Spotlight Practice

Smart Financing for School-Based Behavioral Health

Leveraging, Blending, and Systems Building

CENTER FOR HEALTHY SCHOOLS AND COMMUNITIES
ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY

ALAMEDA COUNTY SCHOOL-BASED BEHAVIORAL HEALTH INITIATIVE

A MULTI-DEPARTMENTAL COLLABORATION WITHIN HEALTH CARE SERVICES AGENCY

The School-Based Behavioral Health (SBBH) Initiative was launched in 2009 to create a shared model for building and financing school-based behavioral health systems across Alameda County. The SBBH Initiative brings together two divisions within the Alameda County Health Care Services Agency: Behavioral Health Care Services and the Center for Healthy Schools and Communities. Thank you to the Initiative Leadership Team and the many providers, schools, school districts, and young people who engage in this critical work every day and have contributed to the development of Alameda County's School-Based Behavioral Health Model and Spotlight Practices.

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Smart Financing for School-Based Behavioral Health

Introduction

Financing comprehensive school-based behavioral health supports can be tricky. School districts rarely have the resources to do it alone and often don't know who to reach out to for help or how local behavioral health systems work. Further, there is no national model or norm for financing school-based behavioral health through partnership, as the resources available and the way they are accessed vary from place to place.

In order for health jurisdictions, school districts, and others to design finance strategies and programs to support school-based behavioral health, it is important to look at examples from neighboring communities and/or districts across the country. This spotlight was written to describe CHSC's core strategies for financing behavioral health. It is our hope it can be used to help other districts design programs to meet their unique needs and circumstances.

When the Center for Healthy Schools and Communities (CHSC) first began providing school-based behavioral health services, our primary focus was to implement and expand school-based behavioral health treatment services in areas with the greatest needs. One might say that this emphasis is contrary to our current model that emphasizes prevention and early intervention.

Yet we live in a community where many neighborhoods are impacted by violence, poverty, and trauma, and where there is a documented need for mental health treatment. Since many of our youth are, in fact, entitled to screening and treatment services through the Federal Medicaid program, implementing and expanding these services was, and remains, a county responsibility and a priority. And since mental health treatment is far more costly than prevention and early intervention, treatment continues to constitute the largest portion of our SBBH Initiative investment.

In 2009, the CHSC and Behavioral Health Care Services launched the formal School-Based Behavioral Health Initiative with a guiding framework of providing a three-tiered continuum of support: prevention, early intervention, and treatment. At that time, our school districts were becoming increasingly aware of the urgent need to reform disciplinary practices and improve school climate; and new and innovative funding streams were available. As a result, we were able to expand to financing and supporting prevention and early intervention behavioral health supports, as well as continue to grow treatment services.

Since then, we have further developed the school-based behavioral health model, and now finance a comprehensive SBBH Initiative that invests over $25 million annually in building school-based behavioral health systems in all 18 of our school districts.

Building a comprehensive and sustainable system of school-based behavioral health supports across a three-tiered continuum requires access to a wide variety of funds and funding streams. Since different institutions have access to different resources, establishing and sustaining strong partnerships between public and private agencies is a must.

This spotlight provides a detailed description of our overall finance strategy over the growth of the SBBH Initiative. It describes our primary funding streams and how we utilize them to fund the full continuum of behavioral health supports. It concludes by offering some general tips – based on our own lessons learned – that anyone interested in financing a school health initiative can consider.

Background

For almost two decades, Alameda County's Center for Healthy Schools and Communities (CHSC) has partnered to develop school health initiatives that eliminate health and education disparities and support the whole child. Our vast network of partners includes the county's school districts, community based providers, youth and families, other public agencies, and policymakers.

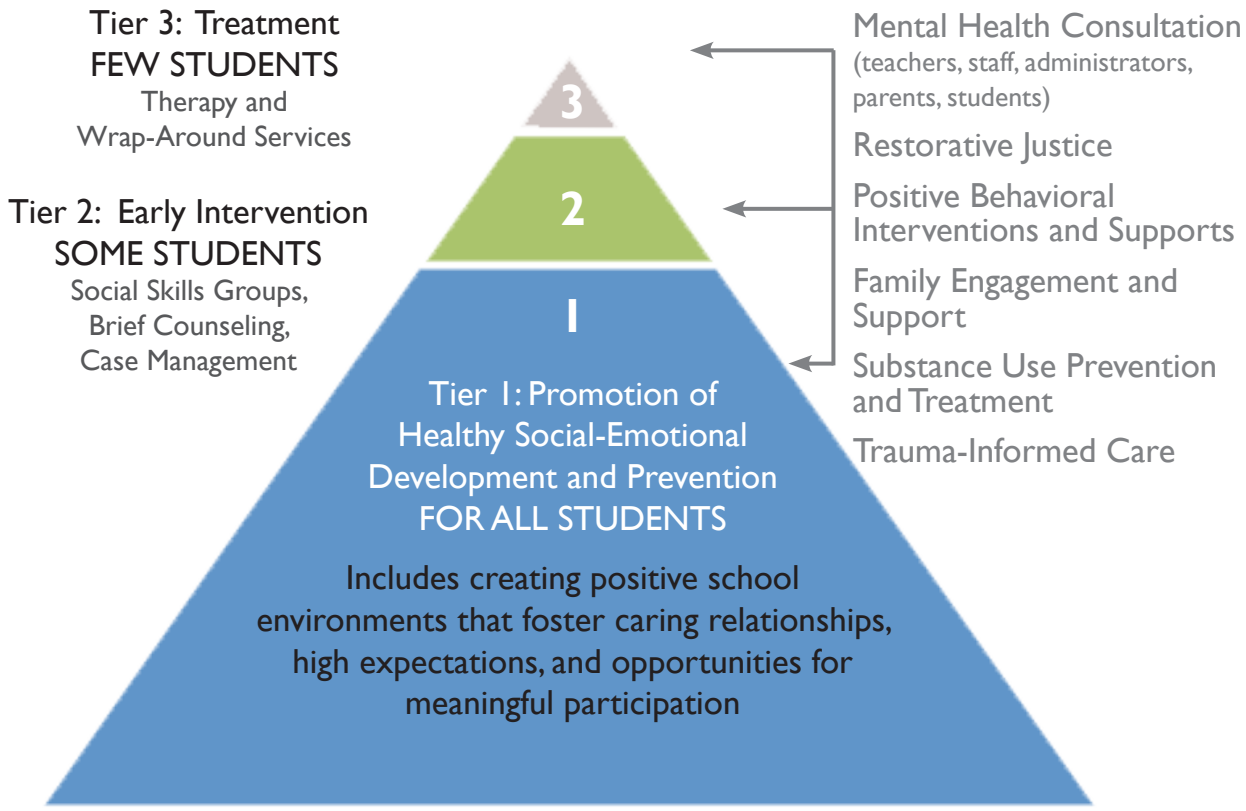
In 2009, the county launched a School-Based Behavioral Health Initiative, bringing together two divisions within the Alameda County health authority to create a shared model for building and financing school-based behavioral health systems across the county. We have since taken the Initiative to scale, investing over $25 million annually in behavioral health supports in over 170 schools in all 18 school districts, and district-level consultation in six of those districts. Our innovative model expands universal access to behavioral health supports, and builds the capacity of schools and districts to promote social-emotional development and learning. Our SBBH model, and all of our tools, are available on our website: achealthyschools.org

The School-Based Behavior Model We Fund

In Alameda County, we have developed a School-Based Behavioral Health Model (SBBH) that provides a common reference point for school districts and behavioral health providers, and guides our technical assistance. The model defines six core components of the SBBH system, which are supported by a set of foundational elements common to all activities of CHSC.

One core component that is especially relevant to the financing model is what we call the Three-Tiered Continuum of Supports. In the past, the approach to behavioral health was to provide counseling almost exclusively to those students with significant behavioral health challenges. Now our model uses a three-tiered continuum of support that is proactive, addresses needs early, and promotes behavioral health for the entire school population. It brings together the health framework of "prevention, early intervention, and treatment" and the Response to Intervention (RtI) model commonly used by districts to design and track academic and behavioral supports.

Figure 1. Three Tiered Continuum of Support



Financing School-Based Behavioral Health Treatment

As a county health department leading this initiative with school districts, we have relied upon a strategy of establishing a core investment of certified public expenditures (CPE)[1], and utilizing that as match to leverage larger public funding streams; especially Medi-Cal (California's Medicaid program). Our Initiative relies heavily on two funding streams tied to Medi-Cal: Early and Periodic Screening Diagnosis and Treatment, and County-Based Medi-Cal Administrative Activities.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

EPSDT was enacted as part of the child health component of Medicaid legislation in 1967, with the deliberate intent to reduce health problems among poor children and youth and improve their chances to succeed in life. EPSDT is an enhanced Medicaid benefit that requires states to screen for and provide services necessary to ameliorate physical and mental health conditions for all persons under age 21 who are eligible. Under EPSDT, young people who qualify for full-scope Medi-Cal (or Medicaid) with mental health conditions that meet medical necessity are entitled to services including, but not limited to, the following: mental health assessment, collateral contacts, therapy, rehabilitation, mental health services, medication support services, day rehabilitation, day treatment intensive, crisis intervention/stabilization, targeted case management, and therapeutic behavioral services. EPSDT services are funded by a combination of Federal, state, and county sources. The county sources must be certified public expenditures (CPE) in order to be used as the county's match for Medi-Cal dollars. Up until 2012, the Federal government provided 50% of the funding, the state 45%, and counties contributed a 5% match. Under California's mental health services realignment of 2012, and in an effort to contain costs and discourage further EPSDT expansion, counties are now given a base allocation of state funds based upon prior claims, but must pay the full 45% state contribution, in addition to the original 5% for any services that exceed the base.

EPSDT in California

Early on, California's implementation of the EPSDT benefit included significant restrictions on the mental health component. In a 1993 lawsuit, the State of California's Medi-Cal program was deemed out of compliance due to these restrictions, and the State was obliged to finance and implement specialty mental health services as needed for children and youth. Under a Federal waiver in 1997-1998, county health plans in California assumed the responsibility of providing the expanded benefit to all eligible children and youth. There followed a dramatic expansion of EPSDT financed services.

[1] Expenditures that a governmental entity certifies it has incurred in furnishing health care services to eligible individuals. CPEs enable an entity to claim reimbursement under the Medicaid program.

Historically, the extent of EPSDT services has varied greatly amongst California counties due to different service philosophies and financial commitments. Early on, Alameda County leadership made a decision to boldly implement EPSDT services as a way to significantly expand access to mental health services for children by investing local funds to implement a place-based service approach (i.e., preschools, schools, juvenile hall, and truancy and mental health courts).

The original matching ratio was so advantageous (5% leveraging 95%), the county identified $2 million to dedicate to the match, thus signaling and demonstrating a commitment to the significant expansion of EPSDT services across the county.

County-Based Medi-Cal Administrative Activities (CMAA)

CMAA was established on January 1, 1995. Under CMAA, participating local governmental agencies are eligible to receive Federal reimbursement for the cost of performing administrative activities that directly support efforts to identify and enroll potentially eligible individuals into Medi-Cal, and to remove barriers to Medi-Cal services.

Eligible activities include: outreach to the general population, outreach to high-risk populations, facilitating Medi-Cal applications, facilitating non-emergency Medi-Cal transportation, contracting for Medi-Cal services, program planning and policy development, and CMAA/Targeted Case Management coordination.

The CMAA program requires a 50% match using eligible match funding, and provides 50% reimbursement (75% for skilled medical professionals) based on total costs and total time spent on eligible activities.

"Having school-based counseling services helps the families, the school community, and the students' overall well-being. Just knowing that any student who needs services can receive them eases the pressure on teachers, families, and students."

— Our Kids Our Families, Clinical Case Manager

Medi-Cal Matching Funds

Our original and primary source of required match for Medi-Cal reimbursement is the county's Tobacco Master Settlement Fund (TMSF); a funding stream that is the result of litigation against four major tobacco companies.

In 2000, the Alameda County Board of Supervisors adopted general policies and recommendations for the allocation of this fund and prioritized new program initiatives in four key service areas, one of which was school-linked services. Specific TMSF dollars were allocated to each of the two divisions driving this initiative – Center for Healthy Schools and Communities and Behavioral Health Care Services – and are the original source of our service growth.

Two million dollars in TMSF funds was allocated to Behavioral Health Care Services (BHCS) as match for EPSDT expansion, and of that, about $500,000 was allocated for school-based mental health services. This was used to fulfil the 5% match requirement for EPSDT Medi-Cal, thereby leveraging approximately $10 million in school-based EPSDT services. We contract out to local, non-profit providers and reimburse them for all qualifying services provided. This funding stream continues to be utilized to provide critical mental health treatment (Tier 3 on the three-tiered continuum of supports) services for students with dire needs who are on full-scope Medi-Cal. As would be expected, these services are concentrated in areas of our county that are most impacted by poverty, health disparities, and trauma.

Two million dollars was also allocated from the TMSF to the Center for Healthy Schools and Communities (CHSC) for school-based health services, and of that, $1 million was allocated to hire Clinical Case Managers (CCMs) to provide services primarily for students and families not eligible for Medi-Cal. CCMs are paired with EPSDT providers at specific schools in Hayward and Oakland where there are high levels of need and significant numbers of students who are not Medi-Cal eligible (many because they are undocumented). This pairing of county staff with EPSDT providers in schools establishes universal access, whereby any student in these schools who needs Tier 3 mental health services can receive them, regardless of their health insurance status.

Critical to this program (called Our Kids Our Families) is its additional leveraging capacity. Because our financing approach is built on health coverage outreach and assessing for Medi-Cal eligibility, we have been able to leverage additional dollars through CMAA reimbursement. CCMs play such an active role in assessing, promoting, and supporting Medi-Cal eligibility that we are able to leverage nearly 40% of their employment costs, whereby our $1 million TMSF investment leverages about $1.4 million in services.

Over the years, we have added additional dollars to this original investment in both BHCS and CHSC as additional CPE matching funds, such as Alameda County Measure A (see below), as new county funding sources have become available. The result has been significant growth of Tier 3 behavioral health supports across the county.

School District Contribution

New Haven and Newark Unified School Districts were two of our first districts eager to hire their own Behavioral Health Consultants to develop school-based behavioral health supports. Through MHSA PEI, the county was able to commit a long-term $56,100 annual investment. However, in the first three years (2010-2013), CHSC committed an additional $55,000 to the districts so they could each hire a full time Behavioral Health Consultant. The agreement was that the districts, over time, would contribute resources generated from school district MAA activities (in part those conducted by their hired Consultants) to be able to sustain the full-time positions. Now, five years later, the same Behavioral Health Consultants are working full time, with the districts contributing the additional $55,000 through their own MAA revenue.

Financing Prevention and Early Intervention in Schools

When our divisions started the joint SBBH Initiative in 2009, we began to rigorously strengthen prevention and early intervention supports.

The Mental Health Services Act (MHSA) passed by California voters in 2004 places a 1% tax on personal incomes above $1 million and is used to "design, expand, and transform California's county mental health systems." The MHSA includes five distinct funding streams; one of which is Prevention and Early Intervention (PEI).

The role of PEI is two-fold: 1) to take action prior to the development of serious mental health issues; and 2) to catch mental health issues in their earliest stages to prevent long-term suffering. Multiple PEI programs have been implemented throughout our county through the approval of the Ongoing Planning Council[2] and by the MHSA Oversight and Accountability Commission.

This purpose of the PEI funding stream is closely aligned with Tier 1 and Tier 2 of our model. As such, in 2009 the Ongoing Planning Council granted an annual allocation of just over $800,000 toward our Initiative for outreach, on-site mental health consultation, screening, and evaluation at elementary, middle and high schools.

We divide the vast majority of these dollars among several of our school districts for the purpose of employing full-time Behavioral Health Consultants.[3] Behavioral Health Consultants work in their respective districts to build and strengthen prevention and early intervention supports, and to create systems of service access for students and families.

The Consultants, who are embedded in the school district administration to fulfill this role, are either hired as district or county employees. If they are district employees, our allocation covers about 50% of each position; and the remaining dollars are matched by the district. If they are county employees that we assign to a school district, we leverage our investment with CMAA dollars (as described above) to fund them full time.

In addition to the ongoing PEI funds, in 2012 we invested one-time PEI funds allocated by our state by providing direct funding to our school districts (total of $558,000 over three years, with specific allocations to each district based on size and need) to enhance their capacity to promote student mental health and well-being through positive school climate activities. These funds provided seed funding for our Behavioral Health Consultants to initiate and later sustain school climate systems work that continues today.

[2] The local stakeholder group responsible for Mental Health Services Act (MHSA) Planning.

[3] For a handful of school districts, the funds support a specific prevention/early intervention strategy delivered by a school or an agency provider.

Additional Funding Streams Utilized by the Initiative

Over time, we have been able to add additional resources to our Initiative. Alameda County's Measure A imposes a half-cent sales tax to support emergency medical, hospital inpatient, outpatient, public health, mental health, and substance abuse services to indigent, low-income, and uninsured adults, children, families, seniors, and other county residents.

In 2011, the Alameda County Board of Supervisors allocated $600,000 from this local tax measure to the SBBH Initiative. We have used the majority of these funds to employ BHCs that further strengthen the work at schools in several districts, as well as to provide additional mental health services to students and their families not eligible for full-scope Medi-Cal. Additionally, we further expanded school-based EPSDT services by blending additional CPE. Through all of this growth, we have applied the same leverage strategies described above.

CHSC has helped develop and support a county-wide network of 28 school health centers. The school health centers approach young people holistically, offering integrated health and wellness services that include medical, dental, behavioral health, health education, and youth development. All of the school health centers are operated by Federally Qualified Health Centers (FQHC), which are non-profit or private entities that serve designated medically underserved populations.

In partnership with the schools, districts, and other providers, FQHCs provide primary, preventive, and enabling health services, including behavioral health services. As FQHCs, all of our school health centers can be reimbursed per visit for behavioral health services provided by a licensed clinical psychologist or licensed clinical social worker and delivered within their scope of practice. As our school health centers expand and our Initiative grows, we are making increasing use of this form of reimbursement.

Finally, we raise additional funds through grants and philanthropic relationships. These funding streams are typically very specific to a specific district, school, or community and tied to several requirements. In seeking this form of funding we are strategic about student, family, and school needs driving the opportunity, rather than allowing the opportunity to drive the program.

Combining Efforts for a Cohesive System

Our SBBH Initiative investment and the number of students and schools served continues to grow over time.

With the tremendous leverage capacity of EPSDT, it should come as no surprise that this funding stream comprises about 76% of our total SBBH Initiative investment. The remaining funds support prevention services, such as positive school climate initiatives, Restorative Justice, mental health consultation, and teacher and parent education.

It also supports early intervention services, such as social skills groups and support groups for at-risk youth, and some direct services to students who are not Medi-Cal eligible. Finally, the SBBH Initiative finances school district capacity building and system coordination strategies, which weaves the services and supports into a comprehensive school-based behavioral health system. While these funds make up about 25% of our total investment, the costs of these types of activities are far less costly than treatment and, consequently, this investment has a considerable impact.

In order to build a cohesive system by blending multiple funding streams and partnering, we not only leverage fiscal resources, but human resources as well. Some of our funding streams are highly restrictive, others are more flexible. With positions and functions funded by more flexible sources, we can allow the work to be highly responsive to the overall needs of a school or school district.

For example, as Medi-Cal eligibility in some of our schools with the Our Kids Our Families program has increased, we have increased staffing and referrals to the EPSDT provider to provide treatment, and shifted the work of our Clinical Case Managers from Tier 3 to Tiers 1 and 2, where they are increasingly responsible for supporting Positive School Climate Initiatives, leading Coordination of Services Teams (COST), providing teacher education and mental health consultation, and doing outreach to families.

Alternatively, while we are aware of and accommodate the needs of our EPSDT providers to generate revenue, we also require them to conduct some non-billable activities that contribute to the overall system, including: participating actively and regularly in COST; responding appropriately and effectively to any mental health crisis that happens on campus; conducting a required number of early intervention groups; and doing outreach to families.

In addition, we work with several of our EPSDT providers to increase staffing through mental health trainees that provide direct services to both Medi-Cal and non Medi-Cal students.

General Tips for Success

Because of the diversity of available resources, governing laws, and varying needs among communities in this country, the best thing for those interested in designing a finance strategy for school-based behavioral health is to look at local and national examples to identify core strategies that might work for them.

This spotlight highlights our core strategies and lessons learned in an effort to inform other communities regarding planning.

In Alameda County we have built a strong Initiative by thinking creatively and proactively about how we can best blend and allocate the resources available toward collective impact in increasing resilience and improving social-emotional, behavioral, and ultimately education outcomes for children and youth. This work never ends, and we continue to strategize about how we can better leverage, expand, and enhance our resources to further increase impact and extend our support.

Over the past several years, we have developed general tips for success that serve to guide all of our finance strategies and decisions.

The first lesson learned is to have a clearly articulated model that you are seeking to implement; and to make sure that all partners understand and are on board with that model. This typically means ensuring that the language and frameworks of that model are aligned with the vision and understanding of all the partners – as this is how you create collective support for the work. Through the lens of the model, it becomes clearer where the gaps and needs are in the system, what kinds of resources are needed to fill them, and what the finance opportunities and challenges might be.

Second, make sure you have a core, stable funding stream that can serve as CPE (eligible for match) upon which to build your initiative. This is similar to needing a strong foundation for a house! In our case, we built our initiative upon Tobacco Master Settlement, Measure A, and Mental Health Services Act funds. Another solution might be to dedicate (long-term) general fund dollars from any of the partner governmental entities.

Third, leverage everything. In this way you increase and enhance services, build and grow your initiative, and increase partner engagement and support. Another important advantage of leveraging is that, when you leverage everything and do it well, you are far

less likely to lose funds dedicated through stable funding streams simply because you are able to provide far more services and have greater impact than anyone would expect from the original allocation. Therefore, leveraging can decrease the likelihood of cuts to your stable funding streams.

Two good examples from our work are our EPSDT services (our county-wide $2 million investment provides $40 million in services), and the CMAA that leverages nearly 40% of our Clinical Case Manager staffing costs.

Another way we leverage is to provide partial funding to school districts for Behavioral Health Consultants if they agree to pay the remainder of the costs. With this strategy, even at times of extreme financial constraint, school districts are less likely to lay off Behavioral Health Consultants, because a large portion of their salaries are already covered.

Fourth, while you do need to leverage everything, make sure that the model and need drives the programs and services you develop. A system of programs and services cannot be effectively developed and implemented based solely on the funding streams. In other words, identify your needs first, then look for funding opportunities that are the best fit for meeting that need. The typical example for failing to do this is applying for grant funds that require implementation of a program that doesn't meet a clear need, and in fact takes you away from your intended focus. It is far better to be strategic up front so that you are truly ready to take advantage of a funding opportunity that is a great fit.

Fifth, this work is best implemented when institutions and public and private entities work in partnership. While partnership work between systems and programs can be challenging at times, the reality is that different public departments have access to different funding streams and, when these are strategically blended, we can have greater collective impact. While sometimes it might be less complicated for individual institutions to drive and manage this work on their own, when we work together in concert, we can create effective and sustainable supports that have a much greater impact on the lives of students and their families.

SBBHI Funding Streams

Source, Use, Strengths, and Challenges

Table 1. SBBHI Certified Public Expenditures Serving or Eligible as Match

Revenue Stream	Tobacco Master Settlement Allocated to Center for Healthy Schools and Communities	Mental Health Services Act, Prevention and Early Intervention (PEI)	Measure A	Foundations and Other Philanthropy	School Districts
Source	Allocated by the Board of Sups. to CHSC to fund EPSDT expansion by BHCS and to CHSC for the Our Kids Our Families program for CHSC.	Designated by the MHSA ongoing planning council (BHCS) to provide school-based mental health consultation.	Allocated by the Board of Sups. to CHSC to provide SBBH services in Emery, Hayward, Newark, New Haven, and San Leandro school districts.	Funds given by a charitable organization or government for purposes of supporting SBBHI programs.	Funds designated by school districts to support SBBHI programming.
SBBHI Use(s)	1) Required match for services provided under the EPSDT funding stream to provide needed services to students with full-scope Medi-Cal. (2) To provide direct services to non Medi-Cal eligible students through the Our Kids Our Families program. Used as match to leverage MAA to help identify and refer families to Medi-Cal.	Allocated to school districts and to one local provider (Tri-Valley) to provide mental health consultation and prevention services in schools. Requires match from districts or other source.	To employ Behavioral Health Consultants at schools in designated districts and to provide additional mental health services to students and their families not eligible for full-scope Medi-Cal.	Vary by funder. Typically used as match to increase services or positions.	Vary by district. Typically used as match to enhance services or increase positions.
Strengths	Flexible. Used as match for EPSDT activities with substantial leveraging. Allows for both infrastructure/ coordination and service activity across the full continuum. CHSC can significantly leverage funds as staff conducts significant MAA activity. Additional activities supported by this funding stream can help fill in the gaps from reliance on more restrictive funds.	Allows for systems building activities (infrastructure/ coordination), prevention activities, mental health consultation at all levels, trainings, parent support, linkages to services, youth development, supervision, and any other supports that are not direct service.	Flexible. Allows for all activities under the SBBH model (though must be for the provision of health services and in areas defined by Board of Supervisors).	Can help fill significant SBBHI system and service gaps when used appropriately. Some grants can be used for systems building and can be easier to sustain and institutionalize post grant funding.	Financial supports from schools builds capacity and typically improves collaboration and coordination as everyone is invested.
Challenges	There are not enough funds to go around. Funds must be carefully targeted to specific pockets of need, or towards broader activities that can serve as many as possible (i.e., capacity building).	Resources significantly limited at less than $1 million in ongoing funds for the entire county. Does not allow for direct service.	There are not enough funds to go around. Funds must be carefully targeted to specific pockets of need, or towards broader activities that can serve as many as possible (i.e., capacity building).	Tendency to have limited time period and sustainability can be a significant challenge.	Very limited resource.

Table 2. Medi-Cal Funding Streams Leveraged by SBBHI

Revenue Stream	County-Based Medi-Cal Administrative Activities (CMAA)	Early Periodic Screening Diagnosis and Treatment (EPSDT)	Federally Qualified Health Center (FQHC)
General	Program may serve Medi-Cal and non Medi-Cal clients of all ages, activities must increase client access to Medi-Cal covered services through a variety of eligible activities. Some eligible activities are discounted by the county Medi-Cal percentage.	Program serves only full-scope Medi-Cal clients, direct mental health services that meet medical necessity. The program serves children aged 0 to 21. Program was established to identify and correct conditions early, for the purpose of curtailing problems later in life.	FQHCs are non-profit or private entities that serve designated medically underserved populations. Program must be an FQHC or be an FQHC sub-recipient in order to claim enhanced Medi-Cal rate on all Medi-Cal encounters. All FQ sites must meet FQHC program requirements.
Eligible Activities	Outreach to the general population, outreach to high-risk populations, facilitating Medi-Cal applications, Medi-Cal transportation, contracting for Medi-Cal services, program planning and policy development, and MAA/TCM Coordination.	Direct services that meet the definition of medical necessity, including but not limited to mental health assessment, collateral contacts, therapy, rehabilitation, mental health services, medication support services, day rehabilitation, day treatment intensive, crisis intervention/stabilization, targeted case management, and therapeutic behavioral services.	FQHCs provide all primary, preventative, enabling health services and additional health services as appropriate and necessary, including behavioral health services.
Ineligible Activities	Direct services are not an eligible activity.	Direct service that does not meet the definition of medical necessity, does not reimburse for non-Medi-Cal clients, does not cover prevention, systems work, or supporting whole classrooms.	If the FQHC is used, then appropriate screening for homelessness, data collection, and referrals/linkages to homeless services must take place.
Match	CPE required, 50% reimbursement, 75% for skilled medical professional, based on total costs and total time spent on eligible activities.	Previously 50% Federal, 45% state, 5% county. Currently 50% match when exceeds state imposed maximum.	Services are reimbursed based on costs of the program. Rates are determined by cost report.
Time study	Yes, perpetual.	No.	No.
Start-up	Add to existing claim plan or create new claim plan. New claim plans require state approval.	Contract for services with existing EPSDT provider or provided by Behavioral Health Care Services Agency programs (such as ERMHS).	Subcontract with existing FQ for primary or behavioral care; they can provide services off-site (on school site) so long as hours do not exceed 20 per week.
Chart/audit	No charting required; time surveys, costs, and other documentation subject to audit.	Must follow all Medi-Cal charting requirements, subject to audit.	Charting required for billing, simpler than Medi-Cal requirements, subject to audit.
Strengths	Encourages outreach to families and linking with needed services. Helps ensure that students and families with Medi-Cal receive services from a Medi-Cal provider. Allows for some program planning related to the identification of students and families that may need services. Indirectly, allows for leveraging of CPE funds, such that more staff can be hired that can flexibly target their activities to meet the needs of students, families, and the school.	Allows for significant range of screening and intervention supports, case management for families, collateral work with teachers/staff, and linkages to other services as needed. In the past required very small match (5%) though exceeding state maximum requires 50%.	Good reimbursement rate with no match requirement. Provides services beyond mental health (i.e., primary care, substance abuse treatment, etc.).
Challenges	Direct service activities not allowable. May have limits on eligible CPE to use as match. Perpetual time survey is required and staff training to ensure compliance is critical.	Limited to serving students on full-scope Medi-Cal and their families; excludes other insured and uninsured. Huge challenge when schools are required to serve anybody based on need, not insurance. Does not allow for activities that don't meet "medical necessity," such as prevention work, systems building (infrastructure and coordination), and supports targeting whole classrooms. The new 50% match is costly when services can only be provided to eligible students and families	Limited to serving students on full-scope Medi-Cal and their families, thereby excluding all other insured and uninsured in a school system. Student/family must have same medical home as provider. Does not allow for activities that don't meet "medical necessity," such as mental health prevention work, systems building (infrastructure and coordination), and supports targeting whole classrooms.

CENTER FOR HEALTHY SCHOOLS AND COMMUNITIES
ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY

About Us

As part of Alameda County Health Care Services Agency, the Center for Healthy Schools and Communities (CHSC) has worked for over 20 years with school districts, community partners, youth, families, and policymakers to build school health initiatives that create equitable conditions for health and learning. Together we have developed 28 school health centers, expanded behavioral health supports to over 190 schools, built and lead operations of the REACH Ashland Youth Center, supported youth wellness and family partnership initiatives, and implemented targeted equity strategies for youth furthest from opportunity. Our school health programs and partnerships address urgent health and education inequities and create opportunities for all young people to cultivate their strengths, resiliency, and promise. We focus on supporting the physical health of students – knowing that students can't learn if they are sick, hungry, or absent from school. But we also focus on other aspects of wellness that youth and families need to thrive: social, emotional, spiritual, intellectual, environmental, and occupational. For more information about CHSC's work, please visit our website at **achealthyschools.org**

How It Works

Look for the School Health Works icon anywhere on the CHSC website to find resources, tools, guides, and videos to help health and education leaders to build school health initiatives.
achealthyschools.org/resources