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"Improving Access to School-Based Health Services"
Assembly Education Committee, Assembly Health Committee and Assembly Budget Subcommittee No. 1 and 2
Informational Hearing
Wednesday, October 13, 2021 at 9:00 a.m.
State Capitol, Room 4202

Introduction

This joint hearing of the Assembly Committees on Education, Health, Budget Subcommittees No. 1 and No. 2 will hear a presentation on the statutorily required report of the Medi-Cal for Students Workgroup (Workgroup) established pursuant to SB 75 (Committee on Budget and Fiscal Review), Chapter 51, Statutes of 2019, an education budget trailer bill. The Workgroup was charged with improving the coordination and expansion of access to available federal funds through the Local Educational Agency Medi-Cal Billing Option Program[i] (LEA BOP), the School-Based Medi-Cal Administrative Activities Program[ii] (SMAA), and medically necessary federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. The Workgroup was required to issue a progress report October 1, 2020 (pursuant to the later enacted SB 98 [Committee on Budget and Fiscal Review], Chapter 24, Statutes of 2020), and a final report on October 1, 2021.

This hearing will include an overview presentation of the final report by WestEd, a national nonpartisan and nonprofit research, development, and service entity contracted with to prepare the report. Testimony will also be provided by representatives of the California Department of Education (CDE) and the Department of Health Care Services (DHCS), followed by two panels of education and health stakeholders.

To provide the budgetary and existing law and program context for the recommendations made in the report, this paper describes the existing Medi-Cal eligibility, benefits and delivery system, school-based Medi-Cal services and the multiple significant changes made in the 2021 Budget Act and the education and health budget trailer bills.

Overview of the Relevant Requirements of SB 75 and SB 98

SB 75, as subsequently amended by SB 98[iii], required a progress report and a final report. The progress report requirement mandated the Workgroup provide the chairs of the relevant policy

committees and budget subcommittees of the Legislature and the Department of Finance with a progress report that includes all of the following:

- A detailed timeline for the implementation of the workgroups, including information on the structure of the workgroups, frequency of meetings, and other relevant information;
- Work conducted by each workgroup to date and initial findings, including information gathered, if any, on potential barriers to access the LEA BOP, SMAA, and EPSDT; and,
- Information on potential barriers to ensure smooth transitions for three-year-old children with disabilities from regional centers to LEAs (this was a separate workgroup and is not included in the scope of this hearing).

SB 98 extended the due date of the final report to on or before October 1, 2021 (instead of October 1, 2020). The final report (a copy of which is included in the hearing materials) is required to include a recommendation for 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 and parity of eligible services throughout the state and country.

SB 75 also required any recommendations provided to include any specific changes needed to state regulations or statutes, need for approval of amendments to the state Medicaid plan or federal waivers, changes to the implementation of federal regulations, changes to state agency support and oversight, and associated staffing or funding needed to implement the recommendations.

The 2019 Budget Act, AB 74 (Ting), Chapter 23, Statutes of 2019, appropriated $500,000 to the State Superintendent of Public Instruction (SSPI) on a one-time basis for purposes of the work associated with the preparation of the report. WestEd established a 21-member steering committee of state staff from CDE, DHCS and the California Health and Human Services Agency, an advisory group of state staff including legislative staff, and a stakeholder workgroup of over 60 members. WestEd held an informational webinar on the SB 75 workgroup process in January 2020 and convened five multiple hours workgroup meetings over seven days between February 2020 and April 2021, including virtual meetings.

Medi-Cal Eligibility, Benefits and Delivery Systems

Medi-Cal is California's Medicaid program. States opting into Medicaid can receive federal financial participation (FFP or Medicaid "matching funds") for services and benefits provided to eligible populations. The federal matching fund rate varies by state and by population and is at least 50%, meaning if a state spends a dollar of its own funds on a Medicaid reimbursable service, it receives at least one dollar in federal Medicaid matching funds.

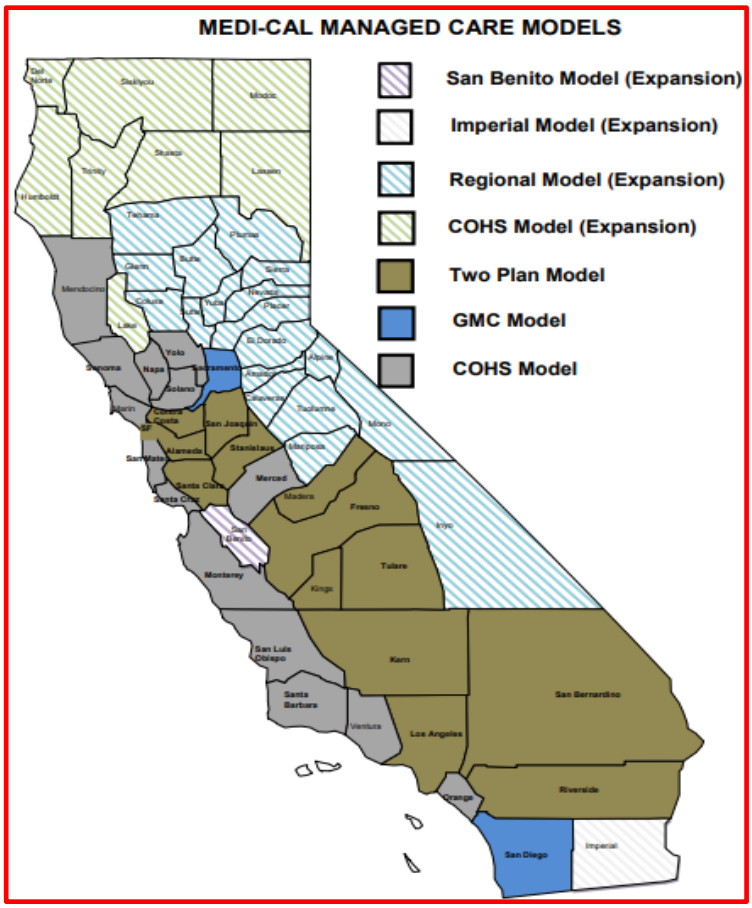
Income eligibility for Medi-Cal for school-age children and youth up to age 19 includes children and youth with family incomes up to 266% of the federal poverty level (FPL).[iv] The FPL is adjusted each year and increases with family size. In 2021, the FPL for a family of two is countable income up to $46,338 annually ($3,862 monthly) and $58,414 annually for a family of three ($4,868 monthly).[v]

Medi-Cal is required to provide a broad scope of benefits under federal Medicaid law. Under the requirements of the federal EPSDT benefit[vi] (EPSDT is the Medicaid benefit for children and

youth under age 21), Medi-Cal must provide coverage for screening, vision, dental, and hearing services and any "such other necessary health care, diagnostic services, treatment, and other Medicaid measures to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the state's Medicaid plan." This entitles children to the full scope of Medicaid funded benefits. The scope of coverage under EPSDT and the medical necessity standard in the federal EPSDT statute of "correct or ameliorate" is broader than the scope of coverage and medical necessity standard[vii] for adults served by the program.

The Medi-Cal delivery system is complex and varies by county. Services are delivered through a variety of different payors, including public and private Medi-Cal managed care (MCMC) plans, Medi-Cal fee-for-service (FFS), county mental health plans (MHPs) and county Drug Medi-Cal (for substance use disorder treatment services).

Most beneficiaries (including children and youth) are required to enroll in a MCMC plan for the majority of the program's services. DHCS contracts with approximately 25 MCMC plans to deliver services. Medi-Cal beneficiaries who are not enrolled in MCMC plans receive services through Medi-Cal FFS. While MCMC exists statewide, it is operated under six different model types. The map shows the six MCMC plan delivery models and the counties in which they operate.



Two Plan Model: In the 13 Two-Plan Model counties, there are a county organized plan called the Local Initiative (a prepaid health plan) and a commercial plan. The Local Initiative plan is a Knox-Keene Act licensed, county sponsored managed care plan that serves one or more counties. DHCS contracts with both plans for the delivery of MCMC services in the county.

County Organized Health System (COHS): In the 22 COHS Model counties, the MCMC health plan is run by the county. In a COHS county, there is only one MCMC plan serving the Medi-Cal population.

Geographic Managed Care (GMC): In the two GMC Model counties, DHCS contracts with multiple Knox-Keene Act licensed commercial health plans (Knox-Keene is the body of law requiring the licensure and regulation of health plans under the jurisdiction of the Department of Managed Health Care) within a single county. The GMC Model serves clearly defined geographic areas.

Regional Model: The 18 rural counties that have not elected to participate as a COHS model or as the Local Initiative of a Two-Plan model MCMC through the Regional Model. The Regional Model developed for the rural expansion and consists of two commercial health plans, that are Knox-Keene Act licensed, wanting to serve two or more contiguous counties in the designated Expansion Region.

San Benito Model: The San Benito Model also originated out of the Regional Model to serve rural expansion needs. In the San Benito Model county, there is one Knox-Keene Act licensed commercial plan that contracts with DHCS. Beneficiaries can choose the MCMC plan or regular (FFS) Medi-Cal.

Imperial Model: The Imperial Model originated out of the Regional Model to serve rural expansion needs. Similarly, in an Imperial Model county, there are two Knox-Keene Act licensed commercial plans that contract with DHCS to serve one or more counties.

Dental services in Medi-Cal are provided through Denti-Cal, which operates outside of MCMC plans through FFS, except in Sacramento County (where enrollment in a dental plan is required) and in Los Angeles, where enrollment in a dental plan is optional.

Medi-Cal mental health benefits are also delivered primarily through two separate systems. County MHPs provide a broad range of specialty mental health services (SMHS) to individuals with more severe mental illnesses, while MCMC plans provide non-SMHS (consisting of a more limited set of services) and some prescription medications. The delivery of SMHS through MHPs and substance use disorder (SUD) services outside of MCMC plans is commonly referred to as a "carve out." A "carve out" is when services covered by the Medi-Cal program are delivered outside of a MCMC plan. Approximately 40 medications for the treatment of severe mental illnesses are carved out of MCMC plans (such as anti-psychotic medications) and are reimbursed through FFS Medi-Cal. Under Governor Newsom's proposed Medi-Cal Rx, eventually all of outpatient prescription drugs will be delivered through FFS when Medi-Cal Rx takes effect.[viii]

MHPs are responsible for providing SMHS to Medi-Cal beneficiaries who meet SMHS medical

necessity criteria. SMHS are delivered through 56 county MHPs (Placer and Sierra Counties and Yuba and Sutter Counties operate two separate dual-county combined MHPs). Medi-Cal beneficiaries who meet medical necessity criteria for SMHS are entitled to receive medically necessary SMHS from their county MHP, regardless of whether or not they are enrolled in a MCMC plan.

For treatment of SUD services, Medi-Cal benefits are delivered either through county opt-in Drug Medi-Cal Organized Delivery Systems (DMC-ODS) or through FFS benefit. DMC-ODS exists in 37 counties serving over 95% of the state's population, with the DMC-ODS SUD benefit provided in seven of the 37 counties through Partnership Health Plan (a MCMC plan) instead of through the counties directly, or in State Plan counties. The FFS benefit in DMC State Plan counties is more limited than the DMC-ODS benefit in terms of covered services, and it is not a managed care program.

Some schools and school districts provide services funded by MCMC plans, county MHPs and Denti-Cal in varying degrees. However, there is no data on the number of students served on school campuses by MCMC plans, county MHPs, and Denti-Cal, or expenditures by those entities on school-based Medi-Cal services. Both MCMC plans and county MHPs are managed care arrangements, and providers providing services to children are typically required to have a contract or type of agreement with the MCMC plan or the county MHP, and health care providers (with exceptions) must enroll through DHCS' provider enrollment process.

School-Based Medi-Cal Services

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.

Outside of the MCMC plan and county MHPs, schools can receive Medicaid matching funds through SMAA and the LEA BOP. Approximately half of California's school districts participate in these two programs.[ix] SMAA allows LEAs to be reimbursed through federal Medicaid matching funds for some of their administrative costs associated with school-based health and outreach activities that are not claimable under the LEA BOP or under Medi-Cal generally. In general, the cost of school-based health and outreach activities reimbursed under SMAA consist of referring students/families for Medi-Cal eligibility determinations, providing health care information and referral, coordinating and monitoring health services, and coordinating services between agencies. LEAs that elect to participate in SMAA must submit claims through a local education consortium (LEC) or local governmental agency (LGA). An LEC is a group of LEAs located in one of the 11 service regions established by the California County Superintendent Educational Services Association. An 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.

The LEA BOP provides FFP through Medicaid reimbursement to LEAs (school districts, county offices of education, charter schools, a state special school, community colleges, California State University, and University of California) for health-related services provided by qualified medical practitioners to students who are enrolled in Medi-Cal. Any of these entities is authorized to bill for services provided to any student, regardless of age, who is a Medi-Cal recipient. LEAs pay for health-related services and are reimbursed for 50% of their costs through Medicaid FFP. LEA services are delivered either through the LEAs (which employ practitioners who provide the services on site) or through local contracted practitioners. LEAs must annually certify that the public funds expended for LEA services provided are eligible for FFP. LEA covered services can include the following:

1) Health and mental health evaluations and health and mental health education;
2) Medical transportation;
3) Nursing services;
4) Occupational therapy and physical therapy;
5) Physician services;
6) Mental health and counseling services;
7) School health aide services;
8) Speech pathology services (speech therapy accounts for most LEA BOP claims);
9) Audiology services; and,
10) Targeted case management services for children regardless of whether the child has an individualized education plan (IEP) or an individualized family service plan (IFSP).

DHCS' May 2021 Medi-Cal Estimate assumes the LEA BOP will draw down $96.3 in FFP in 2021-22, and SMAA will draw down $150.2 million in 2021-22. According to the Senate Bill 75 Medi-Cal for Students Progress Report from October 1, 2020, California ranked 40th in federal Medicaid reimbursement per Medicaid-enrolled school-age child and 39th in federal reimbursement per school-age child in 2014-15, the most recent year for which data was available.

In December 2014, the Centers for Medicare and Medicaid Services issued new guidance authorizing LEAs to serve all Medicaid-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 of all Medi-Cal enrolled children youth, not only those youth with a disability.

Changes to School-Based Services in the Health Budget Trailer Bill

AB 133 (Committee on Budget), Chapter 143, Statutes of 2021, enacted a Children and Youth Behavioral Health Initiative Act (CYBHI Act). The CYBHI Act includes multiple significant provisions, including requiring private health plans and insurers, MCMC health plans, and county behavioral health delivery system to provide coverage for school-based mental health and SUD services, irrespective of the network status of the health care provider. Major changes include:

1) Require DHCS to make incentive payments to qualifying MCMC plans that meet predefined goals and metrics (to be developed) associated with targeted interventions that increase

access to preventive, early intervention, and behavioral health services by school-affiliated behavioral health providers for K-12 children in schools.[x] The Budget Act appropriated $400 million in one-time funds for this purpose.

2) Require each MCMC plan and Medi-Cal behavioral health delivery system (county MHP and DMC-ODS), as applicable, to reimburse providers of medically necessary outpatient mental health or SUD treatment provided at a schoolsite to a student 25 years of age or younger who is an enrollee of the plan or delivery system.[xi]

3) Require providers of medically necessary schoolsite services to be reimbursed, at a minimum, at the fee schedule rate or rates developed, regardless of network provider status.

4) Require DHCS to develop and maintain a school-linked statewide fee schedule for outpatient mental health or substance use disorder treatment provided to a student 25 years of age or younger at a schoolsite.

5) Require health plan contracts and health insurance policies issued, amended, renewed or delivered on or after January 1, 2024, to cover the provision of the services identified in the FFS reimbursement schedule published by DHCS when those services are delivered at schoolsites, regardless of the network status of the LEA, public institution of higher education, or health care provider.[xii]

6) Require DHCS to develop and maintain a school-linked statewide provider network of schoolsite behavioral health counselors.

7) Require DHCS to procure and oversee a vendor to establish and maintain a behavioral health services and supports virtual platform that integrates behavioral health screenings, application-based supports, and direct behavioral health services to children and youth 25 years of age and younger, regardless of payer.[xiii] The Budget Act appropriated $760 million in one-time funds for this purpose.

8) The Budget Act appropriated $429 million in one-time funds to permit DHCS, or its contracted vendor, to award competitive grants to entities it deems qualified for the following purposes:

    a) To build partnerships, capacity, and infrastructure supporting ongoing school-linked behavioral health services for children and youth 25 years of age and younger;
    b) To expand access to licensed medical and behavioral health professionals, counselors, peer support specialists, community health workers, and behavioral health coaches serving children and youth;
    c) To build a statewide, community-based organization provider network for behavioral health prevention and treatment services for children and youth, including those attending institutions of higher education; and,
    d) To enhance coordination and partnerships with respect to behavioral health prevention and treatment services for children and youth via appropriate data sharing systems.

9) Appropriate $250 million in one-time funds to the Mental Health Services Oversight and Accountability Commission to provide additional Mental Health Student Services Act grants to support partnerships between county mental health and LEAs.

10) Authorizes the Department of Health Care Information and Access (previously the Office of Statewide Health Planning and Development), as a component of the Children and Youth Behavioral Health Initiative, to award competitive grants to entities and individuals it deems qualified to expand the supply of behavioral health counselors, coaches, peer supports, and other allied health care providers serving children and youth, including those at schoolsites. Defines a "behavioral health coach" as a new category of behavioral health provider trained specifically to help address the unmet mental health and substance use needs of children and youth.[xiv] The Budget Act appropriated $352M one-time to the Department of Health Care Information and Access.

Changes to School-Based Services in the Education Budget Trailer Bill

AB 130 (Committee on Budget), Chapter 44, Statutes of 2021, made multiple significant changes related to school-based health services. Major provisions include the following:

1) Require CDE, no later than January 1, 2022, to establish an Office of School-Based Health Programs (Office) for the purpose of assisting LEAs regarding the current health-related programs under the purview of the CDE, including collaborating with DHCS and other departments and offices involved in the provision of school-based health services, and assisting LEAs with information on, and participation in, the specified school-based health programs, including SMAA, LEA BOP, and EPSDT.[xv]

2) Require CDE, by January 1, 2022, to appoint a state school nurse consultant to be housed within the Office, responsible for the following:
   a) Serving as a liaison and resource expert in school nursing and school health program areas for local, regional, state, and national school health care providers and policy setting groups;
   b) Monitoring, interpreting, synthesizing, and working to ensure that the office disseminates relevant information associated with changes in health, nursing, and medical care, school nursing practice, legislation, and legal issues that impact schools and the pupils they serve;
   c) Fostering and promoting staff development for school nurses, which may include planning and providing orientation, coordinating or providing educational offerings, and networking with universities and other providers of continuing education to meet identified needs; and,
   d) Participating in state-level public interagency partnerships and private partnerships with statewide stakeholders to foster a coordinated school health program, representing school nurses in multidisciplinary collaborations.[xvi]

3) Establish the School Health Demonstration Project in the Office as a pilot project to expand comprehensive health and mental health services to public school pupils by providing LEAs with intensive assistance and support to build the capacity for long-term sustainability by leveraging multiple revenue sources, with the purpose being to provide training and technical

assistance 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 LEA BOP;
b) SMAA;
c) Contracting or entering into a memorandum of understanding (MOU) with MCMC plans as a participating MCMC plan contracting provider;
d) Contracting with or entering into a MOU with county MHPs for SMHS, such as through EPSDT, and contracting with community-based providers to deliver health and mental health services to pupils in school through contracts with MCMC plans or county MHPs; and,
e) Require SSPI, on or before June 30, 2022, in consultation with the executive director of the state board and DHCS, to select up to three organizations to serve as technical assistance teams for purposes of the pilot project. Requires, on or before September 1, 2022, CDE, in consultation with DHCS, to select up to 25 LEAs to serve as pilot participants for a period of two years.[xvii] The Budget Act appropriated $5 million in one-time funds for this purpose.

4) Require CDE to establish a process to select, with approval from the executive director of the state board, a LEA to provide guidance around Medi-Cal billing and increase LEAs' capacity to successfully submit claims through the LEA BOP.[xviii] The Budget Act appropriated $250,000 in on-going funds for this purpose.

Public Comment

[i] Welfare and Institutions Section 14132.06.
[ii] Welfare and Institutions Section 14132.47.
[iii] Education Code Section 56477.
[iv] Welfare and Institutions Section 14005.26 and 14005.64.
[v] Health Consumer Alliance "California Insurance Affordability Programs Income Levels" available at HCA-FPL-Income-Chart-2021.pdf (healthconsumer.org)
[vi] Section 1396d(r)(5) of Title 42 of the United States Code.
[vii] Welfare and Institutions Section 14059.5.
[viii] Governor Gavin Newsom issued Executive Order N-01-19 (EO N-01-19) on January 7, 2019. Information on Medi-Cal Rx is available on the DHCS webpage at: Medi-Cal Rx | Homepage.
[ix] Senate Bill 75 Medi-Cal for Students Program Report" from the California Department of Education, the California Department of Health Care Services, the California Health and Human Services Agency, the Medi-Cal for Students Workgroup and WestEd.
[x] Welfare and Institutions Section 5961.3.
[xi] Welfare and Institutions Section 5961.4.
[xii] Health and Safety Code Section 1374.722 and Insurance Code Section 10144.53.
[xiii] Welfare and Institutions Section 5961.2 et seq.
[xiv] Health and Safety Code Section 127825.
[xv] Education Code Section 49418 et seq.

[xvi] Education Code Section 49420.
[xvii] Education Code Section 49421.
[xviii] Education Code Section 49422.