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CHAIR

STATE OF MARYLAND

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MARYLAND HEALTH CARE COMMISSION

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Thursday, December 19, 2019

Minutes

Chairman Pollak called the meeting to order at 1:12 p.m.

Commissioners present: Boyer, Boyle, Doordan, Hafey, Hammersla, Metz, O'Grady, Rymer, Sergent and Thomas

Dr. Pollak read a statement outlining his recommendations on the approach for updating the C State Health Plan Chapters. Dr. Pollak's statement is included at the end of these minutes.

AGENDA ITEM 1.

Approval of the Minutes

Commissioner Hafey made a motion to approve the minutes of the November 21, 2019 public meeting of the Commission. The motion was seconded by Commissioner Boyle and unanimously approved.

AGENDA ITEM 2.

Update of Activities

Ben Steffen, Executive Director, reported that MHCC submitted its statutorily required four-year report on mandated health insurance benefits in Maryland to the General Assembly. The transmission letter that accompanied the report noted the Commissioners' recommendations that several of the mandates studied were offered in other states, but not covered in Maryland and should be given consideration. The letter also voiced MHCC's longstanding concerns that while the cost of any one mandate is small, there is a cumulative impact of mandates on increased costs of health insurance premiums for Maryland residents. As a follow-up to the mandate report, MHCC has received a request to estimate the cost of eliminating copayments, coinsurance, and deductibles for the prostate screening antigen (PSA), the principal blood test used in the detection of prostate cancer.

Mr. Steffen, also reported that the legislature requested that MHCC study the potential actuarial impact for mandating insurance benefits for three emergency medical services models of care

(alternative destination, treat and release, and mobile integrated health), on the private insurance market. He noted that a report on this study will be presented at today's meeting and the final report is due to the legislature on December 31, 2019.

Mr. Steffen reported that the staff has submitted a report detailing our progress in developing the inpatient psychiatric regulations by December 31, 2019. He noted that staff will not meet the deadline because of stakeholder concerns about high cost and hard-to-place patients. In response to these concerns, the staff convened a clinical advisory subgroup to examine challenges associated with hard-to-place and high-cost patients.

Mr. Steffen said that the staff will meet with experts from Bailit Consulting and RAND to discuss methodologies for tracking primary care spending. This particular initiative is a priority of the Secretary for the Department of Health.

Next, Mr. Steffen reported on the Maryland Primary Care Program (MDPCP) Advisory Council. The MDPCP Advisory Council will convene a subgroup to discuss options for expanding the number of tracks in the program. The Advisory Council was established by request from the Secretary of the Maryland Department of Health, under the authority of Health General § 2-104(d), to provide input on MDPCP operations, and to serve an advisory role to the Secretary and MDPCP Program Management Office (PMO).

Lastly, Mr. Steffen reported that MHCC issued a grant announcement on November 22nd for pioneering the use of telehealth by nursing homes across the State. Grant applicants must propose a telehealth program that accelerates widespread adoption and that is designed to meet care delivery needs, support transitions, and curb unnecessary emergency department use and re-hospitalizations. Letters of Intent are due on December 10, 2019 by 5:00 PM and the grant application is due on January 31st at 5:00pm.

Theressa Lee, Director of the Center for Quality Measurement and Reporting, updated the Commission on the recent release of a Request for Expressions of Interest (RFI) for entities exploring MHCC designation as the Patient Safety Center for Maryland. The RFI also solicits comments on the performance of the current designee, the Maryland Patient Safety Center, Inc. The RFI document was released on December 6, 2019 and requests responses and public comments by January 14, 2020.

Paul Parker, Director, Center for Health Care Facilities Planning & Development, provided a brief update on population use rates of hospice services as a follow-up to the presentation on hospice services made in November. Using data from HospiceAnalytics.com, he showed that Maryland's Medicare use rate (Medicare hospice deaths/Total Medicare deaths) in 2018 was 47.6%, compared to the national use rate of 49.4%. Maryland's use rate ranked 34th in the nation in 2018 among the 50 states. He also compared Maryland's use rate with that reported for bordering states and the District of Columbia. He noted that Delaware and Pennsylvania have a higher use rate and that Virginia, West Virginia, and the District of Columbia have lower use rates. Mr. Parker provided information on the Maryland jurisdictions with the highest Medicare hospice use rates and the lowest rates.

AGENDA ITEM 3.

ACTION: Certificate of Need – Rehabilitation Hospital Corporation of America, L.L.C. d/b/a Encompass Health Rehabilitation Hospital of Salisbury – Addition of Acute Rehabilitation Beds (Docket No. 18-22-2435)

Kevin McDonald, Chief of Certificate of Need, presented the staff recommendation. He stated that because the number of beds being requested exceeded the MHCC's published high range estimate, the burden of proof was on the applicant to show the need for these beds. Mr. McDonald stated that the applicant presented evidence – i.e., an occupancy rate that has consistently exceeded 90%, a large in-migration by Delaware residents, the applicant's having to turn away almost 300 admissions annually for lack of bed availability, and a measurably higher incidence of Medicare patients with a stroke diagnosis than the average for Maryland – that justified the need for the project. He stated also that the application demonstrated the project's cost effectiveness, viability, and positive impact on the health care system.

In reviewing the application against the State Health Plan chapter's standards, Mr. McDonald noted that Encompass had a very poor track record of providing charity care, but that the applicant had committed to provide charity care at a level equaling 2% of its expense budget going forward and described its plan to achieve a higher performance. He recommended approval of the project with the following condition:

> In its request for first use approval of any or all of the approved beds, Encompass-Salisbury shall provide information, acceptable to Commission staff, that: details the activities it has undertaken following approval of the Certificate of Need to increase the amount of charity care provided to patients; and demonstrates its progress in achieving the level of charity care to which it has committed (i.e., charity care equivalent to two percent of total operating expenses). If staff concludes that Encompass-Salisbury's demonstration of progress is not satisfactory, further action regarding this Certificate of Need may be considered by the Commission at a public meeting.

Commissioner O'Grady made a motion to approve the CON which was seconded by Commissioner Hammersla and unanimously approved with conditions.

ACTION: Certificate of Need – Rehabilitation Hospital Corporation of America, L.L.C. d/b/a Encompass Health Rehabilitation Hospital of Salisbury – Addition of Acute Rehabilitation Beds – (Docket No. 18-22-2435) is hereby APPROVED WITH CONDITIONS.

AGENDA ITEM 4.

PRESENTATION: On Assessment of Types, Quality, and Level of Services provided at the University of Maryland Shore Medical Center at Chestertown

Paul Parker, Director for the Center of Health Care Facilities Planning and Development and Megan Renfrew, Chief of Government Affairs and Special Projects, along with Annette Lindemann from LD Consulting presented an overview of the assessments and findings of the quality, and level of Services provided at the University of Maryland Shore Medical Center at Chestertown (SMC-Chestertown). Ms. Renfrew stated that in the last legislative session, MHCC was tasked with assessing the types, quality and levels of services provided at SMC-Chestertown. He reported that MHCC has been working on this task with the Health Services Cost Review Commission and the Office of Health Care Quality and that report is due to the Legislature on January 1, 2020 but that an extension for submission of the report has been granted until the end of January, 2020.

Ms. Renfrew, stated that MHCC was requested to focus on the time period between 2015 and 2018 because this is the period when the University of Maryland acquired the hospital Shore Health System, identify any services that were reduced or transferred from the SMC-Chestertown to the University of Maryland Shore Medical Center in Easton. Ms. Renfrew said that a full complete report will follow next month.

Mr. Renfrew provided the following background information. The hospital in Chestertown predominantly serves residents in Kent County as well as parts of Queen Anne's County. This is a rural area and Kent County has actually seen a population decline in the past eight years. This area also has a very high percentage of residents over age 65; therefore, compared to the State as a whole and to other areas in the state, this has a proportionally high number of Medicare beneficiaries. The statute required that MHCC examine the: (1) the type of services that were provided; (2) the volume of services that were provided; and (3) quality of services that are provided.

Mr. Parker reported that the assessment of the types of services provided showed a significant decline between 2015 and 2018 in several outpatient services: supply-related visits (-13%); surgical-related visits (operating rooms and anesthesia services) (-29.5%) and electrocardiography visits (-46.2%) while outpatient clinic visits saw a large increase over the 2015-2018 period, almost doubling from 724 to 1,376 visits.

Mr. Parker reported that the assessment of the volume of services provided found that inpatient volume declined between 2015 and 2018, specifically a 15% average annual decline in patient days and a 12% average annual decline in discharges. This decline underlines the drop in licensed acute care beds at SMC-Chestertown between fiscal year 2015 and 2020, from 30 to 12 beds.

Mr. Parker reported that the assessment of the quality of services provided. Our assessment found that in 2015 there were 1,829 admissions and in 2018 and 262 admissions with an average change of -11.6%. In 2015, there were 245 readmissions and 152 in 2018, with an average change of -14.7%. In prevention quality indicator (PQI) admissions there were 415 in 2015 and 129 in 2018 with an average change of -32.3%.

Finally, Mr. Parker noted that the patient care services have not changed fundamentally and that Chestertown hospital is a small medical, surgical, acute care hospital that has experienced changes in volume. Specifically, the demand for inpatient services has declined over the past

few years at a more rapid rate than the decline in Maryland as a whole. Mr. Parker offered that although, inpatient demand is declining overall the outpatient volumes relatively unchanged.

ACTION: NO ACTION REQUIRED

AGENDA ITEM 5.

PRESENTATION: Potential Models for Rural Health Delivery in Maryland

Alana Knudson, co-director of the Walsh Center presented their initial findings on potential models for rural health delivery. Ms. Knudson identified delivery system models that could meet the health care needs of residents in Kent and upper Queen Anne's Counties. Their assessment found that in Inpatient Utilization there was 75% paid by Medicare; 10% paid by Medicaid; about 90% of visits originated in the ED; 90% indicated coming to the hospital from home; approximately 25% of visits were discharged to SNF and roughly 8% of discharges were home health; average length of stay: 3.9 days and average daily census:10 patients

Ms. Knudson reported that the assessment of outpatient utilization was found to have nearly 50% paid for by Medicare; 20% paid for by Medicaid and approximately 1/3 of visits occurred in the emergency department. In addition, she stated they found that residents of the service area were bypassing University of Maryland Shore Medical Center at Chestertown because transportation was a challenge, poor communication and community mistrust of Shore Regional Health, the large older adult population was growing and certain health care services were needed locally which includes inpatient beds.

Finally, Ms. Knudson recommended that implementing a mobile integrated health program in the community and optimizing rural workforce training in the community would be beneficial. She noted that the University of Maryland School of Medicine received a $750,000 training grant from the Health Services and Resources Administration (HSRA), to enhance the training for rural health care providers in the Eastern Shore, possibly in Chestertown.

ACTION: NO ACTION REQUIRED

AGENDA ITEM 6.

ACTION: Approval for Release –Maryland Trauma Physicians Services Fund Annual Report

Ben Steffen, Executive Director for MHCC, presented highlights from a report on the Maryland Trauma Physician Services Fund (Fund), which captures fiscal and policy changes during the fiscal year, implementation of those changes, and projects the solvency of the Fund. Mr. Steffen noted that Bridget Zombro and Denise Ridgely worked on this report.

Mr. Steffen explained that during the 2003 Legislative Session, the Maryland General Assembly established the Maryland Trauma Physician Services Fund to aid Maryland's trauma system by reimbursing trauma physicians for uncompensated care losses and by raising Medicaid payments to 100% of the Medicare rate when a Medicaid patient receives trauma care. The legislation established a formula for reimbursing trauma centers for trauma-related on-call expenses for

trauma surgeons, orthopedists, neurosurgeons, and anesthesiologists. The legislation directed HSCRC to allow trauma center hospitals to include trauma-related standby expenses in approved rates. The Fund is financed through a $5 fee on automobile registrations and renewals.

Mr. Steffen stated the Fund should remain solvent through FY 2021 with implementation of the following staff recommendations in the report: t reimbursement levels to remain at 105% of the Medicare facility rate through 2020; reimbursement of Medicaid/Medicare Differential for FY 2020 (processed at the end of the fiscal year); reimbursement of standby costs for PARC from the fund in FY 2020 and work with HSCRC to include in hospital rates in subsequent years and next steps in the release of the Annual Report to the Legislature.

Commissioner Thomas made a motion to approve the Maryland Trauma Physicians Services Fund Annual Report which was seconded by Commissioner Boyle and unanimously approved.

ACTION: Approval for Release –Maryland Trauma Physicians Services Fund Annual Report is hereby APPROVED.

AGENDA ITEM 7.

ACTION: An Assessment of the Impact of Establishing a Mandate in the Private Insurance Market for New EMS Models of Care

Matt Kukla, Senior Health Economist of BerryDunn presented their findings on the Assessment of the Impact of Establishing a Mandate in the Private Insurance Market for New EMS Models of Care. Mr. Kukla reported that this report is a response to a request from the Chair of the Senate Finance and House, Health and Operations committee of the Legislature and that the report compliments recommendations from MIEMSS on the new models of EMS care by providing evidence based estimates of cost for these programs to be covered by health insurance.

Mr. Kukla reported that the report examined the medical, social, and financial impact of mandating commercial insurers proving coverage analyzing the following EMS benefits. The first is Treat and Release, where the innovative treat and release models identify low-acuity patients who have called 9-1-1 and provide on-scene treatment by a clinician and includes both patients who would have been transported to the ED as well as patients who would have refused to ED transport in absence of the program. Next is the Alternative Destination, where EMS transports 9-1-1 patients with low-acuity conditions to an urgent care or other clinically appropriate setting in lieu of the ED. The final one is the Mobile Integrated Health, where patients identified by local EMS and/or health care providers, EMS partners with health care providers to conduct home visits to assess, treat, and refer patients with chronic conditions to appropriate health care settings and community resources and targets high utilizers of EDs, frequent 9-1-1 callers, or those at high risk for hospital readmission.

Mr. Kukla explained that the alternative destination EMS model would give an alternative destination as a benefit so that EMS would be allowed to transport patients who call 911 but are low acuity patients to an alternative destination such as urgent care or another clinically appropriate setting instead of the emergency department. Mr. Kukla, stated that the mobile integrated health is a slightly different benefit and it is not prompted by a 911 call but essentially

EMS partners with healthcare providers to conduct home visits where they assess, treat, or refer patients to the appropriate healthcare setting. This model will provide community resources to the target population for MIH benefits or those high utilizers of the ED, frequent 911 callers, or those at risk of a hospital readmissions.

Mr. Kukla reported that there are nine pilot programs in Maryland which are largely funded through grants. They are Baltimore City, Charles County, Frederick County, Howard County, Montgomery County, Prince George's County, Queen Anne's County, Salisbury-Wicomico County, Talbot County. The demand and utilization payer options are payer options for controlling induced demand for health care services often depend on external factors, including regulatory requirements; patient cost sharing (e.g., copays, coinsurance, deductibles), utilization management, gatekeeping, and benefit design can impact patient care delivery decisions and volume of 9-1-1 calls; and underlying payment structures and rates (e.g., fee-for-service, bundled payments) and rates can impact EMS provider decisions on where to transport patients, types of services provided, and care intensity.

Mr. Kukla reported on the estimated costs of the three EMS models of care. The costs of the Treat and Release program equal the estimated cost of a treat and release visit and the cost of a follow-up office visit, multiplied by the number of treat and release events and savings equal to the cost of the Emergency Department visit plus the cost of EMS transport, multiplied by the number of treat and release events. The Alternative Destination costs equal the number of additional EMS transports due to mandated benefits multiplied by the cost per transport and related services and savings equal the difference between Emergency Department visit and urgent care visit cost, multiplied by the number of alternative destination transports. Finally the Mobile Integrated Health, costs equal the number of MIH services multiplied by the average cost of MIH services and savings equal the number of avoided ED visits, EMS transports, and hospital readmissions multiplied by the cost associated with those respective services.

Commissioner Hammersla made a motion to approve the Assessment of the Impact of Establishing a Mandate in the Private Insurance Market for New EMS Models of Care and which was seconded by Commissioner Boyle and unanimously approved.

ACTION: An Assessment of the Impact of Establishing a Mandate in the Private Insurance Market for New EMS Models of Care is hereby APPROVED.

AGENDA ITEM 8.

Overview of Upcoming Activities

Mr. Steffen stated that the January Commission meeting agenda will include several CON applications, healthcare data breaches in Maryland hospitals and the first legislative update for the 2020 legislative session. There will also be a presentation on Professional Services and reimbursement.

AGENDA ITEM 9.

ADJOURNMENT

There being no further business, the meeting was adjourned at 4:44 p.m. upon motion of Commissioner Boyle, which was seconded by Commissioner Sergent and unanimously approved.

Statement of Andrew N. Pollak, MD, Chair of MHCC
December 19, 2019

During the 2019 legislative session, the General Assembly passed legislation mandating that the Maryland Health Care Commission begin a regular and deliberative process of updating the State Health Plan chapters within the annotated code of Maryland. The content of these chapters drives our analysis of all applications for certificates of need in the State of Maryland. In particular, the State Health Plan chapters give the Commission and applicants direction when it comes to projecting the need for future bed capacity in any given specialty area in any given jurisdiction. As the Commission proceeds with the development of draft changes to the State Health Plan chapters, initially in the hospital psychiatric services chapter, it is essential that we as Commissioners provide staff with direction in the development of these changes. Stakeholder workgroup meetings have been underway for some time now. Recently, the staff convened a clinical advisory group (CAG) to gain more clinically relevant information about hard to place adolescent and geriatric patients with co-morbidities. Staff are currently digesting the contents of the input from the clinicians. The input from the advisory group will inform the workgroup and provide guidance on how the hospital psychiatric service chapter should be modernized. Commissioners must understand the landscape that these regulations will influence and the importance of these regulations in supporting our objectives under the Total Cost of Care model. Updating these regulations is critical and the legislature has established a timeline for completion. As we update the chapter we must steer clear of the rigid bed need methodologies that have been anchors of many State Health Plan Chapters. Rigid bed need projection once represented the necessary counterbalance to a system of rate regulation that essentially guaranteed hospitals payment sufficient to cover increased depreciation costs that were associated with expansion of bed capacity in the context of older models of rate regulation in the State of Maryland. Since 2014 however, those models have changed dramatically. Since January

2019, not only are hospitals no longer protected from the increase in future depreciation costs associated with future capital investment as they were prior to 2014, they are now penalized for any increases in cost of care, either inpatient or outpatient, that accrue to Medicare beneficiaries under the Total Cost of Care model. Given this important shift in the realities of the healthcare reimbursement environment in the State of Maryland, it is essential that we as the Maryland Health Care Commission shift with this changing paradigm and develop methods to evaluate CON applications that are consistent with the priorities and incentives of the Total Cost of Care model. I'm pleased that staff has proposed eliminating a bed need methodology from the proposed chapter. I understand that some of the stakeholders are reluctant to abandon this methodology, but it is frankly no longer relevant, necessary or valuable.

I believe that our regulations going forward must provide hospitals with the greatest flexibility possible, consistent with the realities of existing statute, to increase or decrease the size of inpatient or outpatient facilities as necessary to meet the needs of their communities. Bed need projections are important, but not always accurate. Hospitals are responsible under Total Cost of Care for the consequences of overestimating bed need projection, and they are therefore incentivized to get bed need projections accurate. It is important for us to recognize that hospitals are also penalized under Total Cost of Care for under-projecting bed needs. More importantly, patients are penalized when we under-project bed needs and when we become unable to deliver on the promise of ensuring access to care for populations.

Each Commissioner needs to carefully evaluate any draft regulations that are presented. I want it to be clear that I will expect staff to develop draft regulations that maximize the flexibility for hospitals to project bed need as long as those projections do not appear to underestimate the needs of the population. I will personally evaluate draft regulations from this perspective and I encourage you to do so as well. I note that Health General § 19-120 does not require us to apply rigid bed need methodologies in our planning responsibilities. Bed need is not referenced in that

section of the statute. We should use that flexibility in the statute to better align our health planning duties with the new realities of Total Cost of Care

I encourage the Commissioners to become involved in our State Health Plan development efforts. The staff welcomes Commissioners involvement during the development process. Participation of Commissioners at an early stage can provide signals to stakeholders on scope of update. You will likely hear from constituent groups regarding their preferred approaches to this process. There is no shortage of perspectives when it comes to health planning and CON issues. I encourage each of you to carefully evaluate what you hear in the context of the potential conflicts of interest associated with the various groups who will reach out to you. I encourage you to carefully evaluate what you hear and to consider the comments in the context of the Total Cost of Care model and the mandates that Maryland is facing in that regard. In 2018, the House and Senate oversight committees told us to reconsider the health planning status quo and align our planning processes with the TCOC model. Vice-Chair Sargent led a task force that made important recommendations for modernizing planning and CON. The oversight committees in the House and Senate supported those recommendations. It is our responsibility to take the next steps.