COUNCIL ON LEGISLATIVE & REGULATORY POLICY

Maryland Hospital Association

October 21, 2024

MHA Offices
6820 Deerpath Road
Elkridge, MD 21075

Maryland
Hospital Association

COUNCIL ON LEGISLATIVE & REGULATORY POLICY

Monday, Oct. 21, 2024 3 - 4 p.m.
Zoom Link: https://mhaonline-org.zoom.us/j/7461443535?omn=88926973946

AGENDA

3 p.m.	Welcome	Kevin Sowers, Chair
3:05 p.m.	Meeting Objectives	Andrew Nicklas, Senior Vice President, Government Affairs & Policy
3:10 p.m.	Informational Update ***(Tab 1)***	
	• Telehealth Sunset	Jake Whitaker, Assistant Vice President, Government Affairs & Policy
	• Workplace Violence Data Survey	Jane Krienke, Director, Government Affairs & Policy
3:20 p.m.	Payer Denials and Accountability ***(Tab 2)***	Steven Chen, Director, Policy Jake Whitaker
3:30 p.m.	Medical Liability ***(Tab 3)***	Jake Whitaker Brandon Floyd, Senior Analyst, Government Affairs & Policy
3:40 p.m.	Pediatric Overstays ***(Tab 4)***	Jane Krienke
3:50 p.m.	State Budget Advocacy ***(Tab 5)***	Natasha Mehu, Vice President, Government Affairs & Policy
4 p.m.	Adjourn	

Next Meeting: Nov. 13, 2024
9:30 – 11:30 a.m.
MHA Boardroom 6820 Deerpath Rd., Elkridge

Maryland Hospital Association

COUNCIL ON LEGISLATIVE & REGULATORY POLICY

Membership Roster
Fiscal Year 2025

Kevin Sowers – Chair
President
The Johns Hopkins Health System
Baltimore

Timothy Adelman
General Counsel & Chief Legal Officer
Luminis Health
Annapolis

Craig Carmichael
President & Chief Operating Officer
Northwest Hospital
Senior Vice President, LifeBridge Health
Randallstown

Cheryl Cioffi
Senior Vice President & Chief Operating Officer
Frederick Health
Frederick

Daniel Cochran
President
Adventist HealthCare Shady Grove Medical Center
Rockville

Jill Donaldson
President
MedStar Harbor Hospital
Senior Vice President, MedStar Health
Baltimore

Marjorie Fridkin, M.D.
Chief Medical Officer & Vice President of Medical Affairs
Garrett Regional Medical Center
Oakland

Jeffrey Grossi
Chief of Government Relations
Sheppard Pratt Health System
Towson

Christopher Hall
Vice President Strategy/Chief Business Officer
TidalHealth
Salisbury

Beau Higginbotham
President & CEO
Ascension Saint Agnes
Baltimore

Theresa Johnson
Vice President, Brand Strategy and Philanthropy
CalvertHealth Medical Center
Prince Frederick

Kristin Jones Bryce
Senior Vice President & Chief External Affairs Officer
University of Maryland Medical System
Baltimore

Kathleen McCollum
President & CEO
UM Baltimore Washington Medical Center
Glen Burnie

Mimi Novello, M.D.
President & Chief Medical Officer
MedStar St. Mary's Hospital
Leonardtown

Ryan O'Doherty
Senior Vice President, External Affairs
Mercy Medical Center
Baltimore

Bradley Schlaggar, M.D., Ph.D.
President & CEO
Kennedy Krieger Institute
Baltimore

Maria Harris Tildon
Vice President, State & Local Affairs
The Johns Hopkins University & Medicine
Baltimore

Meredith Tweedie
Vice President, Government Affairs &
Policy, and Senior Counsel
ChristianaCare, Union Hospital
Elkton

Jason Weiner
Senior Vice President, General Counsel
LifeBridge Health
Baltimore

Elizabeth Wise
President & CEO
University of Maryland Upper Chesapeake
Health System
Bel Air

Tab 1

Informational Updates

INFORMATIONAL REPORTS

Telehealth Sunset

MHA led the passage of the Preserve Telehealth Access Act of 2021, which allows telehealth services to be delivered via audio-only modalities and provides reimbursement parity. The Preserve Telehealth Access Act of 2021 telehealth expansion and reimbursement parity was scheduled to sunset on June 30, 2023. During the 2023 legislative session, MHA again led efforts to pass the Preserve Telehealth Access Act of 2023. This bill extended the sunset date for these flexibilities from July 1, 2023, to June 30, 2025. The 2023 bill also mandated that the Maryland Health Care Commission (MHCC) report its findings and recommendations on delivering telehealth services through audio-only technologies and ensuring reimbursement parity.

In its report, released on Oct. 17, the Commission recommends allowing the "unrestricted use" of telehealth services via audio-only modalities for behavioral health services. For somatic care, audio-only modalities may only be used when the "provider is technically capable of using telehealth, but the patient is not capable of, or does not consent to, the use of audiovisual technology." Additionally, MHCC recommends continuing reimbursement parity for behavioral health and somatic care services whether audio-visual or audio-only modalities are used.

Stakeholders are considering bringing forward a telehealth bill. However, there is currently no clarity on who will lead such efforts given the recent release of the MHCC report and potential varying stakeholder interests. Should the Council desire MHA to take the lead on introducing a bill, MHA will present a detailed telehealth policy proposal for consideration during the November Council on Legislative & Regulatory Policy meeting.

Prepared by: Natasha Mehu, VP, Government Affairs & Policy
Jake Whitaker, AVP, Government Affairs & Policy

Workplace Violence Statewide Survey

In March MHA launched a pilot survey of incident-level workplace violence events. The survey requested six months of data describing incidents between July and December 2023. The results catalog 1,811 workplace violence incidents affecting hospital staff at 32 of the 34 surveyed hospitals in the Data Advisory Group. Only two of the surveyed hospitals had previously developed a single-point process for workplace violence reporting and prompt cross-department review. Another two hospitals faced IT and administrative barriers significant enough to prevent them from submitting data.

At the direction of MHA's Task Force on Maryland's Future Health Workforce, MHA issued a second pilot survey in May to catalog policies and practices. These survey results function as a baseline describing current workplace violence policies, prevention activities, security infrastructure, training, and response. Thirty of the 34 hospitals completed the survey.

MHA will collect the calendar year 2024 workplace violence incident data when the survey goes statewide in January. MHA will coordinate with the Workplace Violence Data Advisory Group and hospitals outside of the pilot to determine the frequency of the data collection.

Prepared by: Sharon Metzler, Analyst, Strategic Analytics
Jane Krienke, Director, Government Affairs & Policy

Attachments
- Workplace Violence Slides

WORKPLACE VIOLENCE PREVENTION

October 21, 2024

Maryland Hospital Association

WPV INITIAL INCIDENT DATA COLLECTION

Distributed in March 2024 to Data Advisory Subgroup

Objectives

- ☑ **Compose a Standardized Survey**
  Take Subgroup's direction on what incident information can be reasonably collected.
- ☑ **Evaluate Effectiveness**
  Review submissions to identify limitations. *Example:* Comparing requested versus submitted. Debrief respondents to understand issues.

Response Rate = 94%

Submissions represent 32 of the 34 facilities in the Data Advisory Subgroup

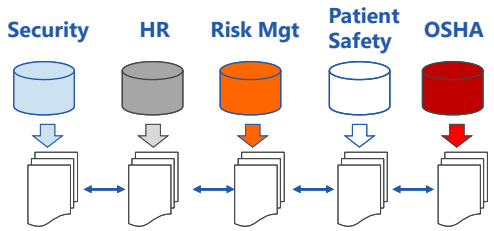
1,811 Incidents collected

Representing 6 months (July to December 2023)

LESSONS: INITIAL WPV INCIDENT DATA COLLECTION

- **Finding & collating individual incident information is onerous for nearly all facilities.**

  The task involves querying multiple databases, then cross-referencing and deduplicating the results



- **OSHA systems are incomplete for WPV logging.**
  - Only 6% of the 1,811 surveyed incidents represent OSHA recordable events.
- **Hospitals need help with WPV reporting.**
  - Only 2 facilities had time & budget to develop a single-point process for WPV reporting *and* prompt cross-department reviewing

1: Source, MHA Workplace Violence Data Advisory Subgroup; September 2024.

Tab 2

Payer Denials

Maryland Hospital Association

Council on Legislative & Regulatory Policy

October 21, 2024

Topic	**Payer Denials**
Objective	To obtain member feedback on proposals to reduce payer denials
Discussion Question	Does the Council support MHA's proposal to initiate a multiyear approach to enhance payer accountability and address payer denials?

Maryland hospitals report an increase in payer denials. Payer denials can occur before a procedure in the form of prior authorization or as a refusal from payers to provide payment after care has been rendered. Regardless of the format, payer denials delay necessary treatment and negatively affect patient health outcomes.

Commercial payers subject to Maryland Insurance Administration's (MIA) jurisdiction are required to publicly report certain denial and appeal data, which is compiled and published annually by the Health Education and Advocacy Unit (HEAU) of the Maryland Office of the Attorney General. Data released by HEAU and MIA, however, do not match hospitals' experiences. For instance, in the fiscal year 2023 report—the most recent data available—payers identified only 191 adverse decisions related to emergency room services. In contrast, data from the Health Services Cost Review Commission denials dataset show over 24,000 emergency department denials.

The sharp discrepancy between the denial data will likely hamper advocacy efforts in the General Assembly. Legislators are less likely to support meaningful payer denial reform without clear data signaling the existence of a problem. Therefore, instead of trying to introduce new payer standards in the 2025 legislative session, MHA proposes a longitudinal effort where we first try to correct the discrepancy between payer-reported and hospital-reported data. Once the published reports by the agencies reflect actual hospital experiences and the extent of the issue, the field can pursue additional reforms as needed.

Prepared by: Jake Whitaker, Assistant Vice President, Government Affairs & Policy
Steven Chen, Director, Policy

Attachment: Annual Report on the Health Insurance Carrier Appeals and Grievances Process, Fiscal Year 2023

PAYER DENIALS

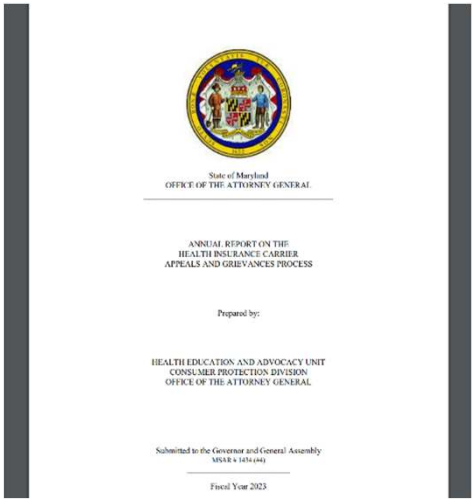
Maryland
Hospital Association

LEGISLATIVE STRATEGY GROUP FEEDBACK (9/25)

Additional payer transparency

Improve payer denial rates and post-acute care prior authorization

EXISTING DISCLOSURE IS FLAWED



State of Maryland
OFFICE OF THE ATTORNEY GENERAL

ANNUAL REPORT ON THE
HEALTH INSURANCE CARRIER
APPEALS AND GRIEVANCES PROCESS

Prepared by:

HEALTH EDUCATION AND ADVOCACY UNIT
CONSUMER PROTECTION DIVISION
OFFICE OF THE ATTORNEY GENERAL

Submitted to the Governor and General Assembly
MSAR # 1454 (44)

Fiscal Year 2023

Carrier Grievances Cases
Types of Services

Carriers must report the types of services involved in the adverse decisions they issue and the internal grievances they receive. The table below details the types of services involved in the adverse decisions issued and internal grievances filed in FY 2023, as reported by carriers.

Type of Service	Adverse Decisions		Grievances	
Dental	14,764	10.862%	2,674	24.568%
Durable Medical Equipment	1,474	1.084%	242	2.223%
Emergency Room	191	0.141%	30	0.276%
Home Health	117	0.086%	6	0.055%
Inpatient Hospital	1,456	1.071%	114	1.047%
Laboratory, Radiology	27,550	20.269%	1,390	12.771%
Mental Health / Substance Abuse	753	0.554%	65	0.597%
Other*	2,677	1.970%	464	4.263%
Pharmacy	57,881	42.584%	5,188	47.666%
Physician	25,264	18.587%	643	5.908%
PT, OT, ST, including inpatient rehabilitation	3,682	2.709%	53	0.487%
Skilled Nursing Facility, Sub Acute Facility, Nursing Home	113	0.083%	15	0.138%
Totals	**135,922**	**100%**	**10,884**	**100%**

*"Other" means obesity, IVF, podiatry, hearing and vision.

https://www.marylandattorneygeneral.gov/CPD%20Documents/HEAU/Anual%20Reports/HEAUannrpt23.pdf

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HSCRC VS HEAU/MIA

Denials by Patient Setting | FY2023

	All Payors	Commercial Only
Outpatient	307,390	58,393
ED	268,899	24,863
Inpatient	60,928	9,732
Total	**637,217**	**92,988**

Source: HSCRC Denials Dataset

Denials by Payor | FY2023

	All Patient Settings	ED Only
Medicaid HMO	310,258	186,240
Medicare FFS	132,967	32,390
Commercial	92,988	24,863
Medicare HMO/Medicare Advantage	43,723	10,880
Medicaid FFS	30,367	6,455
All Other	26,914	8,071
Total	**637,217**	**268,899**

Source: HSCRC Denials Dataset

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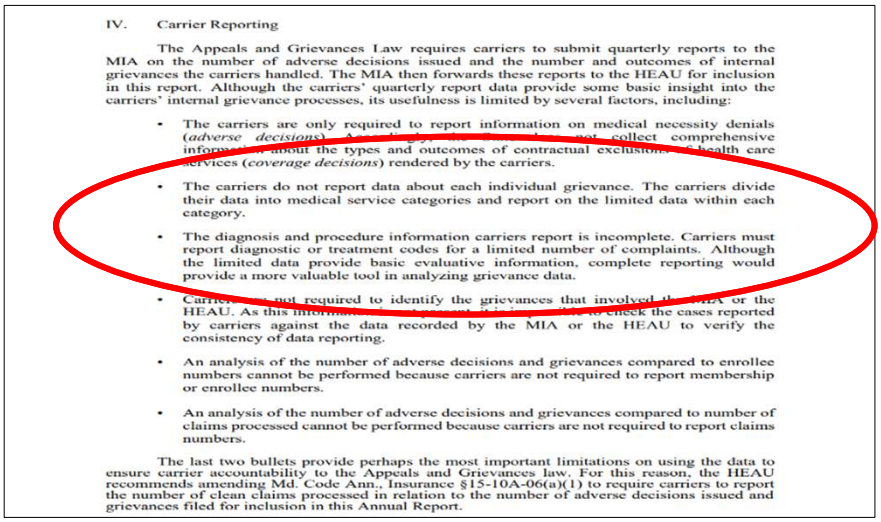
IMPROVE EXISTING DISCLOSURE LAWS?



IV. Carrier Reporting

The Appeals and Grievances Law requires carriers to submit quarterly reports to the MIA on the number of adverse decisions issued and the number and outcomes of internal grievances the carriers handled. The MIA then forwards these reports to the HEAU for inclusion in this report. Although the carriers' quarterly report data provide some basic insight into the carriers' internal grievance processes, its usefulness is limited by several factors, including:

- The carriers are only required to report information on medical necessity denials (*adverse decisions*). As a result, they do not collect comprehensive information about the types and outcomes of contractual exclusions of health care services (*coverage decisions*) rendered by the carriers.
- The carriers do not report data about each individual grievance. The carriers divide their data into medical service categories and report on the limited data within each category.
- The diagnosis and procedure information carriers report is incomplete. Carriers must report diagnostic or treatment codes for a limited number of complaints. Although the limited data provide basic evaluative information, complete reporting would provide a more valuable tool in analyzing grievance data.
- Carriers are not required to identify the grievances that involved the MIA or the HEAU. As this information [illegible] to check the cases reported by carriers against the data recorded by the MIA or the HEAU to verify the consistency of data reporting.
- An analysis of the number of adverse decisions and grievances compared to enrollee numbers cannot be performed because carriers are not required to report membership or enrollee numbers.
- An analysis of the number of adverse decisions and grievances compared to number of claims processed cannot be performed because carriers are not required to report claims numbers.

The last two bullets provide perhaps the most important limitations on using the data to ensure carrier accountability to the Appeals and Grievances law. For this reason, the HEAU recommends amending Md. Code Ann., Insurance §15-10A-06(a)(1) to require carriers to report the number of clean claims processed in relation to the number of adverse decisions issued and grievances filed for inclusion in this Annual Report.

PROPOSED NEXT STEPS

Multiyear effort to enhance payer denial transparency, reduce denial rates (especially for ED visits), and address prior authorization delays for discharges to post-acute settings

- CY 2024
  - Work with HEAU / MIA to understand existing limitations in disclosure requirements
  - Develop—with HEAU / MIA support if possible—refinements to existing commercial payer disclosure requirements, regulatory and/or legislative.
  - Identify potential all-payer disclosure requirements.
- CY 2025 (General Assembly)
  - Pursue legislative fixes to improve payer denial transparency
- CY 2025 (Interim)
  - Identify data to support payer denial and post-acute PA reform
- CY 2026 (General Assembly)
  - Introduce reform legislation as indicated

DISCUSSION/APPROVAL

- Does the Council support MHA's proposal to initiate a multiyear approach to enhance payer accountability and address payer denials?

Tab 3

Liability

Maryland Hospital Association

Council on Legislative & Regulatory Policy

October 21, 2024

Topic	**Medical Liability Reform**
Objective	Advance proactive legislation to amend the HCMCA definition of "healthcare provider" to include all individuals working at hospitals who deliver healthcare.
Discussion Questions	1. Should MHA advance proactive medical liability legislation? 2. Does this Council support MHA's advocacy strategy?

In recent years, Maryland trial attorneys have supported legislation to remove caps on noneconomic damages in personal injury and wrongful death actions. This effort has gained traction largely because it is being presented in the context of supporting the families of victims of the tragic Capital Gazette shooting. So far, this legislation has been unsuccessful.

However, based on conversations with members of the Maryland General Assembly, including the Judiciary Committee chair, we believe the legislature is likely to pass a bill significantly increasing the caps this year. As a result, MHA proposes a proactive liability strategy during the 2025 legislative session to reduce the hospital field's liability exposure.

MHA proposes introducing legislation to broaden the definition of "health care provider" under the Health Care Malpractice Claims Act (HCMCA) to include all clinical staff working in hospitals. Specifically, the definition would include all employees, agents, or contractors licensed, certified, or otherwise authorized to deliver health care services in Maryland.

While most claims against health care providers are filed under HCMCA, the plaintiff's attorneys are arguing that only the providers specifically listed in HCMCA "health care provider" definition are covered. This is significant because the caps on noneconomic damages and wrongful death are lower under HCMA. For example, in a current Maryland case, attorneys are arguing that a respiratory therapist employed by the hospital is not covered under HCMCA because they are not listed under the definition of health care provider. By broadening the definition, fewer hospital employees would be subject to potentially higher or even unlimited damages if the trial attorneys-backed legislation passes in 2025.

MHA sought to strike a balance in crafting a definition that covered as many individuals providing health care in hospitals as possible without being so overly broad that the bill would be politically infeasible. MHA consulted MHA's Liability Work Group and the Legislative Strategy Group to develop a "health care provider" definition that was legally sufficient and politically viable.

Members of the General Assembly, including leadership, said they do not intend to raise or remove the caps on medical malpractice claims. They agree that maintaining the existing medical

malpractice cap structure is critical to Maryland's health care field and a separate issue from the personal injury and wrongful death damages caps. If approved by this Council, MHA will argue the proposed bill is critical to ensuring the hospital field is not unintentionally subject to raised or unlimited caps should the trial attorneys-backed bill pass. For these reasons, we recommend taking advantage of this unique opportunity and ensuring more hospital clinicians have the appropriate liability protections under the law.

Prepared by: Jake Whitaker, Assistant Vice President, Government Affairs & Policy
Brandon Floyd, Senior Analyst, Government Affairs & Policy

Attachment: Medical Liability Reform Slides

MEDICAL LIABILITY

Maryland
Hospital Association

LEGISLATURE POISED TO INCREASE NONECONOMIC DAMAGES CAPS

- MAJ continues to advance a bill to remove or significantly increase noneconomic damages caps for personal injury and wrongful death claims
- Driven by attorneys representing Capital Gazette shooting victims' families
- Multiple sources feel some version likely to pass in 2025
- House Judiciary Chair Luke Clippinger confirmed when he engaged health care stakeholders to discuss the potential impact of the bill

POTENTIAL OPPORTUNITY

- MHA continues to hear the legislature does not intend to impact hospitals by passing this legislation
- Current definition of "health care provider" under the med mal statute can be read to exclude any providers not specially named
  - Current Maryland case: plaintiff's attorney arguing respiratory therapist not covered under med mal
- MHA proposes clarifying that health care provider definition covers all health care providers working in hospitals
  - Aligned with desire not to impact hospitals

CURRENT "HEALTH CARE PROVIDER" DEFINITION

- **Article - Courts and Judicial Proceedings §3–2A–01(f)(1)**
  - "Health care provider" means a hospital, a related institution as defined in § 19–301 of the Health – General Article, a medical day care center, a hospice care program, an assisted living program, a freestanding ambulatory care facility as defined in § 19–3B–01 of the Health – General Article, a physician, a physician assistant, an osteopath, an optometrist, a chiropractor, a registered or licensed practical nurse, a dentist, a podiatrist, a psychologist, a licensed certified social worker–clinical, and a physical therapist, licensed or authorized to provide one or more health care services in Maryland.

POLICY DEVELOPMENT

- Engaged Liability Work Group and Legislative Strategy Group to develop a new health care provider definition
- Sought to balance desire for a broad definition with political viability if overly broad
- Ultimately selected a definition that seeks to cover all hospitals employees, agents, or contractors licensed, certified, or otherwise authorized to deliver health care services in Maryland

PROPOSED "HEALTH CARE PROVIDER" DEFINITION

- **Recommended "Health care provider" Definition** – Includes all employees, agents, or contractors licensed, certified, or otherwise authorized to deliver health care services in Maryland.

- (f) (1) "Health care provider" means a hospital, a related institution as defined in § 19–301 of the Health – General Article, a medical day care center, a hospice care program, an assisted living program, a freestanding ambulatory care facility as defined in § 19–3B–01 of the Health – General Article, a physician, a physician assistant, an osteopath, an optometrist, a chiropractor, a registered or licensed practical nurse, a dentist, a podiatrist, a psychologist, a licensed certified social worker–clinical, and a physical therapist, licensed or authorized to provide one or more health care services in Maryland, **AND AN EMPLOYEE, AGENT, OR CONTRACTOR OF A HOSPITAL OR RELATED INSTITUTION AS DEFINED IN § 19–301 OF THE HEALTH – GENERAL ARTICLE WHO IS LICENSED, CERTIFIED, REGISTERED, OR OTHERWISE AUTHORIZED TO RENDER HEALTH CARE SERVICES IN MARYLAND.**

DISCUSSION/APPROVAL

1. Should MHA advance proactive medical liability legislation?

2. Does this Council support MHA's proposed liability bill?

Tab 4

Pediatric Overstays

Maryland Hospital Association

Council on Legislative & Regulatory Policy

October 21, 2024

Topic	**Pediatric Overstays**
Objective	To receive feedback on the inclusion of a proposal to address pediatric overstays as part of MHA's 2025 legislative priorities
Discussion Questions	1. Should MHA include a proposal to address pediatric overstays as a 2025 legislative priority? 2. Do the proposed focus areas align with addressing the root causes of the pediatric overstay problem?

Overview

MHA has gathered data four times since 2018 to quantify discharge delays from acute care settings and understand the demographics of the patients who are most impacted. Each study identified unique challenges children and transition-age youth face—especially those in the care of the state.

Based on feedback from the field, the root causes can be grouped into three buckets:

- Lack of bed capacity in the state and insufficient reimbursement rates
    - Inpatient beds to meet the needs of high-acuity patients who can face placement challenges due to co-morbidities, low IQ, aggressive behavior, etc.
    - Short-term placement options for youth not meeting criteria for inpatient admission
- State accountability and transparency to support the needs of youth and families in crisis, including:
    - Youth in the state's custody
    - Youth at risk of entering the custody of the state (i.e. neglected by parents or guardians in the emergency department), and
    - Youth whose parents or guardians are turning to the state to address the youth's behavioral health needs (i.e. through the voluntary placement agreement process)
- Outdated processes and administrative burdens that prevent patients from accessing the care they need in a timely manner

MHA has not previously put forward proactive legislation to address the root causes noted above.

State Engagement

MHA hosted the Secretary of Health and the Secretary of the Department of Human Services (DHS) in July 2023 for a member-wide meeting to discuss pediatric overstays. Leading up to this meeting, MHA convened member groups to develop and recommend potential solutions that were shared with the secretaries.

Since then, progress has been made, including increased engagement with the DHS hospital liaison. However, members shared that the problems with pediatric boarding in the emergency department and in inpatient psychiatric units persist. Patients experiencing the longest overstays are generally either under the custody of DHS or under a parent's custody but essentially abandoned in the emergency department. Hospital inpatient psychiatric units also face challenges with long overstays while waiting for numerous state agency approvals for pediatric patients, especially for out-of-state placements.

Member Engagement

During the 2024 interim, MHA developed and vetted various proposals with MHA's 211/Pediatric Overstay member group and the Legislative Strategy Group. In addition, staff engaged external stakeholders, including the Office of the Public Defender and Disability Rights Maryland, to explore legislative changes. These groups led previous efforts to change Maryland law (i.e. HB 406 introduced during the 2022 session) to alleviate these challenges for youth in an overstay status. MHA supported these efforts, but the legislation did not pass.

MHA staff continue to develop proposals to address the three root causes outlined above. MHA will convene a small member workgroup and continue to meet with external stakeholders and plan to present a proactive proposal at the next Council meeting in November. For this meeting, Council members are asked to share feedback on including a legislative priority on pediatric overstays and offer guidance on areas of focus.

Prepared by: Jane Krienke, Director, Government Affairs & Policy

PEDIATRIC OVERSTAYS: 2025 PROPOSED SOLUTION FOCUS AREAS

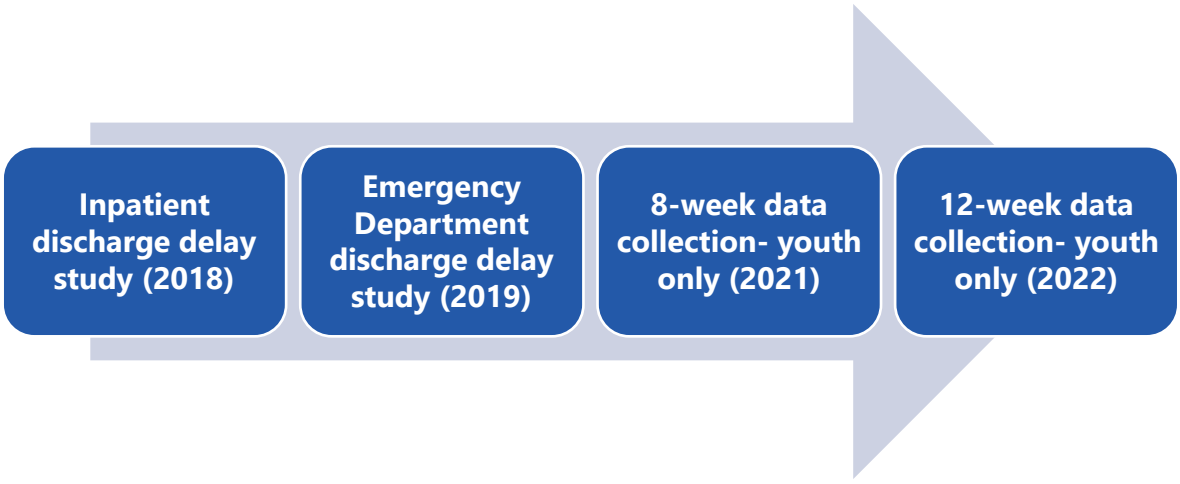
October 21, 2024

Maryland Hospital Association

BACKGROUND

- MHA gathered data four times since 2018 to quantify discharge delays from acute care settings and understand the demographics of the patients who are most impacted
- Each study identified unique challenges children and transition-age youth face, especially those in the care of the state

MHA DATA COLLECTION EFFORTS



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2022 PEDIATRIC HOSPITAL OVERSTAY 12-WEEK DATA COLLECTION

Findings

Maryland Hospital Association

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HOSPITAL OVERSTAYS AMONG MARYLAND YOUTH

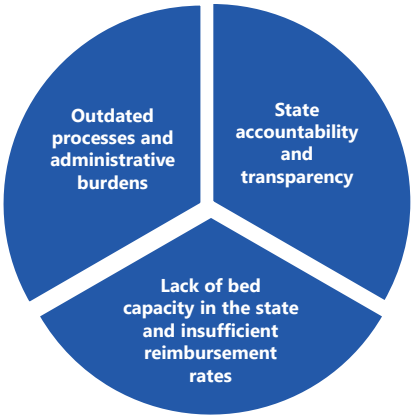
- **Over the course of the data collection period (Average):**
  - **Hospital Unit**
    - Inpatient Unit: **47%**
    - ED: **29%**
    - Observation: **3%**
    - No Unit Reported: **20%**
  - **Age**
    - Age 0-3: **5%**
    - Age 4-5: **1%**
    - Age 6-12: **17%**
    - Age 13-17: **70%**
    - Age 18-21: **7%**
  - **Gender**
    - Male: **49%**
    - Female: **49%**
    - Non-Binary: **1%**
    - Transgender: **2%**
    - Unknown: **0%**
- On average, **48** youth experienced a hospital overstay each week during the data collection period
- Top overstay reasons:
  - Accepted but waiting for behavioral health bed to become available: **30%**
  - No Available Placement: **27%**
  - Aggressive Behaviors: **22%**
  - Diagnosed Developmental Disabilities and/or Autism: **13%**
- State Involvement:
  - Department of Social Services (Alone): **30%**
  - No State Involvement: **22%**
  - Department of Human Services & Social Services: **16%**
- County of Residence:
  - Baltimore County: 24%
  - Baltimore City: 17%
  - Montgomery County: 14%
  - Washington County: 7%
  - Anne Arundel County: 6%

Source: MHA Pediatric Hospital Overstay Survey – June-September 2022
Note (1): Number of Hospitals Reporting : 6/20/22 = 31 ; 6/27/22 = 35 ; 7/4/22 = 34 ; 7/11/22 = 37

PROPOSED FOCUS AREAS AND NEXT STEPS

Maryland Hospital Association

PROPOSED FOCUS AREAS



Supporting all youth and families including:
1. Youth in state custody
2. Youth at risk of entering state custody (i.e. neglected by parents or guardians in the emergency department)
3. Youth in the custody of their parents or guardians turning to the state to address the youth's behavioral health needs (i.e. through the voluntary placement agreement process)

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NEXT STEPS

Convene a small member work group to strategize on focus areas and solutions

Continue discussions with external stakeholders including state agencies and advocacy groups

Present a proactive proposal to the Council at the November meeting

8

QUESTIONS/APPROVAL

1. Should MHA include a proposal to address pediatric overstays as a 2025 legislative priority?

2. Do the proposed focus areas address the field's primary concerns regarding overstays?

Tab 5

State Budget Advocacy

Maryland Hospital Association

Council on Legislative & Regulatory Policy

October 21, 2024

Topic	**2025 State Budget Advocacy**
Objective	To consider a proposed change in the hospital field's budgetary priorities for the 2025 legislative session
Discussion Questions	1. Does the Council support deprioritizing reducing the Medicaid Deficit Assessment on hospitals? 2. Does the Council support prioritizing fully funding the MHA Hospital Bond Program instead?

MHA staff previously proposed that the hospital field request a reduction in the Medicaid Deficit Assessment by $25 million, and if that is not an option, urge the Moore administration and the General Assembly to keep it at current levels. This two-pronged approach was proposed to provide the hospital field with room to negotiate. It also aims to protect us from being a target for state revenue needs given the bleak budget outlook and historical tendency to use the Medicaid Deficit Assessment to generate state revenue in times of need.

The Health Services Cost Review Commission (HSCRC) is contemplating a rate increase to capture excess savings under the Model and provide critical financial relief to hospitals. There is uncertainty around the size, timing, and impact of the potential rate increase, and discussions are ongoing. There may be a need to mitigate the impact of an increase on Medicaid.

The state is facing a $1-billion budget deficit over the next two years—$800 million of which is attributed to projected Medicaid expenditures. The Medicaid Deficit Assessment is a potential vehicle to hold Medicaid harmless if a rate increase occurs, particularly if the impact extends into fiscal year 2026. If this approach is pursued, it would conflict with MHA's initial proposed budgetary request to reduce the assessment, as a rate increase would be more beneficial to hospitals.

Given this update, MHA believes it would be prudent to deprioritize our previous proposal to reduce the Medicaid Deficit Assessment by $25 million. Alternatively, staff recommend making certain that any potential budgetary changes to Medicaid align with broader efforts to bring additional funding to hospitals in the current and next fiscal year. MHA staff would continue to monitor the discussions and work closely with HSCRC, the Department of Budget and Management, and the General Assembly to ensure clear communication and a coordinated approach toward any budgetary actions that would impact hospitals. Should the state decide to increase the Medicaid Deficit Assessment, MHA would work to safeguard hospital interests and ensure the deficit increase is tied to a rate increase for hospitals.

As an alternative budget request, MHA proposes requesting the Moore administration fully fund the MHA Hospital Bond Program.

On May 16, 2024, Governor Moore signed Senate Bill 973 into law, which codified MHA's Hospital Bond Program and increased the recommended annual appropriation to $20 million. Sen. Guy Guzzone, chair of the Senate Budget & Taxation Committee, introduced the legislation to expand access to much-needed capital funding for hospitals. However, the legislation did not require the Governor to fund the program. The administration technically retains the ability to determine whether to fund the program in any given year. Additionally, funding for the MHA Hospital Bond Program in the state's Capital Improvement Program (CIP) remains at $8 million. MHA is proposing an increase in the out-year funding in the CIP to $20 million to align with the intent of SB 973 and urge the administration to provide full funding for the program in the annual budget.

Fully funding the Hospital Bond Program would ensure the inclusion of 22 capital projects that were evaluated and recommended by MHA's Hospital Bond Program Review Committee in the fiscal year 2026 capital budget and sustainable funding of future projects in years to come. It would also align with the administration's 2024 state plan to leave no one behind by supporting world-class health systems for all Marylanders.

The Council is asked to consider deprioritizing the previously proposed state budget request to decrease the Medicaid Deficit Assessment and consider prioritizing fully funding the MHA Hospital Bond Program instead.

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STATE BUDGET ADVOCACY

Maryland
Hospital Association

MEDICAID DEFICIT ASSESSMENT

HSCRC

- HSCRC is contemplating all-payer rate increases, including Medicaid
- To hold Medicaid harmless for the extra funding, the state may increase the Medicaid Deficit Assessment

GENERAL ASSEMBLY

- The state has a bleak budget outlook—especially within Medicaid
- Historically it has used the Medicaid Deficit Assessment to generate revenue in times of need

- Hospitals stand to benefit from an all-payer rate increase even if it comes at the expense of an increase in the Medicaid Deficit Assessment

HOSPITAL BOND PROGRAM

- In 2024, legislation was passed to codify MHA's Hospital Bond Program and increase the *recommended* annual appropriation to $20 million
- However, the legislation did not *require* the Governor to fund the program—allowing the administration to determine whether to fund the program in any given year
- Additionally, funding for the MHA Hospital Bond Program in the state's Capital Improvement Program (CIP) remains at $8 million—$12 million below the recommended appropriation
- Fully funding the Hospital Bond Program in the CIP would safeguard the inclusion of 22 capital projects that were evaluated and recommended by MHA's Hospital Bond Program Review Committee for the fiscal year 2026 capital budget and would provide sustainable capital funding of future projects in years to come
- **MHA is proposing an increase in out-year funding in the CIP of $20 million to align with the intent of SB 973 and to urge the administration to fully fund the program in the annual budget**

DISCUSSION QUESTIONS

- Does the Council support deprioritizing the request to reduce the Medicaid Deficit Assessment on hospitals?
  - Understanding that MHA will work closely with the relevant state bodies to ensure that any potential budgetary changes to Medicaid align with broader efforts to bring additional funding to hospitals in the current and next fiscal year
- Does the Council support prioritizing fully funding the MHA Hospital Bond Program instead?