



MHBE

2024 Value Plan Workgroup

August 6, 2024

12:00PM – 1:30PM

Online Via Google Meets

Members Present:

Nikki Blake

Ken Brannan

Evalyne Bryant-Ward

Matthew Celentano

Steven Chen

Ashton Nicole DeLong

Stephanie Klapper

Allison Mangiaracino

Kathleen McGuire

Lisa Solomon

Tim Ross

Emily Hodson

Brian Espindola

Staff

Becca Lane

Camille Blake Fall

David Mann, M.D.

Adam Zimmerman

Amelia Marcus

Pooja Singh

Michele Eberle

Members of the Public

Philemon Kendzierski

Becca Lane, Senior Health Policy Analyst at the Maryland Health Benefit Exchange (MHBE), welcomed attendees to the meeting.

Approval of Meeting Minutes

Ms. Lane presented the minutes for the July 23, 2024, meeting of the Workgroup, noting that a Workgroup member had identified a name missing (Brian Espindola) from the attendee list in the draft minutes that were shared prior to the meeting, so the minutes will be corrected to include that name. Evalyne Bryant-Ward moved to approve the minutes of the July 23, 2024, Value Plan Workgroup Meeting as amended. Emily Hodson seconded. The Workgroup voted unanimously to approve the minutes.

Agenda

Ms. Lane reviewed the agenda, which is shown in full in the presentation for this meeting. She noted that the Workgroup will hear from Camille Blake Fall and Dr. David Mann from the Maryland Department of Health (MDH) Office of Minority Health & Health Disparities and will consider how to apply insights from the presentation to future Value Plan designs beyond 2026 (the time has passed to make significant changes to the 2026 designs).

Presentation from the Office of Minority Health & Health Disparities

Ms. Blake Fall outlined the points that her and Dr. Mann's presentation will cover. Detailed slides are available in the presentation for this meeting. She asked whether any changes were made to the 2026 Value Plan benefits to advance health equity, citing diabetes as an example of a condition targeted in previous years. Ms. Lane replied that the Workgroup is continuing diabetes cost sharing and has discussed reducing copays for laboratory services, noting the Workgroup's preference for an approach targeting specific services rather than conditions to benefit enrollees with multiple comorbidities, which often include high-disparity, chronic conditions; to avoid logistical challenges, such as making cost sharing dependent on providers' use of certain diagnosis codes; and to remain within actuarial value (AV) constraints.

Ms. Blake Fall introduced herself. She indicated that the name of their office may change as MDH considers that its charge may be broader than the name "Minority Health & Health Disparities" reflects. She also noted that the office will be celebrating 20 years of operation at a conference on December 10, 2024, at Morgan State University, inviting interested Workgroup members to join.

Ms. Blake Fall described her office's mission as supporting MDH and the Secretary of Health in addressing the distinct concepts of social determinants of health and health-related social needs. The office prioritizes community partnerships through three grants, whose awards for fiscal year (FY) 2025 total over \$5 million. She characterized the grassroots work of community organizations and universities as crucial for change. Ms. Blake Fall stated that her office seeks to weave health equity into all Maryland policies and noted that the All-Payer Equity Approaches and Development (AHEAD) model can help improve Maryland's track record in that area. One of the office's initiatives, focused on COVID-19 testing and education, is set to sunset, and its funds will be used to maintain testing and awareness, along with funding preparations for future pandemics.

Dr. Mann introduced himself as the office's epidemiologist, noting his focus on math and data problems. Each Workgroup member introduced themselves.

Ms. Blake Fall then began the content of her presentation. She explained that, with the AHEAD Model, the Centers for Medicare & Medicaid Services (CMS) have codified what Maryland has been doing singularly well under its All-Payer and Total Cost of Care models (as the only state with this kind of global payment system) and have offered it to other states as well. She stated that the AHEAD model makes explicit the focus on health equity and population health as levers by which to achieve quality outcomes for all that was implicit in Maryland's previous models. The AHEAD model emphasizes the need for equity to be embedded in changes made at the provider and the hospital levels and offers an opportunity to expand and improve on previous health equity initiatives in the state, such as the Maryland Primary Care Program and the Maryland Hospital Association's efforts.

Next, Ms. Blake Fall encouraged interested Workgroup members to apply to participate in the AHEAD model's Maryland Commission on Health Equity (MCHE), the governance structure for the model in the state over the next nine years. The model is in a pre-implementation phase from July 1, 2024, through December 2025, during which Maryland will negotiate with CMS about the state's measures and targets. In addition to hospitals' individual health equity plans, MCHE will develop a statewide health equity plan and is looking for individuals doing work in population health to apply to be among its 33 members. Ms. Blake Fall offered to send along the call for MHCE applications.

Ms. Blake Fall closed by explaining that her office will work in tandem with the Secretary of Health as Maryland deepens its investment in health equity. She stated that the office will work both to advance CMS' definition of health equity and a Maryland-specific definition of the term that MCHE will develop, which may be even more robust.

Dr. Mann began presenting, beginning with the Healthy People 2030 definitions for health equity and health disparity. He summarized the definition for health disparity as any time a group is treated differently because of their group identity in a way that affects their social, economic, and health opportunities. He then transitioned to showing data from several sources on a series of disease areas for which disparities exist in Maryland. He showed that death rates for stroke, rates of Baltimore City hospital encounters for hypertension, and rates of hypertension prevalence are significantly higher among Black Marylanders than White Marylanders, with hypertension prevalence similarly elevated for the "Other" racial groups, which generally includes multi-racial individuals and American Indians. He noted that death rates, hospital utilization, and disease prevalence are all commonly used measures of disparity, and, within each measure, disparities can be observed for multiple diseases in Maryland.

Dr. Mann then discussed the role of social factors in determining disparities, showing that analyses completed for the Maryland Diabetes Action Plan found that diabetes prevalence is generally higher in those with lower incomes and those with lower levels of educational attainment across racial groups, as well as observing higher diabetes prevalence in among the Black population than in the White population within each income group and among those with comparable levels of educational attainment. Dr. Mann stated that racial/ethnic group, income, and educational attainment are all important drivers of health disparities that must be addressed.

Next, Dr. Mann described the causal chain from social determinants of health to health outcomes. He noted that the health outcomes he previously reviewed, along with disability and health care costs, are generally results of disease frequency and severity. Disease frequency tends to result from the presence of disease risk factors and access to quality prevention services, whereas disease severity usually results from the severity of risk factors and the access to quality treatment services. Social determinants of health are at the root of each of these and are generally correlated with the place one lives. He noted that one of the MHBE's main roles in this chain is to intervene by providing better access to quality prevention and treatment services but noted that an improvement in any of the factors that predict poor outcomes could lead to better ones.

Dr. Mann then showed data on the disparities that exist between Black and White Marylanders in HIV mortality, infant mortality, receipt of prenatal care, and maternal mortality. He noted that the Hispanic population in Maryland receives late or no prenatal care at about the same rate as the Black population but has much better infant mortality rates than the Black population, indicating that other factors besides prenatal care are likely at play and must be targeted to make change for infant mortality. He also noted that the statistics for maternal mortality are much smaller than for infant mortality but indicated that both are pressing issues for which similar interventions will likely help.

Next, Dr. Mann presented a slide containing steps to successfully manage chronic disease. He described prerequisites for patients seeing a provider—having health insurance, finding an in-network provider, and having the transportation and time to visit them—and interventions, including referrals to Maryland Health Connection (MHC), linking insured individuals to providers who can serve as medical homes and to transportation as needed, and education on optimal and preventive health insurance utilization. Dr. Mann then described possible consequences if individuals do not see a provider for preventive care, including use of the emergency department (ED) for primary care or for a preventable emergency.

Dr. Mann then discussed important factors that must be in place for a provider visit to be successful, including good interaction between patient and provider, a correct evidence-based treatment plan, and successful execution of the treatment plan by the patient. Dr. Mann described cultural competency training for providers, provision of language services as necessary, and case management and community health worker (CHW) services as possible interventions at this stage.

Finally, Dr. Mann discussed potential roles for the MHBE in helping improve patient outcomes in managing chronic conditions, including making plan design more friendly to CHW services; building benefits for transportation or other health-related social needs into plans, such as the ones implemented in some Medicare plans; and connecting Marylanders to quality health insurance plans with reduced copays and coinsurance for critical services, thereby incentivizing enrollees to use preventive care rather than the ED, saving hospitals money that could help reimburse the expense of reducing copays and coinsurance.

Dr. Mann then opened the floor for discussion on equity-related interventions the MHBE could undertake.

Ken Brannan stated that he is working on an initiative with applications for CHWs serving as a trusted medical resource. He asked the speakers to discuss further what the MHBE can do to enhance the participation of CHWs, especially in the context of proposed legislation and Value Plan design. Ms. Blake Fall replied that effectively leveraging CHWs has been a passion of hers and a subject of discussions with the Secretary of Health and with Maryland Medicaid Director Dr. Ryan Moran. She noted that other states embed reimbursement for CHWs in their Medicaid plans, either by

reimbursing the primary care provider office or by reimbursing the CHW directly if they are enrolled as a provider and added that these may serve as templates Maryland can follow, although adjustments may be needed. As a final option, she added that health plans could be reimbursed.

Dr. Mann suggested a model where the CHW service is an explicitly covered service, perhaps for particular conditions. He added that, ideally, a CHW teaches an enrollee over 30-60 days how to be independently successful at self-management as a patient before graduating them, noting that the time-limited nature of the service contains its associated cost, making it fiscally feasible for insurance coverage.

Mr. Brannan characterized this approach as pragmatic and indicated he may reach out to discuss further.

Dr. Mann stated that Prince George's County had very positive results with specific tracks they developed for CHWs to follow for individual diseases and social needs, adding that the county could be asked if those materials are available.

Matthew Celentano asked about the scope of who qualifies as a CHW and if a granular example exists within other Medicaid programs. Ms. Blake Fall responded that a national and an international association of CHWs exist and can be consulted on the variety of contexts for the role. She noted no single definition exists, with the specifics of the role depending on how a provider, hospital, or community organization uses a CHW to meet the community where they are and serve as a bridge. She noted their duties range from patient intake in some practices to outreach and community engagement, characterizing the use of CHWs as exclusively intake staff as ineffective. Dr. Mann added that there are different sub-specialties within the CHW role, focusing on areas as diverse as the patient self-management support he described, cancer navigation, and intake assessment. He stated that CHWs' recruitment from the community they will serve—to leverage their knowledge of, and rapport within, the community—separates the role from other types of patient-facing health professionals.

Mr. Celentano agreed that flexibility in the definition of the role can help meet the community's needs but expressed concern over the possible ambiguity when tying CHW services to reimbursement, stating that the services would have to be concretely defined. Ms. Blake Fall agreed and indicated that the CHW associations may offer options for how to define CHW services but cautioned against being so prescriptive as to disallow tailoring the services to the community being served, giving as an example the enrollees who would not be served were services to be limited to chronic care management. She emphasized the value of health literacy interventions.

Dr. Mann added more disparity statistics: Black Marylanders have asthma ED visit and hospitalization rates two to three times higher than White Marylanders despite having only about 20% higher rates of asthma diagnosis, indicating a disparity in the success of the asthma treatments each population receives. He noted that pre-provider and post-provider factors, along with factors at the provider level, contribute to the success

of the treatment received. For diabetes, around half of the gap in outcomes stems from differences in the respective level of treatment success each population experiences, while HIV represents a case wherein the disease incidence rate, which is ten times as high for Black individuals as for White individuals, is the major driver of disparities. He emphasized the importance of determining whether treatment success or disease incidence is the major driver of disparities for a given condition, offering hypertension and especially asthma as other conditions for which disparities in treatment success play a prominent role in leading to disparate outcomes.

Ms. Lane noted that carriers report each year on high-cost and high-frequency conditions as part of the State Reinsurance Program, and the conditions reported frequently include asthma and pregnancy. She commented that the MHBE will be thinking about the role of treatment success versus disease incidence and how best to intervene and may reach out to discuss further. She asked if the Workgroup has ideas for anything to be addressed in 2027 plans based on the presentation.

Ms. Hodson commented that she is a social worker who does case management and that her work often involves navigating social determinants of health in the community, particularly with those living with HIV. She noted that, at times, there are no resources to refer people to and emphasized the difficulty in narrowing to a particular health condition, stating that targeting the services enrollees with high-disparity conditions need, like the Workgroup has been doing, may be a better approach that provides savings for a wide variety of utilization scenarios. She agreed with Ms. Blake Fall regarding the high level of variability in the needs residents of different geographical areas have and added that the available resources in each area vary as well. Ms. Blake Fall replied that the health care system has been organized to treat specific diseases but stated that communities' social determinants must be treated holistically, with societal conditions that influence health outcomes addressed as far upstream as possible.

Lisa Solomon noted that a combined deductible or a high out-of-pocket maximum may act as a barrier between enrollees in a Bronze qualified health plan and high-cost specialty medications needed to treat conditions like asthma, cancer, and HIV. She noted that these types of prescriptions should be examined for this reason.

Dr. Mann described mental health as an important need but as a case where there are more needs than insurance is designed to cover. He also explained that interventions should seek to manage patients' collections of comorbid chronic disease diseases, giving the example of the cardio-metabolic diseases which share risk factors and between which patients often experience more than one, including hypertension, diabetes, kidney disease, and heart and cerebrovascular diseases. He noted that people with comorbid chronic diseases are often high utilizers, with a small number of outliers making up much of the cost in the state. He noted that the challenge is to minimize the cost to these individuals so that they can use their insurance plans but to avoid overburdening insurers in a way that makes plans unsustainable.

Ms. Blake Fall emphasized that she and Dr. Mann are available if any members would like to reach out and discuss the meeting's topics further.

Next Steps

Ms. Lane stated that the Workgroup's next meeting is on Tuesday, August 20, at 12:00 PM. She also noted that MHBE actuaries provided her with new versions of the Value Plan designs on the day of today's meeting and that she will distribute the new designs in advance of the August 20 meeting. During that meeting, the Workgroup may vote on whether to approve the plan designs for their final recommendations, or they may vote at the last scheduled meeting on September 3. She stated that there will likely be another meeting scheduled once the Federal AV Calculator for the year is published. In September, the Workgroup's recommendations will be presented to the MHBE Standing Advisory Committee and Board of Trustees.

Public Comment

No comments offered.

Adjournment

The meeting adjourned at 1:30 PM.

Chat Log

00:12:03.610,00:12:06.610

Tim Ross: Hello - my system does not allow mic access. I'm Tim Ross, Senior Product Manager for Aetna's Individual ACA membership. Happy to participate!

00:18:34.811,00:18:37.811

Stephanie Klapper: We've been sharing the opportunity to apply to be a member with our networks at Maryland Health Care for All

00:59:09.380,00:59:12.380

Ken Brannan: Becca, Please share the slides