CalAIM Justice Involved Newsletter

November 2023
First Edition

Sheriff's Office - Probation - Behavioral Health - Social Services - Public Health - Office of Education - Community-Based Organizations

The Justice Involved Newsletter is dedicated to the people that serve incarcerated & formerly incarcerated youths and adults. The first edition of this newsletter is designed to establish a common foundation about the Medi-Cal managed care program and to briefly sketch the CalAIM framework. In the next edition, the justice involved reentry initiative will be further unpacked to inform readers about the ways to approach readiness, and to highlight techniques to support financial sustainability for reentry services.

California's Medicaid Program

The Medi-Cal program is divided into two distinct parts and regulated by the California Health and Human Services Agency. The original part is called "Regular Medi-Cal" and is often referred to as "fee for service Medi-Cal". In this part of the program, the State of California contracts with a vendor to process and pay claims submitted by providers. The second half of the Medi-Cal program is "Managed Care", and the State of California contracts with for-profit and non-profit health plans, and pays a fixed amount each month for each person enrolled in the health plan. The health plans, in turn, are responsible for all services and contract with community partners such as physicians, institutions, and caregivers (i.e., primary and specialty care, hospitals, labs, health centers, etc.). Over the last decade, the State of California has been transitioning people into Medi-Cal managed care, and by the end of this year only one-percent (~150,000) of the Medi-Cal beneficiaries will be enrolled in Regular Medi-Cal. This means over 15 million children, youth, and adults will be enrolled in the managed care program by January 2024. Each beneficiary is assigned to a Medi-Cal health plan to administer benefits and access to care, and the ECM benefit adds a secondary layer of coordination, targeting formerly incarcerated individuals with the highest needs.

CalAIM is Advancing and Innovating Medi-Cal

CalAIM stands for "California Advancing and Innovating Medi-Cal". The State of California received a 5-year waiver approval from CMS to deploy CalAIM and the reentry initiative is a cornerstone in this transformation. CalAIM targets the managed care side of the Medi-Cal program and most of the changes occur in this space, with the exception of pre-release services that are linked into Regular Medi-Cal. Nearly two billion dollars was allocated to organizations directly engaged in reenrty, purposed to incentivize capacity-building and readiness. The integration of the justice system and Medi-Cal program has been challenged by the inmate exclusion policy, which prohibits Medicaid funds to be used for incarcerated people. California advanced reentry through AB109 realignment and SB823, and other laws and court actions, to forge the foundation for the CalAIM program.

The justice involved initiative is scheduled to start on October 1st, 2024, and is scheduled to end by September 30th, 2026. CalAIM's reentry initiative is focused on county jails, state prisons, and juvenile justice centers, and the federal prisons and state forensic hospitals are excluded. California is the first state to receive approval from CMS for a justice involved reentry initiative of this magnitude, and fourteen(14) other states are either in process or have received approval from CMS to integrate coordinated reentry into their Medicaid program.

Enhanced Care Management

Enhanced Care Management (ECM) is a covered benefit in Medi-Cal managed care, and a network of services are administered by health plans in each county. The ECM services are available for people with complex physical health, mental health, substance use, and adverse social determinants of health. Population health and health equity factors into the suite of services that include outreach, navigation, care coordination, assessments, referrals, facilitation of warm handoffs, and frequent interactions with the client to ensure they are receiving the needed assistance. The goal is to connect people to services more timely and to improve the quality of life, especially for a person that is struggling with multiple chronic diseases and conditions. ECM is designed for people with complex conditions.

The ECM benefit is accessible to eligible children, youth, and adults enrolled in the Medi-Cal managed care program, and the eligibility criteria is organized into ten(10) categories called "Populations of Focus", or "POF". The CalAIM POFs launched in early 2022 and have continued to go-live in each county, and the final POF in 2024 is the justice involved population. In the first year over 145,000 people statewide were enrolled in ECM and community supports. A person may be eligible for one or more POF, and their eligibility is subject to redetermination as life's circumstances change. The POFs include: 1) adults and families experiencing homelessness 2) high-utilizers of multiple systems, 3) adults with substance use or serious mental illness, 4) adult nursing facility residents transitioning into the community, 5) children and youth eligible for the California Children Services program, 6) children and youth in child welfare, 7) adults at-risk for long-term care, 8) unhoused children & youth, 9) birth equity, and 10) justice involved for youth and adults. POF #1 through #8 have launched statewide, and #6 includes children and youth with intellectual or developmental disabilities. Birth equity and justice involved POFs are scheduled to launch on January 1st, 2024.

In the context of the justice involved populations, all youth are eligible for ECM upon release no matter their circumstance, however for reentry adults they must meet the following criteria: diagnosed with a chronic mental illness, substance use disorder, chronic disease (e.g., hepatitis C, diabetes), intellectual or developmental disability, traumatic brain jury, HIV, or pregnancy. Based on this eligibility criteria, a high number of incarcerated individuals qualify for ECM upon release and the level of effort to engage people is significant, and this factor must be reflected in your staffing model. Medi-Cal managed care beneficiaries have the right to disenroll from ECM, or re-enroll, at any time without reason, and may switch health plans if more than one option is available in their county. Beneficiaries may choose to be assigned to a physician inside of an ECM team or be assigned to a primary care physician in a different part of the network. Bottom line, your approach to building and financing an ECM team must be flexible and scalable as populations change.

Medi-Cal beneficiaries are typically assessed for eligibility each year, or "redetermined", by the county's social services department. During the public health emergency these re-determinations were

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Enhanced Care Management (continued)

artificially driving the enrollment in the Medi-Cal program to reach all-time highs, and today exceeds more than fifteen(15) million children, youth, and adults. The redeterminations restarted in April 2023 and continue for one full year, ending April 2024, and enrollment is expected to reduce by 10% - 15%. The impact of the redeterminations is an important factor to include in your financial modeling for sustainability. The ECM teams consist of multidisciplinary non-clinical staff and in certain cases, clinical specialists, that are equipped to assist people experiencing chronic diseases and conditions, adverse social determinants of health, health inequities, and navigation within the local systems of care. The minimum number of full-time and part-time staff in an ECM team range from six(6) to ten(10) people, and scales upward depending on the number of clients. The average duration for enrollment in ECM services is seven(7) to twelve(12) months, and can be perpetual for people with complex situations. Let's focus on ECM and how the teams are structured. At the top of the ECM staffing model is a Director who is responsible for the daily operations and oversight of the staff. Program Leads report to the Director and oversee the "care team pods", consisting of Care Managers and System Navigators. A manager is hired to coordinate the outreach and engagement, an essential function to generating revenues and growing the number of people served. As an option, a licensed physician can be assigned to support each of the ECM care team pods. The structure and size of your ECM organization is based on the number of people being served, and the populations of focus that you are targeting. A care management plan is shared by the entire team and updated as the status of the individual changes, and the care plan is shared with community partners. Health centers are typically well positioned to qualify as an ECM provider, as well as county agencies and CBOs.

For the reentry initiative, a Pre-Release Care Manager that resides in the correctional facility coordinates with Care Managers in the ECM teams. As the ECM model unfolds in every county, the titles are shifting but the core functions remain consistent. The managed care health plans are responsible to build and maintain the ECM networks, and to support correctional facilities with navigation services. The health plans are hiring liaisons to assist with identifying the right ECM provider to engage as the person is being released from incarceration. The top priority is to facilitate the continuity of care for the formerly incarcerated individual, which is achieved through warm handoffs to the right ECM provider and CBOs in their community. Facilitating these handoffs and maintaining care management plans requires the use of technology, and prompts organizations to invest in new software platforms for data sharing. The State of California has funded billions of dollars through CalAIM PATH, HHIP, IPP, and other incentives. These grants are time-bound and used to offset the costs of preparing an organization to become an ECM provider, or to address facility readiness. The capacity-building grants are not intended to hire staff, or to pay the ongoing costs. The final round of PATH dollars have been paid which starts the 180-days for the delivery of an implementation plan. The State of California issued guidance materials and implementation templates, and in the next edition of this newsletter a detailed timeline will be shared for you to consider in your planning processes.

Community Supports

Community Supports are services that address social determinants of health, encompassing health disparities. A total of fourteen (14) community supports have been constructed inside of CalAIM, and each health plan selects the community supports to offer. These services are leveraged by the ECM teams and available to Medi-Cal managed care enrollees who qualify.

The community supports include housing transition & navigation services, housing deposits, housing tenancy and sustaining services, short-term post-hospitalization housing, medical and non-medical respite care, day habilitation programs, nursing facility transition/diversion to assisted living facilities, community transition services/nursing facility transition to a home, personal care and homemaker services, home modifications (i.e., grab bars, ramps, floor transitions), medically-supportive food & medically tailored meals, sobering centers, and asthma remediation.

On a statewide basis only 3 counties offer the full set of 14 services, while most counties range between 8-12 community supports. Currently these services are defined as "optional services" in Medi-Cal managed care and are not mandated, which partially explains the county-by-county variation. Another factor that drives adoption for community supports is the availability of infrastructure in a particular county. For example, in rural counties, respite care or sobering centers may not be available, and often requires transferring clients into another county. In the future, the State of California may pursue authorization to transform the community support into a defined to create more continuity across the 58 counties.

Data Sharing

The State of California issued guidance in October 2023 on data sharing authorization for CalAIM. Assembly Bill (AB) 133, a California state law that permits disclosure of personal information for the purpose of care coordination. The law applies to "Medi-Cal partners" and includes physicians, caregivers, community-based workers, hospital and health center staff, correctional facility staff, case management staff at health plans, county and public agency staff, behavioral health specialists, and others engaged to support the formerly incarcerated person. Historically, one of the tallest barriers has been the Code of Federal Regulations, section 42 part 2, that protects the confidentiality of substance use disorder patients. "42 CFR Part 2" has hindered the sharing of substance use data, and has remained a constant barrier to delivering comprehensive coordinated care.

AB133 applies to "qualifying inmates of public institutions" as presented by the State of California and targets the pre-release services covered under the CalAIM program. Navigating through the state and federal laws is an essential step in the readiness cycles and should be initiated early in the process. Safeguarding the patient's data is a shared priority, and this involves using the latest technology, applying consistent handling practices, monitoring, and periodic audits.

In light of AB133, the requirement to apply consents and authorizations between community partners, in the pre-release and post-release cycles, remains an open question for review with your County Counsel.

Medi-Cal Authorizations, Claims & Billings

Starting October 1st, 2024, California's state prisons, county jails, and juvenile justice centers may begin to submit claims directly to Regular Medi-Cal for pre-release reentry services. The State of California has defined a two-year period for the facilities to complete the readiness requirements and to certify the facility's operations and the deadline is September 30th, 2026. While the actual go-live date is locally decided, the budgetary impacts of deferring into 2025 or later are significant as counties are funding in-reach and embedded services without a way to claim recoupments.

Pre-Release

The pre-release services are funded by Regular Medi-Cal up to 90 days before the actual release date from custody. Approximately 70% or more of incarcerations in the adult and juvenile detention centers are under a month and considered to be "short-term stays", however when a person exceeds 28 days in a facility their Medi-Cal eligibility is suspended by Social Services and must be reinstated as part of discharge planning. Individuals that are cited and released present an opportunity for referrals, based on initial screenings, into the local Medi-Cal ECM ecosystem. Verifying Medi-Cal eligibility during the initial booking process is a current standard through MCIEP, and the reentry initiative adds a second verification layer during discharge to validate Medi-Cal and ECM eligibility. Adults are transitioning from forensic state hospitals and state prisons leads to questions about the criteria for billing pre-release services, and creates a secondar level of complexity to address the question of "when does the 90-day clock start?". In the state prisons, administered by the California Department of Corrections and Rehabilitation, the likelihood of Medi-Cal eligibility lapsing is higher due to the length of sentence (one year or more).

The billable categories of pre-release services include reentry care management, physical and behavioral health consultations, laboratory services, radiology services, medications, medication-assisted therapy to treat substance use addictions, discharge planning, and system navigation services. While there are a limited number of service categories, the level of detail needed to capture activity and submit claims is extensive, and the coding parameters and reimbursement amounts have yet to be defined. Nonetheless decision must be made about billing, either in-house or subcontracted to a vendor, and procurement needs to be initiated. Selection and implementation of a billing application or vendor is on the critical path, and in the next edition of this newsletter our approach to vendor selection will be featured.

Billing for the pre-release services can be accomplished through a centralized billing function within the county or by contracting with a reputable billing service provider. Depending on the type of embedded and in-reach services in place today, agencies are faced with decisions about their reimbursement strategies, and questions have been raised the risks to CBOs as their revenue shifts from the county to state. In addition, community-based organizations delivering in-reach services in the jails and juvenile halls will need to submit claims to the Regular Medi-Cal, and manage the denials and resubmissions.

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Medi-Cal Authorizations, Claims & Billings (continued)

Post-Release

Post-Release services are deemed as Enhanced Care Management (ECM), and are delivered by organizations contracted with the managed care health plans (i.e., in-reach providers, CBOs, and ECM providers). The State of California pays the health plans for ECM services as part of their monthly base rates and the health plans, in turn, negotiate rates with contracted ECM providers to pay a specific amount for each person that is enrolled in the ECM. For example, if you negotiate an ECM rate of $400 per person, per month, you would need to manage fifty (50) clients per month to generate $20,000 of revenue. The actual number of people you hire is calculated by capacity ratios, volumes of clients served, and specializations that you intend to offer for children, youth, and/or adults. ECM providers generate revenue each month based on enrollment and not by the actual cost to deliver the services in a fiscal year. The actual costs to setup and operate an ECM team are not considered in the rate negotiation as it is based on the number of people you serve each month. Keep in mind, in the Medi-Cal program people are allowed to disenroll from programs at any time, so you have to maintain a consistent pattern of community outreach to sustain the revenues. Forming an ECM team requires an up-front investment in non-clinical program managers, outreach specialists, and navigators...and you have the option of adding a clinical staff into the ECM team structure. If you hire clinical staff for the ECM team, the clinical staff must register through the DHCS' Provider Application and Validation for Enrollment (PAVE) portal to complete the credentialing process, as the National Provider Identifier (NPI) number is required for Medi-Cal reimbursement. The State of California created a new role called the Community Health Workers (CHW), and this position is often referred to as a "promotor" or "system navigator". In the context of pre-release coordinated reentry services, the CHW has a state-defined rate of $26 per 30 minutes, and is billable to Regular Medi-Cal. Once a person is released from incarceration, they are shifted into the ECM post-release framework and as a result, the CHW services are not incrementally billable. Rather, the CHW services are incorporated into the ECM monthly capitation rate. Hiring people with lived experience in encouraged and is a valuable resource in the navigational aspects of the ECM team, however there are considerations when accessing with carceral settings as an in-reach worker (i.e., serious prior offenses). The current rate for CHWs does not meet the fully-loaded costs to hire and retain qualified staff. In our next edition, more information will be shared on the approach to cost modeling and identifying braided funding options to sustain your operations.

Serrano Advisors developed a pre- and post-release forecasting tool that assembles the initial and ongoing revenue, labor expenses, and operating costs into a pro-forma modeler, and is available upon request at no charge.

To receive a free modeling tool, send an email request to scott@serranoadvisors.com

CalAIM Reentry Timeline

The first phase for the reentry initiative begins on January 1st, 2024, and represents the beginning of ECM services for the justice involved populations. The second phase is the preparedness and readiness in the correctional facilities. The third phase is the beginning of pre- and post-release services on October 1st, 2024, and is the earliest date that a correctional facility would be reimbursed for these services. Each facility has two(2) years reach compliance, ending on September 30th, 2026. From a fiscal perspective, counties that implement pre-release services on schedule will be better positioned to claim revenues and offset their budgets sooner, versus deferring until 2025-2026 and no option for recoupment.

Phase One - Enhanced Care Management — January 1st, 2024

- The health plans deploy ECM provider networks for the justice involved population of focus, and offer ECM services to formerly incarcerated adults and youth dating back to January 1st, 2023.
- Sheriff's Office(Jail) and Probation Departments(JJCs) verify Medi-Cal eligibility, and share contact information with the health plans, on or before the day of release. POF eligibility is verified prior to release through embedded or in-reach providers(adults only, youth are automatically eligible).
- Community Supports are referred by the ECM providers, and authorized by the health plans.
- Initiate procurement for a Medi-Cal billing administrator, or develop an in-house solution.

Phase Two - Preparedness & Readiness — November 2023 - October 2024

- Interagency collaboration and cross-agency oversight committees convene routinely to prioritize resources and monitor performance, and to address the data sharing barriers.
- PATH implementation plans are submitted to the State of California by March 31st, 2024.
- For example, go-live on October 1st, 2024, Sheriff's Office and Probation completes Facility Readiness Assessment by April 1st, 2024, submitted six(6) months in advance of the go-live.
- Medi-Cal reinstatements transition from a manual process to automated process.
- Medi-Cal billing system is operational prior to go-live for testing & validation.
- Setup referral handling, data sharing, and regulatory reporting.

Phase Three - Coordinated Reentry — October 1st, 2024 - September 30th, 2026

- Managed care health plans and County Behavioral Health agencies are certified as ready by October 1st, 2024, regardless of the facility go-live dates in each county.
- Pre- and post-release services are deployed on a facility-by-facility basis over a 2-year period.
- Embedded and in-reach providers are linked together with ECM providers and community-based organizations for warm handoffs, and care management plans are shared between the caregivers.
- Discharge planning and ECM lead roles are staffed in the facilities and may be employed by the Sheriff's Office or Probation Department, or through the embedded service provider.
- Release data, care management plans, and Medi-Cal reinstatements are automated and shared between Sheriff's Office, Probation, Social Services, and the health plans.

About the Author

Scott Coffin is the President of Serrano Advisors LLC and is located in El Dorado County, 40 minutes east of Sacramento, California. Scott is a retired managed care executive with over 26 years of experience, and the last 15 years dedicated in the Medi-Cal managed care system.

Most recently Scott served as the Chief Executive Officer from 2015 to 2023 for the Alameda Alliance for Health, administering Medi-Cal to more than 350,000 children, youth, and adults in the East Bay. During his tenure at the Alliance he sponsored initiatives for coordinated reentry, street medicine, food as medicine, and whole person approaches for better care coordination. In semi-retirement, Scott serves as an advisor to the public health, corrections, behavioral health, social services, and other managed care organizations for street medicine, food as medicine, and justice involved reentry initiatives.

Actively participating the CalAIM reentry initiative warrants leveraging the current infrastructure that was built through federal and state legislation, and making it better by connecting more community partners into the reentry operations. This transformation revised traditional standard operating procedures, hiring and training of staff, enhancing and replacing core data systems, re-evaluating vendor partners, and "telling the story" about changed lives. To standardize the transformation, Serrano Advisors developed a reentry toolkit to accelerate the planning and implementation cycles, and is accessible through a facilitated engagement.

For more information, please visit our website: www.serranoadvisors.com

If you have questions or suggestions on topics for this newsletter, I would appreciate hearing directly from you.

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