Draft Meeting Summary
Surgical Services Work Group Meeting
Tuesday, February 14, 2017
10:00 a.m. - 12:00 p.m.
MHCC, 4160 Patterson Avenue, Baltimore, MD 21215

Work Group Member Attendees

Donald C. Bartnick
Kimberly Cammarata
Amy Dilcher (Phone)
Bob Gilbert (Phone)
Andrea Hyatt
Edward Koza (Phone)
Rose Lambie
Lindsay Lowder (Phone)
Brett McCone
Barry Rosen
Dean Teague (Phone)
John Topper
Amar Setty, M.D. (Phone)
Arnaldo Valedon, M.D.

Commission Staff Attendees:

Ose Emasealu
Eileen Fleck
Paul Parker
Kathy Ruben
Hui Su
Ben Steffen
Suellen Wideman

Other Attendees:

Pat Cameron, MedStar Health
Spencer Wildonger, Johns Hopkins Medicine

Introductions

Paul Parker, Director of the Center for Health Care Facilities Planning and Development, opened the meeting at 10:00 a.m. He introduced himself, and all other attendees introduced themselves. Mr. Parker stated that the objective of the meeting was to continue the discussion of possible changes to the State Health Plan chapter for Facilities and Services, COMAR 10.24.11. He said that the key elements for the discussion are included in the discussion guide sent to the work group. Mr. Parker added that he is also open to addressing new ideas.

January Meeting Summary

Mr. Parker asked if there were any corrections or feedback regarding the draft meeting summary for the January work group meeting. Donald Bartnick responded that he thought the meeting summary was well done.

Presentation on Maryland Hospitals and Ambulatory Surgery Trends, 2010 to 2015.

Hui Su, a methodologist for MHCC, explained that her presentation will focus on the questions brought up in the last work group meeting. She said that the topics will include surgical use rates by age, surgical facility specialty, source of payment, and some selected quality measures.

Ms. Su provided a list of data sources that were used for the charts in the presentation, including HSCRC inpatient and outpatient files, U.S. Census Bureau Population Estimates and the 2015 MHCC Annual Ambulatory Survey. She noted that MHCC staff is still waiting for a response from approximately six ambulatory surgery facilities (ASFs). The volume of cases for these six ASFs compose less than 1% of the total number of cases.

Ms. Su then displayed a graph showing operating room (OR) cases in Maryland hospitals and ambulatory surgery facilities (ASFs). She explained that although the number of surgeries performed in ASFs increased over the six year period between CY 2010 to CY 2015, there was a decline in surgeries, both inpatient and outpatient, over the same period in hospital settings.

The next two slides in the presentation showed inpatient and outpatient OR cases by age group. Ms. Su noted that the age group with the highest number of surgeries was 45-64 years. She added that the older age group 65-74, showed a gradual increase of about 3% per year in inpatient OR cases while all the other age groups decreased between CY 2010 to CY 2015. Ms. Su stated that the majority of outpatient cases also fell in the age group 45-64 years, and she also pointed out that outpatient OR cases declined between CY 2010 and CY 2015 for all ages.

Ms. Su then presented statistics on ASFs including the number of ASF OR and procedure room (PR) surgery cases, cases by age group, and OR surgery use rate (per 1,000 population) for combined ASF and OR inpatient facilities. Ms. Su stated that the total number of OR and PR cases generally increased between CY 2010 and CY 2015. She also noted that the number of surgeries in ORs was about a third of the number of surgeries in ASFs. Ms. Su noted that the highest increase in use rate was observed in the 65-74 age group. She described the ASF surgery use rate (per 1,000 population) from CY 2010 to CY 2015, and pointed out that, consistent with previous findings, the age group 65-74 had the highest use rate. She also noted that the use rate for ages 45 and above increased consistently between CY 2010 and CY 2015, but it was stable for the younger population. She noted the gradual use rate decrease in OP OR use over the period CY 2010 to CY 2015, and that the inpatient surgery use rate declined sharply from 30 to 24 surgeries per 1,000 population.

On the next slide, Ms. Su showed the proportion of ASF surgery cases for the top five specialties between CY 2005 and CY 2015. She stated that the top five specialties account for over 80% of the total number of surgery cases. She pointed out that in the last decade, the proportion of surgical case volume for pain management increased from 10% to 19%. She added that for gastric, colon, and rectal surgeries, the proportion of cases slightly decreased; the proportion of eye surgery case remained about the same; and the proportion of urology cases decreased. Ms. Su explained that pain management surgical cases have more than doubled while

the volume of surgical cases for all the other specialties increased only modestly. The twelfth slide was a line graph that displayed the number of ASFs by type of facility. Ms. Su described three categories of ASFs: single specialty, limited specialty and multi-specialty. She stated that over the last decade, the number of single specialty and multi-specialty ASFs increased. She added that the total number of ASFs increased from CY 2005 to CY 2010, dropped in CY 2011 and then increased again in CY 2014. She then showed ASF surgery cases by specialty, and noted that the most inquiry was single specialty.

On the final slides, Ms. Su described ASF net revenue by payer and the rate of the number of patient transfers. She said that third party private payers are the biggest payer (over 50%) and next to this came Medicare. She stated that Medicaid accounted for the least amount of payment, but it increased from 2005-2015 from 1% to 4%. Ms. Su pointed out that the total surgery cases showed a stable rate in the number of transfers from 0.09% to 0.1%

Andrea Hyatt commented that the slides do not address an explanation for the statistics displayed on the slides. Her observation is that procedures are being performed in more appropriate settings, given advancements in procedural technology. She also noted that reimbursement is declining and a lot of procedures are moving from hospitals to ASFs or office based settings. She added that in some cases performing a high volume of procedures, such as endoscopies cases, is the only way to make it work financially.

Ms. Hyatt also stated that it would be helpful to know the number of hospital transfers taking place before the patients enter the OR for surgery. She noted that a significant number of older patients show up unstable and are immediately transferred out before surgery. Ms. Su responded that currently, more detailed information regarding transfers is not readily available. Ben Steffen asked if it's possible to cross reference the source of admission of the patients using the HSCRC discharge data. Ms. Su responded that the source of admission is included in the HSCRC discharge data. Ms. Hyatt noted that accreditation agencies check records to validate the number of patient transfers.

Barry Rosen shared his thoughts on the spike in the use of ASCs for procedures. He stated that with the current opioid epidemic, more people may be choosing surgical intervention rather than pharmacological intervention. He also noted that reimbursement is currently strong for the pain doctors at the ASCs. Ms. Hyatt commented that the average facility fee reimbursement for a pain management case in an ASC is about $300 across all payers which is the same as for an endoscopy procedure. Mr. Bartnick commented that procedures in pain management centers are profitable only to the extent that providers can do a high volume of these cases. He also said that because of more advances in effective analgesic medications more surgeries are performed in an outpatient environment.

Description of Proposed Revisions to Align the State Health Plan (SHP) Chapter for Surgical Services with the SHP Chapter for Freestanding Medical Facilities

Ms. Fleck reviewed changes necessary to align the SHP chapter for surgical services with the SHP chapter for freestanding medical facilities (FMFs). She explained that the applicability

of the SHP chapter for surgical services to CON exemption requests for a general hospital converting to an FMF would be stated. She explained that the design requirements for ASFs in the SHP chapter for surgical services would apply to an FMF with surgical capacity, as well as the operating room capacity standards. She stated that these changes allow for flexibility, which is needed because the licensure standards for FMFs are going to be updated and it is unknown whether surgical services will be included as part of an FMF license or under a separate license.

Mr. Bartnick asked for clarification on the impetus for the proposed changes to the regulations. He asked whether the law changed, the interpretation of a law had changed, or if other factors requiring an update of the regulations for surgical services have changed. Ms. Fleck responded that the law has changed and now allows a general hospital to convert to an FMF through an exemption process. In addition, HSCRC was given the authority to set rates for outpatient services in an FMF, other than emergency services. She explained that outpatient services may include surgical services, but surgical services are not specifically mentioned in the law. She added that HRSCR has the discretion to decide which outpatient services that it will rate regulate, on a case-by-case basis. She noted that the licensure regulations for FMFs need to be updated as a result of statutory changes.

Mr. Edward Koza asked if FMFs are rate regulated. Ms. Fleck responded that HSCRC provides rates for the existing FMFs for emergency services. Mr. Koza followed up by asking if the surgical services component of an FMF would be rate regulated too. Ms. Fleck responded that HSCRC decides whether to provide rates for surgical services at an FMF. She noted that under current licensure rules for FMFs, surgical services cannot be provided. She explained that the licensure rules for both FMFs and ASFs may change, and MHCC is proposing an approach that allows for different possibilities. Mr. Koza next asked whether surgical services provided by an FMF would fall under the CMS waiver cap for Maryland hospitals.

Ms. Fleck responded that if surgical services are considered part of an FMF, then surgical services will likely be rate regulated, but if surgical services at an FMF are licensed separately as an ASF, hypothetically, then surgical services will likely not be rate regulated. She added that if surgical services at an FMF are rate regulated, then these services would be under the CMS waiver cap, but if these services are not rate regulated, then these services would not be under the CMS waiver cap.

Brett McCone added that the HSCRC would have the authority on a case-by-case basis to decide whether to provide rates for a service at an FMF. With regard to the CMS waiver, he noted that the all payer per capita growth limit is applicable. He also noted that there is a Medicare hospital saving target and a target for total Medicare spending that may be relevant regardless of whether a service provided at an FMF is rate regulated.

Description of Proposed Revisions to Align the State Health Plan (SHP) Chapter for Surgical Services with the SHP Chapter for Current Data Collection Practices and Updated Guidelines for the Design of Ambulatory Surgical Facilities

Ms. Fleck explained the process for an applicant seeking to establish a physician outpatient surgery center (POSC) with no more than one operating room. The applicant must answer a list of sixteen questions and then may obtain a Letter of Determination. The Letter of Determination is required before a POSC may be established and licensed. She noted that currently the SHP chapter for surgical services only includes approximately eight of the 16 required questions, and MHCC staff proposes to include all 16 questions in the updated SHP chapter for surgical services.

Mr. Rosen asked for clarification on the level of detail required regarding the ownership of an ASF. He noted that an ASF may have a management company that in turn is owned by many layers of incorporations and organizations up the ladder. Ms. Wideman responded that the level of detail required is determined on a case-by-case basis, and MHCC currently does not want to include that level of detail in the regulations.

Ms. Fleck noted that guidelines for the design of ambulatory surgical facilities that are referenced in the SHP chapter for surgical services, the "FGI Guidelines" need to be changed in order to be consistent with the new definitions and terminology in updated FGI Guidelines. She noted that certain terms would be deleted, such as "Class A," "Class B," and "Class C," which refer to different types of operating rooms.

Discussion of Other Proposed Changes to the SHP Chapter for Surgical Services

With regard to the issues and polices section, Ms. Fleck stated that some of the statistics will be updated, and she noted that someone raised a concern about access to care and the higher cost of care when patients have surgery at ASFs that are out of network. Ms. Fleck asked for feedback on how to address the concern raised.

Mr. Koza asked if the issue could be addressed as part of the application process, such as by asking where an ASF has participating agreements. Ms. Fleck agreed, and she noted that an ASF's participation with insurance providers could be collected through MHCC's annual surgery of ASFs. She clarified that she wanted to know if a policy change or discussion in the SHP chapter is merited.

Mr. Koza asked for clarification on whether there would need to be criteria included in the SHP chapter. Ms. Fleck responded that there is a general statement that allows MHCC to collect information as needed, but she also wanted to feedback on whether a new policy should be included in the SHP chapter or more discussion in the SHP chapter.

Ms. Hyatt commented that there are many parts to the puzzle. For example, there might be anesthesia, pathology services, or even surgeons that are out of network. She also noted that

whether an ASF is in or out of network depends on the coverage of a patient's insurance policy. For these reasons, she noted that it will be difficult for most ASFs to report on participation with insurance providers for their services. She also voiced opposition to requiring across the board in network participation.

Mr. Bartnick said that the in and out of network conundrum cannot be addressed through MHCC's regulations because insurance companies sell out of network benefits. By virtue of that product line, insurance companies encourage some providers to be out of network. He added that at the time when a Letter of Determination is issued, before establishment of an ASF, an ASF may not have finalized contracts in place with insurance carriers.

Mr. Bartnick commented that he prefers that the State insurance carriers and ASFs look at the incentives and create appropriate incentives for protection of the citizens. Additionally, he noted that existing regulations require sharing of information with patients so that patients are fully informed regarding whether a provider is in network or out of network. He also noted that policies within the insurance carrier contracts may dictate that ancillary providers in an ASF are required to be in network if the physician bringing the case to the ASF is in network. He concluded that it is a complicated issues that maybe cannot be addressed in the span of the work group meeting. Mr. McCone commented that the issue of patients being informed of services that are in or out of network is a business issue, and he thinks that the providers should address the issue with individual patients.

Kimberly Cammarata, who is the Director of the Health Education and Advocacy Unit in the Office of the Attorney General, stated that her Unit has seen a significant increase in the number of consumers seeking help because they received medical services from an out of network surgical facility and were shocked by very high medical bills. Some of these consumers did not realize the services that they received were from an out of network provider or may be told that the cost of services will be much lower than the actual billed charges ($1000 versus $29,000). Ms. Cammarata stated that more disclosure is needed. She said current regulations require facilities to disclose the services that are available and charges for services that are not covered by third party payers. She said that the regulations are inadequate because consumers do not know the scope or extent of coverage by third party payers. She recommended that consumers receive full disclosure in time for them to make informed decisions regarding their medical care. She added that the issue is not limited to surgical facilities.

Ms. Fleck asked if there are situations where the information was not even included in the fine print of documents given to patients. Ms. Cammarata responded that her Unit has seen a mix of cases in which the surgery center will quote a certain percentage to patients, such as 150% of the Medicare rate, but then bill the carriers a substantially larger amount. She added that when the private payers were paying 50% of bill charges, a lot of surgery centers were taking advantage.

Ms. Hyatt stated that the circumstances observed by Ms. Cammarata could be due to two different scenarios. She noted that there is a corporate group that has opened a significant

number of out of network surgery centers in the State, and a large number of complaints may be attributed to that corporate group. Second, Ms. Hyatt said that in many cases when a patient goes out of network, the patient receives a bill that could have been significantly less if the patient had used an in network provider. She said that this varies from plan to plan.

Ms. Cammarata agreed that there are patient complaints for surgical facilities owned by one or two corporate groups. However, she added that there are complaints about other surgical facilities too. For example, some patients who have multiple procedures and are unaware that multiple procedures were not going to be covered.

Ms. Hyatt stated that part of the problem is the payment system that is in place; it is based on the Medicare reimbursement system which is broken down by CPT codes and sometimes by the time a procedure is billed, the CPT code for that procedure is no longer on the list of covered services. Mr. Rosen agreed that there is a need for full disclosure but he questioned whether the SHP chapter for surgical services is the right forum for addressing the issue. Instead, he proposed that a legislative response is needed to require disclosure information. He commented that the remedies for consumers are not adequate, but he did not think MHCC could successfully address the issue through its regulations.

Rose Lambie agreed that there is a need for insurance verification and suggested that providers could be asked on MHCC's annual survey of ASFs about the number of full-time equivalent employees dedicated to insurance verification. She explained that this would give MHCC staff an idea of whether an ASF facility provides price transparency. She also noted that patients need to know their health plans.

Mr. Steffen commented that MHCC has relatively few surgery facilities established through a CON application. He added that having a question on the MHCC annual survey of ASFs might be helpful, but MHCC may only be able to provide reporting on the proportion of facilities that are not doing a good job keeping patients informed. He said that it may be difficult for MHCC to enforce standards after the CON process is over. Ms. Lambie noted that prior to CON approval, the previous surveys of the applicant could be used to determine if the applicant had been likely been providing transparent information to patients regarding out of pocket costs. Mr. Bartnick agreed and proposed that such information could be considered for a POSC seeking to expand by adding an operating room. He also proposed that complaints from consumers be considered. Ms. Fleck asked what source MHCC should rely on as the source of complaints. Ms. Cammarata noted that complaints would be to her Unit or the Maryland Insurance Administration. Ms. Fleck asked how other work group members feel about that idea.

Bob Gilbert commented that he thought many facilities are trying to get back in network, and the effort is worthwhile, but the issue raised is less likely to be a problem in the future. Mr. Koza commented that, as already discussed, some surgical facilities are out of network as a business strategy. He added that an applicant for a CON exemption could be questioned about business practices. For example, MHCC could ask whether surgeons or the existing ASF makes an effort to let patients know about in and out of network coverage.

Ms. Cammarata commented that she likes the ideas mentioned. However, she remains concerned about the remedy for consumers when there are violations by an ASF. She wanted to know if the regulations can be used to prevent these violations or to penalize ASFs.

Dr. Valedon commented that he agreed with the comments by Mr. Rosen and questioned whether changes to MHCC's regulations are the right forum for addressing the issue raised. He also stated that detailed clinical information may influence where a patient receives surgical services; whether a location is in or out of network is not the only consideration or money. He favors transparency on billing practices, but the issue is more complicated.

Issues and Policies

Ms. Fleck asked for feedback on this section of the SHP chapter. She noted that MHCC staff has not developed specific changes for the work group's consideration. Mr. McCone commented that all seven of the policies look fine. Ms. Hyatt commented that some ASCs may have problems with policy seven because there has been no guidelines set up yet for requirements for electronic health record systems in ASCs. Ms. Fleck responded that there is not a specific standard for electronic health records included for CON reviews.

General Standards

With regard to quality of care, Ms. Fleck said that MHCC staff are currently considering referencing the CMS standards on the quality of care. She read off a list of those standards and noted that the focus could be on benchmarks and quality scores of health care facilities in relation to regional and national averages. One work group member mentioned that there may be benchmarks by specialty. She added that although these quality measures are not currently published for ASFs, MHCC staff assumes that these quality measures will be published soon. One work group member noted that some quality measures have already been publicly reported. Work group members supported this idea, and no one raised concerns.

Ms. Fleck stated that MHCC staff is not proposing changes to the charity care standard. However, MHCC staff concluded that providing formal guidance on the expectations for applicants for financial assistance and hospitals may be helpful. She noted that Mr. McCone at the last meeting proposed that MHCC refer only to compliance with the financial policies of HSCRC for hospitals, rather than including requirements for the content of hospitals' financial assistance policies.

Mr. McCone responded that the issue is broader than just the general standards for the SHP chapter for surgical services. He emphasized that HSCRC regulates hospital rates including standards for charity care and uncompensated care. Consequently, it should be sufficient to

require compliance with HSCRC's regulations. He proposed not discussing the issue further, and instead agree to disagree.

Ms. Hyatt suggested that MHCC staff consider that patients who need certain elective procedures cannot go to the hospital for those procedures and receive charity care. It is not always an apples to apples comparison. Ms. Fleck responded that what MHCC expects from hospitals is that consumers have timely access to information regarding their eligibility for charity care. Ms. Hyatt agreed with Ms. Fleck, and she added that patients need to be responsibility for providing relevant information as well. Mr. Steffen pointed out that questions consistently arise about charity care from MHCC commissioners during the CON review process.

Project Review Standards

Ms. Fleck stated that MHCC staff plans to update the construction costs standard and evaluate whether the benchmark standard should be updated. Mr. McCone commented that allowing some flexibility makes sense and mentioned an FMF example. Ms. Fleck responded that the standard would not apply to the FMF example that he described because it is a CON standard that does not apply to CON exemption requests. Ms. Fleck asked if anyone else had feedback on the project review standards. She noted that the impact standard in the regulations should be moved to the section with project review standards.

Ms. Hyatt raised questions about the impact standard. She anticipates that hospitals will likely move more of their surgical volume to ASFs, possibly through partnerships with physicians. She wanted to know whether the impact on a hospital and other ASFs in the area should be considered. Ms. Fleck responded that from the impact standard included in the SHP chapter currently focuses on the impact on hospitals, not ASFs. For the exemption process, she noted that it is worth considering the impact of that process on existing facilities and where a facility with two operating rooms established through an exemption process may be located. Ms. Hyatt noted that the issue raised by Ms. Fleck is a separate, much larger issue.

Dr. Valedon asked how service area is defined for the impact standard, and how the standard is enforced. Ms. Fleck explained that usually the zip code areas for patients is used, as reported by ASFs or documented in the HSCRC discharge data and outpatient data. Dr. Valedon commented that there may be a problem if the service area is not well defined. He also commented that utilization of ORs may vary considerably. Ms. Fleck responded that MHCC collects data on the utilization of ORs by type of OR.

Mr. Rosen commented on the low percentage of Medicaid patients for ASF which was mentioned earlier in MHCC's presentation, and asked whether MHCC should consider asking whether surgeons participate in Medicaid rather than asking for a copy of an ASF's charity care policy. He suggested that surgeons' lack of participation in Medicaid may be responsible for the

low percentage of cases with Medicaid as the payer. Ms. Hyatt agreed with Mr. Rosen, noting that facilities have no control over whether doctors take Medicaid or not. She suggests that staff could also look at the geographical location of these ASFs and the rate of Medicaid patients in those areas are.

Mr. Rosen responded that in Maryland, people move from Medicaid to medical assistance HMOs that might be not be defined as Medicaid. He added that a patient's bill might not show Medicaid either because the bill may not go to Medicaid. Mr. Steffen agreed with Mr. Rosen.

Exemption from CON Review

Mr. McCone asked if an existing POSC that seeks to add a second OR would be required to be located on the same site. Ms. Fleck responded that an adjacent site could be chosen too. Work group members agreed that the same location should be maintained. Mr. Bartnick proposed that the same address should be required. Another work group member suggested that a procedure room would likely be converted to an OR if a POSC wanted to add an OR. Someone else commented that the whole operation of a POSC would have to be shut down to add a second operating room at the same location. Mr. Steffen responded that requiring the same address seems overly restrictive. He suggested that other factors such as duration of operation at the current location and space availability could be considered. Mr. Rosen suggested that if a POSC wants to relocate then it should go through a CON process or open another POSC in a different location.

Ms. Fleck noted that most work group members seemed to favor requiring that a POSC seeking to expand remain on the same site. She asked again for feedback on whether flexibility should be allowed for a POSC seeking to add a second operating room through an exemption process. She noted that in an exemption process facilities that may be negatively impacted by the establishment of an ASF with two operating room will not have standing as interested parties and MHCC staff would not be considering the impact on these facilities at all. Mr. Rosen commented that if a POSC remains in the same service area then it would be acceptable, but moving to a different service area would be unacceptable. Mr. Bartnick agreed with Mr. Rosen. Mr. McCone commented that distance or driving miles could be used to define where a POSC could relocate. He added that he strongly supports requiring a POSC remain on the same site or an adjacent site.

Mr. Rosen stated that in most facilities, you can define the service area easily. Mr. McCone asked how to define the same service area when there are two service areas close to one another. Ms. Fleck agreed that the issue is complicated. She described another scenario in which two locations combine to form one especially if the service areas are defined separately. She noted that when the service areas of each POSC are considered together, it could be difficult and have different impact. She asks if anyone wanted to comment on this latter scenario.

Ms. Hyatt asked how often MHCC receives CON applications for two POSCS seeking to combine. Ms. Fleck responded that MHCC rarely receives those requests, but the exemption process is an easier process. Someone also asked about the ability of a hospital converting to an FMF to relocate. Mr. McCone responded that for a conversion of a hospital to an FMF through an exemption process, only a hospital that is the sole hospital in a county or one of two that are part of the same health care system may relocate within five miles of the hospital site. Otherwise the FMF must be located on the same site or an adjacent site.

Mr. Bartnick suggested that Statistical Metropolitan Areas or some other more granular geographic area be used to define service area instead of zip code areas. Mr. McCone responded that Statistical Metropolitan Area could be much larger and commonly refer to Census block designations.

Ms. Fleck asked work group members for feedback on whether to allow a hospital to close ORs and open up an ASF on the same campus. One work group member responded that there should be flexibility to close ORs and reestablish those as an ASF, especially if it is on the same campus. Ms. Fleck responded that this may be inefficient because new support structures to support the ASF will need to be built.

Mr. McCone stated that there are usually market forces such as the commercial payers that pressure hospitals to convert to an FMF. Under the new global budget revenue system (GBR), no additional revenue would be added to the system and the building efficiency issue is a business risk that the facility has to bear. He explained that a hospital supports for an ASF, and the hospital can provide a physician with resources that are not available at an ASF. Mr. Rosen agreed with Ms. Fleck. He commented that the reason why a hospital will want to convert some ORs to an ASF will be to avoid losing volume. He thinks HSCRC should allow the hospital to lower its prices for outpatient surgery. He noted that it is odd to achieve lower prices on outpatient surgery by spending a lot of money building an ASF on the hospital's campus.

Ms. Fleck noted that further discussion of the exemption process is needed, but the meeting already had run late. Mr. Steffen decided to schedule another meeting to complete the discussion of the agenda. Ms. Fleck thanked the work group members and closed the meeting at 12:12pm.