Date of Hearing: March 24, 2021

ASSEMBLY COMMITTEE ON EDUCATION
Patrick O'Donnell, Chair
AB 563 (Berman) – As Introduced February 11, 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: School-based health programs

SUMMARY Requires the California Department of Education (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 Medi-Cal Administrative Activities claiming process (SMAA) and the Local Education Agency Medi-Cal billing option program (LEA Billing Option). Requires that $500,000 in federal reimbursements be made available for transfer through an interagency agreement to CDE for the support of the Office. Specifically, **this bill**:

1) Requires the CDE, no later than July 1, 2022, to establish an Office of School-Based Health Programs (Office), for the purpose of:

   a) Administering current health-related programs under the purview of the CDE; and

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

2) Requires the scope of the Office to include, but not be limited to, collaborating with the Department of Health Care Services (DHCS) on proposals for the expansion of school-based health services; as well as assisting local educational agencies (LEAs) with information on, and participation in, the following school-based health programs:

   a) The SMAA claiming process;

   b) The LEA BOP program; and

   c) All other programs under the federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services entitlement.

3) Requires the Office to identify opportunities for effective coordination between the state's health and education systems at the state, regional, and local levels to advance school-based health programs, and on strategies to leverage school-based Medi-Cal programs to sustain school-based health services.

4) Requires the Office to determine the opportunities for expanding services, simplifying the administration of school-based health programs, increasing LEA participation, and maximizing allowable federal financial participation in the school-based health programs. Requires that these considerations include the benefits, costs, and feasibility associated with the proposed opportunities to expand services.

5) Requires the Office to provide technical assistance, outreach, and informational materials to LEAs on allowable services and the submission of claims. Prohibits the Office from providing informational materials related to the DHCS's school-based health programs that have not been approved the DHCS.

6) Permits the Office to form advisory groups for technical assistance, for support in establishing the Office, and other purposes as deemed necessary.

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

8) Requires the Office to be supported through an interagency agreement with the DHCS and by federal matching funds for eligible staff time. Permits additional funds from grants and other sources to be used to support the Office.

9) Authorizes the CDE to use an existing branch or division with the department to serve as the Office, in lieu of establishing a new office.

10) Increases the annual amount of funds collected for DHCS' administrative costs as a result of the reduction in federal Medicaid payments allocable to LEAs, from $1.5 million to $2 million, and requires $500,000 of this amount to be available for transfer through an interagency agreement to CDE for the support of the Office.

EXISTING LAW:

1) Requires that specified services provided by an 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, and defines the scope of covered services. (Welfare and Institutions (WIC) 14132.06)

2) Defines LEA, for the purpose of the LEA BOP, to include school districts, county offices of education, state special schools, charter schools, and California State University and University of California campuses. (WIC 14132.06)

3) 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 individualized education program (IEP) or an individualized family service plan (IFSP), or whether those same services are provided at no charge to the child or to the community at large. (WIC 14132.06)

4) Authorizes the DHCS to contract with participating local educational consortia to assist with the performance of administrative activities necessary for the proper and efficient administration of the Medi-Cal program, as the Administrative Claiming process. Requires DHCS to provide technical assistance to all participating local educational consortia in order to maximize federal financial participation in the SMAA. (WIC 14132.47)

5) Requires DHCS, in order to assist in the formulating of state plan amendments, to regularly consult with CDE, representatives of urban, rural, large and small school districts, and county

offices of education, the local education consortium, and local educational agencies. This is known as the LEA Ad Hoc Workgroup.

6) Requires DHCS, in consultation with the LEA Ad Hoc Workgroup, to issue and regularly maintain a program guide for the LEA Medi-Cal Billing Option program, as specified.

FISCAL EFFECT: Unknown.

COMMENTS: ***Need for the bill.*** According to the author, "School-based health services play a key role in ensuring that California students are safe and ready to learn. When poorly treated, health and mental health conditions can have a devastating impact on school attendance, behavior, and academic achievement. The COVID-19 pandemic has exacerbated inequities in both education and health care. There is an opportunity for the CDE to play a vital role in increasing school participation and assisting schools that are currently providing health care services to their Medi-Cal students. Unfortunately, in California, there is no institutionalized partnership between the DHCS, which oversees Medi-Cal, and the CDE to coordinate various health programs and services delivered through schools. AB 563 would fill this gap by establishing the Office of School-Based Health Programs within the CDE to ensure a coordinated approach to assist schools in meeting the increased demand for student health and mental health services while drawing down federal reimbursement."

This bill would create an Office of School-Based Health Programs at CDE. According to the CDE, because until recently only students with IEPs and IFSPs were eligible for services through the LEA BOP, the CDE has located its programmatic expertise in its special education division. Now that the program is expanding to all Medi-Cal eligible students, a centralized office may be more appropriate. The bill provides the CDE with the option to use an existing branch or division within the department to serve as this office, in lieu of establishing a new office.

School-based health services in California. Schools are well positioned to respond to the health and mental health needs of pupils because of their access to children and families. One of the key ways that schools fund school-based health services is through the LEA BOP, which was established in 1993. The program 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.

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.

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.

LEAs that elect to participate in SMAA must submit claims through a Local Educational Consortium (LEC) or a Local Governmental Agency (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 SMAA, 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 SMAA claiming process, including claims processing, technical assistance, and monitoring.

The COVID-19 pandemic has increased need for school-based health and mental health services. 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 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.

As schools return to in-person instruction, there will be an increased need to support the mental health needs of students; to ensure regular mandatory vaccinations are up-to-date; to implement COVID-19 public health guidance in schools; to implement ongoing COVID-19 testing and symptom screening; and to respond to COVID-19 outbreaks. Coordinated state level guidance, incorporating both public health and education concerns will be increasingly important in supporting the personnel involved in providing school-based services.

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.

Lack of state level capacity and inter-agency collaboration in school-based health. In addition to the needs arising as a result of the COVID-19 pandemic, several recent developments have made the need for state-level coordination and support more evident. One is the recent expansion of the LEA BOP, which 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.

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. In identifying potential barriers to providing health services and accessing federal reimbursement through school-based Medicaid programs, the report noted the lack of interagency collaboration at the state level:

- "Currently the CDE is not listed as a partner in the state's Medicaid plan and has no formal role in school-based Medicaid. The absence of interagency collaboration was raised repeatedly by workgroup and steering committee members as the single greatest barrier to school-based Medicaid systems improvement."

- "Stakeholders identified that schools need expertise and guidance from both the CDE and the DHCS to ensure that all Medicaid-enrolled children receive services. However, stakeholders reported that, to be effective, the CDE must be given sufficient authority and resources to undertake the collaboration."

- "The DHCS is the only state agency with a formal role in supporting school-based medical services, but it has no staff with education policy or education reform expertise. LEAs typically turn to the CDE for statutory guidance because CDE staff understand the language and cultural of schools and provide technical assistance on compliance with federal education programs, such as Title I. The CDE does not have any dedicated staff to field requests and assistance in this area."

The need for greater collaboration between DHCS and CDE has also been recognized by numerous education and health care stakeholders for many years. In 2017, 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 SMAA and the LEA billing option, and 3) complete the required MOU between CDE and DHCS to facilitate services.

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."

State Auditor identifies need for coordinated state level approach to improve access to health-based services. A September 2020 report by the California State Auditor, *Youth Suicide Prevention*, also identified the importance of inter-agency collaboration at the state level:

> Although the billing option program represents a significant potential source of funds for LEAs, according to Health Care Services data, only 600 of the State's 2,400 LEAs participate in the program. Some LEAs participate through their respective county offices of education. Thus, it is unclear how many of the 1,800 LEAs that are not Medi-Cal providers participate in the billing option program.

State law assigns Health Care Services the responsibility of communicating with LEAs and collaborating with Education to increase LEA participation in the billing option program. Although Health Care Services has conducted some outreach regarding the program's expansion through in-person and online trainings, these efforts were primarily focused on existing participants because Health Care Services does not actively send information about the program to nonparticipating LEAs. According to its branch chief, Health Care Services does not have the staff necessary to conduct additional outreach efforts, and it does not actively track which LEAs do not participate in the program; rather, it relies on Education to forward information on the billing option program to nonparticipating LEAs.

Education's administrator for school health and safety indicated that it has sent some information about the billing option program expansion to all LEAs on behalf of Health Care Services. However, as we describe earlier, it is unclear how many of the 1,800 LEAs across the State that are not Medi-Cal providers take advantage of this program. Further, according to the branch chief for Health Care Services, it has not informed LEAs of the option to leverage county offices of education to handle the administrative tasks associated with the billing option program. Until Health Care Services and Education take a coordinated approach to informing LEAs about this option, some LEAs are less likely to take advantage of these federal funds, which they could use to improve students' access to the mental health care they need.

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 the 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 SMAA and LEA BOP.

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."

How could the administration of these programs improve through inter-agency collaboration? LEAs cite numerous challenges navigating the intersection between education and health care systems. Below are some examples of issues that frequently arise when LEAs participate in the school-based Medi-Cal programs:

- **Compliance** – Issues that arise include compliance requirements regarding eligible services, eligible providers, mechanics of billing outside of special education, implementation of random moment time surveys; provider qualifications in school settings vs. medical settings, documentation of services; student privacy law (FERPA and HIPPA); parental consent; translation; changes to services in an IEP; accounting and other fiscal issues between health and education systems;

- **Communication** – CDE maintains frequent communication with all LEAs and charter schools, and collaboration with the DHCS could establish better communication with the field on the school-based Medi-Cal programs. As the LEA BOP program shifts from a

special education program to a broader program, communication with LEAs will be increasingly important; and

- **Coordination** – LEAs report needing better resources to help them bill for services, particularly with the Free Care expansion, and there appears to be a need for outreach and education for LEAs not participating and those who wish to expand services. Collaboration between the two departments could yield better technical assistance and support to aid with the Free Care expansion (discussed below), as well as leveraging of other funding sources, such as Early Periodic Screening, Diagnostic and Treatment (EPSDT), special education mental health funds, CalMHSA-funded initiatives, and grant opportunities.

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. The SB 75 interim report notes that:

> "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 illustrates 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."

"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.

Recent change in federal policy will expand services to many more students. In addition to the Free Care Rule noted above, another change in federal policy opens up new opportunities for schools to be reimbursed for health services provided to 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 are a student with exceptional needs as outlined in their IEP or 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. 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.

Recommended committee amendments. Staff recommends that the bill be amended with a technical amendment to clarify that DHCS is the only state agency with authority from the Centers for Medicare and Medicaid Services to define allowable services and compliant submission of claims.

Arguments in support. The California School Nurses Organization states "We are the proud co-sponsors of this measure and fully support the establishment of an Office of School Based Health within the Department of Education. Based on a December, 2014 ruling from CMS, the free care rule has been removed which will allow schools to claim reimbursement for services provided to all students who are Medi-Cal eligible, not just for those with IEPs or IFSPs. Under this expansion, the new State Plan Amendment calls for increased numbers of providers, treatments and qualified practitioners.

California presently does not have a formal inter-agency relationship with the Department of Health Care Services (DHCS) which oversees the Medi-cal program. With this new expansion, we believe the time is now to fully develop and formalize the relationship between DHCS and CDE. We believe with the establishment of this office, schools will be encouraged to enroll in the two Medi-Cal school based programs - LEA BOP and SMAA. The increased services and providers that now qualify for reimbursement will allow schools to maintain and increase programs to provide and support student health. The long awaited collaboration and coordination between CDE and DHCS will be implemented."

Related legislation. AB 1322 (Berman) of the 2019-20 Session was substantially similar to this bill. The bill was vetoed by the Governor with the following message:

> This bill would establish a school-based health unit within the California Department of Education (CDE) to administer and support school-based health programs operated by local

> educational agencies. In recognition that all state agencies must work together to better support our youth, the 2019 Budget Act included $500,000 in one-time funding to support the creation of an interagency collaborative between the Department of Education, the Department of Health Care Services, and other regional and state agencies to improve the coordination and accessibility of services and supports to our students. While this bill is well-intentioned, the creation of a school-based health unit at the CDE would be premature given this recent investment.

AB 3192 (O'Donnell) Chapter 658, Statutes of 2018 requires DHCS, in consultation with the LEA Ad Hoc Workgroup, to issue and regularly maintain a program guide for the LEA Medi-Cal Billing Option program, as specified.

AB 834 (O'Donnell) of the 2017-18 Session would have established an Office of School-Based Health Programs within the CDE to administer and support school-based health programs operated by public schools. This bill was held in the Senate Appropriations 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 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. 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 SMAA 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 SMAA. This bill was held in the Assembly Appropriations Committee.

SB 231 (Ortiz), Chapter 655, Statutes of 2001, requires the DHCS to amend the Medicaid state plan with respect to the LEA BOP 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 BOP 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.

REGISTERED SUPPORT / OPPOSITION:

Support

California Association of School Psychologists
California Association of Student Councils
California School Boards Association
California School Nurse's Organization
California School Nurses Organization
California School-based Health Alliance
California Teachers Association
Central Unified School District
James Morehouse Project (bay Area Community Resources--fiscal Sponsor)
LA Clinica De LA Raza, INC.
North County Health Services
San Joaquin County School Nurses and County Office of Education School Nurses
Teachers for Healthy Kids
Teens for Vaccines INC.
The California Children's Trust
The Los Angeles Trust for Children's Health

Opposition

None on file

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