CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

DATE:

Behavioral Health Information Notice No: 25-XXX

TO: California Alliance of Child and Family Services California Association for Alcohol/Drug Educators
California Association of Alcohol & Drug Program Executives, Inc.
California Association of DUI Treatment Programs
California Association of Social Rehabilitation Agencies California Consortium of Addiction Programs and Professionals California Council of Community Behavioral Health Agencies California Hospital Association
California Opioid Maintenance Providers California State Association of Counties Coalition of Alcohol and Drug Associations
County Behavioral Health Directors
County Behavioral Health Directors Association of California County Drug & Alcohol Administrators

SUBJECT: Community Transition In-Reach Services Implementation

PURPOSE: To provide guidance regarding implementation of Medi-Cal Community Transition In-Reach Services by county Behavioral Health Plans (BHPs).

REFERENCE: Welfare & Institutions Code (W&I), § 14184.400, subd. (c) and § 14184.101, subd.(d)

BACKGROUND:

The Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Initiative is designed to increase access to and strengthen the continuum of community-based behavioral health services for Medi-Cal members living with significant behavioral health needs. It also seeks to expand the continuum of care for Medi-Cal members with significant behavioral health needs who are at risk of experiencing extended stays in institutional settings. BH-CONNECT is comprised of a new five-year Medicaid Section 1115 demonstration (No 11-W-00472/9 and 21-W00080/9), State Plan Amendments (SPAs) to expand coverage of Evidence-Based Practices (EBPs) available under Medi-Cal, and complementary guidance and policies to strengthen behavioral health services statewide.

As part of the BH-CONNECT demonstration, the State is authorized to implement optional Community Transition In-Reach Services for qualifying Medi-Cal members in participating BHPs that are approved by DHCS to offer the services.[1] BHPs that opt in to this program will establish community-based, multi-disciplinary care transition teams ("Community Transition Teams") to provide intensive pre- and post-discharge care planning and transitional care management services to support members with significant behavioral health needs who are experiencing or at risk for extended stays in institutional settings in returning to the community.

This Behavioral Health Information Notice (BHIN) describes requirements for Community Transition In-Reach Services and outlines the steps participating BHPs shall take to implement these services.

POLICY:
Community Transition In-Reach Services ("In-Reach Services") are transitional care management services to support members with significant behavioral health needs who are returning to the community after extended stays in inpatient, subacute, and residential facilities, including in facilities that meet the definition of an Institution for Mental Diseases (IMD). Members who are experiencing or at risk of experiencing lengths of stay of 120 days or more are eligible to receive In-Reach Services, for up to 180 days prior to discharge. The goal of this program is to improve care coordination and facilitate transitions to community-based care for Medi-Cal members with the most complex and significant behavioral health needs. In-Reach Services are additive to services offered in inpatient, subacute, or residential settings, and are provided by community-based multi-disciplinary teams, not by the inpatient, subacute, or residential settings themselves, to improve connections to community-based services and providers.

Nothing in this BHIN limits or modifies the role of facilities or their existing obligations to provide care, including discharge planning activities included in applicable licensing

[1] Only BHPs that administer Specialty Mental Health Services (SMHS) are eligible to offer Community Transition In-Reach Services. These services are limited to SMHS and do not include SUD services covered under Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) plans. To qualify for Community Transition In-Reach Services, a Medi-Cal member must meet SMHS access criteria.

requirements. BHPs shall ensure that facilities agree to coordinate with Community Transition Teams leading up to and at the point of discharge for members receiving In-Reach Services.[2]

BHPs that choose to offer In-Reach Services may opt in, using the process described in this BHIN, effective [BHIN publication date], 2025.

Member Eligibility Criteria

To qualify to receive In-Reach Services, a Medi-Cal member must meet **all** of the following criteria:[3]

- Be enrolled in Medi-Cal.
- Be aged 21 years or older or an emancipated minor.[4]
- Meet the Specialty Mental Health Services (SMHS) Program access criteria, as defined in BHIN 21-073.
- Receive care covered by a BHP that has opted to provide Community Transition In-Reach Services regardless of whether the member resides in an in-county or out-of-county facility.
- Reside in a facility that has attested to their willingness to partner with Community Transition Teams for In-Reach Services, as described below.
- Be experiencing or at risk of experiencing an extended length of stay of 120 days or more in a qualifying facility as described below.

Medi-Cal members may receive services in facilities located outside of their county of residence if the member's BHP has opted in to provide In-Reach Services and coordinates with the facility as described in this BHIN.

Members at Risk of Extended Length of Stay

[2] BH-CONNECT Section 1115(a) Demonstration Special Terms and Conditions, (STC 9.1 p.40).
[3] BH-CONNECT Section 1115(a) Demonstration Special Terms and Conditions, (STC 9.4 p. 40-41).
[4] Fam. Code § 7002.

"Members at risk of experiencing extended length of stay" is defined as members in inpatient, residential, or subacute settings with lengths of stay shorter than 120 days but who have clinical presentation and progress similar to the patient profiles of individuals whose lengths of stay exceed 120 days. Patient profiles may include but are not limited to the following:[5]

- Previous inpatient or residential stays;
- Difficulty with adherence to prescribed medication;
- Co-occurring disorders, both behavioral and physical;
- Few or limited family/friend supports in the community;
- Civil commitment;
- Guardianship/conservatorship status;
- Experience of homelessness prior to hospitalization;
- Exhibits severe functional impairment[6] based on clinical evaluation.

Qualifying Facilities

In-Reach Services may be provided in inpatient, residential, or subacute settings, including IMDs.[7] BHPs must ensure that In-Reach Services are only provided in facilities that have attested to their willingness to partner with Community Transition Teams. BHPs must ensure that an agreement between the BHP and the facility is in place before In-Reach Services are rendered in the facility. An optional Facility Participation Agreement template is included as an Enclosure with this BHIN and provided at Opt-in-to-BH-CONNECT (ca.gov) for BHPs who wish to utilize it.

Nothing in this BHIN limits or modifies the role of facilities or their existing obligations to provide care, including discharge planning activities required in applicable licensing requirements. Community Transition Teams shall partner with facilities that have agreed

[5] BH-CONNECT Section 1115(a) Demonstration Special Terms and Conditions, (STC 9.4(e)(i) p.41).
[6] "Severe functional impairment" means that the member has significant distress or impairment in social, occupational, or other important areas of functioning.
[7] BH-CONNECT Section 1115(a) Demonstration Special Terms and Conditions, (STC 9.5 p.41).

to participate leading up to and at the point of discharge for members receiving In-Reach Services.

Access & Privacy Requirements

BHPs are expected to work with qualifying facilities to establish agreements that offer access and privacy for Community Transition Teams to conduct In-Reach Services. Community Transition Teams may utilize existing designated visitor areas within the facility, provided such areas meet established standards for privacy and are appropriate for confidential service interactions.

Scope of Services

In-Reach Services to support care transition and discharge planning consist of transitional care management services that include, but are not limited to:[8]

- Comprehensive assessment and periodic reassessment[9] of individual needs;
- Comprehensive individualized care plan;
- Referral and related activities;
- Monitoring and follow-up activities; and
- Identifying and addressing system barriers.

Comprehensive Assessment and Periodic Reassessment

The comprehensive assessment and periodic reassessment of individual needs is used to determine the need for any medical, educational, social or other services. These assessment activities include:[10]

- Taking client history;

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[8] BH-CONNECT Section 1115(a) Demonstration Special Terms and Conditions, (STC 9.6 p.41-42).
[9] As used in this BHIN, “periodic reassessment” refers to subsequent updates to the comprehensive assessment.
[10] These elements are consistent with the SMHS assessment requirements outlined in BHIN 23-068. This section clarifies their application within the context of Community Transition In-Reach Services under BH-CONNECT Section 1115(a) Demonstration Special Terms and Conditions, (STC 9.6(a) p.41).

- Identifying the member's needs, including housing status, and completing related documentation; and
- Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible member.

BHPs shall use an assessment process for Community Transition Teams that incorporates the activities above and meets the standardized assessment requirements identified in BHIN 23-068. The assessment content may be distinct from assessment performed by the qualifying facility's care team in that it must emphasize factors related to post-discharge skills and abilities, informing the care plan components as outlined below. The process must include details on action steps the team will take based on the assessment to ensure success in the community, including how a recovery-oriented approach will continue once community placement is achieved.

To avoid unnecessary duplication of assessment activities, facility staff and Community Transition Teams may share member assessment information consistent with all applicable information privacy laws. Facilities and Community Transition Teams may also conduct separate assessments in coordination as long as the required content for each entity is included. Coordination between care teams is essential to align care planning and service needs, and to support placement in the least restrictive setting appropriate to the member's condition.

Comprehensive Individualized Care Plan

BHPs shall ensure that Community Transition Teams develop a comprehensive, individualized care plan for each member served based on the member's individual assessment. The individualized care plan must address readiness for discharge and indicate the anticipated post-discharge destination.

The Care Plan shall:[11]

- Specify the self-determined goals and actions to address the medical, social, educational, and other services needed by the member;

[11] BH-CONNECT Section 1115(a) Demonstration Special Terms and Conditions, (STC 9.6(b) p.41-42).

- Include activities such as ensuring the active participation of the eligible member, and working with the member (or the member's authorized health care decision maker) and others to develop those goals and a plan for achieving those goals that reflects the member's preferences with regard to services and support and types of housing they may need to help them successfully transition out of institutions and into living and engaging in their communities; and
- Identify a course of action to respond to the assessed needs and preferences of the eligible member.

Referrals and Related Activities

Referrals and related activities (such as scheduling appointments for the member) may be provided to help the eligible member access needed services including activities that help link the member with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.[12]

Recommendations and referrals to services should include, as clinically appropriate, Assertive Community Treatment (ACT), Forensic ACT, the Individual Placement and Support (IPS) model of Supported Employment, Clubhouse (as applicable) and Peer Support Services. These services shall be made available to the member as specified in the BH-CONNECT STCs.[13]

Monitoring and Follow-Up

BHPs shall develop and implement monitoring and follow-up activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible member's needs. Follow-up activities and contacts may be with the member, family members, service providers, or other entities or individuals. Services shall be provided as frequently as necessary, for a minimum of three months, as medically

[12] BH-CONNECT Section 1115(a) Demonstration Special Terms and Conditions, (STC 9.6(c) p.42).
[13] BH-CONNECT Section 1115(a) Demonstration Special Terms and Conditions, (STC 9.2(c) p.40).

necessary and clinically appropriate. Follow-up services shall include at least one annual monitoring visit, to determine whether the following conditions are met:[14]

- Services are being furnished in accordance with the member's care plan;
- Services in the care plan are adequate to support them to live in stable housing and engage in their communities; and
- Changes in the needs or status of the member are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

Identifying and Addressing System Barriers

In-Reach Services shall include identifying and addressing barriers to member success, including social, financial, and systemic issues, and facilitating linkages to social supports necessary to support successful reintegration of Medi-Cal members into their communities.[15]

Service Provisions and Standards

In-Reach Services must be additive and not duplicative of services provided by qualifying facilities, or services provided by any other Medi-Cal provider. In-Reach Services must also be coordinated with the existing discharge planning services that facilities are required to provide. Community Transition Teams must work collaboratively with facilities leading up to and at the point of discharge to support coordinated care for members receiving In-Reach Services.

Service Duration

In-Reach Services are available for up to 180 days prior to discharge from a qualifying facility. If a member is not discharged after 180 days, BHPs may claim for the period of

[14] BH-CONNECT Section 1115(a) Demonstration Special Terms and Conditions, (STC 9.6(d) p.42).
[15] BH-CONNECT Section 1115(a) Demonstration Special Terms and Conditions, (STC 9.6(e) p.42).

services already rendered for up to 180 days but no further Federal Financial Participation (FFP) shall be claimed.[16]

If a member receiving In-Reach Services steps down from one qualifying facility to a less intensive level of care that is also a qualifying facility, the member may continue receiving In-Reach Services until the cumulative 180-day service duration across both qualifying facilities is reached.

Upon discharge to a setting that does not qualify for In-Reach Services, the Community Transition Team is required to maintain engagement for a minimum of three months as medically necessary and clinically appropriate to support the Medi-Cal member's ongoing stability as described in the Monitoring and Follow-Up section above. Should the member move to a different county of responsibility upon discharge, the Community Transition Team may work with the receiving Community Transition Team (if available) and/or receiving BHP as applicable to transition care for the member.

Service Frequency

The frequency of In-Reach Services must be based on the member's individual needs and incorporated into each eligible member's comprehensive individualized care plan. In-Reach Services can be provided as frequently as determined medically necessary for Community Transition Teams to build a trusting relationship with Medi-Cal members and support care transition and discharge planning.

Community Transition Teams

Community Transition Teams will provide In-Reach and post-discharge care planning, transitional care management, and community re-integration services[17].

For purposes of this BHIN, allowable practitioner definitions and qualification requirements are the same as those in the California Medicaid State Plan for Rehabilitative Mental Health Services.

Provider Requirements and Team Composition

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[16] BH-CONNECT Section 1115(a) Demonstration Special Terms and Conditions, (STC 9.7 p.42).
[17] BH-CONNECT Section 1115(a) Demonstration Special Terms and Conditions, (STC 9.8 p.43).

Community Transition Teams must be multi-disciplinary and, at a minimum, they must include the following practitioner types:[18]

- A Licensed Mental Health Professional (LMHP) as a team lead;
- A certified Peer Support Specialist or other SMHS practitioner with lived experience of recovery from a significant behavioral health condition;
- An occupational therapist[19] (if not serving as team lead), unless the BHP meets the exemption described below;
- At least one additional SMHS practitioner; and
- Access to a prescriber for the purpose of coordinating medication management throughout the care transition[20].

In addition to the minimum team requirements outlined above, BHPs may elect to include additional members as needed to address a specific population.[21]

Occupational Therapist Requirement Exemption[22]

BHPs may request an exemption from the occupational therapist team member requirement for a period of up to 12 months from the date of DHCS' approval of the BHP Readiness Assessment. To qualify for this exemption, BHPs must submit documentation within the Community Transition In-Reach Services BHP Readiness Assessment, described in the subsequent section, that demonstrates there is a shortage of occupational therapists in the county and describes how the Community Transition Teams will still be able to effectively deliver In-Reach Services during the

[18] BH-CONNECT Section 1115(a) Demonstration Special Terms and Conditions, (STC 9.8(a-e) p.43).
[19] Per SPA 24-0041, practitioners permitted to render Rehabilitative Mental Health Services includes both Licensed Occupational Therapists and Clinical Trainees pursuing licensure as Occupational Therapists acting within their scope of their professional license and applicable State law.
[20] A "prescriber" shall mean a practitioner whose scope of practice includes prescribing medication.
[21] BHPs are responsible for ensuring additional team members and their services are not duplicative.
[22] BH-CONNECT Section 1115(a) Demonstration Special Terms and Conditions, (STC 9.8(c)(i) p.43).

exemption period. The exemption request must also include a plan to expand the availability of occupational therapists in the BHP's provider network. BHPs may request renewal exemptions on an annual basis.

The exemption documentation template is included as an Enclosure to this BHIN and must be completed via DHCS' website at Opt-in-to-BH-CONNECT (ca.gov).

BHP Approval of Community Transition Teams

BHPs shall design an approval process for Community Transition Teams to deliver In-Reach Services. Prior to delivering services, the Community Transition Team must be approved by the BHP.

Program Opt-In Requirements

BHPs may opt-in to provide Community Transition In-Reach Services by submitting and receiving DHCS approval of a Community Transition In-Reach Services BHP Readiness Assessment ("BHP Readiness Assessment").

BHPs may submit the BHP Readiness Assessment using the template at any time on or after [BHIN publication date], and shall not provide In-Reach Services until it is approved by DHCS. In the BHP Readiness Assessment, the BHP must:[23]

- Describe (1) how the BHP will assess availability of mental health and/or substance use disorder (SUD) services and housing options, and ensure that an appropriate behavioral health continuum of care is in place within the county; and (2) the process for how the assessment will inform any needed action steps based on the outcome of the assessment. A BHP may only participate in this initiative upon approval by DHCS that the appropriate continuum of care is in place for the county.
- Attest to track and report on an annual basis – or more frequently if required by DHCS – data and trends in the number and utilization of beds across qualifying inpatient, subacute, and residential facilities (including IMDs) in which the BHP places members. These data and trends additionally will inform monitoring and evaluation efforts undertaken by the State.

[23] BH-CONNECT Section 1115(a) Demonstration Special Terms and Conditions, (STC 9.2 p.40).

- Attest to provide Assertive Community Treatment (ACT), Forensic ACT, the IPS model of Supported Employment, and Peer Support Services, including a forensic specialization, within the county and/or ensure these services are covered by the BHP in the county where a member receiving In-Reach Services will ultimately reside upon discharge from a qualifying facility.

The Community Transition In-Reach Services BHP Readiness Assessment addressing these criteria is included as an Enclosure to this BHIN. Participating BHPs must complete and submit the Assessment via DHCS' website at Opt-in-to-BH-CONNECT (ca.gov).

Billing and Claims

The Short Doyle Medi-Cal claiming system will be updated to include In-Reach Services. BHPs shall not submit claims for In-Reach Services until DHCS provides additional claiming guidance and confirms systems updates are in place to claim for these services. BHPs with an approved Readiness Assessment prior to completion of system updates may provide In-Reach Services per that approval and submit retroactive billing when system updates are confirmed.

Rates and Payment Requirements Inside Qualifying Facilities

In-Reach Services provided within a qualifying facility will be billed as a monthly bundled rate as indicated in Table 1 below.

Table 1. Community Transition In-Reach Services Monthly Rate by Demonstration Year[24]

DY1 (2025)	DY2 (2026)	DY3 (2027)	DY4 (2028)	DY5 (2029)
$2,800	$2,900	$3,100	$3,200	$3,400

Note: The monthly rate assumes an annual trend factor.

[24] BH-CONNECT Section 1115(a) Demonstration Special Terms and Conditions, (STC 17.7 p.95).

In order to claim the bundled rate, the Community Transition Team shall provide a minimum of four contacts on four different days in each month of service, of which at least three contacts are in-person with the member. The remainder of contact(s) rendered in each month of service may be in-person, virtual with the member, or collateral. In-Reach Services are claimed in the Short Doyle Medi-Cal claiming system using HCPCS code G9012.

Rates and Payment Requirements Outside Qualifying Facilities

After members have transitioned from the facility into the community, Community Transition Teams will provide post-discharge care planning and transitional care management services using existing unbundled Medi-Cal-covered outpatient behavioral health service codes for a minimum of three months as medically necessary and clinically appropriate, and include at least one annual monitoring visit, consistent with Medi-Cal requirements.

Service Limitations

Federal Financial Participation (FFP) is only available for In-Reach Services provided to members who are residing in qualifying facilities, when the member meets eligibility criteria described above. FFP may be claimed for In-Reach Services furnished to members during stays in qualifying facilities for up to 180 days prior to discharge. Payments will not be made to the facility where the member resides.[25] FFP may not be claimed for unallowable expenditures.[26] Should In-Reach Services be required beyond the 180-day limit for a member in a facility, the team shall not bill Medi-Cal but may provide those services using an alternative funding source.

Prior Authorization

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[25] BH-CONNECT Section 1115(a) Demonstration Special Terms and Conditions, (STC 9.9 p.43).
[26] Unallowable expenditures include: room and board costs for inpatient, residential or subacute treatment service providers, including those that are IMDs, unless they qualify as inpatient facilities under section 1905(a) of the Act; costs for services furnished to beneficiaries who are involuntarily residing in a psychiatric hospital or residential treatment facility by operation of criminal law.

BHPs shall design an approval process for Community Transition Teams to deliver In-Reach Services, as described above, and also for prior authorization of services for each eligible member. Prior to delivering services, the Community Transition Team must be approved by the BHP. The Community Transition Team shall further obtain authorization to provide In-Reach Services to an eligible member through a prior authorization process established by the BHP in compliance with requirements set forth in BHIN 22-016. Upon receipt of authorization from the BHP, the Community Transition Teams may provide In-Reach Services to that member within a qualifying facility and submit claims to the BHP for review and reimbursement. Prior authorization is not required for community-based services provided by the Community Transition Team after discharge.

Documentation

All services shall be documented in accordance with SMHS standards as outlined in BHIN-23-068.

Compliance Monitoring

BHPs are responsible for ensuring accountability and compliance with program requirements applicable to the Community Transition Teams and In-Reach Services. DHCS will first evaluate BHP compliance through approval of the BHP Readiness Assessment as described above. DHCS will continue to monitor Medi-Cal behavioral health delivery systems for compliance with the requirements outlined above, and deviations from the requirements may require corrective action plans or other applicable remedies. This oversight will include verifying that services provided to Medi-Cal members are medically necessary, and that documentation complies with the applicable State and federal laws, regulations, and the BHP contract. Recoupment shall be focused on identified overpayments and fraud, waste, and abuse.

BHPs approved by DHCS to provide In-Reach Services must update their member handbooks for that year. BHPs can do this by either adding the Enclosure # of this BHIN as an insert to the handbook or incorporating the language in the Enclosure to the “Additional Information About Your County” section within the handbook. Additionally, BHPs must send a Notice of Significant Change to each member at least 30 days before the effective date of the handbook. For additional information regarding the Notification of Significant Change delivery method requirements, please reference BHIN 24-034.

Please contact BH-CONNECT@dhcs.ca.gov for questions regarding this BHIN.

Sincerely,

Original signed by

Ivan Bhardwaj, Chief
Medi-Cal Behavioral Health – Policy Division

Enclosures (4)

BH-CONNECT Community Transition In-Reach Services – BHP Readiness Assessment

Overview

County Behavioral Health Plans (BHPs)[27] that intend to participate in Community Transition In-Reach Services ("In-Reach Services") are required to submit a BHP Readiness Assessment as outlined in the [linked BHIN]. A BHP cannot access FFP for In-Reach Services until the Plan is approved by the Department of Health Care Services (DHCS).

BHPs may opt into the program by completing and submitting the BHP Readiness Assessment via DHCS' website on or after [BHIN publication date]. The BHP Readiness Assessment is provided here for reference only. BHPs must submit the BHP Readiness Assessment online. Only one Readiness Assessment is required per BHP for the duration of the demonstration and must be signed by the Behavioral Health Director or their designee.

For further information on program requirements, please refer to [linked BHIN], which includes references to the Special Terms and Conditions (STCs) and existing authorities.

Find more information about BH-CONNECT on the DHCS website. **Reach out to BH-CONNECT@dhcs.ca.gov if you have any questions.**

Section 1: Background information

BHP Name [Drop down]
Name of Individual Completing BHP Readiness Assessment [Free text]
Title/Role of Individual in Completing BHP Readiness Assessment [Free text]
Email Address [Free text]

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[27] Only BHPs that administer Specialty Mental Health Services (SMHS) are eligible to offer Community Transition In-Reach Services. To qualify for Community Transition In-Reach Services, a Medi-Cal member must meet SMHS access criteria.

Section 2: Behavioral Health Care Continuum

Please attest that the BHP will complete the county Integrated Plan (IP) that shall 1) assess the availability of mental health and/or SUD services and housing options within the county and 2) indicate planned action steps (e.g., future service delivery/investments) based on the assessment). The IP is required by the Behavioral Health Services Act (BHSA) as outlined in the BHSA County Policy Manual "Behavioral Health Care Continuum" section.[28]

Completion and approval of the IP is required for approval of the Readiness Assessment. BHPs that opt in to In-Reach Services prior to the IP due date must attest that they will complete the IP. If all other requirements of the BHP Readiness Assessment are satisfied, DHCS will issue conditional approval for BHPs to render In-Reach Services and access FFP until the IP is completed and approved by DHCS.[29]

BHSA County Integrated Plan

[checkbox] Attest that the BHP will complete the BHSA IP that shall 1) assess the availability of mental health and/or SUD services and housing options within the county and 2) indicate planned action steps based on the assessment.

Section 3: Forthcoming Processes for Bed Tracking Data Reports

BHPs will be required to add a bed tracking component pursuant to forthcoming guidance. This data and information will additionally serve to inform the State's monitoring and evaluation efforts required by CMS.

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[28] The BHSA requires counties to submit three-year Integrated Plans (IPs) for Behavioral Health Services and Outcomes. As part of the IPs, counties will describe how they will plan expenditures across a range of behavioral health funding sources and deliver high-quality, culturally responsive, and timely care along the Behavioral Health Care Continuum, including through investments that expand access, close identified gaps, and improve performance. (BHSA County Policy Manual)

[29] Final approval and coverage of waiver services is contingent upon the completed and compliant IP. The BHP assumes the risk for all In-Reach Services rendered during the conditional approval period.

[checkbox] Attest to track and report, on a cadence established by DHCS and at a minimum annually, data and trends in the number and utilization of beds across inpatient, subacute, and residential facilities (including Institutions for Mental Diseases) in which the BHP places members.

Section 4: Additional DHCS Requirements for Evidence-Based Practices

Please attest that the BHP will cover and implement all of the following BH-CONNECT evidence-based practices (EBPs) as outlined in BHIN 25-009. Please note that in addition to completing this BHP Readiness Assessment, BHPs will need to complete the EBP Opt-In Process, which is available on the BH-CONNECT Opt-in landing page.

Assertive Community Treatment (ACT)
[checkbox] Attest to launch Assertive Community Treatment (ACT) services **within one year** of claiming FFP for In-Reach Services.

Forensic Assertive Community Treatment (FACT)
[checkbox] Attest to launch Forensic Assertive Community Treatment (FACT) services **within two years** of claiming FFP for In-Reach Services.

Individual Placement and Support (IPS) Supported Employment
[checkbox] Attest to launch IPS Supported Employment services **within three years** of claiming FFP for In-Reach Services.

Peer Support Services, including Forensic Specialization
[checkbox] Attest that the BHP will provide Peer Support Services **prior to claiming** for In-Reach Services.
[checkbox] Attest to launch Peer Support Services with Forensic Specialization **within one year** of claiming FFP for In-Reach Services.

BH-CONNECT Community Transition In-Reach Services – Occupational Therapist Exemption

BHPs unable to meet the Community Transition Team practitioner type requirements for occupational therapists may request a twelve-month exemption by submission of a description of facts and circumstance as evidence that the proposed exemption is appropriate, and a plan that describes how the BHP will work to resolve the workforce shortage.

A. Please describe the workforce shortage of qualified occupational therapists which impedes the BHP's ability to meet the team composition requirement as described in [linked BHIN]. [text box, 250 word limit]

B. Please describe the BHP's plan to expand the availability of occupational therapists in the licensed mental health professional provider network. [text box, 250 word limit]

C. Please describe how the BHP will ensure Community Transition Teams in the county can perform their required functions without an occupational therapist. [text box, 250 word limit]

Please note DHCS may request supporting documentation such as evidence of contracting efforts or resources used to attempt to locate additional occupational therapist providers.

BH-CONNECT Community Transition In-Reach Services – Facility Participation Agreement *(Optional)*

Participating Facility Information

Facility Name:
Facility NPI:
Facility Authorized Representative:
Representative Contact Information:

Purpose

The purpose of the Facility Participation Agreement is to provide an optional template to document a cooperative partnership between the Qualifying Facility and Community Transition Teams. As overseen by the BHPs, the Community Transition Teams will provide Community Transition In-Reach Services ("In-Reach Services") consisting of intensive pre- and post-discharge care planning and transitional care management services to support members with significant behavioral health needs who are experiencing or at risk for extended stays in institutional settings in returning to the community in accordance with the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Section 1115(a) Demonstration Special Terms and Conditions (STCs).

This agreement applies broadly to Community Transition In-Reach Services such that a single agreement may be signed by the Qualifying Facility and is transferrable across Behavioral Health Plans and Community Transition Teams statewide. Upon execution of the agreement, Community Transition Teams will share a copy of the agreement with the relevant BHP.

In-Reach Services provided by the Community Transition Teams are additive and complementary. Nothing in this agreement limits or modifies the role of the Qualifying Facility or their existing obligations to provide care, including the usual discharge planning activities required under the terms of the facility's licensure.

Scope

The Qualifying Facility will:

- Provide the Community Transition Team with timely, unobstructed access to members receiving In-Reach Services.

- Ensure sufficient privacy when the Community Transition Team is delivering services.
- Coordinate with the Community Transition Team in the interest of avoiding service duplication.

The Community Transition Team will:

- Collaborate with qualifying facilities and BHPs to identify members experiencing or at risk of experiencing an extended length of stay, so that Community Transition Teams may provide In-Reach Services within scope as outlined in the STCs.
- Coordinate with qualifying facilities to address logistical considerations related to the presence of the Community Transition Team.
- Ensure services provided by the Community Transition Team are not duplicative of services provided by the facility in which a member resides or by any other provider providing Medi-Cal services to the member.

Confidentiality

Both parties will adhere to all relevant confidentiality and privacy laws.

_____ _____

Facility Representative Signature Date

BH-CONNECT Community Transition In-Reach Services – Enclosure (Member Handbook Description)

Community Transition In-Reach Services help people who are in a psychiatric hospital or facility for a long time or are at risk of staying there for a long time. The program works with you, your family, the hospital or facility, and other support people to help you move back into the community.

Community Transition In-Reach Services will be provided by a team of health and social support providers who are based in the community. The services are available to you for up to 180 days before you are discharged. Your team will work with you to figure out what kind of support you need to reach your health, social, work, and educational goals. This goal of this service is to help you be successful when you return to your community.