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. The independent party must sign an agreement to conduct the demonstration evaluation in an independent manner in accord with the CMS-approved draft Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

17.3. **Draft Evaluation Design.** The state must submit, for CMS comment and approval, a draft Evaluation Design no later than 180 calendar days after the approval of the demonstration. The Evaluation Design must be drafted in accordance with Attachment A (Developing the Evaluation Design) of these STCs and any applicable CMS evaluation guidance and technical assistance for the demonstration's policy components. The Evaluation Design must also be developed in alignment with CMS guidance on applying robust evaluation approaches, such as quasi-experimental methods like difference-in-differences and interrupted time series, as well as

establishing valid comparison groups and assuring causal inferences in demonstration evaluations. In addition to these requirements, if determined appropriate for the communities impacted by the demonstration, the state is encouraged to consider implementation approaches involving randomized control trials and staged rollout (for example, across geographic areas, by service setting, or by beneficiary characteristic) – as these implementation strategies help create strong comparison groups and facilitate robust evaluation.

The state is strongly encouraged to use the expertise of the independent party in the development of the draft Evaluation Design. The draft Evaluation Design also must include a timeline for key evaluation activities, including the deliverables outlined in STCs 21.22 and 21.23.

For any amendment to the demonstration, the state will be required to update the approved Evaluation Design to accommodate the amendment component. The amended Evaluation Design must be submitted to CMS for review no later than 180 calendar days after CMS's approval of the demonstration amendment. Depending on the scope and timing of the amendment, in consultation with CMS, the state may provide the details on necessary modifications to the approved Evaluation Design via the monitoring reports. The amendment Evaluation Design must also be reflected in the state's Interim (as applicable) and Summative Evaluation Reports, described below.

17.4. **Evaluation Design Approval and Updates.** The state must submit a revised draft Evaluation Design within sixty (60) calendar days after receipt of CMS's comments, if any. Upon CMS approval of the draft Evaluation Design, the document will be included as Attachment T to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within thirty (30) days of CMS approval. The state must implement the Evaluation Design and submit a description of its evaluation progress in each of the Quarterly and Annual Monitoring Reports. Once CMS approves the Evaluation Design, if the state wishes to make changes, the state must submit a revised Evaluation Design to CMS for approval if the changes are substantial in scope; otherwise, in consultation with CMS, the state may include updates to the Evaluation Design in monitoring reports.

17.5. **Evaluation Questions and Hypotheses.** Consistent with Attachments A and B (Developing the Evaluation Design and Preparing the Interim and Summative Evaluation Report) of these STCs, the Evaluation Design must include a discussion of the evaluation questions and hypotheses that the state intends to test. In alignment with applicable CMS evaluation guidance and technical assistance, the evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding the demonstration's impact and its effectiveness in achieving the goals.

The hypothesis testing should include, where possible, assessment of both process and outcome measures. The evaluation must analyze outcomes, such as enrollment and enrollment continuity, and measures of access, utilization, and health outcomes, as appropriate and in alignment with applicable CMS evaluation guidance and technical assistance, for the demonstration policy components. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP,

Consumer Assessment of Health Care Providers and Systems (CAHPS), the Core Set of Health Care Quality Measures for Medicaid-Eligible Adults, the Behavioral Risk Factor Surveillance System (BRFSS) survey, and/or measures endorsed by National Quality Forum (NQF).

Specifically, hypotheses for the DMC-ODS component of the demonstration must include an assessment of the core goals of the program, to include (but are not limited to): initiation and engagement with treatment, reduction in unnecessary and inappropriate utilization of emergency department and inpatient hospitalization through expanded utilization of DMC-ODS services, and reductions in key outcomes such as deaths due to overdose. In addition, the state will also evaluate the effectiveness of the Contingency Management benefits provided to qualifying DMC-ODS beneficiaries. Further, the state will evaluate its program goals to improve alignment and integration and to enhance beneficiary experience under the expenditure authority provided in the demonstration for dually eligible beneficiaries.

Similarly, in alignment with the overarching goals of PATH and DSHP authority to support various infrastructure, transitional non-service expenditures, and capacity building efforts and the overall implementation and operationalization of CalAIM in the state, the evaluation of these demonstration components—for example—will analyze hypotheses focused on items such as how PATH (including the DSHP funding), in conjunction with related CalAIM initiatives, promotes: access to community-based providers of ECM, reentry services, and HRSN services, specifically, the two Community Supports authorized through this demonstration, and improved access and utilization of health care services at the community-level, with particular attention to historically under-resourced or marginalized populations. The evaluation will be informed by progress reports to be submitted to DHCS by Qualified Applicants on the need for and use of PATH funding and achievement of defined milestones.

The demonstration's GPP evaluation must study hypotheses and research questions that help understand, for example, whether the program leads to improvements in care delivery in more appropriate settings and improvements in health equity via improvements in access, quality and experience of care, and health outcomes among the state's uninsured population.

Hypotheses for the HRSN initiatives, i.e., short-term post-transition services and short-term recuperative care, must focus on assessing how the initiatives affect utilization of preventive and routine care, utilization of and costs associated with potentially avoidable, high acuity health care, and beneficiary physical and behavioral health outcomes. In addition, the state must coordinate with its managed care plans to secure necessary data—for a representative beneficiary population eligible for the HRSN services—to conduct a robust evaluation of the effectiveness of the HRSN services in mitigating identified needs of beneficiaries. Such an assessment will require setting up a data infrastructure and/or data sharing arrangement to collect data on beneficiary screening and rescreening and prevalence and severity of beneficiaries' HRSNs, among others. If the data system is not operational to capture necessary data for a quantitative evaluation by the time the state's evaluation activities must be conducted, the state must provide applicable qualitative assessment to this effect leveraging suitable primary data collections efforts (e.g., beneficiary surveys). Given the populations of focus and the program designs of the HRSN initiatives, the state must also include research questions and hypotheses focused on understanding the impact of the HRSN initiatives on advancing health quality, including through the reduction of health disparities, for example, by assessing the

effects of the initiatives in reducing disparities in health care access, quality of care, or health outcomes at the individual and/or community level.

The state is required to examine whether and how state and local investments in housing and any other type of allowable HRSN services change over time in concert with new Medicaid funding toward those services. In addition, in light of how demonstration HRSN expenditures are being treated for purposes of budget neutrality, the evaluation of the HRSN initiatives must include, in alignment with the evaluation required in the state's 1915(b)(1)/(4) Waiver for California Advancing & Innovating Medi-Cal (CalAIM) special terms and conditions for other similar services, a cost analysis to support developing comprehensive and accurate cost estimates of covering such services. The state is also required to include a robust assessment of potential improvements in the efficiency, quality, and effectiveness of downstream services that can be provided under the state plan authority, and associated cost implications, related to the provision of upstream HRSN services.

Evaluation of the reentry demonstration initiative must be designed to examine whether the initiative expands Medicaid coverage through increased enrollment of eligible individuals, and efficient provision of high-quality pre-release services that promote continuity of care into the community post-release. In addition, in alignment with the goals of the reentry demonstration initiative in the state, the evaluation hypotheses must focus on, but not be limited to: cross-system communication and coordination, connections between carceral and community services, access to and quality of care in carceral and community settings, preventive and routine physical and behavioral health care utilization, non-emergent emergency department visits and inpatient hospitalizations.

The state must also provide a comprehensive analysis of services rendered by type of service over the duration of the 90-day coverage period immediately prior to the expected date of release—to the extent feasible, and discuss in the evaluation any relationship identified between the provision and timing of particular services with salient post-release outcomes, including utilization of acute care services for chronic and other serious conditions, overdose, and overdose- and suicide-related and all-cause deaths in the period soon after release. In addition, the state is expected to assess the extent to which this coverage timeline facilitated providing more coordinated, efficient and effective reentry planning, enabled pre-release management and stabilization of physical and behavioral health conditions, and helped mitigate any potential operational challenges the state might have otherwise encountered in a more compressed timeline for coverage or pre-release services.

The demonstration's evaluation efforts will be expected to include an examination of carceral provider qualifications and standards as well as the experiences of carceral and community providers, including challenges encountered, as they develop relationships and coordinate to facilitate transition of individuals into the community. Finally, similar to the state's HRSN initiative, the state must conduct a comprehensive cost analysis to support developing estimates of implementing the reentry demonstration initiative, including covering associated services.

Evaluation of the traditional health care practices demonstration initiative must be designed to examine whether the initiative increases access to culturally appropriate care for beneficiaries served by or through IHS, Tribal, or UIO facilities. In evaluating the effectiveness of the

initiative, the state must capture the perspectives of IHS, Tribal, and UIO facilities through qualitative data collection efforts. The state is also strongly encouraged to consult with IHS, Tribal, and UIO facilities, participating providers, and beneficiaries in the development of the evaluation design. The evaluation must address topics that include but are not limited to: beneficiary awareness and understanding of traditional health care practices; reasons for individuals receiving the traditional health care practices; access to, utilization and costs of traditional health care practices; quality and experience of care; and physical and behavioral health outcomes. The state's evaluation efforts must facilitate understanding the extent to which the traditional health care practices initiative might support reducing existing disparities in access to and quality of care and health outcomes.

In alignment with the CalAIM Section 1915(b) waiver reporting requirements, the state must examine the effects of the managed care amendment on beneficiaries, providers, and plans, particularly regarding achieving equitable beneficiary access to and quality of care.

The state must also investigate cost outcomes for the demonstration as a whole, including but not limited to: administrative costs of demonstration implementation and operation, Medicaid health service expenditures, and provider uncompensated care costs. As noted above, the state must also analyze the costs and the budgetary effects of the HRSN and reentry demonstration initiatives. In addition, the state must use findings from hypothesis tests aligned with other demonstration goals and cost analyses together to assess the demonstration's effects on the fiscal sustainability of the state's Medicaid program.

CMS underscores the importance of the state undertaking a well-designed beneficiary survey and/or interviews to assess, for instance, beneficiary understanding of and experience with the various demonstration policy components, including but not limited to the reentry demonstration initiative and the HRSN components, and beneficiary experience with access to and quality of care. In addition, the state is strongly encouraged to evaluate the implementation of the demonstration programs in order to better understand whether implementation of certain key demonstration policies happened as envisioned during the demonstration design process and whether specific factors acted as facilitators of or barriers to successful implementation. Implementation research questions can also focus on beneficiary and provider experience with the demonstration. The implementation evaluation can inform the state's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings.

Finally, the state must collect data to support analyses stratified by key subpopulations of interest (e.g., by sex, age, race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography). Such stratified data analyses will provide a fuller understanding of existing disparities in access to and quality of care and health outcomes, and help inform how the demonstration's various policies might support reducing such disparities.

17.6. **Evaluation Budget.** A budget for the evaluations must be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluations such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses

and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the designs are not sufficiently developed, or if the estimates appear to be excessive.

17.7. **Interim Evaluation Report.** The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for an extension of the demonstration, the Interim Evaluation Report should be posted to the state's website with the application for public comment.

a. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved Evaluation Design.

b. For demonstration authority or any components within the demonstration that expire prior to the overall demonstration's expiration date, and depending on the timeline of expiration / phase-out, the Interim Evaluation Report may include an evaluation of the authority, to be collaboratively determined by CMS and the state.

c. If the state is seeking to extend the demonstration, the draft Interim Evaluation Report is due when the application for extension is submitted, or one year prior to the end of the demonstration, whichever is sooner. If the state is not requesting an extension for a demonstration, an Interim Evaluation Report is due one year prior to the end of the demonstration.

d. The state must submit the revised Interim Evaluation Report sixty (60) calendar days after receiving CMS's comments on the draft Interim Evaluation Report, if any. Once approved by CMS, the state must post the final Interim Evaluation Report to the state's Medicaid website within thirty (30) calendar days.

e. The Interim Evaluation Report must comply with Attachment B of these STCs.

17.8. **Summative Evaluation Report.** The state must submit a draft Summative Evaluation Report for the demonstration's current approval period within eighteen (18) months of the end of the approval period represented by these STCs. The draft Summative Evaluation Report must be developed in accordance with Attachment B of these STCs, and in alignment with the approved Evaluation Design.

a. The state must submit a revised Summative Evaluation Report within sixty (60) calendar days of receiving comments from CMS on the draft

b. Once approved by CMS, the state must post the final Summative Report to the state's Medicaid website within thirty (30) calendar days.

17.9. **Corrective Action Plan Related to Evaluation.** If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of an extension process when associated with the state's Interim Evaluation Report, or as part of the review of the Summative Evaluation Report.

A corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.11. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

17.10. **State Presentations for CMS.** CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the Interim Evaluation, and/or the Summative Evaluation.

17.11. **Public Access.** The state shall post the final documents (e.g., Implementation Plan, Monitoring Protocol, Monitoring Reports, Mid-Point Assessment, Close Out Report, approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid website within thirty (30) calendar days of approval by CMS.

17.12. **Additional Publications and Presentations**. For a period of twelve (12) months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given thirty 30 calendar days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews.

18. GENERAL FINANCIAL REQUIREMENTS

18.1. **Allowable Expenditures**. This demonstration project is approved for expenditures applicable to services rendered during the demonstration approval period designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.

18.2. **Standard Medicaid Funding Process.** The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures for services provided under this demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within thirty (30) calendar days after the end of each quarter, the state shall submit form CMS-64 (Quarterly Medicaid Expenditure Report), showing Medicaid expenditures made in the quarter that just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with

federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

18.3. **State Certification of Funding Conditions.** As a condition of demonstration approval, the state certifies that the following conditions for non-federal share financing of demonstration expenditures have been met:

a. Total computable expenditures for patient care that are either directly payable under this Demonstration, or the basis for DSH, may be certified by government entities that directly operate health care providers as long as the expenditures are not funded using impermissible provider taxes or donations as defined under section 1903(w) of the Social Security Act or using Federal funds other than Medicaid or Medicare funds (unless the other Federal funding source by law allows use of federal funds for matching purposes, and the federal Medicaid funding is credited to the other federal funding source). To the extent that the funding source for expenditures is a state program funded through this Demonstration, expenditures may be certified only as a total computable expenditure under such program. The State may not claim federal matching funds for a payment to a provider and also claim federal matching funds on the underlying expenditure certified by the provider, except to the extent that the State has an auditable methodology to prevent duplicate claims (such as one that limits claims for federal matching based on the certified expenditure to the shortfall after accounting for the claimed payment). For this purpose, Federal funds do not include GPP payments, PATH payments, or patient care revenue received as payment for services rendered under programs such as Medicare or Medicaid.

b. The state certifies that state and local monies are used as the source of non-federal share for the demonstration expenditures. The state further certifies that such funds shall not be used as matching funds for any other federal grant or contract, except as permitted by federal law or these STCs. All sources of the non-federal share of funding must be compliant with section 1903(w) of the Act and any applicable regulations and are not derived from impermissible provider taxes or donations or federal funds (unless the other federal funding source by law allows use of federal funds for purposes of obtaining additional federal matching funds under Medicaid). For this purpose, federal funds do not include GPP payments, PATH payments, or patient care revenue received as payment for services rendered under programs such as Medicare and Medicaid. Further, these sources and distribution of monies involving federal match are subject to CMS approval. Upon review of the sources of the non-federal share of funding and distribution methodologies, any sources determined to be impermissible by CMS shall be addressed within the time frames set by CMS. For non-federal share funding using intergovernmental transfers, the funding entity shall certify that the funds transferred qualify for federal financial participation pursuant to 42 CFR part 433 Subpart B, and are not derived from impermissible sources such as recycled Medicaid payments, federal money not permitted by law to be used as state share, impermissible taxes, and non-bona fide provider-related donations.

c. Under all circumstances, health care providers must retain 100 percent of their payments received under this demonstration. Moreover, no pre-arranged agreements

(contractual, voluntary, or otherwise) may exist between health care providers and state and/or local governments, or third parties to return and/or redirect to the state any portion of these demonstration payments in a manner inconsistent with the requirements in section 1903(w) of the Act and its implementing regulations. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

d. The State Medicaid Director or his/her designee certifies that all state and/or local funds used as the state's share of the allowable expenditures reported on the CMS-64 for this demonstration were in accordance with all applicable federal requirements and does not duplicate other sources of federal funds.

18.4. **Financial Integrity for Managed Care Delivery Systems.** As a condition of demonstration approval, the state attests to the following, as applicable:

a. All risk-based managed care organization, prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) payments, comply with all applicable requirements for payments, including those in 42 CFR 438.6(b)(2), 438.6(c), 438.6(d), 438.60, and 438.74.

18.5. **Requirements for Health Care-Related Taxes and Provider Donations.** As a condition of demonstration approval, the state attests to the following, as applicable:

a. Except as provided in paragraph (c) of this STC, all health care-related taxes as defined by Section 1903(w)(3)(A) of the Act and 42 CFR 433.55 are broad-based as defined by Section 1903(w)(3)(B) of the Act and 42 CFR 433.68(c).

b. Except as provided in paragraph (c) of this STC, all health care-related taxes are uniform as defined by Section 1903(w)(3)(C) of the Act and 42 CFR 433.68(d).

c. If the health care-related tax is either not broad-based or not uniform, the state has applied for and received a waiver of the broad-based and/or uniformity requirements as specified by 1903(w)(3)(E)(i) of the Act and 42 CFR 433.72.

d. The tax does not contain a hold harmless arrangement as described by Section 1903(w)(4) of the Act and 42 CFR 433.68(f).

e. All provider-related donations as defined by 42 CFR 433.52 are bona fide as defined by Section 1903(w)(2)(B) of the Social Security Act, 42 CFR 433.66, and 42 CFR 433.54.

18.6. **State Monitoring of Non-Federal Share.** If any payments under the demonstration are funded in whole or in part by a locality tax, then the state must provide a report to CMS regarding payments under the demonstration no later than 60 days after the effective date of

the demonstration amendment that added this STC. This deliverable is subject to the deferral as described in STC 14.1. This report must include:

a. A detailed description of and a copy of (as applicable) any agreement, written or otherwise agreed upon, regarding any arrangement among the providers including those with counties, the state, or other entities relating to each locality tax or payments received that are funded by the locality tax;

b. Number of providers in each locality of the taxing entities for each locality tax;

c. Whether or not all providers in the locality will be paying the assessment for each locality tax;

d. The assessment rate that the providers will be paying for each locality tax;

e. Whether any providers that pay the assessment will not be receiving payments funded by the assessment;

f. Number of providers that receive at least the total assessment back in the form of Medicaid payments for each locality tax;

g. The monitoring plan for the taxing arrangement to ensure that the tax complies with section 1903(w)(4) of the Act and 42 CFR 433.68(f); and

h. Information on whether the state will be reporting the assessment on the CMS form 64.11A as required under section 1903(w) of the Act.

18.7. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the demonstration as a whole for the following, subject to the budget neutrality expenditure limits described in Section XII:

a. Administrative costs, including those associated with the administration of the demonstration;

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and

c. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third-party liability.

18.8. **Program Integrity.** The state must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

18.9. **Medicaid Expenditure Groups (MEG).** MEGs are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart table below provides a master list of MEGs defined for this demonstration.

Table 4: Master MEG Chart					
MEG	**To Which BN Test Does This Apply?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
CBAS	Hypo	X		X	An outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, care coordination, and transportation to eligible State Plan beneficiaries.
OOS FFCY	Hypo	X		X	Expenditures for extending eligibility for full Medicaid State Plan benefits to former foster care youth who are under age 26, were in foster care under the responsibility of another state or tribe in such state on the date of attaining 18 years of age or such higher age as the state has elected, and were enrolled in Medicaid on that date
DMC-ODS: IMD	Hypo	X		X	Expenditures for otherwise covered Medicaid services furnished to qualified beneficiaries who are primarily receiving treatment and withdrawal management services for substance use disorder as short-term residents in facilities that meet the definition of an IMD.

Table 4: Master MEG Chart					
MEG	**To Which BN Test Does This Apply?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
IHS Chiropractic Services	Hypo	X		X	Supplemental payments to support participating IHS and tribal facilities that incur costs associated with chiropractic services for which Medi-Cal coverage was eliminated hat are furnished by these providers to individuals enrolled in the Medi-Cal program.
HRSN Services	Capped Hypo		X	X	Short-term Recuperative Care and Short-Term Post Transition Housing
PATH Supports	Non-Hypo			X	Ensuring Access to Services During Transition and Delivery System Transformation and Innovation PATH program
IP UPL PH	Non-Hypo		X		Inpatient Upper Payment Limit for Public Hospitals
GPP	Non-Hypo			X	DSH & SNCP (Safety Net Care Pool)
Contingency Management	Non-Hypo			X	Expenditures for evidence-based, cost-effective treatment for substance use disorder that combines motivational incentives with behavioral health treatments.
Asset Test	Hypo	X		X	Expenditures to extend eligibility for individuals in the following Deemed SSI populations who are eligible based on (1) applying a targeted asset disregard of $130,000 for a single individual and an additional $65,000 per household member

Table 4: Master MEG Chart					
MEG	**To Which BN Test Does This Apply?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
Reentry Demonstration Initiative	Hypo	X		X	Expenditures for targeted services that are otherwise covered under Medicaid provided to qualifying beneficiaries for up to 90 days immediately prior to the expected date of release from participating state prisons, county jails, or youth correctional facilities.
PATH - Reentry Demonstration Initiative Transitional Non-Service Expenditures	Hypo		X	X	Expenditures to for planning and supporting the reentry demonstration initiative including for technology and IT services, hiring and training of staff, purchasing of necessary technology and electronic health records and billing systems, developing protocols and procedures, and other expenditures to provide support for pre-release services.
DSHP	Non-Hypo			X	Expenditures for costs of designated programs which are otherwise state-funded
ADM	N/A				All additional administrative costs that are directly attributable to the demonstration and not described elsewhere and are not subject to budget neutrality.

18.10. **Reporting Expenditures and Member Months**. The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-00193/9). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the

two-digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.

a. **Cost Settlements.** The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b, in lieu of lines 9 or 10c. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.

b. **Premiums and Cost Sharing Collected by the State.** The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by DY on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures incurred in the demonstration year for determination of the state's compliance with the budget neutrality limits.

c. **Pharmacy Rebates.** Because pharmacy rebates are not included in the base expenditures used to determine the budget neutrality expenditure limit, pharmacy rebates are not included for calculating net expenditures subject to budget neutrality. The state will report pharmacy rebates on form CMS-64.9 BASE, and not allocate them to any form 64.9 WAIVER or 64.9P WAIVER.

d. **Administrative Costs.** The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the Master MEG Chart table, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.

e. **Member Months**. As part of the Quarterly and Annual Monitoring Reports described in Section IX, the state must report the actual number of "eligible member months" for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. The term "eligible member months" refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months, each contribute two eligible member months, for a total of four eligible

member months. Appropriate exceptions, as applicable, must be documented in the state's Budget Neutrality Specifications Manual referenced in STC 18.11(f) (e) The state must submit a statement accompanying the annual report certifying the accuracy of this information.

f. **Budget Neutrality Specifications Manual**. The state will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual expenditures related to budget neutrality, including methods used to extract and compile data from the state's Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

Table 5: MEG Detail for Expenditure and Member Month Reporting

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
CBAS		See STC 18.9	Follow CMS-64.9 Category of Service Definition	Date of Service	MAP	Y	1/1/2022	12/31/2026
OOS FFCY		See STC 18.9	Follow CMS-64.9 Category of Service Definition	Date of Service	MAP	Y	1/1/2022	12/31/2026
DMC-ODS: IMD		See STC 18.9	Follow CMS-64.9 Category of Service Definition	Date of Service	MAP	Y	1/1/2022	12/31/2026

Table 5: MEG Detail for Expenditure and Member Month Reporting								
MEG (Waiver Name)	**Detailed Description**	**Exclusions**	**CMS-64.9 Line(s) To Use**	**How Expend. Are Assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
IHS Chiropractic Services		See STC 18.916.6	Follow CMS-64.9 Category of Service Definition	Date of Service	MAP	Y	1/1/2022	12/31/2026
HRSN Services		See STC 18.9	Follow CMS-64.9 Category of Service Definition	Date of Service/ Date of payment	MAP	Y	1/1/2022	12/31/2026
PATH Supports		See STC 18.9	Follow CMS-64.10 or CMS-64.9 Category of Service Definition	Date of Service	ADM/ MAP	N	1/1/2022	12/31/2026
IP UPL PH		See STC 18.9	NA	Date of Service	MAP	N	1/1/2022	12/31/2026
GPP		See STC 18.9	Follow CMS-64.9 Category of Service Definition	Date of Service	MAP	N	1/1/2022	12/31/2026
Contingency Management		See STC 18.9	Follow CMS-64.9 Category of Service Definition	Date of Service	MAP	N	7/1/2022	12/31/2026

Table 5: MEG Detail for Expenditure and Member Month Reporting								
MEG (Waiver Name)	**Detailed Description**	**Exclusions**	**CMS-64.9 Line(s) To Use**	**How Expend. Are Assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
Asset Test		See STC 18.9	Follow CMS-64.9 Category of Service Definition	Date of Service	MAP	Y	7/1/2022	12/31/2026
Reentry Demonstration Initiative			Follow CMS-64.9 Category of Service Definition	Date of Services	MAP	Y	4/1/2024	12/31/2026
DSHP			Follow CMS-64.10 Category of Service Definition	Date of Payment	ADM	N	1/26/2023	12/31/2026
PATH – Reentry Demonstration Initiative Transitional Non-Service Expenditures			Follow CMS-64.10 Category of Service Definition	Date of Payment	ADM	N	1/26/2023	12/31/2026
ADM	Report all additional administrative costs that are directly attributable to the demonstration and are not described		Follow CMS-64.10 Category of Service Definition	Date of Payment	ADM	N	1/1/2022	12/31/2026

Table 5: MEG Detail for Expenditure and Member Month Reporting								
MEG (Waiver Name)	**Detailed Description**	**Exclusions**	**CMS-64.9 Line(s) To Use**	**How Expend. Are Assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
	elsewhere and are not subject to budget neutrality.							

g. **Demonstration Years**. Demonstration Years (DY) for this demonstration are defined in the table below.

Table 6: Demonstration Years		
Demonstration Year 18	January 1, 2022 to December 31, 2022	12 months
Demonstration Year 19	January 1, 2023 to December 31, 2023	12 months
Demonstration Year 20	January 1, 2024 to December 31, 2024	12 months
Demonstration Year 21	January 1, 2025 to December 31, 2025	12 months
Demonstration Year 22	January 1, 2026 to December 31, 2026	12 months

h. **Budget Neutrality Monitoring Tool.** The state must provide CMS with quarterly budget neutrality status updates, including established baseline and member months data, using the Budget Neutrality Monitoring Tool provided through the Performance Metrics Database and Analytics (PMDA) system. The tool incorporates the "Schedule C Report" for comparing demonstration's actual expenditures to the budget neutrality expenditure limits described in Section XIV. CMS will provide technical assistance, upon request.

i. **Claiming Period**. The state will report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state will continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

j. **Future Adjustment to Budget Neutrality**. CMS reserves the right to adjust the budget neutrality expenditure limit:

i. To be consistent with enforcement of laws and policy statements, including regulations and letters, regarding impermissible provider payments, health care related taxes, or other payments, CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

ii. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law, whichever is earlier

iii. The state certifies that the data it provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulations, and policies, and that the data are correct to the best of the state's knowledge and belief. The data supplied by the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

18.11. **Budget Neutrality Mid-Course Correction Adjustment Request.** No more than once per demonstration year, the state may request that CMS make an adjustment to its budget neutrality agreement based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

a. **Contents of Request and Process**. In its request, the state must provide a description of the expenditure changes that led to the request, together with applicable expenditure data demonstrating that due to these expenditures, the state's actual costs have exceeded the budget neutrality cost limits established at demonstration approval. The state must also submit the budget neutrality update described in STC 18.11c. If approved, an adjustment could be applied retrospectively to when the state began incurring the relevant expenditures, if appropriate. Within 120 days of acknowledging receipt of the request, CMS will determine whether the state needs to submit an amendment pursuant to STC 3.8. CMS will evaluate each request based on its merit and will approve requests when the state establishes that an adjustment to its

budget neutrality agreement is necessary due to changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside of the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

b. **Types of Allowable Changes.** Adjustments will be made only for actual costs as reported in expenditure data. CMS will not approve mid-demonstration adjustments for anticipated factors not yet reflected in such expenditure data. Examples of the types of mid-course adjustments that CMS might approve include the following:

   i. Provider rate increases that are anticipated to further strengthen access to care;

   ii. CMS or State technical errors in the original budget neutrality formulation applied retrospectively, including, but not limited to the following: mathematical errors, such as not aging data correctly; or unintended omission of certain applicable costs of services for individual MEGs;

   iii. Changes in federal statute or regulations, not directly associated with Medicaid, which impact expenditures;

   iv. State legislated or regulatory change to Medicaid that significantly affects the costs of medical assistance;

   v. When not already accounted for under Emergency Medicaid 1115 demonstrations, cost impacts from public health emergencies;

   vi. High cost innovative medical treatments that states are required to cover; or,

   vii. Corrections to coverage/service estimates where there is no prior state experience (e.g., SUD) or small populations where expenditures may vary widely.

c. **Budget Neutrality Update.** The state must submit an updated budget neutrality analysis with its adjustment request, which includes the following elements:

   i. Projected without waiver and with waiver expenditures, estimated member months, and annual limits for each DY through the end of the approval period; and,

   ii. Description of the rationale for the mid-course correction, including an explanation of why the request is based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or is due to a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

18.12. **Supplemental Payments to IHS and 638 Facilities.** The state shall make supplemental payments to participating Indian Health Service (IHS) and tribal 638 facilities that incur costs associated with providing chiropractic services. Supplemental payments shall be computed based on the cost for chiropractic services that were eliminated from Medi-Cal coverage in July

2009 pursuant to state plan amendment 09-001, furnished by such facilities to individuals enrolled in the Medi-Cal program. Participating tribal facilities shall maintain policies for furnishing chiropractic services to non-IHS beneficiaries that are in place as of January 1, 2013. Payments shall be based on the approved methodology set forth in Attachment D. The annual limit for such supplemental payments shall be $1,550,000 total computable per year (DY 18-22).

18.13. **Accounting Procedure.** The State has submitted and CMS has approved accounting procedures for CalAIM to ensure oversight and monitoring of demonstration claiming and expenditures. These procedures are included as Attachment H. The State shall submit a modification to the "Accounting Procedures" within 90 days after the renewal approval to account for changes and expansions to the waiver as described within these STCs for the CalAIM Demonstration.

19. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

19.1. **Budget Neutrality Effective Date.** All STCs, waivers, and expenditure authorities relating to budget neutrality shall be effective beginning January 1, 2022. Notwithstanding this effective date, expenditures made for Uncompensated Care Pool payments under GPP during the temporary extension period of July 1, 2020 through December 31, 2021 are permitted.

19.2. **Limit on Title XIX Funding.** California will be subject to a limit on the amount of Federal title XIX funding that California may receive on selected Medicaid expenditures during the period of approval of the Demonstration. The selected Medicaid expenditures consist of the expenditures for the range of services included in the managed care contracts and used to develop the without waiver per member per month limits under the Demonstration. The limit will consist of three parts, and is determined by using a per capita cost method combined with an aggregate amount based on the aggregate annual diverted upper payment limit determined for designated public hospitals in California and disproportionate share hospital (DSH) allotments. Spending under the budget neutrality limit is authorized for all spending related to approved expenditure authorities. Budget neutrality expenditure targets are calculated on an annual basis with a cumulative budget neutrality expenditure limit for the length of the demonstration extension (January1, 2022 through December 31, 2026). Actual expenditures subject to the budget neutrality expenditure limit must be reported by California using the procedures described in the section for General Financial Requirements Under Title XIX. The data supplied by the state to CMS to calculate the annual limits is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the State's compliance with these annual limits will be done using the Schedule C report from the MBES/CBES system.

19.3. **Risk.** California will be at risk for the per capita cost for demonstration enrollees under this budget neutrality agreement, but not for the number of demonstration enrollees in each of the groups. By providing FFP for all demonstration enrollees, California will not be at risk for changing economic conditions which impact enrollment levels. However, by placing California at risk for the per capita costs for demonstration enrollees, CMS assures that the federal demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no demonstration.

19.4. **Calculation of the Budget Neutrality Limits and How They Are Applied.** To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver PMPM cost times the corresponding actual number of member months, and aggregate components, which project fixed total computable dollar expenditure amounts. The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.

19.5. **Main Budget Neutrality Test.** The Main Budget Neutrality Test allows the state to show that approval of the demonstration has not resulted in Medicaid costs to the federal government that are greater than what the federal government's Medicaid costs would likely have been absent the demonstration, and that federal Medicaid "savings" have been achieved sufficient to offset the additional projected federal costs resulting from expenditure authority. The table below identifies the MEGs that are used for the Main Budget Neutrality Test. MEGs designated as "WOW Only" or "Both" are components used to calculate the budget neutrality expenditure limit. MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against the budget neutrality expenditure limit. In addition, any expenditures in excess of the limit from Hypothetical Budget Neutrality Tests count as expenditures under the Main Budget Neutrality Test. However, excess expenditures from the Capped Hypothetical Budget Neutrality Test do not count as expenditures under the Main Budget Neutrality Test. The state is at risk for any amount over the capped hypothetical amount. The Composite Federal Share for this test is calculated based on all MEGs indicated as "Both." Accrued savings generated from this CalAIM demonstration shall be removed from CalAIM in the amount of $5,415,000,000and will be transferred to the BH-CONNECT demonstration.

Table 7: Main Budget Neutrality Test

MEG	PC or Agg.	WOW Only, WW Only, or BOTH	Trend Rate	DY 18	DY 19	DY 20	DY 21	DY 22
Contingency Management	Agg.	WW Only	N/A	$4,866,666	$29,200,000	$31,515,350	$31,515,350	$31,515,350
IP UPL PH	Agg.	WOW Only	N/A	$863,054,000	$863,054,000	$863,054,000	$863,054,000	$863,054,000
DSHP	N/A	WW Only	N/A	The state must have savings to offset these expenditures.				
GPP-DSH	N/A	Both	N/A	The state shall calculate annually in accordance with Attachment Q.				
GPP	N/A	WW Only	N/A	$472,000,000	$472,000,000	$472,000,000	$472,000,000	$472,000,000
PATH Supports	Agg.	WW Only	N/A	The state must have savings to offset these expenditures, except for certain PATH-Reentry Demonstration Initiative Transitional Non-Service Expenditures as shown in Table 8.				

19.6. **Hypothetical Budget Neutrality.** When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), or when a WOW spending baseline for certain WW expenditures is difficult to estimate due to variable and volatile cost data resulting in anomalous trend rates, CMS considers these expenditures to be "hypothetical," such that the expenditures are treated as if the state could have received FFP for them absent the demonstration. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the expenditures on those services. When evaluating budget neutrality, however, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures; that is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state's WW hypothetical spending exceeds the Hypothetical Budget Neutrality Test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending through savings elsewhere in the demonstration or to refund the FFP to CMS.

19.7. **Hypothetical Budget Neutrality Test 1:** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 1. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 1 are counted as WW expenditures under the Main Budget Neutrality Test. The following applies to hypothetical budget neutrality tests under this demonstration:

i. Actual expenditures for the CBAS benefit will be included in the expenditure limit for the demonstration project. The amount of actual expenditures to be included will be the actual cost of providing the CBAS services (whether provided through managed care or fee-for- service) to the SPD Medicaid-only population and to dual eligible.

ii. Actual expenditures for the DMC-ODS benefit will be included in the expenditure limit for the demonstration project. The amount of actual expenditures to be included will be the actual cost of providing the DMC- ODS benefit to the eligible population;

iii. Actual expenditures for the Deemed SSI asset limit increase and elimination will be included in the expenditure limit for the demonstration project. The amount of actual expenditures to be included will be actual cost of increasing and eliminating the asset limit for the Deemed SSI populations;

Table 8: Hypothetical Budget Neutrality Test 1								
Eligibility Group (EG)	**PC or Agg.**	**WOW Only, WW Only, or Both**	**Trend Rate**	**DY 18 PMPM**	**DY 19 PMPM**	**DY 20 PMPM**	**DY 21 PMPM**	**DY 22 PMPM**
CBAS	PC	Both	0 %	$6.90	$6.90	$6.90	$6.90	$6.90
OOS FFCY	PC	Both	5.2%	$371.88	$391.22	$411.56	$432.96	$455.47
DMC-ODS IMD	PC	Both	5.2%	$2,795.87	$2,941.26	$3,094.21	$3,255.11	$3,424.38
IHS Chiropractic Services	PC	Both	4.7%	$539.98	$565.36	$591.93	$619.75	$648.88
Asset Test	PC	Both	4.50%	$980.94	$1,025.08	$1,071.21	$1,119.41	$1,169.78
PATH - Reentry Demonstration Initiative	PC	Both	0%	0	0	$534.85	$604.38	$640.72
PATH- Reentry Demonstration Initiative Transitional Non-Service Expenditures	Agg.	Both	0%	0	$209,000,000	$201,000,000	$0	0

19.8. **Capped Hypothetical Budget Neutrality for Evidence-Based HRSN Initiatives.** When expenditure authority is provided for specified HRSN initiatives in the demonstration (in this approval, as specified in STC 8, CMS considers these expenditures to be "capped hypothetical" expenditures; that is, the expenditures are eligible to receive FFP up to a specific aggregate spending cap per demonstration year, based on the state's expected expenditures. States can also receive FFP for capacity-building, infrastructure, and operational costs for the HRSN initiatives; this FFP is limited by a sub-cap of the aggregate spending cap and is determined by CMS based on the amount the state expects to spend. Like all hypothetical expenditures, capped hypothetical expenditures do not need to be offset by savings, and cannot produce savings; however, unspent expenditure authority allocated for HRSN infrastructure in a given demonstration year can be applied to HRSN services in the same demonstration year. Any unspent HRSN services expenditure authority may not be used to fund HRSN infrastructure. To allow for capped hypothetical expenditures and to prevent them from resulting in savings that would apply to the rest of the demonstration, CMS currently applies a separate, independent Capped Hypothetical Budget Neutrality Test, which subjects capped hypothetical expenditures to pre-determined aggregate limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If actual HRSN initiative spending is less than the Capped

Hypothetical Budget Neutrality Test's expenditure limit for a given demonstration year, the difference is not considered demonstration savings. Unspent HRSN expenditure authority under the cap for each demonstration year can be carried, shifted, or transferred across future demonstration years. However, unspent HRSN expenditure authority cannot roll over to the next demonstration approval period. If the state's capped hypothetical spending exceeds the Capped Hypothetical Budget Neutrality Test's expenditure limit, the state agrees (as a condition of CMS approval) to refund any FFP in excess of the cap to CMS. Demonstration savings from the Main Budget Neutrality Test cannot be used to offset excess spending for the capped hypothetical.

19.9. **Capped Hypothetical Budget Neutrality Test: HRSN.** The table below identifies the MEGs that are used for the Capped Hypothetical Budget Neutrality Test. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Capped Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from the Capped Hypothetical Budget Neutrality Test cannot be offset by savings under the Main Budget Neutrality Test or the Hypothetical Budget Neutrality Tests.

Table 9: Capped Hypothetical Budget Neutrality Test

MEG	Agg	WOW Only, WW Only, or Both	DY 18	DY 19	DY 20	DY 21	DY 22
HRSN Services	Agg	Both	$353,702,693	$371,919,141	$391,653,626	$412,906,148	$434,158,671

19.10. **Monitoring Budget Neutrality for Traditional Health Care Practices.** As discussed earlier, the expenditure authority provided for the coverage of traditional health care practices is limited to practices that are delivered by or through certain facility types that are defined by the IHCIA and ISDEAA (laws that stem from the unique government-to-government relationship between the federal government and Indian Tribes). This expenditure authority is also limited to coverage for Medicaid beneficiaries who are able to receive services from those facilities. Further, traditional health care practices are being covered as a complement to services covered by Medicaid under existing authorities. This expenditure authority is not likely to increase overall expenditures beyond what those expenditures could have been without the demonstration. This expenditure authority will not expand the Medicaid-eligible populations, and CMS anticipates that the Medicaid payment rate for most of these services will be the IHS AIR. CMS has therefore determined that this coverage of traditional health care practices is expected to be budget neutral and will not require a specific budget neutrality expenditure sub-limit. The state will be held to the general monitoring and reporting requirements, as per the STCs, and will continue to be held accountable to the overall budget neutrality expenditure limit

of the demonstration.[4] Failure to meet the monitoring and reporting requirements might result in CMS requiring the state to include these expenditures in the budget neutrality agreement for this demonstration, to ensure that CMS has sufficient information to support its initial determination that the approval of these expenditures is expected to be budget neutral. CMS reserves the right to request budget neutrality expenditures and analyses from the state at any time, or whenever the state seeks a change to the demonstration, per STC 3.7. The state must still report quarterly claims and report expenditures on the CMS 64.9 form.

19.11. **Composite Federal Share Ratios.** The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period by total computable demonstration expenditures for the same period, as reported through MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration's approval period, for the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method. Each Hypothetical Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.

19.12. **Exceeding Budget Neutrality**. CMS will enforce the budget neutrality agreement over the demonstration period, which extends from January 1, 2022 through December 31, 2026. The Main Budget Neutrality Test for this demonstration period may incorporate carry-forward savings, that is, net savings from up to 10 years of the immediately prior demonstration approval period(s) (07/01/2015 to 06/30/2020). If at the end of the demonstration approval period the Main Budget Neutrality Test or a Capped Hypothetical Budget Neutrality Test has been exceeded, the excess federal funds will be returned to CMS. If the Demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

19.13. **Budget Neutrality Savings Cap.** The amount of savings available for use by the state during this demonstration period will be limited to the lower of these two amounts: 1) the savings amount the state has available in the current demonstration period, including carry-forward savings as described in STC 19.12, or 2) 15 percent of the state's projected total Medicaid expenditures in aggregate for this demonstration period. This projection will be determined by taking the state's total Medicaid spending amount in its most recent year with completed data and trending it forward by the President's Budget trend rate for this demonstration period. Fifteen percent of the state's total projected Medicaid expenditures for this demonstration period is $99,215,335,167.

19.14. **Corrective Action Plan.** If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and approval.

[4]For more information on CMS's current approach to budget neutrality, see State Medicaid Director letter #24-003.

CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

Table 10: Budget Neutrality Test Corrective Action Plan Calculation		
Demonstration Year	**Cumulative Target Definition**	**Percentage**
DY 18	Cumulative budget neutrality limit plus:	2.0 percent
DY 18 through DY 19	Cumulative budget neutrality limit plus:	1.5 percent
DY 19 through DY 20	Cumulative budget neutrality limit plus:	1.0 percent
DY 20 through DY 21	Cumulative budget neutrality limit plus:	0.5 percent
DY 21 through DY22	Cumulative budget neutrality limit plus:	0.0 percent

20. MONITORING ALLOTMENT NEUTRALITY

20.1. **Reporting Expenditures Subject to the Title XXI Allotment Neutrality Agreement.** The following describes the reporting of expenditures subject to the allotment neutrality agreement for this demonstration:

a. **Tracking Expenditures.** In order to track expenditures under this demonstration, the state must report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-21 reporting instructions outlined in section 2115 of the State Medicaid Manual.

b. **Use of Waiver Forms.** Title XXI demonstration expenditures will be reported on the following separate forms designated for CHIP (i.e., Forms CMS-21 Waiver and/or CMS-21P Waiver), identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). The state must submit separate CMS-21 waiver forms for each title XXI demonstration population.

c. **Premiums.** Any premium contributions collected under the demonstration must be reported to CMS on the CMS-21 Waiver form (specifically lines 1A through 1D as applicable) for each title XXI demonstration population that is subject to premiums, in order to assure that the demonstration is properly credited with the premium collections.

d. **Claiming Period.** All claims for expenditures related to the demonstration (including any cost settlements) must be made within two years after the calendar quarter in

which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state must continue to identify separately, on the Form CMS-21 Waiver, net expenditures related to dates of service during the operation of the demonstration.

20.2. **Standard CHIP Funding Process.** The standard CHIP funding process will be used during the demonstration. The state will continue to estimate matchable CHIP expenditures on the quarterly Forms CMS-21B for CHIP. On these forms estimating expenditures for the title XXI funded demonstration populations, the state must separately identify estimates of expenditures for each applicable title XXI demonstration population.

a. CMS will make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must report demonstration expenditures through Form CMS-21W and/or CMS-21P Waiver for the CHIP population. Expenditures reported on the waiver forms must be identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). CMS will reconcile expenditures reported on the CMS-21W/CMS-21P Waiver form with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

20.3. **Title XXI Administrative Costs.** All administrative costs (i.e., costs associated with the title XXI state plan and the title XXI funded demonstration populations identified in these STCs) are subject to the title XXI 10 percent administrative cap described in section 2105(c)(2)(A) of the Act.

20.4. **Limit on Title XXI Funding.** The state will be subject to a limit on the amount of federal title XXI funding that the state may receive on eligible CHIP state plan populations and the CHIP demonstration populations described in STC 4 during the demonstration period. Federal title XXI funds for the state's CHIP program (i.e., the approved title XXI state plan and the demonstration populations identified in these STCs) are restricted to the state's available allotment and reallocated funds. Title XXI funds (i.e., the allotment or reallocated funds) must first be used to fully fund costs associated with CHIP state plan populations. Demonstration expenditures are limited to remaining funds.

a. **Exhaustion of Title XXI Funds for CHIP Population**. If the state exhausts the available title XXI federal funds in a federal fiscal year during the period of the demonstration, the state must continue to provide coverage to the approved title XXI separate state plan population.

Attachment A
Developing the Evaluation Design

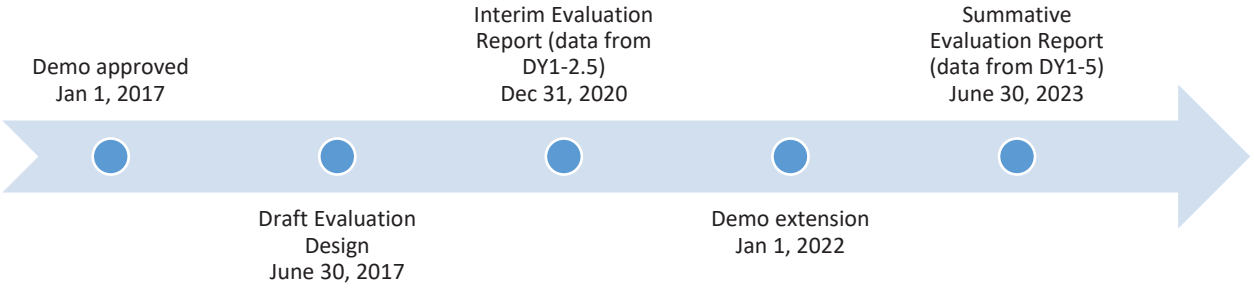
Attachment A
Developing the Evaluation Design

Introduction

Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions. To that end, for states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate information about these policies. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data. Evaluations should include findings about the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration).

Submission Timelines

There is a specified timeline for the state's submission of its draft Evaluation Design and subsequent evaluation reports. The graphic below depicts an example of this timeline for a 5-year demonstration. In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within thirty (30) calendar days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Expectations for Evaluation Designs

CMS expects Evaluation Designs to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html. If the state needs technical assistance using this outline or developing the Evaluation Design, the state should contact its demonstration team.

All states with section 1115 demonstrations are required to conduct Interim and Summative Evaluation Reports, and the Evaluation Design is the roadmap for conducting these evaluations. The roadmap begins with the stated goals for the demonstration, followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However,

the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

The format for the Evaluation Design is as follows:

A. General Background Information;
B. Evaluation Questions and Hypotheses;
C. Methodology;
D. Methodological Limitations;
E. Attachments.

A. General Background Information – In this section, the state should include basic information about the demonstration, such as:

1. The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).
2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.
3. A description of the population groups impacted by the demonstration.
4. A brief description of the demonstration and history of its implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration.
5. For renewals, amendments, and major operational changes: a description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.

B. Evaluation Questions and Hypotheses – In this section, the state should:

1. Identify the state's hypotheses about the outcomes of the demonstration, and discuss how the evaluation questions align with the hypotheses and the goals of the demonstration.
2. Address how the hypotheses and research questions promote the objectives of Titles XIX and/or XXI.
3. Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets can be measured. Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram, which includes information about the goals and features of the demonstration, is a particularly effective modeling tool when working to improve health and health care through specific interventions. A driver diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf.

C. Methodology – In this section, the state is to describe in detail the proposed research methodology. The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, that the results are statistically valid and reliable, and that it builds upon other published research, using references where appropriate.

This section also provides evidence that the demonstration evaluation will use the best available data. The state should report on, control for, and make appropriate adjustments for the limitations of the data and their effects on results, and discuss the generalizability of results. This section should provide enough transparency to explain what will be measured and how, in sufficient detail so that another party could replicate the results. Table A below is an example of how the state might want to articulate the analytic methods for each research question and measure.

Specifically, this section establishes:

1. *Methodological Design* – Provide information on how the evaluation will be designed. For example, whether the evaluation will utilize pre/post data comparisons, pre-test or post-test only assessments. If qualitative analysis methods will be used, they must be described in detail.

2. *Target and Comparison Populations* – Describe the characteristics of the target and comparison populations, incorporating the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally, discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.

3. *Evaluation Period* – Describe the time periods for which data will be included.

4. *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. The state also should include information about how it will define the numerators and denominators. Furthermore, the state should ensure the measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval. When selecting metrics, the state shall identify opportunities for improving quality of care and health outcomes, and controlling cost of care. The state also should incorporate benchmarking and comparisons to national and state standards, where appropriate.

   Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by "owning", defining, validating, securing, and submitting for endorsement, etc.) Proposed health measures could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum. Proposed performance metrics can be selected from nationally recognized

metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology.

5. *Data Sources* – Explain from where the data will be obtained, describe any efforts to validate and clean the data, and discuss the quality and limitations of the data sources. If the state plans to collect primary data (i.e., data collected specifically for the evaluation), include the methods by which the data will be collected, the source of the proposed questions and responses, and the frequency and timing of data collection. Additionally, copies of any proposed surveys must be provided to CMS for approval before implementation.

6. *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative analysis measures that will adequately assess the effectiveness of the demonstration. This section should:
    a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression).
    b. Explain how the state will isolate the effects of the demonstration from other initiatives occurring in the state at the same time (e.g., through the use of comparison groups).
    c. Include a discussion of how propensity score matching and difference-in-differences designs may be used to adjust for differences in comparison populations over time, if applicable.
    d. Consider the application of sensitivity analyses, as appropriate.

7. *Other Additions* – The state may provide any other information pertinent to the Evaluation Design for the demonstration.

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid fee-for-service and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-Sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

D. Methodological Limitations – This section provides more detailed information about the limitations of the evaluation. This could include limitations about the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize these limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review.

CMS also recognizes that there may be certain instances where a state cannot meet the rigor of an evaluation as expected by CMS. In these instances, the state should document for CMS why it is not able to incorporate key components of a rigorous evaluation, including comparison groups and baseline data analyses. For example, if a demonstration is long-standing, it may be difficult for the state to include baseline data because any pre-test data points may not be relevant or comparable. Other examples of considerations include:

1. When the demonstration is:
    a. Non-complex, unchanged, or has previously been rigorously evaluated and found to be successful; or
    b. Could now be considered standard Medicaid policy (CMS published regulations or guidance).

2. When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:
    a. Operating smoothly without administrative changes;
    b. No or minimal appeals and grievances;

c. No state issues with CMS-64 reporting or budget neutrality; and
d. No Corrective Action Plans for the demonstration.

E. E. Attachments

1) **Independent Evaluator.** This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation and prepare objective Evaluation Reports. The Evaluation Design should include a "No Conflict of Interest" statement signed by the independent evaluator.

2) **Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated costs, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design, if CMS finds that the draft Evaluation Design is not sufficiently developed, or if the estimates appear to be excessive.

3) **Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The final Evaluation Design shall incorporate milestones for the development and submission of the Interim and Summative Evaluation Reports. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation Report is due.

Attachment B
Preparing the Interim and Summative Evaluation Reports

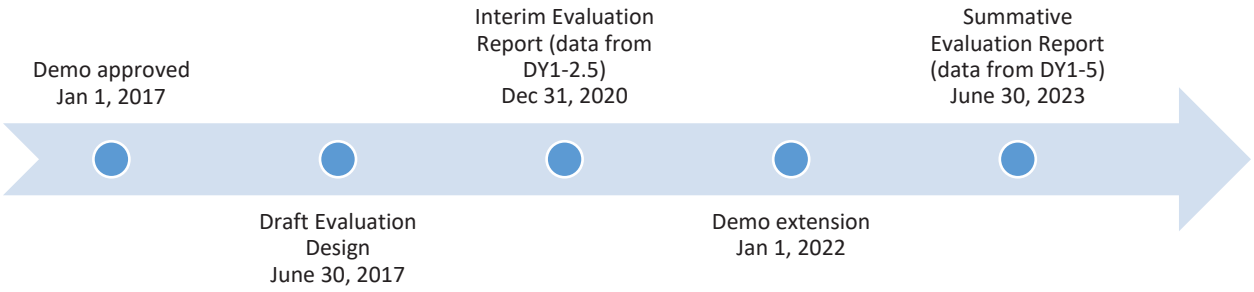
Attachment B
Preparing the Interim and Summative Evaluation Reports

Introduction

Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions. To that end, for states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate information about these policies. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data. Evaluations should include findings about the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration).

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). The graphic below depicts an example of a deliverables timeline for a 5-year demonstration. In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish the Interim and Summative Evaluation Reports to the state's website within thirty (30) calendar days of CMS approval, as per 42 CFR 431.424(d). CMS will also publish a copy to the Medicaid.gov website.



Expectations for Evaluation Reports

All states with Medicaid section 1115 demonstrations are required to conduct evaluations that are valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). The already-approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow

the methodology outlined in the approved Evaluation Design. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

When submitting an application for extension, the Interim Evaluation Report should be posted on the state's website with the application for public comment. Additionally, the Interim Evaluation Report must be included in its entirety with the application submitted to CMS.

CMS expects Interim and Summative Evaluation Reports to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html. If the state needs technical assistance using this outline or developing the evaluation reports, the state should contact its demonstration team.

Intent of this Attachment
Title XIX of the Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's evaluation report submissions must provide comprehensive written presentations of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Attachment is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

Required Core Components of Interim and Summative Evaluation Reports
The Interim and Summative Evaluation Reports present research and findings about the section 1115 demonstration. It is important that the reports incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. The evaluation reports should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy.

A. The format for the Interim and Summative Evaluation reports is as follows: Executive Summary;
B. General Background Information;
C. Evaluation Questions and Hypotheses;
D. Methodology;
E. Methodological Limitations;
F. Results;
G. Conclusions;
H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
I. Lessons Learned and Recommendations; and
J. Attachment(s).

A. **Executive Summary** – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.

B. **General Background Information about the Demonstration** – In this section, the state should include basic information about the demonstration, such as:

1. The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential magnitude of the issue, and why the state selected this course of action to address the issues.
2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.
3. A description of the population groups impacted by the demonstration.
4. A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration.
5. For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes. Additionally, the state should explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable).

C. **Evaluation Questions and Hypotheses** – In this section, the state should:

1. Identify the state's hypotheses about the outcomes of the demonstration, and discuss how the goals of the demonstration align with the evaluation questions and hypotheses.
2. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.
3. Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.
4. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.

Methodology – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration, consistent with the approved Evaluation Design. The Evaluation Design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research, (using references), meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An Interim Evaluation Report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is

appropriate data development and collection in a timely manner to support developing an Interim Evaluation Report.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used. The state also should report on, control for, and make appropriate adjustments for the limitations of the data and their effects on results, and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how, in sufficient detail so that another party could replicate the results. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1) *Methodological Design* – Whether the evaluation included an assessment of pre/post or post-only data, with or without comparison groups, etc.

2) *Target and Comparison Populations* – Describe the target and comparison populations, describing inclusion and exclusion criteria.

3) *Evaluation Period* – Describe the time periods for which data will be collected.

4) *Evaluation Measures* – List the measures used to evaluate the demonstration and their respective measure stewards.

5) *Data Sources* – Explain from where the data were obtained, and efforts to validate and clean the data.

6) *Analytic Methods* – Identify specific statistical testing which was undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).

7) *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.

D. Methodological Limitations – This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

F. Results – In this section, the state presents and uses the quantitative and qualitative data to demonstrate whether and to what degree the evaluation questions and hypotheses of the demonstration were addressed. The findings should visually depict the demonstration results, using tables, charts, and graphs, where appropriate. This section should include findings from the statistical tests conducted.

G. Conclusions – In this section, the state will present the conclusions about the evaluation results. Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically, the state should answer the following questions:

1. In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?

a. If the state did not fully achieve its intended goals, why not?
b. What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

H. Interpretations, Policy Implications and Interactions with Other State Initiatives – In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long-range planning. This should include interrelations of the demonstration with other aspects of the state's Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretations of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels.

I. Lessons Learned and Recommendations – This section of the evaluation report involves the transfer of knowledge. Specifically, it should include potential "opportunities" for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders. Recommendations for improvement can be just as significant as identifying current successful strategies. Based on the evaluation results, the state should address the following questions:

1. What lessons were learned as a result of the demonstration?
2. What would you recommend to other states which may be interested in implementing a similar approach?

J. Attachment(s)

1) Evaluation Design: Provide the CMS-approved Evaluation Design

Attachment C
Global Payment Program Participating Public Health Care Systems

Attachment C
Global Payment Program Participating Public Health Care Systems

Public Health Care Systems participating in the GPP consist of the following designated public hospitals (DPHs), including any successor or differently named hospital as applicable, and their affiliated and contracted providers. The DPHs are operated by a county, a city and county, University of California, or special hospital authority described in Section 101850 or 101852, *et seq*., of the California Health & Safety Code. With the exception of the University of California Los Angeles (UCLA), the DPHs listed below began participating in GPP beginning with Program Year (PY) 1. UCLA Medical Center and Santa Monica UCLA Medical Center participate in GPP beginning with PY 9, and UCLA West Valley Medical Center participates in GPP beginning with PY 10.

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

Attachment D
Funding and Reimbursement Protocol for IHS

Attachment D
Funding and Reimbursement Protocol for IHS

Funding and Reimbursement Protocol for Claiming IHS and 638 Facilities Uncompensated Care Payment Methodology The methodology outlined below has been approved for structuring supplemental payments to IHS and 638 facilities from November 1, 2015 through December 31, 2020 as required by STC 18.12. Using the methodology escribed below in section (A), the state shall make supplemental payments to Indian Health Service (IHS) and tribal facilities to account for the uncompensated costs of furnishing primary care services between April 5, 2013 and December 31, 2013 to uninsured individuals with incomes up to 133 percent of the Federal Poverty Level (FPL) who are not enrolled in a Low-Income Health Program (LIHP). Using the methodology described below in section (A) and (B), the state shall also make supplemental payments to account for the uncompensated costs of furnishing services between April 5, 2013 and December 31, 2014 to individuals enrolled in the Medi-Cal program for benefits that were eliminated from the state plan pursuant to state plan amendment 09-001 and are not covered by Medi-Cal. Costs for optional dental and psychology, that were eliminated through SPA 09-001, but have been added back in through State Plan Amendments are not available for reimbursement through these supplemental payments.

A. Provider Claiming Methodology for services provided November 1, 2015 through December 31, 2020

1. Participating IHS and tribal 638 facilities shall enter into a billing agent agreement with the California Rural Indian Health Board (CRIHB) consistent with the requirements of 42 C.F.R. 447.10.
2. Participating facilities shall track qualifying uncompensated encounters by utilizing a tracking document or other electronic means to record the following:
    a. The qualifying Medi-Cal service provided to a Medi-Cal beneficiary;
    b. Whether the service was provided to an IHS eligible individual; and
    c. The service date.
3. Qualifying encounters shall not include encounters for which any payment was made under Medi-Cal at the IHS published rate.
4. Participating IHS and tribal 638 facilities shall submit to CRIHB, on a quarterly basis, the number of qualifying uncompensated encounters, broken down by status of individual as IHS-eligible (Indian or Alaskan Native).
5. Participating IHS and tribal 638 facilities shall submit to CRIHB, on a quarterly basis, the amount of third-party payments received for Medi-Cal beneficiaries for qualifying uncompensated care. Third party payments received after the end of the quarter shall be reported as a prior period adjustment.
6. CRIHB will process the reports from participating IHS and tribal facilities and submit to DHCS, within 60 working days after the end of each quarter, a

Quarterly Summary Aggregate Encounter Report (Exhibit 1.B) specifying the number of qualifying uncompensated encounters for each IHS/Tribal 638 facility broken down as reported by each facility. The submission will also include a summary page totaling the aggregate qualifying uncompensated encounters as well as the aggregate supplemental payments due based on the applicable IHS encounter rate offset by any third-party payments received by each facility forthe qualifying uncompensated encounters.

7. In support of the Quarterly Aggregate Encounter Rate, CRIHB shall submit a certification, signed by the Executive Director of CRIHB that the information contained therein is current, complete, and accurate.

State Payment Process

1. The state shall make supplemental payments to each participating facility through CRIHB within 30 days of receipt of each quarterly report, based on the reported uncompensated care costs as calculated by multiplying qualifying uncompensated encounters by the appropriate IHS published rate, offset by any third party payments received by each IHS/Tribal 638 facility foruncompensated encounters involving Medi-Cal beneficiaries, including third party payments reported as a prior period adjustment. If third party payments are reported as a prior period adjustment after the supplemental payment period, the state will offset other Medi-Cal payments to the facility by the amount of such payments.
2. The state shall terminate supplemental payments if the cap for the SNCP is met.
3. The CRIHB must maintain, and upon request provide DHCS, documentation sufficient to support the claims for supplemental payments.
4. CRIHB will disburse the supplemental payments received from the state to each IHS facility in accordance with its agreement with each facility, but no later than 20 business days after receipt from the state.
5. The State may claim federal matching funding for supplemental payments to IHS and tribal 638 at the 100 percent FMAP rate only to the extent that the supplemental payments reflect uncompensated care furnished to IHS eligible individuals.

Exhibit 1.B: Aggregate Encounter Report for January 1, 2022 through October 31, 2026

Facility Name	IHS Eligible Medi-Cal Beneficiaries
Total Number of Encounters	
IHS Encounter rate	
Total Expenditures	
Less: Any other payments received	
Total Net Expenditures	

Certification:

I HEREBY CERTIFY THAT:

1. I have examined this statement, for the period from XXX to XXX and that to the best of my knowledge and belief they are true and correct statements prepared from the books and records of the IHS/Tribal 638 facilities and CRIHB.

2. The information contained in this report is current, complete, and accurate.

_____ _____

Title Date

_____

Signature (officer of the governmental entity)

Attachment E
SUD Health IT Plan

Attachment E
SUD Health IT Plan

California Progress on SUD HIT Plan

Overview

The state's Department of Justice (DOJ) manages the Controlled Substance Utilization Review and Evaluation System (CURES), the state's prescription drug monitoring program (PDMP). CURES is governed by strict statutory and regulatory requirements that limit the entities—licensed prescribers, pharmacists, regulatory agency officials, and law enforcement officials--who can access the database. CURES stores Schedule II-V controlled substance prescription information that is reported as dispensed in California. Prescribers must consult CURES to review a patient's controlled substance history no earlier than 24 hours, or the previous business day, before prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient for the first time and at least once every 6 months thereafter if the substance remains part of the treatment of the patient. In accordance with CMS' request, this document details the state of CURES for each functionality included in the SUD HIT.

Prescription Drug Monitoring Program Functionalities

- **Interstate sharing:** AB 1751 (Stats 2018, Ch 478, Low) authorized the DOJ, once final regulations addressing CURES access and use have been issued, to participate in interstate sharing. The DOJ is in the process of developing functionality within CURES to support interstate data sharing and plans to use both RxCheck and sPMPi to facilitate data sharing across states. Additionally, DOJ is actively working with potential data sharing partners. Data obtained from CURES may be provided to authorized users of another state PDMP if the entity operating the interstate data sharing hub, and the PDMP of that state, have entered into an agreement with the DOJ for interstate sharing of PDMP information. Implementation of this functionality is scheduled for Spring 2022.
- **Enhanced "ease of use" for prescribers and other state and federal stakeholders**. CURES launched the Information Exchange Webservice (IEWS) an interoperability platform in 2018 that allows for integration with providers' EHRs and with HIEs where users log into the data system. Currently, 50 health IT entities, including HIEs and large health systems, whose users are authorized to access CURES, use the platform. In addition, DOJ is engaged in a CURES optimization effort to update the "look and feel" of the web-portal and dashboard to promote ease of use. Additionally, interstate searches will be available through the IEWS. Implementation of the optimized CURES is scheduled for Spring 2022.
- **Enhanced connectivity between the state's PDMP and any statewide, regional or local health information exchange.** *See bullet immediately above*
- **Enhanced identification of long-term opioid use directly correlated to clinician prescribing patterns.** CURES presents daily patient safety alerts within the CURES dashboard to prescribers when their patient's aggregate prescription level exceeds certain thresholds, including:

  - Patient is currently prescribed more than 90 morphine milligram equivalents per day
  - Patient has obtained prescriptions from 6 or more prescribers or 6 or more pharmacies during last 6 months

- Patient is currently prescribed more than 40 morphine milligram equivalents of methadone daily
- Patient is currently prescribed opioids more than 90 consecutive days
- Patient is currently prescribed both benzodiazepines and opioids

The CURES database also provides health care practitioners and pharmacists with a messaging capability that allows a message to be sent to another health care practitioner regarding a mutual patient from within the secure CURES environment.

Current and Future PDMP Query Capabilities

- **Facilitate the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP (i.e. the state's master patient index (MPI) strategy with regard to PDMP query).** CURES uses an algorithm to de-duplicate patient entities and that considers various elements of a patient record. It is important to note that use of this algorithm is applied only when CURES generates daily patient safety alerts and for the production of CURES de-identified datasets.

Use of PDMP – Supporting Clinicians with Changing Office Workflows / Business Processes

- **Develop enhanced provider workflow / business processes to better support clinicians in accessing the PDMP prior to prescribing an opioid or other controlled substance to address the issues which follow.** The IEWS platform allows providers easy access to CURES through their EHR as detailed above. State statute requires prescribers to review a patient's history on CURES within 24 hours or one business day before prescribing a controlled substance. In accordance with state law, approved prescribers and pharmacists will be able delegate their authority to access CURES reports. This delegate functionality will become available within the web application in Spring 2022. Delegate access through IEWS is dependent on the National Council for Prescription Drug Programs (NCPDP) to adopt an update to the NCPDP SCRIPT Standard and is therefore on a longer timeframe.
- **Develop enhanced supports for clinician review of the patients' history of controlled substance prescriptions provided through the PDMP—prior to the issuance of an opioid prescription.** In addition to the CURES functionality described above and related to patient alerts, CURES includes links to resources on safe prescribing of controlled substances. For example, the CURES public website includes links to the CDC prescribing guidelines, Medical Board of California guidelines, California's Department of Public Health (CDPH) opioid overdose surveillance dashboard, as well as the CDPH Guidance Letter.

Master Patient Index / Identity Management

- **Enhance the master patient index (or master data management service, etc.) in support of SUD care delivery.** See bullet above on master patient index/patient matching.

Overall Objective for Enhancing PDMP Functionality & Interoperability

- **Leverage the above functionalities / capabilities / supports (in concert with any other state health IT, TA or workflow effort) to implement effective controls to minimize the risk of inappropriate opioid overprescribing—and to ensure that Medicaid does not inappropriately pay for opioids.** Key functionalities intended to help minimize the risk of inappropriate opioid overprescribing are described above. Additionally, in accordance with state statute and regulations, a public or private entity, including a Bona Fide Researcher, is eligible to obtain data from CURES, subject to the requirements of the data request process. Accordingly, there is no

specific data transmittal that occurs between CURES and Medicaid. Related other state IT efforts, DHCS data and clinical staff regularly monitor inappropriate prescribing of opioids through its routine utilization monitoring, an effort that has increased in priority due to the current opioid crisis. Onsite reviews of suspect practitioners have resulted in Drug Code Limitation, a sanction restricting pharmacies from billing for prescriptions written by sanctioned practitioners, and suspension from the Medi-Cal program when there is evidence of potential fraud and/or patient harm. Fraud investigations are conducted and cases are referred to law enforcement for criminal investigation and prosecution when warranted.

Attachment F
Accounting Procedures
(Reserved)

Attachment G
Demonstration and Program Years

Attachment G
Demonstration and Program Years

CalAIM: Demonstration and Program Years

Demonstration Year (DY)	Dates
DY 18	January 1, 2022 through December 31, 2022
DY 19	January 1, 2023 through December 31, 2023
DY 20	January 1, 2024 through December 31, 2024
DY 21	January 1, 2025 through December 31, 2025
DY 22	January 1, 2026 through December 31, 2026

Global Payment Program	
Program Year (PY)	**Dates**
PY 6	July 1, 2020 through December 31, 2020
PY 7	January 1, 2021 through December 31, 2021
PY 8	January 1, 2022 through December 31, 2022
PY 9	January 1, 2023 through December 31, 2023
PY 10	January 1, 2024 through December 31, 2024
PY 11	January 1, 2025 through December 31, 2025
PY 12	January 1, 2026 through December 31, 2026

Attachment H
Community-Based Adult Services (CBAS) Provider Standards of Participation

Attachment H
Community-Based Adult Services (CBAS) Provider Standards of Participation

A. General Provider Requirements

To become a Medi-Cal Community-Based Adult Services (CBAS) provider, the prospective provider must first obtain an Adult Day Health Care (ADHC) center license, issued by the California Department of Public Health and apply for certification for enrollment in Medi-Cal to the Department of Health Care Services (DHCS) or its designee*. Upon meeting the criteria for certification and Medi-Cal provider enrollment, the ADHC center licensee will be certified as a CBAS provider. This specific waiver provider designation will afford CBAS providers the opportunity to deliver outpatient CBAS center services to eligible Medi-Cal beneficiaries (referred to as CBAS participants) in a community setting.

CBAS providers shall:

4. Meet all applicable licensing and certification, as well as Medi-Cal and waiver program standards, as described or referenced in this document;
5. Adhere to these waiver Standards of Participation (SOPs);
6. Enter into contracts with Medi-Cal managed care plans within the provider's geographic area to provide CBAS center services to Medi-Cal plan members;
7. Provide services in accordance with the CBAS participant's Individual Plan of Care (IPC);
8. Adhere to the documentation, training, and quality assurance requirements identified in the Centers for Medicare and Medicaid Services (CMS)-approved 1115 waiver (#11-W-00193/9), inclusive of all the Special Terms and Conditions (STCs) contained therein; and
9. Demonstrate ongoing compliance with the requirements specified in these SOPs.

*The California Department of Aging (CDA) is DHCS' designated representative for the certification of CBAS providers. Future reference in these SOPs will specify CDA.

B. CBAS Center Services

1. CBAS provider shall provide services at the ADHC center, pursuant to a CBAS participant's IPC, developed by the center's multidisciplinary team. These services shall include all of the following, as specified in a CBAS participant's IPC, during a minimum of a four-hour stay at the center. Any length of stay under four hours will not be reimbursed. The CBAS provider is responsible for documenting the provision of services and the duration of attendance of each participant at the center.
    a. Core services: each CBAS participant shall be scheduled to receive ALL of these services on each day of attendance at the center:
        i. Professional nursing.
        ii. Therapeutic activities.

iii. Social services and/or personal care services.
iv. One meal offered per day.

b. Additional services: each CBAS participant shall receive the following services as needed and as specified in his/her IPC:
   i. Restorative physical therapy.
   ii. Restorative occupational therapy.
   iii. Speech therapy.
   iv. Behavioral health services.
   v. Registered dietitian services.

c. Transportation to and from the center and the participant's place of residence, shall be arranged or provided as needed.

2. Requirements specified in Section B.1 of these SOPs may be suspended in the event of qualifying emergencies pursuant to the CBAS STCs for Emergency Remote Services (ERS). All requirements for CBAS ERS specified in the CBAS STCs and further defined in state-issued policy letters must be met to be eligible for reimbursement.

A. Legal Authority and Requirements

1. CBAS providers shall:
   a. Deliver services in licensed ADHC centers in accordance with Health and Safety (H&S) Codes under Division 2, Chapter 3.3 and shall provide services in accordance with the California Code of Regulations (CCR), Title 22 under Division 5, Chapter 10 and with the CMS-approved waiver document(s), except when CBAS ERS supports and services are delivered in accordance with these STCs and SOPs and all requirements specified in state-issued policy letters.
   b. Be certified and enrolled as Medi-Cal providers and shall meet the standards specified in the Welfare and Institutions Codes under Division 9, Chapter 8.7; in the CCR, Title 22 under Division 3, Chapter 5; in Medi-Cal Provider Bulletins and CBAS All Center Letters, and as set forth in these SOPs.
   c. Apply for certification. The application review includes, but is not limited to, evaluation of the provider legal entity and associated individuals to ensure there are no restrictions on their Medi-Cal/Medicaid enrollment status.
   d. Apply for recertification as Medi-Cal providers at least every 24 months and be subject to an application review as specified in Subsection C.1.c. and an onsite review. The onsite review includes, but is not limited to, evaluation of administrative systems and processes, staffing, and the appropriateness and quality of services delivered. Recertification is contingent upon the provider's demonstration of continuing compliance with standards for participation in the Medi-Cal program.

2. If there is a change in adopted laws or regulations governing the licensing of ADHC

centers and/or the certification of CBAS providers, these SOPs shall be interpreted in such a manner as to be in conformance with such laws or regulations.

B. Physical Plant and Health and Safety Requirements

To ensure the health and safety of the CBAS participants, the physical plant of each center shall conform to the requirements of applicable sections of Title 22 of the CCR as described in part by the following:

1. Physical accommodations – Designed, equipped, and maintained to provide for a safe and healthful environment. Each center shall:
    a. Comply with state and local building requirements and codes.
    b. Be maintained in conformity with the regulations adopted by the State Fire Marshal.
    c. Have a working, listed telephone number.
    d. Have a working FAX number.
    e. Have a working email address.
    f. Have electronic equipment, including computers and software, adequate to comply with State CBAS reporting requirements.
    g. Have a working heating and cooling system.
    h. Have adequate lighting.
    i. Have appropriate water supply and plumbing.
2. Space Requirements – Demonstrate all of the following, to include but not be limited to:
    a. Available space sufficient to accommodate both indoor and outdoor activities and store equipment and supplies.
    b. A multipurpose room large enough for all participants to gather for large group activities and for meals.
    c. A secluded area that is set aside for participants who require bed rest and privacy during medical treatments or social service interventions.
    d. Appropriate office area(s).
3. Maintenance and Housekeeping – Be clean, safe, and in good repair at all times; maintenance shall include provisions for cleaning and repair services.
4. Safety – Have appropriate protective devices to guard against hazards by means of supervision, instruction, and installation.
5. Supplies – Maintain sufficient supplies for functional operation and meeting the needs of the participants.
6. Solid Waste – Provide for the storage and disposal of solid waste according to the standards set forth in Title 22.

E. CBAS Eligibility Determination and Authorization

Eligibility determination and authorization for CBAS shall be determined as specified in the CBAS STCs and as follows:

1. A Treatment Authorization Request (TAR) or other agreed upon authorization document shall be prepared by the CBAS provider and submitted to the managed care plan, or to DHCS for beneficiaries exempt from enrolling in a managed care plan, for each beneficiary seeking CBAS. TARs for CBAS must be supported by the participant's IPC.
2. Reauthorization TARs for CBAS must be submitted to the appropriate reviewer at least every six months, or up to 12 months, as specified in the STCs, and must continue to be supported by the participant's IPC. Reauthorization for CBAS ERS is required at least every three months, in accordance with the STCs and all requirements specified in state-issued policy letters.
3. Authorization timeframes shall be in accordance with H&S Code 1367.01 and State Medi-Cal regulations and policy.

F. Individual Plan of Care (IPC)

The participant's IPC shall:

1. Be developed by the CBAS center's multidisciplinary team and signed by representatives of each discipline required to participate in the multidisciplinary team assessment.
2. Be the result of a collaborative process among the CBAS provider, the participant, and if applicable, the participant's authorized representative(s) and/or managed care plan.
3. Be signed by either the CBAS provider's physician or the participant's personal health care provider. "Personal health care provider" may include a physician assistant or nurse practitioner within their scope of practice under the appropriate supervision of the physician.
4. Be based on a person-centered planning process and meet the requirements specified in the CBAS STCs.
5. Be based on assessment or reassessment conducted no more than 30 days prior to the start date of the IPC. If the CBAS participant is a Medi-Cal managed care member and the participant's plan requires submission more than 30 days prior to the IPC effective date, the CBAS provider must identify any change in condition requiring IPC amendment prior to implementation and amend it accordingly if a change to the IPC is needed.
6. Be approved by the participant or participant's authorized representative and documented in the signed CDA ADHC/CBAS Participation Agreement attesting to having participated in the center's care planning process to develop the IPC. Signing the CDA ADHC/CBAS Participation Agreement shall occur after the participant's assessment or reassessment process has been completed and the IPC has been developed, and prior to the delivery of CBAS services identified on the IPC.

G. CBAS Staffing

1. A CBAS provider shall employ or contract with a variety of staff and render required services as described in these SOPs. The staff providing CBAS center services shall meet

all licensing requirements as specified in the California Business and Professions Code, as well as these SOPs, as appropriate to the individual staff person. A CBAS provider's staffing requirements shall be based on the provider's hours of service and the average daily attendance (ADA), including days of service provided under CBAS ERS, from the previous three consecutive months. The ADA can also be tied to ADA levels on various days of the week so long as the CBAS provider can demonstrate that the ADA for those days are consistent.

   a. "Hours of service" means the program hours for the provision of CBAS, which shall be no less than 4 hours excluding transportation. The hours of service shall be defined and posted by the adult day health care center.

2. Professional nursing coverage of the center shall include Registered Nurse (RN) staffing at a ratio of one RN for every 40 participants in ADA, or one RN for the first 40 participants and a half-time Licensed Vocational Nurse (LVN) for every increment of 10 in ADA exceeding 40 participants.
   a. There shall be at least one licensed nurse physically present and performing nursing duties at the center at all times during the center's hours of service during which participants are present. The licensed nurse physically present may be an LVN, providing the LVN is under the supervision of the RN, is working within scope of practice, and the RN is immediately available by phone if needed.
3. Social services staffing must include social workers at a ratio of one medical social worker for every 40 participants in ADA, or one medical social worker for the first 40 participants and a half-time social worker assistant for every increment of 10 in ADA exceeding 40 participants.
4. The program aide staffing shall be at a ratio of one program aide on duty for up to and including 16 participants.
   a. "On duty" means physically present and performing duties at the center at all times during the center's hours of service in which participants are present.
   b. Any number of participants up to the next 16 shall require an additional program aide (for example, 17 participants require two program aides).
5. Participants' needs supersede the minimum staffing requirements specified in these SOPs. The CBAS provider shall be responsible for increasing staffing levels as necessary to maintain the health and safety of all participants and to ensure that services are provided to all participants according to their IPCs.
6. Physical, occupational, and speech therapy, and mental health services shall be provided at a minimum monthly rate of 20 total therapy hours for each increment of five participants in ADA.

H. Organization and Administration

The CBAS center shall be organized and staffed to carry out the services and other requirements specified in the waiver. Such organization shall include:

1. An administrator and full-time program director. An administrator or program director must be on duty at all times.

a. "On duty" means physically present and performing duties at the center at all times during the center's hours of service in which participants are present.
b. The CBAS provider shall have a written policy for coverage of the administrator and program director during times of absence.

2. Sufficient supportive staff to conduct the CBAS provider's daily business in an orderly manner.
3. CBAS staffing that meets the individual professional requirements specified in relevant state laws and regulations and in these SOPs.
4. Financial and accounting records that fully disclose the disposition of all funds.
5. The maintenance of appropriate personnel and CBAS participant health records and personnel records.
6. Ability to comply with State reporting requirements as specified through Provider Bulletins, these SOPs, and as applicable, Medi-Cal managed care plan contract requirements. CBAS providers must report the following:
    a. Discharge plan at time of disenrollment from the CBAS center:
        i. Must be reported to CDA for fee-for-service CBAS participants and to the responsible managed care plan for managed care plan members.
    b. Incident reports:
        i. All incidents that threaten the welfare, safety, or health of the participant(s) shall be reported to CDA, and, if applicable, the CBAS participant's managed care plan within 48 hours of the incident and documented in writing in the required format. Such documentation shall be available to appropriate CDA/managed care plan staff at all times.
7. Written policies and procedures for center operations and the provision of services to CBAS participants.
8. Emergency Services – Maintenance of updated written procedures for dealing with emergency situations. Such procedures shall include, at a minimum all of the following:
    a. Use of the local 911 system.
    b. Appropriately trained personnel; at a minimum, all direct care staff shall be trained in first aid and certified in basic life support.
    c. Written permission from all CBAS participants for transfer to and treatment by local hospitals or other treatment facilities as needed, which can be provided for in the participation agreement.
9. Grievance Procedures – A written grievance process whereby participants and family/caregivers can report and receive feedback regarding CBAS services.
10. Civil Rights and Confidentiality – Adherence to all laws and regulations regarding civil rights and confidentiality of both participants and CBAS staff. CBAS providers are subject to Federal and State laws regarding discrimination and abuse and the reporting of such, inclusive of the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and the Information Practices Act (IPA).

11. Quality Control/Quality Assurance – Quality control/quality assurance reviews that are in accordance with the Quality Assurance Plan, as described in the CMS-approved 1115 waiver (#11-W-00193/9).
12. Training Requirements – Training of all direct care CBAS staff regarding the care appropriate to each participant's diagnoses and his/her individual care needs. Provision of training to CBAS staff is a requirement to be enrolled in Medi-Cal as a CBAS provider and is not separately reimbursable outside of the CBAS provider's rate by either Medi-Cal or the Medi-Cal managed care plans.
    a. A Training of CBAS staff shall include an initial orientation for new staff; review of all updated policies and procedures; hands-on instruction for new equipment and procedures; and regular updates on State and Federal requirements, such as abuse reporting and fire safety.
    b. Training shall be conducted and documented on a quarterly basis and shall include supporting documentation on the information taught, attendees, and the qualifications of the instructor(s).
13. Documentation – Maintenance of a health record for each CBAS participant that shall be available to appropriate DHCS/CDA and managed care plan staff for any scheduled or unscheduled visits.
    a. This health record shall include documentation of all services provided and refused, the current IPC, referral requests and outcomes of said referral(s).
    b. Health record documentation shall be maintained in compliance with applicable Federal and State laws and shall be retained by the CBAS provider for a minimum of seven years. Health records shall be stored so as to protect against loss, destruction, or unauthorized use.
    c. The CBAS provider shall maintain administrative records that document compliance with these SOPs.

Attachment I
Drug Medi-Cal Organized Delivery System (DMC-ODS)
County Certified Public Expenditures (CPE) Protocol

Attachment I
Drug Medi-Cal Organized Delivery System (DMC-ODS)
County Certified Public Expenditures (CPE) Protocol (Updated September 16, 2020)

GENERAL

Consistent with 42 CFR 433.51, a State or a unit of local government may use for its share in claiming federal financial participation (FFP) its public funds appropriated directly to the State or local Medicaid agency, transferred from other public agencies (including Indian tribes) to the State or local agency and under its administrative control, or certified by the contributing public agency as representing expenditures eligible for FFP. Public funds must not be federal funds unless specifically authorized by Federal law to be used for such purpose. The certified public expenditures of each Drug Medi-Cal (DMC) Organized Delivery System (ODS) County are comprised of expenditures incurred for payments made to contracted providers, payments made to contracted managed care plans, and expenditures incurred by county-operated providers, for the furnishing of DMC ODS waiver services specified in the special terms and conditions of this 1115 demonstration waiver, authorized under California's Section 1915(b) waiver, and California's Medicaid State Plan to eligible Medi-Cal beneficiaries. Services provided to beneficiaries residing in an IMD will be reported in the necessary 1115 line items within the CMS-64 report, separate and apart from all other services rendered to beneficiaries residing outside of an IMD.

DMC ODS county expenditures for contracted provider services are the payments made to the contracted providers for substance use disorder services rendered. For the NTP/OTP modality of service, each DMC ODS county pays contracted providers at the lower of the uniform statewide daily rate (USDR) or the provider's usual and customary charge to the general public for the same or similar services. For non-NTP/OTP modalities, each DMC ODS county pays contracted providers at county-specific negotiated rates, subject to contracted provider cost reconciliation as discussed below. The rates are proposed as part of the county fiscal plan that is submitted as addendum to the implementation plan and approved by the Department of Health Care Services (DHCS).

Each DMC ODS county that contracts with a managed care plan pays the managed care plan a county specific interim per utilizer per month (PUPM) rate for all substance use disorder services rendered by county and non-county providers to each user each month. Each county-specific PUPM rate is reviewed and approved by DHCS, and is subject to reconciliation as described below.

The county-specific negotiated rates are based on several criteria as required in the fiscal guidance that has been provided in Mental Health and Substance Use Disorders (MHSUDS) INFORMATION NOTICE NO: 15-034 and MHSUDS INFORMATION NOTICE NO: 16-050. The county will use the projected actual cost for services based on the most current prior fiscal year cost report data, where these services were previously available, with adjustments for increased projected beneficiary counts and the resulting projected increase in units of service (projected utilization) that will result from participation in the pilot. In the cases where the services have not been previously available, the counties will project staff hours for providing the services and calculate a projected cost per unit. Additional adjustments can be applied for

inflation, using an approved government inflation factor, in similar manner to the county interim rate development.

The county-specific interim PUPM rates are based on the following criteria.

- Total enrollment for each county multiplied by assumed prevalence rates and penetration rates by age group equals estimated utilizers for each county.
- Estimated utilizers multiplied by the percentage of utilizers in Marin County, Riverside County, and San Mateo County who used each mode of service.
- Estimated utilizers by mode of services multiplied by the average rate per mode of service paid in Marin County, Riverside County, and San Mateo County or the Fiscal Year 2015-16 county cost trended forward, if available, determined the total cost for each mode of service.
- Summed the total cost across all modes of service to determine the total cost for the estimated utilizers.
- Divided the total estimated cost by the total estimated utilizers to determine the service component of the interim PUPM rate.

As the State reviews proposed county interim rates and county interim PUPM rates, the additional information that is considered in the review includes data that illustrates the contract providers' or contract managed care plan's projected cost per unit for each DMC ODS service. The State is able to provide oversight to the contract provider rate or contract managed care interim PUPM rate development at this stage of the review. If the projected expenditure or the projected utilization appears to be excessive or unsubstantiated, the State will provide feedback in the review process and request additional justification and/or correction to the projections. DMC ODS county expenditures for county-operated provider services are determined through county provider cost reports. Section 14124.24(9) (1) of the Welfare and Institutions Code (WIC) requires that legal entities (i.e., counties and contracted providers), except for those contracted providers providing only narcotic treatment, submit substance use disorder (SUD) cost reports to DHCS by November 1 for the previous state fiscal year, unless DHCS grants a formal extension. A county-operated narcotic treatment facility will be required to submit the complete SUD cost report. A county with an approved PUPM rate will not be required to submit a cost report for non-county-operated providers. The reconciliation of those payments will be subject to a reconciliation based on payments and actual encounters. A county with an approved PUPM rate will be required to submit a county provider cost report for county-operated providers, and payments for services rendered by county-operated providers will be reconciled to county-operated provider cost.

The SUD cost report forms are structured to obtain each legal entity's methodology for allocating costs between the various services provided by the legal entity, separate by provider number. The provider must demonstrate in their cost report the allocation base they used to distribute their total program costs to specific SUD programs and modality types. There is one Excel file that must be completed by the legal entity for each service site that has its own DMC number and DMC certification and maintains its separate accounting records. There are 23 worksheet tabs with data entry areas identified in yellow; however, most of the worksheet areas are automatically populated.

The SUD cost reporting forms were reviewed and approved by the Centers for Medicare and Medicaid Services (CMS) as part of the Medicaid state plan amendment 09-022 review. Direct costs and indirect costs are recognized consistent with federal cost principles, including 2 CFR 200 Subpart E, Medicare cost principles (42 CFR 413 and Medicare Provider Reimbursement Manual Parts 1 and 2), and Medicaid non-institutional reimbursement policy. Any substantive modification to the approved cost reporting form is subject to review and approval by CMS. For the purposes of determining DMC ODS county certified public expenditures for county-operated and contract providers under the 1115 waiver, each county as contractor with the State receives and aggregates the legal entity cost reports into a cost report for all DMC ODS services provided under the contract to eligible Medi-Cal beneficiaries. The county is responsible for certification of public expenditures. DHCS is reconciling the county cost, based on the aggregate of costs incurred by the county for payments to all subcontracted providers and costs incurred by the county-operated providers. Cost reports completed by non-county (i.e., contracted) legal entities (which are required to file cost reports for non-NTP services under the Medicaid state plan), and cost reports completed by county-operated providers, are used to determine the DMC ODS expenditures under the 1115 waiver. These cost reports are used to determine if the reconciled amount was the lower of cost or customary charge (and in the case of dosing and individual/group sessions provided by county-operated NTP providers, the lowest of USDR or cost or customary charge). These cost reports are subject to audit by State and Federal authorities.

This attachment will remain operative until the effective date for the State's implementation of behavioral health payment reform no sooner than July 1, 2023, which will include a shift from the CPE-based framework to a prospective reimbursement rate methodology in DMC-ODS; DHCS will provide CMS with at least 30 days written notice prior to the effective date for behavioral health payment reform and the sunset of CPE-based payments for DMC-ODS, but the State will not be required to seek a formal demonstration amendment.

DEFINITIONS

1. "CMS" means the Centers for Medicare and Medicaid Services.
2. "Cost center" means a department or other unit within an organization to which costs may be charged for accounting purposes.
3. "DHCS" means the California Department of Health Care Services.
4. "Direct costs" means those that are directly incurred, consumed, expanded and identifiable for the delivery of the specific covered service, objective or cost center. Examples of direct costs include unallocated (i.e., directly assigned or directly charged) wages/salaries of employees for the time devoted and identifiable specifically to delivery of the covered services or the final cost objective such as intensive outpatient treatment, outpatient drug free treatment. Other direct costs may include direct materials, equipment, supplies, professional services and transportation that are directly acquired, consumed, or expended for the delivery of the specific covered service or objective.
5. "DMC" means Drug Medi-Cal.
6. "DMC unreimbursable costs" means costs that are not reimbursable or allowable in determining the provider's allowable costs in accordance to the California's Medicaid State Plan, the special terms and conditions of this 1115 demonstration waiver, federal and state laws and regulations, including 2 CFR Part 200 Subpart E, 42 CFR 413, Medicare

Provider Reimbursement Manuals, CMS non-institutional reimbursement policy and California Code of Regulations Titles 9 and 22 (to the extent that they do not conflict with federal cost principles).

7. "Indirect costs" means those costs: a) incurred for a common or joint objective benefiting more than one cost center or objective, and b) are not readily identifiable and assignable to the cost center or objectives specifically benefited, without effort disproportionate to the particular cost center or objective.
8. "Indirect cost rate" means a tool for determining the proportion of indirect costs each program should bear. It is the ratio (expressed as a percentage) of the indirect costs to a direct cost base. A provider's indirect cost rate must be determined and approved by a cognizant agency (federal or state agency).
9. "IOT" means intensive outpatient treatment.
10. "Legal Entity" means each county alcohol and drug department or agency, each corporation and its subsidiaries, sole proprietors, partnerships, agencies, or individual practitioners providing alcohol and drug treatment services under contract with the county alcohol and drug department or agency or with DHCS.
11. "NTP" or "OTP" means narcotic treatment program treatment.
12. "ODF" means outpatient drug free treatment.
13. "Percent of Direct Costs" means a tool for determining the proportion of indirect costs each program should bear. It is the ratio (expressed as a percentage) of each modality or cost center's direct costs to the total direct costs. Percent of Direct Costs is a variation of the Indirect Cost Rate which allows the allocation of indirect costs by line item rather than in aggregate.
14. "Interim Per Utilizer Per Month(PUPM) Rate" means the approved county specific monthly interim rate paid per beneficiary who utilized at least one substance use disorder service for the month in which the service(s) is rendered.
15. "PH" means partial hospitalization.
16. "SUD" means substance use disorder.
17. "Total Utilizer Months" means the number of months during which all beneficiaries utilized at least one substance use disorder service.

SUMMARY OF STATE-DEVELOPED COST REPORT

Modifications to the Current CMS Approved SUD Cost Report Forms

In order to collect accurate cost data for the additional services offered in the DMC ODS, it will be necessary to insert sections into each of the four modality-specific worksheets to capture data for all of the added DMC ODS services that will be offered in each level of care. These include adding case management, physician consultation, withdrawal management, recovery services. and additional medication-assisted treatment. DHCS will also need to add new tabs for Partial Hospitalization (PH) services. These tabs will also include the additional DMC ODS services as described above. These changes will not change how the forms calculate the amounts; they will just add the additional services into the current structure.

The other necessary modification is to remove the current statewide rates that are currently included on the forms. The Cost Allocation tab of the forms will calculate the cost per unit based on total allowable cost/total allowable units. This cost per unit will be used to reconcile the interim payments. The state will not use the current DMC Maximum Allowed for the ODS cost

settlement. However, all other limits including the USDR for NTP services and customary charges will continue to apply as they do under the state plan for DMC services.

Inpatient hospital-based residential and withdrawal management services include ASAM levels 3.7 and 4.

These services are reimbursable in the DMC ODS when they are delivered by a licensed and certified chemical dependency rehabilitation hospital (CDRH) or a licensed and certified freestanding acute psychiatric hospital (FAPH). CMS requires the use of the form CMS 2552-10 for all hospital cost reporting. Contracted CDHRs and FAPHs must submit a copy of the CMS 2552-10 to the county for the purpose of DMC ODS cost reporting. The information from the CMS 2552-10 submitted to the county will be used to identify the relevant cost data that the county will enter into the cost report system.

Cost Report Forms Description:

Provider Information and Certification Worksheet (Tab 1)

This worksheet collects legal entity details, including entity name, address, other contact information, and all related legal entity information under the same county contract. This worksheet is also where the legal entity representative signs and certifies that the cost report is accurate and complies with all Federal and State requirements.

Overall Cost Summary Worksheet (Tab 2)

This worksheet displays a summary of the totals for all the cost centers being reported. No data entry is necessary in this worksheet; information will automatically populate from the Overall Detailed Costs worksheet.

Overall Detailed Costs Worksheet (Tab 3)

This worksheet requires the legal entity to enter all necessary data related to all direct and indirect costs being reported. This worksheet must reflect all costs incurred by the legal entity related to their SUD services and it must demonstrate the allocation methodologies used by the legal entity (in accordance with applicable cost reimbursement standards) to distribute their costs across various cost centers.

Detailed Costs Worksheet (Tab 4 - ODF: Tab I - PH: Tab 12 - IOT: Tab 16 - Residential: Tab 20 - NTPI

This worksheet displays the results of all calculations for the cost reported for the specific modality. No data entry is necessary in this worksheet; information will automatically populate from other worksheets.

Detailed Adjustments For DMC Unreimbursable & Direct Costs Worksheet (Tab 5 - ODF: Tab 9 - PH: Tab 13 - IOT: Tab 17 - Residential: Tab 21 - NTP

This worksheet allows the legal entity to enter the breakout of costs from the program's general ledger for each of the cost categories between the different services. This information automatically populates data in the Detailed Costs worksheet and the Cost Allocation worksheet.

Cost Allocation Worksheet (Tab 6 - ODF; Tab 10 - PH: Tab 14 - IOT: Tab 18 Residential: Tab 22 - NTP)

This worksheet further identifies the breakout of costs between the different services and between private pay, DMC and non-DMC. The legal entity will enter the units of service and the rates that have been charged for the services. The worksheet calculates the maximum reimbursement for DMC services. All other areas are automatically populated based on data entry in other worksheet tabs.

Reimbursed Units Worksheet (Tab 7 - ODF: Tab 1l - PH: Tab 15 - IOT: Tab 19 Residential: Tab 23 - NTP)

This worksheet requires the legal entity to enter the approved units of DMC service based on a report generated by DHCS. There are areas on this sheet that are automatically populated from other worksheets. The worksheet produces specific reimbursement amounts by funding source and aid code category. The county will use the amounts from this worksheet for data entry into the cost report system application.

PUPM Reconciliation Report Description

The PUPM Reconciliation Report reconciles costs eligible for reimbursement with the total PUPM payments the county made to the Managed Care Plan (i.e., Certified Public Expenditures). For non-NTP services provided by non-county-operated providers, cost eligible for reimbursement are equal to the lower of the amount the managed care plan paid the contract provider or the prevailing charge for the same or similar service. For non-NTP services provided by county-operated providers, costs eligible for reimbursement are equal to county-operated provider's allowable cost. Reimbursement for non-NTP inpatient hospital services, provided either by non-county-operated providers or county-operated providers, will not exceed the provider's customary charge for the service. For NTP services provided by non-county operated providers, the cost eligible for reimbursement is equal to the lower of the USDR, or the provider's usual and customary charge for the same or similar services. For NTP services provided by county-operated providers, the cost eligible for reimbursement is equal to the lower of county-operated provider's allowable cost, the USDR, or the provider's usual and customary charge for the same or similar service. The following describes each tab in the PUPM Reconciliation Report and how it is used to calculate costs eligible for reimbursement and to compare those costs eligible for reimbursement to the county's certified public expenditures.

DMC ODS County Information Worksheet

This worksheet captures detailed contact information for the DMC ODS County and its contracted managed care plan. Contact information includes the county code; county name; managed care plan; and name, phone number, and e-mail address of the person the county wants the state to contact with questions about the PUPM Reconciliation Report.

Total Beneficiaries Served Worksheet

The DMC ODS County or contracted managed care plan must enter the total unduplicated beneficiaries served by month and aid code group based upon a report generated by DHCS. This worksheet calculates Total Utilizer Months.

Approved Units of Service Worksheet – Non-County-Operated Providers

The DMC ODS County or contracted managed care plan must enter on this worksheet the total approved units of service rendered by non-county-operated providers for the reporting fiscal year

by aid code group, modality, and population (i.e., perinatal or non-perinatal) based upon a report generated by DHCS.

Cost Per Unit of Service Worksheet – Non-County-Operated Providers

The DMC ODS County or contracted managed care plan must enter on this worksheet the cost of services for each DMC ODS covered service modality provided to Medi-Cal beneficiaries enrolled in the DMC ODS County for which the reconciliation report is submitted. This worksheet calculates the cost per unit of service for each service modality. This worksheet is also prepopulated with the prevailing charge for each service modality. The USDR is the prevailing charge for NTP services.

Third Party Revenue Worksheet

The managed care plan must enter any revenue it received from third parties for the units of service reported in the Approved Units of Service Worksheet.

Eligible Cost Worksheet

This worksheet calculates the managed care plan's eligible costs for each DMC ODS service modality. Eligible costs for each service modality is equal to the total units of service multiplied by the cost per unit of service minus third party revenue.

Eligible Prevailing Charges Worksheet

This worksheet calculates the total prevailing charges less third party revenue for each DMC ODS service modality. Eligible prevailing charges is equal to the total units of service multiplied by the prevailing charge per unit of service minus third party revenue.

Cost Allocation Worksheet

This worksheet calculates the proportion of eligible costs that are to be reimbursed by the federal government, state government, and county government by service modality.

Prevailing Charges For Non-County-Operated Providers Allocation Worksheet

This worksheet calculates the proportion of eligible prevailing charges that would be reimbursed by the federal government, state government, and county government by service modality.

UPL/Budget Neutrality Demonstration Worksheet

This worksheet compares the total actual cost to total prevailing charges by aid code group, selects the lower of total actual cost or prevailing charges, and calculates federal reimbursement based upon the lower of total actual cost or prevailing charges.

County Contracted MCP Reconciliation Worksheet

This worksheet reconciles contracted managed care plan's actual costs eligible for reimbursement with the County interim PUPM payments to the managed care plan. The County or the contracted managed care plan must enter actual costs eligible for reimbursement by aid code group for county-operated providers as determined in the cost report form described on page 5. The worksheet adds the actual costs eligible for reimbursement for non-county-operated providers to calculate the total costs eligible for reimbursement. The county must enter the total interim payments made to the managed care plan. The amount of total costs eligible for reimbursement

less County interim payments to the contracted managed care plan equals the amount due to or from the contracted managed care plan.

DHCS County Reconciliation Worksheet

This worksheet reconciles the DMC ODS County's final total payments to the contracted managed care plan for DMC ODS services with total interim payments made to the DMC ODS County for those services. The DMC ODS County received an overpayment when interim payments exceed the DMC ODS County's final total payments. DHCS will recoup any overpayments to the DMC ODS County and return the overpayment to the federal government. The DMC ODS County received an underpayment when its final total payments to the managed care plan exceed interim payments. DHCS will made addition interim payments to the DMC ODS County when there is an under payment. DHCS will not pay a DMC ODS county more than the amount it paid the managed care plan for DMC ODS services rendered.

County Certification

The County Auditor Controller must certify the final total payments to the managed care plan as reported in the Total Payments Worksheet.

INTERIM RATE SETTING METHODOLOGY

Each county's interim CPE claim submitted to the state will be based on the services provided and the approved county interim rates or county interim PUPM rate for the covered services. Annual county interim rates for each covered service will be developed by the county and approved by the State. Annual county interim PUPM rates for the covered services will also be approved by the State. The approved interim rates will be specified in the State/County contract. These interim rates must conform to SSA §1903(w)(6) and §42 CFR 433.51. All interim payments for services rendered by contract providers and county operated providers will be subject to annual reconciliation and cost settlement consistent with Federal and State requirements. All interim payments for services rendered through contracts with a managed care plan will be subject to an annual reconciliation.

Proposed county interim rates must be developed for each required and (if indicated) optional service modality. The proposed county interim rates must be developed consistent with the terms and conditions of the Waiver, written guidance provided by DHCS, and federal certified public expenditure (CPE) requirements related to interim payments; and are subject to annual reconciliation and cost settlement.

Proposed county interim PUPM rates must be developed for all required and optional service modalities. The proposed county interim PUPM rates must be developed consistent with the terms and conditions of the Waiver, written guidance provided by DHCS, and federal certified public expenditure (CPE) requirements related to interim payments; and are subject to annual reconciliation.

The proposed county interim rates and county interim PUPM rates should be based on the most recently calculated or estimated total county cost with adjustments for projected increases in utilization and the application of the Home Health Agency Market Basket inflation factor. The proposed interim rate should be calculated for each service including both county directly

delivered (if appropriate), and subcontracted fee for service provider costs. For county-operated services the county will be reimbursed based on actual allowable costs. County payments to contracted fee for service providers and managed care plans are considered to be actual expenditures according to the terms and conditions of the waiver.

Uniform Statewide Daily Reimbursement Rate Methodology for DMC ODS Narcotic Treatment Programs

The uniform statewide daily reimbursement (USDR) rate for the daily dosing service is based on the average daily cost of providing dosing and ingredients, core and laboratory work services as described in State Plan Amendment (SPA) 09-022, Section D. The daily cost is determined based on the annual cost per patient and a 365- day year, using the most recent and accurate data available, and in consultation with narcotic treatment providers, and county alcohol and drug program administrators. The uniform statewide daily reimbursement rates for NTP Individual and Group Counseling are based on the non-NTP Outpatient Drug Free Individual and Group Counseling SMA rates as described under SPA 09-022, Section E.1.a.

For interim rate purposes, county-operated NTP/OTP providers are reimbursed at the USDR for dosing, individual/group sessions. However, additional ODS services available to county operated NTPs (case management, physician consultation, recovery services) will be reimbursed at county interim rates discussed above.

For a county that contracts with a managed care plan, the USDR rates for NTP services will serve as the upper payment limit for reconciliation purposes. The managed care plan will pay the provider the lower of the USDR or the provider's usual and customary charge for NTP services.

INTERIM MEDICAID PAYMENTS

The State makes interim payments of FFP to the DMC ODS counties based upon submitted expenditures. The DMC ODS counties will submit monthly CPE claims to the state for interim payments for services provided during the fiscal period. When submitting a claim for FFP for services provided by a county-operated or contracted provider, the DMC ODS county is required to certify that it has made expenditures on which the claim for FFP is based, that the expenditures are no greater than the actual county cost of providing services, and that the expenditures meet all federal and State requirements for claiming FFP. Interim payments for FFP for county contracts with county-specific rates by covered service will be available through claim adjudication for those expenditures the contracting county has officially certified. This certification must satisfy all federal Medicaid and State Medi-Cal CPE, full funds expenditure (federal and non-federal share expenditure), and claims integrity requirements. Claims will be reimbursed at the annual interim rates for each covered service developed by the county participating in the demonstration and approved by the State. All interim rates must conform to 42 CFR. 433.51, and all certified public expenditures continue to be subject to annual reconciliation and cost settlement consistent with Federal and State requirements.

Interim payments of FFP for services rendered through county contracts with managed care plans will be available through claim adjudication at the county Interim PUPM rate for those expenditures the contracting county has officially certified. This certification must satisfy all federal Medicaid and State Medi-Cal CPE, full funds expenditure (federal and non-federal share

expenditure), and claims integrity requirements. Claims will be reimbursed at the interim PUPM rate developed by the county participating in the demonstration and approved by the State. All interim PUPM rates must conform to 42 CFR. 433.51, and all certified public expenditures continue to be subject to annual reconciliation consistent with Federal and State requirements.

INTERIM RECONCILIATION OF INTERIM MEDICAID PAYMENTS – COUNTY SPECIFIC RATES

Consistent with the cost report submission, acceptance, reconciliation, and settlement process outlined in the state plan for DMC services, DHCS will complete the interim settlement of the DMC ODS county cost report no later than eighteen months after the close of the State fiscal year. Each DMC ODS county's expenditures that are used to claim interim FFP payments are reconciled to its State-developed cost report package for the State fiscal year in which services were provided. Each DMC ODS county cost report package is an aggregate of expenditures incurred for payments made to contracted providers and expenditures incurred by county-operated providers as determined through individual legal entity cost reports. Reimbursement under the DMC ODS program is available only for allowable costs incurred for providing DMC ODS services during the fiscal year to eligible Medi-Cal beneficiaries as specified in the special terms and conditions of this 1115 waiver demonstration. If, at the end of the interim reconciliation process, it is determined that a county received an overpayment, the overpayment is properly credited to the federal government in accordance with 42 CFR 433.316. If, at the end of the interim reconciliation process, it is determined that a county received an underpayment, an additional payment is made to the county. The State uses the following process to complete its interim reconciliation of interim Medicaid payments of FFP.

Participating counties and their contracted non-NTP providers must maintain fiscal and statistical records for the period covered by the cost report that are accurate and sufficiently detailed to substantiate the cost report data. The records must be maintained for a period of ten years from the date of service for all claims for reimbursement. All records of funds expended and costs reported are subject to review and audit by DHCS and/or the federal government pursuant to the California Welfare and Institutions Code Section 14124.24(g)(2) and 14170.

Participating counties and their contracted non-NTP providers must compute allowable costs and determine their allocation methodology in accordance with applicable cost reimbursement principles in 42 CFR Part 413, CMS-Pub 15-1 and 15-2, 2 CFR Part 200 Subpart E, CMS noninstitutional reimbursement policy, and California Code of Regulations (CCR) Title 9 and Title 22 (to the extent that they do not conflict with federal cost principles). Direct and indirect costs are determined and allocated using a methodology consistent with that approved for DMC state plan services, except that the methodology is applied to waiver services. The cost allocation plan must identify, accumulate, and distribute allowable direct and indirect costs and identify the allocation methods used for distribution of indirect costs. Although there are various methodologies available for determining actual direct costs and for allocating actual indirect costs, for consistency, efficiency and compliance with federal laws and regulations, the cost report identifies direct cost categories for each modality and establishes a standard methodology of percentage of total direct cost to allocate indirect costs. This methodology is a variation of the indirect cost rate methodology in 2 CFR Part 225 (OMB Circular A-87) and 2 CFR Part 230 (OMB Circular A-122). DHCS recognizes that there are other indirect cost allocation bases (such

as percentage of direct salaries and wages) that result in an equitable distribution of indirect administrative overhead. However, if a provider wishes to use an indirect cost allocation basis other than the one prescribed in the cost report, the provider must obtain their respective county's prior approval. Before granting approval to the provider, the county must seek DHCS's approval and DHCS will make a final determination of the propriety of the methodology used. All allocation plans will still be subject to a review during a DHCS financial audit.

INTERIM RECONCILIATION OF INTERIM PUPM PAYMENTS

DHCS will complete the interim reconciliation and settlement of DMC ODS counties' interim PUPM payments to managed care plans with which they contract no later than twelve months after the close of the State fiscal year. Each DMC ODS county that contracts with a managed care plan must submit a PUPM Reconciliation Report to DHCS by November 1st following the close of the fiscal year. DHCS staff will review the PUPM Reconciliation Report to validate the total beneficiaries served, total approved units of service, and rate per service modality. If the Interim Reconciliation Worksheet shows that the DMC ODS County made additional payments to the managed care plan, DHCS will make an additional payment of FFP to the DMC ODS County. If the Interim Reconciliation Worksheet shows that the DMC ODS County recouped a portion of the Interim PUPM payments already paid to the managed care plan, DHCS will recoup those funds from the DMC ODS County and return them to the federal government. Participating counties and their contracted managed care plan must maintain fiscal and statistical records for the period covered by PUPM Reconciliation report that are accurate and sufficiently detailed to substantiate the PUPM reconciliation data. The records must be maintained for a period of ten years from the date of service for all claims for reimbursement.

All records of funds expended and services rendered are subject to review and audit by DHCS and/or the federal government pursuant to the California Welfare and Institutions Code Section 14124.24(g)(2) and 14170.

FINAL RECONCILIATION OF INTERIM MEDICAID PAYMENTS

Consistent with the cost report submission, acceptance, reconciliation, and settlement process outlined in the state plan for DMC services, the State will audit and complete the final reconciliation and settlement of the cost report or PUPM reconciliation within three years from the date of the interim settlement. The audit performed by the State determines whether the income, expenses, and statistical data reported on the cost report or reconciliation are reasonable, allowable, and in accordance with State and federal rules, regulations, and Medicare principles of reimbursement issued by the Department of Health and Human Services and CMS. The audit also determines that the county's cost report accurately represents the actual cost of operating the DMC program in accordance with Generally Accepted Accounting Principles (GAAP), Title 42, Code of Federal Regulations (42 CFR), Office of Management and Budget (OMB) Circular A-87, Generally Accepted Auditing Standards (GAAS), Generally Accepted Governmental Auditing Standards (GAGAS) as published by the Comptroller General of the United States and other State and federal regulatory authorities. The State audit staff compares the FFP due to the county in the audited cost report with all interim payments, including the interim settlement and supplemental payments to eligible entities. The purpose of this comparison or review is for the State to determine if an overpayment or underpayment exists, and ensure that any overpayment of FFP is promptly returned to the federal government per 42 CFR 433.316 and 433.320. If the State

determines that the county received an underpayment, the State makes an additional payment to the county.

COVID-19 PUBLIC HEALTH EMERGENCY

Notwithstanding any other provisions in this Attachment, the following modified requirements will apply for non-NTP services provided on or after March 1, 2020, until the COVID-19 public health emergency ends:

- Each DMC ODS county may pay contracted providers at up to 100 percent above the approved county-specific negotiated rates, subject to contracted provider cost reconciliation as discussed in this Attachment.
- For purposes of interim Medicaid payments, claims will be reimbursed at the lower of the county's billed amount or the approved annual interim rates for each covered service increased by 100 percent.
- For purposes of interim and final reconciliation, DHCS will settle interim payments for outpatient services to actual allowable cost. The limitation of customary charges is suspended.
- For inpatient hospital-based residential and withdrawal management services (including ASAM levels 3.7 and 4), DHCS will continue to settle interim payments to the lower of actual allowable cost or usual and customary charges.

To the extent necessary to implement these modified requirements, all conflicting provisions in this Attachment are suspended.

Attachment J
SUD Monitoring Protocol

Attachment J
SUD Monitoring Protocol

What follows are the Planned Metrics and Reporting Schedule tabs from the SUD monitoring protocol workbook (part A). The full workbook is also available in spreadsheet format on Medicaid.gov.

Medicaid Section 1115 SUD Demonstrations Monitoring Protocol (Part A) - Planned Metrics (Version 6.0)
State California
Demonstration Name CalAIM

Table: Substance Use Disorder Demonstration Planned Metrics

Standard information on CMS-provided metrics											Baseline, annual goals, and demonstration target			Alignment with CMS-provided technical specifications manual		Phased-in metrics reporting		
#	Metric name	Metric description	Milestone or reporting topic[a]	Metric type	Reporting category	Data source	Measurement period	Reporting frequency	Reporting priority	State will report (Y/N)	Baseline reporting period (MM/DD/YYYY-MM/DD/YYYY)	Annual goal	Overall demonstration target	Attest that planned reporting matches the CMS-provided technical specifications manual (Y/N)	Explanation of any deviations from the CMS-provided technical specifications manual (different data source, definition, codes, target population, etc.)[b,c]	State plans to phase in reporting (Y/N)	SUD monitoring report in which metric will be phased in (Format DY#Q#; e.g., DY1Q3)	Explanation of any plans to phase in reporting over time
EXAMPLE: 1 ***(Do not delete or edit this row)***	*EXAMPLE: Assessed for SUD Treatment Needs Using a Standardized Screening Tool*	*EXAMPLE: Number of beneficiaries screened for SUD treatment needs using a standardized screening tool during the measurement period*	*EXAMPLE: Assessment of need and qualification for SUD treatment services*	*EXAMPLE: CMS-constructed*	*EXAMPLE: Other monthly and quarterly metrics*	*EXAMPLE: Medical record review or claims*	*EXAMPLE: Month*	*EXAMPLE: Quarterly*	*EXAMPLE: Recommended*	*EXAMPLE: Y*	*EXAMPLE: 07/01/2018-06/30/2019*	*EXAMPLE: Increase*	*EXAMPLE: Increase*	*EXAMPLE: N*	*EXAMPLE: The Department will use state-defined procedure codes (list specific codes) to calculate this metric.*	*EXAMPLE: Y*	*EXAMPLE: DY2Q1*	*EXAMPLE: This measure requires an update to the Adult Needs and Strengths Assessment tool that reflects an ASAM level of treatment. The work is in the testing phase with anticipated go live in mid to late 2021.*
1	Assessed for SUD Treatment Needs Using a Standardized Screening Tool	Number of beneficiaries screened for SUD treatment needs using a standardized screening tool during the measurement period	Assessment of need and qualification for SUD treatment services	CMS-constructed	Other monthly and quarterly metrics	Medical record review or claims	Month	Quarterly	Recommended	N								
2	Medicaid Beneficiaries with Newly Initiated SUD Treatment/Diagnosis	Number of beneficiaries who receive MAT or a SUD-related treatment service with an associated SUD diagnosis during the measurement period but not in the three months before the measurement period	Assessment of need and qualification for SUD treatment services	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Recommended	N								
3	Medicaid Beneficiaries with SUD Diagnosis (monthly)	Number of beneficiaries who receive MAT or a SUD-related treatment service with an associated SUD diagnosis during the measurement period and/or in the 11 months before the measurement period	Assessment of need and qualification for SUD treatment services	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	1/1/2022-12/31/2022	consistent	consistent	Y		N		
4	Medicaid Beneficiaries with SUD Diagnosis (annually)	Number of beneficiaries who receive MAT or a SUD-related treatment service with an associated SUD diagnosis during the measurement period and/or in the 12 months before the measurement period	Assessment of need and qualification for SUD treatment services	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	1/1/2022-12/31/2022	consistent	consistent	Y		N		
5	Medicaid Beneficiaries Treated in an IMD for SUD	Number of beneficiaries with a claim for inpatient/residential treatment for SUD in an IMD during the measurement period.	Milestone 2	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	1/1/2022-12/31/2022	consistent	decrease	Y	See attachment for metric 5 calculation methods.	N		
6	Any SUD Treatment	Number of beneficiaries enrolled in the measurement period receiving any SUD treatment service, facility claim, or pharmacy claim during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	1/1/2022-12/31/2022	consistent	consistent	Y		N		
7	Early Intervention	Number of beneficiaries who used early intervention services (such as procedure codes associated with SBIRT) during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	1/1/2022-12/31/2022	consistent	increase	Y		N		
8	Outpatient Services	Number of beneficiaries who used outpatient services for SUD (such as outpatient recovery or motivational enhancement therapies, step down care, and monitoring for stable patients) during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	1/1/2022-12/31/2022	consistent	consistent	Y		N		
9	Intensive Outpatient and Partial Hospitalization Services	Number of beneficiaries who used intensive outpatient and/or partial hospitalization services for SUD (such as specialized outpatient SUD therapy or other clinical services) during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	1/1/2022-12/31/2022	consistent	consistent	Y		N		
10	Residential and Inpatient Services	Number of beneficiaries who use residential and/or inpatient services for SUD during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	1/1/2022-12/31/2022	consistent	decrease	Y		N		
11	Withdrawal Management	Number of beneficiaries who use withdrawal management services (such as outpatient, inpatient, or residential) during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	1/1/2022-12/31/2022	consistent	consistent	Y		N		
12	Medication-Assisted Treatment	Number of beneficiaries who have a claim for MAT for SUD during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	1/1/2022-12/31/2022	consistent	consistent	N	The Department will supplement CMS-provided technical specifications for this metric with codes from CMS Core Set MY2020 OUD measure specifications related to NDCs for OUD Treatments (updated as of May 2020; available at https://www.medicaid.gov/license/form/6461/120781). It was not feasible to embed specific NDC codes in this locked workbook.	N		
13	SUD Provider Availability	The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period	Milestone 4	CMS-constructed	Other annual metrics	Provider enrollment database; Claims	Year	Annually	Required	Y	1/1/2022-12/31/2022	consistent	increase	Y	See attachment for metric 13 calculation methods.	N		
14	SUD Provider Availability - MAT	The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period and who meet the standards to provide buprenorphine or methadone as part of MAT	Milestone 4	CMS-constructed	Other annual metrics	Provider enrollment database; Claims;	Year	Annually	Required	Y	1/1/2022-12/31/2022	consistent	increase	Y	See attachment for metric 14 calculation methods.	N		
15	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD) [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]	Percentage of beneficiaries age 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following: • Initiation of AOD Treatment—percentage of beneficiaries who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis • Engagement of AOD Treatment—percentage of beneficiaries who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit The following diagnosis cohorts are reported for each rate: (1) Alcohol abuse or dependence, (2) Opioid abuse or dependence, (3) Other drug abuse or dependence, and (4) Total AOD abuse or dependence. A total of 8 separate rates are reported for this measure.	Milestone 6	Established quality measure	Annual metrics that are established quality measures	Claims	Year	Annually	Required	Y	1/1/2022-12/31/2022	consistent	increase	Y		N		
16	SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge [Joint Commission]	SUB-3: Patients who are identified with alcohol or drug use disorder who receive or refuse at discharge a prescription for FDA-approved medications for alcohol or drug use disorder, OR who receive or refuse a referral for addictions treatment. SUB-3a: Patients who are identified with alcohol or drug use disorder who receive a prescription for FDA-approved medications for alcohol or drug use disorder OR a referral for addictions treatment.	Milestone 6	Established quality measure	Annual metrics that are established quality measures	Medical record review or claims	Year	Annually	Recommended	N								
17(1)	Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence (FUA-AD) [NCQA; NQF #3488; Medicaid Adult Core Set; Adjusted HEDIS measure][d]	Percentage of ED visits for beneficiaries age 18 and older with a principal diagnosis of AOD abuse or dependence who had a follow-up visit for AOD abuse or dependence. Two rates are reported: - Percentage of ED visits for which the beneficiary received follow-up within 30 days of the ED visit (31 total days). - Percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit (8 total days).	Milestone 6	Established quality measure	Annual metrics that are established quality measures	Claims	Year	Annually	Required	Y	1/1/2022-12/31/2022	consistent	increase	Y		N		
17(2)	Follow-up after Emergency Department Visit for Mental Illness (FUM-AD) [NCQA; NQF #3489; Medicaid Adult Core Set; Adjusted HEDIS measure][e]	Percentage of ED visits for beneficiaries age 18 and older with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. Two rates are reported: - Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit (31 total days) - Percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit (8 total days).	Milestone 6	Established quality measure	Annual metrics that are established quality measures	Claims	Year	Annually	Required	Y	1/1/2022-12/31/2022	consistent	increase	Y		N		
18	Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD) [PQA, NQF #2940; Medicaid Adult Core Set]	Percentage of beneficiaries age 18 and older who received prescriptions for opioids with an average daily dosage greater than or equal to 90 morphine milligram equivalents (MME) over a period of 90 days or more. Beneficiaries with a cancer diagnosis, sickle cell disease diagnosis, or in hospice are excluded.	Milestone 5	Established quality measure	Annual metrics that are established quality measures	Claims	Year	Annually	Required	Y	1/1/2022-12/31/2022	consistent	decrease	Y		N		
19	Use of Opioids from Multiple Providers in Persons without Cancer (OMP) [PQA; NQF #2950]	The percentage of individuals ≥18 years of age who received prescriptions for opioids from ≥4 prescribers AND ≥4 pharmacies within ≤180 days.	Milestone 5	Established quality measure	Annual metrics that are established quality measures	Claims	Year	Annually	Recommended	N								
20	Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer (OHDMP) [PQA, NQF #2951]	The percentage of individuals ≥18 years of age who received prescriptions for opioids with an average daily dosage of ≥90 morphine milligram equivalents (MME) AND who received prescriptions for opioids from ≥4 prescribers AND ≥4 pharmacies.	Milestone 5	Established quality measure	Annual metrics that are established quality measures	Claims	Year	Annually	Recommended	N								
21	Concurrent Use of Opioids and Benzodiazepines (COB-AD) [PQA, NQF #3389; Medicaid Adult Core Set]	Percentage of beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines. Beneficiaries with a cancer diagnosis, sickle cell disease diagnosis, or in hospice are excluded.	Milestone 5	Established quality measure	Annual metrics that are established quality measures	Claims	Year	Annually	Required	Y	1/1/2022-12/31/2022	consistent	consistent	Y		N		
22	Continuity of Pharmacotherapy for Opioid Use Disorder [USC; NQF #3175]	Percentage of adults 18 years of age and older with pharmacotherapy for OUD who have at least 180 days of continuous treatment	Milestone 1	Established quality measure	Annual metrics that are established quality measures	Claims	Year	Annually	Required	Y	1/1/2021 – 12/31/2022	consistent	consistent	Y		N		
23	Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries	Total number of ED visits for SUD per 1,000 beneficiaries in the measurement period	Milestone 5	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	1/1/2022-12/31/2022	consistent	decrease	Y		N		
24	Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries	Total number of inpatient stays per 1,000 beneficiaries in the measurement period	Other SUD-related metrics	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	1/1/2022-12/31/2022	consistent	decrease	Y		N		
25	Readmissions Among Beneficiaries with SUD	The rate of all-cause readmissions during the measurement period among beneficiaries with SUD	Milestone 6	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	1/1/2022-12/31/2022	consistent	decrease	Y		N		
26	Overdose Deaths (count)	Number of overdose deaths during the measurement period among Medicaid beneficiaries living in a geographic area covered by the demonstration. The state is encouraged to report the cause of overdose death as specifically as possible (for example, prescription vs. illicit opioid).	Other SUD-related metrics	CMS-constructed	Other annual metrics	State data on cause of death	Year	Annually	Required	Y	1/1/2022-12/31/2022	consistent	decrease	Y		N		
27	Overdose Deaths (rate)	Rate of overdose deaths during the measurement period among adult Medicaid beneficiaries living in a geographic area covered by the demonstration. The state is encouraged to report the cause of overdose death as specifically as possible (for example, prescription vs. illicit opioid).	Milestone 5	CMS-constructed	Other annual metrics	State data on cause of death	Year	Annually	Required	Y	1/1/2022-12/31/2022	consistent	decrease	Y		N		
28	SUD Spending	Total Medicaid SUD spending during the measurement period.	Other SUD-related metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Recommended	N								
29	SUD Spending Within IMDs	Total Medicaid SUD spending on inpatient/residential treatment within IMDs during the measurement period.	Other SUD-related metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Recommended	N								
30	Per Capita SUD Spending	Per capita SUD spending during the measurement period	Other SUD-related metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Recommended	N								
31	Per Capita SUD Spending Within IMDs	Per capita SUD spending within IMDs during the measurement period	Other SUD-related metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Recommended	N								
32	Access to Preventive/ Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD [Adjusted HEDIS measure]	The percentage of Medicaid beneficiaries with SUD who had an ambulatory or preventive care visit during the measurement period.	Other SUD-related metrics	Established quality measure	Annual metrics that are established quality measures	Claims	Year	Annually	Required	Y	1/1/2022-12/31/2022	consistent	increase	Y		N		
33	Grievances Related to SUD Treatment Services	Number of grievances filed during the measurement period that are related to SUD treatment services	Other SUD-related metrics	CMS-constructed	Grievances and appeals[f]	Administrative records	Quarter	Quarterly	Recommended	N								

Table: Substance Use Disorder Demonstration Planned Metrics

Standard information on CMS-provided metrics											Baseline, annual goals, and demonstration context			Alignment with CMS-provided technical specifications manual		Planned interpretive reporting	
34	Appeals Related to SUD Treatment Services	Number of appeals filed during the measurement period that are related to SUD treatment	Other SUD-related metrics	CMS-constructed	Grievances and appeals	Administrative records	Quarter	Quarterly	Recommended	N							
35	Critical Incidents Related to SUD Treatment Services	Number of critical incidents filed during the measurement period that are related to SUD treatment services	Other SUD-related metrics	CMS-constructed	Grievances and appeals	Administrative records	Quarter	Quarterly	Recommended	N							
36	Average Length of Stay in IMDs	The average length of stay for beneficiaries discharged from IMD inpatient/residential treatment for SUD.	Milestone 2	CMS-constructed	Other annual metrics	Claims; State-specific IMD database	Year	Annually	Required	Y	1-1/2022-12-31/2022	decrease	No more than 30 days	Y	See attachment for metric 36 calculation methods.	N	
Q1	*Number of CBeds*	Total number of CURES Patient Activity Reports (PAR) searched.	Health IT	State-specific	Other annual metrics	Administrative records	Year	Annually	Required	Y	1-1/2022-12-31/2022	consistent	increase			N	
Q2	*Number of Web updates*	Total number of online CURES resources information updates published during the reporting period.	Health IT	State-specific	Other annual metrics	Administrative records	Year	Annually	Required	Y	1-1/2022-12-31/2022	consistent	consistent or increase			N	
Q3	*Number of corrections live*	Connecting corrections systems to SUD delivery system for incarcerated individual release to community	Health IT	State-specific	Other annual metrics	Administrative records	Year	Annually	Required	Y	1-1/2022-12-31/2022	consistent	increase			N	
State-specific metrics																	
Insert rows for any additional state-specific metrics by right-clicking on row 31 and selecting "Insert"																	

[a] There are no CMS-provided metrics related to milestone 3.

[b] If the state is not reporting a required metric (i.e., column K = "N"), enter explanation in corresponding row in column P.

[c] The state should use column P to outline calculation methods for specific metrics as explained in Version 4.0 of the Medicaid Section 1115 Substance Use Disorder Demonstration Monitoring Protocol Instructions.

[d] Rates 1 and 2 reported for Metrics #170) correspond to rates 2 and 3 for Metric #17 from Version 1.1 of the the Medicaid Section 1115 Substance Use Disorder Demonstrations Technical Specifications for Monitoring Metrics

[e] Rates 1 and 2 reported for Metric #172) correspond to rates 1 and 2 for Metric #17 from Version 1.1 of the the Medicaid Section 1115 Substance Use Disorder Demonstrations Technical Specifications for Monitoring Metrics

[f] While grievances and appeals metrics are recommended for reporting, the state is required, per 42 CFR 431.420(a)5, to provide updates on the results of beneficiary satisfaction surveys, if conducted during the reporting year, including updates on grievances and appeals from beneficiaries, in its its annual (Q4) monitoring report.

Medicaid Section 1115 SUD Demonstrations Monitoring Protocol (Part A) - Reporting Schedule (Version 6.0)

State: California
Demonstration Name: CalAIM

Instructions:

(1) In the reporting periods input table (Table 1), use the prompt in column A to enter the requested information in the corresponding row of column B. All monitoring report names and reporting periods should use the format DY#Q# or CY# and all dates should use the format MM/DD/YYYY with no spaces in the cell. The information entered in these cells will auto-populate the SUD demonstration reporting schedule in Table 2. All cells in the input table must be completed in entirety and in the correct format for the standard reporting schedule to be accurately auto-populated.

(2) Review the state's reporting schedule in the SUD demonstration reporting schedule table (Table 2). For each of the reporting categories listed in column F, select Y or N in column H, "Deviation from standard reporting schedule (Y/N)" to indicate whether the state plans to report according to the standard reporting schedule. If a state's planned reporting does not match the standard reporting schedule for any quarter and/or reporting category (i.e., column H="Y"), the state should describe these deviations in column I, "Explanation for deviations (if column H="Y")" and use column J, "Proposed deviations from standard reporting schedule," to indicate the SUD measurement periods with which it wishes to overwrite the standard schedule (column G). All other columns are locked for editing and should not be altered by the state.

Table 1. Substance Use Disorder Demonstration Reporting Periods Input Table

	Demonstration reporting periods/dates
Dates of first SUD demonstration year (SUD DY1)	
Start date	01/01/2022
End date	12/31/2022
Dates of first quarter of the baseline reporting period for CMS-constructed metrics	
Reporting period (SUD DY and Q)	DY7Q1
Start date	01/01/2022
End date	03/31/2022
Broader section 1115 demonstration reporting period corresponding with the first SUD reporting quarter, if applicable. If there is no broader demonstration, fill in the first SUD reporting period. (Format DY#Q#; e.g., DY3Q1)	DY18Q1
First SUD monitoring report due date (per STCs) (MM/DD/YYYY)	05/30/2022
First SUD monitoring report in which the state plans to report annual metrics that are established quality measures (EQMs)	
Baseline period for EQMs	CY2022
SUD DY and Q associated with monitoring report	DY8Q3
SUD DY and Q start date (MM/DD/YYYY)	07/01/2023
SUD DY and Q end date (MM/DD/YYYY)	09/30/2023
Dates of last SUD reporting quarter:	
Start date	10/01/2026
End date	12/31/2026

*California first received approval for a SUD demonstration in 2015 and, as such, the first year of the state's demonstration extension beginning January 1, 2022 aligns with its SUD DY7. However, because the state will begin structured monitoring reporting using the standardized monitoring tools in CY 2022, this is considered as the state's baseline period for the purposes of monitoring reporting.

Table 2. Substance Use Disorder Demonstration Reporting Schedule

SUD reporting quarter start date (MM/DD/YYYY)	SUD reporting quarter end date (MM/DD/YYYY)	Monitoring report due (per STCs) (MM/DD/YYYY)	Broader section 1115 reporting period, if applicable; else SUD reporting period (Format DY#Q#; e.g., DY1Q3)	SUD reporting period (Format DY#Q#; e.g., DY1Q3)	Reporting category	For each reporting category, measurement period for which information is captured in monitoring report per standard reporting schedule (Format DY#Q#; e.g., DY1Q3)[b] SUD	Deviation from standard reporting schedule (Y/N/n.a.)	Explanation for deviations (if column H="Y")	Proposed deviation in measurement period from standard reporting schedule in column G (Format DY#Q#; e.g., DY1Q3)
01/01/2022	03/31/2022	05/30/2022	DY18Q1	DY7Q1	Narrative information	DY7Q1	N		
					Grievances and appeals	DY7Q1	N		
					Other monthly and quarterly metrics				
					Annual metrics that are established quality measures				
					Other annual metrics				
04/01/2022	06/30/2022	08/29/2022	DY18Q2	DY7Q2	Narrative information	DY7Q2	N		
					Grievances and appeals	DY7Q2	N		
					Other monthly and quarterly metrics	DY7Q1	N		
					Annual metrics that are established quality measures				
					Other annual metrics				
07/01/2022	09/30/2022	11/29/2022	DY18Q3	DY7Q3	Narrative information	DY7Q3	N		
					Grievances and appeals	DY7Q3	N		
					Other monthly and quarterly metrics	DY7Q2	N		
					Annual metrics that are established quality measures				
					Other annual metrics				
10/01/2022	12/31/2022	03/31/2023	DY18Q4	DY7Q4	Narrative information	DY7Q4	N		
					Grievances and appeals	DY7Q4	N		
					Other monthly and quarterly metrics	DY7Q3	N		
					Annual metrics that are established quality measures				
					Other annual metrics				
01/01/2023	03/31/2023	05/30/2023	DY19Q1	DY8Q1	Narrative information	DY8Q1	N		
					Grievances and appeals	DY8Q1	N		
					Other monthly and quarterly metrics	DY7Q4	N		
					Annual metrics that are established quality measures				
					Other annual metrics	DY7	N		
04/01/2023	06/30/2023	08/29/2023	DY19Q2	DY8Q2	Narrative information	DY8Q2	N		
					Grievances and appeals	DY8Q2	N		
					Other monthly and quarterly metrics	DY8Q1	N		
					Annual metrics that are established quality measures				
					Other annual metrics				
07/01/2023	09/30/2023	11/29/2023	DY19Q3	DY8Q3	Narrative information	DY8Q3	N		
					Grievances and appeals	DY8Q3	N		

SUD reporting quarter start date (MM/DD/YYYY)	SUD reporting quarter end date (MM/DD/YYYY)	Monitoring report due (per STCs) (MM/DD/YYYY)	Broader section 1115 reporting period, if applicable; else SUD reporting period (Format DY#Q#; e.g., DY1Q3)	SUD reporting period (Format DY#Q#; e.g., DY1Q3)	Reporting category	For each reporting category, measurement period for which information is captured in monitoring report per standard reporting schedule (Format DY#Q#; e.g., DY1Q3)[b] SUD	Deviation from standard reporting schedule (Y/N/n.a.)	Explanation for deviations (if column H="Y")	Proposed deviation in measurement period from standard reporting schedule in column G (Format DY#Q#; e.g., DY1Q3)
					Other monthly and quarterly metrics	DY8Q2	N		
					Annual metrics that are established quality measures	CY2022	N		
					Other annual metrics				
10/01/2023	12/31/2023	03/30/2024	DY19Q4	DY8Q4	Narrative information	DY8Q4	N		
					Grievances and appeals	DY8Q4	N		
					Other monthly and quarterly metrics	DY8Q3	N		
					Annual metrics that are established quality measures				
					Other annual metrics				
01/01/2024	03/31/2024	05/30/2024	DY20Q1	DY9Q1	Narrative information	DY9Q1	N		
					Grievances and appeals	DY9Q1	N		
					Other monthly and quarterly metrics	DY8Q4	N		
					Annual metrics that are established quality measures				
					Other annual metrics	DY8	N		
04/01/2024	06/30/2024	08/29/2024	DY20Q2	DY9Q2	Narrative information	DY9Q2	N		
					Grievances and appeals	DY9Q2	N		
					Other monthly and quarterly metrics	DY9Q1	N		
					Annual metrics that are established quality measures				
					Other annual metrics				
07/01/2024	09/30/2024	11/29/2024	DY20Q3	DY9Q3	Narrative information	DY9Q3	N		
					Grievances and appeals	DY9Q3	N		
					Other monthly and quarterly metrics	DY9Q2	N		
					Annual metrics that are established quality measures	CY2023	N		
					Other annual metrics				
10/01/2024	12/31/2024	03/31/2025	DY20Q4	DY9Q4	Narrative information	DY9Q4	N		
					Grievances and appeals	DY9Q4	N		
					Other monthly and quarterly metrics	DY9Q3	N		
					Annual metrics that are established quality measures				
					Other annual metrics				
01/01/2025	03/31/2025	05/30/2025	DY21Q1	DY10Q1	Narrative information	DY10Q1	N		
					Grievances and appeals	DY10Q1	N		
					Other monthly and quarterly metrics	DY9Q4	N		
					Annual metrics that are established quality measures				
					Other annual metrics	DY9	N		
04/01/2025	06/30/2025	08/29/2025	DY21Q2	DY10Q2	Narrative information	DY10Q2	N		
					Grievances and appeals	DY10Q2	N		
					Other monthly and quarterly metrics	DY10Q1	N		
					Annual metrics that are established quality measures				
					Other annual metrics				
07/01/2025	09/30/2025	11/29/2025	DY21Q3	DY10Q3	Narrative information	DY10Q3	N		
					Grievances and appeals	DY10Q3	N		
					Other monthly and quarterly metrics	DY10Q2	N		
					Annual metrics that are established quality measures	CY2024	N		
					Other annual metrics				
10/01/2025	12/31/2025	03/31/2026	DY21Q4	DY10Q4	Narrative information	DY10Q4	N		
					Grievances and appeals	DY10Q4	N		
					Other monthly and quarterly metrics	DY10Q3	N		
					Annual metrics that are established quality measures				
					Other annual metrics				
01/01/2026	03/31/2026	05/30/2026	DY22Q1	DY11Q1	Narrative information	DY11Q1	N		
					Grievances and appeals	DY11Q1	N		
					Other monthly and quarterly metrics	DY10Q4	N		
					Annual metrics that are established quality measures				
					Other annual metrics	DY10	N		
04/01/2026	06/30/2026	08/29/2026	DY22Q2	DY11Q2	Narrative information	DY11Q2	N		
					Grievances and appeals	DY11Q2	N		
					Other monthly and quarterly metrics	DY11Q1	N		
					Annual metrics that are established quality measures				
					Other annual metrics				
07/01/2026	09/30/2026	11/29/2026	DY22Q3	DY11Q3	Narrative information	DY11Q3	N		
					Grievances and appeals	DY11Q3	N		
					Other monthly and quarterly metrics	DY11Q2	N		
					Annual metrics that are established quality measures	CY2025	N		
					Other annual metrics				
10/01/2026	12/31/2026	03/31/2027	DY22Q4	DY11Q4	Narrative information	DY11Q4	N		
					Grievances and appeals	DY11Q4	N		
					Other monthly and quarterly metrics	DY11Q3	N		
					Annual metrics that are established quality measures				
					Other annual metrics				

[Add rows for all additional demonstration reporting quarters]

[a] **SUD demonstration start date**: For monitoring purposes, CMS defines the start date of the demonstration as the *effective date* listed in the state's STCs at time of SUD demonstration approval. For example, if the state's STCs at the time of SUD demonstration approval note that the demonstration is effective January 1, 2020 – December 31, 2025, the state should consider January 1, 2020 to be the start date of the demonstration. Note that that the effective date is considered to be the first day the state may begin its SUD demonstration. In many cases, the effective date is distinct from the approval date of a demonstration; that is, in certain cases, CMS may approve a section 1115 demonstration with an effective date that is in the future. For example, CMS may approve an extension request on December 15, 2020, with an effective date of January 1, 2021 for the new demonstration period. In many cases, the effective date also differs from the date a state begins implementing its demonstration. To generate an accurate reporting schedule, the start date as listed in Table 1 of the "SUD reporting schedule tab" should align with the first day of a month. If a state's SUD demonstration begins on any day other than the first day of the month, the state should list its start date as the first day of the month in which the effective date occurs. For example, if a state's effective date is listed as January 15, 2020, the state should indicate "01/01/2020" as the start date in Table 1 of the "SUD reporting schedule" tab. Please see Appendix A for more information on determining demonstration quarter timing.

[b] The auto-populated reporting schedule in Table 2 outlines the data the state is expected to report for each demonstration year and quarter. However, states are not expected to begin reporting any metrics data until after monitoring protocol approval. The state should see Section B of the Monitoring Report Instructions for more information on retrospective reporting of data following protocol approval.

Medicaid Section 1115 Substance Use Disorder Demonstrations
Monitoring Protocol Template

Note: PRA Disclosure Statement to be added here

1. Title page for the state's substance use disorder (SUD) demonstration or the SUD component of the broader demonstration

The state should complete this title page as part of its SUD monitoring protocol. Definitions for certain rows are provided below the table. The Performance Metrics Database and Analytics (PMDA) system will populate some rows of the table. The state should complete the rest of the table. The state can revise the demonstration goals and objectives if needed. PMDA will use this information to populate part of the title page of the state's monitoring reports.

State	California
Demonstration name	CalAIM
Approval period for section 1115 demonstration	*Enter the current approval period for the section 1115 demonstration as listed in the current special terms and conditions (STC), including the start date and end date (MM/DD/YYYY – MM/DD/YYYY).* *Start Date:* 01/01/2022 *End Date:* 12/31/2026
SUD demonstration start date[a]	*Enter the start date for the section 1115 SUD demonstration or SUD component if part of a broader demonstration (MM/DD/YYYY).* 01/01/2022
Implementation date of SUD demonstration, if different from SUD demonstration start date[b]	*Enter SUD demonstration implementation date (MM/DD/YYYY).* 01/01/2022
SUD (or if broader demonstration, then SUD-related) demonstration goals and objectives	*Enter summary of the SUD (or if broader demonstration, then SUD-related) demonstration goals and objectives.* During the demonstration period, the state seeks to achieve these goals: 1. Increased rates of identification, initiation, and engagement in treatment; 2. Increased adherence to and retention in treatment; 3. Reductions in overdose deaths, particularly those due to opioids; 4. Reduced utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services; 5. Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate; and 6. Improved access to care for physical health conditions among beneficiaries.

[a] **SUD demonstration start date:** For monitoring purposes, CMS defines the start date of the demonstration as the *effective date* listed in the state's STCs at time of SUD demonstration approval. For example, if the state's STCs at the time of SUD demonstration approval note that the SUD demonstration is effective January 1, 2020 – December 31, 2025, the state should consider January 1, 2020 to be the start date of the SUD demonstration. Note that the effective date is considered to be the first day the state may begin its SUD demonstration. In many cases, the effective date is distinct from the approval date of a demonstration; that is, in certain cases, CMS may approve a section 1115 demonstration with an effective date that is in the future. For example, CMS may approve an extension request on December 15, 2020, with an effective date of January 1, 2021 for the new demonstration period. In many cases, the effective date also differs from the date a state begins implementing its demonstration.

[b] **Implementation date of SUD demonstration:** The date the state began claiming or will begin claiming federal financial participation for services provided to individuals in institutions for mental disease.

2. Acknowledgement of narrative reporting requirements

☒ The state has reviewed the narrative questions in the Monitoring Report Template provided by CMS and understands the expectations for quarterly and annual monitoring reports. The state will provide the requested narrative information (with no modifications).

3. Acknowledgement of budget neutrality reporting requirements

☒ The state has reviewed the Budget Neutrality Workbook (which can be accessed via PMDA – see Monitoring Protocol Instructions for more details) and understands the expectations for quarterly and annual monitoring reports. The state will provide the requested budget neutrality information (with no modifications).

4. Retrospective reporting

The state is not expected to submit metrics data until after monitoring protocol approval, to ensure that data reflects the monitoring plans agreed upon by CMS and the state. Prior to monitoring protocol approval, the state should submit quarterly and annual monitoring reports with narrative updates on implementation progress and other information that may be applicable, according to the requirements in its STCs.

For a state that has monitoring protocols approved after one or more initial quarterly monitoring report submissions, it should report metrics data to CMS retrospectively for any prior quarters (Qs) of the section 1115 SUD demonstration that precede the monitoring protocol approval date. A state is expected to submit retrospective metrics data—provided there is adequate time for preparation of these data— in its second monitoring report submission that contains metrics. The retrospective monitoring report for a state with a first SUD demonstration year (DY) of less than 12 months, should include data for any baseline period Qs preceding the demonstration, as described in Part A of the state's monitoring protocols. (See Appendix B of the Monitoring Protocol Instructions for further instructions on determining baseline periods for first SUD DYs that are less than 12 months.) If a state needs additional time for preparation of these data, it should propose an alternative plan (i.e., specify the monitoring report that would capture the data) for reporting retrospectively on its section 1115 SUD demonstration.

In the monitoring report submission containing retrospective metrics data, the state should also provide a general assessment of metrics trends from the start of its demonstration through the end of the current reporting period. The state should report this information in Part B of its monitoring report submission (Section 3: Narrative information on implementation, by milestone and reporting topic). This general assessment is not intended to be a comprehensive description of every trend observed in the metrics data. Unlike other monitoring report submissions, for instance, the state is not required to describe all metric changes (+ or - greater than 2 percent). Rather, the assessment is an opportunity for a state to provide context on its retrospective metrics

data and to support CMS's review and interpretation of these data. For example, consider a state that submits data showing an increase in the number of medication-assisted treatment (MAT) providers (Metric #14) over the course of the retrospective reporting period. This state may decide to highlight this trend for CMS in Part B of its monitoring report (under Milestone 4) by briefly summarizing the trend and explaining that during this period, a grant supporting training for new MAT providers throughout its state was implemented.

For further information on how to compile and submit a retrospective monitoring report, the state should review Section B of the Monitoring Report Instructions document.

☒ The state will report retrospectively for any Qs prior to monitoring protocol approval as described above, in the state's second monitoring report submission that contains metrics after monitoring protocol approval.

☐ The state proposes an alternative plan to report retrospectively for any Qs prior to monitoring protocol approval: *Insert narrative description of proposed alternative plan for retrospective reporting. Regardless of the proposed plan, retrospective reporting should include retrospective metrics data and a general assessment of metric trends for the period. The state should provide justification for its proposed alternative plan.*

Attachment K
Global Payment Program Funding and Mechanics Protocol

Attachment K
Global Payment Program Funding and Mechanics Protocol

A. Public Health Care Systems (PHCS)

GPP Payments are available for PHCS, which are comprised of a designated public hospital and its affiliated and contracted providers. Each PHCS participating in the GPP is listed in Attachment C. Where multiple designated public hospitals are operated by the same legal entity, the PHCS includes multiple designated public hospitals, as set forth in Attachment C.

The GPP provides support for the delivery of more cost-effective and higher value care for indigent, uninsured individuals. PHCS will provide an assurance that, to the extent the GPP exceeds the amount that is attributable to the state's Adjusted DSH (determined pursuant to STC 78), a percentage of GPP points earned by each PHCS will be associated with care and activities that are furnished through charity care and discount payment policies for financially qualified, uninsured individuals that adhere to California state law ability-to-pay requirements. The required percentage is equal to the amount of the GPP that is in excess of the Adjusted DSH divided by the total GPP for the year. For the first year of the GPP, each PHCS is required in the aggregate to satisfy the above assurance for at least 21.4% of GPP points earned.

Each PHCS shall identify to DHCS the affiliated and contracted providers that will constitute the PHCS, and shall notify DHCS of changes.

B. Determination of GPP Annual Limits

For each GPP PY, DHCS shall work with CMS to determine the annual limit for the GPP consistent with STC 78. The annual limit shall be calculated as the sum of the Adjusted DSH allotment and the Uncompensated Care Component for PY 1-12. F. The Adjusted DSH allotment shall be determined consistent with the provisions of Attachment Q (DSH Coordination Methodology).

C. Establishment of Participating PHCS global budgets

DHCS will determine for each PHCS a global budget for each GPP PY, which is the total amount of funding each PHCS will earn if it meets or exceeds its applicable threshold. Threshold amounts for each PHCS for GPP PY1 are set forth in Attachment L, section B. Threshold amounts for subsequent GPP PYs will be calculated through adjustments in proportion to changes in the size of the aggregate GPP annual limits, except where otherwise allowed during a public health emergency or other state of emergency, as set forth in Attachment L, section B.

To determine a PHCS' global budget for a GPP year, DHCS shall calculate the PHCS' allocation percentage, which is the PHCS's point threshold for a GPP PY divided by the sum of all PHCS point thresholds for the same GPP PY. The PHCS's global budget shall equal the allocation percentage multiplied by the total computable annual limit for the GPP, as set forth in STC 78 of the Special Terms and Conditions ("Funding and Annual Limits").

DHCS shall determine an initial total computable annual limit for a GPP PY based on the initial CA DSH allotment published by CMS for the applicable GPP PY and any uncompensated care funding allocated under the applicable waiver. DHCS shall determine initial threshold amounts and annual budgets for each PHCS based on this information and publish the information on its GPP webpage within 10 days of the determination. Threshold amounts and annual budgets may be adjusted throughout the GPP PY in coordination with funding allocation adjustments.

DHCS shall determine the final total computable annual limit for a GPP PY upon CMS notification of the final CA DSH allotment and shall publish the final amounts, and associated PHCS threshold amounts and annual budgets within 10 days of such determination.

D. Reporting Requirements

By August 15th following each GPP PY, or with respect to GPP PY 6 through 12, by February 15th following the GPP PY, each PHCS shall submit an interim year-end summary report summarizing the aggregate number of uninsured units of service provided during the GPP PY, broken out by the service categories, tiers, and types as defined in Attachment L (GPP Valuation Methodology Protocol). The summary report will also compute the number of points earned based on the corresponding point valuations for the services provided, and the payments due to the PHCS (net of any payments previously received for the GPP PY). Data contained in the interim year-end summary report will be based on the best data available through the close of the GPP PY. Revisions to the interim data will be reflected in the final reconciliation report.

By March 31st following the close of each GPP PY, or with respect to GPP PY 6 through 12, by September 30th following the GPP PY each PHCS shall submit a final year-end reconciliation summary report in the same format as the interim year-end summary report referenced above that includes the PHCS final submission with regard to the services, points, and funds earned for the GPP PY. The final reconciliation summary report shall reflect any necessary revisions to the interim data and shall serve as the basis for the final reconciliation of GPP payments for the GPP PY.

Starting with GPP PY 2, each PHCS shall submit encounter-level data on their uninsured services in order to provide auditable verification that the reported uninsured services were provided. For this purpose, encounter-level data may include line-level encounters or documentation of claims or other reliable methods for determining the number of contracted units of service to the uninsured by contracted providers. Such reporting shall be provided at the time of the final reconciliation summary reports. All reports shall be submitted in a manner and format as set forth by DHCS. In addition, for all GPP PYs, PHCS shall maintain documentation of services and shall make such information available to DHCS or CMS upon request.

DHCS shall review all summary reports and data submitted for accuracy and compliance with established procedures, and perform tests for reasonableness. If discrepancies or inconsistencies are identified, DHCS shall work directly with PHCS staff to promptly resolve issues and correct data and reporting. PHCS shall provide a formal response to DHCS inquiries within five (5) business days of receipt of an inquiry or question; additional time to respond may be requested

by the PHCS and approved by DHCS.

The interim year-end summary report and the final year-end reconciliation summary report shall be due at the times specified in Tables 1 and 1.1 below. If the identified date falls on a weekend or holiday, the report shall be due at the close of the following business day.

Table 1: Reporting timeline, PY 1-6

Report name	**Reporting period**	**Report due date to DHCS**	**Reporting Period**	**Report Due Date to DCHS**
Interim year-end summary report	July 1 – June 30	August 15 (following program year)	GPP PY 6 July 1 – December 31	February 15 (following program year)
Final year-end reconciliation	July 1 – June 30	March 31 (following program year)	GPP PY 6 July 1 – December 31	September 30 (following program year)

Table 1.1: Reporting timeline, PY 7-12

Report name	**Reporting period**	**Report due date to DHCS**
Interim year-end summary report	January 1 – December 31	February 15 (following program year)
Final year-end reconciliation	January 1 – December 31	September 30 (following program year)

E. Payment schedule

Interim Payments

PHCS shall receive interim quarterly GPP payments based on 25% of their annual global budget for the first three quarters of the GPP PY. DHCS will notify PHCS of the IGT due dates and payment dates according to Tables 2 and 2B. For GPP PY 6, PHCS shall receive only two quarterly payments, each based on 50% of their annual budget. DHCS will notify PHCS of the

IGT due dates and payment dates according to Table 2A. Payments will be made within 15 days after the quarter end as long as IGTs are submitted by the IGT due date as identified in Tables 2, 2A, and 2B. However, beginning in PY 7, quarter 2 payments will be made within 30 days after the quarter end as long as IGTs are submitted by the IGT due date as identified in Table 2B. For a PHCS that is comprised of more than one DPH, payments will be made to the health system under which the DPHs operate.

For the fourth quarter of each GPP PY, an interim payment shall be made to each PHCS that is sufficient to bring the PHCS' interim payments for the GPP PY to the amount earned by the PHCS based on its interim year-end summary report. The total Interim payments earned by a PHCS shall be determined by multiplying the PHCS's annual global budget by the ratio of the value of the points earned during the GPP PY to the PHCS's threshold, as reported in the interim year-end summary report; however, no PHCS may earn more than its annual global budget prorated by the number of months in the reporting period. The fourth quarter interim payment shall be calculated based on the amount earned by the PHCS for the GPP PY, net of any GPP payments previously received by the PHCS for the GPP PY. If the PHCS' interim year-end summary report reflects an annual payment that is less than 75% of its total annual budget, no additional interim payment shall be made for the fourth quarter. DHCS shall calculate the amount of the required IGTs for the fourth quarter and make GPP IGT notifications to all PHCS no later than 30 calendar days after submission of the interim year-end summary report, as shown in Tables 2 and 2B. PHCS shall submit IGTs within 7 days of receiving notification. Interim payments will be made to all PHCS no later than one month following their respective IGT notification date, if IGTs are received within the required 7 days.

Final Reconciliation and Redistribution Process

There will be a final reconciliation annually following the submission of each PHCS' final reconciliation summary report and (beginning with GPP PY 2) the required supporting encounter data. DHCS shall determine the amount earned by each PHCS based on the total number of points earned by each PHCS for the GPP PY, as reported in the final year-end reconciliation summary reports. For PHCS that exceeded their threshold for the GPP PY, the amount earned is subject to adjustment in accordance with the following redistribution process set forth below.

DHCS will identify any GPP global budget amounts that PHCS were individually unable to claim and redistribute such unclaimed amounts to the PHCS that exceeded their point thresholds for the applicable GPP PY. To determine redistribution amounts, DHCS shall first calculate a dollar amount of funding per GPP point by dividing the total GPP annual limit for the GPP PY by the aggregate threshold points for all PHCS. DHCS will then multiply this dollar amount by the amount by which each PHCS has exceeded its threshold to determine the PHCS's maximum redistribution amount. Each PHCS that has exceeded its threshold will receive its maximum redistribution amount if there are sufficient unused funds for the year from other PHCS. If there are insufficient unused funds to pay all PHCS that exceeded their thresholds their maximum redistribution amount, then each PHCS will receive an adjusted redistribution amount, prorating the amount of unused funds available by the number of points each PHCS is above its applicable threshold. The redistributed amounts following this determination shall be added to the GPP amounts earned by the applicable PHCS for the purposes of the final reconciliation.

Based on the final reconciliation amounts determined as set forth above, DHCS shall adjust, as necessary, the interim payments previously made to the PHCS for the GPP PY. Within 90 calendar days of receiving the final reconciliation summary reports from the PHCS DHCS shall calculate the amount of the required IGTs for the reconciliation and make GPP IGT notifications to all PHCS, as shown in Tables 2, 2A and 2B.

PHCS shall submit IGTs within 14 days of receiving notification. Final payments will be made to all PHCS no later than 45 days following their respective IGT notification date, if PHCS have submitted the IGTs within the 14-day requirement. If the necessary IGTs are submitted past the 14-day requirement, final payments, as well as any other associated payments, will be made no later than 45 days following submission of the necessary IGT amounts. If, at the end of the reconciliation process, it is determined that the interim GPP funds for a GPP PY exceeded the amounts due upon final reconciliation, DHCS shall recoup the amounts from the appropriate PHCS. In the event of any recoupments, DHCS shall return the associated IGT funds to the transferring entity within 14 calendar days.

Payment Summary Report to CMS

For each GPP PY, DHCS will submit a Payment Summary Report to CMS (following the schedule in Tables 2, 2A and 2B) that summarizes all GPP transactions to date which pertain to that GPP PY and includes a list of entities that have provided IGTs during the report period and the amount of the IGTs provided.

Transactions include interim payments, final payments, and recoupments. Each transaction record will include the name of the PHCS to which the transaction pertains, whether the transaction is an interim, reconciliation, or redistribution payment, the interim year-end Summary Report or Final Reconciliation Summary Report that supports the transaction, and the Quarterly Expenditure Report on which the transaction was or will be reported. The Payment Summary Report following the Final Reconciliation Summary Report will show how the sum of all transactions for each PHCS matches the PHCS final reconciliation amount.

Table 2: Interim and Final Payment timeline, GPP PY 1-5

Payment	Payment Amount	Payment Amount & IGT Notification Date	IGT Due Date	Payment Date	Payment Summary Report to CMS
Interim Quarter 1	25% of Annual	September 15	September 22	October 15	November 15
Interim Quarter 2	25% of Annual	December 15	December 22	January 15	February 15
Interim Quarter 3	25% of Annual	March 15	March 22	April 15	May 15
Interim Quarter 4	Final Interim based on interim year-end summary report	September 15 following the GPP PY end	September 22 following the GPP PY end	October 15 following GPP PY end	November 15 following GPP PY end

Final Reconciliation	Final reconciled amount	June 30 following the GPP PY end	July 14 after notification date	August 15 after notification date	September 15 after notification date

Table 2A: Interim and Final Payment timeline, GPP PY 6

Payment	Payment Amount	Payment Amount & IGT Notification Date	IGT Due Date	Payment Date	Payment Summary Report to CMS
Interim Quarter 1	50% of Annual	September 15	September 22	October 15	November 15
Interim Quarter 2	50% of Annual	December 15	December 22	January 15	February 15
Final Reconciliation	Final reconciled amount	December 31 following the GPP PY end	January 14 after notification date	February 15 after notification date	March 15 after notification date

Table 2B: Interim and Final Payment timeline, GPP PY 7-12

Payment	Payment Amount	Payment Amount & IGT Notification Date	IGT Due Date	Payment Date	Payment Summary Report to CMS
Interim Quarter 1	25% of Annual	March 15	March 22	April 15	May 15
Interim Quarter 2	25% of Annual	July 1	July 7	July 30	August 15
Interim Quarter 3	25% of Annual	September 15	September 22	October 15	November 15
Interim Quarter 4	Final Interim based on interim year-end summary report	March 15 following the GPP PY end	March 22 following the GPP PY end	April 15 following GPP PY end	May 15 following GPP PY end
Final Reconciliation	Final reconciled amount	December 31 following the GPP PY end	January 14 after notification date	February 15 after notification date	March 15 after notification date

Attachment L
Global Payment Program Valuation Methodology Protocol

Attachment L
Global Payment Program Valuation

A. Valuation of Services

Each eligible uninsured service a PHCS provides will earn the PHCS a number of points based on this protocol. Each service has an identical point value for every PHCS, but the assigned point values per service shall vary by GPP Program Year (GPP PY) as described in detail below.

1. Categories and tiers of service

   Services associated with points in the GPP are shown in Table 1 below, grouped into both categories (1-5) and tiers within categories (A-D). These groupings can contain both traditional and non-traditional services. The groupings were intended to better display the full range of services that may be provided to the uninsured under the GPP, to help develop initial point values for non-traditional services (for which cost data is not available), and to clarify which service types it made sense to revalue up or down for GPP purposes over time.

   Categories 1 through 5 are groupings of health care services that are organized according to their similar characteristics. For example, Category 1 contains outpatient services in traditional settings, mostly "traditional" services provided by licensed practitioners. Category 2 is made up of a range of outpatient services provided by non-provider care team members, both inside and outside of the clinic, including health education, health coaching, group and mobile visits, etc. Category 3 services are technologically- mediated services such as real-time video consultations or e-Consults between providers. Category 4 services are those involving facility stays, including inpatient and residential services. Category 5 services are those aiming to advance health equity in the state.

   Grouping of services into tiers was based on factors including training/certification of the individual providing the service, time or other resources spent providing the service, and modality of service (in- person, electronic, etc.). Generally speaking, within each category, tier D is the most intensive and/or costly, and often requires individuals with the most advanced training or certifications, resulting in higher initial point values on average, whereas tier A is on the other end of the spectrum in intensity and resource use. However, there can still be significant point value variation within tiers, based on cost, resource utilization, or other relevant factors.

   The services whose values would decline over time under the GPP (as described in section 4 below) are most service types in categories 1C (emergent outpatient) and 4B (inpatient medical/surgical and mental health), which are higher-cost and judged as the most likely to be reducible through efforts at coordination, earlier intervention, and increased access to appropriate care.

Table 1: GPP Service Types by Category and Tier, with Point Values

Category and description	Tier	Tier description	Service type	Traditional / non-traditional	Initial Point Value
1: Outpatient in traditional settings	A	Care by Other Licensed or Certified Practitioners	RN-only visit	NT	50
			PharmD visit	NT	75
			Complex care manager	NT	75
	B	Primary, specialty, andother non-emergent care (physicians orother licensed independent practitioners)	Primary/specialty **(benchmark)**	T	100
			Contracted primary/specialty (contracted provider)	T	19
			Mental health outpatient	T	38
			Substance use outpatient	T	11
			Substance use: methadone	T	2
			Dental	T	62
	C	Emergent care	OP ER	T	160
			Contracted ER (contracted provider)	T	70
			Mental health ER / crisis Stabilization	T	250
	D	High-intensity outpatientservices	OP surgery	T	776
2: Complementary patient support and care services	A	Preventive health, education and patient support services	Wellness	NT	15
			Patient support group	NT	15
			Community health worker	NT	15
			Health coach	NT	15
			Panel management	NT	15
			Health education	NT	25
			Nutrition education	NT	25
			Case management	NT	25
			Oral hygiene	NT	30
			*Doula service (prenatal or postnatal)	NT	60
			*Peer support	NT	25
	B	Chronic and integrative care services	Group medical visit	NT	50
			Integrative therapy	NT	50
			Palliative care	NT	50
			Pain management	NT	50
	C	Community- based face-to-face	Home nursing visit	NT	75
			Paramedic treat and release	NT	75

		encounters	Mobile clinic visit	NT	90
			Physician home visit	NT	125
3: Technology-based outpatient	A	Non-providercare team telehealth	Texting	NT	1
			Video-observed therapy	NT	10
			Nurse advice line	NT	10
			RN e-Visit	NT	10
	B	eVisits	Email consultation with PCP	NT	30
	C	Store and forward telehealth	Telehealth (patient - provider) - Store & Forward	NT	*100
			Telehealth (provider - provider) – eConsult / eReferral	NT	50
			Telehealth – Other Store &Forward	NT	*100
	D	Real-time telehealth	Telephone consultation withPCP	NT	*100
			Telehealth (patient - provider) - real time	NT	*100
			Telehealth (provider - provider) - real time	NT	90
4: Inpatient	A	Residential, SNF, and other recuperative services; low intensity	Mental health / substance use residential	T	23
			Sobering center	NT	50
			Recuperative / respite care	NT	85
			SNF	T	141
	B	Acute inpatient, moderate intensity	Medical/surgical	T	634
			Mental health	T	341
	C	Acute inpatient,high intensity	ICU/CCU	T	964
	D	Acute inpatient, critical community Services	Trauma	T	863
			Transplant/burn	T	1,131
**5: Equity-Enhancing Services	A	Enhanced care management	Enhanced care management	E	75 PMPM
	B	Community Supports	Asthma remediation	E	80/case
			Community transition: Nursing facility to home	E	220 PMPM
			Day habilitation	E	3/hr
			Housing deposits	E	700/ move-in
			Housing tenancy and sustaining service	E	90 PMPM
			Housing transition navigation service	E	90 PMPM

			Nursing facility transition/diversion to assisted living facility	E	12/day
			Personal care services	E	4/hr
			Short-term post-hospitalization housing	E	15/day
	C	Other Equity-Enhancing Services	Team-based street outreach and engagement	E	150/visit

Notes:
*Services and points marked with an asterisk are applicable to PY 8 and forward. Services and points prior to CalAIM are shown in Medi-Cal 2020 STCs.
**The Equity Enhancing Services Category is effective beginning in PY 9.

2. Valuation of traditional services

Services for which payment typically is made available upon provision of the service, referred to herein as "traditional" services, will receive initial point valuations based on their cost per unit of service in the historical year SFY 2013-14. These traditional services are grouped into categories that reflect generally where care is being provided and intensity. Gross costs incurred for services provided to the uninsured by PHCS in SFY 2013-14, as determined under the applicable claiming methodologies, are summed across all PHCS by service type, using the most complete and reliable data when available, to obtain an average cost per unit for each traditional service. 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. These initial points are shown in table 1; the relative costs per unit of service are shown in Appendix 1.

3. Valuation of non-traditional services

Non-traditional services typically are not directly or separately reimbursed by Medicaid or other payers, and are often provided as substitutes for or complementary to traditional services. These services are assigned initial point values based on their estimated relative cost compared to the benchmark traditional service, and their value in enhancing the efficiency and effectiveness of traditional services.

The non-traditional services in the table 1 provide value to the delivery of health care to the uninsured population by enhancing the efficiency and effectiveness of traditional services, 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 emergency department, 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 PCP and a specialist. This collaboration 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 to a specialist who may be located far from where they live. 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 Appendix 2.

Individuals will be considered uninsured with respect to a non-traditional service if he or she has no source of third party coverage for a comparable traditional service. For example, an individual with coverage for outpatient visits would not be considered uninsured with regard to technology-based outpatient services, even if his or her insurance does not cover those services. DHCS shall, in consultation with the DPH systems, issue guidance letters addressing whether individuals shall be considered uninsured in specific factual circumstances, to ensure that the requirements are consistently applied.

4. Point revaluation over time

Point values for services will be 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 will receive fewer points over time. The changing point structure will be designed to incentivize PHCS to provide care in the most appropriate and cost-effective setting feasible. Point revaluation will be calibrated so that the overall impact would 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, PHCS will be incentivized to provide more of certain valued services and less of certain more costly and avoidable services. This revaluation will be phased in over time to enable PHCS to adapt to the change in incentives. In GPP PY 1, points will be identical to the initial cost-based point values. In GPP PY 2, 20% of the full change will be made to point values. In GPP PY 3, an additional 30% of the revaluation will be phased in, with the final 50% change occurring in GPP PY 4, except that in GPP PY 6, an additional point value change will be made at the same average annual pace of changes from PY1 to PY5. This phase-in is illustrated in Table 2. Point values for GPP PYs 7 through 12 will not change.

Point values will not vary from their initial cost-based amounts by more than 40% at any time during the GPP.

Table 2: Revaluations to categories of service, by year, compared to initial point value, PYs 1-12

Category of service	Initial point value	Point value (% change) PY 1	Point value (% change), PY 2	Point value (% change), PY 3	Point value (% change) PY 4	Point value (% change) PY 5	Point value (% change) PY 6	Point value (% change), PY 7 -12
OP ER	160	160 (0%)	158 (-1%)	156 (-2.5%)	152 (-5%)	152 (-5%)	151 (-5.5%)	151 (-5.5%)
Mental health ER / crisis	250	250 (0%)	248 (-1%)	244 (-2.5%)	238 (-5%)	238 (-5%)	236 (-5.5%)	236 (-5.5%)
IP med/surg	634	634 (0%)	630 (-0.6%)	624 (-1.5%)	615 (-3%)	615 (-3%)	613 (-3.3%)	613 (-3.3%)
IP Mental	341	341 (0%)	339 (-0.6%)	336 (-1.5%)	331 (-3%)	331 (-3%)	329 (-3.3%)	329 (-3.3%)

Values for categories not listed are unchanged. Contracted IP and ER values are changed identically with other IP/ER.

B. PHCS-Specific Point Thresholds

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 service counts by corresponding initial point values. The thresholds for PY1 are shown in Table 3.For GPP PY 2 through 7, each threshold shall be adjusted proportionally to the total GPP funds available for that PY under STC 78, compared to the total GPP funds available in GPP PY 1, e.g. if total GPP funding in PY 2 is 5% less than PY 1 each PHCS threshold will be reduced by 5%.

During a period of public health emergency or other state of emergency only, thresholds may be further adjusted without modifying the applicable total GPP payments available for achieving such thresholds by a determined percentage based upon estimated impact to utilization rates. All threshold adjustment methodologies shall be approved by CMS. In response to the COVID-19 public health emergency GPP PY 5 PHCS thresholds will be reduced by 10% and PHCS threshold adjustments for GPP PY 6 will be reduced by 29%. Any additional PYs impacted by the COVID-19 public health emergency will be proposed once the extent of the impact to the delivery of GPP services due to the public health emergency is determined.

Starting in PY 8 and continuing through PY 12, DHCS will shift to the revised threshold percentages in Table 4, to reflect utilization experience in selected prior years, in order to bring budgets closer to that experience. For PY 8, the final total system threshold is determined by dividing the final GPP budget for PY 8 by the same value per point as PY 1. The resulting PY 8 final total system threshold is then allocated to each PHCS using the recalibrated percentages in Table 4, to determine the final PY 8 system threshold for

each PHCS. For GPP PY 9 and onward, each threshold shall be adjusted proportionally to the total GPP funds available for that PY under STC 78, compared to the final PY 8 thresholds, e.g. if total GPP funding in PY 9 is 5% less than PY 8 each PHCS threshold will be reduced by 5% so that the value for each individual point remains consistent from PY 1 through PY 12.

Table 3: GPP PY 1 PHCS Thresholds, Based on FY 2014-15 Uninsured Services

Public Health Care System	System Threshold, GPP PY1
Los Angeles County Health System	101,573,445
Alameda Health System	19,151,753
Arrowhead Regional Medical Center	7,525,819
Contra Costa Regional Medical Center	5,674,651
Kern Medical Center	3,633,669
Natividad Medical Center	2,959,964
Riverside University Health System – Medical Center	8,066,127
Zuckerberg San Francisco General	12,902,913
San Joaquin General Hospital	3,021,562
San Mateo County General Hospital	8,733,292
Santa Clara Valley Medical Center	19,465,293
Ventura County Medical Center	9,213,731

Table 4: GPP PY 8 PHCS Thresholds

Public Health Care System	Recalibrated System Threshold Percentage, GPP PY 8	Interim System Threshold, GPP PY 8, based on estimated PY 8 budget of $2,535,234,481 and same value per point as PY 1
Los Angeles County Health System	52.40%	121,307,020
Alameda Health System	9.03%	20,893,537
Arrowhead Regional Medical Center	3.32%	7,695,510
Contra Costa Regional Medical Center	2.99%	6,919,139
Kern Medical Center	2.08%	4,817,416
Natividad Medical Center	1.69%	3,922,128
Riverside University Health System - Medical Center	4.44%	10,280,798
Zuckerberg San Francisco General	5.78%	13,387,427
San Joaquin General Hospital	1.50%	3,464,138

San Mateo County General Hospital	4.32%	9,997,269
Santa Clara Valley Medical Center	9.64%	22,316,425
Ventura County Medical Center	2.81%	6,497,487
	100.00%	231,498,294

Appendix 1

Table 5: Categories of Service and Point Values, Traditional

Category	Tier	Service Name	Cost/unit	Initial point value
1: Outpatient	B	OP Primary / Specialty (**benchmark, 100)**	587	**100**
	B	Dental	365	**62**
	B	MH Outpatient	225	**38**
	B	SU Outpatient	62	**11**
	B	SU Methadone	11	**2**
	B	Contracted Prim/Spec	110	**19**
	C	OP ER	942	**160**
	C	Contracted ER	411	**70**
	C	MH ER/Crisis Stabilization	1,470	**250**
	D	OP Surgery	4,554	**776**
4: Inpatient	A	SNF	829	**141**
	A	MH/SU Residential	138	**23**
	B	Med/surg	3,721	**634**
	B	MH Inpatient	2,000	**341**
	C	ICU/CCU	5,663	**964**
	D	Trauma	5,069	**863**
	D	Transplant/Burn	6,644	**1,131**

Appendix 2

Table 6: Categories of Service and Point Values, Non-Traditional

DHCS may update the codes and descriptions contained in this table to reflect ongoing changes made by CMS or other nationally recognized entities. Updated codes and descriptions will be reflected in reporting guidance provided by DHCS to PHCS.

Tier	Service	Relevant codes and description if available (CPT, ICD)	Definition [source] Where no nationally recognized code exists	Relative Points
Service Category 1: Outpatient				

A	RN Visit[84, 85] (includes Wound Assessment visits)	**99211** Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.		50
A	PharmD Visit[86]	**99605, 99606, 99607** Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment, and intervention if provided.		75
A	Complex Care Manager[87]	**99490** Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: • Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, • Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, Comprehensive care plan established, implemented, revised, or monitored.		75
Service Category 2: Complementary Patient Support and Care Services				
A	Wellness[88,89]	G0438 Annual wellness visit; includes a personalized prevention plan of service (PPPS),		15

[84] CMS Source: MCD Search (cms.gov), Accessed 11/14/2015
[85] Understanding When to Use 99211 | AAFP, Accessed 11/10/2015
[86] Pharmacist Services Technical Advisory Coalition, Medication Therapy Management Service Codes | Pharmacist Services Technical Advisory Coalition (pstac.org), Accessed 11/15/2015
[87] CMS Medicare Learning Network, MLN909188 – Chronic Care Management (cms.gov), Accessed 11/15/2015
88 https://www.careimprovementplus.com/pdf/PROVIDER_COMMUNICATION_WELLNESS_AND_PHYSICAL_EXAMINA TION_CODES.pdf
[89] Publications & Multimedia | CMS

Table 7

Tier	Service	Relevant codes and description if available (CPT, ICD)	Definition [source] Where no nationally recognized code exists	Relative Points
		Initial visit G0439 Annual wellness visit, includes a personalized prevention plan of service (PPPS), subsequent visit **S5190** Wellness assessment, performed by non- physician **Z00.00, Z00.01** Z00.00: Encounter for general adult medical examination without abnormal findings Z00.01 Encounter for general adult medical examination with abnormal findings		
A	Patient Support Group	**Non-physician Health Care Professional CPT Code** **98961** Education And Training For Patient Self- Management By A Qualified, Nonphysician Health Care Professional Using A Standardized Curriculum, Face-To-Face With The Patient (Could Include Caregiver/ Family) 2-4 Patients **98962** Education And Training as above; 5-8 Patients		15
A	Community Health Worker (CHW)		Encounters in which a Community Health Worker assists individuals and communities to adopt healthy behaviors. Conduct outreach for medical personnel or health organizations to implement programs in the community that promote, maintain, and improve individual and community health. May provide information on available resources, provide social support and informal counseling, advocate for individuals and community health needs, and provide services such as first aid and blood pressure screening. May collect data to help identify community health needs.[90]	15

A	Health Education		Services provided for the purpose of promoting health and preventing illness or injury. These include risk factor reduction interventions, preventive medicine counseling and behavior change interventions.	25
A	Nutrition Education[91,92]	**97802** Medical nutrition therapy; initial assessment and intervention, individual, face- to-face with the patient **97803** Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient		25

[90] Bureau of Labor and Statistics, Standard Occupational Classification: 21-1094 Community Health Workers. Community Health Workers (bls.gov), Accessed 11/24/2015.
[91] National Coverage Determination (NCD) for Medical Nutrition Therapy (180.1), NCD - Medical Nutrition Therapy (180.1) (cms.gov)
[92] CMS, DHHS: Medical Nutrition Therapy (MNT) Services for Beneficiaries with Diabetes or Renal Disease - POLICY CHANGE, November 1, 2002. Microsoft Word - A02_115.doc (cms.gov)

Table 8

Tier	Service	Relevant codes and description if available (CPT, ICD)	Definition [source] Where no nationally recognized code exists	Relative Points

A	Case management		Case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost- effective outcomes.[93] **Case manager is assigned** to the patient and engages in direct care **OR** coordination of care **OR** manages patient's access to care **OR** initiates and/or supervises other health care services needed by the patient[94]	25
A	Health coach		Health and behavior intervention performed by non-provider member of the health care team to build the knowledge, skills, and confidence required to manage their chronic conditions and improve their health. Includes motivational interviewing, self-management goal setting, patient education and activation and chronic disease support[95]	15
A	Panel management		Document in patient's medical record when staff proactively reach out to a patient and speak with them regarding preventive services, chronic illness management, their care plan, problem list, health goals, and/or treatment options.[96]	15

[93] Case Management Society of America, What Is A Case Manager | Case Management Society of America (cmsa.org), Accessed 11/15/2015
[94] Oregon APM Patient Touches, direct communication with Oregon Health Authority
[95] Per 11/30/2015 communication with Dr. Nwando J. Olayiwola, Associate Professor, Department of Family and Community Medicine, and Director of the Center for Excellence in Primary Care (CEPC), University of California San Francisco. CEPC is a recognized national leader in Health Coach training.
[96] Oregon APM Patient Touches.

Table 9

Tier	Service	Relevant codes and description if available (CPT, ICD)	Definition [source] Where no nationally recognized code exists	Relative Points

A	Oral Hygiene Encounters		Adult and Pediatric oral health services including dental varnishing, oral health education and other prevention services provided by dental hygienists	30
A	Doula service, prenatal or postnatal		Personal support to women, including emotional and physical support, and families throughout a person's pregnancy and postpartum experience, provided by a qualified doula.	60
A	Peer support		Culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths to set recovery goals and identify steps to reach the goals. Services aim to prevent relapse, empower beneficiaries through strength-based coaching, support linkages to community resources, and to educate beneficiaries and their families about their conditions and the process of recovery.	25
B	Group medical visits	**99411-99412** Preventive medicine counseling and/or risk factor reduction provided to individuals in a group setting **99078** Physician educational services rendered to patients in a group setting (eg, obesity or diabetic instructions)		50
B	Integrative medical therapies	**97810-97811,97813-97814:** Acupuncture, one or more needles, with or without electrical stimulation, personal one-on-one contact with the patient		50

B	Palliative Care	**0690-0699 Pre-hospice/Palliative Care Services**: Services that are provided prior to the formal election of hospice care. These services may consist of evaluation, consultation and education, and support services. No specific therapy is excluded from consideration. Care may be provided in the home, hospitals, skilled nursing facilities, or nursing homes by palliative care teams, hospice organizations, or palliative care specialists. Unlike hospice care, palliative care may include potentially curative treatments and there is no requirement for life expectancy parameters.	Encounters with non-provider care team members that focus on preventing and relieving suffering, and improving the quality of life of patients and their families facing serious illness. Palliative care is provided by an interdisciplinary team which works with primary and specialty care providers to identify and treat pain and other distressing symptoms, provide psychosocial and spiritual support, and assist in complex decision-making and advance care planning.	50
B	Pain management		Encounter provided by a non-provider caregiver or care team focused on enhancing self-management of chronic pain, implementing behavioral strategies for managing pain, discussing medication effectiveness and side effects, assessing treatment effectiveness, and adjusting treatment plan and goals. Chronic pain visits may also include assessment for signs of substance use or mental health disorder as well as motivational interviewing or other treatment strategies for these disorders	50
C	Physician Home Visit[97]	**99341 - 99345** Home visit, new patient; **99347 - 99350** Home visit, established patient		125

[97] CMS Billing and Coding Guidelines - L31613 PHYS-081 - Home and Domiciliary Visits: Billing and Coding Guidelines L31613 PHYS-081 - Home and Domiciliary Visits (cms.gov). Accessed 11/10/2015

Table 10

Tier	Service	Relevant codes and description if available (CPT, ICD)	Definition [source] Where no nationally recognized code exists	Relative Points
C	Home nursing visits	**G0162** Skilled services by a registered nurse (RN) for management and evaluation of the plan of care; (the patient's underlying condition or complication requires an RN to ensure that essential non-skilled care achieves its purpose in the home health or hospice setting)	Visits by RNs to patients at home for acute or chronic disease management. May include history taking, physical exam, phlebotomy for lab testing, assessment of ADL, and adjustment of diet, activity level, or medications.	75
C	Mobile Clinic Visits	**CPT Physician Code** **99050** Service(s) provided in office at times other than regularly scheduled office hours, or days when the office is normally closed (eg, holidays, Saturday or Sunday), in addition to basic service **99051** Service(s) provided in the office during regularly scheduled evening, weekend or holiday hours, in addition to basic service **99056** Services typically provided in the office, provided out of the office at request of patient, in addition to basic service **OR 99201-5; 99211-5** Use POS code 15 with the above codes to signify a services provided in a mobile setting[98]		90
C	Paramedic treat and release		Paramedic assessment, treatment if appropriate, and discharge of a patient without ambulance transport[99]	75
Service Category 3: Technology-Based Outpatient[100]				
A	Texting		Texting services provided by the care team to an established patient, parent, or guardian to support care management. Cannot focus on administrative tasks such as scheduling appointments. Must	1

			not originate from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment.	

[98] Ask an AAPC expert ! AAPC
[99] Millin, M. et al. EMS provider determinations of necessity for transport and reimbursement for ems response, medical care, and transport: Combined resource document for the national association of EMS physicians position statements, EMS provider determinations of necessity for transport and reimbursement for EMS response, medical care, and transport: combined resource document for the National Association of EMS Physicians position statements - PubMed (nih.gov) Accessed 11/24/2015
[100] General resource for this section is the American Telemedicine Association Letter to CMS on Telehealth Services, December 31, 2013. Policy - ATA (americantelemed.org) Accessed 10/28/2015

Table 11

Tier	Service	Relevant codes and description if available (CPT, ICD)	Definition [source] Where no nationally recognized code exists	Relative Points
A	Video Observed Therapy		Observation of patients taking their tuberculosis medication in their homes. Observation is done using a live video telephone on both the patient and provider ends[101]	10
A	Nurse advice line102,103	**98966, 98967, 98968** Telephone assessment and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment		10
A	RN e-Visit[104]	**98970-98972** Qualified nonphysician health care professional online digital evaluation and management service, for established patient, for up to 7 days		10

B	Email consultation with PCP[105]	**99421-99423** Online digital evaluation and management service, for established patient, for up to 7 days		30

[101] California Department of Public Health Tuberculosis Control Branch - Guidance for Developing a Video Observed Therapy (VOT) - Policy and Procedures. Tuberculosis (ca.gov), Accessed 11/24/15
[102] CMS, DHHS: Summary of Policies in the 2008 Medicare Physician Fee Schedule and the Telehealth Originating Site Facility Fee Payment Amount, February 1, 2008. CMS Manual System, Accessed 10/20/2015
[103] American Academy of Pediatrics, Charging for Nurse Telephone Triage. Pediatric Nurse Telephone Triage: A Companion To Pediatric Telephone Protocols | AAP Books | American Academy of Pediatrics, Accessed 10/20/2015
[104] CMS, DHHS: Summary of Policies in the 2008 Medicare Physician Fee Schedule and the Telehealth Originating Site Facility Fee Payment Amount, February 1, 2008. Summary of Policies in the 2008 Medicare Physician Fee Schedule and the Telehealth Originating Site Facility Fee Payment Amount | Guidance Portal (hhs.gov), Accessed 10/20/2015
[105] MEDICARE TELEMEDICINE HEALTH CARE PROVIDER FACT SHEET | CMS

Table 12

Tier	Service	Relevant codes and description if available (CPT, ICD)	Definition [source] Where no nationally recognized code exists	Relative Points
C	Telehealth (patient - provider) - Store & Forward106,107	Digital Retinal Screening **92250** (global) Fundus photography with interpretation and report		100
C	Telehealth – Store & Forward	+GQ modifier for distant site: **99241-99243** Office consultation, new or established patient **99251-99253** Initial inpatient consultation **99211-99214** Office or other outpatient visit **99231-99233** Subsequent hospital care OR **99446-99449**: Non-Face-To-Face Services: Interprofessional Telephone/Internet Consultations	Store and Forward services that include images, such as Teleophthalmology and Teledermatology	100

C	Telehealth (provider - provider) – eConsult/ eReferral[108]	**99446-99449, 99451 + modifier GQ** Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional,		50
D	Telephone consultation with PCP109	**CPT Physician Code 99441 through 99443. OR 99201-99215 with modifier 93** Telephone E&M service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment	ALTERNATIVE DESCRIPTION: PCP speaks via telephone with patient about medical/dental/MH/substance use condition or medications AND discusses or creates care plan OR discusses treatment options	100
D	Telehealth (patient provider) - real time[110,111]	**99201-99215** with modifier **95** "Office or other outpatient visits" Claims for telehealth services should be submitted using the appropriate CPT or HCPCS code for the professional service along with the telehealth modifier GT, "via interactive audio and video telecommunications systems"		100

[106] Ophthalmology (ophthal) (ca.gov),Accessed 10/15/2015; Page updated August 2020
[107] Communication with Jorge Cuadros, OD, PhD, Director of Clinical Informatics Research, UC Berkeley School of Optometry, CEO of EyePacs
[108] RTR- ECONSULT CPT CODES, UC Davis, plus communication on 10/27/2015 with Timi Leslie, BluePath Health and Rachel Wick, Blue Shield of CA Foundation in reference to BSCF eConsult grant program.
[109] CMS, DHHS: Summary of Policies in the 2008 Medicare Physician Fee Schedule and the Telehealth Originating Site Facility Fee Payment Amount, February 1, 2008. CMS Manual System, Accessed 10/20/2015
[110]CMS Medicare Learning Network: Telehealth Services, Telehealth Services (cms.gov) Accessed 10/28/2015
[111] Medi-Cal: Provider Manuals, Accessed 10/28/2015

Table 13

Tier	Service	Relevant codes and description if available (CPT, ICD)	Definition [source] Where no nationally recognized code exists	Relative Points
D	Telehealth (provider - provider) - real time[112]		Communication between two providers for purposes of consultation, performed via interactive audio and video	90

			telecommunications systems	
Service Category 4: Inpatient				
A	Sobering Center[113]		Nurse assessment and monitoring, to determine and ensure safety for individuals found intoxicated in public[114]	50
A	Recuperative/Respite Care[115]		Provision of acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets but who are not ill enough to be hospitalized. Services may include recuperative care, completion of therapy (e.g, antibiotics, wound care), temporary shelter, and coordination of services for medically and psychiatrically complex homeless adults[116]	85

[112] *Ibid*
[113] San Francisco Department of Public Health, Housing and Urban Health, Medical Respite and Sobering Center. Community Supports - San Francisco Health Plan (sfhp.org), Accessed 11/25/2015
[114] 12/23/2015 communication with Dr. Hali Hammer, Medical Director for Ambulatory Services, San Francisco Health Network.
[115] National Health Care *for the* Homeless Council, definition of Recuperative Care Home - National Health Care for the Homeless Council (nhchc.org), Accessed 11/24/2015.
[116] Ibid 12/23/2015 communication with Dr. Hammer.

Table 14: Categories of Service and Point Values, Equity-Enhancing Services

Category	Tier	**Service Name** (description when not in CalAIM)	Initial point value
5	**A**	Enhanced care management	75 PMPM
	B	Asthma remediation	80/case
	B	Community transition: Nursing facility to home	220 PMPM
	B	Day habilitation	3/hr
	B	Housing deposits	700/move-in
	B	Housing tenancy and sustaining service	90 PMPM
	B	Housing transition navigation service	90 PMPM
	B	Nursing facility transition/diversion to assisted living facility	12/day
	B	Personal care services	4/hr
	B	Short-term post-hospitalization housing	15/day
	C	Team-based street outreach and engagement: Service for people who have similar needs and intensity to those needing ECM but who are harder to reach, typically houseless, such as referral and transitions to shelter, mental health, substance use, physical health services, sources of income, permanent housing opportunities and/or other supportive services, building sufficient trust to help them navigate to housing and services, including eventually Medi-Cal enrollment and CalAIM services	150/visit

Note: services without descriptions above are defined in accordance with CalAIM.

Attachment M
Global Payment Program Health Equity Monitoring Metrics Protocol

Attachment M
Global Payment Program Health Equity Monitoring Metrics Protocol

A. Health Equity within GPP

GPP provides support to Public Health Care Systems (PHCS) for the delivery of more cost-effective and higher value care for indigent, uninsured individuals. PHCS are comprised of a designated public hospital and its affiliated and contracted providers. Each PHCS participating in the GPP is listed in Attachment C. Where multiple designated public hospitals are operated by the same legal entity, the PHCS includes multiple designated public hospitals, as set forth in Attachment C. In alignment with federal and state equity goals, PHCS will work with DHCS to advance equity through a Health Equity Monitoring Metrics Protocol that improves reporting for equity-related metrics and initiates evaluation of disparities within the GPP program, as described in detail below.

B. Expanded Reporting of Equity-Related Data Fields

PHCS will strengthen data reporting to allow for more robust stratification and improved evaluation of disparities. In the GPP reporting structure, PHCS currently report gender, race (one field), ethnicity, and zip code.[1] However, PHCS generally have the ability to collect more data than they are currently being asked to report in GPP. PHCS, in collaboration with DHCS, will implement the following changes in encounter-level data reporting in order to improve the ability to stratify and evaluate disparities within GPP.

1. The GPP reporting structure will be updated to:
   a. Add fields for multiple race categories, transitioning from the current structure that only allows for reporting of a single race category.
   b. Add a new field for Preferred Language.
   c. Add a new field for Sexual Orientation.
   d. Expand the values allowed for reporting of gender identity (to be determined) that align with other State data collection approaches for gender identity.[2]
2. PHCS will begin reporting these updated and new data fields beginning in 2023 for PY 8 and continuing through PY 12 on an annual basis as part of the existing GPP encounter data reporting process.
3. DHCS will work with PHCS to determine the detailed reporting specifications and update GPP reporting guidance accordingly. DHCS will monitor implementation of these changes in encounter-level data reporting and adjust data specifications as needed.

C. Initiating Evaluation of Disparities

[1] Full RUCA coding requires complete addresses to determine census tracts and, from there, delineation of rural/urban status. GPP reporting includes only zip codes. However, there is a zip-code version of RUCA that approximates census tracts, which could be used in analyzing GPP zip codes data. DHCS can explore this option as part of the demonstration evaluation.

[2] The DHCS proposed stratification methodology for sexual orientation and gender identity (SOGI) is based on federal data standards for SOGI established by ONC during Meaningful Use (2015 Final Rule on Certified EHR Technology, pp 496-7) and approved by ONC in 2021 as part of (USCDIv2, pp12-13). This approach also aligns with the State's standards. DHCS will take into account any future guidance from CMS, as feasible.

DHCS will begin exploring evaluation of disparities in GPP with the aid of more robust data reporting as described in Sections 1 and 2 below.

1. Stratified GPP Utilization Rates and Trends – PHCS and DHCS will evaluate stratified utilization rates and trends over time to determine whether care is shifting from acute settings to primary and preventive services, including non-traditional services – a key objective of the program and the subject of the initial GPP evaluation.
    a. The following two utilization metrics will be examined:
        i. Annual Utilization in selected GPP service categories stratified by race, ethnicity, language, sexual orientation, and/or gender identity
        ii. Annual Utilization trended over time (by GPP program year) in selected GPP service categories stratified by race, ethnicity, language, sexual orientation
    b. PHCS will be required to report utilization, stratified by race, ethnicity, and preferred language spoken (REAL) and sexual orientation and gender identity (SOGI), for selected GPP service categories of interest,[3] including but not limited to:
        i. Physical health: Inpatient, ER and Outpatient
        ii. Behavioral health: Inpatient, ER and Outpatient
        iii. Non-traditional services
        iv. Equity-enhancing services that will be added to GPP beginning in 2023[4]
    c. DHCS will analyze the stratified PHCS annual utilization data by comparing patterns by REAL and SOGI characteristics (within and across GPP service categories). DHCS will trend utilization over time to identify any desirable or undesirable changes. The types of analyses that DHCS conducts may change over time as DHCS becomes more familiar with the data and identifies patterns of interest.
    d. The list of utilization measures is subject to change, based on lessons learned in the initial years of reporting and other factors. Changes to the measures will be uniformly treated for all PHCS and is subject to DHCS approval.
2. Stratified Clinical Quality Measures
    a. PHCS and DHCS will work to identify five clinical quality metrics that are applicable to the GPP and that align as much as possible with goals outlined in the DHCS Comprehensive Quality Strategy submitted to CMS on February 4, 2022.
    b. Initial clinical quality measures that DHCS and PHCS have identified include:

[3] The initial GPP evaluation identified these service categories as categories of interest to track, looking at whether acute care services (such as inpatient and emergency) utilization declines over time and outpatient (including non-traditional) utilization increases over time.

[4] The addition of the equity-enhancing services category was approved by CMS on 2/16/23 (Attachment L, Table 1). The equity-enhancing services category is effective beginning in Program Year 9 (2023); systems will first report these services in 2024, based on 2023 utilization. The equity-enhancing services were selected to mirror the new Medi-Cal Enhanced Care Management and Community Supports benefits that are available as part of CalAIM. Now that these benefits are available to Medi-Cal beneficiaries, the intention was to add these benefits as GPP services to make access to new benefits /services equitable across both populations.

i. Colorectal Cancer Screening: CMS130v10 (UDS)
ii. Controlling High Blood Pressure: CMS165v10 (UDS)
iii. Diabetes: HbA1c Poor Control (> 9%): CMS122v10 (UDS)
iv. Preventive Care and Screening: Screening for Depression and Follow-Up Plan (CMS2v11) (UDS)
v. Coronary Artery Disease (CAD): ACE/ARB Therapy - Diabetes or LVSD (LVEF < 40%) QPP #118 MIPS CQM 2021 (MIPS)

c. The five quality of care measures were selected to align with the quality strategy goals of providing early interventions for rising risk and patient-centered chronic disease management as well as keeping families and communities healthy via prevention. These goals are outlined in the DHCS Comprehensive Quality Strategy (CQS) Report. In addition, although the measure addresses depression for the broader population, the Preventive Care and Screening: Screening for Depression and Follow-Up Plan measure aligns with the state level Bold Goal to improve maternal and adolescent depression screening by 50%.
d. The data used in reference to state and national disparities in these measures come from the DHCS 2021 Health Disparities Report, DHCS Health Disparities in the Medi-Cal Population Fact Sheets, AHRQ 2022 National Healthcare Quality and Disparities Reports, U.S. Department of HHS Office of Minority Health, National Center for Health Statistics, and other peer reviewed publications.
e. The list of clinical quality measures is subject to change, pending changes made to measures at the national level and other factors. Changes to the measures will be uniformly treated for all PHCS and is subject to DHCS approval.

3. DHCS will work with PHCS to develop reporting guidance for all measures, including adjusting metric specifications and identifying which stratifications will be reported for each measure. DHCS will also work with PHCS to interpret performance rates on the measures listed above, considering the challenges with applying national measures and benchmarks to a program like GPP, monitor performance and trends over time, and discuss improvement strategies, if needed, at the end of the waiver period.
4. PHCS will begin reporting these utilization rates and trends and clinical quality measures beginning in 2024 for PY 9 and continuing through PY 12 on an annual basis after the encounter data reporting process with specific dates to be determined. PHCS will report the measure rates to DHCS in a form and manner to be specified by DHCS.
5. The state may retain flexibility on two distinct aspects of the quality of care measures: a) The selection of the composition of the measure set, and b) the selection of benchmarks that will be utilized to determine the level of quality performance.
    a. Measure selection flexibility is due to the nature of the GPP population and the limitations of denominator sizes, which are further limited by measure specification requirements (e.g., age restrictions, diagnosis established, etc.). To ensure that meaningful data is reported the state requests flexibility to identify and select measures with sufficient denominators that also meet the alignment to the Quality Strategy Report discussed above.

b. The state may retain flexibility in the selection of comparison data/benchmarks. The state may select the most appropriate benchmark for each measure based on the closest approximation to the GPP population. DCHS will describe the benchmarks selected in the annual monitoring report.

6. DHCS will report on the progress of the Health Equity Monitoring Metrics Protocol to CMS on an annual basis as part of its Annual Monitoring Report.

Attachment N
Providing Access and Transforming Health (PATH) Supports Funding and Mechanics Protocol

Attachment N
Providing Access and Transforming Health (PATH) Supports
Funding and Mechanics Protocol

In accordance with the State's section 1115 demonstration and Special Terms and Conditions (STC 5.13 – 5.25), this protocol provides additional detail on the requirements for the Providing Access and Transforming Health (PATH) initiative as specifically required by STC 5.23. Designated State Health Programs (DSHP) will be used to support portions of PATH. The State is authorized for up to $1.85 billion (total computable) in expenditure authority for PATH. PATH is one-time transitional funding that will support State efforts to maintain, build, and scale the capacity necessary to transition the Whole Person Care (WPC) Pilot Program and Health Home Pilots approved in the Medi-Cal 2020 demonstration to the California Advancing and Innovating Medi-Cal (CalAIM) initiative. This protocol outlines the award criteria and milestones for Qualified Applicants to receive funding through PATH across the Ensuring Access to Services During Transition and Delivery System Transformation and Innovation Program (which is comprised of five initiatives), as well as the Reentry Demonstration Initiative Planning and Implementation Program. See *Attachment O: PATH Operational and Monitoring Protocol* which outlines allowable state expenditures for activities permitted under PATH, required progress reporting and performance metrics, and the State's approach to PATH-related program integrity.

I. Award Criteria for Qualified Applicants

A. Global Award Criteria For PATH

In order to receive PATH funds through any program or initiative, Qualified Applicants must meet the following global award criteria:

i. The Qualified Applicant must meet the initiative-specific Qualified Applicant criteria outlined in *Section B: Initiative-Specific Award Criteria* of this protocol.
ii. The Qualified Applicant must complete all components required in the application and submit all necessary supporting documentation, as required.
iii. The Qualified Applicant's application must be reviewed and approved by the PATH TPA and/or the State as appropriate.
iv. The Qualified Applicant must be in good standing with the State Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) and other relevant state and federal governmental agencies, and not excluded from participation in any federal health care program under section 1128 or 1128A of the Social Security Act.
v. The Qualified Applicant must attest that funding received through PATH will not supplant funding provided by other Federal, state or local programs, or that the applicable PATH-funded activities will not duplicate reimbursement from such other programs, consistent with clause vi., on an ongoing basis and in a form and manner as required by DHCS.

vi. Other Federal, state or local funding sources and programs that are complementary to or enhance PATH funds will not be considered supplanted by PATH funds or duplicate reimbursement. If applicable, the Qualified Applicant must describe how similar or related services and activities supported by other Federal, state or local funding sources are complemented or enhanced by efforts funded by PATH. For example, if other funding 1) does not fully reimburse activities with the exception of the services provided through the Support for Sustaining Services Through the Transition to Managed Care initiative and the Support for Sustaining Reentry Demonstration Initiative Services Through the Transition to Managed Care initiative, 2) may allow additional/different populations to be served, or 3) may allow additional/different services to be provided beyond those funded by PATH. To the extent otherwise allowable PATH activities are reimbursed by other Federal, state or local programs, PATH funding must not duplicate such reimbursement.

vii. Consistent with federal "free care" guidance, other sources of funding do not need to be exhausted before PATH reimbursement is available.

viii. The Qualified Applicant must submit all necessary progress reports and meet program oversight requirements associated with receipt of PATH funding as outlined in *Section (4): Program Integrity, Oversight and Monitoring* of *Attachment O: PATH Operational and Monitoring Protocol.*

B. Initiative-Specific Award Criteria

In addition to meeting the global award criteria outlined in *Section A: Global Award Criteria For PATH*, Qualified Applicants must also include the following initiative-specific information in applications in order to be considered for funding, as further described and specified in DHCS guidance, applications and related documents:

i. **Support for Sustaining Services Through the Transition to Managed Care**. Initiative specific award criteria include:
   a. Inclusion of appropriate and accurate documentation showing that the former WPC Lead Entity provides a service eligible for PATH-funding (see STC 5.14a-b. for additional information on WPC services that are eligible for PATH funding under this initiative).
   b. Inclusion of FFS or PMPM rate used to bill for the service, for DHCS review and approval.
   c. Inclusion of estimated utilization of services eligible for PATH funding.
   d. The Qualified Applicant must attest that funding received through PATH will only be claimed for allowable services as outlined in the program application and in *Section (1): Allowable Expenditures* of *Attachment O: PATH Operational and Monitoring Protocol*, on an ongoing basis and in a form and manner as required by DHCS.

ii. **Support for Sustaining Reentry Demonstration Initiative Services Through the Transition to Managed Care.** Initiative specific award criteria include:
   a. Inclusion of appropriate and accurate documentation showing that the former WPC Lead Entity provides a service eligible for PATH-funding (see STC 5.14c.

for additional information on WPC services that are eligible for PATH funding under this initiative).

b. Inclusion of DHCS-approved FFS or PMPM rate used to bill for the service.
c. Inclusion of estimated utilization of services eligible for PATH funding.
d. The Qualified Applicant must attest that funding received through PATH will only be claimed for allowable services as outlined in the program application and in *Section (1): Allowable Expenditures* of *Attachment O: PATH Operational and Monitoring Protocol*, on an ongoing basis and in a form and manner as required by DHCS.

iii. **Technical Assistance Marketplace.** Initiative specific award criteria include:

a. Inclusion of appropriate and accurate documentation of the need and goals for the requested technical assistance resource.
b. Inclusion of a copy of all existing, executed contracts with a Medi-Cal Managed Care Plan(s) (MCP) in the State of California for CalAIM-related activities or a copy of a signed letter from an MCP stating the Qualified Applicant's intent to contract with the MCP in a timely manner for CalAIM related activities.
c. The Qualified Applicant must attest that funding received through PATH will only be applied towards allowable purposes as outlined in the program application and in *Section (1): Allowable Expenditures* of *Attachment O: PATH Operational and Monitoring Protocol*, on an ongoing basis and in a form and manner as required by DHCS.

iv. **Collaborative Planning and Implementation for ECM and Community Supports/Health-Related Social Needs (HRSN).** Qualified Applicants responsible for facilitating the Collaborative Planning and Implementation initiative must include the following initiative specific award criteria:

a. Inclusion of a robust description of the approach to collaborative planning and goals.
b. Provision of a detailed description of the process to engage potential collaborative planning participants that includes the following:
    i. List of a diverse set of partners that intend to participate in the collaborative in order to meet its goals and objectives, including, but not limited to: MCPs; city, county, and other government agencies; community-based providers including, but not limited to, public hospitals, community-based organizations (CBOs), and Medi-Cal Tribal and Designees of Indian Health Programs; and others as specified by DHCS.
    ii. A detailed approach for engaging and including providers / organizations that are under-resourced and/or serve historically underserved populations.
c. Submission of required letter(s) of support from collaborative participants in the region served indicating a commitment to work with a facilitator.
d. Inclusion of a copy of all existing, executed contracts with MCP(s) in the State of California for CalAIM-related activities or a copy of a signed letter from an MCP stating the Qualified Applicant's intent to contract with the MCP in a timely manner for CalAIM related activities.

e. The Qualified Applicant must attest that funding received through PATH will only be applied towards allowable purposes as outlined in the program application and in *Section (1): Allowable Expenditures* of *Attachment O: PATH Operational and Monitoring Protocol*, on an ongoing basis and in a form and manner as required by DHCS.

v. **Support for Expanding Access to Services:** Qualified Applicants may apply for up to two years' worth of funding at a time. Qualified Applicants that request PATH funding to sustain allowable activities for longer than two years must reapply for subsequent funding in later application rounds and demonstrate a continued funding purpose as follows:

a. Submission of a detailed justification for why funds are needed to support delivery and/or bolster capacity to support of ECM and/or Community Support/HRSN services.
b. Submission of a detailed description of how the Qualified Applicant intends to coordinate with MCPs to ensure alignment of activities and avoid duplication of MCP reimbursement.
c. Inclusion of a detailed description of approach to sustaining items/activities funded via PATH after PATH funding ends.
d. Inclusion of a detailed description of how funding request will align with CalAIM goals.
e. Inclusion of a copy of all existing, executed contracts with Managed Care Plan(s) (MCP) in the State of California for CalAIM-related activities or a copy of a signed letter from an MCP stating the Qualified Applicant's intent to contract with the MCP in a timely manner for CalAIM related activities.
f. The Qualified Applicant must attest that funding received through PATH will only be applied towards allowable purposes as outlined in the program application and in *Section (1): Allowable Expenditures* of *Attachment O: PATH Operational and Monitoring Protocol*, on an ongoing basis and in a form and manner as required by DHCS.

vi. **Reentry Demonstration Initiative Planning and Implementation Program**

a. Inclusion of a detailed description of all correctional institutions within the applicable jurisdiction including number of facilities and average daily census by facility.
b. Inclusion of a detailed description of current pre-release enrollment, suspension, and Medi-Cal screening processes, and the proposed approach to modifications that need to be made to align with related state mandates.
c. Inclusion of a detailed summary of current IT capabilities including booking / management systems and EHR platform, and the proposed approach to modifications that need to be made to improve data linkages with county departments of social services.
d. Inclusion of a plan to collaborate with local correctional institutions and county departments of social services to support planning and implementation of pre-release Medi-Cal enrollment and suspension processes.

e. The Qualified Applicant must attest that funding received through PATH will only be applied towards allowable purposes as outlined in the program application and in *Section (1): Allowable Expenditures* of *Attachment O: PATH Operational and Monitoring Protocol*, on an ongoing basis and in a form and manner as required by DHCS.

II. Milestones for Ongoing Funding for Qualified Applicants

Qualified Applicants must achieve milestones in order to receive PATH funding for all PATH programs and initiatives. Milestones will be aligned with PATH performance metrics, described in *Attachment O: PATH Operational and Monitoring Protocol*. The TPA will monitor achievements of milestones for the Technical Assistance Marketplace, Collaborative Planning and Implementation, and Support for Expanding Access to Services initiatives, as well as the Reentry Demonstration Initiative Planning and Implementation Program. Achievement of milestones for the Support for Sustaining Services Through the Transition to Managed Care initiative and the Support for Sustaining Reentry Demonstration Initiative Services Through the Transition to Managed Care initiative will be assessed by the State. Receipt of PATH funding for other initiatives will be contingent upon meeting requirements and milestones based on the category of PATH funding, described in B below.

A. Milestone Categories for Support for Sustaining Services Through the Transition to Managed Care initiative and the Support for Sustaining Reentry Demonstration Initiative Services Through the Transition to Managed Care initiative

i. **Support for Sustaining Services Through the Transition to Managed Care**
   a. The Qualified Applicant has submitted and completed all required elements of the invoice and progress reports outlined in *Section (3): Progress Reporting* of *Attachment O: PATH Operational and Monitoring Protocol* in a timely manner.

ii. **Support for Sustaining Reentry Demonstration Initiative Services Through the Transition to Managed Care**
   a. The Qualified Applicant has submitted and completed all required elements of the invoice and progress reports outlined in *Section (3): Progress Reporting* of *Attachment O: PATH Operational and Monitoring Protocol* in a timely manner.

B. Standardized Milestone Categories for Remaining PATH Programs and Initiatives

For the remaining PATH program/initiatives, Qualified Applicants must meet milestones across the first two standardized milestone categories listed below, and depending on the scope of the requested funding, may be required to fulfill interim milestones in order to receive PATH funding.

i. **Written Approval of Application**. Qualified Applicants must submit and receive approval from DHCS or its contracted TPA on their application prior to receiving PATH funding.

ii. **Documented Completion of Activities Outlined in Application.** In order to receive PATH funding, Qualified Applicants must complete the activities outlined in their original application and submit an invoice, utilization or progress report (as requested by DHCS) documenting completion. Activities may include, for example:

a. Timely submission of required progress reports and reporting on performance metrics.
b. Timely submission of an invoice for the delivery of approved services as part of the Support for Sustaining Services Through the Transition to Managed Care and/or Support for Sustaining Reentry Demonstration Initiative Services Through the Transition to Managed Care initiatives.
c. Successful completion of the technical assistance goals outlined by the Qualified Applicant in Technical Assistance initiative application.
d. Completion of a collaborative planning and implementation webinar series.
e. Hiring of a community health worker to support the delivery of ECM and/or Community Supports/HRSN.
f. Successful collaboration between a county Sheriff's office and a county department of social service to identify funding needs to support implementation of pre-release enrollment and suspension processes for the Reentry Demonstration Initiative Planning and Implementation Program.

iii. **Progress Towards Organization/Project Specific Milestones Approved in Application.** Depending on the nature of the project and/or funding request, Qualified Applicants may propose organization / project-specific milestones/deliverables as part of their applications. Ongoing PATH funding may be contingent upon the Qualified Applicant meeting such interim milestones, as determined by DHCS, and defined by Qualified Applicants as part of their initial applications, and approved by the State and its TPA. Sample interim milestones/deliverables may include, for example:

a. Facilitation of a certain percentage of planned convenings in a collaborative planning series.
b. Completion of an assessment of current organizational capabilities prior to determining hiring needs.
c. Conducting a certain number of collaborative planning sessions between correctional institutions and county social service departments to assist with the coordination of Medi-Cal enrollment and suspension processes.

Attachment O
Providing Access and Transforming Health (PATH)
Operational and Monitoring Protocol

Attachment O
Providing Access and Transforming Health (PATH) Operational and Monitoring Protocol

In accordance with the State's section 1115 demonstration Special Terms and Conditions (STC 5.13 – 5.25) this protocol outlines key operational features of the Providing Access and Transforming Health (PATH) initiative as required by STC 5.24. The State is authorized for up to $1.85 billion (total computable) in expenditure authority for two approved PATH Programs: the Ensuring Access to Services During Transition and Delivery System Transformation and Innovation Program (which is comprised of five initiatives) and the Reentry Demonstration Initiative Planning and Implementation Program. PATH is a one-time transitional funding that will support the State's efforts to maintain, build, and scale the capacity necessary to transition the Whole Person Care (WPC) Pilot Program and Health Home Pilots approved in the Medi-Cal 2020 demonstration to the California Advancing and Innovating Medi-Cal (CalAIM) initiative. This protocol outlines: (1) allowable state expenditures for activities permitted under PATH; (2) required performance metrics; (3) progress reporting; and, (4) the State's approach to PATH-related program integrity, oversight and monitoring across the two approved PATH Programs. *See Attachment N: PATH Funding and Mechanics Protocol for the award criteria and milestones for Qualified Applicants to receive funding through PATH.*

(1) **Allowable Expenditures.** Allowable state expenditures under all PATH programs and their associated initiatives are described below. Expenditures under the Ensuring Access to Services During Transition and Delivery System Transformation and Innovation Program are organized by initiative, as described below. PATH funding must complement or enhance, but not supplant related funding provided by other federal, state or local funding sources. To the extent otherwise allowable, PATH activities are reimbursed by other federal, state or local programs, and PATH funding must not duplicate such reimbursement.

Consistent with the federal "free care" guidance with respect to third party payment, other sources of funding do not have to be exhausted before a Qualified Applicant receives and applies PATH funding, or an authorized provider bills an Medi-Cal Managed Care Plan (MCP) for an approved Community Supports/Health Related Social Needs (HRSN) service that the Medi-Cal MCP has elected to offer. For example, where a county or local provider may access funding for comparable housing support services under another program, the county or local provider is not required to use that funding before providing and seeking PATH funding or Medi-Cal MCP reimbursement for a Community Supports/HRSN housing support service to an eligible Medi-Cal enrollee. Double billing or duplicative reimbursement for the same delivered service is not permitted. Other available funding should be used to provide additional and complementary services or supports that may benefit Medi-Cal members or other community residents depending on the purposes of the funds.

Allowable expenditures by PATH program and initiative include:

Ensuring Access to Services During Transition and Delivery System Transformation and Innovation Program:

A. **Support for Sustaining Services Through the Transition to Managed Care:** Qualified Applicants may receive PATH funding for the continued operation of allowable WPC services that will transition to Enhanced Care Management (ECM) and Community Supports/HRSN[5] by January 1, 2024, as approved in their application to the State. *(See Attachment N: PATH Funding and Mechanics Protocol for more details).*

B. **Support for Sustaining Reentry Demonstration Initiative Services Through the Transition to Managed Care:** Qualified Applicants may receive PATH funding for the delivery of allowable WPC reentry demonstration initiative services and supports that will transition to ECM by January 1, 2024, as approved in their application to the State. *(See Attachment N: PATH Funding and Mechanics Protocol for more details).*

C. **Technical Assistance Marketplace:** Qualified Applicants must apply received PATH funding for the purchase of resources or to engage with approved vendors in the technical assistance marketplace to provide customized project specific technical assistance in one or more of the domains listed below**:**
    i. Contracting between Medi-Cal MCPs and providers;
    ii. Collecting, documenting and exchanging data between MCPs and providers;
    iii. Billing for ECM and Community Supports/HRSN services;
    iv. Building provider capacity and developing care plans to support ECM and Community Supports/HRSN service delivery;
    v. Designing new workflows/service delivery models to support ECM and Community Supports/HRSN service delivery;
    vi. Supporting applicants in applying for regional CalAIM collaborative planning and implementation efforts or other types of PATH funding;
    vii. Organizational strategic planning to support CalAIM implementation;
    viii. Promoting health equity through the delivery of ECM and Community Supports/HRSN;
    ix. Engaging with stakeholders to support the implementation of ECM and Community Supports/HRSN;
    x. Aiding entities in understanding and navigating CalAIM program requirements;
    xi. Supporting applicant compliance with monitoring, oversight and program integrity requirements; and/or,
    xii. Other domains approved by the State.

D. **Collaborative Planning and Implementation for ECM and Community Supports**/HRSN**:** Funding from this initiative will support facilitation of local collaborative planning groups. Qualified Applicants must apply received funds for one or more of the activities described below. The State may consider providing funding to

[5] As described in the State's 1115 demonstration and 1915(b) waiver. Community Supports/HRSN are equivalent to in-lieu-of-services (ILOS).

Qualified Applicants for allowable activities performed prior to the start of the application period, but not before January 1, 2022, and only on a case by case basis:

i. Identifying ECM and Community Support/HRSN needs and gaps within the community;
ii. Working with MCPs to review Incentive Payment Program (IPP) Needs Assessment and Gap Filling Plans to prevent duplication with PATH[6];
iii. Educating stakeholders on key topics related to CalAIM and PATH;
iv. Facilitating convenings to identify, discuss, and resolve local implementation issues that arise as CalAIM is rolled out across a county/region;
v. Conducting quality improvement activities to ensure the delivery of high-quality services;
vi. Monitoring how PATH and other funds are being used to address implementation issues to ensure funding is going towards identified and prioritized uses, e.g., closing ECM or Community Supports/HRSN service gaps, addressing community level infrastructure needs to expand access to ECM or Community Supports/HRSN in certain geographic areas;
vii. Disseminating written materials or hosting webinars on best practices on ECM or Community Supports/HRSN service delivery or operational processes and/or providing guidance to collaborative planning entities that addresses implementation issues;
viii. Identifying and inviting entities to participate in local collaborative planning groups;
ix. Conducting outreach to entities that have been historically underutilized and/or under-resourced (as defined by DHCS), and/or that serve the diverse needs of the state's population to encourage participation in CalAIM; and/or,
x. Other activities approved by the State (e.g., hosting topical roundtables on key issues that arise during the collaborative planning process, forming population specific collaboratives such as those serving tribes/tribal entities, providing support to entities in accessing other PATH resources via the Technical Assistance Marketplace or Support for Expanding Access to Services, etc.).

E. Support for Expanding Access to Services. Qualified Applicants must use received funding for one or more or the activities described below. The State may consider providing funding to Qualified Applicants for allowable activities performed prior to the start of the application period, but not before January 1, 2022, and only on a case by case basis:

i. Increasing the provider workforce, including, for example, by assessing current organizational capabilities and capacity to deliver ECM and Community Supports/HRSN and supporting initial hiring, recruiting, onboarding, and

[6] The State has designed and is implementing a $1.5 billion CalAIM Incentive Payment Program (IPP) to stimulate Managed Care Plan (MCP) investments in ECM and Community Supports/HRSN infrastructure and capacity (https://www.dhcs.ca.gov/Pages/ECMandILOS.aspx). To be eligible for incentive payments, MCPs must assess ECM and Community Supports/HRSN capacity and infrastructure gaps in their region and demonstrate progress in filling those gaps against a set of DHCS established metrics and must meet or exceed specified thresholds.

training for staff that have a direct role in executing ECM and Community Supports responsibilities/HRSN;

ii. Modifying, purchasing and/or developing the necessary referral, billing, data reporting or other infrastructure and IT systems, to support integration into CalAIM;

iii. Providing upfront funding needed by Qualified Applicants to support capacity and infrastructure necessary to deliver ECM and Community Supports/HRSN services (e.g., support for hiring additional team members needed to provide ECM/Community Supports/HRSN;

iv. Evaluating and monitoring ECM and Community Supports/HRSN service capacity to assess gaps and identifying strategies to address gaps (e.g., conducting a community health needs assessment to identify where there are gaps in capacity for one or more Community Supports/HRSN);

v. Developing a plan to conduct outreach to populations who have traditionally been under-resourced and/or underserved to engage them in care; and/or

vi. Other activities approved by the State.

PATH Reentry Demonstration Initiative Planning and Implementation Program

F. **PATH Reentry Demonstration Initiative Planning and Implementation Program**: Qualified Applicants must apply received funding for the activities described below. The State may consider providing funding to Qualified Applicants for activities performed prior to the start of the application period, but not before January 1, 2022, and only on a case by case basis:

i. Modifying technology and IT systems needed to support Medi-Cal enrollment and suspension processes. This includes development of electronic interfaces for correctional facilities to communicate with Medicaid county welfare department eligibility and enrollment IT systems to support Medi-Cal enrollment and suspension;

ii. Recruiting, hiring, onboarding, and training staff to assist with the coordination of Medi-Cal enrollment and suspension for justice-involved individuals;

iii. Development or modification of protocols and procedures that specify steps to be taken in preparation for and execution of the Medi-Cal enrollment and suspension processes for eligible individuals;

iv. Facilitating collaborative planning activities between correctional institutions, correctional agencies, county welfare and social services departments, and other stakeholders as needed to support planning, implementation, and modification of Medi-Cal enrollment and suspension processes;

v. Activities to support a milieu appropriate for provision of Medi-Cal pre-release services including accommodations for private space such as movable screen walls, desks, and chairs to conduct assessments and screenings within correctional institutions, and support for installation of audio-visual equipment or other technology to support pre-release services delivered via telehealth.

vi. Planning focused on development or modification of processes and information sharing protocols to:

a. Identify uninsured individuals who are potentially eligible for Medi-Cal;
b. Assisting with the completion of a Medi-Cal application;
c. Submitting an application to the county welfare eligibility and enrollment departments or coordinating suspension;
d. Establishing on-going oversight and monitoring of processes upon implementation; and,

vii. Other activities approved by the State.

(2) **Performance Metrics.** Progress reports submitted by Qualified Applicants will include information detailing their progress towards milestones and performance metrics that are standardized by the initiative. In order to receive ongoing funding, Qualified Applicants must meet both milestones set forth in *Attachment N: PATH Funding and Mechanics Protocol* as well as submit all required progress reports informing progress towards performance metrics detailed here. When appropriate, the Third-Party Administrator (TPA) will summarize and report on performance metrics across Qualified Applicants that have received PATH funding.

A. Support for Sustaining Services Through the Transition to Managed Care: Qualified Applicants must report directly to the State at regular intervals on the following performance metrics, including, at a minimum:

i. Utilization of PATH-funded services as reported in semi-annual utilization reports that include the following information:
   a. Client identification numbers;
   b. FFS/PMPM service codes;
   c. Dates of service; and,
   d. Demographic data on individuals receiving services (if available).[7]

ii. Funding claimed for eligible services as reported in semi-annual invoices summarizing services delivered; and,

iii. Other metrics as defined by the State.

B. Support for Sustaining Reentry Demonstration Initiative Services Through the Transition to Managed Care: Qualified Applicants must report directly to the State at regular intervals on the following performance metrics, including, at a minimum:

i. Utilization of PATH-funded services as reported in semi-annual utilization reports that include the following information:
   a. Client identification numbers;
   b. FFS/PMPM service codes;
   c. Dates of service; and,

[7] In addition, the State will crosswalk demographic data provided through Support for Sustaining Services Through the Transition to Managed Care reporting with existing data from the State's Medi-Cal Eligibility Data System (MEDS).

d. Demographic data on individuals receiving services (if available).[8]

ii. Funding claimed for eligible services as reported in semi-annual invoices summarizing services delivered; and,

iii. Other metrics as defined by the State.

C. Technical Assistance Initiative: The TPA must report to the State at regular intervals across the following Technical Assistance Initiative performance measures, including, at a minimum:

i. Total funding dispersed to entities by county and by Qualified Applicant (to ensure fair distribution of resources);

ii. Which Qualified Applicants have applied for Technical Assistance services;

iii. Which Qualified Applicants were funded to receive Technical Assistance services and how much funding was allocated to the Qualified Applicant;

iv. Which Qualified Applicants applied for Technical Assistance and were not funded and the reason(s) why funding was rejected;

v. Utilization of different Technical Assistance resources by domain and by Qualified Applicant;

vi. Number of Qualified Applicants that met self-defined milestones during the performance period;

vii. Number of Qualified Applicants that failed to meet self-defined milestones during the performance period;

viii. Outreach efforts to reach Qualified Applicants that are under-resourced and/or serve historically underserved communities (as defined by the State and to be documented via a future demonstration Monitoring Report);

ix. Outreach efforts to entities in counties that are not on track to hit target funding disbursements;

x. Number of Qualified Applicants that are under-resourced, and/or serve historically underserved communities (as defined by the State);

xi. Summary of complaints/grievances; and,

xii. Other measures as defined by the State.

D. Collaborative Planning and Implementation Initiative: The TPA must report to the State at regular intervals across the following Collaborative Planning and Implementation Initiative performance measures, including, at a minimum:

i. Entity participation in collaborative planning groups, including which entities are under-resourced, and/or serve historically underserved communities (as defined by the State);

ii. Agendas and meeting summaries of collaborative planning convenings;

iii. Identified successes and challenges experienced by participants in the collaborative planning initiative;

iv. Lessons learned and best practices identified in the collaborative planning group;

[8] In addition, the State will crosswalk demographic data provided through Support for Sustaining Reentry Demonstration Initiative Services Through the Transition to Managed Care reporting with existing data from the State's Medi-Cal Eligibility Data System (MEDS).

v. Results from a participant survey assessing satisfaction with collaborative planning facilitators and recommendations for future topics and convenings;
vi. Summary of complaints/grievances received related to the initiative; and,
vii. Other metrics as defined by the State.

E. Support for Expanding Access to Services Initiative: The TPA must report to the State at regular intervals across the following Support for Expanding Access to Services Initiative performance measures, including, at a minimum**:**

i. Total funding dispersed to entities by county (to ensure fair distribution of resources);
ii. Outreach efforts to entities in counties that are not on schedule to provide target funding disbursements;
iii. Number of Qualified Applicants that met self-defined milestones during the performance period;
iv. Number of Qualified Applicants that failed to meet self-defined milestones during the performance period;
v. Number of Qualified Applicants that received funding, and amount of funding received by type of entity (e.g., county, provider, community-based organization, etc.);
vi. Number of Qualified Applicants that are under-resourced and/or serve historically underserved communities (as defined by the State), and amount of funding received by type of entity (e.g., county, provider, community-based organization, etc.);
vii. Number of Qualified Applicants that were denied funding, and rationale indicating why;
viii. Summary of how funding was applied, including by allowable activity type;
ix. Number of Qualified Applicants that reported applying received funds for purposes that were not documented in applications;
x. Summary of complaints/grievances received related to the initiative; and,
xi. Other metrics as defined by the State.

F. Reentry Demonstration Initiative Planning and Implementation Program: The TPA must submit a report to the State by December 31, 2023 that summarizes performance measures for this program. The report will document at a minimum:

i. Number of Qualified Applicants that received funding, including by type of Qualified Applicant (e.g., Sheriff's Office, Probation Office, County Department of Social Service etc.);
ii. Number of qualified applicants that were denied funding, and rationale indicating why;
iii. Total funding dispersed by type of Qualified Applicant;
iv. Summary of the payments made by type of Qualified Applicant broken out by allowable activities type;
v. Number of Qualified Applicants that met self-defined milestones during the performance period;
vi. Number of Qualified Applicants that failed to meet self-defined milestones during the performance period; and,

vii. Other metrics as defined by the State.

(3) **Progress Reporting**. Qualified Applicants that receive PATH funding must provide progress reports to the State or the TPA (as required) documenting progress toward approved, entity-specific milestones and standardized[9] performance metrics.

i. Progress reports for all PATH initiatives must be submitted to the State or the TPA, at a minimum, bi-annually.

ii. Progress reports for the Support for Sustaining Services Through the Transition to Managed Care and the Support for Sustaining Reentry Demonstration Initiative Services Through the Transition to Managed Care will be submitted directly from funding recipients to the State. Progress reports for all other PATH initiatives and programs will be submitted by the funding recipient to the TPA, who will then collate information in these progress reports into performance metrics, review them, and provide status reports to the State.

iii. Progress reports from Qualified Applicants must include, at a minimum:
   a. Narrative description of achieved milestones, as defined in the Qualified Applicant's application, or progress towards milestones during the reporting period *(described further in Attachment N: PATH Funding and Mechanics Protocol);*
   b. Reporting to inform progress towards standardized performance metrics, including progress towards specific State-specified targets, as appropriate (described in detail in *Section (2): Performance Metrics*);
   c. Description of how funds were applied during reporting period.
   d. Description of activities/milestones that were not achieved as expected during the reporting period, and an explanation indicating why they were not achieved, and the strategies to overcome hurdles to achieve them. Future progress reports should include subsequent progress in completing those activities/milestones, or other mitigation strategies, as applicable;
   e. Requests to modify activities/milestones and the budget, as needed, including the rationale for modification; and,
   f. Attestation of non-duplication of reimbursement and supplantation of PATH funding consistent with the requirements in Attachment N.

iv. For applicable initiatives, the TPA must summarize progress report findings and report them to DHCS.
   a. Upon request, the TPA must make available to the State any individual progress report submitted by a Qualified Applicant, for any initiative.

v. Upon receipt, the State or TPA (as appropriate, based on initiative) is responsible for reviewing and approving the progress report. In the event that progress reports are rejected, the Qualified Applicant will have 30 days to rectify any deficiencies and submit an updated report to the State. If an entity fails to submit an appropriately

[9] DHCS works with the TPA to develop standardized criteria and implement appropriate performance metrics for each of the PATH initiatives. DHCS provides oversight and is accountable for setting criteria, and standardized reporting requirements and metrics. The TPA is responsible for developing recommended criteria and performance metrics for DHCS consideration and for operationalizing the reporting processes (i.e., collecting reports from qualified applicants and analyzing findings) and implementing initiative requirements per DHCS's direction.

updated report then the State may pursue corrective action in accordance with Section (4) below.

(4) **Program Integrity, Oversight and Monitoring:** The State will monitor and enforce program integrity standards in the PATH program, across all initiatives, including through the following mechanisms as required by STC 5.24(a)-(c):

A. Regular Progress Reporting

i. As described in Section (2) (i) above, all Qualified Applicants that receive PATH Funding must submit regular progress reports to the State or its contracted TPA, as applicable, including all required attestations, including updated attestations as needed.
ii. The State or its contracted TPA will monitor for funding irregularities and potential supplantation of federal, state and/or local programs across all PATH programs and initiatives.
iii. The State or its contracted TPA will monitor for funding irregularities and potential duplication of reimbursement by federal, state and/or local programs across all PATH programs and initiatives.

B. Participating in Audit Processes

i. The State or its TPA, as appropriate, must perform spot check audits of funding disbursements across all PATH initiatives. Spot check audits must include, at a minimum:
    a. Review of documentation to support activities identified on PATH invoices to ensure funds were appropriately applied;
    b. With respect to the Technical Assistance, Collaborative Planning and Implementation, Support for Expanding Access, and Reentry Demonstration Initiative Planning and Implementation Program Initiatives, identifying instances where PATH funds have potentially been applied on activities outside of those that are approved;
    c. Detecting irregularities, discrepancies or outliers requiring further investigation; and
    d. Identifying instances of potential payment duplication or supplantation of federal, state and/or local funds. Such review shall take into account the Qualified Applicant's description of how other support from state, federal or local programs are complementary to PATH funding consistent with Attachment N.

C. Actions Taken to Correct Underperformance

i. The State and its contracted TPA will utilize a standardized Corrective Action Plan process for Qualified Applicants who are not meeting progress reporting or other requirements for receipt of PATH funding.
ii. Underperformance is defined as, at a minimum:
    a. Failure to submit timely progress reports or invoices to the State or TPA;

b. Failure to adequately correct progress reports that have been rejected by the State or TPA;
c. Invoice, utilization report or progress report submission errors;
d. With respect to the Technical Assistance, Collaborative Planning and Implementation, Support for Expanding Access to Services, and Reentry Demonstration Initiative Planning and Implementation Program Initiatives, applying PATH funding for non-approved activities, or duplicating reimbursement; and,
e. Significant discrepancies between planned application of PATH funds and actual program activities.

iii. Upon identifying underperformance, the State or its contracted TPA must issue a written notice to the Qualified Applicant detailing their underperformance and requesting a written Corrective Action Plan Strategy that will describe how the Qualified Applicant will improve on areas of underperformance.
iv. Qualified Applicants that receive a request for a Corrective Action Plan Strategy must submit a written plan that will describe how the Qualified Applicant will improve on areas of identified underperformance. The Qualified Applicant must include in their submission a "performance improvement plan" that clearly states the steps taken to rectify the underperformance.
v. Failure to implement steps in the written plan in a timely manner may result in discontinuation and/or recoupment of awarded PATH funding (see addressing non-compliance below).
vi. The TPA will report to the State on any Qualified Applicants that are subject to a Corrective Action Plan process.

D. Actions Taken to Addressing Non-Compliance

i. Funding to Qualified Applicants will be discontinued and/or recouped in the following instances, at a minimum:
    a. Instance where corrective action has been imposed and underperformance continues.
    b. Cases of fraud, waste and/or abuse.
ii. Qualified Applicants that have funding discontinued and/or recouped may also be precluded from being approved to receive additional PATH funding in the future.
iii. The TPA will report to the State on any Qualified Applicants that have had funding discontinued, recouped, and/or have been precluded from being approved to receive additional PATH funding in the future.

Attachment P
Historical Information-Budget Neutrality Test
(Reserved)

Attachment Q
DSH Coordination Methodology

Attachment Q
DSH Coordination Methodology

During any year in which the State of California conducts the Global Payment Program ("GPP"), the state shall make the modifications listed in this Attachment Q to its methodologies for making disproportionate share hospital payments under the DSH State Plan provisions (Attachment 4.19-A, commencing with page 18).

1. The state shall not make disproportionate share hospital payments during a state fiscal year to any designated public hospital that participates in the Global Payment Program during that year.

2. Prior to the start of the applicable GPP PY, or as soon thereafter as possible, the amount of the preliminary federal DSH allotment under SSA § 1923(f) for the FFY that commences prior to the start of (for GPP PYs 7-12) or commences in (for GPP PYs 1-6) the applicable GPP PY shall be determined. For this purpose, the allotment identified for California for the applicable FFY in the Preliminary Disproportionate Share Hospital Allotments file that is released by CMS shall be initially used.

3. Hospitals that meet DSH eligibility criteria and are "non-cost-based DSH facilities," as defined under the DSH State Plan provisions, will receive DSH payments pursuant to the applicable State Plan methodology. The state shall calculate the sum of the DSH payment amounts projected for non-cost-based DSH facilities, less the non-federal share, which shall be the federal DSH allotment amount set aside for these DSH facilities.

4. Hospitals that meet DSH eligibility criteria and are "non-government operated hospitals," as defined under the DSH State Plan provisions, will receive DSH payments pursuant to the applicable State Plan methodology. The state shall calculate the sum of the DSH payment amounts projected for non-government operated hospitals, less the non-federal share, which shall be the federal DSH allotment amount set aside for these DSH facilities.

5. The federal DSH allotment set-aside amounts determined above for non-cost-based DSH facilities in paragraph 3, and for non-government operated hospitals in paragraph 4, will be subtracted from the full federal DSH allotment amount identified in paragraph 2.

6. Hospitals that meet DSH eligibility criteria, and are "cost-based DSH facilities" as defined under the DSH State Plan provisions, and which are licensed to the University of California and not participating in GPP for the applicable PY, will receive DSH payments pursuant to the applicable State Plan methodology, subject to an annual aggregate cap on the associated federal DSH allotment for those payments. The annual aggregate cap is equal to an applicable percentage multiplied by the amount of the federal DSH allotment that is left after the set-asides for non-cost-based DSH facilities and non-government operated hospitals, as calculated in paragraph 5, which shall be the DSH allotment amount set aside

for the University of California DSH facilities. The applicable percentages for each GPP PY are as follows:

GPP PY 1:	26.296%
GPP PY 2:	24.053%
GPP PY 3:	23.150%
GPP PY 4:	21.896%
GPP PY 5:	21.896%
GPP PY 6:	21.896%
GPP PY 7:	21.896%
GPP PY 8:	21.896%
GPP PY 9:	21.896%
GPP PY 10:	21.896%
GPP PY 11:	21.896%
GPP PY 12:	21.896%

Should any cost-based DSH facility licensed to the University of California elect to forego DSH payments to participate in GPP beginning with any GPP PY in the Demonstration, this percent shall be modified to reflect the appropriate shift of funds. Any modification to this percent shall be approved by CMS prior to implementation, and the list of GPP-participating PHCS in Attachment C will be amended accordingly.

7. The full federal DSH allotment amount, less the aggregate DSH allotment set-aside amounts determined for non-cost-based DSH facilities in paragraph 3, for non- government operated hospitals in paragraph 4, and for cost-based DSH facilities licensed to the University of California in paragraph 6, shall constitute the initial "Adjusted DSH" component of the funding for the GPP described in STC 78. For GPP PY 6, the "Adjusted DSH" component shall reflect an additional reduction of 50%. To align federal DSH allotment funding with GPP PYs 7 through 12, 50% of this Adjusted DSH amount will fund a portion of the GPP PY.

8. For GPP PYs 7-12, the remaining allotment funding for the GPP PY will be determined pursuant to the same steps in paragraph 3-7 based on the FFY preliminary federal DSH allotment under SSA § 1923(f) allocated to California for the FFY that commences during the GPP PY, including the application of the 50% reduction to ensure alignment with the GPP PY. Until the Preliminary Disproportionate Share Hospital Allotment file for the FFY commencing during the GPP PY is released by CMS, an estimated 2% increase over the prior FFY DSH allotment will be used.

9. The initial combined Adjusted DSH component pursuant to paragraphs 7 and 8 is determined no later than May 15 prior to the start of GPP PYs 1 through 6 and no later than November 15 prior to the start of GPP PYs 7 through 12.

10. The final combined Adjusted DSH component of the GPP shall be determined pursuant to the steps in paragraphs 1 – 8 above, which shall take into account the following:

a) The allotment identified for California in the Final Disproportionate Share Hospital Allotments file that is released by CMS for the applicable FFY that commences during the GPP PY (for PY 1-6) and for the applicable FFY that commences prior to the start of the GPP PY (for PY 7-12).

b) The actual amount of DSH payments paid or payable to the hospitals described in paragraphs 3, 4 and 6 for the applicable state fiscal year; and

c) The results of the applicable DSH audits for the hospitals, including any adjustments that increase or decrease DSH payments to the hospitals.

11. Adjustments shall be made to the GPP total computable annual limit and GPP annual budgets to take into account the final Adjusted DSH component for the applicable GPP PY determined in paragraph 10, and, notwithstanding the final payment timeline set forth in Attachment K, all final reconciliation payments for the applicable GPP PY made pursuant to Attachment K shall be subject to these adjustments.

12. Within 30 days of its determination of the initial "Adjusted DSH" component discussed in step 9, the state will submit a report to CMS stating the amount of the initial "Adjusted DSH" component for the applicable GPP PY (with explanation for how "Adjusted DSH" component was calculated) and projected DSH payment amounts for all hospitals that will receive DSH payments.

13. Within 30 days of its determination of the final "Adjusted DSH" component discussed in step 10, the state will submit a report to CMS stating the amount of the final "Adjusted DSH" component for the applicable GPP PY, the actual and final amount of DSH payments paid or payable to the hospitals described in paragraphs 3, 4 and 6 for the applicable state fiscal year, and the final GPP total paid to each GPP hospital.

The state will report all DSH payments to "non-cost-based DSH facilities," "non- government operated hospitals," "cost-based DSH facilities" licensed to the University of California, and designated public hospitals not participating in the Global Payment Program, on Forms CMS-64.9 WAIVER, with waiver number 11-W-00193/9, under Waiver Name "DSH," and with project number extension indicating the demonstration year corresponding to the federal fiscal year of the DSH allotment for which the payments were made.

Attachment R
Negative Balance Payment Schedule
(Reserved)

Attachment S
CBAS Program Integrity

Attachment S
CBAS Program Integrity

Following a determination that a credible allegation of fraud exists with respect to a CBAS provider, and that there is no good cause not to suspend payments, the State will initiate an email notification within one business day to all contracted Managed Care Plans (MCPs) that have provider networks in which the CBAS provider participates. Commencing with payments made by an MCP on or after April 1, 2016, MCPs will be required to report to the State all payments made to a CBAS provider for whom a credible allegation of fraud exists for dates of services rendered after the date the MCP was notified. The procedures below outline details regarding the reporting and recoupment process:

- The State's notification email to the MCPs will contain specific instructions for reporting requirements. MCPs will utilize the "Total MCP Payments to CBAS under Credible Allegation of Fraud" form to track total payments made to the applicable CBAS provider on a quarterly basis, commencing with the first quarter that the MCP was notified of the credible allegation of fraud. Reports for all subsequent quarters will indicate the total payments made for the given quarter, as well as the cumulative total payments made to the CBAS provider from the date following initial notification of the credible allegation of fraud.

- MCPs will submit quarterly reports to the State within seven business days from the end date of each quarter. The State will, in turn, submit quarterly reports to CMS reflecting all MCP payments made to applicable CBAS providers within fifteen business days from the end date of each quarter.

- Reporting requirements will remain in effect until the State notifies the MCP that the law enforcement agency investigating the credible allegation of fraud has either charged the CBAS provider with fraud or has informed the State that there is insufficient evidence to bring charges. Upon receipt of such information from the investigating agency, the State will notify the MCPs of the determination via email within three business days.

- The notification of the MCP by the State that there no longer exists a credible allegation of fraud against a CBAS provider will immediately extinguish the MCP's responsibility for quarterly reporting to the State and the State's responsibility for quarterly reports regarding payments to that CBAS provider to CMS.

- If, after investigation, the law enforcement agency brings charges against a CBAS provider for fraud, and the provider is either found guilty by the court or enters into a settlement agreement indicating fault by the provider occurs, the following actions will be required to ensure recovery of all payments made to the CBAS provider:

Recoupment to the State	Recoupment to CMS
1. The MCP will submit to the State within 15 business days of notification of a final report reflecting payments for dates of services rendered up until the date the MCP was notified by the State that the law enforcement agency has charged the CBAS provider with fraud and the provider is either found guilty by the court or enters into a settlement agreement indicating fault by the provider occurs. 2. Within 90 days of receiving the final report, the State will recoup the CBAS provider fraud amount from the MCP capitated payment. The statement issued to the MCP will reflect the CBAS provider fraud amount.	1. The State will submit to CMS within 15 business days of receipt of a final report reflecting MCP payments made to the applicable CBAS provider for dates of services rendered up until the date the MCP was notified by the State that the law enforcement agency has charged the CBAS provider with fraud and the provider is either found guilty by the court or enters into a settlement indicating fault by the provider occurs. 2. The State will reimburse CMS in accordance with its established repayment system by: A. Setting up an Accounts Receivable to reimburse the State General Fund through the MCP's recoupment for the Total Computable (federal and state share), and B. When applicable, completing Federal repayment paper work to reimburse CMS from the State General Fund.

Attachment T
CalAIM Evaluation Design

California Drug Medi-Cal Organized Delivery System

Evaluation Design

Part of California Advancing and Innovating Medi-Cal (CalAIM)

A Section 1115 Demonstration Waiver Evaluation

and

Including the Medi-Cal 2020 Calendar Year 2021 Temporary Extension

Revised 6/9/2023

UCLA David Geffen School of Medicine
Integrated Substance Abuse Programs

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General Background Information

The Drug Medi-Cal Organized Delivery System (DMC-ODS) 1115 demonstration waiver was created by the California Department of Health Care Services (DHCS) with the intent of addressing many previously existing limitations in the DMC system. Prior to the DMC-ODS, the system was comprised of fragmented services, creating gaps that undermined client access and quality of care. The continuum of substance use disorder (SUD) services was uncoordinated, making it difficult for clients to navigate the system. SUD treatment providers indicated that many important services they provided or wished to provide for clients were not billable, were only reimbursable if delivered by a limited number of provider types or were too limited to provide proper care to clients. Providers were not necessarily required to deliver evidence-based practices in line with current research, and counties lacked the authority to fully ensure the quality and accountability of their local providers.

The DMC-ODS was created to test the impact of organizing SUD services to improve service delivery to Medicaid-eligible individuals with SUDs. The intent was to demonstrate that organized SUD care improves quality, access, and coordination/integration of treatment for beneficiaries while decreasing other health care system costs. Under the DMC-ODS waiver, care is organized according to the American Society of Addiction Medicine (ASAM) Criteria for SUD services. The ASAM Criteria are a set of guidelines developed by ASAM to set a standard for appropriate assessment, placement, and treatment planning of clients with SUD and co-occurring disorders as well as to a set standard for SUD providers. Services under the DMC-ODS waiver also create a continuum of care and create requirements allowing for local control, accountability, and greater administrative oversight.

The DMC-ODS waiver was originally approved by CMS in August 2015, and later became part of California's larger Medi-Cal 2020 Waiver, which ended December 31, 2021. It is now part of California Advancing and Innovating Medi-Cal (CalAIM), which is being implemented through a combination of 1115 and 1915b waivers starting January 1, 2022 and continuing through December 31, 2026. Most DMC-ODS services are now covered in the California Medicaid State Plan. This evaluation covers DMC-ODS under CalAIM as an extension of DMC-ODS under Medi-Cal 2020, including an evaluation of the Medi-Cal 2020 calendar year 2021 temporary extension, and will continue to evaluate the impact of DMC-ODS since its inception.

The population targeted by DMC-ODS is Medicaid-eligible individuals with SUDs. As described in the DMC-ODS waiver's Special Terms and Conditions (STCs),[1] for counties that opt-in to the DMC-ODS waiver, beneficiaries must meet the medical necessity criteria and reside in a participating county to receive waiver services. Currently, the DMC-ODS waiver is implemented

[1] https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-1115-Approval-Letter-and-STCs.pdf

in 37 counties that cover 95.9% of the state's population.[2] It is anticipated that currently non-participating counties will be given the option to opt-in to DMC-ODS during the CalAIM demonstration. If they do, they will also become part of the DMC-ODS population for evaluation purposes.

To address rapidly rising stimulant overdoses, the DMC-ODS will also cover Contingency Management (CM) under a new pilot program known as the Recovery Incentives Program: California's Contingency Management Benefit. This program began implementation in March 2023. Stimulant-related overdose death rates in California are 7.2 times higher today than they were 10 years ago, putting stimulants approximately on par with opioids in terms of total overdose-related deaths[3]. Methamphetamine use is also associated with hypertension, myocardial infarction, stroke, aortic dissection, and heart failure (Manja et al., 2023). Currently, no Food and Drug Administration-approved medications exist for the treatment of Stimulant Use Disorders (StimUD), but studies have repeatedly supported the use of CM as a highly effective evidence-based practice in the treatment of StimUD, particularly in reducing drug use (De Crescenzo et al., 2018; Farrell et al., 2019; AshaRani et al., 2020; Brown & DeFulio, 2020; Ronsley et al., 2020). County participation in the Recovery Incentives Program is optional.

The previous DMC-ODS evaluation plan was approved by CMS on June 20, 2016. The resulting evaluation documented DMC-ODS implementation and found that the DMC-ODS waiver has improved access to treatment, treatment quality, and coordination of care, and met the initial goals of the DMC-ODS (Urada et al., 2016, 2017, 2018, 2019, 2021, 2022).[4] Health disparities were identified in treatment placement, however. Under the new waiver, aside from the addition of the Recovery Incentives Program, DMC-ODS remains mostly intact with the addition of changes to clarify or streamline billing, benefit rules, and facilitate Health IT. The current evaluation design will look for any effect of the new changes but is otherwise focused on monitoring maintenance of the measured improvements found during the initial waiver, identifying emerging trends, determining opportunities to facilitate further progress, evaluating health equity, and evaluating the new Recovery Incentives Program.

One component of the waiver is still under review: DMC-ODS services that are provided by Traditional Healers and Natural Helpers. If this benefit is approved in the future, the evaluation team will bring methods already being employed in other parts of the evaluation (e.g., analysis of claims, provider interviews, and client perception surveys described below) to bear on these services.

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[2] Projections Prepared by Demographic Research Unit, California Department of Finance, January 2021: https://www.dof.ca.gov/Forecasting/Demographics/Estimates/e-4/2010-21/documents/E-4_2021InternetVersion.xlsx

[3] Based on 12-month rolling averages from Q2 2021 and Q2 2011 data from: https://skylab.cdph.ca.gov/ODdash/. Total overdose deaths based on combination of psychostimulant and cocaine-related deaths.

[4] Due to data availability the 2022 report covered partial data for CY 2021. Analyses of 2021 data will be incorporated into the current evaluation as described in the methodology section.

If substantial external contextual issues arise in the future, the evaluation team will also measure and discuss these impacts, as the team has in the past with COVID-19 (Bass et al., 2022). Examples of potential contextual changes might include a waning (or increasing) impact of COVID-19, changes in the availability of fentanyl and high-potency stimulants, workforce shortages, increasing use of peers, and an expected IRS ruling that could have an impact on the size and total amount of incentives available to beneficiaries.

Evaluation Questions and Hypotheses

The evaluation will examine whether the DMC-ODS continues to achieve the following six goals as required by STC 46, an additional seventh goal on health disparities in the pursuit of CalAIM's goal of improving health equity, and an eighth goal based on STC 57e requirements specific to a contingency management evaluation. The Recovery Incentives Program also shares some overlapping goals with the rest of DMC-ODS (e.g., increased adherence and retention in treatment, reduced overdose deaths).

1. Increased rates of identification, initiation, and engagement in treatment;
2. Increased adherence to and retention in treatment;
3. Reductions in overdose deaths, particularly those due to opioids;
4. Reduced utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;
5. Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate;
6. Improved access to care for physical health conditions among beneficiaries.
7. Improved health equity across DMC-ODS performance and outcome measures.
8. An effective contingency management program, including cost-effectiveness and effects on beneficiary health outcomes.

UCLA will also coordinate with DHCS to leverage the monitoring metrics[5] that DHCS is reporting to CMS to incorporate these metrics into the evaluation UCLA will conduct more in-depth analyses and additional quantitative and qualitative data collection to provide important context, insights, and recommendations beyond these metrics.

A short summary of the approaches for each of these goals follows. Additional details on the measures can be found in Table 1.

[5] https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/sud-monitoring-metrics.pdf

Increased rates of identification, initiation, and engagement in treatment

UCLA will calculate identification using a combination of data from ASAM level of care screenings and assessments, Managed Care Plan / Fee-for-Service (MCP/FFS), and Drug Medi-Cal claims. Separately, DHCS will report on related metrics: Metric 1 - Assessed for SUD Treatment Needs Using a Standardized Screening Tool, Metric 2 - Medicaid Beneficiaries with Newly Initiated SUD Treatment/Diagnosis, Metric 3 - Medicaid Beneficiaries with SUD Diagnosis (monthly) and Metric 4 - Medicaid Beneficiaries with SUD Diagnosis (annually). DHCS will report the initiation and engagement monitoring metric as required (Metric 15 – Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment). However, there are data quality limitations to the initiation rate due to low rates of SUD diagnosis coding in the MCP/FFS delivery system.

Therefore, UCLA will enhance DHCS' and CMS' understanding of true initiation rates in the DMC-ODS evaluation by conducting more in-depth analyses that take these limitations into consideration. For example, UCLA can calculate initiation among DMC beneficiaries who were referred after an ASAM brief screening to assess the effectiveness of the DMC referral process. Separately, UCLA can calculate clients initiating DMC-ODS treatment after identification in physical health settings (merging DMC claims and MCP/FFS data) as a measure of coordination between the two systems. Trends in referrals to SUD treatment from health care sources will also continue to be monitored, and data on medications prescribed outside of specialty care settings will be reported for context.

Engagement rates as defined by NCQA can be accurately computed using claims data. Engagement has generally been steady over time among DMC-ODS clients (Padwa et al., 2022).

Earlier evaluation reports described increasing admissions and high levels of engagement in the DMC-ODS. About 23% of beneficiaries who had an ASAM-based brief screening received their indicated level of care within 30 days, leaving room for improvement. However, about 88% of clients who started treatment went on to engage in it by attending at least two more sessions (Padwa et al., 2022). Challenges to increase access included a shortage of qualified medical directors, licensed practitioners of the healing arts, bilingual staff, as well as difficulties in expanding medical withdrawal management, youth treatment, and understanding how to take advantage of the recovery services benefit. Penetration rates were likely limited in part due to the national phenomenon that 97.5% of people who need treatment usually do not recognize that need, and a smaller percentage do not seek treatment despite recognizing the need (SAMHSA, 2021). UCLA has recommended increasing outreach and screening in primary care and other non-specialty care settings as a result (Urada et al., 2022; Bass et al., 2022). SUD treatment referrals from health care sources have been flat, however, since the pre-DMC-ODS period (Lee et al., 2022). This may be in part due to increasing buprenorphine prescribing in primary care settings (Darfler et al., 2020). UCLA will continue to monitor these trends and conduct

stakeholder surveys and interviews to further investigate and recommend the best ways to close gaps in the number of people needing and receiving treatment.

Increased adherence to and retention in treatment

UCLA will analyze DMC-ODS claims to calculate length of stay, produce more in-depth analyses (e.g., by county, primary drug, race/ethnicity), and generate recommendations based on these results. The goal of improving overall retention may be complicated by the goal of reducing the statewide average residential length of stay to 30 days (STC 46). However, UCLA has provided recommendations to reduce the residential average length of stay without compromising quality (Urada et al., 2022, p. 108) and will continue monitoring trends. UCLA will also continue to track transitions in care. A slight increase in the rate of residential transitions to outpatient within 14 days was found among DMC-ODS counties, increasing from 7.1% in 2016 to 9.5% in 2020, as rates fell from 7.0% to 2.8% in state plan counties. Transitions from residential withdrawal management to residential treatment rose slightly from 17.0% to 20.2% in DMC-ODS counties from 2016 to 2020, while they rose from 3.2% to 8.0% in state plan counties (Lee et al., 2022).

Reductions in overdose deaths, particularly those due to opioids

While DHCS will be calculating and reporting required monitoring metrics[6] for this topic, specifically metric 26 – Overdose Deaths (count) and 27 – Overdose Deaths (rate), based on data provided to DHCS from CDPH, it will be important to place these metrics in context and control for them to the extent possible. In recent years, overdoses have risen in California despite the DMC-ODS due to external factors such as increasing availability of fentanyl and high-potency stimulants and the onset of the COVID-19 pandemic. In the future, potential emergence of new substances may further affect overdoses. For example, if xylazine use emerges in California, reducing the effectiveness of naloxone,[7] this could increase overdoses and have important policy ramifications for the use of this important tool. To the extent possible, UCLA will collaborate with DHCS and CDPH to examine the effect of treatment on overdose deaths and conduct in-depth analyses, e.g., by county, primary drug, race/ethnicity, and collect supplementary data from stakeholder surveys and/or interviews to generate recommendations. In addition to opioid overdose deaths, stimulant overdose deaths will be a particular focus of the evaluation of the Recovery Incentives Program.

[6] https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/sud-monitoring-metrics.pdf
[7] https://www.sciencedirect.com/science/article/pii/S037687162200117X

Reduced utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services

While DHCS will examine this among all Medi-Cal beneficiaries (metric 23 – Emergency Department Utilization for SUD and metric 24 – Inpatient Stays for SUD), similar to overdose deaths, it is likely that DMC-ODS effects may be overwhelmed by external trends. In both cases, difference in difference analyses will be employed where possible to separate the DMC-ODS effect (see analytic methods below). A decrease in recurring overdoses were observed for a subset of counties following residential treatment under DMC-ODS compared to pre-waiver period and State Plan counties (Khurana et al., 2022, p. 115-117). UCLA will continue to analyze data among people who received SUD treatment under the DMC-ODS to determine whether utilization of emergency departments and inpatient hospital settings decreased relative to the pre-waiver period and will conduct cost analyses to determine whether savings (if any) in these settings offset increased SUD treatment expenses.

Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate

UCLA will continue to use a measure adapted to DMC-ODS settings by focusing on readmissions to withdrawal management within 30 and 90 days of discharge. In 2020, the UCLA evaluation recently found that 17.5% of withdrawal management clients were readmitted within 90 days, down from 20% in 2019 (Padwa et al., 2022, p 64). UCLA will also describe residential readmissions with the understanding that not all readmissions are negative outcomes and examine whether transitions to outpatient treatment reduce residential readmissions.

Improved access to care for physical health conditions among beneficiaries

UCLA will examine improved access to physical health care among clients who participate in DMC-ODS treatment using annual client-reported ratings and administrative data. In 2020, 86% of clients agreed with the UCLA's Treatment Perceptions Survey item: "Staff here work with my physical health care providers to support my wellness," (Padwa et al., p. 66). UCLA will also analyze Medi-Cal MCP/FFS billing data to quantify increases in physical health care following admission to treatment. DHCS will also report metric 32 – Access to Preventative Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD, which identifies the percentage of beneficiaries with ambulatory or preventative care visits.

Additional details on how each measure will be collected and how the hypotheses will be tested are included in the methodology section that follows. A driver diagram for the evaluation can be found in Appendix A.

Improved Health Equity

Past analyses have found that DMC-ODS treatment admissions did trend higher among all racial/ethnic groups (Bass et al., 2022) after DMC-ODS implementation. However, disparities in timely linkage to care have been detected for youth, older adult, Black, and Hispanic Medi-Cal enrollees (Padwa et al., 2022). Also, once admitted, treatment engagement increased among younger clients but decreased among older ones. DHCS plans to use quality improvement efforts via the External Quality Review Organization, for example, to reduce or eliminate disparities. UCLA will also continue to closely examine trends in health equity within each measure included in the six goals previously described above, track these findings over time, investigate causes of any disparities found (e.g., through interviews and surveys), summarize findings, and generate recommendations. At a minimum, groups of interest will include race, ethnicity, age, gender, and location. UCLA and DHCS are examining the feasibility of adding other groups including sexual orientation based on the data availability.

CMS is currently reviewing the addition of Traditional Healers and Natural Helpers to the DMC-ODS. If approved, UCLA will also evaluate the impact of this change, particularly on the American Indian/Alaska Native (AI/AN) population.

An effective contingency management program, including cost-effectiveness and effects on beneficiary health outcomes.

Due to the large number of studies and systematic reviews that have established the efficacy of CM, the primary goal of the Recovery Incentives Program evaluation is not to conduct research aimed at further re-establishing effectiveness, but rather to evaluate the effectiveness of real-world implementation in the California Recovery Incentives Program, document efforts to scale this proven treatment in a large state, and to facilitate quality improvement. A range of hypotheses will be tested as shown in Table 1.

Consistent with STC 57e, to the extent feasible, the state will conduct evaluation analyses stratified by StimUD and other types of SUD. However, the Recovery Incentives Program is currently aimed exclusively at beneficiaries who have StimUD.

Since the Recovery Incentives Program is part of DMC-ODS, the overall DMC-ODS evaluation and all analyses are inclusive of the participating Recovery Incentives Program treatment sites and clients. However, more in-depth data collection and analysis will be specifically applied to the Recovery Incentives Program, including efforts to measure the effects of this program above and beyond that of DMC-ODS, e.g., comparing Recovery Incentives Program StimUD clients to non- Recovery Incentives Program StimUD clients in DMC-ODS.

Summary of key evaluation questions, hypotheses, data sources, and analytic approaches

Table 1 below summarizes the questions, hypotheses, and measures to be used in this study. As previously noted, UCLA will also coordinate with DHCS to incorporate established monitoring metrics[8] that DHCS is reporting to CMS separately. The measures below are meant to supplement DHCS-reported measures to answer remaining DMC-ODS-related questions, often by using data specific to California and DMC-ODS (e.g., California's ASAM LOC Placement data, Incentive Manager data, UCLA-administered surveys).

[8] https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/sud-monitoring-metrics.pdf

Table 1. Summary of key evaluation questions, hypotheses, data sources, and analytic approaches

Driver	Potential Measures	Measure Steward, Endorsement	Numerator	Denominator	Data Source(s)	Analytic approach
Question: Are rates of overdose deaths impacted by the demonstration? Goal: Reduction in overdose deaths, particularly those due to opioids. Hypothesis: People with opioid use disorders (OUD) who receive MAT and people with StimUD who participate in the Recovery Incentives Program will be less likely to have an overdose death compared to people with OUD and StimUD who do not receive these services, respectively.						
Primary Driver: Reduce overdose deaths	Overdose deaths overall and among opioids and stimulants separately	None	N/A	N/A	California Comprehensive Death File, CA Department of Public Health matched to DMC Claims	Compare individuals with StimUD who participated in the Recovery Incentives Program to those who did not Time period: Start of Recovery Incentives Program (2023) through end of waiver (2026) contingent on data availability Compare individuals with OUD who received MAT to those who did not and determine whether access to MAT increased under DMC-ODS (2015-2026, contingent on data availability) Quasi-experimental causal inference designs including but not limited to difference-in-differences augmented with propensity score matching as needed, synthetic controls, etc.

Table 1. Summary of key evaluation questions, hypotheses, data sources, and analytic approaches						
Driver	**Potential Measures**	**Measure Steward, Endorsement**	**Numerator**	**Denominator**	**Data Source(s)**	**Analytic approach**
Question: Does the demonstration increase access to and utilization of SUD treatment services? Goal: Increased rates of identification, initiation, and engagement in SUD treatment services. Hypothesis: Counts or rates will be maintained at benchmark year* levels or higher.						
Primary Driver: increased rates of identification, initiation, and engagement in treatment	Number of ASAM level of care screenings and assessments	None	Number of ASAM LOC screenings and assessments	N/A	ASAM LOC Placement data	Descriptive statistics using parametric and/or non-parametric tests of statistical significance and/or regression analysis to confirm identification, IET rates, and timely admission to the indicated level of care are maintained or improve between comparison & waiver periods (2020-2026, contingent on data availability)
	Initiation among beneficiaries with an ASAM brief screening	NQF #0004 adaptation	Number of beneficiaries who initiated treatment within 14 days of the index episode start date	Number of beneficiaries with an ASAM brief screening with a level of care recommendation	DMC Claims, ASAM LOC Placement data	
	Engagement in treatment among DMC-ODS clients	NQF #0004	Initiation of tx and two or more encounters with any SUD diagnosis within 30 days after initiation	Number of beneficiaries (above) who initiated treatment	DMC Claims, ASAM LOC Placement data	
Secondary Driver: Ensure appropriate and timely placement according to ASAM criteria	Timely admission to the indicated level of care within 30 days of ASAM Criteria-based brief screenings	None	Admission within 30 days of an ASAM Criteria-based brief screening	Beneficiaries with an ASAM brief screening with a level of care recommendation	DMC Claims, ASAM LOC Placement data	Descriptive Statistics (2020-2026, contingent on data availability)

Table 1. Summary of key evaluation questions, hypotheses, data sources, and analytic approaches						
Driver	**Potential Measures**	**Measure Steward, Endorsement**	**Numerator**	**Denominator**	**Data Source(s)**	**Analytic approach**
Secondary Driver: Ensure clients are satisfied with services	UCLA Client Treatment Perceptions Survey ratings, % of clients providing a 4 or higher rating on all questions	UCLA	Clients providing a 4 or 5 rating	All TPS participants	UCLA Client Treatment Perceptions Survey	Descriptive statistics (2020-2025)
Secondary Driver: Quality improvement efforts	UCLA County administrator survey questions on the impact of QI activities and the EQRO	None	N/A	N/A	County administrator survey	Descriptive statistics (2020-2026)
Question: Do enrollees receiving SUD services adhere to and remain in treatment? Goal: Increased adherence to and retention in treatment. Hypothesis: Adherence and retention will be maintained at benchmark year* levels or higher.						
Primary Driver: Adherence to and retention in treatment	Days in treatment	None	N/A	N/A	DMC Claims CalOMS-Tx	Descriptive statistics using parametric and/or non-parametric tests of statistical significance, and/or regression analysis and quasi-experimental causal inference designs including but not limited to difference-in-differences augmented with propensity score matching as needed, synthetic controls, etc. (2020-2026, contingent on data availability)

Table 1. Summary of key evaluation questions, hypotheses, data sources, and analytic approaches						
Driver	**Potential Measures**	**Measure Steward, Endorsement**	**Numerator**	**Denominator**	**Data Source(s)**	**Analytic approach**
Secondary Driver: Improve care coordination and transitions between levels of care	Transition to specialty care after withdrawal management	None	Withdrawal management discharges followed by DMC-ODS treatment within 7 or 14 days	WM discharges	DMC claims, MCP/FFS data**	Descriptive statistics using parametric and/or non-parametric tests of statistical significance, and/or regression analysis (2020-2026, contingent on data availability)
Question: Do enrollees receiving SUD services experience improved health outcomes? Goal: Reduced utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services. Hypothesis: DMC-ODS implementation will be associated with reductions in utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services.						
Primary driver: Reduced utilization of ED and inpatient hospital settings	Utilization (e.g., days)	None	Clients who received DMC-ODS treatment who had any ED and inpatient hospital visits during and after treatment	Clients who receive DMC-ODS treatment	DMC Claims MCP/FFS data**	Descriptive statistics using parametric and/or non-parametric tests of statistical significance, and/or regression analysis. Quasi-experimental causal inference designs including but not limited to difference-in-differences augmented with propensity score matching as needed, synthetic controls, etc. (2015-2026, contingent on data availability)
	Paid claim amounts	None	N/A	N/A	DMC Claims MCP/FFS data**	

Table 1. Summary of key evaluation questions, hypotheses, data sources, and analytic approaches						
Driver	**Potential Measures**	**Measure Steward, Endorsement**	**Numerator**	**Denominator**	**Data Source(s)**	**Analytic approach**
Question: Does the demonstration reduce withdrawal management readmissions? Goal: Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate. Hypothesis: DMC-ODS implementation will be associated with fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate.						
Primary driver: Readmissions to withdrawal management	Re-admissions within 30 days of discharge	None	Clients re-admitted to withdrawal management within 30 days of discharge from withdrawal management	Clients discharged from withdrawal management	DMC Claims CalOMS-Tx	Descriptive statistics using parametric and/or non-parametric tests of statistical significance, and/or regression analysis. Quasi-experimental causal inference designs including but not limited to difference-in-differences augmented with propensity score matching as needed, synthetic controls, etc. (2015-2026, contingent on data availability)

Table 1. Summary of key evaluation questions, hypotheses, data sources, and analytic approaches						
Driver	**Potential Measures**	**Measure Steward, Endorsement**	**Numerator**	**Denominator**	**Data Source(s)**	**Analytic approach**
Question: Does the demonstration improve coordination of care? Goal: Improved access to care for physical health conditions among beneficiaries. Hypothesis: DMC-ODS implementation will be associated with improved access to care for physical health conditions among beneficiaries.						
Primary driver: Ensure client satisfaction with services	Treatment Perceptions Survey item: "Staff here work with my physical health care providers to support my wellness."	None	Clients providing a rating of 4 or 5	All clients responding to the TPS survey	Treatment Perceptions Survey	Confirm client satisfaction w/ coordination is at benchmark year* levels/higher. Descriptive statistics using parametric and/or non-parametric tests of statistical significance, and/or regression analysis (2020-2025)
Secondary driver: Improve care coordination	Percentage of clients with ambulatory or preventive care visits before and following treatment	NCQA adaptation	Number of clients with SUD who had an ambulatory or preventive care visit during the measurement period	Number of beneficiaries with DMC-ODS treatment	MCP/FFS data** DMC claims	Compare ambulatory or preventative care visits before & after treatment. Descriptive statistics using parametric and/or non-parametric tests of statistical significance, and/or regression analysis (2015-2026, contingent on data availability)

Table 1. Summary of key evaluation questions, hypotheses, data sources, and analytic approaches						
Driver	**Potential Measures**	**Measure Steward, Endorsement**	**Numerator**	**Denominator**	**Data Source(s)**	**Analytic approach**
Question: Does the demonstration reduce health disparities? Goal: Improved health equity Hypothesis: Health disparities will decrease.						
Primary Driver: Improve health equity	Timely admission to indicated level of care	None	Clients admitted to their indicated level of care within 30 days of ASAM brief screening	Clients who received an ASAM brief screening	ASAM LOC Placement data DMC Claims	Compare rates by race, ethnicity, and age. Descriptive statistics using parametric and/or non-parametric tests of statistical significance, and/or regression analysis. Quasi-experimental causal inference designs including but not limited to difference-in-differences augmented with propensity score matching as needed, synthetic controls, etc. (2017-2026)
	Treatment engagement	NQF #0004	Initiation of treatment and two or more encounters with any SUD diagnosis within 30 days after initiation	Number of beneficiaries who initiated treatment	DMC Claims	
	Any other measures on which meaningful disparities emerge					

Table 1. Summary of key evaluation questions, hypotheses, data sources, and analytic approaches						
Driver	**Potential Measures**	**Measure Steward, Endorsement**	**Numerator**	**Denominator**	**Data Source(s)**	**Analytic approach**
Question: Has the Recovery Incentives Program been effectively implemented? Goal: An effective contingency management program, including cost-effectiveness and effects on beneficiary health outcomes. Hypothesis: Effective implementation will lead to improvements in client retention, discharge status, self-reported outcomes, drug test results, deaths, and healthcare utilization among clients participating in the Recovery Incentives Program.						
Primary driver: Improvements in Recovery Incentives Program outcomes	Days in treatment, engagement, discharge status, self-reported satisfaction and improvement in health, SUD, arrests, ED and inpatient hospital utilization, costs, deaths	None	N/A	N/A	Client surveys, DMC claims, MCP/FFS data,** CalOMS-Tx, Death data	Compare outcomes between clients with StimUD participating in the Recovery Incentives Program and those in non-Recovery Incentives Program treatment programs (where available), controlling for background characteristics. Comparisons by demographics. Descriptive statistics using parametric and/or non-parametric tests of statistical significance, and/or regression analysis Compare rates of positive, negative, and missed drug screens among individuals with StimUD in the Recovery Incentives Program and compare rates to those found in the literature using a one-sample t-test or analogous procedure (2023-2026)
	Rates of positive, negative, and missed drug screens	None	Negative urinalysis outcomes	Sum of all possible tests over the planned course of treatment	Stimulant drug tests / incentive manager vendor	

Table 1. Summary of key evaluation questions, hypotheses, data sources, and analytic approaches

Driver	Potential Measures	Measure Steward, Endorsement	Numerator	Denominator	Data Source(s)	Analytic approach
Primary driver: Fidelity to the CM model	Drug screen results, Days in treatment, Discharge status, Self-reported improvement, Overdose rates, ED and inpatient hospital utilization (SUD or all diagnoses)	None	N/A	N/A	Data from incentive manager vendor, fidelity assessments, provider surveys, client surveys, CalOMS-Tx, DMC-ODS claims	Compare outcomes (e.g., drug screen results, days in treatment, discharge status, self-reported improvement, overdose rates, ED utilization, inpatient utilization) between higher- and lower-fidelity providers according to measures developed by UCLA Descriptive statistics using parametric and/or non-parametric tests of statistical significance, and/or regression analysis. (2023-2026)
Secondary driver: Implementation of an effective and accessible CM program	Newly developed survey questions adapted from an existing questionnaire and qualitative interviews	None	N/A	N/A	Provider surveys and interviews	Descriptive analyses from survey to track implementation challenges and successes over time and qualitative analyses of interview transcripts
	Use of CM based on DMC claims	None	Clients receiving CM	Clients with StimUD in eligible levels of care	DMC-ODS claims CalOMS-Tx	Track percentage of people in treatment for StimUD who participate in the Recovery Incentives Program; Descriptive statistics using parametric and/or non-parametric tests of statistical significance, and/or regression analysis. (2023-2026)

* Benchmark year is expected to be 2021 but may be adjusted if appropriate. The benchmark for evaluating 2021 will be 2020 or an alternative (see methodology section). Where pre-DMC-ODS data do not exist and maintenance is hypothesized, the starting year is 2020. Where pre-DMC-ODS data do exist, the starting year is set at 2015 to take advantage of this data. Analyses based on recovery incentives-specific data start in 2023 when collection of the relevant data begins.

** ED, hospital, and associated cost data come from MCP/FFS data is historically subject to reporting delays of about 3 years.

In addition to the hypothesis testing described above, the study team may describe emerging facilitators and barriers to DMC-ODS implementation, e.g., associated with implementation of peer support specialists, potential impacts from payment reform, and other emerging issues. For example, between 2015 and 2021 issues such as COVID-19, rising overdose deaths from fentanyl and stimulants, and increasing rates of homelessness were incorporated into DMC-ODS evaluation reports as special topics as these issues took on increased urgency.

To the extent possible, UCLA will also examine total costs as well as cost drivers measured on a Per Member Per Month (PMPM) basis before and during the demonstration periods (2015-2026 contingent on data availability), e.g., total Medicaid costs and total federal Medicaid costs, 2) SUD-IMD costs, other SUD costs and non-SUD costs, and 3) inpatient costs, non-ED outpatient costs, and ED outpatient costs.

Methodology

Evaluation Design Summary

The evaluation uses a mixed-methods design that takes advantage of different comparisons based on the measure in question.

Where appropriate, administrative data from Drug Medi-Cal (DMC) claims and CalOMS-Tx will be used for a difference-in-difference design to account for different county implementation periods, consistent with CMS recommendations for strong evaluation designs.[9] This approach essentially combines pre-post comparisons and comparisons across counties to test whether changes are detected when counties "go live" but not at the same time in other counties. In other cases, data (e.g., stakeholder surveys, interviews, ASAM Criteria-based Level of Care Placement data) will only be available post-implementation, in which case post-only analyses will be conducted.

Evaluation of the Recovery Incentives Program is focused on initial implementation of a specific set of new practices targeted at a specific set of clients in specific settings, in marked contrast to evaluation of the broader DMC-ODS program that has been in place for several years and affects the entire continuum of care. The evaluation approach for the Recovery Incentives Program therefore necessarily has a different focus, organized around the RE-AIM framework (Glasgow, 1999):

[9] Reschovsky, J.D. and Bradley, K. (2019). Planning Section 1115 Demonstration Implementation to Enable Strong Evaluation Designs. Available at: https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/enable-strng-eval-dsgn.pdf

1. **Reach**. This will be measured as the percentage of people in treatment for StimUD who participate in the Recovery Incentives Program. UCLA will also evaluate whether there are disparities in its reach to different beneficiary populations (e.g., race, ethnicity, gender, age, county).

2. **Effectiveness.** Effectiveness will be based on results of drug testing, treatment retention, and treatment engagement.

3. **Adoption.** Adoption will be measured by evaluating how many provider agencies deliver Recovery Incentives Program services.

4. **Implementation.** Implementation will be evaluated by the degree to which CM is implemented with fidelity to the Recovery Incentives Program protocols and by tracking adaptations made. Perceptions of challenges and areas for potential improvement will also be collected from provider staff and participants.

5. **Maintenance.** Maintenance will be measured by evaluating the degree to which programs implementing the Recovery Incentives Program continue providing the service throughout the evaluation period, and information from surveys and interviews focusing on factors that could promote or impede the continued delivery of Recovery Incentives Program services after the end of the pilot period.

Target and Comparison Populations

The population targeted by the DMC-ODS is Medicaid-eligible individuals with SUD. Where appropriate, state plan counties and variation in introduction of the DMC-ODS waiver across counties in California over time will be exploited for comparison purposes as described in the analytic methods section below.

In some cases, particularly when analyzing datasets that did not exist prior to DMC-ODS implementation, the evaluation design is focused on monitoring maintenance of previously measured improvements. In these cases, the waiver year 2021 is proposed as a benchmark year to measure maintenance of improvements as CalAIM extends DMC-ODS into 2022 and beyond. However, COVID-19 or other future trends may eventually make another year more appropriate. For example, the DMC-ODS evaluation previously found that COVID-19 reduced admissions (Bass et al., 2022), so if pandemic-driven trends dissipate in the future and DMC-ODS treatment admissions return to pre-pandemic levels, the pre-pandemic year 2019 could become a more appropriate comparison year to avoid confounding the effects of CalAIM with recovery from the pandemic. If a year other than 2021 is adopted as a baseline year, sensitivity analyses will be performed to quantify the effect of this change. To evaluate the year 2021, 2020 will be used as a comparison, with the understanding that COVID-19 may affect both years. Alternatives to 2020 and 2021 including average benchmarks based on the time series of data available for each outcome variable will also be explored.

In other cases, where improvements have not previously been established, data will be analyzed to establish whether the initial waiver was associated with or caused improvements, as well as whether those improvements have been maintained during the current CalAIM waiver.

As a result of the above considerations, time periods in Table 1 differ by measure according to the following rules: 1. Where maintenance is hypothesized, the starting year is 2020 (to provide a comparison for 2021), though 2021 may then serve as a benchmark for the ensuing years. 2. Where administrative data exist prior to DMC-ODS, the starting year is 2015 to provide two years or more (depending on county) of pre-DMC-ODS data to serve as a baseline. 3. Analyses based on data collected specifically for the Recovery Incentives Program starts in 2023 when data collection begins. Although aspirational 2026 end dates are listed, full 2026 data may not always be available for inclusion in the report due in December 2026. In some cases, e.g. county administrator surveys, this is under the evaluator's control and will be complete in 2026. In the case of administrative datasets, cutoff dates will be determined by data availability which may range from partial 2026 data to a much earlier cutoff in the case of MCP/FFS.

The primary target population for the Recovery Incentives Program evaluation will be clients who receive CM for the treatment of StimUD. The comparison population will consist of clients who receive treatment for StimUD but do not receive CM. Administrative data on this population will be available for the treatment programs participating in the Recovery Incentives Program in both the pre-and post-Recovery Incentives Program periods and will be available for other treatment programs that are not participating in the Recovery Incentives Program.

During the DMC-ODS waiver period, the IRS is expected to make a ruling on whether CM incentives are considered income. Should the IRS determine that it is not income, the current $599 annual cap on incentives provided to individuals would increase by amount to be determined. If this were to occur, in addition to the $599 Recovery Incentives Program group and non-Recovery Incentives Program comparison group, a third, higher-dose Recovery Incentives Program group would be created and evaluated separately from the $599 group but using the same methods.

Evaluation Period

DMC-ODS under CalAIM is considered an extension of DMC-ODS under the previous Medi-Cal 2020 waiver. Therefore, the evaluation period will extend from the date the first counties implemented DMC-ODS on February 1, 2017 through the end of the CalAIM waiver on December 31, 2026. However, exact dates will differ by analysis depending on data availability, normal data reporting lag times, and hypotheses. The first DMC-ODS report (mid-point assessment) will also include previously unreported analyses of 2021 data. The evaluation period for Recovery Incentives Program evaluation will have the same end date, but implementation began in March 2023.

Data Sources

Administrative data sources

California Outcome Measurement System, Treatment (CalOMS-Tx)

CalOMS-Tx is California's existing data collection and reporting system for all clients in publicly funded SUD treatment services. Treatment providers collect information from clients at admission and discharge and send this data to DHCS each month. CalOMS-Tx provides California's contribution to the Treatment Episode Dataset (TEDS) maintained by the Substance Abuse and Mental Health Services Administration (SAMHSA). CalOMS includes client background (e.g. demographics, source of referral, number of prior treatment episodes, housing, employment, criminal justice status, number of children), treatment information (e.g.treatment discharge status, use of medications), and 30-day measures at admission and discharge (e.g. number of arrests & jail days, family conflicts, social support). This makes CalOMS-Tx data richer in many respects than other data sources (e.g. claims), though it has its own limitations (see limitations section). More information on CalOMS-Tx can be found at: http://www.dhcs.ca.gov/provgovpart/Pages/CalOMS-Treatment.aspx

Death Data

The California Department of Public Health (CDPH) provides data from their California Comprehensive Death File to DHCS for all Medi-Cal beneficiaries. UCLA will collaborate with DHCS and CDPH to use this data to identify overdose deaths as a key outcome measure. All-cause deaths will also be examined if the data allows.

Drug Medi-Cal Claims (DMC Claims)

In California, Medicaid-funded SUD treatment is paid for through DMC claims. DMC is a carve-out for specialty care SUD treatment. For the UCLA evaluation, DMC claims data provides information on patient demographics, access to treatment after DMC-ODS waiver implementation, types of services provided, and costs. New billing procedures under development are expected to record the delivery of CM services and potentially positive or negative drug test results. DMC claims data provides detailed data on services received and is likely to be more complete than other datasets like CalOMS-Tx but is limited in scope to billing-related data.

Incentive Manager Vendor Data

The incentive manager vendor for the Recovery Incentives Program, under contract with DHCS, will collect data on incentive payments while administering these incentives. The following data elements are expected to be collected:

- Beneficiary name (recipient's full name: last, first, and middle initial)
- Beneficiary Client Identification Number (CIN) (recipient's unique identification number established by DHCS
- Provider name (billing and/or rendering provider name)
- National provider identifier (billing and/or rendering provider number)
- Date of service (date drug test was performed, incentive disbursed if test was negative for stimulants, excused or unexcused absence)
- Drug test results (positive or negative for stimulants)
- Calculated incentive amount on date of service (incentive amount owed to client)
- Disbursed incentive amount on date of service
- Cumulative disbursed incentive amounts, per client per calendar year (total incentive amounts disbursed to each beneficiary enrolled in the Recovery Incentives Program per calendar year)
- *Other data to be determined by DHCS*

Managed Care Plan/ Fee-for-Service Data (MCP/FFS)

In California, Medicaid-funded medical care (excluding SUD and serious mental illness) is paid for either through managed care plans or fee-for-service reimbursement. For the UCLA evaluation, MCP/FFS data provides information on client demographics, types of services, and costs.

Mental Health (MH) Claims

In California, Medicaid-funded MH treatment is paid for through Short Doyle Medi-Cal claims (SD/MC). SD/MC is a carve-out for serious mental illness treatment services to persons eligible for Medi-Cal. For the UCLA evaluation, SD/MC claims data provides information on the dates, types, and quantities of MH services provided for beneficiaries accessing services for SMI.

Medi-Cal Eligibility Data System (MEDS)

The MEDS database provides information on all California Medi-Cal beneficiaries. These data, particularly the MEDS Monthly Extract File (MMEF), are used to calculate penetration rates.

Master Provider File (MPF)

The MPF is DHCS's comprehensive list of SUD treatment programs in the state of California. The MPF includes information on all SUD treatment facilities, including mailing addresses and DMC certification and decertification dates, among other provider-level information. In combination with lists of IMD facilities, MPF can be used to identify provider identification numbers for these facilities, therefore enabling IMD-specific analyses using CalOMS and DMC Claims data.

UCLA evaluation data collection activities

ASAM Level of Care (LOC) Placement Data

Given that The ASAM Criteria are a defining feature of the DMC-ODS waiver, a large new data collection effort was initiated across DMC-ODS waiver counties to collect data on the use of ASAM Criteria-based LOC brief initial screenings, initial assessments, reassessments, and services delivered. This endeavor has been a collaborative effort between UCLA, DHCS, and counties to collect these data. DHCS Information Notice 17-035 describing the requirements and procedures to collect ASAM Criteria-based LOC data was released in September 2017 and was superseded by Information Notice 18-046 on October 1, 2018. These data include the date of screening or assessment, type (brief initial screen, initial assessment, follow-up assessment), indicated LOCs (per screener or assessment result), actual placement decision(s), the reason for the difference between indicated and actual LOCs (if any), and the reason for delays in placement (if any). Data on three types of screenings or assessments are possible, defined as follows on the data collection instrument.

- Brief Initial Screen: a brief initial screening that preliminarily determines an LOC placement until a full assessment can be performed
- Initial Assessment: a longer comprehensive assessment meant to determine the LOC recommendation and establish medical necessity
- Follow-up Assessment: following an initial assessment, any re-assessment of the client occurring during the same treatment episode

Up to three indicated and actual levels of care could be recorded. Indicated and actual levels of care defined as:

- Indicated LOC. This is the initially recommended LOC according to the screening/assessment instrument prior to taking client preference into account. For example, this would be listed under "Final Level of Care Recommendations" if using CONTINUUM™ software.
- Actual LOC/Withdrawal Management placement decision. This is the actual LOC decided upon after client input and the LOC where the client is referred.

The options for LOC, as worded in the LOC reporting template, are listed below. These include broad To Be Determined (TBD) options to allow for the results of brief initial screenings that may indicate a general treatment modality the client should report to for further assessment (e.g., outpatient) without specifying the exact LOC to be received there (e.g., 1-outpatient or 2.1-intensive outpatient). The list also includes Withdrawal Management (WM) levels of treatment, which can be combined with other levels of care.

Level of Care

None
Outpatient/Intensive Outpatient (OP/IOP), exact level TBD
Residential, exact level TBD
Withdrawal Management (WM), exact level TBD
Ambulatory WM, exact level TBD
Residential/Inpatient WM, exact level TBD
Narcotic Treatment program/Opiate Treatment program (NTP/OTP)
0.5 Early Intervention
1.0 OP
2.1 IOP
2.5 Partial Hospitalization
3.1 Clinically Managed Low-Intensity Residential
3.3 Clinically Managed Population-Specific High-Intensity Residential
3.5 Clinically Managed High-Intensity Residential Services
3.7 Medically Monitored Intensive Inpatient Services
4.0 Medically Managed Intensive Inpatient Services
1-WM Ambulatory WM without Extended Onsite Monitoring
2-WM Ambulatory WM with Extended Onsite Monitoring
3.2-WM Clinically Managed Residential WM
3.7-WM Medically Monitored Inpatient WM
4-WM Medically Managed Intensive Inpatient WM

If at least one of the indicated and actual levels of care do not match, providers are asked to select the reason for the difference. The options are:

Reason for difference

Not applicable - no difference
Clinical judgment
Lack of insurance/payment source
Legal issues
Level of care not available
Managed care refusal
Client preference
Geographic accessibility
Family responsibility
Language
Used two residential stays in a year already.
Other

County Administrator Surveys/Interviews

UCLA will continue to develop and distribute online surveys to obtain information and insights from county SUD/behavioral health administrators participating in the delivery of services under

the DMC-ODS system of care. Surveys will be conducted annually to address DMC-ODS-related perceptions, barriers, and facilitators. Past topics have included, for example, access to care, screening and placement practices, training needs, quality of care, coordination, and integration of services. Additional topics, including on the Recovery Incentives Program, will be included as driven by the evaluation measures and other new issues/external factors as they emerge. UCLA will also conduct in-depth interviews with stakeholders on an as-needed basis to further inform and understand the findings from the administrative and survey data. Surveys will continue to be administered online (e.g., Qualtrics), and will be sent to either all DMC-ODS counties (currently 37) or all counties (58 counties, 57 surveys because Yuba and Sutter counties share a single administrator). Historically nearly all county administrators have responded (most recently 36 out of 37, 97%), eliminating the need for stratification.

Treatment Perceptions Survey (TPS)

The TPS was developed by UCLA as part of the activities for the initial DMC-ODS waiver evaluation activities in 2017. The TPS for adults was based on San Francisco County's Treatment Satisfaction Survey; and the TPS for youth was based on Los Angeles County's Treatment Perceptions Survey (Youth). (Both survey questionnaires include items from the Mental Health Statistics Improvement Program, MHSIP.) Input on the survey development was solicited from and provided by DHCS, the Substance Abuse Prevention Treatment+ Committee (SAPT+) of the County Behavioral Health Director's Association (CBHDA) of California, the DMC-ODS External Quality Review Organization (EQRO) Clinical Committee, Behavioral Health Concepts (BHC), the Youth System of Care Evaluation Team at Azusa Pacific University, and other stakeholders. The tool has since been validated (Teruya et al, 2022) and data collection has occurred annually during a five-day survey period among counties participating in the DMC-ODS waiver since 2018. The TPS data serves multiple purposes. 1) it fulfills counties' EQRO requirement to conduct a client satisfaction survey at least annually using a validated tool, 2) it addresses the data collection needs for the CMS required evaluation of the DMC-ODS waiver, and 3) supports DMC-ODS quality improvement efforts and provides key information on the impacts of the DMC-ODS waiver.

The TPS is administered annually as part of a major statewide undertaking by UCLA, counties, and providers during a specified five-day survey period. Providers are directed to administer the survey to every client receiving services both in-person or via tele-health during this time. During the most recent (2021) data collection period, 16,628 surveys were collected. Among adults, the smallest two racial groups were Native Hawaiian/Pacific Islander (n=259) and Asian (n=410). These sample sizes are sufficient to detect a small effect size (D) of 0.16 with a two-sided alpha of .05 and power (beta) of .80 using an independent samples t-test. TPS response rates have historically been estimated at about 60% but dipped during 2020, during the COVID-19 pandemic. If needed, the sample can be weighted for survey nonresponse to match the demographic profile of clients with DMC claims during the survey period. However, since no large differences were found in ratings between demographic groups in 2021, such weighting may have a minimal impact.

The survey for adults includes 14 statements addressing client perceptions of access, quality, care coordination, outcome, and general satisfaction. The survey for youth includes 18 statements in the same five domains as the adult survey plus an additional domain: therapeutic alliance. Survey respondents indicate the extent to which they disagree or agree with statements using a 5-point Likert scale (1= Strongly disagree and 5= Strongly agree). The survey also collects demographic information (i.e., gender, age, race/ethnicity, and length of time receiving services at the treatment program).

TPS Adult Survey Items by Domain

Access

1. The location was convenient (public transportation, distance, parking, etc.).
2. Services were available when I needed them.

Quality

3. I chose the treatment goals with my provider's help.
4. Staff gave me enough time in my treatment sessions.
5. Staff treated me with respect.
6. Staff spoke to me in a way I understood.
7. Staff were sensitive to my cultural background (race, religion, language, etc.).

Care Coordination

8. Staff here work with my PH care providers to support my wellness.
9. Staff here work with my MH care providers to support my wellness.

Outcome

10. As a direct result of the services I am receiving, I am better able to do things that I want to do.

General Satisfaction

11. I felt welcomed here.
12. Overall, I am satisfied with the services I received.
13. I was able to get all the help/services that I needed.
14. I would recommend this agency to a friend or family member

TPS Youth Survey Items by Domain

Access

1. The location of services was convenient for me.
2. Services were available at times that were convenient for me.
3. I had a good experience enrolling in treatment.

Therapeutic Alliance

4. My counselor and I work on treatment goals together.
5. I feel my counselor took the time to listen to what I had to say.
6. I developed a positive, trusting relationship with my counselor.
7. I feel my counselor was sincerely interested in me and understood me.
8. I like my counselor here.
9. My counselor is capable of helping me.

Quality

10. I received the right services.
11. Staff treated me with respect.
12. Staff were sensitive to my cultural background (race/ethnicity, religion, language, etc.).
13. My counselor provided necessary services for my family.

Care Coordination

14. Staff here make sure that my health and emotional health needs are being met (physical exams, depressed mood, etc.).
15. Staff here helped me with other issues and concerns I had related to legal/probation, family, and educational systems.

Outcome

16. As a result of the services I received, I am better able to do things I want to do.

General Satisfaction

17. Overall, I am satisfied with the services I received.
18. I would recommend the services to a friend who is need of similar help.

TPS survey forms for both adults and youth are available in 13 languages (English, Spanish, Chinese, Tagalog, Farsi, Arabic, Russian, Hmong, Korean, Eastern Armenian, Western Armenian, Vietnamese, Cambodian) and in one-page and two-page (larger font) versions. The relevant MHSUD Information Notices, survey instructions, forms in multiple threshold languages, and other materials (i.e., Frequently Asked Questions, TPS Codebook, sample county and program summary reports) are available online at http://www.uclaisap.org/dmc-ods-eval/html/client-treatment-perceptions-survey.html.

County administrators coordinate the survey administration and data collection within their provider network and submit the paper forms or electronic data files to UCLA for processing. The data are analyzed, and county- and provider-level summary reports are prepared and made available to participating counties. Counties are also given access to their raw data files and respondents' written comments.

Recovery Incentives Program-Specific Data Collection

Recovery Incentives Program Client Surveys

Recovery Incentives Program treatment providers will be asked to distribute a link to an online survey to participating clients. Surveys will be conducted in multiple waves:

- Baseline survey: At the beginning of Recovery Incentives Program treatment (e.g., intake), providers will be asked to provide clients with a link to a UCLA survey and encourage participation. Clients who go to that survey will receive information about the evaluation, provide consent to participate, and will be asked for contact information and a small number of baseline questions.
- Follow-up surveys: Follow-up surveys will be sent to all clients who completed the baseline survey and provided contact information and consent to be contacted for the follow-up survey. The follow-up surveys will occur early and late in treatment, for example five and 13 weeks after the client began treatment. It will capture information on client perceptions of the Recovery Incentives Program, client functioning (e.g., drug use, use of emergency room and hospital services, etc.) including success stories and perceptions of Recovery Incentives Program implementation needing improvement. These surveys will include clients who are still in treatment and those who left treatment. Participants who have left treatment may be more forthcoming in disclosing what aspects of the pilot program did not work well and monitoring for fraud, e.g., if they indicate they weren't using drugs but were recruited by the agency to participate for money. If resources allow, a small cohort may be selected for brief weekly follow-ups to collect information on client perceptions that may help refine the incentive algorithm.

A sample of up to 60 participating provider sites will be asked to provide the baseline survey link and QR code to all new clients who start participating in the Recovery Incentives Program until they reach a target N. Each provider's quota will be based on estimates of Recovery Incentives Program participation that each site provided during the initial application process, or on estimates based on CalOMS-Tx data. The goal of using quotas is to ensure a representative sample across providers, rather than a potentially biased sample from high-performing providers. The total sample will be approximately 600

Participants will be paid a small incentive (e.g., $10) by UCLA to participate. Survey participant eligibility will be verified against data from the incentive manager vendor to avoid participation by people who are not participating in the Recovery Incentives Program. Initially, incentives will likely take the form of an electronic gift card handled separately from the incentive manager. [10]

[10] Although payments would ideally be handled through the incentive manager, this can only occur if the incentive management vendor is able to implement this and the Internal Revenue Service rules that the Recovery Incentives Program incentives are not income. This ruling is pending. If the IRS does not provide a ruling or rules that the incentives are income, then survey incentives cannot be provided through the incentive manager because it could put the participant over the $599 limit and subject the client to income taxes. It is likely the evaluation will begin with electronic gift cards but providing incentives through the incentive management vendor may become possible in later stages of the evaluation.

During a targeted stakeholder Recovery Incentives Program call on 4/12/2022, a large provider confirmed that they would be able to implement baseline surveys this during client enrollment either using iPads, a desktop computer, or asking the client to use their phone to complete the short survey. If needed, they also expressed a willingness to send the link to clients through their approved method of communication.

Once we reach the target N for each provider, they will be asked to stop distribution of the survey link, and new clients from their site will not be allowed to participate (e.g., the survey link may deactivate when a quota for each provider is reached). Based on CalOMS-Tx data, about 5,000 stimulant users participate in publicly funded treatment annually. If only half of these clients participate in the Recovery Incentives Program, as many as 2,500 new clients per month may be admitted. However, previous evaluation findings suggest implementation of new DMC-ODS waiver benefits typically ramp up slowly over time (Urada et al., 2022). We conservatively assume the survey will be initially offered to 600 clients per month. If the response rate is 50% (300/month), it would take only two months to reach the target N of 600.

Data may also be collected from new participants one or more years after implementation has begun to determine whether client responses change after implementation has matured. Methods may mirror those used to collect the initial sample or may involve re-opening the survey for a longer period but only accepting a random sample of respondents to extend the data collection period over a longer period. Methods for these later waves will be based on the degree of success and lessons learned from the initial data collection.

Approximately four weeks after each participant's baseline survey, UCLA will contact the client for a follow-up survey. A 50% response rate from the 600 baseline participants would result in 300 surveys. Participants will also receive incentives for the follow-up survey. This second wave of surveys will include people who may have stopped participating in treatment. Among clients who remained in treatment during the second wave of surveys, a third wave of surveys will occur at a later date, e.g., 13 weeks (estimated N=150), after they have entered the maintenance phase of treatment, resulting in a total of approximately 1,050 client surveys.

Recovery Incentives Program Client Interviews

The study team will conduct semi-structured interviews with approximately 25 clients purposively selected from participants in the baseline Recovery Incentives Program survey who provided permission for UCLA to contact them for an interview during that survey. Participants will be selected to represent a range of perspectives on the Recovery Incentives Program expressed in surveys. Participants will be asked about the program's strengths and ways the program can be improved. Interviews will be recorded, transcribed, and coded using a constructivist grounded theory approach (Charmaz, 2017; Glaser & Strauss, 1967). Recovery Incentives Program client interviews will begin 24 weeks after baseline client survey to allow completion of survey data collection and to allow time for clients to complete or drop out of treatment.

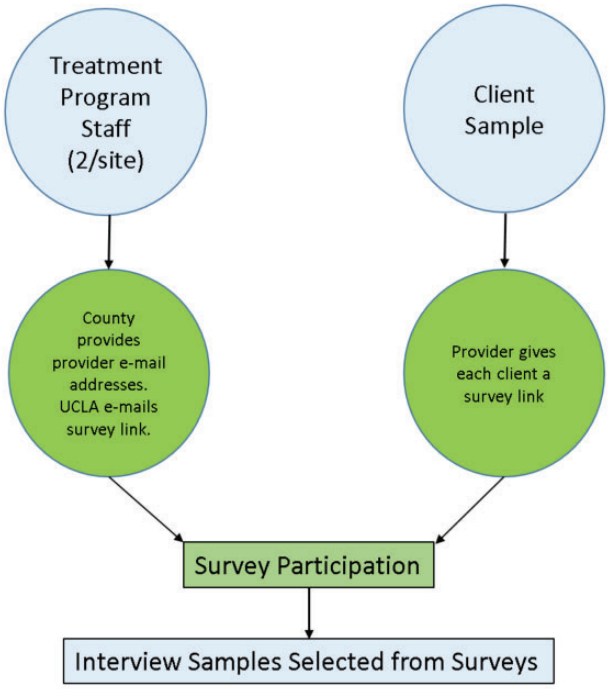
Recovery Incentives Program Provider Surveys

For the Recovery Incentives Program evaluation, provider staff will be surveyed about Recovery Incentives Program implementation, challenges, beliefs, and perceptions and to check for signs of fraud. Counties will be asked to provide an email contact for their participating treatment programs, and evaluators will contact these programs to have online survey invitations sent to the Recovery Incentives Program coordinator and a counselor at each site. The surveys will be conducted online via Qualtrics, early in the implementation process and after the program has participated for approximately six months. A minimum sample of 100 sites will be surveyed and depending on the number of providers sites opting into the Recovery Incentives Program, all sites may be surveyed.

Recovery Incentives Program Provider Interviews

In addition, for the Recovery Incentives Program evaluation the study team will conduct interviews and/or focus groups with a sample of about 25 total provider individuals from agencies that implement the Recovery Incentives Program. Interviews will begin shortly after provider survey data collection has been completed and will end when additional themes cease to emerge from data collection (saturation has been achieved). Interviews and focus groups will focus on identifying the strengths and weaknesses of the Recovery Incentives Program and potential ways to improve the uptake and effectiveness of the program. Interviews and focus groups will be recorded, transcribed, and coded using a constructivist grounded theory approach.

Figure 1. Relationship of Recovery Incentives Program Staff and Client Surveys and Interviews



Fidelity Assessments

California's Recovery Incentives Program training and technical assistance team will collect data on provider knowledge and attitudes during registration for trainings (pre-data), and again after required Recovery Incentives Program trainings have been completed. Following trainings, all participants will receive a link to a post-training test. Providers will also engage in fidelity monitoring sessions twice in the first six months, then every six months thereafter. Tools for these sessions are still in development, but it is anticipated that programs will be rated as high- or low- fidelity through a combination of these fidelity assessments (e.g., trainer's assessments of provider performance on role-playing sessions) and analysis of incentive manager data to measure fidelity to the incentive schedule.

Analytic Methods

Analysis of Quantitative Data

Due to the size of California's population and the associated statistical power available for analysis of statewide databases, comparisons using inferential statistics on many of the datasets used in this report may suggest statistical significance even when these differences are small and not meaningful. Furthermore, inferential statistics are designed to make inferences about a population from a random sample taken from that population. However, many of the datasets used in this evaluation (e.g., DMC claims, CalOMS-Tx, county administrator survey data with near 100% response rates) represent data on essentially the full population of interest rather than a random sample. Therefore, in cases where *p*-values may be inappropriate or misleading, descriptive statistics will be used with percentages, odds ratios, or other methods to convey the size and meaning of differences to readers. However, advanced statistics will also be used to examine multivariate relationships and difference-in-difference analyses as described below.

Event Study (ES) and Difference-in-Difference (DD) designs will be used where appropriate to analyze whether the introduction of the DMC-ODS waiver causally affected certain outcomes of interest. Specifically, we will use these designs when analyzing administrative data (e.g., DMC claims and CalOMS-Tx) for some outcomes. Given the staggered introduction of the DMC-ODS waiver across counties in California over time, exploiting this variation within the ES and DD designs will continue to allow us to estimate a causal effect of the DMC-ODS waiver. These analyses will cover the entirety of the DMC-ODS waiver, including the Medi-Cal 2020 years inclusive of the 2021 extension, and CalAIM. At least 24 months of data (starting in 2015) will also be used for pre-DMC-ODS years.

The canonical difference-in-differences model compares pre-post changes in outcomes in treated units to pre-post changes in outcomes in untreated units, for a single treatment. Given the variation in treatment timing, i.e., the variation in introduction of the DMC-ODS waiver and

programs adopting the Recovery Incentives Program across counties in California over time, exploiting this variation within the ES and DD designs will continue to allow us to estimate a causal effect of the DMC-ODS waiver and the Recovery Incentives Program. This will remain true if new counties opt-in to participate in the DMC-ODS waiver. The widely accepted empirical strategy in this context is the Two-Way Fixed Effect Difference-in-Differences model (2WFE DD) given in the following equation:

$$Y_{it} = \beta_0 + \beta_1 \cdot Treat_{it} + \alpha_t + \theta_i + \epsilon_{it}$$

where *Treat* is a binary variable equal to one when a county or Recovery Incentives Program goes live in the DMC-ODS waiver and equal to zero otherwise; α_t is a time vector containing indicators for the years of data available; and θ_i is a unit vector containing indicators for the 58 counties. Standard errors are clustered by county. The above equation can be modified to include a vector of provider and/or county level time-varying controls. The Average Treatment effect on the Treated (ATT) is given by β_1.

Identification of β_1 comes from within-county variation in DMC-ODS waiver or Recovery Incentives Program implementation during our sample period. The main assumption of DD designs is the parallel trends assumption. This assumption states that in the absence of treatment, the unobserved differences between the treatment and control groups would be similar over time. Although we cannot directly test this assumption, we can assess the assumption in this setting in at least two ways:

1. Include a county-specific linear time trend in the estimating equation. This will control for unmeasured county trends unfolding linearly (e.g., sentiment towards SUD treatments).
2. Perform an event study analysis. This is done by including leads and lags of the DMC-ODS or Recovery Incentives Program indicator variable in the equation above. Ideally, the coefficients on all of the leads of the DMC-ODS or Recovery Incentives Program indicator variable will be statistically insignificant. This will indicate that trends in the main outcomes of interest in the treated and control counties were not trending differently prior to DMC-ODS or Recovery Incentives Program adoption.

We can also modify the above equation to estimate lagged effects and heterogeneous effects of the DMC-ODS waiver or Recovery Incentives Program. Specifically, we can determine if the programs have stronger (or weaker) effects over time and if the effects differ by patient demographics, or by fidelity. For the latter, to determine if the impact of the Recovery Incentives Program differs by high versus low fidelity providers, we can add an interaction term to the above regression, interacting an indicator for high fidelity providers (e.g., high fidelity providers equals one, and zero otherwise) with the Recovery Incentives Program indicator.

Specifically, the DD design will compare the post-treatment (e.g., post-DMC-ODS waiver or Recovery Incentives Program implementation) difference in the outcomes of interest between the

DMC-ODS waiver and State Plan counties (or Recovery Incentives Program and non-Recovery Incentives Program sites/counties) to the pre-treatment (e.g., pre-DMC-ODS implementation/pre-Recovery Incentives Program) difference in the outcomes of interest between DMC-ODS waiver and State Plan counties (or Recovery Incentives Program and non-Recovery Incentives Program sites/counties).

We will do robustness checks to determine if both sets of fixed effects and county/provider controls are needed. Specifically, we will start with a model that only includes time and county fixed effects. We will then estimate another model that includes both sets of FEs plus county and/or provider controls. If the estimates are very similar, we likely do not need to include the controls. However, we will still present both sets of estimates to show how robust they are to strengthen our conclusions about the effect we are seeing. This is standard practice in nearly ever published difference-in-difference paper (including both FEs and time-varying controls). The FEs are only picking up time-invariant county and provider effects. But, if we know things like the poverty rate, unemployment rate, COVID policies, etc. vary across counties and across time, we need to include those in the regression.

The 2WFE DD model captures average treatment effects on the treated but does not allow us to consider time-varying treatment effects. There are several reasons to expect the effects of DMC-ODS waiver to vary over time. To account for potentially time-varying treatment effects, we implement difference-in-differences decomposition (Goodman-Bacon, 2021, Callaway, et. al 2021, Callaway, et. al 2021, Dave, et. al, 2020).

The 2WFE DD estimate is composed of a weighted average of treatment effects estimated from a series of 2x2 treatment/control groups, some of which compare counties treated at the same time to untreated counties, and others compare counties treated at the same time to counties treated at another time (earlier or later).

Comparisons may also be made to always-treated units; however, given that no always-treated counties comprise of only 4% state population and do not form an appropriate comparison group for our treated counties, we cannot pursue this comparison to derive robust average treatment effects. There are 19 timing groups in our data, or groups of counties which experience going live in the DMC-ODS waiver at the same time. There are thus 361 distinct 2x2 treatment/control comparison groups from which the 2WFE DD estimate is constructed: 342 groups in which earlier-treated counties are compared to later-treated counties, or vice versa, and 19 groups in which treated counties are compared to untreated counties. In the presence of time-varying treatment effects, comparisons between earlier and later treated counties may introduce bias into the 2WFE DD estimate. The extent of the bias depends on the share of the 2WFE DD estimate that is derived from these earlier-later comparisons, which in turn depends on group size and the variance of the treatment.

Goodman-Bacon (2021) has developed a method to decompose the 2WFE DD estimate into the 2x2 weighted estimates from which it is derived. Using this difference-in-differences decomposition model, we can uncover the extent to which the 2WFE DD estimate depends on 2x2 DD estimates which compare earlier to later treated counties. The Goodman-Bacon decomposition model is currently only available for strongly balanced panels in which treatment only changes from 0 to 1 over time. To estimate the decomposition model, we define treatment as a binary variable that is equal to one in all years after a county goes live in the DMC-ODS waiver and is equal to zero otherwise. The ES design is similar to the DD design but will allow the effect of the DMC-ODS waiver to vary from a specified number of months prior to introduction of the waiver to a specified number of months after the introduction.

All ES and DD models will continue to use data from either DMC claims or CalOMS-Tx at the county-month-year-level, and control for time-invariant county effects, county-invariant time effects, and the severity of the COVID-19 pandemic, which may be proxied by the county-level COVID-19 case rate per 100,000, and COVID-19 death rate per 100,000 for each month-year cell. All regressions will be weighted by the county population, and standard errors are clustered at the county level (Bertrand, 2004).

The Generalized Synthetic Control (GSC) method introduced by Xu (2017) addresses the case when treatment is imposed at different times for different counties. This approach allows for multiple treated counties and variable treatment periods. This method also has several other advantages. It includes a built-in cross-validation procedure and is easier to implement than other synthetic control methods. The GSC method allows us not only to match counties on pretreatment observables, but also to model unobserved time-varying heterogeneities using interactive fixed effects.

GSC first estimates an Interactive Fixed Effects (IFE) model using only the counties that were never treated and obtains a fixed number of time-varying coefficients (latent factors). It then estimates county-specific intercepts (factor loadings) for each treated county by linearly projecting pretreatment outcomes for treated counties onto the space spanned by the factors. Finally, it generates synthetic control units based on the estimated factors and factor loadings. The method is described as a "bias correction procedure for IFE models when treatment data is heterogeneous across units." (Xu, 2017)

Of note, given that many of DMC-ODS benefits have now been adopted by the state plan,[11] it raises concern regarding the DMC-ODS period under analysis. Since the control group will have similar provisions as DMC-ODS, this falls under spillover effects and violates the assumption of quasi-experimental causal inference methods, called SUTVA (Stable Unit Treatment Value Assumption). This may change the magnitude of estimates. However, since residential treatment will be treated in IMDs in DMC-ODS counties but not in state plan counties, DMC-ODS should

[11] https://www.dhcs.ca.gov/Documents/CA-21-0058-Approval-Package.pdf

maintain an access advantage to residential treatment and we can continue the analysis with the caveat that the average DMC-ODS effect may be reduced after these changes to the state plan.

Analysis of Cost Data

Using the causal inference study designs mentioned above, including but not limited to Difference-in-Difference with staggered implementation, Synthetic Control Methods, or Generalized Synthetic Control Methods, as applicable, UCLA will examine the changes in costs because of DMC-ODS waiver. These costs analyses will focus on total Medicaid and Federal costs as well as cost drivers measured per member per month. Specifically, the analyses will also focus on changes in inpatient costs, non-ED outpatient costs, and ED outpatient costs. The analyses will be based on administrative data provided by DHCS; namely, DMC-ODS claims and Managed Care/FFS claims starting in 2015 (pre-period) and including DMC-ODS implementation from 2017 through CalAIM (including 2021). The DMC-ODS claims data contain all SUD-related claims of Medi-Cal beneficiaries, whereas the Managed Care/FFS claims are all managed care claims of SUD beneficiaries identified in the DMC-ODS claims. This will allow us to identify increased access to residential treatment (the prime goal of DMC-ODS waiver) from DMC-ODS claims data and follow the cost behavior of beneficiaries through the variables and data provided in the Managed Care/FFS claims. A potential hypothesis that UCLA will explore involves cost shift behavior from high-value emergency services (ED costs) to Residential Treatment. However, given that seven Partnership HealthPlan counties joined the DMC-ODS waiver as a regional model on July 1, 2020, it will be difficult to analyze any changes in costs for these counties, given the data lag in sharing Managed Care/FFS claims. Currently, there is a 2–3-year lag, and UCLA is awaiting Managed Care/FFS claims data for 2021. So, the analyses will focus on counties where sufficient post-waiver data is available (if a balanced panel is desired for computation purposes). For Recovery Incentives Program, the evaluation team will also use managed care/fee-for-service claims data to analyze cost-effectiveness, specifically investigating whether emergency department, inpatient hospital utilization, and other medical costs (including any type of physical health problems) are reduced or made more appropriate (e.g., increased primary care costs but reduced emergency department costs) among clients who participated in the Recovery Incentives Program vs. similar clients who did not. Until this data becomes available (projected 2025), UCLA will rely on client self-reports from surveys and interviews, as described above.

Analysis of Recovery Incentives Program Incentive Manager Data

Rates of positive drug tests will be compared to rates from the CM literature using a one-sample t-test or analogous procedure. UCLA reviewed all studies cited in a recent systematic review of CM trials for the treatment of methamphetamine use (Brown & DeFulio, 2020), supplemented by a PubMed search of 2020-2022 articles with the key terms “contingency management” and “stimulant.” Among these sources, three studies (Roll & Shoptaw, 2006; Stitzer et al., 2020;

Strona et al, 2006) reported information sufficient to calculate the percentage of negative results among submitted tests. The average, weighted for study size, was 85.3%.

However, Miguel et al. (2021) determined that the percent of negative urinalysis outcomes out of *all possible* tests showed the most consistent performance, compared to alternative measures e.g., weeks of continuous abstinence. This measure conservatively treats missed tests the same as positive tests. Therefore, a measure similar to this will also be used for the evaluation. Three articles (Carrico et al., 2015; Shoptaw et al, 2006, Miguel et al, 2021) reported sufficient information to calculate the percentage of negative urinalysis results among all possible tests, producing a weighted average of 47.7%.

If the data allows, more advanced techniques (e.g., growth curve modeling) may be used to examine patterns in the drug test data.

Analysis of Quantitative Survey Data

County administrator, provider, and client surveys will include Likert rating scales and binary measures (e.g., yes/no). While the lower Ns for the administrator surveys will mostly limit analyses to descriptive analyses, the provider and client survey data will be analyzed in greater depth.

Descriptive statistics, including mean and standard deviation for continuous outcomes as well as frequency and percentage for binary outcomes, will be estimated for all survey samples. Bivariate comparisons will be made between coordinators and counselors in the case of provider surveys.

The association between pairs of measures in surveys will be estimated using product-moment correlation for continuous measures, point-biserial correlation for the relationship between categorical and continuous measures, and cross-tabulation for categorical measures.

Multiple regression modeling for a continuous outcome (e.g., a 1-5 Likert rating scale) and/or logistic regression modeling for a binary outcome (i.e., yes/no) will be conducted separately. On provider surveys, the staff's role (i.e., coordinators versus counselors) will be a covariate in regression modeling.

For client data, which will consist of multiple waves, descriptive analyses, and trajectory plots in conjunction with the Generalized Growth Curve Model (GGCM) may be applied to examine the change in client responses across the repeated assessments.

All analyses will be conducted at both statewide and county levels, by fidelity level, and by demographic groups to look for differences in access and outcomes by race, ethnicity, gender, and age.

Power analysis

Since statistical significance is a way of evaluating the likelihood that differences found in a sample would be found in the full population, in the case of the main administrative data analyses statistical power will not come into play because we are analyzing the data from essentially the full population. The same is true of surveys of county administrators, since we will be surveying the entire administrator population among counties participating in the Recovery Incentives Program, and we have historically approached a 100% response rate for surveys of California county administrators. For surveys of treatment providers and clients, however, statistical power will become a consideration, since we will be surveying samples of a broader population.

Although the Ns may need to be adjusted based on resource availability, our current estimated Recovery Incentives Program sample sizes of 600 Wave 1 and 300 Wave 2 client surveys will be sufficient to detect a difference in a continuous measure between the waves with a small effect size (d) of 0.20. Our estimated sample size of 300 Wave 2 and 150 client surveys will be sufficient to detect a small effect size of 0.28. Provider surveys from 100 sites will be sufficient to detect a medium effect size of 0.57 when divided into two groups of 50 (e.g., higher and lower fidelity sites). All power analysis computations were computed with a two-sided alpha of .05 and power (beta) of .80.

Analysis of Qualitative Data

Qualitative data will be collected from providers and county administrators through interviews and focus groups. Qualitative data collection will focus on the major themes of the overall evaluation, as well as emerging trends related to SUD and SUD treatment in California. If client perspectives are needed beyond the information they provide through the treatment perception survey, they may also be interviewed, and UCLA will stratify to the extent possible to ensure a representative sample. Qualitative data will be used to contextualize and inform the interpretation of quantitative findings, and identify areas that warrant further inquiry or focus in the evaluation. All interviews and group discussions 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. Where applicable, the evaluation team will then analyze these data using a systematic and iterative process according to established and accepted procedures for qualitative research.

Recovery Incentives Program evaluation qualitative data analysis

Qualitative data will be collected from different stakeholders, including clients, providers, and county administrators. All interviews and group discussions 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. The evaluation team will then analyze these data using a systematic and iterative process according to established and accepted procedures for qualitative research. This process will begin by organizing data into key study domains (King 2004) related to the RE-AIM framework (Reach, Effectiveness, Adoption, Implementation, Maintenance). Within each domain, initial analyses will utilize preliminary codes that are expected to emerge from qualitative data. See Table 2 for a preliminary list of codes that may be used to guide analyses and identify overarching data trends.

Table 2. Preliminary Codes for Recovery Incentives Program Qualitative Data Analysis

RE-AIM DOMAIN	PRELIMINARY CODES
Reach	R1: What determines which StimUD clients receive CM and which do not? R2: What are the barriers and facilitators of Recovery Incentives Program service delivery? R3: Are there disparities in the reach of Recovery Incentives Program services to different treatment populations? What can be done to mitigate these disparities?
Effectiveness	E1: How effective do stakeholders believe the Recovery Incentives Program is in helping clients remain in treatment? Helping them achieve and maintain abstinence from stimulants? E2: Are there aspects of the Recovery Incentives Program (incentives, testing procedures) or other behavioral services and supports delivered in conjunction with CM) that seem to enhance or inhibit the Recovery Incentives Program's effectiveness? E3: What can providers do to enhance the Recovery Incentives Program's effectiveness with the clients they serve? What can administrators and policymakers do to facilitate these changes?
Adoption	A1: What factors do counties consider when deciding whether to participate in the Recovery Incentives Program? What factors do program leaders and individual providers consider? A2: What are the practical barriers to/facilitators of Recovery Incentives Program adoption? A3: What policies and procedures could help promote the effective adoption of the Recovery Incentives Program?

Implementation	I1. What are the barriers to/facilitators of high-fidelity CM implementation? I2. What adaptations are being made to CM as it is being implemented? What impacts do these have on intervention fidelity and effectiveness? I3. What policies and procedures could help promote the effective implementation of the Recovery Incentives Program?
Maintenance	M1. What makes programs and providers decide to participate in the Recovery Incentives Program? What makes them decide to discontinue it? M2. What policies and procedures could help promote the maintenance of the Recovery Incentives program in the future if it becomes a standard Medi-Cal benefit?

After organizing qualitative data with codes, we will use constructivist grounded theory to guide the process of reading transcripts, developing code lists, coding data, and comparing/contrasting emerging patterns and themes using constant comparative methods (Charmaz, 2017; Glaser & Strauss, 1967). Portions of coded transcripts will be randomly and independently coded by two researchers to ensure that the codes are being applied consistently and have acceptable levels of agreement indicating good reliability. The evaluation team will meet regularly to share insights and observations from the interviews and/or focus groups throughout the evaluation and discuss emerging themes. Researchers will review the analytic findings. Qualitative data will be triangulated with survey and other quantitative data to identify areas where the results from the data sets converge, complement one another, and/or expand on one another (Creswell, 2003; Palinkas et al., 2011).

The qualitative data collected from the different stakeholder groups (e.g., county administrators, treatment providers, clients) will be analyzed separately as well as across the different groups, and over time (e.g., early vs. later in the implementation of the project) to identify themes and patterns. Findings will be shared with members of key stakeholder groups (DHCS, county administrators, and program staff) to verify and interpret findings.

Methodological Limitations

The California Administrative data sets used in this evaluation have many of the same shortcomings as other administrative data sets, particularly related to inconsistent reporting and missing data (see, for example, Evans et al., 2010 for a discussion of CalOMS-Tx). Delays in data reporting also limit analyses of recent data. UCLA will analyze CalOMS-Tx and DMC claims using the most recent available complete data, which typically requires disregarding

approximately the most recent 6 months of data due to data reporting lag. This will limit the amount of data that can be used in early reports.

CalOMS-Tx data is partly reliant on self-reported data, particularly with respect to outcome questions (e.g., drug use in the last 30 days). Some terms are also somewhat subjective, like discharge status terms (e.g., completed treatment, satisfactory progress, and unsatisfactory progress). To partly ameliorate this problem, these categories will be combined into "successful" (completed, satisfactory progress) and "unsuccessful" (unsatisfactory progress) discharges.

DMC claims data tend to be more complete than CalOMS-Tx data because providers are more motivated to submit them quickly for payment, but this is not universally true. In some cases, under the DMC-ODS, new billable services (e.g., recovery services) are being delivered but DMC claims are not being submitted, in part due to confusion over what is allowable. While this seems less likely to occur for the relatively well-defined Recovery Incentives Program, UCLA will monitor provider survey and interview responses for signs of billing difficulties that may affect claims data.

While DMC claims data have an advantage over CalOMS in completeness, CalOMS-Tx has advantages in the depth of data. CalOMS includes client background (e.g. demographics, primary and secondary drug, source of treatment referral, number of prior treatment episodes, housing, employment, criminal justice status, number of children), as well as treatment discharge status and a number of outcome measures in the last 30 days, both at admission and discharge (e.g. number of arrests & jail days, family conflicts, social support). These cannot be derived from claims. These datasets are therefore complimentary and can be used together to develop a better understanding of DMC-ODS implementation than either dataset alone.

Interview and survey data are limited by the honesty of respondents and the response rate.

Wherever possible, different types of data will be examined in parallel to converge on underlying constructs being measured and thereby mitigate the limitations of each dataset.

The long time frame since initial implementation of DMC-ODS could introduce challenges in interpreting the data, since external impacts (e.g., COVID-19, changes in the economy and workforce) will affect trends. This will be particularly true if no or few new counties join DMC-ODS and if external impacts have systematically different effects on DMC-ODS and non-DMC-ODS counties. Given that the state's largest counties are all already participating in DMC-ODS, even if new counties do opt-in to DMC-ODS, they would also likely have small beneficiary and treatment client populations and a correspondingly limited impact on statewide analyses. The Recovery Incentives Program evaluation will also depend on implementation of a new program, which has and could continue to experience unforeseen delays or barriers that prevent or limit the planned implementation.

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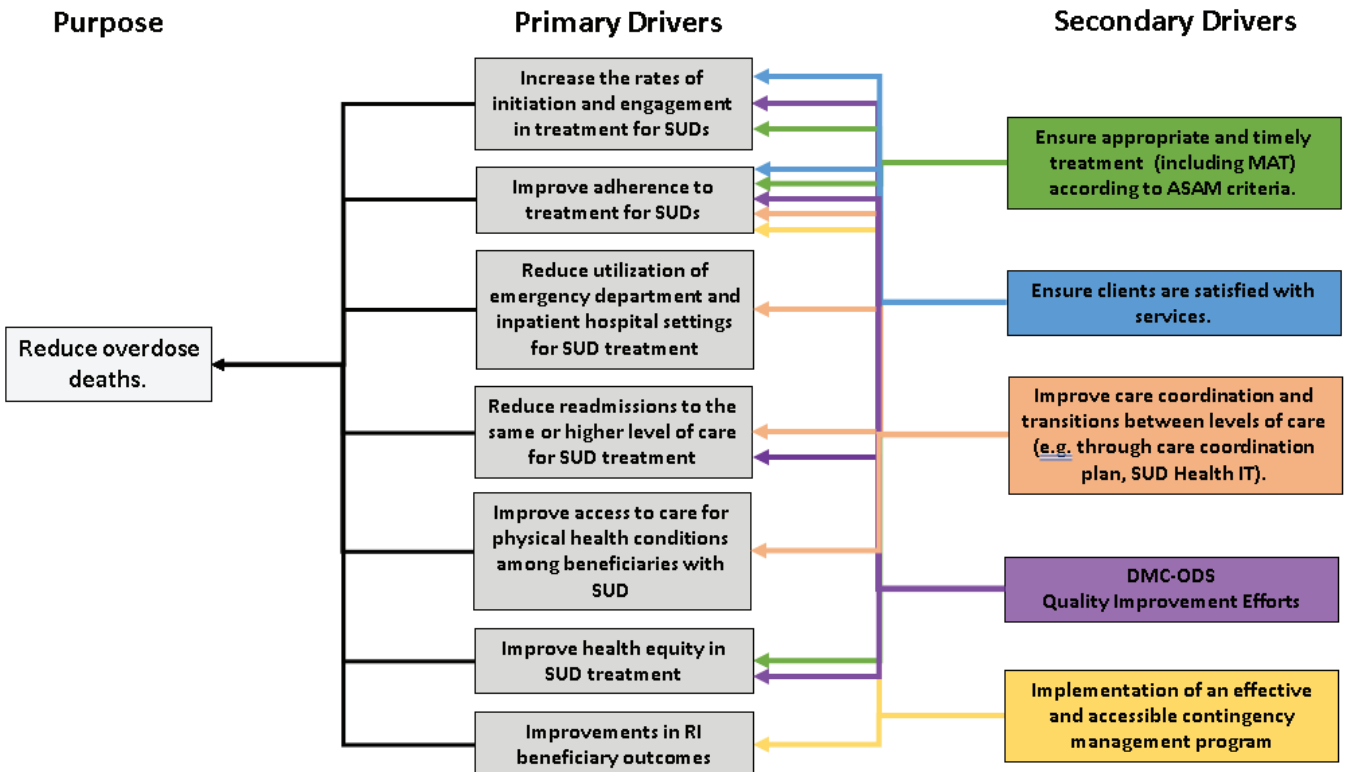
Appendix A: Driver Diagram



California Department of Health Care Services (DHCS)

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

Revised Evaluation Designs for Providing Access and Transforming Health (PATH), Global Payment Program (GPP), Medi-Cal Matching Plan Policy for Dually Eligible Beneficiaries, Reentry Demonstration Initiative, and Managed Care Plans Transition (MCP)

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On behalf of the NORC Evaluation Team

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DHCS
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 five components of the waiver: the Providing Access and Transforming Health (PATH) Initiative, the Global Payment Program (GPP), the Medi-Cal Matching Plan Policy for Dual Eligible Beneficiaries, Reentry Demonstration Initiative, and Managed Care Plan Transition. More details about these programs and evaluation designs are below.

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[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

Independent Evaluation Team

DHCS selected the Regents of the University of California on behalf of its Los Angeles campus (UCLA) as the Independent Evaluator in October 2023 to assess the impact of five Evaluation Components of the CalAIM 1115 Demonstration: PATH, GPP, DUALS, Reentry, and MCP. The evaluation contract was finalized in December 2023. Throughout this evaluation design, the independent evaluators are referred to as "UCLA-RAND", recognizing the shared effort between UCLA, the contracted organization, and the RAND Corporation, the main subcontractor for this evaluation. UCLA-RAND has agreed to conduct the evaluation in an independent manner and in accordance with the CMS-approved Evaluation Design. The independent evaluation team considers the unique goals of each initiative and the overarching impact on CalAIM and population health. UCLA-RAND's approach considers structural change, cost of care, quality of care, and access to care, all of which provide a picture of member experience and impact to the state's administration of the program overall. UCLA-RAND is responsible for developing the evaluation design and reporting results of the evaluation in the Interim and Summative Evaluation Reports.

Projected Timeline

Exhibit 1 shows the planned timeline for important elements of the evaluation as well as the major deliverables. The interim report, summative report, and Reentry mid-point assessment reflect the date that the draft version is due to CMS. As stated in STC 17.4 and 9.10, the final versions are due to CMS 60-days after receiving CMS comments. The due dates of the major required CMS deliverables are listed below:

- Final Evaluation Design: July 29, 2025
- Interim Evaluation Report: December 29, 2025
- Justice-Involved Reentry Demonstration Mid-Point Assessment: September 30, 2027
- Summative Evaluation Report: June 27, 2028

Exhibit 1. Projected Evaluation Timeline

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

[3] UCLA-RAND will conduct PATH, GPP, Duals, Reentry primary data collection
[4] UCLA-RAND will initiate data requests, receipt and conduct follow up as needed
[5] NORC will conduct Quantitative Data Collection & Analysis
[6] NORC will conduct Qualitative Data Collection & Analysis

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

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

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
SDI	Social Deprivation Index
SVI	Social Vulnerability Index
TA	Technical Assistance
TPA	Third Party Administrator
TPM	Two Plan Model
UC	Uncompensated Care
UC Pool	Uncompensated Care Pool
UDS	Uniform Data System
WPC	Whole Person Care

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

General Background Information

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

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

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

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

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

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

Evaluation Questions and Hypotheses

The evaluation design for PATH is guided by the driver diagram shown in Figure 1 The diagram highlights PATH as an intervention to develop systemwide infrastructure and capacity for delivery of ECM and Community Supports services and implementation of the Reentry demonstration in California. Development of this infrastructure is expected to improve eligible Medi-Cal members' access to ECM, Community Supports, and Re-entry demonstration services. Receipt of ECM, Community Supports, and Reentry demonstration services are in turn expected to improve the health of members who receive these services; Community Supports may also reduce costs associated with avoidable acute care utilization for members that receive these services.[7]

Figure 1. Driver Diagram for Path Evaluation

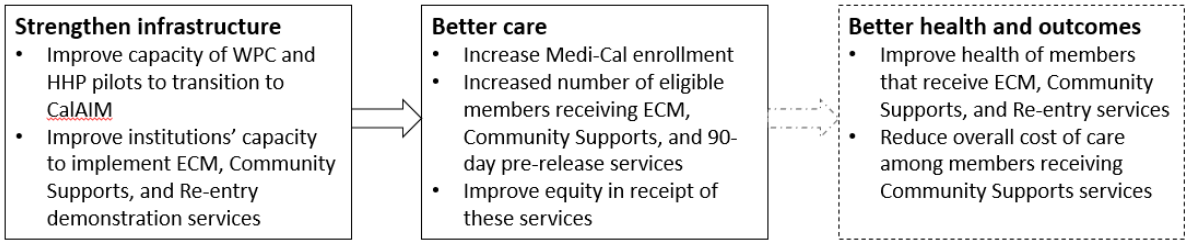

Exhibit 2 shows PATH goals as articulated by DHCS, which are aligned with the CalAIM 1115 Demonstration Special Terms and Conditions (STCs) goals for PATH. The exhibit further includes the evaluation questions (EQs), directional hypotheses (H), and measures developed by DHCS/UCLA to assess whether the goals of PATH were achieved as anticipated. Data sources used to address the EQs and develop measures are identified in the methods section below.

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

Exhibit 2. PATH Evaluation Questions, Hypotheses, and Measures

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

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.***	
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.	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.	» 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

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.***	
H3b: PATH will increase the number of eligible members in under-resourced communities that utilize ECM or Community Supports and the number of ECM and Community Supports services used by eligible members by increasing the number of providers in these communities contracted to provide these services.	» ECM and Community Supports providers' self-reported impact of PATH on their ability to develop collaborative relationships and infrastructure needed to implement ECM or Community Supports and identify and engage eligible members in care.

Evaluation Questions (EQ) & Hypotheses (H)	Measures
Goal 2: ***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	» 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

Evaluation Questions (EQ) & Hypotheses (H)	Measures
Goal 2: *Improve data collection and information sharing infrastructure among ECM and Community Supports providers.*	
number of ECM and Community Supports providers that had shared data with MCPs using these systems.	(EHR) or other electronic care management documentation system » Number and proportion of Community Supports providers with data sharing agreements with the Homeless Management Information System (of those providing housing-related services) » Number and proportion of providers with Medi-Cal billing systems » ECM and Community Supports providers' self-reported impact of PATH on their ability to improve data collection and information sharing infrastructure

Evaluation Questions (EQ) & Hypotheses (H)	Measures
Goal 3: *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?	» 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-

Evaluation Questions (EQ) & Hypotheses (H)	Measures
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.***	
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.	Cal prior to release, stratified by participation in PATH » Self-reported total amount of funding (PATH and non-PATH) used by these institutions to develop capacity and infrastructure needed to screen, enroll, and change the suspension status of individuals eligible for Medi-Cal prior to release » Perceived role of PATH in promoting these institutions' ability to screen, enroll, and change the suspension status of individuals eligible for Medi-Cal prior to release
EQ 6. Did PATH funding improve these institutions' capacity and infrastructure necessary to provide 90-day pre-release services to eligible individuals? **H 6**. PATH funding will improve these institutions' capacity and infrastructure to provide pre-release services by providing funding to invest in needed infrastructure and capacity development.	» Self-reported changes to infrastructure, workflow, and community-based linkages made by correctional facilities, county behavioral health agencies, and other community partners to provide eligible individuals with pre-release services, stratified by participation in PATH. » Self-reported total amount of funding used to develop capacity and infrastructure needed to provide eligible individuals with pre-release services

Evaluation Questions (EQ) & Hypotheses (H)	Measures
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.***	
	» 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

Methodology

Data Source

UCLA will use the following data sources for the PATH evaluation as feasible. UCLA will request all administrative data sources available to DHCS. These include PATH applications, reports and invoices (e.g., Quarterly Implementation Monitoring Reports and JavaScript Object Notation data on ECM and Community Supports membership, utilization, outreach, referral, and provider capacity; PATH implementation plans, and readiness reviews submitted by stakeholders participating in the Reentry demonstration), ECM and Community Supports provider databases, and Medi-Cal eligibility and claims data. UCLA will request Medi-Cal eligibility and claims data going back two years prior to the start of CalAIM (January 2020 to December 2021) in order to include a two-year baseline period in relevant analyses as indicated in the methodology section below. To evaluate PATH Supports for ECM and Community Supports, UCLA will further obtain available external secondary data on community-based providers and

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

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

1. California Department of Health Care Services (DHCS) administrative data from January 1, 2020, through December 31, 2026, including Medi-Cal eligibility and claims data, ECM and Community Supports provider list and characteristics, PATH CITED applications and awardees (ECM and Community Supports), PATH Reentry funding applications and awardees, materials collected or distributed by the PATH Third Party Administrator (TPA) and facilitators responsible for administering different PATH initiatives, reports submitted by MCPs, ECM, Community Supports, or Reentry providers to DHCS (e.g., PATH implementation plans and readiness reviews),

salient data from any DHCS-administered surveys of ECM, Community Supports, and Re-entry stakeholders, and PATH Transition, TA, and CPI participants.

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

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

services; the use and perceived utility of PATH; and facilitators, barriers, and lessons learned in implementing the Reentry demonstration. The RAND team will lead interviews with key informants in correctional facilities and the UCLA team will lead interviews with county social services agencies and other salient community-based implementation partners.

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

Analytic methods

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

To answer EQ 1, which asks whether the number of providers contracted to provide ECM or Community Supports increased over time, UCLA will assess change or rate of growth in the related measures noted in Exhibit 2 over time (i.e., from January 1, 2022, to December 31, 2026). For these measures, we will examine growth over the course of the program and therefore will not include a baseline period. To better understand provider retention as indicated in Exhibit 2, UCLA will also (a) assess the transition of WPC and HHP providers to ECM or Community Supports in the early phase of PATH implementation and (b) examine churn in those providers as well as in newly contracted providers of ECM or Community Supports services. Data will be presented using graphical plots, and we will examine the trend and use the appropriate test (e.g., the Mann-Kendall test or regression modeling) to evaluate whether upward or downward trends are statistically significant. To determine whether the number and proportion of

community-based providers located in under-resourced communities increases over time (H1), UCLA will stratify results by California county and by under-resourced community indices. When stratifying by county is not feasible due to small numbers, UCLA will stratify results by a regional grouping determined in collaboration with DHCS. To determine whether changes in the number of providers can be attributed to PATH (H1), UCLA will also stratify results based on PATH participation. PATH participation will be operationalized as a dichotomous variable. As a sensitivity analysis, UCLA will test alternative specifications of the PATH participation variable (e.g., to assess impact of participation in different PATH initiatives or multiple PATH initiatives) and of under-resourced community indices. UCLA will also attempt to account for provider participation in other capacity-building programs such as IPP or learning collaboratives not facilitated by PATH.

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

thematically analyze qualitative data obtained during key informant interviews to provide further contextual information on factors affecting provider participation in ECM or Community Supports, and whether these factors vary by MCP, provider type or community context.

To answer EQ 3, which assesses whether PATH increased utilization of ECM and Community Supports, UCLA will use Medi-Cal eligibility and claims data to measure rate and patterns of use of ECM and Community Supports during PATH implementation years. UCLA will first examine the rate of use of ECM by population of focus and the rate of use of each Community Support. These analyses will be stratified by California county or region and by under-resourced community indices. UCLA will then use logistic regression analyses to assess characteristics differentiating eligible users and non-users for each ECM Population of Focus (POF) and for each Community Support. Where feasible and applicable, UCLA will also examine member characteristics associated with length of time using services or frequency of service use. Member characteristics examined will include age, gender, race/ethnicity, preferred language, homelessness, California county or region, vulnerability indices, chronic health conditions, severe mental illness, substance use disorder, and baseline service utilization (2 years prior to enrollment in ECM or receipt of Community Support services), among others. UCLA will also use regression analyses to assess differences in patterns of use of ECM and Community Supports by provider characteristics and as feasible, to further examine the potential role of PATH in reducing disparities in access to and use of ECM and Community Supports services by member race/ethnicity language preference, and baseline service use. Sensitivity analyses will entail differing specifications of the PATH participation variable, the Community Supports utilization variable, provider participation in non-PATH capacity development initiatives, and of under-resourced community indices. Regression analyses will be complemented with descriptive analysis of survey data and thematic analysis of interview data to contextualize and explain the findings from the Medi-Cal eligibility and claims data, e.g., by providing data on perceived impact of PATH on providers' ability to develop collaborative relationships and infrastructure needed to implement ECM or Community Supports and to identify and engage eligible members in care.

To answer EQ 4, which examines whether PATH improved ECM and Community Supports providers' data collection and information sharing infrastructure, UCLA will use provider survey or interview responses on what infrastructure they have in place prior to

and after CalAIM, and available administrative data such as provider PATH applications, meeting notes, and progress reports. To test H4, UCLA will use ANCOVA or appropriate regression analyses to assess change in the related measures noted in Exhibit 2 over time, controlling for provider characteristics, county or region, and under-resourced community indices. Sensitivity analyses will entail testing alternative specifications of the infrastructure variables, salient provider characteristics, and community indices. These analyses will be complemented with analysis of interview data on changes in information sharing infrastructure before and after PATH, how such infrastructure was developed or improved by providers during PATH, how data was shared with MCPs, and what were the related barriers and challenges to these activities.

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

To answer EQ 7, UCLA will collaborate with RAND to examine administrative data from CDCR, select county jails, and youth correctional facilities. As feasible, UCLA and RAND will attempt to corroborate enrollment using Medi-Cal enrollment data, pending the availability of a reliable flag in these data identifying previously incarcerated individuals or the ability to link administrative data from CDCR and select carceral facilities with Medi-Cal data. Data on the rate of incarcerated individuals that were screened for Medi-Cal eligibility or enrolled in Medi-Cal prior to release will be graphically plotted, and UCLA will use regression analyses to evaluate whether trends are statistically significant. For these measures, we will examine growth over the course of the program and therefore will not include a baseline period. To test H7, results will be stratified by facility type and region. Due to the large number of correctional facilities and associated implementation partners (e.g., county social service agencies) receiving PATH JI funding,

and the fact that administrative data on county jails and youth correctional facilities will only be available in four counties, UCLA does not believe it will be feasible to stratify administrative data on screening and eligibility rates by facility receipt of PATH funding. Thus, regression analyses will be complemented with descriptive analysis of survey data and thematic analysis of interview data to contextualize and explain the findings, e.g., by providing data on facilitators and barriers to screening and enrollment, and perceived impact of PATH on institutions' ability to screen and enroll eligible members in Medi-Cal prior to release.

Cost Analyses

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

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

UCLA will attempt to assess cost savings by comparing Medi-Cal payments by category of service incurred by members receiving ECM or Community Supports~~,~~ from providers

that participated in PATH to a matched comparison group of eligible members that did not participate in ECM or Community Supports.

Additional analytic considerations

- **Prior participation in similar waiver programs:** For most PATH analyses, UCLA will use a baseline period of 2020-2021. In some counties, ECM and Community Supports are similar to services previously provided as part of California's Medi-Cal Whole Person Care (WPC) Pilot Program (baseline period 2015-2016 and intervention implemented 2017-2021) or by Medicaid managed care plans that participated in the optional Medicaid Health Homes Program (HHP) benefit (baseline 2016-2017 and intervention implemented 2018-2021). In these counties, UCLA will use data from UCLA's prior evaluation of these programs to assess patterns of service use for Medicaid members that previously received WPC or HHP services and subsequently participated in ECM or Community Supports, as feasible. These analyses may be challenging due to churn in enrollment and selection bias (i.e., members that participate in services for a longer period of time may have a higher level of complexity than those that do not).
- **Potential effects of public health emergencies (PHE):** PHEs can impact patterns of health care use and expenditures, and also negatively impact fiscal solvency of many provider organizations. UCLA's previous evaluations of WPC and HHP assessed COVID-19 PHE impact, and did not identify major confounding impacts from the PHE; thus, UCLA also does not believe the COVID-19 PHE will confound PATH evaluation outcomes. However, when appropriate, the UCLA team may include a PHE indicator (e.g. for COVID-19 or other PHE) to determine whether there may be an association with members' subsequent uptake of ECM or Community Supports services.

Methodological Limitations

Attributing outcomes to PATH implementation are challenging because WPC entities and HHP MCPs in most California counties transitioned to PATH by January 2022 and the PATH initiatives were implemented statewide. Furthermore, DHCS has simultaneously implemented other funding initiatives to develop provider infrastructure and capacity such as the CalAIM Incentive Payment Program (IPP), which provided MCPs with $1.5 billion in additional funding to support provider infrastructure, capacity development, and member engagement for ECM, Community Supports, and the

Housing and Homelessness Incentive Program (HHIP), which allowed MCPs to earn incentive payments for investments and progress in addressing homelessness as a social driver of health. Providers that applied for PATH may have been denied funding if they received IPP or HHIP funds and their applications were deemed duplicative. Therefore, it is not feasible to construct a comparison group of counties or geographic areas without a PATH intervention or to fully attribute changes in provider capacity, infrastructure or utilization of ECM and Community Supports to PATH. Self-reported data on changes in the provider organizations due to PATH and perceived impact of PATH on organization and population served are subject to recall and acquiescence bias. In addition, proposed cost analyses only address costs to Medi-Cal and not to other systems of care. The evaluation will also only include data through the end of the waiver period (December 31, 2026) and thus may not reflect longer-term program impacts. Nevertheless, these data are an important element of mixed-method evaluation design; are crucial in understanding providers' actions and motivation for choosing specific PATH implementation approaches; and essential in contextualizing and explaining quantitative outcomes.

Evaluation Design for the Global Payment Program (GPP)

General Background Information

The Global Payment Program (GPP), launched in July 2015 as part of California's Section 1115 Medi-Cal 2020 waiver, established a statewide pool of funding for the uninsured by combining federal disproportionate share hospital (DSH) and uncompensated care (UC) funding to assist public health care systems (PHCS) in their key role of providing health care for the uninsured. The GPP's value-based payment structure uses a value-based point methodology to incentivize a shift in the overall delivery of services to more patient-centered and cost-effective care settings and strategies. By incentivizing a shift in the provision of GPP services from avoidable, costly, low-value care to primary and preventive high-value care in more appropriate venues, non-emergency care delivery can substitute for care provided through emergency departments (EDs) or inpatient hospital settings. To enhance access, utilization, and equity among California's uninsured, GPP also incorporates services that are otherwise available to the state's Medi-Cal members under other 1115 Medicaid waivers. With the approval of California's CalAIM 1115 waiver,[8] GPP will continue through 2026, its twelfth program year (PY). California will continue to test and assess this approach to assist PHCSs to strengthen data infrastructure and completeness necessary to describe and improve health care utilization, quality of care and cost outcomes. This evaluation of the GPP will examine key program features to identify areas that can be improved and those that can be emulated as California strives to strengthen GPP performance and effectiveness for potentially broader application.

PHCSs that participate in the GPP are comprised of designated public hospitals and their affiliated and contracted providers. PHCSs participating in the GPP are shown in Exhibit 3 below. Twelve of the PHCSs listed below began participating in GPP on July 1, 2015 (Program Year 1 (PY1)). UCLA began participating in GPP beginning with PY 9, January 1, 2023.

[8] 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 3. PHCS Participating in the Global Payment Program

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

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

process is summarized below based upon a detailed description in the CalAIM-1115-STC[9].

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

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

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

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

[9] 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 details on non-traditional services, including codes where available and descriptions, are in STC Attachments K and L.[10]

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

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

Significantly, although non-traditional services were not billable in Medi-Cal when GPP was initiated, California included non-traditional services (such as group visits and health coaching) in GPP so that PHCSs could invest in offering these services to the uninsured. With the CalAIM 1115 waiver renewal, California has already added a new doula and a new peer support service to supplement the original 50 GPP services. California's GPP has also now added, a fifth category, *Equity-Enhancing Services*, which spans three tiers: "Enhanced Care Management"; "Community Supports", and "Other Equity Enhancing

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

Services". From the list of fourteen Community Supports included as part of CalAIM's initial provision of CSs,

- Two Community Support services were included in the original list of 50 GPP services including Recuperative Care (Medical Respite) and Sobering Centers.
- Nine Community Support services, included in GPP's fifth category, Equity Enhancing services, are now included as a GPP service including: 1) Housing Transition Services; 2) Housing Deposits; 3) Housing Tenancy and Sustaining Services; 4) Short-Term Post-Hospitalization Housing; 5) Day Habitation Programs; 6) Nursing Facility Transition/ Diversion to Assisted Living Facilities; 7) Community Transition Services/ Nursing Facility Transition to a Home; 8) Personal Care and Homemaker Services; and 9) Asthma Remediation.[11]
- Three remaining Community Support services, Respite Care (for caregivers), Environmental Accessibility Adaptations (Home Modifications) and Medically Tailored Meals are currently not included as GPP services.
- The inclusion of the nine Community Supports not previously included as a GPP service, supplements the two Community Supports already included in the original GPP services. This assures that 11 current CalAIM Community Supports are now covered services under GPP. Currently, GPP lists Team-based street outreach and engagement as the only currently approved "Other Equity-Enhancing Service".

These new services are intended to align GPP service offerings with those available to Medicaid beneficiaries and utilize evidence-based practices to facilitate improvements in health disparities.

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

[11] Within CalAIM's Waiver's STCs, Attachment L, Table 1 of the Program Valuation text (page 18 of Attachment L), the components of the GPP services included in the new GPP Equity Enhancing Services are listed.

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

Evaluation Questions and Hypotheses

This section introduces GPP goals with Exhibits 4 and 5 using driver diagrams, initially presented by DHCS in their Initial Evaluation Design.[13] The discussion of goals is followed later in this section with Exhibits 6, 7, and 8 that provide additional detail about GPP's current evaluation questions (EQs), directional hypotheses (H), and measures developed by UCLA-RAND evaluators to assess whether the goals of GPP are achieved across the evaluation period. The target population for all measures includes individuals for whom the PHCSs submitted points for any GPP service provided by any of the PHCSs participating in the GPP.

[12] 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.

[13] California Department of Health Care Services (DHCS) California Advancing and Innovating Medi-Cal (CalAIM) Section 1115(a) Demonstration. Draft Evaluation Design for PATH, GPP, Duals. June 27, 2022.

Exhibit 4. Driver Diagram (GPP Goals 1 and 2)

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

Exhibit 5. GPP Driver Diagram (GPP Goal 3)

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

To assess the extent to which these goals were met, the GPP Evaluation Team will pursue the following three Evaluation Research Questions and Hypotheses.

- EQ1: Was the GPP successful in improving quality of care to individuals with uninsured services?
- H1: PHCS improved the quality of care to the uninsured.
- EQ2: Was the GPP successful in driving a shift in the provision of services from emergent and select inpatient services to non-emergency outpatient settings, including non- traditional and equity enhancing services?
- H2: PHCS increased the use of outpatient services, non-traditional services, and equity-enhancing services over the course of the GPP.
- EQ3: Was the GPP successful in driving improvements in the data infrastructure necessary to understand health inequities?
- H3: PHCS improved the data collection, reporting and analytics infrastructure to identify and act on health inequities.

Methodology

Overview of Approach to Evaluation Questions and Hypotheses including Building Blocks for Analyses

The Evaluation Team will use descriptive, qualitative and quantitative analyses to address the three GPP goals, research questions, and hypotheses. An overview of the building blocks of the GPP Evaluation Teams' qualitative, descriptive, and quantitative approaches to planned analyses is shown below.

For the quantitative design discussed in more detail below, the evaluator proposes conducting a survey and interview with each of the PHCSs at the beginning and end of the evaluation period. Such qualitative data was collected in the first GPP evaluation and proved to be a highly valuable source of information to contextualize the quantitative data and to understand the efforts of each health care system to meet the goals of GPP.

The qualitative data will be collected via a structured survey and will be completed independently by all PHCSs. Survey responses will be described, categorized and coded by emergent themes. Follow-up interviews will be conducted to address gaps and questions about the original responses. Interview responses will be added to the survey responses and further coded by themes. All interviews will be recorded and transcribed,

while qualitative data from surveys (e.g., free text responses to open-ended questions) will be extracted and organized into a spreadsheet.

Survey and interview topics will include but are not limited to how the system is meeting the goals of GPP and adapting its operations and care delivery during GPP implementation. Topics will also include reports of barriers to adaptation including external factors, such as the COVID pandemic, and how systems are improving the data infrastructure to track and address gaps in care for different population groups. The first survey and interview should take place once the evaluator is onboarded and prepared to conduct interviews. The second survey and interview should take place after data for PY 12 (CY 2026) is submitted. The qualitative data that will address all three GPP goals and provide contextual background for interpreting quantitative analyses. Accordingly, building blocks that characterize the qualitative analyses above will be similar to those described in the paragraphs that follow. Details of both the qualitative and quantitative analyses are described throughout the remainder of this Methodology Section.

GPP's first research goal, question and hypothesis. Clinical quality measures associated with the first goal, research questions, and hypothesis are chosen to include those systematically collected by PHCS and aligned with the DHCS Comprehensive Quality Strategy, derived from the Uniform Data System (UDS)[14]. 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."[15] GPP eligible individuals include those who are uninsured for the service they receive.

GPP' second and third research goals, questions and hypotheses. Metrics associated with GPP's second goal, research question, and hypothesis are pertinent to utilization of services, and metrics associated with the third goal, research question, and hypothesis

[14] 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

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

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.[16] 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[17] include changes in utilization across multiple GPP service categories.

Data Sources

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

[16] 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.

[17] Codes and descriptions, if available for these GPP services, are documented in CalAIM-1115-STC-Technical Corrections, Appendix 2, Table 7, Categories of Service, Pg 204 of 289 pgs. Following Appendix 2, Table 7 shows an extensive set of notes explaining code/definition sources. The source of Updated codes and descriptions will be reflected in reporting guidance provided by DHCS to PHCS.

and to assess factors that are perceived as impactful in determining how GPP meets its goals. The text below respectively describes GPP's primary and secondary data sources.

Primary Data Sources for Planned Primary Data Collection and Analyses

Surveys of GPP Health System Leaders and Teams

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

Interviews with GPP Health System Leaders and Teams

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

interview content. Analyses will present dominant themes related to the GPP experience as well as variations from PHCS-specific experiences.

Primary data collection to examine the patient experience

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

Secondary Data Sources for Planned Secondary Analyses

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

Aggregate Utilization Reports

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

Encounter-Level Data

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

P14 Workbook Data

The P14 workbook has served as a California-specific reporting tool that PHCSs have used to claim federal matching payments for both Medi-Cal and uncompensated care to the uninsured. For the purposes of the GPP, these workbooks provide a record of the aggregate cost of services that each PHCS provided to individuals using GPP services and any payments that these individuals made to that PHCS. These data are expected to be available one year following the end of each fiscal year (June 30). Cost data as reported in the P14 workbook have been available annually since PY 1 (SFY2015-2016). To implement planned pre-post and differences-in-differences analyses, the evaluation team recommends we examine historical P14 workbook data from PY 1 (SFY 2015-2016) through to the present time. This will allow us to develop appropriate analyses across years without and with consideration of the period spanning the COVID Public Health Emergency (PHE).

Medi-Cal Claims, Encounters, and Eligibility Files

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

Medicaid Core Set Measures

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

Managed Care Accountability Set (MCAS) Measures

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

Emergency Department and Hospital Inpatient Encounter Data

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

GPP Point Thresholds

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

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

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

GPP Payments

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

Annual Health Equity Report

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

Analysis Approach

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

GPP Goal 1 Evaluation Design

The first GPP goal is the improvement of quality of care among individuals with uninsured services.

Exhibit 6. GPP Goal 1 Evaluation Questions, Hypotheses, and Measures

GPP Goal 1. Improve the quality of care among individuals with uninsured services.	
Evaluation Questions and Hypotheses	**Measures**
EQ1: Was the GPP successful in improving quality of care to individuals with uninsured services? H1: PHCS improved the quality of care to the uninsured.	1. Colorectal Cancer Screening[18] 2. Diabetes: HbA1c Poor Control (>9%)[19] 3. Preventive Care and Screening: Screening for Depression and Follow-Up Plan[20] 4. Breast cancer screening[21] 5. Cervical cancer screening[22] 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,

[18] Measure specification: CMS130v10. UDS benchmark available. NCQA stewarded.
[19] Measure specification: CMS122v10. UDS benchmark available. NCQA stewarded.
[20] Measure specification: CMS2v11. UDS benchmark available. CMS stewarded.
[21] Measure specification: CMS125v11. UDS benchmark; NCQA stewarded.
[22] Measure specification: CMS124v10. UDS benchmark available. NCQA stewarded.

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).[23] These sources were used since their measures are based on patients seen by the clinic/system and have national benchmarks while most other standardized and nationally stewarded clinical measures are based on a health plan enrolled or provider-assigned population, which does not exist in GPP.
- **Target population:** All individuals receiving GPP services. More specific target populations will be defined by each clinical measure specification. The level of analysis will be at the PHCS level and program level.
- **Comparison group:** None
- **Baseline period:** None
- **Statistical analyses:**
    - Model: Longitudinal analysis
    - Analysis period: 2023-2026
    - Estimates of interest: Yearly change in quality for the target population relative to the first year of the analysis period (2023).
- **Stratifications:** Data available for analyses will be stratified by race, ethnicity, preferred language, gender identity, sexual orientation, age group, and area-level deprivation measures, such as the Social Vulnerability Index, Social Deprivation Index, the Healthy Places Index, or a comparable index. Analyses across all five CalAIM components will seek to align use of area-level deprivation measures where possible and following empirical analysis of their concordance for areas within California.

1.2. Analyses with Comparison Groups

We will also explore conducting analyses that include comparison groups to provide a more rigorous assessment of the effects of GPP on quality of care. For these analyses,

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

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 6). The statistical analysis would use comparative interrupted time series models as there are no data available for the target population prior to the start of GPP. Stratified analyses could be conducted for key patient subgroups defined by race, ethnicity, and area-level deprivation.

1.3. PHCS Survey and Qualitative Interviews Analyses for Goal 1

As part of our analyses to assess GPP Goal 1, we will also examine PHCS responses to PHCS Survey questions on PHCS' strategies to improve access to and continuity of care, timeliness of care for PHCS patients, and perceptions of patient experiences of care at the PHCS. We will summarize the responses by reporting means, standard deviations, and sample sizes (not all items will be applicable to all 13 PHCSs). We will also conduct follow-up interviews with the PHCS to discuss their responses to the survey and gain more contextual information about some of their decision-making around the strategies they do and do not employ to improve access to and continuity of care, their perceptions of patient experiences, and the challenges and successes around providing timely care to PHCS patients.

GPP Goal 2 Evaluation Design

The second GPP goal is to shift the provision of services from emergency and select inpatient settings to non-emergency outpatient settings among those individuals with uninsured services.

Exhibit 7: GPP Goal 2 Evaluation Questions, Hypotheses, and Measures

GPP Goal 2. Drive the shift in the provision of services from emergency and select inpatient services to non-emergency outpatient settings among those individuals with uninsured services.	
Evaluation Questions and Hypotheses	**Measures**
EQ2. Was the GPP successful in driving a shift in the provision of services from emergent and select inpatient services to non-emergency outpatient settings, including non-traditional and equity enhancing services? H2. PHCS increased the use of outpatient services, non-traditional services, and equity-enhancing services over the course of the GPP.	***Utilization measures derived from GPP encounter data:***[24] 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*

[24] GPP service utilization measures are based on number of GPP points provided in each tier and category, defined in Attachment L of the STCs. Non-traditional services and equity-enhancing services are identified in the GPP STCs. The exception is Metric 5 in Exhibit 7 which will be derived based on HEDIS Technical Specifications (https://www.ncqa.org/hedis/measures/follow-up-after-emergency-department-visit-for-people-with-high-risk-multiple-chronic-conditions/)

GPP Goal 2. Drive the shift in the provision of services from emergency and select inpatient services to non-emergency outpatient settings among those individuals with uninsured services.	
Evaluation Questions and Hypotheses	**Measures**
	of providers seen including generalist or specialist provider MD, NP, PA, RN[25] or other provider type) 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).*

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

Analytic methods for GPP Goal 2

2.1. Planned descriptive analyses and analyses with comparison groups

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

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

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

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

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

- **Measures:** We will assess changes in utilization of GPP services using approaches analogous to those used in the initial GPP evaluation while also adding several new measures. Measures 1-4 displayed in Exhibit 7 are based on the number of GPP points provided in each service "category" and "tier" as displayed in Attachment L of the STCs. While these measures do not have national benchmarks, they are valuable to understanding the continued impact of the program in encouraging the use of primary and preventive care. The relevant codes and descriptions for these GPP services are documented in *Technical corrections to the California section 1115 Medicaid demonstration, entitled "California Advancing and Innovating Medi-Cal" (CalAIM) (Project Number 11-W-00193/9) which was approved on August 23, 2023, under*

the authority of section 1115(a) of the Social Security Act (the Act) Appendix 2, Table 7, Categories of Service, Page 204 of 289 pages[1,3] Importantly, within this citation and following Appendix 2, Table 7, is an extensive set of notes explaining the source of codes applied to GPP services. The citation indicates that updated codes and descriptions will be reflected in reporting guidance provided by DHCS to PHCS.

Measures 5-8, which are derived from HCAI encounter data, include two measures of ambulatory care-sensitive (ACS) utilization: ACS hospitalizations[26] and ACS ED visits.[27] 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[28] 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

[26] https://qualityindicators.ahrq.gov/measures/pqi_resources
[27] https://qualityindicators.ahrq.gov/measures/ed_pqi_resources
[28] 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.[29]

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 the four proposed specific analyses are included below:

[29] 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 SDI/SVI, HPI, or comparable index.
- **Analysis 4: Difference-in-differences subgroup analyses.** We will expand Analysis 2 to measure the impact of GPP on utilization for population subgroups defined by race and ethnicity and area-level deprivation measures, such as the SDI/SVI, HPI, or a comparable index, which are the only population subgroups available for stratification that can be measured in the HCAI data. We note that the race and ethnicity in HCAI are unlikely to be self-reported, which is a limitation of these analyses.

2.2 Additional analyses under consideration

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

2.3. PHCS Survey and Qualitative Interview Analyses for Goal 2

As part of our analyses to assess GPP Goal 2, we will also examine PHCS responses to PHCS Survey questions on PHCS' strategies to promote care in cost-effective settings, provision of non-traditional services, and Enhanced Care Management and Community Supports. We will summarize the responses by reporting means, standard deviations, and sample sizes (not all items will be applicable to all 13 PHCSs). We will also conduct follow-up interviews with the PHCS to discuss their responses to the survey and gain more contextual information about some of their decision-making around the strategies they do and do not employ to promote care in cost-effective settings and their provision of non-traditional services, Enhanced Care Management, and Community Supports.

GPP Goal 3 Evaluation Design

To evaluate GPP Goal 3 we will conduct analyses to assess possible improvements in PHCS data infrastructure and completeness that are necessary to understand health inequities among GPP utilizers.

Exhibit 8. GPP Goal 3 Evaluation Questions, Hypotheses, and Measures

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

Analytic methods for GPP Goal 3

3.1. Descriptive Analyses

- **Data sources:** GPP encounter data submitted by each PHCS on a yearly basis.
- **Measures:** Improvements in data infrastructure will be measured by percent completion of 5 individual level characteristics listed in Exhibit 8.
    - Race categories will include American Indian or Alaska Native; Asian; Black or African American; Native Hawaiian or Other Pacific Islander; White; Some Other Race; Two or More Races; No Race Selection and Hispanic or Latino Ethnicity; Asked but No Answer/Unknown.
    - Ethnicity categories will include Hispanic or Latino; Not Hispanic or Latino; Asked but No Answer/Unknown.
    - Preferred Language Spoken will be coded as specified in GPP guidance consistent with the Department of Health Care Access and Information (HCAI) reporting guidance for Preferred Language Spoken.
    - Sexual orientation categories will include Lesbian, gay or homosexual; straight or heterosexual; Bisexual; Other ("Something else, please describe"); Don't Know; Choose not to disclose.

- Gender Identity includes five specific categories, as well as Other ("Additional gender category or other, please specify"), and "Choose not to disclose".

- **Stratifications:** Each measure listed in Exhibit 8 will be stratified by age group (e.g., <18, 18-64, >=65). Stratified reporting by age reflects the fact that willingness to self-report this type of information might vary by age.
- **Target Population:** All individuals receiving GPP services.
- **Comparison Group:** None
- **Baseline Period:** CY 2023 (PY9). This is the first year that PHCSs will be collecting all five stratification variables according to the GPP Health Equity Monitoring Metrics Protocol.
- **Evaluation Period:** CY 2024 (PY 10) through CY 2026 (PY 12)
- **Statistical Analysis:** Measures will be trended annually to assess changes over time during GPP.

3.2. PHCS Survey and Qualitative Interview Analyses for Goal 3

As part of our analyses to assess GPP Goal 3, we will also examine PHCS responses to PHCS Survey questions around data infrastructure, patient portals, use of data, and data challenges. We will summarize the responses by reporting means, standard deviations, and sample sizes (not all items will be applicable to all 13 PHCSs). We will also conduct follow-up interviews with the PHCS to discuss their responses to the survey and gain more contextual information about their data infrastructure, patient portals, use of data, and data challenges.

GPP Cost Analyses

We will use P14 workbooks from each PHCS to measure the cost of services provided to the uninsured provided by the PHCS. Audited P14 data will be used in the cost analysis or the most current unaudited P14 data when audited P14 workbooks are not available. We will then derive per capita cost estimates using unduplicated patient counts from the GPP encounter data. These analyses will support pre-post analyses of per-capita spending from as early as 2015 through the end of GPP. Cost data for a comparison group comprising non-GPP counties could be derived from a combination of hospital and ED encounter-specific charges reported in the HCAI data supplemented with UDS financial cost data reported by FQHCs in the UDS. Although the cost of care for the uninsured may be defined differently for the PHCS and comparison group, these

differences should be stable over time and should be netted out in our difference-in-differences analysis. We will ensure alignment of the cost analyses across all other CalAIM components.

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

Methodological Limitations

This evaluation has several limitations. The small sample size of 13 PHCSs makes it difficult to rule out the possibility that changes observed in analyses of aggregate utilization data are not due to random variation. Data limitations include utilization data quality issues, the lack of detailed patient self-reported measures and only limited access to clinically detailed measures of patient's need for service utilization. Potential biases in survey responses of PHCS leaders and of patients may occur. One limitation of drawing conclusions from survey data is that survey responses come from reports by PHCS leaders. Thus, the survey responses will reflect the perceptions and opinions of the respondents, which may not align with actual utilization and quality of care trends within a PHCS or be what all PHCS staff and leaders believe. However, when supplemented with utilization and quality of care data, the surveys provide context for the trends and patterns observed across PHCSs and experienced by GPP users. While CalAIM and PHCSs have been implementing programs to enhance trust by uninsured individuals in PHCSs, circumstances persist such that some remaining uninsured are hesitant to fully participate in available access to care opportunities.

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

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

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

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

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

General Background Information

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

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

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

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

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

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

While the Medi-Cal Matching Plan Policy in its current form was first implemented in 2022, we recommend the analysis comparing the demonstration and the comparison sites include analysis of similarities between the demonstration and comparison sites that begin at least one year prior to the demonstration's launch. Consistent with the difference-in-differences design recommended by DHCS in its draft Evaluation Design,[30] 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

[30] California Department of Health Care Services (DHCS) California Advancing and Innovating Medi-Cal (CalAIM) Section 1115(a) Demonstration. Draft Evaluation Design for PATH, GPP, Duals. June 27, 2022

Special Needs Plan (FIDE-SNP); and PACE organizations. October 2023 Duals enrollment for each type of MA is provided in this DHCS report: October 2023 MA Enrollment Report (ca.gov). A significant proportion of Duals have opted to enroll in MA plans. As of October 2023, there were 788,869 Duals who were MA enrollees (Exhibit 9).

Exhibit 9: MA Enrollment Among Dual Eligibles in California (October 2023)[31]

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

[31] 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.[32]

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

[32] 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[33]. 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[34] 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.[35] 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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[33] 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

[34] 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

[35] 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 10.

Exhibit 10. General Scenarios for the Medi-Cal Matching Plan Policy

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

Circumstance when Duals[1] consider or request a change in their MCP	Description
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.[36]

Evaluation Questions and Hypotheses

Exhibit 11 shows *Medi-Cal Matching Plan Policy* goals articulated by DHCS. DHCS defines a **Medi-Medi Plan** as an integrated EAE D-SNP; an **Aligned Plan** as a MA plan and MCP affiliated with and operated by the same MCO and an **Unaligned Plan** as a MA plan and MCP operated by different MCOs. The exhibit further includes the evaluation questions (EQs), directional hypotheses (H), and measures developed by UCLA and DHCS to assess whether the goals of the policy were achieved as anticipated. The evaluation team will incorporate feedback from DHCS subject matter experts to ensure that directional hypotheses accurately capture policy nuances across comparison groups.

[36] 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.

Exhibit 11: Alignment and Integration for Dually Eligible Beneficiaries

G 1: Determine the Epidemiology of Plan Changes among Dually Eligible Beneficiaries Eligible for MA Plans and Relate them to Requested MCP Change Requests.	
Evaluation Questions and Hypotheses	**Measures**
EQ 1a: How many Duals enrolled in a MA plan in the 12 counties with a *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 *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*.
EQ 1b: Of Duals that had the policy applied to them, how many changed their MCP to a non-matching plan within 12 months of enrollment?	
H 1: Less than 0.1 percent of Duals in mandatory aligned plans in Matching Plan Counties will change their MCP without changing their MA within 12 months of enrollment during the target period.	
H 2: Duals in aligned plans during the target period, are less likely to change their MCP (without changing their MA) than those in unaligned plans during the target period.	
H 3: Duals who change from a mandatory aligned plan are less likely to change their MA plans (and MCP) than Duals who change from unaligned MA plans during the target period.	

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

Exhibit 12: Driver Diagram for the Medi-Cal Matching Plan Policy

Aim	Primary Drivers	Secondary Drivers
Achieve less than 0.1% monthly rate of Duals changing their MCP to non-matching MCP for those who enroll in MA plans AND who are in counties where the *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** ←		

Methodology

Data Sources

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

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

In Goal #1, the evaluation will attempt to understand the impact of the *Medi-Cal Matching Plan Policy* on Duals plan enrollment changes in counties where the demonstration has been implemented. The evaluation's primary outcomes of interest among Duals enrolled in an MA are: (1) Duals monthly MA plan / MCP change, (2) Duals MA plan and MCP aligned or unaligned, and (3) Duals enrollment in or out of Medi-Medi Plans. We will account for other possible valid transitions (e.g., MA to Original Medicare) that would impact an MCP assignment and modeling of Duals plan choices.[37] 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

[37] 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.

individuals who newly enroll and disenroll from Medi-Cal. In the subgroup analyses, we will break out patterns of changes for newly enrolled individuals as well as individuals who have breaks in enrollment. At present, it is difficult to characterize a priori patterns and characteristics of individuals with breaks in enrollment, which may have antecedent events (e.g. loss of eligibility, moving residences, incarceration, and so on). Furthermore, individuals with two or more changes in MCPs are likely to be relatively uncommon and may be investigated separately given their potential complexity.

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

Target Population: The target population includes Duals in MA plans (with Duals in Original Medicare as a control) in counties with the *Medi-Cal Matching Plan Policy* compared to those in counties without the *Medi-Cal Matching Plan Policy* and also includes Duals in Medi-Medi Plans compared to Duals in other MA plans compared to Duals in Original Medicare.

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

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

Descriptive Analyses

1. Among Duals in MA plans from 2022 (or earlier, if possible) through 2026 (with one year lookback), UCLA will assess the rate and type of MA plan change, MCP change, and MCP alignment, pre- and post- *Medi-Cal Matching Plan Policy* implementation if applicable, comparing Duals in counties with the policy and Duals in counties without (or before) the policy. We will examine the five possible month-to-month Medicare transitions (1) MA – no change, (2) MA – switch to another MA, (3) Original Medicare to MA, (4) MA to Original Medicare, and (5) Original Medicare – no change. MCP choices described in Exhibit 13 follow these Medicare transitions. UCLA will also assess enrollment changes into and out of Medi-Medi Plans.
2. Overall, and stratified by these Medicare transitions, UCLA will examine MCP transitions that follow the MA plan. MCP status will be defined as [MCP change / no change] and [MA plan change (including special case to Original Medicare) / no change and MCP – integrated (MMP) / aligned / not aligned.

In addition to examining the number of Duals who transition at least once, UCLA will also examine the distribution of the number of transitions that individual Duals make during the target period. Individual persons who frequently switch plans may account for a disproportionate number of switches and may require further examination.

3. UCLA will examine Duals' MCP changes to non-matching MCPs, comparing Duals in counties where the policy is implemented and Duals in counties where the policy is not implemented, who change their MCPs.
4. UCLA will then examine the rates of change within demographic categories of Duals – age, gender, race/ethnicity, preferred language, counties, and quartile measure of social need (of residence zip code). Because numbers of observations may be quite small for some categories, UCLA may roll up assessments to 12-month periods.

Multiple Variable Regression Analyses

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

The secondary regression outcome will be "MCP change" and the primary regressor will be presence/absence *Medi-Cal Matching Plan Policy* in the Dual's county of residence at the time of the change. Covariates will include "MCP change", Dual's plan status before change (FFS, MMP, MA-MCP aligned, MA-MCP not aligned), Dual's characteristics (age,

gender, race/ethnicity, preferred language, quartile of social need metric), and time period (likely measured quarterly), plus fixed effect for county of residence.

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

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

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

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

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

Time Period: CY 2023 to CY 2024.

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

We will balance the samples by matching Duals within groups on observable characteristics (age category, gender, race/ethnicity, language, county, and quartile social need). There will be oversampling of race/ethnicity and quartile social need (based

upon zip code of residence) to account for difficult to reach vulnerable populations. Specifically, we will sample equal numbers from the quartiles of social need and within quartiles we will sample equal numbers from the primary four race/ethnicity categories (non-Hispanic white, non-Hispanic black, Hispanic, and Asian-Pacific Islander).

Assuming equal size and variance, comparing between the primary comparison groups (MA enrollees in counties with and without the policy – with 150 individuals per group), we estimate a standardized effect size of 0.32 with 80 percent power to detect differences. Similarly, comparing within county strata – MA versus Original Medicare enrollees (150 versus 50 individuals), we estimate a standardized effect size of 0.50 with 84 percent power to detect differences.

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

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

In the event they have questions or concerns about the survey or if they would like to complete the survey by phone, the letter will include a toll-free number for the participant to be able to call. In addition, the letter will include the survey URL and a unique PIN as well as a QR code for those who prefer to complete the survey via the web using either a computer, tablet, or smart phone. The survey invitation letter will

include a prominent note letting survey invitees know the availability of Spanish, Mandarin, and Vietnamese versions which they can access on the web or by requesting a hard copy in any of these languages by calling the survey's toll-free number or sending an email to a project-specific email.

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

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

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

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

The revised survey design of MCP changers has three sets of comparison strata among individuals enrolled in MA plans [(1) resident county has the policy (yes/no); (2) member changes their baseline MA plan (yes/no); (3) baseline MCP is aligned/integrated with MA plan (yes/no)] plus the external comparison to Duals in traditional (fee-for-service) Medicare who reside in counties with and without the alignment policy. There are 12 cells for MA plan enrollees and two cells for traditional Medicare enrollees. We plan to have 25 completed surveys per MA plan enrollee cell and up to 50 completed surveys per traditional Medicare enrollee cell to yield a total goal of 400 completed surveys. These sample sizes ensure statistical stability for unadjusted estimates yet may not be adequately powered to detect underlying differences for comparisons between the targeted groups. We will oversample on non-White minorities and on individuals residing in zip codes with the lowest quartile SES to balance the sample. Given the shorter time frame required for completing the survey, the evaluation team is balancing ensuring adequate response rates with the survey budget.

Survey Content and Development

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

UCLA additionally recommends supplementing these transition-specific survey items with a small number of items from a standardized tool to enhance case-mix adjustment across surveyed groups and across other components of the overall CalAIM evaluations. Specifically, UCLA recommends drawing validated and standardized items from the 10-item core Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool. This tool is currently being used by CMS to better understand whether finding and dealing with the health-related social needs of Medicare and Medicaid beneficiaries has any effect on their total health care costs and makes their health

outcomes better.[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.[38] 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.

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

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

Survey Analysis – Multiple Variable Regression with Sampling Weights

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

Power Calculations

Churn rates in Medicare program choices for Duals suggest significant activity related for Duals' MCP choices in general and the *Medi-Cal Matching Plan Policy* impact on choice specifically. For example, in March 2023, there were 722,676 Duals MA plan enrollees. Based upon preliminary data provided by DHCS to the independent evaluation team, between March and April 2023, 1.6 percent of dual eligible member MA enrollees switched MA plans and an additional 0.74 percent exited MA plans. An

additional 2.4 percent entered MA plans from Original Medicare. In April, there were 734,746 Duals MA plan enrollees. Between April and May 2023, another 1.2 percent of dually eligible member MA enrollees switched MA plans and 0.66 percent exited MA plans. An additional 2 percent entered MA plans from Original Medicare. Annualized numbers are likely lower than these estimates due to lower churn outside of open enrollment months. Nevertheless, this gives confidence that there will be sufficient activity to evaluate as described.

For the enrollment analyses, the large number of individual observations for MCP changes suggests that we will be able to detect extremely small differences between cases and controls. For example, using a two-year sample (2021 and 2022) with the original 12 policy counties versus remaining 15 non-policy counties (among counties with mandatory managed care enrollment), the total number of individual observations is the total number of months of enrollment for each group – which would conservatively be on the order of a million for each group. We should have adequate power to detect small differences – such as the original benchmark suggested by DHCS – 0.1 percent requests (either per month or per year).

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

Methodological Limitations

There are a number of limitations with the design approach for the evaluation. For Goal #1, which is focused primarily on understanding enrollment and disenrollment behavior among Duals in California, overlapping policy changes and secular events may make inference with regards to timing of the *Medi-Cal Matching Plan Policy* harder. Although the evaluation can account for certain elements of case-mix (e.g., matching demographics), it is not possible to account for selection effects (unmeasured severity correlated with the behavior of interest) that bias estimates in Goal #1 and the survey sample in Goal #2. Plan switching behavior is complex and requested changes (or not) and MCP changes (or not) may not be valid measures of MCP or *Medi-Cal Matching Plan Policy* satisfaction. Other areas of interest with regards to plan alignment – efficiency, cost effectiveness, improved access to care – which might add context and validate measures are outside of the scope of the evaluation of the *Medi-Cal Matching Plan Policy*. Nevertheless, the proposed evaluation design will provide valuable metrics

for determining the success and maturation of the *Medi-Cal Matching Plan Policy* and the maintenance of Duals' plan choice. With the expectation that policies associated with alignment between Medicare and Medicaid plans are likely to mature with time, the findings from this evaluation are likely to inform future efforts design and implementation efforts by CMS and DHCS. Findings will also be of interest to Medicare and Medicaid health plans.

Dissemination

Results of the evaluation of the *Medi-Cal Matching Plan Policy* will be presented in the formal reports to CMS and in-person presentations will be made to the DHCS Duals Program and other stakeholders. We expect that the results from Goal #1 through 2024 and for the survey results from the first wave in Goal #2 will be included in the Preliminary CalAIM Demonstration Evaluation Report. Overall results from Goal #1 through 2026 and for both waves of Goal #2 will be included in the Final CalAIM Demonstration Evaluation Report. Evaluation milestones are displayed in Exhibit 13 below.

Exhibit 13: Evaluation Milestones

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

Evaluation Design for California's Justice-Involved Reentry Initiative (Reentry)

General Background Information

The California Advancing and Innovating Medi-Cal (CalAIM) REENTRY Evaluation will assess the degree to which incarcerated individuals preparing for reentry to the community who are exposed to the Justice-Involved (JI) Reentry Initiative interventions (i.e., the Reentry Waiver Exposed Group) experience different processes and outcomes than those not exposed (i.e. the Reentry Waiver Comparison Group). Evaluation activities will include assessments of changes over time between exposed and comparison groups in (1) access to medical and behavioral health services for incarcerated individuals eligible for the State's Medicaid Program (Medi-Cal); (2) exposure to systems for effectively enrolling eligible detainees into Medi-Cal prior to release; (3) coordination of transitional care between the pre- and post-release setting; (4) coordination of community-based services through Enhanced care Management, and (5) provision of a supply of medications and durable medical equipment at release.[39]

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.[40] 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.

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[39] Cronin-Furman, Margot, et al. "Breaking Ground: How California is Using Medicaid to Improve the Health of People Leaving Incarceration." (2023).

[40] 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."[41] 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.[42]

It is estimated that as many as 80 percent of incarcerated individuals will be eligible for CalAIM JI services.[43] As mandated by state law as of January 2023, counties are developing strategies for expanding Medi-Cal enrollment at intake and California's

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

[42] 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

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

managed care plans (MCPs) are developing systems to expand post-incarceration Enhanced Care Management[44], 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.[45] In addition, more than 2,200 youth are incarcerated at the county level in juvenile halls, camps and ranches.[46] 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:[47] 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.[48] The average

[44] 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

[45] 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

[46] 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.

[47] 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

[48] 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)

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, Orange and Sacramento -- accounted for almost two-thirds of the released population in 2023.[49]

- 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.[50] 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.[51] [52]

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

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

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

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

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

Care Management (ECM) upon release, is expected to increase continuity of health coverage, prevent unnecessary disruptions in care, reduce emergency department visits and inpatient hospital admissions; reduce mental health decompensation, suicide-related death, overdose, overdose-related death and all-cause death; and lead to improved health outcomes in general. This targeted set of pre-release services will be available to certain eligible Medicaid and CHIP members who are residing in state prisons, county jails, or youth correctional facilities, for up to 90 days immediately prior to the individual's expected release date (see Special Terms and Conditions (STC) 9.8).[53]

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.[54] 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,

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

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

including coverage for counseling and services provided by community health workers or Peer Support Specialists with lived experience. Qualifying members will also receive covered outpatient prescription medication (a minimum 30-day supply, as clinically appropriate, consistent with the Medicaid State Plan) and durable medical equipment (DME) upon release.

The goals for the Justice-Involved Reentry Initiative are to:[55]

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

[55] 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).

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.

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

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

Overall Evaluation Strategy

UCLA-RAND Reentry Evaluation Team

The UCLA-RAND Reentry Evaluation team is responsible for the evaluation of the Justice-Involved Reentry Initiative. The team is led by researchers Drs. Lois Davis and Susan Turner from RAND. The team also includes researchers from RAND and UCLA as detailed in the section below titled "Reentry Evaluation Team." The JI Reentry Initiative evaluation period covers October 2024 through December 2026. The UCLA-RAND Reentry evaluation contract period is from December 1, 2023, to May 31, 2029, which includes the development of the evaluation design, its implementation, and completion of all other contract deliverables (i.e. evaluation reports and responses to comments from DHCS and CMS). A detailed project timeline is provided in Exhibit 14. The total budget for the effort is $2,903,678.39.

Timeline for Data Collection Activities

Exhibit 14 on the next page shows the anticipated timeline for the Reentry Evaluation activities. The table shows the data collection activity, timeframe, and goals associated with each activity.

Exhibit 14. Study Timeline for Reentry Data Collection Activities

Activity	Timeframe	Goals
Revise evaluation research design; submit revisions to address CMS' comments	Fall of 2024	1-7
In consultation with DHCS, select the four focal counties for jail and juvenile populations analyses	2025	1-7
Develop research applications, data use agreements, etc. for CDCR and the four focal counties	2024-2025	1-7
Submit research application to CDCR Research Oversight Committee (ROC) for identification of Waiver comparison cohorts, to obtain data on background characteristics, and pre-release services	2024-2025	1-7
Work with Sheriff's Departments and juvenile authorities in the four focal counties on research approvals & data use agreements; access data to identify Waiver comparison cohorts for jail population and juvenile populations	2025	1-7
Qualitative Data Collection & Analysis		
Recruit and conduct interviews with Waiver participants (who were incarcerated in prisons, jails, & juvenile facilities)	2025	3,4,5
Conduct key stakeholder interviews at state and county levels; analyze data	2025	3,4,5
Analyze Waiver participants' interview data and key stakeholders interview data	2025	3,4,5
Quantitative Data Collection & Analysis		
Identify Waiver comparison cohorts (pre-Waiver)	2025-2026	1,2,6,7
Obtain Data for comparison cohorts (pre-	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[56]:

- 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;

[56] 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.[57]

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.[58]

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.[59] CDCR, including all 33 state prisons, will go live with

[57] 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

[58] 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

[59] 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[60]; 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

[60] 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).[61]

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.[62] 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).[63] 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

[61] 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.
[62] ISUDT Annual Outcomes Report 2024 (ca.gov)
[63] 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.[64] 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

[64] 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[65] 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.[66] 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

[65] 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.
[66] 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.[67]

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

[67] 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.[68] 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).[69] 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).[70] 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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[68] 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.

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

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

Exhibit 15 summarizes, for the different interview topic areas, the entities who will be interviewed (including the lead entity), and who the system implementation partners are. Specifically, at the prison-level, evaluation plans are to interview those individuals within CDCR and the CCHCS who were involved in planning for and implementing the Waiver for the incarcerated population in the state's correctional system. Similarly, at the jail and youth correctional facilities, implementation partners listed in Exhibit 15 including county sheriffs, county jail staff and juvenile facility administrators/staff, county probation staff, and state parole staff will be interviewed.

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

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

Exhibit 15. Interview Topic Areas, Lead Entity, and System Implementation Partners

Topics	Lead Entity	System Implementation Partners
Pre-Release Medi-Cal Application Processes in County Correctional Facilities	County Jails and Youth Correctional Facilities	County Sheriff's Offices, County Probation Offices, and County Social Services Departments (SSDs) and other partners responsible for correctional health care services.
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)

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

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

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

Evaluation Questions and Hypotheses

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

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

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

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

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

Exhibit 16 describes Goals, Evaluation Questions and Hypotheses, and Measures for the Reentry Evaluation.

Exhibit 16. Goals, Evaluation Questions, Hypotheses, and Measures

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

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) » Pre-release medication billing (numerator = number who received any medication billed during the 90-day pre-release
H1: The Waiver will increase access to services prior to release and improve	

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**
transitions and continuing of care upon release for eligible Medi-Cal members.	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

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**
	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)[71] » Percent of incarcerated individuals found eligible for Justice-Involved Reentry Initiative services after screening - post-Waiver cohorts compared to pre-Waiver cohorts

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

G 3 Improve coordination and communication between correctional systems, Medicaid and CHIP systems, managed care plans, and community-based providers.	
Evaluation Questions and Hypotheses	**Measures**
EQ 3A: Did the Waiver improve coordination between correctional systems, Medicaid and CHIP systems, managed care plans, and community-based providers? **EQ 3B**: Did the Waiver improve communication between correctional systems, Medicaid and CHIP systems, managed care plans, and community-based providers?	Interviews with individuals released from prison/jail/juvenile facilities could cover: » Challenges/facilitators in transitioning to the community after release (e.g., number of available providers) » Continuity of care from incarceration to community » Effectiveness of case managers 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
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.	

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**
	» ECM services needed and received Interviews with key stakeholders could cover: » Coordination of care between carceral settings (prison, jail, youth correctional facilities) and community service providers (behavioral health, medical care, social services) » Type of formal arrangements (e.g., memorandums of understanding, regular meetings, etc.) to facilitate connections between carceral settings and providers » Facilitators and barriers and how these may vary by type of services provided

G 6: Provide intervention for certain behavioral health conditions and use stabilizing medications like long-acting injectable antipsychotics and medications for addiction treatment for SUDs, with the goal of reducing decompensation, suicide-related death, overdose, and overdose-related death in the near-term post-release.	
Evaluation Questions and Hypotheses	**Measures**
EQ 1: Did the Waiver provide intervention for certain behavioral health conditions and use stabilizing medications like long-acting injectable anti-psychotics and medications for addiction treatment for SUDs for eligible Medi-Cal members?	» Post-release substance use disorder treatment (numerator = number of releasees who received substance use disorder treatment within 30 days of release; denominator = number of releasees)Post-release mental health treatment (numerator = number of releasees who received mental health treatment within 30 days of release; denominator = number of releasees) » Post-release MAT (numerator = number of releasees who received MAT within 30 days of release; denominator = number of releasees) » 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)
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?	

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**
H2: The Waiver will reduce decompensation, suicide-related deaths, overdoses, and overdose-related deaths for eligible Medi-Cal members.	» Medications for addiction treatment for SUDs (numerator = number of releasees who received medications for addiction treatment for SUDs in the 90 days pre-release and post-release (30 days and 90 days); denominator = number of releasees) » Suicide-related emergency department visits (numerator = number of releasees who had suicide-related emergency department visits post-release (30 days and 90 days; denominator = number of releasees) » Suicide-related inpatient hospitalizations (numerator = number of releasees who had inpatient hospitalizations post-release (30 days and 90 days; denominator = number of releasees) » Suicide-related deaths (numerator = number of releasees who died by suicide (30 days and 90 days); denominator = number of releasees) » Emergency department utilization for SUD (numerator = number of releasees who had emergency department utilization for SUD post-release (30 days and 90 days); denominator = number of releasees)

G 6: Provide intervention for certain behavioral health conditions and use stabilizing medications like long-acting injectable antipsychotics and medications for addiction treatment for SUDs, with the goal of reducing decompensation, suicide-related death, overdose, and overdose-related death in the near-term post-release.	
Evaluation Questions and Hypotheses	**Measures**
	» Inpatient stays for SUD (numerator = number of releasees who had inpatient stays for SUD post-release (30 days and 90 days); denominator = number of releasees) » Overdose-related deaths (numerator = number of releasees who had an overdose-related death (30 days and 90 days); denominator = number of releasees) » Decompensation (numerator = number of releasees who had any (and each) post-release decompensation (include psychosis, suicide attempt, depression, anxiety, mania, drug overdose (regardless of intention), drug induced mental disorders, insomnia, social withdrawal, anorexia, aggression, increased substance use) 30 days and 90 days; denominator = number of releasees)

G 7: Reduce post-release acute care utilization such as emergency department visits, inpatient hospitalizations, and all-cause deaths among recently incarcerated Medicaid beneficiaries and individuals otherwise eligible for CHIP if not for their incarceration status through robust pre-release identification, stabilization, and management of certain serious physical and behavioral health conditions that may respond to ambulatory care and treatment (e.g., diabetes, heart failure, hypertension, schizophrenia, SUDs) as well as increased receipt of preventive and routine physical and behavioral health care.	
Evaluation Questions and Hypotheses	**Measures**
EQ 1: Did the Waiver reduce post-release emergency department visits, inpatient hospitalizations, and all-cause deaths for eligible Medi-Cal members?	» All-cause deaths (numerator = number of releasees who died (30 days and 90 days); denominator = number of releasees) » 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 shown in Exhibit 17 are taken directly from the Special Terms and Conditions (STCs) number 9.1 for California.[72]

Exhibit 17. Goals listed in the driver diagrams

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

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

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

Aim	Primary Driver	Secondary Driver
		health and social services pre- and post-release. Improve data systems in carceral settings.
← Causality ←		

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

Aim	Primary Driver	Secondary Driver
Improve access to services prior to release and improve transitions and continuity of care into the community upon release.	Increase Medicaid coverage and MCP 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-

Aim	Primary Driver	Secondary Driver
		centered plan for coordination of their care post-release. Implement processes to ensure that all pre-release service providers have the necessary experience and training, and case managers are knowledgeable about community-based providers.
← Causality ←		

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

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

Aim	Primary Driver	Secondary Driver
	providers, including case managers, either in person or via telehealth.	
← Causality →		

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

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

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

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

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

Aim	Primary Driver	Secondary Driver
Increase access to interventions for behavioral health conditions, access to long-acting injectable 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 ←		

Methodology

Note, the goals are taken from CMS guidance in the STCS.[73]

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

[73] 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[74]

- **Target Population:** People who are eligible Medi-Cal members who met Waiver service criteria and were enrolled and then released from carceral settings following the go live of the Waiver (specific to each facility)
- **Comparison Population:** People who would have met Medi-Cal eligibility and Waiver service criteria and were released from carceral settings prior to the go live of the Waiver (specific to each facility)
- **Individual level data**
- **Evaluation Period:** CY 2021 through CY 2026
- **Methodological Design:** The UCLA-RAND Reentry Evaluation team will use cohort difference-in-differences and event study analyses. The UCLA-RAND Reentry Evaluation team will identify a 12-month cohort of individuals released around the timing of the go live of the Reentry Waiver (i.e., groups released 6 months prior to Waiver go live (control) and the first 6 months after go live (treated)). The UCLA-RAND Reentry Evaluation team will also assess the feasibility of constructing control cohorts from the same 12-month period, for years prior to Reentry Waiver go live. The difference-in-differences models will explore how outcomes vary before and after Waiver go live compared to associated control cohorts (in earlier years) to identify the causal effect of the Reentry Waiver. Importantly, the UCLA-RAND Reentry Evaluation team will be able to follow the outcomes of releasees over time, allowing exploration of dynamic effect in event study models by using monthly data for the outcomes of each individual. Event study models will also allow the UCLA-RAND Reentry Evaluation team to explore whether control and treated cohorts were on parallel trends prior to Waiver go live (a crucial assumption in difference-in-differences models).

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

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

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

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

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

Goal 7: Reduce post-release acute care utilization such as emergency department visits, inpatient hospitalizations, and all-cause deaths among recently incarcerated

Medicaid beneficiaries and individuals otherwise eligible for CHIP if not for their incarceration status through robust pre-release identification, stabilization, and management of certain serious physical and behavioral health conditions that may respond to ambulatory care and treatment (e.g., diabetes, heart failure, hypertension, schizophrenia, SUDs) as well as increased receipt of preventive and routine physical and behavioral health care.

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

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

releasees over time, allowing exploration of dynamic effect in event study models by using monthly data for the outcomes of each individual. Event study models will also allow the UCLA-RAND Reentry Evaluation team to explore whether control and treated cohorts were on parallel trends prior to go live (a crucial assumption in difference-in-differences models).

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

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

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

Cost

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

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

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

UCLA-RAND will stratify these data by county or region, under-resourced community indices, and by provider types. These analyses depend on the feasibility of obtaining average payment rates from MCPs. If MCP are unable to estimate average payment amounts, then the UCLA-RAND Evaluation team will rely on DHCS-provided data pertaining to rates provided to MCPs. The limitation of this approach is that the UCLA-RAND evaluation team would then only be able to examine expenditures in aggregate.

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

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

Alternative Research Design Possibilities

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

The UCLA-RAND Reentry Evaluation team might explore the use of contemporaneous comparison groups post-Waiver including those who refused to sign up for the Waiver or for those who received no Waiver services. However, this will require careful control for factors that may be correlated with the decision to enroll or receive services, and that a large enough sample refused to sign up for the Waiver or did not receive waiver services to be able to draw inferences. The delivery of pre-release services is to be implemented using a phased-in approach; with all participating state prisons, county

jails, and youth correctional facilities needing to demonstrate readiness prior to participating in the Justice-Involved Reentry Initiative. Any delays will impact the evaluation timeline.

Methodological Limitations

As described in the evaluation design, the Reentry cohort is identified through specific eligibility criteria. Identifying these criteria may not be available for incarcerated individuals in the period prior to the Reentry program going live. Because most released individuals qualify for Reentry, even an intention to treat approach and including all released individuals will be a reasonable alternative approach for evaluation and will likely generate conservative estimates of the impact of the intervention.

To the extent possible, we will be assessing data completeness and validity through concordant validity checks with other routinely collected data. Aspects of care within the carceral setting in window of time of eligibility for Reentry for care that should be covered by Reentry may have gold standard comparisons. For example, individuals who are hospitalized or seen in an emergency department will be captured by the carceral setting and by the state hospital discharge and emergency department encounter data sets. Because Reentry covered services should appear in the Medi-Cal data, these data will potentially be comparable to care captured by the carceral setting electronic health record (EHR), such as outpatient visits and prescriptions. Because individuals will be moving directly into managed care after release, post-release services should be more reliably identifiable across all periods.

Despite these potential limitations, the evaluation team will have multiple remedial approaches – as described – to answer the evaluation questions and to ensure a robust assessment of the Reentry Program.

Evaluation Design for the Managed Care Plans Transition (MCP)

General Background Information

Objective

This Evaluation Plan details the ways in which the State will evaluate the transition to limited choice, county-authorized managed care programs. This transition is an amendment to the section 1115(a) CalAIM demonstration and is subject to the limitations of the demonstration as outlined in the special terms and conditions (STCs).[75] 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,[76] 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.

[75] MCP Transition STCs: https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-ManagedCare-Amendment-Approved.pdf

[76] 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).[77] 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.[78]

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

[77] Medi-Cal Managed Care Plan Model Fact Sheets: https://www.dhcs.ca.gov/services/Documents/MMCD/MMCD-Model-Fact-Sheet.pdf.
[78] 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 18 shows the change in models by county. Not all Medi-Cal members in these counties transitioned to a new MCP, but close to 1.2 million members have been involved in the transition in 2024. Members transitioning to a new MCP received a 90-day notice from their exiting MCP, 60-day and 30-day notices from DHCS's enrollment broker, and a welcome packet from their receiving MCP in January 2024.

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

Exhibit 18. Counties Transitioning to a County-Organized Health System (COHS) Model or Single Plan Model under the MCP Transition Amendment

County ***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 is included as a MCP option. In effect, Kaiser will operate in parallel with the single plan or COHS county systems Kaiser has committed to growth of new Medi-Cal members of 25 percent from July 1, 2024, (after the end of the PHE unwinding redetermination period and excluding any population growth resulting from the 2024 default enrollment requirements between January 1, 2024, and June 30, 2024) to the end of the contract term, or December 31, 2028. Kaiser enrollment growth will come from geographic expansion, foster care youth and former foster care youth who elect to enroll in Kaiser, and members dually eligible for Medi-Cal and Medicare residing in Kaiser's geographic service areas, as well as annual enrollment growth through default enrollments in specific counties. There is no enrollment limit for the number of children in foster care, members dually eligible for Medi-Cal and Medicare, and other enrollment resulting from continuity of care rights.

Evaluation Questions and Hypotheses

Implementing expanded COHS and new Single Plan models in select Metro, Large Metro, and Urban counties is consistent with the goals of CalAIM, which include improving quality, access, and accountability. Key drivers in support of this aim are described in Exhibit 19.

Exhibit 19. Driver Diagram for the MCP Transition

Aim	Primary Driver	Secondary Driver
Maintain or improve quality, access to care, and accountability	Maintain or improve access to care	Enhanced protections, included extended eligibility period for out-of-network provider use at the Receiving MCP, for special populations^
		Monitor MCPs' implementation of transition responsibilities
	Ensure continuity of care	Continue medically necessary services for members in an ongoing course of treatment without any form of prior

Aim	Primary Driver	Secondary Driver
		approval and without regard to whether such services are provided by in-network or out-of-network providers
		Allow the member to keep their current PCP
		Automatically enroll dual-eligible members in Medi-Cal Matching Plan counties in a Medi-Cal MCP that matches their Medicare Advantage plan
		Allow transitioning members to keep their out-of-network providers for a 12-month period at their Receiving MCP
		Provide clear communications around the transition (e.g. choice packet sent to members with 60-notice, Welcome Packet from new MCP sent in early January 2023
	Maintain or improve quality of care	Ensure a whole-person, interdisciplinary approach for populations with complex health care needs
		Report on and regularly monitor quality of care measures during the transition period
		Strengthen and maintain quality of care for vulnerable populations
	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)

Aim	Primary Driver	Secondary Driver
		Expand DHCS oversight responsibilities, including an independent access assessment for network adequacy

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

The evaluation will assess the overall impact of the MCP Transition by analyzing trends prior to and after the implementation of the amendment (i.e., 2021-2023 and 2024-2026). We will also contextualize these changes against the backdrop of the existing CalAIM Demonstration initiatives and other statewide care transformation efforts affecting the managed care model in California overall. Exhibit 20 provides an overview of the high-level evaluation hypotheses and evaluation questions as they relate to the goals of the MCP Transition.

Exhibit 20. Summary of MCP Transition Evaluation Design

Goal 1: Maintain or improve overall access to and continuity of care.				
Evaluation Questions & Hypotheses	**Measures**	**Population(s)**	**Data Source(s)**	**Analytic Methods**
EQ1A. How many Medi-Cal members were in the 15 MCP Transition counties? How many Med-Cal members switched plans under the MCP Transition? **H1A.** N/A (descriptive)	» Medi-Cal members residing in MCP Transition counties » Medi-Cal members required to switch MCPs under the MCP Transition	Members in MCP Transition counties; members who switched MCPs under the transition	» Enrollment data	Descriptive analyses
EQ1B. What were the characteristics of Medi-Cal members in MCP Transition counties? **H1B.** N/A (descriptive)	» Sociodemographic characteristics of members in MCP Transition counties	Members in MCP Transition counties	» Enrollment data	Descriptive analyses, pre- post analyses
EQ1C. What was the effect of the Demonstration on access to care? **H1C.** The Demonstration will maintain or improve access to care: network adequacy will stay the same or increase, and access to care grievances will stay the same or decrease.	» Network adequacy (i.e., member-to-provider ratios) » Access to care grievances	MCP Transition counties	» Interviews with members » DHCS grievance data » DHCS Network Adequacy Monitoring data (i.e., 274 Provider File and MIS/DSS enrollment data)	Descriptive analyses; thematic analysis of interviews
EQ1D. To what extent did access to preventive/ ambulatory health services change under the MCP Transition? **H1D.** The Demonstration will maintain or improve access to preventive/ ambulatory health services: rates of well-child visits, immunizations for adolescents, and timeliness of prenatal and postpartum care will stay the same or increase.	» Well-child visits » Immunizations for adolescents » Timeliness of prenatal and postpartum care	Members in MCP Transition counties	» MCAS data; Core Set data	Descriptive analyses; pre-post analyses *(Paired t-tests; chi-squared tests*)
EQ1E. To what extent did access to behavioral health services change under the Demonstration? **H1E.** The Demonstration will maintain or improve access to behavioral health services: rates of follow up after ED visit for mental illness and non-specialty mental health member-to-provider ratios will stay the same or increase.	» Follow up after ED visit for mental illness » Non-Specialty outpatient mental health member-to-provider ratio	Members in MCP Transition counties	» MCAS data; DHCS Network Adequacy Monitoring data (i.e., 274 Provider File and MIS/DSS enrollment data)	Pre-post analyses *(Paired t-tests; chi-squared tests*)
EQ1F. What was the effect of the Demonstration on continuity of care? **H1F.** The Demonstration will maintain or improve continuity of	» Continuity of care grievances	MCP Transition counties	» DHCS grievance records » Interviews with members	Pre-post analyses *(Paired t-tests; chi-squared tests);* thematic

Goal 1: Maintain or improve overall access to and continuity of care.				
Evaluation Questions & Hypotheses	**Measures**	**Population(s)**	**Data Source(s)**	**Analytic Methods**
care: continuity of care grievances will stay the same or decrease.				analysis of interviews

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

Goal 3: Maintain or improve access to high-quality, continuous care among historically marginalized and under-resourced populations.				
Evaluation Questions & Hypotheses	**Measures**	**Population(s)**	**Data Source(s)**	**Analytic Methods**
EQ3A. To what extent were historically marginalized and under-resourced populations, who were members living in MCP Transition counties, enrolled in the Demonstration? **H3A.** N/A (descriptive)	» Sociodemographic characteristics of members in MCP Transition counties	Members in MCP Transition counties by equity relevant sub-populations^	» Enrollment data	Directed content analysis of secondary data; Descriptive analyses; Pre-post analyses
EQ3B. What was the effect of the Demonstration on access to care among historically marginalized and under-resourced populations? **H3B.** The Demonstration will maintain or improve access to care among historically marginalized and under-resourced populations: network adequacy will stay the same or increase, and access to care grievances will stay the same or decrease, within subgroups of such populations.	» Network adequacy (e.g. member-to-provider ratio) » Access to care grievances	Members in MCP Transition counties by equity relevant sub-populations^	» Interviews with members » DHCS grievance data » DHCS Network Adequacy Monitoring data (i.e., 274 Provider File and MIS/DSS enrollment data)	Descriptive analyses; thematic analysis of interviews
EQ3C. To what extent did access to preventive/ ambulatory health services change under the Demonstration among historically marginalized and under-resourced populations? **H3C.** The Demonstration will maintain or improve access to preventive/ ambulatory health services among historically	» Well-child visits » Immunizations for adolescents » Timeliness of prenatal and postpartum care	Members in MCP Transition counties by equity relevant sub-populations^	» MCAS data; Core Set data	Descriptive analyses; Pre-post analyses *(Paired t-tests; chi-squared tests*)

Goal 3: Maintain or improve access to high-quality, continuous care among historically marginalized and under-resourced populations.				
Evaluation Questions & Hypotheses	**Measures**	**Population(s)**	**Data Source(s)**	**Analytic Methods**
marginalized and under-resourced populations: rates of well-child visits, immunizations for adolescents, and timeliness of prenatal and postpartum care will stay the same or increase within subgroups of such populations.				
EQ3D. To what extent did access to behavioral health services change under the Demonstration among historically marginalized and under-resourced populations? **H3D.** The Demonstration will maintain or improve access to behavioral health services among historically marginalized and under-resourced populations: rates of follow-up after ED visits for mental illness will stay the same or increase within subgroups of such populations.	» Follow up after ED visit for mental illness	Members in MCP Transition counties by equity relevant sub-populations^	» MCAS data	Pre-post analyses *(Paired t-tests; chi-squared tests*)
EQ3E. What was the effect of the Demonstration on continuity of care among historically marginalized and under-resourced populations? **H3E.** The Demonstration will maintain or improve continuity of care among historically marginalized and under-resourced populations: continuity of care grievances will stay the same or decrease within subgroups of such populations.	» Continuity of care grievances	Members in MCP Transition counties by equity relevant sub-populations^	» DHCS grievance records » Interviews with members	Pre-post analyses *(paired t-tests; chi-squared tests);* Thematic analysis of interviews
EQ3F. What was the effect of the Demonstration on quality of care outcomes for members among historically marginalized and under-resourced populations? **H3F.** The Demonstration will maintain or improve quality of care outcomes among historically marginalized and under-resourced populations: rates of breast cancer screening and immunizations for adolescents will stay the same or increase, and all-cause readmissions will stay the same or decrease, within subgroups of such populations.	» Breast cancer screening » Immunizations for adolescents » Plan all-cause readmissions	Members in MCP Transition counties by equity relevant sub-populations^	» MCAS data; Core Set data	Difference-in-Differences or Comparative Interrupted Time Series

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

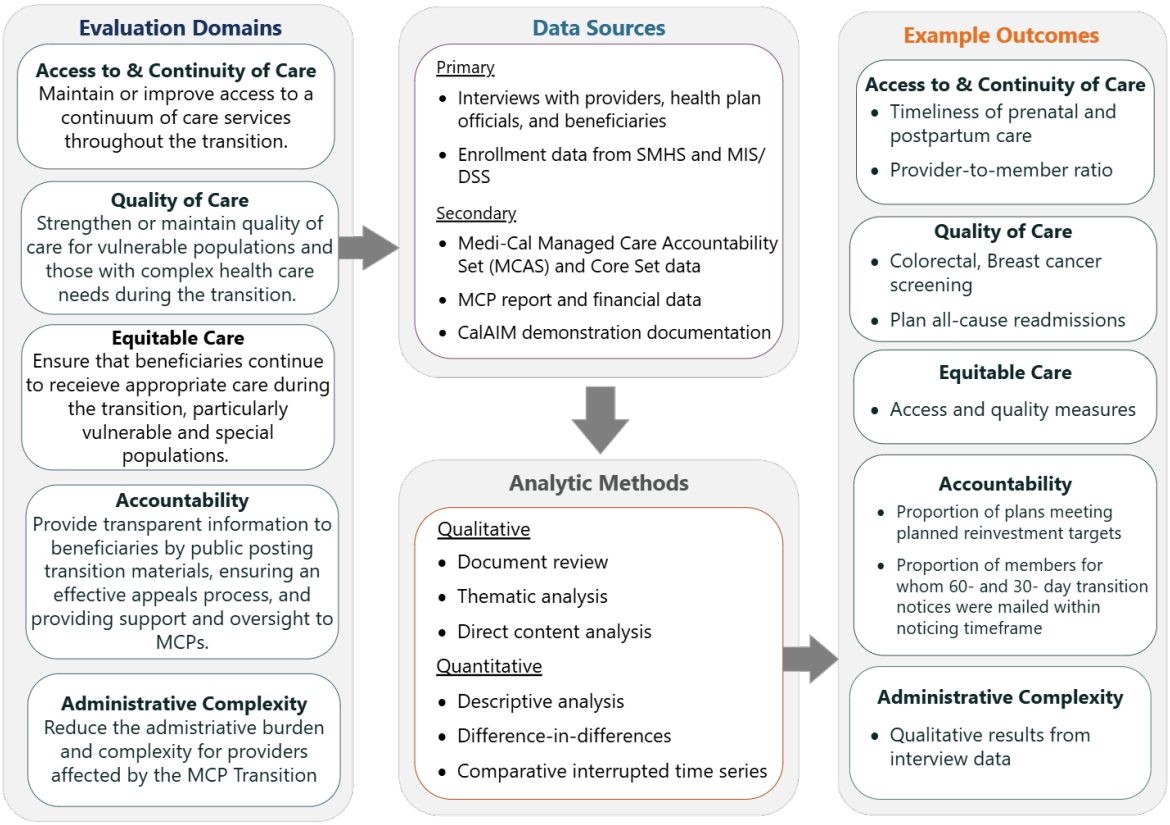
Goal 5: Maintain plan accountability and improve transparency.				
Evaluation Questions & Hypotheses	**Measures**	**Population(s)**	**Data Source(s)**	**Analytic Methods**
EQ5A. To what extent did plans establish and execute their Community Reinvestment Plans, and how? **H5A.** Plans will adhere to transition requirements and execute Community Reinvestment plans.	» Proportion of plans meeting planned reinvestment targets (as defined in Community Reinvestment Plans)^^ » Qualitative data—plan and stakeholder perspectives	Plans in MCP Transition Counties	» Document review of Community Reinvestment Plans, MCP Annual Reports, financial information^^ » Interviews with health plan officials » Focus groups with DHCS Member Stakeholder Committee	Directed content analysis of secondary data, thematic analysis of interviews
EQ5B. To what extent did plans publish required performance and operations documentation as required? **H5B.** Plans will adhere to transition requirements and publish required performance and operations documentation.	» Proportion of plans developing and making publicly available programmatic and financial documentation (i.e., Community Reinvestment Plans, Population Needs Assessments, MCP Annual Reports, etc.) within required timeframes	MCP Transition Counties	» Websites for plans in MCP transition counties	Web scan with directed content analysis

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

Methodology

This evaluation will employ both quantitative and qualitative methods to assess overall impact of the MCP Transition on members, plans, and providers. The proposed approach reflects the aims that DHCS has identified as priorities for this evaluation, which in turn will guide the framing of hypotheses, data sources, measures, analytic approaches, and findings. The evaluation will use both primary and secondary data. Qualitative analysis will be used to describe the core components and status of transition activities in each county, as well as the experiences of directly affected parties (i.e., members, plan officials, and other interest holders) and their perceptions of the transition's impact on care continuity and access. Quantitative analysis will be used to better understand trends in selected process and outcome measures before and after the transition. Exhibit 21 provides a visual overview of the evaluation design.

Exhibit 21. Overall Approach to the Evaluation of the MCP Transition



Evaluation Period

The evaluation period will cover the implementation of the MCP Transition on January 1, 2024, through the end of the amendment approval on December 31st, 2026. Our quantitative impact analysis will use data from 2021-2023 as a baseline period and 2024-2026 as the implementation period. In the Interim Evaluation Report, our

quantitative analyses will include all outcome data available up to the time of analysis, and in the Summative Evaluation Report, we will be able to evaluate the entire post-implementation period.

Quantitative Evaluation

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

Target Population: Medi-Cal members in MCP Transition counties. The target population will be all Medi-Cal members enrolled for at least one year residing in the 15 MCP Transition counties (Alameda, Butte, Colusa, Contra Costa, Glenn, Imperial, Mariposa, Nevada, Placer, Plumas, San Benito, Sierra, Sutter, Tehama, and Yuba) over the course of 2021-2026, the baseline and implementation period.[79] 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.

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

[79] 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

objective of EB[80]. Additionally, unlike matching methods, EB uses all available comparison observations, which retains as much information as possible. The EB models will include member-level demographics and coverage characteristics, member-level clinical characteristics, and area-level community and healthcare delivery system characteristics, which will ensure that the treatment and comparison groups are similar on these key factors.

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

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

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

Quantitative Data Sources

We will use quantitative data sources to construct evaluation measures assessing access to and quality of care, continuity of care, and equity outcomes in each treatment and comparison county. We propose using member-level Medi-Cal enrollment data, member-level Medi-Cal Managed Care Accountability Set (MCAS) data and Medicaid and CHIP Core Sets of Health Care Quality measures data,[81] and publicly available community-level data to conduct our analyses. These data sources are summarized in Exhibit 22.

[80] 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.

[81] Based on the limitations associated with NORC reconstructing outcome measures using claims data and the desire to leverage existing metrics already being reported by the state, we will use the person-level pre-calculated values from the MCAS and Core Set data for outcome metrics.

Exhibit 22. Quantitative Data Sources for the MCP Transition Evaluation

Data Source	Proposed Use
Data Provided by DHCS	
Medi-Cal Enrollment Data	Medi-Cal enrollment data contain member-level demographic and coverage information. We will use the enrollment data to identify Medi-Cal members in treatment and comparison groups, and construct member-level covariates that reflect members' demographic and coverage characteristics.
Medi-Cal Managed Care Accountability Set (MCAS) and Medicaid and CHIP Core Sets of Health Care Quality	These files represent datasets of standardized health care quality measures that states must submit to CMS annually. Person-level MCAS and Core Set files in each year will be used to construct outcome measures on access to, quality, and continuity of care for each member.
MCP Grievances Data	Grievance data contains member level information on grievances from the MCP. Grievances are summarized with the grievance type (e.g., access to care, provider availability), grievance category, benefit type and resolution date and status. We will use the grievance data to assess access to care and continuity of care.
Community-Level Data	
American Community Survey (ACS)	The ACS is a national survey providing area-level data on topics such as demographics, education, employment, income, and housing. We will use ACS data to identify county-level sociodemographic characteristics of counties as a basis for selecting comparison counties, conducting entropy balancing, and adjusting regression models.

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

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

Quantitative Evaluation Measures

The quantitative evaluation measures that will be constructed from the person-level MCAS and Core Set files and provider 274 files are summarized in Exhibit 23. Measures cover the domains of access to care, behavioral, maternal, and preventive healthcare and are based on CMS Core Set and or NCQA/HEDIS technical specifications. Before inclusion in the IER and/or SER, NORC will work with DHCS to conduct a thorough feasibility assessment for each metric based on data quality, timeliness, and availability. In particular, NORC and DHCS will determine whether the MCAS or Core Set data are a more appropriate source for each metric.

Exhibit 23. Quantitative Measures for MCP Transition Evaluation

Measure Name	Description	Numerator	Denominator
Child and adolescent well-care visits	Percentage of children ages 3 to 21 who had at least one comprehensive well-care visit with a primary care practitioner (PCP) or an obstetrician/gynecologist (OB/GYN) during the measurement year	Number of members in the eligible population with one or more well-care visits during the measurement year	Number of members in the eligible population
Follow-up after ED visit for mental illness	Percentage of emergency department (ED) visits for members ages 18 and older with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness within 7/30 days.	Number of eligible follow-up visits within 7 or 30 days of the eligible ED visit including visits that occur on the date of the ED visit	Number of eligible ED visits with a principal diagnosis of mental illness or intentional self-harm
Plan all-cause readmissions	For members ages 18 to 64, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.	Number of observed 30-day readmissions	Number of index hospital stays in the eligible population

Measure Name	Description	Numerator	Denominator
Well-child visits in the first 30 months of life	Percentage of children who had the appropriate number of well-child visits with a primary care practitioner (PCP) during the last 15 months. Separate rates are reported for children who turned ages 15 and 30 months within the measurement year.	The number children in the eligible population with the appropriate number of well-child visits on different dates of service on or before the 15/30 month birthday.	Number of members in the eligible population
Immunizations for adolescents	Percentage of adolescents aged 13 who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates.	Number of patients in the eligible population that are vaccine compliant	Number of members in the eligible population
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	Prenatal care: A prenatal visit during the required time frame. Postpartum	Members within the eligible population with a live birth. Members can count multiple times if they have multiple births.

Measure Name	Description	Numerator	Denominator
	enrollment. • Postpartum Care: Percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery	care: A postpartum visit on or between 7 and 84 days after delivery.	
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
Non-Specialty outpatient mental health member-to-provider ratio	Number of members per outpatient mental health (non-psychiatry) provider (shown as # members to 1 provider)	Number of members enrolled in plan	Number of outpatient mental health (non-psychiatry) providers contracting with plan
Member-to-provider ratio	The ratio of members to providers.	Number of members enrolled in plan	Number of providers contracting with plan

EXHIBIT 23 NOTE: *Measures constructed from enrollment and claims/encounter data; all measures listed except the provider member ratio are endorsed by the National Committee for Quality Assurance (NCQA).*

Statistical Analyses

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

Descriptive Analyses. Descriptive statistics, including frequency distributions and rates over time, will be calculated to highlight trends over time in member-level characteristics and key outcomes. We will tabulate descriptive statistics in each year (time-series analyses) and pooled in baseline and treatment periods (pre-post analyses) to assess changes over time in the baseline years (January 2021 – December 2023) and years after the MCP Transition (January 2024 – December 2026). We will conduct descriptive analyses for both member-level characteristics, to show changes in member populations over time before and after the MCP transition, as well as for all outcome measures (Exhibit 23). We will present the descriptive analyses in tables and exhibits in the Interim Evaluation Report and Summative Evaluation Report.

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

Impact Analysis. If a suitable comparison group is available, we propose using difference-in-differences (DID) or comparative interrupted time series (CITS) analysis as our primary approach to estimate the impact on access, quality, and continuity of care under the MCP transition.[82] 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:

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

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

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.[83] 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).

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

Because beneficiary- and market-level characteristics are largely time-invariant, we propose that these covariates be measured at baseline. Because area-level COVID data

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

is not available after the end of the Public Health Emergency in May 2023, COVID-related covariates would also be measured at baseline and included as time-invariant. For all models, we will consider interactions and higher-order terms.

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

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

Qualitative Evaluation

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

Primary data collection and document review will focus primarily on the waiver implementation period. Interviews may include discussion of pre-implementation activities and differences in member experience of care before and after the transition, and document review will similarly consider descriptions of the plan and service

landscape before and after the transition occurred. These retrospective, largely open-ended data will enable us to understand waiver implementation and impacts, and can help understand the "pre" and "post" period but should not be considered a true "pre"/"post" assessment as we are not able to systematically gather qualitative data before the transition occurred.

Qualitative Data Sources and Data Collection

Document Review

To better understand the components, context and status of the transition in each participating county, we will review select transition-related documentation generated by MCPs, the State, and other relevant groups including but not limited to Demonstration quarterly reports, and documents that must be developed and made public by each transitioning plan (i.e., Community Investment Plans and related annual reports, Population Needs Assessments, CAHPS survey results, financial information, such as profits and reserves, and third party Memoranda of Understanding (MOUs)[84]). 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.

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.

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[84] 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.

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

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

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

DHCS Stakeholder Advisory Committee Members: NORC will conduct a 90-minute virtual focus group with DHCS Stakeholder Advisory Committee members at two time

points (two sessions, up to eight individuals at each session for a total of 16 participants). Participants will be compensated with a gift card incentive (for non-resalable goods or services) in recognition of their time.

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

Qualitative Analyses

Directed Content Analysis of Secondary Data

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

Thematic Analysis of Interviews and Focus Groups

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

Methodological Limitations

Evaluations of 1115 demonstrations necessitate a flexible and adaptive approach, and we anticipate that methodological challenges will arise during the evaluation process. Exhibit 24 outlines the anticipated challenges along with proposed mitigation strategies.

Exhibit 24. Anticipated Methodological Challenges and Proposed Mitigation Approaches

Challenge	Mitigation Approach
Timeliness and quality of MCAS and Core Set data	» Work closely with DHCS data stewards to receive the most recent data, identify appropriate timeframes for run out, and quickly address any data quality issues. » Create automated reports that identify potential quality issues (e.g., missingness, disallowed values) in data elements

Challenge	Mitigation Approach
	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. » Conduct primary data collection over videoconferencing rather than in person to be more flexible with respondents' time.

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

Independent Evaluator

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

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

Conflict of Interest Compliance Process

Overview

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

Introduction

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

NORC Compliance Officer

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

Independent and Impartial

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

Conflicts Policies and Procedures

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

1. Organizational Conflicts

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

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

2. Personal Financial Conflicts

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

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

Authority, Audits and Remediation

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

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

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

11/4/2024

Adil Moiduddin, Senior Vice President, Health Care Evaluation Research

Appendix A: UCLA-RAND Projected Budget for PATH, GPP, Duals and Reentry Evaluation Components

COSTS	Year 1: 12/1/23-6/30/24	Year 2: 7/1/24 – 6/30/25	Year 3: 7/1/25-6/30/26	Year 4: 7/1/26-6/30/27	Year 5: 7/1/27-6/30/28	Year 6: 7/1/28-5/31/29	Total
Personnel (including fringe benefits)	1,321,479	2,653,368	2,793,107	2,596,758	2,618,758	1,091,227	13,074,697
Other Direct Costs (Rent, TIF, etc.)	58,031	103,768	108,370	112,586	113,012	67,686	563,453
UCLA Department of Medicine Statistics Core (DOMSTAT) - data cleaning, analysis, programming, etc.	79,688	121,570	124,467	127,491	130,525	108,027	691,768
Survey non-personnel costs (e.g. translation, printing, mailing, incentives)	0	200,000	0	75,000	75,000	0	350,000
Interview or focus group costs (e.g. interpretation, incentives)	7,500	37,500	7,500	17,500	0	0	70,000
Indirect Costs (F&A)	230,992	385,785	410,835	412,873	406,197	254,400	2,101,082
Other (e.g. materials, supplies, software)*	9,000	8,000	8,000	8,000	8,000	8,000	49,000
TOTAL							**16,900,000**

More information about these costs is as follows:

Personnel. This includes all staff time to complete the evaluation plan and deliverables. Staff roles include research scientists, project managers, research analysts, research associates, and statisticians, and data programmers. Their work

covers all oversight and planning, design, data collection, analysis, reporting, coordination, and all other tasks related to the successful completion of the evaluation plan and deliverables. The personnel budget line includes fringe benefits.

Other direct costs. This includes office rent, Technology Infrastructure Fees (TIF), and General and Employment Liabilities (GAEL).

Department of Medicine Statistics Core (DOMSTAT). DOMSTAT consists of a team of experienced faculty and staff biostatisticians, data managers, and research assistants. They provide investigators at UCLA with state-of-the-art statistical support and advise on study design, data management and statistical analyses.

Survey non-personnel costs. This includes all survey costs including subcontractor costs, translation, printing, and mailing. Compensation for survey respondents is also included in this budget line.

Interview or focus groups. Cost associated with interviews and/or focus groups include subcontractor costs, incentives, translation of materials, verbal translation services, and transcription fees.

Indirect costs. This includes Facilities and Administrative rate (F&A). The University of California F&A rate (base: modified total direct costs) pertains to this California State-Funded off-campus project.

Other. Other costs include software, materials, supplies, etc.

Appendix B: NORC Projected Evaluation Budget for the MCP Transition

Activity	Y1	Y2	Y3	Y4	Y5	Total
Quantitative Data Collection & Analysis	$42,069	$293,991	$185,938	$263,490	$46,573	$832,060
Qualitative Data Collection & Analysis	$21,034	$251,992	$123,959	$105,396	$46,573	$548,954
Evaluation Design	$189,310					$189,310
Interim Evaluation Report Draft	$105,172	$251,992				$357,164
Quarterly Evaluation Reports	$63,103	$41,999	$41,320	$52,698	$23,286	$222,406
Summative Evaluation Report Draft			$61,979	$105,396	$116,432	$283,807
Total	**$420,689**	**$839,974**	**$413,195**	**$526,980**	**$232,863**	**$2,433,701**

UCLA

California Department of Health Care Services (DHCS)

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

Evaluation Design for Community Supports authorized through the CalAIM Section 1115 and 1915(b) Waivers

Submitted by the UCLA-RAND Community Supports Evaluation Design Leadership Team:

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August 4, 2025

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General Background Information

On December 29, 2021, CMS approved the California Advancing & Innovating Medi-Cal (CalAIM) 1115 demonstration and 1915(b) waiver. Community Supports, launched in 2022, are foundational components of CalAIM's transformational focus on breaking down the traditional walls of health care by more holistically addressing member needs and introducing better strategies for care coordination and person-centered care. Community Supports focus on addressing health-related social needs (HRSNs), e.g., for food or housing, of Medi-Cal members. Addressing members' HRSNs is expected to help improve member function, health, and access to care, and reduce avoidable utilization of higher, costlier levels of care. Community Supports supplement a suite of other broad-based delivery system, program, and payment reforms across CalAIM to make Medi-Cal more coordinated and person-centered to help people maximize their health and life trajectory.[1]

A key goal of Community Supports is to allow members to obtain services in the least restrictive setting possible and to keep them in the community as medically appropriate. Building on California's prior experience with Home and Community-Based Services (HCBS) Waivers, the Whole Person Care (WPC) Pilots, Medi-Cal Health Homes Program (HHP), stakeholder input, and experiences elsewhere in the nation, the Department of Health Care Services (DHCS) has approved a list of 14 Community Supports that managed care plans (MCPs) are strongly encouraged to offer, such as, housing transition navigation services, medically tailored meals or medically supportive food and nutrition, asthma remediation, recuperative care, and short-term post-hospitalization housing. A 15th Community Support, transitional rent, was approved in 2025. Community Supports are designed to substitute for covered Medi-Cal services or settings as cost-effective alternatives, decreasing the need for avoidable hospital care, nursing facility care, and emergency department (ED) use. In California, over 90 percent of Medi-Cal members are enrolled in Medicaid managed care. Medicaid managed care plans can choose to offer any or all of the approved Community Supports to members that meet DHCS eligibility criteria for receipt of these services.

Exhibit 1 provides a brief overview of the Community Supports, their eligibility criteria / target population(s), and allowable service durations, while Exhibit 2 shows additional policy guidance related to the Community Supports initiative. Additional information about Community Supports is available in the CalAIM Community Supports Policy

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

Guide.[2],[3] These Community Supports are intended to be integrated with enhanced care management for eligible members and are intended to serve as cost-effective and medically appropriate substitutes for State Plan services or settings.

The evaluation of Community Supports will cover the five-year approval of the demonstration, from December 29, 2021 to December 31, 2026. This evaluation design starts with the presentation of three Exhibits that orient the reader to the key foundations of the evaluation of Community Supports. Exhibit 1 on the next page summarizes data for member eligibility for use of any of the 14 Community Supports described above as documented in the DHCS Community Supports Policy Guide (July 2023).

[2] CalAIM Community Supports Policy Guide, Vol. 1; https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide.pdf

[3] CalAIM Community Supports Policy Guide, Vol. 2; https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide-Volume-2.pdf

Exhibit 1: Community Services Eligibility Criteria

	Housing transition navigation	Housing deposits	Housing tenancy and sustaining	Recuperative care	Short-term post-hospitalization housing	Caregiver respite	Day habilitation	Assisted Living facility transitions	Community or home transition services	Personal care and homemaker services	Environmental accessibility adaptations	MTM/MSF&N	Sobering centers	Asthma remediation	Transitional rent
Eligibility criteria															
1. Homeless*	•	•	•	•	•		•								•
2. At-risk of homelessness**	•	•	•	•	•		•								•
3. Eligible for transitional rent	•	•	•												
4. At-risk of hospitalization or post-hospitalization				•											
5. Living alone with no formal supports				•											
6. Housing insecurity ***				•											
7. Exiting recuperative care					•										
8. Discharged inpatient hospital or nursing facility				•	•							•			•
9. Discharged from residential or correctional facility				•	•										•
10. Chronic conditions	•											•			
11. Qualifying clinical risk factor	•	•	•												•
12. Living in community, compromised in ADLs, and require relief to avoid institutional placement						•									
13. Resided 60+ days in nursing facility and willing and able to live in assisted living								•							
14. Living in community, willing and able to live in assisted living, and meet medically necessary nursing LOC								•							
15. Resided 60+ days in nursing facility or medical respite, willing and able to reside safely in community, and meet medically necessary nursing LOC									•						
16. Interested in moving back to the community and can reside safely in the community with appropriate and cost-effective supports and services.									•						
17. At-risk for hospitalization										•					
18. At-risk for institutionalization in a nursing facility										•	•				
19. Approved for IHSS										•					
20. Functional deficits and no other adequate support										•					
21. Adults who are intoxicated and would otherwise be transported to ED or jail****													•		
22. Individuals with poorly controlled asthma and provider documentation														•	
23. Complete in-home environmental trigger assessment within last 12 months														•	

24. Transitioning***** or eligible for FSP															•
Individuals with extensive care coordination needs												•			
Service duration******															
Once per demonstration period		•													
Maximum duration allowed	N/A	N/A	N/A	6mo per rolling 12mo period	6mo per rolling 12mo period	336 hr/yr			$7.5k max		$7.5k max	12 wks	24hr/stay	$7.5k max	6mo per rolling 12mo period

Exhibit 1 Table Notes:

Community Supports are only available to Medi-Cal members enrolled in Medicaid managed care whose plan chose to offer the Community Support, and who meet DHCS eligibility criteria for receipt of the service. Specific target population(s) for each Community Support are reflected in the DHCS-specified eligibility criteria above.

+Within each column of Exhibit 1, individual Community Supports are shown as column headings. Rows display potential DHCS eligibility criteria for the specific Community Service displayed as column headings. For each row, a bullet within a column indicates that the row-specific eligibility criteria are pertinent to the Community Service that heads the column. Members may need to meet more than one of these criteria in order to be eligible for a given Community Supports (e.g., clinical risk factor requirement and a social risk factor requirement).

Note: Transitional rent is not included in this table because even though it is a Community Support, it is being implemented under the BH-CONNECT 1115 waiver.

MTM/MSF&N = Medically tailored meals / medically supportive food & nutrition; ADL = Activities of Daily Living; HUD = Housing and Urban Development; LOC = level of care; FSP = Full-Service Partnership

* HUD definition of homeless

** HUD definition of at-risk of homelessness with qualifying health or behavioral health conditions OR children or youth that qualify as homeless under other provisions

***Housing insecurity or housing that could jeopardize member health and safety without modification

**** Must also be conscious, cooperative, able to walk, nonviolent, and free from medical distress

***** Transitioning out of institutional, congregate residential, or carceral setting; interim housing; recuperative or short-term post-hospitalization housing; or foster care,

***** This table does not include allowable exceptions, e.g., circumstances under which the Community Support can be provided more than once in a lifetime or for longer than the maximum duration

Data Source: Medi-Cal Community Supports Policy Guide, Volumes 1 and 2 April 2025; requirements subject to change as the Community Supports policy guide is updated and will be revised accordingly.

Exhibit 2 summarizes key principles from CMS and DHCS related to the goals and implementation of the Community Supports initiative.

Exhibit 2: Key principles from CMS and DHCS related to the Community Supports Initiative

1. A key goal of Community Supports is to allow members to obtain care in the least restrictive setting possible and to keep them in the community as medically appropriate.
2. Community Supports are designed to substitute for, and decrease avoidable utilization of, a range of covered Medi-Cal benefits, such as hospital care, nursing

facility care, and emergency department (ED) use.[4] Federal regulation allows states to offer ILOS as an option to MCPs and members.

3. DHCS has determined the 12 approved Community Supports covered under the CalAIM 1915(b) waiver to be cost-effective and medically appropriate substitutes for covered Medi-Cal services or settings. The remaining three Community Supports (recuperative care, short-term post-hospitalization housing, and transitional rent) are considered room and board services, are subject to a global cap, and must meet requirements in 1115 waiver STCs. DHCS selected these 15 services based on prior experience with the Medi-Cal Whole Person Care and Health Home Pilots and evidence that these services can be medically appropriate substitutes for Medi-Cal covered services that are more costly.

   Starting on January 1, 2022, MCPs in all counties have been strongly encouraged to offer one or more of 14 approved Community Supports covered under the CalAIM 1115 and 1915(b) waivers. Effective January 1, 2026 MCPs in all counties will be required to offer transitional rent, which is covered under the BH-CONNECT 1115 waiver. as a contractually covered service.
4. MCPs must report to DHCS which Community Supports are offered in which county.
5. MCPs must also report on data regarding the utilization and cost of Community Supports for the purposes of rate setting but do not need to actively reassess cost-effectiveness for Community Supports at the MCP or individual level for the purposes of compliance with federal requirements. MCPs may apply utilization management techniques as applicable and as permitted by federal managed care regulations and as required to ensure appropriate monitoring and oversight of Community Supports services from a program integrity perspective and to adhere to service definitions and eligibility criteria.
6. DHCS is conducting further statewide aggregate analyses of the cost-effectiveness of each of the approved Community Supports services in the 1915(b) waiver. The evaluation team will also conduct cost or cost-effectiveness analyses as required in the 1115 and 1915(b) waiver STCs.

[4] DHCS CalAIM Enhanced Care Management (ECM) and Community Supports (ILOS), Contract Template Provisions. https://www.dhcs.ca.gov/Documents/MCQMD/MCP-ECM-and-ILOS-Contract-Template-Provisions.pdf

Community Supports Evaluation Requirements

Exhibit 3 highlights common and unique themes in the Special Terms and Conditions (STCs) for evaluation of the CalAIM 1115 and the 1915(b) waivers that authorize delivery of Community Supports under Medi-Cal. Two Community Supports are authorized under the CalAIM 1115 waiver (short-term post-hospitalization services and recuperative care; hereafter referred to as 1115 waiver Community Supports). An additional Community Support, transitional rent, is authorized under the BH-CONNECT 1115 waiver and will also be considered an 1115 waiver Community Support. The remaining 12 Community Supports are authorized under the 1915(b) Managed Care waiver (hereafter referred to as 1915(b) waiver Community Supports). This Evaluation Design has been developed to cover the evaluation requirements of both waivers.

While the specific language used to describe the 1115 and 1915(b) waivers varies by waiver type as shown in the respective columns of Exhibit 3, the respective STCs address similar issues or themes. For example, both 1115 and 1915(b) waivers include STCs that focus on the impact of receiving Community Supports on health care utilization, associated costs, and member health outcomes.

Both waivers also include STCs that focus on whether Community Supports were effective at addressing member needs, with the 1915(b) STCs also requiring measurement of cost-effectiveness.[5] Both waivers also include STCs focused on assessing member experiences, with the

[5] It is important to distinguish between the traditional definition of cost-effectiveness and the way that this is stated in the STCs. Per CMS, cost-effectiveness analysis is a way to examine both the costs and health outcomes of one or more interventions. It compares an intervention to another intervention (or the status quo) by estimating how much it costs to gain a unit of a health.
Cite: https://www.cdc.gov/policy/polaris/economics/cost-effectiveness/index.html#:~:text=Cost%2Deffectiveness%20analysis%20is%20a,gained%20or%20a%20death%20prevented.

To be eligible for inclusion in the 1115 and 1915(b) Waivers, prior research has already established medical appropriateness and cost-effectiveness of the 14 Community Supports. Thus, per STC 8.6 in the 1115 Waiver, cost-effectiveness in the context of the UCLA-RAND evaluation is focused on ensuring that aggregate costs of providing Community Supports do not exceed aggregate costs of providing other services, particularly the institutional care and other services that the Community Supports are expected to substitute for.

Exhibit 3: Special Terms and Conditions for the Evaluation of Community Supports Authorized in the CalAIM 1115 Waiver and in the 1915(b) Waiver		
Common evaluation themes across 1115 and 1915(b) STCs	**STC 17 for 1115 Waiver Community Supports (2)**	**STC 21 for 1915(b) Waiver Community Supports (12)**
Impact of Community Supports on utilization of health care, associated costs, and health outcomes	Focus on assessing how the initiatives affect utilization of preventive and routine care, utilization of and costs associated with potentially avoidable, high acuity health care, and member physical and behavioral health outcomes.	Impact each Community Support had on utilization of state plan-covered services or settings, including the associated cost savings, trends in MCPs and enrollee use of each Community Supports, and impact of each Community Supports on quality of care.
Effectiveness of Community Supports for addressing member needs	Focus on the effectiveness of Community Supports services in mitigating identified needs of members.	Evaluation of whether encounter data supports the state's determination that each Community Supports is a medically appropriate and cost-effective substitute for identified covered services and settings under the state plan.
Member experiences	If the data system is unable to capture necessary data for a quantitative evaluation, then must conduct a qualitative assessment leveraging suitable primary data collections efforts (e.g., member surveys).	Appeals, grievances, and state fair hearings data, reported separately and for each Community Support, including volume, reason, resolution status, and trends.
Health equity	Focus on understanding the impact of Community Supports initiatives on advancing health quality, including	Impact each Community Support had on health equity initiatives and efforts

Exhibit 3: Special Terms and Conditions for the Evaluation of Community Supports Authorized in the CalAIM 1115 Waiver and in the 1915(b) Waiver		
Common evaluation themes across 1115 and 1915(b) STCs	**STC 17 for 1115 Waiver Community Supports (2)**	**STC 21 for 1915(b) Waiver Community Supports (12)**
	through the reduction of health disparities.	undertaken by the state to mitigate health disparities.
Measuring contextual changes in HRSN	Examine whether and how state and local investments in housing and any other type of allowable HRSN change over time in concert with new Medicaid funding toward those services.	
Measuring costs of providing Community Supports	Include, in alignment with the evaluation required in the state's 1915(b)(1)/(4) Waiver for California Advancing and Innovating Medi-Cal (CalAIM) special terms and conditions for other similar services, a cost analysis to support developing comprehensive and accurate cost estimates of covering such services.	Evaluate whether the 1915(b) Community Supports are medically appropriate and cost-effective substitutes for the services and settings covered under the state plan.
Assessment of downstream impacts of Community Support	Include a robust assessment of potential improvements in the efficiency, quality, and effectiveness of downstream services that can be provided under the state plan authority, and associated cost implications related to the provision of upstream Community Supports services.	

1115 Waiver noting direct collection of data from members if required, and the 1915(b) Waiver examining existing appeals and grievances. Finally, both waivers focus on health equity, with the 1115 Waiver assessing whether Community Supports improve health equity for members, and the 1915(b) Waiver focused on assessing the impact of Community Supports on broader, statewide health equity initiatives and efforts.

The 1115 Waiver further focuses on examining trends in state and local investments in Community Supports observed over time; a cost analysis to support developing comprehensive and accurate cost estimates associated with covering Community Support services, and an analysis of potential impacts on quality, health outcomes, and delivery and cost offsets associated with Medi-Cal covered services.

Evaluation Questions and Hypotheses

Community Supports evaluation requirements and research questions are informed by the CalAIM demonstration Special Terms and Conditions (STCs) goals and requirements, including STCs 8.1-8.15, 15.4-15.5, 16.5, 17.6, 17.10, 18.8-18.9, and Attachment U. The questions are further informed by the Donabedian model described in the overall CalAIM evaluation design, conceptual framework for how addressing health-related social needs may affect health outcomes in Figure 1, and the Community Supports evaluation-specific driver diagram shown in Figure 2.

Figure 1. Logic model for how addressing members' health-related social needs can impact health outcomes

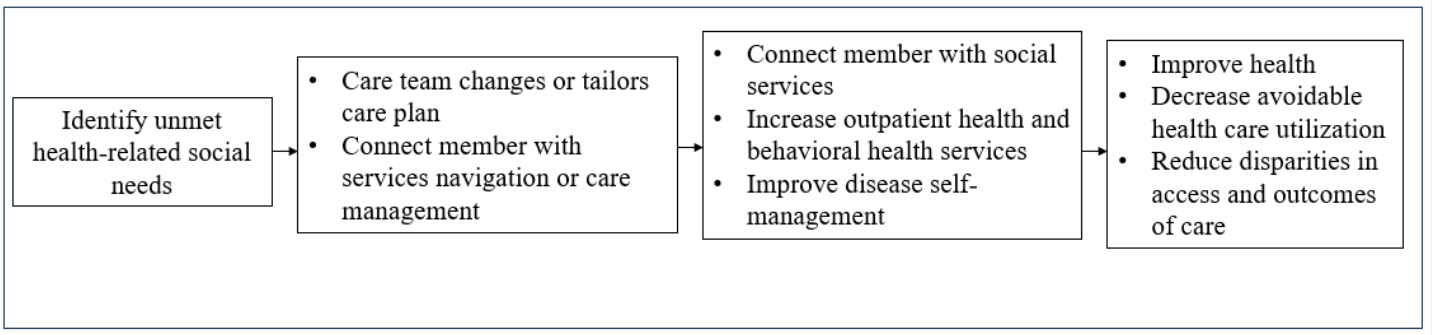
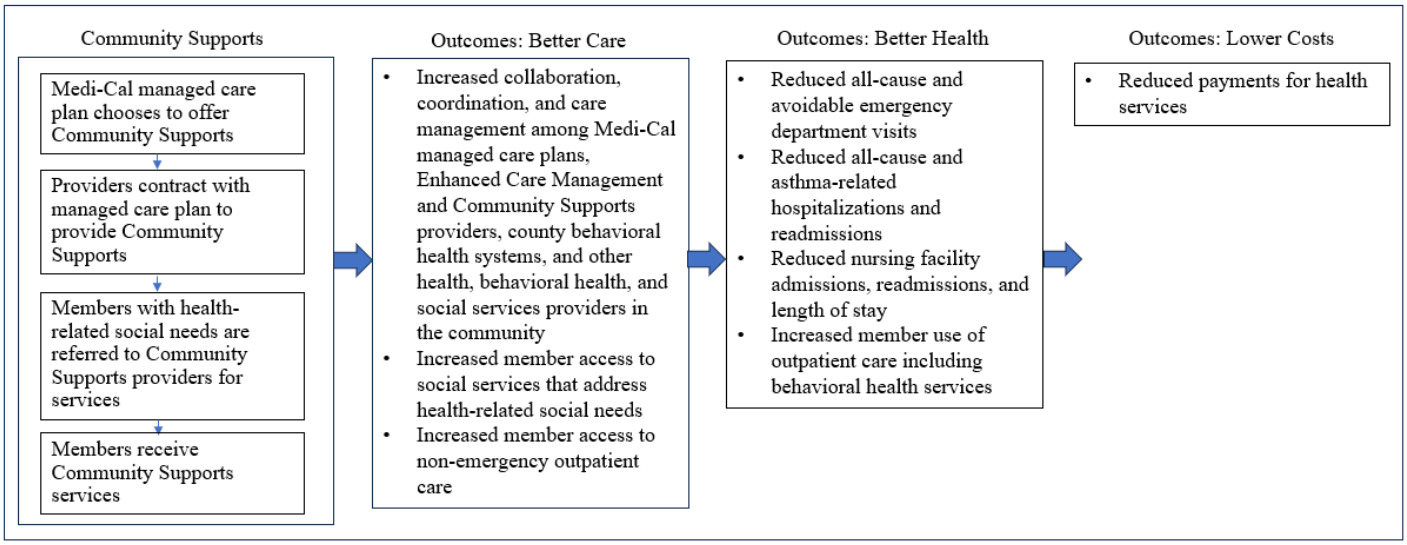


Figure 2. Driver diagram for Community Supports evaluation



A list of specific first order and additional program goals is shown below. First order program goals refer to service goals that must be met before additional goals can be achieved.

First Order Goals

1. Increase offering of Community Supports by MCPs
2. Increase contracts between providers and MCPs for Community Supports services.
3. Increase utilization of Community Supports by eligible members

Additional Goals

4. Examine whether and how public investments in housing and other HRSN services change over time in concert with new Medicaid funding
5. Increase members' access to outpatient care including behavioral health services and reduce acute care utilization and long-term care admissions and stays
6. Improve quality and outcomes of care for eligible members
7. Reduce disparities in service utilization, quality, and outcomes of care for eligible members
8. Ensure Community Supports are cost-effective alternatives to State Plan services and settings.

To evaluate the Community Supports program goals, UCLA-RAND developed related evaluation questions and measures to determine whether the goals were achieved as anticipated. Program goals and related evaluation questions and measures are described in Exhibit 4 on the following pages.

Exhibit 4. Community Supports program goals and related evaluation questions, hypotheses, and measures

Evaluation Questions (EQ) & Hypotheses (H)	Measures
Goal 1: Increase offering of Community Supports by MCPs	
EQ 1: Did the number of MCPs offering Community Supports increase over time? H1: The number of Community Supports offered by MCPs will increase over time.	• Number of MCPs offering each Community Support • Proportion of counties in which each Community Support is offered • Proportion of MCPs in each county offering each Community Support • MCPs' self-reported reasons for offering or not offering Community Supports
Goal 2: Increase contracts between providers and MCPs for Community Supports services	
EQ2: Did the number and diversity of providers contracted to provide Community Supports increase over time? H2: The number and diversity of providers contracted to provide Community Supports will increase over time	• Number of providers contracted to provide each Community Supports • Number of providers providing multiple Community Supports • Ownership and types of providers contracted to provide each Community Supports
EQ3: What factors influence provider participation in Community Supports? H3: Provider capacity and infrastructure and local service availability and need will influence provider participation in Community Supports.	• Providers' self-reported reasons for contracting or not contracting with MCPs to provide Community Supports • MCPs and providers' perceptions of whether the number of eligible and contracted providers are sufficient to meet service need
Goal 3: Increase utilization of Community Supports by eligible members	

Exhibit 4. Community Supports program goals and related evaluation questions, hypotheses, and measures

Evaluation Questions (EQ) & Hypotheses (H)	Measures
EQ4: Did the number of members receiving Community Supports increase over time? H4: The number of members receiving Community Supports will increase over time H4b: Members with housing-related needs will receive more than one Community Supports to address these needs	• Proportion of eligible members that are authorized for and subsequently utilize Community Supports • Number and types of Community Supports used • Frequency[6] and duration of Community Supports use • Number and proportion of eligible Medi-Cal members that used each Community Supports • Demographic and health characteristics of Community Supports users, compared to the population of non-users eligible for these services • Proportion of members with housing needs that receive more than one Community Support simultaneously • Most frequently co-occurring Community Supports • Demographic and health characteristics of members receiving more than one Community Support, relative to members only receiving one Community Support • MCPs and providers' perceptions of factors affecting member utilization of Community Supports

[6] Frequency will only be assessed for Community Supports that can be offered more than once in a lifetime.

Exhibit 4. Community Supports program goals and related evaluation questions, hypotheses, and measures

Evaluation Questions (EQ) & Hypotheses (H)	Measures
EQ5: What strategies are being used to identify and refer eligible members to Community Supports? H5: Members will primarily be connected to Community Supports via community-based provider referrals	• MCPs and providers' self-reported processes for identifying members eligible for Community Supports and connecting them to services • Member self-reports of mechanisms for learning about how their Community Supports needs can be recognized and addressed: family, community orgs, PCP, specialty care • Member self-report of who, how, and when MCP or provider offered information about options for managing their need and/or how Community Supports might address their need • Member self-reports of number, types, and timing of exposure to and use of different types of Community Supports
Goal 4: Examine whether and how public investments in housing and other HRSN services change over time in concert with new Medicaid funding for those services	
EQ6: How is new Medicaid funding for Community Supports impacting existing systems of care? H6: Medicaid funding for Community Supports will be perceived as complementing state and local investments in housing and other HRSN services.	• Number of people experiencing homelessness in California, 2015-2024 • U.S. Department of Housing and Urban Development (HUD) funding to Continuums of Care (CoCs) in California, 2015-2024 • CoC Homeless Assistance Programs Housing Inventory, California, 2015-2024

Exhibit 4. Community Supports program goals and related evaluation questions, hypotheses, and measures

Evaluation Questions (EQ) & Hypotheses (H)	Measures
	• Low-Income Housing Tax Credit (LIHTC) housing units, California, 2015-2024 • MCPs and providers' perceptions of how new Medicaid funding for Community Supports has impacted existing systems of care, including non-Medicaid funding for similar supports or services • MCP and provider descriptions of how they are using new Medicaid funding in concert with state and local investments in housing or other social services to address member needs.
Goal 5: Increase members' access to outpatient care including behavioral health services and reduce acute care utilization and long-term care admission and stays	
EQ7a: Will Community Supports affect access to outpatient care? H7a: Members receiving Community Supports will use more outpatient services than members who do not	• Primary care visits • Specialty care visits • Mental health services • Substance use disorder services • Member self-report of downstream impacts of receiving Community Supports (e.g., on finances and access to needed health care)
EQ7b: Will Community Supports reduce avoidable acute care utilization or long-term care stays? H7b: Members receiving Community Supports will experience greater reductions in avoidable acute care	• Emergency department visits (total; needed, preventable, primary care treatable, non-emergent; mental health-related, alcohol-related or substance use related) • Hospitalizations (total; from ED; potentially avoidable)

Exhibit 4. Community Supports program goals and related evaluation questions, hypotheses, and measures

Evaluation Questions (EQ) & Hypotheses (H)	Measures
utilization and long-term care stays than members who do not	• Long-term care stays • Housing stability (as feasible)
Goal 6: Improve quality of care and outcomes of care	
EQ8: Are members satisfied with Community Supports referral processes and services? H8a: Members who receive Community Supports will be satisfied with services H8b: Member dissatisfaction with services, as indicated by appeals and grievances for each Community Supports relative to total service use, will decrease over time.	• Volume of appeals and grievances for each Community Supports • Reasons and resolution status for appeals and grievances. • Members' self-reported knowledge and satisfaction with anticipated and actual Community Supports received • Providers' self-reported perception of Community Supports' effectiveness at addressing members' identified HRSN • MCPs' self-reported perception of Community Supports' effectiveness at addressing members' identified HRSN
EQ9: Following receipt of housing-related Community Services, are members being transitioned to other appropriate supports, when needed? H9: The proportion of members transitioned to appropriate HRSN supports will increase over time	• Proportion of members receiving recuperative care that transition to short-term post-hospitalization housing • Proportion of members receiving recuperative care or short-term post-hospitalization housing that receive housing transition navigation supports • Proportion of members receiving housing navigation, housing deposits, recuperative care, or short-term post-hospitalization housing that subsequently receive other public housing assistance

Exhibit 4. Community Supports program goals and related evaluation questions, hypotheses, and measures

Evaluation Questions (EQ) & Hypotheses (H)	Measures
EQ10: Will Community Services improve quality and outcomes of health care? H10a: Community Supports will improve member receipt of appropriate care H10b: Community Supports will reduce member receipt of avoidable care H10c: Community Supports will promote maintenance of member function H10d: Community Supports will reduce cause-specific complications	• Initiation and engagement of alcohol and other drug dependence treatment • Follow-up after ED visit for alcohol and other drug abuse or dependence • Health Equity and Quality Measure set (HEQMS) and Healthcare Effectiveness Data and Information Set (HEDIS) measures not already in the HEQMS data set, e.g., A1C control for patients with diabetes and blood pressure control for those with a history of high blood pressure or high risk of coronary artery disease. • Receipt of medications / adherence to recommended medications (based on medication fill rates for chronic conditions) • Overall summary quality metric(s) based upon the full set of measured quality metrics • Maintenance of function • Mortality • Cause-specific complications • Provider and member self-report of appropriate care processes (as needed and feasible)
Goal 7: Reduce disparities in service utilization, quality of care, and outcomes of care	

Exhibit 4. Community Supports program goals and related evaluation questions, hypotheses, and measures

Evaluation Questions (EQ) & Hypotheses (H)	Measures
EQ11: Are there disparities in Community Supports utilization based on member demographic characteristics or health conditions or community characteristics? H11: Community Supports utilization will be higher in urban communities, communities with street medicine programs, and among members with English as preferred language	• Number and type of Community Supports used, stratified by member housing status, demographic and health characteristics, and geographic indicators • Proportion of eligible members that used Community Supports, stratified by member housing status, demographic and health characteristics, and geographic indicators
EQ12: Will Community Supports impact disparities in downstream physical or behavioral health service utilization, quality of care, and outcomes of care? H12a: Community Supports will reduce age, sex, racial/ethnic, linguistic, and functional (disability) disparities in downstream physical or behavioral health service utilization, quality of care, and outcomes of care H12b: Community Supports will reduce disparities in physical or behavioral health service utilization and outcomes of care for individuals experiencing homelessness	• Select measures from Goals 5-6, stratified by member demographic and health characteristics and geographic indicators • MCPs and providers' self-reported participation in health equity initiatives or other efforts to reduce health disparities • Member self-report of discrimination or disparities
Goal 8: Ensure Community Supports are cost-effective alternatives to State Plan services or settings	

Exhibit 4. Community Supports program goals and related evaluation questions, hypotheses, and measures

Evaluation Questions (EQ) & Hypotheses (H)	Measures
EQ13: Will Community Supports impact cost of care? H13: Community Supports are cost-effective alternatives to State Plan services and settings.	• Estimated change in Medi-Cal payments for services such as ED visits, hospitalizations, and long-term care stays for members utilizing Community Supports

Methodology

Data Sources

UCLA-RAND will use multiple data sources for the Community Supports evaluation. To improve cost-efficiencies and consistency across the CalAIM evaluation as well as enhance the evaluation's understanding of potential differential Community Supports' impact on subpopulations of Medi-Cal members, UCLA-RAND will use relevant data already obtained for the PATH, GPP, Duals, and Reentry evaluations when possible. UCLA-RAND has already submitted a consolidated data request for the four initial components of the CalAIM Evaluation to facilitate efficiencies in data accession. The Community Supports' evaluation will also request new administrative data sources from DHCS as needed to address Community Supports' evaluation questions. The UCLA-RAND Evaluation will further obtain available external secondary data on community-based providers and their characteristics, as well as on geographic indicators such as urbanicity, social vulnerability, and health inequity. When appropriate, UCLA-RAND will also draw on data previously collected by UCLA-RAND as part of prior 1115 Waivers or other evaluations (e.g., for GPP, WPC, or HHP). Exhibit 5 lists the data sources that UCLA-RAND plans to use as part of the evaluation, along with the baseline period, follow-up period and/or collection date(s) for each data sources. Periods/dates may change based on data availability and level of effort for data collection as noted below.

Exhibit 5. List of Data Sources for Community Supports Evaluation with Baseline Period, Follow-Up Period, or Collection Date(s)[7]

Data Source	Baseline Period	Follow-Up Period or Collection Date(s)
Primary Data		
Managed Care Plan Semi-Structured Interviews and Surveys	Prior to Community Support implementation – select measures	Q2/Q3 2024 and Q2/Q3 2026 (two collection dates)
Community Support Provider Semi-Structured Interviews and Surveys	Prior to Community Support implementation – select measures	Q4 2024-Q3 2025 and Q2/Q3 2026 (two collection dates)
Member Survey	n/a	2026 (one collection date)
DHCS Administrative Data		

[7] Prospective data collection (member surveys, focus groups, interviews, and chart abstraction) are only for the two 1115 Waiver CS services.

Quarterly Implementation and Monitoring Reports	n/a	January 1, 2022 – December 31, 2026
Medi-Cal Eligibility and Claims Data	January 1, 2020 – December 31, 2021	January 1, 2022 – December 31, 2026
Data on Appeals, Grievances, and State Fair Hearings for Community Supports	n/a	January 1-2022-December 31, 2026
Other documents (e.g., Community Supports Policy Guides, MCP-Submitted Model of Care Templates, Reports on HRSN Capacity Building and Infrastructure Efforts)	n/a	January 1, 2022 – December 31, 2026 or As Available/Collected
Other Member-Level Data		
California Interagency Council on Homelessness (CalICH)'s Homeless Data Integration System (HDIS)	January 1, 2020 – December 31, 2021	January 1, 2022 – December 31, 2026
California Department of Health Care Access and Information (HCAI) Hospital Discharge and Emergency Department Visit Data	January 1, 2020 – December 31, 2021	January 1, 2022 – December 31, 2026
In Home Support Services (IHSS) Annual Functional Evaluation	January 1, 2020 – December 31, 2021	January 1, 2022 – December 31, 2026
State Death Statistical Master File	January 1, 2020 – December 31, 2021	January 1, 2022 – December 31, 2026
State Cancer Registry	January 1, 2020 – December 31, 2021	January 1, 2022 – December 31, 2026
State Vaccine Registry	January 1, 2020 – December 31, 2021	January 1, 2022 – December 31, 2026
MCAS measures	January 1, 2020 – December 31, 2021	January 1, 2022 – December 31, 2026
Medicaid Core Set Measures	January 1, 2020 – December 31, 2021	January 1, 2022 – December 31, 2026
Minimum Data Set (MDS) of Long-Term Care Assessments	January 1, 2020 – December 31, 2021	January 1, 2022 – December 31, 2026
Outcome and Assessment Information Set (OASIS) Home Care Assessments	January 1, 2020 – December 31, 2021	January 1, 2022 – December 31, 2026

Hospital Chart Abstraction Period during which Members were hospitalized	n/a	Select individuals hospitalized between July 2025 through December 2026
Secondary Data		
National Institute for Medical Respite Care Directory	January 1, 2020 – December 31, 2021	January 1, 2022 – December 31, 2026
Continuum of Care Providers	January 1, 2020 – December 31, 2021	January 1, 2022 – December 31, 2026
Uniform Data System	January 1, 2020 – December 31, 2021	January 1, 2022 – December 31, 2026
Lists of PATH CITED and TAM recipients	n/a	January 1, 2022 – December 31, 2026
Enrollment and utilization data on WPC and HHP users	January 2017 to December 2021	
Publicly Available Geographic Data (e.g., Health Places Index)	January 1, 2020 – December 31, 2021	January 1, 2022 – December 31, 2026

Notes: The CalAIM waiver was authorized for the time period January 1, 2022 – December 31, 2026. Baseline period refers to the time frame prior to CalAIM implementation that will be used to help evaluate impact of Community Supports. Follow-up period refers to the time frame after CalAIM implementation used to evaluate impact of Community Supports. Baseline and follow-up periods and collection dates are subject to change based on data availability. Member survey and hospital chart extraction will only be used for evaluation of the two CalAIM 1115 waiver Community Supports, recuperative care and short-term post-hospitalization housing.

Per STC 15.4, UCLA-RAND will attempt, with support from DHCS, to access several databases necessary to characterize our exposed population and comparison groups, as well as member reports of utilization of services and receipt of recommended care services, and data elements describing key structures related to homelessness and other social needs. In all instances, we emphasize the importance of seeking support from DHCS as their support will be critically important in our securing timely and comprehensive data as requested.

Below we provide several examples of specific data requests with associated potential alternatives that could be performed if the primary data request is unsuccessful.

1. The California Interagency Council on Homelessness (CalICH)'s Homeless Data Integration System (HDIS), which integrates local Homeless Management Information System data from all the Continuums of Care (CoC) in California and links this data with Medi-Cal eligibility and claims data on members eligible for Community Supports. If UCLA is unable to obtain the CalICH HDIS data, then UCLA-

RAND will, with input and support from DHCS, determine whether to secure data on member receipt of housing assistance from a purposefully selected sample of local CoCs or from the Los Angeles County Enterprise Linkages Project 2.0. UCLA-RAND will also attempt to procure and link data on people living in Low-Income Housing Tax Credit (LIHTC) and Housing and Urban Development (HUD)-subsidized housing in a small sample of purposefully selected jurisdictions because data on HUD assistance represents only a small component of the overall housing assistance members may receive.

2. Data on social needs screening and results from select community resource referral platforms, health plans, or provider electronic health records. Additionally, UCLA-RAND will survey a purposeful sample of members eligible for the 1115 Waiver Community Supports to obtain member reports of perceived needs for Community Supports, their experiences accessing Community Supports, how their receipt of Community Supports were associated with changes in perceived needs, and any unintended consequences of Community Supports participation.
3. The Minimum Data Set of Long-Term Care database for California nursing home (NH) residents, which will provide comprehensive data on NH resident functional status, cognitive status, active illnesses, adverse events, supportive care, and advanced care preferences – elements that are key to understanding Community Supports measures linked to transitioning NH residents to assisted living or independent living in the community. UCLA-RAND will also attempt to obtain annual In-Home Supportive Services (IHSS) assessments, which provide standardized functional assessments that can be used to track the maintenance of function for a substantial subset of members over time.
4. Medicare managed care encounter data for Duals who are eligible to receive Community Supports services. There is one MCP offering Community Supports that is a fully integrated dual eligible special needs plan; other Duals may also be receiving Community Supports from other MCPs.

   Hospital chart abstraction (post-hospitalization transitional housing) to measure (1) severity of illness, (2) instability at discharge, (3) discharge location, and (4) discharge treatment plan. Hospital chart abstraction will focus on the initial and final aspects of hospitalization (focused on admission notes, discharge summaries, discharge notes, and advanced care planning documentation). Chart abstraction will focus on up to 1000 completed charts – 500 individuals who received post-hospitalization transitional housing and 500 matched individuals (based on demographics, location, diagnosis at admission, and severity of illness based upon

administrative data-based secondary diagnoses). More detailed information about chart abstractions is provided in Appendix 1. If chart abstraction is not feasible, UCLA-RAND will determine, with input from DHCS, whether the member survey or other data could be used to obtain some of this information instead.
Should the chart abstraction design described above not be feasible for the sample size described above, an alternative strategy for assessing member experience would involve a more intense mixed methods approach engaging a smaller study cohort (30-50 individuals). Specifically, UCLA-RAND will conduct a mixed method, focused, short-term (e.g., nine-month) longitudinal assessment of members eligible for use of the short-term post-hospitalization housing 1115 Community Supports. Participants would be invited to sign informed consent for review of medical records and participation in the program. Analysis of this cohort would provide clinically and socially relevant information about how member's lives are changed (or not) with exposure (or not) to a 1115 Community Support. This type of analysis would be focused on individuals meeting eligibility criteria for either the post-hospital short-term housing Community Supports and/or medical respite condition on the individual (1) providing consent to participate in twice monthly video or phone calls, (2) signing medical record consents for access to their medical records, and (3) meeting specific clinical criteria associated with one of the three clinical conditions we anticipate studying.

When administrative or secondary data are not available to address evaluation research questions, UCLA-RAND will address these gaps with primary data collection (e.g., surveys and/or interviews). Any surveys or interviews conducted with MCPs, or providers will be coordinated with other CalAIM evaluation components (e.g., PATH, Re-entry) as appropriate. More specific details of data sources planned for the Community Supports evaluation are provided below.

1. DHCS administrative data on Community Supports from January 1, 2022 through December 31, 2026, including Medi-Cal eligibility and claims data, Quarterly Implementation Monitoring Reports and JavaScript Object Notation Data on ECM and Community Supports, Community Supports policy guides, PATH CITED applications and awardees for Community Supports, Housing and Homelessness Incentive Program (HHIP) and Incentive Payment Program (IPP) reports, reports submitted by MCPs or Community Supports providers to DHCS (e.g., Model of Care templates, implementation plans), data on appeals, grievances, and state fair

hearings for each Community Support, and salient data from any DHCS-administered surveys of MCPs or Community Supports providers.

2. Existing data on previous WPC and HHP users. WPC was implemented in 2017-2021. HHP implementation was staggered, but the program was implemented in 2018-2021.
3. Data on community-based providers and their characteristics, focusing on providers identified by DHCS as "preferred partners" for providing each Community Support (e.g., National Institute for Medical Respite Care directory of medical respite providers in California).
4. Publicly available geographic data such as county, rural-urban commuting area codes (RUCAs), Social Vulnerability Index (SVI), Healthy Places Index (HPI), or Social Deprivation Index (SDI) used to identify members' county of residence, region, rural communities, those with high SVI or SDI scores, or those in the bottom two HPI quartiles.
5. Semi-structured interviews with MCPs and a purposive sample of providers contracted to provide Community Supports, conducted in 2024 and 2026. At each time, we will interview MCPs and a purposefully selected sample of 40-45 community-based providers. Community-based providers will be selected to maximize variation in eligible provider types, Community Support provided, and geographic location, and will be identified based on UCLA-RAND review of provider data as well as MCP recommendation. Interview questions will assess topics such as: (a) factors affecting provider and member uptake of Community Supports, (b) processes for identifying members eligible for Community Supports and connecting them to services, (c) how respondents may be using Community Supports funding in conjunction with other resources to address member needs; (d) approaches for coordinating with other stakeholders to identify and address members' other health, behavioral health, and social needs, (e) perceived effectiveness of Community Supports at addressing members' HRSN, and (f) perceived impacts of Community Supports and other new Medicaid funding on existing systems of care. As appropriate, UCLA-RAND may interview up to 15 additional key informants (e.g., from county human service agencies, public behavioral health, Continuums of Care) in select counties to address (c) and (f). These key informants would only be interviewed at a single point in time. To minimize respondent burden, all interviews will be conducted in coordination with the PATH evaluation; any interviews with key informants from carceral settings will be coordinated with the Reentry evaluation.

6. UCLA-RAND surveys of MCPs and Community Supports providers, administered in 2024 and 2026 to MCPs and Community Supports providers. To minimize respondent burden, surveys will be conducted in coordination with the PATH evaluation. Surveys will collect structured information on Community Supports implementation policies and practices and other topics identified as salient in key informant interviews.
7. UCLA-RAND Member Surveys for a sample of members participating in the two 1115 Waiver Community Supports. Per STC 15.4, UCLA-RAND will attempt, with support from DHCS, to sample members participating in the Post-Hospitalization Transitional Housing Support and a different sample of those participating in the Recuperative Care Support. UCLA-RAND will aim for 200 completed surveys for each of these two 1115 Community Supports with an estimated survey response rate of 10%. Survey recipients will receive an inducement ($20 gift card) for completed surveys. We anticipate survey completion will take approximately 20 minutes. Surveys will be available in English and Spanish and may be translated to additional languages as needed. Questions will focus on member-reported health and social needs, housing instability, health instability, self-reported health, satisfaction, post-intervention housing outcomes, and access to and use of other types of social services. Since *need* can be understood by members through clinical, social, and/or economic lenses, survey items will be specifically designed to understand how members identify and characterize their need(s). Where possible, UCLA-RAND will aim to assess concordance between member reports of their need for specific components of the Community Support bundle they may have anticipated receiving and those they report receiving. The survey will query members about how receipt of Community Supports impacted their health and well-being. If members report not using the approved service, they will be queried about the reason the service was not used. Ideally, a matched set of members not receiving Community Supports will also be identified and surveyed. More detailed information about the member surveys is provided in Appendix 1.

   Among members eligible for a 1115 Community Supports, individuals eligible to participate in this evaluation component would include members known to have claim/encounter evidence for one of three clinical conditions noted to be prevalent among those eligible for a 1115 Community Supports. Applying this restriction will allow our measurement tools to collect focused clinical-condition specific measures regarding changes in burden of illness, processes, and outcomes, including

member report of function and quality of life. For example, if we use active leg ulcers as a diagnosis at the time of hospital discharge, we would be able to include during our proposed nine-month follow-up period, measures describing how the leg ulcer is managed and healing, in addition to measuring member's function and well-being. Conditions likely to be prevalent among members eligible for a 1115 Community Supports include chronic conditions such as diabetes, hypertension, and chronic kidney disease with an acute exacerbation (e.g., with leg ulcer) prompting a recent hospital stay. UCLA-RAND will use empirical analyses of the distribution of diagnoses among those eligible for 1115 Community Supports to assess prevalent conditions. Among prevalent conditions, UCLA-RAND will prioritize the study of conditions for which preexisting measurement tools are documented, appropriate for use in this population, and can support repeat measures across nine months.

If feasible, available data would come from focused medical record review, phone/video visits, member-reported survey data, and claims/ encounter data. Utilization, quality, and quality of life data will be measured.

While this mixed methods approach uses case identification strategies similar to those described above for survey and medical record abstraction, the number of members studied will be fewer than described above with the member survey abstraction analysis. The added value of this focused mixed method approach is somewhat more intense with multiple complementary data elements being available to describe and evaluate stability of hospital discharge, processes, and outcomes, including member experience of their transition to and from a 1115 Community Supports opportunity.

Analyses of this mixed method cohort will be largely descriptive combining thematic analyses and comparative case analysis with quantitative analyses describing utilization and quality for those participating in this mixed methods approach. The analysis will address the member's experience of transitioning to 1115 Community Supports with the description being formed by multiple complementary data sources that are likely to provide answers to the important question of the member's experience participating in a 1115 Community Supports.

Measures

Exhibit 6 on the next page summarizes the data sources and associated data elements that UCLA-RAND anticipates accessing to address Community Supports evaluation goals. Data that UCLA-RAND anticipates using for the evaluation are listed in each column, and measurement domains pertinent to the Community Supports evaluation are listed in each row. Check marks within cells illustrate our expectation of measures available in each data source.

Exhibit 6: Data Sources and Data Elements (Abbreviations and notes are shown at the bottom of the table)

	DHCS	Claims	IHSS	MDS	DSMF	HCAI	House	M Survey	Chart	Fee Sch	Prov	OSurveys	Qual
Member Demographics													
Age	•												
Sex	•												
Race/Ethnicity	•												
Preferred Language	•												
Marital Status				•	•			•					
Social Need (self-report)								•					
Social Need (neighborhood)	•												
Service Need		•						•				•	
Homelessness	•					•	•	•					
Member Case-Mix Severity and Related Selection Criteria													
Reported Diagnoses		•				•							
Active Illnesses				•									
Severity at Admission									•				
Illness Burden at Discharge									•				
Duration in Hospital*		•				•			•				
Duration in Nursing Home*		•		•									
Member Functional Status													

Exhibit 6: Data Sources and Data Elements (Abbreviations and notes are shown at the bottom of the table)

	DHCS	Claims	IHSS	MDS	DSMF	HCAI	House	M Survey	Chart	Fee Sch	Prov	OSurveys	Qual
Activities of Daily Living			•	•									
Cognitive Status				•					•				
Enrollment Characteristics													
Eligibility Status	•												
Duration Enrolled	•												
Medicare Status	•												
Access to Care													
Ease receiving needed care								•					
Distance to Closest Service Provider	•	•									•	•	
Distance to Closest High Volume Service Provider	•	•									•	•	
Outcomes: Utilization Measures													
Hospitalization (All cause, cause-specific, preventable)		•				•							
ED Visit without Hospitalization (All cause, cause-specific, preventable)		•				•							

Exhibit 6: Data Sources and Data Elements (Abbreviations and notes are shown at the bottom of the table)

	DHCS	Claims	IHSS	MDS	DSMF	HCAI	House	M Survey	Chart	Fee Sch	Prov	OSurveys	Qual
Ambulatory Care Visits (All cause)		•											
In-Home Supportive Service Hours		•											
Nursing Home Stays		•		•				•					
Outcomes: Cost of Care													
Overall Estimated Costs	•	•					•			•			
Outcomes: Quality of Care													
HEDIS Measures (Claims-based)		•											
Medicaid Core Measures (Claims-based)		•											
Other Valid Measures (Claims-based)		•											
Outcomes: Clinical Outcomes													
Mortality	•			•	•	•							•
Functional Decline			•		•			•					
Illness Resolution								•					
Non-Clinical Outcomes													
Housing stability							•	•					

Exhibit 6: Data Sources and Data Elements (Abbreviations and notes are shown at the bottom of the table)

	DHCS	Claims	IHSS	MDS	DSMF	HCAI	House	M Survey	Chart	Fee Sch	Prov	OSurveys	Qual
Satisfaction with Assistance								•					
Provider Surveys													•

Note: **DHCS –** DHCS eligibility file; **Claims –** service managed care encounters and paid claims; **IHSS –** In Home Service Support annual evaluations; **MDS –** Minimum Data Set for Long Term Care; **DSMF –** California Death Statistical Master File; **HCAI –** California Health Care Access and Information hospital discharge and ED encounter abstracts; **House –** Public Housing Assistance Data; **MSurvey –** Member Surveys; **Chart –** Hospital Chart Abstraction (Post-Hospitalization Transitional Housing); **Fee Sch –** Fee Schedules; **Prov –** Provider Databases; **OSurveys –** Other Surveys (Plans, Providers, etc.); **Qual** – Qualitative Data.

Exhibit 7 illustrates data elements that UCLA-RAND anticipates using to evaluate each of the 14 pre-approved Community Supports. Within each listed column (all of which represent a unique Community Support), we have included a check mark within cells to illustrate our expectation for data that will be available for analysis of the Community Support named in the associated column.

Exhibit 7: Measures and Community Supports

	1115 services		1915(b) services											
	Short-term post-hospitalization housing	Recuperative care (medical respite)	Housing transition / navigation services	Housing tenancy and sustaining services	Housing deposits	Respite care	Day habilitation programs	Nursing facility transition/diversion to assisted living facility	Community transition services/nursing facility transition to home	Personal care and homemaker services	Environmental accessibility adaptations (home modifications)	Medically tailored meals / medically supportive foods	Sobering centers	Asthma remediation
Member Demographics														
Age	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Sex	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Race	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Preferred Language	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Marital Status	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Social Need (self-report)	•	•												
Social Need (neighborhood)	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Service Need	•	•						•	•					•
Homelessness	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Member Case-Mix Severity and Related Selection Criteria														
Reported Diagnoses	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Active Illnesses								•	•					
Severity at Admission	•													
Illness Burden at Discharge	•													
Duration in Hospital*	•													
Duration in Nursing Home*								•	•					
Member Functional Status														
Activities of Daily Living								•	•	•				
Cognitive Status								•	•					
Enrollment Characteristics														
Eligibility Status	•	•	•	•	•	•	•	•	•	•	•	•	•	•

Exhibit 7 illustrates data elements that UCLA-RAND anticipates using to evaluate each of the 14 pre-approved Community Supports. Within each listed column (all of which represent a unique Community Support), we have included a check mark within cells to illustrate our expectation for data that will be available for analysis of the Community Support named in the associated column.

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Duration Enrolled	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Medicare Status	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Access to Care														
Ease of receiving timely necessary care (self-reported access to care)	•	•												
Distance to Closest Service Provider	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Distance to Closest High Volume Service Provider	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Outcomes														
Utilization Measures														
Hospitalization (All cause, cause-specific, preventable)	•	•	•	•	•	•	•	•	•	•	•	•	•	•
ED Visit without Hospitalization (All cause, cause-specific, preventable)	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Ambulatory Care Visits (All cause)	•	•	•	•	•	•	•	•	•	•	•	•	•	•
In-Home Supportive Service Hours										•	•			
Nursing home Stays	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Cost of Care														
Overall Estimated Costs	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Quality of Care														
HEDIS Measures (Claims-based)	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Medicaid Core Measures (Claims-based)	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Other Valid Measures (Claims-based)	•	•	•	•	•	•	•	•	•	•	•	•	•	•

Exhibit 7 illustrates data elements that UCLA-RAND anticipates using to evaluate each of the 14 pre-approved Community Supports. Within each listed column (all of which represent a unique Community Support), we have included a check mark within cells to illustrate our expectation for data that will be available for analysis of the Community Support named in the associated column.

Exhibit 7: Measures and Community Supports

	1115 services		1915(b) services											
	Short-term post-hospitalization housing	Recuperative care (medical respite)	Housing transition / navigation services	Housing tenancy and sustaining services	Housing deposits	Respite care	Day habilitation programs	Nursing facility transition/diversion to assisted living facility	Community transition services/nursing facility transition to home	Personal care and homemaker services	Environmental accessibility adaptations (home modifications)	Medically tailored meals / medically supportive foods	Sobering centers	Asthma remediation
Clinical Outcomes														
Mortality	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Functional Decline								•	•	•				
Illness resolution	•	•												
non-Clinical Outcomes														
Housing stability (derived)	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Housing stability (self-report)	•	•												
Satisfaction with Assistance	•	•												

Note: Measures that are universally available across all Community Supports would be based upon in-common routinely collected data (enrollment, claims/encounters, hospital ED and discharge data, death certificate data, housing data, and provider data).

Data Cleaning and Validation

This section outlines data cleaning and validation processes that the evaluation team expects to follow based on the team's prior collective experience working with data. Certain aspects of these processes are expected to change based upon data availability and reporting. For the Community Supports evaluation, the evaluation team will rely upon a combination of routinely collected person-level, provider-level, and plan-level data based primarily on data from the state Medicaid program. These data will be supplemented by other routinely collected state and federal data as described in the Data Sources section above as well as by prospectively collected data from Medi-Cal members (surveys), service providers (interviews, possible chart abstraction, and other data), and Medi-Cal managed care plans (surveys and interviews).

For person-level analyses, state Medi-Cal data will provide the overarching source for demographic, geographic, and case-mix severity. Data will be assembled to create longitudinal descriptions of utilization, quality, and outcomes as described in more detail elsewhere. Where possible, we will employ concordant validity across distinct data sources to determine accuracy and completeness of reporting.

For Community Supports, the California Department of Health Care Services has provided guidance to MCPs regarding which codes to use for each Community Support. The accuracy and completeness of codes is unknown at this time. The evaluation team will rely upon concordant and face validity to determine completeness of reporting. For example, data provided in QIMRs will be compared to data available in claims regarding the number of members served and the number of Community Supports services provided. Patient self-report and chart abstraction are independent sources of gold standard information that may be used to validate some of the Community Supports services.

For utilization, key aspects of care can be compared across distinct data sources, contingent on data availability and access. For example, hospitalizations and ED visits within state reported by MCPs can be compared to the gold standard of hospitalization discharge and ED visit abstracts reported to the state by hospitals. Similarly, care delivered by home health care and within registered nursing homes can be compared between the Medi-Cal data and the reporting from the gold standard of Outcome and Assessment Information Set (OASIS) and the Minimum Data Set (MDS) data sets, which also have additional information on demographics, indications for care, comorbidities, physical function, cognitive function, and care delivery in these settings.

Demographics will be drawn from the Medi-Cal eligibility / enrollment file. Data on unhoused individuals or individuals at-risk of being unhoused will be based upon a prior validated approach, e.g., by using residence information from the eligibility file

supplemented by the International Classification of Diseases (ICD)-10-z-codes. This approach is known to be specific, but not sensitive. Certain providers may be able to provide the evaluation team prospectively identified individuals who are unhoused or at-risk of being unhoused, which can be as gold standard validation for existing data. Comorbidities based upon consensus coding (e.g. Elixhauser assigned codes) and a minimum of two separate outpatient or one inpatient code for each condition with consistent observation periods for all individuals provide valid and reliable measures.

As currently conceived, the evaluation team will perform prospective data collection from members receiving Community Supports and from potentially matched members that did not receive Community Supports. The evaluation team's member survey may be used to help assess accuracy, completeness, and reliability of demographics, comorbidities, and service receipt in Medicaid data with self-report. Patient survey will allow the evaluation team to compare service receipt to recorded service delivery. Chart abstraction in the hospital (if feasible) will provide an additional source of gold standard information.

In summary, the evaluation team has a number of strategies that could be employed in cleaning and validating the data. Nevertheless, the evaluation team is aware that there are likely to be issues with accuracy and completeness of reporting of new Community Supports services, particularly when delivered in new settings or by providers without prior experience with Medi-Cal billing and claims. The evaluation team plans to use primary data and ancillary external data to reduce potential threats to validity of the data and our work.

Analyses

UCLA-RAND will respond to the evaluation questions using appropriate qualitative and/or quantitative analytic methods, consistent with the CalAIM evaluation's mixed methods approach. Qualitative analysis will be conducted using thematic analysis or comparative case analysis, as appropriate. Quantitative analysis will include descriptive analyses using t-tests and Chi-square tests, regression models, and difference-in-difference regression models as appropriate. Target populations used in analyses of each Community Support will vary based on DHCS-identified eligibility criteria for that Community Support (high-level overview of which was provided in Exhibit 1). When relevant, baseline periods for each data source are identified in Exhibit 5. Unless otherwise indicated below, the baseline period for difference-in-difference regression models will be January 1, 2020 to December 31, 2021.

Goal 1: Increase uptake of Community Supports by MCPs

To address EQ1, which asks whether the number of MCPs offering Community Supports increase over time, UCLA-RAND will assess change or rate of growth in the related measures noted in Exhibit 1 over time (i.e., from January 1, 2022, to December 31, 2026). Data will be presented using graphical plots, and changes in trends will be measured with appropriate tests (e.g., Mann-Kendall test) to determine whether upward or downward trends are statistically significant. Where appropriate, these analyses will be complemented with descriptive analysis of survey data and thematic analysis of interview data, e.g., to provide insight into factors affecting MCPs' decision to offer Community Supports.

Goal 2: Increase awareness and uptake of Community Supports by providers

To answer EQ2, which examines whether the number of providers contracted to provide Community Supports increases over time, UCLA-RAND will assess change or rate of growth in the related measures noted in Exhibit 1 over time (i.e., from January 1, 2022, to December 31, 2026). To better understand provider retention, UCLA-RAND will also assess provider churn over time. Data will be presented using graphic plots, and changes in trends will be measured with appropriate tests (e.g., Mann-Kendall test) to determine whether upward or downward trends are statistically significant. Where appropriate, these analyses will be complemented with descriptive analysis of survey data and thematic analysis of interview data, e.g., to provide insight into factors affecting providers' decision to contract for Community Supports. UCLA-RAND will also analyze Community Supports Model of Care documents submitted by MCPs to obtain information on MCP processes for vetting providers and any minimum qualifications required of providers. As appropriate, UCLA-RAND will build on the PATH analysis, which examines whether the number and proportion of community-based providers located in under-resourced communities increased over time and the extent of provider participation in capacity-building programs such as PATH, HHIP, and IPP.

To answer EQ3, which assesses factors affecting provider participation in Community Supports, UCLA-RAND will descriptively analyze provider survey data and thematically analyze provider interview data. Because provider participation is also contingent on MCPs being willing to contract with providers, UCLA-RAND will also analyze MCP survey data and MCP interview data for MCP perspective on this topic.

Goal 3: Increase uptake of Community Supports by eligible members

To answer EQ4, which assesses whether the number of members utilizing Community Supports increased over time, UCLA-RAND will use Quarterly Implementation Monitoring

Reports and JavaScript Object Notation Data on Community Supports to measure rate and patterns of use of Community Supports over time. UCLA-RAND will use logistic regression analyses to assess what member characteristics (age, sex, race, preferred language, marital status, social need via self-report and neighborhood characteristic, service need, and homelessness) differentiate eligible users and non-users for each Community Support. No baseline period will be included because Community Supports was not offered prior to the evaluation period. Member characteristics examined include age, sex, race/ethnicity, preferred language, homelessness, California county or region, chronic health conditions, vulnerability indices, severe mental illness, substance use disorder, and Medi-Cal state-funded status, among others. For individuals receiving care in nursing homes, physical function, cognitive status, Resource Utilization Group (RUG) scores, adverse outcomes, and care receipt may be available from the MDS. Individuals receiving IHSS services will have a physical function available from annual IHSS functional assessments. An example equation for logistic regression models is provided below:

$$\log\left(\frac{P(Y_i = 1)}{P(Y_i = 0)}\right) = \beta^0 + \beta^1 \cdot Sex_i + \beta^2 \cdot Race_i + \beta^3 \cdot Language_i + \beta^4 \cdot MaritalStatus_i +$$

$$\beta^5 \cdot SocialNeedSelf_i + \beta^6 \cdot SocialNeedNeighborhood_i + \beta^7 \cdot ServiceNeed_i + \beta^8 \cdot Homeless_i$$

Y_i: Y_i =1 means the member **used Community Supports**, and Y_i = 0 means they **did not.**

i: index of *individual*

When feasible, UCLA-RAND will also assess frequency and duration of Community Supports use and member characteristics associated with the frequency and duration of Community Supports use. UCLA-RAND will also assess the feasibility of applying a UCLA-developed algorithm to improve identification of individuals experiencing homelessness or residing in NHs, assisted living, board and care (also known as senior assisted living), or other group living arrangements. UCLA-RAND will also assess member use of multiple Community Supports and the extent to which Community Supports use coincides with the use of Enhanced Care Management. Regression analyses will be complemented with descriptive analysis of survey data and thematic analysis of interview data to contextualize and explain the findings from administrative data analysis. For example, interviews and survey data can illustrate whether other unmeasured characteristics or systemic barriers affected member use of Community Supports.

For the two 1115 Waiver Community Supports, member survey data will provide additional insight into members' characterization of priority needs, previously experienced barriers to resolving these needs, and extent to which they perceive these Community Supports as helping to address some or all these needs.

To address EQ5, which assesses strategies being used to identify and refer members to Community Supports, UCLA-RAND will analyze Community Supports Model of Care documents submitted by MCPs, which provide information on policies and procedures for how Community Supports are provided, including processes for identifying eligible members, authorizing Community Supports, referring members to authorized Community Supports, and monitoring utilization and/or outcomes resulting from the provision of Community Supports. Document analyses of Model of Care documents will be complemented with a thematic analysis of interview data, which will provide deeper insight into the rationale for developing certain processes and the perceived strengths and weaknesses of different approaches for identifying and referring members to Community Supports.

For the two 1115 Waiver Community Supports, member survey data will be used to characterize number, types, timing of member exposure to information about Community Supports, and member satisfaction with information shared about their Community Supports eligibility, availability, and applicability to their needs.

Goal 4: Examine whether and how public investments in housing and other HRSN services change over time in concert with new Medicaid funding for those services

To address EQ6, which assesses how new Medicaid funding for Community Supports impacts existing systems of care, UCLA-RAND will assess the feasibility of procuring data on California public housing expenditures from federal and state sources from 2018-2026. As necessary, UCLA-RAND may also attempt to secure local public housing expenditure data in 2-3 purposefully selected counties over the same period. As feasible, these data will be analyzed to assess changes in state and local investments in housing over time, using descriptive statistics and ANCOVA or regression analyses as appropriate. To better understand MCP and provider perceptions of how new Medicaid funding for Community Supports has impacted existing systems of care, UCLA will thematically analyze data from semi-structured interviews with MCPs, providers contracted to provide Community Supports, and other key informants in county human service agencies, public behavioral health, local CoCs, or carceral settings. Interview questions will address relevant topics noted in Exhibit 1.

Goal 5: Increase members' access to non-emergency outpatient care and reduce acute care utilization and long-term care stays

To address EQs 7a/7b, which address the impact of Community Supports on members' health care use, UCLA-RAND will analyze the Medi-Cal eligibility and claims data and Quarterly Implementation Monitoring Reports and JavaScript Object Notation data on Community Supports supplemented by MDSS, IHSS annual evaluations, HCAI hospital discharge abstracts, and Medicare claims and managed care encounters to compare health care use of members who received and members who were eligible but did not receive before and after receipt of Community Support services. The period before receipt of Community Support will be defined at the member-level and will include the two years prior to a member's first receipt of a specific Community Support. UCLA-RAND will examine utilization of major categories of services including ambulatory medical care (primary and specialty care), mental health care, substance use disorder treatment, ED visits, hospitalizations, and long-term care stays. Specific measures examined may vary by Community Support and will be finalized with input from DHCS. To measure ED visit type, UCLA-RAND will apply the New York University (NYU) algorithm for differentiating ED types based on diagnosis codes, e.g., as (1) needed, not preventable or avoidable, (2) emergent or primary care treatable, (3) non-emergent; (4) mental health-, alcohol-related, or substance use-related, (5) injury-related, etc.

UCLA-RAND will use difference-in-difference (DD) multivariate regression models to compare changes in health care utilization of members who received Community Supports to a comparison group of members who were eligible for but did not receive Community Supports. An example equation for the difference-in-difference (DD) regression model is provided below:

$$Y_{it} = \beta^0 + \beta^1 \cdot Post_t + \beta^2 \cdot Treat_i + \beta^3 \cdot (Post_t \times Treat_i) + \beta^4 \cdot Demo_{it} + u_i + \varepsilon_{it}$$

Y_{it} : Health care utilization outcome and associated payment for individual *i* at time *t* (e.g., ED visits, inpatient stays)

$Post_t$: Indicator for post-treatment period (1 = post receipt of specific Community Support, 0 = pre)

$Treat_i$: Indicator for treatment group (1 = received Community Supports, 0 = did not)

$Post_t \times Treat_i$: Interaction term for the **Difference in Difference estimator**

$Demo_{it}$: Vector of member-level covariates (age, sex, race, etc.)

u_i : patient-level **random intercept**

ε_{it} : Residual error term

UCLA-RAND anticipates that identifying a single comparison group across Community Supports will be challenging because there are differences in eligibility criteria for each Community Support, in delivery systems and population characteristics in California counties, in MCP implementation approaches, and in the availability of Community Supports within each community over time. One important challenge is UCLA-RAND's incomplete access to complete lists of members who MCPs determine to be service-eligible and lists of the subset of these members who are meaningfully offered services. Furthermore, noting that Community Supports' participation by members is voluntary, UCLA-RAND anticipates that some members who are offered services will decline. Nevertheless, opportunities for selecting a comparison group include selection from: 1) members who had a similar risk profile and were authorized for services but did not participate, and 2) members who were eligible but were not selected, perhaps because of a lower risk profile or because Community Supports were not available in their area or from their MCP. UCLA-RAND will examine the characteristics of members who were eligible and not receiving Community Support(s) before determining the best strategy to identify the comparison group. UCLA-RAND will also consider developing targeted comparison groups based upon patterns of Community Support use to be identified prior to the cohort matching process. For certain Community Supports, such as for the NH transition Community Supports services and individuals receiving IHSS, a more targeted comparison group may be more appropriate. To account for the possibility of clustered data (e.g., repeated measures over time or nesting of members by provider), UCLA-RAND will use methods such as repeated measures ANOVA, ANCOVA, or generalized linear mixed-effects models as appropriate.

Although UCLA-RAND anticipates that targeted comparison groups will be necessary, UCLA-RAND will also examine the possibility of developing a single comparison group rather than creating separate comparison groups for each Community Support to allow for assessment of the overall impact of Community Supports on member health care use. This approach would avoid the anticipated difficulty of identifying an adequate number of members in the comparison group per MCP or Community Support. Because the

comparison group population profile will be designed with the collective population in mind, further assessment is required to determine to what extent the comparison group can be used as a benchmark to assess variation in impact on specific populations (e.g., members experiencing homelessness, members at-risk of institutionalization, etc.) or on MCP-level variation in impact of Community Supports. If needed and feasible, multiple comparison groups may be included allowing for comparison of the results for each group to gain a better understanding of the impact of Community Supports on member health care use.

If the above strategies do not lead to the selection of a reasonable comparison group, UCLA-RAND will develop a model to predict the counterfactual outcomes of interest after Community Supports implementation, or as if Community Supports were not implemented. The observed outcomes will then be compared to the counterfactual predicted outcome. UCLA-RAND will examine all the above methodologies to identify a comparison group to be used in the analyses of the quantitative data.

A key assumption of the DD design is the parallel trends assumption; that is, in the absence of Community Supports, health- and social services use and other outcomes (e.g., health-related quality of life) for enrollees and the comparison group would have been similar with parallel trends. In addition to the approaches described above, UCLA will also use propensity score matching to strengthen the validity of this parallel trends assumption. Specifically, UCLA-RAND will develop a propensity model that includes demographic characteristics, health status, service utilization, county of residence, and cost variables constructed from the Medi-Cal eligibility and claims data. UCLA-RAND will then use the subsequent propensity score in the DD models to "match" members receiving Community Supports to similar members who were eligible for but did not receive services. The models will further include the number of full-scope Medi-Cal enrollment months, indicators for a COVID-19 diagnosis, and participation in ECM.

UCLA will subsequently use multilevel, generalized linear regression models to assess the impact of Community Supports on health services utilization per Medi-Cal member month. Model type will vary based on the nature of the dependent variable. For example, UCLA-RAND anticipates using Poisson or zero-inflated Poisson distribution to assess utilization. Models will control for member demographics, program characteristics, baseline utilization, health status indicators, and other factors identified as important in predicting utilization. The exposure option within a Generalized Linear Model (GLM) will be used to adjust for different number of months of Medi-Cal enrollment and the subsequent different lengths of receipt of Community Supports. To test the parallel trends assumption,

UCLA-RAND will run multilevel models with an individual random intercept and an interaction term that allows for potentially different pre-trends in baseline years between members receiving Community Supports and matched comparison group. As feasible, UCLA-RAND will also run sensitivity analyses to assess potential differential impacts of Community Supports on health services use of different populations (e.g., members who are unhoused and remain unhoused; members who are unhoused and subsequently housed; members with SMI/SUD; Justice Involved (JI); duals; etc.).

Where appropriate, the DD analyses described above will be complemented with descriptive analysis of survey data or thematic analysis of interview data, e.g., to provide insight into factors perceived as affecting members' health care use. For the two 1115 Waiver Community Supports, UCLA-RAND will assess the feasibility of conducting a highly focused medical chart abstraction to provide clinically detailed information about member's prehospital burden of illness, a brief summary of reasons for recent hospitalization that preceded 1115 Community Supports use, and plan of care specified at the time of hospital discharge. This information, combined with member reports of their health status, will provide context for interpreting utilization patterns observed with secondary data analyses and MCP and provider.

Goal 6: Improve quality and outcomes of care

To address EQ8, which assesses member satisfaction with Community Supports referral processes and services, UCLA-RAND will analyze data on appeals, grievances, and state fair hearings for each Community Supports. Specifically, UCLA-RAND will track the number of appeals, grievances, and state fair hearings for each Community Supports over time, relative to Community Supports use, and summarize stated reasons and resolution status for these appeals, grievances, and state fair hearings. UCLA-RAND will also analyze data from MCP and provider-level surveys and interviews regarding perceived effectiveness of Community Supports at addressing members' identified HRSN, when applicable, factors perceived as contributing to any increases in appeals, grievances, and state fair hearings for Community Supports, and opportunities for improvement. For the two 1115 Waiver Community Supports, member surveys will assess member satisfaction with services, ease of accessing services, route of referral, related supportive care, and success in obtaining permanent housing.

To address EQ9, which assesses whether members are being transitioned to appropriate, needed supports following receipt of Community Supports, UCLA-RAND will draw on data

from Medi-Cal eligibility and claims data, Quarterly Implementation Monitoring Reports and JavaScript Object Notation Data on Community Supports utilization, and HDIS or other data on members' receipt of public housing assistance to assess change in the related measures identified in Exhibit 1. Where appropriate, these analyses will be accompanied with thematic analysis of interview data, e.g., to provide information on factors affecting the transition of members to appropriate supports and on lessons learned in implementation. For individuals transitioning from NHs back to the community (home or assisted living), NH assessments will allow for the matching of NH admissions and discharges of individuals with similar profiles of need to assess referral to post-NH stays.

For the two 1115 Waiver Community Supports, member surveys will allow for member report of their general health, well-being, access and quality of care, and the extent to which they perceive the need that prompted their Community Support(s) use is being met.

To address EQ10, which examines the impact of Community Supports on the quality and outcomes of health care, UCLA will use related measures identified in Exhibit 1 from the Health Equity and Quality Measure set (HEQMS) supplemented by items from HEDIS and other consensus measures to create greater granularity for individual and summary quality assessment approaches. In particular, we anticipate assessing individual and overall quality performance. Overall quality assessment has the advantages of expanding the eligible target population for assessment while also increasing the granularity of outcomes by allowing for individuals to be eligible for multiple quality metrics. Quality outcomes of interest – receipt of recommended care or avoidance of non-recommended care – can be succinctly present in terms of both overall "pass" rates or normalized to account for underlying differences in achieving recommended care as measured by individual quality metrics. As with Goal 5, specific quality and outcome measures examined will vary by Community Support and will be selected with input from DHCS.

Using the approach outlined in Goal 5 in addressing EQs 7a/7b, UCLA-RAND will then use difference-in-difference multivariate regression models to assess the impact of Community Supports on the quality of care for members, relative to a matched comparison group. As feasible, UCLA-RAND will also run sensitivity analyses to assess potential differential impacts of Community Supports on quality and outcomes of care for different populations (e.g., members who are unhoused and remain unhoused, members who are unhoused and subsequently housed, members with SMI/SUD, members with diabetes receiving MTM, etc.).

For the two 1115 Waiver Community Supports, UCLA-RAND will assess the feasibility of medical chart abstraction to provide insight into member's chronic and acute medical burden of illness and its association with quality and outcomes. Member surveys will provide additional insight into member-reported access, utilization, quality of care, and health outcomes following receipt of Community Supports.

Goal 7: Reduce disparities in service utilization, quality of care, and outcomes of care

To address EQ11, which assesses whether there are disparities in Community Supports uptake by member demographic characteristics or health conditions, or by community characteristics, UCLA will use data on Medi-Cal eligibility and claims data, Quarterly Implementation Monitoring Reports and JavaScript Object Notation data on Community Supports, and publicly available geographic data identified in Data Sources. These data will be used to examine number and type of Community Supports used, relevant measures identified in Exhibit 1, stratified by member housing status; demographic characteristics such as race/ethnicity, sex, language preference; health status indicators (baseline acute care utilization, baseline Chronic Illness and Disability Payment System risk scores, specific chronic conditions, total count of chronic conditions, behavioral health needs), and geographic indicators (e.g., county of residence, RUCA, HPI quartile). For NH populations, it is possible to obtain physical function, cognitive status, RUG scores, complications, and active conditions. For IHSS recipients, it is possible to obtain physical function scores, which can be used to assess the maintenance of function over time for a subset of members. Disparities will be assessed using appropriate statistical tests, e.g., t-test, MANOVA, chi-square test, etc. These analyses will be supplemented with thematic analysis of interview data regarding factors perceived as affecting Community Supports uptake and for the two 1115 Waiver Community Supports, analysis of member survey data to assess whether there are disparities in measures previously identified in EQs 4-9.

To address EQ12, which examines whether receipt of Community Supports impacts disparities in downstream health care use, quality of care and outcomes of care, UCLA-RAND will examine select measures identified in Goals 5-6, stratified by select member demographic characteristics, health status, and geographic indicators. Specific measures will be selected following review of Goals 5-6 analyses, member characteristics, and with input from DHCS. Analyses will be conducted using the same approach outlined in Goal 5 for EQs 7a/7b, e.g., difference-in-difference models. These analyses will be supplemented with thematic analysis of interview data, e.g., regarding MCP or provider participation in health equity initiatives, efforts to address health disparities, or factors perceived as affecting health equity. Member survey data will be used to examine differences in

perceived health, access to care, and receipt of recommended care between recipients and controls for the 1115 Waiver Community Supports.

Goal 8: Ensure Community Supports are cost-effective alternatives to State Plan services and settings

To address EQ13, which assesses whether the cost of each Community Support is offset by reductions in the costs of State Plan services and settings, UCLA-RAND will also examine categories of costs, including outpatient services, ED visits, hospitalizations, and long-term stays. Examination of these categories of service and costs will help illustrate whether receipt of Community Supports led to a different pattern of health services utilization and associated costs. In other words, the analyses will not only provide estimates of the impact on use of each category of service or cost but will further demonstrate if reductions in acute care services or costs of such services as ED visits and hospitalizations were achieved by provision of Community Supports or different types of outpatient care and associated costs.

UCLA-RAND will use the methodology developed under the WPC and the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) evaluations (in consultation with Mercer and DHCS) to attribute estimated payments to claims. This step is necessary because payment amounts for managed care encounters are not accurate or reliable. Briefly, this methodology includes identifying detailed and unduplicated categories of outpatient service, identifying the appropriate and available Medi-Cal fee schedules for each type of service, and attributing that amount to a claim. For ED visits, all claims on the day of the ED visit will be aggregated and counted as part of the visit. For hospitalization, all claims during the length of stay other than visits with primary care providers on the first or last day of the stay will be aggregated as part of the same stay. Payments for hospitalizations will be estimated using publicly available prices in DHCS's All Patient Refined-Diagnosis Related Group (APR-DRG) Pricing Calculator to calculate payments for each DRG. For long-term stays, institutional fees billed by a facility will be calculated at the per diem rate, which is inclusive of supplies, drugs, equipment, and services such as therapy. Using the approach outlined in Goal 5 for EQs 7a/7b, UCLA-RAND will then use separate difference-in-difference multivariate regression models to assess the impact of each Community Support on the costs of care for members relative to a matched comparison group. As feasible, UCLA will also run sensitivity analyses to assess potential differential impacts of Community Supports on costs of care for different populations (e.g., members who are unhoused and remain unhoused, members who are unhoused and subsequently housed, members with SMI/SUD, etc.).

Additional analytic considerations

- **Overlap in Community Supports received:** Prior to conducting analyses for Goals 5-8, UCLA-RAND will determine if any Community Supports should be examined together. As shown in Table 1, Community Supports differ in service type, eligibility criteria, preferred provider types, and allowable frequency and duration. Nevertheless, some Community Supports are focused on specific populations and are similar in intent. For example, housing transition/navigation, housing deposits, housing tenancy and sustaining services, recuperative care, short-term post-hospitalization housing, and transitional rent (if approved) are all focused on addressing housing-related needs for members experiencing or at-risk of homelessness with varying levels of clinical needs and are likely to be offered sequentially or in conjunction with one another. Similarly, personal care and homemaker services and environmental accessibility adaptations are targeted to members at risk of institutionalization and are designed to prolong and support community living. Therefore, certain populations are likely to receive more than one Community Support, making it difficult to attribute impact on service utilization, costs, or other outcomes of care to a single Community Support. Furthermore, analysis of the impact of receipt of a single Community Support overlooks the possibility of the cumulative impact of other Community Supports that are used in tandem. Therefore, UCLA-RAND will examine the patterns of use of Community Supports before conducting analyses related to Goals 5-8. If the data indicate significant overlap in receipt of Community Supports, UCLA will identify categories of Community Supports that are better analyzed together and will develop analytic models accordingly. For example, UCLA-RAND may develop an analytic model to measure the impact of receiving housing-focused Community Supports on members experiencing homelessness. This model would include indicators for receipt of each Community Support to account for variation in services provided. UCLA will further measure the impact of receipt of different mixes of services and the cumulative impact of multiple services, as feasible. This analytic approach will increase efficiency and improve the usability of the findings. For Community Supports with limited or no overlap, UCLA-RAND will develop separate analytic models.
- **Changing program requirements**: DHCS is continually refining Community Supports requirements in response to feedback from MCPs, contracted providers, and other stakeholders. These changes are typically reflected in annual updates to the DHCS Community Supports policy guide, which are used by MCPs and providers to inform implementation. UCLA-RAND will document these changes and the timeline over

which they occurred as part of UCLA-RAND's evaluation of Community Supports implementation and impact. As appropriate, UCLA-RAND will also adjust or otherwise account for changes in eligibility criteria and other requirements in analyses, e.g., by incorporating into the selection of comparison groups or in planned subgroup analyses.

- **Prior participation in similar waiver programs:** For most analyses, UCLA-RAND will use a baseline period of 2020-2021. In some counties, Community Supports are similar to services previously provided as part of California's Medi-Cal WPC Pilot Program (baseline period 2015-2016 and intervention implemented 2017-2021) or by Medicaid MCPs that participated in the optional Medicaid HHP benefit (baseline 2016-2017 and intervention implemented 2018-2021). In these counties, UCLA will use data from UCLA's prior evaluation of these programs to assess patterns of service use for Medicaid members who previously received WPC or HHP services and subsequently participated in Community Supports, as feasible. These analyses may be challenging due to churn in enrollment and also selection bias (i.e., members who participate in services for a longer period of time may have a higher level of complexity than those who do not).
- **Potential confounding effects of COVID-19 public health emergency (PHE):** Nationally, the PHE impacted patterns of health care use and expenditures, and also negatively impacted the fiscal solvency of many provider organizations. The baseline period (2020-2021) for the Community Supports evaluation is impacted by the PHE. However, UCLA's previous evaluations of WPC and HHP assessed PHE impact. In these prior evaluations, UCLA found that the PHE temporarily increased services use for Medicaid members with COVID-19; for all other members, there was a sharp decrease in all service use between March – June 2020, followed by a nearly complete recovery in the number of outpatient services (due to use of telehealth) and a less than complete recovery of ED visits and hospitalizations, which continued into December 2021. UCLA's examination of COVID-19 related service use showed high rates of hospitalizations and primary care visits, moderate use of ED visits, and low use of specialty, laboratory services, and long-term care stays. These rates were similar to those for the control population. In these evaluations, UCLA used a COVID-19 indicator (i.e., members with a COVID-19 diagnosis in any claims) in selecting a control group and in difference-in-difference models to ensure that parallel trends assumptions of these models would hold and did not identify major confounding impacts from the PHE. Therefore, while UCLA acknowledges the potential confounding effects of the

COVID-19 PHE on health care use and expenditures, UCLA does not believe the PHE will confound Community Supports evaluation outcomes.

- **Sensitivity Analyses:** (1) Clarify differences in claims/encounters and service delivery, including better understanding the gap in reporting between contracted services and billing encounters, which may occur between MCPs that have different contracting arrangements for specific services. (2) Description of patient need (appropriateness) – examine how to identify which individuals are eligible for care and which receive care based on the different data resources available to UCLA-RAND. (3) Selection effects (unmeasured severity of illness is associated with the choice of intervention leading to biased results) – examination of different approaches and data sources for impact on the robustness of estimates. (4) Weakness of relying upon administrative data for determining need / appropriateness. In particular, disease severity and care plan cannot be determined from (2) and (3). We will attempt to assess gaps by comparing survey results and chart abstraction with administrative data-based results.
- **Additional data:** The Urban Institute's analysis of preventable hospitalizations used publicly available claims-based algorithms provided by the Agency for Healthcare Research and Quality. States could use this software to examine preventable hospitalizations across other characteristics available directly in their Medicaid data, or by linking to other datasets within the state that may shed light on a wider range of factors contributing to health inequities. For example, linking Medicaid data with data on access to social services outside the health care system or exposure to environmental pollutants could identify shortcomings in other resources and possible root causes of disparities such as housing instability, food insecurity, or poor air quality. Addressing these social needs may help people avoid hospitalizations and other poor health outcomes.
- **Aligning the Community Supports Evaluation with other Components of the CalAIM Evaluation**

  The Community Supports evaluation represents an important opportunity to assess the implementation of Community Supports and associated concerns regarding capacity. It supplements four other components: PATH, GPP, DUALs, and REENTRY. While each of these components will generate its own unique evaluation, the interim and final reports will integrate these. In preparation for this, the evaluation team will continue to align the designs of the five components.

Community Supports Evaluation Timeline

Per STC 16.7, an Interim Evaluation Report for the two 1115 Community Supports is due to CMS December 31, 2025. A final report that evaluates all 14 Community Supports (1115 and 1915(b)) is due to CMS December 31, 2028. To meet these deadlines, the proposed timeline for the Community Supports evaluation is presented below, which identifies the proposed start dates of major evaluation activities. Data collection will be ongoing across the evaluation period.

1. August 1, 2024: Evaluator selection and contracting
2. October 1, 2024: Initiate the process for receipt of Medi-Cal data
3. November 1, 2024: Begin first round of primary data collection from MCPs and providers and analysis of MCP and administrative documents (e.g., Community Supports Model of Care templates, updated Community Supports policy guide, etc.)
4. January 2025: Receipt of person-level data from DHCS
5. January 1, 2025: Begin analyses of Medi-Cal data for interim report
6. September 2025 to December 2025: Develop and pilot test member survey
7. September 16, 2025: Interim report draft submitted to DHCS; only includes data on the 1115 Community Supports
8. December 31, 2025: Interim report submitted to CMS
9. January 2026 to December 2026: Field and analyze member surveys
10. January 2026 to June 2026: Develop and pilot test medical record accession and abstraction protocol
11. May 1, 2026: Begin final round of primary data collection from MCPs and providers
12. July 2026 to June 2027: If feasible, abstract and analyze medical records re post-hospital transitions
13. June 2026: If feasible, follow-up surveys of Community Supports recipients
14. July 2026 to December 2026: Chart abstraction of post-hospitalization transitions
15. June 2027: Receipt of enrollment and claims data from DHCS
16. June 1, 2027: Begin analyses of Medi-Cal data for final report

17. August to October 2027: If feasible, among Community Support recipients who received services in 2026, conduct a second set of cross-section surveys for a new cohort of CS-recipients
18. December 2028: Submit Final Community Support Evaluation submitted to CMS, including all 14 Community Supports and including meeting 1115 and 1915(b) waiver Community Supports evaluations requirements

Methodological Limitations

Attributing outcomes to Community Supports may be challenging due to the simultaneous implementation of other initiatives also intended to improve member health services access, quality of care, and outcomes (e.g., street medicine expansion, community health worker benefit, etc.). In addition, the proposed cost analyses only address costs to Medi-Cal and not to other systems of care and will not include measurements of cost per life year added, or any similar ratio. The evaluation will also only include data through the end of the waiver period (December 31, 2026) and thus may not reflect longer-term program impacts. UCLA's ability to conduct certain analyses is also contingent on the ability to secure access to appropriate data (e.g., Cal ICH HDIS data, the Minimum Data Set, IHSS assessments, Medicare claims/encounters, and Reentry Program eligibility codes). Finally, while UCLA-RAND will attempt to control for member participation in ECM or other care management/case management programs that might moderate the impact of Community Supports on member health care use, quality of care, and other outcomes, UCLA-RAND may not have complete data on all other services members may be engaged with in addition to Community Supports, particularly services not provided by Medi-Cal. Complete information about members fulfilling or not fulfilling specified eligibility criteria for services may not be available. This will affect the identification of appropriate comparison groups. Furthermore, and related to this is the likelihood of selection bias by members, providers, and MCPs. In other words, there is concern that providers or MCPs may be more likely to refer members with higher (unmeasured) severity for Community Supports, and that these members may also be more likely to opt-in to receive Community Supports). The extent to which we can devise adequate analytic approaches to account for selection effects is a limitation of this evaluation. The inclusion of a medical record abstraction for a cohort of individuals using the 1115 Waivers, can enhance our understanding of a member's chronic and current burden of illness. This information can help to assess the degree of selection bias for those who use Community Supports compared with those eligible but not using and for those whose eligibility was not assessed.

An additional limitation relates to our anticipation that the recording of quality measures is likely to become more digitalized during the tenure of both the 1115 and 1915(b) Waivers. While we are enthusiastic about this advancement, this will present challenges assessing the extent to which changes in quality metric numerators and denominators

may reflect the impact of the interventions we are evaluating or merely changes associated with new data systems.

Attachments

Appendix 1. Member Surveys and Medical Chart Abstraction Additional Information

Member Surveys

As described above, UCLA-RAND will survey members referred for 1115 Community Supports about the type and duration of needs they perceive that could be addressed by Community Supports and their experiences using Community Supports if they did use them. In the latter instance, the survey will address member experiences even if they were unable to use them. For each 1115 Community Supports [(i.e., the Short-Term Post-Hospitalization Housing Community Supports or the Recuperative Care (Medical Respite)], we will field a targeted survey for this Community Support. Members invited to participate in the survey will include potentially three cohorts who were referred for the specific Community Support:

1. The Community Supports - Approved USER cohort will include individuals referred for either 1115 Community Support who have been approved for participation after meeting Community Support eligible criteria. These individuals agree to participate, and initiate use of the Community Support. These individuals may be identified through service encounters provided from DHCS or from the plans.
2. The Community Supports - Approved USER non-responder cohort will include individuals approved for participation with either of the 1115 Community Supports after meeting eligibility criteria. These individuals either declined to participate or have not yet initiated use of the Community Support. These individuals would be identified solely by plans and reported to UCLA-RAND.
3. The Community Supports - Not Approved cohort will include individuals referred for a 1115 Community Support but who were considered not eligible after review of the Community Supports criteria. These individuals would be identified solely by plans and reported to UCLA-RAND.

In addition to these three cohorts who will have been referred for 1115 Community Supports and been evaluated for eligibility, UCLA-RAND recognizes other individuals who might benefit from a Community Support but were not referred for Community Support.

4. The Community Supports - Eligibility Unknown cohort will be derived from a cohort of members matched to Community Supports Approved Users (Groups 1 and 2) based upon member's MCP, demographics, ICD-10 diagnoses, available information about HRSNs, and utilization patterns.

This formulation is possible with member data only available from MCPs. If these data are not available, then using data only from DHCS we would compare Group 1 to a cohort of members matched to Group 1. This revised Group 4 (Group 4*), would thus potentially include individuals who would have been explicitly included previously in Groups 2 and 3.

Ideally, the survey will be fielded to members from all four cohorts. Group 2 (approved but not received Community Supports) is likely to be the smallest group, while Group 4 (or Group 4*) is drawn from a large pool of individuals. Actual numbers will be driven by a review of available data.

Individuals will be contacted in a stepwise manner via email, mail, and phone call. We will offer an incentive ($20) for a completed survey. For both Community Supports surveys, we will include a consent to participate in the survey and an invitation to participate in a small, focused follow-up of a small number of Community Supports and non-Community Supports participants. When applicable, we will include a consent for chart abstraction.

For simplicity, consider a sample of 400 surveys with equal numbers of individuals for Groups 1 and 4* (where the UCLA-RAND evaluation team is only able to receive data from DHCS and not from the plans). Assuming equal standard deviations (SD) for satisfaction for receipt of care in the two populations. This sample would be able to detect a difference of 0.28 (using a normalized measure with SD = 1) between means with an alpha = 0.05 and a power (beta) of 0.80. In the more complicated circumstance with three groups (e.g. Groups 1, 3, and 4) with 133 individuals in each group, this would be able to detect a difference of 0.345 between means with an alpha = 0.05 and a power (beta) of 0.80. Power to detect overall difference would be calculated using ANOVA, but given the lack of data, this is too speculative at this point.

Information about the contribution of the Member Survey to addressing Evaluation Goals is provided in the Evaluation Design Analyses section and also summarized in more detail in Exhibit A1. As UCLA-RAND reviews empirical data that is emerging from DHCS and MCPs about Community Supports utilization, and the four initial CalAIM Evaluation components (PATH, GPP, Duals, Reentry) to collect data about California's vulnerable individuals and their use of services, UCLA-RAND will use this information to further refine

the Member Survey Fielding protocol and survey content, in collaboration with DHCS. UCLA-RAND anticipates fielding the survey during 2025.

Chart Abstraction

We will aim to complete a targeted chart abstraction for up to 500 individuals receiving 1115-authorized Community Supports services and a matched comparison group of 500 individuals (as described above). Informed consent would explicitly be obtained for survey respondents. If possible, implicit consent will be devised for this retrospective quality improvement evaluation effort. We will supplement the explicit consent chart abstractions with a sample of Community Supports recipients and matching Community Supports non-recipients clustered within hospitals. In this case, with the consent of the plans, we will ask for voluntary chart abstraction from the hospitals via the mechanism of the plans performing quality assessment. We believe that this is a feasible approach for a focused chart abstraction of the initial and final portions of hospital-based care.

Chart Abstractions will target patient admission and discharge diagnoses, chronic conditions, instability at discharge, advanced care preferences, and care plans at discharge. These data can be used alone and in combination with the member survey results to generate a comprehensive evaluation that considers documented care plans and post-discharge care, patient experience, and other outcomes (utilization, quality, and costs).

Because ICD-10 codes do not capture either severity of disease, extent of disease, or instability of illness nor do they capture treatment plan AND because the 1115 Community Supports sites differ in level of care, reporting of care, and licensure, such information will allow the UCLA-RAND evaluation team to better account for significant selection effects and differences in reporting between sites. These data will allow the team to not only achieve a better understanding of the receipt and impact of Community Supports services, but they will also be an important validation of the overarching administrative data-based analyses for the 1115 Community Supports services and the parallel analyses to be performed for the 1915(b) Waiver Community Supports services.

Exhibit A1. Member Survey Domains Used to Address each Community Supports Program Goal	
Goal 1: Increase uptake of Community Supports by MCPs, providers, and members	***Member characterization of their priority need(s) that they perceive could be addressed by Community Supports*** Type of need Duration of need Impact of unfulfilled need on function and health-related quality of life ***Previously experienced barriers to resolution of priority needs*** Clinical challenges Social challenges Financial challenges Equity challenges ***Member report of how specific Community Supports might address some or all of their need(s)***
Goal 2: Address members' opportunities for accessing Community Supports	***Member report of Information Shared about Community Supports*** • Characterize the number, types, and timing of exposure to information about Community Supports use • Characterize member interest in and priorities for receiving Community Supports initiation and continuation of different Community Supports types ***Member Awareness of Community Supports Opportunities*** • How did they learn about these? • Who first advised them about these?

	• Who was most helpful in guiding member about Community Supports opportunities? • When did they learn about these? • Did member experience barriers in learning about Community Supports opportunities? ***Member Satisfaction with Information Shared About Community Supports Eligibility, Availability, and How Community Supports May Address Their Needs*** • Understanding of their options for addressing their needs • Awareness of a Community Supports program that could address their need • The quality and completeness of information about member's: o Potential eligibility for any Community Supports o Likelihood of receiving any Community Supports o Likely benefits and risks of Community Supports for relieving their need(s)
Goal 3: Improve collaboration between MCPs, medical providers, and social services providers to address members' physical health, behavioral health, and HRSN	***Member Engagement in Information Sharing and Decision Making Regarding Possible Participation in Community Supports*** • Information shared with member about options for addressing their physical health, behavioral health, and health-related social needs • Type of provider who shared information and opportunities for o Relieving member's medical, social, and financial needs

	○ Guiding member about how Community Supports might address member's medical, social, and financial ○ Sharing member-specific information about member's eligibility for Community Supports ○ Guiding member to prepare materials they would have to provide to be considered for Community Supports • Member satisfaction with: ○ Type and adequacy of information shared about their eligibility for Community Supports use, how to improve their eligibility, the information needed to apply for Community Supports use ○ Their perception of how their MCP, medical provider, and social service providers worked together to address their physical, behavioral health and HRSN ○ How their MCP, medical provider, and social service providers heard and incorporated the member's voice and concerns as decisions about Community Supports eligibility were considered and finalized
Goal 4: Examine whether and how public investments in housing and other HRSN services change over time in concert with new Medicaid funding for those services	***Member's reports of changes over time in how their MCP, medical providers, and social service providers recognized challenges associated with housing and other HRSN services*** Duration of needing and wanting assistance with housing Prior experiences learning about housing options Helpful and unsatisfactory prior experiences with housing options

	Duration of time from learning of Community Supports housing options and final decision about their eligibility for housing Community Supports Duration of time from learning about Community Supports housing options and actual receipt of support Other Medicaid/state-funded services member is using
Goal 5: Increase members' access to non-emergency outpatient care and reduce acute care utilization and long-term care stays	***Member opportunities for and use of Non-Emergency vs Emergency use of Specific Types of Services*** • Characterize typical use of Primary, Specialty, Mental Health, and Substance Use Disorder Services o Emergent vs. Non-emergent Setting o Typical frequency of use o Satisfaction with access and quality o Specific barriers to access and quality • Characterize most recent ED use o Reason for most recent ED visit o Satisfaction with health or social service visits preceding most recent ED visits o Satisfaction with health or social service visits following most recent ED visits o Did the recent ED visit intensify or diminish the member's highest priority need? ***Member use of Acute and Long-Term Care Stays*** Did recent acute care or long-term care stay intensify or diminish the member's highest priority need? ***Members' perceived impact on service access and use***

	• Awareness of duration and future availability of services • Participation with long-term care and/or other community services • Changes since using Community Supports in ED and non-emergency visits and services
Goal 6: Improve quality of care and outcomes of care	***Member overall report of access, quality of care, and outcomes now*** • Member overall reports of changes in fulfillment of their priority need during the last six months • Has access, quality, and outcomes changed since member has learned about Community Supports and since they have participated in Community Supports, or learned they will soon initiate Community Supports, or are not eligible for Community Supports
Goal 7: Reduce disparities in service utilization, quality of care, and outcomes of care	***Member report of disparities experienced in relation to opportunities to:*** • have their priority need recognized as a concern by MCP, medical provider, and social providers • receive optimal quality of care for managing their needs • have Community Supports information shared in a spoken and written language they can understand • learn about Community Support and eligibility requirements for Community Support in a timely manner • gather and share information about their history that could support their eligibility for Community Support Community Support • receive their priority Community Support Community Support • receive an additional Community Supports beyond the one they already have

	Member characterization of specific types of disparity that they have experienced • Looking downstream • Member reports of concerns that progress in addressing needs will be undone once access to Community Supports is terminated
Goal 8: Ensure HRSN expenditures do not exceed aggregate spending caps and Community Supports are cost-effective alternatives to State Plan services and settings	N/A

Appendix 2. Community Supports Quality Metrics

Community Supports	Candidate Measures – Health Condition Specific	Candidate Measures – Not Health Condition Specific	Notes
1115 Community Supports			
Recuperative care		**AMB-ED** - ED Utilization **AHU** - Acute Hospital Utilization **AAP -** Adults' Access to Preventive/ Ambulatory Health Services **Housing Stability** **SNF Admission and LOS –** Admission to skilled nursing facility and length of stay	Housing stability measured by member survey and available data.
Short-term post-hospitalization housing		**AMB-ED** - ED Utilization **AHU** - Acute Hospital Utilization **AAP -** Adults' Access to Preventive/ Ambulatory Health Services **PCR** – Plan All Cause Readmissions **Housing Stability** **SNF Admission and LOS –** Admission to skilled nursing facility and length of stay	Housing stability measured by member survey and available data.
1915(b) Community Supports			
Housing transition / navigation		**AMB-ED** - ED Utilization **AHU** - Acute Hospital Utilization **Housing Stability** **SNF Admissions** **SNF LOS**	Housing stability measured by available data.

Community Supports	Candidate Measures – Health Condition Specific	Candidate Measures – Not Health Condition Specific	Notes
Housing deposits		**AMB-ED** - ED Utilization **AHU** - Acute Hospital Utilization **Housing Stability** **SNF Admissions** **SNF LOS**	Housing stability measured by available data.
Housing tenancy and sustaining		**AMB-ED** - ED Utilization **AHU** - Acute Hospital Utilization **Housing Stability** **SNF Admissions** **SNF LOS**	Housing stability measured by available data.
Day habilitation		**Housing Stability Transition to SNF or Assisted Living.** **SNF Admissions** **SNF LOS**	Housing stability measured by available data.
Caregiver respite		**Housing Stability Transition to SNF or Assisted Living.** **SNF Admissions** **SNF LOS**	Housing stability measured by available data.
Nursing Facility transition / diversion to Assisted Living Facility	**Return to Skilled Nursing Facility within 6 Months**	**HFS - H**ospitalization **F**ollowing Discharge from a **S**killed Nursing Facility **Referrals to or enrollment in Assisted Living Waiver (ALW)** **SNF Readmissions** **SNF LOS**	No specific consensus metrics. Failure may lead to returning to SNF.
Community transition / Nursing Facility to home	**Return to Skilled Nursing Facility within 6 Months**	**HFS - H**ospitalization **F**ollowing Discharge from a **S**killed Nursing Facility	No specific consensus metrics.

Community Supports	Candidate Measures – Health Condition Specific	Candidate Measures – Not Health Condition Specific	Notes
		Referrals to or enrollment in Assisted Living Waiver (ALW) **SNF Readmissions** **SNF LOS**	Failure may lead to returning to SNF.
Personal care and homemaker		**Housing Stability** **Transition to Assisted Living or SNF.** **SNF Admissions** **SNF LOS**	Housing stability measured by available data.
Medically Tailored Meals	**CBP** - Controlling High Blood Pressure **HBD** - Hemoglobin HbA1c Control for Patients with Diabetes – Poor Control (HbAIc > 9%) **EDH** - Emergency Department Visits for Hypoglycemia in Older Adults with Diabetes	**AMB-ED** - ED Utilization **AHU** - Acute Hospital Utilization (any and LOS) **Transition to SNF or Assisted Living (and SNF LOS)**	Weight loss / malnutrition is not measurable
Sobering centers	**FUA - Follow-Up After ED Visit for Substance Use—30 days** **ETOH-specific ED visits**	**AMB-ED** - ED Utilization **AHU** - Acute Hospital Utilization **AAP -** Adults' Access to Preventive/ Ambulatory Health Services	
Environmentally Accessible Adaptations	**Falls resulting in fracture**	**AMB-ED** - ED Utilization **AHU** - Acute Hospital Utilization **AAP -** Adults' Access to Preventive/ Ambulatory Health Services	No specific /consensus measures.

Community Supports	Candidate Measures – Health Condition Specific	Candidate Measures – Not Health Condition Specific	Notes
		Transition to SNF or Assisted Living.	
Asthma remediation	**AMR** – Asthma Medication Management: Continuation Phase Treatment **Asthma-specific ED visits** **Use of Oral Steroids**	**AMB-ED** - ED Utilization **AHU** - Acute Hospital Utilization **AAP -** Adults' Access to Preventive/ Ambulatory Health Services	Metrics reflect overuse of rescue medications OR need for rescue visit to ED.

Note:

Primary data sources for metrics are available administrative data (including routine assessments that may be available to DHCS and the evaluation team) and member surveys specific to the evaluation.

Not every CS may have an expert consensus quality metric that can be assigned. In this case, we can create alternative metrics with face validity using available data.

For most CS services, specific chronic care management measures from MCAS and HEDIS (such as receipt of appropriate recommended care, e.g. receipt of colonoscopy, testing for diabetics, testing for hyperlipidemia, and care follow-up) would be relevant for interventions promoting housing stability, given that individuals with stable housing are more likely to be able to accomplish these tasks but are not listed above for space considerations.

SNS-E (Social Need Screening and Intervention) HEDIS measure is quite relevant to the current work, but this measure is a clinical records system-based metric and is not reported to MCAS.

Appendix 3. Projected Budget and Independent Evaluators

Projected Budget

Exhibit A2. Community Supports Evaluation Estimated Budget

COSTS	Year 1: N/A*	Year 2: 7/1/24 – 6/30/25	Year 3: 7/1/25-6/30/26	Year 4: 7/1/26-6/30/27	Year 5: 7/1/27-6/30/28	Year 6: 7/1/28-5/31/29	TOTAL
Personnel (including fringe benefits)	-	530,249	605,871	563,695	581,354	541,762	2,822,931
Other Direct Costs (Rent, TIF, etc.)	-	13,364	14,259	13,978	14,354	13,788	69,743
Chart Abstraction	-	0	100,000	100,000	0	0	200,000
Survey – Post-Hospitalization Transitional Housing	-	50,000	50,000	50,000	50,000	0	200,000
Survey – Recuperative Care	-	0	100,000	100,000	100,000	0	300,000
Survey – Transitional Rent	-	0	200,000	0	0	0	200,000
Data & Statistical Support (DOMSTAT)	-	17,118	17,632	18,160	18,705	16,605	88,220
Indirect Costs (F&A)	-	131,433	245,239	186,347	165,053	124,450	852,522
TOTAL COSTS							**4,733,416**

*The CS Evaluation was not implemented until Year 2 of the CalAIM1115 Evaluation.

More information about these costs is as follows:

Personnel. This includes all staff time to complete the evaluation plan. Staff roles include research scientists, project managers, research analysts, research associates, and statisticians, and data programmers. Their work covers all oversight and planning, design, data collection, analysis, reporting, coordination, and all other tasks related to the successful completion of the evaluation plan. The personnel budget line includes fringe benefits.

Other Direct Costs. This includes office rent, Technology Infrastructure Fees (TIF), and General and Employment Liabilities (GAEL).

Chart Abstraction. Hospital chart abstraction (post-hospitalization transitional housing) will focus on the initial and final aspects of hospitalization to measure (1) severity of illness, (2) instability at discharge, (3) discharge location, and (4) discharge treatment plan. Chart abstraction will focus on up to 1,000 completed charts – 500 individuals who received post-hospitalization transitional housing and 500 matched individuals. Costs include personnel costs, implementation and set up, quality assurance and error correction, and IT and overhead costs.

Survey – Post-Hospitalization Transitional Housing. This includes all survey costs including subcontractor costs, translation, printing, and mailing. Compensation for survey respondents is also included in this budget line.

Survey – Recuperative Care. This includes all survey costs including subcontractor costs, translation, printing, and mailing. Compensation for survey respondents is also included in this budget line.

Survey – Transitional Rent. This includes all survey costs including subcontractor costs, translation, printing, and mailing. Compensation for survey respondents is also included in this budget line.

Data and Statistical Support (DOMSTAT). The UCLA Department of Medicine Statistics Core (DOMSTAT) provides investigators at UCLA with state-of-the-art statistical support and supports study design, data management, and statistical analysis.

Indirect Costs. This includes Facilities and Administrative rate (F&A). The University of California F&A rate (base: modified total direct costs) pertains to this California State-Funded off-campus project.

Other. Other costs include software, materials, supplies, etc. and is included within the Core budget.

Independent Evaluation Team

DHCS selected the Regents of the University of California on behalf of its Los Angeles campus (UCLA) as the Independent Evaluator to perform the Independent Evaluation of Community Supports. The contract includes two subcontractors – the RAND Corporation, and the University of California (UC) at Berkeley. UCLA, RAND and UC Berkeley agreed to conduct the evaluation in an independent manner in accordance with the draft Evaluation Design. The independent evaluators consider the unique goals of Community Supports and the overarching impact on CalAIM and population health. The Independent Evaluator's approaches consider structural changes, cost of care, quality of care, and access to care, all of which provide a picture of the beneficiary's experience and impact to the state's administration of the program overall. Furthermore, UCLA-RAND is responsible for developing the evaluation design, as well as reporting results of the evaluation in the Interim and Summative Evaluation Reports.

Attachment U
Community Supports Appendix

Attachment U
Community Supports Appendix
Updated December 16, 2024

Service	Service Definition	Eligibility	Duration	Settings
Short-term Post-Transition Housing	Services for eligible individuals who do not have a residence to continue their physical/psychiatric/substance use disorder recovery and need for appropriate medical care upon exiting an institution. Based on the individual's needs and a person's level of care, the services provided may include appropriate physical, mental health, and SUD care, including psychiatric supports as determined by a qualified medical professional, as well as additional supports including: • Support for gaining /regaining ability to perform ADLs • Case management, including connections to Enhanced Care Management The Community Support of housing transition navigation services must be offered to all beneficiaries during	An individual must be exiting an institution. An institution is described as including: short-term recuperative care, inpatient hospital (either acute or psychiatric or Chemical Dependency and Recovery hospital), residential SUD or mental health treatment facility, correctional facility, or nursing facility. An individual must have one of the following: • Receiving enhanced care management, or • Have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. • Individuals who meet the U.S. Department of Housing and Urban Development 's (HUD)	No more than six months in duration. Subject to the global cap of no more than 6 months of HRSN housing interventions that include room and board supports, per beneficiary, in any rolling 12-month period.	Only facility types with appropriate clinical supports, consistent with the STCs, are eligible. These can include, but is not limited to: • Health Centers and Other Clinics • Wellness / Respite Centers • Social Service Centers • Skilled Nursing Facilities • Assisted Living Facilities • Residential Group Homes or Small Apartment Buildings • Community Centers

Service	Service Definition	Eligibility	Duration	Settings
	the period of Short-Term Post- Transition Housing to prepare them for transition from this setting. These housing transition navigation services should include a housing assessment and the development of individualized housing support plan to identify preferences and barriers related to successful housing tenancy after Short-Term Post- Transition Housing.	current definition of homeless and individuals who are at- risk of homelessness as codified at 24 CFR 91.5, with three modifications: (1) if exiting an institution, individuals are considered homeless if they were homeless immediately prior to entering that institutional stay, regardless of the length of the institutionalization; (2) the timeframe for an individual or family who will imminently lose housing is extended from fourteen (14) days for individuals considered homeless and 21 days for individuals considered at-risk of homelessness under the current HUD definition to thirty (30) days and (3) for the at risk of homelessness definition at 24 CFR 91.5, the requirement to have an annual income below 30		

Service	Service Definition	Eligibility	Duration	Settings
		percent of median family income for the area, as determined by HUD, will not apply; and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or • An individual must have on-going physical or behavioral health needs as determined by a qualified health		

Service	Service Definition	Eligibility	Duration	Settings
		professional that would otherwise require continued institutional care if not for receipt of post- transition housing.		
Short-Term Recuperative Care (Medical Respite)	Short-term residential care and ongoing need of medical care, including monitoring of the individual's physical or behavioral health condition, such as: • monitoring of vital signs • assessments • wound care • medication monitoring • limited or short-term assistance with Instrumental Activities of Daily Living &/or ADLs 2 • Coordination of transportation to post- discharge appointments • Connection to any other on-going services an individual may require including mental health and substance use disorder services • Support in accessing benefits and housing	Individuals requiring on-going recovery in order to heal from an injury or illness and who meet the following criteria: • The U.S. Department of Housing and Urban Development's (HUD) current definition of homeless and individuals who are at- risk of homelessness as codified at 24 CFR 91.5, with three modification s: (1) if exiting an institution, individuals are considered homeless if they were homeless immediately prior to entering that institutional stay, regardless of the length of the institutionalization; (2) the timeframe for an individual or family who will imminently lose housing is extended from	No more than six months in in duration. Subject to the global cap of no more than 6 months of HRSN housing interventions that include room and board supports, per beneficiary, in any rolling 12-month period.	Only facility types, with appropriate clinical supports added, consistent with requirements in the STCs, are eligible. These can include, but is not limited to: • Health Centers and Other Clinics • Wellness/ Respite Centers • Social Service Centers • Skilled Nursing Facilities • Assisted Living Facilities • Residential Group Homes or Small Apartment Buildings • Community Centers

Service	Service Definition	Eligibility	Duration	Settings
	• Gaining stability with case management relationships and programs	fourteen (14) days for individuals considered homeless and 21 days for individuals considered at-risk of homelessness under the current HUD definition to thirty (30) days; and (3) For the at risk of homelessness definition at 24 CFR 91.5, the requirement to have an annual income below 30 percent of median family income for the area, as determined by HUD, will not apply.		

Attachment V
Contingency Management Procedures and Protocols

Attachment V
Contingency Management Procedures and Protocols

In accordance with the State's "California Advancing and Innovating Medi-Cal (CalAIM)" Section 1115(a) Demonstration Waiver (Project Number 11-W-00193/9) and Special Terms and Conditions (STCs), this protocol provides additional detail regarding the distribution of motivational incentives to Medi-Cal beneficiaries receiving contingency management as required by STCs 55 and 57. The Department of Health Care Services' (DHCS) contingency management program is based on established clinical research demonstrating effective contingency management treatment and California's unique needs. The contingency management treatment program consists of a structured 24-week outpatient contingency management program, during which motivational incentives will be available, followed by six or more months of additional recovery support services, during which motivational incentives will not be available. DHCS' contingency management program may be provided to eligible Medi-Cal beneficiaries and is intended to complement other substance use disorder (SUD) treatment services already offered by Drug Medi-Cal Organized Delivery System (DMC-ODS) providers. Motivational incentives earned through DHCS' contingency management program shall be excluded from participating beneficiaries' modified adjusted gross income (MAGI)-based eligibility determinations, non-MAGI-based eligibility determinations, and share of cost determinations when determining those beneficiaries' eligibility for Medi-Cal.

I. Treatment Framework

A. Beneficiary Eligibility and Participation. Beneficiaries who meet the contingency management eligibility criteria detailed in STC 54 and who consent to treatment may participate in the contingency management program. A participating beneficiary will be considered to have dropped out of the contingency management program if they are absent from contingency management services for more than 30 days. If the beneficiary later returns to the contingency management provider, they will be invited to re-start the contingency management program if they continue to meet eligibility criteria. Participation in contingency management will have no impact on beneficiary eligibility for, or obligation or right to use, other DMC-ODS services.

B. Incentives. Beneficiaries will receive motivational incentives, as defined in STC 55, for meeting the target behavior of stimulant-non-use as demonstrated by point-of-care UDTs. At the discretion of the State and consistent with STC 55, the definition of target behavior may be revised in accordance with the evidence-base for contingency management as a treatment intervention for SUD to include non-use of substances other than stimulants, and/or other target behaviors such as treatment/medication adherence. During the initial phase of the pilot, DHCS shall set a maximum dollar amount of total incentives in a calendar year that participating beneficiaries will be able to receive for successful completion of the treatment protocol. As described in Attachment V, Section IV below, and consistent with the guardrails described in STC 55, providers have no discretion to determine the size or distribution of motivational incentives.

Attachment V, Sections I.C-F below describe an example of how DHCS will implement

the incentive delivery schedule and corresponding dollar amounts. The final delivery schedule and corresponding dollar amounts are subject to change by DHCS.

C. Treatment Schedule Overview. The contingency management program will consist of two phases: 1) contingency management treatment; followed by 2) contingency management aftercare.

Contingency management treatment will consist of a 24-week outpatient program, during which motivational incentives will be available for meeting the target behavior of stimulant-non-use. Weeks 1–12 of contingency management treatment will serve as the escalation/reset/recovery period, and weeks 13–24 will serve as the maintenance period.

After completing 24-weeks of contingency management treatment, the participating beneficiary will receive contingency management aftercare consisting of six months, or more, of aftercare and treatment services to support ongoing recovery (e.g., counseling and peer support services). During the period of contingency management aftercare, participating beneficiaries may receive informal engagement and recovery-oriented support from DMC-ODS providers, as well as covered DMC-ODS services, including but not limited to Recovery Services.

D. Weeks 1-12: Escalation/Reset/Recovery Period. During the initial 12 weeks of the contingency management treatment, participating beneficiaries will be asked to visit the treatment setting in person for a minimum of two treatment visits per week. Visits will be separated by at least 72 hours (e.g., Monday and Thursday/Friday, or Tuesday and Friday) to help ensure that drug metabolites from the same drug use episode will not be detected in more than one UDT. Participating beneficiaries will be able to earn motivational incentives during each visit the UDT indicates they have a negative sample for stimulants (or other target behaviors, such as a negative sample for other substances, or treatment adherence/medication, as determined by the State and consistent with Section VII of the STCs).

The initial motivational incentive value for the first sample negative for stimulants in a series is $10. For each week the participating beneficiary demonstrates non-use of stimulants (i.e., two consecutive UDTs negative for stimulants), the value of the motivational incentive is increased by $1.50. The maximum aggregate motivational incentive a participating beneficiary can receive during this initial 12-week period is $438.

A “reset” will occur when the participating beneficiary submits a positive sample or has an unexcused absence. The next time they submit a stimulant-negative sample, their motivational incentive amount will return to the initial value of $10.

A “recovery” of the pre-reset value will occur after two consecutive stimulant-negative urine samples. At that time, the participating beneficiary will recover their previously earned motivational incentive level without having to restart the process.

E. Weeks 13-24: Maintenance Period. During weeks 13–24, participating beneficiaries will be asked to visit the treatment setting for testing a minimum of once a week. During weeks 13–18, participating beneficiaries will be eligible to receive $15 per stimulant-negative UDT. During weeks 19–23, they will be eligible to earn $10 per stimulant-negative test, and if their sample is stimulant-negative on week 24, they will earn $21. The maximum aggregate motivational incentive a participating beneficiary will be able to receive during weeks 13–24 is $161.

F. Hypothetical Example: Incentive Delivery Schedule for Perfect Performance. Table 1 illustrates an incentive delivery schedule for a participating beneficiary in a scenario where the beneficiary has a consistent attendance record and submits samples that are stimulant-negative during each visit over the 24-week period.

Table 1: Sample Incentive Delivery Schedule	
Week	**Incentive for Stimulant-Free Test**
Week 1	$10.00 + $10.00 = $20
Week 2	$11.50 + $11.50 = $23
Week 3	$13.00 + $13.00 = $26
Week 4	$14.50 + $14.50 = $29
Week 5	$16.00 + $16.00 = $32
Week 6	$17.50 + $17.50 = $35
Week 7	$19.00 + $19.00 = $38
Week 8	$20.50 + $20.50 = $41
Week 9	$22.00 + $22.00 = $44
Week 10	$23.50 + $23.50 = $47
Week 11	$25.00 + $25.00 = $50
Week 12	$26.50 + $26.50 = $53
Weeks 13-18	$15.00 per week/test
Weeks 19-23	$10.00 per week/test
Week 24	$21.00 per week/test
Total	**$599**

Note: The incentive delivery schedule and corresponding dollar amounts in the section above are an illustrative example of how DHCS will implement the contingency management program. This incentive delivery schedule and corresponding dollar

amounts are subject to change by DHCS.

II. Contingency Management Provider and Staffing Criteria

A. Contingency Management Providers. DMC-ODS providers meeting the criteria detailed in STC 57 and other applicable STCs (e.g., per STC 53, residential providers cannot deliver contingency management; per STC 56, contingency management providers must comply with data reporting requirements) will be eligible to deliver the contingency management benefit

B. Contingency Management Coordinator. At least one trained contingency management coordinator will administer the participating DMC-ODS provider's contingency management program. The contingency management coordinator must meet the practitioner requirements listed in STC 57(c).

C. Role of the Contingency Management Coordinator. The contingency management coordinator will be the main point of contact for all contingency management program participating beneficiaries and will be responsible for collecting UDT samples, inputting test results, and supporting the delivery of motivational incentives as described in Attachment V, Section IV below.

III. Urine Drug Testing

During each visit, the contingency management coordinator will collect a urine sample from the participating beneficiary. The sample will be tested for stimulants, including cocaine, amphetamine and methamphetamine, as well as for opioid, to rapidly indicate whether recent stimulant use occurred (or other substance use defined by the State and consistent with STC 55). Samples will be collected in a point-of-care test cup with specimen validity measures.

IV. Incentive Delivery

A. Overview. The contingency management coordinator will immediately inform the participating beneficiary of the results of the UDT, and enter the results into a secure incentive management program that includes strict safeguards against fraud and abuse. The incentive management program will compute the appropriate motivational incentive earned according to the protocol detailed above in Attachment V, Section I. The incentive amount can be immediately delivered electronically to participating beneficiaries via e-gift cards sent to participating beneficiaries' emails, sent to the provider to print the gift card, or delivered using other strategies developed by the incentive management program. The immediate delivery of the motivational incentive to the beneficiary following the determination of the motivational incentive amount earned by the incentive management program is a critical component of the contingency management benefit and consistent with the evidence-base.

B. Incentive Calculations. A secure incentive management program will automatically calculate the appropriate motivational incentive amount based on the UDT results with adjustments for the escalating value, reset and recovery features as described above in Attachment V, Section I. The program will be designed to prevent tampering with, modifying or overriding the protocol amounts. Upon each visit, the results of the UDT will be entered into the incentive management program. The incentive management program will operate using an algorithm based on the motivational incentive delivery schedule described above. Using this algorithm, when a result is entered, the program will report the amount of any motivational incentive the participating beneficiary should receive per the protocol. A positive test for stimulants will result in the participating beneficiary receiving no motivational incentive. A negative test for stimulants (or other substances as defined at State discretion and consistent with STC 56) will result in an incentive amount as indicated by the software, considering escalations and resets.

C. Oversight. As a safeguard against fraud, waste and abuse, the contingency management coordinator, or other staff trained in the delivery of contingency management under the supervision of a Licensed Practitioner of the Healing Arts (LPHA) consistent with STC 57 when the contingency management coordinator is not available, will be permitted to enter the results of the participating beneficiary's UDT into the incentive management program during the visit. On a recurring basis, the DMC-ODS provider must conduct and document that a regular audit of the incentive delivery functions has been completed, including the software calculations recommended and incentive distributed. This provider audit must be conducted by an individual who has responsibility for overseeing the use of organizational funds (e.g., program or fiscal manager). The providers will be required to routinely submit the results of the audit to their DMC-ODS contracted county. The DMC-ODS county will be required to share the results of the audits with DHCS.

D. Incentive Delivery Method and Parameters. After the motivational incentive amount is determined, the incentive management program will disburse the motivational incentive and will track all motivational incentives awarded to all participating beneficiaries, including the date the incentive was distributed and the amount of the motivational incentive.

E. Incentive Types. To redeem earned motivational incentives consistent with the protocol described in this Attachment V, participating beneficiaries will be able to choose gift or debit cards from a range of retail outlet options to use or redeem the incentive balance, with restrictions placed on the incentives so they are not used to purchase cannabis, tobacco, alcohol or lottery tickets.

Attachment W
Reentry Demonstration Initiative Qualifying Conditions and Pre-Release Services

Attachment W
Reentry Demonstration Initiative Qualifying Conditions and Pre-Release Services

Table 1. Adult Health Care Need Criteria Definitions for the Reentry Demonstration Initiative

Qualifying Condition	Definition
Mental Illness	A person with a "Mental Illness" is a person who is currently receiving mental health services or medications OR meets both of the following criteria: i. The beneficiary has one or both of the following: a. Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities; AND/OR b. A reasonable probability of significant deterioration in an important area of life functioning; AND ii. The beneficiary's condition as described in paragraph (i) is due to either of the following: a. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems; OR b. A suspected mental disorder that has not yet been diagnosed.
Substance Use Disorder (SUD)	A person with a "Substance Use Disorder" is a person who either: i. Meets SUD criteria, according to the criteria of the current editions of the Diagnostic and/or Statistical Manual of Mental Disorders and/or the International Statistical Classification of Diseases and Related Health Problems; OR ii. Has a suspected SUD diagnosis that is currently being assessed through either National Institute of Drug Abuse (NIDA)-modified Alcohol, Smoking and Substance Involvement Screening Test (ASSIST), American Society of Addiction Medicine (ASAM) criteria, or other state-approved screening tool.
Chronic Condition or Significant Non-Chronic Clinical Condition	A person with a "Chronic Condition" or a "Significant Non-Chronic Clinical Condition" shall have ongoing and frequent medical needs that require treatment and can include one of the following diagnoses, as indicated by the individual, and may be receiving treatment for the condition, as indicated: • Active cancer; • Active COVID-19 or Long COVID-19;

Qualifying Condition	Definition
	• Active hepatitis A, B, C, D, or E; • Advanced liver disease; • Advanced renal (kidney) disease; • Dementia, including but not limited to Alzheimer's disease; • Autoimmune disease, including but not limited to rheumatoid arthritis, Lupus, inflammatory bowel disease, and/or multiple sclerosis; • Chronic musculoskeletal disorders that impact functionality of activities of daily living, including but not limited to arthritis and muscular dystrophy; • Chronic neurological disorder; • Severe chronic pain; • Congestive heart failure; • Connective tissue disease; • Coronary artery disease; • Currently prescribed opiates or benzodiazepines; • Currently undergoing a course of treatment for any other diagnosis that will require medication management of three or more medications or one or more complex medications that requires monitoring (e.g. anticoagulation) therapy after reentry; • Cystic fibrosis and other metabolic development disorders; • Epilepsy or seizures; • Foot, hand, arm, or leg amputee; • Hip/pelvic fracture; • HIV/AIDS; • Hyperlipidemia; • Hypertension; • Incontinence; • Severe migraine or chronic headache; • Moderate to severe atrial fibrillation/arrhythmia; • Moderate to severe mobility or neurosensory impairment (including, but not limited to spinal cord injury, multiple sclerosis, transverse myelitis, spinal canal stenosis, peripheral neuropathy); • Obesity; • Peripheral vascular disease; • Pressure injury or chronic ulcers (vascular, neuropathic, moisture-related); • Previous stroke or transient ischemic attack (TIA); • Receiving gender affirming care; • Active respiratory conditions, such as severe bronchitis, COPD, asthma or emphysema;

Qualifying Condition	Definition
	• Severe viral, bacterial, or fungal infections; • Sickle cell disease or other hematological disorders; • Significant hearing or visual impairment; • Spina Bifida or other congenital anomalies of the nervous system; • Tuberculosis; or • Type 1 or 2 diabetes.
Intellectual or Developmental Disability	A person with an "Intellectual or Developmental Disability" is a person who has a disability that begins before the individual reaches age 18 and that is expected to continue indefinitely and present a substantial disability. Qualifying conditions include intellectual disability, cerebral palsy, autism, Down syndrome, and other disabling conditions as defined in Section 4512 of the California Welfare and Institutions Code.
Traumatic Brain Injury	A person with a "Traumatic Brain Injury" means a person with a traumatic brain injury or other condition, where the condition has caused significant cognitive, behavioral, and/or functional impairment.
HIV/AIDS	A person with "HIV/AIDS" means a person who has tested positive for either human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) at any point in their life.
Pregnant or Postpartum	A person who is "Pregnant or Postpartum" is a person who is either currently pregnant or within the 12-month period following the end of the pregnancy.

Table 2. Service Definitions for the Reentry Demonstration Initiative.

Covered Service	Definition
Case Management	Case management will be provided in the period up to 90 days immediately prior to the expected date of release and is intended to facilitate reentry planning into the community in order to: (1) support the coordination of services delivered during the pre-release period and upon reentry; (2) ensure smooth linkages to social services and supports; and (3) ensure arrangement of appointments and timely access to appropriate care and pre-release services delivered in the community. Services shall include: • Conducting a health risk assessment, as appropriate; • Assessing the needs of the individual in order to inform development, with the client, of a discharge/reentry person-centered care plan, with input from the clinician providing consultation services and correctional facility's reentry planning team; o While the person-centered care plan is created in the pre-release period and is part of the case management pre-release service to assess and address physical and behavioral health needs and HRSN identified, the scope of the plan extends beyond release; • Obtaining informed consent, when needed, to furnish services and/or to share information with other entities to improve coordination of care; • Providing warm linkages with designated managed care plan care managers (including potentially a care management provider, for which all individuals eligible for pre-release services will be eligible) which includes sharing discharge/reentry care plans with managed care plans upon reentry; • Ensuring that necessary appointments with physical and behavioral health care providers, including, as relevant to care needs, with specialty county behavioral health coordinators and managed care providers are arranged; • Making warm linkages to community-based services and supports, including but not limited to educational, social, prevocational, vocational, housing, nutritional, transportation, childcare, child development, and mutual aid support groups; • Providing a warm hand-off, as appropriate, to post-release case managers who will provide services under the Medicaid state plan or other waiver or demonstration authority; • Ensuring that, as allowed under federal and state laws and through consent with the beneficiary, data are shared with

Covered Service	Definition
	managed care plans, and, as relevant, to physical and behavioral health/SMI/SUD providers to enable timely and seamless hand-offs; • Conducting follow-up with community-based providers to ensure engagement was made with individual and community-based providers as soon as possible and no later than 30 days from release; and • Conducting follow up with the individual to ensure engagement with community-based providers, behavioral health services, and other aspects of discharge/reentry planning, as necessary, no later than 30 days from release.
Physical and Behavioral Health Clinical Consultation Services	Physical and behavioral health clinical consultation services include targeted preventive, physical and behavioral health clinical consultation services related to the qualifying conditions. Clinical consultation services are intended to support the creation of a comprehensive, robust and successful reentry plan, including: conducting diagnosis, stabilization and treatment in preparation for release (including recommendations or orders for needed labs, radiology, and/or medications); providing recommendations or orders for needed medications and durable medical equipment (DME) that will be needed upon release; and consulting with the pre-release care manager to help inform the pre-release care plan. Clinical consultation services are also intended to provide opportunities for clients to meet and form relationships with the community-based providers who will be caring for them upon release, including behavioral health providers, and enable information sharing and collaborative clinical care between pre-release providers and the providers who will be caring for the client after release, including behavioral health warm linkages. Services may include, but are not limited to: • Addressing service gaps that may exist in correctional care facilities; • Diagnosing and stabilizing individuals while incarcerated, preparing them for release; • Providing treatment, as appropriate, in order to ensure control of qualifying conditions prior to release (e.g. to suggest medication changes or to prescribe appropriate DME for post-release); • Supporting reentry into the community; and • Providing behavioral health clinical consultation which includes services covered in the State Plan rehabilitation

Covered Service	Definition
	benefit but is not limited to clinical assessment, patient education, therapy, counseling, SUD Care Coordination (depending on county of residence), Peer Support services (depending on county of residence), and Specialty Mental Health Services Targeted Case Management covered in the Medi-Cal State Plan.
Laboratory and Radiology Services	Laboratory and radiology services will be provided consistent with the State Plan.
Medications and Medication Administration	Medications and medication administration will be provided consistent with the State Plan.
Medication-Assisted Treatment	• MAT for Opioid Use Disorders (OUD) includes all medications approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262) to treat opioid use disorders as authorized by the Social Security Act Section 1905(a)(29). • MAT for Alcohol Use Disorders (AUD) and Non-Opioid Substance Use Disorders includes all FDA-approved drugs and services to treat AUD and other SUDs. • Psychosocial services delivered in conjunction with MAT for OUD as covered in the State Plan 1905(a)(29) MAT benefit, and MAT for AUD and Non-Opioid Substance Use Disorders as covered in the State Plan 1905(a)(13) rehabilitation benefit, including assessment; individual/group counseling; patient education; prescribing, administering, dispensing, ordering, monitoring, and/or managing MAT. Services may be provided by correctional facilities that are not DMC-certified providers as otherwise required under the State Plan for the provision of the MAT benefit.
Community Health Worker Services	Community Health Worker Services will be provided consistent with the Community Health Worker State Plan.
Services Provided Upon Release	Services provided upon release include: • Covered outpatient prescribed medications and over-the-counter drugs (a minimum 30-day supply as clinically appropriate, consistent with approved Medicaid State Plan). • DME consistent with Medi-Cal State Plan requirements.

Attachment X
Health-Related Social Needs (HRSN) Community Supports Protocol

SPECIAL TERM AND CONDITION 8.11: HEALTH-RELATED SOCIAL NEEDS COMMUNITY SUPPORTS PROTOCOL

CALIFORNIA ADVANCING AND INNOVATING MEDI-CAL (CALAIM) SECTION 1115(A) DEMONSTRATION (PROJECT NUMBER 11-W-00193/9)

MAY 2024

The California Department of Health Care Services (DHCS) is submitting to the Centers for Medicare and Medicaid Services (CMS) this deliverable to satisfy the requirement within the Special Terms and Conditions (STCs) of the California Advancing and Innovating Medi-Cal (CalAIM) Section 1115(a) demonstration (Project Number 11-W-00193/9). STC 8.11 outlines that DHCS must submit, for CMS review and approval, the Health-Related Social Needs Community Supports (HRSN) Protocol (Protocol) covering the HRSN services authorized in this demonstration. Once approved, the Protocol will be affixed as Attachment X to the CalAIM 1115 STCs. The state may stagger the submission of this Protocol with the Maintenance of Effort (MOE; see STC 8.14) information, submitted no later than 90 days after the inclusion of this STC in the demonstration approval. The remaining content of the Protocol must be submitted to CMS no later than nine months after this STC is effective.

Community Supports are an important part of care delivery for addressing members with HRSN, including for those enrolled in Enhanced Care Management (ECM), another key CalAIM program launched by DHCS that provides systematic coordination of services and comprehensive care management to address the clinical and non-clinical needs of high-need, high-cost Medi-Cal Members. As such, DHCS encourages Managed Care Plans (MCPs) to offer a robust menu of Community Supports services to comprehensively address the needs of members—including those with the most complex challenges affecting health, such as homelessness, unstable and unsafe housing, food insecurity, and/or other health-related social needs. **The responses below specifically pertain to the Community Supports authorized under CalAIM 1115 waiver authority –i.e., Short-Term Post-Transition Housing (STPTH) and Short-Term Recuperative Care**.

a. A description of the process for identifying beneficiaries with HRSN, including outlining beneficiary qualification criteria for services.

MCPs are required to use a variety of methods to identify members who may benefit from Community Supports, including, but not limited to, referrals; the MCP's utilization management processes; and provider documentation in the member's care plan. One important method for member identification is through referrals. MCPs are required to inform members and their networks of providers about Community Supports, and on the process to request Community Supports. MCPs must consider requests for Community Supports from members, and on behalf of members, from their families, guardians or caregivers, ECM providers, Community Supports providers, other providers,

and community-based organizations (CBOs). MCPs must also train their call centers about how to manage referrals for Community Supports. DHCS expects MCPs to source the majority of referrals for Community Supports from the community – i.e., from the MCP's network of providers (inclusive of PCPs and other clinical providers, ECM and Community Supports providers) and other community-based referral sources already serving members – whether they are Community Supports providers themselves or not. Thus, it is expected that MCPs will establish strong referral relationships with Community Supports providers and a wide range of organizations in the community, including developing a process for receiving and responding to referral requests from a wide range of sources.

MCPs must be actively monitoring sources of referrals for Community Supports, levels of member engagement/receipt of Community Supports based off referral type, and improving overall referral and engagement patterns to improve Community Supports utilization among eligible members. As part of this monitoring, MCPs should track referral sources to measure how many Community Supports referrals originate from community-based sources, rather than from the MCP itself.

b. A description of the process by which clinical criteria will be applied, including a description of the documented process wherein a provider, using their professional judgment and based on clinical and social risk factors, as applicable, may deem the service to be medically appropriate.

To support members' access to any offered Community Supports, MCPs must have nondiscriminatory authorization processes in place to determine eligibility for members for each Community Support, in accordance with the service definitions approved by DHCS in the MCP's contract with DHCS and as further detailed in the Community Supports All Plan Letter 21-017 *(Revised)* and *Medi-Cal Community Supports, or In Lieu of Services (ILOS), Policy Guide* (Policy Guide). The Policy Guide contains eligibility population sets for each Community Support service, which considers a member's clinical and social factors to determine if the member would qualify for the respective service. Further, DHCS requires MCP policies and procedures detailing how MCPs will identify members for whom a Community Support is a medically appropriate alternative to a state plan service or setting, especially for hard-to-reach populations. As part of the authorization process, MCPs must document their process for ensuring documentation of support for the medical appropriateness of the Community Support. This process must detail that provision of the Community Support, recommended by a provider at the plan or network level using their professional judgement, is likely to reduce or prevent the need for acute care or other Medicaid services, including, but not limited to,

inpatient hospitalizations, skilled nursing facility stays, or emergency department visits. Therefore, the Community Support is medically appropriate for that member. This process may be incorporated into the MCP's utilization management process or may include provider-level documentation in an individual's care plan or other record. The service definitions for several Community Supports already require this documentation.

Most members who receive Community Supports will also qualify for either ECM or CCM. In these instances, MCPs may use ECM or CCM care plans to document member needs that qualify them for a Community Support and ensure it is a medically appropriate substitute for a state plan service. This process may apply to any Community Support provided to a member who is also in one of these care/case management programs.

c. A description of the process for developing care plans based on assessment of need that is also culturally responsive, and trauma informed.

MCPs are contractually required to provide medically necessary covered services in a culturally responsive way and adopt trauma-informed care approaches in order to improve member engagement and health outcomes. Members are assessed for short-term post-transition housing and short-term recuperative care (medical respite) as part of the member's person-centered care planning.

Short-Term Post-Transition Housing

Short-Term Post-Transition Housing is intended to provide members who do not have a residence and who have high medical or behavioral health needs with the opportunity to continue their medical/psychiatric/substance use disorder (SUD) recovery immediately after exiting an inpatient hospital (either acute, psychiatric or chemical dependency and recovery hospital); residential SUD treatment or recovery facility; residential mental health treatment facility; correctional facility; nursing facility; or short-term recuperative care and avoid further utilization of state plan services.

This setting must provide individuals with ongoing supports necessary for recuperation and recovery such as gaining (or regaining) the ability to perform activities of daily living, receiving necessary medical/psychiatric/SUD care, case management, and beginning to access other housing supports such as Housing Transition Navigation.

This setting may include an individual or shared interim housing setting, where residents receive the services described above. Congregate sleeping space, facilities that have been temporarily converted to shelters (e.g., gymnasiums or convention centers),

facilities in which sleeping spaces are not available to residents 24 hours a day, and facilities without private sleeping space are not allowable settings.

Members must be offered Housing Transition Navigation supports during the period of Short-Term Post-Transition Housing to prepare them for transition from this setting. These services should include a housing assessment and the development of individualized housing support plan to identify preferences and barriers related to successful housing tenancy after Short-Term Post-Transition Housing.

The services provided should utilize best practices for members who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma-Informed Care.

Short-Term Recuperative Care (Medical Respite)

Short-Term Recuperative Care, also referred to as medical respite, is short-term residential care for individuals who no longer require hospitalization, but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment. An extended stay in a recovery care setting allows individuals to continue their recovery and receive post-discharge treatment while obtaining access to primary care, behavioral health services, case management and other supportive social services, such as transportation, food, and housing.

At a minimum, the service will include interim housing with a bed and meals and ongoing monitoring of the individual's medical or behavioral health condition (e.g., monitoring of vital signs, assessments, wound care, medication monitoring). Based on individual needs, the service may also include:

- Limited or short-term assistance with Instrumental Activities of Daily Living;
- Coordination of transportation to post-discharge appointments;
- Connection to any other on-going services an individual may require, including mental health and SUD services;
- Support in accessing benefits and housing; and
- Gaining stability with case management relationships and programs.

Short-Term Recuperative Care is used for those individuals who are experiencing homelessness or those with unstable living situations who are too ill or frail to recover

from an illness (physical or behavioral health) or injury in their usual living environment; but are not otherwise ill enough to be in a hospital.

The services provided to an individual while in Short-Term Recuperative Care should not replace or be duplicative of the services provided to members utilizing ECM. Short-Term Recuperative Care may be utilized in conjunction with other housing Community Supports. Whenever possible, other available housing Community Supports should be provided to members onsite in the Short-Term Recuperative Care facility. When enrolled in ECM, Community Supports should be managed in coordination with ECM providers.

The services provided should utilize best practices for members who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma-Informed Care.

d. A plan for establishing and/or improving information technology (IT) infrastructure, data sharing and partnerships with an array of health system and social services stakeholders, to the extent those entities are vital, to provide needed administrative and HRSN-related data on beneficiary characteristics, eligibility, screenings, referrals, and provision of services, which are critical for understanding program implementation and conducting demonstration monitoring and evaluation.

DHCS has adopted a multifaceted strategy to strengthen the delivery system's IT framework. This includes enhancing capabilities for MCPs and Community Supports providers to access vital data, supporting both administrative and care management functions. Outlined below are the following: data system requirements; policy guidance, including California's Data Exchange Framework; and investments being made to develop delivery system capacity and infrastructure.

Data Sharing and Data System Requirements for MCPs

DHCS requires that all MCPs offering Community Supports have the IT infrastructure and data analytic capabilities to support Community Supports, including the capabilities to:

- Consume and use claims and encounter data, as well as other data types listed in Community Supports Contract (See Template Section 6: Identifying Members for Community Supports);
- Assign members to Community Supports providers;
- Keep records of members receiving Community Supports and their consent;

- Securely share data with Community Supports provider;
- Receive, process, and send encounters and invoices from Community Supports providers to DHCS;
- Receive and process supplemental reports from Community Supports providers;
- Send Community Supports supplemental reports to DHCS; and,
- Open, track, and manage referrals to Community Supports providers.

Community Supports providers and MCPs may need to re-configure their existing systems to meet these requirements.

To mitigate administrative burden on Community Supports providers who contract with more than one MCP in particular, MCPs may not require Community Supports providers to utilize their MCP portal for documentation of all services and day-to-day work, such as notes and care plans. MCPs may rely on portals for sharing the information contained in the Member Information Sharing Guidance document (detailed below). Furthermore, MCPs may still offer access to MCP's care management documentation system for all functions, and providers may still choose to take this option. MCPs who may be unsure of how to strike the required balance between robust data sharing with providers and mitigating administrative burden on providers, are advised to contact DHCS for further discussion.

Member Information Sharing Guidance

Many Community Supports providers are CBOs delivering and billing for Medicaid services for the first time. DHCS heard consistent feedback that Community Supports providers and MCPs were challenged by the variation with which information exchange was occurring to support the delivery of Community Supports. Specifically, providers were receiving, and were being asked to share, non-standardized member-level data elements with MCPs in different formats and transmission methods, leading to excessive administrative burden.

Based on this feedback, DHCS released the *CalAIM Data Guidance: Community Supports Member Information Sharing Guidance* (Published: April 2023) to define standards for two key exchanges of information between MCPs and Community Supports providers:

1. **MCP Community Supports Authorization Status File**, in which MCPs share updated authorization status with each contracted Community Supports provider for all members referred by and/or assigned to their organization to receive Community Supports services.

2. **Community Supports Provider Transmission File**, in which Community Supports providers share timely updates about service delivery with MCPs.

This guidance defines a standard set of "minimum necessary" data elements, as well as file formats, transmission methods, and transmission frequencies, to initiate and track the progress of Community Supports service delivery. It was informed by extensive stakeholder engagement, including through a market survey, and conducting interviews with MCPs, Community Supports providers, and Health Information Organizations (HIOs). DHCS continues to explore additional ways of improving infrastructure, enhancing data exchange, and supporting partnerships between health and social service stakeholders and providers.

Additional Guidance on Coding and Data Sharing

DHCS released *CalAIM Data Guidance: Billing and Invoicing between ECM/Community Supports Providers and MCPs* (Updated: April 2023) to provide further instructions for MCP encounter coding and reporting. In addition, DHCS released the *CalAIM Data Sharing Authorization Guidance* in October 2023 to provide guidance to a wide range of individuals and organizations that are providing or overseeing the delivery of health services to people receiving services authorized under CalAIM. It provides specific guidance on data privacy and data sharing consent laws, regulations, and rules for Medi-Cal partners while also navigating important legal protections and includes a description of processes and scenarios that illustrate how data may be shared to support the provision of Community Supports services. DHCS continues to develop and disseminate Community Supports guidance to its contracted MCPs and Community Supports Provider.

» Data Exchange Framework Data Sharing Agreement

DHCS has also defined a single data sharing agreement and common set of policies and procedures governing the exchange of health and social services information among health care entities and government agencies in California. In September 2023, DHCS released APL 23-013 *(Revised)* to inform MCPs of their requirement to sign the California Health and Human Services Agency (CalHHS) Data Exchange Framework (DxF) Data Sharing Agreement (DSA). This DSA defines the parties that are subject to the DxF's new data exchange rules and establishes a common set of terms, conditions, and obligations to support the secure exchange of and access to health and social services information in compliance with applicable laws, regulations, and policies. This promotes whole person care and helps ensure that medical, behavioral, and social services systems in

California are able to work together and securely share information pertinent to an individual's health and wellbeing.

Finally, DHCS has identified program design refinements around referral processes to enable better administrative and HRSN-related data on beneficiary characteristics and to support service delivery to more members.

Data Sharing Requirements for Community Supports Providers

As noted, Community Support providers, especially CBOs new to the Medicaid delivery system, do not have these capabilities to submit standard claims or encounters to MCPs, which is the primary form of data sharing among providers and MCPs. Community Support providers are allowed to submit invoices to MCPs, and MCPs then convert the invoices to encounters for submission to DHCS.

If the Community Supports provider is paid by the MCP on a fee-for-service (FFS) basis, they are expected to generate a claim and send it to the MCP for payment processing if possible. If not possible, the Community Supports provider must send an invoice with a minimum set of data elements necessary for the MCP to convert that information into a compliant 837P encounter that is subsequently submitted to DHCS.

If a Community Supports provider is paid by the MCP on a capitated basis, then the provider is expected to generate and submit a compliant encounter to MCPs. If this is not possible, the Community Supports provider must send a paid invoice with a minimum set of data elements necessary for the MCP to convert that information into a compliant 837P encounter that the plan subsequently submits to DHCS.

DHCS has clarified under APL 23-020 *(Revised)* that MCPs must work with Community Support providers to offer providers training on MCP's billing, invoicing, and claiming processes.

Investments in the Delivery System

Managed Care Plan Incentives

The Community Supports initiative required significant new, and early, investments in care management capabilities; Community Supports infrastructure; IT and data exchange; and workforce capacity across MCPs, city and county agencies, providers, and other CBOs. Effective January 1, 2022, DHCS implemented the Incentive Payment Program (IPP), which was intended to complement and support the growth of ECM and Community Supports, as well as quality and performance improvements and reporting in areas such as Long-Term Services and Supports and other cross-delivery systems.

Further, IPP was also designed to help drive change at the MCP and provider levels through building appropriate and sustainable capacity; driving MCP investment in necessary delivery system infrastructure; bridging current silos across physical and behavioral health care service delivery; reducing health disparities and promoting health equity; achieving improvements in quality performance; and incentivizing MCP take-up of Community Supports.

Providing Access and Transforming Health

DHCS also received targeted expenditure authority as part of its section 1115 demonstration renewal for the Providing Access and Transforming Health (PATH) program. The PATH program is intended to maintain, build, and scale the infrastructure and capacity necessary to ensure successful implementation of ECM and Community Supports. There are five key initiatives within PATH, including:

- **Collaborative Planning and Implementation Initiative:** this initiative, which began providing funding in December 2022, provides support for collaborative planning and implementation groups to promote readiness for ECM and Community Supports.
- **Capacity and Infrastructure Transition, Expansion and Development (CITED) initiative:** this initiative, which is application based, provides grant funding to enable the transition, expansion, and development of capacity and infrastructure to provide ECM and Community Supports.
- **Technical Assistance Marketplace Initiative:** this initiative provides technical assistance to providers, community-based organizations, county agencies, public hospitals, tribal partners, and others in order to successfully implement ECM and Community Supports.
- **Justice-Involved Capacity Building:** this initiative provides funding to support collaborative planning, as well as infrastructure and capacity needed to maintain and build pre-release enrollment and suspension process and implement pre-release services to support implementation of the full suite of statewide CalAIM justice-involved initiatives in 2023.
- **WPC Services and Transition to Managed Care Mitigation:** this initiative provides direct funding for services provided by former WPC pilot Lead Entities until the comparable ECM and Community Support services transition to managed care coverage under CalAIM.

DHCS Monitoring and Evaluation

DHCS is using existing encounter data reporting mechanisms in accordance with the MCP contract for MCPs to report on Community Supports, while simultaneously utilizing a Quarterly Implementation Monitoring Report (QIMR) process using supplemental templates to fill in any gaps and for future data reconciliation purposes. These data feed into DHCS' public reporting, *ECM and Community Supports Quarterly Implementation Report*, as well as internal tools to support DHCS in conducting ongoing monitoring activity.

e. A plan for tracking and improving the share of Medicaid beneficiaries who are eligible for the Supplemental Nutrition Assistance Program (SNAP) who are enrolled in that program, the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), and federal and state housing assistance programs, relative to the number of total eligible beneficiaries, including establishing a timeline for reporting.

In the MCP Contract, DHCS requires all MCPs to enter into Memorandums of Understanding (MOU) with various Third-Party Entities (defined below) to ensure member care is coordinated and members have access to community-based resources in order to support whole-person care, including making referrals to Supplemental Nutrition Assistance Program (SNAP), the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), and federal and state housing assistance programs.

The Third Party Entities including but not limited to: Specialty Mental Health Services in Medi-Cal Mental Health Plans, SUD Services in Drug Medi-Cal Organized Delivery System (ODS) Counties, local health jurisdictions, County Social Services Programs and Child Welfare, Women, Infants and Children (WIC), local governmental agencies, First 5 County Commissions, Local Educational Agencies, California Department of Corrections and Rehabilitations, county jails, and youth correctional facilities.

DHCS issued All Plan Letter 23-029 and is releasing superseding APLs and detailed guidance, which included a MOU requirements for MCPs and relevant third parties, baseline MOU template with required minimum provisions across all MOUs and a bespoke template with program-specific provisions for engagement with specific third parties. The MOUs are intended to clarify roles and responsibilities among parties, support local engagement, and facilitate care coordination and the exchange of information necessary to enable care coordination and improve the referral processes between the parties. The MOUs are also intended to improve transparency and accountability by setting forth certain existing requirements for each party as it relates

to service or care delivery and coordination so that the parties are aware of each other's obligations.

The MOU was intended to memorialize the data sharing protocols between the MCP and the Other Party in order to support care coordination and enable monitoring.

Quarterly Progress Reporting

MCPs must demonstrate a good faith effort to meet the requirements of DHCS guidance beginning in January 1, 2024 in accordance with DHCS guidance. MCPs that are unable to execute their MOUs by the required execution date for MOUs must submit quarterly progress reports and documentation to DHCS demonstrating evidence of their good faith effort to execute the MOU.

DHCS Submissions and Reports

MCPs must submit all fully executed MOUs to DHCS. In their submissions, MCPs must attest that they did not modify any of the mandatory provisions of the Base Template or Bespoke Templates to the extent it does not conflict with or reduce either party's obligations under the Base Template or Bespoke Templates. If the MCP modifies any of the provisions of the Base Template or Bespoke Templates, the MCP must submit a redlined version of the MOU to DHCS for review, prior to execution.

MOU Monitoring and Reporting

Starting January 1, 2025, MCPs must submit an annual report that includes updates from the quarterly meetings and the results of their annual MOU review. The quarterly meetings are to discuss care coordination activities and the specific MOU related issues. The report must include the following elements:

- A list of all attendees, including MCP Responsible Person(s), leadership, and county executives;
- All care coordination and referral concerns discussed;
- Strengths, barriers, and plans to improve effective collaboration between the MCP and the Other Party;
- All disputes and resulting outcomes;
- Strategies to address duplication of services; and,
- Member engagement challenges and successes

To continuously evaluate the effectiveness of the MOU processes, MCPs must review their MOUs annually to determine if any amendments are needed, including incorporating any applicable contractual requirements and policy guidance to their MOUs. The annual report submission must include evidence of the annual review as well as copies of any MOUs amended or renewed as a result. The evidence of the annual review described in the annual report must include a summary of the review process and outcomes, and any resulting amendments to the MOU or policies and procedures.

f. Information as required per STC 8.14 (MOE).

DHCS is submitting to CMS this deliverable to satisfy the requirement within the STCs of CalAIM Section 1115(a) demonstration (Project Number 11-W-00193/9). STC 8.14 outlines that DHCS must submit a plan to CMS for CMS approval that specifies how the state will determine baseline spending for ongoing social services related to housing transition supports, not including one-time or non-recurring spending.

STC 8.14 reads, in full:

> 8.14. **Maintenance of Effort (MOE).** The state must maintain a baseline level of state funding, which the state will submit to CMS for CMS approval, for ongoing social services related to housing transition supports for the duration of the demonstration, not including one time or non-recurring funding. Within 90 days of the approval of the demonstration amendment to integrate the community supports in the HRSN framework, as part of the HRSN Community Supports Protocol, the state will submit a plan to CMS for CMS approval that specifies how the state will determine baseline spending on these services. The annual MOE will be reported and monitored as part of the Annual Monitoring Report described in STC 14.5, with any justifications, including declines in available state resources, necessary to describe the findings.

Determination of Baseline Spending and Annual MOE

DHCS will determine baseline spending for ongoing social services related to housing transition supports, not including one-time or non-recurring spending, by surveying the Fiscal Forecasting Branch of the California Department of Social Services (CDSS) for a list of programs, and associated appropriations, that meet the definition of ongoing social services related to housing transition supports. To ensure completeness and consistency of reporting, DHCS will utilize the same method for collecting data for annual MOE reporting required by STC 8.15 of the CalAIM 1115 waiver STCs as for the annual MOE reporting required by STC 10.18 of the BH-CONNECT 1115 waiver STCs.

DHCS has provided the programs that should be considered in determining baseline spending and the relevant appropriation amounts further below in Appendix A. The appendix also contains detail regarding other social services programs that were evaluated but did not meet the definition due to not being ongoing social services or not specifically providing housing transition supports.

2023-2024 Appropriation

The table below provides funding breakouts tied to the 2023-24 Appropriation (as of the May 2023 Revision), and a link to the premise write-up with specific details of the program.

2023-24 Appropriation

Budget Item	Total	Federal	State/Other
Transitional Housing Supplement	$5,284,000	$1,329,000	$3,955,000
Family Stabilization	$54,960,000	$47,974,000	$6,986,000
Housing Support Program	$95,000,000	$56,105,000	$38,895,000

The State assesses the following program meets the definition of ongoing social services related to housing transition supports:

- Transitional Housing Supplement - Administration: Provides a housing supplement for youth participating in eligible Transitional Housing Placement programs based on the Fair Market Rate for each county published by the United States Department of Housing and Urban Development.
- Family Stabilization: In addition to an increased level of case management, Family Stabilization may include *transitional housing*, emergency shelter, rehabilitative services, counseling, and other services. Note, providing transitional housing is not a requirement of the program.
- Housing Support Program: Interventions are provided to CalWORKs families to help obtain and keep permanent housing by providing rent and move-in assistance, focused case management and individualized services (legal services, credit repair, etc.).

The following programs were evaluated but deemed not to meet the criteria:

- Domestic Abuse Homeless Assistance Program: Provides CalWORKs applicants two periods of 16 cumulative calendar days of temporary shelter assistance. Note, funding is not explicitly for transitional housing.
- Documents for Dependent Children: Social workers are provided 15 minutes per case to document information on the results of referrals to *transitional housing* or

other housing assistance efforts provided to a dependent child in the court report to be submitted at the last regularly scheduled review hearing before a dependent child attains 18 years of age. Note, funding is for administrative time for social workers.

- Housing for Non-Minor Dependents: Social workers will require one hour per case to evaluate placement and emergency housing resources. Note, funding is for administrative time for social workers.
- Housing and Disability Advocacy Program: Housing supports (outreach, case management) and disability benefit application assistance to people likely eligible for disability benefits and experiencing homelessness or at risk of homelessness.

g. Information as required per STC 8.15 (Partnerships with State and Local Entities)

STC 8.15 reads in full:

> 8.15. **Partnerships with State and Local Entities.** The state must have in place partnerships with other state and local entities (e.g., HUD Continuum of Care Program, local housing authority, SNAP state agency) to assist beneficiaries in obtaining non-Medicaid funded housing and nutrition supports, if available, upon the conclusion of temporary Medicaid payment for such supports, in alignment with beneficiary needs identified in the person-centered plans as appropriate. The state will submit a plan to CMS as part of the HRSN Community Supports Protocol that outlines how it will put into place the necessary arrangements with other state and local entities and also work with those entities to assist beneficiaries in obtaining available non-Medicaid funded housing upon conclusion of temporary Medicaid payment, as stated above. The plan must provide a timeline for the activities outlined. As part of the Quarterly and Annual Monitoring Reports described in STC 14.5, the state will provide the status of its fulfillment plan and progress relative to the timeline, and whether and to what extent the non-Medicaid funded supports are being accessed by beneficiaries as planned. Once the state's plan is fully implemented, the state may conclude its status updates in the Quarterly and Annual Monitoring Reports.

MCPs must make a good faith effort to execute MOUs with other parties beginning in January 1, 2024, as outlined below:

MOUs Effective January 1, 2024

Department	Program/Service
County Behavioral Health Departments	SUD Services in Drug Medi-Cal Organized Delivery System (ODS) Counties
Local Health Departments	Including, without limitation, California Children's Services (CCS), Maternal, Child, and Adolescent Health (MCAH), and Tuberculosis Direct Observed Therapy
WIC Local Agencies or Non-Profit Entities	WIC
Regional Centers	Intermediate Care Facility – Developmentally Disabled Services
Local Government Agencies (LGA)	In-Home Supportive Services (IHSS)
LGA/County Social Services Departments	County Social Services programs and Child Welfare

MOUs Effective July 1, 2024

Department	Program
LGA	County-Based Targeted Case Management (TCM)
County Behavioral Health Departments	SUD Treatment Services in Drug Medi-Cal State Plan Counties

MOUs Effective No Sooner than January 1, 2025

Third Party Entity
California Department of Corrections and Rehabilitation, county jails, and youth correctional facilities
First 5 County Commissions
Local Education Agencies (LEAs)

Attachment Y
Approved List of Designated State Health Programs (DSHPs)

The DSHP-eligible expenditures in this list exclude prohibited costs, in accordance with STC 10.1(e).

Program	Description	DSHP-Eligible Expenditures
Department of Developmental Services (DDS or Lanterman)	The Lanterman Act provides for the coordination and provision of services and supports to enable people with intellectual and developmental disability to lead more independent, productive, and integrated lives.	$1,950,977,576
Genetically Handicapped Persons Program (GHPP)	Health care program for adults with specific genetic diseases. GHPP helps beneficiaries with their health care costs. GHPP works with doctors, nurses, pharmacists, and other members of the health care team in providing many types of health services. DSHP-eligible expenditures are for GHPP only member and do not include Medicaid eligible individuals.	$541,856,000
Medically Indigent Long-Term Care (LTC)	Covers long-term care services only for individuals in skilled nursing or an intermediate care facility who do not have other linkage to the Medi-Cal program.	$83,451,730
Prostate Cancer Treatment Program (PCTP)	The PCTP, named Improving Access, Counseling & Treatment for Californians with Prostate Cancer (IMPACT), was developed to expand and ensure, high-quality prostate cancer treatment to uninsured and underinsured men with incomes at or below 200 percent of the federal poverty level.	$12,042,000
California Children Services (CCS)	Provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children with CCS-eligible medical conditions, including but not limited to chronic medical conditions such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries, and infectious diseases producing major sequelae. DSHP-eligible expenditures are for CCS only members and do not include Medicaid eligible individuals.	$343,546,000
Song Brown HealthCare Workforce	Provides grant funds to organizations to support the education and training of primary care professionals. Priority for funding is given to programs that demonstrate success in the following areas:	$310,624,000

Program	Description	DSHP-Eligible Expenditures
Training Program (Song Brown)	graduating individuals who practice in medically underserved areas; enrolling members of underrepresented groups in medicine to the program; locating the program's main training site in a medically underserved area; and operating a main training site where the majority of the patients are Medi-Cal recipients.	
Steven M. Thompson Physical Corp Loan Repayment Program (STLRP)	This program aims to increase the number of appropriate trained physicians providing direct patient care in a qualified facility or area in California.	$17,119,492
Total Allowable DSHP-Eligible Expenditures		$3,259,616,799
Total Allowable DSHP-Eligible Expenditures with 5% Adjustment		$3,096,635,959
Total DSHP Cap. The state must not claim more than the capped amount of DSHP.		$1,292,850,000

Attachment Z
Designated State Health Programs (DSHP) Claiming Protocol

I. CERTIFIED PUBLIC EXPENDITURES – DETERMINATION OF ALLOWABLE COSTS FOR STATE ONLY MEDICAL PROGRAMS

A. General Provisions

Program costs, for each program described in Attachment Y, mean the total expenditures incurred in the Demonstration Year (DY) from all the funding sources. Allowable DSHP expenditures will be applied against each DY using the date of service information from each paid claim. Allowable DSHP costs are DSHP costs for health care services which are allowable under section 1905(a) of the Social Security Act, rendered to the uninsured population.

Net program costs are program costs for health care services only. DSHP costs, for each program described in Attachment Y, are net program costs funded by the State and/or local funds.

Costs associated with providing non-emergency services to individuals who do not meet citizenship or immigration status requirements to be eligible for Medicaid. cannot be claimed. To implement this limitation, 5 percent of total certified public expenditures for services to uninsured individuals will be treated as expended for non emergency care to individuals who do not meet citizenship or immigration status requirements.

B. Program Funding and Claiming

CCS, GHPP, MIA/LTC, and BCCTP
Services are Medicaid-like services funded by the State General Fund. The State fiscal intermediary pays the program claims. Program costs will be compiled from the State fiscal intermediary Paid Claims Data using the specific Aid Codes to identify eligibility and the specific Billing Provider Type to identify the service types by date of services. The total program costs for each program funded by the State General Fund for the uninsured population will be used to determine allowable DSHP costs for reimbursement.

Prostate Cancer Treatment Program (PCTP)

PCTP is funded by State General Fund. Eighty seven percent of the total contract funding shall be used for direct patient care. No less than 70 percent of the total contract funding shall be expended on direct patient care treatment, which is defined as funding for fee-for-service providers for Medi-Cal eligible services at established MediCal rate.

PCTP services for direct patient care treatment are Medicaid-like services. PCTP is the payer of last resort for men who are not eligible for Medi-Cal or Medicare and have no access to local or county resources. PCTP total program costs incurred for direct patient care treatment will be used to determine allowable DSPH costs for reimbursement. PCTP program costs will be compiled from PCTP Paid Claims Data by treatment category and by the eligible population.

Department of Developmental Services (DDS)

DDS Community-Based Services are funded by the following funding sources:

- State Funds
  - State General Fund
  - Mental Health Services Fund
  - California Children and Family Trust Fund (Proposition 10 funding to create a comprehensive and integrated system of information and services to promote early childhood development (from prenatal to age 5) and school readiness, including community health care, quality childcare, and education programs for young children)
- Federal Funds
  - Medicaid (e.g., Home and Community Based Services Waiver (HCBS), Medicaid Administration, Targeted Case Management, 1915(i) State Plan Amendment, and Money Follows the Person Grant)
  - Title XX Block Grant (no State match or MOE is required)
  - Early Start Program Grant for infants and toddlers age 0 to 36 months
  - Foster Grandparents Program (administrative funding supports the volunteer program that establishes person-to-person relationship between low-income senior, age 55 years or older, and children with intellectual disabilities)
  - Homeland Security Grant (funding to regional centers for equipment, training, and exercise to prevent, respond to, and recover from acts of terrorism and other catastrophic events)
- Others
  - Program Development Fund (fees assessed to parents of children under the age of 18 who receive 24-hour out-of-home services purchased with State funds through a regional center)
  - Vocational Rehabilitation (funding by HCBS and GF for transportation expenditures)
  - Developmental Disabilities Services Account (application fees paid by housing developers to reimburse DDS' costs for review and approval of the housing proposals)

The above represents all funding received by DDS for community-based services. The federal funds are deposited into the State General Fund as reimbursement for appropriate claims initially paid from the State General Fund. DDS services to individuals not eligible for Medi-Cal are Medicaid-like services in that they are the same services as State plan approved services and services provided under approved HCBS waivers for Medi-Cal beneficiaries. DDS services applicable to this claiming protocol include uninsured Medicaid-like services provided under Community Based Services to individuals age 3 years and older, including assessment, evaluation and diagnostic services.

Allowable DSHP costs will be the community-based Purchase of Services (POS) expenditures, which exclude administrative expenditures, adjusted for the following exclusions:

- DDS community-based POS costs that are not related to Medicaid-like healthcare services, including:
    - POS contract costs
    - Expenditures for Community Placement Plan (funds paid to regional centers for permanent housing placement)
    - Expenditures for Medical Facilities (payments to Intermediate Care Facilities and Developmentally Disabled Continuous Nursing Care for services not eligible for Medi-Cal).
    - Proposition 10/California & Family Trust Fund expenditures (funds paid to regional centers for development of comprehensive and integrated system of information and services to promote early childhood development and school readiness)
- DDS community-based POS costs related to Medicaid-like healthcare services funded by other payers, including:
    - Expenditures for Early Start program (including federal funds and State matching/MOE funds)
    - Expenditures for services to Medi-Cal beneficiaries (including federal funds, State matching funds, and Vocational Rehabilitation funds)
    - Expenditures related to services eligible for Federal Title XX funds
    - Program Development Fund

DDS program costs will be compiled from DDS POS Claims Data file using Eligibility Codes to identify the uninsured population, Budget Codes to identify the funding sources, and Service Codes to identify the eligible services.

II. CERTIFIED PUBLIC EXPENDITURES – DETERMINATION OF ALLOWABLE COSTS FOR WORKFORCE DEVELOPMENT PROGRAMS

A. General Provisions

Program costs, for each HCAI program described below, mean the total expenditures incurred in the Demonstration Year (DY) from all the funding sources.

Program costs are the expenditures necessary to maintain and support WDPs, including State operation expenditures, loan repayment, and award payments. Net program costs are program costs for award or loan repayments funded by the State or local only. Allowable costs, for each HCAI program described below, are limited to the net program costs paid in the months of each DY per the STCs.

WDP costs will be compiled from the statewide financial system which identifies the actual State expenditures for award payments. All costs claimed must be reasonable, allowable, and allocable under OMB Circular A-87.

B. Program Funding and Claiming

Song-Brown Healthcare Workforce Training Program (Song-Brown Program)

The Song-Brown Program is currently funded by the California Health Data and Planning Fund (CHDPF), a special fee charged to CA licensed health facilities, and the State General Fund (GF). The State pays the program claims.

Steven M. Thompson Physician Corps Loan Repayment Program (STLRP)

STLRP is funded through $25 surcharge for renewal of allopathic physician licenses in CA and through the Managed Care Administrative Fines and Penalties Fund.

Attachment AA
DSHP Sustainability Plan

Attachment AA

DSHP Sustainability Plan

I. Objective

a. This plan meets the requirements of Section 10.6 of the Special Terms and Conditions (STCs) of California's Section 1115 Waiver, the California Advancing and Innovating Medi-Cal (CalAIM) Demonstration (Project Numbers 11-W-00193/9 and 21-W-00077/0) and describes the scope of DSHP-funded initiatives California wants to maintain and the strategy to secure resources to maintain these initiatives beyond the current waiver period.

II. CalAIM DSHP-funded Initiatives

a. As noted in STC 10.3, all PATH initiatives and programs described in STC 5.14 and 5.15, excluding expenditures on Support for Sustaining Services Through the Transition to Managed Care (as described in STC 5.14.a), are DSHP-funded Initiatives.

b. Scope and Description of Initiatives under STC 5.14 and 5.15, excluding 5.14.a

California received targeted expenditure authority for the "Providing Access and Transforming Health" (PATH) initiative as part of its Section 1115 demonstration renewal. This initiative aims to scale whole person approaches to care statewide, emphasizing equity, integrated and comprehensive care, and a smooth transition from the WPC and Health Homes programs. This transition will retain investments made by the state, local partners, and the federal government. PATH will provide one-time funding for services for members during the transition to CalAIM and provide tools and resources to county and community-based providers. These providers include hospitals, county, city, and other government agencies, justice agencies, community-based organizations (CBOs), Medi-Cal Tribal and Designees of Indian Health Programs, and others to ensure successful implementation.

PATH consists of four distinct but aligned initiatives supporting the implementation of Enhanced Care Management (ECM) and Community Supports services in many ways:

1. *Capacity and Infrastructure Transition Expansion and Development (CITED)*
2. *Collaborative Planning and Implementation (CPI)*
3. *Justice-Involved Capacity Building Program (JI)*
4. *Technical Assistance Marketplace (TAM)*

Capacity and Infrastructure Transition Expansion and Development (CITED)

CITED provides funding to enable the transition, expansion and development of Enhanced Care Management (ECM) and Community Supports capacity and infrastructure. CITED applicants are encouraged to coordinate their applications with local organizations they contract with or intend to contract with to provide ECM and/or Community Supports services. Applicants who wish to receive CITED funding must submit an application and funding request indicating how they intend to use CITED funding.

Applicants that receive CITED funding must be actively contracted to provide ECM/Community Supports or have a signed attestation from an Medi-Cal Managed Care Plan (MCP) or other entity that they intend to contract with to provide ECM/Community Supports in a timely manner. MCPs are not eligible to receive CITED funding. Applicants may include, but are not limited to:

- *Community Based Organization (CBO)*
- *County, City, or Local Government Agency*
- *Federally Qualified Health Center (FQHC)*
- *Medi-Cal Tribal and Designee of Indian Health Program*
- *Providers (including but not limited to hospitals and provider organizations)*
- *Others as approved by DHCS*

As CITED applicants are already contracted, this in turn means that rates have been negotiated to provide billable services and sustain long-term operations. Additionally, applicants are required to demonstrate in their application how ECM and Community Supports supported by their award will remain sustainable following the expenditure of their CITED funding. Examples of clear sustainability plans include analysis of current needs in the area they operate, analysis of current staffing models and caseloads required to sustain services based on MCP rates, and description of the time it will take to ramp up billable services to support CITED-funded staff, resulting in a decrease for salary support over the timeframe of the salary request. Applicants that do not clearly describe their sustainability plan are not awarded CITED funding. For example, some awarded applications clearly described how they leveraged support from the TA Marketplace to assess current demand, understand timelines to receive payments from MCPs, and assess reasonable caseloads required to maintain sustainability when determining the total number of Full Time Equivalent (FTEs) requested for each position. Additionally, CITED allowable use guidance focuses on start-up expenses directly related to expanding long-term capacity for awardees to provide ECM and Community Supports. Expenses that are regular, ongoing, or subscription-type items are not

allowable, and applicants must demonstrate long-term plans are in place to sustain requested budget items after their award period. Lastly, there are time limits on salary support requests which cap salary support (across all CITED rounds) at 12 months for existing positions and 18 months for new positions.

Collaborative Planning and Implementation (CPI)

The PATH Collaborative Planning and Implementation (CPI) initiative provides funding for county and regional collaborative planning efforts to support the implementation of Enhanced Care Management (ECM) and Community Supports. Participant registration will remain open throughout the Collaborative Planning initiative. Collaborative Planning and Implementation groups are composed of stakeholders in a county or region that work together to identify, discuss, and resolve topical implementation issues and identify how PATH and other CalAIM funding initiatives may be used to address topical program implementation gaps and improve outcomes.

The Collaborative Planning and Implementation objectives are for local providers' and stakeholders' various needs to shape collaborative planning and implementation activities by county or region. Example focus areas for Collaborative Planning and Implementation groups include:

- *Identifying ECM/Community Supports needs and gaps within the community*
- *Identifying and resolving implementation issues*
- *Monitoring how PATH funds are used to address implementation issues and disseminating best practices*

Collaborative Planning and Implementation facilitators work with key stakeholders in each county or region to identify and invite entities to participate in local collaborative planning efforts, including entities that are contracted with MCPs to provide ECM/Community Supports services. Other entities may proactively register to participate, and all entities that apply for PATH funding through other initiatives (e.g. CITED, or TA Marketplace) will be invited to participate in their county or regional Collaborative Planning and Implementation group. The following entity types are eligible and are strongly encouraged to participate:

- *Community-Based Organization (CBO)*
- *County, City, or Local Government Agency*
- *Federally Qualified Health Center (FQHC)*
- *Managed Care Plans (MCPs)*
- *Medi-Cal Tribal and Designee of Indian Health Program*
- *Providers (including but not limited to hospitals and provider organizations)*

- *Others as approved by DHCS*

Efforts to continue engagement with contracted providers and entities to solicit feedback and input will continue but do not require additional funding beyond the waiver. During the final two years of the waiver period, CPI collaboratives will work with local participants, including MCPs, focusing efforts on the long-term sustainability of ECM and Community Supports through various activities, such as sharing best practices and developed resources across various collaboratives and building cross-collaborative networks.

Justice-Involved Capacity Building Program (JI)

The PATH Justice-Involved Capacity Building Program (JI) provides funding to support the implementation of pre-release Medi-Cal application and suspension processes and provides funding to support collaborative planning, as well as IT system modifications necessary to implement pre-release Medi-Cal application and suspension processes. This program will award funding to correctional agencies, correctional institutions, and county social service departments (County SSDs) that will be made available in two rounds (Round 1 is for planning; Rounds 2 is for implementation). PATH JI also provides funding through Round 3 to support implementation of pre-release services through CalAIM justice-involved (JI) initiatives.

- *Round 1 is a planning grant funding opportunity that provides small planning grants to correctional agencies (or an entity applying on behalf of a correctional agency) to support collaborative planning with county SSDs and other enrollment implementation partners to identify processes, protocols, and IT modifications that are necessary to support the implementation of pre-release enrollment and suspension processes.*
- *Round 2 is an implementation grant funding opportunity that provides larger application-based grants to support entities as they implement the processes, protocols, and IT system modifications that were identified during the Round 1 planning phase. While entities do not need to participate in Round 1 in order to apply for Round 2 funding, the Round 1 planning grant funds provide an opportunity to support the development of a comprehensive application for Round 2 funding.*
- *Round 3 provides funding to support the planning and implementation of the provision of targeted pre-release Medi-Cal services to individuals in state prisons, county jails, and youth correctional facilities who meet the eligibility criteria as outlined in the CalAIM Section 1115 Demonstration approval. This funding will also support county behavioral health agencies to implement behavioral health linkages with state prisons, county jails, and youth correctional facilities to facilitate continued behavioral health treatment in the community. PATH funds*

will be available to support investments in personnel, capacity, and/or IT systems that are needed for collaborative planning and implementation in order to effectuate pre-release service processes. These PATH capacity-building funds are available to qualified entities and will be distributed based on how entities meet certain performance milestones.

The Sheriff's Office, probation department, California Department of Corrections and Rehabilitation (CDCR), and county behavioral health agencies to support behavioral health linkages will be eligible to submit one application per county agency. This application does not have a joint application requirement. In some counties, the Department of Public Health (or another county agency) actively manages correctional health care services and is responsible for coordinating and providing health services for individuals in correctional institutions. In these cases, the county agency that is responsible for coordinating and providing health care services should coordinate with the county sheriff or county probation office to assist in implementation plan development. DHCS requires that only one application from correctional facilities be submitted on behalf of all jails in the county or on behalf of all youth correctional facilities in each county. The following entities are eligible to apply for funding through this initiative:

- *County behavioral health agencies to support behavioral health linkages*
- *County Sheriff's Offices to support county jails*
- *County probation offices to support youth correctional facilities*
- *CDCR to support state prisons*

Suitability for PATH JI funding is reviewed based on an eligibility screening process at the initial application. Only eligible agencies will be considered for JI funding. Eligible JI agencies are only the CDCR, probation departments, sheriff departments, behavioral health agencies, and social services departments. Applicants must outline their plan for sustainability beyond PATH funding within their application (round 2) and implementation plan (round 3). Awardees' progress towards sustainability efforts is reviewed bi-annually as agencies submit their award milestones. DHCS and agencies utilize progress reports and 1:1 TA engagement to identify and address any sustainability concerns. The planning and implementation efforts will continue between DHCS, partners, and stakeholders. All grant milestones will be completed by the end of the waiver period.

Technical Assistance Marketplace (TAM)

The TA Marketplace initiative makes funding available for the provision of technical assistance (TA) for organizations that provide or intend to provide ECM and/or Community Supports. Applicants may apply for TA support from approved TA Vendors. TA

Vendors are promoted via a virtual "Marketplace," which serves as a one-stop-shop environment where entities can access TA resources and expertise.

*TA is available in seven domains, which were determined based on stakeholder listening sessions and the experiences of existing ECM and Community Supports providers (*TA Domains may be revised and expanded throughout the life of the initiative as new TA needs emerge):*

1. *Building Data Capacity*
2. *Community Supports*
3. *Engaging in CalAIM through Medi-Cal Managed Care*
4. *Enhanced Care Management (ECM)*
5. *Promoting Health Equity*
6. *Supporting Cross-Sector Partnerships*
7. *Workforce*

Eligible entities seeking TA are able to access: 1) "Off-the-Shelf" projects (e.g., "ready to go" TA offerings packaged for convenient, efficient delivery) available on the Marketplace, or 2) select a TA Vendor that can provide "Hands-On" TA services (e.g., customized TA projects tailored to the particular needs of the applicant). "Off-the-Shelf" projects are more standardized resources like training programs, well-defined program models or data tools, or best practices guides, that are relevant in a variety of settings with little to no customization. "Hands-On" projects will require the TA applicant and the selected TA Vendor to work together to develop a unique scope of work (SOW) and budget that describe the project and corresponding deliverables.

Through the TA Marketplace, several TA Recipients have received support with developing sustainable staffing models and identifying data and IT infrastructure systems to support ongoing service delivery. Current Off-the-Shelf projects supporting sustainability are included in multiple domains, including Building Data Capacity, Engaging in CalAIM through Medi-Cal Managed Care, and Workforce. Additionally, some Recipients have requested fully customized projects to support the streamlining processes, expanding referral networks, developing more efficient systems, and staff skill-building, with the goals of increased Member engagement and long-term sustainability. As part of the TA Marketplace, Recipients submit progress reports for each project in which they describe how the TA project has supported their ability to provide ECM and Community Supports and future sustainability.

III. Justification

a. These DSHP-funded initiatives were intended to be a one-time transition to support transition and initial CalAIM implementation.

b. California does not see a need to maintain these DSHP-funded initiatives beyond the current waiver period.

Sustainability is a core component in all PATH initiatives. Upon award, all PATH recipients detail the overall goals of their project, their ability to complete their project/goals within the spending timeframe, define services that will be provided by the applicant organization through PATH funding, and their approach to sustainability post PATH funding. Further, while start-up costs are allowable and encouraged in all PATH initiatives, the expectation is for awardees to plan for sustainability and ongoing costs upon project close-out.

Attachment BB
DSHP Related Provider Payment Increase Assessment Attestation Table

Attachment BB

California DSHP Related Provider Payment Increase Assessment – Attestation Table		
The reported data and attestations pertain to DSHP related provider payment increase requirements for the demonstration period of performance DY 19 through DY 22.		
Category of Service	**Medicaid Fee-for-Service to Medicare Fee-for-service Ratio**	**Medicaid Managed Care to Medicare Fee-for-service Ratio**
Primary Care Services	76.46%	88.9%
	Ratio derived under STC 11.5(b) utilizing CY 2021 utilization for codes representing 75% of utilization.	*Ratio derived under STC 11.6(b) utilizing Calendar Year 2021 encounter data for code set utilizing 75% of utilization*
Obstetric Care Services	62.46%	67.76%
	Ratio derived under STC 11.5 (b) utilizing Calendar Year 2021 utilization for code set utilized in Health Affairs article.	*Ratio derived under STC 11.6(b) utilizing Calendar Year 2021 encounter data for code set utilized in Health Affairs article*
Behavioral Health Services	92.61%	96.39%
	Ratio derived under STC 11.5(b utilizing Calendar Year 2021 utilization for top 10 codes that had corresponding Medicare Rate.)	*Ratio derived under STC 11.6(b) utilizing Calendar Year 2021 encounter data for top 10 utilized codes that had a corresponding Medicare Rate.*

In accordance with STCs 11.1 through 11.12, including that the Medicaid provider payment rates used to establish the ratios do not reflect fee-for-service supplemental payments, with the exception of any state plan payments made using revenue derived by The California Healthcare, Research, and Prevention Tobacco Tax Act (Proposition 56, 2016), and do not incorporate Medicaid managed care pass-through payments in accordance with 42 CFR § 438.6(a) and 438.6(d), I attest that at least a two percentage point payment increase will be applied to all the services in each of the three categories in each of the fee-for-service or managed care delivery systems with a ratio below 80 percent if these systems apply to the state's Medicaid program listed herein. Such provider payment increases for each service will be effective beginning on January 1, 2024 and will not be lower than the highest rate for that service code in DY 19 plus at least a two percentage point increase relative to the rate for the same or similar Medicare billing code through at least December 31, 2026, in the total amount of state expenditure of at least $21.76 million across affected delivery systems. For the purpose of deriving the Medicaid to Medicare provider payment rate ratio, and to apply the rate increase as may be required under a fee-for-service delivery system and under a managed care delivery system, the state agrees to define primary care, behavioral health and obstetric care, including identify applicable service codes and providers types for each of primary care, behavioral health and obstetric care in a manner consistent with other state and federal Medicaid program requirements, except that inpatient behavioral health services may be excluded. The services that comprise each service category to which the rate increase must be applied will include all service codes that fit under the state's definition of the category, except the behavioral health codes do not have to include inpatient care services. For provider payment rates paid under managed care delivery system, the data and methodology for any one of the service categories as provided in STC 11.6(b) will be based on Medicaid managed care provider payment rate and utilization data. The effective date of the rate increases is the first day of DY 20 and will be at least sustained, if not higher, through DY 22. The additional payment increases required under STC 11.2 will also be made in the total amount of state expenditure of at least $21.76 million across the affected delivery systems.
California does make Medicaid state plan fee-for-service payments for the following categories of service for at least some populations: primary care, behavioral health, and / or obstetric care. For any such payments, as necessary to comply with the DSHP STCs, I agree to submit by no later than December 31, 2023 for CMS review and approval the Medicaid state plan fee-for-service payment increase methodology, including the Medicaid code set to which the payment rate increases are to be applied, code level utilization, Medicaid and Medicare rates for the same or similar Medicare billing codes, and other data used to calculate the ratio, and the methodology, as well as other documents and supporting information (e.g., state responses to Medicaid funding questions) as required by statutes, regulations and CMS policy, through the submission of a new state plan amendment, following the normal SPA process including publishing timely tribal and public notice and submitting to CMS all required SPA forms (e.g., SPA transmittal letter, CMS-179, Attachment 4.19-B pages from the state), by no later than December 31, 2023.

The state will also provide similar documentation for the additional payment increases required under STC 11.2.
California does include the following service categories within a Medicaid managed care delivery system for which the managed care plans make payments to applicable providers for at least some populations: primary care, behavioral health, and or obstetric care. For any such payments, I agree to submit the Medicaid managed care plans' provider payment increase methodology, including the information listed in STC 11.7 through the state directed payments submission process and in accordance with 42 CFR 438.6(c), as applicable, by no later than *December 31, 2023*. The state will also provide similar documentation for the additional payment increases required under STC 11.2.
If the state utilizes a managed care delivery system for the applicable service categories, then in accordance with STC 11.8, I attest that necessary arrangements will be made to assure that 100 percent of the amount necessary, so that the Medicaid to Medicare ratio increases by two percentage points, will be paid by managed care plans to the providers of those service categories and none of this payment rate increase is retained by the managed care plans. The state will also assure that 100 percent of the additional payment increases under STC 11.2 will be paid to providers of the applicable services.
California agrees not to use DSHP funding to finance any provider payment rate increase required under Section 11. California further agrees not to decrease provider payment rates for other Medicaid- or demonstration-covered services to make state funds available to finance provider rate increases required under STC 11.
I, *Lindy Harrington, Assistant State Medicaid Director*, attest that the above information is complete and accurate. *Lindy Harrington, Assistant State Medicaid Director* April 26, 2023

Attachment CC
Reentry Demonstration Initiative Implementation Plan

Attachment CC

Reentry Demonstration Initiative Implementation Plan

Revised: October 2, 2024

Introduction:

On January 26, 2023, the Centers for Medicare & Medicaid Services (CMS) granted approval of California's request to amend the Section 1115(a) demonstration waiver "California Advancing and Innovating Medi-Cal (CalAIM)" to provide limited coverage for services furnished to a subset of incarcerated individuals for up to 90 days immediately prior to their expected dates of release.[10]

CalAIM Demonstration Special Term and Condition (STC) 9.9 requires California to submit a Reentry Demonstration Initiative Implementation Plan (hereinafter "Implementation Plan"). The following Implementation Plan details California's approach for meeting the five milestones outlined in STC 9.9 and additional conditions articulated in the CMS State Medicaid Director (SMD) Letter# 23-003, "Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated."[11]

The Implementation Plan, effective October 1, 2024, is organized around the following five Section 1115 Demonstration Waiver 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 individuals who are incarcerated to improve care transitions upon return to the community.
3. Promoting continuity of care.
4. Connecting to services available post-release to meet the needs of the reentering population.
5. Ensuring cross-system collaboration.

For each milestone, the Implementation Plan describes (1) a summary of how the State already meets any expectation and specific activities related to each milestone, and (2) any actions needed to be completed by the State to meet all the expectations for each milestone, including the persons or entities responsible for completing these actions and the timelines and activities the State will undertake to achieve the milestone.

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[10] 11-W-00193/9: "California CalAIM Demonstration." Available at https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-calaim-ca1.pdf.

[11] SMD# 23-003, "Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who are Incarcerated," April 17, 2023. Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd23003.pdf.

- DHCS is readying its systems and processes for a go-live in October 2024 and will commence conducting readiness assessments for facilities starting in the spring/summer of 2024. All facilities must go live by October 1, 2026. Nothing in this approval will supersede the state's compliance actions to meet all CAA of 2023 Section 5121 implementation requirements and timelines.

In addition to this Implementation Plan, DHCS released the "Policy and Operational Guide for Planning and Implementing CalAIM Demonstration Reentry Initiative" (hereinafter "Policy and Operational Guide") in October 2023.. (The expectation is that the Policy and Operational Guide will be updated as new policy and operational requirements are identified.) The Policy and Operational Guide provides detailed policy requirements and operational expectations for implementation of the CalAIM Demonstration Reentry Initiative. The audience of the Policy and Operational Guide is the State's implementation partners, including, without limitation, correctional facilities, county behavioral health agencies, county social service agencies/offices),[12] Medi-Cal Managed Care Plans (MCPs), Mental Health Plans (MHPs)/Drug Medi-Cal and Drug Medi-Cal Organized Delivery Systems (DMC/DMC-ODS), and community-based providers. The Policy and Operational Guide will be updated on an ongoing basis as implementation partners begin the process of standing up the CalAIM Demonstration Reentry Initiative.

[12] County social service agencies/offices are responsible for processing Medi-Cal applications and enrollment.

Milestone 1: Increasing coverage and ensuring continuity of coverage for individuals who are incarcerated

STC 9.9.a. The State must describe its plans to fully effectuate, no later than two years from approval of the expenditure authority, a state policy to identify Medicaid- eligible individuals or individuals who would be eligible for CHIP, except for their incarceration status, and suspend a beneficiary's eligibility or benefits during incarceration. It must describe its processes to undertake robust outreach to ensure beneficiary and applicant awareness of the policy and assist individuals with Medicaid application, enrollment, and renewal processes. Other aspects to be included in the Implementation Plan related to this milestone include the State's plan to make available a Medicaid and/or managed care plan identification number or card to an individual, as applicable, upon release; and establish processes to allow and assist all individuals who are incarcerated at a participating facility to access and complete a Medicaid application, including providing information about where to complete the Medicaid application for another State, e.g., relevant State Medicaid agency website, if the individual will be moving to a different State upon release.

CMS State Medicaid Director Letter Specific Requirements	Implementation Approach
1.a. Implement a State policy for a suspension strategy during incarceration (or implement an alternative proposal to ensure that only allowable benefits	***Current State:*** Effective January 1, 2023, all California county social services agencies/offices were required to suspend, rather than terminate, Medicaid coverage for the duration of an individual's incarceration.[13,14] Both adult and youth coverage is suspended for the duration of incarceration.[15,16] State guidance, published in November 2022, provides information related to implementing DHCS' Medicaid benefit suspension and unsuspension (activation) policies, including guidance on suspension timelines for

[13] See ACWDL 21-22 (October 28, 2021) for more information on suspension of Medi-Cal benefits for youth.
[14] Public Health Omnibus Bill, SB 184 (Chapter 47, Statutes of 2022), amended Welfare and Institutions Code § 14011.10(d).
[15] Public Health Omnibus Bill, Senate Bill (SB) 184 (Chapter 47, Statutes of 2022) amended Welfare and Institutions Code § 14011.10(d) in 2022.
[16] Under SB 184, beginning January 1, 2023, Medi-Cal benefits for adults must be kept in suspended status until the individual is no longer an inmate of a public institution. For individuals under the age of 21 or Former Foster Youth (FFY) under the age of 26, under the federal SUPPORT Act and State law (Welfare & Institutions Code § 14011.10 (e)(1) & (2)), the State and counties are prohibited from terminating Medicaid eligibility because the individual is an inmate of a public institution.

CMS State Medicaid Director Letter Specific Requirements	Implementation Approach
are covered and paid for during incarceration, while ensuring coverage and payment of full benefits as soon as possible upon release), with up to a two-year glide path to fully effectuate.	individuals with short-term stays.[17,18] The following summarizes the State's policy and operational approach: • Through the benefit suspension process, the correctional facility reports the member's incarceration status to the county; the social services agency/office will change an individual's Medi-Cal status from "active" to "suspended." While in the suspension period, the individual will be eligible to receive inpatient hospitalization and pre-release services (for no more than 90 days) only. Individuals receive a notice of action when their Medi-Cal coverage is suspended and again upon reactivation. • If inpatient hospital services are required during an individual's incarceration, the correctional facility can submit an application for the county or State Medi-Cal Incarceration Eligibility Program (MCIEP). MCIEP occurs at both a State and county level and allows Medi-Cal reimbursement for inpatient hospital stays of 24 or more hours for incarcerated individuals who are determined eligible for Medi-Cal. • All individuals found eligible for pre-release services, including individuals who were incarcerated for 28 days or less, will be assigned a specific aid code that will ensure the only services that will be provided and paid for are Reentry Demonstration Initiative services. DHCS required social services agencies/offices, County Sheriff's Departments and County Probation Departments to complete and submit readiness assessments in November 2022, through which they attested to their readiness to implement pre-release Medi-Cal application processes.[19] DHCS also implemented a monitoring plan to assess compliance with the mandate, including suspension and unsuspension processes, and ongoing implementation of the mandate.
	Future State: Planned Activities and Associated Timelines:

[17] See ACWDL 22-26 (October 28, 2022) for more information on suspension/unsuspension for individuals incarcerated and released to different counties, the annual renewal policy, change in circumstance redeterminations, and notices of action.
[18] See ACWDL 22-27 (November 10, 2022) for more information on pre-release application processes for juvenile and adult inmates of county correctional facilities and county youth correctional facilities.
[19] See MEDIL 22-46 and MEDIL 22-47 (November 10, 2022) for more information on the Pre-Release Medi-Cal Application Mandate Readiness Assessments for County Social services agencies/offices and County Sheriff's Departments and County Probation Departments.

CMS State Medicaid Director Letter Specific Requirements	Implementation Approach
	• DHCS required all counties to be in full compliance with the CalAIM Medi-Cal Pre-Release Application mandate by June 30, 2023; this mandate includes implementing suspension and reactivation processes described above. • Beginning July 2023, DHCS will implement enforcement actions, including requiring counties that are not in compliance to complete an ongoing Plan of Action and Milestones (POAM) and provide DHCS with bi-monthly updates until they are deemed compliant. (Ongoing, beginning July 2023) • To support tracking of implementation progress and monitoring, DHCS will also require social services agencies/offices, County Sheriff's Departments, and County Probation Departments to submit Pre-Release Medi-Cal application data on a quarterly basis, starting November 1, 2023.[20] **(November 2023)** • DHCS will continue to monitor and evaluate the State's pre-release suspension processes and make program changes, as needed, as pre-releases go live.[21] **(Ongoing)** • DHCS will continue to monitor and evaluate compliance with suspension processes and provide ongoing technical assistance to implementation stakeholders, including correctional facilities and county social services agencies/offices, as needed. **(Ongoing)**
	Challenges and Mitigation Approaches: • **Challenge**: Under Welfare and Institutions Code Section 14011.10(d), social services agencies/offices must suspend, rather than terminate, coverage for Medi-Cal members who are incarcerated for the duration of their incarceration. However, suspending Medi-Cal coverage for all incarcerated Medi-Cal members—and the time lags associated with doing so—may result in situations where individuals re-enter the community without active Medi-Cal, especially for those who were only incarcerated for several hours or days. ○ **Mitigation Approach**: For individuals likely subject to a short-term stay of incarceration, the benefit suspension will only be activated after the individual has been incarcerated for at least 28 days. The objective of this approach is to

[20] See MEDIL 23-24 (April 13, 2023) and Erratum to MEDIL 23-24 (I 23-24E (ca.gov) for more information on reporting requirements for pre-release application data.

[21] See MEDIL 23-24 (April 13, 2023) for more information on DHCS' monitoring plan for the CalAIM mandated pre-release Medi-Cal application process implementation.

CMS State Medicaid Director Letter Specific Requirements	Implementation Approach
	minimize gaps in coverage and ensure the individual has access to full benefits as quickly as possible upon release. Additionally and as noted, individuals found eligible for pre-release services, including those who were incarcerated for 28 days or less, will be assigned a specific aid code to ensure the only services that will be provided and paid for are Reentry Demonstration Initiative services. As noted above, DHCS will also continue to monitor and evaluate the State's pre-release suspension processes and make program changes, as needed. • **Challenge**: Some incarcerated individuals with suspended Medi-Cal may not have their coverage unsuspended upon community reentry due to communication delays or unclear understanding of roles and responsibilities between correctional facilities and social services agencies/offices, among other factors. ○ **Mitigation Approach**: DHCS is requiring that correctional facilities make every effort to notify the social services agency/office a week prior to the individual's expected release date, if known, and no later than one business day before the expected release date. If the release is unplanned, correctional facilities must make best efforts to notify social services agencies/offices within 24 hours of the unplanned release. DHCS is also specifying the specific data elements that must be communicated from the correctional facility to the social services agency/offices to support coordination (e.g., individual's full name (and any known aliases), date of birth, client identification numbers/Social Security numbers, and known/estimated release date). DHCS is also requiring that social services agencies/offices see the release from incarceration is reported, activate coverage within one business day of notification with the ultimate goal of ensuring the individual can access benefits upon release. As noted above, DHCS will also continue to monitor and evaluate compliance with suspension processes and provide ongoing technical assistance to implementation stakeholders, including correctional facilities and county social services agencies/offices as needed.
	Current State:

CMS State Medicaid Director Letter Specific Requirements	Implementation Approach
1.b. Ensure that any Medicaid-eligible person who is incarcerated at a participating facility but not yet enrolled is afforded the opportunity to apply for Medicaid in the most feasible and efficient manner and is offered assistance with the Medicaid application process in accordance with 42 CFR § 435.906 and § 435.908. This could include applications online, by telephone, in person, or via mail or common electronic means in accordance	State prisons already have standardized Medicaid application processes in place, consistent with State policy and CMS sub-regulatory guidance. Effective January 1, 2023, correctional facilities and social services agencies/offices were mandated to implement pre-release Medi-Cal application processes.[22] • County jails and youth correctional facilities are in various States of readiness to implement pre-release Medi-Cal application processes. All County Welfare Directors' Letter (ACWDL) 14-24 describes policies and procedures for the pre-release Medi-Cal application process for State prisons.[23] • ACWDL 22-27 provides detailed guidance and directives for implementing the mandatory pre-release Medi-Cal application process for county social services agencies/offices and county correctional facilities.[24] • As part of the technical assistance provided to correctional facilities and social services agencies/offices, DHCS developed and shared minimum Medi-Cal application and enrollment processes to ensure all potentially eligible individuals are screened for Medi-Cal eligibility at or near intake or at minimum of 135 days prior to release when the release date is known.[25,26] • Correctional facilities or their designated entity are expected to facilitate and submit, and social services agencies/offices must receive and process, pre-release Medi-Cal applications from individuals in correctional facilities submitted online, via mail, telephone, or fax. • In accordance with Medicaid regulations, ACWDL 22-27, requires social services agencies/offices to notify applicants of the outcome of their eligibility determination through an eligibility determination notice (aka Notice of Action) and issue a Benefits Identification Card

[22] In accordance with Penal Code Section 4011.11 and as outlined in ACWDL 22-27 (November 10, 2022).
[23] See ACWDL 14-24 (May 6, 2014) for more information on the State inmate pre-release Medi-Cal application process.
[24] See ACWDL 22-27 (November 10, 2022) for more information on pre-release application processes for juvenile and adult inmates of county correctional facilities and county youth correctional facilities.
[25] A slide deck that provides an overview of the pre-release Medi-Cal application mandate is available here. An issue brief titled Strategies for Conducting Pre-Release Medi-Cal Enrollment in County Jails brief describing best practices for pre-release Medi-Cal enrollment can be found here.
[26] A slide deck that provides an overview of the pre-release Medi-Cal application mandate is available here. An issue brief titled Strategies for Conducting Pre-Release Medi-Cal Enrollment in County Jails brief describing best practices for pre-release Medi-Cal enrollment can be found here.

CMS State Medicaid Director Letter Specific Requirements	Implementation Approach
with 42 CFR § 435.907. All individuals enrolled in Medicaid during their incarceration must be provided notice of any Medicaid eligibility determinations and actions pursuant to 42 CFR § 435.917 and § 431.211.	(BIC), both sent to the community address listed on the Medi-Cal application or on file. Social services agencies/offices and correctional facilities are expected to work together to ensure processes are in place for individuals to receive all communications sent by the Social services agency/office to the applicant.[27] • The State has also worked to establish data-sharing processes between social services agencies/offices and correctional facilities, including allowing correctional facilities to access the State's electronic eligibility verification systems.[28] • DHCS is encouraging correctional facilities or their designees to leverage an Accelerated Enrollment (AE) portal for incarcerated individuals for whom it would be infeasible to complete the Medi-Cal application and enrollment process before the individual's release date (e.g., individuals with very short incarcerations or unpredictable release dates). The AE process provides Medi-Cal applicants with temporary full-scope benefits while their self-attested eligibility information, including income, is being verified; those benefits continue until the final eligibility determination is made on the application. • DHCS also requires that individuals are afforded the right to request a fair hearing (in writing, online, and by telephone, but not in person) regarding any adverse actions related to Medicaid coverage or services. For individuals who remain incarcerated during their scheduled fair hearing date, correctional facilities are required to implement a process by which the incarcerated individual can attend the hearing by telephone, at minimum, or virtually if the individual is able to participate via videoconferencing. Many correctional facilities already have capabilities in place to support telephone or virtual court hearings, and DHCS expects these facilities to leverage this existing infrastructure to support Medi-Cal fair hearings. • In order to support planning for and implementation of pre-release Medi-Cal applications, DHCS provided two rounds of capacity building Providing Access and Transforming Health Initiative (PATH) grant funding to correctional facilities and social services

[27] See ACWDL 22-27 (November 10, 2022) for more information on pre-release application processes for juvenile and adult inmates of county correctional facilities and county youth correctional facilities.

[28] See MEDIL 23-13 (March 6, 2023) for more information on the Eligibility Verification System and its utilization by county correctional facilities and county youth correctional facilities.

CMS State Medicaid Director Letter Specific Requirements	Implementation Approach
	agencies/offices.[29,30] The first round of capacity building grant funding supported collaborative planning activities (e.g., collaborative planning sessions, identification of operational gaps, and hiring processes for staff to support pre-release application processing). The second round of capacity building grant funding supported implementation and administration activities related to pre-release Medi-Cal applications (e.g., IT systems upgrades, physical infrastructure modification, development of protocols and procedures, and staff training to coordinate pre-release applications).
	Future State: Planned Activities and Associated Timeline: • County and youth correctional facilities and social services agencies/offices were required to be in full compliance with the pre-release Medi-Cal application mandate by June 30, 2023. In order to ensure compliance with this mandate, DHCS is requiring that all counties report pre-release application data on a quarterly basis beginning November 2023.[31] **(Ongoing, beginning November 2023)** • DHCS will continue to monitor compliance with the pre-release application mandate throughout the implementation of pre-release services. **(Ongoing)** • DHCS will provide ongoing technical assistance to stakeholders, as needed. **(Ongoing)**
	Challenges and Mitigation Approaches: • **Challenge:** Because individuals are incarcerated, they will not be able to submit applications in person, and submissions via online portals and telephones may be restricted due to the unique nature of correctional facilities. While DHCS provided clear guidance in the Policy and Operational Guide that these standards for enrollment pathways do apply in all correctional facilities, the State cannot guarantee all pathways will be available in every facility. ○ **Mitigation Approach:** The State will monitor Medi-Cal enrollment against the expectation that standards for enrollment pathways apply in all correctional facilities and will work with correctional facilities and social services

[29] Guidance regarding the first round of capacity building grant funding can be found here.
[30] Guidance regarding the second round of capacity building grant funding can be found here.
[31] See MEDIL 23-24 (April 13, 2023) for more information on policies and procedures for county Medicaid eligibility departments and county correctional facilities to document implementation efforts of the pre-release Medicaid mandate.

CMS State Medicaid Director Letter Specific Requirements	Implementation Approach
	agencies/offices to continue to refine operational processes related to Medi-Cal enrollment in correctional settings. • **Challenge:** Individuals will be afforded the right to request a fair hearing, and many correctional facilities already have capabilities in place to support telephone or virtual hearings. While these expectations, guidance, and standards apply and the State will monitor for compliance with them, the State cannot guarantee these processes will be implemented in every instance given the unique nature of carceral settings. For example, the State may observe increased rates of no-shows to fair hearings for incarcerated individuals (compared to individuals in the community) due to facility lockdowns and other factors that contribute to high rates of canceled visits in the correctional setting, broadly. ○ **Mitigation Approach:** DHCS will monitor the number of fair hearing requests of individuals who were found ineligible for Medi-Cal and pre-release services and the rates of no-shows and will work with correctional facilities to continue to refine operational processes related to requests for fair hearings.
1.c. Ensure that all individuals at a participating facility who were enrolled in Medicaid prior to their incarceration are offered assistance with the Medicaid renewal or redetermination process requirements in accordance with 42 CFR § 435.908 and § 435.916. All	***Current State:*** • As described in Section 1.a, social services agencies/offices must suspend coverage for Medi-Cal members who are incarcerated for the duration of their incarceration. Individuals who were enrolled in Medi-Cal at the time of incarceration will not need to reapply for Medi-Cal. Once correctional facilities report the beneficiary's incarceration release date to the social services agency/office, Medi-Cal benefits will be activated upon release. • Effective January 1, 2023, annual redeterminations are not required for individuals who are incarcerated if they are the only individual on their Medi-Cal case. If the incarcerated member is part of a household, the household will still be subject to an annual redetermination.[32] • Upon the individual's release, a redetermination would only be required if one had not been completed within the 12 months prior to the release date, barring any other known changes in circumstance which would require a change of circumstance redetermination under existing policy.

[32] See ACWDL 22-26 (October 28, 2022) for more information on suspension/unsuspension for individuals incarcerated and released to different counties, the annual renewal policy, change in circumstance redeterminations, and notices of action.

CMS State Medicaid Director Letter Specific Requirements	Implementation Approach
individuals enrolled in Medicaid during their incarceration must be provided notice of any Medicaid eligibility determinations and actions pursuant to 42 CFR § 435.917 and § 431.211.	• For instances when redeterminations are required, social services agencies/offices are required to notify applicants of the outcome of an eligibility determination through a Notice of Action sent to the community address listed on the Medi-Cal application or on file. DHCS expects social services agencies/offices and correctional facilities to collaborate to ensure that individuals receive all communications sent by the Social services agency/office to the applicant. • DHCS, in partnership with social services agencies/offices, will continue to work with correctional facilities to ensure annual and change of circumstance redeterminations are completed, as needed.
	Future State: Planned Activities & Associated Timelines: • DHCS will continue monitoring compliance with redetermination processes throughout the implementation of pre-release services. **(Ongoing)** • DHCS will provide ongoing technical assistance to stakeholders, as needed. **(Ongoing)**

	Challenges and Mitigation Approaches:
	• **Challenge:** As described above in Section 1.a., potential time lags in suspending Medi-Cal coverage for incarcerated Medi-Cal members could result in situations where individuals re-enter the community without active Medi-Cal, especially for those who were incarcerated for a short period.
	  ○ **Mitigation Approach:** For individuals likely subject to a short-term stay of incarceration, the benefit suspension will be activated only after the individual has been incarcerated for at least 28 days to ensure gaps in coverage are minimized and the individual has access to full benefits as quickly as possible upon release.
	• **Challenge**: As described above, communication delays between correctional facilities and social services agencies/offices, confusion about roles and responsibilities or other breakdowns in suspension process protocols or timelines could result in incarcerated individuals re-entering the community with their Medi-Cal coverage still suspended.
	  ○ **Mitigation Approach**: DHCS is requiring that correctional facilities make every effort to notify the social services agency/office a week prior to the individual's expected release date, if known, and no later than one business day

CMS State Medicaid Director Letter Specific Requirements	Implementation Approach
	before the expected release date. If the release is unplanned, correctional facilities must make best efforts to notify social services agencies/offices within 24 hours of the unplanned release. DHCS has specified the specific data elements that the correctional facility must share with the social services agency/office support coordination. DHCS is also requiring that social services agencies/offices the release from incarceration is reported, activate coverage within 1 business day of notification. DHCS will continue to monitor compliance with suspension processes and provide ongoing technical assistance to implementation stakeholders, including correctional facilities and county, social services agencies/offices as needed.
1.d. Implement a State requirement to ensure that all Medicaid-enrolled individuals who are incarcerated at a participating facility have Medicaid and/or managed care plan cards or some other Medicaid and/or managed care enrollment documentation (e.g., identification number, digital documentation, instructions on	***Current State:*** • As outlined in State guidance, social services agencies/offices are required to notify applicants of the outcome of their eligibility through an eligibility determination notice (aka Notice of Action) and issue a BIC.[33]
	Future State: Planned Activities & Associated Timelines: • Social services agencies/offices will work with correctional facilities to issue a BIC prior to release; social services agencies/offices and correctional facilities will develop processes to issue a temporary BIC when individuals have short-term stays. DHCS will auto-assign incarcerated individuals who receive pre-release services to an MCP to ensure coverage and access to services upon re-entry into the community. Once coverage is unsuspended and MCP enrollment activated upon release, MCPs will be required to send standard member materials, including a BIC, to each new or re-enrolled member's residence. **(DHCS IT system changes to support the Reentry Initiative will be in place by October 1, 2024[34]. Correctional facility processes will be phased in over a two year period, beginning as soon as October 2024 and no later than**

[33] See MEDIL 23-13 (March 6, 2023) for more information on the Eligibility Verification System and its utilization by county correctional facilities and county youth correctional facilities. See ACWDL 22-27 (November 10, 2022) for more information on pre-release application processes.

34 While minimal viable products for system updates will be ready by October 1, 2024, there will be subsequent IT system builds and phases for full project implementation.

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how to print a card) provided to the individual upon release, along with information on how to use their coverage (coordinated with the requirements under milestone #3 below).	**October 2026, depending on the correctional facilities' go-live date. For more information on go-live dates and readiness assessment requirements please see Appendix.)** • DHCS included guidance for pre-release and re-entry care managers in the Policy & Operational Guide that requires the care managers to ensure that the individual has received the BIC as part of the re-entry care planning process and warm handoff (described in Section 2.c. and 3.d.). **(October 2023)** • DHCS will continue monitoring compliance of the requirement to ensure individuals are able to receive Medicaid-related communication and materials prior to and throughout the implementation of pre-release services.[35] **(Ongoing)** • DHCS will provide ongoing technical assistance to stakeholders, as needed. **(Ongoing)**
	Challenges and Mitigation Approaches: • **Challenge:** Correctional facilities and social services agencies/offices may face challenges with timely issuance and receipt of BICs, particularly for those individuals who are incarcerated for a short period. ○ **Mitigation Approach:** As noted, social services agencies/offices are required to work with the correctional facility to issue a temporary paper BIC to the individual while they are incarcerated so that they can access Medi-Cal immediately upon release. A permanent BIC must also be mailed to the community address listed on the Medicaid application or on file. ○ Individuals will be auto-assigned to an MCP for when they are released into the community. The MCP will send all plan materials and the plan card to the community address listed on the Medicaid application or on file. DHCS will require pre-release and post-release care managers to ensure that the individual has received the Medi-Cal BIC as part of re-entry planning and (where applicable) the warm handoff process, and the plan card in the post-release period. ○ Lastly, DHCS published an issue brief on strategies for conducting pre-release Medi-Cal enrollment in county jails,

[35] See MEDIL 23-24 (April 13, 2023) for more information on policies and procedures for county Medicaid eligibility departments and county correctional facilities to document implementation efforts of the pre-release Medicaid mandate.

CMS State Medicaid Director Letter Specific Requirements	Implementation Approach
	which outlines best practices for ensuring BICs are issued in a timely manner.[36]
1.e. Establish processes to allow and assist all individuals who are incarcerated at a participating facility to access and complete a Medicaid application, including providing information about where to complete the Medicaid application for another State (e.g., relevant State Medicaid agency website, if the individual will be moving to a different State upon release).	***Current State:*** • As outlined in 1.b., correctional facilities and social services agencies/offices are mandated to implement pre-release Medi-Cal application processes. • As part of this mandate, DHCS developed and distributed technical assistance materials[37] and a Policy and Operational Guide chapter that describes expectations that Medi-Cal application processes should occur in correctional facilities at or near intake in order to ensure all potentially eligible individuals are screened for and enrolled in Medi-Cal.
	Future State: Planned Activities & Associated Timelines: • The Policy and Operational Guide includes clear guidance to reentry care managers to provide individuals who may be moving to a different State upon release with Medicaid application information (e.g., State Medicaid agency website or hotline number) to the State in which they will reside. **(October 2023)** • DHCS will continue monitoring compliance with the pre-release application mandate throughout implementation of pre-release services. **(Ongoing)** • DHCS will continue to provide ongoing technical assistance to stakeholders, as needed. **(Ongoing)**
	Challenges and Mitigation Approaches: • **Challenge:** As noted above, incarcerated individuals are not able to submit applications in-person and, due to the unique nature of correctional settings, use of online portals and telephones may be subject to restrictions.

[36] Strategies for Conducting Pre-Release Medi-Cal Enrollment in County Jails, updated August 9, 2022; available here: https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/Issue-Brief-Strategies-PreRelease-MediCal-Enrollmentin-County-Jails-8-18-22.pdf

[37] A slide deck that provides an overview of the pre-release Medi-Cal application mandate is available here. An issue brief titled Strategies for Conducting Pre-Release Medi-Cal Enrollment in County Jails brief describing best practices for pre-release Medi-Cal enrollment can be found here.

CMS State Medicaid Director Letter Specific Requirements	Implementation Approach
	○ **Mitigation Approach:** DHCS will provide clear guidance around expectations for the pre-release application process and for reentry care to managers to provide Medi-Cal application information to individuals who may be moving to a different State upon release. DHCS will monitor Medicaid enrollment to ensure compliance with pre-release application requirements and work with correctional facilities and social services agencies/offices to continue to refine relevant operational processes.

Milestone 2: Covering and ensuring access to the minimum set of pre-release services for individuals who are incarcerated to improve care transitions upon return to the community

STC 9.9.b. The State must describe its plan to implement a screening process to identify individuals who qualify for pre-release services, consistent with the qualifying criteria outlined in these STCs. The State must detail how the facilities will ensure that beneficiaries can access the demonstration benefit package, as clinically appropriate. The State must describe its approach and plans for implementing processes to assure that all pre-release service providers, as appropriate for the provider type, have the necessary experience and training, and care managers have knowledge of (or means to obtain information about) community-based providers in the communities where individuals will be returning upon release. Further, as applicable, the State must establish State requirements for carceral health providers who are not participating in Medicaid or CHIP that are similar to Medicaid provider standards, as well as program integrity standards to ensure appropriate billing.

CMS State Medicaid Director Letter Specific Requirements	Implementation Approach
2.a. Implement State processes to identify individuals who are incarcerated who qualify for pre-release services under the State's proposed demonstration design (e.g., by chronic condition, incarceration in a participating facility).	***Current State:*** • DHCS developed detailed definitions for its pre-release eligibility criteria, which are available in Attachment W of the approved 1115 Demonstration.[38] • DHCS does not yet have State processes in place to identify individuals who are incarcerated who qualify for pre-release services. • DHCS is administering a PATH capacity building funds process to support correctional facilities in their implementation processes. Correctional facilities may use PATH funds to establish a screening process.
	Future State: Planned Activities & Associated Timelines: Correctional facilities will be responsible for operationalizing the pre-release screening process to identify adults eligible for pre-release services, guidance to implementing partners that is further outlined in the state's Policy and Operational Guide. Note, all youth (defined as youth in youth correctional facilities and youth under the age of 21 or former foster youth in an adult facility) will be eligible for pre-release services and will not need to be screened. To implement these requirements, DHCS will:

[38] Please see Attachment W in the CalAIM Reentry Demonstration approval available here.

CMS State Medicaid Director Letter Specific Requirements	Implementation Approach
	• Require that the correctional facility screen all incarcerated Medi-Cal eligible adults for any qualifying conditions in accordance with minimum requirements specified in the Policy & Operations Guide. **(The Policy and Operations Guide was released in October 2023. DHCS IT system changes to support the Reentry Initiative will be in place by October 1, 2024. Correctional facility processes will be phased in over a two year period, beginning as soon as October 2024 and no later than October 2026, depending on correctional facilities' go-live date. For more information on go-live dates and readiness assessment requirements please see Appendix.)** • Allow flexibility for correctional facilities in how they implement the screening process, so long as they are screening for all eligibility criteria (including for behavioral health linkages), and allow individuals to be screened or otherwise identified as qualifying for pre-release services/behavioral health linkages at any time during incarceration (e.g., as part of initial screening at booking, as part of a later screening, through available medical records/diagnoses information, and through self-attestation). Screening tools for behavioral health linkages must be validated, State-approved screening instruments or another State-approved option. DHCS is also exploring how to develop a standardized screening process that will be developed and released at a future date. **(The Policy and Operations Guide was released in October 2023. DHCS IT systems changes to support the Reentry Initiative will be in place by October 1, 2024. Correctional facility processes will be phased in over a two year period, beginning as soon as October 2024 and no later than October 2026, depending on correctional facilities' go-live date. For more information on go-live dates and readiness assessment requirements please see Appendix.)** • Encourage correctional facilities to leverage existing health screening and assessment processes that are already in place to screen individuals for eligibility to receive pre-release services (e.g., based on information collected through a facility's existing screening/assessment processes). **(Correctional facility processes will be phased in over a two year period, beginning as soon as October 2024 and no later than October 2026, depending on correctional facilities' go-live date)** • Require correctional facilities to demonstrate how they will meet this requirement as part of the readiness assessments. No

CMS State Medicaid Director Letter Specific Requirements	Implementation Approach
	correctional facility will be able to bill for pre-release services until it demonstrates that it has a screening process that meets policy and operational requirements. **(DHCS released a draft readiness assessment template in October 2023 for stakeholder comment and plans to release the final readiness assessment tool in late 2023/early 2024. Correctional facility processes will be phased in over a two year period, beginning as soon as October 2024 and no later than October 2026, depending on correctional facilities' go-live date)** • Develop a pre-release services eligibility screening portal for correctional facilities to use to support screening and identification of qualifying individuals. This technical solution, known as the Justice-Involved Screening Portal, will allow correctional facilities to document eligibility for pre-release services, triggering the appropriate aid code for the individual's case in State Medicaid systems. The Portal will also allow the facility to access information about an individual's Medicaid eligibility, status of any other aid codes that may be active, and managed care enrollment, as applicable, to support service delivery. **(DHCS systems to support the Reentry Initiative will be in place by October 1, 2024. Correctional facility processes will be phased in over a two year period, beginning as soon as October 2024 and no later than October 2026, depending on correctional facilities' go-live date)** • Memorialize the minimum requirements for the pre-release screening process in the Policy and Operational Guide. **(October 2023)** • Monitor against pre-release screening requirements and make program changes, as needed, as pre-release services are implemented and needed changes are identified. **(Ongoing, beginning in October 2024)** • Provide technical assistance to stakeholders, as needed. **(Ongoing)**
	Challenges and Mitigation Approaches: • **Challenge:** Given the prevalence of short-term stays and unpredictable release dates, particularly in county jails and county youth correctional facilities, correctional facilities may

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	face operational challenges in screening all individuals who are incarcerated for only a short period of time. ○ **Mitigation Approach:** DHCS has developed detailed "short-term stay" operational guidance and expectations for correctional facilities providing services to individuals who are expected to have short term stays. The expectations seek to take into account the inherent constraints in the corrections environment and articulates minimum requirements and best practices based on the duration of the JI individual's stay within the correctional facility. DHCS will require that individuals are screened for pre-release services eligibility as close to intake as possible to ensure that individuals have access to as much of the full 90 days of pre-release services as possible. DHCS will monitor compliance with these requirements, through qualitative (e.g., survey) and quantitative (e.g., claims data related to screening) data. • **Challenge:** While DHCS is allowing flexibility in screening tools to allow correctional facilities to leverage the existing health screening and assessment processes already in place, variation in screening tools may result in some individuals not being appropriately identified for pre-release services. ○ **Mitigation Approach**: DHCS will provide to correctional facilities the minimum requirements each screening process should have to ensure individuals are properly screened for pre-release service eligibility. DHCS will monitor rates of individuals deemed eligible for pre-release services across correctional facilities to identify discrepancies that may indicate issues with screening processes or tools at a given facility. Dependent on lessons learned from initial implementation experiences and related data, DHCS develop a standardized screening process to be implemented at a future date.
	Current State:

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2.b. Cover and ensure access to the minimum short-term, pre-release benefit package, including case management to assess and address physical and behavioral health needs and HRSN, MAT services for all types of SUD as clinically appropriate with accompanying counseling, and a 30-day supply of medication (as clinically appropriate based on the medication dispensed and the indication) provided to the beneficiary immediately upon release, to Medicaid-eligible individuals identified as participating in the Reentry Section 1115 Demonstration Opportunity. In addition, the State should specify any additional pre-release services that the State proposes to cover for beneficiaries.	DHCS developed definitions for its targeted pre-release services as listed below. Additional details are available in Attachment W of the approved 1115 waiver.[39]
	
	• **Case Management:** Case management is intended to facilitate reentry planning into the community in order to (1) support the coordination of services delivered during the pre-release period and upon reentry, (2) ensure smooth linkages to social services and supports, and (3) ensure arrangement of appointments and timely access to appropriate care and pre-release services delivered in the community.
	• **Medication-Assisted Treatment (MAT):** Covered services for MAT are as follows:
	  ○ MAT for Opioid Use Disorders (OUD) includes all medications approved under Section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under Section 351 of the Public Health Service Act (42 U.S.C. 262) to treat opioid use disorders as authorized by the Social Security Act Section 1905(a)(29).
	  ○ MAT for Alcohol Use Disorders (AUD) and Non-Opioid Substance Use Disorders includes all FDA-approved drugs and services to treat AUD and other SUDs.
	  ○ Psychosocial services delivered in conjunction with MAT for OUD as covered in the State Plan 1905(a)(29) MAT benefit, and MAT for AUD and Non-Opioid Substance Use Disorders as covered in the State Plan 1905(a)(13) rehabilitation benefit, including assessment; individual/group counseling; patient education; and prescribing, administering, dispensing, ordering, monitoring, and/or managing MAT.
	  ○ Note that as part of the approved Reentry 1115 Demonstration, California received approval that MAT services may be provided by correctional facilities that are not Drug Medi-Cal (DMC)-certified providers as otherwise required under the State Plan for the provision of the MAT benefit. Without this authority, correctional facilities that are not DMC-certified providers would have experienced additional challenges in providing MAT services.

[39] Please see Attachment W in the CalAIM Reentry Demonstration approval available here.

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	• **Physical and Behavioral Health Clinical Consultation Services:** Physical and behavioral health clinical consultation services include targeted preventive, physical, and behavioral health clinical consultation services related to the qualifying conditions. Clinical consultation services are intended to support the creation of a comprehensive, robust, and successful reentry plan, including conducting diagnosis, stabilization, and treatment in preparation for release (including recommendations or orders for needed labs, radiology, and/or medications); providing recommendations or orders for needed medications and durable medical equipment (DME) that will be needed upon release; and consulting with the pre-release care manager to help inform the pre-release care plan. Clinical consultation services are also intended to provide opportunities for individuals to meet and form relationships with the community-based providers who will be caring for them upon release, including behavioral health providers, and enable information sharing and collaborative clinical care between pre-release providers and the providers who will be caring for the members after release. Note that behavioral health clinical consultation services may be provided by correctional facilities that are not certified mental health organizations or agencies as otherwise required under the State Plan. Please note that peer support specialists are a provider type that would fall under this benefit. This provider type is distinct Medi-Cal Peer Support Specialist services under the SMHS and DMC-ODS programs. Counties can voluntarily opt-in to provide this service in one or both county behavioral health delivery systems (SMHS, and DMC or DMC-ODS). • **Laboratory and Radiology Services:** Laboratory and radiology services will be provided consistent with the State Plan. • **Medications and Medication Administration:** Medications and medication administration will be provided consistent with the State Plan. • **Community Health Worker Services:** Community Health Worker Services will be provided consistent with the Community Health Worker State Plan. • **Services Provided Upon Release:** Services provided upon release include: ○ Covered outpatient prescribed medications and over-the-counter drugs (a minimum 30-day supply as clinically appropriate, consistent with the approved Medicaid State Plan).

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	○ DME consistent with Medi-Cal State Plan requirements. DHCS is administering a PATH capacity building funds process to support correctional facilities in their implementation processes. Correctional facilities may use PATH funds to establish processes and infrastructure needed to deliver pre-release services. .
	Future State: Planned Activities & Associated Timelines: *Readiness Assessments*. To support implementation of the pre-release services benefit package, DHCS will implement a correctional facility Readiness Assessment and provider enrollment processes, issue necessary guidance including around provision of pre-release services for individuals with short-term stays, and track duration of pre-release services against 90-day limits, among other activities. Implementation activities will take place in accordance with the timelines described below. To ensure the delivery of services in the pre-release period, and as required by the demonstration's STCs, DHCS established policy will require all correctional facilities to demonstrate their readiness to be able to provide pre-release services in order to participate in the Reentry Demonstration Initiative prior to going live with pre-release services. (See Section 5.a. for more details on readiness assessments.) • DHCS will require that correctional facilities submit their readiness assessments to DHCS at least five months prior to their proposed go-live date. As part of the correctional facility readiness assessment, DHCS will assess correctional facilities' ability to provide pre-release services to individuals who are eligible. **(April 2024-Septemberl 2026)** Correctional facilities will need to demonstrate readiness related to Medi-Cal application and suspension processes as well as the following pre-release service provision-related activities: 1. **90-Day Pre-Release Eligibility and Behavioral Health Linkage Screening**

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	a. Screening for Pre-Release Services b. Screening for Behavioral Health Linkages 2. **90-Day Pre-Release Service Delivery** a. Medi-Cal Billing and Provider Enrollment b. Support of Pre-Release Care Management c. Clinical Consultation d. Virtual/In-Person In-Reach Provider Support e. Support for Medications f. Support for MAT g. Support for Prescriptions Upon Release h. Support for DME Upon Release 3. **Reentry Planning and Coordination** a. Release Date Notification b. Care Management Reentry Plan Finalization c. Reentry Care Management Warm Handoff d. Reentry Behavioral Health Linkage 4. **Oversight and Project Management** a. Staffing Structure and Plan b. Governance Structure for Partnerships c. Reporting and Oversight Process *Provider Enrollment Processes* • In order for correctional facilities to deliver and be reimbursed for targeted pre-release services (e.g., care management, medications, MAT, and labs/radiology), DHCS will require that each pharmacy and facility enroll through the Medi-Cal provider process. **(January 2024-September 2026)** ○ Correctional facilities will enroll in Medi-Cal through the following provider enrollment pathways: ▪ *Correctional Pharmacy Enrollment:* DHCS will require that each State prison, county jail, youth correctional facility with an on-site pharmacy, and any pharmacy located in or out of state that is contracted to provide pre-release prescription services to eligible incarcerated individuals, enroll as a Medi-Cal pharmacy. Enrollment will be location-specific, and only one pharmacy per site must enroll. ▪ *Correctional Provider Enrollment:* DHCS will require that each State prison, county jail, and youth correctional facility enroll as a Medi-Cal

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	provider under the Medi-Cal exempt from licensure clinic status. Enrollment will be location-specific, and only one provider enrollment per site will be required. The clinic that is enrolled in Medi-Cal within the correctional facility must oversee all billing submitted to DHCS, with the exception of community-based, in-reach providers who will be separately enrolled as Medi-Cal providers and directly bill DHCS for services. ○ All providers delivering pre-release services within the correctional facility will be licensed, registered, certified, or otherwise appropriately credentialed consistent with Medicaid State Plan requirements. Correctional facilities will be required to attest and provide documentation, as necessary, that the providers delivering Medi-Cal services meet those requirements as part of the readiness assessment. ○ A limited number of correctional facility-based providers who order, prescribe, or refer services and medications and operate under the exempt from licensure clinic status may not be required to enroll in Medi-Cal but will be required to meet the State's Medi-Cal provider participation requirements. ○ DHCS will monitor and regulate all employed and contracted providers under this demonstration through the following mechanisms: ▪ *Monitoring of the exempt from licensure clinic:* All providers will bill under either the pharmacy or exempt from licensure clinic status. As part of the exempt from licensure clinic provider agreement, facilities must attest to compliance with a number of program integrity measures including, but not limited to: billing for claims with an NPI that was registered with CMS; not engaging in conduct contrary to the public health, welfare, safety or fiscal integrity of the Medi-Cal program; ensuring compliance with non-discrimination clauses; agreeing to maintain in good standing liability insurance; making, keeping and maintaining record keeping consistent with state and federal regulations; upon request, making available copies of records to DHCS, the Attorney General and the Secretary; ensuring confidentiality of beneficiary

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	medical records; disclosing all information as required by Federal Medicaid laws and regulations and any other information required by DHCS; and attesting that it shall not engage or commit provider fraud, waste and abuse. ▪ *Monitoring individual providers' ordering and prescribing activities:* DHCS will conduct oversight and monitoring of such providers who are not enrolled in Medi-Cal but are referring, ordering, or prescribing under the correctional facility exempt from licensure clinic. DHCS will continue to require individual level NPIs of the ordering, referring, or prescribing providers on all orders, referrals (as required), and prescriptions. DHCS will track the DME orders and prescriptions (covered as pre-release services) for unusual prescribing and ordering processes. o Pre-release care management may be provided by embedded care managers or in-reach care managers and will be reimbursed on a fee-for-service (FFS) basis. To ensure continuity between the pre- and post-release periods, community-based care managers who will serve the justice-involved population must agree to enroll as FFS Medi-Cal providers and be willing to, at minimum, conduct in-reach warm handoffs with an embedded pre-release care manager. *Provider Payment Process* • Pre-release covered services will be delivered, claimed, and paid for via Medi-Cal's FFS delivery system. FFS claims may be submitted through normal processes utilizing Medi-Cal Rx for pharmacy services; CA-MMIS for clinical services including care management, clinical consultations, MAT, CHW services, laboratory, and radiology. Federally Qualified Health Centers (FQHCs) and Rural Health Clinics may bill and claim within the FFS system, which is supplemental to the prospective payment system (PPS) and not subject to reconciliation, for any in-reach pre-release services. Costs associated with JI pre-release services and billed through the FFS system will be excluded from any future calculations of the PPS rate.

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	• DHCS will allow both providers embedded/contracted in the correctional facility (including care managers and physical and behavioral health clinical consultants) and community-based providers (including care managers/ECM providers and physical and behavioral health clinical consultants) to provide pre-release services. DHCS will provide billing and claiming guidance, including which NPI to bull under and which CPT codes to use in the Policy and Operations Guide and in Medi-Cal provider manuals. • DHCS will provide tiered rates for in-reach, in-person visits (e.g., for care management, clinical consultation, and CHWs) to account for the unique additional complexities and time for individual providers to pass through security clearance and deal with appointment cancellations due to lockdowns or other unique correctional facility challenges. • DHCS will develop five bundled payments for care management services. DHCS will provide guidance on billing care management bundles in the Policy and Operations Guide and in Medi-Cal provider manuals. *Issuance of Operational Guidance for Short-Term Stays and Care Manager Responsibilities* • To support the provision of services to individuals who have short stays in correctional facilities and unpredictable release dates (e.g., non-sentenced individuals in jails or youth in county youth correctional facilities), DHCS will issue clear guidance via the Policy and Operational Guide on how to provide pre-release services to individuals with short-term stays and/or unknown release dates. **October 2023)** ○ The Policy and Operational Guide includes minimum requirements and timelines for correctional facilities to provide Medi-Cal screening, pre-release eligibility screening, provision of pre-release services, and reentry planning and coordination as well as best practices based on duration of stay at a correctional facility. The Policy and Operational Guide will provide specific timelines for meeting minimum requirements in the Short-Term model and will be updated on an on-going basis. • In addition to information on the readiness assessment and short-term model, DHCS included clear guidance for care managers in the Policy & Operations Guide regarding care

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	manager roles and responsibilities to ensure correctional facilities and in-reach providers are able to deliver pre-release services against required timelines. **(October 2023)** *Monitoring the Duration of Pre-Release Services* • DHCS will track the duration of service provision to ensure coverage of pre-release services does not exceed 90 days per facility stay, per incarceration. **(DHCS will provide clear guidance to correctional facilities on starting, pausing, resetting, and tracking the number of days in a pre-release period in forthcoming guidance on the Provider Portal (Spring 2024). Correctional facility processes will be phased in over a two-year period, beginning as soon as October 2024 and no later than October 2026, depending on correctional facilities' go-live date.)** For example: ○
	Challenges and Mitigation Approaches: ○ **Challenges:** Correctional facilities may experience challenges implementing components of the pre-release benefit package. For example: ▪ *Case Management:* Correctional facilities will need to establish new operational processes and infrastructure to enable required coordination with a diverse group of stakeholders including MCPs, county behavioral health agencies, and community-based providers. Additionally, correctional facilities that choose to use embedded providers will need to clearly define roles and responsibilities with community-based care managers prior to warm handoffs to ensure reentry care plan includes accurate details on community-based resources. • ***Mitigation Approach:*** DHCS will require all correctional facilities to pass/conditionally pass a readiness assessment, which will include defined processes for care management delivery, including detailed protocols for warm handoffs based on their care management delivery systems (i.e., either embedded or

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	in-reach care management models); additional information on a conditional pass can be found in section 5.a.. DHCS will also encourage all correctional facilities and counties to work collaboratively with all implementing partners, including MCPs, county behavioral health agencies, and community-based providers to establish processes and protocols that will be submitted to DHCS as part of the readiness assessment. ▪ *Medication Coverage During Pre-Release Period:* DHCS expects there will be some differences between drugs covered by Medi-Cal (as documented in the Medi-Cal Contract Drug List) and the drugs currently used by correctional facilities under their existing formularies. For example, some correctional facilities have stated they are unable to dispense medications in bottles due to safety concerns. Additionally, correctional facilities dispense some medications to individuals from a shared stock (e.g., from a non-patient specific bottle that is dispensed to multiple patients based on patient-specific orders). These medications are dispensed to individuals dose-by-dose in a patient-specific way, though the stock/shared bottle itself is not patient-specific. This medication distribution approach presents some challenges for correctional facility billing through Medi-Cal Rx, as the outpatient pharmacy benefit and federal regulations require that all billed medications be dispensed from the pharmacy in a specific patient manner. Correctional facilities will need to adjust their processes to comply with Medi-Cal Rx requirements. • ***Mitigation Approach:*** DHCS will work with correctional facilities to identify and minimize gaps by supporting the identification of alternative medications that

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	correctional facilities can provide in lieu of those that are currently being used but are not covered by the Medi-Cal Contract Drug List. DHCS will also consider adding high-priority medications used by correctional facilities to the Medi-Cal Contract Drug List. DHCS will provide billing guidance on physician-administered drugs to ensure non-patient specific medications can be billed to Medi-Cal. Additionally, DHCS will allow pharmacies located in or out of state that are contracted to provide pre-release prescription services to eligible incarcerated individuals to enroll in Medi-Cal to be able to bill for medications in the pre-release period and upon release. ▪ *Support for Medications Upon Release*: Correctional facilities that already have on-site pharmacies or partnerships with community-based pharmacies will need to enroll in Medicaid and develop new processes to bill/claim Medi-Cal Rx (including prior authorization, as needed). Correctional facilities that do not provide any medications because they do not have on-site/partnership pharmacy will need to establish new processes for providing medications upon release. DHCS also understands there will be operational complexities associated with sending active medications to a community pharmacy to ensure continued access in the post-release period, specifically for individuals leaving prison who may have been incarcerated for a relatively longer period of time and do not have an established residence/pharmacy. • ***Mitigation Approach***: DHCS developed a list of best practices to support delivery of medications in-hand upon release that was included in the Policy and Operations Guide. These best practices were informed by discussions with county partners and

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	include performing a medical checkout prior to release to ensure reentry with medications in-hand and storing medications to be dispensed upon reentry with an individual's personal property. DHCS recognizes that implementation of best practices will vary based on the specific setting and individual content. DHCS is also requiring pre- and post-release care managers to coordinate to support the individual in transferring medication refill orders to the individual's preferred community pharmacy, as necessary. ▪ *Support for DME Upon Release:* Correctional facilities may have to establish new processes to purchase DME for specific patients (as many currently do not provide DME upon release or provide DME that was used by others within the correctional facility and purchased in bulk at a date outside of the 90-day pre-release period), develop new processes to bill/claim Medicaid for DME, including prior authorization as needed, secure space to store DME until individual is released, and ensure that care managers coordinate to ensure provision of DME. • ***Mitigation Approach:*** DHCS developed a model roles and responsibilities chart that was included in the Policy and Operations Guide that describes a potential approach for coordinating across relevant entities for the provision of DME upon release. • **Challenge**: Implementation partners that have not traditionally billed Medi-Cal (e.g., correctional facilities and community-based providers that will be providing in-reach and post-release care management services) will be enrolling in Medi-Cal and setting up new billing and claiming processes for the first time and may face challenges navigating related requirements. ○ **Mitigation Approach**: To mitigate challenges, DHCS will provide clear guidance on Medi-Cal provider enrollment

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	and billing/claiming systems and processes to correctional facilities and other stakeholders who may be unfamiliar with related requirements; administer PATH capacity funds to support the development of the infrastructure and processes needed for provider enrollment and billing/claiming; and offer targeted technical assistance to stakeholders, including correctional facilities and non-traditional community-based providers, to assist in the development or modification of billing systems as needed. DHCS is also working to develop a Medi-Cal enrollment pathway for community-based organizations that will serve as pre- or post-release care management providers and will establish a glidepath for this requirement to support non-traditional providers who may experience challenges or require additional assistance to enroll as FFS providers. • **Challenge:** The majority of individuals incarcerated in county correctional facilities will not have release dates and may be released unexpectedly, making it difficult for correctional facilities to identify a 90-day pre-release period. ○ **Mitigation Approach:** DHCS will allow correctional facilities to pause and restart the 90-day pre-release period in certain circumstances, as outlined in the section above. • **Challenge:** The vast majority of county corrections incarceration stays is less than 30 days, giving correctional facilities limited time to initiate pre-release services. ○ **Mitigation Approach:** DHCS developed detailed operational guidance for correctional facilities on navigating short-stay situations. DHCS expects all county facilities to begin pre-release services as soon as the individual is identified as eligible. DHCS provided a short-term model in the Policy and Operations Guide outlining the time period for when pre-release services should begin in order to ensure maximum access to services in a short time period.
	Current State:

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2.c. Develop State process to ensure care managers have knowledge of community-based providers in communities where individuals will be returning upon release or have the skills and resources to inform themselves about such providers for communities with which they are unfamiliar.	• DHCS does not yet have pre-release care management processes in place. ***Future State: Planned Activities & Associated Timelines:*** • Care management is a critical component of the State's Justice-Involved Reentry Initiative and essential to supporting individuals preparing for community reentry. DHCS will implement pre-release care management processes and requirements to ensure care managers have knowledge of and can connect individuals to community-based providers in the community to which they will return post-release, as described below. This minimum requirements for care managers is included in the Policy and Operations Guide. • DHCS will require that all individuals receiving pre-release services are assigned a pre-release care manager as close to being identified as eligible for pre-release services as possible (expected timeline requirements can be found in the Policy and Operational Guide). Pre-release care managers will either be in-reach, community-based care managers or embedded correctional facility providers. DHCS defines "in-reach care management model" as a model through which Medi-Cal-enrolled, community-based care management providers deliver care management services to individuals in correctional facilities, either in person or via telehealth. "Embedded care management" is a model through which the correctional facility employs or contracts with care managers to provide services in the correctional facility. All pre-release care managers will bill for services on a fee-for-service basis. Individuals who received pre-release service and who are eligible for managed care will be auto-assigned (with subsequent choice period) into a MCP and, upon release, qualify for the Enhanced Care Management (ECM) benefit.[40] • DHCS aims to maximize continuity of care management across the pre- and post-release periods. DHCS will strongly encourage correctional facilities to use a community-based, in-reach care manager that serves the individuals during both their pre- and post-release periods, such as community-based ECM providers that will continue to provide ECM services to

[40] More information on CalAIM's enhanced care management benefit is available here: https://www.dhcs.ca.gov/Pages/ECMandILOS.aspx.

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	individuals following their reentry into the community.[41] If the correctional facility elects an embedded care management model, the pre-release care management provider will be required to facilitate a warm handoff to the community-based, post-release ECM care manager prior to release (ideally at least two weeks prior to release). DHCS will establish standard requirements for embedded care managers to implement warm handoffs with community-based care managers during the reentry process and will require that all warm handoff meetings include the individual and the pre- and post-release care managers. • As part of the warm handoff process, an embedded care manager is expected to work closely with the individual's assigned community-based, post-release ECM care manager and the individual to identify necessary community resources, as needed, and document them in the re-entry care plan. As part of the care model, embedded and community-based care managers should have information about providers in the communities in which the individual is being released, and the skill and resources to connect the individual to those providers. DHCS will require that the pre- and post-release care managers review the re-entry care plan with the individual as part of the warm handoff meeting. Upon release, individuals who receive reentry services and are eligible for Medi-Cal managed care will be auto-assigned (with subsequent choice period) to a MCP and qualify for ECM which will be delivered by community-based care managers with knowledge of providers available in the community to which the individual will be released.[42] • To facilitate assignment of community-based, in-reach care managers and post-release care managers, as part of the provider directory requirements under the Medi-Cal MCP contracts, DHCS will require MCPs to develop and maintain a list of care managers that have agreed to serve as pre-release care managers (via fee-for-service) and post-release ECM providers (via managed care). MCPs will also be required to establish a publicly posted point-of-contact to whom correctional facilities, pre-release care management providers, and/or ECM

[41] In the post-release period, once the individual is enrolled in managed care, the care management provider will provide ECM services.

[42] More information on CalAIM's enhanced care management benefit is available here: https://www.dhcs.ca.gov/Pages/ECMandILOS.aspx.

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	providers can reach out for support related to provider networks and other issues.
	• Correctional facilities will be required to update their internal processes to accommodate the pre-release services care management model, including the use of the care manager provider directory and the MCP point-of-contact.
	• DHCS released the Policy and Operations Guide to stakeholders to support implementation of pre- and post-release care management to ensure individuals are able to access needed services upon their reentry into the community. **(October 2023)**
	• DHCS released an All Plan Letter that references the requirements as laid out in the Policy and Operations Guide. **(October 2023)**
	• DHCS is implementing a process for monitoring MCPs' implementation of ECM and Community Supports, and for following up through technical assistance and/or escalation – up to and including sanctions, as established in the MCP contract – where implementation deficiencies are seen. DHCS' oversight and monitoring process of ECM and Community supports will be strongly data-centered and implemented in a consistent way across the MCPs. Prior to launch of ECM for Justice Involved Population of Focus (effective January 2024) MCPs are required to submit a comprehensive Model of Care detailing their policies for implementing ECM and Community Supports in the counties in which they operate.
	  ○ Prior to go-live for the justice-involved ECM Population of Focus, MCPs must submit model of care responses pertaining to the new populations they are required to serve, with updated policies to be submitted to DHCS upon request. **(October 2023)**
	  ○ DHCS reviews and approves MOC submissions from each MCP. **(December 2023)**
	  ○ Subsequent to the effective date of the Justice Involved Population of Focus, MCPs will be required to submit quarterly monitoring data through a Quarterly Implementation Monitoring Report. (Starting in Q1 2024)
	  ○ DHCS supplements this data report with a wide range of secondary sources for monitoring, which includes, for example, extensive stakeholder feedback with multiple Advisory Groups. DHCS is committed to long-term

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	monitoring and continuing technical assistance to MCPs. **(Ongoing)** • DHCS will monitor compliance with pre- and post-release care management requirements. **(The Policy and Operations Guide was released in October 2023. Correctional facility processes will be phased in over a two year period, beginning as soon as October 2024 and no later than October 2026, depending on correctional facilities' go-live date; DHCS will monitor compliance on an on-going basis once the correctional facility goes live.)** • DHCS will provide ongoing technical assistance to implementation stakeholders as needed. **(Ongoing)**
	Challenges and Mitigation Approaches: • **Challenge:** Individuals may be released into a different county than the one in which they are incarcerated. This could present challenges for connecting them to community-based providers due to care managers' limited knowledge about providers and services in the county of release. ○ **Mitigation Approach:** DHCS requires that individuals be assigned a post-release care manager (and in-reach pre-release care manager, as applicable) that works in the county in which the individual will be released to ensure the care manager is familiar with and can connect the individual with community-based providers in the county of release. Post-release care managers are expected to collaborate with the pre-release care manager on development of the transitional care plan. If the post-release care manager is located in a different county than the correctional facility, warm handoffs may be provided via telehealth. Correctional facilities and pre-release care managers may also reach out to the established Justice-Involved MCP point-of-contact in the county of release for assistance in identifying community-based providers and coordinating services in the county to which the individual will be released. • **Challenge:** The pre- and post-release care managers may face challenges in facilitating the warm handoff during the pre-release period in some instances, such as when the individuals is released by court order earlier than expected or has a very short stay.

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	○ **Mitigation Approach:** DHCS will require that pre- and post-release care manager conduct the warm handoff in the community post-release within one week, and that the pre-release care manager shares the re-entry plan and other pertinent information with the post-release care manager and the assigned MCP within 24 hours of release (or as close to that timeline as possible). DHCS recommends as a best practice that post-release care managers meet the individual at release if possible, or, if that is not possible, within one to two days of release.

Milestone 3: Promoting continuity of care

STC Language: The State must describe its process to ensure that beneficiaries receive a person-centered plan for coordination post-release to address health needs, as well as HRSN and LTSS, as applicable. The State must detail its plans and timeline for implementing State policies to provide or facilitate timely access to post-release medical supplies, equipment, medication, additional exams, or other post-release services to address the physical and behavioral health care needs identified during the care management assessment and the development of the person-centered care plan. The State must describe its processes for promoting and ensuring collaboration between care managers, providers of pre-release services, and providers of post-release services to ensure that appropriate care coordination is taking place. As applicable, the State must also describe the planning or projected activities to ensure that Medicaid managed care plan and county behavioral health plan contracts include requirements and processes for transfer of relevant health information from the carceral facility, community-based providers, and/or State Medicaid agency to the managed care plan to support continuity and coordination of care post-release.

Prompts	Summary
3.a. Implement a State requirement that individuals who are incarcerated receive a person-centered care plan prior to release to address any physical and behavioral health needs, as well as HRSN and consideration for long term services and supports (LTSS) needs that should be coordinated post-release, that were identified as part of pre-release care management activities and the development of the person-centered care plan.	***Current State:*** • DHCS does not have pre-release care management processes in place. • DHCS is administering a PATH capacity building funds process to support correctional facilities in their implementation processes. Correctional facilities may use PATH funds to set up pre-release and post-release care management processes. ***Future State: Planned Activities & Associated Timelines:*** Care management is a critical component of the State's Reentry Demonstration Initiative and is essential to supporting individuals in preparing for community reentry. As part of pre-release care management services for Medi-Cal enrolled individuals who are incarcerated, DHCS will require that pre-release care managers develop a transitional care plan with and for the individual. **(The Policy and Operations Guide was released in October 2023. Correctional facility processes will be phased in over a two year period, beginning as soon as October 2024 and no later than October 2026, depending on correctional facilities' go-live date.)** As outlined in the Policy and Operations Guide, DHCS will require that the transitional care plan include, at minimum:

Prompts	Summary

	• A completed whole-person care plan assessment that includes an assessment of mental health, substance use, physical health, long-term services and supports (LTSS) needs, health related social needs (HRSN), and functional needs. This assessment must be completed by a licensed professional (e.g., RN care manager, LCSW). HRSN assessments should include the identification of needs the members may have upon release including but not limited to: housing; access to food or medically tailored meals; transportation needs; cell phone/smart phone access; social support including who should be included in care plan (e.g., family/friends/parole/probation).
	• A post-release service needs assessment, including assessment related to functioning in the community upon release such as HRSN; considerations for LTSS; medication management; scheduling community-based appointments; paying bills; and utilizing electronic communication.
	• Plans for post-release medications, including ensuring that the medications have undergone any prior authorizations (PAs) or other requirements for coverage, if necessary.
	• Plans for DME, including ensuring that DME prescriptions have undergone any treatment authorization reviews (TARs) or other requirements for coverage, if necessary.
	• Coordination, scheduling, and linkages to required reentry services, including:
	  ○ MAT and psychotropic medications.
	  ○ Identification of a primary care provider and follow-up appointment scheduled at appropriate time post-release.
	  ○ Required specialty, mental health, substance use, dental, and MCP community supports appointments.
	  ○ Community service referrals.
	  ○ HRSN referrals (e.g., nutrition, housing, transportation).
	  ○ LTSS referrals.
	• Scheduled follow-up appointments with community-based providers, including primary care and others as clinically indicated, to ensure they have access to needed clinical services as soon as necessary and no later than 30 days from release.

Prompts	Summary
	• Scheduled follow-up appointments with community-based providers, behavioral health services, and other aspects of discharge/reentry planning, as necessary, no later than 30 days from release. • Coordination of reentry logistics, including transportation. • Ensuring that, as allowed under federal and State laws and with consent from the beneficiary, data are shared with MCPs, county MHPs, DMC/DMC-ODS, and, as relevant, with physical and behavioral health providers to enable timely and seamless handoffs. • A plan for engagement of identified supports for the member (e.g., probation/parole officer, family, others). • A list of individuals/organizations that will receive the finalized transitional care plan prior to release. • Documentation of any additional consents needed to share information for seamless care. • As described in Section 2.c. and 3.d., DHCS will require that embedded pre-release care managers conduct a warm handoff with the community-based post-release care manager prior to an individual's release (or, if not possible prior to release, within one week of release). During the warm handoff, the pre- and post-release care managers will be required to review the re-entry care plan with the individual as part of the warm handoff meeting. **(The Policy and Operations Guide was released in October 2023. Correctional facility processes will be phased in over a two year period, beginning as soon as October 2024 and no later than October 2026, depending on correctional facilities go-live date)** • DHCS released the Policy and Operations Guide to stakeholders to support implementation of pre- and post-release care management to ensure individuals are able to access needed services upon their reentry into the community. **(October2023)** • DHCS also released an All Plan Letter that will reference the requirements as laid out in the Policy and Operations Guide. **(October 2023)** • DHCS will monitor compliance with requirements related to the transitional care plan **(DHCS will monitor compliance on an on-going basis once the correctional facility goes live.)** DHCS will provide ongoing technical assistance to implementation stakeholders as needed. **(Ongoing)**

Prompts	Summary
	Challenges and Mitigation Approaches: • **Challenge:** Given the prevalence of short-term stays and unpredictable release dates, particularly in county jails and county youth correctional facilities, correctional facilities may face operational challenges in ensuring that individuals incarcerated for a short period receive a person-centered transitional care plan prior to release. ○ **Mitigation Approach**: As noted above, DHCS has developed detailed operational guidance for correctional facilities on navigating short-stay situations. DHCS expects all county facilities to begin pre-release services as soon as the individual is identified as eligible. DHCS provided a short-term model in the Policy and Operations Guide outlining time period for when pre-release services should begin in order to ensure maximum access to services in a short time period. DHCS defined the time period for which an initial health screening and health care need assessment must occur. During the initial health screening, if the individual appears to qualify for ECM under any Population of Focus eligibility criteria (including but not limited to the Individuals Transitioning From Incarceration Population of Focus), the correctional facility will be required to provide the individual with an ECM informational flyer that describes Medi-Cal and ECM and lists the name and phone number of the individual's county ECM contact; this is meant to connect the individual to post-release care management services in instances in which an individual may be deemed eligible to receive pre-release services but released before the correctional facility is able to assign a pre- or post-release care manager or complete the transitional care plan. If the individual is released prior to the development or completion of the transitional care plan, the post-release ECM care manager will be

Prompts	Summary
	required to develop the transitional care plan/ECM Care Management Plan.
3.b. Implement State policies to provide or facilitate timely access to any post-release health care items and services, including fills or refills of prescribed medications and medical supplies, equipment, appliances or additional exams, laboratory tests, diagnostic, family planning, or other services needed to address the physical and behavioral health care needs identified in the course of care management and the development of the person-centered care plan.	***Current State:*** • DHCS does not yet have processes in place to provide or facilitate timely access to post-release health care items and services. • DHCS is administering a PATH capacity building funds process to support correctional facilities in their implementation processes. Correctional facilities may use PATH funds to set up pre-release and post-release care management processes. ***Future State: Planned Activities & Associated Timelines:*** • As described in Section 3.a., as a component of transitional care planning, DHCS will require the pre-release care manager to coordinate and schedule necessary post-release health care services, including but not limited to fills or refills of prescribed medications and medical supplies as well as DME, diagnostic, family planning, primary care, specialty, mental health, substance use, dental, or other services. **(The Policy and Operations Guide was released in October 2023. Correctional facility processes will be phased in over a two year period, beginning as soon as October 2024 and no later than October 2026, depending on correctional facilities' go-live date)** For example: o *Medications in Hand Upon Release***.** Correctional facilities will be required to provide a full supply of prescribed medications in hand to eligible individuals upon their release from a correctional setting.[43] Correctional facilities will also be required to provide naloxone upon release and a clinically appropriate supply of MAT with follow-up to support overdose prevention. In addition to providing the medications in hand upon release, the correctional facility will be required to submit a prescription for any active medication to a community pharmacy as appropriate and feasible so that the individual has access to refills. Correctional facilities and pre-release care

[43] Full supply is defined as the maximum amount that is medically appropriate and allowed by the Medi-Cal State Plan. DHCS will provide additional guidance on minimum requirements for short-term stays in the Policy and Operational Guide.

Prompts	Summary
	managers are required to work with the post-release care manager (if different) to submit prescriptions and transfer medication refill orders to the individual's preferred community pharmacy, near the individual's anticipated residence in the community, as clinically appropriate. DHCS understands concerns in implementing this policy for individuals with short-term stays; the Policy and Operational Guide will provide expected timelines for meeting minimum requirements in the Short-Term model and will be updated on an on-going basis. ○ *Durable Medical Equipment.* Correctional facilities will be required to screen for and provide necessary DME upon release for any individual who is incarcerated for longer than 14 days. Correctional facilities must ensure that, at a minimum, individuals who use DME reenter the community with a prescription for their DME in hand; the prescription should also be provided to the post-release ECM provider/care manager. Individuals entering the community with DME in hand should also be provided with prescriptions for all necessary DME at the time of release in case the DME in hand is lost, stolen, or broken. ▪ For individuals requiring new DME upon their release in the community, the correctional facility, pre-release care manager, and post-release ECM provider/care manager will be required to coordinate to ensure that residential DME is in place when needed. If the necessary residential DME cannot be set up by the time of release, the provider prescribing the DME must share a copy of the prescription and necessary clinical documentation with the individual and the post-release ECM provider/care manager to be filled in the community. ○ *Behavioral Health Linkages.* As part of the Reentry Demonstration Initiative, DHCS will require correctional facilities, county behavioral health agencies, and Medi-Cal MCPs to implement behavioral health linkages to initiate behavioral health care services in the community and to ensure continuity in care management through

Prompts	Summary
	professional-to-professional clinical handoffs.[44] The State mandate to implement behavioral health linkages requires State prisons, county jails, youth correctional facilities, county behavioral health departments, and Medi-Cal MCPs to implement processes for facilitated referrals and linkages to continue behavioral health treatment in the community for individuals who receive behavioral health services while incarcerated. ○ The State will provide services with reasonable promptness consistent with the unique circumstances and constraints of the carceral setting. • DHCS detailed in the Policy and Operational Guide the requirements related to timeliness of provision of pre-release services and follow-up activities in the community. **(October 2023)** • DHCS will monitor reasonable promptness against these expectations **(DHCS will monitor compliance on an on-going basis once the correctional facility goes live)** • DHCS will work with correctional facilities and community-based providers to continue to refine operational processes. **(Ongoing)**
	Challenges and Mitigation Approaches: • **Challenges:** Correctional facilities and pre- and post-release care managers may face challenges in ensuring timely access to post-release items and services. For example: ▪ *Support for Medications Upon Release:* Correctional facilities that already have on-site pharmacies or partnerships with community-based pharmacies will need to enroll in Medicaid and develop new processes to bill /claim Medi-Cal Rx (including prior authorization as needed). Correctional facilities that currently do not provide any medications to have in-hand upon release because they do not have a

[44] Behavioral Health Linkage requirements are outlined in California Penal Code section 4011.11(h)(5) and consistent with the CalAIM behavioral health linkages initiative (see page 51 of the CalAIM Proposal and AB 133).

Prompts	Summary
	pharmacy on-site or a partnership pharmacy will need to establish new processes for providing medications upon release. DHCS also understands there will be operational complexities associated with the requirement that the correctional facility send active medications to a community pharmacy to ensure continued access in the post-release period, specifically for individuals leaving prison who may have been incarcerated for a relatively longer period of time and do not have an established residence/pharmacy. ▪ *Support for DME Upon Release:* Correctional facilities will have to establish new processes to purchase DME for specific patients (as many currently do not provide DME or provide DME that was used by others within the correctional facility and purchased in bulk at a date outside of the 90-day pre-release period), develop new processes to bill /claim Medicaid for DME, including prior authorization as needed, secure space to store DME until individual is released, and ensure that care managers coordinate to ensure provision of DME. ○ **Mitigation Approaches:** DHCS will work with correctional facilities to refine operational processes, providing targeted technical assistance as needed. DHCS will also take targeted mitigation approaches to the challenges listed above, including: ▪ *Support for Medications Upon Release:* DHCS will require, at a minimum, that the care manager be able to facilitate the linkage to a community pharmacy near the individual's anticipated residence in the community for individuals leaving prison and assist with ensuring that the individual is able to obtain refills of needed medications in the community post-release. In order to ensure individuals have

Prompts	Summary
	an established pharmacy in the community, DHCS will require, at a minimum, that the care manager will be able to facilitate this linkage for individuals leaving prison. DHCS does not expect the same operational complexities to exist for those with shorter stays who have preexisting relationships with outpatient pharmacies and permanent preexisting addresses, such as those leaving jails. ▪ *Support for DME Upon Release*: DHCS developed a model roles and responsibilities chart that was included in the Policy and Operations Guide that describes a potential approach for coordinating across relevant entities for the provision of DME upon release. DHCS will also be closely monitoring the amount of DME that is provided to have in-hand and identify correctional facilities that may need more intervention or targeted technical assistance with assisting individuals in obtaining DME.
3.c. Implement State processes to ensure, if applicable, that managed care plan contracts reflect clear requirements and processes for transfer of the member's relevant health information for purposes of continuity of care (e.g., active prior authorizations, care management information, or other information) to another managed care plan or, if applicable, State Medicaid agency (e.g., if the beneficiary is moving to a region of the State served by a different managed care plan or to another State after release) to ensure continuity	***Current State:*** • DHCS does not yet have processes in place for the transfer of the member's relevant health information for the purposes of continuity of care. ***Future State: Planned Activities & Associated Timelines:*** DHCS will take a multi-pronged approach to ensure continuity of coverage, information sharing, and alignment across the pre- and post-release periods. • Pre-release services will be delivered on a fee-for-service basis. DHCS will require that everyone who is eligible for pre-release services be enrolled in managed care and deemed eligible for a post-release ECM care manager, who will be responsible for assisting the individual in connecting to services in the post-release period. **(The Policy and Operations Guide was released in October 2023. DHCS IT systems to support the Reentry Initiative will be in place by October 1, 2024.**

Prompts	Summary
of coverage and care upon release (coordinated with the requirements under milestone #1 above).	**Correctional facility processes will be phased in over a two year period, beginning as soon as October 2024 and no later than October 2026, depending on correctional facilities go-live date)** ○ To ensure smooth reentry, continuity of care management relationships, and access to providers as soon as possible when the individual is released into the community, DHCS will (1) auto-assign individuals to a managed care plan based on the County of Residence in MEDS at the time of release (with choice period post-plan assignment) and (2) establish current month enrollment (i.e., an individual would be enrolled in a MCP beginning the first of the month in which they are released). ○ DHCS will require that individuals be assigned a post-release care manager (and in-reach pre-release care manager, as applicable) that works in the county in which the individual will be released to ensure the care manager is familiar with and can connect the individual with community-based providers in the county of release. MCPs will be required to ensure that ECM providers can support the scheduling of community-based services for the individual post-release. • DHCS will require all pre-release care managers to share information gathered during the pre-release period, including the needs assessment and transitional care plan, with the individual, the post-release care manager, if they are different, during the warm handoff, and with the assigned MCP. MCPs will be required to have processes and data infrastructure in place to receive member data from the correctional facility and pre- and post-release care managers to support care for the individual in the post-release period. The elements of the transitional care plan that must be shared are described above. This information shall also include information related to all active prior authorizations and prescriptions. **(The Policy and Operations Guide was released in October 2023. Correctional facility processes will be phased in over a two year period, beginning as soon as October 2024 and no later than October 2026, depending on correctional facilities go-live date)** • DHCS will update managed care contracts (Medi-Cal MCPs, county MHPs, County Drug Medi-Cal Organized

Prompts	Summary

	Delivery System, and Drug Medi-Cal State Plan) to reflect the requirements described above. **(October 2024)**
	• DHCS released the Policy and Operations Guide that lays out requirements for information sharing across the pre- and post-release periods. **(October 2023)**
	• DHCS is implementing a process for monitoring MCPs' implementation of ECM and Community Supports, and for following up through technical assistance and/or escalation – up to and including sanctions, as established in the MCP contract – where implementation deficiencies are seen. DHCS' oversight and monitoring process of ECM and Community supports will be strongly data-centered and implemented in a consistent way across the MCPs. Prior to launch of ECM for Justice Involved Population of Focus (effective January 2024) MCPs are required to submit a comprehensive Model of Care detailing their policies for implementing ECM and Community Supports in the counties in which they operate.
	  ○ Prior to go-live for the justice-involved ECM Population of Focus, MCPs must submit model of care responses pertaining to the new populations they are required to serve, with updated policies to be submitted to DHCS upon request. **(October 2023)**
	  ○ DHCS reviews and approves MOC submissions from each MCP. **(December 2023)**
	• DHCS will monitor compliance with requirements related to the transfer processes for transfer of the member's relevant health information to MCPs for purposes of continuity of care. **(Ongoing)**
	• DHCS will provide technical assistance to stakeholders as needed. **(Ongoing)**

	Challenges and Mitigation Approaches: • **Challenge:** Correctional facilities and MCPs will need to establish new processes and systems to receive and exchange member data to ensure continuity of care and align services across the pre- and post-release period. ○ **Mitigation Approach:** DHCS will provide clear data guidance to facilitate data exchange between implementing partners.

Prompts	Summary
3.d. Implement State processes to ensure care managers coordinate with providers of pre-release services and community-based providers, if they are different providers. Implement a State policy to require care managers to facilitate connections to community-based providers pre-release for timely access to services upon reentry in order to provide continuity of care and seamless transitions without administratively burdening the beneficiary (e.g., identifying providers of post-release services, making appointments, having discussions with the post-release care manager, if different, to facilitate a warm handoff and continuity of services). A simple referral is not sufficient. Warm hand-offs to a post-release care manager and follow-up are expected, consistent with guidance language in the care management section.	***Current State:*** • DHCS does not yet have processes in place to ensure care managers coordinate with providers of pre-release services and community-based providers, if they are different. • DHCS is administering a PATH capacity building funds process to support correctional facilities in their implementation processes. Correctional facilities may use PATH funds to set up processes for facilitating health service linkages upon release. ***Future State: Planned Activities & Associated Timelines:*** • As described in Section 3.a., as a component of transitional care planning, DHCS will require the pre-release care manager to coordinate and schedule necessary post-release health care services, including but not limited to fills or refills of prescribed medications and medical supplies as well as DME, diagnostic, family planning, primary care, specialty, mental health, substance use, dental, or other services to ensure a minimally burdensome and seamless transition to services post release. **(The Policy and Operations Guide was released in October 2023. Correctional facility processes will be phased in over a two year period, beginning as soon as October 2024 and no later than October 2026, depending on correctional facilities go-live date)** • As described in 2.c., DHCS will require that, in cases where pre-and post-release care managers are different (i.e., the correctional facility leverages an embedded care management model or the individuals is release to a different county from the correctional facility in which they are incarcerated), the embedded care manager implement a warm handoff with the community-based care manager in accordance with the standard requirements described below. **(The Policy and Operations Guide was released in October 2023. Correctional facility processes will be phased in over a two year period, beginning as soon as October 2024 and no later than October 2026, depending on correctional facilities go-live date)**

Prompts	Summary
	○ In cases where pre- and post-release care managers are different, the embedded pre-release care manager and the community-based post-release care manager must conduct a warm handoff with the individual present prior to release. ○ Minimum requirements for the pre- and post-release care managers conducting warm handoffs are as follows: ▪ Sharing the transitional care plan with the individual, the post-release care manager and the individual's assigned MCPs. ▪ Scheduling and conducting a warm handoff meeting that includes the individual and both the pre- and post-release care managers to begin establishing a trusted relationship, review the transitional care plan and address questions, and identify any outstanding service needs and supports required for successful community reentry. ○ For individuals with known release dates, DHCS recommends that the warm handoff meeting occur at least 14 days prior to release. Telehealth may be used to conduct warm handoffs. If it is not possible for the warm handoff, including the requirements listed above, to occur prior to the individual's release (e.g., if the individual is released by court order earlier than expected or has a very short stay), the pre- and post-release care managers must conduct the warm handoff in the community post-release within one week, but the pre-release care manager must share the reentry plan and other pertinent information with the post-release care manager and the assigned MCP within a clinically appropriate time frame (e.g., 24 hours after release). ○ In addition, correctional facilities, county behavioral health agencies, and MCPs must facilitate behavioral health linkages for all individuals who receive behavioral health services while incarcerated, including professional-to-professional clinical handoffs, facilitated referrals, and linkages to continued behavioral health treatment.

Prompts	Summary
	• DHCS released the Policy and Operations Guide that details the requirements as described above. **(September 2023)** • DHCS will monitor compliance with continuity of care, including warm handoff, requirements. **(DHCS IT systems to support the Reentry Initiative will be in place by October 1, 2024. DHCS will monitor compliance on an on-going basis once the correctional facility goes live.)** • DHCS will also provide technical assistance to implementation stakeholders, as needed. **(Ongoing)**

	Challenges and Mitigation Approaches:
	• **Challenge:** The pre- and post-release care managers may face challenges in facilitating the warm handoff during the pre-release period in some instances, such as when the individual is released by court order earlier than expected or has a very short stay.
	  ○ **Mitigation Approach:** DHCS will require that pre- and post-release care manager meet with the individual to conduct the warm handoff in the community post-release within one week, and that the pre-release care manager shares the re-entry plan and other pertinent information with the post-release care manager and the assigned MCP within 24 hours of release (or as close to that timeline as possible). DHCS recommends as a best practice that post-release care managers meet the individual at release if possible, or, if that is not possible, within one to two days of release.
	• **Challenge:** Individuals may be released into a different county than the one in which they are incarcerated. This could present challenges for connecting them to community-based providers due to pre-release care managers' limited knowledge about providers and services in the county of release.
	  ○ **Mitigation Approach:** DHCS requires that individuals be assigned a post-release care manager (and in-reach pre-release care manager, as applicable) that works in the county in which the individual will be released to ensure the care

Prompts	Summary
	manager is familiar with and can connect the individual with community-based providers in the county of release. Post-release care managers are expected to collaborate with the pre-release care manager on development of the transitional care plan. If the post-release care manager is located in a different county than the correctional facility, warm handoffs may be provided via telehealth. Correctional facilities and pre-release care managers may also reach out to the established Justice-Involved MCP point-of-contact in the county of release for assistance in identifying community-based providers and coordinating services in the county to which the individual will be released.

Milestone 4: Connecting to services available post-release to meet the needs of the reentering population

STC Language: The State must describe how it will develop and implement a system to monitor the delivery of post-release services and ensure that such services are delivered within the appropriate time frame, per the guidelines in the forthcoming State Medical Director Letter (SMDL). The Implementation Plan must also capture how the State will monitor and adjust, as needed, ongoing post-release care management and describe its process to help ensure the scheduling and receipt of needed services, as well as other services needed to address HRSN and LTSS. Additionally, the State must describe how it will ensure that care managers are able to effectively serve demonstration beneficiaries transitioning into the community and recently released beneficiaries who are no longer demonstration beneficiaries.

Prompts	Summary
4.a. Develop State systems to monitor individuals who are incarcerated and their person-centered care plans to ensure that post-release services are delivered within an appropriate time frame. We expect this generally will include a scheduled contact between the reentering individual and the care managers that occurs within one to two days post-release and a second appointment that occurs within one week of release to ensure continuity of care and seamless transition to monitor progress and care plan implementation. These short-term follow-ups should include the pre-release and post-release (if different) care managers, as possible, to ensure longer-term post-release care management is as seamless as possible. In keeping with the person-centered care plan and individual needs, CMS is providing these general time frames as suggestions but	***Current State:*** • DHCS does not yet have State processes in place to monitor individuals who are incarcerated to ensure that post-release services are delivered within appropriate time frames**.** • DHCS is administering a PATH capacity building funds process to support correctional facilities in their implementation processes. Correctional facilities may use PATH funds to set up processes for ensuring coordination across the pre- and post-release periods to ensure continuity of care. ***Future State: Planned Activities & Associated Timelines:*** • DHCS will develop processes and oversight and evaluation protocols to monitor individuals who are incarcerated and their person-centered care plans to ensure post-release services are delivered within an appropriate timeframe. **(DHCS IT systems to support the Reentry Initiative will be in place by October 1, 2024. DHCS will monitor compliance on an on-going basis once the correctional facility goes live.** ○ DHCS will require that an individual have a scheduled contact with a post-release ECM care manager as close to release as possible (e.g., within one- or two-days post-release) and a second appointment that occurs within one week of release to ensure continuity and seamless transitions. • Individuals transitioning from incarceration into the community will be eligible to receive the ECM benefit from their MCPs in order to address clinical and non-

Prompts	Summary
recognizes that depending on the beneficiary's individualized needs and risk factors, a care manager may determine that the first scheduled contact with the beneficiary should occur, for example, within the first 24 hours after release and on a more frequent cadence in order to advance the goals of this demonstration.	clinical needs through intensive coordination of health and health-related services, as described in Section 3.c. above. Post-release care management will be delivered by ECM providers and monitored by MCPs. DHCS will require that post-release ECM care managers meet with the individual as close to the release date as possible (e.g., within one or two days post-release) and conduct a follow-up appointment within one week of release to ensure continuity of coverage. ECM care management includes:[45] ○ Conducting outreach and engaging individuals. ○ Updating the individual's needs assessment and care plan with newly identified needs. ○ Coordinating the services necessary to implement the care plan. ○ Providing health promotion services to encourage and support individuals to engage in healthy behaviors. ○ Supporting individuals and their support networks during discharge from the hospital or institutional settings. ○ Ensuring individuals and their support networks are knowledgeable about the individual's conditions. ○ Coordinating referrals and transportation to community and county social service agencies/offices. To ensure implementation of these requirements: • DHCS will ensure post-release care managers are able to deliver post-release services in an appropriate time frame as part of the warm handoff requirements to a community-based care manager prior to release. The post-release care manager will be responsible for ensuring follow-up appointments are scheduled, work with the individual to attend these appointments (for example, helping with transportation), and follow up with the individual if an appointment is missed to ensure it is rescheduled and services are delivered. Post-release care managers will be based in the same geographic community that the member will reenter,

[45]

Prompts	Summary
	ensuring the care manager will be familiar with local resources and provider networks. **(DHCS IT systems to support the Reentry Initiative will be in place by October 1, 2024. Correctional facility processes will be phased in over a two year period,, beginning as soon as October 2024 and no later than October 2026, depending on correctional facilities' go-live date)** • DHCS is implementing a process for monitoring MCPs' implementation of ECM and Community Supports, and for following up through technical assistance and/or escalation – up to and including sanctions, as established in the MCP contract – where implementation deficiencies are seen. DHCS' oversight and monitoring process of ECM and Community supports will be strongly data-centered and implemented in a consistent way across the MCPs. Prior to launch of ECM for Justice Involved Population of Focus (effective January 2024) MCPs are required to submit a comprehensive Model of Care detailing their policies for implementing ECM and Community Supports in the counties in which they operate. ○ Prior to go-live for the justice-involved ECM Population of Focus, MCPs must submit updated policies relevant to the new populations they are required to serve. **(October 2023)** ○ DHCS reviews and approves MOC submissions from each MCP. **(November 2023)** ○ Subsequent to the effective date of the Justice Involved Population of Focus, MCPs will be required to submit monthly monitoring data through the JavaScript Object Notation (JSON) file . **(Starting in Q3 2024)** ○ DHCS will leverage existing Enhanced Care Management program monitoring mechanisms to track ongoing engagement in post-release Enhanced Care Management **(Ongoing)** ○ DHCS supplements this data report with a wide range of secondary sources for monitoring, which includes, for example, extensive stakeholder feedback with multiple Advisory Groups. DHCS is committed to long-term monitoring and continuing technical assistance to MCPs. **(Ongoing)**

Prompts	Summary

	• DHCS will be tracking claims and encounter data in the post-release period to track the number of services that an individual who was eligible for pre-release services received in the post-release period (and within how many months post-release). While DHCS has not yet received CMS' Reentry Monitoring Protocol Template, it is committed to tracking number and types of physical and behavioral health services and medications that an individual has received in the post-release period. **(DHCS IT systems to support the Reentry Initiative will be in place by October 1, 2024. DHCS will monitor compliance on an on-going basis once the correctional facility goes live.**
	• DHCS developed clear requirements for inclusion in the Policy and Operational Guide, regarding:
	  ○ The development of whole-person care plan assessments—including assessment of mental health, substance use, physical health, health-related social needs, long-term services and supports, and functional needs—and the scope of these care plans, which should include plans that address the needs of the member in the community upon release.
	  ○ Guidance on the division of responsibilities during the warm handoff between pre- and post-release care managers (if applicable) and, different entities involved in warm handoffs (correctional facilities, county behavioral health agencies, and MCPs), and required timelines to ensure continuity of care in the community. **(September 2023)**
	• As described in Section 3.c., DHCS will develop MCP auto-assignment enrollment processes for individuals eligible for pre-release services who are not currently enrolled in a MCP, ensuring members will be afforded timely access the ECM benefit and Community Supports services in the community. **(DHCS IT systems to support the Reentry Initiative will be in place by October 1, 2024. DHCS will monitor compliance on an on-going basis once the correctional facility goes live.)**

	Challenges and Mitigation Approaches:

Prompts	Summary

	• **Challenge:** ECM care managers may have challenges contacting individual in the community, because they lack access to a reliable phone or stable housing.
	  ○ **Mitigation Approach:** The pre-release care manager will be required to collect information about how to contact in the individual in the community when released, including names and contact information for the individual's identified support network (e.g., family members or trusted friends). The pre-release care manager will provide this contact information as part of the reentry care plan, shared with the post-release ECM care manager and the MCP. In addition, the post-release ECM care manager contact information and the MCP's contact information will be included in the reentry plan given to the individual upon release so they can reach out directly to the ECM care manager or plan for assistance.
	• **Challenge:** While DHCS is implementing policies to ensure ECM can begin the day of release, including effectuating MCP auto-assignment and ECM enrollment prior to release, there may be instances when short-term stay individuals are released prior to MCP enrollment and are receiving FFS Medi-Cal benefits upon release.
	  ○ **Mitigation Approach:** DHCS has existing state plan authority for FFS case management and is creating policies to ensure that if a member is not yet enrolled in the MCP, the ECM care manager will be able to serve the member post-release and bill FFS case management for reentry case management services for up to 4 weeks post-release.

4.b. Develop State processes to monitor and ensure ongoing care management to ensure successful transitions to the community and continuity of care post-release; to provide an assessment; monitor the	***Current State:*** • DHCS does not yet have State processes in place to monitor ongoing care management to ensure successful transition to the community and continuity of care post-release.

Prompts	Summary
person-centered care plan implementation and to adjust it, as needed; and to ensure scheduling and receipt of needed covered services.	***Future State: Planned Activities & Associated Timelines:*** • DHCS will develop processes and monitor to ensure that individuals receive ongoing care management that ensure successful transition to the community and continuity of care post-release. **(DHCS IT systems to support the Reentry Initiative will be in place by October 1, 2024. DHCS will monitor compliance on an on-going basis once the correctional facility goes live.** ○ To ensure that individuals are provided with continuous care management that facilitates successful re-entry into the community and ongoing services post-release, DHCS will require that individuals be enrolled in an MCP and receive ECM services upon release into the community. ○ DHCS will require MCPs to oversee the delivery of ECM services to the Justice-Involved Population of Focus, and DHCS will continue to oversee and monitor the delivery of ECM for this population, as part of its overall ECM oversight and monitoring processes. This includes oversight of the core responsibility of the ECM provider to develop, review, maintain, and update a comprehensive individualized person-centered care management plan.[46] • DHCS is implementing a process for monitoring MCPs' implementation of ECM and Community Supports, and for following up through technical assistance and/or escalation – up to and including sanctions, as established in the MCP contract – where implementation deficiencies are seen. DHCS' oversight and monitoring process of ECM and Community supports will be strongly data-centered and implemented in a consistent way across the MCPs. Prior to launch of ECM for Justice Involved Population of Focus (effective January 2024) MCPs are required to submit a comprehensive Model of Care detailing their policies for implementing ECM and Community Supports in the counties in which they operate.

[46] Requirements for the ECM comprehensive assessment and care management plan can be found in the CalAIM Enhanced Care Management Policy Guide, available at: https://www.dhcs.ca.gov/Documents/MCQMD/ECM-Policy-Guide.pdf.

Prompts	Summary
	○ Prior to go-live for the justice-involved ECM Population of Focus, MCPs must submitted updated policies relevant to the new populations they are required to serve. **(September 2023)** ○ DHCS reviews and approves MOC submissions from each MCP. **(November 2023)** ○ Subsequent to the effective date of the Justice Involved Population of Focus, MCPs will be required to submit monthly monitoring data through a JavaScript Object Notation (JSON) File **(Starting in Q3 2024)** ○ DHCS will leverage existing Enhanced Care Management program monitoring mechanisms to track ongoing engagement in post-release Enhanced Care Management **(Ongoing)** ○ DHCS supplements this data report with a wide range of secondary sources for monitoring, which includes, for example, extensive stakeholder feedback with multiple Advisory Groups. DHCS is committed to long-term monitoring and continuing technical assistance to MCPs. **(Ongoing)** • As a companion to the Model of Care, DHCS detailed in the Policy and Operational Guide all the requirements for the ECM post-release care manager around ongoing care management and continuity of care following release. **(September 2023)** • DHCS will meet regularly with the MCPs to provide ongoing technical assistance, as needed. **(Ongoing)**
	Challenges and Mitigation Approaches: • **Challenge:** MCPs have expressed concern that there may not be adequate workforce of community-based providers available to provide ECM services to justice-involved individuals in the post-release period. ○ **Mitigation Approach:** DHCS is committed to increasing ECM community-based provider capacity, and through the PATH Capacity and Infrastructure Transition Expansion and Development (CITED) Initiative and the PATH technical assistance marketplace, has funding to support organizations and technical assistance for ECM. DHCS meets monthly with the MCPs and will establish a standing meeting agenda item to assess implementation on an on-going

Prompts	Summary
	basis as it relates to adequate workforce for ECM providers. DHCS will work with MCPs to identify additional mitigation strategies to help address emerging workforce issues including assisting in provider enrollment processes and addressing any other operational issues that may be impacting the number of providers who are willing to serve as ECM care managers for justice-involved individuals. Finally, and as a last resort: similar to other ECM populations of focus, DHCS will allow MCPs to submit an exception to DHCS that allows the MCP to temporarily use their own staff to provide ECM services if there is not enough capacity in the community. • **Challenge:** Ensuring that post-release providers, including the ECM care manager and treating behavioral and physical health providers have information on the medical treatment provided in the carceral system and the care plan developed by the pre-release care manager is critical to ensuring successful transitions. Providers and MCPs have expressed concern about the difficulty of accessing correctional facility health information. ○ **Mitigation Approach:** DHCS outlined requirements and best practices for information sharing between correctional facilities and the receiving providers and plans in the Policy and Operational Guide. DHCS will monitor the effectiveness of reentry data sharing by leveraging monthly meetings with MCPs and County Behavioral Health Providers, to identify data sharing barriers and identify correctional facilities that are not providing timely information to MCPs or County Plans or their contracted ECM, physical health, or Behavioral health providers. DHCS will evaluate the causes of identified issues, provide technical assistance, and clarify guidance or policy, as necessary, on expected and allowable information sharing to the correctional facility. As Necessary, DHCS will develop corrective action plans for correctional facilities to improve timely information sharing.

Prompts	Summary
4.c. Develop State processes to ensure that individuals who are receiving services through the Reentry Section 1115 Demonstration Opportunity are connected to other services needed to address LTSS and HRSN, such as housing, employment support, and other social supports as identified in the development of the person-centered care plan.	***Current State:*** • DHCS does not yet have processes in place to connect individuals eligible for pre-release services to services post-release. ***Future State: Planned Activities & Associated Timelines:*** DHCS will develop oversight and monitoring processes to ensure that individuals receiving pre-release services are connected to other services needed to address LTSS and HRSN that are identified in the care plan. **(DHCS IT systems to support the Reentry Initiative will be in place by October 1, 2024. DHCS will monitor compliance on an on-going basis once the correctional facility goes live.)** ○ As described in Section 3.c., part of pre-release care management for Medi-Cal-enrolled individuals who are incarcerated includes the development of a transitional care plan with the individual; this transitional care plan will include a plan to address LTSS, HRSN, and other social supports available to members once they are in the community. Additionally, as described in Section 4.a., members eligible for managed care will be automatically enrolled into a MCP and eligible for the ECM benefit and Community Supports. (Community Supports are available at plan discretion, and individuals must meet eligibility criteria to receive Community Supports.) • DHCS will be tracking claims and encounter data in the post-release period to track the number of services that an individual who was eligible for pre-release services received in the post-release period (and within how many months post-release). While DHCS has not yet received CMS' Reentry Monitoring Protocol Template, it is committed to tracking number and types of LTSS and HRSN services that an individual has received in the post-release period. **(DHCS IT systems to support the Reentry Initiative will be in place by October 1, 2024. DHCS will monitor compliance on an on-going basis once the correctional facility goes live.)** DHCS detailed in the Policy and Operational Guide requirements related to connecting individuals to LTSS, HRSNs, and other social supports. **(September 2023)**

Prompts	Summary
	• DHCS will meet regularly with the MCPs to provide ongoing technical assistance, as needed. **(Ongoing)**
	Challenges and Mitigation Approaches: • **Challenge:** An on-going challenge that DHCS anticipates is that individuals leaving incarceration will not be connected to HRSNs or LTSS in a timely manner. ○ **Mitigation Approach:** DHCS will be closely monitoring the number of people who received HRSNs and LTSS in the post-release period and will work to identify and implement new policies and operational processes for increasing access and receipt of such services.
4.d. Implement State policies to monitor and ensure that care managers have the necessary time needed to respond effectively to individuals who are incarcerated who will likely have a high need for assistance with navigating the transition into the community.	***Current State:*** • DHCS does not yet have processes in place to connect individuals eligible for pre-release services to services post-release. • DHCS is administering a PATH capacity building funds process to support correctional facilities in their implementation processes. Correctional facilities may use PATH funds to set up processes for facilitating health service linkages upon release.
	Future State: Planned Activities & Associated Timelines: • DHCS will implement policies and monitor to ensure that care managers have the necessary capacity to provide the required high-touch, intensive care management services in the pre- and post-release periods that will be required to effectively serve individuals transitioning from incarceration to their community. **(DHCS IT systems to support the Reentry Initiative will be in place by October 1, 2024. DHCS will monitor compliance on an on-going basis once the correctional facility goes live.))** ○ As described in Section 5.a. below, DHCS will require correctional facilities to demonstrate

Prompts	Summary
	readiness for providing pre-release services. This readiness assessment will include process development and capacity building for delivering care management services and connecting incarcerated individuals to community-based providers. ○ Upon release, individuals who are eligible for pre-release services will also be eligible to receive ECM, which is a MCP benefit available to high-need MCP members that provides systematic coordination of services and comprehensive care management that is community based, interdisciplinary, high touch and person centered. ECM providers will coordinate all care across the physical and behavioral health delivery systems. ECM providers will play a critical role in supporting individuals' transitions into the community. More information about ECM can be found in the ECM Policy Guide. • DHCS released the Policy and Operations Guide that details the requirements as described above. **(October 2023)** • DHCS will also provide technical assistance to implementation stakeholders, as needed. **(Ongoing)** • DHCS is implementing a process for monitoring MCPs' implementation of ECM and Community Supports, and for following up through technical assistance and/or escalation – up to and including sanctions, as established in the MCP contract – where implementation deficiencies are seen. DHCS' oversight and monitoring process of ECM and Community supports will be strongly data-centered and implemented in a consistent way across the MCPs. Prior to launch of ECM for Justice Involved Population of Focus (effective January 2024) MCPs are required to submit a comprehensive Model of Care detailing their policies for implementing ECM and Community Supports in the counties in which they operate. ○ Prior to go-live for the justice-involved ECM Population of Focus, MCPs must submit model of care responses pertaining to the new populations they are required to serve, with updated policies to be submitted to DHCS upon request. **(October 2023)**

Prompts	Summary
	○ DHCS reviews and approves MOC submissions from each MCP. **(December 2023)** ○ Subsequent to the effective date of the Justice Involved Population of Focus, MCPs will be required to submit quarterly monitoring data through a Quarterly Implementation Monitoring Report. **(Starting in Q1 2024)** ○ DHCS supplements this data report with a wide range of secondary sources for monitoring, which includes, for example, extensive stakeholder feedback with multiple Advisory Groups. DHCS is committed to long-term monitoring and continuing technical assistance to MCPs. **(Ongoing)**
	Challenges and Mitigation Approaches: • **Challenge:** For individuals with short term stays, it is possible that there will not be enough time for pre-release care managers respond effectively to individuals who are incarcerated and who will likely have a high need for assistance with navigating the transition into the community ○ **Mitigation Approach:** DHCS will provide operational guidance for correctional facilities on navigating short-stay situations, including minimum requirements and timelines for correctional facilities to provide pre-release care management services and coordinate with community-based providers.

Milestone 5: Ensuring cross-system collaboration

STC Language: The State must describe how correctional facilities will facilitate access for incarcerated beneficiaries to community health care providers, including care managers, either in person or via telehealth. The State must also document its plans for establishing communication and engagement between corrections systems, community supervision entities, health care organizations, the State Medicaid agency, and supported employment and housing organizations. The State must also develop a system (e.g., a data exchange, with requisite data-sharing agreements) and establish processes to monitor individuals' health care needs, HRSN, and access to and receipt of health care services pre-and post-release and identify anticipated challenges and potential solutions. Further, the State must develop and share its strategies to improve awareness about Medicaid coverage and access among stakeholders, including those who are incarcerated.

Prompts	Summary
5.a. Establish an assessment outlining how the State's Medicaid agency and participating correctional system/s will confirm they are ready to ensure the provision of pre-release services to eligible beneficiaries, including but not limited to how facilities participating in the Reentry Section 1115 Demonstration Opportunity will facilitate access within the correctional facilities for community health care providers, including care managers, in person and/or via telehealth, as appropriate. A State could phase in	***Current State:*** To ensure the delivery of high-quality services in the pre-release period, and as required by the 1115 Waiver's Special Terms and Conditions, DHCS developed a readiness assessment with elements that lay out what correctional facilities must demonstrate in order to be eligible to "go live" with the delivery of pre-release services. The correctional facility readiness assessment will assess the ability of correctional facilities to implement and support the focus areas listed below. All correctional facilities will be required to demonstrate ability to designate space for in-reach meetings, including physical space for in-person visits and/or space and technology for individuals to connect to virtual consultation (e.g., laptop or similar device, webcam, internet access, telephone line) while ensuring appropriate security protections remain in place (e.g., Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance). While DHCS will have certain elements marked as minimum requirements, all aspects of the readiness assessment must still be supported and ready to go live prior to the planned go-live date; however, DHCS may use discretion when reviewing minimum requirements to determine whether an agency is ready to go live. All correctional facilities must meet all go-live requirements through their readiness assessment submission and go-live with pre-release services by October 1, 2026. DHCS will also abide by all CAA of 2023 Section 5121 implementation timelines agreed upon with CMS. The focus areas are:

Prompts	Summary
implementation of pre-release services based on the readiness of various participating facilities and/or systems.	1. **Medi-Cal Application Processes** a. Screening *(minimum requirement)* b. Application Support *(minimum requirement)* c. Unsuspension/Activation of Benefits *(minimum requirement)* 2. **90-Day Pre-Release Eligibility and Behavioral Health Linkage Screening** a. Screening for Pre-Release Services *(minimum requirement)* b. Screening for Behavioral Health Linkages *(minimum requirement)* 3. **90-Day Pre-Release Service Delivery** a. Medi-Cal Billing and Provider Enrollment *(minimum requirement)* b. Support of Pre-Release Care Management *(minimum requirement)* c. Clinical Consultation d. Virtual/In-Person In-Reach Provider Support *(minimum requirement)* e. Support for Medications *(minimum requirement)* f. Support for MAT *(minimum requirement)* g. Support for Prescriptions Upon Release *(minimum requirement)* h. Support for DME Upon Release 4. **Reentry Planning and Coordination** a. Release Date Notification *(minimum requirement)* b. Care Management Reentry Plan Finalization *(minimum requirement)* c. Reentry Care Management Warm Handoff *(minimum requirement)* d. Reentry Behavioral Health Linkage *(minimum requirement)* 5. **Oversight and Project Management** a. Staffing Structure and Plan *(minimum requirement)* b. Governance Structure for Partnerships *c.* Reporting and Oversight Process *(minimum requirement)* Correctional facilities must submit their readiness assessments to DHCS at least five months prior to their proposed go-live date (as early as November 2023 and no later than November 2025). DHCS will require each correctional facility to complete a readiness assessment and receive DHCS approval prior to its go-live date. Readiness decisions will be made at the facility level, not at the county level. For example, if a county has five facilities, and three are ready to go live, but two are not, the three can go live.

Prompts	Summary
	In their readiness assessment submission, correctional facilities are expected to explain in a narrative format how they meet or will meet the readiness assessment elements. Correctional facilities will be required to include attachments such as program policy guides, workflows, and organizational charts to respond to questions in the readiness assessment. The readiness assessment will also include a list of attestations that the correctional facility will be expected to sign. Readiness will not be finalized until correctional facilities sign this attestation. DHCS recognizes that some correctional facilities may not have all the required capabilities in place for all five focus areas described below (and/or for each of their facilities) at the time of submitting their readiness assessment. In these instances, agencies will be asked to describe their plan for achieving readiness prior to the planned go-live date. For each of the five focus areas, DHCS will determine a score based on the correctional agency's narrative response, attestation, and documentation of their readiness for implementing pre-release services. The DHCS review team will use the following scoring rubric to determine the score for each focus area *(note DHCS may update terminology around the scoring rubric based on lessons learned)*: • **Pass:** Correctional facility's response is complete and indicates total or almost total readiness (i.e., all minimum requirements are met) and facility receives a pass in each focus area, and the facility has process in place to go-live with non-minimum requirement elements within a timebound glidepath. • **Conditional Pass:** Correctional facility response is complete and indicates that facility meets some, but not all, components of the readiness assessment. The facility must minimally be able to deliver case management, MAT services, and a 30-day supply of medication upon release in order receive a conditional pass, and may phase in the populations that receive this minimum set of services completely within 12 months of the facility going live for increasing their capacity to provide this minimum set of services to all eligible individuals, taking into consideration all appropriate federal laws regarding civil rights such as the Americans with Disabilities Act, etc. Nothing in this approval will supersede the state's compliance actions to meet all CAA of 2023 Section 5121 implementation requirements and timelines. DHCS will require all facilities that receive a conditional pass to specify a structured glidepath and time bound implementation plan for increasing capacity and achieving a pass rating by the

Prompts	Summary
	end of the defined ramp up period as part of their readiness assessment review process. DHCS and correctional facilities will agree on specific target metrics to demonstrate the facility's progress in reaching full compliance and will meet with facilities under conditional approval on a regular basis until all metrics are met and facility receives a "Pass". If a facility does not achieve a pass rating by the end of the 12-month ramp-up period, the facility must submit a corrective action plan or the facility will be considered to have not demonstrated readiness to go live. • **Fail:** Correctional facility's response is incomplete, the provided response does not sufficiently address the question, or the provided response does not indicate readiness to go live. Additional information on what is required for each readiness element is available in DHCS' Policy and Operational Guide.

	Future State: Planned Activities & Associated Timelines:
	
	• Go-Live dates will occur on a quarterly basis (e.g., October 2024, January 2025, March 2025) through October 2026. The readiness assessment process will open at least 6 months prior to each quarterly cohort. The following is an example timeline for the six-month readiness process:
	  ○ By April 1, 2024, correctional facilities submit their readiness assessment plans and materials (gives facilities at least two months to complete).
	  ○ By August 1, 2024, DHCS confirms readiness (gives DHCS four months to review plans, conduct site visits, and follow-up with correctional facilities).
	  ○ By October 1, 2024, first facility goes live (gives facilities two months)
	• DHCS will review assessments and provide approval, on a rolling basis, to facilities demonstrating readiness to go live, with an earliest anticipated go-live date of October 1, 2024. **(The Policy and Operations Guide was released in October 2023. DHCS released a draft readiness assessment template in October 2023 and plans to release the final readiness assessment tool in early 2024. DHCS IT systems to support the Reentry Initiative will be in place by October 1, 2024. Correctional facility processes will be phased in over a two year go-live period, beginning as soon as October 2024 and no later than October 2026, depending on correctional facilities' go-live date. For more information on go-live dates and readiness**

Prompts	Summary
	assessment requirements and timelines, please see Appendix.)

	Challenges and Mitigation Approaches:
	• **Challenge:** DHCS expects Medi-Cal provider enrollment and billing/claiming requirements to be most challenging for correctional facilities to meet.
	  ○ **Billing and Claiming:** Until this 1115 Reentry Demonstration Opportunity, correctional facilities have been unable to bill for Medi-Cal services due to the inmate payment exclusion. Because of this, correctional facilities have not set up billing and claiming systems within their EHRs and do not have robust/standardized data exchange processes in place with DHCS or community-based providers to facilitate billing and claiming of Medi-Cal services.
	  ○ **Provider Enrollment:** Correctional facilities have raised concern around requiring provider enrollment as it relates to administrative burden, lack of staff resources/bandwidth, and union negotiations.
	• **Mitigation Approach:**
	  ▪ **Billing and Claiming:** DHCS will provide technical assistance to all correctional facilities to support billing/claiming processes. DHCS also expects correctional facilities to use PATH funding to build billing/claiming arms of EHRs.
	  ▪ **Provider Enrollment:** As mentioned above, DHCS will enroll all correctional facility and pharmacy providers who provide services under existing enrollment pathways. DHCS will provide technical assistance to all correctional facilities to assist in Medi-Cal enrollment.

5.b. Develop a plan for organizational-level engagement, coordination, and communication between the corrections systems, community supervision entities, health care providers and	***Current State:*** DHCS has been facilitating regular meetings of the cross-sector stakeholder Justice-Involved Advisory Group since 2021. The purpose of the Advisory Group is to communicate program policy, solicit stakeholder feedback to inform program design, and share best practices among implementing entities. Members of the Advisory Group include representatives of corrections systems, community supervision entities, health care providers and provider organizations, county entities, social services organizations, and individuals with lived experience.

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provider organizations, State Medicaid agencies, and supported employment and supported housing agencies or organizations.	DHCS has also been facilitating, and intends to continue to facilitate, one-on-one technical assistance sessions with implementation stakeholders including but not limited to State prisons, county jails, providers, individuals with lived experiences, and MCPs. Depending on the implementing stakeholder, DHCS has been convening these discussions on a weekly, biweekly, monthly, or quarterly basis. The purpose of these meetings is to glean stakeholder feedback to inform program design and provide direct technical assistance to implementing entities. For example, DHCS has been facilitating monthly meetings with CDCR, the state's prison system, on Medicaid provider and pharmacy enrollment and billing and claiming requirements. DHCS has also taken steps to support information sharing between implementing entities. In July 2021, Governor Newsom signed into law the health omnibus trailer bill legislation for the 2021-2022 California Budget (AB 133; Chapter 143 of Statutes of 2021). In recognition of the importance of information sharing in supporting collaboration and communication as part of the implementation of the Reentry Demonstration Initiative and other components of CalAIM, AB 133 included provisions to permit specified entities to disclose personally identifiable information—including protected health information—among one another so long as such disclosure is (1) necessary to implement CalAIM components or the CalAIM terms and conditions and (2) consistent with federal law. AB 133 also modified the California Penal Code to promote information sharing for the purposes of health insurance affordability program enrollment and the provision of behavioral health services post-release. DHCS released guidance on these provisions to the public in March 2022.[47] As part of the CalAIM Reentry Demonstration Initiative approval, DHCS received authority to provide capacity building grants to implementation partners, known as the PATH initiative. These PATH funds are available to correctional facilities and county behavioral health agencies and are intended to support cross-stakeholder coordination. PATH funds may be used toward "activities to promote collaboration," i.e., expenditures related to facilitating collaborative planning activities between correctional agencies, MCPs, county behavioral health agencies, and

[47] Guidance is available here: https://www.dhcs.ca.gov/Documents/MCQMD/CalAIM-Data-Sharing-Authorization-Guidance.pdf.

Prompts	Summary
	other stakeholders as needed to support planning, implementation, and modification of Medi-Cal pre-release service processes.[48] PATH grant awardees are also required to submit periodic progress reports, which include a description of collaborations or working sessions with local social services agencies/offices, local Medi-Cal MCPs, in-reach providers, and correctional agencies/county behavioral health agencies.
	Future State: Planned Activities & Associated Timelines: • DHCS will continue to facilitate the Advisory Group and one-on-one technical assistance sessions with implementation partners. **(Ongoing)** • DHCS will update the data-sharing guidance to include additional use cases and clarifications. The revised guidance is planned for release by September 2023, and additional updates may be released in the future. **(September 2023)** • DHCS released the Policy and Operations Guide that details the requirements as described above. **(October 2023)** • DHCS will provide technical assistance to implementation stakeholders, as needed. **(Ongoing)**
	Challenges and Mitigation Approaches: • **Challenge**: Coordination and communication needs are often unique to the county or locality in which the implementation partners operate, and the individual stakeholders within each, requiring tailored support and technical assistance. ○ **Mitigation Approach:** DHCS plans to leverage the PATH program to support local capacity building and collaboration. This includes leveraging PATH capacity grants for collaboration and planning activities, as well as for building and implementing the necessary processes, systems and formal agreements that are required for ongoing coordination among local implementation partners. It also includes potentially leveraging regional Collaborative Planning and Implementation groups to bring together stakeholders to plan customized

[48] Additional guidance on this funding can be found on the DHCS CalAIM JI website under the Providing Access and Transforming Health Initiative section, available here: https://www.dhcs.ca.gov/CalAIM/Pages/Justice.aspx.

Prompts	Summary
	approaches that build on relationships and processes at the local level. • **Challenge:** Correctional facilities, MCPs, community-based providers and other stakeholders will need to establish new processes and systems to share information, including to receive and exchange member data, to facilitate engagement, coordination, and communication among stakeholders in support of successful program implementation. ○ **Mitigation Approach:** DHCS will provide clear data guidance and technical assistance to facilitate information sharing between implementing partners.
5.c. Develop strategies to improve awareness and education about Medicaid coverage and health care access among various stakeholders, including individuals who are incarcerated, community supervision agencies, corrections institutions, health care providers, and relevant community organizations (including community organizations serving the	***Current State:*** DHCS has taken a multi-pronged approach to improving stakeholder awareness about Medi-Cal and the Reentry Demonstration Initiative. Since 2021, DHCS has hosted 11 Advisory Group webinars about the Reentry Demonstration Initiative to inform the key stakeholders about design decisions, program requirements, and key milestones; these webinars were also open to the public and allowed a chance for non-advisory group members to provide feedback on the Reentry Demonstration Initiative. DHCS has also regularly facilitated meetings of a cross-sector stakeholder advisory group to inform program design, with representation from corrections systems, community supervision entities, health care providers and provider organizations, county entities, and social services organizations. DHCS has also pursued targeted engagement of an array of stakeholders to provide one-on-one ongoing education and technical assistance (e.g., meeting weekly with the State prison system, establishing a small working group of correctional facilities and providers to inform the initiative's billing and claiming approach). DHCS released formal policy and guidance to support program implementation. In 2022, DHCS released guidance to help correctional agencies, county social service agencies/offices, and other entities fulfill their obligation to support incarcerated individuals in completing an application for Medi-Cal coverage prior to their release.[49] In 2023, DHCS also released State guidance to correctional agencies on how to access a tool to verify an individual's enrollment in Medi-Cal.[50]Most recently, DHCS finalized the release of the Policy and Operational Guide based

[49] See ACWDL 22-27 (November 10, 2022) for more information on pre-release application processes.
[50] See MEDIL 23-24 (April 13, 2023) for more information on policies and procedures for county Medicaid eligibility departments and county correctional facilities to document implementation efforts of the pre-release Medicaid mandate.

Prompts	Summary
reentering population).	on extensive stakeholder feedback. .

	Future State: Planned Activities & Associated Timelines:
	• DHCS will release guidance to support stakeholder implementation of the Reentry Demonstration Initiative. Guidance will leverage standard DHCS processes and instruments and will include:
	  ○ Release Policy and Operational Guide laying out operational and information sharing expectations. *(Intended audience: all interested stakeholders)* **(October 2023)**
	  ○ All County Welfare Directors Letter (ACWDL) that provides an overview of the Reentry Demonstration Initiative. *(Intended audience: primarily county social service agencies/offices)* **(October 2023)**
	  ○ Behavioral Health Information Notice (BHIN) that provides an overview of the Reentry Demonstration Initiative. *(Intended audience: primarily county behavioral health agencies)* **(October 2023)**
	  ○ All-Plan Letters that provide an overview of the Reentry Demonstration Initiative. *(Intended audience: primarily Medi-Cal MCPs)* **(October 2023)**
	  ○ Updates to the Medi-Cal Provider Manual, as needed. (*Intended audience: Medi-Cal-enrolled providers)* **(Winter 2024)**
	• DHCS will announce the release of guidance through standard channels including press releases, email listservs, social media, and presentation at meetings with stakeholder representation. **(Ongoing)**
	• DHCS will also continue to provide targeted stakeholder engagement and technical assistance to implementing entities (e.g., correctional facilities, county agencies) partially informed by entities' responses to the justice-involved readiness assessments. (See 5.a. for additional information on readiness assessments) **(Ongoing)**

	Challenges and Mitigation Approaches: • **Challenge:** Due to the nature of carceral settings, potential for lack of trust between correctional facility representatives and individuals who are incarcerated, and the oft-complex health and social needs of this population, facilities may face challenges in attempts to engage members who are incarcerated to improve their awareness and education about Medi-Cal coverage and

Prompts	Summary
	health care services available to them while they are incarcerated and after their transition to the community. ○ **Mitigation Approach:** DHCS will require correctional facilities to provide individuals with all required Notices regarding Medi-Cal coverage and access to services. DHCS will require that correctional facilities provide individuals who were incarcerated for a short period or unexpectedly released to the community, DHCS will require that they are provided with a flyer and other information regarding their eligibility for and how to access ECM and other post-release services. DHCS will work with correctional facilities and other stakeholders to refine messaging and communication protocols to improve engagement and education of incarcerated members regarding Medi-Cal coverage and services. • **Challenge:** Many community-based providers, including those who have traditionally served the justice-involved population and who employ individuals with lived experience, might lack connections to standard Medi-Cal channels of communication and knowledge of Medi-Cal coverage and services. ○ **Mitigation Approach:** DHCS will leverage a broad range of communication strategies to ensure focused outreach to community-based providers and other stakeholders who have not traditionally provided or billed Medi-Cal services. This includes potentially identifying "amplifiers" at the local level with ties to relevant community-based organizations who can serve as a trusted source of information and best practices for implementing partners.
5.d. Develop systems or establish processes to monitor the health care needs and HRSN of individuals who are exiting carceral settings, as well as the services they received pre-release and the care they received post-release. This	***Current State:*** • DHCS does not yet have a monitoring process in place to monitor the health care needs and HRSN of individuals who are exiting correctional facilities or the services required post-release in the Reentry Demonstration Initiative.
	Future State: Planned Activities & Associated Timelines: • DHCS will establish a comprehensive monitoring approach for the Reentry Demonstration Initiative, in alignment with its approved demonstration and State monitoring priorities. The approved demonstration requires DHCS to submit a Monitoring Protocol after the approval of the demonstration and regular Quarterly and

Prompts	Summary
includes identifying any anticipated data challenges and potential solutions, articulating the details of the data exchanges, and executing related data-sharing agreements to facilitate monitoring of the demonstration, as described below.	Annual Monitoring Reports throughout the duration of the demonstration. **(January 2024)** (Note: In light of the fact that CMS intends to develop a Monitoring Protocol template for all Reentry Demonstrations, CMS provided an extension for submitting the Monitoring Protocol with a revised due date of January 2, 2024). It is expected that DHCS' Monitoring Protocol will include: ○ A selection of quality-of-care and health outcomes metrics and population stratifications based on CMS' upcoming guidance on the Health Equity Measure Slate. ○ Standardized reporting on categories of metrics, including but not limited to beneficiary participation in demonstration components, number of primary and specialist provider participation, utilization of services, quality of care, and health outcomes. ○ Metrics related to: ▪ Number of beneficiaries served, and types of services rendered under the demonstration. ▪ Administration of screenings to identify individuals who qualify for pre-release services. ▪ Utilization of applicable pre-release and post-release services (e.g., care management, MAT, clinical/behavioral health assessment pre-release and primary and behavioral health services post-release). ▪ Provision of health or social service referral pre-release. ▪ Participants who received care management pre-release and were enrolled in care management post-release. ▪ Take-up of data system enhancements among participating carceral settings. ○ Methods and timeline to collect and analyze non-Medicaid administrative data to help calculate applicable monitoring metrics. • In addition to the Reentry Demonstration Monitoring Protocol, DHCS also intends to establish an overall program monitoring and evaluation approach. Building upon the readiness assessment process described above, DHCS will establish ongoing monitoring and oversight within the correctional facilities to ensure delivery of pre-release services consistent with the approved Demonstration and the State's Policy and Operational Guide. **(January 2024)** Components of the monitoring and oversight approach will include:

Prompts	Summary
	○ **Use of available administrative data** to support ongoing monitoring and oversight of the Reentry Demonstration Initiative, including but not limited to claims data of services provided to individuals during both the pre- and post-release periods. **(Ongoing)** ○ **Use of data from the Justice-Involved Screening Portal** to support data collection for individuals who were found to be eligible for services, with metrics to include the number of individuals found to be eligible and the duration of services received. **(establish by October 1, 2024)** ○ **Development of care management bundles** to allow the State to track delivery of discrete sets of care management services (e.g., completion of needs assessment, completion of care manager warm hand-off). **(establish by October 1, 2024)** • DHCS is also exploring opportunities to partner with other State departments (e.g., California Department of Corrections and Rehabilitation) and implementing entities to leverage additional data to support ongoing oversight and monitoring. **(DHCS IT systems to support the Reentry Initiative will be in place by October 1, 2024. DHCS will monitor compliance on an on-going basis once the correctional facility goes live.)** • To support the streamlined information exchange required to implement the reentry demonstration, DHCS has develop data-focused guidance for inclusion in policy and operational guidance. **(October 2023)** This guidance will clarify required data exchanges with information on transaction methods and formats. • DHCS is also requiring managed care plans and correctional facilities to establish memoranda of understanding (MOUs) regarding Reentry Initiative data exchange and will release a model MOU. **(DHCS will have template in place by October 1, 2024. DHCS will monitor compliance on an on-going basis once the correctional facility goes live.)** • DHCS will continue to convene stakeholders to understand anticipated data challenges and potential solutions (e.g., as part of a stakeholder advisory group meeting, engaging a targeted group of implementers). **(Ongoing)** • DHCS will also administer PATH capacity building funding opportunities to support implementing entities in establishing the IT systems and processes to support monitoring. **(Ongoing through duration of demonstration period)** ○ PATH funding opportunities will permit implementing entities to apply for funding to support the following activities, among other priorities:

Prompts	Summary
	▪ **Implementing Billing Systems:** This includes expenditures related to modifying IT systems needed to support delivery of and billing for Medi-Cal Reentry Services (e.g., adoption of certified electronic health record (HER) technology, purchase of billing systems). ▪ **Adoption of Certified HER Technology:** This includes expenditures for providers' purchase or necessary upgrades of certified HER technology and training for the staff that will use the HER. ▪ **Technology and IT Services:** This includes the development of electronic interfaces for prisons, jails, and youth correctional facilities to support Medicaid enrollment and suspension/unsuspension and modifications. This also includes support to modify and enhance existing IT systems to create and improve data exchange and linkages with correctional facilities, local county social service agencies/offices, county behavioral health agencies, and others, such as MCPs and community-based providers.
	Challenges and Mitigation Approaches: • **Challenge:** The carceral setting of care delivery as well as the narrow scope of covered services requires the State to establish a comprehensive and nuanced approach to program monitoring and oversight, including with regards to preventing fraud, waste, and abuse. o **Mitigation Approach:** DHCS continues to build a comprehensive, multi-pronged monitoring and oversight approach that considers the complexity of delivering a targeted set of covered services in correctional settings. DHCS plans to leverage the pre-release services aid code to identify individuals eligible for pre-release services and ensure that only eligible individuals receive covered services through the demonstration. DHCS is also building a new code set for billable pre-release service codes to ensure that only the limited set of covered services are billed during the pre-release services period. **(establish by October 1, 2024)**

Appendix

Table A: Implementation Plan Timeline for Identified Activities					
Go-Live Activity	**2023 Q4**	**2024 Q1**	**2024 Q2**	**2024 Q3**	**2024 Q4 – 2026 Q4** *(Quarterly Phase-In Period for On-Boarding Correctional Facilities Based on Determination of Readiness)*
Distribution of PATH JI Funding					
Release Policy and Operational Guide	Complete				
Release Draft Readiness Assessment Template for Correctional Facilities	Complete				
Release Final Readiness Assessment for Correctional Facilities					
DHCS to Complete Systems Readiness				By October 1, 2024	
DHCS to Provide On-Going Technical Assistance to Implementation Partners					
DHCS to Conduct Correctional Facility Readiness Review					Correctional Facilities will have Quarterly Go-Live Dates *(see example table below)*
Program Monitoring and					DHCS will submit quarterly and annual monitoring

Table A: Implementation Plan Timeline for Identified Activities					
Go-Live Activity	**2023 Q4**	**2024 Q1**	**2024 Q2**	**2024 Q3**	**2024 Q4 – 2026 Q4** *(Quarterly Phase-In Period for On-Boarding Correctional Facilities Based on Determination of Readiness)*
Evaluation					reports to CMS based on available data from correctional facilities that have gone live

Table B: Example Timelines for Go-Live Dates Within Two Year Phase In Time Period			
Milestone	**Illustrative Timelines**		
Correctional Facilities Submit Readiness Assessment to DHCS *Correctional Facilities may submit their Readiness Assessment before the April 1 due date*	April 1, 2024	January 1, 2025	April 1, 2026
DHCS Reviews Readiness Assessments *DHCS will engage Correctional Facilities as needed during review*	April – July 2024	January - April 2025	April – July 2026
DHCS Communicates Final Readiness Decision to Correctional Facilities *DHCS will publicly post facilities approved to go-live on the Justice Involved Initiative website after approval is communicated to correctional facilities*	August 1, 2024	May 1, 202	August 1, 2026
Correctional Facilities Finalize Preparations for Go-Live	August – September 2024	May – June 2025	August – September 2026
Correctional Facilities Go Live with Pre-Release Services	October 1, 2024	July 1, 2025	October 1, 2026

Attachment DD
Monitoring Protocol
(Reserved)

Attachment EE
Reentry Demonstration Initiative Reinvestment Plan

Attachment EE

Reentry Demonstration Initiative Reinvestment Plan

In accordance with the California Advancing and Innovating Medi-Cal (CalAIM) Section 1115 Demonstration Special Terms and Conditions (STC 9.11) and CMS' State Medicaid Director Letter (SMDL 23-003), California is required to reinvest federal dollars linked to certain services provided under its recently approved Reentry Demonstration Initiative. This Reentry Initiative Reinvestment Plan defines the total amount of reinvestment required and types of reinvestments that will be made over the term of the Demonstration.

Reinvestment Required

Services Requiring Reinvestment

CMS and the California Department of Health Care Services (DHCS) have identified two categories of Reentry Initiative services for determining whether and how much reinvestment may be required when net new savings are realized, including:

1. "New services" that had not previously been provided by carceral settings prior to the Demonstration; and
2. "Existing services," which would be newly Medicaid matched under the Demonstration but would have been provided by carceral settings prior to the Demonstration.

Federal financial participation (FFP) invested in "new services" does not prompt the need for reinvestment, as these services would not have otherwise been provided through Medicaid. Reinvestment is required in an amount equivalent to the amount of FFP invested in "existing services."

Based on a Statewide assessment of services provided or paid for by carceral settings prior to implementation of the Reentry Initiative, California has identified the following "existing services."

- **Laboratory and radiology services**. Prior to implementation of the Reentry Initiative, all carceral facilities provided laboratory and radiology services on-site or arranged for their provision off-site, as needed.
- **Medication and Medication Administration.** Prior to implementation of the Reentry Initiative, all carceral facilities provided medically necessary medications. However, for some facilities, there may be a gap in the provision of certain high-cost medications, such as long-acting injectables.

All other Reentry Initiative services were determined to be "new services" that had not previously been provided by carceral settings prior to the Demonstration, as further outlined below.

Amount of Reinvestment Required

In line with requirements in the STCs, **California must reinvest at least $65,375,000**, which is the total amount of projected FFP for existing services over the course of the Demonstration. This reinvestment obligation amount is within the bounds of approved budget neutrality estimates for the Demonstration and assumes the following ramp-up in participation by jails and youth correctional facilities across the

Demonstration period: 15% participation in DY 20; 70% participation in DY 21; and 90% participation in DY 22. There are separate ramp-up assumptions for State prisons across the Demonstration period as follow: 0% participation in DY 20 and DY 21; and 100% participation in DY 22.

Types of Reinvestments to Be Made Over the Course of the Demonstration

In total, **California will make an estimated $174,883,000 in reinvestments to improve health care for the justice-involved population over the course of its Demonstration**, including reinvestments in new reentry services and in the Providing Access and Transforming Health (PATH) Reentry Demonstration Initiative Planning and Implementation Program. This amount exceeds the required amount of reinvestment identified above.

New Reentry Services Approved Under the Demonstration

According to STC 9.11, the State's share of funding associated with new services covered under the Reentry Initiative qualifies as reinvestment. Based on a Statewide assessment of services provided or paid for by carceral settings prior to implementation of the Reentry Initiative, California identified the following services as "new services":

- **Care Management.** Requirements and expectations related to providing reentry care management include the following: ensuring a warm handoff to post-release care manager (if different than the pre-release care manager); ensuring the pre-release services are provided; conducting referral activities for post-release such as obtaining consent, scheduling appointments, and making warm linkages to community-based services and supports, including but not limited to educational, social, pre-vocational, vocational, housing, nutritional, transportation, childcare, child development, and mutual aid support groups; connecting individuals to services upon reentry into the community; and providing ongoing monitoring and follow-up activities to ensure the care plan is implemented. Care management may be provided by both correctional and community-based providers. Reentry care management constitutes a new investment in (and a new component of) the continuum of services provided under the Reentry Initiative.
- **Physical and Behavioral Health Clinical Consultation.** Clinical consultation services are intended to support the creation of a comprehensive, robust, and successful reentry plan, including conducting diagnosis, stabilization, and treatment in preparation for release (including recommendations or orders for needed labs, radiology, and/or medications); providing recommendations or orders for medications and durable medical equipment (DME) that will be needed upon release; and consulting with the pre-release care manager to help inform the pre-release care plan, including professional-to-professional warm handoffs for individuals who will receive behavioral health treatment in the community. Physical and behavioral health clinical consultation may be provided by both correctional and community-based providers. Pre-release physical and behavioral health clinical consultation constitutes a new investment in (and a new component to) the continuum of services that support reentry and smooth transitions into the community.
- **Medication-Assisted Treatment (MAT).** For purposes of this demonstration, MAT is defined as medication in combination with counseling/behavioral therapies, as appropriate and individually determined, and should be available for all types of SUD (e.g., both opioid and alcohol use disorders) as clinically appropriate. Correctional facilities will be able to provide all FDA-approved medications for opioid use disorder, including buprenorphine, methadone, and naltrexone, and acamprosate and naltrexone for alcohol use disorder. State prisons currently provide MAT for both

opioid and alcohol use disorders. Delivery of MAT varies by county jail, with roughly 35 out of 58 counties participating in "Expanding MAT in Criminal Justice Settings" initiative; within those 35 counties, jails have taken varied approaches in the types of MAT they provide. Youth correctional facilities generally do not provide MAT. All correctional facilities will need to adjust the delivery of MAT to align with the justice-involved pre-release services requirements, and therefore, the State considers MAT to be a new service under the Reentry Initiative.

- **Community Health Workers.** Community Health Worker (CHW) services are preventive health services, as defined in 42 CFR 440.130(c), to prevent disease, disability, and other health conditions or their progression; prolong life; and promote physical and mental health. CHWs are trusted members of their community who help address chronic conditions, preventive health care needs, and health-related social needs. CHW services constitute a new investment in (and a new component of) the continuum of services that support reentry and smooth transitions into the community.

DHCS estimates the State will reinvest approximately $74,883,000 in State dollars for the above "new services" over the course of the Demonstration. Again, this planned reinvestment amount is consistent with budget neutrality estimates for the Demonstration and assumes the same ramp-up in participation by jails, State prisons, and youth correctional facilities across the Demonstration period as outlined above for "existing services."

PATH

According to STC 9.11, California may also reinvest dollars in a range of allowable initiatives that benefit the justice-involved population broadly, including health information technology and data sharing as well as increased community-based provider capacity linked to the specific needs of justice-involved individuals or individuals at risk of justice involvement. California's investment in the PATH initiative's Reentry Demonstration Initiative Planning and Implementation Program is consistent with these goals. The PATH Reentry Demonstration Initiative Planning and Implementation Program will fund and support planning and IT investments that will enable implementation of the Reentry Initiative and care coordination to support reentry.

Over the course of the Demonstration, DHCS estimates the State will reinvest approximately $100 million in State general fund dollars for the PATH Reentry Demonstration Initiative Planning and Implementation Program.

Summary of Reinvestment Required and Planned

Reinvestment Required	
(A) Projected FFP for existing services	$65,375,000
Reinvestment Planned	
Projected State share of funding for new services	$74,883,000
Projected State share of funding for PATH Reentry Demonstration Initiative Planning and Implementation Program	$100,000,000
(B) Total Reinvestment Planned	$174,883,000

Total Excess Reinvestment Planned (B)-(A)	**$109,508,000**

Attachment FF
Time-limited Expenditure Authority and Associated Requirements for the COVID-19 Public Health Emergency (PHE) Demonstration Amendment

Attachment FF

Time-limited Expenditure Authority and Associated Requirements for the COVID-19 Public Health Emergency (PHE) Demonstration Amendment

Expenditure Authority

Under the authority of section 1115(a)(2) and title XIX of the Social Security Act (the Act), expenditures made by the state for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act, shall be regarded as expenditures under section 1903 of the Act for the period from March 1, 2020 through the end of the unwinding period, or until all redeterminations are conducted during the unwinding period.

Continuous Coverage for Individuals Aging Out of CHIP. Expenditures to provide continued eligibility for CHIP enrollees who turned 19 between March 1, 2020, and the end of the California's unwinding period and therefore would be ineligible for CHIP due to age, and who are ineligible for Medicaid due to having income above 133 percent of the federal poverty level (FPL), provided such individuals have satisfactory immigration status.

Continuous Coverage for Specified Formerly Pregnant Individuals. Expenditures to provide continued eligibility for formerly pregnant individuals for whom coverage in the Medi-Cal Access Program (i.e., having income above 208 percent and up to and including 317 percent of the FPL) in CHIP has ended, and Health Services Initiative (HSI) postpartum coverage has ended, and who:

a. No longer have coverage under the CHIP unborn child option due to the pregnancy ending;
b. Finished up to 12 months of postpartum coverage under the state's HSI;
c. Are otherwise ineligible for Medicaid or CHIP due to the pregnancy ending; and
d. Have satisfactory immigration status.

Expenditures are not allowed for individuals who do not have satisfactory immigration status.

Monitoring and Evaluation Requirements

1. **Evaluation Design.** The state must submit an Evaluation Design to CMS no later than 60 days after the demonstration amendment approval. Once approved, the state is required to post its Evaluation Design to the state's website within 30 days of CMS approval of the Evaluation Design, per 42 CFR 431.424(e). In developing the Evaluation Design, the state can focus on qualitative methods and descriptive data to address evaluation questions that will support understanding the successes, challenges, and lessons learned in implementing the demonstration amendment. The state must also describe its plans to collect and report data on the size of the populations served under this demonstration amendment, and a summary of service utilization. The Evaluation Design must outline plans to assess how demonstration outlays affect the state's response to the PHE. The state must also describe in the Evaluation Design its process to: (1) identify accurately individuals with satisfactory immigration status; and (2) only claim FFP for services for individuals with satisfactory immigration status. CMS will provide additional technical assistance to support developing the Evaluation Design.

2. **Final Report.** The state is required to submit to CMS for review and approval a Final Report,

which will consolidate the monitoring and evaluation reporting requirements for this demonstration amendment. The Final Report is due no later than one year after the end of the expenditure authority. In addition to capturing data on the number of individuals served and utilization of services under this amendment, the Final Report must undertake qualitative and descriptive assessment on the demonstration implementation, lessons learned, and best practices for similar situations. The state is required to track expenditures associated with this demonstration, as applicable, and may include but not be limited to, administrative costs and program expenditures. Furthermore, the state must include in the Final Report a discussion on how it implemented the process—including any challenges encountered and how those were overcome—to accurately identify claims and capitation payments for individuals with satisfactory immigration status, and to assure that individuals with UIS were not included in FFP claims for services. For each year of the amendment that the state is required to complete an Annual [Monitoring] Report per 42 CFR 431.428(a), the state may submit all applicable information for the amendment approval period in the Final Report. CMS will provide additional guidance on the structure and content of the Final Report.

Background:

Attachment GG
Attachment K – Emergency Preparedness and Response; Lump Sum Incentive Payments

Appendix K: Emergency Preparedness and Response

This standalone appendix may be utilized by the state during emergency situations to request amendment to its approved waiver. It includes actions that states can take under the existing Section 1915(c) home and community-based waiver authority in order to respond to an emergency. Other activities may require the use of various other authorities such as the Section 1115 demonstrations or the Section 1135 authorities.[i] This appendix may be completed retroactively as needed by the state.

Appendix K-1: General Information

General Information:

A. State: California

B. Waiver Title: CalAIM Section 1115 Demonstration

C. Control Number: 11-W-00193/9

D. Type of Emergency (The state may check more than one box):

●	**Pandemic or Epidemic**
○	**Natural Disaster**
○	**National Security Emergency**
○	**Environmental**
○	**Other (specify):**

E. Brief Description of Emergency. *In no more than one paragraph each*, briefly describe the: 1) nature of emergency; 2) number of individuals affected and the state's mechanism to identify individuals at risk; 3) roles of state, local and other entities involved in approved waiver operations; and 4) expected changes needed to service delivery methods, if applicable. The state should provide this information for each emergency checked if those emergencies affect different geographic areas and require different changes to the waiver.

COVID-19 pandemic. This Attachment K will apply to specific provider types, providing direct-care services through Community-Based Adult Services (CBAS). The State intends to use funds from section 9817 of the American Rescue Plan (ARP) Act for one-time payment meant to help alleviate financial strain and hardships suffered by California's HCBS direct care workforce during the COVID-19 PHE and expand access to providers and incentivize retention of current California's existing HCBS direct care workforce. The State will begin processing the direct care workforce payments September 1, 2023.

F. Proposed Effective Date:
Start Date: March 1, 2023
Anticipated End Date: November 11, 2023

G. Description of Transition Plan.

All activities will take place in response to the impact of COVID-19 as efficiently and effectively as possible based upon the complexity of the change.

H. Geographic Areas Affected:

These actions will apply to all direct-care HCBS providers impacted by the COVID-19 virus pandemic, across the State of California, providing services through CBAS.

I. Description of State Disaster Plan (if available) ***Reference to external documents is acceptable*****:**

N/A

Appendix K-2: Temporary or Emergency-Specific Amendment to Approved Waiver

Temporary or Emergency-Specific Amendment to Approved Waiver:

These are changes that, while directly related to the state's response to an emergency situation, require amendment to the approved waiver document. These changes are time limited and tied specifically to individuals impacted by the emergency. Permanent or long-ranging changes will need to be incorporated into the main appendices of the waiver, via an amendment request in the waiver management system (WMS) upon advice from CMS.

a.___Access and Eligibility:

i.___Temporarily increase the cost limits for entry into the waiver.
[Provide explanation of changes and specify the temporary cost limit.]

ii.___Temporarily modify additional targeting criteria.

[Explanation of changes]

b.___Services

i.___Temporarily modify service scope or coverage.

[Complete Section A- Services to be Added/Modified During an Emergency.]

ii.__Temporarily exceed service limitations (including limits on sets of services as described in Appendix C-4) or requirements for amount, duration, and prior authorization to address health and welfare issues presented by the emergency.

[Explanation of changes]

iii.___Temporarily add services to the waiver to address the emergency situation (for example, emergency counseling; heightened case management to address emergency needs; emergency medical supplies and equipment; individually directed goods and services; ancillary services to establish temporary residences for dislocated waiver enrollees; necessary technology; emergency evacuation transportation outside of the scope of non-emergency transportation or transportation already provided through the waiver).

[Complete Section A-Services to be Added/Modified During an Emergency]

iv.___Temporarily expand setting(s) where services may be provided (e.g. hotels, shelters, schools, churches) Note for respite services only, the state should indicate any facility-based settings and indicate whether room and board is included:

[Explanation of modification, and advisement if room and board is included in the respite rate]:

v.___Temporarily provide services in out of state settings (if not already permitted in the state's approved waiver). [Explanation of changes]

c. ___ Temporarily permit payment for services rendered by family caregivers or legally responsible individuals if not already permitted under the waiver. Indicate the services to which this will apply and the safeguards to ensure that individuals receive necessary services as authorized in the plan of care, and the procedures that are used to ensure that payments are made for services rendered.

d.___Temporarily modify provider qualifications (for example, expand provider pool, temporarily modify or suspend licensure and certification requirements).

i.___Temporarily modify provider qualifications.

[Provide explanation of changes, list each service affected, list the provider type, and the changes in provider qualifications.]

ii.___Temporarily modify provider types.

[Provide explanation of changes, list each service affected, and the changes in the .provider type for each service].

iii.___Temporarily modify licensure or other requirements for settings where waiver services are furnished.

[Provide explanation of changes, description of facilities to be utilized and list each service provided in each facility utilized.]

e.____Temporarily modify processes for level of care evaluations or re-evaluations (within regulatory requirements). [Describe]

f.__X__ Temporarily increase payment rates

[Provide an explanation for the increase. List the provider types, rates by service, and specify whether this change is based on a rate development method that is different from the current approved waiver (and if different, specify and explain the rate development method). If the rate varies by provider, list the rate by service and by provider].

The State intends to use funds from section 9817 of the American Rescue Plan (ARP) Act for one-time payments meant to help alleviate financial strain and hardships suffered by California's HCBS direct care workforce during the COVID-19 PHE and expand access to providers and incentivize retention of current California's existing HCBS direct care workforce. The State will begin processing the direct care workforce payments September 1, 2023.

In accordance with the American Rescue Plan Act of 2021, Section 9817, allow a one-time incentive payment of $500 to each direct care, non-In-Home Supportive Services (IHSS) provider, identified below, of Medi-Cal CBAS services to Medi-Cal beneficiaries for at least two months during the Public Health Emergency, that are currently providing direct care services through CBAS. These payments are funded through California's HCBS Spending Plan, approved by CMS on January 4, 2022.

The payment will serve as an incentive payment to maintain the pool of provider infrastructure for HCBS. Providers eligible for this incentive payment are currently providing HCBS direct care services and provided services to program recipients during a minimum of two months during the Public Health Emergency, between the dates of March 2020 and March 2022.

- Nurse Case Managers
- Social Work Case Managers
- Social Worker Assistants
- Program Aides
- Activity Coordinators
- Social Worker Aide
- Nurse's Aide
- Activity Coordinator Aide
- Cook
- Driver (Excluding rideshare)
- Nutrition services aide
- Physical therapist
- Physical therapist assistant
- Physical therapist aide
- Occupational therapist
- Occupational therapist assistant
- Occupational therapist aides
- Speech Language Pathologist
- Speech Language Pathologist Aide

The payment will be issued through a self-verification process and provider organizations will apply on behalf of their eligible employees. The State will provide a one-time lump sum payment to the provider organization; and the provider organization will be required to distribute the payments to employees within 30 days of receipt.

These payments are for the direct benefit of direct care service workers and provider organizations cannot take any fees from the $500 direct payment (e.g., administrative costs) and direct care service workers will receive 100% of the payment. If a provider organization is unable to distribute a payment to an eligible employee, they are required to return the funds to the State.

g. ___ Temporarily modify person-centered service plan development process and individual(s) responsible for person-centered service plan development, including qualifications.

[Describe any modifications including qualifications of individuals responsible for service plan development, and address Participant Safeguards. Also include strategies to ensure that services are received as authorized.]

h. Temporarily modify incident reporting requirements, medication management or other participant safeguards to ensure individual health and welfare, and to account for emergency circumstances. [Explanation of changes]

i. Temporarily allow for payment for services for the purpose of supporting waiver participants in an acute care hospital or short-term institutional stay when necessary supports (including communication and intensive personal care) are not available in that setting, or when the individual requires those services for communication and behavioral stabilization, and such services are not covered in such settings.
[Specify the services.]

j. Temporarily include retainer payments to address emergency related issues.

[Describe the circumstances under which such payments are authorized and applicable limits on their duration. Retainer payments are available for habilitation and personal care only.]

k. Temporarily institute or expand opportunities for self-direction.

[Provide an overview and any expansion of self-direction opportunities including a list of services that may be self-directed and an overview of participant safeguards]

l. Increase Factor C.

[Explain the reason for the increase and list the current approved Factor C as well as the proposed revised Factor C]

m. Other Changes Necessary [For example, any changes to billing processes, use of

contracted entities or any other changes needed by the State to address imminent needs of individuals in the waiver program]. [Explanation of changes]

Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the request:

First Name:	Nichole
Last Name	Kessel
Title:	HCBS Policy Branch Chief
Agency:	California Department of Health Care Services
Address 1:	1501 Capitol Avenue
Address 2:	P.O. Box 997413, MS 4502
City	Sacramento
State	California
Zip Code	95899-7413
Telephone:	916-713-8345
E-mail	Nichole.Kessel@dhcs.ca.gov
Fax Number	N/A

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

First Name:	Click or tap here to enter text.
Last Name	Click or tap here to enter text.
Title:	Click or tap here to enter text.
Agency:	Click or tap here to enter text.
Address 1:	Click or tap here to enter text.
Address 2:	Click or tap here to enter text.
City	Click or tap here to enter text.
State	Click or tap here to enter text.
Zip Code	Click or tap here to enter text.
Telephone:	Click or tap here to enter text.
E-mail	Click or tap here to enter text.
Fax Number	Click or tap here to enter text.

8. Authorizing Signature

Signat [redacted] **Date: 5/10/2023**

State Medicaid Director or Designee

First Name:	Jacey
Last Name	Cooper
Title:	State Medicaid Director
Agency:	California Department of Health Care Services
Address 1:	1501 Capitol Avenue
Address 2:	P.O. Box 997413, MS 0000
City	Sacramento
State	California
Zip Code	95899-7413
Telephone:	916-449-7400
E-mail	Jacey.Cooper@dhcs.ca.gov
Fax Number	916-449-7904

Section A---Services to be Added/Modified During an Emergency

Complete for each service added during a time of emergency. For services in the approved waiver which the state is temporarily modifying, enter the entire service definition and highlight the change. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification				
Service Title:				
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:				
Service Definition (Scope)**:**				
Specify applicable (if any) limits on the amount, frequency, or duration of this service:				

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☐	Agency. List the types of agencies:
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☐	Provider managed

[i] Numerous changes that the state may want to make necessitate authority outside of the scope of section 1915(c) authority.

States interested in changes to administrative claiming or changes that require section 1115 or section 1135 authority should engage CMS in a discussion as soon as possible. Some examples may include: (a) changes to administrative activities, such as the establishment of a hotline; (b) suspension of general Medicaid rules that are not addressed under section 1915(c) such as payment rules or eligibility rules or suspension of provisions of section 1902(a) to which 1915(c) is typically bound.