CALIFORNIA HEALTH POLICY STRATEGIES, L.L.C.

California Advancing and Innovating Medi-Cal (CalAIM): Opportunities and Implications for the Reentry & Justice-Involved Population

February 2020

Executive Summary

This policy brief provides an overview of California Department of Health Care Services (DHCS) proposal to re-envision the state's Medi-Cal program and its focus on the reentry/justice-involved population. The brief also suggests opportunities and challenges.

In October 2019, DHCS unveiled its conceptual framework for the state's Medi-Cal program. California Advancing and Innovating Medi-Cal (CalAIM) incorporates on many of the principles underlying the state's Whole Person Care pilot projects and focus on social determinants of health. In addition, CalAIM now focuses attention on Medi-Cal's most complex, costly, and vulnerable populations. The policy targets individuals who are experiencing homelessness, behavioral health challenges, and the growing number of residents newly released from prison or jail and those who are involved with the criminal justice system.

CalAIM represents the boldest and most far-reaching state effort to recognize and address the unique medical and behavioral health needs of the justice-involved population by leveraging the state's Medi-Cal program to improve services to these individuals.

In California, the state's criminal justice system population includes around 200,000 people who are incarcerated. In addition, approximately 36,000 people are released from California prisons each year; and over 560,000 are admitted or released from jails.[1] These individuals tend to have serious co-morbidities which negatively impact their ability to successfully navigate the challenges of release from prison or jail. They also have high rates of mental illness, substance use disorders, and chronic health conditions. When released from custody, they face a cycle of homelessness, emergency room and hospital utilization, and re-incarceration.

For justice-involved individuals, CalAIM seeks to leverage the Medi-Cal medical delivery system to support efforts to improve both health and public safety outcomes. By addressing criminogenic factors such as substance use disorders and other underlying issues such as mental illness, the proposal also hopes to reduce the number of jail, prison, and state hospital felons found incompetent to stand trial populations through both diversion and reduced recidivism.

[1] Extrapolation of data from McConville, Shannon and Mia Bird. "Expanding Health Coverage in California: County Jails as Enrollment Sites." Public Policy Institute of California. May 2016.

The CalAIM proposal includes a broad array of policy changes to focus and coordinate services for individuals who are the most medically vulnerable and complex – the ones who often fall through the cracks of the current system. Many justice-involved individuals in the community who experience homelessness, serious mental illness (SMI) and substance use disorders (SUD), or co-morbid health issues will be eligible for these services. However, the CalAIM proposal also identifies specific interventions that have direct implications for addressing the needs of the reentry population:

- *Pre-Release Planning.* Mandating that all jails have a pre-release planning and Medi-Cal application process.

- *Behavioral Health Warm Hand-off*. Requiring individuals receiving treatment for behavioral health issues in jail to receive a warm hand-off to the county's department for behavioral health. This is intended to improve the continuity of care.

- *Enhanced Care Management and "In Lieu of Services."* Requiring Medi-Cal managed care plans to provide targeted Enhanced Care Management (ECM) and more flexible "in Lieu of Services" for individuals transitioning from incarceration. These services could include supportive and transitional housing, sobering centers, board and care facilities, and other resources not typically covered by these plans.

- *Residential SUD Treatment After Incarceration*. Clarifying limitations of length of stay and American Society of Addiction Medicine (ASAM) criteria.

- *Institutions for Mental Disease (IMD) Expenditure Waiver for Mental Health Services.* Consideration of federal option.

- *Integration of Specialty Mental Health and SUD services*. Integration of clinical, administrative and DHCS oversight functions.

Finally, this policy brief suggests several overarching issues that should be addressed as stakeholders and policy-makers consider the proposal:

1. *Don't Forget CDCR and the State Hospitals.* Although CalAIM's primary focus is on the county-based criminal justice system, individuals coming from, and going to state prison can also benefit from improved coordination and support.

2. *Deploy Community Health Workers – "Trust is the Secret Sauce."* As justice-involved individuals engage with the medical and behavioral health delivery system, trusted relationships can be the key ingredient to successful programs. Community health care workers (CHWs) with lived experiences who understand the unique needs of individuals transitioning from prison and jail can provide the culturally relevant human connectivity

that facilitates warm handoffs and ongoing engagement with community medical and treatment providers.

3. *Consider Programming Challenges in Jails.* Most jail inmates are incarcerated for brief periods. Releases from jail can be unpredictable and often occur at night, after regular work hours. Medical and behavioral health screenings at intake are limited, and often rely on an inmate's ability and willingness to disclose any health conditions or current medications. Suspension of Medi-Cal eligibility and delays in managed care plan selection are also some of the challenges that create barriers for effective reentry programs and warm handoffs.

4. *Expand Access to Housing.* Access to safe, stable, and affordable housing is crucial for the justice-involved population, particularly given the high incidence of mental illness, substance use disorders, and homelessness.

5. *Implement a Continuum of Community-based Interventions.* Many individuals with serious medical and behavioral health issues could be diverted or safely supervised in the community if alternatives were available. A continuum of interventions could be implemented that includes alternatives at each successive point in the criminal justice process, from pre-booking to reentry.

I. Why Prioritize the Justice-Involved Population

CalAIM recognizes the significant gaps in the health and behavioral health care delivery system for people reentering society after being incarcerated.[2] The "reentry" population refers to individuals who have been recently released from prison or jail and are reentering the community. It is a defined here as a subset of the broader "justice-involved" population of those who have touched state or local criminal justice systems and may also be under current supervision in the community by probation or parole.

California's state and local criminal justice system includes around 200,000 people who are incarcerated. Each year about 36,000 people are released from California prisons, and over 560,000 (unduplicated) are admitted and released from jails.[3] Over 330,000 are being supervised by state parole or county probation.[4]

Prior to the passage of the Affordable Care Act most justice-involved individuals were ineligible for Medi-Cal and relied on county safety programs after being released from custody. A network of parole outpatient clinics, for example, was established to provide mental health services for parolees who were generally excluded from receiving county mental health services. Indeed, the Mental Health Services Act (Proposition 63), enacted in 2004, specially prohibited parolees from receiving mental health services funded through the initiative. In 2019, legislation was enacted to remove this bar to parolee services.[5]

Since 2014, federal and state policy changes have dramatically changed the ability and capacity for justice-involved individuals to access community-based medical and behavioral health care services. The Affordable Care Act's expansion of Medi-Cal eligibility to low-income, childless adults now provides an entitlement for care to most justice-involved individual who previously relied on county safety-net services. For newly eligible individuals, the federal government pays for 90% of the cost of eligible health and behavioral health services. Moreover, mandatory enrollment into Medi-Cal managed care programs provides a capitated financing structure with incentives for managing care and risk.

County specialty mental health and SUD managed care plans can now also access the enhanced federal match for eligible individuals. Other important state policy changes are also removing barriers that imposed challenges for the justice involved individuals to receive care. In February 2019, DHCS issued guidance to clarify county special mental health plans are responsible for providing services to individuals on parole, probation or Post Release Community Supervision (PRCS).[6]

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[2] The "reentry" population refers to individuals who have recently released from prison or jail and are reentering the community. It is a subset of the broader "justice-involved" population of those who have touched state or local criminal justice systems and may also be under current supervision in the community by probation or parole.
[3] Extrapolation of data from PPIC report entitled "Expanding Health Coverage In California Jails" published in 2016.
[4] US Department of Justice BJS report entitled "Correctional Populations in the USA, 2016" published in 2018.
[5] AB 389 (Hertzberg) (Chapter 209, 2019 Statutes)
[6] CA DHCS Memo. "MHSUDS Information Notice, Number: 19-007." February 26, 2019. [Link to Memo]

Although eligible, the justice-involved population faces unique challenges that hinder their ability to access care. They often fall through the cracks in the delivery system as they transition from prison and jail to the community. One study found a 12-fold increase in the risk of death in the two weeks following release. Another study found that 1 in 12 individuals leaving prisons and jails with Medicare coverage were hospitalized within 90 days of release. It was also found that the risk of death from all drug overdoses within the first two weeks after release from prison was 129 times that of other state residents.[7] These studies illustrate some of the costs to society, the criminal justice system and the healthcare networks associated with a lack of coordination of care for these individuals.

Homelessness is another factor that aggravates the severity of health and behavioral health conditions and impedes effective efforts to provide ongoing treatment. The prevalence of homelessness among the justice-involved population is overwhelming. The Sacramento County Public Defender's Office recently conducted a study of misdemeanants and found that 50% were homeless.[8] In San Diego County's 2018 point-in-time study, 27% of those in jail identified themselves as unsheltered prior to incarceration. An analysis of the state's unsheltered homeless population in 2017 found a strong connection to the criminal justice system. Based on self-reported data collected through point-in-time counts:

- 70% of unsheltered homeless, about 64,000 individuals, reported a history of incarceration.
- 28% of unsheltered homeless, about 26,000 individuals, reported having recently been released from jail or prison.
- 13% of unsheltered homeless, about 12,000 individuals, reported being presently under community supervision (either probation or parole).[9]

Other barriers to appropriate care include transitions from custody to the community. Continuity of care issues (e.g., switching drug and treatment regimens, switching therapists, etc.) add to the complexity of serving individuals transitioning between correctional and community-based providers. In addition, many former inmates have experienced life traumas that affect their capacity to be trustful of government and other large institutions. There is also a stigma associated with justice-involved individuals that leads some health providers to be uncomfortable, fearful or reluctant to provide services and treatment to this population. For justice-involved individuals – particularly those experiencing serious mental illness and SUD – the lack of effective interventions and treatment perpetuate a costly and tragic cycle of re-arrest, more time in custody, and a return to the street. CalAIM offers an alternative path.

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[7] Ingrid A. Binswanger et al., "Release from Prison—A High Risk of Death for Former Inmates," *The New England Journal of Medicine* 356 (2007): 157-165, https://www.nejm.org/doi/full/10.1056/NEJMsa064115.
[8] Sacramento County Public Defender Office. "Criminal Justice System, Behavioral Health & Homelessness, 2019."
[9] CalHPS "Criminal Justice System Involvement and Mental Illness among Unsheltered Homeless in California." 2018. [Link to Report]

II. What Does CalAIM Propose

The expanded role of Medi-Cal as envisioned by CalAIM recognizes the unique needs and challenges that justice-involved individuals face in seeking medical and behavioral care services. The proposal also acknowledges that too many highly vulnerable individuals are falling through cracks, resulting in higher levels of homelessness, emergency room use, longer hospital stays, as well as higher costs to the criminal justice system and increased rates of recidivism.

As a comprehensive re-design of the Medi-Cal program, CalAIM offers an array of policy changes that are intended to achieve the following three stated primary goals:

- *Identify and manage member risk and need through Whole Person Care Approaches and addressing Social Determinants of Health;*

- *Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and*

- *Improve quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems and payment reform.*

For justice-involved individuals, CalAIM seeks to use and leverage the Medi-Cal delivery system to support efforts to improve both health and public safety outcomes. By addressing criminogenic factors such as substance use disorders and underlying issues such as mental health impairment, the proposal also hopes to reduce the number of jail, prison and state hospital felons found incompetent to stand trial populations through diversion and reduced recidivism. By maximizing options under the Medi-Cal program, most justice-involved individuals who are part of the Affordable Care Act's newly eligible category will be able to access enhanced Federal Financial Participation (FFP) cost sharing, meaning that 90% of the cost of medical services and behavioral health treatment will be reimbursed by the federal government.

Many of the broad CalAIM policy changes are likely to promote better outcomes for this targeted, vulnerable populations with complex health and behavioral health needs, including justice-involved individuals. Improved program integration, administrative simplification, and more flexible access to benefits that address Social Determinants of Health can directly improve the quality and effectiveness of health care services for these populations.

CalAIM also proposes an array of policy changes directly targeting the reentry population that provide the opportunity to better coordinate medical, behavioral health and non-clinical social services for justice-involved individuals prior to and upon release from county jails. Medi-Cal managed care plans would be given greater responsibilities, direction, and more flexibility to meet the needs of their most vulnerable enrollees.

The following section provides an overview of the major components in CalAIM that are most salient for stakeholders and policymakers concerned with the reentry and justice-involved population:

- Pre-Release Medi-Cal Application Process Mandate
- Warm Handoff for Behavioral Health Services
- Enhanced Care Management & In Lieu of Services
- Residential SUD Treatment After Incarceration
- Consideration of Institutions for Mental Disease (IMD) Expenditure Waiver for Mental Health Services
- Administrative Integration of Specialty Mental Health and SUD services

Key CalAIM Proposals that Touch Reentry and Justice-Involved Individuals

A. **Pre-Release Medi-Cal Application Process Mandate**.
DHCS is proposing to mandate that all counties implement a county inmate pre-release Medi-Cal application process by January 1, 2022. This mandate would also apply to juvenile facilities. The proposal's stated goal is to ensure the majority of county inmates/juveniles that are eligible for Medi-Cal and are in need of ongoing physical or behavioral health treatment receive timely access to Medi-Cal services upon release from incarceration. The mandated county inmate pre-release application process will standardize policy, procedures, and collaboration between California's county jails, juvenile facilities, county behavioral health and other health and human service agencies. This collaboration is intended to establish a continuum of care and strengthen ongoing support services for individuals who are transitioning from custody to their communities.

Following passage of the Affordable Care Act, many counties developed outreach efforts to facilitate the enrollment of newly eligible Medi-Cal beneficiaries. Several counties partnered with sheriff departments to begin assistance with Medi-Cal enrollment prior to release because they recognized the importance of health and behavioral health care needs for the reentry population. Much of the funding for these programs was derived from a $50 million state enrollment assistance program that resulted from a one-time $25 million contribution from the California Endowment and matched with federal funds.

DHCS conducted a survey of counties and determined that 18 counties currently maintain a pre-release application process, although the design varies from county to county. Some counties contract with third-party entities (i.e. Community-Based Organizations or vendors) whereas others contract with the sheriff or jail. These application support processes can include dedicated intake staff who complete a visit with inmates prior to their release (see Appendix B).

Leveraging a provision in the H.R. 6 SUPPORT Act (Public Law 115-271), federal legislation enacted in 2018, the CalAIM proposal hopes to access Medicaid funding for health and behavioral health needs 30 days prior to release. This provision could provide a significant source of funding for enhanced care management and treatment (e.g., medication assisted treatment) that begins while the person is still incarcerated. However, federal implementation of the provision in the Act has been lagging. CMS has not yet convened the stakeholder committee as directed in the legislation and has not released guidance (as of February 2020).

Establishing eligibility for health and social service benefits is a key function of pre-release planning efforts. In the case of Medi-Cal, these efforts should also consider (1) establishing eligibility for Medi-Cal if the individual did not have coverage; (2) assisting with the selection of a health plan; (3) restoring Medi-Cal if benefits were suspended as well as re-enrollment in the individual's prior health plan; (3) assisting in determining eligibility for SSI, CalFresh, Veterans, and other benefits.[10]

B. **Warm Handoff for Behavioral Health Services.**

All counties would be mandated to implement warm handoffs from county jail release to county behavioral health departments when inmates are receiving behavioral health services while incarcerated. This transition assistance would allow for a smoother transition of behavioral health treatment in the community. The warm handoff would also include implementation of medical record release processes to allow medical records to be shared with the county behavioral health providers, prior to, or upon release from jail. Implementation would begin in January 2022.

The term "warm handoff" is often used to describe a transition process in which the client never loses contact with the referring provider until contact with the new provider is established. This warm handoff boils down to some simple systems. These include: establishing a medical home with a community provider; making initial appointments following release from custody; sharing medical records as necessary; providing a bridge prescription for necessary medications, until the client can be seen by the community provider, and other treatment regimens continuously after release; and empowering the reentry population with assistance and information to help them to actively participate in managing their behavioral health problems.

The CalAIM proposal focuses exclusively on transitions for inmates receiving behavioral health treatment in the jail. However, these inmates are likely to also have physical health issues that will require the engagement and participation of an eligible individual's Medi-Cal managed care plan. Warm hand-offs are also needed for inmates

[10] For a full discussion of these issues, see CalHPS's letter to DHCS and CalHP's report regarding disability for jail-incarcerated people.

transitioning from CDCR such as parolees and those returning as Post Release Community Supervision (PRCS) individuals. As CDCR launches an aggressive effort to initiate Medication Assisted Treatment for state inmates, the need for continuity of care in the community will be even more essential. State inmates with serious medical and chronic health conditions are also in need of warm hand-offs as they return to the community.

Building a system focused on improving behavioral health transitions is a reasonable first step to connect county jail clinical and custodial staff with their sister county agency responsible for community behavioral health. As implementation begins, planners should consider opportunities for broadening the scope to also include individuals with chronic medical conditions (e.g., diabetes, HIV, etc.) and transitioning state inmates. Further integration with physical health is anticipated by the proposal described below for Enhanced Care Management and In Lieu of Services.

C. **Enhanced Care Management & In Lieu of Services.**

The most significant and far-reaching proposal in CalAIM would focus resources on the state's most complex, high-need Medi-Cal beneficiaries. The new program would establish an innovative interdisciplinary collaboration in combination with more flexible, in lieu of services that recognize Social Determinants of Health and the specialized needs of the population to be served. Together, the proposal builds on the foundation of the Health Home and Whole Person Care pilots.

Enhanced care management would be conducted through "face-to face visits, coordinating all primary, acute, behavioral, developmental, oral and long-term services and supports for the member, including participating in the care planning process."

Target Population – Includes Individuals Transitioning from Incarceration:

There are seven mandatory target populations including individuals transitioning from incarceration (See Appendix C for complete list). The proposal defines these individuals as: *Inmates being released from both jail and state prison who have "significant complex physical or behavioral health needs and may have other social factors influencing their health." It also includes "individuals who are involved in pre or post booking diversion behavioral health and crimogenic treatment programs, and thus, are at risk of incarceration and could, through care coordination and service placement, have a treatment plan designed to avoid incarceration through the use of community-based care and services."*

The target population excludes "individuals who, after multiple outreach attempts, are not cooperative and do not wish to participate in Enhanced care Management services or whose assessment indicates they would not benefit from the services." Also excluded are individuals "whose behavior or environment is unsafe for care coordination staff."

1. **Enhanced Care Management for Individuals Transitioning from Incarceration.** Enhanced care management services are intended to extend beyond standard care coordination and disease management activities. They would be concentrated on the coordination and monitoring of cost-effective, high quality, direct care services, as well as connections to needed community supports for non-direct care needs.

   By January 1, 2023, all Medi-Cal managed care plans would be required to submit to DHCS an Enhanced Care Management Model of Care proposal for reentry for individuals transitioning from incarceration. The proposed timeline for the other six target populations would begin two years earlier.

   The staged implementation for the reentry population reflects the complexity in developing a new model of collaboration between Medi-Cal managed care plans that would have primary responsibility for implementation and the array of justice related agencies with which services must be coordinated. There were only four counties that had Whole Person Care Pilots that focused specifically on the reentry population: Los Angeles, Kern, Riverside and Placer.[11] DHCS would consider whether the post incarceration/reentry service bundles and processes that were created in Whole Person Care pilots could continue in those counties on January 1, 2021.

   Close working relationships with probation, courts, and the local county jail system are needed to ensure connections to care once individuals are released from jail. Managed care plans will need to develop relationships and processes with jails, juvenile facilities and prisons to facilitate initial engagement with inmates before they are released. Public defenders and district attorneys also play key roles in the local criminal justice system. Medi-Cal managed care plans generally do not have experience in working with the local criminal justice system and would need to develop a common understanding of how they work, and how they can work together on behalf of their common clients. Medi-Cal managed care plans would be allowed to contract with county and non-profit entities that work with the justice-involved population.

2. **New "In Lieu of Services" and Payment Incentives**.
   In addition to enhanced care coordination for the priority target populations, CalAIM proposes a new array of flexible benefits that address non-clinical needs and social determinants of health. These wrap-around services are intended to

[11] See CalHPS's policy brief on the Whole Person Care Pilots.

substitute or avoid more expenses services such as a hospital or skilled nursing facility admission or a discharge delay from a hospital.

As part of the plans submit to DHCS in January 2023 for the reentry population, Medi-Cal managed care plans would also need to describe how in lieu of services will be utilized in tandem with their plan for enhanced care coordination.

Examples of in lieu of services include a variety of housing supports. These supports would allow for navigation assistance, security deposits, first and last month's rent, and a variety of other housing related services tailored to meet physical and behavioral needs of the reentry population. As noted earlier, an analysis of the point-in-time survey of unsheltered homelessness found that 13% were currently on probation or parole.

Sobering centers are another important in lieu of services benefit for the justice-involved population with SUD issues. Currently, individuals who are intoxicated in public can be charged with "disturbing the peace" as a public nuisance. In many cases, they will be booked into jail, held in a "drunk tank," and released when sober. Sobering centers can provide an alternative that bypasses the criminal justice system and allows for more effective engagement of their participants into ongoing treatment. A menu of in lieu of service options is provided in Appendix E.

CalAIM does not mandate the use of in lieu of services. Instead, CalAIM acknowledges the need for a new payment methodology that would incentivize Medi-Cal managed care plans to make the necessary investments in infrastructure (e.g., IT systems) and capacity (e.g., sobering centers and housing alternatives).

Currently, Medi-Cal managed care plans are funded through a complex rate methodology that is based on the actuarial value of actual expenditures for medical costs. When a beneficiary is hospitalized, those costs can be reflected in calculations for establishing future rates. This current methodology does not account for non-clinical alternatives that might be more appropriate, effective and less costly. These alternative in lieu of services could be incorporated into the rate structure, removing a disincentive for providing them now.

D. **Residential SUD Treatment After Incarceration.**
Access to residential SUD treatment is a critical need for many individuals transitioning from custody. CalAIM proposes two major policy changes that affect eligibility for residential SUD treatment.

1. **Limitations on Length of Stay.** Currently, within a 365-day period, adult residential substance use disorder treatment services may be authorized for two non-consecutive admissions, for up to 90 days for each stay, with one 30-day extension permitted for one of the stays. Residential length-of-stay should be determined based on the individual's condition, medical necessity, and treatment needs. Given that the two-episode limit is inconsistent with the clinical understanding of relapse and recovery from substance use disorders, DHCS proposes to remove this limitation. The proposition is to base treatment on medical necessity and reimburse services up to the maximum number of authorized days, as agreed upon with CMS, in a 365-day period.

2. **ASAM Criteria Clarification for Formerly Incarcerated Individuals.** Concerns have been raised about how American Society of Addiction Medicine (ASAM) criteria determines the appropriate level of care for individuals being released from incarceration. The criteria may underestimate the need for residential treatment. To the extent that abstinence from substance use while being incarcerated is reflected in the assessment, the resulting score may under-estimate the appropriate level of needed care. The CalAIM proposal also recognizes that individuals under parole/probation supervision may be hesitant to admit to substance use. DHCS has already begun to explore solutions to clarify access criteria for individuals leaving incarceration who have a known substance use disorder.

E. **Consideration of Institutions for Mental Disease (IMD) Expenditure Waiver for Mental Health Services.**

CalAIM opens the door to consideration of a federal option that would allow states to receive federal financial participation (FFP) for IMDs if specific conditions are met. An IMD is a "hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services."[12]

Federal law currently bars states from receiving "any such federal Medicaid payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an IMD." California has already received federal approval for the waiver to alter the IMD payment exclusion for SUD treatment services. Twenty-six states have a Section 1115 waiver to use Medicaid funds for IMD SUD services, as of November 2019. However, Vermont is the only state with an IMD mental health waiver to date.[13]

In addition to budget neutrality, the goals and milestones required by the federal government to implement the option are challenging. These conditions include

[12] See KFF's policy brief (2018) "Medicaid Payment for Services in 'Institutions for Mental Disease.'"
[13] See KFF's policy brief (2019) "State Options for Medicaid Coverage of Inpatient Behavioral Health Services."

improving quality care and care coordination, as well as ensuring access to a full continuum of care such as crisis stabilization and supportive housing. The CalAIM proposal would allow for a county opt in.

F. **Administrative Integration of Specialty Mental Health and SUD services.**
For justice-involved individuals with serious mental illness and co-occurring substance use disorders are highly prevalent and represent a key risk factor for future criminal behavioral, rearrest and recidivism. However, traditional mental health and substance use treatment programs in California offer very limited specialized services of the treatment of individuals with co-occurring disorders (CODs).

At the system level, DHCS contracts with counties to provide mental health and SUD services through separate specialty managed care plans. In the case of SUD services, a comprehensive continuum of services is available in counties that have opted into the state's organized delivery system (ODS) authorized through the state's section 1115 Medi-Cal waiver. Thirty counties accounting for 93% of the state's Medi-Cal population now receive services through these local managed care plans.

At the client level, in typical treatment programs, even if services are co-located, clients are screened and assessed by two or more staff members using two or more instruments. The client information is housed in two separate records and confidentiality regulations require multiple release of information documents that are not unique, which means that duplicate information is collected. Integrated case conferencing and management is not routinely practiced which frequently results in competing treatment plans, as well as fragmented and incomplete continuing care plans.[14]

CalAIM proposes to integrate the administration of specialty mental health and substance use disorder treatment services into one behavioral health managed care program. The goal is to improve outcomes for beneficiaries through coordinated treatment across the continuum of care. An additional goal and benefit would be to reduce administrative and fiscal burdens for counties, providers, and the state of California.

At the local level, the proposal seeks to unify country specialty mental health and SUD behavioral health prepaid inpatient health plans into a single behavioral health managed care plan structure. The integration of mental health and SUD services would be comprehensive at both state and local level. It would include:

[14] See CalHPS's policy brief on different treatment coordination models for co-occurring mental health and substance use disorder.

1. Clinical integration (e.g., access line, intake/screening/referrals; assessment; treatment planning; and beneficiary informing materials);

2. Administrative integration (contracts, data sharing/privacy concerns, electronic health record design and re-design, and cultural competence plans); and

3. Integration of DHCS Oversight functions (e.g., quality improvement; external quality review organizations, compliance reviews, network adequacy, licensing and certification).

III. Key Issues & Overarching Themes:

As it relates to the reentry and justice-involved population, CalAIM represents the most comprehensive and ambitious statewide effort to leverage the state's Medicaid program to improve physical and behavioral health outcomes and address underlying crimogenic factors. These factors, such as substance use disorders and residential stability, if ignored, can perpetuate a costly and dangerous cycle of crime, rearrest, incarceration, and recidivism.

As stakeholders and policymakers consider the CalAIM proposal, several overarching themes should be addressed.

1. **Don't Forget CDCR and the State Hospitals**. Although CalAIM's primary focus is on the county-based criminal justice system, individuals coming from, and going to state prison can also benefit from improved coordination and support. CDCR houses 125,000 inmates and supervises about 50,000 parolees in the community. The state's five state hospitals operated by the Department of State Hospitals (DSH) are also part of the system, providing treatment to about 12,000 patients per year, housing 7,500 patients at any one time; about 90% are forensic patients who are committed by a criminal court. The system is bi-directional with inmates and DSH patients moving from counties to the state and back again. The effective sharing of medical records and treatment regimes at both transition points can help facilitate improved care coordination and continuity. Moreover, warm handoffs, enhanced care management, and access to in lieu of services are also needed for this population, particularly for individuals with serious physical and behavioral health issues.

2. **Deploy Community Health Workers – "Trust is the Secret Sauce".** As justice-involved individuals engage with the medical and behavioral health delivery system, trusted relationships can be the key ingredient to successful programs. Community health care workers (CHWs) with lived experiences who understand the unique needs of individuals transitioning from prison and jail can provide the culturally relevant human connectivity that facilitates warm handoffs and ongoing engagement with community medical and treatment providers. CHWs with lived experience are at the center of current Los Angeles County integrative community health initiatives such as the Care Connections program and the Whole Person Care (WPC) pilot that focuses on the reentry jail population. Across both the Care Connections and WPC programs, Los Angeles Health Services employs approximately 200 CHWs who each serve between 10 and 35 patients.[15] At the local level, the role of public defenders should also be explored as a trusted point of contact.

[15] Center for Health Care Strategies, Inc. 2020. "Recognizing and Sustaining the Value of Community Health Workers and Promotores"

3. **Programming Challenges in Jails.** Most jail inmates are incarcerated for brief periods. According to a PPIC study, nearly 30 percent of people booked into California jails are admitted and released on the same day, while another 45 percent spend less than two-weeks in custody.[16] Releases from jail can be unpredictable and often occur at night, after regular work hours. Medical and behavioral health screenings at intake are limited, and often rely on an inmate's ability and willingness to disclose any health conditions or current medications. Suspension of Medi-Cal eligibility and delays in managed care plan selection are also some of the challenges that create barriers for effective reentry programs and warm handoffs.

4. **Access to Housing.** Access to safe, stable, and affordable housing is crucial for the justice-involved population, particularly given the high incidence of mental illness, substance use disorders, and homelessness. CalAIM's in lieu of services offer an array of supportive housing benefits and fully leverage the potential of Medicaid dollars for this purpose. Assistance in helping the justice-involved individuals with a physical or mental disability access SSI benefits is another strategy that can reduce homelessness. However, additional resources are needed to incentivize the development of more residential treatment and housing capacity, including low-barrier emergency shelters, transitional housing, and permanent supportive housing utilizing a Housing First approach.

5. **Supporting a Continuum of Community-based Interventions.** Many individuals with serious medical and behavioral health issues could be diverted or safely supervised in the community if alternatives were available. An analysis by the Rand Corporation for the Los Angeles County Board of Supervisors found that 61 percent of the jail inmates with mental illness (about 3,368 people) could be appropriately diverted into community based services or supportive housing.[17] The state's new mental health diversion law (AB 1810), enacted in 2018 creates a new process for targeting, assessing, and placing individuals who would otherwise be incarcerated into programs that provide treatment.[18]

   These "front end" strategies can be supplemented with "back end" approaches. Alternative custody reentry programs allow inmates to serve the last part of their sentence in a community-based treatment program. These programs offer a more therapeutic environment. To the extent these community residential programs comply with federal requirements (e.g., freedom of movement), Medi-Cal can be a source of funding for treatment and services, including those offered in CalAIM. Providing these services in the community simplifies transitions, care coordination,

[16] McConville, Shannon and Mia Bird. 2016. "Expanding Health Coverage in California: County Jails as Enrollment Sites." Public Policy Institute of California.
[17] Rand Corporation. 2020. "Estimating the Size of the Los Angeles County Jail Mental Health Population Appropriate for Release into Community Services."
[18] See CalHPS' policy report entitled "Shifting the Paradigm for Mental Health Diversion: The Impact & Opportunity of AB 1810 and SB 215" from 2019.

access to providers, and results in better outcomes.

IV. Conclusion

CalAIM represents an ambitious, and unprecedented effort to address the unique medical and behavioral health needs of the reentry and justice-involved individuals inmates as they transition from custody to the community and fall between the cracks of the medical and behavioral health delivery system.

The envisioned approach in CalAIM leverages the Medi-Cal delivery system to provide a new level of person-centered care coordination and a new array of benefits that address access to housing and other Social Determinants of Health. The proposal also attempts to improve systems for Medi-Cal eligibility establishment and warm hard-offs for individuals receiving behavioral health services in jail.

The CalAIM proposal offers a framework for a new discussion about how best to provide services for the reentry and justice-involved population. It does not solve every problem, but is the first major statewide attempt to try.

As stakeholders and policy-makers begin to consider the challenges of implementation, it is clear that much work remains. However, it is also an opportunity for significant reform that can improve medical and behavioral health outcomes, reduce homelessness, enhance public safety and reduce health and criminal justice system costs.

APPENDICES

A. Timeline: Implementation Schedule for Justice-Related Activities

B. County Inmate Pre-Release Application Process Sample Contracting Models

C. Enhanced Care Management Target Populations Descriptions

D. Description of Individuals Transitioning from Incarceration for Enhanced Care Management

E. Menu of In Lieu of Service Options

F. Institutions for Mental Disease, Serious Mental Illness, or Severe Emotional Disturbance Demonstration Goals & Milestones

Appendix A

Timeline: Implementation Schedule for Justice-Related Activities

Date	Implementation Activity
March 2020	County Inmate Pre-release Application Process – Establish Workgroup
July 2020	County Inmate Pre-release Application Process – Develop Guidance
October 2020	County Inmate Pre-release Application Process – Stakeholder Process
January 2021	County Inmate Pre-release Application Process – Technical Assistance (through December 2021)
January 1, 2022	• County Inmate Pre-release Application Process – Implementation • Warm Hand-off for Behavioral Health – Implementation
January 2023	All Medi-Cal managed care plans required to submit Enhanced Care Management Model of Care Proposal for reentry for individuals transitioning from incarceration

Appendix B

County Inmate Pre-Release Application Process Sample Contracting Models

Contracting Model	Counties Currently Using a Similar Process
County Contracts with County Sheriff's Office	• Butte • Kern • San Bernardino • San Diego • San Francisco • Tuolumne • Ventura • Yolo
County Contracts with County Jail	• Glen • Santa Barbara
County Contracts with Multiple Entities (e.g., Community based organizations, and County Sheriff's Office	• Contra Costa • Imperial • Placer • Sacramento • San Luis Obispo • San Mateo • Solano • Sutter

Source: Attachment C from CalAIM report

Appendix C

Enhanced Care Management Target Populations Descriptions

In December 2019, DHCS provided descriptions of target populations for enhanced care management.[19] These include:

- **Children & Youth:** Children or youth with complex physical, behavioral, developmental, and/or oral health needs (e.g., California Children Services, foster care, youth with Clinical High-Risk syndrome or first episode psychosis.
- **Homeless:** Individuals experiencing homelessness, chronic homelessness or at risk of becoming homeless**.**
- **High Utilizers:** High utilizers with frequent hospital or emergency room visits/admissions.
- **Risk for Institutionalization:** Individuals at risk for institutionalization, eligible for long-term care.
- **Nursing Facility Transition to Community:** Nursing facility residents who want to transition to the community.
- **Serious Mental Illness (SMI), Serious Emotional Disturbance (SED), and Substance Use Disorder (SUD) at Risk for Institutionalization:** Individuals who are at risk for institutionalization who have co-occurring chronic health conditions and SMI (adults), SED (children), or SUD.
- **Individuals Transitioning from Incarceration. (**See Appendix D for detailed description.)

[19] CA DHCS memo distributed to the Enhanced Case Management and In Lieu of Services Workgroup, December 19, 2019

Appendix D

Description of Individuals Transitioning from Incarceration for Enhanced Care Management –

Target Population: (what this person looks like):

- Individuals involved with the justice system who will be transitioning from incarceration in either or a jail or prison setting who have significant complex physical or behavioral health needs and may have other social factors influencing their health.

- Individuals who are involved in pre or post booking diversion behavioral health and criminogenic treatment programs and, thus, are at risk for incarceration and could, through care coordination and service placement, have a treatment plan designed to avoid incarceration through the use of community-based care and services.

Would not include:

- Individuals who, after multiple outreach attempts, are not cooperative and do not wish to participate in ECM services or whose assessment indicates they would not benefit from the services.

- Individuals whose behavior or environment is unsafe for care coordination staff.

Settings:

The role of enhanced care management is, through face-to-face visits, coordinating all primary, acute, behavioral, developmental, oral, and long-term services and supports for the member, including participating in the care planning process, regardless of setting. The Care Manager will build and facilitate an interdisciplinary team as well as establish a comprehensive shared care plan, which is then shared across providers.

For justice-involved individuals, ECM requires coordination with corrections departments, including probation, courts and the local county jail system to both to identify members but also to ensure connections to care once individuals are released from incarceration. The initial ECM settings will depend on the collaborations that MCPs are able to build with local justice partners. At first, ECM staff will begin work with individuals expected to transition from incarceration in the setting where they are incarcerated (or just outside that setting). Post-transition, ECM care managers will engage individuals in the most easily accessible setting for the member. In addition to community-based settings such as a member's home or regular provider, this may also include parole or probation offices if the MCP builds partnerships that allow for this setting.

In addition to the settings above, for diversion efforts, this may include meeting the member at their criminogenic treatment programs.

Appendix E

Menu of In Lieu of Service Options

The following is high-level overview of the proposed menu of in lieu of services that would be covered under CalAIM. (See Appendix D of the DHCS proposal for a complete description of these services, including eligibility, restrictions and limitations, licensing/allowable providers, and state plan services to be avoided.)

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. An in lieu of services can only be covered if: 1) the State determines it is medically-appropriate and a cost-effective substitute or setting for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

Each set of services is described in detail below:

- **Housing Transition Navigation Services.** Description: assist beneficiaries with obtaining housing. Examples include: conducting a tenant screening and housing assessment that identifies the participant's preferences and barriers related to successful tenancy; developing an individualized housing support searching for housing and presenting options; assisting in securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history); assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process; identifying and securing available resources to assist with subsidizing rent (such as Section 8 or Section 202, etc.); identifying and securing resources to cover expenses, such as security deposit, moving costs, adaptive aids, environmental modifications, moving costs, and other one-time expenses; communicating and advocating on behalf of the client.

  The services provided should be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require and access only a subset of the services listed above.

  The services provided should utilize best practices for clients who are homeless and who have complex health and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

  Eligibility: Highly vulnerable individuals with multiple chronic conditions and/or serious mental illness and/or serious substance use disorder. Also, individuals who meet the Housing and Urban Development (HUD) definition of homeless (including those exiting

institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management. For the purpose of this service, qualifying institutions include hospitals, *correctional facilities*, mental health residential treatment facility, substance use disorder residential treatment facility, recovery bridge housing, Institutes for Mental Disease and State Hospitals. Also, individuals who meet the State's No Place Like Home definition of "at risk of chronic homelessness" which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth experiencing homelessness or with significant barriers to housing stability, including *one or more convictions* and history of foster care or involvement with the juvenile justice system and have a serious mental illness and/or a child or adolescent with serious emotional disturbance.

- **Housing Deposits.** Description: identifying, coordinating, securing or funding one-time services and modifications necessary to enable a person to establish a basic household that do not constitute room and board. Examples: Security deposits required to obtain a lease on an apartment or home; set-up fees/deposits for utilities or service access; first month coverage of utilities, including but not limited to telephone, gas, electricity, heating and water; first month's and last month's rent as required by landlord for occupancy. Eligibility: Same as for Housing Transition Navigation Services.

- **Housing Tenancy and Sustaining Services**. Description: provides tenancy and sustaining services, with a goal of maintaining safe and stable tenancy once housing is secured. Examples include: early identification and intervention for behaviors that may jeopardize housing, such as late rental payment, hoarding, substance use, and other lease violations; education and training on the role, rights and responsibilities of the tenant and landlord; coaching on developing and maintaining key relationships with landlords/property managers; assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction; providing independent living and life skills including assistance with and training on budgeting, including financial literacy and connection to community resources.

- **Short-term Post-Hospitalization Housing**. Description: provides beneficiaries who are homeless and who have high medical or behavioral health needs with the opportunity to continue their medical/psychiatric/substance use disorder recovery immediately after exiting an inpatient hospital (either acute or psychiatric), substance abuse or mental health treatment facility, custody facility, or recuperative care.

- **Recuperative Care (Medical Respite).** Description: short-term residential care for individuals who no longer require hospitalization, but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment. It allows individuals to continue their recovery and receive post-discharge treatment while obtaining access to primary care, behavioral health services, case management and other supportive social services, such as transportation, food and housing. Examples: interim housing with a bed and meals

and ongoing monitoring of the individual's ongoing medical or behavioral health condition (e.g., monitoring of vital signs, assessments, wound care, medication monitoring). Also, limited or short-term assistance with activities of daily living; coordination of transportation to post-discharge appointments; connection to any other on-going services an individual may require including mental health and substance use disorder services.

- **Respite.** Description; services provided by the hour on an episodic basis or by the day or overnight on a short-term basis because of the absence of or need for relief for those persons normally providing the care to individuals.

- **Day Habilitation Programs.** Description: programs designed to assist the participant in acquiring, retaining and improving self-help, socialization and adaptive skills necessary to reside successfully in the person's natural environment. Examples of training include: use of public transportation; personal skills development in conflict resolution; community participation; developing and maintaining interpersonal relationships; daily living skills (cooking, cleaning, shopping, money management).

- **Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly & Adult (RCFE) and Adult Residential Facilities (ARF).** Description: facilitate nursing facility transition back into a home-like, community setting and/or prevent skilled nursing admissions for beneficiaries with an imminent need for nursing facility level of care.

- **Nursing Facility Transition to a Home.** Description: assists individuals to live in the community and avoid further institutionalization. Examples: non-recurring set-up expenses for individuals who are transitioning from a licensed facility to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board such as assessing the participant's housing needs and presenting options; assisting in searching for and securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history); communicating with landlord, if applicable and coordinating the move; identifying the need for and coordinating funding for services and modifications necessary to enable a person to establish a basic household that does not constitute room and board, such as: security deposits required to obtain a lease on an apartment or home; set-up fees for utilities or service access; first month coverage of utilities, including telephone, electricity, heating and water; services necessary for the individual's health and safety, such as pest eradication and one- time cleaning prior to occupancy; home modifications, such as an air conditioner or heater; and other medically-necessary services, such as hospital beds, Hoyer lifts, etc. to ensure access.

- **Personal Care (beyond In-Home Services and Supports) and Homemaker Services**. Description: assistance with Activities of Daily Living (ADL) such as bathing, dressing, toileting, ambulation or feeding. Personal Care Services can also include assistance with Instrumental Activities of Daily Living (IADL) such as meal preparation, grocery shopping and money management. Services provided through the In-Home Support Services (In-Home Supportive Services) program include housecleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming and paramedical services), accompaniment to medical appointments and protective supervision for the mentally impaired. Note: these are services above and beyond any approved county In-Home Supportive Services hours, when additional hours are required and if In-Home Supportive Services benefits are exhausted.

- **Environmental Accessibility Adaptations (Home Modifications).** Description: physical adaptations to a home that are necessary to ensure the health, welfare and safety of the individual, or enable the individual to function with greater independence in the home: without which the participant would require institutionalization. Examples: ramps and grab-bars to assist beneficiaries in accessing the home; doorway widening for beneficiaries who require a wheelchair; stair lifts; making a bathroom and shower wheelchair accessible (e.g., constructing a roll-in shower).

- **Meals/Medically Tailored Meals.** Description: meals delivered to the home immediately following discharge from a hospital or nursing home when members are most vulnerable to readmission. Also, meals provided to the member at home that meet the unique dietary needs of those with chronic diseases.

- **Sobering Centers.** Description: alternative destinations for individuals who are found to be publicly intoxicated (alcohol and/or drug) and would otherwise be transported to the emergency department or jail. Sobering centers provide these individuals, primarily those who are homeless or those with unstable living situations, with a safe, supportive environment to become sober. Sobering centers provide services such as medical triage, lab testing, a temporary bed, rehydration and food service, treatment for nausea, wound and dressing changes, shower and laundry facilities, substance use education and counseling, and homeless care support services. Services can also include: screening and linkage to ongoing supportive services such as follow-up mental health and substance use disorder treatment and housing options, as appropriate.

  This service requires partnership with law enforcement, emergency personnel, and outreach teams to identify and divert individuals to Sobering Centers. Best practices suggested for clients who are homeless and who have complex health and/or behavioral health conditions include Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

  This benefit is covered for a duration of less than 24 hours.

Appendix F

Institutions for Mental Disease, Serious Mental Illness, or Severe Emotional Disturbance Demonstration Goals & Milestones

- Reduced utilization and lengths of stay in emergency departments among Medicaid beneficiaries with serious mental illness or serious emotional disturbance while awaiting mental health treatment in specialized settings;

- Reduced preventable readmissions to acute care hospitals and residential settings;

- Improved availability of crisis stabilization services including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state;

- Improved access to community-based services to address the chronic mental health care needs of beneficiaries with serious mental illness or serious emotional disturbance including through increased integration of primary and behavioral health care; and

- Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

- Ensuring quality of care in psychiatric hospitals and residential settings. Involves facility accreditation, unannounced visits, use of a utilization review entity, facilities meeting federal program integrity requirements, and facilities having the capacity to address co-morbid physical health conditions;

- Improving care coordination and transitions to community-based care. Involves implementation of a process to assess housing situations, requirement that facilities have protocols to contact beneficiaries within 72-hours after discharge, strategies to prevent or decrease lengths of stays in emergency departments, and strategies to develop and enhance interoperability and data sharing;

- Increasing access to continuum of care including crisis stabilization services. Involves annual assessments of availability of mental health services across the state, commitment to an approved finance plan, strategies to improve the state's capacity to track available beds, and implementation of an evidence-based assessment tool; an

- Earlier identification and engagement in treatment including through increased integration. Involves strategies for identifying and engaging individuals in treatment sooner, increased integration of behavioral health care in non-specialty settings and establishing specialized settings and services.

Federal Application Requirements

States wishing to pursue this demonstration opportunity must first submit an application to CMS. CMS will consider a state's commitment to ongoing maintenance of effort on funding outpatient community-based mental health services as demonstrated in their application when determining whether to approve a State's proposed demonstration project to ensure that resources are not disproportionately drawn into increasing access to treatment in inpatient and residential settings at the expense of community-based services. Below is a summary of required elements for the application.

- A comprehensive description of the demonstration, including the state's strategies for addressing the goals and milestones discussed above for this demonstration initiative;

- A comprehensive plan to address the needs of beneficiaries with serious mental illness or serious emotional disturbance, including an assessment of how this demonstration will complement and not supplant state activities called for or supported by other federal authorities and funding streams;

- A description of the proposed health care delivery system, eligibility requirements, benefit coverage and cost sharing (premiums, copayments, and deductibles) required of individuals who will be impacted by the demonstration, to the extent such provisions would vary from the State's current program features and the requirements of the Social Security Act;

- A list of the waivers and expenditure authorities that the State believes to be necessary to authorize the demonstration;

- An estimate of annual aggregate expenditures by population group impacted by the demonstration, including development of baseline cost data for these populations.

- Specifically, CMS requests that States' fiscal analysis demonstrate how the proposed changes will be budget neutral, i.e., will not increase federal Medicaid spending. CMS will work closely with States to determine the feasibility of their budget neutrality models and suggest changes as necessary;

- Enrollment data including historical mental health care coverage and projected coverage over the life of the demonstration, of each category of beneficiary whose health care coverage is impacted by the demonstration;

- Written documentation of the State's compliance with the public notice requirements at 42 CFR 431.408, with a report of the issues raised by the public during the comment period and how the State considered those comments when developing the final demonstration application submitted to CMS;

- The research hypotheses that are related to the demonstration's proposed changes, goals, and objectives, and a general plan for testing the hypotheses including, if feasible, the identification of appropriate evaluation indicators; and

- An implementation plan describing the timelines and activities necessary to achieve the demonstration milestones including a financing plan. The implementation plan can be submitted with the application, or within 90 days of application approval from CMS.

Other Demonstration Requirements

In addition to the required application elements above, states must also develop the following:

- Demonstration monitoring reports including information detailing the state's progress toward meeting the milestones and timeframes outlined in the implementation plan, as well as information and data so that CMS can monitor budget neutrality.

- A Health IT plan (health information technology plan) that describes the state's ability to leverage health IT, advance health information exchange(s), and ensure health IT interoperability in support of the demonstration's goals.

- Monitoring protocols that identify expectations for quarterly and annual monitoring reports including agreed upon performance measures (see SMD #18-011 for a list of potential measures), measure concepts, and qualitative narrative summaries. The monitoring protocol will be developed and finalized after CMS approval.

- Interim and final evaluations that will draw on the data collected for the milestones and performance measures, as well as other data and information needed to support the evaluation that will describe the effectiveness and impact of the demonstration using quantitative and qualitative outcomes and a cost analysis. An evaluation design will be developed by the state, with technical assistance from CMS, to be finalized within 180 days of the demonstration approval.

States that fail to submit an acceptable and timely evaluation design as well as any monitoring, expenditure, or other evaluation reporting are subject to a $5 million deferral per deliverable.

About the Author

- **David Panush** is the President of CalHPS. He has over thirty-five years of experience in the California State Legislature, serving as a policy and fiscal advisor to five state senate leaders, and as External Affairs Director for Covered California.

About the Reentry Health Policy Project

- This brief is part of the Reentry Health Policy Project, which seeks to identify state and county level policies and practices that impede the delivery of effective health and behavioral health care services for formerly incarcerated individuals who are medically fragile (MF) and living with serious mental illness (SMI), as they return to the community. The report also offers specific recommendations and best practices for addressing these barriers. The Reentry Health Policy Project has received support from the California Health Care Foundation and L.A. Care.

About California Health Policy Strategies (CalHPS), LLC

- CalHPS is a mission-driven health policy consulting group based in Sacramento. For more information, visit www.calhps.com.