MHBE Health Equity Workgroup

Session 5 – October 22, 2021

MARYLAND HEALTHBENEFIT EXCHANGE

Agenda

1:00 - 1:10 | Welcome
Dania Palanker, co-chair

1:10 – 1:15 | Vote on Session 4 Minutes
All members

1:15 - 1:30 | Insurer Presentation: CareFirst
Brian Wheeler, Vice President, Provider Collaboration and Network Transformation

1:30 - 1:45 | Presentation: Maryland Primary Care Program
Emily Gruber, MDPCP Health Equity Manager

1:45 - 2:25 | Discussion
All members

2:25 - 2:30 | Public Comment

2:30 | Adjournment

Session 4 Minutes

CAREFIRST HEALTH EQUITY APPROACH

MHBE Health Equity Workgroup Presentation

OCTOBER 22, 2022

CareFirst

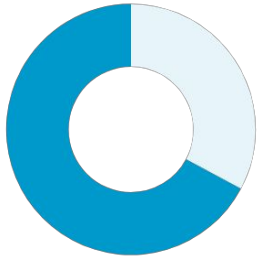
WHO WE ARE

2021 WORLD'S MOST ETHICAL COMPANIES® ™
WWW.ETHISPHERE.COM

The CareFirst Workforce

With almost 7,000 employees and contingent workers at sites across D.C., MD, VA and WV, CareFirst employees represent a broad diversity across many areas.

Mostly Exempt Employees



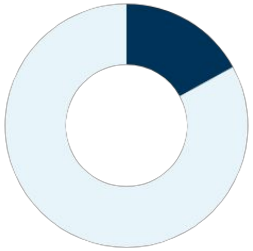
68% vs. 32%

More than half identify as belonging to 1/1+ minority groups

49% White • 34% Black • 11% Asian • 1% Hispanic

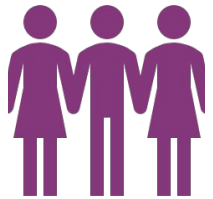
5% 2+ and non/spec

Supervisors+ positions account for 17% of workforce

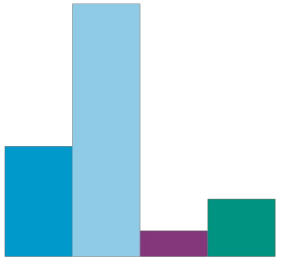


83% Individual Contributors vs.17% Supervisors+

70% female workforce



Just over half of all employees work in Maryland offices



25% DC • 56% MD • 9% VA • 13% WV

Majority are Generation X (born 1966-1981)

27% Boomer • 44% Gen X • 29% Millennial

Health Inequities are Not a One-Dimensional Problem

"Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care." - Robert Wood Johnson Foundation

69.4%
of Black and
67.1%
of Hispanic adults with any mental illness reported receiving no treatment

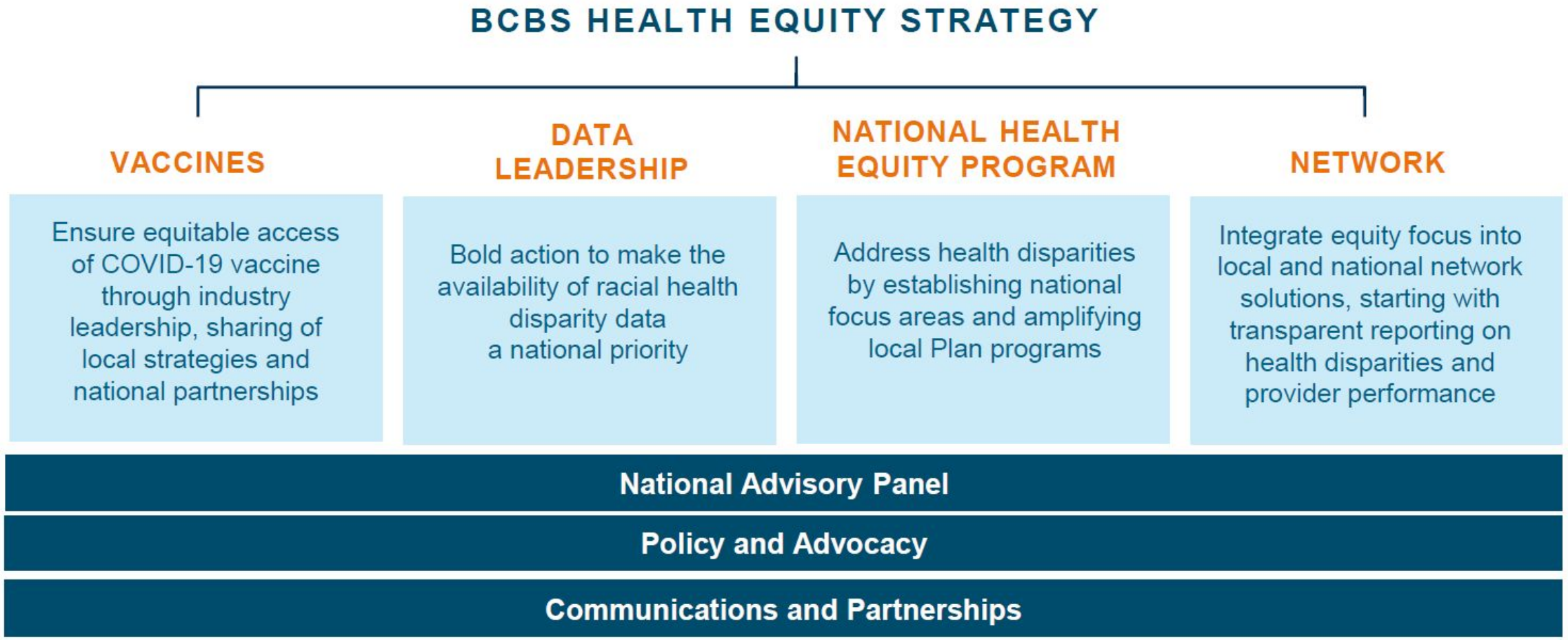
In MD, the adult prevalence of diagnosed diabetes is
highest (13.3%)
in Non-Hispanic Blacks, followed by Non-Hispanic Asians (9.7%), and Hispanics (9.4%), and lowest in Non-Hispanic Whites (8.0%)

MD's maternal mortality rate from 2013-2017
ranked 22nd
among states, with the rate for African Americans almost
4x
that of Whites

Densely populated MD counties were giving out 800 doses per 100,000 adults, compared with just
615 doses
in rural localities as of mid-April

1 https://www.samhsa.gov/sites/default/files/covid19-behavioral-health-disparities-black-latino-communities.pdf
2 https://phpa.health.maryland.gov/ccdpc/Documents/Diabetes%20Action%20Plan%20documents/Diabetes%20Action%20Plan%20June%201%202020.pdf
3 https://hscrc.maryland.gov/Documents/Modernization/SIHIS%20Proposal%20-%20CMMI%20Submission%2012142020.pdf
4 https://www.washingtonpost.com/dc-md-va/2021/04/30/vaccine-disparities-maryland-virginia-dc/

Implementation of the Board-approved Health Equity Strategy is moving forward



Multi-Dimensional Solutions to Reduce Health Inequities

It is the responsibility of health insurers to find ways to address social determinants of health and the best way to do that is to collaborate with the community, state, and national health leaders

CareFirst Strategies include:

Collect data and analytics to measure disparities:

- Standardized data collection
- Uncover insights
- Transparent reporting
- Ongoing evaluation

Incentivize provider performance to embrace health equity:

- Value based care
- MedStar partnership
- Integration of data and systems

Invest strategically to improve social, economic and health outcomes:

- $10M regional diabetes funding
- $6.8M COVID-19 relief funding
- $5M initiative to deliver personal protective equipment

Partner with community-based organizations, public sectors and others to improve community health:

- Baltimore City Public Private Partnership
- Cityblock Health
- Federally Qualified Health Centers

Advocate policy decisions at the state and federal levels to reduce disparities:

- Value based care
- Health Equity Resource Communities

CareFirst Patient Centered Medical Home (PCMH) Program Overview

Launched in 2011 to help members navigate the complex healthcare landscape and reward primary care providers for improved outcomes and value.

Over 4,400 participating PCPs

(More than 80% of PCPs in our service area participate in PCMH)

1.3 million CareFirst members

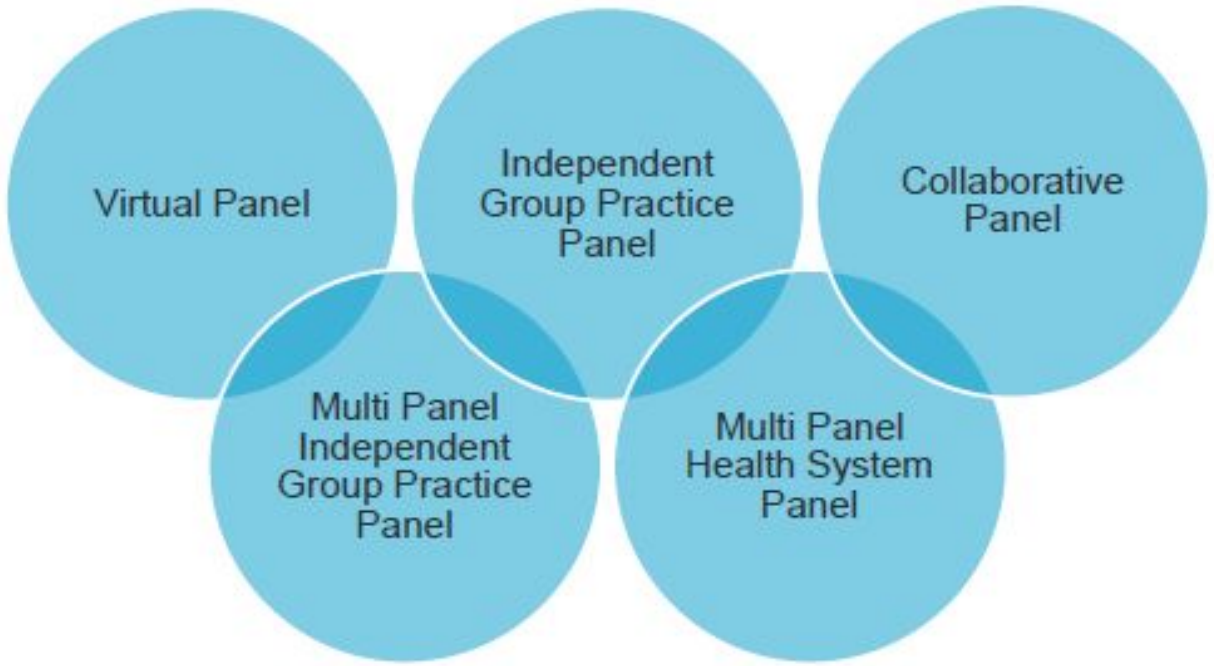
$5.4 billion a year in total spending

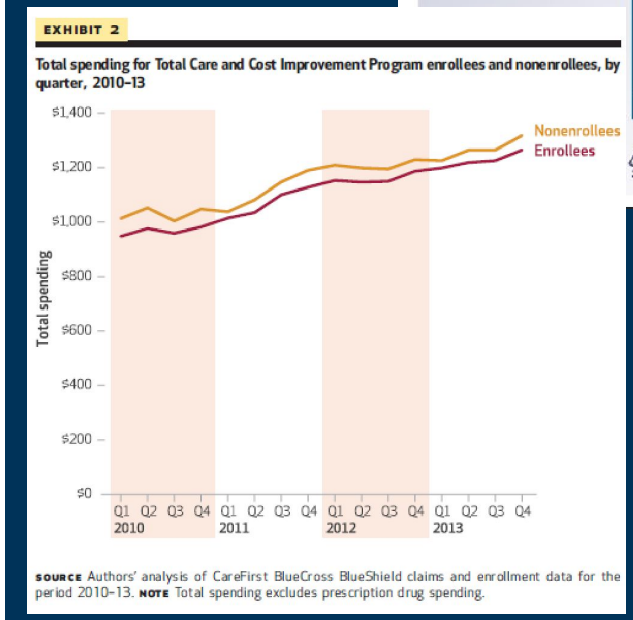
Over $1.4 billion in net savings since 2011

Over a Decade of Results

Drive triple aim reduce the global cost of care, improve population health, and a better patient experience.

- PCPs are organized into Panels, and as a team, are accountable for aggregate quality and cost outcomes of their pooled population.





CareFirst maintains alignment with MDPCP with 5 principles

Principle 1: Financial Incentives *

- Create a more predictable revenue stream through non claims based payments, at risk performance-based payments, partial capitation

Principle 2: Care Management

- Incentivize practices to target high risk, high need members and reduce avoidable utilization

Principle 3: Quality Measures

- CareFirst created a standard quality measure scorecard which aligned with MDPCP metrics and included complementary quality measures that matter to our members

Principle 4: Data Sharing *

- Share deidentified cost and utilization data with CMMI for monitoring and evaluation; make available at the practice level to facilitate care management

Principle 5: Practice Learning

- Provide learning resources to support practices in delivering advanced primary care (CMS led, state led, independent)

* Principles 1 and 4 are highlighted with more details in the coming slides

Conclusion

"This work has just begun. We cannot accept this reality. We can do more. We must embrace the need to change. Each of us individually and collectively as a society."

— Brian Pieninck, CEO, CareFirst

THANK YOU

BRIAN WHEELER
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Maryland Primary Care Program and Health Equity in Primary Care

Emily Gruber, MDPCP Health Equity Manager

October 2021

Agenda

- Brief overview of the Maryland Primary Care Program (MDPCP)
- Overview of Health Equity in MDPCP
- Examples of Health Equity work in MDPCP practices

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Maryland Primary Care Program (MDPCP) Background

MDPCP is….

- A **statewide advanced primary care program**
- **Goal** – Build a strong, effective primary care delivery system, inclusive of medical, behavioral and social needs
- Part of Maryland Total Cost of Care model, a statewide healthcare delivery transformation

Maryland Total Cost of Care Model

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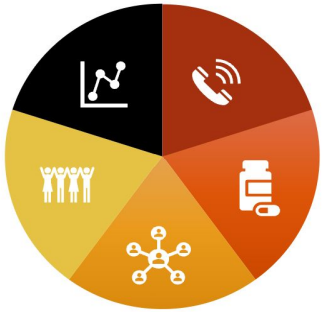
MDPCP's Advanced Primary Care Requirements

Care Delivery Requirements



Access & Continuity – Expanded Access | Alternative Visits (+Telemedicine)

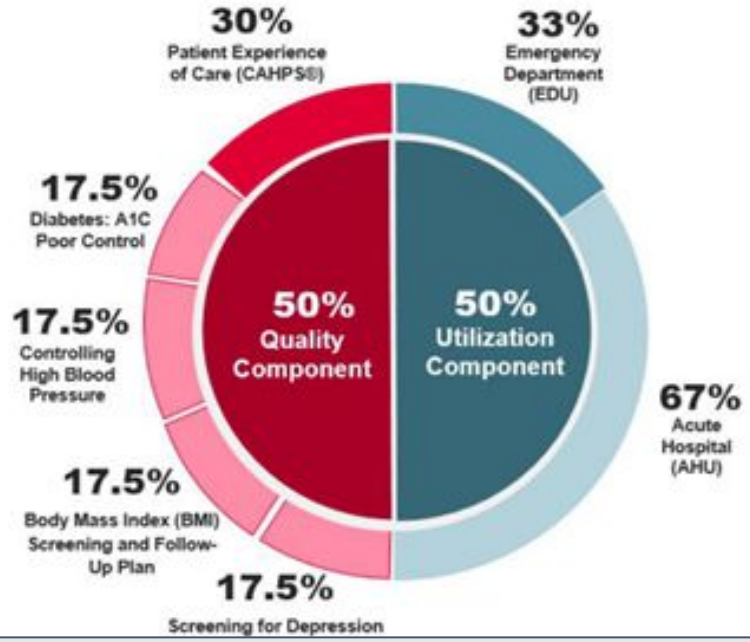
Care Management - Risk-Stratification | Transitional Care Management | Longitudinal, Relationship-Based | Comprehensive Medication Management

Comprehensiveness & Coordination - Behavioral Health Integration | Social Needs Screening & Referral

Beneficiary & Caregiver Experience - Patient Family Advisory Councils | Advance Care Planning

Planned Care for Health Outcomes - Continuous Quality Improvement | Advanced Health Information Technology | CRISP

Quality and Utilization



Clinical Quality measures aligned with State goals – Diabetes Control, Hypertension Control, BMI assessment and follow-up, and Depression assessment and follow-up

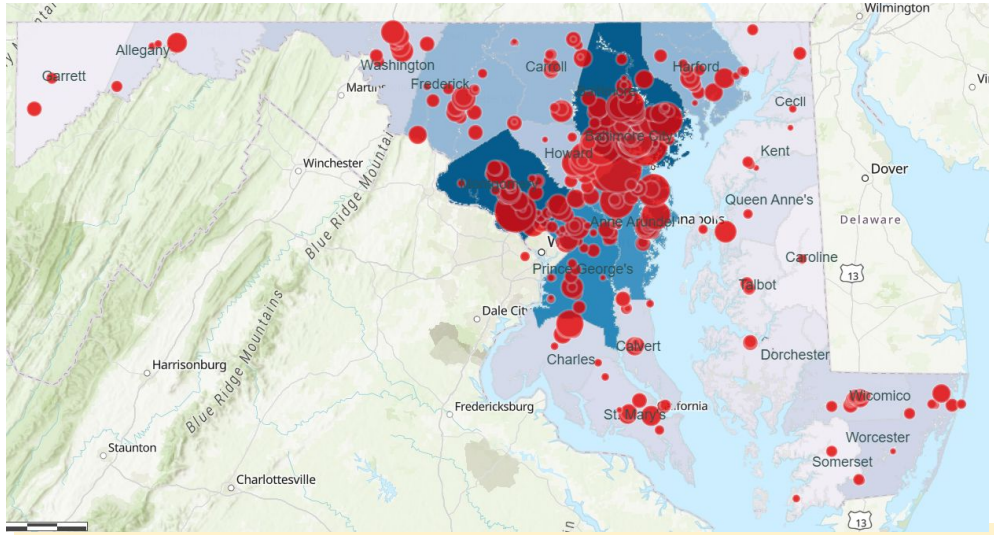
Patient engagement - CAHPS survey for clinicians and groups

Utilization that drives total cost of care - Inpatient hospitalizations and ED visits for Medicare FFS beneficiaries

MDPCP in 2021

PARTICIPANTS	2019	2020	2021
Practice sites	380	476	562**
Providers in MDPCP	~1,500	~2,000	~2,150
FFS Benes Attributed	220,000 (28,717 duals)	356,000 (45,031 duals)	392,000
Marylanders Served	2,000,000 – 3,000,000*	2,700,000 – 3,800,000*	over 4,000,000*

Statewide – Practices in every county



Support infrastructure – 26 Care Transformation Organizations

** *562 sites* – 7 FQHC organizations represent 44 site locations (525 official participants)

* *The Annals of Family Medicine, 2012* http://www.annfammed.org/content/10/5/396.full

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MDPCP Aligned Payers

Goal: further incentivize aims of MDPCP through expansion of advanced primary care initiatives with other payers

Alignment in:

1. Financial incentives
    a. Includes non-visit-based payments and performance incentives
2. Care management
    a. Incentivizes uptake of care management for high-risk patients
3. Quality measures
    a. Same or similar reported quality measures
4. Data sharing
    a. Share de-identified cost and utilization data with CMS
5. Practice learning
    a. Participate and co-lead MDPCP Learning events

- CareFirst is currently an Aligned Payer
- Medicaid on the horizon
- CMS info here

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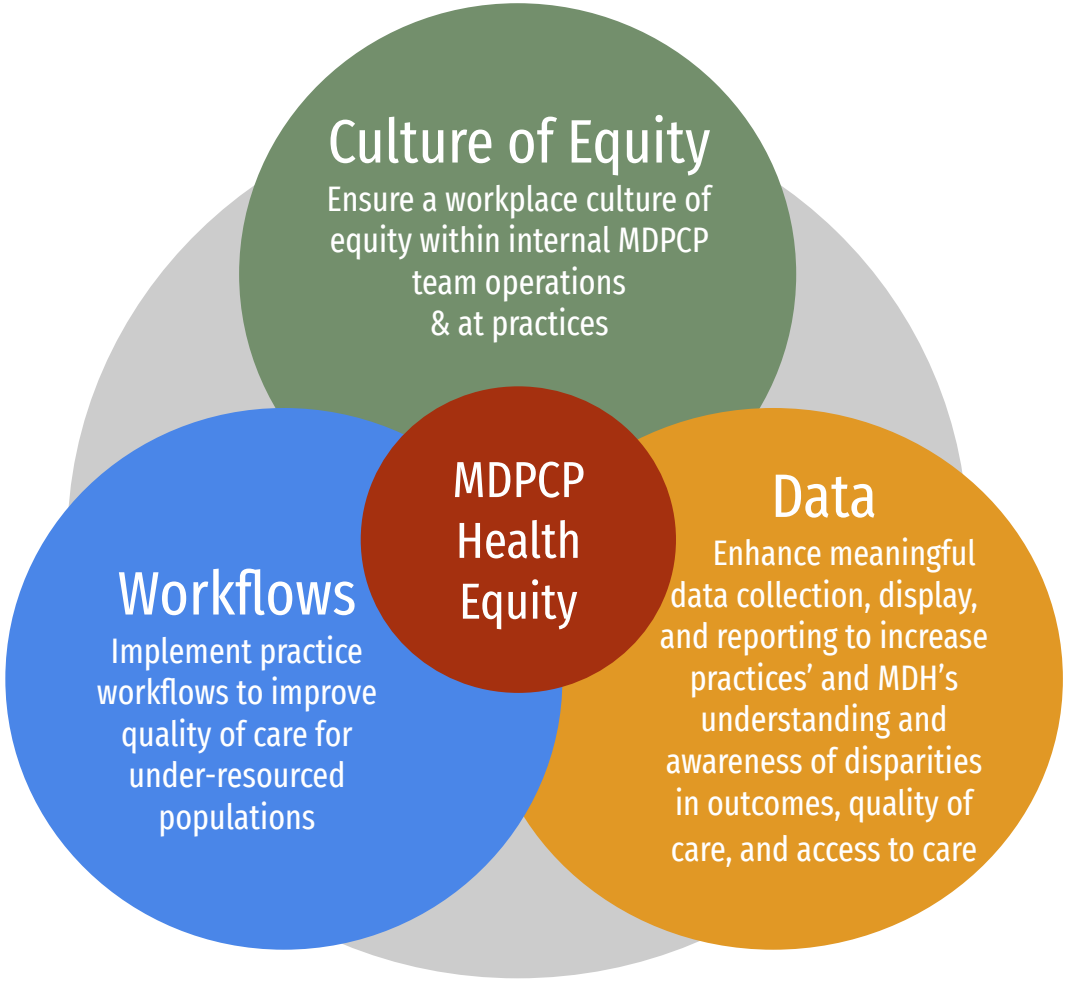
Health Equity in MDPCP



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Examples of Health Equity Work in MDPCP Practices

- Covid vaccine distribution
- Social needs screening
- Multidisciplinary care team including Community Health Workers
- Health equity report in CRISP

Covid-19 Vaccination at Primary Care Practices

Primary Care Advantages

- Where people want to go to get vaccinated
- Trusted relationships
- Reduce hesitancy
- Convenient location
- Existing infrastructure
- Current staff trained
- Data available
- Widely distributed
- Avoids need for complex registration
- Outreach to most vulnerable patients

Primary Care Success

- Over 200,000 doses administered
- Over 440 practices

Breakdown by Race and Ethnicity

Race	PCP	Maryland Demographic	State Vaccination
American Indian or Alaska Native	0.65%	0.60%	0.75%
Asian	3.64%	6.70%	6.64%
Black or African American	29.17%	31.10%	25.67%
Native Hawaiian or Other Pacific Islander	0.21%	2.90%	0.26%
Unknown	13.30%	0.10%	11.64%
White	53.03%	58.50%	55.04%

Ethnicity	PCP	Maryland Demographic	State Vaccination
Hispanic	10.99%	10.60%	9.87%
Non Hispanic	83.21%	89.40%	85.25%
Unknown	5.80%	0.00%	4.88%

Social Needs Screening and Referral

- **MDPCP Requirement:** Screening patients and linking to resources (Track 2)
- Tools to support addressing social needs and proactive outreach:

CRISP e-Referral

Allows bi-directional electronic referrals and communication for social needs including:

- **Food insecurity** - Giant Food Nutrition, Meals on Wheels
- **Housing support** - Catholic Charities
- **Transportation** - Neighbor Ride

Data Tools

Prevent Avoidable Hospital Events tool: (Pre-AH) model presents a risk score for every patient of likelihood of an avoidable hospital event

- Reveals underlying reasons for risk including poverty, education, and other factors

COVID Vulnerability Index - identifies risk of COVID complications based on utilization and non-medical factors

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Multidisciplinary Care Team Approach including Community Health Workers (CHWs)

Organization	CHW Role
UPMC Western Maryland	• Assigned to each primary care practice (PCP) practice • Addresses social determinants of health (SDOH) in partnership with nurse care manager and LCSW • Links patients to the nurse care managers when appropriate • Visits patients in the home - performs an environmental assessment and video chat with the nurse care managers while in the home.
Dr. Lois Narr, independent practice on the Eastern Shore	• Complete blood pressure checks • Teach patients how to use their phones for telehealth visits • Demonstrate how to test and document blood sugar readings • Supportive outreach Note: Obtains CHWs by partnering with Eastern Shore Wellness Solutions, a private, non-profit organization, as well as the Caroline County Health Department

Moving Forward: MDPCP in 2022

- Continued major focus on equity throughout all aspects of MDPCP
  - Quality data extraction and reporting project
- Medicaid integration under consideration
- Point of Care testing equipment project

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Thank you!

Emily Gruber
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Reference Slides

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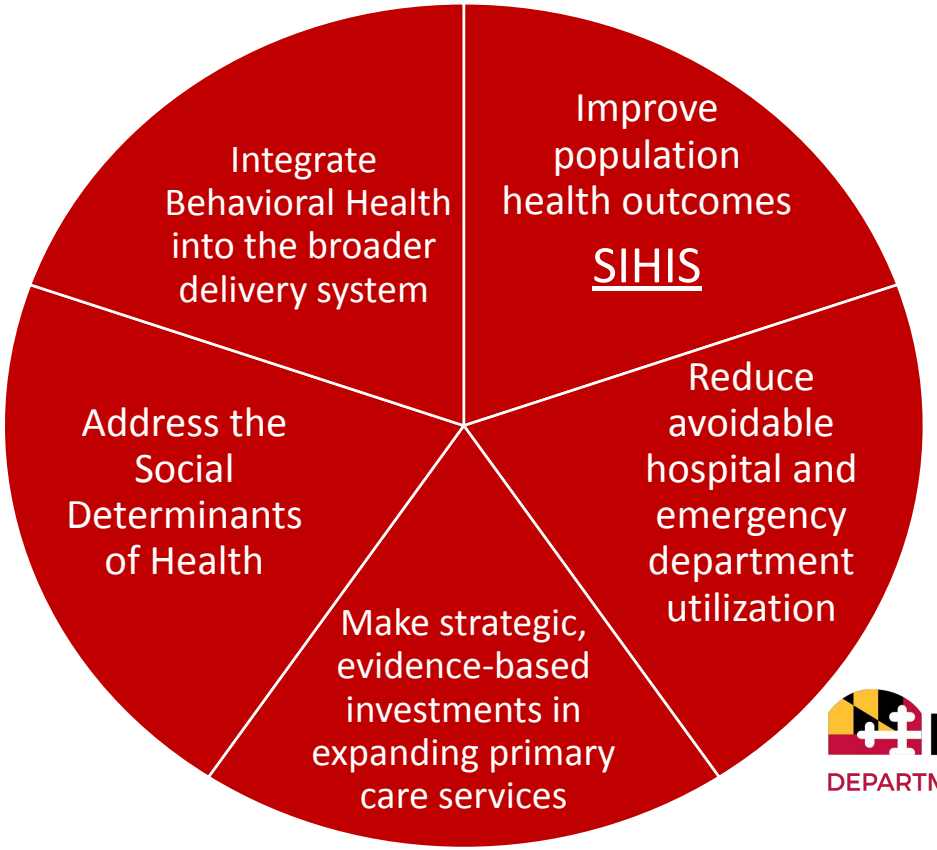
MDPCP Supports Maryland's Statewide Health Transformation

"Under this Model, CMS and the State will test whether **Statewide health care delivery transformation,** in conjunction with Population-Based Payments, improves population health and care outcomes for individuals, while controlling the growth of Medicare Total Cost of Care"

MDPCP Goal –
Build a strong, effective primary care delivery system, inclusive of medical, behavioral and social needs



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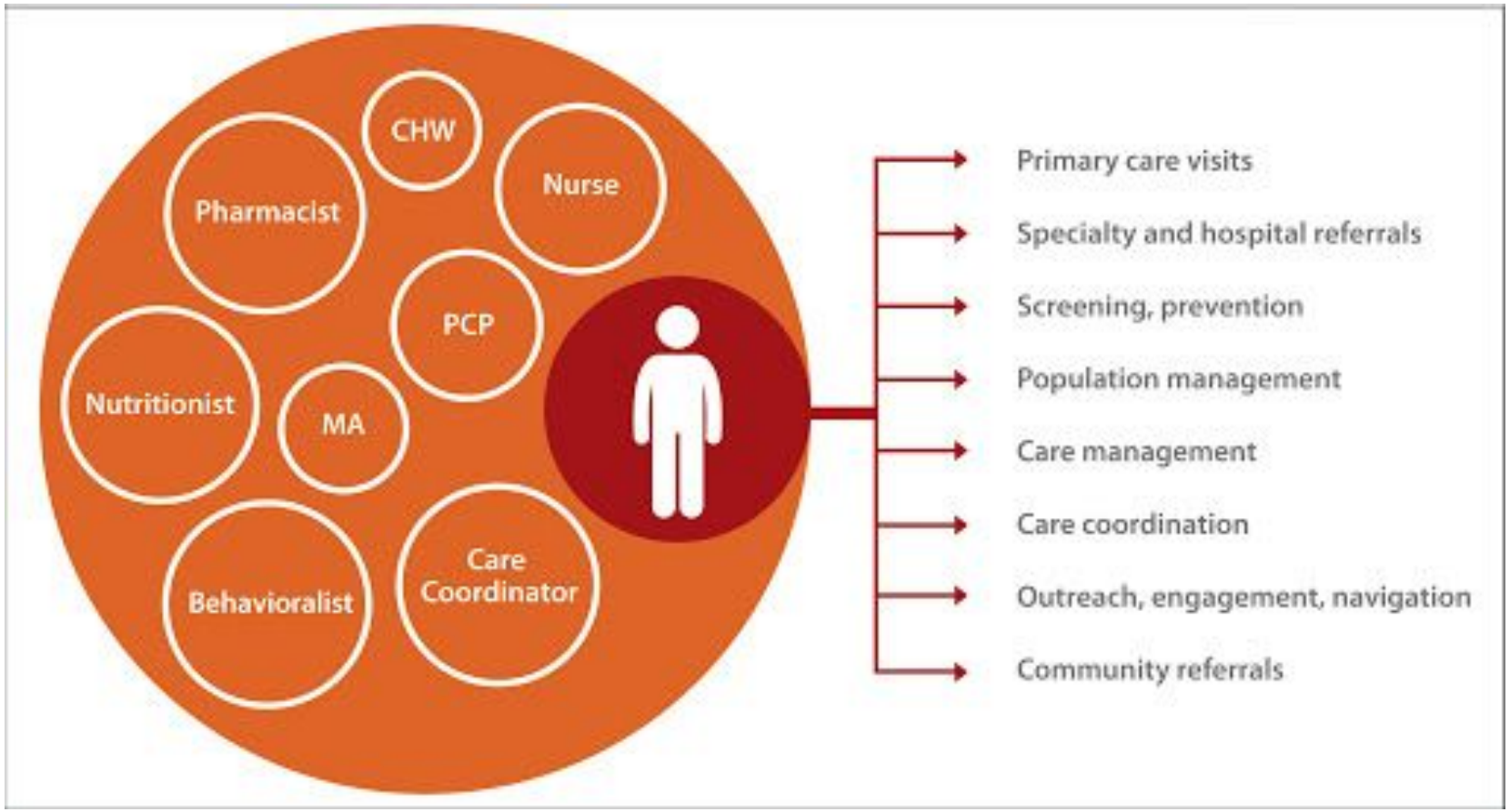
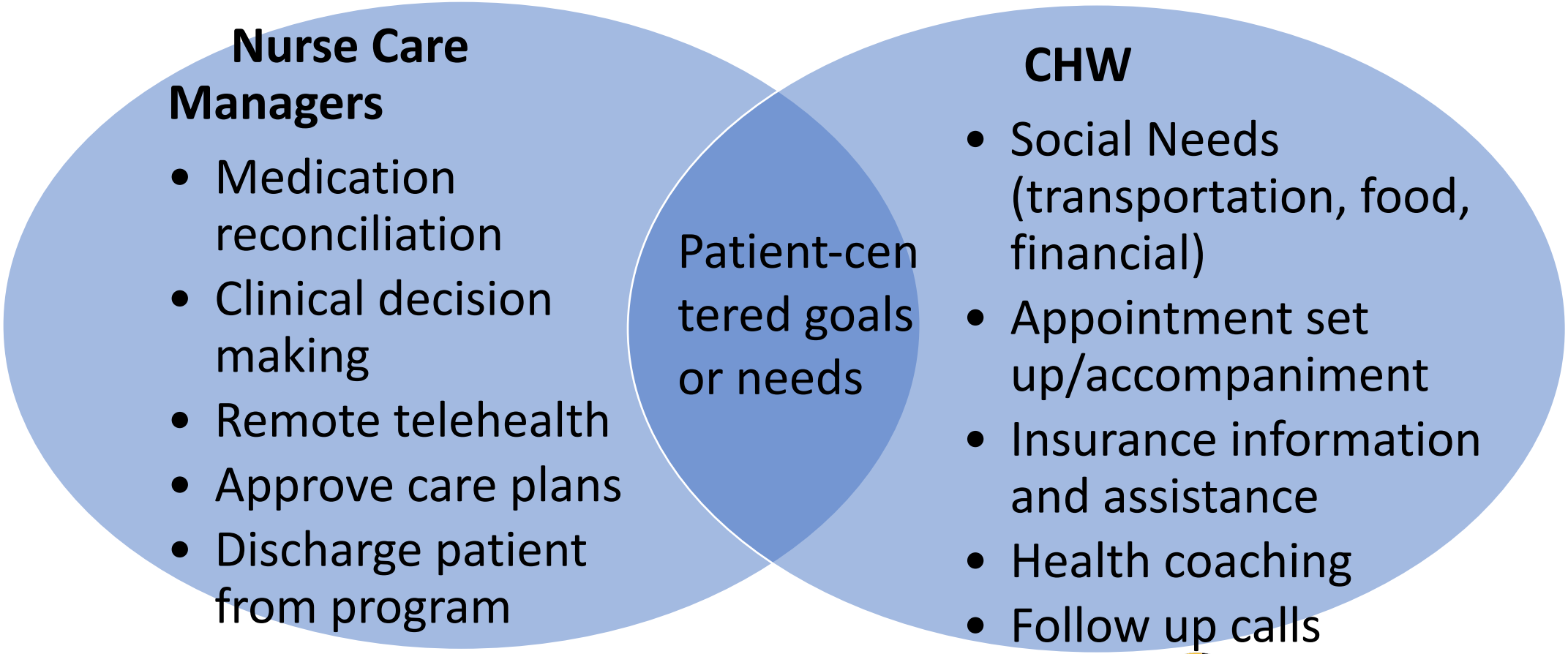
Multidisciplinary care team approach includes CHWs



Source: healio.com

Nurses and CHWs Complement Each Other



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Data on CHWs in MDPCP Care Transformation Organizations (CTO)

Category of Information - 2019 CTO Data	#	%
Total # of CTO CHWs	27	N/A
CTOs With CHWs	7	33.33%
CTOs Without CHWs	14	66.67%
# of CTO CHWs Who Were Full-Time (Where Data is Available)	17	N/A
# of CTO CHWs Who Were Part-Time (Where Data is Available)	2	N/A
Average Hours Worked Per Week by CHWs(Where Data is Available)	37.05	N/A
Median Hours Worked Per Week By CHWs (Where Data is Available)	40	N/A

Source: MDPCP program reporting;
Note: Data not available for practices

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What are CHWs doing in MDPCP?

Organization	CHW Role
HealthLincs CTO	• Address SDOH • Work with lead CM who refers patients to CHW for SDOH • Assist with episodic and longitudinal care management – conduct follow-up calls; explain discharge instructions; checks on meds; social need screen • Recruit patients to participate in patient family advisory council • Transitioned home visits to phone calls due to COVID-19
HealthCare Dynamics International (HCDI) CTO	• Connect patients with food pantry; review diabetic patients list • Work with nurse in practice to follow-up on ED visits • Function as Diabetes Prevention Program (DPP) lifestyle coach - work with prediabetic patients on weight management

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What are CHWs doing in MDPCP?

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What are CHWs doing in MDPCP?

Organization	CHW Role
Netrin CTO	• Social Service Integration: Integrate with community agencies to deliver valuable social service • Customizable Assessments: Assess social barriers to remaining healthy with easily customizable assessment templates • Referral Management: Coordinate among health care providers with referral management • Longitudinal Patient Record: Collect critical medical information for display to all members of a patient's care team

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Thank you!

For information, please visit our website at https://health.maryland.gov/mdpcp/Pages/home.aspx

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Discussion

Discussion Questions

- Questions?
- What are the opportunities for MHBE and insurers to advance health equity through support of the Primary Care Program?
- Are there other ways MHBE and insurers can support team-based care (for example, community health workers)?

Public Comment

Next Steps

Next meeting: Friday, November 5, 1 - 2:30 PM

Workgroup Webpage

MHBE Staff Contacts

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Johanna Fabian-Marks: johanna.fabian-marks@maryland.gov

Appendix

Plan Certification and Affordability Initiatives

Value Plan Standards

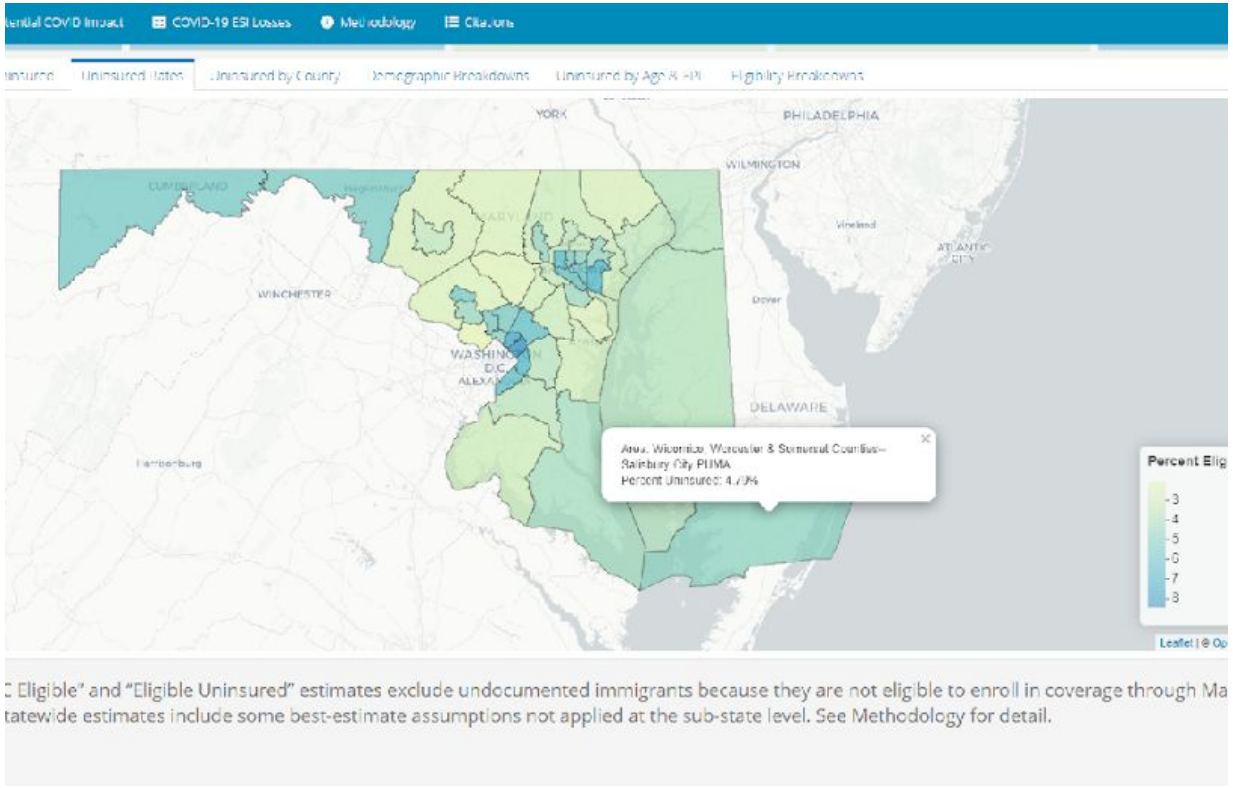
- Diabetes disproportionately affects people of color in Maryland. For PY 2022, MHBE worked to better support Maryland's diabetes initiatives by requiring silver and gold value plans to offer diabetes supplies without cost sharing

Young Adult Subsidy

- Black and Hispanic young adults in Maryland are 2x-3x more likely to be uninsured than White young adults

MHBE Uninsured Dashboard

Interactive MHBE Uninsured Dashboard available at: https://www.marylandhbe.com/wp-content/docs/COVID_Uninsured_Analysis_Dashboard_April2021.html



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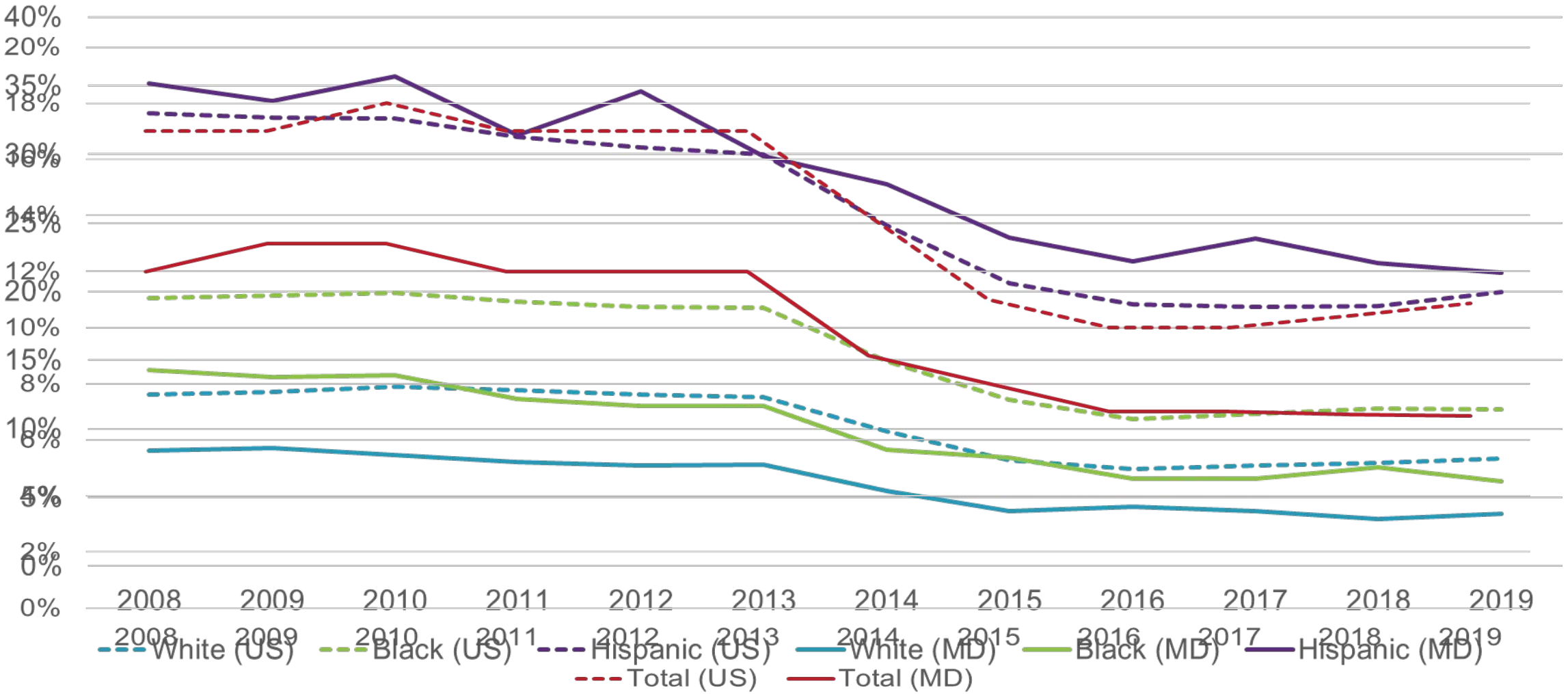
Enrollment by Race & Ethnicity

Percent Uninsured by Race and Ethnicity, MD and US



Data from Kaiser Family Foundation, Uninsured Rates for the Nonelderly by Race/Ethnicity, https://www.kff.org/uninsured/state-indicator/nonelderly-uninsured-rate-by-raceethnicity

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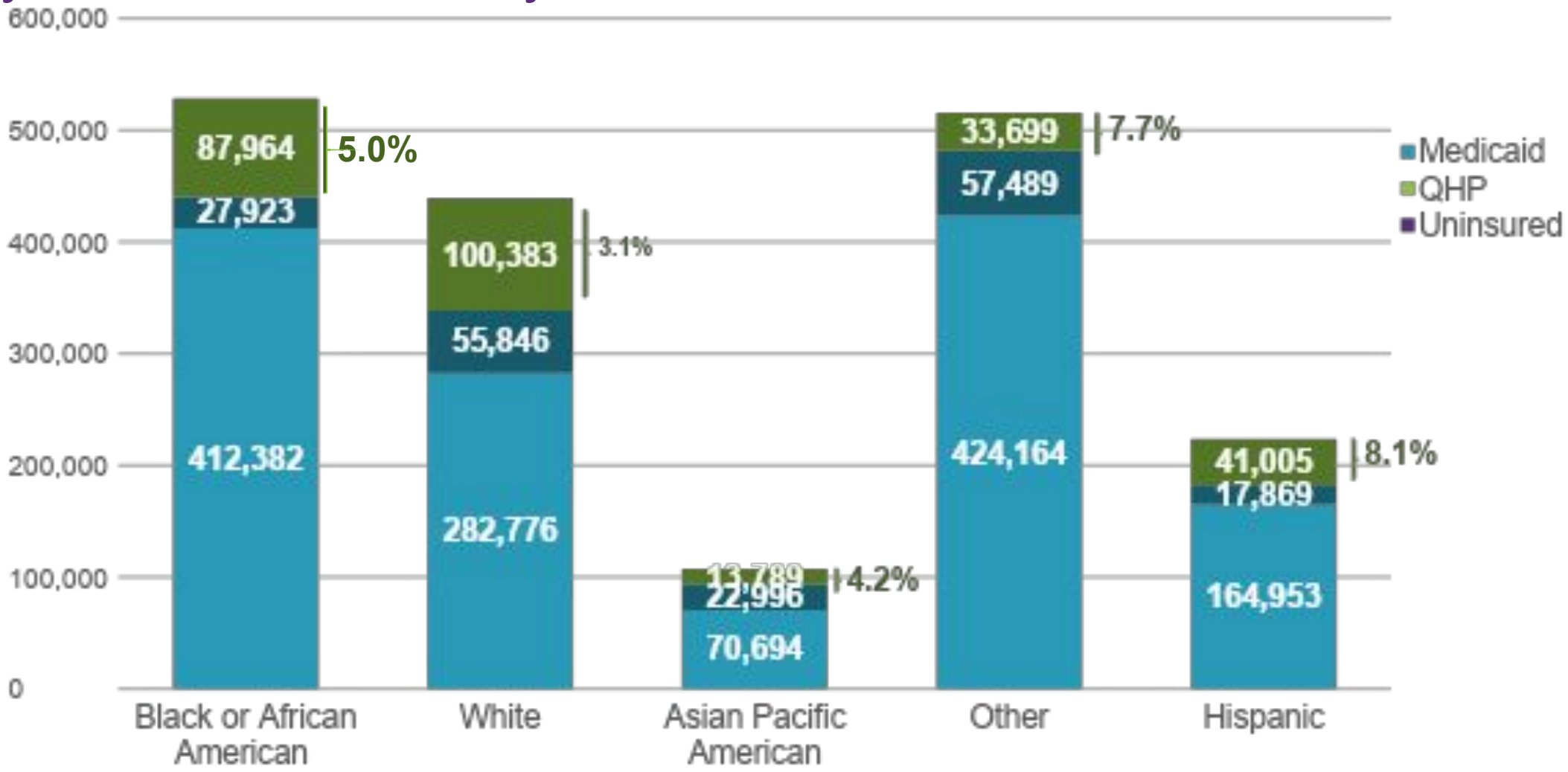
MHBE Medicaid Enrollment, QHP Enrollment, and Uninsured by Race and Ethnicity



MHBE analysis of 2019 5-year American Community Survey Data File. Data excludes individuals ineligible to enroll in Medicaid or QHPs through MHBE.

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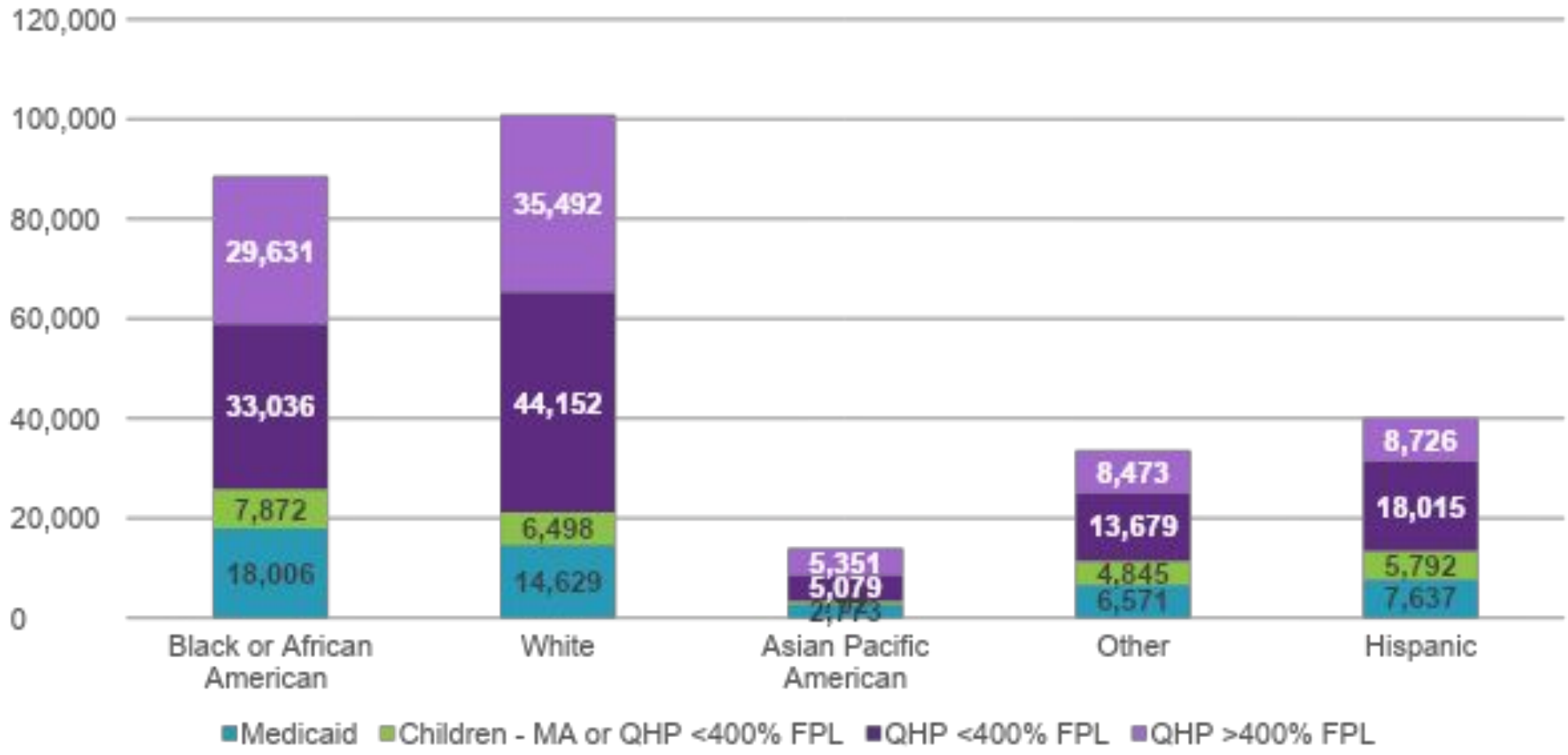
Uninsured by Eligibility for Financial Assistance, by Race and Ethnicity



MHBE analysis of 2019 5-year American Community Survey Data File. Data excludes individuals ineligible to enroll in Medicaid or QHPs through MHBE.

MARYLAND HEALTHBENEFIT EXCHANGE

MHBE 101 – Overview

- **MHBE is a state-based health insurance marketplace/exchange launched in 2014**
  - Operates the **Maryland Health Connection** enrollment platform (website, app, call center)
  - Serves most **Medicaid** enrollees (1.2M) and legally present people in the **individual market** (165,000 - no affordable employer coverage, ineligible for Medicaid/Medicare)
  - Only source of **financial assistance** for people in the individual market: federal subsidies to cap premiums at 0%-8.5% of income and reduce cost-sharing for low-income individuals, state premium assistance for young adulrts
- **MHBE authority/scope includes**:
  - Conducting **outreach and enrollment** activities, overseeing the Navigator program
  - **Enhancing MHC** to improve the enrollment experience
  - **Setting plan certification standards** for individual market plans sold through MHC. Plan certification standards can encompass features such as plan design (e.g. covering certain services pre-deductible) and information provided to consumers (e.g., giving MHBE provider network data so we can offer an integrated provider directory during plan shopping)
  - Administering the **reinsurance** program and **young adult subsidy** program

MHBE 101 - Purposes of the Exchange

(c) Purpose. -- The purposes of the Exchange are to:

(1) reduce the number of uninsured in the State;

(2) facilitate the purchase and sale **of qualified health plans in the individual market** in the State by providing a transparent marketplace;

(3) assist qualified employers in the State in facilitating the enrollment of their employees in qualified health plans in the small group market in the State and in accessing small business tax credits;

(4) assist individuals in accessing public programs, premium tax credits, and cost-sharing reductions; and

(5) supplement the individual and small group insurance markets outside of the Exchange.

Insurance Article 31-102 Annotated Code of Maryland, *Maryland Health Benefit Exchange*

MHBE 101 – General Powers of the Board/Guardrails

- The Board can take “any lawful action that the Board determines is necessary or convenient to carry out the functions authorized by the Affordable Care Act and consistent with the purposes of the Exchange.”
- The powers of the Board cannot supersede the “authority of the Commissioner to regulate business in the State” or the requirements of the ACA.

Insurance Article sections 31-102(d)(1); 31-106 (b) Annotated Code of Maryland

Eligibility & Immigration Status

- Maryland is home to an estimated:
  - 244,693 total undocumented individuals
  - 115,856 **uninsured** undocumented individuals
- MHBE is working on a report on coverage options for undocumented immigrants, as requested by the legislature
  - Staff will notify workgroup members about upcoming briefings
- Resources:
  - Enrollment and Eligibility Information for Immigrant Families (MHC)
  - UNDERSTANDING IMMIGRATION STATUS UNDER THE ACA (MDH)
  - Immigration Fast Facts (CMS)

Eligibility & Immigration Status

Immigration statuses eligible for Individual Marketplace coverage:

- Qualified immigrants under the “5-year bar” (also eligible for APTC)
  - 5-year bar: otherwise-qualified immigrants must be lawfully present for 5 years before they are eligible for Medicaid (with some exceptions)
- Immigrants exempt from 5-year bar
  - Children, pregnant women, asylees, refugees, etc.
- Lawfully residing non-qualified immigrants / individuals with valid nonimmigrant status
  - Student/work visas, temporary resident status, pending application for asylum, etc.

Not eligible for Marketplace coverage:

- Undocumented immigrants
- DACA recipients (7,560 in MD)

Financial assistance eligibility:

- Lawfully present immigrants with income between 138% and 400% FPL
- Qualified immigrants under the 5-year bar with income up to 400% FPL