Maryland Health Benefit Exchange
Board of Trustees

November 15, 2021
2 p.m. – 4 p.m.
Meeting Held at the Maryland Health Care Commission and via Video Conference

Members Present:
Dennis Schrader, Chair
S. Anthony (Tony) McCann, Vice Chair
Dr. Rondall Allen
Kathleen A. Birrane
Mary Jean Herron
Ben Steffen, MA
Dana Weckesser
Robert D'Antonio, PhD

Members Excused:
K. Singh Taneja

Also in Attendance:
Michele Eberle, Executive Director, MHBE
Andrew Ratner, Chief of Staff, MHBE
Venkat Koshanam, Chief Information Officer, MHBE
Sharon Merriweather, Principal Counsel, Office of the Attorney General
Johanna Fabian-Marks, Director, Policy & Plan Management, MHBE
Heather Forsyth, Director, Consumer Assistance, Eligibility & Business Integration, MHBE
Raelene Glasgow, Procurement Manager, MHBE

Welcome and Introductions:
Vice Chair McCann opened the meeting and welcomed all in attendance.

Approval of Meeting Minutes
The Board reviewed the minutes of the October 18, 2021, open meeting. Mr. McCann requested that the minutes be revised to clearly indicate that that the Maryland Health Benefit Exchange (MHBE) staff were directed to develop a plan for the young adult subsidy cap and present it to the Board during the November Board meeting. Mr. McCann moved to approve the minutes and Ms. Herron seconded. The Board voted unanimously to approve the minutes with the revision.

Public Comment

Mr. McCann invited members of the public to offer comment. No comments were offered.

Executive Update

Michele Eberle, Executive Director, MHBE

Ms. Eberle began her remarks with follow up from the last meeting. Mr. Steffen had asked whether the MHBE will poll the producers to determine why there are so many coming into the marketplace. Ms. Eberle responded that the MHBE will conduct a survey of producers after open enrollment ends. Dr. Allen had previously indicated that the two universities on the Eastern Shore were interested in being involved with outreach activities, so the MHBE helped schedule a meeting between these universities and the Connector Entity in the Lower Shore to discuss how public health students can collaborate on activities to support enrollment.

Ms. Eberle next reported that open enrollment started on November 1, 2021, and is off to a good start. She thanked the MHBE staff and community partners for launching open enrollment using remote and hybrid methods. At 15 days in, enrollment is trending 2% higher than last year at the same time. So far, almost 48,000 young adults have enrolled, with 63% receiving subsidies. Compared to enrollment before the pandemic, there has been a 74% increase in enrollment in exchange plans without financial assistance and a 101% increase in dental plan enrollment. MHBE staff are continuing to monitor the activity on the federal Build Back Better bill; currently it appears that the enhanced premium tax credits will prevail in the bill.

Ms. Eberle then provided a staffing update and introduced new staff members: Victor Norris as the manager for small business programs and Megan Neal as the instructional designer for training. Sharron Merriweather, Principal Counsel, introduced Blake Barron the new assistant attorney general to the Board. He was previously an assistant attorney general for the Maryland Transit Administration and will primarily be working on procurement. Mr. McCann asked if there were any remaining issues from the 2016 lawsuit. Ms. Merriweather responded that it has been resolved.

Ms. Eberle noted that there are two open solicitations: one for a technical writer that closes tomorrow and another for an independent assessor of information technology (IT) security that closes on November 30. The ten-year MHBE annual report was recently released. Mr. McCann congratulated all of the MHBE staff on their hard work and accomplishments over the past several years.

Standing Advisory Committee Report

Dana Weckesser, Board Liaison to Standing Advisory Committee

Ms. Weckesser reported that the Standing Advisory Committee (SAC) met virtually on November 4 and discussed several items. The first agenda item was follow-up regarding the navigator program from the September meeting. Then, there was an update from the health equity workgroup; workgroup recommendations are expected in early December. The workgroup discussion focused on race and ethnicity data, outreach and enrollment, insurance literacy, patient-centered primary care, and cost sharing. There was also a presentation on the low-income special enrollment period and an update on the open enrollment focusing on readiness around technical issues and consumer assistance marketing and outreach.

Strengthening and Expanding the Total Cost Of Care model

Megan Renfrew, Associate Director, External Affairs, Health Services Cost Review Commission (HSCRC)

Ms. Renfrew provided an overview of the HSCRC and the Total Cost of Care (TCOC) model. The HSCRC establishes rates for all hospital services and helps develop Maryland's innovative efforts to transform the delivery system and achieve goals under the model. The Maryland Health Model has two components, the All-Payer Hospital Rate Setting System and the Total Cost Care of Model (current agreement with the Centers for Medicare $ Medicaid Services [CMS]). Benefits of the Maryland Health Model include cost containment for the public, increased transparency, stabilized hospital funding, and investments in population health. For example, the HSCRC has been able to fund CRISP, the statewide health information exchange, which connects electronic health records and other health information systems in the state so that health information can flow freely between providers. The Maryland Primary Care Program (MDPCP) was established under the TCOC Model; primary care practices voluntarily join the program and in exchange have access to additional funding for moving into advanced primary care with significant technical assistance from the state.

The previous agreement with CMS was known as the All-Payer Model. It operated from 2014 through 2018 and focused on hospitals, specifically hospital savings, quality, and alignment. The TCOC model started in 2019 and has a broader focus on the total cost of care savings, as well as population health and system-wide provider alignment. The TCOC model has four components: hospital population-based revenue, care redesign programs, MDPCP, and population health. Regarding population health, CMS approved a Statewide Integrated Health Improvement Strategy (SIHIS) that has three components: hospital quality, care transformation across the system, and total population health. Maryland must meet TCOC model targets set by CMS each year. Three of the targets are related to costs, including Medicare savings. Two of the targets are related to quality, readmission reductions and reductions in hospital acquired admissions. The last target is how much of the population is under the value-based model. Maryland has done well under these targets for the first two years of the TCOC model. Ms. Renfrew noted that this year they are a little concerned about the guardrail test, Maryland's performance against national Medicare spending, due to difference in Maryland policies related to COVID-19 both on payment side and the fact that Maryland's shut down was longer than other states.

Maryland is in the third year of the TCOC model, and CMS released its first evaluation of the model in the spring. This evaluation focused on the implementation of the model and had several positive findings including financial stability for hospitals during the pandemic, focus on population health, care transformation initiatives, and substantial savings. The evaluation also identified opportunities for improvement. Total Medicare spending is higher in Maryland than in other states, driven largely by higher hospital prices though Maryland has successfully lowered hospital volume. Maryland can improve incentives for hospitals and care partners to lower the Medicare total cost of care. There is also meaningful room for improvement on population health goals and Maryland can improve on quality measures including readmissions and potentially preventable admissions. Ms. Renfrew provided an overview of the TCOC model timeline. HSCRC staff are focused on model year five when CMS evaluates the SIHIS, releases the second evaluation report, and clears the compounded savings target. In model year six, CMS decides whether to expand the model moving forward. HSCRC staff are working on developing a compounded savings target for the later years of the model and negotiating a new savings target with CMS.

Ms. Weckesser noted that a previous slide mentioned that one of the goals was to save $300 million annually but each year more baby boomers are entering into Medicare and asked how the HSCRC is compensating for that. Ms. Renfrew responded that the baby boomers are already built into the projected savings, which is the hypothetical savings without the model in place.

Mr. McCann commented that Medicare Part C also known as Medicare Advantage is trying to do the same thing as HSCRC and asked how the model interacts with Medicare Advantage. Ms. Renfrew responded that the situation is complicated. Maryland has much lower Medicare Advantage enrollment compared to nationally with fewer plan selections; this is the result of multiple factors. Some counties are high-cost which makes it difficult for plans to make money. Maryland also sets hospital rates so plans cannot negotiate the hospital rates which could also affect profits.

Ms. Weckesser commented that there was a favorable article in the New York Times about HSCRC; she will send it to the Board.

Ms. Renfrew then went over the priorities that the Center for Medicare and Medicaid Innovation (CMMI) which manages the TCOC model has set out for models moving forward. CMMI is looking for equity at the center of all models, as well as for models to drive accountable care, support innovation, address affordability, and partner to achieve system transformation. HSCRC has made progress on all of these priorities and continues to have room to improve. CMMI has been stressing the importance of multi-payer alignment in programs.

Ms. Herron commented that the TCOC model is very valuable to Maryland and allows residents to get healthcare at any hospital across the state and elevates the quality of care for all Marylanders. It is only to Maryland's benefit to make sure that this model works. She noted that she worked with the homeless population for several years and that it was very important that they were able to access to care when they could not afford it, so she knows how incredibly valuable this system is. She also serves on a committee for CRISP, and she wanted to highlight that CRISP is a national model for HIE.

Secretary Schrader commented that it is important to understand the TCOC model particularly as Maryland tries to align Medicaid as a payer with MDPCP. It is also important to continuously evaluate issues that may occur during the model's operation such as the Medicaid Advantage issue previously mentioned and how it interacts with the model. He emphasized that advancing equity has been the foundation of this model since the beginning.

Ms. Renfrew then explained that HSCRC has been working on benchmarking. They have created a benchmarking tool that identifies similar national geographies for each Maryland geography based on demographics and builds a Maryland-like comparison set that captures what Maryland healthcare costs might look like without the Maryland reimbursement system. They used Medicare fee-for-service data and commercial data but excluded Medicaid data due to limited national data availability. Ms. Renfrew provided an overview of a chart that showed the benchmarking results by county, comparing Maryland's commercial insurance costs to national benchmarks. Maryland's commercial costs are significantly below what they would be for a similar geography without the reimbursement model, but Medicare costs are higher.

Mr. Steffen asked whether there is a comparable measure benchmarking premiums in addition to this measure benchmarking costs. Ms. Renfrew noted that under the Maryland Health Model, low commercial rates should translate into savings on commercial health premiums. Published reports and HSCRC benchmarking show that Maryland has a healthcare claims costs advantage for the commercial markets. HSCRC requested Milliman to conduct a study examining premiums, which was publicly released in September. The report compared insurance premiums and costs in Maryland to other states. The report found that Maryland has a premium advantage in the individual and small group markets, but it is not clear which specific policies contribute to that result. However, Maryland does not have a premium advantage in the fully-insured large group market.

Mr. McCann asked Ms. Eberle what percentage of the individual market purchases insurance through the exchange compared to off the exchange. Ms. Eberle responded that roughly 66% of the individual market is through the exchange and the remainder is off the exchange.

Commissioner Birrane commented that that the Maryland Insurance Administration (MIA) provided commentary with regards to the Milliman report and the impact on the private market. Specifically, the MIA provided input on the correlation between premium rates and the model.

Mr. Steffen commented that the Milliman study seems to align with the longstanding work done through the federal survey that shows small group rates in Maryland were historically lower than the national average, but the large group rate has historically been above the national average. He asked whether the report included the federal average. Ms. Renfrew responded that she will follow up on this question. Mr. Steffen noted that the reinsurance program was very helpful in lowering premiums.

Mr. McCann asked if there was any indication that there was input from the Center for Disease Control (CDC) during the discussion with CMS regarding primary care. Ms. Renfrew responded that she did not know the answer because the Project Management Office is run out of the Maryland Department of Health, so HSCRC is not always part of the conversation.

Secretary Schrader suggested that Medicaid Director Steve Schuh provide a presentation on the primary care model at a future meeting. Mr. McCann agreed with this suggestion.

Process for Young Adult Subsidy Program Closure

Johanna Fabian-Marks, Director, Policy & Plan Management, MHBE

Ms. Fabian-Marks began by providing background information on the young adult subsidy program. The Board is required to establish eligibility and payment parameters for the young adult subsidy program and has the authority to limit the availability of subsidies. The MHBE may not provide more than $20 million in subsidies per year. The proposed process for program closure is that MHBE staff will coordinate tracking of enrollment and projected plan year 2022 costs, in consultation with the MIA. The Executive Director will provide a regular update to the Board. When the projected cost reaches $19.5 million, the program will be closed to new enrollees. Ms. Fabian-Marks noted that they do not expect the costs to exceed $19.5 million. Mr. McCann moved to approve the proposed process for the Young Adult Subsidy program closure as presented, seconded by Ms. Herron. The Board voted unanimously to approve the proposed process.

2023 New Plan Certification Standard

Johanna Fabian-Marks, Director, Policy & Plan Management, MHBE

Ms. Fabian-Marks noted that the proposed 2023 plan certification standards were presented to the Board in September. The new certification standards add a Dental PayNow requirement for participating Stand-Alone Dental Plans that would enable dental enrollees to pay their first month's premium to effectuate coverage immediately upon enrolling. This would mirror the PayNow functionality provided for medical plans. The MHBE did not receive any public comments on the proposed plan certification standards. Mr. McCann moved to approve the proposed 2023 plan certification standards as presented, seconded by Ms. Herron. The Board voted unanimously to approve the certification standards.

Low-Income Special Enrollment Period

Johanna Fabian-Marks, Director, Policy & Plan Management, MHBE

Ms. Fabian-Marks reported that the U.S. Department of Health and Human Services (HHS) issued a final regulation in September creating a new special enrollment period (SEP) to expand access to exchange coverage for low-income households. The SEP is available to individuals eligible for advanced premium tax credits with a household income below 150% of the federal poverty level (FPL) and will be available year-round as long as Congress continues enhanced tax credits for these individuals. This SEP will be offered through the federal exchange and is optional for state-based exchanges. It is estimated that 1.5% of the uninsured, individuals with household incomes between 139% and 150% of the FPL, would be eligible for this SEP. It could help individuals who lose Medicaid regain coverage once the federal public health emergency ends. DC will be implementing this SEP. Ms. Fabian-Marks noted that this SEP could result in adverse selection with an estimated .5 to 2% potential premium impact nationally. The MIA has indicated that the 2022 rates could absorb the potential impact of this SEP. There are also mitigating factors on the potential premium impact. Coverage is very low cost and high value, and the reinsurance program helps protect carriers from high claim costs. Massachusetts has year-round enrollment for individuals with incomes below 300% of the FPL and has not experienced adverse selection.

Ms. Fabian-Marks then commented that MHBE leadership believe that the SEP would be beneficial. To implement the SEP, the Board needs to approve the regulations. The draft updates to the SEP regulations are currently in progress and the MHBE plans to release the draft proposed regulations in the winter or spring of 2022 for an informal stakeholder comment period. The Board will be asked to approve the proposed regulations in spring 2022 and the final regulations in summer 2022.

Commissioner Birrane commented that losing Medicaid because of an income change already triggers a 60-day SEP, so the low-income SEP would effectively remove the deadline. She asked if there are any estimates on the number of individuals who would benefit from the removal of the 60-day deadline. Ms. Fabian-Marks responded that they do have some estimated numbers from the Department that they can share. She also noted that individuals who lose Medicaid due to an income change would still need to have an income below 150% FPL to be eligible for this new SEP.

Ms. Weckesser asked if the informal stakeholder comment period in the winter or spring means that the updated SEP regulations will be presented to the SAC first and then their feedback will be incorporated before other stakeholders participate in the public comment period. Ms. Fabian-Marks

responded that the informal feedback period may occur before the next SAC meeting, but they will send out the draft proposed regulations to all SAC members as part of the informal feedback period.

Mr. McCann asked whether the MHBE is prepared for the surge in exchange enrollment that may occur during Medicaid redeterminations when people lose Medicaid coverage. Ms. Eberle responded that the MHBE has been working very closely with the Department to plan for that. The dates for the Medicaid redeterminations have not been finalized yet; it has been extended to March. The current plan is to send notifications to the first round of redeterminations in mid-February and then it will continue on a rolling basis after that and hope to catch up in six months. Mr. McCann requested a full report on the plan for Medicaid redeterminations at the January Board meeting. Ms. Eberle agreed with this suggestion.

Mr. Steffen asked whether the updated SEP regulations will go into effect in the summer of 2022 in time for open enrollment in fall 2022. Ms. Fabian-Marks responded that once the regulations go into effect, the new SEP can be implemented immediately and does not have to wait until open enrollment. Mr. Steffen asked whether the MHBE considered doing emergency regulations to implement the new SEP sooner. Ms. Fabian-Marks responded that they did not discuss emergency regulations. Mr. Steffen asked if there was a reason not to implement the new SEP as soon as possible. Ms. Fabian-Marks responded that absent IT or operational concerns there was no reason not to implement the SEP sooner. Ms. Eberle added that there are logistical concerns, but the MHBE could work on the IT developments while the regulations are in progress so that once the regulations are in effect they will be ready to implement the new SEP immediately. Mr. Steffen suggested that the new SEP be implemented as soon as possible given the constraints on staff because while the population eligible for the SEP is small they are very vulnerable. Mr. McCann noted that communication and marketing is an important part of this; eligible individuals will need to be notified of the low-income SEP. Ms. Eberle will go back to staff and reevaluate and will send an update in December with a realistic timeline. Ms. Weckesser asked if there will be some kind of press release to publicize these regulations when they go into effect. Ms. Eberle responded that the marketing team will publicize the new SEP when it goes into effect.

Secretary Schrader noted that there are a couple hundred thousand people going through Medicaid redeterminations and asked whether a small subset of this population would be affected by the low-income SEP. Ms. Eberle responded that the individuals with incomes between 139-150% FPL would be eligible for a SEP at any time during the year.

FY22Q1 Compliance Update

Caterina Pañgilinan

Ms. Pañgilinan provided on update on the compliance program for the first quarter of fiscal year 2022. During this quarter, there were two allegations of fraud, waste, and abuse that were determined to be not founded. However, one resulted in creation of a ticket to examine how social security numbers validated by the Social Security Administration have separate dates of birth. She then went over the internal assessment and external audit timeline. The Exchange Improper Payment Management Pilot is going well, and they are helping them develop an effective audit tool. The PERM Audit for review year 2023 will be starting in January ,and the MHBE has been working closely with the Department to provide documentation related to eligibility processes and required training.

Ms. Herron asked about the System Security Report and whether it is a cyber security penetration audit. Ms. Pañgilinan confirmed that is a component and they will be testing the exchange systems thoroughly.

Mr. McCann asked if the systems audits examine MDTHINK as it relates to the exchange and what the MHBE does if there is an audit finding related to MDTHINK. Ms. Pañgilinan responded that using the Internal Revenue Service (IRS) audit from last year, any system weakness that was on the MDTHINK side was part of the audit findings and the MHBE was responsible to ensure that MDTHINK corrected the problem. Mr. McCann then asked about the mechanism to enforce that correction. Ms. Pañgilinan responded that the MHBE IT security team meets regularly with the MDTHINK security team, and they receive ongoing reports on improvement activities. Ms. Eberle added that the interagency agreement with MDTHINK spells out what has to be done and who is responsible for which tasks.

Ms. Pañgilinan reported that there was one audit finding from the SMART audit for plan year 2020, and MHBE met with the Center for Consumer Information and Insurance Oversight (CCIIO) in September for further clarification. This is a repeat finding related to a requirement that exchanges use electronic verification sources such as the federal employee database to see if employers provide essential coverage for their employees. The MHBE allows individuals to attest whether they receive employer sponsored coverage and had been doing a random sampling to verify, but it was very onerous to implement. Last May, CMS decided not to hold exchanges responsible for implementing random sampling because they were going to do a study on the efficiency of random sampling. The audit finding this year was that the MHBE did not use an electronic data source, but CMS is not enforcing this requirement currently. The MHBE is reviewing other opportunities and alternatives that may be available and will follow lead of the federal marketplace which is also determining how to meet this requirement.

Ms. Pañgilinan also reported that the MHBE has been working with the Department on their corrective action plan related to eligibility and enrollment applications with the main goal of ensuring that a consumer does not have to reenter application information so that it is more seamless across the eligibility and enrollment systems for modified adjusted gross income (MAGI) and non-MAGI individuals.

Ms. Pañgilinan then provided an update on the Office of Legislative Affair findings. In October, the MHBE connected with BEACON and now have real time wage and unemployment compensation information. In May 2022, requests for unearned income information will be added to the application for Medicaid. Senior leadership will review the override review policy in December.

Mr. McCann asked if the exchange is the sole portal where people apply for Medicaid. Ms. Eberle confirmed that the exchange is the sole portal for MAGI Medicaid, which is income-based Medicaid. Non-MAGI eligibility categories include long-term care and the blind and disabled; non-MAGI individuals go through an eligibility and enrollment system at the Department of Human Services (DHS).

Ms. Pañgilinan reported that the internal reviews are going well. For FY 2021, there were 28 recommendations and 19 have been cleared, 7 are on schedule to be completed, and 1 is late but it is more of an administrative recommendation. Current compliance areas of focus include monitoring

third-party compliance with debarment and sanctions screenings, the privacy incident management process, collaborating with IT security and project management office on IT policies and procedures, and aligning departmental standards and publications with regulations. The privacy program has been doing assessments of their Connector Entities and Maximus which have all been closed out. They have almost closed out the data use agreement with DHS.

Ms. Pañgilinan then provided an overview of the types of security incidents that have occurred and responsible entities. The most common type of incident continues to be misloads, and partner government agencies continue to be the most frequent responsible entity. The MHBE meets with the Department counterparts on a monthly basis to address this problem. There has been a decrease in the number of non-producer incidents because there have not been any Medicaid redeterminations, but the numbers are expected to increase when the redeterminations start.

Mr. McCann asked whether a misload means that a document is uploaded but it is sent to the wrong file. Ms. Pañgilinan responded that sometimes there is an intermediary step where the uploaded document goes to a que and someone else works the queue. Generally, the most misloads are when someone else is working a queue. If the MHBE can always check first name, last name, date of birth, and social security number, then that could decrease the number of misloads. If they can correct an incident prior to anyone seeing it then it does not become a breach.

Mr. McCann asked whether Maximus and the call center are required to do internal reviews or does the MHBE do the reviews for them. Ms. Pañgilinan responded that Maximus does a lot of internal review with a quality department that listens to all of the calls. Last year, there was a finding of a failure to read the penalty of perjury during the last term cycle. Maximus put in a corrective plan and did a random sampling of callers to ensure that the penalty of perjury is read. For all of the privacy incidents, as part of the new accountability process, all entities are required to send the MHBE their corrective action plan and then the MHBE will follow up.

Adjournment

The meeting was adjourned.