# BH-CONNECT EVIDENCE-BASED PRACTICE POLICY GUIDE

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DHCS
CALIFORNIA DEPARTMENT OF
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# Introduction

The Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Evidence-Based Practice (EBP) Policy Guide is a resource for mental health plans (MHPs), Drug Medi-Cal Organized Delivery System (DMC-ODS) counties (together, behavioral health plans (BHPs)), and Drug Medi-Cal (DMC) programs to support implementation of EBPs available through BH-CONNECT.

BH-CONNECT is an initiative of the Department of Health Care Services (DHCS) to increase access to and strengthen the continuum of community-based behavioral health services for Medi-Cal members living with significant behavioral health needs. BH-CONNECT is comprised of a new five-year Medicaid Section 1115 demonstration, State Plan Amendments (SPAs) to expand coverage of EBPs available under Medi-Cal, and complementary guidance and policies to strengthen behavioral health services statewide.

This Policy Guide provides operational guidance to support BHPs and DMC programs and county-operated and county-contracted behavioral health providers in implementing key EBPs available under Medi-Cal. This Policy Guide is also intended to support counties and providers in implementing EBPs pursuant to Behavioral Health Services Act (BHSA) requirements. See BHIN 25-009 for requirements to claim Medi-Cal payment for each EBP and the Behavioral Health Services Act Policy Manual for additional information about BHSA requirements. The EBPs described in this Policy Guide are:[1,2,3]

[1] In December 2024, CMS approved SPA 24-0042 and SPA 24-0051, establishing these EBPs as covered Medi-Cal services, effective January 1, 2025. BHPs and DMC programs have the option to offer some or all of these EBPs at any time in any combination. Guidance on how to commit to offering BH-CONNECT EBPs and claiming and payment requirements is available in BHIN 25-009.

[2] In December 2024, CMS approved SPA 24-0052, which establishes Enhanced Community Health Worker (CHW) services as a covered Medi-Cal service, effective January 1, 2025. BHPs and DMC programs have the option to cover and be paid for Enhanced CHW Services. BHPs and DMC programs must adhere to all applicable claiming and documentation requirements for specialty behavioral health delivery systems, as described in BHIN 23-068 and other relevant DHCS guidance. For more information on the components of Enhanced CHW Services and CHW qualifications, see the Medi-Cal provider manual for Community Health Worker Preventive Services. Additional guidance on Enhanced CHW Services is forthcoming.

[3] BH-CONNECT also includes other EBPs focused on children, youth and families including Multisystemic Therapy (MST), Parent-Child Interaction Therapy (PCIT), Functional Family Therapy (FFT), and High-Fidelity Wraparound (HFW). Additional guidance on these EBPs is forthcoming.

- **Assertive Community Treatment (ACT).** ACT is a community-based, team-based service to support members living with complex and significant behavioral health needs and a treatment history that may include psychiatric hospitalization and emergency room visits, residential treatment, involvement with the criminal justice system, homelessness, and/or lack of engagement with traditional outpatient services. ACT is delivered by a multidisciplinary ACT team and includes a full range of clinical treatment, psychosocial rehabilitation, care coordination and community support services designed to support recovery.
- **Forensic ACT (FACT).** FACT introduces forensic adaptations into the ACT model to address the behavioral health needs of members involved with the criminal justice system by requiring specialized training and staffing requirements.
- **Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP).** CSC is a community-based service designed for members experiencing FEP. By providing timely and integrated support during the critical initial stages of psychosis, CSC reduces the likelihood of psychiatric hospitalization, emergency room visits, residential treatment placements, involvement with the criminal justice system, substance use, and homelessness. CSC is a comprehensive, team-based service in which multidisciplinary teams provide a wide range of individualized supports to members exhibiting initial signs of psychosis.
- **Individual Placement and Support (IPS) Supported Employment.** The IPS model of Supported Employment supports members living with significant behavioral health needs to find and maintain competitive employment in the community. Participation in IPS supports improved employment outcomes as well as improved self-esteem, independence, sense of belonging, and overall health and wellbeing.
- **Clubhouse Services.** Clubhouses are inclusive, community-based environments rooted in empowerment that support members living with mental health conditions in their recovery. Clubhouses provide opportunities for employment, socialization, education, and skill development to improve members' physical and mental health, as well as their overall quality of life and wellbeing.

The guidance presented in this Policy Guide is based on available research and evidence for each EBP and was developed in partnership with state and national experts and implementers. The guidance also reflects the diversity of California's county-based behavioral health system and, where appropriate, presents flexibilities for behavioral health providers delivering care in geographically isolated areas that are disproportionately affected by workforce challenges and other limitations.

DHCS' goal is to ensure each EBP covered under Medi-Cal and funded using BHSA dollars is implemented with fidelity to the evidence-based model and improves outcomes and quality of life among members living with significant behavioral health needs.

Please contact BH-CONNECT@dhcs.ca.gov with any questions related to BH-CONNECT and the EBPs included in this Policy Guide.

# Assertive Community Treatment

## Overview of ACT

ACT is an EBP to support members living with complex and significant behavioral health needs and a treatment history that may include psychiatric hospitalization and emergency room visits, residential treatment, involvement with the criminal justice system, homelessness, and/or lack of engagement with traditional outpatient services. ACT is one of the most well-established and widely researched EBPs in behavioral health care for individuals living with serious mental illness (SMI). It has been extensively studied across various populations and settings around the world, with evidence supporting its effectiveness across rural areas, urban centers, and among homeless populations.[4]

ACT is designed to promote recovery by helping individuals cope with the symptoms of their behavioral health conditions and acquire the skills they need to function and remain integrated in the community, including the ability to obtain and maintain employment and housing and build strong social relationships.

Services are provided by a community-based, multidisciplinary ACT team that includes a psychiatrist or psychiatric prescriber and other licensed or credentialed mental health practitioners who work alongside peer support specialists, employment specialists, and other practitioners. Service intensity and nature are tailored to each member and evolve through regular assessments and meetings with the individual's ACT team.

The evidence-based ACT model is characterized by the following principles:[5]

- **A team-based approach**. Practitioners from various disciplines work together to meet a member's individualized recovery needs.
- **In vivo services.** Members receive services in the environments where they need those services.
- **High staff capacity.** An ACT team consists of approximately 11 team members who serve around 100 members.
- **Time-unlimited services.** Members may receive clinically appropriate services they need for as long as they need them.

[4] Burns et. al (2007)

[5] As outlined in SAMHSA's evidence-based practice toolkit for ACT

- **A shared caseload.** The entire ACT team is responsible for each member's care; practitioners do not have individual caseloads.
- **A flexible service delivery.** Teams adjust services based on changes to a member's needs. Teams meet daily to discuss each member's recovery progress.
- **A fixed point of responsibility.** The ACT team is directly responsible for providing all services the member may need. If another provider is necessary, the ACT team connects the member to the provider and ensures the member receives the additional services they need.
- **24/7 crisis availability.** Members have access to crisis services 24 hours a day, seven days per week.

When delivered with fidelity to the evidence-based model, individuals participating in ACT have demonstrated:

- Improved psychiatric symptoms and reduced side effects from unmanaged medication;[6]
- Increased participation in treatment/care, community, and other life roles;[7]
- Sustained housing that is based on the preferences of the member;[8]
- Reduced substance use and harm or utilization of substance use services;[9]
- Fewer inpatient and emergency department admissions;[10]
- Reduced involvement in the criminal justice system;[11]
- Progress towards vocational/educational goals;[12] and
- Increased integration with and participation in the community.[13]

## Medi-Cal Coverage of ACT

In December 2024, CMS approved SPA 24-0042 to establish ACT as a covered benefit in the Medi-Cal program. Many BHPs have historically provided ACT as an unbundled service using both Medi-Cal and BHSA funding. SPA-24-0042 authorizes BHPs to

[6] Van Vugt et. al. (2014)
[7] Marshall et. al. (2020)
[8] Tsai et. al. (2010)
[9] Penzenstadler et. al. (2019)
[10] Aagard et. al (2017)
[11] Cusak et. al. (2010)
[12] Luciano and Meara (2014)
[13] Lucksted et. al. (2015)

provide ACT as a bundled service with a unique billing code and monthly bundled rate.[14]

BHPs have the option to cover ACT as a bundled service under Medi-Cal. ACT is a covered Specialty Mental Health Service (SMHS). ACT is not covered in the DMC program or DMC-ODS. If a BHP opts to provide ACT as a bundled service, a BHP claiming Medi-Cal payment must meet the requirements set forth in BHIN 25-009. The components of the bundled ACT service are listed in the "ACT Service Components" section of this chapter and in Enclosure 1 of BHIN 25-009. BHPs that do not opt to provide ACT as a bundled service may receive Medi-Cal payment for many of these "unbundled" Medi-Cal-covered service components, and for other covered services as medically necessary, consistent with existing Medi-Cal coverage and billing guidance.[15]

## Evidence-Based Service Criteria for ACT

The ACT model is designed to serve individuals living with complex and significant behavioral health needs who require the highest level of services and are willing to engage in frequent, intensive, community-based contacts. While the service criteria provide a comprehensive view of those who may be appropriate for ACT, not everyone who meets these criteria will need or benefit from ACT. Clinical judgment, structured assessments (e.g., symptoms, ACT step-down readiness), and experienced judgment of illness severity will be needed for decision-making about clinically appropriate utilization of ACT. Most individuals living with SMI do not need the intensive level of services that an ACT program offers.

ACT may be appropriate for Medi-Cal members who:

- Are over the age of 18;[16]
- Have a diagnosis consistent with SMI or co-occurring SMI and substance use disorder (SUD), according to current Diagnostic and Statistical Manual of Mental

[14] In this Policy Guide, "ACT" refers to the bundled Medi-Cal service.
[15] Employment and Education Support Services (distinct from IPS Supported Employment) is a covered service component of ACT but is not available for payment as a standalone Medi-Cal service.
[16] Consistent with the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) mandate, members under age 21 may receive ACT if the service is medically necessary according to the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code.

Disorders (DSM) and the International Statistical Classification of Diseases and Related Health Problems criteria and as determined by a clinician;[17]

- Have significant functional impairment, defined as one or more of the following:
    - Consistent inability to perform practical daily tasks needed to function in the community such as maintaining personal hygiene; meeting nutritional needs; caring for personal business affairs; obtaining medical, legal, and housing services; recognizing and avoiding common dangers or hazards to oneself and one's possessions.
    - Persistent or recurrent failure to perform daily living tasks, except with significant support or help from others such as friends, family, or relatives;
    - Consistent inability to be employed at a self-sustaining level or to carry out homemaker roles; and/or
    - Inability to maintain a safe living situation (e.g., repeated evictions or loss of housing, or under a mental health (Lanterman-Petris-Short (LPS)) conservatorship); ***and***
- Have an indicator of continuous, high-service needs, as evidenced by one or more of the following:
    - High use of psychiatric hospitalization or psychiatric emergency services.
    - Intractable (persistent or recurrent) severe major symptoms (e.g., affective, psychotic, suicidal);
    - Co-existing SUD of significant duration;
    - High risk or a recent history of being involved in the criminal justice system;
    - Living in sub-standard housing, experiencing homelessness, or at imminent risk of becoming homeless;
    - Clinically assessed to be able to live more independently if intensive services are provided; and/or
    - Inability to participate in office-based services.

ACT is typically not appropriate for members solely diagnosed with SUD, personality disorder(s), or intellectual/development disabilities (I/DD).

[17] Most members who are appropriate for ACT will have a diagnosis consistent with a psychotic disorder, such as, bipolar disorder; schizophrenia; schizoaffective disorder; major depressive disorder with psychotic features; and other psychotic disorders.

## ACT Service Components

ACT includes a full range of clinical treatment, psychosocial rehabilitation, care coordination, and community support services designed to promote recovery. Members participating in ACT will likely not require any additional case management or therapeutic supports. All services should be culturally informed and recovery oriented.

The following are covered ACT service components, which are defined in California's Medicaid State Plan:

- Assessment
- Crisis Intervention
- Employment and Education Support Services
- Medication Support Services
- Peer Support Services
- Psychosocial Rehabilitation
- Referral and Linkages
- Therapy
- Treatment Planning

Members may require different service components at different points over their course of treatment.

## Role of Significant Support Persons or Other Collaterals

Working with significant support persons or other collaterals such as the member's family and/or natural support network is also an important component of ACT. A member's support network can provide the ACT team with valuable information about the member's whereabouts and treatment progress, and support their path to recovery. ACT teams are expected to engage with a member's family and/or natural support network and include them in the member's treatment and rehabilitative process, according to the preferences of the member and in accordance with applicable federal and state privacy laws.

## ACT Team Structure

ACT is a multidisciplinary, team-based service. ACT teams should include a diverse array of behavioral health practitioners, including a licensed practitioner to serve as the ACT team lead, a psychiatrist or psychiatric prescriber, one or more registered nurses, and one or more employment specialists and peer support specialists. Given the team-based nature of ACT, all ACT team members are expected to play a role in the member's treatment, not just one or two specific team members.

Medi-Cal payment for bundled ACT services is available when an ACT team has achieved Medi-Cal Fidelity Designation, regardless of staffing structure (see BHIN 25-009 and the "Medi-Cal Fidelity Designation" section of this chapter).

In general, a full size ACT team should be staffed to support a caseload of 80-110 members. However, in some cases, it may be necessary to staff a "small" ACT team that supports a smaller caseload of members.[18] In addition, in most cases ACT practitioners should have a full-time role delivering ACT. However, there may be occasions in which it is appropriate for a practitioner to serve part-time on an ACT team, and part-time delivering other services (for example, a psychiatrist on a small ACT team).

Sample ACT team structures for both a "full size" and a "small" ACT team are outlined in Box 1. Teams may utilize other staffing structures and receive Medi-Cal payment for services as long as the team achieves Medi-Cal Fidelity Designation. All practitioners participating on an ACT team must function within the scope of their professional license and applicable state law.

**Box 1. Sample Team Structure for ACT Teams**
*This specific team structure is not required of all ACT teams; for illustrative purposes only.*

| Full Size ACT Team | Small ACT Team |
|---|---|
| • 2 LPHA (including ACT team lead)<br>• .8 psychiatrist or psychiatric prescriber<br>• 2.85 registered nurses<br>• 2 peer support specialists<br>• 1 AOD counselor<br>• 1 other qualified provider | • 1.5 LPHA (including ACT team lead)<br>• .5 psychiatrist or psychiatric prescriber<br>• 1 registered nurse<br>• 1 peer support specialist<br>• 1 AOD counselor<br>• 1 other qualified provider |

[18] Small ACT teams should be established based on consultation with the ACT training and technical assistance partner. Additional information on training, technical assistance, and fidelity monitoring for ACT teams will be available in forthcoming guidance.

| Box 1. Sample Team Structure for ACT Teams<br>*This specific team structure is not required of all ACT teams; for illustrative purposes only.* | |
|---|---|
| **Full Size ACT Team** | **Small ACT Team** |
| **Total: 9.65 FTE**<br>**Caseload: 80-110 Members** | **Total: 6 FTE**<br>**Caseload: <60 Members** |

# Key Functions of ACT Teams

ACT is a largely self-contained, team-based service. ACT teams are expected to provide the majority of services that a member needs, including therapy, crisis services when needed, supported employment and other recovery supports, care for co-occurring SUDs, and linkages to needed social services and supports. ACT teams should rarely, if ever, refer members to external behavioral health providers for management of their SMI and/or co-occurring SUD, unless the member requires intensive SUD treatment (e.g., SUD residential or inpatient withdrawal management). In addition to providing direct services to members, ACT teams are also expected to participate in regular team meetings to help coordinate care, facilitate information sharing, and help team members remain apprised of a member's treatment progress.

Every ACT team should perform the following key functions: Team Leadership, Medication Management and Other Clinical Support, Crisis Support, Peer Support, Supported Employment and Education, Substance Use Treatment, Other Recovery Support, and Linkages to Other Services and Supports.

## ACT Team Leadership

All ACT teams should have a designated ACT team lead. Leadership of the ACT team is essential to ensuring teams are working collaboratively to best support their members' needs. The ACT team lead has full clinical, administrative, and supervisory responsibility for the ACT team and in most cases should not have responsibilities to other programs during the 40-hour work week. The ACT team lead:

- Leads daily ACT team meetings;
- Ensures all team members are focused on helping ACT members achieve their recovery goals, including through leading regular team meetings;

- Provides clinical leadership to the team, including conducting clinical assessments and providing direct services to members;
- Oversees treatment planning;
- Supports referrals and linkages and engages social service providers and other systems (e.g., housing specialists);
- Plays a minimal role, if any, in providing direct services to members; and
- Oversees the team's administrative operations, including scheduling staff to ensure coverage for day, evening, weekend, holiday, and on-call hours.

## Medication Management and Other Clinical Support

Members receiving ACT often require medications to help manage the symptoms of their behavioral health condition(s), including Medication-Assisted Treatment (MAT) for SUD. ACT teams should include a psychiatrist or other prescriber who is a fully integrated member of the team.

In addition to the psychiatrist or other prescriber, ACT teams should also include fully integrated nurses and other practitioners qualified to provide medication support services, clinical assessments, and clinical services.

### *Crisis Support*

ACT teams should be available for crisis support 24 hours a day, seven days per week. ACT teams should be staffed to operate continuous on-call rotations and have team members available for in-person crisis support when needed. Crisis support by an ACT team includes being the first-line crisis responder and evaluator for all incoming crisis calls from ACT members and addressing crisis calls using a trauma-informed, recovery-based approach. ACT teams are expected to provide crisis intervention in a timely and appropriate manner to help prevent the need for emergency department visits and hospitalizations. For example, if a member is involuntarily detained in a hospital (e.g., a 5150 emergency evaluation) or under observation in a crisis stabilization unit (CSU), the member's ACT team should be notified and deployed to the hospital or CSU where the member is receiving services.

### *Peer Support*

Peer support is a key component of the ACT model; a peer support specialist with lived experience can help bridge the gap between behavioral health practitioners and

members the health care system struggles to engage and serve.[19] On an ACT team, one or more peer support specialists can collaborate with other team members to help promote a team culture that recognizes and respects each member's unique point of view, experiences, and preferences. In addition, peer support specialists can provide direct support to the member and their family members or other significant support person(s), and help provide referrals and linkages.

***Supported Employment and Education***

ACT teams provide employment and educational support services to ACT members when appropriate to support their recovery. Each ACT team should include one or more mental health practitioners with training or experience to deliver employment and education support services;[20] however, the full ACT team can help support the member in achieving their employment and/or educational goals.

Wherever possible, ACT teams should be staffed and trained to provide the full scope of activities included in the IPS model of Supported Employment (see the "Individual Placement and Support Supported Employment" chapter of this Policy Guide).[21] ACT teams that are not equipped to offer all components of IPS should coordinate to ensure members that would benefit from IPS have access to that level of support. When appropriate and not available from the ACT team, members may receive ACT and IPS concurrently as long as employment services remain non-duplicative.

***Substance Use Treatment***

In many cases, members receiving ACT have co-occurring SUDs. ACT teams should provide a full array of integrated co-occurring disorder treatment and should include at least one AOD counselor or other practitioner with training or experience providing SUD services.[22] This team member plays an important role in assessing members for co-occurring SUDs, participating in care planning, providing co-occurring SUD treatment, including arranging for or providing MAT when appropriate, and providing referrals and linkages to other SUD services when needed (e.g., residential treatment, inpatient

[19] Peer Support Services are a service component of the bundled ACT service covered under Medi-Cal. ACT teams must include one or more Peer Support Specialists that meet all Medi-Cal requirements to deliver this service component.

[20] Any behavioral health practitioner may serve in this role if they have training or experience in delivering employment support services. No additional certification is required to provide employment and education support services.

[21] Additional guidance can be found here IPS Supported Employment and ACT Guide

[22] SPA 24-0042 adds alcohol or other drug (AOD) counselor as a SMHS provider type.

withdrawal management, or other intensive SUD services that cannot readily be provided by the ACT team).

### *Other Recovery Support*

In addition to the clinical and recovery services described above, ACT teams are expected to support members in achieving their individualized recovery goals. ACT teams should include other licensed or non-licensed mental health practitioners to provide case management support, teach symptom management and recovery skills, and develop, direct, and provide other support services. Services should address a range of life areas (e.g., physical health, employment, education, social support) based on the member's preferences and may include cultural practices that align with the identities, beliefs and values of the member and their family members and support system.

### *Linkages to Other Services and Supports*

ACT teams are expected to coordinate and provide referrals and linkages to other physical, behavioral and social services and supports to provide comprehensive, individualized treatment based on each member's needs. In particular, ACT teams should work closely with:

- **Inpatient and residential treatment providers.** An ACT team can be a key support when a member requires a short-term hospital stay or residential treatment. ACT teams should be closely involved in hospital and residential admissions and discharges to ensure continuity and coordination of services, and to be a support and advocate for ACT members.
- **IPS teams.** As described above, many members receiving ACT can benefit from IPS. When ACT teams are unable to provide IPS directly, ACT teams should ensure members are connected with an IPS team if it would support their recovery. ACT and IPS teams should coordinate employment services and ensure that services are not duplicated across treatment teams. If a member is receiving ACT and IPS, an IPS team member should attend ACT team meetings as appropriate to support care coordination.
- **Enhanced Care Management (ECM) providers.** In some cases, a member may be engaged with an ACT team through their BHP and with an ECM provider through their managed care plan (MCP). ACT teams should coordinate with ECM providers to ensure any case management is complementary, and not duplicative,

across the two programs.[23] ECM can be particularly important in providing linkages and ensuring access to physical health services while a member is also receiving higher-intensity behavioral health services. In addition, ECM providers can provide support when a member is ready to step down from ACT to a less intensive level of care.

- **Housing services and supports.** In many cases, members enrolled in ACT may be experiencing homelessness or housing instability. The ACT team can play an important role in supporting the member in finding and maintaining stable housing in their community. ACT teams should provide housing support and refer to external housing agencies and housing providers when needed.[24]

There are also a wide range of other services and supports that may complement an ACT team in providing comprehensive care. ACT teams are expected to be knowledgeable of and able to refer and link members to other social services and supports and other care providers, which may include, but are not limited to:

- Family Services
- Adult Protective Services
- Benefit Services
- Emergency Services
- State and Local Psychiatric Hospitals
- Rehabilitation Services
- Housing Agencies/Shelter Systems
- Social Services
- Educational Institutions
- Self-Help/Peer-Run Services
- Independent Living Centers
- Clubhouses
- Natural Community Supports
- Local Correctional Facilities
- Other Culturally Informed Services and Supports

[23] See the ECM Policy Guide for additional information on overlap of ECM with other programs.

[24] See the Community Supports Policy Guide for additional information on other housing services and supports available through Medi-Cal.

# Fidelity Monitoring & Medi-Cal Fidelity Designation

When implemented with fidelity to the evidence-based model, ACT is one of the most effective treatments for individuals living with serious and persistent mental illness. Regularly monitoring fidelity to the model is a key component of ACT to ensure members are receiving the best possible care and to identify where improvements can be made.

As described in BHIN 25-009, ACT teams are required to meet fidelity requirements specified by DHCS for the BHP to claim Medi-Cal payment for bundled ACT services. Fidelity assessments will be conducted by a Center of Excellence (COE) for ACT on a regular cadence for all ACT teams.[25]

BHPs may claim the bundled Medi-Cal rate for up to nine months before an ACT team completes an initial fidelity assessment.[26] For BHPs to claim Medi-Cal payment for ACT on an ongoing basis after the initial nine-month period, ACT teams must achieve and maintain Medi-Cal Fidelity Designation. Medi-Cal Fidelity Designation is granted upon a team meeting a specified fidelity threshold on their fidelity assessment. Medi-Cal Fidelity Designation is granted or renewed following each fidelity assessment. BHPs cannot claim for ACT if an ACT team's Medi-Cal Fidelity Designation is not renewed after a fidelity assessment.[27] Additional details about the fidelity monitoring process and fidelity thresholds required to achieve Medi-Cal Fidelity Designation will be available in forthcoming guidance.

[25] DHCS anticipates that fidelity assessments will be conducted annually for teams that have not achieved Medi-Cal Fidelity Designation, and every 2-3 years for teams that have achieved Medi-Cal Fidelity Designation. Additional information about the timing of fidelity assessments will be available in forthcoming guidance.

[26] To ensure continuity of services, DHCS may adjust timelines if the COE is unable to deliver fidelity assessments on the proposed timelines. If a team does not achieve Medi-Cal Fidelity Designation after its first fidelity review, payment for services provided prior to the fidelity assessment will not be recouped (assuming all other relevant requirements were observed during this period (e.g., Medi-Cal claiming rules)).

[27] To ensure continuity of services for members, DHCS may establish a timeline for teams to respond and make fidelity improvements before their Medi-Cal Fidelity Designation is not renewed. Additional information about the timing of fidelity assessments will be available in forthcoming guidance.

## Medi-Cal Payment for ACT

ACT services delivered by ACT teams that meet the requirements in BHIN 25-009 may be paid using a county-specific, monthly bundled rate. County-specific rates for behavioral health services are posted on the Medi-Cal Behavioral Health Fee Schedule.

Prior authorization is required for ACT. The ACT team should submit a prior authorization request to their BHP following clinical determination that the member is appropriate for ACT.[28] BHPs are responsible for implementing or delegating prior authorization requirements and communicating those requirements to county-operated and county-contracted provider organizations.[29] While awaiting prior authorization for ACT, the ACT team must ensure that the member continues to have access to clinically appropriate and medically necessary services that do not require prior authorization.[30]

The monthly bundled rate is designed to cover the cost of staffing an ACT team and delivering ACT services (including team meetings and care coordination without the member present), including:

- Team annual salaries;
- Employee benefits (e.g., health insurance costs, FICA taxes, and retirement costs);
- 24/7 availability to provide crisis response when needed;
- Vacancy adjustments; and
- Administrative overhead and other indirect costs (e.g., travel costs).

There are two Medi-Cal rates for ACT:

- **Full monthly rate.** For Medi-Cal members that receive at least six contacts on six different days in a month, of which at least four are delivered face-to-face (in-person) to the member. Other contacts may be with a collateral (i.e., family member and/or significant support person) to support the member's recovery. If there are two or more contacts on a day, at least one of which is with the member and one of which is with a collateral, it may be counted as two separate days.

[28] Clinically appropriate and medically necessary services are covered and reimbursable when provided prior to the determination of a diagnosis, including during the assessment process. See BHIN 23-068.
[29] BHPs may work with the COE for ACT to receive technical assistance on establishing appropriate prior authorization procedures for ACT.
[30] See BHIN 22-016.

- **Partial monthly rate.** For Medi-Cal members that receive at least four contacts on four different days in a month, of which at least three are delivered face-to-face (in-person) to the member. Other contacts may be with a collateral (i.e., family member and/or significant support person) to support the member's recovery. If there are two or more contacts on a day, at least one of which is with the member and one of which is with a collateral, it may be counted as two separate days.

A contact is defined as an encounter of at least 15 minutes in duration. Only one contact per day may be counted for payment purposes.

While ACT teams must deliver the minimum contacts required for the BHP to claim either the full or partial monthly bundled rate, ACT teams are expected to provide as many contacts as needed to support a member's recovery. The number of contacts per member may vary over the course of their treatment. In some cases, a member may receive ACT team contacts every day in a month. If a member receives 12 or more ACT team contacts in a month, the BHP may claim for appropriate, unbundled Medi-Cal-covered outpatient behavioral health services in addition to the monthly bundled rate. Unbundled Medi-Cal-covered outpatient behavioral health services delivered by the ACT team can only be claimed after the member reaches 12 contacts in a month.

If a member receives fewer ACT team contacts than the minimum required for either the full or partial monthly bundled rate, the BHP may claim for appropriate unbundled Medi-Cal-covered services. A member that repeatedly receives fewer contacts than the minimum required for either the full or partial monthly bundled rate may require additional outreach and engagement by the ACT team to ensure they are adequately supported in their recovery. If a member consistently does not require the minimum required ACT team contacts, a less intensive level of care may be more appropriate for that member.

ACT teams may utilize other local funds, including BHSA funds in a manner consistent with all applicable BHSA policy guidance, to pay for services and supports that are not covered by Medi-Cal, including outreach and engagement to members that may be eligible for ACT and other recovery supports (e.g., items that offer emotional support, like a musical instrument).

### *ACT Services Provided by Telehealth*

Telehealth can play an important role in increasing access to ACT; however, face-to-face (in-person) contacts between a member and their ACT team are an essential component

of the evidence-based model. For the BHP to claim the full monthly bundled rate for ACT, at least four contacts with the member must be conducted face-to-face. To claim the partial bundled rate for ACT, at least three contacts with the member must be conducted face-to-face. Additional contacts with the member and/or with a collateral may be conducted via telehealth.

### *ACT in Inpatient Settings*

Continuity with a member's ACT team is essential when a member is admitted to a short-term inpatient stay. Whenever possible, ACT teams should be closely involved in hospital admissions and discharges to ensure continuity and coordination of services and to be a support and advocate for ACT members.

When a member is admitted to an inpatient setting, ACT teams are well positioned to conduct activities that may include, but are not limited to:

- Help familiarize the inpatient hospital physician/treatment team with the member's care plan, including their medication regimen;
- Advocate for and support the member during their hospital stay;
- Communicate and coordinate with family members or other collaterals;
- Work with the inpatient hospital discharge staff to help formulate the member's discharge plan; and
- Support the member on the day of discharge and within the week following discharge to help escort them back to their community or to another level of care and provide any needed follow-up care to help decrease the likelihood of readmission to the hospital.

As described in BHIN 25-009, ACT teams may be paid for services provided to a member admitted to an inpatient setting.[31] While the member is in the inpatient setting for the entirety of a month, BHPs may only claim the partial rate. The full ACT rate is only available in the month of the member's admission or discharge to the inpatient setting.

### *ACT in Residential Treatment Settings*

Members in residential treatment settings also benefit from continued contact with an ACT team, particularly during a member's transition from the residential treatment

[31] Inpatient hospital settings include general acute care hospitals, acute care hospitals and psychiatric health facilities. Payment is not available for ACT delivered to members while they reside in inpatient settings that are Institutions for Mental Diseases (IMDs), unless the IMD is participating in the BH-CONNECT (mental health) and/or DMC-ODS (SUD) option to receive FFP for care provided during short-term stays in IMDs, and the inpatient stay meets all requirements associated with the IMD FFP option.

setting back into the community. Like members in inpatient hospital settings, members who are in residential treatment settings[32] may continue to receive ACT services from their ACT team. BHPs may claim the full ACT rate during the month of a member's admission or discharge to the residential treatment setting. If the member is in the residential treatment setting for the entirety of a month, the BHP may only claim the partial rate.

## Training and Technical Assistance

DHCS is committed to the ongoing training and support of ACT practitioners and county partners to ensure ACT is delivered effectively to improve outcomes for participating members. Beginning in 2025, DHCS will offer training and technical assistance for BHPs and ACT practitioners free of charge. Additional details about training and technical assistance requirements for ACT teams will be available in forthcoming guidance. Practitioners may be able to provide ACT services while awaiting and/or participating in any required trainings.

## Outcomes Monitoring

To ensure ACT is effectively supporting the recovery of participating members, ACT teams and county partners will be required to track and report on member outcomes. Specific reporting requirements will be detailed in forthcoming guidance.

[32] Residential treatment settings include Mental Health Rehabilitation Centers, Social Rehabilitation Programs, Short Term Residential Therapeutic Programs, Children's Crisis Residential Programs, Skilled Nursing Facilities with Special Treatment Programs, and SUD crisis residential settings. Payment is not available for ACT delivered to members while they reside in residential settings that are IMDs, unless the IMD is participating in the BH-CONNECT (mental health) and/or DMC-ODS (SUD) option to receive FFP for care provided during short-term stays in IMDs, and the residential stay meets all requirements associated with the IMD FFP option.

# Forensic Assertive Community Treatment

## Overview of FACT

FACT introduces forensic adaptations into the ACT model (see the "Assertive Community Treatment" chapter of this Policy Guide) to address the complex needs of members living with significant behavioral health needs who are also involved with the criminal justice system. Individuals living with significant and complex behavioral health needs are often overrepresented in jails and prisons, are at higher risk of recidivism upon release, and face barriers to community reintegration, including difficulties accessing treatment, employment, housing, and other supports.[33]

FACT introduces forensic adaptations into the ACT model to:[34]

- Improve members' mental health outcomes and daily functioning;
- Reduce recidivism by addressing criminogenic risks and needs;
- Divert individuals in need of treatment away from the criminal justice system;
- Support members with court involvement and probation support;
- Manage costs by reducing reoccurring arrest, incarceration, and hospitalization; and
- Increase public safety.

In practice, FACT is the ACT model with additional training and staffing requirements to serve the needs of justice-involved members. In many cases, the same teams will deliver both ACT and FACT, but their caseload will include some members with criminal justice system involvement. BHPs and practitioners should follow the same guidance for FACT outlined in the "Assertive Community Treatment" chapter of this Policy Guide. In addition, FACT teams are expected to include a team member with criminal justice system involvement, and complete training tailored to the forensic population, as described below.

## Medi-Cal Coverage of FACT

FACT is authorized in the Medi-Cal program under the coverage for ACT in SPA 24-0042. BHPs have the option to provide FACT as a bundled service under Medi-Cal. FACT

[33] SAMHSA (2023)
[34] SAMHSA (2019)

is a covered SMHS. FACT is not covered in the DMC program or DMC-ODS. If a BHP opts to provide FACT as a bundled service, a BHP claiming Medi-Cal payment must meet the requirements set forth in BHIN 25-009. FACT includes the same covered service components as ACT. BHPs that do not opt to provide FACT as a bundled service may receive Medi-Cal payment for many of these "unbundled" Medi-Cal-covered service components and for other covered services as medically necessary, consistent with existing Medi-Cal coverage and billing guidance.[35]

## Evidence-Based Service Criteria for FACT

FACT serves individuals that meet service criteria for ACT (see "Evidence-Based Service Criteria for ACT" in the Assertive Community Treatment chapter of this Policy Guide) who also have lived experience with the criminal justice system. This includes members who have recently been released from a correctional facility (e.g., prison, jail, or youth correctional facility), members who have spent time in a correctional facility, and members who are at high risk of criminal justice involvement (e.g., have a previous arrest, on diversion, or in mental health collaborative courts).

FACT is typically only appropriate for members with the most complex and significant behavioral health needs who require the highest level of services, exhibit high risk for reincarceration or detention, and are willing to engage in frequent, intensive community-based contacts.

## FACT Team Structure

All FACT teams should have similar staffing structures as ACT teams (see "ACT Team Structure" in the "Assertive Community Treatment" chapter of this Policy Guide). In addition, FACT teams are expected to include at least one practitioner with lived experience with the criminal justice system.[36,37] There is evidence that trust and rapport are more easily developed when members feel understood by someone who has been

[35] Employment and Education Support Services (distinct from IPS Supported Employment) is a covered service component of FACT, but is not available for payment as a standalone Medi-Cal service.
[36] Lived experience with the criminal justice system may include previous arrests, convictions, incarceration, or supervision by the courts or probation. See SAMHSA FACT brief.
[37] Teams that do not have access to a staff member with lived experience in the criminal justice system may be eligible to achieve Medi-Cal Fidelity Designation for FACT by meeting training requirements only. Teams will be evaluated on an individual basis during the fidelity process. FACT training will be available free of charge.

through a similar experience,[38] which can lead to increased member engagement and improved outcomes for members living with significant behavioral health needs.[39] There is evidence that use of peers with lived criminal justice experience leads to reduced recidivism rates.[40]

BHPs may claim Medi-Cal payment for both ACT and FACT delivered by the same team if the team serves a caseload of members in which some members have a high risk or recent history of criminal justice system involvement, and other members do not.

## Key Functions of FACT Teams

FACT includes the same covered service components as ACT (see "ACT Service Components" in the "Assertive Community Treatment" chapter of this Policy Guide) and teams should perform the same key functions. In addition, FACT teams should incorporate strategies that address criminogenic risks and needs, such as:[41]

- Screening for criminogenic risk and needs;
- Providing trauma-responsive care for people who are justice involved;
- Using cognitive behavioral approaches for addressing criminogenic needs;
- Offering specialized community resource navigation and benefit acquisition assistance; and
- Understanding confidentiality laws governing information sharing between criminal justice and health systems.

FACT teams should also establish linkages with criminal justice partners to connect eligible members with FACT and to support coordinated care delivery. Criminal justice partners may include local law enforcement, probation and parole agencies, or other pretrial services.

## Fidelity Monitoring & Medi-Cal Fidelity Designation

As described in BHIN 25-009, FACT teams are required to meet fidelity requirements specified by DHCS for the BHP to claim Medi-Cal for bundled FACT services. FACT teams that also provide ACT will use the same fidelity assessment, with forensic components

[38] SAMHSA (2017)
[39] Davidson et. al (2012)
[40] Loveland and Boyle (2007)
[41] SAMHSA (2019)

added. Fidelity assessments will be conducted by a COE on a regular cadence for all FACT teams. [42]

BHPs may claim the bundled Medi-Cal rate for up to nine months before completing an initial fidelity assessment for services delivered by FACT teams.[43] For BHPs to claim for bundled FACT services on an ongoing basis after the initial nine-month period, FACT teams must achieve and maintain Medi-Cal Fidelity Designation. Medi-Cal Fidelity Designation will be granted upon a team meeting a fidelity threshold specified by DHCS. BHPs cannot claim for services provided if a FACT team's Medi-Cal Fidelity Designation is not renewed after a fidelity assessment.[44]

The same team of practitioners may achieve Medi-Cal Fidelity Designation for both ACT and FACT. Additional details about the fidelity monitoring process and fidelity thresholds required to achieve Medi-Cal Fidelity Designation will be available in forthcoming guidance.

## Medi-Cal Payment for FACT

FACT services delivered by FACT teams that meet the requirements in BHIN 25-009 may be paid using a county-specific, monthly bundled rate. County-specific rates for behavioral health services are posted on the Medi-Cal Behavioral Health Fee Schedule.

Prior authorization is required for FACT. The FACT team should submit a prior authorization request to their BHP following clinical determination that the member is appropriate for FACT.[45] BHPs are responsible for implementing or delegating prior authorization requirements and communicating those requirements to county-operated

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[42] DHCS anticipates that fidelity assessments will be conducted annually for teams that have not achieved Medi-Cal Fidelity Designation, and every 2-3 years for teams that have achieved Medi-Cal Fidelity Designation. Additional information about the timing of fidelity assessments will be available in forthcoming guidance.

[43] To ensure continuity of services, DHCS may adjust timelines if the COE is unable to deliver fidelity assessments on the proposed timelines. If a team does not achieve Medi-Cal Fidelity Designation after its first fidelity review, payment for services provided prior to the fidelity assessment will not be recouped (assuming all other relevant requirements were observed during this period (e.g., Medi-Cal claiming rules)).

[44] To ensure continuity of services for members, DHCS may establish a timeline for teams to respond and make fidelity improvements before their Medi-Cal Designation is not renewed. Additional information about the timing of fidelity assessments will be available in forthcoming guidance.

[45] Clinically appropriate and medically necessary services are covered and reimbursable when provided prior to the determination of a diagnosis, including during the assessment process. See BHIN 23-068.

and county-contracted provider organizations. While awaiting prior authorization for FACT, the FACT team must ensure that the member continues to have access to clinically appropriate and medically necessary services that do not require prior authorization.[46]

There are two Medi-Cal rates for FACT:

- **Full monthly rate.** For Medi-Cal members that receive at least six contacts on six different days in a month, of which at least four are delivered face-to-face (in-person) to the member. Other contacts may be with a collateral (i.e., family member and/or significant support person) to support the member's recovery. If there are two or more contacts on a day, at least one of which is with the member and one of which is with a collateral, it may be counted as two separate days.
- **Partial monthly rate.** For Medi-Cal members that receive at least four contacts on four different days in a month, of which at least three are delivered face-to-face (in-person) to the member. Other contacts may be with a collateral (i.e., family member and/or significant support person) to support the member's recovery. If there are two or more contacts on a day, at least one of which is with the member and one of which is with a collateral, it may be counted as two separate days.

Given the enhanced staffing and training expectations for FACT teams, the rate for FACT is equivalent to the rate for ACT with a 3.5% add-on.[47]

All other Medi-Cal billing and claiming requirements for FACT, including claiming for FACT when a member is in an inpatient hospital setting or residential treatment setting, are consistent with the billing requirements for ACT (see BHIN 25-009 and the "Assertive Community Treatment" chapter of this Policy Guide).

## Training and Technical Assistance

DHCS is committed to the ongoing training and support of FACT practitioners and county partners to ensure FACT is delivered effectively to improve outcomes for participating members. To support delivery of FACT, teams will be expected to undergo

[46] See BHIN 22-016.

[47] The add-on was determined based on the pay differential between police officers who work in the field and police officers who work in the office. The City of San Diego Police Department pays police officers who work in the field 3.5% more than police officers who work in the office. DHCS used this pay differential to inform the rate add-on for FACT.

specialized training to prepare them to serve members with criminal justice involvement, in addition to meeting any other applicable training requirements for ACT.

Beginning in 2025, DHCS will offer in-person and virtual training and technical assistance for BHPs and FACT practitioners regarding FACT free of charge. Additional details about training and technical assistance requirements for FACT teams will be available in forthcoming guidance. Practitioners may be able to provide FACT while awaiting and/or participating in any required trainings.

## Outcomes Monitoring

To ensure FACT is effectively supporting the recovery of participating members, FACT teams and county partners will be required to track and report on member outcomes. Specific reporting requirements will be detailed in forthcoming guidance.

# Coordinated Specialty Care for First Episode Psychosis

## Overview of CSC

CSC is an evidence-based, community-based service for members experiencing an FEP. By providing timely and integrated support during the critical initial stages of psychosis, CSC reduces the likelihood of psychiatric hospitalization, emergency room visits, residential treatment placements, involvement with the criminal justice system, substance use, and homelessness that are often associated with untreated psychosis.[48,49] Individuals who receive CSC are significantly less likely to develop an SMI over time compared to those who receive standard care.[50] Individuals who receive CSC have also reported improved psychopathology and overall quality of life.[51]

CSC is a comprehensive outpatient service. Services are provided by a community-based multidisciplinary CSC team that includes a psychiatrist or psychiatric prescriber, peer support specialist, and other licensed and credentialed practitioners. Services are tailored to each member and include a wide range of individualized supports.

## Medi-Cal Coverage of CSC

In December 2024, CMS approved SPA 24-0042, establishing CSC as a covered benefit in the Medi-Cal program. Many BHPs have historically provided CSC as an unbundled service by blending funding sources, including Medi-Cal, BHSA funding, and federal block grant dollars. SPA 24-0042 authorizes BHPs to provide CSC as a bundled service with a unique billing code and monthly bundled rate.

BHPs have the option to provide CSC as a bundled service under Medi-Cal. CSC is a covered SMHS. CSC is not covered in the DMC program or DMC-ODS. If a BHP opts to provide CSC as a bundled service, a BHP claiming Medi-Cal payment must meet the requirements set forth in BHIN 25-009. The components of the bundled CSC service are listed in the "CSC Service Components" section of this chapter and in Enclosure 1 of BHIN 25-009. BHPs that do not opt to provide CSC as a bundled service may receive Medi-Cal payment for many of these "unbundled" Medi-Cal-covered service

[48] Nossel et. al. (2018)
[49] Breitborde et. al. (2023)
[50] Kane et. al. (2015)
[51] Heinssen et. al. (2014)

components, and for other covered services as medically necessary, consistent with existing Medi-Cal coverage and billing guidance.[52]

## Evidence-Based Service Criteria for CSC

CSC is a tailored intervention for individuals who are experiencing initial signs of psychosis or attenuated psychosis symptoms. In most cases, CSC is appropriate for Medi-Cal members who meet the following criteria:

- Have exhibited onset of psychotic symptoms within the past five years; ***or***
- Exhibit attenuated psychosis symptoms that meet criteria for clinical high-risk syndrome.[53]

Members may have a diagnosis of nonaffective psychosis (e.g., schizophrenia, schizoaffective disorder, or schizophreniform disorder) or affective psychosis (e.g., bipolar disorder with psychotic features or major depressive disorder with psychotic features). However, a specific diagnosis associated with psychosis is not required for a member to begin receiving CSC.[54]

CSC is not appropriate for members whose psychotic-like experiences are better attributed to an I/DD or secondary to a physical health condition (e.g., traumatic brain injury). CSC is also not typically indicated for members who experience substance-induced psychosis; however, if a member presents symptoms of psychosis induced primarily by a SUD, a clinician may recommend CSC if they determine the comprehensive CSC model is appropriate to support the member's recovery.

## CSC Service Components

Central to the design of CSC is a person-centered and developmentally informed approach to help members manage their mental health symptoms while also supporting their ability to remain integrated within their communities and participate in activities of daily living. Services are tailored to the needs of members and their families and may

[52] Employment and Education Support Services (distinct from IPS Supported Employment) is a covered service component of CSC, but is not available for payment as a standalone Medi-Cal service.
[53] As defined by the Structured Interview for Psychosis-Risk Syndromes (SIPS). These symptoms can present within a variety of diagnoses. DSM-V captures the Attenuated Psychosis Syndrome under code 298.8 (F28) Other Specified Schizophrenia Spectrum disorder.
[54] Additional information on the access criteria for members to receive SMHS is available in BHIN 21-073.

vary as a member's treatment progresses. In most cases, a member receiving CSC will not require any additional case management or therapeutic supports beyond the services delivered by the CSC team. All services should be culturally informed and recovery-oriented.

The following are covered CSC service components, as defined in California's Medicaid State Plan:

- Assessment
- Crisis Intervention
- Employment and Education Support Services
- Medication Support Services
- Peer Support Services
- Psychosocial Rehabilitation
- Referral and Linkages
- Therapy
- Treatment Planning

Members may require different service components at different points in their course of treatment.

## Role of Significant Support Persons and Other Collaterals

Working with a member's family and natural support network to provide family support and education is a key component of CSC. FEP can have a significant impact on a member's family and close community which can, in turn, impact the member's recovery. Educating families about psychosis and attenuated psychosis symptoms and treatment is foundational to CSC.[55] Increasing understanding of psychotic symptoms, treatment options, and the likelihood of recovery can improve familial communication, protect relationships from the effect of acute and ongoing stress, and promote shared decision-making.[56] In addition, engaging family members can help the CSC team maintain contact with the member in the case of recurring psychotic symptoms and help the family support the affected member. CSC teams are expected to proactively engage with a member's family and/or natural support network and include them in the

[55] Kane et. al. (2015)
[56] Heinssen et. al. (2014)

member's treatment and rehabilitative process, according to the preferences of the member and in accordance with applicable federal and state privacy laws.

## CSC Team Structure

CSC is a collaborative, team-based service. CSC teams include a multidisciplinary array of behavioral health practitioners. All CSC team members are expected to be available to support the member in their treatment and engage in regular communication and collaboration with the team.

Medi-Cal payment for bundled CSC services is available when a CSC team has achieved Medi-Cal Fidelity Designation, regardless of staffing structure (see BHIN 25-009 and the "Medi-Cal Fidelity Designation" section of this chapter).

A fully staffed CSC team should serve a caseload of 35-40 members. A sample staffing structure for a CSC team is shown in Box 2. All practitioners participating on a CSC team must function within the scope of their professional license and applicable state law.

**Box 2. Sample Staffing Structure for CSC Teams**
*This specific team structure is not required of all CSC teams; for illustrative purposes only*

- 1 LPHA (CSC team lead)
- .25 psychiatrist or psychiatric prescriber
- 1 peer support specialist
- 2 other qualified providers

**Total: 4.25 FTE**
**Caseload: 35-40 Members**

## Key Functions of CSC Teams

CSC team members are expected to work together to provide therapy; medication management and health management support; family education and support; service coordination and case management; and supported employment and education. Every CSC team should perform the following key functions: Team Leadership, Medication Management and Other Clinical Support, Peer Support, Supported Employment and Education, Other Recovery Support, and Linkages to Other Services and Supports.

### *CSC Team Leadership*

CSC teams should include a designated CSC team lead. Strong CSC team leadership is shown to result in better coordination across teams, which leads to improved member experience and outcomes.[57] The CSC team lead:

- Leads or co-facilitates weekly CSC team meetings;
- Provides ongoing consultation to team members regarding the principles of early psychosis intervention and treatment;
- Works with other team members in coordinating key services for members;
- Supports individualized treatment planning;
- Makes referrals and linkages and engages with community-based providers of social services and supports;
- Ensures the team has the skills, resources and capacity to meet the cultural and linguistic needs of its members; and
- Ensures the team respects and supports each member's recovery goals.

### *Medication Management and Other Clinical Support*

Many members who benefit from CSC at some point require medications to help manage the symptoms of their mental health condition. CSC teams should include a psychiatrist or other prescriber who can support prescribing of psychotropic medications and medication management when needed. The psychiatrist or other prescriber should conduct appropriate medical work up of psychosis to rule out medical causes, and also collaborate with medical teams to support the evaluation and treatment of co-occurring medical or physical health conditions. They should be available to all members regardless of whether they are taking medications. While the psychiatrist or other prescriber may only play a part-time role on a CSC team, they should attend all team meetings and be actively engaged in the care-planning process.

The CSC team should also support and monitor the overall health of its members and provide other clinical support as needed.

### *Peer Support*

Being able to connect with an individual with similar lived experience can be a powerful support to members and their families as they navigate their early psychosis experience. On a CSC team, a peer support specialist can collaborate with other team members and

[57] Heinssen et. al. (2014)

help promote a team culture that recognizes and respects each member's unique point of view, experiences, and preferences.[58] In addition, a peer support specialist can provide direct support to the member and their family members or other significant support person(s), and help provide referrals and linkages.

### *Supported Employment and Education*

Access to employment and education supports can help a member succeed in school or in the workplace while managing the symptoms of their mental health condition. CSC teams should be trained to provide employment and educational support services to members receiving CSC when appropriate to support their recovery. This may include educational coaching and tutoring, assistance with finding and applying to schools, and job training, development and placements.

Whenever possible, CSC teams should be staffed and trained to provide the full scope of activities included in IPS Supported Employment (see the "Individual Placement and Support Supported Employment" chapter of this Policy Guide). CSC teams that are not equipped to offer all components of IPS should coordinate to ensure members that would benefit from IPS have access to that level of support. When appropriate and not available from the CSC team, members may receive CSC and IPS concurrently.

### *Other Recovery Support*

In addition to the clinical and recovery services described above, CSC teams are expected to support members in achieving their individualized recovery goals. CSC teams should include other licensed or non-licensed mental health practitioners to provide case management support, teach symptom management and recovery skills, and develop, direct, and provide other support services to members, their families, and other significant support person(s) as appropriate. Other recovery supports can include cultural practices that align with the identities, beliefs and values of the member and their family members and support system.

### *Linkages to Other Services and Supports*

CSC teams should coordinate and provide referrals and linkages with other physical, behavioral and social services and supports to provide comprehensive, individualized

[58] Peer Support Services are a service component of the bundled CSC service covered under Medi-Cal. CSC teams must include one or more Peer Support Specialists that meet all Medi-Cal requirements to deliver this service component.

treatment based on each member's needs. In particular, CSC teams should be prepared to work closely with:

- **Inpatient and residential treatment providers.** CSC teams can be a critical support for members who require a short-term hospital stay or residential treatment. CSC teams should be closely involved in inpatient and residential admissions and discharges and maintain ongoing communication with the member and their significant support network to ensure continuity and coordination of services and to advocate for members' specific needs.
- **IPS teams.** If a member would benefit from IPS and the CSC team is unable to provide those services, the team should ensure the member is connected to an IPS team. The CSC and IPS teams should work closely to ensure that employment services are coordinated, and services are not duplicated. If a member is receiving CSC and IPS, an IPS team member should attend weekly CSC team meetings as appropriate to support care coordination.
- **ECM providers.** In some cases, a member may be engaged with a CSC team through their BHP and with an ECM provider through their MCP. CSC teams should coordinate with ECM providers to ensure any case management is complementary, and not duplicative, across the two programs.[59] ECM can be particularly important in providing linkages and ensuring access to physical health services while a member is also receiving CSC. In addition, ECM providers can be a support when a member is ready to step down from CSC to a less intensive level of care.
- **Crisis and emergency services.** CSUs and EDs may be one of the key referral or access points for CSC when a concerned family member brings a member in for treatment, but they do not meet the criteria for hospitalization. CSC teams should coordinate with CSUs and EDs to connect members to services in a timely manner.

There are also a wide range of other services and supports that may complement a CSC team in providing comprehensive care to a member. CSC teams are expected to be knowledgeable of and able to refer and link members to other social services and supports and other care providers, which may include, but are not limited to:

- Family Services
- Adult Protective Services

[59] See the ECM Policy Guide for additional information on overlap of ECM with other programs.

- Benefit Services
- Emergency Services
- State and Local Psychiatric Hospitals
- Rehabilitation Services
- Housing Agencies/Shelter Systems
- Social Services
- Educational Institutions
- Self-Help/Peer-Run Services
- Independent Living Centers
- Clubhouses
- Natural Community Supports
- Other Culturally Informed Services and Supports

## Fidelity Monitoring & Medi-Cal Fidelity Designation

CSC is a highly effective treatment for members experiencing early psychosis when implemented with fidelity to the evidence-based model. Regularly monitoring fidelity is a key component of CSC to ensure members are receiving the best possible care and to identify where improvements can be made.

As described in BHIN 25-009, CSC teams are required to meet fidelity monitoring requirements specified by DHCS for the BHP to claim Medi-Cal payment for bundled CSC services. Fidelity assessments will be conducted by a COE for CSC on a regular cadence for all CSC teams.[60]

BHPs may claim the monthly bundled Medi-Cal rate for up to nine months before a CSC team completes an initial fidelity assessment.[61] For BHPs to claim Medi-Cal payment for bundled CSC services on an ongoing basis after the initial nine-month period, CSC teams must achieve and maintain a Medi-Cal Fidelity Designation. Medi-Cal Fidelity Designation will be granted upon a team meeting a fidelity threshold specified by DHCS.

[60] DHCS anticipates that fidelity assessments will be conducted annually for teams that have not achieved Medi-Cal Fidelity Designation, and every 2-3 years for teams that have achieved Medi-Cal Fidelity Designation. Additional information about the timing of fidelity assessments will be available in forthcoming guidance.

[61] To ensure continuity of services, DHCS may adjust timelines if the COE is unable to deliver fidelity assessments on the proposed timelines. If a team does not achieve Medi-Cal Fidelity Designation after its first fidelity review, payment for services provided prior to the fidelity assessment will not be recouped (assuming all other relevant requirements were observed during this period (e.g., Medi-Cal claiming rules)).

Medi-Cal Fidelity Designation will be granted or renewed following each fidelity assessment. BHPs cannot claim for CSC if a CSC team's Medi-Cal Fidelity Designation is not renewed after a fidelity assessment. [62] Additional details about the fidelity monitoring process and fidelity thresholds required to achieve Medi-Cal Fidelity Designation will be available in forthcoming guidance.

## Medi-Cal Payment for CSC

CSC services delivered by CSC teams that meet the requirements in BHIN 25-009 may be paid using a county-specific, monthly bundled rate. County-specific rates for behavioral health services are posted here.

The monthly bundled rate is designed to cover the cost of staffing a CSC team and delivering CSC services, including:

- Team annual salaries;
- Employee benefits (e.g., health insurance costs, FICA taxes, and retirement costs);
- Swing/night shift coverage;
- Vacancy adjustments; and
- Administrative overhead and other indirect costs (e.g., travel costs).

There are two Medi-Cal rates for CSC:

- **Full monthly rate.** For Medi-Cal members that receive at four contacts on four different days in a month, of which at least three are delivered face-to-face (in-person) to the member. Other contacts may be with a collateral (i.e., family member and/or significant support person) to support the member's recovery. If there are two or more contacts on a day, at least one of which is with the member and one of which is with a collateral, it may be counted as two separate days.
- **Partial monthly rate.** For Medi-Cal members that receive at least two contacts on two different days in a month, of which at least one is delivered face-to-face (in-person) to the member. Other contacts may be with a collateral (i.e., family member and/or significant support person) to support the member's recovery. If there are two or more contacts on a day, at least one of which is with the

[62] To ensure continuity of services for members, DHCS may establish a timeline for teams to respond and make fidelity improvements before their Medi-Cal Designation is not renewed. Additional information about the timing of fidelity assessments will be available in forthcoming guidance.

member and one of which is with a collateral, it may be counted as two separate days.

A contact is defined as an encounter of at least 15 minutes in duration. Only one contact per day may be "counted" for payment purposes.

CSC teams may utilize other local funds, including Mental Health Block Grant and BHSA funds in a manner consistent with applicable BHSA policy guidance, to pay for services and supports that are not covered by Medi-Cal. These may include outreach and engagement to members that may be eligible for CSC, activities that support access and linkages to care, and other recovery supports (e.g., items that offer emotional support, like a musical instrument). While CSC teams must deliver the minimum contacts required for the BHP to claim either the full or partial monthly bundled rate, CSC teams are expected to provide as many contacts as needed to support a member's recovery. The number of contacts per member may vary over the course of their treatment. In most cases, a member will require more contacts per month earlier in their treatment period, and fewer contacts per month as their treatment progresses.

If a member receives fewer contacts than the minimum required for either the full or partial monthly bundled rate, the BHP may claim for appropriate unbundled Medi-Cal-covered services. Members that repeatedly receive fewer contacts than the minimum for either the full or partial monthly bundled rate may require additional outreach and engagement by the CSC team to ensure they are adequately supported in their recovery. If a member consistently does not require the minimum contacts for the full or partial bundled rate, a less intensive level of care may be more appropriate for that member.

### *CSC Services Provided by Telehealth*

Telehealth can support delivery of CSC by strengthening access to CSC team members and promoting continuity of care. For the BHP to claim the full monthly bundled rate for CSC, at least three contacts with the member must be conducted face-to-face. To claim the partial bundled rate for CSC, at least two contacts with the member must be conducted face-to-face. Additional contacts with the member and/or with a collateral may be conducted via telehealth. CSC teams may also choose to use telehealth for administrative functions, such as internal team meetings.

### *CSC in Inpatient Settings*

Continuity with a member's CSC team is essential when a member is admitted to a short-term inpatient stay. As described in BHIN 25-009, CSC teams may be paid for services provided to members admitted to an inpatient setting.[63] When a member is in an inpatient setting for the entirety of a month, BHPs may claim the partial rate. The full CSC rate is only available in the month of the member's admission or discharge to the inpatient setting.

### *CSC in Residential Treatment Settings*

Like members in inpatient settings, members in residential treatment settings benefit from ongoing support from a CSC team, particularly during their transition back into the community. Members in residential treatment settings may continue to receive CSC from their team.[64] When a member is in a residential treatment setting for the entirety of a month, only the partial rate is available. The full CSC rate is only available in the month of the member's admission or discharge to the residential treatment setting.

## Training and Technical Assistance

DHCS is committed to the ongoing training and support of CSC practitioners and county partners to ensure CSC is delivered effectively to improve outcomes for participating members. Beginning in 2025, DHCS will offer training and technical assistance for BHPs and CSC practitioners free of charge. Additional details about training and technical assistance for CSC teams will be available in forthcoming guidance. Practitioners may be able to provide CSC while awaiting and/or participating in any required trainings.

[63] Inpatient hospital settings include general acute care hospitals, acute care hospitals and psychiatric health facilities. Payment is not available for CSC delivered to members while they reside in inpatient settings that are IMDs, unless the IMD is participating in the BH-CONNECT (mental health) and/or DMC-ODS (SUD) option to receive FFP for care provided during short-term stays in IMDs, and the inpatient stay meets all requirements associated with the IMD FFP option.

[64] Residential treatment settings include Mental Health Rehabilitation Centers, Social Rehabilitation Programs, Short Term Residential Therapeutic Programs, Children's Crisis Residential Programs, Skilled Nursing Facilities with Special Treatment Programs, and SUD crisis residential settings. Payment is not available for CSC delivered to while they reside in residential settings that are IMDs, unless the IMD is participating in the BH-CONNECT (mental health) and/or DMC-ODS (SUD) option to receive FFP for care provided during short-term stays in IMDs, and the residential stay meets all requirements associated with the IMD FFP option.

## Outcomes Monitoring

To ensure CSC is effectively supporting the recovery of participating members, CSC teams and county partners will be required to track and report on member outcomes. Specific reporting requirements will be detailed in forthcoming guidance.

# Individual Placement and Support Supported Employment

## Overview of IPS

The IPS model of Supported Employment (from this point forward, "IPS") is an EBP designed to support individuals living with behavioral health needs in obtaining and sustaining competitive employment in the community to support their recovery. Participation in IPS is tied to improved self-esteem, community inclusion, and overall quality of life,[65] as well as reductions in homelessness[66] and criminal justice system[67] involvement.[68] IPS has been shown to be effective among a wide range of individuals living with mental health conditions, SUDs, and co-occurring mental health conditions and SUDs.

IPS is a person-centered intervention that emphasizes a member's strengths, goals, and preferences. A team of employment specialists collaborates with each member to help them in their initial job search and with ongoing follow-along supports once they secure employment. IPS can supplement a wide range of clinical behavioral health interventions, including but not limited to ACT, FACT, CSC, and other intensive outpatient services.

The evidence-based IPS model is characterized by the following principles.[69]

- **Competitive, integrated employment.** Members are supported to seek and retain competitive jobs in the community with market wages and no artificial time limits.
- **Systematic job development.** IPS teams proactively visit employers of interest to members to learn about their business needs and hiring preferences.
- **Rapid job search.** Searching for a job begins quickly and is not delayed by assessment or training.
- **Integrated services.** IPS activities are integrated with mental health care.

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[65] Frederick and VanderWeele (2019)
[66] Post and Horton (2023)
[67] Bond et. al. (2019)
[68] Drake et. al. (2015)
[69] IPS Employment Center (2024)

- **Benefits planning.** Clear, personalized information is provided to members about the interaction of employment with their benefits, so members are not negatively impacted by employment.
- **Zero exclusion**. No member with a behavioral health condition that desires competitive employment is excluded.
- **Time-unlimited supports.** Individualized supports continue as long as the member wants and needs them.
- **Worker preferences.** Services and jobs sought are based on each member's preferences and choices rather than the judgment of the IPS team.

There is evidence individuals who receive IPS experience a range of clinical benefits, including:[70]

- Improved self-esteem;
- Increased social and quality of life;
- Better control of symptoms;
- Reduced substance use; and
- Reduced hospitalization;

## Medi-Cal Coverage of IPS

In December 2024, CMS approved SPA 24-0051 to establish IPS as a covered benefit in the Medi-Cal program. SPA 24-0051 authorizes BHPs and DMC programs to provide IPS as a bundled service with a unique billing code and monthly bundled rate.

BHPs and DMC programs have the option to provide IPS as a bundled service under Medi-Cal. IPS is covered in the SMHS, DMC, and DMC-ODS delivery systems. If a BHP opts to provide IPS as a bundled service, a BHP claiming Medi-Cal payment must meet the requirements set forth in BHIN 25-009. BHPs that do not opt to provide IPS as a bundled service may receive Medi-Cal payment for other covered services as medically necessary, consistent with existing Medi-Cal coverage and billing guidance.[71]

[70] Wallstroem et. al. (2021)

[71] The components of the bundled IPS service are listed in the "Delivery of IPS" section of this chapter and in Enclosure 1 of BHIN 25-009. The components of the bundled IPS service may not be claimed as unbundled service components.

# Evidence-Based Service Criteria for IPS

IPS is designed to support members living with significant behavioral health needs in attaining and maintaining competitive employment to support recovery from their behavioral health condition.

In most cases, IPS is appropriate for members who have a diagnosed or suspected mental health condition or SUD and who require assistance to attain or maintain competitive employment.

A core principle of IPS is that services are available to anyone who wants to work, regardless of their clinical presentation.[72] Factors such as individual presentation, behavioral health symptoms, job readiness, or treatment engagement have no impact on the medical necessity for the service.[73]

# Delivery of IPS

IPS is a person-centered approach to finding, gaining and sustaining competitive employment. The evidence-based model includes a specific set of pre-employment services (e.g., job-related assessment) and employment sustaining services (e.g., ongoing job coaching and follow-along supports). Box 3 includes the IPS service components in SPA 24-0051. IPS is delivered by a team of employment specialists with support from an employment supervisor (see the "IPS Team Structure" section of this chapter).

| Box 3. IPS Service Components | |
|---|---|
| **Pre-Employment Services** | **Employment Sustaining Services** |
| • Job-related discovery or assessment<br>• Person-centered employment planning<br>• Job development and placement<br>• Job carving<br>• Benefits education and planning | • Career advancement services<br>• Negotiation with employers<br>• Job analysis<br>• Job coaching<br>• Benefits education and planning<br>• Asset development<br>• Follow-along supports |

***Pre-Employment Services***

[72] SAMHSA (2009)

[73] Supported Employment Fidelity Scale

Pre-employment services support a member in attaining a competitive job to support their individualized recovery. In most cases, a member will meet with their IPS team at least weekly during the pre-employment stage of IPS. Pre-employment services include:

- **Job-related discovery or assessment.** The IPS team works with the member on an ongoing basis to understand their work experience, job skills and goals, and to identify jobs for the member.
- **Person-centered employment planning.** The IPS team and the member work together to develop a "career profile" that outlines the member's individual strengths, preferences and goals, desired outcomes of IPS, and cultural considerations to support their job search and placement.
- **Job development and placement.** The member works with the IPS team to identify and secure work that aligns with the member's strengths, preferences, and recovery goals.
- **Job carving.** The IPS team engages directly with employers to develop, modify, or customize a specific role that would be appropriate for the member.
- **Benefits education and planning.** The member receives benefits counseling to understand how work may affect their benefits (e.g., Medi-Cal coverage or Social Security income) and guide their plan for starting work.

***Employment Sustaining Services***

Once a member secures competitive employment, the IPS team provides ongoing coaching and follow-along supports to address challenges in the workplace and support the member in achieving their recovery goals. Members typically receive employment sustaining services weekly during the initial months of employment, followed by ongoing coaching and other supports on a less frequent cadence. In most cases, follow-along supports are provided for six months or more after a member secures a job, with the exact duration tailored to the member's ongoing needs and preferences. Job sustaining services include:

- **Career advancement services.** The member works with the IPS team to identify opportunities for promotion or advancement in their role, or to identify new opportunities when appropriate.
- **Negotiation with employers.** The IPS team engages directly with employers to adjust or restructure the member's job or to discuss accommodations on an ongoing basis.
- **Job analysis.** The IPS team and the member review tasks required as part of the member's job and identify skills or training that may be required to succeed in

that role, such as managing social challenges at work, and managing symptoms or medication side effects on the job.
- **Job coaching.** The IPS team works with the member to support them in addressing challenges in the workplace and developing skills to strengthen their performance at work.
- **Benefits education and planning.** Once a member is working, the IPS team helps the member manage their benefits on an ongoing basis as they increase their earnings.
- **Asset development.** The IPS team supports the member in understanding and managing the earnings from their job.
- **Follow-along supports.** The IPS team engages with the member on an ongoing basis to support them in the workplace.

## IPS Team Structure

IPS is a team-based service. IPS teams are typically composed of two employment specialists and an employment supervisor who supports up to five IPS teams. A typical IPS team will support a caseload of 35–40 members. Any behavioral health practitioner may serve as an employment specialist if they are trained in the IPS model. No additional certification is required to serve as an employment specialist.

An employment specialist may also have:

- Experience in employment services, including job development, employment counseling, or vocational rehabilitation;
- An educational background in social work, psychology, vocational rehabilitation, or a related field; and/or
- Experience in client-centered service delivery and case management, including experience managing a caseload, coordinating with other service providers, helping clients address barriers to employment, and cultural competency.

Medi-Cal payment for IPS is available when an IPS team has achieved Medi-Cal Fidelity Designation, regardless of staffing structure (see BHIN 25-009 and the "Medi-Cal Fidelity Designation" section of this chapter).

**Box 4. Sample Staffing Structure for IPS Teams**

- .2 LPHA (employment supervisor)[74]
- 2 employment specialists[75]

**Total: 2.2 FTE**
**Average Caseload: 35–40 members**

## Coordinating IPS with Other Services and Supports

IPS should be coordinated with other services and supports to ensure members receive comprehensive behavioral health treatment. In particular, BHPs, DMC programs and IPS teams should ensure close coordination with Vocational Rehabilitation programs, ACT/FACT programs, and CSC programs.

- **Vocational Rehabilitation.** In some cases, a county's Vocational Rehabilitation program may offer IPS to members that are also eligible for Supported Employment services covered by Medi-Cal. When IPS is available through both Vocational Rehabilitation and Medi-Cal programs in a county, Medi-Cal must serve as the payer of last resort. BHPs and DMC programs can only be paid for IPS by Medi-Cal once services available through Vocational Rehabilitation have been exhausted. Counties in which IPS is available to members through both Vocational Rehabilitation and Medi-Cal should engage with the IPS COE (see the "Training and Technical Assistance" section of this chapter) for technical assistance on how to coordinate delivery of IPS across Vocational Rehabilitation and Medi-Cal programs. In addition, BHPs and DMC programs should coordinate with Vocational Rehabilitation programs on an ongoing basis and identify pathways to further collaborate and support continuity of care for members. For example, counties may encourage employment specialists with training in the IPS model to become Community Rehabilitation Partners and Medi-Cal-contracted behavioral health providers.

[74] One employment supervisor will typically support up to five IPS teams. While the employment supervisor is not required to be a LPHA, consistent with the California Medicaid State Plan, IPS covered by Medi-Cal must be provided by or under the direction of a licensed professional.
[75] Any Medi-Cal behavioral health practitioner may be trained to serve as an employment specialist, including licensed mental health professionals, mental health rehabilitation specialists, physician assistants, pharmacists, other qualified providers, medical assistants, clinical trainees, counselors, licensed practitioners of the healing arts, and peer support specialists. No additional certification is required to serve as an employment specialist.

- **ACT/FACT.** As described in the ACT chapter of this Policy Guide, members may benefit from receiving ACT and IPS concurrently. ACT teams should be equipped to offer Supported Employment "in house" as part of their ACT programs. However, a member can receive both ACT and IPS delivered separately if the ACT team cannot provide Supported Employment services at the level and intensity that is appropriate for the member. When IPS and ACT are delivered separately, an IPS team member should regularly participate in ACT team meetings to support care coordination for that member. In addition, there should be regular communication across IPS teams and ACT teams operating in a county to ensure members have access to both evidence-based services delivered with fidelity, while ensuring services are not duplicated across programs.
- **CSC.** As described in the CSC chapter of this Policy Guide, there are some cases in which a member will benefit from both CSC and IPS. Some CSC teams may be able to provide IPS as part of their CSC programs. However, a member can receive both CSC and IPS delivered separately if the CSC team cannot provide IPS at the level and intensity that is appropriate for the member. When IPS and CSC are delivered separately, an IPS team member should regularly participate in CSC team meetings to support care coordination for that member. In addition, there should be regular communication across the IPS and CSC teams in a county to ensure services are coordinated and not duplicated.
- **Inpatient and residential treatment settings.** Some members residing in an inpatient or residential treatment setting may benefit from IPS. Community-based IPS teams may deliver IPS to members residing in inpatient and residential treatment settings.[76] Inpatient and residential treatment providers should not provide IPS "in house."

While providing pre-employment and employment sustaining services is the primary responsibility of IPS teams, IPS teams should also be available to support members in connecting to healthcare and other services within the community. Employment specialists and employment supervisors should be knowledgeable about, and have relationships with, a wide range of community supports available to members as applicable to securing or maintaining employment. Employment specialists should facilitate referrals, warm handoffs and other linkage activities for members as needed. In

[76] Payment is not available for IPS delivered to members while they reside in inpatient or residential settings that are IMDs, unless the IMD is participating in the BH-CONNECT (mental health) and/or DMC-ODS (SUD) option to receive FFP for care provided during short-term stays in IMDs, and the stay meets all requirements associated with the IMD FFP option.

addition to physical health services, available support connections should include, but are not limited to:

- Housing supports
- ECM providers
- Substance use treatment
- Emergency services
- Social services
- Self-help/peer-run services
- Independent living centers
- Clubhouses
- Natural community supports

## Fidelity Monitoring & Medi-Cal Fidelity Designation

When delivered with fidelity to the evidence-based model, IPS programs have demonstrated robust outcomes among individuals living with significant behavioral health needs. Monitoring fidelity is a key component of IPS to ensure members are receiving high-quality support and to identify where improvements can be made.

As described in BHIN 25-009, IPS teams are required to meet fidelity monitoring requirements specified by DHCS for the BHP or DMC program to claim Medi-Cal payment for bundled IPS services. Fidelity assessments will be conducted by a COE for IPS on a regular cadence for all IPS teams.[77]

BHPs and DMC programs may claim the bundled Medi-Cal rate for up to nine months before an IPS team completes an initial fidelity assessment.[78] To claim Medi-Cal payment for IPS on an ongoing basis after the initial nine-month period, IPS teams must achieve and maintain a Medi-Cal Fidelity Designation. Medi-Cal Fidelity Designation will

[77] DHCS anticipates that fidelity assessments will be conducted annually for teams that have not achieved Medi-Cal Fidelity Designation, and every 2–3 years for teams that have achieved Medi-Cal Fidelity Designation. Additional information about the timing of fidelity assessments will be available in forthcoming guidance.

[78] To ensure continuity of services, DHCS may adjust timelines if the COE is unable to deliver fidelity assessments on the proposed timelines. If a team does not achieve Medi-Cal Fidelity Designation after its first fidelity review, payment for services provided prior to the fidelity assessment will not be recouped (assuming all other relevant requirements were observed during this period (e.g., Medi-Cal claiming rules)).

be granted upon a team meeting a specified fidelity threshold on a fidelity assessment. Medi-Cal Fidelity Designation will be granted or renewed following each fidelity assessment. BHPs and DMC programs cannot claim for services provided if an IPS team's Medi-Cal designation is not renewed after a fidelity assessment.[79] Additional details about the fidelity monitoring process and fidelity thresholds required to achieve Medi-Cal Fidelity Designation will be available in forthcoming guidance.

## Medi-Cal Payment for IPS

IPS services delivered by teams that meet the requirements in BHIN 25-009 may be paid using a county-specific, monthly bundled rate. County-specific rates for behavioral health services are posted here.

The monthly bundled rate is designed to cover the cost of staffing an IPS team and delivering IPS services (including team meetings and care coordination without the member present), including:

- Team annual salaries;
- Employee benefits (e.g., health insurance costs, FICA taxes, and retirement costs);
- Vacancy adjustments; and
- Administrative overhead and other indirect costs (e.g., travel costs).

There are two Medi-Cal rates for IPS:

- **Full monthly rate.** For Medi-Cal members that receive at least four contacts on four different days in a month, of which at least three are delivered face-to-face (in-person) with the member. Other contacts may be with a collateral (i.e., family member and/or significant support person) to support the member's recovery. If there are two or more contacts on the same day, at least one of which is with the member and one of which is with a collateral, it may be counted as two separate days. In most cases, the full rate will be utilized during the delivery of pre-employment services, when members meet regularly with their IPS team during their job search.
- **Partial monthly rate.** For Medi-Cal members that receive at least two contacts on two different days in a month, of which at least one contact is delivered face-

[79] To ensure continuity of services for members, DHCS may establish a timeline for teams to respond and make fidelity improvements before their Medi-Cal Designation is not renewed. Additional information about the timing of fidelity assessments will be available in forthcoming guidance.

to-face (in-person) with the member. Other contacts may be with a collateral (i.e., family member and/or significant support person) to support the member's recovery. If there are two or more contacts on the same day, at least one of which is with the member and one of which is with a collateral, it may be counted as two separate days. In most cases, the partial rate will be utilized when the member has secured a job and requires ongoing follow-along supports on a less frequent basis.

A contact is defined as an encounter of at least 15 minutes in duration. Only one contact per day may be "counted" for payment purposes.

While IPS teams must deliver the minimum contacts required for the BHP or DMC program to claim either the full or partial monthly bundled rate, IPS teams are expected to provide as many contacts as needed to support a member's recovery, consistent with the evidence-based model. The number of contacts per member may vary over the course of their treatment.

***IPS Services Provided by Telehealth***

While telehealth can support delivery of IPS, for the BHP or DMC program to claim the full monthly rate for IPS, at least three contacts with the member must be conducted face-to-face. To claim the partial bundled rate for IPS, at least two contacts with the member must be conducted face-to-face. Additional contacts with the member, contacts with collaterals, and team administrative functions (e.g., team meetings) may be conducted virtually.

## Training and Technical Assistance

DHCS is committed to the ongoing training and support of IPS practitioners and county partners to ensure IPS is being delivered effectively to improve outcomes among participating members. Beginning in 2025, DHCS will offer training and technical assistance for BHPs, DMC programs and IPS practitioners free of charge. Additional details about training and technical assistance for IPS teams will be available in forthcoming guidance. Practitioners may be able to provide IPS while awaiting and/or participating in any required trainings.

## Outcomes Monitoring

To ensure IPS is effectively supporting the recovery of participating members, IPS teams and county partners will be required to track and report on member outcomes. Specific reporting requirements will be detailed in forthcoming guidance.

# Clubhouse Services

## Overview of Clubhouse Services

Clubhouses are inclusive, community-based environments rooted in empowerment that help members improve their quality of life. Unlike traditional clinical services, the Clubhouse model is an intentional, voluntary, and organized support system that uses a strengths-based approach to help members build emotional, cognitive, and social skills in an inclusive, community-based setting. The Clubhouse model is a behavioral health approach that focuses on developing a recovery environment, so people feel less like "patients" and more like members of a community who are dedicated to building relationships, promoting engagement in Clubhouse activities, and encouraging one another to achieve their recovery goals.[80]

In a Clubhouse, members work alongside Clubhouse staff as equals and all members in the Clubhouse work together towards contributing to shared community needs (e.g., making lunch for all Clubhouse members).[81] Clubhouses emphasize membership focused on the whole person, highlighting strengths and capabilities rather than diagnosis or limitations.[82]

Key features of the Clubhouse model include:

- **Work-ordered day.** In a Clubhouse, Mondays through Fridays are structured into a "work-ordered day" in which members participate in Clubhouse functions in collaboration with staff using their strengths and talents.
- **Evening, weekend, and holiday activities.** Clubhouses provide structured opportunities for socialization and recreation on evenings, weekends, and holidays.
- **Community support services**. Clubhouse staff connect members to physical, behavioral, and social services available outside of the Clubhouse that help improve overall health and independence by addressing needs like meals and personal care.
- **Employment programs.** Clubhouses support members in obtaining employment and helping them manage challenges as they restore, maintain, or sustain

[80] Fountain House (2024)
[81] Rollings (2022)
[82] Clubhouse International (2024)

employment. Clubhouses often have an employment coordinator as one of its core staff to support members in their employment goals.

- **Supported education.** Clubhouses assist members to reach their vocational and educational goals by helping them access community-based educational resources and opportunities.
- **Housing supports.** Clubhouse staff support members in securing and sustaining safe and affordable housing, and support them in managing challenges to maintaining housing.
- **Reach out services.** Clubhouse members and staff reach out to current members who have stopped attending, who are becoming isolated in the community, and who are hospitalized. Clubhouse staff also identify and engage new members who may benefit from Clubhouse services.
- **Decision-making and governance.** Members participate in decision-making for all matters of Clubhouse operations.

Research shows that the Clubhouse model improves health and well-being of members. Benefits of engagement in a Clubhouse include:

- Improvement in overall well-being[83]
- Improvement in physical and mental health[84]
- Improvement in quality of life, self-esteem, social engagement, psychosocial functioning[85]
- Significant reduction in hospitalization[86]
- Reduction in criminal justice involvement[87]
- Increased likelihood of employment[88] and longer tenures in jobs[89]

## Medi-Cal Coverage of Clubhouse Services

In December 2024, CMS approved SPA 24-0042, establishing Clubhouse Services as a covered benefit in the Medi-Cal program. SPA 24-0042 authorizes BHPs to provide

[83] Warner et. al. (1999)
[84] Leff et. al. (2004)
[85] McKay et. al. (2018)
[86] Masso et. al. (2001)
[87] Rollings (2022)
[88] Henry (2001)
[89] Kinney (1995)

Clubhouse Services as a bundled service under Medi-Cal with a unique billing code and daily bundled rate.

BHPs have the option to cover Clubhouse Services as a bundled service under Medi-Cal. Clubhouse Services are covered SMHS. Clubhouse Services are not covered in the DMC program or DMC-ODS. If a BHP opts to provide Clubhouse Services as a bundled service, a BHP claiming Medi-Cal payment must meet the requirements set forth in BHIN 25-009. The components of bundled Clubhouse Services are listed in Enclosure 1 of BHIN 25-009. BHPs that do not opt to provide Clubhouse Services as a bundled service may receive Medi-Cal payment for many of these "unbundled" Medi-Cal-covered service components, and for other covered services as medically necessary, consistent with existing Medi-Cal coverage and billing guidance.[90]

## Evidence-Based Service Criteria for Clubhouse Services

Clubhouse Services are typically appropriate for Medi-Cal members with a diagnosis consistent with SMI or co-occurring SMI and SUD, according to current DSM and the International Statistical Classification of Diseases and Related Health Problems criteria and as determined by a clinician.

In many cases, a member may also have significant functional impairment, which may include one or more of the following:

- Inability to perform skills needed for basic independent functioning in the community
- Recurring trouble with performing activities of daily living without assistance
- Inability to maintain self-sustaining employment
- Difficulty carrying out responsibilities to maintain one's household or a safe living environment

Clubhouse Services are not appropriate for members solely diagnosed with SUD, I/DD, or psychosis induced by a medical condition.

[90] Employment and Education Support Services (distinct from IPS Supported Employment) is a covered service component of Clubhouse Services, but is not available for payment as a standalone Medi-Cal service.

# Delivery of Clubhouse Services

Clubhouses are physical, community-based settings that facilitate opportunities to build skills and relationships supportive of autonomous employment, education and housing. All Clubhouse activities are co-designed by members and staff, based on what is required and desired of the Clubhouse.

Services are delivered by Clubhouse staff through structured activities organized into the work-ordered day and evening and weekend programming. Each Clubhouse has its own policies and expectations, designed by members and staff together to ensure the space is welcoming and supportive. In addition to the activities described below, most Clubhouses also engage in regularly scheduled meetings where issues are discussed, and decisions are made.

### *Work-Ordered Day*

In Clubhouses, weekdays are structured using a work-ordered day, an eight-hour period which parallels business hours (Monday through Friday, 9:00am to 5:00pm). During the work-ordered day, members and staff work in collaboration to perform tasks related to Clubhouse functions. These may include:

- Administrative functions
- Meal preparation
- Cleaning
- Creating the Clubhouse newsletter and social media updates
- Organizing the space
- Performing maintenance
- Providing employment and educational supports
- Organizing evening, weekend, and holiday programming

### *Evening and Weekend Programming*

Outside of business hours, Clubhouses offer evening and weekend programming focused on socialization and recreation alongside supplemental employment and education supports. Evening and weekend programs give members a place to go and spend time with others after-hours or on holidays where they might otherwise feel alone or isolated. Evening and weekend programs are scheduled outside of the work-ordered day. Activities may include:

- Cultural activities

- Recreational activities
- Excursions
- Holiday events
- Continued supported employment and education services

### *Supported Employment and Education*

Clubhouses are also expected to assist members in pursuing their individual education and employment goals. In many cases, Clubhouse staff will include one or more employment specialists (see the "Clubhouse Staff" section of this chapter). Clubhouse staff provide education and employment supports directly to members, including support with finding and maintaining a place in school or work, and support with dealing with challenges that arise in those settings. When a member requires more intensive support, Clubhouse staff typically work with other service providers including IPS programs (see the "Individual Placement and Support Supported Employment" chapter of this manual) if additional employment supports are needed.

### *Linkages to Other Services and Supports*

While Clubhouses do not offer clinical services like individual therapy or routine prescribing of medications for individual members, staff should facilitate referrals, warm handoffs, and other linkages for members as needed. In addition to physical health services, Clubhouses should be able to connect members with services and supports that include, but are not limited to:

- Other specialty mental health and SUD services
- Housing services and supports
- ECM providers
- Benefit services
- Emergency services
- Social services
- Self-help/peer-run services
- Independent living centers

## Clubhouse Staff

Clubhouse Services are delivered by a staff of behavioral health practitioners trained in the Clubhouse model.[91] Clubhouse staffing levels are purposefully kept low to ensure there is a need for the active involvement of the members in Clubhouse activities. The role of the staff in a Clubhouse is not to educate or treat the members, but to engage in work alongside them and support increased autonomy.

Medi-Cal payment for Clubhouse Services is available when a Clubhouse has achieved or is actively pursuing Accreditation by Clubhouse International, regardless of staffing structure (see BHIN 25-009 and the "Accreditation" section of this chapter).

Each Clubhouse should be staffed based on the needs of the members that participate in Clubhouse activities. A typical Clubhouse will include at least four staff, including one Clubhouse director and other mental health practitioners with training in the Clubhouse model. However, Clubhouses can vary significantly in size and number of members served, and staffing should be adjusted accordingly as part of the ongoing Accreditation process.

In most cases, only a subset of active members will attend a Clubhouse each day (a Clubhouse may have 100 active members, but support an average daily attendance of 30). Clubhouses generally support a ratio of 4.5 daily members to one staff, or 18 active members to one staff. For example, a staff of 6 FTE would support a Clubhouse with an average daily attendance of 30 members and an active membership of 100 members.

Regardless of role, all staff should:

- Use the Clubhouse environment to develop relationships whereby members experience themselves as valued participants in the Clubhouse community
- Manage Clubhouse resources enabling members to utilize opportunities in society
- Have abilities to effectively fulfill these responsibilities in a communal setting comprised of people living with significant mental health conditions

[91] Medi-Cal behavioral health practitioners that may work in a Clubhouse include licensed mental health professionals, mental health rehabilitation specialists, physician assistants, pharmacists, other qualified providers, medical assistants, clinical trainees and counselors. While Clubhouses are not required to have a LPHA on staff, consistent with all SMHS and the California Medicaid State Plan, Clubhouse Services covered by Medi-Cal must be provided by or under the direction of a licensed professional.

All practitioners delivering Clubhouse Services must function within the scope of their professional license and applicable state law.

## Clubhouse Accreditation

As described in BHIN 25-009, Clubhouses are required to work with Clubhouse International to achieve Clubhouse International Accreditation for the BHP to claim Medi-Cal payment for bundled Clubhouse Services. Accreditation is a researched-based, quality assurance program to ensure Clubhouses are operating effectively and in alignment with the Clubhouse Quality Standards. Standards are reviewed every two years by Clubhouse International's Standards Review Committee, and include:

- **Membership** assures that participation is fully voluntary and that members can access all the opportunities available to them through Clubhouses.
- **Relationships** describe the relationship between Clubhouse staff and members.
- **Space** emphasizes the importance of creating a dignified, attractive environment where work is carried out.
- **Work-Ordered Day** describes the structure of the day-to-day activity within a Clubhouse, organized to help members develop self-esteem, confidence, and friendships.
- **Employment** ensures that Clubhouses offer members organized, effective strategies for moving into and maintaining gainful employment.
- **Education** ensures that Clubhouses offer members opportunities to complete their education.
- **Functions of the House** address the basic requirements for meeting members' needs, with an emphasis on social and healthcare services.
- **Funding, Governance, and Administration** describes requirements for overseeing and managing Clubhouses.

Accreditation can be a time-intensive process that includes a self-study, site visit, and detailed findings report. To ensure Clubhouses are able to operate sustainably while working towards Accreditation, BHPs may claim Medi-Cal payment for Clubhouse Services for up to one year before a Clubhouse begins the Accreditation process, and for up to three years while the Clubhouse is actively pursuing Accreditation. Clubhouses cannot claim Medi-Cal payment for more than four years total before achieving

Accreditation.[92] Additional detail about Clubhouse accreditation will be available in forthcoming guidance.

## Medi-Cal Payment for Clubhouse Services

Clubhouse Services delivered by Clubhouses that meet the requirements in BHIN 25-009 may be paid using a county-specified, daily bundled rate. County-specific rates for behavioral health services are posted on the Medi-Cal Behavioral Health Fee Schedule.

The daily bundled rate is designed to cover the cost of staffing a Clubhouse, including:

- Staff annual salaries;
- Employee benefits, (e.g., health insurance costs, FICA taxes, and retirement costs);
- Vacancy adjustments; and
- Administrative overhead and other indirect costs (e.g., travel costs).

BHPs cannot claim for any unbundled Clubhouse services in addition to the daily bundled rate.

## Training and Accreditation Support

DHCS is committed to working with BHPs to establish Clubhouses and support delivery of Clubhouse Services. Beginning in 2025, DHCS intends to make available additional training and support to Clubhouses in partnership with Clubhouse International free of charge. Additional details about training, technical assistance, and accreditation support for Clubhouses will be available in forthcoming guidance.

[92] DHCS may adjust accreditation timelines if there becomes a backlog of Clubhouses awaiting accreditation by Clubhouse International.