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SB 75

Senate Bill 75

Medi-Cal for Students Workgroup Recommendations

Report to the chairs of the relevant policy committees and budget subcommittees of the California State Legislature and the California Department of Finance

Authorizing State Legislation: California *Education Code* Section 56477, added by Section 50 of Senate Bill 75 (Chapter 51, Statutes of 2019)

From the California Department of Education, the California Department of Health Care Services, the California Health and Human Services Agency, and the Medi-Cal for Students Workgroup

Prepared by WestEd

DHCS California Department of Health Care Services

CHHS California Health & Human Services Agency

Description: This report provides recommendations made by the Medi-Cal for Students Workgroup to the California State Legislature and the Department of Finance for improving coordination and expansion of access to available federal Medicaid reimbursement for local educational agencies through the Local Educational Agency Medi-Cal Billing Option Program, the School-Based Medi-Cal Administrative Activities Program, and the medically necessary federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit in California, under the authority of California Education Code Section 56477, added by Section 50 of Senate Bill 75 (Chapter 51, Statutes of 2019).

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October 1, 2021

To the California State Legislature and the California Department of Finance:

Senate Bill 75 (Chapter 51, Statutes of 2019) charged the California Department of Education (CDE), in collaboration with the California Department of Health Care Services (DHCS), to convene one or more workgroups to identify barriers that may inhibit local educational agency access to federal Medicaid reimbursement for student health services. Once convened, the workgroup would provide recommendations to the relevant subcommittees of the Legislature and the Department of Finance regarding program requirements and support services needed for the Local Educational Agency Medi-Cal Billing Option Program; the School-Based Medi-Cal Administrative Activities Program; and the medically necessary federal Early and Periodic Screening, Diagnostic, and Treatment benefit to ensure ease of use and access for local educational agencies and parity of eligible services throughout the state. Recommendations were to include any specific changes needed to state regulations or statutes, need for approval of amendments to the state Medicaid plan or federal waivers, changes to the implementation of federal regulations, changes to state agency support and oversight, and associated staffing or funding needed to implement the recommendations.

To meet this charge, the CDE contracted with WestEd to establish and facilitate a workgroup focused on improving coordination and expansion of access to available federal reimbursement for local educational agencies through Medicaid. In the course of executing this charge, the CDE, the DHCS, and the California Health and Human Services Agency (CHHS) used this opportunity to engage in cross-agency collaboration that supported meaningful stakeholder engagement and interagency communication and decision-making. The collective efforts of the CDE, the DHCS, the CHHS, and the Medi-Cal for Students Workgroup demonstrate that intentional and sustained collaboration across state agencies and stakeholders will be necessary to successfully implement the recommendations in this report.

This report, and the associated efforts of the Medi-Cal for Students Workgroup to arrive at this moment, raise an important series of observations, challenges, and opportunities for how the various functions of child- and youth-serving agencies work together to design, deploy, and implement school-based health services. The Medi-Cal for Students Workgroup

recommendations and associated actions in this report mark an improved path forward in how California proceeds with policy and regulatory changes that positively impact the lives of California's children through school-based health programs.

The recommendations contained in this report reflect the ideas developed by the Workgroup with input from state agency staff. This report does not necessarily represent the opinions of the CDE, the DHCS, the CHHS, or WestEd, nor does it indicate endorsement of the recommendations by any individual or state agency.

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Executive Summary

Well-designed school-based health programs can effectively address many education- and health-related needs of California's students. Research has shown that millions of children attend school with physical and mental health conditions that, when left unaddressed, interfere with their well-being and educational progress (Basch 2011). Research has also shown that school-based health programs help amend these issues—such programs are associated with improved education- and health-related outcomes (Knopf et al. 2016).

The benefits of access to school-based health services are especially pronounced for historically and currently underserved children and youth who may not have ready access to health care (Knopf et al. 2016), making school-based health programs a critical strategy for advancing education and health equity for all students, especially those enrolled in Medicaid.[1] Approximately half of California's local educational agencies (LEAs) participate in at least one of two programs that enable reimbursement for school-based health services or associated administrative infrastructure through Medicaid: the Local Educational Agency Medi-Cal Billing Option Program (LEA BOP) and the School-Based Medi-Cal Administrative Activities (SMAA) Program (DHCS 2019c). In addition to these cost-based reimbursement programs, some LEAs partner

> "For too long, health and education programs have been siloed. Creating an environment of collaboration could greatly enhance our current system of care in California."
>
> —Workgroup member

[1] Medi-Cal is California's Medicaid program.

with Medi-Cal managed care plans and county mental health plans, through contracts and memoranda of understanding (MOUs), to provide services. These options represent an important path for schools to directly provide or partner with health plans to provide the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit to Medicaid-enrolled students. In recognition of these benefits, many LEAs and health plans in California are working together to provide school-based health services (Briscoe et al. 2020), but many LEAs are also struggling to build partnerships with health plans and participate in Medicaid reimbursement programs (CDE et al. 2020). Consequently, some LEAs are failing to benefit from federal Medicaid reimbursement for a portion of the costs of eligible health services for students.

To address these issues, Senate Bill 75 required the California Department of Education (CDE) and the Department of Health Care Services (DHCS) to convene a workgroup, the Medi-Cal for Students Workgroup ("the Workgroup"), to provide recommendations for improving coordination and expansion of access to available Medicaid reimbursement through the medically necessary federal EPSDT benefit (including through the LEA BOP, and the SMAA Program). Workgroup members represented a diverse set of education and health system stakeholders, including school-based providers, school district administrators, county office leaders, nonprofit executives, and health plan representatives. Members of the Workgroup engaged in a series of working sessions, over 16 months, to investigate the opportunities and challenges present in California's system for supporting schools to access federal reimbursement for student health services through Medicaid, and, based on this investigation, to design recommendations for system improvement.

> "Collaboration is not only possible but necessary to tackle this complex issue."
>
> —Workgroup member

To frame its purpose and guide its work, the Workgroup envisioned a system in which:

- all students have access to the health services they need;
- students and families can quickly and easily access health services; and
- health services are responsive to student needs and experiences.

The Workgroup further identified three key accomplishments necessary to realize this vision,

- LEAs have ready access to the funds they need in order to support student health.

- All LEAs claim a federal match on every eligible dollar.
- California has an integrated system of care to support health services for all children and youths.

About This Report

This report summarizes the context, process, and resulting recommendations of the Workgroup, which convened from February 2020 through May 2021. The recommendations contained in this report reflect the ideas developed by the Workgroup with input from state agency staff. This report does not necessarily represent the opinions of the CDE, the DHCS, the CHHS, or WestEd, nor does it indicate endorsement of the recommendations by any individual or state agency.

The Workgroup identified the following five overarching recommendations to improve the coordination and expansion of access to available federal reimbursement for LEAs through the medically necessary federal EPSDT benefit (including through the LEA BOP and the SMAA Program):

Recommendation 1

State Interagency Collaboration: *Formalize state-level collaboration between education and health systems by*

a. providing necessary resources to the CDE and the DHCS so they can hire and retain dedicated staff to establish a system of ongoing state-level collaboration; and

b. utilizing an advisory group to solve problems and provide guidance related to collaboration between the education and health systems. The advisory group should include youth and families; representatives from departments such as the CDE, the DHCS, the CHHS, and the Department of Managed Health Care; and representatives from county offices of education, school districts, county mental health plans, managed care plans, and community-based organizations.

Recommendation 2

Local Agency Training and Guidance: *Provide targeted training and guidance to LEAs and health plans on implementing school-based health programs to maximize billing and reimbursement on school-based health-care expenditures and to expand access to health-care services for Medicaid-eligible students by*

a. producing training and targeted technical assistance resources for LEAs, county mental health plans, and managed care plans; and

b. creating conditions that will enable collaboration between health plans and LEAs to flourish and, where appropriate and legally allowable, encourage contracts and MOUs between LEAs and managed care plans and county mental health plans.

Recommendation 3

School-Based Health Services Demonstration Sites: *Create school-based health services demonstration sites to improve technical assistance provided to LEAs about school-based health and to capitalize on recent school-based Medicaid investments and initiatives by*

a. engaging a contractor to pilot technical assistance strategies in school-based health services demonstration sites that leverage new school-based Medicaid investments and initiatives that (1) produce effective partnerships between LEAs, managed care plans, county mental health plans, community stakeholders, and LEA BOP and SMAA Program vendors and (2) provide a wider array of services to Medicaid-eligible students across all three primary Medicaid access points: (a) county mental health plans, (b) managed care plans, and (c) the LEA BOP and the SMAA Program; and

b. applying the lessons learned from the school-based health services demonstration sites to inform future technical assistance to LEAs and health plans.

Recommendation 4

LEA BOP Audit Support: *To facilitate the LEA BOP audit process, implement feedback loops between LEAs and the DHCS Audits and Investigations Division that foster collaborative learning and continuous improvement, and develop resources that support LEA audit preparation, by*

a. enhancing auditor practices through auditor training informed by user experience, and gathering regular feedback from LEAs about their LEA BOP audit experiences; and

b. developing audit-related technical assistance processes to support LEAs before, during, and after the LEA BOP audit process.

Recommendation 5

Access to Preventive Services: *Identify options for expanding access to school-based preventive physical health, mental health, and substance use disorder services by*

a. identifying opportunities to provide mental health and substance use disorder treatment in schools when risk factors exist but the child does not have a diagnosis; and

b. developing a framework for school-based preventive physical health, mental health, and substance use disorder services, in accordance with national guidelines for such services, and identifying the funding sources available for each service.

Improving the coordination and expansion of access to available Medicaid reimbursement through the implementation of these recommendations will take time and careful planning.[2] It will also require financial investment from the state in the form of one-time funds to cover start-up costs to successfully implement many of the recommendations, as well as ongoing funds for dedicated state staff to sustain the resulting improvements.[3] However, the potential benefits of implementing these recommendations far outweigh these costs. Embracing the Workgroup recommendations will position California to maximize its federal Medicaid reimbursement through cost-based programs and partnerships with health plans, which will help produce lifelong educational and health benefits for California's students (Knopf et al. 2016).

> "We want the people who read this report to know that this needs to result in action."
>
> —Workgroup member

[2] For more information on the proposed timeline for implementation, see appendix F.

[3] Expenditures of additional state funds may qualify for up to 50 percent federal Medicaid reimbursement, depending on their use for eligible services and administrative activities. Please refer to appendix G for the estimated costs to implement each recommendation.

Introduction

Background

Section 50 of Senate Bill 75 (Chapter 51, Statutes of 2019) added Section 56477 to the California Education Code, requiring the California Department of Education (CDE) and the California Department of Health Care Services (DHCS) to jointly convene one or more workgroups that include representatives from local educational agencies (LEAs), appropriate county agencies, regional centers, and legislative staff to provide input and recommendations in the following areas:[4]

- Improving transition of three-year-old children with disabilities from regional centers (Part C programs) to LEAs (Part B programs) to help ensure continuity of services for young children and families.
- Improving coordination and expansion of access to available federal funds through the Local Education Agency Medi-Cal Billing Option Program (LEA BOP), the School-Based Medi-Cal Administrative Activities (SMAA)

"The members of the Workgroup came from various entities and have various direct and indirect experiences. However, we all have one goal in mind: to improve the services for children."

—Workgroup member

[4] Expenditures of additional state funds may qualify for up to 50 percent federal Medicaid reimbursement, depending on their use for eligible services and administrative activities. Please refer to appendix G for the estimated costs to implement each recommendation.

Program, and the medically necessary federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit.

Two separate workgroups were convened, each addressing one of these areas, and two sets of recommendations were developed accordingly. This final report provides detailed recommendations from the Medi-Cal for Students Workgroup ("the Workgroup") for the second area: improving coordination and expansion of access to available federal funds through the medically necessary federal EPSDT benefit (including through the LEA BOP, the SMAA Program). This report describes the Workgroup's recommendations and the actions necessary to meet the charge set by the legislation. Specifically, it includes program requirements (e.g., changes to interagency coordination practices) and support services (e.g., training and technical assistance) needed to improve the coordination and expansion of LEA access to Medicaid funds for student health services.[5] The recommendations contained in this report reflect the ideas developed by the Workgroup with input from state agency staff. This report does not necessarily represent the opinions of the CDE, the DHCS, the CHHS, or WestEd, nor does it indicate endorsement of the recommendations by any individual or state agency.

Process for Developing the Recommendations

The recommendations in this report were generated between February 2020 and May 2021 through a series of stakeholder engagement activities with a 63-member workgroup representing a wide range of education and health system stakeholders, including school-based providers, school district administrators, county office leaders, nonprofit executives, and health plan representatives. These activities were guided by a 21-member steering committee composed of staff from the CDE, the DHCS, and the California Health and Human Services Agency (CHHS). The steering committee guided the Workgroup's activities and provided expert consultation regarding recommendation design. A 18-member advisory group with representatives from the Legislature and the Department of Finance had the primary function of advising on the intent of the Senate Bill 75 legislation and associated reporting requirements. The processes for developing the recommendations and writing this final report were facilitated by WestEd.[6]

The following problem statement was developed and agreed on by Workgroup and steering committee members and was used to guide this work:

[5] Refer to appendix E for specific changes needed to state regulations or statutes, changes to the implementation of federal regulations, changes to state agency support and oversight, and associated staffing or funding needed to implement the recommendations. Refer to appendix G for additional information regarding staffing and funding needed to implement the recommendations.

[6] See appendix B, figure 2, for an illustration of the structure for stakeholder involvement.

Lack of coordination and access to available federal reimbursement through the medically necessary federal Early and Periodic Screening, Diagnostic, and Treatment benefit (including through the LEA BOP, and the SMAA Program) are creating barriers for California students to access the health services they need.

To frame its purpose and to guide its work, the Workgroup envisioned a system in which

- all students have access to the health services they need;
- students and their families can quickly and easily access health service; and
- health services are responsive to student needs and experiences.

The Workgroup further identified three key accomplishments necessary to realize this vision:

- LEAs have ready access to the funds they need in order to support student health.
- All LEAs claim a federal match on every eligible dollar.
- California has an integrated system of care to support health services for all children and youths.

The recommendations and this final report were developed through a process that involved Workgroup meetings and other input activities, field research, and guidance from a state-level steering committee and advisory group.[7] The process followed design principles for developing recommendations leading to system improvements that are based on analyzing and understanding stakeholder experiences.[8]

[7] See appendix C for more information on the timeline and specific steps in the process.

[8] See appendix D for more information on the frameworks that guided the development of the recommendations.

"This Workgroup is committed to seeing change for children, youth, and families. The work has not been seamless; collaboration across systems is challenging and can be messy. We need to expect messiness moving forward, but the recommendations represent what can be accomplished through collaboration."

—Workgroup member

"Open dialogue and suspension of turf wars allowed for us to look outside the box for solutions."

—Workgroup member

To develop these recommendations, the Workgroup engaged in three main activities:

1. **See, Empathize, and Define**: Investigate potential system strengths and challenges; empathize to learn more about the people most impacted by, and involved in, the system; and develop a shared point of view about stakeholder needs and opportunities for system improvement.
2. **Ideate**: Generate ideas to address the problem.
3. **Design**: Turn ideas into recommendations for changes to policy and practice that will lead to people's improved experiences in the system (National Equity Project n.d.)

The system investigation process and results are described in the *Senate Bill 75 Medi-Cal for Students Progress Report* (CDE et al. 2020). As part of investigating the system, Workgroup members considered what they had learned about student and family experiences in the school-based health system and current state and local policies and practices, together with their own experiences working within the education and health systems, including how these systems connect to serve our children and youths. The Workgroup identified several root causes contributing to challenges in the system, including

- complex administrative processes,
- limited resources and lack of qualified staff,
- lack of education and health system alignment and coherence,
- burdensome auditing processes,
- variable relationships between agencies,

- lack of data sharing,
- challenges accessing services,
- challenges translating models for providing health services to students into the school setting,
- staff knowledge gaps regarding programs and services, and
- complex billing and reimbursement processes.

Using the information gathered during their investigation of the system, the Workgroup brainstormed possible ideas for addressing these challenges at the state and local levels. The Workgroup then refined these initial ideas into the recommendations presented in this report. Each recommendation includes proposed actions for carrying out the respective recommendation, and, for each respective action listed, details about "why this action is important" and "how to get there" (what steps to take to carry out the action). While Workgroup members expressed a strong preference for responsibility for school-based health to be shared between agencies, they deferred to state staff to determine which agency should take primary responsibility for each action identified in the report.

The process of developing recommendations provided opportunities to generate understanding, share experiences, produce ideas, and build relationships across a broad range of California school-based health stakeholders. The Workgroup offered a space for service providers, local agencies, and statewide advocates to work together, across varied interests, through collective investigation and ideation, to design meaningful recommendations for improving coordination and access to available Medicaid reimbursement to support student health care. Workgroup meetings were designed to collectively investigate and understand the current state of California's school-based Medicaid system and to explore opportunities for system improvement. While the Workgroup was focused on making structural improvements to school-based Medicaid, Workgroup engagement activities contributed to new relationships and connections among actors in the education and health systems. As two Workgroup members shared:

"The Workgroup consisted of a diverse set of subject-matter experts who came together in the interest of putting children first in the quest to expand services and improve current program and practice efficiencies."

—Workgroup member

"Regardless of what agency we represent, we all agreed and felt this work was important. This reform needs to happen."

—Workgroup member

Meanwhile, the steering committee provided a critical space for interagency collaboration with the CDE and the DHCS, resulting in greater shared understanding of the respective responsibilities and experiences that each state agency has in school-based Medicaid, increased collaboration between the departments, and shared commitments to sustain collaboration for system improvement over time. The advisory group provided an opportunity to keep staff members from the Legislature and the Department of Finance up to date on the progress of the Workgroup, and to generate a shared understanding, with Department of Finance and legislative staff, of the evolution of the recommendations. Members of the advisory group were quick to respond to the evolving Workgroup recommendations. Several initiatives in the 2021–2022 California Budget[9] reflect some of the findings and recommendations made by the Workgroup.

"I want the people who read this report to know that this is about increasing access to health services for kids. It can be easy to lose that as the centerpiece when talking about high-level activities."

—Workgroup member

"Local educational agencies, county mental health plans, and managed care plans are all unique and cover different areas of the EPSDT benefit. There is no silver-bullet solution. These recommendations stem from leveraging relationships, coordinating efforts, and, more broadly, expanding collaboration in meaningful ways that help meet the needs of the students."

—Workgroup member

California's School-Based Medicaid Landscape

This section describes the school-based Medicaid landscape in California, in order to provide important context for the Workgroup recommendations.

Medicaid is a public health insurance program that is jointly funded by states and the federal government and that is administered by states as governed by federal laws and regulations. States establish and administer Medicaid programs and determine the types, amounts, durations, and scopes of services within broad federal guidelines, as outlined in a Medicaid state plan (Shubel 2020). Medicaid is a critical source of health-care coverage for children and youths (DHCS 2019a).

[9] http://www.ebudget.ca.gov/

The Federal EPSDT Benefit

The federal EPSDT benefit requires states to provide a comprehensive array of prevention, diagnostic, and treatment services for children and youth under age 21 who are enrolled in Medicaid.[10] In California, children and youth under age 21 who qualify for full-scope Medicaid qualify for the EPSDT benefit.[11] EPSDT is key to ensuring that children and youths receive appropriate preventive, dental, mental health, developmental, and specialty services, and is a required part of Medicaid.[12]

> *Federal Medicaid statutes mandate that states ensure the provision of, and pay for, any treatment that is considered "medically necessary" for a child or youth and that is included within the mandatory and optional services in Section 1905(a) of the Social Security Act (CMS 2014). Some examples of services provided under the EPSDT benefit when the beneficiary and the provider meet eligibility criteria are vision screenings, occupational therapy, and psychological services.*

California covers most physical and behavioral EPSDT services through managed care plans (DHCS 2021d), which function like health maintenance organizations.[13] Some services are not covered by managed care plans in California, including specialty mental health services, which are administered through county-operated county mental health plans. The LEA BOP and the SMAA Program, California's cost-based Medicaid claiming and reimbursement programs for LEAs, allow LEAs that enroll as Medicaid providers to receive partial reimbursement for a subset of services covered through the EPSDT benefit, as well as eligible associated administrative costs.

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10 In addition to federal laws and the California State Plan (Supplement 8 to Attachment 4.19-B), several state laws and regulations govern California's administration of the EPSDT benefit (including the school-based Medicaid programs). The state laws and regulations that govern the administration of the EPSDT benefit are outlined in the Welfare and Institutions Code (WIC), Sections 14115.8, 14132.06, and 14132.47 (CDE et al. 2020), and the California Code of Regulations (22 C.C.R., Sections 51051, 51184, 51190.1–.4.1, 51270, 51360, 51491, and 51535.5).

11 "Full-scope Medicaid" is health insurance that covers more than just emergency health care. It also covers medical, dental, mental health, and vision care, as well as alcohol and drug use treatment, prescriptions, and other services. The LEA BOP expands eligibility to individuals under the age of 22 for LEA BOP services (DHCS n.d.c.).

12 In addition to federal laws and the California State Plan, several state laws and regulations govern California's administration of the EPSDT benefit. For a full list of services, see CMS (n.d.).

13 States are responsible for implementing the EPSDT benefit and making decisions about how covered services are defined, delivered, and reimbursed in their Medicaid State Plans. The EPSDT benefit—including the LEA BOP and the SMAA Program, California's two cost-based Medicaid claiming and reimbursement programs for LEAs—is administered at the state level by the DHCS.

California's Cost-Based Medicaid Claiming and Reimbursement Programs for Local Educational Agencies

The LEA BOP and the SMAA Program are California's cost-based Medicaid claiming and reimbursement programs for LEAs (see Table 1). These programs allow LEAs to receive partial (generally up to 50 percent) federal reimbursement for a subset of medical services covered under the EPSDT benefit and associated eligible administrative costs. For the purposes of the LEA BOP, the term "LEA" includes school districts, county offices of education, charter schools, community college districts, California State Universities, and University of California campuses.[14]

Table 1. California's Cost-Based Medicaid Claiming and Reimbursement Programs

Program	Description
Local Educational Agency Medi-Cal Billing Option Program (LEA BOP)	The LEA BOP offers reimbursement for health assessment and treatment services for eligible students and eligible family members within the school environment. The LEA BOP reimburses LEAs the federal share of the maximum allowable rate for approved health-related services provided by qualified health service practitioners to Medicaid-enrolled students (DHCS 2021c). To participate in the LEA BOP, LEAs must enroll through the DHCS as a Medicaid provider.
School-Based Medi-Cal Administrative Activities (SMAA) Program	The SMAA Program reimburses LEAs for the federal share (generally 50 percent) of certain costs for administering the Medicaid program (DHCS 2021e). Through the SMAA Program, LEAs may obtain federal reimbursement for the costs of certain administrative activities that are necessary for the proper and efficient administration of school-based Medicaid. The SMAA Program includes activities such as referring students and families to enroll in Medicaid and coordinating Medicaid services between agencies.

[14] This report focuses primarily on K–12 education. The term "LEA" is used throughout this report when referring to one or more K–12 education entities (i.e., school districts, charter schools, and county offices of education). The term "school district" is used when referring specifically to school districts.

The LEA BOP and the SMAA Program can be administered directly by LEAs, while other services covered under the EPSDT benefit must be accessed through managed care plans or county mental health plans.

Contracts, memoranda of understanding, and other partnerships. LEAs, managed care plans, and county mental health plans all cover a specific subset of EPSDT services, so they must partner if they aim to offer a comprehensive suite of EPSDT services to Medicaid-enrolled students. The term "partnerships" is used broadly in this report to refer to education and health plans working together to provide school-based Medicaid services through contracts, memoranda of understanding (MOUs), or other mechanisms. Such partnerships maximize opportunities for children and youths to receive needed services. Research shows that school-based health programs are associated with improved education- and health-related outcomes, especially for historically and currently underserved children and youths (Knopf et al. 2016), making them a critical strategy for advancing education and health equity.

Local educational agency partnerships with managed care plans. California's counties use a variety of managed care models, which vary in numbers of plans available and whether those plans are county-administered or commercially administered (DHCS 2020). The variety partially results from the different roles that counties have historically played in the financing and provision of health services for Medicaid-eligible individuals (Tatar, Paradise, and Garfield 2016). For example, a county organized health system is a health plan created and administered by a county board of supervisors. In counties that use a county organized health system, all managed care enrollees are in the same plan. Conversely, in counties with a regional expansion model, DHCS contracts with two commercial plans in each county to cover the beneficiaries who live there. Variation in partnerships is inevitable in the current system because California's health plans are different across counties and because LEAs have different ways of approaching their roles in student health care. While the variation can be beneficial when it helps address the local needs of students and communities, it can also make partnerships challenging to navigate and can make provision of effective technical assistance less standardized.

Medicaid providers that wish to provide services to managed care enrollees must participate in the managed care plan's provider network. School-based health centers (which provide health-care services on or near school campuses) are a common strategy for partnerships between LEAs and managed care plans (California School-Based Health Alliance 2020). Federally qualified health centers typically act as the mediating entity for school-based health centers—that is, the federally qualified health center participates in the managed care plan's network and contracts with the LEA to locate the center on or near the school. Direct contracts between LEAs and managed care plans are less common because of a variety of system-level challenges.

One example of a successful direct partnership between an LEA and a managed care plan is the asthma management program between the Kern County Health System and the Bakersfield City School District. In this case, the health system pays the school district, on a quarterly basis, for each service or activity provided to health plan members enrolled in the asthma

management program. For reimbursement, the school district submits quarterly reports to the health system with a list of health plan members who participated in program interventions (California School-Based Health Alliance n.d.b).

Local educational agency partnerships with mental health plans. Non-specialty mental health services are provided by managed care plans, while specialty mental health services and substance use disorder treatment services are provided by county mental health plans under the authority of a waiver approved by the Centers for Medicare & Medicaid Services (CMS) (DHCS 2021a). The county mental health plans are required to provide or arrange for the provision of specialty mental health services to beneficiaries in their counties who meet medical necessity criteria, consistent with the beneficiaries' mental health treatment needs and goals. However, LEAs are responsible for mental health services required by a pupil's individualized education program, for students who are eligible for special education and related services. In some cases, such educationally related mental health services may also qualify as medically necessary specialty mental health services.

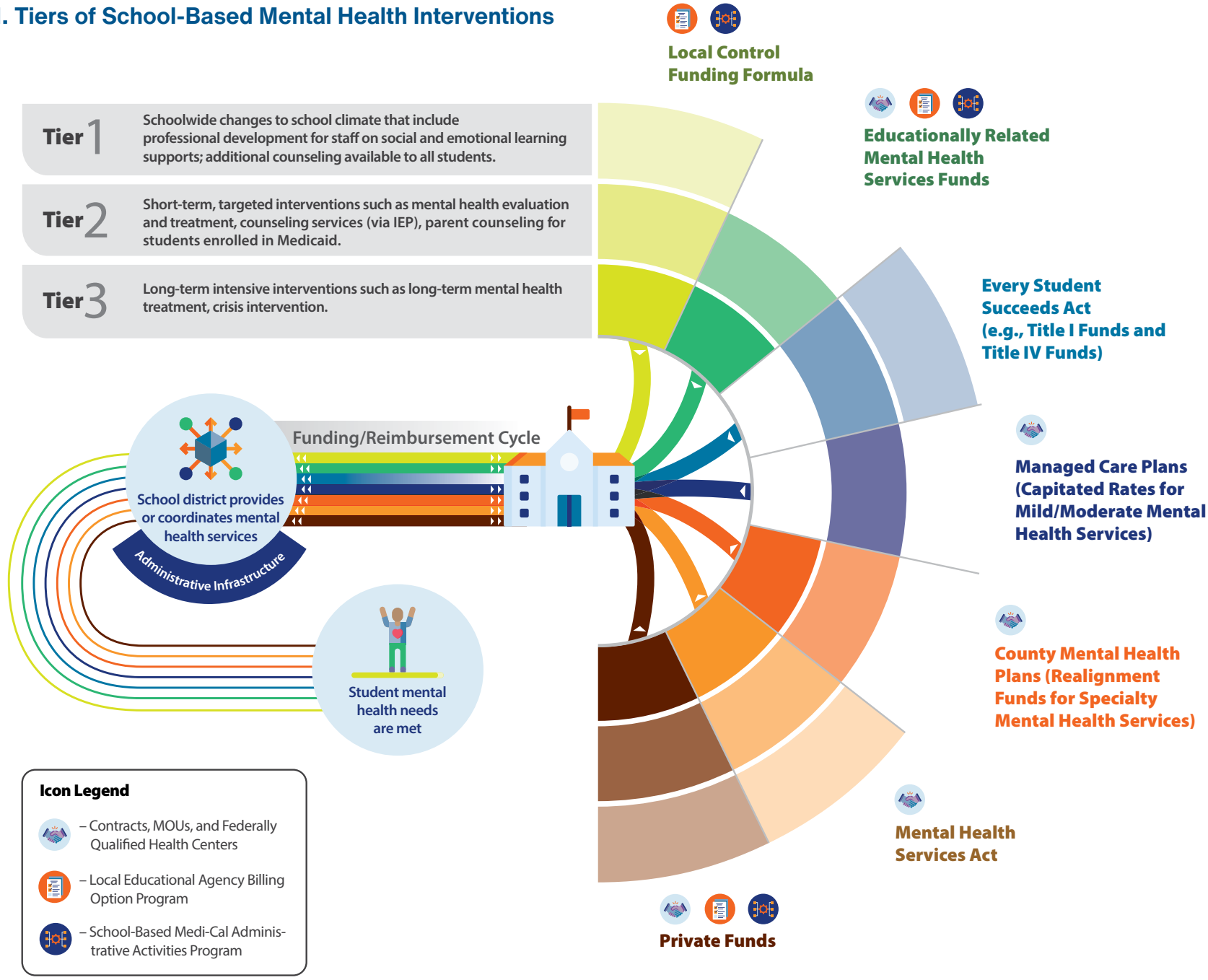
LEAs and county mental health plans may partner to provide a more comprehensive suite of specialty mental health services at or through schools. Various models exist for these mental health partnerships. For example, a school district might contract with a county mental health plan to provide medically necessary, educationally related mental health services at school sites, or a county mental health plan might contract with Medicaid-qualified licensed school staff to provide specialty mental health services. The formal contracts, MOUs, and funding mechanisms for partnerships vary across local communities, just as participation rates vary in the reimbursement programs.

> *LEA participation rates in Medicaid reimbursement programs and formal contract or MOU mechanisms and/or funding models for LEA partnerships with managed care plans and county mental health plans vary across local communities.*

Putting It All Together to Create a Comprehensive System of School-Based Health Care for Students

LEAs play an important role in children's and youths' access to health care by providing them with health services directly and/or by facilitating the delivery of services through contracts, MOUs, and other partnerships with health plans. Figure 1 illustrates how the various Medicaid programs and federal and state funding sources can support different tiers of school-based mental health preventive and treatment services (California School-Based Health Alliance 2018). While, for simplicity, only mental health is shown in the figure, Medicaid-coverable substance use disorder and physical health services are also covered under the EPSDT benefit and have their own specific requirements.

Figure 1. Tiers of School-Based Mental Health Interventions



Source: Adapted with permission from California School-Based Health Alliance 2018.

Figure 1 shows the structure of a familiar service delivery model, a multi-tiered system of support, that school districts and charter schools commonly use to organize their services and supports to students along a tiered continuum. The figure illustrates how a school district might use a variety of funding streams, contracts, partnerships, and Medicaid reimbursement programs to coordinate and pay for a comprehensive suite of school-based mental health services. For example, a school district might design a tiered school-based mental health system that includes the following:

- **Tier 1 (universal support):** The school district uses the unrestricted funds it receives from the state through the Local Control Funding Formula to pay for counseling services available to all students. Some of the students who receive counseling services are enrolled in Medicaid. For counseling services provided to any Medicaid-enrolled students by qualified practitioners, the school district has the option to receive federal reimbursement through the LEA BOP to claim up to 50 percent of the cost of the service (pending an approval of those services through the LEA BOP audit process). Federal Medicaid reimbursement then cycles back into the school district's budget and is used to pay for additional services for the children and youths enrolled in the school district's schools.

- **Tier 2 (targeted support):** The school district partners with a federally qualified health center (a community-based health care provider that receives federal funds to provide primary care services in underserved areas) that is a provider for the managed care plan in the school district's county. The school district provides the federally qualified health center with a building in which it can house and run a school-based health center on a school campus. Students can go to the school-based health center to receive mental health evaluation and treatment through the managed care plan, at no additional cost to the school district.

- **Tier 3 (intensive support):** The school district contracts with its county mental health plan so that the plan provides educationally related mental health services on school sites. The school district pays the plan for the services using its state educationally related mental health services, funds, and, because the county mental health plan is already on site, the county mental health plan provides and pays for specialty mental health services for Medicaid-enrolled children and youths with qualifying conditions.

These types of service-delivery options, and many others, can offer ways for school district and health plans to combine resources and work together to help children, youths, and their families access the health services they are entitled to through the federal EPSDT benefit quickly and easily.

Ecosystem of Current Statewide Initiatives

For 16 months, the Workgroup focused on bringing together research, evidence, and personal experiences to inform a series of recommendations and necessary actions to meet the mandate of the Senate Bill 75 legislation and to set the groundwork for improvements in the school-based Medicaid system. During the workgroup process, the Workgroup members recognized that other efforts initiated at the local, regional, and state levels are aiming to resolve challenges within the same school-based health systems addressed by the Workgroup. The Workgroup, the steering committee, and support staff recognized that they were operating within a complex and intricate ecosystem of statewide initiatives aiming to improve access to health services for children and youths. The graphic displayed in appendix H visually represents some of the current initiatives in the ecosystem, organized by various system components. Although this graphic does not show all state-level initiatives, it offers a snapshot of current efforts and illustrates the context in which California can frame, analyze, and develop solutions for improving school-based Medicaid.

Recommendations

This section provides recommendations from the Workgroup for improving coordination and access for LEAs to available Medicaid reimbursement for student health services.[15] The recommendations were developed beginning in February 2020, and the details of the recommendations and related actions may not reflect legislation developed after that date.

Recommendation 1

State Interagency Collaboration: *Formalize state-level collaboration between education and health systems.*

- **Action 1-A:** Provide necessary resources to the CDE and the DHCS so they can hire and retain dedicated staff to establish a system of ongoing state-level collaboration.

> "Children do not leave their mental or physical health issues at the school's front door. Daily, children come to school with a myriad of health conditions that are barriers to learning. This broad-based, diverse group of leaders has come together in the Workgroup to improve student health and learning by increasing access to health services in the educational setting."
>
> —Workgroup member

[15] This report focuses primarily on K–12 education. The term "LEA" is used throughout this report when referring to one or more K–12 education entities (i.e., school districts, charter schools, and county offices of education). The term "school district" is used when referring specifically to school districts.

- Appendix E, table 4, lists the required changes to regulations, statute, oversight, support, staffing, and funding for each recommendation.
- Appendix F illustrates the proposed implementation timeline for the recommendations and associated actions.
- Appendix G, table 6, describes the estimated costs of implementing each recommendation.

- **Action 1-B:** Utilize an advisory group to solve problems and provide guidance related to collaboration between the education and health systems. The advisory group should include youth and families; representatives from departments such as the CDE, the DHCS, the CHHS, and the Department of Managed Health Care; and representatives from county offices of education, school districts, county mental health plans, managed care plans, and community-based organizations.

This recommendation requests additional resources for the CDE and the DHCS so that they can hire and retain state-level staff dedicated to coordinating and implementing school-based health services. This recommendation also proposes that the CDE and the DHCS utilize an interagency advisory group to provide guidance and solve problems of practice related to state-level collaboration between California's education and health systems.

"Reducing the silos between health and education to deliver health services in schools has been championed by many organizations and individuals in the field for decades. Creating infrastructure at the state level is an important step to share learning and reduce barriers to this effort across the state. It's so exciting!"

—Workgroup member

"Currently, education and health-care systems operate independently of one another (to a large extent) even though they serve the same people and systems (children, youth, families, communities). This recommendation is to bring education and health care together to think about shared goals, points of intersection and alignment, and how to access federal dollars to improve educational and health/public-health outcomes."

—Workgroup member

Recommendation 1 Proposed Actions

Action 1-A

Provide necessary resources to the CDE and the DHCS so they can hire and retain dedicated staff to establish a system of ongoing state-level collaboration.

Why This Action Is Important

Coordinated technical assistance activities would increase access to health services for children and youths and help LEAs maximize Medicaid reimbursement for the eligible services provided in schools. Interagency collaboration was repeatedly identified by Workgroup and steering committee members, and recommended by external stakeholders during interviews, as a crucial part of an effective school-based Medicaid system (CDE et al. 2020). Having dedicated staff is often necessary to facilitate that kind of state-level interagency collaboration. For example, the CDE and the DHCS have demonstrated ongoing commitment to collaboration through the Workgroup and the steering committee; in addition to attending multiday Workgroup meetings, the agencies have met biweekly to discuss questions and solve problems related to school-based health services, as a result of the Senate Bill 75 legislation. However, sufficient staffing must be in place to continue this collaboration. Furthermore, the lack of a formalized collaborative relationship, in school-based Medicaid programs, between the CDE and the DHCS hinders vital opportunities to support EPSDT partnerships among local education and health agencies and to improve participation rates in the Medicaid program.

Despite the potential benefits of collaboration between the CDE and the DHCS, the state has only recently allocated funding to support such collaboration. Both agencies need a sufficient number of staff available to support LEAs with Medicaid reimbursement programs. Historically, the DHCS has had a small number of staff dedicated to this type of support, and the CDE has had none. Meanwhile, neither the DHCS nor the CDE has had any staff dedicated to supporting partnerships between LEAs and health plans (managed care plans and county mental health plans). However, funding recently approved in the 2021 Budget Act should result in improved coordination between the two agencies. The Workgroup identified partnerships between LEAs and health plans as critical opportunities to connect funding streams and expand access to the medically necessary federal EPSDT benefit in schools. Although some LEAs in California have developed successful partnerships with county mental health plans to provide specialty mental health services, few have developed partnerships with managed care plans to provide other mental and physical health services (California Legislative Analyst's Office 2021). Coordinating expertise through collaborative technical assistance (such as the CDE and the DHCS offering advice and training, and sharing information and practical guidance through websites, webinars, guidance documents, resources, and tools) would help generate a more streamlined and responsive support system for LEAs that want to participate in Medicaid reimbursement programs and form school-based health partnerships.

How to Get There

The Workgroup suggests that additional ongoing resources be devoted to the CDE and the DHCS to create and sustain a formal system of collaboration. One possible way to do so would be to hire staff at each agency who are dedicated to collaborating with staff at the other agency on school-based health services. The Legislature should ensure that the CDE and the

DHCS have the necessary resources to dedicate staff to establish and sustain a system of collaboration focused on supporting school-based health services.

Facilitate collaboration and leverage expertise of each agency. The dedicated staff must develop structures for consistent communication and collaboration. The intention of the dedicated staff and of the collaboration would be to leverage the expertise of the DHCS related to understanding the intricacies of Medicaid, and to leverage the CDE's strengths related to designing programmatic and fiscal procedures, to provide technical assistance and support to LEAs. Regardless of the exact format of the collaboration, the CDE and the DHCS should share accountability for successful and sustainable collaboration on supporting school-based health services.

The dedicated staff should focus on five primary activities related to school-based health services:

- Designing any new state-level policy proposals
- Soliciting feedback from an advisory group on state-level proposals
- Analyzing the effectiveness of dedicated staff activities
- Developing a feedback loop for ongoing stakeholder input
- Designing and facilitating technical assistance for LEAs and health plans
- Reaching out to nonparticipating agencies

The dedicated staff should consider successful models of technical assistance delivery, such as a multi-tiered system of support (described in the introduction to this report). Many LEAs use the multi-tiered system of support framework[16] to organize their services and supports to students along a tiered continuum. This framework could also be used when providing technical assistance to LEAs, which could involve providing the following tiered support:
Tier 1 (universal support) could include universal technical assistance, such as written guidance and webinars. Tier 2 (targeted support) could include targeted resources aimed at helping LEAs to navigate the LEA BOP and the SMAA Program and/or to build partnerships with county mental health plans and managed care plans. Tier 3 (intensive support) could include intensive assistance on strategic planning for a small number of LEAs on how to establish and scale up school-based health services. (Additional information about specific topics for technical assistance is available under Recommendation 3, Action 3-A in table 2, which provides a list of recommended technical assistance topics.)

[16] For further information about the multi-tiered system of support framework, go to https://www.cde.ca.gov/ci/cr/ri/mtsscomprti2.asp.

In order to be most effective, the following key competencies should be represented among the dedicated staff:

- Ability to translate existing and new regulations across education and health policy
- Ability to convene and facilitate productive and solution-oriented conversations
- Experience designing school-based Medicaid programs
- Understanding of Medicaid rules, billable services, and fiscal requirements
- Understanding of CDE fiscal and reporting requirements for LEAs
- Understanding of the roles of key school-based health stakeholders (e.g., managed care plans and county mental health plans) in school-based health services
- Experience translating complex information to LEAs

Review relevant data to inform the work. The dedicated staff should review data available across state and local education and health systems; determine appropriate measures of inputs and outcomes of their collaboration, such as the reimbursement of eligible services by LEA type for the LEA BOP; and use these measures to report on the effectiveness of their activities at regular intervals.[17] For example, if staff want to evaluate their effectiveness in LEA BOP enrollment and service reimbursement, they might begin setting baselines by using the initial analyses of LEA BOP claims completed to inform the Workgroup's deliberations.[18] The findings of this investigation would offer useful data to support the subsequent activities and to monitor impact of the activities on key markers, such as the availability of health services in schools. The dedicated staff should also use information gathered from stakeholders (e.g., LEA administrators, service providers, students, and families) about their needs and their lived experiences related to school-based Medicaid, to inform ongoing provision of technical assistance to better help staff from the CDE and the DHCS understand and meet the specific needs of LEAs in relation to school-based health services.

[17] Data sharing should be done with adherence to Health Insurance Portability and Accountability Act (HIPAA) and Family Educational Rights and Privacy Act (FERPA) requirements.

[18] Analyses conducted to inform the Workgroup's deliberations illustrated that LEAs submitted a modest number, and a limited scope, of successful Medicaid claims through the LEA BOP in 2014–15, the most recent year for which data was available. Speech therapy services provided to students with disabilities represented nearly three quarters of all approved LEA BOP claims, even though speech therapy is often among the least expensive services provided by LEAs (CDE et al. 2020). The observations from these preliminary analyses are sufficient to warrant additional and comprehensive review of the gap between the total expenditure for Medicaid-coverable services in school and the number of successful Medicaid claims submitted through the LEA BOP.

Action 1-B

Utilize an advisory group to solve problems and provide guidance related to collaboration between the education and health systems. The advisory group should include youth and families; representatives from departments such as the CDE, the DHCS, the CHHS, and the Department of Managed Health Care; and representatives from county offices of education, school districts, county mental health plans, managed care plans, and community-based organizations.

Why This Action is Important

An advisory group with cross-system representation would support interagency collaboration and provide a space for coordinated problem-solving and systems guidance related to school-based health. Due to the expansiveness and complexity of the school-based Medicaid system, many previous and current initiatives have included only partial representation from key stakeholder groups, such as state agency staff, managed care plans, county mental health plans, and school districts. Moreover, despite the important foci of many previous and current initiatives,[19] their limited connections to state-level program staff charged with implementing these respective initiatives have compromised their abilities to make positive impacts. The purpose of this action is to utilize an advisory group that is intimately tied to decision-makers at the state level and that is representative of local actors in the school-based Medicaid system.

How to Get There

The CDE and the DHCS should either establish a new advisory group or leverage an existing group, such as the DHCS LEA BOP Advisory Workgroup, that includes representatives from education and health systems.

Ensure that the advisory group has a representative membership. The Workgroup recommended that the advisory group include representation from the CDE, county offices of education, and school districts, as well as representation from the DHCS, the California Department of Public Health, the California Department of Managed Health Care, county mental health plans, managed care plans, and the Mental Health Services Act Oversight and Accountability Commission. Workgroup members also noted the importance of including youth, family, and community voices within the group. In sum, a prescribed membership for the group should be developed by the dedicated staff described in Action 1-A, with attention to ensuring diversity of experience and with the goal of including representatives from the state agencies, from LEAs, and from health plans. The Workgroup emphasized the importance of a prescribed membership because the members will drive the priorities of the group. If the membership is unbalanced (e.g., too many representatives from health plans and not enough from LEAs, or vice versa), the group may become limited in scope. Collaboration among the advisory group

[19] A selection of statewide initiatives that aim to improve school-based health care for students is provided in appendix H.

members and the dedicated staff described in Action 1-A is also important, to ensure a balance of thought leaders and decision-makers.

Define the advisory group's responsibilities. Initial and ongoing responsibilities of the advisory group should include the following:

- Meet at regularly scheduled intervals.
- Set a systems-level vision.
- Clarify roles and responsibilities between the dedicated staff and the advisory group.
- Clarify roles and responsibilities of all child-serving systems under the EPSDT benefit (including providing specific direction to all actors in the system about their obligations).
- Define shared goals across agencies and plans that serve Medicaid-enrolled youths, such as schools and managed care plans.
- Identify ways to integrate school-based health into other agency divisions and initiatives across the state.
- Advocate for coordination to address student and family needs across various agencies.
- Offer feedback on new regulations, state plan amendments, state-level policies, or other system changes.

Recommendation 2

Local Agency Training and Guidance: *Provide targeted training and guidance to LEAs and health plans on implementing school-based health programs to maximize billing and reimbursement on school-based health-care expenditures and to expand access to health-care services for Medicaid-eligible students.*

- **Action 2-A:** Produce training and targeted technical assistance resources for LEAs, county mental health plans, and managed care plans.
- **Action 2-B:** Create conditions that will enable collaboration between health plans and LEAs to flourish and, where appropriate and legally allowable, encourage contracts and MOUs between LEAs and managed care plans and county mental health plans.

This recommendation and its associated actions propose providing guidance, training, and resources to LEAs and health plans to promote participation in the LEA BOP and the SMAA Program and to facilitate MOUs, contracts, and other agreements between LEAs and county mental health plans and managed care plans.

> "The basis of this recommendation is that there is a strong need for the systems [education and health] to work together. This recommendation reinforces that need so that we can address the health needs of students—both mental health and physical health."
>
> —Workgroup member

Recommendation 2 Proposed Actions

Action 2-A

Produce training and targeted technical assistance resources for LEAs, county mental health plans, and managed care plans.

Why This Action is Important

High-quality technical assistance resources would help LEAs, managed care plans, and behavioral health agencies (county mental health plans) establish strong practices for developing and procuring MOUs, contracts, and interagency agreements. These interagency agreements can expand the provision of services to students and can lead to greater claiming and reimbursement for Medicaid-approved services provided by or through LEAs (Mays and O'Rourke 2019). Furthermore, training to help LEAs learn to bill directly for services and gain clarity on allowable claims should result in a higher volume of claims and billing, which may lead to greater participation in the reimbursement programs and an increase in federal reimbursement to participating LEAs (Briscoe et al. 2020). Workgroup members noted that current technical assistance for LEAs and other partners on school-based health and Medicaid billing is outdated and difficult to understand, and that there is limited follow-up and guidance in writing.

How to Get There

The DHCS, in collaboration with the CDE, should gather, update, and disseminate technical assistance resources and provide trainings that address a variety of school-based Medicaid topics for LEAs and health plans.

Develop a repository of online resources. The DHCS, in collaboration with the CDE, should develop—or hire a contractor to develop—an online resources repository with training videos, archived webinars, and other resources that address a variety of school-based Medicaid topics, and ensure that LEAs and partner agencies have ease of use and access to the repository. The

CDE should disseminate the resources widely to LEAs and health plans, potentially leveraging California's system of support[20] as a key communication channel. Suggested questions to address through training videos and resources include the following:

- How do LEAs and health plans benefit from Medicaid MOUs, contracts, and interagency agreements?
- What are the requirements to establish contracts with health plans and to develop MOUs and interagency agreements with partners? What does a model contract look like?
- What services does Medicaid cover under county mental health plans, managed care plans, and the LEA BOP and the SMAA Program?
- How can LEAs expand services under State Plan Amendment 15-021, which expands covered services, allowable practitioner types, and coverage to Medicaid-enrolled students without individualized education programs or individualized family service plans, among other changes?
- What does being "eligible" for Medi-Cal, versus being "enrolled" in Medi-Cal, mean?
- What are the requirements for billing for the LEA BOP and the SMAA Program?
- How can LEAs contract with and get reimbursed by managed care plans and county mental health plans?
- How can LEAs meet the targeted case management requirements?
- What do LEAs need to know about compliance, data agreements, and HIPAA? What do county mental health plans and managed care plans need to know about FERPA and other educational requirements?
- What funding streams are available to support partnerships? Which funding streams can be braided together?
- What should LEAs know about Medicaid tracking and reporting of expenditures and reimbursements?
- What is the hierarchy of Medicaid billing, and what does that hierarchy mean for LEAs with school-based health programs?
- What are community-based organizations, and who are community-based service providers? How can LEAs contract with them to provide services on or near school sites?
- What are the county programs in an LEA's area, and how can they help?

[20] For more on California's statewide system of support, see https://www.cde.ca.gov/sp/sw/t1/csss.asp.

- How can LEA staff learn about other LEAs that are successfully providing or coordinating school-based Medicaid services?
- How does an LEA set up a billing system for the LEA BOP and the SMAA Program?

In addition to these resources and recorded trainings, the state agencies should consider conducting live trainings, as well as producing targeted materials and outreach for LEAs that do not participate in Medicaid billing.

Seek feedback from LEAs to inform ongoing updates to resources. The DHCS and the CDE should regularly review and update the resources to reflect the changing needs of students in relation to school-based health services, and to reflect the information learned from the technical assistance activities in Recommendation 3. To update the resources and to create targeted training videos and/or live trainings, the DHCS should engage LEAs to explore and identify where their current gaps in understanding are, among all three Medicaid access points (county mental health plans, managed care plans, and the LEA BOP and the SMAA Program) related to billing, funding sources, and eligible services. Whenever possible, training should convene LEAs, health plans, and community organizations that provide health services, to create opportunities for education agencies and health plans to learn together.

Action 2-B

Create conditions that will enable collaboration between health plans and LEAs to flourish and, where appropriate and legally allowable, encourage contracts and MOUs between LEAs and managed care plans and county mental health plans.

> "We are tired of waiting for health and education agencies to collaborate. We need to make a bold statement to require both to step up for the sake of children and youth who are suffering from mental health and physical health conditions."
>
> —Workgroup member

Why This Action is Important

Collaboration and coordination between LEAs and health plan providers can improve access to appropriate behavioral and physical screening and preventive and treatment services, leading to improved education and health outcomes.

Systematic coordination between education and health systems is required by law[21] and is important for the well-being of Medicaid-enrolled students. Under the EPSDT benefit, states are required to provide comprehensive services and to furnish all Medicaid-coverable appropriate and medically necessary services needed to correct and ameliorate health conditions for children under age 21, based on certain federal guidelines (CMS n.d.). The DHCS pays managed care plans a capitated rate to provide these necessary services.[22] Under the Individuals with Disabilities Education Act (IDEA),[23] the CDE is obligated to ensure that LEAs provide free appropriate public education for eligible children with disabilities, ages 3–21, as a condition of receiving payment from the federal government under Part C and Part B of the IDEA. Eligible children receive free appropriate public education via special education and related services provided through an individualized education program. The child's individualized education program is developed by individualized education program teams at the child's LEA. The requirements for the EPSDT benefit and for free appropriate public education are distinct but interrelated: some medically necessary and Medicaid-coverable EPSDT services (e.g., physical therapy) can be indicated on a Medicaid-enrolled child's individualized education program and covered by the EPSDT benefit.

Both federal education law and federal health law and statutes require coordination between education and health systems and provide guidance to help navigate this coordination. The IDEA[24] implementing regulations specify:

The financial responsibility [for services] of each noneducational public agency . . . including the State Medicaid agency and other public insurers of children with disabilities, must precede the financial responsibility of the LEA (or the State agency responsible for developing the child's individualized education program). . . . If any public agency other than an educational agency is otherwise obligated under Federal or State law . . . to provide or pay for any services that are also considered special education or related services . . . that are necessary for ensuring free appropriate public education to children with disabilities within the State, the public agency must fulfill that obligation or responsibility, either directly or through contract or other arrangement.

The DHCS has produced written guidance for managed care plans on coordinating with other outside entities that are responsible (e.g., under the IDEA) for providing EPSDT services (DHCS 2019a, 9). Specifically, the guidance states:

Where another entity, such as a Local Education Agency (LEA) . . . has overlapping responsibility for providing services to a member under the age of 21, managed care plans must do the following:

- *Assess what level of EPSDT medically necessary services the member requires,*

21 34 CFR, Section 300.154

22 As described in the introduction, specialty mental health services are provided by county mental health plans, not managed care plans.

23 20 U.S.C., Section 1400

24 34 CFR, Section 300.154

- *Determine what level of service (if any) is being provided by other entities, and*
- *Coordinate the provision of services with the other entities to ensure that managed care plans and the other entities are not providing duplicative services, and that the child is receiving all medically necessary EPSDT services in a timely manner.*

[M]anaged care plans have the primary responsibility to provide all medically necessary EPSDT services, including services which exceed the amount provided by LEAs. However, these other entities must continue to meet their own requirements regarding provision of services. Managed care plans should not rely on LEA programs . . . as the primary provider of medically necessary EPSDT services.

Workgroup members largely agreed that coordination and collaboration between LEAs and health plan providers is important for student well-being. However, during Workgroup discussions, disagreement arose about the scarcity of resources. Understandably, Medicaid funding and reimbursement can feel like a zero-sum game. From the LEA perspective, the IDEA mandate to provide services puts schools in a vulnerable financial position. If an LEA does not have an MOU with a health plan, the LEA may end up providing a service that would otherwise fall under the responsibility of the health plan. In other words, LEAs are at risk of, effectively, providing a Medicaid-covered service for a Medicaid beneficiary without receiving any funding from the plan. An oft-cited antidote to this problem is requiring that health plans contract with an LEA as a Medicaid provider, thereby allowing the LEA to receive payment from the plan under the EPSDT benefit. However, this requires partnership from both entities; the Workgroup recognizes that not all LEAs are interested in contracting with managed care plans or county mental health plans or in becoming a Medicaid provider. The Workgroup does not intend that contracts be required where contracts are not desired by all parties. Moreover, the state is not legally allowed to require payments from a health plan to a specific provider.

Despite some disagreement among Workgroup members as to the extent to which the DHCS should require collaboration, there was consensus, within the Workgroup, that collaboration and cooperation between education and health systems is good for children. Thus, the Workgroup recommends that the DHCS focus on connecting resources to the needs of students and, where appropriate and legally allowable, develop further guidance to encourage health plans to contract with LEAs as providers, develop MOUs, or otherwise contribute to the costs of EPSDT services provided by LEAs.

How to Get There

The Workgroup recommends that the DHCS focus on connecting resources to the needs of students and, where appropriate and legally allowable, develop further guidance to encourage health plans to contract with LEAs as providers, develop MOUs, or otherwise contribute to the costs of EPSDT services provided by LEAs.

Put the child at the center. In order to create conditions that will facilitate collaboration between health plans and LEAs, the CDE and the DHCS should frame technical assistance, training, and guidance in terms of the benefit to the child or youth, rather than on the financial benefit to health plans, LEAs, or other agencies. A more child-centered focus will help facilitate collaboration by leveraging the shared purpose of LEAs and health plans to support the well-being of the children and youths they serve.

Develop guidance and offer incentives where appropriate. The Workgroup further recommends that the DHCS develop a model contract and/or give explicit guidance on contract rates, to reduce the need for financial negotiation and to make the financial collaboration more child-centered and seamless. Further, as additional funds become available, the DHCS should consider incentive payments to health plans and/or LEAs to assist with collaboration and cooperation.

Recommendation 3

***School-Based Health Services Demonstration Sites**: Create school-based health services demonstration sites to improve technical assistance provided to LEAs about school-based health and to capitalize on recent school-based Medicaid investments and initiatives.*

- **Action 3-A:** Engage a contractor to pilot technical assistance strategies in school-based health services demonstration sites that:
  - Implement new school-based Medicaid investments and initiatives;
  - Produce effective partnerships among LEAs, managed care plans, county mental health plans, community stakeholders, and LEA BOP and SMAA Program vendors; and
  - Provide a wider array of services to Medicaid-eligible students across all three primary Medicaid access points: (a) county mental health plans, (b) managed care plans, and (c) the LEA BOP and the SMAA Program.
- **Action 3-B:** Apply the lessons learned from the school-based health services demonstration sites to inform future technical assistance to LEAs and health plans.

The first action under this recommendation involves creating school-based health services demonstration sites and engaging a contractor to pilot technical assistance strategies that showcase how local agencies can collaborate to finance school-based health services and provide a wider array of services to Medicaid-eligible students across all three primary Medicaid access points: (a) county mental health plans, (b) managed care plans, and (c) the LEA BOP and the SMAA Program. The second action involves applying lessons learned from the school-based health services demonstration sites to inform effective technical assistance related to school-based health partnerships.

"These recommendations are meant to foster collaboration and establish a shared approach to serving student health-care needs in the most effective way possible. The current system is bifurcated and complex and is in dire need of an articulated guide for LEAs to use when exploring how best to care for their students."

—Workgroup member

"The student should experience a seamless process, a one-stop shop, even if there are different payers. ,So, the work is in the partnerships and collaboration. This needs to be a full commitment."

—Workgroup member

Recommendation 3 Proposed Actions

Action 3-A

Engage a contractor to pilot technical assistance strategies in school-based health services demonstration sites that:

- Implement new school-based Medicaid investments and initiatives;
- Produce effective partnerships between LEAs, managed care plans, county mental health plans, community stakeholders, and LEA BOP and SMAA Program vendors; and
- Provide a wider array of services to Medicaid-eligible students across all three primary Medicaid access points: (a) county mental health plans, (b) managed care plans, and (c) the LEA BOP and the SMAA Program.

Why This Action is Important

Developing and piloting new technical assistance strategies at school-based health services demonstration sites will help the CDE and the DHCS learn how to provide effective technical assistance related to school-based health to LEAs and health plans. The Workgroup expects the universal technical assistance resources described in Recommendation 2 to positively impact school-based health services, but members also recognized that building a comprehensive school-based health program at scale is involved and unprecedented. For this reason, the Workgroup recommends these smaller-scale school-based health services demonstration sites as learning tools prior to broader replication. "Technical assistance," in the context of this

recommendation, refers to providing advice and training, information, guidance documents, resources, and tools for LEAs and health plans on how to build sustainable relationships through MOUs, contracts, and resource sharing across all three primary Medicaid access points: (a) county mental health plans, (b) managed care plans, and (c) the LEA BOP and the SMAA Program.

Piloting technical assistance through school-based health services demonstration sites is a critical action because, as discussed in the introduction, the Workgroup envisioned a system in which students and families access health services quickly and easily. To produce the kind of comprehensive school-based health system that would enable this, LEAs need to partner with, and provide a wider array of services to Medicaid-eligible students across, all three primary Medicaid access points. The Workgroup identified an integrated system of care as a key accomplishment toward that vision. Currently, some Medicaid beneficiaries—in this instance, some school-aged children—need different Medicaid access points in order to receive a full scope of care in California, because multiple agencies are responsible for different aspects of the EPSDT benefit. Often, students and families may require health services that are offered by different providers. When these providers do not work together or share information, students and families have more difficulty seamlessly accessing a comprehensive suite of health services. School-based Medicaid service models bring more Medicaid access points into schools. Bringing all of the access points on or near campus positions schools to act as "one-stop shops" where Medicaid-enrolled students can connect with appropriate providers to cover all of their health needs.

While Action 3-A builds on the current interest in partnership across agencies and plans—as evidenced by the existing successful partnerships between county mental health plans and LEAs in California (Briscoe et al. 2020)—there are currently no examples of model programs that leverage all three primary access points at the local level (California Legislative Analyst's Office 2021). Many LEAs successfully partner with county mental health plans to provide specialty mental health services, and many LEAs are LEA BOP providers, but LEA partnerships with managed care plans are rare. Discussions among Workgroup members identified several reasons why partnerships among all three access points are beneficial but are not always possible: for example, an LEA may not have the resources or support necessary to build a relationship with a managed care plan, or an LEA or managed care plan may decline a request to partner (CDE et al. 2020). Whatever the reason, when LEAs do not partner across all three access points, they can miss opportunities to claim up to 50 percent reimbursement for the eligible services they use state and local funds to provide to Medicaid-enrolled students.

Action 3-A is timely because recent school-based Medicaid investments and initiatives in California aim to reduce the barriers to providing comprehensive school-based health services across all three primary Medicaid access points. Some of these investments include updates to behavioral health medical necessity criteria for EPSDT services, incentives for partnerships between managed care plans and LEAs, expansion of community schools, additional support for student mental and behavioral health needs, expansion of the LEA BOP, and support for state-level interagency collaboration.

Each of these initiatives and investments represents an important new opportunity to expand school-based Medicaid in California. Developing and piloting new strategies for technical assistance through school-based health services demonstration sites will help the CDE and the DHCS learn how to provide effective technical assistance to LEAs in relation to school-based health, to leverage these investments across the state.

How to Get There

Through Action 3-A, the CDE and the DHCS[25] would identify a set of school districts to become school-based health services demonstration sites. These school districts, along with their counties and any health plan partners, would become school-based health services demonstration sites with the purpose of informing the development and provision of technical assistance to them and other local agencies in the future. The Workgroup recommends that the DHCS and the CDE engage a contractor to pilot technical assistance strategies to implement new school-based Medicaid investments and initiatives at the sites in order develop new high-quality technical assistance resources.

Hire a contractor. The contractor should have experience in leading complex stakeholder engagement processes and should be (or be able to subcontract with) a subject-matter expert on each of the three Medicaid access points. The contractor, or the subject-matter expert(s), should have broad enough knowledge and experience that they can address a majority of the problems that might arise during the demonstration site development process on behalf of the LEAs and health plans. Additionally, the contractor should possess the following expertise:

- Demonstrated ability to build and strengthen relationships and coalitions
- Knowledge of existing successful school-based health models in California
- Knowledge about the different kinds of partnerships, health centers, and funding models available to support sites to build and strengthen relationships and referral pathways
- Knowledge of Medicaid managed care rules
- Knowledge of California's Medicaid state plan
- Knowledge of the array of services that exist under various plans, including county mental health plans and managed care plans
- Demonstrated ability to address and support equity in education and health systems

Select a representative set of school-based health services demonstration sites. The contractor would provide technical assistance to school-based health services demonstration sites, which

[25] The Workgroup recommends that the DHCS, in collaboration with the CDE, oversee this contract.

will be counties, regions, or specific LEAs that are implementing comprehensive school-based health systems. The school-based health services demonstration sites would be selected based on an application process, with the goal of having a diverse and representative sample of locales (e.g., diversity in size, location, geography, student demographics, per-pupil spending). Special consideration should be given to LEAs that serve high proportions of students from groups who have historically lacked access to health-care services. If such LEAs are not aware of the opportunity to become a school-based health services demonstration site, or do not have the internal capacity to produce a strong application for demonstration site consideration, the state agencies should intentionally seek out these LEAs and help them apply to become school-based health services demonstration sites.

Provide locally informed and time-intensive technical assistance to school-based health services demonstration sites. Drawing on their expertise, the contractor should provide each school-based health services demonstration site with technical assistance, using the recommended topics outlined in Table 2 to guide its work.

Table 2. Recommended Technical Assistance Topics to Help School-Based Health Services Demonstration Sites Implement Comprehensive School-Based Health Systems

Topic	Technical Assistance Providers Should Help LEAs Do the Following:
Identify existing resources and processes in the LEA's region	Look at effective models and infrastructure, access local expertise, and be mindful of the individual needs and resources of the region. Identify and determine how to maximize existing funding streams to fund service delivery and ongoing collaboration.
Explore service gaps and possibilities	Conduct a local assessment to identify the Medicaid-coverable services gaps in the LEA, then guide the LEA in obtaining access to locally established plans and networks in the local area to partner or contract to fill the service gaps. This assessment process would allow LEAs to determine what services are needed and how to expand their capacity to provide those services.

Topic	Technical Assistance Providers Should Help LEAs Do the Following:
Build relationships in the LEA's region	Build relationships across the three primary Medicaid access points and with primary care providers, community stakeholders, and commercial health plans. Ensure that schools are distinct contributors to the managed care plan planning teams in their counties.
Build the LEA's capacity to develop effective outreach to parents	Produce and disseminate effective materials for parents about Medicaid and school-based health services. Build relationships with community-based or other parent organizations as needed.
Support the implementation of services	Ensure that LEAs have the necessary infrastructure to sustainably participate in the LEA BOP and the SMAA Program and to collaborate with county mental health plans and managed care plans.
Plan for data collection and flexibility	Define the outcomes that the LEA hopes to see through the demonstration site development process and determine how to collect the student-level data that are required to demonstrate effectiveness of new investments and initiatives. Create a plan for when changes to regulations or funding, or other expected or unexpected events, occur.

Action 3-B

Apply the lessons learned from the school-based health services demonstration sites to inform future technical assistance to LEAs and health plans.

Why This Action is Important

Action 3-B is about ensuring that the lessons learned from the school-based health services demonstration sites will benefit additional LEAs as the contractor builds capacity to provide effective technical assistance through Action 3-A and conveys those lessons learned to the CDE and the DHCS. The lessons learned from the school-based health services demonstration sites can help the CDE and the DHCS answer critical questions related to new Medicaid investments and initiatives, such as the following:

- How should the state provide technical assistance to LEAs and other agencies to help them take advantage of recent investments and initiatives to sustain and support school-based Medicaid in the future?
- What technical assistance topics or content are most important for LEAs and their partners to learn more about?
- Which technical assistance strategies can help address barriers that have prevented agencies from entering voluntary contracts or MOUs or developing other methods of collaboration?

How to Get There

The contractor would identify and analyze lessons learned from the school-based health services demonstration sites and share that information with the CDE and the DHCS, as well as with other agencies, as specified in the details of its contract.

Ensure that there is a single technical assistance contractor (or a single coordinator of multiple contractors) to align the work across school-based health services demonstration sites. While ensuring that the piloted technical assistance is suited to the specific school-based health needs of each school-based health services demonstration site is important, having a single entity coordinate across all school-based health services demonstration sites is also critical, so that the lessons learned can be aggregated and shared with state agencies, LEAs, and health plans in a comprehensive and cohesive way.

Produce a blueprint for technical assistance about school-based Medicaid services. The contractor should collaborate with the DHCS, the CDE, and the advisory group proposed in Recommendation 1 to produce a blueprint for effective ongoing technical assistance to LEAs. The blueprint should include the following:

- A plan for how to sustain and/or scale up partnerships after the contractor finishes establishing the school-based health services demonstration sites, so that the sites can be used in the future as models for comprehensive school-based health programs
- A set of technical assistance resources, such as a step-by-step guide for becoming a Medicaid provider, a handbook or other resource about allowable expenditures and potential funding streams, and a library of potential partnership models
- A map or catalog of the different available programs under Medi-Cal—including each program's requirements, restrictions, and available services—so that LEAs can develop working relationships across all three Medicaid access points (also see Action 2-A and Action 5-B)
- Considerations for how to vary technical assistance to address local jurisdictions and contexts

Recommendation 4

LEA BOP Audit Support: *To facilitate the LEA BOP audit process, implement feedback loops between LEAs and the DHCS Audits and Investigations Division that foster collaborative learning and continuous improvement, and develop resources that support LEA audit preparation.*

- **Action 4-A:** Enhance auditor practices through auditor training informed by user experience, and gather regular feedback from LEAs about their LEA BOP audit experiences.
- **Action 4-B:** Develop audit-related technical assistance processes to support LEAs before, during, and after the LEA BOP audit process.

The LEA BOP enables LEAs to be reimbursed for eligible health services rendered to Medicaid-enrolled students. Medicaid reimbursements through the LEA BOP are paid using certified public expenditures, meaning that LEAs pay for all services up front and certify their spending on a cost report. LEAs receive an interim reimbursement based on the cost reported, usually within several weeks, but the reimbursement amount is tentative (based on historical costs), pending an audit. The audit process involves the DHCS Audits and Investigations Division auditing the claims in the cost report. If the claims are not adequately supported for payment—that is, if there is a lack of proper documentation, or if the amount is verified to be less than what was certified on the cost report—federal reimbursement must be paid back. According to LEAs, the audit process for the LEA BOP is complex and often costly (CDE et al. 2020).

The goals of the actions under this recommendation are to shift the culture of the LEA BOP audit process from a primary focus on audit completion toward a focus on providing support and technical assistance to the LEAs that are being audited. This more supportive audit culture can be achieved through implementing auditor training, feedback loops, and preventive (pre-audit activities that prevent audit findings) and corrective (post-audit activities that help LEAs recover from audit findings) action activities.

"The obligation of conducting audits in compliance with CMS standards and requirements is understood, but modifications to the information provided and [the] process of these audits could have a positive impact on the use of LEA BOP and provision of services. Some of the [actions] may not be feasible without modifications to the Medicaid state plan, but there are [many] changes that don't require state plan amendments. Movement on this recommendation is possible now."

—Workgroup member

"The focus of this recommendation is on the audit process, but the real focus is on facilitating more services to children. If we can have a more positive audit process with fewer disallowances, then there will be greater utilization of the LEA BOP. If this is successful with regard to mental health services, then the impact this has [on] collaborations and interactions between LEAs, mental health plans, and managed care plans needs to be explored."

—Workgroup member

Recommendation 4 Proposed Actions

Action 4-A

Enhance auditor practices through auditor training informed by user experience, and gather regular feedback from LEAs about their LEA BOP audit experiences.

Why This Action is Important

In a survey of stakeholders about the LEA BOP, respondents cited the LEA BOP audit requirements as the second most common reason why LEAs do not claim for reimbursement on eligible services for Medicaid-enrolled students, second only to the related barrier of documentation requirements (CDE et al. 2020). Ultimately, stakeholders expressed that California's LEA BOP audit process is a barrier to reimbursement. They contrasted their experiences of California's audit system with their understanding of systems in other states, expressing that other states' auditors fulfill a more supportive role, rather than a role that is chiefly compliance focused. Unfortunately, this concern related to the audit process is not unique to LEAs. The DHCS implements many complex federal programs that may be confusing for various

providers to implement, resulting in negative audit actions. The Workgroup believes that, by implementing Action 4-A, the DHCS can also improve overall understanding of the LEA's responsibility in a certified public expenditure Medicaid reimbursement program. Ideally, implementing this action would lead to fewer audit findings and an increased amounts of Medicaid reimbursement for LEAs.

How to Get There

Conduct a review of LEA BOP audit experiences. The DHCS and the CDE, and/or an independent third-party evaluator, should conduct an in-depth review of experiences with and perspectives on the auditing process, based on data from current and former school-based LEA BOP providers, current and former school-based Medicaid billing staff, and current auditors. This data could be collected using interviews and focus groups. These California-based interviews and focus groups should be coupled with a detailed review of auditor training in other states. The review should specifically include states that use a "relationship model" for their audits—that is, a collaborative, results-driven model (such as the model used in Michigan). The DHCS should use the data gleaned from the review of experiences and other state systems to inform targeted changes and additions to the training that it provides to auditors who work in school-based Medicaid.

Develop a tool to gather LEA feedback. After this initial review and the resulting training, the DHCS, in consultation with the CDE, should develop and use a feedback tool (such as a survey) that gathers information about LEAs' experiences after undergoing a Medicaid audit. The DHCS should use this tool as part of a continuous-improvement approach in which the LEAs' feedback is used to inform ongoing modifications to the audit process. This feedback loop should also continuously inform training for auditors (in ways that help them keep LEAs in mind as the end users) and training for LEAs about how to successfully meet the audit requirements. The DHCS and the CDE should collaboratively provide the aforementioned trainings.

A critical consideration for implementing this recommendation is that the DHCS's auditing for the LEA BOP is currently funded via a withholding of the Medicaid reimbursements paid to LEAs. If the DHCS cannot access general funds, the DHCS may increase the withheld amount, which would reduce the final reimbursement to LEAs. The Workgroup does not recommend increasing the withheld amount because it would reduce the amount of reimbursement received by LEAs. Instead, the Workgroup recommends that the DHCS access other funds (e.g., general funds, through the budget process) to work on the auditing process improvements described in Action 4-A.

Action 4-B

Develop audit-related technical assistance processes to support LEAs before, during, and after the LEA BOP audit process.

Why This Action is Important

Between 2007 and 2015, most LEAs had to pay back a portion of the LEA BOP interim payment after reconciliation.[26] The Workgroup identified that the timeline for repayment, as well as the interest paid on delayed repayment amounts, creates significant financial hardships for LEAs. Moreover, LEAs reported that they do not receive an adequate level of technical assistance to help them avoid repeating past errors in future years as they go through the LEA BOP audit process. Preventive actions, based on risk analysis, and corrective actions can help manage audit risks and reduce the likelihood of large repayment amounts (CMS, Division of Error Rate Management, 2013; Crump 2016), which may minimize the reported financial risk to LEAs and subsequently improve participation rates.

LEAs represented by members in the Workgroup indicated that they need more technical assistance from the DHCS in order to successfully navigate the LEA BOP audit process. Currently, as part of the LEA BOP audit process, DHCS audit staff send information with proposed audit adjustments to LEAs. The LEAs then have 15 calendar days to present additional relevant information (such as documentation) concerning the audit findings.[27] This time period is intended to provide the LEAs with an opportunity to respond and address any necessary adjustments to reverse audit findings. In addition, the DHCS audit team offers an exit conference with each LEA to review and discuss the audit findings, to help the LEAs understand the findings and how to avoid repeating the same errors in the future;[28] the Workgroup recommends that these efforts be expanded or modified in order to improve audit outcomes.

How to Get There

Resources and training. The Workgroup recommends that the DHCS and the CDE provide the following resources and/or training:

- Develop an annually updated LEA BOP audit guide for LEAs, outlining audit requirements.
- Provide training to LEAs on how to prepare for a Medicaid audit, including examples of activities developed by other states, such as Michigan and Massachusetts, that reduce the likelihood of audit findings.
- Implement a pre-audit protocol that includes self-audits and test audits. Develop a self-audit template that LEAs can fill out independently prior to the audit (as in Massachusetts) and implement a test audit process, in which the DHCS auditors review concerns with the LEA prior to the actual audit. The DHCS may find examples from Michigan, Colorado, New Mexico, and Massachusetts useful in developing pre-audit protocols.

[26] Based on webinar notes from the DHCS Audits and Investigations Division.

[27] CCR title 22, Section 51021(b)

[28] CCR title 22, Section 51021(a)

- To make the audit process less technically complex, develop audit templates that LEAs can submit.
- Assign technical assistance staff to provide guidance and support when LEAs undergoing an audit are identified as at risk for audit findings.

In addition to these actions, the DHCS Audits and Investigations Division, in partnership with the CDE, should expand the existing corrective action planning process, which allows LEAs to receive targeted technical assistance after the audit.

Update the audit appeals process and policy. The Workgroup further recommends several statutory changes to the audit appeals process and policy. Specifically, the Workgroup recommends that the Legislature take the following actions:[29]

- Modify the LEA BOP audit statutes to require that all audits be completed, inclusive of the appeals process, within three years of the cost report submission.[30]
- Lower the interest rate for LEA BOP repayments.[31]
- Institute a neutral arbiter during the LEA BOP audit appeal process.[32]

Recommendation 5

Access to Preventive Services: *Identify options for expanding access to school-based preventive physical health, mental health, and substance use disorder services.*

- **Action 5-A:** Identify opportunities to provide mental health and substance use disorder treatment in schools when risk factors exist but the child does not have a diagnosis.
- **Action 5-B:** Develop a framework for school-based preventive physical health, mental health, and substance use disorder services, in accordance with national guidelines for such services, and identify the funding sources available for each service.

[29] Steering committee members note that these recommended statutory changes may require federal approval or significant modifications to the LEA BOP as currently authorized. Additionally, significant changes to the audit timeline may reduce the timeline by which LEAs must either submit claims or appeal DHCS decisions. Ultimately, if the audit timeline is significantly modified, DHCS will likely require significant new staff resources to operationalize the updated timeline.

[30] WIC, Section 14170

[31] WIC, Section 14171

[32] The Workgroup specifically recommends a neutral panel such as the Education Audit Appeals Panel, which serves as the neutral arbiter in informal and formal administrative appeals by K–12 LEAs. For more information about the Education Audit Appeals Panel, visit http://eaap.ca.gov/ or see EC Sections 14502.1, 41344, and 41344.1.

This recommendation calls for identifying options for expanding students' and their families' access to school-based preventive mental and physical health services.

"For children to successfully engage in and benefit from their education, whole-child well-being must be addressed. To achieve this significant undertaking, multiple agencies must collaborate intentionally and meaningfully. This will be complex and will require commitment by all joint agencies to overcome those challenges and work together for the benefit of our state's children."

—Workgroup member

"More resources need to be directed toward health promotion and preventative services to support the whole student (including infants, toddlers, and preschoolers) and their families in a systemic and coordinated way."

—Workgroup member

Recommendation 5 Proposed Actions

Action 5-A

Identify opportunities to provide mental health and substance use disorder treatment in schools when risk factors exist but the child does not have a diagnosis.

Why This Action is Important

Developing a new benefit for health plans, allowing certain types of mental health treatment services when risk factors exist and when the child does not have a diagnosis, could help prevent more serious mental health conditions and support improved education outcomes for Medicaid-enrolled students.

Providing school-based mental health and substance use disorder treatment services is particularly important, as schools are critical actors in young people's mental well-being. Nationwide, children with mental health conditions do not receive as much treatment as they need, and this treatment gap is most pronounced for substance use (Merikangas et al. 2011). Compared with community-based treatment settings, children and youths who have access to school-based health centers are 10 times more likely to make a mental health or substance use visit",

and participate in" screening for other high-risk behaviors (Kaplan et al. 1998). Moreover, nationwide, most children who receive mental health services receive them in school settings (Hurwitz and Weston 2010). Additionally, well-resourced school counseling programs are associated with many benefits for students, such as increased attendance and reduced disciplinary actions (Carey and Dimmitt 2012).

Recognizing these benefits, LEAs in California currently provide a variety of preventive mental health services, such as counseling, to students who do not have a mental health diagnosis. Although schools can provide these types of preventive mental health services, such services are considered treatment services under federal law and cannot be provided through Medicaid health plans unless the child has developed a diagnostic health condition. This is consistent with federal law and regulations for EPSDT, which covers treatment services when they are "medically necessary" to "correct or ameliorate" defects and physical and mental illness conditions for individuals under age 21 who are enrolled with full-scope Medi-Cal (DHCS n.d.c, 1).

How to Get There

Identify behavioral health condition(s) for which there is robust research demonstrating positive outcomes for preventive treatment in the absence of a diagnosis. The preventive family therapy benefit serves as an example of the process for developing and implementing a new benefit for Medicaid-enrolled students. In 2020, the DHCS added preventive family therapy as a benefit that provides covered services for students when certain risk factors are present. The DHCS was able to create this benefit administratively, based on a substantial body of research-based evidence showing that preventive family therapy is effective at correcting or ameliorating some health conditions (Pediatrics Supporting Parents 2020). Under the benefit, preventive services are available when certain factors identified as possible indicators of harm to the child (e.g., child abuse and/or mental health disorders) are present. When these indicators are present, three elements of the service are Medicaid-coverable: the benefit, the provider's qualifications, and the setting where the services are provided. The successful implementation of this preventive benefit suggests that the DHCS could implement a similar process to identify other preventive services for students served in LEAs when certain conditions are present in the student's life.

Conduct a needs assessment to see which preventive treatment services with robust evidence of effectiveness are already frequently being provided in schools or could reasonably be provided in schools.

Create the benefit within Medi-Cal through one of three routes: (a) justify a benefit that fits within the state plan; (b) get approval to add a benefit through a bill, contingent on federal approval; or (c) seek a waiver for the benefit.

Communicate to LEAs the benefit requirements for being reimbursed for these services. Importantly, LEAs should not be expected to expand access to mental health services without

additional access to funding, because LEAs already struggle to fund the preventive mental health services they currently provide.

Consider other options for covering preventive services without requiring a diagnosis, including communicating with LEAs about existing options that they may not be aware of.

Action 5-B

Develop a framework for school-based preventive physical health, mental health, and substance use disorder services, in accordance with national guidelines for such services, and identify the funding sources available for each service.

Why This Action is Important

The provision of school-based preventive health care is linked to a wide variety of improved health outcomes, as well as to improved academic outcomes such as higher grade point averages, lower suspension rates, and higher graduation rates (Knopf et al. 2016; Rochmes 2016). LEAs and health plans would greatly benefit from a framework to help them understand, at a minimum, which preventive physical health, mental health, and substance use disorder services should be offered in a school-based setting and, of these, which should be funded by LEAs and which are eligible to be funded by health plans. Existing frameworks, such as the Bright Futures Guidelines,[33] do not provide information about funding, and primarily emphasize physical health services rather than preventive mental health services. LEAs need additional, California-specific information in order to understand how to expand their role in ensuring access to preventive physical health, mental health, and substance use disorder services.

How to Get There

Produce a state framework for school-based preventive health services. The DHCS, in consultation with the CDE, managed care plans, county mental health plans, the Child Health and Disability Prevention Program offices, county offices of education, and families, should produce a framework for California school-based preventive health services that

- establishes a standard, in addition to, not instead of, the American Academy of Pediatrics Bright Futures framework, for which preventive physical health, mental health, and substance use disorder treatment services should be provided in school-based settings;

[33] The American Academy of Pediatrics and the federal Health Resources and Services Administration Bright Futures Guidelines Periodicity Schedule (American Academy of Pediatrics and Bright Futures 2021; Bright Futures n.d.) provide guidance for health plans and health insurance issuers on which preventive services and screening should be delivered at each well-child visit.

- identifies which of these services should be funded by LEAs and which should be funded by health plans;
- identifies the funding sources available for each service, including when the service is not covered by Medicaid;
- articulates the obligations for school-based services across all three Medicaid access points (managed care plans, county mental health plans, and LEAs); and
- addresses potential care integration issues, such as how the services should be coordinated with Medicaid enrollees' primary care providers and with other insurance primary care providers, how medical records and data should be shared, and how to prevent duplication of services.

Provide guidance, through the framework, on how health services in schools should be provided and funded. The California school-based preventive health services framework should not replace the American Academy of Pediatrics Bright Futures framework. Rather, the California school-based preventive health services framework would help support California's implementation of the American Academy of Pediatrics Bright Futures framework, and add mental health screenings to the American Academy of Pediatrics Bright Futures framework which currently focuses on physical health.[34] Specifically, the California school-based preventive health services framework should provide guidance on how health services in schools can be delivered and funded. Some examples of guidance include how to do the following:

- In collaboration with other providers, **support nationally recognized and recommended preventive services,** such as physical health screenings for Medicaid-enrolled students who have not received health screenings from their primary medical provider, as well as family education about the benefits of preventive health services.
- **Facilitate post-screening assessment, follow-up, and care coordination,** including scheduling appointments, assisting with transportation, and connecting children with supports and services indicated through the screening.
- In collaboration with other providers, **coordinate workforce support** through the SMAA Program by training support providers and other stakeholders to understand how health services are provided through school-based settings.

[34] The Workgroup acknowledges that the structures of school-based health services and the levels of coordination among child- and youth-serving agencies vary widely from county to county and that users should adapt the guidance provided in the proposed framework accordingly. Testing the California school-based preventive health services framework through a pilot (such as through one of the school-based health services demonstration sites described in Recommendation 3) could help establish its validity in different contexts.

As well as identifying funding sources, the California school-based preventive health services framework should include a glossary of terms that both LEAs and health-care providers should use to ensure consensus and understanding. It should also include a crosswalk that lists each of the services that can be billed under each program; descriptions of what services and claims look like in practice; descriptions of which types of staff can provide the services (e.g., required degrees, training, or expertise); and a resource showing a sequence of how funds should be used for certain services when the services are eligible to be paid for from multiple federal and state funding sources, such as Medicaid, IDEA, and state funds made available for special education and related services.

Organize the framework for school-based preventive health services by tiers. The California school-based preventive health services framework could be organized using a familiar service delivery model, such as a multi-tiered system of supports (described in the introduction), that would specify how services at each level can be coordinated and paid for. For example, the CDE and the DHCS might categorize screening services as Tier 1 (universal support), prenatal services to pregnant students as Tier 2 (targeted support), and specialty mental health services as Tier 3 (intensive support).

Future Considerations

In addition to developing the recommendations described in the previous section, the Workgroup recognized that some future additional investigation is warranted, on issues such as:

- using a cost-based reimbursement system for programs such as the LEA BOP,
- finding sufficient local and state funds to build infrastructure for school-based health services and to provide health services to students, and
- evaluating the impact of school-based health improvement initiatives without publicly available data shared across education and health systems.

Addressing underlying challenges related to understanding and improving comprehensive school-based health services requires technical expertise and in-depth study and data analysis beyond the scope of the Senate Bill 75 legislation, but the data collected during the workgroup process can act as a starting point to examine the aforementioned issues in the future.

Conclusion

The recommendations provided by the Workgroup in this report offer a path forward for improving coordination and expansion of access to available federal funds through the medically necessary federal EPSDT benefit (including through the LEA BOP and the SMAA Program). The workgroup process is an example of how diverse system stakeholders can come together, across varied interests and experiences, to collectively identify and understand systemic barriers and strengths, and to generate ideas for improving experiences, opportunities, and education and health outcomes for students and families. Together, the Workgroup established a shared vision for school-based Medicaid in California and generated recommendations for program requirements and support services to ensure ease of use and access and parity of eligible services throughout the state. Following are some closing thoughts from Workgroup members about the workgroup process and recommendations, and about implications for the future of school-based Medicaid in California.

"The Workgroup and these recommendations reflect the complex nature of the issue [financing school-based health] and provide realistic and actionable items for legislative staff and Department of Finance considerations."

—Workgroup member

"These recommendations are illuminated through the lens of frontline school-based health-care service providers that face the challenges of pulling down federal and state reimbursement, which in turn provide vital fiscal resources to support the expansion of additional health services to support youth and children."

—Workgroup member

"We all care about the students, we are in this together, and we are committing a huge amount of expertise to problem-solve the needs."

—Workgroup member

References

American Academy of Pediatrics and Bright Futures. 2021. Recommendations for Preventive Pediatric Health Care. https://downloads.aap.org/AAP/ PDF/ periodicity_schedule.pdf.

Basch, Charles E. 2011. "Healthier Students Are Better Learners: A Missing Link in School Reforms to Close the Achievement Gap." Journal of School Health 81 (10): 593–598. https://pubmed.ncbi.nlm.nih.gov/21923870.

Bright Futures. n.d. Bright Futures Guidelines and Pocket Guide. https://brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/Pages/default.aspx.

Briscoe, Alex, Elizabeth Estes, Aimee Eng, Maureen Burness, and Luz T. Cázares. 2020. Practical Guide for Financing Social, Emotional, and Mental Health in Schools: A Guide for School District Leaders Interested in Exploring Partnerships and Accessing Medi-Cal to Meet the Social, Emotional, and Mental Health Needs of Students in Schools. California Children's Trust and Breaking Barriers. https://cachildrenstrust.org/wp-content/uploads/2020/08/practicalguide.pdf.

California Department of Developmental Services. n.d. Regional Center Projects Focusing on Early Childhood. https://www.dds.ca.gov/services/mhsa/regional-center-projects-focusing-on-early-childhood/.

California Department of Education (CDE). 2020. FERPA Summary Page - Data Governance. https://www.cde.ca.gov/ds/ed/dataprivacyferpa.asp.

CDE. n.d.a. COVID-19 Relief and School Reopening Grants. https://www.cde.ca.gov/ls/he/hn/covidreliefgrants.asp.

CDE. n.d.b. Federal Stimulus Funding. https://www.cde.ca.gov/fg/cr/.

CDE. n.d.c. Mental Health. https://www.cde.ca.gov/ls/cg/mh/.

CDE. n.d.d. Project Cal-Well. https://www.cde.ca.gov/ls/cg/mh/projectcalwell.asp.

CDE. n.d.e. Request for Applications: California Community Schools Partnership Program. https://www.cde.ca.gov/fg/fo/r17/ccspp20rfa.asp.

CDE, California Department of Health Care Services, California Health and Human Services Agency, Medi-Cal for Students Workgroup, and WestEd. 2020. Senate Bill 75 Medi-Cal for Students Progress Report.

DHCS. 2019a. All Plan Letter 19-010: Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21. California Health and Human Services Agency. https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2019/APL19-010.pdf.

DHCS. 2019b. California School-Based Medi-Cal Administrative Activities Manual. California Health and Human Services Agency. https://www.dhcs.ca.gov/ provgovpart/Documents/ACLSS/SMAA/SMAA%20Manual/SMAAManual-Section1-2-3.pdf.

DHCS. 2019c. Local Educational Agency Medi-Cal Billing Option Program: Report to the Legislature: Report Period Fiscal Year 2018–2019 (July 2018 through June 2019). California Health and Human Services Agency. https://www.dhcs.ca.gov/ formsandpubs/Documents/Legislative%20Reports/LEA-Medi-Cal-Billing-Option-Program-FY-2018-19.pdf.

DHCS. 2020a. Medi-Cal Managed Care Program Care Fact Sheet. California Health and Human Services Agency. https://www.dhcs.ca.gov/services/Documents/ MMCD/MMCDModelFactSheet.pdf.

DHCS. 2021a. 1915B Medi-Cal Specialty Mental Health Services Waiver. California Health and Human Services Agency. https://www.dhcs.ca.gov/ services/MH/Pages/1915(b)_Medi-cal_Specialty_Mental_Health_Waiver.aspx.

DHCS. 2021b. LEA Program Glossary of Terms. California Health and Human Services Agency. https://www.dhcs.ca.gov/provgovpart/Pages/LEAGlossary.aspx.

DHCS. 2021c. Local Educational Agency Medi-Cal Billing Option. California Health and Human Services Agency. https://www.dhcs.ca.gov/provgovpart/Pages/LEA.aspx.

DHCS. 2021d. Medi-Cal Managed Care. California Health and Human Services Agency. https://www.dhcs.ca.gov/services/Pages/Medi-CalManagedCare.aspx.

DHCS. 2021e. School Based Medi-Cal Administrative Activities. California Health and Human Services Agency. https://www.dhcs.ca.gov/provgovpart/Pages/SMAA.aspx.

DHCS. n.d.a. California Advancing and Innovating Medi-Cal. https://www.dhcs.ca.gov/ provgovpart/Pages/CalAIM.aspx.

DHCS. n.d.b. Health Homes Program. https://www.dhcs.ca.gov/services/ Pages/HealthHomesProgram.aspx.

DHCS. n.d.c. Medi-Cal Coverage for EPSDT. https://www.dhcs.ca.gov/services/medi-cal/Documents/Medi-Cal-Coverage-for-EPSDT.pdf.

DHCS. n.d.d. Mental Health Services Act. https://www.dhcs.ca.gov/services/ MH/Pages/MH_Prop63.aspx.

DHCS. n.d.e. Whole Person Care Pilots. https://www.dhcs.ca.gov/services/ Pages/WholePersonCarePilots.aspx.

California Early Start. n.d. Statewide Screening Collaborative. https://www.ceitan-earlystart.org/collaborations/statewide-screening-collaborative/.

California for All. n.d. California Cradle-to-Career Data System. https://cadatasystem.wested.org/.

California Health and Human Services Agency. n.d.a. Behavioral Health Task Force. https://www.chhs.ca.gov/home/committees/behavioral-health-task-force/.

California Health and Human Services Agency. n.d.b. Master Plan for Early Learning and Care: California for All Kids. https://californiaforallkids.chhs.ca.gov/home.

California Legislative Analyst's Office. 2021. The 2021–22 Budget: Behavioral Health: Medi-Cal Student Services Funding Proposal. https://lao.ca.gov/reports/ 2021/4377/Medi-Cal-Behavioral-Health-Student-Services-021721.pdf.

California School-Based Health Alliance. 2018. Public Funding for School Mental Health Programs. http://cshca-wpengine.netdna-ssl.com/wp-content/uploads/ 2020/01/Public-Funding-for-School-Mental-Health-Programs-2018.pdf.

California School-Based Health Alliance. 2020. School-Based Health Centers in California: A Growing Trend. https://cshca-wpengine.netdna-ssl.com/wp-content/uploads/2020/11/CSHA-Key-Indicators-Map-20-21.pdf.

California School-Based Health Alliance. n.d.a. About School-Based Health Centers. https://www.schoolhealthcenters.org/school-based-health/.

California School-Based Health Alliance. n.d.b. Managing Asthma in Schools: Health Plan & School District Partnership. https://www.schoolhealthcenters.org/wp-content/uploads/2015/05/P3-Case-Study_Asthma-Management_Kern-County_FINAL.pdf.

Carey, John, and Carey Dimmitt. 2012. "School Counseling and Student Outcomes: Summary of Six Statewide Studies." Professional School Counseling 16 (2): 146–153.

Centers for Disease Control and Prevention (CDC). 2018. Health Insurance Portability and Accountability Act of 1996 (HIPAA). https://www.cdc.gov/phlp/ publications/ topic/hipaa.html.

CDC. n.d.a. Child Development Basics. https://www.cdc.gov/ncbddd/ childdevelopment/facts.html.

CDC. n.d.b. Children's Mental Health. https://www.cdc.gov/ childrensmentalhealth/ index.html.

CDC. n.d.c. Developmental Monitoring and Screening. https://www.cdc.gov/ ncbddd/ childdevelopment/screening.html.

CDC. n.d.d. Training and Professional Development. https://www.cdc. gov/ healthyschools/trainingtools.htm.

Centers for Medicare & Medicaid Services (CMS). 2014. EPSDT—A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents. https://www. medicaid.gov/sites/default/files/2019-12/ epsdt_coverage_guide.pdf.

CMS. 2018. Integrated Care for Kids (InCK) Model. https://www. cms.gov/newsroom/ fact-sheets/ integrated-care-kids-inck-model.

CMS. n.d. Early and Periodic Screening, Diagnostic, and Treatment. https://www. medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html.

CMS, Division of Error Rate Measurement. 2013. Corrective Action Plan (CAP) Process [PowerPoint presentation]. https://www.cms.gov/research-statistics-data-and-systems/monitoring-programs/perm/downloads/2013correctiveactionpowerpoint.pdf.

Crump, Dawn. 2016. Using Audits to Improve Compliance and Reduce Risk. Healthcare Financial Management Association. https:// www.hfma.org/topics/trends/ 48042.html.

Dam, Rikke Friis, and Teo Yu Siang. 2018. What Is Design Thinking and Why Is It So Popular? Interaction Design Foundation. https://www.interaction-design. org/ literature/article/what-is-design-thinking-and-why-is-it-so-popular.

Gibbons, Sarah. 2016. Design Thinking 101. Nielsen Norman Group. https://www. nngroup.com/articles/design-thinking/.

Help Me Grow California. n.d. Policy and Advocacy. https://helpmegrowca. org/ index.php/help-me-grow-california/ policy-and-advocacy/.

Hurwitz, Laura, and Karen Weston. 2010. Using Coordinated School Health to Promote Mental Health for All Students. National Assembly on School-Based Health Care. http://cshca-wpengine.netdna-ssl.com/wp-content/ uploads/2011/07/NASenate BillHC. CSH-Mental-Health.pdf.

Kania, John, Mark Kramer, and Peter Senge. 2018. The Water of Systems Change. FSG. https://www.fsg.org/publications/water_of_systems_change.

Kaplan, David W., B. Ned Calonge, Bruce P. Guernsey, and Maureen B. Hanrahan. 1998. "Managed Care and School-Based Health Centers: Use of Health Services." Archives of Pediatrics & Adolescent Medicine 152 (1): 25–33. https://pubmed.ncbi.nlm.nih.gov/9452704/.

Knopf, John A., Ramona K. C. Finnie, Yinan Peng, Robert A. Hahn, Benedict I. Truman, Mary Vernon-Smiley, Veda C. Johnson, Robert L. Johnson, Jonathan E. Fielding, Carles Muntaner, Pete C. Hunt, Camara Phyllis Jones, Mindy T. Fullilove, and Community Preventive Services Task Force. 2016. "School-Based Health Centers to Advance Health Equity: A Community Guide Systematic Review." American Journal of Preventive Medicine 51 (1): 114–126.

Linden, Russell M. 2002. Working Across Boundaries: Making Collaboration Work in Government and Nonprofit Organizations. San Francisco: Jossey-Bass.

Lyon, Aaron R., Kelly Whitaker, William P. French, Laura P. Richardson, Jessica Knaster Wasse, and Elizabeth McCauley. 2016. "Collaborative Care in Schools: Enhancing Integration and Impact in Youth Mental Health." Advances in School Mental Health Promotion 9 (3–4): 148–168. https://dx.doi.org/10.1080% 2F1754730X.2016.1215928.

Mays, Alex, and Lena O'Rourke. 2019. A Guide to Expanding Medicaid-Funded School Health Services. Healthy Schools Campaign. https://healthyschools campaign.org/wp-content/uploads/2019/12/A-Guide-to-Expanding-Medicaid-Funded-School-Health-Services-12-19-19.pdf.

Merikangas, Kathleen Ries, Jian-ping He, Marcy Burstein, Joel Swendsen, Shelli Avenevoli, Brady Case, Katholiki Georgiades, Leanne Heaton, Sonja Swanson, and Mark Olfson. 2011. "Service Utilization for Lifetime Mental Disorders in US Adolescents: Results of the National Comorbidity Survey–Adolescent Supplement (NCS-A)." Journal of the American Academy of Child & Adolescent Psychiatry 50 (1): 32–45. https://pubmed.ncbi.nlm.nih.gov/21156268/.

Mental Health Services Oversight & Accountability Commission. n.d. Request for Application (RFA) for Mental Health Student Services Act. https://mhsoac.ca.gov/the-act-mhsa/.

National Conference of State Legislatures. 2020. Family First Prevention Services Act. https://www.ncsl.org/research/human-services/family-first-prevention-services-act-ffpsa.aspx.

Merriam-Webster.com. 2021. resource, n. https://www.merriam-webster.com/ dictionary/resources?utm_campaign=sd&utm_medium=serp&utm_source=jsonld.

Pediatrics Supporting Parents. 2020. Analysis of New Medi-Cal Family Therapy Guidance and Dyadic Integrated Care Models Currently Implemented in California. https://first5center.org/assets/files/CA-Family-Therapy-Dyadic-Care-Crosswalk.pdf.

Rochmes, Jane E. 2016. School-Based Healthcare and Academic Performance: Implications of Physical Health Services for Educational Outcomes and Inequality. CEPA Working Paper No. 15-07. Stanford Center for Education Policy Analysis.

Shubel, Jessica. 2020. States Can Quickly Expand Medicaid to Provide Coverage and Financial Security to Millions. Center on Budget and Policy Priorities. https://www.cbpp.org/research/health/states-can-quickly-expand-medicaid-to-provide-coverage-and-financial-security-to.

Tatar, Margaret, Julia Paradise, and Rachel Garfield. 2016. Medi-Cal Managed Care: An Overview and Key Issues. KFF. https://www.kff.org/report-section/medi-cal-managed-care-an-overview-and-key-issues-issue-brief/.

U.S. Department of Health and Human Services and U.S. Department of Education. 2016. The Integration of Early Childhood Data: State Profiles and a Report from the U.S. Department of Health and Human Services and the U.S. Department of Education. https://www2.ed.gov/about/inits/ed/earlylearning/files/integration-of-early-childhood-data.pdf.

WestEd. 2011. A Family-Centered Approach to Early Intervention. https://www.wested.org/wp-content/uploads/2016/11/1372729797article_ familycenteredapproach_2011-3.pdf.

Wright, Terri D., Janet B. Zimmerman, and Ryan Knott. 2013. "At the Intersection: Connecting Health and Education Data in School-Based Health Centers." Lansing: School-Health Alliance of Michigan.

Wright, Ursula. 2019. Systems Change is a Noun and a Verb. FSG. https://www.fsg.org/ blog/systems-change-noun-and-verb.

Appendices

Appendix A. Senate Bill 75

California Education Code (EC) Section 56477 was added by Section 50 of Senate Bill (SB) 75 (Chapter 51, Statutes of 2019)

56477. (a) Commencing with the 2019–20 fiscal year, the department shall jointly convene with the State Department of Developmental Services and the State Department of Health Care Services one or more workgroups that include representatives from local educational agencies, appropriate county agencies, regional centers, and legislative staff. The workgroups shall convene for the following purposes:

> (1) Improving transition of three-year-old children with disabilities from regional centers to local educational agencies, to help ensure continuity of services for young children and families.
>
> (2) Improving coordination and expansion of access to available federal funds through the Local Educational Agency Medi-Cal Billing Option Program, the School-Based Medi-Cal Administrative Activities Program, and medically necessary federal Early and Periodic Screening, Diagnostic, and Treatment benefits.

(b) On or before October 1, 2020, the workgroups shall provide the chairs of the relevant policy committees and budget subcommittees of the Legislature and the Department of Finance with a progress report that includes all of the following:

> (1) A detailed timeline for the implementation of the workgroups, including information on the structure of the workgroups, frequency of meetings, and other relevant information.
>
> (2) Work conducted by each workgroup to date and initial findings, including information gathered, if any, on potential barriers to access the Local Educational Agency Medi-Cal Billing Option Program, the School-Based Medi-Cal Administrative Activities Program, and medically necessary federal Early and Periodic Screening, Diagnostic, and Treatment benefits.
>
> (3) Information on potential barriers to ensure smooth transitions for three-year-old children with disabilities from regional centers to local educational agencies.

(c) On or before October 1, 2021, the workgroups shall provide the chairs of the relevant policy committees and budget subcommittees of the Legislature and the Department of Finance with a final report that includes recommendations for all of the following:

(1) Strategies to improve the state's performance in meeting federal deadlines for transitioning three-year-old children with disabilities from individualized family service plans administered by a regional center to individualized education programs administered by a local educational agency.

(2) Best practices for regional centers and local educational agencies to ensure every three-year-old child with disabilities receives an uninterrupted continuum of support services.

(3) Program requirements and support services needed for the Local Educational Agency Medi-Cal Billing Option Program, the School-Based Medi-Cal Administrative Activities Program, and the medically necessary federal Early and Periodic Screening, Diagnostic, and Treatment benefit to ensure ease of use and access for local educational agencies and parity of eligible services throughout the state and country.

(d) Recommendations provided pursuant to this section shall include any specific changes needed to state regulations or statutes, need for approval of amendments to the state Medicaid plan or federal waivers, changes to the implementation of federal regulations, changes to state agency support and oversight, and associated staffing or funding needed to implement the recommendations.

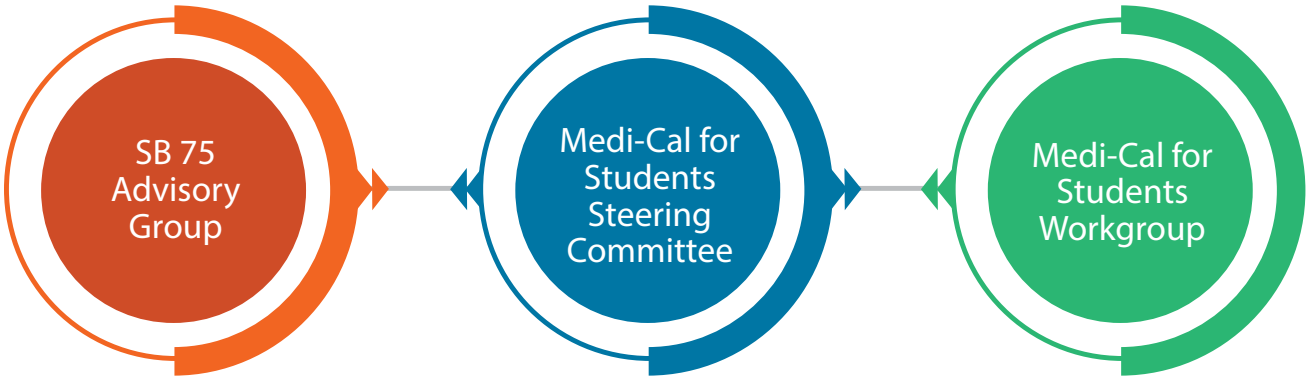
(e) The amount appropriated for purposes of this section in Provision 38 of Item 6100-001-0001 of Section 2.00 of the Budget Act of 2019 shall be available for encumbrance or expenditure until June 30, 2022.

(f) The requirements for submitting a report imposed under subdivisions (b) and (c) are inoperative on October 1, 2024, and October 1, 2025, respectively, pursuant to Section 10231.5 of the *Government Code*.

Appendix B. Group Structure for Implementing the Requirements of the Legislation

Figure 2 illustrates the structure of the groups that were involved in the fulfillment of the requirements of Senate Bill 75 (Chapter 51, Statutes of 2019) of the Statutes of 2019, as codified in California *Education Code* Section 56477, including a 21-member advisory group, a 18-member steering committee, and a 63-member workgroup. For a list of members of the advisory group, the steering committee, and the workgroup and their affiliations, see the Acknowledgments section at the beginning of this report.

Figure 2. Group Structure for Implementing the Requirements of the Legislation



Source: This graphic is based on the work of WestEd and the Medi-Cal for Students Steering Committee.

Appendix C. Recommendation Development Process

Table 3 provides a timeline of specific activities and outcomes, outlining the process for developing the Medi-Cal for Students Workgroup recommendations.

Table 3. Recommendation Development Process

Timeline/Activity	Outcomes
February 2020 **Workgroup Meeting #1**	• Determined a shared vision • Engaged in activities to begin understanding the current system (cause-and-effect analysis, empathy mapping, process mapping)
March–April 2020 **System Investigation**	• Conducted stakeholder survey • Conducted interviews with system stakeholders • Began national scan of other state practices and data • Refined preliminary LEA BOP and SMAA Program process maps
May 2020 **Workgroup Meeting #2**	• Reviewed stakeholder survey findings • Refined LEA BOP and SMAA Program process maps • Reviewed preliminary results from national scan of other state practices and data • Generated preliminary ideas for change
June–July 2020 **System Investigation**	• Continued interviews with system stakeholders • Continued national scan of other state practices and data • Refined LEA BOP and SMAA Program process maps
August–October 2020 **Submit Progress Report**	• Submitted progress report to the Department of Finance and the Legislature
November 2020 **Workgroup Meeting #3**	• Debriefed progress report • Began exploring promising practices, opportunities, and barriers for LEA partnerships • Refined and prioritized emerging recommendation areas

Timeline/Activity	Outcomes
December 2020–January 2021 **Draft Recommendations**	• Continued information gathering to inform recommendations • Drafted recommendations
February 2021 **Workgroup Meeting #4**	• Reviewed findings on promising practices, opportunities, and barriers for LEA partnerships • Refined emerging recommendations
March–April 2021 **Draft Recommendations**	• Continued information gathering to inform recommendations • Continued drafting recommendations
April 2021 **Workgroup Meeting #5**	• Reviewed and provided final input on recommendations
April–September 2021 **Draft Final Report**	• Completed information gathering to finalize recommendations • Drafted final report
October 2021 **Submit Final Report**	• Submitted final report to the relevant committees of the Legislature and the Department of Finance.

Appendix D. Guiding Frameworks for Recommendation Development

Principles from both Design Thinking and systems change theory were adapted and used to guide the development of Medi-Cal for Students Workgroup recommendations. Guided by these principles, the Workgroup established a shared understanding of explicit and implicit conditions that contribute to systemic inefficiencies and inequities and, based on this shared understanding of the system, designed recommendations for system improvement.

Design Thinking

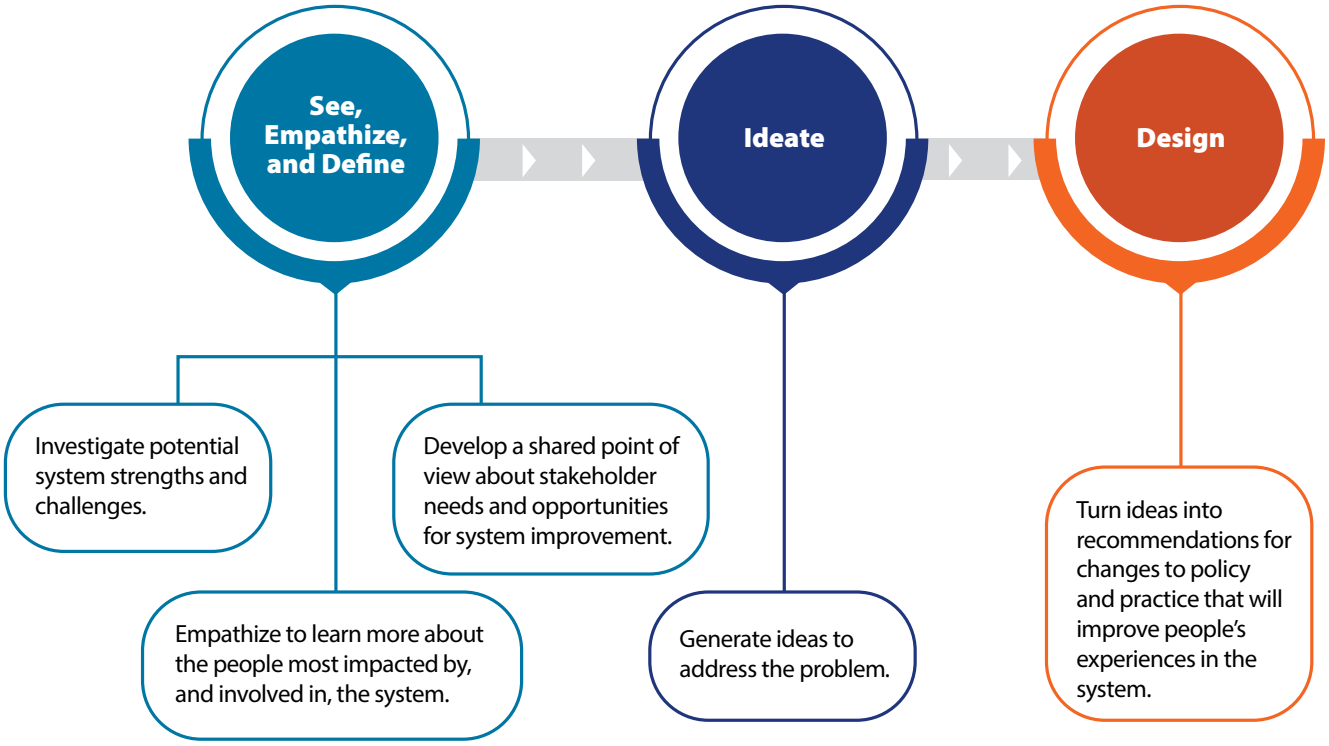
Design Thinking is an iterative process that is employed to understand and apply user-centered experiences to create solutions to problems in creative and innovative ways (Dam and Siang 2020). The cornerstone of Design Thinking is to make improvements based on analyzing and understanding stakeholder experiences. Figure 3 below summarizes the three phases of the Design Thinking process that were used to design the Medi-Cal for Students Workgroup recommendations. The three phases are:

1. **See, Empathize, and Define:** Investigate potential system strengths and challenges; empathize to learn more about the people most impacted by, and involved in, the system; and develop a shared point of view about stakeholder needs and opportunities for system improvement.

2. **Ideate:** Generate ideas to address the problem.

3. **Design:** Turn ideas into recommendations for changes to policy and practice that will lead to people's improved experiences in the system (National Equity Project, n.d.).

Figure 3. Design Thinking



Source: Adapted from National Equity Project (2021).

Conditions of Systems Change

The Six Conditions of Systems Change developed by Kania, Kramer, and Senge (2018) involve identifying and examining root causes through active reflection and examining explicit and implicit systemic conditions that sustain inefficiencies and contribute to systemic inequities. The Six Conditions of Systems Change occur on three tiers: (1) *structural*, (2) *relational*, and (3) *transformative*. Structural change is *explicit* change; it includes areas such as policies, practices, and resource flows. *Relational change* is *semi-explicit* change; it includes areas such as *relationships and connections* as well as *power dynamics*. *Transformative change* is *implicit* change; it includes *mental models* that are shaped by "habits of thought—deeply held beliefs and assumptions and taken-for-granted ways of operating that influence how we think, what we do, and how we talk" (Kania, Kramer, and Senge 2018, 4).

Appendix E. Changes Required in Order to Implement the Recommendations

Table 4 outlines the changes required to regulations, statutes, oversight, support, staffing, and/or funding in order to implement the recommendations contained in this report.

Table 4. Changes Required in Order to Implement the Recommendations

Action	Changes Required for Implementation
Action 1-A: Provide necessary resources to the CDE and the DHCS so they can hire and retain dedicated staff to establish a system of ongoing state-level collaboration.	**State Agency Support and Oversight:** This action would result in changes to the professional development and local program support activities provided by the CDE and the DHCS. **Staffing and/or Funding:** This action would require an examination of existing staffing levels to determine whether additional resources are needed in order for the CDE and/or the DHCS to have dedicated staff focused on collaboration. If staffing levels are determined to be insufficient, this action would require the annual Budget Act to appropriate funding to the CDE and the DHCS to hire and retain dedicated, permanent staff. To be eligible for federal funding, the staff at each agency must be 100 percent dedicated to the federal and state requirements outlined for their agency. For example, DHCS staff must be 100 percent dedicated to administration of the Medicaid state plan. State general funds are needed to support the permanent positions at the CDE and the DHCS.

Action	Changes Required for Implementation
Action 1-B: Utilize an advisory group to solve problems and provide guidance related to collaboration between the education and health systems. The advisory group should include youth and families; representatives from departments such as the CDE, the DHCS, the CHHS, and the Department of Managed Health Care; and representatives from county offices of education, school districts, county mental health plans, managed care plans, and community-based organizations.	**State Regulations or Statutes:** Although advisory groups are not required by law, they are frequently outlined in state statutes to clarify the intent of the group and the composition of required participants. **Staffing and/or Funding:** This action would require the state budget to allocate funding to the CDE and the DHCS to jointly plan and facilitate (or hire contractors to plan and facilitate) the advisory group. Cost considerations include the costs of planning, facilitation, and participation in the group (e.g., participation would involve per diem and travel costs). If the dedicated staff members described in Action 1-A are responsible for this group, any appropriation for the dedicated staff may also include the cost of maintaining the advisory group. Costs may vary depending on whether an existing group is utilized for this purpose.
Action 2-A: Produce training and targeted technical assistance resources for LEAs, county mental health plans, and managed care plans.	**State Agency Support and Oversight:** This action would result in changes to the professional development and local program support activities provided by the CDE and the DHCS. **Staffing and/or Funding:** State general funds are needed to support the permanent positions at the CDE and the DHCS.

Action	Changes Required for Implementation
Action 2-B: Create conditions that will enable collaboration between health plans and LEAs to flourish and, where appropriate and legally allowable, encourage contracts and MOUs between LEAs and managed care plans and county mental health plans.	**State Agency Support and Oversight:** This action would result in changes to the professional development and local program support activities provided by the CDE and the DHCS. **Staffing and/or Funding:** This action would require the annual Budget Act to appropriate funding to the CDE and the DHCS to hire and retain dedicated, permanent staff. To be eligible for federal funding, the staff at each agency must be 100 percent dedicated to the federal and state requirements outlined for their agency. For example, DHCS staff must be 100 percent dedicated to administration of the Medicaid state plan. State general funds are needed to support the permanent positions at the CDE and the DHCS.

Action	Changes Required for Implementation
Action 3-A: Engage a contractor to pilot technical assistance strategies in school-based health services demonstration sites that: • **Implement new school-based Medicaid investments and initiatives;** • **Produce effective partnerships between LEAs, managed care plans, county mental health plans, community stakeholders, and LEA BOP and SMAA Program vendors; and** • **Provide a wider array of services to Medicaid-eligible students across all three primary Medicaid access points: (a) county mental health plans, (b) managed care plans, and (c) the LEA BOP and the SMAA Program.**	**State Regulations or Statutes:** Although it is not required to be in law, the pilot program should be outlined through law that clarifies the scope, intent, duration, selection process (for the contractor and for LEAs), and outcomes. **State Agency Support and Oversight:** This action would result in changes to the professional development and local program support activities provided by the CDE and the DHCS. **Staffing and/or Funding:** This action would require the annual Budget Act to appropriate funding to the CDE and the DHCS to hire and retain dedicated, permanent staff and a contractor. In addition to funding dedicated to state staffing, this action would require an appropriation for the contract itself. State general funds are needed to support these resources. To be eligible for federal funding, the staff at each agency must be 100 percent dedicated to the federal and state requirements outlined for their agency. For example, DHCS staff must be 100 percent dedicated to administration of the Medicaid state plan.

Action	Changes Required for Implementation
Action 3-B: Apply the lessons learned from the school-based health services demonstration sites to inform future technical assistance to LEAs and health plans.	**State Regulations or Statutes:** The pilot program should be outlined in state statutes to clarify the intent of the pilot and the composition of required participants. **State Agency Support and Oversight:** This action would result in changes to the professional development and local program support activities provided by the CDE and the DHCS. **Staffing and/or Funding:** This action would require the annual Budget Act to appropriate funding to the CDE and the DHCS to hire and retain dedicated, permanent staff and a contractor. State general funds are needed to support these resources. To be eligible for federal funding, the staff at each agency must be 100 percent dedicated to the federal and state requirements outlined for their agency. For example, DHCS staff must be 100 percent dedicated to administration of the Medicaid state plan.
Action 4-A: Enhance auditor practices through auditor training informed by user experience, and gather regular feedback from LEAs about their LEA BOP audit experiences.	**State Medicaid Plan or Federal Waivers:** The audit work of the LEA BOP is done within the parameters of the CMS requirements. The state agency may not need a formal approval for the audit process and methodology, but the process must comply with CMS requirements. The state agency needs approval for any changes of requirements used in the audit process. **State Agency Support and Oversight:** This action would result in changes to the professional development and local program support activities provided by the CDE and the DHCS. **Staffing and/or Funding:** This action would require the annual Budget Act to appropriate funding to the CDE and the DHCS to hire and retain dedicated, permanent staff. To be eligible for federal funding, the staff at each agency must be 100 percent dedicated to the federal and state requirements outlined for their agency. For example, DHCS staff must be 100 percent dedicated to administration of the Medicaid state plan. State general funds are needed to support these resources.

Action	Changes Required for Implementation
Action 4-B: Develop audit-related technical assistance processes to support LEAs before, during, and after the LEA BOP audit process.	**State Regulations or Statutes:** Lowering the interest rate for audit recoupment would require a statute change. **State Agency Support and Oversight:** This action would result in changes to the professional development and local program support activities provided by the CDE and the DHCS. **Staffing and/or Funding:** This action would require the annual Budget Act to appropriate funding to the CDE and the DHCS to hire and retain dedicated, permanent staff. To be eligible for federal funding, the staff at each agency must be 100 percent dedicated to the federal and state requirements outlined for their agency. For example, DHCS staff must be 100 percent dedicated to administration of the Medicaid state plan. State general funds are needed to support these resources.
Action 5-A: Identify opportunities to provide mental health and substance use disorder treatment in schools when risk factors exist but the child does not have a diagnosis.	**State Medicaid Plan or Federal Waivers:** Adding benefits to the LEA BOP would require a state plan amendment. **State Agency Support and Oversight:** This action would result in changes to the professional development and local program support activities provided by the CDE and the DHCS. **Staffing and/or Funding:** This action would require the annual Budget Act to appropriate funding to the CDE and the DHCS to hire and retain dedicated, permanent staff. To be eligible for federal funding, the staff at each agency must be 100 percent dedicated to the federal and state requirements outlined for their agency. For example, DHCS staff must be 100 percent dedicated to administration of the Medicaid state plan. State general funds are needed to support these resources.

Action	Changes Required for Implementation
Action 5-B: Develop a framework for school-based preventive physical health, mental health, and substance use disorder services, in accordance with national guidelines for such services, and identify the funding sources available for each service.	**State Regulations or Statutes:** The development of large, multiagency frameworks is frequently outlined in state statutes to clarify the intent of the frameworks and the composition of required participants. **State Medicaid Plan or Federal Waivers:** Adding benefits to the LEA BOP would require a state plan amendment. **State Agency Support and Oversight:** This action would result in changes to the professional development and local program support activities provided by the CDE and the DHCS. **Staffing and/or Funding:** This action would require the annual Budget Act to appropriate funding to the CDE and the DHCS to hire dedicated, permanent staff. To be eligible for federal funding, the staff at each agency must be 100 percent dedicated to the federal and state requirements outlined for their agency. For example, DHCS staff must be 100 percent dedicated to administration of the Medicaid state plan. State general funds are needed to support these resources.

Appendix F. Proposed Recommendation Implementation Timeline[35]

Table 5 illustrates approximately how long implementing each action resulting from the Medi-Cal for Students Workgroup recommendations will take. The timeline for each action starts from the point of assignment of funds in California state trailer bill language and ends with full implementation of ongoing work (as in Actions 1-A, 1-B, 2-A, 2-B, 3-B, 4-A, and 4-B) or completion of time-limited work (as in Actions 3-A, 5-A, and 5-B). Note that many actions are contingent on Action 1-A so that the state agencies have personnel dedicated to implementation of other actions. Actual timelines may vary.

[35] An implementation timeline was generated for each action by CDE and DHCS staff. The CDE based timeline estimates on comparable projects/contracts. These estimates are presented to give a sense of scale and should not be regarded as a detailed evaluation. These timeline estimates are useful in evaluating how much effort will be required to implement the recommendation.

Table 5. Proposed Action Implementation Timeline

Action	Proposed Implementation Timeline
Action 1-A: Provide necessary resources to the CDE and the DHCS so they can hire and retain dedicated staff to establish a system of ongoing state-level collaboration.	Up to two years
Action 1-B: Utilize an advisory group to solve problems and provide guidance related to collaboration between the education and health systems. The advisory group should include youth and families; representatives from departments such as the CDE, the DHCS, the CHHS, and the Department of Managed Health Care; and representatives from county offices of education, school districts, county mental health plans, managed care plans, and community-based organizations.	Up to two years
Action 2-A: Produce training and targeted technical assistance resources for LEAs, county mental health plans, and managed care plans.	Up to three years
Action 2-B: Create conditions that will enable collaboration between health plans and LEAs to flourish and, where appropriate and legally allowable, encourage contracts and MOUs between LEAs and managed care plans and county mental health plans.	Up to three years

Action	Proposed Implementation Timeline
Action 3-A: Engage a contractor to pilot technical assistance strategies in school-based health services demonstration sites that: • **Implement new school-based Medicaid investments and initiatives;** • **Produce effective partnerships between LEAs, managed care plans, county mental health plans, community stakeholders, and LEA BOP and SMAA Program vendors; and** • **Provide a wider array of services to Medicaid-eligible students across all three primary Medicaid access points: (a) county mental health plans, (b) managed care plans, and (c) the LEA BOP and the SMAA Program.**	Up to five years
Action 3-B: Apply the lessons learned from the school-based health services demonstration sites to inform future technical assistance to LEAs and health plans.	Up to six years
Action 4-A: Enhance auditor practices through auditor training informed by user experience, and gather regular feedback from LEAs about their LEA BOP audit experiences.	Up to three years
Action 4-B: Develop audit-related technical assistance processes to support LEAs before, during, and after the LEA BOP audit process.	Up to two years
Action 5-A: Identify opportunities to provide mental health and substance use disorder treatment in schools when risk factors exist but the child does not have a diagnosis.	Up to three years
Action 5-B: Develop a framework for school-based preventive physical health, mental health, and substance use disorder services, in accordance with national guidelines for such services, and identify the funding sources available for each service.	Up to four years

Appendix G. Estimated Staffing and Funding Needed for Recommendation Implementation[36]

Table 6 outlines the estimated costs to implement each of the recommendations made by the Medi-Cal for Students Workgroup. Additional analysis will be needed to determine the exact detailed costs to implement each recommendation and its associated actions.

The CDE believes that any and all recommendations can be implemented by building a team composed of, at minimum, 9 permanent positions at the CDE dedicated to school-based health. This team would collaborate with the DHCS on LEA access to Medicaid reimbursement for school-based health services and implementation of these recommendations. As noted in Recommendation 1 of this report, the CDE currently lacks the necessary infrastructure to support sustained collaboration and shared responsibility with DHCS for increasing LEA access to Medicaid. Thus, the CDE's estimated resources necessary for implementation are the same (a total of 9 permanent positions at CDE) whether some or all of the recommendations are implemented. The CDE believes that a dedicated team at the CDE is essential to successful implementation of each recommendation and for sustainability and continuous improvement in this critical area.

These estimates will likely require refinement as the scope of work and the implementation details for each recommendation develop. Further, this report was drafted while the outcomes of current budget proposals related to improving state-level coordination and LEA access to Medicaid remain unclear. It is possible that the CDE's resource estimation should be seen as a supplemental request based on the 2021 Budget Act finalization.

[36] CDE and DHCS staff generated cost estimates for each recommendation. The CDE based cost estimates on comparable projects/contracts. These estimates are presented to give a sense of scale and should not be regarded as a detailed evaluation. These estimates are useful in evaluating how much effort will be required to implement the recommendations.

Table 6. Estimated Staffing and Funding Needed for Recommendation Implementation

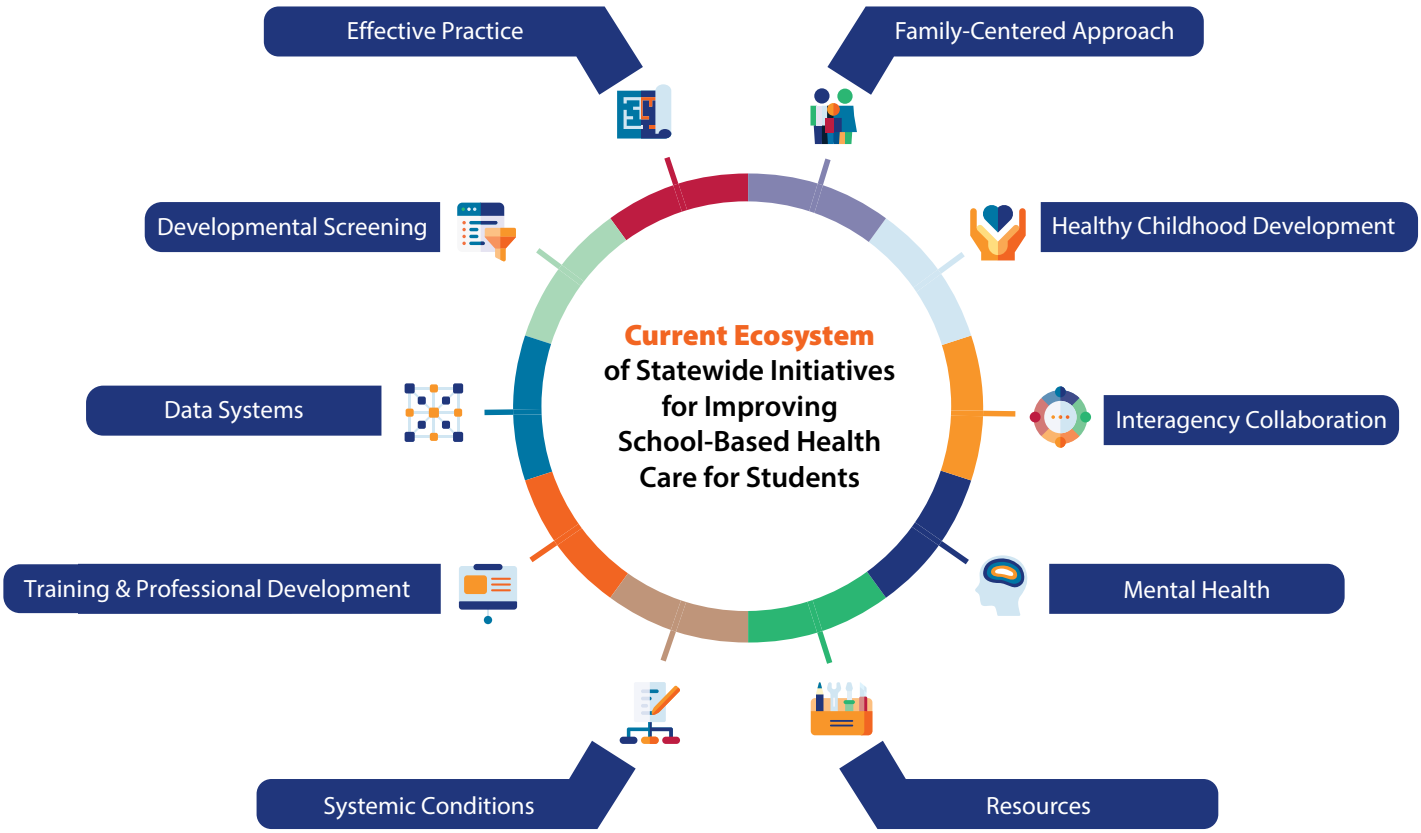
Recommendation	Estimated CDE Staffing and Funding Needed	Estimated DHCS/CHHS Staffing and Funding Needed
Recommendation 1: Formalize state-level collaboration between education and health systems.	9 permanent positions at the CDE: • $1,618,234/year (General Fund [GF]) 1 external contract: • $1,000,000/year (50% GF/50% FF)	8 permanent positions at the DHCS: • $2,250,000/year (50% GF/50% Federal Fund [FF]) 1 external contract: • $1,000,000/year (50% GF/50% FF)
Recommendation 2: Provide targeted training and guidance to LEAs and health plans on implementing school-based health programs to maximize billing and reimbursement on school-based health-care expenditures and to expand access to health-care services for Medicaid-eligible students.	5 permanent positions at the CDE: • $515,894/year (GF) 1 external contract: • $1,500,000/year (50% GF/50% FF)	4 permanent positions at the DHCS: • $1,250,000 /year (50% GF/50% FF) 1 external contract: • $1,500,000/year (50% GF/50% FF)
Recommendation 3: Create school-based health services demonstration sites to improve technical assistance provided to LEAs about school-based health and to capitalize on recent school-based Medicaid investments and initiatives.	6 permanent positions at the CDE: • $564,336/year (GF) 1 external contract: • $1,500,000/year (50% GF/50% FF)	4 permanent positions at the DHCS: • $1,250,000/year (50%GF/50%FF) 1 external contract: • $1,500,000/year (50% GF/50% FF)

Recommendation	Estimated CDE Staffing and Funding Needed	Estimated DHCS/CHHS Staffing and Funding Needed
Recommendation 4: To facilitate the LEA BOP audit process, implement feedback loops between LEAs and the DHCS Audits and Investigations Division that foster collaborative learning and continuous improvement, and develop resources that support LEA audit preparation.	5 permanent positions at the CDE: • $515,894/year (GF)	16 permanent positions at the DHCS: • $4,500,000/year (50% GF/50% FF) 1 external contract: • $1,500,000/year (50% GF/50% FF)
Recommendation 5: Identify options for expanding access to school-based preventive physical health, mental health, and substance use disorder services.	5 permanent positions at the CDE: • $515,894/year (GF)	4 permanent positions at the DHCS: • $1,250,000 /year (50% GF/50% FF) 1 external contract: • $1,500,000/year (50% GF/50% FF)

Appendix H. Medi-Cal for Students Ecosystem of Initiatives

To help readers understand how the Senate Bill 75 legislation and associated recommendations are connected to other statewide initiatives aiming to improve school-based health care for students, figure 4 illustrates a current sample of statewide and federal initiatives organized by system components (data systems, developmental screening, effective practice, family-centered approach, healthy childhood development, interagency collaboration, mental health, resources, systemic conditions, and training & professional development).

Figure 4. Sample of Current Ecosystem of Statewide Initiatives for Improving School-Based Health Care for Students



Source: This graphic is based on the work of WestEd.

Services and Supports of the Current Ecosystem

Data Systems

- CA Cradle to Career Data System
- Help Me Grow California

Developmental Screening

- AB 1004 Development Screening Services
- Family First Prevention Services Act
- Whole Person Care Pilots

Effective Practice

- SB 75 Medi-Cal for Students Workgroup
- CalAIM (Medi-Cal Reform Initiative)
- Community Schools Partnership Program
- SB 803 Implementation

Family-Centered Approach

- Mental Health Services Act
- Mental Health Student Services Act

Healthy Childhood Development

- CA Statewide Screening Collaborative
- Mental Health Services Act
- Mental Health Student Services Act

Interagency Collaboration

- AB 2083 Foster Youth Trauma-Informed System of Care
- SB 75 Medi-Cal for Students Workgroup
- Mental Health Services Act
- Mental Health Student Services Act

Mental Health

- Early Childhood Mental Health
- Mental Health Services Act
- Mental Health Student Services Act

Resources

- SB 75 Medi-Cal for Students Workgroup
- Community Schools Partnership Program
- Healthy Homes Program
- Project CaL-Well
- Expanded Learning Opportunity Grants
- Federal Stimulus Funding

Systemic Conditions

- AB 2083 Foster Youth System of Care
- SB 75 Medi-Cal for Students Workgroup
- Behavioral Health Task Force
- CalAIM (Medi-Cal Reform Initiative)
- Community Schools Partnership Program
- Master Plan for Early Learning and Care

Training & Professional Development

- Community Schools Partnership Program
- Mental Health Services Act
- Mental Health Student Services Act

Methodology for Selecting and Mapping Indsitiatives

For the purposes of figure 4, "initiatives" were defined as collective, structured efforts that use a "multi-sector approach to changing systems for improved population level outcomes" (Wright 2019). These initiatives were identified by reviewing state agencies and other agencies or organizations that were affiliated with Medi-Cal for Students Workgroup members. Input was also solicited from experts in the field, who were asked to identify statewide initiatives. The list of initiatives in the figure is not exhaustive and does not represent the full scope of work done by all agencies in this space, nor does it illustrate ongoing efforts from specific advocacy groups or organizations. It does, however, provide a snapshot of state-level initiatives, to highlight how the Senate Bill 75–related work is connected to and interconnected with other work.

The system components were developed after reviewing several frameworks, including the Collaborative Care Model for Schools (Lyon et al. 2016), the Integrated Care for Kids (InCK) Model (CMS 2018), and the Six Conditions for Systems Change (Kania, Kramer, and Senge 2018).

Table 7 describes each of the categories of initiatives shown in figure 4. Table 8 expands on the information in figure 4 by providing descriptions and references for the initiatives listed in the figure.

Table 7. Categories in the Current Ecosystem of Statewide Initiatives for Improving School-Based Health Care for Students

Category	Description
Data Systems	*Data systems* refer to information that is connected, integrated, secured, maintained, stored, and reported across programs and services (U.S. Department of Health and Human Services and U.S. Department of Education 2016; Wright, Zimmerman, and Knott 2013).
Developmental Screening	*Developmental screening* describes the services and supports that are available to babies and young children with developmental delays and disabilities and their families (CDC n.d.c).
Effective Practice	*Effective practice* refers to the implementation of methodologies, strategies, or approaches that are evidence-based or promising in attaining a desired outcome (California School-Based Health Alliance n.d.a).
Family-Centered Approach	*Family-centered approach* refers to a relationship-based approach in which service providers collaborate closely with a family to develop a shared view of a child and his or her strengths and needs (WestEd 2011).
Healthy Childhood Development	*Healthy childhood development* refers to the idea that children of all abilities, including those with special health-care needs, are able to grow up where their social, emotional, and educational needs are met (CDC n.d.a).
Interagency Collaboration	*Interagency collaboration* describes a collaboration that occurs when people from different organizations produce something through joint effort, resources, and decision-making and share ownership of the final product or service (Linden 2002).
Mental Health	In childhood, *mental health* means reaching developmental and emotional milestones and learning healthy social skills and how to cope when there are problems (CDC n.d.b).
Resources	*Resources* is defined as a source of supply or support (Merriam-Webster.com 2021).

Category	Description
Systemic Conditions	*Systemic conditions* relates to shifting of the policies, practices, resources, relationships and connections, power dynamics, and/or mental models that hold systemic problems in place (Kania, Kramer, and Senge 2018).
Training & Professional Development	*Training* describes an instructional experience provided primarily by employers for employees, designed to develop knowledge and new skills that are expected to be applied immediately on arrival or return to the job. Professional development describes a consciously designed systematic process that strengthens how staff obtain, retain, and apply knowledge, skills, and attitudes (CDC n.d.d).

Table 8. Initiatives in the Current Ecosystem of Current Ecosystem of Statewide Initiatives for Improving School-Based Health Care for Students

Initiative	Description	Categories
California Cradle-to-Career Data System	The California "Cradle-to-Career" Data System (California for All n.d.) aims to securely link data that schools, colleges, social service agencies, financial aid providers, and employers already collect to: • Identify the types of supports that help more students learn, stay in school, prepare for college, graduate, and secure a job • Provide information that teachers, advisors, parents, and students can use to identify opportunities and make decisions • Help agencies plan for and improve educational, workforce, and health and human services programs • Support research on improving policies from birth through career	• Data Systems

Initiative	Description	Categories
Help Me Grow California	Help Me Grow California is designed to help leverage existing resources to ensure that communities identify vulnerable children, establish links to community-based services, and empower families to support their child's healthy development. As part of its policy and advocacy work, the First 5 Association (which plays a role in the Help Me Grow initiative) works with advocates and First 5 Commissions to increase the use of essential Medi-Cal services, especially dental, mental health, and vision services (Help Me Grow California n.d.).	• Data Systems
Assembly Bill 1004 Developmental Screening Services	Assembly Bill 1004 (Chapter 387, Statutes 2019) requires, consistent with federal law, that screening services provided as an EPSDT benefit include developmental screening services for individuals zero to three years of age, inclusive, and requires Medi-Cal managed care plans to ensure that providers who contract with these plans render those services in conformity with specified standards. The bill requires the DHCS to ensure a Medi-Cal managed care plan's ability and readiness to perform these developmental screening services, and to adjust a Medi-Cal managed care plan's capitation rate.[37]	• Developmental Screening

[37] Assembly Bill 1004 Developmental Screening Services, Ch. 387 (C.A. Statutes 2019).

Initiative	Description	Categories
Family First Prevention Services Act	With the Family First Prevention Services Act,[38] states, territories, and tribes with an approved Title IV-E plan have the option to use these funds for prevention services that would allow candidates for foster care to stay with their parents or relatives. States will be reimbursed for prevention services for up to 12 months. A written, trauma-informed prevention plan must be created, and services will need to be evidence-based. The Family First Prevention Services Act also extends the matching rate from the federal government for prevention services to 2026. The Federal Medical Assistance Percentage will be applied beginning in 2027 (National Conference of State Legislatures 2020).	• Developmental Screening
Whole Person Care (WPC) Pilots	WPC Pilots are the coordination of health, behavioral health, and social services, as applicable, in a patient-centered manner, with the goals of improved beneficiary health and well-being through more efficient and effective use of resources. WPC Pilots provide an option to a county, a city and county, a health or hospital authority, or a consortium of any of these entities serving a county or region consisting of more than one county, or a health authority, to receive support to integrate care for a particularly vulnerable group of Medi-Cal beneficiaries who have been identified as high users of multiple systems and who continue to have poor health outcomes (DHCS n.d.e).	• Developmental Screening

[38] The Family First Prevention Services Act was part of the Bipartisan Budget Act of 2018 (H.R. 1892).

Initiative	Description	Categories
SB 75 Medi-Cal for Students Workgroup	As part of Senate Bill 75 (Chapter 51, Statutes of 2019), the Medi-Cal for Students Workgroup will inform recommendations that will be presented to the Legislature and the California Department of Finance, regarding program requirements and support services needed for the medically necessary federal EPSDT benefit (including through the LEA BOP and the SMAA Program) to ensure ease of use and access for LEAs and parity of eligible services throughout the state and the country.[39]	• Effective Practice • Interagency Collaboration • Resources • Systemic Conditions
California Advancing and Innovating Medi-Cal (CalAIM)	CalAIM is a multiyear initiative by DHCS to improve the quality of life and health outcomes of California's population by implementing broad delivery system and program and payment reform across the Medi-Cal program. CalAIM has three primary goals (DHCS n.d.a): • Identify and manage member risk and need through whole-person care approaches and addressing social determinants of health • Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility • Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform	• Effective Practice • Systemic Conditions

[39] *EC* Section 56477, added by Section 50 of Senate Bill 75 (Chapter 51, Statutes of 2019).

Initiative	Description	Categories
Community Schools Partnership Program	Contingent on funding being available, the CDE awards grant funding to school districts, county offices of education, and charter schools, excluding non-classroom-based charter schools, that may be used for expanding and sustaining existing community schools; coordinating and providing health, mental health, and pupil support services to pupils and families; and providing training and support to LEA personnel (CDE n.d.e).	• Effective Practice • Interagency Collaboration • Resources • Systemic Conditions • Training & Professional Development
Senate Bill 803 Implementation	The implementation of Senate Bill 803 (Chapter 150, Statutes of 2020), among other actions that impact the Medi-Cal program, would authorize a county, or an agency that represents a county, to develop a peer support specialist certification program and certification fee schedule, both of which would be subject to DHCS approval.[40]	• Effective Practice
Mental Health Services Act (MHSA)	The MHSA was passed by voters in California in 2004. Funds are applied for and used to address a broad continuum of prevention, early intervention, and service needs and the necessary infrastructure, technology, and training elements to effectively support the public behavioral health system. The MHSA is also part of the CDE's mental health strategies, resources, and training in psychological and mental health issues (DHCS n.d.d; CDE n.d.c).	• Family-Centered Approach • Healthy Childhood Development • Interagency Collaboration • Mental Health • Training & Professional Development

[40] SB 803. Mental Health Services: Peer Support Specialist Certification, Ch. 150, C.A. Statutes of 2020.

Initiative	Description	Categories
Mental Health Student Services Act (MHSSA)	The MHSSA established a competitive grant program to fund partnerships between county mental health plans and LEAs for the purpose of increasing access to mental health services in locations that are easily accessible to students and their families (Mental Health Services Oversight & Accountability Commission n.d.).	• Family-Centered Approach • Healthy Childhood Development • Interagency Collaboration • Mental Health • Training & Professional Development
California Statewide Screening Collaborative	The California Statewide Screening Collaborative identifies and addresses service gaps by improving the synergies among state programs involved in recognition and response activities and adopting a common language, standard tools, and screening protocols for families and children (California Early Start n.d.).	• Healthy Childhood Development
Assembly Bill 2083 Foster Youth: Trauma-Informed System of Care	Among other required actions, Assembly Bill 2083 (Chapter 815, Statutes of 2018) requires each county to develop and implement a memorandum of understanding outlining the roles and responsibilities of the various local entities that serve children and youth in foster care who have experienced severe trauma.[41]	• Interagency Collaboration • Systemic Conditions
Early Childhood Mental Health	Early Childhood Mental Health is an initiative by the Department of Developmental Services, which receives MHSA funds for regional centers to develop and oversee innovative projects. These projects focus on treatment for children and families with mental health diagnoses (California Department of Developmental Services n.d.).	• Mental Health

[41] AB 2083 Foster Youth: Trauma-Informed System of Care, Ch. 815, C.A. Statutes of 2018.

Initiative	Description	Categories
Health Homes Program	The Health Home Program is designed to serve eligible Medi-Cal beneficiaries with complex medical needs and chronic conditions who may benefit from enhanced care management and coordination. The program coordinates the full range of physical health, behavioral health, and community-based long-term services and supports needed by eligible beneficiaries (DHCS n.d.b).	• Resources
Project Cal-Well	Funded by the Substance Abuse and Mental Health Services Administration, Project Cal-Well is designed to raise awareness of mental health and expand access to school and community-based mental health services for youth, families, and school communities (CDE n.d.d).	• Resources
Expanded Learning Opportunity (ELO) Grants	Established by Assembly Bill 86, ELO Grants, as well as In-Person Instruction grants, are part of a $6.6 billion COVID-19 relief package that was signed by Governor Newsom on March 5, 2021 (CDE n.d.a).	• Resources
Federal Stimulus Funding (CARES)	The Coronavirus Aid, Relief, and Economic Security (CARES) Act is a federal relief package that was provided to states with both funding and streamlined waivers to give state educational agencies necessary flexibilities to respond to the COVID-19 pandemic. The relief package included $30.75 billion in emergency education funding (CDE n.d.b).	• Resources

Initiative	Description	Categories
Behavioral Health Task Force	The Behavioral Health Task Force addresses urgent mental health and substance use disorder needs across California. The panel advises efforts to advance statewide behavioral health services, prevention, and early intervention to stabilize conditions before they become severe. The mission of the task force is to develop recommendations for the governor about how California can provide timely access to high-quality behavioral health care for all of its residents (California Health and Human Services Agency n.d.a).	• Systemic Conditions
Master Plan for Early Learning and Care	Also known as California for All Kids, the Master Plan for Early Learning and Care provides a research-based roadmap for building a comprehensive and equitable early learning and care system through goals that focus on programs, the workforce, funding, and administration (California Health and Human Services Agency n.d.b).	• Systemic Conditions

Appendix I. Glossary

Table 9 highlights terms and policies that are often used in the school-based Medicaid field.

Table 9. Medi-Cal for Students Glossary of Terms

Term or Policy	Definition
Centers for Medicare & Medicaid Services (CMS)	The CMS is the federal agency that oversees the Medicare and Medicaid programs, the State Children's Health Insurance Program (SCHIP), and several other health-related programs (DHCS 2021b).
Certified Public Expenditure	A certified public expenditure is an expenditure incurred and certified by a public entity or governmental unit in relation to services to Medi-Cal beneficiaries (DHCS 2019b).
Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT)	The EPSDT program is Medicaid's comprehensive and preventive child health program for individuals under the age of 21 (DHCS 2021b).
Family Educational Rights and Privacy Act (FERPA)	FERPA is a federal law addressing the privacy of students' educational records. FERPA gives parents/guardians certain rights regarding their child's education records. These rights transfer to the student when he or she reaches the age of 18 or attends a school beyond the high school level (CDE 2020).
Free Appropriate Public Education	Free appropriate public education is defined as special education and related services that are provided at public expense, under public supervision and direction, and without charge; that meet the standards of the state educational agency, including the requirements of the Individuals with Disabilities Education Act (IDEA); that include an appropriate preschool, elementary school, or secondary school education in the state involved; and that are provided in conformity with an individualized education program that meets the requirements of the IDEA (U.S. Department of Education 2017).[42]

[42] Section 300.17 Free appropriate public education.

Term or Policy	Definition
Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule	The HIPAA Privacy Rule describes standards that address the use and disclosure of individuals' health information (known as "protected health information") by entities subject to the Privacy Rule. These individuals and organizations are called "covered entities." The Privacy Rule also contains standards for individuals' rights to understand and control how their health information is used. A major goal of the Privacy Rule is to ensure that individuals' health information is properly protected while allowing the flow of health information that is needed to provide and promote high-quality health care and to protect the public's health and well-being (CDC 2018).
Individualized Education Program (IEP)	An individualized education program (IEP) is a written document for a child with a disability, which is developed, reviewed, and revised in an IEP meeting. It must include items such as the child's present levels of performance, annual goals, and progress toward goals, among other requirements.[43]
Individuals with Disabilities Act (IDEA)	The IDEA is the federal law that mandates that all children with disabilities have available to them free appropriate public education that includes special education and related services to meet their developmental and educational needs (DHCS 2021b).
Local Educational Agency Medi-Cal Billing Option Program (LEA BOP)	The LEA BOP is a Medicaid billing program that allows LEAs to bill Medi-Cal for specific health and medical services provided to students and their families in the school setting. Services provided through this program include assessments, treatments, and targeted case management (DHCS 2021b).
Medi-Cal Health Coverage (Medi-Cal)	Medi-Cal is California's Medicaid state plan. It provides free or low-cost health coverage for California residents who meet eligibility requirements (DHCS 2021b).
Medicaid	Medicaid is a federal program established in 1965 under Title XIX of the Social Security Act and jointly funded by the federal government and state governments. Medicaid provides health-care coverage for low-income families; aged, blind, and/or disabled persons; and/or individuals whose income and resources are insufficient to meet the costs of necessary medical services (DHCS 2021b).

[43] 20 U.S.C., Section 1400

Term or Policy	Definition
Medicare	Medicare is a federal program established in 1965 under Title XVIII of the Social Security Act. Medicare provides health-care coverage for people age 65 or older, some people under age 65 with disabilities, and people with end-stage renal disease, which is permanent kidney failure requiring dialysis or a kidney transplant (DHCS 2021b).
School-Based Medi-Cal Administrative Activities (SMAA) Program	The SMAA Program authorizes governmental entities to submit claims and receive reimbursement for activities that constitute administration of the federal Medicaid program. It allows school claiming units to be reimbursed for allowable administrative costs associated with school-based health outreach activities that are not claimable under the LEA BOP or under other Medi-Cal programs (DHCS 2021b).
State Plan Amendment	States may submit amendments to their Medicaid state plans to change eligibility standards, provider requirements, payment methods, or health benefit packages. The amendments are reviewed and processed, according to specific statutory timelines, by the CMS Regional Offices, with consultation and review by the CMS Central Office if necessary (DHCS 2021b).

SB 75

Senate Bill 75

Medi-Cal for Students Workgroup Recommendations

Report to the chairs of the relevant policy committees and budget subcommittees of the California State Legislature and the California Department of Finance

DHCS California Department of Health Care Services

CHHS California Health & Human Services Agency