MHBE

Standing Advisory Committee

September 14, 2023
2:00PM – 4:00PM
Via Google Meets

Members:
Jon Frank, Co-Chair
Mark Meiselbach, Co-Chair
Dana Weckesser, MHBE Board Liaison
Matthew Celentano
Emily Hodson
Diana-Lynne Hsu
Marie-Therese Oyalowo
Kathlyn Wee
Bryan Gere
Catherine Johannesen
Michelle LaRue
Scott London
Allison Mangiaracino
Ligia Peralta
Aryn Phillips
Carmen Larsen
Douglas Spotts
Rick Weldon
Becca Lane
Amelia Marcus
Andrew Ratner

MHBE Staff
Michele Eberle
Johanna Fabian-Marks

Members of the Public
Allison Taylor
Philemon Kendzierski
Pamela Williams
Zach Peters
Sophie Keen
Ashley Fried
Vinny Demarco
Kimberly Cammarata
Sandy Walters
Kate Neuhausen
Jessica Pappas
Katherine Wait
Mahalia Ashraf
Rayva Virginkar
Tracy Grampp
Stacey Shapiro
Brad Boban

Welcome and Minutes
Co-Chair Mark Meiselbach welcomed everyone to the meeting. He moved to approve the minutes of the July 13, 2023, meeting. The minutes were approved.

Board Update
Dana Weckesser, Board Liaison to the SAC, remarked that she especially looks forward to the upcoming presentations since diabetes care costs are so high both in Maryland and across the country. She noted that the presenters will discuss how their organizations work to reduce the impact of both type 1 and type 2 diabetes.

Executive Update
Michele Eberle, Executive Director of the Maryland Health Benefit Exchange (MHBE), started with the executive update. She began by thanking SAC members for their efforts on behalf of the MHBE.

Ms. Eberle then discussed the open enrollment period beginning November 1, noting that the Maryland Insurance Administration (MIA) is finalizing plan rates for 2024, which will allow the MHBE to load the plan onto Maryland Health Connection (MHC) and send out the required notices by October 1. She explained that the proposed rates were on average 5.7% higher than the prior year, an increase that compares favorably to the national average due to the State Reinsurance Program (SRP).

Next, Ms. Eberle described the MHBE's efforts in the ongoing Medicaid unwinding, which she characterized as a return to normal operations post-pandemic. She noted that federal authorities have granted waivers to assist with the unwinding, such as continuing coverage for 12 months for anyone under the age of 19 and for those with income below the federal poverty level (FPL). Recent federal guidance on "ex parte" automatic redeterminations requires that they be performed on the individual rather than the household level, resulting in a great deal of effort by Maryland and other states to comply.

Ms. Eberle then discussed the implementation of the Healthy Babies Equity Act, which provides coverage for undocumented mothers and children, noting that the program has already covered nearly 3,800 people out of the roughly 6,000 projected.

Ms. Eberle concluded her remarks by highlighting the MHBE's data dashboard and monthly data reports, both available on the website. She noted that enrollment numbers are the highest they have ever been, with Hispanic enrollment up 27% and African American enrollment up 13% year-over-year. More than 53,000 young adults enrolled in qualified health plans (QHPs), which has a positive impact on the total risk pool. She cautioned that, due to the impact of the Medicaid unwinding, the MHBE's call center has had challenges with the increased volume of calls. More staff are being brought on board to address the problem.

Sandy Walters asked whether the MHBE has seen any uptick in enrollment through the Small Business Health Options Program (SHOP). Ms. Eberle replied that she did not have the figures on hand, but that they are available in the data report. She added that the SHOP has recently been highlighted on the Maryland Business Express website to bolster enrollment.

Catherine Johannesen asked if there is anything to learn from the high enrollment numbers for August. Ms. Eberle replied that the surge in enrollment is clearly due to the Medicaid unwinding and cautioned that the currently available data do not show effectuation of coverage.

Michelle LaRue asked for an update on the report mandated by the Maryland General Assembly. Ms. Eberle answered that several such reports are underway, noting that the MIA had its last public hearing that day on the House Bill 413 report and is on track for delivery by December 1. A separate Medicaid report is also projected to be complete by the October due date.

Ms. LaRue asked whether the Healthy Babies enrollments have impacted call center volume. Ms. Eberle replied that she would investigate the details, but that the volume is likely due to the Medicaid unwinding.

Allison Mangiaracino asked for an update on the effort to transition enrollees from Medicaid to QHPs. Johanna Fabian-Marks, Director of Policy & Plan Management, MHBE, replied that the program has automatically enrolled nearly 18,000 people thus far, of whom approximately 2,000 have effectuated coverage. Some 1,500 people who were automatically enrolled in a QHP came back to complete an application, after which they were re-enrolled in Medicaid. Ms. Eberle added that the MHBE is surveying Marylanders who are eligible for the program but do not enroll to discover their coverage status, such as whether they have gained spousal coverage or have decided to go without coverage.

Overview of Maryland's State Diabetes Action Plan

Pamela Williams, Director of the Cancer & Chronic Disease Bureau of the Maryland Department of Health (MDH), gave a presentation on the Maryland Diabetes Action Plan. She directed SAC members to a website where the plan is published and described the range of stakeholders involved in its creation, including local health departments, hospitals, insurers, and the Medicaid program. The plan is designed to provide information regarding the disease burden of diabetes and factors impacting risk, to identify interventions and measures for success.

Ms. Williams then shared statistics regarding diabetes both in Maryland and nationwide, showing that the burden of diabetes is quite high—it is the 7th leading cause of death in the state and 9 out of 10 adults with prediabetes are unaware of their condition. She shared estimates from the plan that show the costs associated with diabetes, with roughly $5 billion spent on medical costs and an additional $2 billion in lost economic productivity due to the condition. She compared the prevalence of diabetes by county in Maryland as well as by race/ethnicity.

Next, Ms. Williams described the characteristics and size of the populations targeted in the Diabetes Action Plan along with the goals for those groups. One population is Marylanders who are overweight or obese, numbering roughly 2.8 million people. The plan sets a goal of achieving a favorable change from baseline mean body mass index (BMI) compared with a group of control states through 2026. Another population is the over 1.8 million Marylanders with pre-diabetes. This population is also compared with a group of control states with the goal of averting escalation into full diabetes. The third population includes Marylanders who are living with diabetes and its complications, a

group of nearly 600,000 people. The plan sets a goal to reduce age-adjusted diabetes mortality by 5% by 2024.

Diana Hsu asked whether the numbers presented include gestational diabetes. Ms. Williams answered that gestational diabetes has been the subject of other analyses. Ms. Williams continued discussing the plan goals and progress toward them, including three main objectives to be achieved by 2024: 32% of Maryland adults being of healthy weight, hold the rate of adults with the highest BMI to 66.5%, and the reduction in mortality already mentioned. Ms. Williams noted that, while the first two objectives are on track to meet the targets, the mortality trend appears to be headed in the wrong direction but cautioned that the increase in mortality may have been related to COVID-19. This possible discrepancy will remain unclear until the most recent data for age-adjusted diabetes mortality become available.

Next, Ms. Williams discussed the Diabetes Action Plan's interventions for the three main populations. These include health systems interventions such as care management and self-management education for those with diabetes, community health care interventions such as the National Diabetes Prevention Program for those experiencing pre-diabetes, and community wide interventions like policies to increase access to healthy nutrition and exercise to keep those unaffected by diabetes or pre-diabetes healthy.

Bryan Gere asked whether the plan addresses coverage of anti-obesity medications for people with pre-diabetes. Ms. Williams replied that such coverage is the topic of ongoing discussions with the Medicaid program, where some preliminary approvals have been given, but was not included in the Governor's budget. Ms. Weckesser stressed that other interventions are effective.

Ms. Hsu asked whether the plan includes interventions to address access to healthy food and food deserts. Ms. Williams confirmed that she would soon discuss such interventions.

Ms. Williams then shared an overview of state investments related to diabetes, including funding from her organization, Medicaid, the Maryland Primary Care Program, and the Maryland Health Services Cost Review Commission. She described efforts to implement the plan, including a special effort to encourage employers to offer enhanced benefits that has seen limited success thus far.

Ms. Williams concluded her remarks by outlining the National Diabetes Prevention Program (DPP) and describing next steps for the Diabetes Action Plan, which is currently being updated to collect new data, engage with experts to improve the plan, and schedule a review with external stakeholders in the coming months.

Overview of Diabetes-Related Benefits and Impact on Reinsurance

Johanna Fabian-Marks discussed the state laws that limit diabetes-related cost sharing, including a limit on the monthly cost of insulin to the consumer and a requirement for

free diabetes test strips for all plans except high deductible health plans (HDHPs). She then described how the 2023 and 2024 Value Plans address cost sharing for diabetes care. In 2023, all value plans must cover certain diabetic supplies without cost sharing. In 2024, value plans must offer a range of diabetes care management services without cost sharing, including visits, exams, lab tests, counseling, supplies, and medications. She explained that the total number of individual market enrollees with diabetes has grown each year from 2019 through 2021.

Next, Ms. Fabian-Marks shared details of how diabetes has impacted the SRP, showing that it was among the three most frequent conditions for consumers whose health care triggered an SRP claim during 2019 through 2021. In addition, diabetes was in the top five most costly conditions in the SRP in 2019 and 2020. She noted that, while costs per person were declining during those three years, the improvement was more than offset by the rising volume of claims.

Brad Boban asked whether the figures included all claims for those with diabetes rather than only the diabetes-related claims themselves. Ms. Fabian-Marks confirmed that he was correct.

UHC Individual & Family Plans Diabetes Management Programs & Interventions
A team from United Healthcare (UHC) gave an overview of their organization's efforts toward diabetes management and intervention goals. Dr. Kate Neuhausen, National Chief Medical Officer for UHC Individual & Family Plans, introduced herself and shared some details of her professional background related to diabetes care, public health, and health insurance.

Rayva Virginkar of UHC noted that the company covers preventive prediabetes screenings in accordance with U.S. Preventive Services Task Force recommendations and outpatient self-management training. She explained that nearly 9% of UHC enrollees in Maryland have diabetes. The company's strategy focuses on in-home HbA1c testing, telephonic case management nurse support, and online in-depth diabetes management training through a partnership with Galileo.

Next, Ms. Virginkar went into further detail on the UHC in-home HbA1c testing program. Beginning in October 2023, enrollees receive all of the equipment and supplies necessary to take a blood sample, send that sample to the lab, and receive the results by mail. Any elevated results are also sent to the enrollee's primary care provider (PCP). The program is intended for those enrollees who demonstrate a lack of access to such testing, such as those who are not engaged with a PCP.

Ms. Virginkar then described how diabetes interventions are built into the UHC case management program. Under the program, enrollees are connected via telephone to case management nurses to receive individualized support for managing their condition. UHC employs persistent super utilizer algorithms to target enrollees for the program.

Next, Ms. Virginkar shared information on Galileo, a partner organization and app that provides virtual care to UHC members enrolled in a “Virtual First” or “Virtual Access” plan. Under these plans, Galileo is assigned as the enrollee’s PCP and manages linkages and referrals to other providers.

A meeting participant asked via online chat where Galileo providers are located. Dr. Neuhausen answered that the providers are located all over the U.S., but all are fully credentialed in Maryland.

Diana Hsu referred to the earlier briefing regarding the Diabetes Action Plan and asked how Galileo providers stay abreast of the local resources in Maryland. Dr. Neuhausen replied that she would seek that information and report back.

Sandy Walters asked what share of enrollees use the Galileo offering. Ms. Virginkar replied that 15% of UHC enrollees with a diabetes diagnosis are engaged with Galileo.

Ms. Virginkar concluded her remarks by sharing details of the 2024 benefit design for UHC enrollees with diabetes. She noted that the standards set in the value plans are applied to all UHC plans.

Ligia Peralta asked how Galileo technology will interact with enrollees’ PCPs, especially for challenging patients. Ms. Virginkar replied that Galileo is intended to be the PCP, but they do interact with other brick and mortar providers. Dr. Neuhausen added that enrollees using Galileo can still visit a physically present provider using a warm handoff from Galileo.

Kaiser Permanente of the Mid-Atlantic States Diabetes Management and Prevention

Stacey Shapiro of Kaiser Permanente of the Mid-Atlantic States (KP) gave an overview of KP, its locations in the region, and its model of care delivery. She outlined the organization’s use of technology for proactive patient management, including KP having been a trailblazer in the use of virtual options for health care, such as offering physician visits by video since 2013. She shared figures showing great success at KP in controlling blood pressure and blood sugar and discussed the DPP with over 700 members led by a KP physician. Ms. Shapiro concluded her remarks by listing several health engagement resources available at KP to help address diabetes. She noted that KP members who engage with the supports offered have over 5.5% weight loss on average, with over 100 minutes of physical activity per week.

CareFirst Wellbeing

Ashley Fried, a wellbeing consultant with CareFirst, gave the SAC an overview of two CareFirst programs for enrollees with diabetes—disease management coaching and diabetes virtual care. She noted that the organization offers many more wellbeing services to their members than the two she will highlight. CareFirst disease management coaching, she explained, bases its approach on the principles of

motivational interviewing. Members receive one-on-one personalized coaching from a registered nurse.

Tracy Grampp from CareFirst discussed the diabetes virtual care program at CareFirst. Designed for people with uncontrolled diabetes, the program provides a mobile app, connected devices like a blood glucose meter, unlimited test strips, and access to a virtual care team. She emphasized that these supports are intended to supplement the work of the member's PCP as opposed to replacing the PCP. Ms. Grampp concluded her remarks by displaying outcomes metrics for the program, showing that program participants are reducing their A1c and maintaining those reductions.

Ms. Eberle asked whether CareFirst has been able to link these outcomes with cost savings. Ms. Grampp replied that CareFirst has seen some improvement in medical costs over the past two years that has been accompanied by an increase in pharmacy costs.

SAC Discussion

Ms. Fabian-Marks asked SAC members to share their thought and ideas, especially around what steps the MHBE should take to address the problem of diabetes but also other topics.

Ms. Weckesser expressed gratitude for the presentations but noted that none of them discussed type 1 diabetes and wondered whether the MHBE should consider this condition in value plan design.

Ms. LaRue pointed out that continuous glucose monitoring is shown in the literature to be helpful for both type 1 and complicated type 2 patients. She expressed that having access to the service established in the coverage requirements could be a good move for the MHBE.

Carmen Larsen asked how the presenters' organizations approach educational barriers to effective management of diabetes over and above any language barriers. Ms. Shapiro agreed with the importance of not just language but also cultural humility in improving outcomes.

Marie Therese Oyalowo asked that the SAC be presented information on funding for cancer patients and the barriers they experience trying to access effective treatment due to prior authorization requirements.

Diana Hsu asked for more focus on social determinants of health and how the MHBE can help there, especially with the focus broadened out from just providers.

Mark Meiselbach asked for information on how carriers are maintaining enrollee access to mental and behavioral health providers.

2025 Plan Certification Standards

Ms. Fabian-Marks confirmed that the MHBE does not anticipate making changes to the 2025 value plans.

Public Comment
None offered.

Adjournment
The meeting adjourned at 4:00 PM.

Chat record:
00:00:09
Amelia Marcus -MHBE-: Reminder this meeting is being recorded

00:29:49
Casa Ruben: Excellent question, Bryan.

00:41:42
Allison Taylor: Thanks, this was very interesting!

00:41:57
Michelle LaRue: thank you for a great presentation

00:42:30
Pamela R. Williams -MDH-: Thank you everyone. If there are any questions, please contact me at pamelar.williams@maryland.gov

00:42:44
Mark Meiselbach: thank you, Pamela!

00:53:31
Dana Weckesser: Pamela, I so appreciate your presentation. Let's follow up later.

00:57:48
Bryan Gere: Sorry I have to jump.off to another meeting

00:57:58
Bryan Gere: Thanks everyone

01:02:26
Diana Hsu: I'm sorry - what was the percentage again? 20%?

01:02:36
Diana Hsu: Thank you!

01:03:47
Diana Hsu: Where are the providers on Galileo located? Are they within MD?

01:04:27
Dana Weckesser: What specifically is the complication for statin use among diabetics?

01:16:38
Dana Weckesser: What specifically is the complication for statin use among diabetics?

01:19:50
Doug: my apologies all, I need to jump off and head into another meeting. interesting information and updates. I'll look forward to the minutes of the upcoming presentation and discussion time

01:58:49
Mark Meiselbach: I'll offer another possible topic for future meetings: how are carriers maintaining access to mental/behavioral health providers (psych, treatments for opioid use disorder, etc)