



California Alliance
OF CHILD AND FAMILY SERVICES

AB 3632 → AB 114

Transition of Educationally Related Mental Health Services

Q & A

Q: What happened to AB 3632 mental health services?

A: AB 114, the 2011-12 education budget trailer bill, eliminated all statute and regulations related to AB 3632 which had been the authority for providing mental health services to students in special education whose handicapping condition is emotional disturbance and who required mental health services in order to benefit from the free and appropriate public education (FAPE) to which they are entitled.

The bill transferred responsibility and funding for educationally related mental health services, including residential services, from county mental health and child welfare departments to education.

Q: How much money did the state allocate to education to provide these services? Does it have to be used for educationally related mental health services?

A: A total of \$420.3 million in three pots was allocated to education for educationally related mental health services. Of that, \$386.3 million was additional money categorically restricted to be used for educationally related mental health services:

- \$218.7 million “shall be available only to provide educationally related mental health services, including out-of-home residential services for emotionally disturbed pupils...”
- Schools shall receive \$69 million in federal IDEA funding “only for the purpose of providing educationally related mental health services, including out-of-home residential services...”
- Schools may access \$98.6 million in MHSA funding specifically for mental health services for special education students

The first pot is Proposition 98 dollars of which \$218.7 million is “re-benched;” that is, it represents a recalculation of the base amount used to determine the level of Proposition 98 funding provided to schools by the state each year. The recalculation results in a Proposition 98 funding increase of nearly \$220 million to schools in 2011-12, specifically for mental health services.

An additional \$34 million in continuing Proposition 98 funding is also targeted at mental health services, \$31 million of which previously was used to pay for Non Public School (NPS) placements of children living in Licensed Children’s Institutions (LCI), and \$3 million of which constitutes an extraordinary cost pool for small SELPAs and LEAs. This is not “new” money, but it is funding that could be used by schools for this purpose.

The second pot, IDEA, represents \$69 million in federal funding to help states comply with the Individuals with Disabilities Education Act (IDEA).

Both the first and second pots are distributed by the California Department of Education to Special Education Local Planning Areas (SELPA) based on the Average Daily Attendance

(ADA) of all children in the SELPA, without regard for their special education status. SELPAs, in turn, allocate the funds to the Local Education Agencies (LEAs) that comprise the SELPAs (i.e., primarily school districts and charter schools with LEA status) based on formula unique to each SELPA. This methodology mirrors the way in which most special education funds are allocated.

Half of the appropriated funds will be distributed on October 1, 2011, 25% in spring 2012, and the final 25% based on updated ADA in summer 2012.

The third pot reflects a one-time-only redirection of \$98.6 million in Mental Health Services Act (MHSA) funding to local mental health departments for educationally related mental health services. Redirection of the MHSA funds was authorized by AB 100. The funds have been allocated to counties based upon a formula agreed upon by the California Mental Health Directors Association and the California Department of Mental Health. The funds may only be accessed through an agreement between a SELPA or LEA and its county mental health department. Responsibility for authorizing, contracting for or providing, and paying for educationally related mental health services funded using MHSA dollars, however, rests with LEAs.

According to the Brown Administration, the 2012-13 state budget will reflect a further “re-benchmarking” of Proposition 98 to cover the loss of MHSA funding when the current budget year ends June 30, 2012.

(See “Assembly Bill 114: Available Funding Sources and Spending Parameters;” September 13, 2011)

Q: Do educationally related mental health services include residential care?

A: Yes.

Residential care is one of the “related services” to which children with disabilities receiving special education services may be entitled under IDEA and is specified as such in federal regulations, 34 CFR 300.104:

If placement in a public or private residential program is necessary to provide special education and related services to a child with a disability, the program, including non-medical care and room and board, must be at no cost to the parents of the child.

(See “Assembly Bill 114: Residential Care for Students with Disabilities;” September 13, 2011)

Q: Does the IDEA specify other educationally related mental health services to which special education students are entitled?

A: The IDEA specifies a host of “related services” to which students with disabilities who receive special education may be entitled (34 CFR 300.34). The list, however, is neither exhaustive nor finite, according to the federal Office of Special Education Planning (OSEP). Any service agreed upon by the student’s Individualized Educational Program (IEP) team as necessary for the student to receive a FAPE may be considered a related service.

That said, 34 CFR 300.34(a) defines related services as:

...transportation and such developmental, corrective, and other supportive services as are required to assist a child with a disability to benefit from special education, and includes speech-language pathology and audiology services, interpreting services, psychological services, physical and occupational therapy, recreation, including therapeutic recreation, early identification and assessment of disabilities in children, counseling services, including rehabilitation counseling, orientation and mobility services, and medical services for diagnostic or evaluation purposes. Related services also include school health services and school nurse services, social work services in schools, and parent counseling and training.

OSEP, commenting on a number of requests to specify additional related services in regulation, states, “It would be impractical to list every service that could be a related service, and therefore, no additional language will be added to the regulations.”

OSEP, however, goes on to identify 2 critical requirements for a service to be considered a related service:

1. The child’s IEP team must determine that the related service is required in order for the child to benefit from special education (FAPE);
2. The IEP team’s determination of appropriate services must be written into the child’s IEP.

With those two criteria met, the IEP’s “listed services must be provided in accordance with the IEP at public expense and at no cost to the parents.”

In short, if a service is specified on a student’s IEP, and the IEP is agreed to by the requisite members of an IEP team as indicated by their signatures on the IEP, it is a related service. The IEP rules; it is the definitive legal document.

(See “Related Services Under the Individuals with Disabilities Education Act;” September 13, 2011.)

Q: Could wraparound be considered a related service?

A: Yes.

Again, any service that a child’s IEP team determines is required for the child to benefit from his/her FAPE, and that is written into the IEP and signed by the parents or holder of the child’s educational rights is a related service and must be provided to the child at public expense.

Q: Is the prescription, monitoring and administration of psychiatric medication a related service?

A: Maybe.

The California Department of Education (CDE) has advised SELPAs and LEAs that “in general, medical services are required under the IDEA if they are necessary for the purpose of diagnosis or evaluation. However, medical services provided by a licensed physician for other purposes, such as treatment, may not be a related service required by the IDEA.”

Since the prescription and monitoring of psychiatric medication is a “medical service” provided by a licensed physician but not necessary for diagnosis or evaluation, and is in fact

a part of treatment, CDE contends it may not be required under IDEA, citing federal regulation and the “medical exclusion” arising out of case law.

CDE clarifies, however, that services that can be provided in the school setting by a nurse or qualified layperson are not subject to the medical exclusion and advises LEAs that to the extent administration of medication is done by a school nurse or qualified lay person, that service activity may fall under the IDEA.

CDE further advises LEAs to consider requests for medication monitoring on a case by case basis to determine if they fall under IDEA.

Advocacy attorneys, however, have taken issue with CDE’s interpretation of federal regulation and argue that IDEA does not create a blanket disqualification of the prescription and monitoring of psychiatric medication as related services. Citing case law, the attorneys state, “[C]ourts have held that psychiatric services are required [under IDEA] if they are part of an integrated program of educational, emotional, behavioral, and medical services designed for educational purposes.” The attorneys request that CDE include the information in its advisory to LEAs, which, apparently, it has not.

(See “Assembly Bill 114: Medication Monitoring;” September 13, 2011 and “Memorandum” from Public Counsel and Mental Health Advocacy Services; August 29, 2011.)

Q: Does my agency have to be a Non Public Agency or Non Public School in order to provide educationally related mental health services?

A: No, not if your agency is a certified mental health services contractor of a local county mental health plan (MHP).

CDE has advised SELPAs and LEAs that as long as a community-based mental health organization is a certified contractor of a local mental health department and is authorized by that department to provide the specific related services for which it seeks to contract with the LEA, the organization may provide educationally related mental health services under contract with the LEA.

If the community-based organization is not a mental health contractor or is not authorized to provide the specific educationally related mental health service – whatever it may be – the organization must become certified as a Nonpublic School or Agency through CDE in order to become a contractor of the related services.

Although CDE has advised that it is not necessary for a mental health organization to be a NPA or NPS to provide service, some SELPAs or LEAs may require it anyway. It is their prerogative.

CDE also advises that “community-based mental health professionals must be supervised in their school-based activities by an individual possessing a Pupil Personnel Services (PPS) Credential.” The advisory clarifies that “supervised” in this context means has oversight of the related services activities to ensure “these services are consistent with the needs of students served and are coordinated with other student services.”

(See “Requirements for Securing the Services of Mental Health Professionals to Provide Related Services to Special Education Students;” September 13, 2011.)

Q: Districts and SELPAs have said they want to pay less for mental health services and related services such as residential placement than providers currently are being paid. Under what circumstances may my agency accept lower payments?

A: There are two answers to that question: one for mental health services and one for residential services.

Historically, private provider organizations were paid the same amount for both EPSDT funded mental health services and for those funded through AB 3632, largely because county mental health plans administered both programs, and because many children receiving AB 3632 services were also EPSDT eligible allowing counties to draw down federal matching dollars.

Similarly, residential programs were paid the RCL rate for AB 3632 placements, as the rate payment mechanism was statutorily tied to county child welfare departments that paid providers and to the state and federal foster care programs that govern the rates.

With the abolition of AB 3632 and responsibility for educationally related mental health services shifting solely to schools, the historical and statutory ties between mental health, foster care and educationally related mental health services has been broken.

Mental Health Services Rates

Certified mental health services contractors of county mental health plans (MHP) may not charge an LEA less for a mental health service than it receives in EPSDT reimbursement from an MHP and continue to receive full reimbursement for costs from the MHP.

Agencies that are mental health contractors with a county MHP receive a provisional rate for each service type based on estimated costs to provide those services for a specified number of beneficiaries over the term of the contract, usually a year, up to a contract maximum. The types of services that may be provided are specified in California's Medicaid rehabilitation option.

Contractors bill MHPs for services at the provisional rate over the term of the contract. At the end of the contract period, contractors and MHPs settle to actual cost. If the actual costs are less than the provisional rate, the contractor returns money to the MHP; if costs are higher, the MHP reimburses the contractor up to the contract maximum. Contractor costs per unit are limited by a State Maximum Allowance (SMA) for each service type.

California's Medicaid plan specifies:

The policy of the State Agency is that reimbursement for Short-Doyle/Medi-Cal services shall be limited to the lowest of published charges, Statewide Maximum Allowances (SMAs), negotiated rates, or actual cost if the provider does not contract on a negotiated rate basis.

"Published charges" are usual and customary charges prevalent in the public mental health sector that are used to bill the general public, insurers, and other non-Title XIX payors.(42 CFR 447.271 and 405.503(a)).

So, if for example a contractor has a "published charge" it uses to bill a school district and the charge is lower than the EPSDT reimbursed cost for the same service, the Department of Health Care Services (DHCS, the State Agency) would expect the county MHP to pay the contractor the published charge, not the actual cost, since the published charge is the lower of the two.

DHCS would also likely recoup from the county MHP the difference between the amount charged the school district and the amount reimbursed by the MHP, which in turn would seek to recoup it from the contractor agency.

Conversely, if the contractor's "published charge" used to bill a district is higher than the EPSDT costs, the MHP would be obliged to reimburse the contractor the amount that covers the actual cost to provide the EPSDT service, since it is the lower of the two.

Residential Placement Rates

Agencies may not charge an LEA an amount for residential placement that is lower than the RCL rate, without risking an audit exception from the California Department of Social Services on the amount paid for the care of children funded with foster care dollars.

In the cases of *California Alliance v. Allenby and Ault* and *California Alliance v. Wagner and Rose*, the federal 9th Circuit Court of Appeals ruled that California could not institute two foster care rates systems for group homes, one for federally eligible children and one for those who are not federally eligible, since both groups of children are placed in the same programs and receive the same services.

Since California's Standard Schedule of Rates is designed to pay the average cost of care for children in any give Rate Classification Level (RCL), for the state's plan to pay less for non-federally eligible children, the court reasoned, would necessarily dilute the amount paid for the federally eligible children and deprive them the full benefit of the rate increase that was the focus of the lawsuit.

Similarly, if a residential program that serves children placed through both the education and foster care systems accepts payments from LEAs lower than those for the program's RCL, it would necessarily be using the funds paid for the care of the foster children to supplement the lower rate paid by the LEA and, therefore, would be depriving foster children of the care and supervision to which they are entitled and for which the RCL rate pays.

Residential programs would be at risk for an RCL audit exception, rate reduction, and forfeiture of the difference between the new reduced rate and old rate.

Conclusion

Both EPSDT payments and RCL rates are essentially cost-based. For a provider organization to charge an LEA less than the EPSDT reimbursement for the same mental health services or less than the RCL rate for residential placement would imply that the provider is either illegally using Medi-Cal or foster care funds to pay for education services or, worse, is engaging in fraud.

Providers may offer different programs, with different staffing, different staff qualifications and different service arrays at any rates they choose, but they would have to assure programmatically, fiscally and administratively that the programs could not be misconstrued as simply rebadged EPSDT or RCL programs offered at a lower rate.

(See "Reimbursement for Short Doyle/Medi-Cal Outpatient, Rehabilitative, Case Management and Other Services.")