Date of Hearing: March 24, 2021

ASSEMBLY COMMITTEE ON EDUCATION
Patrick O'Donnell, Chair
AB 552 (Quirk-Silva) – As Introduced February 10, 2021

[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: Integrated School-Based Behavioral Health Partnership Program

SUMMARY: Authorizes local educational agencies (LEAs) and county behavioral health agencies to enter into partnerships to provide school-based behavioral health and substance abuse disorder services on school sites, and authorizes the billing of private insurance providers for these services under specified conditions. Specifically, **this bill**:

1) Establishes the Integrated School-Based Behavioral Health Partnership Program to provide prevention and early intervention for, and access to, behavioral health services for pupils with serious emotional disturbances or substance use disorders, or who are at risk of developing a serious behavioral health condition.

2) Authorizes a county behavioral health agency and the governing board or governing body of an LEA to collaborate on and implement an integrated school-based behavioral health partnership program, and authorizes the two agencies to develop a memorandum of understanding (MOU) outlining the requirements for the partnership.

3) Authorizes multiple LEAs within a single county to form a partnership program with the county behavioral health agency.

4) Encourages the county behavioral health agency and the LEA to formalize the MOU and enter into a contract for the provision of mental health or substance use disorder services.

5) Requires that, in order to secure Medicaid federal matching funds for school-based services, a behavioral health professional who provides services within this partnership program hold an active license or credential with one of the following mental health classifications:

    a) A licensed clinical social worker or registered associate social worker, as specified;

    b) A licensed marriage and family therapist (MFT) or MFT associate, as specified;

    c) A licensed professional clinical counselor (LPCC) or LPCC associate;

    d) A licensed clinical psychologist or psychological intern;

    e) A licensed psychiatrist or psychiatric resident;

    f) A licensed psychiatric mental health nurse practitioner;

    g) A physician specialist in substance use disorder treatment;

h) An individual who holds a services credential with a specialization in pupil personnel services, as specified, that authorizes the individual to perform school counseling, school psychology, or school social work; or

i) An individual who holds a services credential with specialization in health for a school nurse, as specified.

6) Authorizes a behavioral health professional who meets the contracting and licensing requirements specified above to supervise "other trained county behavioral health professionals" participating in the program, defined as health professionals who are subject to the supervision requirements under the Medicaid program when providing Medi-Cal reimbursable specialty mental health services and substance use disorder services, including clinical interns or trainees, certified peer specialists, and registered or certified substance use disorder counselors.

7) Requires the LEA to provide school-based locations, including space at schools, which are appropriate for the delivery of behavioral health services.

8) Requires the county behavioral health agency and participating entities, as appropriate, to collaborate with the LEA to establish hours of service at mutually-agreed upon school-based locations or a process for ensuring timely interventions when needed, or both.

9) Authorizes additional service delivery models that address local needs to be developed under the partnership program.

10) Requires the partnership program to identify whether mental health services or substance use disorder services, or both, are to be provided at school-based locations or through telehealth, and to develop a plan for each pupil who has been identified for services that are not offered at school-based locations, including a process for appropriate referral for the services.

11) Requires that the choice of timeframe and setting for the delivery of mental health services or substance use disorder services, or both, be made in consultation with the pupil and the pupil's parent or guardian and include consideration of the specified needs expressed by the pupil and the parent or guardian.

12) Authorizes the provision of behavioral health services, under this program, at locations that are not school-based in order to accommodate the individual needs of a pupil.

13) Authorizes the continued delivery of Medi-Cal covered behavioral health services at the school-based location beyond the delivery of brief initial interventions, if necessary and appropriate, as determined in consultation with the parent or guardian of the pupil being served, and in compliance with state and federal privacy and parental rights.

14) Requires the LEA and county behavioral health agency, and any participating entities, to jointly develop a referral process to support school personnel in making appropriate referrals to the designated behavioral health professional.

15) Requires the designated behavioral health professional to provide brief initial interventions when necessary for all referred pupils, including uninsured and privately insured pupils, in

addition to Medi-Cal beneficiaries, in order to ensure timely access to behavioral health interventions at the earliest onset of a behavioral health condition.

16) Requires that the array of behavioral health services provided under the partnership program be a subset of Medi-Cal covered mental health or substance use disorder services, including prevention, intervention, and if necessary, intensive intervention services.

17) Authorizes, at the discretion of the partnership program, the use of funding from the Mental Health Services Act, enacted by Proposition 63 in 2004, that are appropriate for a school-based setting to be provided under the partnership program, subject to meeting all requirements including the community planning process.

18) Authorizes prevention services provided by the partnership program to include, but not be limited to, services that address the Prevention and Early Intervention Program of the Mental Health Services Act:

    a) Childhood trauma prevention and early intervention to deal with the early origins of mental health needs;

    b) Early psychosis and mood disorder detection and intervention, and mood disorder and suicide prevention programming that occurs across the lifespan;

    c) Youth outreach and engagement strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs; and

    d) Culturally competent and linguistically appropriate prevention and intervention.

19) Requires that behavioral health interventions provided to pupils through the partnership program comply with all applicable state and federal laws protecting a pupil's right to privacy and parental rights, as specified.

20) Requires the LEA and county behavioral health agency to develop a process to collect information on the health insurance carrier for each pupil, with the permission of the pupil's parent or guardian, to allow the partnership to seek reimbursement for behavioral health services provided to the pupil, when applicable. Also requires that any participating entity be informed of which pupils referred for service are privately insured.

21) Requires, for privately insured pupils, the partnership program to contact the private plan upon initiating the brief initial intervention services, to facilitate a referral to the private plan's network providers, consistent with professionally recognized standards of practice, in consultation with the pupil and their parent or guardian, and in compliance with all applicable state and federal laws protecting a pupil's right to privacy and parental rights.

22) Requires that, if the private plan is unable to meet timely access standards for care delivery required by state law (within 48 hours for an urgent care appointment, or within 15 business days for a nonurgent appointment), the designated behavioral health professional must continue and complete the brief initial intervention services, unless the referring or treating behavioral health provider has determined that a longer waiting time will not have a detrimental impact on the health of the pupil.

23) Requires the private plan to reimburse services provided by the designated behavioral network health professional to pupils enrolled in a private plan at the amount a county behavioral health agency would receive for the same service provided to a Medi-Cal beneficiary.

24) Requires the private plan to meet requirements for the timely payment of claims for a contracted provider. If the private plan disputes the services provided or the amount, the private plan may submit a dispute to the Department of Managed Health Care.

25) Requires, if necessary and appropriate, as determined in consultation with the parent or guardian of the pupil being served, and in compliance with all applicable state and federal laws protecting a pupil's right to privacy and parental rights, the following to occur:

    a) If the private plan can meet timely access standards for care delivery, the designated behavioral health professional must make a referral to the private plan provider; and

    b) If the private plan cannot meet timely access standards for care delivery, the private plan and the county behavioral health agency must negotiate a single case agreement to provide behavioral health services beyond the brief initial intervention services to determine reimbursement for additional services. If an agreement cannot be reached, the private plan must report to the Department of Managed Health Care how it will ensure the pupil receives the necessary services in compliance with state and federal laws, as specified.

26) Encourages private plans to contract with county behavioral health agencies and participating entities to serve pupils who are receiving services from the partnership program.

27) Requires a partnership program to annually report to the CDE, the State Department of Health Care Services (DHCS), and the Mental Health Services Oversight and Accountability Commission (MHSOAC), all of the following:

    a) A brief description of the partnership program, including the service delivery model;

    b) The financial contribution made by the county behavioral health agency and LEA participating in the partnership program;

    c) The definition the partnership program uses to identify pupils "at risk of developing a serious behavioral health condition;

    d) The number of school-based locations involved in the partnership program;

    e) The number of pupils served in the last year, including demographic data on the pupils' race, ethnicity, gender, and language;

    f) The number of pupils who receive school-based services beyond the brief initial intervention;

    g) The number of pupils who participate in the program who report functional improvement, as measured by the Child and Adolescent Needs and Strengths (CANS) assessment tool,

broken down by those pupils who receive only the brief initial intervention, and those that receive additional school-based services; and

h) The percentage of pupils and parents or guardians that report satisfaction with the services provided through the partnership program.

28) Requires the MHSOAC, in collaboration with the DHCS, to provide a report to the Legislature on the Integrated School-Based Behavioral Health Partnership Program, based upon specified metrics, every three years, beginning three years after the establishment of the partnership program, in compliance with Government Code 9795.

29) Authorizes the Partnership Program to support, through collaboration and contracting for services, compliance with the local policies, responsibilities, and interventions that are required through Individualized Education Programs (IEPs), and requires the establishment of a process that does all of the following:

a) Includes guidance describing the collaborations between LEAs and county behavioral health agencies that can support compliance;

b) Distinguishes the local policies, responsibilities, and interventions that are required through IEPs and those relating to special education local plan areas (SELPAs); and

c) Distinguishes through guidance and policies how pupils receive the services required by IEPs and SELPAs, as well as through the partnership program, when appropriate.

30) Specifies that this article does not replace current county requirements related to crisis intervention protocols and prohibits the Partnership Program from providing crisis interventions.

31) Requires the county behavioral health agency and LEA to establish processes for timely interventions that identify nonurgent, urgent, and crisis-related circumstances, including guidelines for when county crisis intervention is needed instead of timely interventions related to urgent or nonurgent needs.

32) Prohibits the partnership program from creating a siloed delivery system and requires the partnership program to establish a process to leverage community-based services and other resources, and a process to identify local resources related to crisis intervention protocols and services.

33) Defines, for the purposes of this article, the following:

a) "At risk of developing a serious behavioral health condition" as defined by the applicable county behavioral health agency and LEA pursuant to the partnership program established;

b) "Brief initial intervention" as Medi-Cal covered behavioral health services, that are a subset of essential health benefits, as defined in state and federal law;

c) "Intervention" and "intensive intervention services" as select Medi-Cal specialty mental health services and substance use disorder services that would be appropriately provided

at a school-based location or through telehealth, including assessments, plan developments, therapy, substance use counseling, rehabilitation, collateral services, medication support services, therapeutic behavioral services, case management, recovery services, and intensive care coordination;

d) "Local education agency" (LEA) as a school district, county office of education, or charter school;

e) "Participating entity" as a community-based organization or other entity, including a LEA, that has contracted with a county behavioral health agency to provide services and participate in the partnership program;

f) "Partnership program" as an integrated school-based behavioral health partnership program established by a county behavioral health agency and the governing board or governing board or governing body of a LEA, which may also include other participating entities; and

g) "Privately insured pupil" as a pupil with comprehensive health coverage that is not run by the state or federal government.

EXISTING LAW:

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

2) Establishes a schedule of benefits under the Medi-Cal program, which includes Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) for any individual under 21 years of age, consistent with federal Medicaid requirements.

3) Requires DHCS, in collaboration with the California Health and Human Services Agency, and in consultation with the MHSOAC, to create a plan for a performance outcome system for EPSDT mental health services provided to eligible Medi-Cal beneficiaries under 21 years of age.

4) Establishes the MHSA, enacted by voters in 2004 as Proposition 63, to provide funds to counties to expand services, develop innovative programs, and integrate service plans for mentally ill children, adults, and seniors through a 1% income tax on personal income above $1 million.

5) Establishes the Mental Health Student Services Act (MHSSA) as a competitive grant program for the purpose of establishing mental health partnerships between a county's mental health or behavioral health departments and school districts, charter schools, and the county office of education within a county. Requires the MHSOAC to award grants to fund partnerships, subject to an appropriation being made for this purpose. (Health and Safety Code 5886)

6) Requires counties to provide for both Medi-Cal specialty mental health services for serious mental illness and safety-net (non-Medi-Cal) community mental health services.

7) Expresses the intent of the Legislature that the governing board of each school district and each county superintendent of schools maintain fundamental school health services at a level that is adequate to accomplish all of the following: preserve pupils' ability to learn, fulfill existing state requirements and policies regarding pupils' health, and contain health care costs through preventive programs and education. (Education Code (EC) 49427).

8) Specifies that the minimum requirements for the services credential with a specialization in pupil personnel services are a baccalaureate degree or higher degree from an approved institution, a fifth year of study, and any specialized and professional preparation that the Commission on Teacher Credentialing (CTC) may require, including completion of a Commission-approved program of supervised field experience that includes direct classroom contact, jointly sponsored by a school district and a college or university. Authorizes the holder of a services credential with a specialization in pupil personnel services to perform, at all grade levels, the pupil personnel service approved by the CTC as designated on the credential, which may include, but need not be limited to, school counseling, school psychology, child welfare and attendance services, and school social work. (EC 44266).

9) Requires any psychologist employed to provide care to the health and physical development of pupils to hold a school psychologist credential, a general pupil personnel services credential authorizing service as a school psychologist, a standard designated services credential with a specialization in pupil personnel services authorizing service as a psychologist, or a services credential issued by the State Board of Education or the CTC (EC 49422).

10) Specifies that the minimum requirements for a services credential with a specialization in health for a school nurse are all of the following: a baccalaureate or higher degree from an accredited institution, a valid California license as a registered nurse, and one year of coursework beyond the baccalaureate degree in a program approved by the CTC (EC 44267.5).

11) Authorizes school districts to utilize community-based service providers, including volunteers, individuals completing counseling-related internship programs, and state licensed individuals and agencies to assist in providing pupil personnel services, provided that such individuals and agencies are supervised in their school-based activities by an individual holding a pupil personnel services authorization (California Code of Regulations, Title 5, Section 80049.1(c)).

12) Defines "licensed mental health service provider" as "a psychologist licensed by the Board of Psychology, registered psychologist, postdoctoral psychological assistant, postdoctoral psychology trainee employed in an exempt setting (as specified), marriage and family therapist, associate marriage and family therapist, licensed clinical social worker, and associate clinical social worker, licensed professional clinical counselor, and associate professional clinical counselor." (Health and Safety Code 128454).

FISCAL EFFECT: Unknown

COMMENTS:

This bill would establish the Integrated School-Based Behavioral Health Partnership Program to provide early intervention for, and access to, behavioral services for students. The collaborative program between the LEAs and the county behavioral health agencies would be established through a memorandum of understanding (MOU). The MOU would require:

- County behavioral health to provide one or more specified licensing professionals to serve pupils with serious emotional disturbances or substance use disorders, or who are at risk of developing a serious behavioral health condition;

- The LEA to provide location and space appropriate for the delivery of behavioral health services;

- Establishment of processes, delivery of services and types of services, as well as requirements for assisting pupils with private insurance and reimbursement procedures;

- Development of a referral process for LEAs to make appropriate referrals to designated County professionals.

The bill also sets specific parameters for services to pupils enrolled in private health insurance plans regarding timelines for provision of services and requirements to reimburse providers for school-based services under certain circumstances.

The Committee may wish to consider whether this approach to the provision of mental health services for students, as proposed by county behavioral agencies, is sufficiently aligned with the existing systems and processes in place in schools, or whether there is a need to more fully vet such partnership models with education stakeholders to ensure that all existing resources and capacity are fully utilized to meet the needs of students.

Need for the bill. According to the author, "As a teacher for over 30 years, there has been a slow but increased understanding of mental and behavioral health especially in children. As California continues to grapple with the COVID-19 pandemic, we are experiencing an unprecedented rise in behavioral health needs among children and youth. Isolation, anxiety over the uncertainty of the immediate and long-term future, lack of peer support, and concerns with family have and will continue to take a toll with children and youth. Behavioral health, mental wellness and support will be crucial when students return to school. In order to serve the mental and behavioral needs of students and provide support to teachers, collaboration is crucial."

Incidence of mental health and behavioral health issues for children and youth. A 2014 UCLA Policy Brief notes that nearly half of all Americans will need mental health treatment some time during their lifetimes, with initial symptoms frequently occurring in childhood or adolescence. According to a report by the American Institutes for Research (AIR), *Mental Health Needs of Children and Youth,* up to 20% of children in the United States experience a mental, emotional, or behavioral health disorder each year.

Youth mental health crisis intensifying as a result of the COVID-19 pandemic. The American Academy of Pediatrics noted in recent guidance that "emotional and behavioral health challenges were of growing concern before the COVID-19 pandemic, and the public health emergency has only exacerbated these challenges." Prior to the pandemic, the incidence of youth mental health crises was increasing at an alarming rate. Suicide rates among youth ages

10-24 increased over 57% between 2007 and 2018, and as of 2018 suicide was the second leading cause of death for youth ages 15-19, according to the Centers for Disease Control and Prevention (CDC). Youth visits to pediatric emergency departments for suicide and suicidal ideation also doubled during this time period (Burstein, 2019).

The pandemic has dealt a particularly hard blow to students' mental health and well-being - increasing social isolation, disrupting routines, and eliminating social traditions and rites of passage, while also reducing students' access to schools, which serve as the de facto mental health system for children and adolescents. For students from families also facing economic and other challenges, the crisis is deeper still.

The available evidence documents intensifying mental health impacts among students during the pandemic:

- FAIR Health analyzed data from its database of over 32 billion private healthcare insurance claim records, tracking month-by-month changes from January to November 2020 compared to the same months in 2019 and found:

    - Overall Mental Health: In March and April 2020, mental health claim lines for individuals aged 13-18, as a percentage of all medical claim lines, approximately doubled over the same months in the previous year;

    - Intentional Self-Harm: Claims for intentional self-harm as a percentage of all medical claim lines in the 13-18 age group comparing April 2020 to April 2019, doubled (100%);

    - Overdoses: For the age group 13-18, claim lines for overdoses increased by 119% in April 2020 over the same months the year before; and

    - Anxiety and Depressive Disorders: For the age group 13-18, in April 2020, claim lines for generalized anxiety disorder increased 93.6% as a percentage of all medical claim lines over April 2019, while major depressive disorder claim lines increased 84% percent and adjustment disorder claim lines 90% percent. Claims for obsessive compulsive disorder also increased for children aged 6-12.

- According to the CDC, the proportion of children's mental health-related emergency room visits among all pediatric emergency room visits increased and remained elevated through between April and October of 2020. Compared with 2019, the proportion of mental health–related visits for children aged 5–11 and 12–17 years increased approximately 24% and 31%, respectively; and

- A student survey conducted by the ACLU of California at the start of the pandemic found rising rates of adolescent students reporting needing mental health services (22% to 32%), and a decline in reported wellness (from 65% to less than 40%). 23% of students rated their mental wellness at a level requiring immediate intervention.

Importance of prevention and early intervention. Several decades of research have shown the promise and potential lifetime benefits of preventing mental, emotional, and behavioral disorders is greatest when focusing on young people, and that early interventions can be effective in

delaying or preventing the onset of such disorders. Mental health problems that are not addressed early in life can result in severe consequences including serious difficulties at home, with peers, and in school; a higher risk for dropping out of school; and increased risk of engaging in substance use, criminal behavior, and other risk-taking behaviors.

Research suggests that nearly half of all children with emotional or behavioral health difficulties receive no mental health services. Among the relatively few children and youth who do receive mental health services, most do so at school, with schools serving as the de facto mental health system for children in the U.S.

Linkages between mental health and educational outcomes. Early intervention improves outcomes, and comprehensive school mental health systems have been associated with multiple positive educational and performance outcomes. No single funding source can adequately support all mental health and substance-related prevention and treatment needs of students and their families and caregivers; however, federal, state, and community-level resources can be leveraged with other funding streams to ensure appropriate levels of support. Providing these services within schools increases the likelihood of children and adolescents receiving needed services, thus better ensuring academic and life success.

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.

Barriers to seeking treatment for mental and behavioral health disorders. Studies cite a lack of insurance coverage as one of the barriers to children and youth receiving mental health services. However, as mental health and substance abuse services were deemed to be an essential health benefit under the Affordable Care Act, this may be somewhat mitigated. Additional barriers to accessing mental health services include parents with limited English proficiency – 88% of children whose parents had limited English proficiency did not receive any mental health treatment compared to 66% of children with English proficient parents. Other barriers include the complexity of the care system, the inadequate linguistic capacity of existing professional services and resources, as well as the stigmas and cultural barriers to recognizing and seeking treatment for mental health problems.

Meeting student mental health needs through a tiered school-based model. Across the country, school systems are increasingly joining forces with community health, mental health, and social service agencies to promote student well-being and to prevent and treat mental health disorders. Utilizing the school environment—where children spend a significant part of their day—for early intervention brings public health efforts to the students, meeting children where they are and therefore providing more accessible services to those in need. It also provides immediate and

continuing resources to students without requiring families to search for already limited sources of care.

Mental health services that are provided in schools may include counseling, brief interventions to address behavior problems, assessments and referrals to other systems. Providing mental health services in a school-based setting helps address barriers to learning and provides supports so that all students can achieve in school and ultimately in life. Schools are also places where prevention and early intervention activities can occur in a non-stigmatizing environment.

According to the Orange County Department of Education, "California's Multi-Tiered System of Support (MTSS) is a comprehensive framework that aligns academic, behavioral, and social-emotional learning in a fully integrated system of support for the benefit of all students. MTSS offers the potential to create needed systemic change through intentional design and redesign of services and supports to quickly identify and match the needs of all students. The evidence-based domains and features of the California MTSS framework provide opportunities for LEAs to strengthen school, family, and community partnerships while developing the whole child in the most inclusive, equitable learning environment thus closing the equity gaps for all students."

Research suggests that comprehensive school mental health programs offer three tiers of support within a MTSS approach:

- Tier 1: Universal mental health promotion activities for all students;
- Tier 2: Selective prevention services for students identified as at risk for a mental health problem; and
- Tier 3: Indicated services for students who already show signs of a mental health problem.

An important first step in developing a school mental health program is to conduct a thorough assessment of the nature and type of student and family behavioral and mental health needs and the capacity of current school and community resources across the promotion-through-treatment continuum to meet them. Schools, working with their community partners, can collect prevalence data to build a foundation to plan, develop, and implement comprehensive mental health programs and services through strong school-community partnerships. This analysis can reveal gaps in programs and services and provide important information for planning, building, and implementing specific components of such programs. ***The Committee may wish to consider*** whether this bill adequately encompasses the need to reflect the needs of an educational setting and the use of a MTSS model.

California lags in providing critical health and mental health support to pupils. Schools offering mental health services may provide services with credentialed school staff trained to address student mental health needs, and/or may rely on partnerships with community systems, such as county behavioral health agencies, community mental health providers or centers, hospitals, and universities. Credentialed school counselors, psychologists, social workers, and nurses provide critical health and mental health services to pupils. The distribution of support personnel in schools differs significantly from one school district to another throughout the state, but it is clear from the data below that, as a state, California lacks sufficient numbers of trained personnel in our schools to meet the mental health needs of over six million pupils.

School health professional	Number of professionals in California schools in 2018/19	2018/19 ratio of students/professional	Recommended ratios by relevant professional associations
School counselors	10,416	576:1	250:1
School psychologists	6,329	948:1	500-700:1
School social workers	865	6,936:1	250:1
School nurses	2,720	2,205:1	750:1

There is a clear benefit to providing a means for accessing additional trained personnel, through community partnerships, to serve the mental health needs of students. However, this should not displace existing trained school personnel.

Expanding the pool of providers for mental health services. This bill authorized current credentialed school mental health professionals to provide services under the proposed partnership program, including credentialed educational professionals such as school psychologists, social workers, counselors, and school nurses, who hold a Pupil Personnel Services (PPS) credential issued by the CTC.

In addition, this bill would authorize additional mental health providers to provide services to students, as a part of the partnership program, including licensed professionals as well as other trained county behavior health professionals who are subject to supervision requirements under the Medicaid program, including clinical interns or trainees, certified peer specialists, and registered or certified substance use disorder counselors.

It is critical to ensure that all individuals providing services to pupils at schools have been vetted through their credential or licensing process, or are clearly supervised by appropriate professionals. Current Education Code authorizes community-based service providers, including volunteers, individuals completing counseling-related internship programs, and state licensed individuals and agencies to assist in providing PPS, provided that such individuals and agencies are supervised in their school-based activities by an individual holding a pupil personnel services authorization.

This bill does not include this supervision requirement for individuals without a credential or license. However, the sponsors note that partnership providers will not be performing PPS services, and as such, the supervision required in Education Code does not apply. They further note that Medicaid requires that non-licensed staff must be supervised by licensed behavioral health professionals. Finally, they note that Medi-Cal requires a live scan process to bill Medi-Cal, and county behavioral health agencies and contracted providers require fingerprinting for employees.

Funding for school-based mental health services in California. There are a number of local, state, and federal funding streams available to link children and youth with mental health

services, although not all sources are available to schools as they are administered through county agencies and thus, require partnership arrangements such as are proposed by this bill:

1) Local Educational Agency Medi-Cal Billing Option (LEA BOP). This program was established in 1993, and is administered by the DHCS, in collaboration with the CDE. The LEA BOP reimburses LEAs (school districts, county offices of education, charter schools, community colleges, and university campuses) for health-related services provided by qualified health service practitioners to Medi-Cal enrolled students. Services eligible for reimbursement under the program include, but are not limited to:

   - Health and mental health evaluations and health education;
   - Nursing services;
   - Occupational and physical therapy;
   - Physician services;
   - Mental health and counseling services;
   - School health aide services;
   - Speech pathology and audiology services; and
   - Targeted case management services.

   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 for the rate relative to the cost of each individual service from federal funds.

   Recent changes to Medicaid, including the "free care rule" and the opportunity for schools to be reimbursed for services provided to all Medi-Cal eligible students, rather than only those with disabilities, provide a significant opportunity to draw down additional federal funds for school-based health and mental health services. These are discussed in a later section.

2) School-Based Medi-Cal Administrative Activities (SMAA) program. The SMAA 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 SMAA program at the federal level, and DHCS administers the SMAA program in California.

3) Early Periodic Screening, Diagnosis, and Treatment (EPSDT). EPSDT is the children and youth under age 21 health benefit in Medicaid. Under federal Medicaid law, EPSDT services include screening, vision, dental, hearing, and other Medicaid health care, diagnostic services, treatment, and other measures to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services. The purpose of EPSDT is to discover and treat childhood health conditions before they become serious or disabling.

States must inform all Medicaid-eligible families about the benefit, screen children at reasonable intervals, diagnose and treat any health problems found, and report certain data regarding EPSDT participation annually to the Centers for Medicare and Medicaid Services. The EPSDT benefit is designed to ensure that eligible members receive early detection and preventive care in addition to medically necessary treatment services, so that health problems are averted or diagnosed and treated as early as possible. At the current time, schools are unable to access EPSDT funds directly, as these funds are administered through the counties.

4) Proposition 63, the MHSA addresses a broad continuum of prevention, early intervention and service needs as well as providing funding for infrastructure, technology and training needs for the community mental health system. The MHSA requires each county mental health department to prepare and submit a three-year plan to DHCS that must be updated each year and approved by the DHCS after review and comment by the Commission. Counties must submit their plans for approval to the Commission before the counties may spend certain categories of funding. The MHSA provides funding for a range of programs including, those that may be used to support school-based partnerships:

   - Prevention and Early Intervention: Provides services to mental health clients in order to help prevent mental illness from becoming severe and disabling; and

   - Innovation: Provides services and approaches that are creative in an effort to address mental health clients' persistent issues, such as improving services for underserved or unserved populations within the community.

5) The Mental Health Student Services Act, established in 2019 through enactment of SB 75, provides $50 million in funding for grants to partnerships between a county behavioral health department and a LEA to address the need for mental health services for children and youth. In some cases, schools may access additional funds for mental health services in cooperation with their county behavioral health agency, including EPSDT and MHSA funds.

California historically poor at drawing down Medicaid funding. For many years California has drawn down a low share of Medicaid funding through the LEA BOP relative to the number of eligible students in the state. Only approximately one half of California school districts participate in the LEA-BOP program. California ranked 40th among states in federal reimbursement per Medicaid-enrolled school age child in 2014-15, despite having one of the highest levels of Medicaid-eligible children.

Rhode Island and New Hampshire each had fewer than 60,000 Medicaid-enrolled children and were reimbursed for roughly $500 in federal Medicaid funds per child. California represents the other extreme – there were more than three million Medicaid-enrolled school age children in the state, but it was reimbursed for just $29 in federal Medicaid funds per Medicaid-enrolled school-age child. (WestEd 2020).

Recent changes in federal policy will expand services to many more Medi-Cal eligible students. In December, 2014, the Centers for Medicare and Medicaid Services (CMS) issued new guidance authorizing LEAs to serve all Medi-Cal-eligible students, whether or not they have a disability, as identified by having an IEP or an individualized family service plan (IFSP). The California Medicaid State Plan Amendment 15-021 was approved on April 27, 2020 by the federal government. It is anticipated that this could result in much higher levels of claiming for

services due to the much broader eligible population, of all Medi-Cal enrolled children and youth, not only those with a disability.

In addition, 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. 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.

Clear need for collaboration between education and mental health agencies at the local level. As noted above, many of the funding sources available to meet the mental health needs of students are within the purview of county behavioral health agencies and thus, partnerships such as those proposed by this bill are likely to expand the funding available to meet the mental health needs of schools. This bill also proposes to allow county behavioral health agencies to access reimbursement for services provided to students who are not Medi-Cal eligible, but are served by private insurers or providers. This approach could enable the provision of mental health services to all students, regardless of their insurance status. ***The Committee may wish to consider*** the impact on services to students if parents are unwilling to provide information on private insurance coverage.

In order to fulfill the promise to serve all students, there is a need for collaboration at the local level. This has been recognized within a workgroup studying the funding of school-based health and mental health services. SB 75 (Committee on Budget and Fiscal Review), chaptered in 2019, required the CDE and the DHCS to jointly convene a stakeholder workgroup to provide input and recommendations on "improving coordination and expansion of access to available federal funds through the LEA Medi-Cal Billing Option Program, the School-Based Administrative Activities Program, and medically necessary federal Early and Periodic Screening, Diagnostic, and Treatment Benefits." The final SB 75 report is due October 1, 2021, however an interim report was released on October 1, 2020. The report notes the potential for schools to collaborate with managed care plans and mental health plans:

> LEAs in California use other strategies to leverage federal Medicaid funds for school-based health services that cannot be billed through the LEA BOP but that can be billed through alternative claiming and reimbursement streams, for example, through managed care plans (MCPs) or other state or federal social service programs, or through a county-operated mental health plan (MHP). Billing for EPSDT services that are not claimable under the LEA BOP and the SMAA program requires partnerships with other agencies and organizations, such as community-based organizations, MHPs, and MCPs. Generally, these strategies utilize traditional medical providers and embed those services in a school setting.

The SB 75 interim report also identifies challenges inherent in establishing these partnerships, related to services for students with disabilities, as well as other Medi-Cal eligible students:

> LEAs are unique Medicaid providers because of the Individuals with Disabilities Education Act (IDEA) Free Appropriate Public Education requirement that obligates LEAs to pay for special education and related services required as part of a student's IEP. LEAs become the de facto provider of many health services because LEAs are obligated, under the IDEA, to find students with disabilities who need special education and related services, and, if these students are found to qualify for special education, LEAs must provide these services, whether or not they have the opportunity to seek reimbursement for the associated costs.
>
> LEAs may also wish to expand service offerings for all Medicaid-enrolled students, not only students with disabilities, but may not be able to seek reimbursement for such expansions because not all services are eligible for billing under the LEA BOP.
>
> LEAs in California have three options when they are legally required to provide a Medicaid-coverable service under the IDEA or want to expand service offerings to all Medicaid enrolled students, but the services are not reimbursable under the LEA BOP. LEAs may (a) provide the service without reimbursement; (b) become a provider with an MCP or an MHP; or (c) contract with a provider, an MCP, or an MHP to provide that service. These contracts are not facilitated by any state agency.
>
> According to stakeholders, if an LEA attempts to use the second or third option with an MCP—become a provider under an MCP or contract with a provider or an MCP—it may not be able find guidance and ultimately not able to forge a relationship. The challenges that stakeholders described in forming these relationships may be due, in part, to the fact that MCPs are paid a capitated rate for all children enrolled in the plan, regardless of the number of services provided or the cost of those services. Such a structure may create policy-based barriers to collaboration among local institutions (e.g., schools and health providers) and increases the steps and actions for a Medicaid beneficiary to take in seeking out such services.

Recommended Committee Amendments. Staff recommends that the bill be amended to:

1) Require that county behavioral health agencies and LEAs conduct a thorough needs assessment as a first step in considering the establishment of a partnership program, including the existing capacity of school-based personnel to provide services and the need to supplement with county or community-based providers;

2) Ensure that the MOU for the partnership program include a requirement that the parties ensure that all mental health professionals providing services to students are appropriately credentialed, licensed, or are supervised as required by state or federal law;

3) Include credentialed school staff as options for referrals for services to pupils;

4) Specify that prevention and intervention services be provided in a school-based setting within an MTSS model approach;

5) Include a technical amendment to add language to clarify the intent in 49440.8 (c), that "if additional behavioral health services beyond initial intervention services are" necessary.

6) Require that the MOU specify how services will be provided and funded for students with private insurance if the parent is unwilling to provide the necessary information.

7) Clarify that the Partnership Program will work together to delineate responsibilities for services required by an IEP for a student with exceptional needs.

Arguments in support. The County Behavioral Health Directors Association, co-sponsors of the bill, state:

> AB 552 would create the Integrated School-Based Behavioral Health Services Partnership Program encouraging LEAs and county behavioral health agencies to collaborate on providing on-school-campus services for students at the earliest onset of a behavioral health condition. Currently, 85% of county behavioral health agencies provide specialty mental health services (SMHS) on school campuses and 53% of agencies provide substance use disorder (SUD) services on campus. Most county behavioral health agencies cover less than half of school campuses providing school-based SMHS. County behavioral health agencies currently cover less schools with SUD services. Thirty-two counties indicated that they cover less than 20% of school campuses with SUD services. In general, county behavioral health agencies serve Medi-Cal beneficiaries and uninsured students on school campuses.
>
> According to a survey of county behavioral health agencies, a barrier encountered in expanding county behavioral health services on school campuses is the reluctance on the part of schools to allow county behavioral health professionals on campus unless all students can be served, including privately insured students. Understandably, school administrators are reluctant to have groups of students treated differently if a behavioral health need is identified. The Partnership Programs will allow LEAs and county behavioral health agencies to serve all referred students. County behavioral health professionals will provide a warm hand-off to private plan providers for privately-insured students, if a provider is available within the state mandated timely access timeframes.

Related legislation. AB 58 (Salas) of this Session requires LEAs to provide suicide awareness and prevention training annually to teachers; states the intent of the Legislature to require the DHCS to create a pilot program to establish a school health center at five LEAs in counties with high rates of youth suicide and self-harm; and requires DHCS to provide technical assistance to the CDE and LEAs to ensure LEAs take full advantage of federal funds for Medi-Cal eligible students.

AB 309 (Gabriel) of this Session requires the CDE to develop model pupil mental health referral protocols, in consultation with relevant stakeholders, subject to the availability of funding for this purpose.

AB 563 (Berman) of this Session requires the CDE to establish an Office of School-Based Health Programs for the purpose of improving the operation of, and participation in, school-based health programs, including the SMAA and the LEA BOP. Requires that $500,000 in federal reimbursements be made available for transfer through an interagency agreement to CDE for the support of the Office.

AB 586 (O'Donnell) of this Session establishes the School Health Demonstration Project to expand comprehensive health and mental health services to students by providing intensive assistance and support to selected local educational agencies to build the capacity for long-term sustainability through leveraging multiple funding streams and partnering with county Mental Health Plans, Managed Care Organizations, and community-based providers. Lessons learned through the pilot project would be used as a basis to scale up robust and sustainable school-based health and mental health services throughout the state.

AB 883 (O'Donnell) of this Session requires Proposition 63 Mental Health Services Act (MHSA) funds unused by counties, within a specified period, to be reallocated to LEAs in that county to provide student mental health services.

AB 1080 (Cunningham) of this Session authorizes school districts to partner with local or community mental health providers or clinics to administer its educational counseling program.

AB 1081 (Cunningham) of this Session requires the SPI, beginning with the 2021-22 fiscal year, to annually adjust the Local Control Funding Formula (LCFF) grade span adjustment by a specified amount for those LEAs documenting a partnership with a local mental health agency to promote integrated services, federal reimbursements, positive school climate, and pupil success, including but not limited to peer-led strengths-based, and wellness-oriented services; as well as alignment with the LCAP and the county's prevention and early intervention plan; and documented service access with at least one mental health professional for every 500 pupils of the school district or charter school.

AB 1117 (Wicks) of this Session establishes the Healthy Start: Toxic Stress & Trauma Resiliency for Children Program within the CDE, in partnership with the Health and Human Services Agency, to oversee a grant program to fund innovative local collaboratives between schools, communities, county and city agencies, nonprofit service providers, and early childhood serving programs and agencies.

SB 14 (Portantino) of this Session adds "for the benefit of the behavioral health of the pupil" to the list of categories of excused absences for purposes of school attendance; and requires the CDE to identify an evidence-based training program for LEAs to use to train classified and certificated school employees having direct contact with pupils in youth behavioral health; and an evidence-based behavioral health training program with a curriculum tailored for pupils in grades 10 to 12.

SB 229 (Dahle) of this Session requires DHCS, in consultation with CDE, to provide up to $500 million in grants annually to LEAs and private schools, to provide mental health services for pupils affected by school closures and distance learning requirements resulting from the COVID-19 pandemic, subject to an appropriation by the Legislature for this purpose.

SB 508 (Stern) of this Session requires specified health care service plans, health insurers, and Medi-Cal managed care plan to enter into a MOU with all LEAs where 15% or more of the pupils of that LEA are insured by the plan or insurer; authorizes the LEA to bill for mental health and substance use disorder services provided if the plan or insurer fails to enter into a MOU with the LEA; approves telehealth as an approved modality for provision of specified services by an LEA; and authorizes a school district to require parents provide information on a pupil's health care coverage.

AB 2668 (Quirk Silva) of the 2019-20 Session was substantially similar to this bill. The bill was held in the Assembly Education Committee.
AB 8 (Chu) of the 2019-20 Session would have required schools to have one mental health professional for every 400 pupils accessible on campus during school hours, and for schools of less than 400 pupils, to employ at least one mental health professional for one or more schools or enter into an agreement with a county agency or community-based organization to provide mental health services to pupils. This bill was held by the Senate Health Committee.

SB 75 (Committee on Budget and Fiscal Review) Chapter 51, Statutes of 2019, establishes the Mental Health Student Services Act as a mental health partnership competitive grant program for establishing mental health partnerships between a county's mental health or behavioral health departments and school districts, charter schools, and the county office of education within the county, as provided. Also requires the CDE to jointly convene with the DHCS, a workgroup that include representatives from local educational agencies, appropriate county agencies, and legislative staff to develop recommendations on improving coordination and expansion of access to available federal funds through the LEA BOP, SMAA, and medically necessary federal EPSDT benefits.

AB 258 (Jones-Sawyer) of the 2019-20 Session would have established the School-Based Pupil Support Services Program Act, to provide grants to LEAs for increasing the presence of school health professionals at schoolsites and providing programs that prevent and reduce substance abuse among pupils. The source of the state funding for the grants awarded under the program would be an appropriation from the Youth Education, Prevention, Early Intervention and Treatment Account established pursuant to the Control, Regulate and Tax Adult Use of Marijuana Act (Proposition 64). This bill was vetoed by the Governor with the following message:

> I support increased access to mental health prevention, early intervention, and support programs in schools, which is why I worked with the Legislature to provide an additional $50 million for those programs. While well intentioned, this bill, however, attempts to change the fund allocation process specified by Proposition 64. DHCS has already directed these funds toward expanding access to child care, which is one of our shared priorities and a commitment reflected in this year's budget deal. Additionally, Proposition 64 does not authorize the Legislature to modify the fund allocation process by July 1, 2028.

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

AB 2315 (Quirk Silva) Chapter 759, Statutes of 2018, requires the CDE, in consultation with the DHCS and appropriate stakeholders with experience in telehealth, to develop guidelines on or before July 1, 2020, for the use of telehealth technology to provide mental health and behavioral health services to pupils on public school campuses, including charter schools.

AB 2471 (Thurmond) of the 2017-18 Session, would have required the transfer of funds from the Youth, Education, Prevention, Early Intervention and Treatment Account established through the passage of the Control, Regulate and Tax Adult Use of Marijuana Act to the CDE to establish a

grant program which would allow schools to provide in-school support services to pupils. This bill was held in the Assembly Appropriations Committee.

SB 1113 (Beall) of the 2015-16 Session, would have authorized a county, or a qualified provider operating as part of the county mental health plan network, and a LEA to enter into a partnership for the provision of EPSDT mental health services. This bill was vetoed by the Governor with the following message:

> Despite significant funding increases for local educational agencies over the past few years, the Local Control Funding Formula remains only 96 percent funded. Given the precarious balance of the state budget, establishing new programs with the expectation of funding in the future is counterproductive to the Administration's efforts to sustain a balanced budget and to fully fund the Local Control Funding Formula. Additional spending to support new programs must be considered in the annual budget process.

REGISTERED SUPPORT / OPPOSITION:

Support

California Alliance of Child and Family Services
Children Now
County Behavioral Health Directors Association
Seneca Family of Agencies
The California Association of Local Behavioral Health Boards and Commissions
United Parents
One individual

Opposition

None on file

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