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ISSUE BRIEF

Connecting Schools to the Larger Youth Behavioral Health System: Early Innovations from California

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Introduction

Children are in crisis nationally at levels never seen before. In every community, children are languishing in emergency departments (EDs) and child welfare offices because too few beds are available to treat them. As a response, in federal fiscal year (FFY) 2023, the Substance Abuse Mental Health Services Administration (SAMHSA) awarded Transformation Transfer Initiative (TTI) funding to states and territories focused on implementing and expanding 988 access and crisis services for children and adolescents.

This is one of the top issues facing the TTI projects focused on children and adolescents this year. State child welfare, Medicaid, and behavioral health agencies often serve the same children, youth, and families in crisis. Given the increased need for services for children and youth with high acuity conditions or serious emotional disturbance, it is important that child welfare, Medicaid, and behavioral health collaborate effectively. Yet these three systems are siloed at the governance, service array, and financing levels, leading to poor outcomes.

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Health Management Associates (HMA) developed this series of issue briefs to give technical assistance to these TTI projects to improve the need for child welfare, Medicaid, and behavioral health systems to better work together to tackle these issues. This issue brief focuses on the role schools can play in ensuring that children and youth get the behavioral healthcare they need.

Highlights

- Policymakers at all levels are recognizing the important role schools can play in addressing behavioral healthcare challenges.
- The multi-tiered system of supports that schools and behavioral health traditionally have used to connect needs to be reimagined and shift the focus from providing support to the few students who require intensive help to promoting the health and well-being of all students.
- California's Children and Youth Behavioral Health Initiative provides a model for promoting social and emotional well-being, addressing health challenges, and providing more equitable and timely access to necessary care for people ages 25 and younger.
- Payment reforms and more extensive use of managed care systems may spur more integrated approaches to delivering behavioral healthcare services to children and young adults.

Schools Play an Integral Role in Supporting Children's Behavioral Health

With growing recognition that schools and community are critical partners on the children's behavioral health continuum, federal, state, and local governments have made substantial investments in school-based mental health programs. In fiscal year (FY) 2023, appropriations from federal sources to community schools total approximately $119 billion. This amount includes an estimated $4.5 billion in Medicaid funding and $5.7 billion in Temporary Assistance for Needy Families (TANF) spending for schools.[1] In addition, more than $178.7 billion in COVID-19 relief spending from the Coronavirus Response and Relief Supplemental Appropriations Act and the American Rescue Plan Act have been allocated through blended or braided funding to state approaches that support public schools.

Another source of federal funding is the Bipartisan Safer Communities Act of 2022, which provided $1 billion in grants to state education agencies under Title IV of the Elementary and Secondary Education Act. These funds were awarded on a competitive basis to local education agencies (LEAs) to establish safer and healthier learning environments, including ways to address community-level mental health needs.

These increases in funding and accelerated policy efforts have spurred actions in states like California that seek to increase child and youth access to behavioral health (BH) services through school-based and school-linked programs. This brief provides an overview of some key changes intended to overcome the historical divide between public schools and the larger behavioral health ecosystem. This overview is intended to catalyze thinking about incentivizing relationships and interactions between public education and managed care organizations (MCOs) to increase access to and use of child and youth BH services.

How Schools Have Traditionally Connected with BH Services

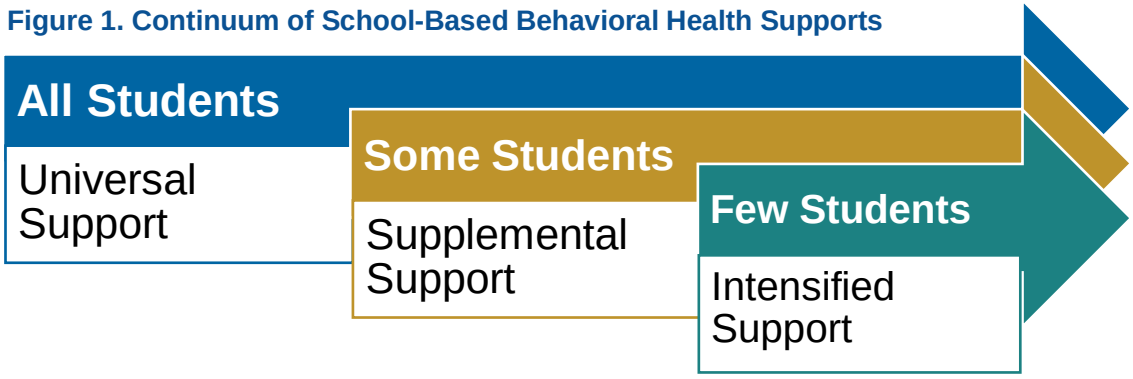
In California, all public schools have been encouraged to adopt a continuum of care model to deliver tiered BH services to students. This model is commonly known as the multi-tiered system of supports (MTSS),[2] which is organized as follows (see also Figure 1):

- **Tier 1:** Universal prevention services to promote wellness and a healthy school climate. Applied to behavioral health, these services typically have included universal screenings, efforts to destigmatize mental health conditions, and parent education and training to recognize related symptoms.
- **Tier 2:** Targeted intervention services for students at risk or displaying signs and symptoms of behavioral health needs. In this context, Tier 2 has often focused on group counseling, support groups for families, and other interventions for mild or moderate behavioral health concerns.
- **Tier 3:** Intensive services, typically for youth in crisis or in need of specialty or acute BH care based on an individualized diagnosis. These more intensive cases typically involve longer-term case management and multiple licensed professionals.

[1] House Committee on Appropriations. Consolidated Appropriations Act, 2023, Summary of Appropriations Provisions by Subcommittee. Available at: https://appropriations.house.gov/sites/democrats.appropriations.house.gov/files/FY23%20Summary%20of%20Appropriations%20Provisions.pdf. Accessed September 25, 2023.

[2] A good framework for MTSS is available from the Orange County Office of Education at https://ocde.us/MTSS/Documents/Revised-California-MTSS-Framework-July-2021.pdf.

Figure 1. Continuum of School-Based Behavioral Health Supports



Historically, schools have focused their attention and funding on Tier 3. To the extent that public schools are connected with the broader behavioral health system, they mostly do so via referrals to specialty youth services that county behavioral health agencies and community-based organizations (CBOs) provide.

To address this focus on Tier 3, California established the Local Education Agency Billing Option Program (LEA BOP) in 1993. This program provides a mechanism for LEAs (school districts, county offices of education, charter schools, and higher education) to receive reimbursement for the federal share of providing approved physical and behavioral health-related services that qualified providers deliver to Medi-Cal-eligible students. Approximately half of the LEAs in California participate in this fee-for-service (FFS) LEA BOP model.

Because LEAs deliver these services, many of them initiated or expanded the employment of healthcare practitioners who provide school-based BH services or subcontracted community-based providers who deliver care in or near schools. As such, the number of BH professionals employed directly or indirectly through public education expanded in California. These LEA-employed BH professionals now comprise a larger share of the BH workforce than ever.

Why These Approaches Have Proved Inadequate

Although well-intentioned, the historical approaches to school-based and school-linked behavioral health have key shortcomings, which limit access for children and youth.

First, the system is underfunded in two of the MTSS's three tiers. Simply stated, the focus on Tier 3 has tended to overshadow both preventive mental healthcare (Tier 1) and access to moderately intensive BH services (Tier 2). Furthermore, the emphasis on Tier 3 demonstrated an overreliance on a clinical model that prioritizes diagnosis and triage, which is often at odds with school culture and climates organized to intervene proactively to remove or surmount barriers to learning.

To understand this situation, it is important to realize that MTSS was first applied in academics and then to positive behavior interventions and support. Educators were trained to think about universal approaches (first-best instruction and schoolwide behavioral norms) and then design interventions for a smaller portion of struggling students who needed additional instructional time (i.e., tutoring or reteaching) or progressive discipline. Only some students received intensive support, usually from multiple out-of-classroom professionals, to address extremely low academic performance or extremely poor adherence to behavioral norms. The entire enterprise was premised on the need to remove or surmount barriers to learning so that students could return to Tier 1 in a timely fashion and thrive.

The emphasis on an individualized medical diagnosis for Tier 3 (in effect until January 1, 2022) meant that children and youth needed to show symptoms or decreased functioning to trigger a school response. Moreover, restrictions on the use of behavioral health funds for collective (Tier 1) or in small-group settings (Tier 2), along with an emphasis on funding intensive services (Tier 3), communicated the priority accorded to individualized intensive therapeutic care. In other words, the behavioral healthcare system in schools reinforced a reactive model for the few high-risk individuals rather than proactive intervention and support for all or even some children and youth.

A second shortcoming was LEA BOP's design, which reimbursed only the federal portion and often reimbursed at a lower rate because of costs. LEAs had to certify that funds expended for LEA-provided health services qualified for federal financial participation. Through the California Department of Health Care Services (DHCS), the state compared each LEA's total actual costs with interim Medi-Cal reimbursement for the preceding year. There was no guarantee that LEAs would recoup the service delivery costs they had frontloaded, nor the significant overhead costs tied to compliance and reporting requirements. Consequently, many LEAs began to question the efficacy and sustainability of the LEA BOP model.

In addition, the fact that more LEAs began to hire and rely on their own behavioral health workforce created structural gaps in access to services and care. School social workers and counselors typically served students only during school hours. Indeed, few LEAs designed more flexible work arrangements for school-based BH staff to start and end their workday later, nor have many LEAs taken advantage of the flexibility to provide BH services in extended day (after-school and during school breaks) settings. As a result, reliance on school-based behavioral health means that access to services is rare outside of the hours of 7:30 am−3:30 pm, 180 instructional days per year.

The growth of a school-based BH workforce that LEAs employ exacerbated the overall BH workforce shortage, as people were diverted from county agencies and community-based providers to LEAs offering better wages, working conditions, and job stability. In general, workforce capacity has shifted location rather than expanded to meet growing needs and demands for behavioral health services. Hence, the move toward a LEA-employed BH workforce reinforces autonomy, with each LEA responding independently to local needs, when a systemic, countywide solution across organizations is needed.

The Children and Youth Behavioral Health Initiative (CYBHI) C Overview

It is against this backdrop that California rolled out the Children and Youth Behavioral Health Initiative (CYBHI) in 2021. CYBHI is a $4 billion investment in reimagining the BH system, regardless of payer or provider, to promote social and emotional well-being, prevent BH challenges, and provide more equitable and timely access to BH services for children and youth ages 0-25.

CYBHI includes multiple workstreams that are led by five departments and offices within the California Health and Human Services Agency—DHCS, the Department of Health Care Access and Information, Department of Managed Health Care, Department of Public Health, and Office of the Surgeon General. This brief describes two of the CYBHI workstreams focused on increasing access to school linked BH for children, youth, and families.

Innovations to Bridge the Gap to Managed Care: SBHIP

Within the CYBHI portfolio is a three-year program called the Student Behavioral Health Incentive Program (SBHIP), budgeted at $389 million.[3] SBHIP is designed to address BH access barriers for students with Medi-Cal coverage by catalyzing closer relationships between Medi-Cal[4] MCOs and LEAs. Administered by the California Department of Health Care Services, SBHIP provides incentive payments to MCOs, which are then distributed locally to participating LEAs for activities that meet any of the following objectives:

- Breaking down silos and improving coordination of child and adolescent BH services for people enrolled in Medi-Cal through increased communication with schools, school-affiliated programs, managed care providers, counties, and mental health providers
- Increasing the number of kindergarten through grade 12 students enrolled in Medi-Cal who receive BH services provided by schools, school-affiliated providers, county behavioral health departments, and county offices of education
- Increasing non-specialty BH services[5] on or near school campuses
- Addressing health equity gaps, inequalities, and disparities in access to BH services.

MCOs and LEAs that participated in this voluntary program were required to select a minimum of four targeted interventions from a list of 14 state-defined options.[6] Examples of allowable activities include:

- Wellness programs (e.g., student wellness centers, mental health first aid, socio-emotional learning)
- Telehealth services
- Enhanced screening for BH and adverse childhood experiences
- Suicide prevention strategies
- Collaboration with substance use disorder treatment providers for early intervention
- Implementation of culturally appropriate and community-defined interventions to support initial and continuous connections with BH services

SBHIP launched January 1, 2022, and will sunset December 31, 2024. In the first year of SBHIP, health plans established relationships with and secured commitments from interested LEAs. The partners collaborated to perform a required BH needs assessment of participating LEAs' student population, which informed selection of specific targeted interventions best suited to each LEA and its students. As of March 2023, 23 health plans were participating in SBHIP, covering all 58 counties in the state, as well as 57 county offices of education, 313 LEAs, and 58 county BH departments.

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[3] California Department of Health Care Services. Student Behavioral Health Incentive Program. Available at: https://www.dhcs.ca.gov/services/Pages/studentbehavioralheathincentiveprogram.aspx. Accessed October 4, 2023.

[4] Medi-Cal is California's Medicaid program.

[5] California employs a bifurcated system to manage public behavioral health services. Non-specialty mental health services (such as for mild to moderate depression or anxiety) are administered by MCPs, whereas specialty mental health services (for severe and persistent mental illness) are carved out to counties.

[6] These include: BH Wellness Programs; Telehealth Services; BH Screenings; Suicide Prevention; Substance Use Disorders; Building Stronger Partnerships; Culturally Appropriate/Targeted; Dashboards/Public Reporting; Technical Assistance for Contracts; Expand BH Workforce; Care Teams; IT Support Systems; Pregnant Students/Teen Parents; and Family Supports. See https://www.dhcs.ca.gov/services/Documents/DirectedPymts/SBHIP-Overview-and-Requirements-01012022-12312024.pdf

As a short-term program, SBHIP is not an ongoing revenue source for school-based or school-affiliated BH services. It's chiefly a catalyst for relationship-building between healthcare and education—two sectors that historically have not engaged in formal or sustained partnerships. Although they serve many of the same children and families, particularly in low-income communities, MCOs and LEAs are largely unfamiliar with each other and differ significantly in their core business, regulatory obligations, and performance metrics. By incentivizing partnership on a shared concern (i.e., addressing the youth mental health crisis more effectively), the state has brokered a cultural exchange between the two sectors, coordinated through the county offices of education (COEs).

An area of opportunity for MCO-LEA partnership is joint participation in community information exchanges that establish closed-loop referral systems with community-based providers. DHCS defines closed-loop referral systems as "people, process, and technologies that are deployed to coordinate and refer health plan members to available community resources and follow-up to verify whether services were rendered."[7] In other words, a closed-loop referral system gives its participating entities the information they need to act on a referral and track its outcome. A key objective of SBHIP is to initiate conversations between LEAs and MCPs about forming closed-loop referral systems, laying the groundwork for deeper collaboration and data sharing.

Innovations to Expand Access: Multi-Payer Fee Schedule

The purpose of the multi-payer fee schedule is to provide clear guidance for LEAs to receive reimbursement for school-linked BH services using a fee-for-service model. State legislation now requires commercial MCPs and Medi-Cal to pay school-linked providers based on a published fee schedule. In addition, BH services provided under the fee schedule may not require copayments, coinsurance, deductibles, or any other form of cost sharing.

Specifically, the fee schedule:

- Defines the scope of services for both outpatient mental health and substance use disorder (SUD) treatment
- Identifies applicable billing codes and rates for BH services
- Specifies which providers may bill for BH services

The fee schedule significantly improves upon the LEA BOP in four ways:

- It covers both Medi-Cal enrolled and commercial insured students.
- It reimburses both federal and state shares; LEAs no longer shoulder the non-federal costs.
- It reimburses LEAs using a straight FFS rate; reimbursements occur at 100 percent of the published rate regardless of network provider status.
- It does not require cost settlement or reconciliation of reimbursement.

[7] California Department of Health Care Services. Student Behavioral Health Incentive Program (SBHIP) Application, Assessment, Milestones, Metrics January 1, 2022–December 31, 2024. Available at: https://www.dhcs.ca.gov/services/Documents/DirectedPymts/SBHIP-Overview-and-Requirements-01012022-12312024.pdf. Accessed October 4, 2023.

Because the fee schedule includes all MCPs, commercial insurers, and other payers, it eases administrative complexity. For example, LEAs are not responsible for contract or rate negotiation with payers. Similarly, LEAs benefit from some streamlining of processes and compliance requirements. In fact, CYBHI is establishing a third-party administrator as a mandatory statewide clearinghouse for claims processing and compliance. The net result is that more dollars go directly to LEAs that provide BH services to students.

To qualify for reimbursement, LEAs will need to identify and designate employed, contracted, or affiliated providers from:

- Prospective Payment System[8] credentialed practitioners (social workers, counselors, nurses, etc.)
- Mental health specialists
- Community-based BH organizations

LEAs also will have to ensure that they have the capacity and infrastructure to collect, store, and transmit data on students, services, practitioners, and school-linked providers.

In sum, the fee schedule forms the basis of a true and transparent FFS model that largely removes ambiguity about coverage, rates, additional costs, or reimbursement protocols. Moreover, it is a permanent, sustainable source of funding. Once implemented, it promises to deliver an approachable model for LEAs and is anticipated to induce more of them to provide school-linked BH services to the children, youth, and families they serve.

Of note, the fee schedule builds on California Advancing and Innovating Medi-Cal (CalAIM), which reformed the medical necessity provision for specialty mental health. In fact, California was the first Medicaid program in the nation to qualify beneficiaries ages 21 and younger for access to specialty mental health services based on exposure to trauma, the child welfare system, or homelessness.

The first cohort of LEAs will participate in the fee schedule beginning in January 2024, followed by a second cohort in July 2024. LEA participation in these early adopters is based on a statement of interest and documentation that demonstrates operational readiness, typically coordinated through and with the involvement of COEs. In practice, operational readiness has meant current participation in both LEA BOP and SBHIP for cohort 1. During these first two pilots, California will assess implementation strategies and use the findings to refine policies and protocols tied to the fee schedule. All LEAs will have the option of implementing the fee schedule beginning in January 2025.

Lessons and Implications for Other States

The policy innovations in California offer important lessons for other states interested in expanding child and youth access to school-based BH service.

[8] Pupil personnel service credentialing or certification qualifies professionals to work as counselors, social workers, psychologists, and additional child welfare and attendance duties in a LEA.

First, **managed care must be part of the conversation.** SBHIP catalyzed and incentivized collaboration and relationship building between LEAs and MCOs. It recognized that these two systems needed a reason to collaborate and find common ground and a common language to move forward. For too long, these systems have moved in parallel but independently. The multi-payer fee schedule built on this model with legislative requirements for an improved reimbursement methodology that reduces administrative complexity so LEAs and MCOs can become partners in providing and paying for BH services. These partnerships sometimes will be uneasy, but they are necessary and are statutorily mandated.

Second, **counties are going to play an important intermediary role.** For both workstreams, the COEs have been heavily involved in brokering and coordinating interactions across LEAs, MCOs, and community-based providers. This hub role is likely to continue and grow with increased interactivity and collaboration across sectors. To overcome the inevitable coordination challenges, counties will need to embrace this intermediary role.

Third, **systems change requires a systemic approach.** The two highlighted CYBHI workstreams (SBHIP and the multi-payer fee schedule) demonstrate the use of multiple levers to influence changes in the behavioral health ecosystem. Both started with a clear problem to resolve and address a host of issues (legal, fiscal, infrastructure, etc.) to eliminate barriers or tendency toward stagnation. Both are predicated on reducing complexity and increasing transparency. Both lean into the premise that "all really does mean all" and equitable access to BH services is non-negotiable.

Though these reforms are in the early stages, the path forward is bound to be messy, complicated, and non-linear. Nonetheless, we can begin to see a breakdown of the silos (both structural and mental) in the BH ecosystem. Some grounds for optimism are apparent that the systems will focus on the possibilities for expanded access to and use of BH services, rather than the historical rationales for restricting the availability of behavioral health services.