Maryland Health Care Commission

Thursday, January 21, 2016

1:00 p.m.

MARYLAND HEALTH CARE COMMISSION

AGENDA

1. **APPROVAL OF MINUTES**
2. UPDATE OF ACTIVITIES
3. ACTION: Approval of Release of MCDB Data to Johns Hopkins Bloomberg School of Public Health
   a. Center for Population Health Information Technology
   b. Jill Marsteller
4. PRESENTATION: Electronic Health Record Incentive Report
5. PRESENTATION: Cost and Utilization Portal Version 1.0: An Overview and Our Strategy for Engagement
6. PRESENTATION: 2016 Legislative Session
   a. Overview of MHCC's Legislative Review Process
   b. Proposed Legislation
7. WORK SESSION: Hospital Conversions: the Issues, MHCC's authority, and Legislative Proposals
8. OVERVIEW OF UPCOMING INITIATIVES
9. ADJOURNMENT

MARYLAND HEALTH CARE COMMISSION

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Approval of Release of MCDB Data to Johns Hopkins Bloomberg School of Public Health

a) Center for Population Health Information Technology
b) Jill Marsteller

(Agenda Item #3)

MCDB Data Releases – JHSPH

COMMISSION MEETING

JANUARY 21, 2016

Overview

- Goal: Review and vote on application for MCDB Data by Johns Hopkins Bloomberg School of Public Health:
  - Center for Population Health Information Technology, PI: Jonathan Weiner
  - Extension of Maryland Multi-Payor Patient Centered Medical Home Evaluation, PI: Jill Marsteller
- Framework for evaluation of applications
- JHSPH application details
- IRB Review

Framework for Evaluation

- Appropriate use of data
  - Is it a permitted use?
  - Is the data appropriate for the project?
- Qualified user
  - Does the applicant have expertise with this type of data?
  - Does applicant have expertise with the specified analyses/projects
- Data Security / Data Management Plan
  - Is there an appropriate plan for securing the data?
  - Is access restricted to qualified users?
  - Adherence to limitations on re-release and reporting of data

JHSPH Application - CPHIT

- Appropriate Use
  - Develop an academic research program
    - Serve as an internal hub for MCDB storage, maintenance, and data security
    - Review and approve releases of data to faculty and students, with centralized data security
    - JHSPH IRB will review all projects
  - Known Projects:
    - **"Evaluation of the Total Patient Revenue Program in Rural Maryland Hospitals"** PI: Bradley Herring, PhD:
    - **Contraceptive Counseling: Building a new provider tool to tailor predictions of contraceptive outcomes to patient sub-populations"**: PI: Caroline Moreau, MD, PhD
- Qualified User
  - JHSPH and the Center for Population Health Information Technology have extensive experience with these types of analyses and are a leading research organization in the area of health policy research.
  - The known project teams has specific expertise with similar analyses, using both state and federal claims data.
- Data Security / Data Management Plan
  - JHSPH has provided appropriate documentation of its data management plan to secure MCDB Data
  - Access to MCDB data will be centrally controlled and all users will be identified to MHCC in the DUA an subsequent reports

JHSPH Application - CPHIT

- Data request is for Commercial and Medicaid Data for CY 2010-2014
- MCDB includes eligibility records and claims files (professional, institutional, and pharmacy)
  - No direct identifiers in the data, such as name, address, SSN, etc.
  - Indirect identifiers include gender, age, zip code of residence, dates of service.
  - Member ID's will be masked to permit linking across MCDB files.
    - DUA will prohibit linking beyond MCDB files at the member level
    - DUA will prohibit efforts to re-identify members
  - No individual payor identification

Recognition of JHSPH IRB and IRB Review

- The JHSPH IRB has been previously recognized by the Commission in May 2016
- JHSPH's IRB has reviewed and qualified both known applications as exempt from IRB review based on 45 CFR 46.101(b)(4): "*Research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available or if the information is recorded by the investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects*"

Next Steps - CPHIT

- If approved by Commissioners, MHCC staff will execute a DUA with JHSPH and release data.
- Ongoing compliance review under DUA

JHSPH Application – Marsteller/MMPP

- Appropriate Use
  - Extend analyses beyond the MMPP evaluation with the goal of better understanding the variation across practices in implementation of MMPP and the outcomes evaluated
  - Hypothesized key factors:
    - Variations in structural and contextual features of primary care practices;
    - A practice's organization of care provision, leadership, and team functioning, and providers' perceptions of the program; and
    - Patients' trust in their providers.
- Qualified User
  - JHSPH and the Department of Health Policy and Management have extensive experience with these types of analyses and are a leading research organization in the area of health policy research.
  - Dr. Marsteller's team has extensive experience with these types of analyses , most recently as part of the evaluation team for the MMPP
- Data Security / Data Management Plan
  - JHSPH has provided appropriate documentation of its data management plan to secure MCDB Data
  - Access to MCDB data will be restricted to project staff, who will be identified to MHCC in the DUA

JHSPH Application

- Data request is for data developed during the MMPP evaluation, including MCDB, Maryland Board of Physicians, and Patient and Practice Surveys
- MCDB includes eligibility records and claims files (professional, institutional, and pharmacy)
  - No direct identifiers in the data, such as name, address, SSN, etc.
  - Indirect identifiers include gender, age, zip code of residence, dates of service.
  - Member ID's will be masked to permit linking across MCDB files.
    - DUA will prohibit linking beyond MCDB files at the member level
    - DUA will prohibit efforts to re-identify members
  - No individual payor identification
- Board of Physician data provides physician license information, including demographics, specialty, and practice location
- Patient and Provider Surveys queried respondents on a variety of dimensions relevant to the MMPP

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Next Steps – Marsteller/MMPP

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MARYLAND HEALTH CARE COMMISSION

PRESENTATION:

Electronic Health Record Incentive Report

(Agenda Item #4)

State-Regulated Payor Electronic Health Records Incentive Program

Summary of Program Progress

January 21, 2016

The MARYLAND
HEALTH CARE COMMISSION

State Incentive Program

- Maryland law enacted in 2009 requires the Maryland Health Care Commission (MHCC) to establish electronic health record (EHR) adoption incentives from certain State-regulated payors (payors)
  - Law aims to promote EHR adoption and use among practices in Maryland, given the relatively low EHR diffusion in 2009
  - In 2009, EHR adoption among Maryland office-based physicians was19 percent, compared to a national rate of 22 percent
  - MHCC convened the Payor EHR Adoption Incentive Program (State incentive program) Workgroup to develop recommendations, which framed the regulations
  - The regulations went into effect on April 21, 2011 and was amended on October 21, 2011

Key Provisions

- Eligibility – Primary care practices, including family, general, internal medicine, pediatrics, geriatrics, and gynecology
- Must adopt a certified EHR in order to qualify
- The six largest private payors required to provide incentives include: Aetna, CareFirst, Cigna, Coventry, Kaiser Permanente, and United Healthcare
- One time payment per payor per practice
- Incentive of up to $15,000 – based on the practice's panel members, calculated at $25 per member

2013 State Incentive Program Assessment

Alignment with the Federal Incentive Programs

2013 State Incentive Program Assessment

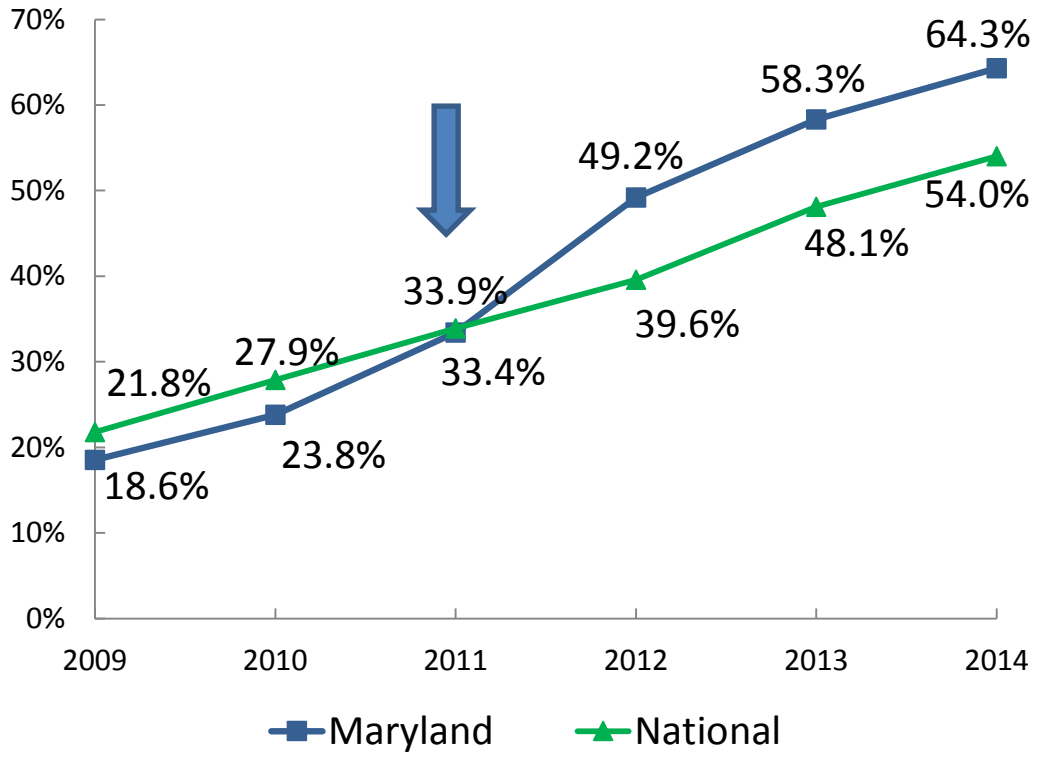
- Staff assessed the progress of the State incentive program to ensure it continues to meet the intent of the law
- Findings:
  - Incentives were largely aimed at paying for the purchase of EHR software (rebates)
  - Program was misaligned with the federal incentive programs creating operational challenges for primary care practices
  - Participation trailed significantly when compared to the federal incentive programs
    - About four percent of eligible primary care physician practices had received a State incentive-compared to 29 percent that had received a federal incentive

Source: Data reported by payors for period October 2011 – April 2013

Key State Incentive Program Changes

- Amended regulations effective June 9, 2014; program changes effective October 7, 2014
  - Qualification for an EHR incentive payment: (1) one or more physicians within the practice have attested to meaningful use (MU); or (2) a primary care physician practice participates in an MHCC approved Patient Centered Medical Home (PCMH) program and achieves National Committee for Quality Assurance PCMH recognition
  - Streamline application and payment process
  - Clarify the definition of a primary care practice eligible for an incentive payment
  - Extend the sunset date by two years to December 31, 2016

EHR Adoption Among Office-based Physicians



EHR adoption among Maryland office-based physician has increased from 33.4 percent in 2011 (around the time the State incentive program went into effect) to 64.3 percent in 2014

Sources:

- Maryland Data – Maryland Board of Physicians
- National Data – 2009-2013 National Center for Health Statistics
- National Data – Centers for Medicare and Medicaid Services EHR Incentive Program data, December 2014

State Incentive Program Progress

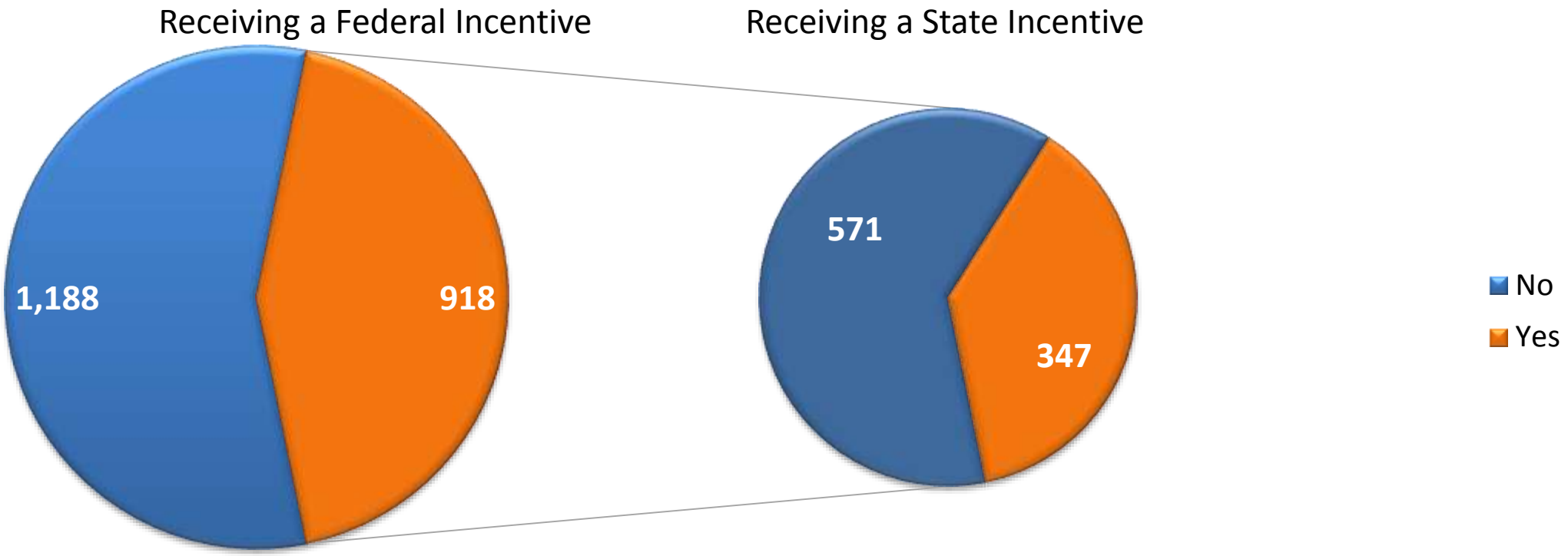
- Between April and September 2015, practices receiving only a federal incentive decreased from 62 percent to 57 percent
- The number of participating practices has grown annually at a rate of about 40 percent since April 2013
- The average number of applications that resulted in payments increased from 33 per month under the previous program to 38 per month under the revised program

Source: Data reported by payors for period October 2011 – September 2015

State Incentive Program Progress

Payor	October 2014-March 2015		April 2015-September 2015		October 2011-September 2015	
	6 months		6 months		46 months	
	Payments Made (#)	Total Paid ($)	Payments Made (#)	Total Paid ($)	Payments Made (#)	Total Paid ($)
Aetna, Inc.	52	211,190	37	56,200	326	2,517,271
CareFirst BlueCross BlueShield	48	345,425	79	492,600	395	3,727,777
CIGNA Health Care Mid-Atlantic Region	61	77,301	31	18,875	337	243,725
Coventry Health Care	30	29,775	19	9,425	215	1,369,760
Kaiser Permanente	9	32,229	6	15,650	47	243,059
UnitedHealthcare, MidAtlantic Region	57	178,667	32	96,700	295	939,775
Total Practice Payments	**257**	**874,587**	**204**	**689,450**	**1,615**	**9,041,367**

Estimated Federal and State Incentive Program Participation among Primary Care Practices



Approximately 38 percent of eligible primary care practices receiving a Medicare or Medicaid incentive also received a State incentive

Sources:

- Data reported by payors for period October 2011 – September 2015
- Medicare and Medicaid EHR Incentive Data, DHMH, September 2015

On the Horizon

- Assess opportunities for Management Service Organizations and medical associations to bolster practice awareness of the State incentive program
- Collaborate with stakeholders on potential program changes required to create value in extending the State incentive program beyond the 2016 sunset date in regulation
  - Explore the impact of more broadly aligning the State incentive program with participation in value-based care delivery models
    - HHS has set a goal to have 30 percent of Medicare payments in alternative payment models by the end of 2016 and 50 percent by the end of 2018
  - Ensure that any program changes do not impact existing carrier operations
- Finalize recommendation for the Commission by September 2016

Thank You!

The MARYLAND
HEALTH CARE COMMISSION

Appendix

Federal Incentive Programs Eligibility

Medicare	Medicaid	
Doctors of medicine or osteopathy	**Doctors of medicine or osteopathy**	30% minimum Medicaid patient volume *20% for Pediatricians Or EP practices predominately in FQHC or RHC with 30% needy individual patient volume
Doctors of podiatric medicine	Nurse practitioners	
Doctors of optometry	Certified nurse-midwives	
Chiropractors	Dentists	
Doctors of dental surgery or dental medicine	Physicians assistants working in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) that is so led by a physicians assistant	
Hospital-based EPs are NOT eligible for incentives 90% or more of their covered professional services in either an inpatient (POS 21) or emergency room (POS 23) of a hospital		

* Receives 2/3 of a Physician's incentive amount

Federal Incentive Programs Background

- The American Recovery and Reinvestment Act of 2009 authorizes the Centers for Medicare & Medicaid Services (CMS) to provide incentive payments to eligible professionals (EPs) and hospitals
- CMS Medicare and Medicaid EHR Incentive programs (federal incentive programs) began January 2011
- Must adopt, implement, upgrade, or demonstrate MU of certified EHR technology to receive an incentive
  - Maximum Medicare incentive of $44,000 over five years through 2016
  - Maximum Medicaid incentive of $63,750 over six years through 2021
- MU requirements were developed to become more advanced as EPs and hospitals progress through three stages

State EHR Incentive Program Progress by Payor

Payor	October 2011 – April 2013		May 2013 - December 2013		January 2014 - September 2014		October 2014 - March 2015		April 2015- September 2015		October 2011 - September 2015	
	18 months		8 months		9 months		6 months		6 months		46 months	
	Payments Made (#)	Total Paid ($)	Payments Made (#)	Total Paid ($)	Payments Made (#)	Total Paid ($)	Payments Made (#)	Total Paid ($)	Payments Made (#)	Total Paid ($)	Payments Made (#)	Total Paid ($)
Aetna, Inc.	84	848,842	47	426,941	106	974,098	52	211,190	37	56,200	326	2,517,271
CareFirst BlueCross BlueShield	86	932,736	84	920,040	98	1,036,976	48	345,425	79	492,600	395	3,727,777
CIGNA Health Care Mid-Atlantic Region	80	31,412	94	63,235	71	52,902	61	77,301	31	18,875	337	243,725
Coventry Health Care	70	551,592	39	326,796	57	452,172	30	29,775	19	9,425	215	1,369,760
Kaiser Permanente	5	39,228	12	47,248	15	108,704	9	32,229	6	15,650	47	243,059
UnitedHealthcare, MidAtlantic Region	85	247,584	75	271,648	46	145,176	57	178,667	32	96,700	295	939,775
Total	**410**	**2,651,394**	**351**	**2,055,908**	**393**	**2,770,028**	**257**	**874,587**	**204**	**689,450**	**1,615**	**9,041,367**
Total Unique Practices	**107**		**124**		**169**		**100**		**91**		**406**	

Source: Data reported by payors for period October 2011–September 2015

* Includes both Base and Additional incentive amounts, where applicable.

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Cost and Utilization Portal Version 1.0: An Overview and Our Strategy for Engagement

Web Site 1(Open)
Web Site 2(Protected)

(Agenda Item #5)

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MARYLAND HEALTH CARE COMMISSION

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2016 Legislative Session

a) Overview of MHCC's Legislative Review Process
b) Proposed Legislation

(Agenda Item #6)

2016 Legislative Process

Erin Dorrien

Government and Public Affairs

Presentation Overview

- Bill Review
- Position Paper Development
- Administration Legislation
- Departmental Legislation
- Privately Sponsored Legislation
- Budget Process
- Session Dates of Interest

Bill Review

- Position of the Commission based on stated priorities or statutory responsibility
- Position of the Administration and other Executive Branch agencies
- Issue precedent
- Actions
  - Letter of Information/ Letter of Concern
  - Support
  - Support with Amendment
  - Oppose

Position Paper Development

- Bill review conference calls will be held as needed

Administration Legislation

- Administration Proposals are the Highest Priority
  - *Any amendments to Administration legislation should ONLY be offered by the Governor's Legislative Office, unless otherwise directed.*
  - Concerns about language in Administration legislation or suggestions for amendments should be addressed to the appropriate person on the Governor's staff.

Departmental Legislation

- All executive department bills are approved by the Governor's Legislative Office before introduction; no Executive Branch representative may oppose a departmental bill before the General Assembly.
  - Concerns that arise after introduction should be brought to the attention of the sponsoring agency and, if necessary, the Legislative Office.
  - Any amendments which a non-sponsoring department feels are necessary should be agreed to and offered by the sponsoring department.
  - Conflicts will be resolved by the Legislative Office of the Governor.

Privately Sponsored Legislation

- Coordinate with the Department on positions
- Legislative liaisons discuss varying positions at weekly Friday meeting
- Generally, conflicts between agencies should be avoided

Budget

- Budget introduced by the Governor and assigned to Budget Committees

- Budget Hearings Scheduled
  - House Appropriations- February 11th
  - Senate Budget and Tax- February 12th

- Chamber Decisions

- Conference Committee

Session Dates of Interest

- **January 13-** General Assembly Convenes
- **January 20-** Budget Bill Introduction
- **February 3-** State of the State
- **February 5-** Senate Bill Introduction Date
- **February 12-** House Bill Introduction Date
- **March 7-** Final date for introduction of bills without suspension of Rules
- **April 4-** Budget bill to be passed by both chambers
- **April 11-** Sine Die

MHCC Briefing and Hearing Dates

- **January 19nd-** Health and Government Operations
  - Health IT Update
  - Self-Referral Workgroup
- **February 4th-** Health and Government Operations
  - Briefing on Hospitals Conversions
- **February 11th-** House Appropriations HHR Subcommittee
  - Budget Hearing
- **February 12th-** Senate Budget and Tax HHS Subcommittee
  - Budget Hearing

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WORK SESSION:

Hospital Conversions: the Issues, MHCC's authority, and Legislative Proposals

(Agenda Item #7)

GENERAL HOSPITALS IN TRANSITION

Issues, Regulatory Authority, Legislation

January 21, 2016

Paul Parker
Center for Health Care Facilities Planning and Development

MHCC | MARYLAND HEALTH CARE COMMISSION

Currently Announced Plans and Plans Under Consideration

- Laurel Regional Hospital – in 2015 announced plan to phase out inpatient services & reconfigure campus for outpatient care, including 24/7 emergency center
- UM Shore Medical Center at Chestertown – Shore Health engaging with community about strategic options – transition to an outpatient campus is an option being considered
- Commission staff is aware of planning for a similar general hospital transition

Current Regulatory Policy

- Hospitals do not need State approval to close or partially close. A hospital must provide 45 days notice. In jurisdictions with less than 3 hospitals, it must hold a public informational hearing & address access, work force, and building reuse.

- If outstanding public obligations exist for the closing hospital, it must provide notice to MHHEFA and HSCRC.
- The current law's transition option, conversion to a "limited service hospital," requires exemption from CON.
- Some new facilities included in a transition plan could require a CON (e.g., ambulatory surgical facility) or would require a CON (e.g., specialty hospital, freestanding medical facility).

Current Regulatory Policy

Limited Service Hospital

- Can only be established through transition of a general hospital
- Provides 24/7 emergency services
- Cannot provide inpatient care – no overnight stays
- Created in the 1990s but never implemented as a transition model

Freestanding Medical Facility

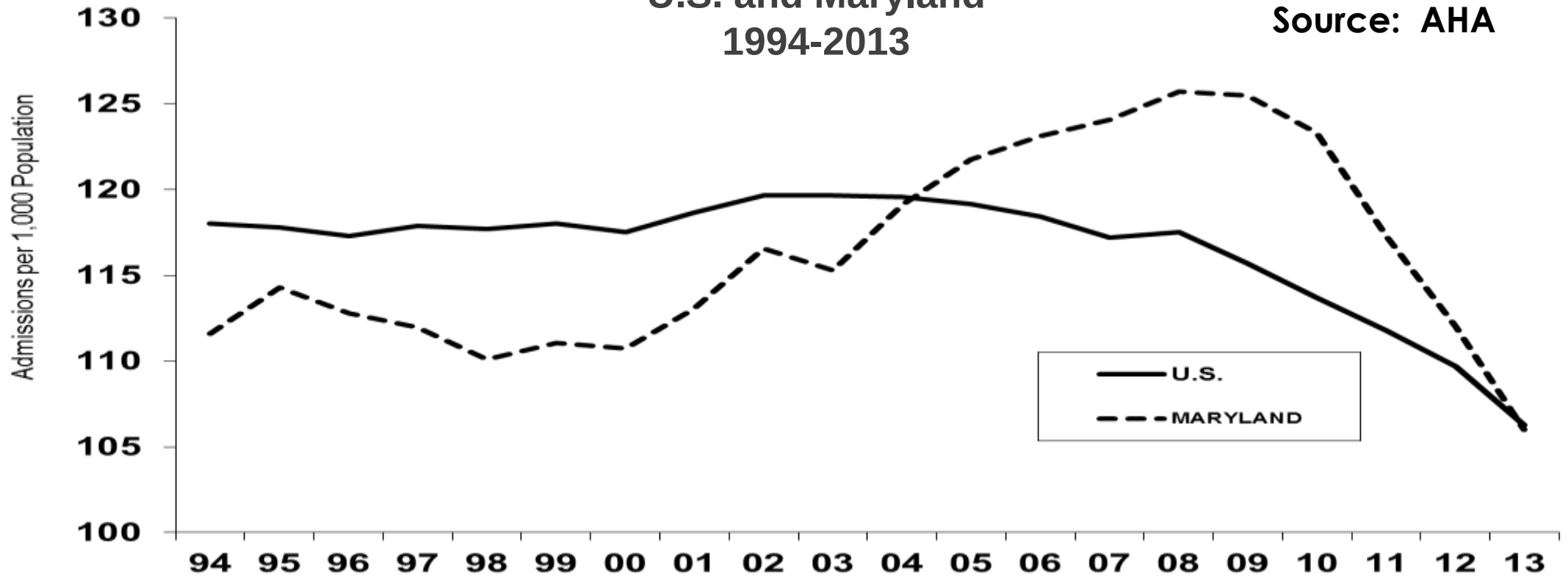
- Can only be established by a general hospital acting as a parent base for a satellite facility
- Like an LSH, provides 24/7 emergency services
- Not currently allowed to bill for inpatient or observation services by HSCRC
- Created in 2006 – three FMFs in operation currently
- Requires CON – State Health Plan chapter projected for Summer, 2016

Recent Trends in Hospital Use

The use of hospitals by the population is declining

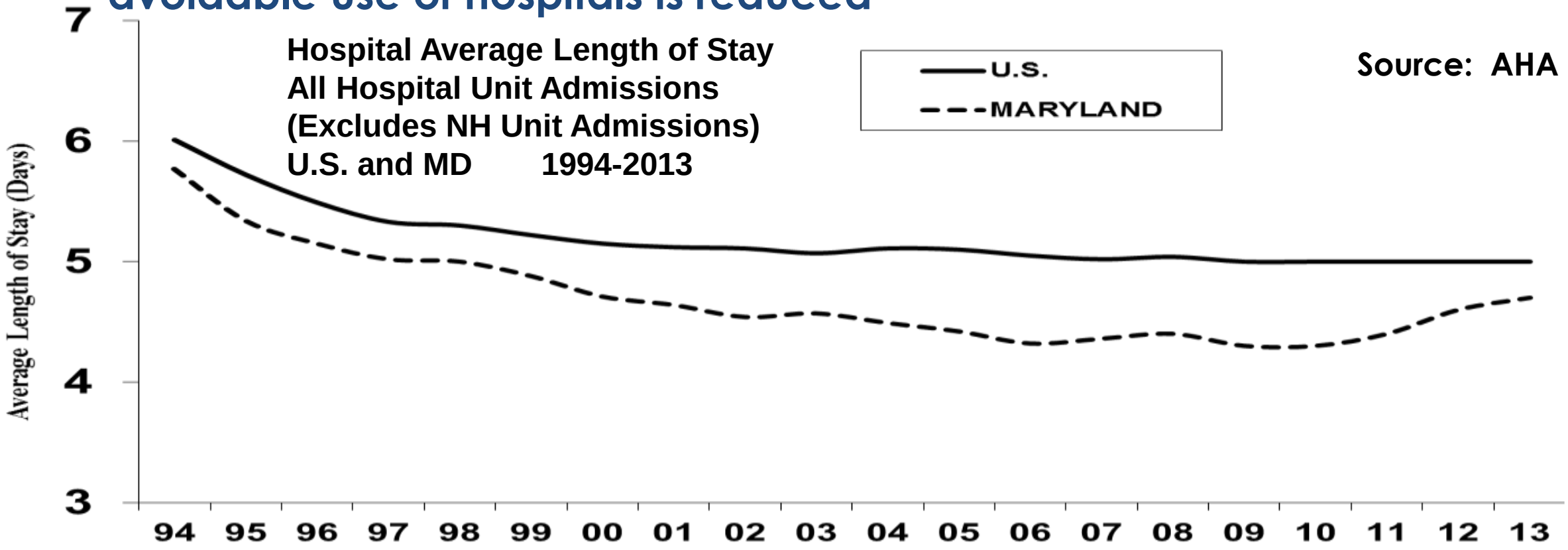
Hospital Admissions per 1,000 Population
All Hospital Unit Admissions (Excludes NH Unit Admissions)
U.S. and Maryland
1994-2013

Source: AHA



Recent Trends in Hospital Use

Hospital average length of stay may continue to rise as potentially avoidable use of hospitals is reduced



Recent Trends in Hospital Use

MSGA Discharge Rate per Thousand Population, Maryland CY 2005- CY 2014

	Medicare	Non-Medicare	Total
2005-06	387.0	72.9	119.5
2007-08	387.5	73.1	120.2
2009-10	375.9	71.1	117.2
2011-12	335.5	62.3	105.3
2013-14	298.1	53.7	94.1

Source: MHCC, Discharge Data Base

Recent Trends in Hospital Use

Average Daily Census of General Hospital Patients
All Maryland Hospitals - FY2011-FY2015

FY 2011	7,556
FY 2012	7,388
FY 2013	7,226
FY 2014	7,000
FY 2015	6,997

-7.4%

Source: MHCC, Discharge Data Base

Recent Trends in Hospital Use

Highest Rate of Decline in Total ADC - FY2011-FY2015

	ADC Decline	Licensed Beds	ADC, FY 15
E.W. McCready	56%	4	2.9
Bon Secours	43%	72	51.4
MedStar Harbor	37%	113	80.7
UMMC Midtown	35%	107	76.4
UM Shore at Chestertown	35%	30	21.4
Laurel Regional	28%	60	42.8
Carroll	26%	140	100.0
Doctors Community	26%	163	116.4

Source: MHCC, Discharge Data Base

Potentially Avoidable Hospital Use

HSCRC estimates that approximately 21% of inpatient and observation admissions in 2014 were associated with potentially avoidable use (PAU) of the general hospital inpatient setting. This estimate includes readmissions within 30 days of discharge, admissions related to ambulatory care sensitive conditions, and admissions related to potentially preventable complications

Potentially Avoidable Hospital Use

Twelve General Hospitals with Highest Proportion of PAU Discharges – CY 2014

E.W. McCready – 41.8%
Fort Washington – 35.4%
Bon Secours – 34.3%
UM Shore at Chestertown – 31.6%
UM Shore at Dorchester – 31.3%
UMMC Midtown – 31.2%
Good Samaritan – 29.3%
Northwest – 28.9%
Atlantic General – 28.7%
Doctors Community – 28.4%
UM Harford Mem. – 27.1%
MedStar Union Mem. – 25.2%

Source: HSCRC

Small Census Hospitals

Seven Hospitals with Smallest ADC - FY2015

	Licensed Beds	ADC FY 15
E.W. McCready	4	2.9
UM Rehabilitation & Orthopaedic	7	5.0
Garrett County Memorial	25	17.9
UM Shore at Chestertown	30	21.4
Fort Washington	34	24.3
UM Shore at Dorchester	47	33.6
Atlantic General	48	34.2
MARYLAND Average – all hospitals	209	149
MARYLAND Median – all hospitals	195	139

Source: MHCC

Financial Performance

Only six general hospitals for which final FY 2015 audited financial statements are available (43 of 47 hospitals) failed to generate an operating profit (considering all revenue and expenses, regulated and unregulated).

Holy Cross Germantown	-$25.2 million (-68.2%)
Laurel Regional	-$16.5 million (-17.9%)
MedStar Southern Maryland	-$ 7.5 million (- 3.3%)
Prince George's	-$ 1.1 million (- 0.4%)
E.W. McCready	-$ 0.5 million (- 3.8%)
UM Rehab & Ortho (Kernan)	-$ 0.1 million (- 0.1%)

Source: HSCRC

Changes in Maryland's Hospital Supply

In the last 35 years, the number of general hospitals operating in Maryland has dropped from 53 to 47.

- Twelve hospitals closed between 1985 and 2010.
- Five of the closures were "effectively" replaced by three new hospitals, one of which subsequently closed.
- Over half of the closures were in Baltimore City.
- Only one "rural area" hospital closed (Frostburg-1994).

- Six hospitals opened between 1982 and 2014.
- Homewood North Hospital that opened in 1982 and Liberty Hospital that opened in 1985 subsequently closed

Alternatives for Preserving Emergent/Urgent Care Capability

Limited Service Hospital

- Requires Commission to issue an exemption from CON
- Commission must find:
  - In the public interest
  - Not inconsistent with the State Health Plan (SHP)
  - Will result in more efficient and effective delivery of health care service
- No limited service hospital has ever been established.

Alternatives for Preserving Emergent/Urgent Care Capability

Freestanding Medical Facility

- Requires sponsoring parent
- Requires Commission to issue CON
- SHP criteria and standards in development
  - Located in parent hospital's service area
  - Responds to ED overcrowding and/or an access problem

Alternatives for Preserving Emergent/Urgent Care Capability

Urgent Care Center

- No approval by MHCC required
- No Maryland license required
- No rate regulation
  - Generally, a lower acuity alternative
  - Proposed by Adventist HealthCare for Takoma Park campus after relocation of Washington Adventist Hospital

Related Legislation in 2016

- SB 12: Gives County Boards of Health authority over hospital closures or partial closures in their jurisdictions
  - Generated from concern with Laurel Regional plan and Shore Chestertown planning discussions
- Likely Bill Introduction: Allowing FMF to replace the LSH as a transition model for preserving access to emergency care
  - Transition FMF subject to exemption review
  - FMF could maintain an observation unit
  - Only available to hospital systems (FMF needs a parent)

Discussion Questions

- Is Maryland policy adequate with respect to
  - Closing a hospital?
  - Partially closing a hospital?
  - Converting a hospital to an ambulatory care campus?
- Should Maryland have an explicit standard for access to general hospital inpatient services?
  - What are the implications of such a standard for hospital autonomy and commitment of State support to sustain smaller hospitals?

MARYLAND HEALTH CARE COMMISSION

AGENDA

1. APPROVAL OF MINUTES

2. UPDATE OF ACTIVITIES

3. ACTION: Approval of Release of MCDB Data to Johns Hopkins Bloomberg School of Public Health
    a. Center for Population Health Information Technology
    b. Jill Marsteller

4. PRESENTATION: Electronic Health Record Incentive Report

5. PRESENTATION: Cost and Utilization Portal Version 1.0: An Overview and Our Strategy for Engagement

6. PRESENTATION: 2016 Legislative Session
    a. Overview of MHCC's Legislative Review Process
    b. Proposed Legislation

7. WORK SESSION: Hospital Conversions: the Issues, MHCC's authority, and Legislative Proposals

8. **OVERVIEW OF UPCOMING INITIATIVES**

9. ADJOURNMENT

MARYLAND HEALTH CARE COMMISSION

Overview of Upcoming Initiatives

(Agenda Item #8)


ENJOY THE REST OF
YOUR DAY