Thursday, March 21, 2024

MINUTES

Chairman Sergent called the meeting to order at 1:36 p.m.

Commissioners present via telephone and in person: Bhandari, Blake, Boyle, Buczynski, Cheatham, Douglas, Gelrud, Gilmore, Jensen, Ojikutu, Stroughton-Duncan, Wang and Wood.

AGENDA ITEM 1a & 1b

ACTION: CONSENT AGENDA

1a. Project Change: Hygea Detox at Camp Meade, LLC .- (Docket No. 23-02-2468)
1b. Approval of Minutes: February 22, 2024

Both items were adopted without objection.

AGENDA ITEM 2

Update of Activities

Ben Steffen, Executive Director for Maryland Health Care Commission (MHCC or Commission), announced Linda Cole's retirement, describing her as capable, organized, and trusted in directing long-term care planning for the past 20 years. Linda Cole's roles included modernizing nursing home regulations, collaborating with the hospice industry, developing reports that showcased the evolution of palliative care and hospital-at-home models and improving the collaboration between hospitals and hospice agencies.

Mr. Steffen discussed the Ahead Model that was submitted on March. 15th. The AHEAD Model provides a pathway for Maryland to continue our long-term commitment to improving statewide healthcare quality, health outcomes, and health equity - all while controlling cost growth. Through AHEAD, Maryland will bridge the healthcare, population health, and social sectors as well as the public and private sectors to implement the solutions Marylanders need, as identified by community members themselves. It will ensure the following:

- Ensure high-value care, by aligning public and private investments towards population health, incentivizing payment reform across care settings, and constraining total cost of care.
- Improve access to care by expanding access to and investment in advanced primary care and supporting efforts to strengthen behavioral healthcare.

- Promote health equity, by elevating community voices and shared decision making, addressing health-related social needs, and building community capacity to drive population health improvement.

MHCC's role in the AHEAD project is the following: measuring primary care investment through the work of the Primary Care Investment Workgroup which guides analysis and recommends ways to improve primary care access and quality, with attention to increasing equity and reducing disparities. The MCDB will support the measurement of all-payer TCOC and primary care spending targets and furthering the state partnership with CRISP. CRISP has long supported interoperability and data exchange across multiple systems, partners, and domains to improve efficiency and quality of care.

Mr. Steffen stated that the Change Health Care (CHC) data breach on February 21, 2024, has paralyzed the exchange of health care claims between providers and payers. MHCC uses an episode grouper, maintained by CHC, for the Wear the Cost website. CHC is an accredited EHN and is registered as an HIE in Maryland. Under 10.25.07 (EHN Regulations), CHC must report to MHCC on the breech and final resolution of the incident.

Mr. Steffen also stated that an American Hospital Association survey of nearly 1,000 hospitals conducted between March 9th and 12th found that 94% of hospitals have felt financial impact from the attack, and more than half have reported a "significant or serious" impact. Seventy-four percent of hospitals reported a direct effect on patient care. Also, HHS has called on UnitedHealth to "take responsibility to ensure no provider is compromised by their cash flow challenges" and to expedite the delivery of payments. The government urged the company to communicate about recovery efforts more frequently and with more transparency to both the healthcare system and state Medicaid agencies.

Mr. Steffen stated that in February 2024, 2,102 users visited the "Wear the Cost" site. This was a significant increase from the 419 visitors in January. The site now contains comparisons for 24 episodes of care for the commercially insured and 17 episodes of care for individuals insured through Medicaid.

Finally, Mr. Steffen talked about the hospital bed inventory and that it is now accessible on the MHCC website. Staff finalized and published the results from the annual supplemental hospital inventory survey on MHCC's website in February. The report was developed by Katie Neral and Eliot Burkom in Eileen Fleck's division.

AGENDA ITEM 3

ACTION: Mandated Health Insurance Services Evaluation: Comprehensive Analysis of Maryland's Mandated Health Insurance Services

Ms. Traci Hughes from Lewis and Ellis presented key findings from the Comprehensive Analysis of Maryland's Mandated Health Insurance Services report. The analysis focused on 68 mandates in Maryland's insurance code, with 56 applying to all markets. Changes in mandates were tracked since the last analysis in 2020, with seven amendments and nine additions. The next step involved comparing mandates to essential health benefits (EHB) required by the Affordable Care Act, with most mandates covered by the EHB-benchmark plan. Individual, Small group, and fully insured large group market plans, including the state employee health plan—self-insured non-ERISA (Employee Retirement Income Security Act of 1974), were included in the analysis as plans subject to state mandates. The analysis included surveys with major insurance carriers to gather data on mandated benefits, helping to determine the market applicability of each mandate. Overall, the report highlights the impact of mandates on the above-mentioned insurance markets in Maryland.

The presentation included a detailed analysis of each mandate's cost as a percentage of premium and the state average annual wage for each insurance market segment, including the State Employee Health Benefit Plan. Ms. Traci Hughes, explained that the state plan's premiums are larger due to self-funding, making them more like funding contribution estimates. The individual market had the lowest premium per member per month (PMPM), largely due to the 1332 waiver reinsurance program. Ms. Hughes noted that anti-selection in individual markets can increase utilization and costs. Mr. Ben Steffen, the Executive Director of the Commission, explained that in the individual market, the reinsurance program covers a portion of what would be paid by premiums. Therefore, the denominator for the individual market is only a portion of the total uninsured premium, resulting in the total cost exceeding 100% as some of the total cost is subsidized through the reinsurance program. Overall, the true cost of insurance products in the individual market may be higher than perceived due to these factors.

Ms. Traci Hughes answered questions from commissioners about the full cost analysis, including how the grand total PMPMs were calculated for premiums and the mandates full cost. Ms. Hughes explained that the results were weighted averages (by premium) across all insurance markets and the state plan. Ms. Hughes also discussed the top 10 highest cost mandates and their impact on premiums. The report details the drivers behind these costs, such as broad mandates like mental health and substance abuse treatment, high utilization of services like cancer screenings, and expensive treatments like oral chemotherapy.

Commissioners also inquired about Child Wellness Services, with Ms. Hughes confirming that the cost includes vaccines. She explained that some costs are due to high utilization. Ms. Hughes noted that the marginal cost of these mandates is low, at only 0.1 percent. Ms. Traci Hughes discussed the impact of various healthcare mandates on premium costs. She highlighted the significant gap in cost between the top mandate, mental health and substance abuse services, and the subsequent mandates. Child wellness services, while in the top ten,

have a minimal cost impact. Lymphedema treatment was surprisingly high on the list due to its prevalence and average cost. Behavioral health spending has increased post-pandemic, with mental health services constituting about 6% of all healthcare spending in 2016. The marginal cost of mandates, representing the additional cost induced by mandates, is only around 0.1%. Factors influencing marginal cost include coverage outside mandated areas and compliance with ACA requirements. The residual cost specifically induced by mandates averages around 0.8% of premiums.

Ms. Traci Hughes also discussed the impact the EHB requirements on large group plans (none) and the compliance of mandates in the self-insured market. Ms. Hughes explained how large group benefits often mirror small group benefits for competitive reasons, even though EHB requirements do not extend to large groups. Ms. Hughes highlighted the challenges in evaluating self-insured plans due to their customization and flexibility under ERISA regulations. The analysis also compared Maryland's mandates with neighboring jurisdictions like Delaware, DC, Pennsylvania, and Virginia, showing the varying levels of mandate compliance and cost impacts. Overall, the study found that most self-funded plans cover at least half of the mandated benefits, with room for improvement in aligning Maryland's mandates with those of neighboring states.

In short, Maryland's health insurance mandates are on par with neighboring states in terms of reducing or aligning mandates, with the full cost falling within a 4% range. Ms. Hughes highlighted that the full cost of 68 mandates in Maryland averages 17.3% of premiums, mostly covered by benchmark plans or outside individual and small group markets. Marginal costs are less than 1%. Self-funded entities typically cover most mandates. After further general discussions on mandates and mandate studies, including mandated benefit studies from the 2023 legislative session such as Alopecia Areata, Commissioners voted unanimously to approve the report.

Commissioner Jensen moved to APPROVE the Mandated Health Insurance Services Evaluation: Comprehensive Analysis of Maryland's Mandated Health Insurance Services, which was seconded by Commissioner Gelrud and, after discussion, unanimously approved.

ACTION: Mandated Health Insurance Services Evaluation: Comprehensive Analysis of Maryland's Mandated Health Insurance Services is hereby APPROVED.

AGENDA ITEM 4

PRESENTATION: Legislative Update

Tracey DeShields, Director of Policy Development and External Affairs gave a legislative update on the legislative session. Ms. DeShields provided a few quick statistics on the session. She noted Monday March 18th was the date for bills in the House and Senate to crossover to the opposite chamber. April 1st is the 83rd day of the session and the date the budget should be passed. Ms. DeShields mentioned that MHCC was following about 215 bills.

Ms. DeShields discussed four major bills that MHCC has weighed in on and worked on over the interim:

- SB 1054/HB 1051 - Maternal Health – Assessments, Referrals, and Reporting (Maryland Maternal Health Act of 2024);
- HB 784 - Task Force on Reducing Emergency Department Wait Times;
- SB 1000/HB 1122 - Maryland Health Care Commission – Nursing Homes – Acquisitions; and
- SB 1092 - Vehicle Registration - Emergency Medical System Surcharge - Increase and Distribution of Funds.

Additionally, she also noted a few potential studies that MHCC will have to do or be a part of in some manner.

ACTION REQUESTED: NONE

AGENDA ITEM 5

PRESENTATION: A Maryland APCD Data Use Case: Physician and Physician Practice Research Database (3P-RD)

Dr. Herbert Wong, Director of the Division of Statistical Research and Methods at AHRQ, and Dr. Jennifer Smith, Principal Data Scientist at NORC, presented an overview of the AHRQ's Physician and Physician Practice Research Database (3P-RD) to Commissioners. Dr. Wong discussed the mission and motivation of the 3P-RD project, while Dr. Smith provided an overview of the database. AHRQ developed the 3P-RD as part of the AHRQ Data Innovations initiative to fill existing data gaps. AHRQ's mission is to produce evidence for safer, higher quality, and more accessible healthcare. They fund research through grants and contracts and have a history of data development, including programs like MEPS and HCUP. The healthcare market has been evolving, leading to a need for new databases to address emerging issues in healthcare delivery.

Dr. Wong emphasized the need for more data to inform policy on equity, health insurance, healthcare markets, and competition, particularly in response to the COVID-19 pandemic. The 3P-RD project was established to address data gaps highlighted by the COVID-19 national emergency. Dr. Jennifer Smith detailed the project's process, including planning, data acquisition, processing, and testing to ensure quality and alignment of data sources. The database consists of data from 13 states, including Maryland's APCD, sourced from various common and unique data sources. Data quality, benchmarking, and addressing key questions were key criteria during testing. The project is currently in the sharing phase, where interested parties can access the database. Overall, the project aims to provide standardized and comprehensive data on physicians and practices to inform healthcare policy effectively.

Dr. Smith discussed the process of linking different data sources to create the 3P-RD database focusing on physicians. They started with state medical board data and linked it to NPPES for

key information like medical license and NPI, then connected it to PECOS for provider details. Specialty information was a challenge due to variations across data sources. Some states provided unique information like military affiliation or board certifications. The final 3P-RD includes 13 states with APCD data from Arkansas, Colorado, Maryland, and Washington. Characteristics from CMS Medicare fee-for-service and Medicaid data were added to all states. Geographical representatives like Arizona, Missouri, and Montana were chosen to test different provider policies. The goal was to harmonize all data and build a comprehensive database for analyzing physician information.

Dr. Smith discussed the use of TMSIS data from Maryland instead of Maryland Medicaid data. Data on physician characteristics and practice variables were collected, defining practices based on service locations. Testing against the Association of American Medical Colleges (AAMC) Workforce Survey revealed differences in physician identification. An assessment of data anomalies in Maryland revealed outliers, such as a pathologist with high number of claims (~128,588), attributed to specialized medical roles such as the medical director of the state for an immunization program.

Dr. Smith discussed the importance of the 3P-RD database in tracking providers across state lines. The database includes key information about physicians and practices, allowing for accurate tracking and analysis. A unique global provider ID was created to overcome data protection issues and maintain usability. The database is available on the AHRQ website in three different files, including a public use file (PUF) with basic information. Restricted use files from a RUF require a DUA, with limited APCD variables varying state by state due to different restrictions based on DUAs. A geographic PUF aggregates data up to the zip code level. The database can identify Maryland anesthesiologists and doctors by specialty, with primary and secondary specialties listed. The database currently only has one year of data, with plans for an upgrade in 2026.

ACTION REQUESTED: NONE

AGENDA ITEM 6

OVERVIEW OF UPCOMING ACTIVITIES

Mr. Steffen briefly spoke about April's Commission meeting. He stated that there will be an update on Implementing HB 812, Health-Reproductive Health Services-Protected Information and Insurance Requirements, proposed permanent regulations on COMAR 10.25.18, a presentation on the Maryland Quality Reporting Consumer Website, and a couple of Certificate of Ongoing Performance for Cardiac Surgery Services.

ACTION REQUESTED: NONE

AGENDA ITEM 7

ADJOURNMENT

Chairman Sergent asked for a motion to adjourn the meeting. There being no further business, the meeting was adjourned at 3:56 p.m. upon the motion of Commissioner Boyle and second by Commissioner Jensen.