

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

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 assistance, please do not hesitate to contact me at relliott@policypartners.net or (443) 926-3443.

Sincerely,

A handwritten signature in black ink, appearing to read "Robyn Elliott". The signature is written in a cursive, flowing style.

Robyn Elliott