Health Benefit Exchange Authority Executive Board Meeting

MINUTES

Date: July 12, 2023
Time: 5:30 PM
Location: Via Zoom/By Video or Conference Call Only
Registration Link: https://dchealthlink.zoom.us/meeting/register/tZcsfu-orDIoHdSdabIYwYWHDhni44v-QaEp

Members Present: Henry Aaron, Leighton Ku, Diane Lewis, Khalid Pitts, Ramon Richard, Tamara Watkins
Members Absent: Ayanna Bennett, Gabriella Mossi, Wayne Turnage, Laura Zeilinger

Welcome, Opening Remarks, and Roll Call

Diane Lewis, Chair

This is the public meeting of the Executive Board of the District of Columbia Health Benefit Exchange authority. Today is Wednesday, July 12, 2023. And the time is 5:39 p.m. Before we begin, I want to thank former Director of DC Health, Dr. Sharon Lewis for her participation on the Executive Board and welcome Dr. Ayanna Bennett as the newest board member who will represent DC Health.

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

Approval of Agenda

Diane Lewis, Chair

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

Approval of Minutes

Diane Lewis, Chair

It was moved and seconded to approve the May 10, 2023 draft Minutes. The motion passed without objection, with Dr. Ku, Ms. Lewis, Mr. Pitts, Mr. Richards, and Ms. Watkins voting yes.

Discussion Items

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

Melisa Byrd: Thank you so much for your continued interest and the continued partnership with the Exchange as we move forward on Medicaid renewals. We restarted renewals on April 1, with our first two cohorts, with coverage ending May 31 and June 30. We have a Medicaid renewal dashboard on our website. From our first month of renewals, more than 80% of beneficiaries with an end date of May 31 were renewed or are pending renewal. Less than 1% (fewer than 100 individuals) were determined ineligible; the remaining 18% had no response. Our renewed and pending percentage will continue to increase. There's a 90-day reconsideration period. For 90 days after someone's end date, they can still submit their Medicaid renewal. If they're found still eligible for the program, their eligibility is continued as if it did not lapse. At the end of May, 3,200 individuals were disenrolled. Now, about six weeks out of that first end date period, we are down to 2,700. We will continue to update and augment our eligibility renewal dashboard with additional information and characteristics of beneficiaries. If you look across the states that are reporting data right now, you will see that the District's procedural termination rate (no response provided) is pretty high. We believe that this is partly because we have such high eligibility levels.

(Leighton Ku): If people who are terminated in May, at a certain point have another medical need and say, I didn't even realize I got kicked out of Medicaid. Will you have a way of tracking people who were terminated and come back?

Melisa Byrd: I believe we should, I can follow up and ask our data analytics team, but I expect that we will certainly do that. We're doing it in part already. We have folks already from May to now who have come back into the program. They likely fell in that procedural termination bucket. What we don't know is, why, i.e. Did you not receive it? Did you just not get to it in time? Or did you try to go to the doctor or to the pharmacy and get a prescription, and were not able to fill it? I can tell you, you know, and this is all anecdotal at this point. We have not heard of folks turning up at the doctor's office and finding out that they do not have coverage.

Diane Lewis: I could follow up on the last question, which is, if the person shows up at the provider's office, can the provider then assist in helping them fill out or give them a form and direct them to how to reapply for Medicaid?

Melisa Byrd: What we've expressed to our provider community is, if it's within the 90-day reconsideration period, the provider will get paid for that service. Our providers also are familiar with the Medicaid retroactive eligibility. Our providers are familiar that while they may not have that active enrollment, they can still be paid for that service. Our FQHCs for sure are working closely with folks. I was just talking to one of our clinics earlier today. And you know, they've had some good success where provider reaches out to say to their patient

"You have an appointment, but we see that at that time, your Medicaid hasn't been updated." Then yyou need to work through that process with them.

Looking at June, the renewal patterns are similar: we have about 72% of our June cohort that has renewed or is pending. I'm hopeful that we'll see the same upward trajectory -- that will be getting closer to the 80% number by the end of July. And folks continue to renew even past the June deadline. The one thing that's important to highlight here is that June was our first month of what we call our non-Magi population and their renewals. This is really people with disabilities and adults over 65, we did extend coverage for this group by one month, we had a very low renewal rate by about mid-June. We have a new eligibility system that for this group is the first time that they're going through it. And this is an eligibility group where you have a more complex process, you have things like level care assessments, you have case managers involved, and other providers. So, we've extended the time as everyone gets more familiar with the system and the new processes.

Diane Lewis: Melissa, do you think that part of that procedural termination group/terminated ineligible group we'll see at HBX? Because they won't be eligible for Medicaid?

Melisa Byrd: I think they're folks who are ineligible for Medicaid that would likely be referred to HBX. I do think there's a chance that we may see more folks going to the exchange after July. But what number, I don't know for sure.

Mila Kofman: And I'll just add, the notice that Medicaid sends out tells folks they may no longer be eligible, but there is the DC Health Link for them. Some folks, as soon as they get that notice, they just go directly to our website, and they get themselves enrolled in private health insurance coverage directly. This is happening in other states as well. Pennsylvania recently reported seeing the same thing and a couple of other state-based marketplaces, that as soon as they get that Medicaid notice they're just going directly to the exchange. In addition to that, we do get reports from Melissa's team on a monthly basis. And we comb through that information to figure out who's eligible and we assign those folks to our assisters to follow up and get them enrolled. We have a robust process with Melissa's team.

Tamara Watkins: Do we track it where we'll actually be able to report the number that actually went on to secure coverage? Will it be with that level of specificity?

Melisa Byrd: I think that the goal, to be able to track. I know, there's reporting required from the federal government, I think for state-based exchanges, as well as for Medicaid. And that is the intention, to try to track folks as best we can.

Mila Kofman: Exactly. We're tracking both folks who we get on the Medicaid reports, as well as folks who come in directly through our system. We match that up. We're pulling information from two sources, but who actually enrolls through us -folks who have lost Medicaid or will lose Medicaid soon because they're no longer eligible? I don't think we'll ever have a full picture whether all of those folks get coverage somewhere else, maybe they move to another state or they have large employer coverage, or some other source, I don't think we'll ever have a full picture on that. We will at some point in time through the census data know sources of coverage. But we'll report out to you our number of the individuals who are coming to us.

Melisa Byrd: This is a 14-month process. Folks will be getting renewal notices, they got them in April, some will be getting them right now. Some will get them in February. As I mentioned earlier, as we get more data and we continue to look through and try to answer questions or make sense of some of the patterns that we're

seeing, we'll pivot and adjust our approach. You'll still see media outreach from us. We've got monthly text messaging and automated phone calls. Our managed care organizations, in terms of outreach, are doing all the same kinds of things.

And then of course, we're looking at some new strategies. CMS issued new flexibilities in June. We're looking at a couple of them, such as renewing the Medicaid eligibility for folks with income at or below 100% of the federal poverty level with no data returned. CMS is now allowing states to allow their managed care plans to actually assist enrollees in completing and submitting their Medicaid renewal forms. That's something that's under consideration with us as well. And then we have monthly trainings on District Direct. Last time we realized we had some beneficiaries trying to work through how best to renew through District Direct and we realized we needed to have some beneficiary-focused town halls that are really limited to beneficiaries – and not other community-based organizations or advocacy groups. So, we're going to kick that off at the end of this month, and scheduling time on evenings and weekends that might be a better time for the folks that we serve. And that is it. I'm happy to take any other questions. And again, do appreciate the ongoing collaboration with and support from the Exchange as we continue through the renewal process.

Diane Lewis: Are there any questions? Hearing none, Melissa, thank you so much. You know, we're all in this together. And the bottom line being get everyone covered, whether it's Medicaid or private coverage. This is critically important for us as well. And we're more than happy to partner as always, with Medicaid in moving this forward. Thank you so much. Special Enrollment Period for HealthCare4ChildCare – *Chris Gardiner, Chair, Standing Advisory Board*

On June 9, 2023, the Standing Advisory Board met, discussed, and unanimously approved a new special enrollment period for the HealthCare4Child Care Program. This program provides free or low-premium health insurance through DC Link for employees of child development centers and homes licensed by the DC Office of the State Superintendent for Education. Coverage is through DC Health Link's individual and family market or SHOP market. The special enrollment period would allow for year-round availability to ensure that employees and their dependents can enroll into the free or low-cost health insurance available through the program without delay. In some cases, an employee may have already been enrolled in the individual, family or SHOP marketplaces but needs to change plans to be eligible for the HC4CC program. It has been difficult to ensure coverage for this population. Up to this point, the exchange has been using the special enrollment period associated with public health emergency to process enrollments.

Exercise Option-Year for Certified Business Enterprise (CBE) IT Consulting Services for Data Net Systems Corp. – *Mila Kofman, Executive Director*

Mila Kofman: We need Board approval to exercise option year four for a CBE that provides IT staff support and other services for us called Data Net Systems Corporation. The option year would be for up to $800,000. The Finance Committee has already reviewed this and approved this to go to the full Board for approval. If you approve, we will exercise the option year which will start the next fiscal year—October 1.

Printing and Mailing Services with Immediate Mailing Services – *Mila Kofman, Executive Director*

Mila Kofman: One other contract approval we need is for a printing and mailing vendor. Under the Affordable Care Act, we are required to mail certain notices to folks covered through us, and in some cases not covered through us. The printing vendor is Immediate Mailing Services. We need full Board approval to continue our contract with IMS. The contract would not exceed $330,000 and it would be for the period starting next fiscal year. The Finance Committee has already reviewed this and recommended this go to the full Board for approval.

Social Justice and Health Disparities Working Group Recommendation Year Two Review – *Mila Kofman, Executive Director*

Mila Kofman: I'm going to move on to an update of the implementation of the Social Justice Working Group recommendations, which the full Board adopted in a Resolution. This is a Year Two summary of activities, mostly focusing on what our health plans have been doing to implement the commitments that they have made through this work on addressing health disparities and working toward health equity. There were three main areas.

Under the first focus area, in terms of improving access to care, Kaiser Permanente launched its mobile health vehicle. I just want to applaud the immediate steps that Kaiser Permanente has taken to increase access to medical care in areas that traditionally are underserved. Another carrier partners with a different organization each month to hold health screenings, and the primary focus is Wards seven and eight. In terms of improving access to diverse providers, one carrier conducts an annual assessment of its provider networks. The factors the carrier looks at include language and race, and the carrier uses those to determine where there are opportunities to do additional hiring and to address geographical distribution throughout this network. Another carrier has collected language, country of birth, and gender from its providers and uses that data to identify gaps within its network.

Under focus area two, we've also seen substantial progress. In addition to changes to our standard plans, that our health plans have been very actively engaged in collecting member data, race, ethnicity, and language data. One carrier reports that it has data on 87%. That's incredibly important. Because when you have that kind of data, you can do all sorts of analysis with it, including how the populations that you serve. And then another carrier reports that it collects data from plan sponsors and individual members on a voluntary basis through digital member portal; we did not have percentages of data that they've obtained unfortunately. One carrier is actively working to implement patient interventions to ensure ethical care, including colon cancer screening and glycemic control for people with diabetes. And again, that's using the race, ethnicity and other data that that carrier has in terms of the population and serves. Another carrier has partnered with a healthcare analytics company to aggregate data and identify where social determinants of health risks are concentrated and try and prioritize those patients for interventions. So that's a new development as well.

Moving on to focus area three, two carriers have started their NCQA health equity accreditation process, and both are aiming to complete that in 2024. This is a very rigorous, data intensive process, resource intensive effort. And I just want to applaud the two carriers who are engaged in this because it means they have to do a lot of work on there. So that's huge, and I think it just deserves kudos to the two plans that have started that process. Another carrier requires annual health equity training with a focus of mitigating implicit bias and

supporting culturally and linguistically competent services for primary care providers participating in its medical homes initiative. And then all carriers urge providers to complete annual health equity training. The fact that all carriers are encouraging providers to complete the annual equity training is definitely a step in the right direction. One carrier provides training throughout the year and another carrier enables providers to receive digital badges displayed in the provider directory reflecting trainings completed, related to culturally responsive care.

I'll also mention that we had difficulties getting information from one of our carriers. We're looking at discussions with our insurance regulator partners to figure out what else could be done to have more information from one carrier that was not able to provide information to us to include in this report, so I just want to make sure I say that. Happy to take any questions.

Public Comment

No public comment was offered.

Vote

Special Enrollment Period for HealthCare4ChildCare Resolution

It was moved and seconded to vote to approve the Resolution. The motion passed without objection, with Dr. Ku, Ms. Lewis, Mr. Pitts, Mr. Richards, and Ms. Watkins voting yes.

Exercise Option Year Four for Certified Business Enterprise (CBE) IT Consulting Services for Data Net Systems Corp.

It was moved and seconded to vote to approve the Contract. The motion passed without objection, with Dr. Ku, Ms. Lewis, Mr. Pitts, Mr. Richards, and Ms. Watkins voting yes.

Printing and Mailing Services with Immediate Mailing Services

It was moved and seconded to vote to approve the Contract. The motion passed without objection, with Dr. Ku, Ms. Lewis, Mr. Pitts, Mr. Richards, and Ms. Watkins voting yes.

Executive Board Finance Committee Report

Henry Aaron, Chair (Dr. Aaron, Chair of the Finance Committee, was unavailable, so Chairwoman Lewis, also a member of the committee, provided the update.)

The Finance Committee met on May 16, June 8, and July 6. The committee considered investment decisions at all three meetings. The Finance Committee reviewed and approved an assessment rate for Fiscal Year 2024. At the budget oversight hearing in March, the agency project entered a rate of 0.0820%. And at the committee meeting, we approved an actual rate of 0.0825%. All previous year outstanding assessments have been collected, and we thank our staff for the hard work that they've done in successfully getting that those

assessments in. In July, the committee also reviewed and approved for board consideration two contracts. You've already acted on those. In June and July, the committee reviewed the monthly budget and spending report and found nothing of concern.

Executive Director Report

Mila Kofman, Executive Director

I'll try to give you the highlights, there's a lot to report this month. DC Council passed a new law which requires infertility treatment to be covered. And that includes to be covered by the health plans through DC Health Link. This is the first mandate that the city has passed since the ACA, and it triggers a cost offset under the Affordable Care Act. The legislation requires an actuarial study to figure out how much the offset should be. And once that is known, the city is supposed to fund that cost offset for DC Health Link health plans and requires HBX to administer the defrayal payments. Our staff worked very closely with Council members and their staff to provide feedback while this legislation was being drafted and deliberated. We also consulted with the federal government to confirm that the legislation would in fact trigger the ACA defrayal requirements.

A very quick update on HealthCare4ChildCare. As of July 10th, we cover more than 1,000 people, combined, on the small group side and the individual marketplace side. In mid-May, we received new data from OSSE which had an update on currently licensed eligible facilities, as well as an updated list of employees who work for those facilities. Of approximately 377 facilities likely eligible for health care for childcare, we enrolled 150 in SHOP.

At the May board meeting, you approved HC4CC Outreach and Engagement Partnership Grants, we have provided several trainings now that we have finalized those grant awards, and we provided a two-day training on June 26th and 27th. And just today, there was a half day of health insurance literacy training we provided and there's another training scheduled for later this summer. Our HC4CC advisory council had its meeting in June.

The HealthCare4ChildCare program is getting more attention. In fact, in a recent Urban Institute case study, it was described as a "landmark public investment". So, we are very, very pleased that there's more attention to it, and we hope to see other states follow the District's lead.

The Biden Administration proposed a rule to update lawful presence definition. And for us, that essentially impacts DACA folks. The good news is we're thrilled that the administration is addressing this population and making sure that this population will have access to affordable quality health coverage. And the other good news for us is because of the way we built our IT system, we will not need to make any changes to our IT system to bring in these additional folks because they're now that they will newly be eligible once the rule is finalized. It is not yet final, but we expect it to become effective by open enrollment.

The Biden Administration also just recently issued a revised proposal on short-term limited duration health insurance plans. Comments are due September 11, and we will comment. If you recall, we commented on older proposals first by President Obama and then President Trump. We are thrilled to see that the Biden administration is reinstating consumer protections for these products. They're sometimes called Junk Insurance, bare-bones insurance, where consumers sign up thinking they have coverage that covers them when they have a medical need. And then too late learning that the coverage they signed up for doesn't cover what they need. The proposal reinstates many of the initial protections that existed, that unfortunately, under the prior administration were overturned. I just want to make sure it is clear, when junk plans proliferate, that really makes the comprehensive health insurance private market a lot more expensive, because junk plans tend to attract healthier people. So that's another reason we're very pleased that additional consumer protections are being proposed to stop the cherry picking and to keep the ACA markets, private markets stable. I do want to remind you that in DC, we partnered with DISB, and it was actually a DISB-led initiative to make sure that when the prior administration loosened up rules around these products that DC protected the ACA market and consumers and employers who rely on it. And so DISB led this, and we supported them to prevent junk plans from proliferating. So, in DC, we have local laws with high consumer protections, which have resulted in no or very few of these junk plans actually being sold.

Okay, I want to switch to just a quick update on social justice, you received our Year Two report. There has been some national coverage around our efforts, including a recent report from the United Hospital fund, focusing on the role of carriers in promoting health equity. Those researchers recognized and highlighted the recommendations of the Social Justice and Health Disparities Working Group which you as a Board adopted, and in particular, the report reference or equity-based benefits design, and the work to stop bias in in clinical algorithms and our efforts to promote the diversity of provider networks and cultural competency.

Just as a reminder, internally we have a speaker series. And we celebrated Arab American Heritage Month with Dr. Amal, David, Warren, David founders that they are an American foundation, and they spoke to us late June. And then we have another speaker coming up next week to help us celebrate LGBTQ plus Pride Month. I know we're a little late on all these months, but better late than never, and people's schedules are complicated. We're just thrilled to have guest speakers join us. Next week, we'll have Derek T, who is the president of a professional men of color. That concludes my report and happy to take any questions.

Closing Remarks and Adjourn

Diane Lewis, Chair

Thank you very much. That concludes our business for today. The meeting stands adjourned at 6:40 p.m. on Wednesday, July 12, 2023. Our next meeting is scheduled for September 13, 2023 at 5:30 p.m.