Draft Meeting Summary
Cardiac Services Advisory Committee (CSAC)
Wednesday, October 23, 2024, 7:00pm-9:00pm
Maryland Health Care Commission (MHCC) – Online Only

Committee Member Attendees

Thomas Aversano, M.D.
Heather Green, R.N.
Anuj Gupta, M.D.
Christopher Haas, D.O.
Steve Hearn, M.D.
Josemartin Ilao, M.Ed.
David Caparrelli, M.D.
Reed Quinn, M.D.
Rawn Salenger, M.D.
Stuart Seides, M.D.
Henry Sun, M.D.
Liza Vizcarrondo
Matthew Voss, M.D.
John Wang, M.D.
Stafford Warren, M.D.

Other Attendees

Diane Alejo
Sal Lauria, M.D.
Michael Chen, M.D.
Kristin Feliciano
Katie Hall
Rani Hasan
Michelle Hardester
Erica Pullins
Toni Schiller

MHCC Staff Attendees

Alexa Bertinelli, Assistant Attorney General
Eileen Fleck, Chief, Acute Care Policy and Planning
Wynee Hawk, Director, Center for Health Care Facilities Planning and Development
Theressa Lee, Director, Center for Quality Management and Reporting
Katie Neral, Program Manager, Acute Care Policy and Planning
Ben Steffen, Executive Director
Caitlin Tepe, Assistant Attorney General

The meeting was called to order by MHCC Executive Director, Mr. Ben Steffen, and welcome remarks were made by the committee co-chairs, Dr. Stafford Warren and Dr. Rawn Salenger. Ms. Eileen Fleck called roll for committee members and other attendees introduced themselves.

Mr. Steffen reminded members that in January 2020, the Center for Medicare and Medicaid Services (CMS) changed its payment rules regarding PCI procedures in ambulatory surgical centers (ASCs). While little evidence has been gathered from Medicare beneficiaries (those over 65 years old), some PCI procedures have been completed in ASCs for privately insured patients. Additionally, he stated that many large health systems have expanded or acquired ASCs in Maryland over the past few years.

Although CMS rules allow payment for PCI procedures on Medicare beneficiaries in ASCs, Maryland State laws prohibit PCI in ASCs. Mr. Steffen acknowledged that MHCC received a few inquiries about changing Maryland's statute to allow PCI services in ASCs. Mr. Steffen

stated that before any laws are changed it is important to ensure input is obtained from clinicians who deliver cardiac care in Maryland, through discussion by CSAC members. Mr. Steffen then turned the meeting over to Ms. Fleck.

Ms. Fleck highlighted the goals of the meeting. These include identifying the costs and benefits of allowing PCI services in ASCs in Maryland, deciding on the timing for an evaluation, and considering other issues that merit further discussion and research. Committee members were then directed to *Handout #1: Preliminary Analysis of Elective PCI Volume That Potentially May Be Shifted to ASCs*.

Ms. Fleck explained that MHCC estimates the total number of PCI cases in Maryland to be about 8,500 cases, of which approximately 6,300 are elective PCI cases. Ms. Fleck explained that only a relatively small number of these elective cases could be shifted to an ASC and the methodology used to generate the estimated volume that could be shifted. Using the American College of Cardiology's (ACC) CathPCI Registry data for calendar year 2022, Ms. Fleck identified the number of patients in each hospital who underwent elective PCI and were discharged from the hospital on the same day as the PCI procedure. She assumed that all of those patients were appropriate for same day discharge. Results of this analysis suggest that approximately 13 percent of elective PCI cases could be shifted to an ASC.

The number of elective PCI cases that could be shifted varies by hospital. As described by Ms. Fleck, five hospitals have less than 10 elective PCI cases that could be shifted to an ASC, which represents less than 10 percent of the elective PCI cases at each of the five hospitals. Two of these hospitals already perform less than 200 PCI cases annually, which is the target volume of PCI cases in COMAR 10.24.17, the regulations for cardiac surgery and PCI services. For another four hospitals, between 13 and 23 PCI cases (four to 24 percent of total PCI volume) could be shifted to ASCs; two of these hospitals already perform fewer than 200 PCI cases each year. There are five hospitals in the State where between 42 and 54 elective PCI cases (24 to 30 percent of total PCI volume) could be shifted to an ASC. There are four hospitals where between 66 and 79 PCI cases (13 to 26 percent of total PCI volume) could be shifted, and five hospitals where potentially more than 100 elective PCI cases (25 to 47 percent) could be shifted to an ASC. Two of the hospitals that currently perform over 200 PCI cases would see a decline to less than 200 PCI cases annually.

Ms. Fleck suggested that more analysis should be completed to verify the estimate that 47 percent of PCI cases could be shifted from one hospital. Mr. Steffen expressed uncertainty that five hospitals were identified as having less than 10 elective PCI cases that could be shifted. Because this seemed like a very small number to him, he asked what might explain it. He wondered if these hospitals are more cautious than other hospitals. Ms. Fleck contacted a few to ask if the estimates seemed reasonable, but to answer this question staff would need to follow up with additional hospitals individually.

Some CSAC members commented on the reliability of the methodology MHCC staff used to compute the percentage of elective PCI cases that could be shifted to an ASC setting for services. Dr. Warren expressed concern that some patients with an overnight hospital stay will be pushed towards same day discharge if treated in an outpatient setting; therefore, the number of PCI cases

that could be shifted may be even greater than that estimated by MHCC staff. Adding to this, Dr. Thomas Aversano suggested that most of the individuals being counted by MHCC did not seek treatment for an angioplasty but were instead seen for diagnostic cardiac catheterization and subsequently underwent angioplasty. He estimated that the numbers proposed by MHCC are only a fraction of those who would seek PCI services in an ASC setting – maybe a quarter or a third of PCI cases. Dr. Aversano also estimated that approximately 25 to 30 percent of diagnostic catheterizations result in angioplasty.

Dr. John Wang agreed that the methodology used by MHCC underestimates the PCI case volume that could be shifted. He added that it shouldn't be assumed that the percentage of PCI patients with same day discharge will stay the same. An ASC will almost always discharge someone on the same day, unless there are serious complications that make discharge to the patient's home unsafe. In that situation, the patient would have to be transferred to an acute care hospital. Dr. Wang also pointed out that MHCC's methodology assumes that there are no new patients. He advised MHCC staff to consider the possibility of new PCI volume, if ASC services were offered in an area where a population may not have been willing to travel for services in the past. He wondered whether patients would be willing to schedule a PCI if there was less travel time, consequently increasing the volume of cases that may be performed in the ASC. Additionally, Dr. Salenger noted that the methodology excludes all PCIs with complications by assuming all procedures will proceed without the need for further care in a hospital.

CSAC member, Mr. Josemartin Ilao, who brings a patient's perspective, expressed concern that a PCI procedure could be labeled "elective" after being completed, resulting in a lack of insurance coverage. Mr. Ilao also asked when the patient should expect to have a conversation with the physician regarding the recommended setting for the PCI procedure and its safety. Dr. Anuj Gupta responded that there are two possible sources of PCI patients. Some patients come through the emergency department (ED) with chest discomfort and have abnormal electrocardiograms (ECGs) with abnormal blood work – these patients are seen urgently and will always be treated in the hospital. The other source of patients is those who are seen in an outpatient setting, with a referral for a diagnostic angiogram. He suggested that this population would be most appropriate for PCI in an ASC setting.

Dr. Warren added to the discussion, stating that there are two options: one is a hospital-operated ASC, and the other is an ASC run by a group of private physicians. In thinking about the latter possibility, he expressed concern about the distance between the ASC and a tertiary care center that can perform emergency cardiac surgery if needed. While not a large percentage of elective PCI cases, a few would result in transfer to a tertiary care center, and he questioned what the distance or time should be between the two. Because there is such a big difference between performing elective PCI in a hospital setting versus an ASC, Dr. Aversano mentioned that the distance between the ASC and a tertiary care center should be very little or even non-existent. Dr. Wang suggested the provision of elective PCI services in an ASC is analogous to the Cardiovascular Patient Outcomes Research Team Non-Primary PCI (C-PORT E) study, where hospitals providing elective PCI cases had to be within 30 minutes of a tertiary care center.

Dr. Caparrelli requested clarification of the procedures considered for this shift, stating that the Heart Rhythm Society also looks at ablation as an outpatient procedure. Mr. Steffen indicated

that ablation is not regulated like PCI and does not fall under the same legal statute. Ms. Fleck received similar questions from the Office of Health Care Quality (OHCQ), as they are doing the inspections for licensing of ASCs.

Dr. Wang noted that PCI is being done in ASCs across the country and, with the right resources and appropriate informed consent, it can be done safely. Dr. Wang then compared the potential shift to that which took place in vascular surgery 20 years ago. Large physician groups opened ASCs to get a portion of the Medicare technical fee in addition to the professional fee. He questioned whether there are still physician groups or individual doctors who would have an interest in opening an ASC for cardiac procedures in the State. He noted that with the current landscape in the Baltimore region, which has many PCI providers already, establishing an ASC to perform elective PCI does not make a lot of sense. However, opening an ASC in a more rural area that it might improve patient access may make sense.

As follow up, Dr. Aversano asked Mr. Steffen and Ms. Fleck whether there is a financial advantage to the healthcare system. Mr. Steffen responded that MHCC staff has not looked at this closely. However, outpatient rates are historically lower in non-hospital settings than in a hospital setting. He commented that ASC rates are approximately 60 to 75 percent of Medicare's hospital outpatient rate.

Dr. Aversano clarified that he was trying to understand the motivation for the study and whether the health care system will benefit. Ms. Fleck commented that staff would need to look at the issue carefully because, as Dr. Seides mentioned, there would be excess capacity in hospitals and costs would not be lower because the hospital must still provide PCI services 24 hours a day, seven days a week. It was noted that if the cost is much lower in the ASC setting then there may be a lower overall cost to the healthcare system.

Dr. Rani Hasan added that on a per case basis, PCI procedures would be cheaper at an ASC than at a hospital, but for the overall system, hospitals must still pay for the maintenance and staffing of a CCL, plus on-call coverage. Unlike other areas such as orthopedic or ear, nose, and throat (ENT) procedures, PCI services cannot completely shift to an outpatient setting, resulting in the need to continue to provide PCI services in hospitals. Because of this, Dr. Hasan stated there will be no reduction in cost to the overall operation on a macro level; hospitals still need to staff CCLs for patients coming through the ED 24 hours per day, seven days per week.

Dr. Aversano expressed significant concern regarding the effect that this shift would have on CCL staffing across the State, asserting that there will not be enough experienced staff available to handle an expansion of PCI services to ASCs in Maryland. Ms. Liza Vizcarrondo also voiced apprehension, stating that it is already very hard for Holy Cross Hospital to find skilled staff, and she strongly believes that staff will choose to work at an ASC rather than a hospital, if there is a choice. Dr. Hasan emphasized that this shift in staffing ASCs would "cannibalize" staff in hospital CCLs. Mr. Steffen mentioned that the manpower issue is more compelling than whether hospitals make money.

Dr. Wang suggested that the federal government may favor shifting procedures to ASCs, because it results in a reduction in payment, as services are less expensive than in hospital settings. However, it would not be advantageous to hospitals to complete PCI in a hospital-associated ASC, unless it resulted in the hospital gaining additional PCI volume that it otherwise would not get. This would have to be considered carefully because of the investment required and lower payment is received for procedures done in an ASC. The only healthcare system or insurance carrier that Dr. Wang sees as having a potential advantage for shifting PCI to ASCs is the Kaiser group, which has large outpatient facilities. Otherwise, he doesn't see the motivation for employed healthcare systems to open ASCs.

Mr. Ilao thanked CSAC members who responded to his questions. Mr. Ilao expressed concerns with the "cannibalization" of staff and referred to quality metrics that are currently used to measure cardiac surgery and PCI services. He questioned how patients will know which ASCs can be trusted to provide quality services. Mr. Steffen echoed that these are good questions, and while not immediately necessary to answer, these questions would need to be addressed if there was a new regime. Ms. Fleck agreed that quality is important and thanked Mr. Ilao for raising these concerns. She informed the group that the ACC has a new registry to track PCI cases completed in ASCs, which will provide associated risk-adjusted mortality ratings (AMR), morbidity, and other quality ratings.

Ms. Katie Hall, Director of Cardiac Interventional Centers (CICs) at Maryland Institute for Emergency Medical Services System (MIEMSS) commented that she would echo some of the sentiments expressed about staffing. Ms. Fleck interjected and asked her to provide some background to participants who may not know her. Ms. Hall explained that she is responsible for redesignation of CICs and the focus is on the interface with EMS. Through her role she has been able to assess the resources at hospitals for emergency PCI services. She mentioned doing a survey recently and discussed her recent observations at hospitals.

She noted that not only are nurses and technical staff spread very thin, but there is also a shortage of interventional cardiologists. A survey was completed by MIEMSS in January 2024, which looked at the distribution of various resources in CCLs across the State. At the time of the survey, there were 60 interventional cardiologists covering the entire state, and the number may have dropped slightly since that time. Ms. Hall asked how the State will maintain an adequate volume of experienced staff when already at a deficit, stating that Maryland is not recruiting and cultivating experienced staff as fast as staff are leaving the field.

Dr. Warren asked Ms. Hall how far patients had to travel the most to reach a hospital with PCI services in Maryland. Ms. Hall noted that nationally some patients are 150 miles away from a designated CIC, but in Maryland the longest distance is approximately 40 miles. She also mentioned that MIEMSS has a memorandum of understanding with three hospitals in Delaware and one hospital in the District of Columbia that perform primary PCI services.

Dr. Warren also asked Ms. Hall about which staff roles are most difficult to fill because of shortfalls. Ms. Hall noted that the biggest deficit is with radiology technicians (RTs). While Howard County Community College has an Registered Cardiovascular Invasive Specialist (RCIS)

program to train RTs, Ms. Hall stated that other RT programs across the State are not advertising CCL as an available track. She reports on-call shifts also make it difficult to recruit technicians.

As a business decision, Dr. David Caparrelli asserted that it does not make sense for a hospital system to move PCI volume to ASCs because it would decrease the hospital's revenue. However, it would also result in additional space being opened for more urgent PCI cases to be completed in the hospital. He commented that most PCIs are not completed by hospital-employed physicians. Anne Arundel Medical Center has five private physician groups that use the CCL. In his opinion, it would not be unfathomable to think that these physician groups could open an ASC a mile away from the hospital, get the technical component of the Medicare fee, and take all hospital CCL technicians with them. Dr. Caparrelli shared that he was recently employed by a hospital that was purchased by the Hospital Corporation of America (HCA), where this happened. Dr. Warren agreed that this is a possibility.

Mr. Steffen responded, stating that the recent trend has leaned more toward hospital employment, but private equity plays a role. Venture capitalists and private equity support this shift around the country, and they are involved with roughly 25 to 30 percent of ASCs in Maryland. He also proposed that it would be very risky to open an ASC in a rural area because PCI programs in those areas tend to be smaller and may not survive if the simple PCI cases were offloaded to an ASC. He noted that Maryland has worked very hard to keep specialty hospitals out of the State. ASCs, if allowed to provide PCI procedures, could use this as a backdoor to become a specialty provider. Hospital representatives say those specialty providers would skim off the more desirable cases.

Someone asked what prevents an ASC from providing elective PCI services now. Ms. Fleck responded that the law does not allow it. Only hospitals can provide PCI services. Mr. Steffen added that while Maryland is beginning to think about this, it would take a couple of years to put any plan in place. It cannot be done in just six months.

Hospital administrator, Ms. Heather Green stated that when vascular surgery transitioned volume outpatient at Carroll Hospital Center, it had negative consequences for the hospital. Although the hospital continued to receive the most acute and complex vascular cases, the remining staff were unseasoned and less familiar with vascular issues, and the hospital had to work very hard to ensure that staff maintain competencies in this area. She expressed concern that this could also happen in cardiac surgery.

Dr. Caparrelli stressed that the issues raised by Ms. Green would arise with cardiac procedures. He explained that the easier PCI cases would be transferred to an ASC setting, which would not be good for training or the competency of staff. Not only would the shift of PCI to ASCs have a huge impact on staffing, but it would also affect PCI volume at hospitals and acuity. Dr. Steve Hearne agreed, echoing the struggle that his hospital faced when a private vascular group stripped the vascular program from the hospital and took staff with them.

Dr. Seides emphasized that PCI procedures are not like hip or knee replacements. This is an entirely different situation; no person needs a hip replacement urgently in the middle of the night. While he agrees that with the right equipment, staff, and patients, PCI can be done safely in

an outpatient setting, he asked if anyone in the group thinks it is a good idea to transition PCI cases to ASCs in Maryland.

Dr. Warren commented that MHCC has the luxury of time because no one is pushing the legislature currently. He suggested doing research on what other states have done might be beneficial. Dr. Hearne commented that Maryland just got ranked the worst state in the country for practicing medicine. He stated that it is a real issue when providers do not want to come to the State to work. Recruiting is already difficult at Peninsula Regional Medical Center, which is two hours from Baltimore. Ms. Hall agreed, stating that she has heard similar concerns from other hospitals, not just on the Shore but in more urban areas as well.

Ms. Fleck noted that she is hearing a lot of concerns about allowing elective PCI in an ambulatory surgery setting. She asked which states should be studied. Mr. Steffen suggested states with similar regulatory structures (Michigan, New York, Pennsylvania). In addition to this, Ms. Hall recommends looking at the volume of PCI centers in different regions and where other states are building ASCs, suggesting that a side-by-side comparison be made between other select states and Maryland.

Mr. Steffen commented that a compelling reason not to move too quickly is that Maryland has done well establishing PCI centers across the State, and the volume of unmet need is likely very low. He proposed that anything that is done with ASCs would call into question the current volume requirement and quality framework that MHCC has established for PCI programs over the past decade. He also underscored the concern that any shift of PCIs to ASCs will reduce the volume of PCIs completed in hospitals.

Ms. Fleck noted that concerns were brought up about the workforce, and she asked if MHCC should survey the current workforce, gathering information on how long vacancies take to fill and how much money is being spent on traveling nurses, as there seems to be a consensus on staffing shortages. Ms. Hall agreed with this approach, suggesting that MHCC look at the number of staff who will retire in the next five or ten years.

Dr. Warren asked to what end this survey will be conducted and what action could be taken as a result. Mr. Steffen responded that historically the Commission has completed a considerable number of workforce studies; however, MHCC should think carefully about doing studies where the results are probably already known. Staff could try to benchmark Maryland to other states, but staffing and recruiting issues are a problem nationally. Dr. Wang agreed that there is not a huge benefit to gathering this information because we already know the answer.

Dr. Wang also noted that the MedStar facilities use traveling nurses who get paid more, and these nurses still don't want to work in Maryland. Additionally, RTs don't have the strongest representation, and when nurses get raises, RTs don't get the same pay increase. Dr. Wang suggested that it will be a multi-year endeavor that will ultimately require the hospitals to pay more for RTs. In terms of projecting the future, he stated that things are often unpredictable, and it may not be easy to forecast what the field will look like in the next five years. With aging staff, Liza

Vizcarrondo suggested that it might be beneficial to look at, and work with, colleges in Maryland to see if the RT profession can get some help.

Dr. Salenger agreed with Ms. Vizcarrondo. He also proposed that the point of a workforce study may be to give MHCC a platform that could influence the legislature in the future. Ms. Fleck added that this data might sway the legislature to do something, but it may also be useful to learn from other states. She reasoned that looking at numbers and comparing data to other states that look similar to Maryland, would be beneficial.

Mr. Ilao asked if MHCC's approval of policies to allow ASCs to do PCI would exacerbate the problem with staffing RTs, in ways that have not yet been determined. Dr. Hearne commented that having more employment opportunities for less people is going to drive up costs. He observed that the current generation of 20- and 30-year-olds prefer to work from home on a computer, rather than physically going to work, and they can make high salaries in those types of jobs. Hospitals trying to staff CCLs cannot compete with those alternatives; RTs are vastly underpaid. Ms. Hall added that the remaining staff in hospitals must manage increased workloads and PCI volumes, while also taking an increased number of on-call shifts. She worried about how long this could continue. Ms. Fleck concurred that it would be helpful to have staffing numbers to compare with other states that have made a change to allow PCI in ASCs or states that have a similar regulatory approach to Maryland.

Ms. Fleck summarized the discussion by noting that while there is interest in gathering more information, there seems to be a lack of enthusiasm for shifting elective PCI procedures to ASCs in Maryland. She asked if there was other data collection that might be beneficial that had not been discussed yet.

Dr. Seides stated that he had not heard anyone provide a good reason for Maryland to allow elective PCI services in ASCs. Ms. Fleck asked if there was any reason to continue to talk about this topic at another meeting. Committee members suggested that MHCC staff do more research on the issue and report back. One CSAC member recommended that this project be put on the backburner. With such big staffing shortages in Maryland, he commented that allowing PCI in ASCs would further dilute what staff are available to hospitals. Mr. Ilao suggested that if there is no temporal pressure for this to happen now, and if this is a national movement, Maryland should watch what other states are doing, and not take on the burden of risk associated with making a change in Maryland. Dr. Warren agreed that there is no need for a separate CSAC meeting to address allowing elective PCI services in ASCs. He suggested that MHCC staff report back on additional research completed on the topic at the next CSAC meeting.

Dr. Wang inquired as to whether MHCC had been approached by anyone seeking to establish PCI in ASCs. Mr. Steffen stated that MHCC has received a couple of questions about the process for ASCs to provide PCI services since the CMS rule, and legislative staff have also received questions during the last two legislative sessions, but these have just been inquiries. MHCC responded to these inquiries indicating that this would require a statutory change. There has been no legislation proposed to change the statute.

Mr. Steffen explained that he has been pressing staff to get ahead of this issue and look at what is happening in other states. Also, more and more health systems in Maryland are building ASCs, largely due to the total cost-of-care model. At times it is more lucrative for hospitals to offload services to an unregulated space. However, it is difficult to determine the profit or loss resulting from these changes because total cost-of-care economics are complicated. Additionally, the increase in investors in ASCs has led hospitals to raise questions about the accessibility of services. Optum and HCA have moved into the ASC realm in an aggressive way. Mr. Steffen doesn't expect legislation to come up in the 2025 session, but he believes it is important to continue to work on the issue.

Dr. Aversano asked whether the legislature could require the Commission to regulate ASCs that provide PCI services. Mr. Steffen stated the law can be changed, but the legislature would likely take into consideration the opinions of clinicians and hospitals. He added that the two inquiries regarding changing the law came from hospitals and there does not seem to be much momentum for changing the law.

Dr. Aversano asked if it is prudent to get as much information as possible, so that MHCC is prepared for a request in the future, even if the request comes years down the road. The idea of allowing PCI in ASCs may come from someone other than physician groups. Ms. Hall agreed, noting that research should be as comprehensive as possible, to try and cover all potential blind spots. Ms. Fleck commented that it may be worth gathering more information on the workforce issue. It is a different issue, but it is related to any decision to allow PCI in ASCs. Dr. Gupta strongly supported a move by MHCC to let the legislature know that the shortage of RTs in Maryland is at a catastrophic level. In his opinion, opening another school for RTs, even if it could be quickly credentialed and produce 20 RTs a year, would only be a drop in the bucket.

Someone asked which hospitals wanted to change the law to allow PCI in ASCs. Mr. Steffen noted that he heard about the inquiries from legislative staff. He did not hear directly, and nothing was proposed, which suggests a lack of interest in pursuing a change in the law. Mr. Steffen said that it is prudent to continue to examine all dimensions of the situation, while managing staff's time so it does not become all consuming. He added that if Maryland were to go ahead with this shift in the future, then a major modification in the current regulatory framework would be required.

The co-chairs made a few closing remarks, Dr. Salenger thanked the group for a good discussion focused on quality. He liked that there was consensus on the issue. Dr. Warren agreed with Dr. Salenger's comments. It was noted earlier in the meeting by Dr. Warren that there is not a need to have another CSAC meeting focused on the issue of whether to allow elective PCI in ASCs. Staff can just update the group on research findings from other states. Mr. Steffen agreed with that suggestion.

For the next CSAC meeting, the discussion will likely focus on minor changes to regulations for both PCI and cardiac surgery. The next CSAC meeting may not be scheduled until the spring or summer in 2025.

Mr. Steffen remarked that MHCC has recognized the need to come up with a process to accelerate the process for Certificates of Ongoing Performance for PCI programs, especially for

those that are doing fine. Additionally, staff are working with the ACC to get CathPCI data directly from the ACC instead of from the hospitals. This will reduce the hospital's administrative burden. Ms. Fleck indicated that a data use agreement will need to be signed by each hospital before the ACC provides the data to MHCC.

Before adjourning the meeting, Mr. Steffen asked if Ms. Wynee Hawk wanted to add any remarks. Ms. Hawk agreed with Ms. Green that it is inevitable that elective PCI in ASCs will eventually be allowed. Ms. Hawk stated that having this discussion was a good first step, but MHCC should be prepared. Mr. Steffen thanked everyone for their participation and contribution to the discussion and adjourned the meeting.