Mercer

Student Behavioral Health Incentive Program

Stakeholder Meeting Five

California Department of Health and Human Services
December 8, 2021

A business of Marsh McLennan

1. Welcome
2. SBHIP Workgroup: Overview and Stakeholder feedback
3. County Behavioral Health Overview
4. SBHIP Timeline and Partnership Criteria
5. Assessment
6. Targeted Interventions, Goals, and Metrics
7. Incentive Payment Methodology
8. Open Discussion
9. Next Steps
10. Technical Assistance Introduction
11. Closing

Agenda

Welcome

SBHIP Workgroup Overview

Student Behavioral Health Incentive Program

Overview

Assembly Bill 133: Section 5961.4

- The State Department of Health Care Services shall make incentive payments to qualifying Medi-Cal managed care plans that meet predefined goals and metrics developed pursuant to subdivision (b) associated with targeted interventions that increase access to preventive, early intervention and behavioral health services by school-affiliated behavioral health providers for TK-12 children in schools.
- (b) The department, in consultation with the State Department of Education, Medi-Cal managed care plans, county behavioral health departments, local educational agencies, and other affected stakeholders, shall develop the interventions, goals, and metrics used to determine a Medi-Cal managed care plan's eligibility to receive the incentive payments described in this section.

January 1, 2022: Incentive program effective date

Intent of Incentive Payments:

- Break down silos and improve coordination of student behavioral health services through communication with schools, school affiliated programs, MCPs, county BH, and BH providers.
- Increase number of TK-12 students receiving preventive and early intervention BH services provided by schools, providers in schools, school affiliated community based organization or clinics, county BH departments and school districts, charter schools, and/or county offices of education within the county.
- Get non-specialty services on or near school campuses.

Role of DHCS to Develop:

- **Interventions:** Those activities that will be accepted as targeted interventions that increase access to preventive, early intervention, and BH providers for TK-12 children in schools.
- **Goals**: Desired outcomes, locations, and/or populations to reach with each intervention.
- **Metrics:** Requirements, steps, and measures to assess selected targeted interventions meet desired goals and outcomes.
- **Funding mechanism program/allocation methodology.**

SBHIP Duration and Sustainability

SBHIP Design Period (August 2021–December 2021)

- Stakeholder engagement and education
- Develop metrics, interventions, and goals
- Determine payment structure to MCPs
- Develop structures for implementation (oversight and governance)

SBHIP Implementation Period (January 2022–December 2024)

- Continued stakeholder education
- MCP assessment/gap analysis with technical assistance to support engagement between LEAs and MCPs
- MCPs design and implement interventions in coordination with COEs, LEAs, County BH Departments, and BH providers
- MCPs receive payments based on metrics achieved

Post-SBHIP (January 2025 and beyond)

- BH infrastructure in schools are strengthened, benefiting both Medi-Cal and non Medi-Cal students
- More MCPs, COEs, County BH Departments, and LEAs have contracts to support Medi-Cal payment for BH services in schools
- Relationships between MCPs, LEAs, and county BH are strengthed to support coordination of services

SBHIP Stakeholder Workgroup

Objective

- Assist DHCS in determining the design and approach to implementation of SBHIP. In particular:
  - Provide feedback and guidance on interventions, goals, and metrics.
  - Help identify activities that best target gaps, disparities, and inequities.
  - Provide feedback on funding mechanism: incentive payment methodology, financial model, etc.

Process

- Four or more two-hour meetings.
- Email responses to requests for feedback or in response to questions raised at meetings.
- Individual/small group meetings, if need to additional meetings may be scheduled with smaller groups to address specific topics in more detail. Any outputs of individual/small group meetings will be shared with the workgroup for feedback.

Expectations of Members

- Attend all SBHIP Stakeholder Workgroup meetings.
- Engage in discussion and secure feedback from your organization as necessary.
- Provide subject matter expertise and ground-level knowledge of needs, gaps, constraints, and strategies.
- Discuss needed guidance and technical assistance.
- Maintain focus on the Incentive Program, not on related programs or school-based services in general.

Workgroup Members

Health Plan

- Elizabeth Martinez, Health Plan of San Joaquin
- Isabel Silva, Kern Health System
- Heather Waters, Inland Empire Health
- Belinda Rolicheck, California Health and Wellness
- Kinisha Milles Campbell, Kaiser Permanente Southern CA
- Hilary Frazer, Kaiser Permanente Northern California
- Linnea Koopmans, Local Health Plans of California
- Amber Harvey-Ligget, Aetna Better Health Group California
- David Bond, Blue Shield Health Plan
- Arnold Noriega, Community Health Group
- Bridgitte Lamberson, United Health Care
- Charles Bacchi, California Association of Health Plans
- Marie Montgomery, LA Care
- Farid Hassanpour, Chief Medical Office, CenCal Health
- Mark Bontrager, Partnership Health Plan
- Belinda Rolicheck, Health Net and CA Health and Wellness
- Natalie McKelvey, Santa Clara Family Health Plan
- Scott Coffin, Alameda Alliance for Health
- Lucy Marrero, Gold Coast Health Plan
- Robert Auman, Contra Coast Health Plan
- Natalie Zavala, CalOptima
- Kathleen McCarthy, Central California Alliance for Health
- Michael Brodsky, LA Care BH and Social Services
- Megan Noe, Health Plan of San Mateo

Behavioral Health

- Michelle Cabrera, CA Behavioral Health Directors Association
- Chris Stoner-Mirtz, CA Alliance of Child and Family Services
- Leora Wolf-Prusan, School Crisis Recovery and Renewal Project
- Le Ondra Clark-Harvey, CA Council of Community BH Agencies
- Lisa Eisenberg, CA School Based Health Alliance
- Adrienne Shilton, CA Alliance of Child and Family Services
- Libby Sanchez, Government Relations Advocate, SEIU California
- Lishaun Francis, Children Now
- Brent Malicote, Sacramento County Office of Education
- Adrienne “Addy” Pacheco, Chaffey Joint Union High School District
- Erica Zamora, Alvord Unified School District
- Greg Palatto, Charter Oak Unified School District
- Aj Kaur, Martinez Unified School District
- Norlon Davis, Los Angeles Unified School District
- Emi Botzler-Rodgers, Behavioral Health Director at Humboldt County
- Timothy Hougen, San Bernardino County Behavioral Health
- Marni Sandoval, Monterey County Behavioral Health

Workgroup Members

School Districts or County Office of Education

- Rosalee Hormuth, Orange County Dept of Education
- Rhonda Yohman, Madera County Superintendent of Schools
- Michael Lombardo, Placer County Office of Education
- Patrice Breslow, San Diego Unified School District
- Margie Bobe, Los Angeles Unified School District
- Katie Nilsson, San Joaquin County Office of Education
- Belinda Brager, Calaveras USD
- Dave Gordon, Sacramento County Superintendent
- Janice Holden, Stanilaus County Office of Education
- Coreen Deleone, Glenn County Office of Education
- Amanda Dickey, Santa Clara County Office of Education
- Jeremy Ford, Oakland Unified School District
- Will Page, Teacher, Los Angeles unified School District
- Angelo Reyes, Public Health, City of Pasadena
- Moncia Lamelle, San Luis Obispo County
- Andrea Ball, President and Advocate, Ball/Frost Group
- Lisa Eisenburg, CA School Based Health Alliance
- Helio Brasil, Small School Districts' Association
- Armando Fernandez, CA Association of School Psychologists
- Toni Trigueiro, California Teacher Association

Government Agencies

- Laila Fahimuddin, CA State Board of Education
- Daniel Lee, California Department of Education
- Stephanie Welch, California Health and Human Services
- Derick Daniels, Capitated Rates Development, DHCS
- Jillian Mongetta, Local Government Finance, DHCS
- Michel Huizar, Managed Care Quality and Monitoring, DHCS
- Jim Kooler, Medi-Cal Behavioral Health, DHCS
- Jacob Lam, Health Care Financing, DHCS

Meeting Schedule and Topics

Kick-Off

- Introductions
- Program Purpose and Scope
- Goals and Priority Areas
- Incentive Mechanism
- Workgroup Schedule

SBHIP Overview

- SBHIP Guiding Principles
- Existing obligations and funding streams
- Overview of targeted interventions, goals, and metrics
- Overview of incentive Payment Methodology

Targeted Interventions, Goals, and Metrics

- Review suggested targeted interventions, goals, and metrics
- Assess approach for impact to high priority groups
- Assess impacts/considerations for metrics by geography and intervention
- Allocation update

Assessment and Financial Model

- Incentive payment calculation (location, phase, amount)
- Payment methodology (frequency)

Finalize Design

- Implementation considerations
- Formal guidance and resources
- Oversight and governance plan
- Finalize design

Possible Meetings

- Meeting time held if needed:
  - Updates on allocation
  - Check in on assessment process
  - Other

Stakeholder Workgroup Meeting 4

Follow up on Feedback

- **Key Themes**
  - Concerns about complexity of assessment
  - Concerns on assessment timeframe
  - Request for flexibility throughout process
  - Request for overarching metrics
  - Support for partner list being a deliverable
  - Support for COE signature being required
  - Support for updated list of targeted interventions

Stakeholder Workgroup Meeting 4

Follow up on Feedback

- Multiple responses raised concerns with complexity of assessment.
  - The assessment is structured to ensure there is coordination among all stakeholders while providing comparable information for those MCPs, county BH, LEAs, and other stakeholders participating in SBHIP.
  - The assessment is provided in a template format to simplify process.

- Request clarification on how assessment is submitted if more than one MCP in one county participate in SBHIP.
  - To be discussed further today

- Request that more contract detail be required as part of the assessment.
  - Additional question added to template to capture contract information.
  - MOU requirement added as key component of targeted intervention process.

Stakeholder Workgroup Meeting 4

Follow up on Feedback

- Multiple responses recommend one or two project-wide measures.
  - Project wide measures have been developed and will be reviewed in more detail today.
- Comments on payment methodology and allocation by county versus MCP.
  - Allocation has been done by county to ensure statewide impact and to ensure appropriate distribution based on population.
- Request clarification on how ‘LEA’ is defined for SBHIP
  - LEA Minimum: the LEA count informing the 10% minimum expectation includes data provided by the California Department of Education that contains all active and pending districts and county offices of education.
  - In smaller counties COEs are synonymous with school districts.
  - SBHIP Participation: all LEAs, including those defined as charter schools, the California Schools for the Deaf, and the California School for the Blind, should reach out to their COE and MCPs.

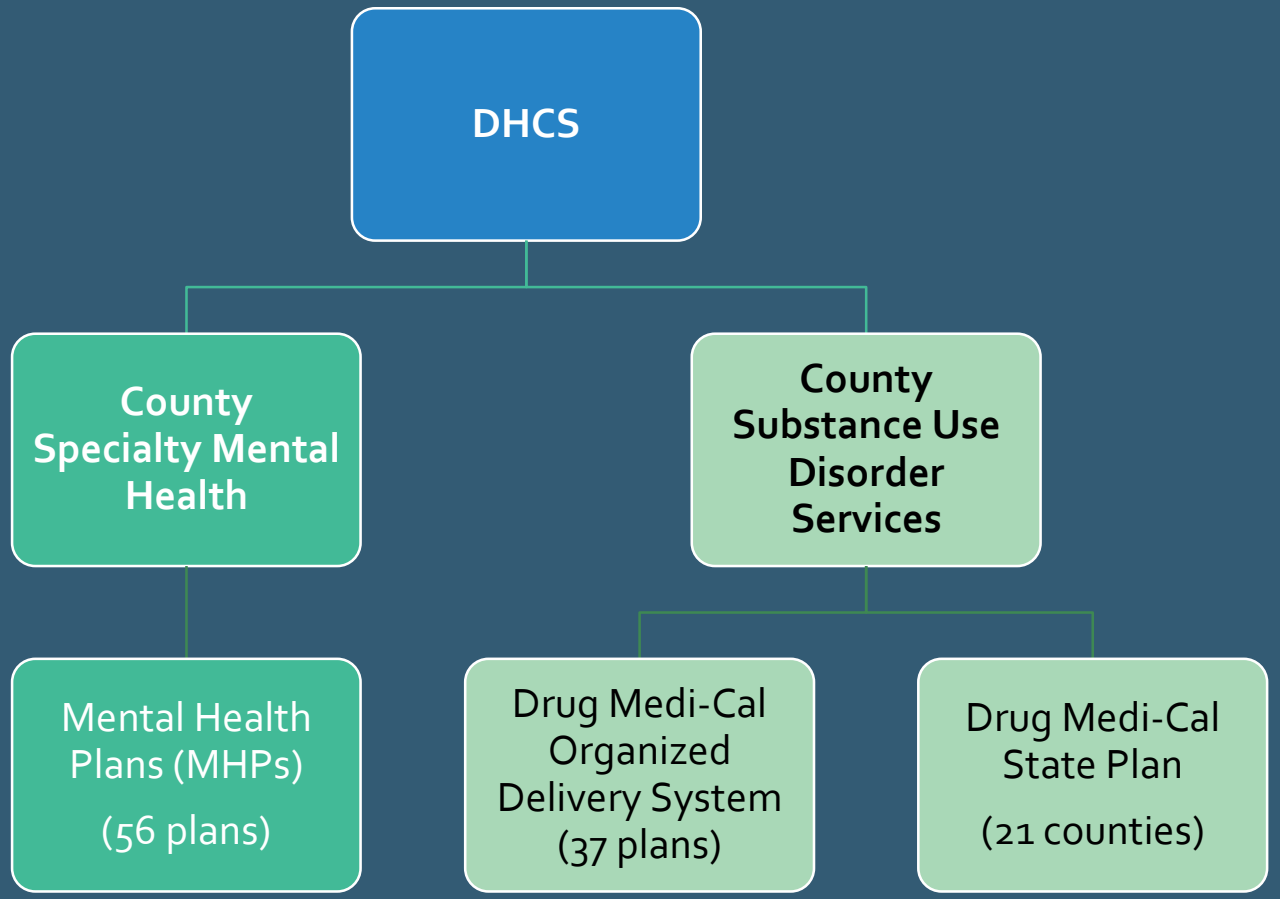
Stakeholder Workgroup Meeting 4

Follow up on Feedback

- Multiple concerns about timeline for assessment and impact to implementation of targeted interventions (at stakeholder meeting it was shared as nine months).
  - Timeline now 12 months, should address concerns raised in feedback.
  - Option to start targeted interventions prior to completion of assessment addresses concerns that critical work will be delayed by assessment requirement.
- Request for more time to submit letter of intent:
  - LOI due date pushed out one month to January 31, 2022
- Concerns about COE signature expectation
  - MCPs are required to show they have attempted to contact the COE if they are unable to provide a signature. The expectation is MCP attempts to contact the COE at minimum three times and engages the technical assistance contractor for support in making contact.
  - Following attempts to contact, if it is not possible to get a COE signature, signatures from the LEA partners could be submitted in its place.

County Behavior Health Overview

MEDI-CAL SPECIALTY BEHAVIORAL HEALTH



MEDI-CAL COVERED BEHAVIORAL HEALTH SERVICES

Mild-to-Moderate ***MCP***	Specialty Mental Health County County MHP	Drug Medi-Cal State Plan 21 Counties	Drug Medi-Cal Organized Delivery System 37 County SUD plans
•*Individual and group mental health evaluation and treatment (psychotherapy)* •*Psychological testing* •*Outpatient services to monitor drug therapy* •*Outpatient lab, drugs, supplies and supplements* •*Psychiatric consultation*	•Mental health services •Medication support services •Day treatment intensive •Day rehabilitation •Crisis intervention •Crisis stabilization •Adult residential treatment services •Crisis residential treatment services •Psychiatric health facility services •Intensive Care Coordination (for beneficiaries under the age of 21) •Intensive Home Based Services (for beneficiaries under the age of 21); •Therapeutic Behavioral Services (for beneficiaries under the age of 21); •Therapeutic Foster Care (for beneficiaries under the age of 21); •Psychiatric Inpatient Hospital Services; and, •Targeted Case Management •Peers (optional benefit without dedicated funding)	•Outpatient Drug-Free Treatment •Perinatal Intensive Outpatient Treatment • Perinatal Residential Treatment (16 beds only) • Inpatient Hospital Detoxification •Narcotic Treatment Program Services (methadone)	•Outpatient Treatment Services •Intensive Outpatient Treatment •Residential Treatment Services (no bed limit)3.1, 3.3,3.5 •WM (residential 3.2) •NTP/OTP Services with Methadone, Buprenorphine, Disulfiram, and Naloxone •Recovery Services •Case Management •Physician Consultation •Additional MAT (optional) •3.7 and 4.0 Inpatient and Withdrawal Management

COUNTY BEHAVIORAL HEALTH
BEYOND MEDI-CAL

Lanterman-Petris-Short (LPS Act) - 1967 State Law

- Involuntary Holds/Treatment/Conservatorship
- State Hospitals

Bronzan McCorquodale Act - 1991 Realignment of Community MH

- Broad community mental health mandate, to the extent resources are available

Federal Substance Abuse and Mental Health Block Grants

Mental Health Services Act (MHSA) - 2004 Voter Initiative

- As directed through community planning or by Oversight & Accountability Commission
- No Place Like Home

MEDI-CAL VS NON-MEDI-CAL FUNDED SERVICES
COUNTY BEHAVIORAL HEALTH

Upstream: No Medi-Cal

Sources: MHSA, MHBG, SABG

- Prevention/Wellness
- Outreach & Engagement
- Pre-diagnosis Treatment (until CalAIM changes take effect)
- Community Defined Evidence Practices
- Uninsured
- Private Commercially Insured
- Housing
- Board & Care
- Non-Medi-Cal peer services

Medi-Cal Funded

Sources: MHSA, 1991 & 2011 Realignment, FFP

- **Assessment**
- **Case Management**
- **Outpatient Treatment**
- **Recovery & Rehabilitation**
- **Crisis Services**
- **Inpatient (general acute care hospitals)**
- **Residential Treatment**
- **Detox/Withdrawal Management**
- **Peers**
- **Prescription medications**

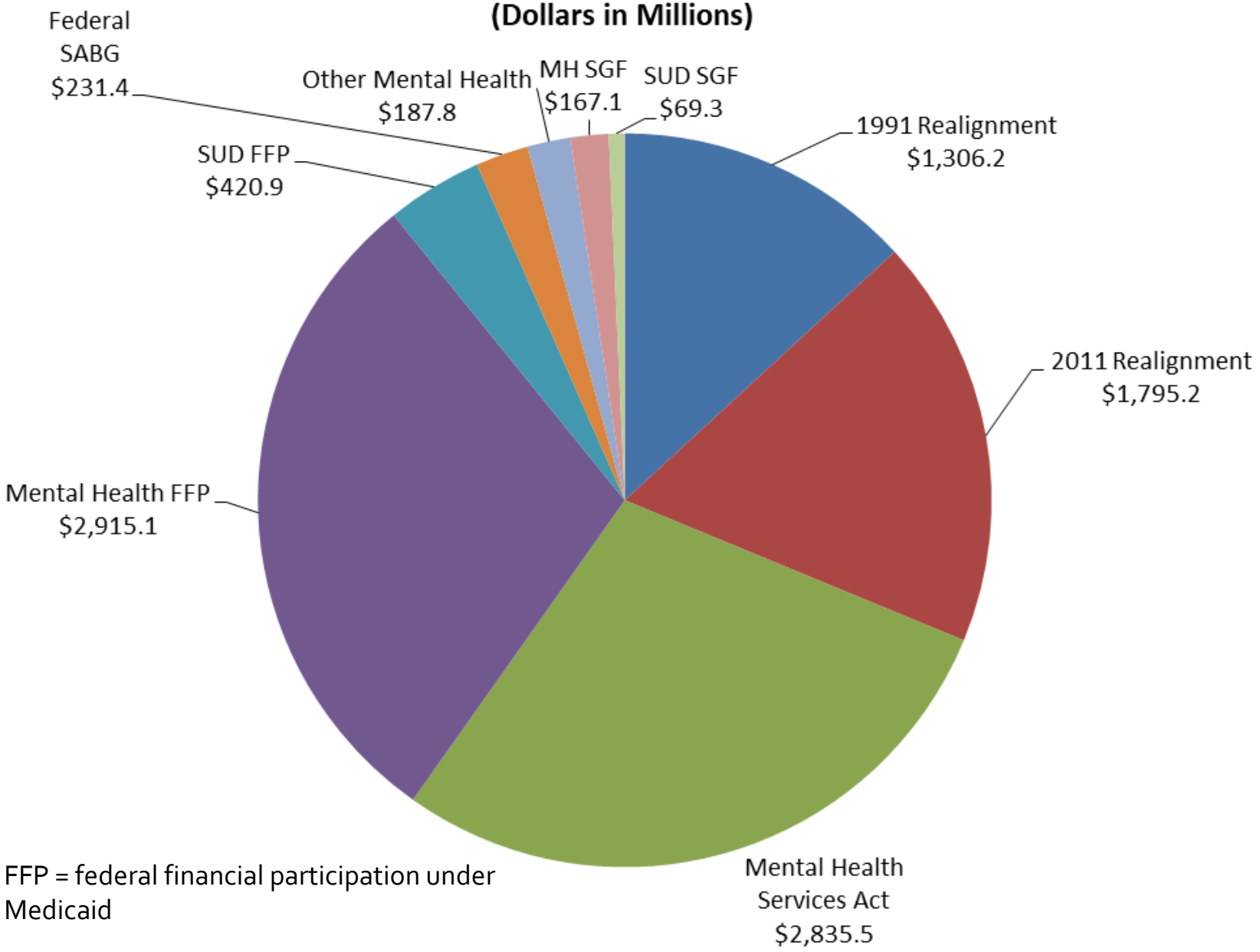
Acute/High End: No Medi-Cal

Sources: MHSA (limited), 1991 Realignment

- Mobile crisis services not reimbursable via Medi-Cal
- Crisis services over 24 hours
- Treatment facilities over 16 beds (locked or unlocked)
- Jail based treatment
- Public Guardian
- State Hospital
- Housing
- Board and care
- "Whatever it Takes" Wraparound Services
- Uninsured
- Private Commercially Insured

FY22-23 Estimated Behavioral Health Funding

$9.9 Billion
(Dollars in Millions)



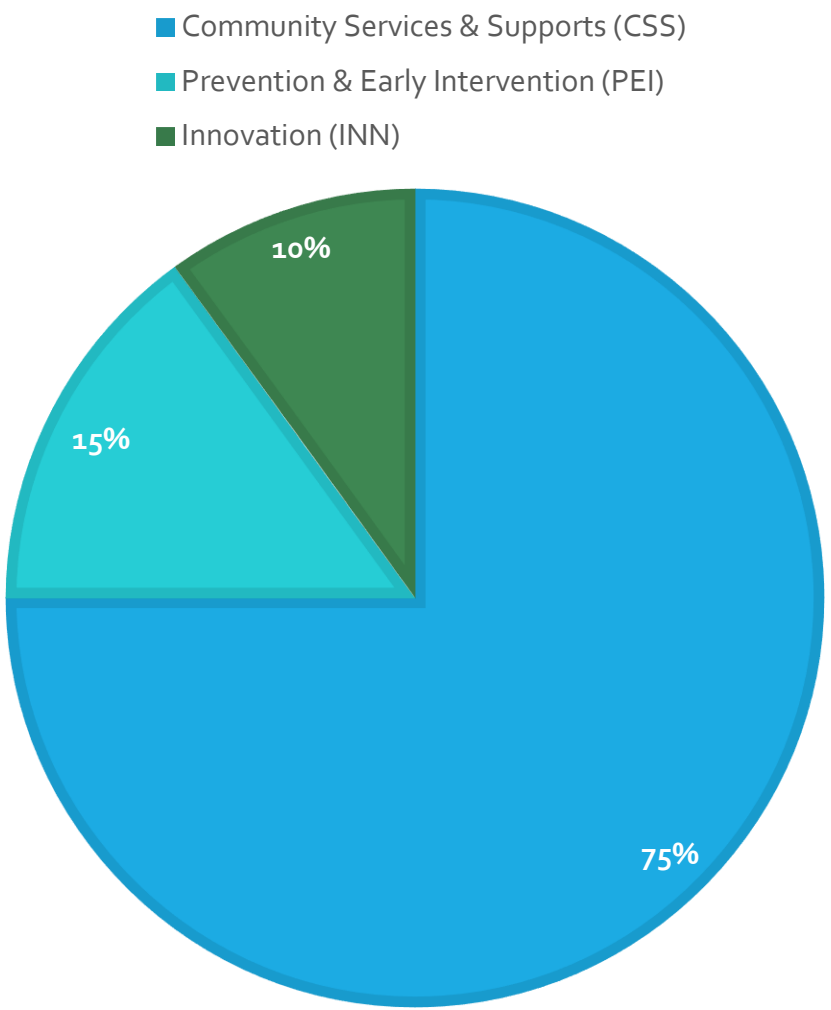
FFP = federal financial participation under Medicaid

CORE (NON-FEDERAL) FUNDING SOURCES FOR MEDI-CAL

Mental Health Services Act (MHSA)

1991 Realignment (Bronzan-McCorquodale Act)

2011 Realignment



MENTAL HEALTH SERVICES ACT (MHSA) COMPONENTS

MEDI-CAL CALAIM INITIATIVE

TRANSFORMING CHILDREN'S ACCESS

- **Remove requirement for a diagnosis:**
  - *Effective **January 2022** for Specialty Mental Health*
- **Creates automatic eligibility for the following groups of children (January 2022):**
  - Child welfare or juvenile justice involved
  - Homeless children/youth
  - Children/youth who meet a certain level of trauma (TBD)
- **No Wrong Door (Jan 2022)**
  - Children can receive mental health services from both the MCP and MHP simultaneously, if the child requires specialty services not provided by the MCP
  - Plans will need to coordinate to avoid duplication

COUNTY BEHAVIORAL HEALTH OVERSIGHT & ACCOUNTABILITY

DHCS

- Contracts
- Network Adequacy Requirements
- External Quality Review Organization (EQRO)
- Cost Reports
- Triennial Review
- Compliance Audits
- Licensing & Certification of Facilities
- Grievance & Appeals
- MHSA Plan & Annual Revenue & Expenditure Reports
- Cultural Competence Plans

County

- County Board of Supervisors
- MHSA Local Planning Body
- Local Mental Health Boards & Commissions

MHSA OAC

- Innovation Fund Approvals
- Dashboards (Transparency)

KEY CONSIDERATIONS & COMMON MISPERCEPTIONS

- **Overall: "County behavioral health has plenty of funding."**
  - Funding is variable, categorical, and not tied to the number of Medi-Cal enrollees
  - California's per capita funding falls far behind levels in NY, WA, Oregon, and other comparable states
- **MHSA: Concerns regarding unspent MHSA or lack of transparency/accountability**
  - Less than 1% is reverted/unspent
  - MHSA is highly regulated at the local and state level
  - MHSA funding is restricted in terms of use
  - MHSA funding leverages over $1 billion in Medicaid Federal Financial Participation
- **County behavioral health is highly fragmented/siloed**
  - In fact, county behavioral health partners across health, human services, education, and justice system partners, among others.
- **You've Seen One County, You've Seen One County**
  - Many services are funded through categorical funding or competitive grants and/or cuts across multiple payers/populations, so services are variable by design. Medi-Cal services are consistent with contract obligations.

COUNTY BEHAVIORAL HEALTH IN SCHOOLS CBHDA SURVEY

85% Provide Specialty Mental Health Services on School Campuses

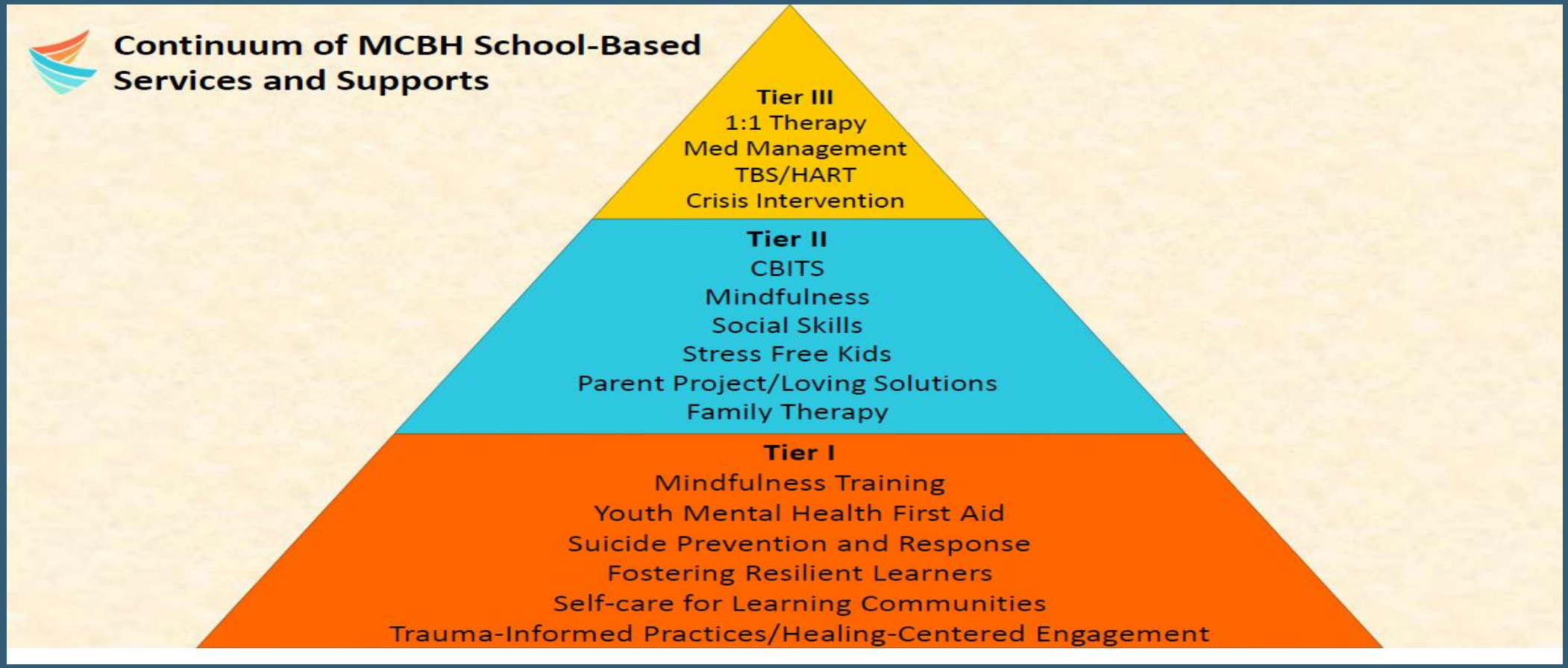
70% Cover approximately 50% or more school campuses in county

SUD prevention and treatment services also provided at schools

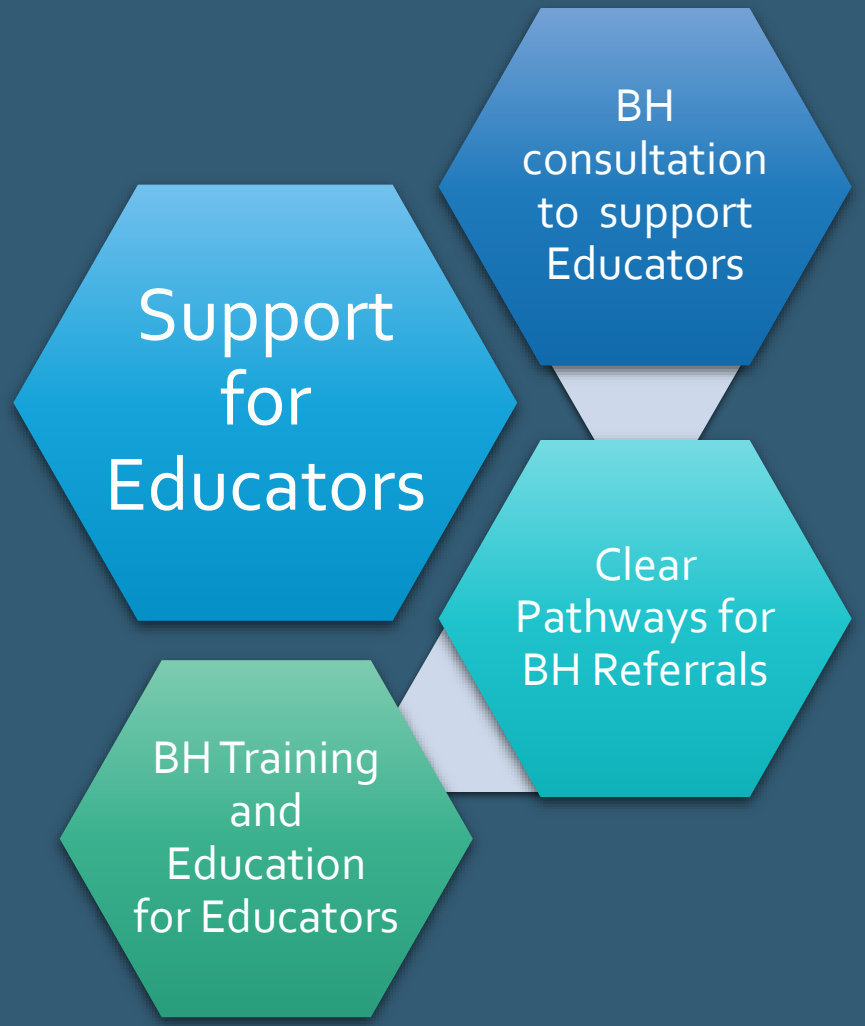
65% Provide School-Based BH Services to Non-Medi-Cal Beneficiaries

*January 2021 Survey of County Behavioral Health Agencies - 97% Response Rate

COUNTY BEHAVIORAL HEALTH SERVICES ON SCHOOL CAMPUSES



COUNTY BEHAVIORAL HEALTH SERVICES ON SCHOOL CAMPUSES



COUNTY BEHAVIORAL HEALTH IN SCHOOLS – COLLABORATIVE MODELS

The Most Common Collaborative Models to Deliver SMH Services at Schools

*Local collaborations/agreements may provide different levels of financial resources and funding to ensure service delivery across systems

Model 1
(49% utilize this model)

School staff provide ERMHS and county behavioral health agencies operate on school sites and provide SMHS.

School staff refer students receiving ERMHS as well as other students that are meeting academic standards and may not qualify for ERMHS, for onsite SMHS.

Model 2
(29% utilize this model)

Schools contract with county behavioral health agencies to provide ERMHS on school sites with schools paying for ERMHS services.

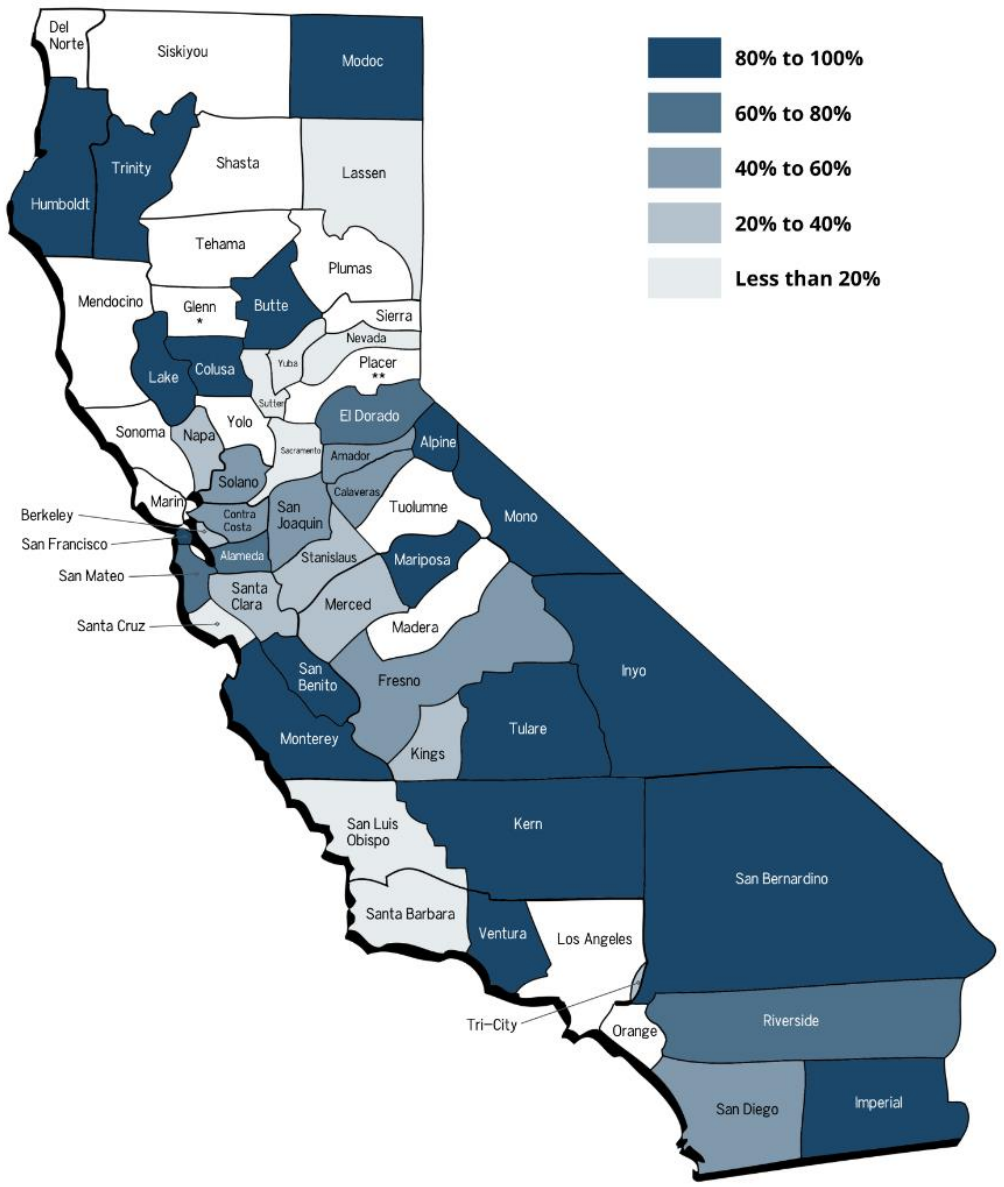
In this model, county behavioral health agencies also provide and pay for SMHS for students both on school sites and when necessary, in the community.

Model 3
(10% utilize this model)

County behavioral health agencies contract directly with licensed school staff to provide SMHS.

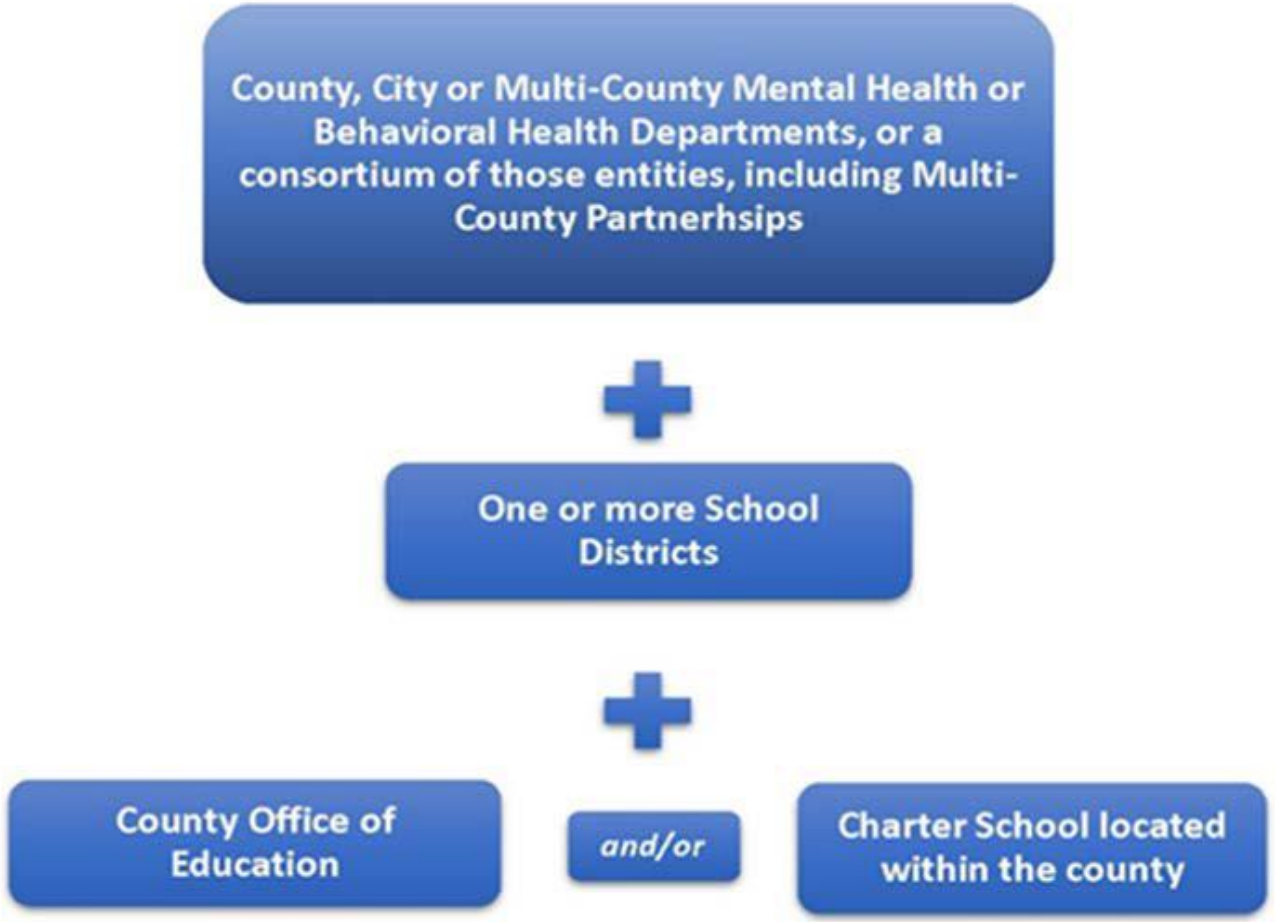
In this model, schools continue to provide and pay for ERMHS outside of their county behavioral health contract.

County Behavioral Health Specialty Mental Health in Schools



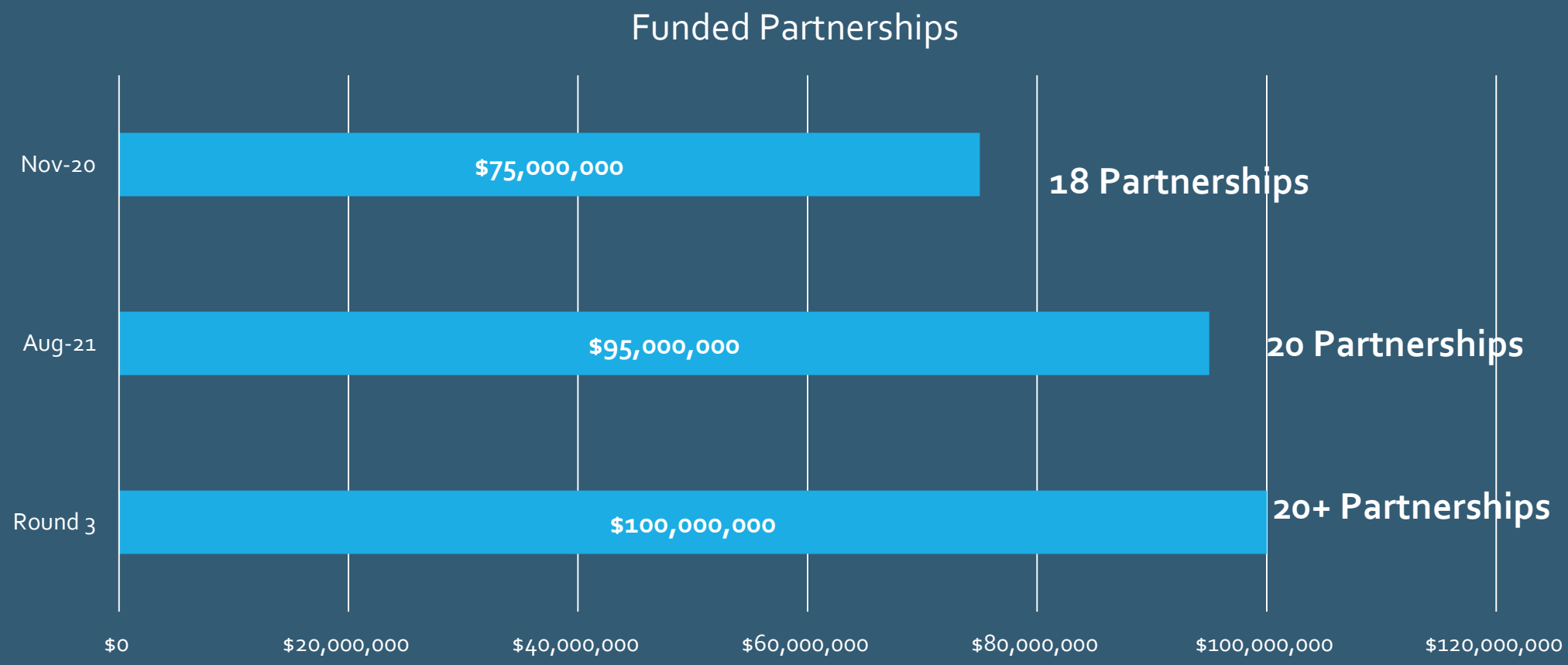
Source: January 2021 CBHDA Member Survey

MHSSA Partnerships



MENTAL HEALTH STUDENT SERVICES ACT (MHSSA) FUNDING

MENTAL HEALTH STUDENT SERVICES ACT (MHSSA) FUNDING



QUESTIONS & ANSWERS

Contact:

Michelle Doty Cabrera

mcabrera@cbhda.org

SBHIP Timeline and Partnership Criteria

4

SBHIP Proposed Timeframe and Steps

SBHIP Timeline	Date
SBHIP Design Period: DHCS works with stakeholders to develop metrics, interventions, and goals to inform incentive payments to Medi-Cal managed care plans.	August 2021-December 2021
MCPs Letters of Intent to participate in SBHIP due to DHCS	January 31, 2021
MCPs work with County office of Education to select collaborative partners and student population to target and submit information to DHCS	First Quarter 2022
MCPs and selected partners conduct assessment	First/Second Quarter 2022
MCPs finalize needs assessment, referral process, and resource map: submit to DHCS	Fourth Quarter 2022
MCPs and selected partners: a. Select targeted intervention(s) and student population to target with selected intervention(s) b. Draft project plan to submit to DHCS	Fourth Quarter 2022
DHCS reviews MCP project plan for each MCP and each targeted intervention[1]	First Quarter 2023
MCPS and selected partners implement targeted intervention(s)	First/Second Quarter 2023
Interim project plan	Quarterly
MCPs and selected partners submit project outcomes document for each targeted intervention	Fourth Quarter 2024
SBHIP operations close	December 31, 2024

1. Targeted interventions may be implemented prior to completion of assessment

Partnership Assessment Criteria

Criteria to Assist MCP in Collaboration with County Office of Education Determine LEA Partners

LEAs with high density **Unduplicated Students** Students who:

(1) Are English learners,

(2) Meet income or categorical eligibility requirements for FRPM meal under the National School Lunch Program

(3) Are foster youth

"Unduplicated count" means that each student is counted only once even if the student meets more than one of these criteria

LEAs with high density of Medi-Cal plan enrollees or FRPM schools

LEAs with demographic trends identifying specific needs (e.g., high percentage of English language learners, foster youth, or chronic absenteeism)

LEAs with a high interest in participating in SBHIP

SBHIP Deliverables

- ❑Letter of Intent
- ❑LEA Partners Identified: MCP must engage COE and demonstrate effort to engage LEA, county behavioral health departments, and other stakeholders.
- ❑SBHIP Assessment
- ❑SBHIP Milestone 1: Project plan
- ❑SBHIP Interim project plan update
- ❑SBHIP Milestone 2: Project outcome

Letter of Intent

- The Letter of Intent will be due no later than 5 p.m. PST January 31, 2022

- The Letter of Intent will be a form and will request:
  - MCP organization name
  - Number of counties serviced by MCP
  - List of counties serviced by MCP
  - Anticipated number of SBHIP collaborative counties
  - Anticipated list of SBHIP collaborative counties
  - MCP contact person, title, telephone, and email address
  - Organization mailing address
  - Signed by MCP CEO, CFO, or someone of similar status

  Note: Incentive payment aligned with the letter of intent will be initiated in First Quarter 2022 once MCPs share list of SBHIP partners.

SBHIP Partners

- MCPs must submit a form to DHCS identifying their SBHIP partners, no later than end of first quarter 2022. It is requested that MCPs demonstrate they tried to engage those entities unable to participate.

- The SBHIP Partner form will include **for each partner** the:
  - SBHIP Partner Organization
  - SBHIP Partner Contact Person
  - SBHIP Partner Contact Person Title
  - SBHIP Partner Telephone Number
  - SBHIP Partner Email Address
  - SBHIP Partner Mailing Address

- **Signature from COE Superintendent** be included with partnership form. COE's role is to assist the MCP in determining the appropriate LEAs. The signature signifies that the COE worked with the MCP and provided a list and/or feedback of which LEAs to possibly engage in SBHIP.

Note: Incentive payment aligned with the letter of intent will be initiated in First Quarter 2022 once MCPs share list of SBHIP partners.

Assessment

5

Assessment Approach

Timeframe:

- Up to 12 months to complete assessment and resource mapping.
- Targeted Interventions may be implemented prior to completion of assessment.

Partnership:

- MCPs will be required to partner with the COE(s) to help with selection of LEAs, county behavioral health departments, and other stakeholders to engage in development of the needs assessment.
- There will be one assessment per county. However, the assessment will focus on selected LEAs in the county, not represent the entire county.
- LEAs as referenced in SBHIP applies to school districts and county offices of education.

Assessment Approach

MCP Partnership and the Assessment:

- MCPs collectively must engage at minimum 10% of the LEAs in their county.
- It is not expected that each MCP in a county engage 10% of the LEAs in that county. As part of the initial assessment, it is expected that MCPs coordinate to ensure their combined efforts impact 10% of LEAs in their shared county.
- Proposed Approach to Implementation:
  - MCPs in shared county meet with COE to determine LEAs to engage in SBHIP. As a group they select the LEAs they plan to engage, ensuring there is a minimum of 10% engaged in county.
  - MCPs may work together or separately to then complete the assessment template for their selected LEA(s).
    - If MCPs do not collaborate to conduct their assessment they may need to check in periodically on progress and/or develop a timeline to ensure all MCPs complete assessment at same time.
  - When assessment template is complete, MCPs meet to synthesize LEA component. This may consist of multiple assessments combined as one, requiring minimal if any changes to individual assessments. The initial question on assessment, the LEA Partner Selection Template, will only have one response:
    - DHCS provided parameters based on specific criteria to utilize when selecting LEA partners for SBHIP. As a component of this assessment, please identify the specific steps taken to select the participating LEA(s), any distinct characteristics of the selected LEA(s), and describe why that particular LEA(s) was chosen. (500 words or less).
    - If there were LEA(s) that wanted to participate in SBHIP but were ultimately not chosen, please identify those particular LEAs and articulate the specific reasons why those LEAs were not selected to participate. (500 words or less)

Assessment Template

LEA Partner Selection Template:

1. DHCS provided parameters based on specific criteria to utilize when selecting LEA partners for SBHIP. As a component of this assessment, please identify the specific steps taken to select the participating LEA(s), any distinct characteristics of the selected LEA(s), and describe why that particular LEA(s) was chosen. (500 words or less).
2. If there were LEA(s) that wanted to participate in SBHIP but were ultimately not chosen, please identify those particular LEAs and articulate the specific reasons why those LEAs were not selected to participate. (500 words or less)

Identified Student Behavioral Health Needs

3. What is the greatest behavioral health need presented by students in the selected LEA(s)? Please identify and describe the specific need. Please identify what information (including data sources as applicable) was used to determine that need?
4. What measurable actions could be taken to address that need within the selected LEA(s)? (250 words or less)
5. What specific steps (if any) are being taken to address that need within the selected LEA(s)? (250 words or less)
6. If additional behavioral needs of students were identified, please list the next (2-7) most pressing behavioral health needs presented by students in this LEA? Please identify the specific needs.
7. What measurable actions could be taken to address those needs within the selected LEA(s)? (250 words or less)
8. What measurable steps (if any) are being taken to address those needs within the selected LEA(s)? (250 words or less)

Identified Gaps

9. Are there any identifiable gaps in the delivery of behavioral health services within the selected LEA(s)? If identified, please list the gaps.
10. If gaps were identified, what measurable actions could be taken to address those gaps (250 words or less)?
11. If gaps were identified, what measurable steps (if any) are being taken to address those gaps (250 words or less)?

Identified Disparities

12. Are there any identified disparities in behavioral health needs based on different populations within the selected LEA(s)? If identified, please list the disparities.
13. If identified, what measurable actions could be taken to address those disparities within the selected LEA(s)? (250 words or less)
14. If identified, what measurable steps (if any) are being taken to address those disparities within the selected LEA(s)? (250 words or less)

Barriers to Behavioral Health Referrals

15. Are there any identified barriers to the behavioral health referral process within the selected LEA(s)? If identified, list those specific barriers?
16. What specific steps (if any) are being taken to address those barriers within the selected LEA(s)? (250 words or less)
17. Are there any identified barriers to the behavioral health referral process within the community? If identified, list those specific barriers?
18. What specific steps (if any) are being taken to address those barriers within the community? (250 words or less)

Behavioral Health Resources and Enhancements

19. What is the current funding allotment for behavioral health services within the selected LEA(s)?
20. Are there any behavioral health-related program areas that would better serve student needs through additional supports/funding? If identified, please list those specific areas.
21. What measurable actions could be taken to address those enhancements? (250 words or less)
22. What identifiable steps (if any) are being taken to address needed enhancements and/or improvements? (250 words or less)
23. Are there any LEA behavioral health resources, not currently utilized, that may be helpful to incorporate to the existing collection of LEA resources? If identified, please list what programs those would be and why they would be helpful to this LEA student population. (250 words or less)
24. Are there any behavioral health community resources (not currently included in the community behavioral health list) that may be helpful to incorporate for students? If identified, please identify what programs those would be and why they would be helpful to this LEA student population. (250 words or less)
25. What percentage of behavioral health services are provided via a telehealth medium within the selected LEA(s)?
26. What percentage of students are referred out to community resources for behavioral health services and supports within the selected LEA(s)?

Publicizing Behavior Health Resources

27. Describe the specific methods used to promote behavioral health services to students within the selected LEA(s). (250 words or less)
28. Describe the specific methods used to promote behavioral health services to staff within the selected LEA(s). (250 words or less)
29. Describe the specific methods used to promote behavioral health services to parents/guardians of students within the selected LEA(s). (250 words or less)

Assessment Deliverables

The Assessment has six components, all of which must be completed in entirety:

- Stakeholder Meetings
- Data Collection Strategy
- Needs Assessment Template
- LEA and Community Resource Map
- LEA and External Provider Behavioral Health Referral Processes
- Behavioral Health Self-Report

A detailed assessment template will be provided to help guide the assessment process. Stakeholder, surveys, interviews, and focus groups are encouraged as an initial step to inform the template, map, and referral information. The intent to ensure coordination among all stakeholders in assessing TK-12 BH needs for the selected LEA.

Questions on MCP Assessment Approach

Questions for Stakeholders?

- Referral maps
- Resources

Targeted Interventions, Goals, and Metrics

Targeted Interventions

Clarifying Points

- The Targeted Interventions list is designed to provide broad parameters for acceptable interventions under SBHIP. MCPs, in collaboration with selected stakeholders, may select two or more of the targeted interventions listed. They then, in collaboration with stakeholders, will determine the details for their intervention that aligns with the needs of the school district and students it is designed to serve.
- Milestones/Metrics are required for each targeted intervention.
- MCPs will be required to implement a minimum of two to four interventions depending on their maximum allocation amount.
- A MOU is required for each intervention. However, it is not required that they have two to four MOUs. One MOU may work if multiple interventions are targeted in the same LEA.

Targeted Interventions

Requirement to receive incentive payment for each Targeted Intervention:

- MCPs must engage partners in implementation of selected targeted intervention. Targeted interventions cannot be implemented exclusively by a MCP (e.g., using MCP staff only).
- MCPs must have MOU with the selected partner(s) for each targeted intervention.
  - It is understood that it may take time to administer a MOU. While an MOU may not be in place at time of project plan, it is expected that MOUs have an effective date retroactive to the date the targeted intervention is selected.
  - The majority of MOUs will be between the MCP, LEA, COE, and/or County BH Department. If an MOU is between the MCP and CBO, documentation of an agreement between the CBO and LEA is also required.
  - MOU documentation will be a required component of Milestone 2.

Targeted Interventions

Revised List of Targeted Interventions

1. **Behavioral Health Wellness Programs:** Develop or pilot BH wellness programs to expand greater prevention and early intervention practices in school settings (examples include Mental Health First Aid and Social and Emotional Learning) by Medi-Cal managed care plans and county BH departments building a dedicated school BH team to engage schools and address issues for students with BH needs. If wellness programs already exist, funds may be used to build on and expand on these efforts.
2. **Telehealth Services and Access to Technological Equipment:** Increase BH telehealth services in schools, including app-based solutions, virtual care solutions, and within the community health worker or peer model. Ensure all schools and students have access to equipment to provide telehealth services, like a room, portal, or access to tablets or phones, within their school with appropriate technology.
3. **Behavioral Health Screenings:** Enhance developmentally appropriate BH screenings (ACE and other) and referral processes in schools (completed by BH provider), including when positive screenings occur, providers taking immediate steps, including providing brief interventions (e.g., motivational interviewing techniques) and ensuring access or referral to further evaluation and evidence-based treatment, when necessary.
4. **Suicide Prevention Strategies:** Implement a school suicide prevention strategy.
5. **Substance Use Disorder**: Increase access to substance use disorder prevention, early intervention, and treatment, including MAT where feasible and co-occurring counseling and behavioral therapy services for adolescents.

Targeted Interventions

Revised List of Targeted Interventions

6. **Building Stronger Partnerships to Increase Medi-Cal reimbursable services:** Incentive funds may provide for technical assistance, training, toolkits, and/or learning networks for schools to build new or expand capacity of Medi-Cal services for students, integrate local resources, implement proven practices, ensure equitable care, and drive continuous improvement.
7. **Culturally Appropriate and Targeted Populations:** Community defined interventions and systems to support initial and continuous linkage to BH services in schools. Incentives may focus on unique populations including the most vulnerable communities, such as students living in transition or homeless and those involved in the child welfare system.
8. **Behavioral Health Public Dashboards and Reporting:** Improve performance and outcomes-based accountability for BH access and quality measures through, local student BH dashboards or public reporting.
9. **Technical Assistance Support for Contracts:** Medi-Cal managed care plans and/or county BH departments execute contracts with schools to provide preventive, early intervention, and BH services. It is expected that this targeted intervention would go above and beyond the MOU requirement.
10. **Expand Behavioral Health Workforce:** Expand the workforce by using community health workers and/or peers to expand the surveillance and early intervention of BH issues in school aged kids. Funding may cover the cost to certify peers to provide peer support services on school-based sites. Particular focus on grades TK–12, since young people tend not to see their primary care provider routinely after their vaccinations are complete.

Targeted Interventions

Revised List of Targeted Interventions

11. **Care Teams:** Care teams that can conduct outreach, engagement and home visits, as well as provide linkage to social services (community or public) to address non-clinical needs identified in BH interventions.
12. **IT Systems to Support Behavioral Health Services:** Implement information technology and systems for cross-system management, policy evaluation, referral, coordination, data exchange, and/or billing of health services between the school and the managed care plan and county BH department.
13. **Pregnant Students and Teen Parents:** Increase prenatal and postpartum support services, increasing access to mental health and substance use disorder screening and treatment for teen parents.
14. **Parent and Family Services:** Providing evidence-based parenting and family services for families of students, including, but not limited to, those that have a minimum of “’promising” or “supported” rating in the Title IV-E Clearinghouse Prevention Services or the California Evidence-Based Clearinghouse for Child Welfare

Targeted Interventions: Milestone 1 Detail

Project Plan

Submission of a project plan, completed by the MCP in collaboration with the selected LEA(s) and stakeholders to implement the selected intervention. The project plan should contain the following components:

1. Description of targeted intervention selected
2. Information on how intervention increases access to BH for students
3. Description of the importance of the targeted intervention to Medi-Cal beneficiaries
4. Description of the project design for implementing selected intervention (implementation steps)
5. Narrative description of activities to be completed and dates of anticipated intervention outcomes
6. Organizational capacity and leadership support
7. Description of how proposed intervention will be sustained long-term; post SBHIP
8. Select Metric and provide detailed information on how it will be measured for specific intervention.
9. A transition plan may be requested due to 2024 procurement

Targeted Interventions: Interim Project Plan Report

The purpose of the SBHIP Interim Project Plan Quarterly Reports are to provide information to DHCS related to the SBHIP project status throughout the program duration. The quarterly reports provide an opportunity for MCPs to share intervention progress, challenges encountered, successes achieved, inform DHCS of any modifications made to the original project plan submissions, and to ensure the project plan is on target to successfully complete the proposed interventions. The SBHIP interim project plan quarterly report further serves as an opportunity to increase communication and collaboration between DHCS and the participating MCPs throughout the project duration:

1. Provide an estimate of the percentage of SBHIP project completed.
2. Description of progress and status update.
3. Identify any changes in SBHIP partners based on initial plan.
4. Identify any changes in student population identified as recipients of selected intervention.
5. Changes to metrics.
6. Identify internal and external SBHIP challenges.

Targeted Interventions: Milestone 2 Detail

Completed Project Outcomes

Project outcomes, completed by the MCP in collaboration with the selected LEA(s) and stakeholders documenting the implementation of the selected intervention. The narrative plan should contain the following components:

1. Documentation of the implementation, or expansion of, the selected intervention
2. Documentation of challenges and successes resulting from intervention
3. Documentation of the current status of the implemented intervention
4. Information on how intervention increases access to BH for students
5. Description of the importance of the targeted intervention to Medi-Cal beneficiaries
6. Documentation of efforts to refine/adjust intervention for future implementation
7. Documentation of anticipated expansion of intervention (note targeted populations)
8. Description of how proposed intervention will be sustained long-term; post SBHIP
9. Updated metrics post implementation, supported by measures outlined in project plan
10. Documentation of MOU.

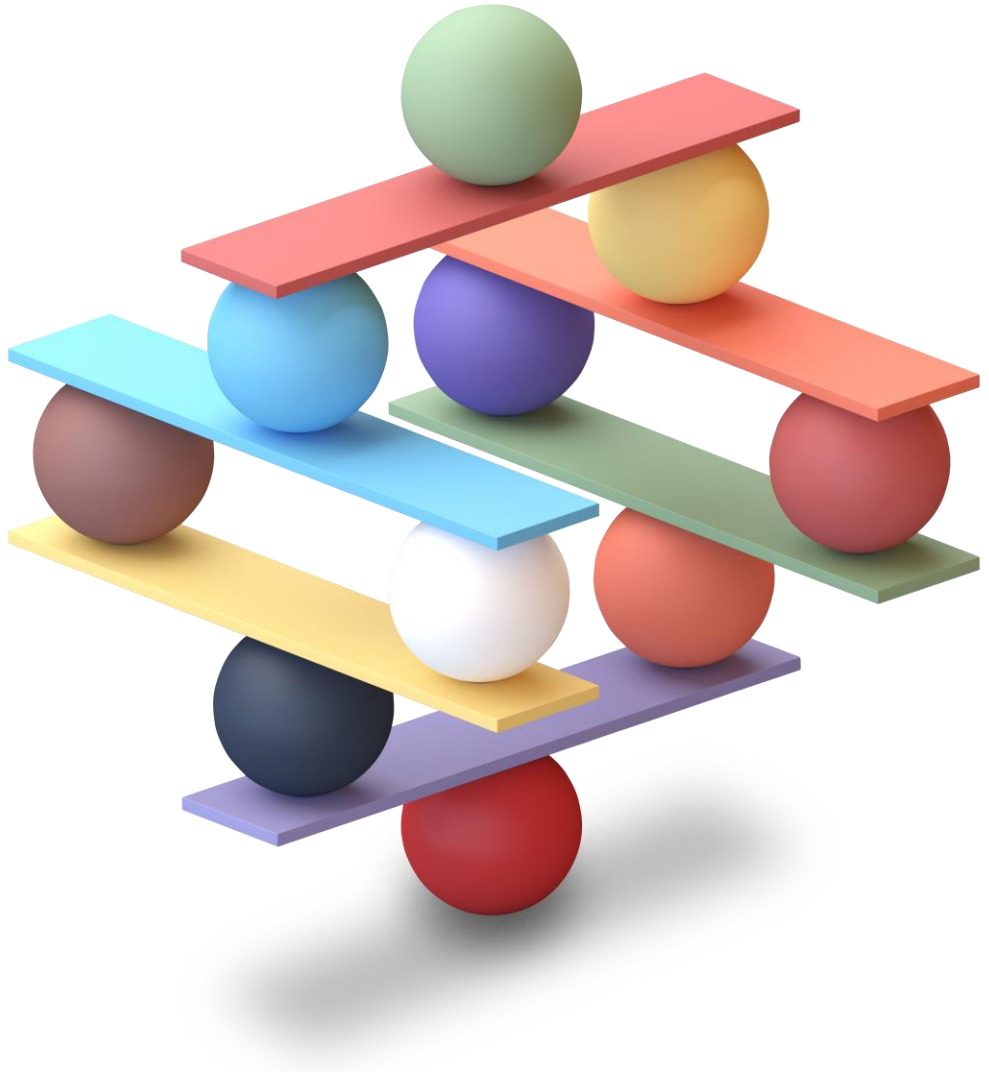
Targeted Interventions: Metrics

For every targeted intervention selected, a targeted intervention metric must also be selected and reported as part of the project plan and project outcome plan. Managed care plans in collaboration with selected partners, will provide two detailed measures which support either one of the metrics below.

- Increase Access to BH (capacity, infrastructure, sustainability, BH service):
  - Increase access to BH services on or near campus OR,
  - Increase access to BH services provided by school-affiliated BH providers
- Increase Number of students Receiving BH Services:
  - Increase number of students receiving BH services on or near campus **or**,
  - Increase number of students receiving BH services from school-affiliated BH providers

Questions on Revised Targeted Interventions and Proposed Approach to Metrics

- ?



Incentive Payment Methodology

7

Incentive Payments: Funding Allocation

SBHIP Incentive Payment:

- $389 million over three-year period (January 1, 2022– December 31, 2024)
- Allocation by year:

Program Year (PY)	% of Total SBHIP funding
PY 1	~ 10-15%
PY 2*	~ 40-45%
PY 3	~ 45%

*Expectation that outgoing MCPs will coordinate with incoming MCPs

- Two Fund Groups: Assessment and Targeted Interventions
  - Assessment fund: approximately $39 million
  - Targeted Intervention fund: approximately $350 million

Incentive Payments: Funding Allocation

- Assessment Allocation Methodology Considers:
  - Allocation by Medi-Cal member month per plan per county
  - Assessment ‘floor’ for each county: $225 thousand
  - MCPs may combine funding but must engage in assessment for each county funded
- Targeted Intervention Allocation Methodology Considers:
  - Allocation by Medi-Cal member month
  - Allocation by unduplicated pupil count
  - Final allocation based on 50% member months, 50% unduplicated pupil count
  - Targeted intervention ‘floor’: $500 thousand

Incentive Payments: Funding Allocation

- Funding Milestones:
  - Letter of intent/partnership list: 50% of assessment allocation
  - Assessment: 50% of assessment allocation
  - Project plan for each targeted intervention: up to 50% of outcome allocation
  - Project outcome with achieved metrics for each targeted intervention: remaining % of outcome allocation

- Payments to be provided bi-annually in alignment with funding milestones

Note: Upfront funding for LOI/partnership and project planned are considered unearned funds until completion and approval of the assessment and project outcome. The upfront funds percentage amount is not indicative of what will paid for LOI/partnership list and the project plan.

Incentive Payments: Funding Allocation and Targeted Interventions

Targeted Intervention Minimums:

- MCPs in counties with a maximum allotted incentive payment of $1 million or more are required to complete four interventions for maximum payment.
- MCPs in counties with a maximum allotted incentive payment of less than $1 million are required to complete two interventions for maximum payment.
- MCPs will receive the full incentive payment for their county **if** they implement two/four targeted interventions.
- MCPs are not required to use their full incentive payment maximum, they may opt to implement fewer interventions and receive 20–80% of their maximum incentive payment in line with amount of interventions implemented.

Requiring two to four targeted interventions is intentional to increase coordination among stakeholders. SBHIP incentive payments are provided to help develop new collaborative initiatives and to build on existing school-based partnership. The SBHIP incentive payments is designed to offset costs and barriers for MCPs, COEs, LEAs, County BH Departments, and other stakeholders to coordinate around the selected targeted interventions. However, it is implicit that other funding sources may be used in addition to SBHIP incentive payments to ensure targeted interventions success and long-term sustainability.

Incentive Payments: Funding Allocation

Targeted Intervention Incentive Payment:

- Those MCPs in counties with a maximum allotted incentive payment of $1 Million or must implement four targeted interventions to receive their full incentive payment maximum:
  - Each targeted intervention may utilize up to 20% of the maximum allocation for that county/MCP. The remaining 20% may be added to support one additional targeted intervention or be divided among the targeted interventions as deemed appropriate by the MCP.
  - Each targeted intervention is capped at 40% of the maximum allocated for that targeted county/MCP.
  - Targeted interventions with a proposed funding amount over 30% of the maximum allocation will require additional review by DHCS.
- Those MCPs in counties with a maximum allotted incentive payment less than $1 Million must implement two targeted interventions to receive their full incentive payment maximum:
  - Each targeted intervention may utilize up to 50% of the maximum allocation for that county/MCP. Up to 20% may be added to support one of the targeted interventions.
  - Each targeted intervention is capped at 70% of the maximum allocated for that targeted county/MCP.
- Targeted interventions with a proposed funding amount over 60% of the maximum allocation will require additional review by DHCS.

Open Discussion

Open Discussion

- Questions/feedback on today’s agenda
- Request for information for future meetings
- Other areas for discussion

Next Steps

Next Steps

SBHIP Document Release:

- SBHIP Overview to be finalized December 22, 2021
- SBHIP Evaluation Criteria to be finalized December 22, 2021
- SBHIP Templates to be available on SBHIP Webpage December 30, 2021

- Email responses to questions to shannon.kojasoy@mercer.com by December 15
- Email any feedback to Shannon at any time, Shannon will route to the appropriate staff at DHCS
- Upcoming small workgroup meetings as needed and requested
- SBHIP Webpage: https://www.dhcs.ca.gov/studentbehavioralheathincentiveprogram

Technical Assistance Contractor

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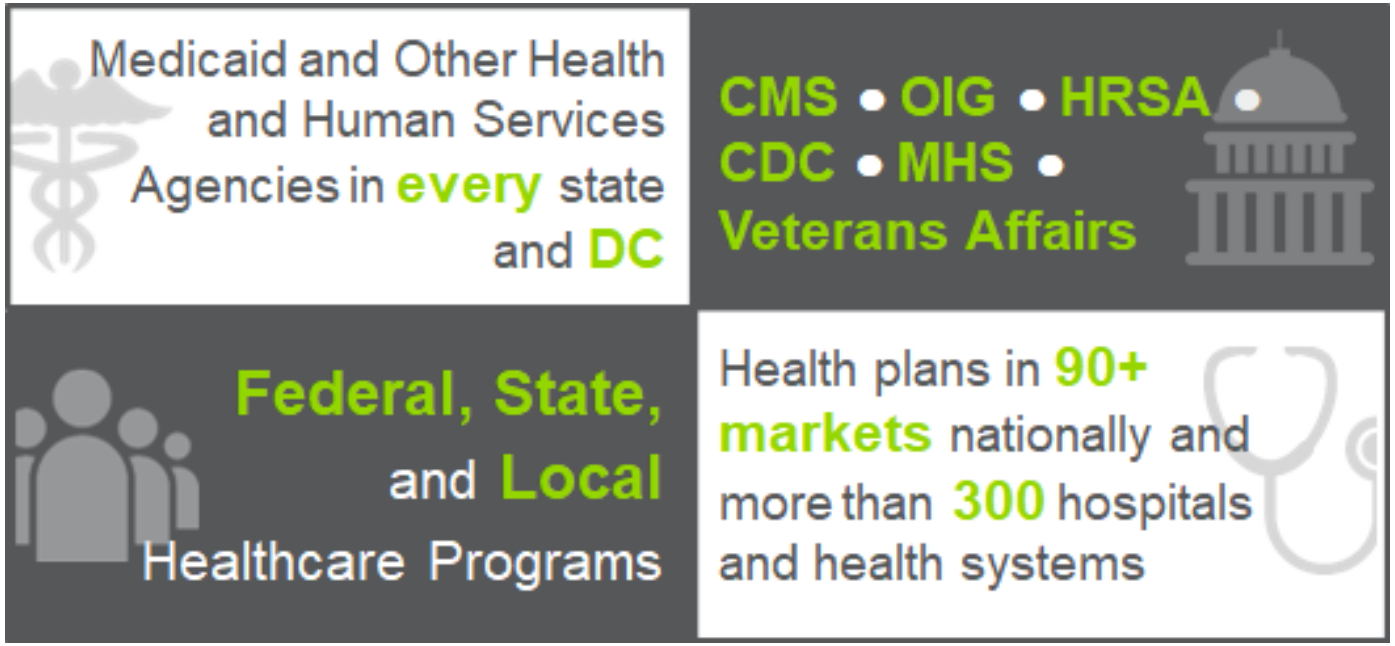
Guidehouse has worked with DHCS for 15+ years on the LEA Medi-Cal Billing Option Program

Who we are

- Former Federal, State, and Local Medicaid and Other Health and Human Services Agency Leadership and Frontline Staff
- Former Hospital, Health System, and Health Plan Leadership and Frontline Staff
- Clinicians, Social Workers, and Other Providers
- Actuaries and CPAs
- Data Analytics, Business Process Management, and Change Management Experts

Who we work with



Guidehouse will provide technical assistance for implementing, coordinating, and managing the SBHIP

Technical Assistance support activities will include:

1. Transition and/or establish stakeholder meetings
2. Develop comprehensive project communication plan
3. Create educational materials to assist stakeholders understand SBHIP processes
4. Track and monitor assessment and targeted intervention progress
5. Coordinate activities across all stakeholders (DHCS, MCPs, COEs, LEAs, Students and their Families [as appropriate], etc.) to align on program requirements and objectives

Next Steps and Upcoming Events

1. DHCS MCP Small-Group Meetings:
   a. *TBD:* Schedule a meeting with the MCP small workgroup to discuss implementation moving forward
   b. *Subsequent Meetings:* Guidehouse will schedule subsequent monthly meetings to provide and receive status updates and discuss progress, issues, etc.
2. Additional large-group stakeholder meetings
   a. *Jan 14, 2022 and Feb 11, 2022: Guidehouse will facilitate the scheduled meetings*
3. Beginning in January 2022, DHCS and Guidehouse will conduct bi-weekly Office Hour sessions for COEs and LEAs:
   a. *2nd Tuesday of every month:* 3:00 – 4:00 pm
   b. *4th Thursday of every month:* 9:00 – 10:00 am

Closing Message

11

Acronyms

ACE	Adverse Childhood Experience
BH	Behavioral health
CBO	Community-Based Organization
CDE	California Department of Education
COE	County Office of Education
DHCS	Department of Health Care Services
EPSDT	Early and Periodic Screening, Diagnostics, and Treatment
FAPE	Free Appropriate Public Education
FRPM	Free or Reduce Price Meal
FTE	Full-time employee/equivalent
LEA	Local Education Agencies
LEA BOP	Local Educational Agency Billing Option Program
MAT	Medication Assisted Treatment
MCO	Managed care organization
MCP	Managed Care Programs
MH	Mental health
MHP	Mental health provider
MOU	Memorandum of Understanding
SA	Special assistance
SBHIP	Student Behavioral Health Incentive Program
SMHS	Specialty Mental Health Services
SUD	Substance use disorder
TA	Technical Assistance

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