Advocates' Guide to the BH-CONNECT Initative: Services

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In late 2024, California received approval from the Centers for Medicare and Medicaid Services (CMS) of a Medi-Cal demonstration waiver to implement a new initiative aimed at improving access to community-based services for Medi-Cal beneficiaries with significant behavioral health needs.[1] The Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) demonstration, is effective from January 2025 to December 2029, and complements the California Advancing and Innovating Medi-Cal (CalAIM) Medi-Cal waiver demonstration, a larger initiative focused on improving access, quality, and coordination of mental health and substance use disorder (SUD) services in the Medi-Cal system that has been in place since 2022. Together, these demonstrations are designed to help low-income individuals navigate an increasingly complex behavioral health system and are one of California's most important tools in its fights against the mental health and substance misuse crises.

The BH-CONNECT demonstration includes various initiatives with distinct goals. These initiatives have been authorized through a Section 1115 Medicaid waiver and through various state plan amendments (SPA) that allow the state government to use federal funding to test innovative programs to address ongoing issues with access to health care. Whereas Medi-Cal services and initiatives must regularly be available statewide, the demonstration waiver allows the State to limit some of these new benefits to only counties that elect to opt in to provide them. Now that a year has passed since BH-CONNECT kicked off, this issue brief provides a summary of the services available through the initiative's main components and of the current state of implementation.
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[*] A companion issue brief summarizing BH-CONNECT quality and access initiatives is forthcoming. Those quality and access initiatives include: the Access, Reform and Outcomes Incentive Program, the Workforce Initiative programs, and initiatives to support children and youth.

Coverage of Evidence-Based Practices

Beginning on January 1, 2025, BH-CONNECT offers county behavioral health plans (BHPs) the opportunity to make available evidence-based practices (EBPs) for adults through the Specialty mental Health Services (SMHS), Drug Medi-Cal (DMC), or Drug Medi-Cal Organized Delivery System (DMC-ODS) systems.[2] EBPS are services that have been proven effective in treating significant behavioral health conditions. BHPs have the option of covering at least one of the following EBPs, either independently or as bundled services in any combination:[3]

- Assertive Community Treatment (ACT): team-based services that extend to crisis services, clinical treatment, psychosocial rehabilitation, prescription and arrangement of medications (including medication assisted treatment (MAT) for opioid use disorders (OUD)), care coordination, peer support services, and community and recovery support services (including supported employment and education).[4] ACT targets individuals with complex treatment history (e.g., psychiatric hospitalization, emergency room visits, residential treatment, criminal justice system involvement, homelessness, and lack of engagement with outpatient services).[5] ACT is available *only* as a Specialty Mental Health Service (SMHS).[6]

- Forensic ACT (FACT): adjusts ACT services to the behavioral health needs of individuals involved with the justice system.[7] FACT is available *only* as a Specialty Mental Health Service SMHS).[8]

- Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP): individualized community-based service that provides support during the initial stages of psychosis.[9] A team that includes a psychiatrist or psychiatric prescriber, peer support specialist, and other licensed and credentialed practitioners provides therapy, medication management and health management support, family education and support, service coordination and case management, and supported employment and education.[10] CSC for FEP is available *only* as a Specialty Mental Health Service (SMHS).[11]

- Individual Placement and Support (IPS) Supported Employment: services that support individuals with complex behavioral health needs to find and maintain employment in the community.[12] Includes pre-employment services (job-related assessment; person-centered employment planning; job development and placement; job carving; and benefits education and planning), as well as employment sustaining services (career advancement; negotiation with employers; job analysis; job coaching; benefits education and planning; asset development; and follow-along supports).[13] IPS is

provided by a team who is also responsible for coordinating other behavioral health and support services.[14] IPS is available as a SMHS, DMC, or DMC-ODS service.[15]

- Clubhouse Services: community-based services that provide opportunities for employment, socialization, education, and skill development aimed at improving physical and mental health.[16] Includes work-ordered day in which individuals participate in Clubhouse functions in collaboration with staff; socialization and recreational activities on evenings, weekends, and holidays; community support services; employment programs; supported education; housing supports; reach-out services for individuals who have stopped attending, are becoming isolated, or are hospitalized; and governance activities integrating beneficiaries into the decision-making process.[17] Clubhouse services are available *only* as a Specialty Mental Health Service (SMHS).[18]

- Enhanced Community Health Workers (ECHW) Services: services to prevent disease, disability, and other health conditions.[19] CHW has been a statewide benefit available under managed care or fee-for-service since 2022 as part of the CalAIM initiative.[20] The CHW benefit includes health education; health navigation; screening and assessment; and individual support or advocacy.[21] BH-CONNECT allows BHPs to offer ECHW that specifically target individuals with behavioral health conditions. ECHW is available as a SMHS, DMC, or DMC-ODS service.[22]

Current Status of EBP Coverage

As of January 2026, 6 counties have submitted requests to and received approval from the Department of Health Care Services (DHCS) to begin offering the newly available EBPs: San Diego County, Sacramento County, and Santa Clara County began offering services in 2025.[23] San Diego's BHP offers ECHW in their SMHS system since May 9, 2025; Sacramento's BHP offers ECHW in their SMHS system since July 1, 2025; and Santa Clara's BHP offers IPS and ECHW for mental health since October and November 2025, respectively. Santa Clara will also begin offering ACT, FACT, CSC and ECHW for SUD in 2026. Three additional counties (Inyo, Merced, and Santa Barbara) will begin offering at least one EBP in 2026. The table below summarizes counties that are currently offering or will begin offering EBPs in 2026 and includes the effective date for the corresponding benefit:

County	ACT	FACT	CSC for FEP	IPS	Clubhouse Services	ECHW
Inyo	4/1/2026	4/1/2026	4/1/2026			
Merced						5/1/2026 (SMHS)
Sacramento						7/1/2025 (SMHS)
San Diego						5/9/2025 (SMHS)
Santa Barbara				7/1/2026 (SMHS) 7/1/2026 (DMC/DMC-ODS)		
Santa Clara	4/6/2026	4/6/2026	7/13/2026	10/72025 (SMHS)		11/5/2025 (SMHS) 4/1/2026 (DMC/DMC-ODS)

Specialty Mental Health Services in Institutions for Mental Diseases

The federal Medicaid Act prohibits states from using federal funds, or federal financial participation (FFP), for services provided to an individual while residing at an Institution for Mental Diseases (IMD).[24] IMDs are inpatient and residential facilities with more than 16 beds that focus primarily on mental health and SUD treatment. The IMD exclusion is a long-standing Medicaid policy that incentivizes states to spend Medicaid dollars on building up more cost-effective community-based services rather than services that lead to the institutionalization of individuals with behavioral health conditions. In recent years, however, CMS has authorized states to utilize Section 1115 Medicaid demonstrations to waive the exclusion in an effort to address the lack of availability of mental health and SUD providers. In

2016, California was the first state to receive an IMD exclusion Medicaid waiver limited to individuals with SUD; that waiver was renewed in 2021 and is still in effect as part of the DMC-ODS program.[25] Since 2018, CMS has encouraged states to seek IMD waivers for individuals with serious mental illness (SMI) and serious emotional disturbance (SED) in addition to individuals with SUD.[26]

The BH-CONNECT Section 1115 waiver includes an initiative that allows counties to draw down federal funds to pay for services to individuals with mental health conditions residing in IMDs for short-term stays.[27] The initiatives' goals are to reduce utilization and lengths of stay in emergency departments; reduce preventable readmissions to acute care hospitals and residential settings; and improve access to crisis stabilization services, community-based services, and care coordination services to address the needs of adults with SMI.

Specifically, the BH-CONNECT initiative gives BHPs the option of receiving FFP for mental health services provided to adults aged 21 to 64 during short-term stays of 60 days or fewer at IMDs.[28] While treatment after 60 days of stays is not coverable under the initiative, BHPs are responsible for continuing to provide all medically necessary services and using other sources of funding to cover the costs.[29] Overall, BHPs are required to achieve an average length of stay of 30 days for all IMDs for which they are claiming FFP.

Guardrails to prevent inappropriate use of inpatient stays

IMDs pose a heightened risk of subjecting individuals to coerced (and therefore ineffective) treatment and, in some cases, harmful and abusive practices. For such reason, California's initiative includes various guardrails that seek to reinforce and improve availability of community-based services and to ensure that individuals are only placed in residential settings when needed and moved to lower levels of care as soon as medically feasible. For example, in order to opt in to this program, BHPs must cover peer support services, as well as all of the EBPs described in the previous section, except for Clubhouse services.[30] BHPs must implement coverage of ECHW and peer support services prior to claiming FFP for IMD stays; coverage of ACT within 1 year of beginning to claim FFP for IMD stays; coverage of FACT and CSC within 2 years of beginning to claim FFP for IMD stays; and coverage of IPS within 3 years of beginning to claim FFP for IMD stays.[31] This policy ensures that BHPs are not funding residential and inpatient care at the expense of community-based evidence-based services that better serve the needs of individuals with complex behavioral health conditions.

Second, BHPs claiming FFP for IMD stays are required to implement various accountability measures to oversee IMD services. BHPs must ensure that IMDs have practices in place to screen all admitted individuals for co-occurring physical conditions or SUD and for suicidal

ideation.[32] IMDs must also have the capacity to treat these conditions on site or partner with external providers in the community.[33] BHPs must also ensure that IMDs have discharge planning practices in place and actively coordinate with managed care plans (MCPs), BHPs, and support services for continuation or initiation of services upon discharge, which includes making appropriate referrals to external providers.[34] BHPs are also responsible to ensure that either the BHP or the IMD contact the individual within 72 hours of discharge to ensure that follow-up care is being accessed and are responsible for the use of a standardized assessment tool that helps determine the level of care the individual requires.[35]

Finally, BHPs must take steps to ensure that increased access to residential and inpatient care is not negatively impacting access to community-based SMHS.[36] For example, when opting in to claim FFP for IMD, BHPs must explain to DHCS how they will reinvest FFP claimed for IMDs to support the provision of community-based behavioral health services.[37] Beginning in 2026, BHPs must also engage in an analysis to evaluate the use of IMD services and SMHS, including EBPs, and implement strategies to increase uptake of community-based services.[38]

Current Status of IMD FFP Initiative

As of January 2026, only 3 counties, Sacramento, San Diego, and Santa Clara, have received approval to receive FFP for short-term inpatient stays at IMDs for individuals with mental health conditions.[39] The IMD FFP plans from Sacramento and San Diego were approved on September 4, 2025 and became effective on June and July 2025, respectively. The IMD FFP plan from Santa Clara was approved in November 2025 with an effective date of November 5, 2025. As explained before, by opting in to receive FFP for IMD stays for individuals with mental health conditions, these counties have also committed to providing peer support services for individuals with behavioral health conditions as well as all newly available EBPs, except for clubhouse services.

Transitional Rent

Federal Medicaid funds are typically restricted to paying for health care services for low-income populations. Improving the health of this population, however, also requires addressing the social conditions that contribute to health problems, such as housing, nutrition, and education (commonly known as social determinants of health (SDOH)). Based on this need, in 2023 CMS urged states to request Section 1115 waivers to begin using FFP for health-related social needs services (HRSN) that seek to address SDOH and improve the likelihood that other health care services are effective.[40]

Pursuant to this authority, the BH-CONNECT initiative allows California to provide coverage for short-term rental assistance that extends to room and board without clinical assistance for MCP enrollees experiencing or at risk of homelessness.[41] Transitional Rent will be available for up to 6 months, which may be used during different intervals or sequentially, for the entire duration of the five-year BH-CONNECT demonstration (i.e., 2025–2029).[42]

The benefit joins other room-and-board Community Support services available through CalAIM (Short-Term Post-Hospitalization Housing and Recuperative Care). Together, a managed care enrollee may receive up to a maximum of 6 months of any of these 3 services during a 12-month period.[43] This cap remains even if the enrollee switches to a different MCP. Additionally, Transitional Rent compliments the "housing trio" of Community Supports—Housing Transition Navigation Services, Housing Deposits, and Housing Tenancy and Sustaining Services.[44] If an individual is authorized for Transitional Rent, then they are also automatically authorized for the "housing trio" (as well as Enhanced Care Management).[45]

Access Criteria for Transitional Rent

Pursuant to the BH-CONNECT waiver terms and conditions, transitional rent assistance is available only for "Medicaid or CHIP eligible [individuals] with clinical and social risk factors and a documented medical need for this service."[46] Beginning January 1, 2026, MCPs must provide transitional rent assistance to any enrollee who meets the criteria for the "Behavioral Health Population of Focus (POF)."[47] Enrollees are eligible for Transitional Rent under the Behavioral Health POF if they meet **all three** of the following criteria:

1. The enrollee meets the access criteria for SMHS, DMC, or DMC-ODS;[48]

   AND

2. The enrollee is part of one of the following transitioning populations:[49]
   - **Individuals transitioning out of an institutional or congregate residential setting**, including but not limited to an inpatient hospital stay, an inpatient or residential SUD treatment facility, an inpatient or residential mental health treatment facility, or a nursing facility.
   - **Individuals transitioning out of a carceral setting**, including those transitioning out of a state prison, county jail, youth correctional facility, or other state, local, or federal penal setting where they have been involuntarily held in custody through operation of law enforcement authorities.
   - **Individuals transitioning out of interim housing**, including those transitioning out of transitional housing, rapid re-housing. a domestic violence shelter or domestic

violence housing, a homeless shelter, or other interim housing, whether funded or administered by HUD, or at the State or local level.

- **Individuals transitioning out of recuperative care or short-term post-hospitalization housing**, whether the stay was covered by Medi-Cal managed care or another source.
- **Individuals transitioning out of foster care**: Youth having aged out of foster care up to age 26 (having been in foster care on or after their 18th birthday) either in California or in another state.[50]
- **Individuals experiencing unsheltered homelessness**:[51] Individuals or families with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or campground.[52]
- **Individuals eligible for Full-Service Partnership (FSP)**:[53] FSP is a comprehensive behavioral health program for individuals living with significant mental health and/or co-occurring substance use conditions that have demonstrated a need for intensive wraparound services.[54]

AND

3. The enrollee is experiencing or at risk of homelessness.[55]

For the purpose of Transitional Rent eligibility, "experiencing or at risk of homelessness" is defined by the U.S. Department of Housing and Urban Development (HUD) regulations.[56] However, the BH-CONNECT waiver allows DHCS to incorporate three modifications to that definition. First, if an individual is exiting an institution, they are considered homeless if they were homeless immediately prior to entering the institution or became homeless during their stay at the institution regardless of the length of stay. Second, the timeframe for an individual or family who will imminently lose housing is extended from 14 days for individuals considered homeless and 21 days for individuals at risk of homelessness to 30 days. Finally, the requirement for individuals at risk of homelessness to have an annual income below 30% of the median family income for the area does not apply.[57]

Beginning January 1, 2026, all MCPs must cover Transitional Rent for the Behavioral Health POF. However, plans also have the option of offering the service to individuals with one or more of the following clinical risk factors: (1) pregnant or up to 12-months postpartum, (2) have one or more serious chronic physical health conditions, or (3) have one or more physical, intellectual, or developmental disabilities.[58] Individuals must always be part of one of the transiting populations described above (criteria #2) and be experiencing or at risk of homelessness (criteria #3).[59]

These additional eligibility pathways for Transitional Rent, while currently optional, will become mandatory for managed care plans to cover no sooner than January 1, 2027.[60] Further guidance on this is forthcoming.

Allowable Settings

Transitional Rent covers rental assistance in allowable settings, as well as storage fees, amenity fees, and landlord-paid utilities that are part of the rent.[61] Allowable settings include both interim or permanent settings. Permanent settings are those with a renewable lease agreement of at least 1 month and include single-family and multi-family homes, apartments, mobile homes, accessory dwelling units (ADUs), shared housing, single room occupancy units, tiny homes, recovery housing, among others.[62] Interim settings include single room occupancy units, tiny homes, hotels or motels serving as primary residence, interim setting with a small number of individuals, transitional and recovery housing, among others.[63]

MCPs are not allowed to make payments directly to landlords. Rather, plans must contract with Transitional Rent providers who are responsible for issuing payments for housing or directly providing housing to enrollees.[64] Transitional Rent providers may be county agencies (including BHPs), affordable housing providers, supportive housing providers, providers of services for individuals experiencing homelessness, among others.[65]

Transitional Rent Reimbursement Ceilings

DHCS will reimburse MCPs the actual cost of rent or temporary housing paid to landlords or property owners up to a specified reimbursable ceiling.[66] These maximum reimbursable amounts were developed to reflect the cost of living in various settings across California.[67] The reimbursable ceilings are a monthly rate based on a percentage of the HUD Small Area Fair Market Rents (SAFMR).[68] SAFMRs vary by zip code, housing type, and unit size, and they are updated by HUD annually.[69]

For permanent settings, the monthly reimbursable ceilings for Transitional Rent are 82.5% of SAFMR for single room occupancy units, a prorated share of 110% of SAFMR for shared housing, and 110% of SAFMR for all other allowable permanent settings.[70] For interim settings, the monthly reimbursable ceilings for Transitional Rent are 150% of SAFMR hotels/motels, a prorated share of 110% of SAFMR for shared rooms, and 110% of SAFMR for all other allowable interim settings.[71]

Current Status of Transitional Rent

On January 1, 2026, Transitional Rent became mandatory for all managed care plans to offer to the Behavioral Health POF.[72] MCPs may cover additional POFs, as described above; however, none have yet opted to do so. Additional POFs will become mandatory no sooner than January 1, 2027.

Community Transition In-Reach Services

In an additional effort to ensure that beneficiaries are connected to and accessing community-based services, the BH-CONNECT initiative gives BHPs the option to provide in-reach services to individuals with significant behavioral health needs who are returning to the community after long-term stays in inpatient, subacute, and residential facilities, such as IMDs. To be eligible for these services, individuals must be experiencing or at risk of experiencing lengths of stay of 120 days or more at one of these settings.[73] Community transition in-reach services will be available up to 180 days prior to the discharge date.[74]

Eligibility for Community Transition In-Reach Services

To be eligible for community transition in-reach services, individuals must be enrolled in Medi-Cal, be 21 years of age or older or an emancipated minor, meet the SMHS access criteria, receive care through a BHP that has elected to provide community transition in-reach services, reside in a facility that partners with the BHP to provide the services, and be experiencing or at risk of experiencing a stay of 120 days or more in a qualifying facility.[75] DHCS defines "at risk of experiencing extended length of stay" as an individual who is an inpatient, residential, or subacute setting with lengths of stay shorter than 120 days but with clinical profiles similar to those experiencing longer lengths of stay (factors include previous inpatient or residential stays, difficulty adhering to medications, co-occurring disorders, civil commitment, experiencing homelessness, among others).[76]

Scope of Community Transition In-Reach Services

BHPs will be required to establish community-based, multi-disciplinary care transition teams ("Community Transition Teams") to provide intensive pre- and post-discharge care planning and transitional care management services.[77] These services include comprehensive assessment and periodic reassessment of needs; comprehensive individualized care plan; referral and related activities; monitoring and follow-up activities; and identifying and addressing system barriers.[78]

Community transition teams will be made up of a Licensed Mental Health Professional (LMHP) as a team lead; a certified Peer Support Specialist or other SMHS practitioner with lived experience of recovery from a significant behavioral health condition; an occupational therapist; at least one additional SMHS practitioner; access to a prescriber for the purpose of coordinating medication management throughout the care transition; and any additional members as needed to address a specific population.[79]

Current Status of Community Transition In-Reach Services

Starting November 25, 2025, BHPs are able to offer community transition in-reach services after submitting a Readiness Assessment to DHCS and receiving approval.[80] As of January 2026, DHCS has yet to approve any Readiness Assessment to provide these services.

Conclusion

BH-CONNECT has introduced various initiatives that expand the number of services and settings available for Medi-Cal beneficiaries with significant mental health conditions and SUD. These initiatives have been crafted to ensure that individuals receive the care they need at the most appropriate setting for their condition. To date, only a handful of county BHPs have adopted coverage of newly available EBPs or began claiming FFP for IMD stays for individuals with mental health conditions. Similarly, few MCPs are actively covered transitional rent assistance prior to January 2026. Now that MCPs are required to cover transitional rent, however, and as the roll out continues and more BHPs opt into the programs, these services will hopefully become an essential component of California's specialty behavioral health system. As such, advocates should be aware of these new services and eligibility criteria and should understand the extent to which BHPs and MCPs in their counties are participating. Advocates should also understand the guardrails that have been established around these services and monitor county and MCP compliance, as the success of the BH-CONNECT initiative as a tool to connect individuals with community-based behavioral health care rests on implementation of such guardrails.

ENDNOTES

[1] CMS, Approval Letter for California's Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Section 1115 Demonstration (Dec. 16, 2024), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-bh-connect-ca-12162024.pdf [hereinafter BH-CONNECT Approval Letter].

[2] BHPs are the entities responsible for providing specialty mental health services (SMHS) and Drug Medi-Cal (DMC) or Drug Medi-Cal organized Delivery System (DMC-ODS) SUD services to Medi-Cal beneficiaries. SMHS are available statewide, whereas counties can elect to provide DMC-ODS services for individuals with SUD. Counties that do not opt in to the DMC-ODS program provide state plan DMC SUD services.

[3] In addition to expanding availability of EBPs for adults, DHCS plans to update guidance regarding availability of EBPs for minors under 21 under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. Those EBPs include Multisystemic Therapy (MST), Functional Family Therapy (FFT), Parent-Child Interaction Therapy (PCIT), and High-Fidelity Wraparound (HFW), all of which Medi-Cal is required to cover when necessary to correct or ameliorate a diagnosed or suspected behavioral health condition. As of the date of publication, DHCS had yet to finalize clarifying guidance on EBPs for children. *See* Dep't Health Care Servs., Children and Youth Evidence-Based Practices, https://www.dhcs.ca.gov/CalAIM/Pages/Children-and-Youth-Evidence-Based-Practices.aspx (last visited Feb. 4, 2026).

[4] CMS, Approval Letter for California State Plan Amendment 24-0042 at 2h–2i (Dec. 19, 2024), https://www.dhcs.ca.gov/SPA/Documents/SPA-24-0042-Approval.pdf [hereinafter SPA 24-0042]; Cal. Dep't Health Care Servs., *BH-CONNECT Evidence-Based Practice Policy Guide* 7–22, https://www.dhcs.ca.gov/Documents/EBP-Policy-Guide.pdf [hereinafter *EBP Policy Guide*]; Cal. Dep't Health Care Servs., Behavioral Health Information Notice No. 25-009 at 2 (Apr. 11, 2025), https://www.dhcs.ca.gov/Documents/BHIN-25-009-Coverage-of-BH-CONNECT-Evidence-Based-Practices.pdf [hereinafter BHIN No. 25-009].

[5] *EBP Policy Guide*, *supra* note 4, at 7.

[6] *Id.* at 9.

[7] *EBP Policy Guide*, *supra* note 4, at 23–28; BHIN No. 25-009, *supra* note 5, at 2.

[8] *EBP Policy Guide*, *supra* note 4, at 23–24.

[9] SPA 24-0042, *supra* note 4, at 2i; *EBP Policy Guide*, *supra* note 4, at 29–40; BHIN No. 25-009, *supra* note 4, at 3.

[10] *EBP Policy Guide*, *supra* note 4, at 32.

[11] *Id.* at 29.
[12] CMS, Approval Letter for California State Plan Amendment 24-0051 (Dec. 18, 2024), https://www.dhcs.ca.gov/SPA/Documents/SPA-24-0051-Approval.pdf; *EBP Policy Guide*, *supra* note 4, at 41–50; BHIN No. 25-009, *supra* note 4, at 3–4.
[13] *EBP Policy Guide*, *supra* note 4, at 43.
[14] *Id.* at 45–48.
[15] *Id.* at 42.
[16] SPA 24-0042, *supra* note 4, at 2i–2j; *EBP Policy Guide*, *supra* note 4, at 52–59; BHIN No. 25-009, *supra* note 4, at 3.
[17] *EBP Policy Guide*, *supra* note 4, at 52–53.
[18] *Id.* at 53–54.
[19] CMS, Approval Letter for California State Plan Amendment 24-0052 (Dec. 16, 2024), https://www.dhcs.ca.gov/Documents/Approval-CA-24-0052-SPA-Redacted.pdf [hereinafter SPA 24-0052]; BHIN No. 25-009, *supra* note 4, at 3.
[20] *See* CMS, Approval Letter for California State Plan Amendment 22-0001 (July 26, 2022), https://www.dhcs.ca.gov/formsandpubs/laws/Documents/SPA-22-0001-Approval.pdf. For more information on the CalAIM CHW benefit, see Cal. Dep't Health Care Servs., Community Health Workers, https://www.dhcs.ca.gov/community-health-workers (last visited Feb. 4, 2026).
[21] SPA 24-0052, *supra* note 19, at 18e–18f. Cal. Dep't Health Care Servs., Behavioral Health Information Notice No. 25-028 at 3 (July 8, 2025), https://www.dhcs.ca.gov/Documents/BHIN-25-028-BH-CONNECT-Enhanced-CHW-Services.pdf [hereinafter BHIN No. 25-028].
[22] *EBP Policy Guide*, *supra* note 4, at 4, n. 2; BHIN No. 25-028, *supra* note 21, at 2.
[23] Cal. Dep't Health Care Servs., BH-CONNECT County Participation, https://www.dhcs.ca.gov/CalAIM/Pages/County-BHP-Participation.aspx (last visited Feb. 4, 2026).
[24] *See* 42 U.S.C. § 1396d(a)(30(B). States may opt in to provide coverage for services rendered to individuals with SUD residing in IMDs pursuant to 42 U.S.C. § 1396n(l).
[25] *See* CMS, Approval Letter for California's California Advancing and Innovating Medi-Cal (CalAIM) Demonstration Renewal (Dec. 29, 2021), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-calaim-ext-appvl-12292021.pdf.
[26] CMS, Dear State Medicaid Director Letter No. 18-001 (Nov. 13, 2018) (SMD # 18-011), https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf.

[27] BH-CONNECT Approval Letter, *supra* note 1, at 4–5.
[28] This option has been available since April 30, 2025, but BHPs are allowed to claim FFP retroactively back to the date upon they can demonstrate coverage of peer support services and ECHWs. *See* Cal. Dep't Health Care Servs., Behavioral Health Information Notice No. 25-011 at 7 (Apr. 11, 2025), https://www.dhcs.ca.gov/Documents/BHIN-25-011-BH-CONNECT-Option-to-Receive-FFP-for-SMHS-in-IMDs.pdf.
[29] *Id.* at 4.
[30] *Id.* at 5–6.
[31] *Id.*
[32] *Id.* at 8.
[33] *Id.*
[34] *Id.* at 8–10.
[35] *Id.* at 10.
[36] *Id.* at 3.
[37] *Id.*
[38] *Id.* at 11–12.
[39] Cal. Dep't Health Care Servs., Mental Health Institutions for Mental Diseases Federal Financial Participation Program, https://www.dhcs.ca.gov/CalAIM/Pages/MH-IMD-FFP-Program.aspx.
[40] CMS, CMCS Informational Bulleting Re: Coverage of Services and Supports to Address Health-Related Social Needs in Medicaid and the Children's Health Insurance Program (Nov. 16, 2023), https://www.medicaid.gov/federal-policy-guidance/downloads/cib11162023.pdf. While CMS rescinded its 2023 guidance in 2025, the rescission kept in place all pre-approved HRSN Section 1115 waivers, including California's. *See* CMS, CMCS Informational Bulleting Re: Rescission of Guidance on Health-Related Social Needs (Mar. 4, 2025), https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/AID/cib03042025.pdf.
[41] BH-CONNECT Approval Letter, *supra* note 1, at 6–7.
[42] DHCS, Community Supports Policy Guide Volume 2 at 57 (Apr. 2025), https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide-Volume-2.pdf [hereinafter CS Policy Guide Vol. 2].
[43] *Id.* at 13–14.
[44] *Id.* at 24–42.
[45] *See id.* at 69.
[46] BH-CONNECT Approval Letter, *supra* note 1, at 6.

[47] CS Policy Guide Vol. 2, *supra* note 42, at 61.
[48] *Id.* For the access criteria that apply to SMHS, see Cal. Dep't Health Care Servs., Behavioral Health Information Notice No. 21-073 (Dec. 10, 2021), https://www.dhcs.ca.gov/Documents/BHIN-21-073-Criteria-for-Beneficiary-to-Specialty-MHS-Medical-Necessity-and-Other-Coverage-Req.pdf. For the access criteria that apply to DMC services, see Cal. Dep't Health Care Servs., Behavioral Health Information Notice No. 21-071 at 3 (Dec. 3, 2021), https://www.dhcs.ca.gov/Documents/BHIN-21-071-Medical-Necessity-Determination-Level-of-Care-Determination-Requirements.pdf.
For the access criteria that applies to DMC-ODS services, see Cal. Dep't Health Care Servs., Behavioral Health Information Notice No. 24-001 (Dec. 21, 2023), https://www.dhcs.ca.gov/Documents/BHIN-24-001-DMC-ODS-Requirements-for-the-Period-of-2022-2026.pdf.
[49] CS Policy Guide Vol. 2, *supra* note 42, at 58–59 (defining the transitioning populations), 61 (providing the BH POF criteria).
[50] Members transitioning out of foster care on or after their 18th birthday are eligible to receive Transitional Rent until their 26th birthday and may be authorized at any time during this window (i.e., not just during the time period when they're actively transitioning out of foster care). *Id.* at 60.
[51] Experiencing or being at risk of homelessness is sufficient for inclusion in the Behavioral Health POF. Individuals do not need to meet another "transitioning population" criteria. *Id.* at 61, n. 96.
[52] As described in 24 C.F.R. § 91.5(1)(i). CS Policy Guide Vol. 2, *supra* note 42, at 59, n. 91.
[53] Being FSP-eligible is sufficient for inclusion in the Behavioral Health POF. Individuals do not need to meet another "transitioning population" criteria. CS Policy Guide Vol. 2, *supra* note 42, at 61, n. 96.
[54] For FSP eligibility criteria, see *Id.* at Appendix E.
[55] *Id.* at 58; *see also id.* at Appendix C (detailing the definition of "experiencing or at risk of homelessness," as based on HUD's definitions with three modifications).
[56] 24 C.F.R. § 91.5(1)(i)
[57] BH-CONNECT Approval Letter, *supra* note 1, at 182, Att. H. *See also* CS Policy Guide Vol. 2, *supra* note 42, at 113, App. C.
[58] *Id.* at 58.
[59] *Id.* at 58–60.
[60] BH-CONNECT Approval Letter, *supra* note 1, at 52, Special Terms and Conditions.
[61] CS Policy Guide Vol. 2, *supra* note 42, at 63.

[62] *Id.* at 64–65.
[63] *Id.* at 65.
[64] *Id.* at 67–69.
[65] *Id.* at 67–68.
[66] Cal. Dep't Health Care Servs., Transitional Rent Payment Methodology 3 (Oct. 2025), https://www.dhcs.ca.gov/services/Documents/DirectedPymts/Transitional-Rent-Payment-Methodology.pdf (hereinafter "Transitional Rent Payment Methodology").
[67] *Id.* at 1.
[68] *Id.* at 3.
[69] *Id.*; *see* HUD, FY 2025 SAFMR Lookup System, https://www.huduser.gov/portal/datasets/fmr/fmrs/FY2025_code/select_Geography_sa.odn (last visited Feb. 4, 2026).
[70] Transitional Rent Payment Methodology, *supra* note 66, at 6.
[71] *Id.* at 6–7.
[72] CS Policy Guide Vol. 2, *supra* note 42, at 61.
[73] BH-CONNECT Approval Letter, *supra* note 1, at 5; Cal. Dep't Health Care Servs., Behavioral Health Information Notice No. 25-041 at 2 (Nov. 25, 2025), https://www.dhcs.ca.gov/Documents/BHIN-25-041-Community-Transition-In-Reach-Services.pdf [hereinafter BHIN No. 25-041].
[74] BH-CONNECT Approval Letter, *supra* note 1, at 5; BHIN No. 25-041, *supra* note 73, at 2.
[75] BHIN No. 25-041, *supra* note 73, at 3.
[76] *Id.* at 4.
[77] *Id.* at 2.
[78] *Id.* at 5.
[79] When there is a shortage of occupational therapists in the county and if the BHP describes how the Community Transition Teams will still be able to effectively deliver In-Reach Services, DHCS may exempt BHPs from the requirement to include an occupational therapist as part of the team. This exemption may last up to 12 months. *Id.* at 10.
[80] *Id.* at 11.