01. MCO INCENTIVE PAYMENTS - $400M

PURPOSE

The state will offer incentive payments to Medi-Cal managed care plans that "**increase access to preventative, early intervention and behavioral health services by school-affiliated behavioral health providers for K-12 children in schools.**"

NEW & EXISTING

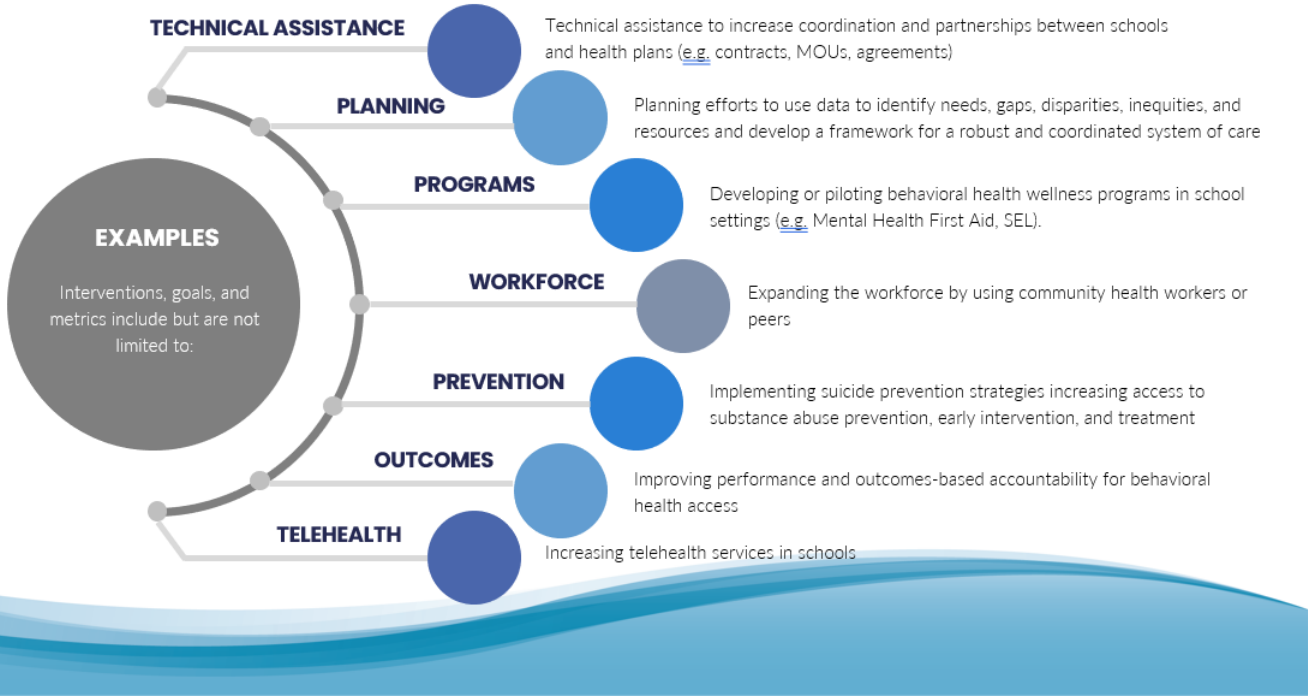
Incentive payments shall be used to develop "new collaborative initiatives" and "build on existing school-based partnerships."

SUPPLEMENT, NOT SUPPLANT

Incentive payments must supplement, not supplant existing funding and services.

STAKEHOLDER INPUT

DHCS shall hold stakeholder workgroups to develop interventions, goals, and metrics used to determine eligibility



DRAFT RECOMMENDATIONS

MCOs should be eligible for incentive funds for a <u>limited list of activities</u>:

- Covered services provided on school campuses. This looks like paying an MCO an additional flat rate or percentage if a covered mild/moderate service is delivered to a child on a school campus. This incentive payment would be in acknowledgement that provision of services at a school can incur additional costs, the most frequent being time and travel expenses of the provider and the cost to increase the number of providers in order to ensure that there are enough staff to offer regular, accessible services on campus.
    - E.g. An MCO contracts with an LEA, CBO, or MHP to hire 2 LMFT/LSW/PPS providers for 4 school sites with 500 children each. Each provider spends half the week at one school site and half at another. Providers offer mild/moderate services at each school site such as short-term 1-to-1 counseling and group therapy sessions and participates in coordination and case management activities for specific children experiencing an ACE like an incarcerated family member, divorce, or pandemic-related anxiety. The MCO receives an additional incentive payment for these providers in recognition that, by being stationed at the school site, the provider is able to identify more children who need services, provide more services in an ecological setting, and participate in additional case management activities with teachers and staff to meet student needs in a way that would not otherwise be possible.
- Additional preventative and intervention services (beyond those currently covered) provided on school campus as part of an integrated framework. This looks like reimbursing an MCO's cost to contract with an LEA to provide intervention/prevention activities that minimize the onset of mental health conditions or reduce the impact of challenging behaviors. The MCO should first identify the LEA(s) it intends to work with and then work with the LEA(s) to determine who will provide services (e.g. LEA staff or a mutually agreed upon contractor).
    - E.g. An MCO contracts with an LEA that has 50 school sites and 5,000 students to pay for 2 FTEs with expertise in childhood development, MTSS, and behavioral health. The FTEs provide staff and teachers with training on student mental health first aid and mindfulness; visit each 6th grade and 10th grade health class for 2 days each to deliver age-appropriate lessons on mental health awareness, signs and symptoms, prevalence, and resources; conduct virtual intake sessions for students who have self-identified a need for behavioral health services; and attends back-to-school nights and family events to offer short education sessions on mental health signs and symptoms for caregivers.
- Adding existing school based mental health professionals as MCO in-network providers. This looks like a reimbursing an MCO for a contract between the MCO and an LEA wherein the MCO provides funding for any of the following: 1) contract with the LEA's staff to expand the availability and accessibility of student behavioral health services (similar to how MCOs contract with a community-based provider); 2) hire consultants or billing vendors to help the LEA get their staff certificated with the MCO and to assist with submitting required documentation and claims to the MCO; 3) contract with a qualified licensed behavioral health professional who can provide the supervision needed for PPS credentialed staff or associate social workers/marriage family therapists to earn the supervised hours necessary to obtain a license.
- Streamlining data sharing and claiming systems. The MCO would contract with a COE to establish a system that is used by all districts in the county to share important student information and submit claims for covered mental health services provided by qualified providers to enrolled students. Incentives would be based on meeting deliverables in setting up the system and then based on the percentage of claims that are approved and reimbursed by the MCO.
    - E.g. Both MCOs, the COE, and all participating districts, and the MHP enter into an mutual data sharing agreement that is FERPA compliant and allows for general practitioners, school mental health professionals, and MHP staff or contractors to better coordinate delivery, monitor care, and avoid duplication of services. The MCOs work with education stakeholders to establish a linked and streamlined claiming platform in which school-based providers or school contractors can easily submit

claims for reimbursement, regardless of insurance provider. Each one of these activities has defined deliverables which include incentive payments, but the majority of payments are held until the system is operational and school-based providers begin submitting claims at which point MCOs are provided incentive payments based on the number of claims submitted as a percentage of the student population covered, the number of claims paid, and the time between submission and payment of a claim.

Incentive funds should <u>not pay</u> for the following:

- Absent exceptional circumstances, no incentive funds should be paid unless services or activities are provided on, or adjacent to, a school campus or childcare facility, or are directly related to facilitating student access to future school-based behavioral health services. Children are 21 times more likely to receive services when they are provided on school campus and attrition rates increase exponentially when children are referred off-campus to receive services. The traditional clinical referral-based model has not worked and MCOs should not be allowed to continue to double-down on it.
    - E.g. MCO is not eligible for incentives because it contracted with a CBO to provide services at a facility that was not on or adjacent to a school site.
- No incentive funds should be paid unless the provider of services (both direct or indirect) is mutually agreed upon by the LEA. Prevention, intervention, and mild/moderate services necessarily require interaction and close coordination with school staff, teachers, and students. Given the strict bargaining rules, background checks, and privacy rules that schools must comply with, it is imperative that providers are chosen in coordination identified with LEA partners. One of the key problems with the current delivery system is that MCOs contract with a CBO or MHP without consideration of what a particular school or student group needs. This allows the CBO or MHP to dictate the terms, providers, and services they offer, making what schools and students need an afterthought and often making it impossible for schools to work with the MCO's contracted provider who does not meet education mandates that are in place to protect the vulnerable, underage population we work with.
    - E.g. MCO not eligible for incentives because it contracted with a CBO that was not mutually agreed upon with its LEA partner.

02. PARTNERSHIPS, INFRASTRUCTURE & CAPACITY GRANTS - $550M

PURPOSE

PARTNERSHIPS

Build partnerships, capacity, and infrastructure for ongoing school-linked BH services for children 0 to 25

ACCESS

Expand access to licensed medical and BH professionals, counselors, peer support, community health workers, and BH coaches

COORDINATION

Enhance coordination and partnerships providing BH prevention and treatment via data sharing systems

NETWORK

Build a statewide community-based provider network for BH treatment of children

ALLOWABLE ACTIVITIES INCLUDE, BUT ARE NOT LIMITED TO:

Addressing behavioral health disparities while providing linguistically and culturally competent services

Supporting administrative costs including planning, project management, training, and technical assistance

Linking plans, counties, and school districts with local social services and community-based organizations

Implementing telehealth equipment and virtual systems in or near schools

Implementing data-sharing tools, information technology interfaces, or other technology investments designed to connect to behavioral health services

DRAFT RECOMMENDATIONS

Allowable uses of funds should include:

- Addressing the barriers to submitting claims to MCOs and commercial health plans including: 1) navigating the process to get existing school mental health professionals approved as an in-network provider; and 2) training staff and providers how to use the managed care plans' claiming system and comply with documentation and submission requirements.
- Facilitating provision of services on campuses. To create the space needed to provide Tier 1 to 3[1] services on school campuses, some LEAs will need to modify existing classroom or office configurations to create space for confidential consultations. Schools may also need funding to comply with other Medi-Cal requirements such as confidential storage space and various facilities safety mandates (though more flexible for schools, there are still costs).
- The staff time and consultants needed to participate in negotiations and relationship building with managed care plans, especially in those counties where there are more than two MCOs or many commercial plans. This may include funding necessary to hire consultants or attorneys to help draft facilities or staff agreements, MOUs, confidentiality trainings, data sharing agreements, etc.
- Supplies and modifications needed to create wellness centers. As the Initiative is implemented and services are integrated into school culture, more school sites will likely seek to create wellness centers which house activities, resources, and counseling services for students. To create wellness centers that are a welcoming and safe environment for students, funding could be used for facilities modifications, supplies, materials, and technology.
- Given the workforce shortage and the overwhelming needs of students, funding could be used in the short term to increase access to telehealth services by purchasing software and hardware necessary for telehealth, as well as expanding the number and availability of services through contracting with experienced mental health professionals to provide services.
- The initial cost to hire additional school-based mental health staff. This staff would, once onboarded and trained, become partially self-sustainable through billing Medi-Cal and MCOs for covered services that are provided to students by school mental health professionals.

[1] Note: Tier 3, in the context of school settings, does not include inpatient services. Tier 3 refers to ongoing outpatient counseling services for management and treatment of a specific diagnosis.

03. WORKFORCE DEVELOPMENT GRANTS - $ 448M

04. BEHAVIORAL HEALTH COACHES - $352M

PURPOSE

"Competitive grants to entities and individuals OSHPD deems qualified to expand the supply of BH counselors, coaches, peer supports, and other allied health care providers serving children and youth, including those at schoolsites"

Training new and existing staff on working with youth

Scholarships, loan repayment, coaching, and stipend programs

Expansion of existing workforce programs and creation of new programs

The state agency shall create and define the qualifications for a new category of behavioral health provider that is trained to address the unmet MH and substance abuse needs of children and youth

- Purpose: Increase the diversity and capacity of the MH profession
- Engage and support youth in cultural, linguistic and age-appropriate services
- Refer and link to higher levels of care
- Included as members of a care team, supervised by licensed staff
- Training and qualifications may include, but are not limited to, psychoeducation, system navigation, crisis de-escalation, safety, planning, coping skills, and motivational interviewing

DRAFT RECOMMENDATIONS

To address the workforce shortage and increase diversity, workforce investments should align with the following recommendations:

- Credentialed school psychologists and school social workers, both of whom hold a Pupil Personnel Services (PPS) credential, have completed nearly identical coursework and similar supervised hours as those who become a Licensed Marriage and Family Therapist (LMFT) or Licensed Social Worker (LSW). Reports indicate that there are approximately 40,000 active PPS credentials in California, but only about half of these credential holders are currently employed as a school counselor or psychologist. Many of these professionals have been pushed out of practice by inconsistent and inadequate funding. In the immediate term, to meet the crisis needs of students, workforce funding should be used to incentivize these qualified PPS mental health professionals to return to behavioral health for the purpose of increasing school-based counseling services to students.
- In the mid-term, funds should be used to pay for the supervision hours that PPS credentialed staff need to obtain a license. The current barrier to licensing is that nearly no schools employ a staff member who is approved to provide the supervision hours required to earn a license.
- Also in the mid-term, workforce funds should be used to fund well-paid internships and apprenticeships in school-based settings. 116,500 bachelor's degrees in psychology and 131,600 master's degrees in health professions are conferred nationally each year[2], yet only a fraction of these individuals go on to work in the field (as demonstrated by the current workforce shortage). Of particular interest is the fact that, although the vast majority of the current behavioral health profession is White, the majority of degrees in psychology are conferred to individuals of color. Black and Hispanic students are significantly more likely than White students to earn a bachelor's degree in psychology, and Black, Hispanic, and Pacific Islander students are just as likely as White students to earn a master's degree in psychology.[3] The only racial/ethnic group less likely than White students to earn a degree in psychology is Asian students. Given the diversity of those earning degrees, it becomes difficult to explain the lack of professional diversity unless one accounts for the historic and systemic race-based inequities that have created generational wealth and opportunity gaps. Because internship hours are required to become licensed and because unpaid or very low paid internships/apprenticeships are common in the behavioral health field, individuals of color who do not benefit from generational wealth are more frequently precluded from earning the requirements needed to climb the behavioral health career ladder. To address the lack of diversity of those practicing in the field, and to ensure that students have access to culturally competent professionals, workforce funding should be used to fund well-paid school internship and apprenticeship programs where anyone with a master's degree in psychology or social work (who also meet education's strict HR requirements) could earn a PPS credential and achieve board licensure while simultaneously earning a competitive salary.
- In the long term, for the reasons explained above, workforce dollars should be used to fund scholarships targeted at individuals of color who have earned a bachelor's degree in psychology. These scholarships would ideally also include paid apprenticeship opportunities for scholarship recipients wherein recipients could earn required hours and experience working with students while completing their master's degree. Workforce dollars should also be dedicated to programs targeting recruitment of the one under-represented race/ethnic group in psychology: Asian Americans.
- Also in the long term, we recommend that state leadership work with the Commission on Teacher Credentialing, the Board of Behavioral Sciences, and education stakeholders with an expertise in public school hiring rules and restrictions, and school-based Medi-Cal claiming experts, to determine whether it would be appropriate to define a new position such as a behavioral health liaison or coach. This position could include responsibilities

[2] National Center for Education Statistics.

[3] https://nces.ed.gov/programs/raceindicators/indicator_ref.asp

such as conducting student intake, scheduling and connecting students with appropriate mental health services, working with county services agencies to meet student and family needs, facilitating group behavioral health activities and services, assisting with professional development training for staff and teachers, and helping to relieve the administrative burden on special education and mental health services staff (e.g. help with IEP paperwork, maintaining documentation for claiming). It is key, however, that this position be eligible to claim Medi-Cal reimbursement after one-time grant funds expire. Schools cannot invest in or employ behavioral health staff who do not have the potential to generate federal match dollars in the long term.

05. REIMBURSEMENT FOR SCHOOL-BASED SERVICES

Must be provided By a licensed or Authorized mental Health provider

HEALTH PLANS WILL BE REQUIRED TO REIMBURSE SCHOOLS FOR SERVICES PROVIDED TO YOUTH AGES 0-25

WHO?

Applies to MCOs, MCPs, and disability insurance plans

WHAT?

All mental health and substance abuse services that the plan is required to cover

WHERE?

Schools: A facility or location used for K-16 purposes and locations not owned or operated by an LEA if the LEA provides or arranges for the provision of the treatment

WHEN?

Starting January 1, 2024

CURRENT :
SCHOOLS SUBMIT CLAIMS, HEALTH PLANS DENY OR IGNORE THEM

- Denied for out of network provider
- Denied for lack of preauthorization
- Denied for lack of diagnosis
- Ignored for claim in wrong format

VS

CYBHI :
HEALTH PLANS CAN ONLY DENY A CLAIM FOR 3 REASONS

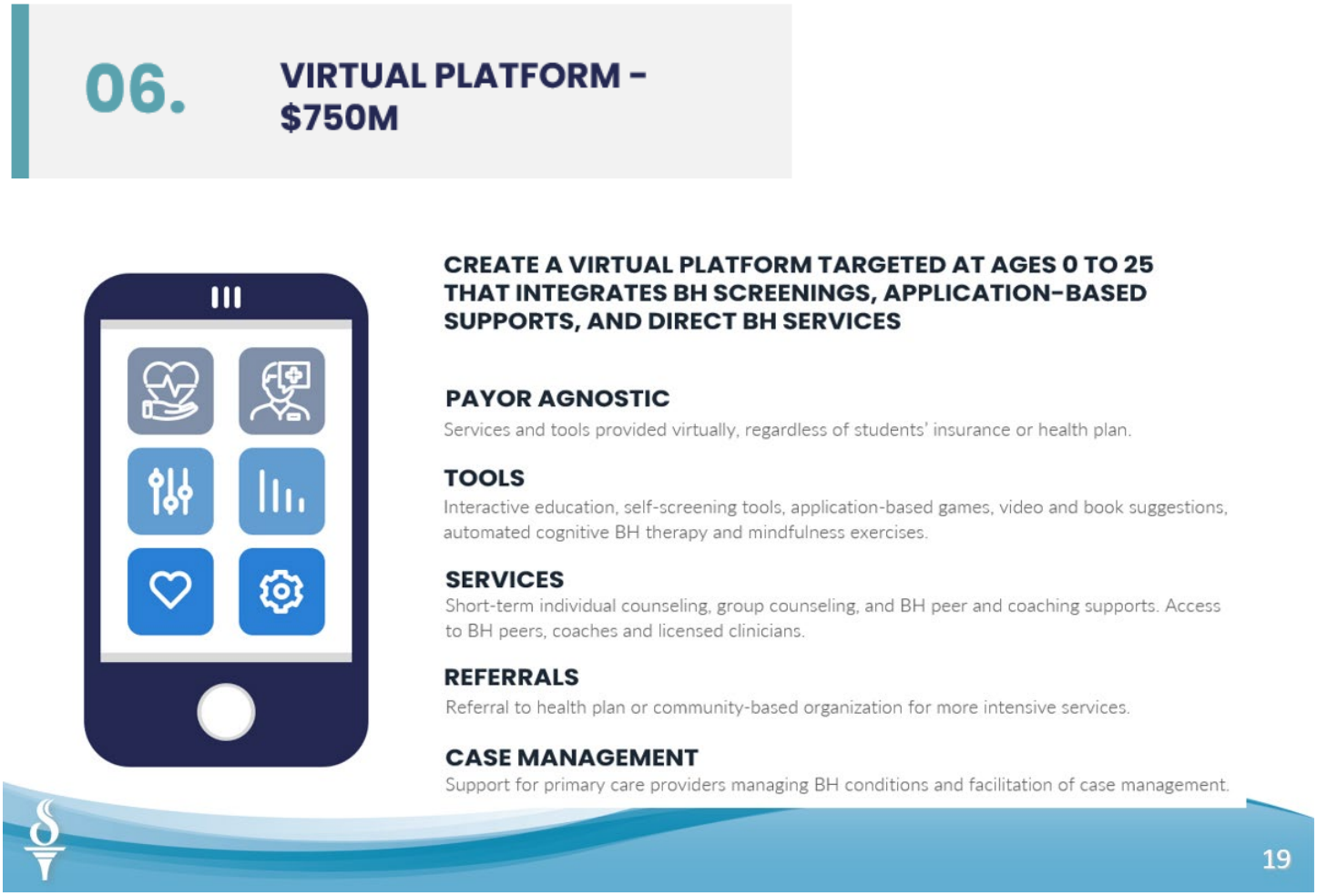
- Not a member of the health plan
- Services were not actually provided
- Not a licensed or authorized MH provider

*Caveat: Does not relieve an LEA from the requirement to "accommodate or provide services" to a student with an IEP. However, the Medi-Cal for Students report makes clear that schools are the payor of last resort even when a student has an IEP .

DRAFT RECOMMENDATIONS/COMMENTS

This element of the Initiative is critical for the following reasons:

- Creating sustainable funding streams that will maintain school-based behavioral health services past the expiration of one-time grants is essential to integrating behavioral health services in schools. A lack of sustainable funding is the chief limitation that schools face when trying to integrate behavioral health services on school campuses. Without sustainable funding, schools experience constant staff churn, staff shortages, and a lack of infrastructure (i.e. staff filter in and out of schools based on grant funding, it is difficult to hire staff for temporary or part-time positions, and without consistent staff leadership behavioral health never truly gets integrated into school culture or internal administrative divisions like curriculum and instruction or professional development).
- Currently, cost recovery for services is limited to services provided to Medi-Cal eligible students (via LEA BOP claiming). There are long standing issues with the LEA BOP audits, but it currently generates the only source of sustainable funding that schools can use to reimburse for services and staffing. Past evaluations indicate that the student Medi-Cal eligibility rate must be 60 to 65% to generate enough sustainable funding for it to be feasible to hire behavioral health staff for a school site. This is a huge barrier given that, on average, only 55% of students are enrolled in Medi-Cal. In higher wealth areas, this percentage is even lower. By requiring MCOs and commercial health plans to pay for eligible services provided to covered students, more schools will be able to meet the 60 to 65% billing threshold necessary to sustain funding for behavioral health staff.
- This mandate also supports another key concept inherent in the public education system: universal access to services, regardless of student income. The current limitation described above (i.e. schools only receive reimbursement for Medi-Cal students through LEA BOP) has limited the willingness of school leaders to expand behavioral health programs based on the concern that, due to limited capacity and the need to generate sustainable funding, behavioral health providers would need to restrict access to only Medi-Cal eligible students from whom they could be reimbursed. The idea that students with commercial health plans would not be able to access school-based services, and that services would not be based on student need but on health plan provider, made it very difficult if not impossible to expand services beyond those required by IEPs or to sites with Medi-Cal rates lower than 65%. The mandate that health plans reimburse schools for the school-based behavioral health services we provide will remove the barrier to universal access and help to establish sustainable funding regardless of Medi-Cal rate.



DRAFT RECOMMENDATIONS

The virtual platform created by state should include mechanisms to address the following issues:

- Every school, MHP, MCO, or managed care plan that seeks to enter into a relationship must research confidentiality and consent rules, create mutual agreements for data sharing, and purchase software and data sharing platforms. The state could eliminate this massive duplication of effort by creating, as part of the virtual platform, a state supported data sharing system which meets state and federal privacy guidelines and offers an interactive platform that helps schools and health partners navigate the decision-making and MOU process.
- Each year, schools pay billing vendors millions of dollars to submit and invoice SMAA and LEA BOP Medi-Cal claims. If not addressed, this cost will significantly increase when schools begin actively billing MCOs and commercial health plans for services, each of whom have their own complex process and software system. The state could utilize the virtual platform to streamline billing and documentation by both virtual platform consultants as well as schools, thus eliminating administrative burden on schools, freeing up time of mental health professionals to serve students, and limiting the unnecessary cost of vendors.
- Rather than purchasing their own software and entering into contracts with external mental health providers, the state's virtual project could build the platform so that it could be integrated with school-based student use. Schools could use the platform to submit a referral to a virtual consultant on behalf of a student, facilitate scheduling an appointment for the student with a virtual provider, and provide the reliable technology and safe space needed for students to complete telehealth sessions. The school could also facilitate or create the space and opportunity for regular student screenings and assessments using the virtual platform.