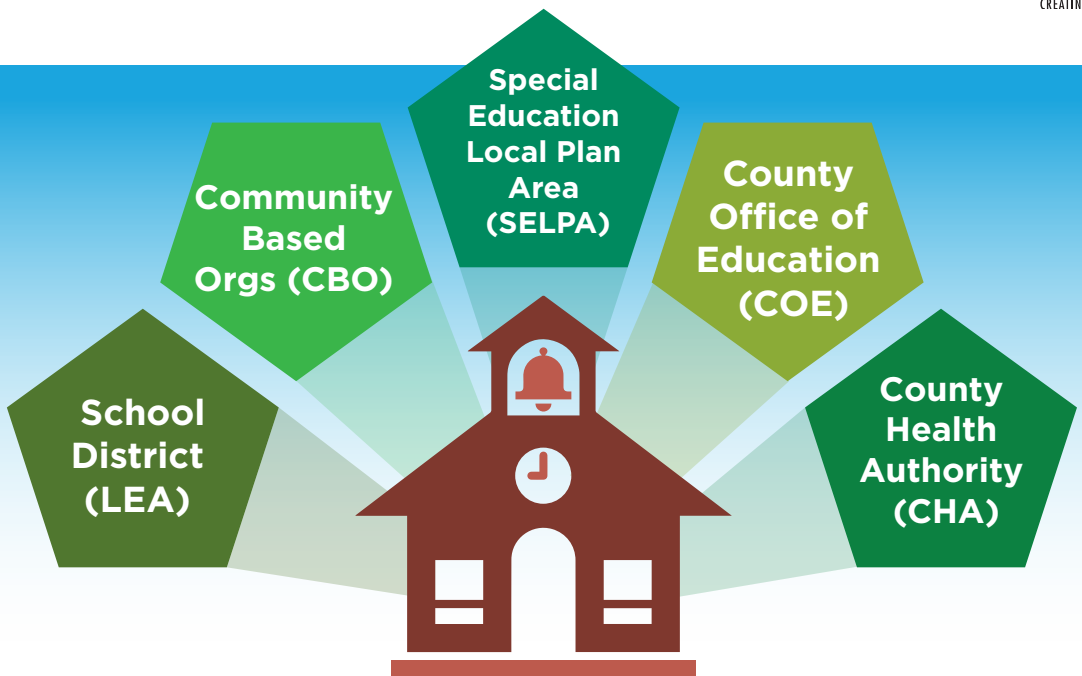
Practical Guide for Financing Social, Emotional, and Mental Health in Schools

A guide for school district leaders interested in exploring partnerships and accessing Medi-Cal to meet the social, emotional, and mental health needs of students in schools

California Children's Trust

breaking barriers
CREATING A COMMUNITY OF CARE



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The California Children's Trust (The Trust) is a statewide initiative to reinvent our state's approach to children's social, emotional, and developmental health. We work to transform the administration, delivery, and financing of child-serving systems to ensure that they are equity driven and accountable for improved outcomes. The Trust regularly presents its Framework for Solutions and policy recommendations in statewide and national forums. Learn more at www.cachildrenstrust.org.

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Breaking Barriers

Breaking Barriers is a collaborative of leaders from across child-serving systems throughout California who are united by the conviction that only through collaborative planning and problem solving can we ensure the educational, social, emotional, and behavioral well-being of California's children and youth. The 5th Annual Breaking Barriers Interagency Symposium is taking place online this fall. To learn more and register for the conference, visit www.breakingbarriersca.org.

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Introduction

Even before COVID-19, there was a youth mental health crisis. In the decade prior, children and youth ages 5-19 in the U.S. experienced a 52% increase in mental health hospitalizations.[1] And suicide is the second leading cause of death among young people ages 15 to 24.[2] The current global pandemic has created further anxiety and stress, and exacerbated and deepened equity divides. **Schools are critical to leveraging any solution addressing the youth mental health crisis at scale.** Not only are schools in direct, regular communication with children and youth, but schools can explore creative financing strategies to support a continuum of services.

Medicaid, known in California as Medi-Cal, can and should be a strategic tool used to support and expand social, emotional, and mental health services in schools at scale and address complex trauma that students from under-resourced communities are facing. Despite the known shortcomings, Medicaid is the third largest federal funding source in schools after Title I and the Individuals with Disabilities Education Act (IDEA). More importantly, in California, Medi-Cal funded services have the potential to grow significantly in schools. California has the nation's largest Medicaid program, and the number of children in the program is growing dramatically. Since 2014, there has been a 30% increase in the number of children in the program. Medi-Cal has the potential to do far more than relieve some budgetary pressures felt by districts: Medi-Cal resources should be seen as a critical component of a comprehensive district-wide strategy and approach to supporting students' healthy development and healing-centered community schools[3]. While districts can rethink academic and student support services based on this approach, an effective and sustainable solution may also require external partnerships to implement strategies.

After a "crash course" in Medi-Cal, this guide will present five different ways school districts can partner with state or county-level agencies to access Medi-Cal and expand billable mental health services for their students. These models are not mutually exclusive and some districts are already utilizing several different strategies.

The guide then addresses the steps that district leaders can take to utilize untapped Medi-Cal funds to help create an integrated, coordinated, and sustainable system of social, emotional, and mental health support for students.

Finally, we provide some additional resources and a glossary where school district leaders can find more information and learn about these approaches. While it is not possible for us to provide all the necessary details in one document, district leaders can use this guide to further build out their social, emotional, and mental health strategies and better understand available Medi-Cal resources to support a whole child approach to learning.[4]

A WORD ABOUT TERMINOLOGY

The terminology in this paper is a compromise. We have purposely left out the term "behavioral health"—except when referring to an agency of that name—because members of our coalition have experienced the term "behavioral" as stigmatizing and not representing the impact of racism and poverty on the health of children. This paper uses the term "social, emotional, and mental health" to be inclusive of the social and emotional, substance abuse, mental health, and developmental challenges facing young people.

1 Torio CM, Encinosa W, Berdahl T, McCormick MC, Simpson LA. Annual report on health care for children and youth in the United States: national estimates of cost, utilization and expenditures for children with mental health conditions. *Acad Pediatr.* 2015;15(1):19-35. doi:10.1016/j.acap.2014.07.007 Retrieved from: https://pubmed.ncbi.nlm.nih.gov/25444653/

2 Curtin SC, Heron M. Death rates due to suicide and homicide among persons aged 10–24: United States, 2000–2017. NCHS Data Brief, no 352. Hyattsville, MD: National Center for Health Statistics. 2019. Retrieved from: https://www.cdc.gov/nchs/data/databriefs/db352-h.pdf

3 See Children's Trust issue brief on Healing-Centered Community Schools (To be posted fall 2020 at https://cachildrenstrust.org/our-work/

4 Darling-Hammond, L., & Cook-Harvey, C. M. (2018). Educating the whole child: Improving school climate to support student success. Palo Alto, CA: Learning Policy Institute. Retrieved from: https://learningpolicyinstitute.org/product/educating-whole-child-report

Reimagining Systems to Support Child Well-Being

This guide is intended to spur conversations about opportunities within the current scope of the behavioral health and education systems. That being said, fundamental structural reform is needed in both public systems for the promise of this partnership between behavioral health and education systems to be realized at the local level. It has been the experience of many education and behavioral health leaders that the effort required to access Medi-Cal funds is not necessarily worth the level of Medi-Cal revenue generated.

The administrative barriers and collaborative challenges are real. The recent changes to Medi-Cal could increase billing and there are more potential reforms on the horizon. **Given the rapidly growing number of students eligible for Medi-Cal, we strongly encourage education leaders to take a second look and take initial steps to set up or expand billable Medi-Cal programs as a strategy to improve social, emotional, and mental health support to students.**

STATE LEADERSHIP FOR REFORM: SB 75 MEDI-CAL FOR STUDENTS

The California Children's Trust and Breaking Barriers are partnering with the California Department of Education (CDE) and Department of Health Care Services (DHCS) on the SB 75 Medi-Cal for Students Workgroup. SB 75 is a statewide planning effort to improve access to Medi-Cal funded services and supports in schools. For more information, see the SB 75 workgroup website.

The California Children's Trust is actively working on necessary policy and systems level changes in California aligned to its Framework for Solutions to reimagine how the education and behavioral health systems can work together to better support the well-being of our students to address some of these barriers. This includes a goal of "removing diagnosis" as a precursor to receiving social, emotional, and mental health services so that a greater number of students can benefit and have access to support they need. The Trust is also actively pursuing strategies that would reduce the administrative burden and time requirements for school districts, and ultimately enable districts to greatly expand access to Medi-Cal resources to support a comprehensive plan centered on student wellness. The Trust seeks the support of educators throughout the state to help shape our agenda and ensure that Medi-Cal is optimized as a sustainable funding stream providing services to support the social, emotional, and mental health of students.

The needs of students and families are real and pressing. Expanding access to social, emotional, and mental health services must be a priority now and going forward, and there is no better time to begin this much needed work.

Medi-Cal 101: What School District Leaders Need to Know

A BITE-SIZED UNDERSTANDING OF MEDI-CAL

Medi-Cal financing can be distilled to a key concept: Think of Medicaid (known in California as Medi-Cal) as a pot of gold sitting in Washington, DC. To get a dollar from the pot, school districts have to put up a dollar and spend it on an eligible service, by an eligible provider, to an eligible beneficiary. Every Medi-Cal expenditure is part federal and part state or local. The key is identifying eligible non-federal dollars to draw down Medi-Cal.

Medi-Cal is a complex and fragmented system, and it will take more than just one overview or one discussion to fully grasp the ways that the resource can be used as a tool to support students' mental health and social and emotional well-being in schools. To learn more about Medi-Cal financing and how it could be applied to school settings, see The California Children's Trust's recent publications *Financing New Approaches to Achieve Child Well-Being* and *Medi-Cal Financing Detail and Sources*.

What Is Medi-Cal?

- Medicaid is a federal entitlement program that provides free or low-cost medical services, including mental health services, for children and adults with limited income and resources.
- Medicaid is the third largest federal funding source in schools after Title 1 and IDEA. Each year, schools across the country bill for $13-$14 billion dollars in Medicaid.
- The program is federally funded but administered at the local level; it can take a circuitous path for federal reimbursement to get to local agencies, particularly schools.
- Each state negotiates its own Medicaid plan with the federal government about how the program is administered. In California, Medi-Cal is administered by the Department of Health Care Services (DHCS). However, California uniquely delegates most of the Medi-Cal program to local jurisdictions. As a result, many of the essential partners for schools are county level public systems or health plans.
- Due to many factors California's current program tends to be administratively burdensome for school districts which may explain why in aggregate, California schools bill far less for Medicaid services than other states. As a result, California lags other states in tapping this valuable resource. For example, California spends $29 per Medi-Cal eligible child, while Montana generates over $500 per eligible child.[5]

Who Is Covered by Medi-Cal?

- Most students in public schools are covered by Medi-Cal and the number of students on Medi-Cal has increased significantly in recent years and will continue to grow. Before the current global pandemic, 6 out of 10 children across California were eligible for Medi-Cal. Enrollment in the program is projected to increase to 7 or 8 out of 10 children enrolled in public schools.
- Medi-Cal overlaps with Free and Reduced Lunch (FRL) yet has different eligibility qualifications: Medi-Cal covers children living in households with incomes under 250% of the Federal Poverty Level (FPL). FRL includes eligibility at or below 130% FPL for free meals (185% for reduced-price meals).
- Children under 19 years of age are eligible for Medi-Cal benefits regardless of immigration status, as long as they meet the income standards. In other words, undocumented students can qualify for full Medi-Cal benefits.

5 Expenditure Reports from Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) Retrieved from: https://www.medicaid.gov/medicaid/financial-management/state-expenditure-reporting-for-medicaid-chip/expenditure-reports-mbescbes/index.html

How Does the Medi-Cal Program Work?

- To draw down federal Medicaid (Medi-Cal) funding (called federal financial participation or "FFPs"), public systems must identify eligible matching funds from non-federal sources (these are called certified public expenditures or "CPEs"). The federal share of Medicaid (FFP) is a guaranteed match, or uncapped resource.
- Numerous state, county, and local funds can qualify for this "non-federal match." It is critical for districts to think creatively about what counts as a match.
- Some Medi-Cal programs operate on a cost reimbursement basis, which means that districts must provide upfront investment (staff time and dollars) and bill for reimbursement of those services that are received on a quarterly or annual basis. Other Medi-Cal programs operate on a fee-for-service or interim reimbursement model. The lag time often acts as a disincentive and a barrier for school districts to participate. For the sake of simplicity, we will refer to Medi-Cal as a revenue source in this document.

THE FEDERAL MATCH IS GUARANTEED

Federal FInancial Participation (FFP) = The Federal share of Medicaid dollars—GUARANTEED match without limit or cap

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.

LEVERAGING ONE-TIME INVESTMENTS

One-time funds can be used as seed funding to support the upfront investment needed to establish a student mental health and well-being program that could then be supported by Medi-Cal reimbursement. The Mental Health Services Oversight and Accountability Commission (MHSOAC) recently awarded $75 million dollars over a four-year grant cycle to county behavioral health departments to fund partnerships between educational and county mental health agencies to provide mental health support services on school campuses. School districts could partner with their county agencies to explore similar opportunities and jointly apply for grants to start a program that fits in the social, emotional, and mental health continuum of services.

Potential "non-federal" funding sources include:		Federal funding that *does not* qualify as a match includes:
✓ Local Control Funding Formula (LCFF)	✓ Local parcel taxes	× Title I
✓ State Special Education funding, including AB 114 funds	✓ First Five Commission (Proposition 10) funds	× Title II Part A
✓ After School Education and Safety (ASES) funds	✓ Mental Health Services Act (Proposition 63) grants	× Title III
✓ Community Schools grant program	✓ County General Fund dollars	× IDEA
✓ Philanthropic investments[6]	✓ State Realignment funds	× 21st Century Learning Center
	✓ State Juvenile Probation grants	× CARES Act
	✓ California Cannabis Tax Fund (Proposition 64)	

6 Using philanthropic funds as CPE is possible but will require a partnership with a public agency.

How Does Medi-Cal Funding Work for Schools?

Medi-Cal resources flow from the federal to the local level through several different public system entities. Each of these public systems has direct access to federal Medi-Cal matching funds. Each revenue stream has different requirements for eligibility and services.

The primary established Medi-Cal revenue streams for schools are:

Local Education Agencies (LEAs)

School districts, County Offices of Education, and SELPAs can bill directly for Medi-Cal services by participating in the Local Education Agency Medi-Cal Billing Option Program (LEA BOP) and also recoup administrative costs by participating in the Schools Medi-Cal Administrative Activities program (SMAA). As of April 2020, the LEA BOP has been improved by expanding eligibility for services and removing restrictions for providing services to general education students. (See box below.) Conservatively, this could mean a 30% increase in billing through this program (from $140 million to $180 million).

County Mental Health Plans (MHP)

County MHPs are federally designated health plans that manage the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) mental health benefit for children. County Mental Health Plans are often called County Behavioral Health Departments. County MHPs also control Prop 63/MHSA funds. The most common example of school-based mental health services financed by Medi-Cal are County Mental Health Plans, usually contracting with CBOs to locate and staff services at school sites. School districts can explore creative financing strategies with their local Mental Health Plans to generate federal matching funds. For example, school districts could work with their County Mental Health Plans to generate federal matching funds for city and county funding for after-school or youth development programs by billing for eligible services such as care coordination.

Local Government Agency (LGA)

School districts can expand both clinical and non-clinical Medi-Cal funded services by partnering with their Public Health Department to claim Targeted Case Management (TCM) and County-Based Medi-Cal Administrative Activities (CMAA). County Public Health Departments (as distinguished from Mental Health Plans in County Behavioral Health Departments) can claim federal matching funds for public health nursing, some case management functions, and for programs and services that link children and families to services. Examples are home visiting programs or community-based organizations such as family resource centers that offer care coordination and referral services for children and families.

In addition, collaborations with Federal Qualified Health Centers (FQHCs) and Managed Care Organizations (MCOs) show promise as revenue streams:

Federal Qualified Health Centers (FQHC)

Community health centers can directly bill for mental health services. There are approximately 277 school-based health centers in California. For many, there may be potential new billing options with the new "mild to moderate" benefit and the new family therapy guidance from DHCS. There are a few emerging models of this intermediary/school district partnership such as what Sacramento County Office of Education is exploring.

County Medi-Cal Managed Care Organizations (MCO)

Since the "mild to moderate" mental health benefit

NEW OPPORTUNITIES TO EXPAND THE LEA BOP PROGRAM!

California's LEA BOP program was recently changed through a State Plan Amendment (SPA) so more students can qualify for services through this entitlement. This can increase reimbursable services to reinvest in other health programs and offset the contribution the district is already investing to support these programs with general fund dollars.

The SPA to the LEA BOP program now includes:

- Extension of dollars to general education
- Expansion of eligible providers and services

Additional guidance from DHCS is forthcoming and trainings are underway. School district leaders can sign up for the DHCS listserve to receive details and updates. While these changes are encouraging and some districts will benefit long-term, The Children's Trust believes fundamental structural change to the mental health system is necessary to meet the alarming rates of increased mental health needs of students.

was created in 2014,[7] MCOs are increasingly important actors in the children's social, emotional, and mental health landscape. MCOs are licensed health plans contracted by the state and include public health plans and private health plans. Every county has one or more health plans serving children in Medi-Cal. CCT is working to increase the function of MCO health plans in school-based mental health services. Few health plans partner with schools and this is an important and emerging opportunity for public education. School districts are encouraged to partner with local health plans to explore co-location of services and/or blended contracts with community-based providers. To learn more about which MCOs operate in your county, go to the DHCS Managed Care website.

What Does Medi-Cal Pay For?

School districts can bill Medi-Cal for direct services when eligible health services are provided by eligible providers to eligible students. Examples of billable direct services include mental health assessments, therapy and mental health services, and crisis intervention. In essence, school districts can bill Medi-Cal if the following conditions are met:

- **Eligible Student =** The student is enrolled in Medi-Cal
- **Eligible Service =** The health service is medically necessary
- **Eligible Provider =** The health service is provided by a licensed professional, most often a clinician or social worker

School districts can also bill Medi-Cal for certain costs of administering the Medi-Cal program, known as Medi-Cal Administrative Activities (MAA). Examples of administrative activities include outreach, enrollment, program planning, care coordination, and claims administration. A key difference in this program is that students without a "medical diagnosis" are eligible for services and these services do not have to be conducted by licensed professionals. Furthermore, MAA does not require the identification of an individual Medi-Cal beneficiary—and it is outcome agnostic meaning that the activity being billed for does not necessarily have to produce a specific result in order to generate revenue. Instead, districts bill for time spent on claimable activities. For example, districts can bill for the time staff spend on outreach to students and are not tied to the number of students that enroll or connect to services.

Many school districts are already doing these types of activities and may not be maximizing Medi-Cal reimbursement. **Billing more under Medi-Cal administrative activities could generate additional revenue for school districts to reinvest in the program to better support social, emotional, and mental health services.** For example, school districts could partner with their county health agency to bill for services provided by after-school staff (district or contracted); funds generated by this program could be used to hire additional after-school staff, trained in youth development principles to provide and support social and emotional learning activities. As another example, school districts could explore emerging opportunities to bill Medi-Cal for restorative justice or community school staff under administrative claiming mechanisms.

There are different requirements and billing rates for direct services and administrative activities. As a general rule, the higher the Medi-Cal billing rate, the more restrictive the requirements.

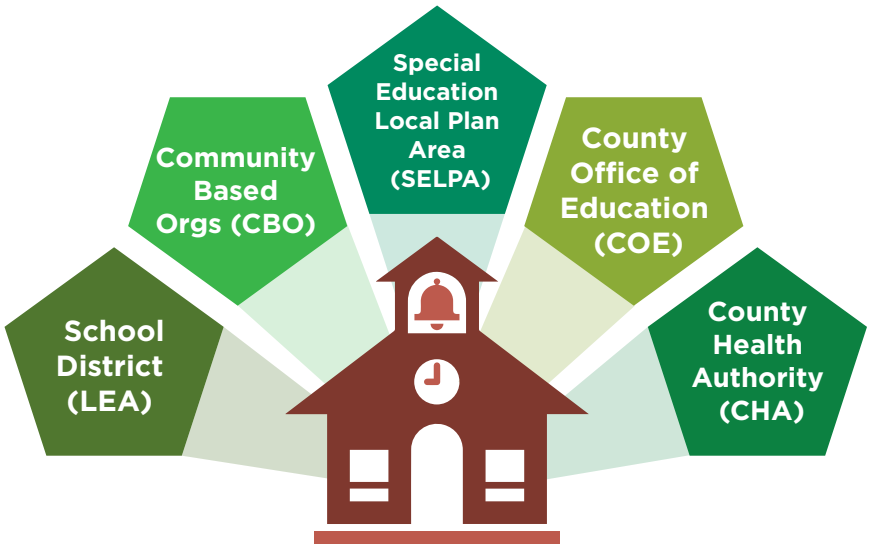
DIRECT AND ADMINISTRATIVE SERVICES	
DIRECT SERVICES	**ADMINISTRATIVE SERVICES**
EXAMPLES	
Mental health assessment Therapy Mental health services Day rehabilitation Day treatment intensive Crisis intervention/ stabilization Targeted case management Therapeutic behavioral services *For a complete list of billing codes, check DHCS website.*	Outreach and enrollment Care coordination and monitoring Transportation Referral Eligibility determination Program planning Policy development Interagency coordination *For a complete list of billing codes, see this DHCS training.*
ELIGIBILITY	
Requires medical "diagnosis" to receive mental health services	Does not require medical diagnosis
PROVIDER QUALIFICATION	
Licensed clinicians and social workers	No clinical license required
REIMBURSEMENT	
100% of eligible activity qualifies for reimbursement	50% of eligible activity qualifies for reimbursement

7 For more information on mild-to-moderate, see: Kingdon, D, Brassil, M, Jones, E. (2016) California Health Care Foundation. *The Circle Expands: Understanding Medi-Cal Coverage of Mild-to-Moderate Mental Health Conditions.* https://www.chcf.org/publication/the-circle-expands-understanding-medi-cal-coverage-of-mild-to-moderate-mental-health-conditions/#related-links-and-downloads

Five Ways That School Districts Integrate Medi-Cal Funded Supports for Students

There are five primary models through which California school districts integrate Medi-Cal funded mental health services into school settings:

1. **Local Education Association (LEA) or School District Model**
2. **Community-Based Organizations (CBO) or Nonprofit Model**
3. **Special Education Local Plan Area (SELPA) Model**
4. **County Office of Education (COE) Model)**
5. **County Health Authority (CHA) Model**



These models are not mutually exclusive: Districts can utilize more than one of these structures to support their continuum of mental health services and access different reimbursement streams.

For example, a school district could have an established LEA BOP program and bill for services provided directly by staff, become vendorized through the county to support a counseling enriched class, and contract with local community-based providers to provide services. Geography, availability and quality of community-based providers, and internal capacity of school districts to bill Medi-Cal and/or provide Medi-Cal funded services are key considerations in the district's decision making. In other words, context matters in deciding which models make sense in establishing partnership for mental health services and there is no one right answer.

Districts can also partner to access additional revenue streams through Managed Health Plans (MHPs), Managed Care Plans (MCPs), the Mental Health Services Act (MHSA), and Federally Qualified Health Centers (FQHCs). School districts can work with partner agencies to explore accessing additional sources of public and private revenue (local taxes, philanthropy) that can be used as the non-federal match for Medi-Cal.

These partnership models are aligned with other efforts gaining momentum in the education field such as the community schools approach.[8] The current pandemic has further demonstrated the need and opportunity for school districts and public agencies to work cross-sector, particularly at the intersection of health and education.

The two essential questions school leaders must wrestle with are:

1. **Who will handle the administrative burden of securing Medi-Cal reimbursement?**
2. **Who will employ the staff and deliver services to children and families?**

We encourage you to hold these questions in your mind as you work through this document and review each model.

8 Community Schools Playbook (2018). Partnership for the Future of Learning. Retrieved from: https://communityschools.futureforlearning.org/

LOCAL EDUCATION AGENCY (LEA) OR SCHOOL DISTRICT MODEL

Through the **Local Education Agency Medi-Cal Billing Option Program (LEA BOP)**, school districts provide and bill for services directly through DHCS. This program is a cost reimbursement program, meaning districts must provide the upfront investment to hire and fund staff positions (or contract out) to deliver services and DHCS provides federal matching funds after the fact. In other words, school districts provide the non-federal share (match) through their staffing costs or contracts. To claim the federal match through the LEA BOP school districts must have an eligible expenditure to claim matching funds against.

This is the only model in which a school district bills Medi-Cal directly for school district staff.

School district participation in LEA BOP has been low; less than half of the districts in California participate.[9] However, recent changes through the Special Plan Amendment (SPA) will allow more opportunities to bill Medi-Cal for services. (See box on pg. 6.) Participating districts should revisit their LEA BOP to ensure they are maximizing revenue; those not participating should explore fiscal projections given the changes to see if it makes sense to pursue this reimbursement program. Additionally, a district can become an approved provider through County Mental Health Plans and provide Medi-Cal services by becoming an approved EPSDT provider of Medi-Cal services (specialty mental health services through MHPs). In such cases credentialing, invoicing, and billing for reimbursement are done through the county health department. A contract between the school district and the county health agency is required for the school district to bill EPSDT services.

MEDI-CAL REVENUE STREAMS:
MHP/EPSDT, LEA BOP/MAA

• EXAMPLE •

Los Angeles Unified School District (LAUSD) has the largest Billing Option Program in the state and was billing ~$15.5 million through LEA BOP prior to the pandemic. Before the SPA, LAUSD billed BOP primarily for special education services including assessments and counseling services for students . LAUSD delivers these services by hiring staff and contracting with outside providers. Students have to have an IEP to receive these services. The SPA will help LAUSD expand LEA BOP billing by: 1) allowing LAUSD to bill for more positions in special education; and 2) allowing LAUSD to bill for more services for students who have a referral but not an IEP such as a vision and hearing assessment for a general education student, which is required by CDE but was not previously connected to any reimbursable public funding streams. Districts like LAUSD could now begin billing for these services with minimal additional upfront investment.

The revenue generated by the LEA BOP is then reinvested into health programs—including social, emotional, and mental health supports—as determined by an LEA Medi-Cal Collaborative, a requirement through the Provider Participation Agreement with DHCS. In LAUSD, the Collaborative is comprised of representatives from community partners (including county), parents, teacher's union, and district and school staff. They review proposals and decide how to reinvest the funds generated by the LEA BOP into programs. In LAUSD, funds are reinvested in the district's Healthy Start Program which uses case management to support and refer families to resources. Funds are also reinvested into 14 school-based health clinics to expand student support services. In addition to billing LEA BOP, LAUSD has an EPSDT contract with LA County Department of Mental Health, and a state contract with the Child Health and Disability Prevention Program.

9 LEA Program Paid Claims Data Reports. Retrieved from: https://www.dhcs.ca.gov/provgovpart/Pages/LEAReports.aspx

COMMUNITY-BASED ORGANIZATIONS (CBO) OR NON-PROFIT MODEL

School districts can partner with **community-based organizations (CBOs) or nonprofits** that can act as an intermediary (contract holder with Medi-Cal payor) and as the direct clinical provider. CBOs co-locate on school campuses as an approved provider under an MHP or MCO and under 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 (including mental health) services and handle all administrative and billing functions. CBOs often blend other public dollars and philanthropy to address reimbursement barriers or challenges.

MEDI-CAL REVENUE STREAMS:
MHP, MCO, FQHC

CBOs contract directly with health plans (MHPs and MCOs) to deliver services and handle all Medi-Cal billing.

• EXAMPLES •

Hathaway-Sycamores, a non-profit with offices throughout Southern California, works with 35 schools across 4 school districts in the Los Angeles County region (LAUSD, Pasadena USD, Alhambra USD, Hacienda La Puente USD). The agency hires their own clinical staff who are placed in full-time roles to work in teams on school campuses with their own dedicated space including a confidential area where clinicians can see student clients.

School-site teams include LCSWs and community wellness specialists providing Tier 1-3 services, coordinating with school site staff. The clinical staff provides 1:1 therapy and behavioral intervention while the community wellness specialists support Tier 1 strategies across campuses including social and emotional learning and wellness activities and other programs to build a positive and welcoming school culture. In addition to hiring and managing the staff, Hathaway-Sycamores handles the administrative and billing functions and receives reimbursement through a contract with the LA County Department of Mental Health through funding streams such as EPSDT, MHSA, PEI, and targeted case management funds. Hathaway-Sycamores employs 350-400 program staff—billing hours through these programs. Each district identifies a contact or departmental team lead (mental health, child welfare, or attendance departments) to work with Hathaway-Sycamores and monitor and respond to student needs. MOUs are coordinated between Hathaway-Sycamores and each school district either on a district-wide or individual school level.

Seneca Family of Agencies is a statewide non-profit providing comprehensive school and community-based services across the continuum of mental health needs. Seneca contracts with 12 counties and 55 districts in the Bay Area, Central Coast, and Southern California and partners with schools to offer therapeutic and behavioral services and counseling enriched classrooms. Seneca has created an innovative model called Unconditional Education,[11] which partners with the county and school district to braid public and private funding streams to create an integrated approach to social and emotional learning and mental health services in schools across the continuum of need. Seneca has been developing and piloting this program in both charter and district school settings including West Contra Costa Unified School District in Contra Costa County for five years. The agency recently published a book describing the model.

10 Unconditional Education: http://www.unconditionaleducation.org/our-model.html

SPECIAL EDUCATION LOCAL PLAN AREA (SELPA) MODEL

A **SELPA** can act as a school district's intermediary for Medi-Cal contracts and billing through the county health department, and can provide clinical services. 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.[11]

Historical partnerships (AB 3632 to AB 114) and the ability to serve multiple school sites characterize this model. SELPA services have historically been focused on IDEA programs and services. By contracting directly with the county health department or brokering services through a CBO, mental health services are available through various funding streams including EPSDT, MHSA, and targeted case management funds.

Requires strong expertise in Special Education and multi-district collaboration

MEDI-CAL REVENUE STREAM:
MHP

• EXAMPLE •

In 2003, the **Desert Mountain SELPA (DM SELPA)** was vendorized to be a local Medi-Cal provider delivering mental health services to students by billing EPSDT funds through the San Bernardino County Department of Mental Health. In response, an internal division known as the Desert Mountain Children's Center (DMCC) was created under the administrative umbrella of the Office of San Bernardino County Superintendent of Schools to act as the primary counseling center, through which mental health services are provided to Medi-Cal eligible youth, students with IEPs, and general education students throughout San Bernardino County's multiple school districts. The characteristics of the region— being a large, rural area with high rates of poverty— naturally lent itself to promoting collaboration among agencies, schools, and community providers. This unique internal approach, through which the DMCC has become the largest children's mental health provider in San Bernardino County, has allowed the districts in the DM SELPA consortium to implement tiers of mental health and behavioral support with flexibility, and coordinate services for special education and general education students into a single system using separate funding streams. Other programs followed including the first screening, assessment, referral, and treatment (SART) clinic in the county that was funded primarily through EPSDT funds from the county with a local match from First 5.

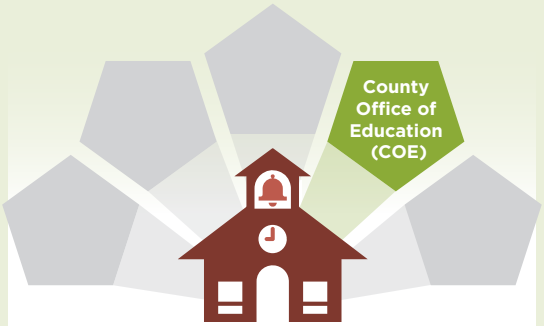
True to its motto, "The relentless pursuit of whatever works in the life of a child," the DM SELPA changed its governance structure to operate as a Joint Powers Authority (JPA) in 2015. As a separate legal entity, the California Association of Health and Education Linked Professions (CA HELP) consolidated responsibility and control over the various entities that serve children within its service area. Similar to a JPA for property and liability insurance or workers compensation, the member school districts accept the legal responsibility for all of the operations of the DMCC, the former DM SELPA, and the newly-formed DM Charter SELPA.

11 https://www.schoolhealthcenters.org/start-up-and-operations/funding/mental-health/ermhs/

COUNTY OFFICES OF EDUCATION (COE) MODEL

County Offices of Education (COE) are emerging as a newer model and increasingly acting as an intermediary between one or several districts and the county health department to provide mental health services as well as professional development, site coordination, and other health and wellness services.

COEs already interface with districts through oversight of LCAPs, budget adoption and monitoring, technical assistance and trainings, so this model can draw on existing collaborative relationships.



Leverages existing collaboration between County Offices of Education and school districts

MEDI-CAL REVENUE STREAMS:
MHP, LEA BOP/MAA, MCO, FQHC

• EXAMPLES •

Fresno County Office of Education (FCOE) is in its third year of a 5-year initiative called All 4 Youth, partnering with Fresno County Behavioral Health Department and local school districts and schools. The goal is to increase access to mental health services for all children regardless of Medi-Cal eligibility and insurance coverage, and to provide flexible, family-driven mental health services in the school, community, or home. FCOE acts as an intermediary between districts and the county behavioral health department and has formal and informal structures set up including a steering committee and interagency meeting. FCOE hires and trains licensed clinicians located at school sites to provide Tier 3 intervention services and at community hubs across the county to support students and families. FCOE also provides staff training for school districts funded through PEI grants on topics such as trauma resilience and brain development.

FCOE works with the county behavioral health department to handle Medi-Cal billing. The model is financed through a combination of revenue sources including Medi-Cal (EPSDT), MHSA (used as the non-federal match), and PEI. FCOE will work with various school districts to identify additional funds to expand the program including LCFF, AB 114, and LEA BOP. FCOE was recently awarded a $6 million grant through OAC which it will use to open (and in most cases construct) five wellness centers at or adjacent to a school campus.

New Program! After over a year of planning, in June 2020 **Sacramento County Office of Education (SCOE)** announced a new partnership with the Sacramento County Department of Health Services to provide a mental health clinician (LCSW or LMFT) at every school in the county over the next several years to shape schools into "centers of wellness" in their communities. Clinicians will provide services to students 1:1 and in group settings and will also work with school staff on relationship building strategies to improve school culture and climate through an MTSS approach. There will also be student-led initiatives to support these efforts. In the first phase in fall 2020, 11 school sites identified as the highest need across the county will participate. The clinicians will be Medi-Cal funded SCOE employees, with ongoing training and professional development also funded through SCOE. In this model, SCOE is acting as the direct provider of Medi-Cal services and is able to invoice and bill directly to access Medi-Cal reimbursement using the county's federally qualified health center (FQHC) status for its school sites. It is estimated that it may take up to three years before the Sacramento County Department of Health Services receives all the revenue via federal reimbursement that can be reinvested to sustain the program.

COUNTY HEALTH AUTHORITY (CHA) MODEL

County Health Authority (CHA)[12] can serve as a school health-specific intermediary. In this model, the CHA acts as both direct provider of services and biller. Often, the CHA contracts out to CBOs or LEAs to deliver services to a school site, but county clinical staff also provide some 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.

Consolidates relationships between and among payors, which leads to streamlined operations

MEDI-CAL REVENUE STREAMS:
MHP, MCO, FQHC, CMAA

• EXAMPLES •

For over 20 years, Monterey County has exemplified a strong partnership between the **Monterey County Behavioral Health Agency (MCBH)** and County Office of Education (MCOE) SELPA formalized through an MOU and Interagency Agreement. Monterey County has 25 school districts and 130 school sites. MCBH is responsible for staffing and training clinicians placed at schools. All Monterey County students with IEP designated mental health needs receive mental health services provided by the County. MCBH bills Medi-Cal for the EPSDT services. Additionally, MCBH has MOUs with districts to provide services for students that are not IEP involved but present with mental health needs, through the Services to Education program. MCOE complements this work by supporting PBIS implementation and the Interconnected Systems Frameworks at school sites. Districts contribute to the cost of on-site clinicians. The School Climate Transformation Leadership team coordinates between MCBH, MCOE SELPA, and districts to integrate mental health services across schools, and participating schools hold school site meetings with the district team. Currently Monterey County Behavioral Health has 46 clinical staff designated to the Services to Education program.

Alameda County Behavioral Health (ACBH) is an advanced model of a school district-county health department partnership. In 1999, Alameda County developed a department to act as an intermediary between school districts, service providers (CBOs), and the health department. ACBH is the main provider of Medi-Cal services, holding the contracts for EPSDT funding and directing these dollars to CBOs on school campuses. In Oakland, ACBH partnered with Oakland Unified School District on a bond measure to finance the construction of school-based health clinics at middle and high schools. Community-based providers operate the community clinics and hold contracts to deliver Medi-Cal funded mental health services. The Center for Healthy Schools and Communities, alongside ACBH, provides the coaching, technical assistance, and start-up funding to school districts in Alameda County on how to build sustainable systems and infrastructure needed to support these funding streams. These mental health services were built with existing school climate and prevention practices in mind, understanding that a tiered approach to intervention with multiple funding streams and practices must be in place to reach all students. ACBH is able to reach over 200 schools across Alameda County's 18 school districts through the School-Based Behavioral Health Initiative (SBBHI).

12 Each county organizes its services differently. Other names used include: health agency, behavioral health care agency, mental health agency, public health departments.

Five Actions School Leaders Can Take Now

Commit to social, emotional, and mental health as a district priority: Identify activities (immediate, short, long-term) that can be done to address the youth mental health crisis which has only grown more stark during the current pandemic.

Identify your key collaborators: Connect with your thought-partners and potential agency collaborators. If applicable, determine who will provide the services and who will do the billing.

Prepare financial scenarios: Determine your Medi-Cal eligible student population. Identify the costs you are incurring that can be claimed from direct and administrative services. Estimate the new and/or additional Medi-Cal revenue that could be generated.

Design your partnership: Develop the new, enhanced, or expanded services to be financed with the new and/or additional Medi-Cal revenue. Convene a working group to apply the step-by-step process outlined in the next section.

Execute your strategy: Bill Medi-Cal for services and ensure revenue is reinvested to support students' social and emotional well-being.

Steps to Integrate Medi-Cal into a Coordinated System of Supports

The following is a recommended step-by-step process by which school districts and their collaborating local partners can plan the expansion of Medi-Cal funded services.

STEP ONE: Deepen Your Understanding of Student Needs in Your District	
KEY ACTIONS	**CRITICAL QUESTIONS AND STRATEGIC TIPS**
Review the existing plans and documents that articulate student needs and current strategies to support their academic and social emotional well-being.	Key documents include: + Local Control Accountability Plan (LCAP) + SELPA Local Plan + Single Plans for Student Achievement (SPSA) + Strategic Plan
Consolidate data on student demographics, social, emotional and mental well-being, and needs.	+ California Dashboard, CA Healthy Kids Survey, KidsData, Race Counts, CANS + Use proxy indicators to estimate students who are Medi-Cal eligible, e.g., free/reduced meals, student level data in Title 1 schools + Review students receiving mental health related services through IEPs[13]
Convene key stakeholders to contextualize the data and understand the root causes.	+ Engage a diverse cross-section of individuals that can represent various perspectives including school and district leaders, teachers, students, families, and community partners.
Develop consensus among your team regarding the students most in need of mental health services.	+ Which populations, schools, neighborhoods, or regions in your district are the highest priority?

13 Note that the non-federal portion of your school district's AB 114 funding could be used as the state and local match to draw down federal Medicaid funds.

STEP TWO: Evaluate Your District's Current Approach to Social, Emotional, and Mental Health Services and Identify Gaps

KEY ACTIONS	CRITICAL QUESTIONS AND STRATEGIC TIPS
Map the current array of programs to support student services.	+ What social, emotional and mental health services are students provided? How are they funded? How effective are they? + Do schools have established Coordination of Service Teams (COST)? + How do schools invite student and family engagement in district and school-level decision making? + Where are the gaps in services and supports?
Map the supports available to staff.	+ Are staff trained in best practices in social and emotional learning[14] (i.e., trauma-informed and healing-centered approaches, implicit bias)?
Identify your framework.	+ Does your district have an MTSS strategy including social, emotional, and mental health services and supports for students? + What enhancements can you make to the framework based on the student data and landscape assessments above? + If you do not have an MTSS strategy, how can you build a comprehensive framework that can be used to guide your approach?
Assess your district's current Medi-Cal strategy.	+ Are you leveraging Medi-Cal reimbursement to provide mental health services? + Are any current district expenditures potential Certified Public Expenditures eligible to draw down Medi-Cal reimbursement?

IMPROVING COLLABORATION AND COORDINATION IN THE CHILD SERVING SAFETY NET

Since the mid 90s, California's local safety net has collaborated on the principles of a Children's System of Care. AB 2083 is built on these principles and encourages local collaboration among and between child-serving systems and formalized agreements through a Children and Youth System of Care MOU. The bill outlines a system of care model for local public agencies (County Child Welfare, Probation, County Office of Education, Regional Centers, Department of Rehabilitation Regional Office, and other local partners as desired) in each county, to work collaboratively to address the needs of children and youth, and to provide services that are coordinated, integrated, culturally proficient, timely, and trauma-informed. School district leaders can the track the progress of AB 2083 within the county and align efforts. For more information please visit https://www.chhs.ca.gov/home/system-of-care/.

14 See The Collaborative for Academic, Social, and Emotional Learning (CASEL) https://casel.org

STEP THREE: Conduct Asset Mapping in Your Community

KEY ACTIONS	CRITICAL QUESTIONS AND STRATEGIC TIPS
Identify essential health and human service providers (public, private, and non-profit) in your community. **Invite key stakeholders to your school campus to understand current and future program offerings, align interests, and discuss potential collaboration to support students.**	+ What non-profits provide mental health services in your area and/or district? How are they funded? + Are there any programs, initiatives or trainings designed to support social, emotional, or mental health needs of students provided by your county office of education? Your county health authority? + What health plans are available in your county? Which ones are your students enrolled in? + What managed care organizations are in your county? Are they currently partnering with school districts?
Understand the MHSA resources available in your county using the MHSA Transparency Tool.	+ Develop an asset map of resources in your community that your school district can tap into when designing your model. + Are there county programs, hospitals, foundations, faith-based organizations, non-profits, etc. to tap into for support?

STEP FOUR: Select the Partnership Model(s) Most Appropriate for Your Needs

KEY ACTION	CRITICAL QUESTIONS AND STRATEGIC TIPS
Given the needs of your students and the current infrastructure and assets of your school community, determine which of the five School-Medi-Cal models (LEA, CBO, SELPA, COE, CHA) your district can pursue to leverage Medi-Cal to provide student services.	+ What are the pros and cons of: • Developing your capacity as a school district to directly administer Medi-Cal billing for mental health services to obtain federal reimbursement? • Hiring school district staff to provide services to students and/or directly contracting out the work to community-based agencies? • Partnering with another agency (CBO, SELPA, COE, CHA) to handle Medi-Cal billing and/or hire and supervise staff to provide services to students? + How will the Medi-Cal revenue model impact your cash flow projections? Can your existing cash management tools address the impact? + How can you plan for and/or absorb the impact of potential negative audit results? Can you establish a contingency to minimize the financial impact? + How can this work be integrated into the organizational structure? Is there a position or team ready to take on the tasks? Would a stand-alone position serve you best?

STEP FIVE: Create Formal Contractual Agreements for Your Partnership Model(s)	
KEY ACTIONS	**CRITICAL QUESTIONS AND STRATEGIC TIPS**
Determine what formal and informal structures are needed to support the delivery of services in the selected partnership model.	+ Clearly articulate any financial commitments between partners from the beginning. + Develop shared goals, outcomes, data collection and sharing agreements. + Identify individuals with primary responsibility to be decision makers and assign staff to be the day-to-day liaison between agencies (and between district and schools).
Create MOUs between partner agencies to define roles in partnerships and support with coordination and implementation.	Key issues to address in contract language: + Staffing +Facilities + HIPAA, FERPA, IDEA, and 504 Plans + Access to student records + Grievance procedures + Communication protocols
Manage and monitor the MOU upon execution.	+ Train staff involved in legal compliance and hold regular trainings (at least annually). + Regularly assess partnerships and data for results to ensure services are improving outcomes for students' academic, social, emotional, and behavioral health needs.

Conclusion

Never before has it been more important to build a robust and coordinated system of social, emotional, and mental health supports for students. COVID-19 has accelerated and exacerbated equity gaps and widely exposed the need for youth mental health supports—and the limited structures school districts and partners have in place to support and fund the services. Medi-Cal can and should be a sustainable financing strategy for social, emotional, and mental health supports for students. This Practical Guide lays out five models of partnership and outlines steps to selecting and pursuing the one that's right for your school district. Breaking Barriers has developed key partnerships with counties and school districts across the state to share knowledge about what an integrated and supportive behavioral health system can look like. The California Children's Trust is focused on a statewide policy agenda which would allow more students access to social, emotional, and mental health supports that they need. School districts play a critical role in addressing the youth mental health crisis. Now is the time for education and mental health leaders to come together in partnership to build strategies and reform systems to benefit our students' futures.

Additional Resources

The California Children's Trust's website provides more information about the Trust's policy agenda to reimagine the children's mental health system in California.

Breaking Barriers' 2019 Briefing Book and 2019 Tool Kit include more details and examples of integrated children's mental health systems. Also, a new publication and landscape analysis of related California initiatives will be available on their website in winter 2020.

Summaries of County-School Partnerships to Advance School Mental Health: A handy chart that outlines several counties across California that are funding school-based mental health services, all in various stages with their funding mechanisms and service delivery.

California School Based Health Alliance (SBHA) has a wealth of resources on their website including this brief on Public Funding for School-Based Mental Health Programs; SBHA and MHSOAC are also developing an Implementation Guide which be released in December 2020 that delves into further details about this topic including helpful examples of MOUs and job descriptions.

Alameda County Behavioral Health Initiative: A helpful overview and example of a County Health Authority partnership with local school districts (County Health Authority model).

Smart Financial Practices for School-Based Health Centers: An overview of Alameda County's school-based behavioral health initiative and the types of financing used to fund both prevention and intervention services. Check out the chart on Medi-Cal revenue streams on page 16.

Medicaid 101 for School Superintendents: An overview of the federal Medicaid program written for school superintendents by the ASSA, The School Superintendents Association, and Healthy Schools Campaign.

Guide to Expanding Medicaid Funded School Health Services: A detailed resource created by Healthy Schools Campaign and Trust for America's Health focused on Medicaid expansion in schools nationally.

Kaiser Permanente's Thriving Schools website and Playbook: This website and Playbook covers concrete steps schools can take to support staff and student well-being.

Learning Policy Institute's Partnership Brief on Community Schools: This brief outlines several models in which counties are partnering with local agencies to access funding and providing services to community schools. Highlighted in this brief are Alameda County, Los Angeles County, and Seneca Family of Agencies as models.

MHSOAC Brief on Schools as Centers of Wellness: This report (still in draft) highlights key principles and best practices of a comprehensive approach to schools as centers for wellness and healing. The MHSOAC website also has helpful information.

CalMatters Resource Guide: Links to different bills, articles, and resources from the CalMatters "Crisis in Mental Health" virtual discussion.

California AfterSchool Network (CAN): A Whole Child Health and Wellness Collaborative working with after-school providers and partner agencies.

Coordination of Services Team (COST) Guide: An overview of Alameda County's COST process: referrals, assessments, service delivery, tracking, and evaluation.

Medi-Cal Tracker by County: A quick overview of Medi-Cal enrollment and actions taken by different counties in California to protect the mental health safety net in response to COVID-19.

Glossary

AB 114, Special Education Transition	Signed in 2011, this law ended the state mandate on county mental health agencies to provide mental health services to students with disabilities. After the passage of AB 114, school districts are solely responsible for ensuring that students with disabilities receive special education and related services, including some services previously arranged for or provided by county mental health agencies. In some cases, school districts still contract with counties, or county-contracted providers, to provide mental health services to students with IEPs.
CMAA (County Medi-Cal Administrative Activities)	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 and high-risk populations, facilitating Medi-Cal applications, contracting for Medi-Cal services, and program planning and policy development.
COST (Coordination of Services Team)	A strategy for managing and integrating various learning supports and resources for students. In this model, multidisciplinary teams of school staff and providers meet regularly to identify and address student needs holistically and collaborate on linking referred students to resources and interventions that support academic success and healthy development.
DHCS (Department of Health Care Services)	The state agency charged with administering the Medicaid program for the federal government, known as Medi-Cal in California. The DHCS website has a wealth of information about how various Medi-Cal programs are administered.
EPSDT (Early Periodic Screening Diagnosis and Treatment)	An enhanced Medi-Cal 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 with mental health conditions that meet Medi-Cal 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 Specialty Mental Health Services	As provided by county Mental Health Plans, EPSDT Specialty Mental Health Services refers to the "moderate to severe" Medi-Cal mental health benefits that county behavioral health agencies are responsible for. Medi-Cal Managed Care Organizations (MCOs, i.e. health plans) are largely responsible for the rest of the EPSDT benefit for beneficiaries under age 21.
IDEA (Individuals with Disabilities Education Act)	Originally passed in 1975 and reauthorized in 2004, IDEA is the federal law that delineates the responsibilities of the public education system for individuals with disabilities from birth to age 22. Its primary tenets are "FAPE in the LRE" or a Free, Appropriate Public Education (FAPE) in the Least Restrictive Environment (LRE), in an effort to ensure that opportunities for access to general education peers and general education curriculum are maximized for each and every student/child with a disability to the extent most appropriate.
LEA BOP (LEA Medi-Cal Billing Option Program)	A program for LEAs to bill Medi-Cal for specific health and medical services provided to students and their families in the school setting. Services provided through this program include assessments, treatments, and targeted case management.

Many definitions were pulled from http://mhsoac.ca.gov/mhsa-transparency-glossary#A and https://www.dhcs.ca.gov/provgovpart/Pages/LEAGlossary.aspx

MAA (Medi-Cal Administrative Activities)	A program for LEAs to be reimbursed for staff activities necessary for the proper and efficient administration of the Medi-Cal program. The amount of reimbursement is based on an operational plan and periodic time surveys. The MAA program is separate from the LEA Medi-Cal Billing Option.
MCOs (Managed Care Organizations)	Managed care is a health care delivery system organized to manage cost, utilization, and quality. Medi-Cal managed care provides benefits and services to Medi-Cal members through contracted arrangements between the state oversight agency, DHCS, and individual MCOs who are paid a set-per-member per-month (capitation) payment for services.
LCAP (Local Control Accountability Plan)	A tool for local educational agencies (LEAs) to set goals, plan actions, and leverage resources to meet those goals to improve student outcomes. The plan is aligned with state funding that LEAs receive to achieve those goals and support the overall functioning of the LEA.
MHSA (Mental Health Services Act)	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. MHSA programs and services are intended to enhance, rather than replace, existing programs. A majority of MHSA funding goes to counties, and counties are required to submit three-year program and expenditure plans and annual updates.
MOU (Memorandum of Understanding	An agreement between two parties that is not legally binding, but which outlines the responsibilities of each of the parties to the agreement. These agreements may describe the relationship between counties, LEAs, and community provider(s) and outline the responsibilities and expectations of partnerships between the various entities.
MTSS (Multi-Tiered System of Support)	An integrated, comprehensive framework that focuses on Common Core State Standards, core instruction, differentiated learning, student-centered learning, individualized student needs, and the alignment of systems necessary for all students' academic, behavioral, and social success. MTSS is based in the principles of UDL, Universal Design for Learning, and is a tiered intervention model, with varying options for Universal, Targeted and Intensive Instruction and Interventions.
PEI (Prevention and Early Intervention)	One of five categories of expenditures in MHSA. This category is intended to fund programs and services that intervene prior to the development of serious mental health issues and catch mental health issues in their earliest stages to prevent long-term suffering. 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.
PBIS (Positive Behavioral Interventions and Supports)	A framework for enhancing the adoption and implementation of a continuum of evidence-based interventions to achieve academically and behaviorally important outcomes for all students. As a "framework," the emphasis is on a process or approach, rather than a curriculum, intervention, or practice. The "continuum" notion emphasizes how evidence- or research-based behavioral practices are organized within a multi-tiered system of support.
SELPA (Special Education Local Plan Area)	Consortiums in geographical regions with sufficient size and scope to provide for all special education service needs of children residing within the region's boundaries. Each region develops a local plan describing how it would provide special education services. SELPAs vary in size— some serve just one school district, some serve multiple school districts, some serve an entire county.