

## FAQs: BH CONNECT ACT

DHCS resource: [BH CONNECT FAQs](#)

- **How will ACT/FACT bill for services prior to Authorization?**

Per [BHIN 23-068](#)- while awaiting prior authorization for ACT/FACT, the ACT/FACT team must ensure that the client continues to have access to clinically appropriate and medically necessary services that do not require prior authorization. Once the ACT/FACT referral is sent to the program by the SPOA, providers must ensure that the client is opened to their program either in Requested Status or Enrolled status within **two (2) business days** to allow Optum to enter the ACT/FACT MHP Referral Authorization which will cover the first **21 days** of service, to allow time for providers to engage and enroll client in the ACT/FACT program, complete necessary assessments and provide clinically appropriate and medically necessary services that may be required by the client. Once the provider has completed assessments and determined that the client meets criteria for ongoing ACT/FACT level of services, the provider must submit the Prior Authorization request no later than 14 days from opening client, prior to the expiration of the MHP ACT/FACT Referral Authorization. Any services provided outside of the date range covered by an authorization cannot be included toward the bundled rate requirements.

- **Authorization: If a client moves in and out of qualifying for ACT/FACT services during the 6-month authorization period, should the program simply adjust billing accordingly (switching to ICM or FFS Outpatient), or must this change be reported to Optum?**

When the client no longer meets criteria for ACT/FACT, their enrollment would transition to a lower level of care. Discharging the client from ACT/FACT will automatically end the ACT/FACT authorization. A new authorization would need to be requested when the client is determined to meet criteria for ACT/FACT and return to ACT/FACT level of services.

- **Can services provided while a client is in custody/incarcerated be claimed as part of the bundled rate?**

No, services cannot be claimed under the ACT/FACT bundled rate. The primary Medi-Cal services available to individuals while incarcerated are the targeted pre-release services authorized under the CalAIM Justice-Involved Initiative (which can be provided in the 90 days prior to release). These include (but are not limited to) reentry care management services and behavioral health clinical consultation services. Through these pre-release services, an individual could be assessed and linked to an ACT or FACT team for post-release care. (ref: BH-CONNECT Team, DHCS)



- **What services can be claimed as the bundled rate when a client or a new referral is in an inpatient or residential setting?**

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

Like clients in inpatient hospital settings, clients who are in residential treatment settings may continue to receive ACT/FACT services from their ACT/FACT team. BHPs may claim the full ACT/FACT rate during the month of a client's admission or discharge to the residential treatment setting. If the client is in the residential treatment setting for the entirety of a month, the BHP may only claim the partial rate.

- **Clarify the difference between Flex Funds and Participant Assistant Funds**

Flex funds can be used for costs not directly connected to housing or obtaining housing, this includes transportation, food resources, medication, copays, clothing, and documents (ID, immigration). The purpose of Participant Assistant Funds is to remove practical barriers for people with behavioral health needs who are homeless or at risk of homelessness, supporting their ability to achieve immediate and stable housing placement. Use of Participant Assistance funds must follow DHCS BHSAs requirements outlined in the BHSAs County Policy Manual [7. BHSAs Components and Requirements](#) (C 9.4.2) and Participant Assistance Funds FAQ;

- **Can ACT/FACT services be provided by Telehealth?**

Yes, however, face-to-face (in person) contacts between a client and their ACT/FACT team are an essential component of the evidence-based model. In order to claim the full monthly bundled rate for ACT, at least four (4) contacts with the client must be conducted face-to-face. To claim the partial bundled rate for ACT/FACT, at least three (3) contacts with the client must be conducted face-to-face. Telehealth services do not meet the definition for a face-to-face in-person service. Additional contacts with the client and/or a collateral may be conducted via telehealth if clinically indicated.

**Currently in SmartCare, there is not a service indicator for "provided to" like there was in Cerner. Is there consideration if something will be added to SmartCare such as a "provided to" service indicator or perhaps a service selection of "collateral" for mode of delivery so that we are able to differentiate collateral services from direct client services? We know about the new caretaker procedure codes, but these do not meet the need as only certain types of contacts count under the caretaker procedure code and only certain credentials are able to use those codes.** CalMHSA is reviewing options to address the ability to differentiate collateral contacts from client contacts in the service note/service details, however there is no definitive timeline currently.

Providers have two options when providing a collateral service:



- Select the appropriate telehealth option from the Location field drop-down and the ACT/FACT bundled rate MOD **OR**
- Utilize the most appropriate Caregiver procedure code that supports the service provided as allowable by their credential.

When providing a telehealth service with client, providers should select the appropriate telehealth option from the Location field dropdown, and the ACT/FACT bundled rate MOD.

- **What is the role of the ACT/FACT team when a client or new referral is admitted to an inpatient setting?**

Continuity with a client’s ACT/FACT team is essential when a client or new referral is admitted to a short-term inpatient stay. Whenever possible, ACT/FACT 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/FACT clients. When a client or new referral is admitted to an inpatient setting, ACT/FACT teams are well positioned to conduct activities that may include, but are not limited to:

- Help to familiarize the inpatient hospital physician/treatment team with the client’s care plan, including their medication regimen;
- Advocate for and support the client during their hospital stay;
- Communicate and coordinate with family members or other collaterals;
- Work with the inpatient hospital discharge staff to help formulate the client’s discharge plan; and
- Support the client 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 follow-up care needed to help decrease the likelihood of readmission to the hospital.

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

- **What is the role of the ACT/FACT team when a client or new referral is admitted to a residential setting?**

Clients in residential treatment settings also benefit from continued contact with an ACT/FACT team, particularly during a client’s transition from the residential treatment setting back into the community. Like clients in inpatient hospital settings, clients who are in residential treatment settings may continue to receive ACT/FACT services from their ACT/FACT team. BHPs may claim the full ACT/FACT rate during the month of a client’s admission or discharge to the residential treatment setting. If the client is in the residential treatment setting for the entirety of a month, the BHP may only claim the partial rate.

