Thursday, March 17, 2022

MINUTES

Chairman Pollak called the meeting to order at 1:07 p.m.

Commissioners present via telephone and in person: Akintade, Bhandari, Brahmbhatt, Cheatham, Doordan, Jensen, Metz, O'Connor, Sergent, Wang and Wood.

Before turning to the agenda, Chairman Pollock introduced and welcomed Commissioner Wood. Chairman Pollack noted that Commissioner Wood resides in Charles County and is the Executive Vice President and Director of Business Development for the Community Bank of the Chesapeake. Sarah Pendley, Assistant Attorney General and Counsel to the Maryland Health Care Commission (Commission or MHCC) introduced and welcomed Alexa Bertinelli, the Commission's new Assistant Attorney General.

AGENDA ITEM 1.

Approval of the Minutes

Commissioner Jensen made a motion to approve the minutes of the February 24, 2022, public meeting of the Commission, which was held by teleconference hybrid. The motion was seconded by Commissioner Doordan and unanimously approved.

AGENDA ITEM 2.

Update of Activities

Ben Steffen, Executive Director of the Commission, informed the Commissioners that Sarah Pendley, who has served as Assistant Attorney General and counsel to the Commission for the past four years, will be leaving in early April to take a position as Principal Counsel for the Maryland Department of Aging. Mr. Steffen noted that this position will be a promotion for Sarah. He also expressed his appreciation for the work she has done for the Commission and wished her the very best at the Department of Aging.

Mr. Steffen reported that the Trauma Fund Budget Reconciliation and Financing Act of 2023 reallocated $4 million of the $8 million taken from the fund in 2018. The Commission will expect to solicit input from the network.

Next, Mr. Steffen updated us on several collaborations with the Commission as follows:

(a) Total Cost of Care Initiatives
(b) Secretary's vision group meeting
    a. Feature of the SIHIS Population Health Workgroup
    b. Departmental Update Secretary Schrader
    c. Outcome-Based Credits (OBC)
    d. Population Health Implementation for Opioid Deaths Reduction, Diabetes, Maternal health, Asthma

Mr. Steffen stated that the Maryland Primary Care Program (MDPCP) expects to receive feedback from Centers for Medicare & Medicaid Services (CMS) on the Track III proposal that Maryland submitted to the Advisory Council in January 2022. The key feature would be to move practices that have been in the program for three years or more to two-sided risks and all practice to Track III by 2026.

Mr. Steffen briefed the Commission on an informal workgroup on Medicare Advantage Plans challenges. The total enrollment in Medicare Advantage as of February 2022 was 200,000, up from 175,000 Medicare Beneficiaries that were previously enrolled in Medicare Advantage.

Finally, Mr. Steffen stated that the CMS Innovation Center recently announced that Global and Professional Direct Contracting model will be transitioning to a new model called ACO REACH. This updated model will prioritize health equity among underserved populations, provide leadership and governance, and greater transparency for beneficiaries. He noted that Accountable Care Organizations and Medicare Advantage Plans can apply to participate.

AGENDA ITEM 3.

ACTION: Emergency Certificates of Need Pursuant to Secretary Schrader's Request for a Continuation Through April 30, 2023

Paul Parker, Director of the Center for Health Care Facilities Planning and Development, briefed the Commission on the request by the Secretary of the Maryland Department of Health, Dennis Schrader, to extend the emergency Certificates of Need (E-CONs) previously issued by the Commission to increase hospital bed capacity. Secretary Schrader requested that the E-CONs, which are currently set to expire April 30, 2022, be extended through April 30, 2023. Mr. Parker noted that Mr. Steffen, in his Memorandum issued on March 17, 2022, recommends

that MHCC extend all hospital E-CONs (listed in Attachment 1 of the Memorandum) that have been used to activate bed capacity after issuance. Mr. Steffen further recommends that MHCC staff gather information from hospitals that had been issued E-CONs to determine whether the additional bed capacity had been activated and whether an extension of the E-CON is needed. Mr. Steffen's extension of E-CONs would be considered for confirmation by the Commission at its next meeting, scheduled for April 21, 2022.

Chairman Pollak noted that he had spoken with Secretary Schrader about this recommended response to the request, and that the Secretary does not object to this approach. Chairman Pollack remarked on the risk of additional COVID-19 variants, including the Omicron BA.2 variant strain, and the need to maintain some flexibility in capacity. He reminded the Commissioners that an earlier survey of hospitals indicated that the authorized emergency plans for adding bed capacity were not implemented by a high proportion of hospitals because the additional beds were not needed to manage patient census.

Commissioner Jensen asked whether there were financial implications associated with the extension of the E-CONs. Mr. Parker noted that the cost of the authorized projects (cost estimates are included in the E-CONs issued) did not result in any adjustments of the hospitals' global budget revenue and that revenue obtained from use of the capacity added through E-CONs was regulated in the same way as any hospital revenue under the current payment model. Chairman Pollak noted that staffing additional beds was the biggest resource availability and cost challenge in the most recent pandemic-related surge and not the availability of beds. Commissioner Sergent stated that several types of expenses were related directly or indirectly to E-CONs and noted that a category of cost unrelated to direct utilization of the hospital was that of retaining additional capacity in readiness. Commissioner Bhandari asked about the field hospital tents that had been erected on hospital campuses and their relevance to the proposed extensions. It was noted that some E-CONs did involve adding bed capacity located in these field hospital units.

Commissioner Doordan asked for clarification of the proposed motion. Chairman Pollack clarified that the action sought at this time was on the Executive Director's recommendation to extend all hospital E-CONs that have been used to activate additional bed capacity, and that confirmation of the specific extensions granted by Mr. Steffen using this criterion would be sought at the April meeting. Hospitals that did not activate the bed capacity authorized by their E-CON will be given an opportunity to show cause why the E-CON should not be relinquished.

Commissioner Doordan made a motion to adopt the Executive Director's recommendation and it was seconded by Commissioner Jensen. The recommendation was unanimously approved.

ACTION: Executive Director's recommendation, pursuant to the request of the Maryland Secretary of Health's to extend all hospital emergency Certificates of Need, that the Commission extend all hospital emergency Certificates of Need that had been activated, is hereby APPROVED.

AGENDA ITEM 4.

ACTION: Certificate of Need – Establish an Alcoholism and Drug Abuse Intermediate Care Facility – Hygea Detox, Inc. (Docket No. 21-03-2450)

Jeanne Marie Gawel, Program Manager, CON Analyst, briefed the Commissioners on the recommendation for a Certificate of Need (CON) application filed by Hygea, Inc., to establish a Track One Intermediate Care Facility (ICF), which will be licensed for 50 beds. The facility will offer the American Society of Addiction Medicine (ASAM) Level 3.7 medically monitored inpatient services and withdrawal management for adults. Ms. Gawel stated that although the bed need methodology in the ICF chapter of the State Health Plan is outdated, it still showed a need for 23-65 beds in the Central Planning Region of Maryland. To supplement its demonstration of need, the applicant also highlighted the Governor's Heroin and Opioid Emergency Task Force data on the impact of the COVID-19 pandemic on drug and alcohol addiction, long wait times for treatment, and the rise of unintentional intoxication deaths in Maryland.

The applicant will be working with Middle River Ventures, real estate developers that will absorb all the costs related to the land and construction of the facility. The applicant's lease will include 7.27 acres with a 29,308 square foot (SF) facility. Hygea Detox proposes to enter a 12-year lease for the facility and surrounding land. The total value of the project is over $11 million; however, the applicant's portion of the total cost for this project is $482,840 and will be funded with a business loan.

The review process produced recommendations on the imposition of three conditions, listed below which are included in the staff report:

1. Hygea Inc. shall document the provision of a minimum of 15 percent of patient days to indigent and gray area patients, as defined at COMAR 10.24.14.08B(9) and (11), by submitting annual reports auditing its total days and the provision of days to indigent and gray area patients as a percentage of total days. Such audit reports shall be submitted to the Commission following each fiscal year, from the project's inception and continuing for five years thereafter.

2. Hygea Inc. must receive preliminary accreditation for the Level 3.7 services it will provide, including withdrawal management and post-withdrawal treatment programming, by the Commission on the Accreditation of Rehabilitation Facilities (CARF) prior to First Use Approval by the Commission and must timely receive final accreditation by CARF; and

3. Hygea Inc. shall document referral agreements, prior to First Use approval by the Commission, demonstrating that at least 15 percent of its

> annual patient days, required by COMAR 10.24.14.08, will be incurred by the indigent or gray area populations, including days paid under a contract with the Behavioral Health Administration or a jurisdictional alcohol or drug abuse authority, or the Medical Assistance program; [COMAR 10.24.14.05K(2)].

Ms. Gawel stated that Hygea's application meets the general CON criteria as well as the specific standards in the State Health Plan chapter governing ICF's. She states that the project is needed, is viable, and will not have an adverse impact on other providers and therefore, recommends that the Commission **APPROVE** the project.

Commission O'Connor moved to approve the project, which was seconded by Commissioner Jensen and after discussion, unanimously approved.

ACTION: Certificate of Need – Establish an Alcoholism and Drug Abuse Intermediate Care Facility – Hygea Detox, Inc. is hereby APPROVED.

AGENDA ITEM 5.

PRESENTATION: Professional Services Report

Shankar Mesta, Chief, Cost and Quality, Center for Analysis and Information Systems, presented the results of the professional services annual report on payments for in-network professional services for Maryland's privately insured from 2018 through 2020 using data from the Maryland Medical Care Data Base (MCDB). Mr. Mesta noted that this report is limited to in-network professional services only and excludes Federal Employees Health Benefit Program (FEHBP) and self-insured ERISA plans. He also mentioned that this report study included the age population under 65 and large private payors including CareFirst and United Healthcare data.

Mr. Mesta discussed the impact of payment rates for professional services in Maryland by market share, geographical region, and compared these rates to Medicare and Medicaid. Mr. Mesta noted that payments per Relative Value Unit (RVU) for all payers increased about 1.4 percent in 2020, which was in contrast to the 0.3 percent decrease from year 2018 through 2019.

Mr. Mesta informed the Commission that private payment rates in Maryland were 103 percent of the Medicare rates, and private rates had been modestly above the Medicaid rates. He noted that a similar analysis performed by the health care cost institute using 2017 employer-sponsored insurance claims showed that the average private rates varied dramatically across

the states, from below Medicare rates in Alabama (98%) to nearly twice Medicare rates in Wisconsin (188%). Maryland showed an average private rate of (104%).

Chairman Pollak noted the payment rates in the report include the only fee-for-service payment. They do not have incentive-based payments, which resulted in the underestimation of physician payment rates. Mr. Steffen acknowledged that value-based payments are not captured in the data that is used in the report.

Commissioner Jensen enquired if professional services are included in global budget rates. Chairman Pollak clarified that the report does not include professional services under global budget rates.

Commissioner Bandari enquired if it is possible to know how many doctors participated in this value-based program. He also added that it is challenging to recruit new physicians in MD due to lower compensation than Virginia. Chairman Pollak commented that the values mentioned in the report reflect why it becomes harder for private practices to compensate more than other states and maintain sustainability. He also added that the global budget rate diverts the cost to practice expenses to pay for losses which dramatically impacts the cost of hospital care but negatively impacts the sustainability of the private practices model.

Commissioner Doordan enquired what commissioners could recommend to fix the issue of the private professional rates that are identified in the report. Chairman Pollak responded that this report is intended to inform Health Services Cost Review Commission (HSCRC) to develop a better payment model in partnership with the Center for Medicare and Medicaid Innovation (CMMI). The CMMI should consider the realities of cost-shifting due to the total cost of care. Mr. Steffen added that information in this report is better received by the payment lobbies in Annapolis. He commented that the Commission role would be better served to inform policymakers about the implications of lower payment rates on private practice sustainability rather than recommending the payment floor for professional services. He shared that CMS is considering expanding residency programs to diverse healthcare workforce. He pointed out that private payment rates in Wisconsin are higher due to provider practices consolidation, which created enormous leverage to negotiate higher payment rates.

Commissioner Sergent commented that pharmaceutical impact on total cost is not reflected in the report. He also mentioned that isolated policies to manage the total cost of care might not be helpful rather, a comprehensive approach is needed. He inquired if the report could include a breakdown of professional payment rates by specialties. Mr. Mesta replied that staff would incorporate this information in the following report.

Commissioner Bhandari asked why evaluation and management services are lower than imaging and test categories. He questioned if the staff could identify the reason for higher payment for imaging and testing. Mr. Mesta replied that the team would research that observation and include it in the following report.

ACTION: NO ACTION REQUIRED

AGENDA ITEM 6.

PRESENTATION: Preserve Telehealth Access Act of 2021 - Study Update

David Sharp, Director, Center for Health Information Technology, and Innovative Care Delivery, presented on a multi-faceted telehealth study as required by the *Preserve Telehealth Access Act of 2021*. The National Opinion Research Center at the University of Chicago was competitively selected to complete study activities in September 2021. The presentation overviewed key study components: a literature review; claims analysis; provider survey; and consumer focus groups. Recommendations on telehealth coverage and payment levels relative to in-person care are due to the Senate Finance Committee and the House Health and Government Operations Committee by December 1, 2022. It was noted that a draft Technical Report and Final Recommendation Report will be presented to the Commission at its November meeting for consideration.

ACTION: NO ACTION REQUIRED

AGENDA ITEM 7.

PRESENTATION: Legislative Update

Shadae Paul, Program Manager, Government Relations and Special Project in the Executive Office, the legislative update for the current legislative session.

Ms. Paul noted that the crossover date is on March 21. There have been 1,488 bills introduced to the Senate and 2,053 bills introduced in the House. MHCC is currently tracking approximately 188 bills related to the health information exchange, behavioral health, nursing homes, electronic advance care planning, and proposed studies and workgroups. Ms. Paul highlighted two priority bills, *SB 253 – Maryland Health Care Commission – User Fee Assessments* and *HB 213 – MHCC Health Information Exchange – Definition*. Both bills have passed third reader and have been referred to Senate Finance.

Ms. Paul provided an overview of all priority bills to MHCC:

SB 398/HB 421 – Out-of-State Health Care Practitioners – Provision of Behavioral Health Services via Telehealth - Authorization

The Commission provided a Letter of Information for this bill. The bill was heard by the Senate Education, Health, and Environmental Affairs Committee and the House Health and Government Operations Committee.

HB 636/SB 531 – Maryland Health Care Commission – Assisted Living Programs – Study
The Commission submitted a Letter of Information for this bill and its cross-file. Both the House and Senate bills were passed and sent to the opposite chamber for first reading. There is a cost impact of less than $100,000.

HB 915/SB 591 – Maryland Health Care Commission – Patient Safety Center – Designation and Fund
The Senate bill passed and was referred to the opposite chamber. The Commission will continue to provide strong support for this bill.

HB 378 – Maryland Health Care Commission – Palliative Care Services - Workgroup
The Commission provided a letter of support for this bill. It passed in the House and will be heard by Senate Finance. There is a cost impact of less than $100,000.

SB 734 – Health and Health Insurance – Primary Care Reform Commission
The Commission provided a letter of support with amendments and worked with the Department to make extensive revisions to the bill. Ben Steffen provided oral testimony. The bill is currently being heard in Senate Finance. There is a cost impact of <$100,000.

HB 747/SB 677 – Maryland Health Care Commission – Nursing Homes – Audit
The bill has been heard in Health and Government Operations hearings. The Commission will continue to track the progress of this bill. There is a cost impact of more than $200,000.

HB 912/SB 707 – Health Insurance – Provider Panels – Coverage for Nonparticipation
The Commission submitted a Letter of Information for this bill. The bill passed favorable with amendments by in the House, and the cross-file SB 707 is being heard by Senate Finance. There is a cost impact of $100,000-$200,000.

HB 972/SB 804 – Continuing Care at Home – Certificate of Need – Exemption
The Commission provided a Letter of Support for this bill and a written testimony. It passed in the House and was referred to Senate Finance.

HB 1073/SB 824 – Health – Accessibility of Electronic Advance Care Planning Documents
The Commission provided technical amendments for the bill. It was heard in House Health and Government Operations and Senate Finance. Ben Steffen and David Sharp provided written and oral testimony.

HB 625/SB 440 – Commission to Study the Health Care Workforce Crisis in Maryland – Establishment

This is an emergency bill. It passed in the House and Senate with amendments after third reading and will be referred to the opposite chamber for hearings.

HB413/SB 395 – Health Insurance – Individual Market Stabilization – Extension of Provider Fee
This bill was passed in House Health and Government Operations and will be referred to Senate Finance.

HB 1397 – Health Insurance – Prescription Insulin Drugs – Limits on Copayment and Coinsurance (Insulin Cost Reduction Act)
The Commission has not yet been asked to complete a study. The Senate bill passed after third reading and was referred to the House Health and Government Operations Committee.

Ms. Paul said that MHCC has received four study requests from the Chair of Health and Government Operations and Senate Finance. The "Expansion of Interstate Telehealth: Are Interstate Compacts the Correct Mechanism" study would assess interstate licensure compacts for out of state behavioral health providers who provide care in the State. Ms. Paul noted that the Commission has suggested to the Health and Government Operations that a request from the Chair would facilitate support for this study.

The Commission has seen a number of insurance mandates introduced during this legislative session. Three mandates studies— Expanding Coverage of In-Vitro Fertilization, HIV Prevention Drugs-Prescribing and Dispensing by Pharmacists and Insurance Requirement, and Physical Therapy Insurance Copays— explores the financial, medical, and social impact of establishing new mandates. The Commission proposed use of the existing statutory framework under the Insurance Article to promote consistency for these studies.

Mr. Steffen provided a brief update for bills in the House Appropriations and the Senate Budget and Tax, and an update on activities of our priority bills.

ACTION: NO ACTION REQUIRED

AGENDA ITEM 8.

Overview of Upcoming Activities

Mr. Steffen announced that in April, the Commission plans on staff returning to work on a hybrid model. He stated that because hospital admissions are low, the Commission is comfortable bringing the staff back to the office. Each Center will meet in the office together on a specific day. The agenda of the April Commission meeting will include a presentation on the bills that passed the legislative session,, a contested CON application, and a presentation

by MedChi. He further noted that a hybrid Commission meeting is planned for April. Mr. Steffen stated that the MHCC's Annual Report was sent out with this month's mailing of documents to the Commission. He thanked Theressa Lee, Richard Proctor, Tracey DeShields, Shadae Paul, and Dee Stephens for working on the Annual Report.

AGENDA ITEM 9.

ADJOURNMENT

There being no further business, the meeting was adjourned at 3:16 p.m. upon motion of Commissioner Jensen, which was seconded by Commissioner Doordan and unanimously approved.