Maryland Department of Health (MDH) Health Regulatory Commissions
M00R01
Fiscal Year 2024 Operating Budget
Response to Department of Legislative Services Analysis

Senate Budget and Taxation Committee
Health and Human Services Subcommittee
Senator Cory McCray
March 6, 2023

House Appropriations Committee
Health and Social Services Subcommittee
Delegate Kirill Reznik
February 23, 2023

The Department thanks the Governor, the Department of Budget and Management, and the Budget Committees for their support. We thank the Department of Legislative Services for its insightful budget analysis.

The department should explain why it has not made progress in completing the independent analysis of the behavioral health crisis response system, procuring a health research and analytics vendor, convening a stakeholder workgroup, and preparing an interim report on these activities. (pg. 2)

MDH Response: The MDH Behavioral Health Administration (BHA) has been working closely with MHCC to inform the planning process for the independent analysis of the behavioral health crisis response system. In parallel, BHA and the Medicaid Program have undertaken a rate setting process in consultation with Health Management Associates, engaging providers and stakeholders in the process, to establish a rate structure for mobile crisis teams and crisis stabilization centers. Regulations to implement each service are in the process of being drafted for release for public comment. BHA and Medicaid have utilized the Crisis Resource Calculator established by SAMHSA to estimate funding needed for expansion in mobile crisis teams and crisis stabilization centers beyond the current capacity in the state. Beginning July 1, 2023, Medicaid reimbursements for these services will be available for patients covered by Medicaid. BHA will be working with local jurisdictions to determine additional funding needs to ensure availability of the services beyond the current Medicaid population across the state.

MHCC Response:

Multiple gap analyses have been completed by BHA and the Medicaid Administration. After multiple meetings with BHA and Medicaid staff, MHCC has concluded that another gap analysis of the behavioral health crisis system is not needed at this time. The implementation of enhanced behavioral health crisis response services is well in hand in Medicaid and BHA. Specific actions and accomplishments include:

- BHA has completed a Maryland Mobile Response and Stabilization Environmental Scan (needs assessment) and for Children, Youth, and families.
- BHA is conducting a Maryland Mobile Response and Stabilization Environmental Scan (needs assessment) for adults.
- BHA is working closely with the Health Services Cost Review Commission (HSCRC) to align with Greater Baltimore Regional Integrated Crisis System (GBRICS), Totally Linking Care (TLC-Prince George's County) and Tri-County Behavioral Health Engagement (TRIBE- Lower Eastern Shore).
- Maryland Medicaid Administration and the Behavioral Health Administration have worked to develop, prepare for, and implement qualifying community-based mobile crisis intervention services under the Medicaid program.

A program evaluation may be appropriate in the future. That evaluation should be carefully coordinated with all state and federal oversight agencies. MHCC could undertake this evaluation in consultation with operational agencies. There may be opportunities to engage commercial insurers in this work and MHCC could use its experience in the commercial insurance market to further commercial insurer participation. In the meantime, we continue to work and collaborate with BHA and Medicaid.

For more information, please see the attached response (**Attachment**) from the MHCC, dated February 15, 2023, on this subject.

As of December 2022, the Consortium was developing the first call for proposals under the Coordinated Community Supports Partnerships grant program and was expecting to issue the call for proposals in early calendar 2023. MDH should provide an update on the timeline for issuing a fiscal 2023 call for proposals and distributing Coordinated Community Supports Partnerships grants. (pg. 7)

MCHRC Response:

The Consortium has been meeting since last August and has formed four subcommittees to organize its work, as pointed out by the DLS analysis. The Consortium is considering a collective impact model to create and implement a statewide framework to provide access to behavioral health and wraparound services to fulfill its statutory responsibilities. The Consortium launched a public comment period this past fall and generated more than 80 comments from interested parties and stakeholders. These comments were reviewed by the Consortium and are informing the content for the first Consortium Call for Proposals that is expected to be released by the CHRC later this spring. The goal is that this first round of grants awarded by the CHRC will result in the delivery of services during the first semester of CY 2023-2024.

MDH should provide fiscal 2022 statewide and median hospital operating margins and comment on whether Maryland hospitals' financial position during the COVID-19 public health emergency continues to be stable based on final fiscal 2022 financial reports and preliminary fiscal 2023 financial reports. In addition, the department should provide an update on whether the $75 million in workforce and COVID-19 assistance included in the fiscal 2023 working appropriation will be taken into account in future rate setting. (pg. 14)

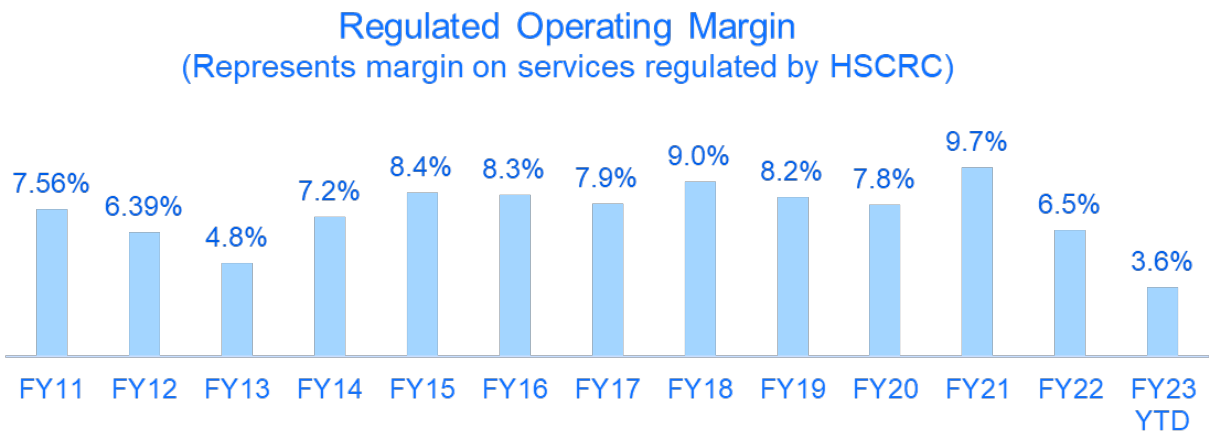
HSCRC Response:

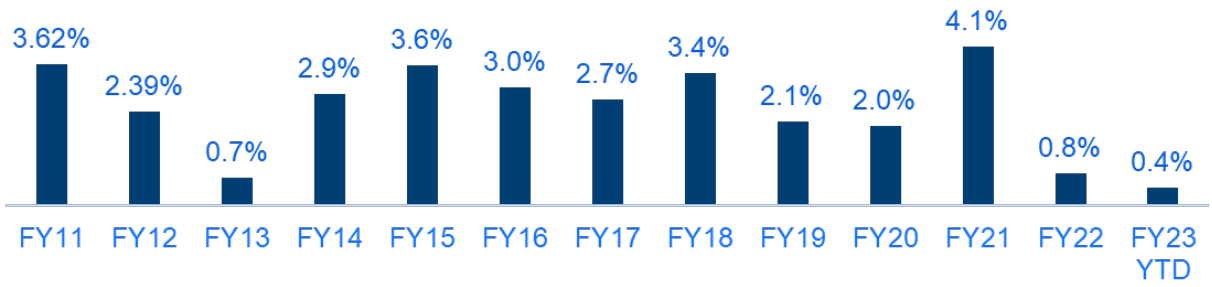
The financial position of hospitals in Maryland remains stable due to the long term support provided by the system, even as immediate cost pressures and high unregulated losses cause short term margin deterioration in FY 23.

HSCRC regulates all-payer rates for certain hospital services (inpatient services, emergency services, and outpatient services that are either provided at a hospital or at a freestanding medical facility (FMF)). HSCRC does not regulate rates for physician services or other professional fees. HSCRC also does not regulate outpatient services that are not at a hospital or FMF.

HSCRC evaluates hospital margins in two ways:

1. Regulated margins: income from services regulated by the HSCRC as a percent of revenue.
2. Total margins: income from the entities regulated by HSCRC as a % of revenue. This includes unregulated business that is organized as part of the regulated entity.

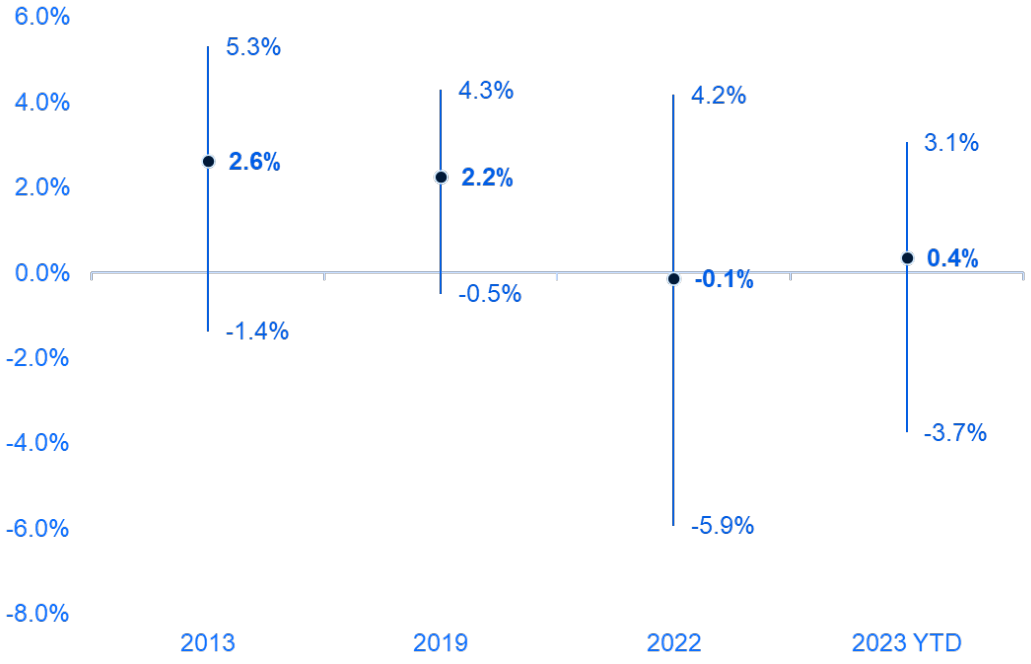




Regulated margins were strong in all periods and are stronger under GBRs than in the pre-GBR period. Fiscal Year 21 was the best year for hospital margins under the global budgets. Fiscal Year 22 and Fiscal Year 23 (YTD December, annualized) margins are the lowest for any period under global budgets. Hospitals attribute low margins to the loss of COVID-19 relief funds that helped sustain FY 20 and FY 21 margins and high inflation in workforce costs (particularly agency costs) and unregulated service losses, including physician services.

Unregulated costs pull total margins down. Most unregulated costs are physicians owned by the hospital or affiliated with the hospital on which the hospital experiences a loss. The organization of unregulated entities is up to each hospital. Some hospitals place more of their physician business under a corporate entity rather than as part of the hospital. This results in varying levels of total margin depending on where the hospital or health system records losses associated with physician expenses.

Distribution of Hospital Margins (Total Operating Margin)

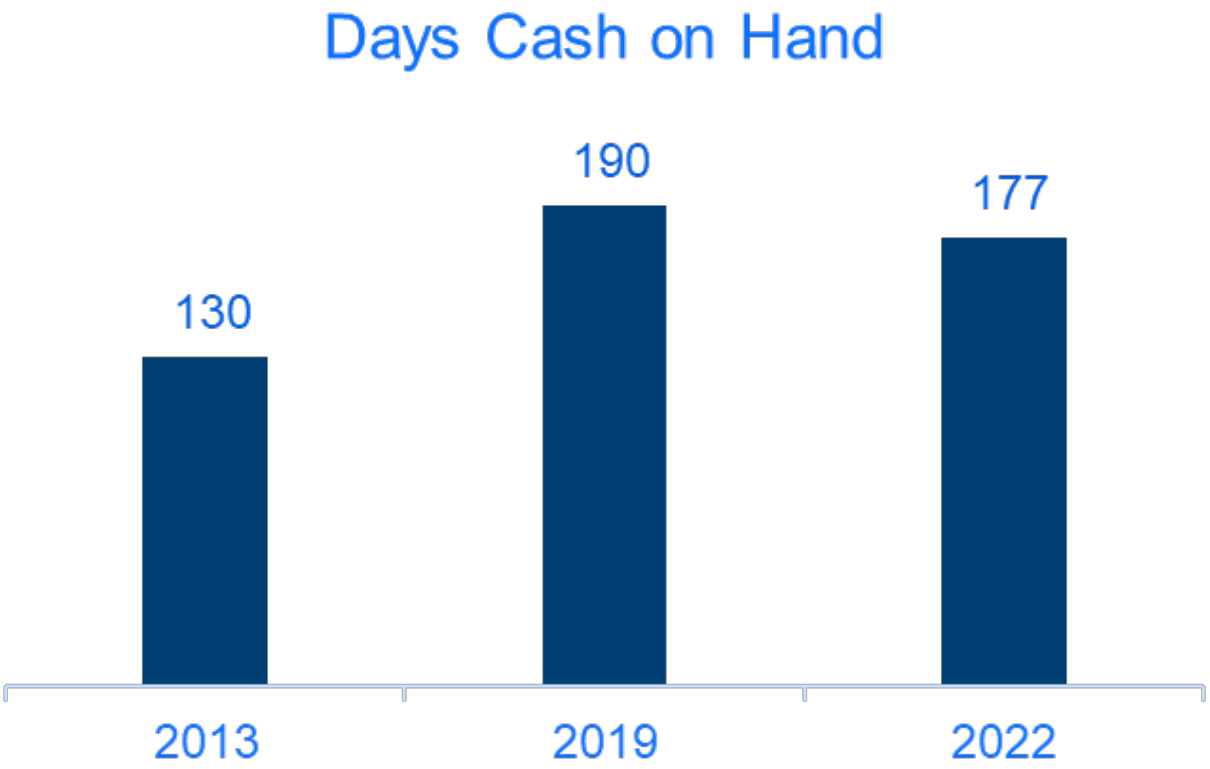


The graph above shows the median (circle) and 25th to 75th percentile (line) % margin by hospital for selected years. In 2022 and 2023 YTD, a significant group of hospitals are losing money, although the overall median is close to breakeven.

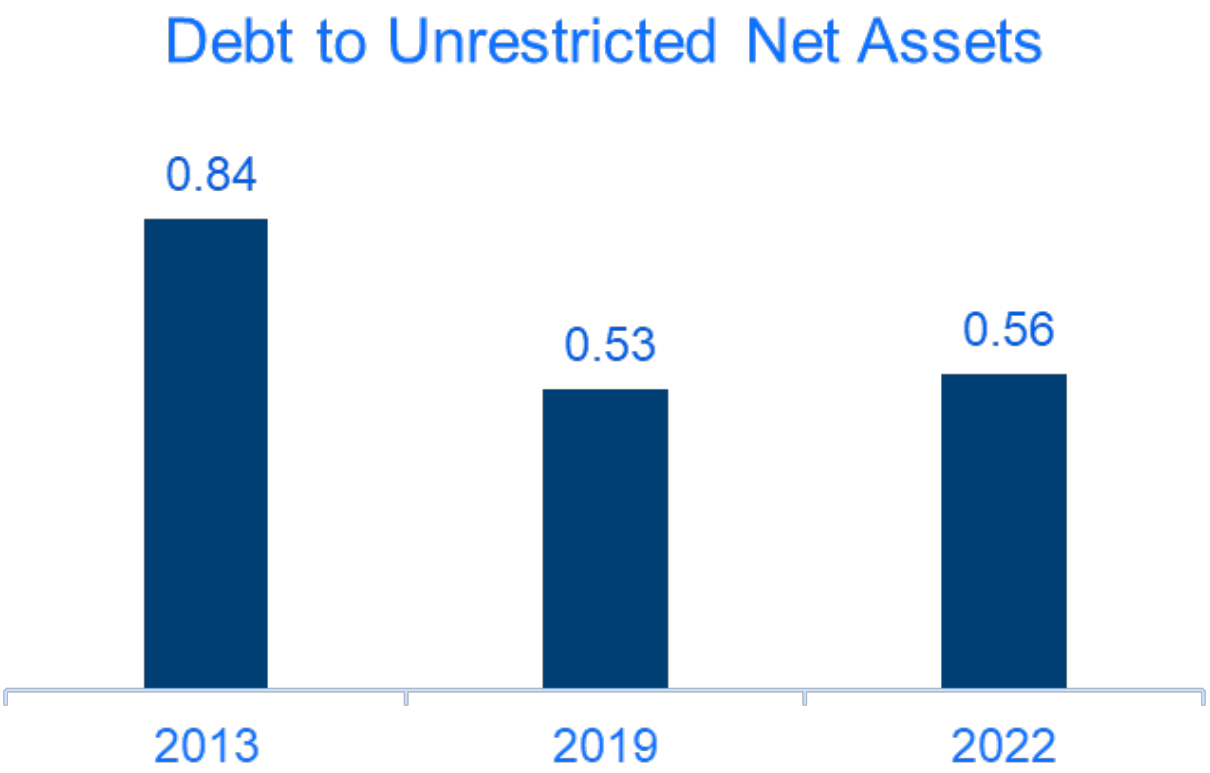
In addition to margins, hospitals realize non-operating gains, primarily from income on investments. While this source of income may be unstable over time, over the life of global budgets, that income would add 1.6% to the margins above.

HSCRC also looks at two balance sheet measures, "days cash on hand" and "debt to unrestricted net assets" to evaluate the financial health of hospitals.

The "days cash on hand" measure calculates the number of days a hospital could pay its cash operating expenses if it received no revenue. For this calculation, unrestricted and board-restricted investments are considered as cash equivalents. National rating agencies use a rule-of-thumb that a hospital with less than 75 days cash on hand has potential issues. A cash on hand value around 100 was typical for Maryland hospitals in the early 2000's. In FY 2022, average cash on hand for Maryland hospitals was 177 days, representing a 36% increase in this measure under GBRs. This measure peaked in 2019. Federal and State funding eliminated any negative effects of the COVID pandemic on this measure through June 2021. Days cash on hand has dropped recently due to recent cost pressures, including workforce challenges. However, the financial balances are still higher than pre-GBR levels.



Another important balance sheet metric is “Debt to Unrestricted Net Assets”. This metric calculates the degree to which a hospital relies on borrowing to finance its activities. Unrestricted Net Assets is the not-for-profit equivalent of equity. Higher values indicate greater debt and a higher risk that the hospital will not be able to meet its obligations. Values below 1 are desirable. During the period of GBRs hospitals have been able to strengthen their cash positions, as shown above, while also paying down debt (see below). Debt ratios eroded slightly as a result of COVID and related cost pressures, but remain 33% below 2013 levels (the year before GBRs started).



All hospital financial data is reported by the hospitals to HSCRC. Note that for Fiscal Year 23, HSCRC is relying on unaudited financial data, as audited data is not yet available.

Hospitals have several avenues to pursue with the HSCRC if losses become unsustainable.

HSCRC does not plan to offset the $75 million in workforce support when setting hospital rates. HSCRC continues to consider hospitals' overall financial position, including government funding, in evaluating the adequacy of hospital rates.

Considering the net increase in TCOC model costs, the Department of Legislative Services (DLS) recommends adopting committee narrative requesting a report from HSCRC evaluating the MDPCP. HSCRC should comment on potential changes to the MDPCP to make it cost effective given the disappointing financial results and the difficulty the State is having comply with the TCOC cost targets. (pg. 17)

MDH Response: The Department concurs on a report evaluating the MDPCP.

MDPCP is a cornerstone of Maryland's long-term investment in population health by providing comprehensive, advanced primary care for Marylanders. Advanced primary care, which Maryland has successfully implemented, also has the core goal of reducing acute utilization, not necessarily net TCOC savings. In the 2022 JCR analysis, HSCRC confirmed that MDPCP has generated a significant reduction in avoidable hospital utilization and gross total cost of care savings. To address the broader issue of TCOC Model dissavings, HSCRC has initiated a plan to rectify the problem. MDPCP continues to work closely with HSCRC to ensure the Model's success.

It should be noted that MDPCP is now the nation's largest Medicare advanced primary care model on a practice and per capita basis. The program is a model for the nation, recognized nationally in the print press and health policy journals. The MDPCP investment in transforming the health care delivery system in Maryland has demonstrated notable success in reducing death rates during COVID-19, implementing groundbreaking programs to address behavioral health including opioids, addressing the equitable access to high value healthcare, and building multi-disciplinary, care management support teams in the community for Marylanders.

HSCRC Response:

HSCRC concurs on a report evaluating cost and utilization under the MDPCP program, similar to the reports completed in each of the past three years. HSCRC notes that the MDPCP program is in part an investment in care transformation to develop coordinated, advanced primary care for Marylanders and the financial results should be viewed as such. The program has resulted in a small amount of additional cost over the first three years of program evaluation. MDPCP has reduced hospital utilization, but the savings resulting from the reduced hospital utilization does not fully offset the costs of additional payments to participating practices and Care Transformation Organizations. There has been substantial volatility in the savings rate over the first three years of the Program, especially given abnormal health care utilization patterns resulting from the COVID-19 pandemic. As practices continue to mature in their adoption of advanced primary care and assume greater risk under the program, cost and utilization data may change.

In considering the appropriate entity to make recommendations about changes to the MDPCP program, it is important to consider the program's governance structure. The MDPCP is jointly run by the federal Centers for Medicare and Medicaid Services (CMS) and MDH. CMS remains committed to this program, as evidenced through the conclusion of recent negotiations around Track 3, which increases accountability for participating physicians through downside risk (which will likely decrease program costs) and the Health Equity Advancement Resource and Transformation (HEART) Payments, which focus support on patients with high medical and social needs. Any changes to the program would likely require CMS approval, which is a time consuming

process. At the state-level, MDPCP has a robust governance structure level, with a project management office in MDH and an active advisory council which is staffed by the Maryland Health Care Commission.

MDH should comment on how it will spend the $18 million in special funds from the Maternal and Child Health Population Health Improvement Fund, particularly the $10 million budgeted within HSCRC in fiscal 2024. (pg. 19)

MDH Response:
Funding supports the following MCH initiatives within Maryland Medicaid:

1) referrals through the Prenatal Risk Assessments,
2) Home Visiting Services (HVS) pilot expansion,
3) reimbursement for doula services,
4) enhanced reimbursement for CenteringPregnancy, a group-based prenatal care model,
5) enhanced reimbursement for Healthy Steps, a clinic-based intensive prenatal and postpartum case management framework, and
6) Maternal Opioid Misuse (MOM) model expansion for Medicaid participants with Opioid Use Disorder

Funding to PHPA supports the expansion and/or implementation of mutually reinforcing programs through grant funds:

1) Medicaid's asthma home visiting program,
2) Community-based asthma home visiting initiatives,
3) community-based maternal and infant home-visiting services and CenteringPregnancy implementation, and
4) coordination for the PHPA MCH SIHIS activities. Further information on these activities can be found in the SIHIS 2022 Annual Report.

HSCRC Response: No additional comments from HSCRC.

ATTACHMENT

Maryland Health Care Commission

FISCAL YEAR 2024

BUDGET PRESENTATION

TO THE LEGISLATURE

M00R0101

FEBRUARY. 23, 2023 & MARCH 6, 2023

The Maryland Health Care Commission

is a 15-member independent regulatory agency. The Maryland Health Care Commission is organized around the health care systems we seek to evaluate, regulate, or influence, utilizing a wide range of tools (data gathering, public reporting, planning and regulation) in order to improve quality, address costs, or increase access.

Mission:

Is to plan for health system needs, promote informed decision-making, increase accountability, and improve access in a rapidly changing health care environment by providing timely and accurate information on availability, cost, and quality of services to policy makers, purchasers, providers and the public.

Strategic Intent: Reduce health care disparities while improving health care access, quality, outcomes, and cost in Maryland by…

- Aligning health care payers around State strategic goals, including primary and behavioral health care access, chronic disease prevention and management and other emerging priorities;
- Increasing the use of actionable cost and quality data to drive improvements in care; and
- Using MHCC authorities to increase geographic, racial, and ethnic health care equity.

Our Roles

Plan for health facility development;

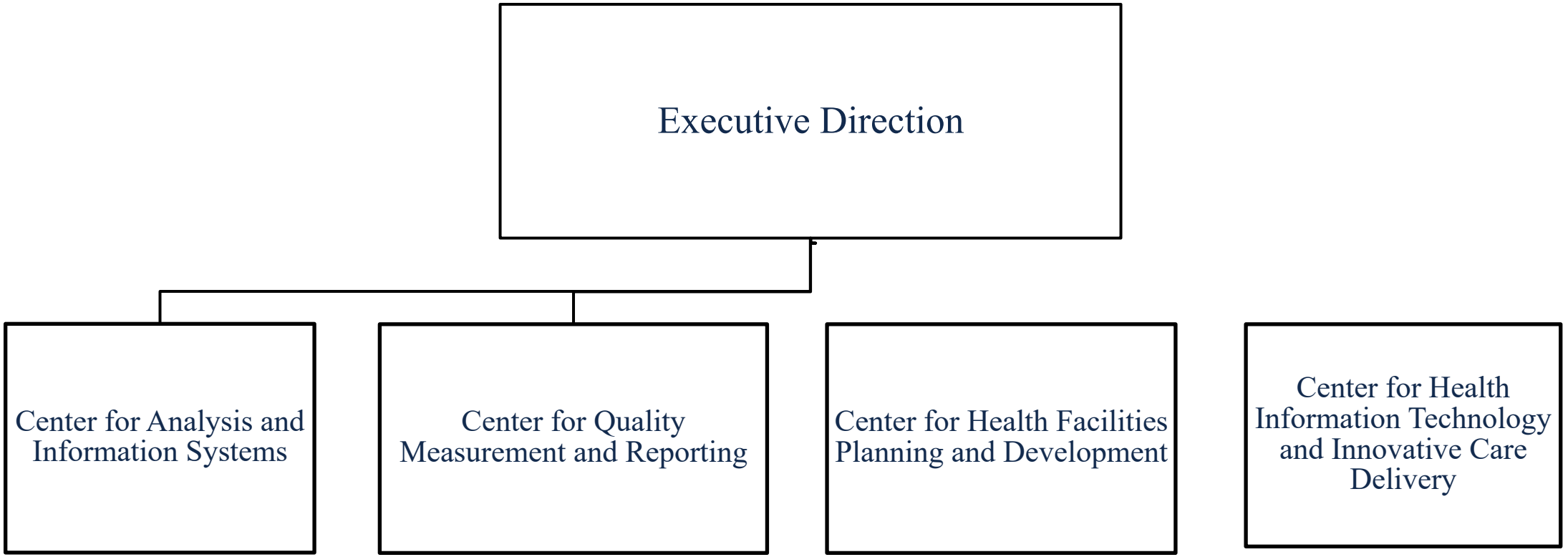
Measure and aggregate cost and quality data;

Enable information technology innovation;

Convene and engage stakeholders; and

Assess health policy options

Organizational Structure



Center for Analysis and Information Services

Monitor Costs and Quality

- Produces annual reports and issues briefs on spending and health care coverage
- Collaborates with MDH on expanding the health care work force and reducing health care disparities

Enhance MCDB (APCD)

- Practitioner Performance Measurement
- Collaborates with MIA in enhanced rate review
- Collaborates with HSCRC and Medicaid on use of APCD for TCOC

Develop Data and Software

- Develops information dissemination systems
- Manages data acquisition, data release and data use agreement compliance
- Conducts data analysis for sister MHCC centers
- Serves as the center for technical innovation

Center for Quality Measurement and Reporting

- **Health Plan Quality and Performance**
  - Publishes HMO/PPO Consumer Guide
  - Collaborates with Maryland Health Benefit Exchange to provide quality reporting on QHPs
- **Long Term Care Quality and Performance**
  - Publishes Nursing Home and Assisted Living Guides
  - Monitors flu vaccine rates among health care facility workers
- **Hospital Quality and Performance**
  - Publishes Hospital Guide
  - Maintains quality outcome measures
  - Reports on hospital efforts in surgical infection prevention
  - Supports HSCRC quality improvement efforts
- **Maintains Maryland Health Care Quality Reports Website**
  - https://www.marylandqmdc.org/

Center for Health Facilities Planning and Development

- **Acute Care Planning**
  - Planning & policy development for regulation of hospital, ambulatory surgical, and other acute care services

- **Long Term Care Planning**
  - Planning and policy development for regulation of nursing home, home health agency, hospice services

- **Certificate of Need**
  - Management of the Certificate of Need (CON) program, regulating the supply & distribution of hospitals & hospital bed capacity, nursing homes & nursing home bed capacity, surgical facilities & services, specialized hospital services, home health agency services, hospice services, residential treatment centers, & intermediate care facilities.

Center for Health Information Technology and Innovative Care Delivery

Innovative Care Delivery

- Directs the Primary Care Investment Workgroup
- Partners with MDH, local health departments, and providers in developing programs for advanced primary care such as the MDPCP.

Health Information Exchange

- Leads the development of the statewide health information exchange
- Designates the state HIE, provides management oversight and audit to CRISP

Health Information Technology

- Educates providers on the options for adopting Electronic Health Records and Telemedicine
- Designates direct management service organizations that are responsible for supporting providers to adopt and use HIT
- Collaborates with payers and providers to develop policies, programs, and business practices that promote use of HIT.

Policy and Legislative Reports Released in Nov 2022 – January 2023

- Coverage of Home Test Kits for Sexually Transmitted Diseases (January 2023)
- Prevent Workplace Violence Awareness Campaign Workgroup Report (SB 700 January 2023))
- Advancing Implementation of Health Data Utility Models: Issue Brief (December 2022)
- Financial Restrictions on Access to Organ Transplants (December 2022)
- Maryland Trauma Physician Services Fund (December 2022)
- Preserve Telehealth Act of 2021 - Telehealth Recommendations (December 16, 2022)
- Revisions to HB 142 - Health Insurance Coverage of In Vitro Fertilization (November 22, 2022)
- Health Insurance Cost Sharing - Physical Therapy Parity with Primary Care Services (November 9, 2022)

MHCC Fiscal Year 2024 Budget Allowance

FY 2024 Allowance - $37,253,921

1. Operating Budget - $19,353,921 ($18,793,921 SF and $560,000 RF)
   - Industries Assessed – Payers, Hospitals, Nursing Homes, and Health Occupation Boards
   - FY 2022 Closing Revenue Balance - $3,516,315 Million
   - Total Permanent Staff : 55.9
   - Total Contractual Staff: 1.0 Full Time and 3.0 Part-Time
2. Managing Critical Funds – Trauma and Maryland Patient Safety Center
   - Maryland Trauma Physicians Services Fund - $12,000,000
   - Maryland Trauma Grants - $600,000
   - Shock Trauma Grant - $3,700,000
   - Maryland Patient Safety Center - $1,000,000 – General Funds
3. Serving where we can help in FY 2024
   - Sustaining the MDPCP - $600,000

MHCC Strategic Priorities

2019-2022

1. Educate, inform, and engage the health care community on MHCC activities to elevate the success of the Commissions work in all priority areas.
2. Make MHCC the trusted source of quality and cost information.
3. Modernize the Certificate of Need Program to minimize administrative burden and support the State's goals under the Total Cost of Care (TCOC) Model.
4. Enable providers to participate in value-based payment models. Collaborate with stakeholders to engage specialty groups and facilitate wider adoption of alternative payment models.
5. Expand the use of telehealth services in a variety of health care settings by educating providers and patients and evaluating grant programs.

2023-2026

1. Increase the intentionality of a health equity focus in MHCC programs and services.
2. Use MHCC's health care facility regulatory authority to enhance equity in health care delivery by improving access to services, and the quality and outcomes of care.
3. Facilitate the adoption of new technologies and health care data innovations and assess their impact on access and quality of health care.
4. Increase the use of data among policymakers, payers, providers, purchasers, and patients to improve the quality, affordability and outcomes of health care delivered in the State.
5. Promote new models of care to address barriers to reducing the Total Cost of Care in Maryland and use new authorities under Health Insurance: Two-Sided Incentive Arrangements and Capitated Payments – Authorization (Chapter 297 laws of Maryland)

The 2019-22 Strategic Priorities: What We Did

1. Educate, inform, and engage the health care community on MHCC activities

- Led legislative effort to fund the Maryland Patient Safety Center and worked with that organization to plan a public awareness campaign on public health workplace violence awareness campaign.
- Implemented a public awareness campaign for MHCC Quality Website through a $200k MPT contract- using cable news/digital ads.
- Advanced consumer awareness and understanding of telehealth through public service announcements (PSAs), podcasts, and educational flyers. PSAs were aired in 90 Giant stores and about 30 radio stations during the public health emergency in 2020.
- Implemented a consumer telehealth campaign with ~~ 30 Baltimore City hair salons. Salons posted various flyers that highlighted the value of virtual care during the pandemic.
- Implemented advance directive awareness campaign in collaboration with CRISP, MDH, OAG, payers, and hospitals.
- **Observation:** future efforts must use earned media and MHCC funds.

2. Make MHCC the trusted source of quality and cost information

- Expand the “Wear The Cost” initiative by adding nine clinical episodes for a total of thirteen episodes to the initiative using privately insured data, but episode construction has temporarily stalled due to need to transition to Change Health Care.
- Accelerated the compliance, acquisition and the scope of data submissions to the Medical Care Data Base from private payers.
- Increased the support to HSCRC, MIA, Medicaid, MHBE, and PDAB in use of the Medical Care Data Base, specific support to HSCRC for TCOC, MIA for rate review, MHBE private market reform.
- Created new data release regulations (COMAR 10.25.05) to modernize the data release process and expand data sharing.
- Transitioned to a new and more capable data base vendor that opens opportunities for collaborating with other states.

2. Make MHCC the trusted source of quality and cost information

- Expand the “Wear The Cost” initiative by adding nine clinical episodes for a total of thirteen episodes to the initiative using privately insured data, but episode construction has temporarily stalled due to need to transition to Change Health Care.
- Accelerated the compliance, acquisition and the scope of data submissions to the Medical Care Data Base (MCDB) from private payers.
- Increased the support to HSCRC, MIA, Medicaid, MHBE, and PDAB in use of the MCDB, specific support to HSCRC for TCOC, MIA for rate review, MHBE private market reform.
- Created new data release regulations (COMAR 10.25.05) to modernize the data release process and expand data sharing.
- Transitioned to a new and more capable data base vendor that opens opportunities for collaborating with other states.

Unresolved

- Data leakage from the MCDB because the federal government and private employers, protected under ERISA from state oversight, do not submit to the MCDB.
- Wear The Cost expansion to include episodes using Medicare and Medicaid data.

2. Make MHCC the trusted source of quality and cost information

- Launched a revised and expanded Maryland Quality Reports that presents information on hospitals, nursing homes, assisted living centers, home health agencies, hospices, outpatient surgery centers, urgent care centers, and health plans.
- Established expanded data collection (descriptive info only) for ambulatory surgery centers.
- Expanded /enhanced data collection NH Experience of Care survey - online and Spanish versions; HCW Flu vac survey of hospice and home health; urgent care centers.
- Established collaborative relationship with Department of Aging.
- Note public outreach campaign using MPT.

Underway

- Reestablished infrastructure for Hospital Consumer Assessment of Healthcare Providers and Systems(HCAHPS) data collection to permit analysis by race, ethnicity, age, gender to support public reporting and HSCRC Quality Based Revenue program.
- Established MHCC as a lead agency in inventorying health equity programs and other initiatives that address vulnerable populations.

3. Modernize the Certificate of Need Program to support the Total Cost of Care Model

- Issued a Report on CON Modernization, informed by a Taskforce, which led to legislation in 2019. Legislation allowed established drug treatment programs and hospices to add beds without CON; allowed establishment of ASCs with up to two ORs without CON, including hospitals; eliminated capital threshold as a basis for requiring CON for all health care facilities other than hospitals; raised capital threshold for hospital projects to lesser of $50M or 25% of GBR, consistent with rate review threshold of HSCRC; and established deemed approval for most CON reviews not completed within 120 days of docketing.
- Adopted new nursing home regulations that added performance, character, and fitness standards for applicants seeking to establish new facilities or add beds to existing facilities.
- Authorized hospitals to establish five new freestanding medical facilities to replace under-utilized hospitals (2018-2021) in Laurel, Cambridge, Havre de Grace, Baltimore City, and Crisfield.
- Worked with HSCRC to develop more standardized and coordinated assessment of the financial feasibility of hospital projects.

3. Modernize the Certificate of Need Program to support the Total Cost of Care Model

Unresolved

Developing new procedural regulations (recommended by the MHCC CON Modernization Task Force). Finalization anticipated in 2023.

- Reduce statutory scope of CON regulation by deregulating drug treatment programs ("intermediate care facilities") from review requirements. Proposed bills in 2018 and 2019 were not adopted.
- Reduce scope of CON to exempt state facilities from CON review. A proposed bill in 2020 was not adopted.

4. Enable providers to participate in value-based payment models

- Convened the MDPCP Advisory Council, which provides recommendations to the Secretary to reform the MDPCP program beginning in 2019.
- Convened a primary care workgroup required by SB 734, Maryland Health Care Commission - Primary Care Report and Workgroup (2022).
- Established a practice transformation initiatives to prepare practices for participation in value-based payment models. Awarded to MedChi for Practice Transformation in Ambulatory Practices. 75 primary care and specialty practices completed.
- Guide and Symposium development
  - Developed a Care Management Capabilities and Readiness Assessment Guide.
  - An interactive tool aimed at helping practices assess their readiness to engage in care management, define a care manager's role in a practice, and identify leading care manager responsibilities.

4. Enable providers to participate in value-based payment models

Unresolved

- MHCC take responsibility for establishing value-based program with specialists
- MHCC is convening a workgroup on value-based programs in post-acute care
- MHCC should monitor unintended impact of value-based arrangements on certain practice types including small and minority owned practices

5. Expand the use of telehealth services in a variety of health care settings

- Launched a Telehealth Virtual Resource Center (TVRC) web page featuring information to assist providers in the adoption and use of telehealth.
- Implemented an interactive web-based Telehealth Readiness Assessment Tool
- Awarded a School-Based Teletherapy for Special Education Services – Grant to Charles County Schools
- Awarded contracts to 3 Management Services Organization (MSOs) to provide technical guidance to practices implementing telehealth. The MSOs worked with over 100 practices in 2020.
- Developed a Telehealth Technology Vendor Portfolio featuring 75 vendors to assist providers seeking information on telehealth technology.
- Developed telehealth coverage and reimbursement materials to inform providers about measures taken by Medicare, Medicaid, and private payers to broaden telehealth coverage during the PHE.
- Developed a Payer Remote Patient Monitoring Policies – A Reference Guide for Ambulatory Practices (guide

5. Expand the use of telehealth services in health care settings

- Developed an information brief, Engaging Patients Using Telehealth – Tips, for providing telehealth services to meaningfully engage consumers as active participants in their own care.
- Note Giant PSAs and work with Baltimore hair salons on public awareness of telehealth.

Policy Development

- HB 123/SB 3 (2021) directed MHCC to make recommendations on continuation of telehealth waivers post 2023.
- Directed via legislative request to convene a workgroup to study appropriate oversight of telehealth services by out-of-state providers

Unresolved

- Is treatment delivered via telehealth equivalent to in-person visits and what is the appropriate reimbursement for telehealth and audio-only care.

Communicating with MHCC . . .

See us on the Web

MHCC on Twitter

MHCC on Facebook

MHCC on YouTube