CALIFORNIA SCHOOL-BASED HEALTH ALLIANCE
Putting Health Care Where Kids Are

Public Funding for School-Based Mental Health Programs

Introduction

Students with undiagnosed or untreated mental health issues rank among the most pressing concerns in schools across California, directly impacting student attendance, behavior, and readiness to learn.[1] When student mental health needs are not addressed, they are more likely to experience difficulties in school, including higher rates of suspensions, expulsions, dropouts, and truancy, as well as lower grades and test scores. For students with mental health needs, treatment is not always accessible or affordable. More than 20 percent of school-aged children have a mental health diagnosis but only one-third of diagnosed children and teens in the general population receive treatment.[2] For teens with diagnosed mental health disorders living in poverty, 90 percent report not receiving counseling or other services.[3]

An effective approach linking youth to mental health services is to provide services where students are: at school. In partnership with county agencies and community-based organizations, schools have a leading role to play in the prevention and treatment of student mental health needs. Indeed, 70 percent of children nationwide receiving mental health services get them at school.[4] School sites are prime locations to provide a continuum of mental health services - from providing teacher training to creating a positive learning environment for all to conducting screenings and assessments to providing treatment and linking to more intensive services in the community.

One of the chief barriers to creating comprehensive systems of school-based mental health services is identifying funding streams that support interventions throughout the three tiers of intervention. This resource is intended to identify and explain the public mental health funding streams in California that can support the full continuum of school-based mental health services. It should also help illustrate how schools can best leverage public mental health funding streams and community partnerships to maximize existing resources.

Guiding Principles

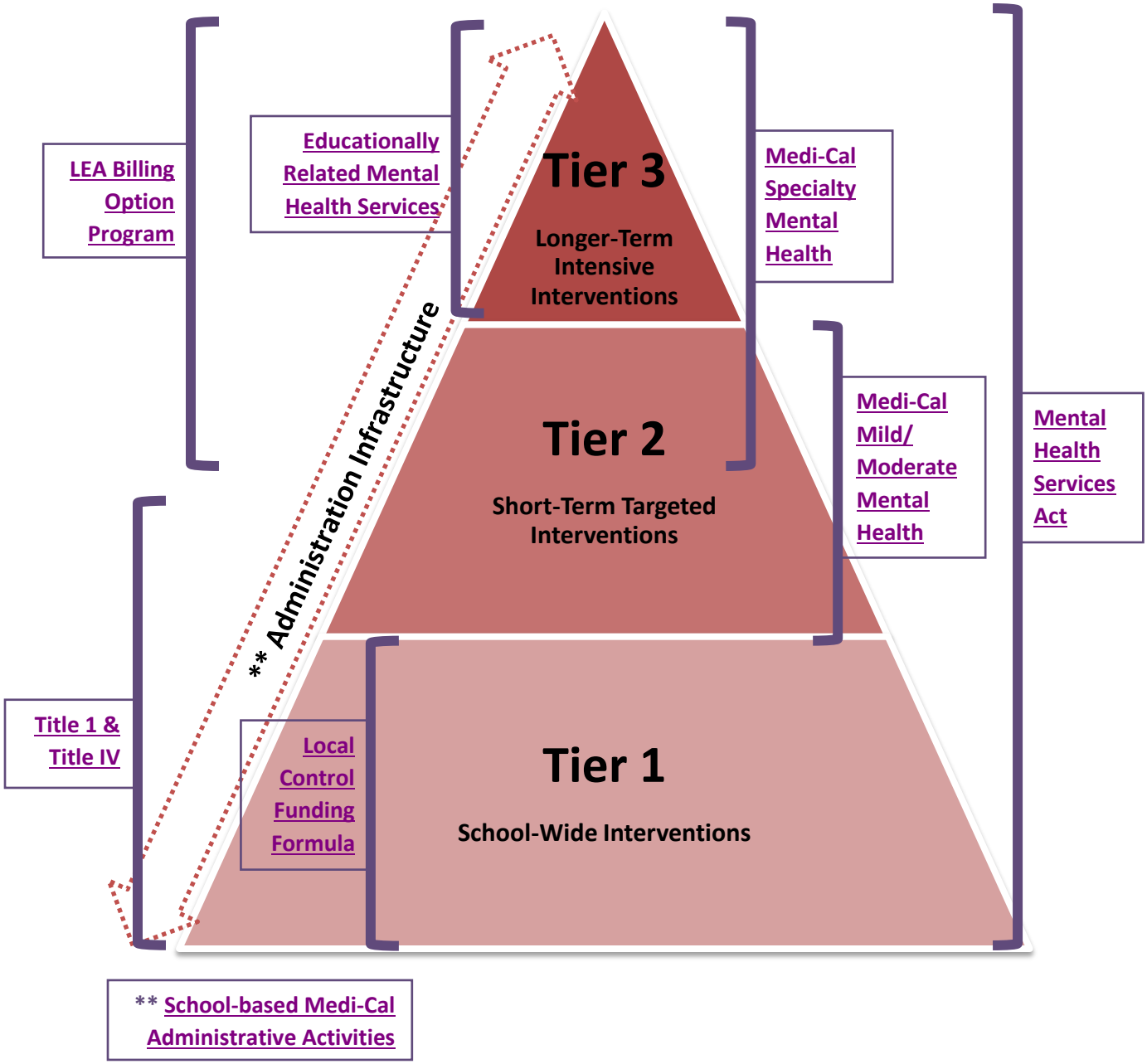
There are many different ways that schools *can* knit together resources to address the mental health needs of students. This resource presents certain strategies for how to maximize funding that is available to schools and identify new funding resources. The following principles or assumptions guide our recommendations:

- School districts should not create mental health services on their own. There are considerable resources in the community and the county that can help if school districts do their homework, invest in infrastructure, and understand the needs of their students. Community partners may also be in a better position than school staff (because of federal law called FERPA) to protect students' confidentiality.
- Many of the funding streams included have lots of flexibility in how they can be used. However, there more strategic ways to use funding so that school districts can create comprehensive systems of mental health services and programs.
- School districts that strategically invest in administration and coordination are best positioned to leverage outside resources.

- Investing in tier 1 (schoolwide prevention) and tier 2 (targeted interventions) are just as important as investing in traditional, one-on-one mental health inventions (tier 3). Tier 1 investments lay the foundation for a comprehensive school mental health system and Tier 2 services provide important prevention and early intervention services that can mitigate the need for more intensive mental health supports.

Model for Funding School-Based Mental Health

With the overall goal of identifying funding that can support a continuum of mental health services, below is a model for how to understand what funding sources can support different tiers of school-based interventions. Each funding stream is described in more detail.



Medi-Cal Specialty Mental Health Services	
Description	Low-income children under 21 enrolled in Medicaid (called Medi-Cal in California) are entitled to comprehensive and preventative health care services under a federal entitlement called Early, Periodic Screening, Diagnosis and Treatment (EPSDT). The EPSDT entitlement aims to ensure that all children and adolescents have access to appropriate preventive, dental, mental health, developmental, and specialty services. Medi-Cal EPSDT includes two key benefits for all eligible children: • *Comprehensive Screening Services*: Comprehensive health screenings that include, at a minimum, medical, dental, vision, and hearing; developmental history; physical exams including assessment of nutritional status, immunizations, laboratory tests, health education, lead screenings. • *Medically Necessary Services:* States are required to provide medical, diagnostic, and treatment services in order to "correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services" (42 USC § 1396d(r)(5)). Through EPSDT, Medi-Cal children are entitled to comprehensive mental health services. In California, specialty mental health services are "carved-out" of the broader Medi-Cal program, meaning that specialty mental health services for children and adults are provided through county mental health plans instead of through managed care health plans with the rest of the EPSDT benefits. Often county specialty mental health services may be referred to as "EPSDT services" but EPSDT actually refers to the comprehensive health services available to children and youth enrolled in Medi-Cal, not just mental health services. Generally, for an eligible child to receive services through the county mental health plan, a child must be referred to the county mental health department and then undergo an assessment for mental health needs. County staff may conduct the assessment directly or through a contracted provider, either an individual mental health professional or non-profit organization. With a qualifying mental health diagnosis, the county mental health department is responsible for providing, or arranging for the provision of, specialty mental health services. These services can be provided directly by county employed staff through counseling, therapy, or other covered services. Additionally, counties may contract with community-based organizations that have the administrative and organizational capacity to deliver services and maintain the records necessary to file claims for federal reimbursement.
Eligible Child or Adolescent Populations	Medi-Cal children and youth must have a covered diagnosis and meet the following criteria to receive specialty mental health services: 1. Have a condition that would not be responsive to physical health care based treatment; and 2. The services are necessary to correct or ameliorate a mental illness and condition discovered by a screening by the Medi-Cal managed care plan, the Child Health and Disability Prevention Program, or any qualified provider operating within the scope of his or her practice.[5]

Funding Process	Funding for Medi-Cal programming is a split between federal and state dollars - in California, this is a 50/50 match. However, in 2011, California transferred financial control for many programs, including children's specialty mental health, to counties (this is called "Realignment"). Realignment funding starts with a base allocation to counties based on historical spending on the programs. The state collects dedicated revenue (for example, fees and taxes) which is distributed monthly until each county receives their base allocation. Leftover dedicated revenue funds are placed into separate, designated growth accounts. At the end of the year, these growth accounts are distributed to county programs based on a state-determined formula. The base amount plus the growth amount equals the next year's base. Until 2011, counties received a 90% reimbursement for EPSDT specialty mental health services — 50% from the federal government and 40% from the state government. Now, counties are responsible for providing the entire non-federal share using 2011 realignment allocations.
What can this look like in schools?	County mental health plans vary significantly in how they deliver specialty mental health services. The options available for schools to work with their counties to deliver specialty mental health services depends, in large part, on the county's overall system of care, priorities, and how school-based strategies align. ● *School District providers* – In some cases, the school district can contract directly with the county mental health plan to become a contracted provider of specialty mental health services. Provider qualifications and billing requirements can be significant barriers to this option. ● *County providers* – In counties where the majority of specialty mental health services are provided "in house," i.e. by county-employed mental health professionals, schools can develop arrangements with the county to have permanent or visiting county employees provide assessment and treatment services on the school campus. ● *School-based health centers or community providers* - Many counties contract the delivery of specialty mental health services through community providers. These providers can be community mental and behavioral health agencies, individual practitioners, healthcare providers like federally qualified health centers, and/or school-based health centers.
Additional Information	➢ Flowchart: Access to Mental Health Services for Medi-Cal Youth Ages 0-21: http://www.dhcs.ca.gov/services/Documents/Medi-Cal%20MHS%20Referral%20Processes/Scenario%204.pdf ➢ Information about county mental health plans: http://www.dhcs.ca.gov/services/Pages/MH_plan_information.aspx ➢ *A Complex Case: Public Mental Health Delivery and Financing in California* (California Health Care Foundation): http://www.chcf.org/publications/2013/07/complex-case-mental-health

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Medi-Cal Mild/Moderate Mental Health	
Description	Prior to 2014, individuals that did not meet the criteria for specialty mental health services received limited services through their primary care provider. Psychology services for children were also available through fee-for-service mental health providers. In 2014, Medi-Cal managed care health plans became responsible for the delivery of an expanded set of mental health services to beneficiaries with mild-to-moderate mental, emotional, or behavioral health needs. This expansion did not necessarily increase access to mental health services for children in Medi-Cal because (a) the eligibility criteria for children for specialty mental health services meant that many children with identified mental health needs were served by counties and (b), prior to 2014, children were an eligible population for psychology services through fee-for-service mental health providers. However, this expansion has brought significant attention to the role of managed care health plans in meeting mental health needs and coordinating care with county specialty mental health plans. These mental health services provided through managed care health plans are called "mild to moderate mental health services" and include individual and group mental health evaluation and treatment, outpatient services for the purposes of monitoring drug therapy, and psychiatric consultation. Medi-Cal managed care health plans continue to cover services provided within a primary care physician's scope of practice or contract with a network of mental and behavioral health providers to ensure access to the expanded set of covered services. The state does recognize, however, that many children with mental health impairments that may be considered moderate meet the medical necessity criteria to access Medi-Cal specialty mental health services provided by county mental health plans (see above).[6]
Eligible Child or Adolescent Populations	Children under 21 who are enrolled in Medi-Cal managed care health plans.
Funding Process	The state provides funding to Medi-Cal managed care health plans through "capitated rates," a set monthly payment per type of enrolled member in the health plan (for example, rates are different for adults vs. children). Capitation rates for each contracted plan were increased in 2014 to reflect the new coverage for mild/moderate mental health services. Health plans then must contract with a network of providers. More than half of health plans in California subcontract with a managed behavioral healthcare organization (MBHO) to support the administration of the new mental health coverage responsibilities[7]. Either the MBHO or the managed care health plan pay providers directly for services to enrolled beneficiaries.

What can this look like in schools?	To receive reimbursement for mild/moderate mental health services, providers must contract with the local Medi-Cal managed care health plan or MBHO and be included in the network established by the health plan or MBHO. ● *School-based health centers (SBHCs)* – More than half of California's SBHCs are run by federally-qualified health centers (FQHCs). Most FQHCs are contracted providers for the local Medi-Cal managed care health plans and are able to bill for mild/moderate mental health services, including those provided in the SBHC. ● *Contract with Medi-Cal health plans* – While still relatively uncommon, schools are growing relationships with their local Medi-Cal managed care health plan. In some cases this results in direct reimbursement to schools for health services rendered to health plan members. As health plans are growing their network of behavioral health providers, there is an opportunity for school-based providers to participate in those networks.
Additional Information	➢ Medi-Cal managed care plans by county: http://www.dhcs.ca.gov/individuals/Pages/MMCDHealthPlanDir.aspx ➢ *The Circle Expands: Understanding Medi-Cal Coverage of Mild-to-Moderate Mental Health Conditions* (California Health Care Foundation): http://www.chcf.org/publications/2016/08/circle-expands-medical-mental

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Mental Health Services Act (MHSA)	
Description	The Mental Health Services Act (MHSA) was created in 2004 with the passage of Proposition 63, which levied a 1 percent tax on personal income above $1 million. MHSA provides the state's second largest public funding stream for mental health services, after Medi-Cal.[8] MHSA programs and services are intended to enhance, rather than replace, existing programs. There are five funding categories within MHSA: ● Community Support Services (CSS) – The largest category is intended to provide funding for services identified in children's and adult's system of care treatment plans that are not funded through any other source (public or private insurance). ● Prevention and Early Intervention (PEI) – This category is intended to provide resources to prevent mental illness from becoming severe and disabling and to improve timely access for underserved populations. PEI programs emphasize strategies to reduce negative outcomes that may result from untreated mental illness: suicide, incarcerations, school failure or dropout, unemployment, prolonged suffering, homelessness, and removal of children from their homes. ● Innovation (INN) – The goal of INN is to incentivize counties to test novel approaches to delivering health services. A county must get approval from the Mental Health Services Oversight and Accountability Commission (MHSOAC) to spend innovation funds on a project. Projects must do one of the following: (1) introduce a mental health practice or approach that is new to the overall mental health system, (2) make a change to an existing practice in the field of mental health, for example applying a practice to a different population, or (3) apply to the mental health system a promising community-driven practice or approach that has been successful in non-mental health contexts or settings. ● Other MHSA – Counties are permitted to meet local needs by transferring funds from CSS to other components: Capital Facilities and Technological Needs (CFTN) and Workforce Education and Training (WET). MHSA requires county mental health programs to submit three-year program and expenditure plans and annual updates for MHSA programs and expenditures. In their MHSA plans, counties are required to include a list of all programs for which MHSA funding is requested and identify expenditures for each type of funding and for each target age group.
Eligible Child or Adolescent Populations	Target populations include children and adolescents with Serious Emotional Disturbance and transition-aged youth who are unserved, underserved, or inappropriately served (e.g., homeless, frequent hospital users, individuals with criminal justice history). ● All ages must be served by a county's CSS components. Disparities in access to services for underserved populations and regions of the county must be addressed. ● PEI programs must serve all age groups and at least 51 percent of county PEI funding must target individuals between the ages of 0 and 25. Counties with a population less than 200,000 are exempted from these age requirements.

Funding Process	Revenues are distributed directly to counties, with no more than 5 percent used for state-level administration. Funding is approved of and administered by each county's behavioral health or mental health department after review and comment by the local Mental Health Board. Counties submit an integrated plan comprised of the relevant MHSA components to Mental Health Services Oversight and Accountability Commission (MHSOAC). Counties are required to have a community engagement process in the development of their MHSA spending plans. School district staff and community mental health providers should become aware of and attend meetings to highlight the role of schools in meeting the counties spending and program goals.
What can this look like in schools?	In schools, once other funds are exhausted for mental health needs, MHSA can fill in for other interventions, programs, and/or populations not covered through billable funding streams (like Medi-Cal). This can help to round out the overall continuum of school-based mental health services offered. MHSA-funded, school-based programs vary significantly. The following report, *2016 School-Based Mental Health Services Act Prevention and Early Intervention Programs,* provides helpful examples of school-based programs and strategies using MHSA funds: http://www.cbhda.org/wp-content/uploads/2014/12/School-Based_MHSA_PEI-Final_Draft_2016.pdf
Additional Information	➢ Fiscal reports, by county: http://mhsoac.ca.gov/fiscal-reporting ➢ County plans and updates: http://www.dhcs.ca.gov/services/MH/Pages/MHSA-County-Plans-and-Updates.aspx

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Educationally-Related Mental Health Services (ERMHS)	
Description	The federal government provides funding to states to provide children with disabilities a free and appropriate public education. The Individuals with Disabilities Act (IDEA) sets requirements for state programs and includes two main components: special education and related services. "Special education" refers to the specially designed instruction to meet the needs of a student with a disability. "Related services" refers to other developmental and supportive services required to help students with disabilities benefit from special education, including mental health services. Local Education Agencies (LEAs) are required to evaluate students and develop an individualized education program (IEP), including the special education and related services needed for the student. According to California state data, in the 2014–15 school year nearly 14% of students with an IEP received a mental health service as part of their IEP[9]. In July 2011, the state changed the process by which students in special education receive mental health services. Previously, county mental health departments were responsible for assessing students, recommending mental health services to be included in an IEP, and providing those services. After the passage of AB 114, school districts are solely responsible for ensuring that students with disabilities receive the mental health services necessary to benefit from a special education program. The California Department of Education designates a portion of California's federal special education funding specifically for the purpose of providing mental health services to special education students. In addition, the state has dedicated part of its own special education funding for the same purpose. Funds from these two funding sources are considered restricted and can be used only for educationally-related mental health services (ERMHS).
Eligible Child or Adolescent Populations	Students with IEPs who demonstrate behavioral health issues that impact their ability to learn and access the school curriculum. ERMHS funds are not restricted to students who have "emotional disturbance" as their identified disability.
Funding Process	State and federal funding for special education and related services is distributed from the California Department of Education directly to Special Education Local Plan Areas (SELPAs) based on the average daily attendance of all pupils in the SELPA (regardless of how many pupils have an IEP or disability). SELPAs then determine how to allocate dollars to the individual districts and schools. Some funding may also retained by the SELPA to support administrative activities and/or any services provided directly by the SELPA, which can include mental health services.

What can this look like in schools?	Services must be included in the IEP and can include: individual counseling, parent counseling, social work services, psychological services, and residential treatment. Any service agreed upon by the student's IEP team as necessary for the student to receive a free and appropriate public education may be considered a related service and covered by ERMHS funds. There are three primary ways districts are meeting the ERMHS requirement: ● School districts hire mental health professionals (i.e., credentialed and/or licensed social workers, psychologists) and provide services through these staff. ● School districts contract with community mental health agencies or other qualified professionals to provide services. ● School districts contract with county mental health departments to provide services.
Additional Information	➢ Special Education guidance for ERMHS and AB 114 from the California Department of Education: http://www.cde.ca.gov/sp/se/ac/ab114twg.asp

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Local Educational Agency (LEA) Medi-Cal Billing Option Program	
Description	The federal government provides an option for school districts to recover a portion of the costs of providing Medi-Cal services to eligible and enrolled children. The LEA Billing Option Program allows LEAs to become Medi-Cal providers, bill for covered services provided by qualified employed or contracted practitioners, and claim federal dollar reimbursement to match the education dollars already being spent for health services for eligible children. Mental health-related covered services include psychology, counseling, and psychosocial assessments. The LEA Medi-Cal Billing Option Program provides the federal share of reimbursement for health assessments and treatment services for Medi-Cal eligible students who have an Individualized Education Plan (IEP), an Individualized Family Services Plan (IFSP), and/or an Individualized Health and Support Plan (IHSP). LEA Medi-Cal Billing Option Program funds are a reimbursement for services rendered, and are not considered federal dollars upon receipt by the school. Federal funds are based upon a cost reimbursement model; therefore, there is no State General Fund expense for this program. LEAs must have the funds budgeted for program administration and practitioners providing services prior to seeking reimbursement through the LEA Medi-Cal Billing Option Program. In order to seek reimbursement through the LEA Medi-Cal Billing Option Program, LEAs must have an approved Provider Participation Agreement (PPA) with the Department of Health Care Services (DHCS). As a condition of participation, LEAs must reinvest reimbursements in health and social services for children and their families and maintain a collaborative committee to assist them in decisions regarding the reinvestment of LEA reimbursements. *What about "free care"?* In 2014, the federal government reversed a long standing policy that impeded the ability of school districts to get reimbursed for the school health services they provide to all Medi-Cal eligible students (called the "Free Care Rule"). Prior to this change, LEAs were basically limited to receiving reimbursement for health services to special education students. In September 2016, DHCS updated the provider manual to reflect the 2014 policy change and allow for reimbursement for health services to Medi-Cal eligible students, including general education students.
Eligible Child or Adolescent Populations	Medi-Cal eligible students who have an Individualized Education Plan (IEP), an Individualized Family Services Plan (IFSP), and/or an Individualized Health and Support Plan (IHSP).
Funding Process	The LEA Billing Option Program is a reimbursement program. LEAs hire practitioners based on the school budget for the fiscal year. LEAs pay for the services upfront and are reimbursed the federal match (50%) for the cost of providing services based upon a "cost reimbursement" model.
What can this look like in schools?	Schools can either directly employ eligible practitioners (see the Provider Manual for more information) or may contract with outside providers. When contracting with outside providers, LEAs must be careful that outside providers are not also billing separately for the services provided.

Additional Information	➢ LEA Onboarding Handbook: http://www.dhcs.ca.gov/provgovpart/Documents/ACLSS/LEA/Program_Req_and_Info/2016_LEA__Onboard_Handbook_REV2.pdf ➢ LEA Provider Manual: http://www.dhcs.ca.gov/provgovpart/Pages/LEAProviderManual.aspx ➢ More information about the change to Free Care: http://www.schoolhealthcenters.org/policy/policy-priorities/free-care-rule/

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Local Control Funding Formula (LCFF)	
Description	The Local Control Funding Formula (LCFF), enacted through the 2013-14 state budget, is the new system for calculating funding for most public schools in California. Each district receives a "base grant" per student, plus additional "supplemental and concentration" grants for targeted students who are low income, foster youth, or English-Language Learners. LCFF funds almost every service provided by public schools, including teacher salaries, professional development, learning support services, classroom materials, and facilities. LCFF can be used for school-based mental health programs and staff, including social workers, counselors, nurses, and psychologists.
Eligible Child or Adolescent Populations	All K-12 students in public schools are eligible for LCFF funds, with more funding for targeted students who are low income, English-Language Learners, or in foster care.
Funding Process	School districts are currently receiving LCFF funds, which will increase through 2020. Districts must submit a three-year Local Control and Accountability Plan (LCAP) and annual LCAP updates to their County Office of Education. The LCAP must demonstrate how funds will be used to support all students and targeted students in eight distinct state priorities. The state priorities most linked to student mental health include "pupil engagement" as measured in part by attendance and "school climate" as measured in part by suspension and expulsion rates. It is estimated that, after years of cuts, at full implementation, LCFF will bring school funding back to at least 2007 levels.
What can this look like in schools?	LCFF can fund many different strategies for increasing mental health services and programs in schools. As the most flexible funding available to schools, LCFF funds should be used last, after other funding options have been exhausted. Some examples: ● *Staffing infrastructure for service coordination* to pay for staff responsible for coordination of services at school sites. Investments in staffing infrastructure to support coordination of services can enhance both the reach and effectiveness of services and supports. ● *Direct mental health service providers* to fill in for services for which there is no other reimbursement. Note that LCFF funds should be used for direct mental health services only after other funding streams have been fully tapped. ● *Staff development and trainings* that support the effective implementation of school climate initiatives, e.g. trainings and ongoing coaching for trauma-informed classroom management and restorative justice practices. ● *Schoolwide services and programs* that help to promote an overall positive, nurturing and supportive school climate.
Additional Information	• California Department of Education – Local Control Funding Formula: http://www.cde.ca.gov/fg/aa/lc/

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Title I and Title IV, Every Student Succeeds Act (ESSA)	
Description	The Every Student Succeeds Act (ESSA) replaced No Child Left Behind (NCLB) in December 2015. While ESSA preserves federal funding at levels similar to NCLB and maintains a focus on closing achievement gaps, the new law is significantly less prescriptive than its predecessor and expands the allowable uses of the funds. This expansion includes promoting investments beyond academically focused learning supports to social emotional learning, positive behavioral interventions, trauma informed practices, school climate, counseling, mental health and health services, integrated services, and improved school community partnerships. Under ESSA, states (through developing individual state plans) are required to establish indicators of student achievement and success, incorporate those indicators into a system of meaningful annual differentiation, and use that system to identify schools in need of improvement. The law requires states to identify schools for comprehensive support and improvement (CSI) and those that will receive targeted support and improvement (TSI). There are multiple funding streams under ESSA, but with the new law there is more flexibility around blending or combining these resources. Some key funding streams include: • *Title I, Part A* funds are used to support effective, research-based educational strategies that close the achievement gap and enable the students to meet the state's challenging academic standards. Title I-funded schools are either targeted assistance schools or schoolwide program schools. • *Title I, Schoolwide Program* is a comprehensive reform strategy designed to upgrade the entire educational program in a Title I school; its primary goal is to ensure that all students, particularly those who are low-achieving, demonstrate proficient and advanced levels of achievement on state academic achievement standards. • *Title IV, Part A* Student Support and Academic Enhancement Grants (SSAEC) consolidates 49 separate grant programs into one new grant program. This new consolidated grants program authorizes activities in three priority areas, including supporting safe and healthy school environments (e.g. comprehensive school health and mental health, drug and violence prevention, health and physical education). Districts that receive an SSAEC grant must spend at least 20% of the funds on 'supporting safe and healthy school environments' activities. NOTE: Each state submitted a plan with more specifics around ESSA implementation. Implementation of California's ESSA plan may affect how these funds work in California.
Eligible Child or Adolescent Populations	In general, schools receive Title I funds when 40% of their student population is "low-income." While funding is meant to be targeted to students with low-income status, funding school-wide strategies is an integral part of the law. ESSA directs that districts will receive Title IV / SSAEC grant funds based on the Title I formula but California's final ESSA plan will have more specific information about how these grants work in California.
Funding Process	Title I and SSAEC (Title IV) funds are distributed to states and then from states to school districts according to the Title I formula based largely on number of low-income students.

What can this look like in schools?	Title I and Title IV funds are very flexible and can be used to fund staff who coordinate support services and who deliver direct services. Funding can also be used to support staff development and training. With this flexibility, Title I and Title IV funds should be used strategically to fund staffing infrastructure and student support services that cannot be funded any other way. These funds can also be used to support mental health services for all students, including those that are not covered by Medi-Cal programs or are uninsured. For example, instead of using Title I funds to provide direct mental health services (schools should maximize partnerships with community-based mental health providers who can bill Medi-Cal to provide these services, see above), Title I funds can be used more strategically to fund schoolwide activities to build positive and nurturing school climates. As with LCFF funds, Title I funds can also be used to fund staffing infrastructure, for example, to pay for staff time spent on multidisciplinary teams or coordinating services and community-based partners at school sites. Investments in staffing infrastructure to support coordination of services can enhance both the reach and effectiveness of services and supports. Title IV funds can be utilized to fund the full spectrum of mental health services including: • Promoting community and parent involvement in schools; • Providing school-based mental health services and counseling; • Promoting supportive school climates to reduce the use of exclusionary discipline and promoting supportive school discipline; • Supporting transition services for justice-involved youth; • Implementing systems and practices to prevent bullying and harassment; • Developing relationship building skills to help improve safety through the recognition and prevention of coercion, violence, or abuse; and • Establishing community partnerships. NOTE: Title I and Title IV dollars are federal funding and cannot be used to match and draw down other federal reimbursement (i.e. through LEA Billing or SMAA). Other non-federal funds should be used to hire staff or contract with providers that can bill Medi-Cal programs.
Additional Information	➢ For updates on California's ESSA plan: https://www.cde.ca.gov/re/es/index.asp ➢ Title I, Part A: https://www.cde.ca.gov/sp/sw/t1/titleparta.asp ➢ Details about schoolwide programs from CDE: http://www.cde.ca.gov/sp/sw/rt/ ➢ Non-regulatory guidance about SSAEC grants: https://www2.ed.gov/policy/elsec/leg/essa/essassaegrantguid10212016.pdf

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School-based Medi-Cal Administrative Activities (SMAA)	
Description	The federal government provides an option for school districts to recover a portion of the costs of administering the Medi-Cal program for eligible children. The School-based Medi-Cal Administrative Activities (SMAA) program reimburses school districts for the federal share (50%) of certain activities. These activities include: outreach, enrollment and facilitating the Medi-Cal application process, and making referrals for enrolled students to Medi-Cal covered services. SMAA also reimburses districts for arranging non-emergency/non-medical transportation and program infrastructure like program planning, policy development, and SMAA claims coordination. Many school districts use this program only in relationship to their LEA Billing Option program and for administration related to special education services, but SMAA can be used more universally to do Medi-Cal outreach and enrollment among the student population as a whole. This is especially effective at schools with high Medi-Cal eligible populations, such as Title I schools.
Eligible Child or Adolescent Populations	Medi-Cal eligible students. NOTE: Very generally speaking, reimbursement formulas are based on the percentage of a school's or district's student population that is Medi-Cal eligible.
Funding Process	To participate in the SMAA program, school districts must contract with the Department of Health Care Services through their Local Educational Consortium (LEC) or Local Governmental Agency (LGA, for example a participating county health department). SMAA claims are calculated through a random moment time study. SMAA reimbursements are considered local funding and are not restricted in terms of how the district chooses to reinvest. SMAA reinvestments are not considered federal funds, and are not limited by concerns about "double dipping" so the funds can be used to draw down federal funds.
What can this look like in schools?	SMAA can be used to draw down federal reimbursements for school staff and program costs to conduct outreach and help families get students enrolled in Medi-Cal. The more students who are enrolled and stay enrolled in Medi-Cal, the better able the district is to get reimbursements for direct mental health services to Medi-Cal eligible students (see LEA Billing Option and Medi-Cal Specialty Mental Health Services). These activities can be conducted by a district staff person, district department or by family resource center staff. In addition, for students enrolled in Medi-Cal, SMAA can help cover costs for planning and connecting students to Medi-Cal covered services - like mental health services. Staff participating in school based-multidisciplinary teams that are connecting students to mental health services can participate in the time study to drawn down SMAA reimbursements.

Additional Information	➢ SMAA landing page from DHCS: http://www.dhcs.ca.gov/provgovpart/Pages/SMAA.aspx ➢ Program Description from DHCS: http://www.dhcs.ca.gov/provgovpart/Pages/SMAADescription.aspx ➢ LEC and LGA map and contact information: http://www.dhcs.ca.gov/provgovpart/Pages/MapoftheLECService.aspx ➢ DHCS contact list of SMAA analysts by region: http://www.dhcs.ca.gov/provgovpart/Pages/SMAAProgramContactInformation.aspx

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[1] Barrett, S., Eber, L., & Weist, M. (2013). Advancing Education Effectiveness: Interconnecting School Mental Health and School-wide Positive Behavior Support. *Center for School Mental Health*.

[2] Barrett, et. al

[3] California Health Interview Survey. CHIS 2005 Public Use File. Los Angeles, CA: UCLA Center for Health Policy Research.

[4] Hurwitz, Laura and Weston, Karen, *Using Coordinated School Health to Promote Mental Health for All Students*, National Assembly on School-Based Care, July 2010.

[5] MHSUDS Information Notice 16-061

[6] APL 13-021

[7] CHCF, The Circle Expands: Understanding Medi-Cal Coverage of Mild-to-Moderate Mental Health Conditions

[8] UCLA Center for Healthier Children, Youth, and Families, "California's Investment in the Public Mental Health System: Proposition 63," (June 2011), http://archive.mhsoac.ca.gov/Evaluations/docs/Evaluation_Deliverable1A_BriefSummary.pdf.

[9] California State Auditor, *Student Mental Health Services: Some Students' Services Were Affected by a New State Law, and the State Needs to Analyze Student Outcomes and Track Service Costs*, Report 2015-112, January 2016