Implementing the Medicaid Reentry Waiver in California

October 2, 2024

Key Policy and Operational Insights from 11 Counties

JSP | JUSTICE SYSTEM PARTNERS

HARP
THE HEALTH AND REENTRY PROJECT

SAFETY+JUSTICE CHALLENGE
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Executive Summary

In January 2023, California became the first state in the nation to receive approval from the federal Centers for Medicare and Medicaid Services (CMS) for a Medicaid Section 1115 demonstration request to amend Medicaid's inmate exclusion. People detained in jails and prisons have high rates of chronic and acute health needs, including physical, mental health, and substance disorders and reentry is a high-risk time.[1] A key to addressing these reentry risks is addressing people's health needs while they are incarcerated and building continuity of care from jail to community when they are released.

California's waiver, called California's Advancing and Innovating Medi-Cal (CalAIM), and the specific component focused on individuals who are transitioning out of the criminal justice system, the Justice Involved (JI) initiative, will for the first time provide a targeted set of Medicaid-covered services right before someone is released from prison or jail. These services aim to smooth reentry transitions from jail and prison to the community, establish better connections to community-based providers at release, and enhance access to necessary care and support.[2] California's approach is designed to reduce the high risk of post-release mortality, morbidity, and other adverse outcomes, including repeat contact with the criminal justice system, by bringing Medicaid financing and coverage standards to bear.

The work to implement California's waiver and make these changes a reality is demanding, involving multiple partners at the state, county, and local level who have not previously worked together at this level of vital cross-system collaboration. Implementation of these changes is well underway, and county-level changes will roll out over the next two years, starting in October 2024. This paper highlights California's implementation approach, focusing on the county-level impacts on jails, health care providers, and reentry processes. It also explores several implementation challenges and the steps the state and the counties have taken thus far to implement this change.

The John D. and Catherine T. MacArthur Foundation's Safety and Justice Challenge Initiative provides funding for this project, including technical assistance conducted by Justice System Partners (JSP) and the Health and Reentry Project (HARP). As part of the project, JSP and HARP conducted interviews and group discussions with representatives from 11 California counties and the California Department of Health Care Services (DHCS) who offered insights into implementation challenges and promising approaches to maximize the benefits of these important changes.

Key Findings

Federal and State Policy Changes Bring Pre-Release Medicaid to Jails and Prisons for the First Time.

The new waiver opportunity allows Medicaid to cover a targeted set of services for up to 90 days pre-release. California is implementing the CalAIM JI Initiative in all state prisons, county jails and youth correctional facilities. State law requires correctional facilities and county behavioral health agencies to implement the CalAIM JI Initiative.[56]

California's goal is to build a bridge to community-based care for JI Medi-Cal members by offering them services up to 90 days prior to their release to address their health conditions and establish a plan for community-based care (collectively referred to as "pre-release services"). Pre-release Medi-Cal services include care management, physical and behavioral health clinical consultation, medications and lab services, and medication assisted treatment for substance and alcohol use disorder, among others. Correctional facilities will provide Medicaid screening and enrollment support during detention. Following release, people will connect to enhanced case management, a comprehensive set of Medicaid-covered benefits, and social services such as nutrition and housing, where available.

California Counties Are Expanding Reentry Health Care Systems.

The 11 participating counties reported in interviews that they expect the majority of people detained in their jails will be eligible for Medicaid-reimbursed reentry services under this initiative. To meet the need for services, counties are enlisting new partners and building infrastructure and processes to achieve greater coordination and communication. Reflecting on their implementation efforts to date, the counties reported:

- Extensive collaboration between sectors that have not traditionally worked together is essential. This includes jails, correctional health care providers, community-based health and behavioral health providers, reentry services providers, managed care health plans and, in many places, community support providers (housing, food, employment, etc.).
- Service expansions in each sector are needed, especially for post-release care management and community-based organizations that provide reentry services, and developing the correctional and health care workforce needed to deliver services is a key challenge.
- Even in jails that have historically offered robust health care services, the number of people who will receive pre-release services will increase significantly under new policies, which also bring Medicaid as a new financing source for service provision.
- Real-time communication, including electronic data sharing, is needed between health care partners in the jail and community. This requires expanded data sharing agreements and new IT systems with appropriate privacy protections.
- In jails, many people are detained for less than a week, requiring nimble coordination between correctional and community health care providers to organize transitional care plans, offer services, and develop robust connections to community services post-release for many people in a short period of time.

California Counties Are Creating Solutions in Real Time.

In interviews, counties reported building new approaches to Medicaid screening and enrollment support, developing new ways of delivering reentry services, and leveraging innovative IT solutions. Counties also reported building on their experiences with existing reentry services, reentry health care projects such as California's State Opioid Response projects that built MAT capacity in jails across the state and the Medi-Cal Whole Person Care initiative, as well as community mapping processes like sequential intercept mapping. Leadership must prioritize thoughtful planning, cross-sector collaboration, and resource allocation to support these initiatives and achieve these important outcomes.

Implications for Federal and State Policy Makers.

Federal and state policy changes are advancing the efforts of counties and other entities to implement these new services in California. Examples of policy changes that are having an impact include:

- Significant planning implementation funding available to counties and others through California's Providing Access and Transforming Health Initiative;
- Building people's trust and engagement in care through advisory groups and inclusion of people with lived experience of incarceration in service provision;
- Developing Medicaid enrollment and service provision policies that apply in circumstances when jail stays are short;
- Developing administrative models and providing technical assistance that support community-based providers in transitioning to Medicaid;
- Encouraging the use of telehealth in service delivery to overcome logistical and workforce challenges involved in providing services in prisons and jails.

Going forward, approaches that support workforce development and finance the development and operations of systems and staffing costs are ripe areas for potential additional federal and state policymaking.

Implications for States and Counties Outside California.

California's initiative represents a groundbreaking effort to better integrate health care and correctional reentry systems at the state and county levels, offering a model for other states to follow. With 22 other states and the District of Columbia proposing similar waivers, 11 of which are approved by CMS as of August 2024, California's implementation provides valuable lessons for national, state, and local policymakers. Successful implementation requires a new level of collaboration between state and county government in most states. The implementation experience of counties in California will inform future efforts to strengthen health care access for justice-involved individuals across the country.

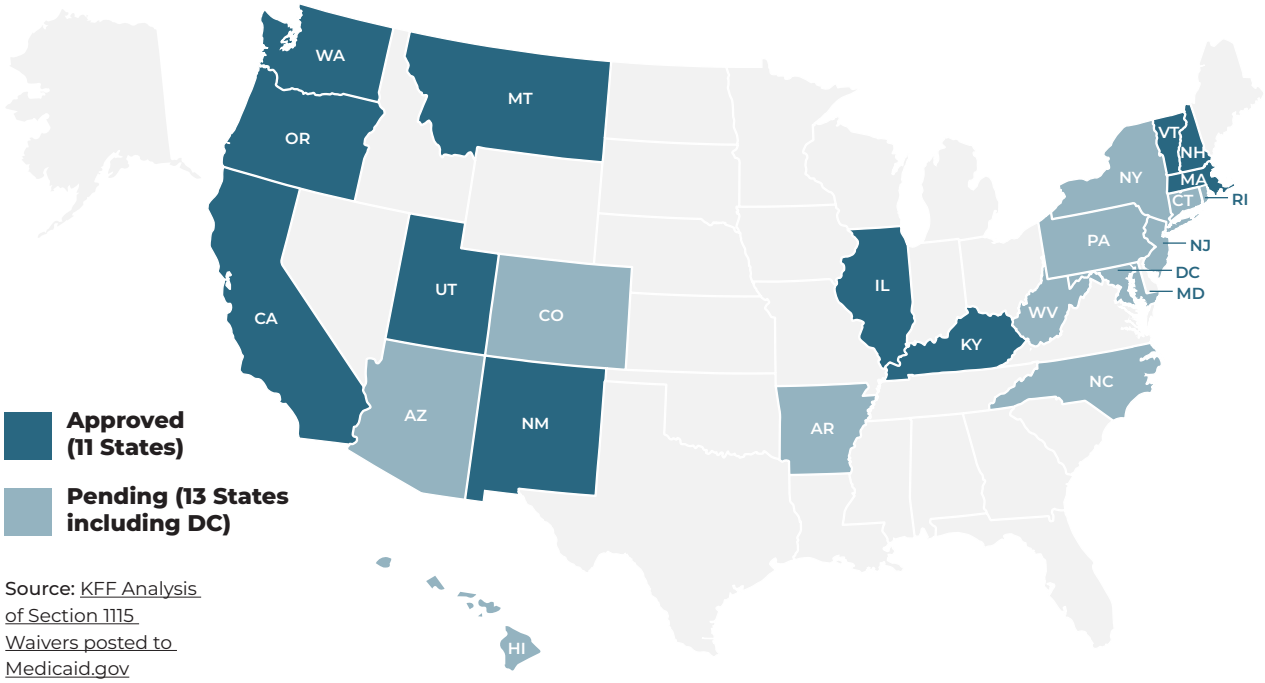
Introduction

In January 2023, California became the first state in the nation to receive approval from the federal Centers for Medicare and Medicaid Services (CMS) for a Medicaid 1115 demonstration request to amend Medicaid's inmate exclusion policy and cover a set of pre- and post-release services for many groups of incarcerated individuals, beginning 90 days prior to an expected release date.[2]

This is a milestone moment resulting from decades of advocacy and efforts to build systems that address the complex challenges in meeting the medical, behavioral health, and health-related social needs of people who are reentering the community from jails and prisons.[3] In partnership with CMS, California is putting into place the regulatory framework, funding, and partnerships needed to transform correctional health care and to support reentry and continuity of care for people returning to the community from state prisons, county jails, and youth correctional facilities. Twenty-two additional states and the District of Columbia have proposed reentry waivers, and the lessons from California's implementation can inform implementation efforts in those states as well as other efforts to strengthen access to health care for people who are leaving prison or jail. They can also inform the implementation of national requirements on using Medicaid to connect youth and young adults who are leaving the justice system to health care, beginning in January 2025.[4]

SECTION 1115 WAIVERS: MEDICAID PRE-RELEASE COVERAGE FOR INDIVIDUALS WHO ARE INCARCERATED

As of September 10, 2024



Source: KFF Analysis of Section 1115 Waivers posted to Medicaid.gov

24 states, including DC, proposed waivers to CMS (August 2024).

California counties are responsible for implementing these changes for people detained in their local jails and youth correctional facilities. The work to envision and implement these changes is demanding, involving multiple partners who have not previously worked together at this level of vital cross-system collaboration. Success is critical, though, as the implications of doing this well will have a significant impact and improve health outcomes for the more than 350,000 people booked into California jails each year, their families and communities.[5] To this end, California's Advancing and Innovating Medi-Cal (CalAIM) initiative aims to transform California's Medicaid program (known as Medi-Cal) by creating a more coordinated, person-centered and equitable health system, including adding a new focus area for people involved in the justice system. The CalAIM Justice-Involved (JI) Initiative (CalAIM JI) envisions groundbreaking changes that affect most people who are incarcerated in the state and requires unprecedented cross-sector collaboration. CalAIM JI establishes a framework, supported through state legislation, to create a new continuum of care between correctional and community health care settings.

The John D. and Catherine T. MacArthur Foundation's Safety and Justice Challenge (SJC) has been working with jurisdictions nationally to rethink how America thinks about jails, reducing unnecessary use of jails and decreasing disparities since it was launched in 2015. Through its California peer learning network, the SJC is supporting 12 sites in 11 California counties in their CalAIM JI planning work.[6] This network is led by SJC technical assistance (TA) provider, Justice System Partners (JSP), in collaboration with the Health and Reentry Project (HARP). JSP is a non-profit, multidisciplinary team committed to assisting justice and community partners with transforming their systems to be more equitable, effective, and humane. HARP is a cross-sector initiative that pioneers stronger policies and practices to expand access to health care for people directly impacted by incarceration. This team conducted a series of interviews and group discussions (June 2023 – May 2024) with people at the center of the work in California that provided insight into the challenges and opportunities counties are facing, along with promising approaches the state and counties are considering to maximize the benefit of these important changes. For more information on the engagement framework used to support counties in the learning collaborative, see the companion paper, **Using a Learning Collaborative to Facilitate Broad Systems Transformation: Supporting 11 California Counties' Implementation of the Medicaid Reentry Waiver.**

California counties are completing their plans to implement these complex transformational changes now, and initial implementation will begin as early as fall 2024.[7] This paper is intended to inform thinking beyond California, as other states and counties implement their own waivers. The paper draws on extensive discussions with representatives from the 11 counties participating in the network. It describes the challenges those California counties are taking on and the intended results, the key changes California is making in jail reentry, and the processes those counties are using to design and manage these complex systems changes. Central challenges counties are encountering are described along with some early solutions. The paper concludes with early policy considerations for other states pursuing similar waivers. While this paper does not specifically address considerations for state prisons, these considerations may be relevant for implementation for these facilities as well.

Unless otherwise cited, information in this paper draws from our conversations with representatives from counties participating in the learning network, California's Department of Health Care Services (DHCS), California's State Medicaid Agency, and other key stakeholders.

Jails, Reentry, and Health Care

Jails are local correctional facilities that are mostly used to detain people awaiting trial and those serving short sentences or community supervision sanctions, although there is significant variation in length of stay. In contrast, prisons are generally run by the state and incarcerate individuals serving longer term sentences.[8] Most county jails are run by independently elected sheriffs and are predominantly funded through county and state funding streams.[9]

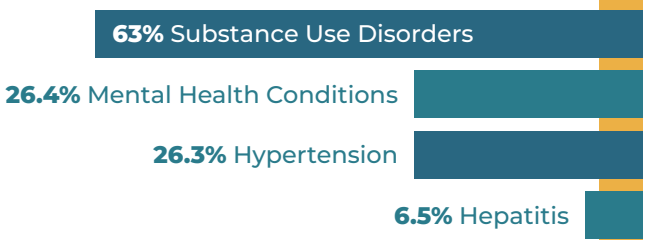
Many people booked into jails stay less than a week and are released during the pretrial phase of their case on money or recognizance bonds, on pretrial monitoring, and/or upon dismissal or disposition of their case.[10,11] The length of a jail stay varies from one day to multiple years. Release decisions are predominantly made by the court and many people are released from jail in an unpredictable manner, due to procedural issues designed to protect due process rights and/or payment of money bond. A person may attend a court hearing in the morning and be ordered released that day.

A larger number of people are impacted by jail than prison in the United States: in 2022, there were 7.3 million admissions to jails compared with 469,200 admissions to prisons.[12,13] In 2019 there were over 368,000 admissions to California jails and 34,889 to California prisons.[14,15] The MacArthur SJC Initiative tracks monthly jail releases for 23 of the participating grantee sites across the U.S. and in April 2024 45,914 people were released from these 23 jails. In California, both Los Angeles County and the City and County of San Francisco participate in the SJC. Their SJC data indicates that in April 2024, Los Angeles County released 5,234 people and the City and County of San Francisco released 1,228 people.[16]

Addressing Health Care Needs During Detention

The extent to which jails address peoples' health care needs varies. Data indicate that people detained in jails have significant, acute health needs that require ongoing treatment including hypertension (26.3%), hepatitis (6.5%), mental health conditions (26.4%) and substance use disorders (63%).[1,17,18] Health care access during detention is impacted by many factors beyond length of stay. These include funding levels, jail size and space, how care is structured, the type of entity that provides correctional health care (commercial vendor or local health care system), and the availability of local health care workforce. Numerous studies have found that people detained in many jails and prisons are under-treated for their conditions, with inadequate access to medical examinations, laboratory services and medications, as well as treatment for mental health conditions and substance use disorders.[19,20] One study found that more than half of people with an established mental health condition received no treatment for that condition during their jail stay.[17]

Numerous studies have found that people detained in many jails and prisons are **under-treated for their conditions**. People in jails have significant health needs, including:



Source: Bureau of Justice Statistics.[1,17,18]

This makes it difficult to generalize about the care people receive when they are incarcerated. Some people who are arrested and brought to the jail for booking need immediate care due to injury or an urgent medical or behavioral health issue, which should make triage and stabilization the initial priority (people with critical medical care needs that exceed the capacity of the local jail may be diverted to local hospitals or detoxification centers).[21] Many jails, especially larger ones, conduct medical triage screening during intake, (i.e., within 24 hours), but not all do.[22] While screening may occur early on in detention, it may take substantially longer to see a health care provider and receive medications or other treatment. One study showed that 60% of people with chronic illness in jails did not receive prescription medications while they were detained and 39% of those people said it was because they had not seen a medical provider.[22] People with very short stays are even more likely to be released without seeing a health care provider.

A larger number of people are impacted by jail than prison in the United States.

Source: Washington, DC: Bureau of Justice Statistics[12,13]

The process of leaving jails and prisons and returning to the community is also fraught with risks. Correctional health care, community health care, and community behavioral health care are usually managed and funded by different governmental entities. There are few well-established paths for correctional health care providers to give their patients a direct linkage to a community provider, share case management or treatment notes, or support continued access to medication, which strains continuity of care for individuals returning home. While some jails provide patients with a short term (7-30 day) supply of medication upon release, along with a prescription, others may simply refer patients to a community provider for medication and treatment needs.[23,24]

The cumulative impact of these limitations is evident in very high rates of deaths immediately after people transition back to communities. Extensive research shows that the two weeks after release are a particularly high-risk time for people leaving incarceration from prison and jail with higher overall risk of death (12x), including elevated risk of suicide (2x), overdose (40-120x), and homelessness (10x).[25,26,27,28,29,30,31,32,33,34]

Importance of Reentry Health Care

Given the complex needs of many people detained in jails and the high risk of death and other negative outcomes during reentry to the community, strong continuity of care between the jail and the community is essential. Reentry case management, linkages to behavioral health services, and trauma-informed approaches are key parts of successful reentry services, as are linkages to social services such as housing.[35,36]

To date, comprehensive jail reentry health care has been limited in the U.S.[37] There are exceptions where political will and funding have aligned in particular communities, such as programs that provide reentry health care for people with HIV/AIDS and substance use disorders.[38,39,40,41,42] These programs offer instructive examples of how the key elements can be combined to reduce post-release illness and deaths. However, they are often grant funded, time-limited, and limited in the number of people they can support.

Federal Policy Changes to Support Comprehensive Reentry Health Care

Medicaid is an insurance program that is operated by states within federal parameters and jointly funded by the federal government and states. It provides health care coverage to low-income individuals in the U.S. The program is overseen by the federal Centers for Medicare and Medicaid Services (CMS). Each state establishes its own Medicaid program and determines who is eligible, what services are covered, how services are organized, and how providers are paid within the federal guidelines.

Historically, Medicaid has played a limited role for people in the justice system. Medicaid's inmate exclusion policy barred Medicaid coverage of most services when people are incarcerated, limiting the ability to create continuity of health care between jail and community.[23] Over time, state and local governments have tried to strengthen connections to Medicaid coverage for people who are leaving prison and jail, and the federal government has made policy reforms to encourage those connections.[3] Many states have strengthened processes to help people leaving prisons and jails apply for and, if eligible, enroll in Medicaid coverage. This improved people's ability to access care after they return to the community but has not been sufficient to reduce negative reentry outcomes. [43,44,45,46,] To support state efforts to strengthen continuity of care and improve reentry outcomes, in 2023 CMS announced the new Medicaid Reentry Section 1115 Demonstration Opportunity.[47] For the first time, Medicaid can be used to cover health and behavioral health care services inside jails and prisons for up to 90 days prior to date of release as well as post-release care, reentry case management, and social supports. As of August 2024, CMS has approved proposals from 11 states (California, Illinois, Kentucky, Massachusetts, Montana, New Hampshire, New Mexico, Oregon, Utah, Vermont, and Washington), with 13 applications pending and others in development.[48]

Research on the types of interventions these states will be implementing shows that access to care, particularly substance use and mental health treatment, is associated with reduced justice involvement among other impacts.[49,50,51,52] Research regarding the impact of Medicaid expansion on low-income adults shows both promising increases in health care utilization and reduction in incarcerations.[53,54,55] Authorizing Medicaid to cover and finance some of these reentry services offers an opportunity to improve health and public safety outcomes.

For the first time
Medicaid funds can be used to reimburse for reentry health care costs.

Before and After CalAIM JI
The Potential Impact on Individuals' Lives
→ Andrew

The following hypothetical "before and after" story illustrates how the CalAIM JI initiative may improve life circumstances for people leaving jail, recognizing that the people impacted by incarceration are varied and diverse. This is intended to illustrate how the many discrete changes in policy and practice that are necessary to implement CalAIM JI may have interrelated and cascading effects on individual people's reentry.

While these policy changes are dramatic improvements, challenges within the system will remain and not all of these changes will happen quickly. It is critically important to pay attention to and engage the voices of people impacted by CalAIM JI throughout the implementation process and in measuring outcomes.

Andrew's Experience Pre-CalAIM JI

Andrew suffers from depression and has experienced unstable housing for several years. He was recently arrested on a minor charge and began participating in a mental health treatment court. The court team helped him enroll in Medicaid benefits and enter supportive housing, which allowed him to participate more fully in his treatment for severe depression. When he successfully graduated from the court program though, he lost access to the housing. He had friends and family who allowed him to stay with them temporarily, but when he started drinking alcohol to dull his pain, they asked him to leave. He had a job but when he showed up to work drunk one day, he was fired. Without income, he began engaging in behavior that eventually led to another arrest and jail stay. When he was subsequently released from jail, he faced a waiting period to get his Medicaid benefits reinstated and return to treatment. He was immediately faced with finding a place to stay and managing his depression on his own again. Andrew felt despondent.

How Andrew's Experience May Be Different Under CalAIM JI

After Andrew's loss of supportive housing and subsequent mental health deterioration, he began engaging in behavior that led to another arrest and jail stay. This time his connections to care in the jail looked a little bit different. During the intake process, the jail's health care staff kept his Medicaid benefits active because the type of charge he was booked on normally resulted in a jail stay under 90 days. Andrew remained in jail for a month during which the jail health staff were able to access his treatment records from his community-based provider and ensure that the medications that were successful for him in the past could be continued.

Andrew shared his challenges with depression and anxiety with his case manager, and together, they crafted a detailed post-release treatment strategy. As his release neared, Andrew's apprehension about the transition began to surface. However, this time, continuity of care was built into the system. Fourteen days before his release, a video call introduced him to his lead care manager in the community, who also had incarceration experience and was enthusiastic about helping Andrew over the next several months. The care manager is from a community-based organization that a long history of serving people returning from jail and prison. They met in-person on the day of his release and scheduled an appointment (for three weeks post-release) with the same treatment provider he was seeing before his arrest. They also helped him connect with a cousin who had a spare bedroom he could stay in as long as he remained in the treatment program.

The day Andrew walked out of jail, he carried a 30-day supply of his medications. He talked with his new care manager about how to maintain his medication regimen and about his upcoming appointment with his doctor (who had access to Andrew's health records from jail). But the support didn't stop there. His care manager also connected Andrew with an employment agency and housing support through his health plan. This housing support helped Andrew join a waiting list for a subsidized apartment, ensuring he had a stable and safe place to live after leaving his cousin's house. Andrew found a job, thanks to the employment agency, and his stable housing allowed him to maintain a consistent routine, significantly benefiting his mental health.

Over time, Andrew's depression and anxiety became more manageable as he adhered to his treatment plan in a more stable environment. The combination of continuous medical and behavioral health care, employment support, and stable housing enabled Andrew to rebuild his life, breaking the cycle of incarceration and instability.

Key Changes to Reentry Health Care in California

California is implementing the CalAIM JI Initiative in all state prisons, county jails, and youth correctional facilities. State law requires correctional facilities and county behavioral health agencies to implement the CalAIM JI Initiative.[56] California's goal is to build a bridge to community-based care for JI Medi-Cal members by offering them services up to 90 days prior to their release to stabilize their health conditions and establish a plan for their community-based care (collectively referred to as "pre-release services").

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

- Reentry care management services.
- Physical and behavioral health clinical consultation services provided through telehealth or in person, as needed, to diagnose health conditions, provide treatment as appropriate, and support pre-release care managers' development of a post-release treatment plan and discharge planning.

- Laboratory and radiology services.
- Medications and medication administration.
- Medication for substance use disorder (SUD) for all Food and Drug Administration (FDA)-approved medications and biological products, including coverage for counseling or behavioral therapies to provide a "whole-patient" approach to the treatment of SUD.[57]
- Services provided by community health workers (CHWs) with lived experience.

In addition to the above pre-release services, qualifying members will receive covered outpatient prescribed medications, over-the-counter (OTC) drugs, and durable medical equipment (DME) upon release, consistent with Medi-Cal coverage policies.

California's Goals and Implementation Approach

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

- Increase coverage, continuity of coverage, and appropriate service uptake through assessment of eligibility and availability of coverage for benefits in carceral settings just prior to release.
- Improve access to services prior to release and improve transitions and continuity of care into the community upon release.
- Improve coordination and communication between correctional systems, Medicaid, and Children's Health Insurance Plan (CHIP) systems, Medicaid managed care plans (MCPs), and community-based providers.
- Increase investments in health care and related services aimed at improving the quality of care for beneficiaries in carceral settings and in the community to maximize successful reentry.
- Improve connections between carceral settings and community services upon incarcerated individuals' release to address physical health, behavioral health, and health-related social needs.
- Provide intervention for certain behavioral health conditions and stabilizing medications such as long-acting injectable antipsychotics and medications for addiction treatment for SUDs, with the goal of reducing decompensation, suicide-related deaths, overdoses, and overdose-related deaths in the near-term post-release.
- Reduce post-release acute care utilization, such as emergency department visits and inpatient hospitalizations, and all-cause deaths among recently incarcerated Medicaid beneficiaries and individuals who would otherwise be eligible for CHIP if not for their incarceration status, through robust pre-release identification, stabilization, and management of certain serious physical and behavioral health conditions that may respond

to ambulatory care and treatment (e.g., diabetes, heart failure, hypertension, schizophrenia, SUDs), as well as increased receipt of preventive and routine physical and behavioral health care.

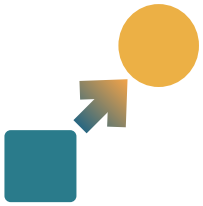
Over a three-year period, DHCS worked collaboratively with key implementation partners and stakeholders in California to operationalize its approved 1115 demonstration waiver and publish a comprehensive Policy and Operational Guide for Planning and Implementing the CalAIM Justice-Involved Initiative (October 2023).[58] California counties are responsible for implementing these complex changes in jails. Implementation will begin between October 2024 and October 2026 as counties submit their plans and DHCS reviews their compliance with the Policy and Operational Guidelines and readiness to proceed.[58]

To ensure a successful launch of the CalAIM Justice-Involved Initiative in California counties and state prisons, the initial CalAIM 1115 waiver approval authorized $151 million in Providing Access and Transforming Health (PATH) funding to support collaborative planning and information technology (IT) investments intended to support implementation of pre-release Medi-Cal application and enrollment processes. The subsequent demonstration approval for the 1115 Reentry Demonstration Initiative provided an additional $410 million in PATH funding to support collaborative planning for and IT investments in implementation of pre-release Medicaid services.[59]

California aims to **build a bridge** from correctional facilities to community-based health care.

What is Changing at the County Level?

To effectively bridge the gap between jail and community health care, DHCS expects counties and Medicaid managed care plans (MCPs) to collaboratively implement specific practice changes in both correctional and community health care.[60] This paper describes these changes in four categories: 1) eligibility and enrollment in Medi-Cal, California's Medicaid program, 2) in-jail medical and behavioral health care provision, 3) release planning, and 4) continuity of care from jail to the community. For each category, we summarize the current state of practice, the future state as envisioned in CalAIM JI and California's larger CalAIM reforms, and the implications for the justice system and the people impacted by the system.



ELIGIBILITY AND ENROLLMENT IN MEDI-CAL, CALIFORNIA'S MEDICAID PROGRAM

Before CalAIM JI

- Medi-Cal eligibility for adults includes people with an income at or below 138% of the federal poverty level and those qualifying for specific eligibility due to health conditions and other criteria. Medi-Cal provides health coverage for children and youth under various eligibility criteria.[61, 62]
- Medi-Cal does not reimburse for services provided to eligible people detained in jails (except when hospitalized in the community for over 24 hours).[63]
- Medi-Cal benefits must be suspended for the duration of a person's incarceration, as long as they remain otherwise eligible, and are reinstated upon release (effective January 1, 2023).[58]
- Prior to DHCS PATH funding[60] for IT systems, enrollment status was often tracked manually (i.e., via spreadsheets) versus through integrated data systems.[11]

Under CalAIM JI

- Counties will be required to screen for eligibility and enrollment for people booked into jail and support the application process for those who are eligible but not enrolled.[58]
- Eligibility for CalAIM JI will be based on (1) Medi-Cal eligibility and, for adults ages 21 and over, (2) having at least one of the following health conditions: mental illness, substance use disorder, chronic medical condition or significant clinical condition, intellectual or developmental disorder, traumatic brain injury, HIV/AIDS, and pregnant or postpartum status.[58, 64]
- Jails and youth facilities will activate CalAIM JI benefits 90 days prior to release. Counties may suspend benefits during detention and reinstate at release if it appears detention will exceed 28 days.[60]

Implications

- Confirmed Medi-Cal enrollment is the key to all CalAIM JI benefits. Without it, people cannot access the care they need after release.
- If a person is released prior to completing an enrollment application, the application will need to be completed in the community with support from a health enrollment navigator or a county eligibility worker.[11]
- Most people detained in jail will meet the Medi-Cal eligibility criteria. Counties estimate that approximately 80% of detainees will meet the additional CalAIM JI health criteria.[11]
- Counties are developing IT systems to facilitate real-time screening and enrollment activities, including connections to state systems, with support from DHCS.[11] Counties are also expanding data sharing agreements to address these new requirements, in compliance with California's privacy laws.[11]

IN-JAIL MEDICAL AND BEHAVIORAL HEALTH CARE PROVISION

Before CalAIM JI

- Medi-Cal does not reimburse for health and behavioral health services provided within jails.[65]
- Health care and behavioral health screenings and provisions in jails are limited due to funding and workforce availability.[11,66]
- Jail health and behavioral health care budgets are expense-based and determined locally.[11]
- Medication-Assisted Treatment/Medication for Opioid Use Disorder (MAT/MOUD) provision in jails is often limited due to funding, workforce availability, stigma, operational challenges, and concerns about diversion of MAT medications within jails. Only a small proportion of people in need receive care.[11]
- Counties have built up their MAT/MOUD treatment systems and formularies over time as public funding and grants allowed, including significant investments for MAT in jails through California's State Opioid Response (SOR) initiative. The SOR investment led to more than 31,000 people receiving MAT while detained in county jails.[67] A survey of participating counties revealed that most counties provide at least one form of MAT/MOUD and are planning to add more.[11]

Under CalAIM JI

- Counties will screen all eligible individuals entering the jail for medical and behavioral health needs, including MAT/MOUD needs.[60]

- Care standards will be governed by Medi-Cal rules, which require that services be medically necessary. DHCS's policy guide outlines requirements for when clinical oversight is allowed and/or required.[58,68]
- Medi-Cal will reimburse counties for eligible health services provided to eligible detainees within 90 days of release.[60] Eligible services include reentry case management; clinical consultation for diagnosis, treatment and development of transitional care plan; laboratory and radiology; medications and medication administration; MAT and counseling; and services provided by community health workers with lived experience.[60]
- Correctional health/behavioral health providers will be required to share health records with Medi-Cal enrolled community providers and managed care plans.[58]
- MAT/MOUD
  - » Counties will provide all available forms of MAT/MOUD, consistent with Medi-Cal regulations.[58]
  - » Clinicians will initiate needed care on the first day of detention, as appropriate.[60]
  - » Ideally, treatment will be sustained during the entire period of detention, although it is only reimbursable under Medi-Cal up to 90 days prior to release.[68]
  - » As part of release planning, people will receive linkages to MAT/MOUD providers in the community.[60]

Implications

- More people may receive needed care while they are detained and as they reenter the community, improving outcomes such as reducing overdoses upon release.[68]
- Workforce challenges are significant. New positions are being created to provide enhanced reentry services, including new position classifications such as community health worker and peer support specialist. Correctional health care providers must also be trained to provide Medi-Cal level services.[11]
- Structural changes are being made to correctional facilities to facilitate the new reentry activities, including creating additional interview spaces in intake/booking and space for detainees to receive services and meet with post-release care managers (in person or via telehealth).[11]
- Counties are developing processes and billing systems to manage the Medi-Cal reimbursement requirements.[11]
- IT systems are being developed to support exchange of medical records between correctional health care, community providers, and managed care plans.[11]

RELEASE PLANNING

Before CalAIM JI

- Pre- and post-release care management
  - » Only a limited number of people receive release planning, with a focus on people with high-risk medical conditions, people with HIV/AIDS, substance use, and mental health conditions.[11]
  - » Funding availability limits the scope and scale of reentry support.[11]
- Medications and Durable Medical Equipment (DME)
  - » Counties often provide a 7-30-day supply of medications to people leaving jail with significant medical conditions. In some cases, prescriptions, rather than the medications themselves, are provided.[11]
  - » People not actively enrolled in Medi-Cal may not be able to afford to fill their prescriptions.[11]
  - » Many counties do not provide DME to people leaving jail.[11]

Under CalAIM JI

- Pre- and post-release care management
  - » Pre- and post-release care managers will coordinate "warm handoffs" as people leave jails and return to the community.
  - » In cases in which a correctional facility elects to offer in-reach care management through a community-based organization, the same care manager can work with a person before and after they leave jail, with post-release care management services through the Enhanced Care Management (ECM) benefit.[60]
  - » ECM is a Medi-Cal managed care benefit that recently became available to high need Medicaid beneficiaries, including but not limited to people leaving the justice system. ECM addresses clinical and non-clinical needs of high-need individuals through the coordination of services and comprehensive care management. ECM gives qualified members, from specific populations of focus, dedicated support from an ECM care manager.
  - » People leaving jails will be eligible to receive post-release care management (ECM), for at least 12 months post-incarceration, to support their engagement in medical, behavioral health, and social supports in the community.[60]
- Behavioral Health Links
  - » California's waiver requires correctional facilities and county behavioral health agencies to identify individuals with mental illness and/or substance use disorders (SUD) and create a behavioral health link between the county jail and the county behavioral health agencies to ensure that individuals are receiving timely and appropriate mental health and/or SUD treatment, both in the carceral setting and in the community upon release.
  - » This includes coordination and information sharing related to care plans and transition/discharge plans, scheduling of community-based appointments, and completion of consent forms (including written consent per 42 C.F.R. part 2) among the CF behavioral health providers, the county behavioral health agency providers, and, as applicable,

the pre-release care manager and Enhanced Care Management (ECM) provider developing the transition reentry care plan.

  - » County jails can leverage in-reach clinical consultations from county behavioral health agency providers to foster relationship building prior to release and enable professional-to-professional clinical handoffs with post-release behavioral health treatment providers.

- Medications and Durable Medical Equipment (DME)
  - » Counties will provide a 30-day supply of all prescribed medications and DME to people eligible for CalAIM JI services at release from detention.[60]

Implications

- ECM supports continuity and continued engagement in medical and behavioral health care as people reenter the community.[58, 69]
- Pre- and post-release care management
  - » Pre-release care management may be provided by staff working within the jail or by community partners. Jail security requirements sometimes make it challenging for community partners to access their clients for pre-release work.[11]
  - » Managed Care Plans (MCPs) will need to vastly increase the Enhanced Care Management workforce to meet the demand for this service.[11]
  - » Community organizations report capacity concerns about taking on the administrative and financial challenges of becoming Medi-Cal providers and contracting with MCPs.[11]
  - » People released before treatment begins will need to be provided with recommendations and referrals for community care as well as Enhanced Care Management (ECM) information. Post-release follow-up by ECM providers will be essential.[11]
  - » IT systems are being developed to support private exchange of medical records between correctional health care, community providers and managed care plans.[11]
- Medications and Durable Medical Equipment (DME): Counties are working out the logistical challenges of purchasing, storing and distributing medications at a much larger scale. Short notice release decisions, which are common in jails, complicate the process of delivering the right medications at the right time to people being released from detention.[11]
- It is anticipated that many more people will leave jail with their medications in hand. This supports the goal of increased medication adherence and greater health after release.[11]
- Counties are developing data sharing agreements and methods to securely share health records and discharge treatment plans with community providers and managed care plans, requiring the development of new data use/sharing agreements and IT systems in compliance with California's privacy laws.[11]

CONTINUITY OF CARE FROM JAIL TO THE COMMUNITY

Before CalAIM JI

- Direct referrals for medical and behavioral health care and social supports, with warm handoffs and transitional care plans, are provided to a limited number of people being released from detention, with a focus on people with high-risk medical conditions, people with HIV/AIDS, substance use, and mental health conditions and align with available public and grant funding.[11]
- Outside of special programs, referrals to community health centers are not routine.[11]

Under CalAIM JI

- Managed care plans (MCPs) will be responsible for ensuring access to medical and behavioral health care, and social supports in the community for people who are Medi-Cal JI eligible and leaving detention with follow up care recommendations.[58]

Implications

- Under CalAIM, community supports, available at the option of the MCP in each county, recently became available to support Medicaid beneficiaries with significant social needs. People leaving the justice system are one group that qualifies to receive these services. Community supports include but are not limited to housing transition navigation services, housing deposits, and housing tenancy and sustaining services.[70] A request to cover transitional rent as an additional community support is currently pending federal approval.[71]
- Improved continuity of medical and behavioral health care and access to safe housing, food, and employment is designed to establish and maintain wellness and stability post-release and reduce future justice system involvement.[11]
- Expanded capacity will be needed among community health, behavioral health, and social support providers to meet the growing demand.[11]
- Jail stays frequently disrupt people's existing housing and employment and people often have difficulty re-establishing them after release. Counties indicate that limited affordable housing and long waiting lists pose a significant challenge.[11]
- IT systems are needed to support private exchange of medical records between correctional health care, pre- and post-release care managers, community providers, and managed care plans.[11]

Before and After CalAIM JI
The Potential Impact on Individuals' Lives
→ John

The following hypothetical "before and after" story illustrates how the CalAIM JI initiative may improve life circumstances for people leaving jail, recognizing that the people impacted by incarceration are varied and diverse. This is intended to illustrate how the many discrete changes in policy and practice that are necessary to implement CalAIM JI may have interrelated and cascading effects on individual people's reentry.

While these policy changes are dramatic improvements, challenges within the system will remain and not all of these changes will happen quickly. It is critically important to pay attention to and engage the voices of people impacted by CalAIM JI throughout the implementation process and in measuring outcomes.

John's Experience Pre-CalAIM JI

John's history with the justice system was marked by a revolving door of short-term jail stays for minor offenses. Chronic medical issues had plagued him, leaving him in constant pain and with limited mobility, making each day a struggle. He applied for Medicaid benefits once, but his construction job (which he left ten years ago) had put him just above the eligibility threshold and he never made another attempt to enroll in coverage. Without insurance to cover medical care, he resorted to buying oxycontin from a neighbor and became addicted, leading to repeated arrests and the revolving door of jail stays. Upon each release, John was left without health coverage or support system to address the root cause of his pain and treat his addiction. This lack of care was followed by a vicious cycle of pain management through substance misuse, and subsequent arrests. John's chronic pain and the struggle with mobility hindered his hope for rehabilitation and stability.

How John's Experience May Be Different Under CalAIM JI

John's history with the justice system was marked by a revolving door of short-term jail stays for minor offenses. Chronic medical issues had plagued him, leaving him in constant pain and with limited mobility, making each day a struggle. However, during his most recent jail stay, things started to look up. At booking, jail staff determined he was eligible for Medicaid and helped him complete the enrollment paperwork. Jail staff estimated he was within 20-days of release so was eligible for Medicaid-funded services. Upon meeting with his case manager in the jail, he learned that his case manager had a similar experience with medical issues and justice system involvement. Despite John's mistrust of and frustration with the medical system, their shared experience helped John to feel comfortable talking with his case manager. The case manager talked about how to access and use medical benefits, as well as how they might help his quality of life. John began to feel more open to meeting with a doctor in the jail and willing to accept the help of the case management staff.

He then received a clinical consultation from an in-reach physician specializing in chronic pain management to address the root causes of his pain. The physician developed a treatment plan, including getting fitted for a cane, that slowly began to offer him some relief. In addition, he began meeting with a behavioral health treatment provider, completed an assessment for his opioid use disorder, and started medication assisted therapy. In the past, health care he received in jail didn't follow him to the community, but this time was different. His case manager took the time to understand John's medical, behavioral health, and social support needs and introduced him to community health worker, who would be working with him after his release. They also set up appointments with a community-based medical provider and behavioral health provider in advance of his release to avoid a long wait.

John felt comfortable meeting with his community health worker after release since he knew them already. They talked about the upcoming meetings with his providers and how best to approach those. These providers had access to John's medical records and seamlessly continued the treatment he had started in jail. John continued to meet regularly with his community health worker who helped him navigate his recovery as well as basic life challenges, such as transportation issues, getting to medical and court appointments on time, and taking better care of himself. With consistent care and support, John found his health improving, which gave him a new lease on life and a chance to break the cycle of re-arrests.

How Counties are Implementing These Changes

Counties involved in the SJC CalAIM JI Network are planning for implementation as early as October 2024. In interviews between June 2023 and May 2024, county representatives described challenges they face. This section summarizes common challenges of the 11 counties we interviewed and provides some early local, state, and federal policy considerations for responding to those challenges.

California state law requires that all counties engage in the CalAIM JI process. Other states' waiver proposals vary though, (e.g., some involve only state prisons, while others involve both prisons and jails), so these challenges will apply in varying degrees. However, since most people released from prisons and jails return to their county of origin and will seek continued care there, implementation challenges across reentry waivers are likely to have much in common.

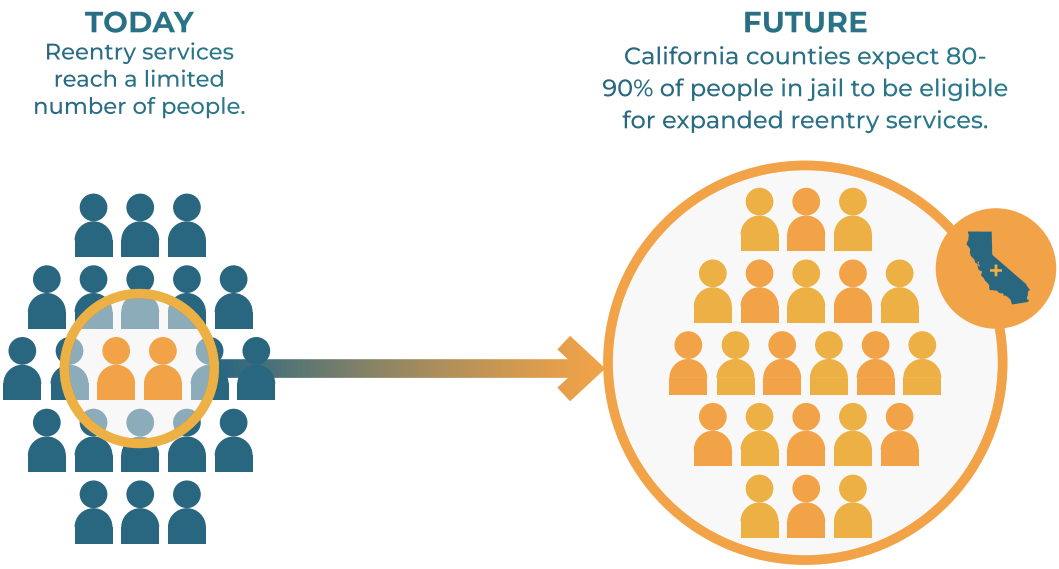
IN CALIFORNIA, TWO OVERARCHING CHALLENGES DRIVE THE NEED FOR CHANGES AT THE COUNTY LEVEL.

Significant Increase In The Number Of People Who Will Be Eligible To Receive Targeted Pre-Release Health Services.

Counties told us they anticipate that 80% or more of people detained in their jails will be eligible for Medi-Cal and meet CalAIM JI eligibility criteria. This will result in many more people receiving reentry services. For example, one county noted that they currently support about 2,100 people detained in their jail each year with comprehensive health-related reentry services through local and state funding and grants. Because Medicaid coverage makes services available to all Medicaid beneficiaries who meet specific eligibility criteria, once the new CalAIM JI changes are fully implemented, that same county expects to provide approximately 20,000 detainees with reentry services each year – nearly a ten-fold increase. Other counties describe expecting similar growth in people receiving reentry services.

Enacting Continuity Of Care Through Building New Cross-System Partnerships.

County jails, correctional health care, and Medicaid managed care plans (MCPs) are developing processes to coordinate service connections at release to minimize gaps in care. At the same time, as part of larger CalAIM reforms, MCPs are building systems to facilitate expanded access to post-release ECM care management and, in some cases, community benefits such as housing and food security. Criminal justice partners, including courts, pretrial services, and probation are considering how conditions of release and supervision intersect with this new system as well (both for sharing information and avoiding duplication of services). The increased need for real-time communication between all partners demands new data-sharing infrastructures, requiring IT investments and new or expanded data-sharing agreements.



Planning and Coordination Efforts

Just as California is the first state in the nation to implement the new Medicaid Reentry Section 1115 waiver, the State's counties are the first in the nation to implement the new systems and services in jails. Through interviews and other conversations with county leaders, we gained a broad perspective across 11 counties on how they are approaching this complex cross-system planning effort.

From the outset, counties we spoke with worked at a fast pace to understand the opportunities and challenges created by CalAIM JI, to understand DHCS' guidelines, and to catalyze their own planning teams. They pursued PATH funding opportunities to obtain support for planning, IT system development and initial implementation. In April 2024, counties began to submit their PATH implementation plans and go-live readiness assessments (which must be approved before implementation can begin) to DHCS. As of August 2024, four counties, have submitted readiness assessments for DHCS review. Implementation across all counties is expected to take place between October 2024 and October 2026.[11]

IMPLEMENTATION GOVERNANCE PROCESSES

CalAIM JI is new and cuts across multiple systems, requiring the development of innovative, cross-sector oversight and accountability processes. Specifically, while these are changes to Medicaid policy, they will be carried out primarily in the criminal justice system, requiring oversight from both the health and corrections sectors to meet shared public health and safety goals. In addition, as correctional health care services have not previously needed to meet a Medicaid standard of care, careful attention is needed to ensure that services delivered meet the standards set by CMS in the waiver.

All counties convened cross-agency planning groups with key partners including corrections, correctional health care, community health and behavioral health providers, probation, pretrial, and community agencies offering reentry case management, housing, and other needed supports. The core responsibilities of the planning groups include:

- Translating state requirements and expectations into workable systems for their counties;
- Envisioning ways to provide the expanded set of services required by CalAIM JI;
- Planning for the provision of required services to all Medi-Cal eligible people detained in jails;
- Providing cross-education between custody, correctional health care, reentry, and county health department staff and outside partners, such as community service providers and managed care plans;
- Developing and managing work plans that are in compliance with DHCS guidelines and timelines;
- Addressing data sharing and IT infrastructure requirements; and
- Building more robust and flexible recruitment and hiring processes to address workforce requirements and challenges.

One promising practice in governance is the inclusion of people with lived experience of incarceration in CalAIM JI planning teams and governance bodies. People who have received health care services in jails and prisons and have

navigated the challenges of accessing care in the community after release hold knowledge critical to the success of this initiative that other planning partners may not have. This includes a unique understanding of what does and does not meet their needs, where systems and communication may break down, and where trust needs to be built to encourage increased participation in services. Examples of engagement include:

- Appointing people with lived experience on the county's planning and governance board; and
- Conducting surveys with people currently or previously detained in jail to gain insight into ways of improving health care and reentry services.

BUILDING ON EXPERIENCE

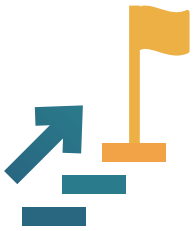
Counties described ways they are applying lessons learned from other reentry projects and how those lessons are informing their thinking about their CalAIM JI plans. Examples include:

- Pre-release Medi-Cal screening and enrollment projects;
- Projects between corrections and county behavioral health services that manage the in-jail and post-release care for people with substance use and mental health conditions;
- Efforts to expand medication-assisted treatment (MAT) within jails;

States could support counties by providing prepared messaging on key policy changes, local impacts, and intended outcomes.

- Peer-based community navigator programs that provide support to people returning to the community from jails, including assistance with accessing housing, employment, food, and health care;
- Collaborative courts such as drug and mental health courts, often funded by specific grants, that also coordinate in-jail and post-release care and involve criminal justice partners;
- Joint projects with counties and local managed care plans that provide people with chronic medical conditions care in-jail and after release, such as California's Whole Person Care pilots, especially those with Justice-Involved populations of focus; and
- Cross-system planning efforts, such as Sequential Intercept Mapping (SIM), which facilitate identification of existing resources and gaps in services at major decision points across the criminal justice system.[72, 73]

Implementation Challenges and Emerging Solutions



Several issues were identified as top challenges across all counties. These include organizing services within the jail; managing uncertain release dates; adding Medi-Cal reimbursement and billing functions; incorporating those revenue streams to existing county finance structures; and hiring enough people to provide all the new services. Each challenge requires specific attention and innovative solutions from the cross-system planning team. State and federal policy decisions can help to alleviate these challenges and/or provide resources to assist counties in addressing them.

In addition to these topic-specific challenges, counties' implementation structures must account for the evolving nature of these new policies and the inevitable transitions of project staff and leadership that will occur during implementation. Since California is the first state in the nation to implement these new federal policies, there has been a continuous learning process between the state and counties regarding the operational realities of jails, correctional health care, and Medi-Cal. While counties report that everyone is working toward the same vision, local implementation plans and governance structures have had to remain flexible enough to shift in response to those learnings and related adjustments to federal and state guidelines and agreements. County leadership and implementation teams have also had to anticipate and respond to mid-course changes in internal leadership and line staff by developing real time educational, on-boarding, and communication materials.

In each section that follows, we focus on the challenges faced by counties, and potential county, state, and federal policy approaches for addressing these challenges.

CHALLENGE #1: ORGANIZING CARE TRANSITIONS WITH SHORT STAYS AND UNCERTAIN RELEASE DATES.

Predicting release dates is inherently difficult in local jails as they commonly receive only a short window of notice – often a few hours– before they are required to release people. These unpredictable release dates present a significant operational challenge as CalAIM requires counties to cover specific pre-release services (transition planning and reentry services) for all eligible detainees within 90 days of an expected release date.

Coordinating these services during short jail stays, which can sometimes be less than 48 hours, is similarly challenging. As discussed earlier, counties anticipate providing services to many more people under these time pressures,

requiring a significant increase in communication between many partners, including correctional health care, custody staff, community health and behavioral health providers, reentry care managers (pre- and post-release), and managed care plans. This also increases urgency for real-time information sharing, ideally through electronic data-sharing systems and nimble coordination to manage care transitions.

STATE POLICY APPROACH:

Creating a Short-Term Model to Front-load Release Planning: California has approached the issue of short jail stays and unpredictable release dates by outlining a short-term model, developed in consultation with county partners.[58] The model outlines minimum requirements for how facilities should handle short stays and provides best practices for ensuring that Medicaid eligibility screening, enrollment, pre-release service provision, and reentry planning happen at intake, where possible, after someone is identified as potentially having a short stay. The flexibility to complete eligibility screening and activate the justice-involved aid code, which identifies people in the Medi-Cal system as being eligible for Medi-Cal pre-release services, as early as possible allows providers to create reentry plans and initiate connections with community providers, including reentry case managers. Some elements of the short-term model are currently recommendations, not expectations, and California plans to update its short-term model after implementation of pre-release services goes live.

Keeping Medi-Cal Enrollment Active During Detention. Another key piece of California's response to short and unpredictable stays is to keep Medi-Cal active, instead of suspending it, for stays that are expected to be under 28 days. Keeping Medi-Cal active decreases the risk of someone being released unexpectedly without active benefits and access to care. In addition, knowing that a large percentage of people move in and out of county jails within 48 hours, California has identified minimum expectations for "very short" stays. These minimum expectations include the option to use accelerated Medi-Cal enrollment processes and allowing pre-release case managers to communicate with community providers and Managed Care Plans (MCPs) in the period immediately following release as opposed to pre-release.[58]

FEDERAL POLICY APPROACH:

Medicaid and Release Dates. CMS's Medicaid reentry policy allows states to cover certain pre-release services for up to 90 days prior to an expected release date. This construct of allowing services within a certain period prior to release is rooted in federal law. Passed in 2018, the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) required CMS to issue guidance on an 1115 waiver opportunity for states to improve transitions of care for Medicaid-eligible individuals who are leaving jails and prisons. Because the CMS guidance and underlying federal statute are explicitly focused on reentry care transitions, the resulting CMS guidance limits Medicaid coverage to a period of time pre-release. New national requirements affecting incarcerated youth and young adults similarly require that some services be provided starting 30 days prior to release. Setting release dates will also be an operational challenge in implementing these new requirements.[4,74] Legislation has also been introduced in Congress that would take different approaches to authorizing Medicaid coverage of some services provided in corrections that are not

specifically tied to reentry and would, therefore, not require states to identify an expected release date. They would cover a significantly more expansive set of services than the 2017 CMS waiver policy does but their legislative prospects are unclear.[75] In addition, one state, Rhode Island, has proposed that Medicaid cover services for people entering, rather than leaving, jails.[76]

CHALLENGE #2: TRANSITIONING CORRECTIONAL HEALTH CARE SERVICES DOCUMENTATION AND BUDGET MODELS TO MEET MEDI-CAL REIMBURSEMENT REQUIREMENTS.

CalAIM JI allows Medi-Cal to cover targeted pre-release health care services provided up to 90 days prior to release. Reimbursement claims will be submitted by and reimbursed to the county facilities under their Medicaid national provider identifier (NPI). Counties will need to develop processes to manage the service documentation and billing requirements. Those that have county-run health systems may already have billing systems that can extend to correctional health care to manage the claim submittal and reimbursement process, but others will need to develop this capacity. In interviews, county representatives expressed that this is a significant change. Counties that contract with correctional health care vendors are considering how to address these requirements, with options including adding contract provisions to meet service and documentation requirements for the new services required under CalAIM JI. They may also need to build (or contract for) systems to manage the reimbursement process.

STATE POLICY APPROACH:

PATH Funding. To ensure a successful launch of the CalAIM Justice-Involved Initiative, the initial CalAIM 1115 waiver approval authorized $151 million in Providing Access and Transforming Health (PATH) funding to support collaborative planning and information technology (IT) investments intended to support implementation of pre-release Medi-Cal application and enrollment processes. The subsequent demonstration approval for the 1115 Reentry Demonstration Initiative provided an additional $410 million in PATH funding to support collaborative planning for and IT investments in implementation of pre-release Medi-Cal services.

Integrate Necessary Planning into Approval Process. One key component of these systems will be to ensure that correctional providers have processes in place for collecting, monitoring, and reporting data to DHCS.[59] DHCS has required these processes, and facilities must demonstrate their ability to report required measures in order to receive approval from DHCS to begin providing Medicaid-covered services.

Provide Communication Tools for Local Officials. County planning teams are asked to describe the many types of changes that will occur as a result of CalAIM JI implementation to local leadership and communities. States could support counties by providing prepared messaging on key policy changes, local impacts, and intended outcomes.

CHALLENGE #3: SCALING UP REENTRY CARE MANAGEMENT SERVICES AND EQUIPPING COMMUNITY PROVIDERS TO MEET THE NEED.

In many communities, reentry support services are provided by small community-based organizations that are often staffed, in part, by people with direct experience of incarceration. These organizations play a key role in helping people return to the community from jail or prison and have typically earned the trust of the community over time. Some jurisdictions report facing challenges with fully engaging these community-based providers in CalAIM JI, however, due to a historic lack of partnerships and trust between corrections systems and community service providers, uncertain financial incentives for organizations to care for this population, and, especially in very rural communities, general scarcity of or geographic distance from reentry organizations.

A key issue raised by several California counties is concern about reentry organizations transitioning from contract and grant-based funding models to the billing model required to become Medi-Cal providers. While becoming a Medi-Cal provider can be a pathway to long-term financial sustainability, doing so requires a higher level of administrative capacity than some smaller community-based organizations (CBOs) have access to.

STATE POLICY APPROACH:

Providing Technical Assistance to Develop Administrative Capacity.

California has responded to the need to support community providers by developing a technical assistance (TA) marketplace that provides resources and direct assistance to organizations who want to provide care management within CalAIM, including CalAIM JI. Topics for TA include how to get set up for Medicaid billing, best practices around information sharing, trauma informed care, and more. One large urban county is exploring a model that would support CBOs by creating an administrative hub that would handle administrative compliance, documentation, and billing for these organizations. This idea is designed to create more efficient processes where CBOs can focus their resources on providing care and services rather than developing administrative capacity.

CHALLENGE #4: BUILDING TRUST AND ENGAGEMENT IN CARE.

People with lived experience of incarceration report that people who have been detained often have difficulty trusting the health care and health advice they receive within and outside of the correctional system. Trust building is needed both at the individual (provider-to-patient) level in correctional health care and at the community level. One promising practice is including people with lived experience in the design and provision of care. This work may be done through reentry service providers or through community health workers (who are now eligible to provide reimbursable services under CalAIM). One model for integrating people with lived experience of incarceration into care teams was developed by the Transition

Trust building between patients and providers is needed both at the individual and community levels.

Clinic Network.[77] Counties reported that they have involved people with lived experience in their planning teams. They have also reported conducting surveys with people with lived experience asking about their care priorities and preferences as they build their CalAIM JI systems. Further, counties reported challenges with providing jail access for people with criminal records to provide in-reach care due to security concerns. While these policies may be rooted in correctional facility safety, they negatively impact the ability to meet staffing needs with people who are uniquely qualified (based on their lived experience) to do these jobs.

STATE POLICY APPROACH:

Justice-Involved Advisory Group:
At the state level, California engaged with people with direct experience through their Justice-Involved Advisory Group to inform their waiver development and early implementation thinking. However, additional engagement at the state and county level for implementation will be essential to continuing to build trust and engagement in care.[78]

FEDERAL POLICY APPROACH:

In its State Medicaid Director Letter announcing the reentry waiver opportunity, CMS "strongly encourages" states to include individuals with lived experience of incarceration in the design of their waiver proposals and implementation of approved waivers.[79] CMS's recommendation reflects the unique value of engaging these perspectives and insights in policy design and implementation.

CHALLENGE # 5: WORKFORCE SHORTAGES.

Successful implementation of CalAIM JI rests on the availability of an effective and well-trained workforce across the health and justice sectors. Unfortunately, workforce shortages persist. California's community health centers' average turnover rate was 31.4% in 2022 which is 3 times higher than in 2020.[80] Counties told us in interviews (Summer 2023) that they were running at 25-30% vacancy rates for corrections and health care positions prior to considering the additional staff needed for CalAIM JI.

At the same time, CalAIM JI presents an opportunity to strengthen support for correctional officers (COs) by better responding to the complex behavioral and health needs of individuals entering the jails and prisons. Promoting the health needs of individuals during the period of incarceration, coupled with providing a bridge to services in the community, can not only benefit those receiving the care but enhance the safety and security of staff and facilities as well. Staffing shortages can result in front line staff taking on the duties of clinicians or social workers. Corrections professionals have few supports for those duties, which has a negative impact on the wellness of the workforce as well as recruitment and retention. The more individuals with acute health needs

receiving care in the community, the greater the possibility there is to improve the climate of congregate settings for correctional staff and the individuals in custody. Overtime, Medicaid coverage of services offers an opportunity to meet the needs of those in custody while allowing correctional officers to focus on their core responsibilities of care, custody, and control.

COUNTY POLICY APPROACH:

Innovative IT Solutions. At the local level, counties are developing creative initiatives to address workforce challenges. For example, one large urban county is piloting an IT solution that extends its medical and behavioral health workforce in its local jails. The county has 150+ people entering their jails each day, many with significant health, behavioral health, and social needs. To help their clinicians meet this need, they have developed an artificial intelligence (AI) program, or "bot," that searches through the existing health, mental health, and social service records for incoming patients and populates a needs assessment form for clinician review. This program is designed to help clinicians work more efficiently by lessening the documentation burden as well as proactively identifying high-risk individuals who may need more intensive additional support.

STATE POLICY APPROACH:

Investing in the Workforce and Policy Shifts. While there are few immediate solutions to broad workforce shortages, California has approached workforce challenges related to CalAIM-JI in several key ways, including allowing the use of telehealth to connect people during incarceration to providers, including ECM providers, in the community. Allowing telehealth can expand the reach of community providers who may not be able to meet with a client in person during their jail stay due to distance or other logistical issues. Jail facilities may need to be modified to develop telehealth capacity, including technology set up and changes to the physical environment where telehealth visits will occur.

FEDERAL POLICY APPROACH:

As a part of California's waiver approval process, CMS is providing $410 million in transitional investments to support implementation. This investment, called Providing Access and Transforming Health (PATH), will help California support the collaboration, planning, and infrastructure needed to put their waiver into practice. One area in which California is investing some of these funds is in workforce hiring and training, including efforts to build the correctional workforce and community provider capacity to support the justice-involved population during and after reentry.

CHALLENGE #6: DATA SHARING AGREEMENTS AND IT SYSTEMS.

CalAIM JI requires counties to share private and protected health information between correctional health care, managed care plans, and community reentry and support providers quickly and continuously to manage care transitions for all eligible people detained in their jails. The full process of Medi-Cal eligibility screening, enrollment, suspension, and reinstatement also requires continuous information sharing between corrections health and county agencies that manage Medi-Cal enrollment. Where these processes were not previously covered by formal data sharing agreements that include all parties, new or expanded data sharing agreements are needed. All of this information exchange needs to be handled electronically to meet the demands of volume and timelines, requiring investment in new IT infrastructures. Questions of whether and what data should be shared with courts, probation, and other entities need to be addressed.

STATE POLICY APPROACH:

Providing Guidance to Counties. California is working to support counties with resources for the development of data sharing processes. California currently has a data sharing workgroup and has released CalAIM Data Sharing Authorization Guidance to support development of these systems.[81] DHCS also supports a Technical Assistance Marketplace listing qualified vendors that can assist counties with planning in this and other areas.[2]

FEDERAL POLICY APPROACH:

Forthcoming Guidance on Use of Medicaid IT and Administrative Matching Rates. Medicaid has enhanced matching rates for IT (90%) and Administrative (50%) costs that can be used by states to support ongoing investments in these areas to carry out new Medicaid reentry policies.[82,83] While California's waiver includes up-front investments for infrastructure development, guidance from CMS to states is needed on how to take advantage of Medicaid enhanced information technology and administrative matching rates. The Consolidated Appropriations Act of 2024 requires CMS to release this guidance by September 2025 and it is expected to speak to how these matching rates can and should be used to support sustainability.

Learning from California's Experience

As of August 2024, 23 states, including California, and the District of Columbia have submitted applications under the Medicaid Reentry Section 1115 Demonstration Opportunity. While each waiver proposal is different based on each state's target population, resources, goals, and timeline, all states must incorporate the key elements required by CMS. The ways each state chooses to implement these key elements within its state and county corrections system will vary based on the underlying state Medicaid plans and the way state and county corrections are organized. At the same time, the challenges of bridging the disconnect between correctional health care and community health care have much in common across states. Thus, national policymakers as well as states and counties beyond California have ample opportunity to gain valuable insights for their own waiver applications and cross-system implementation processes from California's vast undertaking.

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End Notes

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SAFETY+JUSTICE CHALLENGE
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