California Department of Health Care Services

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

October 20, 2023

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

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i. 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 Prison, County Jail, or Youth Correctional Facility)
CHIP	Children's Health Insurance Program
CHW	Community Health Worker
CMAA	County-Based Medicaid Administrative Activities
CMHS-M	Correctional Mental Health Screen for Men
CMHS-W	Correctional Mental Health Screen for Women
CMS	Centers for Medicare & Medicaid Services
CODs	Co-Occurring Diagnoses
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
HIPAA	Health Insurance Portability and Accountability Act
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HRSN	Health-Related Social Needs
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
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
MSIP	Medi-Cal State Inmate Program
NIDA	National Institute of Drug Abuse
NTP	Narcotic Treatment Providers
NOA	Notice of Action
OTC	Over The Counter

Acronym	Term
OUD	Opioid Use Disorder
PA	Prior Authorization
PAVE	Provider Application and Validation Enrollment
PATH	Providing Access and Transforming Health
PII	Personally Identifiable Information
POF	Population Of Focus
ROI	Release Of Information
SMHS	Specialty Mental Health Services
SMI	Serious Mental Illness
SMDL	State Medicaid Director Letter
SSD	County Social Services Departments
STC	Special Terms and Conditions
SUD	Substance Use Disorder
TA	Technical Assistance
TAR	Treatment Authorization Request
TCM	Targeted Case Management
TCUDS V	Texas Christian University Drug Screen V
TPA	Third-Party Administrator
UM	Utilization Management
WPC	Whole-Person Care
YCF	County Youth Correctional Facility

ii. Glossary of Terms

Glossary of Terms	
Term	**Definition**
Behavioral Health Link	Behavioral health links seek to ensure continuity of treatment for individuals who receive behavioral health services while they were 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. CFs and County Behavioral Health Agencies will work in partnership to facilitate professional-to-professional clinical handoffs to post-release providers and share information with the member's health plan (e.g., county MHP, DMC/DMC-ODS counties, and MCPs as needed) or the provider who will prescribe the medication for substance use disorder.
Correctional Facility	State prisons, county jails, and county youth correctional facilities.
County Behavioral Health Provider	A behavioral health provider provides services paid by County Behavioral Health Agencies either as a county-operated or county-contracted provider. Under the JI initiative, if the behavioral health provider is providing pre-release services, they are not acting under the county's behavioral health agency, but either under the CF (correctional facility) as a contractor, or as an independent in-reach, community-based provider. Under the JI initiative, county behavioral health providers will be paid through Medi-Cal FFS rather than through the County Agency.
County Behavioral Health Agencies	Under the JI initiative, a county-based health agency, that pays for specialty mental health or substance use disorder services delivered by County Behavioral Health Providers. These include MHPs and DMC and/or DMC-ODS operating in their capacity as a payer and not as a

Term	Definition
	provider. For example, paying for clinical services (i.e., professional-to-professional clinical handoff), arranging for the provision of SMHS, or contracting with providers).
Embedded Clinical Staff	A clinical provider employed or directly contracted by the CF (e.g., correctional facility staff, third-party vendor, contracted County BH provider, or other contracted provider) to provide health care services (physical health and behavioral health) in the CF.
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. ECM is a Medi-Cal benefit that is only available through a MCP, meaning JI members will only receive ECM once they are in the community and enrolled in a MCP.
ECM Lead Care Manager	A member's designated care manager for ECM, who works for the ECM Provider. The Lead Care Manager operates as part of the member's care team and is responsible for coordinating all aspects of ECM and referrals for any Community Supports. To the extent a member has other care managers, the Lead Care Manager will be responsible for coordinating with those individuals and/or entities to ensure a seamless experience for the member and non-duplication of services.
ECM Provider	A Provider of ECM. ECM Providers are community-based entities with experience and expertise providing intensive, in-person care management services to individuals in one or more of the Populations of Focus for ECM.
Embedded Care Management Model	A model through which embedded care managers (i.e., care managers employed by or contracted with the CF) deliver pre-release care management services to individuals eligible for pre-release services.
Fee-For-Service	FFS providers render services and then submit claims for payment that are adjudicated,

Term	Definition
	processed, and paid for by the Medi-Cal program's fiscal intermediary. All pre-release services will be rendered through FFS delivery system.
Full Supply	The maximum amount of medication that is medically appropriate and allowed by the Medi-Cal State Plan.
In-Reach Care Management Model	A model through which community-based care management providers deliver pre-release care management for individuals eligible for pre-release services, either in person or via telehealth.
Justice-Involved ECM Provider (JI ECM Provider)	An ECM Provider that meets the minimum requirements to be considered a JI ECM Provider, as defined in this Guide. JI ECM Providers may serve as in-reach pre-release care managers and/or post-release ECM Providers for justice involved individuals enrolled in an MCP.
Justice-Involved Individual	An individual who is currently or was formerly incarcerated within the past twelve months.
Medication Assisted Treatment or medications for addiction treatment (MAT)	DHCS defines this term as Medications for Substance Use Disorder Treatment and will refer to it as such in the document. This includes medications to treat opioid use disorder or medications (MOUD) to treat 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.
Managed Care Plan	Medi-Cal contracts for health care services through established networks of organized systems of care, which emphasize primary and preventive care. Managed care plans are a cost-effective use of health care resources that improve health care access and assure quality of 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.
Peer Supports	Under the JI initiative, Peer Supports service, covered under SMHS or DMC/DMC-ODS (depending on the county), are covered pre-release services. Peer Support services can be billed as in-reach services in order to establish

Term	Definition
	relationships and continue to provide meaningful Peer Support Services in the post-release.
Pre-Release Care Manager	The person who will act as the primary point of contact to ensure whole-person reentry services are provided as outlined by the CalAIM JI policy. The care manager will work, as appropriate, with other providers, including CF providers, post-release ECM Providers (if different than the pre-release care manager), county behavioral health agency providers, and community-based resources.
Post-Release ECM Lead Care Manager	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. If this provider is different from the pre-release care manager, they should have a warm handoff of the member, ideally at least two weeks prior to release.
Reentry Care Plan	Pre-release care managers must develop a person-centered reentry care plan for all individuals receiving pre-release care management.
Targeted Case Management (TCM)	TCM services, covered under SMHS or DMC/DMC-ODS, are pre-release services that can be billed as in-reach services by the county behavioral health agency in order to facilitate BH links to these 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 additional targeted case management support specific to behavioral health links.
Care Manager Warm Handoff	In cases where different care managers provide pre- and post-release care management services (i.e., if the CF leverages an embedded care management model or if the individual will be released into a county in which their in-reach pre-release care manager does not operate), the two care managers must conduct a warm handoff with

Term	Definition
	the individual prior to release. The warm handoff is the first step in establishing a trusted relationship between the individual and the new care manager to ensure seamless service delivery and coordination.

iii. Introduction

On January 26, 2023, California became the first state in the nation to receive federal approval to offer a targeted set of Medicaid services to Medi-Cal-eligible youth and adults in state prisons, county jails, and youth correctional facilities (YCFs) for up to 90 days prior to release. Through a federal Medicaid 1115 demonstration waiver[1] approved by the Centers for Medicare & Medicaid Services (CMS), the Department of Health Care Services (DHCS) will partner with state agencies, counties, providers, and community-based organizations (CBOs) to establish a coordinated community reentry process that will assist people leaving incarceration in connecting to the physical and behavioral health services they need prior to release and reentering their communities. The initiative will help California address the unique and considerable health care needs of justice-involved (JI) individuals, improve health outcomes, deliver care more efficiently, and advance health equity across the state.

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

This Policy and Operational Guide memorializes policy and operational requirements for implementing the CalAIM Justice-Involved Initiative. The Guide is intended to delineate for implementing stakeholders – correctional facilities (CFs), county behavioral health agencies, providers, CBOs, County Social Services Departments (SSD) and Medi-Cal managed care plans (MCPs), among others – the policy design and operational processes that will serve as the foundation for implementing this important initiative.[2] As implementing partners begin to advance in the process of standing up the CalAIM Justice-Involved Initiative, and as CMS continues to refine its own sub-regulatory guidance for states that receive demonstration approval, it is expected that this Guide will be updated on an ongoing basis to reflect new policy decisions and operational requirements.

[1] California's approved CalAIM 1115 Demonstration; Medicaid 1115 demonstration waiver, available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-calaim-ca1.pdf
[2] Section 13 below outlines MCP requirements for implementing the CalAIM Justice-Involved Initiative.

Updates to this Guide will be published as needed and posted on DHCS' Justice-Involve Initiative webpage, where stakeholders can also find other relevant resources and information.

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

iv. Context Setting

In California, an estimated 400,000 individuals are released from CFs each year.[3] Of these individuals, an estimated 80-90 percent are eligible for Medi-Cal.[4] Formerly incarcerated individuals are more likely to experience poor health outcomes and face disproportionately higher rates of physical and behavioral health diagnoses. They are also at higher risk for injury and death as a result of violence, overdose, and suicide compared to people who have never been incarcerated.[5]

- Incarcerated individuals in California jails under active care for mental health issues rose by 63 percent between 2009 and 2019.[6]
- As of 2019, 66 percent of people in California jails and prisons have a moderate or high need for substance use disorder (SUD) treatment.[7]
- Overdose death rates are more than 100 times higher in the two weeks after release from incarceration than for the general population.[8]

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. In California, average

[3] 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.
[4] "From Corrections to Community: Reentry Health Care," California Health Care Foundation, 2018. Available at: https://www.chcf.org/project/corrections-community-reentry-health-care/
[5] 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.
[6] The Prevalence of Mental Illness in California Jails is Rising: An Analysis of Mental Health Cases & Psychotropic Medication Prescriptions, 2009-2019, California Health Policy Strategies, 2020. Available at: https://calhps.com/wp-content/uploads/2020/02/Jail_MentalHealth_JPSReport_02-03-2020.pdf
[7] Improving In-Prison Rehabilitation Programs, Legislative Analyst's Office, available at: https://lao.ca.gov/Publications/Report/3720; and, The Prevalence of Mental Illness in California Jails is Rising: An Analysis of Mental Health Cases & Psychotropic Medication Prescriptions, 2009-2019, available at: https://calhps.com/wp-content/uploads/2020/02/Jail_MentalHealth_JPSReport_02-03-2020.pdf.
[8] Analysis of 2017 Inmate Death Reviews in the California Correctional Healthcare System, 2018. Available at: https://cchcs.ca.gov/wp-content/uploads/sites/60/MS/2017-Inmate-Death-Reviews.pdf

monthly Medicaid costs for JI members following release are about twice the monthly costs for these members prior to incarceration.[9]

Evidence suggests that improving health outcomes for this high-needs group of people requires focused, high-touch care management to assess needs and strengths and connect individuals to the services they need when released into their communities.[10] Service provision in the pre-release period is designed to engage eligible JI populations, prepare them for their return to the community, and mitigate gaps in services and medication. In-reach care management to ensure the medical, behavioral, and social needs that are tied so closely to health--including housing and transportation –are met. The approach of providing services in the period prior to release helps to establish trusted relationships with care managers to develop a transition plan, coordinate care, and support stabilization upon reentry. Extending Medicaid coverage in CFs also allows for pre-release management of ambulatory care sensitive conditions (e.g., diabetes, heart failure, and hypertension), which could reduce post-release acute care utilization. Absent such management, a period of incarceration perfectly aligns with the time needed for a well-controlled condition (e.g., diabetes, HIV, schizophrenia) to worsen.

Across the country, people of color are more likely to be incarcerated due to mental health issues, the criminalization of SUDs, and systemic inequities rife in the criminal justice system. Although Black and Latino/a individuals are not more likely than White individuals to misuse alcohol or drugs, they are more likely to be incarcerated for related behaviors.[11] 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.[12,13]
- For Latino men, the imprisonment rate is 1,016 per 100,000 as compared to 314 per 100,000 for men of other races.[14]
- 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

[9] Medicaid physical health costs for JI individuals prior to incarceration were $494 per member per month on average, whereas costs for this population after release were $972 per member per month on average. These figures are based on DHCS analysis of Medi-Cal managed care and fee-for-service (FFS) cost data for individuals released from incarceration in CY 2019.
[10] "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
11 "Comparing Black and White Drug Offenders: Implications for Racial Disparities in Criminal Justice and Reentry Policy and Programming," National Library of Medicine. Available at: Comparing Black and White Drug Offenders: Implications for Racial Disparities in Criminal Justice and Reentry Policy and Programming, PMC (nih.gov)
[12] Criminal Justice Fact Sheet, NAACP. Available at: https://naacp.org/resources/criminal-justice-fact-sheet.
[13] "California's Prison Population," Public Policy Institute of California, 2017. Available at: https://www.ppic.org/publication/californias-prison-population/.
[14] Ibid.

data collection challenges, AI/AN populations are generally lumped into the "Other" category, making it difficult to report on their incarceration rate.[15]

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

- Since 2015, state prisons have been required to use a standardized process for gathering and processing pre-release applications to ensure that JI individuals are enrolled in Medi-Cal before their return to the community.
- From 2016 to 2021, 17 counties offered whole-person care (WPC) pilots dedicated to serving individuals reentering the community post-incarceration and have designed programs to directly engage local jails and/or probation departments.[16] These programs have transitioned to become Enhanced Care Management (ECM)/Community Supports programs in CalAIM.[17]
- Since January 1, 2023, all counties are mandated to implement pre-release Medi-Cal application processes in county jails and YCFs.[18]
- Since January 1, 2023, and as authorized by SB 184, Medi-Cal benefits for juveniles and adults may be kept in suspended status until the individual is no longer an inmate of a public institution.[19]

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

[16] 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.

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

[18] AB-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; DHCS, issued a series of inmate pre-release policies described in All-County Welfare Directors' Letters (ACWDLs) 07-34 (January 2, 2008), 14-24 (May 6, 2014), and 14-24E (July 11, 2014). Additionally, DHCS and CDCR issued ACWDLs 14-26 (May 6, 2014)and 14-26E (July 11, 2014)to describe their suspension policies. DHCS also released ACWDL 22-26 (October 28, 2022) to update its suspension policy and 22-27 (November 10, 2022) on the pre-release Medi-Cal application mandate.

[19] 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 (January 19, 2021) re: Implementation of At-Risk Youth Medicaid Protections for Inmates of Public Institutions (Section 1001 of the SUPPORT Act), CMS, January 19, 2021. Available at: https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21002.pdf.

- Behavioral health links were created under state law AB 133 in 2021 to implement a process requiring 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 incarcerated members who received behavioral health services while incarcerated to allow for the continuation of behavioral health treatment. These referrals are called behavioral health links.[20]
- MCPs are required to offer intensive, community-based care management for members transitioning to the community through the statewide ECM and Community Supports benefit. 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 also encouraged to offer Community Supports (in lieu of services such as housing supportive services or recuperative care) for JI populations upon reentry into the community.
- On January 21, 2022, DHCS released its assessment of the continuum of care for behavioral health services, which included behavioral health services provided to JI populations.[22]
- DHCS is also leveraging multiple federal funding streams to support the delivery of behavioral health services to individuals who are incarcerated, including, but not limited to, funding to expand MAT in county jails and drug courts, funding MAT training and technical assistance for the California Department of Corrections and Rehabilitation (CDCR), and Community Mental Health Services Block Grant funding.
- To support behavioral health links, DHCS laid out expectations[23] with respect to coordination between ECM and county behavioral health agencies and/or their subcontracted providers.

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

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

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

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

- DHCS is also laying out data exchange requirements. To date, DHCS has released CalAIM Data Sharing Authorization Guidance[24] and detailed data exchange goals in the Behavioral Health Quality Improvement Program guidance.[25]

[24] CalAIM Data Sharing Authorization Guidance, draft for public comment, released June 2023. Available at: https://www.dhcs.ca.gov/Documents/MCQMD/CalAIM-Data-Sharing-Authorization-Guidance-Version-2-Draft-Public-Comment.pdf
[25] CalAIM Behavioral Health Quality Improvement Program, Goal 3. Available at: https://www.dhcs.ca.gov/bhqip.

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

1.1 Summary of the 1115 Demonstration Approval

In alignment with the SUPPORT Act[26] and the state's focus on health equity and coverage for JI populations, in January 2023, California received approval in its five-year 1115 demonstration renewal request to authorize federal Medicaid matching funds for selected Medicaid services for eligible JI individuals in the 90-day period prior to their release from a CF.[27,28] Under a provision of federal Medicaid law known as the "inmate exclusion," all states are prohibited from drawing down federal Medicaid funds to finance the health care of any individual committed to a jail, prison, detention center or other penal facility unless the incarcerated individual is treated in a medical institution outside the jail or prison for 24 hours or more.[29] Medicaid can, however, finance the cost of services provided to eligible members after their release. The 1115 demonstration provides waiver and 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").

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

- Reentry care management services.
- Physical and behavioral health clinical consultation services provided through telehealth or in person, as needed, to diagnose health conditions, provide treatment

[26] 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.

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

[28] While DHCS received approval for providing 90 days of pre-release services, most individuals incarcerated in county facilities will have significantly shorter lengths of stay, which will limit the duration of covered services for many individuals while incarcerated. Please see ***Section 8.2*** of this document for more information on expectations for delivering services to individuals with anticipated short-term stays.

[29] 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.

as appropriate, and support pre-release care managers' development of a post-release treatment plan and discharge planning.

- Laboratory and radiology services.
- Medications and medication administration.
- Medication for Substance Use Disorder 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.[30]
- Services provided by CHWs with lived experience.

In addition to the above pre-release services, qualifying members will receive covered outpatient prescribed medications, over-the-counter (OTC) drugs, and DME upon release, consistent with approved state plan coverage authority and policy.

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

- Increase coverage, continuity of coverage, and appropriate service uptake through assessment of eligibility and availability of coverage for benefits in carceral settings just prior to release.
- Improve access to services prior to release, and improve transitions and continuity of care into the community upon release.
- Improve coordination and communication between correctional systems, Medicaid, and CHIP systems, MCPs, and community-based providers.
- Increase investments in health care and related services, aimed at improving the quality of care for beneficiaries in carceral settings and in the community to maximize successful reentry post-release.
- Improve connections between carceral settings and community services upon incarcerated individuals' release, to address physical health, behavioral health, and health-related social needs.

[30]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

- Provide intervention for certain behavioral health conditions and for using stabilizing medications such as long-acting injectable antipsychotics and medications for addiction treatment for SUDs, with the goal of reducing decompensation, suicide-related deaths, overdoses, and overdose-related deaths in the near-term post-release.
- Reduce post-release acute care utilization, such as emergency department visits and inpatient hospitalizations, and all-cause deaths among recently incarcerated Medicaid beneficiaries and individuals who would otherwise be eligible for CHIP if not for their incarceration status, through robust pre-release identification, stabilization, and management of certain serious physical and behavioral health conditions that may respond to ambulatory care and treatment (e.g., diabetes, heart failure, hypertension, schizophrenia, SUDs), as well as increased receipt of preventive and routine physical and behavioral health care.

1.2 Legal Authority

State law mandates that DHCS administer and that CFs and Medi-Cal behavioral health delivery systems implement the CalAIM Justice-Involved Initiative. Effective July 27, 2021, Welfare and Institutions Code section 14184.102 required DHCS to seek federal approval for and to implement the CalAIM initiative, which includes the provision of targeted pre-release Medi-Cal benefits to qualified individuals.[31] Per state law, DHCS must implement the CalAIM initiative as approved by CMS. Subsection (d) of Welfare and Institutions Code section 14184.102 also provides DHCS with authority to implement, interpret, or make specific the CalAIM article commencing with Welfare and Institutions Code section 14184,100[32] or the CalAIM Terms and Conditions,[33] 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 Welfare and Institutions Code section 14184.102 allows DHCS to enter into contracts for the purposes of implementing the CalAIM article or the CalAIM Terms and Conditions. DHCS may utilize this subsection to enter into memoranda of understanding, interagency agreements, or similar contractual arrangements with applicable parties including state and local correctional agencies and to memorialize mandated activities, performance standards, remedies for noncompliance, etc., related to the provision of pre-release services.

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[31] Welfare and Institutions Code section 14184.102 is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14184.102&lawCode=WIC.
[32] Welfare and Institutions Code section 14184.100 is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14184.100.&nodeTreePath=16.6.17.53&lawCode=WIC.
[33] CalAIM Terms and Conditions re available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-calaim-ca1.pdf

Furthermore, Welfare and Institutions Code section 14184.800[34] 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 1115 demonstration approved by CMS, the CalAIM Special Terms and Conditions (STCs) related to the CalAIM Justice-Involved 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 must obtain approval for its Implementation Plan for this initiative which DHCS submitted to CMS within 120 days of the approval of the 1115 demonstration. As of the date of this Guide's publication, the Implementation Plan has not yet been approved by CMS.

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

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

2.1 PATH Funding Background

To ensure a successful launch of the CalAIM Justice-Involved 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 Initiative provided an additional $410 million in PATH funding to support collaborative planning for and IT investments in implementation of pre-release Medi-Cal services.[35]

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

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

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

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

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

[35] THE JI PATH Website is available here: https://ca-path.com/justice-involved

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

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

JI PATH Round 1 was a planning grant funding opportunity that provided small planning grants to probation offices, sheriff's offices, and CDCR (or its delegate) to support collaborative planning with county 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.[36]

Permissible Uses of Justice-Involved PATH Round 1 Funding. For more information on permissible uses of JI PATH Round 1 funding for CFs (or their delegates) and county SSDs, include: go to https://www.dhcs.ca.gov/CalAIM/Pages/CalAIM-PATH.aspx

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

Awardee JI PATH Round 1 Expenditure Deadline and Sustainability Plan. DHCS did not set a deadline or a time frame within which awardees must spend PATH Round 1 funds. Since JI PATH Round 1 is a planning grant, DHCS did not perceive the need to establish a sustainable funding mechanism to support the permissible uses of JI PATH Round 1 funding on an ongoing basis.

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

JI PATH Round 2 was an implementation grant funding opportunity that supported county SSDs, county sheriff's offices, county probation offices (or their delegate), and

[36] 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.

the CDCR as they implement the processes, protocols, and IT system modifications that were identified during the Round 1 planning phases for implementing pre-release applications. The application for JI PATH Round 2 was open from January 30, 2023 through March 31, 2023.[37] Any leftover funding from JI PATH Rounds 1 and 2 were carried over to fund other CalAIM JI PATH funding initiatives, including provision of pre-release services.

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

- Modifying technology and IT systems needed to support Medi-Cal enrollment and suspension processes (e.g., building or updating data systems to track individuals who cycle in and out of incarceration or to integrate health and eligibility data into one platform).
- Recruiting, hiring, onboarding, and training staff to assist with the coordination of Medi-Cal enrollment and suspension for JI individuals.
- Developing or modifying protocols and procedures that specify steps to be taken in preparation for and execution of the Medi-Cal enrollment and suspension processes for eligible individuals.
- Facilitating collaborative planning activities among correctional institutions, correctional agencies, county SSDs, and other stakeholders as needed to support planning, implementation, and modification of the Medi-Cal enrollment and suspension processes.
- Modifying the physical infrastructure of CFs to support implementation of pre-release Medi-Cal enrollment and suspension processes.
- Supporting salaries for CF staff or their delegates (e.g., a CBO, health department, or county SSD) that administer the pre-release Medi-Cal application process (i.e., assisting applicants with completing and submitting applications) for a limited time--after which Medicaid administrative activity (MAA) funding may become available (subject to the guardrails described below).[38]
- Setting up infrastructure/processes for CFs (or their DHCS delegate) to draw down MAA funding to support salaries of staff who administer the pre-release Medi-Cal

[37] Additional information on Path JI Round 2 is available at: https://www.dhcs.ca.gov/CalAIM/Justice-Involved-Initiative/Pages/Path-JI.aspx.

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

application process as MAA funding potentially becomes available and approved by CMS.

- Other activities approved by the state.

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

- JI PATH funds may support only the portion of full-time-equivalent employees associated with pre-release Medi-Cal applications.
- Requests for salary support must be reasonable relative to the salaries for similar positions.
- Applicants may apply for up to 5 percent additional funding to support indirect costs.[39]
- Direct salary support may include costs associated with reasonable rates for fringe benefits.
- County SSDs may allocate JI PATH Round 2 funding only to support the salaries of new positions.

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

- County SSDs: must expend, within the project timeframe approved by DHCS during the Round 2 application process. Support for salaries of staff who support the planning/implementation of the pre-release Medi-Cal application process may begin at any point within the overall project timeline, but new positions supported through PATH are only eligible to be funded for a period not to exceed 18 total service months.
- CFs (or their delegate):
    - CFs must expend their allocation within the project timeframe approved by DHCS during the Round 2 application process. Support for salaries of staff who support the planning/implementation of the pre-release Medi-Cal application process may begin at any point within the overall project timeline, but positions supported through PATH are only eligible to be funded for a defined period of service months as follows:

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

  - 18 months after they receive it for new positions.
  - 12 months after they receive it for positions with new responsibilities.
- For the salaries of staff that administer pre-release Medi-Cal applications (i.e., helping applicants complete and submit applications), CFs must expend their allocation within two years—at which point MAA funding may become available.

Proposed Approach for Long-Term Sustainability of Pre-Release Medi-Cal Applications. DHCS will pursue federal approval for MAA funding to support the salaries for CF staff who administer the pre-release Medi-Cal application process (i.e., helping applicants complete and submit applications) on an ongoing basis, subject to the following considerations:

- Counties/CDCR would not be required to contribute the non-federal share to support this program, which differs from other MAA programs.
- Leveraging MAA funding could necessitate the establishment of new administrative and operational processes for DHCS and counties. MAA is cost-reconciled, and counties will be subject to cost reporting. To minimize the administrative burden for the state, DHCS recommends that county CFs that wish to participate in this program work with their county MAA partners to streamline billing to DHCS. Most counties already participate in county-based MAA (CMAA).[40] However, DHCS will explore new methods to make the MAA process less complicated for DHCS and its partners.
- DHCS will need to obtain approval from CMS to leverage MAA funding to support the salaries for CF staff who administer the pre-release Medi-Cal application process.

Additionally, DHCS will work with CMS to obtain approval for on-going MAA activities to support the Reentry Demonstration. DHCS does not yet have a timeline for CMS approval of these activities and will provide an update to stakeholders once available.

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

As outlined in the Section 1115 Reentry Demonstration approval, the JI PATH Round 3 Capacity Building Program will provide funding to support the planning and implementation of the provision of targeted pre-release Medi-Cal services to individuals in state prisons, county jails, and YCFs who meet the eligibility criteria. as outlined in the Section 1115 Reentry Demonstration approval. This funding will also support county behavioral health agencies into implementing behavioral health links as required by AB 133. PATH funds will be available to support investments in personnel, capacity, and/or

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

IT systems that are needed for collaborative planning and implementation in order to effectuate pre-release service processes. These PATH capacity building funds were available to qualified entities and will be distributed based on meeting certain performance milestones.

The funds available in PATH Justice-Involved Round 3 are dedicated exclusively to justice-involved pre-release services and behavioral health links implementation; additional stakeholders must avail themselves of other PATH funding as appropriate *(see list of other funds available below)*.[41]

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

- County Sheriff's Offices to support county jails
- County Probation Offices to support YCFs
- CDCR to support state prisons
- County behavioral health agencies to support behavioral health links

See JI PATH Round 3 guidance for further details.[42]

In some counties, the Department of Public Health (or another county agency) currently manages correctional health care services and is responsible for coordinating and providing health services for individuals in correctional institutions (i.e., jails and YCFs). In these cases, the county agency that is responsible for coordinating and providing health care services (e.g., the Department of Public Health) will coordinate with the county sheriff or county probation office to assist in Implementation Plan development. These entities may submit a joint application on behalf of all CFs in the county and/or on behalf of all YCFs in each county. It is not necessary for all CFs and YCFs to apply separately for funding.

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

CFs seeking PATH funds must demonstrate how they plan to use the funds to support the planning for and implementation of the *Operational Expectations (detailed Table 3 of*

[41] 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 here: Justice-Involved Initiative Home (ca.gov).
[42] JI PATH Round 3 guidance can be found on the Justice-Involved Capacity Building Program website, available at: https://www.ca-path.com/justice-involved.

this Guide) that must be met in order to be deemed ready to go live; the list below further describes processes and activities for which PATH Justice-Involved Round 3 funds can be used to meet go-live requirements. Entities unsure of whether their planned activities would qualify as permissible uses of funding under this initiative are encouraged to check with the PATH TPA prior to submitting their application by emailing justice-involved@ca-path.com, with the subject "Justice-Involved Reentry Initiative Capacity Building Program Funds."

DHCS will not set a deadline by which PATH Justice-Involved Round 3 funds recipients must spend their funds, but applicants are required to define their grant period (i.e., start and end dates for spending their award) in both their PATH Justice-Involved Round 3 funds implementation plan and their grant agreement.

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

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

- **Implementing Billing Systems:** This includes expenditures related to modifying IT systems needed to support delivery of and billing for Medi-Cal Reentry Services (e.g., adoption of certified electronic health record (EHR) technology, purchase of billing systems). Please note that DHCS anticipates that implementing Medi-Cal billing and claiming services will be a heavy lift for many implementation partners and suggests CFs prioritize PATH funding in this area.
- **Adoption of Certified EHR Technology:** This includes expenditures for providers' purchases or necessary upgrades of certified EHR technology and training for the staff that will use the EHR.
- **Technology and IT Services:** This includes the development of electronic interfaces for prisons, jails, and YCFs to support Medicaid enrollment, and suspension/activation, and modifications. This also includes support to modify and enhance existing IT systems to create and improve data exchange and connections with CFs, local county SSDs and agencies, county behavioral health agencies, and others, such as MCPs and community-based providers. This could also include establishing technology to facilitate video/teleconferences between individuals and community-based care coordinators or providers.
- **Hiring of Staff and Training:** This includes expenditures related to recruiting, hiring, onboarding, and supporting staff salaries for personnel supporting the planning and delivery of Medi-Cal Reentry Services (as mandated in AB 133).
- **Development of Protocols and Procedures:** This includes developing or modifying protocols and procedures that specify steps to be taken in preparation for and delivery of Medi-Cal Reentry Services and reentry coordination.

- **Additional Activities to Promote Collaboration:** This includes expenditures related to facilitating collaborative planning activities between correctional institutions, correctional agencies, MCPs, county behavioral health agencies, and other stakeholders as needed to support planning, implementation, and modification of Medi-Cal pre-release service processes.
- **Planning:** This includes developing policies and protocols for operationalizing the delivery of Medi-Cal Reentry Services, including process flows and procedures to incorporate already developed Medi-Cal application processes (and update them as needed), including (1) identifying uninsured individuals who are potentially eligible for Medi-Cal; (2) assisting with the completion of an application; (3) submitting an application to the county SSD agency or coordinating suspension/activation; (4) incorporating new Medi-Cal Reentry Services processes, including screening for eligibility for Medi-Cal Reentry Services and reentry planning in a period for up to 90 days immediately prior to the expected date of release; (5) delivering, either directly through embedded providers or through in-reach providers,[43] necessary services to eligible individuals in a period for up to 90 days immediately prior to the expected date of release and care coordination to support reentry; and (6) establishing ongoing oversight and monitoring processes upon implementation.
- **Screening for Pre-Release Services** *(time limited to two years):* CFs may leverage PATH Justice-Involved Round 3 funding to pay for screening for pre-release services for a two-year limited period of time; DHCS will identify an ongoing reimbursement mechanism (e.g., Medicaid Administrative Activity (MAA) funding) for screening for pre-release services and will provide additional guidance once an approach is confirmed.
- **Other Activities to Support Provision of Medi-Cal Reentry Services:** This could include accommodations for private space such as movable screen walls, desks, and chairs to conduct assessments and interviews within correctional institutions; support for installation of audio-visual equipment or other technology to support provision of Medi-Cal Reentry Services delivered via telehealth; oversight and monitoring activities to ensure compliance with implementation plans; or other activities approved by the state to support the provision of pre-release Medi-Cal services.

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

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

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

Awardee JI PATH Round 3 Funds Expenditure Deadline. DHCS has not set a deadline for awardees to expend Round 3 funding, with the exception, (as noted above), of requiring CFs to expend JI PATH funding related to setting up processes for screening individuals for pre-release services eligibility within two years of receiving the award. CFs must follow the guidelines defined in the DHCS implementation plan.

Proposed Approach for Long-Term Sustainability of Pre-Release Services. All reentry services that are provided within this initiative will be paid for through fee-for-service and reimbursed at the Medicaid financing match rate. DHCS will work with CMS to obtain approval for on-going MAA activities to support the Reentry Demonstration. DHCS does not yet have a timeline for CMS approval of these activities and will provide an update to stakeholders once available. Additionally, counties will not be required to contribute the non-federal share to support MAA activities related to the Reentry Demonstration.

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

3.1 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 1115 demonstration negotiations and provide input on policy and operational guidance. The CalAIM Justice-Involved Advisory Group was formed to solicit stakeholder input on the design of multiple CalAIM JI initiatives. The group continued to meet bimonthly until the approval of the 1115 demonstration; DHCS will continue to convene this group on an as-needed basis.

Members of the CalAIM Justice-Involved Advisory Group include:

- CDCR'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 Youth Correctional Facilities
- Board of State and Community Corrections (BSCC)
- County Welfare Directors Association
- County health departments
- County Health Executives Association of California
- County Social Services Departments (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 separately engaged with managed care plans on the implementation of ECM for the Individuals Transitioning from Incarceration Population of Focus throughout 2022 and 2023.

3.2 Policy and Operational Planning

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

- **Enrolling in Medi-Cal Coverage.** Implement Medi-Cal application processes, including to screen for Medi-Cal eligibility and current enrollment and to support individuals in applying for coverage, in coordination with the county SSD.
- **Screening for Pre-Release 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 pre-release services aid code. Ineligible individuals will receive an appropriate notice outlining the reason(s) for denial.
- **Providing Pre-Release Services During the 90-Day Pre-Release Period.** Deliver the full scope of covered 90-Day pre-release services. This includes establishing processes to initiate care manager assignment and pre-release care management services – either embedded or community-based – and to provide logistical support for arranging in-person or virtual consultations, clinical consultations, medications, laboratory and radiology, and MAT.
- **Provider Enrollment and Payment.** DHCS will require CFs to become Medi-Cal-enrolled providers and to follow billing and claims processes that match current FFS processes in order to track the delivery of pre-release services and to reimburse facilities for providing those services.
- **Supporting Reentry Services.** Reentry planning and coordination encompasses notifying stakeholders (including 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.

- **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., county SSDs, MCPs, county behavioral health agencies, ECM providers, community supports), and creating a reporting process to monitor program performance.

4. Enrolling in Medi-Cal Coverage

4.1 Background

State law and Section 1115 demonstration STC 9.6 and 9.9 require California to set up pre-release Medicaid application processes for adults and youth to better position individuals leaving incarceration from County CFs and county YCFs to have access to Medicaid coverage immediately upon release into the community.[44] Under California statute, all counties must have implemented pre-release Medi-Cal application processes by January 1, 2023.[45] Enrolling in Medi-Cal those individuals who are reentering the community from carceral settings is key to ensuring this population has access to the 90-day pre-release services, as requested in California's 1115 waiver, and to critical medical and behavioral health services upon their release into the community. The implementation of pre-release Medi-Cal application processes will help the state establish a continuum of care between carceral settings and the community, which will ultimately improve health outcomes and reduce the demand for costly and inefficient services.

4.2 Pre-Release Medi-Cal Application Process Implementation Requirements

DHCS published ACWDL 22-27, which provides detailed guidance and directives for implementing the mandatory pre-release Medi-Cal application process for County SSDs and County CFs.[46] Please review ACWDL 22-27 for detailed implementation recommendations and requirements. This section of the Policy and Operational Guide outlines requirements for implementing the pre-release Medi-Cal application process at a high level.

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

[45] AB-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; DHCS, issued a series of inmate pre-release policies described in All-County Welfare Directors' Letters (ACWDLs) 07-34 (January 2, 2008), 14-24 (May 6, 2014), and 14-24E (July 11, 2014). Additionally, DHCS and CDCR issued ACWDLs 14-26 (May 6, 2014)and 14-26E (July 11, 2014)to describe their suspension policies. DHCS also released ACWDL 22-26 (October 28, 2022) to update its suspension policy and 22-27 (November 10, 2022) on the pre-release Medi-Cal application mandate.

[46] See ACWDL 22-27 (November 10, 2022), available at: https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/22-27.pdf

Best practices have been identified based on counties that have already implemented a pre-release Medi-Cal application process or are in the process of doing so.[47] One best practice includes ensuring that the board of supervisors in each county, the county sheriff for jails, the county SSD, and the county probation officer for YCFs closely coordinate to implement a pre-release Medi-Cal application process in compliance with the state mandate. While no one approach will work for all pre-release Medi-Cal enrollment processes, county SSD and CFs can collaborate on planning and design of each of the following steps in order to implement a customized pre-release Medi-Cal application process:

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

Starting January 1, 2023, County CFs and county SSDs must meet the minimum requirements below for implementing the pre-release Medi-Cal application process mandate. DHCS will implement a monitoring plan to ensure that the county SSDs and County CFs are in compliance with the mandate, as described in MEDIL 23-24 and MEDIL 23-24E.[48] County SSDs and County CFs will be required to comply by June 30, 2023.

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

Please see Table 1 for minimum operational requirements.

[47] Note that the term “Best Practices” can be found throughout the Policy and Operations Guide. Best practices included in this document are DHCS identified best practices and are not a requirement.
[48] See MEDIL 23-24 (April 12, 2023), available at: https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/I23-24.pdf and MEDIL 23-24E (August 4, 2023), available at: https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/I23-24E.pdf.

Table 1. Minimum Operational Requirements for Pre-Release Medi-Cal Application Process for New Enrollees		
Operational Requirements	**County CF or Delegate**	**County SSD**
Step 1. Initial Enrollment Screening	• Screen individual for Medi-Cal enrollment during/near intake.[49] • Verify Medi-Cal enrollment through DHCS eligibility verification system (EVS) or in collaboration with the county SSD, and identify individuals who are not currently enrolled in Medi-Cal. The County CF must have processes in place to obtain consent to submit a Medi-Cal application on behalf of youth under 18 years old.[50] o **If the individual is enrolled in Medi-Cal and incarceration is not reported**, County CF shall communicate the incarceration details to the county SSD (including incarceration date and expected release date, if known). o **If the individual is enrolled in Medi-Cal and incarceration or suspension is displayed**, the County CF shall communicate the expected release date to the county SSD, if known, and verify that	• Collaborate with the County CF to verify the current Medi-Cal enrollment status of the individual to assist the County CF with identifying individuals who require a pre-release Medi-Cal application. o **If the individual is enrolled in Medi-Cal and incarceration is not reported**, the county SSD shall obtain incarceration details from the County CF, **including** incarceration date and expected release date (if known), and verify that the other demographic information on file is accurate. If applicable, the county SSD shall suspend benefits. o **If the county SSD determines that the individual is not enrolled in Medi-Cal**, the county SSD shall notify the County CF of the individual's current enrollment

[49] Overview of pre-release Medi-Cal Application mandate is available at: https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/Pre-ReleaseMedi-CalAppWebinar12192022.pdf.
[50] See ACWDL 22-27 (November 10, 2022) for the detailed process requirements for working with individuals under 18 years old. Available at: https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/22-27.pdf.

Table 1. Minimum Operational Requirements for Pre-Release Medi-Cal Application Process for New Enrollees		
Operational Requirements	**County CF or Delegate**	**County SSD**
	the other demographic information on file is accurate. o **If the individual is not enrolled in Medi-Cal**, the County CF shall assist the individual with completing/submitting a Medi-Cal application.	status so the County CF can assist the individual with completing/ submitting a pre-release Medi-Cal application.
Step 2. Application Submission and Processing (Requirements in Step 2 should only be completed if the incarcerated individual is not currently enrolled in Medi-Cal)	• Complete and submit the Medi-Cal application. County CFs shall submit the Medi-Cal application at least 135 days before release if the release date is known. o If the individual is to be released under probation or parole, then the mandated county of release should be used for Medi-Cal applications and MCP enrollment. If there is no mandated county of release, the County CF shall ask the individual for the address where they plan to reside upon release from incarceration and use this address on the application. The individual failing to provide an address is not a reason for the County CF to deny assistance for Medi-Cal enrollment. As a best practice,	• Receive and process pre-release applications from County CFs. county SSDs must accept Medi-Cal applications via mail, online, phone, fax, or in person. o If the county SSD receives an application for an individual expected to be reside in a different county, it should coordinate with the county of responsibility to transition the application, following standard Inter-County Transfer (ICT) processes in ACWDL 18-02E and BHIN 21-032 and BHIN 21-072. [51] o County SSDs must work with the YCF to ensure that the application

[51] ACWDL 18-02E is available at https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/18-02E.pdf; BHIN 21-032 is available at: https://www.dhcs.ca.gov/Documents/BHIN-21-032.pdf; and BHIN 21-072 is available at: https://www.dhcs.ca.gov/Documents/BHIN-21-072-County-of-Responsibility-for-SMHS-Arbitration-Between-MHPs.pdf. DHCS is in the process of publishing an updated BHIN on ICTs processes and will update this document once available.

Table 1. Minimum Operational Requirements for Pre-Release Medi-Cal Application Process for New Enrollees		
Operational Requirements	**County CF or Delegate**	**County SSD**
	the County CF should use the county P.O. Box as an address for individuals who may not have a permanent address. o If the County CF uses a paper application, it should submit the application to the county where the individual intends to reside upon release. o It is recommended that applications of all forms (paper, electronic, etc.) include a cover sheet/transmittal letter. Note: Cover letter recommendations and requirements can be found in ACWDL 22-27. o If the individual plans to move to another state upon their release, the County CF must provide them with Medicaid application information (e.g., website) for the state in which they will reside. DHCS supports the best practice of conducting regular check-ins and follow-ups with the individual in the months after the individual's release and subsequent move to another state. • DHCS supports the best practice of CFs assisting in Medicare enrollment and completing SSI/SDI applications in additional	for an incarcerated youth is completed and processed appropriately. • Communicate with the County CF to troubleshoot application questions, request follow-up information, and obtain other information needed to process the application. o The SSD should initiate an ICT following standard ICT processes as outline in ACWDL 18-02E and BHIN 21-032 and BHIN 21-072and when possible, this should be initiated and completed prior to the individual's planned release. o CFs should update addresses in MEDS as soon as possible to allow ICTs to be processes prior to release.

Table 1. Minimum Operational Requirements for Pre-Release Medi-Cal Application Process for New Enrollees		
Operational Requirements	**County CF or Delegate**	**County SSD**
	to Medi-Cal applications for those who would qualify upon release. • Communicate with the county SSD to troubleshoot application questions, request follow-up information, and obtain other information needed for the county SSD to process the pre-release Medi-Cal application.	
Step 3. Eligibility Determination	• Ensure the individual has their county SSD contact information upon release. • Submit the following minimum information to the county SSD within one week of the individual's expected release and no later than one business day before release, unless the release is unplanned: o Full name (and any known aliases); o Date of birth; o Address o Client Identification Numbers/Social Security Numbers o Known or estimated release date For members being released, the County CF may provide the above information to the county SSD once known, even if this is more than one week prior to the individual's expected release. In this circumstance, the County CF shall notify the	• The county SSD must follow standard Medi-Cal application policy and determine eligibility within 45 days of receipt, or 90 days of receipt for individuals being determined eligible on the basis of a disability. • Notify the county CF if the Medi-Cal determination is not expected to be complete before the individual's release (if the release date is known). • Notify the applicants and the county CF of the outcome of their eligibility determination, provide all necessary Medi-Cal documentation (i.e., Notice of Action (NOA)), and issue a benefits identification card (BIC), if approved. • Provide the member with contact information for the county SSD in the

Table 1. Minimum Operational Requirements for Pre-Release Medi-Cal Application Process for New Enrollees		
Operational Requirements	**County CF or Delegate**	**County SSD**
	county SSD of any changes to the individual's address/release date, as available.	county in which the individual will reside. • Once notified of a member's release, the county SSD must activate Medi-Cal benefits by reporting the release date in the Medi-Cal Eligibility Data System (MEDS). o When there is an immediate need for services, the county SSD shall arrange with the County CF to issue a temporary paper BIC to the individual so they can access Medi-Cal benefits upon release.

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

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

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

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

4.2.c Inter-County Transfers (ICT)

The member's Medi-Cal should be established in the county in which they intend to reside upon release. It is important for the CF and the county SSD to ensure the residence address and the county of responsibility on file for this population is accurate. However, there are times in which a member's Medi-Cal may need to be transferred to another county through a process called ICT. In order to process ICTs quickly and efficiently, CFs must report changes to community-based addresses where the member intends to reside upon release, to the county SSD as soon as that information is known to the CF. For more information on DHCS' ICT guidance, please refer to: ACWDL 18-02E, BHIN 21-032, and BHIN 21-072. [52]

[52] ACWDL 18-02E is available at https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/18-02E.pdf; BHIN 21-032 is available at: https://www.dhcs.ca.gov/Documents/BHIN-21-032.pdf; and BHIN 21-072 is available at: https://www.dhcs.ca.gov/Documents/BHIN-21-072-County-of-Responsibility-for-SMHS-Arbitration-Between-MHPs.pdf. DHCS is in the process of publishing an updated BHIN on ICTs processes and will update this document once available.

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

As discussed earlier in this section, CFs are required to develop processes that enroll uninsured individuals in Medi-Cal as close to the intake process as possible to help facilitate provision of pre-release services. To help the county SSDs and CFs navigate the potential operational challenges associated with members who have short-term stays, DHCS identified the following enrollment options to allow the county SSD and CFs to implement a process that works best for their JI population and correctional/enrollment staff. DHCS strongly encourages CFs and county SSDs to implement both of these options; the Medi-Cal Accelerated Enrollment (AE) pathway helps to ensure expedited enrollment in CFs where individuals do not have known release dates and/or are expected to stay for only short periods of time.

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

Option	Summary	Implementation Considerations
Facilitate Accelerated Enrollment through CalHEERS and CalSAWS	Medi-Cal's Accelerated Enrollment (AE) program allows new Medi-Cal applicants to receive real-time "conditional eligibility" and immediately access medical services, if applicable. DHCS grants AE to Medi-Cal applicants who apply through the coveredCA.com web application or by phone to Covered California's service center and applications submitted through BenefitsCal. Unlike presumptive eligibility, AE provides Medi-Cal applicants with temporary full-scope benefits while their self-attested eligibility information, including income, is being verified; those benefits	• Allows CFs or their designees to directly submit Medi-Cal applications for individuals, rather than submitting them through a the county SSD. • Allows for real-time application submission and expedited eligibility determination. • Covered California requires that CFs or their designees become qualified application assisters.[53]

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

Table 2. Justice-Involved Pre-Release Enrollment Pathway Options		
Option	**Summary**	**Implementation Considerations**
	continue until the final eligibility determination is made on the application. DHCS strongly encourages CFs or their designees to leverage AE for incarcerated individuals for whom it would be infeasible to complete the Medi-Cal application and enrollment process before the individual's release date (e.g., individuals with very short incarcerations or unpredictable release dates).	
Embed County SSD staff within CFs or implement other local best-practice processes to facilitate the Medi-Cal application and enrollment process.	Under this option, the county SSDs and CFs or their designees would work together to develop processes and/or additional capacity to facilitate processing of Medi-Cal applications as identified in best-practice guidance released by DHCS.[54]	• Enables counties to develop their own processes to align with localized needs while adhering to the broader JI requirements.

[54] An issue brief titled "Strategies for Conducting Pre-Release Medi-Cal Enrollment in County Jails" describes best practices for implementing the pre-release Medi-Cal application process. Available at: https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/Issue-Brief-Strategies-PreRelease-MediCal-Enrollmentin-County-Jails-8-18-22.pdf.

4.4 Suspension/Activate of Medi-Cal Benefits

Under Welfare and Institutions Code (WIC) section 14011.10, county SSDs must suspend, rather than terminate, coverage for Medi-Cal members who are incarcerated, and the suspension remains in place throughout the duration of their incarceration and ends on the date they are no longer an inmate of a public institution. This includes individuals who are enrolled in Medi-Cal through the pre-release Medi-Cal application process.[55,56]

Upon notification of an incarceration, the county SSD will change an individual's Medi-Cal status from "active" to "suspended". Once the release from incarceration is reported to the county SSD, they will activate the suspended Medi-Cal benefits without requiring a new application, as long as the individual remains otherwise eligible throughout their incarceration. The individual must be notified in a timely manner when their Medi-Cal coverage has been suspended and again upon activation via an application NOA. Additional information on the policy for Suspension/Activate of Medi-Cal Benefits can be found in ACWDL 21-22, 22-26 and 22-27.[57]

Although the individual may not receive regular Medi-Cal services while their Medi-Cal coverage is suspended during their incarceration, they may still be eligible to receive Medi-Cal covered inpatient services off the grounds of the CF if they are determined eligible under the state or county Medi-Cal Inmate Eligibility Program (MCIEP) and are hospitalized or expected to be hospitalized for more than 24 hours. If enrolled in the MCIEP, that coverage ends the last full day of their incarceration. They may also receive pre-release Medi-Cal services if determined eligible (see ***Section 6.2*** for details on eligibility criteria and ***Section 6.3*** for information on screening for pre-release services).

4.4.a Suspension for Short-Term Stays

ACWDL 22-26 provides updated information and guidance to implement DHCS's Medi-Cal benefit suspension and activation policies, including guidance on suspension timelines for individuals with short-term stays. For situations in which an individual is subject to a short-term stay of incarceration with a release in under 28 days, the county SSD will not report the incarceration in MEDS. Because the individual will be released in less than 28 days, their Medi-Cal benefits should not be suspended. For individuals incarcerated 28 days or longer, the county SSD will record the incarceration in MEDS

[55] Public Health Omnibus Bill, SB 184 (Chapter 47, Statutes of 2022), amended Welfare and Institutions Code §14011.10(d).
[56] Under SB 184, beginning January 1, 2023, Medi-Cal benefits for adults must be kept in suspended status until the individual is no longer an inmate of a public institution. For individuals under the age of 21 or former foster youth under the age of 26, under the federal SUPPORT Act and state law (Welfare & Institutions Code § 14011.10(d)(1), (2)), the state and counties are prohibited from terminating Medicaid eligibility because the individual is an inmate of a public institution.
[57] See ACWDL 21-22, 22-26 and 22-27 for more information on suspension/activation for individuals incarcerated and released to different counties, the annual renewal policy, change in circumstance redeterminations, and NOAs.

via the EW32 transaction on or after the 28th day, which will suspend the Medi-Cal benefits.

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

ACWDL 22-27 requires that CFs notify the county SSD as soon as they become aware of an individual's expected release date to ensure that Medi-Cal coverage is active upon release. CFs should make every effort to notify the county SSD a week prior to the individual's expected release date and no later than one business day before the expected release date (unless the release is unplanned). Upon notification or no later than one business day, county SSDs will activate benefits. No such action will be necessary for individuals to be released in less than 28 days, as their Medi-Cal benefits should not be suspended. To ensure continuity of care for individuals with an immediate need for medical services, the county SSD must follow the standard immediate need process. County SSDs can utilize an EW15 transaction and the EW32 transaction to activate Medi-Cal coverage. This will allow individuals who are released from incarceration to access benefits upon release, if needed.

4.4.c Redeterminations

Upon release, Medi-Cal must be activated without the need to submit a new application. Once the release from incarceration is reported, benefits will be activated the following day. A redetermination is required only if one has not been completed within 12 months prior to the release date, barring any other known changes in circumstance that would require a redetermination under existing policy. If a redetermination is applicable, county SSDs shall use available information to conduct the redetermination, including the information available in the individual's case record and through electronic data sources without contacting the individual. CFs will need to provide support for individuals who are subject to annual redeterminations. Their eligibility must be activated without submitting a new application if the information available to the County is sufficient to determine that the former inmate is still eligible (Welf. & Inst. CodeWIC §14011.10 (d)(1)). Additional information regarding the process and requirements for annual renewal and change in circumstance redeterminations can be found in ACWDL 21-22.

5. Readiness Assessments

5.1 Implementation Timeline

DHCS will implement a phased approach for the state prison system and county CF (inclusive of county jails and YCFs) to go live in several readiness-based cohorts on a quarterly basis over a two-year phase-in period. All county behavioral health agencies will be required to go-live with behavioral health links by October 1, 2024. All CFs and county behavioral health agencies will need to demonstrate readiness prior to their go-live date. The following summarizes the phased approach:

- CFs may go live as early as October 1, 2024, depending on their readiness assessment and DHCS approval for go live, as described in more detail below.
    - All CFs must go live by September 30, 2026.
    - As described in ***Section 5.2.b***, CFs will submit their readiness assessment materials indicating their requested go-live date to DHCS on a quarterly basis across the two-year implementation period (i.e., between October 1, 2024 and September 30, 2026).
- County behavioral health agencies must go live on October 1, 2024.
- CFs will coordinate with their county SSD on implementation timing to ensure that county SSD processes will be ready by the CF's approved go-live date.

5.2 Implementation Readiness – Correctional Facilities

5.2.a Correctional Facility Readiness Assessment Approach

Per the Section 1115 waiver STCs outlined in ***Section 1.1***, all CFs will be required to demonstrate readiness to participate in the JI initiative prior to going live with pre-release services by the dates listed above. DHCS will require each individual CF to complete a readiness assessment and receive DHCS approval prior to its go-live date. The readiness assessment will focus on the five key areas needed to operationalize 90-day pre-release services, described below in Table 3.[58,59]

In Q4 2023, DHCS will release the Readiness Assessment Template that CFs will use to attest to their readiness. The Readiness Assessment Template will contain additional detail on required readiness elements and the readiness assessment process.

As a part of the Readiness Assessment Template, CFs are expected to attest to their ability to meet minimum requirements and explain in a narrative format how they will meet these requirements. CFs must additionally include supplementary documentation

[58] Where appropriate, CFs may leverage prior information provided in the JI PATH Capacity-Building Program progress reports to populate their readiness assessment submissions.
[59] DHCS expects that participating facilities will leverage JI PATH funding to support the planning activities necessary to demonstrate readiness.

(such as program policy guides, workflows, and organizational charts) to support attestations of readiness and related narrative descriptions. The Readiness Assessment Template released by DHCS will also include a required list of attestations for CF's to sign.

CFs that do not complete or do not have an approved readiness assessment will not be eligible to go live with pre-release services. For additional information on evaluation of correctional facility readiness assessment submissions, see ***Section 5.2.c***.

As further described in Table 3 below, some readiness elements are categorized as minimum requirements, indicating that the CF must have the capability in place in order to go live with pre-release services. Those readiness elements marked as non-minimum requirements must still be supported and CFs must demonstrate that the facility will be ready to implement non-minimum requirements within six months of the requested go-live date as a condition of DHCS' approval.

Table 3. Correctional Facility Readiness Assessment Structure

Focus Areas	Readiness Element	Minimum/Non-Minimum Requirement
1. Medi-Cal Application Processes	**1a. Screening** – Defined process and support model to screen for current Medi-Cal enrollment and eligibility if not yet enrolled.	Minimum Requirement
	1b. Application Support – Defined process to support individuals in applying for Medi-Cal coverage and submitting an application.	Minimum Requirement
	1c. Activation of Benefits – Process and data sharing capability to notify the county SSD of the individual's release date to reactivate coverage and deactivate the pre-release services aid code/enable full scope of benefits upon release.	Minimum Requirement
2. 90-Day Pre-Release Eligibility and Behavioral Health Link Screening	**2a. Screening for Pre-Release Services** – Defined process and support model to screen eligibility for 90-day Medi-Cal pre-release services and document results in the Screening Portal. Screening should include securing consent from the individual to release information to relevant parties (e.g., assigned care manager), when required under federal and all other applicable law. DHCS supports the best practice of developing documentation of individuals' previous screenings in CF's applicable electronic data systems (e.g., electronic medical records) to expedite their enrollment upon re-incarceration.	Minimum Requirement

Table 3. Correctional Facility Readiness Assessment Structure		
Focus Areas	**Readiness Element**	**Minimum/Non-Minimum Requirement**
	2b. Screening for Behavioral Health Links – Defined process and support model to conduct an initial mental health and SUD screening at intake. As indicated, a second screen and/or full assessment with tools and processes mutually agreed upon by the CF and the county behavioral health agency should be completed to determine if the individual's behavioral health need meets the behavioral health criteria and requires a behavioral health link.	Minimum Requirement
3. 90-Day Pre-Release Service Delivery	**3a. Medi-Cal Billing and Provider Enrollment** – Established plan is in place to enroll the facility as an *Exempt From Licensure Clinic* Medi-Cal provider in order to bill fee-for-service for pre-release services (e.g., care management, X-rays/labs) and a process is in place to bill for services. Facilities with a pharmacy on-site that intend to provide pre-release authorized medications must also enroll as a Medi-Cal pharmacy.	Minimum Requirement
	3b. Short-Term Model – Defined process and support model to provide pre-release services to individuals who have short stays or unknown release dates, as required in ***Section 8.2.***	Minimum Requirement

Table 3. Correctional Facility Readiness Assessment Structure		
Focus Areas	**Readiness Element**	**Minimum/Non-Minimum Requirement**
	3c. Support of Pre-Release Care Management, Including: • Care Manager Assignment – Established process for leveraging the MCP JI Liaison and Provider Directory[60] to: o identify and assign an in-reach, community-based care manager to the individual shortly after determining eligibility for 90-day Medi-Cal Reentry Services; o identify if an individual has an existing relationship with community-based ECM care managers who could be assigned to provide pre-release care management services; or o to assign an embedded care manager[61,62,63] • Support Needs Assessment– Infrastructure and processes are in place to support the assigned care manager to perform comprehensive needs assessment. This includes obtaining consent to access and share any needed medical records with community-based providers/health plans, and coordination and support of delivery of services by CF clinical staff. • Support Coordination of Care – Infrastructure and processes are in place to support the assigned pre-release care manager, or ECM provider, to coordinate all needed care as part of the reentry stabilization, treatment, and planning for release. • Support Reentry Care Plan Finalization, Warm Handoffs (for care management and behavioral health links), and Reentry Continuity of Care Plan (see ***Focus Area 4*** below).[64]	Minimum Requirement

[60] See ***Section 13*** for details on the MCP Provider Directory, the MCP JI Liaison and care manager assignment.
[61] See ***Section 13.3.e.*** for details on correctional facility requirements as it pertains to care manager assignment.

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

[62] Note that the CF must reach out to an individual's assigned MCP for assistance with ECM provider assignment, once the individual has been assigned to a MCP. If the individual has not yet been assigned to an MCP at the time of ECM provider assignment, the CF must assign an ECM provider by using a MCP Provider Directory.
[63] DHCS encourages MCPs and CFs to collaborate as appropriate on a county-specific process to determine the appropriate ECM provider assignment for each member.
[64] State Medicaid Director Letter #23-003 refers to the Reentry Care Plan as the "person-centered care plan".

Table 3. Correctional Facility Readiness Assessment Structure		
Focus Areas	**Readiness Element**	**Minimum/Non-Minimum Requirement**
	3g. Support for MAT – Infrastructure and processes are in place to support MAT. This entails covering all forms of FDA-approved medications for the treatment of alcohol use disorder (AUD) and substance use disorder (SUD), and providing assessment, counseling, and patient education. Providing at least one form of an FDA-approved opioid agonist or partial agonist for opioid use disorder treatment is required to go live.	Minimum Requirement
	3h. Support for Prescriptions Upon Release – Infrastructure and processes are in place to support dispensing of Medi-Cal medications on day of release, or an action plan has been defined to support provision of Medi-Cal medications on day of release.	Minimum Requirement
	3i. Support for DME Upon Release – Infrastructure and processes are in place to support provision of DME on day of release or an action plan has been defined to support provision of DME on day of release.	Non-Minimum Requirement
4. Reentry Planning and Coordination	**4a. Release Date Notification** – Established process to provide electronic notification of the individual's release date to the county SSD, DHCS, pre-release care manager, post-release ECM provider (if different than the pre-release care manager), Medi-Cal MCP, and county behavioral health agencies and/or their subcontracted providers (as applicable).	Minimum Requirement
	4b. Care Management Reentry Care Plan Finalization – Established processes and procedures to ensure and support assigned care manager in creating final reentry care plan that is shared with the member, CF clinical care team, MCP, and post-release ECM provider if different from the pre-release care manager.	Minimum Requirement

Table 3. Correctional Facility Readiness Assessment Structure		
Focus Areas	**Readiness Element**	**Minimum/Non-Minimum Requirement**
	4c. Reentry Care Management Warm Handoff – Established process to ensure and support a warm handoff between pre-release care manager and ECM Lead Care Manager, if the ECM Lead Care Manager is different from the pre-release care manager (e.g., providing space and infrastructure for warm handoff meeting either in person or via telehealth). *Note, if CF is using an embedded care manager,*[65] *CF must establish processes and procedures to ensure a warm handoff will occur between the pre-release care manager and the ECM Lead Care Manager in the pre-release period and for behavioral health links to occur based on clinical acuity. In cases when a warm handoff cannot occur prior to release (e.g., unexpected early releases from court) warm handoffs must occur within one week of release. This should include information sharing within one business day of release with the ECM provider, the MCP, and the county behavioral health agencies and/or their subcontracted providers as appropriate.*	Minimum Requirement

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

Table 3. Correctional Facility Readiness Assessment Structure		
Focus Areas	**Readiness Element**	**Minimum/Non-Minimum Requirement**
	4d. Behavioral Health Links – Established process to allow for in-person behavioral health links, when clinically indicated, between the pre-release care manager, individual, pre-release service care team, and post-release behavioral health care manager where possible and if the post-release behavioral health care manager is different from the pre-release care manager (i.e., providing space in a reentry area for warm handoff meeting, either in person or via telehealth). Behavioral health links must include basic care coordination for referrals to continued treatment post-release. Processes for behavioral health links will be designed and mutually agreed upon by the correctional facility and the county behavioral health agency.	Minimum Requirement
5. Oversight and Project Management	**5a. Staffing Structure and Plan** – Clear staffing and/or contractor structure to support each readiness element and compliance with DHCS requirements for the 90-day Medi-Cal Reentry Services and reentry coordination.	Minimum Requirement
	5b. Governance Structure for Partnerships – Defined governance structure for coordinating with key partners (e.g., regular collaboration with the county SSD, care management organizations, providers, MCPs, county behavioral health agencies; MOUs). DHCS will require CFs and county behavioral health agencies to enter into memoranda of understanding (MOU) with DHCS. DHCS will be coordinating the MOU development and discussions with applicable entities. Further guidance, including MOU templates, will be released at a later date.	Non-Minimum Requirement
	5c. Reporting and Oversight Processes – Established process to collect, monitor, and report on DHCS required measures, including corrective action processes to address operational challenges.	Minimum Requirement

5.2.b. Correctional Facility Readiness Assessment Submission Process & Timeline

To ensure that DHCS can review the readiness assessment prior to the go-live date and engage with CFs as needed during the review, as well as to ensure sufficient time for CFs to finalize preparations for go-live, CFs will be required to submit their assessments at least six months prior to their proposed go-live date. DHCS will determine and announce the CF's readiness decision two months before the planned go-live date. Readiness assessments will be conducted on a quarterly basis.

The following steps outline the Readiness Assessment Submission Process:

1. DHCS releases Readiness Assessment Template.
2. CF submits readiness assessment and accompanying materials to DHCS.
3. DHCS evaluates CF's readiness assessment responses and materials and works with CF to address questions/feedback.
4. DHCS communicates final readiness decision to CF.
5. DHCS publicly posts CF approvals.
6. CF goes live with pre-release services on approved go-live date.

The table that follows provides an example Readiness Assessment submission process timeline for CFs that plan to go live on October 1, 2024 (*specific dates are subject to change*).

Table 4. Example Readiness Assessment Submission Process – Illustrative Timeline

Milestone	Example Timeline for October 1, 2024 Go-Live
CFs Submit Readiness Assessment to DHCS *CFs may submit their Readiness Assessment before the April 1 due date*	April 1, 2024
DHCS Reviews Readiness Assessments *DHCS will engage CFs as needed during review*	April – July 2024
DHCS Communicates Final Readiness Decision to CFs *DHCS will publicly post facilities approved to go-live on the Justice Involved Initiative website after approval is communicated to CFs*	August 1, 2024
CF Finalizes Preparations for Go-Live	August – September 2024
CF Goes Live with Pre-Release Services	October 1, 2024

5.2.c. DHCS Approach for Evaluating Correctional Facility Readiness Assessments

For each of the five focus areas contained in the Readiness Assessment Template, DHCS will determine a composite score based on the CF's attestation and supporting documentation of its meeting the minimum requirements associated with each readiness element. Readiness decisions will be made at the county level. Specifically, all facilities within an agency (i.e., all jails in a county or all YCFs in a county) must go live with all required services at the same time. If there are situations where a facility within an agency will not be ready at the same time as the rest of the county, DHCS may consider an exception process.

DHCS reviewers will use the rubric shown in Table 5 to determine the score for each focus area.

Table 5. Focus Area Scoring Rubric
Pass: Correctional facility's response is complete and indicates total or almost total readiness (i.e., all minimum requirements are met) and facility receives a pass in each focus area, and the facility has a process in place to go-live with non-minimum requirement elements within 6 months of their go-live date.
Conditional Pass: Correctional facility response is complete and indicates that the correctional facility meets some, but not all, components of the readiness assessment, and demonstrates a time-bound glidepath to meeting outstanding requirements by the requested go-live date, and that the facility will be ready to go-live with non-minimum requirement elements within 6 months of their go-live date.
Fail: Correctional facility's response is incomplete, the provided response does not sufficiently address the question, or the provided response does not indicate readiness to go live.

To receive approval from DHCS to go live, a CF must receive a "Pass" in all five focus areas by meeting each requirement categorized in the Readiness Assessment Template as a minimum requirement for go-live. The CF must also demonstrate that it has a process in place to implement the three non-minimum requirement elements identified in Table 3 above (Clinical Consultation, Support for Durable Medical Equipment Upon Release, Governance Structure for Partnerships) within six months of go-live.

In some cases, a CF may receive a "Conditional Pass," indicating that the facility meets some, but not all, required components of the readiness assessment and has adequately demonstrated a time-bound action plan to meeting outstanding minimum requirements by the requested go-live date. In these cases, DHCS will work with the CF to determine if required components of the readiness assessment will be ready by the go-live date.

If a CF receives a "Fail" in any focus area, DHCS will engage the CF to develop an implementation plan so that it can work toward readiness by the proposed go-live date or for a future go-live date.

Based upon readiness assessment submissions and receipt of Pass/Conditional Pass, DHCS will develop and maintain a publicly accessible report on the DHCS JI website to display the pre-release service go-live date for CFs in each county, updated on a quarterly basis. The report will also include information on whether each facility plans to pursue an in-reach or embedded care management model. DHCS encourages county-level communication between implementing partners, to facilitate the collaborative drafting of readiness assessments and sharing of approved readiness assessment to ensure all implementing partners are aligned with roles and responsibilities.

5.3 Implementation Readiness – County Social Services Departments (SSDs)

DHCS will require all county SSDs to complete a brief readiness assessment template provided by DHCS, which will exclusively focus on new processes (Table 6) required to support the implementation of 90-day pre-release services. The county SSD readiness assessment will not cover Medi-Cal application processes, as outlined in MEDIL 23-24E, as this is being monitored separately.

Table 6. County SSD Readiness Elements	
1. Activate Medi-Cal Benefits at Release	Process for receiving release dates from CF and activating Medi-Cal.
2. Support Oversight and Project Management	Established process to collect, monitor, and report on DHCS required measures, including corrective action processes to address operational challenges.[66]

DHCS will assess the county SSD's readiness based on the same scoring rubric used for CFs (see Table 5), to determine whether the county SSD is ready to go live and/or needs technical assistance support from DHCS. If the county SSD is not prepared to go live in one or more focus areas, DHCS will collaborate with the county SSD to resolve open issues to ensure that the agency is able to achieve readiness by, or close to, the October 1, 2024 go-live date.

5.4 Implementation Readiness – County Behavioral Health Agency

Key to the larger CalAIM JI Initiative is implementing behavioral health links to behavioral health providers to initiate or continue behavioral health care through professional-to-professional clinical handoffs, as set forth in California Penal Code section 4011.11(h)(5) and consistent with the CalAIM behavioral health links initiative (see page 51 of the CalAIM Proposal and AB 133). Through the CalAIM Justice-

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

Involved Initiative, DHCS will require state prisons, county CFs, YCFs, county behavioral health agencies, and MCPs to implement processes for facilitated referrals and links to continued behavioral health treatment in the community for individuals who receive behavioral health services while incarcerated. It is expected that behavioral health links will be fully integrated into the delivery of the pre-release services, once implemented. Behavioral health-related pre-release services and behavioral health links will be provided in partnership with county behavioral health agencies and CFs. Additional information about behavioral health links is available in ***Section 11.4***, Behavioral Health Links.

In order to implement behavioral health links, DHCS will require all county behavioral health agencies to complete a readiness assessment template provided by DHCS, which will focus on new processes required to support the implementation of behavioral health links, as required by AB 133. All county behavioral health agencies are expected to go-live on October 1, 2024. DHCS will assess the county behavioral health agency's readiness based on the same scoring rubric used for CFs (see Table 5), to determine whether the county behavioral health agency is ready to go live and/or needs technical assistance support from DHCS. If the county behavioral health agency is not prepared to go live in one or more focus areas, DHCS will collaborate with the county behavioral health agency to resolve open issues to ensure that the agency is able to achieve readiness by, or close to, the October 1, 2024 go-live date.

Components of the readiness assessment with respect to behavioral health links are shown in Table 7 below.

Table 7. County Behavioral Health Agency Readiness Assessment Structure

Focus Areas	Readiness Element	Minimum Requirement to Go Live
1. Initial Data Sharing	**1a. Initial Data Sharing** – Defined process to (1) obtain medical records as appropriate for individuals with treatment history; and (2) notify MCP (if enrolled) that care coordination with the county behavioral health agencies and/or their subcontracted providers is occurring, as necessary.	Minimum Requirement
2. Data Sharing	**2a. Data Sharing for Release** – Defined process to (1) receive CF medical record information and ensure that it is incorporated into post-release medical record; and (2) identify any individuals who may benefit from a warm handoff.	Minimum Requirement
3. Release Planning	**3a. Follow-up Appointments** – Defined process to provide follow-up appointment date/time/location within a clinically	Minimum Requirement

Table 7. County Behavioral Health Agency Readiness Assessment Structure		
Focus Areas	**Readiness Element**	**Minimum Requirement to Go Live**
	appropriate window (e.g., for someone on medications for SUD, recommended follow-up would be next day post-release).	
	3b. Transportation – Defined process to ensure transportation to appointment is arranged.[67]	Minimum Requirement
4. Professional-to-Professional Clinical Handoff	**4a. Professional-to-Professional Clinical Handoff** – Established process to provide in-person/telehealth warm handoffs between correctional provider and county behavioral health agency and/or its subcontracted provider, as necessary, and defined processes in place to ensure the county behavioral health agency is able to participate in care transition meetings for any client that has been identified as needing additional team coordination by correctional staff, the care manager, or clinical consultants (e.g., clients identified to have high/complex needs).[68]	Minimum Requirement
5. Follow-up Post-Release	**5a. Post-Release Scheduling** – Established process to schedule individual for appointments on an ongoing basis as needed. Appointment scheduling should occur within a clinically appropriate time frame, ensuring they have adequate transportation to appointment.	Minimum Requirement
	5b. Post-Release Follow-up – Established process to provide follow-up to the individual if they miss an appointment in the community. DHCS supports the best practice of deploying a CHW to work with the ECM provider to reschedule missed appointments as soon as possible.	Minimum Requirement

[67] Transportation services refer to Non-Emergency Medical Transportation which are an MCP covered benefit. Pre-release care managers would be responsible for working with MCPs to coordinate transportation, if MCP is known. Information on NEMT is available here: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-008.pdf

[68] While some care coordination and information sharing activities may occur via email or other asynchronous forms of communication, the professional-to-professional clinical handoff must be completed synchronously (i.e., in-person or via telehealth) to meet this minimum requirement.

Table 7. County Behavioral Health Agency Readiness Assessment Structure		
Focus Areas	**Readiness Element**	**Minimum Requirement to Go Live**
6. Oversight and Project Management	**6a. Staffing Structure and Plan** – Clear staffing and/or contractor structure to support each readiness element and compliance with DHCS requirements for behavioral health links. This includes the identification of county-operated and/or county-contracted providers that will (1) fulfill the required processes described above and (2) receive referrals for follow-up visits in the community for continued behavioral health care.	Minimum Requirement
	6b. Governance Structure for Partnerships – Defined governance structure for coordinating with key partners (e.g., CFs, care management organizations, providers, MCPs).	
	6c. Reporting and Oversight Processes – Established process to collect, monitor, and report on DHCS required measures as part of the oversight and monitoring processes, including corrective action processes to address operational challenges.	Minimum Requirement

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

6. Pre-Release Services and Behavioral Health Links Eligibility and Screening Process

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

6.1 Eligible Facilities

A targeted set of Medi-Cal services will be provided during a 90-day period prior to release to eligible individuals either prior to adjudication or post-conviction. Correctional agencies – inclusive of State prisons, county jails/detention centers/detention facilities[69] and county YCFs – are statutorily mandated to comply with the requirement to provide pre-release services per California Welfare and Institutions Code section 14184.800. DHCS will work with agencies to demonstrate readiness to provide these services by the mandated go-live date and will require agencies to provide ongoing reporting on their progress in achieving and maintaining readiness. Should an agency or facility fail to implement the full requirements, DHCS will exercise compliance enforcement mechanisms, additional guidance for which will be released at a later date.

Targeted pre-release services will only be provided to individuals prior to leaving a CF and reentering the community. Generally, individuals who are in state hospitals return to prisons or jails prior to their release and will be eligible to receive services upon their return to the CF.[70] Based on the waiver authority granted by CMS, individuals who are incarcerated in the CF but incompetent to stand trial and awaiting placement in a state hospital may not receive pre-release services if they will not be released into the community. If an individual is expected to be released into the community, they may receive pre-release services in the 90 days immediately prior to their expected date of release from the CF.

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

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

DHCS will track the duration of service provision to ensure coverage of pre-release services does not exceed 90 days per facility stay. Protocols for some common scenarios pertaining to delivery of pre-release services are as follows:

- There may be circumstances where an individual could receive 90 days of pre-release services in a county jail and then be transferred to a state prison and receive 90 days of pre-release services in that facility prior to their release. While the individual may receive pre-release services under these circumstances, such time period may not exceed 90 days per facility per incarceration. Note that when an individual is transferred from one state prison to another the 90-day period will not restart.
- There may be circumstances where an individual is found to be incompetent to stand trial and transferred to a state hospital from a jail to get a mental health assessment. In situations where the individual is transferred back to the jail, the 90-day period will restart. Note that Medi-Cal reimbursement for pre-release services will not be available while the individual is in the state hospital.
- There may be situations where the expected release date is unexpectedly extended. Under these circumstances, county SSDs will pause the aid code so that pre-release services are unable to be reimbursed using Medi-Cal funding. Once a new expected release date is confirmed, the 90-day period will reset and the individuals will have a new 90-~~day~~ period for the provision of pre-release services. The state will implement a system to track the date an individual was found eligible for pre-release services to ensure services were not provided for a period longer than a total of 180 days. (This period includes a maximum of the initial 90 days of pre-release services and an additional 90 day reset period that began prior to the new expected release date).
- There may be circumstances in which an individual is incarcerated multiple times in the same year. In these situations, individuals will be eligible for up to 90 days of pre-release services for each time the individual is incarcerated.
- There may be circumstances that an individual was provided pre-release services in a county CF and not released to the community, the State's tracking system will monitor the number of days and ensure that no payment will be made for services provided after the initial 90 days. The 90-day period may restart when a release date is identified.

DHCS continues to work with CMS to confirm approaches for delivering pre-release services under additional scenarios, such as when an individual's release date is postponed due to changes in trial dates or when additional charges are added, which further extends the release date.

6.2 Eligible Individuals

The eligibility criteria for pre-release services were informed by existing criteria defined for other Medi-Cal transformation projects (e.g., Health Homes, WPC pilots), definitions

leveraged by CDCR and based on both stakeholder feedback through the JI CalAIM Advisory Group and common conditions among the JI population.

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

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

AND

- Be a youth in custody of a YCF (no health care criteria are applied).[71]
- OR
- Be an adult and meet one or more health care needs criteria as defined in Table 8.[72]

Table 8. Qualifying Health Care Needs Criteria Definitions

Qualifying Condition	Definition
Mental Illness	A person with a mental illness is someone who is currently receiving mental health services or medications OR meets both of the following criteria: • The member has one or both of the following: ○ Significant impairment, where “impairment” is defined as distress, disability, or dysfunction in social, occupational, or other important activities.

[71] Note that youth versus adult eligibility criteria are determined by facility, not by age. For example, individuals aged 18-21 in custody of a county jail or CDCR must meet adult health care needs criteria; individuals aged 18-25 in custody of YCF must meet youth eligibility criteria, which means they do not need to demonstrate health care needs.
[72] Health care needs criteria are aligned with ECM JI POF. See CalAIM ECM Policy Guide (July 2023). Available at: https://www.dhcs.ca.gov/Documents/MCQMD/ECM-Policy-Guide.pdf

Table 8. Qualifying Health Care Needs Criteria Definitions	
Qualifying Condition	**Definition**
	○ A reasonable probability of significant deterioration in an important area of life functioning. • The member's condition as described in bullet above is due to either of the following: ○ A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Statistical Classification of Diseases and Related Health Problems. ○ A suspected mental disorder that has not yet been diagnosed.
Substance Use Disorder	A person with a SUD is a person who either: • Meets the criteria for an SUD as defined in the current editions of the DSM and/or the *International Statistical Classification of Diseases and Related Health Problems*. • Has a suspected SUD diagnosis that is currently being assessed through either the National Institute of Drug Abuse (NIDA)-modified Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) or American Society of Addiction Medicine (ASAM) criteria.
Chronic Condition or Significant Non-Chronic Clinical Condition	A person with a chronic condition or a significant non-chronic clinical condition is one who has ongoing and frequent medical needs that require treatment, including one of the following diagnoses, as indicated by the individual, and who may be receiving treatment for the condition, as indicated: • Active cancer. • Active hepatitis A, B, C, D, or E. • Advanced liver disease. • Advanced renal (kidney) disease. • Autoimmune disease, including but not limited to rheumatoid arthritis, lupus, inflammatory bowel disease, and multiple sclerosis.

Table 8. Qualifying Health Care Needs Criteria Definitions	
Qualifying Condition	**Definition**
	• Chronic musculoskeletal disorders that impact functionality of activities of daily living, including but not limited to arthritis and muscular dystrophy. • Chronic neurological disorder. • Severe chronic pain. • Congestive heart failure. • Connective tissue disease. • Coronary artery disease. • Currently prescribed opiates or benzodiazepines. • Currently undergoing a course of treatment for any other diagnosis that will require management of three or more medications or one or more complex medications that requires monitoring (e.g., anticoagulation therapy) after reentry. • Cystic fibrosis and other inherited metabolic disorders. • Dementia, including but not limited to Alzheimer's disease. • Epilepsy or seizures. • Foot, hand, arm, or leg amputee. • Hip/pelvic fracture. • HIV/AIDS. • Hyperlipidemia. • Hypertension. • Incontinence. • Severe migraine or chronic headache. • Long COVID-19. • Moderate to severe atrial fibrillation/arrhythmia. • Moderate to severe mobility or neurosensory impairment (including but not limited to spinal cord injury, multiple sclerosis, transverse myelitis, spinal canal stenosis, peripheral neuropathy).

Table 8. Qualifying Health Care Needs Criteria Definitions	
Qualifying Condition	**Definition**
	• Obesity. • Peripheral vascular disease. • Pressure injury or chronic ulcers (vascular, neuropathic, moisture-related). • Previous stroke or transient ischemic attack. • Receiving gender-affirming care. • Active respiratory condition, such as severe bronchitis, chronic obstructive pulmonary disease (COPD), asthma, or emphysema. • Severe viral, bacterial, or fungal infection. • Sickle cell disease or other hematological disorder. • Significant hearing or visual impairment. • Spina bifida or other congenital anomalies of the nervous system. • Tuberculosis. • Type 1 or 2 diabetes.
Intellectual or Developmental Disability	A person with an intellectual or developmental disability is one who has a disability that begins before the individual reaches age 18 and that is expected to continue indefinitely and present a substantial disability. Qualifying conditions include intellectual disability, cerebral palsy, autism, Down syndrome, and other disabling conditions as defined in Section 4512 of the California Welfare and Institutions Code.
Traumatic Brain Injury	A person with a traumatic brain injury is one with a condition that has caused significant cognitive, behavioral, and/or functional impairment.
HIV/AIDS	A person with HIV/AIDS is one who has tested positive for either HIV or AIDS at any point in their life.
Pregnant or Postpartum	A person who is pregnant or postpartum is one who is either currently pregnant or within the 12-month period following the end of a pregnancy.

6.3 Screening Approach

To ensure that all Medi-Cal-eligible individuals who meet the pre-release access criteria are able to receive pre-release Medi-Cal services, CFs must screen all Medi-Cal-eligible adults for physical and behavioral health needs (see qualifying conditions in Table 8). Youth in YCFs do not need to be screened to assess whether they meet a qualifying condition. DHCS is exploring how to standardize pre-release eligibility screening processes. Until such standardized screening processes are provided by DHCS, CFs will be expected to leverage existing health screening and assessment processes to screen individuals for eligibility to receive pre-release services (e.g., assess whether an individual has health needs listed in Table 8 based on information collected through a CF's existing screening/assessment processes). CFs will be required to meet a minimum set of expectations for screening individuals for access to pre-release services, but they will have flexibility in how they implement the screening process.

At a minimum, CFs must screen all Medi-Cal-eligible individuals who become incarcerated for access to pre-release services.[73] CFs may use JI PATH Round 3 funding to develop policies and protocols to screen individuals for pre-release services; CFs may use PATH funding to pay staff for screening for up to two years after they receive their JI PATH Round 3 award.[74] After two years, CFs may be able to bill for screening for pre-release services as a MAA if CMS approves funding.[75]

> County correctional facilities shall submit screening information to activate the pre-release aid code 90-days prior to an individual's anticipated release, using the best available information (e.g., on level of charges). The aid code should be activated as soon as possible for individuals with anticipated stays of less than 90 days, or for those with unclear anticipated lengths of stay at the time of entry. The JI pre-release aid code may only be activated for individuals enrolled in Medi-Cal.

DHCS will leverage an existing provider Screening Portal (referred to as the Screening Portal), which will be modified specifically for the purpose of collecting and sharing pre-release service eligibility data between CFs and DHCS, in addition to activating the pre-release aid code. CFs may still design their screening process to fit the needs of the individual facility; the Screening Portal does not necessitate the establishment of a standardized screening process across CFs. The CF must conduct a screening to determine whether and by what criteria an individual is made eligible. (See minimum expectations for screening below.) The Screening Portal will initially collect "yes – eligible" and "no – ineligible" data; DHCS will provide additional guidance on recording qualifying information in the Screening Portal in future guidance. Regardless of what is

[73] Screening for qualifying health conditions of youths in YCFs is not required for them to access pre-release services. Individuals in adult facilities who are intellectually or developmentally disabled, have a traumatic brain injury, HIV/AIDs or are pregnant or postpartum are eligible for pre-release services and do not need to demonstration additional health care needs.
[74] See ***Section 2.2.c*** on permissible uses of JI PATH Round 3 funding.
[75] Pending CMS approval.

recorded in the Screening Portal, the CF must conduct a screening to determine whether and by what criteria an individual is made eligible. (See minimum expectations for screening below.) DHCS will use this information to send a NOA to individuals determined ineligible for pre-release services.

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

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

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

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

  County CFs may have multiple opportunities to screen individuals for access to pre-release services. Screening should occur as close to intake as possible to ensure that individuals have access to as much of the full 90 days of pre-release services as possible. Screening for access to pre-release services may occur at the following points:

  - Tier 1 – Initial Health Screening: CFs conduct an initial safety assessment at booking, which varies by facility, but generally assesses the individual for immediate physical and behavioral health needs, including the likelihood of harm to self or others, acute psychiatric distress, pregnancy, communicable diseases, and SUD withdrawal. The CF staff conducting the initial safety assessment may simultaneously screen the individual for access to pre-release services while conducting the safety assessment, or they may review their clinical records or ask the individual to self-attest to meeting the clinical eligibility criteria. At this point, the CF will already know whether the individual is Medi-Cal-eligible and/or enrolled in Medi-Cal. If the individual is already enrolled, the results of the screening will then be entered via the Screening Portal. This screening should occur within 96 hours (see ***Section 8.2*** on the short-term model).
  - Tier 2 – Comprehensive Health Screening: If it is not possible to assess the individual during the initial health screening due to mitigating circumstances (e.g., individual is intoxicated, insufficient time), the CF may conduct the screening during the individual's comprehensive health screening and enter the results via the Screening Portal. Comprehensive health screenings are generally conducted within two weeks of booking. Screening should occur

with sufficient time prior to release for the individual to receive the full 90 days of pre-release services.

- Ongoing: If a clinician identifies at any time an individual who is eligible for pre-release services, including after the Tier 1 and 2 screenings, or if the individual self-attests to having a qualifying condition, the CF staff may still submit the screening results through the Screening Portal so that the individual may access pre-release services.

In summary, individuals in county CFs must be screened within 96 hours of intake for pre-release services during an existing health screening or assessment process, which must include a self-attestation option. Additional screenings for pre-release services should be conducted throughout the individual's stay through clinical observation, medical record review, and/or self-attestation.

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

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

To ensure individuals with behavioral health needs are identified and behavioral health links are provided, as required by AB 133, DHCS will require that CFs have the ability to systematically screen all individuals entering the CF for mental illness and SUD, including any history of alcohol, sedative or opioid withdrawal. Screening tools can be used by non-clinical staff and should be used alongside regular screenings upon intake for individuals in CFs. Screening for mental health and SUD should be performed using validated tools, with demonstrated applicability in justice settings. DHCS has provided a list of screening tools below. DHCS encourages entities to use validated tools for other types of screening and assessment (physical health, functional needs, housing needs), where available. Additionally, screening and assessments must be performed or overseen by a licensed professional.

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

Potential behavioral health screening tools:

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

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

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

Delivery systems:

- **County Mental Health Plans (MHPs).** If an individual is identified as needing county MHP services at any point of incarceration, they will qualify for SMHS and require a behavioral health link with a SMHS provider prior to release.[76]

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

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

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

- **Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS)**. If an individual meets the diagnostic criteria for a SUD diagnosis, they will qualify for DMC/DMC-ODS and require a behavioral health link with a DMC or DMC-ODS provider prior to release.[77]If an individual is identified as needing MAT or receives MAT during any point of incarceration, they are eligible to continue MAT services through either their MCP or their DMC/DMC-ODS county upon release. If these individuals receive a behavioral health link to an MCP network provider offering MAT prior to release, the care manager shall notify both the MCP and the county DMC or DMC-ODS agency prior to release
- **MCP or FFS Providers.** If an individual has an identified behavioral health need that does not meet criteria for SMHS, DMC, or DMC-ODS (e.g., members defined on page 4 of APL 22-006), their behavioral health needs will be managed by providers through their MCP. These individuals will have their behavioral health link facilitated through the care manager/ECM provider.

6.5 Aid Codes

An assessment of eligibility for pre-release services will be conducted by the CF, and information about such eligibility will be captured by the state-maintained Screening Portal (see ***Section 6.3***, *Screening Approach for additional detail)*. Effective October 1, 2024, DHCS will establish five new aid codes (I2, I3, I4, I5, and I6) to identify the populations eligible to receive pre-release services, provide access to the limited set of services available to the eligible JI population, correctly process claims payments, and accurately draw down federal matching funds, based on the funding for the primary Medi-Cal aid code under which incarcerated individuals are eligible. Pre-release services will be limited to a 90-day period.[78]

Incarcerated individuals will be concurrently eligible under both the primary Medi-Cal and pre-release services aid codes, regardless of whether the incarceration period has been reported to MEDS and Medi-Cal benefits have been suspended. In this situation,

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

[78] The pre-release services will be provided at CFs or outside the correctional facilities with appropriate transportation and security oversight provided by the CF, subject to DHCS approval of a facility's readiness, according to the phase-in schedule described in STC 9.8.

the pre-release services aid code takes precedence over the primary Medi-Cal aid code, as services under the primary Medi-Cal aid code are not allowable during incarceration.

Services provided off the grounds of the CF that require a hospital stay of 24 or more hours may be covered under state or county MCIEP. When an individual is also eligible for MCIEP, their pre-release in-reach aid code and their MCIEP aid code would be returned and billing would be determined based on the service and service location.

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

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

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

Individuals have the right to submit a Medicaid application in person, by telephone, online, or by mail. Through the JI Initiative, and as detailed in ***Section 4*** of this Guide, 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. 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., phone, online, mail) where possible. Given the unique constraints of the corrections environment, individuals' ability to use these modalities may be limited by facility resources (e.g., lack of an internet connection would hinder submission of online applications) and/or inmate privileges (e.g., use of telephones). DHCS does not expect that incarcerated individuals, who lack freedom of movement, will be able to submit Medicaid applications in person at a county SSD office.

California state prisons have already implemented pre-release Medicaid applications, and, as of January 1, 2023, all CFs are required to implement pre-release application processes. DHCS communicated this requirement to counties through ACWDL 22-27, released in November 2022. In addition, in December 2022, via MEDILs 22-46 and 22-47, DHCS required all county CFs and county SSDs to complete a brief readiness assessment that describes the processes they have – or will have – in place to support pre-release Medicaid applications. DHCS will implement an ongoing monitoring approach to ensure compliance with the mandate, as described in MEDIL 23-24.

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

Individuals have the right to receive notice of any adverse action regarding their coverage, such as denials of Medicaid coverage or 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 able to meet this requirement by sending the appropriate notice of adverse decision 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 are designated as an Authorized Representative by the individual, county SSDs will receive the Authorized Representative 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. For individuals who are released before the notice is mailed, the county SSDs must mail the notice to the individual's last known address.

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

Federal rules require that states provide the ability for individuals to request a fair hearing regarding any adverse actions related to Medicaid coverage or services. Individuals have the right to request a fair hearing in writing, online, by telephone, or in person, and states may not limit or interfere with the individual's freedom to make a request. In general, DHCS anticipates that individuals will be able to submit a request for a fair hearing through all modalities, with the exception of in-person requests at 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.

8. Providing Pre-Release Services Delivery Model

8.1 Definitions of Covered Pre-Release Services

The following benefits will be available to eligible individuals in the 90 days prior to release. Pre-release covered services will be delivered, claimed, and paid for via Medi-Cal's FFS delivery system.[79] Please see section 10 for more details on provider enrollment and billing and payment requirements.

Table 9. 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 in order 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. ○ 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. • 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 BH links with receiving county behavioral health agencies and/or MCP ECM providers,

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

Table 9. Pre-Release Covered Services	
Covered Service	**Definition**
	• 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. For county behavioral health agencies providing in-reach behavioral health care management, care management shall include SUD care coordination (depending on the county of residence), Peer Support services (depending on the county of residence), and SMHS Targeted Case Management covered in the Medi-Cal State Plan.
Physical and Behavioral Health Clinical Consultation Services	Physical and behavioral health clinical consultation services include targeted preventive, physical, and behavioral health clinical consultation services related to the qualifying conditions. Clinical consultation services are intended to support the creation of a comprehensive, robust, and successful reentry plan, and include diagnosing, stabilizing, and treating the individual in preparation for release (including recommendations or orders for needed labs, radiology, and/or medications); providing recommendations or orders for DME that will be needed upon

Table 9. Pre-Release Covered Services	
Covered Service	**Definition**
	release; and consulting with the pre-release care manager to help inform the pre-release care plan. Clinical consultation services are also intended to provide opportunities for members to meet and form relationships with the community-based providers who will be caring for them upon release, including behavioral health providers, and enable information sharing and collaborative clinical care between pre-release providers and the providers who will be caring for the members after release, including behavioral health links. Services may include, but are not limited to: • Addressing service gaps that may exist in correctional care facilities. • Diagnosing and stabilizing individuals while incarcerated, preparing them for release. • Providing treatment, as appropriate, in order to ensure control of qualifying conditions prior to release (e.g., to recommend medication changes or ordering appropriate DME for post-release). • Supporting reentry into the community. • Behavioral health clinical consultation includes clinical assessment, , peer supports, and treatment, such as behavioral health counseling, therapy, patient education, and medication services[80] 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.[81]
Medications and Medication Administration	Medications and medication administration will be provided consistent with the State Plan.

[80] Medication services are defined as Medication Services" includes 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 Alcohol Use Disorders (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

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

Table 9. Pre-Release Covered Services	
Covered Service	**Definition**
MAT	• MAT for opioid use disorder (OUD) includes all medications approved under section 505 of the federal Food, Drug, and Cosmetic Act (21 U.S.C. § 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. § 262) to treat OUD as authorized by Social Security Act Section 1905(a)(29). DHCS will require 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) rehabilitation 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 prescription OTC drugs (a minimum 30-day supply as clinically appropriate, consistent with the approved Medicaid State Plan). • DME consistent with Medicaid State Plan requirements.

8.2 Short-Term Model Minimum Requirements

Many individuals have unknown release dates at the time of incarceration, and a large percentage will be in and out of county CFs within 48 hours. Given the short and unpredictable nature of county CF stays, county CF staff may face operational challenges in providing and/or facilitating pre-release services. To mitigate these challenges, DHCS established a short-term model to ensure CFs are providing services to individuals with short-term stays.

Pre-release services must begin once the aid code is activated and as close to intake as possible for any person who has an anticipated short or unknown length of stay in a county CF. Pre-release planning requirements for individuals in county CFs who have a known release date and are likely going to stay longer than 30 days should begin services in the 90-day period prior to their release. For more information on starting, pausing, and resetting the 90-day period see ***Section 6.2.***

Table 10 provides the minimum requirements for county CFs to provide and coordinate pre-release service delivery and reentry planning during the 21 days of incarceration for those with unknown release dates. The timelines in the below table should be followed as soon as an incarcerated individual is confirmed to be enrolled in Medi-Cal and their JI aid code is activated. In order to meet these requirements, DHCS expects Medi-Cal applications and screening for pre-release services to occur as close to intake as possible. Additional requirements related to Medi-Cal pre-release enrollment can be found in ***Section 4.2 and Section 6.3.*** While Table 10 identifies the minimum services county CFs must provide in the 21 days of incarceration for those with unknown release dates, county CFs can initiate services earlier than the following timeline requirements based on available staffing and resources. A county CF's ability to comply with the short-term model will be assessed as part of the county CF's readiness assessment. DHCS will only approve a facility to go-live if it can attest to having processes in place that meet the minimum requirements.

At the time of the publication of this Guide, all timelines associated within the first seven days of JI aid code activation will be considered recommended implementation practices and not requirements. DHCS will continue to update this short-term model after implementation of pre-release services and DHCS and implementation partners have a better understanding of how to operationalize the delivery of pre-release services within the first seven days of JI aid code activation. DHCS expects to mandate all timelines in the short-term model in the near future, and will memorialize those requirements in subsequent iterations of this Guide. Table 10 includes recommended implementation practices for services that occur within the first week of aid code activation to assist county CFs in developing their processes that will ultimately become requirements.

Table 10. Short-Term Model: Key Activities and Timeline Requirements	
Key Activities	**Timeline and Requirements for Providing Services**
1. Medi-Cal Application Process	
DHCS expects Medi-Cal pre-release application processes to occur as close to intake as possible. Requirements related to Medi-Cal pre-release applications can be found in ***Section 4.2*** and ***Section 6.3.***	
2. 90-Day Pre-Release Access Screening Process	
Obtain necessary **consents/release of information (RoI)** to disclose personal information.	**Minimum Requirement:** For incarcerated individuals who have had an active JI aid code for at least eight days, the county CF (or its designated entity) must obtain necessary consents to disclose personal information. **Recommended Implementation Practices:** • For people who have had an active JI aid code for at least 96 hours, the county CF (or its designated entity) should obtain necessary consents to disclose personal information. • The county CF (or its designated entity) should obtain necessary consents as part of the intake process.[82] • The county CF should leverage already-signed consent forms for those who have previously been incarcerated and should initiate a connection to a previously assigned ECM provider, as available.
Tier 1 Screening: High-level screening of individual for pre-release services eligibility and behavioral health needs.	**Minimum Requirement:** For incarcerated individuals who have had an active JI aid code for at least eight days, the CF (or its third-party health provider contractor) must conduct a high-level screening for pre-release service access criteria and behavioral health link

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

Table 10. Short-Term Model: Key Activities and Timeline Requirements	
Key Activities	**Timeline and Requirements for Providing Services**
	requirements.[83] *Note: YCFs are required[84] to provide medical screenings within 96 hours of booking and should leverage this process to meet behavioral health need screening criteria for behavioral health links within this required timeframe.* **Recommended Implementation Practices:** • For people who have an active JI aid code for at least 96 hours, the CF (or its third-party health provider contractor) should conduct a high-level screening for pre-release service access criteria and behavioral health link requirements.[85] A high-level screening can leverage existing safety/health intake processes and should assess for suspected or self-attested mental health, behavioral health, and chronic conditions as part of meeting access screening criteria, including screening for the use of medications. This screening is a quick, high-level screening for very short stays; a more in-depth screening is done for people who are "likely eligible" at a later time (see below).

[83]Youth in YCFs do not need to meet health care need criteria to be eligible for pre-release services; however, youth should still be screened for behavioral health links.
[84] Pursuant to Title 15, YCFs must provide a medical clearance/screening, health examination, and screening for mental health/behavior problems, including a follow-up assessment when indicated by the screening (see sections 1430, 1432, and 1437).
[85]Youth in YCFs do not need to meet health care need criteria to be eligible for pre-release services; however, youth should still be screened for behavioral health links.

Table 10. Short-Term Model: Key Activities and Timeline Requirements	
Key Activities	**Timeline and Requirements for Providing Services**
Tier 2 Screening: In-depth screening of individual for pre-release services eligibility, including behavioral health needs.	**Minimum Requirement:** If the Tier 1 Screening does not occur within the first 96 hours of JI aid code activation and/or if the individual is not found eligible as part of the initial screening[86], the county CF (or its third-party health provider contractor) must complete a comprehensive health screening for pre-release services including behavioral health needs by day eight of JI aid code activation. The CF should leverage this assessment to identify any new individuals who would be eligible for pre-release services. **Recommended Implementation Practices:** • If the assigned care manager is the one conducting the screening, the screening can be leveraged to include screening for behavioral health links with tools and processes mutually agreed upon by the CF and the county behavioral health agency to determine whether the individual's behavioral health needs meet the behavioral health link criteria (see ***Section 11.4*** for additional information on behavioral health links). • If a new medical condition is identified during incarceration, individuals who were not previously found eligible for pre-release services should be reevaluated for pre-release services. • If an individual was incarcerated in the past 12 months, CFs should leverage medical records to update previous pre-release screening and initiate services as soon as possible.

[86]Youth in YCFs do not need to meet health care need criteria to be eligible for pre-release services; however, youth should still be screened for behavioral health links.

Table 10. Short-Term Model: Key Activities and Timeline Requirements	
Key Activities	**Timeline and Requirements for Providing Services**
3. 90-Day Pre-Release Services Delivery[87]	
Activate Aid Code or Issue Denial NOA: Record pre-release services eligibility determination and release date, if known, in the Screening Portal to activate the aid code or send a denial NOA. Once the aid code is activated, CF can bill/claim for pre-release services. Note that pre-release services are date specific and cannot be reimbursed unless the aid code is turned on via the Screening Portal.	**Minimum Requirement:** Submit the results of the screening (can be the initial health and safety screening, high-level screening, in-depth screening, or any screening conducted at any point of the incarceration period) to the Screening Portal within one business day.

[87] CFs are required to provide all needed health care services for the entirety of the time an individual is incarcerated. The table below provides a detailed timeline of the targeted pre-release services. Billing/claims for these services can be done retroactively with limitations, as long as JI aid code is active for service dates.

Table 10. Short-Term Model: Key Activities and Timeline Requirements	
Key Activities	**Timeline and Requirements for Providing Services**
ECM Flyer: [88] Provide a hard copy of the name and phone number of the county ECM provider, to be kept with the individual's personal belongings.	**Minimum Requirement:** None at this time. **Recommended Implementation Practices:** • During the initial health and safety screening, the CF should provide the individual with an ECM informational flyer that describes Medi-Cal and ECM and lists the name and phone number of the individual's county ECM contact/managed care plans. • If the individual appears to qualify for any ECM POF, including but not limited to, the Individuals Transitioning From Incarceration POF, this flyer should be given to individual to be kept with the individual's personal belongings.

[88] DHCS, CFs and county partners, including MCPs, will work together to develop a generic flyer that lets individuals know they likely are eligible for Medi-Cal and ECM. The flyer should list information on how to access Medi-Cal information, which may include a list of the providers they can contact in their community. This flyer can also be shared with probation/parole officers.

Table 10. Short-Term Model: Key Activities and Timeline Requirements	
Key Activities	**Timeline and Requirements for Providing Services**
Deliver **Medication for Substance Use Disorder Treatment**, as needed.	**Minimum Requirement:** All CFs are responsible for initiating and providing medications for SUD as soon as a need is identified. For this initiative, county CFs must bill and claim for medications for SUD within eight days of JI aid code activation. Individuals with an identified need must have access to all forms of medications for opioid uses disorder (MOUD) (including one agonistic medication (i.e., either methadone or buprenorphine)) and medications for alcohol use disorder (MAUD). **Recommended Implementation Practices:** • Billing/claiming medication and medication administration for SUD within twenty-four hours of JI aid code activation. • The county CF should determine the needed medications for SUD for the incarcerated individual during the initial intake process (ideally this should occur within the first eight hours of incarceration, or prior to the county CF's next scheduled dosage time/med pass) and assess additional medication needs. • County CFs should seek to work with pre-release care manger to confirm medications for SUD that are provided while incarcerated will be available in the community upon release. It is the role of the pre-release care manager to ensure that the individual's prescribed medications align with medications available in the community; this confirmation should occur during health risk assessment and reentry care plan *(see below).*

Table 10. Short-Term Model: Key Activities and Timeline Requirements	
Key Activities	**Timeline and Requirements for Providing Services**
Provide needed **medications** to individuals.	**Minimum Requirement:** All CFs are responsible for providing medications as soon as a need is identified. Within eight days of aid code activation, the county CF shall bill/claim Medi-Cal for medication and medication administration. **Recommended Implementation Practices:** • Within twenty-four hours of aid code activation, the county CF should bill/claim for medication and medication administration. • The county CF should determine the needed medication for an individual during the initial intake process , within the twenty-four hours of incarceration, or prior to the county CF next scheduled dosage time/med pass) and assess additional medication needs. • County CFs should try to confirm medication provided while incarcerated will be available in the community upon release. It is the role of the pre-release care manager to ensure that prescribed medications align with medications available in the community; this should occur with comprehensive assessment and care transition planning. • If an individual has been incarcerated one or more times in the past 12 months, the county CF should leverage previous medical records to initiate Medi-Cal-aligned medication as close to intake as possible. • Provide medications to individuals as keep-on-person (KOP) to the maximum extent possible.

Table 10. Short-Term Model: Key Activities and Timeline Requirements	
Key Activities	**Timeline and Requirements for Providing Services**
Care manager assignment	**Minimum Requirement:** The county CF must contact and make arrangements with community-based or embedded care managers within eight days of activating the JI aid code. **Recommended Implementation Practices:** • The CF should contact and make arrangements with community-based or embedded care managers within two business days of activating the JI aid code. • *If the individual is already enrolled in a MCP:* Contact the MCP JI Liaison at the member's assigned MCP to support pre-release care manager assignment (if the CF will use community-based, in-reach providers) and/or a ECM Lead Care Manager (if the CF will use embedded providers) to the member. • *If the individual is not yet assigned to a MCP:* Leverage the MCP ECM Provider Directory to refer and assign a pre-release care management provider (if the CF will use community-based, in-reach providers) and/or a ECM Lead Care Manager (if the CF will use embedded providers) to the member. • If the individual has previously been incarcerated, the CF should make this referral as close to intake as possible and/or contact the previously assigned ECM Lead Care Manager.

Table 10. Short-Term Model: Key Activities and Timeline Requirements	
Key Activities	**Timeline and Requirements for Providing Services**
Health Risk Assessment: Support completion of a health risk assessment.	**Minimum Requirement:** The CF must support completion of the health risk assessment within the first eight days of JI aid code activation for embedded model and within first ten days of JI aid code activation for in-reach model. Contact to schedule with the in-reach provider must be initiated within 3 business days of JI aid code activation and appointments must be scheduled within the next seven days. **Recommended Implementation Practices:** • The county CF should support completion of the health risk assessment by the care manager within the first five days of JI aid code activation for embedded model and within first eight days of JI code activation for in-reach model. • The county CF must ensure a care manager performs a health risk assessment, leveraging the health screenings and other available information. • The county CF will determine whether the meeting should be in person while the individual is in the facility, via telehealth, or in the community post-release.
Reentry Care Plan: Assess the needs of the individual to develop a person-centered reentry care plan in collaboration with the individual, the clinician(s) providing consultation services (as available) and CF's reentry planning team.	**Minimum Requirement:** The county CF must support the completion of reentry care plan within the first fourteen days of aid code activation**.** To complete the reentry care plan, the county CF will determine whether the care manager meeting should be in-person or via telehealth while the individual is in the facility or in the community post-release.

Table 10. Short-Term Model: Key Activities and Timeline Requirements	
Key Activities	**Timeline and Requirements for Providing Services**
Clinical Consultation: Schedule consultation(s) based on the needs identified in the care manager's needs assessment.	**Minimum Requirement:** County CFs must support clinical consultations, based on the care manager's needs assessment, within the first 21 days of aid code activation. The care manager must coordinate with the county CF to schedule an embedded or in-reach provider clinical consultation service, including a DME consultation, as needed. The county CF will determine whether the meeting should be in person while the individual is in the facility, via telehealth, or in the community post-release.
Provide **laboratory/radiology services**, as needed.	**Minimum Requirement:** County CF must support the provision of lab/radiology services within the first 21 days of aid code activation, based on the care manager's needs assessment and clinical consultations.
CHW services: Schedule and facilitate CHW service provision	**Minimum Requirement:** The county CF must support CHW services based on the care manager's needs assessment, as appropriate, by working in coordination with the post-release pre-release ECM Lead Care Manager within the first 21 days of aid code activation. **Recommended Implementation Practices:** • If an individual has an identified housing need, the pre-release care manager should contact the CHW, who, in coordination with the ECM Lead Care Manager, can help navigate housing supports and meet the individual upon release. • If an individual is receiving MAT, the county CF should contact the CHW to help navigate community-based care and meet the individual upon release.

Table 10. Short-Term Model: Key Activities and Timeline Requirements	
Key Activities	**Timeline and Requirements for Providing Services**
Provide needed **medications** to individual **upon release**, along with any needed prescriptions for ongoing treatment.	**Minimum Requirement:** The CF is responsible for developing processes to prepare for writing prescriptions and providing prescribed medication in-hand upon release for individuals who have had an active JI aid code for at least 48 hours. Identifying the necessary medications and prescriptions can be based on any medication need identified through the standard medical screening procedures and according to the timelines specified by the CF for those procedures. **Recommended Implementation Practices:** • If an individual has previously been incarcerated, the county CF should leverage previous medical records to ensure the necessary medications can be provided in-hand upon release.
Provide **DME upon release**.	**Minimum Requirement:** Individuals who have a JI aid code active for at least 14 days must receive any medically needed DME and a prescription for that DME upon release. **Recommended Implementation Practices:** • If an individual has previously been incarcerated, the county CF should leverage previous medical records to ensure the necessary DME can be provided in-hand upon release.
4. Reentry Process	
Release Date Notification: Alert the county SSD of an individual's upcoming release date.	**Minimum Requirement:** Per ACWDL 22-27, CFs must make every effort to submit confirmation of release information to the county SSD within a week of the expected release date, and no later than one business day after release date. In situations with unplanned release, the CF shall provide as much notice as possible, so that the county SSD can close the incarceration period and activate benefits, as appropriate. The CF shall submit this notification via email or electronic interface, when possible.

DHCS

Behavioral Health Link: Contact the county behavioral health agency or post-release ECM Lead Care Manager, as appropriate, to facilitate behavioral health links at release.	**Minimum Requirements:** • *For individuals who are found to require SMHS and/or DMC/DMC-ODS services* (assessments may be at the initial intake screening) (e.g., those who have serious mental illness, are taking psychotropic medications, have SUD, are actively withdrawing from drug use, etc.) and then confirmed during the health risk assessment required for those with an active JI aid code for at least seven days. The county CF must contact the county behavioral health agency within two business days of behavioral health needs identification to ensure assessments for services and appropriate behavioral health links occur according to mutually agreed upon standards between the CF and the county behavioral health agency. • For those who have identified behavioral health needs and have been able to schedule a reentry care coordination meeting, DHCS will require CFs to also complete behavioral health information sharing between correctional and county providers, support appointment scheduling with community-based providers, and complete any follow-up from the reentry care coordination meeting (as indicated) prior to release, or within two business days of release for unexpected/early releases. • *For individuals with a behavioral health need who are not referred to SMHS and/or DMC/DMC-ODS services:* For people who have an active JI aid code for at least seven days and have completed a health care needs assessment that identifies them as having behavioral health needs but who are not eligible for SMHS and/or DMC/DMC-ODS services, the county CF must share the identified needs with a pre-release care manager or an ECM provider if the individual is released prior to pre-release care management services being initiated. The county CF also must participate in warm handoffs with a community behavioral health provider coordinated by the pre-release care manager/post-release ECM Lead Care Manager, including sharing information and providing professional-to-professional communication as needed. DHCS expects CFs and county behavioral health agencies to mutually agree upon screening/assessment tools to determine whether an individual's behavioral health needs meet the behavioral health criteria for accessing SMHS and/or DMC/DMC-ODS services.
Support the pre-release care manager in facilitating a **warm handoff** of the	**Minimum Requirement:** If the county CF is using correctional staff for care management services, it must facilitate a warm handoff with a community-based provider/post-release ECM Lead Care Manager. This warm handoff must occur if the individual has a JI aid code active

Table 10. Short-Term Model: Key Activities and Timeline Requirements	
Key Activities	**Timeline and Requirements for Providing Services**
individual to the post-release ECM Lead Care Manager (e.g., provide dedicated space at release).	for at least 14 days; individuals who are incarcerated for less time should leave with an ECM referral.
Data sharing	**Minimum Requirement:** For people who have completed a health care needs assessment, the county CF must transfer the medical information and reentry care plan to the MCP (as available), post-release ECM Lead Care Manager, providers, and parole/probation officers no later than seven days after aid code activation.

8.3 Telehealth Services

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

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

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 scheduling. DHCS will require 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 in order to maximize data exchange, minimize appointments that would gather repetitive information, and ensure providers can efficiently conduct telehealth appointments. Depending on the type of telehealth visit (e.g., case management, establishing a new patient, MAT, mental health counseling), 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 EHR (e.g., pertinent notes, labs, radiology, problem lists), the discharge plan and needs assessment, and medication lists with the medication administration record (MAR), as appropriate.

8.4 Care Management Model

Care management is a critical component of the Justice Involved Initiative, which is intended to (1) support the coordination of services delivered during the pre-release period and upon reentry; (2) ensure warm handoffs and linkages to services and supports; and (3) ensure the arrangement of appointments and timely access to appropriate care delivered in the community.[89]

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

The care management model has four primary goals:

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

The care management model begins with pre-release care management billable during the 90 days prior to an individual's release, which are paid on a FFS basis by Medi-Cal.

Enhanced Care Management (ECM) is delivered and paid for in the managed care delivery system, specifically by the MCP in which the individual is enrolled post-release. Individuals should be enrolled in an MCP immediately upon release so that they may immediately access ECM. If an individual's MCP enrollment is not immediately effectuated, post-release care management services will be provided by the post-release ECM Lead Care Manager and paid for on a FFS basis until their MCP enrollment has been effectuated. MCP requirements for implementing ECM for the Individuals Transitioning from Incarceration (JI) Population of Focus (POF) can be found in ***Section 13.*** The pre- and post-release care management models are outlined below.

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

To maximize the continuity of care management and access to services across the pre- and post-release periods, CFs may pursue an in-reach model or an embedded care management includes a warm handoff between pre- and post-release providers.

DHCS defines an in-reach care management model as a model through which community-based care management providers, who will become the ECM Lead Care Manager after managed care enrollment, deliver care management services to individuals eligible for pre-release services, either in person or via telehealth.[90]

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

DHCS defines an "embedded care management model" as a model through which embedded care managers (i.e., care managers employed by or contracted with the CF) deliver care management services to individuals eligible for pre-release services.[91]

CFs that use an embedded care management model will be required to implement a warm handoff between the pre-release care manager and post-release ECM Lead Care Manager. Warm handoff meetings may be conducted via telehealth, as appropriate. Conducting the warm handoff meetings via telehealth could be for reasons that include, but are not limited to, the post-release ECM Lead Care Manager being unable to enter the CF due to security clearance issues or the post-release ECM Lead Care Manager being located in another county. If an individual receives pre-release care management by an in-reach provider, but will be released to a different county than that in which the pre-release in-reach care manager operates, CFs must ensure that the pre-release in-reach care manager conducts a warm handoff to a post-release ECM Lead Care Manager that operates in the county in which the individual will reside. Additional details on requirements for warm handoffs are included in ***Section 8.4.f***.

Requirements for JI ECM providers participation in pre-release care management services and warm handoffs is informed by the pre-release care manager led by the CFs in their counties of operation:

a. If the CFs in the counties in which the JI ECM provider operates use an in-reach care management model:
    i. JI ECM providers must offer pre-release care management services as in-reach care management
    ii. The post-release ECM Lead Care Manager must be the same person as the pre-release in-reach care management provider.
        1. In the instances in which the in-reach pre-release care manager cannot continue to serve as the individual's post-release ECM Lead Care Manager (e.g., an individual changes planned release location to a county the pre-release care manager does not serve), the in-reach pre-release care manager must be able to conduct a warm handoff to the post-release ECM Lead Care Manager.
b. If the CFs in the counties in which the JI ECM provider operates use an embedded care management model:
    i. The post-release ECM Lead Care Manager must conduct a warm handoff with the pre-release embedded care manager (e.g., CF providers) during the pre-release period, if possible ***(See Section 8.4.f)***.

[91] CFs may also leverage contracted care management providers that serve the CF population but do not also provide community-based services.

The requirements outlined above seek to maximize continuity of care management between the pre- and post-release periods. (All individuals who are eligible to receive pre-release services and are enrolled in managed care will be eligible to receive ECM post-release.) See ***Section 9,*** Provider Enrollment and Payment, for details on how pre-release in-reach care managers will be reimbursed. See ***Section 13*** for MCP requirements for ensuring that ECM providers provide pre-release in-reach care management warm handoffs.

DHCS will develop and maintain a publicly-accessible report on the DHCS JI website to display the pre-release service go-live date for correctional facilities in each county, updated on a quarterly basis. The report will include information on whether each facility plans to pursue an in-reach or embedded care management model.

8.4.b Correctional Facility Requirements for Pre-Release Care Manager Provider Assignment

CFs will be responsible for ensuring that individuals who receive pre-release services are assigned a pre-release care manager.[92] If the pre-release care manager is an in-reach care manager, they will become the individual's post-release ECM provider.

If the pre-release care manager is an embedded care manager, they will initiate a warm handoff with the post-release ECM provider, prior to release. In addition, under the embedded care management model, the CF will be responsible for ensuring that individuals are assigned a post-release ECM provider.

Roles and responsibilities for provider assignment at facilities leveraging either an in-reach or embedded care management model are outlined in Tables 11 and 12 below. In addition to the processes below, DHCS encourages MCPs and CFs to collaborate as appropriate on a county-specific process to determine the appropriate provider assignment for each individual.[93]

[92] Correctional facilities are additionally responsible for ensuring the pre-release care manager completes the pre-release care manager tasks outlined in Section 8.4.c.

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

Table 11: Provider Assignment: Embedded Care Management Model			
Action		**Correctional Facility Responsibility**	**MCP Responsibility**
Assign an embedded pre-release care manager.		CF uses existing processes to assign the pre-release care manager.	N/A
Assign a post-release ECM provider.	If the individual's MCP assignment is known:	CF/pre-release care manager must reach out to the publicly-posted MCP JI Liaison at the MCP to which the individual is assigned.	MCP JI Liaison will assign an post-release ECM Provider and communicate that assignment to the correctional facility.
	If the individual's MCP assignment is unknown:	CF must use the MCP Provider Directory from a MCP in the county to which the individual will be released to reach out to a JI ECM provider and assign the individual a post-release ECM provider. CF must communicate post-release ECM provider to MCP, once assigned.	MCP must receive communication from CF regarding post-release ECM provider assignment.

Table 12: Provider Assignment: In-Reach Care Management Model			
Action		**Correctional Facility Responsibility**	**MCP Responsibility**
Assign an in-reach pre-release care manager.	If the individual's MCP assignment is known:	CF/pre-release care manager must reach out to the publicly posted MCP JI Liaison at the MCP to which the individual is assigned.	MCP JI Liaison will assign an in-reach pre-release care manager and communicate that assignment to the CF
	If the individual's MCP assignment is unknown:	CF must use the MCP Provider Directory from a MCP in the county to which the individual will be released to reach out to a JI ECM provider and assign the individual a post-release ECM provider. CF must communicate post-release ECM provider to MCP, once assigned.	MCP must receive communication from CF regarding post-release ECM provider assignment.
Additional Considerations • The in-reach pre-release care manager should continue to serve as the individual's ECM Lead Care Manager post-release. • CFs must assign a pre-release, in-reach care management that works in the county in which the individual will be released. Providers may conduct pre-release services and warm handoffs via telehealth, including if the provider is in a different county than the CF. • CFs located in a different county than the county of release may reach out to the MCP JI Liaison in the county of release for assistance (if MCP assignment is known). • If the CF does not work with the individual's assigned MCP JI Liaison to assign a provider (e.g., because MCP assignment is unknown), the CF is responsible for ensuring that information on the assigned in-reach pre-release care manager/ECM provider is shared with the MCP prior to release. Information about assigned care managers must additionally be included in the Reentry Care Plan, which will be shared with the MCP. The CF is additionally responsible for notifying the MCP of the CF location. The CF may work with the pre-release care manager to make these notifications.			

8.4.c Correctional Facility Requirements for Care Management Service Delivery by the Pre-Release Care Manager

In addition to assigning or supporting the assignment of an individual's pre-release care manager/post release ECM provider, as detailed in Tables 11 and 12, CFs are responsible for:

- Scheduling an initial appointment and any follow-up appointments between the pre-release care manager and the individual, including ensuring appropriate space, technology, and privacy for all appointments and follow-up meetings. These appointments include:
    - Initial pre-release care manager appointment:
        - The initial appointment with the pre-release care manager (embedded or in-reach) must be scheduled within 8 days of pre-release service aid code activation (as a best practice, the initial appointment should be scheduled within 2 business days of aid code activation) per requirements in the Short-Term Model.
            - For members who have longer incarcerations and facilities using an embedded model, if a care manager had been providing care prior to activation of pre-release services, that individual should continue to provide pre-release care management once pre-release services are activated.
        - If the member is released prior to the initial appointment occurring, the CF must ensure that any relevant health information is shared with the post-release ECM provider and MCP, in alignment with the individual's consent.
    - Follow-up appointments and warm handoff:
        - Follow-Up Appointments: During 90-day pre-release services, CFs must ensure access to appropriate technology and space as well as privacy for any needed pre-release care manager follow-up appointments to complete all care management activities.
        - Warm Handoff: CFs leveraging an embedded care management model must ensure that the pre-release care manager and post-release ECM provider conduct a warm handoff with the individual. For more information on Warm Handoff requirements, see ***Section 8.4.e***.
        - Post-Release: CFs must support post-release engagement with the post-release ECM Lead Care Manager as close to release as possible (e.g., within two business days post-release) to ensure continuity and seamless transitions.
- Obtaining consents for release of information from the individual when required by state or federal law.[94]

[94] CalAIM Data Sharing Authorization Guidance: https://www.dhcs.ca.gov/Documents/MCQMD/CalAIM-Data-Sharing-Authorization-Guidance-Version-2-Draft-Public-Comment.pdf

- Ensuring CF medical staff coordinate with, assist, and share information with the pre-release care manager as needed.
- Coordinating with case records personnel and probation/parole to communicate with the pre-release care manager and post-release ECM provider on changes in release, including accelerated release or community-transition program releases.
- Ensuring that the pre-release care manager and the MCP link the individual with required supports, including but not limited to conducting a warm handoff with the post-release ECM Lead Care Manager, facilitating behavioral health links, and making referrals to community supports as needed.

8.4.d Requirements for Pre-Release Care Managers

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

- Ensuring the completion of a health risk assessment and pre-release services goals and objectives documented in the medical record, including assessment of needs and pre-release goals and objectives in each of the following areas: physical health, mental health, substance use, housing, other health-related social needs, functional needs, strengths, and support resources.[95] The health risk assessment should be used to identify the pre-release goals and objectives, including additional clinical care or clinical assessments that are needed to diagnose, stabilize, or treat in preparation for reentry. The pre-release care manager should leverage the health risk assessment to create a reentry care plan and set up services to address each identified need across all identified areas. Specific requirements for the health risk assessment includes:
    - Meeting with member (face to face or through telehealth) to conduct/review their health risk assessment.
    - Reviewing prior records as available.
    - Obtaining informed consent, when needed, to furnish services and/or to share information with other entities to improve coordination of care.
    - All components of the health risk assessment with corresponding pre-release goals and objectives must be completed with the member, considering current needs and needs that may arise upon reentry into the community, and identifying the goals and objectives of the care during the pre-release services time period. This will help prioritize pre-release services, including any needed clinical consultations, and will serve as the basis for the reentry care plan. The health risk assessment and pre-release goals and objectives document must include the following:

[95] Assessments may be conducted by different members of the individuals' care team (e.g., physician or nurse, LCSW, mental health professionals). The pre-release care manager is responsible for ensuring the completion of all elements of the whole-person needs assessment and documentation in the medical record.

- **Physical health needs assessment:** inclusive of but not limited to: an assessment that identifies prior medical issues, any symptom burden, potential for undiagnosed conditions, need for clinical consultations, needs for medications, needs for DME, needs for IHSS, needs for establishing care with primary care and any specialists in preparation for release, preventative care access (e.g., cancer screening, vaccinations, a physical exam within the last year).
- **Mental health needs assessment**: inclusive of but not limited to: prior mental health treatment and diagnoses; use of validated screening tools; need for clinical consultations; identification of any needed medications for release, identification of potential benefit for long-acting injectable use, identification of the need for a behavioral health link, identification of need for mental health follow-up and appropriate level of care.
- **Substance use disorder (SUD) needs assessment:** inclusive of, but not limited to, prior SUD treatment and diagnoses; use of validated screening tools; identification of potential need for MAT; identification of potential benefit for long-acting injectable use; identification of any needed clinical consultations; identification of the need for a behavioral health link; identification of need for substance-use disorder follow-up and appropriate level of care.
- **Housing needs assessment**: inclusive of, but not limited to, identification of planned housing upon release and identification of any housing needs.
- **Other health-related social needs assessment: i**nclusive of but not limited to: any needs related to access to food or to medically tailored meals; transportation needs; cell phone/smart phone access; job or education/training needs; social support including who should be included in care plan (e.g., family/friends/parole/probation).
- **Functional needs assessment: i**dentification of needs member may have related to functioning in community upon release such as medication management; scheduling community-based appointments; paying bills; utilizing electronic communication; ability to perform activities of daily living (ADLs) or instrumental activities of daily living (IADLs).
- **Strengths and support resources assessment: i**dentification of member's existing strengths and existing/needed supports and resources.
- **Pre-release goals and objectives:** inclusive of but not limited to: Plans for how to further assess, diagnose, treat, or coordinate

identified physical, mental health, SUD, housing, health related social needs, and functional needs during the pre-release period.

- Creating care links and coordinating with community-based providers and services. Specific requirements for creating of care linkages and coordinating of services include:
    - Pre-release coordination with post-release clinical consultants to address and/or identify physical health, mental health, or SUD needs, including coordinating any needed labs, radiology, or medications (including MAT).
    - Pre-release coordination, including non-patient and patient- facing, as needed, to create care links to community-based providers.
    - Pre-release coordination to arrange appointments with or admission to physical and behavioral health care providers, including specialty county behavioral health coordinators and managed care providers, as relevant to care needs.
    - Ensuring the individual has any necessary DME prescriptions, including coordinating with providers to perform face-to-face visits, documentation of medical necessity, and prescriptions.
    - Assisting in information exchange and obtaining consent as needed to facilitate care with in-reach providers and other community care providers.
    - Assisting with submission of prior authorization or treatment authorization requests and collecting any needed information.
    - Facilitating a warm handoff with member and community-based providers.
    - Ensuring coordination and receipt of pre-release services.
- Participating in an in-person or telehealth warm handoff that, at minimum, must include the member and the community-based ECM Lead Care Manager. The warm handoff will serve to introduce the new ECM Lead Care Manager, review the reentry care plan, including the health risk assessment and goals and objectives, with the member, and identify any additional needs. Warm handoffs are only required when the pre-release care manager is different from the post-release ECM Lead Care Manager. Specific requirements for a warm handoff include:
    - Participate in a face-to-face or telehealth visit with the member to meet new post-release ECM Lead Care Manager.
    - Review and update the health risk assessment and reentry care plan with the member.
    - Provide education on reentry care plan and reentry services.

  - Modify the reentry care plan based on new knowledge of community resources or input from member.
  - Post-release ECM Lead Care Manager must receive and discuss the reentry care plan with pre-release care manager and receive all appropriate records and information from the pre-release period.
  - Obtain any necessary consents for information sharing.
- Completing a final reentry care plan documented in the medical record, including release plans related to physical health, mental health, substance use, housing needs, other health-related social needs, functional needs, strengths, and support resources. The final reentry care plan must be completed in collaboration with the member and must be shared with post-release ECM Lead Care Manager, MCP, county behavioral health agency (if applicable), the member, and the member's family/support persons (in accordance with the member's consent). Specific requirements for the warm handoff include:
  - Complete reentry care plan, created with the member, with input from the clinician(s) providing consultation services and CF's reentry planning team. Provide care plan to member (as well as the post-release ECM provider, MCP, county behavioral health agency, and the member's family/support persons, as applicable) and confirm all connections and appointments required as part of the reentry care plan have been scheduled, completed, or have plans to be completed.
  - Complete data exchange, as allowed under federal and state laws, that includes beneficiary authorizations, reentry care plan, and necessary medical records, with post-release care manager and managed care plans, and, as relevant, with physical and behavioral health/SMI/SUD providers to enable timely and seamless hand-offs.
  - Confirm that the individual has medications/prescriptions in hand upon release.
  - Confirm that the individual has any needed DME or DME prescriptions in hand upon release.
  - Confirm that the individual has a Benefits Identification Card (BIC) upon release.

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

8.4.e Reentry Care Plan

Pre-release care managers should develop a person-centered reentry care plan with the individual. The reentry care plan may be included in the individual's medical record, with the member providing consent (as needed) to share information. The CF and pre-release care manager are responsible for sharing the reentry care plan with the post-

release ECM provider and MCP during the warm handoff. Additional information on warm handoffs can be found in ***Section 8.4.f***.

For CFs with an embedded care management model, in which pre-release care management providers are not familiar with community-based services in the county in which the individual will be released, the pre-release care management provider must collaborate with the post-release ECM Lead Care Manager to develop the reentry care plan and coordinate post-release community-based services. Additional information on billing for the creation of the reentry care plan can be found in ***Section 10***.

At a minimum, the reentry care plan should include the following elements:

- A completed whole-person care plan that includes a plan for any identified needs and pre-release goals and objectives based on the completed health risk assessment of mental health, substance use, physical health, long-term services and supports (LTSS) needs, home and community-based service (HCBS) needs, health related social needs, and functional needs.[96] This assessment and care plan must be overseen and completed by a licensed professional (e.g., RN care manager or LCSW), although specific components of the assessment or care plan (e.g., screening for HRSN) may be done by other non-licensed team members, according to licensing and oversight requirements by state law.
- Post-release planning, including the identification of needs the member may have related to functioning in the community upon release such as HRSN, housing needs, considerations for LTSS, medication management, scheduling community-based appointments, paying bills, and utilizing electronic communication.
- Plans for post-release medications, including ensuring that the medications have undergone any prior authorizations (PAs) or other requirements for coverage, if necessary.[97]
- Plans for DME, including ensuring that DME prescriptions have undergone any treatment authorization reviews (TARs) or other requirements for coverage, as necessary.
- Coordination, scheduling, and warm handoffs to required reentry services, including:
    - MAT and psychotropic medications.
    - Identification of a primary care provider and follow-up appointment scheduled at appropriate time post-release.
    - Required specialty, mental health, substance use, or dental care.

[96] DHCS recommends including Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) screenings and pain management plans in the reentry care plan as a best practice.
[97] All FDA-approved medications can be covered by Medi-Cal to treat the conditions for which they were approved, but some drugs may be subject to various authorization and utilization management (UM) policies. If necessary, PA should occur during the pre-release planning period, so that the individual has access to their prescriptions immediately upon release.

  - Referrals and coordination for any housing needs[98]
  - Coordination of MCP benefits including non-emergency medical transportation
  - MCP Community Supports, as eligible and as needed, including short-term post-hospitalization housing and recuperative care (i.e., medical respite).[99]
  - Community service referrals.
  - HRSN referrals (e.g., nutrition and housing supports, cell phone service[100]).
  - Long-Term Services and Supports (LTSS) referrals
- Plan for follow-up with the individual to ensure engagement with community-based providers, behavioral health services, and other aspects of reentry planning, as necessary.[101]
- Coordination of reentry logistics, including transportation.
- Ensuring that, as allowed under federal and state laws and always through consent with the member, data are shared with MCPs and, when relevant, with physical and behavioral health/SMI/SUD providers to enable timely and seamless handoffs.
- A plan for engagement of identified supports for the client (e.g., probation/parole officer, family, others).[102]
- A list of individuals/organizations that have provided or will provide care or services for the individual and will receive the finalized reentry care plan prior to release. This list of individuals/organizations shall include the post-release ECM Lead Care Manager, MCP, county behavioral health agency (if applicable), the member, and the member's family/support persons (in accordance with the member's consent).
- Documentation of any additional consents needed to share information for seamless care.

[98] DHCS recommends that correctional facilities and pre-release care managers collaborate with Probation/Parole to identify and obtain housing for individuals with post-release housing needs.
[99] Additional information on Community Supports can be found in the Medi-Cal Community Supports, or In Lieu of Services (ILOS) Policy Guide, available here: https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide.pdf
[100] Best Practice: Include plans for care manager to assist member in applying for federal lifeline phone service and phone (if available as available as a part of their post-release MCP)
[101] Court-ordered requirements should not be included in the reentry care plan unless the court-ordered requirements are directly related to a health care condition or need.
[102] Inclusion of contact information for the assigned probation/parole officer in the reentry care plan is considered a best practice.

8.4.f Requirements for Care Manager Warm Handoff

In cases where different people provide pre- and post-release care management services (i.e., if the CF leverages an embedded care management model or if the individual will be released into a county in which their in-reach pre-release care manager does not operate), the two care managers must conduct a warm handoff with the individual prior to release. The warm handoff is a required meeting to ensure care coordination and is the first step in establishing a trusted relationship between the individual and the new care manager. The warm handoff ensures seamless service delivery and coordination.

The minimum requirements of the pre-release care manager for the warm handoff include:

- Schedule and conduct a warm handoff meeting, either in-person or via telehealth, that includes both the member and post-release ECM Lead Care Manager[103]
- Obtain any necessary consents for information sharing.
- Share the reentry care plan with the post-release ECM Lead Care Manager and the individual's assigned MCP,
- Review and provide education on the reentry care plan and reentry services with the member.
- Identify any outstanding service needs or other supports required for successful community reentry (e.g., transportation or housing) with input from the member and the post-release ECM provider.
- Modify the reentry care plan based on any new knowledge.
- Ensure the individual has received their Benefits Identification Card (BIC).

The required responsibilities of the post-release ECM Lead Care Manager for the warm handoff include:

- Coordinate with pre-release care manager to schedule and participate in a warm handoff meeting, either in-person or via telehealth, that includes both the pre-release care manager and the member. [104]
- Begin establishing a trusted relationship with the member, including reviewing the release plan and providing education and support to the member.
- Receive, review, and discuss the reentry care plan with the pre-release care manager.
- Work with the pre-release care manager and the member to identify any community-based services to address any outstanding service needs or supports and assist in updating the reentry care plan.

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

- Receive all appropriate records and information from the pre-release period.

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

For individuals with known release dates, DHCS recommends that the warm handoff meeting occur at least 14 days prior to release. Telehealth may be used to conduct warm handoffs.

If it is not possible for the warm handoff to occur prior to the individual's release (e.g., if the individual is released by court order earlier than expected or has a very short stay), the pre-release care manager and post-release ECM provider must conduct the warm handoff in the community (i.e., post-release) within one week. In situations where a post-release handoff is necessary, the CF/pre-release care manager must share the reentry care plan and other pertinent information with the post-release ECM Lead Care Manager and the assigned MCP within one business day of release.

CFs will be required to work with the MCPs in their counties and their county behavioral health agencies to develop policies and procedures for instances when warm handoffs do not occur prior to release, to ensure that (1) warm handoffs occur within the first week post-release and information is shared within one business day; and (2) the member is served during this "gap period" after release prior to the warm handoff, with a best practice of the post-release ECM Lead Care Manager meeting the individual at the door at release.

8.4.g Reentry Care Management

All individuals who are eligible for pre-release services and enrolled in Medi-Cal managed care[105] will be eligible for ECM (see ***Section 11.1***), and they may begin to access ECM as soon as their enrollment in an MCP has been effectuated, which should occur at or shortly after release. Until the individual can access ECM services, their assigned post-release care manager may continue to provide care management services post-release. Post-release care management services can be rendered and billed through FFS. Once MCP enrollment has been effectuated, the ECM provider must begin to provide ECM services. ECM services are included in the MCP capitation rate.[106]

As a best practice, ECM providers should meet the individual at release. If that is not possible, the ECM provider should meet the individual within one to two business days

[105] Populations exempt from managed care include AI/AN, former foster care youth, and children/youths in foster care, depending on the county. Population that are not enrolled in a managed care plan will not receive ECM services.
[106] An MCP may reassess the individual no sooner than six months after release to determine whether they should continue to receive ECM services or receive another type of care management that may be more appropriate.

of release, or notification of release, and receipt of necessary data from the CF/pre-release care manager. The ECM provider should also follow up with the individual within one week of release to ensure continuity of care and a seamless transition, and to monitor progress and the implementation of the reentry care plan.[107]

Post-release care management through ECM can include both care management and CHW activities, including:[108]

- Conducting outreach and engaging members.
- Updating the member's health risk assessment and care plan with newly identified needs.
- Coordinating the services necessary to implement the care plan.
- Providing health promotion services to encourage and support members to engage in healthy behaviors.
- Supporting members and their support networks during discharge from the hospital or institutional settings.
- Ensuring members and their support networks are knowledgeable about the member's conditions.
- Coordinating referrals and transportation to community and social services.

Please see the ECM Policy Guide (updated July 2023)[109] for more information on ECM services.

8.4.h Care Management Reimbursement

Pre-release care managers will be able to bill for the required activities outlined above via FFS. For more information on Medi-Cal billing for these services, see Section 10 on payment bundles for pre-release care management. For more information on reimbursement for JI ECM providers in the pre-release period and for warm handoffs, see *Section 13.2.d*.

8.5 Physical and Behavioral Health Clinical Consultation

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

[107] SMDL 23-003 (April 17, 2023) suggests that care managers should initiate contact within one to two days post-release and a second appointment that occurs within one week of release to ensure continuity of care and seamless transition to monitor progress and reentry care plan implementation.
[108] CHWs are permitted and encouraged to be a part of the care team. Payment for CHW activities associated with ECM are included in the ECM rate and such activities may not be billed separately.
[109] ECM Policy Guide is available here: https://www.dhcs.ca.gov/Documents/MCQMD/ECM-Policy-Guide.pdf

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

Behavioral health clinical consultation services include a scope of services that enable diagnosis, evaluation, treatment, stabilization, and support reentry coordination activities, including behavioral health links for SMI and SUD per the approved STCs. Behavioral health clinical consultation includes outpatient services covered in the Medicaid State Plan rehabilitation benefit[110] to diagnose, treat, and stabilize behavioral health conditions. Such services include the following:

- Clinical assessments.
- Recommending medications.
- Pre-release and post-release discharge planning.
- Patient education.
- Treatment, such as behavioral health counseling, therapy, patient education, and medication services including medications clinically effective at treating substance use disorders outside of the FDA-approved indications.

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

- eConsults and care coordination to facilitate behavioral health links for recommending treatment, post-release follow-up planning, and transferring of care with behavioral health post-release providers.

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

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

For all minimum treatment requirements listed above, clinical consultation is covered by Medi-Cal (with additional billing guidance forthcoming).

CFs and care managers should coordinate to identify needs, identify outside entities to provide needed services, and schedule visits. CFs must share relevant identifiers, medical records, consent forms or ROI (when needed), and other supporting information on individuals receiving in-reach services with outside entities prior to visit. For in-person visits, CFs must facilitate facility clearance and other requirements for visiting entities, as needed.

8.6 Medication Coverage During the Pre-Release Period

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

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

CFs and/or their community-based pharmacies will be required to use Medi-Cal Rx to bill for and claim medications. The Medi-Cal Rx system is designed to ensure pharmacy benefits are compliant with state and federal laws. For this reason, DHCS will require

CFs that have on-site pharmacies to enroll as a Medi-Cal pharmacy and to follow billing and claims processes, including all real-time or batched billing/claims requirements and prior authorization (PA) requirements, that match current FFS processes in Medi-Cal Rx for prescriptions.[111] For CFs that partner with community-based pharmacies or pharmacies that are not on-site, DHCS will similarly require those pharmacies to be Medi-Cal-enrolled pharmacies and bill through the Medi-Cal Rx system.

CFs and/or their community-based pharmacies will be able to seek reimbursement for any medication covered by Medi-Cal (i.e., medications covered by the Medi-Cal Contract Drug List). The Contract Drug List includes a wide array of medications for the full range of acute and chronic conditions (e.g., Ciprofloxacin for infections, Abacavir Sulfate for HIV, Elbasvir/Grazoprevir for hepatitis C).[112]

DHCS expects there will be some differences between drugs listed in the Medi-Cal Contract Drug List and the drugs currently used by CFs under their existing formularies. For example, some CFs have stated that they are unable to dispense medications in glass bottles due to safety concerns. DHCS will work with CFs to identify and minimize gaps by supporting the identification of alternative medications that CFs can provide in lieu of those that are currently being used but are not covered by the Medi-Cal Contract Drug List. DHCS will also consider adding high-priority medications used by CFs to the Medi-Cal Contract Drug List.

DHCS is aware that some CFs may dispense a subset of their medications to individuals from a shared stock (e.g., by distributing medications from a non-patient specific bottle to multiple patients based on patient-specific orders). While DHCS encourages CFs to change as many medications over to normal prescriptions dispensed from the pharmacy in patient-specific bottles, it understands that this may not be possible for all medications, and a subset may still be dispensed from shared stock bottles. For medications provided in this manner, DHCS will require CFs to bill medications to Medi-Cal FFS via the California Medicaid Management Information System (CA-MMIS) – instead of Medi-Cal Rx - using medication administration billing codes for at least the following categories of medications:

- All medications with existing HCPCS codes for drug-specific administration[113];
- Any MAT medication (except methadone – further guidance on methadone billing forthcoming); and
- All injectables (including those without an existing drug-specific HCPCS code).

[111] See Section 9 for more information on provider and pharmacy enrollment.
[112] The Contract Drug List is available on the DHCS Medi-Cal Rx website. Covered drugs are subject to change; examples of covered drugs in this Policy and Operations Guide are current as of August 1, 2023.
[113] More information about existing medication-specific HCPCS codes is available in the General Medicine section of the Provider Manual. Available at: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/publications/manual?community=general-medicine

DHCS will provide the technical assistance required for CF pharmacies to enroll and bill for these services.

8.7 Medications for Substance Use Disorder Coverage During the Pre-Release Period

The scope of targeted pre-release services under the Section 1115 demonstration includes medications and medication administration to treat substance use disorder (SUD). This is also known as medication-assisted treatment or medications for addiction treatment both referred to as MAT. The scope of coverage for SUD medications includes MOUD and MAUD both during the pre-release period and to have in hand upon release. Under federal guidance for the 1115 Reentry Demonstrations, medications for substance use disorder are a required minimum service as clinically appropriate.[114]

Rationale: In addition to 1115 requirements to provide access to medications for the treatment of SUD, the U.S. Department of Justice has released clear guidance that OUD in particular is a disability and that inhibiting access to MOUD is a violation of the Americans with Disabilities Act.[115] Case law and accepted practice regarding the provision of MOUD in carceral settings are clear that MOUD is the standard of care. CFs ***must*** provide MOUD and other medications for the treatment of SUD in a clinically appropriate manner to California's incarcerated population.

Coverage Under Existing Medi-Cal Benefits: To cover medications for SUD, the JI Initiative will leverage existing Medi-Cal benefits.

It is usually clinically appropriate to offer medications concurrently with other DMC and DMC-ODS services in outpatient, residential, and inpatient settings, supplemental to individual and/or group counseling, peer support, and other recovery supports. DHCS also supports offering standalone medications when a member is not ready to seek counseling or other treatment services, which is consistent with the best available science and DHCS-issued guidance.[116] While most specialty SUD services will need to be provided through DMC/DMC-ODS, many persons with SUD receive MOUD such as buprenorphine or MAUD, such as naltrexone, through primary care providers such as Federally Qualified Health Centers or community health centers (rather than through specialty providers within DMC/DMC-ODS) and in this instance clinical services should be coordinated between primary care and DMC/DMC-ODS.

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[114] SMD #23-003, "Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who are Incarcerated. Available at: https://www.medicaid.gov/sites/default/files/2023-04/smd23003.pdf

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

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

Goals of JI Initiative Regarding treatment of Substance Use Disorders: To ensure that treatment is provided to Medi-Cal-enrolled individuals eligible for the JI Initiative prior to release, DHCS will leverage and expand on the current delivery of SUD treatment for incarcerated individuals with the following goals in mind:

- Cover and promote all medications for the treatment of SUD available in Medi-Cal. Provide reimbursement for all formulations of medications covered under Medi-Cal – including long-acting injectable forms of addiction treatment consistent with existing Medi-Cal policy to increase the provision of effective pharmacotherapy.
- Ensure that people who need methadone receive it continuously throughout incarceration. Assist CFs and NTPs in developing methadone delivery strategies and payment methods that eliminate the practice of terminating individuals from methadone treatment during incarceration, provide daily methadone dosing throughout incarcerations, and support induction onto methadone during incarceration.
- Expand access to concurrent behavioral health in CFs. For example, ensure that evidence-based therapy, including cognitive behavioral therapy, is available to those who desire to receive it.
- Provide technical assistance and support based on knowledge gained through this initiative and best practices of peer institutions. Work closely with CFs and community-based providers to identify best practices and provide intensive technical support to achieve seamless continuity of SUD treatment services during the reentry period.
- Ensure that opioid overdose reversal medication is available, and staff have been trained in its use. Support access to overdose-reversal medication (naloxone).
- Ensure continuity of care by providing an adequate supply of medication specific to each patient's needs. Provide an adequate supply of medications in hand upon release, covered by Medi-Cal, dependent on the timing of the follow-up visit and for use post-release into the community.[117]

Treatment Approach. Given the evolving legal, regulatory, and clinical standards for treatment of addiction, DHCS strongly supports the use of evidence-based screening and/or assessment instruments as part of any carceral intake for potential opioid, alcohol, and other substance withdrawal. DHCS recommends validated SUD screening tools as described in ***Section 6.4*** "Screening for SMHS/DMC/DMC-ODS/Non-SMHS. After a potential SUD has been identified through a screening, individuals are entitled to receive MAT and other SUD treatment services and correctional facilities can bill Medi-Cal for these services during the pre-release period if they meet the eligibility criteria

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

described in ***Table 8 in Section 6.2*** "Eligible Individuals" based on an assessment as follows:

- Meets the criteria for an SUD[118] as defined in the current editions of the DSM and/or the *International Statistical Classification of Diseases and Related Health Problems*; or
- Has a suspected SUD diagnosis that is currently being assessed through either the National Institute of Drug Abuse (NIDA)-modified Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) or American Society of Addiction Medicine (ASAM) criteria.

All non-residential SUD treatment services are eligible for Medi-Cal reimbursement during the 90-day period prior to release.[119,120] The following lays out treatment approach for OUD and AUD. Not every patient will meet the criteria for or require all treatments listed below.

Requirements for treatment for OUD include the following:

- Assessment of individuals who screened positive for OUD.
- Treatment planning, consistent with Medi-Cal requirements, including Cal. Code Regs. Tit. 9, § 10305 – Patient Treatment Plans (also known as "Title 9") for applicable NTP services, in collaboration with the patient.
- Management of opioid withdrawal with agonist medication (i.e., either methadone or buprenorphine) using evidence-based tools and interventions.[121]
- Timely induction of an appropriate form of medication based on the individual's preference for agonist or antagonist treatment.
- Timely continuation of any agonist medication prescribed in the community, for the duration of incarceration.
    - CF providers must use the available legal pathways to administer these medications, including the Drug Enforcement Administration's (DEA) 72-hour emergency rule for methadone, where needed (see Section on Legal and Regulatory Requirements for Methadone below)
    - CF must have policies and procedures to support evidence-based dosing, urine drug screening, diversion control, and patient expectations/consent.

[118] Aligned with BHIN 23-001, available at: https://www.dhcs.ca.gov/Documents/BHIN-23-001-DMC-ODS-Requirements-for-the-Period-of-2022-2026.pdf
[119] Beneficiaries whose county of residence has opted into the DMC-ODS are entitled to receive "Covered Expanded SUD Treatment Services" described in the State Plan upon release. See California State Plan, Supplement 3 to Attachment 3.1-A, pages 6f-6r.
[120] Beneficiaries whose county of residence has not opted into the DMC-ODS are entitled to receive "Substance Use Disorder Treatment Services" described in the State Plan upon release. See California State Plan, Supplement 3 to Attachment 3.1-A, pages 3-6c.
[121] May require transfer to a local hospital if capacity is not available. When an individual is hospitalized off grounds for 24 hours or more, that individual is found to be Medicaid-eligible and services should be billed through Medi-Cal State Inmate Program (MSIP) or the Managed Care Incentive Payment (MCIP) Program.

- Tapering or discontinuation (determined by both the clinician and the patient and on a case-by-case basis in accordance with evidence-based practices).
- Services and placement in non-residential level of care (if available within CF) as determined by a full ASAM Criteria assessment. The ASAM Criteria assessment shall be completed for individuals who are estimated to be in the CF for more than 30 days. For county CFs, the ASAM Criteria assessment shall be completed within 30 days of the individual's first visit with an LPHA and/or SUD counselor.
- Examples of evidence-based practices that may be provided as part of non-residential SUD treatment include:
  - Motivational interviewing.
  - Cognitive behavioral therapy.
  - Peer support services.
  - Psychoeducation.
- Maintenance of continuity of care by transitioning to community provider (including but not limited to medication access through primary care and SUD treatment) through close coordination with pre-and post-release care managers.
- Providing an appropriate supply of medication in hand upon release to meet the need between release and transition to community provider. Because medications used for addiction include those that create a high risk of overdose or diversion, the quantity of these medications depends on the timing of the arranged follow-up visit, the particular risk for the patient, and the clinical judgment of the prescriber. For methadone, CFs should leverage the methadone take-home flexibilities described below in Legal and Regulatory Requirements Specific to Methadone.

Requirements for treatment for AUD include the following:

- Assessment of individuals who screened positive for AUD, using the ASAM criteria to determine the appropriate level of treatment when applicable.
- Treatment planning is consistent with Medi-Cal requirements, in collaboration with the patient.
- Management of alcohol withdrawal using evidence-based tools and interventions.[122]
- Timely introduction of medication based treatment. This includes access to disulfiram, naltrexone, acamprosate and other medications as appropriate.

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

- Timely continuation of any medication prescribed in the community, for the duration of incarceration.
- Policies and procedures to support evidence-based treatment of AUD and patient expectations/consent.
- Tapering or discontinuation determined in shared decision-making between the clinician and the patient on a case-by-case basis and in accordance with policies.
- Discontinuation determined by both clinician and patient, and on a case-by-case basis in accordance with evidence-based practice.
- Services and placement in non-residential level of care (if available within CF) as determined by a full ASAM Criteria assessment. The ASAM Criteria assessment shall be completed for individuals who are estimated to be in the CF for more than 30 days. For county CFs, the ASAM Criteria assessment shall be completed within 30 days of the individual's first visit with an LPHA and/or SUD counselor. Examples of evidence-based practices include:
  - Motivational interviewing.
  - Cognitive behavioral therapy.
  - Peer support services.
  - Psychoeducation.
- Maintain continuity of care by transitioning to community provider (including but not limited to medication access through primary care and SUD treatment) through close coordination with pre- and post-release care managers.
- Providing an appropriate supply of take-home medication in hand upon release to meet the need between release and transition to community provider.

Legal and Regulatory Requirements Specific to Methadone. Medication treatment for OUD must be provided under the JI Initiative both in the carceral setting and upon release, in a manner consistent with federal and state regulations. To prescribe and deliver buprenorphine, only a standard DEA registration is required.[123] However, methadone has additional regulations that must be considered.

With a few exceptions, only narcotic treatment providers (NTPs) may offer methadone. Specifically, NTPs are required to directly offer medications to members with SUD diagnoses that are treatable with FDA-approved medications and biological products.[124] Correctional facilities providers can partner with NTP providers or become NTP providers themselves to deliver methadone, or may consider the options below.

<u>Pathways for CF to deliver methadone without becoming NTP-registered providers:</u>

[123] As of January 12, 2023, all prescriptions for buprenorphine only require a standard DEA registration number. DEA announces important change to registration requirement (usdoj.gov)
[124] CA 20-0006-B MAT SPA Approval Package.pdf

There are two pathways for delivering methadone for OUD that can apply to CFs in specific circumstances that do not require an NTP-registered provider. The following two pathways should allow CFs to provide methadone for the majority of their population when clinically indicated:

1. Methadone may be administered as an **incidental adjunct** to medical or surgical conditions other than opioid dependency **in a state and DEA registered hospital or clinic.**[125] In other words, administration under this circumstance is for maintaining or detoxifying a person as an incidental adjunct treatment to conditions other than addiction. All of the following is required to be able to deliver methadone under this regulation:
    - Registration with the state as a clinic: The CF's Exempt from Licensure Clinic Medi-Cal enrollment path, which will be the billing entity for all embedded services by the CF or their contractors (see Section 9.3.), is considered a state registered clinic under this regulation.
    - Registration with the DEA: For this exception to apply, CF clinics must be registered with the DEA as a hospital/clinic.
        - If not already registered, CF clinics may register with the DEA, through the DEA website under the hospital/clinic registration using form 224.
    - **Administration of methadone as an incidental adjunct treatment:** Any methadone provided under this regulation must be done as an incidental adjunct treatment while the individual is receiving treatment for a medical or surgical condition other than SUD.
        - If an individual is being treated for another condition by the CF clinic (e.g., pregnancy, hypertension, depression), they meet this definition. If an individual only has SUD without any other co-occurring illnesses that are being treated, they do not qualify for this exception.
2. Providing methadone under the **DEA 72-hour emergency rule**.
    - The 72-hour rule allows a practitioner to administer (but not prescribe) narcotic drugs, including methadone, to a patient for the purpose of relieving acute withdrawal symptoms while arranging for the patient's treatment. This rule can be lifesaving for individuals with OUD.

Methadone Take-Home Flexibilities. In order to ensure individuals can be released with a clinically appropriate supply of medications, including methadone, CFs should

[125] The DEA's provision regarding hospitals' use of methadone can be found at 21 C.F.R. § 1306.07(c). This regulation states that hospitals can use methadone "as an incidental adjunct to medical or surgical treatment of conditions other than addiction." Additional guidance on how to apply this provision in correctional settings can be found in the 2000 and 2022 DEA guides for narcotic treatment programs.

leverage the following recent regulatory take-home flexibilities that apply to methadone dispensed by NTPs.[126]

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

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

Medication for Substance Use Disorder Readiness Assessment. To ensure the successful implementation of medication for SUD as a pre-release service in all state prisons, county jails, and YCFs, CFs must pass a readiness assessment. The following list provides readiness requirements that would demonstrate full compliance:

- Processes are in place to immediately and systematically screen all individuals entering a jail for SUD, including any history of alcohol, sedative or opioid withdrawal.
- Facilities can provide all medication treatment options that would be available to individuals if they were not incarcerated. The decision to obtain medication for SUD, including OUD or AUD, and the specific medication chosen, should be the individual's decision and be informed by consultation with medical and treatment providers.
- Processes are in place for all individuals who screen positive for an SUD or who later report SUD-associated cravings to be clinically assessed by a qualified treatment provider to determine whether treatment is clinically indicated.
- Policies and processes related to medications do not limit the types of medication, dosages, or duration of treatment.
- All persons for whom medications are clinically indicated and who consent to its use are inducted into treatment in a timely fashion and maintained on treatment throughout incarceration.

[126] On May 11, 2023, upon the expiration of the federal COVID-19 PHE, SAMHSA implemented new Methadone Take-Home Flexibilities Extension Guidance that will remain in effect for the period of one year from the end of the COVID-19 PHE, or until such time that the U.S. Department of Health and Human Services publishes final rules revising 42 C.F.R. part 8 entitled 'Medications for the Treatment of Opioid Use Disorder' (87 FR 77330), whichever occurs sooner. These take-home flexibilities were granted to ensure continuity of care until SAMHSA finalizes updating the take-home medication requirements and guidance due to the positive outcomes in treatment.

- Assessment and provision of medication continuation and withdrawal management are available every day, with the goal of preventing gaps in care that can unnecessarily precipitate or sustain withdrawal.
- Processes are in place for treatment programs to include ongoing monitoring through drug screening and other diversion/risk mitigation strategies, including protocols for when an individual has a urine drug test that indicates medication nonadherence.
- Processes are in place for pregnant individuals to receive specialized treatment services to prevent and reduce health risks during pregnancy.
- Processes are in place for individuals to couple medications with counseling and appropriate wraparound services where clinically indicated and the patient agrees.
- Correctional staff have received training and education on medication based treatment and naloxone use.
- Facilities are able to store medicines and have processes in place for appropriately safeguarding their inventory.
- Processes are in place to transition individuals receiving medications via a warm handoff and/or a behavioral health link at reentry to community providers (see ***Sections 6.4 and 11.3*** for more on behavioral health link eligibility and requirements).
- Processes are in place to provide an appropriate supply of take-home medication in hand upon release to meet the need between release and transition to community provider

Technical Assistance and Implementation Support. To increase access to treatment in CFs and improve the standard of care in delivering these services to JI populations, DHCS will ensure CFs understand the treatment requirements under CalAIM through the provision of technical assistance to CDCR, jails, and YCFs.

Additionally, as part of CalAIM, JI PATH funds will be available to CFs and should be leveraged to help them establish or update existing treatment services to meet DHCS' minimum requirements; the PATH funds can also support CFs/vendors in becoming Medi-Cal-enrolled providers/NTPs or to develop contracts with NTPs or community-based addiction treatment providers.

8.8 Medications Upon Release

The CalAIM Justice-Involved Initiative includes the provision of medications in hand to eligible individuals upon release from a correctional setting in order to ensure individuals have enough medications to follow their treatment plans; maintain stabilization on the medications they were prescribed when incarcerated; and avoid decompensation in the

period between release and any appointments they may have with their community-based physical and/or behavioral health providers.

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

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

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

CFs must provide a full supply of all active medications in hand upon release to incarcerated individuals receiving pre-release services. "Full supply" is defined as the maximum amount that is medically appropriate and allowed by the Medi-Cal State Plan. At a minimum, CFs are required to develop processes for providing prescribed medications in hand upon release for individuals who have had an active JI aid code for 48 hours. Determining which medications are necessary can be based on any medication need identified through the standard medical screening procedures and according to the timelines specified by the CFs for those procedures.

Example scenarios include the following:

- An individual diagnosed with a chronic disease (e.g., type 2 diabetes) should receive the maximum supply of the associated medications (e.g., metformin) as medically appropriate and allowable under the Medi-Cal State Plan.
- An individual with an acute condition (e.g., bacterial infection) should receive a sufficient supply of medications (i.e., antibiotics) to complete the prescribed course of treatment.
- An individual receiving medications that are required to be delivered by a clinician (e.g., long-acting injectables[127]) should receive a final dose of the medication as close to release as possible, as indicated and medically appropriate.

[127] Members who receive provider-administered injectable medications must be scheduled for a follow-up appointment with a provider who can continue treatment within appropriate time-frames.

- An individual receiving a controlled substance should receive the amount that is clinically appropriate based on the clinician's assessment (e.g., a one-week supply of opioids for someone with cancer-related pain).
- An individual diagnosed with SUD (e.g., OUD) should receive a supply that is deemed clinically appropriate and takes into account the date of their next follow-up appointment (e.g., a minimum of a 14-day supply of buprenorphine for an individual on a stable treatment dose and who has a follow-up appointment with their SUD treatment provider within two weeks of release).
- An individual taking OTC medications should be provided with a supply of such medication from the CF's general stock upon release, as indicated and medically appropriate. (CF may prescribe and bill Medi-Cal for OTC medications if the provided medication is in a formulation that is covered by Medi-Cal's Contract Drug List.)

In addition to providing the medications in hand upon release, the CF should submit a prescription for any active medication to a community pharmacy as appropriate and feasible so that the individual has access to refills. The prescriptions should be sent, in order of preference, electronically, by fax, by phone, or, as a last resort, by providing the individual with a handwritten prescription.[128] The recommended practice is to have medications submitted to a community pharmacy near the individual's anticipated residence in the community, as clinically appropriate.[129] Providing both a supply of medications and an opportunity to obtain refills will allow the individual sufficient time to establish relationships with community providers upon release and further reduce the risk of gaps in medication adherence upon reentry to the community.

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

[128] Without a health information exchange between CFs and pharmacies, sending prescriptions electronically will not be possible and paper prescriptions will be the norm, at least initially. DHCS hopes electronic prescription submissions become the norm as CFs and implementation partners continue to expand the JI program and build information exchanges. Note that e-prescribing is not required and any valid prescription is permissible. California allows exceptions to e-prescribing (BPC 688 (e)) for various situations. Medi-Cal will reimburse for claims that meet one of the acceptable formats as detailed in the Medi-Cal Rx Provider Manual, Section 4.0.

[129] DHCS understands there will be operational complexities for many individuals leaving prison who do not have an established residence/pharmacy. DHCS does not expect the same operational complexities to exist for those with shorter stays who have preexisting relationships with outpatient pharmacies and permanent preexisting addresses, such as those leaving jails.

discharge planning are expected to provide timely notice to CF health care staff and the pre-release care manager of upcoming releases of all persons receiving JI pre-release services.

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

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

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

8.8.c Minimum Requirement #3: Comply with Medi-Cal's Prior Authorization (PA) and Utilization Management (UM) Requirements

CFs and partnered Medi-Cal-enrolled pharmacies are expected to comply with existing Medi-Cal PA/UM requirements. DHCS, in partnership with Magellan, accepts and processes PA requests and provides a response to the submitting Medi-Cal provider within 24 hours of receiving a PA request (or the next business day if the request is received after hours), pursuant to applicable state law.[130,131] The pre-release services care manager is responsible for supporting the submission of PAs and coordinating with the Medi-Cal pharmacy to ensure that medications are available for provision to individuals upon release. Establishing PA history during the pre-release period will support the individual's transition into the community by creating a documentation trail of prior approvals for needed medications in the community.

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

At the time of release, all individuals must be offered naloxone and instruction on its use, regardless of any history of OUD. For individuals with OUD, CFs and pre-release care managers should additionally ensure access to opioid treatment and related resources at the time of release. CFs should provide individuals, as medically indicated,

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

[131] There are several ways to submit a PA request for review. Medi-Cal Rx will accept PA requests via the following methods: NCPDP P4 – Request Only; online via the Medi-Cal Rx provider portal or CoverMyMeds®; fax; U.S. mail. Source: https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/forms-and-information/manuals/Medi-Cal_Rx_Provider_Manual.pdf.

with MAT medications at the time of release and facilitate a warm handoff and/or behavioral health link to community providers.

Naloxone is a Medi-Cal-covered drug, and many CFs already provide group training on naloxone for those in custody. Distribution of naloxone to all individuals leaving jail was identified as a best practice during the CalAIM JI Advisory Group meetings. In California, pharmacists already dispense naloxone without a prescription from a health care provider, as authorized and in compliance with Business and Profession Code Section 4052.01.

8.9 Durable Medical Equipment Upon Release

As part of its targeted set of pre-release services, Medi-Cal covers DME that is provided upon release from a correctional setting.[132,133] Medi-Cal will not cover DME that is provided to an individual while they are incarcerated.

Individuals eligible for pre-release services are entitled to all Medi-Cal State Plan covered DME upon release when such DME is considered medically necessary, if prescribed by a physician, nurse practitioner, clinical nurse specialist, or physician assistant.[134,135] DME is "medically necessary" if it preserves bodily functions essential to activities of daily living or is needed to prevent significant physical disability. Medi-Cal may also cover DME that helps a parent/guardian care for a child. DME coverage is limited to the lowest-cost item that meets the individual's medical needs. A member's need for DME must be reviewed annually by a provider.[136]

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

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

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

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[132] CalAIM JI Advisory Group: Review of Justice-Involved Initiative Policy and Operational Process Expectations (July 2022). Available at: https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/CalAIMJIAdvisory072822.pdf
[133] DHCS does not need 1115 waiver expenditure authority to provide DME to individuals, as such services will be provided to the individual when they are no longer an inmate.
[134] Durable Medical Equipment (DME): An Overview (September 2020). Available at: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/dura.pdf
[135] DHCS acknowledges that short-term stays and unplanned release dates may impact CFs' ability to provide DME to individuals upon release.
[136] See Appendix A for a full list of Medi-Cal-covered DME.

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

CFs must screen for and provide necessary DME upon release for any individual who has had an active JI aid code for 14 days or longer. The need for DME can be identified at any time during incarceration (e.g., at intake, at an evaluation that occurs 14 days after booking, at a pre-release care manager-initiated meeting). CFs' clinical providers are responsible for identifying and addressing DME needs, though they may be supported by the pre-release care manager, the post-release ECM Lead Care Manager, and in-reach clinical consultants.

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

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

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

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

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

Individuals entering the community with DME in hand should also be provided with prescriptions for all necessary DME at the time of release in case the DME in hand is lost, stolen, or broken. DHCS anticipates that providing prescriptions – in addition to DME – at the time of release will support individuals in their ability to obtain the needed DME in the community, especially for DME that requires replacement or refills (e.g., oxygen tanks), until the individual is able to develop relationships with their MCP and community providers.

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

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

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

As described in ***Section 8.9.b***, if the necessary residential DME cannot be set up by the time of release, the provider prescribing the DME must share a copy of the prescription with the individual, the pre-release care manager, and the post-release ECM provider, to be filled in the community.

8.9.d DHCS Standard Policy for Providing DME Upon Release

CFs opting to bill Medi-Cal for DME that will be provided upon release must follow all existing Medi-Cal rules related to the provision of DME.[137] Such CFs are responsible for familiarizing themselves with existing Medi-Cal rules; DHCS will provide technical assistance to stakeholders as needed.

The following steps summarize the process for providing and prescribing DME, in keeping with existing Medi-Cal rules (a potential model for provision of DME which follows the steps below can be found in Table 13).

1. The CF provider or the pre-release care manager identifies an individual's need for DME.
2. The treating provider[138] has a face-to-face encounter with the member that is related to the primary reason the recipient requires the DME. (Face-to-face encounters may be done via telehealth.)
3. The treating provider must communicate the clinical findings of that encounter to the prescribing prescriber.[139] The treating provider and the prescribing provider may be the same person (e.g., a clinician at the CF).

[137] Additional information about DHCS's billing rules for DME are available on the DHCS website. Select references include: a. Durable Medical Equipment (DME): An Overview; b. Durable Medical Equipment (DME): Bill for DME; c. Durable Medical Equipment (DME): Billing Codes

[138] The treating provider is the provider performing the face-to-face encounter that is required for all DME (physician, nurse practitioner, clinical nurse specialist, or physician assistant).

[139] The prescribing provider is the provider writing the DME prescription (physician, nurse practitioner, clinical nurse specialist, or physician assistant).

4. The prescribing provider writes a prescription for needed DME, documenting that the face-to-face encounter has occurred within six months prior to the date on the DME prescription.
5. The prescribing provider submits the DME prescription with all needed documentation to the rendering provider.[140]
6. The rendering provider dispenses the needed DME and bills for services, consistent with any treatment authorization requests (TAR), as relevant.[141]

8.9.e Operational Approach and Illustrative Roles and Responsibilities

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

DHCS anticipates that roles and responsibilities may vary across CFs and counties. As such, it will allow flexibility in the roles and responsibilities related to delivering DME. One potential model for the provision of DME is described in Table 13 below.

[140] The rendering provider is the provider providing/dispensing the DME (i.e., the DME vendor).
[141] Additional information about TAR requirements is available in a. Durable Medical Equipment (DME): An Overview

Table 13. Potential Model for Provision of DME					
#	**Step**	**Operational Approach**	**Correctional Facility (CF) Role**	**Pre-Release Care Manager (CM) Role**	**Post-Release ECM Provider Role**
1	**Identify Need for DME**	Assess individuals for potential DME needs through a medical record review, interview with the individual, clinical assessment, and/or coordination with other providers (e.g., physicians, physical therapists, occupational therapists) to obtain further clinical assessments as needed. This may occur at any point during an individual's incarceration.	Provide CM with access to necessary records and staff.	**Identifies initial DME need (*Lead*)**	
2	**Face-to-Face Encounter with Provider**	Once the DME need has been identified, a qualified provider (i.e., physician, nurse practitioner, clinical nurse specialist, or physician assistant) conducts a face-to-face encounter to validate the reason the patient requires the DME. The face-to-face encounter must have occurred within six months prior to when the prescription for DME is written, and findings			

Table 13. Potential Model for Provision of DME					
#	**Step**	**Operational Approach**	**Correctional Facility (CF) Role**	**Pre-Release Care Manager (CM) Role**	**Post-Release ECM Provider Role**
		should be shared with the individual's pre-release care manager and incorporated into the CF medical record. The face-to-face encounter may be completed through methods that include:			
		a. Assessment by CF staff (e.g., in the comprehensive medical assessment 14 days after intake).	**Perform assessment (*Lead*)**	Coordinate, as needed	
		b. Assessment by in-reach clinical consulting provider.	Provide clinical consultant with facility permissions	Coordinate assessment **Clinical consultant to lead*.	
		c. Pre-release care manager reviews prior records.	Provide CM with access to records	**Review records (*Lead*)**	
3	**Treating Provider Communicates Clinical Findings**	The CF provider (as opposed to the in-reach clinical consulting provider) should be responsible		**Support communication if face-to-face provider**	

Table 13. Potential Model for Provision of DME					
#	**Step**	**Operational Approach**	**Correctional Facility (CF) Role**	**Pre-Release Care Manager (CM) Role**	**Post-Release ECM Provider Role**
	to Prescribing Provider	for prescribing and dispensing DME, as they are responsible for supporting the individual's reentry into the community. As such, if the face-to-face encounter is conducted by an in-reach clinical consulting provider (or through care manager record review), the treating provider must communicate the clinical findings from the face-to-face encounter to the prescribing provider. The care manager should be kept informed of and support communication between the treating provider and prescribing provider. In scenarios where a CF provider both conducts the face-to-face encounter and writes the prescription, the providers would serve as both the treating and prescribing providers.		**is in-reach provider (*Lead*)**	

Table 13. Potential Model for Provision of DME					
#	**Step**	**Operational Approach**	**Correctional Facility (CF) Role**	**Pre-Release Care Manager (CM) Role**	**Post-Release ECM Provider Role**
4	**Provider Prescribes DME**	Write the prescription for appropriate DME using standard DME ordering requirements. CF provider and pre-release CM collaborate to determine whether the DME should be provided (1) in hand upon release or (2) via in-residence setup.	**Write prescription (*Lead*)**	Support determination of mode of DME delivery.	
5	**Submit DME Prescription**	Submit DME prescription to rendering provider with necessary documentation for TARs, as appropriate.		**Submit prescription for DME needed upon release (*Lead*)**	(Submit prescription if needed after release)
6	**Rendering Provider Bills for and Provides DME**	Rendering provider bills for and supplies DME. CF provider and pre-release care manager coordinate to ensure that the individual receives the DME (1) in hand upon release or (2) via in-residence setup – as well as the DME prescription, as appropriate.	**Ensure delivery of DME upon release (*Lead*)**	Support as needed	(Support delivery of DME if the individual will obtain it after release)

9. Provider Enrollment and Payment

9.1 FFS Delivery Model

Pre-release covered services will be delivered, claimed, and paid for via Medi-Cal's FFS delivery system. Claims may be submitted through normal processes utilizing Medi-Cal Rx for pharmacy services and CA-MMIS for clinical services including care management, clinical consultations, MAT, CHW services, laboratory, and radiology.

DHCS will allow both providers embedded in the CF (including CF staff and contractors) and in-reach community-based providers (including care managers/ECM providers and physical and behavioral health clinical consultants) to provide pre-release services, but all pre-release providers must enroll in Medi-Cal as an FFS provider. The sections below provide additional detail on which providers must enroll as Medi-Cal providers and the applicable pathway for doing so.

9.2 Medi-Cal Provider Enrollment for Community-Based Providers

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

DHCS is also in the process of establishing a "community-based organization" provider type which will be eligible to provide certain JI pre-release services, such as case management.

DHCS is developing further guidance on community-based organization provider enrollment and enrollment pathways for behavioral health providers that do not currently have an existing pathway to enroll as a FFS provider.

9.3 Medi-Cal Provider Enrollment for Correctional Facilities

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

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

Pharmacy Enrollment

- DHCS requires each CDCR facility and any jail or YCF facility with a pharmacy on-site, and any pharmacy located in or out of state that is

contracted to provide pre-release prescription services to eligible incarcerated individuals, to enroll as a Medi-Cal pharmacy.

- Enrollment will be location-specific, and only one pharmacy per site must enroll.
- Pharmacy enrollment information can be accessed here: https://www.dhcs.ca.gov/provgovpart/Pages/PharmacyProviderApplicationInformation.aspx

Provider Enrollment

- DHCS will require that each State prison, county jail, and YCF enroll as a Medi-Cal provider under the Medi-Cal *exempt from licensure clinic* enrollment type.
- CF enrollment will be location-specific, and only one provider enrollment as an exempt from licensure clinic will be required per site.
- The clinic that is enrolled in Medi-Cal within the CF must oversee all billing submitted to DHCS, with the exception of community-based, in-reach providers who will be separately enrolled as Medi-Cal providers and directly bill DHCS for services.[142]

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

Federal and state law requires all providers who provide medical care to have a national provider identification (NPI), meaning each correctional exempt from licensure clinic (i.e., correctional agency or county health department who is responsible for providing all correctional health care services) will need to have a registered NPI. Facilities within an agency (e.g., jails in the same county or all state prisons) can apply as an organization; each individual pharmacy site requires its own unique NPI.

Additionally, the approved STCs waive DMC and SMHS certification requirements for CFs and their vendors.

CFs will be required to ensure that any embedded providers they employ or contract meet minimum credentialling requirements that mirror DHCS enrollment requirements to provide services.[143] The identification of these providers will be confirmed through implementing partners' implementation plan and readiness assessment.

[142] Correctional facility clinics should be enrolled by a public entity (county or state agency) that is responsible for correctional facility healthcare. In most instances, this is the correctional facility, in some cases this may be the County Health Department.
[143] Any embedded providers enrolled directly with DHCS as Medi-Cal providers may be considered to have met all state and federal enrollment requirements.

For more information on how CFs can enroll in Medi-Cal, please refer to DHCS guidance, available here: https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/PAVE-Enrollment-for-Correctional-Facilities.pdf

9.4 Role of the Correctional Facility in Provision of Pre-Release Services

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

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

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

9.5 Embedded/In-Reach Provider Considerations

Care management and clinical consultations may be provided by either embedded/contracted or in-reach community-based providers. (CHW services must be

provided only by in-reach providers.) In-reach services may be delivered via telehealth or in person by community-based in-reach providers, including care managers, behavioral or physical health providers, CHWs, and peer support specialists (when applicable).

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

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

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

Alternatively, if the provider is acting on behalf of the county in their role in the community – for example, participating in a behavioral health link – that service would be considered in-reach. See Table 14 for types of providers, both embedded and community-based, and provider examples.

Table 14. 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 contracted by correctional agency	Yes	Private contractor/vendor clinician or county behavioral health agency and/or its subcontracted providers providing CF behavioral health services as outlined in contract with Sheriff's Office.	Correctional Health Care Facility NPI
Community-based provider who provides services (not under contract of the CF) 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 not under contract of the CF (includes professional-to-professional clinical handoff within behavioral health link)	Community-Based Provider NPI

9.6 ECM Provider Network

MCPs are responsible for administering ECM for the Individuals Transitioning from Incarceration Population of Focus ("JI POF") in the community and developing a sufficient network of JI ECM providers to meet the needs in the county in which they operate. All contracted JI ECM providers must meet DHCS' definition of a "JI ECM Provider" in addition to the standard provider requirements put forth in the ECM Policy Guide (updated July 2023). Additional details on ECM for the JI POF can be found in the ECM Policy Guide, and detailed requirements for MCP implementation of ECM for the JI POF can be found in ***Section 13.***

10. Pre-Release Service Rate Setting

10.1 Billing and Claims Approach for Pre-Release Services

DHCS will pay for all pre-release services under Medi-Cal FFS. Claims may be submitted through normal processes utilizing Medi-Cal Rx for pharmacy services and CA-MMIS for clinical services including care management, clinical consultations, MAT, CHW services, laboratory, and radiology. In addition:

- Federally Qualified Health Centers (FQHCs) and Rural Health Clinics may bill and claim within the FFS system, which is supplemental to the prospective payment system (PPS) and not subject to reconciliation, for any in-reach pre-release services. Costs associated with JI pre-release services and billed through the FFS system will be excluded from any future calculations of the PPS rate.
- Tribal Clinics may bill their existing all-inclusive rates for any pre-release services done as an in-reach provider through CA-MMIS.

County behavioral health agencies and/or their subcontracted providers (i.e., county MHP, DMC, DMC-ODS) will be able to submit claims for their portion of behavioral health links through normal processes utilizing Short Doyle;[144] all other behavioral health pre-release services will be billed FFS directly by providers through CA-MMIS rather than through the county behavioral health agency and/or its subcontracted provider.

DHCS expects to leverage existing rates, payments, policies, and procedures for pre-release services with a few modifications to account for some of the complexity of doing this work in CFs. For example:

- DHCS will provide tiered rates for in-reach, in-person visits (e.g., for care management, clinical consultation, and CHWs) to account for the unique additional complexities and time for individual providers to pass through security clearance and deal with appointment cancellations due to lockdowns or other unique CF challenges.
- DHCS developed a bundled payment approach for care management services (*See **Section 10.2***).

10.1.a. Billing for Services by Embedded Providers:

As described above in ***Section 9.5***, services that are rendered by the CF staff or any of their contracted providers for services which they are already required to provide (meaning required to provide prior to go-live of pre-release services) or have historically provided are considered to be embedded services. All of these services should be billed

[144] Short Doyle/Medi-Cal Billing Manual: https://www.dhcs.ca.gov/services/MH/Pages/MedCCC-Library.aspx

through the CFs enrolled exempt from licensure clinic (see ***Section 9.3***) using CA-MMIS.

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

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

10.1.b. Services Provided by County Behavioral Health Agency

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

All other pre-release services that could be delivered by county-based or county contracted providers, including clinical consultation, care management, and MAT should

be billed by the behavioral health provider and not by the agency to CA-MMIS as either in-reach or embedded services as defined **in Section 9.5.**

10.1.c. Medications/Pharmacies:

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

10.2 Proposed Approach for Care Management Bundles

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

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

10.2.a. Bundle 1: Health Risk Assessment / Whole-Person Needs Assessment

Overview
Pre-release care managers are responsible for ensuring the completion of a health risk assessment[145] (HRA) and documentation of pre-release services goals and objectives (‘goals and objectives'). The HRA should be used to identify goals and objectives, including additional clinical care or clinical assessments that are needed to diagnose, stabilize, or treat in preparation for reentry.

Both the HRA and the goals and objectives must be documented in the medical record and must include assessment of needs and pre-release goals and objectives in each of the following areas:

1. Physical health
2. Mental health
3. Substance use
4. Housing
5. Other health-related social needs

[145] The ‘Health Risk Assessment / Whole-Person Needs Assessment’ is hereinafter referred to as the ‘Health Risk Assessment’.

6. Functional needs
7. Strengths and support resources

Specific requirements for the health risk assessment include:

- Meeting with member (face to face or through telehealth) to conduct/review their health risk assessment.
- Reviewing prior records, as available.
- Obtaining informed consent, when needed, to furnish services and/or to share information with other entities to improve coordination of care.
- All components of the HRA with corresponding pre-release goals and objectives must be completed with the member, consider current needs and needs that may arise upon reentry into the community, and identify the goals and objectives of the care provided during the pre-release services time period. This work will help prioritize pre-release services, including any needed clinical consultations, and will serve as the basis for the reentry care plan.

Minimum Documentation Needed to Bill Bundle

- Completed whole-person HRA (documented in medical record).[146]
  - Assessment must include assessment of all required components of the HRA. (See ***Table 15*** for detail.)
  - Must include documentation of <u>at least one</u> face-to-face or telehealth encounter with member directly by a licensed professional. The encounter must include:
    - (1) Completed direct assessments of each component.
    - (2) Review of any prior assessments in prior medical records and other documentation for each component. *Note: review must be completed with the member and must include identification of new needs, resolved needs, and documentation of no new additional needs, as applicable;* ***<u>OR</u>***
    - (3) Some combination of direct assessments and review of prior assessments.
- Completed pre-release services goals and objectives for the member (documented in medical record).[147]
  - Must include documentation of <u>at least one</u> face-to-face or telehealth encounter with member directly by a licensed professional. *Note: The encounter used to develop goals and objectives is permitted to be the same encounter used to develop the HRA.*

[146] The care manager may meet with the member over multiple visits/encounters as needed, but may only bill this bundle once the HRA is complete.
[147] Goals and objectives may be documented in the same document as the needs assessment, or in a separate document.

- *Note: A licensed professional (e.g., RN care manager or LCSW) must participate in and oversee the completion of the HRA and the goals and objectives. Unlicensed individuals may support completion by, for example, obtaining records and consent for information sharing or completing health-related social needs and functional needs assessments.*

If the pre-release care manager does not meet the minimum requirements to bill this bundle, they may bill Bundle 2 for partial completion up to 3 times. See Bundle 2 for details.

Table 15. Required Components of Health Risk Assessment (HRA)

#	Component Overview	Component Detail[148]
1	Physical health needs assessment	• Prior medical issues • Any symptom burden • Potential for undiagnosed conditions • Need for clinical consultations • Need for medications • Need for DME • Need for IHSS • Need for establishing care with primary care and any specialists in preparation for release • Preventative care access (e.g., cancer screening, vaccinations, a physical exam within the last year)
2	Mental health needs assessment	• Prior mental health treatment and diagnoses • Use of validated screening tools • Need for clinical consultations • Identification of any needed medications for release • Identification of potential benefit for long-acting injectable use • Identification of need for behavioral health links • Identification of need for mental health follow-up and appropriate level of care
3	Substance use needs assessment	• Prior SUD treatment and diagnoses • Use of validated screening tools • Identification of potential need for MAT • Identification of potential benefit for long-acting injectable use • Identification of any needed clinical consultations • Identification of need for behavioral health links

[148] The information types listed in 'Component Detail' are illustrative and are not intended to fully capture the range of information that may need to be discussed and documented for each component of the HRA.

Table 15. Required Components of Health Risk Assessment (HRA)		
#	**Component Overview**	**Component Detail**[148]
		• Identification of need for substance-use disorder follow-up and appropriate level of care
4	Housing needs assessment	• Identification of planned housing upon release and identification of any housing needs
5	Other health-related social needs assessment	• Identification of any needs related to access to food or to medically tailored meals • Transportation needs • Cell phone/smart phone access • Job or education/training needs • Social support including who should be included in care plan (e.g., family/friends/parole/probation)
6	Functional needs assessment	• Identification of needs member may have related to functioning in community upon release such as o Medication management o Scheduling community-based appointments o Paying bills o Using electronic communication. o Ability to perform activities of daily living (ADLs) or instrumental activities of daily living (IADLs)
7	Strengths and support resources assessment	• Identification of member's existing strengths and existing/needed supports and resources.

10.2.b. Bundle 2: Care Coordination

Overview
Pre-release care managers are responsible for creating care links and coordinating with community-based providers and services. Specific responsibilities include:

- Pre-release coordination with post-release clinical consultants to address and/or identify physical health, mental health, or SUD needs, including coordinating any needed labs, radiology, or medications (including MAT).
- Pre-release coordination, including non-patient and patient facing, as needed, to create care links to community-based providers.
- Pre-release coordination to arrange appointments with or admission to physical and behavioral health care providers, including specialty county behavioral health coordinators and managed care providers, as relevant to care needs.

- Ensuring member has any necessary DME prescriptions, including coordinating with providers to perform face-to-face visits, documentation of medical necessity, and prescriptions.
- Assisting in information exchange and obtaining consent as needed to facilitate care with in-reach providers and other community care providers.
- Assisting with submission of prior authorization or treatment authorization requests and collecting any needed information.
- Facilitating a warm handoff with member and community-based provider.
- Ensuring coordination and receipt of pre-release services.

In some cases, the post-release ECM providers may also provide similar services in the pre-release setting. For example, there may be scenarios in which the pre-release care manager is an embedded provider and needs assistance with connections to community services of which the post-release ECM provider may have significantly more knowledge than the embedded care manager.

Minimum Documentation Needed to Bill

- **Documentation indicating that at least one of the following occurred (for each billing instance):**
  - Conducted face-to-face or telehealth encounter with the member to provide education, update the HRA, or update the reentry care plan.
  - Scheduled meeting with a clinical consultant or other community-based provider, with appropriate data sharing.
  - Held a face-to-face or telehealth meeting with a clinical consultant or other community-based provider, with documentation of discussion.
  - Facilitated warm handoff to community-based provider (via face-to-face encounter or telehealth) with any needed data sharing.
    - *Special Billing Note:*
      - *The pre-release care manager may bill this bundle for meeting with the post-release ECM provider. Meetings that include the pre-release care manager, post-release ECM provider, and the member, should be billed under **Bundle 3** – see **Bundle 3** for details.*
  - Completion and submission of forms or documentation necessary for reentry planning (e.g., prior authorizations, TARs, applications for residential mental health services, applications for social services such as housing or CalFresh).
  - Arranged for DME and medications (or their prescriptions) to be provided in hand, upon release, with relevant education.
  - Partial completion of Bundle 1 (Health Risk Assessment):
    - Completion of (1) HRA **and** (2) goals and objectives, for at least 2 of the 7 key components (*see **Table 15***).

- *Special Billing Notes:*
  - *This bundle may be billed up to 3 times per member (for each episode of incarceration) if Bundle 1 has not been billed. As a result, this bundle may be used to seek reimbursement for assessments, goals, and objectives cumulatively performed for up to 6 of 7 key components (see **Table 15**).*
  - *Bundle 2 may not be billed for the partial completion of Bundle 1 if Bundle 1 has been billed.*

- Partial completion of Bundle 4 (Reentry Care Plan):
  - At least one of the following must apply:
    - Completed reentry care plan that is shared and discussed with the member.
    - Completed reentry care plan that is shared with at least one of the following: post-release ECM provider or MCP.
    - Confirmed that (1) medications/medication prescriptions **and** (2) DME/DME prescriptions are provided in hand at time of release, as applicable, to the member, with relevant education. Medication lists and a copy of DME prescriptions must also be given to either the ECM provider or MCP.
  - *Special Billing Notes:*
    - This bundle may be billed up to 3 times per member (for each episode of incarceration) if Bundle 4 has not been billed.
    - Bundle 2 may not be billed for the partial completion of Bundle 4 if Bundle 4 has been billed.

10.2.c. Bundle 3: Care Manager Warm Handoff

Overview
In scenarios where the pre-release care manager is different from the post-release ECM provider, the pre-release care manager must arrange and participate in an in-person or telehealth warm handoff that must include the member and the post-release ECM provider. The warm handoff will serve as an opportunity to introduce the new post-release ECM provider, review the reentry care plan (including the health risk assessment and goals and objectives), and identify any additional needs.

Specific requirements to bill for the warm handoff include:

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

In scenarios where it is not possible to arrange a meeting between all three of the required participants[149] (e.g., due to short-stays, or unexpected releases),

- The pre-release care manager and post-release ECM provider should make every effort to conduct a warm handoff meeting with each other, even if the member is unable to attend; and
- The post-release care manager should make every effort to meet with the member to introduce themselves and prepare for reentry.[150]

Minimum Documentation Needed to Bill Bundle

- ***Note: This bundle will only be billable if the pre-release care manager is different from the post-release ECM Provider (for example, in an embedded pre-release care manager model).***
- For the Post-Release ECM Provider:
  - Documentation of participating in a face-to-face or telehealth encounter with the member to introduce themselves and review the HRA and/or reentry care plan to identify any additional needs. Documentation must include evidence of:

[149] Pre-release care manager, post-release ECM provider, and member.
[150] In cases where the pre-release care manager does not participate in the meeting between the member and the post-release ECM provider, the post-release ECM provider should ensure that they obtain all necessary care information from the pre-release care manager and review the information prior to the meeting with the member.

- Face-to-face or telehealth encounter with member directly;
- Sharing and discussion of the latest assessments and the reentry care plan with the member; ***and***
- Sharing of appropriate clinical information about the member between the pre-release care manager and the post-release ECM provider, including but not limited to the following:
  - HRA;
  - Goals and objectives;
  - Current reentry care plan;
  - Relevant clinical notes; and
  - Medication lists.
- Special *Billing Note:*
  - *The post-release ECM provider may bill for this bundle for having met with the member even if the pre-release care manager is unable to participate synchronously.*
  - *If the post-release ECM provider meets with the pre-release care manager* ***without participation from the member,*** *the post-release ECM provider may bill* ***Bundle 2 –*** *see* ***Bundle 2*** *for details.*

- For Pre-Release Care Manager
  - Documentation of participating in a face-to-face or telehealth encounter **that must include the member and the post-release ECM provider.**
  - Special *Billing Notes:*
    - *If the pre-release care manager meets with the member* ***or*** *the post-*release *ECM provider (but not both), the pre-release care manager may bill* ***Bundle 2*** *– see* ***Bundle 2*** *for details.*

10.2.d. Bundle 4: Reentry Care Plan

Overview
The pre-release care manager is responsible for completing a final reentry care plan documented in the medical record including release plans related to physical health, mental health, substance use, housing needs, other health-related social needs, functional needs, and strengths and support resources. The final reentry care plan must be completed in collaboration with the member and must be shared with the post-release ECM provider, MCP, county behavioral health agency (if applicable), the member, and the member's family/support persons (in accordance with the member's consent).

Specific requirements for the warm handoff include:

- Complete reentry care plan, created with the member, with input from the clinician(s) providing consultation services and correctional facility's reentry planning team. Provide care plan to member (as well as the post-release ECM provider, MCP, county behavioral health agency, and the member's family/support persons, as applicable) and confirm all connections and

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

Minimum Documentation Needed to Bill Bundle
- A completed final reentry care plan that:
  - Is documented in the medical record;
  - Includes plans related to all of seven of the key components described in Table 15; and
  - Was completed in collaboration with the member.
- Documentation that the reentry care plan was shared with the post-release ECM provider, MCP, county behavioral health agency (if applicable), the member, and the member's family/support persons (in accordance with the member's consent).
- Documentation to confirm that (1) medications/medication prescriptions and (2) DME/DME prescriptions are provided in hand at time of release, as applicable, to the member, with relevant education. Medication lists and a copy of DME prescriptions must also be given to either the ECM provider or MCP.

If the pre-release care manager does not meet the minimum requirements to bill this bundle, they may bill Bundle 2 for partial completion up to 3 times. See Bundle 2 for details.

10.2.e. Bundle 5: Post-Transition Support

Overview
Some members may require additional post-transition support in the period immediately following reentry to the community. For example, there may be scenarios in which the care manager warm handoff was unable to be completed prior to release (e.g., due to short stays or unplanned releases), requiring the pre-release care manager and the post-release ECM provider to work together to ensure adequate support in the critical days following reentry. There may also be scenarios in which an individual may not yet have active enrollment in an MCP at time of reentry, requiring the post-release ECM provider to provide services billed to fee-for-service Medi-Cal for a limited period of time.

Specific activities that the **post-release ECM provider** may perform (if MCP enrollment has not yet been activated) include the following[151]:

- Participate in a warm handoff meeting with the pre-release care manager if this was not done prior to release.
- Conduct a face-to-face or telehealth visit with the member to determine whether the member has any new needs and assist them in connecting to services to meet those needs. (Must be done as often as clinically indicated, but at a minimum, a visit should be held within 1-2 business days of release or notification of release and receipt of necessary data from the correctional facility/pre-release care manager. The ECM provider should also follow up with the individual within one week of release to ensure continuity of care and a seamless transition, and to monitor progress and the implementation of the reentry care plan.)
- Conduct follow-up activities with community-based providers to ensure engagement was made with member within a clinically appropriate timeframe, not to exceed more than 1 day after date of recommended follow-up. (E.g., if follow-up has been recommended during release planning for care to be provided within 1 day of release [example: someone on MAT who needs to see a prescribing substance use provider very quickly], the scheduled appointment should be scheduled within a 1 day timeframe of the recommended follow-up).
- Conduct follow up with the member to assist their engagement with community-based providers, behavioral health services, and other aspects of the reentry care plan within a clinically appropriate timeframe, not to exceed more than 1 day after date of recommended follow-up.
- Other care coordination activities (e.g., supporting scheduling of appointments, completing applications/documentation for services).

Specific activities that the **pre-release care manager** (if different than the post-release ECM provider) may perform include the following[152]:

- Activities related to the warm handoff with the post-release ECM provider.

Minimum Documentation Needed to Bill Bundle

- For the Post-Release ECM Provider:
  - ***Note: The post-release ECM provider may only bill this bundle prior to the MCP enrollment effective date. Once the individual's MCP enrollment is active, services must be authorized and reimbursed by the MCP in accordance with the MCP's policies.***

[151] The post-release ECM provider may only bill this bundle in the four weeks immediately following reentry.
[152] The pre-release care manager may only bill this bundle in the one week immediately following reentry.

- Documentation of at least one of the following[153]:
  - Participate in a warm handoff meeting with an embedded provider (via face-to-face meeting or telehealth). Must include evidence of synchronous communication and appropriate data sharing (e.g., of the reentry care plan, needed medical records).
    - Special *Billing Note:*
      - *If the warm handoff meeting also includes participation from the client, this bundle may be billed twice.*
  - Participate in meeting with the member (via face-to-face meeting or telehealth).
    - *Special Billing Note:*
      - *If the post-release ECM provider completes another task encompassed by this bundle during the meeting, the provider may bill this bundle twice.*
  - Assist member in getting to a follow-up appointment.
  - Complete and submit applications and/or documentation for services (e.g., housing applications; TARs for DME).
  - Support scheduling of new appointment(s) with a community-based provider.
  - Assist member with seeking and obtaining needed services provided by the MCP, such as Community Supports.

- For the Pre-Release Care Manager
  - ***Note: The pre-release care manager may only bill this bundle if the care manager warm handoff did not occur prior to release due to rapid or unexpected circumstances or circumstances outside of the correctional facility's control that prevented warm handoff prior to release.***
  - Documentation of:
    - Participation in a warm handoff meeting with the post-release ECM provider (via face-to-face meeting or telehealth). Must include evidence of synchronous communication and appropriate data sharing (e.g., of the reentry care plan, needed medical records).
      - Special *Billing Note:*
        - *If the warm handoff meeting also includes participation from the client, this bundle may be billed twice.*

[153] All options require evidence of information sharing with health plans, care providers, and community supports as needed and appropriate based on consent and information sharing laws.

11. Reentry Planning

11.1 ECM Eligibility

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

Table 16. Individuals Transitioning From Incarceration ECM POF Definitions

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

Please see the ECM Policy Guide (updated July 2023) for more details on ECM.

11.2 Pre- and Post-Release Warm Handoff Requirement

When different individuals provide pre- and post-release care management services (i.e., if the CF leverages an embedded care management model) the two care managers must conduct a warm handoff with the individual prior to release. The warm handoff is a required meeting to ensure care coordination and is the first step in establishing a trusted relationship between the individual and the new care manager. The warm handoff ensures seamless service delivery and coordination. See ***Section 8.4.f***, Requirements for Care Manager Warm Handoff, for detailed requirements.

11.3 Managed Care Auto-Assignment and Current Month Enrollment

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

1. Auto-Assignment:
    - *For individuals who already have Medi-Cal and an assigned MCP upon entry to the CF,*
        - The individual's MCP enrollment will be put in a 'hold' status for up to 12 full months of incarceration. This will allow the individual to maintain the same MCP after release, without having to go through another MCP enrollment process and for MCP activation to happen as soon as the suspension is lifted.
        - Plan assignments will not be disrupted for existing MCP members who remain in the same county as where they resided before incarceration.
    - *For individuals who <u>do not</u> have Medi-Cal nor an assigned MCP upon entry to the CF,*
        - The individual will be assigned an MCP, triggered by the activation of the JI aid code. The individual's MCP enrollment will be put in a 'hold' status for up to 12 full months of incarceration. This will allow MCP activation to occur as soon as the suspension is lifted.
        - DHCS will auto-assign Medi-Cal-enrolled individuals into an MCP in their county of residence listed on their Medi-Cal application. DHCS will use existing processes to auto-assign individuals into an MCP, including prior plan assignment and plan assignment of family members. If neither of these two criteria enables plan assignment, the individual will be placed into a plan using the default algorithm. Members may switch plans after auto-assignment.
        - Individuals will be sent a confirmation letter with the plan assignment and information on how to change plans, as needed.
2. Communicating Current Month Enrollment to MCPs:
    - Incarcerated individuals with an assigned MCP in a hold will be noted as such in the daily/monthly 834 file which DHCS shares with MCPs. This will be for any JI incarcerated Medi-Cal member with a suspended primary aid code and MCP, not just those with pre-release services.
    - In the daily/monthly 834 file, there will also be a JI indicator which is applied when the JI pre-release service aid code is activated. This is how MCPs will become aware of the JI population for whom they are responsible.

- After an individual is auto-assigned to an MCP, upon release DHCS will activate the individual's plan enrollment for the current month (i.e., if the member is released on April 15, the individual will be enrolled in the plan starting April 1). The MCP must send the individual a welcome packet to the address listed on their Medi-Cal application, including information on how to access the provider directory and member handbook. The MCP must begin to care for the member the day of release (including ECM services provided on the day of release).

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

11.4 Behavioral Health Links

Behavioral health links seek to ensure continuity of treatment for individuals who receive behavioral health services while they were 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. CFs and County Behavioral Health Agencies will work in partnership to facilitate professional-to-professional clinical handoffs to post-release providers and share information with the member's health plan (e.g., county MHP, DMC/DMC-ODS counties, and MCPs as needed) or the provider who will prescribe the medication for substance use disorder.

CFs, county behavioral health agencies, and MCPs are required to implement behavioral health links as set forth in California Penal Code section 4011.11(h)(5) and consistent with the CalAIM Behavioral Health Links initiative *(see page 51 of the CalAIM Proposal and AB 133)* [154] (see ***Section 11.4.c.*** for a breakdown of roles and responsibilities for implementing behavioral health links).

Specifically, behavioral health links include reentry care coordination for JI individuals to the following Medi-Cal delivery systems post-release:

- **SMHS/County MHP:** If an individual is identified as needing MHP services at any point of incarceration, they will qualify for SMHS and require a behavioral health link to a SMHS provider prior to release.
- **DMC/DMC-ODS:** If an individual is identified as needing MAT at any point of incarceration, they will qualify for DMC/DMC-ODS and require a behavioral health link to a county DMC or DMC-ODS provider prior to release. If an

[154] As set forth in California Penal Code section 4011.11(h)(5) and consistent with the CalAIM Behavioral Health Links initiative *(see page 51 of the CalAIM Proposal and AB 133)*.

individual meets the diagnostic criteria for SUD, or if they previously had an SUD diagnosis prior to incarceration,[155] they will qualify for DMC/DMC-ODS and require a behavioral health link to a DMC or DMC-ODS provider prior to release.[156]

- **MCP or FFS Providers:** If an individual has an identified behavioral health need that does not meet criteria for SMHS (e.g., members defined on page 4 of APL 22-006), their mental health needs will be managed by providers through their MCP. These individuals will have their behavioral health link facilitated through the ECM Lead Care Manager.

In order to identify behavioral health needs, CFs and pre-release care managers will be required to screen for mental health and substance use need (see ***Section 6.4*** for additional detail on this screening process). Once the pre-release care manager has completed the full health risk assessment with tools and processes mutually agreed upon by the CF and the county behavioral health agency, the pre-release care manager will determine whether the individual's behavioral health needs either meet the criteria for county behavioral health agency referral (SMHS/MHP, DMC, or DMC-ODS) or will be addressed by non-specialty behavioral health services.

Goals of Behavioral Health Links. Behavioral health links facilitate the initiation or continuation of behavioral health treatment once individuals are released to the community. In order to support a comprehensive, robust, and successful reentry process, behavioral health links should, at a minimum:

- Optimize data sharing between CFs and counties to identify individuals with mental illness and/or SUD.
- Ensure coordination and information sharing related to care plans and transition/discharge plans, scheduling of community-based appointments, and completion of consent forms (including written consent per 42 C.F.R. part 2) among the CF behavioral health providers, the county behavioral health

[155] Aligned with BHIN 23-001, available at: https://www.dhcs.ca.gov/Documents/BHIN-23-001-DMC-ODS-Requirements-for-the-Period-of-2022-2026.pdf

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

agency providers, and, as applicable, the pre-release care manager and ECM provider developing the transition reentry care plan.

- Leverage in-reach clinical consultations[157] to facilitate relationship building prior to release and enable professional-to-professional clinical handoffs with post-release behavioral health treatment providers.
- Ensure there are scheduled/available follow-up appointments with behavioral health providers and necessary prescribers upon release for those with behavioral health needs.
- Ensure the post-release care manager and/or CHW will help individuals connect to any needed services and show up for the behavioral health appointments.
- Facilitate connections between pre-/post-release enhanced care managers and parole/probation officers to ensure they are aware of any connections made with county behavioral health agency providers.

11.4.a Behavioral Health Links and Pre-Release Services

In addition to behavioral health links, CFs will be responsible for ensuring behavioral-health related pre-release services can be provided. Behavioral health-related pre-release services and behavioral health links will be provided in partnership by county behavioral health agencies, pre-release care managers, providers, and CFs. In order to provide needed links to high-need JI individuals, DHCS will require county behavioral health agencies to go-live with behavioral health links on October 1, 2024. The delivery of behavioral health-related pre-release services will not go live until DHCS has deemed a correctional facility ready to go-live per the Readiness Assessment. . Table 17 provides additional detail on the roles and responsibilities of the county behavioral health agency related to each of the activities in the table.

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

Pre-release services that may overlap with those provided by the county behavioral health agencies (if contract is in place between CFs and county behavioral health agencies to provide behavioral health services) include screening/assessment,

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

obtaining consent, and behavioral health treatment – including MAT, clinical consultations, and care management.

- **Medications to treat SUD.** CFs must offer and provide the full scope of medications to treat SUD, and as part of this initiative they will be able to bill/claim for these medications and medication administration in the 90 days prior to release. County behavioral health agency providers may enter into agreements, by mutual consent, with the CFs to provide these services and bill Medi-Cal in the 90 days prior to release.
- **Clinical Consultations.** Under the JI Initiative, CFs must offer clinical consultation services that stabilize and treat the individual and ensure they have a robust reentry care plan and connections. County behavioral health agency licensed practitioners of the healing arts may enter into agreements with the CF, by mutual consent, to provide behavioral health services in the 90 days prior to release, including assessments and treatments as well as professional-to-professional communications and bill Medi-Cal in the 90 days prior to release.
- **Pre-Release Care Management/Post-Release ECM.** Care management is a core function of the JI Initiative. The aim is to provide whole-person care both pre-release and upon reentry, ideally with the same care manager, which, in many cases, can facilitate behavioral health links. Care management during the pre-release period will be done by a pre-release care manager in FFS. Post-release, after enrollment in an MCP, care management will continue with an ECM Lead Care Manager. If the pre-release care manager is not the same person as the ECM Lead Care Manager, a warm handoff will be required prior to release. County behavioral health agency providers may choose to be an ECM provider and also provide pre-release care management. If they are not the pre-release care manager, they are required to work closely with the care manager and post-release ECM provider to ensure behavioral health links occur. To distinguish the whole-person care management roles of the pre-release care manager and post-release ECM Lead Care Manager and the roles of the providers for provision of behavioral health links, see key definitions and roles and responsibilities in ***Section 11.4.c.***

It is the responsibility of CFs to ensure the provision of pre-release services occur. To accomplish this, CFs can contract with other entities, including county behavioral health agencies. Covered behavioral health pre-release services will be delivered, billed to, and paid for via Medi-Cal's FFS delivery system. To provide and bill for pre-release services, providers must enroll in Medi-Cal as a FFS provider. Pre-release services provided by the CF or its contractors will be billed under the correctional health care facility's NPI. Pre-release services provided by non-contracted community-based providers can be billed via Medi-Cal FFS through CA-MMIS, if the provider has enrolled as a Medi-Cal FFS provider.

CFs and county behavioral health agencies are responsible for completing behavioral health links for anyone with an identified SMI/SUD. For professional billable services under behavioral health links (see professional-to-professional clinical handoff in Table 17), county behavioral health agencies may bill Short Doyle, and CFs may bill CA-MMIS. Table 17 outlines the behavioral health-related services that are provided within the CalAIM Justice-Involved Initiative and indicates whether the service is considered part of the pre-release services or behavioral health links requirement.

Table 17. Responsibilities for Pre-Release Services and Behavioral Health Links

Activity	Description of County Behavioral Health Agency[158] Responsibilities	Pre-Release Service for Behavioral Health or Behavioral Health Link
Screening/ Assessments for Behavioral Health Needs	Based on CF capacity, CFs may contract with a county behavioral health agency provider to perform behavioral health assessments. If a CF contracts with a county behavioral health agency to conduct an assessment, the visit must occur within the same timeline as set forth in community standards or outlined in the contract put in place with the CF. The CF may also choose to have a county provider participate as an in-reach provider.	Pre-Release Service for Behavioral Health performed either by: • Correctional facility staff • Correctional facility contracted provider • In-reach provider
Consent	Based on CF capacity, obtain consents, as needed, to provide clinical consultations during the pre-release period.	Pre-Release Service for Behavioral Health performed either by: • Correctional facility staff • Correctional facility contracted provider • In-reach provider
	Based on CF capacity, obtain consents, as needed to assume responsibility for care in the post-release setting and connect individuals to resources as needed.	Behavioral Health Link • Dual responsibility of County Behavioral Health and Correctional facility.

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

Table 17. Responsibilities for Pre-Release Services and Behavioral Health Links		
Activity	**Description of County Behavioral Health Agency[158] Responsibilities**	**Pre-Release Service for Behavioral Health or Behavioral Health Link**
Initial Data Sharing	Based on CF requests: • Provide medical records as appropriate for individuals with treatment history.	Behavioral Health Link • Dual responsibility of County Behavioral Health and Correctional facility.
Behavioral Health Treatment, including MAT, and clinical consultations	Based on CF capacity, CFs may contract with a county behavioral health agency provider to perform timely in-reach behavioral health clinical consultations, assessments, counseling or therapy, Medi-Cal Peer Support Services, medications for substance use disorder, other medications and/or medication administration, and any other DMC/DMC-ODS or SMHS covered service as part of the pre-release service benefit as appropriate. If the CF contacts the county behavioral health agency to conduct behavioral health treatment, the visit must occur within the same timeline as set in community standards or outlined in the contract put in place. If there is not an existing contract in place for these services, CFs may elect to have in-reach providers, who may be county providers, provide these services.	Pre-Release Service for Behavioral Health performed either by: • Correctional facility staff • Correctional facility contracted provider • in-reach provider
Data Sharing	Based on information collected by CF, • Send/receive the CF medical record information and ensure that it is incorporated into post-release medical record. • Identify any individuals who may benefit from BH links.	Behavioral Health Link • Dual responsibility of County Behavioral Health and Correctional facility.

Table 17. Responsibilities for Pre-Release Services and Behavioral Health Links		
Activity	**Description of County Behavioral Health Agency[158] Responsibilities**	**Pre-Release Service for Behavioral Health or Behavioral Health Link**
Release Planning	• If the individual consents, schedule a follow-up appointment date/time/location within a clinically appropriate window, as defined by the care manager with input from clinical providers. Follow-up appointments should be scheduled no later than 1 business day after recommended timeline for urgent needs (e.g., medications for SUD) and no later than 1 week for less urgent needs (e.g., a stabilized SMI follow-up appointment) For example, based on a practice that occurs today, a behavioral health provider can meet an individual immediately upon their release at the correctional facility and escort them to follow-up behavioral health care. • Work with the MCP, as appropriate, to ensure transportation to appointment has been arranged.	Behavioral Health Link • Dual responsibility of County Behavioral Health and Correctional facility.
Professional-to-Professional Clinical Handoff	• Participate in care transitions meeting, facilitated by the pre-release care management team, for any client that has been identified by correctional staff, care manager, or clinical consultants as needing additional team coordination (e.g., clients identified to have high/complex needs). o This could include BH team members such as psychiatrists, psychologists, LSCWs, behavioral health care managers (Targeted	Behavioral Health Link • Dual responsibility of County Behavioral Health and Correctional facility. **Billable by the county behavioral health agency through Short Doyle and by CF through CA-MMIS**

Table 17. Responsibilities for Pre-Release Services and Behavioral Health Links		
Activity	**Description of County Behavioral Health Agency[158] Responsibilities**	**Pre-Release Service for Behavioral Health or Behavioral Health Link**
	Case Management - TCM), or peer supports. *DHCS understands there may be workforce capacity constraints to complete this activity for all eligible individuals. DHCS will require that a good faith effort must be made to connect individuals to a post-release behavioral health provider and that effort must be documented.*	
Follow-Up Post-Release	• Offer to schedule the individual for appointments on an ongoing basis as needed, within clinically appropriate timeframe, no later than 3 days later than recommended follow-up. • Work with the MCP to ensure they have adequate transportation to appointment.[159] • If the individual does not come to appointment, follow-up with the individual, consider deploying Certified Peer Support Specialist, and work with post-release ECM Lead Care Manager to reschedule as soon as possible for individual.	Behavioral Health Link • Responsibility of County Behavioral Health Agency **Billable by the county behavioral health agency through Short Doyle**

11.4.b Minimum Requirements for Behavioral Health Links

To achieve continuity of treatment for individuals who receive behavioral health services while incarcerated, and who will continue to receive behavioral health services from SMHS, DMC, and/or DMC-ODS in the community, DHCS will require CFs and county behavioral health agencies to work in partnership to facilitate behavioral health links to post-release behavioral health agency providers and share information with the

[159] Information on MCPs responsibility to provide NEMT is available here: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-008.pdf

individual's behavioral health agency plan (e.g., county MHP, DMC/DMC-ODS counties, and MCPs as needed).[160]

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

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

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

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

11.4.c Roles and Responsibilities

Table 18 outlines the roles, responsibilities, and requirements for CFs, county behavioral health agencies and their providers, care managers, and MCPs in order to operationalize this process. DHCS understands that the provision of these services is dependent on the individual's length of stay. DHCS will provide additional detail on provision of services in the short-term model guidance. At a minimum, DHCS requires asynchronous data exchange and care coordination (e.g., the CF or pre-release care manager coordinates with the county behavioral health agency on identification of behavioral health needs, appointment scheduling, referral, etc.) for individuals with an active JI aid code for at least 7 days.

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

- **Correctional Embedded Clinical Staff.** A clinical provider employed or directly contracted by the CF (e.g., private contractor or provider contracted County BH provider (see embedded provider definitions in ***Sections 9.5 and 10.1.a***)) to provide health care services (physical health and behavioral health) in the CF.
- **County Behavioral Health Agency:** Under the JI initiative, a county-based health agency, that pays for specialty mental health or substance use disorder services delivered by County Behavioral Health Providers. These include MHPs and DMC and/or DMC-ODS operating in their capacity as a payer and not as a provider. For example, paying for clinical services (i.e., professional-to-professional clinical handoff), arranging for the provision of SMHS, or contracting with providers).
- **County Behavioral Health Agency Provider.** A behavioral health provider provides services paid by County Behavioral Health Agencies either as a county-operated or county-contracted provider. Under the JI initiative, if the behavioral health provider is providing pre-release services, they are not acting under the county's behavioral health agency, but either under the CF (correctional facility) as a contractor, or as an independent in-reach, community-based provider. Under the JI initiative, county behavioral health providers will be paid through Medi-Cal FFS rather than through the County Agency.
- **County Behavioral Health Plan.** County based health plan, inclusive of MHPs and DMC and/or DMC-ODS operating in their capacity as a plan and not as a provider (e.g., arranging provision of SMHS, contracting/credentialing providers, etc.)
- **Pre-Release Care Manager.** The person who will act as the primary point of contact to ensure whole-person reentry services are provided as outlined by the CalAIM JI policy. The care manager will work, as appropriate, with other providers, including CF providers, post-release care managers, county

behavioral health agency providers, and the MCP care manager if different from the pre-release care manager.

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

Table 18. Proposed Roles and Responsibilities for Behavioral Health Links					
Process	**Correctional clinical staff** (including behavioral health clinical staff)	**Behavioral health provider** (may be county employed or county-contracted)	**Pre-release Care Manager**[161] (ideally same provider as post-release ECM provider)	**Post-release ECM Care Manager** (ideally same as in-reach care manager)***, with MCP oversight responsibility***	**County Behavioral Health Plan**
Identification of Behavioral Health Need and Coordination of Treatment Pre-Release					
Screening and assessing for behavioral health needs	At screening and assessment, identify anyone with behavioral health needs and stratify to the best of their ability: 1. Anyone who qualifies for SMHS, using the state-provided tool. 2. Anyone who qualifies for DMC/DMC-ODS services, based on medical need. 3. Those with behavioral health needs that do not qualify for SMHS or DMC/DMC-ODS services and will be	Perform behavioral health assessments at CF if contracted to do so. If a CF contacts the county behavioral health agency to conduct an assessment, the visit must occur within normal community standards or as written in the contract.	Provide a comprehensive needs assessment, inclusive of identifying any behavioral health needs through standardized screening tools and any further needed assessments. If not already done, identify those who have been treated in the community for behavioral health and identify their provider.	NA	Only participates if under contract with CF, billing would be submitted by CF.

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

Table 18. Proposed Roles and Responsibilities for Behavioral Health Links					
Process	**Correctional clinical staff** (including behavioral health clinical staff)	**Behavioral health provider** (may be county employed or county-contracted)	**Pre-release Care Manager**[161] (ideally same provider as post-release ECM provider)	**Post-release ECM Care Manager** (ideally same as in-reach care manager)***, with MCP oversight responsibility***	**County Behavioral Health Plan**
	served through an MCP (members defined on page 4 of APL 22-006). Identify those who have been treated in the community for behavioral health and identify their provider.				
Consent	Obtain any needed consents related to receiving information from prior providers, the county behavioral health plan, and/or the MCP. Obtain any needed consent to share information with a county behavioral	Obtain consents as needed to share the requisite information with any care team member/insurance.	Obtain consents as needed to gather information or share the requisite information with any care team member/ insurance.	NA	NA

Table 18. Proposed Roles and Responsibilities for Behavioral Health Links					
Process	**Correctional clinical staff** (including behavioral health clinical staff)	**Behavioral health provider** (may be county employed or county-contracted)	**Pre-release Care Manager**[161] (ideally same provider as post-release ECM provider)	**Post-release ECM Care Manager** (ideally same as in-reach care manager)***, with MCP oversight responsibility***	**County Behavioral Health Plan**
	health agency, the MCP, a care manager, and the county behavioral health agency provider, as indicated. Note that consent will need to be specifically obtained to share SUD data (42 C.F.R. part 2).				
Initial data sharing	**All Correctional Facilities:** If the individual has been identified as having received treatment in the community prior to incarceration, the correctional clinical/ support staff must make best efforts to contact the prior treating provider within two business days to	Share medical records as applicable and allowable under federal and state regulations.	**Care Managers Across All Correctional Facilities:** If the individual has been identified as having received treatment in the community prior to incarceration, the care manager must contact the prior treating provider(s) if not already done by the correctional facility to obtain treatment	NA	If the correctional facility or pre-release care manager is unable to identify or obtain records directly from the prior treating behavioral health provider, the county behavioral health agency can identify the prior treating

Table 18. Proposed Roles and Responsibilities for Behavioral Health Links					
Process	**Correctional clinical staff** (including behavioral health clinical staff)	**Behavioral health provider** (may be county employed or county-contracted)	**Pre-release Care Manager**[161] (ideally same provider as post-release ECM provider)	**Post-release ECM Care Manager** (ideally same as in-reach care manager)***, with MCP oversight responsibility***	**County Behavioral Health Plan**
	obtain treatment records, outreach efforts should be documented.		records. Care managers should then review all available records related to behavioral health care (community and correctional facility) and use that information when developing the health risk assessment and care plan. Care manager should also notify MCP (if enrolled), county behavioral health agency (if implicated) that care coordination is occurring, as necessary. **Care Managers for Jails:** If an individual has an identified behavioral health need, the care manager must contact the county behavioral		provider as necessary. Share medical records as appropriate for individuals with a treatment history. Notify the MCP (if enrolled) that county behavioral health care coordination is occurring, as necessary

Table 18. Proposed Roles and Responsibilities for Behavioral Health Links					
Process	**Correctional clinical staff** (including behavioral health clinical staff)	**Behavioral health provider** (may be county employed or county-contracted)	**Pre-release Care Manager**[161] (ideally same provider as post-release ECM provider)	**Post-release ECM Care Manager** (ideally same as in-reach care manager)***, with MCP oversight responsibility***	**County Behavioral Health Plan**
			health agency in the county they will be released to, their prior county-contracted behavioral health provider if applicable, and their MCP (if already enrolled) two business days to alert them that they have an individual who will need behavioral health links at release; the care manager should request prior patient information, as available, and share patient information with relevant health plans. **Care Managers for CDCR:** If an individual is part of the Mental Health		

Table 18. Proposed Roles and Responsibilities for Behavioral Health Links					
Process	**Correctional clinical staff** (including behavioral health clinical staff)	**Behavioral health provider** (may be county employed or county-contracted)	**Pre-release Care Manager**[161] (ideally same provider as post-release ECM provider)	**Post-release ECM Care Manager** (ideally same as in-reach care manager)***, with MCP oversight responsibility***	**County Behavioral Health Plan**
			Services Delivery System and/or receiving ISUDT, CDCR must, within 30 to 60 days prior to the individual's release, contact the county behavioral health agency in the county they will be released to and share relevant patient information. **Care Managers for YCFs:** If a youth is found to have a behavioral health need during incarceration, the probation officer must contact the county behavioral health agency in the county they will be released to, their prior county-contracted behavioral health		

Table 18. Proposed Roles and Responsibilities for Behavioral Health Links					
Process	**Correctional clinical staff** (including behavioral health clinical staff)	**Behavioral health provider** (may be county employed or county-contracted)	**Pre-release Care Manager**[161] (ideally same provider as post-release ECM provider)	**Post-release ECM Care Manager** (ideally same as in-reach care manager)***, with MCP oversight responsibility***	**County Behavioral Health Plan**
			provider if applicable, their CHW if applicable, and their MCP (if enrolled) to alert them that they have an individual who will need a behavioral health link at release and to share the patient's information.		
Pre-Release Treatment					
Behavioral health treatment, including medications for SUD, clinical consultations, and care management	Provide in-reach care or support for any necessary ongoing behavioral health needs, including assessments, counseling or therapy, peer support services, medications for SUD, other medications and/or medication administration, and any	If contracted or requested by a correctional facility, provide in-reach behavioral health clinical consultations, assessments, counseling or therapy, peer support services, medications for SUD, other medications and/or medication	Identify and coordinate any needed clinical consultations or behavioral health needs to stabilize individuals in preparation for release. Identify high-risk clients who would benefit from clinical consultation, to establish therapeutic relationships with their	If different from the pre-release care manager, coordinate on the treatment plan and clinical consultation needs.	Only participates if under contract with correctional facility to provide treatment services, billing would be submitted by correctional facility.

Table 18. Proposed Roles and Responsibilities for Behavioral Health Links					
Process	**Correctional clinical staff** (including behavioral health clinical staff)	**Behavioral health provider** (may be county employed or county-contracted)	**Pre-release Care Manager**[161] (ideally same provider as post-release ECM provider)	**Post-release ECM Care Manager** (ideally same as in-reach care manager)***, with MCP oversight responsibility***	**County Behavioral Health Plan**
	other DMC/DMC-ODS service or SMHS covered as part of the pre-release services benefit as appropriate. Correctional facilities (and probation officers for YCFs) must facilitate appointments with county behavioral health agencies and community-based behavioral health providers as needed.	administration, and any other DMC/DMC-ODS service or SMHS covered as part of the pre-release services benefit as appropriate.	post-release behavioral health provider and schedule in-reach clinical consultations for those individuals.		
Behavioral Health Links					
Data sharing for release	For ALL members with behavioral health needs, share clinical information, including medications, diagnoses, and	Identify any individuals who may benefit from a transitional care team meeting.	For ALL clients with behavioral health needs, incorporate their clinical information into the care plan. Maintain copies to ensure that appropriate	For ALL clients with behavioral health needs, coordinate with the pre-release care manager (if different from the post-	For ALL clients with behavioral health needs, receive and ensure that their

Table 18. Proposed Roles and Responsibilities for Behavioral Health Links					
Process	**Correctional clinical staff** (including behavioral health clinical staff)	**Behavioral health provider** (may be county employed or county-contracted)	**Pre-release Care Manager**[161] (ideally same provider as post-release ECM provider)	**Post-release ECM Care Manager** (ideally same as in-reach care manager)***, with MCP oversight responsibility***	**County Behavioral Health Plan**
	pertinent treatment notes, with receiving providers, health plans, and care managers.		care team members have the needed information. Work with clinical staff to identify any individuals who may benefit from a transitional care team meeting.	release care manager) on the care plan. For identified complex clients with high needs: Participate in the care team transition meeting for any client who has been identified by correctional staff, the care manager, or clinical consultants as needing additional team coordination.[162]	clinical information is part of the client medical record to facilitate seamless treatment after release.
Release planning	Identify an appropriate time frame for needed follow-up, and assist		Schedule follow-up appointments and identify the appropriate	Work with the pre-release care manager (if different), the client, and	Offer follow-up appointment date, time, and location

[162] Care team transition meetings must include all relevant care team members. For example, in the reentry care coordination meeting both the embedded and in-reach providers are required, but the post-release ECM provider does not have to be present. If the post-release ECM provider is not present, they should receive communication from the professionals regarding the results of the meeting, as relevant to their role (e.g., information that needs to be updated in the individual's reentry care plan).

Table 18. Proposed Roles and Responsibilities for Behavioral Health Links					
Process	**Correctional clinical staff** (including behavioral health clinical staff)	**Behavioral health provider** (may be county employed or county-contracted)	**Pre-release Care Manager**[161] (ideally same provider as post-release ECM provider)	**Post-release ECM Care Manager** (ideally same as in-reach care manager)***, with MCP oversight responsibility***	**County Behavioral Health Plan**
	the pre-release care manager as needed with scheduling follow-ups and any needed transportation.		time frames for needed follow-up. Schedule transportation to all needed appointments. Perform screening/ assessment with tools and processes mutually agreed upon by the correctional facility and county behavioral health agency, to identify the appropriate level of follow-up care. If different from the post-release care manager, ensure the post-release care manager is aware of all needed follow-up appointments and assist in scheduling.	the probation/parole officer as needed to ensure scheduled appointments will work for the client. Ensure transportation is arranged for all follow-up appointments. **Best Practice:** If the behavioral health provider is unable to meet the individual, the care manager should meet the individual in the lobby upon release and escort them to follow-up care.	within a clinically appropriate time but no later than three days after the recommended follow-up (e.g., for someone on medications for SUD with a recommended follow-up of the next day post-release, the appointment must be within four days post-release). Ensure transportation to the appointment has been arranged. **Best Practice:** The behavioral health

Table 18. Proposed Roles and Responsibilities for Behavioral Health Links					
Process	**Correctional clinical staff** (including behavioral health clinical staff)	**Behavioral health provider** (may be county employed or county-contracted)	**Pre-release Care Manager**[161] (ideally same provider as post-release ECM provider)	**Post-release ECM Care Manager** (ideally same as in-reach care manager)***, with MCP oversight responsibility***	**County Behavioral Health Plan**
					provider should meet the individual in the lobby upon release and escort them to follow-up care.
Professional-to-professional clinical handoff	For complex clients with high needs[163] who have been identified as such by in-reach clinical consultants, the care manager, or correctional staff, participate in the care team transition meeting with the correctional facility behavioral health provider, the	For identified complex clients with high needs, as requested by the county health plan, participate in the care team transition meeting for any client who has been identified by correctional staff, the care manager, or clinical consultants as	For identified complex clients with high needs, schedule, coordinate, and participate in the care team transition meeting for any client who has been identified by correctional staff, the care manager, or clinical consultants as needing additional team coordination.	For identified complex clients with high needs, participate in the care team transition meeting for any client who has been identified by correctional staff, the care manager, or clinical consultants as needing additional team coordination. Professional-to-	For identified complex clients with high needs, identify providers appropriate to participate in Professional-to-professional clinical handoff and facilitate scheduling and data sharing.

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

Table 18. Proposed Roles and Responsibilities for Behavioral Health Links					
Process	**Correctional clinical staff** (including behavioral health clinical staff)	**Behavioral health provider** (may be county employed or county-contracted)	**Pre-release Care Manager**[161] (ideally same provider as post-release ECM provider)	**Post-release ECM Care Manager** (ideally same as in-reach care manager)***, with MCP oversight responsibility***	**County Behavioral Health Plan**
	county behavioral health agency provider, the care manager/ECM provider, and the client as appropriate.	needing additional team coordination. This may include an intake or clinical visit with the client to establish a therapeutic relationship prior to release.	Professional-to-professional clinical handoff should also include follow-up planning, such as confirming transportation to scheduled appointments, follow-up or touch points in advance or following a missed appointment, and assigning a CHW.	professional clinical handoff should also include follow-up planning, such as confirming transportation to scheduled appointments, follow-up or touch points in advance or following a missed appointment, and assigning a CHW.	
Follow-up post-release	Provide any needed information/ communication to the treating provider post-release to ensure there are no disruptions in needed care.	Offer to schedule the individual within a clinically appropriate time frame, no later than three days after the recommended follow-up. Ensure they have adequate transportation to the appointment. If the	If the clinical handoff to the post-release care manager/ECM provider has not occurred, assist the individual with transportation to all needed appointments and ensure a professional-to-professional clinical	Ensure individuals get to all needed appointments and have all needed medications and services.	Offer to schedule the individual within a clinically appropriate time frame, no later than three days after the recommended follow-up. Ensure they have adequate

Table 18. Proposed Roles and Responsibilities for Behavioral Health Links					
Process	**Correctional clinical staff** (including behavioral health clinical staff)	**Behavioral health provider** (may be county employed or county-contracted)	**Pre-release Care Manager**[161] (ideally same provider as post-release ECM provider)	**Post-release ECM Care Manager** (ideally same as in-reach care manager)***, with MCP oversight responsibility***	**County Behavioral Health Plan**
		individual does not show up for the appointment, follow up with them, consider deploying a CHW, and work with the ECM provider to reschedule as soon as possible for the individual.	handoff with the ECM provider occurs.		transportation to the appointment. If the individual does not show up for the appointment, follow up with them, consider deploying a CHW, and work with the ECM provider to reschedule as soon as possible for the individual.

12. Monitoring and Evaluation

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

- **Justice and Social Services Agency Readiness Assessments.** DHCS will require CFs and county SSDs, prior to launching pre-release services, to complete two readiness assessments that will gauge their readiness to comply with the waiver's program and regulatory requirements. The first readiness assessment, conducted in December 2022, focused on the implementation of pre-release Medi-Cal applications. The second readiness assessment will focus on correctional facilities' and county SSDs' readiness to support pre-release services, including assessments for pre-release services eligibility, service delivery, care management and coordination, and reentry planning. DHCS will use the findings from the readiness assessments to evaluate compliance with program and statutory requirements and identify any gaps that need to be addressed, see ***Section 5*** for more information on the readiness assessment.
- **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 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 individual providers' ordering and prescribing activities: DHCS will conduct oversight and monitoring of such providers who are not enrolled in Medi-Cal but are referring, ordering, or prescribing under the correctional facility exempt from licensure clinic. DHCS will continue to require individual level NPIs of the ordering, referring, or prescribing providers on all orders, referrals (as required), and prescriptions. DHCS will track the DME orders

and prescriptions (covered as pre-release services) for unusual prescribing and ordering processes.

- **Implementation Technical Assistance.** DHCS will deliver technical assistance to correctional facilities and county SSDs as they plan to implement the JI Initiative. Technical assistance will be available prior to the launch of pre-release services, to support stakeholders in their implementation planning and compliance with section 1902(a) and other requirements. DHCS will also deliver more targeted and intensive technical assistance to counties and facilities where capability and/or compliance gaps are identified through the readiness assessments. DHCS plans to provide 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 require correctional facilities and County SSDs to submit data on DHCS-specified measures to monitor program performance and integrity. DHCS will establish a comprehensive monitoring approach for this initiative, in alignment with its CMS approved monitoring protocol and State monitoring priorities. While DHCS has not yet received CMS' Reentry Monitoring Protocol Template, it is committed to tracking number and types of physical and behavioral health services and medications that an individual has received in the post-release period. DHCS will provide additional information on CMS required monitoring metrics once available. It is expected that DHCS' Monitoring Protocol will include:
    - A selection of quality-of-care and health outcomes metrics and population stratifications based on CMS' upcoming guidance on the Health Equity Measure Slate.
    - Standardized reporting on categories of metrics, including but not limited to beneficiary participation in demonstration components, number of primary and specialist provider participation, utilization of services, quality of care, and health outcomes.
    - Metrics related to:
        - Number of beneficiaries served, and types of services rendered under the demonstration.
        - Administration of screenings to identify individuals who qualify for pre-release services.
        - Utilization of applicable pre-release and post-release services (e.g., care management, MAT, clinical/behavioral health assessment pre-release and primary and behavioral health services post-release).
        - Provision of health or social service referral pre-release.
        - Participants who received care management pre-release and were enrolled in care management.

        - Take-up of data system enhancements among participating carceral settings.
    - Methods and timeline to collect and analyze non-Medicaid administrative data to help calculate applicable monitoring metrics.

Post-Release Service Monitoring: DHCS will track 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). Additional guidance on DHCS's approach to monitoring and oversight will be released at a later date.

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

13.1 Overview

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

The care management model has four primary goals:

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

The care management model begins with pre-release care management services available during the 90 days prior to an individual's release, which is paid for on a fee-for-service (FFS) basis by Medi-Cal. As further described in ***Section 8.4***, to ensure continuity of care between the pre- and post-release period, the pre-release care manager will either:

- Serve as the individual's post-release ECM Lead Care Manager; or
- Closely coordinate with the individual's post-release ECM provider,[164][165] which includes conducting a warm handoff with the post-release ECM Lead Care Manager. While the targeted set of Medicaid pre-release services will be billed FFS, MCPs and ECM providers will play a key role as individuals transition from pre-release services into the community, and receive ECM services, upon release. [166] This section of the Policy and Operational Guide describes how the CalAIM Justice-Involved Initiative implicates MCPs and outlines activities that MCP must execute to stand up and implement the Initiative on an ongoing basis.

[164] Note that individuals who are not enrolled in an MCP will not receive ECM, since ECM is an MCP benefit, but they may receive another type of care management. Populations that are not enrolled in managed care will not receive post-release ECM services. Populations exempt from required enrollment in managed care include AI/AN, former foster care youth, and children/youths in foster care, depending on the county.
[165] The ECM Lead Care Manager is the individual provider delivering ECM services. The ECM provider is the organization that provides ECM. Please see the ECM Policy Guide (updated July 2023) for additional detail.
[166] Note that while ECM will become available to the individual once their MCP enrollment has been effectuated, correctional facilities and MCPs will begin the process of assigning an individual to an ECM provider prior to release and MCP enrollment.

Specifically, the section outlines MCP responsibilities for implementing ECM for the Individuals Transitioning from Incarceration (JI) Population of Focus (POF) (hereinafter "JI POF") and the required infrastructure that MCPs must establish to ensure MCPs are able to successfully provide ECM to the JI POF, as close to the day of release as possible.[167] The section is organized into four sub-sections, with data sharing requirements woven throughout each:

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

MCPs may reference the ECM Policy Guide (updated July 2023) for additional information regarding ECM. Where there are differences between ECM policy for all POFs (as articulated in the ECM Policy Guide) and JI ECM policy for the JI POF (as articulated in the Policy and Operational Guide for Planning and Implementing CalAIM Justice Involved Initiative), JI POF-specific guidance supersedes.

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

ECM for the JI POF will go live on January 1, 2024. On this date, MCPs must be prepared to begin providing ECM for the JI POF, which includes:

1. Establishing a sufficient network of JI ECM providers that meet DHCS' definition of "JI ECM Provider" and that meet capacity needs for JI ECM providers in the county in which the MCP operates (based on level of need that will exist prior to the go-live of pre-release services);
2. Establishing JI ECM provider network overlap across MCPs in each county (in counties with more than one MCP); and
3. Updating the MCP's public provider directory to include information about each in-network JI ECM provider.

- Note that January 1, 2024 precedes the go-live of pre-release services for the JI POF. Individuals who meet the JI POF eligibility criteria will be eligible for ECM prior to when pre-release services go live in correctional facilities (i.e., through referrals; see ***Section 13.3.b***).

- Correctional facilities may begin to provide pre-release services as early as April 1, 2024, once DHCS has determined the facility is ready to go live, based on the facilities' readiness assessment (see ***Section 5***). Facilities' go-live timelines will be phased in over two years, with all correctional facilities being required to go live by March 31, 2026. DHCS will maintain a public facing dashboard which will include information on which correctional facilities have met readiness requirements and are

[167] MCPs must also ensure that required services are available on the day of release, as clinically indicated, including seeking prior authorization for services such as Community Supports.

ready to go-live. By April 1, 2024, MCPs will be required to begin to provide services to individuals who received pre-release services and coordinate with correctional facilities to support members as they transition into managed care and ECM.

- For a comprehensive breakdown of effective dates for JI MCP Requirements, please refer to Table 17 in ***Section 13.6***.

13.1.b. JI ECM Model of Care Template Requirement

All MCPs must complete the JI ECM Model of Care Template, which DHCS will use to assess each MCP's readiness to implement ECM for the JI POF.[168] The MOC follows the same format and sections as this Section of the Policy and Operational Guide. MCPs should refer to this section as they complete their MOC for policy details.

Each section of the MOC includes an attestation table; a number of sections also include narrative questions which MCPs must complete to attest to their readiness to implement ECM for the JI POF. If the MCP does not have policies and procedures in place to implement a requirement, they will have the opportunity to request technical assistance from DHCS.

MCPs must also complete a Provider Capacity Attachment which will detail the MCP's provider networks via a fillable Excel form.

In addition, MCPs may submit a Provider Exception Attachment, consisting of a narrative question, which DHCS will use to assess exceptions to JI ECM provider network overlap requirements on a case-by-case basis. Note that, for the JI POF, MCPs may not request exception to provide plan-based ECM.

13.1.c. MCP Coordination with Correctional Facilities

MCPs must have operational processes in place to engage and coordinate with correctional facilities, including state prisons, county jails, and youth correctional facilities. For county jails and youth correctional facilities in the MCP's county of operation, MCPs must work with the correctional facility (CF) to establish mutually agreed upon mechanisms for coordination (e.g., operational protocols, monthly case conference meetings, and/or regional implementation collaboratives which should include the correctional facilities, MCPs, and county-based plans in the region).

DHCS will require MOUs between MCPs and correctional facilities in their counties or regions of operation, including state prisons; additional details, including a timeline for when this requirement must be implemented, will be shared once a model MOU has been released by DHCS. Until that point, MCPs do not need to execute MOUs or contracts with correctional facilities in their county or region of operation.

[168] Please find the draft JI ECM Model of Care here. This link will be updated to the final JI ECM Model of Care in the final JI Policy and Operational Guide.

In instances in which the MCP receives an individual from a CF located in a different county/region with whom they do not have mutually agreed upon operational processes and/or an MOU in place for coordination, the MCP and the CF must establish formal communication and coordinated operational processes to serve that specific member. MCPs and correctional facilities located in a different county/region are not required to establish a MOU. In the future, DHCS may implement requirements for formal agreements between MCPs and any correctional facilities not in their county of operation who are primary referrers to that MCP.

13.2. ECM Network Development and Reporting

MCPs are responsible for administering ECM for the JI POF in the community (i.e., once an individual is released from incarceration). To do so, MCPs must establish a JI ECM provider network in each county in which they operate. This section lays out MCP requirements for developing its JI ECM provider network.

13.2.a. Minimum Requirements for JI ECM Providers

A key objective of the CalAIM Justice-Involved Initiative care management model is ensuring continuity of care between the pre- and post-release periods. In order to promote both continuity and quality of care management, DHCS will require MCPs to ensure that all providers with which they contract to provide ECM for the JI POF meet minimum expectations. MCPs may leverage their provider contracts as a tool to ensure that all providers meet minimum expectations. DHCS will provide standard boilerplate language that MCPs can leverage in JI ECM provider contracting.

The minimum requirements to be considered a JI ECM provider are listed below:

1. **Meet Standard ECM Provider Requirements.** All contracted JI ECM providers must meet the standard requirements to be considered an ECM provider as laid out in the ECM Policy Guide (updated July 2023).[169] See also Policy and Operational Guide ***Section 13.2.c,*** Table 16 which outlines alignment between JI ECM Provider minimum requirements and existing requirements for ECM providers in the ECM Policy Guide.
2. **Participate in Pre-Release Care Management Services and Warm Handoffs.**[170]
    a. If the correctional facilities in the counties in which the JI ECM provider operates use an in-reach care management model:
        i. JI ECM providers must offer pre-release care management services as in-reach care management providers.

[169] See ECM Policy Guide (updated July 2023).
[170] Note that prior to the launch of pre-release services, MCPs need only attest and confirm that the JI ECM providers in their network will be able to meet this requirement when pre-release services go live in their county.

ii. The post-release ECM Lead Care Manager must be the same person as the pre-release in-reach care manager.[171]
    1. For instances in which the in-reach pre-release care manager cannot continue to serve as the individual's post-release ECM Lead Care Manager (e.g., an individual unexpectedly changes planned release location to a county the pre-release care manager does not serve, or the pre-release care manager leaves their position and thus cannot continue as a post-release ECM Lead Care Manager), the in-reach pre-release care manager must conduct a warm handoff to the post-release ECM Lead Care Manager.

b. If the correctional facilities in the counties in which the JI ECM provider operates use an embedded care management model:
    i. The post-release ECM Lead Care Manager must conduct a warm handoff with the pre-release embedded care manager (e.g., CF care management provider). The warm handoff should take place during the pre-release period, if possible ***(See Section 8.4.e)***.

DHCS will develop and maintain a publicly-accessible report on the DHCS JI website to display the pre-release service go-live date for correctional facilities in each county, updated on a quarterly basis. The report will include information on whether each facility plans to pursue an in-reach or embedded care management model.

3. **Bill FFS for all Pre-Release Care Management Services and Warm Handoffs.**[172] All JI ECM providers must ensure that claims for any pre-release care management services and/or warm handoffs rendered by their providers are submitted under FFS. To meet this requirement, all JI ECM providers must **either**:
    a. Enroll through the Provider Application and Validation for Enrollment (PAVE) system in order to provide FFS Medi-Cal services.
        i. A Medi-Cal enrollment pathway for CBOs that serve as JI ECM providers in PAVE is under development by DHCS.[173]
    b. Contract with the CF to provide pre-release services.
        i. DHCS understands that some JI ECM providers may not want to enroll as FFS providers. ECM providers who may not want to enroll

[171] Individuals should be assigned an in-reach pre-release care manager based on the individual's planned county of release. DHCS acknowledges that there may be last-minute changes to planned county of release, after an individual is already working with an in-reach pre-release care manager that does not operate in the new county of release, that will necessitate a warm handoff.
[172] Note that prior to the launch of pre-release services, MCPs need only attest and confirm that the JI ECM providers in their network will be able to meet this requirement once pre-release services go-live.
[173] The PAVE CBO enrollment pathway will be online with enough time for providers to submit applications by April 2024.

in FFS may contract directly with correctional facilities to provide services and bill under the CF NPI (see ***Section 9.5***).[174]

c. See ***Section 13.2.b*** for details on a glidepath to meeting JI ECM provider enrollment requirements.

As a best practice, DHCS recommends that MCPs prioritize contracting with JI ECM providers that employ individuals with lived experience, including community health workers (CHWs).[175]

13.2.b. JI ECM Provider Enrollment Glidepath

As the JI initiative is implemented incrementally over a two-year period, DHCS expects that the demand for JI ECM providers will increase over time and understands the challenges associated with establishing a robust network of ECM providers equipped to serve the unique needs of the JI POF. DHCS requires that MCPs have a sufficient network of JI ECM providers to meet the capacity needs in their county of operation. Specifically:

- Prior to the launch of pre-release services statewide, JI ECM providers do not need to be enrolled in FFS or contracted with correctional facilities to provide in-reach services/warm handoffs. They must only attest to their ability and willingness to do so once pre-release services go-live.
- At the launch of pre-release services, if the correctional facilities in the MCP's county of operation are not yet live, the MCP must have only a sufficient JI ECM provider network to serve individuals who have received pre-release services in another county and are released into the MCP's county of operation (e.g., if a member is enrolled in an MCP in Alameda County, where they live, but is incarcerated in San Francisco County Jail, once San Francisco County Jail is live with pre-release services, the MCP in Alameda County must have sufficient network capacity so that their ECM providers can participate in a warm handoff with the pre-release care manager and individual incarcerated in San Francisco County Jail. The individual will then receive ECM in Alameda County upon release).
- When pre-release services are live in the MCP's county of operation, MCPs must ensure that their network consists of sufficient JI ECM providers that are either (1) enrolled as FFS providers to conduct in-reach pre-release care management and/or facilitate warm handoffs or (2) contracted with correctional facilities to conduct embedded care management or warm handoffs.

DHCS expects that capacity needs will be low prior to the go-live of facilities in the MCP's county of operation. As such, MCPs will have an opportunity to ramp up network capacity over time as correctional facilities in their counties of operation go live. As a

[174] All JI ECM Providers providing pre-release services or warm handoffs are considered in-reach providers. This includes any JI ECM providers that are submitted claims under FFS via establishing a contract with the CF.
[175] DHCS understands that MCPs may encounter barriers to contracting with providers that employ individuals with lived experience, so this is considered a best practice, as opposed to a requirement.

best practice, DHCS encourages engaging and partnering with existing providers[176] who serve the JI population to identify and train ECM providers to serve the JI POF.

13.2.c. Alignment with ECM Provider Requirements

As described in ***Section 13.2.a***, in addition to meeting standard ECM Provider requirements, JI ECM providers are also subject to JI-specific requirements, as outlined in Table 19.

Table 19. Minimum ECM Provider Requirements

Examples of Requirements that Apply to All ECM Providers[177]	Additional Requirements and Recommendations that Apply to JI ECM Providers
Enroll through state-level Medi-Cal enrollment pathway.	• For the JI POF, all JI ECM providers must either:[178] o Enroll through the PAVE system in order to provide FFS Medi-Cal services; or o Establish contracts with correctional facilities in the counties in which they operate to serve as a contracted embedded care manager, which includes being able to bill under the CF NPI.
Have experience serving the POF.	JI ECM Providers must have experience serving the JI POF and a JI-specific model of care. Examples of what experience serving the JI POF include: • Experience working with correctional facilities (prisons, jails, YCFs) • Experience working with probation and parole • Experience serving populations with disproportionate levels of contact with the justice system • Employment of individuals with lived experience in the justice system, including community health workers (CHWs)[179]

[176] Example providers that serve the JI population include, but are not limited to: Amity Foundation, HealthRight 360, Neighborhood House Association - Project In-Reach, California Association of Alcohol and Drug Program Executives, Transitions Clinic Network, and WestCare,
[177] The full set of ECM provider requirements can be found in the ECM Policy Guide (updated July 2023).
[178] DHCS has established a glidepath to this requirement. See Section 13.2.a for additional details.
[179] DHCS understands that MCPs may encounter barriers to contracting with providers that employ individuals with lived experience, so this is considered a best practice, as opposed to a requirement.

Table 19. Minimum ECM Provider Requirements	
Examples of Requirements that Apply to All ECM Providers[177]	**Additional Requirements and Recommendations that Apply to JI ECM Providers**
	Please note the above are intended as illustrative examples; MCPs should share additional information on how they define "experience with the JI POF" in their JI ECM Model of Care Template. MCPs should determine what they deem as "sufficient experience" and should think creatively about how to engage providers with JI-specific experience. *As a best practice and as noted above, DHCS encourages engaging and partnering with existing providers*[180] *who serve the JI population to identify and train ECM providers to serve the JI POF.*
Have capacity to provide culturally appropriate and timely in-person care management activities.	No additional requirements or recommendations that apply to JI ECM providers.
Have formal agreements and processes in place to engage and cooperate with other entities to coordinate care as appropriate for each member.	MCPs must have operational processes in place to engage and coordinate with correctional facilities (e.g., monthly case conference meetings, data sharing agreements). See ***Section 13.1.c.***
Must use a care management documentation system or process that supports documentation of integrated services and information. As described in the ECM Policy Guide, MCPs may **not** require ECM Providers to utilize an MCP portal for documentation of ECM services. However, MCPs may choose to offer access to their care management documentation	No additional requirements or recommendations that apply to JI ECM providers.

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

Table 19. Minimum ECM Provider Requirements	
Examples of Requirements that Apply to All ECM Providers[177]	**Additional Requirements and Recommendations that Apply to JI ECM Providers**
system as an option for Providers.	
Ensure each member is assigned a Lead Care Manager who interacts directly with the member and/or their family member(s), guardian, caregiver, and/or authorized support person(s), as appropriate.	• **If the CF uses in-reach model:** DHCS requires the post-release ECM Lead Care Manager to be the same person as the pre-release care manager, to the greatest extent possible. • **If the CF uses an embedded model:** DHCS requires the post-release ECM Lead Care Manager to participate in a warm handoff with the pre-release care manager. The warm handoff should take place during the pre-release period, if possible.
Submit claims for the provision of ECM-related services to the MCP using the national standard specifications and code sets to be defined by DHCS, or invoices, adhering to DHCS' billing and invoicing standards.	No additional requirements or recommendations that apply to JI ECM providers.

13.2.d JI ECM Provider Reimbursement in the Pre-Release Period and for Warm Handoffs

ECM providers must ensure that their services are submitted as claims under FFS in the pre-release period and when participating in warm handoffs. As such, ECM providers must either enroll in Medi-Cal FFS through PAVE or contract with the CF to provide services prior to release (e.g., pre-release care management services, warm handoff) ***(see Section 13.2.a).***

If the JI ECM provider has chosen to enroll in Medi-Cal FFS, warm handoffs and in-reach services will be reimbursed in FFS. If the JI ECM provider has contracted with correctional facilities as a contracted embedded care manager in all counties in which they operate, warm handoffs and in-reach services will be reimbursed according to contractual terms established between the JI ECM provider and CF, and billing for the warm handoff will occur under the CF NPI. For additional information, see ***Section 9.*** Once MCP enrollment has been effectuated post-release, ECM providers will be reimbursed per the terms of their contract with the MCP.

13.2.e. JI ECM Provider Network Sufficiency

MCPs must meet network sufficiency requirements (i.e., the MCP must contract with a sufficient network of JI ECM providers to meet the projected need in the county in which it operates). MCPs in each county must collaborate among themselves to project their anticipated needed JI ECM hours, by quarter, based on JI ECM client numbers and workload.[181] Each MCP must contract with enough JI ECM providers to meet their estimated projected need. MCPs will be responsible for identifying JI ECM providers.

As a best practice for identifying appropriate JI ECM providers with which to contract, MCPs may consider:[182]

- Partnering with correctional facilities to identify providers that have demonstrated experience serving the justice-involved population;
- Reaching out to established organizations that serve the justice-involved population; and/or
- Contracting with organizations that employ individuals with justice-involved lived experience.[183]

DHCS assessment of network sufficiency will be based on the following:

- **JI ECM Model of Care Template.** MCPs must attest to their plans to contract with a sufficient network of ECM providers to meet the projected need in the county in which they operate. MCPs must also describe how they plan to coordinate with other MCPs and correctional facilities to estimate ECM capacity needs and share estimates (if available). MCPs must submit an Excel workbook that lists their anticipated ECM providers by county for DHCS review, including JI ECM Providers (see JI ECM Provider Capacity Attachment). Alongside the Provider Capacity Attachment, MCPs may submit requests for exceptions from JI ECM Provider network overlap requirements by responding to a Provider Exception narrative question.
- **Update of Anticipated Need for JI ECM.** DHCS may require MCPs to submit an update of their estimate of anticipated need of JI ECM providers six months after the JI pre-release services go live in correctional facilities in their counties.
- **JavaScript Object Notation (JSON) File.** MCPs will be required to submit their JI ECM provider networks via the JSON file, which DHCS will monitor, beginning in 2024. See ***Section 13.2.h*** for additional detail on JI ECM Provider Network

[181] DHCS is working to provide rough county-level estimates for numbers of individuals who will be eligible for ECM under the JI POF. However, MCPs should supplement this information with county-specific data obtained through partnerships with correctional facilities. Additional details on how to determine estimates are forthcoming.
[182] See Best Practices for Engaging the Reentry Population in Health Care (Transitions Clinic Network).
[183] Example providers that serve the JI population include, but are not limited to: Amity Foundation, HealthRight 360, Neighborhood House Association - Project In-Reach, California Association of Alcohol and Drug Program Executives, Transitions Clinic Network, and WestCare,

Monitoring. See ECM Policy Guide (Updated July 2023) for additional information on JSON file implementation for all ECM POFs and Community Supports.

13.2.f. Network Overlap to Ensure Care Management Continuity Across the Pre- and Post-Release Periods

MCPs must ensure continuity of care for individuals who receive pre-release care management and post-release ECM services. To do so, MCPs must ensure that, to the extent possible, individuals receive care management services from the same provider in the pre- and post-release periods, starting on or as close as possible to the day of release.[184] [185] [186]

To achieve this requirement, DHCS will require overlap of both pre-release provider networks and JI ECM provider networks to the maximum extent possible, as described below, which will ensure that the provider that is assigned by the CF in the pre-release period is guaranteed to be in-network, no matter which plan the Medi-Cal member is eventually enrolled in post-release.[187] [188]

DHCS will require MCPs to collaborate to contract with their JI ECM provider network in order to ensure network overlap in counties with more than one MCP.[189] DHCS will provide standard boilerplate contract language that each MCP can incorporate into their JI ECM provider contract/scope of work. MCPs may update or amend the boilerplate language as they see fit, and they may add separate addenda to the boilerplate language to establish any further provisions between the MCP and JI ECM provider, including rates.

To ensure mandatory provider overlap in each county, MCPs must notify the other plans in their counties when they identify a new JI ECM provider. MCPs should also monitor other plans' network JI ECM providers to identify any potential new providers. They may do so by referencing other plans' Provider Directory. DHCS will monitor provider overlap

[184] Alternatively, a pre-release care manager could conduct a warm handoff with a post-release ECM provider, if pre-release and post-release providers are different. Note that post-release ECM services should begin on the day of release.
[185] To ensure continuity of care for individuals who will reenter the community in a different county from where they are incarcerated, the CF should assign the individual a pre-release, in-reach care management/post-release ECM provider that works in the county in which the individual will be released. Pre-release services may be provided via telehealth (see ***Section 13.3.e*** for details).
[186] Existing inter-county transfer processes should be followed if an individual enrolled in an MCP (i.e., the individual's MCP enrollment is placed into a hold status during the period of incarceration) is released to a county in which that MCP does not operate.
[187] This requirement aligns with the requirement that all JI ECM providers in counties in which the correctional facilities have implemented an in-reach care management model must agree to also provide pre-release, in-reach services either through FFS or through establishing contracts with correctional facilities in those counties.
[188] As a best practice, DHCS encourages the establishment of regional collaboratives to support seamless transitions to ECM, especially for individuals who may be released across county lines.
[189] Network should be comprised of JI ECM providers that are either enrolled in Medi-Cal FFS or contracted with correctional facilities in the counties in which they operate.

using the JSON file (***see Section 13.2.h***) and notify plans if they are missing any JI ECM providers from their networks.

If an MCP is not able to contract with the network of providers with which other MCPs in the county contract, the MCP must submit to DHCS for prior approval of any requests for exceptions to this requirement and indicate the reason network overlap is not possible.[190] Permissible exceptions include:

1. Justified quality-of-care concern with ECM provider(s);
2. MCP and ECM provider(s) are unable to agree on contracted rates;
3. ECM provider(s) is/are unwilling to contract;
4. ECM provider(s) is/are unresponsive to multiple attempts to contract;
5. ECM provider(s) is/are unable to comply with the Medi-Cal enrollment process or vetting by the contractor; or
6. For ECM Provider(s) without a State-level pathway to Medi-Cal enrollment, ECM Provider(s) is/are unable to comply with Contractor processes for vetting qualifications and experience.

13.2.g. Provider Directory

MCPs must update their standard Provider Directory to include contact information for ECM providers that serve the JI POF. By January 1, 2024, MCPs must update their Provider Directory to include their JI ECM provider network and share a link to the Provider Directory with DHCS.[191] By April 1, 2024, MCPs must include the following information on JI ECM Providers:

- Indication of which POFs the provider serves and any specialization (if applicable);
- If the provider serves adults, youth, or both;
- *For JI ECM providers only:* Indication of the mechanism through which the ECM provider will bill FFS (i.e., whether the provider will be enrolled as an FFS provider through PAVE or contracted with correctional facilities to bill under the CF's NPI);
- *For JI ECM providers only:* Indication of whether the provider has agreed to provide pre-release care management services and warm handoffs, or has only agreed to provide warm handoffs;[192]
- County of operation; and
- Care management provider organization information:

[190] Requests for exceptions will be submitted as a part of the Provider Exception Question attachment to JI ECM Model of Care.
[191] DHCS is exploring how it will update Provider Directory requirements across all POFs. MCPs will not be expected to create a separate Provider Directory for JI ECM providers. Rather, the standard Provider Directory should include the information detailed in this section.
[192] If correctional facilities in the counties in which a JI ECM Provider operates use an in-reach model, the JI ECM Provider must agree to provide warm handoffs and in-reach services. If correctional facilities in the counties in which a JI ECM Provider operates use an embedded model, the JI ECM Provider must agree to conduct warm handoffs with the pre-release care manager.

1. Provider organization name;
2. Organization mailing address;
3. Contact information for new referrals, including telephone and email; and
4. Contact info for existing patients, including telephone and email (if different than contact information for new referrals).

The Provider Directory will serve as a critical tool for correctional facilities to assign individuals to pre-release care management providers and/or post-release ECM providers. The MCP must ensure that all listed JI ECM providers are clearly labeled in the Provider Directory. MCPs must also ensure that JI ECM providers meet minimum requirements to be considered an ECM provider and the additional requirements to be considered a JI ECM provider (see ***Section 13.2.a*** and Table 22). Provider Directories must be updated in compliance with 42 CFR 438.10(h)(3)(ii)[193], which requires that electronic provider directories must be updated no later than 30 calendar days after the MCP receives updated provider information.

13.2.h. Network Reporting

DHCS will require MCPs to report their JI ECM provider network via the JSON file, beginning in 2024.[194][195] DHCS will use the data submitted via the JSON file to monitor mandatory provider network overlap (i.e., to ensure that all identified JI ECM providers are contracted with all MCPs in the county). To ensure that network overlap is accurately monitored, MCPs must collaborate amongst themselves to ensure that all MCPs are reporting JI ECM providers on the JSON form using the same NPI number.

MCPs must submit the following data on the JSON file:

1. Justice Involved care management provider/entity organization with which MCP contracts;
2. NPI;
3. County in which care management provider/entity organization is contracted to operate;
4. Contact information: mailing address, telephone number, and email address;
5. Confirmation that provider has agreed to provide in-reach services and warm handoffs or only provide warm handoffs; and
6. If the provider will provide pre-release services and warm handoffs via FFS or by contracting with correctional facilities in the county of operation.

[193] 42 CFR 438.10(h)(3)(ii). Available at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.10
[194] The JSON file begins implementation in 2024. See ECM Policy Guide (Updated July 2023) for additional information on JSON file implementation for all ECM POFs and Community Supports.
[195] If the JSON file rollout faces significant delays, DHCS may require supplemental provider network submissions from MCPs, which will be aligned to the extent possible with existing network reporting requirements.

13.3. Member Enrollment into an MCP and ECM

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

13.3.a. Auto-Assignment and Current Month Enrollment

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

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

MCP auto-assignment will occur at the time of pre-release service activation and will be based on the county of residence to which the individual will return, as listed in the Medi-Cal Eligibility Data System (MEDS). Existing auto-assignment policy, including prior MCP enrollment and family member assignment, will be considered in the MCP auto-assignment process. Plans will be notified on the monthly/daily 834 file when members are assigned/enrolled, even if that is prior to release. Incarcerated individuals with an assigned MCP in a hold will be noted as such in the daily/monthly 834 file that DHCS shares with MCPs. This will be for any JI incarcerated Medi-Cal member with a suspended primary aid code and MCP, not just those with pre-release services. Additionally, the 834 file will include a JI indicator, which is applied when the JI pre-release service aid code is activated and will alert MCPs of JI members who qualify to receive pre-release services and are therefore automatically eligible for ECM. MCPs may use historic 834 files to identify individuals who have previous exposure to the justice system (as evidenced by prior active JI pre-release service aid code indicators).

For members who are auto-assigned in Non-County Organized Health System (COHS) and non-Single Plan counties, a confirmation letter will be mailed to the residential address they listed on their Medi-Cal application (i.e., an address in the community).

The confirmation letter will include information on their MCP assignment and how to change plans if more than one MCP operates in their county of residence. After their release, members will be provided a choice period and an opportunity to change plans, consistent with DHCS managed care enrollment policy. MCPs should send their standard member materials to each new or reenrolled member's residence.

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

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

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

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

MCPs must have referral pathways in place by January 1, 2024, for members who do not receive pre-release services, when ECM goes live for the JI POF.[196] MCPs must:

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

- Accept self-referrals; and
- Accept referrals from a family member, community-based organization serving the member, probation or parole officer, or provider.

Additionally, DHCS recommends that MCPs:

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

As outlined in ***Section 13.1.c***, DHCS will require MOUs between MCPs and correctional facilities in their counties of operation; additional details, including a timeline for when this requirement must be implemented, will be shared once a model MOU has been released by DHCS. Until that point, MCPs do not need to execute MOUs or contracts with correctional facilities.

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

Individuals who received pre-release services will automatically be eligible to receive ECM under the JI POF, as the eligibility criteria for pre-release services and ECM for the JI POF are identical. Additionally, anyone who has received pre-release services has been screened and deemed eligible under the eligibility criteria (see ***Section 6***). Correctional facilities will refer individuals who receive pre-release services directly into ECM (i.e., a direct pathway will be established between the CF, MCP, and post-release ECM provider). Additionally, as described above, auto-assignment and current month enrollment will ensure that individuals can be enrolled in and begin to receive ECM immediately upon release. MCPs must establish pathways for ECM to be automatically approved for any member who received pre-release services. MCPs will be notified of individuals who are eligible for pre-release services and therefore eligible for ECM through the daily/monthly 834 file with the JI indicator. The daily/monthly 834 file is shared by DHCS.

The CF is responsible for notifying the ECM provider, the MCP, and the county-based plans (i.e., Drug Medi-Cal (DMC), Drug Medi-Cal Organized Delivery System (DMC-ODS), county Mental Health Plan (MHP), as applicable) of the release. The CF may work with the pre-release care manager to make this notification.

Additionally, the MCP enrollment ‘hold’ indicator on the daily/monthly 834 files will be removed upon unsuspension of the primary Medi-Cal aid code, serving as another indicator of an individual’s release.

13.3.d. ECM Presumptive/Retroactive Authorization

A member who receives pre-release services must be presumptively/retroactively authorized to receive ECM services on the day of release or, if MCP enrollment is effectuated after release, on the day of MCP enrollment. ECM must continue until the MCP is able to evaluate the need for services, no sooner than six months after release to ensure that the member has access to the services for which they qualify.[197] Because all members who receive pre-release services have already been assessed and deemed eligible for services, and the eligibility criteria is the same for ECM, no additional assessment is needed to qualify for ECM until at least six months after release.

As they would for any member, MCPs must coordinate care for members who opt not to participate in ECM. Further, a member who is determined eligible and initially declines pre-release care management, or post-release ECM, may decide to opt in to receive ECM at any point during their 12-month post-release period. If so, the MCP must ensure the provision of ECM to that member under the JI POF.

13.3.e. Pre-Release Care Manager and Post-Release ECM Provider Assignment

Correctional facilities will be responsible for ensuring that individuals who receive pre-release services are assigned a pre-release care manager.

- If the pre-release care manager is an in-reach care manager, they will become the individual's post-release ECM provider.
- If the pre-release care manager is an embedded care manager, they will initiate a warm handoff with the post-release ECM provider, prior to release.

In addition, under the embedded care management model, the CF will be responsible for ensuring that individuals are assigned a post-release ECM provider.

Roles and responsibilities for provider assignment at facilities leveraging either an embedded or in-reach care management model are, respectively, outlined in Tables 20 and 21 below. In addition to the processes described in Tables 20 and 21, DHCS encourages MCPs and correctional facilities to collaborate as appropriate on a county-specific process to determine the appropriate provider assignment for each individual.[198][199]

[197] MCPs will re-authorize/deny ECM during the ECM reassessment no sooner than six months after enrollment.
[198] County-specific collaborations are not expected to address all issues, which is why the MCP must have a MCP JI Liaison publicly available for out of county correctional facilities or state prisons to be able to coordinate. See Section 13.4.b for more information on MCP JI Liaison requirements.
[199] As a best practice, DHCS encourages the establishment of regional collaboratives to support seamless transitions to ECM, especially for individuals who may be released across county lines.

Table 20: Provider Assignment: Embedded Care Management Model[200]			
Action		**Correctional Facility Responsibility**	**MCP Responsibility**
Assign an embedded pre-release care manager.		Correctional facility uses existing processes to assign the pre-release care manager.	N/A
Assign a post-release ECM provider.	If the individual's MCP assignment is known:	Correctional facility/pre-release care manager must reach out to the publicly-posted MCP JI Liaison at the MCP to which the individual is assigned.	MCP JI Liaison will assign a post-release ECM provider and communicate that assignment to the CF.
	If the individual's MCP assignment is unknown:	CF must use the MCP Provider Directory from a MCP in the county to which the individual will be released to reach out to a JI ECM provider and assign the individual a post-release ECM provider. CF must communicate post-release ECM provider to MCP, once assigned.	MCP must receive communication from CF regarding post-release ECM provider assignment.

Table 21: Provider Assignment: In-Reach Care Management Model[201]			
Action		**Correctional Facility Responsibility**	**MCP Responsibility**
Assign an in-reach pre-release care manager.	If the individual's MCP assignment is known:	CF must reach out to the publicly-posted MCP JI Liaison at the MCP to which the individual is assigned.	MCP JI Liaison will assign an in-reach pre-release care manager and communicate that assignment to the CF. The in-reach pre-release care manager should continue to serve as the ECM Provider upon release.

[200] Table 20 is also included in Section 8.4: Care Management Model as Table 11.
[201] Table 21 is also included in Section 8.4: Care Management Model as Table 12.

Table 21: Provider Assignment: In-Reach Care Management Model[201]			
Action		**Correctional Facility Responsibility**	**MCP Responsibility**
	If the individual's MCP assignment is unknown:	CF must use the MCP Provider Directory from a MCP in the county to which the individual will be released to reach out to a JI ECM provider and assign the individual a pre-release care manager, who will become the ECM Provider upon release. CF must communicate pre-release care manager/post-release ECM provider to MCP, once assigned.	MCP must receive communication from CF regarding post-release ECM Provider assignment.
Additional Considerations • The in-reach pre-release care manager should continue to serve as the individual's ECM Lead Care Manager post-release. • Correctional facilities must ensure that the pre-release, in-reach care manager works in the county in which the individual will be released. Providers may conduct pre-release services and warm handoffs via telehealth, including if the provider is in a different county than the CF. • Correctional facilities located in a different county than the county of release may reach out to the MCP JI Liaison in the county of release for assistance (if MCP assignment is known). • If the CF is not able to work with the individual's assigned MCP JI Liaison to assign a provider (e.g., because MCP assignment is unknown), the CF is responsible for ensuring that information on the assigned in-reach pre-release care manager/ECM provider is shared with the MCP prior to release. Information about assigned care managers must additionally be included in the Reentry Care Plan, which will be shared with the MCP.[202] The CF is additionally responsible for notifying the MCP of the CF location. The CF may work with the pre-release care manager to make these notifications.			

[202] CFs and MCPs must ensure that the reentry care plan is shared via a secure communication (i.e., secure email, fax).

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

One of the key goals of the CalAIM Justice-Involved Initiative is to ensure that individuals are supported during the transition from incarceration into the community through the provision of pre-release services, including pre-release care management, and post-release services like ECM and Community Supports.[203] MCPs will play a critical role in coordinating the transition from the pre-release to post-release periods (i.e., the 90-day pre-release period when the individual will receive FFS Medi-Cal services and the post-release period when the individual will be enrolled in an MCP and begin to receive managed care services).

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

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

13.4.b. MCP JI Liaison (formerly MCP Point-of-Contact)

As described above, MCPs will need to include a publicly posted MCP JI Liaison to whom correctional facilities, pre-release care managers, and ECM providers can reach out for support. The MCP JI Liaison may be an individual or a team (i.e., not a hotline) who will be available to support correctional facilities, pre-release care management providers, and/or ECM providers as needed. The MCP JI Liaison at the plan should be prepared to provide information on topics including but not limited to pre-release care manager and ECM Provider assignment, MCP policy pertaining to the JI POF, prior authorization, MCP services such as Community Supports and non-emergency medical transportation, PCP assignment, and network providers. The MCP JI Liaison must be available by phone and electronic communication during regular business hours; DHCS expects that asynchronous communications be addressed within 1 business day (e.g., an email received at 9pm on a Tuesday should receive a response by the end of the business day on Wednesday).[204] By April 1, 2024, MCPs must post the contact information (including phone number and email) for their MCP JI Liaison publicly on their website, clearly indicate that the contact information is for the justice-involved MCP JI Liaison, and share a link to the contact information with DHCS. If the contact information for the MCP JI Liaison changes, MCPs are expected to provide DHCS with an updated link to the MCP JI Liaison's information.

[203] MCPs are not required to offer Community Supports, so not all individuals who are transitioning from incarceration will have access to this service.
[204] If an individual requires after-hours or emergency authorization of services, the CF/pre-release care manager should contact the MCP's existing 24/7 resources.

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

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

- **Receive Member Data.** The CF is responsible for sharing member data, including the Reentry Care Plan, with the MCP for future care coordination and management purposes. The MCP must have processes and data infrastructure in place to receive member data from the CF to support care for the individual in the post-release period once the individual is enrolled in managed care. The MCP must ensure that the post-release ECM Provider has access to necessary member data in the post-release period.
- **Ensure Warm Handoff Occurs.** DHCS requires that all efforts are made to have the warm handoff occur in the pre-release period (see ***Section 8.4.e.*** for warm handoff requirements).[205] If an individual receives care management services from different providers in the pre- and post-release periods (e.g., if an individual unexpectedly changes planned release location to a county the pre-release care manager does not serve, or the pre-release care manager leaves their position and thus cannot continue as a post-release ECM Lead Care Manager), the two care managers will be required to conduct a warm handoff to ensure continuity of care across the pre- and post-release periods. The pre-release care manager is responsible for initiating the warm handoff by contacting the post-release ECM Provider. Both the pre-release care management provider and the post-release ECM Provider are responsible for following through on completing of the warm handoff. The MCP will be responsible for ensuring that their contracted JI ECM Providers participate in a warm handoff with the pre-release care management provider during the pre-release period.
- **Post-Release Warm Handoff** (only if not done prior to release).[206] DHCS understands that there are situations in which it will not be possible to conduct the warm handoff in the pre-release period (e.g., the individual is incarcerated for only 48 hours, or the individual is released unexpectantly from court). In such cases, the MCP must ensure that its network ECM Providers conduct the warm handoff in the post-release period, within one week of release. The CF/pre-release care manager must share the reentry care plan with the MCP

[205] DHCS understands there may be workforce capacity constraints to complete this activity for all eligible individuals. DHCS will require that a good faith effort must be made to conduct a warm handoff and that effort must be documented.

[206] Note that pre-release care manager and post-release ECM Lead Care Managers should do their best to ensure that the warm handoff occurs in the pre-release period. If the warm handoff does not occur in the pre-release period, it must occur in the post-release period as a minimum requirement. DHCS expects that warm handoffs should rarely occur in the post-release period.

and post-release ECM Provider within 1 business day of release. The MCP must ensure that any necessary data/information, including the Reentry Care Plan, has been shared with the ECM provider within one business day of release (i.e., in cases where the post-release ECM Provider was not assigned until after the individual was released and did not receive necessary data/information, including the Reentry Care Plan, from the CF).

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

the community. In this case, the MCP must ensure that the ECM Providers can support the scheduling of community-based services (paid in FFS or through contracting with a CF).

- **Community Supports.** MCPs have the option to offer one or more of the Community Supports services (e.g., housing transition navigation services, housing deposits, medically tailored meals/medically-supportive food). If the MCP offers Community Supports, the MCP must ensure that the ECM Provider is able to connect the individual with any needed Community Supports that are available through the MCP, including through working with the MCP to begin coordinating the authorization process as well as scheduling services pre-release. The MCP must ensure that ECM Providers can coordinate any needed Community Supports and ensure that they are available on the day of release.[207] [208]
- **Non-Emergency Medical Transportation.** Individuals returning from the community from incarceration may also need Non-Emergency Medical Transportation (NEMT) to get to their physical and/or behavioral health appointments. The MCP must ensure that the ECM Provider is able to set up NEMT for post-release services for the individual in the community and sets up NEMT services as necessary. This will include NEMT on the day of release, if needed.[209]

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

13.5. Post-Release ECM

Once an individual enrolled in Medi-Cal is released into the community, they will be eligible to receive full-scope Medi-Cal services, including ECM, consistent with their assigned aid code. As described in ***Section 13.3***, MCP enrollment will be effectuated on the day of release, so MCPs should begin to provide services, including ECM, as soon as the individual reenters the community.

The MCP must ensure that ECM services become available on the day of release, or if not yet enrolled in the MCP, on the day of MCP enrollment. DHCS suggests as a best practice that ECM Providers should 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 release to ensure continuity of care and a

[207] Additional information on MCP's responsibility for authorizing Community Supports is forthcoming.
[208] Additional information on Community Supports for the Justice-Involved population can be found in the Medi-Cal Community Supports, or In Lieu of Services (ILOS), Policy Guide.
[209] Additional information on MCP's responsibility for NEMT is forthcoming.

seamless transition and to monitor progress and the implementation of the reentry care plan.[210]

13.5.a. Care Management Plan

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

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

13.6. Effective Dates for Managed Care Plan Requirements

Table 22 below articulates effective dates for JI MCP requirements:

[210] 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

Table 22: Effective Dates for Justice-Involved Managed Care Plan Requirements		
Requirement	**MCPs must meet the following requirements by 1/1/2024**	**MCPs must meet the following additional requirements by go-live of pre-release services[211]**
ECM for the JI POF	ECM for the JI POF goes live. MCPs must: • Establish a sufficient network of JI ECM providers*; • Establish JI ECM provider network overlap across MCPs in each county; and • Begin providing ECM to JI individuals (individuals will be referred via self-referral and family/ provider referral prior to go-live of prerelease services). **Note: MCPs must have a sufficient network of JI ECM providers to meet the capacity needs in their county of operation. By 4/1/2024, MCPs who operate in counties where pre-release services have not yet gone live must have a sufficient JI ECM Provider network to serve individuals who received pre-release services in another county and are*	For Members who receive pre-release services, MCPs must: • Presumptively/retroactively authorize ECM services; and • Ensure receipt of ECM services on the day of release or, if MCP enrollment is effectuated after release, on the day of MCP enrollment.

[211] See ***Section 13.2.b*** for additional information on the JI ECM Provider Enrollment Glidepath.

Table 22: Effective Dates for Justice-Involved Managed Care Plan Requirements		
Requirement	**MCPs must meet the following requirements by 1/1/2024**	**MCPs must meet the following additional requirements by go-live of pre-release services[211]**
	released into their county of operation. DHCS expects that capacity needs will be low prior to the go-live of facilities in the MCP's county of operation.	
Provider Directory	Update MCP Provider Directory to contain contact information of all in-network JI ECM providers per existing provider directory requirements under ECM.	Update MCP Provider Directory to contain JI-specific contact information for JI ECM Providers, including: • Indication that the ECM provider is a JI ECM Provider. • Indication of the mechanism through which the ECM provider will bill FFS (i.e., whether the provider will be enrolled as an FFS provider through PAVE or contracted with correctional facilities as an embedded provider); • If JI ECM provider will provide pre-release care management services and warm handoffs, or warm handoffs only.
MCP Liaison	N/A	MCPs must publicly post the MCP Liaison contact information (phone

Table 22: Effective Dates for Justice-Involved Managed Care Plan Requirements		
Requirement	**MCPs must meet the following requirements by 1/1/2024**	**MCPs must meet the following additional requirements by go-live of pre-release services[211]**
(formerly MCP Point of Contact)		number/email) and ensure that the MCP Liaison is: • Knowledgeable about MCP policy, including MCP policy pertaining to the JI POF; and • Available by phone/electronic communication during business hours; asynchronous communications received after business hours must be addressed within one business day.

Appendix

Appendix A. Medi-Cal-Covered DME by Group

DME Group	DME Included in Group
Other DME.[212]	• Ambulation Devices • Bathroom Equipment • DME for Disabled Parent • Hospital Beds and Accessories • Patient Lifts and Standing Frames • Patient Transfer Systems • Phototherapy • Pneumatic Compressors • Miscellaneous Equipment, Accessories, and Supplies o Blood Glucose Monitors o Blood Pressure Equipment o Breastfeeding: Lactation Management Aids o Cough Stimulating Device o Electrodes and Lead Wires o Haberman Feeder o Negative Pressure Wound Therapy Devices o Osteogenesis Stimulator o Pulsed Irrigation Enhanced Evacuation (PIEE) o Positioning Seat o Ramps, Portable o Scales o TheraTogs o Transcutaneous Electrical Nerve Stimulators (TENS) o Tumor-Treating Field Devices

[212] Durable Medical Equipment (DME): Other DME, available at: https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/duraother.pdf

	• Wearable Cardiac Defibrillator
Wheelchairs and Wheelchair Accessories[213]	The term "wheelchair" describes manual wheelchairs, power mobility devices (PMD) including power wheelchairs (PWC), power-operated vehicles (POV), and push-rim-activated power-assist devices (PAD). Seating and positioning components (SPC) describe seat, back, and positioning equipment mounted to the wheelchair base.

Oxygen Contents, Oxygen Equipment, and Respiratory Equipment[214]	• Aerosol Masks
	• Airway Clearance Devices
	  o Cough Stimulating Devices
	  o High-Frequency Oscillation Systems
	  o Intrapulmonary Percussive Ventilators/Devices
	  o Oscillatory Positive Expiratory Pressure Devices
	  o Percussors
	• Apnea Monitors and Supplies
	• Continuous Positive Airway Pressure (CPAP) and Bi-Level Positive Airway Pressure (Bi-PAP) Equipment
	• Bi-Level Positive Airway Pressure ST (Bi-PAP ST) Equipment
	• Humidifiers
	• Nebulizers and Air Compressors
	• Oral Appliances for Obstructive Sleep Apnea
	• Oximeters
	• Oxygen Contents, Equipment, and Supplies
	• Suction Machines
	• Ventilators (primary and backup)
	• Unlisted Oxygen Equipment and Respiratory Equipment
	• Unlisted Supplies, Accessories, and Service Components

[213] Durable Medical Equipment (DME): Wheelchair and Wheelchair Accessories Guidelines, available at: https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/durawheelguide.pdf
[214] Durable Medical Equipment (DME): Oxygen and Respiratory Equipment, available at: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/duraoxy.pdf

Infusion Equipment[215]	• Ambulatory Infusion Pumps • Enteral Nutrition Infusion Pumps • Implantable Infusion Pumps • Insulin Infusion Pumps • Mechanical External Infusion Pumps • Miscellaneous Supplies • Parenteral Infusion Pumps • Unlisted Equipment • Unlisted Supplies, Accessories, and Service Components
Therapeutic Anti-Decubitus Mattresses and Bed Products[216]	• Replacement Pads • Pressure Sore Products
Speech Generating Devices[217]	A Speech-Generating Device (SGD) is an electronic or non-electronic aid or system which accommodates an expressive communication disability that precludes purposeful functional communication medically necessary to accomplish activities of daily living (ADLs).

[215] Durable Medical Equipment (DME): Infusion Equipment, available at: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/durainf.pdf
[216] Durable Medical Equipment (DME): Therapeutic Anti-Decubitus Mattresses and Bed Products, available at: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/durathp.pdf
[217] Durable Medical Equipment (DME): Speech Generating Devices (SGD), available at: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/duraspe.pdf