Date of Hearing: March 22, 2017

ASSEMBLY COMMITTEE ON EDUCATION
Patrick O'Donnell, Chair
AB 834 (O'Donnell) – As Introduced February 16, 2017

[Note: This bill is doubled referred to the Assembly Health Committee and will be heard by that Committee as it relates to issues under its jurisdiction.]

SUBJECT: School-based health programs

SUMMARY: Establishes an Office of School-Based Health Programs within the California Department of Education (CDE) to administer and support school-based health programs operated by public schools. Specifically, **this bill**:

1) Requires that the CDE, by July 1, 2018, establish an Office of School-Based Health Programs (Office) for the purposes of:

   a) administering current health-related programs under the purview of the CDE

   b) advising on issues related to the delivery of school-based Medi-Cal services in the state

   c) developing recommendations for an interagency agreement or memorandum of understanding between the Department of Health Care Services (DHCS) and the CDE

   d) assisting DHCS in formulating the Medi-Cal state plan amendments

2) Defines the scope of the Office to include improving the operation of, and participation in, the Medical Administrative Activities (MAA) program and the local educational agency Medi-Cal billing option (LEA billing option).

3) Requires the Office to, by January 1, 2019, provide input to the CDE on the development of and, if applicable, continuing operations of the interagency agreement or memorandum of understanding (MOU).

4) Requires the recommendations of the Office to:

   a) identify opportunities for effective coordination between the state's health and education systems at the state, regional, and local level

   b) identify ways the CDE can maximize its school-based Medicaid program expertise

   c) recommend an appeals process for the MAA program and the LEA billing option

   d) identify necessary legislation or state plan amendments to support its recommendations

5) Requires the Office to advise the CDE on creating consistency across local educational consortia (LECs), local governmental agencies (LGAs), and the CDE with respect to contracts and processes for the MAA program.

6) Requires the Office to determine the opportunities for, and the benefits, costs, and feasibility of the following:

   a) increasing LEA participation and maximizing allowable federal financial participation in the MAA program and the LEA billing option programs

   b) increasing contracting options for LEAs participating in MAA, such as allowing an LEA to contract with an LEC or LGA outside of the LEA's region

   c) reducing the number of quarterly random moment time surveys

   d) identifying areas that may require a state plan amendment

   e) integrating and expanding other school-based health and mental health programs with the MAA program and the LEA billing option, including those being implemented in accordance with the LEA's local control and accountability plan

7) States that the Office may develop a workgroup to assist its efforts that is representative of the diversity of California LEAs with respect to size, type, and geographic diversity, and include representatives from county offices of education, urban, suburban, and rural LEAs, and Local Educational Consortias (LECs) and Local Governmental Agencies (LGAs).

8) Requires the workgroup to include representatives of the LEA Ad Hoc Workgroup, members with expertise in school-based health and mental health programs, representatives from the LEC Advisory Committee, and representatives of the LGA.

9) Requires the workgroup to, on a regular basis, provide input to the Office on the degree to which the process and implementation of MAA and the LEA billing option are meeting the needs of LEAs with respect to cost-effectiveness, program structure, and operational effectiveness, including the processing of appeals and balancing withheld funds and actual expenses.

10) States that the Office may form technical advisory groups as necessary that are required to report back to the Office on the development of plans and timelines to implement the changes and expanded options described in this section.

11) Requires CDE to make available to the Office any information on other school-based dental, health, and mental health programs, including mental health programs and school-based health centers that may receive Medi-Cal funding.

EXISTING LAW:

1) Establishes the Medi-Cal program, administered by the DHCS, under which qualified low-income persons receive health care benefits.

2) Requires that specified services provided by a LEA are covered Medi-Cal benefits, to the extent federal financial participation (FFP) is available, are subject to utilization controls and standards adopted by DHCS, and are consistent with Medi-Cal requirements for physician prescription, order, and supervision.

3) Defines the scope of covered services that an LEA may provide, which included targeted case management services (TCM) for children with an IEP or an Individualized Education Program (IEP) or an Individual Family Service Plan (IFSP).

4) Defines LEA, for the purpose of the LEA billing option, to include school districts, county offices of education, state special schools, charter schools, and California State University and a University of California campuses.

5) Requires the DHCS to seek FFP for covered services that are provided by an LEA to a Medi-Cal eligible child regardless of whether the child has an IEP or an IFSP, or whether those same services are provided at no charge to the child or to the community at large.

6) Requires each LEA that elects to participate in MAA to submit claims through its LEC or LGA, but not both.

7) Authorizes DHCS to contract with each LGA or LEC to assist with the performance of administrative activities.

8) Authorizes each participating LGA or LEC to subcontract with private or public entities to assist with the performance of administrative activities.

9) Defines a LEA for purposes of MAA as the governing body of any school district or community college district, the county office of education, a state special school, a California State University campus, or a University of California campus.

10) Permits a LGA or local educational consortium to charge an administrative fee to any entity claiming Administrative Claiming through that agency.

FISCAL EFFECT: Unknown

COMMENTS:

Need for the bill. The author states, "School-based health services play a key role in ensuring that California students are safe and ready to learn. When poorly treated, health problems such as asthma, diabetes, and mental health issues can have a devastating impact on school attendance, behavior, and academic achievement.

Due to a recent federal change, schools will soon have access to far greater resources to pay for these services. This change means that many more students will be eligible to receive health services at school, including school nurse services for chronic conditions, mental health and counseling services, occupational therapy, speech pathology, audiology, and targeted case management.

To run smoothly and maximize funding eligibility, school districts require support from state agencies. But in California there is no institutionalized partnership between the Department of Health Care Services and the California Department of Education. This is in part because, unlike many other states, California does not have an office within CDE to coordinate various health programs and services delivered through the schools.

AB 834 will ensure that California schools have such a resource. The Office of School-Based Health Programs will support and advise school districts on issues related to the delivery of school-based health services.

Other states have successfully drawn down federal funds to support the administrative costs of supporting school districts when they interface with both their state health agencies and the federal government, and California could do the same to support an Office of School-Based Health Programs.

The expansion of eligibility to receive federal funds for school-based health services presents an unprecedented opportunity for the CDE to play a key role assisting districts that wish to serve the health and mental health needs of their students."

Need for greater state-level capacity and interagency coordination. According to the California School-Based Health Alliance, "the disciplines of health and education have traditionally operated in separate siloes," despite common and mutually beneficial goals.

The author notes that as least as far back as 2000, education stakeholders have identified better coordination and collaboration between the DHCS and CDE as key to the success of efforts to establish and support school-based health services *(Building Infrastructure for Coordinated School Health - California's Blueprint, CDE).* This was recently reaffirmed in the CDE's 2015 *Blueprint for Great Schools*, which identifies a need to "develop infrastructure at the CDE to improve cross-agency collaboration in support of student health."

The need for greater collaboration between DHCS and CDE is also recognized by health care stakeholders. In January of this year, the Medi-Cal Children's Health Advisory Panel (MCHAP), which advises DHCS on matters related to children enrolled in Medi-Cal and their families, issued a draft recommendation urging increased collaboration between DHCS and CDE. The MCHAP recommended that DHCS "collaborate with CDE to develop guidelines for mental health services and clarify reimbursement and financial responsibilities." Specifically, it recommended that DHCS 1) strengthen state-level collaboration with CDE to ensure an adequate continuum of services and remove barriers to reimbursement across different programs available to school providers, 2) offer joint communication about how to develop, deliver and strengthen school-based services through MAA and the LEA billing option, and 3) complete the required MOU between CDE and DHCS to facilitate services.

Several recent developments have made the need for state-level coordination and support more evident. One is the anticipated expansion of the LEA billing program, which, as described below, presents a significant opportunity for increased provision of school-based health services. It also likely means an increased demand for state-level coordination, as well as state support and technical assistance to LEAs.

The California School-Based Health Alliance notes that while the LEA billing option process is primarily overseen and administered by the DHCS, "CDE is familiar with the regulatory policies and responsibilities that schools must adhere to, which can help with ensuring that information is disseminated to the right individuals and communicated to the broader education field. If given the proper tools, resources, and authority, CDE could play a much larger role in helping school districts implement the policies proposed in the state plan amendment and consider possibilities

for expanding and improving the delivery of services." Because until recently only students with IEPs an IFSPs were eligible for services through the LEA billing option, CDE has located its programmatic expertise in its special education division. Now that the program is expanding to all Medi-Cal eligible students, the author believes that a centralized office is appropriate.

Another factor contributing to the demand for increased capacity and collaboration between health and education agencies is the renewed and increasing recognition of the intrinsic connection between student health and academic outcomes. While the associations between physical health problems and school attendance, behavior, and academic achievement have been noted for decades, increasing attention is now being paid to the relationship between adverse childhood experiences (ACEs), student mental health, and academic outcomes. Research has demonstrated a strong association between ACEs and poor performance in school, including a higher risk of learning and behavior problems. Other research into the effects of chronic stress on children (often caused by ACEs), has identified a profound effect on the developing brain, which in turn affects school performance and behavior. This research has led to an increased focus on the provision of health services at schools, and is promoting closer connections between health and education agencies.

Recent change in federal policy will expand services to many more students. The LEA Medi-Cal Billing Option Program was established in 1993 and since then has provided Medicaid funds to LEAs for health-related services provided to students who have IEPs or IFSPs.

Reimbursement is based upon a fee-for-service model, and school expenditures for qualified services rendered are reimbursed at 50% of cost using federal Medicaid matching funds. Under the program, LEAs bill Medi-Cal for the direct medical services they provide to Medi-Cal eligible students. LEAs pay for the services and are reimbursed the FFP rate relative to the cost of each individual service from federal funds.

In December, 2014, the Centers for Medicare and Medicaid Services (CMS) issued new guidance which will allow LEAs to serve all Medi-Cal-eligible students, whether or not they have an IEP or an IFSP. It is anticipated that this will result in higher levels of claiming for services, including:

- Health and mental health evaluations
- Health and mental health education
- Medical transportation
- Nursing services
- Occupational therapy
- Physical therapy
- Physician services
- Mental health and counseling services
- School health aide services
- Speech pathology services
- Audiology services
- Targeted case management services

California historically poor at drawing down Medicaid funding. For many years California drawn down a low share of Medicaid funding through the LEA billing option relative to the number of eligible students in the state. A 2000 report by the U.S. General Accounting Office found that California ranked in the bottom quartile of states by funding received through this option. The amount claimed has been increasing in recent years: a 2012 report from the DHCS on the LEA billing option found that statewide reimbursement increased from $60 million in 2000-01 and to $130 million in 2009-10.

But while California receives the largest total share of federal funds, the amount the state receives per eligible student is low relative to other states. In 2009-10, California served 240,000 of its 3.3 million eligible students, resulting in an average of $159 per eligible student. The average among the 32 states surveyed was $544 per eligible student. Nebraska (with 103,000 eligible students) received $796 per eligible student, Vermont received $694 per eligible student, and Rhode Island received $635 per eligible student (all figures include Medicaid administrative funds).

"Free Care Rule" eliminated. Under long-standing policy known as the "free care rule," LEAs could not receive payment for services which they made available without charge to Medi-Cal eligible students or to the community at large unless all students were billed for the service.

For example, if all children in a school received hearing evaluations, Medi-Cal could not be billed for the hearing evaluations provided to Medi-Cal recipients unless *all students*, regardless of insurance status, were billed for the services as well. This meant that before being able to bill, schools had to bill a variety of private insurers as well as Medi-Cal. This was an administrative burden that many LEAs found prohibitive.

In 2004 the state of Oklahoma won a legal challenge to the rule, but the CMS continued to apply the rule to all other states. A subsequent challenge to the rule by San Francisco Unified School District in 2013 was also successful, but the policy did not change until December of 2014.

Under December, 2014 guidance, Medicaid reimbursement is available for covered services under the approved state plan that are provided to Medicaid beneficiaries, regardless of whether there is any charge for the service to the beneficiary or the community at large. As a result, funding is available for Medicaid payments for care provided through providers that do not charge individuals for the service, as long as all other Medicaid requirements are met.

School-Based Medi-Cal Administrative Activities (MAA) program. The MAA program provides federal reimbursements to LEAs for the federal share of certain costs for administering the Medi-Cal program. Those activities include outreach and referral, facilitating the Medi-Cal application, arranging non-emergency/non-medical transportation, program planning and policy development, and Medi-Cal administrative activities claims coordination. The CMS administers the MAA program at the federal level, and DHCS administers the MAA program in California.

LEAs that elect to participate in MAA must submit claims through a LEC or LGA. A LEC is a group of LEAs located in one of the 11 service regions established by the California County Superintendent Educational Services Association. A LGA is a county, county agency, chartered city, Native American Indian tribe, tribal organization, or subgroup of a Native American Indian tribe or tribal organization.

DHCS contracts with LGAs and LECs which consolidate claims provided by LEAs for a fee. As a condition of participation in MAA, each participating LGA and LEC is required to pay an annual fee to DHCS. The participation fee is used to cover the DHCS' cost of administering the MAA claiming process, including claims processing, technical assistance, and monitoring.

Due to concerns regarding a lack of compliance and oversight, CMS has deferred reimbursements for claims through the MAA program since 2012. Approximately $500 million in reimbursable funds have not been paid to California school districts in the last five years.

Interagency Agreement or Memorandum of Understanding. This bill requires the Office to make recommendations regarding an interagency agreement or memorandum of understanding between the DHCS and CDE. CMS guidance states that an interagency agreement, which describes and defines the relationships between the state Medicaid agency, the state Department of Education and/or the school district or local entity conducting the activities, must be in place in order to administer the MAA and LEA billing option programs. California does not have such an agreement.

According to the author, this interagency agreement could clearly delineate the division of programmatic and fiscal responsibilities for the two departments, provide a mechanism for the transfer of any administrative funds between departments, and establish systems of joint communication. As noted above, the Medi-Cal Children's Health Advisory Panel has issued a draft recommendation calling for the completion of this "required MOU." The author notes that other states have such agreements between their health and education agencies.

Transition to Random Moment Time Survey (RMTS) for LEA Billing Option. RMTS is a statistically valid means of determining the amount of time spent performing an activity, in this case for purposes of determining reimbursement rates under Medi-Cal. According to DHCS, the RMTS method polls randomly selected participants at random time intervals and totals the results to determine the work effort for the entire population of participants over that time period.

The MAA program uses RMTS, and the LEA billing option program will be transitioning to RMTS as well. DHCS reports that they are working on the design and development of a new RMTS for the LEA billing option program. They state that the results of the RMTS will be combined with provider-specific costs in order to determine provider-specific reimbursement for direct service claiming.

This bill requires the Office to determine the opportunities for, and the benefits, costs, and feasibility of reducing the number of quarterly random moment time surveys. A 2015 report by the State Auditor found that, with respect to the MAA program, DHCS missed an opportunity to cut costs through the implementation of a single statewide quarterly time survey when it implemented the RMTS methodology. The Audit estimated that the MAA program could save as much as $1.3 million annually in coding costs alone if DHCS conducted a single statewide quarterly time survey.

Recommended amendment. Staff recommends that the bill be amended to remove an unnecessary reference to Local Control and Accountability plans by striking, on page 3, line 35, strike "including" to the end of the sentence.

Related and prior legislation. AB 481 (Thurmond) of this Session would provide that an LGA or LEC may only require an LEA to contract for services that are actually provided and necessary for the performance of specified oversight and monitoring activities, and would require the development of a process by which an LEA may appeal an action of the department with respect to the MAA, among other provisions. This bill is pending in the Assembly Health Committee.

SB 123 (Liu) of the 2015-16 Session would have established a revised process for school-based and non-school-based administrative claiming, beginning January 1, 2018, authorized DHCS to administer or oversee a single statewide quarterly random moment time survey, required the DHCS and CDE to enter into an interagency agreement or memorandum of understanding by July 1, 2018, and established a workgroup to provide advice on issues related to the delivery of school-based Medi-Cal services to students. This bill was vetoed by the Governor, who stated:

> This bill establishes a work group jointly administered by the Departments of Health Care Services and Education to recommend changes to school-based Medi-Cal programs.
>
> There is an advisory committee within the Department of Health Care Services whose very purpose is to continuously review and recommend improvements to these programs. Collaboration among the health and education departments and local education groups is very important, but the existing advisory committee is working well and certainly up to the task. Codification in this case is not needed.

SB 276 (Wolk), Chapter 653, Statutes of 2015, requires the DHCS to seek federal financial participation (FFP) for covered services that are provided by a LEA) to a Medi-Cal eligible child regardless of whether the child has an IEP or an IFSP, or whether those same services are provided at no charge to the child or to the community at large. This measure also stated that if there is no response to a claim submitted to a legally liable third party by an LEA within 45 days, the LEA may bill the Medi-Cal program.

AB 1955 (Pan) of the 2013-14 Session, would have required DHCS and CDE to cooperate and coordinate efforts in order to maximize receipt of federal financial participation under the MAA process, and required DHCS, through an interagency agreement with the CDE, to provide technical advice and consultation to local educational agencies participating in a demonstration project established by the bill, in order to meet requirements to certify and bill valid claims for allowable activities under MAA. This bill was held in the Assembly Appropriations Committee.

SB 231 (Ortiz), Chapter 655, Statutes of 2001, requires the State Department of Health Services (DHS) to amend the Medicaid state plan with respect to the LEA billing option to ensure that schools are reimbursed for all eligible services they provide that are not precluded by federal requirements. The bill requires DHS to regularly consult with specified entities to assist in the formulating of the state plan amendments, and permits DHS to enter into a sole source contract to comply with the requirements of this bill. It also authorizes DHS to undertake all necessary activities to recoup matching funds from the federal government for reimbursable services that have already been provided in the State's public schools.

AB 2608 (Bonilla), Chapter 755, Statutes of 2012, made permanent and expanded provisions relating to program improvement activities in the Lea billing option program. AB 2608 also expanded the scope of reimbursable transportation services.

SB 870 (Ducheny), Chapter 712, Statutes of 2010, (the 2010-11 Budget Bill) required DHCS to withhold one percent of LEA reimbursements, not to exceed $650,000, for the purpose of funding the work and related administrative costs associated with the audit resources approved in a specified budget change proposal to ensure fiscal accountability of the LEA billing option and to comply with the Medi-Cal State Plan.

The Budget Act of 1998 provided $3 million in one-time Proposition 98 funding to support technical assistance to school districts in LEA billing through a consortium of county offices of education. Related supplemental report language required the consortium to report to the JLBC and the appropriate fiscal and policy committees of the Legislature on the amount of Medi-Cal LEA billing generated by this program in each fiscal year of the program and on barriers to LEA billing and recommendations on improving rates of LEA billing in the future.

REGISTERED SUPPORT / OPPOSITION:

Support

California School Based Health Alliance (sponsor)
California Association for Health, Physical Education, Recreation and Dance
California Pan-Ethnic Health Network
California Partnership to End Domestic Violence
CaliforniaHealth+ Advocates
Children Now
Children's Defense Fund-California
Equal Justice Society
Genders and Sexualities Alliance Network
InnerCity Struggle
Los Angeles Trust for Children’s Health
Los Angeles Unified School District
Our Family Coalition
Partnership for Children and Youth
Philliber Research and Evaluation
Promesa Boyle Heights
Public Counsel
Santa Monica-Malibu Unified School District
Teachers for Healthy Kids

Opposition

California Right to Life Committee, Inc.

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