750 EAST PRATT STREET, 6TH FLOOR
BALTIMORE, MD 21202
marylandhbe.com

MARYLAND HEALTH BENEFIT EXCHANGE

Maryland State Reinsurance Program Regulations Hearing

August 16, 2018
Maryland Health Benefit Exchange
750 E. Pratt Street, 6th Floor
Baltimore, MD 21205

Welcome & Introductions

John-Pierre Cardenas, Director of Policy and Plan Management of the Maryland Health Benefit Exchange (MHBE), welcomed the public to the hearing and thanked all of the stakeholders for their presence during the expedited hearing process. He stated that the final waiver application was posted on the MHBE website on August 15, 2018, which includes the addendum submitted to the Centers for Medicare & Medicaid Service (CMS) on August 4, 2018, as well as Maryland's responses to federal review and comments. Mr. Cardenas gave an overview of the agenda and topics for the hearing.

Reinsurance Program Regulations Overview

Mr. Cardenas explained that the last hearing discussed incentives that already exist in the individual market. He emphasized the investment in the individual market by the state and the role that issuers play through managing the care of their enrollees. Mr. Cardenas acknowledged the high level of interest in this issue and thanked stakeholders and consumers for their insight. Mr. Cardenas emphasized the importance of participants expressing their points of view, but also stated that participants will be questioned on any points that are of interest to the state. Mr. Cardenas explained that the goal of this hearing is to gather information on incentives in the individual market, and then the public may speak on any other topic at the end of the hearing. Mr. Cardenas provided a summary of the questions on the agenda to be addressed at the hearing. He stated that respondents should provide justification for their recommendations and assume that incentive payments will take effect for the 2020 plan year. Mr. Cardenas acknowledged concern about uncompensated care and noted that the state would like to hear from stakeholders on the issue.

Public Testimony

Mr. Cardenas then invited any attendee who so desired to offer their testimony for the record. Five individuals offered testimony.

Bill Wehrle, Vice President of Health Insurance Exchanges, Kaiser Permanente, offered the following testimony:

> *"Bill Wehrle, with Kaiser Permanente, I am not Stacey Shapiro, but she is seated next to me. She is my colleague and our Senior Director of Population Care Management here in the Mid-Atlantic region. So, we're going to take you through a little bit of a deep dive about how we approach population care management and chronic care, chronic condition management. We tried to tie back as often as we could to specific measures that we think the Exchange could leverage if it wanted to design an incentive program in some way as part of the reinsurance program. We also tried to be specific as you will hear from Stacey in our reporting about results for the MHBE population specifically whenever we could do that. We weren't able to all the time. And then, mostly my job is to nod sagely as Stacey speaks, so I will turn it over to her."*

Stacey Shapiro, Senior Director of Population Care Management and Quality Improvement Professional, Kaiser Permanente, offered the following testimony:

> *"Thank you, Bill. Good afternoon. I am Stacey Shapiro. I am the Senior Director of Population Care Management for the Mid-Atlantic Permanente Medical Group of Kaiser Permanente. I have been working in this arena for Kaiser Permanente for over 19 years, and in my role in preventive care and chronic condition management, I design, implement, and evaluate systems, change, workflows, processes, and quality improvement processes and activities to address preventive care and chronic conditions. On behalf*

of Kaiser Permanente, I would like to thank the MHBE Board and staff and the MIA for holding a series of hearings on the reinsurance program and for your work to date to develop an approach to stabilize the individual market in Maryland. Kaiser Permanente continues to fully support these efforts in the development of a state-based reinsurance program. Chronic condition management and population care management are important to Marylanders to help prevent and/or delay the onset of primary or secondary conditions to improve outcomes through care that is engaging, accessible, reliable, evidence-based, and equitable. All of our medical office buildings are recognized by NCQA as a PCMH, or a Patient-Centered Medical Home at a level three, the highest level available for both pediatric and adult medicine. The topics that the MHBE staff asked stakeholders to address today are related to chronic condition management and population care management. The goal of our program is to create systematic and reliable workflows and processes that allow staff and physicians to their full maximum full scope of practice while eliminating barriers and missed opportunities and to base these processes on several foundational principles of a quality improvement model, including benchmarking or comparing the organization to the best within Kaiser Permanente and across the United States and striving to reach the highest performance through transparency, employing openness, sharing performance results with all physicians, and using data to drive change, reliability, creating evidence based processes and workflows that perform exactly as expected every time to decrease variation in practice.

The care model used by Kaiser Permanente within the Mid-Atlantic States has six main components. The first is population identification. The second is design of care delivery based on evidence-based care built on clinical practice guidelines. Next, patient-centered care that involves the patients in their own care and tailored to address the specific needs of the members and the physician patient relationship preserved. Next, customized decision support tools and information systems. Patient self-management skill building, and finally, measurement and reporting. This testimony will address chronic condition management in terms of the continuum of care from wellness to prevention to chronic conditions and through to acute care. The state reinsurance program can be leveraged to address the utilization management of high claims chronic conditions by supporting evidence-based and successful chronic condition models as described in this testimony. The recommendation regarding which methodology should be used to select included diseases includes the following parameters: COMAR regulations and other state of Maryland requirements, alignment with quality priorities and publicly reported measures, burden of disease in the population, existing evidence-based guidelines to manage care and utilization, and finally, the feasibility of identifying the population. My recommendation would be to select conditions with higher prevalence among Marylanders to include at a minimum: hypertension, diabetes, depression, and asthma, or conditions that tend to have a higher rate of inpatient utilization such as heart failure and COPD.

Starting with the discussion about preventive care, the Kaiser Permanente approach to preventive care is just one example of how the organization addresses the social determinants of health that play a big role in the individual's ability to get healthcare. Because physicians and clinicians are not dependent on reimbursement from in-office visits, Kaiser Permanente can provide care in a variety of ways that best meet the needs of our members. Need a lab test at 2AM? No problem. Need your blood pressure checked on a Saturday afternoon? No problem. Not only do we offer 24/7 urgent care at our clinical decision units, that are 23 hour observational units, staffed by Board Certified emergency department physicians, but these same Kaiser Permanente medical centers enable members to pick up a medication, get lab tests, immunizations including flu shots, or blood pressure checked any time of day or day of the week. We create systems to maximize care delivered when a member is already in our office building. From same day mammograms for breast cancer screening to pneumonia vaccines during urgent care visits to scheduling a pap test during an optometry visit to flu shots available in the lobby whenever the building is open. We don't want our members to need to come back over and over to get care we know they need before they walked in the door in the first place. Our systems recognize that time away from work, coordinating child care or elder care, and transportation are all impactful to a member's behaviors in getting the needed healthcare. Our facilities offer certified bilingual translators and access to the language line. Our KP.org member portal and materials are available in a variety of languages. Per protocol, based on the reason for visit, primary care and some specialty departments can provide telehealth via a secure video so a member can be seen without leaving home or the office. The member portal also allows appointments to be made online, allows a daily updated summary of a members' care gaps with instructions on how to close those

care gaps and information about managing that condition and allows for secure email messaging with your physician or other care team members with defined parameters for when to receive a response. Although, a high percentage of the time, the response time is significantly less than the two-day required turnaround time. Kaiser Permanente Mid-Atlantic States also has multi-cultural healthcare distinction provided by the National Committee for Quality Assurance, or NCQA.

Moving into a discussion about chronic conditions, starting with diabetes. The care management program goal is to improve the health outcomes of people with diabetes through frequent provider touchpoints for care that is engaging, accessible, reliable, evidence-based, and equitable. It's comprised of a coordinated team of pharmacists, registered nurses, and nurse practitioners that provide panel-based care for the Kaiser Permanente Mid-Atlantic States members with poor glycemic control. It is under the leadership of our physician director for population care management and myself. Our members enter the program through physician case management or other care provider referral, care management program staff case finding through our panel management systems, and/or auto-enrollment based on laboratory results. This process is not based on claims-based diagnoses. Care managers work in collaboration with the patient and the patient's primary care physician to determine the patient's goals and therapeutic intervention plans. During weekly touchpoints with the care manager, predominantly through phone or secure message, patients or members receive self-management skill building, diabetes education, lifestyle management, and diabetes medication titration by protocol or in collaboration with the primary care physician, all to reach their goals.

Our key differences compared to other organizations is that, as with all care delivered within Kaiser Permanente, documentation and coordination is conducted through the Kaiser Permanente electronic health record to ensure coordination of care between care management program staff and other care providers. So for chronic condition management, Kaiser Permanente has long been at the forefront of using technology to innovate and improve the healthcare of our members. An example is remote data monitoring, supporting hypertension management for our patients outside of the conventional clinical setting. In addition to remote monitoring for high blood pressure, we also have an ongoing study, research study, for people with diabetes to monitor for foot ulcers, scales to help support heart failure treatment and monitoring, and later on early next year, glucometer remote monitoring for diabetes. By using evidence-based interventions, implementing standardized reliable practices, and taking care every visit to address blood pressure regardless of the department, primary care or specialty care, urgent care day or night, Kaiser Permanente of the Mid-Atlantic States reached number one status among health plans reporting HEDIS to NCQA for the commercial line of business for three years in a row.

Leveraging existing, publicly reported measures for prevention and chronic condition management, like the HEDIS dataset from NCQA, allows a standardized set of audited data with which to compare and identify successes, opportunities, and gaps. Using the quality rating score, QRS, for qualified health plans that are offered on the Exchange supports this recommendation. QRS includes both HEDIS measures of clinical quality and the results of CAHPS surveys of enrollees in the individual market to assess consumer satisfaction with their carrier as an insurance company and their physicians and other care providers. These measures are well-established and familiar to insurers, essentially unchanged since they were implemented in 2014 as required by the ACA. So what does all this mean for outcomes? Where does it get us? Does it make us better? Our outcomes demonstrate the benefit of our integrated approach to chronic condition management and population-based care. Per the Kaiser Permanente HEDIS 2017 results, specifically for Maryland marketplace enrollees, among health plans reporting HEDIS data to NCQA, Kaiser Permanente enrollees are in the 95th percentile or above the cut point of five for the following effectiveness of care topping areas. The composite measures with a cut point of five or above include: behavioral health, diabetes care, checking for cancer, maternal health, staying healthy for adults, staying healthy for children, and a composite of four for clinical quality management.

Our Maryland marketplace HEDIS 2017 results to NCQA were above the 95th percentile for the following measures: follow-up after hospitalization for a heart attack, initiation and engagement of alcohol and other drugs, controlling high blood pressure, diabetes care for eye screening and kidney disease screening and testing for A1c or glycemic control, post-partum care chlamydia screening, well-child visits for children

who are early elementary. And there are three cancer screenings that were all above the 95th percentile for Maryland marketplace specifically. Breast cancer screening rate of 91.6 was above the Maryland average among marketplace enrollees. The Maryland average for the subpopulation was 69.5. Again, our rate was 91.6. For cervical cancer screening, our screening rate was 78.6 as compared to the Maryland average among Maryland marketplace enrollees, the average being 56.4. And then for colorectal cancer screening, our rate of 78.9 when the Maryland average among marketplace enrollees was 51.6. Another HEDIS measure, specifically for Maryland marketplace, the risk adjusted emergency room utilization was also above the 95th percentile. The measure risk adjusted hospital utilization was a very similar rate to the emergency department rate. However, NCQA does not provide comparison information for the risk adjusted hospital utilization measure, so it's not feasible to say how we compared to other health plans for that component.

Kaiser Permanente is tracking at a 26 percent lower admissions rate for the first seven months of 2018. As compared to the 2016 state of Maryland benchmark rate, and that benchmark rate is provided by the Kaiser Family Foundation. Kaiser Permanente is tracking at 33 percent improved utilization or hospital bed days multiplied by average length of stay per 1000 members, as compared also to the 2016 state of Maryland benchmark, and that benchmark provided by the Kaiser Family Foundation. And, our year over year rate for the first seven months of 2018, as compared to the first seven months of 2017, shows almost five percent improved utilization.

So, how does this translate into long-term outcomes and dollars saved? As an integrated delivery system, where preventive care and chronic condition management are built into the daily work, calculating return on investment is a challenge. However, it is feasible to translate our population care successes into potential dollars saved. Take for example, our colon cancer screening program whereby we mail an in-home colon cancer screening kit to patients at average risk for colon cancer when they're due. That's one of our interventions in addition to many. As a result of our multitude of programs to support colon cancer screening, we've screened almost 45,000 patients or members aged 50-75 for colon cancer. Thereby, theoretically identifying 159 cases of colon cancer with the number needed to screen of 282 and preventing 51 deaths from colon cancer, again with the number needed to screen of 871. And that number needed to screen data is provided by National Institutes of Health, National Cancer Institute. It takes the controlling the blood pressure of 36 people to prevent one heart attack or stroke.

So getting a little bit more relatable and applying this logic to the Maryland exchange enrollees using HEDIS 2017 data, leads us to the following. Kaiser Permanente had 1,849 Maryland marketplace members who qualified for the controlling high blood pressure measure for HEDIS 2017. So, that includes continuously enrollment criteria, so it is a subset of our overall population of patients that we're taking care of with hypertension within the Maryland marketplace. Our screening rate was 85.6, which equates to about 1,583 patients. And, that screening rate was over the 95th percentile. The 50th percentile was 58.9 or the equivalent of 1,088 people. That difference of 495 people, of the way that we manage the blood pressure, as compared to the average health plan, theoretically prevented 14 strokes or heart attacks. If the hospitalization billing costs alone, not subsequent treatment, not professional costs, of treating one stroke or heart attack averages about $9,040 per CMS data based on billing from 38 hospitals in Maryland and assuming no complications, equals $126,550 for one condition for a small population, and that's just the differential between our rate and the average rate, not the total. That concludes my testimony on population care management and chronic condition management. Thank you, and I am happy to answer any questions."

Mr. Cardenas thanked Ms. Shapiro and Mr. Wehrle for their testimony and commended them on their attention to detail. Mr. Cardenas asked Ms. Shapiro and Mr. Wehrle how Kaiser Permanente is performing on screenings that are required for certain age groups, providing the example of the number of people screened for depression under the age of 18.

Ms. Shapiro responded:

> *"So, the depression screening for the adolescent through adult population was a first-year measure last year, so it hasn't been publicly reported with comparable information. So, I actually am not able to provide, we are just now getting the HEDIS 2018, which would be the first year that it is publicly reported. No, I am a year behind. This is the first year. I apologize. So, we won't have comparable data until next year that we can share. NCQA will provide quality compass data next year for that information."*

Mr. Cardenas asked if there was another example she could provide that could show general performance against benchmarks.

Ms. Shapiro responded:

> *"Different than the cancer screenings and the chlamydia screenings than I mentioned earlier? So, I can certainly follow-up. The ones that I mentioned, the screening populations that I have now. I can certainly tell you for our commercial population. I have that more readily available at the top of my head, but I think it may be best to follow-up with more details around specifically the Maryland exchange population. I think one of the opportunities is a small population size because our overall enrollees and when you get into these subpopulations with age, gender, etc., the denominator and the population size gets very small very quickly where small variations can make a big impact. So, I just wanted to put that caveat, but we will certainly follow-up with more specific comparison information."*

Mr. Cardenas thanked Ms. Shapiro and asked what percent of current Kaiser Permanente enrollees with hypertension can be determined as being effectively managed.

Ms. Shapiro responded:

> *"So that was our screening rate for HEDIS 2018. I'm sorry. Our hypertension, I said screening rate; it is actually our control rate. I am sorry. I misspoke. It is a control rate, and it is 85.9. Our commercial population, we three years in a row have been the number one in the country within our commercial population. And, of course we don't do anything differently for our commercial population we do for our all of our members. Hypertension control in particular is embedded into every aspect of care. Our physicians and staff are checking blood pressure at all primary care appointments, urgent care, specialty appointments, including optometry. You come in for an eye exam, you're getting your blood pressure checked. There's workflows and systems in place whereby if your blood pressure is elevated the first time, it is retaken in a few minutes or at the end of the visit. We know that going to the physician in some cases will artificially increase someone's blood pressure, but we also want to be sure that we're not just assuming that those increases are because of that reason, so we will retake that blood pressure. Depending on the department you're in, if it's primary care, it will certainly be addressed right then and there. If you're in a specialty care department, depending on the blood pressure reading, we'll either have you connect with your primary care physician right then and there, have them call you back the next day, as well for sure schedule you a follow-up appointment just to get your blood pressure checked at no additional charge within the next two weeks.*
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> *So, we have a pretty robust plan in place when a patient comes in for their blood pressure, a member comes in for their blood pressure check, there's protocol driven tool documentation and action tools built into our systems, so if the result is at goal, then the patient will receive certain instructions and the clinical staff will receive certain instructions as to how to proceed. If the result is elevated but not super high, there will be another set of instructions as how to manage it. Clearly if it is elevated, the patient will either have their medications titrated at that moment or within the next 24 hours. And then the patient receives instructions as well. We're also looking at medication adherence. A patient or member may come in, and their blood pressure is elevated. Well, we're going to ask, if they are on a medication, did you take your medication today? If the answer is yes, it is a different process than if they said no. If they say no, then we have the clinical pharmacists and the physicians and the other clinical staff nurses who can have those*

conversations about adherence to medication. If it's an issue with refilling the medication or cost, then we can work with them to address the cost barriers potentially to refilling those medications. As well as our decision support tools will notify a user when the patient has a history of high blood pressure. It tracks the blood pressure over time. I could go on and on and on, but in the interest of time, I will not."

Mr. Cardenas asked, if the state were to apply incentives onto the broader marketplace, how the state can ensure they are universally attainable given the different models administering care.

Ms. Shapiro responded:

"So, I think I mentioned it in the very beginning. I think, reliable systems and processes and accountability are three keys, and you can create reliability. You can create accountability really in any organization. Even if it is not an integrated delivery system. First, you have to know, again it's that population identification those factors I mentioned, who your patients are, how you're going to take care of them. You need to measure it. If you don't measure it, you don't know where you are, and I think all of those components are transferable even outside of the integrated delivery system."

Mr. Cardenas asked if an issuer's performance on the clinical management QRS sub score is indicative of both chronic disease management and preventive care and if it is holistic enough to be utilized as a proxy for performance on those.

Ms. Shapiro responded:

"I have to be honest. I am going to have to follow-up with you on a later date. I am going to have to look at it in a little more detail before I can responsibly answer that question."

Mr. Cardenas explained that, in contemplating incentives, the state does not want to over-burden the issuers, so the state would be interested in any existing proxies that could be leveraged.

Mr. Wehrle responded:

"JP, the one thing that I would add is there are specific, you identified one of the specific sub cohorts. I don't know what the right term is, but you identified one of the subsections of the QRS. But, the HEDIS and CAHPS measures in general, the advantage that they have, and there are some that we perform on better than others, we are no different than anyone else in that regard, but they are very familiar to issuers, to providers. You know, I don't want to speak for Deb, but I know that CareFirst tracks HEDIS data and reports it, so you're not having to reinvent the wheel with some other set of measures. So, whichever specific ones you pick or whether you go for an overall, we do think there is a lot of merit in looking at HEDIS and CAHPS. It's been around for a long time. It has also been validated as good, strong measures with things like consistent enrollment to have an opportunity to make it a good comparison. So, we would kind of point to that as something that is more familiar."

Mr. Cardenas, noting that a big portion of the QRS quality measure is based upon the CAHPS score, raised concern about low income population participation and ability to participate in such surveys. Mr. Cardenas asked how the state can be certain that they are not masking how health plans administer care to lower income populations if the state leverages the QRS or one of those measures. Mr. Cardenas also asked if Kaiser Permanente has any outreach in place that is specific to low income populations.

Ms. Shapiro responded:

"So, in a nutshell, the care is available to everybody right? But we do recognize that different populations have different barriers to receiving care, so we do a lot of data analysis to understand populations, subpopulations, sub-subpopulations. And how we can best meet that group's needs. When we talk about making care convenient, it's things like telemedicine, video visits where someone who may be working, may

not be able to take time off of work, but may have a 15 minute break, can potentially receive care during that 15 minute break on a phone call or video visit at no additional cost. There is no copay for those particular visits at this time. Secure messages, you know you finish, you get home from your activity, whatever it is. You can email your physician and get a response overnight without having to come into the office. And so, by providing care in many different ways and different approaches, we can potentially try to reach a larger audience.

One of the things I didn't mention before, and it's not directly tied to low income, but I do want to mention it because it's related to subpopulations and data measurement. Is we also are looking at our variation of performance across different age groups and different races, spoken language, and ethnicities because we don't want to have variation. We're providing care the same way, but people respond to how care is received to them. Everybody has different approaches to how they take care of their own health. They have different social norms, community norms, and so, we do measure the variation, and we try and create alternate methodology, messaging, technology, tools to ensure that we are closing that care gap. One of those examples is around high blood pressure. Recognizing that traditionally certain people who self-identify as African American tend to have a lower rate of control, so creating, not excluding, but just monitoring and being aware and ensuring that people are receiving it and having blood pressure control that is the same no matter what. And our rate over time, our gap has decreased and is something that we're looking very closely at. Same thing with age. How an older adult is going to approach their care is very different than a millennial for example. And so, people respond differently, so you need to provide care differently for those populations."

Mr. Cardenas asked about Kaiser Permanente approaches in addressing morbidity due to depression and specifically asked if their approaches have resulted in a reduction in morbidity.

Ms. Shapiro responded:

"As you mentioned, NCQA is just starting to measure depression screening. Although depression screening is one aspect of managing depression, certainly we have quite a robust and integrated approach to managing depression. Starting from monitoring, promoting the use of an evidence-based tool, the patient health questionnaire-9, which is a tool that helps to identify, diagnose, and track the treatment plan for patients who have been diagnosed with major depression. Into that tool is integrated into our processes in primary care and behavioral health and maternal and child health. Our prenatal and postpartum care program pays particular attention to not only depression, but also anxiety and other mood disorders as part of that prenatal care screening program and also postpartum. So, not only are we providing the PHQ-9, or the patient health tracking tool in the office visit as a tracking tool, but we are also emailing it to patients to ensure that even if they are not in the office, we are staying in touch with them.

We're looking at medication adherence with depression medications and not only through the HEDIS measures but also in our EMR. Users can see not only the depression adherence rates but also all of the chronic condition adherence rates, so when you're taking care of a patient you can actually look and see. We have a threshold at which we'll start to do interventions for that population. We know that people with depression and diabetes have a higher likelihood of hospitalization. I don't have that data here that I can share with you, but it is something that we have integrated into our programs. Doing depression screening with our case management program, so that when a patient enters the program, we are trying to identify whether they have a diagnosis and triaging them from there."

Mr. Wehrle responded:

"The integration of the questionnaire is a fairly new intervention I had thought in the last couple of years."

Ms. Shapiro responded:

"Probably has been about three plus years now. That it's available."

Mr. Wehrle responded:

"So this is an effort, I know a little bit about. This is an effort where we affirmatively are using doctor visits and other encounters to look for depression as opposed to waiting for someone to tell us that they have it. That is as you know, with that condition that is a pretty big part of it."

Ms. Shapiro responded:

> *"We also have total health assessment that our members can complete, and there are trigger responses including depression for the measure I had mentioned in my formal testimony. The member portal online tool is another avenue where you can complete the questionnaire. Also, our health encyclopedia. There are multiple ways that people can do self-assessments. We also have a tremendous amount of emotional health, as well call it, support on our website with podcasts, physical activity support. Looking at emotional support self-care in a multitude of ways because different things are going to work for different people. It's not all about the medication, but we do have behavioral health services available urgently as well as routine where members can participate in individual or group therapy as well."*

Mr. Cardenas asked if telehealth services are accessible for behavioral health.

Ms. Shapiro responded:

> *"I don't recall. We will check. Certainly telephone visits are for sure. Secure email message for sure. Obviously secure email message is not going to be the preferable way if someone is in a crisis, but all of our care providers in all of our departments have the ability to secure message and set up telephone appointments as well."*

Beth Sammis, President, Consumer Health First, Board of Directors, offered the following testimony:

> *"We will take this time, since it is the last meeting, to thank you for the open and deliberative process you have engaged in around reinsurance and of course, for the opportunity to address you today on behalf of consumers across the state. I am Beth Sammis. I am President of Consumer Health First, and Leni Preston is with me today, who needs no introduction, but formally, she is the Vice President of Consumer Health First. We are going to do a little bit of tag teaming today. I have provided comment to you on July 26 regarding the priorities and objectives for the state reinsurance program. Just to recap what we said then, from a consumer perspective, the priorities and objectives should be to lower premiums in order to maintain or lower the state uninsured rate. This should be done in such a way that the subsidization provided by HMO members to PPO members is lower in order to maximize the premium reduction for the most popular and medically managed product, the HMO.*
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> *We were unable to attend the subsequent hearings, and so we want to take this opportunity to quickly present our views on the questions addressed at these hearings. It won't be a long thing. I promise you. At the August 2 hearing, you asked for public comment on the objectives for modifying reinsurance payments to account for overlapping risk adjustment payments. Virtually, all of the risk adjustment payments made by Kaiser go to offset the claims costs for CareFirst PPO products, and note that the CareFirst HMO products did receive some risk adjustment payment this year. But, I think I did the calculation before I went on vacation, and it was like 95 or 97 percent of the risk adjustment payment went to the CareFirst PPO. The objective here should be the same as for the reinsurance program generally: to lower premiums, to maximize the premium reduction for the most popular and medically managed product, the HMO. To us, this means following more closely the dampening methodology that was suggested by Wakely.*
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> *The second set of questions posed for the August 2 hearing were centered on how to create incentive funding for the state reinsurance program. We would reframe this question and ask should the state reinsurance program include an incentive program or should the goals of incentives be attained through contractual measures. To this question, we would submit an incentive program is not needed if the*

reinsurance program accounts fully for the overlapping risk adjustment payment using the Wakely methodology. Wakely's methodology results in a lower premium for products based on their degree of medical management. The premium reductions are highest for the HMO products, which are more tightly managed. I think it's fair to say with what we heard today, Kaiser is a highly, tightly managed product. CareFirst HMO is a little less so, but nonetheless is more managed than their PPO. The lowest managed of course is the PPO itself. Incentives are only needed if the MHBE moves forward with the MIA methodology, which lowers the PPO premium more than is warranted given its looser medical management. Now, I know from last time that CareFirst maintains that its utilization management and quality improvement policies are the same, but the fact is that PPO members can and do go out of network. When they go out of network, they receive care from physicians with no financial incentives to adhere to CareFirst programs or to try to help those members and encourage them to join CareFirst PCMH program in particular.

The August 9th hearing posed questions about existing incentives to manage care both in terms of utilization management and quality improvement. CareFirst noted, more PPO members are enrolled in its PCMH program than HMO members. What we don't know is this, I am as nerdy as you. I listened to the phone conversation while I was on vacation. Why then, are claims costs so much higher for PPO than HMO members. Is it because of the differences in demographics, such as their age, sex, race, place of residence? Is it because of differences in health status? Is it because of the nature of the product? The ability to go out of network versus staying in network. Or is it because overall the percentage of PPO members with ongoing chronic conditions or costly acute conditions enrolled in PCMH may be higher than the HMO but is overall relatively low? We didn't hear exact numbers last time. Again, our position is this, if the MHBE moves forward with incentives, they should be based on actual performance in the individual market, documenting year over year performance in the enrollment of HMO and PPO members in care management programs that are designed to lower claims costs, particularly for the PPO.

That brings us to the questions posed for today's hearing regarding chronic diseases and population health, and for that I am going to turn it over to Leni, who finds these questions much more interesting than I do."

Leni Preston, Vice President, Consumer Health First, Board of Directors, offered the following testimony:

"I want to start, again, by thanking you for this very thoughtful and open process. The MHBE has really set the standard for this, and as consumer advocates, we are so appreciative. If you do not know, Consumer Health First's mission is to advance health equity. Meaning that everyone has the ability to attain their highest level of health, and within MHBE's context, that is applicable by promoting policies that increase access to comprehensive, affordable, and accessible healthcare. Given that health equity is one of MHBE's statutory principles, we would simply encourage you to use that lens as you develop not only the reinsurance program regulations, but in fact analysis of any policies or regulations. It's impossible to successfully advance health equity or in fact to address the questions that you've posed for the reinsurance program without actionable data, which we heard a lot about from Kaiser just now.

So, I want to focus my remarks on that and also provide some recommendations on the value-based design issue. So, Beth, by inference, referenced the need for data in regard to gaining a better understating of those who are in the PPO plans, and to do that and to gain a greater understanding overall of the individual market. We believe it's critical that MHBE, and in fact all relevant agencies and stakeholders, have access to comprehensive and stratified data that includes age, sex, race, ethnicity, and language as well as gender, gender identity, sexual orientation, disability, socioeconomic status, and geographic distribution. And we are not blind to the fact that gathering and analyzing that data is a challenge, but we believe that without such knowledge and evidence, you simply can't make informed and effective decisions whether it be about incentives or anything else. So that brings me to what I believe is another critical element that is unique to Maryland.

You mentioned the Total Cost of Care contract, and we believe it is absolutely critical that there be a

complete alignment in the collection of standardized data, as well as other relevant policies across all of the healthcare initiatives. We're wasting time and energy if we're not creating a greater standardization here. We've spoken often of the importance of not only alignment but integration of private and public insurance with the delivery system transformation initiatives. Something that we will keep beating the drum about. With the signing of the Total Cost of Care contract, it is critical that these new programs have performance measures and policies that are designed to drive a unified approach leading to success on all fronts. And those measures and policies have to promote both the reduction in health disparities and opportunities for health literacy and for consumer engagement. I've often been told that I don't need to worry because all the agencies are holding hands, and my response is that's not good enough. You need to get in bed with each other. So, we're working towards that goal I'm sure. Specific to your request for input on chronic disease and population health, I would note, of course, the national resources, some of which have been cited. We believe the useful state example is the model of the Oregon Health Authority, which through statute, created a health plans quality metrics committee to 'Identify outcome, quality, and equity measures,' (Note the equity measures.) 'That may be applied to services provided by coordinated care organizations or paid for by health benefit plans sold through the health insurance exchange or offered by the Oregon Educators Benefit Board or the Public Employee's Benefit Board.' I would note one of the measures that they've incentivized as an example is enrollment in patient-centered primary care homes.

Let me wrap up with value-based benefit design. In 2014, actually when the issue last arose, we and 16 other organizations submitted comments, which at that time focused primarily on the process that had been used, which we felt in our usual way lacked transparency and consumer engagement and the type of engagement that we are now engaged in. So, today I just want to share some of the criteria that we think would be important as you look at this issue. And that the program has to be based on rigorous evidence of improved outcomes with a publicly available, independent assessment. It must ensure that all information on the plans are comprehensible to all consumers at the time of plan selection, so that will require standardized and multi-faceted communications. Obviously, it has to be designed to avoid risk selection and therefore, should probably be considered sold off and on the exchange. There has to be equal access with no discriminatory impact, and to determine that of course, we need stratified data collection. There has to be analysis to identify unintended consequences specific to cost sharing variations. Those should identify among other things, the cost saved for variations that are reflected in reduced premiums, and that specific subpopulations are not actually worse off as a result. And, comprehensive reporting as always to determine overall effectiveness that is both transparent and available to the public. So, again, thank you for the opportunity to provide the perspective of us as consumer representatives, and as always, look forward to working with you in the future."

Mr. Cardenas thanked Ms. Sammis and Ms. Preston for their testimony and asked them to provide more insight on utilizing contracting process instead of including incentives in the construct of the reinsurance program.

Ms. Sammis responded:

"So, obviously one of the key ways to do that is to say that, contractually, health plans are expected to do the following and to make measured progress. Right? I know that that is a challenge because there are not an enumerable number of health plans participating. I realize that, but I think if you look at other states, that is generally the way in which they have done these incentives. I think our concern is really more that the money is here in the reinsurance program to lower the rates, particularly in a fairly dramatic way the first year. To the extent to which money is siphoned off from that program that takes away from that goal and because the individual mandate has been taken away and because of things that I don't want to talk about are happening in the world, I think that 2019 is a pretty crucial year. And so, just making sure that that money is there to maximize continued participating in the individual market seems to us to be the most important thing. And again, you know, designing incentives about quality measures, health equity measures, particularly because we know the PPO is the problem. How do we do that without more data? Right? And so, we could incentivize and incentivize around things that turn out later to be wrong, and then, we have taken money away from lowering premium at a time at which it is critical to keep people in the individual market."

Mr. Cardenas acknowledged that data reported at the aggregate level can mask subgroups and stated that the Exchange is interested in potential differential outcomes between people enrolled in cost sharing reduction plans and people who are unsubsidized. He emphasized the need for issuers to consider their members' incomes.

Ms. Sammis responded:

> *"I would be remiss if I didn't say this. The reason why we are so concerned about the PPO performance is that the HMO members, particularly from Kaiser, are subsidizing the PPO membership. And so, the risk adjustment payment is actually, the rates would be lower absent the risk adjustment. I understand and support the risk adjustment payment completely. It's just that because of the, as you know, the structure of the risk adjustment payment and its basis in terms of the average premium. The delta between that average premium makes it such that the subsidization is far greater and makes our market so much different than everybody else and so much more challenging to stabilize."*

Mr. Cardenas acknowledged her concern and emphasized the need for the state to create a reinsurance program that encourages additional market entrants, such that the burden of risk adjustment payments are spread out across different entities.

Debbie Rivkin, Vice President Government Affairs, CareFirst BlueCross BlueShield offered the following testimony:

> *"For the record, I am Debbie Rivkin, Vice President of Government Affairs for CareFirst BlueCross BlueShield. Today's discussion, which is on leveraging reinsurance to try to impact utilization management of high claims for chronic disease and also, population health, looking at underserved population and preventive care wellness. While that is really important, the looking at population health and utilization management, it's not going to surprise you, it's consistent with what I have said at every other hearing. We absolutely do not believe it's appropriate to be done through the reinsurance program. As I have said, and I will say it again to anyone who wants to listen, it's extremely important to use the money to get the rates down as low as possible in the next two years, so we can start stabilizing this market. That is the only thing the money should be used for, so that is my overarching statement, again. Therefore, I can't really directly answer your questions because we should say no. It should never be done through the reinsurance program, and that's what you were asking.*
>
> *But, I will say that we really do believe that it's important to look at these things, and it's important for the state to do so. But, I want to caution that not only should it not be done through the reinsurance program, we would say it shouldn't be done just in the individual market alone. That would be a big mistake. If you really want to have a meaningful impact, and I mentioned this last week as well, you need to look at all market segments. You need to look at the individual market, the small group market, the fully insured large group market, and the self-funded marketplace. And that's really important, and let me explain why. If you look at the Maryland Insurance Administration Covered Lives Report for 2017, and you could look at every other year prior because what I am going to tell you is very sobering because the numbers are getting worse each year. When you look at Maryland state law and who it applies to, insurance law, it's less than 20 percent of the population that is under 65. Around 19 percent of the population under 65 actually have state laws apply to them, and that also translates to around less than 35 percent of all covered lives are within regulation of the state law. So what does that mean? Almost 70 percent of anyone with insurance either has a self-funded plan, Medicaid, Medicare, but they are not regulated by the state. So, if you drill down for that a little bit more, you have this small, under 20 percent, the individual market is a fraction of that. So, you really aren't going to get the results you're looking for if we just put metrics in the individual market. It's too small to bend the curve or to move the needle.*
>
> *Something I mentioned this last week, and I tried to get some more statistics. I told you that we find that members stay with us, but they don't just stay in one market segment. People change jobs. They have life changes, life events, so you could start in the small group market, end up working for the state for a couple of years and then moving into the individual market and then back to a small group plan again. We have*

found, I've looked at since the ACA started since 2014 to 2017, just about 70 percent of our members have stayed with us. That doesn't meant they have stayed in the individual market, those that were in the individual market or those that were in the small group market. Like I said, they move back and forth. That is another reason you need to look at the continuum because if you're just going to focus on CareFirst's population in the individual market, Kaiser's population in the individual market, you're missing the vast majority of opportunity to really make a difference. The other thing is change doesn't happen overnight. Behavior change doesn't happen overnight, nor does changing someone's health condition happen. It's a long term process. We've had our PCMH program in effect, I think it's over around seven years. We're starting to see success, but it takes a while because you have to change physician behavior, patient behavior, and also move outcomes. So, that's the other reason why you have to look across the continuum because no one is just sitting in the individual market, they're moving. So, that is my big messages if we're going to move somewhere as a state, we really have to look at this in a bigger picture, and we want to be a partner in that. We want to sit down and have that conversation, but it cannot be done in the individual market to make any difference. We would recommend you not to move forward in this but to be part of a bigger conversation.

Secondly, you asked about what's happening right now, I guess, to expand preventive care and chronic disease management. I just wanted to come up, tell you a couple things. Some you have heard about already. I don't want anyone to lose sight of the fact that the ACA itself did a great job to help expand preventive care because of the zero cost share. So, all preventive care is basically free for an individual, so what you heard Kaiser Permanente do, which is wonderful, and I can tell you that our PCMH providers do as well, is they engage their members. You heard Jennifer talk, when Jennifer Baldwin came with me the other day. Jennifer spoke about how important the whole PCMH program incentive is. A big component of that is member engagement, so the PCMH providers, or PCPs, are telling their members get the screenings, get what you need, and they are free. So, I think the ACA, number one, did a great job because you should be able to get that because it's not going to cost you anything. We also told you about our PCMH program and our TCCI support, so we think that also is helping those members with the complex and chronic care conditions.

So, we are looking at the two ends of the spectrum. We are engaging our members to get the preventive services they need. We're focusing on our members that have chronic care conditions. Again, it's really important that they stay well-managed because they'll have breakdowns. Something that I don't think was really focused on when you were asking me questions last week that I just want to mention. You said, 'How many people are in care plans?' That's not really the point because you could have members that have MS or diabetes, and so, we want to focus on those members to make sure that they are being well-managed. And they may already be well-managed. They're not having breakdowns, so we don't need to put them in a care plan. We need to monitor them. We need to know that they're getting the care that they need, that they're staying on their meds, that they're having strong engagement with their physicians. They might not need, they're doing great, and so what we do is we try to find those members that are not managed. That need more provider engagement and get them into care plans because they are not a well-managed member. Those are the people who are going into the care plans, but we are still looking at everyone with certain disease states to make sure that they are managed.

So, I would argue to you that through our PCMH program, we are a highly managed program and that goes for our PPO and our HMO. It does bother me when people say that our PPO is an unmanaged program or unmanaged plan. Yes, we allow people to choose what doctors they want to go to. I will tell you that the statistics show that less than, I think, it's around I think 98 percent and I can get the full statistic across all of our products, you know small group, individual, large group stay in network. We don't have this huge migration out of network because we have a large network to begin with, and again, the primary care physician is the one that's doing the management. So, you may go out of network for something, but it is still being managed by the primary care PCMH physician, so there is still controls that are put into place. It's as I said, we have more members in care plans. That's because the individual PPO member is sicker, and they're older. We've said that to the MIA when we showed them why the rates are where they are, unfortunately. We find that the sickest individual is picking the PPO, but we are managing them to the best way possible. So, it is still a managed plan within the confines of what the product looks like.

When we find someone who is not managed, and we want to get them under control for their conditions, we make sure that they don't have gaps in care. They probably have multiple chronic conditions. They're probably not taking their meds. That's when we pull in the TCCI programs and the PCMH programs, so it's only in those instances that it's really necessary. We also have, I would say, value-based benefit designs, and I know you asked about that, so I just wanted to give you a few. Again, we think our PCMH program is value-based because our providers are incented, you heard Jennifer talk about that, to engage and make sure people are in the right, get the right care, in the right location, and at the right time. So, those incentives are value-based benefit designs. We also have our cost share waiver which you heard about last week as well. We think that's novel. We are the only one in the country, we believe, that does this, so not only do we encourage people to go get their preventive care because they don't have to pay for it. If you're in a care plan, we want to make sure you don't have a barrier because the cost is high for that copay, so we waive the copay in your care plan for sick visits. To see your specialists because we want to make sure that the individual is getting the care they need, when they need it, and that they're not delaying care because of cost. We're the only one that's doing that.

Finally, we also have something where our benefit design is incentivizes the member to go to the less costly sites of service. Now, they can go anywhere they want, but they are going to pay more for some versus others. If you go to a hospital-based setting, it is more expensive. You will have a higher copay or coinsurance amount. There's a whole continuum. If you go to a lab that's on hospital grounds, it costs more. You'll pay more. You go to LabCorp, you're going to pay less. So, we do that, and we let people know if you go to your primary care doctor, you go to a specialist, you're going to have a lower copay than if you do something on a hospital setting. If you go to an urgent care center, you go to a CVS or Walgreens clinic, that's going to be less than other settings. Depending on what lab you pick, so we try to give the patient the ability, you can still go somewhere, but it's going to cost you more. So, it is another plan design we have put in place to incent members to go to a lesser costly sites of services. And so, that is something else we do for value-based design. That's everything I wanted to say on this topic today, so unless you have any questions for me."

Mr. Cardenas thanked Ms. Rivkin for CareFirst's active engagement in the process and for providing information on what CareFirst is doing. Mr. Cardenas acknowledged Ms. Rivkin's comments on the specific focus on the individual market and stated that any action taken in the individual market will have important impacts because in other product classes already there are incentive structures in place, particularly in the large group marketplace, Medicare Advantage, and the MCO space. Mr. Cardenas stated that there is a degree of incentives all of those, so the individual market could be a complimentary space for that.

Ms. Rivkin responded:

"May I ask you a question? You just said Medicare and Medicaid, but not all carriers are in Medicare and Medicaid, so you might think that there is a spectrum, but you have to look at the marketplace and see what is there. Right? So, you have a number of carriers who are not in the individual market at all, and yet they have members in other market segments or in the small group market or in the large group market. Don't we want to incentivize everyone? Don't we want to get a whole population? You got to look bigger to see that there's other carriers that are not playing in this space, and there are carriers that are in different market segments."

Mr. Cardenas stated that the individual market is the only place where there is a degree of risk magnification in a specific product, and if you are looking at other markets, it is more distributed due to additional actors in that space. Mr. Cardenas added that the individual market is important and incentives are impactful because individual market enrollment is directly linked with the number of people who are uninsured. Mr. Cardenas asked how CareFirst assesses members and makes the determination to place members into wellness plans based upon the data.

Ms. Rivkin responded:

"I would rather come back and tell you. I think there are six different areas that we assess. I mean it is cost

of services, whether someone has chronic conditions. We also look at particular conditions, but if we for example have MS as one of those conditions, and then we go look at every single member who has MS. We will say, this person is managed. They're on their drugs. They never miss that. They go to every appointment. Their PCMH physician is doing a great job with them, and their specialist is doing a great job. So, we review, but there are six specific categories that we look at and cull through the data to make sure. But, no matter where you end up, if you're in a care plan, or we think you're well managed, we continually, monthly look at that data, and we go back and share that with the doctors and the nurse coordinators that we have throughout the region to go back to the physicians to say, hey, this member is starting to have a breakdown, or we're starting to see a problem here. So, they may move in the continuum, but we are constantly re-evaluating that data to see where you are in the spectrum to make sure you're getting the appropriate care you need to either stay healthy or to try to move you back towards that healthy area or stabilize you."

Mr. Cardenas emphasized the importance of reporting this information because of the notion that it is an unmanaged product.

Ms. Rivkin responded:

"And I maintain that's really unfair because somebody says that doesn't mean it is. Can I just jump in for a second? Because I think it's wrong. When I can say to you that it is not unmanaged because we have more individuals in our PPO that are in care plans, and we have more than in the HMO. We have more individuals in the individual market than we do in other. It is based on the illness and the chronic conditions and the multiple chronic conditions and whether or not they had barriers to get stabilized. And so, it is highly managed, so when people say that, I think it's a misnomer, and it's one of those things that becomes something that sounds good to say, but it's not true. It is not true in another aspect I would argue and submit to you to consider. In our self-funded marketplaces, our plans, including the state of Maryland, including school systems, it is their money when they self-fund. They all insist on a PPO. If they thought it was really this unmanaged, wild wild west that anybody could do anything, they're looking at how much they're spending on those numbers. They want the PPO, and they ask for it. So, when you have someone who's the steward of their own money, and I'll use the words that you've said about being the steward. You're the state of Maryland, and you say that you will have a PPO for my members. They would not do that, I would submit to you, if they really felt that this was something that we take a hands-off approach and people can go anywhere they want, and their costs would be through the roof. I would ask everyone, you and everyone behind me, to really reconsider saying PPOs are unmanaged because that is not true, and we have different results in the cost structure in our PPO in the other market segments. There is something about this segment. They are just sicker, and they are older. It's not because it is unmanaged."

Mr. Cardenas clarified that his questions are not intended to reaffirm the statement that the product is unmanaged but to provide evidence to substantiate the opposite. Mr. Cardenas stated that it is clear that CareFirst does make the determination as to whether a person is managed or not. He added that different market segments have different rationales for preferring the PPO product and stated that it is important to consider the uniqueness of the individual market. Mr. Cardenas thanked CareFirst for their action, presence, and transparency.

Mr. Cardenas stated that at the rate hearing on July 30th, it was reported that 3.2 percent of CareFirst's individual market enrollees are enrolled in wellness plans. Mr. Cardenas asked if CareFirst has any plans to increase the percentage of their population enrolled in wellness plans.

Ms. Rivkin responded:

"So, let me correct that, again, I think you meant in our care plans. Well, I just described to you that one of the reasons that is happening is because there might be other people that are well-managed. So, what we were doing is trying to find in that population. So we take the top stratum of our pyramid, and we take the different data that we have. We go through the data and we try to find who are not managed. Just because you hear that number doesn't mean we are not doing the right thing because we are still looking at the rest

of the population. They don't need to be in a care plan, or they don't need some of these supports because they are doing just fine. So, I think you have to look at it that way. If you want us to come back and give you some more information. You want to sit down. You want to come to CareFirst. We can certainly bring people to the table and sit with you, so you can ask the questions. But, that doesn't mean it is a small number. It means we are doing the right thing for that population that needs a care plan and needs the support. Others may not."

Mr. Cardenas suggested that the appropriate measure to relay may then be the percentage of members in care plan target population who are enrolled in care plans. Mr. Cardenas thanked Ms. Rivkin.

Maansi Raswant, Vice President, Policy & Data Analytics, Maryland Hospital Association, offered the following testimony:

"Good afternoon. I promise to be short and sweet. For the record, Maansi Raswant, Vice President, Policy & Data Analytics with the Maryland Hospital Association. Want to start off by thanking the MHBE for having a great set of hearings over the past few weeks. It has been definitely really helpful to learn, so hospitals do support wholeheartedly the 1332 waiver and the development of the reinsurance program. I think we have gone on record and been happy to be engaged in this process. Broad-based coverage has been integral to the success of the All-Payer Model, and I think it's going to be even more critical as we move to the Total Cost of Care Model where were focused on accountability for whole person care as you know. And also, have an increased focus on population health. We did advocate for the inclusion of care management incentives in the reinsurance program, and to that point, I want to thank the state for seriously considering care management incentives. It has been very helpful to learn about the programs that carriers have in place around some of the measures that we think could be helpful. I think to that point I also want to thank the state for the questions that they have asked around those programs because, I think Michele even asked last time, around parlaying to savings. How some of these programs translate to savings. Your questions around whether we are actually hitting the target populations are important.

So, we do believe that the addition of some incentives provides the opportunity to align coverage and delivery, and especially for this vulnerable population, given that we are headed to the Total Cost of Care Model. We agree that the primary objective of the program is to get it underway and to be able to provide some cushion against large claims, but for the long-term stability of the market we think we do need to address the underlying high cost of claims. So, whether those measures are focused on utilization and quality to deliver high-value care or on chronic conditions that decrease the morbidity of the pool or on population health that increases the healthy enrollees or ideally all of those combined. We do believe there needs to be some focus, so we hope that you consider the addition of care management incentives for long-term stability. I think echoing some of the points that Beth and Leni have made. I just want to reiterate our support and want to mention that as we head to the Total Cost of Care Model, I think you will see hospitals. They've been engaged in this, but we would like to seek more opportunities to meaningfully engage in better linking coverage and delivery. Thank you."

Mr. Cardenas thanked Ms. Raswant.

Dourakine Rosarion, Special Assistant to the Director, Montgomery County Department of Health and Human Services, offered the following testimony:

"To follow protocol, my name is Dourakine Rosarion. I am with the Montgomery County Department of Health and Human Services, and as with all previous speakers, thank you so much for allowing us the opportunity to share our thoughts. HHS serves as a connector entity partnership with the MHBE. We have served as an outreach and enrollment provider since the first year of the ACA, and in our experience, we are very pleased to see that there are efforts being made to keep the cost of care manageable. Our clients who come in for in-person enrollment assistance, they're making very difficult decisions in order to maintain health insurance coverage, and our hope is that since all of the relevant agencies are dancing, that there will be an incentive, to meet our enrollees, a greater bridge towards meeting our enrollees

halfway. Care and health and wellness happens outside of the clinics and the hospitals, and what we are certainly in support of is ensuring that community health workers, a focus on equity, really looking at the health disparities that are present within all of the jurisdictions within the state are really focused upon in order to really impact the health and wellness of insureds inside the exchange, outside the exchange does not matter, all Maryland residents should benefit. If incentives that go along these lines are not incorporated within the waiver funding, then are there opportunities to really partner with community agencies that will be able to support health literacy and really look at other ways in which we could work with community partners in order to ensure that residents are able to follow through on care plans, understand the medications that they are provided, and ensure that they're able to access care effectively.

So, we see a lot of residents that churn between MA, Medicaid eligibility and the QHP marketplace, and so with that comes a lot of changes, and sometimes it takes a while for a resident to really be able navigate a new system, a new set of terminology, new providers, perhaps. So, it really does beyond looking at the dollars and cents of how we implement the waiver program, if approved and really looking at the entire universe, the ecosystem that an enrollee has to navigate. I don't think I could show up to the next all CE connector entity meeting without really putting in a plug for what we're experiencing as boots on the ground in partnership with the MHBE and really sharing some of the challenges that we're seeing as individuals are really committed to maintaining the care but still need some hand holding to ensure that they know how to effectively access the plans that they have. Similar things have been shared the first three sessions, and I think all of the other voices have really advocated for looking at the ways in which to support insureds. We definitely want to make sure that during this particular session that that goes on the record as well."

Mr. Cardenas asked Ms. Rosarion to speak to continuity of care with respect to the churn population.

Ms. Rosarion responded:

"Well, within our churn population, once the determination is made…So, if an individual comes in, and they are slightly above income, it becomes a very significant financial decision that needs to be made for the household. Often, we may have some households who decide, I am going to hold on making that decision at the moment, which essentially may mean we are not going to have coverage or not the entire household will sign up coverage. So, it is a very difficult decision to be made, and it is one that is made under significant duress as our households manage mortgage, rent, and other life necessities, while also trying to decide, okay what kind of plan are we able to afford, if at all. Then, our individuals who may be going from QHP to MA due to life changes, there's a different set of terminology, a different set of providers that they may be working with, and that's a learning curve in and of itself. So, if you're within the QHP marketplace and within the Medicaid enrollees, if you are new to the system, you do need additional support, and if we are not able as a state of interested and committed partners to do so, we are definitely failing our residents."

Mr. Cardenas stated that the agencies are working together on a continuity of care report that they will be providing to the Legislature and emphasized the importance of issuers considering how they manage and screen new enrollees at the lower federal poverty levels for existing conditions that could impact risk pool as well as how issuers mitigate that risk as they transfer from system to system.

Ms. Rosarion responded:

"Montgomery County is well-resourced, that is true. However, we do have clusters of need where we see that there are significant health disparities. We have been a CE from the very beginning, and our recent health status report indicates that disparities still exist, social determinants of health are impacting our residents. We would love to share with MHBE and anyone who is interested, our health status report where we really look at the data, how as a county we have significant areas of need and the demographics that are shifting within our region to help support some decisions that may be coming down the pipeline."

Mr. Cardenas thanked Ms. Rosarion and asked her to share that report.

Mr. Cardenas then invited any attendee on the phone or in the room who so desired to offer testimony for the record. No one offered testimony.

Ms. Eberle, Executive Director, Maryland Health Benefit Exchange, thanked Mr. Cardenas for conducting the hearings and everyone who attended the hearings and presented information. Ms. Eberle added that all of the input provided has been very helpful and informative.

Closing

Mr. Cardenas thanked everyone for their participation in the hearings. Mr. Cardenas closed the hearing and thanked everyone who attended.

Participants

Maryland Health Benefit Exchange
Michele Eberle, Executive Director (by phone)
John-Pierre Cardenas, Director of Policy and Plan Management
Aaron Jacobs, Director, Organizational Effectiveness and Human Resources

Maryland Department of Health
Laura Goodman

Members of the Public
George Canova
Diane Lawrence
Laurie Kuiper
Natasha Murphy
Leni Preston
Maansi Raswant
Deb Rivkin
Dourakine Rosarion
Beth Sammis
Stacey Shapiro
Jared Sussman
Bill Wehrle
Bryant Woodford