SENATE COMMITTEE ON HEALTH
Senator Dr. Richard Pan, Chair

BILL NO: SB 508
AUTHOR: Stern
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CONSULTANT: Kimberly Chen

SUBJECT: Mental health coverage: school-based services

SUMMARY: Requires a health plan, health insurer, or a Medi-Cal managed care plan (MCMC) that is required to cover mental health services to enter into a contract with all local educational agencies (LEAs) in which 15% or more of the students at the LEA, are enrolled are covered by the health plan, insurer, or MCMC, as specified. Authorizes a mental health professional employed by a LEA that has not executed a contract with a health plan, insurer, or MCMC to provide and be reimbursed for mental health services to all referred students, as specified. Exempts the contracting and reimbursement provisions of this bill from applying to county mental health plans. Requires telehealth be included as an approved modality for the Medi-Cal program for the specified services provided by an LEA.

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, the Department of Health Care Services (DHCS) to administer the Medi-Cal program, and the Attorney General, who has charge of all legal matters in which California is interested, except as specified. [HSC §1340, et seq., INS §106, et seq., WIC §14000, et seq., GOV §12500, et seq.]

2) Establishes California's essential health benefits (EHBs) under the federal Affordable Care Act (ACA) which include mental health and substance use disorder (SUD) services, and requires nongrandfathered individual and small group health plan contracts and health insurance policies to cover these EHBs and comply with Knox-Keene Act requirements. Requires coverage of mental health and SUD services along with any scope and duration limits in compliance with the federal Paul Wellstone and Pete Dominici Mental Health Parity and Addiction act of 2008 (MHPAEA). [HSC §1367.005 and INS §10112.27]

3) 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]

4) 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]

5) 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]

6) Requires DMHC to develop and adopt regulations to ensure that enrollees have access to needed health care services in a timely manner and consider the following as indicators of timeliness of access to care:

   a) Waiting times for appointments with physicians, including primary care and specialty physicians;
   b) Timeliness of care in an episode of illness, including the timeliness of referrals and obtaining other services, if needed; and,
   c) Waiting time to speak to a physician, registered nurse, or other qualified health professional acting within his or her scope of practice who is trained to screen or triage an enrollee who may need care. [HSC §1367.03]

7) Requires CDI to promulgate regulations to ensure that insureds have the opportunity to access needed health care service in a timely manner and ensure adequacy of number and locations of facilities and providers and consider the regulations adopted by DMHC in an effort to accomplish maximum accessibility within a cost efficient system of indemnification. [INS §10133.53]

8) 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]

9) 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 a local educational agency (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, or LEA BOP). [WIC §14132, 14132.03, 14132.06]

10) Requires Medi-Cal managed care plans (MCMC) 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]

11) 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]

12) 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]

13) 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]

14) 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]

15) 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:

Contracting requirements

1) Requires a health plan, insurer, or MCMC to contract with an LEA if the health plan, insurer or MCMC provides coverage for 15% or more of students at the LEA. Requires the contract terms to include one or more of the following ways to require the health plan, insurer, or MCMC to coordinate with the LEA to provide diagnosis and medically necessary treatment of mental health disorders for covered students:

    a) Reimburse LEAs for services provided to students at the same rate provided under LEA BOP, if the health plan, insurer, or MCMC is unable to offer the student an appointment with an in-network provider within 48 hours for an urgent care appointment or within 15 business days for non-urgent appointments;
    b) Provide one or more mental health providers on campus through in-network providers or contracted community-based organization providers, in order to ensure covered students are able to receive access to diagnosis and medically necessary mental health services. Authorizes the mental health provider to use telehealth for purposes facilitating diagnosis, consultation, treatment, education, care management, and self-management of the student on campus while the provider is at a distant location;
    c) Provide one or more mental health providers within a 30-mile radius of the school campus through in-network providers or contracted community-based organization providers, in order to ensure covered students receive access to diagnosis and medically necessary services within 48 hours for an urgent appointment and 15 business days for a non-urgent appointment;
    d) Provide the LEA an annual payment that the LEA will use to fund one or more mental health professional positions; or,

e) Designate one or more mental health professional employed by the LEA as an in-network provider.

2) Requires an LEA, no later than March 1, 2022 and annually thereafter, to calculate the percent of enrolled students who are enrolled in each health plan, insurer, or MCMC. Requires the LEA to notify the health plan, insurer, or MCMC, if they cover 15% or more of the LEA's students, and inform them of the requirements of this bill.

3) Requires a health plan, insurer, or MCMC to begin negotiations on a contract with an LEA within 30 business days of the notice and to reach an agreement within 90 business days of the notice. Authorizes an extension of up to 90 business days if an agreement cannot be reached within the first 90 business days.

4) Authorizes one or more LEA to enter into a joint partnership agreement with the county office of education for the purposes of implementing this bill. Authorizes LEAs in a joint partnership agreement to combine their enrollment numbers to calculate the percent of enrolled students in each health plan, insurer, or MCMC.

5) Requires DHCS, CDI, DHMC, and CDE to develop a model contract for purposes of LEAs and health plans, insurers or MCMC implementing the contracting requirements of this bill.

Default reimbursement option

6) Authorizes a mental health professional employed by an LEA to provide mental health services to all students covered by a health plan, insurer, or MCMC that has not executed a contract with an LEA, in the following manner:

   a) Authorizes the mental health professional to provide brief initial interventions in order to ensure timely access to behavioral health interventions at the earliest onset of a behavioral health condition;
   b) Requires a mental health professional, or their designee, to contact the student's health plan, insurance, or MCMC upon initiating brief initial intervention services, in order to facilitate a referral to an in-network provider. Requires the contact and referral to be conducted in a manner that is consistent with professionally recognized standards of practice, in consultation with the student and their guardian, and in compliance with existing law on a student's right to privacy and right to consent;
   c) Requires the mental health professional to make a referral to an in-network provider of a student's plan or insurer if an appointment can be offered within 48 hours for an urgent care appointment and 15 business day for a non-urgent appointment.
   d) Authorizes the mental health professional to complete the brief initial intervention, if the plan or insurer is unable to offer the student an appointment with an in-network provider within 48 hours for an urgent care appointment or within 15 business days for a non-urgent appointment.
   e) Requires a plan, insurer, or MCMC to reimburse an LEA for services provided by the mental health professional at the same rate that is provided to LEAs participating in the LEA BOP, unless the health plan, insurer, or MCMC negotiates a single case agreement with the LEA; and,
   f) Authorizes a plan, insurer, or MCMC to dispute the services provided or amount to their respective regulating authorities. Requires a plan or insurer to meet requirements for timely payment of claims for a contracted provider, until the dispute is resolved.

7) Defines "brief initial interventions" to mean behavioral health services that are defined in existing state and federal law, including but not limited to mental health disorder services specified in California's essential health benefits benchmark plan and existing regulations and LEA BOP services described in existing regulations.

8) Encourages a plan, insurer, or MCMC to contract with an LEA to serve students who are receiving mental health services through process described in 6) above.

Additional provisions

9) Prohibits a plan, insurer, or MCMC from limiting benefits or coverage for medically necessary services on the basis that those services should be or could be covered by a public entitlement program, as specified, in accordance with existing law.

10) Exempts the contracting and reimbursement provisions of this bill from applying to county MHPs.

11) Requires telehealth be included as an approved modality for the Medi-Cal program for the specified services provided by an LEA.

12) Makes findings and declarations about the increasing rates of youth suicide, the shortage of qualified mental health professionals, the opportunities for students to receive services on school campus, and the costs LEAs incur by providing medically necessary interventions and services to students.

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

COMMENTS:

1) *Author's statement.* According to the author, the suicide rate for children ages 10 to 14 has more than doubled in the last decade. Despite this, children still have limited access to mental health services. COVID-19 has exacerbated the youth mental health crisis and we will be dealing with the ramifications of that long after the last vaccine is administered. This bill will provide California students with the resources they need while ensuring the financial burden of children's mental health does not fall fully on the shoulders of our public schools. With the added flexibility of tele-health options, we are able to use technology to combat public health challenges set forth by COVID. We need to meet the youth mental health crisis head-on with the urgency it requires, and health insurance plans must work with schools to ensure children's mental health needs are met.

2) *State and federal mental health parity law*. Under the federal MHPAEA of 2008, carriers providing group coverage that cover mental health and SUDs must provide coverage that is no more restrictive than coverage for other medical/surgical benefits. MHPAEA does not require a carrier to provide mental health and SUD benefits. Rather, if a carrier provides medical/surgical and mental health and SUD benefits, it must comply with MHPAEA's parity requirements. This parity provision applies to financial requirements (for example, deductibles and copayments) and treatment limitations. The 1996 federal Mental Health Parity Act prohibited large group health plans from imposing annual or lifetime dollar limits on mental health benefits that are less favorable than such limits on medical/surgical benefits. The federal Department of Labor (DOL), the federal Department of Health and Human Services, and the U.S. Treasury collectively promulgated interim final regulations on February 2, 2010 to implement the provisions of MHPAEA. Final regulations were adopted in 2013. The ACA explicitly includes mental health and SUD, including behavioral health treatment, as one

of the ten categories of service that must be covered as EHB's. The ACA further mandates that mental health and SUD benchmark coverage be provided at parity with other medical and surgical benefits offered by carriers, pursuant to MHPAEA.

The state's initial mental health parity law, as enacted by AB 88 (Thomson, Chapter 534, Statutes of 1999) required health plans and insurers to cover the diagnosis and medically necessary treatment of "severe mental illness" of a person of any age, and of "serious emotional disturbances" of a child. Coverage was intended to be required at parity - under the same terms and conditions applied to other medical conditions. AB 88 required parity with respect to enrollee cost-sharing for covered benefits. SB 855 (Wiener, Chapter 151, Statutes of 2020) established a broader requirement on health plans and disability insurers to cover medically necessary treatment of mental health and SUDs under the same terms and conditions applied to other medical conditions. SB 855 established new requirements for medically necessary care determinations and utilization review and banned discretionary clauses in health plan and contracts. California's current mental health parity law applies to the large group, small group, and individual markets.

According to the Kaiser Family Foundation, in 2019, for children up to the age of 18, 47.5% received health care coverage through an employer-sponsored plan, 42% received coverage through Medi-Cal, 5.4% received coverage through an individually purchased plan, 3.6% were uninsured, and 1.6% were covered through other means. The two state agencies that have primary oversight of health plan and insurer compliance with state and federal mental health parity laws and their implementing regulations are DMHC and CDI. This includes most employer-sponsored plans.

All MCMC plans, except for five of the six county organized health systems (COHS), are subject to dual oversight by DHCS and DMHC. MCMC plans enter into contracts with DHCS in order to provide or arrange services for Medi-Cal beneficiaries. While, federal and state laws establish the rules that govern MCMC plans, many significant requirements are established and enforced by DHCS through these contracts, including compliance with financial viability and standards; quality improvement systems; utilization management; and, access and provider networks. While the requirements set forth in the contracts largely mirror those required by the Knox-Keene Act, there are significant differences in the delivery of mental health services.

3) *Medi-Cal mental health services.* Under Medi-Cal, mental health services are delivered under two systems, with county MHPs providing SMHS to those with more severe mental illness (SMI) and MCMC providing services outside of that. MCMC may deliver their mental health benefits directly, through a subcontract with a specialized mental health plan, or contracting with the county behavioral health department.

Whether a beneficiary has been diagnosed with one of 19 covered conditions and meets impairment and intervention criteria for the diagnosed condition determines which delivery system provides mental health services for the beneficiary. However, state regulations establish separate and more broadly defined impairment criteria for children, who qualify for mental health services as an EPSDT benefit. EPSDT is a federally mandated benefit available to all Medi-Cal eligible individuals under the age of 21. Under EPSDT, Medi-Cal is required to provide comprehensive services and cover all medically necessary services needed to correct and ameliorate health conditions, including any medical, dental, vision, hearing, or mental health needs, whether or not such services are covered under the state's Medicaid program. In addition to the "correct and ameliorate" medical necessity standard, the "impairment" criteria component of SMHS medical necessity is also broader for children than for adults.

DHCS requires MCMCs to cover and pay for mental health services conducted by licensed mental health professionals, which includes licensed psychologists, licensed clinical social worker (LCSW), licensed professional clinical counselor (LPCC), or licensed marriage and family therapists (LMFT). The services include individual and group mental health evaluation and treatment (psychotherapy); psychological testing when clinically indicated to evaluate a mental health condition; outpatient services for the purposes of monitoring medication therapy; outpatient laboratory, medications, supplies, and supplements; and, psychiatric consultation.

For children, DHCS requires MCMCs to ensure all individuals up to the age of 21 receive required preventive services and screenings specified under the "Bright Futures Guidelines." The Bright Futures Guidelines is a schedule of recommended preventive care screenings and well-child visits for children and adolescents developed by the American Academy of Pediatrics (AAP). The Bright Futures Guidelines require all primary care providers (PCPs) to conduct psychosocial/behavioral assessments for newborns to adolescents up to the age of 21 and to conduct depression screenings for all children beginning at the age of 12. Beneficiaries with positive screening results may be further assessed either by the PCP or referred to a network mental health provider. In addition to mental health screenings and services provided by the PCP, at any time, MCMC beneficiaries can choose to seek and obtain a mental health assessment from a licensed mental health provider within the MCMC provider network.

4) *Timely access requirements.* Both DMHC and CDI have similar timely access regulations which require each health plan or insurer to contract with adequate numbers of physicians and other health care providers in each geographic area to meet clinical and time elapsed standards. The DMHC standards include that enrollees must be offered appointments within the following timeframes:

   a) Urgent care without prior authorization: within 48 hours;
   b) Urgent care with prior authorization: within 96 hours;
   c) Non-urgent primary care appointments: within ten business days;
   d) Non-urgent non-physician mental health care providers: within ten business days,
   e) Non-urgent specialist appointments: within 15 business days; and,
   f) Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness or other health condition: within 15 business days.

   MCMC are also required to have the following standards for outpatient mental health services:

   a) **15 miles or 30 minutes** from the beneficiary's place of residence: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara;
   b) **30 miles or 60 minutes** from the beneficiary's place of residence: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura;
   c) **45 miles or 75 minutes** from the beneficiary's place of residence: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba;
   d) **60 miles or 90 minutes** from the beneficiary's place of residence: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino,

Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne;

DHCS may permit MCMCs to adhere to alternative access standards that deviate from any of the required time and distance requirements under certain circumstances.

5) *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 Individualized Education Program (IEP) or an Individual Family Service Plan (IFSP). In December, 2014, 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:

a) Audiology services;
b) Physical therapy;
c) Health and mental health evaluation;
d) Psychology and counseling and education assessments;
e) School health aide services;
f) Medical transportation;
g) Speech therapy;
h) Nursing services;
i) Targeted case management; and,
j) Occupational therapy.

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 physicians 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) Referall, 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.

6) *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.

   a) *County partnerships*. Under a contract with the county, the county can provide services related to 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 covered non-SMI services provided by licensed mental health provider to students. SBHC sites run by FQHCs are subject to additional DHCS requirements.

   c) *MCMCs*. Schools can establish a relationship with MCMCs 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. MCMCs can also arrange for their network providers to be located at school sites. DHCS requires MCMCs 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.

7) *Medi-Cal for Students Workgroup*. SB 75 (Committee on Budget and Fiscal Review, Chapter 51, Statutes of 2019) required, commencing with the 2019-20 fiscal year, CDE to jointly convene with the Department of Developmental Services and DHCS one or more workgroups that include representatives from LEAs, appropriate county agencies, regional centers, and legislative staff. The workgroups are required to convene for several purposes, including:

   a) Improving coordination and expansion of access to available federal funds through the LEA BOP, MAA, and medically necessary EPSDT benefits;

b) Program requirements and support services needed for the LEA BOP, MAA, and medically necessary EPSDT benefits to ensure ease of use and access for LEAs and parity of eligible services throughout the state and country; and,
c) Recommendations include any specific changes needed to state regulations or statute, need for approval of amendments to the state Medicaid plan or federal waivers, changes to implementation of federal regulations, changes to state agency support and oversight, and associated staffing or funding needed to implement recommendations.

The workgroup issued a draft report on student health services in late 2020. In the report, it stated approximately half of California's school districts participate in LEA BOP and MAA programs. California ranked 40th in federal Medicaid reimbursement per Medicaid-enrolled school-age child and 39th in federal Medicaid reimbursement per school-age child in 2014-15, the most recent year for which data about reimbursements is available. The report states that CDE is not listed as a partner in the state's Medicaid plan and has no formal role in school-based Medicaid. The absence of interagency collaboration was raised repeatedly by workgroup and steering committee members as the single greatest barrier to school-based Medicaid systems improvement. This barrier was further identified in external interviews, which cited interagency collaboration as the most crucial part of an effective school-based Medicaid system. The report states that it is important to note that collaboration is not a cure-all for the other considerations, but it represents a critical infrastructure for problem solving.

8) *Budget proposals on student mental health services*. There are several proposals in the Governor's proposed 2021-22 budget seeking to increase access to student mental health services. Under DHCS, the Governor has proposed $400 million ($200 million General Fund) in one-time funding over three years to DHCS to implement an incentive program through Medi-Cal managed care to build infrastructure for establishing partnerships with schools and county behavioral health. The goal is to increase the number of students receiving behavioral health services— with a particular focus on prevention and early intervention services—through Medi-Cal. The incentive payments would be provided for a variety of interventions and activities, including local planning efforts to identify service gaps, establishing contracts with schools to provide behavioral health services on-site, and providing technical assistance to schools to ensure services are reimbursed through Medi-Cal.

According to the Legislative Analyst Office, there are key pieces missing in the DHCS incentive payment proposal. For instance, DHCS has not yet determined the allocation methodology for how incentive payments would be distributed to MCMCs. The LAO also notes that the proposal does not include the specific metrics MCMCs must meet in order to receive incentive payments. The proposal also does not detail how funding made available by the incentive payments to MCMCs will flow to schools or county MHPs. Finally, the LAO notes that there are both gaps in, and duplication of, services currently being provided by MCMCs, county MHPs, and schools. The LAO recommends the administration clarify where the gaps may be and where duplication of services may occur.

The Governor's budget also includes one-time $25 million to expand the existing county-school partnership grant program under the MHSA and $25 million ongoing Proposition 98 matching funds for county children's mental health projects.

9) *DHCS post-COVID 19 telehealth policy recommendations*. As a result of the COVID-19 public health emergency (PHE), DHCS implemented broad telehealth flexibilities offered

under a myriad of federal waivers and flexibilities. On February 2, 2021, DHCS released a set of telehealth policy recommendations to maintain some of the temporary PHE policy changes and implement new telehealth policies after the conclusion of the PHE. According to DHCS, prior to COVID-19, synchronous telehealth was limited to LEA BOP speech therapy. Under the post-PHE policy, synchronous and asynchronous telehealth will be expanded to all services provided by licensed practitioners who are acting within their scope of practice (with the exception of services that are not amenable to a telehealth modality such as specialized medical transportation). DHCS's telehealth policy recommendations are currently included as proposed trailer bill language for the 2021-22 budget.

10) *Double referral.* This bill is double referred. Should it pass out of this committee, it will be referred to the Senate Committee on Education.

11) *Related legislation.* SB 14 (Portantino) adds "for the benefit of the behavioral health of the pupil" to the list of categories of excused absences for purposes of school attendance. Requires CDE to identify an evidence-based training program for LEAs to use to train classified and certificated school employees having direct contact with pupils in youth behavioral health; and an evidence-based behavioral health training program with a curriculum tailored for pupils in grades 10 to 12. *SB 14 was heard in the Senate Committee on Education on March 10, 2021, and passed by a vote of 7-0.*

SB 224 (Portantino and Rubio) requires each school district to ensure that all pupils in grades 1 to 12 receive medically accurate, age-appropriate mental health education from instructors trained in the appropriate courses, and that each pupil receive this instruction at least once in elementary school, at least once in junior high school or middle school, and at least once in high school. *SB 224 was heard in the Senate Committee on Education on March 10, 2021, and passed by a vote of 7-0.*

SB 229 (Dahle) requires 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, subject to an appropriation by the Legislature for this purpose. *SB 229 was heard in this Committee on April 14, 2021, and passed on a vote of 11-0.*

SB 773 (Roth) requiresDHCS, beginning the January 1, 2022 rating period through December 31, 2024, to make incentive payments to MCMCsthat meet predefined goals and metrics that increase access to behavioral health services for children enrolled in kindergarten and grades 1 to 12. Requires DHCS, in consultation with specified stakeholders, to develop the interventions, goals, and metrics used to determine a MCMC eligibility to receive the incentive payments. *SB 773 was heard in this Committee on April 14, 2021, and passed on a vote of 11-0.*

AB 58 (Salas) requires LEAs to provide suicide awareness and prevention training annually to teachers; states the intent of the Legislature to require DHCS to create a pilot program to establish a school health center at five LEAs in counties with high rates of youth suicide and self-harm; and requires DHCS to provide technical assistance to CDE and LEAs to ensure LEAs take full advantage of federal funds for Medi-Cal eligible students. *AB 58 is pending in the Assembly Committee on Education.*

AB 309 (Gabriel and O'Donnell) requires CDE to develop model pupil mental health referral protocols, in consultation with relevant stakeholders, subject to the availability of funding for this purpose. *AB 309 is pending in the Assembly Committee on Education.*

AB 552 (Quirk-Silva) authorizes LEAs and county behavioral health agencies to enter into partnerships to provide school-based behavioral health and SUD services on school sites, and authorizes the billing of private insurance providers for these services under specified conditions. *AB 552 was heard in the Assembly Committee on Education on March 24, 2021, passed by a vote of 7-0, and is pending in the Assembly Committee on Health.*

AB 563 (Berman and Ramos) requires CDE to establish an Office of School-Based Health Programs for the purpose of improving the operation of, and participation in, school-based health programs, including SMAA and LEA BOP. Requires that $500,000 in federal reimbursements be made available for transfer through an interagency agreement to CDE for the support of the office. *AB 563 was heard in the Assembly Committee on Education on March 24, 2021, passed by a vote of 7-0, was heard in the Assembly Committee on Health on April 13, 2021, passed by a vote of 15-0.*

AB 586 (O'Donnell and Wood) establishes the School Health Demonstration Project to expand comprehensive health and mental health services to students by providing intensive assistance and support to selected LEAs to build the capacity for long-term sustainability by leveraging multiple funding streams and partnering with county mental health plans, managed care organizations, and community-based providers, and to help scale up robust and sustainable school-based health and mental health services throughout the state. *AB 586 was heard in the Assembly Committee on Education on April 7, 2021, passed by a vote of 7-0, and is set to be heard in Assembly Committee on Health on April 13, 2021.*

AB 883 (O'Donnell) requires 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 heard in the Assembly Committee on Health on April 6, 2021, passed by a vote of 15-0, and is pending the Assembly Committee on Education.*

AB 1117 (Wicks) establishes the Healthy Start: Toxic Stress & Trauma Resiliency for Children Program within CDE, in partnership with the Health and Human Services Agency, to oversee a grant program to fund innovative local collaboratives between schools, communities, county and city agencies, nonprofit service providers, and early childhood service programs and agencies. *AB 1117 is pending in the Assembly Committee on Education.*

12) *Prior legislation.* SB 855 (Wiener, Chapter 151, Statutes of 2020) repealed California's mental health parity law and replaced it with a broader requirement on health plans and disability insurers to cover medically necessary treatment of mental health and SUDs under the same terms and conditions applied to other medical conditions; establishes new requirements for medically necessary care determinations and utilization review; and bans discretionary clauses in health plan contracts.

AB 2668 (Quirk Silva and Weber of 2020) was substantially similar to AB 552 (Quirk-Silva). *AB 2668 was not heard in the Assembly Committee on Education.*

SB 75 (Committee on Budget and Fiscal Review, Chapter 51, Statutes of 2019) establishes the MHSSA as a mental health partnership competitive grant program for establishing mental health partnerships between a county's mental health or behavioral health departments and school districts, charter schools, and the county office of education within the county, as provided. Requires CDE to jointly convene with the DHCS a workgroup that include representatives from LEAs, appropriate county agencies, and legislative staff to develop recommendations on improving coordination and expansion of access to available federal funds through the LEA BOP, SMAA, and medically necessary federal EPSDT benefits.

SB 276 (Wolk, Chapter 653, Statutes of 2015) requires DHCS to seek federal financial participation for covered services that are provided by a LEA to a child who is an eligible Medi-Cal beneficiary, regardless of whether the child has an IEP or an individualized family service plan, or whether those same services are provided at no charge to the beneficiary or to the community at large, if the LEA takes all reasonable measures to ascertain and pursue claims for payment of covered services against legally liable third parties.

AB 1644 (Bonta of 2016) would have renamed the Early Mental Health Intervention and Prevention Services for Children Act as "the Healing from Early Adversity to Level the Impact of Trauma in Schools Act." Required the Department of Public Health (CDPH) to establish a four-year program to support local decisions to provide funding for early mental health support services, required CDPH to provide technical assistance to LEAs, and required CDPH to select and support school sites to participate in the program. *AB 1644 was held in the Senate Committee on Appropriations.*

AB 580 (O'Donnell of 2015) would have required CDE to develop model referral protocols for voluntary use by schools to address the appropriate and timely referral by school staff of students with mental health concerns. *AB 580 was vetoed by the Governor, whose veto message stated that California does not currently have specific model referral protocols for addressing student mental health as outlined by the bill; however, the California Department of Education recently received a grant from the federal Department of Health and Human Services, Substance Abuse and Mental Health Services Administration to identify and address critical student and family mental health needs. The Governor further stated that it's premature to impose an additional and overly prescriptive requirement until the current efforts are completed and the state can strategically target resources to best address student mental health.*

AB 1018 (Cooper of 2015) would have required DHCS and CDE to convene a joint taskforce to examine the delivery of mental health services to children. *AB 1018 was held in the Senate Committee on Appropriations.*

AB 1025 (Thurmond of 2015) would have required CDE to establish a three-year pilot program in school districts to encourage inclusive practices that integrate mental health, special education, and school climate interventions following a multitiered framework. *AB 1025 was held in the Senate Committee on Appropriations.*

AB 1133 (Achadjian of 2015) would have established a program substantially similar to the one proposed by AB 1644 (Bonta). Established a four year pilot program, the School-Based Early Mental Health Intervention and Prevention Services Support Program, to provide outreach, free regional training, and technical assistance for LEAs in providing mental health services at school sites. *AB 1133 was held in the Assembly Committee on Appropriations.*

AB 2608 (Bonilla, Chapter 755, Statutes of 2012) makes permanent and expands provisions relating to program improvement activities in the Medi-Cal Local Billing Option program, through which LEAs can draw down federal funding for health care services provided to Medi-Cal-eligible students. AB 2608 also expanded the scope of transportation services for which Medicaid reimbursements can be received.

SB 1009 (Committee on Budget and Fiscal Review, Chapter 34, Statutes of 2012) requires DHCS, in collaboration with California Health and Human Services Agency, and in consultation with the MHSOAC and a stakeholder advisory committee, to develop a plan for a performance outcomes system for EPSDT specialty mental health services provided to eligible Medi-Cal beneficiaries under the age of 21. The purpose of the system is to improve beneficiary outcomes and inform decisions regarding the purchase of services.

AB 3632 (Brown, Chapter 1747, Statutes of 1984) requires the referral of students with exceptional needs who also have mental health needs and services documented in their IEPs by LEAs to county mental health agencies for treatment.

13) *Support*. This bill is sponsored by the Santa Clara County Office of Education, San Diego Unified School District, and Los Angeles Unified School District. In a joint letter, they state that prior to the pandemic, suicide rates among children ages 10 to 14 had doubled yet California had one of the lowest children's mental health service rates in the nation. The mental health crisis has only intensified during COVID-19: intentional self-harm among 13 to 18 year-olds increased by 91%, overdoses increased by 95%, and diagnoses of major depressive disorder increased by 84%. However, during the first six months of the pandemic California recorded the largest decline in access to youth mental health services than any other state. These numbers indicate a clear failure of managed care organizations and health plans to meet youth mental health needs, both prior to and during the pandemic. They argue that this bill would address three key issues that are currently a barrier to youth receiving much needed mental health services. First, it would allow schools to utilize telehealth to provide services. Second, it would make clear that, if a health plan failed to reasonably respond to a student referred for mental health services, the school could provide services and be reimbursed. Third, the bill would require health plans to enter into a contract with a district when 15% or more of enrolled students are insured by a particular health plan. They note that MCMC are already required to collaborate with schools, but few, if any, do. The sponsors conclude that there are many student mental health proposals being contemplated this year, this bill is the only one that would ensure children received greater access to mental health and wellness services on or adjacent to school campus at no additional cost to the state. Numerous organizations have shared similar sentiments in support.

14) *Opposition*. The California Association of Health Plans (CAHP) and the Association of California Life and Health Insurance Companies (ACLHIC) oppose this bill and argue that this bill takes the wrong approach in ensuring access to mental health services. In a joint letter, they write that while they certainly appreciate the intent and spirit of this, they are very concerned that logistical framework outlined is extremely complex and not implementable. They also state that this approach is unnecessarily complex, and will only cause confusion for students, parents, school officials and health plans and insurers. Conceivably, health plans and insurers could be required to enter into multiple different types of contracts depending on the school districts in the plan or insurers service area. They believe that this arrangement will needlessly add complexity and administrative costs.

They also note that it is unclear how this bill would work for students covered under a county MHPs. This currently exempts students covered under a county MHPs, which excludes all Medi-Cal SUD treatment and any mental health condition that is beyond "mild to moderate." Lastly, they note that unclear how the reimbursement methodology included in the bill would work with respect to out-of-network (OON) providers. They state that reimbursement standards for OON providers are complicated at best and vary depending on the service, how it is selected, and where the product is regulated.

15) *Concerns*. The County Behavioral Health Directors Association of California (CBHDA) have shared a letter of concerns. They state that the bill continues to create confusion regarding which Medi-Cal behavioral health services will be provided to student Medi-Cal beneficiaries by mental health professionals that are employed or contracted with LEAs. The description of brief initial intervention services that LEA mental health professionals would be able to provide include Medi-Cal covered behavioral health services, as outlined, including mental health services specified in California's essential health benefits benchmark plan. CBHDA is concerned that, as introduced, the bill will allow LEAs to provide Medi-Cal SMHS that county behavioral health plans are contracted to provide to students and ready to provide to students who are Medi-Cal beneficiaries. CBHDA requests language to clarify that any Medi-Cal SMHS provided to a Medi-Cal beneficiary must be done under a contract with a county behavioral health plan or should be provided by other county behavioral health plan providers, with the exception of any of these services that are Educationally-Related Mental Health Services (ERMHS). CBHDA requests language to clarify and reiterate existing law, which holds school districts responsible for ERMHS provided to Medi-Cal beneficiaries.

16) *Policy comments*. In order to increase access to mental services to students, this bill establishes contracting requirements between a health plan, insurer, or MCMC and an LEA and a default reimbursement option. These provisions poses a number of policy and implementation challenges.

a) *Credentialed professional vs. licensed provider*. LEAs may directly employ, contract with, or both employ and contract with both licensed providers and credentialed, but non-licensed professionals. Existing law requires health plans, insurers, and MCMC cover mental health services provided by a licensed provider. It is unclear whether a health plan, insurer, or MCMC can, or should, reimburse a non-licensed provider for the provision of medical services, without the recommendation of a licensed provider or under a supervisorial structure with a licensed provider. This bill authorizes, and in some instances would require, health plans, insurers, and MCMC to pay non-licensed providers for the provision of services to students. *The Committee may wish to amend the bill to require health plans, insurers, and MCMC to only reimburse for services provided by a licensed provider or provide a structure under which a non-licensed provider can provide specified services under the supervision and upon the recommendation of a licensed provider.*

b) *Default reimbursement option*. For students who are covered by a health plan, insurer, or MCMC that does not have a contract with the LEA, including any students enrolled in a plan that does not reach the 15% threshold, a mental health professional employed by the LEA may initiate and complete 'brief initial interventions' and additional services beyond that, as specified. The definition of 'brief initial interventions' includes both mental health services covered by plans and services authorized under the LEA BOP. *The Committee may wish to*

clarify which specific services are covered under 'brief initial interventions' and which services are considered 'additional services.'

If a mental health professional employed by an LEA provides mental health services to a student, this bill requires health plans and insurers to reimburse any OON providers for services provided to students enrolled in their plan. While LEAs cannot charge students or their families for the provision of mental health services as school, it is unclear whether students may incur OON costs related to these services when a mental health professional employed by the LEA bills their health plan or insurer. *The committee may wish to require LEAs to notify students and their parents or guardians of the potential OON costs for services provided by a LEA mental health professional.*

This bill requires a mental health professional be reimbursed at the same rate as under the LEA BOP. The LEA BOP covers only a limited set of mental health-related services. Absent a single use agreement, it is unclear the methodology health plans, insurers, or MCMCs should use to reimburse mental health professionals for services beyond the LEA BOP. *The Committee may wish to clarify whether or not health plans, insurers, or MCMCs should reimburse for services beyond the LEA BOP services, and if so, the methodology by which reimbursement should be determined.*

c) *Contracting requirements.* This bill requires LEAs to calculate the percent of students who are enrolled in each health plan, insurer, or MCMC and to provide notice once enrollment reaches 15%. Most LEAs collect student health coverage information annually in the context of collecting emergency contact information for use only in the event of an emergency. The author has indicated that this is where LEAs will collect data on insurance enrollment of students. *The Committee may wish to consider requiring LEAs to notify parents that health coverage information is being collected for purposes of this bill and the provision of mental health services to students at schools.*

This bill authorizes a health plan, insurer, or MCMC to implement the contracting requirements by providing an annual payment to LEAs to fund mental health professionals employed by the LEA. It is unclear if this payment is intended to be a grant, private donation, or other type of payment arrangement. The bill does not require the LEA to report or provide any accounting on how funds are spent, or to verify whether students covered by the health plan, insurer, or MCMC actually received services because of the payment. *The Committee may wish to authorize health plans, insurers, or MCMCs to establish public-partnerships or pilot programs with specific expectations for deliverables, student outcomes, and reporting.*

This bill authorizes a health plan, insurer, or MCMC to implement the contracting requirements by providing one or more mental health providers within a 30-mile radius of the school campus. *The Committee may wish to specify whether the health plan, insurer, MCMC, LEA, or the student's parent or guardian is responsible for transportation between the school and the provider.*

d) *Technical comments.* This bill has technical drafting issues that should be addressed. This includes correcting inadvertent references to "mental health" and "mental health services" as "mental health disorders" and "mental health disorder services" and clarifying that the provisions of this bill also apply to COHS that are not licensed under DMHC.

SUPPORT AND OPPOSITION:

Support: Los Angeles Unified School District (co-sponsor)
Santa Clara County Office of Education (co-sponsor)
San Diego Unified School District (co-sponsor)
Alliance for a Better Community
Association of California School Administrators
California Association of School Counselors
California Federation of Teachers
California School Boards Association
California School Nurses Association
California School-based Health Alliance
California Teachers Association
City of San José
Humboldt County Office of Education
InnerCity Struggle
Monterey County Office of Education
National Association of Social Workers, California Chapter
OCHIN, Inc.
Riverside County Office of Education
San Benito County of Education
San Francisco Unified School District
San Mateo County Office of Education
Santa Clara County Office of Education
Santa Cruz County Office of Education
The California Children's Trust
The Children's Partnership
The Los Angeles Trust for Children's Health

Oppose: Association of California Life & Health Insurance Companies
California Association of Health Plans

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