Health Benefit Exchange Authority Executive Board Meeting
MINUTES

Date:	March 8, 2023
Time:	5:30 PM
Location:	Via Web Ex/By Video or Conference Call Only
Call- in Number:	1-650-479-3208; Access code: 180 604 0392; Password: exchange
Join via Video:	Join meeting

Members Present: Henry Aaron, Leighton Ku, Khalid Pitts, Diane Lewis, Laura Zeilinger
Members Absent: Gabriela Mossi, Sharon Lewis, Ramon Richards, Wayne Turnage, Tamara Watkins, Karima Woods.

I. Welcome, Opening Remarks and Roll Call, *Diane Lewis, Chair*

A roll call confirmed a quorum with four voting members present (Dr. Aaron, Dr. Ku, Ms. Lewis, Mr. Pitts).

II. Approval of Agenda, *Diane Lewis, Chair*

It was moved and seconded to approve the agenda.
The motion passed unanimously, with Dr. Aaron, Dr. Ku, Ms. Lewis, and Mr. Pitts voting yes.

III. Approval of Minutes, *Diane Lewis, Chair*

It was moved and seconded to approve the January 11, 2023 minutes. The motion passed unanimously with Dr. Aaron, Dr. Ku, Ms. Lewis, and Mr. Pitts voting yes.

IV. Executive Board Discussion Items

Medicaid Unwinding – *Melissa Byrd, Medicaid Director, DHCF*

Thank you for your time this evening to talk about what's taking up most of our attention here at the Department of Health Care Finance. We are finally restarting Medicaid renewals. I will briefly talk about background on renewals and the key messages that we have just released this week for beneficiaries and stakeholders, our communication and notices going forward and Medicaid renewal next steps and I'm open to certainly to any questions and answers.

Medicaid beneficiaries will have to renew their coverage for the first time in over three years. Typically, we have an annual renewal period for individuals, but in March 2020, at the beginning of the federal public health emergency, we had the option to waive renewals and exchange if you will, with the maintenance of effort of receiving additional federal funding for extending that coverage. During this time we have seen in our enrollment increase about 20% in the District. We have over 300,000 District residents enrolled in the Medicaid program today. We started at about 250,000, a little higher than that at the beginning of the public health emergency.

When Congress passed the Omnibus act of 2023, it put a date certain that ends what we call the continuous eligibility requirement, and that end date is March 3. So, what that means for us as a Medicaid program is that we start the renewal process for all Medicaid beneficiaries starting April 1 of this year. If you're familiar with our local only programs in the district, the Alliance and Immigrant Children's programs, we restarted renewals for eligibility last July.

This gives you just a really high simple view of our milestone activities over the next several months. Getting some of these dates certainly at the end of December meant that we spent January, taking all these plans and actually finalizing our operations and communications plan since we had some finally some firm information to share. In February, we began issuing our operations plan and just this week in our communications Toolkit. In March, we are focused on outreach to stakeholder groups, including, obviously the Health Benefits Exchange, and then in April is when we go live, and our first notice to beneficiaries go out. When we talk about notice for Medicaid, we're required to provide written notice to beneficiaries when they need to renew coverage, and then again, before their coverage actually ends. And then in May, we'll have our first disenrollment of individuals from the Medicaid program who are no longer eligible for the program. Next slide, please

Henry Aaron: I understand that Medicaid is, relatively speaking, larger in the District than in most other jurisdictions. But the administrative challenge of re-enrolling more than a third of the district population strikes me is, to put it mildly, large. And I agree, I am wondering how it is possible that we don't end up with a great number of people sort of disenrolled either because they failed to understand they needed to reapply. Or they reapplied and did something wrong. Or the administrative apparatus just got overwhelmed. And this strikes me is we're watching a pileup about to occur on a freeway. And it's inevitable most and we can't do anything about it.

Melisa Byrd: Well, I think you just outlined for everyone when I think about at about 3am every evening. So, I'll move to the next slide. And I think this might give a little bit of help, if you will, and

I'll break it down. Because right now what you see before you is just a whole bunch of numbers. These numbers represent cases, not individuals. The first thing one, you're absolutely correct. I mean, I see what we're about to do as Medicaid programs across the nation as the most significant undertaking since implementing the Affordable Care Act.

But we have several different things, some things working in our favor, and some things that don't work, work against us or create additional challenges. One is the simple fact as you mentioned, it we have more people who need to reenroll, which even makes that more challenging today than it would have been, you know, pre pandemic is that we have, you know, a portion of the 50,000 people who are new to our program, if they are truly new to Medicaid, during the pandemic have never been in the program before. You know, renewing is a completely new concept as well. And then you add to that caseworkers who have not conducted a renewal either. So that's more challenging issues that we're dealing with. What's positive and working in our favor as in the District is we do have a new eligibility system where folks have an option to renew online for the first time.

The next thing that's really beneficial to the District is that we have what is called ex parte we call it passive renewal. So, we have, and what that means is that for a large percentage of our population, we can check different sources electronically, and confirm someone's continued eligibility without them having to do anything. And so, you will see in the second bullet on the left side of your screen, but before the public health emergency, we had a passive renewal rate of about 82% of a subset of our populations are MAGI. Folks, what we're expecting through with the renewal process over the next 14 months, is that about 112,000 of our MAGI cases, 77% of folks, will actually be able to passively renew, so they won't have to respond to anything. They don't have to submit anything, we will do all the checks in the system, and their coverage continues seamlessly.

Henry Aaron: This is a question of clarification, when you say that, so you expect these people to renew that is some cases, because of the passive renewal process. So, you expect more than 100,000 to make it through it to be reviewed automatic. Is that what you're saying?

Melisa Byrd: It is important to know that it is required, we have to do a renewal process for everyone. So even for those individuals we know will no longer be eligible, we will still go through a full renewal process. And I say that because we get a lot of questions of that like once, once the unwinding, and we're just gonna flip the switch and kick folks off of Medicaid coverage. And that's just not the way it's going to work. We do anticipate about 25,000 individuals are no longer eligible for Medicaid, and while we will still do a renewal process for them, we do expect that they will drop off because they no longer meet eligibility requirements.

Henry Aaron: When people originally try to apply, you've determined, at some point, they probably wouldn't be eligible based on the criteria?

Melisa Byrd: yes, it can be a few different things, it could be that they may have attested to residency and other requirements that we need to confirm some folks we know have aged out of certain programs. So, they've lost eligibility by virtue of their age, or we may know through other touch points, that their income has likely increased, and they no longer meet the eligibility income requirements. For the remaining folks, most of our individuals have an option or assistance, if you will, through case management through either one of our managed care plans, or through case managers, all of our what

we call our waiver program. Individuals and these are largely folks who have disabilities, may be have a physical or developmental disability, or be of a certain age, and we have case managers whose jobs are in or to help their recertifying timely to, to retain their benefits. So, once we go through all of that we have a smaller portion of the population, where I do think will be kind of what I would consider the most vulnerable in the sense that they don't have a natural touch point or connection to ensure they do know what is going on and what is required of them at this time. I do think back to the original question.

The first kind of step and we can go to the next slide, is really making sure that we have correct contact information of beneficiaries. Folks may have moved over the past three years. The first thing when they move may not be to, you know, to reach out to Medicaid and update their address. So, part of the communications campaign that we kicked off this week is really encouraging folks to not wait, but to update. And then you will see we've been working with staff from the Health Benefits Exchange, and other district agencies. And we'll be doing more so with our various stakeholder groups in really sharing materials, we issued a communications toolkit to make sure messaging can be pulled, that's all aligned just for the simple fact of trying to amplify the message. We will have several trainings over the next few weeks for folks who want to know how to fill out an application and can kind of a train the trainer, and really working through some of our key provider groups, our pharmacies, our federally qualified health centers and our behavioral health providers, and making sure they are fully aware of what's going on and how to help someone out as again, those are the provider groups who have been in the most touch points with folks that we serve.

Henry Aaron: Let me amplify the question further. If I look at the non-MAGI and the non-passive renewals, that's about 80,000 people, to which one would add any of the group that I just raised a question about, that's about at least five or six months' worth of normal caseload based on the other data in the column. I don't know whether I'd be comforted or not comforted by the fact that a lot of people are going to be passively renewed. But a lot aren't. And so, I'm back to my original question. Is this an accident that's baked in the cake and is going to happen? congestion problem? Or do you have hopes that given your resources, you actually can pull off this without seriously inconveniencing people? I say that as the husband of a woman who was incorrectly disenrolled from our health insurance plan and can't get her prescriptions refilled!

Melisa Byrd: I do not think this will go off without a hitch because I haven't been involved in anything in Medicaid that goes off without a hitch. I mean, that's just a fact I raised like, you know, I would, I would be disingenuous to say anything else. What I do believe is obviously was obvious, we are doing our best to prepare and anticipate where we will have some challenges. We know already from restarting our alliance, our local only program, we have some challenges. Staffing is certainly one of them, specifically, what I'm terming right now, document management, the handling of paper, I think it will be a challenge for us. And it's something that we're working with our colleagues at ESA to provide additional staff and make sure that we can quickly and efficiently handle mail, if you will, mail has become a hot topic for Medicaid programs these days. Where I am hopeful is that once we get an application or renewal in the system, and a person's eligibility should stay until we process that application. I think we will definitely have bumps in the road. We have bumps in the road when we just in a normal renewal process, right? Whether someone doesn't get the information we already know it can be challenging to reach Medicaid beneficiaries folks move. Now everyone looks at their mail. We are really trying to outreach in ways that we have not in the past. And really, you know, exploring all the avenues and ways that we can actually, you know, see folks and touch on them, whether it's through

how we can utilize working with DC public schools and then Office of the State Superintendent of Education and providing information that goes out to all families.

Next slide. This is just a sample of what you'll start to see around the district. This is what's available in our communications toolkit which has been disseminated to all stakeholders, folks can download flyers, print them out, we have text messaging folks can use drop in articles for newsletters, etc., to amplify the same message. And next slide, please. We're starting the communications' campaign this month, what I think is really important to keep in mind--Mr. Aaron, I think you touched on this a little bit--there's a lot of focus and emphasis on like April 1, when most states will start this renewal process. But it's a renewal process for the next 14 months. So, there are people who are going to get their notices starting in April, or may in June, but then some folks won't be getting them until next February. There really is more of a marathon feeling about this in terms of outreach and connecting with individuals and getting renewal forms.

Leighton Ku: Thanks for doing this. I was actually the person who requested this briefing. So obviously, to the extent that the DC Health Benefit Exchange can help support your efforts, we want to do that. You have estimates of how many people you think might lose coverage. What are you setting up in terms of your monitoring? It looks as though when we saw your timetable, you had a fairly specific timetable with how many people you were thinking to process. Are you planning to sort of monitor on a week by week basis to know: are we keeping up with our schedule? do we need to make adjustments? For example, have you hired additional staff? Have you hired contractors to help with some of this massive effort?

Melisa Byrd: We will have a dashboard, I actually expect that we'll be making it public where we're tracking, you know, the number of cases to be renewed that month, the number of receive the number, continued eligibility, the number have dropped, and have that shared out but our ability between our data analytics team. Where I see the analytics happening within the agency that's been the most valuable is really the insight it's giving us to our programs, or in this case, to the eligibility processes for oversight and accountability. So the short answer is yes, we will be tracking that that's the best way we can see when we think there's a blip or something's going on. And, you know, it's a much better place to be in where we can identify that internally first, and then start working out it.

One thing, you know, CMS is our federal regulators requiring that we process or have no more than 1/9 of our population renewing in any month. So that is one thing that's driving how you see the buckets, we're trying to maintain our kind of our normal cadence. So just, you know, this isn't the only time people are going to renew we need to have a normal cadence for workload purposes. Right now, we've brought on additional staff for our call center. We also right now have staff that have been reassigned to support our call center. And then we are working to bring in this staff to support service centers really on that document management side. The other piece, is there a lot of requirements for us specific to return mail and how we track those things as well. So that's where I think that's where our staff will be focused.

Leighton Ku: Great, thanks.

Kris Hathaway (AHIP) [public comment]: Once you're doing the redeterminations, is there a tiering system? For those that are going kind of being determined first, is that by age, maybe by complexities? I didn't know if you'll had like a particular prioritization of those. And that was it. Thank you.

Melisa Byrd: We outline everything that we're doing in our operational plan that's now available on our website. I'll direct you to that. It's probably more than you want to see. But it covers all the stuff we're doing eligibility all the waivers we've received from CMS, all the things we're doing for unwinding the public health emergency, so getting to enhance provider rates, etc. The short answer that question is we're mostly maintaining our renewal based on the month of the person supposed to recertified and that's why we're taking the full 14 months, what we the one kind of priority area that we are taking is that group of individuals that we believe will no longer be eligible for our program, we are prioritizing them in months, three, seven, and eight. And that's for a couple of reasons, we didn't want to start right at the very beginning, we wanted to give caseworkers a little bit of chance to kind of ramp up before we added additional folks for the renewal. But then we also have to be cognizant of the budget implications of potentially maintaining individuals who are not eligible for the program. So that three-to-eight-month period is where you see us bringing in what we call our PHE population into the process for renewals.

We are working through that now we have the focus in what we've been talking about specific to those that we think could be more likely to be referred to the exchange is in that 25,000-person population. And what we've been discussing internally is, you know, can we identify individuals that we think are like, why would they no longer be eligible? I think those who would no longer be eligible for income reasons are the ones that are probably most likely to have a referral over to. But I don't have that detail yet. But that's something that we are talking with staff about to try to understand. Also, just also trying to know when folks, the folks that we think might be most likely to be referred to HBX.

Diane Lewis: Anything else? Melisa, thank you so much. I greatly appreciate it.

PY 2024 Standard Plans – *Leighton Ku, Chair, Standard Plan Working Group*

Leighton Ku: Once again, we remember that we have to renew the standard plans this year a priority had been modifying the sort of pediatric mental health benefits. When CMS issued its draft AV calculator for Plan Year 2024 that necessitated some further changes. No changes were necessary in the Platinum plan. In the Gold plan, although the AV was slightly outside of the de minimis range, we are able to actually reduce cost sharing for the out-of-pocket maximum. We are proposing to reduce the surgery facility copayment from $525 to $375 and to increase the outpatient surgery physician surgeon services from $75 to $125. That leads to a net reduction overall from $600 in PY 2023 to $500 in PY 2024. In addition to this, we're able to lower the out-of-pocket maximum from $5,900 (as approved by the Board in November Resolution) back to the PY 2023 level, $5800. I will say this was a proposal from Allison Mangiaracino and team at Kaiser Permanente who noticed that there were some quirks in the way the AV calculator works for OP Surgery that enabled us to make these changes. In the Silver plan, we didn't have to make some of the changes beyond those that we had discussed at an earlier time. We found that we didn't need to increase the out-of-pocket maximum. We are now recommending reducing the amount of out-of-pocket maximum from $9,100 back to $8,850. For the Bronze copay

plan, the recommendation of the working group is to increase the out-of-pocket maximum from $9,100 to $9,150. For the Bronze HSA plan, the recommendation is to increase the out-of-pocket maximum from $6,900 to $7,200. In addition, there were a variety of smaller clarifications and net technical corrections that were made. Those are explained in the attachment that we made.

Purvee Kempf: Just to note that the AV calculator that CMS released is still the draft, it is conceivable when the final AV calculator is finalized, there will need to be some further technical changes. We don't expect any changes in the final AVC, but it's a possibility. If anything happens, we will circle back with you, seek your feedback, and make any complaint changes.

Diane Lewis: Thank you. Any further comments? Hearing none, we will move to the next item HBX staff travel and training policy and HBX Board reimbursement policy.

HBX Employee Reimbursement Policy and HBX Board Reimbursement Policy – *Mila Kofman, Executive Director*

Mila Kofman: Until this point, we have been using the District's travel reimbursement policy for staff as well as federal reimbursement policy as the as kind of a guideline. So, before you today, we have an HBX Travel Policy for staff that we've drafted to memorialize our practices, as well as to make clear where we want to do something slightly different than what the DC government does in a couple of areas. This policy we discussed with the Board Operations Committee and they approved us moving forward with it for the full Bard consideration. So essentially a few areas where we were slightly different than the district's reimbursement policy. One is we only reimburse per diem for meals for travel, we did not reimburse actuals in the district policy where you allows actual reimbursement. Under certain standards, we did not do that, we only do per diem, like the federal government. Another area of difference is we want to allow reimbursement for tips up to 25%. The District's policy, at least now, it wasn't always this way is to limit tips to 10 or 15%, before ground transportation. So we want to make sure that we reimburse up to 25%. Those are the major differences between the policy that we want to adopt and the current district policy. We are also asking to make a small tweak to the board, travel policy, not that any of you ever use it, I guess in the early years you did. But to make that consistent in terms of the reimbursing tips up to 25%.

Henry Aaron: What is the meaning of having a 25% allowance, but with a per diem handling for meals?

Mila Kofman: The 25% cap is for tips for transportation. Okay. It's intended to cover everything. Yes. Very similar to what the federal government does. Any other questions?

Diane Lewis: Thank you. Any further comments? Hearing none, we will move to the next item: HC4CC proposed grant program.

HealthCare4ChildCare Outreach Partner Grant Program – *Mila Kofman, Executive Director*

Mila Kofman: Thank you. Yes. So, as you know, we've been implementing healthcare for childcare. And I'm excited about all the successes that we've had to date. But we also have learned many lessons. And the lessons are that we are not a trusted voice. With the early child development community. It's kind of very similar to the lessons we learned early on when we were implementing the Affordable Care Act. And back then, in 2013, we actively engaged with, with trusted voices, we partnered with the chambers, we partnered with many community health centers through our sisters and navigators, we were able to have trusted voices in the community, talking to people in the community who they trust. We want to do something very similar with Healthcare4Childcare. And so we want to establish a grant program to get trusted voices in this community to help us with outreach. I, we have taken this to the Finance Committee for consideration and they approved this moving forward to establish this grant program. So essentially, the total amount for school year, which is the really kind of the remainder of this fiscal year from June, one through September 30. With the $160,000 in grants, and for fiscal year 2024. For the entire fiscal year, the grant program would total $480,000. We plan to issue a request for proposals or applications sometime this week, and then the process will be to review applications where we're setting a piano to review. Our staff will make recommendations and we'll share it with various Board committees first, and then we'll bring the final recommendations to the full Board. Our plan is to bring it back to you in May for board review and approval both amounts as well as the organizations we would like to provide grant funding to. So that's in a nutshell, what we're proposing to do. I'm happy to take any questions

Khalid Pitts: where is the funding coming from? Is it reallocated from other places? And if so, where?

Mila Kofman: Yes, we have unassigned fund balance. And usually, that pays for IT development. And we have a three-year IT development plan; essentially, anytime we have an emergency or something unexpected, instead of dipping into our operational or capital reserves, we essentially put certain IT development projects on hold or on a slower track in order to fund more immediate needs. I just want to be clear, it is not funded by anyone else, and it would be funded by us. And it would be using some of the unassigned fund balance.

Diane Lewis: Other questions? Hearing none, we will go to public comment. Are there any public comments, please identify yourself. If you'd like to comment, if you're not commenting, please mute yourself. Any public comment?

V. Vote

Diane Lewis: Hearing no public comment, we will move to a vote. At this time, we will proceed to vote on the discussion items listed in section one of the agenda.

a. First is the vote on the Plan Year (PY) 2024 Standard Plans Resolution

It was moved and seconded to move to approve the Resolution.
The motion passed unanimously, with Dr. Aaron, Dr. Ku, Ms. Lewis, and Mr. Pitts voting yes.

b. Second is the vote on HBX Employee Reimbursement Policy and HBX Board Reimbursement Policy

It was moved and seconded to move to approve the Policy.
The motion passed unanimously, with Dr. Aaron, Dr. Ku, Ms. Lewis, and Mr. Pitts voting yes.

VI. Executive Director Report, *Mila Kofman, Executive Director*

Mila Kofman: On February 1, the Council Health Committee held a Performance Oversight hearing on HBX. I testified in person with public witnesses testifying via Zoom. We had many witnesses come out from the public to testify in support of HBX efforts and specifically to talk about the value of health care for childcare and how they're benefiting. So it was, it was a terrific hearing, especially with all of the public witnesses providing input on our efforts. The Budget Hearing has been scheduled by the Health Committee for March 30. Both Diane Lewis and I will be testifying, and I believe that's going to be in person for government witnesses, so we will be there in person.

As you all know, open enrollment ended January 31. Now, of course, people can sign up if they have a qualifying event, like marriage or moving into the District, we had a very successful outreach effort with lots of events. before open enrollment closed.

A quick update on Healthcare4Childcare: I just want to share with you some really terrific numbers in terms of our enrollment. This is through March 1, we have enrolled 31% of eligible workers who live in the District. So that means that we looked at all of the workers who live in the District to qualify, we did not do anything with folks who have Medicaid. Now, because they have coverage, we reached out to those who are eligible for individual market coverage. The other data point I want to share with you is that we've also been able to enroll about we enrolled 125 facilities that are eligible out of 394. And that's through that's January, February, and March start dates. What's really terrific in my view is that out of the 125, or actually, that's 80 employers because each employer can have multiple facilities. So out of the 80 employers, we have 44, newly insured, so they did not offer health insurance before health care for childcare. And of the ones who did who offered through DC Health Link before we know that for 18 of them, the take up rate went up. Employees who used to not participate because they couldn't

afford their employee share of the premium now are participating. The total for on the group side that we've enrolled equals 581 employees, and 55% of them are newly insured.

We are working with OSSE on continued outreach and OSSE is sending emails out to the eligible population, along with a gazillion emails and phone calls that we do.

I just want to add that the federal government is establishing a special enrollment period for the federal marketplace for this population, that unwinding population. And we will be using the federal SEP here. So right now, we don't believe we need to take any action to establish any new special enrollment since we'll be using the federal ones.

And then I just want to close out by saying there continues to be significant interest in the equity work that we are engaged in, especially in equity-based benefit design. We've been doing briefings and public presentations around that. We continue to do that. With that, I'm going to stop and I am happy to take any questions.

VII. Executive Board Finance Committee Report, *Henry Aaron, Chair*

Diane Lewis: Thank you. Henry, I think you can move to the Finance Committee report.

Henry Aaron: The committee met twice since our last full meeting here on February 2, and March 3. You've heard from Mila about the HealthCare4Childcare and the fact we're going to be spending basically $40,000 a month from for the rest of this fiscal year and next fiscal year on that. In addition, we discussed and approved a budget of $191,000 for communications outreach, and marketing for FY 23. Also related to health care for childcare, we're paying for this through other projects delayed that we won't be investing in this year. The auditors from McConnell and Jones joined the February meeting. They had no concerns. Their findings were unqualified, which is exactly what one wants to hear. We received some updates on the "Eye" street lease renewal and on CMS Flexibility to Stabilize the Market II -- that's a grant program from them. And finally, the Finance Committee received a monthly budget and spending report which we receive each month. And as is customary, we found nothing of concern here. The committee also reviewed the FY 2022 year in close out report. Again, no concerns.

VIII. Public Comment

No public comment was proffered.

IX. Closing Remarks, *Diane Lewis, Chair*

Diane Lewis: Thank you. That concludes our public business for today.

That concludes our public business for today. We will reconvene in Executive Session pursuant to DC Official Code Section §§ 2-575(b)(2), (4A), and 31-3171.11 to discuss contracts and legal advice.

Because we will not be recommending any official action in the Executive Session, we will not reconvene the public portion of the meeting.

> Vote: It was moved and seconded to move to Executive Session.
> The motion passed unanimously, with Dr. Aaron, Dr. Ku, Ms. Lewis, and Mr. Pitts voting yes.

The public meeting stands adjourned at 6:45 p.m. on Wednesday, March 8, 2023. Our next meeting is scheduled for May 10, 2023. Thank you and everyone have a good evening.