Meeting Summary
Certificate of Need (CON) Modernization Task Force
Maryland Health Care Commission
Meeting of Friday, March 23, 2018
MHCC Offices, 4160 Patterson Avenue, Baltimore, MD

Committee Members in Attendance:
Frances Phillips, Co-Chair
Randy Sergent, Co-Chair
Regina Bodnar
Ellen Cooper
Lou Grimmel
Elizabeth Hafey
Anne Horton
Andrea Hyatt
Brett McCone
Mark Meade
Michael O'Grady (Phone)
Barry Rosen
Andrew Solberg
Ben Lowentritt, M.D.

MHCC Staff in Attendance:
Julie Deppe
Paul Parker
Ben Steffen
Sarah Pendley
Kevin McDonald

Others in Attendance:
Brian Ackerman
Keith Hobbs
Anne Langley
Ann Mitchell
Tyler Pickrel
Laura Russell
Howard Sollins
Noson Weisbord

Co-Chair Sergent called the meeting to order.

Comments related to the January meeting minutes were requested and Paul Parker asked the Task Force to review the February meeting summary document and provide any comments. Mr. Parker also noted that today's meeting would be divided into three primary components related to nursing homes, home health agencies, and hospices. Discussion related to nursing home comments then began.

Nursing Home Discussion

Mr. Parker introduced the process and comment summary regarding nursing home CON regulations and pointed out some of the key issues, including:

- Overall, the nursing homes that commented supported maintaining CON regulation.
- Some concerns related to capital expenditure threshold were expressed.
- Desired improvements related to performance requirements post-approval and the overall regulatory process were also expressed.

The group reviewed the nursing home fact sheet and profile document that was provided to attendees. Howard Sollins was then asked to speak on behalf of the nursing home provider community.

Mr. Sollins introduced himself and provided an overview of regulations on nursing homes. He noted that he had helped HFAM and LifeSpan write their comments and would summarize the comments for the group today starting with the more significant issues.

CMS's Five-Star System

Mr. Sollins stated that using the Five-Star ranking system as a gating requirement is problematic. Mr. Sollins provided background on the ranking system and noted that CMS uses survey results as quality metrics. Mr. Sollins is concerned that this is a moving ranking regarding performance relative to peers within a particular state. This can be problematic as a facility can be only a Two-Star program in Maryland, but a One-Star program in a different state.

He also stated that the CMS Five-Star System ranks based on deficiencies or absence of violations, and not the actual quality of care. For example, Mr. Sollins compared the system to ranking a restaurant Five-Stars because nobody has died of food poisoning from eating at the restaurant. He also stated that the results of the system are not adjusted or weighted and CMS sometimes changes the criteria, which can cause a facility to drop to a lower rating after measures have changed.

Mr. Sollins provided an example of a significant issue associated with a nursing home that wants to impact total cost of care by tying its medical records with hospitals. In the example, this partnership has resulted in some of the best turnaround times for hip fractures; however, this facility also has a dementia unit. In that unit one event occurred where a resident walked out the door (elopement) but was immediately identified and brought inside. Due to that one elopement, the facility would drop to One-Star, regardless of the quality of other areas. Mr. Sollins made the

point that to transform care, Maryland should be lobbying for changes in the regulatory system to allow for more effective evaluation across the continuum of care.

Medicaid MOU

Second, Mr. Sollins stated, both HFAM and LifeSpan feel strongly that the Medicaid MOU should no longer be a requirement as it is an outdated measure. The Medicaid MOU was relevant years ago, when it was sometimes difficult to place Medicaid patients in nursing homes. The MOU was established to improve the access issue. Mr. Sollins contended that this lack of access has significantly improved as some facilities, including some owned by major chains, have 80 percent Medicaid occupancy levels.

Mr. Sollins emphasized that it seems counterintuitive to have a system to punish facilities for not being able to maintain a certain percentage of Medicaid patient days. Mr. Sollins suggested that instead of Medicaid MOU, the task force can enforce Medicaid access by requiring that all facilities accept Medicaid, without imposing a certain percentage that facilities must reach.

Capital Cost Threshold Differential between Nursing Homes and Hospitals

Third, Mr. Sollins noted that the capital cost differential can be problematic and that the Task Force should collectively consider the threshold and what types of project can be exempted from CON to make the process more straightforward and efficient. Mr. Sollins stated that it does not make sense that the capital expenditure threshold of capital-intensive organizations such as nursing homes is comparable to home health agencies, when there are better parallels to hospital projects where the capital threshold is over $12 million. Mr. Sollins also questioned why it is necessary for a facility to have CON approval if it wants to replace a building on the same campus/location given that the cost increase is already accounted for in the rates.

Other Issues

Mr. Sollins identified other issues that he brought to the attention of the Task Force.

1. Waiver Beds – Mr. Sollins expressed that if a nursing home has doubles/triples/quads and wants to increase the number of private rooms but needs an extra 10 beds in order to pay for that, the nursing home should be able to use its waiver beds. Mr. Sollins noted that this doesn't mean we throw the barn door open because CON is needed/wanted by most.

2. Performance Requirements – Mr. Sollins stated that CON regulations are inconsistent as they allow up to 24 months to complete a CON for improvements to an existing facility, but only 18 months for a CON to construct new facilities. He further argued that the Commission should have more flexibility to approve phased capital projects. Under current rules, an applicant has only one opportunity for to extend performance requirements. As a consequence, applicants must pay extra money to bring on extra staff to meet deadlines, which causes an unnecessary waste of resources.

3. Changes in configuration of ownership after CON, but before construction completion – Mr. Sollins noted that currently, adding/changing even minority investment isn't allowed. He stated that this is sometimes a concern when an applicant wants to bring in a small equity investor as the project is being developed. He suggested that this impermissible change should modified to allow for instances where small ownership changes do not materially alter the integrity of the project.

Mr. Sollins also briefly mentioned other minor issues related to looking again at occupancy thresholds, unchecked competition for nursing facilities, and performance requirements related to zoning.

In summary, Mr. Sollins made the point that his main concerns fall into three primary buckets:

1. Avoid using Five-Star Rankings as gatekeeper indicator
2. Eliminate MOU or make it more limited
3. Update CON requirements to enable entities to modernize facilities when there was no planned expansion in the number of beds.

Mr. Randolph said that he appreciated Mr. Sollins comments regarding the suggested areas for improvement as opposed to completely removing CON. Mr. Randolph then asked for any comments or questions.

Barry Rosen asked for an explanation regarding how nursing homes are paid now. Mr. Sollins observed that that nursing homes used to be reimbursed based on cost basis but Medicare is now using the RUGS (Research Utilization Groups) methodology, although there are ongoing discussions that Medicare may be potentially moving away from RUGS approach because it is heavily dependent on therapy as a metric for measuring outcome. Mr. Sollins noted that on the Medicaid side, up until a few years ago Maryland was the last cost-based reimbursement state. Now, Maryland has a version of the RUGS system with some factors that are regional, based on rural or urban/suburban areas.

Mr. Sollins emphasized that the key issue for the Commission is that capital is not unlimited as an evaluation is in place to ensure facilities do not pay for excessive capital costs. He said that to Mr. Rosen's point, some of the considerations of CON to monitor excessive costs are not as necessary as they once were.

<u>Discussion – Future of Nursing Homes</u>

Mr. Rosen asked if there are going to be nursing homes in the future given that assisted living is making its move into the nursing space, along with other factors. Mr. Sollins stated that demographics alone with drive up demand, but the question of demand for what types of services remains given evolving consumer expectations.

It was noted that we have real opportunity to re-make the capital infrastructure of nursing homes in Maryland. It was suggested that there should be a path for those that want to go into assisted living or other opportunities, and for those willing/able to make capital investments with oversight, they should be encouraged to do so, with oversight but not micromanagement.

Discussion - Quality

Ben Steffen asked the group whether using specific quality measure was preferable to a composite measure such as the Five-Star Measure. He also asked the group regarding whether there should be efficiency metrics that could be tied to metrics in the planned Total Cost of Care Demonstration.

Lou Grimmel commented that regarding quality measure, he agreed with Mr. Sollins that any one issue can knock a Five-Star facility to One-Star facility and that it was more important to look at performance in the long-term rather than a single incident. Regarding Mr. Rosen's question on the need for nursing homes, Mr. Grimmel believed the answer is no and yes. No for traditional nursing home models and yes for those that fit in the waiver/total cost of care to help hospitals and the State meet the need for lower cost of care. He stated that traditional nursing home patients will have other alternatives that offer better patient satisfaction and provide lower cost alternatives to patients. Traditional models of nursing homes, in turn, will be phased out. Mr. Grimmel suggested that regulations need to catch-up with what industry needs to do to attract new customers and match to total cost of care. The question of how to compliment the hospital better should also become a priority.

Regarding CON performance requirements issues, it was noted that hospitals already have a campus and the right zoning, so they can start building after CON approval. However, nursing homes often do not even have the land available at the time of submission. Once CON approval is issued there is another process to go through to obtain needed zoning approvals. Performance requirements force some facilities to take advantage of whatever wiggle room there is to achieve their goals.

Mr. Sollins noted that community-based services used to be the focus, now total cost of care is the focus. The CON process should be established to look towards the future and quality shouldn't be a gating issue. He stated that the Commission should have flexibility to assess quality, and facilities will need to defend their quality, but there shouldn't be a gating standard.

Andrew Solberg addressed the group and stated that he disagreed with Mr. Sollins' remarks that there shouldn't be a standard. Mr. Solberg expressed that was not a good idea because there has to be some sort of standard if you want to use quality, which relates back to the point Mr. Steffen raised, what can/should CON contribute in quality area given the fact that licensing already reviews quality.

It was noted that although the group could not think of an instance where a nursing home was denied because of quality, it may want to keep that ability to do so in order for CON to serve as a gatekeeper to keep out entities that the State wouldn't want to admit in. Co-Chair Fran Phillips then asked for clarification from Mr. Sollins on his suggestion that there should be no quality standard.

Mr. Sollins clarified that he believed there should be a quality standard, but that the Five-Star system might not be best/only approach. He made the point that the Five-Star ranking shouldn't be a barrier to applying if you achieve a certain standard. You should be able to come in with best evidence on how you will meet the standard, there shouldn't be a barrier.

Mr. Parker clarified for the group that we do look at the Five-Star ratings for CON applicants. If you're not above a certain level you cannot submit an application. He said that applicants need to show performing above a certain level before even spending time reviewing the application and that the intent is to promote expansion of quality providers who have a good track record by requiring that they reach these levels to get through the gate. The question is, is there some merit in looking at past performance?

Mr. Sollins emphasized that the Five-Star system should not serve as a gating issue but should be considered along with other relevant metrics/measures. He believes that entity shouldn't be prohibited from applying for a CON because it failed to meet a metric that the Commission does not control.

Discussion – Medicaid MOU

Ms. Phillips then shifted the conversation back to the discussion of Medicaid MOU and requested further information and clarification. Mr. Sollins stated that the MOU had outlived its usefulness. He suggested that if eliminating the MOU is not palatable, then an alternative is to require that you accept Medicaid, but without requiring a certain percentage. He expressed concern that it's responding to a problem that is no longer an issue.

Brett McCone was asked for any comments from the hospital perspective. He stated that he felt it was important to maintain a CON process but to ensure flexibility given that the need for the services as shown/demonstrated at some point. Second, Mr. McCone stated that he agreed with the need to ensure alignment with total cost of care efforts and stated that within the preamble to the State Health Plan or elsewhere, the point regarding the alignment with total cost of care should be made.

Ann Horton then contributed a comment from a CMS official on the Five-Star rating system from a few years ago who stated that they weren't really sure how the use of these rankings were going to work out. She provided the analogy that the Five-Star system is like looking at a snapshot in time, such as one month of financials instead of an entire year, plus that snapshot reflects performance that is often more than a year in the past.

Given time constraint, Mr. Randolph suggests the group shift focus to discussion of next topic, home health.

Home Health Discussion

Linda Cole provided a review of the home health fact sheet and profile document provided to attendees, noting that innovation efforts among home health facilities include value-based

purchasing programs and joint ventures with hospital systems. Home health, in fact, is the only type of home care provider that require CONs, residential service facilities are not regulated.

Reflecting on information from the fact sheet, Mr. Randolph asked if CON has caused more utilization per provider in Maryland and why is there CON at all in home health given the low capital investment and presence of licensure requirements?

Ms. Cole responds by noting that the patient population is one that is very vulnerable, and CON serves as a way to protect them. Mr. Randolph followed by wondering if that was more of an issue for licensure and not CON? To which Ms. Cole responded by questioning if that was possible given the level of resources and capacity of licensure.

Regina Bodnar then stated that CON does protect quality, noting that the absence of CON would open the market to too many providers. From OHCQ perspective, the present staffing at OHCQ would not be able to monitor influx of entrants. Ms. Bodnar then echoed Ms. Cole's statement about vulnerable patients, indicating that is very real in today's home health and hospice environments.

Ms. Horton then provided and overview of the home health comments. She stated that for home health and private duty Residential Service Agencies (RSAs), it's very difficult to come up with a single position on this issue as there are varying opinions among the constituencies. She stated that it is clear that home health plays critical role in serving triple aim, and it is necessary in order to achieve the goals of the all payer system. Ms. Horton than noted the following information for Maryland:

- 67% of Medicare home health patients have multiple chronic diseases.
- 79% of MD home health agencies are at or above the national star average.
- Compared to nearby markets, close to 60 percent of Maryland agencies are in the Four to Five-Star category. In Virginia, a non-CON state, only 27 percent of agencies are in those categories…and 29 percent in D.C.
- Maryland is also involved in CMS experiment in home health value-based purchasing, currently involved in five-year program that involves payment adjustments of 3 to 8 percent depending on certain quality standards. Penalties and bonuses are being done starting 2018.

Ms. Horton summarized that the comments from home health can be grouped into two main categories:

1. The need for CON
2. Ways to refine the process

<u>Need for CON</u>

Ms. Horton stated that most home health providers agree that there is a need to keep CON. She made the point that CON assists with fraud prevention given the potential inability to otherwise manage oversight if the number of home health agencies grew rapidly in the absence of CON. Ms.

Horton stated that workforce is another big concern, given that there is already inadequate skilled workforce to serve all the home health providers in Maryland.

Ms. Horton made the point that home health provides an enormous cost savings in terms of total cost of care and asked the question of why hospitals are not using home health more.

Need for Refinement of the Process

Ms. Horton reported that the consensus (particularly the RSAs) is that CON process offer more flexibility for organization trying to enter the market. Ms. Horton also introduced the idea that in some instances CON can lead to lower quality ratings because it keeps high-performing organizations from entering markets in which the incumbent providers have lower quality ratings. Additional thoughts expressed by Ms. Horton included:

- Provide for a more streamlined process, including providing the ability to use available State data instead of recompiling and resubmitting data.
- Ensure that the star rating system uses updated data with each release. Related to that is the question of how we deal with that when those values change in the middle of the CON process?
- Clarify the ability to allow RSA providers to get a CON. Particularly, how does CON evaluate RSAs?
- Decrease level of complication associated with RSA provider CONs.
- Streamline the process for those applicants who are longstanding, high-quality providers in Maryland.
- Improve applicability of portions of home health CON application to home health services vs. general/other facility services, which might not be applicable to home health.
- Ensure clear and timely communication with applicants and protesting organizations to avoid them having to communicate directly with each other.

Ms. Horton suggested that additional concerns related to providers being uncomfortable releasing CON-required financial and referral source information for public view.

Mr. Randolph asked about doubling the number of providers and if that would increase uptake, or is utilization dependent on something else? Ms. Horton commented that utilization in Maryland is just slightly lower than the national average, but the expectation is it should be slightly higher given all payer model. She noted that the State is working on that already, and it's difficult to come up with one reason why. At a later point in the conversation Mr. Rosen pointed out that the notion of capped hospital payment is relatively new and goes against 30-years of history, so it should not be a surprise that utilization of home health hasn't caught up yet.

Discussion - Quality

Mr. Steffen raised the question, if home health CON is not well-aligned with the proposed TCOC Demonstration, should we be relying on it all? Are we creating a situation where we are protecting existing business, limiting innovation, and constraining success under the proposed TCOC Demonstration?

Ms. Horton followed up on that question by asking if we are convinced that the Five-Star system is sustainable long-term. She stated that the system is not as meaningful as it used to be. Ms. Hyatt then commented that it appears we are using CON to compensate for things that should be taken care of in licensure.

Ms. Horton further responded by stating that it is really a question about how big you want the funnel to be for licensure through OHCQ. She observed that it could range from very open to highly selective. Under the CON, OHCQ can maintain a fairly open process because CON acts as the screener. Without CON, licensure would need be more selective. Ms. Horton observed that OHCQ does not have the capacity to deal with the situation. She also raised another issue related to inadequate number of skilled workers available to support all of these types of post-acute providers.

Mr. Grimmel then brought up the point that MHCC has provided multiple grants for telehealth and telemedicine, which has facilitated the reduction of not only ED visits, but also admissions. Mr. Grimmel explained his efforts to offer bundled payments and the use of nursing homes to efficiently stabilize high-risk patients, returning them to home using telehealth, which provides a low-cost/high patient satisfaction alternative. Mr. Grimmel explained he is currently limited to doing this just for certain payer classes and would be interested in expanding those efforts to have a more dramatic impact on the overall total cost of care in Maryland.

Discussion – Urban/Rural

Mr. Rosen pointed out that it's important to note the difference between a rural and urban/suburban markets. For some rural providers, the notion of limiting who can provide home health or hospice makes sense given there's not enough population to support more than one provider. It doesn't make sense, however, to restrict urban/suburban providers. Mr. Rosen made the point that while CON does help to keep the fraudsters out, a significant license fee could accomplish the same objective.

Ms. Horton countered that he has had conversation with providers and the opposite is true. Rural areas where population and demand are low should be opened up, because if you're willing to go as a licensed home health provider you should be able to go. Ms. Horton than made the point that opening up the urban areas will lead to us becoming Texas or Florida, with increased fraud.

Mr. Parker stated that the State has already opened rural areas (Eastern, Southern, Western) but have received limited interest because market limitations have overwhelmed the providers. He stated that there is very little interest in serving rural areas. The process is simple and welcoming for organization with a good track record, but there has been little interest because the market is too small.

Discussion – Alternatives to CON

Mr. Parker then stated that the evidence suggests that the presence of CON indirectly impacts quality as it results in far fewer agencies that we would have otherwise. Mr. Parker than suggested that if growth is the main concern, why not just limit growth through OHCQ? Maybe permit only

a certain number each year and rather than CON, there could be a lottery system that limits the number of new agencies. One could provide the standards that must be met to put your name in the hat. Mr. Parker explained that this would provide the benefit of CON while letting people go into areas they want to go. If we do that, Mr. Parker wondered about the value of CON in a system like that.

Ms. Horton asked about the unintended consequences of such an approach and wondered if it had been done elsewhere. Ms. Horton stated that a vision for what that process would need to be created and evaluated.

Mark Meade then stated that what we're talking about here is the continuum of care, noting that we all represent different aspects of the continuum. He stated that we must ensure that the CON process is not building Chinese walls to prevent our ability to put patients in best quality/lowest cost sites of care.

Mr. Randolph then asked about the difference between CON and a more robust licensure structure. Mr. Solberg concluded that CON does help to keep out bad providers, but in doing so, it also keeps out good providers of home health services. He stated that the ability for a health planner to project the need for a number of agencies is fiction. There might be other reason to keep CON, such as ensuring access to charity.

Mr. Steffen reminded the group of the time and need to transition conversation to hospice.

Hospice Discussion

Ms. Cole provided a review of the hospice fact sheet and profile document provided to attendees, noting that utilization in increasing overall, but has decreased recently for minorities.

Ms. Bodnar was introduced as representing the Hospice Network of Maryland to summarize comments for the group. Ms. Bodnar began by providing a brief CON history for hospice, noting that in 2003, hospice CON in Maryland was recalibrated and limited the geographies based on the jurisdictions that facilities provided care to for the 12-month period prior to Dec 31 of 2001. As a result, many hospice providers in the State received CON for jurisdictions that they didn't have robust presence in. Ms. Bodnar stated that right now there are some jurisdictions where hospice providers have a CON but they don't have a significant presence. Ms. Bodnar also reported that in 2010 the Commission reevaluated its position on CON for inpatient beds and since that time a CON is required if you want to expand beds or put beds in a joint venture.

Ms. Bodnar then explained that there are four levels of care associated with hospice, including routine home health hospice (90% of patients fall in this category), respite care, continuous care, and general inpatient care. Ms. Bodnar noted that the number of hospices by jurisdictions varies, but all have at least one general hospice service.

Ms. Bodnar then explained that the comments from hospice providers largely echoed home health comments, including the desire to maintain some level of CON, with modifications.

Need for CON

Ms. Bodnar provided several pieces of information and opinion related to the need to maintain CON for hospice services, including:

- The loss of CON would result in large influx of providers, majority of whom would be for-profit entities. She provided an example: Maryland has 27 hospices, compared to nearly 300 in Pennsylvania.
- CON provides mechanism to ensure quality as demonstrated by the fact that Maryland has had no incidence of fraud while patterns of fraud exist across the country.
- Non-profit hospice organizations depend heavily on donations and the presence of additional providers would heighten competition for donated dollars.
- CMS requires volunteers to provide at least five percent of total patient care hours provided by paid staff. Competition for limited resources of volunteers is already a challenge, along with the ability to recruit a qualified workforce.
- Presence of additional providers would escalate cost of care because it would negatively impact the current economies of scale used by existing providers. For example, one receptionist is needed whether you have 300 patients or just 10 patients.
- Hospitals see hospices as strong partners. Ms. Bodnar's hospice hospital readmission rate less than one percent.

Need for Refinement of the Process

Ms. Bodnar then provided suggestions for improving the current CON process, which included:

- Simplify the methodology for determining unmet need for establishment of new programs.
- Establish a methodology for determining the need for inpatient beds. This methodology does not currently exist, yet providers must still go through the CON process to expand.
- Consider establishing thresholds for minority utilization, particularly for jurisdictions with higher minority demographics. Recognizing that this may be a challenge given it's less an access issue and more an acceptance issue.
- Include a weighted focus on publicly reported quality measures when reviewing applications.
- Utilize survey data and actual complaint data during review process.
- Ask any application docketing for a CON how they propose to maintain and facilitate a decrease of the total cost of care.
- Ensure all applicants are held accountable for adhering to required timelines for review.

Mr. McCone confirmed that hospice is in fact included in the total cost of care relative to the waiver.

Discussion – Provider Types, Geography, and Demographics

Mr. Grimmel then highlighted the difference between for-profit and non-profit hospices. Indicating that the numbers for-profit providers have exploded and that non-profit facilities do a much better job keeping patients for only the appropriate length of stay. In this instance CON can act as an effective watchdog for Maryland.

Ms. Bodnar then explained that hospice payment is the same regardless of how many/any staff in patients' home, so the opportunity to provide less than adequate care for purposes of improved profitability is significant.

Mr. Rosen then reiterated the point regarding the difference between rural and suburban given the distance between homes in rural markets, stating that there's no point of CON for urban and suburban regions except for keeping out fraudsters. It was stated that Maryland had a moratorium on hospice for 15 years and, as a result, Maryland has one of the lowest hospice penetration rates in the country.

Mr. Rosen also stated that we must be careful saying that the minority population doesn't want care, as it could also be a history of racism on the provision of care to minorities that's driving some of the low use. Mr. Rosen also cautioned against the assumptions that all for-profit providers are bad given that a number of good for-profit providers do exist. Ms. Bodnar responded by saying her comment was certainly not making a sweeping assumption that all for-profits are not good but suggested that there is research showing that for-profits do have larger bottom lines due to differences and staffing and visit intensity.

The point was then brought up that the real issue is not access but acceptance. Often, the number one complaint about hospice is that families wish they knew about it sooner. As a result, the focus should be going to non-traditional sources to get the word out, and that the number of hospice providers in the State doesn't necessarily dictate utilization.

Mr. Solberg then remarked that when hospice puts a unit in a hospital, the number of people that die in a hospital bed drops markedly. Maybe the commission should consider a policy that encourages such units around the State as a way of decreasing total cost of care.

Discussion – Impact on Innovation

Mr. Steffen then stated that he agreed with Mr. Rosen and Ms. Bodnar's remarks. He also raised the question on whether CON stifles innovation by making the point that all existing providers are going to say that they have been innovative. Mr. Steffen wondered if maybe we have to realize there might be other ways to innovate that we're simply not aware of in Maryland and that we might be slower to innovate in Maryland because we have 30 years of historical referral patterns and nobody else is able to enter the market and provide a difference perspective.

Ms. Horton responds by agreeing that many small independent providers across the State home health and hospice arenas don't have the experience and exposure, but many others can bring back what we're experiencing across the country. Ms. Bodnar commented that the hospice network does an incredible job in working with providers across the State and sharing best practices; Maryland is respected across the country

Meeting Conclusion

Mr. Randolph then declared that the group was out of time for this session and asked the Task Force to review the hospital draft problem statements and provide any comments, which will be discussed at a later date to allow sufficient time for discussion.

Mr. Parker thanked Ascendient for their efforts to develop materials and a meeting summary for the February meeting and reminded the members that hard copies of all materials and comments are available. Mr. Steffen stated that for those that want to provide additional comments, please feel free to do so and let the Commission know within the next ten days so the comments may be incorporated into April 20th meeting.

Mr. Steffen then stated that the next meeting will consider Ambulatory Surgery issues, a review of problem statements, and a discussion of the structure of the interim report. Mr. McCone asked a process question related to the timing of MHA sharing suggested solutions from its workgroup before June. Ms. Phillips requested that MHA not provide that information until after June to remain focused on understanding issues at this time.