Date of Hearing: January 11, 2022

ASSEMBLY COMMITTEE ON HEALTH
Jim Wood, Chair
AB 552 (Quirk-Silva) – As Amended April 5, 2021

SUBJECT: Integrated School-Based Behavioral Health Partnership Program.

SUMMARY: Authorizes a county behavioral health agency (county BH agency) and the governing board or governing body of a local educational agency (LEA) to establish an Integrated School-Based Behavioral Health Partnership Program (Partnership Program) to provide prevention and early intervention for, and access to, behavioral health services for pupils with serious emotional disturbances (SED) or substance use disorders (SUDs), or who are at risk of developing a serious behavioral health condition. Establishes requirements for county BH agencies and LEAs establishing a Partnership Program, for designated behavioral health professionals participating in the Partnership Program including a requirement that the designated behavioral health professional provide brief initial interventions when necessary for all referred pupils. Requires private health plans to reimburse for brief initial intervention services provided by the designated behavioral health professional to pupils enrolled with the private plan at the amount a county BH agency would receive for the same services provided to a Medi-Cal beneficiary if the private plan is unable to offer an appointment within existing non-urgent and appointment availability requirements. Specifically, **this bill**:

1) Establishes the Partnership Program to provide prevention and early intervention for, and access to, behavioral health services for pupils with SED or SUDs, or who are at risk of developing a serious behavioral health condition.

2) Authorizes a county BH agency and the governing board or governing body of an LEA (defined as a school district, county office of education, or charter school) to:
   a) Agree to collaborate on conducting a needs assessment on the need for school-based mental health and SUD services;
   b) Implement a Partnership Program pursuant to this bill; and,
   c) Develop a memorandum of understanding (MOU) outlining the requirements for the Partnership Program, as provided in this bill.

3) Permits multiple LEAs within a single county to join to form a Partnership Program with the county BH agency. Encourages, when appropriate, the county BH agency and the LEA, to formalize the MOU and enter into a contract for the provision of mental health or SUD services.

4) Requires a county BH agency to designate and provide, through its own staff or through its network of contracted participating entities, one or more behavioral health professionals that meet the licensing and supervision requirements of one or more of the classifications listed in this bill to serve pupils with SED or SUDs, or who are at risk of developing a serious behavioral health condition, pursuant to the Partnership Program.

5) Requires the county BH agency, to secure Medicaid federal matching funds for school-based services, to require any behavioral health professional who provides mental health or SUD services pursuant to a Partnership Program to contract with the health agency to provide

those services and to hold an active license or credential with one or more of the following classifications:

a) A licensed clinical social worker or registered associate social worker;
b) A licensed marriage and family therapist (MFT) or MFT associate;
c) A licensed professional clinical counselor (LPCC) or LPCC associate;
d) A licensed clinical psychologist or psychological intern;
e) A licensed psychiatrist or psychiatric resident;
f) A licensed psychiatric mental health nurse practitioner;
g) A physician specialist in SUD treatment;
h) An individual who holds a services credential with a specialization in pupil personnel services that authorizes the individual to perform school counseling, school psychology, or school social work;
i) An individual who holds a services credential with specialization in health for school nurse; or,
j) A licensed educational psychologist.

6) Permits a behavioral health professional who meets the contracting and licensing requirements in this bill to supervise other trained county BH professionals.

7) Requires all behavioral health professionals who participate in the Partnership Program to have a valid, current satisfactory background check.

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

9) Requires the county BH agency and participating entities, as appropriate, to collaborate with the LEA to establish hours of service at mutually agreed upon school-based locations or a process for ensuring timely interventions when needed, or both. Permits additional service delivery models that address local needs to be developed under the Partnership Program.

10) Requires the Partnership Program to identify if mental health services or SUD services, or both, will be delivered at the school-based location or through telehealth. Requires the Partnership Program, if the Partnership Program determines that only mental health services or only SUD services are required to be provided at the school-based location, to develop a plan for each pupil who has been identified as needing behavioral health services that are not offered at the school-based location, and requires the plan to include appropriate referral for services not offered at the school-based location.

11) Requires the choice of timeframe and setting for the delivery of behavioral health services to be made in consultation with the pupil and the pupil's parent or guardian, and to include consideration of the specified needs expressed by the pupil and the pupil's parent or guardian. Permits behavioral health services to be provided at locations that are not at the school-based location for purposes of accommodating the individual needs of a pupil.

12) Permits Medi-Cal covered behavioral health services to continue to be delivered at the school-based location beyond the delivery of brief initial interventions, if necessary and appropriate, as determined in consultation with the parent or guardian of the pupil being served and in compliance with state and federal law protecting the pupil's right to privacy and parental rights.

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

14) Requires, to ensure timely access to behavioral health interventions at the earliest onset of a behavioral health condition, the designated behavioral health professional to provide brief initial interventions when necessary for all referred pupils, including uninsured and privately insured pupils, in addition to Medi-Cal beneficiaries.

15) Requires the array of behavioral health services provided pursuant to the Partnership Program to be a subset of Medi-Cal covered mental health or SUD services, and to include prevention, intervention, and, if necessary, intensive intervention services, within a multi-tiered system of support or other similar framework employed by the LEA.

16) Permits, at the discretion of the Partnership Program, services developed using funding from the Mental Health Services Act (the MHSA was enacted by Proposition 63 of 2004), that are appropriate for a school-based setting to be provided under the Partnership Program. Requires the Partnership Program to use this funding to meet all MHSA requirements, including the community program planning process.

17) Permits prevention services provided by the Partnership Program to include, but are not limited to, services that address specified priorities in existing law including childhood trauma prevention and early intervention, early psychosis and mood disorder detection and intervention, mood disorder and suicide prevention programming, youth outreach and engagement strategies, and culturally competent and linguistically appropriate prevention and intervention.

18) Requires behavioral health interventions provided to pupils through the Partnership Program to comply with all applicable state and federal laws protecting a pupil's right to privacy and parental rights.

19) Requires the LEA and county BH agency to develop a process to collect information on the health insurance carrier for each pupil, with the permission of the pupil's parent or guardian, to allow the Partnership Program to seek reimbursement for behavioral health services provided to the pupil, when applicable. Requires the process to include informing any participating entity which pupils referred for services are privately insured.

20) Requires the MOU of the Partnership Program to specify how a privately insured pupil will be served if the parent or guardian does not provide the necessary information on the health insurance carrier.

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

22) Requires the designated behavioral health professional, after contacting the private plan, if the private plan is unable to offer the pupil enrolled in the plan an appointment with a

network provider within 48 hours for an urgent care appointment or within 15 business days for a non-urgent appointment, to continue and complete the brief initial intervention services.

23) Permits the applicable waiting time for a particular appointment to be extended if the referring or treating licensed behavioral health provider, or the health professional providing triage or screening services, as applicable, acting within the scope of the individual's practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee.

24) Requires the private plan to reimburse for brief initial intervention services provided by the designated behavioral health professional to pupils enrolled with the private plan at the amount a county BH agency would receive for the same services provided to a Medi-Cal beneficiary.

25) Requires private plans and insurers to meet the existing law requirements for timely payment of claims for a contracted provider. Permits, if the private plan disputes the services provided or the amount, the private plan to submit a dispute to the Department of Managed Health Care (DMHC), but requires the private plan to comply with requirements for timely payment, including for services or amounts in dispute. Requires the DMHC to have trained staff available to address any disputes arising from the Partnership Program.

26) Requires, if additional behavioral health services beyond the brief initial intervention services are necessary and appropriate, as determined in consultation with the parent or guardian of the pupil being served and in compliance with all applicable state and federal laws protecting a pupil's right to privacy and parental rights, the following to occur:
    a) Requires, if the private plan can meet timely access standards for care delivery, the designated behavioral health professional to make a referral to the private plan provider; and,
    b) Requires, if the private plan cannot meet timely access standards for care delivery, the private plan and the county BH agency to negotiate a single case agreement to provide behavioral health services beyond the brief initial intervention services to determine reimbursement for additional services.

27) Requires the private plan, if an agreement cannot be reached, to report to DMHC regarding how it will ensure the pupil receives the necessary services in compliance with state and federal law, including state and federal mental health parity requirements.

28) Encourages private plans, county BH agencies, and participating entities to contract to serve pupils who are receiving services from the Partnership Program.

29) Requires a Partnership Program to annually report to the Department of Health Care Services (DHCS) and the Mental Health Services Oversight and Accountability Commission (MHSOAC) all of the following:
    a) A brief description of the Partnership Program, including the service delivery model;
    b) The financial contribution made by the county BH agency and LEA participating in the Partnership Program;
    c) The definition the Partnership Program uses to identify pupils "at risk of developing a serious behavioral health condition;"

d) The number of school-based locations involved in the Partnership Program and the percentage of pupils who are Medi-Cal beneficiaries at each school-based location;
e) The number of pupils served in the last year including demographic data of the pupils' race, ethnicity, gender, and language;
f) The number of pupils who receive school-based services beyond the brief initial intervention;
g) For Partnership Programs that provide specialty mental health services (SMHS), the number of pupils who participate in the program who report functional improvement, as measured by the Child and Adolescent Needs and Strengths (CANS) assessment tool or other evidence-based tools, broken down by those pupils who receive only the brief initial intervention and those that receive additional school-based services;
h) For Partnership Programs that provide SMHS, only the relevant components of the CANS assessment tool, as determined by the treating designated behavioral health professional, are required to be completed for non-Medi-Cal beneficiaries who receive brief initial interventions; and,
i) The percentage of pupils and parents or guardians that report satisfaction with the services provided through the Partnership Program.

30) Requires the MHSOAC, in collaboration with DHCS, to provide a report to the Legislature on the Partnership Program, based upon the metrics in this bill, beginning three years after the establishment of a Partnership Program pursuant to this bill.

31) Permits a Partnership Program to provide services to pupils with exceptional needs, including, but not limited to, services required by the pupil's individualized education program (IEP). Requires the Partnership Program to clearly delineate responsibilities for any services provided to pupils with exceptional needs that are included in a pupil's IEP, and requires the Partnership Program to provide services consistent with state and federal law related to pupils with exceptional needs, including, but not limited to, statutes enacted under the federal Individuals with Disabilities Education Act.

32) Prohibits this bill from replacing current county requirements related to crisis intervention protocols, and prohibits the Partnership Program from providing crisis interventions.

33) Requires the county BH agency and LEA to establish processes for timely interventions that identify non-urgent, urgent, and crisis-related circumstances, and requires the process to include guidelines for when county crisis intervention is needed instead of timely interventions related to urgent or non-urgent needs.

34) Prohibits the Partnership Program from creating a siloed delivery system.

35) Requires the Partnership Program to establish a process to leverage community-based services and other resources, and a process to identify local resources related to crisis intervention protocols and services.

EXISTING LAW:

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

2) Makes Medi-Cal eligible children up to age 18 with incomes up to 266% of the federal poverty level (FPL) and individuals age 19 and up to 138% of the FPL eligible for Medi-Cal.

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

4) Requires, under federal Medicaid law, EPSDT services to 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.

5) Establishes the scope of covered Medi-Cal benefits, which include mental health and SUD services included in the essential health benefits (EHB) package adopted by the state pursuant to state law and approved by the US Secretary of Health and Human Services.

6) Requires health plan contracts and health insurance policies issued, amended, renewed or delivered on or after January 1, 2024, that are required to provide coverage for medically necessary treatment of mental health and substance use disorders pursuant to specified provisions of existing law to cover the provision of the services identified in the fee-for-service (FFS) reimbursement schedule published by the DHCS when those services are delivered at school sites, regardless of the network status of the LEA, institution of higher education, or health care provider.

7) Requires, when a LEA or institution of higher education provides or arranges for the provision of treatment of a mental health or SUD services by a health care provider for an individual 25 years of age or younger at a school site, the student's health plan or health insurance policy to reimburse the LEA or institution of higher education for those services.

8) Requires a health plan or health insurer to provide reimbursement for services provided to students under these requirements at the greater of either of the following amounts:
   a) The health plan's contracted rate with the LEA, institution of higher education, or health care provider, if any; or,
   b) The FFS reimbursement rate published by DHCS for the same or similar services provided in an outpatient setting.

9) Prohibits services provided pursuant to the above described requirements from being subject to copayment, coinsurance, deductible, or any other form of cost sharing.

10) Requires the DMHC Director, no later than December 31, 2023, to issue guidance to health plans regarding compliance with 6) through 9) above, and exempts this guidance from the regulatory rulemaking requirements of the Administrative Procedure Act (APA). Requires any guidance issued pursuant to be effective only until the director adopts regulations pursuant to the APA.

FISCAL EFFECT: This bill has not been analyzed by a fiscal committee.

COMMENTS:

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

2) **BACKGROUND ON MENTAL HEALTH NEEDS OF CHILDREN/YOUTH.** According to the US Surgeon General's recently released "Protecting Children's Mental Health: Surgeon General's Advisory," even before the COVID-19 pandemic, mental health challenges were the leading cause of disability and poor life outcomes in young people, with up to one in five children ages three to 17 in the US with a reported mental, emotional, developmental, or behavioral disorder. In 2016, of the 7.7 million children with treatable mental health disorder, about half did not receive adequate treatment. According to the report, in recent years, national surveys of youth have shown major increases in certain mental health symptoms, including depressive symptoms and suicidal ideation. From 2009 to 2019, the proportion of high school students reporting persistent feelings of sadness or hopelessness increased by 40%; the share seriously considering attempting suicide increased by 36%; and the share creating a suicide plan increased by 44%. Between 2011 and 2015, youth psychiatric visits to emergency departments for depression, anxiety, and behavioral challenges increased by 28%. Between 2007 and 2018, suicide rates among youth ages 10-24 in the US increased by 57%. Early estimates from the National Center for Health Statistics suggest there were tragically more than 6,600 deaths by suicide among the 10-24 age group in 2020.

3) **BACKGROUND ON CALIFORNIA BH SYSTEM.** The BH delivery system for both privately and publicly insured individuals involves multiple payers. Health plans providing services to individuals with private individual and group coverage are required to provide mental health services, but the services are often delivered through specialized plans (such as Beacon and Magellan) separate from the individual's primary health plan. In Medi-Cal, SMHS for more severe mental health conditions are delivered by county mental health plans (MHPs), while Medi-Cal managed care (MCMC) plans provide a narrower set of services, and outpatient prescription drugs are reimbursed through FFS Medi-Cal. While county MHPs are required by law to have an MOU with MCMC plans, LEAs and county BH agencies are not. Schools deliver educationally-related services to pupils, and some LEAs arrange for the provision of mental health services on school campuses in several ways through arrangements with county MHPs. For example, some schools have county mental health staff on campus providing services directly, while other schools have mental health staff from community-based organizations that contract with the county to provide services on campus. The principal effect of this bill is to establish obligations on schools and county BH agencies that enter into a Partnership Program and to require private health plans to reimburse for services if they are unable to meet existing appointment availability standards for state-regulated plans.

4) **CHILDREN AND YOUTH BEHAVIORAL HEALTH INITIATIVE ACT.** As part of Governor Newsom's May Revision to his proposed 2021-22 state budget, the Governor proposed trailer bill language as part of new Children and Youth Behavioral Health Initiative Act. This included several provisions, including a new requirement that health plans and health insurers cover the provision of the behavioral health services identified in the FFS reimbursement schedule published by DHCS when those services are delivered at school sites, regardless of the network status of the LEA, institution of higher education, or health care provider. This requirement was codified in the health budget trailer bill, AB 133 (Committee on Budget), Chapter 143, Statutes of 2021, and is scheduled to take effect on January 1, 2024. DMHC was charged with issuing guidance on implementation of these new requirements.

5) **SUPPORT.** This bill is jointly sponsored by the California Alliance of Child and Family Services and the County Behavioral Health Directors Association (CBHDA). CBHDA states that more than 50% of mental illness cases begin by age 14. For children whose mental health concerns go unnoticed or untreated, especially those between the ages of 12 and 17, rates of substance abuse, depression, and lower school achievement increase leading to other health-related problems and a lower quality of life. Addressing behavioral health conditions as early as possible is critical in promoting the health and well-being of students. By providing early intervention services at schools, behavioral health conditions can be identified at the earliest onset. CBHDA states that, currently, 85% of county BH agencies provide SMHS on school campuses and 53% of agencies provide SUD services on campus. Most county BH agencies cover less than half of school campuses providing school-based SMHS. County behavioral health agencies currently cover less schools with SUD services. Thirty-two counties indicated that they cover less than 20% of school campuses with SUD services. In general, county BH agencies serve Medi-Cal beneficiaries and uninsured students on school campuses.

   According to a survey of county BH agencies, a barrier encountered in expanding county BH services on school campuses is the reluctance on the part of schools to allow county BH professionals on campus unless all students can be served, including privately insured students. Understandably, school administrators are reluctant to have groups of students treated differently if a behavioral health need is identified. The Partnership Programs proposed by this bill will allow LEAs and county BH agencies to serve all referred students as county behavioral health professionals will provide a warm hand-off to private plan providers for privately-insured students, if a provider is available within the state mandated timely access timeframes. CBHDA cites a recent report by Milliman found that some California private insurers were 5.7 times more likely to use out-of-network providers for outpatient behavioral health care when compared to medical/surgical outpatient facilities and 5.4 times more likely to use out-of-network providers for office visits for behavioral health care when compared to medical/surgical primary care office visits. This report found in 2017, a behavioral health care office visit for a privately-insured child was 10.1 times more likely to be with an out-of-network provider when compared to a primary care office visit – twice the disparity experienced by privately insured adults. In Partnership Programs authorized under this bill, for those instances when a private plan needs an out-of-network provider to ensure timely access is met, county BH professionals can serve as the out-of-network provider for vulnerable privately-insured students in need of school-based early intervention services. The bill will specify that for those private plan student enrollees served by county BH, the private plan will reimburse the county at the rate the county BH agency would

receive for the same service provided to a Medi-Cal beneficiary, as published on the DHCS website.

CBHDA concludes the COVID-19 pandemic has created a significant barrier for the provision of behavioral health services on school campuses, resulting in an unprecedented rise in behavioral health needs among children and youth. CBHDA concludes that school-based behavioral health, mental wellness and support will be crucial for this generation of students.

6) **SUPPORT IF AMENDED**. The California Psychological Association writes it would support this bill if it were amended to include a psychological registrant, psychological trainee, or other supervised individual permitted to provide psychological services under the Psychology Licensing Law to the list of licensed or credentialed providers contained in this bill.

7) **DOUBLE REFERRAL.** This bill was previously heard in the Assembly Education Committee on March 24, 2021 and passed on a 7-0 vote.

8) **PREVIOUS LEGISLATION.** AB 2668 (Quirk-Silva) of 2020 was substantially similar to this bill but was never heard in the Assembly Education Committee.

9) **POLICY ISSUES.**

   a) **Coverage requirement for children and youth in self-insured plans**. County MHPs plans (administered by county BH agencies) are required to provide SMHS to Medi-Cal beneficiaries, including children. The obligation of these agencies to provide services to individuals who are not covered by the Medi-Cal entitlement is limited "to the extent resources are available" or to the extent funding is available. This bill places a requirement on the county BH agency that elects to participate in the Partnership Program to serve all students. This would include students who are in a self-insured plan where the employers reimburses claims. The California Health Benefits Review Program estimates there are slightly over 1 million (1,012,000) children and youth age five to 18 in self-insured plans. However, self-insured arrangements are regulated under federal law, the mandate to reimburse for students receiving coverage through self-insured arrangement would likely be pre-empted by federal law (the Employee Retiree Income Security Act).

   b) **Forthcoming DMHC guidance required under health budget trailer bill**. AB 133 requires, when a LEA or institution of higher education provides or arranges for the provision of treatment of a mental health or SUD services subject to this bill by a health care provider for an individual 25 years of age or younger at a school site, the student's health plan or health insurance policy to reimburse the LEA or institution of higher education for those services. DMHC indicates whether or not county-provided services would be reimbursed under the "provides or arranges" requirement will be dependent upon both the specific circumstances of the school/county at issue and what will ultimately be provided through DMHC guidance, which is required to be issued by the end of 2023. AB 133 requires the reimbursement to go to the LEA, as opposed to the county BH agency under this bill. Whether the plan would have to pay the school's contracted provider (in this scenario, the county) directly or if the LEA would need to pass the reimbursement on to the provider is a detail that has not been finalized by

DMHC. DMHC indicates details such as these will need to be considered for the guidance eventually to be issued to health plans.

10) **PROPOSED AMENDMENTS**. Following discussions between the author's staff, committee staff and the bill's sponsors, the author is proposing to amend this bill. Major changes included in the proposed amendments: a) revise the definition of "brief initial intervention" services to delete the references to EHBs and the proposed definitions of "intervention" and "intensive intervention" services; b) clarify the definition of a "privately insured pupil;" c) delete the reference to the supervision requirements; d) to delete the references to the proposed benefits in the Partnership Program; and, d) clarify services may be delivered through both telehealth and in-person; e) to delete the reference to a pupils right to privacy and parental rights and instead prohibit the bill from being construed to modify, expand or restrict applicable patient privacy and parental rights; f) clarify the provisions of when a Partnership Program is required to contact a private plan; g) require a designed BH professional to provide crisis intervention to address an immediate need; h) delete specified Partnership Program reporting requirements. To ensure this bill is not delayed in its referral to the Assembly Appropriations Committee, these amendments will be adopted in that committee.

REGISTERED SUPPORT / OPPOSITION:

Support

California Alliance of Child and Family Services (cosponsor)
County Behavioral Health Directors Association (cosponsor)
American Academy of Pediatrics, California
California Behavioral Health Planning Council
Children Now
Los Angeles County Office of Education
National Alliance on Mental Illness-California
County of San Diego
Seneca Family of Agencies
Steinberg Institute
The California Association of Local Behavioral Health Boards and Commissions
United Parents

Opposition

None on file.

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