**Thursday, May 19, 2022**

# MINUTES

Chairman Sergent called the meeting to order at 1:04 p.m.

**Commissioners present via telephone and in person:** Bhandari, Boyle, Brahmbhatt, Doordan, Jensen, Metz, O'Connor, O'Grady, Wang and Wood.

## AGENDA ITEM 1.

**Approval of the Minutes**

Commissioner Doordan made a motion to approve the minutes of the April 21, 2022, public meeting of the Maryland Health Care Commission (Commission or MHCC), which was held by teleconference hybrid, subject to an amendment to include Commissioner O'Connor as present. The motion was seconded by Commissioner Bhandari and the April 21, 2022, minutes were unanimously approved as amended.

## AGENDA ITEM 2.

**Update of Activities**

Ben Steffen, Executive Director of the Commission, gave an update on new initiatives arising from the last legislative session. A solicitation to study mandated insurance coverage for at home test kits for sexually transmitted diseases has already been released for bid. Solicitations for contractors to study the expansion of in vitro fertilization and physical therapy coverage are in development. MHCC is looking for a firm to study the impact of interstate compacts on expanding interstate telehealth to allow State residents to use telehealth to receive health services from out–of–state practitioners. All of these reports are due by December 2022. Mr. Steffen also discussed MHCC's new oversight responsibilities related to two-sided incentive arrangements due to the passing of HB 1148/SB 834).

Next, Mr. Steffen briefed the Commission on a request from the Secretary for assistance in supporting a workgroup to develop a public awareness campaign on preventing workplace violence in health care settings.

Mr. Steffen then spoke about Health Data Utilities (HDUs). One of the bills that passes, HB 1127, authorized CRISP to establish a public HDU. MHCC is working on to establish a definition of an HDU. Mr. Steffen noted that HDUs involve (a) combining data to support clinical decision making and public health; (b) delivering data back to clinicians in the field; and (c) supporting public health interoperability projects for surveillance and prediction and new functions of addressing health equity and fostering evolution of new care delivery models.

Finally, Mr. Steffen noted that Melanie Cavalier will present how Health IT is improving person-centered care at the Academy Health Annual Conference next month.

**AGENDA ITEM 3.**

**ACTION: Certificate of Need – Confirmation of Emergency Certificate of Need - University of Maryland Capital Region Medical Center - Addition of 16 Medical/Surgical Beds – (Docket No. EM-H22-16-043)**

Wynee Hawk, Chief, Certificate of Need, briefed the Commissioners on an Emergency Certificate of Need (CON) issued after the Commission's last meeting authorizing Dimensions Health Corporation d/b/a University of Maryland Capital Region Medical Center (UM Capital Region Medical Center) to add bed capacity, on a temporary basis, by converting 16 of its 20 observation beds on the first level of the hospital to be used as medical/surgical/gynecological/addictions (MSGA) beds. The cost of converting the observation bed space is minimal, estimated to be $100,000, and the project timeline is approximately 60 days, and expected to be operational by July 1.

Commissioners Bhandari and O'Connor asked questions about occupancy, existing capacity and covid admissions at UM Capital Region Medical Center and discussed whether there was a basis for needing the additional capacity. Ms. Hawk responded that first quarter occupancy at UM Capital Region Medical Center was reviewed, and the average occupancy was 84%, which appeared to support the request. Ms. Hawk further explained that currently only five rooms in the observation unit are being used as observation rooms, with 15 of the 20 beds being used for ancillary medical clinic space, which will be relocated to the modular units located adjacent to the hospital building. Any overflow observation will go to the pre-operative unit.

Commissioner O'Grady moved to approve the Confirmation of Emergency CON-University of Maryland Capital Region Medical Center - Addition of 16 Medical/Surgical Beds, which was seconded by Commissioner Boyle and after discussion, unanimously approved.

**ACTION: Certificate of Need – Confirmation of Emergency Certificate of Need - University of Maryland Capital Region Medical Center - Addition of 16 Medical/Surgical Beds – is hereby APPROVED.**

## AGENDA ITEM 4.

**ACTION: Change in Approved Certificate of Need – Encompass Health Rehabilitation Hospital of Southern Maryland, LLC (Prince George's) – Docket No. 18-16-2423**

Moira Lawson, Program Manager, Center for Health Care Facilities Planning and Development, stated that Encompass Health Rehabilitation Hospital of Southern Maryland, LLC (Encompass-Southern Maryland) requested a second project change after CON approval of the construction of a special rehabilitation hospital in Bowie. The original CON was granted in May 2020, with a modification approved in March 2021. The current request is to authorize an increase of the total allowable project costs from $45,982,206 to $52,683,586. Ms. Lawson stated that Encompass-Southern Maryland attributes the cost increase to building design modifications, permitting delays, additional site work based on unsuitable soils, the unanticipated need to relocate a gas line, additional paving, drainage, and changes in utilities requirements as a result of that relocation, and inflation.

Ms. Lawson stated that because there are no material changes occurring either in the location, capacity, or nature of the project, staff concludes that this requested modification does not change the need for the project or its impact on existing providers, consistent with the Commission's prior findings in the initial CON review. She added that the cost increase will not result in higher costs for the Medicare and Medicaid programs and that the applicant will cover the additional cost with cash. For these reasons, staff recommended that the Commission approve the proposed changes to the CON issued to Encompass-Southern Maryland.

Commission O'Connor moved to approve Change in Approved Certificate of Need – Encompass Health Rehabilitation Hospital of Southern Maryland, LLC (Prince George's), which was seconded by Commissioner Bhandari and after discussion, unanimously approved.

**ACTION: Change in Approved Certificate of Need – Encompass Health Rehabilitation Hospital of Southern Maryland, LLC (Prince George's) is hereby APPROVED.**

## AGENDA ITEM 5.

**ACTION: Annual Assessment of the State Health Plan – Priorities and Timeline for Review and Revision of State Health Plan Regulations**

Paul Parker, Director of Health Facilities Planning and Development, briefed the Commission on staff's recommendations on the priority order and timeline of the State Health Plan (SHP) chapter review and revision, providing information on age, level of functionality, and frequency of use of the 15 chapters. Mr. Parker noted that this year, the General Hospital Services chapter, COMAR 10.24.10, last updated in 2009, is the top priority, replacing the Psychiatric Hospital Services chapter updated in 2021. Staff recommended the following other high priorities: Alcoholism and Drug Abuse Intermediate Care Facility Services (2002/2013); General Hospice Services (2013); and Home Health Agency (HHA) Services (2016). Mr. Parker estimated that the revisions to the hospital and hospice regulations would be completed in FY 2023 and the other two high priority chapters would be completed in FY 2024.

Commissioners asked questions and discussed: the pace of technological change and its effect on prioritizing regulatory updates; the way in which standards used to consider new market entrants can provide an unfair advantage to incumbent providers; the recent discussion of changes in the SHP at strategic planning sessions of the Commission; the excessive length of many CON project reviews; and how the process of prioritization does or does not account for variance in the complexity or difficulty encountered in completing revisions.

Mr. Parker responded by noting the following:

1) Staff considered the level of obsolescence in recommending priorities.. Most SHP chapters will gradually require more updates because of changes in technology, reimbursement, or reordering of the care delivery system and its providers.
2) The introduction of quality measures more directly in project review standards, which began about 10 years ago, does introduce the potential for making market entry more difficult than in previous years. The performance requirements may require a new entrant to exceed the track record of performance seen by existing providers of the service at issue, which are not subject to any direct action by MHCC. Mr. Parker noted that the two chapters that are the best examples of this effect are HHA and nursing home services, which require average or better performance, as defined by staff based on the performance measurement system adopted for use in the SHP, to establish a new facility.
3) The proposed action on the SHP does not account for the recent strategic planning discussion of SHP reform with respect to creating a more pro-active set of goals for changing health care delivery related to CON regulation and, probably, other related issues not directly falling under MHCC's regulatory oversight. It only attempts to fulfill the statutory requirement for updating the SHP as these regulations are currently configured.
4) Mr. Parker noted that changes have been made to reduce the length of time for CON review. The first legal requirements "with teeth," where an application is deemed approved 120 days after docketing, were adopted two years ago but are limited to certain types of uncontested projects. Updating the procedural regulations, which is planned for 2022, would further improve the process.
5) Staff does not explicitly account for the difficulty in updating a chapter in its recommendations. The level of difficulty can vary considerably and unforeseen difficulties sometimes emerge as the industry and, in turn, legislators, react to proposed changes under discussion.

Finally, Mr. Parker noted that, in his view, the key basis for the pattern seen in Maryland of many jurisdictions with only one authorized hospice is the historic use of jurisdictions as the basis for CON regulation of hospice services. He stated his belief that creation of regional markets with larger service area populations would be necessary to make entry or expansion into less densely populated areas of the state more attractive for development.

Commission O'Connor moved to approve the approve Annual Assessment of the State Health Plan – Priorities and Timeline for Review and Revision of State Health Plan Regulations, which was seconded by Commissioner Doordan and after discussion, unanimously approved.

**ACTION: Annual Assessment of the State Health Plan – Priorities and Timeline for Review and Revision of State Health Plan Regulations is hereby APPROVED.**

## AGENDA ITEM 6.

**ACTION: Maryland MCDB Data Request Application by Johns Hopkins Center for Public Health IT**

Mr. Kenneth Yeates-Trotman, Director of the Center for Analysis and Information Systems, presented the Maryland Care Data Base (MCDB) data request application submitted by the Center for Population Health IT, Johns Hopkins Bloomberg School of Public Health (JHSPHIT)..

Mr. Yeates-Trotman said that under the current statutes and regulations governing access to MCDB data for research use, a non-governmental data requester must submit an application and acquire approval of the application by the Commission before the release of the MCDB data. Mr. Yeates-Trotman gave a brief overview of the data release process components, including the governing regulations, COMAR 10.25.05, submission of the data application, posting of the application for public comment, review of the application by the Data Release Advisory Committee, and entering into a data use agreement.

Mr. Yeates-Trotman noted that the applicant JHSPHIT had completed five projects in the past using the MCDB data. This request is for a new research project on "Advancing Maryland's Statewide Suicide Data Warehouse to Improve Individual and Population-level Mortality Prediction ad Prevention." Mr. Yeates-Trotman said that death by suicide is a serious problem not only in Maryland but throughout the US. As a result, there is an increased interest in developing predictive models of individuals at risk for suicide. For example, the National Academies of Sciences, Engineering, and Medicine is currently hosting an array of webinars on the topic.

Mr. Yeates-Trotman also gave an overview of the project's purpose, the data sources that would be linked to the MCDB data during the project, the proposition of the project, and its funding source. National Institutes of Mental Health (NIMH). The MCDB data requested consists of the eligibility files and professional services, institutional services, and pharmacy claims files for the privately insured and Medicaid Managed Care Organization data for the years 2016 – 2020. The timeline of the project will be for two years (2022 – 2024). JHSPHIT will plans to disseminate results through published peer-reviewed manuscripts and conferences. JHSPHIT may share additional aggregate results with the funding agency, NIMH, as requested per National Institutes of Health (NIH) guidelines. The fees charged to use the data are based on a new tired approach and amount to $96,000.Mr. Yeates-Trotman mentioned that the JHSPHIT team includes Hadi Kharrazi (Associate Professor / Co-Director), Thomas Richards (Technical Director), and Elyse Lasser (Research Associate / Center Coordinator).

Mr. Yeates-Trotman said that based on staff's review, JHSPHIT's MCDB Data Request Application meets the regulatory requirements that the use of the data be for research purposes and in the public interest. As a result, MHCC staff recommends that the Commission vote to approve the MCDB Data Request Application submitted by JHSPHIT to provide access to the requested data. MHCC staff also recommends that the Commission approve the Applicant's request to use the requested data until December 31, 2024, beginning on the date the Data Use Agreement is executed based on the new tier-based fee schedule, which is expected to be effective on or around June 16, 2022.

Commission Boyle asked about the fee structure and whether fees were a barrier to accessing data. Mr. Yeates-Trotman responded that the new payment structure was created to eliminate the barrier of cost for prospective MCDB data recipients applying for the data. The new tier-based fee structure gave a discount if prospective applicants request to use three or more years of MCDB data. Commissioner O'Grady commented by asking the Applicant to consider a broader dissemination approach of the findings of the project to reach a wider audience, such as practitioners on the ground, Medicare, and SAMHSA, which will have a bigger impact on this important project. The Applicant agreed.

Chair Sergent commented that he would be in favor of seeing a general practice of tracking projects to which MHCC has contributed data and making the public aware of MHCC's contribution. Dr. Kharrazi confirmed that JHSPHIT will share its findings to the Commission. Mr. Yeates-Trotman also noted that MHCC is working on its own internal studies using MCDB data, which will be shared to the Commission and the public.

Chair Sergent also asked that, given disparities between male and female rates of suicide attempts versus rates of death, whether suicide attempts in addition to deaths by suicide will be included in the study. Dr. Kharrazi said that NIH was very interested in the project because the study not only predicts attempts but predicts deaths as well. Dr. Kharrazi also said that the data will be stratified to see results among different sub-populations, especially among vulnerable minority populations.

Commission O'Grady moved to approve the MCDB Data Request Application by Johns Hopkins Center for Public Health IT, which was seconded by Commissioner Wood and after discussion, unanimously approved.

**ACTION: Maryland MCDB Data Request Application by Johns Hopkins Center for Public Health IT is hereby APPROVED.**

## AGENDA ITEM 7.

**PRESENTATION: Practice Transformation Grant Activities Update**

Melanie Cavaliere, Chief, Innovative Care Delivery and Gene Ransom, Chief Executive Officer, MedChi, The Maryland State Medical Society provided an update on the *Advancing Practice Transformation in Ambulatory Practices* grant. MedChi Care Transformation Organization (CTO) was awarded the grant in June 2021 to engage qualifying primary care and specialty practices in a practice transformation program. Approximately 25 primary care and 23 specialists were selected to participate in the program. The CTO has completed a baseline readiness assessment and the development of practice workplans is underway. Mr. Ransom discussed the significance on readying practices to participate in value-based care models.

**ACTION: NO ACTION REQUIRED**

## AGENDA ITEM 8.

**PRESENTATION: An Update on Nursing Home Acquisitions and the Roles of Government Agencies**

Linda Cole, Chief of Long-Term Care Policy and Planning, presented a brief update on initiatives on both the federal and state level with respect to nursing home acquisitions. Ms. Cole reported on federal initiatives, including: Medicare Advisory Commission's (MedPAC) report to Congress in June 2021; Government Accountability Office's (GAO) study of private equity investments in health care, which is due fall of 2022; Centers for Medicare and Medicaid Services' (CMS) establishment of a new federal database on changes in nursing home ownership from 2016 to present; and the federal recommendation to impose civil money penalties on owners, rather than administrators when the nursing home has closed.

According to the MedPAC study, private equity accounted for about 4 percent of the ownership of hospitals and about 11 percent of the ownership of nursing homes. A November 2021 *Journal of the American Medical Association (JAMA*) study found that "private equity firm

owned nursing homes provided somewhat lower quality long-term care than other for-profit homes based on two widely used quality measures and were associated with higher total per-beneficiary Medicare costs."

Ms. Cole then discussed oversight of nursing home acquisitions in Maryland. The Office of Health Care Quality (OHCQ) developed a dashboard for nursing home changes of ownership (CHOW). Required forms include detailed provider ownership, evidence of financial ability to operate, and disclosure of adverse legal actions/convictions. OHCQ also has the authority to collect civil money penalties, which are placed into a Health Care Quality Account used to fund education and quality initiatives by state nursing homes. Ms. Cole explained that MHCC has a more limited role with respect to oversight of facility acquisitions. Although MHCC has broad authority for review of CONs to establish a facility under COMAR 10.24.01.03, acquisitions require notice to MHCC 30 days prior to closing. In accordance with the SHP chapter (COMAR 10.24.20), this notice must include:the identity of each person with an ownership interest; history of each person's experience in ownership of health care facilities; corporate structure; purchase price; source of funds; percentage of nursing home beds controlled before and after the acquisition. In addition, an "affirmation is required, under penalties of perjury that within the past 10 years no owner, former owner…has been convicted of a felony or crime or pleaded guilty…and that the applicant…has not paid a civil penalty in excess of $10 million dollars that relates to the ownership or management of a health care facility."

Lastly, Ms. Cole presented data on the increasing number of CHOWs reported in MHCC's Long Term Care Survey (17-22 in the last 3 years), and the enhancements and detailed reporting on nursing home acquisitions in the monthly Commission update. New data added includes levels of ownership; years the facility was owned; star ratings; multiple bed rooms; and CMS citations as special focus facilities. This is an effort to increase transparency in these transactions. Next steps include continuing to monitor developments at the national and local level, monitoring legislative proposals, as well as to update MHCC's regulations and reporting as needed.

**ACTION: NO ACTION REQUIRED**

**AGENDA ITEM 9.**

**PRESENTATION: Nursing Home Family Experience of Care Survey Results for 2021**

Stacy Howes, Chief of Long-Term Care and Health Plan Quality Initiative, summarized a report of the results of the 2021 Nursing Home Family Experience of Care survey, which concluded in April 2021. The overall response rate was 32 percent, with 31 percent of respondents completing the survey online and 2 percent by telephone. In past years, satisfaction scores had been steadily decreasing, and, in 2021 scores continued to decline after a brief

stabilization in 2020. The state average percentage of respondents who would recommend the nursing home was 75 percent. Respondents were asked to provide a rating on a scale of one to 10 (with 10 being the most positive) indicating how satisfied they were with the care provided by the nursing home, and the state average was 7.5. In addition, the survey included three questions about the nursing home's response to the COVID outbreak. MHCC found that 80 percent of respondents felt that they received timely information about how COVID affected loved ones and 75 percent felt that staff kept them involved in their loved one's care decisions during COVID. Finally, 78 percent rated the nursing home a 7 or higher on the general COVID response (on a scale of one to 10 with 10 being the most positive).

Multivariate analyses indicated that those who were white, in not-for-profit nursing homes, and using Medicaid were significantly more satisfied than those who were non-white, in for-profit nursing homes, and using other types of insurance, respectively. Overall, results indicated a "good" to "ok" level of satisfaction in all categories statewide. Commissioners asked whether families should be included when the resident has passed away and Ms. Howes confirmed that these cases were included.

Commissioner Boyle asked if MHCC staff could report the percent of families who responded where the resident passed away. Additionally, Chairman Sergent asked the staff to complete an analysis of the acquisitions data while looking at for profit versus not-for-profit homes. Staff will provide a report at a later date and the data will be included in MHCC's Maryland Quality Reporting site by the end of June.

**ACTION: NO ACTION REQUIRED**

**AGENDA ITEM 10.**

**PRESENTATION: Spending and Use Among Maryland's Privately Insured, 2020**

Shankar Mesta, Chief of Cost and Quality, Center for Analysis and Information Systems, presented the results of the annual report on health care spending and utilization patterns for Maryland's privately insured (PI) members from 2018 through 2020, using data from the MCDB. In his background information, Mr. Mesta noted the 2020 PI report excludes Federal Employees Health Benefits (FEHBP) and self-insured Employee Retirement Income Security Act (ERISA) plans, which resulted in an estimated loss of 1.68 million enrollees, ~ 44 percent. In 2020, annual per capita spending for all markets was $5,732, a growth rate of 2.2 percent among Maryland's privately insured population, compared to a 2.6 percent increase from 2018 to 2019. Nationally, annual per capita spending in the privately insured population declined by 2.6 percent based on the 2020 National Health Expenditure (excluding the net cost of private health insurance (NCPHI), Medigap, and Dental).

Mr. Mesta provided an overview of membership enrollment in all markets from 2018 through 2020, noting that MHCC's analysis found that overall enrollment remained stable between

2019 and 2020 compared to a 2 percent increase reported by State Health Access Data Assistance Center. He then noted that the illness burden only decreased marginally (1.34 in 2019 v. 1.33 in 2020) for all markets combined. He explained that the individual market's higher risk score compared to the national average in 2020 was primarily due to increased illness burden in the individual market due to the migration of Maryland health insurance plan high-risk pool members in the individual market.

Mr. Mesta reported per member spending by individual service categories and explained about cost drivers for each of these categories. He highlighted that inpatient, professional services, and prescription drug expenditures per member increased for 2020. He added that these three service types were the primary contributors to the overall (2.2 percent) spending increase in 2020. Mr. Mesta noted that the prescription drug per capita spending increase of about 7.2 percent in 2020 was primarily driven by the rise in unit cost (5.9 percent) and utilization (1.3 percent). He concluded that the Health Services Cost Review Commission's intervention during the pandemic to increase unit cost offset the losses in hospital revenues due to low utilization.

Mr. Mesta described the COVID-19 prevalence among all market members. He noted that the Centers for Disease Control and Prevention (CDC) guidelines for ICD-10 coding of COVID-19 identification was applied. Mr. Mesta reported that there was a total of 51,037 patients with COVID-19 diagnosis with a case rate of 378 per 10,000 enrollees, and females had a slightly higher case rate than males. He informed that other studies had shown no gender difference in COVID-19 occurrence; however, males were more at risk for worse outcomes and death. Mr. Mesta informed that there was a total of 2,710 COVID-19 related hospitalizations with a rate of 20 hospitalizations per 10,000 enrollees. He concluded that 72 percent of COVID-19 related hospitalizations lasted two to seven days.

Mr. Mesta reported that the COVID-19 pandemic led to the temporary shutting down of many healthcare settings and a rapid switch to telehealth strategies for patient care. He added that within the privately insured members, telehealth claims grew at a very slow rate before March 2020. He noted that with the onset of the pandemic, there was an abrupt spike in telehealth claims in spring 2020, reaching about 40 percent of total visits. After that, it started to decline and then leveled off to approximately 20 percent from the summer of 2020 onwards. Mr. Mesta highlighted that mental health disorders were the leading diagnosis for telehealth visits before and during the pandemic.

Commissioner O'Connor inquired if staff analyzed the impact of cost of telehealth visits on overall increase of professional services. Mr. Steffen replied that the Commission is working on a project that will research the impact of telehealth and in- person visits on the total costs of care. Chairman Sergent commented that inpatient hospital facility service category only contributed 15 percent to per capita spending, while the prescription drugs category contributed to 30 percent and the need to address all categories to reduce the total cost of care.

**ACTION: NO ACTION REQUIRED**

**AGENDA ITEM 11.**

**Overview of Upcoming Activities**

Mr. Steffen stated that June's Commission meeting agenda will likely include several CON issues and presentations on the Maryland Primary Care Program and patient quality and safety results.

**AGENDA ITEM 12.**

**ADJOURNMENT**

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