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**Notes from 21 July 2022 DHCS Meeting with Dr. Mark and DHCS Local Government Financing:**

**Addressing PHE Redetermination and COVID Immunizations for K-12 Students and their Families**

**Background**

Teachers for Healthy Kids (THK) a non-profit 501 c3 has been involved in outreach and enrollment projects over the last 22 years with California Local Education Agencies (LEAs). Originally funded by The California Endowment, its mission is enrollment, retention and access to services for students and their families eligible for Medi-Cal. It was formed as an unlikely partnership between the California Teachers Association and the California Association of Health Plans. THK maintains close ties to the school community by working in over 265 LEAs to involve school personnel in outreach and enrollment and access to services as well as linking districts to outside agencies who can support their efforts. The focus has changed from outreach and enrollment into Medi-Cal as these efforts have been successful. When THK was founded in 2000, only 34% of students eligible for Medi-Cal were enrolled. By 2021, 95% of Medi-Cal eligible students have health coverage. Data in the early years of THK found that over 250,000 had been enrolled in covered through LEAs. School districts, counties and clinics are the three main locations for Medi-Cal enrollment and retention. One outreach project was funded by a grant from CMS where THK managed a program with nine school districts to determine effective outreach and tracking strategies. Other grants piloted a project to introduce Salesforce in school districts for tracking enrollment and redetermination efforts. Other funding has provided laptop computers to school staff so they could do Medi-Cal enrollment and retention for families. A health plan through THK provided a grant to pay Family Resource Center staff outside of school hours and on the weekends to help families complete their applications and retain coverage. Enrollment and retention continue to be important given the expansion of school-based programs under the new State Plan Amendment that allows all students covered by Medi-Cal, not just those who receive Special Education Services to receive health services at school and for schools to bill Medi-Cal for these services.

This memo presents some ideas and best practices based upon our long experience in using LEAs to reach families. Some of the changes to streamline the system and best practices gained from years of on the ground experience should be adopted to prevent disenrollment when the PHE ends, and redetermination of eligibility is required. This memo also addresses who the PHE program and the need to increase vaccination rates for school aged children and their families who are Medi-Cal beneficiaries can work together.

**Assistance with Redetermination**

Based on twenty-two years of experience with application, enrollment and redetermination efforts, the ending of the PHE can be successfully addressed by allowing school districts to be active partners. Currently, the Ambassador program is aimed at counties and CBOs even though during the expansion of Medi-Cal, schools were one of the three top locations for enrollment and redetermination. Enrollment and retention is part of what schools do and are reimbursed for through the School-based Medi-Cal Administrative Activities program that provides a match, currently 56.2% due to the PHE but dropping once the PHE expires, for these activities at the school site. LEAs now have greater incentive to increase and maintain eligibility since under a SPA enacted in 2021, they may now bill through the LEA Billing Option program (LEA BOP) for all Medi-Cal students not just those with an Individual Education plan, i.e.Special Education Students who make up about 12% of the student population. The 700 LEAs in the LEA BOP program have an average of about 60% of their students eligible or enrolled in Medi-Cal. The Medi-Cal percentage is part of the determination for reimbursement for school-based health programs.

These are some best practices that have been learned to reach families and offer to assist with redeterminations. School enrollment data available to school districts is a rich source of the most up to date information for parent cellphone numbers for texting, addresses and school site and location for students. These efforts can be combined with vaccination particularly COVID vaccinations that lag for the Medi-Cal covered population.

* Use a data match between LEA BOP enrollment data which includes school site information, BIC number, name and birthday and share with school personnel in the S-MAA program now that DUAs can be modified to allow data sharing. A free program was funded by CMS and could be upgraded and used now that DHCS has agreed to allow data matching at the request of the school districts. Attached is a Powerpoint explaining the program. Page 9 gives an example of how the data could be arrayed by school districts. S-MAA funded staff could outreach to families where the LEA BOP data shows their coverage status and help prevent disenrollment.
* Use existing social media channels already employed by school districts - these include District websites that often include a Wellness link that could link to enrollers at the school site, online, counties or CBOs, YouTube, Facebook, Parent Hub websites that could feature an explanation of how to maintain enrollment
* Use existing channels of virtual communication to distribute Ambassador materials. These include robo-calls from principals as well as posting on the website of the zoom presentation and slides, virtual leaflets.
* Develop text messages to families about redetermination events and how to contact school based staff at Family resource centers, community based schools and Healthy Start sites to assist with redetermination
* Use district based culturally and linguistically appropriate staff to reach parents and provide education and encouragement
* Partner with health plans to do school-based events in schools where there is a high level of disenrollments. Health plans often provide incentives, raffle prizes etc to draw families to these events. School districts with support, can provide healthy snacks at these events

The practices have been employed and tested already in over 135 school districts in California by THK

DHCS could also support AB 2680 (Arambula), legislation to provide grants to CBOs to do outreach by adding Local Educational Agencies to the language in Section 1, part b. Link to the bill is [**https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill\_id=202120220AB2680**](https://nam04.safelinks.protection.outlook.com/?url=https%3A%2F%2Fleginfo.legislature.ca.gov%2Ffaces%2FbillNavClient.xhtml%3Fbill_id%3D202120220AB2680&data=05%7C01%7CJacobs_Jessica%40lacoe.edu%7C449a64ba493a4d1d533408da6b8de05d%7C9a85f50685664ae19bd3b3fba8220f09%7C0%7C0%7C637940554498470228%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=KOL6qPihcZCtBu8uJ3f2F9OpsAO8JyM72RwQYjHzIHI%3D&reserved=0)**.**

**Assistance for Outreach for Immunizations**

As a result, in part of the COVID emergency, immunization data reflects a record number of children who have not received their regular immunization as required by state law. This is the case even though proof of immunization is a requirement for parents to comply with to enroll their children in kindergarten and for those students matriculating into seventh grade. In past years, school districts have had compliance rates of over 95%. Part of this is due to schools losing ADA (Average Daily Attendance) funds for each child who is unvaccinated and does not have a valid exemption. For this reason, schools have precise data on children who are not vaccinated and have outreach programs already in place to reach these children. Vaccine requirements have been waived due to the PHE so there has been less emphasis on meeting this requirement. These will be reinstated once the PHE ends.

Part of this drop in immunizations might have been due to the response to COVID-19. School staff that in previous years might have provided immunizations at school sites at the end of sixth grade and at school enrollment were unable to do so due to school closures. Robust outreach efforts at school sites were not possible when learning went virtual. Parents did not understand the need for immunizations in a virtual learning environment and were wary of the social media negative reaction to vaccine mandates and the misinformation on vaccine safety. Districts that offered clinics cut back their schedules if they were offered at all. Anti-vaxxers showed up to school board meetings, intimidated staff and politically attacked school board members. Pediatricians and clinics have reported a decline in the number of families taking their children for well child visits due to apprehension about the safety of clinic and physician visits.

The drop in regular immunizations most likely is reflected in the lower rate of COVID vaccinations for those eligible for Medi-Cal. According to DHCS, Medi-Cal recipients who are school aged have a lower vaccination rate than those with private health insurance.

Teachers for Healthy Kids in conjunction with school districts and health plans and the California School Nurses Organization has been working informally to increase immunization rates for eligible but unvaccinated students by piloting new ways to engage parents through developing a generic outreach tool for parents that would increase the rate of immunizations and help meet vaccination requirements for students. Efforts have used social media platforms that go beyond current school-based efforts that include mailed notices and phone calls.

When school resumes this fall, there is a need to help meet the current requirements as well as to help parents understand the need for vaccinating students for COVID. Getting the word out has proven to be difficult using existing methods of communication. Children who are the least likely to be vaccinated live in families where English is not the first language spoken in the home. According to CDE, students of color, many of whom live in immigrant families make up about 74.5 % of public school students. Immigrant families who maybe undocumented or applying for citizenship are concerned about their immigration status being impacted if they receive health services from the county. Schools are seen as trusted messengers of information making them a good resource for information. Informative materials including scripts, texts and supporting materials could be tailored for posting on school websites and to assist school health workers. The Ambassador program could include outreach to schools as part of their PE unwinding plan.

**Background- Immunizations and Schools**

**Current Immunization requirements:**

This is a list of the vaccines already required for school attendance:

 Vaccines/immunizations are services that are part of Medi-Cal EPDST program.

<https://files.medi-cal.ca.gov/pubsdoco/medsupply/Medi-Cal_coverage_immunizations_faq.aspx>

CHDP covers preventive health assessments and immunizations for Medi-Cal beneficiaries up to 21 years of age who have full scope Medi-Cal. Vaccines, both those provided by the federal VFC program and vaccines not provided by the VFC program, are covered by CHDP. The covered vaccines are listed on the [CHDP Gateway to Health Coverage](http://www.dhcs.ca.gov/services/chdp/Pages/default.aspx) website.

<https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf>

Within the Redbook Immunization schedule, children that are 18 months to 18 years immunizations have the following schedule

<http://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf>

**Changes to school health programs that support immunizations through schools**

One of the greatest challenges to schools providing vaccinations has been that they were not covered by the LEA BOP program. SPA 15-021, implemented in October 2021 now allows immunizations to be billable through LEA BOP under EPSDT Screenings based on the following:

1. Immunizations fall under EPSDT Screenings for all Medi-Cal enrolled children under the age of 22
2. Authorization comes from the Periodicity Schedule or the California Education Code or Health and Safety Code screening requirements at required intervals
3. Minimum time requirements must be met (seven continuous minutes to bill in 15 minutes increments)

**Several obstacles that need to be addressed in coordination with DPH and CDE to encourage schools to participate in vaccinations:**

* Only about 50 school districts out of 1104 LEAs according to a list from DPH dated 11/21, are providers under the VFC program due to requirements that do not take into account the differences of providing vaccines within a school rather than clinic setting
* This may have recently changed, but data on vaccinations can only be added to CARES by VFC participants. Schools now have “Read Only” access to CARES so they can check on a student’s record but not add information. Schools participate in local programs that may not be linked with CARES.
* School districts could only check CARES by entering each student name. This is both time consuming and expensive. electronically to check vaccination status. This hopefully has been resolved but districts may be unaware of this change.
* Documentation required by Audits and Investigations (A&I) when auditing school-based programs does not clearly lay out requirements
* Counties in some cases have been reluctant to enroll LEAs in VFC
* It is not clear if COVID vaccines can be billed under LEA BOP
* The Ambassador program has not fully embraced schools and understood their ability to reach families as addressed in the redetermination section above
* Health plans have not focused on schools with exceptions as a place to reach out to their unvaccinated members. Currently Medi-Cal has overly strict laws to allow health plans on campus- they need a 30 day period to apply to DHCS for approval prior to an event. This seems outdated due to the recent efforts by CHHS to create better working relationships between MCOs and schools
* The 15-minute time interval may be irrelevant under the new CRCS system implemented by SPA 15-021 due to the cap implicit on charging that takes into account salary level as a cap
* There needs to be a coordinated effort between DHCS, CDE, DPH, LEAs and groups working in health within schools.

**Here are some ideas for addressing the issues:**

* Simplify VFC enrollment and regulations. Work with counties to outreach to schools to bring them into the program. Use ARA funds to help districts purchase refrigerators
* Allow non-VFC LEAs to enter data when they complete vaccinations into CARES. Develop protocols for data sharing between vaccine data bases
* Instead of checking CARES by each student’s name run school enrollment data against CARES data to determine those who are unvaccinated and use this information to drive outreach efforts by those practices listed above. Train LEAs in how to do this.
* Work with A&I on agreed to documentation for audits. Accept VFC forms as proof rather than creating separate documents or see attached samples of what is already used and accept this for audit purposed
* Encourage counties to partner with schools so that districts as VFC providers can operate their own vaccination programs and take pressure off of what are often limited county services provided at locations that not be accessible to families with limited transportation options
* Clarify and let the schools know if they can receive funding through LEA BOP for COVID vaccinations for students. Help them to use other funding sources through the county or stae to pay for these vaccinatiuons and to cover vaccinations to family members.
* Combine the Ambassador Medi-Cal enrollment efforts with school-based vaccination programs. Put on vaccine parental consent forms a check box asking families if they want COVID vaccines and a check box asking if they need help with redetermination. Have Ambassadors available to do redeterminations during vaccine programs. Some school districts require parents to be present when their child is vaccinated so this is a way to combine efforts that will reach the families of the six million kids who attend public schools.
* Encourage health plans to participate in school-based events. Simplify the notification process that requires DHCS permission for health plans to do outreach at schools. This would also help health plans meet HEDIS standards.
* Get permission from CMS to reconsider the 15 minute increment given that is irrelevant to billing under the new SPA that uses the RMTS and CRCS form.
* Put together a working group on vaccinations with representatives from state agencies and departments, counties and Local Education Agencies. Same could be done for the end of the PHE.

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