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

SPONSOR Candelaria **ORIGINAL DATE** 02/18/15 **LAST UPDATED** **HB**

SHORT TITLE School Health Centers in Restricted Networks **SB** SB 436

ANALYST Dunbar

APPROPRIATION (dollars in thousands)

Appropriation		Recurring or Nonrecurring	Fund Affected
FY15	**FY16**		
	NA		

(Parenthesis ( ) Indicate Expenditure Decreases)

Relates to SB44

Relates to Appropriation in the General Appropriation Act

SOURCES OF INFORMATION

Responses Received From
Department of Health (DOH)
Human Services Department (HSD)
Public Education Department (PED)
Office of the Superintendent of Insurance (OSI)
Attorney General (AG)

SUMMARY

Synopsis of the Bill

Senate Bill 436 amends and enacts new sections of the Preferred Provider Arrangements Law, the Health Maintenance Organization Law and the Nonprofit Health Care Plan Law to require that school-based health centers (SBHCs) be included in restricted networks. It adds a definition for "school-based health center". It also adds new sections to law allowing a health care plan to include as a network provider any school based health center within the service area of the health care plan.

FISCAL IMPLICATIONS

Senate Bill 436 has the potential of increasing the number of options for billing services for a number SBHCs in the state. This matter discussed by PED in significant issues below makes the point on concerns surrounding the topic on sustainability of SBHSCs.
HSD on the other hand, comments that it would be time consuming for service providers to

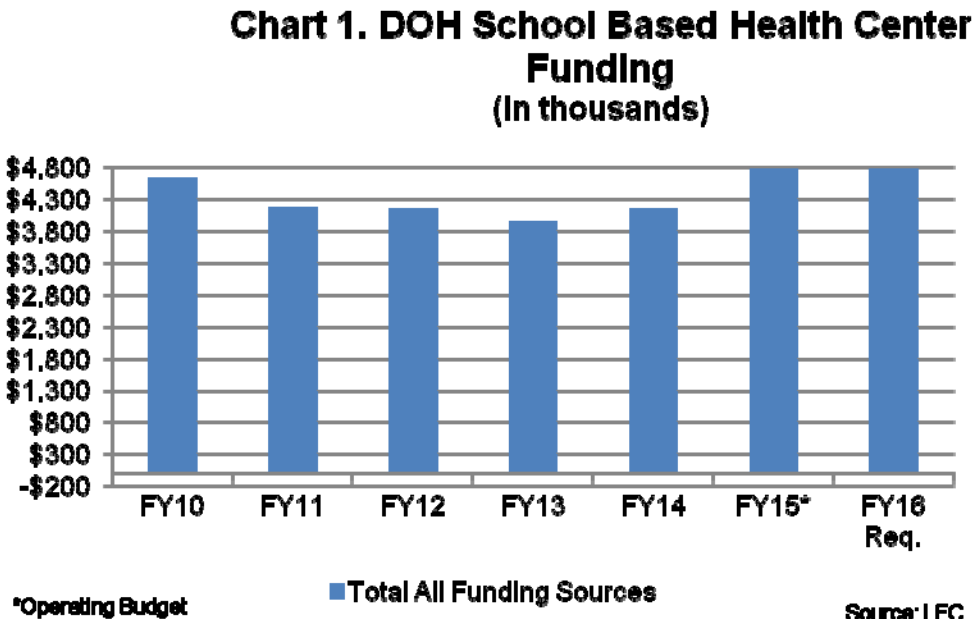
become "credentialed" by an array of multiple insurers. And without credentialing, the service provider cannot bill. Another point made by HSD is that at these clinics, there would not be adequate staff, funding, or infrastructure in place to be able to bill or process claims for multiple insurers.

Another matter described by DOH is that despite the savings that SBHCs provide, many of the services delivered remain uncompensated. Billing and claims data for 13 SBHCs for the 2013-2014 school year found that 3,722 claims went unbilled (Apex, Unbilled SBHC Visits for 2013-2014 School Year, November 2014). Almost half of these visits (1798 or 48 percent) were for adolescents who had private insurance. The estimated value of these services using *The School Based Health Center Scope of Service Rates for November 2013* was $297,977, a substantial sum for these SBHCs. SBHCs that are unable to bill private insurance depend on grant funds and other resources to make up lost revenue.

Another issue identified by OSI on SB 436 relates to the narrowing of networks as one way that carriers control costs. Adding SBHCs to the restricted networks might potentially raise premiums for consumers.

Given all the remarks noted above, billing issues with SBHSCs should be discussed.
Following the implementation of the Affordable Care Act (ACA) there was a significant increase of individual and families in New Mexico who became eligible for health insurance coverage. Billing issues, although currently problematic, need to be addressed as substantial federal funds and other revenues could be made available to fund these programs. The advantageous of securing federal funds would address, as per PED, sustainability issues for the SBHSCs and possibly provide funds for expansion to other schools.

The Legislative Education Study Committee provided the following chart on the funding of SBHSCs. LFC staff updated the chart to reflect FY15 and FY16. The GF increase between FY 14 and FY15 was approximately 500 hundred thousand dollars. This information reveals that most of the funding increase was related to the general fund which brings up sustainability issues and the need to address additional funding sources.



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An analysis of school based health care administered to the 14,500 students in NM in school year 2012-2013 revealed a projected savings of $20.1 million compared to the total SBHC budget of $3.3 million. In other words, NM SBHCs yielded a return on investment of $6.07 for every dollar expended (Ginn and Associates, 2013). Some of the savings include:

- A projected annual net hospitalization savings of $206,725 for asthmatic students;
- A projected annual net savings of $692,827 from early detection and treatment of gonorrhea and chlamydia;
- A projected lifetime net savings of $1,033,216 due to mental health services provided at SBHCs; and,
- A projected annual net savings of $690,557 due to projected decrease in prescription drug costs. (Ginn and Associates, 2013)

SIGNIFICANT ISSUES

SB 436 includes in its definition of a school-based health center, that it is an entity licensed by the Department of Health. However, DOH does not license school-based health centers. Rather, the SBHCs who are part of the Centennial Care managed care network and bill Medicaid are "certified" by DOH Office of School and Adolescent Health (OSAH) and the Human Services Department (HSD) Medical Assistance Division (MAD). It is not clear if this bill is proposing that SBHCs become "licensed."

SB 436 also proposes that school-based health centers be considered in-network service providers for health care plans in this state. School-based health centers are largely designed to provide primary health care and behavioral health services to underserved children and youth. HSD contracts with Centennial Care managed care organizations (MCOs) to provide these services to Medicaid eligible children and youth who are enrolled in the Medicaid managed care program. At present, SBHCs that are supported by a medical entity such as a Federally-Qualified Health Center (FQHC) are the only ones who have a system in place to bill other insurers besides

Medicaid.
SBHCs that are not sponsored by a medical entity have no structure in place to bill any other payer except Medicaid as noted by HSD. At these clinics, there would not be adequate staff, funding, or infrastructure in place to be able to bill or process claims for multiple insurers. Most insurers have a process in place for credentialing a clinic/ providers as approved participants. It would be time consuming for service providers to become "credentialed" by an array of multiple insurers. Without credentialing, the service provider cannot bill.

The U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), defines School-Based Health Centers (SBHCs) as clinics that are utilized by students and their families to receive certain age appropriate health services. PED observes that this definition of SBHCs seems to support the consideration presented in SB 436 of an SBHC as a "network provider" as defined in 59A-46-2 NMSA 1978, which states: "a person or a group of persons licensed, certified or otherwise authorized to provide health care services in the state that has entered into a written agreement with a health care plan to provide services to eligible individuals."

According to the DOH, "SBHCs are not generally recognized as a provider in private insurance networks, and, therefore, youth, their families, and staff who have access to an SBHC often pay higher co-payments or fees." PED goes on to say that by including SBHCs as network providers, there would be an increase in the number of options for billing health services. By increasing the avenues for billing, it may be reasonable to consider that the sustainability of SBHCs in New Mexico may be improved.
Source: http://www.hrsa.gov/ourstories/schoolhealthcenters/

DOH-funded SBHCs provide a substantial amount of health services to New Mexico students and their families. According to the DOH Office of School and Adolescent Health (OSAH), DOH-funded SBHCs currently serve 53 school campuses within 26 New Mexico counties. Furthermore, in school year 2013-14, over 33,000 adolescents had access to an SBHC, and of these students more than 10,400 students actually visited an SBHC in their area. The National Assembly on School-Based Health Care supports the idea that SBHCs increase access to health care, and they state, "a national multi-site study of school-based health centers conducted by Mathematica Policy Research found a significant increase in health care access by students who used school-based health centers: 71% of students reported having a health care visit in the past year compared to 59% of students who did not have access to an SBHC." This research supports the idea that it may be beneficial to improve the sustainability of SBHCs in order to continue to provide New Mexico students and their families increased access to health care.
Source:
http://ww2.nasbhc.org/RoadMap/Communications/Benifits%20of%20SBHC%20Investment%20NASBHC.pdf

OSI specifies that network adequacy is a topic receiving high scrutiny right now. New Mexico has extensive existing regulations regarding network adequacy (NMAC 13.10.22.8). The Affordable Care Act added another layer of network requirements, including Essential Community Providers, which was added to insure that a percentage of all networks included services in low-income and underserved communities. If a school clinic is a FQHC, it can be counted as an Essential Community Provider in a carrier's provider network. Limited provider networks must still meet all state and federal requirements.

Health insurance carriers, additionally, have their own requirements for providers that they add to their provider networks.

A point of interest brought up by OSI is that a model to consider is the university school clinic model. University school health plans are specifically addressed under the ACA. In general, any university that contracts with a health plan to offer it to students will have the school clinic included in the provider network with which it contracts, but the plan must still also meet all state and federal network adequacy guidelines. Many university clinics are only included in the network of the carrier with which it contracts, not all carriers.

PERFORMANCE IMPLICATIONS

SB 436 relates to the DOH FY16 Strategic Plan, Result 1: Improve Health Outcomes for the People of New Mexico.

HSD currently holds a contract with DOH to provide Medicaid funding and oversight for SBHCs that provide services for Medicaid covered children and youth. This bill could impact the ability of HSD to work effectively with DOH in ensuring SBHCs are able to meet the Standards and Benchmarks required to become certified as Medicaid approved billing sites.

SB 436 may support the PED's strategic lever that all students are ready to learn by reinforcing the linkage between health and academic success.

ADMINISTRATIVE IMPLICATIONS

It is unclear whether or not the DHI and/or the Public Health Division would require additional full time employees to support the inclusion of SBHCs in the facility licensing process.

HSD may need to redefine its role to work with insurers who are not focused on providing services to the poor and underserved. This may require additional staff time and possibly additional staff.

No IT impact, as SBHCs are already functioning inside the MMIS system, and minor changes related to this bill would be managed as maintenance & operations.

RELATIONSHIP

A related bill is SB 44 which makes an appropriation of $16,625,000 to the Department of Health (DOH) for expenditure in FY 15 through FY 20 for the Office of School and Adolescent Health (OSAH) to expand access to behavioral health treatment and services through school-based health centers (SBHCs), expand hours of operation for existing centers, and establish 22 new SBHCs by 2020.

TECHNICAL ISSUES

SB 436 is unclear if the intent is to have all members of a plan be able to use the school clinic health providers. To address this issue, OSI is suggesting the following language

"all willing school health clinics," since individuals outside the school community might opt to access services from the school clinic. Alternately, the carrier may have to agree to accept the school's statement of who it serves, namely only students.

OTHER SUBSTANTIVE ISSUES

SBHCs provide care for many uninsured adolescents providing a much needed point of access to health care services. Of the 43,056 visits to SBHCs in school year 2013-2014, 66% were to non-white adolescents and 8% were to American Indian youth (2014 OSAH SBHC Annual Status Report). "SBHCs have the capacity to increase access to basic health care for low-income children and adolescents. Data suggests they are perceived as acceptable by students and families and can target underserved racial and ethnic minorities, thereby fostering equity in access to care and health outcomes for the most vulnerable populations" (Institute of Medicine, Highlights and Considerations for State Health Policymakers, 2009).

Nationally, school-based health centers (SBHCs) are known to improve access to health care for children and adolescents (Kisker & Brown, 1996), as well as reduce emergency room rates (Santelli, Kouzis & Newcomer, 1996), and Medicaid expenditures (Wade & Guo, 2010). SBHCs also bolster academic achievement by reducing absenteeism and tardiness (Gall, Pagano, Esmond, Perrin & Murphy, 2000; Walker, S.C., Kerns, S., Lyon, A.R., Brun, E.J., & Cosgrove, T.J., 2010), the dropout rate (McCord, Klein, Foy & Fothergill, 1993), and discipline referrals (Jennings, Pearson & Harris, 2000).

AMENDMENTS

DOH offers the following amending language:

Page 4, Line 10

- Delete the word "services" after primary care, and insert "behavioral health care or oral health services"

Page 11, Line 15

- Delete the word "services" after primary care, and insert "behavioral health care or oral health services"

Page 16, Line 21

- Delete the word "services" after primary care, and insert "behavioral health care or oral health services"

These three definitions should read as follows:
"Provides health care through health professionals who are licensed, certified or otherwise authorized pursuant to state law to render primary care, behavioral health care or oral health services; and"

BD/bb/aml