California Department of Health Care Services (DHCS)

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

Draft Evaluation Design for

Providing Access and Transforming Health (PATH) Initiative,

Global Payment Program (GPP), and

Dually Eligible Beneficiary Satisfaction in the Medi-Cal Matching Process

June 27, 2022

Table of Contents

GENERAL BACKGROUND INFORMATION 3
Providing Access and Transforming Health Initiative 4
Global Payments Program 5
Alignment and Integration for Dually Eligible Beneficiaries 6
EVALUATION QUESTIONS AND HYPOTHESES 8
Providing Access and Transforming Health Initiative (PATH) 8
Global Payments Program 11
Alignment and Integration for Dually Eligible Beneficiaries 13
METHODOLOGY 14
Providing Access and Transforming Health Initiative 14
Global Payments Program 18
Alignment and Integration for Dually Eligible Beneficiaries 22
METHODOLOGICAL LIMITATIONS 25
ATTACHMENTS 27

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 beneficiaries 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 – will focus on a person-centered approach, first authorized as Whole Person Care (WPC) pilots by the Medi-Cal 2020 demonstration, in order to meet the physical, behavioral, developmental, long-term care, oral health, and health-related social needs of all beneficiaries.

The CalAIM demonstration, along with related authorities, including the 1915(b) waiver also approved by CMS on December 29, 2021, will enable 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 beneficiaries 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 will launch the Population Health Management (PHM) program, a cornerstone of CalAIM. PHM will establish a cohesive, statewide approach that ensures Medi-Cal members have access to a comprehensive program that leads to longer, healthier and happier lives, improved health outcomes, and health equity. Under PHM, plans and their networks and partners will be 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 supports 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 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. Based on our discussion with the Centers for Medicare and Medicaid Services (CMS) on January 27, 2022, the Department of Health Care Services (DHCS) will submit two separate Evaluation Designs for these two components of the waiver, one regarding the Drug Medi-Cal Organized Delivery System and another regarding the Contingency Management component of the waiver.

As a result, this Draft Evaluation Design covers the evaluation of three components of the waiver: the Providing Access and Transforming Health (PATH) Initiative, the Global Payment Program (GPP), and the alignment and integration for dually eligible beneficiaries. More details about these programs are below.

Providing Access and Transforming Health Initiative

PATH is a five-year, $1.44 billion[1] (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 others, to successfully participate in the Medi-Cal delivery system as California widely implements Enhanced Care Management and Community Supports and Justice Involved services under CalAIM. Drawing upon the success and lessons learned from the Whole Person Care and Health Homes Pilots, PATH funding will address the gaps in local organizational capacity and infrastructure that exist statewide, enabling these local partners to scale up the services they provide to Medi-Cal beneficiaries. With resources funded by PATH—such as additional staff, billing systems, and data exchange capabilities—community partners will 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 will help California advance health equity, address social drivers of health, and move towards an equitable, coordinated, and accessible Medi-Cal system.

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

[1] An additional $451 million in PATH funds are pending CMS approval of the full Justice Involved Initiative.

- **Support for Implementation of Enhanced Care Management and Community Supports.** PATH will support the expansion of the capacity and infrastructure needed to implement ECM and Community Supports, and increase access to services statewide. This involves four integrated initiatives:
    - **Whole Person Care Services and Transition to Managed Care Mitigation Initiative:** PATH will fund services provided by former Whole Person Care Pilot Lead Entities until the services transition to managed care coverage under CalAIM. This funding will end by January 1, 2024.
    - **Technical Assistance Initiative:** PATH will provide a virtual “marketplace" that offers hands-on technical support and off-the-shelf resources from vendors to establish the infrastructure needed to implement ECM and Community Supports.
    - **Collaborative Planning and Implementation Initiative:** PATH will fund regional collaborative planning and implementation efforts among managed care plans, providers, CBOs, county agencies, public hospitals, tribes, and others to promote readiness for ECM and Community Supports.
    - **Capacity and Infrastructure Transition, Expansion and Development (CITED) Initiative:** PATH will provide direct funding to support the delivery of Enhanced Care Management and Community Supports services. Entities, such as providers, CBOs, county agencies, public hospitals, tribes, and other, 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.

- **Justice-Involved Capacity Building Program.** PATH will provide funding to support the implementation of statewide CalAIM justice-involved initiatives. This includes support for implementation of pre-release Medi-Cal enrollment and suspension processes, as well as the delivery of Medi-Cal services in the 90 days prior to release. This includes:
    - **Collaborative planning:** PATH funding will 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 funding will support correctional agencies, institutions, and other justice-involved stakeholders as they implement pre-release Medi-Cal enrollment and suspension processes.

Global Payments Program

Although the number of uninsured individuals has fallen since implementation of the Affordable Care Act, a recent publication estimates there will be approximately 3.2 million uninsured Californians in 2023. This uninsured projection includes individuals

who have restricted scope Medi-Cal, limited to emergency, pregnancy-related services, or limited long term care. Undocumented immigrants age 26 years and below and 50 years and older with full scope Medi-Cal (covered with state only funds) are considered insured. The Global Payment Program (GPP), launched in July 2015 at part of the 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, whereby financial incentives are in place for public health care systems (PHCS) to invest in patient-centered primary and preventive care for the uninsured, shifting care away from less cost-effective acute settings, such as emergency and inpatient settings. Significantly, the state also included non-traditional services (such as group visits and health coaching), which were not billable in Medi-Cal, in GPP so that PHCS could invest in offering these services to the uninsured.

Starting with the Medi-Cal 2020 waiver, GPP redesigned how systems earn existing funding. Under the current payment structure, PHCS receive GPP payments calculated using a value-based point methodology that incorporated factors designed to incentivize a shift in the overall delivery of services to more patient-centered and cost-effective settings. With the CalAIM 1115 waiver, the state will add new GPP services and align GPP service offerings with those available to Medicaid beneficiaries, both of which may facilitate addressing health disparities.

As part of the CalAIM waiver, the state will also begin 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, language, urban/rural status, disability, and sexual orientation and gender identity. The state will outline certain metrics focused on access, utilization, quality of care, or health outcomes, as well as population stratifications of interest. Systematic measurement and reporting of such metrics will support understanding of the landscape of health inequities among the uninsured population who receive GPP services in California and help inform meaningful future mitigation strategies.

An evaluation of GPP was conducted through Program Year (PY) 3 (FY 2017-2018). Briefly, the evaluation found that PHCS 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 increased over time.

This evaluation design for GPP applies to a renewal of the state's section 1115 demonstration.

Alignment and Integration for Dually Eligible Beneficiaries

California is addressing the bifurcated Medicare and Medi-Cal delivery systems that make integrated and coordinated care challenging for dually eligible beneficiaries. This population is among the highest need and highest cost groups in both programs.

An estimated 43 percent of the 1.5 million dual eligible beneficiaries in California are enrolled in some type of Medicare Advantage (MA) plan. Of those, over 200,000 are in "regular" MA plans; approximately 140,000 are in "look-alike" plans; 130,000 are in true Dual Eligible Special Needs Plans (D-SNPs); and 140,000 are in the Cal MediConnect financial alignment demonstration or other integrated plans. As of January 1, 2022, approximately 70 percent of dually eligible beneficiaries are in a Medi-Cal managed care plan, primarily in 27 counties.   Of the approximately 470,000 dually eligible individuals in non-integrated MA plans or D-SNPs, approximately two-thirds are in counties where Medi-Cal managed care enrollment is mandatory.

For dually eligible beneficiaries, having to navigate separate health plans for their Medicare and Medi-Cal benefits can be challenging and places an additional burden on these beneficiaries and their caregivers and providers to coordinate across programs and health plans.

To address the challenges of coordinating across different health plans for Medicare and Medi-Cal benefits, DHCS has a Medi-Cal matching plan policy in 12 counties. Under this policy, a beneficiary's MA plan choice is the lead, and the Medi-Cal plan follows. This means that for dually eligible beneficiaries that choose to enroll in an MA plan in those counties, their Medi-Cal plan must align with their MA plan choice, if there is a Medi-Cal plan affiliated with their MA plan. The Medi-Cal matching plan policy does not change or impact a beneficiary's MA plan choice.

The 12 counties with this Medi-Cal matching plan policy are: Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, Santa Clara, and Stanislaus counties.

As of January 1, 2023, most of the remaining dually eligible beneficiaries will be enrolled in a Medi-Cal managed care plan, and the state will authorize Exclusively Aligned Enrollment (EAE) D-SNPs. These EAE D-SNPs will have members enrolled in the same plan organization for their Medicare and Medi-Cal benefits, and Cal MediConnect members will transition to these integrated plans.

This demonstration impacts those dually eligible beneficiaries enrolled in a MA plan that is not an integrated plan, who reside in one of the 12 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 beneficiary experience.

This evaluation design applies to an extension of the state's section 1115 demonstration.

EVALUATION QUESTIONS AND HYPOTHESES

The proposed evaluation of these portions of the 1115 Waiver will address the following questions and related hypotheses. Additionally, information related to how these hypotheses will be generally measured is also provided. Specific measures related to the hypotheses are presented in the Methodology section.

Providing Access and Transforming Health Initiative (PATH)

Goal 1: Increase the number of Enhanced Care Management (ECM) and Community Supports community-based providers (e.g. CBOs and other providers such as community health workers or other providers approved by DHCS) and consequently increase Medi-Cal beneficiary ECM and Community Supports utilization according to community needs.

- Research Question 1: Did PATH Technical Assistance; Capacity, Infrastructure, Transition, Expansion, and Development (CITED), and Collaborative Planning resources increase the number of community-based providers that have successfully contracted with MCPs for ECM and Community Supports?
- Hypothesis: MCPs will contract with more community-based ECM and Community Supports providers to provide services to Medi-Cal beneficiaries specifically for each provider type supported by PATH, within Healthy Places Index[2](HPI) quartiles, with particular attention quartiles 1 and 2 (lower quartiles indicate less healthy community conditions).
- Driver diagram:

Aim	Primary Drivers	Secondary Drivers
Increase the number of under-resourced, community-based ECM and Community Supports providers that will provide Medi-Cal services, within each Healthy Places Index[1] (HPI) quartiles	Provide CITED technical assistance and funding for specific capacity needs to support the transition, expansion, and development of ECM and Community Supports services	Recruit under-resourced community-based providers
← Causality ←		

- Research Question 2: Did PATH increase utilization of ECM/Community Supports3 with particular attention to the historically under-resourced and marginalized populations[3] within HPI 1 and 2?
- Hypothesis: PATH will increase utilization of ECM and Community Supports within each HPI quartile, with particular attention to historically under-resourced and marginalized populations.

[2] https://www.healthyplacesindex.org

[3] Under-resourced or marginalized populations are defined based on the individuals enrolled as reported by MCPs.

- Driver diagram:

Aim	Primary Drivers	Secondary Drivers
Increase the number of Medi-Cal beneficiaries that use ECM and Community Supports, with particular attention to historically under-resourced and marginalized populations Increase the number of ECM and Community Supports used by Medi-Cal beneficiaries, with particular attention to historically under-resourced and marginalized populations	Conduct educational workshops to target populations about ECM/Community Support services availability	Increase outreach to under-resourced and marginalized populations
← Causality ←		

Goal 2: Improve data collection and information sharing infrastructure among providers of ECM and Community Supports with the MCPs.

- Research Question: Did PATH increase the number of ECM and Community Supports providers with health IT infrastructure capabilities including 1) access to electronic health records (EHR) or a care management documentation system in order to share data with the MCPs and 2) billing systems?
- Hypothesis: PATH will increase the number of existing ECM and Community Supports providers sharing data with MCPs using EHR technology or a care management documentation systems and billing systems.
- Driver diagram:

Aim	Primary Drivers	Secondary Drivers
Increase the number of providers who use electronic care management and billing systems Improving the quality of data collected and shared	Develop IT infrastructure and billing systems among providers	Provide funding to establish IT infrastructure and billing system Provide training/technical assistance to IT infrastructure and electronic health record system (EHR)

among networks of providers of ECM and Community Supports and MCPs		Provide funding to hire IT staffing
	Increase number of high-quality data submissions	Provide technical assistance on data collection, data quality and data submission
	Increase the number of data sharing agreements among providers and MCPs	Provide technical assistance on data sharing agreements among providers and MCPs
←	Causality	←

Goal 3: Improve the ability for state prisons, county jails, and youth correctional facilities to screen, enroll, and change the suspension status 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.

- Research Question 1: Did these entities modify their key workflows, IT systems, processes, and staffing to improve their ability to achieve these objectives?
- Hypothesis: PATH will improve the ability for these entities to screen, enroll, and change the suspension status for eligible individuals in Medi-Cal prior to release.
- Driver diagram:

Aim	Primary Drivers	Secondary Drivers
Improve the ability for state prisons, county jails, and youth correctional facilities to screen, enroll, and change the suspension status for eligible individuals in Medi-Cal prior to release	Improve the IT infrastructure Establish operational process for screen, enroll, and change the suspension status for eligible individuals in Medi-Cal prior to release Increase staffing to improve screening prior to release	Provide funding to establish IT infrastructure Establish workflow of screening process and documentation Provide funding to hire IT staff
←	Causality	←

- Research Question 2: Did the number of eligible individuals screened and enrolled in Medi-Cal prior to release increase as a result of the PATH funding as compared to prior to PATH funding?
- Hypothesis: PATH will increase the number of eligible individuals screened and enrolled in Medi-Cal prior to release.
- Driver diagram:

Aim	Primary Drivers	Secondary Drivers
Increase the number of eligible individuals screened and enrolled in Medi-Cal prior to release	Improve the effectiveness and accuracy of the process for screening eligible individuals prior to release Increase the effectiveness of the process for enrolling eligible individuals to Medi-Cal prior to release	Improve system to identify eligible individuals accurately Improve workflow to screen eligible individuals in a timely manner Improve system to enroll eligible individuals to Medi-Cal Establish and Implement Key policy Provide funding to hire IT staffing
← Causality ←		

Global Payments Program

Goal 1: Improve the quality of care among those individuals with uninsured services.

- Research Question: Was the GPP successful in improving quality of care to individuals with uninsured services?
- Hypothesis: PHCS improved the quality of care to the uninsured.

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.

- Research Question: 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?
- Hypothesis: PHCS increased the use of outpatient services, non-traditional services, and equity-enhancing services over the course of the GPP.

Driver Diagram (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	←

Goal 3: Improve PHCS data infrastructure and completeness that are necessary to understand health inequities among GPP utilizers.

- Research Question: Was the GPP successful in driving improvements in the data infrastructure necessary to understand health inequities?
- Hypothesis: PHCS improved the data collection, reporting and analytics infrastructure to identify and act on health inequities.
- Driver diagram:

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	Develop Health Equity Monitoring Metrics Protocol (currently under review by CMS) Require PHCS to adhere to Health Equity Monitoring Metrics Protocol by submitting performance data stratified by demographic data
←	Causality	←

Alignment and Integration for Dually Eligible Beneficiaries

Goal: Maintain a high degree of satisfaction with the Medi-Cal matching process among dually eligible beneficiaries in MA plans who are matched.

- Research Question 1: How many dually eligible beneficiaries enrolled in a MA plan in the 12 counties with a Medi-Cal matching plan policy had the policy applied to them, and of these dually eligible beneficiaries, how many subsequently requested to change their Medi-Cal plan within 12 months of enrollment?
- Hypothesis 1: Dually eligible beneficiaries will be satisfied with the mandatory alignment of their Medi-Cal plan to their Medicare Advantage plan choice, and less than 0.1 percent will request to change their Medi-Cal plan within 12 months of enrollment.

- Research Question 2: Are dually eligible beneficiaries satisfied with the information and process for mandatory Medi-Cal aligned enrollment when they choose a MA plan?
- Hypothesis: Dually eligible beneficiaries will be satisfied with the mandatory alignment of their Medi-Cal plan to their Medicare Advantage plan choice, and the minority who request to change their Medi-Cal plan will be satisfied with the process for doing so.

- Driver Diagram (Research Questions 1 and 2):

Aim	Primary Driver	Secondary Driver
Achieve less than 0.1% rate of beneficiaries requesting to change their Medi-Cal plan for dually eligible beneficiaries who are in matching plan counties AND who enroll in MA plans by 2025	Improve dually eligible beneficiary satisfaction with mandatory Medi-Cal aligned enrollment to their MA plan	Educate dually eligible beneficiaries and their caregivers benefits behind Medi-Cal/MA plan alignment Reduce administrative burden on dually eligible beneficiaries when enrolling for an aligned Medi-Cal plan Improve access to services and care coordination between aligned Medi-Cal and MA plans
← Causality ←		

METHODOLOGY

Providing Access and Transforming Health Initiative

Goal 1: Increase the number of Enhanced Care Manager (ECM) and Community Supports community-based providers (e.g. CBOs and other providers such as community health workers or other providers approved by DHCS) and consequently increase Medi-Cal beneficiary ECM and Community Supports utilization according to community needs.

- Research Question 1: Did PATH Technical Assistance, Capacity, Infrastructure, Transition, Expansion, and Development (CITED), and Collaborative Planning resources increase for community-based, non-clinical providers that have successfully contracted with MCPs for ECM and Community Supports?
- Hypothesis: MCPs will contract with more community-based ECM and Community Supports providers to provide services to Medi-Cal beneficiaries, specifically for each provider type supported by PATH, within HPI quartiles, with particular attention quartiles 1 and 2 (lower quartiles indicate less healthy community conditions).
- Measures:
    - Number of under-resourced, community-based ECM and Community Supports providers (e.g. CBOs and other providers such as community health workers or other providers approved by DHCS) (all providers).
    - Number of under-resourced, community-based ECM and Community Supports providers (e.g. CBOs and other providers such as community health workers or other providers approved by DHCS) (new providers).
- Target Population: Under-resourced, community-based providers of ECM and Community Supports.
- Comparison Population: Pre/post comparison.
- Data will be stratified by county, HPI quartile, and provider type.
- No sampling methodology will be used.
- Evaluation Period: CY 2022 through CY 2026.
- Methodological Design: Before and after comparison will be used to compare the number of ECM and Community Supports providers, overall, and by HPI quartiles. If the number of providers is higher after implementing PATH then the hypothesis is affirmed.
- The data sources for this portion of the evaluation will be data collected by a third party administrator (TPA), DHCS provider data, and HPI data.
- Analytic Methods: Descriptive summary, t-tests and Chi-square statistical tests will be used in accordance with the methodological design and in consultation with the independent evaluator.

- Research Question 2: Did PATH increase utilization of ECM/Community Supports with particular attention to the historically under-resourced and marginalized populations within HPI quartile 1 and 2?
- Hypothesis: PATH will increase utilization of ECM and Community Supports within each HPI quartile, with particular attention to historically under-resourced and marginalized populations.
- Measures:
    - Number of beneficiaries who used ECM and Community Supports services.
    - Total number of ECM and Community Supports services delivered.
- Target and Comparison Populations: The Medi-Cal population who used ECM and CS services; each county/MCP will define the historically under-resourced or marginalized populations.
- Comparison Population: Pre/post comparison and the general Medi-Cal population.
- Data will be stratified by county, by the HPI quartile, and by historically under-resourced and marginalized populations (as defined by each county/MCP).
- No sampling methodology will be used.
- Evaluation Period: CY 2022 through CY 2026.
- Methodological Design: Before and after comparison will be used to compare: 1) number of defined beneficiaries of historically under-resourced or marginalized populations who used ECM and CS services, overall and stratified by HPI quartile; 2) total number of ECM and Community Supports services be delivered to the defined historically under-resourced or marginalized populations before and after implementing PATH, overall and stratified by HPI quartile. If the number is higher after implementing PATH then the hypothesis is affirmed. The utilization of ECM and CS services of the defined historically under-resourced and marginalized populations will be compared with the general Medi-Cal population in the same county by using Difference-in-Difference analysis.
- The data sources for this portion of the evaluation will be data collected by the TPA, Medi-Cal enrollment data, DHCS encounter/claims data, and HPI data.
- Analytic Methods: Descriptive summary, t-tests and Chi-square statistical tests will be used in accordance with the methodological design and in consultation with the independent evaluator. Difference-in-difference analysis will be used for comparison with the control group.

Goal 2: Improve data collection and information sharing infrastructure among providers of ECM and Community Supports (CS) with the MCP

- Research Question: Did PATH increase the number of ECM and Community Supports providers with health IT infrastructure capabilities including 1) access to electronic health records (EHR) or a care management documentation systems in order to share data with the MCPs and 2) billing systems?
- Hypothesis: PATH will increase the number of existing ECM and Community Supports providers sharing data with the MCPs using EHR technology or a care management documentation systems and billing systems.
- Measures:
  - Number and percent of ECM and Community Supports providers with data sharing agreements with MCPs.
  - Number and percent of existing ECM and Community Supports providers who have EHR technology or an electronic care management documentation system or billing system.
  - Number and percent of existing ECM and Community Supports providers who share data successfully with the MCPs using EHR technology or an electronic care management documentation system or billing system.
- Target Population: Existing providers of ECM and Community Supports
- Comparison Population: Pre/post comparison
- Data will be stratified by county.
- Sampling methodology may be needed depending on data collecting methodology.
- Evaluation Period: CY 2022 through CY 2026.
- Methodological Design: Surveys will be conducted with the whole population or a sample of the whole population of the existing ECM and Community Supports providers to identify the providers who have data sharing agreements with MCPs, have EHR technology or an electronic care management documentation system or billing system, and have shared data successfully with the MCPs using EHR technology or a care management documentation system or billing system. Before and after comparison will be used to compare the number and percent of existing providers who share data successfully before and after PATH was implemented. If the number is higher after implementing PATH then the hypothesis is affirmed.
- The data sources for this portion of the evaluation will include survey data collected by the TPA, PATH data collected by DHCS, Provider data.
- Analytic Methods: Descriptive summary, t-tests and Chi-square statistical tests will be used in accordance with the methodological design and in consultation with the independent evaluator.

Goal 3: : Improve the ability for state prisons, county jails, and youth correctional facilities to screen, enroll, and change the suspension status 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.

- Research Question 1: Did justice-involved entities modify their key workflows, IT systems, processes, and staffing to improve their ability to achieve these objectives?
- Hypothesis: PATH will improve the ability for these entities to screen, enroll, and change the suspension status for eligible individuals in Medi-Cal prior to release.
- Measures:
    - Evidence of changes, including but limited to, policy, regulation, staffing, process/workflow, and IT systems that supports an entities' ability to screen, enroll, and change the suspension status for eligible individuals in Medi-Cal prior to release.
- Target Population: County/Entities.
- Comparison Populations: Pre/Post comparison.
- Data will be stratified by county.
- No sampling methodology will be used.
- Evaluation Period: CY 2022 through CY 2026.
- Methodological Design: Before and after comparison will be used to compare the evidence of changes – including but not limited to, policy, regulation, staffing, process/workflow, and IT systems that supports the justice-involved entities' abilities to screen, enroll, and change the suspension status for eligible individuals in Medi-Cal, prior to release – before and after implementing PATH. If these changes are identified and confirmed after implementing PATH, then the hypothesis is affirmed.
- The data sources for this portion of the evaluation will include data collected by the TPA
- Analytic Methods: Descriptive summary, t-test and Chi-square statistical tests will be used in accordance with the methodological design and in consultation with the independent evaluator.

- Research Question 2: Were more eligible justice-involved individuals screened and enrolled in Medi-Cal prior to release as a result of the PATH funding compared to prior to PATH funding?
- Hypothesis: PATH will increase the number of eligible individuals screened and enrolled in Medi-Cal prior to release.
- Measures:
    - Number and percent of eligible individuals screened for Medi-Cal eligibility prior to release.

  - Number and percent of eligible individuals who were enrolled in Medi-Cal prior to release.
- Target Population: Justice-involved individuals who are being released
- Comparison Populations: Pre/Post comparison.
- Data will be stratified by county.
- No sampling methodology will be used.
- Evaluation Period: CY 2022 through CY 2026.
- Methodological Design: Before and after comparison will be used to compare the number and percent of the eligible individuals screened and enrolled in Medi-Cal prior to release before and after implementing PATH. If the number is higher after implementing PATH then the hypothesis is affirmed.
- The data sources for this portion of the evaluation will include data collected by the TPA.
- Analytic Methods: descriptive summary, t-test and Chi-square statistical tests will be used in accordance with the methodological design and in consultation with the independent evaluator.

Global Payments Program

Goal 1: Improve the quality of care among those individuals with uninsured services.

- Research Question: Was the GPP successful in improving quality of care to individuals with uninsured services?
- Hypothesis: PHCS improved the quality of care to the uninsured.
- Measures:
  Clinical quality measures were chosen based on alignment with the DHCS Comprehensive Quality Strategy and were derived from the Uniform Data System (UDS) and Meri-based Incentive Payment System (MIPS). These sources were used since their measures are based on patients seen by the clinic/system and have national benchmark 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. These measures include:
  - Colorectal Cancer Screening
    (Measure specification: CMS130v10) (UDS benchmark; NCQA stewarded)
  - Controlling High Blood Pressure
    (Measure specification: CMS165v10) (UDS benchmark; NCQA stewarded)
  - Diabetes: HbA1c Poor Control (> 9%)
    (Measure specification: CMS122v10) (UDS benchmark; NCQA stewarded)

- Preventive Care and Screening: Screening for Depression and Follow-Up Plan (Measure specification: CMS2v11)(UDS benchmark; CMS stewarded)
- 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)

- Target population: Individuals who receive GPP services, with more specific target populations defined by each clinical measure specification. The level of analysis will be at the provider (PHCS) and program level.
- Comparison group: GPP utilizers in CY 2021 (PY 7) (i.e., prior to CalAIM). Clinical measures will be trended annually to assess changes over time within GPP and compared to national benchmarks.
- Data will be stratified by race/ethnicity, preferred language, gender, sexual orientation, and age group.
- No sampling methodology will be used.
- Evaluation period: CY 2021 (PY7) through CY 2026 (PY 12).
- Methodological design will involve pre/post data comparisons as well as a trending of annual performance on the above measures to assess changes over time with GPP and compared to national benchmarks. Improvement will be measured by gap closure from each measure's baseline rates to each measure's national 90th percentile benchmarks. This approach will be applied to both the overall measure's performance rate as well as the performance rates for each of the stratifications.
- The data source for this portion of the evaluation will be performance data on the above clinical quality measures. As part of the GPP Health Equity Monitoring Metrics Protocol (currently under review by CMS), PHCS will be required to submit stratified performance data on the five clinical quality measures listed above. That required reporting process can be leveraged for the purposes of this evaluation. PHCS will submit performance rates on an annual basis for the five clinical quality measures following the program year. The data sources for the performance data include administrative data (i.e., claims data) and medical record documentation (e.g., structured and unstructured EHR data, clinical and immunization registry data, pharmacy and lab data).

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.

- Research Question: 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?

- Hypothesis: PHCS increased the use of outpatient services, non-traditional services, and equity-enhancing services over the course of the GPP.
- Measures:
  DHCS proposes continuing to assess utilization as was done in the initial GPP evaluation, which assessed a core objective of the program: to shift care from inpatient and emergency settings to primary and preventive services, including non-traditional services. 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. These measures include:
    - Change in utilization of GPP non-behavioral health outpatient non-emergency, emergency, and inpatient med/surg services over time (based on number of GPP points provided in each category)
    - Change in utilization of GPP behavioral health outpatient non-emergency, emergency, and inpatient services over time (based on number of GPP points provided in each category)
    - Change in utilization of GPP non-traditional services over time (non-traditional services are identified in the GPP STCs)
    - Change in utilization of GPP equity-enhancing services over time (equity-enhancing services are identified in the GPP STCs)
- Target population: All individuals receiving GPP services
- Comparison group: GPP utilizers in CY 2021 (PY 7) (i.e., prior to CalAIM). Measures will also be trended annually to assess changes over time within GPP
- Data will be stratified by race/ethnicity, preferred language, gender, sexual orientation, and age group.
- No sampling methodology will be used.
- Evaluation period: CY 2021 (PY7) through CY 2026 (PY 12).
- Methodological design will involve pre/post data comparisons as well as a trending of annual utilization, which will be compared over time with GPP.
- The data source for this portion of the evaluation will be the year-end GPP summary and encounter data reports submitted by each system. As part of the GPP reporting process, PHCS submit aggregate and encounter data nine months after the program year is over. For example, reports are due 9/30/23 for PY 8 (CY 2022). This reporting process is well-established. Systems have submitted encounter data reports since PY 2, and the quality and completeness of data has improved over time. The sources of data for each system's summary and encounter data reports include services provided by the PHCS, contracted providers, and local behavioral health providers. Using the summary and aggregates reports from each system from PY 8-12, the evaluator can calculate the utilization measures listed above.

Goal 3: Improve PHCS data infrastructure and completeness that are necessary to understand health inequities among GPP utilizers.

- Research Question: Was the GPP successful in driving improvements in the data infrastructure necessary to understand health inequities?
- Hypothesis: PHCS improved the data collection, reporting and analytics infrastructure to identify and act on health inequities.
- Measures:
  - Percent completion of race, ethnicity, preferred language, sexual orientation, and gender identify fields among GPP utilizers
- Target population: All individuals receiving GPP services
- Comparison group: GPP utilizers in CY 2021 (PY 7) (i.e., prior to CalAIM). Measures will also be trended annually to assess changes over time within GPP.
- Data will be stratified by age group
- No sampling methodology will be used.
- Evaluation period: CY 2021 (PY 7) through CY 2026 (PY 12)
- The data source for this portion of the evaluation will once again be the data obtained from the PHCS as required through the GPP Health Equity Monitoring Metrics Protocol (currently under review by CMS).

GPP qualitative design:

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

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

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

DHCS also proposes working with the external evaluator to use existing or add new questions to the California Health Interview Survey (CHIS) to capture member experience data for the uninsured, and analyze these data to look at trends over the demonstration period.

GPP analytic methods:

The analysis will include descriptive statistics of GPP utilizers, including a report of enrollment numbers and stratification by demographic factors. The analysis will also include trending data on both clinical and utilization metrics as well as demographic data completeness.

Statistical testing will be determined in conjunction with the independent evaluator. DHCS will confer with the independent entity on how best to isolate the effects of the demonstration.

Alignment and Integration for Dually Eligible Beneficiaries

Goal: Maintain a high degree of satisfaction with the Medi-Cal matching process among dually eligible beneficiaries in MA plans who are matched.

- Research Question 1: How many dually eligible beneficiaries enrolled in a MA plan in the 12 counties with a Medi-Cal matching plan policy had the policy applied to them, and of these dually eligible beneficiaries, how many subsequently requested to change their Medi-Cal plan within 12 months of enrollment?
- Hypothesis 1: Dually eligible beneficiaries will be satisfied with the mandatory alignment of their Medi-Cal plan to their Medicare Advantage plan choice, and less than 0.1 percent will request to change their Medi-Cal plan within 12 months of enrollment.
- Measure:
    - Percent of dually eligible beneficiaries enrolled in a MA plan in the 12 counties with a Medi-Cal matching plan policy who subsequently requested to change their Medi-Cal plan
- Target population: Dually eligible beneficiaries who are in matching plan counties AND who enroll in MA plans. The level of analysis will be at the program level.
- Comparison group: Dually eligible beneficiaries who are:
    - In matching plan counties AND do not enroll in MA plans
    - In non-matching plan counties AND who enroll in MA plans
    - In non-matching plan counties AND do not enroll in MA plans
- Planned stratification by race/ethnicity, gender, and age
- No sampling will be used.
- Evaluation period will be CY 2023 and 2024

- Methodological design will be comparing the four above groups and conducting a difference-in-difference analysis comparing the rate of requested change in Medi-Cal plan enrollment in the target population with those of the comparison groups. We will also perform a secondary analysis excluding data during the period of Dec 2022 through Feb 2023 due to dually eligible beneficiaries transitioning January 1 - February 1, 2023 as part of the implementation of CalAIM's mandatory managed care initiative. Requests to change Medi-Cal plans may increase due to the mandatory Medi-Cal managed care policy (as opposed to the matching plan policy) in counties not part of the Coordinated Care Initiative. Therefore, it may be difficult to distinguish between requests to change plans related to the mandatory managed care policy vs the matching plan policy. .
- The data sources for this portion of the evaluation will be Medi-Cal and Medicare enrollment files. Enrollment data is considered high quality and is not anticipated to need extensive validation and cleaning.

- Research Question 2: Are dually eligible beneficiaries satisfied with the information and process for mandatory Medi-Cal aligned enrollment when they choose a MA plan?
- Hypothesis 2: Dually eligible beneficiaries will be satisfied with the mandatory alignment of their Medi-Cal plan to their Medicare Advantage plan choice, and the minority who request to change their Medi-Cal plan will be satisfied with the process for doing so.
- Measures:
    - Surveys, and possibly focus groups, of dually eligible beneficiaries enrolled in Medicare Advantage plans in matching plan counties and non-matching plan counties, soliciting satisfaction and understanding of the Medi-Cal enrollment process.
- Target population: Dually eligible beneficiaries who are in matching plan counties enrolled in MA plans and stay with their assigned Medi-Cal plan. The level of analysis will be at the program level.
- Comparison groups: Dually eligible beneficiaries who are:
    - In matching plan counties and enroll in MA plans, but request to change their Medi-Cal plan
    - In non-matching plan counties, enroll in MA plans, and choose a matching Medi-Cal plan
    - In non-matching plan counties, enroll in MA plans, and choose a non-matching Medi-Cal plan
- Planned stratification by race/ethnicity, primary language, gender, age, and plan/county
- Sampling methodology will be determined in conjunction with the independent evaluator
- Evaluation period will be CY 2023 and 2024

- Methodological design will be comparing beneficiary surveys responses between the target population and comparison groups.
- The data sources for portion of the evaluation will be beneficiary surveys, to be developed in conjunction with the independent evaluator.

Dually Eligible Beneficiary Satisfaction Analytic Methods:

The analysis will include descriptive statistics of the demographics and rates of change in Medi-Cal plan enrollment of dually eligible beneficiaries in the target population as well as the comparison groups.

The independent evaluator will analyze rates of change in Medi-Cal plan enrollment using a quasi-experimental pre-post, intervention-comparison group analytic design and difference-in-difference (DD) methodology for analyses of quantitative data. DHCS will confer with independent entity on feasibility of doing this and how best to structure. Statistical testing will be determined in conjunction with the independent evaluator.

Analytic Approach to Survey and Interview Data for GPP and Dually Eligible Beneficiary Satisfaction

Qualitative data from surveys and interviews will undergo content analysis to evaluate patterns in responses and identify recurring themes. The independent evaluator will obtain and interpret these data using a grounded theory method and leverage accepted methodological procedures for qualitative research. Data will be coded and used to generate hypotheses, which will then be organized into key study domains related to the RE-AIM framework (Reach, Effectiveness, Adoption, Implementation, and Maintenance). Within each domain, initial analyses will utilize preliminary codes that are expected to emerge from qualitative data. Again, DHCS will determine the specific approach to this qualitative analysis in conjunction with the independent evaluator.

METHODOLOGICAL LIMITATIONS

Administrative data has limitations related to missing data and data reporting lags. DHCS will instruct the independent evaluator to assess the available administrative data for data completeness and reflect that assessment and its potential implications in its reports. Due to the data reporting lag, DHCS will disregard the most recent 6 months of data, which will limit the amount of data that can be used, especially in early reports.

Moreover, completeness of enrollment data variables/elements for historically under-resourced or marginalized populations may be lacking. DHCS will work with the independent evaluator to assess how complete such data is and make note of its potential impact and the caution that should be exercised in its interpretation in the evaluations. Regarding PATH, the before and after comparisons do not necessarily establish causal relationships. However, in some cases, certain PATH inventions will be very specific so the causal relationship can be more confidently concluded. Difference-in-difference approaches will also allow evaluators to adjust for differences in comparison populations over time, helping to further establish a causal inference.

Regarding GPP, although PHCS are experienced at reporting GPP services and have improved the quality of data over time, some limitations likely remain, particularly the quality and completeness of behavioral health data. Behavioral health services are typically provided by departments or agencies that are separate from PHCS, although still within the same overall PHCS umbrella. Behavioral health departments also have different data systems. Data exchange between the separate departments, privacy concerns related to sharing behavioral health data, and data from two different data systems make reporting of behavioral health data more complicated than for services provided directly by the PHCS.

Furthermore, PHCS will be reporting performance on clinical quality measures for the first time in 2023. Although PHCS have significant experience reporting on quality measures for the Quality Incentive Pool (QIP) program, measuring and reporting on clinical quality with data based on uninsured care is unique and unprecedented for PHCS. As with GPP reporting in the previous waiver, it is anticipated and expected that the quality of this data will improve over time.

Similarly, equity-enhancing services are in GPP for the first time, starting in 2023 (pending CMS approval), as is the requirement to report GPP data stratified by race, ethnicity, preferred language, gender sexual orientation, and age group (as required by the GPP Health Equity Monitoring Metrics Protocol). As with any new GPP service or reporting requirements, PHCS are expected to improve their capacity to collect new data fields and report new services over time.

The PHCS participating in GPP essentially have no control group, since there is not a group of health care systems that do not participate in GPP but are otherwise similar to PHCS. However, while inferences about causality may be limited, the evaluation will be able to assess change over time within GPP and can cautiously interpret comparisons

of clinical performance rates between national benchmarks and individuals who receive GPP services, acknowledging the complexity of making such comparisons.

For the dually eligible beneficiary satisfaction portion of the evaluation, the evaluation is focused on beneficiary satisfaction only as it relates to the Medi-Cal enrollment process and does not reflect satisfaction levels with any other aspect of the Medi-Cal or Medicare programs, reflecting previous discussions with CMS.

Portions of the evaluation relying on survey and interview data (e.g., GPP and Dually Enrolled Beneficiary Satisfaction) are also limited by the honesty of respondents and the response rate. DHCS will work to ensure the independent evaluator has the necessary expertise and experience in soliciting forthright and robust survey and interview data.

ATTACHMENTS

Independent Evaluator:

The State will contract with an independent entity and ensure that the entity is free of conflict of interest to conduct this evaluation. The State will contract with an entity that does not have a direct relationship to DHCS. A data use agreement will be included in the contract to allow for the sharing of data with and access to data by the independent entity for purposes of conducing this evaluation. The State will seek proposals from interested entities that have prior experience conducting large-scale health care program evaluations. Proposals will be scored along pre-determined criteria related to the entity's ability to conduct in a timely manner quantitative and qualitative research with a high level of sophistication with regards to data analysis and statistical testing. Follow-up interviews with potential vendors will be scheduled to clarify the Department's questions or concerns with the higher scoring applicants before making a final decision.

Evaluation Budget:

DHCS has allocated $10.5 million (total) in contract costs for these components of the 1115 evaluation, and anticipates contracting with a single independent vendor to conduct the evaluation.

Additionally, pending legislative approval of the California state FY 2022-23 budget, DHCS has approval to hire the following staff outlined below who will support all of DHCS' CalAIM evaluation activities in both the 1115 and 1915(b) waivers.

- Data Management and Analytics Division (4.0 permanent positions to pull data needed by external evaluators):
    - 1.0 Research Scientist Supervisor II – $246,000 in FY 2022-23 and $237,000 in FY 2023-24 and ongoing.
    - 3.0 Research Scientists III - $579,000 in FY 2022-23 and $552,000 in FY 2023-24 and ongoing.

- Quality and Population Health Management Division (2.0 permanent positions to do contracting and coordination between external evaluators and various DHCS programs):
    - 1.0 Associate Governmental Program Analyst – $ 141,000 in FY 2022-23 and $132,000 in FY 2023-24 and ongoing.
    - 1.0 Health Program Specialist I - $151,000 in FY 202223 and $142,000 in FY 2023-24 and ongoing.

Timeline and Major Milestones:

December 29, 2021
1115 CalAIM Waiver demonstration approved by CMS

June 27, 2022
Draft Evaluation Design and Budget submitted to CMS

- DHCS will submit to CMS a revised draft Evaluation Design within 60 calendar days after receipt of CMS's comments
- DHCS will publish the Evaluation Design to the state's Medicaid website within 30 calendar days of CMS approval, as per 42 CFR 431.424(c).

August 31, 2022
Issue Request for Information for independent evaluator by this date or prior.

December 31, 2022
Execute contract with the independent evaluator by this data or prior.

December 31, 2024
Submit Interim Evaluation Report to CMS

- DHCS will submit to CMS a revised Interim Evaluation Report within 60 calendar days after receipt of CMS's comments
- DHCS will publish the report to the state's Medicaid website within 30 calendar days of CMS approval, as per 42 CFR 431.424(d).

December 31, 2026
End of expenditure authority of this 1115 demonstration

June 30, 2027
Submit Final Summative Evaluation Report to CMS

- DHCS will submit to CMS a revised Final Summative Evaluation Report within 60 calendar days after receipt of CMS's comments
- DHCS will publish the report to the state's Medicaid website within 30 calendar days of CMS approval, as per 42 CFR 431.424(d).