MARYLAND HEALTHBENEFIT EXCHANGE

750 E. Pratt St., 6th floor
Baltimore, MD 21202
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MHBE Health Equity Workgroup Minutes – Session 2

Friday, September 10, 2021
1:00 – 2:30 PM

Held via Google Meet

In Attendance:
Richard Amador, HealthCare Access Maryland (HCAM)
William Ashley, LifeBridge Health System
Ken Brannan
Noel Brathwaite, Maryland Office of Minority Health and Health Disparities
Alyssa Brown, Maryland Department of Health (Medicaid)
Shari Curtis, Prince George's Healthcare Action Coalition
Diana Hsu, Maryland Hospital Association
Kim Jones-Fearing, MD LLC
Stephanie Klapper, Maryland Citizen's Health Initiative
Theressa Lee, Maryland Health Care Commission
Nicole Mallette, Maryland Insurance Administration
Allison Mangiaracino, Kaiser Permanente
Jomy Mathew, United Health Care
Marie-Therese Oyalowo, UMES
Dania Palanker, Georgetown University
Ligia Peralta, Casa Ruben Inc.
Kashay Webb, filling in for Megan Renfrew, Health Services Cost Review Commission
Patricia Swanson, CareFirst
Nikki Highsmith Vernick, The Horizon Foundation
Sheila Woodhouse, University of Maryland Medical Center

MHBE Staff:
Michele Eberle
Johanna Fabian-Marks
Becca Lane

Welcome and Updates

Johanna Fabian-Marks, Director of Policy and Plan Management, kicked off the session by presenting the agenda for the day. She thanked members for completing the prioritization survey that was circulated prior to the meeting and noted that this session's

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focus, race and ethnicity data collection, was ranked as a high-priority topic on that survey.

Johanna explained that MHBE does collect race and ethnicity data on enrollees, and some other states are trying to increase their response rates for this kind of data. Race and ethnicity data is used in a number of ways and having robust data is helpful for analysis.

Johanna updated the group that the charter and the co-chairs, Dania Palanker and Sheila Woodhouse, were all approved via virtual vote. Johanna mentioned that more details on the results of the prioritization exercise would be shared later in the meeting. Johanna then paused for co-chair remarks.

Sheila Woodhouse shared that she looks forward to working with the workgroup and making significant recommendations so that we can track what changes can be implemented to improve access and enrollment and improve care for all residents in the area.

Dania Palanker shared that she is also looking forward to the work, noting that Maryland is one of only a few states that are actively looking at how to use the marketplace to improve health equity. She plans to invite some of her students listen in to one of the meetings.

MHBE 101
Johanna thanked the co-chairs and continued by presenting a more detailed background on MHBE than what was presented in the first meeting. This information can be found in the slide presentation for this session.

Survey Results
Becca Lane, MHBE Health Policy Analyst, then presented on the results from the prioritization exercise. The highest priority areas were health literacy; outreach and enrollment; and race, ethnicity and language data collection and analysis. The next-highest priority topic was “coverage for populations currently ineligible through MHC,” followed by “aligning with statewide quality of care initiatives.” Insurance design (including cost-sharing/benefits and provider diversity) had lower interest, and quality improvement was prioritized lowest across the board.

Becca then paused for comments on the survey results from the co-chairs.
Sheila noted that the three top priorities align with our goals and objectives, which is good, knowing that the workgroup can’t address everything at once and has to start somewhere.

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Dania said that she expects the group will still touch on things that may not have been ranked particularly highly so that we can have a robust conversation.

Discussion about eligibility for immigrant populations
Kimberly Jones-Fearing asked which groups are currently considered ineligible for insurance. Johanna responded that those who are not eligible for coverage through MHC include undocumented immigrants, circumstances where there would be duplication of coverage through Medicare, and individuals who have an offer of affordable employer coverage. In general, undocumented immigrants comprise the largest group that is not eligible for coverage through MHC and does not have another form of coverage available. Dania added that there are some people who are technically legally present under the Marketplace's (and Federal government's) definition, who have valid visas, but who are unable to buy coverage through the individual marketplace under federal law. There are also people who are eligible to buy coverage but not eligible for subsidies, even if their income qualifies; some also may not be eligible because their spouse has an offer of employer coverage.

Ligia Peralta asked about more granular data on who the ineligible people are. She recalled that in the first session, the group discussed needing more information about the people who are technically documented because they have visas, but are still ineligible for coverage, so they are in a gray area.

Dania responded saying that recent immigrants (<5 years) who would otherwise be eligible for Medicaid if not for having immigrated <5 years ago, are eligible for MHC coverage as well as premium tax credits and cost-sharing reductions.

Johanna assured the group that staff will make the data and information that MHBE has on this topic available and will set aside time to go over it in a future session. This will include information on eligibility standards on the exchange and data on the uninsured immigrant population.

Ligia emphasized the importance of understanding eligibility for different immigration statuses and reiterated that looking at data on how many people are not being reached will help the workgroup understand where to focus.

Dania reminded the group that MHBE is limited in its ability to make significant changes to statute or change rules about who is eligible.

<u>Vote on Session 1 Meeting Minutes</u>
Marietherese Oyalowo from UMES requested a correction to how the minutes characterized her comment on transportation on the eastern shore. Rather than *the*

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biggest issue, transportation is *one of many* big issues when it comes to access on the eastern shore.
The workgroup voted to approve the minutes, conditional upon the correction described above.

Health Equity Concepts Refresher
Next, Becca covered some basic health equity concepts and definitions to ensure robust discussion. Please see the presentation for more details.

MHBE's Current Race, Ethnicity and Language Data Collection Processes
Becca then gave an overview of REL data collection processes at MHBE. As with most states, MHBE's race and ethnicity questions are optional. MHBE adheres to data collection standards from OMB and HHS, meaning that the format used on the MHC application gives many different response options for "race," all of which roll up to the traditional race categories. 35 percent of applicants select "other" on this question, which weakens MHBE's ability to analyze the data and use it to improve outreach or track enrollment trends.

The MHC application also asks applicants about their "primary language," and gives 42 answers to choose from. The full MHBE website (including full translation of videos and other features) is available in both English and Spanish; the other language data informs customer support entities.

MHBE collects other demographic data, including sex, age, location, and household size; however, MHBE is limited in what else it can ask for that is not necessary for enrollment. Asking too many questions that seem irrelevant can undermine consumer trust.

Best Practices for Race, Ethnicity and Language Data
Michelle Jester, Executive Director of Social Determinants of health at America's Health Insurance Plans (AHIP), presented on best practices for collecting demographic data to advance health equity, and to a lesser extent, on promoting diverse provider networks. Please see the presentation and recording for more information.

Discussion
Johanna suggested combining the presentation Q&A and discussion part of the meeting. She acknowledged that the time for discussion would be shorter than planned, saying that staff would ensure more time for discussion in future sessions.

Shari Curtis from the Prince George's Healthcare Action Coalition shared that the PG County connector program has had cross-trained community health workers for about five years and is the only connector program in Maryland to do so. Based on her years

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of experience with improving use of coverage in PG County, Shari advocated for the importance of making sure people know how to use their coverage, improving quality of coverage use and retention, to improve equity,

Shari also mentioned literacy challenges as a barrier to high response rates. She said that as her work in PG County has gone virtual, her team has been getting better data by talking to people and asking them questions rather than having consumers fill forms out online on their own. People's literacy challenges have become more apparent—people may check any box because they don't understand the question even though the language has been simplified. Also, asking about race alone might not be adequate for people's self-identification, which is helped by including the collection of ethnicity and language data.

Stephanie Klapper from MCHI asked about how MHBE originally developed the current race and ethnicity question and how much authority MHBE has to change how that data is collected. She expressed support for MHBE's collection of race data in a way that allows disaggregation by many subcategories of Asian American/Pacific Islander and asked whether that is used for any targeted outreach or programs. She noted that the way the major race categories could be improved to make it easier for people to find their answer. She also expressed support for how AHIP's example included an option for "I only identify as Latinx/Hispanic" and suggested MHBE consider including this option. Lastly, she advocated for including a statement about how the data will be used.

Tricia Swanson from CareFirst suggested that navigators be deployed strategically. She suggested that each navigator have a focus on a particular social determinant of health within the area they serve. She also raised the idea of meta regions for future discussion by the group.

Richard Amador from HCAM asked Shari Curtis whether the navigator-CHW cross-training at the PG County Connector was funded by MHBE, because the budgets have not increased much lately. Shari responded that the cross-training was already built into their plan from the beginning and so is funded.

Richard then asked Dania for more information about which visas make a person ineligible for coverage. He is on the immigration committee at HCAM and does the training guide for the pre-credentialing program for navigators being hired now. HCAM enrolls people with B1/B2 (tourism) visas. Dania responded that immigration is not her area of expertise so she does not know; she was intending to make a point that there are some people who are legally present but cannot enroll. She then said that the group will find time to discuss immigration status in more depth.

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Allison Mangiaracino from Kaiser Permanente advocated for the group to explore training and scripts for collecting race and ethnicity data for navigators, producers, call centers, and anyone who assists with enrollment. She asked a question about CMS requirements for this data: what exactly are the limitations imposed by CMS? Does it relate to how the questions are asked or what answers are available? Johanna responded that we have to be able to roll up the data we collect into the main categories as dictated by CMS, but we have flexibility otherwise. Alyssa Brown from MDH Medicaid agreed, adding that CMS also prohibits making these questions mandatory on the application.

Public Comment
No public comments were offered.

Adjournment
The workgroup adjourned at 2:30. The next session will be held at 1:00pm on Friday, September 24, 2021.

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Chat comments:
00:20:17.723,00:20:20.723
Nikki Vernick: A few other states have expanded some health care coverage to undocumented immigrants and it would be helpful to know how they are providing coverage.

00:27:20.324,00:27:23.324
Richard Amador: If you're curious about immigration statuses and the ACA, there is an abundance of information about the topic at healthcare.gov, marylandhealthconnection.gov, and the CMS website.

00:31:28.182,00:31:31.182
Richard Amador: Also, DACA recipients are EAD cardholders coded as C33 and, even though they are lawfully present, they are ineligible for all insurance affordability programs available through MHC. In the past, the HBX system would glitch and provide them with the wrong eligibility determination. Once PDM became more rigorous, that issue was resolved.