Maryland Health Benefit Exchange
Board of Trustees

October 21, 2024
2 p.m. – 4 p.m.
Meeting Held via Video Conference

Members Present:
Laura Herrera Scott, M.D., Chair
Ben Steffen, Vice Chair
Aika Aluc
Laura Crandon
Marie Grant
Katherine Rodgers

Members Absent:
Maria Pilar Rodriguez
K. Singh Taneja
Dana Weckesser

Also in Attendance:
Michele Eberle, Executive Director, MHBE
Andrew Ratner, Chief of Staff, MHBE
Venkat Koshanam, Chief Information Officer, MHBE
Shirelle Green, Procurement Officer, MHBE
Johanna Fabian-Marks, Director of Policy & Plan Management, MHBE
Makeda (Mimi) Hailegeberel, Manager, Small Business Programs, MHBE
Amelia Marcus, Health Policy Analyst, MHBE
Betsy Plunkett, Director, Marketing & Web Strategies, MHBE
Tamara Gunter, Director of Consumer Assistance & Eligibility, MHBE

Meeting Call to Order
Sec. Herrera Scott called the meeting to order.

Approval of Minutes
Sec. Herrera Scott asked for a motion to approve the minutes of the August 19, 2024, meeting with an addendum to include additional information presented in the Finance Committee report as requested by Mr. Taneja. Mr. Steffen motioned to approve the August 19, 2024 meeting minutes as amended. Ms. Grant seconded the motion. The Board approved the minutes unanimously with Ms. Rodgers abstaining because she was not on the Board for the August 19 meeting.

Sec. Herrera Scott asked for a motion to approve the minutes of the September 16, 2024, meeting. Ms. Rodgers moved to approve the minutes, seconded by Ms. Crandon. The Board approved the minutes unanimously.

Executive Update

Ms. Eberle began her remarks by welcoming Marie Grant to the Board as acting Commissioner of the Maryland Insurance Administration. Ms. Grant brings a wealth of experience in public health and insurance to the Board.

Ms. Eberle started with the federal update. She noted that Congress is in recess until November 12. The continuing resolution has been approved which continues federal funding through December 20; the MHBE is not concerned about funding at this point. She explained that the current rule allowing deferred action for childhood arrivals (DACA) recipients to enroll in coverage through the Maryland Health Connection (MHC) goes into effect on November 1 with recipients being able to enroll in coverage for the rest of 2024 or for 2025 with tax credits. The MHBE intends to move forward with implementing this rule until told otherwise. Ms. Eberle noted that the most significant federal legislation for the MHBE is the continuation of the expanded tax credit. If the expanded tax credits end, then individuals who used those credits to purchase insurance will likely be unable to afford their coverage. She encouraged everyone attending the meeting to examine and share the information posted on the MHBE website regarding the expanded tax credits including impact information.

Ms. Eberle then provided the state update. The MHBE is currently preparing for the twelfth open enrollment. Ms. Eberle reported that the MHBE is in the best position ever for the open enrollment because enrollment continued to grow throughout 2024 instead of dropping towards the end of the year as in past years. She explained that individuals who lost Medicaid coverage during the public health emergency unwinding moved into the exchange which contributed to the increased enrollment. As of September 2024, 216,000 individuals are enrolled which is 3,000 more than the peak enrollment during 2023. Black and Hispanic enrollment has increased by 24% compared to last year and young adult enrollment has increased by 45%. Ms. Eberle noted that the MHBE is entering the next open enrollment with huge success and hopes to build on it with the strategies being discussed today. She thanked the MHBE's partners, the Maryland Insurance Administration (MIA), the Department of Health (the Department), Department of Human Services (DHS), Connector Entities (CE), the call center, fulfillment center, and others for their collaboration which has contributed to increased insurance coverage in the state.

Ms. Eberle ended with staff updates. She reported that the MHBE marketing team received a silver award for brand awareness at the American Marketing Association in Baltimore following three marketing awards in 2023 and one award in 2022. She noted that Venkat Koshanam recently received his PhD at the University of Maryland.

Mr. Steffen asked about the factors that contributed to the increased enrollment at the end of the year. Ms. Eberle responded that individuals moving from Medicaid to the exchange after losing Medicaid coverage during the unwinding contributed to the increased enrollment. She noted that there were also additional special enrollment periods during 2024 such as a new special enrollment

period for individuals with household incomes below 150% of the federal poverty level (FPL) allowing them to enroll in coverage at any point during year. Ms. Eberle remarked that the primary reason for the increased enrollment is individuals moving from Medicaid to the exchange.

Final MHC for Small Business Regulations

Amelia Marcus, Health Policy Analyst, MHBE

Ms. Marcus explained that MHBE staff are requesting final Board approval of the proposed small business program regulations and authorization to submit them to the Maryland Register for final publication. She noted that the MHBE is proposing regulatory updates for small business operations to incorporate changes to the minimum participation rate and waiting period requirements for qualified employers offering coverage through MHC for Small Business. The proposed updates were brought before the Board for approval during the July 15 meeting and then published to the Maryland Register in August for a 30-day public comment period. The MHBE did not receive any public comments, so no changes were made to the proposed regulations.

Ms. Marcus explained the proposed modifications to the regulations. The minimum participation rate for a qualified employer's Small Business Health Options Program (SHOP) eligibility will be reduced from 75% to 60% for both employee choice and employer choice models. The maximum waiting period a small employer may impose for employees newly enrolling in coverage will be reduced from 90 days to 60 days, with coverage effective the first of the month after the end of the waiting period date. The proposed updates were discussed during Small Business Programs Advisory Committee meetings. Ms. Marcus explained that while the federal exchange generally requires a 70% minimum participation rate, federal regulations allow state marketplaces the flexibility to determine their SHOP minimum participation rate. Federal regulations limit waiting periods for coverage to become effective to a maximum of 90 calendar days from the date an employee is first eligible for coverage. Under current state regulations the waiting period is limited to 90 days but specify that coverage effectuates at the first of the month following the end of the waiting period which could amount to 120 days total. Therefore, the MHBE is proposing to reduce the maximum waiting period to 60 days to ensure that the latest effective date of coverage for an employee would be within 90 days.

Ms. Marcus reiterated that the MHBE is asking the Board to approve the regulations as proposed, then they will be published as final regulations in the November 1st Maryland Register and become effective on November 11. Sec. Herrera Scott asked for a motion to approve the final Small Business program regulations as presented and authorize MHBE to submit them to the Division of State Documents for publication in the Maryland Register as presented. Ms. Rodgers moved to approve the regulations as presented and Ms. Grant seconded. The Board approved the motion unanimously.

MIA Network Adequacy Findings

David Cooney, Associate Commissioner for Life and Health, MIA

Mr. Cooney provided an overview of the MIA's network adequacy standards and review process. Network adequacy refers to a carrier's ability to deliver the benefits promised in the insurance contract by providing reasonable access to enough in-network primary and specialty care practitioners and facilities who are qualified to provide all the health care services covered by the health plan. Network adequacy is evaluated at the aggregate level, not at the individual level, and it focuses on clinical appropriateness rather than consumer preferences.

Mr. Cooney noted that the network adequacy regulatory requirements that apply to health benefit plans are in COMAR 31.10.44. Mr. Cooney noted that the MIA's network adequacy standards have a much broader scope than MHBE's qualified health plan (QHP) certification standards. He highlighted that the that the MIA's network adequacy regulations were revised last year. The MIA regulatory standards apply to all commercial insurance plans that utilize a network of healthcare providers. This includes qualified health plans (QHPs) in the individual and small group markets, off-exchange plans, large group plans, student health plans, and short-term limited duration health plans. The MIA standards apply at the network level for all health benefit plans issued by the carrier that use the same provider network. The MIA evaluates whether the network is sufficient for all enrollees covered under any plan provided by the carrier not just whether the network is sufficient for enrollees in a particular QHP.

Mr. Cooney explained that there are two main types of network adequacy standards: qualitative standards and quantitative standards. Qualitative standards are network adequacy standards based on subjective criteria that allow for flexibility in reporting and interpretation. One example of a qualitative standard might be a general requirement that networks must have sufficient number and types of providers to ensure enrollees can access care without unreasonable delay. He noted that qualitative standards are helpful for setting general regulatory expectations but are difficult to measure and enforce objectively. Quantitative standards are network adequacy metrics that can be measured objectively such as a requirement that a network must include at least one in-network cardiologist within 10 miles of an enrollee residence. A benefit of quantitative standards is that they can be measured and enforced in a relatively straightforward manner, and they facilitate the analysis of trends over time and comparisons across carriers. However, it can be challenging to ensure that appropriate thresholds are established for quantitative standards.

Mr. Cooney reported that Maryland has both quantitative and qualitative standards. He presented a snapshot of some of the standards in a slide. He then provided an overview of the four main types of quantitative standards. First, travel distance standards set a maximum road distance to the nearest provider from an enrollee residence for various provider specialties and facilities. Appointment waiting time standards for ten different appointment types set the time between request for services and earliest in-person appointment offered for specified categories of somatic and behavioral health services. There are also minimum provider to enrollee ratios for specified service types such as primary care, pediatrics, obstetrics and gynecology, mental health, and substance use disorder (SUD) care. Lastly there are standards for the percentage of available essential community providers (ECP) that the carriers must include in their network and the standards must be met separately for ECPs' medical, mental health, and SUD services in each geographic area. Mr. Cooney noted that group model HMOs such as Kaiser are subject to slightly less stringent travel distance standards and are not subject to provider to enrollee ratios and ECP standards, and they are required to develop their own alternative standards for addressing the needs of low income, medically underserved individuals.

Mr. Cooney explained that carriers are required to file access plans with the MIA annually on July 1. Each filing must contain descriptions of policies and procedures related to qualitative measures, supporting documentation for quantitative standards, data on complaints, telehealth utilization, out-of-network claims, an executive summary, and waiver justification. Mr. Cooney showed excerpts of executive summaries for illustrative purposes. He noted that while the executive summaries are

public documents most of information from the carrier access plans must be treated as proprietary information by the MIA and kept confidential.

Mr. Cooney reported that if a carrier fails to meet one or more of the quantitative standards, then the carrier must provide additional information in their filings to document their efforts to add a sufficient number of providers to the network. The MIA then has the ability to grant a one-year waiver of one or more of the standards if the carrier sufficiently demonstrates that the providers necessary for an adequate network are not available, if the providers are unable to reach an agreement to contract with the carrier, or due to limitations or constraints with the measurement methodology rather than an actual deficiency in the network. Mr. Cooney provided a list of specific information that carriers must submit as part of the waiver justification if any quantitative standards are not met.

Mr. Cooney explained that the travel distance and appointment wait time standards are based on the availability of in-person services. However, recognizing the value of including telehealth providers in a carrier's network, the 2023 revisions to the network adequacy regulations included a provision allowing carriers to request limited credits for meeting both the travel distance standard and appointment wait time standard based on the availability of telehealth services. For travel distance there is a per enrollee mileage credit that increases the maximum miles permitted to the nearest provider for certain enrollees in zip codes where the carrier offers telehealth. The maximum credit varies based on geographic region with 5 miles for urban enrollees, 10 miles for suburban enrollees, and 15 miles for rural enrollees. The credit may be applied to no more than 10% of enrollees for each provider type and geographic region. To apply the credit, the carrier must demonstrate that telehealth is clinically appropriate and utilized for the requested specialty and that telehealth services are available and accessible in the requested geographic region. Mr. Cooney noted that the MIA has complete discretion to grant or reject the credit in whole or in part based on the carrier's justification.

Mr. Cooney explained that, for the appointment wait time standards, carriers are generally required to meet each applicable standard for 90% of in-person appointments offered. The wait time telehealth credit allows carriers to request up to 10 additional percentage points to be applied toward meeting the required 90% threshold of appointments offered within the required maximum wait time. For this credit to be applied carriers must demonstrate that telehealth is clinically appropriate and accessible for the requested appointment type. Carriers must also provide coverage for a corresponding in-person service if the enrollee does not elect telehealth. Carriers must have written policies and procedures to assist enrollees in obtaining a timely in-person appointment if telehealth is not clinically appropriate, available, or accessible. Approval of the wait time credit is solely at the MIA's discretion.

Mr. Cooney reported that, in evaluating the annual access plans, the MIA considers various factors. Carriers must complete standardized MIA-developed templates for each required component of the network access plan. Each plan is evaluated based on the carrier's self-reported performance against each regulatory standard, the quality and detail of the documentation justifying the reported compliance, detailed descriptions of carrier efforts to resolve network gaps or long wait times, and detailed descriptions of carrier efforts to proactively assist enrollees impacted by network deficiencies.

Mr. Cooney explained the MIA's network adequacy regulations first went into effect in 2017 and were revised in 2023. Since 2019, the MIA has imposed penalties ranging from $5,000 to $150,000 on carriers for various network deficiencies. In recent years most plans have demonstrated compliance with the standards or included sufficient justification for a waiver. He noted that the MIA has entered

into consent agreements with some carriers that have included remediation efforts to assist enrollees who may have been harmed by network deficiencies. For example, carriers may have to reimburse enrollees who had to seek care out-of-network due to the carrier's inadequate network. The MIA found that 2023 filings showed widespread regression in compliance due to limited time to comply with the 2023 regulatory changes. Mr. Cooney noted that since carriers are still working to comply with the new standards and several standards are effective for the first time in 2024 the MIA expects the growing pains may continue for another year, but the MIA does not believe that the networks are any less adequate in 2023 and 2024 than 2022. The MIA expected the new regulatory standards to significantly improve their ability to evaluate the sufficiency of networks moving forward.

Mr. Cooney encouraged everyone interested in more information to visit the MIA's network adequacy regulations website where the carrier access plans are posted.

Ms. Eberle asked Mr. Cooney to speak to the timing of access plans. Mr. Cooney responded that, under Maryland statute, a carrier is not required to submit an access plan until they have enrollees in that plan. The access plans are filed on July 1 and examine the performance of the network the prior year, so the access plans are a retrospective review based on actual enrollment. He noted that the federal government evaluates networks prospectively based on projections for enrollment, but this allows carriers to develop projections that make them look better. The MIA's retrospective review looks at actual enrollment and whether a plan's network is sufficient for those enrollees. Ms. Eberle added that this is important because CMS's recent Notice of Payment Parameters is asking exchanges to do network adequacy evaluations prospectively and the MHBE reported to CMS that Maryland, like some other states, does network adequacy evaluations retrospectively so it is not practicable to switch to prospective reviews.

Sec. Herrera Scott asked for more information regarding the wait time standard and how it is evaluated. Mr. Cooney responded that the wait time metric is the most challenging to measure and the most important to consumers. One of the big changes from the 2023 regulations revision was standardizing the methodology for the wait time standard requiring carriers to make direct contact with provider offices for each appointment type. Previously, the regulations didn't provide a methodology, so it was hard to compare carriers and none of the carriers had a robust methodology. The revised regulations include an option for the state to develop a centralized survey of all providers and then crosswalk it to the carrier networks. The MIA has not pursued this option yet, but it is available under the regulations. Currently, carriers self-report and make direct contact with provider offices to collect information on appointment wait times. The MIA has received feedback from carriers that the process is challenging because providers often do not respond to the carriers' requests for information.

Sec. Herrera Scott asked if there is a distinction between existing patients and new patients in regard to the appointment wait time standard. Mr. Cooney responded that the appointment wait time standards do not currently differentiate between existing patient and new patients but vary based on provider type such as urgent care or behavioral health.

Sec. Herrera Scott asked for more information regarding the penalties for noncompliance with the network adequacy requirements, specifically the cause of the $150,000 penalties. Mr. Cooney responded that the regulations specify various factors the MIA must consider when issuing penalties such as the seriousness of the violation, the impact on the public, the assets of the violator, and

history of prior violations. The higher penalties occurred when all of these factors were higher. For example, larger, national carriers were subject to higher penalties than local carriers. When the network adequacy requirements were first implemented the MIA took a gradual approach to enforcement for the first few years, giving the carriers time to address deficiencies, so carriers that did not show improvement after a couple of years got higher penalties. He noted that failing to meet the wait time standard resulted in higher penalties than the travel distance standard. Mr. Cooney explained that Maryland is unique in that the travel distance standard is 100% so even if one enrollee lives outside the maximum travel distance than the standards is considered not met. The federal government and other states have a lower threshold for the travel distance standard such as 95% or 80%. He noted that the carriers are usually at 98% compliance for the travel distance standard, so it is a small deficiency. The larger penalties are usually for larger deficiencies in appointment wait time standards. Mr. Cooney commented that some carriers have expressed difficulty identifying certain kinds of specialists in their networks in alignment with the regulations, so they have reported lower compliance but provided justification that they have the specialists in network, but they are categorized differently.

Plan Year 2025 Open Enrollment Readiness

Andy Ratner, Chief of Staff, MHBE
Venkat Koshanam, Chief Information Officer, MHBE
Betsy Plunket, Director of Marketing, MHBE
Tamara Gunter, Director of Consumer Assistance and Eligibility, MHBE

Mr. Ratner provided an overview of the goals for the upcoming 2025 open enrollment. He reported that the first goal is to build on the successes of 2024; enrollment at the start of September was 217,692, an all-time high. Enrollment has increased more than 30% since 2021 before the enhanced tax credits went into effect. Wellpoint is entering the market in 2025 bringing the total number of carriers up to 5, the most since 2017. Mr. Ratner noted that over 3 million peopled have enrolled in coverage through MHC in both private plans and Medicaid in the 11 years it has been operating.

Mr. Ratner noted that the second goal is continuing to make progress enrolling young adults. The young adult subsidy program has been extended through 2025 which provides additional discounts to eligible individuals aged 18 to 37 years old on a sliding scale basis for individuals with incomes below 400% of the FPL. On average, young adults receive a subsidy of roughly $40 a month in addition to any federal tax credits. Mr. Ratner commented that exchange enrollment is high partly because individuals are staying in the exchange due to the plans being more affordable. Young adult enrollment has increased to nearly 78,000, a 46% increase year over year.

Mr. Ratner reported that the third goal is focusing on the underinsured populations. The MHBE has continuously targeted marketing towards Black and Hispanic consumers. Enrollment for both groups increased by more than 20% in 2024. Mr. Ratner explained that the MHBE wants to close the insurance gaps, which are particularly acute in the Hispanic community.

The fourth goal is to strengthen outreach to the “Meta” areas. Mr. Ratner explained that roughly half of the state’s uninsured population are in select areas such as the Washington suburbs, the middle Eastern Shore, and parts of Arundel and Baltimore counties. The MHBE is providing more concentrated consumer assistance and marketing focused on affordable options in these areas.

The fifth goal is to reach DACA recipients. Mr. Ratner explained that starting November 1, 2024, DACA recipients will be able to get a private health plan and financial assistance through MHC with coverage starting as soon as December 1. This was an initiative of the Biden Administration. The MHBE will communicate any updates on this initiative to consumers through email and social media.

The sixth goal is to promote value plans that offer lower deductibles and coverage for more health care services before the deductible is met.

The seventh goal is to promote the dental and vision plans available on the MHC.

Mr. Steffen asked for more information regarding Aetna's departure from the small group market. Ms. Grant responded that she shares Mr. Steffen's concern, but the MIA does not have additional information on Aetna's departure other than what is available in the news regarding challenges Aetna is facing. She added that there is declining enrollment in the small group market, which is concerning and may indicate that small business owners are sending employees to the individual market but there is no data available on the individuals leaving the small group market. Ms. Grant suggested discussing this issue in further detail in the future.

Sec. Herrera Scott asked whether the public health emergency unwinding has impacted the small group enrollment, because it has resulted in increased enrollment in the individual exchange. Ms. Grant responded that the MIA does not have available data that addresses that question.

Mr. Koshanam provided an overview of technology preparedness for open enrollment. He noted that the information technology (IT) preparation for open enrollment began several months before open enrollment starts with multiple software releases beginning in September and going through January 2025. The software releases are primarily focused on updates to implement changes to the system to add a new carrier and incorporate user experience recommendations. The plans are uploaded and validated in September, and anonymous browsing where consumers can see quotes for 2025 plans began in October. Mr. Koshanam noted that 99% of eligible enrollees have been auto renewed for 2025. The small business plans were uploaded in September and the open enrollment readiness tasks were completed by mid-October. The IT team will continue to perform testing when open enrollment starts. Catch-up renewals for enrollees who were left out in the prior auto renewal will occur in October and December. In January 2025, the IT team will complete several post open enrollment tasks such as ensuring that enrollees have the correct coverage.

Mr. Koshanam explained that open enrollment readiness consists of eight parts: the command center, carrier management, security readiness, operational readiness, application readiness, testing and quality assessment readiness, reporting, and resource readiness.

Mr. Koshanam then reported on new items for 2025. A new carrier, Wellpoint, is joining the exchange for 2025 and has been onboarded in MHC. DACA recipients will be eligible to shop for private health plans through MHC. The chatbot, Flora, will be connected to artificial intelligence (AI) to provide more precise, context-specific responses to consumer questions within the consumer portal. The AI will not use consumer data for the response. The IT team will evaluate how beneficial this enhancement is for consumers after the open enrollment. The IT team has also expanded automatic verification of consumer information by implementing robotic process automation for Social Security Number (SSN) verification to increase accuracy, minimize human error, and enhance operational efficiency and data

integrity. Automated information notices to consumers to file or reconcile federal taxes to avoid losing eligibility for APTC will be implemented under certain conditions.

Mr. Steffen asked if there are accreditation or certification requirements from the federal government regarding the use of generative AI. Mr. Koshanam responded that the MHBE is approaching the use of AI cautiously and are not using it with regards to consumer data. He noted that there is state guidance in terms of identifying and reporting on technology connected to AI but there is no federal guidance available beyond an executive order providing a guideline on the use of AI technology. Mr. Koshanam explained that existing Maryland regulations for data protection and privacy are robust and may cover a lot of AI technology especially in regard to decisions around consumer data. The MHBE is monitoring AI regulations in other states such as California as well. Currently, the MHBE is very cautious and will not touch consumer data when using AI technology. The MHBE has a draft AI policy which is under review. Right now, the MHBE is only using the comprehensive power of AI to better understand and respond to consumer questions. Once the MHBE has an AI policy in place they will expand the use of AI technology as appropriate.

Sec. Herrera Scott asked if the chatbot will be available in Spanish. Mr. Koshanam responded that the chatbot is already available in Spanish.

Ms. Plunket provided an update on the marketing and outreach campaign for 2025. She reported that the digital campaign began in mid-October with digital video placements, YouTube ads, and digital audio placements across podcasts and music. This year there will be ads on dating platforms and Reddit for the first time. The MHBE is also utilizing micro influencers who are local to Maryland and have a significant following among the MHBE's target populations. Ms. Plunket noted that the traditional media campaign will begin after November 6 through television and radio commercials in both English and Spanish and will run through open enrollment. MHC will also have print ads to engage Black and Latino communities and drive enrollment through newspaper ads. Ms. Plunket then showed two 15 second commercials as well as a social media ad. She explained that the marketing campaign is focus on mental and behavioral health this year.

Ms. Plunket reported that new marketing initiatives for this year include out-of-home advertising (billboards) targeting gig workers at Amazon warehouses who may not have employer sponsored health insurance and ads in church bulletins across the state in November and December. The MHBE webinar provided to stakeholders, partners, and the media in October briefed all partners on what's new this year and ways to engage with their communities.

Ms. Plunket noted that the MHBE will provide another webinar at the end of October focusing more on mental health with a representative from the Maryland Chapter of the National Alliance on Mental Illness. She provided examples of two digital ads that will be running during open enrollment.

Ms. Plunket then provided an overview of the MHBE's outreach efforts. The CEs are hosting or participating in roughly 40 events during open enrollment. The MHBE also has two outreach managers who participate in outreach events across the state. The outreach campaign is targeting the meta areas, Latinos, Blacks, small businesses, and stakeholders. The MHBE is also prioritizing digital storytelling with eleven videos since June showing a variety of stakeholders and consumers in English and Spanish. Ms. Plunket showed a sample list of events where outreach has been performed.

Ms. Gunter provided an overview of the open enrollment training plan. The training department is currently working to ensure that all the virtual trainings are implemented to help consumer assistance workers understand existing and updated policies and procedures. There have been open enrollment prep trainings for brokers, CEs, application counselors, MDH staff, DHS staff, and Maximus (the MHBE Call Center vendor) supervisors and leads. Ms. Gunter explained that the training department has evolved over the last ten years and is acting as both a credentialing and training department. In regard to credentialing, the training department ensures that consumer assistance workers have trainings and are up to date with their certifications whether they are a CE, application counselor, or with Maximus.

Ms. Gunter then provided an overview of the CEs' open enrollment readiness. She explained that the MHBE closely tracks the annual training and renewal of authorization activity to ensure that all navigator certification requirements are current which includes credentialing and testing for new navigators. Ms. Gunter noted that last year there were 100 navigators and there will be 110 for the upcoming open enrollment. The MHBE hosted an in-person meeting for the CEs to review policy-based best practices with the goal of increasing health coverage enrollment numbers. The plan management team also had a virtual meeting with the navigators to review the plans for 2025. The MHBE updated the connector entity manual to include updated definitions of "meta-areas." Lastly the MHBE discussed the strategic plan to decrease the 6.1% uninsured rate statewide with the CEs. Ms. Gunter explained that each CE was tasked with developing a corrective action plan to address the uninsured rate in their areas.

Ms. Gunter noted that there are eight CEs across eight regions with border-to-border coverage for all Marylanders all year round. She showed a map displaying the CE for each region. Ms. Gunter then displayed a map identifying the zip codes with the highest uninsured rate. She noted again that the MHBE requested the CEs to develop a plan of action for performing outreach in these areas. She stressed the importance of the MHBE's mission to ensure all Marylanders have access to health care.

Ms. Gunter provided an overview of open enrollment readiness for the broker program. There are roughly 1,800 brokers who are authorized to sell plans through the exchange. The MHBE is currently onboarding 250 new brokers, so the MHBE is on target to have roughly 2,000 brokers, which is a significant increase from 964 brokers two years ago. Updated training videos were recorded for the brokers and uploaded to the broker portal and broker guides and materials were also updated and distributed. The MHBE is closely monitoring current authorized brokers' completion of the annual training and sending weekly reminders. An open enrollment readiness meeting was held on September 25 to update brokers on current best practices and distribute important information. A final selection was made for the BatPhone brokers who will work with Maximus to get access to the system and licensing.

Ms. Grant asked about how recent the data is for the map displaying the zip codes with highest uninsured rates which MHBE is target. Ms. Gunter responded that she believes that the data is from 2022 because the new data based on the census is not available yet. The MHBE is in the process of getting updated data but believe the map is still accurate and the uninsured are concentrated in these areas. Ms. Plunket confirmed that the data for the map is from 2022.

Ms. Grant noted that there is more recent data available on zip codes with a high level of churn due to the Medicaid unwinding and asked if the MHBE has looked into this data. Mr. Ratner responded that the MHBE has also examined their own enrollment data. He noted that the American Community Survey performed by the Census Bureau is the only one that tracks the uninsured rate by Public Use Microdata Areas (PUMAs) and they recently released the 2023 survey results. He noted the areas on the map that have consistently had high uninsured rates. He explained that the MHBE's targeted outreach is based on the map as well as the MHBE's enrollment data. Ms. Gunter added that this year, each CE was required to develop a plan and have boots on the ground in these specific areas, which will hopefully result in a decrease in uninsured rates. Ms. Eberle added that the MHBE can also examine the Medicaid data in their records in response to Ms. Grant's comments.

Ms. Crandon remarked that the map states that the top uninsured PUMAs are based on a 2024 analysis of State Health Access Data Assistance Center (SHADAC) data and asked if that is accurate since 2022 data was used. Ms. Gunter responded that the analysis was performed in 2024 using 2022 data and that it can be clarified on the map.

Ms. Gunter provided an overview of open enrollment readiness for the consolidated service center, which is the call center. She explained that the same consumer assistance tools are being offered this year such as Flora, the virtual assistant which answers consumer questions, and live chat from the call center which has gotten popular with an average of 14,000 chats per month. There are roughly 2,000 trained brokers. Ms. Gunter noted that Broker Connect allows consumers to receive a call back from a broker within 30 minutes for assistance with enrolling in a plan.

Ms. Gunter reported that the MHBE training department has met with Maximus to provide training to supervisors and team leads to ensure they are ready for open enrollment with best practices. In preparation for open enrollment, the MHBE is focused on recruitment efforts and training ramp-up to ensure the vendor has enough call center representatives to answer calls. She noted that the public health emergency unwinding has ended but there are leftover actions and cohorts that have caused an increase in call volume, which the MHBE is closely monitoring. The MHBE is also working with the Department to ensure access to recent Medicaid data for forecasting. The MHBE is implementing password reset technology as a system enhancement which will streamline passwords and help consumers who are able to access the system outside the call centers business hours.

Ms. Gunter provided an overview of the hours of operation for the call center, critical business days, and closure dates.

A video message from Governor Wes Moore to the MHBE with a pep talk for the upcoming open enrollment was shown. Ms. Eberle added that the video message was very motivating for MHBE staff.

Unified Benefits NTE

Shirelle Green, Procurement Manager, MHBE
Venkat Koshanam, Chief Information Officer, MHBE

Mr. Koshanam stated that today the MHBE is requesting an increase to the not-to-exceed amount for the Indefinite Delivery/Indefinite Quantity (IDIQ) contract to perform the integration of the unified benefits system hosted by DHS with the Health Benefit Exchange (HBX) system. He explained that

the United Benefit system is a screener that caters to all health and human services requests from consumers. Sec. Herrera Scott explained that the MDTHINK platform hosts many apps. She noted that, since last year, the Department has been working with DHS on a Unified Benefit platform. They performed a crosswalk of different programs with the same eligibility criteria, for example a Medicaid participant may also be eligible for the Supplemental Nutrition Assistance Program (SNAP) but would have to apply separately for SNAP. Currently, an individual must apply for each benefit such as Medicaid, SNAP, or Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) separately. The Department has been working on an enrollment process where applicants will be connected to other programs, they are eligible as part of the enrollment process which will require some connection to the exchange. Mr. Koshanam explained that the Unified Benefits system can intake consumer benefit requests, collect data, and perform an identity check. If a consumer requests Medicaid eligibility, then their information will be transmitted to HBX and upon an eligibility determination the Unified Benefits system can request Medicaid enrollment. Once HBX receives the data, HBX will process the consumer data in real time and validate, verify, and ensure that the data is in sync with the Unified Benefits system and then send the data for a Medicaid eligibility determination. Once eligibility is determined then the real time status will be provided to the Unified Benefit system as well as upon the request of the consumer and automatically facilitate enrollment. Mr. Koshanam explained that from the consumer point of view there will be one login with one data entry and consumers will be able to access either the Unified Benefits system or HBX system with the same account ID and move between systems seamlessly.

Mr. Koshanam reported that an estimated 6,330 hours across various labor categories will be needed for the integration, and the plan was submitted to CMS and approved. He provided an overview of the project timeline. The project is expected to begin in October with approval of a memorandum of understanding (MOU) between the Department and MHBE, which is currently underway. The design, development, testing, and integration phases will occur in parallel.

Ms. Green stated that, on September 20, 2024, CMS approved a total of $754,227 for the design, development and implementation of the integration of the HBX system with the Unified Benefits system. MHBE is entering into an MOU with the Department for reimbursing the state portion of the implementation budget.

Ms. Green presented the IDIQ itemized budget for 2025 by federal and state amounts. The federal government will pay for 90% of costs for the Unified Benefits system integration with HBX and the state will cover 10%. Sec. Herrera Scott asked for a motion to approve an increase the FY 2025 Not-to-exceed (NTE) amount of the IT IDIQ (Indefinite Delivery Indefinite Quantity) budget by $754,227 to a new NTE amount of $36,229,227, with a total federal financial participation amount of $26,366,004 and state participation amount of $9,863,223. Mr. Steffen moved to approve, and Ms. Grant seconded. The Board approved the motion unanimously.

Mr. Steffen commented that, regarding the budget table, the development, enhancements, and PMO item is marked as having 90% federal funding, but the state is funding $4 million out of a total of roughly 20 million which is more than 10%. Mr. Koshanam responded that for the development, enhancements, and PMO item, the 90% federal funding is based on 88% of the total amount and the remaining amount is paid by the state. He explained that the Unified Benefits system integration with HBX item has a straight 90% federal match because CMS has determined this item warrants more funding. Sec. Herrera Scott clarified that the Unified Benefits system integration with HBX item is the

subject of the NTE request today and is a small amount of money to streamline the application process for multiple benefit programs.

Adjournment

Sec. Herrera Scott closed the meeting. The next official Board meeting is in January 2025. The meeting was adjourned at 3:45 PM.