CHILDREN AND YOUTH BEHAVIORAL HEALTH INITIATIVE

TOTAL: $4 billion over 5 years, including one-time federal and general fund and ongoing federal matching funds.

Proposal	Amount	Details
School-Linked Behavioral Health Services	$950 million	- Incentive payments to LEAs, counties, health plans, community based providers and Medi-Cal managed care plans to provide services on or near school campuses - Expand access to behavioral health school counselors and coaches - Administrative costs including project management, facilities, training and technical assistance - Adoption of telehealth and data sharing systems - Flexible funding to address student needs identified by teachers and staff - Establishes a fee schedule for school mental health providers and requires health plans to pay for services.
Behavioral Health Virtual Platform	$680 million	- Establish a virtual platform targeted at ages 0 to 26 that offers Tier 1 and Tier 2 services, with some Tier 3 services and streamlined referrals to health plans for more intensive services. - Services provided primarily virtually, regardless of insurance or health plan. Includes links to other social services like housing and food assistance.
Enhance Medi-Cal Benefits	$800 million	- Creates two new Medi-Cal benefits including ACEs and Dyadic benefits - $200 million per year over 4 years, 50% from federal matching funds
School Behavioral Health Workforce Capacity	$430 million	- Create a school behavioral health counselor system by producing up to 10,000 culturally and linguistically proficient counselors and coaches to serve K-12 and college age youth. - Funds would provide for tuition, training, mentorship, and a two year stipend. Would include both licensed and credentialed (PPS) behavioral health professionals. - Would be created in coordination with education stakeholders.
Behavioral Health Workforce Capacity	$430 million	- Build out other aspects of the behavioral health workforce serving youth by creating a new certificate for youth substance use counselors, educating and training up to 7,500 psychiatric nurses, creating apprenticeship models, youth peer support specialists, and providing specialized training to justice system involved youth.
Public Education Campaign	$125 million	- Create a culturally and linguistically proficient public education campaign that seeks to raise behavioral health awareness and acceptance, educate on prevention and recognizing signs early, and create youth-led behavioral health engagement and education efforts using social media and apps.

The MR eliminates the January proposal to create a Prop 98 behavioral health match ($25 million) but maintains and increases the commitment to a second round of MHSSA funding ($30 million). It also maintains the commitment to MTSS ($50 million), establishing a Medi-Cal Billing system of support lead and PLNs ($5 million), and increases the investment in community schools from $100 million to $2.95 billion over 5 years.

QUESTIONS FOR CONSIDERATION

Children and Youth Behavioral Health Initiative

1. ***Given the amount of money being proposed and the fact that it is outside of K-12's normal sphere of influence, education advocates have pushed for DHCS to provide TBL on their proposal. Once TBL is released, how much should CCSESA seek to define details around how the funding is allocated, to whom, and what it can be used for?***
    - DHCS would prefer to use a stakeholder process (multiple sessions over the summer) to determine the terms and requirements for grants and incentive payments. Education advocates have expressed concern that we will not have an equal seat at the table in this process given DHCS's long-standing relationship with county health and health care plans.
2. ***Sustainability has been identified as a key outstanding issue that needs to be addressed in this proposal. One solution is to ensure that Medi-Cal and commercial health plans are required to reimburse for services provided by school mental health staff to eligible students even after the incentives expire. Is this something CCSESA should push for? Are there other ideas to address sustainability?***
    - Many education initiatives require applicants to indicate how they will sustain programs after funding expires. However, DHCS has indicated that funds related to services will be provided as incentive payments, not grants.
3. ***This proposal would make schools eligible to become in-network providers of mental health services, regardless of whether a student has Medi-Cal, Medi-Cal managed care, or commercial insurance. What systems, training, or technical assistance (and funding for same) would schools need to facilitate becoming in-network providers?***
    - DHCS's memo implies that the proposal could include a state-created system to standardize and streamline billing and a state-created data system to help with the kind of data sharing that will likely be needed between schools, health plans, and insurance.
4. ***To what extent should CCSESA advocate for PPS credentialed staff to be included as reimbursable mental health providers? Should the School Behavioral Health Workforce grants include recruitment and training of PPS credentialed staff or just licensed staff? What should be the minimum qualifications for school-based health providers?***
    - Most mental health professionals employed by schools hold a PPS credential and are not licensed by the Board of Behavioral Sciences. The qualifications to become a licensed marriage and family therapist and or a credentialed school psychologist (PPS) are very similar. Unlicensed staff holding a PPS credential are Medi-Cal eligible providers of mental health services but only a licensed provider can "order" services in an IEP/504/health plan. DHCS is clearly confused about the qualifications of PPS credential holders and their eligibility to bill for Medi-Cal.
5. ***Should CCSESA push to require that, in order to be eligible for incentive payments, all services must be provided on a school campus? If CCSESA wants to allow greater flexibility to provide services off-campus, how close should the services be to the school site (e.g. 1 mile)?***
    - Currently the proposal indicates that there is a strong preference (but no requirement) for services to be provided on campus. The proposal does not define how far services

can be from campus or whether certain services (e.g. intensive) can be provided elsewhere.

6. ***Absent a requirement to provide services on a school campus, it appears that Medi-Cal managed care plans could choose to only collaborate with county mental health or community-based organizations serving students. What should we ask for to ensure that schools are key partners in the delivery of student services?***
7. ***How do county offices envision that this proposal would integrate with and build upon existing investments in school-based services like MHSSA and school-based Medi-Cal programs like LEA BOP and SMAA? Do we have suggestions to facilitate integration into existing investments?***

Community Schools

8. ***The MR proposal for community schools builds upon the grant program created in the 2020 budget. One new grant requirement is that LEAs provide a 50% match, only 25% of which can be from in-kind facilities. Given that the intended recipients of this grant are schools with 80%+ FRPM, is this requirement reasonable?***
9. ***The language also includes new prioritizations including that 70% of funds should be reserved for new community schools (30% for existing) and that there will be a priority for applicants that will provide coordinated health, mental health, and social services. Are thoughts on these changes/additions to the grant priorities?***
10. ***MR includes a new provision that would create at least 5 community schools TA leads housed at LEAs. Preference would be given to LEAs who partner with higher ed or non-profits. Given the new priority to coordinate with health, mental health, and social services, should CCSESA recommend that other agencies or organizations be added to this list of preferred partners?***
11. ***Given that COEs are likely to be chosen as TA leads, should CCSESA weigh-in on the amount of funding that should be provided to the leads and/or the funding formula? (This is currently not defined in MR TBL.)***

Other

12. ***The MR includes a second round of MHSSA funding in the amount of $30 million. Is this enough?***
    - The MHSOAC Executive Director has indicated that $30 million would be sufficient to fund the remaining 20 counties that applied and did not receive the first round of MHSSA grants. With a second round of funding, 38 counties would have MHSSA grants.
13. ***The Administration's proposal to establish TA on Medi-Cal billing is competing with AB 586 (O'Donnell). There are two key differences between the proposals: 1) AB 586 proposes providing TA on all Medi-Cal funding streams (not just the LEA billing option program), and 2) AB 586 would focus on providing TA to a small number of pilots whereas the Administration proposes that the TA provider and PLNs would cover the entire state and be integrated into the statewide system of support. Which of these proposals do county offices most support?***