F I S C A L I M P A C T R E P O R T

SPONSOR Ortiz y Pino **ORIGINAL DATE / LAST UPDATED** _____ **HB** _____

SHORT TITLE Child Behavioral and Developmental Screenings **SB** 24

ANALYST Chilton

APPROPRIATION (dollars in thousands)

Appropriation		Recurring or Nonrecurring	Fund Affected
FY16	**FY17**		
	$75.0	Non-recurring	General Fund

(Parenthesis ( ) Indicate Expenditure Decreases)

SOURCES OF INFORMATION

Children Youth and Families Department (CYFD)
University of New Mexico Health Sciences Center (UNM HSC)
Human Services Department (HSD)

SUMMARY

Synopsis of Bill

This bill was developed at the behest of the J. Paul Taylor Task Force, a multiple-year effort of early childhood experts convened by the University of New Mexico intent upon improving the outcome of children in this state. The bill was introduced for the Legislative Interim Committee on Health and Human Services and pre-filed on December 16, 2015 by Senator Ortiz y Pino.

The bill would require that those providing Early and Periodic Screening, Detection, and Treatment (EPSDT) services to child Medicaid recipients include among those services at each visit screening for developmental and behavioral health concerns. It would require the Human Services Department (HSD) to determine what screening procedures would be required by December 31, 2016, establish an educational program for providers of EPSDT services by the same date and then begin requiring the ascertainment that such screenings were being done in order for payment to be made for the EPSDT evaluation. An advisory group specified to be made up of representatives of the Department of Health, the Children, Youth and Families Department and the Medicaid managed care organizations would be set up to advise HSD on these measures and to "improve access to prevention and early intervention services."

Screenings would be age-appropriate, and would include a "comprehensive health, mental health and developmental history, including an assessment of behavioral health and social-emotional development and an assessment for substance abuse disorder as part of every eligible recipient's

screening," and that relationship axis disorder coding be used for each child less than five years of age. It would further require that providers create a "medical schedule" in which to record each service provided.

As required by EPSDT regulations, each disorder found would be treated.

FISCAL IMPLICATIONS

The appropriation of $75 thousand in this bill is a nonrecurring expense to the general fund. Any or expand unecencumbered balance remaining at the end of FY18 reverts to the general fund.

The $75,000 appropriation is earmarked for expert consultation regarding the development of a list of required screens to be performed by providers of EPSDT services at each EPSDT visit during childhood. As the bill envisions education for providers being developed to enable them to appropriately apply these screens and to make referrals for children screening positive for one or multiple conditions, the costs involved in providing that education, including Continuing Medical Education (CME) credit, is assumed to be borne by HSD. If HSD were also to participate in creating referral resource lists for those occasions when children screen positive for problems that would also increase the burden on HSD.

If providers were denied payment for EPSDT services based on the lack of performance of the required screens, it is possible that Medicaid expenditures would be decreased. However, most of the saved Medicaid dollars would redound to the benefit of the Medicaid managed care organizations (MCOs) rather than to the state.

HSD estimates an increased cost of $49 for each well child visit due to prolonging the visit from 20 to 30 minutes. However, as the codes for well child visits (also called EPSDT visits) are dependent upon the age of the child, not the length of the encounter, it is more likely that the increased cost to the provider of the longer visits would be borne by the provider and not the MCO or the state.

SIGNIFICANT ISSUES

1. The timing for setting up the advisory committee and for developing the required elements of an EPSDT exam are both set for "by December 31, 2016." No timetable for educational efforts or for beginning requirement for mandatory elements' inclusion is specified.
2. The bill requires that upon initiation of the program, HSD deny payment for EPSDT services if the required elements have not been done. There is no mention of the Medicaid managed care organizations (which cover a large majority of Medicaid recipients) doing the same.
3. Experts have specified many different items that they feel should be included in well child exams. It would appear important that the list of those items to be included be possible within the time that practitioners can allot to a well child visit, typically 15 to 20 minutes.
4. The group to be set up to advise HSD is composed of DOH, CYFD, and Medicaid MCO representatives. No representative of providers or patients are included.

5. Education that is accessible to providers would be important prior to the onset of the requirement. Continuing Medical Education (CME) credit would be best provided, and a variety of ways of accessing the training should be available.
6. Rural practitioners would seem especially important to support, given the small number available in most rural parts of New Mexico, and the difficulty many experience in finding replacements or additional providers for their practices.
7. Resources for referral of children screen-positive for disorders of behavior or development are difficult to come by in many if not all parts of New Mexico. HSD and its advisory board could help develop a list of referral resources. Providers will be frustrated if they detect disorders and no resources can be found to be brought to bear.
8. Relationship axis disorder coding, specified in the required elements, is commonly used by mental health practitioners, but not by pediatricians or family physicians. Education in its use would be essential if that requirement stands.

ADMINISTRATIVE IMPLICATIONS

HSD is directed to develop a list of age-appropriate screening instruments which an EPSDT provider would apply at each visit. HSD would seek guidance from an expert or experts, as well as from its advisory committee and from published screening tools.

In addition, HSD is tasked with developing educational efforts to acquaint providers with the new regulations and the screening tools adopted. It is likely that this would initially be a major effort, given the large number of providers of EPSDT services in New Mexico, and the variation in their learning styles.

If the legislation intends that Medicaid MCOs also will be charged with enforcing the implications of the bill through denial of claims that do not substantiate performance of all of the screenings required, that requirement will have to be included by HSD in the contracts for those MCOs and guidance given as to when and how sanctions on providers should be applied.

OTHER SUBSTANTIVE ISSUES

The American Academy of Pediatrics' State Government Affairs Office was unable to find similar legislation in other states; its reading of the bill indicated that the bill would seem unduly coercive and punitive.

On the other hand, an August, 2015 report from the Colorado Children's Campaign, entitled "Young Minds Matter: Supporting Children's Mental Health Through Policy Change" notes the importance of seeking out disorders of children's psychosocial development. Numerous studies have shown the importance of a list of Adverse Childhood Experiences (ACEs: problems such as parental separation or divorce, living in poverty, parental incarceration, mental health disorders, or substance abuse) in determining mental and even physical health, both in childhood and in later adulthood. In addition, studies have shown that important developmental problems such as developmental delay and autism are often discovered later than optimal; most such disorders have better outcomes if detected early, with early onset of treatment.

Thus screening for these disorders appears to be of great importance. The prevalence of ACEs is greater among children living in poverty than children in better socio-economic status is increased, threatening their future. As New Mexico ranks very high among the status in

prevalence of childhood poverty, it is likely that screening for ACEs would be highly productive, as long as resources for referral of those children were available.

ALTERNATIVES

It might be possible to offer positive incentives for performing well in applying the screening tools developed. If a negative incentive is desired, a reduction in payment to providers, rather than an outright denial of payment, might have the desired effect.

WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL

Most providers know of the importance of Adverse Childhood Experiences and of "toxic stress" in early childhood and screen in some way(s) for these problems. Failure to enact the bill would allow practitioners to continue avoiding collecting this important information.

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