MARYLAND COMMISSION ON PUBLIC HEALTH

Thursday, June 6, 2024 | 2:00 – 5:00 PM EDT
Baltimore County Department of Health (Hybrid) | 6401 York Rd, Baltimore MD 21212

Meeting Minutes

Commissioners present in person or virtually
Chris Brandt
Meena Brewster
Jean Drummond
Boris Lushniak
Oluwatosin Olateju (Presiding Co-Chair)
Frances Phillips
Nicole Rochester
Maura Rossman
Michelle Spencer
Allen Twigg
Heather Bagnall
Nilesh Kalyanaraman
Camille Blake Fall

I. Call to Order
    a. Quorum met

II. Adoption of the Agenda
    a. C. Blake Fall motion to approve
    b. M. Brewster seconded
    c. Approved

III. May Minutes Review and Approval
    a. Minutes approved (no motion/second)

IV. Presentation: State of Maryland Department of Health (MDH) and Priorities
Laura Herrera Scott, MD
Secretary, Maryland Department of Health
    a. Role of Medicaid
        i. Anti-poverty program
        ii. GIFT Act passed this session
        iii. Maryland successful in addressing Medicaid unwinding
        iv. Leveraging data to make interventions against insurance churn
        v. Total Cost of Care includes Medicaid – Means beneficiaries have better access to care (particularly hospital services)

1. Under new model, will include primary care and quality alignment

vi. Communication between ASO and MCOs

b. Care and Services Rooted in Equity
   i. Linking to Z-scores
   ii. Discussion covering social services
c. Behavioral Health
   i. Technology and data
   ii. Workforce challenges – Maryland worse than other states in terms of COVID recovery
   iii. Increasing screening rates
   iv. Crisis stabilization reimbursement expanded
   v. Investigating where people fall off accessing services and looking to address those barriers
d. Model of Health
   i. Found grants were aligned with clinical services, and so double paying for some services in certain jurisdictions – population health model requires rethinking how things are funded
e. States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model
f. Q&A
   i. C. Brandt: 3-5 things in advance in measurable ways
      1. Behavioral health
      2. Assisted outpatient treatment
      3. Medicaid and social drivers of health
      4. Maternal/child health
   ii. J. Drummond: Provider network adequacy is crucial, hold accountable for this
      1. Other states have workforce database, but MD boards each have their own systems
      2. Major IT development project for nursing platform
      3. Provider directories are a national problem
   iii. J. Drummond: Reimbursement for doulas
   iv. J. Drummond: Primary care and quality alignment
      1. Trying to align quality of care agonistic of payer
   v. J. Drummond: Innovation around SDOH
   vi. C. Brandt: Challenge in discontinuity where patient rotates in/out Medicaid or in/out plans. MD has CRISP, which can integrate data across silos (probabilistic matching identities). Addressing political silos across social services?
   vii. C. Brandt: Possible to revamp how we incentivize MCOs to build toward better public health?

1. How to create a window of 2-3 year blocks for population health outcomes to lead to cost avoidance? (As compared to one year time windows)

viii. F. Phillips: Population health in the hospital system and public health at county level – act as two completely siloed entities. How to reconcile?
   1. Hospitals not population health experts, local public health departments are
   2. F. Phillips: How can the Commission help advance this? Opportunity for collaboration and not duplication

ix. C. Brandt: Things could really improve if hospitals had incentive
   1. There are already incentives but not enough money
   2. Under AHEAD model, every hospital will need a health equity plan with population health focus
   3. C. Brandt: In a position to do things no other states can, hope we can be aggressive

x. N. Rochester: Hospitals are trying to address these issues, but siloed efforts in hospital system, not structure for information sharing
   1. Used to be local health improvement coalitions – some counties successful keeping this going, others not
   2. How to structure/set the floor so everyone is at least doing something in their jurisdiction. Dr. Kalyanraman is working on this

xi. M. Brewster: Primary care foundational, how public health delivered locally has to do with access to primary care and partnerships with primary care in local communities. Mentioned reexamining investment in clinical care, but in some communities (not in central MD) health care service sector not meeting primary care needs, concern about significant gaps of basic preventative health care services. Shifting funding away from there without ensuring support of primary care is a risk
   1. Will not break system
   2. MHCC leading work of primary care investment
   3. Worse than a lot of states in investment in primary care pipeline
   4. Pipeline doubled number of clinicians, MD does not have shortage, they are not distributed effectively.
   5. HSCRC – GME dollars slots we do pay for, how do they support primary care residency
   6. M. Brewster: Family residents stay

7. C. Brandt: Family medicine docs control about $10 million per year on medical spending – directing traffic

xii. O. Olateju: Formalizing interagency relationships through state-run board of health? Would it impede the already short workforce?
   1. Would not impede. Knowing the workforce we have and how they prioritize care would be helpful when thinking about where the workforce is. Need to think about incentives like loan repayment or free tuition if staying to practice in the state

xiii. M. Rossman: Maryland not attractive in terms of salaries for primary care.

xiv. M. Rossman: SME for population health: What is the role of local public health in population health goals?
   1. LHDs drive this work – have connections with providers

xv. H. Bagnall: Political aspect to policy but health care needs to be agnostic. How can we establish guardrails to make sure work continues even if there is a change in administration? See both positive results in real time and long term? How can the Commission help?
   1. Use tools specific to expertise of each Commissioner
   2. Success locally translates to state success

xvi. M. Brewster: Role of FQHCs and community health centers play role in addressing gaps in primary care. Could have more robust strategy for supporting establishing and maintaining CHCs
   1. Dollars for infrastructure for net new providers in health professional shortage areas in AHEAD

xvii. B. Lushniak: Our goal is to come up with robust and good recommendations. Need to be working with the partners that do public health across the state – state and local. Report handed over to leadership and legislative branch. Co-chairs will continue briefings.

V. Break

VI. Commission Updates
   a. Timeline updated to include changes from statute and checkpoints from workgroups
   b. Shifting focus from assessment to initial findings of workgroups – may translate into domains of recommendations
   c. Project activity details sheet includes specificity on workgroup activities
   d. Workgroup charter – more definitive guidance on what workgroups should be doing and where Commission is going

i. Tracking specific asks in legislation
ii. Best practices from national framing

e. Assessment
   i. Robust presentation from academic partners in August about methods
      1. C. Brandt: Align timeline with quality metrics/how MCOs measured (Health Commission) and AHEAD – should track these processes
         a. J. Drummond: Monies directly incentivizing this. Alignment between equity, primary care, EPSCT, population health, HEDIS
         b. C. Brandt: Informing ways Medicaid paid. Beneficial both ways – amplifying those measures too
         c. M. Rossman: Public health and health care very separate in Maryland
   ii. Workgroup assessment questions due by June 21
   iii. F. Phillips: Important process occurring in next 12 months and to align our work with these external forces
      1. H. Bagnall: Can align with interim report

f. Listening Sessions
   i. Updates on Western Maryland Public Listening Session and Site Visit (Washington County)
      1. Saw some news coverage
   ii. Upcoming LHD Site Visits and Regional Public Listening Sessions
      1. Howard County has 24 registered to speak so far
      2. Baltimore City Health Department may host something between Sep 9 and 20
   iii. F. Phillips: Who does promotion?
      1. Primarily local county and health departments and community-bases partners in the region
      2. F. Phillips: Important local delegation invited

VII. Presentation: Overview of the Maryland Health Care Commission

Ben Steffen, MA, BA
Executive Director, Maryland Health Care Commission

a. Maryland Health Care Commission
b. Roles
c. Organizational Structure
d. MHCC Strategic Priorities
e. Primary Care Investment Rationale
f. 2023 – The First Year of the Primary Care Investment Work Group

g. PCIW vs AHEAD Model
    i. Private Payers
    ii. Medicare Advantage
    iii. Medicare FFS
h. Primary Care Takeaways
    i. Highest spend in the commercial market, and declining as we move from Medicare Advantage to traditional Medicare
    ii. There needs to be an agreement on the definition of "primary care"
i. BH Workforce Assessment Maryland Senate Bill 283 passed in 2023
j. Trailhead Pulled Workforce Data Based on 15 Standard Occupational Classification (SOC) Codes
k. Number of Behavioral Health professionals in Maryland in 2023
l. Behavioral Health Workforce by Planning Regions
m. A few other takeaways
    i. Living wage here is different from the Federal Poverty Line. The living wage has been determined by academic institutions as the salary needed to reasonably care for a family
n. Q&A
    i. J. Drummond: What will be the impact of the new requirement from CMMI about Medicaid patients seeing someone in a set number of days?
        1. Networks must be adequate
        2. Culturally appropriate care important
    ii. How to be intentional about health equity?
        1. Health planning for facilities and services – particularly in underserved communities
        2. Outreaching to communities where services are scarce
        3. Reporting on quality – looking to break out by race and ethnicity
        4. Working with Department on maternal mortality report card
        5. Take some time to look at the Conceptual Model for the Maryland Commission
    iii. Email Ben with additional questions

VIII. Workgroup Updates
a. Communications & Public Engagement
    i. Compiling questions, will share out
b. Data & Information Technology
    i. Final revisions of assessment questions, have subcommittee
    ii. Themes: EHR capabilities, function of and systems used by LHDs, how LHDs work together
c. Funding

i. Questions submitted
ii. Detailed presentations on public health funding on state and local level, core funding, community benefit spending
iii. Next meeting, look at funding from private sector, including philanthropic groups
iv. Will have recommendations after

d. Governance & Organizational Capabilities
i. More definition of accountability between state and local
ii. Advanced professional development and orientation for public health leaders
iii. Clarity on legal representation on local health departments
iv. Would like to interface with other workgroups more – looking for opportunities for joint meetings

e. Workforce
i. Last meeting, broke group into subsections to develop questions

IX. Announcements
a. Next meeting: July 11, 2024, 2-5pm at Prince George's County Health Department with virtual option
b. Upcoming Central Maryland Regional Public Listening Session, June 13, 2024, 5:00pm at Howard County Health Department
c. Deadline for CoPH workgroup co-chairs to submit final assessment questions is June 21, 2024

X. Adjournment
a. M. Rossman motion to adjourn
b. H. Bagnall seconded
c. Adjourned 5:10pm