California Children's Trust

HEALING CENTERED SCHOOLS:

FINANCING JUSTICE AND EQUITY AT THE NEXUS OF PUBLIC HEALTH AND PUBLIC EDUCATION

Breaking Barriers

November 19th, 2020

DRINKING FROM A FIRE HYDRANT

15 MINUTES TO COVER….

- A Paradigm Shift at the Nexus of Health and Education
- Context: The Social and Emotional Health of Children in California
- Schools as Essential Actors in Any Solution at Scale
- How MediCaid Works and What It Means for Schools : The 4 Essential MediCal Payors for Schools
- 5 Models that Schools and Health Systems Are Exploring
- How Philanthropy Can Engage
- Systems Change In Practice: What's Happening and Where

HEALING CENTERED SCHOOLS:
THE NEXUS OF PUBLIC HEALTH AND PUBLIC EDUCATION

1. There are **financing opportunities to scale just and equitable services and systems** in schools.

2. Acting on them requires cross-system actors to understand and leverage **two essential public systems …..while concurrently transforming them** to to be just, equitable, and healing-centered.

THERE IS A CRISIS IN CHILDREN'S MENTAL HEALTH

Consider the facts before COVID-19:

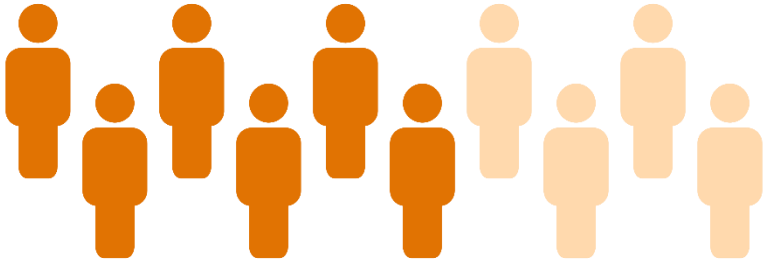
Increase in inpatient visits for suicide, suicidal ideation, and self injury for children ages 1-17 years old, and 151% increase for children ages 10-14

Increase in mental health hospital days for children between 2006 and 2014

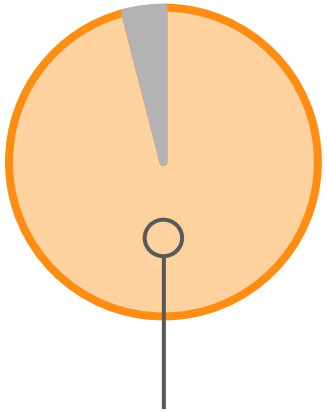
Increase in the rate of self-reported mental health needs since 2005

California ranks low in the country for providing behavioral, social, and development screenings that are key to identifying early signs of challenges

AND ALTHOUGH ELIGIBILITY FOR MENTAL HEALTH SERVICES HAS INCREASED



5+ million of California's 10 million children are covered by Medi-Cal and EPSDT entitlement (a 30% increase over last five years)



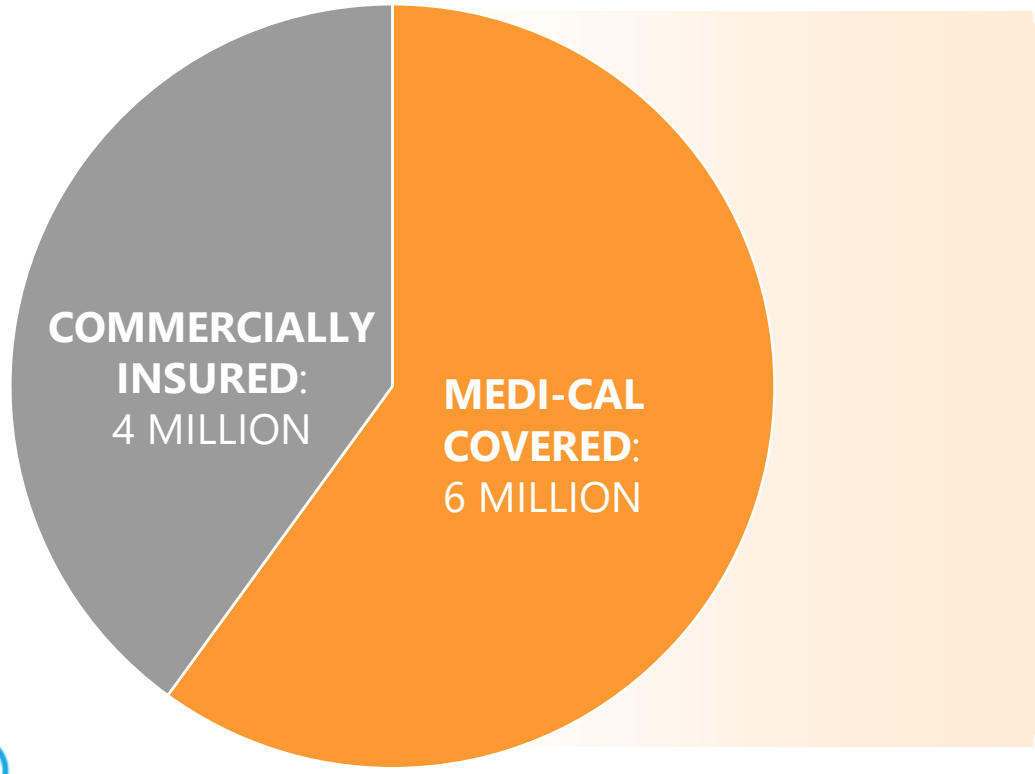
96% of California children are covered by a health plan with a **mental health benefit**

THE SYSTEMS

MEDICAID BY THE NUMBERS – CALIFORNIA'S KIDS

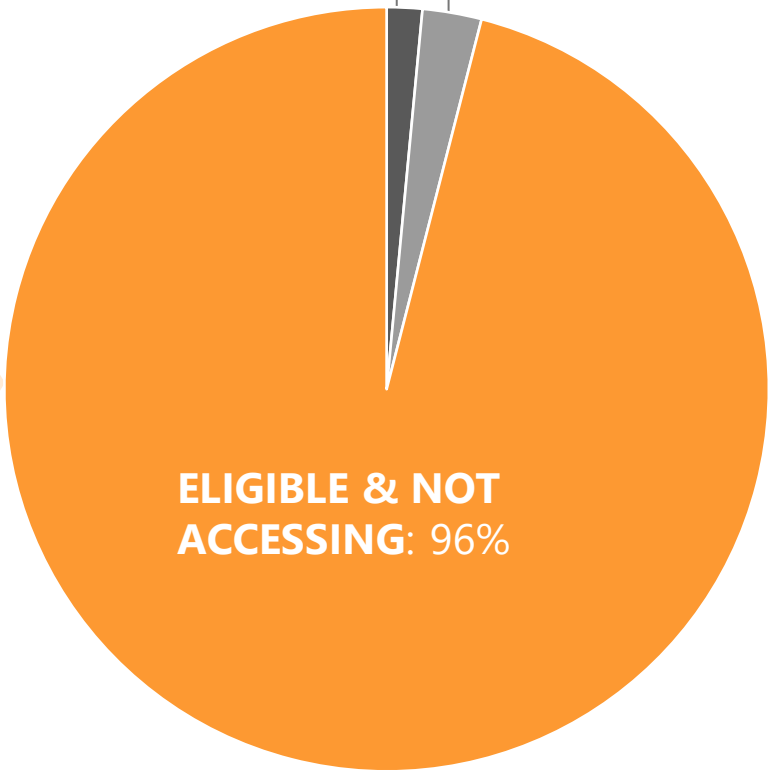
Almost 6 out of 10 children are covered by Medi-Cal. They are covered by county administered Specialty Mental Health Plans (MHP) and Medi-Cal Managed Care Organizations (MCO'S)

Total California Children: 10 Million



MCO Total Served Annually: 90,000 Kids

MHP Total Served Annually: 152,409 Kids



COVID IS COMPOUNDING THE CRISIS; DEEPENING DISPARITIES

Collateral damage of COVID-19…

Exacerbates Equity Gap: Operating outside of school structures decreases access to resources—tech, food, MH supports, child abuse screening, etc.

Massive Disruption to Children's Routines: Increases anxiety, social isolation, and erosion of social capital

Economic Insecurity and Isolation: Increased risk of intimate partner violence.

Destabilization of the Provider Network: Dramatic disruption in access to care—behavioral and mental health, reproductive services, etc.

"We're going to see increased stress-related cognitive impairment and diseases and probably increased toxic stress among young people. Experts say that when kids return to schools, the demand for mental health care will be greater than the available services, as the effects of the coronavirus disruptions cut across socioeconomic status, affecting all children throughout California."

-- California Surgeon General Dr. Nadine Burke Harris

COVID RELATED STATS: What we feared is coming to pass…..

ED VISITS

Beginning in April 2020, the proportion of children's mental health–related ED visits among all pediatric ED visits increased and remained elevated through October

24/31%

Compared with 2019, the proportion of mental health–related visits for children aged 5–11 and 12–17 years increased approximately 24%. and 31%, respectively

25%

One in four young adults between the ages of 18 and 24 say they've considered suicide because of the pandemic, according to new CDC data that paints a bleak picture of the nation's mental health during the crisis.

THE "PRICE" IS HIGHER FOR BLACK AND BROWN CHILDREN

Many receive the wrong services at the wrong time…in restrictive or punitive settings.

81%

81% of children on medicaid are **black or brown**.

2X

The **suicide rate for black children**, ages 5-12, is 2x that of their white peers.

70%

70% **of youth in California's juvenile justice system have unmet behavioral health needs**, and youth of color are dramatically over-represented.

Making Healing Centered Schools a reality isn't simply a matter of tweaking access or programs…

It requires rooting out racist infrastructure.

ELIGIBILITY FOR MENTAL HEALTH SERVICES HAS INCREASED, BUT ACCESS REMAINS LIMITED

Less than 5% get access to any care, and only 3% are in ongoing care.

The Children's Trust projects a **20% increase in enrollment by fall 2020**, bringing the total to **70% of the state's children relying on Medi-Cal.**

DRAMATIC UNDER-INVESTMENT IN CHILDREN

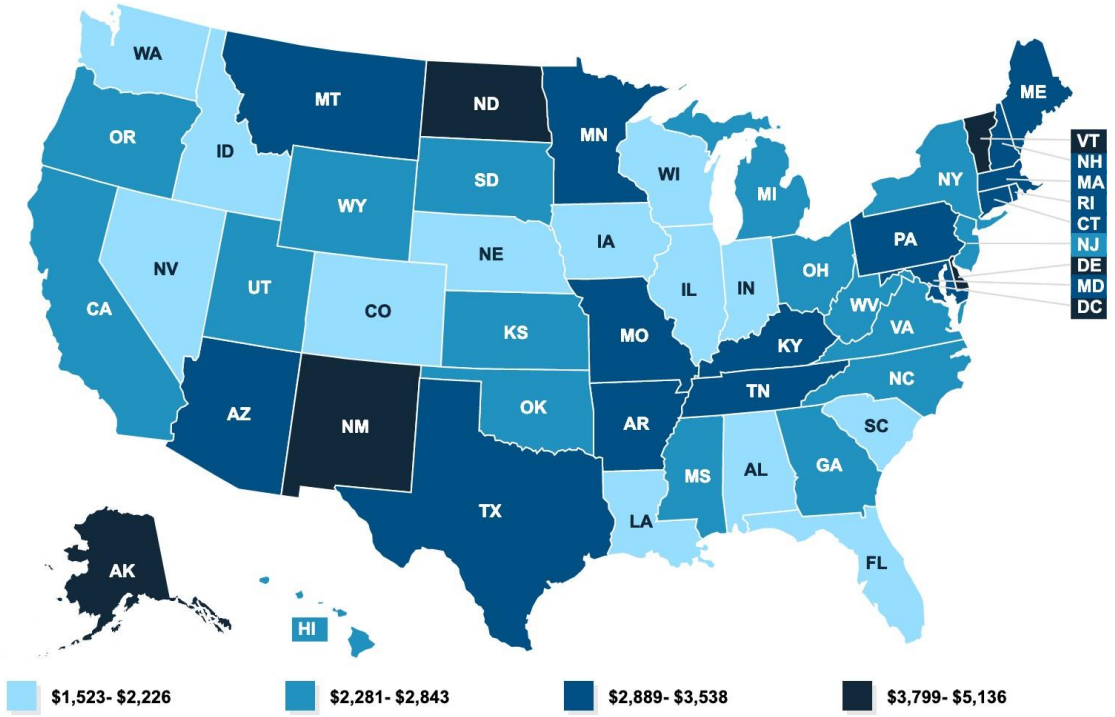
California is in the bottom 1/3 nationally for health spending at $2,500 per child enrollee.

Children represent **42% of enrollees** but only **14% of all expenditures**.

California operates the largest MediCaid Program in the nation—**April 2019 Audit exposed** significant underperformance under the EPSDT Mandate and Bright Futures Guidelines.

Medicaid Spending per Child

FY 2014



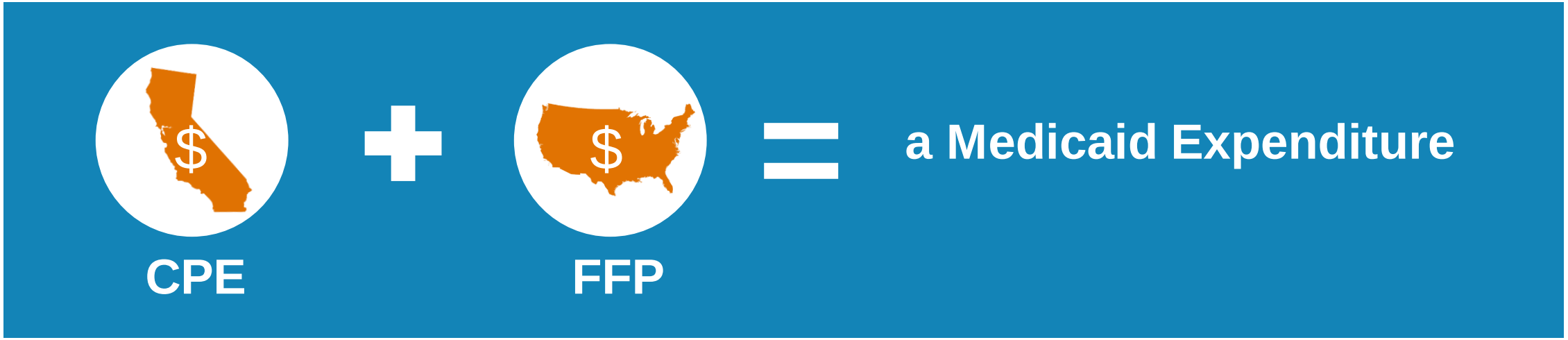
SCHOOLS CAN BE ESSENTIAL ACTORS IN OUR RESPONSE TO CRISIS

Schools are ground zero for the youth mental health crisis, and our collective failure at supporting them has contributed to the marginalization of black and brown children.

The Health Care System Needs Schools: Children ages 8-18 have the lowest rate of primary care utilization of any demographic in MediCal—and 75% of mental illness manifests in adolescence. Not only are schools essential actors in a reformed mental health system that overtly addresses healing, justice, and structural racism, but they are also essential service setttings for children with clinical needs.

The Finances Align: Schools have what the publicly funded Medicaid system needs….access to kids and the non federal dollars to claim against (CPE).

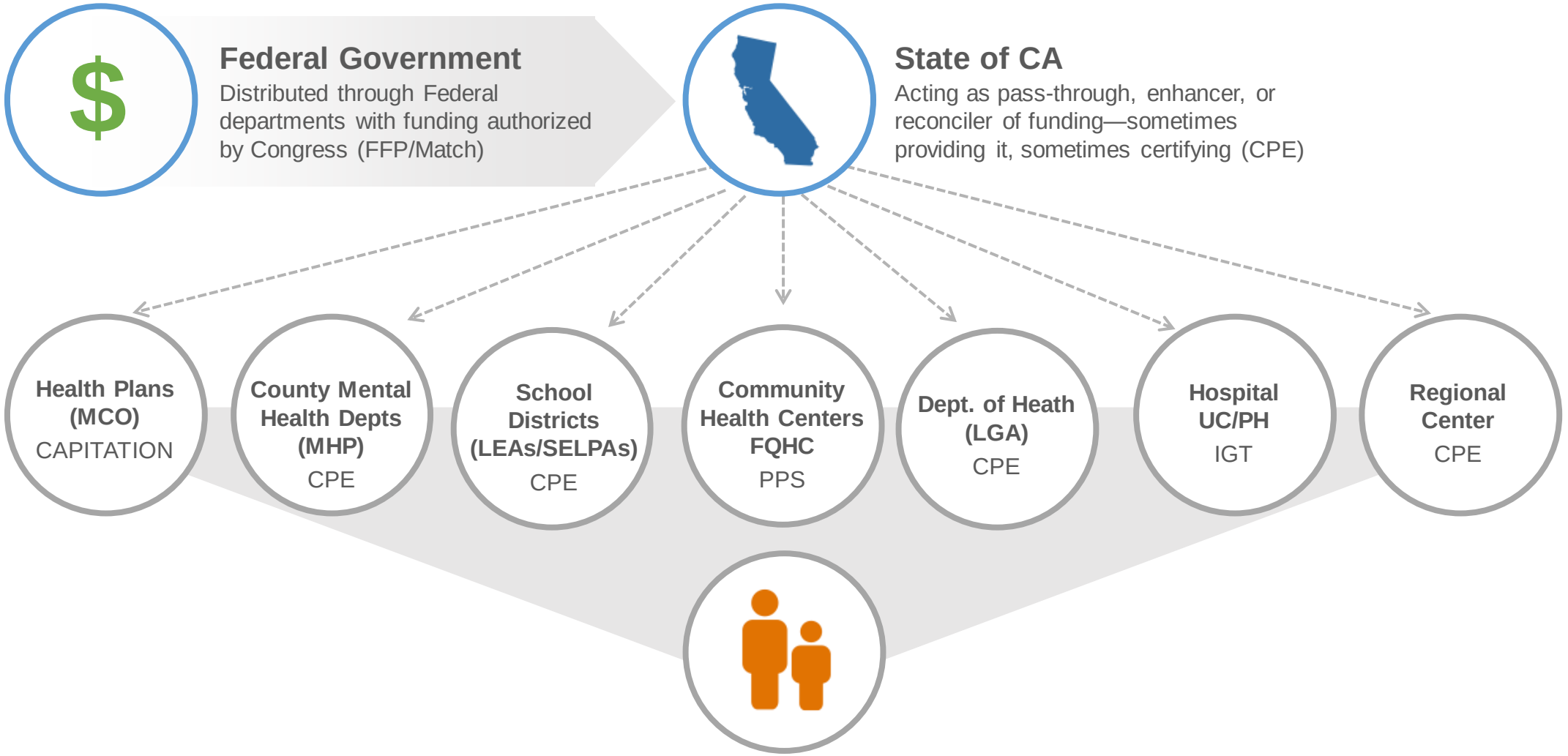
THE FEDERAL MATCH IS GUARANTEED:



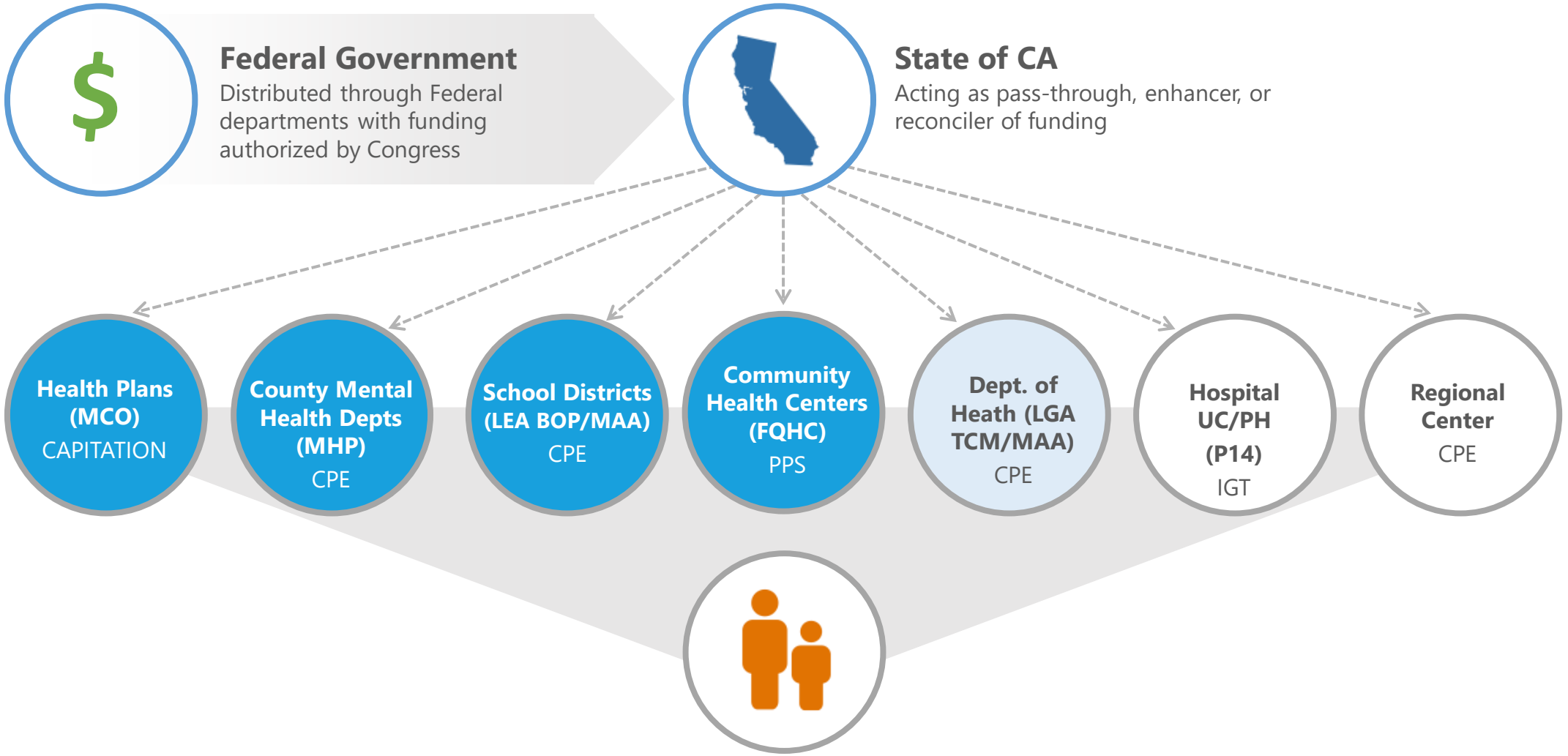
Certified Public Expenditure (CPE) = A state's use of public funds spent by other government entities (state or county) to claim federal reimbursement for Medicaid services.

Federal Financial Participation (FFP) = The Federal share of Medicaid dollars – GUARANTEED match without limit or cap.

FOLLOW MEDICAID DOLLARS TO FIND MONEY LEFT ON THE TABLE



FOLLOW MEDICAID DOLLARS TO FIND MONEY LEFT ON THE TABLE



There Are Five Models That Schools Use to Interact With Medical Payors

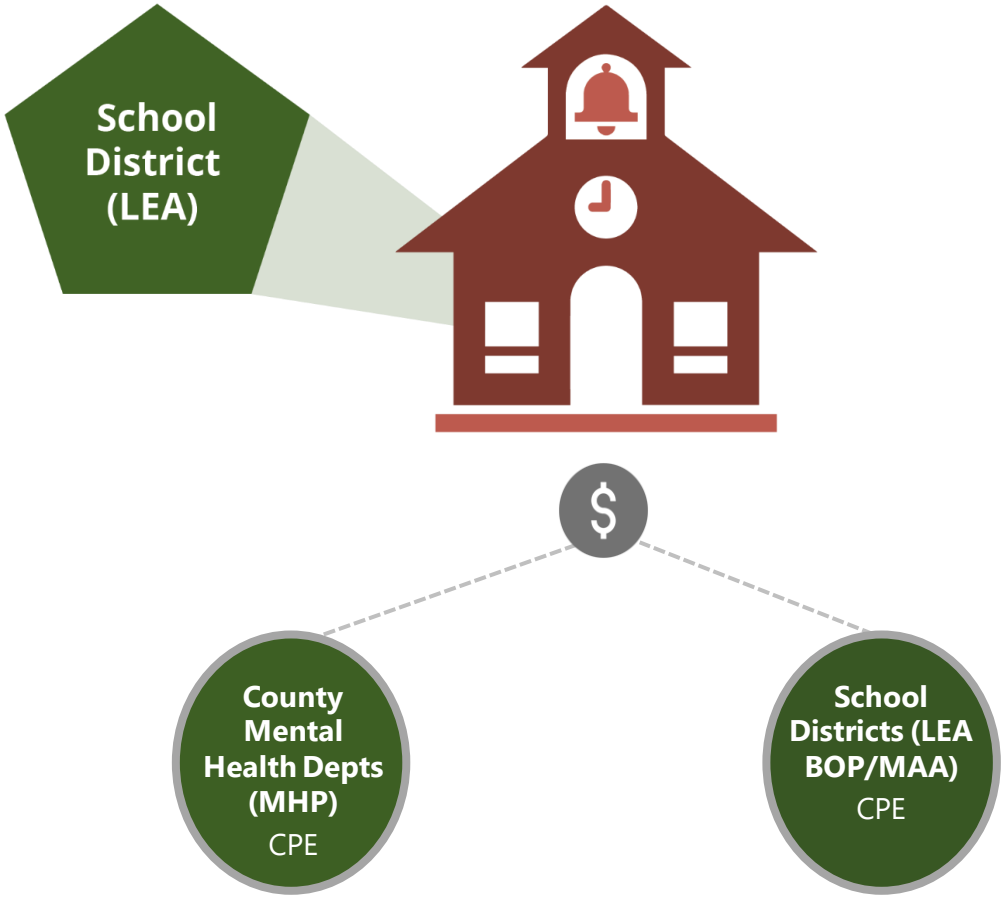
THE LEA MODEL:
Local Education Agency (school district)

A **school district** (LEA) can bill for Medi-cal services directly, either under the LEA Billing Option Program (LEA BOP) or by becoming vendorized with their county health department under their own EPSDT contract.

LEAs can and often do hire their own clinical staff and bill the county mental health plan for services rendered to individual students. Services have historically been focused on special education students because of school culture, high administrative burdens, and billing exclusions. LEAs expanded in some large districts to general education between 2001-2011.

Revenue streams: MHP/MHSA, LEA BOP/MAA

Example: LAUSD



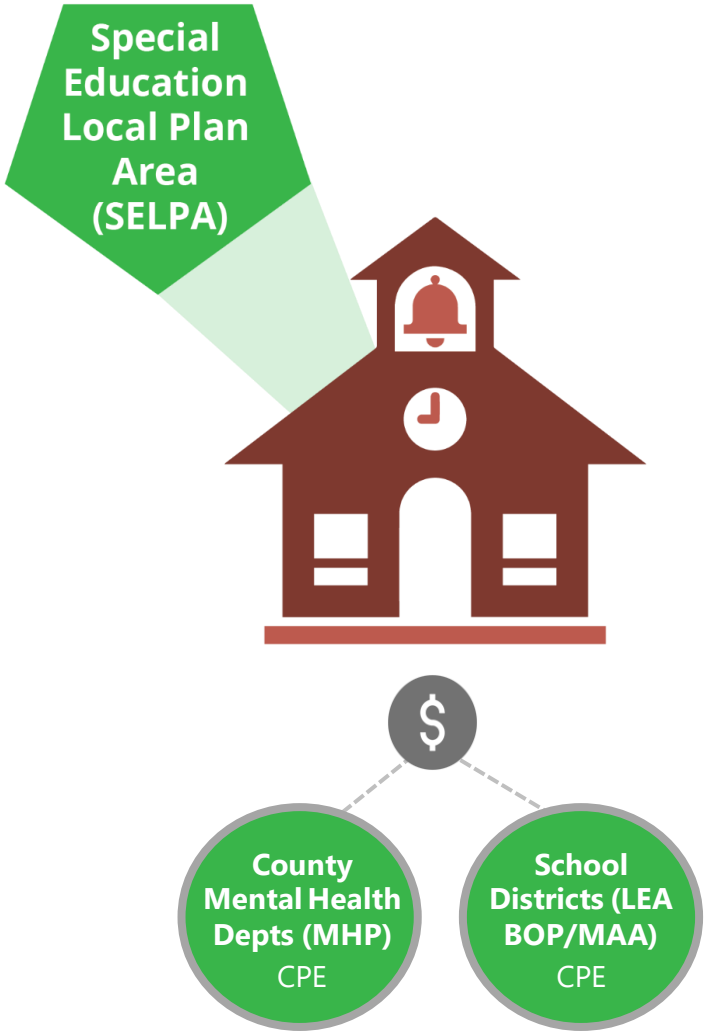
THE SELPA MODEL:
SPECIAL EDUCATION LOCAL PLAN AREA

A **SELPA** can act as a school district's intermediary for Medi-cal contract and billing, as well as provide clinical services, but most often SELPAs purchase or broker services and contract out to CBOs. SELPAs can partner with a single district or multiple districts within their region.

Historical partnerships (AB3632) and ability to serve multiple school sites characterize these models that have historically been focused in IDEA programs and services.

Revenue streams: MHP, LEA BOP/MAA

Example: Desert Mountain or San Mateo



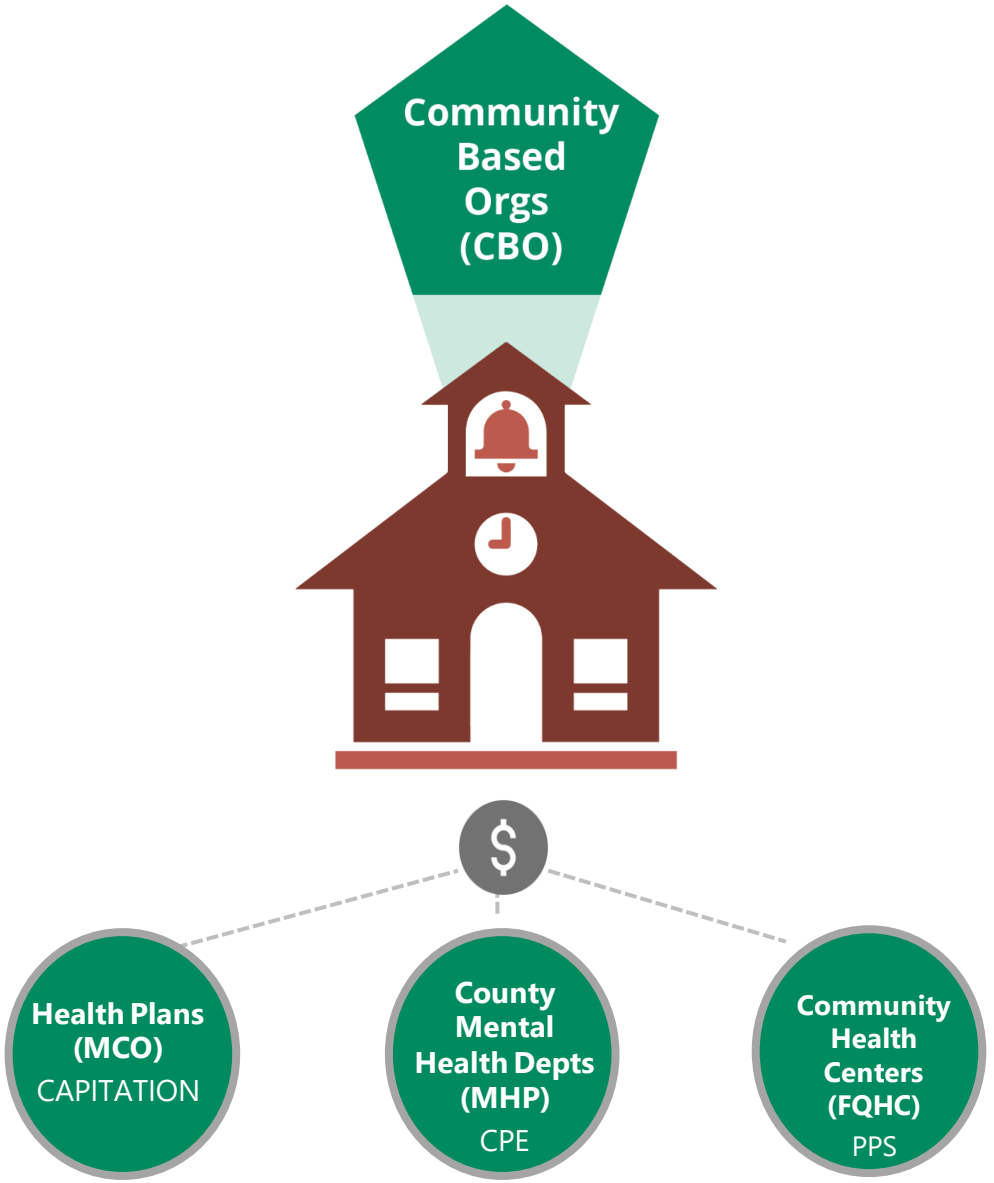
CBO OR NONPROFIT MODEL: COMMUNITY-BASED ORGANIZATION

Community-based organizations (CBOs), or non-profits, act as an intermediary (contract holder with payor) and as clinical provider. CBOs co-locate on school campuses under contract with payors and formal agreements (usually MOUs) with school districts or school sites.

CBOs establish school-site specific programs or district-wide programs and provide/manage their own staff for both clinical services and administrative and billing functions. CBOs often blend/braid other public dollars and philanthropy to address reimbursement barriers or challenges.

Revenue streams: MHP, MCO, FQHC

Example: Seneca or Hathaway Sycamores or La Clinica



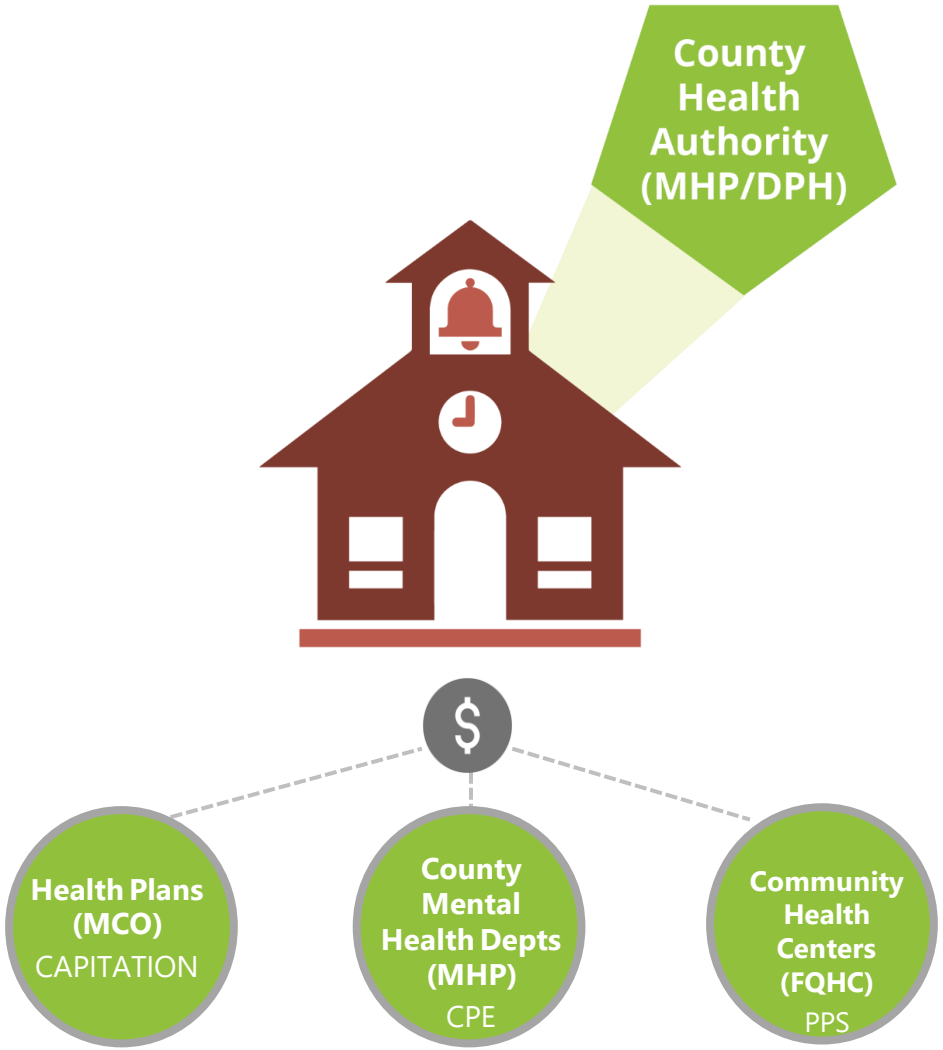
THE COUNTY HEALTH AUTHORITY MODEL

County Health Authority (healthy agency, behavioral health care services or MHP, or public health departments) can develop school health specific intermediaries. These County Health agencies act as payor (they contract with CBOs to work at school sites) and as a provider (county staff also provides services). In this model most of the services are contracted out to community based organizations or LEAs, but often include a mix of county staff doing direct services, evaluation, and professional development.

Districts can and often do partner with their county health departments to at least some degree for prevention, nursing, and other services, and most often the county health authority contracts with CBOs to deliver services to a school site or district.

Revenue streams: MHP, MCO, FQHC (potentially)

Example: Alameda County, Monterey County



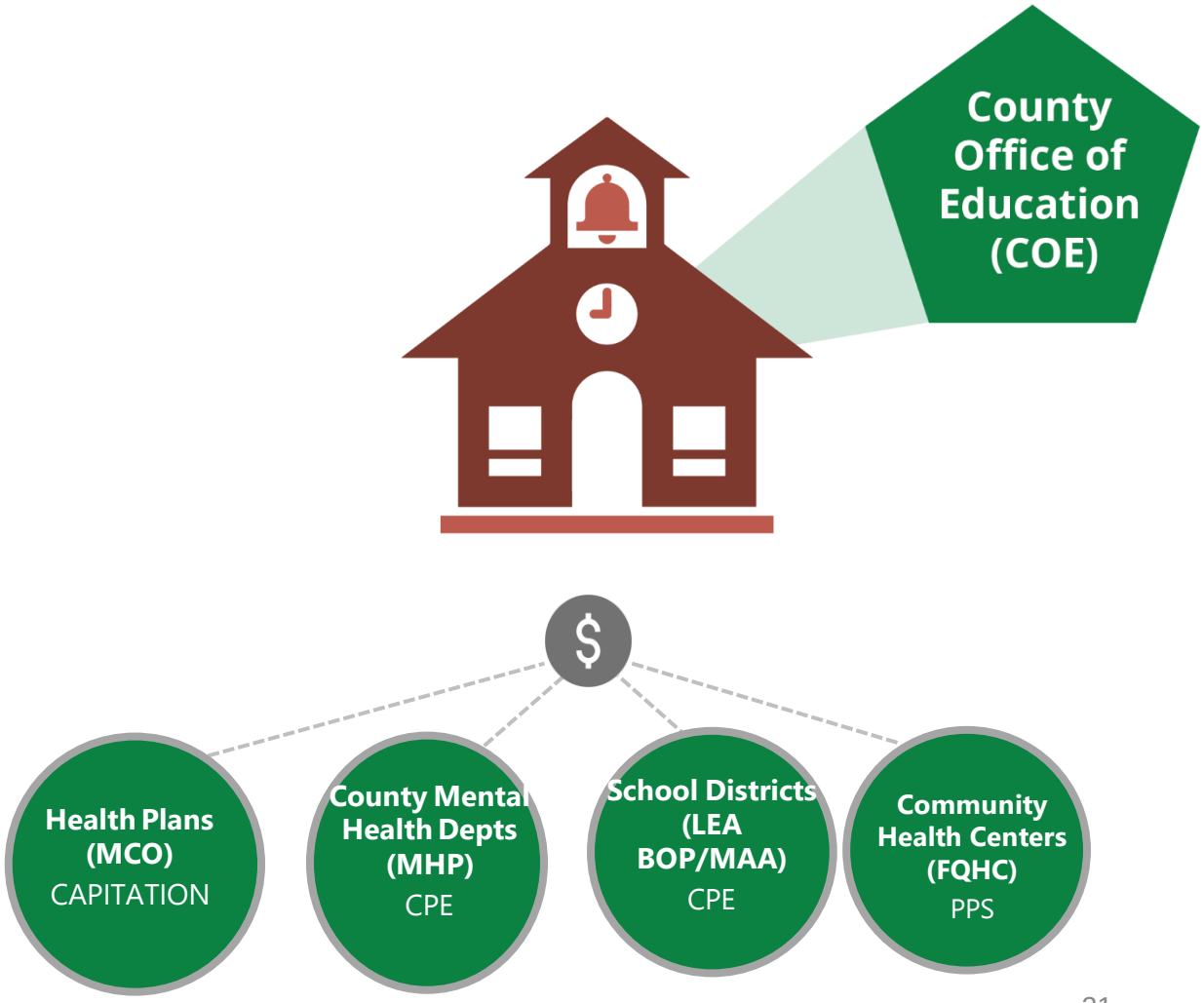
THE COUNTY OFFICE OF EDUCATION MODEL

County Offices of Education are increasingly acting as an intermediary between a school district (or several districts) and the county health department to directly provide mental health services (like a CBO) as well as serve as the intermediary that offers professional development and other health and wellness services and site coordination functions.

County Offices of Education already interface with school districts regularly through oversight of LCAPs, so there is often a relationship established between the two entities.

Revenue streams: EPSDT, LEA BOP/MAA, MCO, FQHC (potentially)

Examples: Fresno County Office of Education, Sacramento County Office of Ed or Solano County Office of Ed



WE HAVE A ONCE-IN-A-GENERATION OPPORTUNITY TO ADDRESS THE CRISIS

Public opinion and policymaker agendas are aligned

Political Will: New administration has a stated focus on children's well-being and has expressed interest and willingness to engage.

Community Support: Half (52%) of all Californians say their community does not have enough mental health providers to serve local needs.

Emerging Consensus and Consciousness: Of the impact of adversity, structural racism, and the pandemic on the social and emotional health of children.

TO TAKE ADVANTAGE OF THIS MOMENT IN TIME WE MUST:

- Embrace the critical need to reform our financing and delivery models in schools so that they are healing and relationship centered.
- Adopt a concurrent but aligned paradigm shift across child serving systems, with particular focus on the role of MediCal in schools.

WHERE CAN WE HAVE THE BIGGEST IMPACT?

Support technical assistance and capacity building efforts	Fund systems change efforts	Incentivize cross-sector collaborations and host convenings	Fund Timely Programmatic and Professional Development opportunities	Act as a knowledge broker	Provide risk capital to create sustainable models
Provide planning grants, feasibility study or training for school districts to develop and assess their own Medicaid billing strategies to sustain.	Invest in local community advocacy efforts and statewide reform - CalAIM, CDE, DHCS, SB 75, waiver.	Take a lead role in hosting conversations between a school district, local county agencies and local providers to identify which partnership model and funding mechanisms will best support the district's vision on healing-centered schools.	Invest in CBOs to partner with school districts to provide services and/or professional development to invest in training for staff (i.e. restorative justice, implicit bias training, racial justice initiatives).	Support and disseminate case studies and other research to share best practices and effective models.	Provide upfront one-time investment for public sector agencies to use as the non-federal share to unlock more Medicaid resources to expand services and build just and equitable models.

SYSTEMS CHANGE IN PRACTICE

Federal, state, and local systems leaders are increasingly active at the nexus of health and education.

HERE ARE REFORM INITIATIVES TO TRACK:

- SB75: MediCal For Students
- LEA Billing Option Program State Plan Amendment (SPA) Implementation
- MHSA Mental Health Student Services Act
- DHCS Family Therapy Medical Necessity Guidance
- ASES Funding Expansion and Leveraging Opportunities

SYSTEMS CHANGE IN PRACTICE

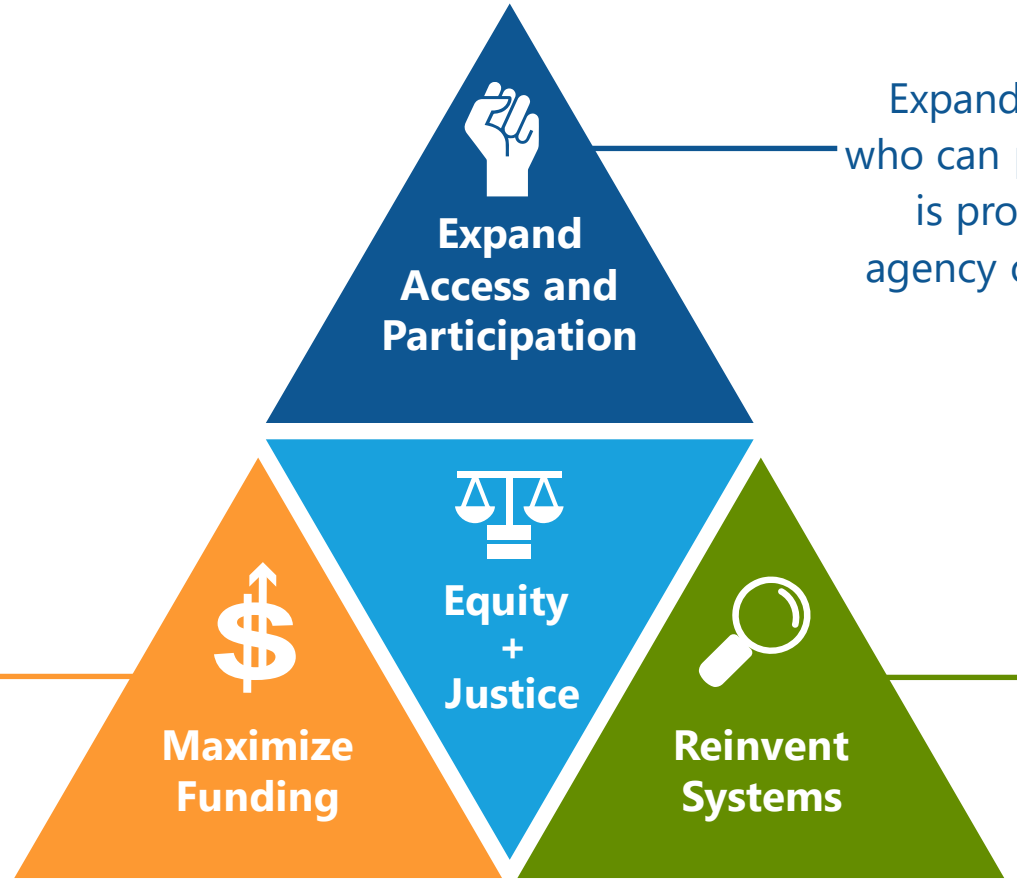
Federal, state, and local systems leaders are increasingly active at the nexus of health and education.

HERE ARE SOME (NOT ALL!) **REFORM INITIATIVES TO TRACK:**

- CalAIM (MediCal Reform Initiative)
- HHS/DHCS Behavioral Health Taskforce
- AB 2083 System of Care Implementation
- FFPSA Adoption and Implementation
- CARES/Stimulus/100% FMAP Campaign

WHAT WILL CALIFORNIA DO—
AS THE FIFTH LARGEST ECONOMY IN THE WORLD—WHEN IT SEES THAT TWICE AS MANY OF ITS CHILDREN ARE TRYING TO KILL THEMSELVES?

THIS IS THE TRUST'S FRAMEWORK FOR SOLUTIONS



Expand who is eligible, who can provide care, what is provided, and the agency of the beneficiary

Increase state and county spending, and fully claim the federal match

Increase transparency and accountability

1 **Root Causes**

The BIG THREE: A Recommendation for each of the major payors…

1) Increase the role and function of MCO (Health Plans) in school-based services

-Direct DHCS and DMHC to collaborate to explore strategies to increase MCO investments in school-based services and explore creative partnerships with FQHCs—essential community provider status is one route.

- Formal requirements (in DHCS contract w MCOs) to develop care coordination and case management contracts with school based culturally relevant community-based organizations.

2) Fundamentally reform The LEA BOP and SMAA program by adding a supplemental payment program.

-Augment the LEA BOP program's cost-based reimbursement model with a supplemental payment program that calculates the unreimbursed costs of eligible services in LEA's and seeks federal matching funds. (As demonstrated by Pediatric Trauma SPA, Disproportionate Share Program, Private Hospital Supplemental Fund, The Reimbursable Advance).

3) Reform EPSDT specialty MHP claiming methodology to encourage braided funding solutions

- Reform medical necessity definition (remove diagnosis and pre requisite for care for Specialty System.

- Develop claiming models (IGT) that allow EPSDT claiming on existing expenditures in other child serving Systems (as demonstrated by Whole Person Care)

STAY CONNECTED FOR MORE

@CAChildrenTrust

California Children's Trust

www.cachildrenstrust.org

alex@cachildrenstrust.org