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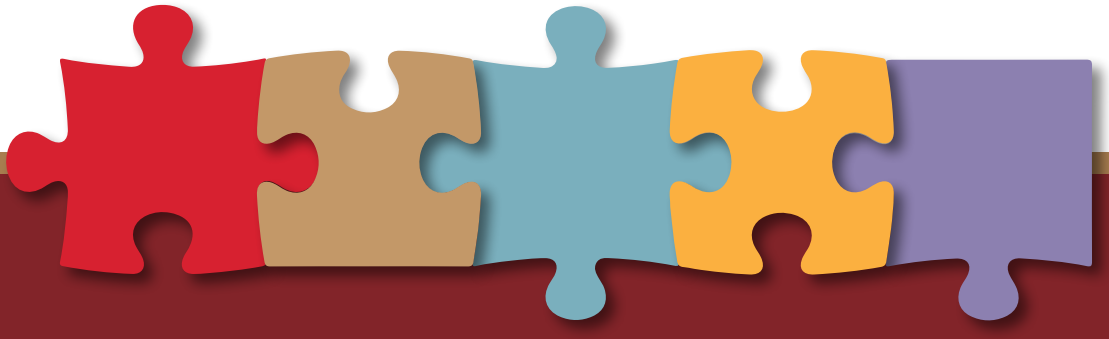
Putting Health Care Where Kids Are



Public Funding for School-Based Mental Health Programs

by the California School-Based Health Alliance

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INTRODUCTION

Well before COVID-19 turned school and family life upside down in March 2020, young people in California were already experiencing a mental health crisis. Rates of suicide and self-harm had risen sharply, especially among the youngest teens. Increases in depression and anxiety were rising as well, and a heightened awareness about the impact of childhood trauma increased social sensitivity to adverse childhood experiences, including the impact of racism and toxic stress. The COVID pandemic amplified many of these concerns as students lost access to routines, peers, trusted adults, and various sources of engagement, pride, and normalcy.

Even without the pandemic exacerbating need, the majority of California youth with mental health needs do not receive any mental health care, and that those who do primarily receive it in a school setting. Students with undiagnosed or untreated mental health issues rank among the most pressing concerns in schools across California, directly impacting student attendance, behavior, and readiness to learn.[1] When students' mental health needs are not addressed, they are more likely to experience difficulties in school, including higher rates of suspensions, expulsions, dropouts, and truancy, as well as lower grades and test scores. For students with mental health needs, treatment is not always accessible or affordable. More than 20 percent of school-aged children have a mental health diagnosis but only one-third of diagnosed children and teens in the general population receive treatment.[2] For teens with diagnosed mental health disorders living in poverty, 90 percent report not receiving counseling or other appropriate services.[3]

One effective approach for linking youth to mental health services is to provide these services where students most commonly are – on school campuses. In partnership with county agencies, health plans, community-based organizations, and providers, schools play a leading role in the prevention and treatment of student mental health needs. Indeed, 70 percent of children nationwide receiving mental health services get them at school.[4] Schools are trusted locations for students and families to access services. And school sites are prime locations to provide a continuum of mental health services - from providing teacher training to creating a positive learning environment for all to conducting screenings, assessments and basic counseling to providing intensive treatment and linking to other community services. A common model for school mental health is to provide services across three tiers of interventions: (1) school-wide, (2) targeted, and (3) intensive services. A summary of common practices and interventions across the three tiers is available here: Overview of School-Based Mental Health Programs.

One of the chief barriers to creating comprehensive systems of school-based mental health services is identifying and ensuring sustained funding streams that support practices throughout the three tiers of intervention.

This document is intended to identify and explain the *ongoing* public mental health funding streams in California that can support the full continuum of school-based mental health services. It also helps illustrate how schools can best leverage public mental health funding streams and community partnerships to maximize existing resources. Given the growing awareness of and interest in addressing student mental health, California also proposed significant *one-time* investments in school mental health as part of the 2021-2022 state budget. This resource also includes a brief description of those investments and how to strategically leverage the funding to support school-based mental health services and programs.

Overview of One-Time State & Federal Investments:

- $400 million for Medi-Cal Managed Care Incentive program to increase school-based mental health services
- $550 million for additional school-linked behavioral health partnerships
- $2.8 billion for a grant program to convert school campuses into full-service community schools
- $205 million for the Mental Health Student Services Act Partnership Grant Program to fund partnerships between county behavioral health departments and schools
- $21 billion in federal COVID relief funding directly to local education agencies

More information on these investments below.

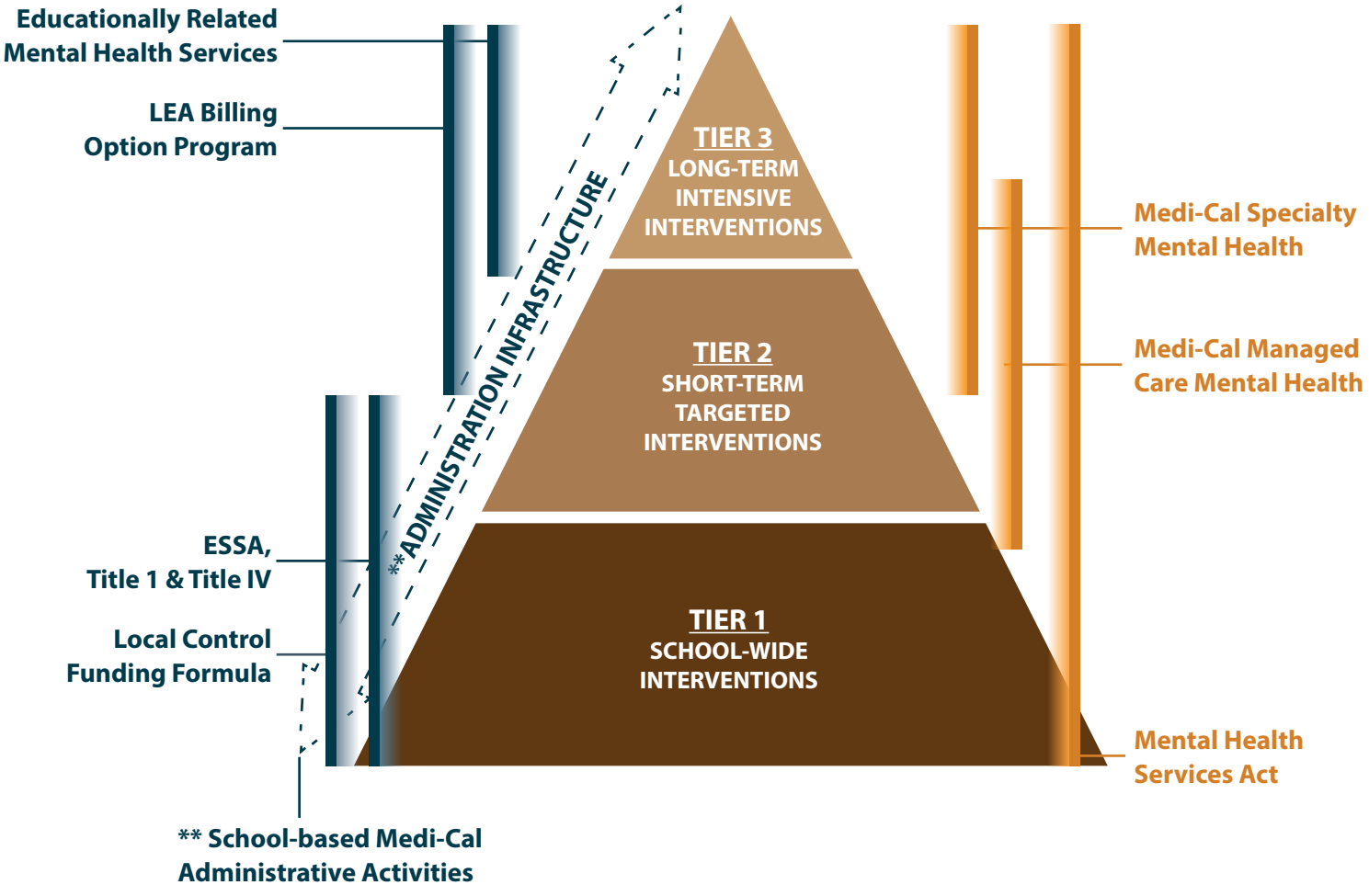
GUIDING PRINCIPLES

There are many different ways that schools can knit together resources to address the mental health needs of students. This resource presents selected strategies for how to utilize funding that is available to schools and partners and identify new funding resources. The following principles and assumptions guide these recommendations:

- Many of the funding streams included can be used in a variety of ways. However, there are more strategic ways to use funding so that school districts and partners can create comprehensive systems of mental health services and programs. This toolkit includes strategic approaches in the descriptions of funding streams below.
- The most comprehensive school mental health programs utilize multiple different funding sources. For examples of blending and braiding funding, see Summaries of County-School Partnerships to Advance School Mental Health.
- School mental health services address the educational and health needs of young people. School mental health services decrease barriers to educational success for students and increase access to health services that help young people live healthier lives.
- School districts should consider various models for meeting students' mental health needs, including creating partnerships with community partners and county agencies. There are resources in most communities and counties that can help if schools and partners do their homework, invest in infrastructure, share goals and accountability, and understand the needs of their students.
- School districts that strategically invest in administration and coordination are best positioned to leverage outside resources.
- All three tiers are important to creating a comprehensive school mental health system. Investing in Tier 1 (schoolwide prevention) and Tier 2 (targeted interventions) are just as important as investing in traditional, one-on-one mental health inventions (Tier 3). Tier 1 investments lay the foundation for a comprehensive school mental health system and tier 2 services provide important prevention and early intervention services that can mitigate the need for more intensive mental health supports.

MODEL FOR FUNDING SCHOOL-BASED MENTAL HEALTH

With the overall goal of identifying funding that can support a continuum of mental health services, below is a model for how to understand what funding sources can support different tiers and components of school-based mental health interventions. Each funding stream is described in more detail.



ONGOING FUNDING SOURCES

This section provides more detail about the eight ongoing funding streams highlighted in the model above. Each description includes a general overview of the funding, the entity that administers the funding, eligible child and adolescent populations, the funding process, and some examples and strategies for how that funding stream can support school-based mental health services.

Understanding Medicaid and EPSDT

Low-income children under 21 enrolled in Medicaid (called Medi-Cal in California) are entitled to comprehensive and preventive health care services under a federal entitlement called Early, Periodic Screening, Diagnosis and Treatment (EPSDT). The EPSDT entitlement aims to ensure that all children and adolescents have access to appropriate preventive, dental, mental health, developmental, and specialty services.

Medi-Cal EPSDT includes two key components for all eligible children:

- *Comprehensive Screening Services:* Comprehensive periodic and interperiodic health screenings that include, at a minimum, medical, dental, vision, and hearing; developmental history; physical exams including assessment of nutritional status, immunizations, laboratory tests, health education, lead screenings.
- *Medically Necessary Services:* States are required to provide medical, diagnostic, and treatment services in order to "correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services" even if those services are not part of the state plan for adult populations (42 USC § 1396d(r)(5)). Per federal guidance, behavioral health services need not be curative or completely restorative to ameliorate a behavioral health condition.[5] Services that sustain, support, improve, or make more tolerable a behavioral health condition are considered to ameliorate the condition, are thus medically necessary, and are covered as EPSDT services. **Through EPSDT, children and youth with Medi-Cal coverage are entitled to comprehensive mental health services.**

Medi-Cal Delivery System

- *Managed Care Plans:* Most Medi-Cal enrollees now receive health services through Managed Care Plans (MCPs). MCPs are licensed health plans that contract with the state to provide covered services on a capitated basis (fixed payment per member per month) to enrolled members.
- *County Mental Health Plans:* The Mental Health Plan (MHP) in each county is responsible for providing or arranging for the provision of Specialty Mental Health Services (SMHS) to Medi-Cal beneficiaries in their county.
- *Fee-for-Service:* A fee-for-service delivery model is generally one in which individual providers deliver services to Medi-Cal beneficiaries outside of managed care, and then submit a claim to the State for payment. California has largely moved away from this model although there are some populations, like foster youth, who may still be enrolled in fee-for-service.

Medi-Cal Specialty Mental Health Services

Administered by County Mental Health Plans

Description and Background

In California, specialty mental health services are "carved out" of the broader Medi-Cal program, meaning that specialty mental health services for children and adults are provided through county mental health plans instead of through managed care health plans with the rest of the EPSDT benefits. Often county specialty mental health services for children may be referred to as "EPSDT services" but EPSDT refers to the comprehensive health services available to children and youth enrolled in Medi-Cal, not just specialty mental health services.

"Specialty mental health services" include:

- rehabilitative mental health services (including mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential treatment services, and psychiatric health facility services);
- psychiatric inpatient hospital services;
- targeted case management;
- psychiatric and psychologist services;
- EPSDT supplemental specialty mental health services; and
- psychiatrist nursing facility services.[6]

Litigation has established that other EPSDT specialty mental health services include intensive care coordination (ICC), intensive home-based services (IHBS), therapeutic foster care (TFC), and therapeutic behavioral services (TBS).[7]

As part of California's Advancing and Innovating Medi-Cal (CalAIM) initiative, the state updated guidance clarifying medical necessity and access for beneficiaries 21 years and younger. As of January 2022, the state definition of "medical necessity" aligns with the federal definition under EPSDT (see call-out box above: *Understanding Medicaid and EPSDT*).

When a child meets medical necessity and access criteria (described below), the county mental health plan is responsible for providing, or arranging for the provision of, specialty mental health services. These services can be provided directly by county employed staff or counties may contract with community-based organizations that have the clinical, administrative, and organizational capacity to deliver services and maintain the records necessary to file claims for federal reimbursement.

Eligible Child and Adolescent Populations:

Medi-Cal children and youth are eligible for all medically necessary specialty mental health services if ***either*** of the following criteria are met[8]:

1. The beneficiary has a condition placing them at high risk for a mental health disorder due to experience of trauma*

OR

2. The beneficiary meets ***both*** of the following requirements:

a. The beneficiary has a significant impairment or a reasonable probability of significant deterioration or of not progressing developmentally AND

b. The condition is a diagnosed or suspected mental health disorder or a result of significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a licensed mental health professional.

Funding Process

Funding for Medi-Cal programming is a split between federal and state dollars - in California, this is usually 50/50 match. However, in 2011, California transferred financial control for many programs, including children's specialty mental health, to counties (this is called "Realignment").

Realignment funding starts with a base allocation to counties based on historical spending on the programs. The state collects dedicated revenue (for example, fees and taxes) which is distributed monthly until each county receives their base allocation. Leftover dedicated revenue funds are placed into separate, designated growth accounts. At the end

* Per the DHCS guidance, "experience of trauma" is evidenced by a high-risk score using an approved trauma-screening tool, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness.

of the year, these growth accounts are distributed to county programs based on a state-determined formula. The base amount plus the growth amount equals the next year's base.

Until 2011, counties received a 90% reimbursement for EPSDT specialty mental health services — 50% from the federal government and 40% from the state government. Now, counties are responsible for providing the entire non-federal share using 2011 realignment allocations.

What can this look like in schools?

County mental health plans vary significantly in how they deliver specialty mental health services. The options available for schools to work with their counties to deliver specialty mental health services depends, in large part, on the county's overall system of care, priorities, and how school-based strategies align.

- *School-based health centers or community providers* - Many counties contract for the delivery of specialty mental health services through community providers. These providers can be community mental and behavioral health agencies, individual practitioners, healthcare providers like federally qualified health centers, and/or school-based health centers.
- *School District providers* – In some cases, the school district or county office of education can contract directly with the county mental health plan to become a contracted provider of specialty mental health services. However this arrangement is not common as provider qualifications and billing requirements can be significant barriers.
- *County providers* – In counties where the majority of specialty mental health services are provided "in house," i.e. by county-employed mental health professionals, schools can develop arrangements with the county to have permanent or periodic county-employed clinicians provide assessment and treatment services on the school campus.

Additional Information

Flowchart: Access to Mental Health Services for Medi-Cal Youth Ages 0-21: http://www.dhcs.ca.gov/services/Documents/Medi-Cal%20MHS%20Referral%20Processes/Scenario%204.pdf

Information about county mental health plans: http://www.dhcs.ca.gov/services/Pages/MH_plan_information.aspx

Meeting the Moment: Understanding EPSDT and Improving Implementation in California to Address Growing Mental Health Needs (The California Children's Trust): https://cachildrenstrust.org/wp-content/uploads/2021/01/Meeting-the-Moment_FINAL.pdf

A Complex Case: Public Mental Health Delivery and Financing in California (California Health Care Foundation): http://www.chcf.org/publications/2013/07/complex-case-mental-health

Medi-Cal Managed Care Mental Health

Administered by Medi-Cal Managed Care Plans

Description and Background

Prior to 2014, despite the broad EPSDT entitlement for children, individuals that did not meet the criteria for specialty mental health services received limited services through their primary care provider.[9] Psychology services for children were also available through fee-for-service mental health providers. In 2014, Medi-Cal managed care plans became responsible for the delivery of an expanded set of mental health services to beneficiaries with mild-to-moderate mental, emotional, or behavioral health needs. This expansion did not necessarily increase access to mental health services for children in Medi-Cal because (a) the eligibility criteria for children for specialty mental health services meant that many children with identified mental health needs were already being served by counties and (b), prior to 2014, children were an eligible population for psychology services through fee-for-service mental health providers. However, this expansion has brought significant attention to the role and responsibilities of managed care plans in meeting mental health needs and coordinating care with county specialty mental health plans.[10]

These mental health services provided through managed care health plans are often referred to as "mild to moderate mental health services" but the "mild/moderate" distinction is only relevant for adult populations. Since children and youth enrolled in Medi-Cal are covered under the EPSDT entitlement, managed care plans are responsible for all medically necessary services that are not carved out as specialty mental health services, not just "mild to moderate" services. The state recognizes that many children with mental health impairments that may be considered moderate meet the medical necessity criteria to access Medi-Cal specialty mental health services provided by county mental health plans (see above).

Medi-Cal managed care mental health services include individual and group mental health evaluation and treatment, outpatient services for the purposes of monitoring drug therapy, psychiatric consultation, and a recently added family therapy benefit. Medi-Cal managed care plans cover services provided within a primary care physician's scope of practice and can also contract with a network of mental and behavioral health providers to ensure access to the expanded set of covered services.

Eligible Child or Adolescent Populations

Children under 21 who are enrolled in Medi-Cal managed care plans.

Funding Process

The state provides funding to Medi-Cal managed care plans through "capitated rates," a set monthly payment per type of enrolled member in the health plan (for example, rates are different for adults vs. children). Capitation rates for each contracted plan were increased in 2014 to reflect the new coverage for mental health services. Health plans then must contract with a network of providers. More than half of health plans in California subcontract with a managed behavioral healthcare organization (MBHO) such as Beacon to support the administration of the mental health coverage responsibilities.[11] Either the MBHO or the managed care plan pays providers directly for services to enrolled beneficiaries.

What can this look like in schools?

To receive reimbursement for mental health services covered by Medi-Cal managed care plans, providers must contract with the local Medi-Cal managed care plan or MBHO and be included in the network established by the health plan or MBHO.

- *School-based health centers (SBHCs)* – More than half of California's SBHCs are run by federally qualified health centers (FQHCs). Most FQHCs are contracted providers with their local Medi-Cal managed care plans and bill for non-specialty mental health services, including those provided in their SBHCs.
- *Schools or mental health providers contract with Medi-Cal health plans* – While still relatively uncommon, schools are growing relationships with their local Medi-Cal managed care plans. In some cases, this results in direct reimbursement to schools for health services rendered to Medi-

Cal managed care members. As health plans are growing their network of behavioral health providers, there is an opportunity for school-based providers to participate in those networks.

Additional Information

Medi-Cal managed care plans by county:
http://www.dhcs.ca.gov/individuals/Pages/MMCDHealthPlanDir.aspx

The Circle Expands: Understanding Medi-Cal Coverage of Mild-to-Moderate Mental Health Conditions (California Health Care Foundation):
http://www.chcf.org/publications/2016/08/circle-expands-medical-mental

Medi-Cal Managed Care: A Primer to Inform Youth Mental Health (California Children's Trust):
https://cachildrenstrust.org/wp-content/uploads/2021/02/CCT_MCP-Primer-FINAL.pdf

Mental Health Services Act (MHSA)

Administered by County Mental/Behavioral Health Departments

Description and Background

The Mental Health Services Act (MHSA) was created in 2004 with the passage of Proposition 63, which levied a one percent tax on personal income above $1 million. MHSA provides the state's second largest public funding stream for mental health services, after Medi-Cal.[12] MHSA programs and services are intended to enhance, rather than replace, existing programs.

There are five funding categories within MHSA:

- *Community Support Services (CSS)* – The largest category is intended to provide funding for services identified in children's and adult's system of care treatment plans that are not funded through any other source (public or private insurance).
- *Prevention and Early Intervention (PEI)* – This category is intended to provide resources to prevent mental illness from becoming severe and disabling and to improve timely access for underserved populations. PEI programs emphasize strategies to reduce negative outcomes that may result from untreated mental illness: suicide, incarcerations, school failure or dropout, unemployment, prolonged suffering, homelessness, and removal of children from their homes.
- *Innovation (INN)* – The goal of INN is to incentivize counties to test novel approaches to delivering mental health services. A county must get approval from the Mental Health Services Oversight and Accountability Commission (MHSOAC) to spend innovation funds on a project. Projects must do one of the following: (1) introduce a mental health practice or approach that is new to the overall mental health system, (2) make a change to an existing practice in the field of mental health, for example applying a practice to a different population, or (3) apply to the mental health system a promising community-driven practice or approach that has been successful in non-mental health contexts or settings.
- *Other* – Counties are permitted to meet local needs by transferring funds from CSS to other components: Capital Facilities and Technological Needs (CFTN) and Workforce Education and Training (WET).

MHSA requires county mental health programs to submit three-year program and expenditure plans and annual updates for MHSA programs and expenditures. In their MHSA plans, counties are required to include a list of all programs for which MHSA funding is requested and identify expenditures for each type of funding and for each target age group. To learn more about how counties spend MHSA funding, use the MHSOAC transparency tools.

Eligible Child or Adolescent Populations

Target populations include children and adolescents with Serious Emotional Disturbance (SED) and transition-aged youth (TAY) who are unserved, underserved, or inappropriately served (e.g., youth in foster care, youth experiencing homeless, frequent hospital users, individuals with criminal justice history).

- All ages must be served by a county's CSS components. Disparities in access to services for underserved populations and regions of the county must be addressed.
- PEI programs must serve all age groups and at least 51 percent of county PEI funding must target individuals between the ages of 0 and 25. Counties with a population less than 200,000 are exempted from these age requirements.

Funding Process

Revenues are distributed directly to counties, with no more than 5 percent used for state-level administration.

Funding is approved of and administered by each county's behavioral health or mental health department after review and comment by the local Mental Health Board. Counties submit an integrated plan comprised of the relevant MHSA components to MHSOAC.

Counties are required to have a community engagement process in the development of their MHSA spending plans. School district staff and community mental health providers can attend meetings to highlight the role of schools in meeting their county's spending and program goals.

What can this look like in schools?

MHSA funds cannot be used to cover services that can be funded through federal programs (i.e. Medicaid). In schools, MHSA funding can be used for services that cannot be funded through Medi-Cal (examples include tier 1 and tier 2 prevention and early intervention programs) and populations that are not covered through other funding streams. This can help to round out the overall continuum of school-based mental health services offered.

Additional Information

MHSA fiscal reporting, for the state and by county: https://mhsoac.ca.gov/transparency-suite/monthly-allocation/

A searchable database by county of MHSA-funded programs and services: http://transparency.mhsoac.ca.gov/searchpage

County plans and updates: http://www.dhcs.ca.gov/services/MH/Pages/MHSA-County-Plans-and-Updates.aspx

Educationally-Related Mental Health Services (ERMHS)

Administered by Special Education Local Plan Areas (SELPAs)

Description and Background

The federal government provides funding to states to provide children with disabilities a free and appropriate public education. The Individuals with Disabilities Act (IDEA) sets requirements for state programs and includes two main components: special education and related services. "Special education" refers to the specially designed instruction to meet the needs of a student with a disability. "Related services" refers to other developmental and supportive services required to help students with disabilities benefit from special education, including mental health services. Local education agencies (LEAs) are required to evaluate students and develop an individualized education program (IEP) or 504 Plan, including the special education and related services needed for the student to access their education. According to California state data, in the 2014–15 school year nearly 14% of students with an IEP received a mental health service as part of their IEP.[13]

In July 2011, the state changed the process by which students in special education receive mental health services. Previously, county mental health departments were responsible for assessing students, recommending mental health services to be included in an IEP, and providing those services. After the passage of AB 114, school districts are solely responsible for ensuring that students with disabilities receive the mental health services necessary *to access their education*. However, this does not supersede a Medi-Cal Managed Care Plan's (MCP) or County Mental Health Plan's (MHP) responsibility to provide medically necessary mental health services for covered youth under the EPSDT benefit. Many students with mental health needs will require services for both educational and non-educational purposes. The Department of Health Care Services issued guidance clarifying that schools may not be the sole payer for mental health services if the mental health need affects the child outside of school.[14]

The California Department of Education designates a portion of California's federal special education funding specifically for the purpose of providing mental health services to special education students. In addition, the state has dedicated part of its own special education funding for the same purpose. Funds from these two funding sources are considered restricted and can be used only for educationally related mental health services (ERMHS).

Eligible Child or Adolescent Populations

Students with IEPs or 504 Plans who demonstrate behavioral health issues that impact their ability to learn and access the school curriculum. ERMHS funds are not restricted to students who have "emotional disturbance" as their identified disability. Funds may also be spent on intervention and prevention services for students without an IEP or 504 Plan, although funding is typically exhausted first for services to students with IEPs or 504 Plans.

Funding Process

State and federal funding for special education and related services is distributed from the California Department of Education directly to Special Education Local Plan Areas (SELPAs) based on the average daily attendance of all pupils in the SELPA (regardless of how many pupils have an IEP or disability). SELPAs then determine how to allocate dollars to the individual districts and schools. Some funding may also be retained by the SELPA to support administrative activities and/or any services provided directly by the SELPA, which can include mental health services.

What can this look like in schools?

Mental health services must be included in the student's IEP or 504 Plan and can include: individual counseling, parent counseling, social work services, psychological services, and residential treatment. Any service agreed upon by the student's IEP team as necessary for the student to receive a free and appropriate public education may be considered a related service and covered by ERMHS funds.

There are three primary ways districts meet the ERMHS requirement:

- School districts hire mental health professionals (i.e., credentialed and/or licensed social workers, psychologists) and provide services through these staff.

- School districts contract with community mental health agencies or other qualified professionals to provide services.
- School districts contract with county mental health departments to provide services.

Additional Information

Special Education guidance for ERMHS and AB 114 from the California Department of Education:
http://www.cde.ca.gov/sp/se/ac/ab114twg.asp

Local Educational Agency (LEA) Medi-Cal Billing Option Program

Administered by Local Education Agencies (LEAs)

Description and Background

The federal government provides an option for school districts to recover a portion of the costs of providing Medi-Cal services to eligible and enrolled children. The LEA Billing Option Program (LEA BOP) allows LEAs to become Medi-Cal providers, bill for covered services provided by qualified employed or contracted practitioners, and claim federal reimbursement to match the education dollars already being spent for health services for eligible children. Mental health-related covered services include psychology, counseling, and psychosocial assessments.

The LEA Medi-Cal Billing Option Program allows local education agencies (LEAs) to seek partial reimbursement for health and mental health assessments and services provided to Medi-Cal eligible students. Reimbursement rates vary but, generally, schools can receive up to 50% of the cost of services. In 2014, the federal government reversed a long-standing policy that impeded the ability of school districts to be reimbursed for the school health services they provide to all Medi-Cal eligible students (called the "Free Care Rule"). Prior to this change, LEAs were limited to receiving reimbursement for health services to special education students only. In April 2020, the federal government approved a California state plan amendment allowing the state to implement the reimbursement for health services to all Medi-Cal eligible students, including general education students.

To seek reimbursement through the LEA Medi-Cal Billing Option Program, LEAs must have an approved Provider Participation Agreement (PPA) with the Department of Health Care Services (DHCS). As a condition of participation, LEAs must reinvest reimbursements in health and social services for children and their families and maintain a collaborative committee to assist them in decisions regarding the reinvestment of LEA reimbursements.

Eligible Child or Adolescent Populations

All Medi-Cal eligible students. Covered treatment services must be included in a student's Individualized Education Plan (IEP), an Individualized Family Services Plan (IFSP), and/or an Individualized Health and Support Plan (IHSP). An IHSP is an umbrella term that encompasses many types of plans or documents utilized by school districts, including but not limited to care plans, nursing plans, and 504 Plans. LEA BOP also covers screenings and assessments prior to a special or general education student having a formal plan.

Funding Process

The LEA Billing Option Program is a reimbursement program. LEAs hire practitioners based on the school budget for the fiscal year. LEAs pay for the services upfront and are reimbursed the federal match (generally 50%) for the cost of providing services based upon a "cost reimbursement" model. LEAs must certify that non-federal funds are used for the staff time and services eligible for reimbursement. Schools receive an interim payment, which is based on their estimated costs and services. LEA BOP claims are calculated through a random moment time study. This is later audited and schools may be required to pay back funds if they have not maintained adequate records and documentation.

What can this look like in schools?

Schools can either directly employ eligible practitioners (see the Provider Manual for more information) or may contract with outside providers. When contracting with outside providers, LEAs must be careful that outside providers are not also billing separately for the services provided.

Additional Information

LEA Medi-Cal Billing Option website: https://www.dhcs.ca.gov/provgovpart/Pages/LEA.aspx

Onboarding Handbook: https://www.dhcs.ca.gov/provgovpart/Documents/ACLSS/LEA%20BOP/Program_Req_and_Info/2018-LEA-Onboard-Handbook.pdf

LEA Provider Manual: https://www.dhcs.ca.gov/provgovpart/Pages/LEAProviderManual.aspx

More information about the change to Free Care: http://www.schoolhealthcenters.org/policy/policy-priorities/free-care-rule/

Local Control Funding Formula (LCFF)

Administered by Local Education Agencies (LEAs)

Description and Background

The Local Control Funding Formula (LCFF), enacted through the 2013-14 state budget, is the system for calculating funding for most public schools in California. Each district receives a "base grant" amount from the state per student, plus additional "supplemental and concentration" grants for targeted students who are low income, youth in foster care, English-Language Learners, and youth experiencing homelessness.

LCFF funds almost every service provided by public schools, including teacher salaries, professional development, learning support services, classroom materials, and facilities. LCFF can be used for school-based mental health programs and staff, including social workers, counselors, nurses, and psychologists.

Eligible Child or Adolescent Populations

All K-12 students in public schools are eligible for LCFF funds, with more funding for targeted students who are low income, English-Language Learners, or in foster care.

Funding Process

All school districts currently receive LCFF funds. Districts must submit a three-year Local Control and Accountability Plan (LCAP) and annual LCAP updates to their County Office of Education. The LCAP must demonstrate how funds will be used to support all students and targeted students in eight distinct state priority categories. The state priorities most linked to student mental health include "pupil engagement" as measured in part by attendance and graduation rates and "school climate" as measured in part by suspension and expulsion rates.

What can this look like in schools?

Pursuant to Prop 98, LCFF funds must be spent on instructional improvement and accountability for students in grades K to 14. LCFF dollars can be used for mental health services and supports to the extent that doing so supports instructional improvement and the state's accountability priorities. LCFF funds can be used to fill in program and service gaps unfunded by sources that are more restrictive. Some examples:

- *Staffing infrastructure for service coordination* to pay for staff responsible for coordination of mental health and other services at school sites. Investments in staffing infrastructure to support coordination of services can enhance both the reach and effectiveness of services and supports.
- *Direct mental health service providers* to fill in for services for which there is no other reimbursement. Note that LCFF funds should be used for direct mental health services only after other funding streams have been fully leveraged.
- *Staff development and trainings* that support the effective implementation of school climate initiatives, e.g. trainings and ongoing coaching for trauma-informed classroom management and restorative justice practices.
- *Schoolwide services and programs* that help to promote an overall positive, nurturing and supportive school climate.

Additional Information

California Department of Education – Local Control Funding Formula:
http://www.cde.ca.gov/fg/aa/lc/

Every Student Succeeds Act (ESSA), Title I and Title IV

Administered by Local Education Agencies (LEAs)

Description and Background

The federal Every Student Succeeds Act (ESSA) replaced No Child Left Behind (NCLB) in December 2015. While ESSA preserves federal funding at levels similar to NCLB and maintains a focus on closing achievement gaps, the new law is significantly less prescriptive than its predecessor and expands the allowable uses of funds. This expansion includes promoting investments beyond academically focused learning supports to social emotional learning, positive behavioral interventions, trauma informed practices, school climate, counseling, mental health and other health services, integrated services, and improved school community partnerships.

Under ESSA, states (through developing individual state plans) are required to establish indicators of student achievement and success, incorporate those indicators into a system of meaningful annual differentiation, and use that system to identify schools in need of improvement. The law requires states to identify schools for comprehensive support and improvement (CSI) and those that will receive targeted support and improvement (TSI).

There are multiple funding streams under ESSA, but with the new law there is more flexibility around blending or combining these resources. Some key ESSA funding streams include:

- *Title I, Part A* funds are used to support effective, research-based educational strategies that close the achievement gap and enable students to meet the state's challenging academic standards. Title I-funded schools are either targeted assistance schools or schoolwide program schools.
- *Title I, Schoolwide Program* is a comprehensive reform strategy designed to upgrade the entire educational program in a Title I school; its primary goal is to ensure that all students, particularly those who are low-achieving, demonstrate proficient and advanced levels of achievement on state academic achievement standards.
- *Title IV, Part A* Student Support and Academic Enhancement Grants (SSAEC) consolidates 49 separate grant programs into one new grant program. This new consolidated grants program authorizes activities in three priority areas, including supporting safe and healthy school environments (e.g. comprehensive school health and mental health, drug and violence prevention, health and physical education). Districts that receive an SSAEC grant must spend at least 20% of the funds on 'supporting safe and healthy school environments' activities.

California's state ESSA plan incorporates many of the required ESSA components into the existing structure, monitoring, and reporting requirements laid out in the state's priority areas as established by the Local Control Funding Formula and reported in Local Control Accountability Plans (LCAPs).

Eligible Child or Adolescent Populations

In general, most LEAs with low-income students are eligible and receive Title I funding. However, the allocation formula increases when the low-income rate is higher. While funding is meant to be targeted to students with low-income status, funding school-wide strategies under certain circumstances is allowable. If an LEA receives a Title I allocation, it will receive a Title IV allocation similar to the proportion of the total Title I allocation the LEA received.

Funding Process

Title I and Title IV funds are distributed to states and then from states to school districts according to the Title I formula based largely on number of low-income students.

What can this look like in schools?

Title I and Title IV funds are very flexible and can be used to fund staff who coordinate support services and who deliver direct services. Funding can also be used to support staff development and training. With this flexibility, Title I and Title IV funds can be used strategically to fund staffing infrastructure and student support services that cannot be funded any other way. These funds can also be used to support mental health services for all students, including those that are not covered by Medi-Cal programs or are uninsured.

Title I and IV funds can be utilized to fund the full spectrum of mental health services, from Tier 1 to Tier 3, including:

- Promoting community and parent involvement in schools;
- Providing school-based mental health services and counseling;
- Promoting supportive school climates to reduce the use of exclusionary discipline and promoting supportive school discipline;
- Supporting transition services for justice-involved youth;
- Implementing systems and practices to prevent bullying and harassment;
- Developing relationship building skills to help improve safety through the recognition and prevention of coercion, violence, or abuse; and
- Establishing community partnerships.

NOTE: Title I and Title IV dollars are federal funding and cannot be used to match and draw down other federal reimbursement (i.e. through LEA Billing or SMAA). Other non-federal funds should be used to hire staff or contract with providers that can bill Medi-Cal programs.

Additional Information

For updates on California's ESSA plan:
https://www.cde.ca.gov/re/es/index.asp

Title I, Part A:
https://www.cde.ca.gov/sp/sw/t1/titleparta.asp

Non-regulatory guidance about SSAEC grants:
https://www2.ed.gov/policy/elsec/leg/essa/essassaegrantguid10212016.pdf

More information on ESSA allocations, details, and strategies to leverage for student health services:
Framework for Action: Addressing Mental Health and Wellbeing through ESSA Implementation and State ESSA Plans to Support Student Health and Wellness: A Framework for Action (from Healthy Schools Campaign)

School-based Medi-Cal Administrative Activities (SMAA)

Administered by Local Education Agencies (LEAs)

Description and Background

The federal government provides an option for school districts to recover a portion of the costs of administering the Medi-Cal program for eligible children. The School-based Medi-Cal Administrative Activities (SMAA) program reimburses school districts for the federal share (50%) of certain activities. These activities include outreach, enrollment and facilitating the Medi-Cal application process, and making referrals for enrolled students to Medi-Cal covered services. SMAA also reimburses districts for arranging non-emergency/non-medical transportation and program infrastructure like program planning, policy development, and SMAA claims coordination.

Many school districts use this program only in relationship to their LEA Billing Option Program and for administration related to special education services, but SMAA can be used more universally to do Medi-Cal outreach and enrollment among the student population as a whole. This is especially effective at schools with high Medi-Cal eligible populations, such as Title I schools.

Eligible Child or Adolescent Populations

Medi-Cal eligible students. NOTE: Very generally speaking, reimbursement formulas are based on the percentage of a school's or district's student population that is Medi-Cal eligible.

Funding Process

To participate in the SMAA program, school districts must contract with the Department of Health Care Services through their Local Educational Consortium (LEC) or Local Governmental Agency (LGA) - for example a participating county or city health department). SMAA claims are calculated through a random moment time study.

What can this look like in schools?

SMAA can be used for school staff and program costs to conduct outreach and help families get students enrolled in Medi-Cal. The more students who are enrolled and stay enrolled in Medi-Cal, the better able the district is to get reimbursements for direct mental health services to Medi-Cal eligible students (see LEA Billing Option Program and Medi-Cal Specialty Mental Health Services). These activities can be conducted by some school staff, district staff, and/or by family resource center staff. A full list of eligible administrative service providers is available in the SMAA Manual (Section 6-7).

In addition, for students enrolled in Medi-Cal, SMAA can help cover costs for planning and connecting students to Medi-Cal covered services - like mental health services. Staff participating in school based-multidisciplinary teams that are connecting students to mental health services can participate in the time study to draw down SMAA reimbursements.

Additional Information

SMAA landing page from DHCS:
http://www.dhcs.ca.gov/provgovpart/Pages/SMAA.aspx

Program Description from DHCS: http://www.dhcs.ca.gov/provgovpart/Pages/SMAADescription.aspx

LEC and LGA map and contact information:
https://www.dhcs.ca.gov/provgovpart/Pages/MapLECsLGAs.aspx

California passed a state budget in June 2021 that includes unprecedented investments in child and youth behavioral health, with a special focus on school-based services and supports. While it is still too early to know exactly how these investments will be implemented, this table includes some general information about each state investment.

Also, in response to the public health crisis, three federal COVID relief packages sent nearly $26.4 billion to California to cover COVID-related learning and school reopening expenses. These funds can also be used to address student health and wellness activities and services. A significant portion of federal funds, summarized in this table, will go directly to local education agencies.

Medi-Cal Managed Care Incentive Payment Program

$400 million

Dispersed by the Department of Health Care Services, through Medi-Cal Managed Care Plans

Part of the Child & Youth Behavioral Health Initiative

Slated to begin January 2022, this program will provide incentive payments paid through California's Medi-Cal managed care plans (MCPs) to build infrastructure, partnerships, and capacity statewide for school behavioral health services. Incentives cannot be used for treatment because these services are already eligible for reimbursement through various delivery systems.[15]

The new program will support interventions, goals, and metrics that include, but are not limited to, the following:[16]

1. Local planning efforts to review existing plans and documents that articulate children and youth needs in the area; compile data; map existing behavioral health providers and resources; identify gaps, disparities, and inequities; and convene stakeholders and develop a framework for a robust and coordinated system of social, emotional, and behavioral health supports for children and youth;
2. Providing technical assistance to increase coordination and partnerships between schools and health care plans to build an integrated continuum of behavioral health services using contracts, a memorandum of understanding, or other agreements;
3. Developing or piloting behavioral health wellness programs to expand greater prevention and early intervention practices in school settings, such as Mental Health First Aid and Social and Emotional Learning.
4. Expanding the workforce by using community health workers or peers to expand the surveillance and early intervention of behavioral health issues in school-age children 0 to 25 years of age, inclusive;
5. Increasing telehealth in schools and ensure students have access to technological equipment;
6. Implementing school-based suicide prevention strategies;
7. Improving performance and outcomes-based accountability for behavioral health access and quality measures through local student behavioral health dashboards or public reporting;
8. Increasing access to substance use disorder prevention, early intervention, and treatment.

Key Recommended Strategies for School Mental Health

- Focus on leveraging existing providers contracted with MCPs, incentivizing the provision of school-based behavioral health services, or expand contracts with health plans to existing school-based behavioral health providers.
- Plan, implement, and expand school-based health centers.
- Focus on non-reimbursable targeted Tier 2 interventions like peer mentoring programs and topic-focused support groups for students.

School-Linked Behavioral Health Partnerships

$550 million

Competitive grants administered by the Department of Health Care Services

Part of the Child & Youth Behavioral Health Initiative

In addition to the above investment, DHCS will administer a competitive grant program for eligible entities, including counties, city mental health authorities, tribal entities, local educational agencies, institutions of higher education, publicly funded childcare and preschools, health care service plans, community-based organizations, and behavioral health providers.[17]

Allowable activities can include, but not be limited to, the following:

1. Addressing behavioral health disparities while providing linguistically and culturally competent services for children and youth who lack access to adequate behavioral health services or otherwise are difficult to reach.
2. Supporting administrative costs, including planning, project management, training, and technical assistance.
3. Linking plans, counties, and school districts with local social services and community-based organizations.
4. Implementing telehealth equipment and virtual systems in schools or near schools.
5. Implementing data-sharing tools, information technology interfaces, or other technology investments designed to connect to behavioral health services.

Key Recommended Strategies for School Mental Health

- Plan, implement, and expand school-based health centers.
- Focus on targeted interventions (Tier 2) like peer mentoring programs and support groups for students around specific issues.

Mental Health Student Services Act Partnership Grant Program

$205 million

Administered by the Mental Health Services Oversight and Accountability Commission (MHSOAC)

Part of the Child & Youth Behavioral Health Initiative

This investment is additional funding for the MHSOAC's existing student mental health partnership program. The purpose of this program is to establish mental health partnerships between a county's mental or behavioral health department and school districts, charter schools, and the county office of education within that county.

More information about previous grants awarded through this program is available here. More information about existing school-county partnerships is available through this resource: Summaries of County-School Partnerships to Advance School Mental Health.

Key Recommended Strategies for School Mental Health

- Coordinate planning, partnership building, and interventions with Medi-Cal Managed Care Plans also operating in the county. Ensure that efforts through the MCP incentive payment program are not duplicative.
- Establish clear referral protocols between County Behavioral Health Departments, schools, and Medi-Cal Managed Care Plans. Include contracted behavioral health providers whenever possible.

Community Schools Partnership Program

$2.8 billion

Administered by the California Department of Education

Community Schools are public schools with strong and intentional community partnerships and specifically include:

1. Integrated supports services, including the coordination of trauma-informed health, mental health, and social services;
2. Family and community engagement;
3. Collaborative leadership and practices for educators and administrators, including professional development to transform school culture and climate; and
4. Extended learning time and opportunities.[18]

Although not a necessary component, school health and mental health services are a logical component of a strong Community Schools program.

Most of the funding available will go to local education agencies (LEAs) to establish new and expand existing community schools. Grant categories include:

- *Planning grants:* $200,000 for up to 2 years
- *Implementation grants* for new or existing community schools: $500,000 per year for a minimum of 5 years
- *Coordination grants for existing community schools:* $100,000 per year, allocated annually from 2024–25 fiscal year, through the 2027–28 fiscal year.

Planning and implementation grants require a local match of one third the total grant amount. Coordination grants require a local 1:1 match.

Key Recommended Strategies for School Mental Health

- Establish coordination teams and referral systems to leverage existing school mental health services and incentivize new partnerships with community-based mental health providers.
- Transform school climate and culture to address student mental health needs.
- Build leadership and peer support opportunities for students and parents/families.

Federal COVID Relief Funding

$21 billion

Administered by the California Department of Education but dispersed directly to local education agencies (LEAs)

Three federal COVID relief packages included significant funding for LEAs:

- Coronavirus Aid, Relief, and Economic Security Act (CARES Act, March 2020)
- Coronavirus Response and Relief Supplemental Appropriations Act (CRRSA Act, December 2020)
- American Rescue Plan Act (ARPA, March 2021)

The amount of funding that LEAs receive is based on the LEA's share of funding received under Title I, Part A in FY 20–21, so schools with more low-income students will receive more funding. There is a lot of flexibility for the use of these funds.

Key Recommended Strategies for School Mental Health

- Universally screen students for unmet physical and mental health needs as they return to school campuses.
- Fund school based health providers (e.g., nurses, social workers, psychologists) and community based health and wellness staff (e.g. community clinics) to conduct screenings and deliver school-based or school-linked services.
- Begin planning with community partners to develop or strengthen school-based wellness strategies, such as school-based health centers.

More information on this funding source and how to support student health and wellness is available here: Advancing Student and Staff Health and Wellness Using COVID Relief Funding.

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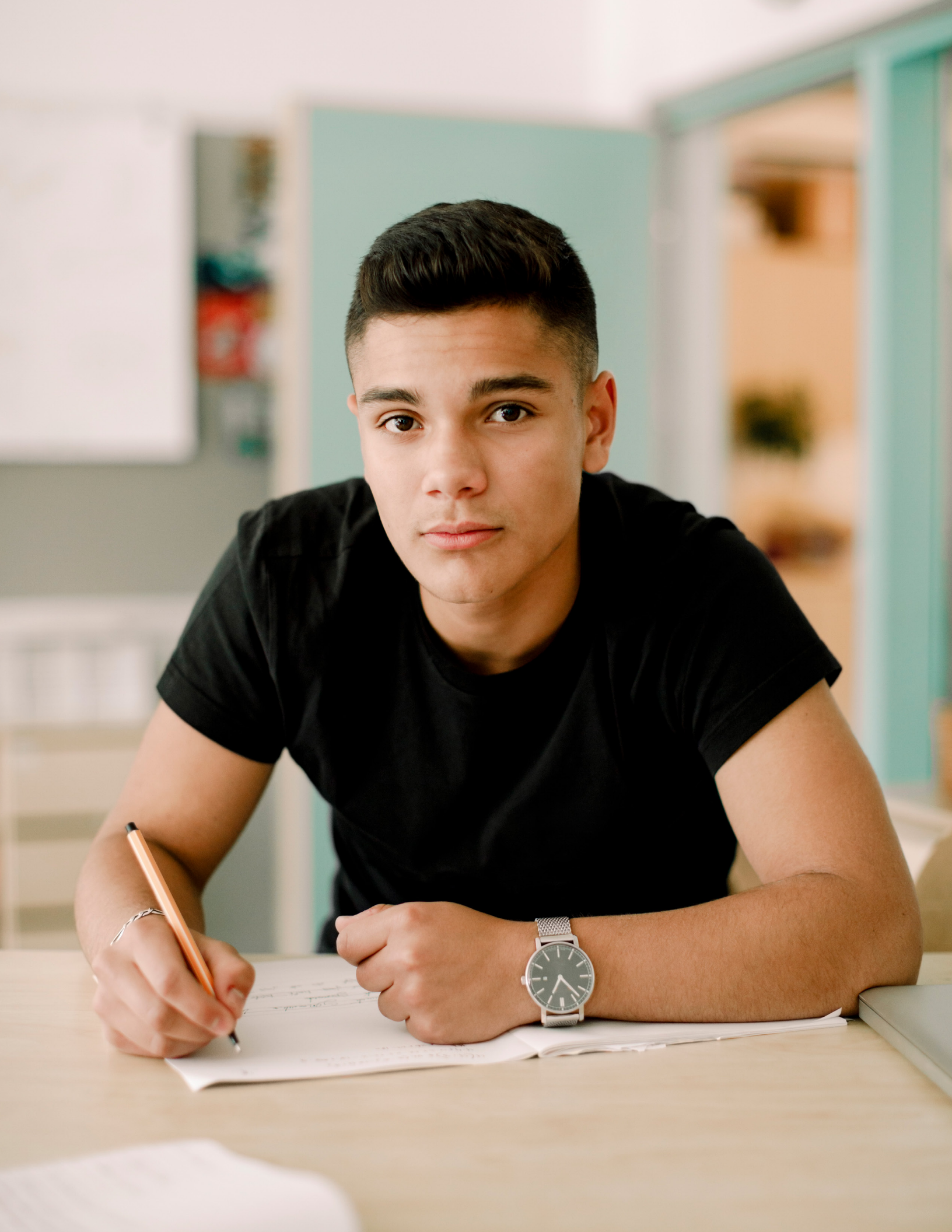

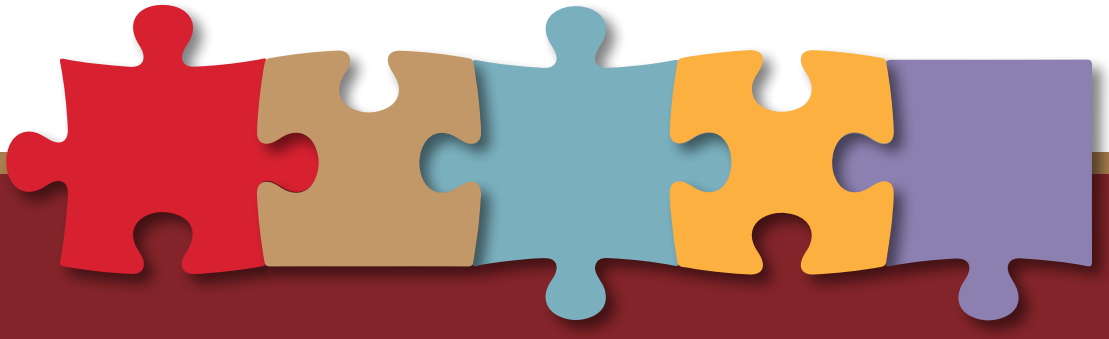

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