California Department of Health Care Services

Policy and Operational Guide for Planning and Implementing CalAIM Justice-Involved Reentry Initiative

DRAFT FOR STAKEHOLDER REVIEW:
June 2023

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

Dear CalAIM JI Stakeholders and Implementing Partners,

Please find a draft Policy and Operational Guide for Planning and Implementing CalAIM Justice-Involved Reentry Initiative. This draft guidance memorializes policy and operational requirements for implementing the Medi-Cal Justice-Involved Reentry Initiative. The draft guidance is intended to lay out to implementing stakeholders – correctional facilities, behavioral health agencies, providers, CBOs, and Medi-Cal managed care plans (MCPs), among others – the policy design and operational processes that will serve as the foundation for implementing this important initiative.

This complex initiative requires a close working partnership across multiple stakeholders in order for it to be successful. **To that end, DHCS requests stakeholders submit written feedback to this guide by June 30, 2023. Feedback should be sent to the Justice Involved Advisory Group inbox** (CalAIMJusticeAdvisoryGroup@dhcs.ca.gov).

Thank you,
DHCS

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Acronym/Initialism Table	
Acronym	**Term**
ACWDL	All County Welfare Directors' Letter
AE	Accelerated Enrollment
AI/AN	American Indian and Alaska Native
ASAM	American Society of Addiction Medicine
ASSIST	Alcohol, Smoking, and Substance Involvement Screening Test
AR	Authorized Representative
AUD	Alcohol Use Disorder
BIC	Benefits Identification Card
BJMHS	Brief Jail Mental Health Screen
BSCC	Board of State and Community Corrections
CA-MMIS	California Medicaid Management Information System
CalHEERS	California Healthcare Eligibility and Enrollment Retention System
CalSAWS	California Statewide Automated Welfare System
CBO	Community-Based Organization
CCJBH	Council on Criminal Justice and Behavioral Health
CDCR	California Department of Corrections and Rehabilitation
CCF	County Correctional Facility
CF	Correctional Facility (inclusive of State Prison, County Jail, or Youth Correctional Facility)
CHIP	Children's Health Insurance Program
CHW	Community Health Worker

CMAA	County-Based Medicaid Administrative Activities
CMHS-M	Correctional Mental Health Screen for Men
CMHS-W	Correctional Mental Health Screen for Women
CMS	Centers for Medicare & Medicaid Services
CODs	Co-Occurring Diagnoses
County Behavioral Health Plan	Includes Mental Health Plans and DMC or DMC-ODS
DEA	Drug Enforcement Administration
DHCS	Department of Health Care Services
DMC	Drug Medi-Cal
DMC-ODS	Drug Medi-Cal Organized Delivery System
DME	Durable Medical Equipment
DSM	Diagnostic and Statistical Manual of Mental Disorders
ECM	Enhanced Care Management
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EHR	Electronic Health Record
EVS	Eligibility Verification System
FDA	Food and Drug Administration
FFP	Federal Financial Participation
FFS	Fee For Service
FQHC	Federally Qualified Health Center
HIPAA	Health Insurance Portability and Accountability Act
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HRSN	Health-Related Social Needs
ICT	Inter-County Transfer

IT	Information Technology
ISUDT	Integrated Substance Use Disorder Treatment
JI	Justice-Involved
JI PATH	Justice-Involved Providing Access and Transforming Health
KOP	Keep-On-Person
LPHA	Licensed Practitioner of the Healing Arts
MAA	Medicaid Administrative Activity
MAR	Medication Administration Record
MAT	Medication-Assisted Treatment or Medications for Addiction Treatment
MCIEP	Medi-Cal Inmate Eligibility Program
MCIP	Medi-Cal County Inmate Program
MCP	Medi-Cal Managed Care Plan
MEDS	Medi-Cal Eligibility Data System
MHP	Mental Health Plan
MSIP	Medi-Cal State Inmate Program
NIDA	National Institute of Drug Abuse
NTP	Narcotic Treatment Providers
NOA	Notice of Action
OTC	Over The Counter
OUD	Opioid Use Disorder
PA	Prior Authorization
PAVE	Provider Application and Validation Enrollment
PATH	Providing Access and Transforming Health
PII	Personally Identifiable Information
POF	Population Of Focus

ROI	Release Of Information
SMHS	Specialty Mental Health Services
SMI	Serious Mental Illness
SSD	County Social Services Department
STC	Special Terms and Conditions
SUD	Substance Use Disorder
TA	Technical Assistance
TAR	Treatment Authorization Request
TCM	Targeted Case Management
TCUDS V	Texas Christian University Drug Screen V
TPA	Third-Party Administrator
UM	Utilization Management
WPC	Whole-Person Care
YCF	County Youth Correctional Facility

i. Introduction

On January 26, 2023, California became the first state in the nation to receive federal approval to offer a targeted set of Medicaid services to Medi-Cal-eligible youth and adults in state prisons, county jails, and youth correctional facilities (YCFs) for up to 90 days prior to release. Through a federal Medicaid 1115 demonstration waiver approved by the Centers for Medicare & Medicaid Services (CMS), the Department of Health Care Services (DHCS) will partner with state agencies, counties, providers, and community-based organizations (CBOs) to establish a coordinated community reentry process that will assist people leaving incarceration in connecting to the physical and behavioral health services they need prior to release and reentering their communities. The initiative will help California address the unique and considerable health care needs of justice-involved (JI) individuals, improve health outcomes, deliver care more efficiently, and advance health equity across the state.

By providing pre-release and reentry services to individuals who are incarcerated, DHCS aims to improve health outcomes and reduce health disparities. Pre-release services will be anchored in comprehensive care management and include physical and behavioral health clinical consultation, lab and radiology services, medication-assisted treatment (MAT), medications and medication administration, community health worker (CHW) services, and provision of medications and durable medical equipment (DME) upon release. For people receiving these services, a care manager will be assigned – either on-site in the carceral setting or via telehealth – to establish a relationship with the individual, understand their health needs, coordinate vital services, and plan for community transition, including connecting the individual to a community-based care manager they can work with upon their release.

This draft Policy and Operational Guide memorializes policy and operational requirements for implementing the Medi-Cal Justice-Involved Reentry Initiative. The Guide is intended to lay out to implementing stakeholders – correctional facilities, behavioral health agencies, providers, CBOs, and Medi-Cal managed care plans (MCPs), among others – the policy design and operational processes that will serve as the foundation for implementing this important initiative.[1] As implementing partners begin to advance in the process of standing up the Medi-Cal Justice-Involved Reentry Initiative, and as CMS continues to refine its own subregulatory guidance for states that

[1] Section 13 outlines MCP requirements for implementing the CalAIM Justice-Involved Initiative.

receive demonstration approval, it is expected that this Guide will be updated on an ongoing basis to reflect new policy decisions and operational requirements.

This complex initiative requires a close working partnership across multiple stakeholders in order for it to be successful. To that end, the DHCS team is available to provide technical assistance support and answer any questions and can be reached at CalAIMJusticeAdvisoryGroup@dhcs.ca.gov.

ii. Context Setting

In California, an estimated 400,000 individuals are released from CFs each year.[2] Of these individuals, an estimated 80-90 percent are eligible for Medi-Cal.[3] Formerly incarcerated individuals are more likely to experience poor health outcomes and face disproportionately higher rates of physical and behavioral health diagnoses. They are also at higher risk for injury and death as a result of violence, overdose, and suicide compared to people who have never been incarcerated.[4]

- Incarcerated individuals in California jails under active care for mental health issues rose by 63 percent between 2009 and 2019.[5]
- As of 2019, 66 percent of people in California jails and prisons have a moderate or high need for substance use disorder (SUD) treatment.[6]
- Overdose death rates are more than 100 times higher in the two weeks after release from incarceration than for the general population.[7]

As research has demonstrated, people leaving incarceration are at increased risk of ending up in the emergency room or requiring costly institutional care and of suffering

[2] There are an estimated 40,000 releases per year from state prisons; for county jails, release numbers vary from 350,000 to 368,000 per year, based on the source. Note that annual release data for youth CFs are unavailable, but the average daily population is roughly 2,200.

[3] "From Corrections to Community: Reentry Health Care," California Health Care Foundation, 2018. Available at: https://www.chcf.org/project/corrections-community-reentry-health-care/

[4] Ingrid A. Binswanger, Marc F. Stern, Richard A. Deyo, Patrick J. Heagerty, Allen Cheadle, Joann G. Elmore, and Thomas D. Koepsell. "Release from Prison – A High Risk of Death for Former Inmates," *New England Journal of Medicine*, January 2007.

[5] The Prevalence of Mental Illness in California Jails is Rising: An Analysis of Mental Health Cases & Psychotropic Medication Prescriptions, 2009-2019, California Health Policy Strategies, 2020. Available at: https://calhps.com/wp-content/uploads/2020/02/Jail_MentalHealth_JPSReport_02-03-2020.pdf

[6] Improving In-Prison Rehabilitation Programs, Legislative Analyst's Office; The Prevalence of Mental Illness in California Jails is Rising: An Analysis of Mental Health Cases & Psychotropic Medication Prescriptions, 2009-2019

[7] Analysis of 2017 Inmate Death Reviews in the California Correctional Healthcare System, 2018. Available at: https://cchcs.ca.gov/wp-content/uploads/sites/60/MS/2017-Inmate-Death-Reviews.pdf

severe health consequences, including overdose and death. In California, monthly Medicaid costs for JI individuals following release are about twice the monthly costs for these individuals prior to incarceration, on average.[8]

Evidence suggests that improving health outcomes for this high-needs group of people requires focused, high-touch care management to assess needs and strengths and connect individuals to the services they need when released into their communities.[9] Service provision in the pre-release period is designed to engage eligible JI populations, prepare them for their return to the community, and mitigate gaps in services and medication. In-reach care management is needed to ensure the medical, behavioral, and social needs that are tied so closely to health – including housing and transportation – are met. The approach of providing services in the period prior to release helps to establish trusted relationships with care managers to develop a transition plan, coordinate care, and support stabilization upon reentry. Extending Medicaid coverage in CFs also allows for pre-release management of ambulatory care sensitive conditions (e.g., diabetes, heart failure, and hypertension), which could reduce post-release acute care utilization. Absent such management, a period of incarceration perfectly aligns with the time needed for a well-controlled condition (e.g., diabetes, HIV, schizophrenia) to worsen.

Across the country, people of color are more likely to be incarcerated due to mental health issues, the criminalization of SUDs, and systemic inequities rife in the criminal justice system. Although Black and Latino/a individuals are not more likely than White individuals to misuse alcohol or drugs, they are more likely to be incarcerated for related behaviors.[10] For instance:

- Approximately 29 percent of male prisoners in California are Black (as compared to 5.6 percent of California's adult male population); nationally, 5 percent of illicit

[8] Medicaid physical health costs for JI individuals prior to incarceration were $494 per member per month on average, whereas costs for this population after release were $972 per member per month on average. These figures are based on DHCS analysis of Medi-Cal managed care and fee-for-service (FFS) cost data for individuals released from incarceration in CY 2019.

[9] "How Strengthening Health Care at Reentry Can Address Behavioral Health and Public Safety: Ohio's Reentry Program." Available at: https://cochs.org/files/medicaid/ohio-reentry.pdf

10 "Comparing Black and White Drug Offenders: Implications for Racial Disparities in Criminal Justice and Reentry Policy and Programming," National Library of Medicine. Available at: Comparing Black and White Drug Offenders: Implications for Racial Disparities in Criminal Justice and Reentry Policy and Programming, PMC (nih.gov)

drug users are Black, yet they represent 29 percent of those arrested and 33 percent of those incarcerated for drug offenses.[11, 12]

- For Latino men, the imprisonment rate is 1,016 per 100,000 as compared to 314 per 100,000 for men of other races.[13]
- There is also a large American Indian and Alaska Native (AI/AN) population that is incarcerated relative to their proportion of the general population; however, due to data collection challenges, AI/AN populations are generally lumped into the "Other" category, making it difficult to report on their incarceration rate.[14]

To address these issues, California has developed local and statewide initiatives for JI individuals with behavioral health issues. Many of these programs aim to prevent unnecessary incarceration for individuals with chronic behavioral health conditions or to connect such individuals with treatment resources after release from jail or prison. Several initiatives that focus efforts on ensuring Medi-Cal enrollment and benefits upon release from CFs include the following:

- Since 2015, state prisons have been required to use a standardized process for gathering and processing pre-release applications to ensure that JI individuals are enrolled in Medi-Cal before their return to the community.
- From 2016 to 2021, 17 counties offered whole-person care (WPC) pilots dedicated to serving individuals reentering the community post-incarceration and have designed programs to directly engage local jails and/or probation departments.[15] These programs have transitioned to become Enhanced Care Management (ECM)/Community Supports programs in CalAIM.[16]

[11] Criminal Justice Fact Sheet, NAACP. Accessed September 8, 2021. Available at: https://naacp.org/resources/criminal-justice-fact-sheet.
[12] "California's Prison Population," Public Policy Institute of California, 2017. Available at: https://www.ppic.org/publication/californias-prison-
[13] Ibid.
[14] Roxanne Daniel, "Since you asked: What data exists about Native American people in the criminal justice system," Prison Policy Initiative, April 22, 2020. Available at: https://www.prisonpolicy.org/blog/2020/04/22/native/
[15] Counties with JI WPC pilots were identified through a review of WPC contracts and confirmed by targeted interviews and surveys conducted by DHCS and Manatt in May 2021. The 17 counties include Contra Costa, Kern, Kings, Los Angeles, Mendocino, Monterey, Orange, Placer, Riverside, Sacramento, San Diego, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Sonoma and Ventura.
[16] ECM went live on January 1, 2022 in the 17 counties that offered WPC pilots dedicated to serving individuals reentering the community post-incarceration.

- Since January 1, 2023, all counties are mandated to implement pre-release Medi-Cal application processes in county jails and youth correctional facilities.[17]
- Since January 1, 2023, and as authorized by SB 184, Medi-Cal benefits for juveniles and adults may be kept in suspended status until the individual is no longer an inmate of a public institution.[18]
- A 2021 state law (AB 133) requires CFs to implement a process to facilitate referrals to county specialty mental health services (SMHS), Drug Medi-Cal (DMC), the Drug Medi-Cal Organized Delivery System (DMC-ODS), and/or Medi-Cal MCPs for incarcerated individuals who received behavioral health services while incarcerated, to allow for the continuation of behavioral health treatment. These referrals are called behavioral health linkages.[19]
- MCPs are required to offer intensive, community-based care management for individuals transitioning to the community through the statewide ECM and Community Supports benefit. All individuals who are eligible for pre-release Medi-Cal services and enrolled in managed care will also be eligible to receive ECM upon release to the community.[20]

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[17] AB-720 inmates: health care enrollment. Available at: http://leginfo.legislature.ca.gov/faces/billCompareClient.xhtml?bill_id=201320140AB720&showamends=false; Cal. Pen. Code § 4011.11. Available at: https://casetext.com/statute/california-codes/california-penal-code/part-3-of-imprisonment-and-the-death-penalty/title-4-county-jails-farms-and-camps/chapter-1-county-jails/section-401111-entity-to-assist-county-jail-inmates-with-submitting-an-application-for-a-health-insurance-affordability-program; DHCS, issued a series of inmate pre-release policies described in All-County Welfare Directors' Letters (ACWDLs) 07-34 (January 2, 2008), 14-24 (May 6, 2014), and 14-24E (June 25, 2014). Additionally, DHCS and the CDCR issued ACWDLS 14-26 and 14-26E to describe their suspension policies. DHCS also released ACWDL 22-26 to update its suspension policy and 22-27 on the pre-release Medi-Cal application mandate.

[18] Under the federal SUPPORT Act and CMS guidance, California required counties to implement unlimited suspension for individuals under age 21 who were incarcerated prior to January 1, 2023. See State Medicaid Director Letter re: Implementation of At-Risk Youth Medicaid Protections for Inmates of Public Institutions (Section 1001 of the SUPPORT Act), CMS, January 19, 2021. Available at: https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21002.pdf

[19] Brief Overview of the Department of Health Care Services (DHCS)' California Advancing and Innovating Medi-Cal (CalAIM) Proposals that Impact the Criminal Justice Population, CCJBH, September 2021. Available at: https://www.cdcr.ca.gov/ccjbh/wp-content/uploads/sites/172/2021/09/CalAIM-Proposals-Relevant-to-Justice-System-Partners_September-2021.ADA_.pdf?label=Brief%20Overview%20of%20CalAIM%20Proposals&from=https://www.cdcr.ca.gov/ccjbh/publications/

[20] For additional details on the Individuals Transitioning From Incarceration Populations of Focus, see the CalAIM ECM Policy Guide. Available at: https://www.dhcs.ca.gov/Documents/MCQMD/ECM-Policy-Guide.pdf

- MCPs are also encouraged to offer Community Supports (in lieu of services such as housing supportive services or recuperative care) for JI populations upon reentry into the community.
- On January 21, 2022, DHCS released its assessment of the continuum of care for behavioral health services, which included behavioral health services provided to JI populations.[21]
- DHCS is also leveraging multiple federal funding streams to support the delivery of behavioral health services to individuals who are incarcerated, including, but not limited to, funding to expand MAT in county jails and drug courts, funding MAT training and technical assistance for the California Department of Corrections and Rehabilitation (CDCR), and Community Mental Health Services Block Grant funding.
- To support behavioral health linkages, DHCS laid out expectations[22] with respect to coordination between ECM and county behavioral health providers.
- DHCS is also laying out data exchange requirements. To date, DHCS has released CalAIM Data Sharing Authorization Guidance[23] and detailed data exchange goals in the Behavioral Health Quality Improvement Program guidance.[24]

[21] Assessing the Continuum of Care for Behavioral Health Services in California, released on January 21, 2022. Available at: Assessing the Continuum of Care for Behavioral Health Services in California

[22] CalAIM Enhanced Care Management Policy Guide, updated December 2022. Available at: https://www.dhcs.ca.gov/Documents/MCQMD/ECM-Policy-Guide.pdf

[23] CalAIM Data Sharing Authorization Guidance, released March 2022. Available at: https://www.dhcs.ca.gov/Documents/MCQMD/CalAIM-Data-Sharing-Authorization-Guidance.pdf

[24] CalAIM Behavioral Health Quality Improvement Program, Goal 3. Available at: https://www.dhcs.ca.gov/bhqip

1. California's 1115 Demonstration to Cover Medi-Cal Services for Justice-Involved Populations Prior to Release and State Legal Authority

1.1 Summary of the 1115 Demonstration Approval

In alignment with the SUPPORT Act[25] and the state's focus on health equity and coverage for JI populations, in January 2023 California received approval in its five-year 1115 demonstration renewal request to authorize federal Medicaid matching funds for selected Medicaid services for eligible JI individuals in the 90-day period prior to their release from a CF.[26,27] Under a provision of federal Medicaid law known as the "inmate exclusion," all states are prohibited from drawing down federal Medicaid funds to finance the health care of any individual committed to a jail, prison, detention center or other penal facility unless the incarcerated individual is treated in a medical institution outside the jail or prison for 24 hours or more.[28] Medicaid can, however, finance the cost of services provided to eligible individuals after their release. The 1115 demonstration provides waiver and expenditure authority for a limited set of Medi-Cal services to incarcerated individuals in the 90-day period prior to release.

The demonstration's goal is to build a bridge to community-based care for JI Medi-Cal members, offering them services up to 90 days prior to their release to stabilize their

[25] Section 5032, SUPPORT for Patients and Communities Act (SUPPORT Act), H.R. 6. Available at: https://www.congress.gov/bill/115th-congress/house-bill/6/text. On October 24, 2018, the SUPPORT Act was signed into law to address the opioid epidemic. As part of the federal legislation, the statute directs the U.S. Department of Health and Human Services (HHS) to convene a stakeholder group and develop policies that help states implement innovative strategies for JI populations (its report to Congress can be found here). The statute directs HHS to work with states to develop innovative strategies to help JI individuals enroll in Medicaid and to issue a state Medicaid director letter on opportunities to design 1115 demonstration projects to improve care transitions to the community for incarcerated individuals who are eligible for Medicaid.

[26] On January 26, 2023, DHCS received approval from CMS to provide Medi-Cal reentry services to incarcerated individuals in the 90 days prior to their release. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-calaim-ca1.pdf

[27] While DHCS received approval for providing 90 days of pre-release services, most individuals incarcerated in county facilities will have significantly shorter lengths of stay, which will limit the duration of covered services for many individuals while incarcerated. Please see Section8.2 of this document for more information on expectations for delivering services to individuals with anticipated short-term stays.

[28] 42 C.F.R. § 435.1010; see also CMS, Letter to State Health Officials, "To Facilitate Successful Re-entry for Individuals Transitioning from Incarceration to Their Communities," April 28, 2016. Available at: https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/sho16007.pdf

health conditions and establish a plan for their community-based care (collectively referred to as "pre-release services").

These pre-release Medi-Cal services include the following:

- Reentry care management services.
- 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 care managers' development of a post-release treatment plan and discharge planning.
- Laboratory and radiology services.
- Medications and medication administration.
- MAT for all Food and Drug Administration (FDA)-approved medications, including coverage for counseling.
- Services provided by CHWs with lived experience.
- In addition to the above pre-release services, qualifying members will receive covered outpatient prescribed medications and over-the-counter (OTC) drugs and DME upon release, consistent with approved state plan coverage authority and policy.

This demonstration will address the health care needs of California's JI population, advance the state's health equity priorities, and promote the objectives of the Medi-Cal program by ensuring JI individuals with high physical or behavioral health risks receive needed coverage and health care services pre-release and for reentry into the community. By establishing relationships between community-based Medi-Cal providers and JI populations prior to the incarcerated individuals' release, California seeks to improve the chances that individuals with a history of substance use, mental illness, and/or chronic disease will receive stable and continuous care. By working to ensure JI populations have a ready network of health care services and supports upon discharge, this demonstration seeks to:

- Increase coverage, continuity of coverage, and appropriate service uptake through assessment of eligibility and availability of coverage for benefits in carceral settings just prior to release.
- Improve access to services prior to release and improve transitions and continuity of care into the community upon release.

- Improve coordination and communication between correctional systems, Medicaid, and Children's Health Insurance Program (CHIP) systems, MCPs, and community-based providers.
- Increase 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.
- Improve connections between carceral settings and community services upon incarcerated individuals' release, to address physical health, behavioral health, and health-related social needs.
- Provide intervention for certain behavioral health conditions and for using stabilizing medications such as long-acting injectable antipsychotics and medications for addiction treatment for SUDs, with the goal of reducing decompensation, suicide-related deaths, overdoses, and overdose-related deaths in the near-term post-release.
- Reduce post-release acute care utilization, such as emergency department visits and inpatient hospitalizations, and all-cause deaths among recently incarcerated Medicaid beneficiaries and individuals who would otherwise be 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.

1.2 Legal Authority

Effective July 27, 2021, Welfare & Institutions Code section 14184.102 required DHCS to seek federal approval for and to implement the CalAIM initiative, which includes the provision of targeted pre-release Medi-Cal benefits to qualified individuals. Per state law, DHCS must implement the CalAIM initiative as approved by CMS. Subsection (d) of Welfare and Institutions Code section 14184.102 also provides DHCS with authority to implement, interpret, or make specific the CalAIM article in the Welfare and Institutions Code or the CalAIM Terms and Conditions, in whole or in part, by means of all-county letters, plan letters, provider bulletins, information notices, or similar instructions, without taking any further regulatory action. DHCS intends to use these letters to

implement the targeted pre-release services, which includes providing all benefits for the JI population.

Subsection (e) of Welfare and Institutions Code section 14184.102 allows DHCS to enter into contracts for the purposes of implementing the CalAIM article or the CalAIM Terms and Conditions. DHCS may utilize this subsection to enter into memorandums of understanding, interagency agreements, or similar contractual arrangements with applicable parties including state and local correctional agencies and to memorialize mandated activities, performance standards, remedies for noncompliance, etc., related to the provision of pre-release services.

Furthermore, Welfare and Institutions Code section 14184.800 provides state authority for when the inmate would be eligible to receive the targeted services under state law, where both subsections (a) and (b) point to the CalAIM Terms and Conditions. Specifically:

> (a) Notwithstanding any other law, commencing no sooner than January 1, 2023, a qualifying inmate of a public institution shall be eligible to receive targeted Medi-Cal services for 90 days, or the number of days approved in the CalAIM Terms and Conditions with respect to an eligible population of qualifying inmates if different than 90 days, prior to the date they are released from a public institution, if otherwise eligible for those services under this chapter and subject to subdivision (f) of Section 14184.102.
>
> (b) Targeted Medi-Cal services made available to qualifying inmates pursuant to subdivision (a) shall be limited to those services approved in the CalAIM Terms and Conditions.

With the 1115 demonstration approved by CMS, the CalAIM Special Terms and Conditions (STCs) related to the Justice-Involved Reentry Initiative are mandatory per federal and state law. In addition to the state being obligated to comply with the waiver conditions, DHCS must obtain approval for its implementation plan for this initiative; DHCS is required to submit its implementation plan to CMS within 120 days of the approval of the 1115 demonstration.

2. Justice-Involved PATH Funding for Implementation of Pre-Release Medi-Cal Applications and Pre-Release Services

2.1 Context Setting

To ensure a successful launch of the Justice-Involved Reentry Initiative, the initial CalAIM 1115 waiver approval authorized $151 million in Providing Access and Transforming Health (PATH) funding to support collaborative planning and information technology (IT) investments intended to support implementation of pre-release Medi-Cal application and enrollment processes. The subsequent CalAIM JI waiver approval provided an additional $410 million in PATH funding to support collaborative planning for and IT investments in implementation of pre-release Medi-Cal services.

Based on the experience of WPC pilots that include in-reach services in carceral settings, DHCS estimates that it will take at least a year from demonstration approval and the release of this Policy and Operational Guide to ensure collaborative planning between CFs, county enrollment offices, MCPs, and community providers and the development of the infrastructure and operational capacity needed to implement care continuity as Medi-Cal members are transitioned from correctional facilities to the community. Essential implementation work includes developing Medi-Cal billing systems; mapping new workflows; developing protocols; deploying IT tools to improve workflow effectiveness and efficiency; and creating linkages between JI and community-based providers.

Justice-involved PATH (JI PATH) funding is available in three funding rounds to support start-up costs related to:

- The implementation of the pre-release Medi-Cal application process mandate (PATH Funding Round 1 for planning grants and PATH Funding Round 2 for implementation grants).
- Pre-release services (PATH Funding Round 3 for implementation grants).

JI PATH funding is designed to support the planning for and implementation of the Justice-Involved Reentry Initiative but is not intended as a long-term funding source to support the ongoing operating costs beyond the start-up phase. As such, DHCS has committed to its correctional implementation partners that it will work collaboratively with them to identify other ongoing and sustainable sources of funding to transition from the short-term PATH funding.

This section of the Policy and Operational Guide provides an overview of the permissible uses for JI PATH funding.

2.2 Permissible Uses of Justice-Involved PATH Funding and Proposed Sustainability Approach for Justice-Involved Pre-Release Applications and Pre-Release Services

2.2.a Justice-Involved PATH Round 1: Planning Grants for Pre-Release Medi-Cal Applications

JI PATH Round 1 was a planning grant funding opportunity that provided small planning grants to probation offices, sheriff's offices, and CDCR (or its delegate) to support collaborative planning with county social services departments (SSDs), county behavioral health departments, and other enrollment implementation partners to implement or modify pre-release Medi-Cal enrollment and suspension processes, by identifying and scoping out the needed processes, protocols, and IT system modifications. PATH Round 1 guidance is available here. The application for JI PATH Round 1 grants closed on July 31, 2022, and funds were disbursed in fall 2022. The JI PATH Round 1 funding awards can be found here.

Permissible Uses of Justice-Involved PATH Round 1 Funding. Permissible uses of JI PATH Round 1 funding for correctional facilities (or their delegates) and SSDs include:

- Facilitating meetings and collaborative planning sessions between correctional institutions and SSDs.
- Hiring vendors or consultants to help identify operational gaps that need to be addressed in order to implement pre-release enrollment and suspension processes, including but not limited to IT system modifications.
- Support for initial costs related to recruiting, hiring, and onboarding staff who will have a direct role in planning for implementation of pre-release enrollment and suspension processes.
- Support for staff time devoted to planning, meeting facilitation, and development of applications for JI PATH Round 2 funding.

Awardee JI PATH Round 1 Expenditure Deadline and Sustainability Plan. DHCS did not set a deadline by which or time frame within which awardees must spend PATH Round 1 funds. Since JI PATH Round 1 is a planning grant, DHCS did not perceive the

need to establish a sustainable funding mechanism to support the permissible uses of JI PATH Round 1 funding on an ongoing basis.

2.2.b Justice-Involved PATH Round 2: Implementation Grants for Pre-Release Medi-Cal Applications

JI PATH Round 2 is an implementation grant funding opportunity that will support SSDs, county sheriff's offices, county probation offices (or their delegate), and the CDCR as they implement the processes, protocols, and IT system modifications that were identified during the Round 1 planning phases for implementing pre-release applications. The application for JI PATH Round 2 was open from January 30, 2023 through March 31, 2023. See JI PATH Round 2 guidance for further details. Any leftover funding from JI PATH Rounds 1 and 2 may be carried over to fund other CalAIM JI PATH funding initiatives, including provision of pre-release services.

Permissible Uses of Justice-Involved PATH Round 2 Funding. JI PATH Round 2 is primarily intended to cover the costs of (1) planning and implementing the pre-release Medi-Cal application process by SSDs and correctional facilities, and (2) administering and operating the pre-release application process by correctional facilities. JI PATH Round 2 funding is available to both SSDs and correctional facilities (or their delegates) unless otherwise noted that the funding is limited to correctional facilities. Permissible uses of Round 2 funding included the following:

- Modifying technology and IT systems needed to support Medi-Cal enrollment and suspension processes (e.g., building or updating data systems to track individuals who cycle in and out of incarceration, or to integrate health and eligibility data into one platform).
- Recruiting, hiring, onboarding, and training staff to assist with the coordination of Medi-Cal enrollment and suspension for JI individuals.
- Developing or modifying 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.
- Facilitating collaborative planning activities among correctional institutions, correctional agencies, SSDs, and other stakeholders as needed to support planning, implementation, and modification of the Medi-Cal enrollment and suspension processes.

- Modifying the physical infrastructure of correctional facilities to support implementation of pre-release Medi-Cal enrollment and suspension processes.
- Supporting salaries for correctional facility staff or their delegates (e.g., a CBO, health department, or SSD) that administer the pre-release Medi-Cal application process (i.e., assisting applicants with completing and submitting applications) for a limited time, until Medicaid administrative activity (MAA) funding becomes available (subject to the guardrails described below).[29]
- Setting up infrastructure/processes for correctional facilities (or their delegate) to draw down MAA funding to support salaries of staff who administer the pre-release Medi-Cal application process.
- Other activities approved by the state.

Guardrails for Using JI PATH Round 2 Funding for Staff Salaries. As noted above, JI PATH Round 2 funding may be used to fund staff salaries for positions that support the planning, implementation, or administration (i.e., helping applicants complete and submit applications) of pre-release Medi-Cal application processes, subject to the following guardrails:

- JI PATH funds may support only the portion of full-time-equivalent employees associated with pre-release Medi-Cal applications.
- Requests for salary support must be reasonable relative to the salaries for similar positions.
- Applicants may apply for up to 5 percent additional funding to support indirect costs.[30]
- Direct salary support may include costs associated with reasonable rates for fringe benefits.
- SSDs may allocate JI PATH Round 2 funding only to support the salaries of new positions.

[29] SSDs are not eligible to apply for salary support for processing (i.e., reviewing and making eligibility determinations) pre-release Medi-Cal applications, as these costs are currently budgeted for in the CalAIM Inmate Pre-Release Program Policy Change and are expected to be an ongoing administrative cost.

[30] "Indirect costs" are defined as administrative overhead expenses that are not readily identified with or directly pertinent to the funding request but are necessary for the general operation of activities outlined in the funding request.

Awardee JI PATH Round 2 Expenditure Deadline. DHCS did not set a deadline by which or time frame within which awardees must spend their JI PATH Round 2 awards across most permissible uses of funding, with the exception of salary support, which is time-limited, as described below:

- SSDs: SSDs must expend, within 18 months after they receive the award, their allocation for the salaries of staff who support the planning/implementation of the pre-release Medi-Cal application process.
- Correctional facilities (or their delegate):
- For the salaries of staff that support the planning/implementation of the pre-release Medi-Cal application process, correctional facilities must expend their allocation within:
    - 18 months after they receive it for new positions.
    - 12 months after they receive it for positions with new responsibilities.
- For the salaries of staff that administer pre-release Medi-Cal applications (i.e., help applicants complete and submit applications), correctional facilities must expend their allocation within two years, at which point MAA funding will become available.

Proposed Approach for Long-Term Sustainability of Pre-Release Medi-Cal Applications. DHCS will pursue federal approval for MAA funding to support the salaries for correctional facility staff who administer the pre-release Medi-Cal application process (i.e., assisting applicants in completing and submitting applications) on an ongoing basis, mindful of the following considerations:

- Counties/CDCR would not be required to contribute the non-federal share to support this program, which differs from other MAA programs.
- Leveraging MAA funding could necessitate the establishment of new administrative and operational processes for DHCS and counties. MAA is cost-reconciled, and counties will be subject to cost reporting. To minimize the administrative burden for the state, DHCS recommends that county CFs that wish to participate in this program work with their county MAA partners to streamline billing to DHCS. Most counties already participate in county-based MAA

(CMAA).[31] However, DHCS will explore new methods to make the MAA process less complicated for DHCS and its partners.

- DHCS will need to obtain approval from CMS to leverage MAA funding to support the salaries for correctional facility staff who administer the pre-release Medi-Cal application process.

2.2.c Justice-Involved PATH Round 3: Planning and Implementation Grants for Pre-Release Services

The PATH Justice-Involved Reentry Initiative Capacity Building Program will provide 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 as required by AB 133. 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 meeting certain performance milestones.

The funds available in PATH Justice-Involved Round 3 are dedicated exclusively to justice-involved pre-release services and behavioral health linkage implementation; additional stakeholders must avail themselves of other PATH funding as appropriate *(see list of other funds available below)*. Additional information regarding available capacity building PATH funds for supporting justice-involved Medi-Cal application and suspension processes may be found on the DHCS CalAIM justice-involved webpage.

Qualified Entities. The following entities are qualified to apply for funding through this initiative from May 1, 2023, to July 31 (90 days after application portal opens):

- County Sheriff's Offices to support county jails
- County Probation Offices to support youth correctional facilities
- California Department of Corrections and Rehabilitation (CDCR) to support state prisons
- County Behavioral Health Agencies to support behavioral health linkages

[31] As of March 2023, counties that do not participate in CMAA include Alpine, Amador, Butte, Colusa, Del Norte, Fresno, Kings, Modoc, San Benito, San Bernadino, Sierra, Solano, Tehama, and Yuba.

See JI PATH Round 3 guidance for further details.

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 (i.e., jails and youth correctional facilities). 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. In these cases, the county agencies may submit a joint application on behalf of all jails in the county and/or on behalf of all youth correctional facilities in each county. It is not necessary for all county jails and youth correctional facilities to apply separately for funding.

The PATH Justice-Involved Round 3 funding is intended to support both planning and implementation of justice-involved reentry services, including investments in capacity and IT systems that are needed to effectuate Medi-Cal justice-involved reentry services. Qualified entities may pass through funding to individual correctional institutions, vendors, in-reach providers (including County Behavioral Health Agencies if they are contracted to provide pre-release services by correctional facilities or the Department of Public Health, or another county agency that actively manages correctional health care services), and other entities, as needed, to support implementation activities.

Correctional facilities seeking PATH funds must demonstrate how they plan to use the funds to support the planning for and implementation of the *Operational Expectations (detailed in guidance memo)* that must be met in order to be deemed ready to go-live; the list below further describes processes and activities for which PATH Justice-Involved Round 3 funds can be used to meet go-live requirements. Entities unsure of whether their planned activities would qualify as permissible uses of funding under this initiative are encouraged to check with the PATH TPA prior to submitting their application by emailing justice-involved@ca-path.com, with the subject "Justice-Involved Reentry Initiative Capacity Building Program Funds."

DHCS will not set a deadline by which PATH Justice-Involved Round 3 funds recipients must spend their funds, but applicants will be required to define their grant period (i.e., start and end dates for spending their award) in both their PATH Justice-Involved Round 3 funds implementation plan and their grant agreement. DHCS intends to release justice-involved reentry policy and operational guidance that will provide additional details regarding implementation expectations for the initiative.

Please note that the purpose of the PATH Justice-Involved Round 3 program is to provide start-up funding to support planning and implementation of reentry services only, and reentry services will be funded through Medi-Cal service claims.

Permissible Uses of JI PATH Round 3 Funding. Permissible funding uses for correctional agencies include, but are not limited to, the following:

- **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 (EHR) technology, purchase of billing systems). Please note that DHCS anticipates that implementing Medi-Cal billing and claiming services will be a heavy lift for many implementation partners and suggests correctional facilities prioritize PATH funding in this area.
- **Adoption of Certified EHR Technology:** This includes expenditures for providers' purchase or necessary upgrades of certified EHR technology and training for the staff that will use the EHR.
- **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 services departments, county behavioral health agencies, and others, such as MCPs and community-based providers. This could also include establishing technology to facilitate video/teleconferences between individuals and community-based care coordinators or providers.
- **Hiring of Staff and Training:** This includes expenditures related to recruiting, hiring, onboarding, and supporting staff salaries for personnel supporting the planning and delivery of Medi-Cal Reentry Services (as mandated in AB 133) (see "Guardrails for Supporting Staff Salaries" below for additional information).
- **Development of Protocols and Procedures:** This includes developing or modifying protocols and procedures that specify steps to be taken in preparation for and delivery of Medi-Cal Reentry Services and reentry coordination.
- **Additional Activities to Promote Collaboration:** This includes expenditures related to facilitating collaborative planning activities between correctional institutions, correctional agencies, MCPs, county behavioral health agencies, and

other stakeholders as needed to support planning, implementation, and modification of Medi-Cal pre-release service processes.

- **Planning:** This includes developing policies and protocols for operationalizing the delivery of Medi-Cal Reentry Services, including process flows and procedures to incorporate already developed Medi-Cal application processes (and update them as needed), including (1) identifying uninsured individuals 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) incorporating new Medi-Cal Reentry Services processes, including screening for eligibility for Medi-Cal Reentry Services and reentry planning in a period for up to 90 days immediately prior to the expected date of release; (5) delivering, either directly through embedded providers or through in-reach providers,[32] 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 ongoing oversight and monitoring processes upon implementation.
- **Screening for Pre-Release Services** *(time limited to two years)***:** Correctional facilities may leverage PATH Justice-Involved Round 3 funding to pay for screening for pre-release services for a two-year limited period of time; DHCS will identify an ongoing reimbursement mechanism (e.g., Medicaid Administrative Activity (MAA) funding) for screening for pre-release services and will provide additional guidance once an approach is confirmed.
- **Other Activities to Support Provision of Medi-Cal Reentry Services:** This could include accommodations for private space such as movable screen walls, desks, and chairs to conduct assessments and interviews within correctional institutions; support for installation of audio-visual equipment or other technology to support provision of Medi-Cal Reentry Services delivered via

[32] DHCS defines an embedded provider as a provider employed or contracted by the correctional facility. DHCS recognizes that in some counties the department of health or county behavioral health agency provide both behavioral health services to correctional facilities *and* community-based services. In those circumstances, the determination of whether the provider is embedded or in-reach/community-based would be based on the role of the provider is playing and whether the provider has a contract with the Sheriff's Office to provide such services. If the provider is furnishing services in their role as a correctional facility contracted entity and performing services that correctional facilities are required to provide, those services would be considered embedded services. Alternatively, if the provider is acting on behalf of the county in their role in the community – for example, accepting a warm linkage – that service would be considered in-reach.

telehealth; oversight and monitoring activities to ensure compliance with implementation plans; or other activities approved by the state to support the provision of pre-release Medi-Cal services.

Permissible funding uses of JI PATH Round 3 funds by county behavioral health agencies include, but are not limited to, the following:

- Training, technical assistance, and planning efforts to support agencies standing up behavioral health in-reach (if correctional facilities develop an agreement with county behavioral health agencies to perform these activities) and establishing linkages to the community.
- Recruitment, hiring, onboarding, and supporting staff salaries for personnel supporting behavioral health in-reach services and behavioral health linkages (as mandated in AB 133. Please note that the use of PATH funding to support the recruitment and onboarding of a behavioral health workforce to provide behavioral health in-reach services and behavioral health linkages is designed to serve as a short-term glide path to support initial implementation efforts and increasing productivity rates over time; following the temporary capacity development period supported by PATH funding, these behavioral health in-reach service delivery and behavioral health linkages functions are to be sustained through Medi-Cal reimbursement.

Awardee JI PATH Round 3 Funds Expenditure Deadline. DHCS has not set a deadline for awardees to expend Round 3 funding, with the exception, as noted above, of requiring correctional facilities to expend JI PATH funding related to setting up processes for screening individuals for pre-release services eligibility within two years of receiving the award.

3. Approach to Planning and Implementation of Pre-Release Services

In designing, implementing, and delivering Medi-Cal services for JI individuals, DHCS has adhered, and will continue to adhere, to the following guiding principles:

- Work in close partnership with state, county, and local agencies, providers, MCPs, CBOs, and individuals with lived experience.
- Leverage existing infrastructure, processes, and resources to the maximum extent possible, where appropriate.
- Support flexible implementation and service delivery, including facilitating service provision by external providers.
- Ensure individuals receive the services for which they are eligible.
- Respect the privacy of JI individuals, as required by federal and state law.

3.1 Stakeholder Engagement

Beginning in October 2021, DHCS began actively meeting with its CalAIM Justice-Involved Advisory Group, one-on-one with implementation partners, and with additional sub-working groups, including during its monthly pre-release technical assistance office hours sessions, to inform the 1115 demonstration negotiations and provide input on policy and operational guidance. The CalAIM Justice-Involved Advisory Group was formed to solicit stakeholder input on the design of multiple JI CalAIM initiatives. The group continued to meet bimonthly until the approval of the 1115 demonstration; DHCS will continue to convene this group on an as-needed basis.

Members of the CalAIM Justice-Involved Advisory Group include:

- CDCR/California Correctional Health Care Services, which delivers health care services in state prisons.
- County jails, including correctional officers and correctional health staff.
- Chief probation officers of California/County Youth Correctional Facilities.
- Board of State and Community Corrections (BSCC).
- County Welfare Directors Association.
- County health departments.

- County Health Executives Association of California.
- SSDs.
- County Behavioral Health Directors Association of California (including the working group of county behavioral health directors).
- Council on Criminal Justice and Behavioral Health (CCJBH).
- Office of Youth and Community Restoration.
- Reentry providers (including TCN, STOP, Healthright360, WestCare, and Amity Foundation).
- MCPs.
- Individuals with lived experience.
- CBOs.

In January 2023, DHCS transitioned to an implementation stakeholder group, composed of implementers including, but not limited to, CDCR and a half dozen county jails and youth correctional facilities, to focus on establishing pre-release services policy and operational guidance. Additionally, DHCS separately engaged with managed care plans on the implementation of ECM for the Individuals Transitioning from Incarceration Population of Focus throughout 2022 and 2023.

3.2 Policy and Operational Planning

DHCS has organized its policy and operational planning into the following objectives:

- **Enrolling in Medi-Cal Coverage.** Implement Medi-Cal application processes, including to screen for Medi-Cal eligibility and current enrollment and to support individuals in applying for coverage, in coordination with the SSD.
- **Screening for Pre-Release Services and Behavioral Health Linkages.** Implement processes to screen individuals to see whether they meet the access criteria for 90-day pre-release services and for behavioral health linkages. If the individual is eligible, this screening process will lead to the activation of a pre-release services aid code. Ineligible individuals will receive an appropriate notice outlining the reason(s) for denial.
- **Providing Pre-Release Services During the 90-Day Pre-Release Period.** Deliver the full scope of covered 90-Day pre-release services. This includes establishing processes to initiate care manager assignment and pre-release care

management services – either embedded or community-based – and to provide logistical support for arranging in-person or virtual consultations, clinical consultations, medications, laboratory and radiology, and MAT.

- **Provider Enrollment and Payment.** DHCS will require correctional facilities to become Medi-Cal-enrolled providers and to follow billing and claims processes that match current FFS processes in order to track the delivery of pre-release services and to reimburse facilities for providing those services.
- **Supporting Reentry Services.** Reentry planning and coordination encompasses notifying stakeholders (including SSD, the post-release care manager, the MCP, and the county behavioral health agency (as available)) of the individual's release date and providing logistical support for warm handoffs and behavioral health linkages that occur prior to reentry, including a plan to exchange health- and discharge-related patient information with the care manager, community-based provider, behavioral health provider, and MCP, as relevant and allowed by privacy and consent laws. Reentry planning also includes any necessary prescribing, billing, and dispensing of medications and DME upon the incarcerated individual's release.
- **Oversight and Monitoring.** Oversight and project management includes defining a staffing or contractor structure to support 90-day pre-release services, establishing processes for collaborating with key implementation partners (e.g., SSDs, MCPs, county behavioral health agencies, ECM providers, community supports), and creating a reporting process to monitor program performance.

4. Enrolling in Medi-Cal Coverage

4.1 Background

State law and Section 1115 demonstration STC 9.6 and 9.9 require California to set up pre-release Medicaid application processes for adults and youth to better position individuals leaving incarceration from county correctional facilities (CCFs) and county youth correctional facilities (YCFs) to have access to Medicaid coverage immediately upon release into the community.[33] Under California statute, all counties must have implemented pre-release Medi-Cal application processes by January 1, 2023,[34]. Enrolling in Medi-Cal those individuals who are reentering the community from carceral settings is key to ensuring this population has access to the 90-day pre-release services, as requested in California's 1115 waiver, and to critical medical and behavioral health services upon their release into the community. The implementation of pre-release Medi-Cal application processes will help the state establish a continuum of care between carceral settings and the community, which will ultimately improve health outcomes and reduce the demand for costly and inefficient services.

4.2 Pre-Release Medi-Cal Application Process Implementation Requirements

DHCS published ACWDL 22-27, which provides detailed guidance and directives for implementing the mandatory pre-release Medi-Cal application process for SSDs and CCFs.[35] Please review ACWDL 22-27 for detailed implementation recommendations and

[33] See also CMS, SHO #16-007, "To Facilitate Successful Re-entry for Individuals Transitioning from Incarceration to their Communities" (April 28, 2016). Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/sho16007.pdf; CMS, "The Coverage Learning Collaborative: Medicaid and Justice-Involved Populations: Strategies to Increase Coverage and Care Coordination" (August 17, 2017). Available at: https://www.medicaid.gov/state-resource-center/downloads/mac-learning-collaboratives/justice-involved-populations.pdf

[34] AB-720 inmates: health care enrollment. Available at: http://leginfo.legislature.ca.gov/faces/billCompareClient.xhtml?bill_id=201320140AB720&showamends=false; Cal. Pen. Code § 4011.11. Available at: https://casetext.com/statute/california-codes/california-penal-code/part-3-of-imprisonment-and-the-death-penalty/title-4-county-jails-farms-and-camps/chapter-1-county-jails/section-401111-entity-to-assist-county-jail-inmates-with-submitting-an-application-for-a-health-insurance-affordability-program; DHCS, issued a series of inmate pre-release policies described in All-County Welfare Directors' Letters (ACWDLs) 07-34 (January 2, 2008), 14-24 (May 6, 2014), and 14-24E (June 25, 2014). Additionally, DHCS and the CDCR issued ACWDLS 14-26 and 14-26E to describe their suspension policies. DHCS also released ACWDL 22-26 to update its suspension policy and 22-27 on the pre-release Medi-Cal application mandate.

[35] See ACWDL 22-27, available at: https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/22-27.pdf

requirements. This section of the Policy and Operational Guide outlines requirements for implementing the pre-release Medi-Cal application process at a high level.

Best practices have been identified based on counties that have already implemented a pre-release Medi-Cal application process or are in the process of doing so.[36] One best practice includes ensuring that the board of supervisors in each county, the county sheriff for jails, the SSD, and the county probation officer for YCFs closely coordinate to implement a pre-release Medi-Cal application process in compliance with the state mandate. While no one approach will work for all pre-release Medi-Cal enrollment processes, SSDs and correctional facilities can collaborate on planning and design of each of the following steps in order to implement a customized pre-release Medi-Cal application process:

- **Step 1.** Initial enrollment screening to determine whether the incarcerated individual is a current Medi-Cal member and, if not, whether they would like to apply for Medi-Cal.
- **Step 2.** Application completion and submission to SSD.
- **Step 3.** Eligibility determination by SSD in alignment with Medi-Cal policies and procedures.
- **On an ongoing basis**, SSDs and CCFs must also ensure they have partnerships established for communication and data sharing to support implementation and monitoring of incarceration and release dates for Medi-Cal benefit suspension processes.

Starting January 1, 2023, CCFs and SSDs must meet the minimum requirements below for implementing the pre-release Medi-Cal application process mandate. DHCS will implement a monitoring plan to ensure that SSDs and CCFs are in compliance with the mandate, as described in MEDIL 23-24. SSDs and CCFs will be required to be in compliance by June 30, 2023.

4.2.a Minimum Operational Requirements for Pre-Release Medi-Cal Application Process

Please see Table 1 for minimum operational requirements.

[36] Note that "Best Practices" can be found throughout the Policy and Operations Guide. Best practices included in this document are DHCS identified best practices.

Table 1. Minimum Operational Requirements for Pre-Release Medi-Cal Application Process		
Operational Requirements	**CCFs**	**SSD**
Step 1. Initial Enrollment Screening	• Screen individual for Medi-Cal enrollment during/near intake. • Verify Medi-Cal enrollment through DHCS eligibility verification system (EVS) or in collaboration with the SSD, and identify individuals who are not currently enrolled in Medi-Cal. The CCF must have processes in place to obtain consent to submit a Medi-Cal application on behalf of youth under 18 years old.[37] ○ **If the individual is enrolled in Medi-Cal and incarceration is not reported**, CCF shall communicate the incarceration details to the SSD (including incarceration date and expected release date, if known). ○ **If the individual is enrolled in Medi-Cal and incarceration or suspension is displayed**, the	• Collaborate with the CCF to verify the current Medi-Cal enrollment status of the individual to assist the CCF with identifying individuals who require a pre-release Medi-Cal application. ○ **If the individual is enrolled in Medi-Cal and incarceration is not reported**, the SSD can obtain incarceration details from the CCF, including incarceration date and expected release date (if known). If applicable, the SSD shall suspend benefits. ○ **If the SSD determines that the individual is not enrolled in Medi-Cal**, the SSD shall notify the CCF of the individual's current enrollment status so the CCF can assist the individual with completing/

[37] See ACWDL 22-27 for the detailed process requirements for working with individuals under 18 years old.

Table 1. Minimum Operational Requirements for Pre-Release Medi-Cal Application Process		
Operational Requirements	**CCFs**	**SSD**
	CCF shall communicate the expected release date to the SSD, if known. ○ **If the individual is not enrolled in Medi-Cal**, the CCF shall assist the individual with completing/submitting a Medi-Cal application.	submitting a pre-release Medi-Cal application.
Step 2. Application Submission and Processing	• Complete and submit the Medi-Cal application. CCFs shall submit the Medi-Cal application at least 135 days before release if the release date is known. ○ The CCF shall ask the individual for the address where they plan to reside upon release from incarceration and use this address on the application. ○ If the CCF uses a paper application, it should submit the application to the county where the individual intends to reside upon release. ○ Applications of all forms (paper, electronic, etc.) should include a cover sheet/transmittal letter. Note: Cover letter requirements can be found in ACWDL 22-27.	• Receive and process pre-release applications from CCFs. SSDs must accept Medi-Cal applications via mail, online, phone, fax, or in person. ○ If the SSD receives an application for an individual expected to be released in a different county, it should coordinate with the county of responsibility to transition the application. ○ SSDs must work with the YCF to ensure that the application for an incarcerated youth is processed appropriately. • Communicate with the CCF to troubleshoot application questions,

Table 1. Minimum Operational Requirements for Pre-Release Medi-Cal Application Process		
Operational Requirements	**CCFs**	**SSD**
	○ If the individual plans to move to another state upon their release, the CCF must provide them with Medicaid application information (e.g., website) for the state in which they will reside. • Communicate with the SSD to troubleshoot application questions, request follow-up information, and obtain other information needed for the SSD to process the pre-release Medi-Cal application.	request follow-up information, and obtain other information needed to process the application. ○ The SSD should initiate an intercounty transfer (ICT) if necessary.
Step 3. Eligibility Determination	• Ensure the individual has their SSD's contact information upon release. For individuals being released, the CCF shall notify the SSD of the individual's release date, once known. ○ The CCF shall submit information to the SSD within one week of the individual's expected release and no later than one business day before release, unless the release is unplanned. ○ At a minimum, the CCF shall provide the SSD with the individual's full name (and any known aliases), date of birth, client identification	• Notify the CCF if the Medi-Cal determination is not expected to be complete before the individual's release (if the release date is known). • Notify the applicants of the outcome of their eligibility determination, provide all necessary Medi-Cal documentation (i.e., Notice of Action (NOA)), and issue a benefits identification card (BIC). ○ When there is an immediate need for services, the SSD shall arrange with the CCF to issue a temporary BIC to the individual so they can

Table 1. Minimum Operational Requirements for Pre-Release Medi-Cal Application Process		
Operational Requirements	**CCFs**	**SSD**
	numbers/Social Security numbers, and known/estimated release date.	access Medi-Cal benefits upon release. • Provide the individual with contact information for the SSD in the county in which the individual will reside. • Once notified of an individual's release, the SSD must activate/unsuspend Medi-Cal benefits by reporting the release date in the Medi-Cal Eligibility Data System (MEDS).

4.2.b Data Exchange to Support the Pre-Release Medi-Cal Application Process

Stakeholders utilize a range of IT systems to document, store, integrate, analyze, and transmit Medi-Cal enrollment data. DHCS recommends, but does not require, that correctional facilities submit Medi-Cal applications via an online portal (CalHEERS BenefitsCal, or MyBenefitsCalWin). Applications may also be mailed, faxed, or hand-delivered to the county SSD. See ACWDL 22-27 for additional information on data exchange and communications that are expected to take place between CFs and SSDs, including guidance on transmitted data elements.

The efficiency and effectiveness of workflows and processes would be enhanced by the deployment of systems that collect data electronically in machine-readable formats that adhere to agreed-upon standards and exchange data using automated tools and interfaces.

ACWDL 22-27 outlines specific requirements with regard to storing and sharing Medi-Cal personally identifiable information (PII). The guidance requires that SSDs and CFs enter into written agreements that impose certain restrictions and conditions, such as restricting disclosures of Medi-Cal PII; using appropriate administrative, physical, and technical safeguards to protect Medi-Cal PII; and reporting to the SSD if there is any breach, security incident, intrusion, or unauthorized access to Medi-Cal PII.

4.3 Justice-Involved Pre-Release Enrollment Pathway for New Medi-Cal Members Identified at Intake

As discussed earlier in this section, correctional facilities are required to develop processes that enroll uninsured individuals in Medi-Cal as close to the intake process as possible to help facilitate provision of pre-release services. To help SSDs and CFs navigate the potential operational challenges associated with individuals who have short-term stays, DHCS identified the following enrollment options to allow SSDs and CFs to implement a process that works best for their JI population and correctional/enrollment staff.

Table 2. Justice-Involved Pre-Release Enrollment Pathway Options

Option	Summary	Implementation Considerations
Facilitate Accelerated Enrollment through CalHEERS and CalSAWS (option available by the end of 2023)	Medi-Cal's Accelerated Enrollment (AE) program allows new Medi-Cal applicants to receive real-time "conditional eligibility" and immediately access medical services, if applicable. DHCS grants AE to Medi-Cal applicants who apply through the coveredCA.com web application or by phone to Covered California's service center. The AE program will be expanded to include applications submitted through BenefitsCal before the end of 2023. Unlike presumptive eligibility, AE provides Medi-Cal applicants with temporary full-scope benefits while their self-attested eligibility information,	• Allows correctional facilities or their designees to directly submit Medi-Cal applications for individuals, rather than submitting them through an SSD. • Allows for real-time application submission and expedited eligibility determination.

Table 2. Justice-Involved Pre-Release Enrollment Pathway Options		
Option	**Summary**	**Implementation Considerations**
	including income, is being verified; those benefits continue until the final eligibility determination is made on the application. CFs or their designees can leverage AE 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).	• Requires that CFs or their designees become qualified application assisters.[38]
Embed SSD staff within CFs or implement other local best-practice processes to facilitate the Medi-Cal application and enrollment process.	Under this option, the SSDs and CFs or their designees would work together to develop processes and/or additional capacity to facilitate processing of Medi-Cal applications as identified in best-practice guidance released by DHCS.[39]	• Enables counties to develop their own processes to align with localized needs while adhering to the broader JI requirements.

[38] For more information on becoming a Covered CA certified enrollment counselor, please see Covered California's resources. Available at: https://hbex.coveredca.com/enrollment-counselors/

[39] An issue brief titled "Strategies for Conducting Pre-Release Medi-Cal Enrollment in County Jails" can be found here. The issue brief describes best practices for implementing the pre-release Medi-Cal application process.

4.4 Suspension/Unsuspension (Activation) of Medi-Cal Benefits

Under Welfare and Institutions Code section 14011.10(d), SSDs must suspend, rather than terminate, coverage for Medi-Cal members who are incarcerated, including individuals who are enrolled in Medi-Cal through the pre-release Medi-Cal application process, for the duration of their incarceration.[40,41]

Through the suspension process, the correctional facility reports the incarceration of the member to the SSD; the SSD will change an individual's Medi-Cal status from "active" to "suspended." The SSD must activate the individual's Medi-Cal coverage upon the individual's release. Although the individual may not receive regular Medi-Cal services while their Medi-Cal coverage is suspended, they may still be eligible to receive Medi-Cal covered inpatient services off the grounds of the correctional facility if they are determined eligible under the state or county Medi-Cal Inmate Eligibility Program (MCIEP) and are hospitalized or expected to be hospitalized for more than 24 hours. If enrolled in the MCIEP, that coverage ends the last day of their incarceration. They may also receive pre-release Medi-Cal services if determined eligible (see ***Section 6.2*** for details on eligibility criteria and ***Section 6.3*** for information on screening for pre-release services). The individual must be notified properly and timely when their Medi-Cal coverage has been suspended and again upon activation via an application NOA.

Upon release, Medi-Cal must be activated without the need to submit a new application. Once the release from incarceration is reported, benefits will be activated the following day. A redetermination is required only if one has not been completed within 12 months prior to the release date, barring any other known changes in circumstance that would require a redetermination under existing policy.

4.4.a Suspension for Short-Term Stays

ACWDL 22-26 provides updated information and guidance to implement DHCS's Medi-Cal benefit suspension and unsuspension (activation) policies, including guidance on

[40] Public Health Omnibus Bill, SB 184 (Chapter 47, Statutes of 2022), amended Welfare and Institutions Code §14011.10(d).

[41] 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 under the age of 26, under the federal SUPPORT Act and state law (Welfare & Institutions Code § 14011.10(d)(1), (2)), the state and counties are prohibited from terminating Medicaid eligibility because the individual is an inmate of a public institution.

suspension timelines for individuals with short-term stays.[42] For situations in which an individual is subject to a short-term stay of incarceration with a release in under 28 days, the SSD will not report the incarceration in MEDS. Because the individual will be released in less than 28 days, suspending their Medi-Cal benefits is not necessary. For individuals incarcerated 28 days or longer, the SSD will record the incarceration in MEDS via the EW32 transaction on or after the 28th day, thereby suspending the Medi-Cal benefits.

4.4.b Notification of Release Dates for Unsuspension (Activation) of Benefits and Immediate Need Policy

ACWDL 22-27 requires that correctional facilities notify SSDs as soon as they become aware of an individual's expected release date to ensure that Medi-Cal coverage is active upon release. Correctional facilities should make every effort to notify the SSD a week prior to the individual's expected release date and no later than one business day before the expected release date (unless the release is unplanned). Upon notification or no later than one business day, SSDs will unsuspend (activate) benefits. To ensure continuity of care for individuals with an immediate need for medical services and those who were approved for pre-release services, the SSD must follow the standard immediate need process. SSDs can utilize an EW15 transaction and the EW32 transaction to activate Medi-Cal coverage. This will allow individuals who are released from incarceration to access benefits upon release, if needed.

[42] See ACWDL 22-26 for more information on suspension/unsuspension for individuals incarcerated and released to different counties, the annual renewal policy, change in circumstance redeterminations, and NOAs.

5. Pre-Release Service Readiness Assessments

5.1 Implementation Timeline

DHCS will implement a phased approach for the state prison system, county correctional agencies (including county jails and YCFs), and county behavioral health agencies to go live in several readiness-based cohorts over the period of the demonstration. All CFs and county behavioral health agencies will need to demonstrate readiness prior to the go-live dates. The following summarizes the phased approach:

- Correctional facilities and county behavioral health agencies may go live as early as April 1, 2024, depending on their readiness assessments, as detailed below.
    - All correctional facilities and county behavioral health agencies must go live by March 31, 2026. Correctional facilities will determine their go-live date, and county behavioral health agencies will align with their county correctional facility's go-live date.
    - Correctional facilities and county behavioral health agencies will coordinate with their SSD on implementation timing to ensure that the SSD's processes will be ready by the planned go-live dates.

5.2 Implementation Readiness – Correctional Facilities

Readiness Assessment Approach. Per the Section 1115 waiver's STCs outlined in ***Section 1.1***, all correctional facilities will be required to demonstrate readiness to participate in the JI initiative prior to going live with pre-release services by the dates listed above. DHCS expects that participating facilities will leverage JI PATH funding to support the planning activities necessary to demonstrate readiness. DHCS will require correctional agencies (e.g., state prison system, county jails, youth correctional facilities) to complete a readiness assessment covering all their facilities prior to their go-live date, which will focus on the five key areas needed to operationalize 90-day pre-release services, described below in Table 3.

Correctional agencies must submit their readiness assessments to DHCS at least five months prior to their proposed go-live date on behalf of all facilities under their authority. DHCS recognizes that some agencies 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 (or shortly

after) the planned go-live date. To streamline the submission process, DHCS will release a readiness assessment tool that correctional agencies will use to attest to their readiness. Where appropriate, correctional agencies may leverage prior information provided in the JI PATH Capacity-Building Program progress reports to populate their readiness assessment submissions. Correctional agencies that do not complete or do not have an approved readiness assessment will not be eligible to go live with pre-release services.

As further described in Table 3 below, some readiness elements are categorized as minimum requirements, indicating that the correctional agency must have the capability in place in order to go live with pre-release services. Elements that are not flagged as minimum requirements must still be supported, but DHCS may use discretion when reviewing these elements to determine whether an agency is ready to go live.

Table 3. Correctional Agency Readiness Assessment Structure

Focus Areas	Readiness Element	Minimum Requirement for Pass?
1. Medi-Cal Application Processes	**1a. Screening** – Defined process and support model to screen for current Medi-Cal enrollment and eligibility if not yet enrolled.	Minimum Requirement
	1b. Application Support – Defined process to support individuals in applying for Medi-Cal coverage and submitting an application.	Minimum Requirement
	1c. Unsuspension/Activation of Benefits – Process and data sharing capability to notify the county Social Services Department (SSD) of the individual's release date to reactivate coverage and deactivate the pre-release services aid code/enable full scope of benefits upon release.	Minimum Requirement

Table 3. Correctional Agency Readiness Assessment Structure		
Focus Areas	**Readiness Element**	**Minimum Requirement for Pass?**
2. 90-Day Pre-Release Eligibility and Behavioral Health Linkage Screening	**2a. Screening for Pre-Release Services** – Defined process and support model to screen eligibility for 90-day Medi-Cal Reentry Services. Screening should include securing consent from the individual to release information to relevant parties (e.g., assigned care manager). DHCS supports the best practice of developing documentation of individuals' previous screenings in correctional facilities' applicable electronic data systems (e.g., electronic medical records) to expedite their enrollment upon re-incarceration.	Minimum Requirement
	2b. Screening for Behavioral Health Linkages – Defined process and support model to conduct an initial mental health and SUD screening at intake, and then as indicated, a second screen and/or full assessment with tools and processes mutually agreed upon by the correctional facility and the county behavioral health agency to determine if the individual's behavioral health need meets behavioral health criteria and requires behavioral health linkage.	Minimum Requirement
3. 90-Day Pre-Release Service Delivery	**3a. Medi-Cal Billing and Provider Enrollment** – Established plan is in place to enroll the facility as an *Exempt From Licensure Clinic* Medi-Cal provider in order to bill fee-for-service for pre-release services (e.g., care management, X-rays/labs) and a process is in place to bill for services. Facilities with a pharmacy on-site that intend to provide pre-release authorized medications must also enroll as a Medi-Cal pharmacy.	Minimum Requirement

Table 3. Correctional Agency Readiness Assessment Structure		
Focus Areas	**Readiness Element**	**Minimum Requirement for Pass?**
	3b. Support of Pre-Release Care Management, Including: • Care Manager Assignment – Established process for leveraging the MCP Provider Directory[43] to: identify and assign an in-reach, community-based care manager to the individual shortly after determining eligibility for 90-day Medi-Cal Reentry Services; identify if an individual has an existing relationships with community-based ECM care managers who could be assigned to provide pre-release care management services; or to assign an embedded care manager.[44][45][46] • Support Needs Assessment– Infrastructure and processes are in place to support assigned care manager to perform comprehensive needs assessment, inclusive of obtaining consent to access and share any needed medical records with community-based providers/health plans, and coordination and support of delivery of services by correctional facility clinical staff. • Support Coordination of Care – Infrastructure and processes are in place to support assigned pre-release care manager, or ECM provider to coordinate all needed care as part of the reentry stabilization, treatment, and planning for release. • Support Reentry Care Plan Finalization, Warm Linkages (for care management and behavioral health linkage), and Reentry Continuity of Care Plan (see ***Focus Area 4*** below).[47]	Minimum Requirement

Table 3. Correctional Agency Readiness Assessment Structure		
Focus Areas	**Readiness Element**	**Minimum Requirement for Pass?**
	3c. Clinical Consultation – Infrastructure and processes are in place to support clinical consultation to ensure diagnosis, stabilization, treatment, coordination, and linkages to establish relationships with community providers. This includes but is not limited to correctional facility clinical staff obtaining consent to provide and share information with community-based providers/health plans, providing these clinical services directly, prescribing durable medical equipment (DME) and medications, and/or ensuring in-reach clinical consultations occur in a timely manner as needed.	
	3d. Virtual/In-Person In-Reach Provider Support – Established processes for supporting rapid scheduling and providing space, including physical space for in-person visits and/or space and technology for virtual visits (e.g., laptop or similar device, webcam, internet access telephone line), for in-reach provider services (care management, clinical consultation, or community health worker) while ensuring appropriate security protections remain in place.	Minimum Requirement

[43] See ***Section 13*** for details on the MCP Provider Directory.
[44] DHCS acknowledges that MCPs may be better positioned to assign appropriate ECM providers in the future. As data exchange and infrastructure is established, DHCS will consider having MCPs take a more active role in ECM provider assignment in the future.
[45] Note that the correctional facility may reach out to an individual's assigned MCP for assistance with ECM provider assignment, once the individual has been assigned to a MCP. If the individual has not yet been assigned to an MCP at the time of ECM provider assignment, the correctional facility may reach out to any MCP in the county for assistance, as all DHCS will require MCPs to contract with the same set of ECM providers.
[46] DHCS encourages MCPs and Correctional Facilities to collaborate as appropriate on a county-specific process to determine the appropriate ECM provider assignment for each member.
[47] State Medicaid Director Letter #23-003 refers to the Reentry Care Plan as the "person-centered care plan".

Table 3. Correctional Agency Readiness Assessment Structure		
Focus Areas	**Readiness Element**	**Minimum Requirement for Pass?**
	3e. Support for Medications – Infrastructure and processes are in place to support the provision of all medications covered under Medi-Cal medication benefit, or an action plan has been defined to support provision of Medi-Cal-covered medications by March 31, 2026.	Minimum Requirement
	3f. Support for MAT – Infrastructure and processes are in place to support MAT, or an action plan has been defined to support MAT by March 31, 2026. This entails covering all forms of FDA-approved medications for the treatment of alcohol use disorder and substance use disorder (SUD), and providing assessment, counseling, and patient education. Providing at least one form of an FDA-approved opioid agonist or partial agonist for opioid use disorder treatment is required to go-live.	Minimum Requirement
	3g. Support for Prescriptions Upon Release – Infrastructure and processes are in place to support dispensing of Medi-Cal medications on day of release, or an action plan has been defined to support provision of Medi-Cal medications on day of release by March 31, 2026.	Minimum Requirement
	3h. Support for DME Upon Release – Infrastructure and processes are in place to support provision of DME on day of release or an action plan has been defined to support provision of DME on day of release by March 31, 2026.	

Table 3. Correctional Agency Readiness Assessment Structure		
Focus Areas	**Readiness Element**	**Minimum Requirement for Pass?**
4. Reentry Planning and Coordination	**4a. Release Date Notification** – Established process to provide electronic notification of the individual's release date to the SSD, DHCS, pre-release care manager, post-release ECM provider (if different), and Medi-Cal MCP.	Minimum Requirement
	4b. Care Management Reentry Plan Finalization – Establish processes and procedures to ensure and support assigned care manager in creating final reentry care plan that is shared with the member, correctional facility clinical care team, MCP, and post-release ECM provider if different from the pre-release care manager.	Minimum Requirement

Table 3. Correctional Agency Readiness Assessment Structure		
Focus Areas	**Readiness Element**	**Minimum Requirement for Pass?**
	4c. Reentry Care Management Warm Handoff – Established process to ensure and support a warm handoff between pre-release care manager and post-release ECM provider, if the post-release ECM provider is different from the pre-release care manager (e.g., providing space and infrastructure for warm handoff meeting either in person or via telehealth). *Note, if correctional facility is using an embedded care manager,*[48] *correctional facility must establish processes and procedures to ensure a warm handoff will occur between the pre-release care manager and the post-release ECM provider in the pre-release period and for behavioral health linkage to occur based on clinical acuity. In cases when a warm handoff cannot occur prior to release (e.g., unexpected early releases from court) warm handoffs must occur within one week of release . This should include information sharing within 24 hours of release with the post-release ECM provider, the MCP, and the county behavioral health provider as appropriate.*	Minimum Requirement

[48] DHCS recognizes that in some counties, the department of health or county behavioral health agencies will provide behavioral health services to correctional facilities and also provide community-based services. For these counties, the determination of embedded or community-based would be based on the role of the provider at that moment. If the provider is furnishing services in their role as a contracted entity and performing services that correctional facilities are required to provide, those services would be considered embedded services. Alternatively, if the provider is acting on behalf of the county in their role in the community, for example accepting a warm linkage, that service would be considered to be in-reach.

Table 3. Correctional Agency Readiness Assessment Structure		
Focus Areas	**Readiness Element**	**Minimum Requirement for Pass?**
	4d. Reentry Behavioral Health Linkage – Established process to allow for an in-person warm handoff, when clinically indicated, between pre-release care manager, beneficiary, pre-release service care team, and post-release behavioral health care manager, where possible and if the post-release behavioral health care manager is different from the pre-release care manager (i.e., providing space in reentry area for warm handoff meeting, either in person or via telehealth). The handoff must include behavioral health linkages, including basic care coordination for referrals to continued treatment post-release. Processes for behavioral health linkage will be designed and mutually agreed upon with correctional facility and county behavioral health agency.	Minimum Requirement
5. Oversight and Project Management	**5a. Staffing Structure and Plan** – Clear staffing and/or contractor structure to support each readiness element and compliance with DHCS requirements for 90-day Medi-Cal Reentry Services and reentry coordination.	Minimum Requirement
	5b. Governance Structure for Partnerships – Defined governance structure for coordinating with key partners (e.g., SSD, care management organizations, providers, MCPs, County Behavioral Health Agencies).	
	5c. Reporting and Oversight Processes – Established process to collect, monitor, and report on DHCS required measures, including corrective action processes to address operational challenges.	Minimum Requirement

To ensure that DHCS can review the readiness assessment prior to the go-live date, agencies will be required to submit their assessments at least five months in advance of their proposed go-live date, based on the timeline depicted in Table 4.

Table 4. Readiness Assessment Submission Process and Timeline

Activities	State Prisons and Early-Adopter County Jails and Youth Correctional Facilities	All Other County Jails and Youth Correctional Facilities
DHCS releases readiness assessment submission tool(s)	Q4 2023	Q4 2023
DHCS facilitates all-comers webinar	Q4 2023	One per quarter until March 31, 2026
Readiness assessment submitted to DHCS	November 1, 2023	5 months before go-live
DHCS evaluates assessment and engages facility to address questions/feedback	December 2023-February 2024	3-4 months before go-live
DHCS communicates approvals with county SSDs and MCPs	February-March 2024	1-2 months before go-live
Correctional agency goes live with pre-release services	April 1, 2024	1st day of each quarter after April 1, 2024 (Note: All facilities must go live by March 31, 2026)

DHCS Approach for Evaluating Correctional Agency Readiness Assessments. For each of the five focus areas, DHCS will determine a score based on the correctional agency's attestation and documentation of its readiness for implementing pre-release services. The team will use the rubric shown in Table 5 to determine the score for each focus area.

Table 5. Focus Area Scoring Rubric
Pass: Correctional agency's response is complete and indicates total or almost total readiness in the focus area across all facilities.
Partial Pass: Correctional agency's response is complete and indicates that some, but not all, facilities within the agency are ready to go live.
Fail: Correctional agency's response is incomplete, the provided response does not sufficiently address the question, or the provided response does not indicate readiness to go live.

To receive approval from DHCS to go live, a correctional agency must receive a "pass" in all five focus areas and for each element categorized as a minimum requirement, indicating that the correctional agency is ready to go live. In some cases, a correctional agency may receive a "partial pass," indicating that some, but not all, facilities under the agency's jurisdiction are ready to go live. In these cases, DHCS will work with the correctional agency to provide partial approval to allow facilities to go live that are ready to do so, rather than require them to wait until the remaining facilities in the county are ready. If a correctional agency receives a "fail" in any focus area, DHCS will engage the agency on corrective actions so that it can work toward readiness by the proposed go-live date or for a future go-live date.

5.3 Implementation Readiness – Social Services Departments

DHCS will require all SSDs to complete a brief readiness assessment template provided by DHCS, which will exclusively focus on new processes (Table 6) required to support the implementation of 90-day pre-release services. The readiness assessment will not cover existing processes (e.g., Medi-Cal application processes).

Table 6. SSD Readiness Elements	
1. Unsuspend/Activate Medi-Cal Benefits at Release	Process for receiving release dates from correctional facilities, unsuspending/activating Medi-Cal benefits, and terminating the pre-release services aid code (where applicable).
2. Support Oversight and Project Management	Established process to collect, monitor, and report on DHCS required measures, including corrective action processes to address operational challenges.[49]

[49] DHCS is in the process of defining these measures.

DHCS will assess the SSD's readiness based on the same scoring rubric used for correctional facilities (see Table 5), to determine whether the SSD is ready to go live and/or needs technical assistance support from DHCS. If an SSD is not prepared to go live in one or more focus areas, DHCS will collaborate with the SSD to resolve open issues to ensure that the agency is able to achieve readiness by or close to the go-live date.

5.4 Implementation Readiness – County Behavioral Health Agency

Key to the larger CalAIM JI Reentry Initiative is implementing linkages to behavioral health providers to initiate or continue behavioral health care through professional-to-professional clinical handoffs, as set forth 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). Through the CalAIM JI Reentry Initiative, DHCS will require state prisons, county jails, youth correctional facilities, county behavioral health departments, and MCPs to implement processes for facilitated referrals and linkages to continued behavioral health treatment in the community for individuals who receive behavioral health services while incarcerated. It is expected that behavioral health linkages will be fully integrated into the delivery of the pre-release services, once implemented. Behavioral health-related pre-release services and behavioral health linkages will be provided in partnership with county behavioral health agencies and correctional facilities. Additional information about behavioral health linkages is available in ***Section 11.4***, Behavioral Health Linkages.

In order to implement behavioral health linkages, DHCS will require all county behavioral health agencies to complete a readiness assessment template provided by DHCS, which will focus on new processes required to support the implementation of behavioral health linkages, as required by AB 133. Components of the readiness assessment with respect to behavioral health linkages are shown in Table 7 below.

Table 7. County Behavioral Health Agency Readiness Assessment Structure

Focus Areas	Readiness Element	Minimum Requirement to Go Live
1. Initial Data Sharing	**1a. Initial Data Sharing** – Defined process to (1) obtain medical records as appropriate for individuals with treatment history; and (2) notify MCP (if enrolled) that county	Minimum Requirement

Table 7. County Behavioral Health Agency Readiness Assessment Structure		
Focus Areas	**Readiness Element**	**Minimum Requirement to Go Live**
	behavioral health care coordination is occurring, as necessary.	
2. Data Sharing	**2a. Data Sharing for Release** – Defined process to (1) receive correctional facility medical record information and ensure that it is incorporated into post-release medical record; and (2) identify any individuals who may benefit from professional-to-professional clinical handoff.	Minimum Requirement
3. Release Planning	**3a. Follow-up Appointments** – Defined process to provide follow-up appointment date/time/location within clinically appropriate window (e.g., for someone on MAT, recommended follow-up would be next day post-release).	Minimum Requirement
	3b. Transportation – Defined process to ensure transportation to appointment has been arranged.	Minimum Requirement
4. Professional-to-Professional Clinical Handoff	**4a. Reentry Professional-to-Professional Clinical Handoff** – Established process to provide in-person/telehealth professional-to-professional clinical handoff between correctional provider and county behavioral health provider, as necessary, and defined processes in place to ensure county behavioral health agency is able to participate in care transitions meeting for any client that has been identified by correctional staff, care manager, or clinical consultants as needing additional team coordination (e.g., clients identified to have high/complex needs).	Minimum Requirement
5. Follow-up Post-Release	**5a. Post-Release Scheduling** – Established process to schedule individual for appointments on an ongoing basis as needed, within clinically appropriate time	Minimum Requirement

Table 7. County Behavioral Health Agency Readiness Assessment Structure		
Focus Areas	**Readiness Element**	**Minimum Requirement to Go Live**
	frame, ensuring they have adequate transportation to appointment.	
	5b. Post-Release Follow-up – Established process to provide follow-up to individual if they miss an appointment in the community. DHCS supports the best practice of deploying a community health worker to work with the ECM provider to reschedule missed appointments as soon as possible.	Minimum Requirement
6. Oversight and Project Management	**6a. Staffing Structure and Plan** – Clear staffing and/or contractor structure to support each readiness element and compliance with DHCS requirements for behavioral health linkages, including identification of county-operated and/or county-contracted providers that will (1) fulfill the required processes described above and (2) receive referrals for follow-up visits in the community for continued behavioral health care.	Minimum Requirement
	6b. Governance Structure for Partnerships – Defined governance structure for coordinating with key partners (e.g., correctional facilities, care management organizations, providers, MCPs).	
	6c. Reporting and Oversight Processes – Established process to collect, monitor, and report on DHCS required measures, including corrective action processes to address operational challenges.	Minimum Requirement

DHCS will assess the county behavioral health agencies' readiness based on the same rubric used for correctional facilities (see Table 5) to determine whether the agency is ready to go live and/or needs technical assistance support from DHCS. If a county

behavioral health agency is not prepared to go live in one or more focus areas, DHCS will collaborate with the agency to resolve open issues to ensure that the agency is able to achieve readiness by or close to the go-live date.

6. Pre-Release Services Eligibility and Screening Process

After an individual has been enrolled in Medi-Cal coverage (or concurrent to the enrollment process if an individual has a short-term stay), the CF must determine whether the individual is eligible to receive pre-release Medi-Cal services. For individuals in custody at CFs who have a longer sentence (e.g., AB 109 population) and/or whose release date is known, eligibility screening for pre-release services should occur before the 90-day pre-release period begins (note that an exact number of days before release by which screening must occur has not yet been finalized). CFs should screen individuals with short-term stays or unknown release dates at or close to intake to ensure they have full access to pre-release services, if they are determined eligible for Medi-Cal. The timely and accurate exchange of eligibility and release date information is critical to the success of this service.

6.1 Eligible Facilities

A targeted set of Medi-Cal services will be provided during a 90-day period prior to release to eligible individuals either prior to adjudication or post-conviction. Correctional agencies – inclusive of State prisons, county jails/detention centers/detention facilities[50] and county youth correctional facilities – are statutorily mandated to comply with the requirement to provide pre-release services per California Welfare and Institutions Code section 14184.800. DHCS will work with agencies to demonstrate readiness to provide these services by the mandated go-live date and will require agencies to provide ongoing reporting on their progress in achieving and maintaining readiness. Should an agency or facility fail to implement the full requirements, DHCS will exercise compliance enforcement mechanisms, additional guidance for which will be released at a later date.

Targeted pre-release services will only be provided to individuals prior to leaving a correctional facility and reentering the community. Generally, individuals who are in state hospitals return to prisons or jails prior to their release and will be eligible to receive services upon their return to the correctional facility.[51] Based on the waiver

[50] DHCS' Medi-Cal Eligibility Division (MCED) has identified institutions that qualify as low-security institutions, including g camps (one conservation camp for adults and 21 camps for youth) and two honor farms. Individuals within these facilities are deemed inmates and do not have freedom of movement. The delivery of pre-release services will be included in these facilities but may require more ramp-up time to implement.

[51] State hospitals provide mental health services to patients admitted to Department of State Hospital facilities. There are five state hospitals in California. A list is available at: https://www.dsh.ca.gov/hospitals/

authority granted by CMS, individuals who are incarcerated in the correctional facility but incompetent to stand trial and awaiting placement in a state hospital may not receive pre-release services if they will not be released into the community. If an individual is expected to be released into the community, they may receive pre-release services in the 90 days immediately prior to their expected date of release from the correctional facility.

DHCS will track the duration of service provision to ensure coverage of pre-release services does not exceed 90 days per facility stay. There will be some circumstances where an individual will be provided services for up to 90 days in a county jail with the expectation that they will be released to the community but then that individual is not released to the community but rather transferred to a prison. The individual will be eligible to receive another 90 days of services in the state prison immediately prior to release.

6.2 Eligible Individuals

The eligibility criteria for pre-release services were informed by existing criteria defined for other Medi-Cal transformation projects (e.g., Health Homes, WPC pilots), definitions leveraged by the CDCR and based on both stakeholder feedback through the JI CalAIM Advisory Group and common conditions among the JI population.

To be considered eligible for pre-release services, incarcerated individuals must meet the following criteria:

- Be part of a Medi-Cal or CHIP eligibility group. Individuals must meet all other income, immigration/citizenship, and household composition eligibility criteria. Individuals will be eligible for pre-release services if they otherwise meet requirements for an eligibility group, regardless of whether the group is funded through state dollars only.
    - Medi-Cal eligibility groups include new adults; parent/caretaker relatives; youth under 19 (note that all incarcerated youth are eligible for pre-release services and do not need to demonstrate a health care need); pregnant or postpartum individuals; aged, blind, or disabled individuals; children or youths currently in foster care; and former foster care youths up to age 26.
    - CHIP eligibility groups include:
        - Youths under 21.

- Pregnant or postpartum individuals.

AND

- Be a youth under 21 in custody of a YCF (no health care criteria are applied).[52]
- OR
- Be an adult and meet one or more health care needs criteria as defined in Table 8.[53]

Table 8. Qualifying Health Care Needs Criteria Definitions

Qualifying Condition	Definition

Mental Illness	A person with a mental illness is someone who is currently receiving mental health services or medications OR meets both of the following criteria:
	• The member has one or both of the following:
	  ○ Significant impairment, where "impairment" is defined as distress, disability, or dysfunction in social, occupational, or other important activities.
	  ○ A reasonable probability of significant deterioration in an important area of life functioning.
	• The member's condition as described in bullet above is due to either of the following:
	  ○ A diagnosed mental health disorder, according to the criteria of the current editions of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and the *International Statistical Classification of Diseases and Related Health Problems*.
	  ○ A suspected mental disorder that has not yet been diagnosed.

Substance Use Disorder	A person with a SUD is a person who either:

[52] Note that youth versus adult eligibility criteria are determined by facility, not by age. For example, individuals aged 18-21 in custody of a county jail or CDCR must meet adult health care needs criteria; individuals aged 18-21 in custody of YCF must meet youth eligibility criteria, which means they do not need to demonstrate health care needs.
[53] Health care needs criteria are aligned with ECM JI POF. See CalAIM ECM Policy Guide (December 2022). Available at: https://www.dhcs.ca.gov/Documents/MCQMD/ECM-Policy-Guide.pdf

Table 8. Qualifying Health Care Needs Criteria Definitions	
Qualifying Condition	**Definition**
	• Meets the criteria for an SUD as defined in the current editions of the DSM and/or the *International Statistical Classification of Diseases and Related Health Problems*. • Has a suspected SUD diagnosis that is currently being assessed through either the National Institute of Drug Abuse (NIDA)-modified Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) or American Society of Addiction Medicine (ASAM) criteria.
Chronic Condition or Significant Non-Chronic Clinical Condition	A person with a chronic condition or a significant non-chronic clinical condition is one who has ongoing and frequent medical needs that require treatment, including one of the following diagnoses, as indicated by the individual, and who may be receiving treatment for the condition, as indicated: • Active cancer. • Active hepatitis A, B, C, D, or E. • Advanced liver disease. • Advanced renal (kidney) disease. • Autoimmune disease, including but not limited to rheumatoid arthritis, lupus, inflammatory bowel disease, and 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.

Table 8. Qualifying Health Care Needs Criteria Definitions	
Qualifying Condition	**Definition**
	• Currently undergoing a course of treatment for any other diagnosis that will require 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 inherited metabolic disorders. • Dementia, including but not limited to Alzheimer's disease. • Epilepsy or seizures. • Foot, hand, arm, or leg amputee. • Hip/pelvic fracture. • HIV/AIDS. • Hyperlipidemia. • Hypertension. • Incontinence. • Severe migraine or chronic headache. • Long COVID-19. • 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. • Receiving gender-affirming care.

Table 8. Qualifying Health Care Needs Criteria Definitions	
Qualifying Condition	**Definition**
	• Active respiratory condition, such as severe bronchitis, chronic obstructive pulmonary disease (COPD), asthma, or emphysema. • Severe viral, bacterial, or fungal infection. • Sickle cell disease or other hematological disorder. • Significant hearing or visual impairment. • Spina bifida or other congenital anomalies of the nervous system. • Tuberculosis. • Type 1 or 2 diabetes.
Intellectual or Developmental Disability	A person with an intellectual or developmental disability is one 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 is one with a condition that has caused significant cognitive, behavioral, and/or functional impairment.
HIV/AIDS	A person with HIV/AIDS is one who has tested positive for either HIV or AIDS at any point in their life.
Pregnant or Postpartum	A person who is pregnant or postpartum is one who is either currently pregnant or within the 12-month period following the end of a pregnancy.

6.3 Screening Approach

To ensure that all Medi-Cal-eligible individuals who meet the pre-release access criteria are able to receive pre-release Medi-Cal services, CFs must screen all Medi-Cal-eligible adults for physical and behavioral health needs (see qualifying conditions in Table 8).

DHCS expects that CFs will leverage existing health screening and assessment processes to screen individuals for eligibility to receive pre-release services (e.g., assess whether an individual has health needs listed in Table 8 based on information collected through a CF's existing screening/assessment processes). CFs will be required to meet a minimum set of expectations for screening individuals for access to pre-release services, but they will have flexibility in how they implement the screening process.

At a minimum, CFs must screen all Medi-Cal-eligible individuals who become incarcerated for access to pre-release services.[54] CFs may use JI PATH Round 3 funding to screen individuals for pre-release services for the two years after they receive their JI PATH Round 3 award.[55] After two years, CFs will be able to bill for screening for pre-release services as an MAA.[56]

DHCS will leverage an existing provider screening portal (referred to as the Screening Portal), which will be modified specifically for the purpose of collecting and sharing pre-release service eligibility data between CFs and DHCS, in addition to activating the pre-release aid code. Correctional facilities may still design their screening process to fit the needs of the individual facility; the Screening Portal does not necessitate the establishment of a standardized screening process across CFs. The Screening Portal will collect "yes – eligible" and "no – ineligible" data; DHCS will not collect data to indicate by which clinical criteria the individual is eligible for pre-release services, but the correctional facility must conduct a screening to determine whether and by what criteria an individual is made eligible. (See minimum expectations for screening below.) DHCS will use this information to send an NOA to individuals determined ineligible for pre-release services.

Individuals may also be found eligible for pre-release services through self-attestation. Because there are multiple avenues for an individual to be identified as eligible for pre-release services, an individual could be identified as eligible for pre-release services both by a clinician and through self-attestation.

Clinical oversight is allowed but will not be required for screening for pre-release services; non-clinical correctional facility staff can submit screening data through the portal, and clinical review is not required as screening may also be based on self-attestation or medical record review.

[54] Screening for qualifying health conditions of youths in YCFs is not required for them to access pre-release services.
[55] See ***Section 2.2.c*** on permissible uses of JI PATH Round 3 funding.
[56] Pending CMS approval.

Minimum expectations for county and state correctional facilities with respect to screening include the following:

- **County CF** (applies to individuals with unknown release dates or incarcerations of less than one year; does not apply to individuals in the custody of jails for more than one year.)

  CCFs may have multiple opportunities to screen individuals for access to pre-release services. Screening should occur 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. Screening for access to pre-release services may occur at the following points:

  - Tier 1 – Initial Health Screening**.** Correctional facilities conduct an initial safety assessment at booking, which varies by facility, but generally assesses the individual for immediate physical and behavioral health needs, including the likelihood of harm to self or others, acute psychiatric distress, pregnancy, communicable diseases, and SUD withdrawal. The correctional facility staff conducting the initial safety assessment may simultaneously screen the individual for access to pre-release services while conducting the safety assessment, or they may review their clinical records or ask the individual to self-attest to meeting the clinical eligibility criteria. At this point, the correctional facility will already know whether the individual is Medi-Cal-eligible and/or enrolled in Medi-Cal. If the individual is already enrolled, the results of the screening will then be entered via the Screening Portal. This screening should occur within 48 hours (see ***Section 8.2*** on the short-term model).
  - Tier 2 – Comprehensive Health Screening. If it is not possible to assess the individual during the initial health screening due to mitigating circumstances (e.g., individual is intoxicated, insufficient time), the correctional facility may conduct the screening during the individual's comprehensive health screening and enter the results via the screening portal. Comprehensive health screenings are generally conducted within two weeks of booking. Screening should occur with sufficient time prior to release for the individual to receive the full 90 days of pre-release services.
  - Ongoing. If a clinician identifies at any time an individual who is eligible for pre-release services, including after the Tier 1 and 2 screenings, or if the

individual self-attests to having a qualifying condition, the correctional facility staff may still submit the screening results through the portal so that the individual may access pre-release services.

In summary, individuals in CCFs must be screened within 48 hours of intake for pre-release services during an existing health screening or assessment process, which must include a self-attestation option. Additional screenings for pre-release services should be conducted throughout the individual's stay through clinical observation, medical record review, and/or self-attestation.

- **Prisons**. Since prison stays are typically longer relative to jail and YCF stays, prison staff may screen the individual for access to pre-release services during a health screening that takes place closer to the individual's release date. Prison staff may also reference medical records to determine whether an individual is eligible for pre-release services. Screening should occur ahead of the 90 days of pre-release services period so that the individual can access services for the full 90 days. All screening results should be entered via the Screening Portal.

6.4. Screening for SMHP/DMC/DMC-ODS/Non-SMHS

To ensure individuals with behavioral health needs are identified and behavioral health linkages are provided, as required by AB 133, DHCS will require that correctional facilities have the ability to systematically screen all individuals entering jail for mental illness and SUD, including any history of alcohol/sedative or opioid withdrawal. Screening tools can be used by non-clinical staff and should be used alongside regular screenings upon intake for individuals in county jails and YCFs. All screening tools should be validated and reliable, with demonstrated applicability in justice settings.

Individuals in state prisons are currently receiving care and will be screened for SMHS/DMC/DMC-ODS need based on their current treatment plan and care manager assessment. Note that in state prisons, CDCR will leverage individuals' current placement in their SUD program – including any integrated substance use disorder treatment (ISUDT) program they are receiving – and/or their mental health program (mental health delivery system, MHDS to identify individuals who will require a behavioral health linkage.

Potential behavioral health screening tools:

- **Mental Health:** Recommended options for mental health screening tools that are validated and reliable in justice settings include:

  - Brief Jail Mental Health Screen (BJMHS)
  - Correctional Mental Health Screen for Men (CMHS-M)
  - Correctional Mental Health Screen for Women (CMHS-W)
  - Mental Health Screening Form III (MHSF-III)
- **SUD:** Recommended options for SUD screening tools include:
  - Texas Christian University Drug Screen V (TCUDS V)
  - Alcohol Smoking and Substance Involvement Screening Test (ASSIST)
  - Simple Screening Instrument (SSI)

Considerations for Co-Occurring Diagnoses (CODs): To promote greater awareness of CODs and reduce unnecessary repetition of screening and assessments for individuals identified as having CODs, DHCS recommends that, whenever feasible, similar and standardized screening and assessment instruments for CODs should be used across justice settings. A combination of screening tools can be used to improve detection of co-occurring issues as needed (i.e., BJMHS and TCUDS V, CMHS-M and TCUDS V, or CMHS-W and TCUDS V).

These tools can be used during intake screening as a best practice and prior to release, to help identify individuals who have an SMHS or SUD treatment need and therefore will require a behavioral health linkage. Information regarding results of screenings should be shared across all care providers (e.g., carceral, CBOs, health plans).

Delivery systems:

- **Specialty Mental Health Plan (SMHP)/County Mental Health Plans (MHPs).** If an individual is identified as needing county MHP services at any point of incarceration, they will qualify for SMHS and require a behavioral health linkage with a county SMH provider prior to release. [57]

[57] As outlined in WIC Section 14184.402 (d) (1) of the CalAIM Act of 2021, County mental health plans shall provide medically necessary specialty mental health services to beneficiaries who are under 21 and are at high risk for a mental health disorder due to involvement in the juvenile justice system.

(A) For the county mental health plan to cover specialty mental health services, the beneficiary must also have one of the following conditions:
- A significant impairment;
- A reasonable probability of significant deterioration in an important area of life functioning;
- A reasonable probability of not progressing developmentally as appropriate; or
- A need for specialty mental health services that are not covered under Medi-Cal.

(B) The beneficiary's condition (in paragraph A) must be due to one of the following:
- A diagnosed mental health disorder
- A suspected mental health disorder (not yet diagnosed)
- Significant trauma putting them at risk of future mental health condition, based on assessment of licensed mental health professional

- **Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS).** If an individual is identified as needing MAT at any point of incarceration, they will qualify for DMC/DMC-ODS and require a behavioral health linkage to a county DMC or DMC-ODS provider prior to release. If an individual meets the diagnostic criteria for an SUD diagnosis, they will qualify for DMC/DMC-ODS and require a behavioral health linkage with a DMC or DMC-ODS provider prior to release.[58]
- **MCP or FFS Providers.** If an individual has an identified behavioral health need that does not meet criteria for SMHS, DMC, or DMC-ODS (e.g., members defined on page 4 of APL 22-006), their behavioral health needs will be managed by providers through their MCP. These individuals will have their behavioral health warm linkage facilitated through the care manager/ECM provider.

6.5 Aid Codes

An assessment of eligibility for JI pre-release services will be conducted by the correctional facility, and information about such eligibility will be captured by the state-maintained Screening Portal (see ***Section 6.3***, *Screening Approach for additional detail)*. Effective April 1, 2024, DHCS will establish five new aid codes to identify the populations eligible to receive JI pre-release services, provide access to the limited set of services available to the eligible JI population, correctly process claims payments, and accurately draw down federal matching funds, based on the funding for the primary Medi-Cal aid code under which incarcerated individuals are eligible.

Similar to the MCIEP, incarcerated individuals will be concurrently eligible under both the primary Medi-Cal and pre-release services aid codes regardless of whether the incarceration period has been reported to MEDS and Medi-Cal benefits have been

[58] Beneficiaries 21 years and older: To qualify for DMC-ODS services after the initial assessment process, beneficiaries 21 years of age and older must meet one of the following criteria: (1) have at least one diagnosis from the DSM for substance-related and addictive disorders, with the exception of tobacco-related disorders and non-substance-related disorders; OR (2) have had at least one diagnosis from the DSM for substance-related and addictive disorders, with the exception of tobacco-related disorders and non-substance-related disorders, prior to being incarcerated or during incarceration, determined by substance use history.
Beneficiaries under the age of 21: Covered services provided under DMC-ODS shall include all medically necessary SUD services for an individual under 21 years of age as required pursuant to 42 U.S.C. § 1396d(r). Federal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) statutes and regulations require states to furnish all Medicaid-coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, regardless of whether those services are covered in the state's Medicaid state plan. Consistent with federal guidance, services need not be curative or completely restorative to ameliorate a mental health condition, including substance misuse and SUDs. Services that sustain, support, improve, or make more tolerable substance misuse or an SUD are considered to ameliorate the condition and are thus covered as EPSDT services.

suspended. In this situation, the JI pre-release services aid code takes precedence over the primary Medi-Cal aid code as services under the primary Medi-Cal aid code are not available during incarceration and can be identified by the aid code.

JI pre-release services will be limited to a 90-day period.[59] Services provided off the grounds of the correctional facility that require a hospital stay of 24 or more hours are covered under the MCIEP. When an individual is eligible for MCIEP, a pre-release in-reach aid code, and a primary Medi-Cal aid code, all aid codes would be returned and billing would be determined based on the service and service location.

[59] The JI pre-release services will be provided at correctional facilities or outside the correctional facilities 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.

7. Compliance With Section 1902(a) of the Social Security Act

In implementing the CalAIM JI initiative through the 1115 waiver and as required by CMS in the 1115 demonstration, DHCS will seek to ensure compliance with Medicaid statutory requirements, as defined in Section 1902(a) of the Social Security Act and consistent with implementation plan STC 9.9, before and after Medi-Cal-enrolled individuals are released from a correctional facility.

Among the requirements described in Section 1902(a) are the rights to submit a Medicaid application through various modalities, receive notices for adverse determinations, and request fair hearings, which require special considerations to operationalize in a pre-release correctional setting. The following describes DHCS's requirements for ensuring that each of these requirements is supported across correctional facilities and SSDs.

7.1 Right to Submit a Medicaid Application (Section 1902(a)(8))

Individuals have the right to submit a Medicaid application in person, by telephone, online, or by mail. Through the JI Reentry Initiative, and as detailed in ***Section 4*** of this Guide, correctional facilities will support individuals' right to submit a pre-release Medicaid application by providing on-site, in-person assistance to JI individuals. Because most JI individuals experience short incarcerations and release dates can be unpredictable in general, DHCS encourages correctional facilities to support individuals in submitting applications for Medicaid at, or shortly after, the intake process. Doing so will help ensure that individuals can at least apply for Medicaid even if their time within a correctional facility lasts only a few days.

DHCS is working with correctional facilities and SSDs to enable electronic submission of Medicaid applications that are completed within a correctional facility. However, the Department will encourage correctional facilities to support all application submission modalities (i.e., phone, online, mail) where possible. Given the unique constraints of the corrections environment, individuals' ability to use these modalities may be limited by facility resources (e.g., lack of an internet connection would hinder submission of online applications) and/or inmate privileges (e.g., use of telephones). DHCS does not expect that incarcerated individuals, who lack freedom of movement, will be able to submit Medicaid applications in person at an SSD office.

California state prisons have already implemented pre-release Medicaid applications, and, as of January 1, 2023, all county jails and YCFs are required to implement pre-

release application processes. DHCS communicated this requirement to counties through ACWDL 22-27, released in November 2022. In addition, in December 2022, via MEDILs 22-46 and 22-47, DHCS required all county jails, YCFs and SSDs to complete a brief readiness assessment that describes the processes they have – or will have – in place to support pre-release Medicaid applications. DHCS will implement an ongoing monitoring approach to ensure compliance with the mandate, as described in MEDIL 23-24.

7.2 Right to Receive Notice of an Adverse Decision (Section 1902(a) and 42 C.F.R. §§ 435.917, 435.918)

Individuals have the right to receive notice of any adverse action regarding their coverage, such as denials of Medicaid coverage or denial of eligibility for pre-release services, and federal rules require that the state mail the notice to the individual at least 10 days prior to the date of any adverse action. In general, DHCS anticipates that SSDs will be able to meet this requirement by sending the appropriate notice of adverse decision to individuals and their authorized representative (AR) (i.e., correctional facilities, if applicable) for adverse determinations related to Medicaid and pre-release service eligibility. Correctional facilities will be required to process and deliver mail to individuals and ensure logistical and security issues do not cause delays. For individuals who are released before the notice is mailed, the SSD must mail the notice to the individual's last known address.

7.3 Fair Hearings (Section 1902(a)(3))

Federal rules require that states provide the ability for individuals to request a fair hearing regarding any adverse actions related to Medicaid coverage or services. Individuals have the right to request a fair hearing in writing, online, by telephone, or in person, and states may not limit or interfere with the individual's freedom to make a request. In general, DHCS anticipates that individuals will be able to submit a request for a fair hearing through all modalities, with the exception of in-person requests at an SSD due to lack of freedom of movement. As noted earlier, DHCS expects that correctional facilities will support individuals' ability to submit requests in writing, online, or by phone, but recognizes that some modalities may be constrained by the capabilities of the correctional facility and/or privileges of the individual inmate.

For individuals who remain incarcerated during their scheduled hearing date, correctional facilities and SSDs will be required to implement virtual fair hearings so that

JI individuals may participate via videoconferencing or telephone. Many correctional facilities already have capabilities in place to support virtual court hearings, and DHCS expects these facilities to leverage this existing infrastructure to support Medicaid fair hearings.

8. Providing Pre-Release Services Delivery Model

8.1 Definitions of Covered Pre-Release Services

The following benefits will be available to eligible individuals in the 90 days prior to release. Pre-release covered services will be delivered, claimed, and paid for via Medi-Cal's FFS delivery system.[60] Please see section 10 for more details on provider enrollment and billing and payment requirements.

Table 9. Pre-Release Covered Services

Covered Service	Definition
Case Management	Case management (also referred to as care management within this guide) 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 including screening for mental health and SUD needs to determine appropriate behavioral health linkages and referrals, as appropriate. • Assessing the needs of the individual in order to inform development, with the member, of a discharge/reentry person-centered care plan (referred to hereafter as the reentry care plan), with input from the clinician providing consultation services and the correctional facility's reentry planning team. ○ While the reentry 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 any identified health-related social needs (HRSN), the scope of the plan extends beyond release.

[60] DHCS will permit correctional facilities to provide pre-release services, but both embedded and community-based providers must be enrolled as Medi-Cal FFS providers.

Table 9. Pre-Release Covered Services	
Covered Service	**Definition**
	• 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 county behavioral health agencies and/or MCP ECM providers, which includes sharing discharge/reentry care plans with the appropriate delivery system (i.e., SMHP, county MHP, DMC/DMC-ODS, and/or MCP) reentry. • Ensuring that necessary appointments are arranged with physical and behavioral health care providers, including, as relevant to care needs, with specialty county behavioral health coordinators and ECM providers. • 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 handoff, as appropriate, to post-release case managers who will provide services under the Medicaid state plan or other waiver or demonstration authority (i.e., non-ECM case management providers). • Ensuring that, as allowed under federal and state laws and through consent with the member, data are shared with MCPs and, as relevant, with physical and behavioral health providers to enable timely and seamless handoffs. • Conducting follow-up with community-based providers to ensure they engaged with the member as soon as possible and no later than 30 days from release. • Conducting follow-up with the member to ensure their engagement with community-based providers, behavioral health services, and other aspects of discharge/reentry planning, as necessary, no later than 30 days from release. For county behavioral health agencies providing in-reach behavioral health case management, case management shall include SUD care coordination (depending on the county of residence), Peer Support services (depending on the county of

Table 9. Pre-Release Covered Services	
Covered Service	**Definition**
	residence), and SMHS Targeted Case Management covered in the Medi-Cal State Plan.
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, and include diagnosing, stabilizing, and treating the individual in preparation for release (including recommendations or orders for needed labs, radiology, and/or medications); providing recommendations or orders for 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 members 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, 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 recommend medication changes or ordering appropriate DME for post-release). • Supporting reentry into the community. Behavioral health clinical consultation includes clinical assessment, patient education, therapy and counseling, and peer supports.

Table 9. Pre-Release Covered Services	
Covered Service	**Definition**
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.
MAT	▪ MAT for opioid use disorder (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 OUD as authorized by Social Security Act Section 1905(a)(29). DHCS will require correctional facilities to provide access to at least one agonist medication (i.e., either methadone or buprenorphine), as further described in ***Section 8.7.*** ▪ MAT for alcohol use disorder (AUD) and non-opioid substance use disorder 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 disorder 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. 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.
CHW Services	CHW services will be provided consistent with the CHW Medi-Cal State Plan specifications.
Services Provided Upon Release	Services provided upon release include: • Covered outpatient prescribed medications and OTC drugs (a minimum 30-day supply as clinically appropriate, consistent with the approved Medicaid State Plan).

Table 9. Pre-Release Covered Services	
Covered Service	**Definition**
	• DME consistent with Medicaid State Plan requirements.

8.2 Short-Term Model Minimum Requirements

According to the BSCC, the average length of stay for non-sentenced individuals in county jails is 17.31 days, and the average length of stay in county YCFs is 24 days. However, many of these individuals have unpredictable release dates, and a large percentage will be in and out of jails within 48 hours (for example, 64 percent of San Mateo's and 60 percent of Riverside's jail population is released within 48 hours). Given the short and unpredictable nature of jail/YCF stays, correctional facilities will face significant operational challenges in facilitating Medi-Cal applications and pre-release services.

In response, DHCS developed the following operational guidance for correctional facilities on navigating short-stay situations, which was informed by targeted stakeholder interviews with county jail/YCF and JI providers. This short-term stay model considers the inherent constraints in the corrections environment and offers best practices for facilities based on the duration of the JI individual's stay within a correctional facility. Specifically, this document includes guidance on minimum requirements and best practices, which is organized based on the duration of the individual's incarceration.

In order to provide as many of the CalAIM JI pre-release services to individuals as possible during short and/or unpredictable stays, DHCS has developed the following requirements, laid out by the time period someone is incarcerated. Additionally, this document highlights best practices jails/YCFs can leverage to increase pre-release service delivery, if the jail/YCF has the available resources. While the following table identifies the minimum a jail/YCF should provide, jails/YCFs can initiate services earlier than the following timelines based on available staffing and resources. Ability to comply with the short-term model will be assessed in the jail/YCF's readiness assessment, and DHCS will only approve programs that can attest to having processes in place that meet the minimum requirements.

Table 10 provides the minimum requirements for jails/YCFs with respect to Medi-Cal screening, pre-release eligibility screening, provision of pre-release services, and reentry planning and coordination for short-term stays. When possible, DHCS has provided

examples of best practices to assist jails/YCFs in developing their processes. Note that pre-release planning requirements for jail/YCF stays longer than 30 days with a known release date and/or post-adjudication processes will mirror those for prison discharge planning.

Table 10. Short-Term Model: Key Activities and Timeline Requirements		
Key Activities	**Timeline for Providing Services**	**Requirements for Providing Services**
1. Medi-Cal Application Process		
Screen individual for Medi-Cal eligibility	Minimum Requirement: Incarceration for at least 48 hours	**Minimum Requirement: For people who have been incarcerated for at least 48 hours**, the jail/YCF or its designated entity must screen individuals for Medi-Cal eligibility. Note that YCFs must screen youths under the age of 18 for Medi-Cal eligibility when a parent/legal guardian is present. **Best Practice:** The jail/YCF or its designated entity screens individuals for Medi-Cal as part of the intake process. • Individuals can apply to Medi-Cal at any time during their incarceration via whatever means the facility makes available. For example, Riverside county jails include a direct phone line for individuals to apply.

Table 10. Short-Term Model: Key Activities and Timeline Requirements		
Key Activities	**Timeline for Providing Services**	**Requirements for Providing Services**
Obtain AR's signature[61]	Minimum Requirement: Incarceration for at least 48 hours	**Minimum Requirement: For people who have been incarcerated for at least 48 hours,** the jail/YCF or its designated entity should provide the inmate the opportunity to name the jail/YCF or designated entity as the AR and give it the authority to complete and/or sign the application on the inmate's behalf in the event the individual is released early. For youths under the age of 18, YCFs must provide the opportunity to designate an AR when a parent/legal guardian is present. Applicants may appoint an individual as the AR using the MC 382 or the Medi-Cal application form. If an applicant wants to appoint an organization (e.g., the jail or YCF office), then the MC 383 is also required to enable certain individuals at the organization to act as AR on behalf of the organization.

[61] Per ACWDL 22-27, an AR is not required for a CF to submit an application on behalf of an inmate or youth as part of the pre-release application process. However, during the application process, the inmate or youth may designate an individual or an organization as an AR to act responsibly on their behalf in assisting with their application, renewal of eligibility, and other ongoing communications with the CWD. More information about ARs can be found in ACWDL 18-26E and 20-28.

Table 10. Short-Term Model: Key Activities and Timeline Requirements		
Key Activities	**Timeline for Providing Services**	**Requirements for Providing Services**
Submit Medi-Cal application to SSD	Minimum Requirement: Incarceration for at least 72 hours	**Minimum Requirement: For people who are incarcerated at least 72 hours**, the institution must submit the signed application if the individual has decided to participate in the pre-release services process. • If an individual signed the application and/or designated an AR, the AR should complete, sign, and submit the application, even if the individual has been released. **Best Practice:** If the jail/YCF is unable to submit an application for anyone who is incarcerated for less than 72 hours, it can provide the individual with a paper application, county information, contact information for application assisters and social services workers, instructions regarding how to submit an online application, and a QR code linking to the online application, to allow the individual to submit their own application after they have returned to the community.
Alert SSD to suspend Medi-Cal coverage	Minimum Requirement: Incarceration for at least 28 days	**Minimum Requirement: For people who have been incarcerated at least 28 days**, the jail/YCF is required to follow current suspension processes per ACWDL 22-26 and 22-27, which requires that the jail/YCF notify the SSD/DHCS about incarcerated Medi-Cal recipients and provide the incarceration details, including incarceration date and release date, if known. This requires that the SSD only suspend Medi-Cal benefits during the incarceration period, once the individual has been incarcerated for 28 days.

Table 10. Short-Term Model: Key Activities and Timeline Requirements		
Key Activities	**Timeline for Providing Services**	**Requirements for Providing Services**
Notify the SSD/DHCS when the individual is released from custody to ensure full benefits are activated	Minimum Requirement: Within 24 hours of release for anyone incarcerated for at least 24 hours	**Minimum Requirement: For people who have been incarcerated for at least 24 hours**, and per ACWDL 22-27, in order to ensure individuals' Medi-Cal benefits are active upon release into the community, jails/YCFs will be required to develop processes and infrastructure to notify the SSD, **within 24 hours of their release**, of all individuals who are released from custody. **SSDs will have one business day to activate Medi-Cal benefits, if applicable.** **Best Practices:** • Correctional facilities should communicate such information electronically for more expeditious information transfer. • Over time, jails/YCFs should develop processes that enable them to share the release plan and other available medical information with parole/probation partners, MCPs, and community-based providers as indicated by the release of information (ROI). Note that YCFs should ensure that parents/legal guardians have the opportunity to sign an ROI for individuals under the age of 18 to facilitate this information exchange, likely at intake. • Over time, jails/YCFs should develop processes for sharing health care service information with prisons for individuals transferring to prisons, if known.

Table 10. Short-Term Model: Key Activities and Timeline Requirements		
Key Activities	**Timeline for Providing Services**	**Requirements for Providing Services**
2. 90-Day Pre-Release Access Screening Process		
Obtain necessary consents to disclose personal information[62]	Minimum Requirement: Incarceration for at least 48 hours	**Minimum Requirement: For people who have been incarcerated for at least 48 hours**, the jail/YCF or its designated entity must obtain necessary consents to disclose personal information. **Best Practices:** • The jail/YCF or its designated entity should obtain necessary consents as part of the intake process. • The jail/YCF should leverage already-signed consent forms for those who have previously been incarcerated and should initiate connection to a previously assigned ECM provider, as available.
High-level screening of individual for pre-release services eligibility and behavioral health needs	Minimum Requirement: Incarceration for at least 48 hours	**Minimum Requirement: For people who are incarcerated for at least 48 hours**, the jail/YCF or its third-party health provider contractor must conduct a high-level screening for pre-release service access criteria and behavioral health linkages. A high-level screening can leverage existing safety/health intake processes and must assess for suspected or self-attested mental health, behavioral health, and chronic conditions as part of meeting access screening criteria, including screening for the

[62] As part of the pre-release application process, the jail/YCF or third-party contractors should complete a universal ROI that includes:
- Consent to share health status and incarceration status updates with the MCP.
- Consent to share information with the ECM provider in the individual's county of residence, if the individual is deemed eligible for pre-release services

Table 10. Short-Term Model: Key Activities and Timeline Requirements		
Key Activities	**Timeline for Providing Services**	**Requirements for Providing Services**
		use of medications. This screening is a quick, high-level screening for very short stays; a more in-depth screening is done for people who are "likely eligible" at a later time (see below).

In-depth screening of individual for pre-release services eligibility and behavioral health needs	Minimum Requirement: Incarceration for at least seven days	**Minimum Requirement: If screening for pre-release services does not occur during the first 48 hours of incarceration and/or the individual is not found eligible as part of the initial screening,** the jail/YCF or its third-party health provider contractor must complete a comprehensive health screening within seven days of incarceration. The jail/YCF should leverage this assessment to identify any new individuals who would be eligible for pre-release services. Screening should also include a second screen and/or a full assessment, with tools and processes mutually agreed upon by the correctional facility and the county behavioral health agency to determine whether the individual's behavioral health needs meet behavioral health linkage criteria (see ***Section 11.4*** for additional information on behavioral health linkages). YCFs are required[63] to provide medical screenings within 96 hours of booking; DHCS will require that YCFs complete pre-release screenings within the 48-hour timeframe. • If a new medical condition is identified during incarceration, individuals who were not previously found eligible for pre-release services should be reevaluated for pre-release services. • If an individual has been incarcerated in the past 12 months, medical records should be leveraged to update previous pre-release screening and initiate services as soon as possible.
Complete pre-release services eligibility via the Screening Portal	Minimum Requirement: Incarceration for	**Minimum Requirement: As noted above, people who are incarcerated for at least seven days** will have completed a comprehensive health assessment. The jail/YCF or its designated entity must notify DHCS *(via Screening Portal, currently*

Table 10. Short-Term Model: Key Activities and Timeline Requirements		
Key Activities	**Timeline for Providing Services**	**Requirements for Providing Services**
	at least seven days	*under development)* when an individual meets a pre-release health care criterion, within 24 hours of that need being identified.[64]
Record pre-release services eligibility and release date, if known, in the Screening Portal to activate the aid code or send a denial notice.	Minimum Requirement: Within 24 hours of identification during the initial health and safety screening	**Minimum Requirement: During the initial health and safety screening, high-level screening, or in-depth screening**, if individuals are identified as meeting pre-release services criteria while applying for Medi-Cal, the **jail/YCF should communicate this information to DHCS via the Screening Portal and continue enrollment via its established enrollment process.** If the individual is identified as meeting pre-release services criteria after the Medi-Cal application is submitted, the jail/YCF must notify DHCS via the Screening Portal and within 24 hours of making the determination that the individual meets the pre-release services criteria. • Once the SSD receives information that someone in a jail/YCF qualifies for pre-release services, it will activate the aid code to allow for billing/claims for pre-release services.

[63] Pursuant to Title 15, YCFs must provide a medical clearance/screening, health examination, and screening for mental health/behavior problems, including a follow-up assessment when indicated by the screening (see sections 1430, 1432, and 1437).
[64] See Appendix W in the approved STCs for a list of pre-release health care criteria. Youths are not required to meet health care criteria to be eligible for pre-release services.

Table 10. Short-Term Model: Key Activities and Timeline Requirements		
Key Activities	**Timeline for Providing Services**	**Requirements for Providing Services**
3. 90-Day Pre-Release Services Delivery[65]		
Provide a hard copy of the name and phone number of the county ECM provider, to be kept with the individual's personal belongings.	Minimum Requirement: During the initial health and safety screening	**Minimum Requirement: During the initial health and safety screening**, the jail/YCF should 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, which should be kept with the individual's personal belongings,[66] if the individual appears to qualify for any ECM POF, including but not limited to the Individuals Transitioning From Incarceration POF.
Complete a comprehensive health screening for the individual.	Minimum Requirement: Within the first seven days of incarceration	**Minimum Requirement: The jail/YCF must complete the comprehensive health screening within the first seven days of incarceration.** • Facilities should leverage this assessment to identify any new individuals who would be eligible for pre-release services.

[65] Correctional facilities are required to provide all needed health care services for the entirety of the time an individual is incarcerated. The table below provides a detailed timeline of the targeted pre-release services. Billing/claims for these services can be done retroactively.

[66] The expectation is to provide a generic flyer that lets individuals know they likely are eligible for Medi-Cal and ECM and to give them a list of the providers they can contact in their community. CCJBH is developing an ECM referral flyer to be given at release. The flyer will also be shared with probation/parole officers.

Table 10. Short-Term Model: Key Activities and Timeline Requirements		
Key Activities	**Timeline for Providing Services**	**Requirements for Providing Services**
Leverage the MCP ECM Provider Directory to refer and assign a pre-release care management provider (if the jail/YCF will use community-based, in-reach providers) and/or a post-release ECM provider (if the jail/YCF will use embedded providers) to the individual.	Minimum Requirement: Within 48 hours of identifying the individual as eligible for pre-release services	**Minimum Requirement: The jail/YCF must contact and make arrangements with community-based or embedded care managers within 48 hours of identifying an individual as eligible for pre-release services (this action should occur by day 9; timelines for eligibility screening are noted above).** If the individual has previously been incarcerated, the jail/YCF should make this referral as close to intake as possible and/or contact the previously assigned ECM care manager.

Table 10. Short-Term Model: Key Activities and Timeline Requirements		
Key Activities	**Timeline for Providing Services**	**Requirements for Providing Services**
Schedule a care manager visit to further assess the individual's needs.	Minimum Requirement: Incarceration for at least seven days	**Minimum Requirement: For people who are incarcerated for at least seven days**, the jail/YCF must ensure a care manager performs a complete needs assessment, leveraging the initial health assessment or in-depth health assessment, to start a reentry plan. It can do this through an embedded care manager (must begin within three days of determining eligibility for pre-release services). If an in-reach care manager will be doing pre-release care management services, contact with an in-reach care manager must occur within three days of determining eligibility for pre-release services and schedule in-reach care management appointment to occur within the next seven days. The jail/YCF will determine whether the meeting should be in person while the individual is in the facility, via telehealth, or in the community post-release. After a needs assessment is created, care managers must either create a reentry plan or determine that someone is not eligible for pre-release services and communicate with DHCS through the Screening Portal to deactivate the aid code.
Schedule an in-reach consultation(s) based on the needs identified in the care manager's needs assessment.	Minimum Requirement: Incarceration for at least 30 days	**Minimum Requirement: For people who are incarcerated for at least 30 days**, and based on the care manager's needs assessment, the care manager will coordinate with the jail/YCF to schedule in-reach provider clinical consultation services, including a DME consultation, as needed.

Table 10. Short-Term Model: Key Activities and Timeline Requirements		
Key Activities	**Timeline for Providing Services**	**Requirements for Providing Services**
Provide laboratory/radiology services, as needed.	Minimum Requirement: Incarceration for at least 30 days	**Minimum Requirement: For people who are incarcerated for at least 30 days**, and based on the care manager's needs assessment and clinical consultations, the jail/YCF must facilitate laboratory and radiology services, as needed.
CHW services	Minimum Requirement: Incarceration for at least 30 days	**Minimum Requirement: For people who are incarcerated for at least 30 days**, and based on the care manager's needs assessment, the jail/YCF must facilitate the meeting with the CHW and with the member, as appropriate, by working in coordination with the ECM provider. **Best Practices:** • If an individual has an identified housing need, the pre-release care manager should contact the CHW, who, in coordination with the ECM provider, can help navigate housing supports and meet the individual upon release. • If an individual is receiving MAT, the jail/YCF should contact the CHW to help navigate community-based care and meet the individual upon release.

Table 10. Short-Term Model: Key Activities and Timeline Requirements		
Key Activities	**Timeline for Providing Services**	**Requirements for Providing Services**
Deliver MAT as needed	Minimum Requirement: Incarceration for at least four hours	**Minimum Requirement: For people who are incarcerated for at least four hours**, the jail/YCF must provide individuals with access to all forms of MAT for OUD (including buprenorphine, methadone, and naltrexone) and AUD. The jail/YCF must initiate MAT as needed for individuals who are incarcerated for more than four hours. For the purposes of CalAIM, the jail/YCF should determine the needed MAT for the incarcerated individual during the initial intake process (at a minimum this should occur within the first eight hours of incarceration, or prior to the jail/YCF's next scheduled dosage time/med pass) and assess additional medication needs. It is the role of the pre-release care manager to ensure that the individual's prescribed medications align with medications available in the community; this should occur during comprehensive assessment and care transition planning.

Table 10. Short-Term Model: Key Activities and Timeline Requirements		
Key Activities	**Timeline for Providing Services**	**Requirements for Providing Services**
Provide needed medications to individuals.	Minimum Requirement: Within the first eight hours of incarceration	**Minimum Requirement:** The jail/YCF is responsible for providing medications as soon as a need is identified. For the purposes of CalAIM, the jail/YCF should determine the needed medication for an individual during the initial intake process (at a minimum this should occur within the first eight hours of incarceration or prior to the jail/YCF's next scheduled dosage time/med pass) and assess additional medication needs. It is the role of the care manager to ensure that prescribed medications align with medications available in the community; this should occur with comprehensive assessment and care transition planning. **Best Practices:** • If an individual has been incarcerated one or more times in the past 12 months, the jail/YCF should leverage previous medical records to initiate Medi-Cal-aligned medication as close to intake as possible. • Provide medications to individuals as keep-on-person (KOP) to the maximum extent possible.

Table 10. Short-Term Model: Key Activities and Timeline Requirements		
Key Activities	**Timeline for Providing Services**	**Requirements for Providing Services**
Provide needed medications to individual upon release, along with any needed prescriptions for ongoing treatment.	Minimum Requirement: Incarceration for at least 24 hours	**Minimum Requirement: The jail/YCF is responsible for developing processes to prepare for writing prescriptions and providing prescribed medication in-hand upon release for individuals who have been incarcerated for at least 24 hours.** Identifying the necessary medications and prescriptions can be based on any medication need identified through the standard medical screening procedures and according to the timelines specified by the jail/YCF for those procedures. **Best Practices:** • If an individual has previously been incarcerated, the jail/YCF should leverage previous medical records to ensure the necessary medications can be provided in-hand upon release. • To improve prescription fill times, the Los Angeles jail/YCF issues two prescriptions for medications – one to be KOP while incarcerated and one to be provided in-hand upon release.

Table 10. Short-Term Model: Key Activities and Timeline Requirements		
Key Activities	**Timeline for Providing Services**	**Requirements for Providing Services**
Provide DME upon release.	Minimum Requirement: Incarceration for at least 14 days	**Minimum Requirement: Individuals who are incarcerated for at least 14 days should receive any medically needed DME and a prescription for that DME upon release.** **Best Practice:** If an individual has previously been incarcerated, the jail/YCF should leverage previous medical records to ensure the necessary DME can be provided in-hand upon release.
4. Reentry Process		
Alert the SSD of an individual's upcoming release date.	Minimum Requirement: No later than one week after becoming aware of the expected release date	**Minimum Requirement:** Per ACWDL 22-27, correctional facilities must notify the SSD of an individual's upcoming release date as soon as they become aware of it, but no later than one week after becoming aware of the expected release date.

Contact the county behavioral health program or ECM provider, as appropriate, to facilitate behavioral health linkages at release.	Minimum Requirement: No later 48 hours after identifying need	**Minimum Requirements:** • **For individuals who are found to require SMHS and/or DMC/DMC-ODS services** (assessments may be at the initial intake screening (e.g., those who have serious mental illness (SMI) on medications or suicidal ideation, or those who are actively withdrawing from drug use) and then confirmed during the full health assessment required for those incarcerated for at least seven days). The jail/YCF must contact the county behavioral health program within 48 hours of behavioral health needs identification to ensure assessments for services and appropriate behavioral health warm linkages occur according to mutually agreed upon standards between the correctional facility and the county behavioral health agency. • For those who have identified behavioral health needs and have been able to schedule a clinician-to-clinician warm handoff, DHCS will require correctional facilities to also complete behavioral health information sharing between correctional and county providers, support appointment scheduling with community-based providers, and complete any follow-up from the clinician-to-clinician handoff (as indicated) prior to release, or within 48 hours of release for unexpected/early releases. • **For individuals with a behavioral health need who are not referred to SMHS and/or DMC/DMC-ODS services:** For people who are incarcerated for at least seven days and have completed a health care needs assessment that identifies them as having behavioral health needs but who are not eligible for SMHS and/or DMC/DMC-ODS services, the jail/YCF must share the identified needs with a pre-release care manager or an ECM provider if the individual is released prior to pre-release care management services being initiated. The jail/YCF also must participate in warm linkages with a

Table 10. Short-Term Model: Key Activities and Timeline Requirements		
Key Activities	**Timeline for Providing Services**	**Requirements for Providing Services**
		community behavioral health provider coordinated by the pre-release care manager/ECM care manager, including by sharing information and providing clinician-to-clinician communication as needed. DHCS expects correctional facilities and county behavioral health agencies to mutually agree upon screening/assessment tools to determine whether an individual's behavioral health needs meet the behavioral health criteria for accessing SMHS and/or DMC/DMC-ODS services.
Support the pre-release care manager in facilitating a warm handoff of the individual to the post-release care manager (e.g., provide dedicated space at release).	Minimum Requirement: Incarceration for at least 14 days for a warm handoff; incarceration for less than 14 days for an ECM referral	**Minimum Requirement: If the jail/YCF is using correctional staff for care management services**, it must facilitate a warm handoff with a community-based provider. This warm handoff should occur if the individual has been incarcerated for at least 14 days; individuals who are incarcerated for less time should leave with an ECM referral.

Table 10. Short-Term Model: Key Activities and Timeline Requirements		
Key Activities	**Timeline for Providing Services**	**Requirements for Providing Services**
Data sharing	Minimum Requirement: Incarceration for at least seven days	**Best Practice:** For people who are incarcerated for at least seven days and have completed a health care needs assessment, the jail/YCF should transfer the medical information and release plan to the MCP (as available), community-based care manager, providers, and parole/probation officers.

8.3 Telehealth Services

When services are provided by embedded correctional health care providers, the expectation is that such services will be delivered in-person.

When services are provided by community-based in-reach providers, telehealth will be an important modality for delivering care management and clinical consultation services and for ensuring that providers, including post-release ECM providers, can meaningfully engage and build a trusted relationship prior to reentry (e.g., as part of the warm linkages). DHCS considers telehealth an effective alternative to health care provided in person, particularly for correctional settings.

Video and Audio-Only Telehealth Services. DHCS understands the importance of providing flexibility with respect to using telehealth to provide pre-release services, in order to address potential capacity issues (e.g., staffing constraints, space, appointment slots, equipment, and maintaining security). DHCS will allow appointments to be conducted by video or audio only, as clinically appropriate and consistent with Medi-Cal policy. For example, some procedures require in-person contact by their nature (e.g., vaccinations). But generally, DHCS will rely on providers' clinical judgment as to the appropriateness of telehealth and assume that the provider meets all the requirements of the billing code in order to bill it.

Telehealth Equipment and Space. DHCS expects providers to use their routine equipment and will allow flexibility in approved telehealth equipment to ensure providers can continue to use equipment they are accustomed to using (audio and/or video modalities with equipment and platforms). Telehealth equipment is necessary to meet the minimum requirements established by correctional facilities related to bandwidth and scheduling. DHCS will require providers to be in HIPAA-compliant spaces when providing telehealth services to JI individuals.

Information Sharing. DHCS encourages correctional facilities and in-reach providers to leverage their existing telehealth infrastructure in order to maximize data exchange, minimize appointments that would gather repetitive information, and ensure providers can efficiently conduct telehealth appointments. Depending on the type of telehealth visit (e.g., care management, establishing a new patient, MAT, mental health counseling), DHCS will mandate that correctional facilities be able to share the following types of information: an individual's medical record or a specific subset of the EHR (e.g., pertinent notes, labs, radiology, problem lists), the discharge plan and needs

assessment, and medication lists with the medication administration record (MAR), as appropriate.

8.4 Care Management Model[67]

Care management is a critical component of the CalAIM JI Reentry Initiative, which is intended to (1) support the coordination of services delivered during the pre-release period and upon reentry; (2) ensure smooth linkages to services and supports; and (3) ensure arrangement of appointments and timely access to appropriate care delivered in the community.

The care management model has four primary goals:

1. Develop and facilitate a care plan to help stabilize conditions prior to release.
2. Build trusted relationships between the individual who is incarcerated and the care manager, who will support the individual's transition back to the community.
3. Create and implement a reentry care plan in consultation and collaboration with the individual and other providers.
4. Maximize continuity of care management and access to services to the extent possible as individuals transition between incarceration and reentry into the community.

The care management model begins with pre-release care management services available during the 90 days prior to an individual's release, which are paid on an FFS basis by Medi-Cal. The pre-release care manager is required to closely coordinate with the individual's post-release care management provider (likely an ECM provider) – if the pre-release and post-release care managers are not the same person – to ensure continuity of care between the pre- and post-release periods. ECM services are delivered and paid for in the managed care delivery system, specifically by the MCP in which the individual is enrolled post-release. Individuals should be enrolled in an MCP immediately upon release so that they may immediately access ECM, but if their MCP enrollment is not immediately effectuated, post-release care management services will be provided by the post-release care management provider and paid for on an FFS basis until their MCP enrollment has been effectuated. MCP requirements for implementing ECM for the Individuals Transitioning from Incarceration (JI) Population of Focus (POF)

[67] This section provides an overview of the full care management model – even services that take place outside the 90-day pre-release services window – in order to keep the explanation of the full model together in one section.

can be found in ***Section 13***. The pre- and post-release care management models are outlined below.

8.4.a Pre-Release Care Management Model (In-Reach and Embedded Care Management)

To maximize the continuity of care management and access to services across the pre- and post-release periods, correctional facilities may pursue an in-reach model or an embedded care management model that includes a warm handoff between pre- and post-release providers. DHCS defines an "in-reach care management model" as a model through which community-based care management providers, who will become the ECM provider after managed care enrollment, deliver care management services to individuals in correctional facilities, either in person or via telehealth.[68]

DHCS understands that some correctional facilities will not choose to implement an in-reach care management model; therefore, DHCS will allow correctional facilities to have embedded care managers (i.e., care managers employed by or contracted with the correctional facility) to serve individuals eligible for pre-release services.[69] Correctional facilities that use an embedded care management model will be required to implement a warm handoff between the pre- and post-release care managers. Warm handoff meetings may be conducted via telehealth, as appropriate, for reasons that include, but are not limited to, the post-release care manager being unable to enter the correctional facility due to security clearance issues or the post-release care manager being located in another county. Additional details on requirements for warm handoffs are included in ***Section 8.4.e***.

Ideally, the ECM provider should provide in-reach pre-release care management services either in person or via telehealth on an FFS basis, or at a minimum conduct warm handoffs on an FFS basis during the pre-release period. This strategy will ensure individuals who are incarcerated can be cared for by the same care manager in both the

[68] DHCS recognizes that in some counties the department of health or county behavioral health agency provide both behavioral health services to correctional facilities *and* community-based services. In those circumstances, the determination of whether the provider is embedded or in-reach/community-based would be based on the role of the provider is playing and whether the provider has a contract with the Sheriff's Office to provide such services. If the provider is furnishing services in their role as a correctional facility contracted entity and performing services that correctional facilities are required to provide, those services would be considered embedded services. Alternatively, if the provider is acting on behalf of the county in their role in the community – for example, accepting a warm linkage – that service would be considered in-reach.

[69] Correctional facilities may also leverage contracted care management providers that serve the correctional facility population but do not also provide community-based services (e.g., Wellpath).

pre- and post-release periods. (All individuals who are eligible to receive pre-release services and are enrolled in managed care will be eligible to receive ECM services post-release.) See ***Section 9,*** Provider Enrollment and Payment, for details on how pre-release in-reach care managers will be reimbursed. See ***Section 13*** for MCP requirements for ensuring that ECM providers also provide pre-release in-reach care management.

8.4.b Correctional Facility Requirements for Pre-Release Care Management

Correctional facilities will be responsible for identifying and assigning an embedded or community-based care manager to the individual after they have been found eligible for pre-release services. The correctional facility will also be responsible for assigning a post-release ECM provider (if the individual was receiving embedded pre-release care management).[70] Specifically, correctional facility staff or their contractors will be responsible for:

- Assigning a pre-release care manager to the individual. Facilities using community-based care managers may use the MCP Provider Directory, which will list JI ECM providers, to assign the individual a care manager (who must also be enrolled as a Medi-Cal FFS provider to provide pre-release services, as described above). Additional details on MCP requirements for the Provider Directory and the requirement that ECM providers also enroll in Medi-Cal FFS and provider pre-release, in-reach care management services can be found in ***Section 13***. Facilities using embedded care managers may use any existing processes to assign the pre-release care manager to the individual.
- Scheduling an initial appointment and any follow-up meetings between the care manager and individual. Correctional facilities will be required to schedule contact with a post-release ECM care manager and the individual 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.
- Obtaining needed consents for release of information from the individual.
- Ensuring correctional facility medical staff coordinate with, assist, and share information with the pre-release care manager as needed.

[70] DHCS acknowledges that MCPs may be better positioned to assign appropriate ECM providers in the future. As data exchange and infrastructure is established, DHCS will consider having MCPs take a more active role in ECM provider assignment in the future.

- Coordinating with case records personnel and probation/parole on changes in release, including accelerated release or community-transition program releases.
- Ensuring that the pre-release care manager and the MCP link the individual with required support, which may include but is not limited to conducting a warm handoff with the post-release care manager, facilitating behavioral health linkages, and making referrals to community supports, as needed.

8.4.c Requirements for Pre-Release Care Managers

Requirements for all pre-release care managers include the following:

- Completion of whole-person needs assessment documented in medical record including assessment of needs in each of the following areas: mental health, substance use, physical health, housing, other health-related social needs, and functional needs. This assessment should be used to identify what additional clinical care or clinical assessments are needed to diagnose, stabilize or treat in preparation for reentry and be the basis to create a care plan that will set up services to address each identified need across all identified areas. Specific requirements for a whole-person needs assessment includes:
    - Meet with member (face to face or through telehealth) to conduct/review assessment.
    - Review prior records, as available.
    - Obtain informed consent, when needed, to furnish services and/or to share information with other entities to improve coordination of care
    - All components of the needs assessment must be completed with the member, consider current needs and needs that may arise upon reentry into the community. The needs assessment will be leveraged to prioritize the pre-release services, including any needed clinical consultations and as the basis for the robust reentry plan. The needs assessment must include the following:
        - **Physical health needs assessment:** Inclusive but not limited to: prior medical issues, any symptom burden, potential for undiagnosed conditions, need for clinical consultations; needs for medications, needs for DME, needs for IHSS, needs for establishing care with primary care and any specialists in preparation for release, preventative care access (e.g., cancer screening, vaccinations, a physical exam within the last year).

- **Mental health needs assessment:** prior mental health treatment and diagnoses; use of validated screening tools; need for clinical consultations; identification of any needed medications for release, identification of potential benefit for long-acting injectable use, identification of need for behavioral health warm linkages, identification of need for mental health follow-up and appropriate level of care.
- **Substance use disorder needs assessment:** prior substance use disorder treatment and diagnoses; use of validated screening tools; identification of potential need for MAT; identification of potential benefit for long-acting injectable use; identification of any needed clinical consultations; identification of need for BH warm linkages; identification of need for substance-use disorder follow-up and appropriate level of care.
- **Housing needs assessment**: Identification of planned housing upon release and identification of any housing needs.
- **Other health-related social needs assessment:** Identification of needs member may have upon release including but not limited to: any needs related to access to food or to medically tailored meals; transportation needs; cell phone/smart phone access; social support including who should be included in care plan: family/friends/parole/probation.
- **Functional needs assessment:** identification of needs member may have related to functioning in community upon release such as medication management; scheduling community-based appointments; paying bills; utilizing electronic communication.

- Creation of care linkages and coordination with community-based providers and services. Specific requirements for a creation of care linkages and coordinate of services include:
    - Pre-release coordination with any post-release clinical consultant to address and/or identify physical health, mental health, or substance use disorder needs, including coordinating any needed labs, radiology, or medications (including MAT).
    - Pre-release coordination, including non-patient and patient facing, as needed, to create care linkage to community-based provider.
    - Pre-release coordination to arrange appointments with or admission to physical and behavioral health care providers, including specialty county

behavioral health coordinators and managed care providers, as relevant to care needs.
    - Ensure individual has any necessary DME prescriptions, including coordinating with providers to perform face-to-face visits, documentation of medical necessity, and prescriptions.
    - Assist in information exchange and obtaining consent as needed to facilitate care with in-reach providers and other community care providers.
    - Assist with any prior authorization or treatment authorization requests on submitted and collecting any needed information.
    - Facilitate warm linkage with member and community-based provider.
    - Ensure coordination and receipt of pre-release services.
- Participation in warm linkage face-to-face or telehealth encounter that at minimum must include member and community-based provider to introduce new care manager and review current assessment and/or release plan with the member and identify any additional needs. Warm handoffs are only required when the pre-release care manager is different from the post-release care manager. Specific requirements for a warm handoff include:
    - Participate in face-to-face or telehealth visit with member to meet new post-release ECM care manager.
    - Review and update needs assessments and reentry care plan with member.
    - Provide education on reentry plan and reentry services.
    - Modify reentry care plan based on new knowledge of community resources or input from member.
    - Post-release care manager must receive and discuss care plan with pre-release care manager and receive all appropriate records and information from the pre-release period.
    - Obtain any necessary consents for information sharing.
- Completion of a final care plan documented in medical record including release plans related to mental health, substance use, physical health, health related social needs, and functional needs. Final care plan must be completed in collaboration with member and must be shared with post-release care manager and the member. Specific requirements for a final care plan include:
    - Complete discharge/reentry person-centered care plan, created with the client, with input from the clinician providing consultation services and correctional facility's reentry planning team. Provide care plan with member and confirm all connections and appointments required as part of

the reentry plan have been scheduled, completed or have plans to be completed with a responsible care manager in clinically appropriate time.
- Complete data exchange, as allowed under federal and state laws, that includes beneficiary authorizations, reentry care plan, and necessary medical records, with post-release care manager and managed care plans, and, as relevant, with physical and behavioral health/SMI/SUD providers to enable timely and seamless hand-offs.
- Confirm individual has medications/prescriptions in hand upon release.
- Confirm individual has any needed DME or DME prescriptions in hand upon release.

For more detailed information on DHCS' proposed minimum document and service requirements for billing/claiming pre-release care management, see ***Section 10.2.***

8.4.d Reentry Person-Centered Care Plan

Pre-release care managers should develop a reentry person-centered care plan (henceforth referred to as a reentry care plan) with the individual and share the care plan during the warm handoff with the post-release care manager, described below. For correctional facilities that leverage an embedded care management model, in which pre-release care management providers are not familiar with community-based services in the county in which the individual will be released, the pre-release care management provider must collaborate with the post-release ECM provider to develop the reentry care plan and coordinate post-release community-based services. Additional information on billing for the creation of the reentry care plan can be found in ***Section 10***.

The reentry care plan should minimally include the following elements:

- Completed whole-person care plan that includes a plan for any identified needs based on the completed needs assessment of mental health, substance use, physical health, long-term services and supports needs, health related social needs, and functional needs. This assessment and care plan must be overseen and completed by a licensed professional (e.g., RN care manager or LCSW), although specific components of the assessment or care plan (e.g., screening for HRSN) may be done by other non-licensed team members, according to licensing and oversight requirements by state law.
- Post-release planning, including identification of needs member may have related to functioning in community upon release such as HRSN; housing needs;

considerations for LTSS; medication management; scheduling community-based appointments; paying bills; 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.[71]
- Plans for DME, including ensuring that DME prescriptions have undergone any treatment authorization reviews (TARs) or other requirements for coverage, as necessary.
- Coordination, scheduling, and warm 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, or dental care.
    - Referrals and coordination for any housing needs
    - Coordination of an MCP benefits including non-emergency medical transportation or any needed
    - MCP Community Supports, as eligible and as needed, including short-term post-hospitalization housing and recuperative care (i.e., medical respite) .[72]
    - Community service referrals.
    - HRSN referrals (e.g., nutrition and housing supports).
    - LTSS referrals.
- Plan for follow-up with the individual to ensure engagement with community-based providers, behavioral health services, and other aspects of discharge/reentry planning, as necessary.
- Coordination of reentry logistics, including transportation.

[71] All FDA-approved medications can be covered by Medi-Cal to treat the conditions for which they were approved, but some drugs may be subject to various authorization and utilization management (UM) policies. If necessary, PA should occur during the pre-release planning period, so that the individual has access to their prescriptions immediately upon release.

[72] Additional information on Community Supports can be found in the Medi-Cal Community Supports, or In Lieu of Services (ILOS) Policy Guide, available here: https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide.pdf

- Ensuring that, as allowed under federal and state laws and always through consent with the beneficiary, data are shared with MCPs and, as relevant, with physical and behavioral health/SMI/SUD providers to enable timely and seamless handoffs.
- A plan for engagement of identified supports for the client (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.

8.4.e Requirements for Care Manager Warm Handoff

In cases where different people provide pre- and post-release care management services (i.e., if the correctional facility leverages an embedded care management model), the two care managers must conduct a warm handoff with the individual prior to release. The warm handoff is the first step in establishing a trusted relationship between the individual and the new care manager and ensures seamless service delivery and coordination.

While MCPs will not be responsible for paying for warm handoffs, they must ensure that all ECM providers agree to enroll in Medi-Cal FFS through their contract in order make pre-release warm handoffs possible. See ***Section 13*** for MCP requirements for ensuring the warm handoff occurs.

Minimum requirements for the pre- and post-release care managers conducting warm handoffs are as follows:

- Sharing the transitional care plan with 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:[73]
    - Begin establishing a trusted relationship between the individual and the post-release care manager.

[73] If it is not possible for the pre-release care manager, post-release ECM provider, and member to meet together, pairs should meet separately (i.e., the pre-release care manager and post-release ECM provider; the pre-release care manager and member; and the post-release ECM provider and member).

- Review the transitional care plan with the individual and address questions.
- Identify any outstanding service needs and other supports required for successful community reentry (e.g., transportation or housing).

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 24 hours of release.

Correctional facilities will be required to work with the MCPs in their counties and their county behavioral health partners to develop policies and procedures for instances when warm handoffs do not occur prior to release, to ensure that (1) warm handoffs occur within the first week post-release and information is shared within 24 hours; and (2) the member is served during this "gap period" after release prior to the warm handoff, with a best practice of a care manager meeting the individual at the door at release.

8.4.f Reentry Care Management

All individuals who are eligible for pre-release services and enrolled in Medi-Cal managed care[74] will be eligible for ECM (see ***Section 11.1***, ECM Eligibility), and they may begin to access ECM as soon as their enrollment in an MCP has been effectuated, which should occur at or shortly after release. Until the individual can access ECM services, their post-release care manager may continue to provide care management services post-release for which they can bill through FFS. Once MCP enrollment has been effectuated, the ECM provider must begin to provide ECM services, which are included in the MCP capitation rate.[75]

[74] Populations exempt from managed care include AI/AN, former foster care youth, and children/youths in foster care, depending on the county. Population that are not enrolled in a managed care plan will not receive ECM services.
[75] An MCP may reassess the individual six months after release to determine whether they should continue to receive ECM services or receive another type of care management that may be more appropriate.

As best practice, ECM providers should meet the individual at release if possible, and if that is not possible, the ECM provider should meet the individual within one to two days of release. The ECM provider should also follow up with the individual within one week of release to ensure continuity of care and a seamless transition, and to monitor progress and the implementation of the reentry care plan.[76]

Post-release care management through ECM can include both care management activities and community health worker activities, including.[77]

- 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 social services.

Please see the ECM Policy Guide (updated December 2022) for more information on ECM services. See Appendix A, Illustrative Examples of Care Management Approach.

8.4.g Care Management Reimbursement

Pre-release care managers will be able to bill for the required activities outlined above via FFS. For more information on Medi-Cal billing for these services, see ***Section 10*** on payment bundles for pre-release care management. JI PATH funding is available to support the development of reimbursement policies and procedures, IT and infrastructure, and staff to support pre-release care management.

[76] SMDL 23-003 suggests that care managers should initiate contact 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.

[77] Community health workers are permitted and encouraged to be a part of the care team. Payment for community health worker activities associated with ECM are included in the ECM rate and such activities may not be billed separately.

8.5 Physical and Behavioral Health Clinical Consultation

Individuals eligible for 90-day pre-release services will receive physical and behavioral health in-reach clinical consultation services. The scope of covered services for in-reach providers and embedded providers will be the same and will cover all services outlined in STCs. Clinical consultation services include clinician services that accomplish the following goals:

- **Diagnose, treat, and stabilize** individuals with qualifying health conditions to address service gaps that may exist in correctional care facilities and prepare them for release. This includes any outpatient clinician services that may be needed for diagnosis such as behavioral health assessments or physical health diagnostic evaluations and procedures, or outpatient clinician services that treat or stabilize individuals, such as behavioral health therapy, physician-administered medications, or prescribing of medications.
- **Provide prescriptions and clinical documentation for all medications, services, and equipment that will be needed in the immediate post-release period**, such as prescribing or recommending medications to manage chronic conditions and providing appropriate clinical documentation for any PA, or prescribing DME and providing appropriate clinical documentation including face-to-face encounters and medical necessity documentation.
- **Support reentry coordination among professionals**, including time spent coordinating with the pre-release care manager and providing clinician-to-clinician consultations and coordination, including behavioral health warm linkages.
- **Facilitate members' connections with post-release providers**, including allowing in-reach initial consults and evaluations prior to release that establish relationships between individuals with complex needs and the health care providers who will be providing post-release physical and behavioral health care.

Behavioral health clinical consultation services include a scope of services that enable diagnosis, evaluation, treatment, stabilization, and support reentry coordination activities including behavioral health professional-to-professional warm handoff for SMI and SUD per the approved STCs. Behavioral health clinical consultation includes outpatient services covered in the Medicaid State Plan rehabilitation benefit[78] to

[78] Includes services covered in the state plan rehabilitation benefit but is not limited to clinical assessment, patient education, therapy, counseling.

diagnose, treat, and stabilize behavioral health conditions. Such services include the following:

- Clinical assessments.
- Recommending medications;
- Pre-release and post-release discharge planning.
- Patient education.
- Treatment, such as behavioral health counseling/therapy.
- eConsults and care coordination to facilitate linkages for recommending treatment, post-release follow-up planning, and transference of care with behavioral health post-release providers.

Physical health clinical consultation services include a scope of services that enable diagnosis, evaluation, treatment, stabilization, and support reentry coordination activities for any of the qualifying conditions. Physical health clinical consultations will include applicable evaluation and management (E/M) CPT codes to diagnose, treat, and stabilize physical health care conditions. Such services include:

- History and physical initial visit, initial consults, and follow-up provider clinical consultation visits.
- eConsults and coordination-of-care conferences.
- E/M visits by physical, occupational, or speech therapists, or other professionals for identifying necessary physical health care services and DME recommendations.

For all minimum treatment requirements listed above, clinical consultation is covered by Medi-Cal (with additional billing guidance forthcoming). JI PATH funding is available to support development of reimbursement policies and procedures, IT and infrastructure, and staff for pre-release and post-release services.

8.6 Medication Coverage During the Pre-Release Period

The scope of targeted pre-release services under the Section 1115 demonstration includes medication and medication administration consistent with the State Plan in the 90-day period prior to release and a supply of medication upon release. The goals of providing medication coverage during the pre- and post-release period are as follows:

- Ensure access to medications that are traditionally difficult to obtain in correctional facilities (such as long-acting injectables).
- Stabilize individuals with chronic conditions on medications that they will be able to access (medications available on Medi-Cal, or Medi-Cal Rx medications) once released to ensure their conditions are well controlled during the immediate post-release period.
- Provide Medi-Cal Rx medications upon discharge to ensure there is no gap in access to critical medications.

In order to operationalize the provision and billing/claims of medications during the pre-release period, correctional facilities and/or their community-based pharmacies will be required to use Medi-Cal Rx to bill for and claim medications. The Medi-Cal Rx system is designed to ensure pharmacy benefits are compliant with state and federal laws. For this reason, DHCS will require correctional facilities that have on-site pharmacies to enroll as a Medi-Cal pharmacy and to follow billing and claims processes, including all real-time or batched billing/claims requirements and PA requirements for medications, that match current FFS processes via Medi-Cal Rx for prescriptions.

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 that they are unable to dispense medications in glass bottles due to safety concerns. DHCS will work with correctional facilities to identify and minimize gaps by supporting the identification of alternative medications that 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.

For correctional facilities that partner with community-based pharmacies or pharmacies that are not on-site, DHCS will require those pharmacies to be Medi-Cal-enrolled pharmacies and bill through the normal Medi-Cal Rx systems. For medications that are dispensed from the pharmacy in non-patient-specific formulations but then delivered in patient-specific dosing using a clinic-administered pathway, DHCS will require correctional facilities to utilize California Medicaid Management Information System (CA-MMIS) medication administration billing codes. DHCS will provide the technical assistance required for correctional facility pharmacies to enroll and bill for/claim these services. Correctional facilities will also have access to JI PATH funding to update their

EHRs to assist in billing/claims and building out partnerships and needed workflows with Medi-Cal-enrolled community pharmacies.

8.7 MAT Coverage During the Pre-Release Period

The scope of targeted pre-release services under the Section 1115 demonstration includes medications and medication administration for addiction treatment, also known as MAT, for OUD, AUD, and other SUDs both during the pre-release period and to have in hand upon release.

MAT is covered as a Medi-Cal state plan benefit for any person who meets the medical necessity criteria. It is often provided concurrently with other DMC and DMC-ODS services in outpatient, residential, and inpatient settings. Consistent with federal regulations for opioid treatment providers and California state requirements, only narcotic treatment providers (NTPs) may offer methadone. Specifically, NTPs are required to directly offer MAT to members with SUD diagnoses that are treatable with FDA-approved medications and biological products, including methadone, buprenorphine (transmucosal and long-acting injectable), naltrexone (oral and long-acting injectable), naloxone, and disulfiram.

In March 2020, during the novel coronavirus (COVID-19) public health emergency (PHE) Substance Abuse and Mental Health Services Administration (SAMHSA) issued an exemption to NTPs allowing states to request "a blanket exception for patients to receive take-home medication doses for opioid use disorder." These take-home flexibilities resulted in increased treatment engagement, improved patient satisfaction with care, with relatively few incidents of misuse or medication diversion. On May 11, 2023, upon the expiration of the federal COVID-19 PHE, SAMHSA implemented new Methadone Take-Home Flexibilities Extension Guidance that will remain in effect for the period of one year from the end of the COVID-19 PHE, or until such time that the U.S. Department of Health and Human Services publishes final rules revising 42 C.F.R. part 8 entitled 'Medications for the Treatment of Opioid Use Disorder' (87 FR 77330), whichever occurs sooner. These take-home flexibilities were granted to ensure continuity of care until SAMHSA finalizes updating the take-home medication requirements and guidance due to the positive outcomes in treatment.

Of note, many persons with OUD receive buprenorphine through their primary care providers (rather than through specialty providers within DMC/DMC-ODS). It is a best practice to offer MAT as part of holistic SUD treatment, supplemental to individual and/or group counseling, peer support, and other recovery supports. DHCS also

supports offering standalone MAT when a member is not ready to seek counseling or other treatment services, which is consistent with best practices for harm reduction and DHCS-issued guidance.[79]

The U.S. Department of Justice has released clear guidance that OUD is a disability and that inhibiting access to MAT is a violation of the Americans with Disabilities Act.[80] Case law and accepted practice regarding the provision of MAT in carceral settings are clear that MAT is the standard of care for OUD regardless of setting. Correctional facilities must provide MAT in a clinically appropriate manner to California's incarcerated persons as part of the JI Reentry Initiative.

To ensure that MAT is provided to Medi-Cal-enrolled individuals eligible for the JI Reentry Initiative prior to release, DHCS will leverage and expand on the current delivery of MAT for incarcerated individuals with the following goals in mind

- Provide reimbursement for all formulations of MAT covered under Medi-Cal – including long-acting injectable forms of MAT consistent with existing medical necessity requirements – to increase the provision of effective pharmacotherapy for OUD specific to the needs and wishes of each individual.
- Assist correctional facilities and NTPs in developing methadone delivery strategies and payment methodologies that eliminate the practice of terminating detainees from methadone treatment during incarceration; provide daily methadone dosing throughout incarcerations; and support induction onto methadone during incarceration.
- Expand access to behavioral health SUD treatment therapies in jails.
- Work closely with prisons, jails, and community-based providers to establish core requirements and provide intensive technical support to achieve seamless continuity of MAT and SUD treatment services during the reentry period.
- Support access to overdose-reversal medication (naloxone).

[79] Behavioral Health Information Notice No: 23:001, issued January 6, 2023. Available at: https://www.dhcs.ca.gov/Documents/BHIN-23-001-DMC-ODS-Requirements-for-the-Period-of-2022-2026.pdf

[80] U.S. Department of Justice, Civil Liberties Division. The Americans with Disabilities Act and the Opioid Crisis: Combating Discrimination Against People in Treatment or Recovery. Accessed November 9, 2022. Available at: https://www.ada.gov/opioid_guidance.pdf

- Provide an adequate supply of MAT medications, covered by Medi-Cal, dependent on timing of follow-up visit and for use post-release into the community.[81]

Treatment Approach. Given the evolving legal, regulatory, and clinical standards for treatment of SUD in correctional facilities, DHCS strongly supports the use of universal screening using evidence-based instruments as part of any carceral intake for potential opioid, alcohol, and other substance withdrawal.

All SUD treatment services are eligible for Medi-Cal reimbursement during the 90-day period prior to release. The following lays out treatment approach for OUD and AUD. Not every patient will meet the criteria for or require all treatments listed below.

Requirements for treatment for OUD include the following:

- Assessment of individuals who screened positive for OUD, using the ASAM criteria to determine the appropriate level of treatment when applicable.
- Treatment planning, consistent with Medi-Cal requirements, including Cal. Code Regs. Tit. 9, § 10305 – Patient Treatment Plans (also known as "Title 9") for applicable NTP services, in collaboration with the patient.
- Management of opioid withdrawal with agonist medication (i.e., either methadone or buprenorphine) using evidence-based tools and interventions.[82]
- Timely induction of the appropriate form of MAT. This includes access to buprenorphine and naltrexone for persons aged 16 or older and access to agonist (i.e., either methadone or buprenorphine) and other medications as appropriate for persons aged 18 or older.
- Timely continuation of any MAT prescribed in the community, for the duration of incarceration. Correctional facility providers must use the Drug Enforcement Administration's (DEA) 72-hour emergency rule for methadone,

[81] Because medications used for addiction include those that create a high risk of overdose or diversion, the quantity of these medications depends on the timing of the arranged follow-up visit, the particular risk for the patient, and the clinical judgment of the prescriber.

[82] May require transfer to a local hospital if capacity is not available. When an individual is hospitalized off grounds for 24 hours or more, that individual is found to be Medicaid-eligible and services should be billed through Medi-Cal State Inmate Program (MSIP) or the Managed Care Incentive Payment (MCIP) Program.

where needed,[83] and policies and procedures to support evidence-based dosing, urine drug screening, diversion control, and patient expectations/consent.

- Tapering or discontinuation (determined by both the clinician and the patient and on a case-by-case basis in accordance with evidence-based practices).
    - Evidence-based individual behavioral therapy.
    - Evidence-based group therapy.
    - Peer support services.
    - Psychoeducation.
- Maintenance of continuity of care by transitioning to community provider (including but not limited to MAT access through primary care and SUD treatment) through close coordination with pre- and post-release care managers.

Requirements for treatment for AUD include the following:

- Assessment of individuals who screened positive for AUD, using the ASAM criteria to determine the appropriate level of treatment when applicable.
- Treatment planning is consistent with Medi-Cal requirements, in collaboration with the patient.
- Management of alcohol withdrawal using evidence-based tools and interventions.[84]
- Timely introduction of appropriate MAT.
- Timely continuation of any MAT prescribed in the community, for the duration of incarceration.
- Policies and procedures to support evidence-based treatment of AUD and patient expectations/consent.

[83] The 72-hour rule allows a non-waivered practitioner to administer (but not prescribe) narcotic drugs to a patient for the purpose of relieving acute withdrawal symptoms while arranging for the patient's treatment. This rule can be lifesaving for individuals with OUD and AUD. As of January 12, 2023, all prescriptions for buprenorphine only require a standard DEA registration number: DEA announces important change to registration requirement (usdoj.gov)

[84] May require transfer to a local hospital if capacity is not available. When an individual is hospitalized off grounds for 24 hours or more, that individual is found to be Medicaid-eligible, and services should be billed through MSIP or the MCIP Program.

- Tapering or discontinuation determined in shared decision-making between the clinician and the patient on a case-by-case basis and in accordance with policies.
- Discontinuation determined by both clinician and patient, and on a case-by-case basis in accordance with evidence-based practice.
    - Evidence-based individual behavioral therapy.
    - Evidence-based group therapy.
    - Peer support services.
    - Psychoeducation.
- Maintain continuity of care by transitioning to community provider (including but not limited to MAT access through primary care and SUD treatment) through close coordination with pre- and post-release care managers.

Medi-Cal Reimbursement. Both embedded and in-reach providers can bill for Medi-Cal reimbursement for medications and withdrawal management and treatment of OUD and AUD and for reentry planning/care coordination during the 90 days prior to release for individuals enrolled in Medi-Cal. DHCS will provide separate guidance on billing and claims.

For all minimum treatment requirements listed above, professional services and medication costs are covered by Medi-Cal (with additional billing guidance forthcoming). JI PATH funding is available to support the development of policies and procedures, IT and infrastructure, and staff.

MAT Readiness Assessment. To ensure the successful implementation of MAT as a pre-release service in all state prisons, county jails, and youth correctional facilities, correctional facilities must pass a readiness assessment. The following list provides readiness requirements that would demonstrate full compliance:

- Processes are in place to immediately and systematically screen all individuals entering a jail for SUD, including any history of alcohol/sedative or opioid withdrawal.
- Facilities are able to provide all MAT options that would be available to individuals if they were not incarcerated. The decision to obtain medication for OUD or AUD, and the specific medication chosen, should be the individual's decision and be informed by consultation with medical and treatment providers.

- Processes are in place for all individuals who screen positive for an SUD or who later report OUD-associated cravings to be clinically assessed by a qualified treatment provider to determine whether MAT is clinically indicated.
- Policies and processes related to MAT do not limit the types of MAT, dosages, or duration of treatment.
- All persons for whom MAT is clinically indicated and who consent to its use are inducted into treatment in a timely fashion and maintained on treatment throughout incarceration.
- Assessment and provision of MAT continuation and withdrawal management are available every day, with the goal of preventing gaps in care that is intended to precipitate or sustain withdrawal.
- Processes are in place for MAT programs to include ongoing monitoring through drug screening and other diversion/risk mitigation strategies, including protocols for when an individual has a urine drug test that indicates medication nonadherence.
- Processes are in place for pregnant individuals to receive specialized MAT services to prevent and reduce health risks during pregnancy.
- Processes are in place for individuals to couple MAT with counseling and appropriate wraparound services where clinically indicated and the patient agrees.
- Correctional staff have received training and education on MAT.
- Facilities are able to store MAT medicines and have processes in place for appropriately safeguarding their inventory.
- Processes are in place to transition individuals receiving MAT via a warm handoff at reentry to community providers.

To increase access to MAT in correctional facilities and improve the standard of care in delivering these services to JI populations, DHCS will ensure correctional facilities understand the MAT requirements under CalAIM through the provision of technical assistance to CDCR, jails, and YCFs.

Additionally, as part of CalAIM, JI PATH funds will be available to correctional facilities and should be leveraged to help them establish or update existing MAT services to meet DHCS' minimum requirements; the funds can also support correctional facilities/vendors

in becoming Medi-Cal-enrolled providers/NTPs or to develop contracts with NTPs or community-based MAT providers.

8.8 Medications Upon Release

The CalAIM JI Reentry Initiative includes the provision of medications in hand to eligible individuals upon release from a correctional setting in order to ensure individuals have enough medications to follow their treatment plans; maintain stabilization on the medications they were prescribed when incarcerated; and avoid decompensation in the period between release and any appointments they may have with their community-based physical and/or behavioral health providers.

DHCS' minimum requirements for correctional facilities with respect to having the processes and partnerships in place to provide medications in hand upon release include, but are not limited to, the following:

- Provide a "full" supply of medications in hand upon release with prescriptions for refills in place, as appropriate.
- Use a Medi-Cal-enrolled pharmacy to fill medications provided upon release.
- Comply with Medi-Cal's PA/ UM requirements.
- Support overdose prevention by providing naloxone upon release and a clinically appropriate supply of MAT with follow-up.

JI PATH funding will be available to assist correctional facilities in standing up new processes to support the provision of medications in hand upon release, including the processes for accepting deliveries from community pharmacies for release medications, PA processes, and IT infrastructure to enable the exchange of medication information between correctional facilities and pharmacies.

8.8.a Minimum Requirement #1: Provide Full Supply of Medications in Hand Upon Release with Prescriptions for Refills in Place, as Clinically Appropriate

Correctional facilities must provide a full supply of all active medications in hand upon release to incarcerated individuals receiving pre-release services. "Full supply" is defined as the maximum amount that is medically appropriate and allowed by the Medi-Cal State Plan. Correctional facilities will develop processes for providing prescribed medications in hand upon release at a minimum for individuals who have been incarcerated for more than 24 hours. Determining which medications are necessary can be based on any medication need identified through the standard medical screening

procedures and according to the timelines specified by the correctional facility for those procedures.

Example scenarios include the following:

- An individual diagnosed with a chronic disease (e.g., type 2 diabetes) should receive the maximum supply of the associated medications (e.g., metformin) as medically appropriate and allowable under the Medi-Cal State Plan.
- An individual with an acute condition (e.g., bacterial infection) should receive a sufficient supply of medications (i.e., antibiotics) to complete the prescribed course of treatment.
- An individual receiving medications that are required to be delivered by a clinician (e.g., long-acting injectables) should receive a final dose of the medication as close to release as possible, as indicated and medically appropriate.
- An individual receiving a controlled substance should receive the amount that is clinically appropriate based on the clinician's assessment (e.g., a one-week supply of opioids for someone with cancer-related pain).
- An individual diagnosed with SUD (e.g., OUD) should receive a supply that is deemed clinically appropriate and takes into account the date of their next follow-up appointment (e.g., a minimum of a 14-day supply of buprenorphine for an individual on a stable treatment dose and who has a follow-up appointment with their SUD treatment provider within two weeks of release).
- An individual taking OTC medications (e.g., ibuprofen following a dental procedure) should be provided with a supply of such medication from the correctional facility's general stock upon release, as indicated and medically appropriate. (Correctional facilities may prescribe and bill Medi-Cal for OTC medications if the provided medication is in a formulation that is covered by Medi-Cal's Contract Drug List.)

In addition to providing the medications in hand upon release, the correctional facility should submit a prescription for any active medication to a community pharmacy as appropriate and feasible so that the individual has access to refills. The prescriptions should be sent, in order of preference, electronically, by fax, by phone, or, as a last

resort, by providing the individual with a handwritten prescription.[85] The preference is to have medications submitted to a community pharmacy near the individual's anticipated residence in the community, as clinically appropriate.[86] Providing both a supply of medications and an opportunity to obtain refills will allow the individual sufficient time to establish relationships with community providers upon release and further reduce the risk of gaps in medication adherence upon reentry to the community.

As part of the discharge planning process, the pre-release services care manager will be responsible for developing a list of active and discontinued medications that will be provided to the individual upon release. This list should include the name and dosage of all medications and the name of the dispensing pharmacy. The pre-release services care manager will also work with the post-release care manager (if different) to support the individual in transferring medication refill orders to the individual's preferred community pharmacy, as necessary. The proposed approach will require close coordination between correctional facility staff (including both health and non-health staff) and the pre-release care manager. Correctional facility staff responsible for monitoring lengths of stay and discharge planning are expected to provide timely notice to correctional facility health care staff and the pre-release care manager of upcoming releases of all persons receiving JI pre-release services.

Best Practices. Some best practices for ensuring that individuals receive medications to have in hand upon their release include the following:

- Multiple Prescriptions. In order to improve prescription fill times, Los Angeles County jails process and fill two prescriptions for medications – one supply of medications to be dispensed while incarcerated and one to be provided in hand upon release.
- Storing Medications with Personal Property. When the release date is known and imminent, correctional facilities can provide discharge medications to be included

[85] Without a health information exchange between correctional facilities and pharmacies, sending prescriptions electronically will not be possible and paper prescriptions will be the norm, at least initially. DHCS hopes electronic prescription submissions become the norm as correctional facilities and implementation partners continue to expand the JI program and build information exchanges.

[86] DHCS understands there will be operational complexities for many individuals leaving prison who do not have an established residence/pharmacy. DHCS expects, 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.

in an individual's personal property. Such an approach allows medications to be provided upon release, even if the release dates change or if the individual is released during times when pharmacy services are unavailable or limited (e.g., the middle of the night or on weekends). DHCS recognizes that such an approach may not always be possible (e.g., in correctional facilities where individuals' property is kept off-site).

- Medical Checkout. Los Angeles County has developed an approach in which incarcerated individuals are engaged for a final health and medical visit just prior to release. During this medical checkout, the responsible staff ensure that the individuals are provided with medications/prescriptions in hand. Such an approach is especially beneficial for individuals with unexpected or sudden releases who are unlikely to have received other forms of discharge planning. Medical checkouts should ideally include correctional facility health staff, the pre-release care manager, and the individual being released. Components of the medical checkout could include the following:
    - Review of active and discontinued medications.
    - Dispensing of all active prescribed or OTC medications upon release, including necessary medications that are to be taken when scheduled or as needed.
    - Confirming the pharmacy to which prescriptions for active medications will be submitted.
- Patient Consultation. Where correctional facilities have an on-site pharmacy, a patient consultation should be conducted by an on-site pharmacist, similar to hospital discharge practices.

8.8.b Minimum Requirement #2: Use of Medi-Cal-Enrolled Pharmacy and Compliance with Existing Medi-Cal Rules

Correctional facilities will be required to obtain medications from a Medi-Cal-enrolled pharmacy, using all standard Medi-Cal Rx processes, in order for the prescriptions to be paid for under the CalAIM JI Reentry Initiative. Correctional facilities that currently do not have a Medi-Cal-enrolled pharmacy will be required to enroll their pharmacy as a Medi-Cal provider, contract with a Medi-Cal-enrolled pharmacy vendor, or obtain medications from a Medi-Cal-enrolled community pharmacy. Correctional facilities will be required to bill and submit claims to Medi-Cal for all prescription medications provided upon release.

Additional information on pharmacy billing is available in ***Section 10***, Pre-Release Service Rate Setting.

8.8.c Minimum Requirement #3: Comply with Medi-Cal's PA/UM Requirements

Correctional facilities and partnered Medi-Cal-enrolled pharmacies will be expected to comply with existing Medi-Cal PA/UM requirements. DHCS, in partnership with Magellan, accepts and processes PA requests and provides a response to the submitting Medi-Cal provider within 24 hours of receiving a PA request (or the next business day if the request is received after hours), pursuant to applicable state law.[87,88] The pre-release services care manager will be responsible for supporting the submission of PAs and will coordinate with the Medi-Cal pharmacy to ensure that medications are available for provision to individuals upon release. Establishing PA history during the pre-release period will support the individual's transition into the community by creating a documentation trail of prior approvals for needed medications in the community.

8.8.d Minimum Requirement #4: Overdose Prevention – Naloxone Upon Release and Clinically Appropriate Supply of MAT With Follow-up

At the time of release, all individuals must be offered naloxone and instruction on its use, regardless of any history of OUD. For individuals with OUD, correctional facilities and pre-release care managers should additionally ensure access to opioid treatment and related resources at the time of release. Correctional facilities should provide individuals, as medically indicated, with MAT medications at the time of release and facilitate a warm handoff to community providers through the behavioral health warm linkage process.

Individuals recently released from correctional facilities with a history of opioid use have an elevated risk for overdose. Overdose education and naloxone distribution programs have been implemented in correctional settings across a number of states, with one study showing that such a program was associated with a 36 percent decrease in overdoses in the four weeks following release.

Naloxone is a Medi-Cal-covered drug, and many correctional facilities already provide group training on naloxone for those in custody. Distribution of naloxone to all

[87] *See* Welfare & Institutions Code § 14133.37. DHCS, Medi-Cal Rx PA/UM and Related Appeals Processes (Version 3.1). Available at: https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/Medi-Cal-Rx-Prior-Authorization.pdf

[88] There are several ways to submit a PA request for review. Medi-Cal Rx will accept PA requests via the following methods: NCPDP P4 – Request Only; online via the Medi-Cal Rx provider portal or CoverMyMeds®; fax; U.S. mail. Source: Medi-Cal Rx Provider Manual

individuals leaving jail was identified as a best practice during the CalAIM JI Advisory Group meetings. In California, pharmacists can already dispense naloxone without a prescription from a health care provider, as authorized and in compliance with Business and Profession Code Section 4052.01.

8.9 Durable Medical Equipment Upon Release

As part of its targeted set of pre-release services, DHCS will cover DME that is provided upon release from a correctional setting.[89,90] Medi-Cal will not cover DME that is provided to an individual while they are incarcerated.

Individuals eligible for pre-release services are entitled to all Medi-Cal State Plan covered DME upon release when such DME is considered medically necessary, if prescribed by a physician, nurse practitioner, clinical nurse specialist, or physician assistant.[91,92] DME is "medically necessary" if it preserves bodily functions essential to activities of daily living or is needed to prevent significant physical disability. Medi-Cal may also cover DME that helps a parent/guardian care for a child. DME coverage is limited to the lowest-cost item that meets the individual's medical needs. A member's need for DME must be reviewed annually by a provider.[93]

DHCS seeks to accomplish the following goals through the provision of DME upon an individual's release from a correctional facility:

- Ensure that all individuals reentering the community have access to the DME they need.
- Enable individuals to easily replace their DME in the community (if equipment is lost, damaged, stolen, etc.).
- Ensure individuals who have an immediate need for residential DME have access to the needed equipment upon release.

[89] CalAIM JI Advisory Group: Review of Justice-Involved Initiative Policy and Operational Process Expectations (July 2022). Available at: https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/CalAIMJIAdvisory072822.pdf

[90] DHCS does not need 1115 waiver expenditure authority to provide DME to individuals, as such services will be provided to the individual when they are no longer an inmate.

[91] Durable Medical Equipment (DME): An Overview (September 2020). Available at: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/DE2DC0F1-4109-442F-BDB5-E8125DD45EFB/dura.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO

[92] DHCS acknowledges that short-term stays and unplanned release dates may impact correctional facilities' ability to provide DME to individuals upon release.

[93] See Appendix B for a full list of Medi-Cal-covered DME.

Aligned with the above goals, DHCS's minimum requirements for providing DME upon release are described in the following subsections.

8.9.a Minimum Requirement #1: Identification of Need and Provision of DME in Hand Upon Release

Correctional facilities must screen for and provide necessary DME upon release for any individual who is incarcerated for longer than 14 days. The need for DME can be identified at any time during incarceration (e.g., at intake, at an evaluation that occurs 14 days after booking, at a pre-release care manager-initiated meeting). Correctional facilities' clinical providers are responsible for identifying and addressing DME needs, though they may be supported by the pre-release care manager, the post-release ECM provider, and in-reach clinical consultants.

The pre-release care manager must include an individual's DME needs and a plan for acquiring DME within the person's transitional care plan. They must help coordinate with the correctional facility to facilitate the individual's access to DME upon release.

DME can be ordered/delivered in a variety of ways, depending on the preferences and capabilities of the correctional facility. Facilities that currently send individuals into the community with the DME they used while in custody may continue to do so. Alternatively, facilities that prefer to individually order DME and bill it to Medi-Cal upon the individual's release may do so.

While DHCS is requiring that correctional facilities provide all needed DME upon release for any individual with a stay longer than 14 days, DHCS expects that facilities will provide any needed DME required for an individual to safely reenter the community, even for those with a stay of less than 14 days.

8.9.b Minimum Requirement #2: Provision of DME Prescriptions Upon Release

Correctional facilities must ensure that, at a minimum, individuals who use DME reenter the community with a prescription for their DME in hand. The pre-release care manager and the post-release ECM provider should also receive copies of the prescription.

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. DHCS anticipates that providing prescriptions – in addition to DME – at the time of release will support individuals in their ability to obtain the needed DME in the community, especially for DME that requires replacement or refills (e.g., oxygen

tanks), until the individual is able to develop relationships with their MCP and community providers.

Sometimes an individual with an identified DME need may not receive the necessary DME in hand upon release (e.g., due to a short stay or unforeseen delays in procuring the needed DME). In such cases, correctional facilities must provide DME prescriptions in hand upon release to the individual, to be filled in the community. The pre-release care manager should document in the reentry plan a plan for filling the prescription in the community. The post-release ECM care manager will be responsible for helping to coordinate the filling of these DME prescriptions as needed.

8.9.c Minimum Requirement #3: Coordination to Ensure Residential DME Will Be in Place When Needed

Some individuals reentering the community may need DME to be set up in their home or residence in the community so that it is available when they are released. One example of DME that would require at-home setup would be a transfer system to assist an individual in moving between a wheelchair and the toilet. The provider prescribing DME, supported by the pre-release care manager, will be responsible for determining whether an individual has a need for residential DME. For individuals requiring residential DME, the correctional facility, pre-release care manager, and post-release ECM provider must coordinate to ensure that residential DME is in place when needed.

As described in ***Section 8.9.b***, 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 with the individual, the pre-release care manager, and the post-release ECM provider, to be filled in the community.

8.9.d DHCS Standard Policy for Providing DME Upon Release

Correctional facilities opting to bill Medi-Cal for DME that will be provided upon release must follow all existing Medi-Cal rules related to the provision of DME.[94] Such correctional facilities are responsible for familiarizing themselves with existing Medi-Cal rules; DHCS will provide technical assistance to stakeholders as needed.

[94] Additional information about DHCS's billing rules for DME are available on the DHCS website. Select references include:

a. Durable Medical Equipment (DME): An Overview
b. Durable Medical Equipment (DME): Bill for DME
c. Durable Medical Equipment (DME): Billing Codes

The following bullets summarize the steps for providing and prescribing DME, in keeping with existing Medi-Cal rules (a potential model for provision of DME which follows the steps below can be found in Table 11).

1. The correctional facility provider or the pre-release care manager identifies an individual's need for DME.
2. The treating provider[95] has a face-to-face encounter with the member that is related to the primary reason the recipient requires the DME. (Face-to-face encounters may be done via telehealth.)
3. The treating provider must communicate the clinical findings of that encounter to the prescribing prescriber.[96] The treating provider and the prescribing provider may be the same person (e.g., a clinician at the correctional facility).
4. The prescribing provider writes a prescription for needed DME, documenting that the face-to-face encounter has occurred within six months prior to the date on the DME prescription.
5. The prescribing provider submits the DME prescription with all needed documentation to the rendering provider.[97]
6. The rendering provider dispenses the needed DME and bills for services, submitting a treatment authorization request (TAR), as needed.

8.9.e Operational Approach and Illustrative Roles and Responsibilities

Correctional facilities, pre-release care managers, and post-release ECM providers will coordinate to ensure provision of DME in keeping with the minimum requirements described earlier in this section. The table below shows the operational approach for providing DME in cases where the DME will be billed to Medi-Cal, as well as an illustrative description of the roles and responsibilities of correctional facilities, pre-release care managers, and post-release ECM providers.

DHCS anticipates that roles and responsibilities may vary across correctional facilities and counties. As such, it will allow flexibility in the roles and responsibilities related to delivering DME. One potential model for the provision of DME is described in Table 11

[95] The treating provider is the provider performing the face-to-face encounter that is required for all DME (physician, nurse practitioner, clinical nurse specialist, or physician assistant).
[96] The prescribing provider is the provider writing the DME prescription (physician, nurse practitioner, clinical nurse specialist, or physician assistant).
[97] The rendering provider is the provider providing/dispensing the DME (i.e., the DME vendor).

below.

Table 11. Potential Model for Provision of DME					
#	**Step**	**Operational Approach**	**Correctional Facility (CF) Role**	**Pre-Release Care Manager (CM) Role**	**Post-Release ECM Provider Role**
1	**Identify Need for DME**	Assess individuals for potential DME needs through a medical record review, interview with the individual, clinical assessment, and/or coordination with other providers (e.g., physicians, physical therapists, occupational therapists) to obtain further clinical assessments as needed. This may occur at any point during an individual's incarceration.	Provide CM with access to necessary records and staff.	**Identifies initial DME need (*Lead*)**	
2	**Face-to-Face Encounter with Provider**	Once the DME need has been identified, a qualified provider (i.e., physician, nurse practitioner, clinical nurse specialist, or physician assistant) conducts a face-to-face encounter to validate the reason the patient requires the DME. The face-to-face encounter must occur within six months of when			

Table 11. Potential Model for Provision of DME					
#	**Step**	**Operational Approach**	**Correctional Facility (CF) Role**	**Pre-Release Care Manager (CM) Role**	**Post-Release ECM Provider Role**
		the prescription for DME is written, and findings should be shared with the individual's pre-release care manager and incorporated into the correctional facility medical record. The face-to-face encounter may be completed through methods that include:			
		a. Assessment by correctional facility staff (e.g., in the comprehensive medical assessment 14 days after intake).		**Perform assessment (*Lead*)**	Coordinate, as needed
		b. Assessment by in-reach clinical consulting provider.		Provide clinical consultant with facility permissions	**Coordinate assessment (*Lead)***
		c. Pre-release care manager reviews prior records.		Provide CM with access to records	**Review records (*Lead)***
3	**Treating Provider Communicates Clinical Findings**	The correctional facility provider (as opposed to the in-reach clinical consulting provider) should be responsible for prescribing and dispensing DME,		**Support communication if face-to-face provider is in-reach provider (*Lead*)**	

Table 11. Potential Model for Provision of DME					
#	**Step**	**Operational Approach**	**Correctional Facility (CF) Role**	**Pre-Release Care Manager (CM) Role**	**Post-Release ECM Provider Role**
	to Prescribing Provider	as they are responsible for supporting the individual's reentry into the community. As such, if the face-to-face encounter is conducted by an in-reach clinical consulting provider (or through care manager record review), the treating provider must communicate the clinical findings from the face-to-face encounter to the prescribing provider. The care manager should be kept informed of and support communication between the treating provider and prescribing provider. In scenarios where a correctional facility provider both conducts the face-to-face encounter and writes the prescription, the providers would serve as both the			

Table 11. Potential Model for Provision of DME					
#	**Step**	**Operational Approach**	**Correctional Facility (CF) Role**	**Pre-Release Care Manager (CM) Role**	**Post-Release ECM Provider Role**
		treating and prescribing providers.			
4	**Provider Prescribes DME**	Write the prescription for appropriate DME using standard DME ordering requirements. CF provider and pre-release CM collaborate to determine whether the DME should be provided (1) in hand upon release or (2) via in-residence setup.	**Write prescription (*Lead*)**	Support determination of mode of DME delivery.	
5	**Submit DME Prescription**	Submit DME prescription to rendering provider with necessary documentation for TARs, as appropriate.		**Submit prescription for DME needed upon release (*Lead*)**	(Submit prescription if needed after release)
6	**Rendering Provider Provides DME**	Rendering provider supplies DME. Correctional facility provider and pre-release care manager coordinate to ensure that the individual receives the DME (1) in hand upon release or (2) via in-	**Ensure delivery of DME upon release (*Lead*)**	Support as needed	(Support delivery of DME if the individual will obtain it after release)

Table 11. Potential Model for Provision of DME					
#	Step	Operational Approach	Correctional Facility (CF) Role	Pre-Release Care Manager (CM) Role	Post-Release ECM Provider Role
		residence setup – as well as the DME prescription, as appropriate.			

9. Provider Enrollment and Payment

9.1 FFS Delivery Model

Pre-release covered services will be delivered, claimed, and paid for via Medi-Cal's FFS delivery system. DHCS will allow both providers embedded 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, but all pre-release providers must enroll in Medi-Cal as an FFS provider. The sections below provide additional detail on which providers must enroll as Medi-Cal providers and the applicable pathway for doing so.

9.2 Medi-Cal Provider Enrollment (Community-Based Providers)

Community-based providers must enroll under existing Medi-Cal provider types, using existing processes (the full list of Medi-Cal provider types is available on DHCS's provider enrollment website). For example, a community-based physician providing clinical consultation services would need to be enrolled as a physician/surgeon provider type to receive reimbursement.

DHCS is not creating new FFS/PAVE enrollment requirements for rendering providers above and beyond what is currently required. DHCS is also in the process of establishing a 'community-based organization' provider type which will be eligible to provide JI pre-release services (e.g., care management) - more information about the CBO provider type will be made available in future guidance.

9.3 Medi-Cal Provider Enrollment (Correctional Facilities)

Correctional facilities must enroll as Medi-Cal providers to be reimbursed for the delivery of targeted pre-release services (e.g., care management, as appropriate; clinical consultations, as appropriate; medications; MAT; radiology; and laboratory services) and behavioral health linkages. As part of the approved Reentry 1115 Demonstration, California received approval that 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.

DHCS has identified the following pathway for correctional facilities to enroll as Medi-Cal providers.

Pharmacy Enrollment

- DHCS requires each CDCR facility and any jail or YCF facility with a pharmacy on-site to enroll as a Medi-Cal pharmacy.
- Enrollment will be location-specific, and only one pharmacy per site must enroll.
- Pharmacy enrollment information can be accessed here: https://www.dhcs.ca.gov/provgovpart/Pages/PharmacyProviderApplicationInformation.aspx

Provider Enrollment

- DHCS requires each CDCR facility, county jail, and YCF facility to enroll as a Medi-Cal exempt-from-licensure clinic.
- Enrollment will be location-specific, and only one enrollment per site is required.

Medi-Cal FFS provider application information for exempt-from-licensure clinics can be found on the DHCS website. The PAVE online portal allows for the registration and login of multiple roles; therefore, someone in an administrator role can create and complete an application for each location and then route the applications to an individual authorized to sign and submit pursuant to California Code of Regulations, title 22, section 51000.30(a)(2)(B).

Federal and state law requires all providers who provide medical care to have a national provider identification (NPI), meaning each correctional agency will need to register for an NPI. Facilities within an agency (e.g., jails in the same county or all state prisons) can apply as an organization; each facility with a pharmacy requires a unique NPI.

As mentioned above, DHCS is not creating new FFS/PAVE enrollment requirements for rendering providers above and beyond what is currently required. Additionally, the approved STCs waive DMC and SMHS certification requirements for correctional facilities and their vendors.

Correctional facilities will be required to ensure that any embedded providers they employ or contract meet minimum credentialling requirements that mirror DHCS enrollment requirements to provide services. The identification of these providers will be confirmed through implementing partners' implementation plan and readiness assessment.

9.4 Role of the Correctional Facility in Provision of Services

DHCS recognizes that many correctional facilities do not yet have processes in place to claim or bill for Medi-Cal services. JI PATH Round 3 dollars are available to support development of the infrastructure and processes for Medi-Cal billing/claims. DHCS is committed to providing targeted technical assistance to assist correctional facilities in developing or modifying EHRs and billing systems.

To effectuate the delivery of Medi-Cal covered services, correctional facilities will need to establish operational processes to both (1) allow in-reach providers to provide services and (2) develop billing/claims processes with DHCS to confirm services have been provided when furnished by correctional facility providers. Specifically, correctional facilities will need to develop processes to support the following:

- **Pre-Release Care Manager Assignment.** Correctional facilities will need to initiate the assignment of a care manager; care managers can be either correctional (e.g., correctional staff or contracted) or community-based providers. If the care manager is a correctional/contracted provider, the correctional facility will need to build processes for warm handoffs to community-based providers.
- **In-Reach Care Management, Clinical Consultation, and/or CHWs.** Correctional facilities will need to provide support for scheduling and facilitating virtual or in-person appointments as indicated with in-reach care managers, clinical consultations and CHWs, as appropriate; the pre-release care manager will play an important coordinating role in setting up the clinical consultations and CHW appointments, as appropriate.
- **Medications, MAT, and Labs/Radiology.** Correctional facilities will be responsible for delivering medically necessary medications, MAT, labs, and X-rays. Facilities may leverage their existing processes for delivering these services and will be reimbursed for the provision of such services based on claims submitted and adjudicated.
- **Post-Release Medication and DME.** Correctional facilities will play an important role in helping to ensure individuals have access to Medi-Cal-covered medications and DME in hand upon release and prescriptions for refills or replacements.

9.5 Embedded/In-Reach Provider Considerations

Care management and clinical consultations may be provided by either embedded/contracted or in-reach community-based providers. (CHW services must be provided only by in-reach providers.) In-reach services may be delivered via telehealth or in person by community-based in-reach providers, including care managers, behavioral health or physical health providers, CHWs, and peer support specialists (when applicable).

DHCS understands the potential barriers to facilitating the provision of services for in-reach providers:

- A community-based provider may need to complete a background check prior to their visit and then pass through multiple security checkpoints prior to entry for in-person visits; community-based providers may also have a one-time security clearance process for telehealth.
- There may be limited physical space or correctional officer capacity to transport individuals to allow private visits (in person or via telehealth).
- Strategies to make provision of in-reach services feasible could include:
    - Utilizing the consulting provider pathway to assist in-reach providers who provide services regularly.
    - Setting regular hours for in-reach providers (e.g., every Tuesday and Thursday from 8 a.m. to 2 p.m.).
    - Leveraging telehealth to minimize in-person visits.

DHCS recognizes that in some counties the department of health or county behavioral health agency provide both behavioral health services to correctional facilities *and* community-based services. In those circumstances, the determination of whether the provider is embedded or in-reach/community-based would be based on the role of the provider is playing and whether the provider has a contract with the Sheriff's Office to provide such services. If the provider is furnishing services in their role as a correctional facility contracted entity and performing services that correctional facilities are required to provide, those services would be considered embedded services and therefore billed through the correctional facility NPI.

Alternatively, if the provider is acting on behalf of the county in their role in the community – for example, accepting a warm linkage – that service would be considered

in-reach. See Table 12 for types of providers, both embedded and community-based, and provider examples.

Table 12. Provider Type, Embedded or Community-Based, Provider Examples and NPI

Type of Provider	Embedded	Provider Examples	Correctional Facility or Separate Provider NPI
Correctional agency staff	Yes	Psychiatrist employed solely by correctional facility	Correctional Facilit NPI
Staff contracted by correctional agency	Yes	Private contractor (e.g., Wellpath) clinician or county behavioral health provider providing correctional facility behavioral health services as outlined in contract with Sheriff's Office.	Correctional Facilit NPI
Community-based provider who provides services (not under contract of the correctional facility) to individuals via telehealth and/or by traveling to the correctional facility	No (referred to as in-reach provider)	CHW, county behavioral health provider performing services not under contract of the correctional facility (includes receiving behavioral health warm linkage/professional-to-professional warm handoff)	Community-Based Provider NPI

9.6 ECM Provider Network

MCPs are responsible for administering ECM for the JI POF in the community and developing a sufficient network of JI ECM providers to meet the needs in the county in which they operate. All contracted JI ECM providers must meet DHCS' definition of a "JI

ECM Provider", in addition to the standard provider requirements put forth in the ECM Policy Guide. Additional details on ECM for the JI POF can be found in the ECM Policy Guide, and detailed requirements for MCP implementation of ECM for the JI POF can be found in ***Section 13.***

10. Pre-Release Service Rate Setting

10.1 Billing and Claims Approach for Pre-Release Services

DHCS will pay for all pre-release services under Medi-Cal 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. In addition:

- Federally Qualified Health Centers (FQHCs) may bill and claim within the FFS system, outside of the PPS rate for any in-reach pre-release services just like any other provider.
- Tribal Clinics may bill their existing all-inclusive rates for any pre-release services done as an in-reach provider through CA-MMIS.

Behavioral health linkages for SMI or SUD to county behavioral health plans (i.e., SMHP, DMC, DMC-ODS) will be able to submit claims through normal processes utilizing Short Doyle; all other behavioral health pre-release services will be billed FFS directly by providers through CA-MMIS rather than through the county behavioral health plan. DHCS expects to leverage existing rates, payments, policies, and procedures for these services with a few modifications to account for some of the complexity of doing this work in correctional facilities. For example:

- DHCS is exploring 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 is also exploring the use of bundled rates for some targeted services, such as care management services.

10.1.a. Billing for Services by Embedded Providers:

As described above in ***Section 9.5***, services that are rendered by the correctional facility staff or any of their contracted providers for services which they are already required to provide (meaning required to provide prior to go-live of pre-release services) or have historically provided are considered to be embedded services. All of these services should be billed through the correctional facilities enrolled exempt from licensure clinic (see ***Section 9.3***) using CA-MMIS.

- Services that can only be billed by embedded providers:
    - Laboratory Services
    - Radiology
- Services that can only be billed by in-reach providers:
    - CHW
    - Receiving Care management warm linkage
    - Receiving behavioral health warm linkage
- Services that could be billed by either embedded or in-reach providers based on contracting arrangements and historically provided services at the correctional facility include:
    - Care Management
    - Clinical Consultation
    - MAT
    - DME

DHCS understands that many correctional facilities use multiple different contractors for different services and may not have their own billing and claiming expertise. DHCS allows for providers to use third party administrators to submit claims on their behalf. In these instances, correctional facilities could contract with a separate third-party administrator to submit all claims on their behalf or the correctional facility could add language to their existing contracts with each of their contractors to have them act as a third party administrator, submitting claims for services they perform under the correctional facility clinic NPI. In these circumstances, claims would be adjudicated, and the correctional facility would be paid. Correctional facilities would still negotiate contracts with their vendors to perform services.

10.1.b. Services Provided by County Behavioral Health Providers or MHPs:

The only pre-release services where MHPs, DMC, DMC-ODS will participate as a health plan is for behavioral health linkages, as mandated by *AB 133*. In order to maximize the effectiveness of behavioral health linkages, including record sharing with the MHP, leveraging a provider network and credentialling processes, and ensuring continuity of care for those who require SMHS or SUD services, behavioral health linkages to SMHS or SUD will be billed through Short Doyle. Specific codes that can be used will be identified

by DHCS at a later date. Only the DHCS identified codes will be billed through Short Doyle during the pre-release services.

All other pre-release services that could be delivered by county-based providers, including clinical consultation, care management, and MAT should be billed as either in-reach or embedded as defined **in Section 9.5.**

10.1.c. Medications/Pharmacies:

Per federal and state laws, the pharmacy that dispenses the medication is responsible for billing Medi-Cal through Medi-Cal Rx. The pharmacy may use a third-party administrator to submit the claims, but they must be submitted under the NPI of the pharmacy that dispensed the medication.

10.2 Proposed Approach for Care Management Bundles

DHCS will pay for all pre-release services under Medi-Cal FFS. Claims will be able to be submitted through normal processes utilizing CA-MMIS for medical services including care management, clinical consultations, laboratory, and radiology and Medi-Cal Rx for pharmacy services. DHCS expects to leverage existing rates, payments, policies, and procedures for these services with a few modifications to account for some complexity of doing this work in correctional facilities, including:

- DHCS is exploring 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 is also exploring the use of bundled rates for some targeted services, such as care management services.

In response to stakeholder feedback related to billing and claiming for care management services in the FFS environment, DHCS is exploring development of five care management bundles for CalAIM JI pre-release services. The following care management bundles do not include community health worker services, such as patient outreach and education. Supervisors of in-reach community health workers will be able to bill Medi-Cal under FFS for delivery of community health worker services.

Additionally, if providers do not meet the minimum required services to bill the bundles described below, providers are able to bill existing individual services under FFS care management CPT codes.

10.2.a. Bundle 1: Full Needs Assessment

Minimum Documentation Needed to Bill Bundle:

- Completed whole-person care plan assessment documented in medical record including assessment of mental health, substance use, physical health, housing needs, other health-related social needs, and functional needs. A licensed professional (RN care manager or LCSW) must participate in and oversee the completion of the assessment. Unlicensed individuals may participate in the completion of the assessment, for example in obtaining records and consent for information sharing and completing health-related social needs and functional needs screening.
    - Must include documentation of at least one face-to-face or telehealth encounter/assessment with member directly by the licensed professional. This encounter must include either direct assessments of each area, or review with the member of any prior assessments through prior medical record review and other documentation review with identification of new or resolved needs or the documentation of no new additional needs. This could occur over multiple visits/encounters as needed, but can only be billed once full assessment is complete.

Specific Requirements/Tasks Included in Bundle:

- Meet with member (face to face or through telehealth) to conduct/review assessment.
- Review prior records, as available.
- Obtain informed consent, when needed, to furnish services and/or to share information with other entities to improve coordination of care
- All components of the needs assessment must be completed with the member, consider current needs and needs that may arise upon reentry into the community. The needs assessment will be leveraged to prioritize the pre-release services, including any needed clinical consultations and as the basis for the robust reentry plan. The needs assessment must include the following:
    - **Physical health needs assessment:** Inclusive but not limited to: prior medical issues, any symptom burden, potential for undiagnosed conditions, need for clinical consultations; needs for medications, needs for DME, needs for IHSS, needs

for establishing care with primary care and any specialists in preparation for release, preventative care access (e.g., cancer screening, vaccinations, a physical exam within the last year).

- **Mental health needs assessment:** prior mental health treatment and diagnoses; use of validated screening tools; need for clinical consultations; identification of any needed medications for release, identification of potential benefit for long-acting injectable use, identification of need for BH warm linkages, identification of need for mental health follow-up and appropriate level of care.
- **Substance use disorder needs assessment:** prior substance use disorder treatment and diagnoses; use of validated screening tools; identification of potential need for MAT; identification of potential benefit for long-acting injectable use; identification of any needed clinical consultations; identification of need for BH warm linkages; identification of need for substance-use disorder follow-up and appropriate level of care.
- **Housing needs assessment**: Identification of planned housing upon release and identification of any housing needs.
- **Other health-related social needs assessment:** Identification of needs member may have upon release including but not limited to: any needs related to access to food or to medically tailored meals; transportation needs; cell phone/smart phone access; social support including who should be included in care plan: family/friends/parole/probation.
- **Functional needs assessment:** identification of needs member may have related to functioning in community upon release such as medication management; scheduling community-based appointments; paying bills; utilizing electronic communication.

10.2.b. Bundle 2: Creation of care linkages and coordination with community-based providers and services

Minimum Documentation Needed to Bill Bundle must include at least one of the following that occurred during the billing week:

- Scheduling clinical consultation with appropriate data sharing.
- Meeting with clinical consultants with documentation of discussion.
- Scheduled appointment with community-based provider inclusive of any needed data sharing.
- Facilitation of warm linkage with community-based provider inclusive of any needed data sharing.
- Completion and submission of forms or documentation for any needed prior authorizations, TARs, applications for residential mental health services, or applications for social services such as housing.
- Face-to-face or telehealth encounter with member to update care plan/assessment.

Specific Tasks Included in Bundle:

- Pre-release coordination with any post-release clinical consultant to address and/or identify physical health, mental health, or substance use disorder needs, including coordinating any needed labs, radiology, or medications (including MAT).
- Pre-release coordination, including non-patient and patient facing, as needed, to create care linkage to community-based provider.
- Pre-release coordination to arrange appointments with or admission to physical and behavioral health care providers, including specialty county behavioral health coordinators and managed care providers, as relevant to care needs.
- Ensure individual has any necessary DME prescriptions, including coordinating with providers to perform face-to-face visits, documentation of medical necessity, and prescriptions.
- Assist in information exchange and obtaining consent as needed to facilitate care with in-reach providers and other community care providers.
- Assist with any prior authorization or treatment authorization requests on submitted and collecting any needed information.
- Facilitate warm linkage with member and community-based provider.
- Ensure coordination and receipt of pre-release services.

This bundle will be billed for services delivered pre-release. References to the post-release ECM provider in this bundle refers to the community-based care manager who

will become the ECM provider in the community post-release. This bundle does *not* include actual warm linkage meetings and all coordination between pre-release care manager and post-release ECM care manager for the warm linkage (this is included in Bundle 3).

10.2.c. Bundle 3: Care Manager Warm Handoff

This bundle would only be billable if the pre-release care manager is different from the post-release ECM Care Manager (for example, in an embedded pre-release care manager model)

Minimum Documentation Needed to Bill Bundle:

- Participation in warm linkage face-to-face or telehealth encounter that at minimum must include member and community-based provider to introduce new care manager and review current assessment and/or release plan with the member and identify any additional needs. *(Can include pre-release embedded care manager, and if embedded care manager participates in face-to-face or telehealth meeting with member, they can also bill this code. If the pre-release embedded care manager does not participate in meeting with client, they can bill inter-professional consultation code for time meeting with post-release ECM provider.)*
    - Must include documentation of face-to-face or telehealth encounter with member directly
      AND
    - Sharing of assessments and current reentry care plans

Specific Requirements/Tasks Included in Bundle:

- Participate in face-to-face or telehealth visit with member to meet new post-release ECM care manager.
- Review and update needs assessments and reentry care plan with member.
- Provide education on reentry plan and reentry services.
- Modify reentry care plan based on new knowledge of community resources or input from member.
- Post-release care manager must receive and discuss care plan with pre-release care manager and receive all appropriate records and information from the pre-release period.
- Obtain any necessary consents for information sharing.

This bundle will be billed for services delivered pre-release. References to the post-release ECM provider in this bundle refers to the community-based care manager who will become the ECM provider in the community post-release.

10.2.d. Bundle 4: Final care plan created and delivered to client upon release

Minimum Documentation Needed to Bill Bundle:

- Completed final care plan documented in medical record including release plans related to mental health, substance use, physical health, health related social needs, and functional needs. Final care plan must be completed in collaboration with member and must be shared with post-release care manager and the member.

Specific Requirements/Tasks Included in Bundle:

- Complete discharge/reentry person-centered care plan, created with the client, with input from the clinician providing consultation services and correctional facility's reentry planning team. Provide care plan with member and confirm all connections and appointments required as part of the reentry plan have been scheduled, completed or have plans to be completed with a responsible care manager in clinically appropriate time.
- Complete data exchange, as allowed under federal and state laws, that includes beneficiary authorizations, reentry care plan, and necessary medical records, with post-release care manager and managed care plans, and, as relevant, with physical and behavioral health/SMI/SUD providers to enable timely and seamless hand-offs.
- Confirm individual has medications/prescriptions in hand upon release.
- Confirm individual has any needed DME or DME prescriptions in hand upon release.

10.2.e. Bundle 5: Post-transition support

Minimum Documentation of Services for Community-based care manager to bill bundle: Must include documentation of at least one of the following: (Note: This is only billable prior to MCP effective date.)

- Warm linkage occurs with embedded provider.
- Assist individual in getting to a follow-up appointment.
- Meet with individual face-to-face or via telehealth.
- Assist in or complete submission of forms/documentation for services (e.g., housing applications; DME TAR requests).

- Scheduling new appointment with information sharing that is needed.
- Assisting with MCP communication for needed services such as community supports.

Specific Requirements/Tasks Included in Bundle:

- Conduct follow-up with community-based providers to ensure engagement was made with individual and community-based providers within clinically appropriate time, but no later than 1 day after recommended follow-up. (i.e., if follow-up has been recommended during release planning for care within 1 day of release [ex: someone on MAT who needs to see a prescribing substance use provider very quickly], the scheduled appointment should be scheduled within a 1-day timeframe of the recommended follow-up).
- Conduct follow up with the individual to assist with individual being able to engage with community-based providers, behavioral health services, and other aspects of transitional plan within clinically appropriate time, but no later than 1 day after recommended follow-up.
- Conduct in-person visit with individual to assess for any newly identified needs and assist individual in connecting to services to meet those needs.
- Facilitate information sharing with health plans, care providers, and community supports as needed and as is appropriate based on consent and information sharing laws.

Embedded providers are also eligible to bill this bundle as follows

Minimum Documentation of Services for Embedded provider to Bill Bundle: (only billable if warm transition did not occur prior to release due to rapid, unexpected, or circumstances outside of correctional facility control that prevented warm linkage prior to release. Prior to release is the goal.)

- Warm linkage occurs between embedded provider, member, and community-based provider
  OR
- Warm linkage occurs between embedded provider and community-based provider.

11. Reentry Planning

11.1 ECM Eligibility

The Adult and Youth Transitioning From Incarceration ECM POF aligns with the eligibility criteria to receive 90-day pre-release Medi-Cal services in order to ensure that individuals who are eligible to receive pre-release services will also be eligible to receive ECM upon reentry into the community, if they are enrolled in managed care.

Table 13. Individuals Transitioning From Incarceration ECM POF Definitions[98]	
Adults	Individuals who: • Are transitioning from incarceration or transitioned from incarceration within the past 12 months **AND** • Have at least one of the following conditions: ○ Mental illness ○ SUD ○ Chronic condition/significant clinical condition ○ Intellectual or developmental disability (I/DD) ○ Traumatic brain injury ○ HIV/AIDS ○ Pregnancy or postpartum
Children/ Youths	Youths who are transitioning from incarceration or transitioned from incarceration from a YCF within the past 12 months

Please see the ECM Policy Guide (updated December 2022) for more details on ECM.

11.2 Pre- and Post-Release Warm Handoff Requirement

When different individuals provide pre- and post-release care management services (i.e., if the correctional facility leverages an embedded care management model), the two

[98] The conditions listed above align with the eligibility criteria for targeted pre-release services that will be available to inmates in CFs, as requested in California's 1115 Demonstration Amendment and Renewal Application as of the date of publication of this Guide. The above criteria are subject to change based on CMS's approval of California's 1115 waiver.

care managers must conduct a warm handoff with the individual prior to release. The warm handoff is the first step in establishing a trusted relationship between the individual and the new care manager and ensuring seamless service delivery and coordination. See section 8.4.3, Requirements for Care Manager Warm Handoff, for detailed requirements.

11.3 Managed Care Auto-Assignment and Current Month Enrollment

To ensure smooth re-entry, continuity of care management relationships, and efficient access to providers, DHCS intends to develop new processes for individuals eligible for pre-release services who are not currently enrolled in an MCP, and who are eligible for an MCP. This process will (1) auto-assign individuals into an MCP (with the choice period available post-release, in the community), and (2) establish current month enrollment (i.e., an individual would be enrolled in an MCP beginning the first of the month in which they are released).

1. Auto-Assignment:
    - *For individuals who already have Medi-Cal and an assigned MCP upon entry to the correctional facility,*
        - The individual's MCP enrollment will be put in a 'hold' status for up to 12 full months of incarceration. This will allow the individual to maintain the same MCP after release, without having to go through another MCP enrollment process and for MCP activation to happen as soon as the suspension is lifted.
        - Plan assignments will not be disrupted for existing MCP members who remain in the same county as where they resided before incarceration.
    - *For individuals who <u>do not</u> have Medi-Cal nor an assigned MCP upon entry to the correctional facility,*
        - The individual will be assigned an MCP, triggered by the activation of the JI aid code. The individual's MCP enrollment will be put in a 'hold' status for up to 12 full months of incarceration. This will allow MCP activation to occur as soon as the suspension is lifted.
        - DHCS will auto-assign Medi-Cal-enrolled individuals into an MCP in their county of residence listed on their Medi-Cal application. DHCS will use existing processes to auto-assign individuals into an MCP, including prior plan assignment and plan assignment of family members. If neither of these two criteria enables plan assignment, the individual will be placed into a plan using the default algorithm. Members may switch plans after auto-assignment.

- Individuals will be sent a confirmation letter with the plan assignment and information on how to change plans, as needed.

2. Communicating Current Month Enrollment to MCPs:
    - Incarcerated individuals with an assigned MCP in a hold specific to JI status will be noted as such in the daily/monthly 834 file which DHCS shares with MCPs. This will be for any JI incarcerated Medi-Cal member with a suspended primary aid code and MCP, not just those with pre-release services.
    - In the daily/monthly 834 file, there will also be a JI indicator, which is applied when the JI pre-release service aid code is activated. This is how MCPs will become aware of the JI population for whom they are responsible.
    - After an individual is auto-assigned to an MCP, upon release DHCS will activate the individual's plan enrollment for the current month (i.e., if the member is released on April 15, the individual will be enrolled in the plan starting April 1). The MCP must send the individual a welcome packet to the address listed on their Medi-Cal application, including information on how to access the provider directory and member handbook. The MCP must begin to care for the member the day of release (including ECM services provided on the day of release).

Ensuring that MCP assignment occurs when the JI aid code is turned on and/or ensuring that an individual is reassigned to an MCP in which they were previously enrolled will allow the correctional facility time to coordinate with the MCP on reentry planning. See ***Section 13.3.a.*** for additional details on MCP requirements related to auto-assignment and current month enrollment.

11.4 Behavioral Health Linkages

Correctional facilities, county behavioral health agencies, and MCPs will be required to implement linkages to behavioral health providers to achieve behavioral health care initiation or continuity through professional-to-professional clinical handoffs as set forth 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)*. state prisons, county jails, youth correctional facilities, county behavioral health departments, and MCPs to implement processes for facilitated referrals and linkages to continued behavioral health treatment in the community for individuals who receive behavioral health services while incarcerated (see ***Section 11.4.d.*** for a breakdown of roles and responsibilities for implementing behavioral health linkages).

Behavioral health-related pre-release services and behavioral health linkages will be provided in partnership by county behavioral health agencies, pre-release care managers, providers, and correctional facilities. Specifically, behavioral health linkages include referrals and professional-to-professional clinical handoffs for Justice-Involved individuals to the following Medi-Cal delivery systems post-release:

- **SMHS/County MHP:** If an individual is identified as needing MHP services at any point of incarceration, they will qualify for SMHS and require a behavioral health linkage with a county SMH provider prior to release.
- **DMC/DMC-ODS:** If an individual is identified as needing MAT at any point of incarceration, they will qualify for DMC/DMC-ODS and require a behavioral health linkage to county DMC or DMC-ODS provider prior to release. If an individual meets diagnostic criteria for a SUD diagnoses they will qualify for DMC/DMC-ODS and require a behavioral health linkage with a DMC or DMC-ODS provider prior to release.[99]
- **MCP or FFS Providers:** If an individual has an identified behavioral health need that does not meet criteria for SMHS (e.g., members defined on page 4 of APL 22-006), their mental health needs will be managed by providers through their managed care plan. These individuals will have their behavioral health warm linkage facilitated through the care manager/ECM provider.

In order to identify behavioral health needs, correctional facilities and pre-release care managers will be required to screen for mental health and substance use need (see ***Section 6.4*** for additional detail on this screening process). Once the pre-release care manager has completed the full needs assessment with tools and processes mutually agreed upon by the correctional facility and the county behavioral health agency, the

[99] Beneficiaries 21 years and older: To qualify for DMC-ODS services after the initial assessment process, beneficiaries 21 years of age and older must meet one of the following criteria: i. Have at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, OR ii. Have had at least one diagnosis from the DSM for Substance Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, prior to being incarcerated or during incarceration, determined by substance use history.
Beneficiaries under the age of 21: Covered services provided under DMC-ODS shall include all medically necessary SUD services for an individual under 21 years of age as required pursuant to Section 1396d(r) of Title 42 of the United States Code. Federal EPSDT statutes and regulations require States to furnish all Medicaid-coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, regardless of whether those services are covered in the state's Medicaid State Plan. Consistent with federal guidance, services need not be curative or completely restorative to ameliorate a mental health condition, including substance misuse and SUDs. Services that sustain, support, improve, or make more tolerable substance misuse or an SUD are considered to ameliorate the condition and are thus covered as EPSDT services.

pre-release care manager will determine whether the individual's behavioral health needs either meet the criteria for county behavioral health referral (SMHS/MHP, DMC, or DMC-ODS) or will be addressed by non-specialty behavioral health services. A detailed process flow of these pathways can be found in ***Section 11.4.c.***

Goals of Behavioral Health Linkages. Behavioral health linkages will allow for commencement or continuation of behavioral health treatment once individuals are released to the community. In order to support a comprehensive, robust, and successful reentry process, behavioral health linkages should, at a minimum:

- Optimize data sharing between correctional facilities and counties to identify individuals with mental illness and/or SUD.
- Ensure coordination and information sharing related to care plans and transition/discharge plans, scheduling of community-based appointments, and completion of consent forms (including written consent per 42 C.F.R. part 2) among the correctional facility behavioral health providers, the county behavioral health providers, and, as applicable, the pre-release care manager and ECM provider developing the transition reentry care plan.
- Leverage in-reach clinical consultations[100] to facilitate relationship building prior to release and enable professional-to-professional clinical handoffs with post-release behavioral health treatment providers.
- Ensure there are scheduled/available follow-up appointments with behavioral health providers and necessary prescribers upon release for those with behavioral health needs.
- Ensure the post-release care manager and/or CHW will help individuals connect to any needed services and show up for the behavioral health appointments.
- Facilitate connections between pre-/post-release enhanced care managers and parole/probation officers to ensure they are aware of any connections made with county behavioral health providers.

[100] As part of the CalAIM JI pre-release services, eligible individuals will receive behavioral health clinical consultation services provided through telehealth or in person, as needed, to diagnose health conditions, provide treatment as appropriate, and support the pre-release care manager's development of a post-release care plan and discharge planning.

11.4.a Behavioral Health Linkages and Pre-Release Services

Behavioral health linkages will work hand in hand with pre-release services; however, in order to provide needed linkages to high-need JI members, DHCS will require some behavioral health linkage services to go live prior to a county's implementing pre-release services. Table 14 outlines behavioral health services under the CalAIM JI Reentry Initiative and the authority under which they can be provided; note that services can be provided either in-person or via telehealth. Table 15 provides additional detail on the roles and responsibilities of the county behavioral health agency related to each of the activities in the table.

Behavioral health-related pre-release services and behavioral health linkages will be provided in partnership by county behavioral health agencies and correctional facilities. Correctional facilities will be required to facilitate processes and referrals necessary for providing these services. If correctional facilities contract county behavioral health agencies to assist in providing pre-release services, contracts will be required to clearly delineate each agency's responsibilities.

Pre-release services that may overlap with those provided by the county behavioral health agencies (if contract is in place between correctional facilities and county behavioral health agencies to provide behavioral health services) include screening/assessment, obtaining consent, and behavioral health treatment – including MAT, clinical consultations, and care management.

- **MAT.** Correctional facilities, under CalAIM, must offer and provide the full scope of MAT services to individuals who have an SUD in the 90 days prior to release. County behavioral health providers may enter into agreements, by mutual consent, with the correctional facilities to provide these services and bill Medi-Cal in the 90 days prior to release as an in-reach provider.
- **Clinical Consultations.** Under CalAIM, correctional facilities must offer clinical consultation services that stabilize and treat the individual and ensure they have a robust reentry plan and connections. County behavioral health licensed practitioners of the healing arts may enter into agreements with the correctional facility, by mutual consent, to bill Medi-Cal and provide in-reach behavioral health services in the 90 days prior to release, including assessments and treatments as well as clinician-to-clinician communications.
- **Pre-Release Care Management/Post-Release ECM.** Care management is a core function of the JI Reentry Initiative. The aim is to provide whole-person care both

pre-release and upon reentry, ideally with the same care manager, which, in many cases, can facilitate behavioral health warm linkages. Care management during the pre-release period will be done by a pre-release care manager in FFS. Post-release, after enrollment in an MCP, care management will continue with an ECM provider. If the pre-release care manager is not the same person as the ECM provider, a warm handoff will be required prior to release. County behavioral health providers may choose to be an ECM provider and also provide pre-release care management. If they are not the pre-release care manager, they will work closely with the care manager and ECM provider to ensure behavioral health warm linkages occur. To distinguish the whole-person care management roles of the pre-release care manager and ECM providers and the roles of the providers for provision of behavioral health warm linkages, see key definitions and roles and responsibilities in ***Section 11.4.d.***

Behavioral health and pre-release covered services will be delivered, billed to, and paid for via Medi-Cal's FFS delivery system. To provide and bill for pre-release services, providers must enroll in Medi-Cal as a FFS provider. If a correctional facility and county behavioral health agency contracts with the county behavioral health agency or its subcontracted providers will provide pre-release services, services will be billed by the correctional facility. For non-contracted in-reach services outside of the specific behavioral health warm linkages activities, providers can enroll and bill Medi-Cal FFS through CA-MMIS.

Pre-Release services are the responsibility of correctional facilities; to ensure services are provided, correctional facilities can contract with other entities, including county behavioral health.

The completion of Behavioral Health Linkages are under the responsibilities of both correctional facilities and county behavioral health plans to complete for anyone with SMI/SUD. For professional billable services under behavioral health linkages (see Profession-to-Professional warm handoff in Table 14), county behavioral health plans may bill Short Doyle, and correctional facilities may bill CA-MMIS. Table 14 outlines the behavioral health-related services that are provided within the CalAIM JI Reentry Initiative and indicates whether the service is considered part of the pre-release services or behavioral health linkages requirement.

Table 14. Responsibilities for Pre-Release Services and Behavioral Health Linkages		
Activity	**Description of County Behavioral Health Agency[101] Responsibilities**	**Pre-Release Service for Behavioral Health or Behavioral Health Linkage**
Screening/ Assessments for Behavioral Health Needs	Based on correctional facility capacity, correctional facilities may contract with a County behavioral health provider to perform behavioral health assessments. If correctional facility contacts County behavioral health agency to conduct an assessment the visit must occur within the same timeline as set in community standards or outlined in contract put in place with correctional facility. Correctional facility may also opt to have county provider participate as in-reach providers.	***Pre-Release Service for Behavioral Health, responsibility of correctional facility: performed either by corrections, by facility contracted provider (in some counties this may be through county BH plan); or if existing contract not in place, by in-reach providers.***
Consent	Based on correctional facility capacity, obtain consents, as needed, to provide clinical consultations during the pre-release period.	***Pre-Release Service for Behavioral Health, responsibility of correctional facility: performed either by corrections, by facility contracted provider (in some counties this may be through county BH plan); or if existing contract not in place, by in-reach providers.***
	Based on correctional facility capacity, obtain consents, as needed to assume	***Behavioral Health Linkage; Dual***

[101] Behavioral health-related pre-release services are the responsibility of the correctional facility, but they may contract for services or if a contract does not already exist, use an in-reach provider model. Behavioral health linkages will be provided in partnership by county behavioral health agencies and correctional facilities.

Table 14. Responsibilities for Pre-Release Services and Behavioral Health Linkages		
Activity	**Description of County Behavioral Health Agency[101] Responsibilities**	**Pre-Release Service for Behavioral Health or Behavioral Health Linkage**
	responsibility for care in the post-release setting and connect individuals to resources as needed.	***responsibility by County Behavioral Health and Correctional facility.***
Initial Data Sharing	Based on correctional facility requests: • Provide medical records as appropriate for individuals with treatment history.	***Behavioral Health Linkage; Dual responsibility by County Behavioral Health and Correctional facility.***
Behavioral Health Treatment, including MAT, and clinical consultations	Based on correctional facility capacity, correctional facilities may contract with a County behavioral health provider to perform timely in-reach behavioral health clinical consultations, assessments, counseling or therapy, Peer Support Services, MAT, other medications and/or medication administration, and any other DMC/DMC-ODS or SMHS service covered as part of the pre-release service benefit as appropriate. If correctional facility contacts County behavioral health agency to conduct behavioral health treatment, the visit must occur within the same timeline as set in community standards or outlined in contract put in place with correctional. If there is not an existing contract in place for these services, correctional facilities may elect to have in-reach providers, who may be county providers, provide these services.	***Pre-Release Service for Behavioral Health, responsibility of correctional facility: performed either by corrections, by facility contracted provider (in some counties this may be through county BH plan); or if existing contract not in place, by in-reach providers.***

Table 14. Responsibilities for Pre-Release Services and Behavioral Health Linkages		
Activity	**Description of County Behavioral Health Agency[101] Responsibilities**	**Pre-Release Service for Behavioral Health or Behavioral Health Linkage**
Data Sharing	Based on information shared by correctional facility, • Receive correctional facility medical record information and ensure that it incorporated into post-release medical record. • Identify any individuals who may benefit from professional-to-professional Clinical Handoff.	***Behavioral Health Linkage; Dual responsibility by County Behavioral Health and Correctional facility.***
Release Planning	• If individual consents, schedule follow-up appointment date/time/location within clinically appropriate window, as defined by care manager with input from clinical providers. Follow-up appointments should be scheduled no later than 1 business day after recommended timeline for urgent needs (e.g., MAT) and no later than 1 week for less urgent needs (e.g., a stabilized SMI follow-up appointment) • Work with MCP, as appropriate, to ensure transportation to appointment has been arranged. • *Best Practice: behavioral health provider meets individual in lobby upon release and escorts to follow-up care.*	***Behavioral Health Linkage; Dual responsibility by County Behavioral Health and Correctional facility.***

Table 14. Responsibilities for Pre-Release Services and Behavioral Health Linkages		
Activity	**Description of County Behavioral Health Agency[101] Responsibilities**	**Pre-Release Service for Behavioral Health or Behavioral Health Linkage**
Professional-to-Professional Clinical Handoff	• Participate in care transitions meeting, facilitated by pre-release care management team, for any client that has been identified by correctional staff, care manager, or clinical consultants as needing additional team coordination (e.g., clients identified to have high/complex needs). • This could include BH team members such as psychiatrists, psychologists, LSCWs, behavioral health care managers (TCM), or peer supports.	***Behavioral Health Linkage: Dual responsibility by County Behavioral Health Plan and Correctional facility. Billable by County Behavioral Health Plan through Short Doyle and by correctional facility through CA-MMIS***
Follow-Up Post-Release	• Offer to schedule individual for appointments on an ongoing basis as needed, within clinically appropriate timeframe, no later than 3 days later than recommended follow-up. • Work with MCP to ensure they have adequate transportation to appointment. • If individual does not come to appointment, follow-up with individual, consider deploying Certified Peer Support Specialist, and work with ECM provider to reschedule as soon as possible for individual.	***Behavioral Health Linkage: Responsibility by County Behavioral Health Plan, applicable services will be billable by County Behavioral Health Plan through Short Doyle***

Go-Live Timeline for Behavioral Health Linkages. DHCS has developed the following go-live timelines for implementing the behavioral health linkages requirements.

- **For individuals reentering the community from state prisons**
    - CDCR must implement all components of behavioral health linkages, as identified in Table 14, including initiating referrals to county behavioral health agencies, by April 1, 2024.
    - County behavioral health agencies must implement all components of behavioral health linkages (see Table 14), including the ability to receive referrals from correctional facilities in all counties, by April 1, 2024.
- **For individuals reentering the community from jails and YCFs**
    - Jails and YCFs must implement all components of behavioral health linkages when they go live with pre-release services.
    - County behavioral health agencies must implement all components of behavioral health linkages, including the ability to receive referrals from correctional facilities in all counties, by April 1, 2024, except the professional-to-professional clinical handoffs.
    - The professional-to-professional clinical handoff component of behavioral health linkages would be a requirement for a county behavioral health agency only when the referring correctional facility is live with pre-release services and the pre-release aid code is active, as this service leverages pre-release enrollment/screening processes.
-

11.4.b Minimum Requirements for Behavioral Health Linkages

To achieve continuity of treatment for individuals who receive behavioral health services while incarcerated and will continue to receive behavioral health services from SMHS, DMC, and/or DMC-ODS in the community, DHCS will require correctional facilities and county behavioral health agencies to work in partnership to facilitate behavioral health professional-to-professional clinical handoffs to post-release behavioral health providers

and share information with the individual's health plan (e.g., county MHP, DMC/DMC-ODS counties, and MCPs as needed). [102]

To operationalize behavioral health linkages for individuals who will receive services through SMHS/MHPs, DMC, and DMC-ODS, DHCS has laid out the following minimum requirements for correctional facilities, county behavioral health agencies, and pre-release care management providers/post-release ECM providers:

- Correctional facilities will be required to leverage their existing processes to screen and identify individuals who may qualify for a behavioral health linkage.
- County jails and YCFs will be expected to screen for this need at intake; CDCR will be expected to leverage existing treatment plans to screen for need.
- Pre-release care managers should review all available records related to behavioral health care (in the correctional facility and the community) and if standard screening was not already performed, complete the standardized behavioral health screening to identify behavioral health needs, determine whether a behavioral health linkage is needed, and build the care plan.
- Once a correctional facility implements pre-release services, they are responsible to implement any needed pre-release services, including but not limited to behavioral health clinical consultations including clinical assessment, patient education, therapy, counseling; MAT and psychosocial services delivered in conjunction with MAT; and care management as part of the pre-release services benefit, as appropriate. County behavioral health agencies may enter into agreements or amend current agreements as needed, by mutual consent, with the correctional facilities to provide or support in-reach provision of pre-release services related to reentry behavioral health treatment.
- As part of warm linkages, County behavioral health agencies will be required, within 14 days prior to release (if known) and in coordination with the care

[102] MCPs must manage the behavioral health needs of individuals who do not meet the criteria for SMHS, DMC or DMC-ODS, including ensuring their care manager/ECM provider conducts a warm handoff to behavioral health services. MCPs must support reentry coordination by:

1. Ensuring that the post-release ECM providers participate in behavioral health transition meetings, warm handoffs and follow-up planning;
2. Ensuring individual has transportation to appointments in the community; and
3. Assisting individual with appointment scheduling.
4. Warm handoffs should include follow-up planning, including confirming transportation, following up regarding any missed appointments.
5. Ensuring infrastructure and processes are in place to share and receive data related to facilitating the behavioral health warm handoff.

manager, to ensure processes are in place for a warm linkage between the correctional behavioral health provider, a county behavioral health provider, and the member.

11.4.c Roles and Responsibilities

Table 15 outlines the roles, responsibilities, and requirements for correctional facilities, county behavioral health plans and providers, care managers, MCPs, and DHCS in order to operationalize this process. DHCS understands that the provision of these services is dependent on the member's length of stay. DHCS will provide additional detail on provision of services in the short-term model guidance. At a minimum, DHCS requires asynchronous data exchange and care coordination (e.g., the correctional facility or pre-release care manager coordinates with the county behavioral health agency on identification of behavioral health needs, appointment scheduling, referral, etc.) for members who are incarcerated for less than 15 days.

The following roles and services are essential in establishing behavioral health linkages:

- **Correctional Embedded Clinical Staff.** A clinical provider employed or directly contracted by the correctional facility (e.g., Wellpath provider, or contracted County BH provider (see embedded provider definitions in ***Sections 9.5 and 10.1.a***)) to provide health care services (physical health and behavioral health) in the correctional facility.
- **County Behavioral Health Provider.** A county-operated or county-contracted behavioral health provider who meets state plan qualifications. If acting as in-reach provider to provide pre-release services, they are not acting under the county's behavioral health plan, but under the correctional facility.
- **County Behavioral Health Plan.** County based health plan, inclusive of MHPs and DMC and/or DMC-ODS operating in their capacity as a plan and not as a provider (e.g., arranging provision of SMHS, contracting/credentialing providers, etc.)
- **Pre-Release Care Manager.** The person who will act as the quarterback to ensure whole-person reentry services are provided as outlined by the CalAIM JI policy. The care manager will work, as appropriate, with other providers, including correctional facility providers, post-release care managers, county behavioral health providers, and the MCP care manager if different from the pre-release care manager.

- **Post-Release ECM Provider.** The person who will act as the quarterback after reentry, once the individual is enrolled in an MCP and at any point during the post-release period enrollment gap when the individual is still in the FFS delivery system. If this provider is different from the pre-release care manager, they should have a warm handoff of the member, ideally at least two weeks prior to release.
- **TCM.** TCM services, covered under SMHS or DMC/DMC-ODS, are pre-release services that can be billed as in-reach services by the county behavioral health agency in order to facilitate warm linkages to these care management providers, who will provide behavioral health-specific care management services post-release. TCM will only be billed if someone meets the eligibility criteria for and needs additional targeted case management support specific to behavioral health linkages.
- **Peer Supports.** Peer supports services, covered under SMHS or DMC/DMC-ODS (depending on the county), are covered pre-release services that can be billed as in-reach services by the county behavioral health agency in order to facilitate warm linkages to these peer support providers, who will provide behavioral health-specific support services post-release.
- **MCPs:** MCPs must manage the behavioral health needs of individuals who do not meet the criteria for SMHS, DMC or DMC-ODS, including ensuring their care manager/ECM provider conducts a warm handoff to behavioral health services, which could be achieved through contract provisions. MCPs must have infrastructure and processes in place to share and receive data related to the behavioral health linkage. MCPs must support reentry coordination by:
    1. Ensuring that the post-release ECM providers participate in behavioral health transition meetings, warm handoffs and follow-up planning;
    2. Ensuring individual has transportation to appointments in the community; and
    3. Assisting individual with appointment scheduling.
    4. Warm handoffs should include follow-up planning, including confirming transportation, following up regarding any missed appointments.

Table 15. Proposed Roles and Responsibilities for Behavioral Health Linkages						
Process	**Correctional clinical staff** (including behavioral health clinical staff)	**Behavioral health provider** (may be county employed or county-contracted)	**Pre-release care manager**[103] (ideally same provider as post-release ECM provider)	**Post-release ECM care manager** (ideally same as in-reach care manager)***, with MCP oversight responsibility***	**County Behavioral Health Plan**	**DHCS**
Identification of Behavioral Health Need and Coordination of Treatment Pre-Release						
Screening and assessing for behavioral health needs	At screening and assessment, identify anyone with behavioral health needs and stratify to the best of their ability: 1. Anyone who qualifies for SMHS, using the state-provided tool. 2. Anyone who qualifies for DMC/DMC-ODS services, based on medical need. 3. Those with behavioral health needs that do not qualify for SMHS or DMC/DMC-ODS services and will be	Perform behavioral health assessments at correctional facility if contracted to do so. If a correctional facility contacts the county behavioral health agency to conduct an assessment, the visit must occur within normal community standards or as written in the contract.	Provide a comprehensive needs assessment, inclusive of identifying any behavioral health needs through standardized screening tools and any further needed assessments. If not already done, identify those who have been treated in the community for behavioral health and identify their provider.	NA	Only participates if under contract with correctional facility, billing would be submitted by correctional facility.	Develop guidance to allow in-reach behavioral health providers to bill and submit claims for behavioral health assessment.

[103] This can be community-based in-reach provider, correctional staff, correctional facility vendor, county behavioral health provider (if contracted to do so or acting as an in-reach provider), or county health department

Table 15. Proposed Roles and Responsibilities for Behavioral Health Linkages						
	served through an MCP (members defined on page 4 of APL 22-006). Identify those who have been treated in the community for behavioral health and identify their provider.					
Consent	Obtain any needed consents related to receiving information from prior providers, the county behavioral health plan, and/or the MCP. Obtain any needed consent to share information with a county behavioral health agency, the MCP, a care manager, and the behavioral health provider, as indicated. Note that consent will need to be specifically obtained to share SUD data (42 C.F.R. part 2).	Obtain consents as needed to share the requisite information with any care team member/insurance.	Obtain consents as needed to gather information or share the requisite information with any care team member/ insurance.	NA	NA	Provide guidance on needed consent and data-sharing expectations.

Table 15. Proposed Roles and Responsibilities for Behavioral Health Linkages						
Initial data sharing	**All Correctional Facilities:** If the individual has been identified as having received treatment in the community prior to incarceration, the correctional clinical/ support staff must contact the prior treating provider within 48 hours to obtain treatment records.	Share medical records as applicable and allowable under federal and state regulations.	**Care Managers Across All Correctional Facilities:** If the individual has been identified as having received treatment in the community prior to incarceration, the care manager must contact the prior treating provider(s) if not already done by the correctional facility to obtain treatment records. Care managers should then review all available records related to behavioral health care (community and correctional facility) and use that information when developing the needs assessment and care plan. Care manager should also notify MCP (if enrolled), county BH (if implicated) that county behavioral health care coordination is occurring, as necessary. **Care Managers for Jails:** If an individual has	NA	If the correctional facility or pre-release care manager is unable to identify or obtain records directly from the prior treating behavioral health provider, the county behavioral health agency can identify the prior treating provider as necessary. Share medical records as appropriate for individuals with a treatment history. Notify the MCP (if enrolled) that county behavioral health care coordination is occurring, as necessary	Develop data-sharin guidance to allow the exchange of information betwee correctional facilities and county behavioral health agencies, MCPs, and in-reach care managers.

Table 15. Proposed Roles and Responsibilities for Behavioral Health Linkages						
			an identified behavioral health need, the care manager must contact the county behavioral health agency in the county they will be released to, their prior county-contracted behavioral health provider if applicable, and their MCP (if already enrolled) within 48 hours to alert them that they have an individual who will need behavioral health linkages at release; the care manager should request prior patient information, as available, and share patient information with relevant health plans. **Care Managers for CDCR:** If an individual is part of the Mental Health Services Delivery System and/or receiving ISUDT, CDCR must, within 60 to 90 days prior to the individual's			

Table 15. Proposed Roles and Responsibilities for Behavioral Health Linkages						
			release, contact the county behavioral health agency in the county they will be released to and share relevant patient information. **Care Managers for YCFs:** If a youth is found to have a behavioral health need during incarceration, the probation officer must contact the county behavioral health agency in the county they will be released to, their prior county-contracted behavioral health provider if applicable, their CHW if applicable, and their MCP (if enrolled) to alert them that they have an individual who will need a behavioral health linkage at release and to share the patient's information.			
	Pre-Release Treatment					

Table 15. Proposed Roles and Responsibilities for Behavioral Health Linkages						
Behavioral health treatment, including MAT, clinical consultations, and care management	Provide in-reach care or support for any necessary ongoing behavioral health needs, including assessments, counseling or therapy, peer support services, MAT, other medications and/or medication administration, and any other DMC/DMC-ODS service or SMHS covered as part of the pre-release services benefit as appropriate. Correctional facilities (and probation officers for YCFs) must facilitate appointments with county behavioral health agencies and community-based behavioral health providers as needed.	If contracted or requested by a correctional facility, provide in-reach behavioral health clinical consultations, assessments, counseling or therapy, peer support services, MAT, other medications and/or medication administration, and any other DMC/DMC-ODS service or SMHS covered as part of the pre-release services benefit as appropriate.	Identify and coordinate any needed clinical consultations or behavioral health needs to stabilize individuals in preparation for release. Identify high-risk clients who would benefit from clinical consultation, to establish therapeutic relationships with their post-release behavioral health provider and schedule in-reach clinical consultations for those individuals.	If different from the pre-release care manager, coordinate on the treatment plan and clinical consultation needs.	Only participates if under contract with correctional facility to provide treatment services, billing would be submitted by correctional facility.	Develop guidance to enable in-reach behavioral health providers to bill and submit claims for in-reach care management; in-reach behavioral health clinical consultation, including assessments, counseling or therapy, peer support services, MAT, other medications and/or medication administration, and any other DMC/DMC-ODS service or SMHS covered as part of the pre-release services benefit.
	Behavioral Health Linkages					
Data sharing for release	For ALL members with behavioral health needs, share clinical information, including	Identify any individuals who may benefit from a transitional care team meeting.	For ALL clients with behavioral health needs, incorporate their clinical information into the	For ALL clients with behavioral health needs, coordinate with the pre-release care manager (if	For ALL clients with behavioral health needs, receive and	Develop guidance to allow for data sharing of the transitional care plan with the

Table 15. Proposed Roles and Responsibilities for Behavioral Health Linkages						
	medications, diagnoses, and pertinent treatment notes, with receiving providers, health plans, and care managers.		care plan. Maintain copies to ensure that appropriate care team members have the needed information. Work with clinical staff to identify any individuals who may benefit from a transitional care team meeting.	different from the post-release care manager) on the care plan. For identified complex clients with high needs: Participate in the care team transition meeting for any client who has been identified by correctional staff, the care manager, or clinical consultants as needing additional team coordination.	ensure that their clinical information is part of the client medical record to facilitate seamless treatment after release.	post-release care manager, the county behavioral health agency, and the client's assigned MCP (as available).
Release planning	Identify an appropriate time frame for needed follow-up, and assist the pre-release care manager as needed with scheduling follow-ups and any needed transportation.		Schedule follow-up appointments and identify the appropriate time frames for needed follow-up. Schedule transportation to all needed appointments. Perform screening/ assessment with tools and processes mutually agreed upon by the correctional facility and county behavioral health	Work with the pre-release care manager (if different), the client, and the probation/parole officer as needed to ensure scheduled appointments will work for the client. Ensure transportation is arranged for all follow-up appointments. **Best Practice:** If the behavioral health	Offer follow-up appointment date, time, and location within a clinically appropriate time but no later than three days after the recommended follow-up (e.g., for someone on MAT with a recommended follow-up of the next day post-release, the appointment must be within four days post-release). Ensure	NA

Table 15. Proposed Roles and Responsibilities for Behavioral Health Linkages						
			agency, to identify the appropriate level of follow-up care. If different from the post-release care manager, ensure the post-release care manager is aware of all needed follow-up appointments and assist in scheduling.	provider is unable to meet the individual, the care manager should meet the individual in the lobby upon release and escort them to follow-up care.	transportation to the appointment has been arranged. **Best Practice:** The behavioral health provider should meet the individual in the lobby upon release and escort them to follow-up care.	
Professional-to-professional clinical handoff	For complex clients with high needs[104] who have been identified as such by in-reach clinical consultants, the care manager, or correctional staff, participate in the care team transition meeting with the correctional facility behavioral health provider, the county behavioral	For identified complex clients with high needs, as requested by the county health plan, participate in the care team transition meeting for any client who has been identified by correctional staff, the care manager, or clinical consultants as needing additional team coordination.	For identified complex clients with high needs, schedule, coordinate, and participate in the care team transition meeting for any client who has been identified by correctional staff, the care manager, or clinical consultants as needing additional team coordination. Professional-to-	For identified complex clients with high needs, participate in the care team transition meeting for any client who has been identified by correctional staff, the care manager, or clinical consultants as needing additional team coordination. Professional-to-professional clinical	For identified complex clients with high needs, identify providers appropriate to participate in clinician-to-clinician handoff and facilitate scheduling and data sharing.	Develop guidance to enable in-reach behavioral health providers to bill and submit claims for professional-to-professional clinical handoffs.

[104] Complex clients with high needs include (1) anyone who is identified by their treating provider or their care manager as needing this service; (2) anyone with co-occurring SUD and SMI; (3) anyone with a history of overdose or at high risk of overdose; (4) anyone who will be released to unstable housing; (5) anyone whose first language is not English; (6) anyone who is a new patient to county-based behavioral health services.

Table 15. Proposed Roles and Responsibilities for Behavioral Health Linkages						
	health provider, the care manager/ECM provider, and the client as appropriate.	This may include an intake or clinical visit with the client to establish a therapeutic relationship prior to release.	professional clinical handoff should also include follow-up planning, such as confirming transportation to scheduled appointments, follow-up or touch points in advance or following a missed appointment, and assigning a CHW.	handoff should also include follow-up planning, such as confirming transportation to scheduled appointments, follow-up or touch points in advance or following a missed appointment, and assigning a CHW.		
Follow-up post-release	Provide any needed information/ communication to the treating provider post-release to ensure there are no disruptions in needed care.	Offer to schedule the individual within a clinically appropriate time frame, no later than three day after the recommended follow-up. Ensure they have adequate transportation to the appointment. If the individual does not show up for the appointment, follow up with them, consider deploying a CHW, and work with the ECM provider to reschedule as soon as possible for the individual.	If the clinical handoff to the post-release care manager/ECM provider has not occurred, assist the individual with transportation to all needed appointments and ensure the professional-to-professional clinical handoff with the ECM provider occurs.	Ensure individuals get to all needed appointments and have all needed medications and services.	Offer to schedule the individual within a clinically appropriate time frame, no later than three days after the recommended follow-up. Ensure they have adequate transportation to the appointment. If the individual does not show up for the appointment, follow up with them, consider deploying a CHW, and work with the ECM provider to reschedule as soon as possible for the individual.	Develop guidance to enable community-based providers to claim and bill on an FFS basis if the individual is not enrolled in an MCP upon release.

12. Monitoring and Evaluation

12.1 Overview

The following describes DHCS's approach to supporting a successful implementation of JI reentry services and behavioral health linkages across correctional facilities and county SSDs:

- **Formal Guidance to Justice and Social Services Agencies.** DHCS will release guidance to correctional facilities and SSDs in the form of ACWDLs and related guidance that includes detailed descriptions of program and compliance requirements and of each stakeholder's role in supporting them.
- **Justice and Social Services Agency Readiness Assessments.** DHCS will require correctional facilities and SSDs, prior to launching pre-release services, to complete two readiness assessments that will gauge their readiness to comply with the waiver's program and regulatory requirements. The first readiness assessment, conducted in December 2022, focused on the implementation of pre-release Medicaid applications. The second readiness assessment will be conducted after CMS approves the waiver and will focus on correctional facilities' and SSDs' readiness to support pre-release services, including assessments for pre-release services eligibility, service delivery, care management and coordination, and reentry planning. DHCS will use the findings from the readiness assessments to evaluate compliance with program and statutory requirements and identify any gaps that need to be addressed.
- **Implementation Technical Assistance.** DHCS will deliver technical assistance to correctional facilities and SSDs as they plan to implement the JI Reentry Initiative. technical assistance will be available prior to launching pre-release services, to support stakeholders in their implementation planning and compliance with section 1902(a) and other requirements. DHCS will also deliver more targeted and intensive technical assistance to counties and facilities where capability and/or compliance gaps are identified through the readiness assessments. DHCS anticipates continuing to provide technical assistance after the launch of pre-release services as counties and facilities gain more experience with the program and navigate compliance issues.
- **Ongoing Reporting and Monitoring.** DHCS will require correctional facilities and SSDs to submit data on DHCS-specified measures to monitor program performance and integrity. While DHCS is in the process of defining these measures, it anticipates

the measures will address key priorities such as the length of time to facilitate Medi-Cal enrollment and length of time that a member's coverage is suspended. DHCS will regularly monitor reported data and engage facilities and agencies that are not compliant with program or statutory requirements on an ongoing basis, including through the development of corrective action plans.

Additional guidance on DHCS's approach to monitoring and oversight will be released at a later date.

13. Managed Care Plan (MCP) Requirements for Implementing Enhanced Care Management for the Justice Involved Population of Focus

13.1 Overview

Care management is a critical component of the CalAIM Justice-Involved Reentry Initiative, which is intended to (1) support the coordination of services delivered during the pre-release period and upon reentry into the community; (2) ensure smooth linkages to services and supports; and (3) arrange appointments and timely access to appropriate care delivered in the community.

The care management model has four primary goals:

- Develop and facilitate a care plan to help stabilize conditions prior to release;
- Build trusted relationships between the individual who is incarcerated and the care manager, who will support the individual's transition back to the community;
- Create and implement a reentry care plan in consultation and collaboration with the individual and other providers; and
- Maximize continuity of care management and access to services, to the extent possible, as individuals transition between incarceration and reentry into the community.

The care management model begins with pre-release care management services available during the 90 days prior to an individual's release, which is paid for on a fee-for-service (FFS) basis by Medi-Cal. As described in ***Section 8.4***, the pre-release care manager is required to closely coordinate with the individual's post-release care management provider (i.e., Enhanced Care Management (ECM) provider),[105] including conducting a warm handoff – if the pre-release and post-release care managers are not the same person – to ensure continuity of care between the pre- and post-release periods.

While the targeted set of Medicaid pre-release services will be billed FFS, MCPs and ECM providers will play a key role as individuals transition from pre-release services into the community upon release. This section of the Policy and Operations Guide describes how the CalAIM Justice-Involved Reentry Initiative implicates MCPs and outlines

[105] Note that individuals who are not enrolled in an MCP will not receive ECM, since ECM is an MCP benefit, but they may receive another type of care management.

activities that MCP must execute to stand up and then implement the Initiative on an ongoing basis.[106] This chapter specifically outlines MCP responsibilities for implementing ECM for the Individuals Transitioning from Incarceration (JI) Population of Focus (POF) (hereinafter "JI POF") and the required infrastructure that MCPs must establish to ensure MCPs are able to successfully provide ECM to the JI POF, as close to the day of release as possible.[107] This chapter is organized into four sections, with data sharing requirements woven throughout each section: [108]

- ECM Network Development and Reporting
- Member Enrollment into an MCP and ECM
- Supporting Member Transition from Incarceration into Managed Care
- Post-Release MCP Services

13.1.a. Key Dates for MCP Implementation of the CalAIM Justice-Involved Reentry Initiative

ECM for the JI POF will go-live on January 1, 2024. On this date, MCPs must be prepared to begin providing ECM for the JI POF, which will include developing a JI ECM provider network. By January 1, 2024, MCPs will be required to:

1. Establish a sufficient network of JI ECM providers that meet DHCS' definition of "JI ECM Provider" and that meet the need for JI ECM services in the county in which they operate;
2. Establish JI ECM provider network overlap across MCPs in each county;
3. Create and maintain an up-to-date public provider directory that includes information about each in-network JI ECM provider; and
4. Begin reporting its JI ECM provider network to DHCS.

Correctional facilities may begin to provide pre-release services as early as April 1, 2024, once DHCS has determined the facility is ready for go-live, based on its readiness assessment (see ***Chapter 5*****).** Facilities' go-live timelines will be phased in over two years with all correctional facilities being required to go live by March 31, 2026. By April 1, 2024, MCPs will be required to begin to provide services to individuals who received

[106] Note that implications for MCPs are also woven throughout the Policy and Operations guide.

[107] Note that while ECM will become available to the individual once their MCP enrollment has been effectuated, correctional facilities and MCPs will begin the process of assigning an individual to an ECM provider prior to release and MCP enrollment.

[108] MCPs must also ensure that required services are available on the day of release, as clinically indicated, including seeking prior authorization for services such as Community Supports. DHCS is developing forthcoming policy requirements related to authorizing approval of prior authorizations in order to ensure receipt of services on or as close as possible to the day of release.

pre-release services and coordinate with correctional facilities to support members as they transition into managed care and ECM. Note that individuals who meet the JI POF eligibility criteria will be eligible for ECM prior to when pre-release services go live (see ***Section 13.3.b***).

13.1.b. ECM Model of Care (MOC) Requirement

All MCPs are required to complete the Model of Care (MOC) Addendum III, which DHCS will use to assess each MCP's readiness to implement ECM for the JI POF. The MOC follows the same format and sections as this chapter, so MCPs should refer to this chapter as they complete their MOC for policy details. Each section includes an attestation table; a number of sections also include narrative questions, which MCPs must complete to attest to their readiness to implement ECM for the JI POF. If the MCP does not have policies and procedures in place to implement a requirement, they will have the opportunity to request technical assistance from DHCS. MCPs must submit their responses to the MCP Readiness Assessment by September 1, 2023.

13.2. ECM Network Development and Reporting

MCPs are responsible for administering ECM for the JI POF in the community (i.e., once an individual is released from incarceration). To do so, MCPs must establish a JI ECM provider network in each county in which they operate. All contracted JI ECM providers must meet DHCS' definition of a "JI ECM Provider" in addition to the standard provider requirements put forth in the ECM Policy Guide.[109] This section lays out MCP requirements for developing its ECM provider network.

13.2.a. Minimum Requirements for JI ECM Providers

A key objective of the CalAIM Justice-Involved Reentry Initiative care management model is ensuring continuity of care between the pre- and post-release periods. In order to promote both continuity and quality of care management, DHCS will require MCPs to ensure that all providers with which they contract to provide ECM for the JI POF meet minimum expectations. All contracted JI ECM providers must meet the standard requirements to become an ECM provider, which are laid out in the ECM Policy Guide, in addition to several requirements that are unique to the JI POF. MCPs may leverage their provider contracts as a tool to ensure that all providers meet minimum expectations.

[109] Note that this MOC does not enumerate the ECM provider requirements that apply to all POFs, but rather requires that MCPs attest to their ability to contract with providers that meet the set of standard requirements in addition to the JI-specific requirements.

DHCS will provide standard boiler plate language that MCPs can pull into their contracts.

The minimum requirements described in Table 16 below align with the existing requirements in the ECM policy guide; the second column describes JI POF-specific requirements:

Table 16. Minimum ECM Provider Requirements	
Examples of Requirements that Apply to All ECM Providers[110]	**Additional Requirements and Recommendations that Apply to JI ECM Providers**
Enroll through state-level Medi-Cal enrollment pathway.	• For the JI POF, all JI ECM providers must enroll through the Provider Application and Validation for Enrollment (PAVE) system in order to provide FFS Medi-Cal services. [111] • DHCS intends to develop a Medi-Cal enrollment pathway for CBOs that serve as JI ECM providers in PAVE.[112]
Have experience serving the POF.	DHCS recommends that MCPs prioritize contracting with JI ECM providers that employ individuals with lived experience, including community health workers (CHWs).[113]
Have capacity to provide culturally appropriate and timely in-person care management activities.	No additional requirements or recommendations that apply to JI ECM providers.
Have formal agreements and processes in place to engage and cooperate with other entities to coordinate care as appropriate for each member.	MCPs must have operational processes in place to engage and coordinate with correctional facilities.

[110] The full set of ECM provider requirements can be found in the ECM Policy Guide.

[111] DHCS will establish a glidepath to this requirement. Additional details are forthcoming.

[112] An enrollment pathway for CBOs does not currently exist and needs to be developed. Additional information is forthcoming.

[113] DHCS understands that MCPs may encounter barriers to contracting with providers that employ individuals with lived experience, so this is considered a best practice, as opposed to a requirement.

Have expertise in providing core ECM-like services.	No additional requirements or recommendations that apply to JI ECM providers.
Must use a care management documentation system or process that supports documentation of integrated services and information.	No additional requirements or recommendations that apply to JI ECM providers.
Ensure each member is assigned a Lead Care Manager who interacts directly with the member and/or their family member(s), guardian, caregiver, and/or authorized support person(s), as appropriate.	• **If the correctional facility uses in-reach model:** DHCS requires the Lead Care Manager to be the same person as the pre-release care management provider. • **If the correctional facility uses an embedded model:** DHCS requires the Lead Care Manager to conduct a warm handoff with the pre-release care manager during the pre-release period, if possible.
Submit claims for the provision of ECM-related services to the MCP using the national standard specifications and code sets to be defined by DHCS, or invoices, adhering to DHCS' billing and invoicing standards.	No additional requirements or recommendations that apply to JI ECM providers.

In addition to the JI ECM provider requirements listed above, and to ensure continuity of care between the pre- and post-release periods, MCPs must contract with JI ECM providers that agree to enroll in Medi-Cal FFS.[114, 115] JI ECM providers must also agree to:

1. Offer FFS pre-release care management services as an in-reach care management provider; and
2. Conduct in-reach warm handoffs (i.e., pre- and post-release care management providers must meet with the individual to begin to establish a trusted relationship, review the reentry care plan, and discuss

[114] MCPs may contract with providers that only provide ECM services and do not agree to enroll in Medi-Cal FFS and provide pre-release care management services or participate in pre-release warm handoffs, but such providers would not be considered JI ECM providers.

[115] CBOs will be able enroll in Medi-Cal FFS via the PAVE application in changes that are forthcoming.

community-based services that the individual may access in the post-release period) with an embedded pre-release care management provider (e.g., correctional facility providers) prior to release in FFS.[116]

DHCS understands that JI ECM providers may not be able to enroll as FFS providers immediately, so DHCS will establish a glidepath for this requirement, with additional details forthcoming.

13.2.b. JI ECM Provider Network Sufficiency

MCPs must meet network sufficiency requirements (i.e., the MCP must contract with a sufficient network of JI ECM providers to meet the projected need in the county in which it operates). MCPs in each county must collaborate among themselves to project their anticipated needed JI ECM hours, by quarter, based on JI ECM client numbers and workload.[117] Each MCP must contract with enough JI ECM providers to meet their estimated projected need. Note that MCPs will be responsible for identifying JI ECM providers.

As a best practice for identifying appropriate JI ECM providers with which to contract, MCPs may consider:[118]

- Partnering with correctional facilities to identify providers that have demonstrated experience serving the justice-involved population;
- Reaching out to established organizations that serve the justice-involved population; and/or
- Contracting with organizations that employ individuals with justice-involved lived experience.[119]

DHCS assessment of network sufficiency will be based on:

- **MOC Addendum III.** MCPs must attest to their plans to contract with a sufficient network of ECM providers to meet the projected need in the county in which they operate in MOC Addendum III, and they must also describe how they plan to coordinate with other MCPs and correctional facilities to estimate ECM capacity

[116] See Section 8.4.e. for requirements for the care manager warm handoff.

[117] DHCS will provide rough county-level estimates for numbers of individuals who will be eligible for ECM under the JI POF. However, MCPs should supplement this information with county-specific data obtained through partnerships with correctional facilities. Additional details on how to determine estimates are forthcoming.

[118] See Best Practices for Engaging the Reentry Population in Health Care (Transitions Clinic Network).

[119] Example providers that serve the JI population include, but are not limited to: Amity Foundation, HealthRight 360, Neighborhood House Association - Project In-Reach, California Association of Alcohol and Drug Program Executives, Transitions Clinic Network, and WestCare,

needs and share estimates (if available). Lastly, MCPs must submit an Excel workbook that lists their anticipated JI ECM providers by county for DHCS review (see forthcoming ***MOC Addendum III, Provider Capacity Attachment: ECM Network Development*** available on DHCS' JI and ECM webpages).

- **Update of Anticipated Need for JI ECM.** DHCS may require MCPs to submit an update of their estimate of anticipated need of JI ECM providers six months after go-live of the JI pre-release services.
- **Provider 274 Form.** MCPs will be required to submit their JI ECM provider networks via a Provider 274 form, which DHCS will monitor.

13.2.c. Care Management Continuity Across the Pre- and Post-Release Periods

MCPs must ensure continuity of care for individuals who receive pre-release care management and post-release ECM services. To do so, MCPs must ensure that, to the extent possible, individuals receive care management services from the same provider in the pre- and post-release periods, starting on or as close as possible to the day of release.[120, 121]

To achieve this requirement, DHCS will require mandatory overlap of both pre-release provider networks and JI ECM provider networks as described below to the maximum extent possible, which will ensure that the provider that is assigned by the correctional facility in the pre-release period is guaranteed to be in-network, no matter which plan the Medi-Cal member is eventually enrolled in post-release.[122, 123]

DHCS will require MCPs to collaborate to contract with their JI ECM provider network in order to ensure network overlap.[124] DHCS will provide standard boilerplate contract language that each MCP can incorporate into their JI ECM provider contract/scope of work. MCPs may update or amend the boiler plate language as they see fit, and they

[120] Alternatively, a pre-release care manager could conduct a warm handoff with a post-release ECM provider, if pre-release and post-release providers are different. Note that post-release ECM services should begin on the day of release.

[121] To ensure continuity of care for individuals who will reenter the community in a different county from where they are incarcerated, the correctional facility should assign the individual a pre-release, in-reach care management/post-release ECM provider that works in the county in which the individual will be released. Pre-release services may be provided via telehealth (see CalAIM Policy and Operations Guide ***Section 13.3.e*** for details).

[122] This requirement aligns with the requirement that all ECM providers must agree to also provide pre-release, in-reach services through FFS.

[123] DHCS may consider other mechanisms to achieve the requirement of care management continuity starting on the day of release, including a single case agreements or letters of agreement.

[124] Network should be comprised of JI ECM providers that are enrolled in Medi-Cal FFS.

may add to the boilerplate language separate addenda to establish any further provisions between the ECM and JI provider, including rates.

To ensure mandatory provider overlap in each county, MCPs are expected to notify the other plans in their counties when they identify a new JI ECM provider. MCPs should also monitor other plans' network JI ECM providers to identify any potential new providers. They may do so by referencing other plans' Provider Directory or the DHCS public posting of the Provider 274 file data. DHCS will monitor provider overlap using the Provider 274 file (***see Section 13.2.e***) and notify plans if they are missing any JI ECM providers from their networks.

If an MCP is not able to contract with the network of providers with which other MCPs in the county contract, the MCP must notify DHCS and indicate the reason network overlap is not possible. Permissible exceptions include:

1. Justified quality-of-care concern with ECM provider(s);
2. MCP and ECM provider(s) is/are unable to agree on contracted rates;
3. ECM provider(s) is/are unresponsive to multiple attempts to contract with the MCP;
4. ECM provider(s) is/are unable to comply with the Medi-Cal enrollment process or vetting by the contractor; or
5. ECM provider(s) does not have capacity to contract with all MCPs in the county.

13.2.d. Provider Directory

MCPs must update their standard Provider Directory to include contact information for ECM providers that serve the JI POF. By January 1, 2024, MCPs must update their Provider Directory to include their JI ECM provider network and share a link to the Provider Directory with DHCS.[125]

The Provider Directory will serve as a critical tool for correctional facilities to assign individuals to pre-release care management providers and/or post-release care management providers. The MCP must ensure that all listed JI ECM providers are clearly labeled in the Provider Directory. MCPs must also ensure that JI ECM providers meet minimum requirements to be considered an ECM provider and the additional requirements to be considered a JI ECM provider (see Table 16). Provider Directories

[125] DHCS is exploring how it will update Provider Directory requirements across all POFs. MCPs will not be expected create a separate Provider Directory for JI ECM providers. Rather, the standard Provider Directory should include the information detailed in this section.

must be updated in compliance with 42 CFR 438.10(h)(3), which requires that electronic provider directories must be updated no later than 30 calendar days after the MCP receives updated provider information.

The following data must be included in the Provider Directory for all ECM providers, including JI ECM providers:

- Indication of which POFs the provider serves and any specialization (if applicable);
- If the provider serves adults, youth, or both;
- *For JI ECM providers only:* If the provider is enrolled as an FFS provider and has agreed to provide pre-release services or warm-handoffs;
- County; and
- Care management provider organization information:
    1. Provider organization name;
    2. Organization mailing address;
    3. Contact information for new referrals, including. telephone and email; and
    4. Contact info for existing patients, including telephone and email (if different than contact information for new referrals).

13.2.e. Network Reporting

DHCS will require MCPs to report their JI ECM provider network via the Provider 274 file.[126] DHCS will use the data submitted via this form to monitor mandatory provider network overlap (i.e., ensure that all identified JI ECM providers are contracted with all MCPs in the county) and to ensure that all contracted providers are enrolled in Medi-Cal FFS. DHCS is in the process of updating its Provider 274 file to include data on which POFs each provider serves, including the JI POF.

MCPs must submit the following data on the Provider 274 file:

1. Justice-involved care management provider/entity organization with which MCP contracts;
2. NPI;
3. County in which care management provider/entity organization is contracted to operate;
4. Contact information: mailing address, telephone number, and email address; and

[126] DHCS will phase out the QMIR reporting requirement for provider networks, and instead, DHCS expects all ECM providers to share their provider network data with DHCS via a Provider 274 file. DHCS is hoping to have processes in place in time to only have to use the Provider 274 file for the JI POF.

5. Confirmation that provider has agreed to provide in-reach services or warm handoff prior to release via FFS.

Note that DHCS is in the process of updating the Provider 274 file to include data on which POFs each provider services, including the JI POF, and will notify MCPs once the form is available for MCP use.

13.3. Member Enrollment into an MCP and ECM

This section describes MCP responsibilities for ensuring that managed care members begin to receive care, are enrolled in ECM, and are assigned an ECM provider immediately upon or as close as possible to release.

13.3.a. Auto-Assignment and Current Month Enrollment

DHCS is establishing new policies and operational processes to ensure justice-involved individuals will be able to begin receiving services, including ECM services, immediately upon, or as close as possible to release. The assignment process will vary based on if the individual was previously enrolled in an MCP, but coverage for all members will be effective retroactive to the first day of the month their managed care plan enrollment is activated.

- **Individuals who were already enrolled in Medi-Cal and an assigned MCP upon entry to the correctional facility:** The individual's MCP enrollment will be put in a "hold" status for up to 12 full months of incarceration. This will allow the individual to maintain the same MCP after release, without having to go through another MCP enrollment process. MCP enrollment will be activated upon release as soon as the suspension is lifted.
- **Individuals who were not enrolled in Medi-Cal nor assigned an MCP upon entry to the correctional facility:** The individual will be enrolled in an MCP, triggered by the activation of the JI aid code. The individual's MCP enrollment will be put in a "hold" status for up to 12 full months of incarceration. MCP enrollment will be activated upon release as soon as the suspension is lifted.

MCP auto-assignment will occur at the time of pre-release service activation and will be based on the county of residence to which the individual will return, as listed in the Medi-Cal Eligibility Data System (MEDS). Existing auto-assignment policy, including prior MCP enrollment and family member assignment, will be considered in the MCP auto-assignment process. Plans will be notified on the monthly/daily 834 file when members are assigned/enrolled, even if that is prior to release. Incarcerated individuals with an

assigned MCP in a hold specific to JI status will be noted as such in the daily/monthly 834 file that DHCS shares with MCPs. This will be for any JI incarcerated Medi-Cal member with a suspended primary aid code and MCP, not just those with pre-release services. Additionally, the 834 file will include a JI indicator, which is applied when the JI pre-release service aid code is activated, which will alert MCPs of JI members qualified for pre-release services, and therefore automatically qualify for ECM.

For members who are auto-assigned in Non-County Organized Health System (COHS) and non-Single Plan counties, a confirmation letter will be mailed to the residential address they listed on their Medi-Cal application (i.e., an address in the community). The confirmation letter will include information on their MCP assignment and how to change plans if more than one MCP operates in their county of residence. Members will be provided a choice period and an opportunity to change plans, consistent with DHCS managed care enrollment policy. MCPs should send its standard member materials to each new or reenrolled member's residence.

Upon release, if the primary aid code had been suspended, through correctional facility communication with SSD, the primary aid code will be unsuspended, the JI aid code will be terminated, the health care plan status will change from "hold" to "active" status, and the individual will be fully active in Medi-Cal managed care. There will also be a mechanism to turn off the JI aid code upon release or when the 90 days expire, even if it is not associated with the unsuspension of the primary aid code. An individual's MCP enrollment will be effective retroactive to the first day of the month in which they are released. For example, if the individual is released on April 15, the individual's plan enrollment will be effective retroactive to April 1. In light of this current month enrollment policy, MCPs will be paid the full monthly capitation rate retroactively for the month in which the individual was enrolled. This policy is intended to ensure MCPs accept and serve new members, immediately upon, or as close as possible to the day of release as.

13.3.b. ECM Referral Pathways for Members Who Do Not Receive Pre-Release Services.

Individuals may still qualify for the JI ECM POF even if they did not receive pre-release services. The following are example scenarios of when an individual could be eligible under the JI POF without having received pre-release services:

- Pre-release services are not yet live. As described above, ECM for the JI POF will go-live on January 1, 2024, while pre-release services will be phased in over two years, between April 1, 2024 and March 31, 2026.
- An individual was incarcerated for a very brief time period and the correctional facility did not have enough time to identify eligibility and/or provide pre-release services.
- An individual was not eligible for pre-release services when they were incarcerated but became eligible within 12 months of release. For example, an individual could develop a qualifying health condition post-release and qualify for ECM under the JI POF.

MCPs must have referral pathways in place by January 1, 2024 for members who do not receive pre-release services, when ECM goes live for the JI POF.[127] MCPs must:

- Accept self-referrals; and
- Accept referrals from a family member or provider.

Additionally, DHCS recommends that MCPs:

- Establish a partnership with prisons, jails, and youth correctional facilities, including developing a data sharing agreement between the correctional facility and/or correctional health services and the MCP and ECM provider before pre-release services go live. Correctional facilities can refer individuals to ECM.
- Establish a partnership with community-based organizations (CBOs), probation and parole offices, and community-based physical and behavioral health providers. Partner organizations can refer individuals to ECM.

13.3.c. Referral Pathways for Members that Receive Pre-Release Services

Individuals who received pre-release services will automatically be eligible to receive ECM under the JI POF, as the eligibility criteria for pre-release services and ECM for the JI POF are identical. Additionally, anyone who has received pre-release services has been screened and deemed eligible under the eligibility criteria (see ***Section 6***). Correctional facilities will refer individuals who receive pre-release services directly into ECM (i.e., a direct "pipeline" will be established between the correctional facility, MCP, and post-release ECM provider). Additionally, as described above, auto-assignment and current month enrollment will

[127] Whole Person Care counties that went live with JI for the ECM POF in January 2022 should already have referral pathways in place.

ensure that individuals can be enrolled in and begin to receive ECM immediately upon release. MCPs must establish pathways for ECM to be automatically approved for any member who received pre-release services. MCPs will be notified of individuals who are eligible for pre-release services and therefore eligible for ECM through the daily/monthly 834 file with the JI indicator.

13.3.d. ECM Presumptive Authorization

A member who receives pre-release services must be presumptively authorized to receive ECM services on the day of release or, if MCP enrollment is effectuated after release, on the day of MCP enrollment. ECM must continue until the MCP is able to evaluate the need for services, no sooner than six months after release to ensure that the member has access to the services for which they qualify.[128] Because all members who receive pre-release services have already been assessed and deemed presumptively eligible for services, and the eligibility criteria is the same for ECM, no additional assessment is needed to qualify for ECM until at least six months after release.

13.3.e. ECM Provider Assignment

Correctional facilities will be responsible for assigning a pre-release care management provider to individuals who receive pre-release services. This pre-release care manager will either (1) become the individual's post-release ECM provider (if the correctional facility uses an in-reach care management model) or (2) initiate a warm handoff with the post-release ECM provider, prior to release (if the correctional facility leverages an embedded model). The correctional facility should use the MCP provider directory to identify a JI ECM provider to serve the individual. The correctional facility may receive assistance from MCPs, especially if the individual's MCP assignment is already known.[129]

The MCP must make their point-of-contact known and available to correctional facilities, in order to support ECM assignment. MCPs must ensure the point-of-contact has sufficient knowledge of JI POF ECM providers (see ***Section 13.4.b.***)[130] DHCS encourages MCPs and correctional facilities to collaborate as appropriate on a county-specific

[128] MCPs will re-authorize/deny ECM during the ECM reassessment within six months of enrollment.

[129] MCPs and correctional facilities may collaborate to establish processes/ procedures that work for their local counties. However, since individuals can be released from correctional facilities that are not in their county of residence, MCPs must be able and willing to accept referrals from all carceral settings and assist with referrals according to this policy guide.

[130] DHCS acknowledges that MCPs may be better positioned to assign appropriate ECM providers in the future. As data exchange and infrastructure are established, DHCS will consider having MCPs take a more active role in ECM provider assignment in the future.

process to determine the appropriate ECM provider assignment for each member.[131] Correctional facilities must assign a pre-release, in-reach care management/post-release ECM provider that works in the county in which the individual will be released. If this provider is located in a different county than the correctional facility, pre-release services, including the warm handoff, may be conducted via telehealth. Correctional facilities located in a different county than the county of release may reach out to the MCP contact in the county of release for assistance.

13.4. Supporting Members' Transition from Incarceration into an MCP and ECM

One of the key goals of the CalAIM Justice-Involved Reentry Initiative is to ensure that individuals are supported during the transition from incarceration into the community through the provision of pre-release services, including pre-release care management, and post-release services like ECM and Community Supports.[132] MCPs will play a critical role in coordinating the transition from the pre-release to post-release periods (i.e., the 90-day pre-release period when the individual will receive FFS Medi-Cal services and the post-release period when the individual will be enrolled in an MCP and begin to receive managed care services).

13.4.a. Identifying Individuals that Receive Pre-Release Services

As described above, DHCS will share member assignment data with the MCP when the member's pre-release service aid code has been activated. The MCP will use this data to identify members with whom they will need to work to coordinate the transition between the pre- and post-release period.

13.4.b. MCP Point-of-Contact

As described above, MCPs will need to include a publicly posted point-of-contact to whom correctional facilities, pre-release care managers, and ECM providers (if different) can reach out for support. The point-of-contact must be an individual (i.e., not a hotline) who will be available to support correctional facilities, pre-release care management providers, and/or ECM providers as needed. The point-of-contact at the plan should be prepared to provide information on topics including but not limited to MCP policy

[131] County-specific collaborations are not expected to address all issues, which is why the MCP must have a point of contact publicly available for out of county or state correctional facilities to be able to coordinate.

[132] MCPs are not required to offer Community Supports, so not all individuals who are transitioning from incarceration will have access to this service.

pertaining to the JI POF, prior authorization, MCP services such as Community Supports and non-emergency medical transportation, PCP assignment, and network providers. DHCS will provide more information on where MCPs will be required to post their MCP point-of-contact information and how it could be used by correctional facilities.

13.4.c. Creation of Person-Centered Care Reentry Plan

The MCP must support pre-release care management providers and ECM providers (if different) with the development of a Reentry Care Plan for individuals who will be enrolled in managed care upon release. The following outlines key expectations of the MCP in supporting the development of the Reentry Transitional Care Plan.

- **Receive Member Data.** The correctional facility is responsible for sharing member data, including the reentry care plan, with the MCP for future care coordination and management purposes. The MCP must have processes and data infrastructure in place to receive member data from the correctional facility to support care for the individual in the post-release period once the individual is enrolled in managed care.
- **Ensure Warm Handoff Occurs.** DHCS requires that all efforts are made to have the warm handoff occur in the pre-release period (see ***Section 8.4.e.*** for warm handoff requirements). If an individual receives care management services from different providers in the pre- and post-release periods, the two care managers will be required to conduct a warm handoff to ensure continuity of care across the pre- and post-release periods. The pre-release care manager is responsible for initiating the warm handoff by contacting the post-release care manager. Both the pre-release care management provider and the ECM provider are responsible for following through on completion of the warm handoff. The MCP will be responsible for ensuring that their contracted JI ECM providers participate in a warm handoff with the pre-release care management provider during the pre-release period.
- **Post-Release Warm Handoff** (only if not done prior to release).[133] DHCS understands that there are situations in which it will not be possible to conduct the warm handoff in the pre-release period (e.g., the individual is incarcerated for only 48 hours, or the individual is released unexpectantly from court). In such cases, the MCP must ensure that its network ECM providers conduct the warm handoff in the post-release period, within one

[133] If the warm handoff does not occur in the pre-release period, it must occur in the post-release period as a minimum requirement.

week of release.[134] The MCP must also ensure that any necessary data/information, including the reentry transitional care plan, is shared with the ECM provider within one day of release.

- **Receive and Share the Reentry Care Plan.** MCPs must have processes and infrastructure in place to receive member information and the reentry care plan from the correctional facility as part of the warm handoff. The MCP must also have processes in place to share the reentry transitional care plan with appropriate care providers, including the individual's ECM provider, within one day of the individual's release, in the case that the pre-release care manager and post-release ECM provider are not able to conduct the warm handoff and transfer the reentry care plan during the pre-release period.
- **Behavioral Health Linkages.** As described in ***Section 11.4***, as part of the CalAIM Justice-Involved Reentry Initiative, individuals who have been identified as being in need of behavioral health services will be linked to community-based services upon reentry into the community to ensure continuity of care between the pre- and post-release periods. For individuals who received behavioral health services during the pre-release period, the ECM provider will be responsible for participating in behavioral health transition meetings, warm handoffs, and follow-up planning, including confirming transportation to needed behavioral health services. To support the ECM provider, the MCP must facilitate referrals to community-based behavioral health services for any behavioral health needs that the individual will not receive as county-based services (e.g. non-specialty mental health services, MAT, tobacco cessation); facilitate referrals to county-based behavioral health services, when appropriate; coordinate with the pre-release care manager and ECM provider to ensure transportation is arranged to any needed appointments or admissions to treatment facilities; and ensure the ECM provider follows up with members post-release to ensure connection to identified behavioral health services.
- **Scheduling Community-Based Services.** The post-release ECM provider may play an active role in helping the individual schedule post-release physical, behavioral health, and social services (see ***Section 8.4.d***). The role of the post-release ECM provider may vary depending on the pre-release care

[134] Note that pre-release care management and post-release ECM providers should do their best to ensure that the warm handoff occurs in the pre-release period. DHCS expects that warm handoffs should rarely occur in the post-release period.

management provider's comfort with and knowledge of community-based services. For example, if a correctional facility leverages an embedded pre-release care management model, and the individual is released to a county outside of where the correctional facility is located, the pre-release care management provider may rely on the post-release ECM provider to schedule post-release community-based services, since they would have better knowledge of the available providers in the community. In this case, the MCP must ensure that the ECM providers can support scheduling of community-based services (paid in FFS).

- **Community Supports.** MCPs have the option to offer one or more of the Community Supports services (e.g., housing transition navigation services, housing deposits, housing tenancy and sustaining services). If the MCP offers Community Supports, the MCP must ensure that the ECM provider is able to connect the individual with any needed Community Supports that are available through the MCP, including through working with the MCP to coordinate prior authorization as well as scheduling services pre-release. The MCP must ensure that ECM providers can coordinate any needed Community Supports and ensure that they are available on the day of release.[135] [136]
- **Non-Emergency Medical Transportation.** Individuals returning from the community from incarceration may also need Non-Emergency Medical Transportation (NEMT) to get to their physical and/or behavioral health appointments. The MCP must ensure that the ECM provider is able to set up NEMT for post-release services for the individual in the community and sets up NEMT services as necessary. This will include NEMT on the day of release, if needed. [137]

In addition, the MCP must facilitate PCP assignment, provide information on in-network providers, support scheduling of physical and non-specialty mental health services, and provide other information on MCP plan benefits.

13.5. Post-Release ECM

Once an individual who is enrolled in Medi-Cal is released into the community, they will be eligible to receive full-scope Medi-Cal services, including ECM, consistent with their

[135] Additional information on MCP responsibility for authorizing Community Supports is forthcoming.

[136] Additional information on Community Supports for the Justice-Involved population can be found in the Medi-Cal Community Supports, or In Lieu of Services (ILOS), Policy Guide.

[137] Additional information on MCP responsibility for NEMT is forthcoming.

assigned aid code. As described in ***Section 13.3***, MCP enrollment will be effectuated on the day of release, so MCPs should begin to provide services, including ECM, as soon as the individual reenters the community.

The MCP must ensure that ECM services become available on the day of release, or as close to the day of release as possible. DHCS suggests as a best practice that ECM providers should meet the individual at release if possible; or, if that is not possible, within one to two days of release. The MCP will also be required to ensure that ECM providers conduct a second follow-up appointment with recently released individuals within one week of release to ensure continuity of care and a seamless transition and to monitor progress and the implementation of the reentry care plan.[138]

13.5.a. Care Management Plan

As described in the ECM Policy Guide (***Section V.2***), all ECM providers across all POFs must conduct a comprehensive needs assessment and develop a care management plan for the members they serve. The care management provider should involve the ECM member and their parent, caregiver, and/or guardian, as well as the appropriate clinical input in the development of a comprehensive, individualized person-centered care plan. The care plan should be based on the needs and desires of the member and should be reassessed based on the member's progress or changes in their needs. The care plan should cover the member's needs in the areas of physical health, mental health, SUD, community-based LTSS, oral health, palliative care, social supports and social drivers of health (SDOH).

All individuals who received pre-release services will reenter the community with a Reentry Care Plan as described in in ***Section 13.4.c***. Upon release, the Reentry Care Plan will become the member's Care Management Plan (i.e., the members ECM provider should follow the care plan developed during the pre-release period once the individual reenters the community). As described above, the ECM provider should reassess the member's progress and changes in their needs on an ongoing basis and update their Reentry Care Plan/Care Management Plan as necessary. The ECM care management provider must ensure that the Reentry Care Plan reflects all Care Management Plan requirements described in the ECM Policy Guide.

[138] SMDL 23-003 suggests that case managers should initiate contact within one to two days post-release and conduct a second appointment that occurs within one week of release to ensure continuity of care and seamless transition and to monitor progress and care plan implementation.

Appendix

Appendix A. Medi-Cal-Covered DME by Group

DME Group	DME Included in Group

Other DME[139]	• Ambulation Devices
	• Bathroom Equipment
	• DME for Disabled Parent
	• Hospital Beds and Accessories
	• Patient Lifts and Standing Frames
	• Patient Transfer Systems
	• Phototherapy
	• Pneumatic Compressors
	• Miscellaneous Equipment, Accessories, and Supplies
	  ○ Blood Glucose Monitors
	  ○ Blood Pressure Equipment
	  ○ Breastfeeding: Lactation Management Aids
	  ○ Cough Stimulating Device
	  ○ Electrodes and Lead Wires
	  ○ Haberman Feeder
	  ○ Negative Pressure Wound Therapy Devices
	  ○ Osteogenesis Stimulator
	  ○ Pulsed Irrigation Enhanced Evacuation (PIEE)
	  ○ Positioning Seat
	  ○ Ramps, Portable
	  ○ Scales
	  ○ TheraTogs
	  ○ Transcutaneous Electrical Nerve Stimulators (TENS)
	  ○ Tumor-Treating Field Devices

[139] Durable Medical Equipment (DME): Other DME, available at: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/58152677-9614-44AB-AA0A-1F3F04123E7D/duraother.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO

	• Wearable Cardiac Defibrillator
Wheelchairs and Wheelchair Accessories[140]	The term "wheelchair" describes manual wheelchairs, power mobility devices (PMD) including power wheelchairs (PWC), power-operated vehicles (POV), and push-rim-activated power-assist devices (PAD). Seating and positioning components (SPC) describe seat, back, and positioning equipment mounted to the wheelchair base.

Oxygen Contents, Oxygen Equipment, and Respiratory Equipment[141]	• Aerosol Masks
	• Airway Clearance Devices
	  ○ Cough Stimulating Devices
	  ○ High-Frequency Oscillation Systems
	  ○ Intrapulmonary Percussive Ventilators/Devices
	  ○ Oscillatory Positive Expiratory Pressure Devices
	  ○ Percussors
	• Apnea Monitors and Supplies
	• Continuous Positive Airway Pressure (CPAP) and Bi-Level Positive Airway Pressure (Bi-PAP) Equipment
	• Bi-Level Positive Airway Pressure ST (Bi-PAP ST) Equipment
	• Humidifiers
	• Nebulizers and Air Compressors
	• Oral Appliances for Obstructive Sleep Apnea
	• Oximeters
	• Oxygen Contents, Equipment, and Supplies
	• Suction Machines
	• Ventilators (primary and backup)
	• Unlisted Oxygen Equipment and Respiratory Equipment

[140] Durable Medical Equipment (DME): Wheelchair and Wheelchair Accessories Guidelines, available at: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/3E27D197-BFAC-4236-865F-D938BC445BF0/durawheelguide.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO

[141] Durable Medical Equipment (DME): Oxygen and Respiratory Equipment, available at: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/93D7E3AE-AF5C-433C-8518-D7189E038AAE/duraoxy.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO

	• Unlisted Supplies, Accessories, and Service Components
Infusion Equipment[142]	• Ambulatory Infusion Pumps • Enteral Nutrition Infusion Pumps • Implantable Infusion Pumps • Insulin Infusion Pumps • Mechanical External Infusion Pumps • Miscellaneous Supplies • Parenteral Infusion Pumps • Unlisted Equipment • Unlisted Supplies, Accessories, and Service Components
Therapeutic Anti-Decubitus Mattresses and Bed Products[143]	• Replacement Pads • Pressure Sore Products
Speech Generating Devices[144]	A Speech-Generating Device (SGD) is an electronic or non-electronic aid or system which accommodates an expressive communication disability that precludes purposeful functional communication medically necessary to accomplish activities of daily living (ADLs).

[142] Durable Medical Equipment (DME): Infusion Equipment, available at: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/768172CB-9B92-4B2A-BA9E-29BC7E8C9B7E/durainf.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO

[143] Durable Medical Equipment (DME): Therapeutic Anti-Decubitus Mattresses and Bed Products, available at: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/52484AC3-28E2-4260-BBEE-8AE442B3D21A/durathp.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO

[144] Durable Medical Equipment (DME): Speech Generating Devices (SGD), available at: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/B2D8C86B-9DDE-4069-8DFB-8917B8EFAEAD/duraspe.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO