masbhc
MARYLAND ASSEMBLY ON
SCHOOL-BASED HEALTH CARE
education+health=success

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To: The Maryland Insurance Administration

From: Robyn Elliott on behalf of the Maryland Assembly on School-Based Health Care

Date: November 12, 2019

Subject: Network Adequacy Regulations

Thank you for the opportunity to submit public comments on network adequacy standards. The Maryland Assembly on School-Based Health Care (MASBHC) requests a modification to health and dental plans standards to recognize school-based health centers as essential community providers (ECP).

We made this request when the Maryland Insurance Administration (MIA) first proposed network adequacy standards in 2017. We believed, and still do, that it is important for the State to have a consistent approach to defining essential community providers. The Maryland Health Benefit Exchange (MHBE) already recognizes school-based health centers as essential community providers.

We have attached our 2017 request as well as follow-up information provided to then Associate Commissioner Bob Morrow. We would greatly appreciate reconsideration of our request for the following reasons:

- Young children and adolescents rely on school-based health centers for critical primary care, behavioral health, and dental services. School-based health centers serve low-income children in over 80 schools across Maryland. For continuity of care, it is critical that school-based health centers are in networks across different insurance markets;

- The MIA has a definition of essential community provider that is identical to the MHBE's definition with the exception of school-based health centers. This small difference can create considerable confusion in determining ECP participation rates in provider networks;

  - For qualified health plans, ECP participation rates are calculated using the total number of ECPs in a plan's area in the denominator. The MHBE keeps the list of essential community providers, including school-based health centers; and

  - For plans outside of the Exchange, the ECP participation rate would have to be calculated by removing the school-based health center providers from the MHBE list. This makes it more onerous for either the MIA or carriers to determine compliance with ECP compliance for plans outside of the Exchange.

Thank you for your consideration of our request. If you should need any additional information, please contact me at relliott@policypartners.net or (443) 926-3443.

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August 21, 2017

Lisa Larson
Regulations Manager
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, MD 21202

Dear Ms. Larson:

Thank you for the opportunity to comment on proposed regulations under COMAR 31.10.44 to establish network adequacy regulations. The Maryland Assembly on School-Based Health Care (MASBHC) appreciates the work of the Maryland Insurance Administration (MIA) to work with stakeholders in developing network adequacy regulations. The proposed regulations help advance standards that will help ensure consumers have sufficient access to health care providers.

We believe it is the MIA's intent to align the definition of essential community provider (ECP) with the definition used by the Maryland Health Benefit Exchange (MHBE). The MHBE's definition of ECP also includes school-based health centers. Therefore, we are requesting the addition of "school-based health centers" to COMAR 31.10.44.01 B(6).

The key reasons for aligning the MIA's definition of ECP with the MHBE's definition from the regulatory perspective include:

- Carriers should have a consistent methodology to calculate the ECP participation rate in their provider networks. Carriers now include school-based health centers in their calculations for qualified health plans; and

- Regulators should have a consistent mechanism for evaluating ECP participation rate in provider networks. We believe it would make it simpler to determine if carriers are compliant.

It might be of interest to note the history of adding school-based health centers to the MHBE's definition of ECP. When the MHBE was examining the issue through its Network Adequacy Workgroup, MASBHC requested school-based health centers be added to the state definition of ECP. Many, but not all, school-based health centers already met the federal ECP definition. This inconsistency was creating

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widespread confusion on whether school-based health centers were ECPs. For more detailed background information, we have attached MASBHC's comments to the MHBE on its Draft 2017 Issuer Letter.

Thank you for the opportunity to submit these comments. If we can provide any additional information, please contact me at (443) 926-3443 or relliott@policypartners.net.

Sincerely,

R S. Elliott

Robyn Elliott
Public Policy Consultant

Attachment

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November 13, 2017

Lisa Larson
Regulations Manager
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, MD 21202

Dear Ms. Larson:

Thank you for the opportunity to comment on proposed regulations under COMAR 31.10.45 to establish network adequacy regulations for dental plans. The Maryland Assembly on School-Based Health Care (MASBHC) appreciates the work of the Maryland Insurance Administration (MIA) to work with stakeholders in developing network adequacy regulations. The proposed regulations help advance standards that will help ensure consumers have sufficient access to dental providers.

We recommend the inclusion of school-based health centers (ECPs) in the definition of essential community providers (ECPs). The MHBE recognizes several different provider types in addition to providers types qualified under the federal definition. In the proposed regulations for dental plans, the MIA recognized all these State-defined providers with the exception of SBHCs. We believe this was a technical oversight.

SBHCs provide health care services to low-income children in K-12 schools. Not every SBHC offers dental services. However, when a SBHC does offer dental services, it is because there is a provider shortage in the community. SBHCs are essential community providers, as families depend on them to access dental services. Given the importance of ensuring access to pediatric dental services, it only makes sense for providers of our most underserved communities are recognized.

Thank you for the opportunity to submit these comments. If we can provide any additional information, please contact Robyn Elliott, our public policy and governmental affairs consultant, at relliott@policypartners.net or (443) 926-3443.

Sincerely,
Donna Behrens
Co-Chair

Public Policy Partners
A Firm of Ciekot, Elliott, and Douglas

November 13, 2017

Bob Morrow
Associate Commissioner of Life and Health
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, MD 21202

Dear Mr. Morrow:

Thank you for the opportunity to discuss the request regarding the inclusion of school-based health centers (SBHCs) in the definition of essential community provider (ECP) in the network adequacy standards for health plans. I would like to provide some additional background information on behalf of the Maryland Assembly on School-Based Health Care.

A SBHC is a community health center within an elementary, middle, or high school. All SBHCs provide primary care, and some SBHCs provide behavioral health and/or dental services. All SBHCs are approved by the Maryland State Department of Education. To bill Medicaid, SBHCs must meet the SBHC provider requirements of the Maryland Department of Health (MDH). Most, if not all, SBHCs are Medicaid providers.

There are about 80 SBHCs across the State. SBHCs are located in schools with a high concentration of low-income families. SBHCs must have a sponsoring entity. The most common sponsoring entities are local health departments and federally-qualified health centers.

I believe that there is only one difference between the ECP definition proposed by the MIA and the final definition adopted by the Maryland Health Benefit Exchange (MHBE) for qualified health plans (QHPs). The MHBE definition includes SBHCs, while the MIA definition does not. This means that the MIA will be creating a difference of only about 80 providers under its proposed definition of ECP.

I suspect that this 80-provider difference will create significant confusion from both the carrier's and MIA's perspective. The crux of the issue is what number is used in the denominator for the calculation of ECP participation.

For QHPs, the MHBE provides guidance on how the denominator is determined. The denominator is a combination of all ECPs that meet the federal definition (FQHCs and other provider who are eligible for 340B status) and all ECPs that meet the expanded State definition (local health departments, behavioral health programs, and school-based health centers). The MHBE uses a federal list to determine the number of ECPs that meet the federal definition; and then, the MHBE uses a list, as

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provided by MDH, to determine the number of ECPs that meet the State definition. The basis for the ECP denominator is the federal list plus the State list.

By creating a difference in the ECP definition, both carriers and the MIA will need to use a different denominator than the MHBE denominator. I think that this will create a significant administrative burden on all parties. I also suspect that it is not implementable, unless the MIA plans to create its own ECP list which would require an investment of resources.

I have written a great deal about the technical matters of ECP calculations. From the consumer perspective, however, access is the most pressing issue. SBHCs provide core health care services to children from a young age through adolescence. Families rely on SBHCs, particularly when transportation problems or work schedules make it difficult to access other providers. For many families, SBHCs are essential to ensuring their children receive health care services.

Thank you for all of the MIA's work on the network adequacy regulations. If I can provide any further information or assistant, please do not hesitate to contact me at relliott@policypartners.net or (443) 926-3443.

Sincerely,

Robyn Elliott