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

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DHCS
CALIFORNIA DEPARTMENT OF
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2. Purpose

The Department of Health Care Services (DHCS) is releasing this Policy and Operational Guide (also referred to as the "Guide") to memorialize policy design and operational requirements for implementing the Justice-Involved (JI) Reentry Initiative. This Guide intends to delineate for implementing stakeholders – correctional facilities (CFs), county behavioral health agencies, providers, community-based organizations (CBOs), County Social Services Departments (SSD) and Medi-Cal managed care plans (MCPs), among others – DHCS design and operational processes that will serve as the foundation for implementing this important initiative.

This Guide serves as the foundational framework for implementing the JI Reentry Initiative.[1] In addition to this foundational document, the Guide contains additional standalone, supplemental chapters that provide in-depth policy and operational guidance on the Reentry Initiative. These chapters will be posted to the JI Reentry Initiative web page.[2] Additional supplemental chapters include:

Chapter 1: Enrolling Eligible Individuals in Medi-Cal

Chapter 2: Screening and Identification of Eligible Members

Chapter 3: Special Requirements for Incarcerated Youth

Chapter 4: Managed Care Plan Requirements

Chapter 5: Pre-Release Service Policy and Benefit Guidance

- Care Management Services
- Clinical Consultations, including Physical Health Services, Behavioral Health (BH) Services, and BH Links
- Medication-Assisted Treatment (MAT)

[1] Subsection (d) of WIC section 14184.102 provides DHCS with authority to implement, interpret, or make specific the CalAIM article commencing with WIC section 14184,100[1] or the CalAIM Terms and Conditions,[1] 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 will include providing all benefits for the JI population.

[2] The complete Guide is available at: https://www.dhcs.ca.gov/CalAIM/Justice-Involved-Initiative/Pages/Resources.aspx

- Pharmacy Services, including Medications, Medication Administration, and Medications In-Hand Upon Release
- Physical Health Clinical Consultation
- Laboratory and Radiology Services
- Community Health Worker (CHW) Services
- Peer Support Services
- Durable Medical Equipment (DME) Upon Release

Chapter 6: Short-Term Model

Chapter 7: Medi-Cal Billing and Claims Requirements

Chapter 8: Considerations for Small and Rural Counties

Chapter 9: Data Sharing Requirements

Chapter 10: Program Monitoring

As DHCS and its implementing partners identify best practices and lessons learned throughout the JI Reentry Initiative, 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 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.

3. Background and Context Setting

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[3] approved by the Centers for Medicare & Medicaid Services (CMS), the DHCS is partnering with state agencies, counties, providers, and 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

[3] California's approved CalAIM 1115 Demonstration, CMS, January 2023. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-calaim-ca1.pdf

communities. The initiative helps California address the unique and considerable health care needs of 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 are anchored in comprehensive care management and include physical and behavioral health clinical consultation, MAT (also referred to as medications for substance use disorders (SUD)), medications and medication administration, lab and radiology services, CHW services, and provision of medications and DME upon release. Individuals receiving pre-release services are assigned a care manager – 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 the community-based care manager they will work with upon their release.

In California, an estimated 400,000 individuals are released from CFs each year.[4] Of these individuals, an estimated 80-90 percent are eligible for Medi-Cal.[5] 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 because of violence, overdose, and suicide compared to people who have never been incarcerated.[6]

- Incarcerated individuals in California jails under active care for mental health issues rose by 63 percent between 2009 and 2019.[7]

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[4] 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.

[5] "From Corrections to Community: Reentry Health Care," California Health Care Foundation, June 2023. Available at: https://www.chcf.org/project/corrections-community-reentry-health-care/.

[6] 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. Available at: https://www.nejm.org/doi/full/10.1056/nejmsa064115.

[7] "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, February 2020. Available at: https://calhps.com/wp-content/uploads/2020/02/Jail_MentalHealth_JPSReport_02-03-2020.pdf.

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- As of 2019, 66 percent of people in California jails and prisons have a moderate or high need for SUD treatment.[8]
- Overdose death rates are more than 100 times higher in the two weeks after release from incarceration than for the general population.[9]

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 severe health consequences, including overdose and death when compared to the general population. In California, average monthly Medicaid costs for JI members following release are about twice the monthly costs for these members prior to incarceration.[10]

Evidence suggests that improving health outcomes for this high-needs group of people requires focused, high-touch care management to assess needs and strengths as well as connect individuals to the services they need when released into their communities.[11] Reentry care management is critical to ensure that the medical, behavioral, and social needs that are tied so closely to health—including housing and transportation –are met. 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. Providing services in the period prior to release helps to establish trusted relationships with care managers to develop a reentry plan, coordinate pre-and post-release care, and support stabilization upon reentry to their community. Extending Medi-Cal coverage in CFs also allows for pre-release management of ambulatory care sensitive conditions (e.g., diabetes, heart failure, and hypertension), which could stabilize

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[8] "Improving In-Prison Rehabilitation Programs," Legislative Analyst's Office, December 2017. Available at: https://lao.ca.gov/Publications/Report/3720; "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, February 2020. Available at: https://calhps.com/wp-content/uploads/2020/02/Jail_MentalHealth_JPSReport_02-03-2020.pdf.

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

[10] 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 FFS cost data for individuals released from incarceration in CY 2019.

[11] Community Oriented Correctional Health Services, "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.

conditions (e.g., diabetes, human immunodeficiency virus (HIV), Hep C, schizophrenia) prior to release and reduce post-release acute care utilization.

Across the country, people of color are more likely to be incarcerated due to mental health issues, the criminalization of SUDs, and systemic inequities 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.[12] 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 drug users are Black, yet they represent 29 percent of those arrested and 33 percent of those incarcerated for drug offenses.[13,14]
- For Latino men, the imprisonment rate is 1,016 per 100,000 as compared to 314 per 100,000 for men of other races.[15]
- 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.[16]

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:

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[12] "Comparing Black and White Drug Offenders: Implications for Racial Disparities in Criminal Justice and Reentry Policy and Programming," National Library of Medicine, December 2016. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5614457/.

[13] Criminal Justice Fact Sheet, NAACP. Available at: https://naacp.org/resources/criminal-justice-fact-sheet.

[14] Heather Harris and Sean Cremin, "California's Prison Population," Public Policy Institute of California, September 2024. Available at: https://www.ppic.org/publication/californias-prison-population/.

[15] Ibid.

[16] Roxanne Daniel, "Since you asked: What data exists about Native American people in the criminal justice system," Prison Policy Initiative, April 2020. Available at: https://www.prisonpolicy.org/blog/2020/04/22/native/.

Medi-Cal Enrollment and Suspension:

- 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.
- As of January 1, 2023, all counties were mandated to implement pre-release Medi-Cal application processes in county jails and YCFs.[17]
- As of January 1, 2023, and as authorized by Senate Bill 184, Medi-Cal benefits for juveniles and adults must be kept in suspended status until the individual is no longer an inmate of a public institution.[18]

Care Management and Enhanced Care Management (ECM):

- 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.[19] These programs have transitioned to become ECM/Community Supports programs in CalAIM.[20]

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[17] Assembly Bill-720 inmates: health care enrollment. Available at: https://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; Pre-release policies are described in ACWDL 24-04 (February 29, 2024)

[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 (SMDL) 21-002 re: Implementation of At-Risk Youth Medicaid Protections for Inmates of Public Institutions (Section 1001 of the SUPPORT Act), Centers for Medicare & Medicaid Services, January 2021. Available at: https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21002.pdf.

[19] 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.

[20] ECM went live on January 1, 2022, in the 17 counties that offered WPC pilots dedicated to serving individuals reentering the community post-incarceration.

- MCPs are required to offer intensive, community-based care management for members transitioning to the community through the statewide ECM benefit and may offer Community Supports services. All members 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.[21]
- MCPs are 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 to address health-related social needs of members.

Behavioral Health Services & Behavioral Health:

- 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.[22]
- DHCS leverages 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 medications for SUD 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.
- Behavioral health links are codified in PEN §4011.11 and require CFs 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 non-specialty mental health services (NSMHS) for incarcerated members who received behavioral health services while incarcerated to allow for the continuation of medically necessary services to meet the behavioral health needs in the community.[23]

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[21] For additional details on the Individuals Transitioning from Incarceration Populations of Focus, see the "CalAIM Enhanced Care Management Policy Guide," Department of Health Care Services, September 2023. Available at: https://www.dhcs.ca.gov/Documents/MCQMD/ECM-Policy-Guide.pdf.

[22] "Assessing the Continuum of Care for Behavioral Health Services in California," Department of Health Care Services, January 21, 2022. Available at: https://www.dhcs.ca.gov/Pages/Assessing-the-Continuum-of-Care-for-Behavioral-Health-Services-in-California.aspx.

[23] PEN §4011.11. Available at: https://protect-us.mimecast.com/s/rOJAC4xY94hpYg1yhxKDys?domain=leginfo.legislature.ca.gov

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- DHCS also laid out data exchange requirements through the CalAIM Data Sharing Guidance and a JI Reentry Initiative Toolkit.[24]

4. Federal and State Legal Authority

4.1 Summary of the Section 1115 Demonstration Approval

In alignment with the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act[25] and the state's focus on health equity and coverage for JI populations, California received approval for its five-year Section 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 expected date of 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

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[24] These documents are updated regularly. please check The Data Sharing Authorization Guidance "Medi-Cal Housing Support Services" and "Reentry Initiative" Toolkits, Department of Health Care Services. Available at: https://www.dhcs.ca.gov/dataandstats/Pages/Data-Sharing-Authorization-Guidance-Medi-Cal-Housing-Support-Services-and-Reentry-Initiative-Toolkits.aspx.

[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. The HHS report to Congress is available at: https://aspe.hhs.gov/sites/default/files/documents/d48e8a9fdd499029542f0a30aa78bfd1/health-care-reentry-transitions.pdf. 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. This approval was updated in March 2024 to reflect the approval of the Implementation Plan and again on December 16, 2024, to include language on youth eligibility. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-calaim-dmnstrn-appvl-12162024.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.

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] The Section 1115 Demonstration provides expenditure authority that enables DHCS to cover a targeted set of Medi-Cal services for 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 by offering them services up to 90 days prior to their release to stabilize their health conditions and establish a plan for their community-based care (collectively referred to as "pre-release services"). It seeks to 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:

- **Improve physical and behavioral health** care by strengthening access to care before and after release, building on the state's investments in continuity of Medi-Cal coverage and care for Reentry populations.
- **Build a bridge to community-based care** for Medi-Cal members reentering from incarceration by delivering coordinated pre-release services to stabilize conditions and developing individualized Reentry Care Plans that support continuity of care post-release.
- **Enhance coordination and communication** among correctional facilities, Medi-Cal MCPs, county behavioral health agencies, and community-based providers to ensure seamless person-centered service delivery during reentry.
- **Invest in quality health care and related supports** across correctional and community settings to address physical health, behavioral health, and health-related social needs, to maximize successful reentry and minimize disparities.

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[28] 42 C.F.R. § 435.1010; see also CMS, Letter to State Health Official (SHO) letter 16-007, "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.

- **Evaluate the impact of targeted pre-release services on health outcomes and system efficiency**, including reductions in preventable emergency department visits, inpatient hospitalizations, other costly and inefficient care, and all-cause mortality among Medi-Cal eligible individuals post-release.

4.2 Section 5121 of the Consolidated Appropriations Act

On December 29, 2023, Congress enacted the federal Consolidated Appropriations Act (CAA).[29] This law requires that all states, including California, provide a targeted set of Medicaid-financed services to incarcerated youth who are post disposition (i.e., youth who are incarcerated after conviction or adjudication). Specifically, the CAA requirements apply to individuals under 21 years of age, or between the ages of 18 and 26 if they are former foster care youth, who are being held post-disposition at a youth correctional facility or an adult prison or jail. However, DHCS does not delineate between pre and post disposition for the purposes of the JI Reentry Initiative.

The requirements set forth by the CAA went into effect on January 1, 2025. Per this federal law and CMS implementation guidance,[30] California is required to have an internal operational plan in place to deliver the following services to eligible youth:

- **Screening and diagnostic services**[31] in the 30 days prior to release (or no later than one week, or as soon as practicable, post-release); and,
- **Targeted case management** in the 30 days prior to release and for at least 30 days post-release for Medicaid and Children's Health Insurance Program (CHIP) enrolled youth who are incarcerated and post-disposition.

The services required under the CAA fully align with the services DHCS is providing under its JI Reentry Initiative. To meet the requirements to provide Targeted Case Management (TCM) services, CFs will follow the care management guidance detailed in

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[29] Consolidated Appropriations Act (P.L. 117-328), enacted December 2022. Available at: https://www.congress.gov/bill/117th-congress/house-bill/2617/text.

[30] State Health Official Letter 24-004, "Provision of Medicaid and CHIP Services to Incarcerated Youth," Centers for Medicare & Medicaid Services, July 2024. Available at https://www.medicaid.gov/federal-policy-guidance/downloads/sho24004.pdf; State Health Official Letter 24-006, "Provision of Medicaid and CHIP Services to Incarcerated Youth – FAQs," Centers for Medicare & Medicaid Services, December 2024. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/sho24006.pdf.

[31] Screening and diagnostic services must meet reasonable clinical standards in accordance with Early and Periodic Screening, Diagnostic, and Treatment (ESPDT) standards for those under the age of 21.

this Guide and the supplemental chapters titled, "Pre-Release Service Policy and Benefit Guidance" and "Reentry Care Management Services." To meet the requirements to provide screening and diagnostic services, CFs will ensure youth have received screening and diagnostic services for medical, dental, vision, and hearing needs, as well as mental health, developmental, and substance use disorders. Type and frequency of screening and diagnostic services will depend on the age of the individual and clinical appropriateness; screening and diagnostic services equivalent to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) are only available to those under 21.[32] Screening and diagnostic services are discussed in further detail in the supplemental chapter titled, "Special Requirements for Incarcerated Youth (including CAA requirements)."

DHCS received CMS approval for its Reentry Initiative Implementation Plan/CAA Operational Plan on October 2, 2024.[33] CMS confirmed through the approval of DHCS' Section 1115 Reentry Implementation Plan/CAA Operational Plan, that California may fully subsume the CAA requirements into its JI Reentry Initiative. Under the approved Implementation Plan, CMS authorized DHCS' approach that it will implement the CAA across all correctional facilities over a two-year period, from October 1, 2024 – September 30, 2026, to align with the roll-out of the JI Reentry Initiative. As part of DHCS' Readiness Assessment (RA) of correctional facilities going live with Reentry Initiative services, DHCS assesses whether the CFs are compliant with CAA requirements.

4.3 Medi-Cal Member Rights: Compliance with Section 1902(a) of the Social Security Act

In implementing the JI Reentry Initiative through the Section 1115 Demonstration, CMS requires DHCS to ensure compliance with Medicaid statutory requirements, as defined in Section 1902(a) of the Social Security Act and consistent with implementation plan Special Term and Condition (STC) 9.9, before and after Medi-Cal/CHIP-enrolled individuals are released from a CF.

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

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[32] Additional information on billing for screening and diagnostic services is contained in Section 7 of this Guide.

[33] Approved Section 1115 Reentry Implementation Plan, October 2024. Available here: https://www.dhcs.ca.gov/provgovpart/Documents/CMS-Approval-Letter-and-Updated-Reentry-Implementation-Plan.pdf.

operationalize in a pre-release correctional setting. Below are DHCS's requirements for ensuring that each of these requirements is supported across CFs and county SSDs.

4.3.a. 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, CFs 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 CFs to support individuals in submitting applications for Medicaid at, or shortly after, the intake process and no later than 135 days before release, if release date is known. Doing so will help ensure that individuals can at least apply for Medicaid even if their time within a CF lasts only a few days.

DHCS is working with CFs and county SSDs to enable the electronic submission of Medicaid applications that are completed within a CF. However, the Department will encourage CFs to support all application submission modalities (i.e., telephone, online, fax, 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 incarcerated individual's 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 a county SSD office.

California state prisons have already implemented pre-release Medicaid applications, and, as of January 1, 2023, all CFs were required to implement pre-release application processes. DHCS communicated this requirement to counties and county SSDs and reissued the guidance to state prisons in All County Welfare Directors' Letter (ACWDL) 24-04.[34]

4.3.b. 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 a Notice of Action (NOA) regarding their coverage, such as denials of Medicaid coverage or denials 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 county SSDs will be

[34] See ACWDL 24-04 (February 29, 2024), available at: https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/24-04.pdf

able to meet this requirement by sending the appropriate NOA to individuals and their delegated Authorized Representative (AR) (i.e., CFs, if applicable) for adverse determinations related to Medicaid and pre-release service eligibility. If the CF or their delegated entity is designated as an AR by the individual, county SSDs will receive the AR information and record it in the CalSAWS system. CFs will be required to process and deliver mail to individuals and ensure logistical, and security issues do not cause delays. When mailing to the CFs, an Inmate Number or other identifying information for the individual may be required. For individuals who are released before the notice is mailed, the county SSDs must mail the notice to the individual's last known address.

4.3.c. Fair Hearings (Section 1902(a)(3))

Federal rules require that states ensure individuals can 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, except for in-person requests at a county SSD due to a lack of freedom of movement. As noted earlier, DHCS expects that CFs 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 CF and/or privileges of the individual inmate.

For individuals who remain incarcerated during their scheduled hearing date, CFs and county SSDs will be required to implement virtual fair hearings so that JI individuals may participate via videoconferencing or telephone. Many CFs 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.

5. JI Reentry Initiative Services Delivery Models

Medi-Cal enrolled individuals who meet qualifying criteria for pre-release services will be able to receive a targeted set of covered pre-release Medi-Cal services and services upon release, including:

- **Pre-release care management services.**
- **Physical and behavioral health clinical consultation services** to screen for and diagnose health conditions, provide treatment as appropriate, and support development of a Reentry Care Plan.

- **MAT/Medication for SUD** for all Food and Drug Administration (FDA)-approved medications and biological products, including coverage for counseling or behavioral therapies to provide a "whole-patient" approach to the treatment of SUD.[35]
- **Behavioral Health Links.**
- **Medications, medication administration, and medications in hand upon release**.
- **Laboratory and radiology services.**
- **Screening and diagnostic services.**
- **Services provided by CHWs** with lived experience.[36]
- **Peer Support Services (PSS)** provided by Peer Support Specialists.
- **DME upon release**.

The federal Demonstration approval limits what services may be paid for by Medi-Cal. Numerous services covered by full-scope Medi Cal – for example, transportation, dental treatment, and vision benefits – are not included as part of the 90-day pre-release set of services. [37]

As described in other sections, pre-release services will be provided at CFs or, when necessary, at off-site locations (e.g., community clinic) with appropriate transportation and security oversight provided by the facility.

5.1 Fee-For-Service Delivery System and Reimbursement Model

[35] For more information on DHCS' policy related to MAT, please see BHIN 21-024. Available at: BHIN-21-024-DMC-ODS-Expanding-Access-to-Medications-for-Addiction-Treatment-MAT.pdf

[36] DHCS defines lived experience as first-hand experience with the criminal justice system, including a history of arrest or incarceration, or second-hand experience, including having a close family member, being a caregiver, or having a partner who has experience with the criminal justice systems.

[37] While screening and diagnostic services will be available to all JI individuals, the type and frequency of this service will depend on an individual's age and when medically necessary. Billing information for required screening services for individuals under 21 years of age is available in "Section 3: American Academy of Pediatrics Bright Futures" in the Preventive Services section of the Medi-Cal Provider Manual. Former foster youth (up to age 26) are required to have medically necessary screening and diagnostic services, as clinically appropriate.

Pre-release covered services are delivered, claimed, and paid for via Medi-Cal's Fee-For-Service (FFS) delivery system. Claims may be submitted through normal processes utilizing Medi-Cal Rx for pharmacy services and the California Medicaid Management Information System (CA-MMIS) for clinical services including care management, clinical consultations, MAT, CHW services, PSS, laboratory, and radiology.

DHCS will allow both providers embedded in the CF (including CF staff and contractors) and in-reach community-based providers (including pre-release care managers/post-release JI ECM providers and physical and behavioral health clinical consultants) to provide JI Reentry Initiative services, but all providers must enroll in Medi-Cal as an FFS provider. All ORP providers billing under the correctional facility exempt from licensure clinic must be individually enrolled in Medi-Cal FFS; for additional detail, see below section on Medi-Cal Provider Enrollment Requirements.

5.2 Role of the Correctional Facility

CFs may either deliver pre-release services through their own staff, including contracted providers (referred to as embedded model), facilitate service delivery through community-based providers (referred to as in-reach model), or use a mix of embedded and in-reach providers (referred to as mixed model). Service delivery models are described in more detail below. To ensure the required Medi-Cal covered pre-release services are delivered to all eligible individuals, CFs will need to establish operational processes to: (1) identify embedded and in-reach providers to deliver pre-release services; and (2) develop billing/claims processes.

CFs play a critical role in ensuring effective delivery and coordination of pre-release services across all delivery models. The following lists CF responsibilities for the provision of pre-release service:

- **Screen for Medi-Cal Eligibility and Coordinate Enrollment,** including coordinating with the county SSD to determine eligibility for Medi-Cal coverage, supporting completion and submission of Medi-Cal Pre-Release Applications for eligible individuals, and troubleshooting any requests from county SSD to confirm enrollment.
- **Screen for Pre-Release Services Eligibility** for all Medi-Cal eligible individuals.
- **Activate the JI Screening Portal** by entering required information in the JI Screening Portal to activate the member's JI aid code.
- **Coordinate Assignment of a Pre-Release Care Manager.** Pre-release care management must be provided by an embedded care manager (i.e., CF staff or

contractor), an in-reach care manager (i.e., a community-based JI ECM provider who will continue to serve the individual post-release), or a mix of embedded and in-reach providers. All care management models will require CFs to coordinate with MCPs to assign a care manager for the individual's pre- and/or post-release period.

- *Assigning an Embedded Pre-Release Care Manager:* CFs uses existing processes to assign the pre-release care manager. If a care manager had been providing care prior to activation of pre-release services, that care manager should continue to serve the individual in the reentry period (e.g., for individuals with longer stays).
  - *Assigning a Post-Release JI ECM Provider:* If an individual is served by an embedded pre-release care manager, the CF must additionally **support the assignment of a post-release JI ECM Provider** prior to release using mutually agreed upon and formally documented processes. CFs should follow the same process as assigning an in-reach care manager.
- *Assigning an In-Reach Care Manager*: MCPs and CFs may collaborate on a county-specific process to determine the appropriate provider assignment for each individual; this process should be documented in the CF's policies and procedures. MCPs and CFs may use the following approach:
  - If MCP assignment is known: CF reaches out to the publicly posted MCP JI Liaison at the MCP to which the individual is assigned. The MCP JI Liaison assigns an in-reach pre-release care manager and communicates the assignment to the CF.
  - If MCP assignment is unknown: The CF uses the MCP Provider Directory from an MCP in the county to which the individual will be released to reach out to a JI ECM provider and assign the individual an in-reach pre-release care manager. The CF must communicate the in-reach pre-release care manager assignment to MCP once the MCP is assigned.

» **Support Delivery of Pre-Release Care Management by the Pre-Release Care Manager.** Pre-release care management ensures identification and coordination of services delivered during the pre-release period and upon reentry as well as smooth linkages to social services and supports that will be used in the

community, including arranging appointments and timely access to appropriate post-release care. CF responsibilities include:

- Supporting (e.g., schedule, allow access to individual during appointment times) the in-reach and/or embedded pre-release care manager in developing a Health Risk Assessment, developing a Reentry Care Plan, care coordination activities, and participating in a warm-hand off (if the pre-release care manager and post-release JI ECM Provider are different; note that for facilities adopting a mixed care management model, a warm handoff must take place at the time the in-reach provider is expected to begin working with the individual).
- The supporting data-sharing between care management providers, as appropriate,
- Communicating known changes to the release date to the care management team,
- Developing (in partnership with MCPs) formally documented policies and procedures to ensure completion of warm handoffs if they do not occur prior to release, and
- Sharing the Reentry Care Plan with the post-release JI ECM Provider (if different than the pre-release care manager). The JI ECM Provider is then responsible for sharing the Reentry Care Plan with appropriate post-release entities, including the MCP. If the post-release JI ECM provider has not been assigned, the CF must ensure the Reentry Care Plan is shared with the MCP, which is then responsible for sharing with post-release providers.

Additional, detailed information on pre-release care management expectations is available in Appendix C and Supplemental Chapter 5: Pre-Release Service Policy and Benefit Guidance in the Care Management Services subsection.

- **Support Delivery of Additional Pre-Release Services** by ensuring embedded or in-reach providers have access to the individual and are able to provide physical and behavioral health clinical consultation services, screening and diagnostic services, behavioral health links, laboratory and radiology services, medications, Medication-Assisted Treatment, CHWs, and peer support services.

- **Provide Medications and DME Upon Release.** Ensure access to Medi-Cal-covered medications and DME in hand upon release, including a clinically appropriate supply of medications and any necessary prescriptions for refills or replacements, consistent with the State Plan.
- **Notify the individual's assigned MCP of release within 1 business day,** if the individual is assigned to an MCP.
- **Support Data Exchange with implementing partners** to facilitate pre-release Medi-Cal applications, pre- and post-release care management, and pre-release service delivery, with appropriate consent from the individual. This may include requested medical records, behavioral health and physical health data, the Reentry Care Plan, or Behavioral Health Link information.
- **Terminate the JI Aid Code in the JI Screening Portal.** Upon release from incarceration, communicate to the county SSD to unsuspend the primary aid code, and the individual's MCP enrollment will change from "hold" to "active" status. Once the member's enrollment changes to "active", the JI Aid Code will be terminated.

5.3 Embedded and In-Reach Provider Models and Considerations

As described above, CFs may deliver pre-release services through their own staff, including contracted providers (referred to as embedded providers), and/or facilitate service delivery through community-based providers (referred to as in-reach providers).

Two pre-release services must be delivered exclusively by one type of provider.

- **CHW services and Peer Support Services** must be provided exclusively by in-reach providers.
- **Dental diagnostic services** must be delivered exclusively by embedded providers.[38]
    - Dental diagnostic services must be billed to CA-MMIS under the CF's exempt-from-licensure pathway, consistent with the State Plan and DHCS guidance. Dental services should not be billed to California Dental

[38] Pursuant to Section 1902(a)(84)(D) of the Social Security Act and the Consolidated Appropriations Act of 2023, dental diagnostic services are required, as medically necessary, for youth, including former foster youth, incarcerated in a correctional facility. Dental diagnostic services are not covered for adults incarcerated in a correctional facility.

Medicaid Management Information System (CD-MMIS). Claims billed to CD-MMIS while an individual has the JI Aid Code activated will be denied.

5.3.a. Embedded, In-Reach, and Mixed Care Management Models

Pre-release care management services are provided by embedded care managers (i.e., correctional facility staff or contractors) and/or in-reach care managers (i.e., community-based JI ECM Providers) depending on which of the following three care management models a CF adopts:

1. **In-Reach Care Management Model:** Pre-release care management services are delivered by in-reach community-based care management providers who are contracted with MCPs as a JI ECM Provider. In-reach care managers deliver pre-release care management services in person or via telehealth. In-reach care managers should become the individual's JI ECM Provider after release from incarceration; if they cannot continue to serve the individual (i.e., due to a change in the individual's county of release), a warm handoff is required to take place with the JI ECM Providers and the individual.
    - In-reach care managers must be enrolled in Medi-Cal FFS and bill for services under their own NPI.
2. **Embedded Care Management Model:** Embedded care managers are directly employed or contracted with CFs and deliver pre-release care management services in person or via telehealth. Embedded care managers must participate in a warm handoff with the post-release JI ECM provider and the individual (in person or via telehealth) prior to release.
    - Embedded Care Managers do not need to individually enroll in Medi-Cal FFS; embedded Care Managers must bill for services under the CF clinic's exempt from licensure clinic NPI.[39]
3. **Mixed Care Management Model**: Within the Mixed Care Management Model, CFs can elect to pursue one of two approaches:
    - Population Level: In-reach care managers will deliver pre-release care management services to some individuals (e.g., mental health

[39] CF clinics must be enrolled by a public entity (county or state agency) that is responsible for CF healthcare. In most instances, this is the CF, in some cases this may be the County Health Department.

population) and embedded care managers will deliver pre-release care management services to all other eligible individuals.

- Individual Level: Pre-release care management responsibilities for one eligible individual will be split between an embedded and an in-reach care manager (e.g., embedded completes health risk assessment, in-reach completes reentry care plan). The embedded pre-release care manager is considered the "lead" care manager, and the CF is ultimately responsible for ensuring delivery of all pre-release care management services, including those services delegated to the in-reach care manager.

If adopting a mixed care management model, the CF retains ultimate responsibility for ensuring that eligible individuals receive all pre-release care management services; the CF must clearly specify the delegated responsibilities of the in-reach care manager in their Readiness Assessment. Additionally, for CFs adopting the mixed care management model, the in-reach care manager, embedded care manager, and individual must conduct a warm handoff at the time the in-reach provider is expected to begin working with the individual.

More detailed information on care management can be found in the Supplemental Chapter 5: Pre-Release Service Policy and Benefit Guidance in the Care Management Services subsection.

5.3.b. Embedded and In-Reach Clinical Consultation Providers

Table 1 summarizes provider types that may deliver pre-release clinical consultation services (including professional-to-professional warm handoff required under BH links), whether through embedded or in-reach models, and associated billing considerations.

Table 1. 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 CF	Correctional Health Care Facility NPI
Staff/vendor contracted by correctional agency	Yes	Private contractor/vendor clinician or county	Correctional Health Care Facility NPI

Table 1. Provider Type, Embedded or Community-Based, Provider Examples and NPI			
Type of Provider	**Embedded**	**Provider Examples**	**Correctional Facility or Separate Provider NPI**
as the primary carceral health care provider		behavioral health agency and/or its subcontracted providers providing CF behavioral health services as outlined in contract with Sheriff's Office.	
Community-based provider who provides services (under contract with the CF, but not the primary carceral health care provider) to individuals via telehealth and/or by traveling to the CF	No (referred to as in-reach provider)	CHW, county behavioral health agency and/or its subcontracted provider performing services under contract of the CF (but not as the primary carceral health care provider). Includes professional-to-professional clinical handoff within behavioral health link.	Community-Based Provider NPI

5.4 Fee-For-Service Delivery System and Reimbursement Model

MCPs are responsible for supporting reentry coordination activities for incarcerated members receiving JI Reentry Initiative pre-release services, including members in a suspend status. MCPs are expected to collaborate with the CF in alignment with the terms of the MCP-CF MOU (see Section 8 for additional information). DHCS expects MCPs to support the assignment of an in-reach pre-release care manager/post-release JI ECM provider; engage in data-sharing with the CF and pre-release care manager; support primary care provider assignment and scheduling of post-release appointments;

provide information on in-network providers and MCP plan benefits; and comply with Closed-Loop Referral Guidance.[40]

MCP enrollment should be effectuated at or shortly after release for all MCP-enrolled individuals. If an individual's MCP enrollment is not immediately effectuated, or the individual is in a FFS population, post-release care will be provided under FFS Medi-Cal.

All individuals who are eligible to receive 90-day pre-release services are automatically eligible to receive ECM services upon reentry into the community if they are enrolled in managed care, as the eligibility criteria for pre-release services and ECM for the JI population of focus (POF) are identical. The MCP must establish pathways to automatically approve ECM for any member who received pre-release services. The MCP must ensure that ECM services become available on the day of release, or if not yet enrolled in the MCP, on the day MCP enrollment begins.

DHCS suggests as a best practice that ECM Providers meet the individual at release if possible; or, if that is not possible, within two business 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 notification of release to ensure continuity of care, a seamless transition, and to monitor progress and the implementation of the reentry care plan.[41]

The MCP must develop written policies and procedures to coordinate post-release warm handoffs, in partnership with the CF. If an individual's MCP enrollment is not immediately effectuated, post-release care management services will be provided by the post-release JI ECM Provider and paid for on an FFS basis via Care Management Bundle 5 until their MCP enrollment has been effectuated. Additional detail on Care Management Bundle 5 can be found on the DHCS web site and Supplemental Chapter

[40] Closed Loop Referral Guidance (an addendum to the Population Health Management Policy Guide) is available at: https://www.dhcs.ca.gov/CalAIM/Documents/WIP-CLR-Implementation-Guidance.pdf

[41] SMDL 23-003 (April 17, 2023) 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. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/smd23003.pdf.

5: Pre-Release Service Policy and Benefit Guidance in the Care Management Services subsection.[42]

MCPs are responsible for ensuring access to medically necessary post-release services as well as oversight and administration of post-release ECM in alignment with the ECM Policy Guide.[43]

Additional details on MCP obligations related to the Justice-Involved Reentry Initiative are described in Supplemental Chapter 4: Managed Care Plan Requirements.

5.5 Telehealth Services

Telehealth is an important modality for delivering care management and clinical consultation services and for ensuring that providers, including post-release JI ECM providers, can meaningfully engage and build a trusted relationship prior to reentry (e.g., as part of the warm handoffs). DHCS considers telehealth an effective alternative to health care provided in person, particularly when delivering services for individuals who are in correctional settings.

Video and Audio-Only Telehealth Services. DHCS understands the importance of leveraging telehealth to provide pre-release services to address potential capacity and infrastructure 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 telehealth policy. For example, some procedures require in-person contact by their nature (e.g., immunizations). 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.

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 CFs related to bandwidth and

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[42] DHCS hosted a public webinar to review care management bundles in June 2024. The webinar presentation, recording, and transcript is accessible at: https://www.dhcs.ca.gov/CalAIM/Justice-Involved-Initiative/Pages/Webinars-Meetings.aspx

[43] The ECM Policy Guide is available at: https://www.dhcs.ca.gov/CalAIM/ECM/Documents/ECM-Policy-Guide.pdf

scheduling. DHCS requires providers to be in HIPAA-compliant spaces when providing telehealth services to JI individuals.

Information Sharing. DHCS encourages CFs and in-reach providers to leverage their existing telehealth infrastructure 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., case management, establishing a new patient, mental health screening), DHCS will mandate that CFs be able to share the following types of information: an individual's medical record or a specific subset of the electronic health record (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.

6. Medi-Cal Provider Enrollment Requirements

6.1 Correctional Facilities

CFs must enroll as Medi-Cal providers to be reimbursed for the delivery of allowable Medi-Cal pre-release services (e.g., care management, clinical consultations, medication and medication administration (including medications for SUD), radiology, laboratory services) and behavioral health links. Since all pre-release services are reimbursed through the Medi-Cal FFS delivery system, all providers must be enrolled as Medi-Cal FFS providers through DHCS' Provider Enrollment system.

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

Correctional Facility Enrollment – By Facility

- Each State prison, county jail, and YCF will enroll as a Medi-Cal provider under the Medi-Cal *exempt from licensure clinic* enrollment type.
- CF enrollment is location-specific, meaning only one provider per cite is required to enroll as an exempt from licensure clinic.
  - For example, if a county has multiple jail facility sites, each jail clinic must enroll as an exempt from licensure clinic.
- For county CFs, the county entity primarily responsible for providing or arranging for the provision of correctional health care services at the facility will serve as the enrolled entity.
  - For example, in adult jails, the lead entity varies by county. In some counties the county sheriff is the lead entity and in other counties, another

county entity (e.g., public health) that assumes the lead agency role. The lead agency completes the enrollment.

- The lead county agency will enroll as a provider in Medi-Cal, input data into the JI Screening Portal, oversee claims submissions, maintain the electronic health record, as applicable, and generally administer pre-release services for eligible individuals.
- The lead county agency (i.e., the enrolled provider) may contract a third-party correctional health care services provider for the actual delivery of services. The lead county agency may also contract with a third-party administrator/billing entity responsible for managing the JI Screening Portal and/or submitting claims on the agency's behalf.
- Community-based, in-reach providers must separately enroll as Medi-Cal providers and directly bill DHCS for services.[44]

DHCS published a step-by-step guide to assist correctional facilities with Medi-Cal provider enrollment processes. Medi-Cal FFS provider application information for exempt-from-licensure clinics can be found on the DHCS website.[45] The DHCS provider enrollment 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). CFs should submit their Medi-Cal enrollment applications at the same time as, or in advance of, their Readiness Assessment submission. DHCS will approve clinic and pharmacy enrollments upon a facility's demonstration that they meet the Medi-Cal provider enrollment requirements, effective date of the enrollment will align with the facility's approved go-live date. CFs may not bill for pre-release services prior to their approved go-live date.

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[44] CF clinics should be enrolled by a public entity (county or state agency) that is responsible for CF healthcare. In most instances, this is the CF, in some cases this may be the County Health Department.

[45] Application information for exempt from licensure clinic is available at: https://pave.dhcs.ca.gov/sso/login.do,
For more information on how CFs can enroll in Medi-Cal, please refer to DHCS guidance, available at: https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/PAVE-Enrollment-for-Correctional-Facilities.pdf.

6.2 National Provider Identifier Requirements

All Medi-Cal providers, including billing providers and rendering or furnishing providers, must obtain a National Provider Identifier (NPI) as a pre-requisite for participation in the Medi-Cal program. The NPI is a unique, 10-digit identification number assigned to healthcare providers by CMS.[46] CFs and individual practitioners need an NPI for various reasons, such as billing for services, compliance with regulations, or improving care delivery.[47]

There are two types of NPI numbers: Type I for individual practitioners/providers (e.g., physicians, registered nurses, licensed clinical social workers) and Type II for organizational providers (e.g., correctional facilities/exempt from licensure clinics). Each provider must select an applicable taxonomy code and apply for an NPI based on that taxonomy class.[48]

Applications can be submitted through the CMS National Plan and Provider Enumeration System (NPPES) website. The amount of time it takes to obtain an NPI is dependent upon the volume of applications being processed by CMS, whether the application was submitted electronically or by mail, and whether the application was complete and free of errors. That said, CMS states that a provider who submits a properly completed electronic application could receive an NPI in fewer than 10 business days. Paper application reviews take approximately 20 business days. Application errors may delay assignment. Providers or practitioners submitting applications online may track the progress of their application and will receive an email with the new NPI number when the application is processed and approved.

6.3 Ordering, Referring and Prescribing (ORP) Providers

Under federal Medicaid law, all ORP providers must individually enroll in Medicaid. Generally, ORP providers are defined as follows:

- An ‘ordering or referring’ provider is a provider who orders non-physician services such as lab tests, imaging, or DME or refers a patient to another provider or facility for services and that covered service cannot be obtained without a referral.

[46] DHCS does not assign NPIs.

[47] For more information, please refer to CMS-approved resources on NPIs.

[48] There are more than 800 taxonomies available covering multiple types of providers. There is a taxonomy specific to correctional health. Consider Taxonomy Code: 261QP2400X; Prison Health Clinic/Center.

- A ‘prescribing’ provider is a provider who writes prescriptions for medications or services.

DHCS requires all ORP practitioners, with an FFS enrollment pathway, to enroll as a Medi-Cal FFS provider. Per CMS mandate, Medi-Cal providers that bill for goods or services ordered or referred by another provider are required to list the NPI (Type I) of the provider who ordered, referred or prescribed the goods or services being billed on the Medi-Cal claim. The ordering or referring provider must be enrolled as a participating provider in Medi-Cal using their Type 1 NPI even if the provider does not send claims directly to Medi-Cal for the services they furnish.

Individual practitioners within the CF will not need to enroll independently as providers if they are operating under the CF NPI unless they are an ORP provider.

CFs must submit to DHCS a list of all embedded organizational providers, embedded individual providers, and approved in-reach providers for each facility. This list must be submitted initially as part of the CF’s Readiness Assessment; and then on a monthly-basis following CF’s go-live with pre-release services. CFs will be required to ensure that any embedded providers they employ or contract with meet minimum credentialling requirements that comply with DHCS’ enrollment requirements to provide services.[49]

DHCS will monitor each CF’s compliance with state and federal provider enrollment requirements.

6.4 Pharmacy Enrollment

Each CDCR facility and any county jail or YCF facility with an on-site pharmacy, any local community or out-of-state pharmacy contracted by the CF to provide pre-release prescription services must enroll as a Medi-Cal pharmacy. Further, any community-pharmacy used by the CF to fulfill the medications in-hand upon release requirement must be enrolled in Medi-Cal. Enrollment is location-specific and only one pharmacy per site is required to enroll.[50]

6.5 Behavioral Health Providers

[49] Any embedded providers enrolled directly with DHCS as Medi-Cal providers may be considered to have met all state and federal enrollment requirements.

[50] Pharmacy enrollment information is available at: https://www.dhcs.ca.gov/provgovpart/Pages/PharmacyProviderApplicationInformation.aspx.

Except in limited circumstances,[51] for the purposes of the JI Reentry Initiative, behavioral health providers, including county behavioral health plans that furnish services directly to Medi-Cal members for the SMHS, DMC, and DMC-ODS programs and community behavioral health providers that contract with county behavioral health plans, must enroll in Medi-Cal with DHCS Provider Enrollment as FFS Medi-Cal providers.

6.6 Medi-Cal Provider Enrollment for Community-Based Providers

To obtain reimbursement for in-reach pre-release services, including pre-release care management delivered by in-reach care managers, community-based providers must enroll in Medi-Cal FFS. 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). [52] For example, a community-based physician providing in-reach or telehealth clinical consultation services would need to be enrolled as a physician/surgeon provider type to receive Medi-Cal reimbursement.

DHCS established a "community-based organization" provider type to support enrollment of providers for certain JI pre-release services, including pre-release care management. The "community-based organization" provider type is applicable for care management providers and CHWs. Providers enrolling under this type must be a 501(c)3 or licensed entity of a 501(c)3.[53]

7. CF Readiness Assessment Requirements

CF must complete the Readiness Assessment (RA) process and meet all prerequisites prior to going live with Medi-Cal pre-release services. DHCS uses the RA to verify that each CF has the governance, staffing, workflows, systems, training, and documentation

[51] County behavioral health plans that will only bill for receiving the 'behavioral health link' through existing processes (i.e., Short-Doyle Medi-Cal) and do not furnish in-reach behavioral health services (e.g., psychotherapy) are not required to enroll in Medi-Cal FFS.

[52] DHCS provider enrollment website is available at: https://www.dhcs.ca.gov/provgovpart/Pages/Provider-Enrollment-Options.aspx. More information on provider types eligible to bill JI is available at: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/0D63B413-5E69-4611-8A10-A5E63529AD0C/justinv.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO.

[53] A detailed overview of the provider enrollment process for community based organizations is available at: https://www.dhcs.ca.gov/provgovpart/Documents/Enrollment-for-CBOs-LHJs-using-PAVE.pdf.

in place to implement the JI Reentry Initiative and to begin billing Medi-Cal FFS for pre-release services.[54] The RA consolidates key readiness elements and reviewer criteria aligned with the Guide and must be completed and approved by DHCS prior to a facility's go-live.

DHCS will make a preliminary decision about the CF's go-live date within 30 calendar days of receipt of the CF's initial RA submission to DHCS. However, final approval for going live is predicated upon completion of the identified prerequisites and all mandatory onboarding activities. CFs must also complete all required training and onboarding activities prior to go-live. Documentation must be submitted to substantiate completion of prerequisites and training activities. CFs must be responsive to DHCS' request for additional information, if applicable.

8. Memoranda of Understanding (MOU) Requirements

DHCS requires CFs and each MCP in their county of operation to execute an MOU, using DHCS' approved MOU template.[55] County Jails and County YCFs must enter into MOUs at a county level (e.g., a County Sheriff will enter into a MOU on behalf of all jails in the county; County Probation will enter into a MOU on behalf of all YCFs in the county). State prisons will enter into a MOU with all MCPs in the state. The CF and any public entities (e.g., Public Health Agency) responsible for the delivery of correctional health services should each be parties to the MOU.[56] Below are the timeline requirements for executing the MOU:

- For CFs that go live with pre-release services prior to or on January 1, 2026, the effective date for CFs and MCPs to demonstrate a good faith effort to enter into

[54] The Readiness Assessment template is available at: https://www.dhcs.ca.gov/CalAIM/Justice-Involved-Initiative/Pages/Resources.aspx; the Readiness Assessment Webinar is available at: https://www.dhcs.ca.gov/CalAIM/Justice-Involved-Initiative/Pages/Webinars-Meetings.aspx.

[55] The MOU template is available at: https://www.dhcs.ca.gov/Pages/MCPMOUS.aspx.

[56] Being "party" to the MOU means that by signing the MOU, the signing entity is agreeing to carry out the obligations set forth in the MOU as necessary and delineated among the parties to the MOU. For example, if the county Public Health Agency provides correctional services at the CF, the county Public Health Agency and the CF should both be parties to the MCP-CF MOU and must delineate among themselves which obligations under the MOU each party is responsible for carrying out.

a MOU is by January 1, 2026. Prior to finalizing a MOU, the MCP and CF must both submit quarterly reports on progress to DHCS.

- For CFs that go live with pre-release services after January 1, 2026, the effective date for CFs and MCPs to demonstrate a good faith effort to enter into a MOU is by the CF's go-live date. Prior to finalizing a MOU, the MCP and CF must both submit quarterly reports on progress to DHCS.

As a best practice, DHCS recommends that CFs and MCPs begin negotiating the MOU as soon as possible and no later than upon submission of the CF's RA.

9. DHCS Monitoring and Oversight

State law mandates that DHCS administer, and that CFs and Medi-Cal behavioral health delivery systems implement, the JI Reentry Initiative. Effective July 27, 2021, Welfare and Institutions Code (WIC) section 14184.102 required DHCS to seek federal approval for and to implement the JI Reentry Initiative, which includes the provision of targeted pre-release Medi-Cal benefits to qualified individuals.[57] Per State law, DHCS must implement the JI Reentry Initiative as approved by CMS. Subsection (d) of WIC section 14184.102 also provides DHCS with authority to implement, interpret, or make specific the CalAIM article commencing with WIC section 14184.100[58] or the CalAIM Terms and Conditions,[59] 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 will include providing all benefits for the JI population.

Subsection (e) of WIC section 14184.102 allows DHCS to enter into contracts, or amend existing contracts, for the purposes of implementing the CalAIM article or the CalAIM Terms and Conditions. DHCS may utilize this subsection to enter into memoranda of understanding, interagency agreements, or similar contractual arrangements with applicable parties including state and local correctional agencies and to memorialize

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[57] WIC Section 14184.102. Available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14184.102&lawCode=WIC.

[58] WIC section 14184.100. Available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14184.100.&nodeTreePath=16.6.17.53&lawCode=WIC.

[59] CalAIM Section 1115 Demonstration Special Terms and Conditions. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-calaim-dmnstrn-appvl-12162024.pdf.

mandated activities, performance standards, remedies for noncompliance, etc., related to the provision of pre-release services.

Furthermore, WIC section 14184.800[60] provides state authority for when an 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 Section 1115 Demonstration approved by CMS, the CalAIM STCs related to the JI Reentry Initiative are mandatory for DHCS to implement and CFs and county behavioral health agencies to participate in per federal and state law. In addition to the state being obligated to comply with the waiver conditions, DHCS obtained approval from CMS for its Implementation Plan from CMS as described above.[61]

DHCS has established program requirements through this Guide, Providing Access and Transforming Health (PATH) JI Round 3 funding approval documents (implementation plan, interim progress report, and final progress report), Readiness Assessments, and the JI ECM Model of Care.

The following describes DHCS's approach to supporting successful implementation of JI reentry services and behavioral health links across CFs:

- **CF and County Behavioral Health Agency Readiness Assessments.** DHCS requires CFs to complete Readiness Assessments that will gauge their readiness

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[60] Welfare and Institutions Code section 14184.800.Available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14184.800.&lawCode=WIC.

[61] Approved Section 1115 Reentry Implementation Plan, Department of Health Care Services, October 2024.Available at: https://www.dhcs.ca.gov/provgovpart/Documents/CMS-Approval-Letter-and-Updated-Reentry-Implementation-Plan.pdf.

to comply with the waiver's program and regulatory requirements prior to launching pre-release services. All county behavioral health agencies were required to submit a readiness assessment by April 1, 2024, to confirm the agency was ready to go-live with receiving behavioral health links. DHCS will use the findings from the RA to evaluate compliance with program and statutory requirements and identify any gaps that need to be addressed.

DHCS will require implementing partners to submit on-going periodic compliance reports at a cadence to be determined (e.g., every six months or annually) following the evaluation of the initial RA. Ongoing reports could include, but are not limited to:

- Narrative reporting on each milestone as laid out in the RA including highlights of progress made, challenges, and mitigation strategies;
- Updated policies and process flows;
- Technical assistance needs; and,
- Available data on the number of individuals served.

- **Provider Enrollment:** DHCS will monitor and regulate all employed and contracted providers under this demonstration through the following mechanisms:
  - Monitoring of the exempt from licensure clinic: All CF embedded providers will bill under either the pharmacy or exempt from licensure clinic status. As part of the exempt from licensure clinic provider agreement, facilities must attest to compliance with a number of program integrity measures including, but not limited to: billing for claims with an NPI that was registered with CMS; not engaging in conduct contrary to the public health, welfare, safety or fiscal integrity of the Medi-Cal program; ensuring compliance with non-discrimination clauses; agreeing to maintain in good standing liability insurance; making, keeping and maintaining record keeping consistent with state and federal regulations; upon request, making available copies of records to DHCS, the Attorney General and the Secretary; ensuring confidentiality of beneficiary medical records; disclosing all information as required by Federal Medicaid laws and regulations and any other information required by DHCS; and attesting that it shall not engage or commit provider fraud, waste and abuse.
  - Monitoring eligibility of ORP providers: DHCS will conduct oversight and monitoring of ORP providers in compliance with state and federal laws and

regulations. Claims must include the Type I NPI of the ordering, referring, or prescribing providers on all orders, referrals (as required), and prescriptions, as well as the Type I NPI of the rendering provider.

- **Implementation Technical Assistance.** DHCS will deliver technical assistance to CFs, county behavioral health agencies, and county SSDs as they plan to implement the JI Reentry Initiative. Technical assistance is available to implementing partners prior to the launch of pre-release services, to support implementation planning and compliance with section 1902(a) and other requirements. DHCS delivers targeted and intensive technical assistance to counties and facilities where capability and/or compliance gaps are identified through the RA. DHCS provides continued 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 establish a comprehensive monitoring approach for this initiative, in alignment with its CMS approved monitoring protocol and State monitoring priorities. DHCS will monitor claims and encounter data, number and types of physical and behavioral health services and medications that an individual has received in the pre- and post-release periods. DHCS will monitor service utilization, including DME orders and prescriptions (covered as pre-release services) for unusual prescribing and ordering processes.
- DHCS intends to monitor the ongoing progress of the initiative through the following multi-pronged effort which includes, but is not limited to:
    - A selection of quality-of-care and health outcomes metrics and population stratifications based on CMS' guidance;
    - Standardized reporting on categories of metrics, including but not limited to beneficiary participation in demonstration components, number of primary and specialist provider participation, utilization of services, quality of care, and health outcomes;
    - Periodic reviews of claims and encounter data, by CF, to assess:
        - Number of beneficiaries served, and types of services rendered under the demonstration;
        - Administration of screenings to identify individuals who qualify for pre-release services;

        - Utilization of applicable pre-release and post-release services (e.g., care management, Medications for SUD, clinical/behavioral health assessment pre-release and primary and behavioral health services post-release);
        - Provision of health, behavioral health, and/or social service referrals pre-release;
        - Participants who received care management pre-release and were enrolled in ECM; and,
        - Take-up of data system enhancements among participating carceral settings.
    - Claims and encounter data in the post-release period to track the number of services that an individual who was eligible for pre-release services received in the post-release period (and within how many months post-release);
    - Scheduled site visits or remote desk audits, including policy and procedure reviews and chart audits;
    - Surveys to implementation partners; and,
    - Solicitation of stakeholder feedback on implementation progress. For example, community-based providers can provide input on successes and/or challenges with setting up in-reach services and MCPs can provide feedback on how consistent CFs have been with sharing information for warm handoff.

Based on DHCS' ongoing monitoring, DHCS will identify and discuss with CFs any operational issues occurring within CFs, establish channels for one-on-one technical assistance support, develop and implement corrective action plans (CAPs) outlining remediation requirements and monitor implementation of CAPs, as needed.

DHCS will also develop monitoring protocols to ensure treatment is not delayed for required services, including MAT. (CFs are required under state and federal law to provide needed medications and cannot delay medication treatment until Medicaid funding is available.)

Appendix A. Acronyms

Acronyms	
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
CCHCS	California Correctional Health Care Services
CCJBH	Council on Criminal Justice and Behavioral Health
CDCR	California Department of Corrections and Rehabilitation
CF	Correctional Facility (inclusive of state prisons, county jails, or youth correctional facilities)
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
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

Acronym	Term
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
HCPCS	Healthcare Common Procedure Coding System
HIPAA	Health Insurance Portability and Accountability Act
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HRA	Health Risk Assessment
HRSN	Health-Related Social Need
ICT	Inter-County Transfer
IHHS	In Home Health Services
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
MAUD	Medications for Alcohol Use Disorder
MCIEP	Medi-Cal Inmate Eligibility Program
MCIP	Medi-Cal County Inmate Program
MCP	Medi-Cal Managed Care Plan
MEDIL	Medi-Cal Eligibility Division Information Letter
MEDS	Medi-Cal Eligibility Data System
MHP	Mental Health Plan
MOUD	Medications for Opioid Use Disorder
MSIP	Medi-Cal State Inmate Program

Acronym	Term
NEMT	Non-Emergency Medical Transportation
NMT	Non-Medical Transportation
NSMHS	Non-Specialty Mental Health Services
NIDA	National Institute of Drug Abuse
NTP	Narcotic Treatment Providers
NOA	Notice of Action
OTC	Over The Counter
ORP	Ordering, Referring, and Prescribing
OUD	Opioid Use Disorder
PA	Prior Authorization
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
SMDL	State Medicaid Director Letter
SSD	County Social Services Departments
STC	Special Terms and Condition
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
WIC	Welfare and Institutions Code
WPC	Whole-Person Care
YCF	Youth Correctional Facility

Appendix B. Glossary of Terms

Glossary of Terms	
Term	**Definition**
Behavioral Health Link	The facilitation of referrals, by correctional facilities (CFs), 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 members who received behavioral health services while incarcerated, to allow for the continuation of behavioral health treatment. Behavioral health links seek to ensure continuity of treatment for individuals who receive behavioral health services while they are incarcerated and who wish to continue to receive these services from SMHS, DMC, and/or DMC-ODS in the community. Behavioral health links are also for individuals who receive medication treatment for SUD, including through the MCP provider network.
California Medicaid Information Management System (CA-MMIS)	A legacy automated computer processing system that processes and adjudicates Medi-Cal Fee-For-Service (FFS) claims.
Care Manager Warm Handoff	A required meeting to ensure care coordination. The warm handoff is the first step in establishing a trusted relationship between the individual and the new care manager to ensure seamless service delivery and coordination.
Clinic Stock Medications	Medications for patient administration that are in non-patient specific containers/packaging and not dispensed from a licensed pharmacy.
Correctional Health Care Agency	The entity which provides health care services for the correctional facility (e.g., correctional agency, county health department responsible for providing all correctional health care services).

Term	Definition
Correctional Facility (CF)	State prisons, county jails, and county youth correctional facilities.
CF Responsible Person	The person designated by CF to oversee coordination and communication with MCP and ensure CF's compliance with the Guide. It is recommended that this person be in a leadership position with decision-making authority and authority to effectuate improvements in JI related practices.
County Behavioral Health Provider	A behavioral health provider (i.e., a county-operated or county-contracted provider, or specialty behavioral health provider who is part of the county behavioral health plan's network), that furnishes services covered under the County Behavioral Health Agency's contract with DHCS.
County Behavioral Health Agencies	The county entity responsible for coverage of Medi-Cal Specialty Mental Health Services (SMHS) and Medi-Cal substance use disorder services as part of the Drug Medi-Cal (DMC) State Plan or Drug Medi-Cal Organized Delivery System (DMC-ODS).
Disposable Outpatient Medical Supplies	Single-use, disposable medical devices required for medical necessity and used by a member to mitigate, or ameliorate a medical condition, in the member's home. They are products that are commonly found in a pharmacy and are for the member's personal use.
Durable Medical Equipment (DME)	Equipment used for medical reasons that can withstand repeated use, used by a member to mitigate, or ameliorate a medical condition, and used in the member's home.
Enhanced Care Management (ECM)	A whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-cost and/or high-need members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered.

Term	Definition
Embedded Care Management Model	A model through which embedded care managers (i.e., care managers employed by or operating under contract with the CF) deliver pre-release care management services to individuals eligible for pre-release services.
Embedded Clinical Staff	A clinical provider employed or directly contracted by the CF (e.g., correctional facility staff, third-party vendor, contracted specialty behavioral health provider, or other contracted provider) to furnish health care services (physical health and behavioral health) to individuals incarcerated in the CF as the primary carceral physical or behavioral health provider.
Enteral Nutrition Formula	A special liquid food mixture containing all the nutrients required to meet nutrition needs, such as protein, carbohydrates, fats, vitamins, minerals, and other nutrients. The formula can include ready-to-feed liquids, formulas made from powder or a concentrate.
Fee-For-Service (FFS)	The delivery system through which all pre-release services will be reimbursed. Claims submitted by FFS providers are adjudicated, processed, and paid for by the Medi-Cal program's fiscal intermediary.
Full Supply of Medication	The maximum amount of medication that is clinically appropriate and allowed by the Medi-Cal State Plan.
HCPCS Code	A collection of standardized codes that represent medical procedures, supplies, products, and services. The codes are used by pharmacy providers for billing on a medical claim using a CMS *1500* form.
In-Reach Clinical Staff	A clinical provider based in the community (e.g., a community-based physician, a CHW, a county health department and its providers) performing services in person or via telehealth under contract of the CF (but not as the primary carceral physical or behavioral health care provider).
In-Reach Care Management Model	A model through which community-based care management providers deliver pre-release care

Term	Definition
	management for individuals eligible for pre-release services, either in person in the CF or via telehealth.
Justice-Involved ECM Provider (JI ECM Provider)	An ECM provider (i.e., a community-based entity with experience and expertise providing intensive, in-person care management services to individuals in one or more of the ECM Populations of Focus) that meets the minimum requirements to administer ECM services to justice-involved individuals and participate in warm handoffs.
Justice-Involved (JI) Individual	An individual who is currently or was formerly incarcerated within the past twelve months.
Lived Experience	First-hand experience with the criminal justice system, including a history of arrest or incarceration, or second-hand experience, including having a close family member, being a caregiver, or having a partner who has experience with the criminal justice system.
Medi-Cal Rx	The Medi-Cal pharmacy benefits administered by the department in the Fee-For-Service (FFS) delivery system for all Medi-Cal members, regardless of their delivery system of care. Medi-Cal Rx was established under Executive Order N-01-19.
Medication Assisted Treatment or Medications for Addiction Treatment (MAT), also referred to as Medications for Substance Use Disorder Treatment	Medications to treat opioid use disorder (MOUD) or alcohol use disorder (MAUD), including the important use of medication as a stand-alone treatment without the pre-requisite use of psychosocial services, when clinically indicated. DHCS defines this term as Medications for Substance Use Disorder Treatment and will refer to it as such in this Guide.
Medi-Cal Managed Care Plans (MCPs)	Organized systems of care that provide cost-effective resources to improve health care access and quality of care, with an emphasis on primary and preventative care.
MCP JI Liaison	An individual or a team (i.e., a live person not an automated hotline) who will be available to support correctional facilities, pre-release care managers, and/or ECM providers as needed.

Term	Definition
Mixed Care Management Model	A model where a CF delegates responsibility for pre-release care management services between a "lead" embedded care managers (i.e., care managers employed by or contracted with the CF) and an in-reach care managers (i.e., community-based care management provider) serving the same individual.
Peer Supports	Recovery services are designed to provide social support to individuals during the pre- and post-release periods.
Pharmacy	A facility licensed by the California State Board of Pharmacy to dispense patient specific drugs under the authority of a licensed pharmacist.
Pre-Release Care Manager	The person who will act as the primary point of contact to ensure whole-person reentry services are provided during the pre-release period.
Prescription	A patient specific medication order with legally required elements received by a licensed pharmacy for dispensing patient specific drugs.
Post-Release ECM Provider	The person who will act as the primary point of contact after reentry once the member is enrolled in an MCP and at any point during the post-release period enrollment gap when the member is still in the FFS delivery system.
Reentry Care Plan	A patient-centered health care plan of action created in collaboration with the individual, the clinician(s) providing consultation services (as available) and CF's reentry planning team prior to the individual's release.
Targeted Case Management (TCM)	Pre-release services that can be billed as in-reach services by the county behavioral health agency to facilitate BH links to the care management providers, who will provide behavioral health-specific care management upon release. TCM will only be billed if someone meets the eligibility criteria for and needs

Term	Definition
	additional targeted case management support specific to behavioral health links.

Appendix C. Definitions of Covered Pre-Release Services

The following benefits will be available to eligible individuals in the 90 days prior to expected date of release. Pre-release covered services will be delivered, claimed, and paid for via Medi-Cal's FFS delivery system.[62]

Pre-Release Covered Services	
Covered Service	**Definition**
Care Management	Care management will be provided in the period up to 90 days immediately prior to the expected date of release and is intended to facilitate reentry planning into the community in order to (1) support the coordination of services delivered during the pre-release period and upon reentry; (2) ensure warm handoffs 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 links and referrals, as appropriate. » Assessing the needs of the individual to inform development, with the member, of a person-centered reentry care plan (referred to hereafter as the reentry care plan), with input from the clinician providing consultation services and the CF's reentry planning team. o While the reentry care plan is created in the pre-release period and is part of the care 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.

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

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 handoffs and/or behavioral health links with receiving county behavioral health agencies and/or MCP ECM providers. » Support behavioral health links for those eligible. » 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 handoffs 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 care managers who will provide services under the Medicaid state plan or other waiver or demonstration authority (i.e., non-ECM care 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.

Pre-Release Covered Services	
Covered Service	**Definition**
	For county behavioral health agencies providing in-reach behavioral health care management, care management must provide medically necessary SUD care coordination (depending on the county of residence), Peer Support services (depending on the county of residence), and SMHS Targeted Case Management, as applicable for members meeting access criteria for these services, covered in the Medi-Cal State Plan and Medi-Cal 1115 and 1915(b) waivers.
Physical and Behavioral Health Clinical Consultation Services	Services to screen, 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: physical, behavioral health, and dental exams; diagnosis, such as behavioral health assessments or physical health diagnostic evaluations and procedures; immunizations; or outpatient clinician services that treat or stabilize individuals, such as behavioral health therapy, physician-administered medications, or the prescribing of medications. Clinical consultation services are intended to support the creation of a comprehensive, robust, and successful reentry plan, and include screening, 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, enteral nutrition formula, or disposable outpatient medical supplies 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

Pre-Release Covered Services	
Covered Service	**Definition**
	members after release, including behavioral health links. Services may include, but are not limited to: » Addressing service gaps that may exist in correctional care facilities. » Screening, diagnosing and stabilizing individuals while incarcerated, preparing them for release. » Providing treatment, as appropriate, to ensure control of qualifying conditions prior to release (e.g., to recommend medication changes or ordering appropriate DME, enteral nutrition formula, or disposable outpatient medical supplies for post-release). » Supporting reentry into the community. » Behavioral health clinical consultation includes clinical assessment, peer supports, and treatment, such as behavioral health counseling, therapy, patient education, and medication services[63] including medications clinically effective at treating substance use disorders outside of the FDA-approved indications.
Laboratory and Radiology Services	Laboratory and radiology services will be provided consistent with the State Plan.[64]

[63] Medication services include prescription or administration of medication related to SUD services, or the assessment of the side effects or results of the medication. Medication Services does not include MAT for OUD or MAT for AUD and other Non-Opioid Substance Use Disorders. Medication Services includes prescribing, administering, and monitoring medications used in the treatment or management of SUD and/or withdrawal management not included in the definitions of MAT for OUD or MAT for AUD services. Additional information is available in BHIN 23-001, available at: https://www.dhcs.ca.gov/Documents/BHIN-23-001-DMC-ODS-Requirements-for-the-Period-of-2022-2026.pdf

[64] California State Plan is available at: https://www.dhcs.ca.gov/formsandpubs/laws/Pages/CaliforniStatePlan.aspx

Pre-Release Covered Services	
Covered Service	**Definition**
Medications and Medication Administration	Medications and medication administration will be provided consistent with the State Plan.
MAT/ Medications for SUD	» 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 CFs 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 SUD 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 SUD as covered in the State Plan 1905(a)(13) benefit, including assessment; individual/group counseling; patient education; and prescribing, administering, dispensing, ordering, monitoring, and/or managing MAT. Services may be provided by CFs 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 prescribed OTC drugs (a minimum 30-day supply as clinically appropriate, consistent with the approved Medicaid State Plan).

Pre-Release Covered Services	
Covered Service	**Definition**
	» DME, enteral nutrition formula, and disposable outpatient medical supplies consistent with Medicaid State Plan requirements.

Appendix D. JI PATH Funding for Implementation of Medi-Cal Applications, Reentry Initiative Services, and Behavioral Health Links

To ensure a successful launch of the JI 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 demonstration approval for the 1115 Reentry Demonstration (JI Reentry Initiative) provided an additional $410 million in PATH funding to support capacity building and implementation of JI Reentry Initiative services.[65]

JI PATH funding was available in three funding rounds:

JI PATH Round 1: Provided small planning grants to probation offices, sheriff's offices, and CDCR (or its delegate) to support collaborative planning with county SSDs, county behavioral health agencies, 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. The application for JI PATH Round 1 grants closed on July 31, 2022, and funds were disbursed in fall 2022.[66]

JI PATH Round 2: Supported county SSDs, county sheriff's offices, county probation offices (or their delegate), and the CDCR (or its delegate) 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

[65] The JI PATH Website and links to JI PATH reference materials are available here: https://ca-path.com/justice-involved

[66] PATH Round 1 guidance is available at: https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/PATH-JI-Capacity-Building-Round-1-Guidance-Memo.pdf; The JI PATH Round 1 funding awards is available at: https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/PATH-Round-1-Awards-11-21-2022.pdf.

PATH Round 2 was open from January 30, 2023, through March 31, 2023, and the dispersal of funds for JI Path Round 2 are complete.[67]

JI PATH Round 3: Provided funding to support the planning and implementation of the provision of pre-release services and behavioral health links.[68] Funds may be used 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.[69] JI PATH Round 3 funds were available to county sheriff's offices, probation offices, behavioral health agencies, and CDCR; applications closed on July 31, 2023. Funds will be distributed based on meeting certain performance milestones.

JI PATH funding is designed to support the planning for and implementation of the JI 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 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.

PATH funding was made available for providers seeking to become ECM and Community Support contracted providers serving JI populations. Providers exploring opportunities to serve JI populations were able to apply for CITED funding[70], take part in

[67] PATH Round 2 guidance is available at: https://tpa-reference-material-prod.s3.us-west-2.amazonaws.com/docs/justice-involved/PATH-JI-Capacity-Building-Round-2-Guidance-Memo%202%2027%202023.pdf; The JI PATH Round 2 funding awards is available at: https://www.dhcs.ca.gov/CalAIM/Justice-Involved-Initiative/Documents/PATH-JI-Round-2-Awardees-List-and-Funding-Uses.pdf.

[68] PATH Round 3 guidance is available at: https://tpa-reference-material-prod.s3.us-west-2.amazonaws.com/2023-07-06T11:48:27.859890_PATH%20JI%20Capacity%20Building%20Round%203%20Guidance%20Memo_Final%20Guidance_June%202023.pdf

[69] 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. Available at: Justice-Involved Initiative Home (ca.gov).

[70] Information on CITED funding applications and eligibility is available at: https://www.ca-path.com/cited

Collaborative Planning and Implementation groups[71], and participate in the PATH Technical Assistance (TA) Marketplace.[72]

[71] Information on Collaborative Planning opportunities is available at: https://www.ca-path.com/collaborative

[72] Information on the PATH TA Marketplace is available at: https://www.ca-path.com/technical-assistance

Appendix E. Approach to Planning and Implementation of Reentry Initiative Services and Behavioral Health Links

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.

Stakeholder Engagement: Beginning in October 2021, DHCS began actively meeting with its CalAIM Justice-Involved Advisory Group, implementation partners, and with additional sub-working groups. DHCS also held monthly pre-release technical assistance office hours sessions to inform the Section 1115 Demonstration (JI Reentry Initiative) 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 reentry initiatives. The group continued to meet bimonthly until the approval of the JI Reentry Initiative; DHCS will continue to convene with this group on an as-needed basis.

Members of the CalAIM Justice-Involved Advisory Group include, but are not limited to:

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

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- County Health Executives Association of California
- County 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 representation from county CFs and YCFs, to focus on establishing pre-release services policy and operational guidance. Additionally, DHCS also engaged with MCPs on the implementation of ECM for the Individuals Transitioning from Incarceration Population of Focus throughout 2022 and 2023.

JI Reentry Initiative Learning Collaboratives and Office Hours: In the Fall of 2024, DHCS launched its series of Learning Collaborative and Office Hours webinars related to correctional facility implementation and readiness. These sessions focused and will continue to focus on a variety of policy, operational, and implementation topics, including, but not limited to, the JI screening portal, short-term model, behavioral and physical health services, enhanced care management, pharmacy services, CAA, scenario process flows, and oversight and monitoring. Recordings, transcripts, and materials from these Learning Collaborative webinars and office hours are available on the DHCS JI Reentry Initiative Resources Webpage.[73]

Policy and Operational Planning: DHCS organized its policy and operational planning across the following objectives:

- **Enrolling in Medi-Cal Coverage.** Implement Medi-Cal application processes, including screening for Medi-Cal eligibility and current enrollment and to

[73] Resources are available at: https://www.dhcs.ca.gov/CalAIM/Justice-Involved-Initiative/Pages/Resources.aspx.

support individuals in applying for coverage, in coordination with the county SSD.

- **Screening for Reentry Initiative Services and Behavioral Health Links.** Implement processes to screen individuals to see whether they meet the access criteria for 90-day pre-release services and for behavioral health links. If the individual is eligible, this screening process will lead to the activation of a JI services aid code. Ineligible individuals will receive a notice of action outlining the reason(s) for denial.
- **Providing Reentry Initiative 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 assignments and pre-release care management services 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 CFs to become Medi-Cal-enrolled providers and to follow billing and claims processes that match current FFS processes 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 implementation partners (including the county 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 links 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.[74]
- **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.,

[74] Please check the Data Sharing landing page for the latest version of data sharing guidance documents, available at: https://www.dhcs.ca.gov/dataandstats/Pages/Data-Sharing-Authorization-Guidance-Medi-Cal-Housing-Support-Services-and-Reentry-Initiative-Toolkits.aspx

county SSDs, MCPs, county behavioral health agencies, ECM providers, community supports), meeting regularly with DHCS to discuss on-going implementation, and creating a reporting process to monitor program performance.