Date of Hearing: April 22, 2026

ASSEMBLY COMMITTEE ON EDUCATION
Darshana R. Patel, Chair
AB 2704 (Addis) – As Amended March 19, 2026

SUBJECT: Statewide Fee Schedule Pilot Program

SUMMARY: Creates a pilot program to provide intensive technical assistance and support to help small and rural school districts, and programs serving children under five years of age or transition-age youth, participate in the Children and Youth Behavioral Health Initiative (CYBHI) Fee Schedule, wherein those entities can receive reimbursement for behavioral health services provided to children and youth. Requires the California Department of Education (CDE) to provide funding to the Monterey County Office of Education (COE) to administer the pilot, subject to appropriation. Specifically, **this bill**:

1) Establishes the Statewide Fee Schedule Pilot Program to serve the following purposes:

    a) To address inconsistent access to the statewide fee schedule caused by the limited capacity and expertise of small and rural schools, early learning and care providers, and institutions of higher education serving transition-age youth in billing for behavioral health claims;

    b) To increase the number of behavioral health services provided to children who are 0 to 5 years of age, students attending small and rural schools, and transition-age youth; and

    c) To reduce the burden of participating in the school-linked statewide fee schedule for entities providing behavioral health services to underserved communities and groups.

2) Requires the pilot lead, in coordination with the Department of Health Care Services (DHCS), to select 25 entities to participate in the pilot program for up to 3 years and requires the prioritization of applicants who will do one or more of the following:

    a) Increase the number of children 0 to 5 years of age receiving behavioral health services;

    b) Increase the number of transition-age youth 16 to 25 years of age receiving behavioral health services;

    c) Increase the number of children and youth enrolled in small school districts that receive behavioral health services;

    d) Increase the number and amount of statewide fee schedule reimbursements;

    e) Increase the number and amount of statewide fee schedule reimbursements being utilized to support community schools;

    f) Provide diverse representation of communities and geographic areas throughout the state;

    g) Operate in communities with higher proportions of unduplicated students; and

h) Ensure behavioral health service providers have past experience, and specialize in serving children and youth of the age that the entity intends to serve.

3) Requires by February 1, 2027, the pilot lead to create and publish a brief application for those interested in participating in the pilot program, including the following information:

a) The number and age of children and youth currently enrolled at the entity;

b) The number and age of children and youth currently receiving behavioral health services from the entity or an affiliated provider that the entity has designated;

c) The number and qualifications of behavioral health service providers, including affiliated providers, currently offering behavioral health services to children and youth enrolled at the entity;

d) The entity's interest in, and capacity to, increase behavioral health services to children and youth in their community; and

e) The entity's current ability to meet the minimum qualifications required to participate in the school-linked statewide behavioral health provider network and the completed fee schedule cohort readiness application created by the DHCS.

4) Requires the pilot lead, between April 1, 2027, and July 1, 2030, to provide intensive technical assistance and support to the entities participating in the statewide fee schedule pilot program, including, but not limited to, technical assistance and support with the following activities:

a) Obtaining national provider identification numbers and completing the statewide fee schedule credentialing process for all employees and affiliated providers that will offer services within scope of services covered by the statewide fee schedule;

b) Obtaining an easy to navigate and integrate electronic health records system that is made available to all pilot participants, at no charge, for documentation and submission of claims;

c) Assistance in determining the applicability of privacy laws, including, but not limited to, the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act (HIPAA), to each participating entity. This may include legal and technology supports necessary to adopt the policies, documents, and forms required by applicable privacy laws, including, but not limited to, consent forms, privacy notices, and data policies;

d) Providing training and coaching for behavioral health service providers related to documentation of services, proper coding and noting procedures, obtaining required consents, applicable privacy laws and disclosure requirements, and referral protocols, including escalation of services;

e) Obtaining and maintaining health plan information for each individual receiving services, including conducting insurance discovery and follow up activities where information is absent;

f) Review of all claims prior to submission to ensure services are appropriately coded, documented, and noted, with the goal of increasing the likelihood of submitting a clean claim; and

g) Submission of claims on the entities' behalf, including providing assistance to the entity to resolve any potential issues or missing documentation causing the denial of a claim.

5) Authorizes the pilot lead to subcontract with additional experts, as needed, to fulfill the requirements of this pilot program.

6) Requires the pilot lead, by January 1, 2028 to submit a report to the Legislature on the progress of the statewide fee schedule pilot program, including but not limited to, all of the following:

   a) The number of and names of entities accepted to participate in the pilot program;

   b) The number of entities that have completed the minimum qualifications required to participate in the school-linked statewide behavioral health provider network, established pursuant to Section 5961.4, and the fee schedule cohort readiness application created by the State Department of Health Care Services;

   c) The number of entities participating in the pilot program that have completed training and onboarding with an electronic health records system, and adopted required data sharing policies, privacy notices, and disclosure and release forms;

   d) The number of behavioral health service providers that have completed the statewide fee schedule certification process, including obtaining a National Provider Identifier;

   e) The number of children and youth, disaggregated by age, that have been enrolled in an electronic health records system; and

   f) The percentage of children and youth with verified health plan information in an electronic health records system and completed consent forms.

7) Requires the pilot lead, by January 1, 2031, to submit a summative report to the Legislature on the success of the pilot program in achieving the specified goals, including but not limited to all of the following:

   a) The number of claims submitted by pilot participants from small and rural school districts;

   b) The number of claims submitted by pilot participants for services provided to children 0 to 5 years of age, inclusive;

c) The number of claims submitted by pilot participants for services provided to transition-age youth;

d) The total number of claims submitted by pilot participants and the percent of claims that are approved and paid;

e) The total value of claims submitted by pilot participants; and

f) The total number of behavioral health services providers, including affiliated providers, authorized by pilot participants to provide services.

8) Requires the CDE to allocate funds to the Monterey COE to administer the fee schedule pilot program over a three-year period, upon an appropriation by the Legislature.

EXISTING LAW:

1) Establishes the CYBHI, administered by the California Health and Human Services Agency and its departments, to transform the state's behavioral health system into an innovative ecosystem in which all children and youth 25 years of age and younger, regardless of payer, are screened, supported, and served for emerging and existing behavioral health needs. (Welfare and Institutions Code (WIC) 5961)

2) Requires the DHCS to develop and maintain a school-linked statewide fee schedule for outpatient mental health or substance use disorder treatment provided to a student who is 25 years of age or younger at a schoolsite. (WIC 5961.4)

3) Requires the CDE to establish the Office of School-Based Health by January 1, 2022 to assist local educational agencies (LEAs) regarding health-related programs and to collaborate with the DHCS and other departments and agencies involved in the provision of school-based health services. (Education Code (EC) 49421)

4) Establishes the School Health Demonstration Project and appropriates $5 million to the CDE to expand comprehensive health and mental health services to public school pupils by providing LEAs with intensive assistance and support to build the capacity for long-term sustainability by leveraging multiple revenue sources. (EC 49421)

5) Requires the CDE, by June 1, 2025, to develop model referral protocols for addressing student mental health concerns, in consultation with specified agencies and stakeholders, and authorizes these protocols to be used on a voluntary basis by schools. (EC 49428.1)

6) Requires the governing boards or bodies of LEAs, by January 31, 2026, to adopt at a regularly scheduled meeting, a policy on referral protocols for addressing student behavioral health concerns of students in grades 7 to 12. (EC 49428.2)

FISCAL EFFECT: The Office of Legislative Counsel has keyed this bill as a possible state-mandated local program.

COMMENTS:

Need for the bill. According to the author, "For too many families on the Central Coast and in rural communities, mental health care is limited or simply out of reach. AB 2704 helps close that gap by giving schools a real pathway to deliver and sustain early behavioral health services."

This bill would establish a pilot program to provide additional intensive technical assistance to increase participation in the CYBHI by educational entities serving children from 0-5, those in small or rural communities, and those serving transition age youth.

CYBHI. The CYBHI is a multi-pronged initiative that began in 2021 and aims to promote the mental health and wellness of California's children and teens. The initiative works across four strategic areas (workforce training and capacity, behavioral health ecosystem infrastructure, coverage and public awareness) and contains numerous individual programs and initiatives. Most initiatives are time-limited and focused on building infrastructure and capacity of the behavioral health system for children.

CYBHI Fee Schedule. Of the various components of CYBHI, the CYBHI Fee Schedule has the potential to have the most significant long-term impact in the provision of services because it is the only initiative designed to create an ongoing funding source to support the delivery of behavioral health in schools and in school-linked settings.

State law requires DHCS to develop and maintain a multi-payer, school-linked statewide fee schedule for mental health or substance use disorder services provided to a student 25 years of age or younger at or near a school site. State law also requires Medi-Cal managed care and commercial plans and insurers to reimburse for such schoolsite services designated by DHCS, at or above the fee schedule rate, regardless of whether the school site is a network provider, and without subjecting services to prior authorization or cost-sharing. This means plans are prohibited from applying any copayment, coinsurance, or deductible that would normally apply to the service rendered, based on the plan design.

The CYBHI Fee Schedule requires payers to reimburse LEAs or institutions of higher education (IHEs) for a set of services provided at a school site, as defined. The services are provided by or arranged by the LEAs. Specifically, LEAs can provide the services "in-house" with their own staff or arrange for the provision of services through community-based providers that provide services at the school or otherwise partner with the LEA to provide services to students.

In this context, "school site" means a facility or location used for public kindergarten, elementary, secondary, or postsecondary purposes. It also includes a community-based facility or location, if the school or school district provides or arranges for the provision of services to its students at that location, including off-campus clinics, mobile counseling services, and similar locations.

To implement the fee schedule, DHCS has onboarded LEAs and IHEs into implementation "cohorts," each selected based on operational readiness. The selection process considers factors such as Medi-Cal enrollment, service delivery infrastructure and capacity, data collection and documentation, and billing infrastructure. In addition, the state has selected Carelon Behavioral Health as the third-party administrator who serves as the statewide clearinghouse that receives and adjudicates claims from LEAs, and pays these claims on behalf of health plans. Carelon is

also responsible for credentialing school-based providers for participation in the statewide fee schedule, as well as providing training and technical assistance to participating LEAs.

Implementation of the Fee Schedule. DHCS and participating LEAs and IHEs have made significant, if slow, progress in implementing the Fee Schedule. As of March 30, 2026:

a) 700 LEAs and IHEs are enrolled in the CYBHI Fee Schedule program;

b) 3.6M students enrolled across participating schoolsites;

c) 169 LEAs/IHEs (including 8 school-linked providers) have submitted claims;

d) $7.35 million in unique clean claims (includes all in-process and approved claims) have been submitted for reimbursement;

e) 121,397 claims have been reimbursed, totaling $6.84 million in new revenue for LEAs and IHEs;

f) 31,567 unique students have received services submitted for reimbursement; and,

g) 36 Managed Care Plans/Insurers are represented in the claims data.

The limited number of LEAs that have successfully submitted claims are disproportionately larger, better-resourced districts and COEs, which tend to have the staffing, administrative expertise, and economies of scale required to implement medical billing infrastructure. As one-time funds expire, the bill sponsor, Monterey COE, notes that under-resourced entities, including small and rural LEAs are at risk of being left without an ongoing funding source for behavioral health services.

Significant mental health problems in young children. Children can exhibit characteristics of anxiety disorders, attention-deficit/hyperactivity disorder, depression, post-traumatic stress disorder, and neurodevelopmental disabilities at an early age. Research suggests that approximately 9 to 14% of children from birth to 5-years-old experience emotional or behavioral disorders.

Factors such as persistent poverty, recurrent abuse or chronic neglect, exposure to domestic violence, parental mental health issues or substance abuse, as well as poor childcare conditions, increase the risk of serious mental health problems among young children.

Left untreated, early mental health disorders can impact every aspect of a child's development, including physical, cognitive, communication, sensory, emotional, social, and motor skills. These negative impacts can affect a child's ability to succeed in school and in life and increase the risk of poor educational outcomes, ill health, and juvenile delinquency later in life. (Harvard University, 2013).

Early intervention is critical in addressing early mental health concerns. Research finds that early prevention and treatment of mental health disorders is considered more beneficial and cost-effective than attempting to treat emotional difficulties and their effects on learning and health after they become more serious. During the infant and toddler years, there are opportunities to

treat mental health problems before they manifest into more severe problems later in life. It is critical to treat young children's mental health issues within the context of their families, homes, and communities. The emotional well-being of young children is directly connected to the functioning of their families and caregivers.

School-Based Behavioral Health Services. Behavioral health services for children and transition-age youth function as forms of early intervention and preventive care, which can help avoid long-term or future unnecessary and costly mental health interventions, such as crisis stabilization, emergency department visits, or inpatient psychiatric hospitalization. Students are more likely to receive behavioral health services when they are provided on a school campus because it eliminates the need for transportation to off-site appointments, facilitates parent participation, encourages student self-referral, and increases the likelihood of completing treatment. In addition, school-based mental health professionals can better identify aggravating causal factors based on their more holistic knowledge of a student.

Consortium Models*.* According to DHCS, LEAs and IHEs may enroll in the CYBHI Fee Schedule program individually or as part of a consortium. Consortia are another option to support LEAs and IHEs who may lack the capacity to administer all of the activities related to the fee schedule. A consortium model allows one or more LEAs and an IHE to share administration services for claims submission and reimbursements. In a consortium, one Lead LEA or one Lead IHE serves as an intermediary between the participating Consortium members (participating member LEAs) and Carelon Behavioral Health, the third-party administrator. The specific consortium model may vary depending on which program requirements (e.g., data sharing, submitting claims, receiving reimbursement) are delegated to a Lead LEA or IHE by its participating members. For example, the Lead LEA or IHE may be responsible for collecting and submitting required pre-requisite documentation and claims, as well as receiving and distributing payments on behalf of consortium members.

Distinction between this bill and other technical assistance contracts and materials*.* DHCS and its contractors have provided and continue to provide technical assistance, training, responses to questions, toolkits, and other resources, in addition to grant providing funding for capacity-building. However, the cultural and administrative differences between health care programs and education entities are vast, staffing and expertise to implement such a technically complex program as the fee schedule is limited, and in spite of all the resources and effort that has been expended on technical assistance thus far, many LEAs and IHEs are still struggling to operationalize the fee schedule. The sponsor of this bill explains that many LEAs and IHEs lack the capacity to process and make use of the available resources, and really just need hands-on, direct help operationalizing the various aspects of the fee schedule, which is what this bill would allow a lead entity to do.

Recommended Committee Amendments. Committee staff recommend the bill be amended as follows:

1) Change the name of the pilot to "The Statewide Fee Schedule Intensive Technical Support for Onboarding Program";

2) Clarify who is eligible to participate in the pilot;

3) Specify that up to 25 entities may participate in the pilot;

4) Remove Monterey COE as lead entity and provide qualifications to be considered by the CDE in selecting the lead entity;

5) Adjust the timelines to provide time for CDE to solicit applications, select, and contract with the lead entity;

6) Clarify the scope of the technical assistance to be provided by the lead entity; and

7) Other technical and conforming changes.

Arguments in support. The Monterey County Office of Education writes, "With the help of the DHCS, LEAs have made significant progress in implementing the Fee Schedule over the last 5 years. However, as of March 2026 less than 10% of LEAs had submitted claims and just $4.9 million had been reimbursed to LEAs for behavioral health services. Of those LEAs who have submitted claims, nearly all are larger and better-resourced districts and county offices of education, which have the staff, expertise, and economies of scale required to implement medical billing infrastructure. Meanwhile, no claims have been submitted for services provided to children ages 0 to 5 and few have been submitted by small and rural schools or community colleges.

Without targeted intervention for under-resourced entities, the Fee Schedule will widen—not close—inequities in access to behavioral health services. AB 2704 would help to address this gap by establishing a three-year Fee Schedule Pilot Program that is intentionally designed to correct the imbalance in participation among entities providing behavioral health services to children ages 0 to 5, small and rural schools, and community colleges. The Pilot Lead would provide intensive technical assistance to help entities surmount barriers currently preventing participation in the Fee Schedule, including meeting Medi-Cal pre-requisites, adopting necessary disclosures and releases, determining the applicability of various privacy laws, conducting insurance discovery, training staff on privacy and billing requirements, and implementing an EHR to support billing and documentation.

In addition to drawing down more federal dollars to support students, the Fee Schedule Pilot would also help to address repercussions created by COVID-19's disruption to early learning environments and social-emotional development. Since the pandemic, California has experienced significant increases in behavioral challenges among children in preschool and early grades, as well as a surge in the identification of children for special education services. Increased access to the early intervention services covered by the Fee Schedule could help address these behavioral challenges and mitigate rising special education costs.

As Members of the Committee consider policy and budget priorities this year, we urge you to support AB 2704 and appropriate $50 million one-time dollars to fund the Pilot Program."

Related legislation. AB 2429 (B. Rubio) of the 2025-26 Session would require the early childhood mental health consultation service used in a childcare setting to employ an early care and education classroom observation tool once per year to inform the specific activities and support the consultant will provide.

AB 121 (Committee on Budget), Chapter 8, Statutes of 2025, appropriates $20 million one-time Proposition 98 General Fund to the CDE to allocate the funds to Sacramento COE, in partnership with the Santa Clara COE, no later than October 2025. Specifies funds will be administered

through the capacity grant infrastructure, as established by the CYBHI, to LEAs to support, in the order of priority: (1) to prevent the disruption of youth mental health services; and (2) to provide technical assistance to LEAs for the continued implementation of the statewide fee schedule.

SB 153 (Committee on Budget and Fiscal Review) Chapter 38, Statutes of 2024, requires the CDE, as of June 1, 2025, to develop model referral protocols for addressing student behavioral health concerns, for use, on a voluntary basis, by LEAs and requires LEAs to adopt a policy on referral protocols for addressing student behavioral health concerns in grades 7 to 12 by January 31, 2026.

AB 133 (Committee on Budget) Chapter 143, Statutes of 2021, establishes the framework for the CYBHI and the Fee Schedule Program, among other components of the CYBHI.

AB 2052 (Jones-Sawyer) of the 2023-24 Session would have updated and expanded the School-based Health Center Support Program, requiring the CDPH, in collaboration with the Office of School-Based Health Programs at the CDE, to provide technical assistance to school-based health centers (SBHCs). The bill also would have increased funding for new and existing SBHC facilities, contingent upon an appropriation. The bill was held in the Assembly Appropriations Committee.

AB 2034 (O'Donnell & Wood) of the 2021-22 Session would have required DHCS to revise its audit process for the Local Education Agency Medi-Cal Billing Option Program (LEA BOP) and provide technical assistance to LEAs. This bill was held in the Senate Education Committee.

AB 438 (Muratsuchi & Wood) Chapter 527, Statutes of 2023 modifies and imposes new requirements related to timelines, reporting, technical assistance, stakeholder engagement, and guidance for the LEA BOP, a program that allows schools to claim reimbursement for a portion of the cost of delivering health services to Medi-Cal eligible students.

AB 2022 (Chu) Chapter 484, Statutes of 2018, requires each school of a school district or COE, and each charter school, to notify students and parents or guardians of students, at least twice per school year, about how to initiate access to available student mental health services on campus or in the community.

AB 130 (Committee on Budget) Chapter 44, Statutes of 2021 requires the CDE to establish the Office of School-Based Health by January 1, 2022 to assist LEAs regarding the current health-related programs under the purview of the department. The scope of the office also includes collaborating with the DHCS and other departments and offices involved in the provision of school-based health services; establishes the School Health Demonstration Project and appropriates $5 million in one-time funding to the CDE to establish a pilot project to expand comprehensive health and mental health services to public school pupils by providing LEAs with intensive assistance and support to build the capacity for long-term sustainability by leveraging multiple revenue sources.

AB 586 (O'Donnell, Salas, & Wood) of the 2021-22 Session, would have established, subject to an appropriation for this purpose, the School Health Demonstration Project to provide intensive technical assistance to selected LEAs to enable the long-term sustainable provision of health and mental health services to pupils. This bill was held in the Senate Education Committee.

REGISTERED SUPPORT / OPPOSITION:

Support

Alameda County Office of Education
California Youth Empowerment Network
EveryChild California
First 5 Association of California
Fresno County Office of Education
Kidango
Monterey County Office of Education
The Children's Partnership

Opposition

None on file

Analysis Prepared by: Debbie Look / ED. / (916) 319-2087