CalAIM Behavioral Health: Preliminary Implementation Feedback Report

February 26, 2024

Contents

Executive Summary

The Department of Health Care Services (DHCS)'s *California Advancing and Innovating Medi-Cal (CalAIM) Behavioral Health: Preliminary Implementation Feedback Report* assesses the feedback and perspectives provided by implementation partners and key stakeholders regarding several CalAIM Behavioral Health policies and initiatives that went live in 2022 and 2023: Access Criteria for Specialty Mental Health Services, No Wrong Door for Mental Health Services, the Screening and Transition of Care Tools for Medi-Cal Mental Health Services (Screening and Transition of Care Tools), and Medi-Cal Peer Support Services.

To develop this report, DHCS primarily collected qualitative data to inform future DHCS policy guidance, training, and technical assistance. Data sources include:

- Three statewide surveys:
    - One targeting Medi-Cal Managed Care Plans (MCPs)
    - One targeting county Mental Health Plans (MHPs), and
    - One targeting MHPs and substance use disorder plans (collectively, Behavioral Health Plans (BHPs)) that opted to implement Medi-Cal Peer Support Services.[1]
- Targeted deep-dive interviews with three MCPs and three MHPs.
- Targeted deep-dive interviews with one consumer group and two provider organizations.
- California Mental Health Services Authority (CalMHSA) Peer Support Specialist certification data.[2]
- Informal stakeholder feedback received through official DHCS mailboxes and technical assistance activities.

In future reviews, DHCS plans to conduct targeted data analytics to assess the impact of these CalAIM behavioral health policies and initiatives on member access to care and service utilization.

CalAIM Behavioral Health Preliminary Implementation Feedback work is distinct from routine DHCS compliance and monitoring activities and focuses on program improvement during CalAIM implementation.

[1] Collectively, county mental health and substance use disorder plans and Medi-Cal managed care plans are referred to as "health plans or "plans."

[2] Quantitative data source.

This report highlights key themes in initial implementation through qualitative input, including both overarching and initiative-specific successes and challenges. Most MCPs and MHPs report that the greatest successes of the CalAIM Behavioral Health policies and initiatives include improving coordination across delivery systems and supporting members by providing better and faster access to care. Areas for improvement include suggestions to improve technical assistance delivery, such as by providing more touchpoints and faster responses from DHCS to stakeholder questions to support implementation in real time. DHCS also received significant feedback on the functionality of the Screening Tools and workload associated with the use of the Transition of Care Tools, as well as general feedback that many MCPs and MHPs are struggling with the pace of CalAIM implementation as they face ongoing workforce challenges.

Introduction

Background

With the implementation of the CalAIM initiative, DHCS aims to improve the quality of life and health outcomes of the Medi-Cal population through broad delivery system, program, and payment reform across the Medi-Cal program. This report focuses on several intersecting CalAIM behavioral health policies and initiatives implemented in 2022 and 2023, including the Access Criteria for Specialty Mental Health Services, No Wrong Door for Mental Health Services, Screening and Transition of Care Tools, and Medi-Cal Peer Support Services benefit and Medi-Cal Peer Support Specialist certification implementation.

Overview

Access Criteria for Specialty Mental Health Services (Access Criteria) and the definition of medical necessity were updated through BHIN 21-073 and went into effect January 1, 2022. The new access criteria clarify the circumstances in which MHPs must provide specialty mental health services (SMHS) to adult and youth Medi-Cal members. The access criteria for non-specialty mental health services (NSMHS) and MCP responsibilities for delivery of NSMHS are outlined in APL 22-006, released in March 2022.

The No Wrong Door for Mental Health Services policy (No Wrong Door) outlines responsibilities of MCPs and MHPs to ensure that Medi-Cal members receive timely

mental health services without delay regardless of the delivery system where they seek care, and that members are able to maintain treatment relationships with trusted providers without interruption. The No Wrong Door policy clarifies that services are covered and reimbursable during the assessment period even if it is eventually determined that a member does not meet the access criteria for a given delivery system. No Wrong Door also clarifies that services are covered and reimbursable when they are provided concurrently (e.g., a member can receive NSMHS and SMHS if the services are coordinated and not duplicative). No Wrong Door also clarifies a longstanding policy that SMHS are covered when a member has a co-occurring substance use disorder. The No Wrong Door policy was communicated through BHIN 22-011 and APL 22-005 and went into effect July 1, 2022.

The Screening and Transition of Care Tools for Medi-Cal Mental Health Services (Screening and Transition of Care Tools) are a set of standardized tools that support interactions between MCPs, MHPs, and Medi-Cal members. The Screening Tools help determine the appropriate delivery system for adult and youth Medi-Cal members who are not currently receiving mental health services when they contact their MCP or MHP seeking mental health services. The Transition of Care Tool supports timely and coordinated care when a member's services are transitioned from one delivery system to the other or adding a service from the other delivery system. MCPs and MHPs must administer Screening Tools when members initially contact the MCP or MHP to seek mental health services and use Transition of Care Tools for member transitions between the MCP and MHP.

The Screening and Transition of care Tools and policies were published via BHIN 22-065 and APL 22-028 and went into effect January 1, 2023. DHCS developed the tools over the course of a two year period that included extensive clinical consultation and stakeholder engagement, including consultation with the RAND Corporation (RAND), who conducted a nation-wide analysis of state and validated clinical instruments and provided a conceptual framework and recommendations to inform development of the Youth Screening Tool; two multisectoral working groups to inform tool development

and testing process;[3] beta testing to refine the tools;[4] pilot testing to ensure statewide applicability;[5] field testing to identify issues following revisions to the tools;[6] and several public comment periods to solicit additional feedback from stakeholders.[7]

The Medi-Cal Peer Support Services benefit establishes Medi-Cal Peer Support Specialists as a unique provider type and Peer Support Services as a Medi-Cal benefit. Pursuant to Senate Bill 803, DHCS also developed guidelines for Medi-Cal Peer Support Specialist Certification programs. Guidance for certification programs and BHPs implementing the benefit is posted on the Peer Support Services website. Beginning July 1, 2022, BHPs are able to cover Medi-Cal Peer Support Services through SMHS and/or Drug Medi-Cal/Drug Medi-Cal Organized Delivery Systems (DMC/DMC-ODS).

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[3] DHCS convened two working groups to inform tool development and process. The Small Working Group, comprised of MCP and MHP clinical leadership and representatives from key behavioral health associations and advocacy organizations, met regularly from February 2021 to November 2022 to support drafting and refinement of the tools prior to and following each testing period. The Large Working Group participated in development via targeted written comment periods and stakeholder convenings to ensure that a broad range of perspectives were included in the development process. Working Group rosters can be found on the DHCS website: https://www.dhcs.ca.gov/Documents/Public-Screening-and-Transition-Tools-Roster-2-4-22.pdf.

[4] Adult beta testing was conducted from September 7, 2021, to October 8, 2021, by one MCP-MHP dyad serving the same county. During adult beta testing, the Adult Screening Tool was administered 467 times, and the Transition of Care Tool was completed 36 times. Youth beta testing was conducted from February 22, 2022, to March 18, 2022, by one MCP-MHP dyad serving the same county. During youth beta testing, the Youth Screening Tool was administered 225 times, and the Transition of Care Tool was completed 28 times. Results from adult and youth beta testing are available on the DHCS website: https://www.dhcs.ca.gov/Pages/Screening-and-Transition-of-Care-Tools-for-Medi-Cal-Mental-Health-Services.aspx

[5] Adult pilot testing was conducted from March 1, 2022, to May 31, 2022, by four MCP-MHP dyads. During adult pilot testing, the Adult Screening Tool was administered 897 times, and the Transition of Care Tool was completed 26 times. Youth pilot testing was conducted from June 20, 2022, to September 26, 2022, by eight MCP-MHP dyads. During youth pilot testing, the Youth Screening Tool was administered 1,960 times, and the Transition of Care Tool was completed 112 times. Results from adult and youth pilot testing are available on the DHCS website: https://www.dhcs.ca.gov/Pages/Screening-and-Transition-of-Care-Tools-for-Medi-Cal-Mental-Health-Services.aspx.

[6] Following pilot testing, the Adult Screening Tool scoring methodology was adjusted. Additional field testing was conducted from September 6, 2022, to October 3, 2022 to pilot the new methodology by two MCP-MHP dyads. During field testing, the Adult Screening Tool was administered 111 times. Results from adult field testing are available on the DHCS website: https://www.dhcs.ca.gov/Documents/STT-Public-Adult-Field-Testing-Results-Summary-11-14-22.pdf.

[7] The Adult and Youth Screening and Transition Tools and associated guidance were released for public comment in April 2022 (youth tools only), July 2022 (adult tools and draft APL/BHIN), and October 2022 (adult and youth tools and draft APL/BHIN). During these periods, a total of 459 comments were received from 31 organizations. Draft tools were released to members of the Small and Large Working Groups for feedback three times prior to public comment.

To monitor implementation and early performance of these policies, DHCS assessed MCPs' and MHPs' experiences, whether the policies are meeting their primary objectives, and how they are impacting Medi-Cal members. DHCS also sought to identify lessons learned, outstanding questions, and opportunities to provide technical assistance relating to implementation of the policies.

Data Collection and Analysis

Surveys

DHCS fielded web-based surveys to all MCPs and MHPs during August and September of 2023. Questions assessed implementation approach and status, including identifying key challenges and technical assistance needs, and perspectives on how well the initiatives were meeting primary objectives. This survey was completed by 20 of 21 MCPs (95% completion rate) and 52 of 56 MHPs (93% completion rate).

DHCS separately fielded a Medi-Cal Peer Support Services-focused survey to all Medi-Cal Peer Support Services opt-in BHPs in October 2023. The survey questions focused on implementation experiences to date, BHP efforts to build their Medi-Cal Peer Support Specialist networks, and Medi-Cal member's and Peer Support Specialists' experiences with implementation. The survey was completed by 40 of 50 Medi-Cal Peer Support Services opt-in BHPs (80% completion rate).

Interviews

The surveys were followed by in-depth interviews with three MCPs, three MHPs, one consumer group, and two provider organizations (including a peer-run organization) between October and December 2023. All interviews were conducted via Zoom and were facilitated by DHCS staff. Interviews were semi-structured using interview protocols that included a set of standardized questions and were tailored to include questions specific to the entity being interviewed. To promote open discussion on a range of topics, interviews were conducted confidentially.

Other Data Sources

DHCS validated survey and interview findings against approximately 800 stakeholder questions and comments submitted from 2022 through 2023 to two DHCS electronic mailboxes dedicated to CalAIM behavioral health policy initiatives, and during public comment periods, webinars, and other technical assistance forums. Finally, DHCS reviewed Medi-Cal Peer Support Services certification data to assess the implementation of Medi-Cal Peer Support Services.

Table 1: Summary of Submitted Stakeholder Comments by Initiative

Initiative	# Comments	# Organizations
Screening and Transition of Care Tools	459	31
No Wrong Door for Mental Health Services	186	47
Medi-Cal Peer Support Services	81	8
Access Criteria for Specialty Mental Health Services	61	8

As noted above, DHCS intends to conduct future quantitative analyses of Medi-Cal claims to assess the impact of CalAIM behavioral health policies on access, service utilization, and member outcomes.

Findings

This report presents overall findings and key takeaways related to implementation of all policies and initiatives, followed by in-depth analysis of each policy and initiative. Findings are organized by thematic area into key successes and challenges identified by stakeholders, followed by a summary of feedback on the thematic area overall.

Overall Findings and Key Takeaways

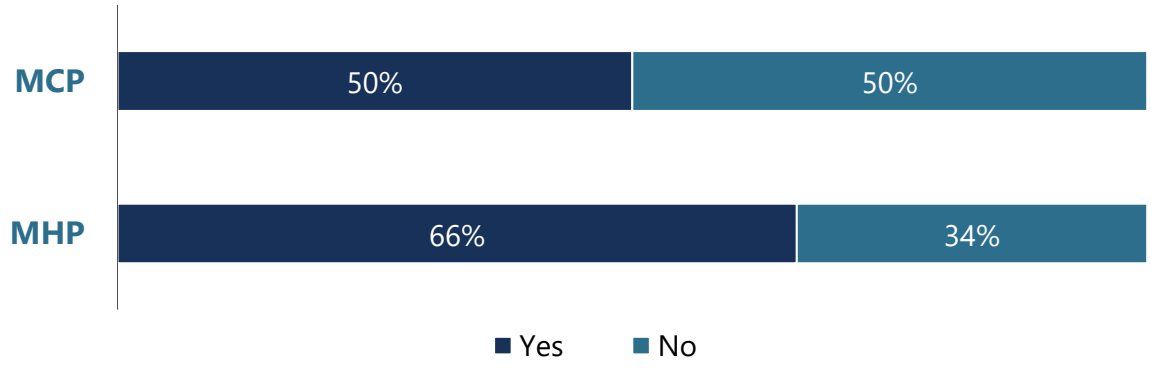
Several themes emerged related to all initiatives including the impact of policies on barriers to care, cross-delivery system coordination, and overall administrative burden, which are discussed in the following sections.

Impact on Access to Care

MCPs and MHPs were asked whether the implementation of these initiatives reduce barriers to care for Medi-Cal Members. While 66% of MHPs felt that the initiatives reduce barriers to care, MCPs were divided (Figure 1). Among MCPs and MHPs who did not report reduced barriers to care, several noted that there are opportunities to improve referral coordination processes. Additionally, MCPs and MHPs reported the Screening Tools can add unintended complexity to the process of seeking care for members.

Figure 1: Are Policies Resulting in Fewer Barriers to Care for Medi-Cal Members?

Q3 2023 Access Criteria, No Wrong Door, and Screening and Transition of Care Tools



Source: *Year 1 MHP & MCP Surveys (n=69), August-September 2023*.
Note: Graphic represents responses to question; "Is implementation of No Wrong Door and Access Criteria and use of the Screening and Transition of Care Tools resulting in fewer barriers to care for Medi-Cal members?". Three MHP responses were recorded as N/A and omitted from analysis. N/A Responses reflected instances where MHPs had unique contracting arrangements or insufficient data to provide a yes or no response.

Generally, MCPs and MHPs report that the policies are reducing barriers to care by:

- Increasing access to care for youth.
- Increasing speed of member engagement in services and treatment.
- Facilitating smoother transitions and connections to services for members in crisis.

MCP and MHP survey and interview results reflected a disparity in views across the different delivery systems: in interviews, MHPs tended to point to ongoing MHP workforce capacity issues (which the initiatives did not address) as key barriers to care, and also reported more administrative burden (particularly related to the new Screening Tools), while MCPs primarily attributed the lack of reduction of barriers to implementation of the Screening and Transition of Care Tools. Both MCPs and MHPs shared that not enough time has passed to understand the impact of all initiatives on member access overall, as they continue to spend significant time designing and revising workflows, training staff, and coordinating between delivery systems to improve implementation of these policies.

Remaining opportunities for performance improvement include strengthening cross-delivery system coordination, gathering data and conducting further analysis on MCP and MHP concerns that the screening tools do not consistently refer members to the most appropriate system of care and identifying potential improvement strategies, and expanding access to care through MCP and MHP provider network expansion, which is outside the scope of the CalAIM Behavioral Health initiatives covered in this report.

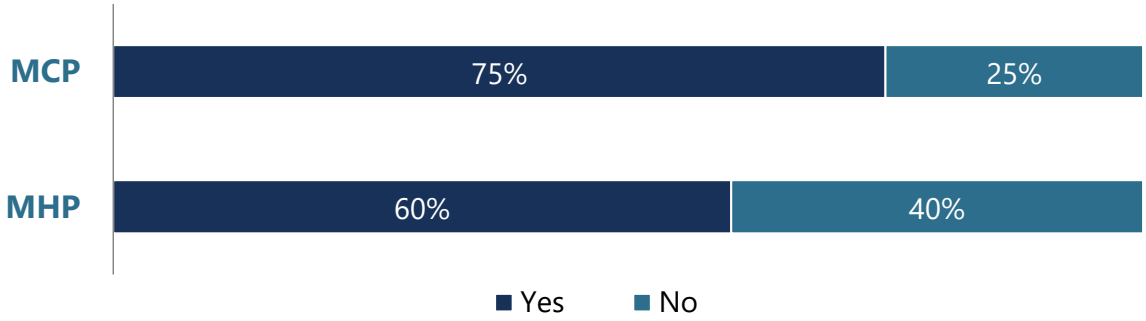
Impact on Delivery System Coordination: Differing MCP and MHP Perspectives

A majority of MCPs (75%) reported that the policies are fostering improved coordination between the two mental health service delivery systems (i.e., MCPs and MHPs), while only 60% of MHPs reported the same (Figure 2). In surveys, MCPs and MHPs attributed increased coordination to improved information sharing, referral tracking workflows, and alignment between No Wrong Door and the Screening and Transition of Care Tools. However, more MHPs reported that work is still needed to improve alignment, citing workflow development challenges as the biggest barriers to improved coordination. In contrast, most of the MCPs who did not report improved coordination stated that this was because they had already established good coordination with their MHP partners.[8]

[8] See the Experiences with Policy Implementation and Administration section of this report for further discussion of cross-system coordination.

Figure 2: Are Policies Fostering Improved Cross-System Coordination?

Q3 2023 Access Criteria, No Wrong Door, and Screening and Transition of Care Tools



Source: *Year 1 MHP & MCP Surveys (n=65), August-September 2023.*
Note: Graphic represents responses to question; "Is implementation of Access Criteria, No Wrong Door, and Screening and Transition Tools fostering improved coordination with the MCP(s) in the other delivery system?". Seven MHP responses were recorded as N/A and omitted from analysis. N/A Responses reflected instances where the plans had unique contracting arrangements, insufficient data to provide a yes or no response, or determined question did not apply to their situation given existing positive relationships with MCPs.

Research conducted by the California Health Care Foundation (CHCF)[9] also uncovered disparate MCP and MHP perceptions around improved coordination, demonstrating that work is needed to address the disparity between the MCP and MHP experience with implementation. Coordination is heavily dependent on strong agreements, workflows, and policies and procedures between MCPs and MHPs, which are discussed in more detail below. The revised Memoranda of Understanding (MOU) guidance for MCPs and MHPs[10] released in late 2023 provides a template and information on DHCS' expectations regarding coordination across delivery systems. Specifically, the MOU template outlines the responsibilities and obligations of both MCPs and MHPs to coordinate and facilitate the provision of services to members where they are served by both parties, and requires increased care coordination, coordinated referrals, and processes for exchanging data. The MOU template is designed to facilitate the

[9] Goodwin Simon Strategic Research. "*CHCF. CalAIM Experiences: Implementer Views After 18 Months of Reforms"*, December 5, 2023.
[10] See BHIN 23-056 and APL 23-029.

implementation of effective MCP-MHP referrals, care coordination, and information sharing. The MOUs contain updates for CalAIM initiatives that require effective MCP-MHP referrals, care coordination, and information sharing, including Enhanced Care Management, Community Supports, No Wrong Door, and Screening and Transition of Care Tools.

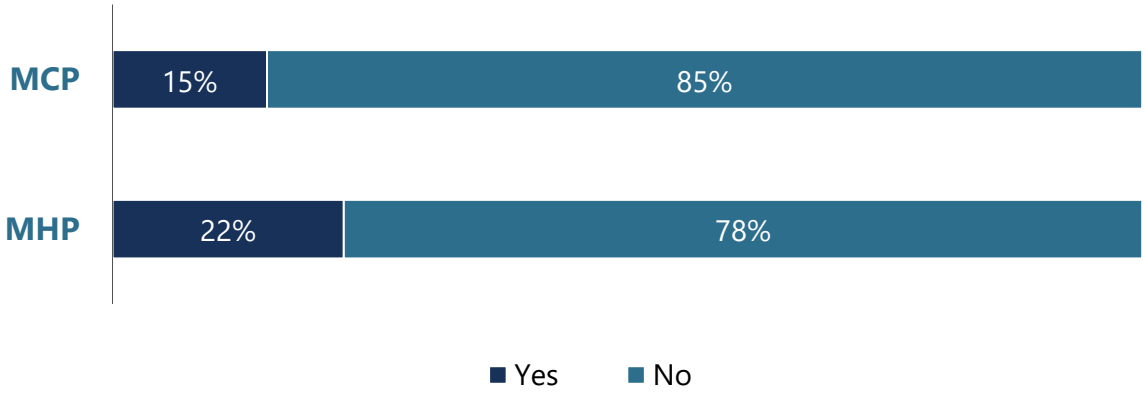
Impact on Administrative Burden

Survey data suggest that the initial year of implementation did not reduce the administrative load on MCPs and MHPs, with 85% of MCPs and 78% of MHPs answering that the policies are not resulting in less daily administrative burden for plans and providers (Figure 3). Respondents provided the following reasons for continued administrative burden: 1) duplication of clinical assessments across delivery systems (following screening and referral), 2) time spent correcting data entry issues, and 3) limited capacity to provide assessments to an increasing number of Medi-Cal members. A majority of the reasons provided were related specifically to Screening and Transition of Care Tools, which are discussed further in the Screening and Transition of Care Tools section below.

MHPs also cited a need for funding to support implementation and noted staffing shortages and capacity as barriers to timely implementation of the new initiatives. MCPs reported administrative challenges related to restrictions around data sharing. During in-depth interviews, MHPs also noted that other CalAIM initiatives, such as Payment Reform, require internal MHP training and implementation capacity, causing a strain on already limited implementation resources.

Figure 3: Are Policies Resulting in Less Daily Administrative Burden?

Q3 2023 Access Criteria, No Wrong Door, and Screening and Transition of Care Tools



Source: *Year 1 MHP & MCP Surveys (n=69), August-September 2023.*
Note: Graphic represents responses to question; "Is implementation of No Wrong Door and Access Criteria and use of the Screening and Transition of Care Tools resulting in fewer barriers to care for Medi-Cal members?". Three MHP responses were recorded as N/A and omitted from analysis. N/A Responses reflected instances where MHPs had unique contracting arrangements or insufficient data to provide a yes or no response.

Successes and Challenges in Implementation of Initiatives

In summary, MCPs and MHPs reported that No Wrong Door, Access Criteria for Specialty Mental Health Services, and the Screening and Transition of Care Tools at least partially achieve their aims to reduce barriers to care and foster improved coordination across delivery systems. However, MCPs and MHPs reported policies do not significantly reduce administrative burden for health plans.

Additional key successes and challenges emerging from MCP and MHP feedback related to overall experience of initiative implementation are outlined below.

Success: MCP and MHP Technical Assistance for Staff and Providers

Most MCP and MHP interviewees developed and led technical assistance efforts, including mandatory staff and provider trainings, on-demand webinars and trainings for provider groups, office hours, and desk guides. Plans also engaged in scenario planning to develop training workflows. These workflows include detailed instructions to assist staff in day-to-day work, expanding beyond their formal implementation policies and procedures, which were sometimes too broad to support staff workflows. MCPs reported offering ongoing provider training on Screening and Transition of Care Tools, which included targeted refreshers on the Transition of Care Tool whenever challenges were flagged by MHP partners.

Success: Collaboration with Third-party Administrators

Several MCPs and MHPs reported success partnering with third-party administrators that operated their call centers. Third parties helped train and coordinate with provider networks, and MCPs and MHPs noted that these partnerships are crucial to policy implementation and helped hardwire new processes for crisis and call center staff.

Challenge: Referral Tracking and Cross-Delivery System Communication

MCPs and MHPs reported that referral tracking and achieving closed loop referrals is a significant challenge. Most plans described a labor-intensive referral tracking process in which they share trackers with their counterparts across delivery systems and manually review them to identify gaps and update referral status. Many plans said that they are conducting ongoing quality improvement activities related to referral tracking workflows and exploring automated processes to track referrals and reconcile discrepancies using electronic records systems. DHCS continues to engage health plans on referral coordination and will be issuing guidance on closed-loop referral requirements in the future.

Additionally, general communication across delivery systems is a challenge for some MCPs and MHPs. One MCP described a range of experiences with MHPs depending on the size and complexity of the county. They noted that their most successful communication is with mid-sized MHPs that have sufficient staffing capacity to answer MCP questions and provide timely services to members, yet are small enough to remain nimble when resolving complex questions.

DHCS has multiple initiatives aimed at facilitating and supporting data exchange and consent management between MHPs and MCPs including, CalAIM Behavioral Health

Quality Improvement Program (BHQIP); the CalAIM Authorization to Share Confidential Medi-Cal Information (ASCMI) Pilot; and CalAIM Data Sharing Authorization Guidance. These initiatives are not included in the analysis for this report but are further described in the "Experiences With Policy Implementation and Administration" section.

Challenge: Workforce and Provider Network

Many MHPs reported ongoing workforce challenges, including a lack of providers and MHP staff. This created challenges with initiative implementation and timely delivery of services. Some plans also reported organizational lag operationalizing the policies and had minimal feedback to share on each of the initiatives at the time of the surveys.

Access Criteria for Specialty Mental Health Services

Success: Increased Member Access

Surveys and interviews demonstrated that No Wrong Door and the updated access criteria increase access to SMHS. MHPs discussed receiving significant positive feedback from providers about the criteria and reported satisfaction with the increased access to services they are able to provide members.

Success: Consistency and Alignment with Existing Efforts

MHPs also noted that training on the access criteria helped to support consistency and shared language in their system. This allowed for a more defined process and less variance upon the integration of the access criteria into their EHRs. MHPs also noted that the updated access criteria complement pre-CalAIM efforts to ensure members receive the appropriate level of services or are referred to the services that will best meet their needs.

Challenge: Building Capacity and Clarifying Access Criteria For Children and Youth

Several MHPs discussed the impact of the updated access criteria for children and youth on organizational capacity; MHPs restructured programs and staff as they prepared to accommodate newly eligible children and youth in SMHS. Several MHPs reported uncertainty about how to interpret the broadened access criteria for children and youth, specifically about how to interpret levels of child welfare and juvenile justice system involvement for youth. They expressed a desire for additional nuance in the criteria to help ensure that they implement the policies in alignment with DHCS' intent.

Conclusion: Access Criteria

Overall, MHPs gave positive feedback on the updated access criteria, noting that the criteria support standardization and expand access to SMHS for members. Some MHPs were concerned that the updated access criteria could increase the volume of members seeking SMHS services, especially for children and youth, though these concerns were anecdotal and have not yet been verified through SMHS claims analysis.

No Wrong Door

Success: Improved Coordination and Faster Service Provision

Plans reported increased MCP-MHP coordination after the implementation of No Wrong Door. Further, they reported the No Wrong Door initiative reinforces existing plan-level "no wrong door" policies by allowing for claiming throughout the assessment period consistent with the policy described in the No Wrong Door for Mental Health Services Policy guidance[11]. Plans also reported that these changes help de-stigmatize co-occurring treatment among their provider network, allow providers to focus on quality of care, create more capacity for providers to address members' identified social needs during the assessment timeframe, and link members to case management and other appropriate supportive services prior to obtaining a definitive diagnosis.

> **"The impact of No Wrong Door has been entirely positive… It's really improved access and made it significantly easier for members to get services."**
> - MCP

Challenge: Coordination and Implementation

Plans reported few policy-related challenges on No Wrong Door implementation. A few plans reported issues connecting and coordinating with partners in the other mental health delivery system on policy and procedure and workflow updates.

Conclusion: No Wrong Door

Overall, MCP and MHP feedback indicated smooth implementation experiences for No Wrong Door. DHCS continues to monitor MCPs and MHPs' ongoing implementation compliance.

[11] Refer to BHIN 22-011 for more information.

Screening and Transition of Care Tools

Success: Increased Clinical Efficiency and Standardization

Several MHPs reported an increase in clinical efficiency and streamlined processes after building the Screening and Transition of Care Tools into their EHRs. Some MCPs noted that standardized tools increases consistency in the application of screenings and in the type of information exchanged between delivery systems.

> **"Having standard forms cuts down on confusion and ensures the type of information exchanged is consistent."** – MCP

Success: Benefits of Pilot Participation

MCPs and MHPs who participated in DHCS-led Screening and Transition of Care Tools pilots and workgroups noted that early insight into policy and tool development helped them navigate implementation. One MHP reported that greater visibility into the development of the tools provided insights that were helpful in answering provider and staff questions. An MCP noted that piloting the tools helped them understand how implementing the tools would impact capacity and call wait times before statewide implementation.

Success: Transition of Care Tool Gives Insight into Service Delivery

In targeted interviews, one MCP discussed how the Transition of Care Tool helps provide real-time insight in instances when members receive services in both systems of care without having to wait for claims data. This allows the MCP to ensure care coordination and avoid duplication of services during transitions to the MHP or when adding services from the other delivery system (e.g., adding SMHS to the plan of care for a member already receiving NSMHS).

> "***We'd see how [members] are presenting, and we're dealing with family members of adults who are really ill. And we feel bad sending them to the wrong level of care based on what we see vs. the screening score based on if the [Screening Tool] missed something, or that the member answered wrong, or based on what we know from CPS."*** – MHP

Challenge: Adult and Youth Screening Tools (Screening Tools): Lack of Autonomy Making Referrals When Scores Don't Reflect Clinical Observation

Ninety-one percent or more of MCP and MHP implementers surveyed reported that they believe members are being directed to the appropriate delivery system for clinical assessment most of the time or always for the Youth and Adult Screening Tools.[12] However, the most common narrative feedback from MHPs and MCPs was that outputs of the Screening Tools sometimes lead to members being sent to the wrong system of care to meet their needs based on implementer perspective. MCPs and MHPs also reported the Screening Tools could be too sensitive for members with mild to moderate mental health needs and for whom NSMHS would be most appropriate; plans also reported that the Screening Tools can fail to capture contextualizing information about members who would benefit from referrals to SMHS. This concern was echoed by representatives from a pediatric provider association, which noted that the Youth Screening Tool do not capture all salient information about member needs, has not been validated, and has a limited ability to distinguish those who need specialty mental health from those who do not. In interviews, MCPs and MHPs noted that for some individuals, such as those experiencing psychosis, the tools' output is frequently out of alignment with the member's needs, creating undue barriers for members. This discordance also sometimes occurs when family members answer questions on behalf of a youth.

During in-depth interviews, many plan representatives requested the ability for an informed clinician at the plan to "override" a Screening Tool score when they do not agree with the results. This is in line with feedback DHCS has received from stakeholders outside of the performance monitoring effort, but conflicts with feedback from beta and pilot testing conducted in 2022.

Further exploration, data collection, and analysis is needed to understand how often the Screening Tool leads to an incorrect referral. Plans would need to analyze data to identify members who receive services and a full clinical assessment in one delivery system and are referred back to the other delivery system, or otherwise follow up to collect feedback from Medi-Cal members on their experiences seeking care.

[12] During the last round of testing, those administering the Screening Tools felt that the member was referred to the right level of care for assessment 93% of the time for the Youth Screening Tools and 91% of the time for the Adult Screening Tools. Additional results from beta, pilot, and field testing can be found on the Screening and Transition of Care Tools webpage.

Challenge: Screening Tools: Administration

Thirty percent of MCPs and 35% of MHPs surveyed use only clinical staff to administer the Screening Tools. One MHP noted that it is inappropriate for administrative staff with no clinical training to administer the Screening Tools; consequently, the MHP is investing clinician time in administrative activities related to member screening when this time would ideally be spent on care delivery. Notably, the tools were developed and tested to allow for both clinical and non-clinical staff to administer the screening.

Challenge: Transition of Care Tool: Duplication of Effort

The most common challenge noted regarding the Transition of Care Tool was around duplication of effort and double documentation. Some MHPs noted that it would be less duplicative to send member data directly with a referral rather than filling out all of the domains in the Transition of Care Tool. Several plans noted that they established adequate transition documentation and protocols prior to the go-live of the Transition of Care Tool, and new requirements create inefficiencies that did not exist before. DHCS developed the Transition of Care tool to provide a singular and standardized method for sharing critical information to support Medi-Cal members. The new tool requires organizations to modify existing workflows and adopt the new tool.

Challenge: Referral Coordination: Tracking Data and Closing Loops

MCPs and MHPs reported challenges developing referral coordination and follow-up processes and closing referral loops. Many plans discussed ongoing efforts to improve workflows for sharing tracking logs, which is especially burdensome for MHPs and MCPs working with multiple partners in the other delivery system. Seventy-five percent of MHPs reported integrating the tools into their EHRs, while only 35% of MCPs reported the same, instead relying on more manual processes to share the tools with MHPs. To address these challenges, MCPs and MHPs are identifying clear points of contact for coordination, using health information exchanges and developing data sharing dashboards, using MOUs to implement data sharing frameworks, and building Screening and Transition of Care Tool workflows into their EHRs. However, building the workflows into EHRs reportedly requires a large time investment and presents challenges due to data sharing restrictions.

Conclusion: Screening and Transition of Care Tools

MCP and MHP feedback on the Screening and Transition of Care Tools was mixed, but overall, more positive than expected, given the feedback the implementation team received during the initiative's first year. Challenges raised around the length of the Transition of Care Tool and potential for duplication of chart information were

surprising, given minimal stakeholder feedback on this topic during the two-year policy development process, which was driven by intensive, sustained MCP and MHP engagement.

In December 2023, DHCS hosted the inaugural MCP/County BH Summit attended by all MCP Chief Executive Officers (CEOs) and County Behavioral Health Directors. In discussions with MCPs and MHPs at the summit, MCPs and MHPs indicate that plans adopted the tools successfully and are taking steps to address challenges with data sharing and referral tracking, while the ability of the Screening Tools to match members to the most appropriate delivery system remains a challenge. As needed, DHCS and health plans may consider further research into the appropriateness of the Screening Tool determinations.

Medi-Cal Peer Support Services

In July of 2022, DHCS launched the Medi-Cal Peer Support Services benefit, providing Medi-Cal members in participating counties with the opportunity to access recovery-oriented, culturally appropriate services within their communities. DHCS established certification program standards, including a curriculum and core competencies for certification. Each participating county is responsible for developing a certification program that aligns with DHCS standards and for ensuring that it is administered appropriately.

While the Peer Support Services benefit is not directly related to the other CalAIM Behavioral Health initiatives discussed in this report, DHCS leveraged the opportunity of the Preliminary Implementation Feedback process to assess early implementation of the Peer Support Services benefit and Peer Support Specialist certification.

Preparing for Implementation

In the lead up to go-live, BHPs prepared to expand their peer workforces. Efforts included funding contracted providers and community-based organizations (CBOs) (including peer-run organizations and other local community groups) to provide non-Medi-Cal peer services,[13] training their existing peer workforce and others interested in becoming certified Medi-Cal Peer Support Specialists, and creating new county Medi-Cal Peer Support Specialist roles. BHPs also made changes to their recruitment processes, hosted Medi-Cal Peer Support Services planning work groups, and developed

[13] Consistent with BHIN 22-055

career ladders to help attract Medi-Cal Peer Support Specialists. Under the Behavioral Health Workforce Development (BHWD) initiative, DHCS funded the Peer Workforce Investment (PWI) which helped to expand, elevate, enhance, and empower BH peer-run organizations throughout California. These organizations, led by individuals with lived experience of having behavioral health challenges, provide invaluable support and services to their communities. The PWI project provides grants of up to $500,000 to established peer-run organizations and has already funded grants to 73 peer-run organizations. These grants help ensure financial stability and broaden access to critical peer support for individuals with behavioral health issues. Through round two funding, PWI will support an additional six new organizations in four counties[14].

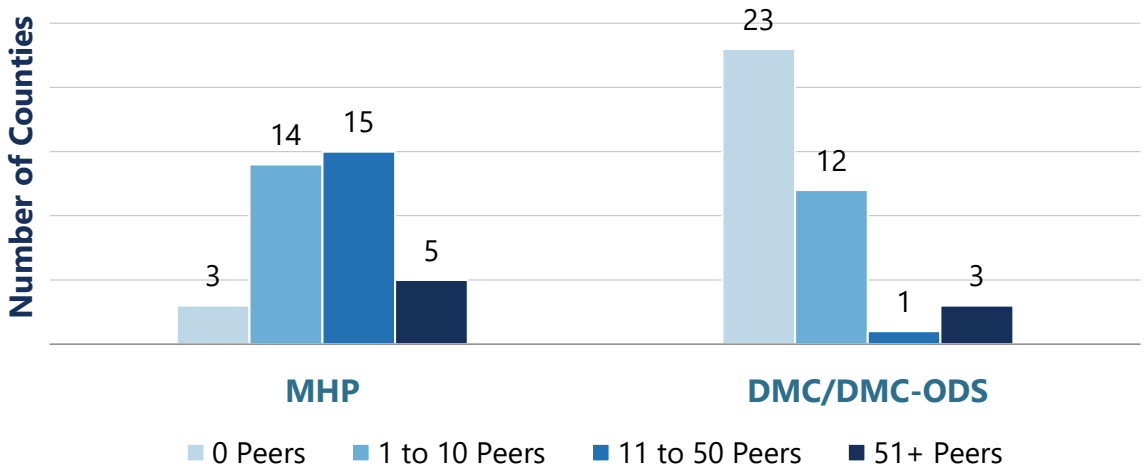
Peers by the Numbers

The Medi-Cal Peer Support Services survey asked implementing partners (BHPs that have opted to cover Medi-Cal Peer Support Specialist services) about their experience with implementation, workforce development, and member and peer feedback on the benefit. The survey solicited information on the number of Medi-Cal Peer Support Specialists in their MHP and DMC/DMC-ODS networks, but some BHPs did not differentiate between certified Medi-Cal Peer Support Specialists and other peer workers, which could include both county staff and contracted providers (Figure 4).

According to the survey, opt-in BHPs have between zero to nearly 400 peer workers in their networks, with an average of 39 and a median of 13 peer workers.[15] Eight percent of BHP respondents reported having no Medi-Cal Peer Support Specialists in their networks. DHCS is engaging counties to learn more about network gaps and options for remediation.

[14] For more information on BHWD and PWI, including award details, please visit the BHWD website.
[15] Calculations were performed using the number of peer workers that counties reported in their survey responses. In instances where the county provided both the total number of peer workers and the number of certified Peer Support Specialists, the number of certified Peer Support Specialists was used.

Figure 4: Number of Peer Workers by Delivery System
MHP and DMC/DMC-ODS Systems, Q4 2023



Source: *Medi-Cal Peer Support Services Survey (n=36), October-November 2023.*
Note: Graphic represents responses to question, "How many Medi-Cal Peer Support Specialists are in your DMC/DMC-ODS/MHP provider networks as of August 31, 2023?". Numbers may include all workers who are considered "peer workers", and not exclusively Medi-Cal Peer Support Specialists. Three MHPs and 1 DMC/DMC-ODS counties did not have available data and were omitted from analysis. Figure shown by count of delivery system reporting given number of peer workers.

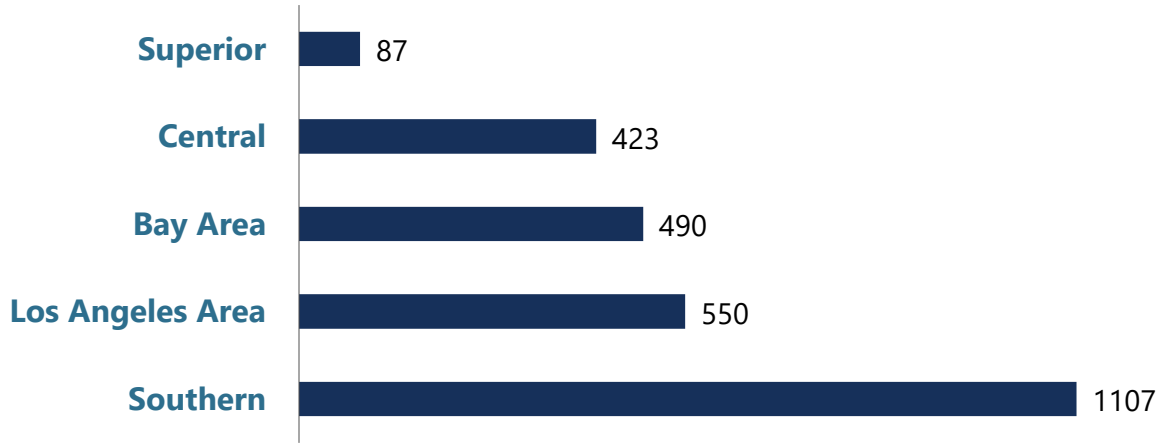
DMC/DMC-ODS plans, which generally serve a smaller member population than MHPs, reported fewer peer workers, with between zero and 68 peers in their networks, an average of seven, and median of zero peer workers. In total, three opt-in MHPs and 23 opt-in DMC/DMC-ODS systems did not have any peer workers in their provider networks when surveyed, indicating BHPs may be encountering delays in developing their provider networks.

Medi-Cal Peer Support Specialist certification data from CalMHSA, the sole Medi-Cal Peer Support Specialist certification program, shows that certifications continue to increase at a steady pace. In total, 1,368 individuals were certified as Medi-Cal Peer Support Specialists in fiscal year (FY) 2022-23, and another 1,173 have been certified to date in FY 2023-24, for a total of 2,541.[16] Figure 5 shows the total number of Medi-Cal Peer Support Specialists certified by region.

[16] See CalMHSA's Peer Certification Dashboard. Data current as of January 31, 2024.

Figure 5: Number of Peer Certifications by Region

Fiscal Year 2022-2023 and 2023-January 2024

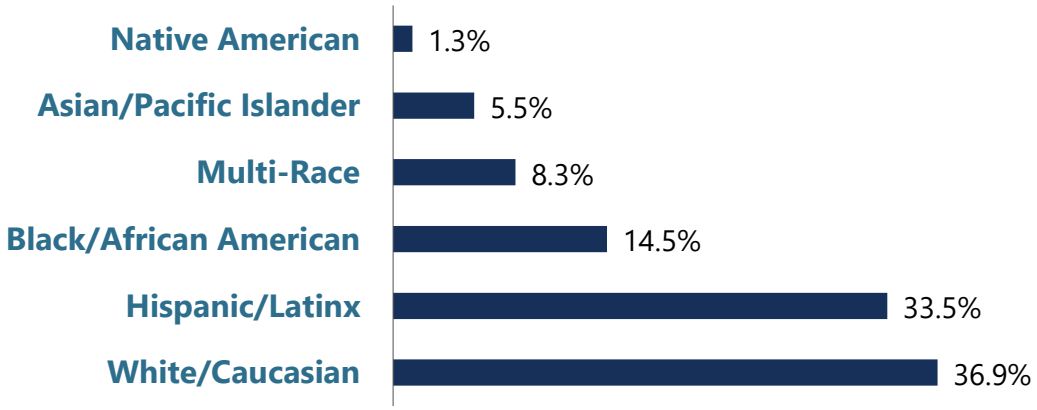


Source: *CalMHSA Peer Certification Program Dashboard | https://www.capeercertification.org/certification-program-data-dashboard/. Data Represented: Fiscal Year 2022-2023 and 2023-January 2024 | Data Downloaded: January 31, 2024.*

Note: Counts represent total number of Medi-Cal Peer Support Services Peers certified in each region. Region categories provided by CalMHSA.

Figure 6: Percent of Certified Medi-Cal Peer Support Specialists by Race/Ethnicity

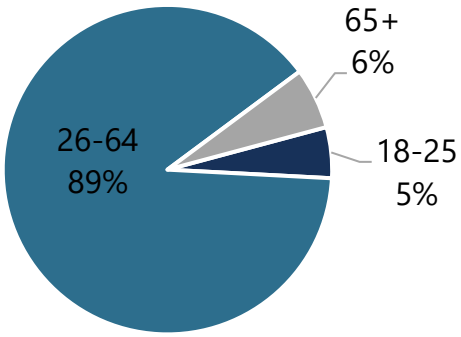
Fiscal Year 2022-2023 and 2023-January 2024



Source: *CalMHSA Peer Certification Program Dashboard | https://www.capeercertification.org/certification-program-data-dashboard/. Data Represented: Fiscal Year 2022-2023 and 2023-January 2024 | Data Downloaded: February 7, 2024.*

Figure 7: Percent of Certified Medi-Cal Peer Support Specialists by Age Group

Fiscal Year 2022-2023 and 2023-January 2024



Source: *CalMHSA Peer Certification Program Dashboard | https://www.capeercertification.org/certification-program-data-dashboard/. Data Represented: Fiscal Year 2022-2023 and 2023-January 2024 | Data Downloaded: February 7, 2024.*

Workforce and Network Development Activities

BHPs are engaged in efforts to grow their network of certified Medi-Cal Peer Support Specialists and ensure that the Medi-Cal Peer Support Specialists in the BHP's network reflects the demographics of the county's clients. Efforts include enhancing recruitment strategies by partnering with peer-run and community organizations to reach diverse populations, surveying staff to understand workforce demographics, and developing pipelines for MHP members to become Medi-Cal Peer Support Specialists. BHPs also reported encouraging or requiring existing peer staff to obtain certification and training in areas of specialization, [17] with many BHPs providing scholarships to fund trainings and certification exams. Additionally, BHPs hire for specific peer roles, such as mobile crisis peers and peers with lived experience in areas of specialization and support contracted provider organizations' peer workforces in obtaining certification. Other BHP efforts include making the necessary changes to EHRs to support claiming for Medi-Cal Peer Support Services, as some BHPs' systems are not able to support claiming under multiple taxonomy codes for the same provider, which is necessary for certified Peer Support Specialists who also provide other Medi-Cal services under other provider types. Nine BHPs reported that they are not conducting any focused activities to ensure that their peer workforce reflected client demographics.

BHP and Peer-Run Organization Challenges

The majority of BHPs surveyed (85%) reported challenges implementing the Medi-Cal Peer Support Services benefit. Figure 6 shows the types of challenges counties reported facing during Peer Support Services implementation. Workforce development challenges include creating Medi-Cal Peer Support Specialist roles, and attracting, certifying, and retaining candidates. BHPs noted that interested peers are deterred by the GED requirement, low Medi-Cal Peer Support Specialist pay compared to other available roles that required comparable investment in training and certification, such as Alcohol and Other Drug Counselor, and issues accessing and completing the certification exam.

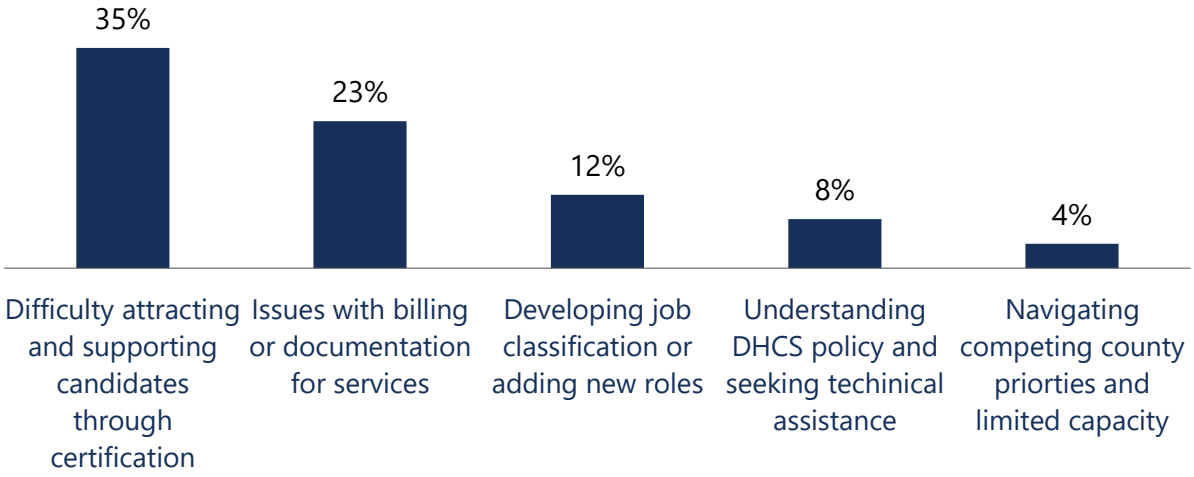
Counties also described challenges with billing and documentation (Figure 6). Specific challenges include configuring the EHRs to bill for the new services, allowing providers to switch between taxonomy codes if providing non-Medi-Cal Peer Support Services, supporting CBOs through obtaining site certification, and understanding what activities

[17] Peer Support Specialists may receive additional training in areas of specialization, including crisis services and homelessness and trainings for forensic (justice involved) and parent, caregiver, and family member peers (see BHIN 22-066).

Medi-Cal Peer Support Specialists can bill for and how to document, code, and claim for Medi-Cal Peer Support Services.

Figure 8: Challenges to County Peer Support Services Implementation

Percent of Counties Experiencing Challenge, Q4 2023



Source: *Medi-Cal Peer Support Services Survey (n=40), October-November 2023*.
Note: Graphic represents responses to question "Have you experienced challenges in implementing the Medi-Cal Peer Support Services benefit since Peer Support Specialist certification became available in fall 2022? If yes, what challenges have you experienced?". Figure shown by percent of opt-in counties reporting.

Peer-run organizations providing peer services reported difficulty obtaining contracts with BHPs, despite receiving financial support through the DHCS Behavioral Health Workforce Development initiative to build capacity to bill for Medi-Cal Peer Support Services.[18] One peer-run organization interviewed expressed concern that BHPs are not aware of the value of community-based peer services in their ability to fill care delivery gaps.

Conclusion: Medi-Cal Peer Support Services

A year and a half into implementation of the Medi-Cal Peer Support Services benefit, BHPs are developing their provider networks and creating internal systems to hire Medi-Cal Peer Support Specialists and bill for Medi-Cal Peer Support Services. Counties are

[18] Reported in interviews, via Peers inbox (Peers@dhcs.ca.gov).

growing their Medi-Cal Peer Support Specialist networks by working with provider partners and developing internal opportunities for peers. Many BHPs reported that attracting, certifying, and retaining Medi-Cal Peer Support Specialists is the biggest challenge, raising the question of if and how they are able to meet demand for Medi-Cal Peer Support Services among Medi-Cal members. DHCS will conduct ongoing monitoring of service delivery through claims data to support DHCS' understanding of how the benefit is reaching members and whether additional technical assistance is needed to support network development.

Impact of Access Criteria, No Wrong Door, Screening and Transition of Care Tools, and Peer Support Services Initiatives on Medi-Cal Members

The following are the key takeaways provided by health plans and provider and consumer organizations engaged in DHCS' Preliminary Implementation Feedback work. Medi-Cal members were not surveyed as part of report development, so perspectives on the impact of the new initiatives on members is limited to impressions provided by the plans, providers, and consumer organizations surveyed and interviewed.

Success: Member Feedback

Some MCPs and MHPs interpreted a lack of negative member feedback as a positive early indicator of the implemented policies. One consumer organization noted that it is more frequently hearing positive feedback from members about the speed at which they are able to get services. Several health plans indicated that providers are also giving positive feedback around the speed at which they can engage members in services, attributing the change to the impact of the No Wrong Door policy.

Challenge: Lack of Personalization and Difficulty Connecting to Care

Several stakeholders raised concerns that the Screening Tools might negatively impact members' experience connecting with services by making it less personalized, since the tools reduce opportunities for human touch between members and providers and may make navigation more complicated. DHCS will need to engage members directly to understand their experience with connecting to services.

Challenge: Referral Coordination

Both MCPs and MHPs reported that challenges coordinating referrals with the other delivery system can negatively impact members. MCPs reported long MHP wait times

and delays in linking members to care due to Screening Tool requirements. MHPs noted that members have difficulty navigating care transitions and accessing providers in the MCP network and raised concerns that the policy changes may contribute to increased member hesitancy to engage with their MHP for services.

Conclusion: Member Impact

Overall, it may be too early to fully assess the impact of the initiatives on members. Initial findings are mixed, with a perception that there is increased access to care and mixed feedback around timely access to services. One consumer organization discussed how the Screening Tool questions create confusion for some members who are not expecting a screening when contacting their health plan about a specific need.

Experiences With Policy Implementation and Administration

To implement the updated policies, most of the MCPs and MHPs interviewed engaged their quality improvement or regulatory compliance teams to review new state guidance, comparing policy changes against their existing policies and procedures and preparing to make updates. Early implementation activities included collaboration with MCP/MHP partners, providers, and delegated entities to discuss updating policies and procedures, workflows, and memoranda of understanding (MOUs).

Leveraging Smaller MHP Teams

Small and medium-sized MHPs are able to take advantage of their size by being adaptable when reacting to implementation challenges. Individuals running small MHP quality departments were also able to streamline implementation by serving as single points of contact for all implementation and quality-related questions and providing staff trainings. One small MHP administrator noted that in the face of workforce challenges, having key administrative staff in place to handle new reporting requirements during initiative ramp-up is key to successful implementation.

Change Management and Communication Strategies

MCPs and MHPs cited the importance of change management to implementation. One MCP noted the importance of repeating key messages about the new initiatives with network providers and MHP partners to ensure an aligned understanding of each entity's role in care delivery, particularly when working across multiple counties. The same MCP also noted that effective engagement across delivery systems requires

significant lead time ahead of implementation to develop a communication strategy. Stakeholders pointed to ongoing change management as key to standing up new data systems, noting that visibility into daily staff processes was helpful in hardwiring the changes.

MCPs and MHPs cited several concerns around added administrative burden related to the new initiatives. Concerns include duplicate assessments across mental health delivery systems, added time spent correcting data entry issues stemming from the Screening and Transition of Care Tools, providing screening and assessments for increased volume of members across both delivery systems, and increased MCP/MHP touchpoints for members navigating unnecessary transitions between the delivery systems.

Workflow Development

Many MHPs reported difficulty with workflow development, including navigating consent management and sharing data directly with MCPs. One large MHP is exploring developing a universal consent form, working with a health information exchange to sequester sensitive member information, and leveraging their EHR to manage the SUD consent and referral process. EHR workflow development in general is also a pain point for many MHPs, though most interviewed noted that they are making progress in standing up their systems.

DHCS has multiple initiatives aimed a facilitating and supporting data exchange and consent management between MCPs and MHPs. These include the CalAIM Behavioral Health Quality Improvement Program (BHQIP), an incentive payment program designed to support counties as they implement CalAIM by funding staffing, technology, infrastructure and more; the CalAIM Authorization to Share Confidential Medi-Cal Information (ASCMI) Pilot, which pilots a new voluntary standard release of information, designed to be securely stored and managed and easily accessible to the member, their providers, health plans, and county agencies; and CalAIM Data Sharing Authorization Guidance released in October 2023, which provides guidance on data privacy and data sharing consent laws, regulations, and rules.

Cross-Delivery System Coordination

MHPs sometimes struggle to identify appropriate contacts to work with at their partner MCPs. One small MHP noted that identifying the correct points of contact at the MCP to discuss workflow development and plan roles and responsibilities is critical to long-term change management and often complicated by turnover across the delivery systems. Other MCPs discussed difficulty finding appropriate contacts to coordinate with on

member care and transitions. This trend also emerged in CHCF's research, where BHPs were 14% more likely to report that they had no point of contact in the other delivery system to assist with challenging transfers or cases.[19]

To facilitate communication and local engagement between MCPs and MHPs, DHCS issued MOU requirements in accordance with the 2024 MCP Contract and APL 23-029. Among other requirements, the MOUs necessitate the MCP and MHP to identify the designated point of contact at each entity to ensure appropriate and ongoing communication.

Conclusion: Policy Implementation and Administration

Overall, MCPs and MHPs reported that policy implementation was relatively straightforward, but hardwiring the changes requires significant resources and internal and external coordination. MHPs tended to report more implementation challenges related to overall organizational capacity, including staffing shortages, and many MCPs and MHPs were continuing to build out their workflows and cross-delivery systems processes well into 2023.

[19] CHCF. CalAIM Experiences: Implementer Views After 18 Months of Reforms

DHCS Technical Assistance and Guidance

Success: Clarity of Technical Assistance

MCPs and MHPs generally had positive feedback about DHCS' technical assistance and guidance on the Screening and Transition of Care Tools, Access Criteria, and No Wrong Door, finding it clear and actionable. MCPs and MHPs are appreciative of opportunities to engage directly with DHCS. MCPs, in particular, appreciated opportunities to ask questions, brainstorm, or provide real-time updates to DHCS during implementation.

Challenge: TA Formats and Delivery

Most MCPs and MHPs interviewed requested that DHCS answer questions more quickly, especially those that came up during MCP and all-county calls. One MHP noted that it is not always clear where to send questions, leading to lost time trying to get questions to the appropriate DHCS division.

Challenge: State Coordination on TA and Guidance Development

Several MCPs and MHPs requested more coordination on guidance from the state to address interconnections in policy across Medi-Cal behavioral health and managed care. One rural MHP reported too much change is happening at the same time, both for MHPs and the state, which leads to confusion about how all the changes relate.

Challenge: Tracking Existing Guidance and TA

During interviews, several MHPs raised questions about policy intersections that DHCS previously addressed through FAQs, such as the intersection between continuity of care policy and No Wrong Door and flexibility in referrals related to implementation of the Screening Tools.[20] Some MHPs were not aware of updates to initiative FAQs, noting challenges tracking all updates made across various FAQ pages. One small MHP interviewed noted though they are aware of DHCS' FAQ updates, they are concerned that the BHINs and FAQs do not always align, and in those cases opt to defer to the appropriate BHIN. DHCS is actively updating FAQs to ensure consistency with applicable guidance.

[20] Screening and Transition of Care Tools FAQ: If a provider (e.g., a primary care physician or school nurse) specifically refers an individual to an MCP for non-specialty mental health services or to an MHP for specialty mental health services based on an understanding of the individual's needs, the MCP/MHP is not required to use the Screening Tools.

Challenge: Specific Requests: Data Sharing, Roles, and Timelines

In addition to broader feedback on DHCS' technical assistance and guidance, MCPs and MHPs had specific suggestions for technical assistance topics, including:

- Requests for greater clarity around roles in care delivery and closed-loop referral timelines
- Data sharing guidance between MCPs and MHPs and TA around data sharing workflows and dashboard development
- Technical assistance tailored to local needs, particularly for small counties

Conclusion: Technical Assistance and Guidance

In both surveys and interviews, MCPs and MHPs demonstrated a range of perspectives around navigating DHCS guidance and technical assistance materials. Though not universal, some plan representatives expressed frustration with the technical assistance and guidance development process, citing short implementation runways and difficulty tracking all the materials DHCS released in 2022 and 2023. Overall, MHPs are concerned with the rapid pace of CalAIM policy changes, the development of new guidance, and the volume of new requirements. CalAIM policy changes, coupled with existing staffing challenges, have forced many to continually reprioritize where to focus their attention.

In general, MHPs also tended to discuss more challenges with implementation than MCPs. This finding tracked with CHCF's research on CalAIM implementation, which found that satisfaction with CalAIM overall tended to be higher among MCPs than MHP behavioral health organizations.[21] Additionally, resources needed by MCPs and MHPs varied, according to CHCF, with MCPs asking for more state support troubleshooting problems and opportunities to learn from peers, and MHPs tending to ask for fewer administrative requirements and more financial resources to support staffing.

Conclusion

DHCS' *CalAIM Behavioral Health: Preliminary Implementation Feedback Report,* which conveys perspectives and feedback regarding MCP and MHP implementation of the Access Criteria for Specialty Mental Health Services, No Wrong Door for Mental Health Services, Screening and Transition of Care Tools for Medi-Cal Mental Health Services, and Medi-Cal Peer Support Services in 2022 and 2023, demonstrates significant strides in implementation of the first round of CalAIM Behavioral Health initiatives. Major successes include the smooth adoption of the Access Criteria and No Wrong Door

[21] CHCF. CalAIM Experiences: Implementer Views After 18 Months of Reforms.

policies. In addition, members, MCPs, and MHPs all reported that the implementation of these policies have improved access to care by removing barriers and expanded the certified Medi-Cal Peer Support Specialist workforce statewide. The implementation of the Screening and Transition of Care Tools represents an opportunity for growth and an area of ongoing work as DHCS continues to assess stakeholder feedback on the Screening Tools and collaborate with health plans on implementation activities and the need for targeted technical assistance.

DHCS will continue to solicit and review feedback and identify opportunities to support implementation and improve and clarify policy guidance associated with the CalAIM Behavioral Health policy initiatives described in this report, including by hosting additional MCP/BHP summits. DHCS is also committed to exploring and analyzing quantitative claims-based service utilization data to inform the need for technical assistance, resource development and/or future policy development. The iterative implementation and continuous quality improvement of CalAIM Behavioral Health policy initiatives are aligned with significant steps DHCS is taking to expand access to care, expand the continuum of community-based behavioral health facilities, invest in a diverse behavioral health workforce, and strengthen access-related monitoring and compliance enforcement for MCPs and MHPs, all of which aim to address the underlying concerns regarding workforce and provider network shortages reflected in this report.

Appendices

Appendix A: Overview of CalAIM Performance Monitoring Data Sources

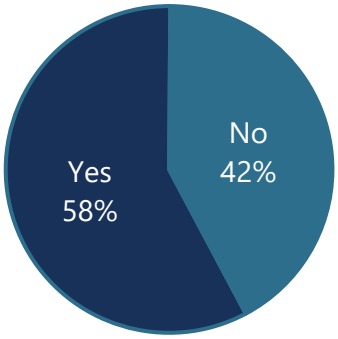
Data Source	Date of Data Collection or Date Range	Stakeholders Included/Consulted
MCP & MHP Surveys	August – September 2023	All non-specialty MCPs and all MHPs.
Medi-Cal Peer Support Services Survey	October – November 2023	All opt-in county behavioral health systems
Interviews with MCPs, MHPs, and consumer groups	October – December 2023	3 MCPs, 3 MHPs, 1 consumer groups, and 2 provider groups[22]
Stakeholder feedback	October 2022 – December 2023	Any/all stakeholders who provided feedback to DHCS Behavioral Health CalAIM inbox and Peers inbox or through technical assistance forums
Medi-Cal Peer Support Specialist certification data	FYs 2022–23 and 2023–24	CalMHSA

[22] To promote open discussion on a range of topics, interviews were conducted confidentially. Only the number and types of interviewees are reported here to maintain confidentiality.

Appendix B: Enhanced Care Management

Though not the primary focus of Year One Preliminary Implementation Feedback work, DHCS also collected feedback from MHPs and MPCs on Enhanced Care Management (ECM) implementation. More than half of all MHPs surveyed are contracted by MCPs to provide ECM (Figure 7). Additionally, 15% of MHPs and 25% of MCPs reported that ECM plays a role in implementation of No Wrong Door and Screening and Transition of Care Tools, mostly through supporting connections to other needed services. More information on the implementation of ECM is covered in DHCS's ECM and Community Supports implementation report[23] and CHCF's research on CalAIM implementation.[24]

Figure 9: MHP Contracting With at Least One MCP to Provide ECM Services, Q3 2023



Source: *Year 1 MCP Survey (n=19), August-September 2023*.
Note: Graphic represents responses to question; "Is your organization currently contracting with at least one entity in the other delivery system to provide Enhanced Care Management (ECM) services?". One MCP responce was recorded

[23] DHCS. Medi-Cal Enhanced Care Management and Community Supports Year One Report
[24] CHCF. CalAIM Experiences: Implementer Views After 18 Months of Reforms

Appendix C: MCP Survey

Survey Purpose

This survey is being conducted as a part of the California Department of Health Care Services' (DHCS) efforts to better understand MCPs' and MHPs' experiences implementing several CalAIM Behavioral Health policy initiatives, including Access Criteria for Specialty Mental Health Services (Access Criteria), No Wrong Door, and Screening and Transition of Care Tools for Medi-Cal Mental Health Services (Screening and Transition Tools). DHCS may follow up with select respondents for virtual interviews in late spring.

This survey is mandatory for all Medi-Cal managed care plans to complete. Please complete all fields. If a field does not apply to your organization's situation, please select or type "N/A." Your responses to survey questions will not impact your entity's compliance standing or result in corrective actions. Results from this survey and following interviews will inform future policy development and technical assistance efforts. A separate, similar survey is being executed with county Mental Health Plans (MHPs).

Instructions

This survey should be completed **once per entity**. Individual(s) most knowledgeable in implementing the initiatives within your plan should inform the answers but only **one** individual should fill out the Survey Monkey form.
If you would prefer to collaborate with internal colleagues on your response, please send the Word version of the survey to relevant individuals and compile all responses in the document before transferring responses into Survey Monkey.

Confidentiality

Responses to this survey will be confidential and DHCS will never share individual MHP or MCP responses. However, DHCS may share aggregate, deidentified survey findings in a summary report to MHPs and MCPs once compiled.
Please direct questions to the CalAIM Behavioral Health inbox at BHCalAIM@dhcs.ca.gov. We kindly ask that you submit the survey by **September 19, 2023.**

Respondent Information

1. Name of your MCP: _____

This survey is focused on the MCP perspective and should be filled out by the individual(s) within the MCP that are most knowledgeable about the MCP's experience implementing No Wrong Door and Screening and Transition Tools. While this survey may be completed by several staff members, to enable follow-up for future interview coordination or survey response clarification, please provide the name of a primary point of contact for your organization.

Name	Title	Department/ Division (if applicable)	Role in Implementation	Email/Contact Info

Questions in reference to both No Wrong Door and Screening and Transition of Care Tools

Please rate the extent to which each of the following **aspects of member access have improved since implementation** of No Wrong Door **and/or** Screening and Transition of Care Tools policy:

2. The rate of improvement of these aspects of **member access**:

	Substantially Worse	Slightly Worse	No Change	Slightly Improved	Substantially Improved	N/A	If possible, please indicate which policy you are referencing to inform your response. Check all that apply.		If you answered 'Slightly Worse' or 'Substantially Worse' for any of the statements above, please explain why.
							STT	NWD	
A member's ability to receive **timely clinical assessment**.									
A member's ability to receive **timely services**.									
A member's ability to receive timely services in the **delivery system(s) most appropriate for their needs**.									

	Substantially Worse	Slightly Worse	No Change	Slightly Improved	Substantially Improved	N/A	If possible, please indicate which policy you are referencing to inform your response. Check all that apply.		If you answered 'Slightly Worse' or 'Substantially Worse' for any of the statements above, please explain why.
							STT	NWD	
A member's ability to **maintain trusted relationships** with providers.									
A member's access to **concurrent, non-duplicative** SMHS and NSMHS.									
A member's ability to access needed **co-occurring treatment for mental health and SUD needs.**									

3. Is implementation of No Wrong Door and use of the Screening and Transition of Care Tools resulting in **fewer barriers to care for your Medi-Cal members**?

☐ Yes
☐ No
☐ N/A

4. If no, why not? (Please indicate if you have data that informs your response)

5. Is implementation of No Wrong Door and use of the Screening and Transition of Care Tools resulting in less daily administrative burden for your county and/or contracted providers?

☐ Yes
☐ No
☐ N/A

6. If no, why not? (Please indicate if you have data that informs your response)

7. Is implementation of No Wrong Door and/or Screening and Transition Tools **fostering improved coordination** with the MHP(s) in the other delivery system? (Examples may include coordination related to administrative or operational procedures (e.g., MOUs, contracts, workflows) or the care related to individual members.)

☐ Yes
☐ No
☐ N/A

8. Please explain why coordination has or has not improved.

9. Please describe whether and how MHP/MCP Dispute Resolution processes (as outlined in APL 21-013) played a role in implementation of No Wrong Door and/or Screening and Transition of Care Tools.

10. What **Technical Assistance or resources**, if any, would help improve implementation for No Wrong Door and/or Screening and Transition Tools?

11. Please describe **major successes** related to implementation of No Wrong Door and Screening and Transition of Care Tools. (Examples might include improved access to care, improved MCP-MHP coordination, refining parameters for episode of care, updating electronic health record configuration, utilization of a universal Release of Information, or others.)

12. Please describe **major barriers** related to implementation of No Wrong Door and Screening and Transition of Care Tools.

13. Please provide **any other comments** related to No Wrong Door and/or Screening and Transition of Care Tools policy implementation (optional).

No Wrong Door

14. Please rate the extent to which each of the following have **improved since implementation** of the No Wrong Door policy:

	Substantially Worse	Slightly Worse	No Change	Slightly Improved	Substantially Improved	N/A	If you answered 'Slightly Worse' or 'Substantially Worse' for any of the statements above, please explain why.
The ability for MCPs to provide a Medi-Cal member **service prior to a definitive diagnosis**							
The ability for Medi-Cal members to **maintain relationships** with trusted providers							
Clarity regarding the **responsibilities of the MHP and MCP** related to providing services prior to definitive diagnosis							

15. During the initial implementation of No Wrong Door, describe your experience working with MHP(s) to **update policies and procedures.**

16. Describe providers' experience implementing these policies.

Screening and Transition of Care Tools

17. Is there clarity on when, how, and with whom to use the Screening and Transition of Care Tools?

☐ Yes
☐ No
☐ N/A

18. If no, what clarification or additional information is needed? (Please specify for which tools and audiences)

19. DHCS continues to release Frequently Asked Questions (FAQs) regarding Screening and Transition of Care Tools on an ongoing basis. Are there areas where additional clarification is needed?

20. Are you using non-clinical, clinical, or both types of staff to administer the Screening Tools?

☐ Non-Clinical Only
☐ Clinical Only
☐ Both
☐ N/A

21. Please explain the rationale for your approach.

22. Are you requiring contracted providers to use the Transition of Care Tool?

☐ Yes
☐ No
☐ N/A

23. Please explain the rationale for your approach.

24. How are you operationalizing the Screening and Transition of Care Tools?

☐ Electronic System
☐ Fillable PDF
☐ Other
☐ N/A

25. Please explain the rationale for your approach.

26. Please indicate how much time on average it takes to **complete appropriate referrals.**

	When receiving referrals	When sending referrals	Comments
Screening Tool: process the referral and offer/confirm an appointment for clinical assessment	☐ 1 – 4 days ☐ 5 – 9 days ☐ 10+ days ☐ N/A	☐ 1 – 4 days ☐ 5 – 9 days ☐ 10+ days ☐ N/A	
Screening Tool: process the referral and offer/confirm an appointment for clinical assessment	☐ 1 – 4 days ☐ 5 – 9 days ☐ 10+ days ☐ N/A	☐ 1 – 4 days ☐ 5 – 9 days ☐ 10+ days ☐ N/A	
Transition of Care Tool: process the referral, ensure connection with a provider, and offer/confirm an appointment for services	☐ 1 – 4 days ☐ 5 – 9 days ☐ 10+ days ☐ N/A	☐ 1 – 4 days ☐ 5 – 9 days ☐ 10+ days ☐ N/A	

27. How often do you believe members are being **referred to the appropriate delivery system** for clinical assessment based on their screening score?

	Rarely	Most of the time	Almost always	N/A	Comments (please indicate if you have data that informs your response)
Adults aged 21 and older					
Youth under age 21					

Enhanced Care Management

28. Is your MCP currently contracting with at least one MHP to provide Enhanced Care Management (ECM) services?

☐ Yes
☐ No
☐ N/A

29. If yes, please describe whether and how ECM plays a role in your MCP's implementation of No Wrong Door and/or Screening and Transition of Care Tools.

Appendix D: MHP Survey

Survey Purpose

This survey is being conducted as a part of the California Department of Health Care Services' (DHCS) efforts to better understand MCPs' and MHPs' experiences implementing several CalAIM Behavioral Health policy initiatives, including Access Criteria for Specialty Mental Health Services (Access Criteria), No Wrong Door, and Screening and Transition of Care Tools for Medi-Cal Mental Health Services (Screening and Transition Tools). DHCS may follow up with select respondents for virtual interviews in late summer.

This survey is mandatory for all Medi-Cal mental health plans to complete. Please complete all fields. If a field does not apply to your organization's situation, please select or type "N/A.". Your responses to survey questions will not impact your entity's compliance standing or result in corrective actions. Results from this survey and following interviews will inform future policy development and technical assistance efforts. A separate, similar survey is being executed with Medi-Cal Managed Care Plans (MCPs).

Instructions

This survey should be completed **once per entity**. Individual(s) most knowledgeable in implementing the initiatives within your county, should inform the answers, but only **one** individual should fill out the Survey Monkey form.

If you would prefer to collaborate with internal colleagues on your response, please send the Word version of the survey to relevant individuals and compile all responses in the document before transferring responses into Survey Monkey.

Confidentiality

Responses to this survey will be confidential and DHCS will never share individual MHP or MCP responses. However, DHCS may share aggregate, deidentified survey findings in a summary report to MHPs and MCPs once compiled.

Please direct questions to the CalAIM Behavioral Health inbox at BHCalAIM@dhcs.ca.gov. We kindly ask that you submit the survey by **September 19, 2023.**

Respondent Information

1. Name of your MHP: _____

This survey is focused on the MHP perspective and should be filled out by the individual(s) within the MHP that are most knowledgeable about the MHP's experience implementing Access Criteria, No Wrong Door, and Screening and Transition Tools. While this survey may be completed by several staff members, please provide the name of a primary point of contact for your organization. This will support follow-up for future interview coordination or survey response clarification.

Name	Title	Department/ Division (if applicable)	Role in Implementation	Email/Contact Info

Questions in reference to any/all policies: Access Criteria, No Wrong Door, Screening and Transition of Care Tools

Please rate the extent to which each of the following **aspects of Medi-Cal beneficiary access have improved since implementation** of Access Criteria, No Wrong Door, **and/or** Screening and Transition of Care Tools policy implementation:

2. The rate of improvement of these aspects of Medi-Cal **beneficiary access**:

	Substantially Worse	**Slightly Worse**	**No Change**	**Slightly Improved**	**Substantially Improved**	**N/A**	**If possible, please indicate which policy you are referencing to inform your response. Check all that apply.**			**If you answered 'Slightly Worse' or 'Substantially Worse' for any of the statements above, please explain why.**
							AC	**NWD**	**STT**	
A beneficiary's ability to receive **timely clinical assessment**.										
A beneficiary's ability to receive **timely services**.										

	Substantially Worse	Slightly Worse	No Change	Slightly Improved	Substantially Improved	N/A	If possible, please indicate which policy you are referencing to inform your response. Check all that apply.			If you answered 'Slightly Worse' or 'Substantially Worse' for any of the statements above, please explain why.
							AC	NWD	STT	
A beneficiary's ability to receive timely services in the **delivery system(s) most appropriate for their needs**.										
A beneficiary's ability to **maintain trusted relationships** with providers.										
A beneficiary's access to **concurrent, non-duplicative** SMHS and NSMHS.										
A beneficiary's ability to access **co-occurring treatment for mental health and SUD needs.**										

3. Is implementation of Access Criteria and No Wrong Door, and use of the Screening and Transition of Care Tools resulting in **fewer barriers to care for Medi-Cal beneficiaries**?

☐ Yes
☐ No
☐ N/A

4. If no, why not? (Please indicate if you have data that informs your response)

5. Is implementation of Access Criteria and No Wrong Door and use of the Screening and Transition of Care Tools resulting in less daily administrative burden for your county and/or contracted providers?

☐ Yes
☐ No
☐ N/A

6. If no, why not? (Please indicate if you have data that informs your response)

7. Is implementation of Access Criteria, No Wrong Door, and Screening and Transition Tools **fostering improved coordination** with the MCP(s) in the other delivery system? (Examples may include coordination related to administrative or operational procedures (e.g., MOUs, contracts, workflows) or the care related to individual Medi-Cal beneficiaries.)
   - ☐ Yes
   - ☐ No
   - ☐ N/A

8. Please explain why coordination has or has not improved.

9. Please describe whether and how MHP/MCP Dispute Resolution processes (as outlined in BHIN 21-043) played a role in implementation of No Wrong Door and/or Screening and Transition of Care Tools.

10. What additional **Technical Assistance or resources**, if any, would help improve implementation for Access Criteria, No Wrong Door, and/or Screening and Transition Tools?

11. Please describe **major successes** related to implementation of Access Criteria, No Wrong Door, and Screening and Transition of Care Tools. (Examples might include improved access to care, improved MCP-MHP coordination, refining parameters for episode of care, updating electronic health record configuration, utilization of a universal Release of Information, or others.)

12. Please describe **major barriers** related to implementation of Access Criteria, No Wrong Door, and Screening and Transition of Care Tools.

13. Please provide **any other comments** related to Access Criteria, No Wrong Door, and/or Screening and Transition of Care Tools policy implementation (optional).

Access Criteria and No Wrong Door

14. Please rate the extent to which each of the following have **improved since implementation** of Access Criteria and/or No Wrong Door policy implementation:

	Substantially Worse	Slightly Worse	No Change	Slightly Improved	Substantially Improved	N/A	If you answered 'Slightly Worse' or 'Substantially Worse' for any of the statements above, please explain why.
The ability to implement the **criteria for adults** (individuals aged 21 or older) **to access SMHS**							
The ability to implement the **criteria for youth** (individuals under age 21) **to access SMHS**							
The ability to implement the criteria for individuals to access **non-specialty mental health services**							

	Substantially Worse	Slightly Worse	No Change	Slightly Improved	Substantially Improved	N/A	If you answered 'Slightly Worse' or 'Substantially Worse' for any of the statements above, please explain why.
The consistency that **evaluated needs are guided to the appropriate services for adults** (aged 21 or older)							
The consistency that **evaluated needs are guided to the appropriate services for youth** (under age 21)							
The ability for MHPs to provide a Medi-Cal beneficiary **service prior to a definitive diagnosis**							
The ability for Medi-Cal beneficiaries to **maintain relationships** with trusted providers							
Clarity regarding the **responsibilities of the MHP and MCP** related to providing services prior to definitive diagnosis							

15. Describe your organization's experience implementing the **updated SMHS access criteria and matching** Medi-Cal beneficiary **needs to the medically necessary services across the continuum of care**.

16. During the initial implementation of No Wrong Door, describe your experience working with MCP(s) to **update policies and procedures.**

17. Describe providers' experience implementing these policies.

Screening and Transition of Care Tools

18. Is there clarity on when, how, and with whom to use the Screening and Transition of Care Tools?

☐ Yes
☐ No
☐ N/A

19. If no, what clarification or additional information is needed? (Please specify for which tools and audiences)

20. DHCS continues to release Frequently Asked Questions (FAQs) regarding Screening and Transition of Care Tools on an ongoing basis. Are there areas where additional clarification is needed?

21. Are you using non-clinical, clinical, or both types of staff to administer the Screening Tools?

☐ Non-Clinical Only
☐ Clinical Only
☐ Both
☐ N/A

22. Please explain the rationale for your approach.

23. Are you requiring contracted providers to use the Transition of Care Tool?

☐ Yes
☐ No
☐ N/A

24. Please explain the rationale for your approach.

25. How are you operationalizing the Screening and Transition of Care Tools?

- ☐ Electronic system
- ☐ Fillable PDF
- ☐ Other
- ☐ N/A

26. Please explain the rationale for your approach.

27. Please indicate how much time on average it takes to **complete appropriate referrals.**

	When receiving referrals	When sending referrals	Comments
Screening Tool: process the referral and offer/confirm an appointment for clinical assessment	☒ 1 – 4 days ☒ 5 – 9 days ☐ 10+ days ☐ N/A	☐ 1 – 4 days ☐ 5 – 9 days ☐ 10+ days ☐ N/A	
Transition of Care Tool: process the referral, ensure connection with a provider, and offer/confirm an appointment for services	☒ 1 – 4 days ☐ 5 – 9 days ☐ 10+ days ☐ N/A	☐ 1 – 4 days ☐ 5 – 9 days ☐ 10+ days ☐ N/A	

28. How often do you believe Medi-Cal beneficiaries are being **referred to the appropriate delivery system** for clinical assessment based on their screening score?

	Rarely	Most of the time	Almost always	N/A	Comments (please indicate if you have data that informs your response)
Adults aged 21 and older					
Youth under age 21					

Enhanced Care Management

29. Is your county currently contracting with at least one MCP to provide Enhanced Care Management (ECM) services?

☐ Yes
☐ No
☐ N/A

30. If yes, please describe whether and how ECM plays a role in your county's implementation of No Wrong Door and/or Screening and Transition of Care Tools.

Appendix E: Peer Support Services Survey

Survey Purpose

This survey is being conducted as a part of the California Department of Health Care Services' (DHCS) efforts to better understand counties' experiences implementing the CalAIM Behavioral Health policy initiative, Medi-Cal Peers Support Services (Peers).

This survey is mandatory and is not part of DHCS compliance activities. Your responses to survey questions will not impact your entity's compliance standing or result in corrective actions. Results from this survey and following interviews will inform future policy development and technical assistance efforts.

Instructions

This survey should take 10-15 minutes and is to be completed **once per entity**. Individual(s) most knowledgeable in implementing Peer Support Services within your county should inform the answers, but only **one** individual should fill out the Survey Monkey form.

If you would prefer to collaborate with internal colleagues on your response, please send the Word version of the survey to relevant individuals and compile all responses in the document before transferring responses into Survey Monkey.

Confidentiality

Responses to this survey will be confidential and DHCS will never share individual MHP responses. However, DHCS may share aggregate, deidentified survey findings in a summary report to counties and Medi-Cal Managed Care Plans once compiled.

Please direct questions to the CalAIM Behavioral Health inbox at BHCalAIM@dhcs.ca.gov. We kindly ask that you submit the survey by [DATE].

Respondent Information

1. Name of your county: _____

This survey is focused on the county perspective and should be filled out by the individual(s) within the county that are most knowledgeable about the county's experience implementing Medi-Cal Peer Support Services. While this survey may be completed by several staff members, please provide the name of a primary point of contact for your organization. This will support follow-up for future interview coordination or survey response clarification.

Name	Title	Department/ Division (if applicable)	Role in Implementation	Email/Contact Info

Medi-Cal Peer Support Services

[Note: These questions will only be shared with counties that have opted into the Medi-Cal Peer Support Services benefit.]

2. How many Medi-Cal Peer Support Specialists are in your MHP provider network as of August 31, 2023?

3. How many Medi-Cal Peer Support Specialists are in your DMC/DMC-ODS provider networks as of August 31, 2023?

4. Prior to the availability of certification, how did your county prepare to expand your peer workforce?

5. How are you outreaching to and supporting potential peers to grow your network of Medi-Cal Peer Support Specialists?

a. Please explain your approach to sourcing potential peers with DHCS-approved areas of specialization.

6. How does your county promote the availability of Medi-Cal Peer Support Specialists who reflect the demographics of the Medi-Cal beneficiaries receiving services?

7. Have you experienced challenges in implementing the Medi-Cal Peer Support Services benefit since Peer Support Specialist certification became available in fall 2022?

☐ Yes
☐ No

b. If yes, what challenges have you experienced?

c. How have you resolved or attempted to resolve these challenges?

8. Are you soliciting feedback regarding Medi-Cal members' experience receiving care from Medi-Cal Peer Support Specialists?

☐ Yes
☐ No

d. If yes, what are your findings? (Please indicate if you have data that informs your response)

9. How many Medi-Cal Peer Support Specialist supervisors are working in your county as of August 31, 2023?

10. How many Peer Support Specialist supervisors received a certificate of completion of supervisor training through CalMHSA?

11. How many Medi-Cal Peer Support Specialist supervisors received a certificate of completion of supervisor training within 60 days of beginning to supervise Medi-Cal Peer Support Specialists?

12. Are you soliciting feedback on Medi-Cal Peer Support Specialists' experience?

☐ Yes
☐ No

e. If yes, what are your findings? (Please indicate if you have data that informs your response)