Date of Hearing: April 7, 2021

ASSEMBLY COMMITTEE ON EDUCATION
Patrick O'Donnell, Chair
AB 586 (O'Donnell) – As Amended March 25, 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: Pupil health: health and mental health services: School Health Demonstration Project

SUMMARY: Establishes, subject to an appropriation for this purpose, the School Health Demonstration Project to provide intensive technical assistance to selected local educational agencies (LEAs) to enable the long-term sustainable provision of health and mental health services to pupils. Specifically, **this bill**:

1) Establishes the School Health Demonstration Project (Project), subject to an appropriation for this purpose, to expand comprehensive health and mental health services to public school pupils by providing LEAs with intensive assistance and support to build the capacity for long-term sustainability by leveraging multiple funding streams.

2) Provides training and technical assistance to LEAs on the requirements for health care provider participation in the Medi-Cal program to enable LEAs to participate in, contract with, and conduct billing and claiming in the Medi-Cal program through all of the following:

   a) The Local Educational Agency Medi-Cal Billing Option Program (LEA BOP);

   b) The School-Based Medi-Cal Administrative Activities Program (SMAA);

   c) Contracting with Medi-Cal managed care plans as a participating Medi-Cal managed care plan contracting provider; and

   d) Contracting with county mental health plans for specialty mental health services through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program.

3) Requires the Superintendent of Public Instruction (SPI), in consultation with the State Board of Education (SBE) and the Department of Health Care Services (DHCS), by March 1, 2022 to select up to three organizations to serve as technical assistance teams for purposes of the Project.

4) Requires that an organization selected as a technical assistance team be an LEA, county agency, community-based organization, or consortia with extensive experience in school finance, Medicaid billing, commercial health insurance, and data analysis.

5) Requires the technical assistance teams to provide hands-on, intensive support for a two-year period to the LEAs selected to be participants in the Project, to create capacity for those LEAs to become self-sustaining by securing federal reimbursement and other funding streams for health and mental health services to pupils.

6) Requires that, in selecting the technical assistance teams, consideration be given to those organizations with demonstrated expertise including, but not limited to, the following:

    a) Knowledge of the process to submit claims through the LEA BOP, the SMAA, and drawing down federal reimbursement for Medi-Cal services, including EPSDT;

    b) The knowledge and capacity to provide direct, hands-on assistance and support to selected LEAs in securing federal reimbursement for health and mental health services provided to pupils, and identifying additional sources of funding; and

    c) Experience working with the California Department of Education (CDE), DHCS, county health departments, county behavioral health departments, Medi-Cal managed care plans, private health care service plans and health insurers, and the Mental Health Services Oversight and Accountability Commission (MHSOAC).

7) Requires the CDE, by May 1, 2022, in consultation with DHCS, to select up to an unspecified number of LEAs to serve as participants in the Project for a period of two years.

8) Requires all of the following to be considered in selecting participating LEAs:

    a) Demonstrated need for health and mental health services for pupils;

    b) Commitment of the LEA's leadership to expand health and mental health services for all pupils;

    c) Willingness to reinvest increased reimbursements gained through the pilot project into direct health and mental health services for pupils;

    d) Unduplicated pupil count;

    e) Geographic diversity of the state; and

    f) Mix of urban, suburban, and rural.

9) Requires that an LEA selected to serve as a participant receive up to $500,000 per year for each of the two years as a participating location in the Project, requires that funds be used for contracting with one of the selected technical assistance teams, and authorizes funds to be also used for, but not be limited to, any of the following:

    a) Staffing, including the hiring of support staff responsible for Medi-Cal and other insurance billing;

    b) Professional development and participation in professional learning networks related to pupil health and mental health;

    c) Conducting outreach to pupils and families; and

    d) Data analysis and reporting.

10) Requires the selected technical assistance teams, under the direction of CDE, to work with each participating LEA to do all of the following:

    a) Conduct an analysis of all of the following related to the LEA:

        i) The need for health and mental health services for pupils;

        ii) The current capacity within the LEA to meet those needs;

        iii) Current participation in LEA BOP and SMAA programs;

        iv) Barriers to participating in LEA BOP and SMAA programs; and

        v) Any existing partnerships with county agencies or community-based agencies to provide health and mental health services to pupils.

    b) Work with the LEA staff to establish or expand the expertise necessary to maximize federal reimbursement revenue through an analysis of past claims and review eligible school expenditures to ensure maximum usage of potential Medi-Cal reimbursements, including the EPSDT services provided to eligible pupils; and

    c) Facilitate the exploration of opportunities to collaborate with county mental health plans (MHPs), Medi-Cal managed care plans (MCPs), and private health care service plans and health insurers to establish partnerships through memoranda of understanding (MOU) or other means to coordinate the funding and provision of health and mental health services to pupils.

11) Requires the CDE, in consultation with the DHCS, participating LEAs, and the technical assistance teams, to prepare and submit to the Legislature, by an unspecified date, a final report of the Project, including, but not limited to all of the following:

    a) Best practices developed by LEAs that ensure every pupil receives an uninterrupted continuum of care services;

    b) Program requirements and support services needed for the LEA BOP, SMAA, and medically necessary federal EPSDT benefits, to ensure ease of use and access for LEAs;

    c) Total dollars drawn down from federal sources by LEAs participating in the Project;

    d) The number of pupils receiving health and mental health services by participating LEAs throughout the course of the Project, including breakdowns by subgroups;

    e) Recommendations for expanding the program statewide, including an estimate of the cost of fully funding an ongoing technical assistance and support program on a statewide basis; and

    f) Recommendations on specific changes needed to state regulations or statute, the need for approval of amendments to the state Medicaid plan or federal waivers, changes to

implementation of federal regulations, changes to state agency support and oversight, and associated staffing or funding needed to implement the recommendations.

12) Requires the CDE to coordinate and collaborate with expert lead agencies identified as part of the statewide system of support, special education resource leads, the DHCS, and the MHSOAC in developing a statewide system of support for school-based health and mental health services.

13) Requires the CDE, in consultation with the technical assistance teams, the DHCS, and the MHSOAC, to prepare materials for use by LEAs in developing the capacity to effectively secure sustainable funding for the delivery of comprehensive health and mental health services to pupils.

14) Requires the DHCS to seek federal financial participation for the activities conducted as part of the Project.

15) Defines the following terms for the purposes of this section:

    a) "County mental health plan" means an entity authorized pursuant to Article 5 (commencing with Section 14680) of Chapter 8.8 of Part 3 of Division 9 of the Welfare and Institutions Code; and

    b) "Medi-Cal managed care plan" means an individual, organization, or entity that enters into a contract with the department to provide services to enrolled Medi-Cal beneficiaries, as specified.

EXISTING LAW:

1) 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).

2) Requires that specified services provided by an LEA be covered Medi-Cal benefits, to the extent federal financial participation (FFP) is available, be subject to utilization controls and standards adopted by DHCS, and be consistent with Medi-Cal requirements for physician prescription, order, and supervision, and defines the scope of covered services (Welfare and Institutions Code (WIC) 14132.06).

3) Establishes a schedule of benefits under the Medi-Cal program, which includes EPSDT for any individual under 21 years of age, consistent with federal Medicaid requirements.

4) Requires the DHCS, in collaboration with the California Health and Human Services Agency, and 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.

5) 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.

6) 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)

7) 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.

8) 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).

9) 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).

10) 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).

11) 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 LEAs. This is known as the LEA Ad Hoc Workgroup.

12) 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, "AB 586 establishes the School Health Demonstration Project to expand comprehensive health and mental health services to students by providing intensive assistance and support to selected LEAs 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 will be used as a basis to scale up robust and sustainable school-based health and mental health services throughout the state.

For too long, schools have lacked the guidance and support necessary to take advantage of the multiple funding streams available to support school-based health and mental health services. California schools bill far less, and draw down significantly less in federal reimbursements for Medicaid services than other states. For example, California spends $29 per Medi-Cal eligible child, while Montana generates over $500 per eligible child. Schools have the opportunity to bill more under Medi-Cal to generate additional federal revenue to better support health services for students.

This bill will enable select LEAs to receive the support and guidance they need to expand the availability of comprehensive health and mental health services, which are so desperately needed by our students."

Funding for 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. There are a number of funding streams potentially available to schools to fund these critical services, including, but not limited to:

1) Local Education Agency Billing Option Program (LEA BOP). 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. 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.

    Recent data identifies the most common procedure reimbursed under the LEA-BOP in California in 2018-19 as speech therapy, accounting for 73% of all approved reimbursement claims. Clearly, there is an opportunity for schools to bill for a much broader range of services, but this may require additional training and support.

    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 elimination of 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. 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.

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. 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.

4) Proposition 63, the Mental Health Services Act (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) Mental Health Student Services Act (MHSSA), 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. In California 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 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.

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.

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 promoting 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.

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	# 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

The COVID-19 pandemic has increased the 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.

Clear need for support for LEAs. Participation by LEAs in existing programs to support school-based health services is particularly low, with only approximately 50% of school districts participating in the LEA BOP. 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 support for LEAs as one of the key barriers to participation in these programs:

> The DHCS currently provides technical assistance to LEAs on school-based Medicaid. Activities include multiple trainings per year as well as virtual and on-site technical assistance. However, the DHCS has only four full-time equivalents (FTEs) designated for oversight and assistance to LEAs related to the LEA BOP and seven FTE for the SMAA program. To put this number in perspective, if all LEAs participated in the LEA BOP, each staff person would be responsible for approximately 150 LEAs. As evidence of the strain on DHCS resources, only just over 20% of statewide survey respondents indicated that they received training from the DHCS on the LEA BOP. The CDE, meanwhile, does not have any designated staff or funding to support the LEA BOP or the SMAA program.

Outside of the DHCS, most school-based Medicaid training is regional. The state does not have a statewide technical assistance center, and the CDE does not play a formal technical assistance role. Survey respondents identified COEs and LECs as most likely to provide training for LEAs on the SMAA program (48% of respondents) and the LEA BOP (35% of respondents). LECs step in to provide training on the LEA BOP, even though, until SPA 15-021, they had no formal administration or supervisory role in the LEA BOP.

Nearly 10% of survey respondents indicated that no entity provides them with training on the SMAA program or the LEA BOP. However, stakeholders expressed the importance of having administrators who are familiar with and supportive of Medicaid billing in order to build sustainable infrastructure for Medicaid reimbursement programs. This was reported as especially critical in LEAs that experience high rates of staff turnover.

Other barriers to participation in these programs, identified by LEAs, include a lack of interagency collaboration between the DHCS and the CDE; extensive documentation requirements; the audit process; the discrepancy between interim and final reimbursement amounts; and the difficulties associated with establishing partnerships with MCPs and MHPs.

Recommended committee amendments. Staff recommends that the bill be amended:

1) To clarify that schools may contract with community-based providers to deliver health and mental health services, through the pilot project, to pupils, provided that they are contracted with Medi-Cal managed care plans or county mental health plans.

2) To require the report to the Legislature from the CDE, in consultation with DHCS, LEAs participating in the pilot, and the technical assistance team, be provided no later than January 1, 2025 or six months after the completion of the School Health Demonstration Project, whichever comes first.

Arguments in support. According to California Children's Trust, "There is a well-documented crisis in children's mental health, exacerbated by the social isolation and stress of the pandemic. According to a recent report from the CDC, through most of 2020, the proportion of pediatric emergency admissions for mental health issues, like panic and anxiety, was up by 24% for young children and 31% for adolescents compared to the previous year.

We believe public schools are essential partners to any response at scale to the children and youth mental health crisis, and there is considerable untapped opportunity for school districts to leverage Medi-Cal to support unmet student needs. Nearly 60% of all children in California, are enrolled in Medi-Cal, but only 5% of low-income children currently access the mental health services they are entitled to—and the majority do so in schools.

We have seen firsthand how education leaders are eager for information and yet currently lack the capacity to provide services directly and/or to develop partnerships to effectively access Medi-Cal funding and support school-based health and child wellness services. AB 586 will address these challenges by developing a two-year grant program with LEAs to build the infrastructure and partnerships needed to secure federal Medi-Cal funding for health and mental

health services, as well as other relevant sources of funding. The program will be tied to robust technical assistance for LEAs by expert teams to guide them in working with local county health and mental health plans to start up new services, become self-sustaining, and maximize available revenues.

Finally, The School Health Demonstration Project will be overseen by the California Department of Education, which at the end of the pilot project will report on the success of the program in serving student needs, securing federal funds, as well as share best practices, and make recommendations for the expansion of the program statewide."

Related legislation. 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. The bill 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 552 (Quirk Silva) of this Session authorizes 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.

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

SB 508 (Stern) of this Session requires health care service plans, health insurers, and Medi-Cal managed care plan to enter into MOUs 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.

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 the DHCS, in consultation with the 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.

AB 1322 (Berman) of the 2019 Session would have required the CDE to establish a School-Based Health Unit, and required that $500,000 in federal reimbursements be made available for transfer through an interagency agreement to CDE for the support of the Unit. 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 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 MHSSA 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. The bill also requires the CDE to jointly convene with the DHCS a workgroup that includes representatives from LEAs, 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 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 DHCS and CDE to recommend changes to school-based Medi-Cal programs. There is an advisory committee within the DHCS 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.

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 Act) required DHCS to withhold 1% 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.

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 the DHCS to regularly consult with specified entities to assist in the formulating of the state plan amendments, and permits the DHCS to enter into a sole source contract to comply with the requirements of this bill. It also authorizes the DHCS 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.

REGISTERED SUPPORT / OPPOSITION:

Support

State Superintendent of Public Instruction Tony Thurmond (Sponsor)
Association of Community Human Service Agencies
Bay Area Clinical Associates
California Access Coalition
California Afterschool Network
California Alliance of Child and Family Services
California Association of Private Special Education Schools
California Association of School Counselors
California Catholic Conference
California Council of Community Behavioral Health Agencies
California School Nurses Organization
California School-based Health Alliance
Californians for Justice

Campbell Union School District
Children Now
Children's Defense Fund-California
Children's Health Council
East Bay Asian Youth Center
Family Care Network, INC.
First 5 Sonoma County
Fred Finch Youth and Family Services
Generation Up
Healthier Kids Foundation
LA Clinica De LA Raza, INC.
Mono County Office of Education
Opportunity Institute
Optimal Solutions Consulting
Pivotal Connections
Plumas Rural Services
Public Advocates INC.
San Mateo County SELPA
Santa Clara County Office of Education
Santa Cruz County Office of Education
Sonoma County Aces Connection
The California Children's Trust
The Victor Agencies
Thrasys, INC.
United Latinos
United Ways of California
Vinaj Ventures
Voices Youth Centers
Westcoast Children's Clinic
Youth Forward
Numerous individuals

Opposition

None on file

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