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521st MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
August 12, 2015

EXECUTIVE SESSION
12:00 p.m.
(The Commission will begin in public session at 12:00 p.m. for the purpose of, upon motion and approval, adjourning into closed session. The open session will resume at 1PM.)

1. **Update on Contract and Modeling of the All-payer Model vis-a-vis the All-Payer Model Contract – Authority General Provisions Article, §3-104, and 3-305(b)(7)**
2. **Consultation with Legal Counsel on Contested Care Implications – General Provisions Article, §3-305(b)(7)**

PUBLIC SESSION OF THE
HEALTH SERVICES COST REVIEW COMMISSION
1:00 p.m.

1. **Review of the Minutes from the Public Meeting on June 10, 2015**
2. **Executive Director's Report**
3. **CRISP report on Integrated Care Network Infrastructure**
4. **New Model Monitoring**
5. **Docket Status – Cases Closed**

   None
6. **Docket Status – Cases Open**

   2298A – MedStar Health
   2299A – MedStar Health
   2300R – Washington Adventist Hospital
   2301R – Holy Cross Hospital
   2302A – University of Maryland Medical Center
   2303R – Frederick Memorial Hospital
   2304N – UM St. Joseph Medical Center
   2305A – University of Maryland Medical Center
7. **Report of the Consumer Engagement Task Force**
8. **Maryland Health Care Commission on Status of Certificate of Need Applications**
9. **Legal Report**
10. **Hearing and Meeting Schedule**

Executive Director's Report

The Executive Director's Report will be presented at the Commission Meeting.

CRISP

CHESAPEAKE REGIONAL INFORMATION SYSTEM FOR OUR PATIENTS

ICN Infrastructure Tools and Services
Update on Progress

August 12, 2015

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Columbia, MD 21046
877.952.7477 | info@crisphealth.org
www.crisphealth.org

Presentation Outline

1. Project Organization
2. Leadership/Governance
3. Working with Regional Partnerships and organizations that want to pilot initiatives
4. ICN Roadmap
5. Goals

Project Organization

1. AMBULATORY CONNECTIVITY

The project aims to achieve bi-directional connectivity with ambulatory practices, long-term-care and, other health providers. Multiple methods of connectivity will be employed, including HL7 interfaces, CCDA exchange, and administrative networks.

2. DATA ROUTER

A key concept of the infrastructure effort is to send relevant patient-level data to the healthcare organizations who can use it for better care management. The data router will receive and normalize health records, determine a patient-provider relationship, verify patient consent, and forward the records where they should go in near real time.

3. CLINICAL PORTAL ENHANCEMENTS

The existing clinical query portal will be enhanced with new elements, including a care profile, a link to a provider directory, information on other known patient-provider relationships, and risk scores.

4. NOTIFICATION & ALERTING

New alerting tools will be built such that notification happens within the context of a providers existing workflow. So for instance, if a patient who is part of a specific care management initiative shows up at the ER, an in-context alert could inform the clinicians that the patient has a care manager available.

5. REPORTING & ANALYTICS

Existing reporting capabilities, built on Tableau and Microsoft Reporting Services, will be expanding and made available to many more care managers. Will also plan for a potential new solution to support thousands of ambulatory practices.

6. BASIC CARE MANAGEMENT SOFTWARE

The current scope is for planning only, as the advisors help us determine an appropriate path.

7. PRACTICE TRANSFORMATION

The current scope is for planning only, as the advisors help us determine an appropriate path.

Terminology

	Definition
Clinical Query Portal Enhancements	Improvements to the existing clinical query portal including approaches to simplify access, incorporating new content such as access to care profiles, and displaying the patient's providers.
In-Context Notifications and Alerting	Inclusive of a range of alert types sent to the point-of-care or to a care manager, in a manner consumable with their workflow. Alerts may pertain to critical information about a patient, identify care gaps, indicate post-discharge follow-up care has not occurred, etc.
Care Profile View	The care profile provides, in one readily viewable place, the key characteristics of a patient and their current medical status. Key elements in the care profiles could include patient demographics, most recent clinical alerts, summary of recent hospital encounters – diagnoses and procedures, visit dates, subscribing providers, and the existence of a current care plan.
Data Router	The router is a service that includes key functionality to support connectivity, consent management, data routing to other services or data consumers, and patient-provider relationship determination. The approach may rely on connectivity through a health system, through a hosted EHR, directly to the practice, or via an administrative network.
Standardized Risk Stratification Tools	Deployment of one or more centralized risk stratification methodologies to support stratification of patients initially using HSCRC case mix data housed in CRS but expanding to include broader data sets. Predictive risk score will be shared through a range of tools, including the query portal and ENS.

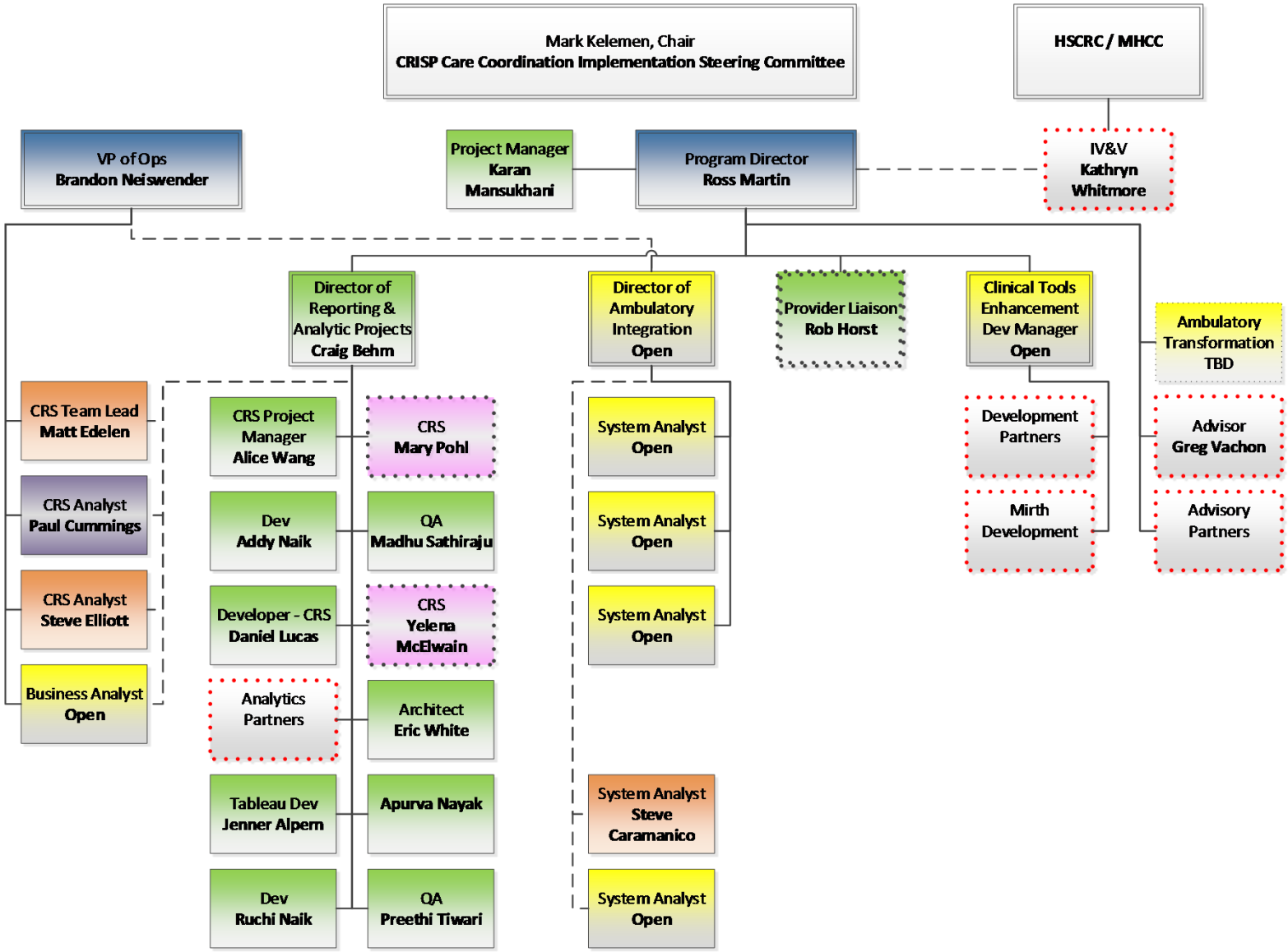
CRISP ICN Infrastructure Committee

- CRISP Board established an ICN Infrastructure Steering Committee
  - Charged with providing oversight and offering guidance on how best to pursue those services that can and should be offered as common infrastructure
  - Translating and further defining the Care Coordination Workgroup report into set of work activities
- CRISP Executive Committee is actively engaged in reviewing recommendations, reviewed budget and leadership decisions

ICN Infrastructure Steering Committee

Name	Title	Organization
Mark Kelemen, MD (Chair)	CMIO	University of Maryland Medical System
Patty Brown	SVP and President	Johns Hopkins Medicine, Johns Hopkins HealthCare LLC
Ernest Carter, MD	Deputy Health Officer	Prince George's County Department of Health
Patricia Czapp, MD	Chair of Clinical Integration	Anne Arundel Health System
DeWayne Oberlander	Executive Director	Columbia Medical Practice
Nicole Stallings	Vice President, Policy & Data Analytics	Maryland Hospital Association
Adam Kane	Senior Vice President of Corporate Affairs	Erickson Living
David Sharp	Director, Center for Health IT	Maryland Health Care Commission
Linda Dunbar	Vice President, Population Health & Care Management	Johns Hopkins Healthcare
John Kontor, MD	EVP	Advisory Board Company
Robb Cohen	CEO	Advanced Health Collaborative
John McLendon	CIO	MedStar Health System

Team Organization



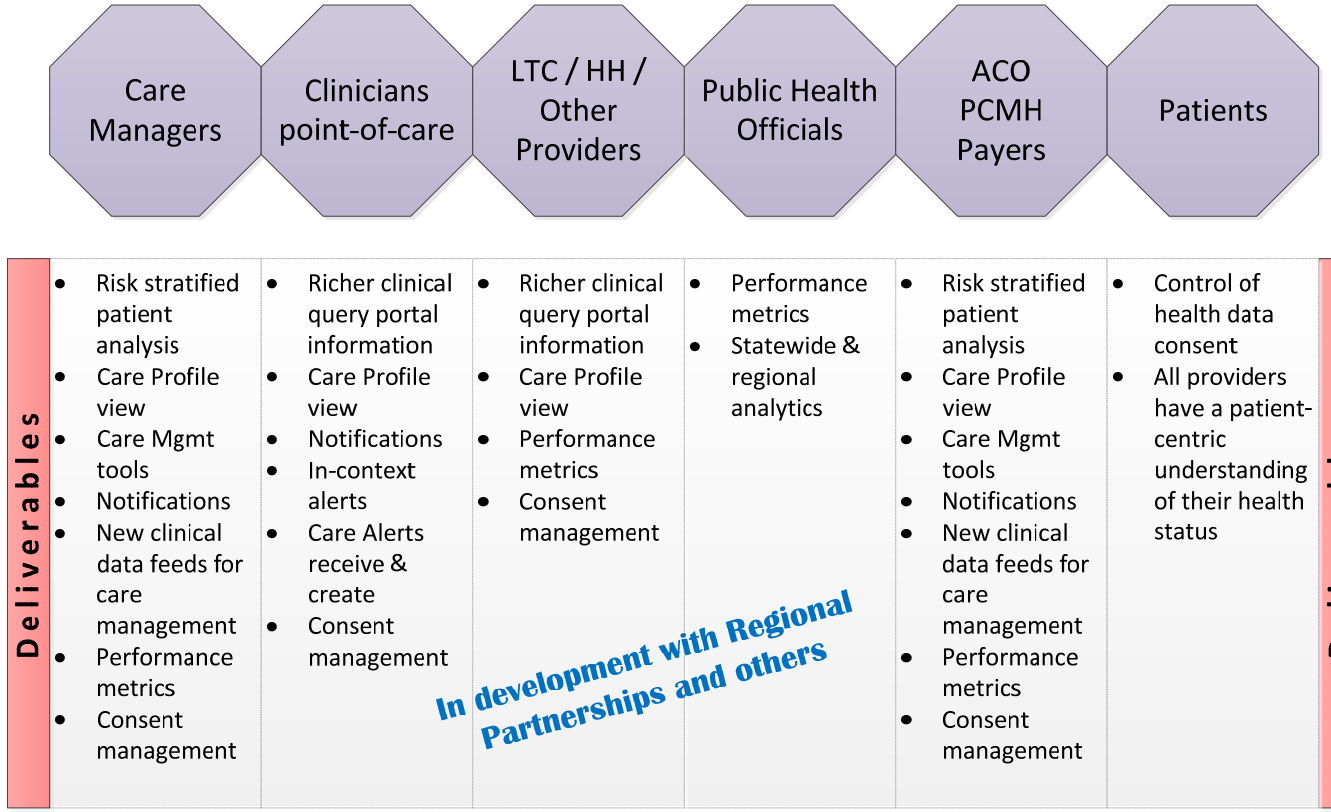
CRISP and Statewide ICN Infrastructure

- CRISP's role in pursuing ICN infrastructure and services is rooted on identifying and deploying those services that can and should be offered as common state-level infrastructure and are best pursued cooperatively.
- We are in part translating (and in some cases further defining) the Care Coordination Workgroup report into a set of work activities building towards agreed upon common infrastructure and services.
- CRISP's new tools should complement the ongoing and significant investments health systems, hospitals and ambulatory providers have already made.
- For some providers, CRISP will offer new solutions and tools. For other providers, CRISP will provide new data, make connections among different health system providers, and facilitate a shared understanding of the needs of shared patients.
- Consistent with CRISP's history and mission, we will be thoughtful about maintaining an incremental approach defined by CRISP users' needs.
- CRISP will work within its broad-based governance structure to define and prioritize work and partner with early adopters and innovators to pilot and refine initiatives.

Gaining Input and Direction from Users

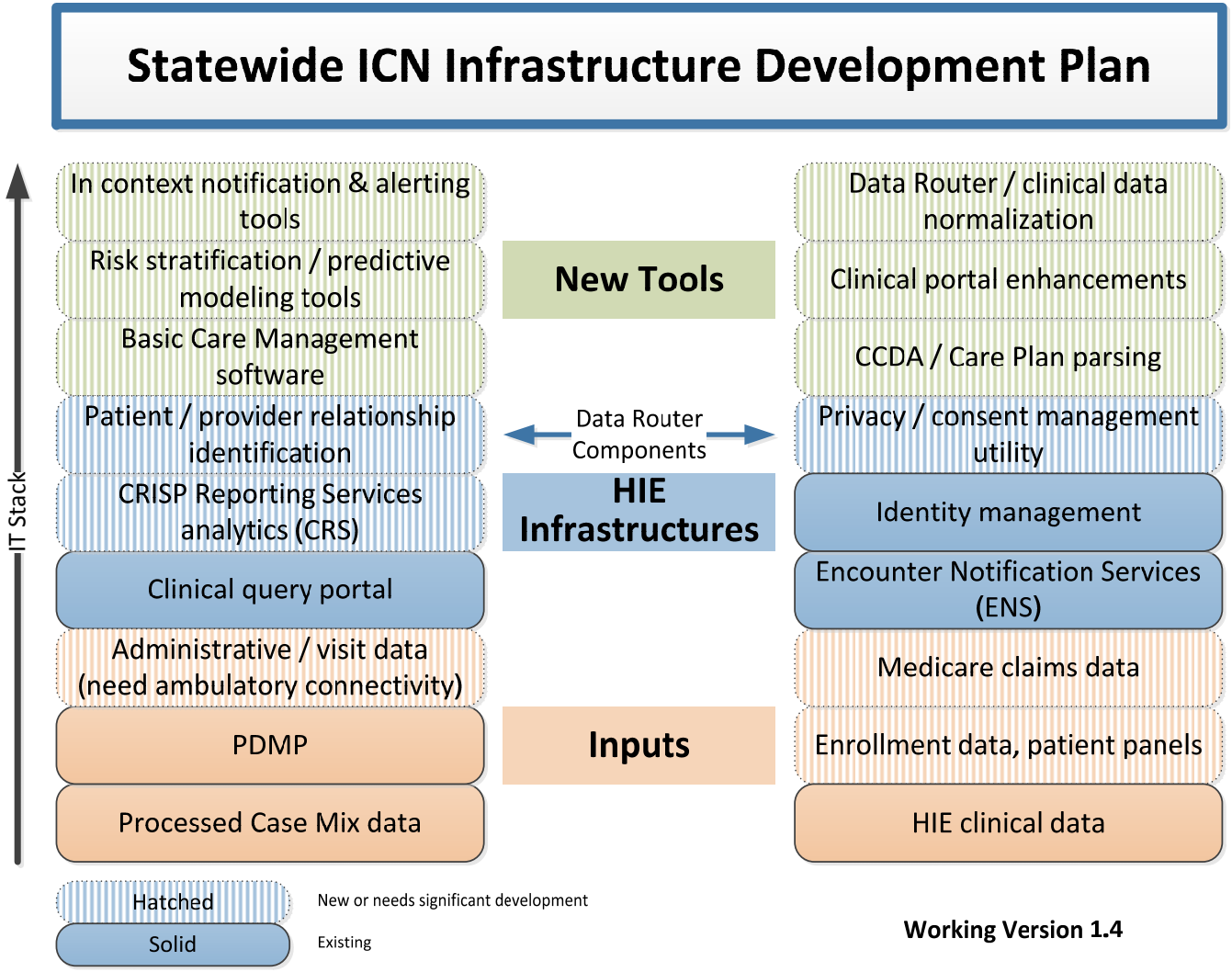
- CRISP is actively engaged with users to understand their needs and work towards better defining solutions and piloting efforts
  - Regional Partnerships have provided a good forum
  - Working with other collaborative efforts as well
- Our experience is that we can be more successful when working with partners to pilot real solutions that can be implemented quickly and improved incrementally over time
- Alignment strategies are critical to engaging ambulatory and long term care providers

ICN Infrastructure Concept



Statewide ICN Infrastructure Development Plan

ICN Infrastructure Concept



Draft Goals

Goal	6-Month Goal Dec 31. 2015	12-Month Goal Jun 30, 2016	24-Month Goal Jun 30, 2017
ICN Tools and Services			
Deploy Router	**Routing data from 40 total ambulatory practices to 2 care management programs / 150 practices**	Router supporting 1,000 providers	Router supporting 5,000 providers
Consent Utility	**Opt out for ambulatory data is made more granular and working / ENS opt out working**	Opt out for ENS is working	3,000 peope have opted out of ENS
		Better patient notification options are implemented	1,000 people are receiving notifications
		Care Managers are starting to rely on the CRISP consent utility	Consent utility is integral to many care management initiatives
Deploy Risk Stratification solution against case mix data	**Risk stratification tool selection complete and production pilot underway for 4 partners / 10 partners**	Risk stratification broadly available through reports and or query portal	Risk stratification includes clinical data inputs
Deploy uniform "base" approach for Health Risk Assessment	**Build consensus among Steering Committee on uniform "base" approach to HRAs**	TBD	TBD
Deploy standardized approach for Care Profile development and sharing	**Steering Committee agrees on standardized approach to Care Profile, Care Alert development / live in portal**	Care Profiles available prominently in the clinical query portal	TBD
Deploy approach for Care Plan viewing through HIE	**Care Plan viewable through the clinical portal from 2 organizations / 4 organizations**	Care Plans available for 10,000 patients	Care Plans available for 40,000 patients
Deploy In-Context Notifications	**In context notifications in 4 EDs, for presence of a Care Plan or recent discharge / 10 EDs**	In-context notifications available to 100 ambulatory providers	In-context notifications available to 5,000 ambulatory providers
Enhance Clinical Query Portal with new information	**ENS Provider Subscription information available in Clinical Query Portal / with provider contact info**	Provider Directory contact information integrated into Clinical Query Portal	Robust patient attribution information, for providers and care managers, feeding the Clinical Query Portal
Deploy Reporting & Analytics tools for patient panels / attributed patients	**Tableau access available to all hospitals, and used by 20 / 40**	TBD	TBD
	Regional Partnerships are meaningfully using CRS reports		

Draft Goals 2

Goal	6-Month Goal Dec 31. 2015	12-Month Goal Jun 30, 2016	24-Month Goal Jun 30, 2017
New Data Sources			
Data Sharing Framework	**Pilot data Sharing Policy in place to enable use of All Payer Report / improved approach to 42 CFR Part 2 data agreed**	PA addendum signed by a majority of hospitals	Advanced ability to filter on 42 CFR Part 2
ENS Panel Growth	**An ENS message is sent for 55% of Medicare discharges / 60%**	An ENS message is sent for 65% of Medicare discharges	An ENS message is sent for 80% of Medicare discharges
CMS Data availability	**Partner with MHA and HSCRC to formally request data**	CMS data in use	
Admin / Visit Data growth	**1,000 providers sending administrative data / 2,000**	2,000 providers sending administrative data	5,000 providers sending administrative data
Ambulatory Clinical Data growth	**500 ambulatory providers sending clinical data / 1,000**	1,000 ambulatory providers sending clinical data	TBD
Increase SNF Connectivity	**Steering committee agrees approach to coordinating with SNFs and data sharing**	TBD	TBD
Industry / Community Partner Engagement			
Operational Practice Transformation Center	**Initial funding and plan in place / statewide effort funded**	TBD	TBD
Support Regional Partnerships	**At least one goal or obligation is defined and agreed in an MOU for each regional partnership / plus 5 other than RPs**	TBD	TBD
CRS / Tableau directly leveraged by strategic partners	**At least 2 partners have direct access to Tableau in support of provider organizations / 6 partners**	TBD	TBD

Questions

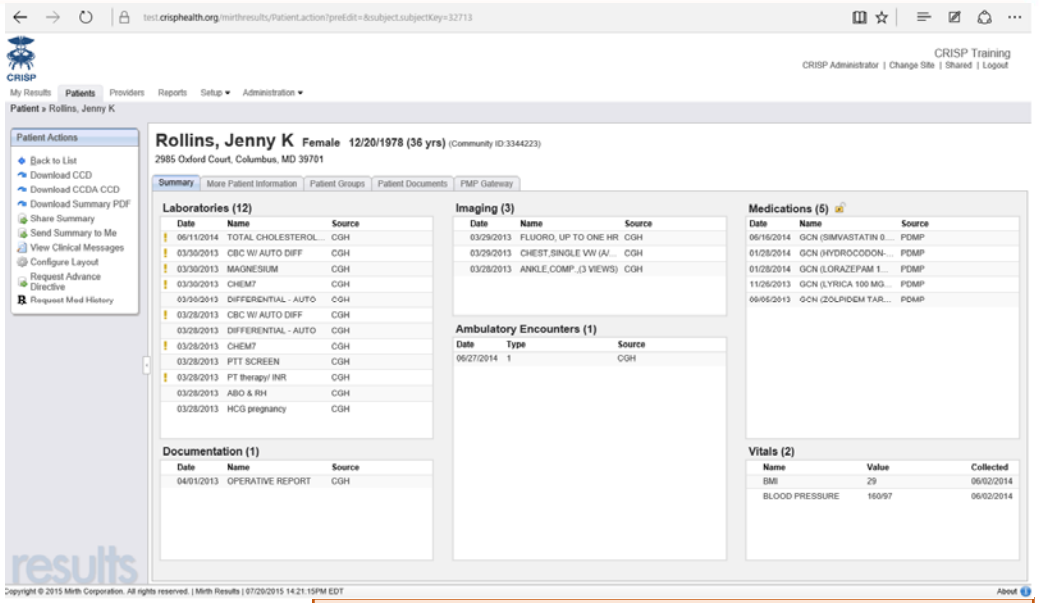
Appendix

1. Current Tools
2. New Tools and Services

Current Tools and Services

Clinical Query Portal

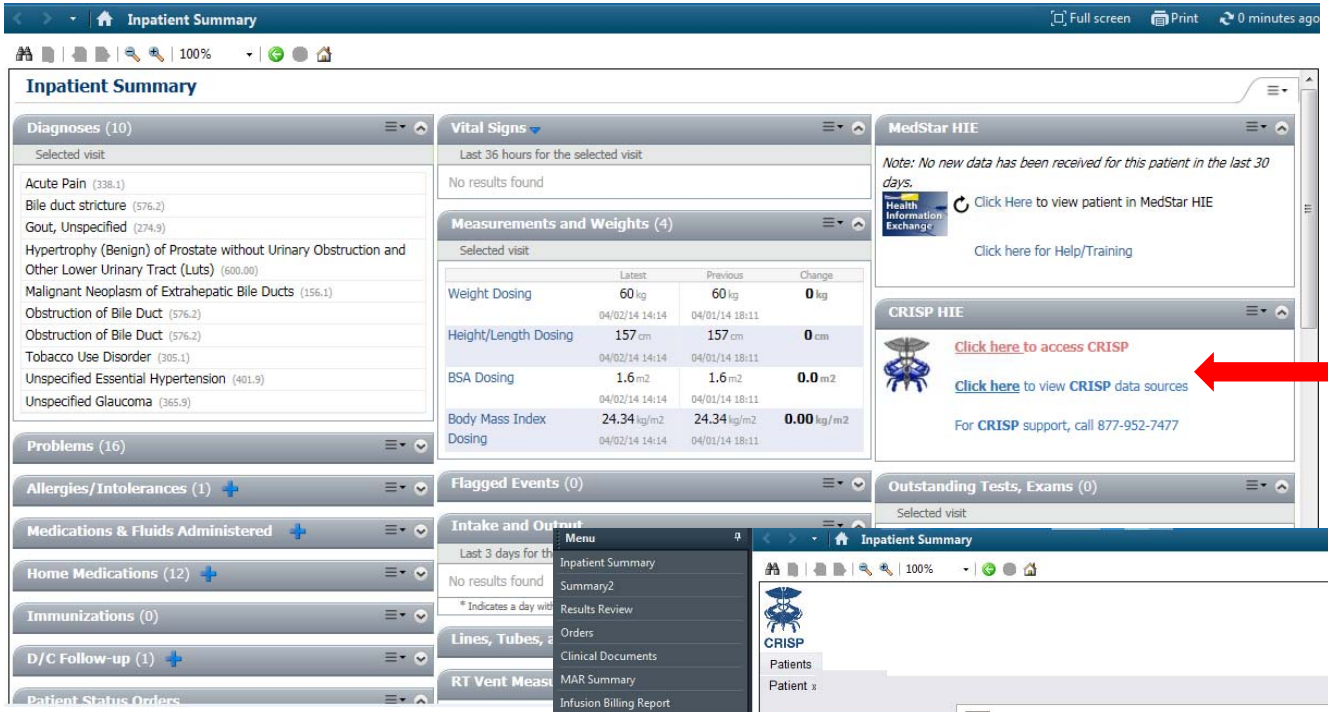
- The clinical query portal allows credentialed users to search the HIE for clinical data.
- All 47 acute care hospitals in Maryland and 6 of 8 DC hospitals share clinical data.
- There are currently over 100,000 queries per month.
- 10 hospitals have enabled "single sign-on" connectivity to the portal enabling single-click access to data in CRISP.



Types of data available:

- Patient demographics
- Lab results
- Radiology reports
- **PDMP Meds Data**
- Discharge summaries
- History and physicals
- Operative notes
- Consult notes

Clinical Query Portal - Single Sign-on



Single Sign-On (SSO) is an approach to enable faster and more efficient access to the query portal through the EHR.

By securely sending a local user's credentials and the current patient medical record number (or other demographics), CRISP can send the user directly to the patient summary screen.

Encounter Notification Service – Current Capabilities

- CRISP currently receives Admission Discharge Transfer messages in real-time from:
  - All Maryland Acute Care Hospitals
  - 6 of 8 D.C. Hospitals
  - All Delaware Hospitals

- Through ENS, CRISP generates **real - time hospitalization notifications** to PCPs, care coordinators, and others responsible for patient care.

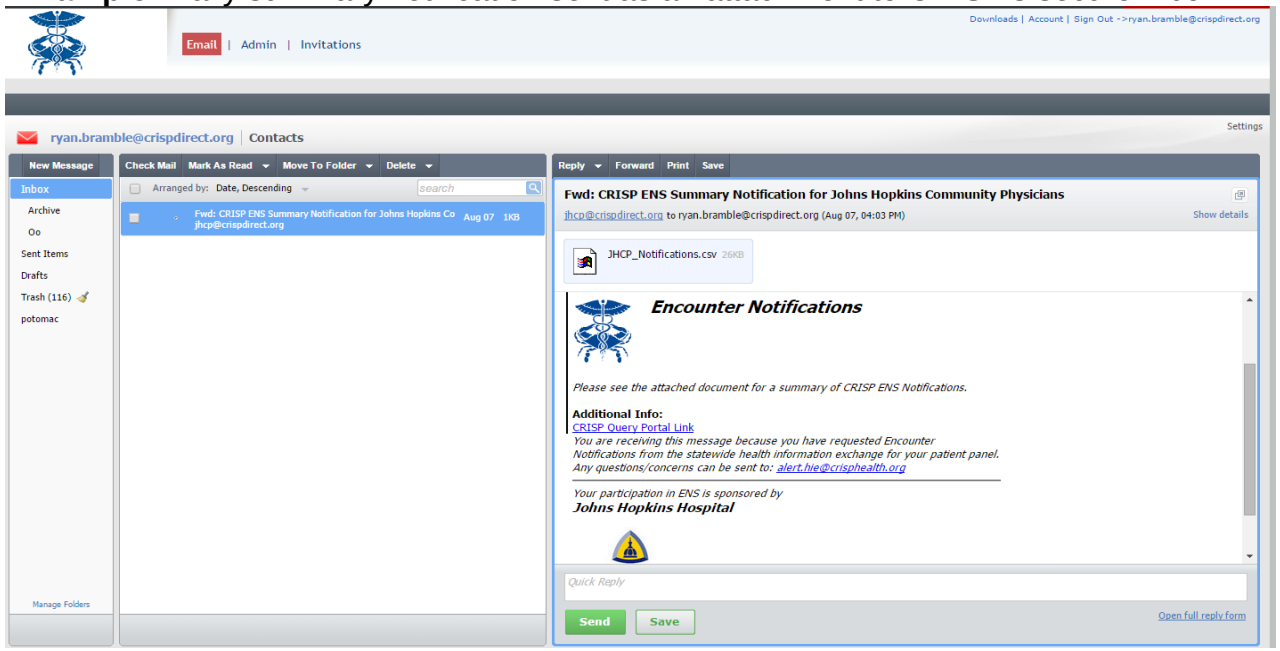
Important Current Capabilities

- Full Continuity of Care Documents (CCDs) are also routed through ENS to subscribing providers, who elect to receive them to support transitions of care.
  - 10 Hospitals currently send CCDs to CRISP
- Hospitals can “auto-subscribe” so they can be alerted when one of their past discharges is being readmitted within 30 days. This same capability allows the receiving hospital to be notified, when a patient arriving at their facility had been discharged from another facility, within the past 30 days.
  - 34 hospitals currently auto-subscribe to receive readmission notifications
- ENS was recently enhanced to include the ER and IP visits for a given patient with the past 6 months.

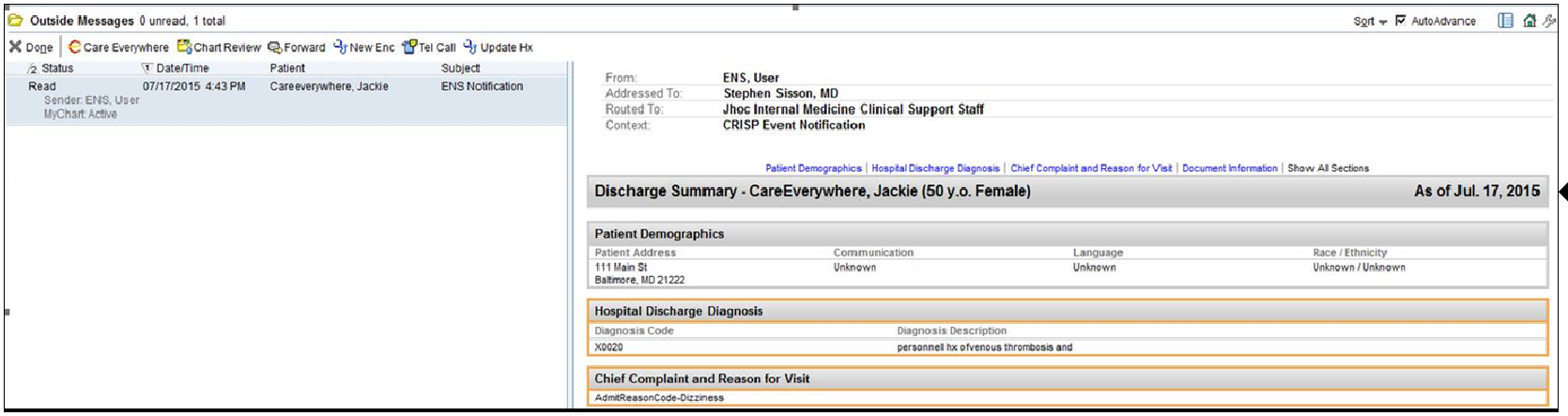
Methods to Receive Notifications

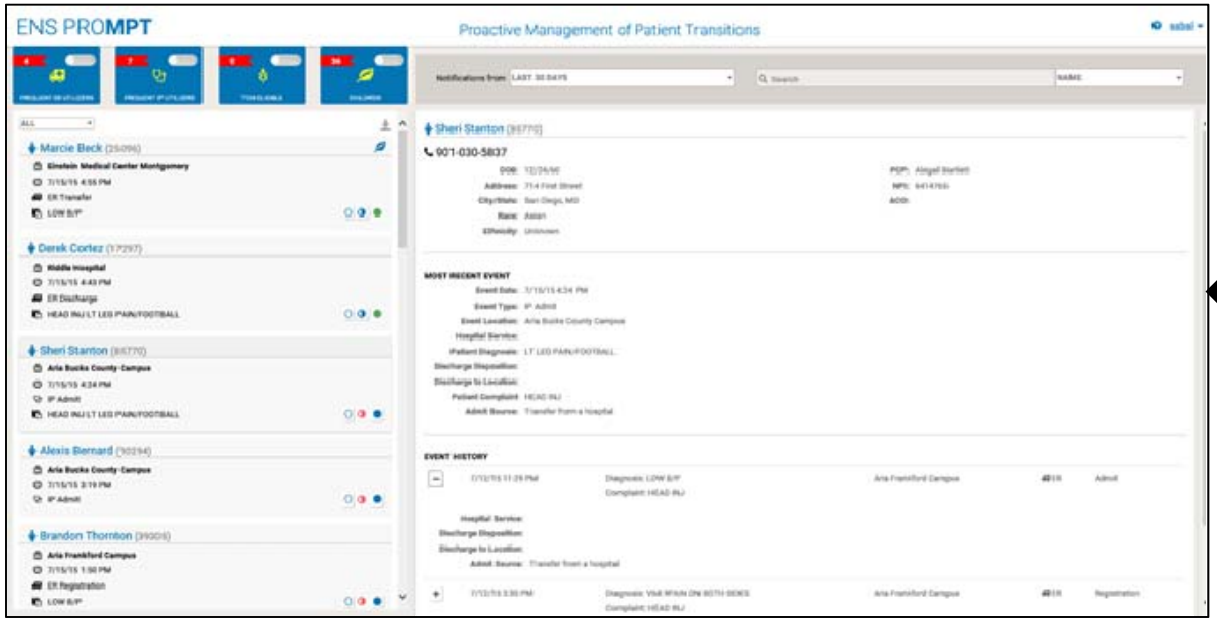
- Currently, ENS recipients can choose to receive real-time or a daily (or twice daily) summaries of the prior 24 hours of hospitalizations.
- Most notifications are sent via CRISP secure direct messaging tool (shown below).
- Some ENS subscribers choose to integrate notifications into their EHR by receiving the notifications in the form of an ADT.

Example: Daily summary notification sent as an attachment to CRISP's secure inbox



Near-term Additional Approaches for ENS

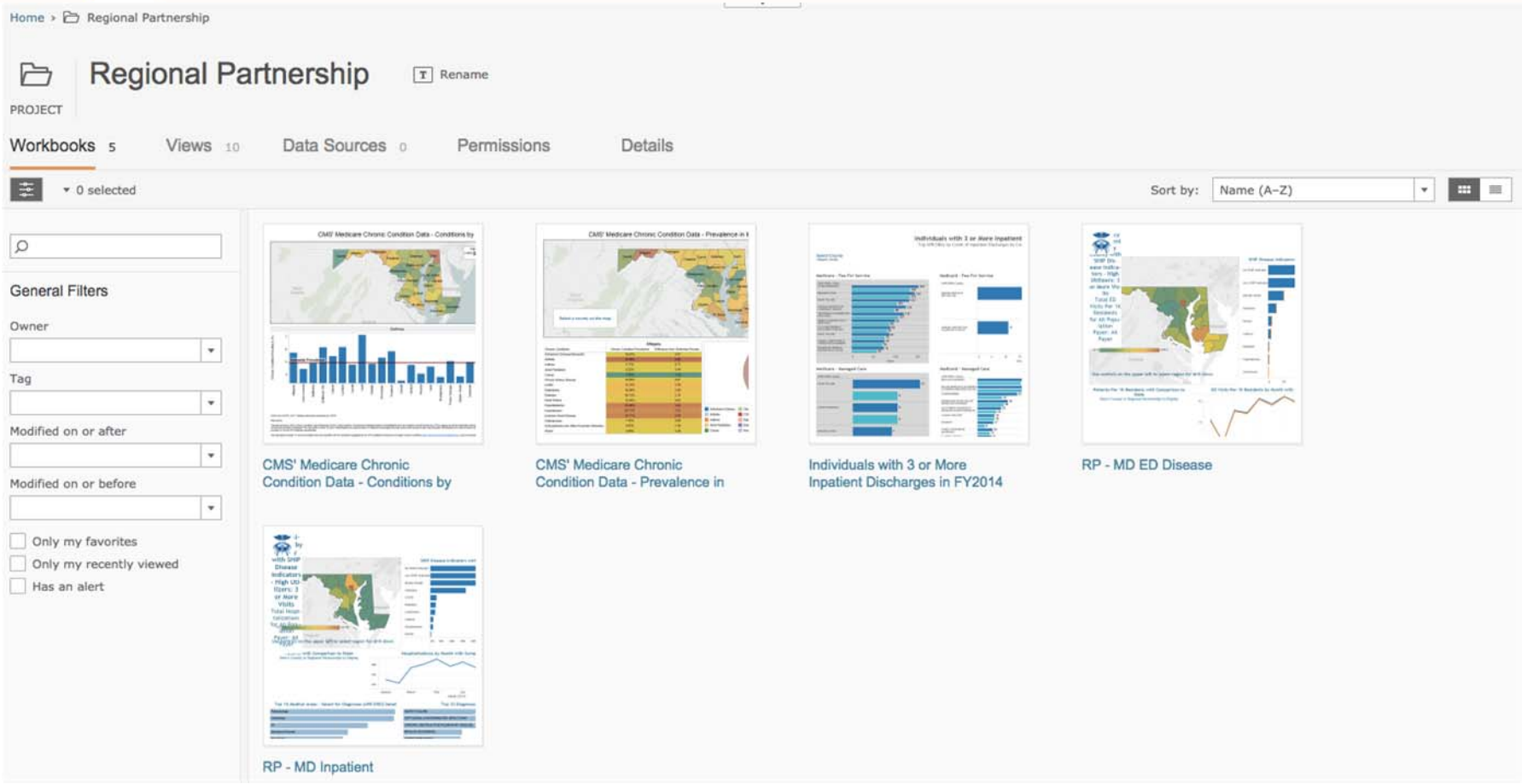




- ENS is in final testing to deliver notifications directly into Epic.
- Notifications are also currently flowing into other recipient systems in production.

- CRISP will also offer an ENS user interface beginning in early August rather than simple spreadsheet via secure email.
- Users will still have the ability to download the spreadsheet.

CRISP Reporting Services (CRS)

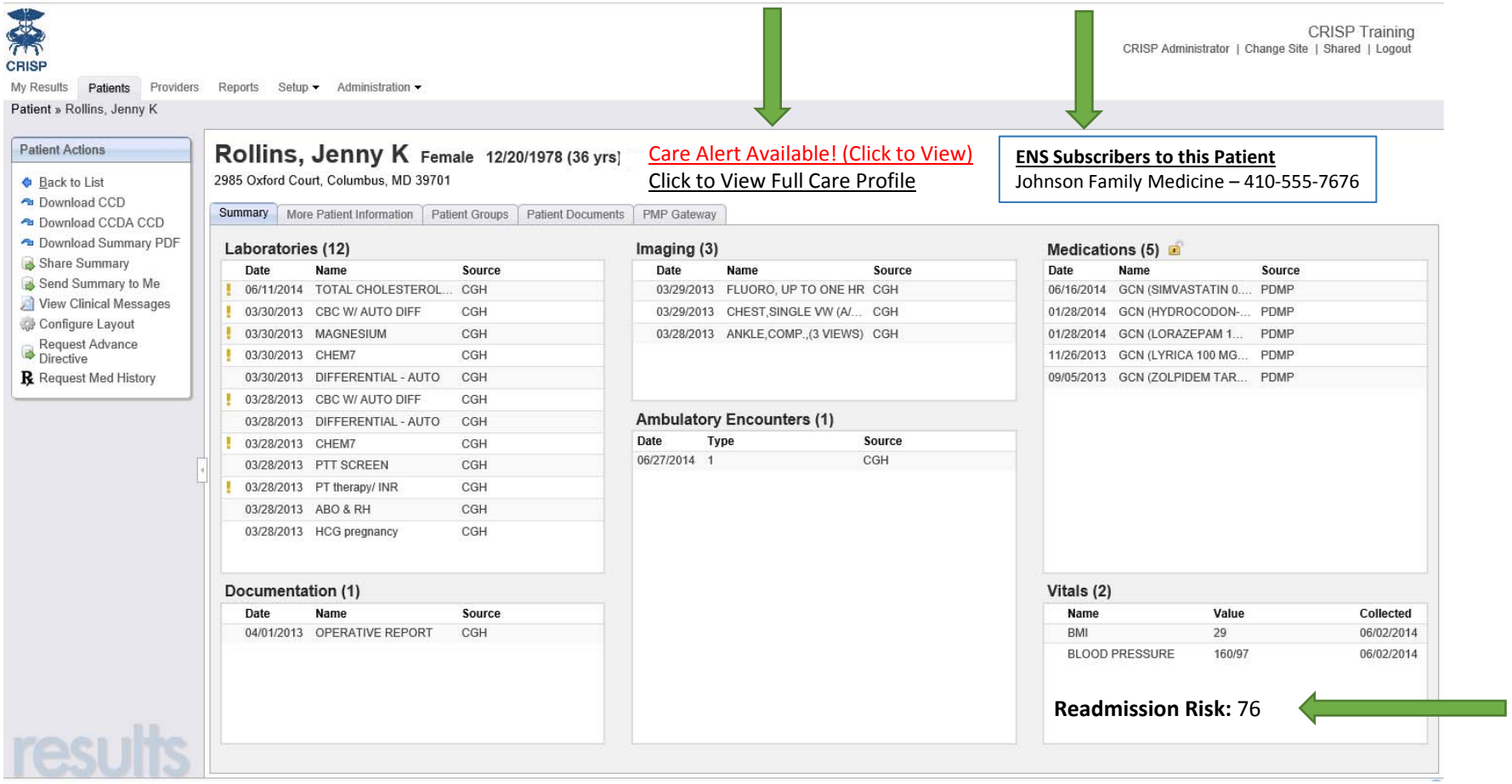


Link to July 9th Webinar Materials and Recording

http://pophealth.dhmh.maryland.gov/transformation/SitePages/Technical%20Assistance.aspx

ICN Infrastructure Tools and Services

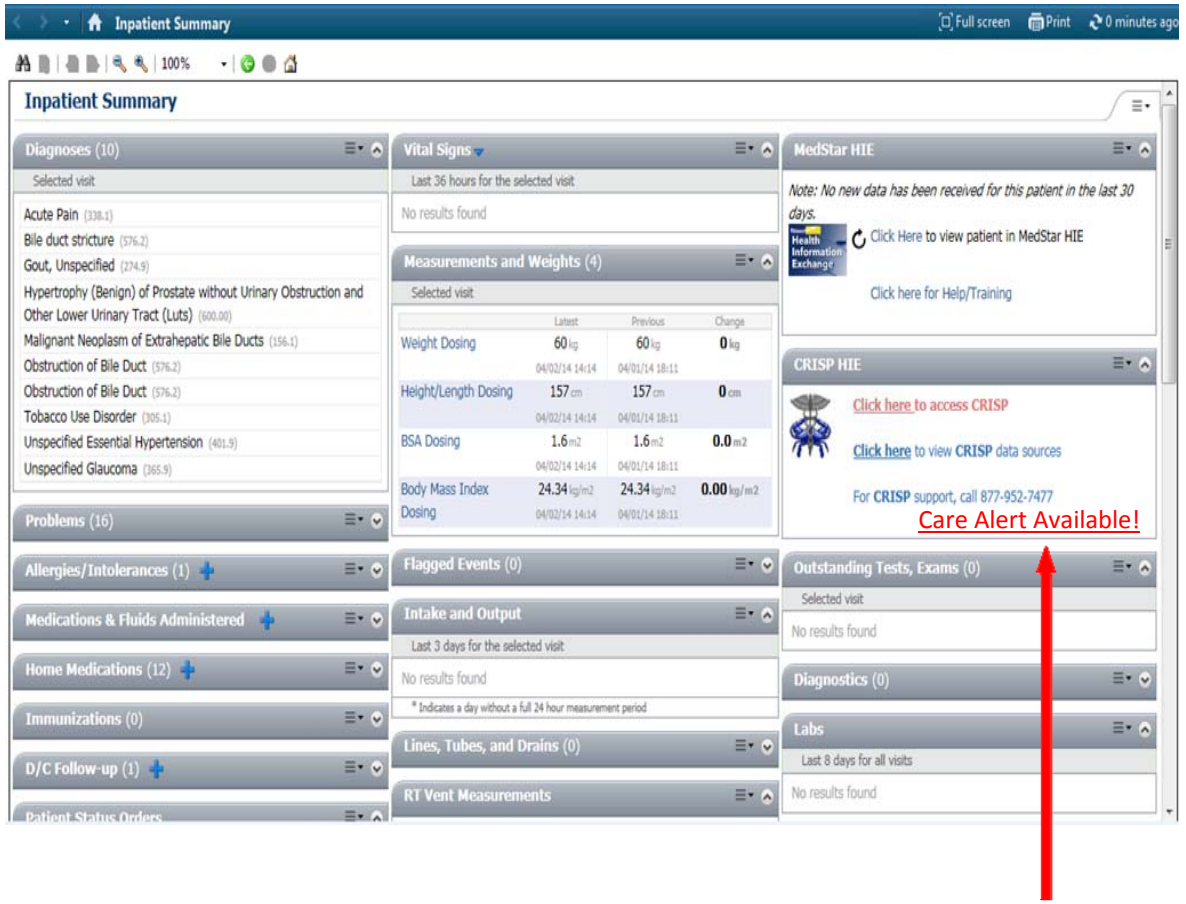
Clinical Query Portal Enhancements



Clinical Query Portal Enhancements – Improvements to the existing clinical query portal including approaches to simplify access, incorporating new content such as access to care profiles, and displaying the patient's providers.

In-Context Notifications and Alerting

- In-context alerting is intended to provide key information to clinical decision makers at the most effective point in their clinical workflows.
- An example of an in-context alert is pushing information to a hospital ER when a patient is registered indicating if a care plan is available in CRISP.
- In this in-context alert use case, a pre-defined method to access the care plan (or just key sections such as the care alert) would be established between CRISP and the receiving organization.



In-Context Notifications and Alerting – inclusive of a range of alert types sent to the point of care or to a care manager that pertains to critical information about a patient, identifies care gaps, indicates post-discharge follow-up care has not occurred, etc.

Care Profile View

Content Type / Source	Update Frequency
Patient Demographics	Daily
Clinical Alert Information	Daily
ENS Subscriber Information	Daily
ADT Data	Daily
CRS Case Mix Data	Monthly
Care Plan Availability Indicator	Daily

= to be developed

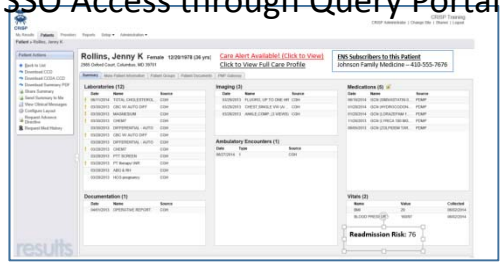
Care Profile

CRISP Care Profile Repository

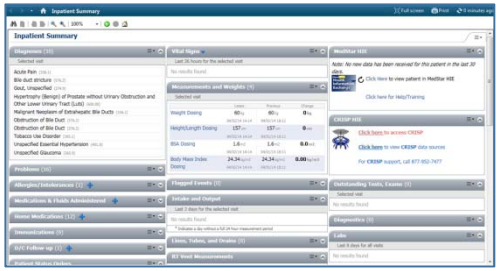
API

Access Methods

SSO Access through Query Portal



API call from EHR

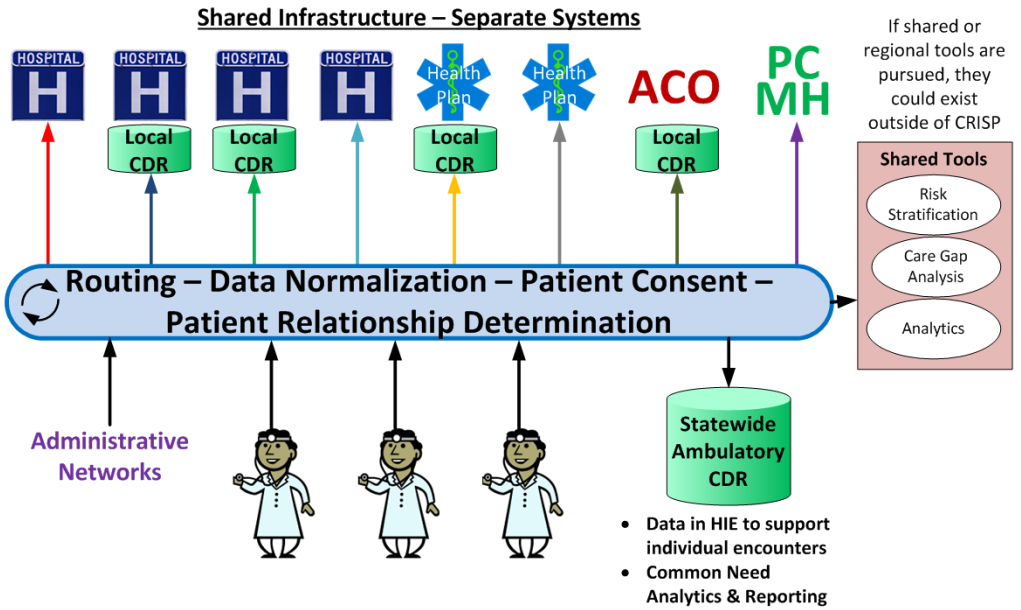


Link from ENS User Interface

Data Router and Non-Hospital Connectivity

Key Functions include:

- Consent management
- Data normalization
- Data routing
- Patient-provider relationships determination and management



Data Router - The router is a service that includes key functionality to support connectivity, consent management, data routing to other services or data consumers, and determine patient-provider relationships. These approaches may rely on connectivity through a health system, through a hosted EHR, directly to the practice, or via an administrative network.

Router Continued

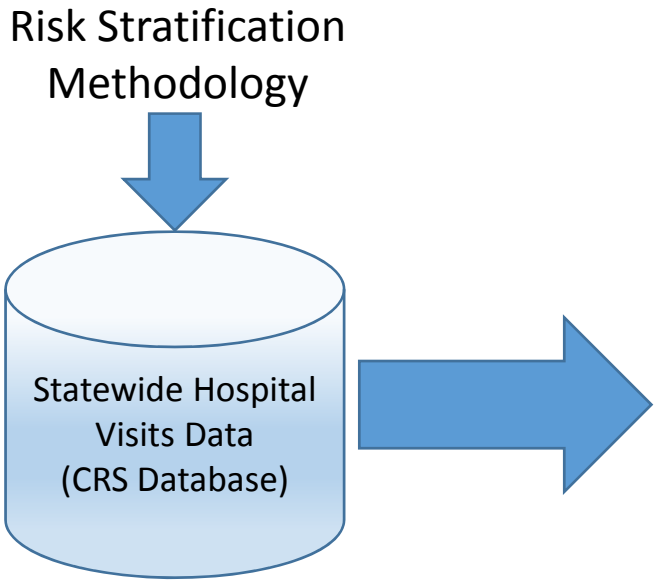
- **Connectivity and Routing** – inclusive of a range of connectivity approaches including connections to practice through health systems, direct connectivity to EHRs, hosted EHR connectivity, and administrative network connections.

- **Data Normalization** – applications of message transformation and vocabulary mapping services to inbound data.

- **Consent Engine** – the centrally managed consent engine will still require provider / care manager patient engagement and a significant patient education campaign. The consent engine will enable individuals to select more granular consent preferences that the current "all - in or all - out" choice.

- **Relationship Determination** – patient to provider relationships could be established and maintained through a range of data types flowing through CRISP, for example by using administrative claim data and ENS subscription panels. Other tools to enable management of those relationships are also planned in order to facilitate program enrollment (and consent), such as CCM.

Standardized Risk Stratification Tools



- Standardized and shared risk stratification and predictive modeling tools
- Supporting common understanding high risk patients
- Data feeds to provider care management systems
- Risk scores available through broader set of CRISP tools

Note: Over time, additional data, such as Medicare claims data, can supplement the currently available hospital case mix data.

Standardized Risk Stratification Tools - deployment of one or more centralized risk stratification methodologies to support stratification of patients initially using HSCRC case mix data housed in CRS but expanding to include broader data sets. Predictive risk score will be shared through a range of tools, including the query portal and ENS.

New Model Monitoring Report

The Report will be distributed during the Commission Meeting

Closed Cases

There were no closed cases from the June Commission meeting

H.S.C.R.C's CURRENT LEGAL DOCKET STATUS (OPEN)

AS OF AUGUST 4, 2015

A: PENDING LEGAL ACTION : NONE
B: AWAITING FURTHER COMMISSION ACTION: NONE
C: CURRENT CASES:

Docket Number	Hospital Name	Date Docketed	Decision Required by:	Rate Order Must be Issued by:	Purpose	Analyst's Initials	File Status
2298A	MedStar Health	6/2/2015	N/A	N/A	ARM	DNP	OPEN
2299A	MedStar Health	6/2/2015	N/A	N/A	ARM	DNP	OPEN
2300R	Washington Adventist Hospital	6/8/2015	8/12/2015	11/5/2015	Capital	GS	OPEN
2301R	Holy Cross Hospital	6/12/2015	8/12/2015	11/5/2015	CCU/ICU	CK	OPEN
2302A	University of Maryland Medical Center	6/18/2015	N/A	N/A	ARM	DNP	OPEN
2303R	Frederick Memorial Hospital	7/10/2015	8/12/2015	12/7/2015	FULL	JS	OPEN
2304N	UM St. Joseph Medical Center	7/17/2015	8/17/2015	12/14/2015	CCU/DEF	CK	OPEN
2305A	University of Maryland Medical Center	7/30/2015	N/A	N/A	ARM	DNP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
MEDSTAR HEALTH	*	**DOCKET:**	**2015**
	*	**FOLIO:**	**2108**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2298A**

Staff Recommendation

August 12, 2015

I. INTRODUCTION

MedStar Health filed an application with the HSCRC on June 2, 2015 on behalf of Union Memorial Hospital and Good Samaritan Hospital (the "Hospitals") to participate in an alternative method of rate determination, pursuant to COMAR 10.37.10.06. Medstar Health requests approval from the HSCRC for continued participation in a global rate arrangement for orthopedic services with MAMSI for a one year period beginning September 1, 2015.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by Helix Resources Management, Inc. (HRMI). HRMI will manage all financial transactions related to the global price contract including payments to the Hospitals and bear all risk relating to services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating the mean historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will continue to submit bills to HRMI for all contracted and covered services. HRMI is responsible for billing the payer, collecting payments; disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The Hospitals contend that the arrangement between HRMI and the Hospitals holds the Hospitals harmless from any shortfalls in payment from the global price contract.

V. STAFF EVALUATION

The staff reviewed the experience under this arrangement for the last year and found that it was favorable. The staff believes that the Hospitals can continue to achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' request for continued participation in the alternative method of rate determination for orthopedic services, for a one year period, commencing September 1, 2015. The Hospital will need to file a renewal application for review to be considered for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document will formalize the understanding between the Commission and the Hospitals, and will include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**
DETERMINATION	*	**COMMISSION**
MEDSTAR HEALTH	*	**DOCKET: 2015**
	*	**FOLIO: 2109**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2299A**

Staff Recommendation

August 12, 2015

I. INTRODUCTION

MedStar Health filed an application with the HSCRC on June 2, 2015 on behalf of Union Memorial Hospital (the "Hospital") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. Medstar Health requests approval from the HSCRC for continued participation in a global rate arrangement for cardiovascular services with the Kaiser Foundation Health Plan of the Mid-Atlantic, Inc. for one year beginning August 1, 2015.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by Helix Resources Management, Inc. (HRMI). HRMI will manage all financial transactions related to the global price contract including payments to the Hospital and bear all risk relating to services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates was renegotiated in 2007. The remainder of the global rate is comprised of physician service costs. Also in 2007, additional per diem payments were negotiated for cases that exceed the outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospital will continue to submit bills to HRMI for all contracted and covered services. HRMI is responsible for billing the payer, collecting payments, disbursing payments to the Hospital at its full HSCRC approved rates, and reimbursing the physicians. The Hospital contends that the arrangement between HRMI and the Hospital holds the Hospital harmless from any shortfalls in payment from the global price contract.

V. STAFF EVALUATION

The staff reviewed the results of last year's experience under this arrangement and found that they were favorable. Staff believes that the Hospital can continue to achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's request for continued participation in the alternative method of rate determination for cardiovascular services for a one year period commencing August 1, 2015. The Hospital will need to file a renewal application for review to be considered for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document will formalize the understanding between the Commission and the Hospital, and will include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, and confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE PARTIAL RATE	*****	**BEFORE THE HEALTH SERVICES**
APPLICATION OF THE	*****	**COST REVIEW COMMISSION**
HOLY CROSS	*****	**DOCKET: 2015**
HOSPITAL	*****	**FOLIO: 2111**
SILVER SPRING, MARYLAND	*****	**PROCEEDING: 2301R**

Staff Recommendation

August 12, 2015

Introduction

On June 12, 2015, Holy Cross Hospital (the "Hospital"), submitted a partial rate application to the Commission requesting its July 1, 2015 Medical Surgical Intensive Care (MIS) and Coronary Care (CCU) approved rates be combined effective July 1, 2015 utilizing FY 2016 approved volumes and revenues.

Staff Evaluation

This rate request is revenue neutral and will not result in any additional revenue for the Hospital as it only involves the combining of two revenue centers. The Hospital wishes to combine these two centers because the majority of these services relate to medical/surgical intensive care versus coronary care; the patients have similar staffing needs; and nursing to patient staffing ratios for both patient populations are very similar. In addition, the Hospital will be consolidating these services into a single unit in November 2015. The Hospital's currently approved rates are as follows:

	Current Rate	Budgeted Volume	Approved Revenue
Medical Surgical Intensive Care	$1,714.92	12,791	$21,936,193
Coronary Care	$1,769.05	276	$488,016
Combined Rate	$1,716.09	13,067	$22,424,209

Recommendation

After reviewing the Hospital's application, the staff recommends as follows:

1. That the Hospital be allowed to collapse its CCU rate into its MIS rate effective July 1, 2015;
2. That FY 2016 approved volume and revenue will be utilized to calculate the combined rate; and
3. That no change be made to the Hospital's Global Budget Revenue.

IN RE: THE APPLICATION FOR	*****	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*****	**SERVICES COST REVIEW**	
DETERMINATION	*****	**COMMISSION**	
UNIVERSITY OF MARYLAND	*****	**DOCKET:**	**2015**
MEDICAL CENTER	*****	**FOLIO:**	**2112**
BALTIMORE, MARYLAND	*****	**PROCEEDING:**	**2302A**

Staff Recommendation

August 12, 2015

I. INTRODUCTION

The University of Maryland Medical Center ("Hospital") filed an application with the HSCRC on June 18, 2015 requesting approval to continue its participation in a global rate arrangement with Maryland Physicians Care ("MPC") for solid organ and blood and bone marrow transplant services for a period of one year beginning August 23, 2015.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by University Physicians, Inc. (UPI), which is a subsidiary of the University of Maryland Medical System. UPI will manage all financial transactions related to the global price contract including payments to the Hospital and bear all risk relating to services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospital will continue to submit bills to UPI for all contracted and covered services. UPI is responsible for billing the payer, collecting payments, disbursing payments to the Hospital at its full HSCRC approved rates, and reimbursing the physicians. The Hospital contends that the arrangement between UPI and the Hospital holds the Hospital harmless from any shortfalls in payment from the global price contract.

V. STAFF EVALUATION

Staff found that the actual experience under the arrangement for the last year has been favorable. Staff believes that the Hospital can continue to achieve favorable performance under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for solid organ and blood and bone marrow transplant services, for a one year period commencing August 23, 2015. The Hospital will need to file a renewal application for review to be considered for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospital for the approved contract. This document would formalize the understanding between the Commission and the Hospital, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN **RE: THE APPLICATION FOR**	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
UNIVERSITY OF MARYLAND	*	**DOCKET:**	**2054**
MMEDICAL CENTER	*	**FOLIO:**	**2115**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2305A**

Staff Recommendation

August 12, 2015

I. INTRODUCTION

University of Maryland Medical Center (the Hospital) filed an application with the HSCRC on July 30, 2015 seeking approval to participate in an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC to continue to participate in a global rate arrangement for solid organ and blood and bone marrow services with Interlink Health Services for a period of one year beginning November 1, 2015.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by University Physicians. Inc. ("UPI"), which is a subsidiary of the University of Maryland Medical System. UPI will manage all financial transactions related to the global price contract including payments to the Hospital and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating mean historical charges for patients receiving solid organ and blood and bone marrow transplant services at the Hospital. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will continue to submit bills to UPI for all contracted and covered services. UPI is responsible for billing the payer, collecting payments, disbursing payments to the Hospital at its full HSCRC approved rates, and reimbursing the physicians. The Hospital contends that the arrangement among UPI, the Hospital, and the physicians holds the Hospital harmless from any shortfalls in payment from the global price contract. UPI maintains that it has been active in similar types of fixed fee contracts for several years, and that UPI is adequately capitalized to bear the risk of potential losses.

V. STAFF EVALUATION

Staff found that the experience under this contract for the previous year was favorable.

Staff believes that the Hospital can continue to achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for solid organ and blood and bone marrow transplant services for a one year period commencing November 1, 2015. The Hospital will need to file a renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospital for the approved contract. This document would formalize the understanding between the Commission and the Hospital, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

HSCRC Consumer Engagement Taskforce Preliminary Report

Promoting Patient-Centered Approaches in the NAPM

HSCRC Meeting * August 12, 2014

CETF Members

Task Force Members

- Leni Preston, Chair
- Linda Aldoory, Herschel Horowitz Center for Health Literacy, University of Maryland
- Barbara Brookmyer, Frederick County Health Officer
- Kim Burton, Mental Health Association of Maryland
- Tammy Bresnahan, AARP
- Michelle Clark, Maryland Rural Health Association
- Shannon Hines, Kaiser Permanente
- Donna Jacobs, University of Maryland Medical System
- Michelle LaRue, CASA DE MARYLAND
- Karen Ann Lichtenstein, The Coordinating Center
- Susan Markley, HealthCare Access Maryland
- Suzanne Schlattman, Health Care for All!, MCHI
- Hillery Tsumba Primary Care Coalition of Montgomery County
- Gary Vogan, Holy Cross Hospital

DHMH Staff

- Dianne Feeney, HSCRC
- Theressa Lee, MHCC

CETF Charge #1

- Provide a rationale for health literacy and consumer engagement within the context of the New All-Payer Model (NAPM)
- Define audiences, identify messages, and propose engagement strategies as appropriate, including:
  - Systemic adjustments
  - Education and communication strategies
- Reflect the outcomes from the Communications and Community Outreach Task Force and the Care Coordination Workgroup

CETF Charge # 2

- Advise decision-makers, regulators, etc. on the impact of system transformation on individual and community health issues
- Provide guidance for ensuring an appropriate and consumer-friendly communications process
- Make recommendations for enhanced ways for consumers to provide feedback and for hospitals to act on that input

CETF Charge Fulfillment Process

- Monthly Taskforce Meetings
- Regular Subgroup Meetings
  - Charge 1-2 Subgroup
  - Consumer Outreach and Engagement Subgroup
- Weekly Leadership Meetings
- Ad-Hoc Committee Meetings and Assignments

CETF Charge Fulfillment Process

- Consultation and/or Presentations from Subject Matter Experts in:
  - Consumer Advocacy
  - Population Health
  - Consumer Engagement in Global Budget Environment
  - Consumer Complaints
  - Health Literacy
  - Consumer and Patient Advisory Boards
  - Evaluation
  - Care Coordination
  - Total Patient Revenue/Global Budgets
  - Performance Measurement

Recommendations

Consumer Engagement Goals

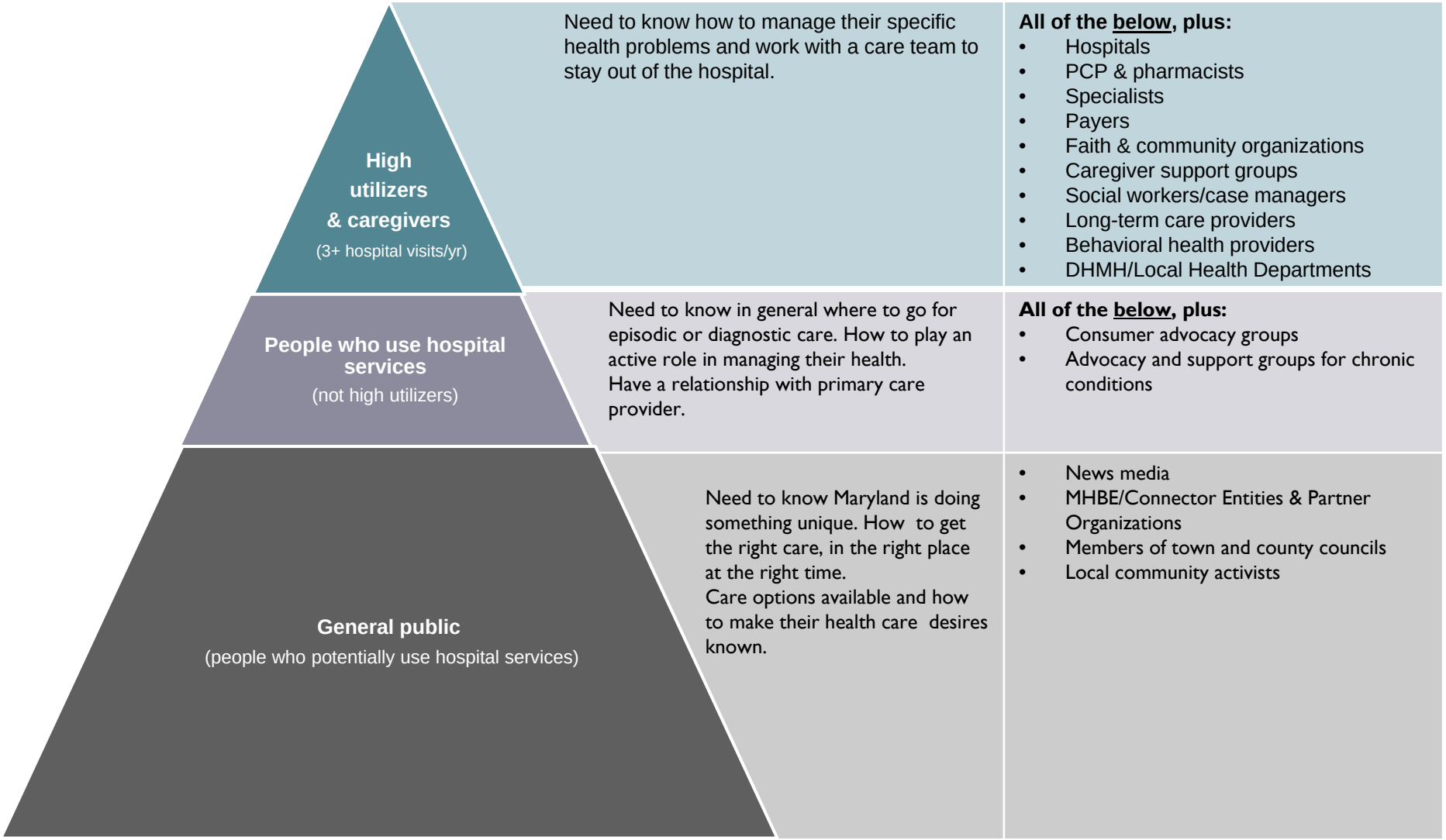
Goal #1

Establish a consumer-centered health care delivery system with an ongoing role for consumers to participate in the design and implementation of policies and procedures at all levels.

Goal #2

Engage, educate, and activate people who use or are potential users of hospital services in their own health care in order to promote efficient and effective use of the health care system.

Audiences Messages and Messengers



Communication Strategy:
Sample Recommended Strategies

Stakeholder	Strategy
All Stakeholders	Develop a statewide public education campaign to promote health and wellness.
Policymakers	Foster a consumer-centered health care system with policies and procedures informed by stakeholder involvement: • Consumer representative on HSCRC and standing advisory committee • Educate consumers on opportunities to serve on and/or interact with HSCRC and hospital patient and family advisory councils • Standardize hospital processes for receiving consumer feedback and establish data systems to aggregate and analyze feedback • Develop and promote a Consumer Gold Star system for hospitals based upon consumer engagement standards
Hospitals and Providers	Incentivize hospitals to support patients and caregivers ability to manage their own care, including access to community based health care resources.
Consumers	• Provide consumers with information and resources needed to make wise decisions and better manage their care. • Create a sense of ownership and involvement in the NAPM for the prime audiences by educating Marylanders about the NAPM and instilling pride and excitement that Maryland is creating a unique model of delivery system transformation • Engage local and regional news media to distribute frequent updates about the NAPM to their audiences

A Consumer-Centered Approach to Materials Development

- The following checklist serves as a minimum standards to ensure cultural/linguistic appropriateness of materials and accessibility of and efficacy of the messages provided:
  - Involve consumer representatives in developing materials
  - Use surveys and/or focus groups to solicit consumer feedback prior to mass production
  - Materials reflect the cultural and linguistic diversity of the populations served
  - Involve health literacy experts to ensure basic health literacy and CLAS standards are followed
  - Write materials for consumers at a 6th grade reading level
  - Ensure electronic materials are Section 508 compliant
  - All information is available in at least one format that is appropriate for all ability types and literacy levels
  - All information is available in print, online, and mobile formats allowing each consumer to select the format that is most helpful to him/her

CETF Final Report to Commission

- Overview, Vision, Mission, Principles, Goal, and Objectives
- Review of Existing Consumer Engagement Infrastructure
- Opportunities to Strengthen Infrastructure
- Recommended Communication Strategy
- Recommendations and Immediate Next Steps

CETF Next Steps

- Identify and Address Gaps in Information or Learnings
- Finalize Communication Strategy
- Finalize and Submit Report to Commission

Questions?

Hospital CON Applications – August 5, 2015

	Applicant	Project Description	Cost	Status
Active Hospital Relocation Projects	**Washington Adventist Hospital – Takoma Park (Montgomery Co.)**	Relocation of acute general hospital (170 beds) except for psychiatric services) to Silver Spring (approx.. 6 miles NE of current location) Reconfiguration of existing campus to create special hospitals for psychiatric and acute rehabilitation services + outpatient services including 24/7 urgent care	Estimated Cost:: **$330,829,524 for** relocated general hospital **$5,223,506 for** Takoma Park Total: **$336,053,030** Source of Funds: Equity: **$51M** Debt: **$245M** Other: **$36M**	Docketed Jan. 2015 Three opposing interested parties; Laurel, Regional, Medstar Montgomery, & Holy Cross of Silver Spring City of Takoma Park is a participating entity Commissioner Phillips is Reviewer
	Prince George"s Hospital Center - Cheverly (Prince George's Co.)	Relocation of acute general and special hospital (231 beds – 216 acute general and 15 for Mt. Washington Pediatric) to Largo (approx.. 5 miles SE of current location)	Estimated Cost: **$651,223,000** Source of Funds: Equity: **$0** Debt: **$207M** Other: **$445M**	Docketed April 2015 Two opposing Interested parties: Doctors Community & Anne Arundel Prince George;s Co. HD is supportive interested party . Commissioner Moffit is Reviewer
	Sheppard Pratt at Ellicott City - Ellicott City (Howard Co.)	Relocation of special hospital-psychiatric (100 beds) to Elkridge	Estimated Cost: **$102,653,372** Source of Funds: Equity: **$18M** Debt: **$70M** Other: **$15M**	Filed April 2015 Not yet docketed
Other Active Hospital Projects	**Anne Arundel Medical Center - Annapolis (Anne Arundel Co.)**	Introduce cardiac surgery	Estimated Cost: **$2,500,381** All cash	Docketed June 2015 Interested party filing in opposition by MedStar
	University of Maryland Baltimore Washington Medical Center - Glen Burnie (Anne Arundel Co.)	Introduce cardiac surgery	Estimated Cost: **$1,259,117** All cash	Docketed June 2015 Interested party filing in opposition by MedStar
	Suburban Hospital - Bethesda (Montgomery Co.)	Major expansion & renovation Replace ORs, create new main entrance, add nursing units to create more private rooms, expand support service & mechanical space, shelled space, medical office space 300K SF in new consr. & 18K in renovation	Estimated Cost: **$200,550,831** Source of Funds: Equity: **$91M** Debt: **$70M** Other: **$40M**	Filed April 2015 Not yet docketed

	Inactive Hospital Projects			
	University of Maryland Shore Medical Center at Easton - Easton (Talbot Co.)	Relocation of general acute care hospital and special hospital unit for rehabilitation (126 beds) Approx. 2 miles NW of current site	Estimated Cost: **$283,240,375** Source of Funds: Equity: **$10M** Debt: **$243M** Other: **$31M**	Docketed Jan 2013 Inactive since 2014 – anticipated activation in late 2015
	MedStar Southern Maryland Hospital Center - Clinton (Prince George's)	Major expansion & renovation Four-story addition plus basement (165K SF) Renovation (44K SF) Modernize and expand the:ED, Surgery., ICU/CCU Establish a 32-bed dedicated Observation Unit	Estimated Cost: **$131,712,678** Source of Funds: Equity: **$37M** Debt: **$89M** Other: **$5M**	Not docketed Not responsive to questions posed in April, 2014

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Proposed Hospital Capital Projects: 2012-2015

A presentation to the Health Services Cost Review Commission

August 14, 2015

Center for Health Care Facilities Planning and Development
Maryland Health Care Commission

MARYLAND HEALTH CARE COMMISSION

Chronology

Filed in 2012

- **Fort Washington Medical Center: $20 M - Expansion/Renovation**
  Reconfigured to avoid CON regulation. Declined acceptance of "pledge" determination. Withdrawn.
- **University of Maryland Shore Medical Center at Easton: $283 M - Relocation/Replacement**
  Docketed. Inactive.

Filed in 2013

- **Washington Adventist Hospital: $331 M - Relocation/Replacement**
  Docketed. Active review.
- **Prince George's Hospital Center: $651 M - Relocation/Replacement**
  Docketed. Active review.
- **MedStar Southern Maryland Hospital Center: $132 M - Expansion/Renovation**
  Not docketed. Inactive.

Filed In 2015

- **Anne Arundel Medical Center: $2.5 M - Introduce Cardiac Surgery**
  Docketed. Active review.
- **University of Maryland Baltimore Washington Medical Center: $1.3 M - Introduce Cardiac Surgery**
  Docketed. Active review.
- **Sheppard Pratt at Ellicott City: $103 M - Relocation/Replacement**
  Not docketed. Active review.
- **Suburban Hospital: $201 M - Expansion/Renovation**
  Not docketed. Active review.

Relocation/Replacement Projects

	Gen. Acute Beds Lic.	PBC	Proposed	SF	Capital Costs	Total Costs
SMCE	112	184	112	359K	$265.6M	$283.2M
WAH	230	309	170/210	428K	$301.5M	$330.8M
PGHC	237	296	216	750K	$615.9M	$651.2M
SP/EC	92	92	100	171K	$100.7M	$102.7M

Source: MHCC/CON Applications

Relocation/Replacement Projects

	Source of Funds			Annual Interest/Depreciation/Amortization	
	Equity	Debt	Other	Most Recent	Post-Project
SMCE	$10M	$243M	$31M	$14M	$30M
WAH	$51M	$245M	$36M	$8M	$30M
PGHC	$0	$207M	$445M	$9M	$40M
SP/EC	$18M	$70M	$15M	$252K	$7M

Source: CON Applications/Audited Financial Statements

Expansion/Renovation Projects

	Source of Funds			Annual Interest/Depreciation/Amortization	
	Equity	Debt	Other	Most Recent	Post-Project
SMHC	$37M	$89M	$5M	$10M	$19M
Suburban	$91M	$70M	$40M	$16M	$31M

Source: CON Applications/Audited Financial Statements

More Information

The complete CON application filings for these projects can be found at:

http://mhcc.maryland.gov/mhcc/Pages/hcfs/hcfs_con/hcfs_con_filed_applications.aspx

Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

Chapter 10 Rate Application and Approval Procedures

Authority: Health-General Article, §§ 19-201, and 19-207; Annotated Code of Maryland

NOTICE OF PROPOSED ACTION

The Health Services Cost Review Commission proposes to amend Regulations **.07-1** under **COMAR 10.37.10 Rate Application and Approval Procedures**. This action was considered and approved for promulgation by the Commission at a previously announced open meeting held on August 12, 2015, notice of which was given pursuant to General Provisions Article, § 3-302(c), Annotated Code of Maryland. If adopted, the proposed amendments will become effective on or about November 23, 2015.

Statement of Purpose

The purpose of this action is to conform to legislation passed in the 2015 General Assembly, which establishes that outpatient services associated with the federal 340B Program and that meet certain criteria shall be considered provided "at the hospital" and thereby subject to HSCRC rate jurisdiction.

Comparison of Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

See Statement of Economic Impact.

Opportunity for Public Comment

Comments may be sent to Diana M. Kemp, Regulations Coordinator, Health Services Cost Review Commission, 4160 Patterson Avenue, Baltimore, Maryland 21215, or (410) 764-2576, or fax to (410) 358-6217, or email to diana.kemp@maryland.gov. The Health Services Cost Review Commission will consider comments on the proposed amendments until October 5, 2015. A hearing may be held at the discretion of the Commission.

.07-1 Outpatient Services – At the Hospital Determination.

A. (text unchanged)

B. (text unchanged)

C. In accordance with Health-General Article, § 19-201, Annotated Code of Maryland, the Commission's rate-setting jurisdiction extends to outpatient services provided at the hospital. *Outpatient services associated with the federal 340B Program under the federal Public Health Service Act provided in a department of a regulated hospital that, on or before June 1, 2015, is under a merged asset hospital system, and which are physically located at another regulated hospital under the same merged asset hospital system, shall be subject to the rate-setting jurisdiction of the Commission.*

D.-J. (text unchanged)

JOHN M. COLMERS
Chairman
Health Services Cost Review Commission

Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

Chapter 10 Rate Application and Approval Procedures

Authority: Health-General Article, §§ 19-207, 19-219, and 19-222; Annotated Code of Maryland

NOTICE OF PROPOSED ACTION

The Health Services Cost Review Commission proposes to amend Regulations **.10** under **COMAR 10.37.10 Rate Application and Approval Procedures**. This action was considered and approved for promulgation by the Commission at a previously announced open meeting held on August 12, 2015, notice of which was given pursuant to General Provisions Article, § 3-302(c), Annotated Code of Maryland. If adopted, the proposed amendments will become effective on or about November 23, 2015.

Statement of Purpose

The purpose of this action is to assure that rate applications are submitted in easily readable formats.

Comparison of Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

The proposed action has no economic impact.

Opportunity for Public Comment

Comments may be sent to Diana M. Kemp, Regulations Coordinator, Health Services Cost Review Commission, 4160 Patterson Avenue, Baltimore, Maryland 21215, or (410) 764-2576, or fax to (410) 358-6217, or email to diana.kemp@maryland.gov. The Health Services Cost Review Commission will consider comments on the proposed amendments until October 5, 2015. A hearing may be held at the discretion of the Commission.

.10 Docketing and Receipt.

A. – B. (text unchanged)

C. The hospital shall file an original and three copies of each rate application and its supporting documents, if any. *The Commission may prescribe the format to be used in the submission of rate applications and their supporting documents.* In addition, the hospital shall file with each rate application a certificate of service indicating that the application and supporting documents have been mailed or served upon all designated parties to that proceeding and upon the Commission at its offices.

JOHN M. COLMERS
Chairman
Health Services Cost Review Commission

Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

Chapter 01 Uniform Accounting and Reporting System for Hospitals and Related Institutions

Authority: Health-General Article, §§ 19-207, 19-212, and 19-215; Annotated Code of Maryland

NOTICE OF PROPOSED ACTION

The Health Services Cost Review Commission proposes to amend Regulations **.02** under **COMAR 10.37.01 Uniform Accounting and Reporting System for Hospitals and Related Institutions**. This action was considered and approved for promulgation by the Commission at a previously announced open meeting held on August 12, 2015, notice of which was given pursuant to General Provisions Article, § 3-302 (c), Annotated Code of Maryland. If adopted, the proposed amendments will become effective on or about November 23, 2015.

Statement of Purpose

The purpose of this action is to update the Commission's manual entitled "Accounting and Budget Manual for Fiscal and Operating Management (August, 1987), which has been incorporated by reference.

Comparison of Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

The proposed action has no economic impact.

Opportunity for Public Comment

Comments may be sent to Diana M. Kemp, Regulations Coordinator, Health Services Cost Review Commission, 4160 Patterson Avenue, Baltimore, Maryland 21215, or (410) 764-2576, or fax to (410) 358-6217, or email to diana.kemp@maryland.gov. The Health Services Cost Review Commission will consider comments on the proposed amendments until October 5, 2015. A hearing may be held at the discretion of the Commission.

02 Accounting System; Hospitals.

A. The Accounting System.

(1) (text unchanged)

(2) The “Accounting and Reporting System for Hospitals”, also known as the Accounting and Budget Manual for Fiscal and Operating Management (August, 1987), is incorporated by reference, including the following supplements:

(a)- (t) (text unchanged)

(u) Supplement 21 (June 5, 2012); [and]

(v) Supplement 22 (March 3, 2014) [.] ; and

(w) Supplement 23 (July 28, 2015).

(3) – (5) (text unchanged)

B. – D. (text unchanged)

JOHN M. COLMERS

Chairman
Health Services Cost Review Commission

State of Maryland
Department of Health and Mental Hygiene

John M. Colmers
Chairman

Herbert S. Wong, Ph.D.
Vice-Chairman

George H. Bone, M.D.

Stephen F. Jencks, M.D., M.P.H.

Jack C. Keane

Bernadette C. Loftus, M.D.

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Donna Kinzer
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Principal Deputy Director
Policy and Operations

David Romans
Director
Payment Reform
and Innovation

Gerard J. Schmith
Deputy Director
Hospital Rate Setting

Sule Gerovich, Ph.D.
Deputy Director
Research and Methodology

TO: **Commissioners**

FROM: **HSCRC Staff**

DATE: **August 5, 2015**

RE: **Hearing and Meeting Schedule**

September 9, 2015	To be determined - 4160 Patterson Avenue HSCRC/MHCC Conference Room
October 14, 2015	To be determined - 4160 Patterson Avenue HSCRC/MHCC Conference Room

Please note that Commissioner's binders will be available in the Commission's office at 11:45 a.m..

The Agenda for the Executive and Public Sessions will be available for your review on the Thursday before the Commission meeting on the Commission's website at http://www.hscrc.maryland.gov/commission-meetings-2015.cfm

Post-meeting documents will be available on the Commission's website following the Commission meeting.