CalAIM for Reentry and Justice-Involved Adults and Youth: A Policy Implementation Guide

PREPARED BY

CALIFORNIA HEALTH POLICY STRATEGIES (CALHPS), LLC
& HEALTH MANAGEMENT ASSOCIATES (HMA)

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NOTE: All details and dates for implementation provided in this guide are subject to change as DHCS continues with CalAIM planning. Please visit https://www.dhcs.ca.gov/CalAIM/Pages/calaim.aspx or contact DHCS to verify implementation details and timelines.

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NOTE: California Department of Healthcare Services (DHCS) continues to plan for the CalAIM implementation. To assure timely and accurate information please visit https://www.dhcs.ca.gov/CalAIM

Overview

The California Advancing and Innovating Medi-Cal (CalAIM) Program is the State's new plan for re-envisioning and reforming the Medi-Cal program that provides health and behavioral health services for nearly one in three Californians. CalAIM offers a unique and unprecedented opportunity to improve the quality of medical and behavioral health care for the most medically vulnerable and complex populations through a broad array of policy changes intended to align and improve services.

The services provided through CalAIM specifically include *justice-involved individuals* who are released from custody and who experience homelessness, serious mental illness (SMI), substance use disorders (SUD), or medical co-morbidities will be eligible for these services. Medi-Cal managed care plans (MCPs) will receive funding through DHCS and will be responsible for administering key elements of the CalAIM program.

This policy implementation guide provides an overview of CalAIM's key program elements relevant to justice-involved individuals and an initial implementation framework. The guide is intended as a resource for justice system agencies, MCPs, providers, advocates, and other stakeholders who are key to designing and implementing this new program in their county and community to serve justice-involved individuals. An in-depth description of the background and policy context for the CalAIM policy is provided in *Appendix A*.

Key CalAIM Program Elements

Population of Focus

Justice-Involved/Reentry: Mandatory Population. Justice-involved/reentry adults and youth are one of seven mandatory populations of focus defined in CalAIM. Individuals transitioning from incarceration[1] are those *"who are **BOTH** transitioning from incarceration or transitioned from incarceration within the past 12 months; **AND** have at least one of the following conditions:*

- *Chronic mental illness,*
- *SUD*
- *Chronic Disease (e.g., hepatitis C, diabetes)*
- *Intellectual or developmental disability*
- *Traumatic brain jury*
- *HIV*
- *Pregnancy"*

This target population includes both adults and youth, as well as individuals transitioning from state prison, jail, state hospital, and juvenile justice facilities.

[1] CalAIM Enhanced Care Management Policy Guide, September 2021.

Services and Mandates: New Under CalAIM

- ***Enhanced Care Management (ECM)*** can provide face-to-face, on-the-ground case management and support in navigating the health care system.[2] It can also be a funding source for community health care workers with lived experience. Funding is provided through MCPs. Implementation for the justice-involved/reentry population is expected to begin on July 1, 2023, pending federal approval of the State's waiver request for the 90-day pre-release planning and care coordination proposal. However, implementation of ECM began on January 1, 2022, for other populations of focus that are likely to overlap with the justice-involved population, e.g., individuals experiencing homelessness and those with serious behavioral health issues, and adult high utilizers.[3]

- ***Community Supports*** (formerly called "in lieu of services") allow the use of Medi-Cal funds to pay for a variety of non-clinical services that address "social determinants of health" such as housing.[4] Examples of Community Supports include one-time housing-related costs such as security deposits, first and last month rent, and up to six months of housing for individuals with behavioral health and medical needs leaving a hospital or jail and who would otherwise be homeless. Implementation of community supports for the justice-involved population is also expected to begin on July 1, 2023, but it is also aligned with federal approval for the 90-day pre-release planning and care coordination proposal. However, justice-involved individuals are able to access community supports if they are in an overlapping population of focus (e.g., individuals experiencing homelessness).

- ***90-Day Pre-Release Planning and Care Coordination*** for incarcerated persons is currently pending acceptance of the State's waiver submitted to Centers for Medicare and Medicaid Services (CMS). If approved, these services may be reimbursable for up to 90 days prior to release from jail and prison. The State's proposal would also allow detention facilities to provide a 30-day supply of medication for inmates upon release from custody, including FDA-approved medications for opioid use disorder (MOUD) treatment and long-acting injectable psychotropic medications. Implementation is expected to begin on July 1, 2023, pending federal approval of the State's waiver proposal. (There are nine other states that are seeking federal approval for similar proposals to provide pre-release related service through Medicaid.[5])

- ***Medi-Cal Application Process: Jail/Juvenile Facility – New State Mandate*** requires that all jails and juvenile facilities have a pre-release planning Medi-Cal application process. State legislation enacted as part of the State budget package requires the Board of Supervisors in each county, in consultation with the county sheriff, to designate an entity or entities to assist both county jail inmates and juvenile inmates with the Medi-Cal application process. *Effective date: January 1, 2023*.

- ***"Warm Handoff" – Behavioral Health Facilitated Referral and Linkage – New State Mandate*** requires individuals receiving treatment for behavioral health issues in jail to receive a "facilitated referral and linkage" to the county's department for behavioral health upon release from custody. This is intended to

[2] DHCS, CalAIM Enhanced Management Policy Guide
[3] DHCS CalAIM Justice-Involved Advisory Group, July 28th 2022
[4] DHCS Care Coordination Project: Social Determinants of Health
[5] Medicaid and Reentry, Policy Changes and Considerations for Improving Public Health and Public Safety, Council on Criminal Justice, March 2022

improve continuity of care. *Effective date: Implementation is expected to begin on July 1, 2023, but is also aligned with federal approval of the other key components for the justice-involved population.*

Building Capacity: Other Related Key Elements

- ***Medi-Cal Managed Care Plan Incentive Payment Program (IPP)*** provides $1.5 billion over three years to MCPs to invest in planning, staffing, training, information management system, and other infrastructure to support ECM and Community Supports.
- ***Providing Access and Transforming Health (PATH)*** provides $561 million over five years for CalAIM justice system initiatives with another $1.3 billion designated for other CalAIM infrastructure needs. Eligible funding recipients include counties, community-based organizations (CBOs), probation, sheriffs, and adult/juvenile correctional facilities. MCPs are not eligible. PATH funding for pre-release eligibility and enrollment implementation support is described in recent DHCS Guidance.
- ***Community Care Expansion (CCE)*** provides $803 million over three years to fund acquisition, construction, and rehabilitation to preserve and expand adult and senior care facilities that serve the Supplemental Security Income (SSI) State Supplementary Payment (SSI/SSP) and Cash Assistance for Program and Immigrants (CAPI).
- ***Behavioral Health Continuum Infrastructure Program (BHCIP)*** provides $2.4 billion over two years for competitive grants to counties, tribes or providers to construct, acquire, and rehabilitate real estate assets to expand the community continuum of behavioral health treatment facilities.
- ***Housing and Homelessness Incentive Program (H-HIP)*** provides $1.3 billion to MCPs to develop a Homelessness Plan in partnership with local Continuum of Care (CoC) organizations, public health agencies, county behavioral health, social services, and housing departments.
- ***Homeless Housing, Assistance, and Prevention Program (HHAP)*** is an expansion of funding that provides $2 billion in flexible funding to local government to address homelessness.
- ***Contingency Management (CM)*** authorizes any of the 38 counties in the Drug Medi-Cal Organized Delivery System (DMC-ODS) to pilot the effectiveness of CM, an evidence-based behavioral intervention modality for stimulant use disorders, including methamphetamine. $58.5 million is allocated to support this initiative.

New Funding in Governor's 2022-2023 Budget

- ***Behavioral Health Bridge Housing*** over two years for bridge housing projects to address the immediate housing and treatment needs of people experiencing homelessness who have serious behavioral health conditions: $1.5 billion.
- ***Medications for Addiction Treatment (MAT)*** to address the opioid epidemic: $101 million.
- ***Health Workforce Development*** proposals include funding to recruit and train 25,000 community health care workers (CHWs) by 2025. Note: specialized training could be provided through this effort to develop the workforce needed to serve specific populations including the justice-involved, the unhoused, older adults, or persons with disabilities. This is part of a $1 billion (over three years) health

workforce proposal. (In addition to CHWs, Peer Support Specialists can become another workforce option because of legislation enacted in 2021.[6])

Implementing CalAIM for Justice-involved Individuals: Key Considerations

CalAIM's justice system initiative offers unprecedented opportunities to address fundamental service delivery system gaps that contribute to higher costs and poor medical and behavioral health outcomes for justice-involved individuals, as well as higher recidivism rates and justice system costs. However, CalAIM implementation for this population is multifaceted and challenging. As counties, MCPs, justice system agencies, providers, advocates, and other stakeholders undertake the planning process to launch this new effort, the following issues should be considered:

- ***County Stakeholder Collaboration and Leadership.*** Developing a county-level CalAIM implementation plan requires collaboration among MCPs, key justice system agencies, county health and behavioral health, social services, housing departments, and other key stakeholders. Engagement with the County Board of Supervisors and other elected officials is advised to align and focus the planning process. Gathering baseline data about the medical, behavioral health, and housing needs of the county's justice-involved population can help establish priorities and inform metrics that will determine effectiveness.
- ***Planning for Implementing New State Mandates.*** Jails and juvenile facilities will be responsible for establishing processes for Medi-Cal enrollment and behavioral health warm handoffs to county behavioral health agencies. These new processes will require collaborations with other county agencies including county human services and behavioral health.
- ***Include California Department of Corrections and Rehabilitation (CDCR) and State Hospitals.*** Although CalAIM's primary focus is on the county-based criminal justice system, individuals coming from and going to state prison and state hospital can also benefit from improved coordination and support. Without the potential benefits of CalAIM interventions, many released from state prison or state hospital who have serious medical and behavioral health issues are likely to fall into a pattern of homelessness and/or continued involvement in the criminal justice system.
- ***Deploy Community Health Workers (CHWs) with Lived Experience.*** *"Trust is the Secret Sauce."*[7] As justice-involved individuals engage with the medical and behavioral health delivery system, trusted relationships can be the key ingredient to successful programs. The recruitment and training of CHWs with lived experiences who understand the unique needs of individuals transitioning from prison and jail can provide the culturally relevant human connection that facilitates warm handoffs and ongoing engagement with community medical and treatment providers.
- ***Engage the Broader Criminal Justice System – Not Just Jails.*** Most jail inmates are incarcerated for brief periods. Releases from jail can be unpredictable and often occur at night after regular work hours when jails must immediately execute judicial release orders. While all detainees receive medical and behavioral health intake screenings, these screenings often rely on an inmate's ability and willingness to

[6] Note: Peer Support Specialists for Medi-Cal behavioral health services is also a related effort to expand the workforce. DHCS is implementing the provisions of SB 803, enacted in 2021, as a county option. See DHCS FAQ.
[7] Improving Care Coordination and Service Delivery for the Reentry Population, CalHPS, 2018.

disclose any health conditions or current medications. Suspension or termination of Medi-Cal eligibility during incarceration and delays in MCP selection for individuals also create barriers for effective reentry and warm handoffs. Jails and juvenile facilities are a critical engagement point for the justice-involved population, but the broader system that includes courts, probation, public defenders, and district attorneys must also be engaged and aligned to promote a strategy for justice-involved individuals that emphasizes treatment for mental health, SUD, and medical issues.

- ***Expand Access to Housing.*** In the justice-involved population, there is a high incidence of mental health and substance use challenges and housing instability, making access to safe, stable, and affordable housing crucial for this population. When individuals are not housed, other interventions are likely to have limited success. CalAIM can provide tenancy support services and one-time funding for some housing-related costs, but it does not provide rental subsidies or funding for the construction or acquisition of new housing capacity for this population. Other collaborative efforts must address this need.
- ***Implement a Continuum of Community-Based Interventions.*** Many individuals with serious medical and behavioral health issues can be diverted from incarceration or acute levels of health care, such as emergency departments, or safely supervised in the community when appropriate alternatives are available. Best practices interventions can offer alternatives at each point in the criminal justice process, from pre-booking to reentry.

Questions and Considerations to Inform Implementation Design and Action Steps

County Framework for CalAIM Implementation

- How is your county organizing the planning process? Who is at the table?
- What data are needed to inform the decision-making process?
- How does your county currently serve the justice-involved population? What works and what does not? How can CalAIM implementation build on what is working?
- How can CalAIM resources be used to refinance current county spending, thereby freeing up funds that can be used for other programs or services?
- What are the policy goals that the county hopes to achieve? Reduce recidivism and homelessness? Reduce number of mentally ill inmates in jail? Reduce overdose deaths? Improve medical and behavioral health outcomes for justice-involved individuals? Reduce health disparities? What are the priorities?
- How can the county establish outcome measures that assess CalAIM effectiveness and success?

Enhanced Care Management (ECM) Implementation Issues/Questions

- How are MCPs and counties working together to provide ECM for the justice-involved population?
- Which organizations or agencies will be responsible? Will ECM be provided by organizations that have direct experience and understanding of the criminal justice system for adults and juveniles? How will they work together and coordinate with justice system agencies (e.g., probation, courts, sheriff and jail

staff, district attorney and public defender, medical and behavioral health providers that primarily service the reentry population)?

- Will the ECM staff include individuals with lived experience?
- How will ECM coordinate with agencies that provide Community Supports such as housing/tenant supports?
- Is specialized training needed for this workforce?
- How will eligible justice-involved individuals be enrolled into ECM?
- What IT system will be used to ensure the ECM staff will have access to client and program information?
- How will MCPs track ECM client encounters and outcomes?
- What outcomes measures should be used to evaluate performance and quality?

CalAIM Community Supports: Implementation Issues/Questions

- Which Community Supports have the MCPs in your county opted to provide? What Community Supports are needed for the justice involved but are not proposed?
- How will justice-involved individuals access these new services?
- Will the providers of Community Supports understand and have experience with the justice-involved population?
- How can existing county programs serving justice-involved individuals (e.g., sobering center) be incorporated into the new Community Supports services?
- In counties with multiple Medi-Cal plans, how will Community Supports be coordinated to assure geographic access and to avoid duplication?
- How will PATH and Incentive Payment Program funds be accessed to increase capacity, including workforce development and IT needs?
- What outcomes should be measured to ensure accountability and effectiveness of services provided?

90 Day Pre-Release Provision (Pending Approval by CMS) Implementation Issues/Questions

- What pre-release services are currently offered in jail for high-risk populations (e.g., HIV/AIDS, pregnancy, SMI, SUD)? Which types of services are provided? Who provides them? How are inmates currently screened for medical and behavioral health issues?
- Do inmates now leave with a prescription or a supply of medication upon release? What about durable medical equipment (DME) (e.g., wheelchairs)?
- Who will be responsible for providing pre-release services? In-custody staff? Contracted health care services? CBOs? Will additional training be needed?
- What kind of security protocols/clearances will be required for access to the jail?

- How can services be organized and provided for short-stay inmates or for those where the release date is uncertain?
- How will Medi-Cal eligibility be determined?
- How will jail in-reach programs coordinate with MCPs for post-release care?
- Are medical records digitized? Is there a data exchange system that facilitates transfer of medical records from jail to community providers?

Pre-Release Medi-Cal Eligibility and Enrollment Implementation Issues/Questions

- Does your county currently have a pre-release process for facilitating Medi-Cal enrollment of jail and juvenile inmates?
- Is data available to help assess the effectiveness of the current effort? What percentage of current jail and juvenile inmates leave custody with active Medi-Cal?
- What is the most effective way of reaching the most inmates? Can the eligibility process begin at intake?
- Who will perform this function? County human services workers, community organizations using "assisters," custody staff? What training is provided?
- To facilitate trusted relationships, how are individuals with lived experience used in the process? Is there a process for them to obtain security clearances that will allow them to work in a jail/juvenile hall setting?
- Where will the application process occur in a jail/juvenile facility? How can privacy be protected?
- Does your jail "suspend" Medi-Cal eligibility for inmates who are in custody for more than 30 days? What is the process for restoring eligibility when the inmate is released from custody?
- Are there other potential benefits (e.g., CalFresh, VA, SSI) that require an application process to be initiated prior to release from custody? Can the process be used to help individuals obtain photo ID or a cell phone?
- What IT system will be used to exchange data between correctional facilities and county social services offices?
- What process can be developed to help inmates obtain a benefits identification card (BIC) or temporary BIC at release?

Behavioral Health Transitions Implementation Issues/Questions

- What is the current process for transitioning individuals in jail who have serious mental health or SUD issues?
- Who currently provides behavioral health services in the jail? Is county behavioral health responsible? Is there a data system that allows the county staff to identify inmates who have previously received county behavioral health services in the community?
- What percentage of individuals with SMI or SUD are likely to experience homelessness upon release?

- What services will the "warm handoff" entail? How will CalAIM's ECM program support this effort?
- What process will be used to ensure access to housing for those who are likely to be unhoused upon release?

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Appendix A: Policy Development and Overview of CalAIM

Background

CalAIM recognizes the significant gaps in the health and behavioral health care delivery system for people reentering society after being incarcerated. The "reentry" population refers to individuals who have been recently released from prison or jail and are reentering the community. This population is a subset of the broader "justice-involved" population which references people who have ever been incarcerated in state prison or county jail and/or have ever been on probation or parole.

California's prison system currently incarcerates about 123,000 inmates and supervises about 51,000 parolees.[8] In addition, approximately 36,000 people are released from California prisons each year; over 560,000 (unduplicated) are admitted or released from jails annually.[9] Over 330,000 people are currently being supervised by state parole or county probation.[10] This justice-involved population has high rates of mental illness, substance use disorders (SUD), and chronic health conditions. When released from custody, they face a cycle of homelessness, emergency room and hospital utilization, and re-incarceration.

- Overdose death rates are more than 100 times higher in the two weeks after release from incarceration than for the general population.[11]
- Over the past decade, the proportion of incarcerated individuals in California jails with an active mental health case rose by 63%.[12]
- California's correctional health care system drug overdose rate for incarcerated individuals is three times the national prison rate.[13]
- Among justice-involved individuals, two of three individuals incarcerated in California have high or moderate need for SUD treatment.[14]

The over-representation of people of color in the justice system is another factor that must be addressed as the State intends to address long-standing health disparities through CalAIM. African American men, for example, account for over 28% of the incarcerated population but are only 5.6% of the State's population.[15]

Prior to 2014, most justice-involved individuals did not meet the eligibility requirements for Medi-Cal and were considered "medically indigent adults." The Affordable Care Act (ACA) dramatically improved access to community-based medical and behavioral health care services for justice-involved individuals. The ACA allowed California to expand Medi-Cal eligibility to low-income childless adults, creating an entitlement to medical and behavioral health care for most individuals in this population. Under the new coverage option, qualifying individuals with incomes below 138% of the Federal Poverty Level (FPL) are eligible for Medi-Cal in California.[16]

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[8] Department of Corrections & Rehabilitation, Spring 2020 Population Projects.
[9] 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.
[10] US Department of Justice BJS report entitled "Correctional Populations in the USA, 2016" published in 2018.
[11] Release from Prison: a High Risk of Death for Former Inmates, NIJM, 2007.
[12] The Prevalence of Mental Health Illness in California Jails is Rising, CalHPS, 2020.
[13] Analysis of 2017 Inmate Death Reviews in California Correctional Health Care System, Ken Imai, MD, 2018.
[14] Improving In-Prison Rehabilitation Program, Legislative Analyst Office 2017.
[15] California's Prison Population, PPIC, 2018.
[16] See CA DHCS "Do You Qualify for Medi-Cal Benefits?"

This is an annual income for an individual of about $18,000 in 2021. More than 80% of justice-involved individuals are now eligible for Medi-Cal[17], dramatically increasing access to health care for those leaving jails and prisons.

Federal matching funds for this newly eligible population also dramatically changed. In California, the federal government generally provides a 50% match for most Medi-Cal adult eligibility categories. However, as an incentive for state participation, the ACA initially provided 100% of the cost of coverage for the newly eligible, phasing down to a 90% match in 2020. This means for every $1 dollar spent by the state for the new childless adult category, the federal government pays $9 for services provided through Medi-Cal.

Behavioral health services for mental health treatment and SUD are also reimbursed with a 9:1 matching ratio. However, the formula for responsibility for the non-federal share is complicated. In 2014, California enacted legislation to provide mental health services for Medi-Cal eligible individuals with mild and moderate mental health needs. This was a new benefit for Medi-Cal beneficiaries that did not exist prior to the ACA.[18,19]

The addition of this new benefit created a bifurcated system for the delivery of mental health services. County-operated specialty mental health plans are responsible for caring for individuals with serious mental illness (SMI), and managed care plans (MCPs) are responsible for treating individuals with mild and moderate conditions. *In both cases, for the newly eligible population of childless adults, the state pays for the 10% nonfederal share of cost. Counties have no share of cost for the treatment of this newly eligible population.*

(See Appendix F for a more detailed description of cost sharing for various adult eligibility categories.)

However, the ACA did not change the Medicaid "inmate exclusion policy," which prohibits the use of federal matching funds to pay for health services for people in prison unless they are patients in a non-prison medical institution.[20,21] This means that the full cost of health care and behavioral health services in California jails and prisons is paid by state and county government without the benefit of federal matching funds.

Overview: California Advancing and Innovating Medi-Cal (CalAIM)

CalAIM is the name of the State's ambitious plan to re-envision and redesign the State's Medi-Cal program. First unveiled by the Department of Health Care Services (DHCS) in October 2019, the revised proposal was released in January 2021 and enacted as part of the State 2021-22 budget.

CalAIM builds on the practices, principles, and lessons learned from two earlier initiatives: county-operated Whole Person Care (WPC) pilots and the Health Homes Program (HHP). Both efforts focus on social determinants of health to improve health outcomes for Medi-Cal's most complex, costly, and vulnerable

[17] Impact of Medi-Cal Expansion on Adults Formerly Incarcerated in California State Prisons, 2018.

[18] Senate Bill X1 1 (Hernandez, Chapter 4, Statutes of 2013), effective January 1, 2014. Mental health services included in the essential health benefits package adopted by the State, pursuant to Health and Safety Code Section 1367.005 and the Insurance Code Section 10112.27, and approved by the United States Secretary of Health and Human Services under Title 42, Section 18022 of the United States Code. Referenced in Hamblin, Allison et al. 2016. "Promising Practices to Integrate Physical and Mental Health Care for Medi-Cal Members."

[19] Arnquist, Sarah, and Peter Harbage. 2013. "A Complex Case: Public Mental Health Delivery and Financing in California." *California Health Care Foundation.*

[20] Gates, Alexandra et al. 2014. "Health Coverage/Care for the Adult Criminal Justice-Involved Population." *Kaiser Family Foundation.*

[21] The Medi-Cal Inmate Eligibility Program (MCIEP) allows for federal cost sharing for inpatient services at a medical facility located off the grounds of the correctional facility if a Medi-Cal eligible inmate has an expected stay of more than 24 hours.

populations. CalAIM builds upon the WPC and HHP initiatives by creating a statewide policy and funding framework that integrates the WPC approach with the State's Medi-Cal managed care program.

MCPs, organized around counties or regions, are now responsible for organizing and funding most health care services for Medi-Cal beneficiaries. These plans are also responsible for providing services to members with mild and moderate mental health conditions. In California, about 83% of the State's 14 million Medi-Cal beneficiaries are enrolled in MCPs (link to State's directory of Medi-Cal managed care plans by county). For most individuals eligible for Medi-Cal, the State requires beneficiaries to enroll into a MCP which receives a capitated payment from the State as an incentive for managing care and risk.

CalAIM creates an on-going funding mechanism that relies on MCPs to provide new non-clinical tools that improve care for complex, hard-to-serve "populations of focus." These new tools include Enhanced Care Management (ECM) and Community Supports (formerly called "in lieu of services or ILOS"). These Community Supports are non-clinical, alternative, or non-traditional services that can be cost effective in reducing unnecessary emergency room visits and hospitalizations by addressing social determinants of health.[22]

[22] DHCS, A Summary of Evidence-base on Cost Effectiveness and Medical Appropriateness of ILOS

Appendix B: CalAIM Implementation Schedule

CalAIM is proposing a phased implementation schedule:

- MCPs Operating Health Homes Programs (HHP) or in Whole Person Care (WPC) Pilot Counties: Plans were required to submit a transition and coordination plan to DHCS by July 1, 2021. Implementation began on January 1, 2022, for target populations currently being served by these programs, and by July 1, 2022, for all enhanced care management (ECM) target populations.
- MCPs in counties without WPC pilots and/or HHP were required to submit their Model of Care plan by January 1, 2022, and implementation would begin on July 1, 2022. *This applies to the following populations of focus: individuals experiencing homelessness, high-utilizer adults, and adults with SMI/SUD*.
- All MCPs in all counties must implement for other target populations by January 1, 2023. However, implementation for *individuals transitioning from incarceration* is expected to begin July 1, 2023, pending federal approval.[23]

[23] DHCS, Model of Care Template: Instructions and Timelines.

Appendix C: Other CalAIM Populations of Focus

In addition to the re-entry population, there are six other populations of focus that often have significant overlaps with the justice involved.

- ***Homeless:*** Individuals experiencing homelessness, chronic homelessness, or at risk of becoming homeless. *(Note: about 70% of individuals experiencing homelessness report a history of incarceration.[24])*
- **High Utilizers:** High utilizers with frequent hospital or emergency room visits/admissions.
- ***Serious Mental Illness (SMI) 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) or SUD.
- ***Children or youth with complex physical, behavioral, developmental and oral health needs*** (e.g., California Children Services, foster care, youth with clinical high-risk syndrome or first episode of psychosis).
- ***Individuals at risk for institutionalization*** who are eligible for long-term care services.
- ***Nursing facility residents*** who want to transition to the community.

[24] California Health Policy Strategies, Criminal Justice Involvement Among Unsheltered Homeless in California, 2018.

Appendix D: Description of CalAIM Services

1. Enhanced Care Management (ECM)

Enhanced Care Management (ECM) is a new benefit that is offered by MCPs for individuals identified as being in one of the seven Populations of Focus described in Appendix C. Eligible individuals cannot be required to receive ECM but must have the option of enrolling into it. ECM goes beyond standard care coordination and disease management activities by providing a "high-touch, on-the-ground, and face-to-face" approach.[25]

CalAIM notes that MCP members may be assigned to one of three types of case management based on risk and need:

- ***Basic case management*** for members that require some level of coordination or disease management program.
- ***Complex case management*** for members that require a program of coordinated care and services following a critical event or diagnosis that requires extensive use of resources.
- ***Enhanced Care Management (ECM)*** that is designed to provide a whole-person approach to care that is collaborative and interdisciplinary and addresses clinical and non-clinical needs. Enhanced care managers would work with primary care and behavioral health providers and develop relationships with members and their families, so they can participate in the needs assessment and care planning process. ECM would coordinate all primary, acute, behavioral, developmental, oral, and long-term services and support for the member, including participating in the care planning process.

As described in the DHCS Enhanced Care Management Policy Guide, there are seven core services that must be provided to all populations of focus, including individuals transitioning from incarceration. These services include:

- ***Outreach and Engagement.*** MCPs are required to develop comprehensive outreach policies and procedures that can include, but are not limited to:
    - Attempting to locate, contact, and engage Medi-Cal beneficiaries who have been identified as good candidates to receive ECM services, promptly after assignment to the plan.
    - Using multiple strategies for engagement including in-person meetings, mail, email, texts, telephone, community and street-level outreach, follow up if presenting to another partner in the ECM network or using claims data to contact other providers the beneficiary is known to use.
    - Using an active and progressive approach for outreach and engagement until the beneficiary is engaged.
    - Documenting outreach and engagement attempts and modalities.
    - Using educational materials and scripts developed for outreach and engagement.

[25] DHCS, CalAIM Enhance Care Management Policy Guide

  - Sharing information between the MCP and ECM providers to assess beneficiaries for other programs if they cannot be reached or decline ECM.
  - Providing culturally and linguistically appropriate communications and information to engage members.

- ***Comprehensive Assessment and Care Management Plan.*** MCPs must conduct a comprehensive assessment and develop a comprehensive, individualized, person-centered care plan with beneficiaries, family members, other support persons, and clinical input. The plan must incorporate identified needs and strategies to address those needs, such as physical and developmental health care, mental health care, dementia care, SUD services, long-term services and supports (LTSS), oral health services, palliative care, necessary community-based and social services, and housing.
- ***Enhanced Coordination of Care.*** Enhanced coordination of care includes coordination of the services necessary to implement the care plan. This coordination could include:
  - Organizing patient care activities in the care management plan.
  - Sharing information with the care team and family members or support persons.
  - Maintaining regular contact with providers, including case conference, ensuring continuous and integrated care with follow up with primary care, physical and developmental health care, mental health care, SUD treatment, LTSS, oral health care, palliative care, necessary community-based and social services, and housing.
- ***Health Promotion***. MCPs must provide services to encourage and support lifestyle choices based on healthy behavior, such as identifying and building on successes and support networks, coaching, strengthening skills to enable identification and access to resources to assist in managing or preventing chronic conditions, smoking cessation or other self-help recovery resources, and other evidence-based practices to help beneficiaries with management of care.
- ***Comprehensive Transitional Care.*** MCPs must provide services to facilitate transitions from and among treatment facilities, including developing strategies to avoid admissions and readmissions, planning timely scheduling of follow-up appointments, arranging transportation for transitional care, and addressing understanding of rehabilitation and self-management activities and medication management.
- **Member and Family Supports.** MCPs must ensure the beneficiary and family or support persons are knowledgeable about the beneficiary's conditions, including documentation and authorization for communications, providing a primary point of contact for the beneficiary and family or support persons, providing for appropriate education of the beneficiary and family or support persons, and ensuring the beneficiary has a copy of the care plan and how to request updates.
- ***Coordination of and Referral to Community and Social Support Services.*** MCPs must ensure any present or emerging social factors can be identified and properly addressed, including determining appropriate services to meet needs such as housing or other community supports services, and coordinating and

referring beneficiaries to available community resources and following up to ensure services were provided.

As ECM implementation begins, a key factor for consideration is the recruitment and training of a workforce that can meet the unique challenges of the justice-involved population. This is recognized in CalAIM, which expects enhanced care managers to meet their clients "where they are." Trust is the intangible quality that is essential for medical management care planning for the justice-involved population. CalAIM's ECM proposal allows MCPs to contract with county and non-profit entities that currently work with the justice-involved population to support the development of new, or enhancement and scaling of existing, diversion or deflection efforts that help individuals served avoid incarceration.

The ECM workforce could include utilization of community health workers (CHWs) with lived experience. CHWs with lived experiences who understand the unique needs of individuals transitioning from prison and jail can provide the culturally relevant human connection that facilitates warm handoffs and ongoing engagement with community medical and treatment providers.

2. Community Supports (formerly called "in lieu of services")

In addition to ECM for populations of focus, CalAIM proposes a new array of flexible benefits that address non-clinical needs and social determinants of health such as housing. These new supportive services will be funded and administered through the MCPs.[26]

Currently, MCPs are funded through a complex rate methodology that is based on the actuarial value of actual expenditures for medical costs. Those costs can be reflected in calculations for establishing future rates when a beneficiary is hospitalized. The current methodology does not incentivize non-clinical alternatives that might be more appropriate to meet people where they are and help them avoid higher levels of care or justice involvement – strategies that can reduce overall costs to the system while improving outcomes for people served. Under CalAIM, Community Supports that drive this system improvement can now be incorporated into the rate structure of the MCPs, providing incentivization for an on-going funding source for these types of non-clinical supportive services.

CalAIM builds on the foundation of the WPC pilots to allow Medi-Cal funding of 14 Community Supports. These are listed in Figure 1 below.

Figure 1. CalAIM Community Supports
1. Housing Transition Navigation Services
2. Housing Deposits
3. Housing Tenancy and Sustaining Services
4. Short-term Post-Hospitalization (or Post-Incarceration) Housing
5. Recuperative Care (Medical Respite)
6. Respite Services
7. Day Habilitation Programs
8. Nursing Facility Transition/Diversion to Assisted Living Facilities
9. Community Transition Services/Nursing Facility Transition to a Home
10. Personal Care and Homemaker Services.
11. Environmental Accessibility Adaptations (Home Modifications)
12. Meals/Medically Tailored Meals

[26] DHCS, Community Supports for Social Drivers of Health

13. Sobering Centers
14. Asthma Remediation

The MCPs in each county have the responsibility to choose which Community Supports they will offer to their enrollees. Federal rules do not allow the State to require the Medi-Cal managed care plans to offer these in lieu of services but can encourage them to do so. Each Medi-Cal managed care plan has identified which Community Supports they intend to offer. These plan choices are summarized by county and by Medi-Cal MCP in this link. However, MCPs have the option of *adding* new Community Supports with six months prior notification to DHCS.

DHCS has prepared non-binding pricing guidance to help MCPs and Community Support providers engage in new contracting and payment relationships (see policy brief on CalAIM Community Support that summarizes DHCS pricing guidelines).

CalAIM and Housing/Tenancy Supports

Housing is one of the most complex challenges facing counties, especially for community members with behavioral health issues and involvement with the criminal justice system. Life on the streets can also exacerbate mental illness and substance use. Individuals who have been incarcerated – and those with mental health and/or SUD – experience significant stigma which creates barriers finding subsidized housing options in a competitive supported housing marketplace. Housing is a critical element for program effectiveness in serving justice-involved individuals with behavioral health needs.

- The homeless population in California increased 31% from 2015 to 2019, and 70% of the homeless population report a history of incarceration.[27]
- An analysis by the RAND Corporation for the Los Angeles County Board of Supervisors found that 61% of the jail inmates with mental illness (about 3,368 people) could be appropriately diverted into community-based services or supportive housing.[28]
- Homelessness can be both a cause and consequence of having a criminal record. More than 25% of people experiencing homelessness report being arrested for activities that are the direct result of their homelessness including loitering, lying down, or sleeping in public.[29]
- The first 30 days from release of incarceration is when most individuals will experience homelessness.[30]
- Justice-involved individuals face unique barriers to accessing housing because of stigma, Housing and Urban Development (HUD) rules that exclude from the definition of "chronic homelessness" individuals who have been incarcerated for more than 90 days, and challenges in accessing Coordinated Entry Systems for placement.[31] (Coordinated Entry Systems facilitate the coordination of local resources to connect the highest need, most vulnerable persons in the community to available housing and supportive services.)

[27] California Health Policy Strategies, Criminal Justice System Involvement and Mental Illness among Unsheltered Homeless in California.
[28] Rand Corporation, Los Angeles County Jails Could Divert More Individuals to Community-based Mental Health Services, 2020.
[29] National Center on Homelessness and Poverty, No Safe Place – the Criminalization of Homelessness in American Cities.
[30] Stephen Metraux, Recent Incarceration History Among a Sheltered Homeless Population, University of Pennsylvania, 2006.
[31] Council on Criminal Justice and Behavioral Health, Annual Legislative Report, December 2018.

Homelessness aggravates the severity of health and behavioral health conditions and impedes effective efforts to provide ongoing treatment. There is a high rate of homelessness among the justice-involved population. The Sacramento County Public Defender's Office recently conducted a study of misdemeanants and found that 50% were homeless.[32] In San Diego County's 2018 point-in-time study, 27% of those in jail identified themselves as unsheltered prior to incarceration.[33] A CalHPS 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).[34]

CalAIM's Community Supports include several new options that can enhance efforts to access and maintain housing for the justice-involved population with medical and behavioral health needs. The services provided should be based on individualized assessment of needs and documented in the individualized housing support plan. The CalAIM services would 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 would be available to highly vulnerable individuals with multiple chronic conditions and/or SMI and/or serious SUD. Also eligible are individuals who meet the 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 ECM.

Menu of CalAIM Community Supports

CalAIM's Community Supports can include the following programs:

- ***Housing Transition Navigation Services.*** These services 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); identifying and securing resources to cover expenses, such as security deposit, moving costs, adaptive aids, environmental modifications, and other one-time expenses; and communicating and advocating on behalf of the client.
  DHCS Non-binding Pricing Guidance Rate Range: $324-$449 per person per month

[32] Sacramento County Public Defender Office. "Criminal Justice System, Behavioral Health & Homelessness, 2019."
[33] CalHPS "Criminal Justice System Involvement and Mental Illness among Unsheltered Homeless in California." 2018.
[34] Ibid.

- ***Housing Deposits.*** These include services 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. They include 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; or first month and last month's rent as required by landlord for occupancy. Eligibility is extended to the same groups eligible for Transition Navigation Services.
  DHCS Non-binding Pricing Guidance Rate Range: $5,000 (once in a lifetime)

- ***Housing Tenancy and Sustaining Services.*** Tenancy and sustaining services are provided with a goal of maintaining safe and stable tenancy once housing is secured. Examples include early identification and intervention of 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; and providing independent living and life skills including assistance with and training on budgeting, including financial literacy and connection to community resources.
  DHCS Non-binding Pricing Guidance Rate Range: $413-$475 per person per month

- ***Short-Term Post-Hospitalization/Correctional Facility Housing***. This service may provide *up to six months* of housing for recouperation for beneficiaries who are homeless and who have high medical or behavioral health needs. This provides the opportunity to continue their medical/psychiatric/SUD recovery immediately after exiting an inpatient hospital (either acute or psychiatric), substance abuse or mental health treatment facility, custody facility, or recuperative care. This service would generally be available once in an individual's lifetime.
  DHCS Non-binding Pricing Guidance Rate Range: $97-$118 per day

- ***Recuperative Care (Medical Respite)*** is 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 SUD services.
  DHCS Non-binding Pricing Guidance Rate Range: $181-$226 per diem

- ***Respite*** includes 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.
  DHCS Non-binding Pricing Guidance Rate Range: $26-$38 per hour

- ***Day Habilitation Programs*** are 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 (e.g., cooking, cleaning, shopping, money management).
  DHCS Non-binding Pricing Guidance Rate Range: $46-$67 per diem
- ***Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly & Adult (RCFE) and Adult Residential Facilities (ARF).*** These services include the facilitation from 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.
  DHCS Non-binding Pricing Guidance Rate Range: $422-$496 per diem
- ***Nursing Facility Transition to a Home*** assists individuals to live in the community and avoid further institutionalization. Examples include 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 or Hoyer lifts to ensure access.

  DHCS Non-binding Pricing Guidance Rate Range: $422-$496 per person per month
- ***Personal Care (beyond In-Home Services and Supports) and Homemaker Services*** includes 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

Supportive Services (IHSS) 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 IHSS hours when additional hours are required and if IHSS benefits are exhausted.
DHCS Non-binding Pricing Guidance Rate Range: $29-$38 per hour

- ***Environmental Accessibility Adaptations (Home Modifications)*** are 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 include 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).
  DHCS Non-binding Pricing Guidance Rate Range: $7,500 lifetime cap
- ***Meals/Medically Tailored Meals*** are meals delivered to the home immediately following discharge from a hospital or nursing home when members are most vulnerable to readmission, as well as meals provided to the member at home that meet the unique dietary needs of those with chronic diseases.
  DHCS Non-binding Pricing Guidance Rate Range: $7-$12 per delivered meal
- ***Sobering Centers*** are an important alternative to jail for individuals with SUD. Currently, individuals who are intoxicated in public can be charged with "disturbing the peace" as a public nuisance. In many cases these individuals are booked into jail and released when sober. Sobering centers provide an alternative that bypasses the criminal justice system and allows for more effective engagement of participants into ongoing treatment. (See Santa Clara County's Mission Street Center which reports that the county jail has experienced a 26% decrease in intoxication bookings as a result of the sobering center alternative.[35])
  DHCS Non-binding Pricing Guidance Rate Range: $154-$186 per diem

3. Pre-Release Services Offered During 90 Prior to Release

Current federal Medicaid rules do not allow reimbursement for medical or behavioral health services to inmates who are incarcerated. DHCS is now seeking a federal waiver of this rule to allow Medi-Cal to pay for an array of services 90 days prior to release with the goal of improving health services and outcomes when the inmate has transitioned to the community. If federal approval is received from the Centers for Medicare and Medicaid (CMS), California would be the first state in the country to demonstrate the effectiveness of providing pre-release services. *As of the writing of this policy brief, negotiations with CMS are continuing and final federal approval is still pending.*

The DHCS proposal would allow Medi-Cal to pay for medical and behavioral health care coordination and transition services up to 90 days prior to an inmate's release from incarceration. This would apply to both juveniles and adults. This policy change is intended to create a mechanism to improve continuity with support and health services post-release by building trusted relationships with care managers, increasing pre-release management and stabilization of sensitive health conditions (e.g., diabetes, heart failure, hypertension) and

[35] DHCS, Whole Person Care Promising Practices: A Roadmap for Enhanced Care Management and In Lieu of Services, December 2020.

sustainable support for behavioral health treatment regimens (i.e., injectable long-acting anti-psychotics for mental health conditions and medications for addiction treatment) that could reduce decompensation from mental illness and post-release overdoses.

The proposed services, which would be paid for on a fee-for-services (FFS) basis, include:

- Conducting initial care needs assessment (e.g., medical, mental health, SUD, social needs)
- In-Reach physical and behavioral health clinical consultation services
- Developing a transition plan for community-based care
- Screening and referrals to community-based services and post-release appointments
- Developing a medication management plan in consultation with clinical providers
- Limited laboratory/x-rays provided pre-release
- Medications for addiction treatment (MAT)
- Psychotropic medications provided pre-release
- Providing a 30-day supply of medication upon release
- Durable medical equipment (DME) for use post-release into the community (e.g., wheelchairs)

The target population definition aligns with the eligibility criteria for ECM. Adult eligibility for the pre-release services would be limited to individuals who are Medi-Cal eligible AND who have one of the following health related conditions: mental illness, SUD, chronic or significant clinical condition, intellectual or developmental disability, traumatic brain injury, HIV/AIDS, or pregnant or post-partum. All incarcerated youth would be eligible and would not need to demonstrate a specific health care need.

DHCS is proposing to establish a standardized screening tool that would be used by correctional staff in prisons, jails, and youth correctional facilities to identify individuals who would have access to pre-release services. For individuals with longer-term stays and set release dates (e.g., individuals in state prison and AB 109 populations in county jails), screening for access to services could start as early as 120 days prior to release. DHCS is also exploring the potential of screening for access to pre-release services at intake or as close to intake as possible. This would assist individuals with shorter-term stays and unpredictable release dates (e.g., pre-adjudicated jail inmates).

As the State considers program models, there is broad recognition of the logistical and administrative challenges related to implementation. A study of California jail population found that nearly 30% of inmates were admitted and released on the same day, while another 45% spent less than two weeks in custody.[36] For these short-term inmates, there are clearly fewer opportunities for extensive screening, assessment and pre-release planning efforts.

[36] Public Policy Institute of California, Expanding Health Coverage in California: County Jails as Enrollment Sites. 2016.

4. State Mandate: Pre-Release Medi-Cal Application Process

Many inmates leave incarceration without having active Medi-Cal status. A 2019 (pre-COVID) Alameda County study found that 41% of inmates incarcerated for 30 days or more did not have Medi-Cal when they left Santa Rita Jail. More than half of these individuals had no record of ever being enrolled in Medi-Cal. Some may have had other health coverage (e.g., Veterans, Covered California, or Medicare) or were ineligible for Medi-Cal because of their immigration status.[37] Establishing Medi-Cal eligibility is a necessary precondition for the reentry population to access medical and behavioral health services. It is also needed for accessing CalAIM-related services.

Consistent with the State's goal of ensuring access to Medi-Cal and CalAIM's benefits, legislation in 2021 was enacted to mandate that all counties implement a pre-release Medi-Cal application process. The statutory requirement is contained in Penal Code Section 4011.11. This law requires the Board of Supervisors in each county, in consultation with the county sheriff, to designate an entity or entities to assist both county jail inmates and juvenile inmates with the Medi-Cal application process. This mandate goes into effect on January 1, 2023.

Many counties have already developed outreach efforts to facilitate enrollment into Medi-Cal of their incarcerated population. Several counties have 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. 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 (e.g., CBOs 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.[38]

The state mandate is intended to standardize policy, procedures, and collaboration between California's county jails, juvenile facilities, MCPs, county behavioral health, and other health and human service agencies to ensure all county inmates/juveniles that are eligible for Medi-Cal and need on-going physical or behavioral health treatment receive timely access to Medi-Cal services upon release from incarceration. 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.

California has received targeted resources through the "Providing Access and Transforming Health (PATH)" program as part of its federal waiver request. $151 million has been allocated to support implementation of the pre-release enrollment and suspension processes. (DHCS is currently negotiating approval for an additional $410 million to support other CalAIM justice-involved initiatives.) Counties may apply for these PATH funds to support planning and capacity building to improve Medi-Cal eligibility access for inmates transitioning from prison, jails, and juvenile detention facilities. The deadline for requesting implementation grants is December 31, 2022, and formal DHCS guidance can be found on this link.

[37] Alameda County Health Care Services Agency Director Colleen Chawla, Memo to Alameda County Board of Supervisors, November 16, 2020.
[38] Key Elements of Effective Pre-Release Enrollment Processes (Part 2), CalAIM Pre-Release Medi-Cal Application Workgroup January 18, 2022

Not all inmates may see the value of enrolling into Medi-Cal. For some justice-involved individuals, trauma experience and fear of government may be discouraging factors. This challenge can be addressed by engaging individuals with lived experience who can cultivate trust with incarcerated youth and adults.

As a best practice, DHCS suggests that inmates leave custody with a "benefits identification card (BIC)" when possible as evidence of Medi-Cal coverage. According to DHCS, Riverside, San Diego and Santa Clara counties try to provide a paper BIC upon release. It has been reported that most counties mail the plastic BIC to the individual's address on file or the address of their "Authorized Representative." Orange County uses a regional office as a mailing address for individuals experiencing homelessness. DHCS recommends that a permanent BIC should be mailed to the inmates while they are in custody. If this is not possible, it is recommended that the county provide a temporary BIC and mail the permanent BIC to the individual's post-release address or allow for pick up.[39]

DHCS is working with the California Welfare Directors Association (CWDA) to facilitate Medi-Cal enrollment of inmates through its automated web-based IT portal called CalHEERS (California Healthcare Eligibility, Enrollment, and Retention System). At present, CalHEERS is unable to process Medi-Cal applications for inmates because of a programming issue. This results in cumbersome and labor-intensive county workarounds. However, a system enhancement for CalHEERS is being developed that will streamline the process and allow eligibility regardless of the administrative verifications of incarceration.

Broadening the CalAIM pre-release planning process to include CalFresh (formerly called food stamps) is another potential opportunity to improving transitioning to the community. In 2022, the maximum CalFresh benefits for an individual are $250 per month.[40] Currently, the application process for CalFresh occurs after an inmate is released. However, counties can request a waiver to this federal requirement from the United States Department of Agriculture (USDA) with the support of California Department of Social Services (CDSS). Orange County received federal approval to move forward on this approach, and the county is now in the early stages of implementation. In the Orange County model, eligibility is limited to individuals who are released in and plan to continue residing in Orange County.[41] Complementary legislation, AB 3073 (Wicks), was enacted in 2020 and requires CDSS to encourage other counties to pursue similar federal waivers. There is also a new requirement in state law that requires counties to train Medi-Cal eligibility staff to include CalFresh screening and eligibility determination as part of the Medi-Cal application and renewal process.[42]

Note: *The 2022-23 State budget includes funding to expand Medi-Cal eligibility for all eligible Californians, regardless of immigration status. If enacted, implementation would begin in January 2024, and undocumented inmates who had previously been ineligible for Medi-Cal would be able to access Medi-Cal services for their health and behavioral care.*

5. State Mandate: Facilitated Referral and Linkage to County Behavioral Health Services.

CalAIM requires a new referral and linkage process to county behavioral health to facilitate improved continuity of care for inmates receiving behavioral health services as they transition back to community-based treatment.

[39] Ibid.
[40] Guide to CalFresh Benefits, Legal Services of Northern California.
[41] Pre-release Inmate Nutrition Innovation Granted Federal Approval, Orange County Board of Supervisors February 6, 2021
[42] Welfare and Institutions Code, Section 18918.1. (Added in AB 79, Human Services Omnibus Budget Trailer bill, chaptered in 2020.)

A new statutory mandate was enacted (Penal Code 4011.11) that "requires the State Department of Health Care Services, no sooner than January 1, 2023, in consultation with counties, county sheriffs, probation departments, MCPs, and Medi-Cal behavioral health delivery systems, to develop and implement a mandatory process by which county jails and county juvenile facilities coordinate with MCPs and Medi-Cal behavioral health delivery systems to facilitate continued behavioral health treatment in the community for county jail inmates and juvenile inmates that were receiving behavioral health services before their release."

CalAIM targets county jail inmates and/or youth in juvenile facilities that are receiving mental health or SUD treatment in custody, and mandates that all counties implement a process for "facilitated referral and linkage" that connects them to county specialty mental health, Drug Medi-Cal, Drug Medi-Cal-Organized Delivery System (DMC-ODS), and MCPs. This process would allow for the continuation of behavioral health treatment in the community when the inmate or juvenile is released from custody. DHCS is aligning this initiative with the 90-day pre-release services, which is pending federal approval. However, it is expected to begin on July 1, 2023.

Navigating the complex network of health and behavioral health services for continued care and treatment can be challenging for formerly incarcerated individuals. Warm handoffs are a best practice to reduce the instances of individuals not accessing needed care and support services. The warm handoff process to support reentry should include coordinating the release of medical records; establishing a medical home with a community provider; making initial appointments; providing a bridge prescription for necessary medications until the client can be seen by the community provider; and ensuring other treatment regimens continue after release. Medi-Cal eligible individuals should also receive assistance in selecting a MCP and services for mild and moderate mental health conditions in addition to physical health needs. The process should seek to empower individuals with information and guidance that enables them to actively participate in managing their own behavioral health treatment needs to the greatest extent possible.

Community health workers (CHWs) with lived experience can play an important role in facilitating the referral and linkage process. This will be discussed more in the context of CalAIM's ECM proposal.

The CalAIM proposal focuses exclusively on transitions for inmates and juveniles receiving in-custody behavioral health treatment while in county jails or juvenile halls. However, facilitating referrals and linkages is also important for justice-involved individuals who have physical health issues that will require the engagement and participation of an eligible individual's MCP. Warm handoffs are also needed for inmates transitioning from CDCR such as parolees and those returning from state prison to be supervised by county probation under Post Release Community Supervision (PRCS). As CDCR continues to implement MAT for state inmates, the need for continuity of care in the community will be even more essential.

Appendix E: Building Capacity: Other Related Key Elements

CalAIM recognizes that new infrastructure investments will be needed to ramp up the programs and services envisioned by the new initiative. Workforce recruitment and training, interoperable data systems and data exchange processes, and planning new collaborations between MCPs, counties, and justice system agencies all require focused attention. In addition, new housing options and behavioral health treatment capacity is also essential.

Substantial one-time funding has been budgeted by the State to support infrastructure and capacity-building local efforts. As CalAIM justice-involved stakeholders develop implementation strategies, these new funding sources and programs should be considered.

1. Medi-Cal Managed Care Plan Incentive Payment Program (IPP)[43] ($1.5 billion over three years)

The IPP program provides $1.5 billion over three years in additional one-time funding to MCPs to invest in planning, staffing, information management systems, and other infrastructure needed for implementation of both ECM and Community Supports. The on-going costs of the program would be incorporated into the annual rate setting process as the program matures. By FY 2024-2025, these incentive payments would be phased out, and on-going costs for maintaining the CalAIM initiatives would be paid for through the Medi-Cal managed care rate setting process.

MCPs are responsible for developing a needs assessment and gap filling plan to help determine where investments are needed. These plans are also required to include metrics that can measure effective use of the funds. The deadline for submitting the gap filling plan and needs assessment was January 2022. Current plans call for DHCS to publish the local filings in Summer 2022 to be followed by a progress report in September 2022.

Year 1 priorities are focused on the following investments:

- ***Delivery System Infrastructure:*** fund core provider health information technology (HIT) and data exchange infrastructure for MCPs, ECM and Community Supports providers
- ***ECM Provider Capacity Building***: Workforce, training, TA, workflow development, etc.
- ***Community Supports Provider Capacity Building and Medi-Cal Managed Care Take Up***: Fund Community Supports training, TA, workflow development, operational requirement, take up and oversight
- ***Quality:*** Fund reporting of baseline data collection to inform quality outcomes measures to be collected in future program years

2. Providing Access and Transforming Health (PATH) ($1.3 billion over 5 years). PATH for Justice System Initiative ($561 Million over 5 years)[44]

PATH funds provide funding to CBOs, counties, and other local providers to support capacity building as they begin to implement and scale ECM and Community Supports. MCPs are NOT eligible to receive PATH funds. $1.3 billion has been allocated over five years for this program. These new resources are intended to support populations and communities that have been historically under-resourced and under-served.

[43] DHCS, CalAIM Incentive Payment Program FAQ
[44] DHCS, PATH and IPP Program Overview

In addition, PATH provides up to $561 million over five years to support justice-involved adults and youth by maintaining and building pre-release and post-release services to support implementation of the CalAIM justice-involved initiatives. The State has already received approval of $151 million, but the remaining $410 million is pending federal approval.

Eligible applicants include counties, CBOs, probation, sheriffs, adult/juvenile correctional facilities, and public hospitals. As proposed, PATH funding can be used for:

- ***Whole Person Care Pilot Transition.*** Direct funding for former WPC Pilot Lead Entities to pay for existing WPC services before they transition to CalAIM on or before January 1, 2024
- ***Technical Assistance.*** Registration-based TA program for all counties, providers, CBOS and others
- ***Collaborative Planning and Implementation.*** Support for collaborative planning efforts involving MCPs counties, CBOs, providers, tribes and others
- ***Capacity and Infrastructure Transition, Expansion and Development Initiative (CITED).*** Funding to build and expand capacity and infrastructure necessary to support ECM and Community Supports

3. Community Care Expansion (CCE) ($805 million over 3 years)

The CCE program provides funding for acquisition, construction, and rehabilitation to preserve and expand adult and senior care facilities that serve SSI-SSP and Cash Assistance for Program for Immigrants (CAPI) applicants and recipients. Additional information can be found in the chart below:

Population Focus	People who are experiencing or at risk of homelessness, including those who may be involved in the criminal justice system
Applicants	Counties, cities, non-profit organizations, or private/for-profit organizations
Budget	$806M over 3 years
Capital Expansion Projects	• Approximately 75% of total CCE funds will be made available for capital expansion projects including acquisition, construction, and rehabilitation of residential care settings. • Grantees may be approved to use a portion of these funds to establish a capitalized operating subsidy reserve (COSR) for these projects, available for use for up to five years. This means these funds can be used to offset some of the operating costs (e.g., resident's rent contributions, utilities) of the project for the first five years. • Applicants that receive CCE funding must commit to provide services and restrict building use for 30 years for new facilities or 20 years if funding is used to expand an existing facility. A portion of the CCE budget includes federal funding that must be obligated by June 2024 and liquidated by December 2026.
Match Requirements	Applicants will be required to provide matching funds as part of the project. Match requirements are set according to applicant type. • Tribal entities = 5% match • Counties, cities, and nonprofit providers = 10% match • For-profit providers and/or private organizations = 25% match

Eligible Uses	These funds can be used for several types of residential facilities/settings that expand the long-term care continuum and serve the target population, including: • Licensed adult and senior care facilities (ARFs and RCFEs) • Recovery residence/sober living homes • Recuperative or respite care settings, including peer respite • Permanent supportive housing (PSH) and other independent residential settings that serve the needs of seniors and adults with disabilities (including models that provide site-based care, such as Program for All Inclusive Care for the Elderly [PACE] and the Assisted Living Waiver programs)
NOTE: the Request for Application (RFA) was opened on February 15, 2022. Applications for CCE capital expansion project funding will be accepted on a project basis through the joint RFA (which also includes funding for the State's Behavioral Health Continuum Infrastructure Program) and funded on a rolling basis until funds are exhausted.	

See links to joint RFA and webinar describing this funding opportunity.

4. Behavioral Health Continuum Infrastructure Program (BHCIP)[45] ($2.4 billion over 2 years)

BHCIP provides funding for competitive grants for counties, tribes, or providers to construct, acquire, and rehabilitate real estate assets to expand the community continuum of behavioral health treatment resources. Funding could be used on a variety of facility types and be used for both mental health and SUD treatment facilities. Entities are required to provide matching funds or real property.

The following facility types may be considered for project funding through BHCIP:

- Community wellness centers
- Hospital-based outpatient treatment (e.g., outpatient detox or withdrawal management)
- Intensive outpatient treatment
- Narcotic Treatment Programs (NTPs)
- NTP medication units
- Office-based outpatient treatment
- Sobering centers
- Acute inpatient hospitals – medical detox or withdrawal management
- Acute psychiatric inpatient facilities
- Adolescent residential treatment facilities for SUD
- Adult residential treatment facilities for SUD
- Chemical dependency recovery hospitals
- Children's crisis residential programs (CCRPs)

[45] DHCS, Behavioral Health Continuum Infrastructure Program website

- Community treatment facilities (CTFs)
- Crisis stabilization units (CSUs)
- General acute care hospitals (GACHs) and acute care hospitals (ACHs)
- Mental health rehabilitation centers (MHRCs)
- Psychiatric health facilities (PHFs)
- Short-term residential therapeutic programs (STRTPs)
- Skilled nursing facilities with special treatment programs (SNFs/STPs)
- Social rehabilitation facilities (SRF)
- Peer respite
- Recovery residence/sober living homes

BHCIP funds are being released by DHCS through six grant rounds targeting various gaps in the State's behavioral health facility infrastructure. BHCIP Rounds 1 and 2 were released in 2021:

- Round 1: Mobile Crisis, $205M ($55M Substance Abuse and Mental Health Services Administration [SAMHSA] grant funding)
- Round 2: County and Tribal Planning Grants, $16M

The remaining BHCIP rounds will be released in 2022:

- Round 3: Launch Ready, $518.5M
- Round 4: Children & Youth, $480.5M
- Round 5: Behavioral Health Needs Assessment Phase One, $480M
- Round 6: Behavioral Health Needs Assessment Phase Two, $480.7M

Round 3: Launch Ready ($518.5M) will provide funding to construct, acquire, and rehabilitate real estate assets to expand the behavioral health continuum of treatment and service resources in settings that serve Medicaid (Medi-Cal) beneficiaries. Proposed behavioral health infrastructure projects must demonstrate they have been through a planning process and are ready for implementation.

5. Housing and Homelessness Incentive Program (H-HIP) ($1.3 billion over two years)[46]

H-HIP is a new program that provides one-time funding to MCPs to make investments and progress in addressing homelessness and keeping people housed. The program requires the collaboration of the MCPs and the local homeless continuum of care, in partnership with local public health jurisdictions, county behavioral health, public hospitals, county social services, and local housing departments to develop and submit a Local Homelessness Plan to DHCS.

[46] DHCS Housing and Homelessness Incentive Program website

The Local Homelessness Plan must outline how H-HIP services and supports would be integrated into the county's system for serving individuals experiencing homelessness. This would include a housing and services gaps/needs assessment and how these funds would prioritize aging and disabled homeless Californians (including those with a behavioral health disability). DHCS suggests that these local plans should enhance existing local HUD or other homeless plans and be designed to address unmet needs.

In counties with more than one MCP, plans would need to work together to submit one plan per county. The Homelessness Plans must include mapping the continuum of services with focus on homelessness prevention, interim housing (particularly for the aging and/or disabled population), rapid re-housing (families and youth), and permanent supportive housing. MCPs were required to submit these *initial Local Homelessness Plans (LHPs) to DHCS by June 30, 2022.*

H-HIP funds can be used to support and facilitate coordination between MCPs and other entities, but it cannot be used to pay for room and board, and it cannot be a simple "pass through" from the MCP to other entities. Examples of uses include:

- Develop partnerships between MCPs and social service agencies, counties, public health agencies, and public-based housing agencies to address homelessness
- Provide rapid rehousing for Medi-Cal families and youth, and interim housing for aging and disabled populations
- Expand access to housing services and street medicine
- Improve access to coordinated housing, health, and other social services
- Improve whole person health for Medi-Cal enrollees, including behavioral health treatment and resources

There is no requirement that H-HIP local plans involve justice system stakeholders in the planning process. However, as noted earlier, more than two-thirds of unsheltered individuals experiencing homelessness have a history of incarceration. CalAIM justice system reentry initiatives could become effective engagement opportunities to connect former inmates with housing. Coordinating these efforts will require justice system agencies to be at the table as H-HIP plans are developed.

6. Homeless Housing, Assistance, and Prevention Program (HHAP) Expansion[47] ($2 billion over 2 years)

This program provides flexible funding to support local governments (Continuums of Care, counties, and cities) to address homelessness. The funding in the 2021-2022 budget expands the existing HHAP program. Local governments will be required to develop and submit local homeless action plans, and the HHAP program aims to close persistently unequal demographic gaps for populations disproportionately likely to experience homelessness.

[47] Business, Consumer Services and Housing Agency, HHAP Website

7. Project Homekey[48] ($2.75 billion over 2 years)

This program, administered by the Department of Housing and Community Development (HCD), provides competitive grants to local governments to acquire or renovate hotels, motels, and other properties for conversion to non-congregant, interim or permanent long-term housing for individuals experiencing homelessness.

8. Contingency Management [49](CM) ($58.5 million)

This authorizes any of the 38 counties in the Drug Medi-Cal Organized Delivery System (DMC-ODS) to pilot the effectiveness of contingency management (CM), the only treatment known to be effective for stimulant use disorder (e.g., methamphetamines). $58.5 million has been allocated to support this initiative.

9. New Funding in Governor's 2022-2023 Budget[50]

- ***Behavioral Health Bridge Housing.*** Proposes $1.5 billion over two years for bridge housing projects to address the immediate housing and treatment needs of people experiencing homelessness who have serious behavioral health conditions.
- ***Medication Assisted Treatment (MAT).*** To address the opioid overdose crisis, the budget includes $101 million for MAT initiatives.
- ***Health Workforce Development.*** Proposes funding to recruit and train 25,000 community health care workers by 2025 with specialized training to work with specific populations including the justice-involved, the unhoused, older adults, or persons with disabilities. This is part of a $1 billion (over three years) health workforce proposal.

[48] Department of Housing and Community Development Project Homekey Website
[49] DHCS, Medi-Cal Contingency Management Pilot Program Policy Design
[50] DHCS, 2022-2023 Governor's Budget Highlights

Appendix F: Medi-Cal Claiming Rates for Selected Behavioral Health Services by Eligibility Category

Table 1. Medi-Cal Claiming Rates for Selected Behavioral Health Services by Eligibility Category – 2021[51]

	Adults without children below 138% FPL[52]	Aged, disabled, or blind receiving Supplemental Security Income/State Supplemental Payment	Parents living with their children
Treatment for Mild to Moderate Mental Health	90% federal 10% state	50% federal[53] 50% state	50% federal 50% state
Treatment for Serious Mental Illness (SMI)[54]	90% federal 10% state	50% federal 50% county	50% federal 50% county
State Plan Drug Medi-Cal Services in All Counties[55]	90% federal 10% state	50% federal 50% county	50% federal 50% county
Additional Services Provided in Counties Participating in the Drug Medi-Cal-Organized Delivery System[56]	90% federal 10% county	50% federal 50% county	50% federal 50% county
Local Government Agency Targeted Case Management	90% federal 10% local agency	50% federal 50% local agency	50% federal 50% local agency
Medi-Cal Administrative Activity Claims[57]	50% or 75% federal 50% or 25% local agency	50% or 75% federal 50% or 25% local agency	50% or 75% federal 50% or 25% local agency

[51] These claiming rates reflect those in effect during 2021. Some of these eligibility rates are different for services provided in prior years.
[52] This eligibility category is the optional Medi-Cal category that was added after the establishment of the requirements for local funding established during the 2011 Realignment. The costs for this category are borne by the state.
[53] The 50% share does not reflect the enhanced federal funding that is available during the COVID-related emergency during which an added 6.2% is available for the categories that normally receive 50% funding.
[54] These services are provided or financed by county behavioral health departments. County funding here could consist of county general fund, Mental Health Service Act funds, or realignment funds.
[55] These services are provided in all counties; services are provided or financed by county behavioral health departments. County funding here could consist of county general fund or realignment funds. Counties can also use federal SAMHSA block grant funds for th ese kinds of services, but these federal funds cannot be used as a match for Medicaid funds.
[56] Counties pay the non-federal share for the expansion services offered by ODS counties. The state continues to pay the non-federal share in those counties for traditional drug Medi-Cal state plan services.
[57] The 75% federal sharing is provided when the activity is provided by a licensed health professional.

Appendix G: State Mandate Statutory Language:

Medi-Cal Enrollment Process & Behavioral Health Warm Handoff

Section 4011.11 of the Penal Code is amended to read:

4011.11.

(a) (1) Through December 31, 2022, the board of supervisors in each county, in consultation with the county sheriff, may designate an entity or entities to assist county jail inmates with submitting an application for a health insurance affordability program consistent with federal requirements.

(2) The board of supervisors shall not designate the county sheriff as an entity to assist with submitting an application for a health insurance affordability program for county jail inmates unless the county sheriff agrees to perform this function.

(3) If the board of supervisors designates a community-based organization as an entity to assist with submitting an application for a health insurance affordability program for county jail inmates, the designation shall be subject to approval by the jail administrator or their designee.

(b) (1) The jail administrator, or their designee, may coordinate with an entity designated pursuant to subdivision (a), through December 31, 2022.

(2) Commencing January 1, 2023, the jail administrator, or their designee, shall coordinate with an entity designated pursuant to subdivision (h), as applicable.

(c) Consistent with federal law, a county jail inmate who is currently enrolled in the Medi-Cal program shall remain eligible for, and shall not be terminated from, the program due to their incarceration unless required by federal law, they become otherwise ineligible, or the inmate's suspension of benefits has ended pursuant to Section 14011.10 of the Welfare and Institutions Code.

(d) Notwithstanding any other state law, and only to the extent federal law allows and federal financial participation is available, an entity designated pursuant to subdivision (a) or (h) is authorized to act on behalf of a county jail inmate for the purpose of applying for, or determinations of, Medi-Cal eligibility for acute inpatient hospital services authorized by Section 14053.7 of the Welfare and Institutions Code. An entity designated pursuant to subdivision (a) or (h) shall not determine Medi-Cal eligibility or redetermine Medi-Cal eligibility, unless the entity is the county human services agency.

(e) The fact that an applicant is an inmate shall not, in and of itself, preclude a county human services agency from processing an application for the Medi-Cal program submitted to it by, or on behalf of, that inmate.

(f) For purposes of this section, "health insurance affordability program" means a program that is one of the following:

(1) The state's Medi-Cal program under Title XIX of the federal Social Security Act.

(2) The state's children's health insurance program (CHIP) under Title XXI of the federal Social Security Act.

(3) A program that makes coverage in a qualified health plan through the California Health Benefit Exchange established pursuant to Section 100500 of the Government Code with advance payment of the premium tax credit established under Section 36B of the Internal Revenue Code available to qualified individuals.

(4) A program that makes available coverage in a qualified health plan through the California Health Benefit Exchange established pursuant to Section 100500 of the Government Code with cost-sharing reductions established under Section 1402 of the federal Patient Protection and Affordable Care Act (Public Law 111-148) and any subsequent amendments to that act.

(g) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the State Department of Health Care Services may implement this section, in whole or in part, by means of all-county letters or similar instructions, without taking any further regulatory action.

(h) (1) Notwithstanding any other law, commencing January 1, 2023, the board of supervisors in each county, in consultation with the county sheriff, shall designate an entity or entities to assist county jail inmates with submitting an application for, or otherwise assisting their enrollment in, a health insurance affordability program consistent with federal requirements. The board of supervisors in each county, in consultation with the chief probation officer, shall designate an entity or entities to assist juvenile inmates in county juvenile facilities with submitting an application for, or otherwise assisting with an application for enrollment in, a health insurance affordability program consistent with federal requirements.

(2) The board of supervisors shall not designate the county sheriff as an entity to assist with submitting an application for a health insurance affordability program for county jail inmates unless the county sheriff agrees to perform this function, and shall not designate the chief probation officer as an entity to assist with submitting an application for a health insurance affordability program for juvenile inmates unless the chief probation officer agrees to perform this function.

(3) If the board of supervisors designates a community-based organization as an entity to assist with submitting an application for a health insurance affordability program for county jail inmates, the designation for county jail inmates shall be subject to approval by the jail administrator or their designee, and the designation for juvenile inmates shall be subject to approval by the chief probation officer or their designee.

(4) (A) The department shall develop the data elements required to implement this section, in consultation with interested stakeholders that include representatives of counties, county sheriffs, county probation agencies, and whole person care pilot lead entities with experience working with incarcerated individuals.

(B) Notwithstanding any other law, the department, counties, county sheriffs, and county probation agencies shall share the information and data necessary to facilitate the enrollment of inmates in health insurance affordability programs on or before their date of release and to appropriately suspend and unsuspend Medi-Cal coverage for beneficiaries.

(5) (A) No sooner than January 1, 2023, the State Department of Health Care Services, in consultation with counties, county sheriffs, probation departments, Medi-Cal managed care plans, and Medi-Cal behavioral health delivery systems, shall develop and implement a mandatory process by which county jails and county juvenile facilities coordinate with Medi-Cal managed care plans and Medi-Cal behavioral health delivery systems to facilitate continued behavioral health treatment in the community for county jail inmates and juvenile inmates that were receiving behavioral health services before their release.

(B) Notwithstanding any other law, including, but not limited to, Sections 11812 and 11845.5 of the Health and Safety Code and Section 5328 of the Welfare and Institutions Code, the sharing of health information, records,

and other data with and among counties, Medi-Cal managed care plans, Medi-Cal behavioral health delivery systems, and other authorized providers or plan entities shall be permitted to the extent necessary to implement this paragraph. The department shall issue guidance identifying permissible data-sharing arrangements.

(C) For purposes of this paragraph, the following definitions shall apply:

(i) "Medi-Cal behavioral health delivery system" has the same meaning as set forth in subdivision (i) of Section 14184.101 of the Welfare and Institutions Code.

(ii) "Medi-Cal managed care plan" has the same meaning as set forth in subdivision (j) of Section 14184.101 of the Welfare and Institutions Code.

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.

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