Justice Involved (JI) Reentry Initiative Q&As

Refer to the questions and answers (Q&As) below regarding the JI Reentry Initiative. For additional information, refer to the *Policy and Operational Guide for Planning and Implementing the CalAIM Justice-Involved Initiative* (the *Guide*) found on the Resources page of the Department of Health Care Services (DHCS) website under the Guiding Documents, Communications and Resources heading.

Policy

1. **What components of the Health Risk Assessment (HRA) must be completed by a licensed professional?**

A licensed professional, such as a Registered Nurse (RN), care manager or Licensed Clinical Social Worker (LCSW), must participate in and oversee the completion of the HRA and the goals and objectives. Unlicensed members may support the completion of the HRA by, for example, obtaining records and consent for information sharing or completing health- related social needs and functional needs assessments. Licensed professionals must follow their scope of practice and not delegate items that require a license to perform. They must oversee all aspects of the HRA.

2. **How was the 10 percent administrative payment increase determined?**

The 10 percent administrative payment increase as developed based on the estimate of additional time it would take for providers to register and enter the correctional facility (CF). DHCS took into consideration the additional time it would take to go through security clearance and appointment cancellations due to lockdowns or other CF challenges.

3. **Is the HRA required annually post-release if the member is still enrolled in Enhanced Care Management (ECM), or is it only required in the pre-release phase of ECM?**

ECM must continue until the Managed Care Plan (MCP) is able to evaluate the need for services, no sooner than 12 months after release to ensure that the member has access to the services for which they qualify. Because all members who receive pre-release services have already been assessed and deemed eligible for services, and the eligibility criteria are the same for ECM, no additional assessment is needed to qualify for ECM until at least 12 months after release.

For additional information about HRA completion, see Section 13.3.d of the *Guide*.

4. **Urgent care, emergency services and procedures provided outside of CF, provided in a county's health care facilities, do not result in an inpatient admission, and are less than 24 hours are outpatient services. Additionally, the county hospital is considered an "in-reach" provider. Is it appropriate to use the hospital National Provider Identifier (NPI) when billing for these services?**

Since the County hospital is considered an "in-reach" provider as outlined in Policy Guide 9.5, it is appropriate to use the hospital NPI to bill for these services, as long as all other billing criteria are met. The use of the hospital NPI should be compliant with DHCS guidelines, assuming the hospital is properly enrolled and qualified under Medi-Cal for billing these types of services. This is also from the Policy and Operational Guide (POG).

5. **Are CFs responsible for the fee-for-service billing and reimbursement to the embedded county behavioral health service provider?**

Yes. If the provider is furnishing services in their role as a CF contracted entity and performing services that CFs are required to provide, those services would be considered embedded services and therefore be billed through the correctional health care facility NPI and exempt from licensure clinic.

Refer to the Embedded/In-Reach Provider Considerations (Section 9.5) and Billing Services by Embedded Providers (Section 10.1.a) of the *Guide* for more information.

6. **What is the difference between a behavioral health link service and a regular behavioral health service?**

Correctional facilities (CFs) and county behavioral health agencies are responsible for completing behavioral health links for anyone with an identified serious mental illness (SMI) or substance use disorder (SUD). Behavioral health links seek to ensure continuity of treatment for individuals who receive behavioral health services while they were incarcerated and who wish to continue to receive these services from Specialty Mental Health Services (SMHS), Drug Medi-Cal (DMC), and/or Drug Medi-Cal Organized Delivery Systems (DMC-ODS) in the community.

Clinical consultation services are intended to support the creation of a comprehensive, robust, and successful reentry plan, and include diagnosing, stabilizing, and treating the individual in preparation for release.

Refer to the Definitions of Covered Pre-Release Services (Section 8.1) and Behavioral Health Links (Section 11.4) in the *Guide* for more information.

7. **What is the difference between a care manager warm hand-off and a professional-to-professional clinical handoff?**

As part of behavioral health links, a professional-to-professional clinical handoff between the correctional behavioral health provider, county behavioral health agency provider, and the member is necessary. The handoff supports complex members with high needs, occurs between two professionals, and allows the pre-release provider to share information with the member's health plan.

The care manager warm handoff serves as an opportunity to introduce the new post-release Enhanced Care Management (ECM) provider, review the reentry care plan (including the health risk assessment, goals and objectives) and identify any additional needs.

Refer to the Requirements for Care Manager Warm Hand-Off (Section 8.4.f), Bundle 3: Care Manager Warm Hand-Off (Section 10.2.c) and Behavioral Health Links (Section 11.4.a) of the *Guide* for more information.

8. **Is there a reason that the Alcohol and Other Drug (AOD) counselors are not listed in the Medi-Cal Provider types that are eligible to provide pre-release services?**

AOD counselors are not excluded from providing services in the JI Reentry Initiative. However, they must be working under a licensed provider. AOD counselors are not a provider type that can enroll in PAVE.

9. **Do youth have a different protocol for Medication Assisted Treatment (MAT) introduction than members that are above the age of 18?**

There is no separate MAT induction protocol (for opioid use disorder) for youth. Youth who meet criteria for substance use disorders should be offered MAT, including agonist therapies, when clinically indicated. DHCS recommends reviewing the American Society of Addiction Medicine (ASAM) National Practice Guideline for the Treatment of Opioid Use Disorder, which features a section focused on the care of adolescents.

10. **Which counties are live?**

Yuba, Santa Clara and Inyo are live.

11. **If a county's health system applied for and received a separate set of NPIs for services provided in CFs, how can Tax ID and NPI usage be navigated?**

Per provider manual sections *CMS-1500 Completion*, *UB-04 Completion: Inpatient Services* and *UB-04 Completion: Outpatient Services*, the federal tax (ID) number is not required by Medi-Cal.

Eligibility

1. Who is eligible to receive JI pre-release services?

To be eligible for pre-release services, members must meet the following criteria:

- Be a part of a Medi-Cal or Children's Health Insurance Program (CHIP) eligibility group.

AND

- Be a youth in custody or
- Be an adult who meets one or more of the following health care needs criteria:
  - confirmed or suspected mental health diagnosis
  - confirmed or suspected substance use disorder diagnosis
  - chronic clinical condition or significant non-chronic clinical condition
  - traumatic brain injury
  - intellectual or developmental disability
  - positive test or diagnosis of HIV or AIDS, and/or
  - are pregnant or within a 12-month postpartum period.

All youth under 21 and former foster youth between 18 to 26 years of age do not need to demonstrate a health care need to qualify for pre-release services. Youth can be incarcerated at a youth or adult facility.

For additional information about eligible members, see Section 6.2 of the *Guide,* referenced at the top of this page.

2. How should CFs handle federal inmates awaiting sentencing? They are not included on the exclusion list.

Federal institutions are not included in the waiver.

3. Should patients be entered in the Portal if they do not qualify, or is the expectation only to enter patients in the Portal who have Medi-Cal and qualify for JI pre-release services based on medical screening criteria? What is the purpose of the CF completing the Deny workflow?

CFs must screen all Medi-Cal-eligible members who become incarcerated for access to pre-release services and report if they are eligible or ineligible. This allows them to receive the appropriate Approval or Denial Notice of Action. Please refer to Section 6.3 Screening Approach in the Policy and Operational Guide.

4. **Are federal marshal inmates not eligible for the Cal AIM JI program even though there is reimbursement by the feds for their medical care?**

This is correct, federal institutions are not included in the waiver.

5. **If someone does not qualify for services, why would they be entered into the Portal? For example, why enter them only to deny them? Should only eligible patients be entered into the Portal?**

CFs must screen all Medi-Cal-eligible members who become incarcerated for access to pre-release services and report if they are eligible or ineligible. This allows them to receive the appropriate Approval or Denial Notice of Action.

Providers can review Section 6.3 Screening Approach in the Policy and Operational Guide for Planning and Implementing the CalAIM Justice-Involved Initiative. In addition to program guidelines, the information will be used for Centers for Medicare and Medicaid Services (CMS) reporting purposes.

Enrollment

1. **Where can providers obtain information related to provider enrollment?**

For more information related to provider enrollment, refer to the following:

- Section 9 of the *Guide*, referenced at the top of this page.
- The Provider Enrollment page of the Medi-Cal Providers website.

2. **How do CFs enroll?**

Each state prison, county jail and California youth correction facility (CYCF) must enroll as a Medi-Cal provider under the Medi-Cal Exempt from Licensure Clinic enrollment type.

For more information about provider enrollment, refer to Section 9, Provider Enrollment and Payment, of the *Guide*, referenced at the top of this page.

3. **How do pharmacies enroll?**

For specific information related to Pharmacy enrollment, refer to the Pharmacy Provider Application Information page of the DHCS website.

4. **Do providers have to be enrolled in Medi-Cal to provide pre-release services?**

Yes, embedded and in-reach providers must have a valid National Provider Identifier (NPI) number and be enrolled in Medi-Cal as a fee-for-service provider.

5. **Is enrollment required for every embedded provider or simply for one embedded provider per CF site?**

Each CF site must complete an application to enroll as a Pharmacy provider and an application to enroll as an Exempt from Licensure Clinic.

6. **How do eligible members enroll in Medi-Cal?**

County jails, CYCFs, prisons and designated entities are responsible for identifying members potentially eligible for Medi-Cal, assisting them with the application and submitting the application to county Social Services Departments (SSDs).

7. **What is the list of inmate eligibility programs that would prevent the ability to enroll in 90-day, pre-releases?**

State Medical Parole, County Compassionate Release or County Medical Probation Program.

8. **Will the JI Portal hard stop enrollment for members with suspended Medi- Cal? It seems like having to manually unsuspend will cause significant delays in providing services.**

The Portal does not unsuspend. As long as the member meets the requirements of the program, they can be enrolled and receive 90-day, pre-release services, regardless of if their Medi-Cal is suspended due to incarceration. The suspension does not apply to the JI aid code.

9. Even if the facility is Medi-Cal certified, is it required for each provider providing services to enroll as a Medi-Cal Provider?

DHCS will allow both providers embedded in the CF (including CF staff and contractors) and in-reach community-based providers (including care managers/ECM providers and physical and behavioral health clinical consultants) to provide pre-release services, but all pre- release providers must enroll in Medi-Cal as an FFS provider. Refer to Section 9 Provider Enrollment and Payment in the Policy and Operational Guide for Planning and Implementing the Cal AIM Justice-Involved Reentry Initiative on the Resources web page of the DHCS website.

10. Is the CF required to enroll with the Provider Application and Validation for Enrollment (PAVE) Provider Portal? If so, is the organization required to be non-profit?

Yes, each CF is required to enroll with the PAVE Portal as a Medi-Cal provider under the Medi-Cal Exempt from Licensure Clinic enrollment type. Medi-Cal fee-for-service provider application information for exempt-from-licensure clinics can be found on the PAVE Portal page of the DHCS website.

For more information on how CFs can enroll in Medi-Cal, refer to the *Fee-For-Service Enrollment for Correctional Facility Pharmacies and Clinics Using the PAVE System* found on the Resources page of the DHCS website under the Guiding Documents, Communications and Resources heading.

A Community-Based Organization (CBO) provider must be a public or private non-profit organization with a 501(c)(3) status or a fiscally sponsored entity of a 501(c)(3) non-profit organization. For more information, refer to the Provider Enrollment Division (PED) page of the DHCS website

Provider Enrollment Division (PED) Enrollment

1. **If PED approval is not received, how can an organization get through the JI Portal access?**

Access to the JI Screening Portal is not granted prior to approval from the Provider Enrollment Division.

2. **Whenever "enrolled provider" is mentioned, does that mean an approved PAVE application?**

Correct. Every enrolled provider has been approved through PAVE.

3. **Is PAVE used for billing?**

PAVE is only to enroll as a Medi-Cal provider. Billing cannot be done through PAVE.

4. **What is the contact information to check the status of PAVE applications?**

For Justice Involved applications, PED cannot approve an application until all readiness criteria has been met. The providers should reach out PED for PAVE application statues. The Office of Strategic Partnerships (OSP) can assist with Readiness Assessment status.

5. **Can providers use the Department of Health & Human Services (HHS) or public health NPI?**

Access to the JI part of the Provider Portal requires provider type 45, exempt from licensure clinic. If the entities referenced are not provider type 45 or exempt from licensure clinic, they would not be able to access the JI Screening Application Portal.

6. **Can providers use an existing NPI and select exempt from licensure or is a new NPI that is specifically for exempt from licensure needed?**

The provider can use a Type 2 NPI of their choosing, such as physician group, hospital, or any other organization health care provider, for the exempt from licensure clinic applications. If they are also enrolling a pharmacy, each pharmacy needs their own NPI. If registering on National Plan and Provider Enumeration System (NPPES), ensure that the legal name matches the tax ID of the county. They can add a Doing Business As (DBA) to NPPES as well.

7. **If a county's health system applied for and received a separate set of NPIs for services provided in CFs, how can Tax ID and NPI usage be navigated?**

From an enrollment perspective, the provider determines how their NPIs are used. The distant site can bill for the telehealth service and list the originating site on their claims. There are some guidelines that the provider must follow based on JI; however, most of the instructions follow the normal Medi-Cal billing guidelines. The requirements for both JI and Medi-Cal for billing telehealth services are included in the *Medicine: Telehealth* section of the Part 2 provider manual and in article Justice-Involved Reentry Initiative: Claim Submission and Services Update.

8. **If an organization uses a Social Security Department to handle Medi-Cal applications, does the Social Security Department need their own PAVE account/Medi-Cal number?**

Whoever is going to get the payment for services is the provider number holder. That is the billing provider number that would be enrolled and paid, but if they're just a department within a facility, they should be able to use the NPI number.

9. **If a distant site is in one of the county's healthcare sites outside of the CF while the originating site is in the CF, having the same Tax ID, can the distant site use its own NPI?**

Yes. The distant site can bill for the telehealth service and list the originating site on their claims. There are some guidelines that the provider must follow based on JI; however, most of the instructions follow the normal Medi-Cal billing guidelines. The requirements for JI and Medi-Cal for billing telehealth services can be found in article Justice-Involved Reentry Initiative: Claim Submission and Services Update and the *Medicine: Telehealth* section of the provider manual.

National Provider Identifier (NPI)

1. **If a qualified pre-release service is provided by a provider outside of the CFs, which NPI should be used?**

For information regarding which NPI to use, refer to Section 9.5, Table 14 of the *Guide*, referenced at the top of this page.

2. **Can multiple facilities share a single NPI?**

Multiple facilities can share one NPI. Facilities will bill for the services rendered by their employees and certain contractors with the CF's NPI.

3. **When Eligibility Technicians enter information in the JI Portal for two different CFs using two separate NPIs, do they need to register within the Portal prior to being able to enter information so that the NPIs are reflected within their profiles?**

One administrator will register the organization, then give NPI permissions to additional JI processors or administrators to perform JI Transactions for the appropriate NPI. A processor or administrator can select the appropriate NPI to enter the member's JI 90-day, pre-release services.

4. **If there are two CFs with the same NPI, does only one need to enter the JI eligibility?**

Yes. If there are multiple facility locations with one NPI, there will be a dropdown list in the JI Screening Portal to select the correct location.

5. **If a member is entered into the Screening Portal while at Facility A and is transferred to Facility B, and each facility has its own NPI, is there a process to capture that change?**

Not at this time for the same county, but the team is looking into future enhancements to accommodate this scenario.

6. **Since the activation will be done manually in the JI Screening Portal, will multiple staff members be able to log in and use the same organization NPI at the same time?**

Yes. The Provider Portal organization administrator can add other organization administrators and processors, as needed.

7. **Can users access the Portal simultaneously?**

Yes. Multiple people can log in using the same NPI, as added by the organization administrator.

8. **Does a provider need to apply for an NPI number? Is there a contact or landing page for generating a new NPI number?**

An organization must obtain an NPI prior to enrolling via PAVE. The provider will register through the CMS National Plan and Provider Enumeration System (NPPES) for the NPI number. Afterwards, the provider can bill Medi-Cal and go to PAVE. Medi-Cal does not generate NPI numbers.

General Billing

1. **How are pre-release covered services billed?**

Pre-release covered services shall be delivered, claimed and reimbursed via Medi-Cal's fee-for-service delivery system. Claims may be submitted through normal processes utilizing Medi-Cal Rx for Pharmacy services and the California Medicaid Management Information System (CA-MMIS) for clinical services including care management, clinical consultations, Medication-Assisted Treatment (MAT), Community Health Worker (CHW) services, laboratory and radiology.

2. **Are there specific billing codes for the JI Reentry Initiative?**

Billing codes for **Behavioral Health, Warm Hand-Off**, and **Care Management Bundle** services will be published in late August 2024. Most other medical services allowed by JI can be found in the corresponding provider manuals.

3. **Is there a specific template, member email or clearing house Portal for billing for JI pre-release services?**

New providers are encouraged to review the New Provider Checklist that they receive upon successful enrollment which covers key tools and resources including eligibility, claim forms and claim submission, electronic billing and Remittance Advice Details (RADs), timeliness and checkwrite schedules, the Provider Portal, general resources and outreach/education/provider training. Additional webinars and trainings will be conducted prior to October 1, 2024.

4. **What is the minimum amount of pre-release services that need to be completed to bill for members serving short-term stays (stays less than 14 days)?**

Refer to Section 8.2, Short-Term Model Minimum Requirements, of the *Guide*, referenced at the top of this page.

All timelines associated within the first seven days of JI aid code activation will be considered recommended implementation practices and not requirements. Table 10 includes recommended implementation practices for services that occur within the first week of aid code activation to assist county CFs in developing processes that will ultimately become requirements.

5. **Is it possible for there to be duplicate billing between ECM and the pre- release care manager?**

ECM is only an eligible service after the member is released and enrolled into an MCP, so there should be no possibility of duplicating billing for pre- and post-release care services.

6. **When will the billing guide be released?**

Additional JI resources and guidance, including articles, training resources and updates to the Medi-Cal provider manual, are in development. More information will be shared on the Publications page of the Medi-Cal Providers website beginning in July.

7. **Are JI pre-release services claimed via Short Doyle?**

No, all JI pre-release services are billed fee-for-service via CA-MMIS. The exception to this is when the behavioral health agency receives the behavioral health link, and those claims can be submitted through normal processes via Short Doyle.

8. **Are CFs required to obtain authorizations for any services (bundled or non-bundled) prior to rendering treatment?**

Most codes, including the bundles, do not require prior authorization. If a code currently requires a *Treatment Authorization Request* (TAR) in fee-for-service Medi-Cal, then it is likely to require a TAR for JI providers. Additional billing resources and guidance will be available to stakeholders prior to go live.

9. **How is the JI aid code applied (I2-I6)? Is it automatically applied in the Portal based on the qualifying condition, or is the CF supposed to select one?**

Medi-Cal Eligibility Database System (MEDS) determines the JI aid code based on the Medi-Cal eligibility assigned to the member.

10. **How are the JI Aid Codes used?**

The aid codes are used to track the member's eligibility for claiming purposes. They also assist with determining the appropriate state and federal fund participation associated with the Medi-Cal services provided.

11. **If a member is active in county A but incarcerated in county B, can county B bill for JI services even though their Medi-Cal eligibility is active in another county?**

The county where the member is incarcerated can bill for pre-release services because that is where they are receiving services. It does not matter what county their Medi-Cal eligibility is active in.

12. **Is there clear guidance on how to bill for JI services if an inmate has Medicare? If a member has Medicare or other health insurance primary is there an override for JI codes?**

JI services can be billed regardless of whether someone has Medicare. The JI aid codes are programed to override the standard Medi-Cal rules for billing Other Health Coverage (OHC), including Medicare. Under normal Medi-Cal, Medicare and OHC must usually be billed first. JI services are not required to follow this rule. JI aid codes are programmed to bypass Medicare and OHC. If the member has Medicare and/or OHC, JI aid codes can be billed first.

13. **Are ambulance transports a covered JI service and will there be guidance from Medi-Cal regarding this?**

Transportation is not a covered service for the 90-day, pre-release services at this time according to the Policy and Operational Guide for Planning and Implementing the CalAIM Justice-Involved Initiative.

14. Which JI pre-release services require an eTAR? Can these services be called out in a JI Operational Guide update?

If a TAR is required, it will be listed in the provider manual. See section *TAR Overview* of the Part 1 provider manual. Behavioral Health Codes, Care Management Bundles 1-5 and Warm Hand off for JI do not require a TAR at this time. There are too many services to call out in the Policy Operational Guide, and services may change at any time. Reference the *Justice-Involved Pre-Release Services* section of the Part 2 provider manual for more information.

Note: certain DME codes will require a TAR. See *Durable Medical Equipment: An Overview* of the Part 2 provider manual for more information.

15. Can radiology and lab charges use traditional revenue codes?

No. Reference the *Justice-Involved Pre-Release Services* section of the Part 2 provider manual.

16. Can multiple services be billed on one UB 04? For example, a clinic visit occurs on the same day a physician administered drug is given. Can the services be billed on one claim form and from the same facility?

Yes. Multiple services can be included on a single claim form. It is generally recommended to submit claims one month at a time. Additionally, ensure that both services were provided by or under the same NPI.

17. Can a provider bill radiology and a physician administered drug on one claim? Who should be billed for medication if a pre-release prescription is given to a member?

The recommendation is to bill two separate claims, one for the radiology services and one for the prescription which is dispensed by the pharmacy. Review the *Justice-Involved (JI) Pre-Release Services* section of the Part 2 provider manual for information about billing Medi-Cal Rx consistent with existing Medi-Cal billing practices.

18. Can two different months of services be billed on the same claim forms?

The recommendation is to bill two separate claims, one for each month of service.

19. Are non-licensed associates allowed to bill for JI services?

Non-licensed associates can provide JI pre-release services if these services are overseen by a licensed supervisor or an enrolled Medi-Cal provider. Review the *Justice-Involved (JI) Pre-Release Services* section of the Part 2 provider manual for more information

Bundle Billing

1. **What are the allowable billing frequencies?**

The billing frequencies and parameters for the care management bundles are per episode of incarceration (each 90-day set of pre-release services).

2. **Are there documentation requirements for the care management bundles, and is there a documentation guide for these billing codes?**

Yes, there are documentation requirements for each care management bundle. See section 10.2 of the *Guide*, referenced at the top of this page.

3. **Which bundle would a provider use if they are billing for pre-release behavioral health assessments to determine treatment assignments as part of release?**

Providers billing for pre-release behavioral health assessments to determine treatment assignments as part of release would use Bundle 1: Health Risk Assessment/Whole-Person Needs Assessment. Refer to slide 12 of the CalAIM Justice-Involved Initiative: Care Management Bundles webinar.

4. **Is there a limitation to the number of times providers can bill for Bundle 2?**

Bundle 2 may be billed up to eight times per week with a maximum of 13 times (per member, per episode of incarceration) across all providers.

5. What services are billable for Bundle 2?

The following services are billable for Bundle 2 with documentation indicating that at least one of the following occurred (for each billing instance):

- Conducted face-to-face or telehealth encounter with the member to provide education, update the HRA or update the Reentry Care Plan.
- Scheduled meeting with a clinical consultant or other community-based provider, with appropriate data sharing.
- Held face-to-face or telehealth meeting with a clinical consultant or other community-based provider, with documentation of discussion.
- Facilitated warm handoff to community-based provider (via face-to-face encounter or telehealth) with any needed data sharing.
- Completion and submission of forms or documentation necessary for reentry planning (for example, prior authorizations, TARs, applications for residential mental health services and/or applications for social services such as housing or CalFresh).
- Arranged for Durable Medical Equipment (DME) and medications (or their prescriptions) to be provided in hand upon release, with relevant education.
- Partial completion of Bundle 1 (HRA).
- Partial completion of Bundle 4 (Reentry Care Plan).
- For special billing notes and further detailed information on billable services for Bundle 2, refer to Section 10.2.b, Bundle 2: Care Coordination, of the *Guide*, referenced at the top of this page.

6. Can both the embedded pre-release care manager and the post-release ECM provider bill Bundle 3 for the same member?

Bundle 3 may be billed by both the pre- and post-release care managers if they are different providers.

7. Is it a single billing code per bundles

Yes, each bundle should use a single code.

- G9001, Health Risk Assessment
- G9002, Care Coordination
- G9012, Care Manager Warm Handoff
- T2024, Reentry Care Plan
- G9002 Post Transition Support.

For more information regarding the Care Management Model, refer to sections 8.4 and 10.2 of the *Guide*, referenced at the top of this page.

8. **Are the bundle codes the only codes that are billable for members?**

The care management bundle codes are not the only codes to be utilized for JI pre-release services. Existing Medi-Cal codes and unique codes for JI behavioral health and warm handoff services will also be utilized. Medi-Cal uses the healthcare industry standard Current Procedural Terminology (CPT®) to code for services allowed by the Medi-Cal program. JI-specific billing codes for behavioral health, warm handoff and care management bundle services will be published late August 2024.

9. **Is it typical for medications, clinical services and medication administration to be consolidated into a package claim?**

There are 22 lines on the *UB-04* claim form which can be used to bill multiple codes. Refer to the *UB-04 Completion: Outpatient Services* section of the provider manual.

10. **Where are the Base Bundle Rates published?**

The rates will be published in October 2024, on the Medi-Cal Rates page of the Medi-Cal Providers website.

11. **What does DHCS mean when it states that Bundle 5 may be billed twice if the warm handoff meeting also includes participation from the member?**

A warm handoff meeting between the pre- and post-release care managers represents one activity for this bundle; meeting with the member represents a separate activity. As a result, if both occur simultaneously, this bundle can be billed for each of these separate activities in alignment with permitted billing frequencies.

12. **How should billing be coordinated for Care Management Bundle 2 between pre-release and post-release providers?**

Bundle 2 is primarily billed by the pre-release care manager. Post-release ECM providers may bill this bundle only in cases where the pre-release care manager is an embedded provider and needs assistance with connections to community services of which the post- release ECM provider may have significantly more knowledge. In this scenario, both the post-release ECM provider and the pre-release care manager may bill this bundle if they each separately meet minimum documentation requirements.

Embedded pre-release care managers and in-reach post-release ECM providers may both bill in the same week if they are not billing for duplicative services (for example, both a clinical consultation was scheduled and data shared as appropriate by the embedded pre- release care manager, and a housing application was completed and submitted by the post- release ECM care provider).

Providers should coordinate as necessary.

13. How does the DHCS decide who is involved in rate development?

DHCS employs a systematic approach to rate development that includes various key elements and assumptions:

- Stakeholders: While stakeholder feedback is not solicited during the initial rate development, it is incorporated through clinical consultants when developing time assumptions for service bundles.
- Time Assumptions: Time required for licensed and unlicensed providers to deliver each service bundle is estimated by clinical consultants with stakeholder feedback. This ensures practical and realistic time estimates.
- Hourly Cost Assumptions: Practitioner hourly costs are based on California's annual mean wages as reported by the U.S. Bureau of Labor Statistics Occupational Employment and Wage Statistics. For unlicensed providers, the rate is based entirely on the Community Health Worker (CHW) occupation.
- Cost Adjustments: Salary costs are adjusted to include inflation, benefits and an overhead component to ensure a comprehensive ("fully loaded") practitioner hourly cost.
- Rate Calculation: The rate for each service bundle is calculated by multiplying the practitioner hourly cost by the time required for each practitioner type.
- In-Reach and In-Person Visits: Services provided through in-reach, in-person visits receive an additional 10 percent rate increase. This increase accounts for the added complexities and time required for non-facility providers to deliver services in CFs.

By following this structured approach, DHCS aims to develop fair and accurate rates that reflect the true costs of providing services while considering the unique challenges of different service delivery settings.

14. Will DHCS provide examples for proof of compliance or performance indicators to ensure CFs are meeting the requirements for bundles?

CFs and county SSDs are required to submit data on DHCS-specified measures to monitor program performance and integrity. DHCS will establish a comprehensive monitoring approach for this reentry initiative in alignment with Centers for Medicaid & Medicare (CMS) approved monitoring protocol and state monitoring priorities. Additional information on CMS required monitoring metrics will be provided once available.

For more information about monitoring and evaluation, refer to Section 12 of the *Guide*, referenced at the top of this page.

Durable Medical Equipment (DME) Billing

1. **Some CFs are not enrolled as DME providers but have a vendor that provides DMEs to members and handles their billing to DHCS. In the event that a CF provides a DME item to members, but the vendor is not able to bill and thus invoices the CF for the expense, will the CF be able to receive reimbursement for the expense of the DME item from DHCS? If so, how?**

To determine next steps, more information would be needed about why the CF would not be able to bill DHCS. It could be a correctable error on the claim. Either the CF or the DME vendor would need to be enrolled with the authority to bill for DME.

2. **How can DHCS be billed for DME "only on the day of release?" Is the expectation a prescription for DME that will be received post-release? If yes, would that be a post-release ECM service or can the CF bill Medi-Cal fee for service on day of release even though the individual will not receive the equipment until released?**

CFs may bill Medi-Cal fee-for-service for DME provided to the member only upon the day of release if the DME is covered under Medi-Cal policy, considered medically necessary and prescribed by a physician, nurse practitioner, clinical nurse specialist or physician assistant after a face-to-face evaluation. The evaluation and prescription should occur prior to release in order to determine the member's need and provide the DME upon day of release. For post-release, a prescription will be needed.

3. **DHCS clarified that only Pharmacy DME are billable via Medi-Cal Rx for both pre-release and upon release. Are DME items provided to members upon admission at discharge of custody billable?**

Non-Pharmacy DME items, such as those provided to patients upon admission or at discharge, are not billable under the Medi-Cal Rx Program typically. To confirm, verify the following:

- The DME items meet the criteria for fee for service billing.
- The facility is appropriately set up as a DME provider or working with an enrolled provider for billing purposes.

This is from the DHCS Policy and Operations guide for the JI Initiative.

4. **Does a license exempt CF require additional set up to bill DME?**

A license-exempt CF does not require any special set up to bill DME but it must follow Medi-Cal billing instructions for DME. Most of the DME products require a TAR submission and/or thresholds amounts depending on the DME.

Federally Qualified Health Center (FQHC)

1. **For pre-release services that occur in a county-operated FQHC and are provided to CF members, can the FQHC use the CF's NPI to submit claims through the fee-for-service system since the FQHC NPI is set up to bill only under the FQHC PPS? If not, is there an alternative method for FQHC to bill through the fee-for-service system?**

The FQHC should not use the CF's NPI. According to the Policy and Operational Guide for Planning and Implementing the CalAIM Justice-Involved Initiative, FQHCs and Rural Health Clinics may bill and submit claims within the fee-for-service system, which is supplemental to the prospective payment system (PPS) and not subject to reconciliation, for any in-reach, pre-release services. Costs associated with JI pre-release services and billed through the fee-for-service system will be excluded from any future calculations of the PPS rate.

Medi-Cal Eligibility Database System (MEDS)

1. **Do JI aid codes go to MEDS?**

JI aid codes are activated via the JI Screening Portal and are reflected in MEDS.

2. **Is it possible for JI aid codes to be frozen in MEDS due to Burman Holds? If so, how should Social Services Departments fix that? For example, there are many runaway aid codes that are terminated in California Statewide Automated Welfare System (CalSAWS) but open in MEDS because of a Burman Hold.**

The JI aid codes will not be managed by the Social Service Departments in CalSAWS. DHCS and the CFs will manage these aid codes. The JI aid codes will operate like our Presumptive Eligibility (PE) aid codes and will always have a set termination date to prevent any "run-away" aid codes. DHCS will be monitoring these aid codes and taking appropriate action, as needed.

3. **How will MEDS report the JI aid code to CalSAWS?**

The JI aid codes will not be available in CalSAWS, as the program is not managed by County Social Service Departments. JI eligibility is managed by CFs with DHCS and will only be available in MEDS similar to other DHCS programs.

Provider Portal

1. **What is the process to access the Provider Portal through PAVE enrollment?**

Once the PAVE application is approved, a letter and PIN will be sent, indicating enrollment in Medi-Cal. Afterwards, the Provider Portal profile may be created on/after 10/1. The JI screen application or Provider Portal cannot be accessed until then. See Provider Portal User Guide: Provider Organization for more information.

2. **What should a provider do if they are receiving an error message when trying to create a Provider Portal profile?**

If an enrolled provider is missing their token letter in the mail, they can call the Telephone Service Center to electronically register. For information about registering in the Provider Portal, refer to the Provider Portal User Guide: Provider Organization.

3. **Is a PAVE account needed to generate a Provider Portal account?**

Yes. Organizations must have enrolled through PAVE in order to generate a Provider Portal account and subsequently a JI Screening Portal account.

4. **Can the NPI be given to the Social Services Department (SSD) so they can create a Provider Portal account to activate the JI aid code?**

Yes. The administrator will give them authority and access by creating their User ID to the Portal, so they don't have to have their own.

JI Screening Portal

1. **CFs have been advised that the effective date of the 90-day pre-release services is the date the JI Aid Code is activated in the Portal - can this date be "back dated"?**

Currently, the effective date in the JI Screening Portal can only be back dated to the first of the current month.

2. **Why are CFs entering the effective date? Doesn't the Portal dictate effective date?**

The CF enters the effective begin date and the system calculates the termination date 90 days from the Effective Begin Date, or the release date (if entered).

3. **Is BH Agency expected to utilize the Portal, even if they are not an embedded/contracted provider at CF?**

The JI Screening Portal will be used by CFs or their delegated entities to establish eligibility for the 90-day services program. That will be a decision between the CF and the behavioral health agency.

4. **How can the organizational administrators for the JI Portal be found? How are administrators assigned?**

Administrators are assigned by the CF. The first person from the CF to register the organization in the Portal will be the administrator. See the Medi-Cal Provider Portal User Guide: Provider Organization.

5. **Can any designated staff serve as an administrator?**

Yes. The first user that enters the NPI and register the facility will automatically be an administrator. After the facility is registered, other administrators or processors can be assigned. The administrator(s) will be responsible for adding other users within the system for the organization.

6. **Are there plans in the works or on the road map for any kind of data exchange in bulk submission, i.e. bulk eligibility file uploads instead of member lookup via the Portal?**

Yes. Work is being done through the Office of Strategic Partnerships (OSP) to create this functionality tailored to the needs of member counties and CFs, but nothing is concrete yet.

7. **Is DHCS expecting that county Medi-Cal eligibility staff manage all the status changes in Portal, or are the CFs responsible for that?**

The aid codes are not managed by the County Social Service Departments. The CF and its designees will manage the member's eligibility in the JI Screening Portal.

8. **If a member is transferred from one jail to another jail within the same county during the 90-day, pre-release period, is the location able to be updated in the JI Portal?**

As intercounty transfers are not considered new incarcerations, the JI Screening Portal does not currently have the functionality to change the location; the teams will take this back for further review.

9. **Does the JI Portal have the ability to manage about 3,000 daily sensors? Are there any reporting capabilities that will allow the ability to download a batch data file, making it easier for staff to manage the volume?**

Currently, that is not available. It is understandable that there will be additional use cases and functionality defined for the application, but again, that is currently not available.

10. **Will the JI Portal integrate with the Jail Management System (JMS) for the update dates? Is there a way to migrate new release dates from the Jail Management System into the JI Portal?**

Currently, there is no mechanism for the JI Screening Portal to interface with county's systems. It is something DHCS is exploring for the future.

11. **If the patient's information is entered into the JI Portal after they are discharged, will the JI Portal provide retroactive information?**

Retroactive enrollment can only be added back to the first of the current month. For example, if today is 11/15/24, the earliest effective date that could be used would be 11/1/24.

12. **Is the JI Portal different from the PAVE Portal?**

The JI Portal is different from PAVE. The JI Portal is an application that will manage JI member's eligibility. The PAVE application is used by providers to submit provider enrollment applications. JI applications can be found in the Provider Portal. Refer to the Justice-Involved (JI) Reentry Initiative Screening Portal User Guide for more information.

13. **Which transactions take one business day and two business days?**

The possible transactions are Activate, Deny, Pause, Reset, Restart and Terminate. Transactions completed before 5 p.m. on business days are available the next business day. Transactions completed after 5 p.m. on business days or transactions completed on non-business days are available in two business days. For example, if a transaction is made after 5 p.m. on Friday it will be reflected on the following Tuesday assuming Monday is a business day. This transaction is available in two business days.

14. **When a member is reported in JI Screening, will the JI aid code trigger in MEDS?**

Once the member has been activated in the JI Screening Portal, a transaction will be initiated to start the JI aid code in MEDS.

15. **When resetting a member's JI 90-day, pre-release services in the JI Screening Portal, what should be entered for the incarceration date?**

The member's most recent incarceration date should be entered.

16. **If a member times out before sentencing, does the JI Screening Portal automatically terminate the 90-day pre-release services or do providers need to keep track of that termination date and go into the Portal to terminate the member when they time out?**

The JI Screening Portal is a fully manual process, so any changes to dates or terminations of the JI period need to be entered by the CF. In the instance that a member is in the facility and set up but then it is determined that they are at risk of being timed out, the CF will pause the 90-days of service temporarily then reset the member for a new set of 90-day, pre-release services.

If the member times out before sentencing, there is no reason to go into the Portal to terminate the member. The member's JI aid code eligibility will automatically expire upon the entered termination/end date. However, if the member is at risk of being timed out, the CF can pause 90-days of service temporarily because the release date is either unknown or is beyond the initial 90-days. Once a new release date is known, the CF can reset the member for a new set of 90-day pre-release services.

17. **When a member of a county jail is timed out of pre-release services and their court date is a year away, would the recommendation be to pause that member, indicating that their release date is unexpectedly extended, or terminate that member's pre-release services, knowing they will time out and re-enter their information into the JI Screening Portal once they are sentenced with the updated release date?**

The general approach is to wait to have their services activated closer to their release with the goal of 90-days prior to release. In the event the member is timed out, the CF user should pause the member.

18. **If a member's Medi-Cal is suspended due to incarceration, does the suspension need to be lifted before entering the member into the JI screening Portal?**

No. The suspension of the member's Medi-Cal does not need to be lifted to enroll a member in 90-day, pre-release services. Suspension has no effect on the 90-day, pre-release services aid codes.

Pause, Restart, Reset and Terminate

1. **What are the definitions for Pause, Reset, Restart and Terminate?**

Pause JI 90-day, pre-release services for a member

- A temporary stoppage of 90 days of services because of a qualifying event within the same period of incarceration
- Examples:
  - Member is found to be incompetent to stand trial, transferred to a state hospital, and then returns to the jail. JI benefits would be paused when transferred to a state hospitable and then reset (or restarted) when returned to jail.
  - Member is held in a county jail for more than 90 days with an unknown release date. JI benefits would be paused until a release date is known/expected.
  - Member's release date is unexpectedly extended or delayed. JI benefits would be paused until a release date is known/expected.
- Must pause a member first in order to reset benefits Reset JI 90-day, pre-release services for a member
- A new set of 90-day, pre-release services after a pause within the same period of incarceration
- Adults have one reset available
- One reset must be used for adults before a restart can be used
- Youth have unlimited resets available

Restart JI 90-day, pre-release services for a member

- A restart of the remaining days within the same period of incarceration
- One reset must be used for adults before a restart can be used
- Must pause or terminate a member in order to restart benefits Terminate JI 90-day, pre-release services for a member
- Sets the end date of 90-day, pre-release services

2. **If a member is sent out of the CF for outpatient care (for surgery, as an example), does the JI aid code need to be paused via the JI Screening Portal?**

A standard hospital stay does not qualify for a pause. Unless the incarcerated member's release date is impacted in this scenario, this would not be considered a qualifying event for a pause. Providers can review Section 8.1 Definitions of Covered Pre-Release Services in the Policy and Operational Guide for Planning and Implementing the CalAIM Justice-Involved Reentry Initiative.

Additional resources that may be helpful to review include information for the Medi-Cal Inmate Eligibility Program and All County Welfare Directors Letter (ACWDL) 24-04.

3. **How long would a member need to be out of the jail for treatment to be considered for a pause?**

There are specific qualifying events where a pause is permitted. Those two qualifying events are if an member is found to be incompetent to stand trial and they are transferred to a State hospital; and if the member's release date is unexpectedly extended or delayed.

If an member is in the process of being transferred to a state hospital, pause at that point. When they return to the facility, either reset or restart.

4. **Can services be reset after someone is released? For example, if someone is arrested on 7/1/2024, the release date is unknown, the field is left blank and the JI code is terminated on 10/1/2024. If the inmate is unexpectedly released on 12/1/2024 and the provider does not find out until after the date, can the inmate be entered in the Portal on 12/2/2024 with the activation date as 10/1/2024?**

Not currently. The recommendation would be for the CFs to monitor those who have been activated without known release dates, as outlined in the short-term model. In these instances, the CF would ideally pause the benefits prior to the termination and then reset/restart benefits closer to the release date.

5. **How long would a member need to be out of the jail for treatment to be considered for a pause?**

A pause only occurs for specific, qualifying events: 1) Member is found to be incompetent to stand trial and transferred to a state hospital and then returns to the jail or 2) Member's release date is unexpectedly extended or delayed. A pause should occur at the time these events occur, otherwise, a pause is not applicable.

6. **When a youth experiences a "circumstance change," will they need a different aid code or a "reset" to get a new 90-day period?**

If a qualifying event occurs and the member's benefits are paused, resetting the member's eligibility in the JI Screening Portal will provide them with a new set of 90-days of pre-release services. It is the responsibility of the CF to manage the member's eligibility in the JI Screening Portal.

7. **If youth can have unlimited resets, does the member's information need to be entered every 90-day to reset?**

It is the responsibility of the CF to manage the member's eligibility in the JI Screening Portal. A reset occurs after a member's benefits have been paused.

8. **What is the restart and no-limit note for youths?**

Policy says that for youth there can be any number of resets. A reset is a new 90-day period of pre-release services, so there's no reason for them to ever have a restart. They'll always have a reset.

Resource Navigation

1. **Is there a timeline on when JI presentations will be available on the DHCS website?**

Slides, webinar recordings and transcripts relating to the JI Reentry Initiative can be found on the JI Initiative page of the DHCS website.

2. **Where can the PDF be accessed if the Q&A and PowerPoint is not available?**

PDF copies of all PowerPoint presentations are available in the Medi-Cal Learning Portal, under the course description. See Catalog: Justice-Involved Reentry Initiative

3. **What is the contact for the Office of Strategic Partnerships (OSP)? Is there a contact for additional JI Portal questions?**

For policy questions, providers can contact CalAIMJusticeAdvisoryGroup@dhcs.ca.gov. For general and JI Medi-Cal billing questions, providers can contact Outreach@gainwelltechnologies.com.

4. **Are there transcripts of training sessions?**

Although a transcription is not available, a recorded webinar will be published to the Medi-Cal Learning Portal within a week of the session.

5. **Will the JI Screening Portal User Guide be ready prior to October and will notice be given when it is available?**

The JI Screening Portal User Guide is available on the Medi-Cal Providers website under Justice-Involved (JI) Reentry Initiative.

6. **Is the prerequisite course, "Navigating the Medi-Cal Provider Portal Recorded Webinar" required to be completed before the Medi-Cal Learning Portal allows enrollment in The JI Screening Portal webinar?**

Yes. Navigating the Medi-Cal Provider Portal Recorded Webinar was added as a true pre-requisite for the JI Screening Portal.

7. **Where can recorded videos be viewed?**

The recorded webinar will be found in the Medi-Cal Learning Portal from the Medi-Cal homepage within seven to ten days of the event.

8. **How can providers access the resources that were shared in the chats of the recorded webinars?**

Resources were emailed directly to the participants following the session. Email the Outreach and Education organization at medi-caloutreach@gainwelltechnologies.com if the resources were not received.

9. **Are there any identified vendors for JI billing?**

Electronic submitters do not vary by program or initiative. Therefore, there are no JI specific vendors. The CMC Developers, Vendors and Billing Services Directory can be used as an aid in finding vendors, however, the listing may not be current and stakeholders will need to do their own research to validate accuracy.

10. Is the guidance for revenue codes documented in the provider manual?

Yes. Guidance for revenue codes is documented in the provider manual, as referenced in the article, Justice-Involved Reentry Initiative: Claim Submission and Services Update.

11. Should the JI webinars be shared with the Health Services Administration (HSA) for the jail medical vendor?

Yes. It is recommended to share as appropriate, especially with anyone responsible for checking the member's eligibility, as they could benefit from this information.

Other Questions

1. **What services can be provided to eligible members?**

Pre-release Medi-Cal services may be provided within the embedded (CF facility) or Medi-Cal in-reach (non-CF, CF subcontractor or CF employee) provider's scope of services during the 90-day, pre-release period and may include, but is not limited to, 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-Assisted Therapy for all Food and Drug Administration (FDA)-approved medications, including coverage for counseling.

For additional information, refer to Section 8.1 of the *Guide*, referenced at the top of this page.

2. **What additional services are to be provided upon release?**

For a list of current services allowable upon release, refer to the *Guide*, referenced at the top of this page.

3. **How does the JI Reentry Initiative increase access to Medication Assisted Treatment or Medications for Addiction Treatment (MAT)?**

To increase access to MAT in incarcerated settings and improve the standard of care in delivering these services to JI populations, the provision of MAT is a required pre-release service. DHCS will work with CFs to build off their current progress in providing MAT and provide technical assistance to California Department of Corrections & Rehabilitation (CDCR), jails and CYCFs, to ensure all facilities are able to provide MAT.

4. **Does the DHCS recommend that CFs use a specific model, embedded and/or in-reach?**

Due to diverse sizes, geographic characteristics and the current state towards implementation, a one-size-fits-all model is unlikely to be effective. County teams should choose a model that suits their specific arrangements. As implementation moves forward, best practices may emerge.

5. **How are the HRA pre-release goals and objectives different from the Reentry Care Plan?**

The HRA is an assessment of needs and plans for what needs to occur prior to release (including starting coordination and set up of services for release). The Reentry Care Plan is the plan of care for the reentry period, to be delivered in the community.

6. **Can unlicensed members conduct a warm handoff if they are under the supervision of licensed professionals?**

The warm handoff services identified in Bundle 3 may be provided by both licensed and unlicensed professionals.

7. **Is there a standard template available for Reentry Care Plan?**

DHCS is not providing a template for the Reentry Care Plan. Providers should refer to the requirements located in Section 10.2.d of the *Guide*, referenced at the top of this page.

8. **Are Medi-Cal providers required to provide JI ECM providers with a list of members who have been authorized to receive ECM services?**

No, Medi-Cal providers are not required to issue a list of members to their JI ECM providers. However, JI ECM providers are encouraged to identify members who would benefit from ECM and send a request to the Managed Care Plan (MCP) to determine if the member is eligible for ECM, consistent with the MCP's process for such requests. The MCP shall communicate new member assignments to the JI ECM provider as soon as possible, no later than ten business days after ECM authorization.

For more information about monitoring and evaluation, refer to Section 12 of the *Guide*, referenced at the top of this page.

9. **Is the pre-release care manager expected to share the HRA with the post-release ECM care manager?**

Yes, as part of the warm handoff requirements, the pre-release care manager is responsible for sharing the HRA with the ECM Lead Care Manager.

10. **Do MCPs still need to complete an HRA as part of their standard protocol or does the pre-release HRA meet that requirement?**

ECM must continue until the MCP is able to evaluate the need for services no sooner than twelve months after release to ensure that the member has access to the services for which they qualify. Because all members who receive pre-release services have already been assessed and deemed eligible for services, and the eligibility criteria is the same for ECM, no additional assessment is needed to qualify for ECM until at least twelve months after release.

For more information about HRA completion, refer to Section 13.3.d of the *Guide*, referenced at the top of this page.

11. **What are the implications of the Consolidated Appropriation Act for the JI Reentry Initiative?**

DHCS is currently awaiting CMS guidance on the Federal Consolidated Appropriation Act requirements and will share additional information with stakeholders as soon as possible.

12. How do MCP and Primary Care Physician (PCP) assignments work in 2-plan counties for members who are new to Medi-Cal during incarceration?

For details on the MCP assignment process for members who were Medi-Cal members before incarceration and for those who are new to Medi-Cal, refer to Section 13.3.a of the *Guide*, referenced at the top of this page.

13. Will providers be able to proceed with services if a patient has Medi-Cal that is currently suspended because they are incarcerated?

As long as a member has Medi-Cal eligibility they can be determined eligible for 90-day pre-release services, regardless of if their benefits are suspended. Upon release, the CF will report the release to the county social service department to activate their primary Medi-Cal benefits.

14. Who updates all the Medi-Cal statuses? Where does the policy guidance exist on DHCS's expectations for the people completing these updates, such as letters that are going to counties or guides detailing the specific expectations for the CFs?

Under the Pre-Release Medi-Cal Application Processes, counties are mandated to establish processes in county jails/youth facilities to ensure incarcerated members are screened for Medi-Cal and assist with the application enrollment of those not currently enrolled. They must also establish processes for reporting incarcerations and releases. This is often referred to as their "primary Medi-Cal" in the context of the 90-day services. When someone is incarcerated, counties shall be using the CF as the mailing address to ensure that they are able to receive appropriate Medi-Cal correspondence. The policy for this can be found in All County Welfare Directors Letter 24-04.

CFs or their delegated entity will be responsible for maintaining the JI aid code. The policy for this is in the Policy and Operations Guide.

15. What is considered a "circumstance change" for youth? Is it due to a transfer to a Youth Correctional Facility (YCF)?

The following is an example scenario where an expected release date has changed for a youth member: there may be very limited circumstances when a youth is incarcerated in a county YCF and is provided pre-release services prior to a court date/expected release date, but the judge does not approve the discharge recommendation, and the youth is held in the YCF for another six months until the next discharge hearing. In this scenario, DHCS will not set a limit on the number of times a YCF can reset the 90-day pre-release service benefit 90 days prior to the next discharge hearing.