Andrew N. Pollak, M.D.
CHAIR

STATE OF MARYLAND

Ben Steffen
EXECUTIVE DIRECTOR

MARYLAND HEALTH CARE COMMISSION

4160 PATTERSON AVENUE – BALTIMORE, MARYLAND 21215
TELEPHONE: 410-764-3460 FAX: 410-358-1236

Thursday, January 21, 2020

Minutes

Chairman Pollak called the meeting to order at 1:02 p.m.

Commissioners present via telephone: Akintade, Bhandari, Boyer, Boyle, Doordan, McCarthy, Metz, O'Connor, O'Grady, Rymer, Sergent, Thomas, and Wang

AGENDA ITEM 1.

Approval of the Minutes

Commissioner O'Connor made a motion to approve the minutes of the December 17, 2020 public meeting by teleconference of the Commission. The motion was seconded by Commissioner Boyle and unanimously approved.

AGENDA ITEM 2.

Update of Activities

Commissioner Bhandari asked how the Commission disburses information to the consumer from the Commission's website. Ben Steffen, Executive Director responded that the Commission is spending a small amount of money to raise awareness with a $50,000 contract. The Commission is also working with the Maryland Public Television (MPT), a State agency, to request the agency to develop a broader initiative of engaging patients in awareness of price and quality information. The Commission has not reached an agreement with the MPT but plans to use an inter-agency agreement, which allows State agencies to work together more easily than by contracts. The MPT is engaged in several public health initiatives and outreach efforts with other State agencies on COVID-19 and HIV. The Commission is assessing if the MPT can take on an additional initiative of quality initiatives and raising awareness on telehealth. As of January1, 2021, health care organizations, including health systems and payers, are required to provide additional information and MHCC will be monitoring the rollout of these efforts. The MHCC will work with experts to identify ways to involve others to raise awareness.

Ben Steffen, Executive Director, also stated that price and transparency information is not always available, and that because people do not buy healthcare often, it is always better for consumers to go to their insurance carrier or employer for purchase coverage and prices.

Chairman Pollak offered his perspective on COVID 19 based on the State of Maryland's daily reporting and the University of Maryland Medical System experience. Chairman Pollak reported that the State has seen a decrease in the positivity rate during the past two weeks to 7.7% as reported by the State. The new COVID strain that is more infectious could possibly increase the numbers substantially, which could bring an increase in the positivity rate. Dr. Pollak also stated that he has looked at the national and local modeling and predicts that relatively high numbers of hospitalizations and high stress on the healthcare system are likely through March. As of today, Chairman Pollak offered that State hospitalization numbers are down to 1,800 from close to 2,000 a couple of weeks ago.

Mr. Steffen stated that vaccinations have been given out on a week-by-week basis. Maryland receives 72,000 vaccine doses a week, which are distributed to health systems and county health departments. Independent of the distribution to the State, CVS and Walgreens are administering vaccines to workers and to long term care facilities, nursing homes, and assisted living centers.

Next, Mr. Steffen reported that on December 27, 2020 President Trump signed the Consolidated Appropriations Act, 2021, which included twelve appropriations bills and the coronavirus response and relief supplemental appropriations. This Act includes provisions on surprise billing, which means payers and providers would have to be prepared for these new surprise billing provisions to take effect on January 1, 2022. Mr. Steffen added that this federal legislation includes grant funding of $125 million for states to establish all-payer claims databases (APCDs), which contain data on health care claims, such as medical, pharmacy, or dental claims from a variety of public and private payers. This data can provide policymakers and researchers with much-needed information to understand health care costs, utilization, and quality. To date, there are twenty-one (21) states that have established or are implementing APCDs, and an additional eleven (11) states that have indicated a "strong interest" in doing so. This interest will surely be bolstered by the new grant program, which authorizes three-year grants of $2.5 million for states that apply and meet the requirements. There will be incentives for states to work together to build multi-state initiatives by working with providers, payers, and State agencies to on how to spend the $2.5 million.

Finally, Mr. Steffen reported that the launch of the re-competition of the Commission's APCD contract early this spring has been deferred due to the volume of contracts from other State agencies being considered by the Department of General Services (DGS), which now has oversight of State procurement. Mr. Steffen added that it is in the Commission's best interest to extend the existing APCD contract with Social and Scientific Systems to the end of the year.

Lastly, Vice Chair Sergent asked if, with the change of federal administrations, there are any changes at the federal level regarding the ERISA and all-payer claims databases, to which Mr. Steffen answered that under the federal stimulus legislation, the Department of Labor must develop common data to be used by the ERISA plan. To further enhance data collection, the Secretary of HHS may prioritize multi-state applications for APCDs or applications when the state will adopt a new reporting format for self-funded group health plans. Under a Supreme Court decision from

2015, states cannot require third-party administrators or self-funded group health plans to contribute data to an APCD. This remains true under the federal legislation, which does not disturb that precedent. The legislation separately requires the development of a standardized reporting format for group health plans to enable voluntary reporting to state APCDs. The Secretary of Labor must provide guidance to states on the process that could be used to collect this voluntary data in the standardized format.

Theressa Lee, Director for the Center for Quality Measurement and Reporting (CQMR), introduced Diana Estrada Alamo, a new member of the CQMR team. Ms. Estrada Alamo will play a lead role in coordinating the development of the Center's new health disparities initiative, which includes a new reporting feature on the Healthcare Quality Reports consumer website.

Ms. Lee also expressed appreciation for the feedback the Commissioners provided during the last public meeting on the redesign of the Quality Reports consumer website. She noted the feedback was helpful for staff and led to additional improvements to the site. She also noted that the staff reviewed various state websites and found no compelling reason to withhold reporting of aggregate resident race and ethnicity data for nursing homes and other long term care facilities when available. Finally, she added that the staff will look at the impact of resident race and ethnicity on nursing home performance on quality measures to better understand that relationship. The consumer website is scheduled for release on March 1st.

David Sharp, Director, Center for Health Information Technology, and Innovative Care Delivery introduced Kelly Scott who joined the Commission on January 13th as a Program Manager in the Health Information Technology Division. Ms. Scott previously worked for Medical Decision Logic, Inc., a medical software development organization where she worked on projects related to health information exchange, electronic health records, and value-based care delivery.

AGENDA ITEM 3.

ACTIONS: Confirmation Docket – Emergency Certificates of Need

Commissioners received the four Emergency Certificates of Need (CON) that were issued by Ben Steffen, as well as the underlying applications and the recommendations from OHCQ that each Emergency CON application should be approved. The documents were posted on the Commission's website and the Commission voted on both emergency CON's separately.

A. Confirmation of approved Emergency Certificate of Need – Establishment of a Temporary 10-Bed Acute Inpatient Psychiatric Unit at the Temporary Remote Location of UM Prince George's Hospital Center at UM Laurel Medical Center (Docket No. EM-H20-16-039)

Chairman Pollak noted that he would recuse himself from Agenda Item 3A and that Vice Chair Sergent would chair this part of the meeting.

The first emergency CON, issued by the Executive Director, was for establishment of a Temporary 10-Bed Acute Inpatient Psychiatric Unit at the Temporary Remote Location of UM Prince George's Hospital Center at UM Laurel Medical Center.

Commissioner O'Connor made a motion to adopt staff's recommendation and award UM Prince George's Hospital Center at UM Laurel Medical Center an Emergency CON, which was seconded by Commissioner Boyle and unanimously approved.

ACTION: Emergency Certificate of Need – UM Prince George's Hospital Center at UM Laurel Medical Center is hereby CONFIRMED.

B. Confirmation of approved Emergency Certificate of Need – Atlantic General Hospital -Establishment of Up To 16 Additional Inpatient Beds at Berlin Nursing and Rehabilitation Center (Docket No. EM-H21-23-040)

The second emergency CON issued by the Executive Director was for Atlantic General Hospital for establishment of up to 16 additional inpatient beds at Berlin Nursing and Rehabilitation Center.

Commissioner Sergent made a motion to adopt staff's recommendation and award Atlantic General Hospital an Emergency CON, which was seconded by Commissioner Doordan and unanimously approved.

ACTION: Emergency Certificate of Need – Atlantic General Hospital is hereby CONFIRMED.

C. Confirmation of approved Emergency Certificate of Need – Johns Hopkins Surgery Center Series - Establishment of One Additional Operating Room at Green Spring Station Surgery Center (Docket No. EM-MISC20-03-001)

The third emergency CON issued by the Executive Director was for Johns Hopkins Surgery Center Series - Establishment of One Additional Operating Room at Green Spring Station Surgery Center.

Commissioner Sergent made a motion to adopt staff's recommendation and award Johns Hopkins Surgery Center Series an Emergency CON, which was seconded by Commissioner Boyle and unanimously approved.

ACTION: Emergency Certificate of Need – Johns Hopkins Surgery Center Series is hereby CONFIRMED.

D. Confirmation of approved Emergency Certificate of Need – Establishment of a 16-bed Intensive Care Unit for COVID-19 Positive Patients at the Alternative Care Site and Temporary Remote Location of Adventist HealthCare, Inc. d/b/a Adventist HealthCare White Oak Medical Center at the Former Site of Washington Adventist Hospital in Takoma Park, Maryland (Docket No. EM-H21-15-041)

The fourth and final emergency CON issued by the Executive Director was for establishment of a 16-Bed Intensive Care Unit for COVID-19 Positive Patients at the Alternative Care Site and

Temporary Remote Location of Adventist HealthCare, Inc. d/b/a Adventist HealthCare White Oak Medical Center at the Former Site of Washington Adventist Hospital in Takoma Park, Maryland.

Commissioner Thomas made a motion to adopt staff's recommendation and award Adventist HealthCare, Inc. d/b/a Adventist HealthCare White Oak Medical Center at the Former Site of Washington Adventist Hospital in Takoma Park, Maryland an Emergency CON, which was seconded by Commissioner Boyer and unanimously approved.

ACTION: Emergency Certificate of Need – Adventist HealthCare, Inc. d/b/a Adventist HealthCare White Oak Medical Center at the Former Site of Washington Adventist Hospital in Takoma Park, Maryland is hereby CONFIRMED.

AGENDA ITEM 4.

PRESENTATION: Selected Episodic Spending Among Maryland's Privately Insured

Mahi Nigatu, Chief of APCD Public Reporting and Data Release, presented the spending amount for selected episodes among Maryland's Privately Insured population. Episodic care cost was reported under the 'Wear The Cost' price transparency initiative. Since its launch, this initiative had three releases and is currently developing the fourth round covering 2018/2019 data.

Ms. Nigatu provided introductory background information. She conveyed that the three releases' data was sourced from the Medical Care Data Base (MCDB) privately insured claims data. She also noted that the study windows represent the years of data used to create episodes for a cohort. The 'Wear The Cost' team comprises MHCC staff, Signify Health, and DLH Corp to execute the software and the website's development. The four episodes selected for this presentation are Hip Replacement, Knee Replacement, Vaginal Delivery, and Hysterectomy as these episodes are part of the first release and common across all three study windows.

Ms. Nigatu reported that the statewide average episode cost shows that Hip Replacement cost declined, and vaginal delivery observed a 7% and 3% increase for 2015/2016 and 2016/2017 study windows, respectively. Simultaneously, the change in average cost for Knee Replacement and Hysterectomy episodes across the study windows is inconclusive as there is an increase in cost for 2015/2016 and then a decline in 2016/2017 for Knee Replacement. Similarly, there is a slight decrease in 2015/2016 and an increase of 5.7% in 2016/2017 for Hysterectomy.

Ms. Nigatu explained that the cost for episodes on the Wear The Cost site is risk-adjusted, which means the cost is adjusted to reflect the severity of the patient mix's episodes/illness burden. The grouper looks at the patient demographics and co-morbidities identified from diagnostic codes from historical claims data.

When looking at Hip Replacement, Ms. Nigatu reported that Adventist Healthcare saw a decrease of 5.8% in 2015/2016 and an increase of 15.8% in 2016/2017. Sinai hospital has the highest cost among the hospitals, and an increase of 4.8% in 2015/2016 and 7.5% in 2016/17. Anne Arundel hospital had a decline for both subsequent study windows. Similarly, for Knee Replacement

Adventist, Medstar Southern and Sinai have relatively higher cost among hospitals across study windows. Medstar Union had a decrease in the cost of 8.7%, followed by 2.8% in the subsequent study window. Frederick Memorial hospital had an increase of 15.8% in 2016/2017 from the prior study window. However, the breakdown for vaginal delivery mirrors the statewide average trend. There is a steady increase similar to the statewide average for Vaginal Delivery at the hospital level. There was an increase across all hospitals except Medstar Harbor Hospital and Meritus Medical Center that have seen a 2% and above decrease in cost in the 2016/2017 study window. Medstar Southern saw the most significant increase of 18.5% and 16% for subsequent study windows. Lastly, for Hysterectomy, there is a mix of changes across study windows among hospitals. Most of the hospitals saw a decrease in cost in the 2016/2017 cycle, particularly Adventist and Hopkins had a decrease of above 17%. Howard County General Hospital change remained steady with a slight decrease of 0.2% and .7% for subsequent study windows.

Ms. Nigatu continued to episode volumes and reported that the total episode counts increased as we progress through the study window. Ms. Nigatu noted that having more episodes means increasing the number of hospitals that can be reported. For both 2015/2016 and 2016/2017 for Hip Replacement episodes, the total episode counts increased, and there were also episodes from additional counties like Calvert, Wicomico, and St. Mary's in 2016/2017, as well as episodes from Queen Anne's county. On average, there was a 15% increase in volume in the other counties with episodes from the prior period. Similarly, for Knee Replacement in 2016/2017, the total episode volume increased by 177% from what it was in 2014/2015; now, there are episodes from all counties. Vaginal Delivery being a common episode, there has always been a good volume. It is partly because the study window modification has a minimal impact on the episode's completeness, as the lookback window for Vaginal Delivery is just three days. For Hysterectomy, episodes are from eastern Maryland, as progress depicts through the study windows.

Lastly, Ms. Nigatu noted that in the 2016/2017 data, birth month and year were incorporated into the input file, which allowed for a breakdown by age group. About 13% of Hip Replacements comprise the age group below 50. And only 6.3% of the Knee Replacement comprises the age group below 50. 12.3% of Hysterectomy episodes were done for patients below the age of 40. For the newly added episodes, 8.3% of Bariatric Surgery episodes were for the age group below 30. 23.7% of the C-Section episodes were for the age group below 30.

ACTION: NO ACTION REQUIRED

AGENDA ITEM 5

PRESENTATION: Legislative Process

Tracey DeShields, Director of Policy Development, provided an update on legislation for the 2021 legislative session. Ms. DeShields presented the names of each bill, the hearing dates, and the position the Commission will take on each bill. The Commission will be supporting multiple House and Senate bills during the 2021 legislative session focused on health information technology, telehealth, accessibility of race and ethnicity data, implicit bias training, and health equity. Ms. DeShields briefly discussed how the legislative process will be different this year due

to the COVID-19 pandemic. The Commissioners asked clarifying questions about bill status reporting and are interested in complementing the Preserve Telehealth Access Act of 2021 (SB3, HB123) with a study to assess the statewide impact of telehealth on health outcomes.

ACTION: NO ACTION REQUIRED

AGENDA ITEM 6.

Overview of Upcoming Activities

Mr. Steffen stated that the February Commission meeting may include Certificates of Ongoing Performances for PCI, one CON action, additional information on the Maryland Primary Care Program Track 3, a further look at our legislative bills, and discussion of the budget hearing scheduled for February 15th.

AGENDA ITEM 7.

MOTION: Adjourn to Closed Session to Consult with Counsel to Obtain Legal Advice Regarding the Commission's Oversight of Acquisitions, Pursuant to General Provisions Article § 3-305(b)(7)

There being no further open session business, the Chair sought a motion to adjourn to closed session pursuant to General Provisions Article § 3-305(b)(7) to consult with counsel to obtain legal advice regarding the Commission's oversight of acquisitions. Commissioner O'Grady made the motion, which was seconded by Commissioner Boyer, and approved by all the Commissioners present, Commissioners Akintade, Bhandari, Boyer, Boyle, Doordan, McCarthy, O'Grady, Rymer, Sergent, Thomas, and Wang. The Chair announced that there would be approximately a five-minute break before the closed session would begin. The open session adjourned at 3:02 pm.

The closed session began at 3:08 p.m. Present at the closed session were Commissioners Akintade, Bhandari, Boyer, Boyle, Doordan, McCarthy, O'Grady, Rymer, Sergent, Thomas, and Wang. Also present were Commission staff members Ben Steffen, David Sharp, Paul Parker, Kenneth Yeates-Trotman, Tracey DeShields, and Richard Proctor, and Assistant Attorneys General Suellen Wideman and Sarah Pendley. Due to an internal technical difficulty, Commissioner O'Grady entered the closed session at approximately 3:15. Commissioner Thomas left the closed session at 4:00 p.m.

In the closed session, Commissioners received advice from counsel regarding legislative and regulatory options for Commission oversight of acquisitions, particularly focused on nursing home acquisitions. No actions were taken. The closed session experienced technical difficulties at approximately 3:45 but continued approximately five minutes later. The session adjourned at 4:18 p.m. upon motion by Commissioner Boyle, seconded by Commissioner Boyer, and unanimously approved by all Commissioners present.