Justice Involved

CalAIM Reentry Toolkit

Correctional Facilities, Behavioral Health Agencies, Managed Care Health Plans, and Community-Based Organizations serving justice involved populations

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Scott Coffin is a retired health care administrator with over 28 years of experience billing Medicaid and Medicare. Scott formed Serrano Advisors LLC in July 2023 to support the Sheriff's Offices, Probation Departments, Behavioral Health Agencies, managed care health plans, providers, and California's regulatory agencies with the CalAIM justice involved reentry initiative.

Serrano Advisors LLC publishes a series of toolkits & readiness templates to guide interagency collaboration, Medi-Cal billing, and facility readiness for pre-release services. The perspectives contained in this document are based on the interpretation of publicly available documents issued by the California Department of Health Care Services and is not endorsed by the agency.

In addition to the CalAIM Reentry Toolkit, Serrano Advisors has authored the following resources:

- CalAIM Billing Toolkit
- CalAIM Facility Readiness Toolkit
- CalAIM Proforma Toolkit
- CalAIM MOU Toolkit
- CalAIM Data Exchange Toolkit
- CalAIM Billing Vendor Selection Toolkit

For more information on the toolkits and other resources, contact Scott Coffin at 510-414-6681 or email scott@serranoadvisors.com.

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ACRONYMS

BH..... Behavioral Health
BSCC..... Board of State and Community Corrections
BQuIP..... Brief Questionnaire for Initial Placement
CalAIM ..... California Advancing and Innovating Medi-Cal
CalSAWS ..... California Statewide Automated Welfare System
CBO ..... Community-Based Organization
CDCR..... California Department of Corrections & Rehabilitation
CA-MMIS ..... California Medicaid Management Information System (DHCS)
CITED ..... Capacity and Infrastructure Transition, Expansion, and Development
CMS ..... Centers for Medicare and Medicaid
DHCS..... California Department of Health Care Services
DMC ..... Drug Medi-Cal
ECM..... Enhanced Care Management
EVS..... Eligibility Verification System
FTE ..... Full-Time Equivalency
HHS ..... Health & Human Services Agency
JMS ..... Jail Management System
JI ..... Justice Involved
LGFD..... Local Governmental Financing Division (DHCS)
MAT ..... Medication-Assisted Treatments
MAUD..... Medications to treat Alcohol Use Disorder
MCP..... Medi-Cal Managed Care Health Plan
MEDS..... Medi-Cal Eligibility Determination System
MOU..... Memorandums of Understanding
MOUD..... Medications to treat Opioid Use Disorder
NCCHC ..... National Commission on Correctional Healthcare
NPI ..... National Provider Identifier
ODS ..... Organized Delivery System
PATH..... Providing Access and Transforming Health
PAVE..... Provider Application and Verification Enrollment
PBD ..... Pharmacy Benefit Division (DHCS)
ROI ..... Releases of Information
SMI ..... Severely Mentally Ill
SUD..... Substance Use Disorder
SSD ..... Social Services Department
TAR..... Treatment Authorization Request

CONTENT

The **CalAIM Reentry Toolkit** is structured into the following sections:

01. Overview

The Affordable Care Act authorized the integration of reentry services and California passed the Assembly Bill 720 in 2014, and over a decade later the CalAIM program is continuing to expand Medi-Cal services to the Justice Involved (JI) populations. The California Department of Health Care Services (DHCS) is the lead agency for the implementation of the CalAIM justice involve program for youths and adults and navigated the approval of the 1115 Demonstration Waiver. The DHCS hosted a series of technical assistance webinars in 2023-2024 to address the CalAIM policies and readiness requirements which have been accompanied by presentations, FAQs, and Q&As. The content from these information sources has been distilled into the **CalAIM Reentry Toolkit** and is a resource for the executive leaders in the correctional agencies, behavioral health agencies, state prisons, and managed care organizations.

During the next two years, custody operations leaders will be preparing their organizations for the expansion of pre-release services for individuals during the last 90 days of incarceration. By the end of 2026 the correctional facilities (excluding federal prisons) in California will be administering pre-release services to youths and adults. The transformation of health delivery in the correctional facilities is reinforced by the integration of Medicaid services into the carceral system of care. The variety of infrastructure, embedded health models, provider networks, and in-reach services in each county is uniquely different. In some counties the contracted embedded health provider is the primary caregiver and other counties a hybrid model is employed with the behavioral health agency and a mixture of non-profit organizations. Significant investments were made for more than a decade through AB 109 adult realignment, coordinated reentry programs were implemented for the youth, and local judicial systems expanded the use of diversion courts.

The CalAIM justice involved program builds upon the reentry infrastructure to enhance the way people are connected into services and opens the door to pathways into the safety-net and managed care delivery system. New relationships are being forged between the correctional facilities, behavior health agencies, social services departments, and Medi-Cal managed care health plans. The enhanced care management provider networks and community supports offer more access to physical health, mental health, and social determinants of health. The objective of the toolkit is to simplify the steps that will advance into facility readiness and to support the implementation of sustainable linkages into community-based reentry programs.

02. Best Practices

Readiness for the CalAIM Justice Involved Reentry

The **CalAIM Reentry Toolkit** begins with a set of best practices to consider in your planning for facility readiness and to support the post-mortem "lessons learned" following the go-live of pre-release services.

Medi-Cal Eligibility

Determining Medi-Cal eligibility is a high priority and enables the reimbursements to occur. On average, maintain a rate of 90% or higher on determinations for individuals with "active" status. As the rate of non-determinations increases, the facility will realize higher revenue losses. For correctional facilities, apply for access to the DHCS' Electronic Verification System "EVS" and include into the standard operating procedures during the intake & release processes. See **Exhibit A**.

Pre-Release Screening

Youth are not required to be screened for pre-release services in the juvenile justice centers. Adults must be screened for pre-release services. See **Exhibit B** for a listing of the conditions and diseases for eligibility determination. The screening occurs during the intake process while the individual is being classified for placement into housing. The list of qualifying conditions for the adults is extensive, and many of the individuals will be eligible

Embedded Health Provider

The embedded health provider is typically contracted with the correctional agency, county public health, or county's administrative office. In any case, the embedded health provider maintains a contract with the county and is reimbursed through the county's general funds. After pre-release services begin, the correctional agency generates revenues that directly offsets the costs associated with the embedded health provider. In some facilities, the physical health, mental health, and substance use treatments are distributed to more than one vendor. For example, physical health could be delegated to the first vendor, and the mental health and substance

use are delegated to a second vendor. Both vendors are considered "embedded" since they are administering services inside the secure area of the facility, and each maintains a contract with the county agency. Typically, the embedded health provider does not bill on behalf of the facility unless there is a circumstance where a billing vendor has formed an alliance with the health provider.

Prior Authorizations

Prior authorizations are required for pre-defined set of billing codes that DHCS establishes in the Medi-Cal program. Authorizations must be obtained to receive reimbursement for products, services, and medications. A best practice is to develop a list of the most common services and products that requires a prior authorization and validate with the billing vendor (i.e., medications, durable medical equipment). Revise the standard operating procedures and train the administrative and clinical staff on the usage of prior authorizations. Failure to obtain an authorization results in denials of payment from the DHCS, and the dollars add up.

Medi-Cal Aid Code

Modify the intake and release standard operating procedures for to include the use of the DHCS Justice Involved Portal (**Exhibit I**) to change the individual's Medi-Cal aid code. The alteration of this code starts and stops the billing cycle for the individual's stay in the facility. Aid codes are allowed to be "reset" and "restarted"; resetting adds another three-month window for pre-release service and restarting resumes the 90-day clock if the individual's stay is paused for some reason. DHCS allows for "one reset" for adults, for a total of 60 days, per stay. Failure to change the aid code results in a claim denial. Refer to **Exhibit C**. For correctional facilities, apply for access to the DHCS' Provider Portal and include into the standard operating procedures during the intake & release processes.

90 Days

CalAIM justice involved reentry applies **during the last 90 days** of incarceration. On average more than 50% of adults are not sentenced, and over 70% are released in the less than 30 days. Release dates are known in the state prison, however in the county jails and juvenile detention centers more than half of individuals booked into custody do not have a known release date. Calculating the actual 90-day period will require, in certain cases, a combination

of experience and forecasting. The DHCS JI portal is designed to capture the “stop” and “start” of the 90 days as the individual’s status changes while they are in the facility. In the first year of billing, approximately one-third of the denials may result from starting and stopping the 90-day clock and should stabilize in the second or third year of operation.

Timely Filing

Submit claims to the DHCS within six(6) months of rendering the service to receive full payment. Payments are reduced by 25% for claims submitted 7-9 months after the service is rendered, reduced by 50% for submissions in 10-12 months, and zero payment is available after 12 months from the date of service. An appeal process exists for claims older than 12 months however it is time-consuming, and the probability of overturning the denial is limited. In the first year, a bi-weekly filing of claims would allow for development of workflows and processes, and results in a 26-week billing interval. In years two and three, consider tightening up the billing cycle to weekly to sustain cash flow and better manage the frequency & patterns of denials.

Service Encounters

Correctional facilities, behavioral health agencies, embedded health providers, and in-reach providers that participate in the pre-release services are eligible to submit claims for reimbursement. Capturing the actual services, also referred to as the “service encounters”, is essential to the financial sustainability. The encounters are gathered in an electronic health record or coding system and sent to the Medi-Cal billing vendor to build the claim, so the billing vendor needs to understand exactly which services were rendered to accurately code and submit a “clean claim” to the DHCS for payment. Failure to communicate the service encounters results in “revenue leakage” (otherwise known as missed revenues).

Correctional facilities with multiple locations in a single county transfer some individuals between locations during a single stay. As a result, establishing a centralized way of tracking service encounters by facility is required to comply with the CalAIM program. For example, the number of times a care coordination bundle can be billed is thirteen(13) times per stay. Tracking the number of care coordination interventions by facility will help to reduce the number of denials and minimize the impact on staff to reconcile with the billing vendor.

Data Exchange

Engage with county agencies serving the justice involved populations to understand which data elements are needed to coordinate the pre-release handoffs. The correctional facilities own the reentry care plan which contains up to 25-30 data elements about the individual, including their actual release date. Automating the Medi-Cal eligibility determination process is common in many of the correctional facilities, especially for the county jails with higher number of bookings. PATH funds are being allocated to replace the manual processes with automated solutions to streamline the eligibility process, which often involves a partnership with the social services agency. Whether the solution entails passing a spreadsheet back and forth or the custody operations system is connected to the county's eligibility system (CalSAWS, MEDS), integrating data, or automating the custody operations systems, the objective is to maximize the number of Medi-Cal eligibility determinations each day. The results will yield more revenues for the correctional facilities and agency partners that participate in the pre-release billing.

Inter-County Transfers

Individuals detained in a county that is different than their place of residence often results in more steps in the reentry process. And in certain cases, there are individuals enrolled into Medi-Cal in a different county altogether. Correctional facilities should develop reports for inter-county transfers and coordinate sooner with the social services agency to ensure the individual is "active" on Medi-Cal prior to release. In cases where individuals are newly enrolled into Medi-Cal, the enrollment process may take 30-45 days or more and often exceeds the duration of the stay.

Contact Cards

Develop a contact card (**Exhibit D**) with all the personnel inside and outside of the correctional facility and include the Medi-Cal managed care health plans along with each of the agency partners (behavioral health, social services, public health, and others as needed). The warm handoffs are defined in the care management bundle #3 and is dependent on a chain of events that begins inside of the correctional facility. The contact card serves as a quick reference for the pre-release care managers, clinicians, and reentry teams. Share the contact card with all the reentry partners inside and outside of the facility.

Short Stays

Individuals in the facility for less than 48 hours most likely will receive the initial screening by the embedded health provider. Development of a routine set of services for short-stay individuals could increase the amount of revenue being generated by the correctional facility and behavioral health agency. In the case of a short stay, the individual would be released by the time a follow-up assessment or treatment could begin, which impacts the number of reimbursements being claimed by the facility. Focus on the linkages and handoffs based on observations by staff and attempt to connect the individual to community-based providers upon release from the facility.

Quick Releases

Unknown release dates are common for youths and adults at time of booking. For a variety of reasons, a release date is not determined or communicated to the custody operations and is often at the discretion of the courts. The facility would be reimbursed for any of the qualifying health services such as sick calls, mental health counseling, medications, labs, radiology, and other incremental services. The challenge with quick releases relates to status of the bundled services and the necessity to accelerate the completion of the reentry care plan and to conduct the warm handoffs prior to release from the facility.

Denials & Appeals

The objective for the correctional facilities and behavioral health agency is to minimize the occurrence of payment denials. The DHCS may deny the entire claim or a portion of the claim, and the two most commons reasons are ineligibility and lack of authorization. A denial can be appealed however this process takes time from the billing vendor and from the staff working in the correctional facility; the amount of resources to respond to payment denials is excessive and time is better spent on building a ‘clean claim’ that has all the essential components for processing. In the first year of operations, the denial rates will likely be higher and depend on the quality of the claims being submitted. In the second and third years of billing operations, the number of denials should range from 3% to 5% on average. If the denial rates remain higher than 10%, it is an indicator that something is broken in the billing process and needs to be repaired.

Pre-Release Checklist

Develop a pre-release checklist that is signed by a custody supervisor to ensure all the essential tasks are completed by the agencies, including the Medi-Cal determination, medications in hand, reentry care plan in hand, and linkages into community-based services. The pre-release care manager is responsible for assembling this information however it requires the engagement with other agencies, including social services, behavioral health services, managed care health plans, and the enhanced care management providers. The checklist will help you to maximize revenues, to validate the essential tasks, and defend the actions when a payment denial or partial payment is being appealed.

Reentry Care Plan

The reentry care plan is designed to support the linkages and handoffs to community-based providers, justice involved agencies, and managed care health plans. Agencies are developing a reentry care plan for adults, and a separate reentry template for youths to accommodate the legal and regulatory requirements. Approximately thirty(30) data elements are contained in the reentry care plan and automation is recommended to reduce the amount of time to complete a reentry care plan. Creating a reentry care plan is labor-intensive, and the DHCS forecasts between 1 to 2 hours per reentry care plan to gather the data from the different systems and involves the engagement of two(2) or more people – such as the Pre-Release Care Manager, non-clinical staff analyst, or others. Target to automate 90% of the process to gather data from multiple systems, average 5-10 minutes of staff time per reentry plan to review and confirm linkages with post-release partners in the community. By reducing the manual steps to gather the data manually, staff will have more time to focus on the discharge planning, linkages, and referrals.

Linkages & Handoffs

The linkages and “warm” handoffs are cornerstones of the CalAIM reentry program and represent a significant lift for organizations to orchestrate. While the linkages and handoffs are initiated in the correctional facility, multiple reentry partners are engaged in the reentry cycles. Knowing who to contact in each of the organizations is vital during the release process, especially in court-ordered releases for individuals. Develop a Contact Card with all the personnel inside and outside of the correctional facility and include

the Medi-Cal managed care health plans along with each of the agency partners (behavioral health, social services, public health, and others as needed). The warm handoffs are defined in the care management bundle and is dependent on a chain of events that begins inside of the correctional facility.

The intakes, screenings, and treatments are rolled into the reentry care plan, and the individual is supplied with a 30-day supply of medications upon release. Linkages, referrals, and handoffs are arranged prior to discharge from the facility, and connections are made with the behavioral health agency and managed care health plan. Attaining successful linkages and handoffs requires a structured, repeatable approach to gathering the essential data about the individual and making the connections in a timely manner. Individuals that are short stays and quick releases will pose a challenge to pre-release care managers, so developing a game plan early will benefit everyone.

Release Medications

Release medications (30-day supply) should be dispensed at the time of release along with the individual's reentry care plan. The DHCS has articulated, based on federal guidance from CMS, that medications must be provisioned at the time of release. Most facilities do not have a pharmacy within the facility and electronically transmit the prescription, via the embedded health provider, to a local pharmacy for pick-up later. Under the CalAIM program, "meds in hands" is required for all youths and adults being released from a facility.

Medication Assisted Treatments

Medication Assisted Treatments (MAT) should be available in the facility to treat opiate and alcohol addiction. Other MAT treatments are encouraged for inhalants, methamphetamines, and other types of substances. Individuals booked into custody are screened for substance use and if they are currently being treated in an addiction medicine program, the treatments would continue. If an individual is treated outside of the correctional facility, either at an acute care hospital or skilled nursing facility and MAT is administered for the first time, MAT treatments would continue after the individual is discharged from the treatment facility and returned to the correctional facility. New inductions in the facility are not mandatory but encouraged under the CalAIM JI reentry program and often ties back to the individual's medical necessity.

Transportation

Correctional facilities should coordinate with the Medi-Cal managed care health plan to facilitate transportation as needed from the facility to a health provider or to health-related resources. Picking up medications from the pharmacy or durable medical equipment from a local vendor are a couple of examples. Health plans are responsible to provision the transportation for individuals being released from the facility, and the correctional facility should consider negotiating with the health plans to use transportation vouchers. Health plans often request 2-3 days of lead time to schedule transportation and that does not fit with release schedules in many cases. Vouchers can be negotiated with the health plans to offer the pre-release care managers a more convenient and timely way of provisioning transportation and minimizes the financial burden on the correctional facility.

Split Billing for Behavioral Health Agencies

Behavioral health agencies may bill for services rendered inside the facility and for receiving post-release linkages. Receiving handoffs from the correctional facility is a billable service through Short Doyle and applies to intra-county and inter-county transfers. The second way of reimbursement for behavioral health agencies rendering services inside of the facility, including screenings, assessments, and treatments. These services are categorized as “clinical consultations” and are billed through the fee-for-service system called CA-MMIS (/kay-miss/). Split billing applies to the behavioral health agency but not for the correctional facility, as the facility is reimbursed solely by the fee-for-service system. The behavioral health agency claims for reimbursements for services rendered in the facility after go-live of pre-release services; only linkages from the facility into the community are allowable for reimbursement until the facility is approved to launch pre-release services.

National Provider Identifier “NPI”

Submit the form for a National Provider Identifier “NPI” number in the early stages of planning. The DHCS is mandating that each facility file for the NPI and the support team at DHCS. Effective February 10, 2025, DHCS will mandate that facilities calling the help center will need to present their NPI number before assistance. The phone number to the DHCS Medi-Cal Help Desk is 1-800-541-5555. See **Exhibit G** for a full list of contacts to support you in the facility readiness and ongoing operations for

pre-release services. Aside from access to the Help Desk, the NPI number is a requirement for accessing the Justice Involved Portal and to submit claims for reimbursement.

Exempt from Licensure Clinic

Correctional facilities that deliver health services in the facility, and intend to submit claims for reimbursement of services, are required to register with the DHCS as "exempt from licensure clinic". The exemption differentiates the health services in the correctional facility from the community-based clinics, medical offices, hospitals, and other types of health care settings. In the CalAIM program, the DHCS treats the correctional facilities as Medi-Cal providers and requires a registration through the Provider Application and Validation for Enrollment "PAVE". After you receive the NPI number for the correctional facility or behavioral health agency, go to the PAVE portal and start the application process. The PAVE application is essential to launching the pre-release services and has been a hurdle for several of the correctional facilities – start this process early in the planning cycles to avoid go-live delays.

Opt-In

Medi-Cal is an entitlement program and available to everyone who meets the eligibility criteria, and the same rules apply to the post-release enhanced care management services. While these services are offered to eligible youths and adults through the Medi-Cal managed care program, participation is not mandatory and people are allowed to decline services, and re-enroll, at any time.

Pre-Release Care Manager

The Pre-Release Care Manager is a modified version of a Discharge Planner. Care Managers oversee the individual's screenings, assessments and treatments while in the facility. The warm handoffs, linkages, and reentry care plan are also the responsibility of the Care Manager. In the context of post-release transitions into the community, the Care Manager is coordinating with the health plan liaison and enhanced care manager for continuity of care, such as medication-assisted treatment or addressing a chronic health condition. The Care Manager is clinically certified and is empowered to escalate to the right clinical supports within the facility and has the responsibility to connect the individual into the appropriate community-based services. Whether the job title remains as "Discharge Planner" or changes to "Care Manager" in the facility,

modify the job description to encompass the engagement cycles from intake through release. In certain cases, the changes to the core functions requires engagement with organized labor representatives so plan accordingly.

Medi-Cal Managed Care Health Plan

Form a relationship with the Medi-Cal managed care health plans that serve in the county. Each health plan is required to delegate a contact person, referred to as a "ECM Liaison" to support the pre-release care managers with post-release linkages. The health plans are responsible to maintain contracts with ECM providers, assign individuals to the ECM providers, and to manage the overall capacity of the ECM provider network. Therefore, the health plans need to know in advance about the release dates so they can orchestrate the connection to the proper ECM provider in the community. In certain cases where an individual is not assigned to a managed care health plan at the time of release, the pre-release care manager will work directly with the ECM provider. In cases where the managed care health plan is verified in the justice involved portal or EVS (see Exhibits A & I), the pre-release care manager coordinates directly with the health plan's ECM Liaison.

Audit Ready

Agencies participating in the CalAIM justice involved program should design their operations for routine and focused audits by the Department of Health Care Services (DHCS). The desk audits may begin in calendar year 2027-28 and would relate to the reimbursements for services in the facility and linkages into the community. Based on the mixture of federal and state funding, the findings from the audits would be circulated through DHCS and CMS. A best practice is to establish internal audits that are conducted annually to ensure the standard operating procedures are being followed, and that procedures comply with current regulatory requirements. Reporting the status of linkages into the community, and any outcomes such as appointment follow-through or connections into housing services, would be advantageous to document with the auditors.

03. Landscape Analysis

The landscape analysis is intended to inventory the current health delivery model in the correctional facility, as well as the in-reach services being delivered by county health agencies serving justice involved youths and adults. Documenting the services being rendered in the secure and non-secure areas of a detention facility is a starting point, and the inventory expands into the surrounding community to include the specialists, hospitals, and other providers treating incarcerated individuals. Health delivery services vary by correctional facility across the state with variations of county-based health models, embedded health providers, and other forms of hybrid health care delivery.

The landscape analysis is tailored to the county's structure, resources, and partners, and may include the following attributes:

01. List the correctional facilities in the county, including state prisons (if applicable), county jail, and juvenile detention facilities
02. Research and document the legal judgements, active consent decrees, and other pending litigation related to the operations of the correctional facility
03. List the population statistics for each facility (average population, gender mix, average length of stay, long-term commitments, etc.)
04. List the embedded health provider's staffing matrix (clinical and non-clinical FTEs, work schedules on a 24x7 basis)
05. List the facility's health provider utilization (service encounters) during the last four quarters
06. List the behavioral health & substance use treatment practices in the facility (e.g. criteria for new MAT inductions, continuation of MAT)
07. Review the volume of intakes, transfers, and releases by month and year
08. List the screening tools used in the facilities for physical health, mental health, substance use, social determinants, etc.
09. List each core data system used by county agencies, community health exchanges; examples include ATIMS / Tiburon for the Sheriff's Office, Tyler for Probation or Courts, and SmartCare for County Behavioral Health

10. List in-reach health providers with access into the secure areas of the correctional facility, and areas on the property where in-reach providers meet with individuals in the unsecure areas
11. List community-based organizations serving justice involved populations on a post-release basis
12. List the services administered by the County's Public Defender and pre-trial courts, including diversion, re-entry, behavioral health, collaborative, and co-occurring
13. List the acute hospitals, sub-acute, and specialty providers contracted to serve the individuals while incarcerated at the facility
14. List the steering committees that address justice involved populations in the county (E.g., AB109, reentry programs)
15. List the Diversion Courts and Public Defender programs, and the interactions between the Sheriff's Office and Probation Departments
16. List the ECM providers contracted with the Medi-Cal managed care health plan(s) in the county
17. List the community support providers operating in the county (housing, respite, food, other)
18. List the counties sub-contracted with the facility for detentions, including state prison and federal inmates (adult)

Listed below are the commons roles and responsibilities for **embedded health vendors** in the correctional facility:

01. Intake assessments (physical health, mental health, substance use, and other social determinants)
02. Chronic care management (diabetes, asthma, cancer, hypertension)
03. Physician and nurse staff 24x7 schedule for sick calls
04. Emergency response in the facility & triaging to acute care
05. Coordinate onsite medical appointments – dental, vision, orthopedics, physical therapy, and obstetrical care

06. Coordinate offsite medical appointments – emergency room referrals, specialty care (pulmonology, oncology, cardiology, etc.)
07. Wound care, including complex and simple wound care, along with minor suturing
08. Transfer individuals to and from facilities
09. Administer medications (incl. physician administered drugs)
10. Medication-Assisted Treatment (youth and adult), substance use counseling, and monitoring for withdrawal from alcohol, opiates, and stimulants
11. Transfers to other detention facilities (out-of-county warrants, state prisons, etc.)
12. American Disability Act management, equipment used to assist with modification needs
13. Discharge planning and Medi-Cal eligibility verification
14. Child welfare services engagement with Probation, and the eligibility services for the "dually enrolled youth" (i.e.., foster care youth detained in the juvenile justice center)

04. Eligibility

In October 2022, the DHCS released guidance for correctional facilities to track and report the number of Medi-Cal screenings, new applications, and declinations. The requirement to screen individuals began statewide on January 1, 2023. The results have been reported quarterly by each county to the DHCS, and a broad range of results have resulted (10% to 90%). In cases where an individual has multiple identities, or identification cannot be made at the time of booking, validating the individual's Medi-Cal eligibility typically requires coordination with local social services agencies. The Medi-Cal eligibility process is owned by the county's social services agency. Eligibility determination is a cornerstone of the CalAIM justice involved reentry initiative. Correctional facilities began screening for Medi-Cal eligibility for individuals being booked into custody, and quarterly reports have been submitted to the DHCS.

The following data is reported each quarter by the correctional facilities:

01. Average number of individuals incarcerated within the facility
02. Total number of individuals screened for Medi-Cal within the facility
03. Total number of individuals who declined to apply for Medi-Cal
04. Total number of individuals interested in Medi-Cal, but were confirmed to be already enrolled
05. Total number of Pre-Release Medi-Cal applications submitted

State prisons, county jails, and juvenile detention facilities report the data to the DHCS every three(3) months and precedes the implementation of the CalAIM pre-release services. The eligibility determinations are crucial to generating revenues and achieving a sustainable operation and represents one of the most important tasks in the billing cycle. During the booking process the individuals are questioned about their Medi-Cal status and multiple attempts to confirm their eligibility is often necessary during the first week of incarceration.

Medi-Cal pre-release services are a covered benefit which means people who meet eligibility are entitled to the services, and there is no lifetime maximums set for individuals. For the repeat offenders, a person can receive pre-release services an unlimited number of times, and there are no limits on the correctional facilities who serve the individuals. For example, an individual could be booked and released each month, and each time the clock restarts on the 90-day pre-release services.

ADULTS IN COUNTY JAIL

Adults in the county jails will experience two forms of eligibility determination in the booking process, with the first being the Medi-Cal eligibility and the second is the pre-release screening. For the incarcerated adults (21 and over), the Medi-Cal eligible person must have a mental health diagnosis, a substance use disorder, a chronic or significant clinical condition, a traumatic brain injury, intellectual or developmental disability, HIV/AIDS, or are pregnant or postpartum. Young adults (18-20 years of age) booked into a county jail are not required to be screened for pre-release services and are automatically deemed eligible for CalAIM services. Former foster youth, up to the age of twenty-six(26), are treated as youth when incarcerated in the adult facility.

ADULTS IN STATE PRISON

Adults in the state prisons are screened for Medi-Cal and pre-release services in a similar manner to the county jail. Eligibility criteria in the state prison is equivalent to the county jail mention above. The California Department of Corrections and Rehabilitation is in the process of

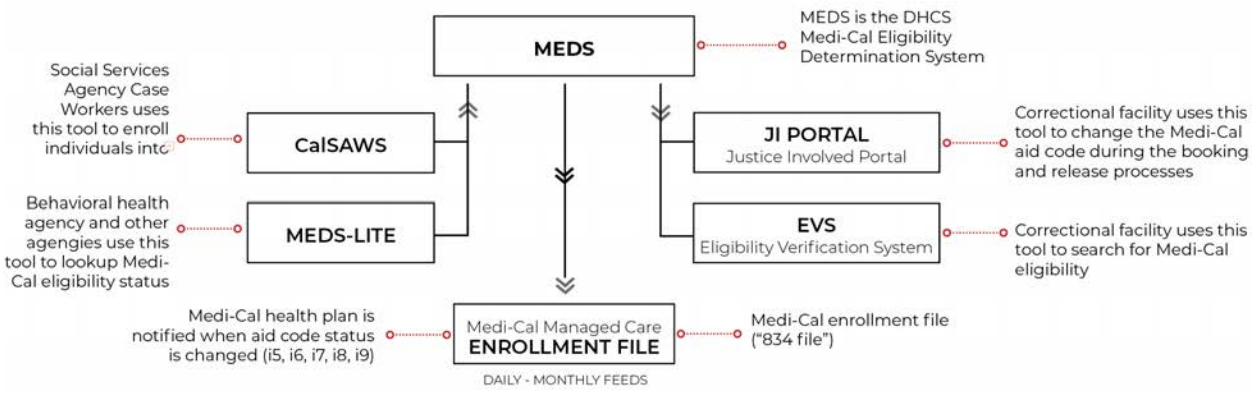
developing a pre-release framework to coordinate with county agencies, managed care health plans, and enhanced care management providers.

YOUTH IN JUVENILE JUSTICE CENTERS

Youth are verified for Medi-Cal eligibility but do not require pre-release screening, since 100% of youth are eligible for pre-release services. Under the law, youth in custody with Probation can be held through age 25 (i.e. SFTY, long-term commitments). Regardless of age, if an individual is booked into a juvenile justice center, the eligibility rules follow the facility where the individual is detained.

MEDI-CAL ELIGIBILITY SYSTEMS

The following is a list of Medi-Cal enrollment and eligibility systems used by county agencies and managed care organizations:



California Medi-Cal Eligibility System "**MEDS**" is a state-operated system that interfaces with CalSAWS and CalHEERS. MEDS is a statewide data hub serving a variety of eligibility, enrollment and reporting functions for Medi-Cal and other state and federal benefits. MEDS is used by Case Workers to look up coverage and confirm eligibility, aid code(s), and managed care plan assignment.

California Statewide Automated Welfare System "CalSAWS" is the primary system used by Social Services Case Workers to administer the eligibility determination process. A second system called "**MEDSLITE**" (/meds-lite/) is used by some county agencies to administer Medi-Cal eligibility.

CalHEERS / Covered CA: This system interfaces with CalSAWS. Social Service Case Workers primarily uses this system to assist with verifying income, social security number, and citizenship.

Eligibility Verification System "EVS" is a state-operated eligibility viewing system. EVS is the coverage look-up tool for providers and correctional facilities. The EVS application is accessed through the DHCS provider portal and requires a registration for a user account and password.

Application Eligibility Verification System "AEVS" is a state-operated system, telephonic-based platform for verifying Medi-Cal eligibility.

Justice Involved Portal is a state-operated portal that is used by the correctional facilities to verify eligibility, and to change the individual's Medi-Cal aid code. The aid code is changed during the booking process, and again during the release process.

Medi-Cal managed care health plans receive an enrollment file each month from the DHCS, typically in first week. The enrollment file contains the names of the individuals that are enrolled in Medi-Cal managed care and assigned to the health plan. Each day following the initial notification, health plans receive daily feeds of individuals through the last day of the month. As the Medi-Cal aid codes are changed during the incarceration period, the health plan receives a daily update and will be able to identify when a person is booked into custody, and when they are released.

The DHCS' Medi-Cal Eligibility System "MEDS" is the core system for Medi-Cal program, and the county agencies access MEDS data through the CalSAWS and the MEDSLITE system. Medi-Cal managed care health plans receive a list of assigned members during the first week of each month, then daily updates are sent to the health plans as members are assigned. Health plans are required to receive an enrollment confirmation from the DHCS before Medi-Cal managed care services begin. DHCS created a service bundle called "post transition support" to support individuals that are pending assignment to the health plan, and in this case would receive up to 28 days of post-release support from the correctional facility.

JUSTICE INVOLVED PORTAL & AID CODES

The DHCS released a web portal in 2024 for correctional facilities to use during the booking and release processes, and to modify the status of the individual during their stay in the facility. The justice involve portal is used

to change the individual's Medi-Cal aid code and initiates the 90-day pre-release billing period. See **Exhibit I** for a preview of the portal.

The Medi-Cal program covers nearly fourteen(14) million people in California and there are more than three hundred(300) aid codes. Everyone in the Medi-Cal program is assigned to an aid code, and the DHCS has issued five (5) new Medi-Cal aid codes for the reentry program including "i5, i6, i7, i8, and i9". The Medi-Cal aid code is changed at least two times; the first time in booking and again during the release process. The individual's overall release status may change due to court action, addition of offenses, and other factors that may extend beyond the 90-day window. As changes in the status of the individual occur, the facility is required to update the JI portal, and as their circumstances change. The billing is dependent on the Medi-Cal aid code being changed to match the individual's status in the facility. The JI portal also shows the Medi-Cal managed care health plan assignment whereas the EVS and CalSAWS show Medi-Cal eligibility but do not display the health plan assignment, which is needed for warm handoffs into the enhanced care management provider network.

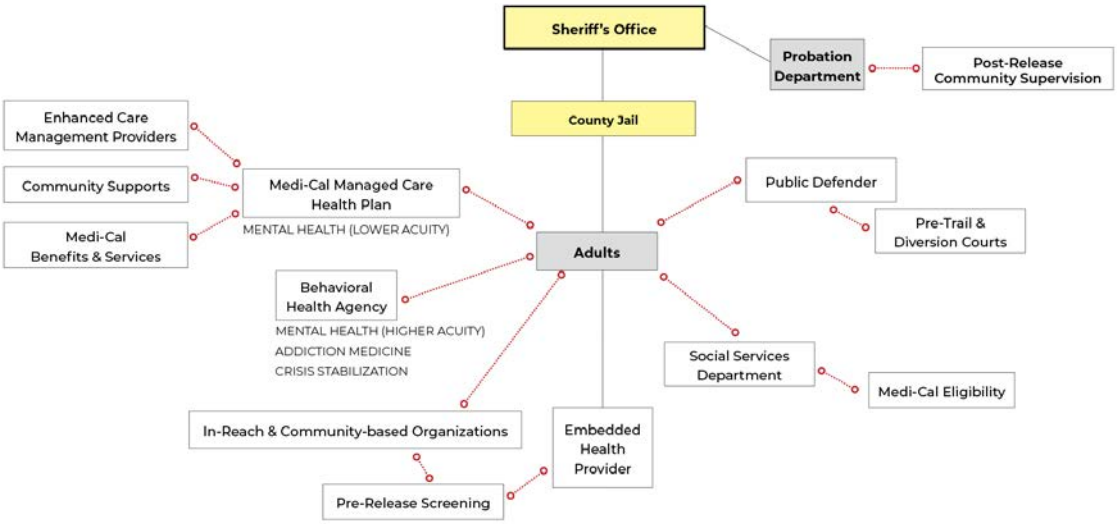
The time required to lookup the individual and change their Medi-Cal aid code is approximately 10-15 minutes and must be factored into the intake and release processes. The JI Portal must be used to start and stop the pre-release period and is required for billing of the pre-release services by contracted in-reach or embedded providers, such as behavioral health agencies. See **Exhibit C** for a definition of the new Medi-Cal justice involved aid codes.

Click here to view the Justice Involved Screening Portal User Guide

05. Workflows & Processes

Documenting the current and future state workflows and processes is a critical step in the facility readiness phases. Most of the correctional and behavioral health agencies in California applied for PATH JI funding, and subsequently submitted implementation plans and readiness assessments. In addition to the PATH-related submissions to DHCS, a readiness assessment is required six(6) months prior to launching the pre-release services. The readiness assessment contains examples of the future state workflows in each of the focus areas and validates the operational readiness for the facility. The landscape analysis serves as the starting point for capturing the "as is" in the custody operations and is referenced throughout the readiness cycles to guide the development of new workflows to meet the CalAIM reentry requirements.

SHERIFF'S OFFICE

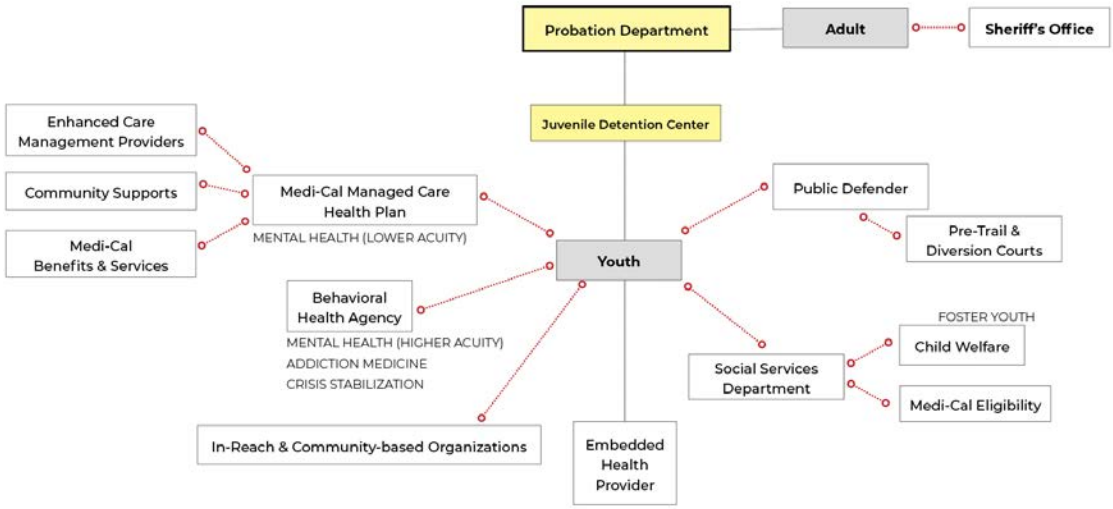


The following workflows in the county jail are recommended for documentation as part of the facility readiness:

01. Medi-Cal eligibility process and timeframes for determination
02. Medi-Cal expedited enrollments for new applicants
03. New Medi-Cal applications
04. Suspense to reactivation of Medi-Cal (stays longer than 28 days), and interaction with the social services department
05. Screenings and assessments
06. Medication-Assisted Treatment oversight by sworn staff
07. Level of Care Assignments (based on acuity of individual)
08. Intake & booking through disposition
09. Inter-county transfers
10. Discharge planning and release processes
11. Pre-trial interactions and releases coordinated with adult Probation
12. Release of information and consents by embedded health providers, in-reach-providers, and other community-based providers

The Sheriff's Office typically has developed a working relationship with social services and behavioral health agencies for AB109 individuals (10%-15% of the adult population). CalAIM expands the communication loop across all agencies and add the Medi-Cal managed care health plan into the release planning. The current state workflows for the Sheriff's Office should be documented, as well as the future state workflows, as part of the facility readiness.

PROBATION DEPARTMENT



The following workflows in the juvenile detention facilities are recommended for documentation as part of the facility readiness efforts:

01. Coordination with foster care youth and child welfare services
02. Medi-Cal eligibility process and timeframes for determination
03. Medi-Cal expedited enrollments for new applicants
04. New Medi-Cal applications
05. Suspense to reactivation of Medi-Cal (stays longer than 28 days)
06. Health screenings and assessments
07. Level of Care Assignments (based on acuity of individual)
08. Medication-Assisted Treatment oversight by Sworn Staff (Probation Officers, Institutional Counselors)
09. Intake & booking through disposition
10. Inter-county transfers for youth
11. Discharge planning and release for youth
12. Pre-trial interactions with the Sheriff's Office in the county jail
13. CDCR transfers of adults from state prison into post-release community supervision (PCRS)
14. As the individual is engaged by staff in the facility, document the release of information and consents by embedded health providers, in-reach-providers, and other agencies engaging with individuals
15. Inventory of contracts, funding, and payments to embedded and in-reach providers

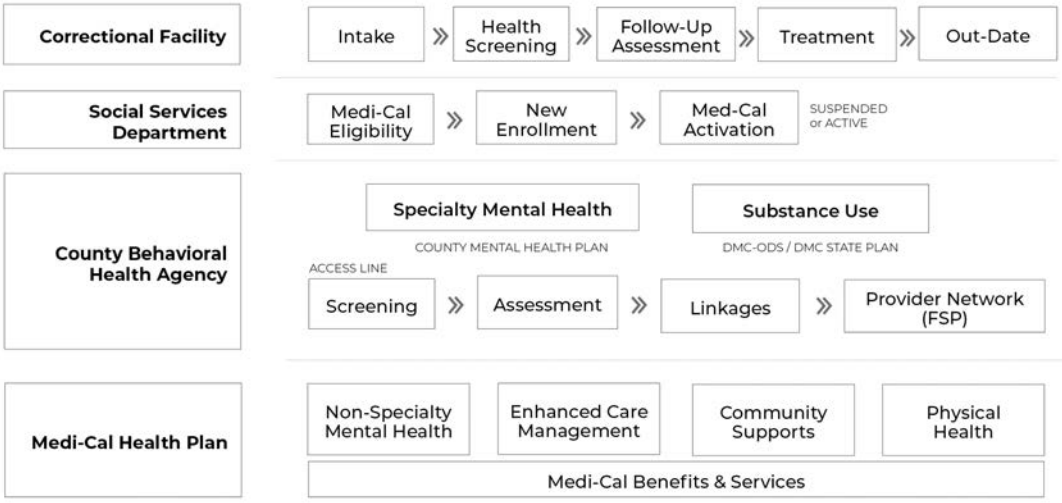
BEHAVIORAL HEALTH AGENCY

The framework of the behavioral health agency varies in each county as well as the engagement in the correctional facilities. Some counties operate a forensic behavioral division within the secure area of the facility, while other behavioral health agencies are completely external to the facility and intercept the individuals on a post-release basis through referrals and the crisis access line. Spending time to document the current role of the behavioral health agency in the landscape analysis supports the redesign efforts as the agency's role changes to enable the linkages and warm handoffs. The following behavioral health workflows are recommended to be documented as part of the CalAIM justice involved readiness:

01. Intra-county referrals into specialty mental health access line
02. Intra-county referrals into addiction medicine services
03. Inter-county transfers into specialty mental health services (Access)
04. Inter-county transfers into substance use services (DMC-ODS)
05. Referral process between the managed care health plan and the county behavioral health agency; pertains to individuals with mild to moderate, moderate to severe, or severe mental health issues
06. Referral process between the managed care health plan and county behavioral health agency for addiction medicine services; MAT for opiate or alcohol use, or other substances such as inhalants or methamphetamines
07. Full-service partnership "FSP" provider networks and the behavioral health agency's referral process
08. Case conferencing with the Medi-Cal managed care plans for the handoffs of the mild-to-moderate individuals, and transitions for the moderate-to-severe diagnoses
09. Screenings, assessments, linkages, and referrals into the full-service partnership network of providers should be documented thoroughly.

The following illustration highlights the future state engagement between the agency partners, health plans, and other partners serving the justice involved populations. At the top left, the individuals are booked and processed into the facility.

Medi-Cal eligibility is completed at this point. Initial pre-release screening takes place and if they are detained in the facility long enough for a follow-up assessment, treatments are initiated inside the facility.



As the individual is being prepared for release, the eligibility determination is confirmed as “active”, and the Medi-Cal ID card and reentry care plan are handed to the individual. Behavioral health agencies have an established process for connecting youths and adults into services for mental health treatment, addiction medicines, and other crisis stabilization services. Formerly incarcerated individuals are being supported through the county’s crisis support teams through post-release referrals, and the CalAIM reentry initiative adds a new level of pre-release coordination and closed-loop referrals to ensure handoffs are occurring. The “Access Lines” are often the entry point for these services and would likely continue to serve in this capacity for the justice involved populations. The pre-release care manager has arranged for post-release appointments with the enhanced care management provider, and the appointment cards are included in the release packet. The behavioral health agency plays a critical role in the transition of the individual into the community. More than fifty percent(50%) of youths and adults being incarcerated are experiencing mental illness, substance use, and co-occurring conditions that require navigation and supports from trained specialists. Under CalAIM, the connection between the physical and mental health is accomplished through warm handoffs that promote access to care and treatment continuity.

PRE-RELEASE FOR COUNTIES WITHOUT A JUVENILE DETENTION FACILITY

The facility readiness process for the CalAIM Justice Involved reentry is focused on agencies that administer custody operations in a facility. In California, there are eighteen(18) counties that do not operate a juvenile detention facility, including:

Alpine	Mariposa *
Amador	Modoc
Calaveras	Mono
Colusa **	Nevada
Del Norte *	Plumas
Glen	Sierra
Inyo *	Siskiyou
Lake	Sutter **
Lassen	Trinity

** Special Purpose Facility* *** Tri-county facility for Yuba, Sutter, and Colusa Counties*

The CalAIM reentry program defines the policies for agencies that operate a detention facility or serve individuals inside the detention facility. Counties that do not operate a juvenile detention center are innovating the role of juvenile reentry through collaborative techniques. The Probation Department in the "home county" (where the youths reside) plays a role in the delivery of pre-release services. The home county's Probation Department may assist with the transitions for the youth coming back into their community and be reimbursed for the qualified activities.

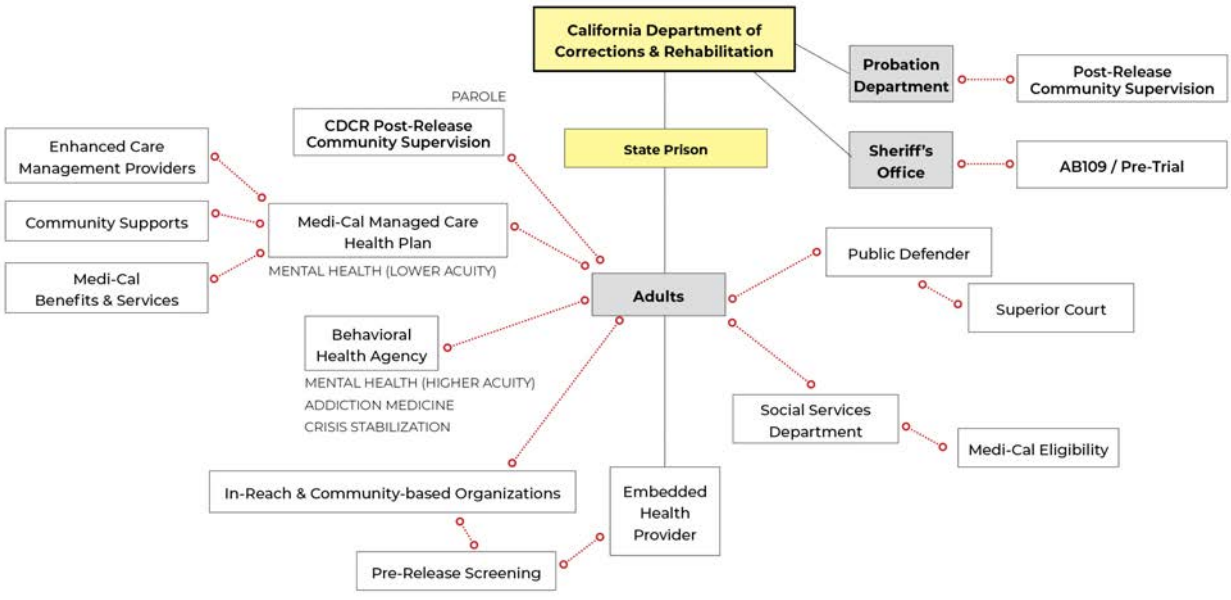
Listed below are the categories of pre-release services:

01) Screenings
02) Health Risk Assessments
03) Clinical Consultations
04) Care Coordination
05) Warm Handoffs
06) Reentry Care Plan
07) Linkages & Referrals
08) Release Planning
09) Medi-Cal Billing
10) Monitoring, Oversights, and Reporting

The services delivered for the youth in the facility is the responsibility of the Probation Department that oversees the facility (**01, 02, 04**), and the home county's probation department participates in most of the release activities (**03, 05-10**).

STATE PRISON

The California Department of Corrections and Rehabilitation operates thirty-one(31) facilities and thirty-eight (38) pharmacies in California. Adults in the state prison system are incarcerated for more than one(1) year have a similar pattern for reentry coordination as compared to county jails and juvenile detention centers. Many of the incarcerated adults reside in a different county than where they are housed, resulting in a higher volume of inter-county transfers. Statewide there are approximately 2,000 releases from the State Prisons per year that are estimated to be eligible for Medi-Cal system. Los Angeles, San Bernardino, Riverside, San Diego, Sacramento, Kern, and other central valley counties rank amongst the highest concentrations of individuals returning to their home county. The Medi-Cal eligibility rate, for individuals being release from state prison, from 70% to 100%, and averages 80-85%. Due to the length of stay in the facility, linkages into the home county's provider network becomes a vital resource for the person transitioning back into their community.



The California Department of Corrections & Rehabilitation (CDCR) is coordinating with county social services to reinstate Medi-Cal eligibility approximately four(4) months in advance of the release date. Unlike the county jails and juvenile detention centers where 95% of stays are less than

one year and many release dates are unknown, the individuals in the state prison system are automatically suspended from Medi-Cal upon sentencing. CDCR staff conduct a pre-release screening to determine eligibility and change the Medi-Cal aid code in the DHCS Justice Involved. CDCR personnel are responsible for the warm handoffs, linkages, and reentry care plans. The coordination between the ECM providers and CDCR staff is slightly different than with county jails and juvenile halls. For example, ECM providers may be more active in completing the reentry care plan and to establish linkages in the community. Approximately thirty(30) days prior to release the assignment to the enhanced care management provider is facilitated through the managed care health plan, and for individuals with several mental illness or addictions are linked into county behavioral health services. In the final week of incarceration, CDCR prepares the reentry care plan for distribution to the county agency partners, managed care health plans, and enhanced care management providers. A release notification is sent to the reentry partners, and the handoff is complete. Probation agencies continue to receive a prison packet for individuals ordered by the court to participate in post-release community supervision. Opportunities exist for probation departments to coordinate with behavioral health agencies and managed care health plans to obtain a copy of the reentry care plan from CDCR prior to the individual's actual release date.

06. Screenings

The CalAIM Justice Involved policy guidelines define two tiers of screening in the facility referred to as the initial and follow-up screenings. The timeframe for each screening aligns with Title 15 requirements and requires the use of a specific mental health screening tool. The selection of a second screening tool for substance use is a joint decision between the behavioral health agency and the correctional facilities and documented through the execution of a memorandum of understanding. The substance use screening tools are based on criteria from the American Society of Addiction Medicine and includes more recent developments of screeners from academic institutions. One example of a substance use screening tool is "BQuIP", published by UCLA. The result from screening the individuals ties into the health risk assessment and reentry care plan. The illustration below shows the relationship of eligibility determination, pre-release screening, health screening, health risks assessment, and follow-up screening and treatments. Screenings may be performed by non-clinical staff and sworn staff. Assessments, on the other hand, are performed by licensed clinicians.

The DHCS has published the following screening resources:

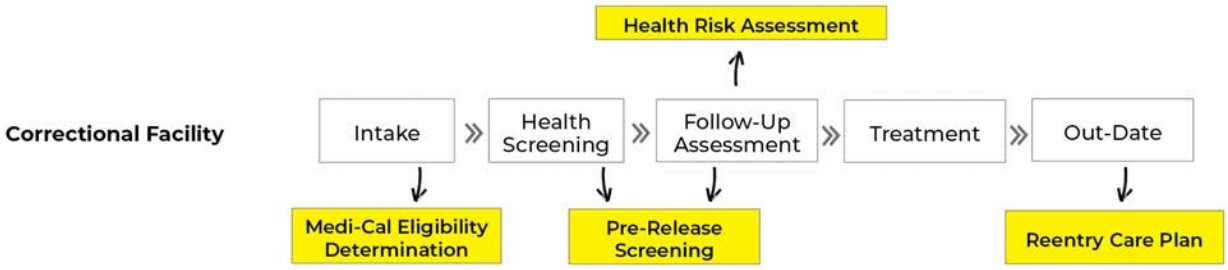
01. Mental health screening tool (youth & adult)
https://www.dhcs.ca.gov/Pages/Screening-and-Transition-of-Care-Tools-for-Medi-Cal-Mental-Health-Services.aspx

02. Substance use screening tool (youth & adult)
https://www.dhcs.ca.gov/provgovpart/Pages/County_Resources.aspx

The mental health screening templated issued by the DHCS is mandatory, and the substance use screening tool may be jointly selected by the correctional facility and behavioral health agency. The substance use screening tool is documented in a memorandum of understanding between the behavioral health agency and the correctional facility.

07. Linkages & Warm Handoffs

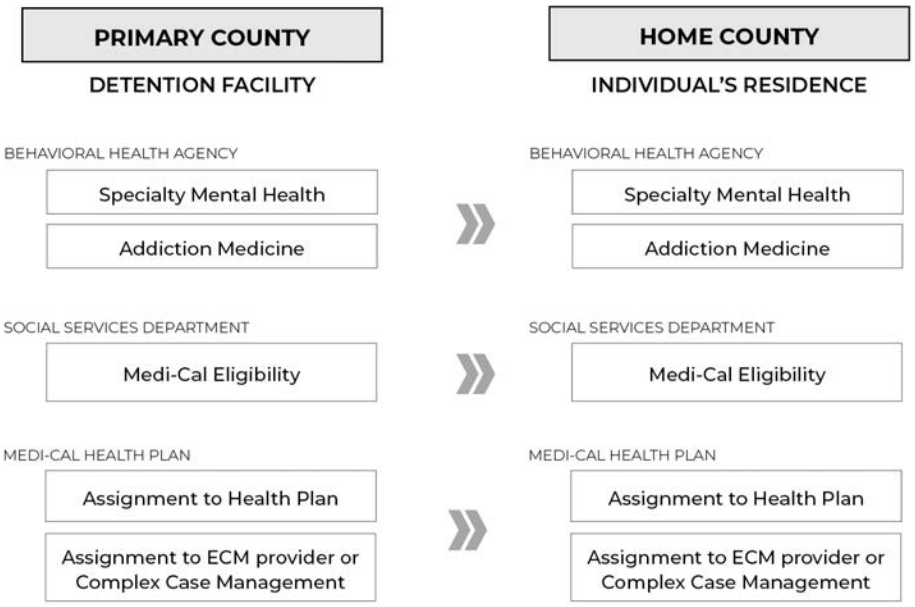
Linkages & handoffs are critical for individuals with high acuities and those being treated for substance use, such as addiction medicines for opiates and alcohol. Screenings are completed in the first twenty-four(24) hours inside the facility and is followed by assessments and treatments. The reentry care plan is developed to use as a source for transition into the community. The intensity of the warm handoffs is influenced by the individual's level of urgency, acuities, and type of care needed for the youth or adult as they are released from incarceration. Continuation of treatments following discharge from a facility and the handoffs are intended to maintain their regiment and to avoid setbacks that leads to reoffences. In some counties the correctional facilities have been coordinating with behavioral health agencies for high acuity individuals which makes for a simpler transition into CalAIM reentry services.



Behavioral health agencies are reimbursed for navigation and "warm JI linkages" through Short Doyle when individuals are transitioning from other counties. The difficulties with inter-county transfers pertain to the handoffs and sequencing of events between social services and behavioral

health agencies, and with the managed care health plan that is chosen by the individual to administer the Medi-Cal benefits.

Intra-County Releases are more linear since the individual being released is a resident of the same county as the correctional facility, and the agency partners that serve the justice involved populations know each other. There is a higher likelihood the individual has been engaged in the behavioral health system within the county and is also known to the agency's staff. The newest partner in the reentry equation for intra-county releases is the Medi-Cal managed care health plan, and the connections into the non-specialty mental health services. The Medi-Cal health plan is introduced into the justice system for the first time to connect the individual to non-specialty mental health services, enhanced care management providers for complex case management, assignment to health providers, community supports, transportation, and other Medi-Cal services. The linkages into the Medi-Cal health plan are an essential component in the referral chain and connects the specialty and non-specialty health services together. As the relationships grow between the correctional facilities and health plans, data sharing agreements are executed to allow for the reentry care plan to be distributed.



Inter-County Releases occur when an individual being released from a different county than their place of residence. This type of release typically requires engagement from several agencies due to the complexities of county-to-county Medi-Cal eligibility. For example, an individual can be enrolled in Medi-Cal in a different county than where they live, which introduces steps to resolve the discrepancies to access care in their home county. In contrast to intra-county releases, the county's staff may not

know each other or who to contact to conduct the warm handoffs, even in cases of a neighboring county. Individuals that are newly enrolled into Medi-Cal may not reach “active” status, nor be assigned to the health plan, by the time they are released from the facility. The handoffs and linkages may be more complicated when Medi-Cal eligibility is incomplete. Approximately 25% of incarcerations in juvenile justice centers and county jails are out-of-county, and each instance carries a unique set of linkage opportunities for behavioral health agencies.

08. Pre-Release Services

Pre-release services are Medi-Cal reimbursed services for individuals that meet the eligibility criteria and apply during the last ninety(90) days of incarceration. Two categories of services are eligible for reimbursement, including incremental services and care management bundles.

The pre-release services are organized into ten(10) functional areas.

01) Screenings
02) Health Risk Assessments
03) Clinical Consultations
04) Care Coordination
05) Warm Handoffs
06) Reentry Care Plan
07) Linkages & Referrals
08) Release Planning
09) Medi-Cal Billing
10) Monitoring, Oversights, and Reporting

Correctional facilities, behavioral health agencies, in-reach providers, and community-based organizations participating in the CalAIM program are eligible to receive compensation for services. The DHCS architected a two-tier payment system, and is organized into 1) incremental services, and 2) care management bundles.

INCREMENTAL SERVICES

Incremental services include the routine medical, mental health, and substance use disorder services rendered in the correctional facility. Payment is made by the DHCS for each service rendered, incrementally. Reimbursements are limited to the evaluation and management services, as defined in the Medi-Cal program.

The following groups of services are covered under the pre-release services:

01. **Clinical consultations** (physical & mental health)
02. **Laboratory** and **radiology** services
03. **Medications**, including over-the-counter drugs, specialty drugs, and physician-administered drugs & long-term injectables
04. **Medication-Assisted Therapy** (MAT)
05. Community Health Workers (**in-reach**)

CARE MANAGEMENT BUNDLES

Care Management Bundles are services that organized into five (5) billable units and contain a series of activities in each of the bundles. The bundles apply to a single stay in the correctional facility and the DHCS pays a flat rate for each of the bundles. DHCS may pay the full amount specified below in the rate table or could partially fund a service bundle based on the level of completion.

01. Health Risk Assessment
02. Care Coordination
03. Care Manager Warm Handoff
04. Reentry Care Plan
05. Post Transition Support

Correctional facilities are responsible for the administration of the pre-release services and the managed care health plans oversee the post-release services. In the pre-release phase, correctional facilities may be contracted with an embedded health provider, county public or behavioral health agency, or a combination of organizations for health services.

The contracted medical, mental health, and substance use, and other services are paid directly to the vendors or agencies. Dental services are carved out of the CalAIM JI program, and not subject to reimbursement. The revenues earned from the CalAIM justice involved program offset the expenses being incurred from the existing contracts. In the long run, one of the objectives is to reduce the overall spend on health services in the facility, and a second objective entails connecting individuals to needed services as they reenter into the community.

SCREENINGS

Two health screenings are required under the CalAIM policy. The first is the initial health screening and occurs within the first twenty-four(24) hours of detention unless there are reasons that prohibit the screening (i.e., intoxication,). The second is the follow-up screening and is more comprehensive and occurs within fifteen(15) days from the initial date of incarnation in the adult facility, and ninety-six(96) hours in the juvenile facilities. Under CalAIM, both screenings are setup to align with Title 15 requirements.

HEALTH RISK ASSESSMENT

As the individual is booked into custody, the initial screening occurs to identify any immediate health issues that require more immediate attention. Health Risk Assessments, or "HRAs" are more comprehensive and address physical health, mental health, substance use, housing, workforce, and other forms of social determinants (food, clothing, nutrition). The HRA is the primary source for the reentry care plan and information is added as treatments occur in the facility. At least one face-to-face or telehealth is required to bill for this bundle, and the encounter must be documented to substantiate the conversation with the individual. A licensed clinician oversees and approves the reentry care plan prior to distribution. Section 10.2.a of the CalAIM Policy and Operations Guide outlines the requirements for reimbursement.

CLINCIAL CONSULTATIONS

Clinical consultation is a category of service that encompasses the screenings, assessments, and treatments inside the facility. Clinical consultations occur in the facility prior to release and may be conducted between clinicians through in-person or video visits; consultations may include clinical conferences between medical providers in the facility and community-based providers (e.g. ECM providers, specialists). Individuals with higher acuities may require more attention by caregivers and subsequently need a higher level of release planning. The consultations are outlined in several sections of the CalAIM Policy and Operations Guide, and section 8.5 outlines a comprehensive role for this service.

LINKAGES & WARM HANDOFFS

Linkages & warm handoffs are intended to create a continuum of care for the individual by bridging the pre-release into the post-release experience.

The requirements associated to warm handoffs are defined in Section 8.4.f of the CalAIM Policy and Operations Guide. The pre-release care manager organizes the discharge planning and gathers most of the data for the reentry care plan, and outreaches to the community-based organizations to ensure the proper contacts are made in advance of the release.

REENTRY CARE PLAN

The reentry care plan is defined at the federal level by the Center for Medicare and Medicaid as the "person-centered care plan" and serves as the centerpiece for communicating the status and needs of the individual. The reentry care plan, under the CalAIM program, is a document that is shared with the individual as they leave the facility, and between the justice involved partners to arrange for services and to conduct the warm handoffs. A licensed clinician oversees and approves the reentry care plan prior to distribution. Section 8.4.e of the CalAIM Policy and Operations Guide outlines the requirements for reimbursement.

CARE COORDINATION

For individuals held in the facility for less than 90 days, care coordination begins at the time of intake and continues through the release process. In cases of a longer sentence or incarceration, the "90-day clock" starts as the care coordination is reimbursed during the final three months of the stay. The care coordination activities include the oversight of care for individuals in the facility and the connection to post-release services upon release. Care coordination is a service bundle that can be billed up to thirteen (13) times per incarceration with a maximum of eight(8) times in a single week. Section 10.2.b of the CalAIM Policy and Operations Guide outlines the requirements for reimbursement.

POST-TRANSITION SUPPORT

The fifth bundle is the "post-transition support" involves contact between the facility's pre-release care manager and the community-based enhanced care provider. In certain cases when the individual's Medi-Cal assignment to the health plan is pending confirmation, the facility would engage for up to 28 days following the individual's release date. Care coordination activities would be primary function to ensure warm handoffs are occurring for services based on the individual's health status. Section 10.2.e of the CalAIM Policy and Operations Guide for more information on the post-transition support. The post-transition bundle only applies when

the individual is not assigned to the Medi-Cal managed care health plan, and the ECM provider is allowed to submit claims for reimbursement.

RELEASE PLANNING

Schedule the follow-up appointments is driven by the needs of the individual being released. A person with a substance use disorder would be scheduled for treatment within the next twenty-four (24) hours following release from a facility. Identifying the needs of an individual is often derived through several interactions and becomes more crucial for short-term stays as time is limited. The secondary part to the identification of needs is securing the resources in the community. Locating a bed at a subacute facility or arranging for transition housing may take days and even weeks to attain the necessary results.

MEDI-CAL BILLING

Medi-Cal billing is a core part of the administrative "back-office" that is not reimbursed like other services. For example, Medi-Cal billing codes do not exist to reimburse the agencies for their time to prepare and submit claims. The facilities may go-live without operationalizing the billing office. If a facility launches pre-release services without a billing capability in place it is pertinent to be aware of the timely filing limit of six(6) months to avoid reimbursement penalties. Revenues that are generated by pre-release services offset the costs for health care in the correctional facility which represents significant expenditures monthly, so there is an incentive to align the go-live with the billing system in place. The level of effort to process the claims in arrears is extensive and may lead to missed revenue to the complexities in billing the Medi-Cal program. For more information about Medi-Cal Billing, please contact Scott Coffin at scott@serranoadvisors.com for a free copy of the **CalAIM Billing Toolkit**.

MONITORING & REPORTING

The DHCS requires all correctional facilities to continuously monitor the reentry program for performance and integrity. DHCS and CMS are finalizing the monitoring protocols and should release in 2025. In preparation for monitoring and reporting requirements, standard operations reports should be developed to list the type of services being rendered in the facility. Utilization rates for pre-release and post-release services, linkages and warm handoffs, and scheduling of follow-up appointments are a few examples. Section 12 of the CalAIM Policy and Operations Guide for more information on the monitoring and evaluation.

09. Interagency Collaboration

A successful CalAIM implementation, as well as sustaining the reentry partnerships, is reliant upon interagency collaboration throughout the project lifecycles. The public agency leaders that oversee the reentry services should convene periodically to work together, to understand each other's roles, and to decide how data will be exchanged between the agency partners. The governance structure is framed using a charter that establishes the roles of the reentry committee, and multi-agency topics serve as the centerpiece for meetings, including releases of information, memorandums of understanding, data exchange, electronic health record systems, and ongoing performance monitoring.

The following is a list of stakeholders to consider in the formation of an effective CalAIM collaborative or steering committee.

01. Chief Administrator or Executive Office
02. Health & Human Services
    - Behavioral Health
        - Mental Health Plan (Specialty Mental Health)
        - Substance Use (DMC-ODS or DMC State Plan)
    - Social Services Department
        - Medi-Cal Eligibility & Financial Assistance
        - Child Welfare Services (Foster Care)
    - Public Health Department
03. Probation Department
04. Sheriff's Office
05. Information Technology
06. County Counsel
07. Public Defender's Office
08. Superior Court Judges & Court Staff
    - Diversion, Collaborative, Co-Occurring Courts
09. Diversion, Collaborative, Co-Occurring Courts
10. Medi-Cal Health Plan(s)
    - Non-specialty mental health

- Enhanced Care management
- Community Supports
- Other Medi-Cal services

11. Community-based organizations serving the justice involved populations (enhanced care management providers)

The CalAIM JI collaborative is a governing body comprised of leaders from the county agencies, managed care health plans, safety-net organizations, and other community-based organizations. The working committee oversees the coordinated re-entry services for youth and adults transitioning from incarceration that are enrolled in the Medi-Cal managed care program. Maintaining a multi-agency oversight governance is a critical step in the sustainability of reentry services, and is purposed to oversee the following outcomes:

01. Coordinate resources to complete CalAIM project milestones and to address issues that impact one or more agencies
02. Develop the release on information requirements for individuals transitioning into the community
03. Create a standard data sharing structure for agency partners and community providers to facilitate the warm handoffs and behavioral health linkages
04. Form multi-agency memorandums of understanding that defines roles and data sharing
05. Maintain regulatory compliance for the CalAIM program and collectively address other regulatory requirements

Maintaining a multi-agency oversight governance is a critical step in the sustainability of reentry services. The leadership framework extends beyond the launch of pre-release services and provides a structure for regulatory reporting into the future. Setting up the cadence for routine governance meetings is often faced with time conflicts, especially with senior agency leaders. Aligning 60-120 minutes of time each month with agency leaders can be challenging. Re-purposing and existing meeting or extending the scope of a meeting that is already attended by the needed parties is one option to consider. It is not necessary to form a justice involved reentry committee, as the title of a meeting is less important than the agenda it carries and the involvement of the right people to make decisions.

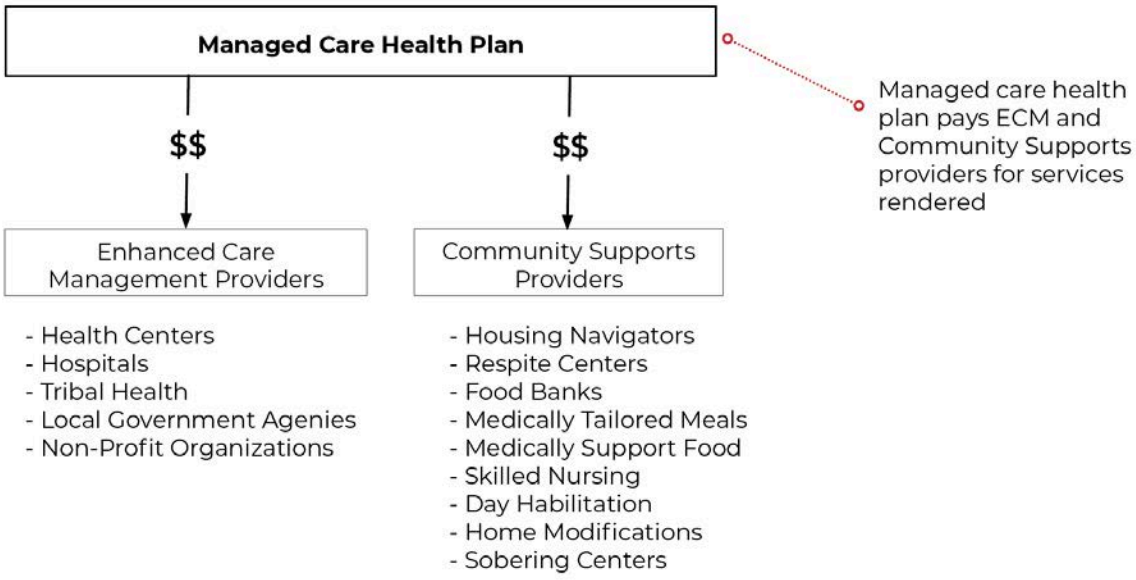
10. Enhanced Care Management

Enhanced care management services are a Medi-Cal covered benefit for adults, children, and youth enrolled in the Medi-Cal managed care program. Enhanced care management is equivalent to complex case management supports people with access to care. A total of nine(9) categories are summarized in the table below:

#	Population of Focus	Adults	Children & Youth
01.	Individuals or families experiencing homelessness	X	X
02.	Individuals at risk for avoidable hospital or emergency room visits (high utilizers of multiple systems of care)	X	X
03.	Individuals with serious mental or substance use disorders	X	X
04.	**Individuals transitioning from incarceration**	**X**	**X**
05.	Adults living in the community at risk for long-term care	X	-
06.	Adults in nursing facilities transitioning to the community	X	-
07.	Children & youth enrolled in the California Children's Services program	-	X
08.	Children & youth involved with child welfare services	-	X
09.	Birth equity	X	X

The fourth population of focus is assigned to the adults and youth transitioning from incarceration. The enhanced care management services are administered by the Medi-Cal managed care health plans and apply to post-release only. Enhanced care management services are not applicable during the individual's incarceration. Medi-Cal managed care health plans contract with community-based providers to deliver the post-release care, and the structure of these clinical teams is designed for "whole person care" oversight. In certain cases, the provider that is contracted with the health plan is also contracted with the correctional facility to administer in-reach services; the in-reach services are billed through the correctional facility's claim submissions to the DHCS, and the post-release services are

funded by the Medi-Cal managed care health plan. The illustration below shows the financial relationship between the Medi-Cal managed care health plan and the network of enhanced care management & community supports providers.



Managed care health plans are paid a fixed monthly fee by the DHCS for covered & optional services. The health plans negotiate reimbursement contracts with community providers, administering the access to services and overseeing the quality of care. Kaiser Permanente is an exception as they administer Medi-Cal in thirty-two(32) counties and offer treatment in their facilities and contract a network of enhanced care management providers.

11. Community Supports

Community supports are optional services in the Medi-Cal managed care program that are authorized by the DHCS and administered by the health plans. As a result of the Community Supports being optional, the health plans are allowed to establish their own authorization protocols and pathways and subsequently limit the amount of financial commitment for the service. The DHCS is leaning toward establishing these services as “covered benefits” under Medi-Cal in the future which would standardize the extent of the service and create more continuity between health plans. The number of Community Supports varies by each county, and as of Q4-2024 there were nineteen(19) counties that offered all the services listed

with exception to #15 – housing rent – which is scheduled to phase-in by January 2026 and allow for up to $5,000 in rental assistance for up to six (6) months. The following community supports are maintained by the health plans:

01. Housing transition & navigation services
02. Housing deposits (up to $5,000)
03. Housing Tenancy and Sustaining Services
04. Short-Term Post-Hospitalization Housing
05. Recuperative Care (Medical Respite)
06. Respite Services (Non-Medical Respite)
07. Day habilitation programs
08. Diversion to assisted living facilities
09. Transitions from skilled nursing facility into a home
10. Personal Care and Homemaker Services such as Residential Care Facilities for the Elderly and Adult Residential Facilities; Community Transition Services / Nursing Facility Transition to a Home
11. Environmental Accessibility Adaptations (Home Modifications)
12. Medically Tailored Meals & Medically Supportive Foods
13. Sobering Centers
14. Asthma Remediation
15. Transitional housing rent, up to 6 months (authorized by DHCS for a two-part phased rollout in 2025-2026)

Click here to view the DHCS report on Community Supports by county.

12. Specialty & Non-Specialty Mental Health

SPECIALTY MENTAL HEALTH

Specialty mental health services are administered by the county's mental health plan, which is typically housed inside of the behavioral health agency. The specialty mental health services are divided into three(3) categories including outpatient, residential, and inpatient services for people with high acuity levels. County agencies are responsible to administer the networks of providers, referred to as "full-service partnerships", and to monitor the access to care. Specialty mental health plans were formed in each county and receive funding from the Department of Health Care Services to operate.

Once the individual is assessed with severe mental illness, the following services are made available by the county's behavioral health agency:

Outpatient services:

01. Mental health services
02. Medication support services
03. Day treatment intensive services
04. Day rehabilitation services
05. Crisis intervention services
06. Crisis stabilization services
07. Targeted case management services
08. Therapeutic behavioral services, individuals under 21 years of age
09. Intensive care coordination, individuals under 21 years of age
10. Intensive home-based services, individuals under 21 years of age
11. Therapeutic foster care, individuals under 21 years of age

Residential services:

01. Adult residential treatment services
02. Crisis residential treatment services

Inpatient services:

01. Acute psychiatric inpatient hospital services
02. Psychiatric inpatient hospital professional services
03. Psychiatric health facility services

Counties are required to maintain an Access Line into Specialty mental health services, which serves as the front door for people experiencing severe mental illness. Crisis counseling through 24-hour hotlines, evaluation of psychotropic medications, and case management services are available through the behavioral health agency. Case workers connect the individual to food, financial assistance, housing, signing up for social security disability, and connecting to the managed care health plans for other types of healthcare services.

NON-SPECIALTY MENTAL HEALTH

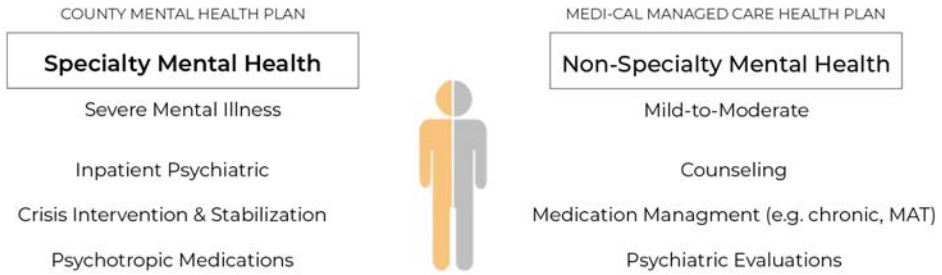
Non-specialty mental health services are administered by the Medi-Cal managed care health plans, referred to a “mild to moderate” mental health. Individuals experiencing lower mental health acuities are entitled to access services for the following types of treatments and support:

01. Individual & group therapy
02. Psychoeducation
03. Psychological testing when clinically indicated to evaluate a mental health condition
04. Psychiatric consultation
05. Medication management

Accessing the non-specialty mental health services is attained by contacting the Medi-Cal health plan and making a request. Staff are available to locate a clinical specialist in the vicinity to support the individual with referrals into treatment. In 2025, Medi-Cal health plans will be required to demonstrate a “closed-loop referral” system which goes one step beyond the referral and circles back with the provider or individual to confirm the appointment was completed.

MILD, MODERATE & SEVERE

The mental health benefit was implemented in 2014 under the Affordable Care Act and organized into multiple parts and assigned to different organizations. Three(3) categories are defined that identify a person’s condition, including: 1) mild to moderate, 2) moderate to severe, and 3) severe mental illness. The person experiencing mental illness may be treated by the county’s behavioral health agency and the managed care health plan simultaneously and toggle between them based on acuity levels. Higher acuities that fall into the “severe” category are managed by the county’s mental health plan, and lower acuities deemed as “mild to moderate” are administered by the Medi-Cal health plan.



In certain cases, individuals are assessed with “moderate to severe” mental health acuities and require the coordination between the managed care health plan and behavioral health agency; the coordination is typically a case conferencing session between clinicians and caregiver to determine the best course of action for the individual. The DHCS is planning to integrate the behavioral health services by 2028 and create a single platform for individuals to receive services and treatment.

13. Substance Use Disorders

The use of opioids, alcohol, and other drugs is identified in nearly half of the individuals booked into custody. Heroin, Fentanyl and other synthetics, and pain-relievers are widely available. People are combining opioid use with non-opioid substances to mix cocktails using a variety of products, and clinical studies are being conducted to fully understand the patterns and treatment options. Evidence-based research show that addiction medicines work for people that maintain their treatments and fight diligently to stay away from drugs and alcohol. Treatment for chemically dependent individuals leads to reduced re-offenses and recidivism, and the CalAIM JI program has placed the substance use disorders in its crosshairs.

The most common medication-assisted treatment for opioid use disorder (OUD) are:

- Methadone is a long-acting synthetic that helps to reduce the craving for opioid dependence.
- Buprenorphine (also called Suboxone) helps to reduce the withdrawal symptoms.
- Extended-release naltrexone (also called Vivitrol)

MAT treats alcohol use disorder (AUD) with the following medications:

- Acamprosate
- Disulfiram (also called Antabuse)
- Naltrexone

County behavioral health agencies operate a specialty mental health plan and either a Drug Medi-Cal State Plan (19 counties) or Drug Medi-Cal Organized Delivery System “DMC-ODS (39 counties). The county’s mental health plans, and both forms of Medi-Cal drug delivery systems, are reimbursed through the Short Doyle program. County behavioral health agencies are not reimbursed by Medi-Cal fee-for-service until pre-release services begin in the correctional facility. Short Doyle reimburses for

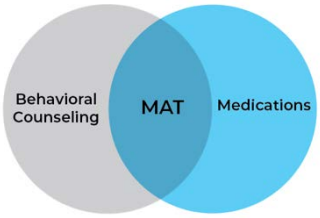
certain services inside of the correctional facility, as well as outside of the correctional facility.

The CalAIM reentry focuses on MAT programs in the facility and making the connections to community-based services to continue treatments in a timely manner following release. The release policy stipulates making the MAT connection within twenty-four(24) hours of release from the facility. While arrangements are made in advance, the decision rests with the individual to comply with the regiment and show up to the appointments. More information about MAT is provided in the following section.

For more information about Medi-Cal Billing, please contact Scott Coffin at scott@serranoadvisors.com for a free copy of the **CalAIM Billing Toolkit**.

14. Medication-Assisted Treatments

Medication-Assisted Treatments (MAT) are typically administered, in combination with addiction medicine, counseling and behavioral therapies. The most common addiction medicines administered by the embedded health provider to treat opiates and alcohol substance use. Treatment for methamphetamines, inhalants, and other substances are available in certain regions. DHCS has defined two forms of addiction medicine in the policy and operations guide, including medications to treat opioid use disorder (MOUD) or medications to treat alcohol use disorder (MAUD). The MAT program in the facility is one of the essential services required prior to launching the pre-release services. MAT is a combination of counseling and medications and should be considered in the facility's staffing model.



The CalAIM policy for Medication-Assisted Treatments (MAT) specifies that facilities must offer new inductions for youths and adults, however some facilities are planning to limit the services to individuals already in a MAT treatment program at time of booking. Individuals that claim to be in MAT treatment during the booking process are often required to participate in a urine test to validate adherence, and if they pass the initial test, MAT treatments continue. In certain cases, such as a hospital stay or transfer into an acute psychiatric facility, individuals are initiated into MAT, and once they return to the correctional facility the MAT treatment would continue. For higher-risk individuals, sworn staff are often pulled away from other duties to stay with the individual after the treatment concludes to monitor reactions. Correctional agencies determining prohibit new inductions should document in their PATH

implementation plan and confer with the DHCS through a technical assistance call as a secondary form of validation. The warm handoffs and linkages are purposed to address continuity of care needs of the individual, such as treatment with addiction medicine which requires a continuous regiment. Individuals participating in MAT programs should be coordinated with the behavioral health agency in advance of their release date, and the necessary arrangements in place to ensure the individual has the resources to continue post-release treatment (i.e., transportation, scheduled appointment prior to release).

15. Managed Care Health Plans

Medi-Cal managed care health plans administer the Medi-Cal benefits for over fourteen(14) million children, youths, and adults. In each county, a single health plan, or multiple health plans, are contracted with the DHCS to administer the Medi-Cal benefits and services. The health plans that are formed either by the county or through the public health system, often referred to as local initiatives or county organized health plans, represent about eighty (80) percent of the enrollment. For example, Partnership Health Plan administers Medi-Cal in twenty-four(24) counties in the northern regions of California and supports nearly 900,000 members. The managed care health plans receive a fixed amount of revenue per member, per month, which is referred to as a "capitated rate". The capitated rate is purposed to pay for all services rendered to the individual that is enrolled in their health plan. The health plan, in turn, administers the provider networks and pays the providers for their services. Below is a short-list of the Medi-Cal managed care health plans assigned to multiple counties, or with the higher enrollments of underserved populations in California:

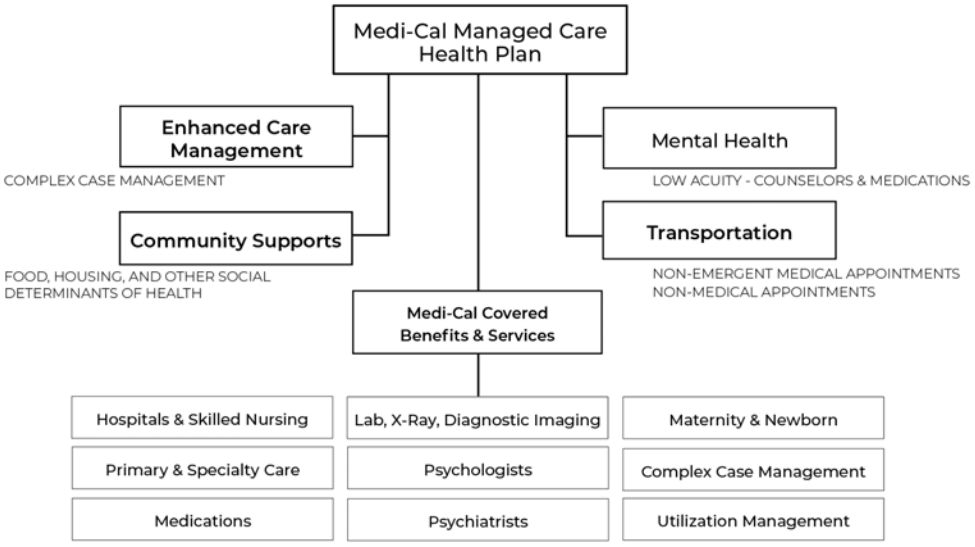
Medi-Cal Health Plan	Assigned Counties	Total Members
HealthNet / Centene	15	2.5M
LA Care (Los Angeles)	1	2.3M
Inland Empire Health Plan	2	1.5M
Kaiser Permanente	32	1.1M
CalOptima (Orange)	1	900K
Partnership Health Plan	24	900K
Anthem Blue Cross	15	827K

The Medi-Cal program offers a wide variety of services to address chronic diseases & conditions, addictions, and much more. California's Medicaid

program, known as Medi-Cal, has one of the broadest arrays of covered benefits and optional services, including:

01. Emergency room, hospital inpatient, and sub-acute care (skilled nursing)
02. Maternity and newborn care
03. Pediatric services, including oral and vision
04. Mild to moderate mental health
05. Prescription drugs
06. Diagnostic imaging
07. Prevention & wellness services, and chronic disease management
08. Enhanced Care Management
09. Community Supports (food, housing navigation, rent)
10. Transportation to medical appointments

Health plans contract with providers for enhanced care management (complex case management), community supports, and transportation. Managed care health plans may contract with providers to administer medication-assisted treatments for alcohol, opiate, and other substances. Community supports are a group of fourteen(14) services offered by health plans and is funded through the Medi-Cal program. Housing, food, sobering centers, day rehabilitation, respite care, asthma remediation, and other services are available. See Section 11 in the Reentry Toolkit for more information about the Community Supports.



On a post-release basis, transportation services are the responsibility of the health plan for individuals without a vehicle or way to travel to the pharmacy or other health-related vendor in the community following release from the facility. Health plans are not responsible for transportation during the pre-release period, only during the post-release. In a similar manner, the enhanced care management services apply only to the post-release experience, and the health plans are responsible to cover the costs for transportation and other Medi-Cal benefits. Correctional facilities may coordinate with the health plan to arrange for health-related transportation from the correctional facility at the time of release (i.e., enhanced care manager, primary care or specialty appointment).

16. CalAIM JI Readiness Roadmaps

Roadmaps are used to illustrate the major intersections and turning points throughout the readiness process from a higher level. Command Staff in the Sheriff's Office and Probation, as well as behavioral health and other agency executives, often benefit from a broader view of the pathways to reach a successful completion. Related to the justice involved reentry initiative, certain parts of the readiness for pre-release services are complex and requires a significant amount of lift from each agency partner. Roadmaps are used to communicate with all levels of management, to gain consensus on the roles for each organization, and to inform the steering committees and the local elected.

On October 1, 2024, the behavioral health linkages launched statewide, and it required that all behavioral health agencies demonstrate the ability to receive a referral for severe mental illness or substance use disorder. The administration of the referral linkages is associated to individuals being released from incarceration experiencing mental illness, substance use, or both.

BEHAVIORAL HEALTH AGENCIES

Behavioral health agencies are responsible under the CalAIM program to complete the ten(10) focus areas listed below by October 1, 2024:

01. Initial Data Sharing (1A)
02. Data Sharing (2A)
03. Follow-Up Appointments (3A)
04. Transportation (3B)
05. Reentry Professional-to-Professional "Clinical Handoffs" (4A)

06. Follow-Up post-release (5A)
07. Post-Release Follow-Up (5B)
08. Staffing Structure and Plan (6A)
09. Governance Structure for Partnerships (6B)
10. Reporting and Oversight Processes (6C)

The roadmap for behavioral health is linked into the DHCS Readiness Assessment and serves as a compass for the development of a project plan that contains the detailed activities, resources, milestones, and targeted completion dates. The project plan contains the details and is linked into the roadmap which sets cadence for the correctional facilities. Benchmarks are the applied standards to achieve compliance with the reentry program, and to complete the most important readiness requirements.

CORRECTIONAL FACILITIES

The structure of the CalAIM JI Roadmap is linked to the is linked into the DHCS Readiness Assessment and the tasks are cross-referenced into the PATH focus areas. The twenty-one (21) elements are organized into the CalAIM facility readiness checklist and must be completed and approved prior to the launch of pre-release services.

01. Screening for Medi-Cal (1A)
02. Application Support (1B)
03. Unsuspension / Activation (1C)
04. Screening for Pre-Release (2A)
05. Screening for Behavioral Health (2B)
06. Billing (3A)
07. Short-term model (3B)
08. Pre-Release Care Management (3C)
09. Clinical Consultations (3D)
10. In-Reach / Virtual (3E)
11. Medications (3F)
12. Medication-Assisted Treatments (3G)
13. Release Medications (3H)

14. Durable Medical Equipment (3I)
15. Release Date Notification (4A)
16. Reentry Care Plan (4B)
17. Warm Handoff (4C)
18. Behavioral Health Links (4D)
19. Staffing Structure (5A)
20. Governance (5B)
21. Reporting & Oversight (5C)

The twenty-one(21) readiness elements are divided into sixty-four (64) benchmarks that are tracked in the project plan. Each of the readiness elements is organized and assigned to an activity or outcome, and slotted into one of fourteen(14) categories, including:

01. Screening
02. Eligibility
03. Workflows
04. Policies & Procedures/Standard Operating Procedures
05. Data exchange & technology
06. Internal Controls
07. Memorandums of Understanding (MOU)
08. Facility Improvements
09. Regulatory Compliance
10. Procurement
11. Contracting
12. Staff recruitment, hiring, and training
13. Billing & revenue cycle management
14. Monitoring & Reporting

In addition to the readiness elements described in the previous section, the project plan should include the regulatory filings, credentialing, and other requirements associated to the CalAIM reentry program.

17. Policies & Procedures

The readiness assessment for the correctional facilities contains a series of policies and procedures that need to be in place prior to go-live. The landscape analysis is outlined in Section 02 of the **CalAIM Reentry Toolkit** and includes the inventory of existing policies and procedures in the operations. Comparing the existing to the required list of policies and procedures for the CalAIM reentry would serve as a starting point. A combination of new policies will be developed, and the remainder are achieved through amendment to the existing policies. Listed below is a list of policies and procedures required for go-live of pre-release services.

Readiness Element	Policy & Procedure
1A. Screening/Medi-Cal	Verify Medi-Cal eligibility determinations (ACWDL 22-27)
1B. Application Support	Notice of Action mailing
1B. Application Support	Request process by inmate for a state fair hearing
1C. Unsuspension/Activation	Release date notification
2A. Screening/Pre-Release	Pre-Release screening - Tier 1 (initial screening)
2A. Screening/Pre-Release	Pre-Release screening - Tier 2 (comprehensive)
2B. Screening SMI/SUD	Screenings for SMI, SUD (intake)
3A. Billing	Evaluation and management codes, service bundles
3B. Short-term model	Initiate screenings & assessments (72 hours or less)
3C. Pre-Release Care Management	Assign post-release ECM care manager
3C. Pre-Release Care Management	Pre-Release Care Manager roles and responsibilities
3C. Pre-Release Care Management	Development of the reentry care plan
3C. Pre-Release Care Management	Use of the consents and release of information
3C. Pre-Release Care Management	Medi-Cal aid code change, Justice Involved Portal
3D. Clinical Consultation	Obtain consent to share information JI partners
3D. Clinical Consultation	Prescribe durable medical equipment to individual
3D. Clinical Consultation	Request process for in-reach consultations
3E. Virtual/In-Reach	Virtual or in-reach services in the facility
3F. Support for Medications	Medi-Cal authorizations for pharmaceuticals
3F. Support for Medications	Medi-Cal billing/claiming for pharmaceuticals

Readiness Element	Policy & Procedure
3G. Medication-Assisted Treatments	Screening for Opioid Use Disorder (OUD)
3G. Medication-Assisted Treatments	Screening for Alcohol Use Disorder (AUD)
3G. Medication-Assisted Treatments	Counseling for MAT services
3G. Medication -Assisted Treatments	Screening for pre-natal MAT services
3G. Medication-Assisted Treatments	Storage of MAT medicines in facility's inventory
3G. Medication-Assisted Treatments	MAT continuation, withdrawal management
3G. Medication-Assisted Treatments	Specialized MAT services for pregnant individuals
3G. Medication-Assisted Treatment	Program Procedures and Workflows
3H. Release Medications	30-day supply of release medications in hand
3H. Release Medications	Overdose prevention, naloxone upon release
3H. Release Medications	Prior authorizations for release medications
3I. Durable Medical Equipment	Screening for Durable Medical Equipment (DME)
3I. Durable Medical Equipment	Provisioning of DME upon release from facility
3I. Durable Medical Equipment	Treatment Authorization Request (TAR) for DME
4A. Release Date Notification	Release date notification
4B. Reentry Care Plan	Reentry care plan creation and maintenance
4B. Reentry Care Plan	Reentry care plan distribution to caregivers
4B. Reentry Care Plan	Timeline for completing the reentry care plan
4B. Reentry Care Plan	Clinical sign-off and approval prior to release
4C. Warm Handoff	Scheduling of in-person or telehealth warm handoffs
4C. Warm Handoff	Handoffs to Enhanced Care Management Provider
4C. Warm Handoff	Post-release care management warm handoffs
4D. Behavioral Health Linkages	Consents for behavioral health linkages
4D. Behavioral Health Linkages	Data sharing - physical, mental, substance
5A. Staffing	Pre-Release Care Manager job description
5B. Governance	Data sharing MOU with JI Partners
5B. Governance	Collection, monitoring, and report of measures
5B. Reporting	Corrective Action Plans (CAP) for JI Partners

18. Short-Term Model

The CalAIM justice involved reentry policy applies to anyone that enters a correctional facility, whether they are detained for two hours, twenty days, or longer. Individuals that are cited and released and remain in the non-secure area of the facility, are intermittently screened and do not receive health care services (located in the secure area of the facility). The cited and release population represents almost half of the bookings, and the remainder are booked and detained. The most common challenges with short stays in the facility pertain to the completion of the pre-release services in a reduced period. Another challenge with short stays is the time required to activate the Medi-Cal eligibility, which is the responsibility of the social services agency.

The CalAIM justice involved reentry program currently includes any individual admitted into the facility, and this includes people that are cited and released. The "short-term model" is outlined in Section 8.2 of the CalAIM Policy and Operations Guide that addresses the individuals that are booked into custody and released within 48 hours. In certain cases where the individual is incoherent or unable to participate in a screening (i.e. detoxing), the correctional staff could document observations.

Individuals that are booked and detained, and remain in the facility for 1-2 days, would receive the initial health screening during the booking process, resulting in a few billable services. The individual may be released by the time a follow-up assessment or treatment could begin, which impacts the number of reimbursements being claimed by the facility.

The policies and procedures that apply to the short-term model should be clearly articulated for the county jails due to the higher volumes of adult bookings each year.

19. Memorandums of Understanding

In the Medi-Cal system of care, the Memorandums of Understanding (MOU) are non-financial forms of agreement between one or more parties. The DHCS has increased the pattern of MOUs in the Medi-Cal system and issued requirements for multiple county agencies to execute MOUs with the Medi-Cal managed care health plans, primarily to define roles and responsibilities on the various public health programs.

The DHCS requires health plans to report the status of MOUs on a quarterly basis, and currently there are more than twenty (20) different agreements required for specialty mental health, child welfare, substance

use disorder treatment, children's services, in-home supportive services, targeted case management, tribal health, local education agencies, regional centers and First 5 agencies, and in other parts of the public health system. Historically the MOUs have been executed and were not maintained effectively, and the new protocol is to revisit each MOU annually and adjust the language to meet programmatic requirements. The number of MOUs will continue to grow each year as well, as the DHCS is mandating more structure in the delivery of public health services and the MOUs serve as the vehicles to establish the roles and responsibilities.

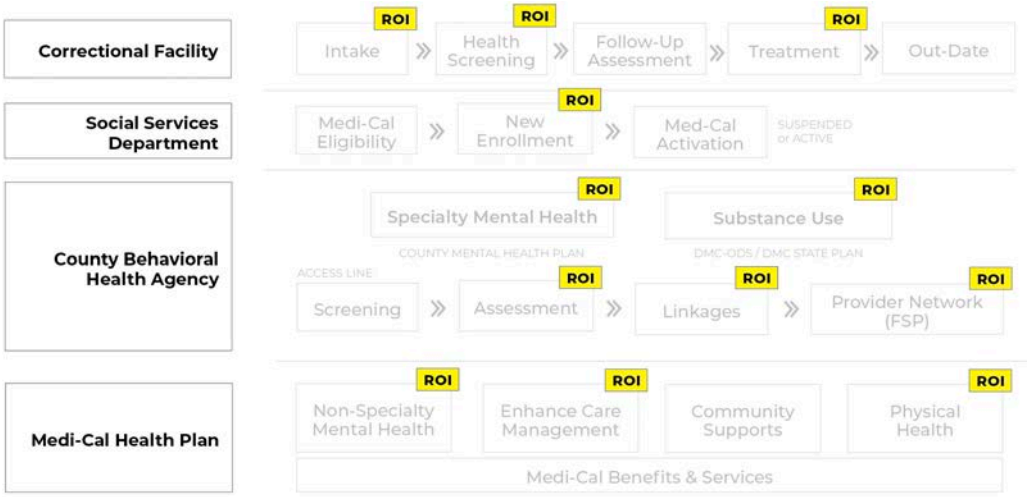
The CalAIM justice involved reentry initiative requires the execution of a MOU for data sharing and for the agency roles and responsibilities. Some counties are exploring the opportunity to amend an existing MOU while others are creating a new MOU. The DHCS issued a document in October 2023 that articulates the basic construct for the MOU and a template is forthcoming for the justice involved program. The template is expected in Q1-2025 and the correctional agencies in counties going live with pre-release services are independently executing MOUs; revisions may be required to comply with the requirements defined by the DHCS in the upcoming template.

Serrano Advisors LLC publishes a **CalAIM MOU Toolkit** and is available free of charge. Contact Scott Coffin at 510-414-6681 or email scott@serranoadvisors.com and request a copy.

20. Releases of Information

Releases of Information (ROIs) are a form of legal disclosure commonly used by organizations to obtain treatment consents and to allow for sharing of information with specific caregivers. Individuals that are booked into custody may experience several instances where ROIs are presented for signature. The movement toward a "universal" release of information is being forged in the CalAIM reentry initiative to simplify the consent process for pre- and post-release services. Vendors and embedded health providers often require ROIs and consents when a universal ROI is implemented, however the number of times a signature is required for health service is greatly reduced.

The following visual illustrates the potential occurrences of points in the pre- and post-release cycles where a release of information is signed and is often based on the number of organizations involved with navigation or treatment in the health system.



Documenting the points in time when a release of information is signed by the individual is an essential step in the planning process and should be included in the landscape analysis.

21. Data Exchange

The State of California issued guidance in October 2023 on data sharing authorization for Cal-AIM. Assembly Bill (AB) 133, a California state law that permits disclosure of personal information for the purpose of care coordination. The law applies to Medi-Cal partners and the list of organizations is extensive – physicians, caregivers, community-based workers, hospital and health center staff, correctional facility staff, case management staff at health plans, county and public agency staff, behavioral health specialists, and others engaged to support the formerly incarcerated person. Historically, one of the tallest barriers has been the Code of Federal Regulations, Section 42 Part 2, referred to as “CFR 42-2”, that protects the confidentiality of substance use disorder patients. This legislation has hindered the sharing of substance use data without prior consent and has remained a barrier to achieving the full potential of care coordination. AB 133 applies to “qualifying inmates of public institutions” as presented by the State of California and targets the pre-release services covered under the CalAIM program. Navigating through the state and federal laws is an essential step in the readiness cycles and should be

initiated early in the process. Safeguarding the patient's data is a shared priority, and this involves using the latest technology, applying consistent handling practices, monitoring, and periodic audits. The requirement to use consents and authorizations, and at which point in the data sharing between community partners, remains in question, and is recommended for review by County Counsel. The request for County Counsel is to consider this new law for sharing the substance use treatment data for purposes of care coordination, and to determine the use of Releases of Information, consents, and disclosures for pre-to-post release coordination. Core data systems are inventoried during the landscape analysis and support the planning efforts to exchange data between systems, and longer-term options to develop integration between the agency partners. The data required for a successful transition into the community can be extensive, and often there are requests for access to historical data that does not support the reentry efforts. The most sensitive information revolves around the substance use treatments and medications, and the federal legislation.

The concept of sharing "essential data" is being adopted by many agencies to overcome the legal concerns of privacy and security. County Counsels, County Agency Directors, and correctional facility leaders are devising a phase-based approach to data sharing. By narrowing the amount of data being shared, while meeting the regulatory requirements, it allows for validation of the essential data elements that are needed to successfully complete linkages and warm handoffs.

Listed below is a minimum set of data that should be documented in the reentry care plan:

01. Individual's **contact information**, address, telephone
02. **Actual release date**, **or "out-date"** – sourced from the JMS or case management system
03. **Medi-Cal eligibility** and health plan assignment – available in MEDS, MEDS-LITE and EVS (health plan assignment is not available CalSAWS)
04. Brief snapshot of **treatment history** related to the physical health, mental health, and substance use; includes snippets from the screening and/or assessment results.
05. **Level of treatment**, how the individual is responding to treatment, and highlights about treatment's effectiveness. This data is captured during the intake process, and throughout the incarceration as needed (based on acuity levels)
06. Current **medications**
07. Primary care physician contacts and **follow-up appointments**
08. Durable medical equipment
09. Emergency contacts

10. **Identification documents** (birth certificate, driver's license)
11. **Housing** – does the person have a place to go?
12. **Home modifications** – fall prevention, floor transitions, wheelchair ramps?
13. **Transportation** – does the person have a way to get to the pharmacy and follow-up medical appointments?
14. **Food & Clothing** needed?
15. **Next court date** following release from the facility?
16. Service **referrals** to community-based organizations
17. **ECM provider referral**, contact information, and address

Shorter stays will lead to prioritization of the essential data based on the availability of information gathered during the initial screening. In certain cases, the person's name, Medi-Cal identification, and observation of severe mental illness may be the only data points available to make the post-release referrals into the Medi-Cal managed care system.

22. Reentry Care Plan

The reentry care plan is a major deliverable in the readiness phase and is a required element to launch pre-release services. The reentry care plan is prepared during the individual's stay, and a copy is handed to the individual as they are released from the facility. In addition, an electronic copy is distributed to health partners in the community involved with the warm handoffs. Data sharing for the purpose of care coordination has been faced with issues concerning privacy, security, consent, and revocation. Electronic health records contain an abundance of data about an individual and often becomes the centerpiece of a conversation about data sharing. The challenge with health records (paper or electronic) is the level of detail and applicability to the individual's situation, and the question pertains to what is needed to facilitate a successful reentry experience and to connect the individual to the right caregivers.

The essential data would be shared securely between the county's behavioral health agency, managed care health plan, correctional facility (Juvenile Hall or County Jail), and other Medi-Cal partners. To facilitate the exchange of care management data, a multi-agency Memorandum of Understanding (MOU) is recommended to serve as the primary data sharing agreement.

The reentry care plan defines the level of treatment, how the individual is responding to treatment, and highlights about treatment's effectiveness. This data is captured during the intake process, and throughout the

incarceration as needed based on acuity levels. To simplify the privacy and legal concerns, the concept of “essential data” is introduced as a foundation for the reentry communications. In other words, reach agreement with the justice involved partners in the community about the types of data this is “essential” to complete a pre-release to post-release transition for an individual.

Reentry care plan includes the following essential data elements:

01. Name of the youth or adult
02. Actual release date from incarceration
03. Medi-Cal ID number (CIN)
04. Medi-Cal managed care health plan assignment
05. Address
06. Telephone
07. Screening & health risk assessment, findings & treatment plan
08. Treatment History (snapshots)
    - Mental health
    - Physical health
    - Substance use treatments (i.e., addiction medicines)
09. List of the individual’s chronic conditions
10. Prescribed Medications
11. Primary physician contacts
12. Scheduled Appointments
13. Housing
14. Employment
15. Income and benefits
16. Food & Clothing
17. Transportation
18. Identification documents
19. Life skills
20. Family and children
21. Emergency contacts
22. Court date(s)
23. Service referrals
24. Home Modifications
25. Durable Medical Equipment

Serrano Advisors LLC has developed an AI solution to streamline the development of the reentry care plan by automating the collection of data from multiple systems. For more information on the AI solution, contact Scott Coffin at scott@serranoadvisors.com.

23. Credentialing

Credentialing is a process to verify the clinician's status as a rendering provider and is required under the CalAIM Justice Involved reentry initiative. The Correctional facilities are responsible to administer the credentialing for the clinical staff rendering treatments in the facility and could either be employed by the embedded health care provider. The contracted in-reach providers are required to credential their clinical staff.

In addition to the credentialing each provider rendering treatment in the facility, regardless of their employer, is registered in the DHCS PAVE portal.

Oversight of the care management bundles is required by a licensed clinician in the correctional facility, and includes one or more of the following clinical designations:

- Medical Director (MD)
- Registered Nurse (RN)
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Clinical-Level Social Worker (LCSW)
- Licensed Psychiatrist, Psychiatric Nurse Practitioner, Mental Health Counselor, Mental Health Therapist, and Substance Use Counselor

Credentialing is mandatory and applies to practitioners who are licensed, certified, or registered by the State of California to practice independently (without direction or supervision). The credentialing service bureaus charge an annual fee to monitor the status of the clinical staff in the facility and is offered by many billing agencies as a standard service.

24. Regulators

The Department of Health Care Services(DHCS), in partnership with the Centers for Medicare and Medicaid(CMS), invested nearly $2.0 billion dollars in grant funding to prepare for the coordinated reentry services. DHCS pursued federal funding through the 1115 Waiver, referred to as "matching dollars", to support the capacity building in each county. The

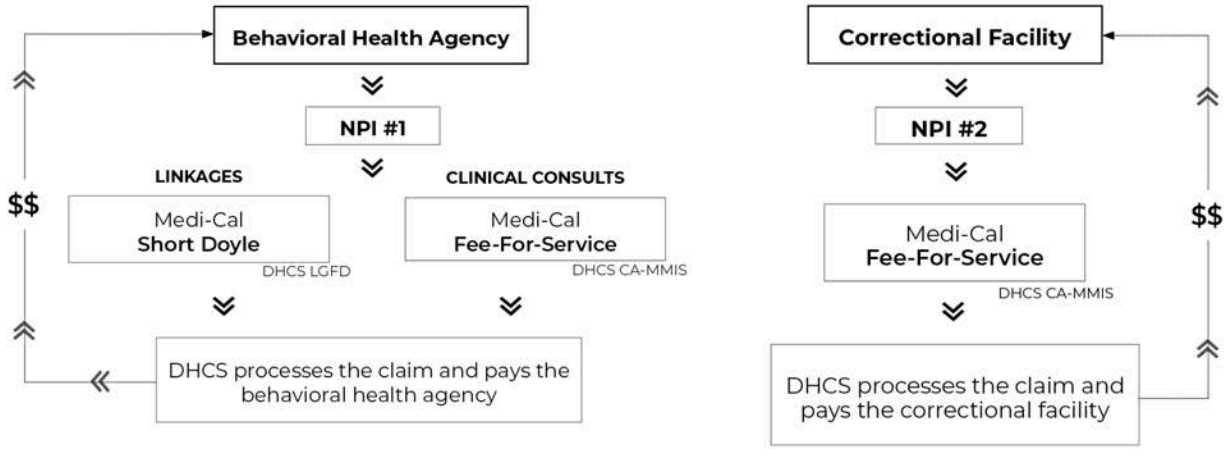
"federal freeze" that was announced in January 2025 targets immigration, climate, energy, and a few other non-health related parts of the federal funding. While a temporary block has been issued by a federal judge, it is unclear if the 1115 Demonstration Waiver (CalAIM's partial source of funding) will be impacted. CalAIM PATH funding is divided into two parts, the first being the "CITED" funding for the community-based organizations; and the second is the "Justice Involved" or "JI" funding for the correctional facilities and agencies serving the justice involved populations. CITED funding has four rounds of awards and the latest round of funding was launched in November 2024. The PATH JI dollars had three rounds of funding, and the deadline to submit is January 1, 2026. Organizations that applied for PATH funding are required to submit progress reports on spending activity which occurs every six(6) months.

Recipients of the grant funding are required to update the DHCS on the progress of spending and aligns to the federal requirements (defined in the special terms and conditions between CMS and DHCS). Budget modifications of 5% or more in each cost category results in a justification, which is comprised of a brief statement explaining the rationale for the revision. Compliance monitoring for Title 15, Title 24, the Board of State and Community Corrections (BSCC), and Office of Youth and Community Restoration (OYCR) is managed in parallel to the CalAIM justice involved initiative. Some organizations maintain accreditations for health services, mental health services, and opioid treatment programs through the National Commission on Correctional Healthcare (NCCHC). The pattern of facility-based audits will be expanded to include routine & focused audits by the DHCS starting in calendar year 2028-2029.

25. Medi-Cal Billing

Medi-Cal billing is new to the correctional facilities and represents one of the greater challenges to reach compliance with the CalAIM program. Historically the correctional facilities and Medi-Cal system have been separated, crossing over in certain cases when an individual became hospitalized for more than twenty-four(24) hours, and were placed into Medi-Cal for the duration of their hospital stay. The functional aspects of billing the Medi-Cal system for reimbursement has never been tested nor ventured by other states. California is the first to connect the two systems of care together. The facility is responsible to generate claims on industry-standard forms and submit to the DHCS for reimbursement. Contracted medical providers that are embedded in the facility, including contracted in-reach providers rendering services in different parts of the facility are funded directly by the facility. The behavioral health agency may be

serving as an embedded provider or in-reach provider depending on the contracted relationship and staffing model inside the facility.

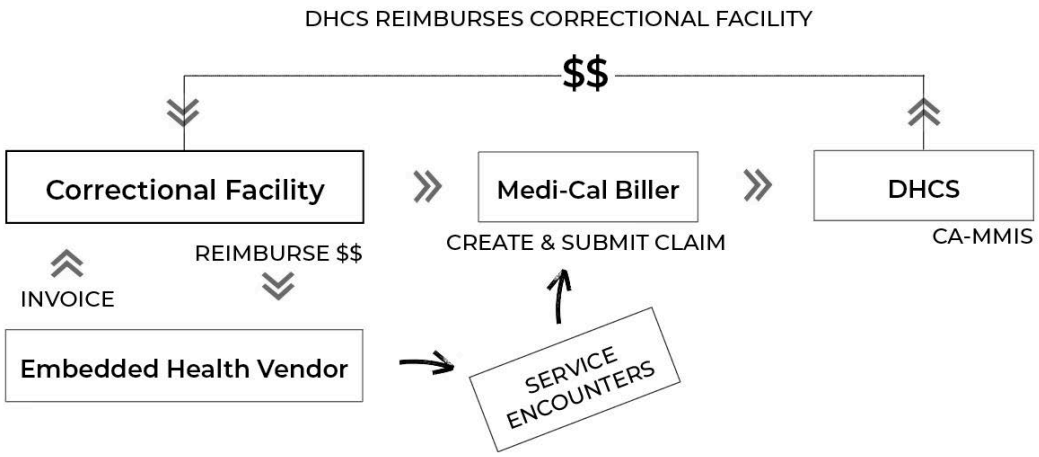


As the individual transitions into the community and depending on the acuity level of the individual being released, a handoff occurs to the behavioral health agency, managed care health plan, or both. The post-release coordination into a variety of Medi-Cal services is conducted through the health plan, as the provider networks are administered by the health plan for non-specialty mental health, enhanced care management, community supports, and other primary care and specialty service networks. The behavioral health agencies coordinate with health plans through referrals and case conferencing to support individuals with severe mental illness, addictions, or co-occurring conditions. Behavioral health agencies may setup a hybrid billing system to collect revenues for pre-release services and for facilitating linkages into the community resources.

REIMBURSEMENT FLOWS

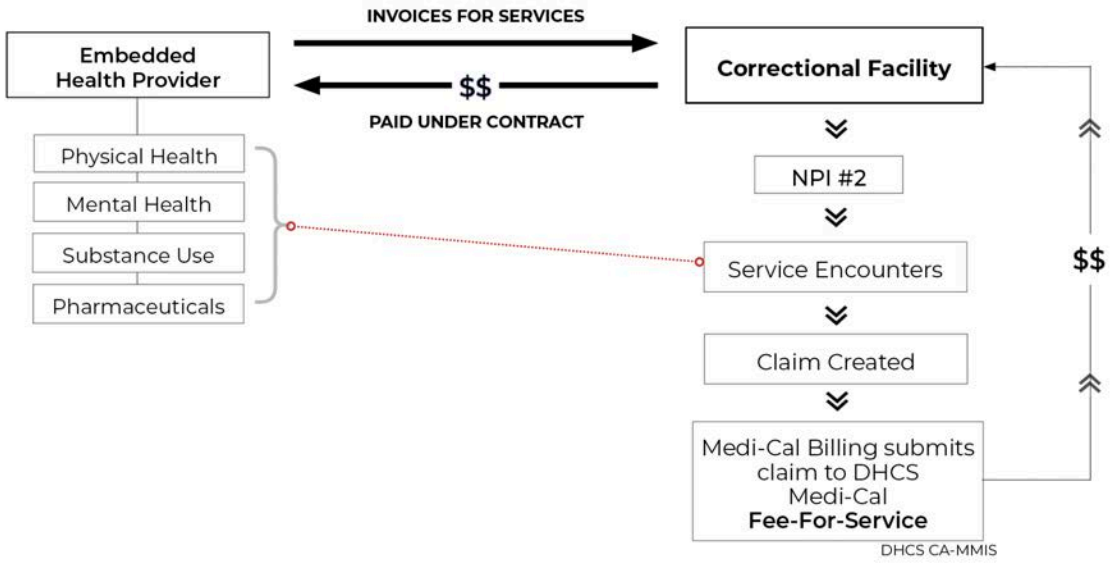
The reimbursement flows for correctional facilities and behavioral health agencies are structured in similar ways. DHCS is leveraging the standard Medi-Cal billing codes for reimbursement and added a group of new codes for behavioral health agencies and correctional facilities to use. The flow of funding changes after the facility launches pre-release services. Costs incurred by the embedded health provider and the new stream of revenues may be used to offset the fees being paid for embedded health services.

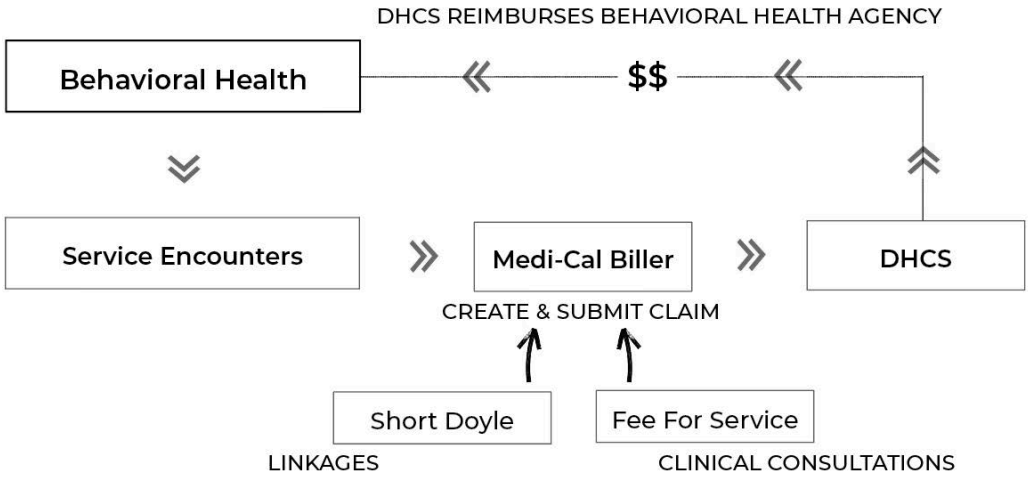
Reimbursements for eligible pre-release services start by capturing the actual service encounter, otherwise referred to as a product or service that is provisioned for the individual during the last 90 days in the facility.



In the scenario above, the correctional facility is contracting with an embedded provider to administer services in the secure area of the facility. Examples include Medi-Cal enrollment assistance, reentry planning, applying for housing, workforce development, or other types of transition services. If a contract exists between the facility and in-reach provider, the service encounters may be merged into the claiming by the embedded health provider, resulting in a single payment to the correctional facility. The facility, in turn, pays the embedded health provider and in-reach provider based on the fee schedules defined in the contracts.

The illustration below outlines the flow of money between DHCS, the correctional facility, and the embedded health provider. The correctional facility maintains contracts with embedded and in-reach providers, and the services rendered by the vendors are reported as encounters that may be claimed for reimbursement.





The reimbursement flow shown above is a high-level view of the billing cycle for behavioral health agencies under the CalAIM JI program. Agencies are reimbursed in two methods and depends on the type of service rendered. The first method of payment is through fee-for-service and the second is Short Doyle. Both reimbursements are administered by the DHCS. Either way the services are documented as "encounters" which represents a detailed accounting of the actual services, location of service, and the actual time spent with the individual. The service encounters are gathered on a routine basis and delivered to the Medi-Cal billing vendor to generate the claims. After the claims are developed, the billing vendor uploads the electronic claims into the DHCS portal for processing. Split billing is common for behavioral health agencies in the CalAIM JI program and is based on the type of service. Clinical consultations are funded through the CA-MMIS processing center in Sacramento, California. CA-MMIS processes and pays claims for hospitals, primary care physicians, specialists, and other providers in fifty-eight(58) counties.

Contact Scott Coffin for a free copy of the **Medi-Cal Billing Toolkit** by calling 510-414-6681, or email scott@serranoadvisors.com.

26. Proforma

Correctional agency and public health leaders, and their fiscal management teams, are interested to learn about the revenue opportunities related to pre-release, post-release linkages, and other reentry services. Nearly two-billion dollars in grant funding has been infused into the justice involved delivery system, and the spending ends on 12/31/2026 (aligned to the 1115 Waiver expiration). Justice involved

organizations will be required to sustain their operations through the Medi-Cal reimbursements.

The **CalAIM Proforma Toolkit** encompasses the following efficiencies, utilization rates, and population health statistics. The data should be collected for all shifts in the facility (24x7).

A set of data elements for the revenue forecast are listed below:

01. Percent of time the health risk assessment is completed
02. Percent of time the pre-release care manager coordinates care in the facility
03. Percent of time warm handoffs are completed
04. Percent of time care plans are completed prior to the release date
05. Percent of time post-transition supports are delivered by the facility's pre-release care manager (up to 28 days following release)
06. Completion factor for initial screening in first 24 hours
07. Completion factor for follow-up medical assessment with 15 days (Title 15)
08. Percent of individuals eligible for Medi-Cal
09. Percent of individuals verified by staff for Medi-Cal eligibility
10. Percent of individuals released from the facility in suspended or inactive status (Medi-Cal)
11. Percent of individuals verified for Medi-Cal eligibility by the Sheriff's Office
12. Percent of individuals that decline Medi-Cal (opt-out)
13. Percent of individuals eligible for Pre-Release services
14. Percent of individuals eligible for post-release ECM services
15. Percent of individuals that decline post-release ECM services (opt-out)
16. Percent of unassigned individuals to MCP at time of release from facility
17. Percent of individuals screened/assessed as SMI, SUD, or co-occurring
18. Percent of service encounters captured for billing
19. Rate of compliance to change the Medi-Cal aid code during intake through the JI portal
20. Rate of compliance to change the Medi-Cal aid code during release through the JI portal
21. Number of bookings per year in the facility
22. Average daily population in the facility
23. Number of long-term commitments (individuals) in the facility
24. Average number of days for individual stays excluding long-term commitments (90 - 365 days, one year or more)
25. Number of releases per month from the facility

26. Percent of sentenced individuals
27. Percent of non-sentenced individuals
28. Percent of individuals with a known release date
29. Percent of individuals with an unknown release date
30. Percent of individuals residing in the same county
31. Percent of individuals residing in a different county
32. Percent of stays less than 72 hours (short stays)
33. Percent of stays 3-14 days
34. Percent of stays between 15-30 days
35. Percent of stays 31-60 days
36. Percent of stays 61-90 days
37. Percent of stays more than 90 days
38. Percent of individuals cited and released
39. Percent of individuals classified into housing and detained in the facility
40. Rate of annual growth in bookings related to SB 36
41. Percent of individuals with SMI only
42. Percent of individuals with SUD only
43. Percent of individuals with co-occurring SMI and SUD
44. Percent of population with high blood pressure
45. Percent of population with diabetes (type 1 or 2)
46. Percent of population with asthma
47. Percent of population with congestive heart failure
48. Percent of population with HIV/AIDS
49. Percent of population with Hepatitis C
50. Percent of population with renal disease
51. Percent of population with cancer
52. Percent of population with autoimmune disease
53. Percent of population with sickle cell disease
54. Percent of population with Tuberculosis
55. Percent of population with traumatic brain injury
56. Percent of population with intellectual or developmental disability
57. Percent of population in gender-affirming care or treatments (transition)
58. Number of screenings during intake
59. Number of psychiatric sick calls
60. Number of lab/blood draws
61. Number of psychiatric chart reviews
62. Number of individuals treated
63. Number of discharge plans
64. Number of sick calls

65. Number of Chronic Cares
66. Number of MAT counseling sessions
67. Number of individuals treated in MAT
68. Number of new MAT inductions
69. Number of Tuberculosis testing & assessments
70. Number of diagnostic imaging visits offsite
71. Number of offsite appointments
72. Number of chart reviews by clinical staff
73. Number of OB/GYN appointments (prenatal/post-partum)
74. Number of individuals in need of durable medical equipment

For more information about **CalAIM Proforma Toolkit**, please contact Scott Coffin for a free copy at 510-414-6681 or email scott@serranoadvisors.com.

27. Conclusion

The objective for the **CalAIM Reentry Toolkit** is to support the readiness efforts and to develop lasting structure within the custody operations to meet regulatory compliance. As the CalAIM policies evolve and more is learned through implementations in each of the county's correctional health systems, the toolkit will be updated to reflect the latest advancements. In 2027-2028, the DHCS is planning to integrate the mental health and substance use services into the Medi-Cal managed care system, further linking into a unified model of care. The justice involved reentry initiative is a cornerstone to the behavioral health integration.

California's prisons release over 2,000 individuals per year, and county jails represent the highest volumes of bookings, reaching nearly one million per year. The lowest volume is with the juveniles and many of the facilities are positioned with pre-release services and engaged with the courts and child welfare services in their community. Mental health and substance use accompany a significant portion of the incarcerated populations. Diversion and co-occurring courts, and other forms of alternatives to sentencing, have been implemented to reduce the number of people being detained in custody. The passing of Proposition 36, which reclassifies misdemeanor drug and theft charges as felonies, is expected to increase the average daily population by 5% to 10% over the next year. Amongst the legislative landscape the correctional facilities are required to meet new reentry standards and link together with agency partners in the Medi-Cal managed care system.

Approximately twenty(20) cents or more of every dollar is allocated to health care in the correctional facilities. Data analyses consistently shows that incarcerated youths and adults are amongst the highest medically vulnerable populations and require more attention to address the infectious disease and chronic conditions. State prisons, county jails and juvenile detention facilities are being called through CalAIM to change the way transitions are made into the community's health system through a variety of interventions. Community-based provider networks are forming to deliver enhanced care management for the individuals facing complex diseases and conditions. Transitions into the communities are being re-calibrated to create a unified experience for individuals being released from custody. The concept of coordinated reentry has been in place for decades however the CalAIM program is chartering pathways for people to receive a more consistent experience.

28. Exhibits

A. Medi-Cal Eligibility Verification System “EVS”
B. Pre-Release Screening Criteria
C. Medi-Cal Justice Involved Aid Codes
D. Behavioral Health Contact Card
E. DHCS Guidance
F. Medi-Cal Billing References
G. DHCS Customer Service
H. 1115 Waiver Demonstrations
I. Justice Involved Screening Portal

Exhibit A
Medi-Cal Eligibility "EVS"

The Medi-Cal electronic verification system, referred to as "EVS" [ee-vez], is used to verify Medi-Cal eligibility. Each correctional facility is assigned a shared account by the DHCS to verify Medi-Cal eligibility and is accessed through the Provider Portal in the "Transaction Services" portal. A login ID and password is required to access the portal, and can be requested by completing the registration form and sending via e-mail to: CalAIMJusticePreReleaseApps@dhcs.ca.gov

The application is typically processed within two weeks, and you receive an e-mail with a User ID and PIN.

After you receive the User ID and PIN, login to the DHCS Transaction Services Portal at: https://secure.medi-cal.ca.gov/mcwebpub/login.aspx

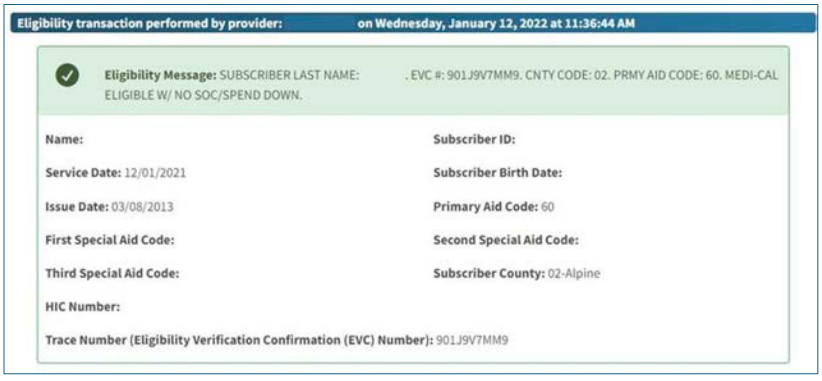
The Transaction Services portal presents a series of options, select "Single Subscriber" in the Eligibility section of the first screen.

The following information is required to verify Medi-Cal eligibility:

1) Subscriber ID: Medi-Cal beneficiary ID Number (BIC), Client Identification Number (CIN), or Social Security Number
2) Birth date: individuals' date of birth
3) Issue date: the issue date is located on the Medi-Cal BIC, or use **today's date**
4) Service date: use **today's date**

A subscriber identification is required to lookup the individual's eligibility. If you do not have the social security number or Medi-Cal card, contact your local Social Services Department for assistance.

After the information is entered into the transaction services portal, a screen returns with the eligibility status of the individual. A green banner at the top indicates the person is active in the Medi-Cal program; if the banner is yellow, it means their Medi-Cal is suspended, and a red banner indicates ineligibility.



The pre-release care manager in the facility should review the banner across the top to document the health plan assignment which is used in the reentry care plan and for the warm handoffs.

Exhibit B
Medi-Cal JI Pre-Release Screening Criteria

The DHCS defines the pre-release eligibility criteria in the CalAIM JI Policy and Operations Guide, Table #8, pages 62-66.

Listed below is a summary of the criteria for pre-release screening.

YOUTH

100% of youth in the juvenile justice centers are eligible for pre-release services.

ADULTS

Young adults, ages 18-20, booked into a county jail are automatically eligible for pre-release services.

Adults must undergo a two forms of eligibility determination. The first is Medi-Cal eligibility, and the second is the pre-release screening.

Pre-release screening is determined by clinical and non-clinical staff in the correctional facility and occurs during the intake process. The individual may verbalize their condition or disease, or the correctional staff [or embedded provider] conducting the intake may determine based on observations.

Adult Pre-Release Criteria:

A. Pregnant or post-partum
B. Blind
C. Mental disorder, receiving mental health services treatment or medications
D. Substance use disorder, alcohol, opiates, meth, inhalants, etc.
E. Any chronic condition or significant non-chronic clinical condition
F. Chronic condition that needs treatment, or is being treated for one or more of the following:

    01. Active cancer
    02. Active hepatitis A, B, C, D, or E
    03. Advanced liver disease

04. Advanced renal (kidney) disease
05. Autoimmune disease (arthritis, lupus, inflammatory bowel disease, and musculoskeletal disorders)
06. Neurological disorder
07. Severe chronic pain
08. Congestive heart failure
09. Connective tissue disease
10. Coronary artery disease
11. Cystic fibrosis
12. Dementia / Alzheimer's disease
13. Epilepsy or seizures
14. Foot, hand, arm, or leg amputee.
15. HIV/AIDS
16. Hyperlipidemia
17. Hypertension
18. Incontinence
19. Severe migraine or chronic headache
20. Atrial fibrillation/arrhythmia
21. Obesity
22. Peripheral vascular disease
23. Pressure injury or chronic ulcers (vascular, neuropathic, moisture-related)
24. Previous stroke or transient ischemic attack
25. Receiving gender-affirming care
26. Asthma
27. Bronchitis
28. Emphysema
29. Chronic obstructive pulmonary disease (COPD)
30. Sickle cell disease or other hematological disorder
31. Significant hearing or visual impairment
32. Spina bifida or other congenital anomalies of the nervous system
33. Tuberculosis
34. Type 1 or 2 diabetes
35. Intellectual or Developmental Disability
36. Cerebral Palsy
37. Autism
38. Down Syndrome
39. Traumatic Brain Injury

Exhibit C
Medi-Cal JI Aid Code

Aid Code	Description
i2	**90-Day Pre-Release Services Affordable Care Act (ACA)**. Grants limited Justice-Involved pre-release services to incarcerated individuals currently eligible on a 90/10 ACA primary Medi-Cal aid code. Federal financial participation (FFP) is 90 percent federal and 10 percent State General Fund for this aid code. The pre-release eligibility period is during 90 days prior to the release date. The services must be provided onsite of the facility in which the individual is incarcerated.
i3	**90-Day Pre-Release Services** Title XIX. Grants limited Justice-Involved pre-release services to incarcerated individuals currently eligible on a 50/50 Title XIX primary Medi-Cal aid code. FFP is 50 percent federal and 50 percent State General Fund for this aid code. The pre-release eligibility period is up to 90 days prior to the release date. The services must be provided onsite of the facility in which the individual is incarcerated.
i4	**90-Day Pre-Release Services** Title XXI. Grants limited Justice-Involved pre-release services to incarcerated individuals currently eligible on a 65/35 Title XXI Medi-Cal primary aid code. FFP is 65 percent federal and 35 percent State General Fund for this aid code. The pre-release eligibility period is up to 90 days prior to the release date. The services must be provided onsite of the facility in which the individual is incarcerated.
i5	**90-Day Pre-Release Services State Only**. Grants limited Justice-Involved pre-release services to incarcerated individuals currently eligible on a 0/100 State General Fund Medi-Cal primary aid code. FFP is 100 percent State General Fund for this aid code. The pre-release eligibility period is up to 90 days prior to the release date. The services must be provided onsite of the facility in which the individual is incarcerated.
i6	**90-Day Pre-Release Services Unsatisfactory Immigration Status (UIS)**. Grants limited Justice-Involved pre-release services to incarcerated UIS individuals currently eligible on a Title XIX Medi-Cal primary aid code. FFP is Title XIX for emergency services, Title XXI for pregnancy services, and 100 percent State General Fund for in-reach services not covered under emergency or pregnancy. The pre-release eligibility period is up to 90 days prior to the release date. The services must be provided onsite of the facility in which the individual is incarcerated.

Exhibit D
Behavioral Health Contact Card

The Contact Card is used by the Pre-Release Care Manager in the facility and by the reentry coordinators across the agencies and health plans. The purpose is to create a short-list of key contacts for the linkages and warm handoffs. Below is a list of the primary contacts by type of organization.

01. County Agencies

Behavioral Health / mental health
Access line coordinator

Behavioral Health / substance use
Access line coordinator

Probation Department
CalAIM program lead

Sheriff's Office
CalAIM program lead

Social Services Department
Medi-Cal Case Worker
Medi-Cal Enrollment Assister

02. Managed Care Health Plans

Transportation scheduler
ECM liaison
Community supports coordinator
Non-specialty mental health liaison

03. Enhanced Care Management Providers

Appointment scheduler
Medi-Cal enrollment assister

04. Community-based organizations

Medi-Cal Enrollment Assister
Housing navigator

Serrano Advisors LLC launched a public portal in December 2024 to support the linkages and warm handoffs. The domain is www.bhlinkages.com, and is intended to support the inter-county transitions for youths and adults.

Exhibit E
DHCS Guidance

- DHCS Facility Readiness Template
- DHCS Data Sharing Authorization
- DHCS Memorandums of Understanding
- DHCS Screening Tools
- DHCS Transition of Care Toolkit
- DHCS Policy and Operational Guide for Planning and Implementing CalAIM Justice-Involved Reentry Initiative
- DHCS Community Supports
- DHCS Rx Provider Manual
- DHCS Justice Involved Portal
- DHCS Community Supports
- DHCS Medi-Cal Aide Codes
- DHCS ECM Policy & Operations Guide

Exhibit F
Medi-Cal Billing References

Medi-Cal Publications
https://mcweb.apps.prd.cammis.medi-cal.ca.gov/publications/manual?community=medi-cal-program-and-eligibility

Medi-Cal Rate Lookup
https://mcweb.apps.prd.cammis.medi-cal.ca.gov/rates?page=1&tab=rates

Medi-Cal Pharmacy / Rx Forms
https://medi-calrx.dhcs.ca.gov/provider/forms/

Medi-Cal Pharmacy / Rx Drug Lookup
https://medi-calrx.dhcs.ca.gov/provider/drug-lookup/

Medi-Cal Specialty Mental Health Billing Manual
https://www.dhcs.ca.gov/Documents/SMHS-Billing-Manual-May-2024.pdf
https://www.dhcs.ca.gov/Documents/SMHS-Billing-Manual-v1-5.pdf

Medi-Cal DMC-ODS Billing Manual
https://www.dhcs.ca.gov/Documents/DMC-ODS-Billing-Manual-v-2-0.pdf
https://www.dhcs.ca.gov/Documents/DMC-ODS-Billing-Manual-v-1-5.pdf

DHCS CalAIM Billing Library
https://www.dhcs.ca.gov/services/MH/Pages/medccc-library.aspx

DHCS Claims Submission and Service Updates
https://mcweb.apps.prd.cammis.medi-cal.ca.gov/news/32984.28

DHCS Justice-Involved Reentry Initiative Implementing for Medi-Cal Services
https://mcweb.apps.prd.cammis.medi-cal.ca.gov/news/32984.22#msdynttrid=2-bQKavVFHANFrhc_0BK6SJHl5te3U2wXlTjX5Jqj2k

DHCS "ORP" Providers - Ordering / Referring / Prescribing Only
https://www.dhcs.ca.gov/provgovpart/Pages/Ordering_Referring_Prescribing_Providers.aspx

DHCS CA-MMIS "Fee for Service" for Justice Involved
https://mcweb.apps.prd.cammis.medi-cal.ca.gov/references/ji

DHCS Medi-Cal rates
https://mcweb.apps.prd.cammis.medi-cal.ca.gov/rates?page=14&tab=conversion

DHCS Specialty Mental Health & Drug Medi-Cal Guidelines
https://www.dhcs.ca.gov/services/MH/Pages/medi-cal-behavioral-health-fee-schedules.aspx

Exhibit G
Customer Service Contacts

California Department of Health Care Services (DHCS)

Department of Health Care Services	Telephone / e-mail
Medi-Cal Provider Services California Medicaid Management Information System (CA-MMIS) for claim submissions, denials, and appeals Electronic Verification System (EVS) Justice Involved Portal	**1-800-541-5555** **NPI number is required to receive support from the DHCS Provider Services Center**
Medi-Cal Pharmacy Claims	**1-800-977-2273**
Medi-Cal PAVE Provider Enrollment	**1-866-252-1949**
PATH Technical Support	justice-involved@ca-path.com
Justice Involved Advisory Group	calaimjusticeadvisorygroup@dhcs.ca.gov
PATH Applications and Interim Progress Reports	calaimjusticeprereleaseapps@dhcs.ca.gov
Statewide Pre-Release Go-Live Schedule	https://www.dhcs.ca.gov/CalAIM/Justice-Involved-Initiative/Pages/County-readiness-status.aspx
Justice Involved Portal	https://www.dhcs.ca.gov/CalAIM/Justice-Involved-Initiative/Pages/home.aspx

Exhibit H
1115 Waiver Demonstrations

State	Reentry Program Name
California	California Advancing and Innovating Medi-Cal (CalAIM)
Illinois	Illinois Behavioral Health Transformation
Kentucky	TEAMKY
Massachusetts	MassHealth Medicaid and Children's Health Insurance Plan (CHIP) Section 1115 Demonstration
Montana	Montana Healing and Ending Addiction through Recovery and Treatment (HEART)
New Hampshire	Substance Use Disorder, Serious Mental Illness, and Serious Emotional Disturbance, Treatment Recovery and Access
New Mexico	New Mexico Turquoise Care
Oregon	Oregon Health Plan
Utah	Medicaid Reform 1115 Demonstration
Vermont	Vermont Global Commitment to Health
Washington	Washington Medicaid Transformation Project

https://www.medicaid.gov/medicaid/section-1115-demonstrations/reentry-section-1115-demonstration-opportunity/index.html

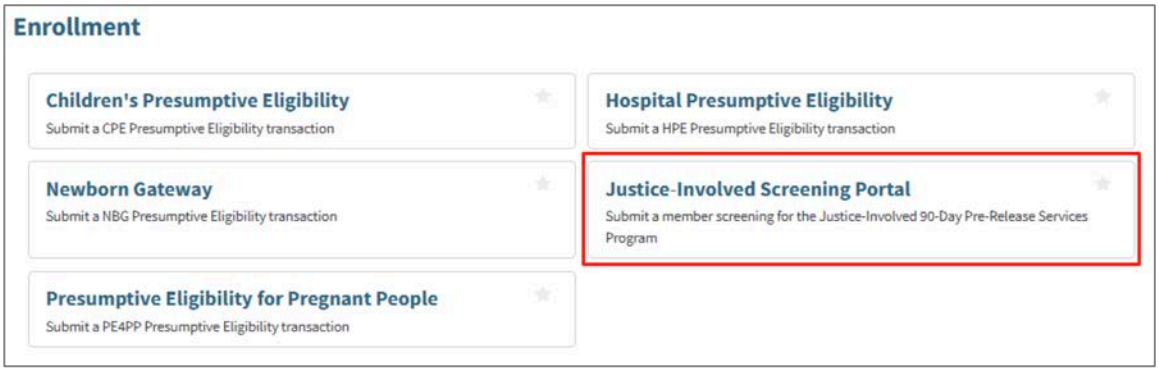
Exhibit I
Justice Involved Screening Portal

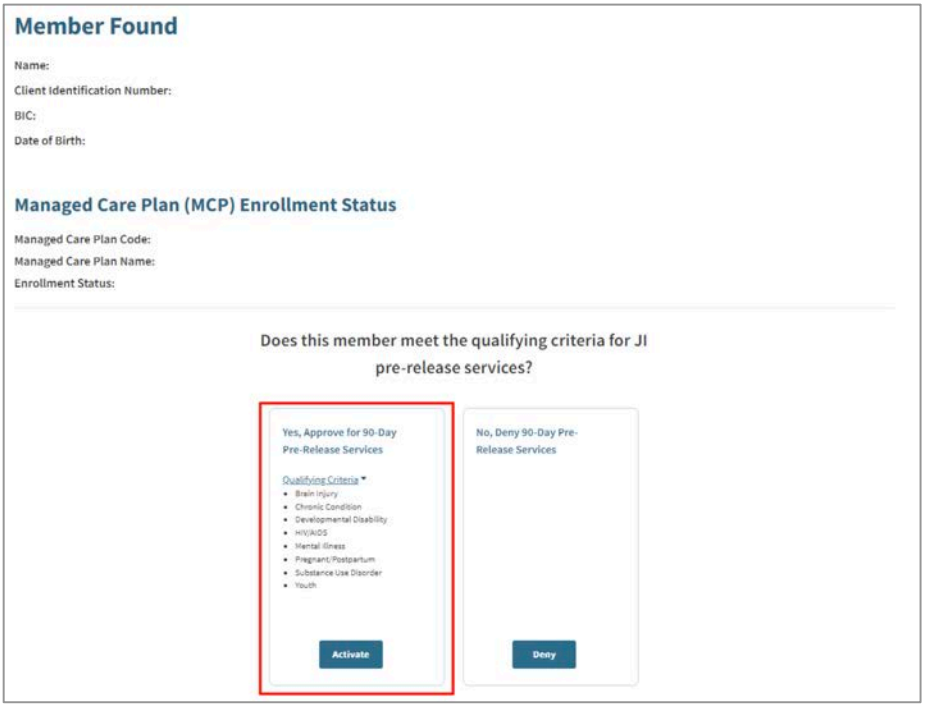
The **DHCS Justice Involved portal** is in the **Medi-Cal Provider portal**, nested inside of the **TRANSACTION SERVICES** section.

Login to the JI screening portal at the following address:

https://provider-portal.apps.prd.cammis.medi-cal.ca.gov/login

The Provider Portal requires an email address and password.





Source: California Department of Health Care Services