California Advancing and Innovating Medi-Cal (CalAIM) Justice-Involved Advisory Group

Care Management During 90 Day Pre-Release Period and Reentry Planning

Thursday, February 24, 2022
10:30 am – 12:30 pm

DHCS

February 2022

Housekeeping Guidelines

In order to keep the Advisory Workgroup meeting focused, productive, and efficient:

Chat function will be disabled for all public participants; Advisory Group members are asked to only use chat functions to request technical support.

All participants will be muted throughout the course of the presentation.

Advisory Workgroup members should raise their hand if they have a question or comment during the designated discussion periods, and DHCS will facilitate conversation.

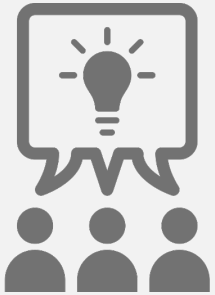
Members of the public should email questions and comments to CalAIMJusticeAdvisoryGroup@dhcs.ca.gov.

Advisory Group Key to Justice-Involved Initiatives Design

Overarching Objective

To solicit stakeholder input on policy and operational design of multiple justice-involved CalAIM initiatives.

Workgroup Logistics



- **When:** October 2021 – July 2023 *(slides from previous meetings available here)*
- **Where:** Sacramento (in person) or virtually
- **Who:** Advisory Group members

Sub-Workgroups

DHCS will also facilitate sub-workgroups that will meet separately on specific topic areas that emerge from the Advisory Group meetings. Sub-workgroups will be comprised of individuals with relevant expertise, including those from the Advisory Group. Design recommendations discussed in the sub-workgroups will be shared with the full Advisory Group.

Current sub-workgroups include:

- Medi-Cal Pre-Release Application Process Workgroup
- 90-Days Services Pre-Release and Reentry Workgroup

Please email CalAIMJusticeAdvisoryGroup@dhcs.ca.gov if you are interested in joining a sub-workgroup.

Agenda

- **Context Setting**
  - Recap from January Advisory Group
- **Domain 2.2: Pre-Release Services Delivery Model – Care Management**
  - Vision for Pre-Release Care Management
  - Most Common Care Management Scenarios
  - Proposed Statewide Standardized Requirements for Warm Handoffs
  - Discussion
- **Propose Care Management Model**
- **Advisory Group Members' Questions and Comments Next Steps**
- **Next Steps**

Context Setting

DHCS Continues Negotiations on 1115 Waiver

CMS Update

- **Negotiations between the State and CMS on the request to provide targeted services in the 90 days prior to release are ongoing.**
- DHCS will provide an update on the status of negotiations as information becomes available to share.
- All pre-release service parameters discussed today are subject to change.

Source: 11-W-00193/9, "California CalAIM Demonstration," December 29, 2021, available at https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-1115-Waiver-Approval-Letter-STCs-12-29-21.pdf.

Rationale for Provision of Services in the 90 Days Prior to Release

The intent of the 90-day pre-release window is to give DHCS and corrections facilities enough time to enroll individuals in Medi-Cal, be screened for eligibility for the pre-release services, assign a care manager, meaningfully engage with the individual, and set up 30-day prescriptions and DME for release.

Building Trusted Relationships

The 90-day period allows a care manager to visit multiple times, as appropriate, with the individual while they are incarcerated.

This ensures enough time to:

- Develop a transition plan
- Coordinate care
- Support stabilization upon re-entry.
- Build familiarity and trust in a way that ensures continuity once an individual re-enters the community

Pre-Release Management and Stabilization

The 90-day period allows for:

- Better management of ambulatory care sensitive conditions (e.g., diabetes, heart failure and hypertension) which could reduce post-release acute care utilization
- Stabilization of treatment regimens (e.g., injectable long-acting anti-psychotics and medications for addiction treatment) which could reduce decompensation and overdoses post-release.

Connecting to Services Post Release

The 90-day period allows for:

- Sufficient time to coordinate seamless hand-offs to community-based physical, behavioral health treatment, and supportive social services upon re-entry.
- Adequate time for the coordination and provision of durable medical equipment (oxygen, wheelchairs, wound care supplies) for post-release.
- Adequate time for data sharing with managed care plans to enable seamless hand-offs

Advisory Group Feedback on Covered Services

- **Services provided in the 90-day pre-release should:**
  - Stabilize individuals prior to release, as appropriate
  - Ensure early engagement with care managers prior to release to build trusting relationships in order to support meaningful transitions in the post-release period
  - Coordinate seamless hand-offs to community-based physical and behavioral health treatment and supportive social services upon reentry

- **Advisory Group feedback on medications included the following:**
  - Use of long-acting injectables, when appropriate
  - Best practices related to naloxone distribution
  - Supply of medications provided upon release should be consistent with Medi-Cal clinical policy
  - DME that is offered in the post-release period should be aligned with Medi-Cal clinical policy so that it there is alignment upon return to the community

Advisory Group Feedback on Service Delivery Approach

The intent of the 90-day pre-release initiative is to support the reentry of justice-involved populations.

In order to do that, it is important to minimize transitions in the trusted relationship with the care manager, especially around the time of release, which is a transition itself.

Therefore, the "north star" for the service delivery model is to ensure continuity of providers and services to the maximum extent possible.

During today's meeting we will dive deeper into the role of the care manager and discuss guiding principles for implementation.

Before we move on, are there any additional thoughts on this framing of the service delivery north star?

Domain 2.2 Pre-Release Services Delivery Model – Care Management

Reminder: Pre-Release Service Target Populations

Medi-Cal-eligible individuals will be able to receive targeted Medi-Cal pre-release services 90 days prior to release from county jails, state prisons, and youth correctional facilities.

Criteria for Pre-Release Medi-Cal Services

Incarcerated individuals must meet the following criteria to receive in-reach services:

- ✓ Be part of a **Medicaid or CHIP Eligibility Group**, and
- ✓ Meet **one** of the following health care need criteria:
  - Mental Illness
  - Substance Use Disorder (SUD)
  - Chronic Condition/Significant Clinical Condition
  - Intellectual or Developmental Disability (I/DD)
  - Traumatic Brain Injury
  - HIV/AIDS
  - Pregnancy or Postpartum

Note: *All incarcerated youth are able to receive pre-release services and do not need to demonstrate a health care need*

Medi-Cal Eligible:

- Adults
- Parents
- Youth under 19
- Pregnant or postpartum
- Aged
- Blind
- Disabled
- Current children and youth in foster care
- Former foster care youth up to age 26

CHIP Eligible:

- Youth under 19
- Pregnant or postpartum

Vision for Pre-Release Care Management

Care management will be provided during the 90-day pre-release period to facilitate re-entry planning into the community in order to:

- **Establish trusted relationships with care managers** that will be continuous pre- and post-release;
- **Support the coordination of pre-release services** including physical health, behavioral health care, dental and primary care;
- **Ensure smooth linkages to post-release care**, including clinical and social services.

Guiding Principles for Implementation

Trusted Relationships Between Client and Care Manager
Care managers should foster close relationships with the client to gain their trust and encourage continued engagement throughout the pre- and post-release periods.

Client-Centered Care
Client must be actively engaged and respected in their goals and decisions around their care.

Primary Point of Contact
Care manager should be point of contact for coordination of all pre-release services, including with county behavioral health providers and care coordinators.

Timely Sharing of Information
Care managers, service providers and other stakeholders should strive for timely delivery of information to support coordinated service delivery during the pre-release and re-entry period.

Warm Linkages
Transitions between care managers should be minimized, but when transition is required, warm handoffs must be prioritized to foster post-release relationship building. At minimum, warm handoff must include sharing transitional care plans and other information with the managed care plan (MCP) care manager before re-entry, and conducting a meeting with the pre-release care manager, post-release care manager, and client.

Care Management Standards

- *In several areas, DHCS will describe statewide standardized requirements that entities must meet for certain aspects of the care management model (e.g., requirements for warm handoffs at release).*
- *Proposed statewide standardized requirements will be explicitly called out in these and future materials describing the care management model.*
- *All other aspects of the care management model are recommended guidelines that entities will have flexibility in tailoring to localized needs.*

What is Care Management?

Care managers should build trusted relationships with clients and ensure continuity in engagement and relationships, where possible, throughout the pre- and post-release periods.

90-Day Pre-Release Care Management (*Proposed statewide standardized requirements*)

- Conduct a health needs assessment
- Coordinate in-reach consultations prior to the client's release
- Develop a transitional care plan with the client
- Coordinate with key care partners to prepare for release, including sharing information and care plan across correctional facility providers, post-release providers, MCP, and post-release care manager (if applicable)
- Coordinate with county behavioral health plans and DMC, DMC-ODS, SMHS providers to ensure alignment
- Make referrals and appointments to community-based clinical and social services post-release
- Ensure client has appropriate medications (i.e., MAT, psychotropics, chronic condition stabilizing medications) upon release and DME

Transition

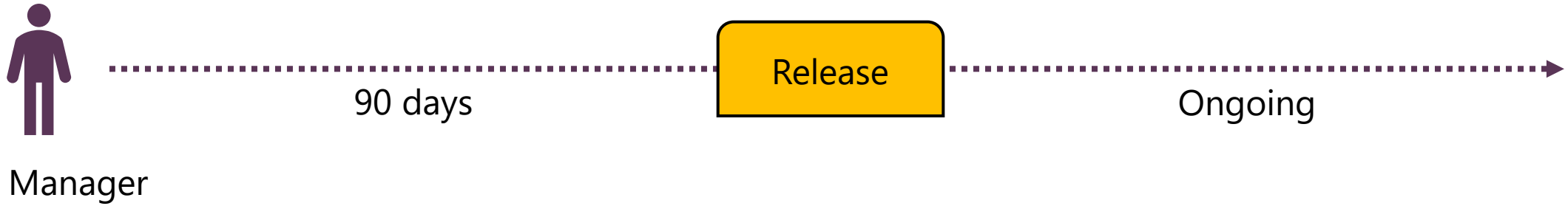
Post Release Care Management Activities

- Conduct outreach and engage clients
- Update client assessment and care plan with any newly identified needs
- Coordinate services necessary to implement the care plan
- Provide health promotion services to encourage and support clients to engage in healthy behaviors
- Support clients and their support networks during discharge from hospital or institutional setting
- Ensure clients and support networks are knowledgeable about client's conditions
- Coordinate referrals and transportation to community and social services

Most Common Care Management Scenarios

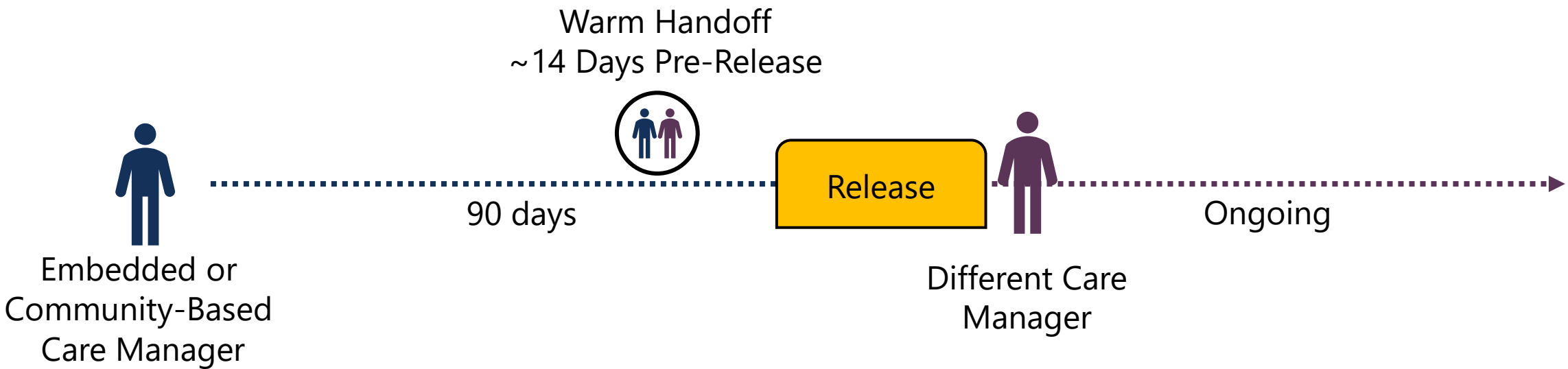
★**Scenario Most Aligned with Care Management Vision:**

Pre-release care manager is same person as post-release care manager



Alternate Scenario:

Pre-release care manager is a different person than post-release care manager



Proposed Statewide Standardized Requirements for Warm Handoffs

As described in the alternate scenario, when the pre- and post-release care managers differ, a warm handoff should occur approximately 14 days prior to release to begin establishing a trusted relationship with the new care manager and ensure seamless service delivery and coordination.

Proposed Statewide Standardized Requirements

Approximately 14 days prior to the client's release, the pre-release care manager must do the following:

- ✓ Share the transitional care plan and other relevant information (e.g., support network information) with the post-release care manager and client's assigned managed care plan.
- ✓ Schedule and conduct a pre-release care management meeting with the client that includes participation from the pre- and post-release care managers. The purpose of the meeting is to:
  - Begin establishing a trusted relationship between the client and the post-release care manager.
  - Review the transitional care plan with the client and address questions.
  - Identify any outstanding service needs and other supports needed to support a successful re-entry to the community (e.g., transportation, housing).

Note: This meeting can occur in-person or virtually. If it is not possible to include the client in the meeting, then the pre- and post-release care managers should meet to coordinate the transition.

Discussion

- What other care management functions should be supported in the pre-release period? In the post-release period?
- What operational considerations need to be addressed to support these functions (e.g., space in jail/prison, timely access to information)?
- What other statewide standardized requirements should be included for the warm handoff?

Proposed Care Management Model

Proposed Care Management Model

The care management process flow below applies to clients who are eligible for Medi-Cal and 90-day pre-release services.

Today's Discussion

Medi-Cal and 90 Day Pre-Release Service Eligibility Determination

Step 1: Care Manager Assignment

Step 2: Client Engagement and Information Gathering

Step 3: Coordination of Pre-Release Clinical Consultations

Step 4: Development of Transitional Care Plan

Step 5: Release Planning & Warm Linkages to Post-Release Care

Post-Release Services

Step 1: Care Manager Assignment

Goal Assign care manager in the pre-release period that will establish a trusted and continuous relationship with the client before and after release.

Step	Lead
1a: Gather client information to inform pre-release care manager assignment, including: • Where client will live post-release • Medi-Cal enrollment status* • Managed Care Plan (MCP) and prior ECM provider (if applicable)	Correctional Facility
1b: Share release date, information collected in step 1a, and relevant medical information with MCP to inform pre-release care manager assignment *Note: if the client is in FFS Medi-Cal, the correctional facility will still reach out to a local ECM organization for a pre-release care management assignment.*	Correctional Facility
1c: Assign pre-release care manager to the client based on key factors (e.g., location of release, prior ECM provider assignment, care manager capacity) and notify the correctional facility of the assignment	MCP
1d: Schedule meeting with client and their assigned care manager	Correctional Facility

Step 1: Discussion Questions

- How quickly can these steps be completed within the 90 day pre-release period?
- What additional information and/or operational considerations need to be addressed?
- Is there a common role within the correctional facility that would be best positioned to support these steps?

Step 2: Client Engagement and Information Gathering

Goal Assess and document the needs of the client to inform further pre-release consultations, transitional care plan development, and post-release service delivery.

Pre-Release Care Manager/Client Meeting Schedule Guidelines

Meeting	Meeting Objectives
#1 Relationship Building	• Establish working relationship • Ask open ended questions/listening to client goals/needs • Where applicable, ask client to sign consents to obtain medical records from outside facilities/health plans • **Post meeting:** care manager should gather data from health plans/medical offices/hospitals, and correctional facility as necessary

#2 Needs Assessment and Consent to Share Information	• Conduct needs assessment using DHCS-provided template
	  ○ Pre-populate with available information from first meeting and medical records
	  ○ Verify pre-populated information with client
	  ○ Ask questions to fill out the rest of the assessment
	• Discuss living arrangements (e.g., housing and social supports) post-release
	• Assess needed consultations pre-release to stabilize the client and post-release (e.g., primary care, behavioral health)
	• Secure consent to share information with MCP, County behavioral health plans, community providers, and social support person(s)

Step 2: Discussion Questions

- What challenges will we face in securing at least two care management meetings with the client prior to release (note: additional client meetings may be needed for clinical consultations – see Step 3)?
  - How can these challenges be overcome?
- How can pre-release care managers establish trust and solicit disclosure of health needs/history (e.g., SUD) without fear of repercussion from correctional facility?
- What best practices should be addressed in the needs assessment template?
- What additional information would be useful to collect in this step?

Step 3: Coordination of Clinical Consultations

Goal Arrange additional pre-release consultations with primary care and/or specialty providers prior to release.

Additional Pre-Release Clinical Consultation

- Care managers may identify a need for additional in-reach provider consultations during Step 2
- Care manager will coordinate with in-reach providers and correctional facility for in-person/telehealth services
- Care manager will document consultations in transitional care plan and coordinate with the post-release care manager to schedule follow-up appointments

Coordinating Consultations for Clients with Specialty Behavioral Health Service Needs

- If the client's behavioral health care provider is an ECM provider, then the behavioral health provider will serve as the lead care manager pre- and post-release.
  - If not, then the client will be assigned a lead care manager who will coordinate with the behavioral health provider during the pre- and post-release periods, including:
    - Arranging any consultations with behavioral health providers prior to release
    - Working with the post-release ECM provider (if different) to support the transition to behavioral health care in the community

Step 3: Discussion Questions

- What operational challenges need to be addressed to arrange additional pre-release consultations?
- On average, how many visits will this model require for each client prior to release?
  - How does this compare to facilities are currently doing?
  - What are considerations to expand to accommodate additional appointments?

Step 4: Development of Transitional Care Plan

Goal

Develop a robust transitional care plan that incorporates information from all available sources.

Proposed Statewide Standardized Requirements for Transitional Care Plan

- ✓ **Post-release planning**
  - ❑ Plans for post-release medications, including ensuring that the medications chosen during the pre-release period are those that are covered by Medi-Cal post-release
  - ❑ Plans for Durable Medical Equipment
- ✓ **Coordination and scheduling of required reentry services, including:**
  - ❑ MAT and psychotropic medications
  - ❑ Primary care provider identified and follow-up appointment scheduled at appropriate time post-release
  - ❑ Required specialty, mental health, substance use, dental, and MCP community supports appointments
  - ❑ Community service referrals
- ✓ **Coordination of reentry logistics**
  - ❑ Plan for engagement of identified supports for the client (e.g., probation/parole officer, family, others)
  - ❑ 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.

Step 4: Discussion Questions

- Are there any other types of information that should be included in the proposed statewide standardized requirements?
  - Should the transitional care plan include any notes on post-release peer supports that may have been identified?

Step 5: Release Planning & Warm Linkages to Post-Release Care

Goal Communicate care plan to all stakeholders involved in the client's care pre- and post-release and conduct final pre-release meeting with the client and post-release care manager to ensure continuous care management and access to services .

14 Days Pre-Release Care Manager Should Do the Following

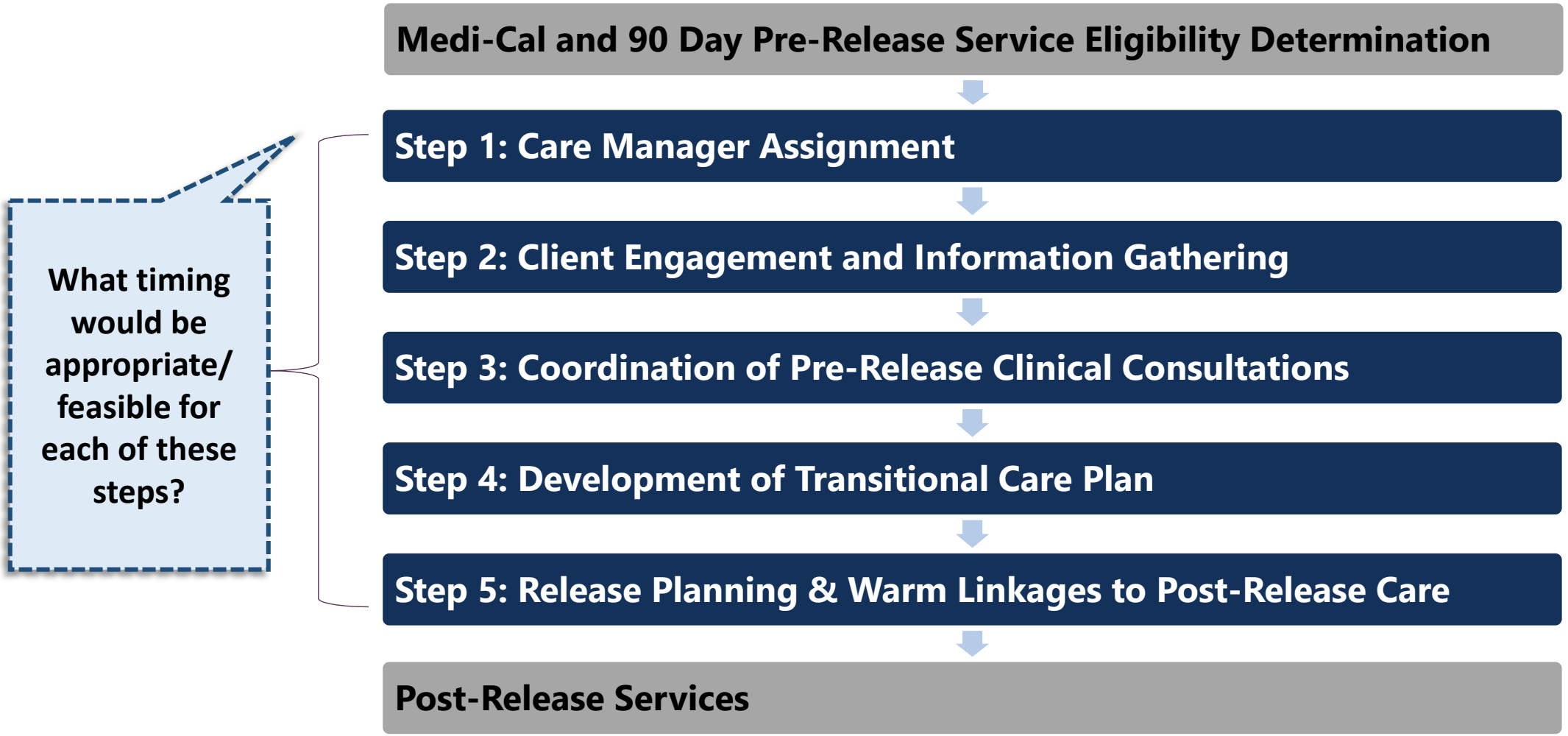
Step	Lead
5a: Share the final transitional care plan electronically with all identified stakeholders	Pre-release care manager
5b: Coordinate medication (including MAT) and DME, including sharing educational materials with the client and ensuring DME is available	Pre-release care manager
5c: Prepare client for reentry, including conducting warm handoff to post-release care manager (if applicable), by: • Conduct joint meeting between pre-release and post-release care manager (if applicable) and client 14 days pre-release • Reviewing transitional care plan with client (and post-release care manager, if applicable) • Alerting post-release care manager of release date and ensuring follow-up meeting is scheduled • Post-release care manager is responsible for handling care coordination post-release.	Pre-/Post-release care manager

Step 5: Discussion Questions

- Is the 14-day suggested timing for the final pre-release meeting and warm handoff feasible?
- What other supports are needed to facilitate a successful warm handoff?

Additional Questions and Comments: Care Management Model

The care management process flow below applies to clients who are eligible for Medi-Cal and 90 day pre-release services.



Advisory Group Members' Questions and Comments

Next Steps

Next Steps and Looking Ahead

- **Advisory Group members to share pressing issues, feedback, and comments**

- **Upcoming meetings :**
  - March 24, 10:30 – 12:30 pm PT
  - April 28, 10:30 – 12:30 pm PT
  - May 26, 10:30 – 12:30 pm PT

Thank you

Please send questions and comments to
CalAIMJusticeAdvisoryGroup@dhcs.ca.gov

Appendix

CalAIM Justice-Involved Advisory Workgroup Charter

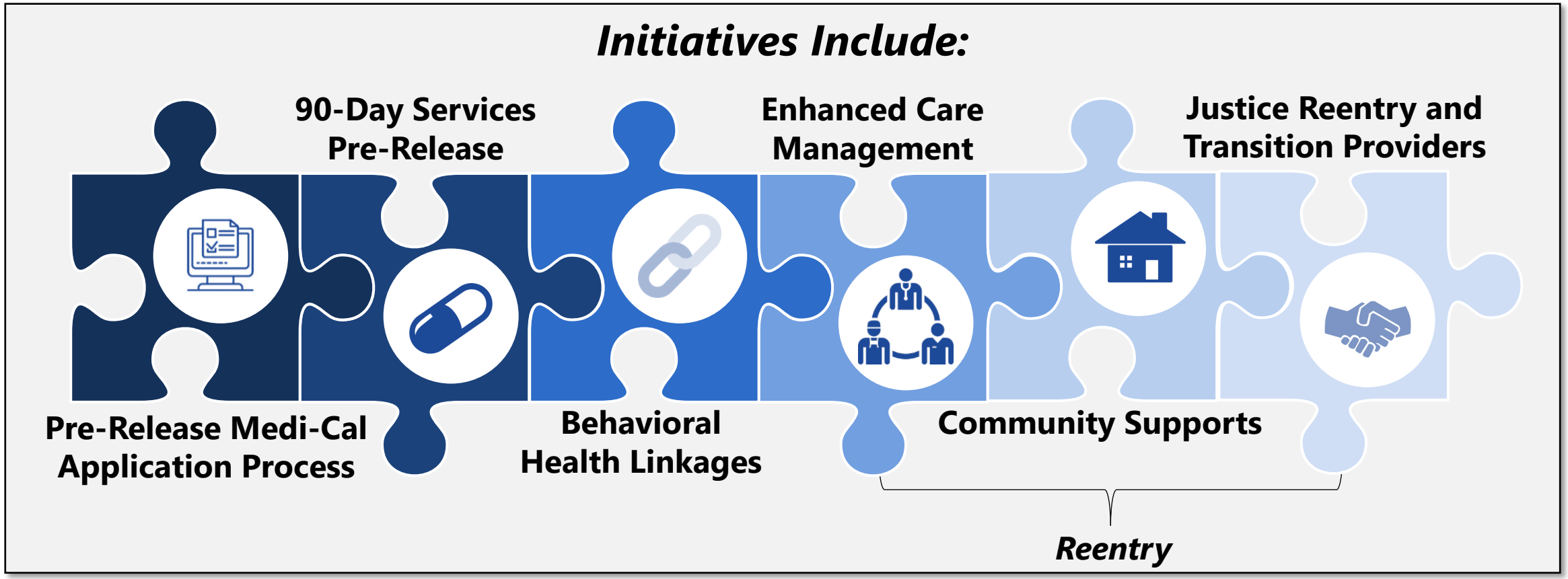
Workgroup meetings will provide a mechanism for direct communication and problem solving with DHCS and initiative implementers. Members are asked to bring a collaborative, pragmatic, and solution-oriented mindset.

Objectives	**The Advisory Workgroup will:** ✓ Offer regular input on key policy and implementation issues to support the launch and ongoing success of CalAIM ✓ Review and provide feedback on select decisions and documents before broad distribution ✓ Evaluate select high-priority issues spanning all CalAIM initiatives
Expectations	**Advisory Workgroup members have been selected for their expertise, and will be expected to:** ✓ Consistently attend and actively participate in meetings ✓ Review materials in advance of each meeting and provide input when requested ✓ Keep statements respectful, constructive, relevant to the agenda topic, and brief ✓ Be solutions-oriented, offering alternatives or suggested revisions where possible ✓ Represent their cross-sector perspective, but not advocate on behalf of their sector
Meeting Preparation	**DHCS will help Advisory Workgroup members prepare for meetings by:** ✓ Circulating agendas, minutes, and pre-decisional materials for review in advance of meetings ✓ Conducting outreach to the Advisory Work before/after meetings to solicit additional input ✓ Post materials on the CalAIM Justice-Involved Advisory Group webpage after meetings ***Note:*** Members are invited to take materials back to your organizations, but are asked to refrain from wider dissemination of material beyond your immediate organizations prior to finalization by DHCS

Decisions on CalAIM design and implementation are made at the sole discretion of DHCS.

Reminder: CalAIM Initiatives to Support Justice-Involved Populations

CalAIM justice-involved initiatives support justice-involved individuals by providing key services pre-release, enrolling them in Medi-Cal coverage, and connecting them with behavioral health, social services, and other providers that can support their reentry.



Key Planning Domains and Program Design Requirements for Justice-Involved Initiatives

DHCS will work with stakeholders through a Justice-Involved Advisory Group to resolve open policy questions, address operational issues, and identify necessary IT systems changes and financing to support these justice-involved initiatives across numerous domains.

Domain 1: Medi-Cal Pre-Release Application Process

- 1.1 Medi-Cal Application/ Enrollment/ Suspension

Domain 2: 90-Day Services Pre-Release and Reentry

- 2.1 Screening for Enrollment in Pre-Release Services
- 2.2 Pre-Release Services Delivery Model
- 2.3 Provider Network and Payment
- 2.4 Prescription Drug Coverage
- 2.5 Reentry Planning

Domain 3: Governance, Oversight, and Management

- 3.1 Governance Oversight and Monitoring → 3.2 1115 Waiver Evaluation Oversight

DHCS will engage stakeholders throughout the policy design process across domains, Including the design of reentry planning policies.

Pre-Release Care Manager Job Responsibilities (Proposed Statewide Standardized Requirements) (1/2)

- **Conduct a health needs assessment**, inclusive of social support needs, behavioral health needs, physical health needs, and any social services needs including housing.
- **Arrange for and coordinate in-reach consultations prior to the client's release** (e.g., primary/specialty care, behavioral health) to support stabilization during incarceration, inform the development of the transitional care plan, and ease the transition to post-release services.
- **Develop a transitional care plan with the client and secure necessary consent to share it with key stakeholders**, including the correctional facility, consultative providers, specialty behavioral health providers as appropriate, family members as appropriate, and parole/probation officers.
- **Coordinate with key stakeholders to prepare for release** (e.g., correctional facilities, consultative providers) to ensure that each client is released with the needed medications, vaccinations, durable medical equipment (DME), and referrals to appropriate services and supports in the community to be successful post-release.
- **Coordinate with specialty county behavioral health coordinators and ODS providers** to ensure aligned and consistent engagement with the client on their behavioral health needs.

Pre-Release Care Manager Job Responsibilities (Statewide Standardized Requirements) (2/2)

- **Make referrals and appointments to community-based services post-release**, including:
  - Clinical services, including dental providers, behavioral health, or substance use disorder (SUD) providers.
  - Social services and supports including but not limited to educational, social, prevocational, vocational, housing, nutritional, transportation, childcare, child development, and mutual aid support groups.
- **Facilitate a warm handoff to designated ECM providers of managed care plans at release**, which includes sharing transitional care plans and other needed information with ECM providers and managed care plans prior to re-entry, as well as conducting a meeting with the client that includes participation from the pre-release care manager and post-release ECM provider.