State of California—Health and Human Services Agency
Department of Health Care Services

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Student Behavioral Health Incentive Program Objectives and Process

In accordance with State law (AB 133, Welfare & Institutions Code Section 5961.3), the Department of Health Care Services (DHCS) is directed to design and implement the Student Behavioral Health Incentive Program (SBHIP). $389 million is designated over a three-year period (January 1, 2022-December 31, 2024) for incentive payments to Medi-Cal managed care plans (MCPs) that meet predefined goals and metrics. SBHIP goals and metrics are associated with targeted interventions that increase access to preventive, early intervention and behavioral health services by school-affiliated behavioral health providers for children in public schools in Transitional-Kindergarten (TK) through grade 12.

Incentive payments shall be used to supplement and not supplant existing payments to MCPs. In addition to developing new collaborative initiatives, incentive payments shall be used to build on existing school-based partnerships between schools and applicable Medi-Cal plans, including Medi-Cal behavioral health delivery systems.

Objective of Student Behavioral Health Incentive Payments

- **Break down silos and improve coordination** of child and adolescent student behavioral health services through increased communication with schools, school affiliated programs, managed care providers, county behavioral health plans, and behavioral health providers.

- **Increase the number of TK-12 public school students enrolled in Medi-Cal receiving behavioral health services** through schools, school-affiliated - providers, county behavioral health departments, and county offices of education.

- **Increase non-specialty services on or near school campuses**.

Objective of the SBHIP Workgroup

In accordance with the State law (AB 133: Welfare & Institutions Code Section 5961.3(b)), DHCS established a SBHIP Stakeholder Workgroup to develop the targeted interventions, goals, and metrics used to determine incentive payments to MCPs. The SBHIP Stakeholder Workgroup has been asked to assist DHCS in determining the design and approach to guide implementation of SBHIP, in particular to:

- Provide feedback and guidance on interventions, goals, and metrics.

- Help identify activities that best target gaps, disparities, and inequities.

- Provide feedback on incentive payment calculation and payment methodology.

The SBHIP Stakeholder Workgroup has representation from the California Department of Education (CDE), MCPs, county behavioral health departments, local educational agencies (LEAs), and other affected stakeholders. Between August 2021 and December 2021, there were multiple meetings to engage and collect feedback from stakeholders.

DHCS to finalize by January 1, 2022

The SBHIP effective date is January 1, 2022. By that date, targeted interventions, metrics, goals, incentive payment calculation, and allocation methodology will be defined for the SBHIP. MCPs interested in participating in the SBHIP will need to submit a letter of intent to DHCS.

- Targeted Interventions: Activities that will increase access to preventive, early intervention and behavioral health services by school-affiliated behavioral health providers for TK-12 children in public schools.

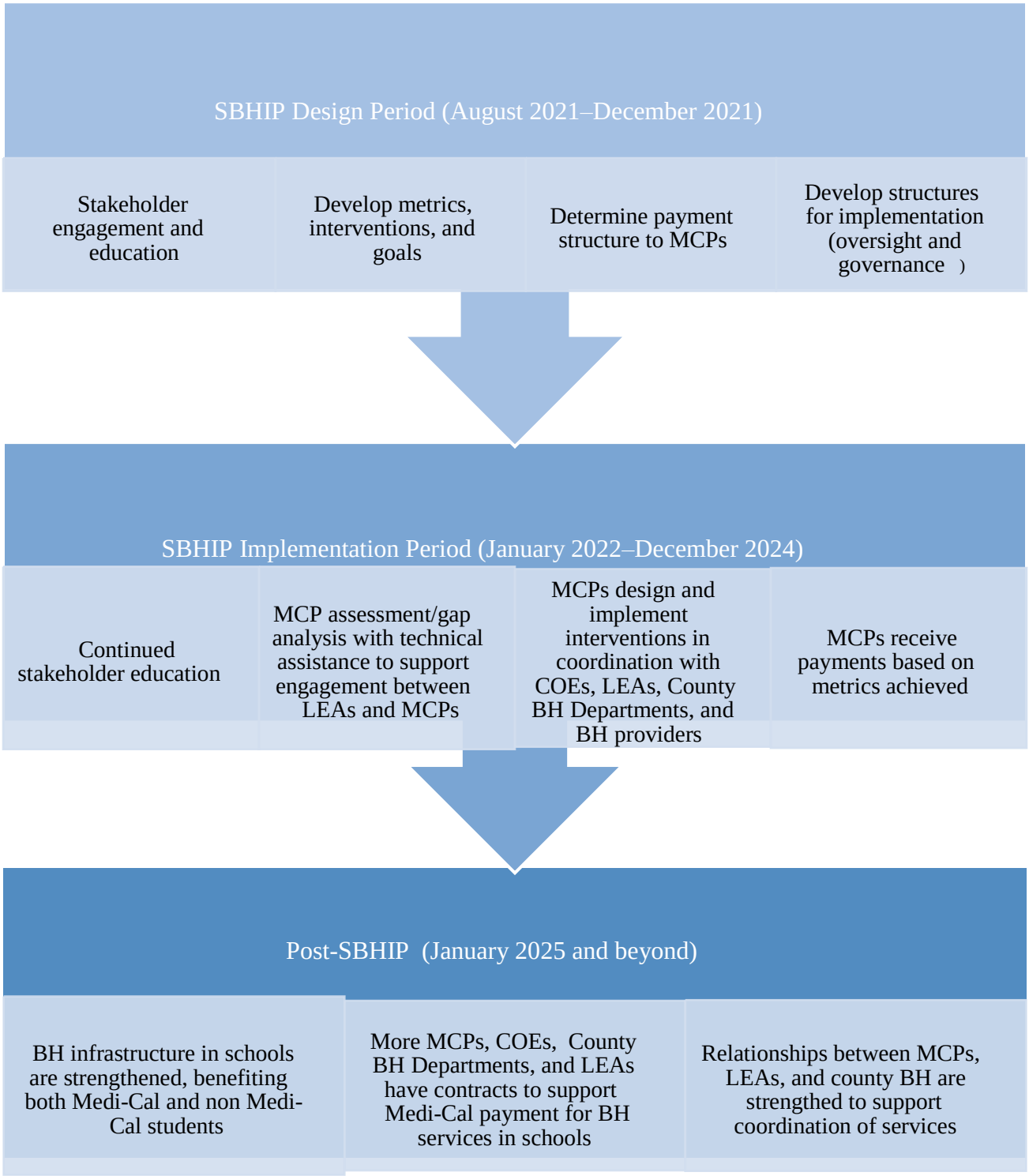
- Goals: Desired outcomes, locations, and/or populations to reach with each intervention or quality measure.

- Metrics: Specify the requirements, steps, and measures to assess achievement of selected targeted interventions or quality measures.

- Allocation Methodology: Identifies the methodology used to allocate and distribute incentives earned for implementing the selected targeted interventions and achieving specified quality measures.

SBHIP Duration and Sustainability

SBHIP will follow three distinct phases; design, implementation, and post-SBHIP. The design and implementation of SBHIP is structured with the intention to build infrastructure and relationships that extend beyond the three year incentive period.



Background

California is in an unprecedented time. Leaders across sectors recognize the growing mental health crisis among youth and are committed to change. While there are multiple examples of excellence across the State, including partnerships between county behavioral health departments and school districts, DHCS seeks to improve the statewide continuum of care to ensure every child receives the behavioral health services they are entitled to, the first time, and every time, they seek care.
The consequences of unaddressed child and adolescent mental health conditions often extend to adulthood. According to the World Health Organization, half of all mental health conditions start by 14 years of age. Most substance use disorders (SUDs) also start in adolescence. The majority of these cases are undetected or untreated. The United States is experiencing a youth behavioral health crisis. The last decade saw an increase in the number of mental health hospitalizations, death by suicide, and overdose deaths in children and youth. These increases have been compounded by the Coronavirus Disease 2019 (COVID-19). Stay-at-home orders and school closures have resulted in increased social isolation, exposure to traumatic experiences, and chronic stress which has significantly negatively impacted children and youth. In addition, unemployment and economic uncertainty increase the risk of domestic violence, and concerns are growing that stay-at-home orders masked growing rates of child abuse. Parents may not recognize their child's challenging behaviors as signs of a mental health condition, and young people rarely seek help until their conditions are quite severe. As students return to school, it is imperative to reach young people where they are and develop connections with people who can recognize distress, intervene early, and ensure their mental well-being. Schools are a critical point of access for preventive and early intervention behavioral health services as children are in school more than half of each year. Early identification and treatment through school-affiliated behavioral health services can reduce progression to serious mental illness and SUDs. These interventions decrease the number of youth who present for help in a crisis, at the emergency department and/or require restrictive care, attempt suicide, overdose, experience an acute psychiatric emergency, or are placed in a restrictive special education setting, out of home placement in foster care, and/or residential care.
School-based health care is also a powerful tool for achieving health equity among children and adolescents who experience disparities in outcomes simply because of their race, ethnicity, or family income. Increasing health care in the school system is a dynamic solution to the inequalities that many children in California face. For example:

- The mental health needs of African American, Native American and Pacific Islander students are more likely to be interpreted as willful misbehavior and result in higher rates of exclusionary discipline and chronic absenteeism.
- Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ) students are two times more likely to report depression and three times more likely to report suicidal ideation than non-LGBTQ peers.
- Latinx students are less likely to access Medi-Cal behavioral health services.

The disproportional impact of COVID-19 builds on existing inequities, leading to a more profound impact on the emotional wellbeing of children of color. Building a culturally responsive, cross-system partnership is critical in improving outcomes, reducing disparities, and achieving racial equity.

Better integrating behavioral health services can help break down historical siloes and stigma. Investing in mental health prevention and earlier identification can enhance learning and student wellness. In addition, with nearly 40 percent of California children enrolled in Medi-Cal, significant investment of infrastructure of behavioral health access in schools for Medi-Cal students will indirectly build capacity and access for non-MediCal students.

The SBHIP supports the goals of California's Advancing and Innovating Medi-Cal (CalAIM) initiative that people served by DHCS programs have longer, healthier, and happier lives. There will be a whole-system, person-centered approach to health and social care, in which services are only one element of supporting people to have better health and wellbeing throughout their whole lives. It will be an integrated "wellness" system, which aims to support and anticipate health needs, to prevent illness, be equitable and to reduce the impact of poor health.

Flexible Contract Models

Medi-Cal already covers many behavioral health services in schools. The challenge is in how to navigate the operational, financial, cultural, and political barriers that prevent MCPs, mental health plans (MHPs), drug Medi-Cal (DMC) programs, and schools from working together to deliver coordinated care. DHCS believes a one-time investment can bring the key players to the table to find local solutions to overcome these barriers. Some counties are already providing excellent and integrated behavioral health services in schools, and DHCS wants to build on that success by creating incentives to expand access and increase integration of care in all counties regardless of size, location, and current capacity.

Medi-Cal services provided by county MHPs are restricted to children with specialty mental health needs. MCPs are responsible for providing all non-specialty mental health services for children. SBHIP is designed to support interventions to get these nonspecialty services on or near school campuses, so young people have access to services where and when they need them.

Some schools have been successful in expanding services billed to Medi-Cal by coordinating and contracting with Medi-Cal MCPs, MHPs, county SUD programs, and participating in the Local Educational Billing Option Program (LEA BOP), while others provide very few Medi-Cal reimbursable services. SBHIP incentive payments is designed to incentivize Medi-Cal MCPs to support implementation of targeted interventions for planning and coordination, to contract with school-based behavioral health providers, to build infrastructure, fund school-based staff, and expand access to services. Incentives may also be provided to preserve and expand existing programs for

school districts that have existing programs that align with the list of targeted interventions.

As part of the SBHIP, DHCS will work with CDE to facilitate partnerships between MediCal MCPs, county behavioral health departments, and schools. Initial planning efforts will include technical assistance for an assessment of existing capacity and to facilitate relationships among participating entities for the duration of the SBHIP. In an effort to increase coordination, Medi-Cal MCPs will be required to have an MOU for each targeted intervention implemented.

School-Based Health Care in California

Children may access behavioral health services through their MCP, MHP, county health plan, and on school campus during the school day. Each system is designed to address and provide a specific set of services: although in practice, these services often overlap resulting in various levels of coordination between each system.

Many children with intense medical needs are provided health services during the school day. In these cases, the educational and related medical services are outlined in the student's Individual Educational Programs (IEP) or Individual Family Service Plan (IFSP), per the Individuals with Disabilities Education Act (IDEA). The IDEA requires school districts to provide a free appropriate public education (FAPE) for students with disabilities, which creates a legal obligation for districts to ensure services included on an IEP/IFSP are provided to the student. In many cases, schools employ and contract with health service practitioners (e.g., nurses, psychologists, occupational therapists, physical therapists, etc.) to provide these services to students. Schools may elect to participate in the LEA BOP to receive federal reimbursement for certain assessments and treatments for Medi-Cal enrolled students with an IEP/IFSP or Individualized Health and Support Plan (IHSP) or other Care Plan. Approximately 600 LEAs participate in LEA BOP, representing 58 percent of all distinct LEAs in California. Total enrollment in these LEAs represents approximately 88 percent of total student enrollment in the state of California.

In accordance with federal regulation, DHCS is responsible for providing full-scope Medi-Cal beneficiaries under the age of 21 with a comprehensive, high-quality array of preventive (such as screening), diagnostic, and treatment services under Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT). These services expand beyond those that may be required in an IEP/IFSP or IHSP. Specific to behavioral health services, non-specialty mental health services are provided by MCPs while specialty mental health services (SMHS) and SUD treatment services are "carvedout" of the MCP's responsibility. Medi-Cal beneficiaries may access SMHS through county mental health plans, and SUD services through county SUD programs that are required to provide or arrange for the provision of outpatient and inpatient behavioral health services to beneficiaries in their counties.

Schools, MCPs, county MHPs, and county SUD programs all share responsibility for children, but operate separately, with their own networks of contracted providers and reimbursement mechanisms for providing health care services to Medi-Cal students during the school day. The participation requirements of the educational model and the medical model are often at odds, further dividing health care between services provided in a school-based setting versus a community setting.

The SBHIP provides incentives to increase coordination among MCPs, county behavioral health plans, and schools with the understanding it will significantly impact the delivery of services to this population and ultimately benefit all delivery systems. Creating a comprehensive and continuous system of care for Medi-Cal students to access the entire scope of available benefits is consistent with the national movement of increasing access to Medicaid services in schools.

Existing Funding Streams

To fund prevention, early intervention and behavioral health services at schools, California uses many funding streams, each with its own rules, requirements and restrictions. Few school systems have staff on-site with experience and time to navigate the complexity of the funding sources listed below. One long-term goal of SBHIP is to incentivize the creation of infrastructure that more effectively integrates, coordinates, and aligns these funding streams.

Managed Care

Medi-Cal Managed Care Plans (MCPs): Nearly 40 percent of California's children are enrolled in Medi-Cal, and the vast majority of them are enrolled in MCPs that are paid via capitation to ensure children and youth have access to health benefits, including physical health and non-specialty mental health services. Non-specialty mental health services include education, preventive services, counseling, psychological testing, and psychiatric evaluation.

Schools rarely have the expertise and health care know-how to contract with MCPs, and MCPs are not incentivized to contract with schools. This is largely due to MCP financial arrangements and requirements for primary care providers which complicate implementation of contracts.

Commercial Insurance: Almost all California children are insured, largely due to California's participation in the Affordable Care Act and a concerted statewide effort to ensure all children have access to Medi-Cal or affordable insurance through the exchange.

LEAs are obligated to bill other commercial payers that are by statute or contract legally responsible for payment of a claim. However, schools are not staffed to manage the substantial administrative work involved in contracting with multiple payers, all with differing credentialing, provider oversight, and contracting requirements.

County

County behavioral health departments, covering Specialty Mental Health Services (SMHS) and SUD treatment: SMHS are offered to Medi-Cal beneficiaries with serious mental illness, serious emotional disturbance, or with mental health conditions requiring services beyond what is offered by MCPs. This system of care is tailored to children requiring specialty mental health, not for the general population. SUD treatment is offered through Drug Medi-Cal Organized Delivery Systems (county-administered SUD managed care for more than 95% of California's population) or Drug Medi-Cal (a fee for service delivery system with more limited SUD services).

Many county behavioral health departments have established school-based services, but this varies from county to county. In a recent survey conducted by the California Behavioral Health Directors Association in January 2021, 44 of 58 counties responded:

- 34 percent of counties indicated that they covered 80-100 percent of school campuses.
- 17 percent of counties covered less than 20 percent of campuses.
- 49 percent fell somewhere in between.
- 88 percent of respondents provide specialty mental health services.
- 53 percent provide substance use disorder services.

Substance Abuse and Mental Health Services Authority (SAMHSA) Block Grants: Funding is administered through county behavioral health departments and used for mental health and substance use disorder prevention and treatment services. These grants are widely used in school settings and after-school programs to cover education, prevention, early intervention and any other services that would be not be covered by Medi-Cal.

Mental Health Services Act (MHSA): MHSA is tax revenue administered through county behavioral health departments, and 20 percent of the funding must be spent on prevention and early intervention (PEI) services, and at least 51 percent of this funding must be spent on people under age 26.

Every county has a different process to determine how the funding should be spent, based on the needs of the county. Some county behavioral health departments use these funds to provide PEI services in schools. Unlike Medi-Cal mental health services, which are an entitlement, MHSA revenues vacillate with the economy.

Schools

Local Educational Agency Medi-Cal Billing Option Program (LEA BOP): Medi-Cal offers LEA BOP which is a federally reimbursed Certified Public Expenditure (CPE) program that schools can choose to participate in. LEA BOP reimburses schools for certain health-related services that have already been provided to Medi-Cal enrolled students by qualified health care practitioners employed by the LEA or under contract with a LEA. The funds are restricted in their use and must supplement, not supplant, existing services. Services are available to students who have a care plan either an IEP/IFSP or IHSP.

LEA BOP is not designed to cover "drop-in" services to take advantage of a youth seeking help at a moment in time, and is not connected with the broader health care system, so any behavioral or medical needs requiring additional services may not be coordinated back to the child's primary care provider.

Privacy laws governing school services (FERPA) are different from privacy laws governing health care services (HIPAA), complicating information exchange.

School-Based Medi-Cal Administrative Activities (SMAA) Program: The SMAA Program promotes access to health care for students in the public school system, preventing costly or long-term health care problems for at-risk students, and coordinating students' health care needs with other health care providers. The SMAA Program is a CPE program in which schools may choose to voluntarily participate. The SMAA Program offers a path for schools to obtain federal reimbursement for the cost of performing certain administrative activities necessary for the proper and efficient administration of the Medi-Cal program.

Local Control Funding Formula funds: The Local Control Funding Formula (LCFF) gives local communities control and flexibility over allocated Proposition 98 General Fund and helps deliver resources to the neediest students. Built on a needs criterion, target based grants are distributed in certain amounts, with those amounts rising when the concentration of English learner, low-income, and foster youth grows.

LCFF funding is allocated through the Principal Apportionment and is funded through a combination of local property taxes and state funding from the State School Fund and Education Protection Account.

LEAs must use a Local Control and Accountability Plan to set goals, plan actions, and leverage resources to meet those goals to improve student outcomes. This includes the use of LCFF funds, when other funding is not available, to meet Individuals with Disabilities Education Act requirements related to the school districts' responsibility to provide a free appropriate public education for students with disabilities.