SENATE COMMITTEE ON HEALTH
Senator Dr. Richard Pan, Chair

BILL NO: AB 552
AUTHOR: Quirk-Silva
VERSION: January 27, 2022
HEARING DATE: June 15, 2022
CONSULTANT: Jen Flory

SUBJECT: Integrated School-Based Behavioral Health Partnership Program

SUMMARY: Authorizes the Integrated School-Based Behavioral Health (BH) Partnership Program to provide prevention and early intervention for, and access to, BH services for pupils with serious emotional disturbances or substance use disorders (SUDs), or who are at risk of developing a serious BH condition. Authorizes a county BH agency and the governing body of a local educational agency to agree to collaborate on conducting a needs assessment on the need for school-based mental health and SUD services, and implement an integrated school-based BH partnership program, to develop a memorandum of understanding outlining the requirements for the partnership program, and to enter into a contract for mental health or SUD services. Requires private health plans to reimburse for brief initial intervention services provided by designated BH 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.

Existing federal law: Requires Early and Periodic Screening, Diagnostic and Treatment (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. [42 USC §1396d]

Existing state law:
1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act) and the California Department of Insurance (CDI) to regulate health insurance, and the Department of Health Care Services (DHCS) to administer the Medi-Cal program. [HSC §1340, et seq., INS §106, et seq., WIC §14000, et seq.]

2) Requires every health plan contract and disability insurance policy that provides hospital, medical, or surgical coverage issued, amended, or renewed on or after January 1, 2021 to provide coverage for medically necessary treatment of mental health and SUD disorders under the same terms and conditions applied to other medical conditions, as specified. [HSC §1374.72 and INS §10144.41]

3) Defines "medically necessary treatment of mental health or SUD" as a service or product addressing the specific needs of that patient, for the purposes of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner as specified. [HSC §1374.72 and INS §10144.41]

4) Authorizes preferred provider organizations to require enrollees who reside or work in geographic areas served by a specialized health plan or disability insurance policy or mental health plan or policy to secure all or part of their mental health services within those geographic areas served by specialized plans or mental health plans, provided the services are within those geographic service areas within timeliness standards. [HSC §1374.72 and INS §10144.41]

5) Requires health plans and health insurers to ensure that their contracted provider networks have adequate capacity and availability of licensed health care providers to offer enrollees and insureds appointments that meet the following timeframes:

   a) Urgent care appointments for services that do not require prior authorization: within 48 hours of the request for appointment;
   b) Urgent care appointments for services that require prior authorization: within 96 hours of the request for appointment;
   c) Nonurgent appointments for primary care: within ten business days of the request for appointment;
   d) Nonurgent appointments with specialist physicians: within 15 business days of the request for appointment;
   e) Nonurgent appointments with a nonphysician mental health care or SUD provider: within 10 business days of the request for appointment;
   f) Commencing July 1, 2022, nonurgent followup appointments with a nonphysician mental health care or SUD provider: within ten business days of the prior appointment for those undergoing a course of treatment for an ongoing mental health or SUD condition; and
   g) Nonurgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition: within 15 business days of the request for appointment. [HSC §1367.03 and INS §10133.54]

6) Allows the applicable waiting time for a particular appointment to be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, acting within the scope of their 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. [HSC §1367.03 and INS §10133.54]

7) 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 SUDs for an individual 25 years of age or younger 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 local educational agency (LEA), institution of higher education, or health care provider. [HSC §1374.722, INS §10144.53]

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. [HSC §1374.722, INS §10144.53]

9) Prohibits services provided pursuant to 7) and 8) above from being subject to copayment, coinsurance, deductible, or any other form of cost sharing. [HSC §1374.722, INS §10144.53]

10) Requires the DMHC Director and CDI Commissioner, no later than December 31, 2023, to issue guidance to health plans and health insurers regarding compliance with 7) through 9) above, and exempts this guidance from the regulatory rulemaking requirements of the Administrative Procedure Act (APA). Requires any guidance issued to be effective only until regulations are adopted. [HSC §1374.722, INS §10144.53]

11) Requires Medi-Cal eligible children up to age 18 with incomes up to 266% of the federal poverty level (FPL) and individuals age 19 to 65 up to 138% of the FPL to be eligible for Medi-Cal. [WIC §14005.27, 14005.60 and 14005.64]

12) Establishes a schedule of benefits in the Medi-Cal program, which includes:

a) The EPSDT program for any individual under 21 years of age, consistent with the specified requirements federal Medicaid law;
b) Mental health services included in the essential health benefits adopted by the state, including individual and group psychotherapy, psychological testing, psychiatric consultation, and medication management; and,
c) Specified services provided by an LEA, to the extent federal financial participation (FFP) is available, subject to utilization controls and standards adopted by DHCS, and consistent with Medi-Cal requirements for physician prescription, order, and supervision (also known as the LEA Billing Option Program (BOP), or LEA BOP). [WIC §14132, 14132.03, 14132.06]

13) Requires Medi-Cal managed care (MCMC) plans to provide mental health benefits covered in the California's Medicaid State Plan, excluding those benefits provided by county mental health plans (MHPs). Requires DHCS to implement mental health managed care through contracts with county MHPs for the provision of specialty mental health services (SMHS). [WIC §14712, 14189]

14) Requires DHCS to implement and monitor compliance with time and distance to ensure that all Medi-Cal managed care covered services are available and accessible to enrollees of MCMC in a timely manner, as specified. [WIC §14197]

15) Defines LEA to mean any school district or community college district, the county office of education, a charter school, a state special school, a California State University campus, or a University of California campus. [WIC §14132.06]

16) Authorizes DHCS to contract with a local government agency (LGA) or a local educational consortium (LEC) to assist with the performance of administrative activities necessary for the proper and efficient administration of the Medi-Cal program and designates this activity as the Administrative Claiming process (also known as the School-Based Medi-Cal Administrative Activities Program (SMAA). Establishes requirements for LGAs or LEC participating in the SMAA. [WIC §14132.47]

17) Requires DHCS-related LEA BOP activities to be funded and staffed by proportionately reducing federal Medicaid payments allocable to LEAs for the provision of LEA BOP Medi-Cal benefits, up to $1.5 million dollars. [WIC §14115.8]

18) Requires DHCS to establish a school-linked statewide fee schedule for outpatient mental health or SUD treatment provided to a student 25 years of age or younger at a school site and a school-linked statewide provider network of BH counselors. Starting January 1, 2024, requires each MCMC plan and Medi-Cal BH delivery system to reimburse providers of medically necessary outpatient mental health or SUD treatment provided at a school site to a student 25 years of age or younger who is an enrollee of the plan or delivery system but only to the extent the MCMC plan or Medi-Cal BH delivery system is financially responsible for those services under its approved managed care contract with DHCS. Requires MCMC plans and Medi-Cal BH delivery system to reimburse providers of medically necessary school site services at the fee schedule rate or rates developed by DHCS regardless of network provider status. [WIC §5961.4]

19) Requires DHCS to make incentive payments to qualifying MCMC plans that meet predefined goals and metrics associated with targeted interventions that increase access to preventive, early intervention and BH services by school-affiliated BH providers for K-12 children in schools. Requires DHCS to consult with the California Department of Education (CDE), MCMC plans, county BH departments, LEAs, and other affected stakeholders, to develop interventions, goals, and metrics used to determine a MCMC plan's eligibility to receive incentive payments. [WIC §5961.3]

20) Establishes the Mental Health Services Oversight and Accountability Commission (MHSOAC) to oversee the implementation of the Mental Health Services Act (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 one percent income tax on personal income above $1 million. [WIC §5845]

This bill:

<u>Integrated School-Based BH Partnership Program</u>

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

2) Defines "partnership program" as an integrated school-based BH partnership program established by a county BH agency and the governing board or governing body of LEA. Permits a partnership program to include one or more participating entities.

3) Authorizes a county BH agency and the governing body of an LEA to agree to collaborate on conducting a needs assessment on the need for school-based mental health and SUD services, and implement an integrated school-based BH partnership program, and develop a memorandum of understanding (MOU) outlining the requirements for the partnership program. Permits multiple LEAs within a single county to join to form a partnership program with the county BH agency. Encourages 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 participating county BH agency to designate and provide, under the partnership program and through its own staff or through its network of contracted participating entities,

one or more BH professionals that meet specified licensing and supervision requirements to serve pupils with serious emotional disturbances or SUDs, or who are at risk of developing a serious BH condition.

5) Requires the county BH agency, in order to secure Medicaid federal matching funds for school-based services, to require any BH 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, so long as these professionals have a valid, current satisfactory background check:

   a) A licensed clinical social worker (LCSW) 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;
   j) A licensed educational psychologist; or
   k) Other trained county BH professionals, including clinical interns or trainees, certified peer specialists, and registered or certified SUD counselors, so long as these professionals are supervised pursuant to existing Medi-Cal requirements for any intervention services provided on school sites.

<u>Provision of services under local partnership programs</u>

6) Requires the LEAs to provide school-based locations, including space at schools, appropriate for the delivery of BH services. Allows for BH services to be provided at locations that are not at the school-based location for purposes of accommodating the individual needs of a pupil.

7) 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.

8) Allows Medi-Cal-covered BH 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 and in compliance with state and federal law protecting the pupil's right to privacy and parental rights.

9) 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 BH professional.

10) Requires the designated BH professional to provide brief initial interventions when necessary for all referred pupils, including uninsured and privately insured pupils, in addition to Medi-

Cal beneficiaries to ensure timely access to BH interventions at the earliest onset of a BH condition. Defines brief initial intervention as select Medi-Cal specialty mental health services and SUD services that would be appropriately provided at a school-based location or through telehealth, including assessments, plan developments, therapy, SUD counseling, rehabilitation, collateral services, medication support services, therapeutic behavioral services, case management, recovery services, and intensive care coordination.

Coverage for partnership program services

11) Requires the array of BH services provided to be a subset of Medi-Cal covered mental health or SUD services, and to include prevention, intervention, and, if necessary, brief initial interventions, within a multitiered system of support or other similar framework employed by the LEA.

12) 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 county BH agency or the participating entity to seek reimbursement for BH services provided to the pupil, when applicable. Requires the process to include informing any participating entity which pupils referred for services are privately insured. Requires the MOU of a 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.

13) Requires a partnership program to contact with the health plan of privately insured pupils before initiating or during an assessment to determine whether a privately insured pupil needs an urgent or nonurgent appointment and to facilitate a referral to the health plan's network providers, as appropriate and consistent with professionally recognized standards of practice. Defines "Privately insured pupil" as a pupil with comprehensive health coverage that is not coverage provided through the Medi-Cal program, including, but not limited to, the Optional Targeted Low-Income Children's Program, and the County Health Initiative Matching Fund Program.

14) Requires the designated BH professional to facilitate the referral to the health plan's network providers after completing the assessment if the health plan is able to offer the pupil enrolled in the plan an appointment within 48 hours for an urgent care appointment or within 15 business days for a nonurgent appointment. Requires the designated BH professional to continue and complete the brief initial intervention services if the health 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 nonurgent appointment.

15) Allows the applicable waiting time for a particular appointment to be extended if the referring or treating licensed BH 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.

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

17) Requires health plans and insurers to meet existing requirements for timely payment of claims. Permits a health plan, if it disputes the services provided or the claim amount, to submit a dispute to DMHC, but requires the health plan to comply with requirements for timely payment, including for services or amounts in dispute.

18) Requires DMHC have trained staff available to address any disputes arising from a partnership program.

19) Requires the following to occur if additional BH services beyond the brief initial intervention services are necessary and appropriate, as determined in consultation with the pupil's parent or guardian and in compliance with all applicable state and federal laws protecting a pupil's right to privacy and parental rights:

    a) Requires the designated BH professional to make a referral to the health plan provider if the plan can meet timely access standards for care delivery; and,
    b) Requires the health plan and the county BH agency to negotiate a single case agreement to provide BH services beyond the brief initial intervention services to determine reimbursement for additional services if the health plan cannot meet timely access standards for care delivery. Requires the health plan to report to DMHC how it will ensure the pupil receives necessary services in compliance with state and federal law if an agreement cannot be reached.

20) Contains language that encourages health plans, county BH agencies, and participating entities to contract to serve pupils who are receiving services from a partnership program.

Reporting requirements

21) Requires a partnership program to annually report to DHCS and the 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 BH 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 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 BH 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.

22) Requires MHSOAC, in collaboration DHCS, to provide a report to the Legislature on the Integrated School-Based BH Partnership Program, based on the abovementioned metrics, every three years, beginning three years after the establishment of a partnership program.

Miscellaneous

23) 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 a 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 a partnership program to provide services consistent with state and federal law related to pupils with exceptional needs, including federal law on students with disabilities.

24) Prohibits this bill from replacing current county requirements related to crisis intervention protocols, and prohibits a partnership program from providing crisis interventions. 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.

25) Prohibits a partnership program from creating a siloed delivery system. Requires a 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.

FISCAL EFFECT: According to the Assembly Appropriations Committee:

1) Estimated costs to DHCS of $120,000 to prepare guidance letters and bulletins regarding policies and procedures related to this bill, and to prepare the report for the Legislature (50% General Fund and 50% federal funds).

2) The MHSOAC estimates a cost of $70,000 annually, beginning in fiscal year (FY) 2025-26 (Mental Health Services Act Fund).

3) DMHC states that costs for dispute resolution and reviewing health plan reports are indeterminate, but potentially significant.

PRIOR VOTES:

Assembly Floor:	76 - 0
Assembly Appropriations Committee:	12 - 0
Assembly Education Committee:	7 - 0

COMMENTS:

1) *Author's statement.* According to the author, as a teacher for over 30 years, there has been a slow but increased understanding of mental and BH especially in children. As California continues to grapple with the COVID-19 pandemic, we are experiencing an unprecedented

rise in BH 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. BH, 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) *Need for greater access to BH services by youth.* A 2014 UCLA Policy Brief notes that nearly half of all Americans will need mental health treatment some time during their lifetimes, with initial symptoms frequently occurring in childhood or adolescence. According to a report by the American Institutes for Research (AIR), *Mental Health Needs of Children and Youth,* up to 20% of children in the United States experience a mental, emotional, or behavioral health disorder each year. Rates of depression and suicidal feelings among high school students have steadily increased in the last decade. According to the Centers for Disease Control and Prevention, in 2019, 45.3% of high school students in California experienced persistent feelings of sadness or hopelessness, with higher rates reported by female students and Hispanic students. 26.6% of high school students seriously considered attempting suicide. For California high schoolers identifying as gay, lesbian, or bisexual the rate is twice as high: 51.3% seriously considered attempting suicide in the previous year.

3) *LEA BOP and SMAA.* DHCS operates two programs that enable LEAs to claim federal Medicaid funds related to providing health services to any Medi-Cal eligible student up to the age of 21—LEA BOP and SMAA. The LEA BOP was established in 1993 and initially was only provided to students who have IEPs or an Individual Family Service Plan (IFSP). In December 2014, the Centers for Medicare and Medicaid Services (CMS) issued new guidance which will allow LEAs to serve all Medi-Cal-eligible students, whether or not they have an IEP or an IFSP. This is known as the "free care" rule. The LEA BOP allows LEAs to become Medi-Cal providers and bill for certain health related assessments and services, including mental health evaluations and psychology and counseling and education assessments.

   LEAs may directly employ, contract with, or both employ and contract with, qualified providers to provide LEA services to Medi-Cal enrolled students and their families. For mental health related services, qualified providers include LCSW, LMFT, licensed physician or psychiatrist, licensed psychologist, licensed educational psychologist (LEP), credentialed school psychologists, and credentialed school counselor. Credentialed school psychologists and credentialed school counselors receive a Pupil Personnel Services (PPS) credential under California Commission on Teacher Credentialing. LCSWs, LMFTs, LEPs, licensed Ophysicians or psychiatrists, and licensed psychologists are licensed by their respective boards under the Department of Consumer Affairs. The behavioral health services eligible for reimbursement under the LEA BOP are less intensive than the services health plans, insurers and MCMC are required to provide. Moreover, students with an IEP or IFSP are eligible for a different set of mental health services than those without an IEP or IFSP.

   The SMAA allows LEAs to receive federal reimbursement for up to 50% of the cost of LEA staff time performing certain Medi-Cal administrative activities. Federal regulations require documentation accounting for all time spent, either directly or derived from a sample. Documentation can include worker logs and random moment time surveys. LEAs submit completed reimbursement claims to their LEC or LGA for review and approval. 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 to consolidate claims provided by LEAs. As a condition of participation in SMAA, each participating LGA and LEC is required to pay an annual fee to DHCS. The participation fee is used to cover the DHCS' cost of administering the SMAA claiming process, including claims processing, technical assistance, and monitoring. The SMAA activities include:

a) Medi-Cal outreach;
b) Facilitating applications for Medi-Cal;
c) Referal, coordination, and monitoring of Medi-Cal services;
d) Arranging transportation to support Medi-Cal services;
e) Translation of documents related to Medi-Cal services;
f) Program planning, policy development, and interagency coordination related to Medi-Cal services; and,
g) Medi-Cal claims administration, coordination, and training.

4) *Additional partnerships to provide mental health services to students*. Mental health services can also be provided to students at school with a partnership with the county, through a school-based health center (SBHC), or with contract with a MCMC plan.

a) *County partnerships.* Under a contract with the county, the county can provide services related to serious mental illness (SMI) on the school campus, either though county providers or contracted community-based providers. In addition, the Mental Health Student Services Act (MHSSA) in the 2019-20 budget provided $40 million one-time and $10 million ongoing Mental Health Services Act (MHSA) funding to establish a competitive grant program to encourage county-school partnerships and increase student access to mental health services. County-school partnerships under the grant program can provide services beyond treatment for SMI.

b) *SBHC.* There is no single funding stream or formal criteria for a SBHC. However, schools can partner with federally qualified health centers (FQHCs) to establish a SBHC, which then can offer MCMC plan covered non-SMI services provided by licensed mental health provider to students. SBHC sites run by FQHCs are subject to additional DHCS requirements.

c) *MCMC plans.* Schools can establish a relationship with MCMC plans to provide behavioral health services in schools in order to receive reimbursement for providing MCMC covered, non-SMI services to students on campus. However, these services must be provided by a licensed mental health provider. MCMC plans can also arrange for their network providers to be located at school sites. DHCS requires MCMC plans to ensure that these arrangements do not duplicate services that LEAs may be billing for under the LEA BOP. According to the Legislative Analyst's Office (LAO), these partnerships are very rare.

5) *Potential sources of health care coverage for California students.* According to the Kaiser Family Foundation, in 2019, 47.5% of children under age 18 are covered by employer coverage in California, 42% are covered by Medi-Cal, 5.4% are covered by non-group health coverage policies (e.g. a Covered California or other plan purchased on the individual market), 3.6% are uninsured, and 1.6% are covered by another public program. Most students in California with private health coverage (employer-covered or individual

market/Covered California) are enrolled in health plans regulated by DMHC, with a small number enrolled in health insurance regulated by CDI. An even smaller number (slightly over one million children and youth age five to 18) are enrolled in self-insured plans. Self-insured plans are not California-regulated plans, thus the mandate to reimburse for students receiving coverage most likely cannot be applied to these plans due to federal ERISA preemption. While attention has been given to drawing down Medi-Cal funds for school-based behavioral health services, it has been more difficult to draw down payment from private health plans and insurers. Students with private coverage are not necessarily getting needed behavioral health services from their private coverage either, as health plans and insurers have struggled to maintain adequate behavioral health networks.

6) *Children and Youth Behavioral Health Initiative.* The 2021-2022 California State Budget included additional support for BH services to children and youth. In addition to a number of grants and coordinating efforts, the initiative includes a new requirement that health plans and insurers cover the provision of the BH 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. Health plans and insurers are prohibited from charging co-pays, deductibles, or other cost-sharing for services received at school sites. This requirement is scheduled to take effect on January 1, 2024, and DMHC and CDI must issue guidance or regulations to implement the requirement in the meantime. The FFS reimbursement schedule is also to be used by MCMC plans

7) *Double referral.* This bill was previously heard in the Senate Education Committee on June 1, 2022 and passed on a 7-0 vote.

8) Prior legislation. SB 229 (Dahle of 2021) would have required DHCS, in consultation with CDE, to provide up to $500 million in grants annually to LEAs and private schools, to provide mental health services for pupils affected by school closures and distance learning requirements resulting from the COVID-19 pandemic. *SB 229 was held in the Senate Appropriations Committee.*

SB 508 (Stern of 2021) would have required specified health care service plans, health insurers, and MCMC plans to enter into a MOU with all LEAs where 15% or more of the pupils of that LEA are insured by the plan or insurer; authorizes the LEA to bill for mental health and SUD 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 508 was not heard in the Senate Health Committee.*

AB 130 (Committee on Budget, Chapter 44, Statutes of 2021) included the School Health Demonstration Project administered by CDE and DHCS to expand comprehensive health and mental health services to public school pupils by providing training and support services to selected LEAs to secure ongoing Medi-Cal funding for those health and mental health services.

AB 133 (Committee on Budget, Chapter 143, Statutes of 2021) included the Children and Youth Behavioral Health Initiative which requires, starting January 1, 2024, a health care service plan contract or insurance policy that is required to provide coverage for medically necessary treatment of mental health and SUDs to cover the provision of specified services

when delivered at school sites, regardless of the network status of the LEA or health care provider. It requires the plan or insurer to reimburse the entity that provided the services at the Medi-Cal rate and requires the services to be provided without prior authorization or cost sharing. AB 133 also requires DHCS to set a fee structure for BH services provided at school sites for MCMC plans and requires DHCS to set up an incentive program for qualifying MCMC plans providing BH services at school sites.

AB 586 (O'Donnell of 2021) would have established 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 MHPs, Managed Care Organizations, and community-based providers. *The contents of AB 586 were included in the budget trailer bill AB 130.*

AB 883 (O'Donnell of 2021) would have required MHSA funds unused by counties, within a specified period, to be reallocated to LEAs in that county to provide student mental health services. *AB 883 was held in the Assembly Appropriations Committee.*

AB 2668 (Quirk-Silva of 2020) was substantially similar to this bill. *AB 2668 was held in the Assembly Education Committee.*

SB 75 (Committee on Budget and Fiscal Review, Chapter 51, Statutes of 2019) established the Mental Health Student Services Act as a mental health partnership competitive grant program for establishing mental health partnerships between a county's mental health or BH departments and school districts, charter schools, and the county office of education within the county, as provided.

AB 258 (Jones-Sawyer of 2019) would have established the School-Based Pupil Support Services Program Act, to provide grants to LEAs for increasing the presence of school health professionals at school sites and providing programs that prevent and reduce substance abuse among pupils. *AB 258 was vetoed by Governor Newsom stating that the bill attempts to change the fund allocation process specified by Proposition 64 which the Legislature is not authorized to do and these funds are already allocated.*

SB 1113 (Beall of 2016) would have authorized a county, or a qualified provider operating as part of the county mental health plan network, and a LEA to enter into a partnership for the provision of EPSDT mental health services. *SB 1113 was vetoed by the Governor Brown stating that additional funding to LEAs must be considered in the annual budget process.*

9) *Support.* Co-sponsor California Behavioral Health Directors Association writes 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 BH 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 BH need is identified.

The partnership programs will allow LEAs and county BH agencies to serve all referred students. County BH 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. A recent report by Milliman found that some California private insurers were 5.7 times more likely use out-of-network providers for outpatient BH services when compared to medical/surgical outpatient facilities and 5.4 times more likely to use out-of-network providers for office visits for behavioral healthcare when compared to medical/surgical primary care office visits. This report found in 2017, a BH 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, 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 Medi-Cal rate.

10) *Policy comments.* Given the new requirement passed in the 2021-2022 Budget that health plans and insurers cover behavioral health services provided at school sites at a rate to be set by DHCS and without any cost-sharing from the student's family, the author should consider conforming this bill to that new circumstance and delaying the implementation of this reimbursement portion of the bill until that requirement takes effect January 1, 2024. Health plans and insurers now have specific obligations that previously were not clear. The new requirements allow for a simpler way to bill for services to students who are covered by plans regulated by DMHC or health insurance regulated by CDI at a fixed rate. These new requirements also ensure that when a student's private health coverage is paying for services provided at a school site that these services are free to the student, which will further reduce barriers.

Additionally, should the author still keep a process for referral back to the plan's network providers, the timeline needs to be updated to reflect recent changes to appointment timeliness standards for BH appointments at 10 days in most cases, rather than the 15 days in the current language. The author should also consider whether partnership programs will still help students who have private health coverage but cannot afford the cost sharing required by that coverage and if so, how to notify parents of that possibility.

In addition, language regarding health plans and insurers obligations should include reference to both DMHC and CDI where applicable.

Finally, it is not clear what is contemplated for students who may have a health plan or health insurance that is not regulated by DMHC or CDI.

11) *Amendment from the Senate Education Committee.* Given the timing between committees, the author will be taking the following amendment as requested by the Senate Education Committee:

Add to section 49440.5 the following language as a new subsection (b):
"The local educational agency shall notify parents and guardians, pursuant to Section 48980, of the prevention and early intervention for, and access to, behavioral health services offered for pupils pursuant to this article. The notification shall, consistent with Section 124260 of the Health and Safety Code, include a form on which a parent or guardian may indicate that they do not consent to their child receiving those services and to, consistent with Section 124260 of the Health and Safety Code, opt out their child, if the child is under 12 years of age, from receiving prevention and early intervention for, and access to, behavioral health services offered pursuant to this article by submitting the completed form to the local educational agency."

The Chair of this committee is requesting the following additional language:
"If a pupil for whom a form has been submitted is later identified as needing behavioral health services, this shall not preclude the local education agency from reaching out to the parent or guardian to seek consent for services."

SUPPORT AND OPPOSITION:

Support: California Alliance of Child and Family Services (co-sponsor)
County Behavioral Health Directors Association (co-sponsor)
American Academy of Pediatrics, California
Association of Regional Center Agencies
California Association of Alcohol and Drug Program Executives
California Association of Local Behavioral Health Boards and Commissions
California Association of Private Special Education Schools
California Behavioral Health Planning Council
California Charter Schools Association
California Council of Community Behavioral Health Agencies
California State Association of Psychiatrists
Children Now
United Parents
County Welfare Directors Association of California
Los Angeles County Office of Education
Los Angeles Trust for Children's Health
National Alliance on Mental Illness-California
County of San Diego
Seneca Family of Agencies
Steinberg Institute
National Center for Youth Law
Sycamores
Women's Foundation of California, Solis Policy Institute

Oppose: None received

-- END --