Maryland Health Care Commission

Thursday, March 17, 2016

1:00 p.m.

MARYLAND HEALTH CARE COMMISSION

AGENDA

1. **APPROVAL OF MINUTES**

2. **UPDATE OF ACTIVITIES**

3. **ACTION**: Certificate of Conformance for Emergency and Elective Percutaneous Coronary Intervention Services: University of Maryland Shore Medical Center at Easton (Docket No. CC-15-20-0001)

4. **ACTION:**
   4) COMAR 10.24.16 – State Health Plan for Facilities and Services: Home Health Agency Services – Final Regulation
   5) COMAR 10.24.08 – State Health Plan for Facilities and Services: Nursing Home Services – Final Regulation

6. **PRESENTATION:** Status Report and Update on Hospice Need Projections

7. **UPDATE:** Legislative Session

8. **PRESENTATION:**2014 Patient Centered Medical Home Shared Savings Update

9. **PRESENTATION:** Hospital Health IT Assessment Report

10. **OVERVIEW OF UPCOMING INITIATIVES**

11. **ADJOURNMENT**

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(Agenda Item #3)

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(Agenda Items #4 & #5)

State Health Plan for Facilities and Services: Home Health Agency Services, COMAR 10.24.16

Consideration for Adoption as Final Regulations

March 17, 2016

Cathy Weiss
Center for Health Care Facilities Planning and Development

MHCC | MARYLAND HEALTH CARE COMMISSION

Background: COMAR 10.24.16

- Comprehensive update and new approach
- Create opportunities for new or expanded HHAs to enhance consumer choice, market competitiveness, and/or quality performance
- Rely on performance score(s) to qualify applicants
- Reward quality providers

Changes Requested by Commissioners for Proposed Regulations: COMAR 10.24.16

.03C. Issues and Policies: HHA Quality Measures and Performance

- Use Maryland performance score for existing Medicare-certified HHA in Maryland
- Use average performance score for non-Maryland Medicare-certified HHAs

.07C. Quality Measures for Non-Maryland Medicare-certified HHA

- Consistent with .03C, use average score of all its Medicare-certified HHAs

.07D(2)–(5). Quality Measures for Hospital and Nursing Home

- Consistent with .03C and .07C, added language to distinguish Maryland from non-Maryland hospital or nursing home applicants

Comments

Received from 4 organizations:

- Elizabeth Cooney Care Network (1 comment)
- Maxim Healthcare Services (3 comments)
- Virginia HealthCare Services (2 comments)
- Visiting Nurse Association (VNA) of Maryland (2 comments)

Categories:

- Qualifying Applicant: Regulation .06
- Quality Measures and Performance Levels: Regulation .07
- CON Review Standards: Regulation .08
- CON Preference Rules in Comparative Reviews: Regulation .09
- Acquisition of an HHA: Regulation .11

Lookback Period

.06C. Qualification for all applicants

(2) Has not been convicted of Medicare or Medicaid fraud or abuse within the last ten years;

.11F. Information Required for an HHA Acquisition

(3) A purchaser, any of its principals, a related entity, or a principal of a related entity shall not have pled guilty to, have been convicted of, or received a diversionary disposition for a felony within the last ten years;

(4) A purchaser, any of its principals, a related entity, or a principal of a related entity shall not have pled guilty to, been convicted of, or received a diversionary disposition for a felony involving Medicare or Medicaid fraud or abuse within the last ten years;

Staff Recommendation: No change

Fraud and Abuse

.06C. Qualification for all applicants

(9) Affirms under penalties of perjury, that none of its owners or senior management or an owner or senior management of any related or affiliated entity has within the last ten years been convicted of a felony or crime or pleaded guilty, nolo contender, entered a best interest plea of guilty, or received a diversionary disposition regarding a felony or crime.

Staff Recommendation: non-substantive change

Staff Recommendation

.06C. Qualification for all applicants

(9) Affirms under penalties of perjury, that <u>within the last ten years</u>, no [none of its owners] owner or senior management or an owner or senior management of any related or affiliated entity has [within the last ten years] been convicted of a felony or crime or pleaded guilty, nolo contender, entered a best interest plea of guilty, or received a diversionary disposition regarding a felony or crime.

Source of Survey Citations

.06C. Qualification for all applicants

(3) Has received at least satisfactory findings reflecting no adverse citations on the most recent two survey cycles from its respective state agency or accreditation organization, as applicable;

…

(5) Has submitted an acceptable plan of correction for any valid and serious patient-related complaint investigated over the past three years;

Staff Recommendation: non-substantive change

Staff Recommendation

.06C. Qualification for all applicants

(3) Has received at least satisfactory findings reflecting no serious adverse citations on the most recent two survey cycles from its respective state agency, [or] accreditation organization, or both, as applicable to the type of applicant;

CMS Star Rating Threshold

.07C. Quality Measures for Non-Maryland Medicare-Certified HHAs

In order for an application to be accepted by an applicant that has any common ownership with a Medicare-certified HHA in a state other than Maryland, it shall demonstrate that:

(1) The average rating on the CMS Star Rating system of all the Medicare-certified HHAs with which it has any common ownership met or exceeded the specified rating level; and

(2) The average performance level on selected process and outcome measures from CMS Home Health Compare for the most recent 12-month reporting period of all the Medicare-certified HHAs with which it has any common ownership met or exceeded the specified performance level.

Staff Recommendation: no change

RSA Accreditation Timeframe

.07D. Quality Measures for Licensed and Accredited Hospital, Nursing Home, or Maryland RSA Providing Skilled Nursing Services.

(1) In the case of a Maryland licensed RSA applicant, it has operated with an established quality assurance program that includes systematic collection of process and outcome measures, and experience of care measures and has maintained accreditation through a deeming authority recognized by Maryland's Department of Health and Mental Hygiene for at least the three most recent years;

Staff Recommendation: no change

Value-Based Payment Arrangements

Commenter suggested adding new CON review standard:

.08L. An applicant shall demonstrate ongoing participation or capability to participate in value-based payment arrangements within the proposed service area that promote the utilization of efficient and effective home health agency services.

Commenter suggested adding new preference rule:

.09F Proven Track Record in Providing Efficient and Effective Home Health Agency Services. An applicant that participated in value-based payment arrangements will be given a preference over an applicant that participated exclusively in conventional fee-for-service reimbursement arrangements for providing home heath agency services.

Staff Recommendation: do not add; no change

Commission Action

- Approve adoption of new COMAR 10.24.16 as final regulations, with two non-substantive changes based on comments
- Approve amendment of COMAR 10.24.08 to repeal sections on HHA services as final regulations
- Effective date: April 11, 2016

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MARYLAND HEALTH CARE COMMISSION

PRESENTATION:

Status Report and Update on Hospice Need Projections

(Agenda Item #6)

MARYLAND HEALTH CARE COMMISSION

Status Report and Update on Hospice Need Projections

March 17, 2016
Commission Meeting

Hospice State Health Plan (SHP) Chapter Development: 2011-2013

- 2011-2012:
  - Convened Hospice Work Group/began SHP update process - October, 2011
  - Hospice Work Group meetings-January/August, 2012
  - Release of draft chapter for informal review-April, 2012
  - Senate Finance Committee briefing-September, 2012
- 2013:
  - Reconvened Hospice Work Group to reach consensus on need methodology-January, 2013
  - Senate Finance Committee briefing-January, 2013
  - Release of draft chapter for second informal review-April, 2013
  - Adoption of proposed regulation by MHCC-June, 2013
  - Release for formal review-July, 2013
  - Final regulations effective-October, 2013

Implementation of Hospice SHP Chapter

- In response to comments received from the Hospice Network and the Senate Finance Committee, MHCC agreed to delay implementation (CON review) until June, 2015;
- In 2014, SB 646 was introduced (with 46 cosponsors), requiring the MHCC to document that existing hospices could not meet needs prior to initiating CON review;
- SB 646 was withdrawn, but MHCC agreed to delay CON review until June, 2016 and to facilitate education and outreach;
- Updated need projections identify need in Baltimore City and Prince George's County.

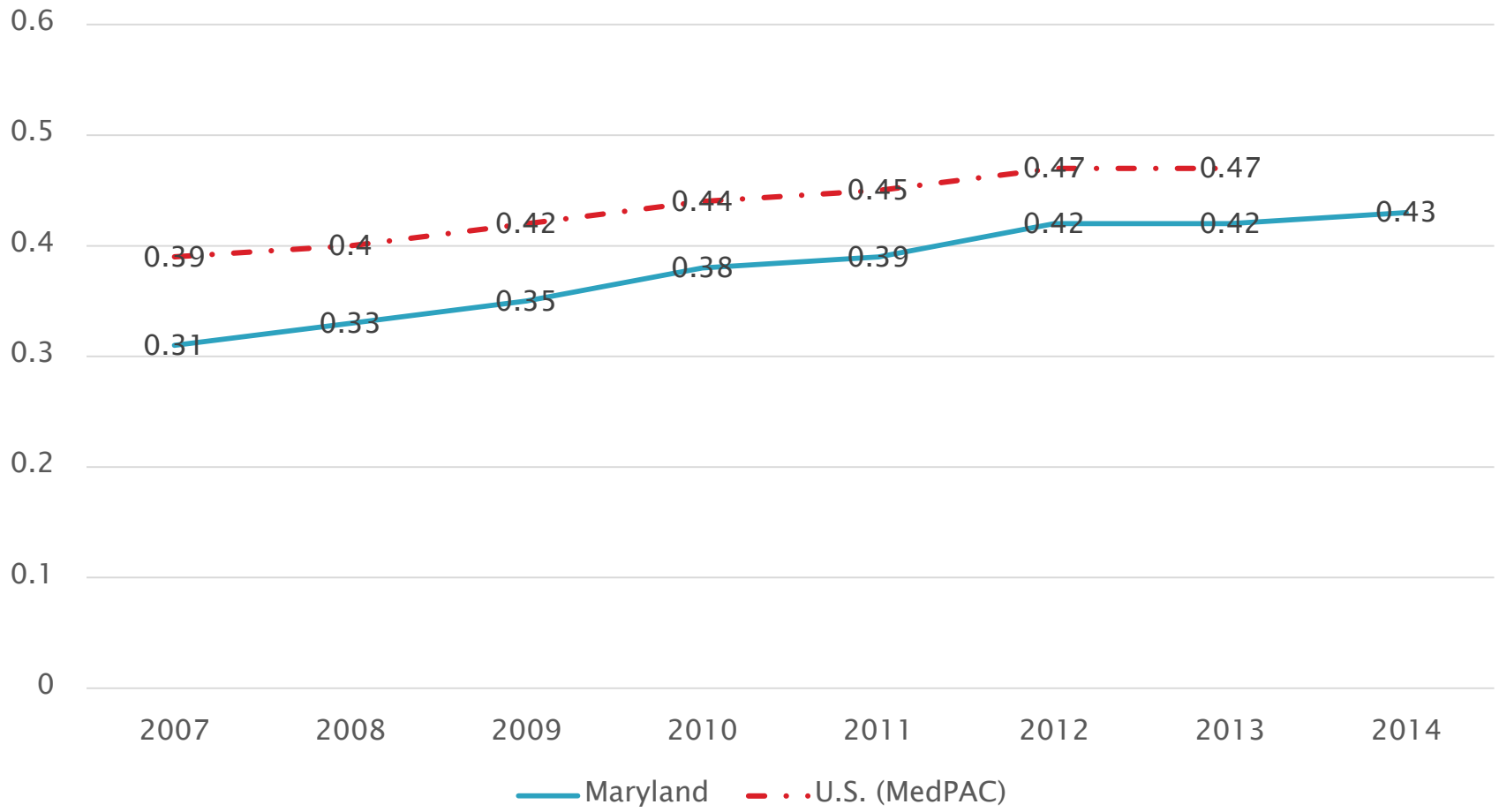
Hospice Education and Outreach: 2013-2015

- 2013:
  - Senate Finance Committee recommended work on education and outreach
  - Three meetings of Hospice Education Initiative Work Group: April to September, 2013
- 2014:
  - Planning meetings for jurisdiction-specific education and outreach convened-June, 2014 with hospice providers in Prince George's County and July, 2014 with Baltimore City hospices
  - Education and outreach meeting for Prince George's County providers in October, 2014
  - Education and outreach meeting for Baltimore City providers in October, 2014
- 2015:
  - Statewide education and outreach meetings jointly sponsored by MHCC and Hospice Network- June, 2015
  - Included Hospice Network in MHCC Hospital Palliative Care Study, completed in December, 2015

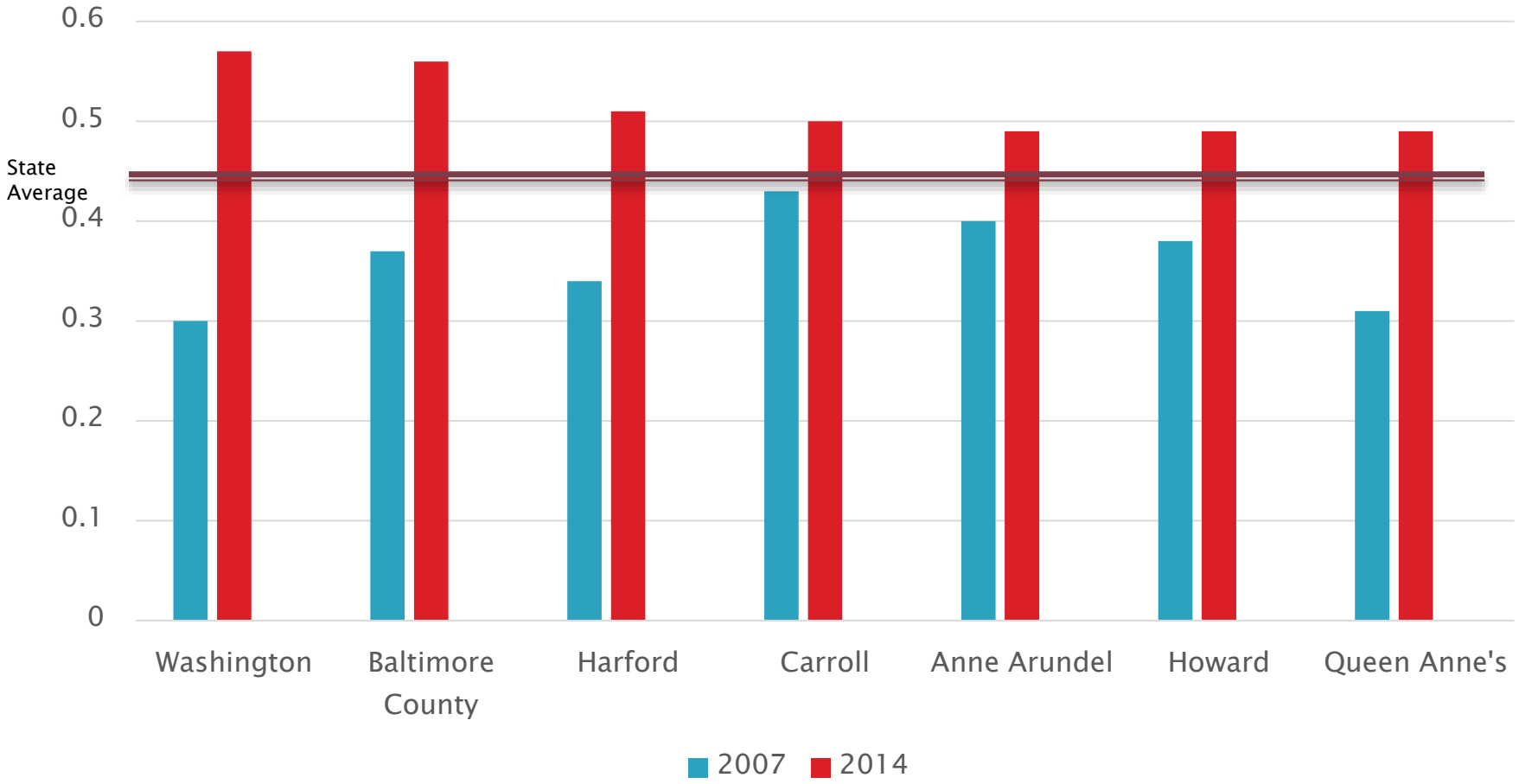
Hospice Data Sources

- Maryland Hospice Survey conducted annually by MHCC
- Other data sources:
  - Population death data: Maryland Vital Statistics Administration
  - Target year use rate: MedPAC
  - Population projections: Maryland Dept of Planning
- Need Methodology requirements specified in COMAR 10.24.13.06

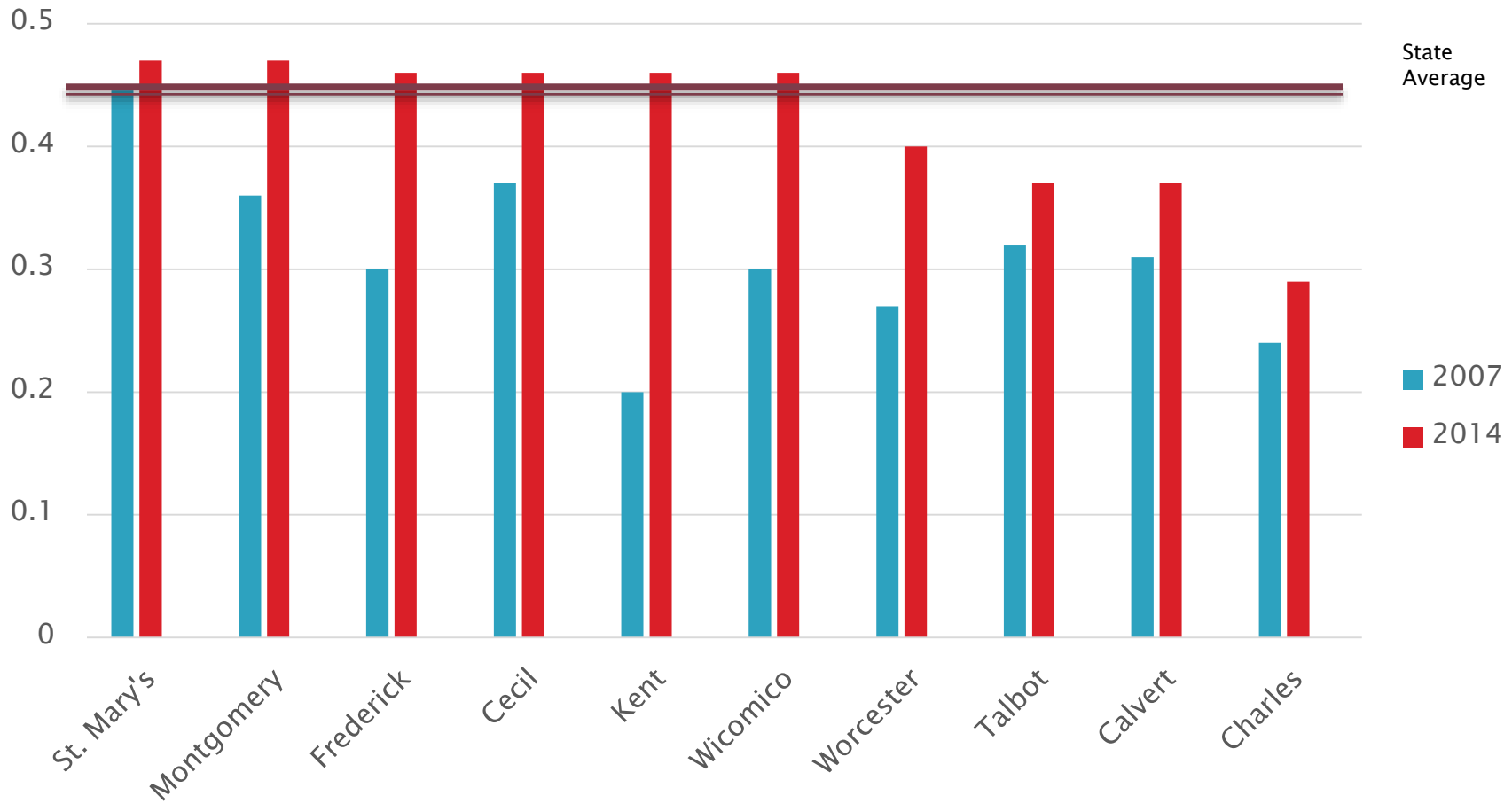
Hospice Use Rates, Maryland (35+ population) and U.S. (Medicare beneficiaries):2007-2014



Top Quartile Hospice Use Rates by Jurisdiction: 2007 & 2014



Middle Quartiles Hospice Use Rates by Jurisdiction: 2007 & 2014



Bottom Quartile Hospice Use Rates by Jurisdiction: 2007 & 2014

Hospice Need Methodology

- Objective: Identify jurisdictions with both low hospice use and a large gap between projected use, based on most recent five-year trend, and potential use, at the higher target use rate
- 2016 Update uses:
  - Base Years: 2010-2014
  - Target Year: 2019
  - Target Use Rate (from MedPAC): 47.3%
  - Target Population: aged 35+
- Steps:
  - Project population deaths in target year by jurisdiction;
  - Calculate gross need by jurisdiction, using target use rate;
  - Calculate target year capacity (projected use) by applying compound annual growth rate extrapolated over 5 years;
  - Calculate net need by jurisdiction (the gap between potential use and projected use);
  - Calculate volume threshold = median statewide hospice deaths for most recent base year;
  - Jurisdictional need identified if target year net need > volume threshold.

Jurisdictions with Projected Unmet Need

- Baltimore City:
  - 2014 use rate: 0.25
  - Target year capacity: 1,522
  - Target year gross need: 2,756
  - Target year net need: 1,233
- Prince George's County:
  - 2014 use rate: 0.28
  - Target year capacity: 1,812
  - Target year gross need: 2,474
  - Target year net need: 662
- Statewide 2014 use rate: 0.43

Upcoming Federal Hospice Quality Measurement

- Starting in FY 2014, CMS will reduce market basket update for hospices by 2% if quality data is not reported (ACA requirement)
- Hospice Item Set
  - Data collection began 7/1/14
  - HIS includes 7 data items
- Hospice CAHPS®
  - Data collection began 1/1/15; affects payment for FY 2017
  - 6 composite and 5 single questions; survey given to caregiver of decedent
  - Quality measures are “pay for reporting” not performance
- No public reporting yet

Upcoming MHCC Steps

- Publish updated hospice need projections in *Maryland Register*
- Post need projection tables on MHCC website
- Develop and publish CON Review Schedule
- Continue data collection for FY 2015

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MARYLAND HEALTH CARE COMMISSION

UPDATE:

Legislative Session

(Agenda Item #7)

Legislative Update

Erin Dorrien
Chief, Government and Public Affairs
March 17, 2016

MHCC | MARYLAND HEALTH CARE COMMISSION

Presentation Outline

- Health Facility Legislation
- Legislation Related the Maryland Patient Referral Law
- Legislation Related to Health Information Technology

Hospital Conversion

- SB 707/ HB 1350 Freestanding Medical Facilities- Certificate of Need, Rates and Definitions
  - Establishes a process for a licensed general hospital to convert to a freestanding medical facility through a CON exemption.
  - Expands the scope of services that can be offered at the FMF to observation stays and outpatient services authorized by HSCRC.
  - Expands public notification requirements for closure or conversion.

Bills Related to CON/ Health Planning

- SB 12/HB 1121 Health Care Facilities- Closures or Partial Closures of Hospitals- County Board of Health Approval
- HB 1018 Prince George's County- Closures or Partial Closures of Hospitals- Board of Health Approval PG 406-16
- SB 352 Maryland Health Care Commission- Certificate of Need Review- Interested Party

Bills Related to Maryland Patient Referral Law

- SB 886 Health- Collaborations to Promote Provider Alignment offered by MHA
  - HB 929 Health Occupations- Prohibited Patient Referrals- Exceptions -- offered by MPCAC

- SB 739/HB 1422 Integrated Community Oncology Reporting Program – offered by medical oncology

Advanced Directives

- HB 1385 Public Health- Electronic Advance Directives- Witness Requirements, Information Sheet, and Repository
  - Requires MHCC and DHMH to approve an electronic advanced directive service that will connect with CRISP
  - Requires CRISP to make paper advanced directives available through the approved electronic advanced directive service
  - Requires payers and MCO's to notify enrollees of the electronic advanced directive service

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2014 Patient Centered Medical Home Shared Savings Update

(Agenda Item #8)

Maryland Multi-Payor Patient Centered Medical Home Program

Private Payor – Shared Savings Update

March 17, 2016

The MARYLAND
HEALTH CARE COMMISSION

Program Goals

Leading goals of the Maryland Multi-Payor Patient Centered Medical Home Program (MMPP) are to increase quality, control costs, and improve patient experience of care

Increase Quality

Control Costs

Improve Patient Experience of Care

2014 PCMH Results

- Every MMPP practice receives up front fixed transformation payments (FTP); a total of ~$4.4M in both 2013 and 2014 from commercial payors

- Nearly half (21 of 51) of MMPP practices generated savings; 24 generated savings in 2013

- Incentive payments for ten practices were reduced due to exceeding ten percent of the per capita total health care costs in the performance year in both 2013 and 2014

- Approximately 17 percent improvement over the last four years in the quality measure composite score

MMPP Shared Savings Overview

- Shared savings payments will be distributed to MMPP practices whose total cost of care is below budget
- Total cost of care includes all health services received by patients, regardless of care delivery site
- Budget is set by practice's baseline period costs, increased by statewide trend
- Statewide trend is the increase in the total cost of care for the performance year over the baseline year for all non-MMPP primary care practices in Maryland

Shared Savings Methodology

- Based on quality measure reporting, utilization measure results, and the ability to control cost
- MMPP practices are eligible to receive a payment of 30, 40, or 50 percent of the cost savings in addition to the upfront FTP
- Only patients attributed to the practice in 2013 and 2014 are included in the cost savings calculation
  - Incentive payments are paid based on all attributed and eligible patients as of December 31, 2014
- To address outliers, the methodology includes patient-level cost adjustments, such as a per patient annual maximum of $75K

MMPP Shared Savings Status

Category	2011	2012	2013	2014
Practices that received shared savings	21 (42%)	19 (38%)	24 (47%)	21 (42%)
Practices that reported shared savings but did not receive payments because the FTP cancelled it out	1 (2%)	4 (8%)	5 (10%)	4 (8%)
Number of practices that did not report any shared savings	28 (56%)	27 (54%)	22 (43%)	25 (50%)
Total	50	50	51	50

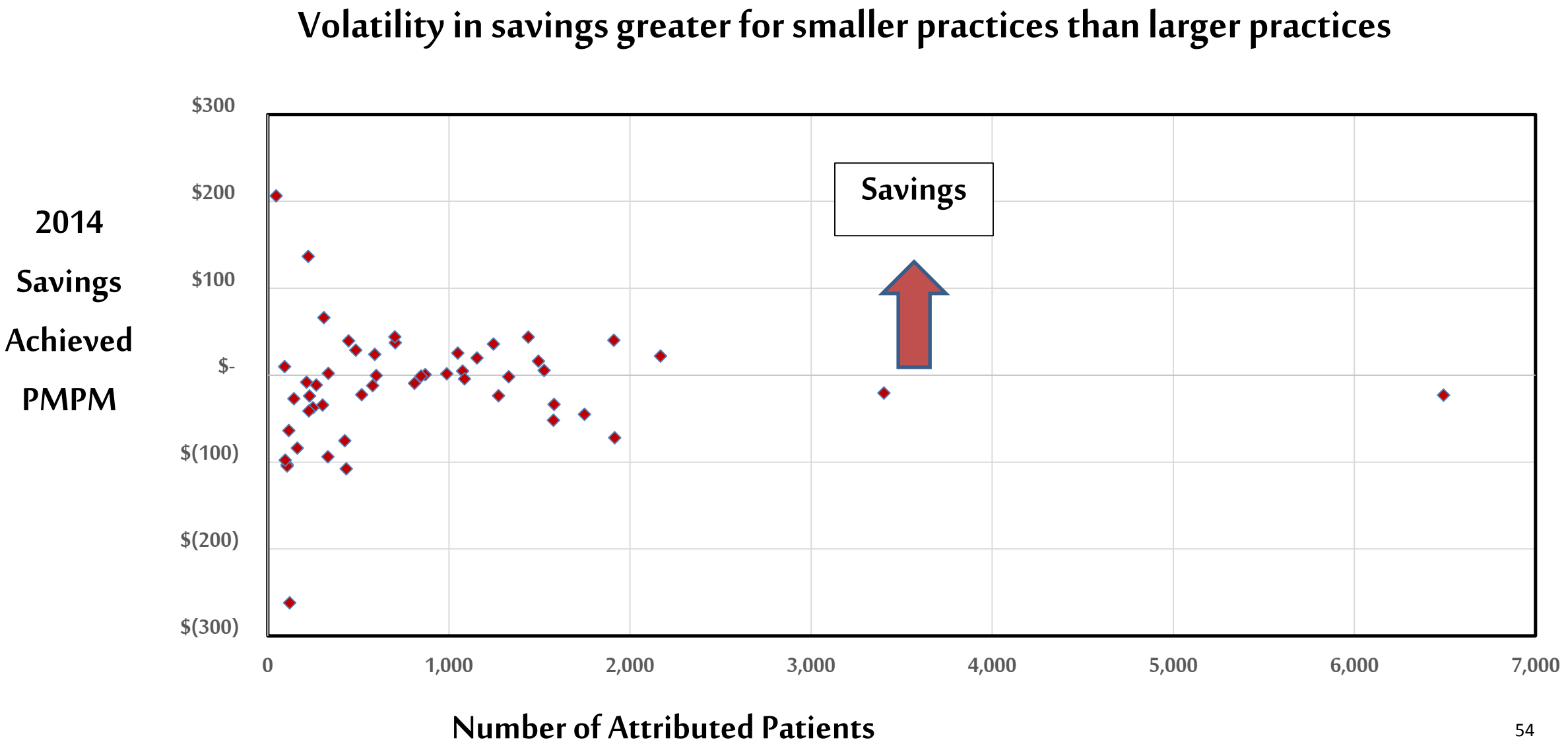
Quality & Utilization Metrics 2014

Percentage of shared savings for which each practice was eligible based on quality measures and utilization metrics (parentheses = practices that achieved savings)				
% Eligibility	Total Practices	Pediatric	Adult	Both
50	17	6(4)	5(3)	6(2)
40	23	0	3(0)	20(7)
30	10	0	5(3)	5(2)
Total	50	6(4)	13(6)	31(11)

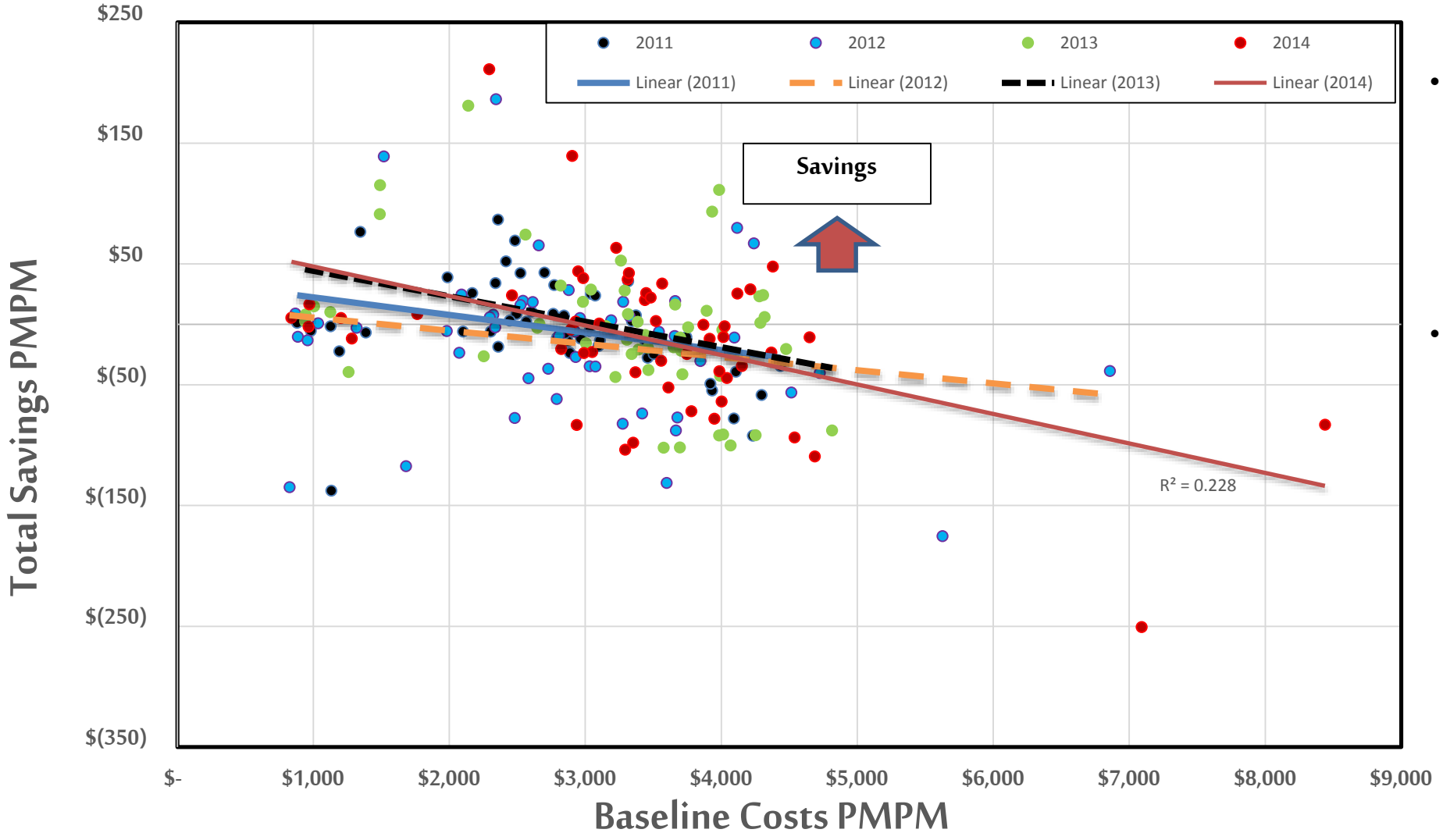
19 Practices Achieved Net Savings for 2011-2014

County	Total County	2011	2012	2013	2014	Total
Anne Arundel	5	(173,144)	183,156	77,854	695,596	783,462
Baltimore	2	402,876	(207,386)	(60,686)	(6,005)	128,799
Baltimore City	2	(108,110)	184,614	92,440	198,401	367,345
Calvert	2	804,881	(289,550)	677,141	(736,127)	456,345
Carroll	1	126,665	289,891	(348,008)	(55,379)	13,169
Frederick	2		970,550	(824,181)	878,678	1,025,047
Montgomery	1	(441,264)	(131,121)	142,753	503,949	74,317
Prince George's	1	269,221	(11,025)	(80,005)	(142,873)	35,318
St. Mary's	1	223,503	58,402	310,196	733,830	1,325,931
Talbot	1	205,359	(139,450)	91,839	(66,002)	91,746
Worcester	1	385,375	(59,672)	(523,381)	256,516	58,838
Grand Total	19	1,695,362	848,409	(444,038)	2,260,584	4,360,317

Shared Savings Results



Baseline Costs vs Total Savings



- Higher PPPM Baseline costs generally correlate to lower savings
- Baseline costs tend to be increasing somewhat over time

Commercial Payment by Carriers per Year

Carrier	2011	2012	2013	2014	Total
Aetna	$ 27,431	$ 74,644	$ 162,589	$ 191,401	$ 456,064
CareFirst	$ 590,703	$ 1,457,178	$ 1,141,724	$ 1,932,852	$ 5,122,456
Cigna	$ 10,848	$ 29,830	$ 41,943	$ 42,364	$ 124,985
Coventry	$ 21,544	$ 33,441	$ 27,827	$ 30,119	$ 112,930
UHC	$ 159,912	$ 324,803	$ 407,175	$ 539,882	$ 1,431,772

MMPP Practice Quality Measures

Quality Measures Performance			
	Average Number of Measures Reported		Combined Measure Score %
2011	15 (of 21)		47
2012	17 (of 21)		56
2013	18 (of 21)		62
2014	14 (of 17)		64

2016 Leading Initiatives

- Convened a Primary Care Council to explore opportunities to align primary care with the requirements of the new hospital global payment model and to consider policy issues such as risk stratified care management, access to services and continuity of care, shared learning, and payment methodology

- Work with CMS Practice Transformation Network grantees (NJ & VA) to explore including Maryland providers in their initiatives

- Promoting optimal use of health information technology to support practice transformation

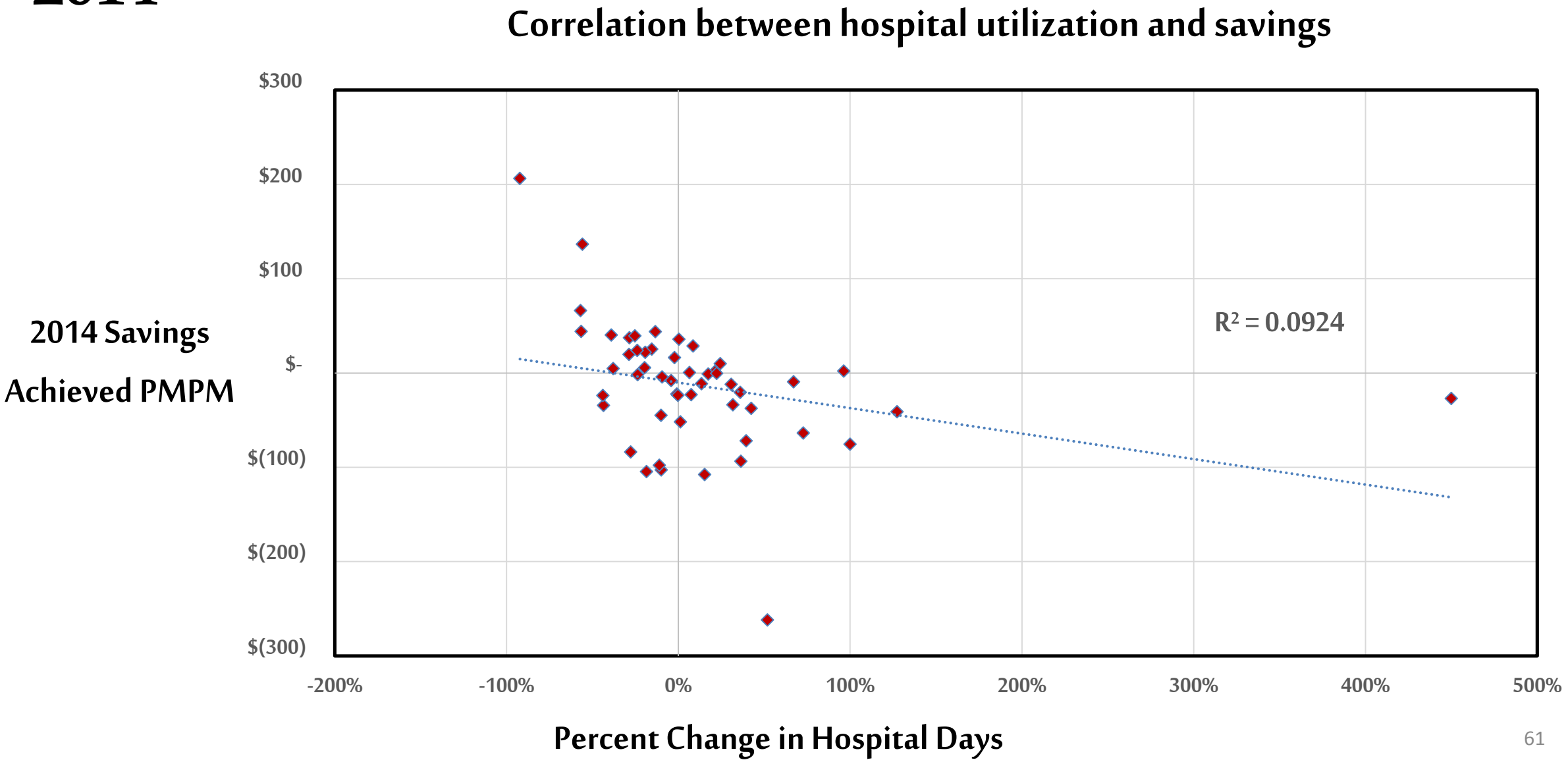
- Develop practice transformation and EHR education materials to assist ambulatory practices in transformation

Thank You!

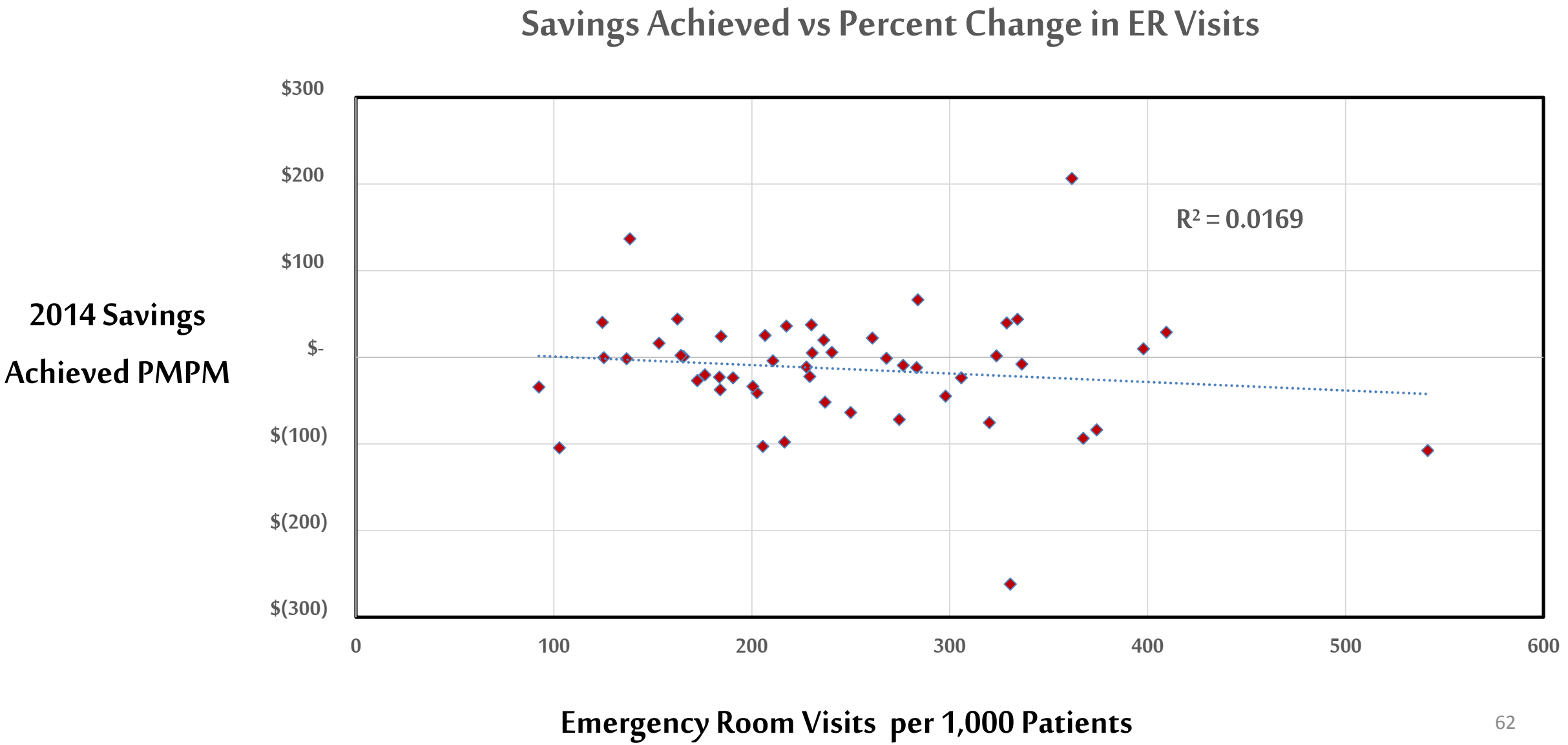
The MARYLAND
HEALTH CARE COMMISSION

APPENDICES

Results by Percent Change in Hospital Days 2013-2014



Results by Emergency Room Visits



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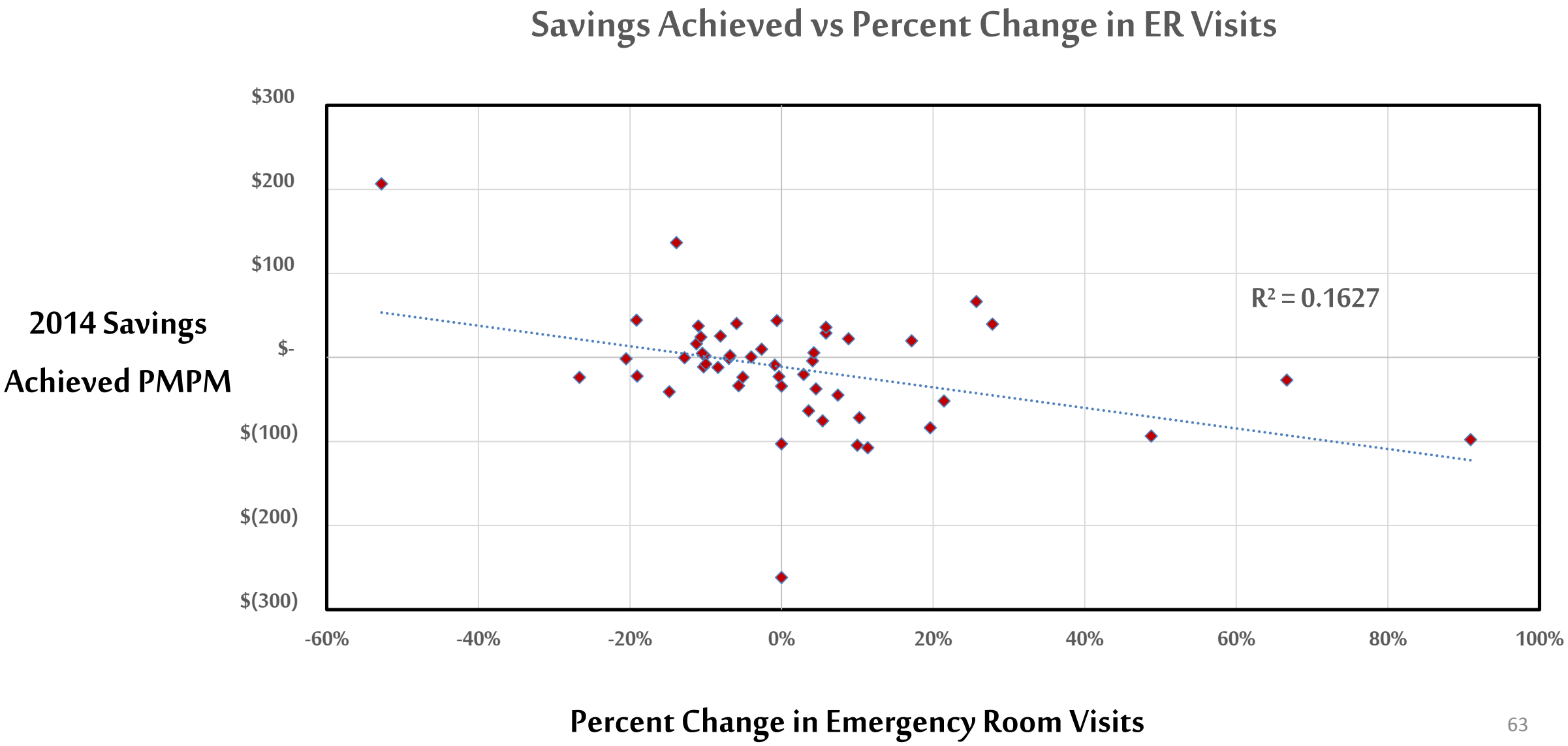
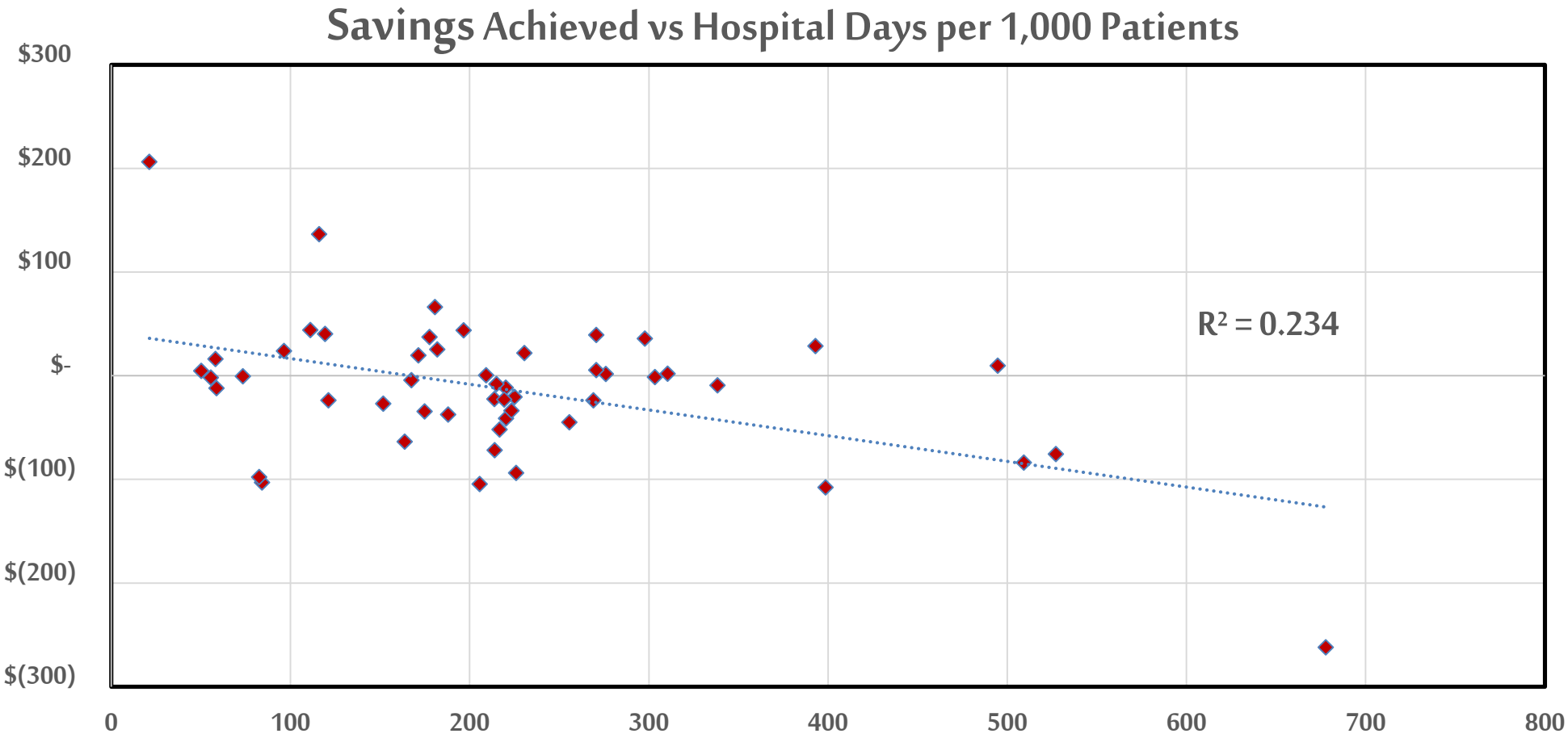


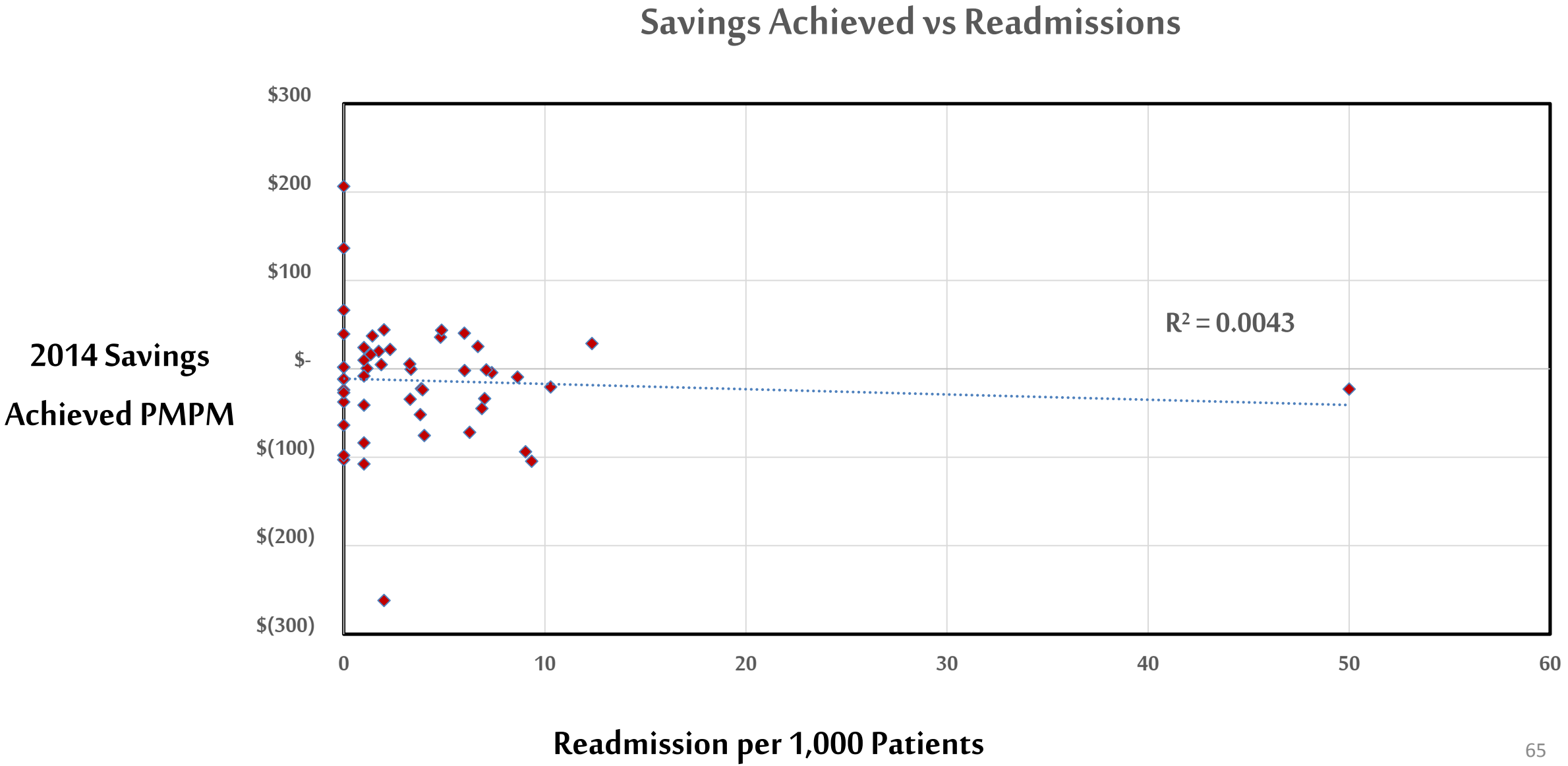
Results by Hospital Days per 1,000 Patients



2014 Savings Achieved PMPM

Hospital Days per 1,000 Patients

Results by Hospital Readmissions



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   5) COMAR 10.24.08 – State Health Plan for Facilities and Services: Nursing Home Services – Final Regulation

6. **PRESENTATION:** Status Report and Update on Hospice Need Projections

7. **UPDATE:** Legislative Session

8. **PRESENTATION:**2014 Patient Centered Medical Home Shared Savings Update

9. **PRESENTATION:** Hospital Health IT Assessment Report

10. **OVERVIEW OF UPCOMING INITIATIVES**

11. **ADJOURNMENT**

MARYLAND HEALTH CARE COMMISSION

PRESENTATION:

Hospital Health IT Assessment Report

(Agenda Item #9)

Health Information Technology

Diffusion Among Maryland Acute Care Hospitals

Commission Brief

March 17, 2016

The MARYLAND HEALTH CARE COMMISSION

Background

- The Maryland Health Care Commission (MHCC) conducts an annual assessment to identify current trends and the future direction of health information technology (health IT) use among Maryland acute care hospitals in comparison to hospitals nationally

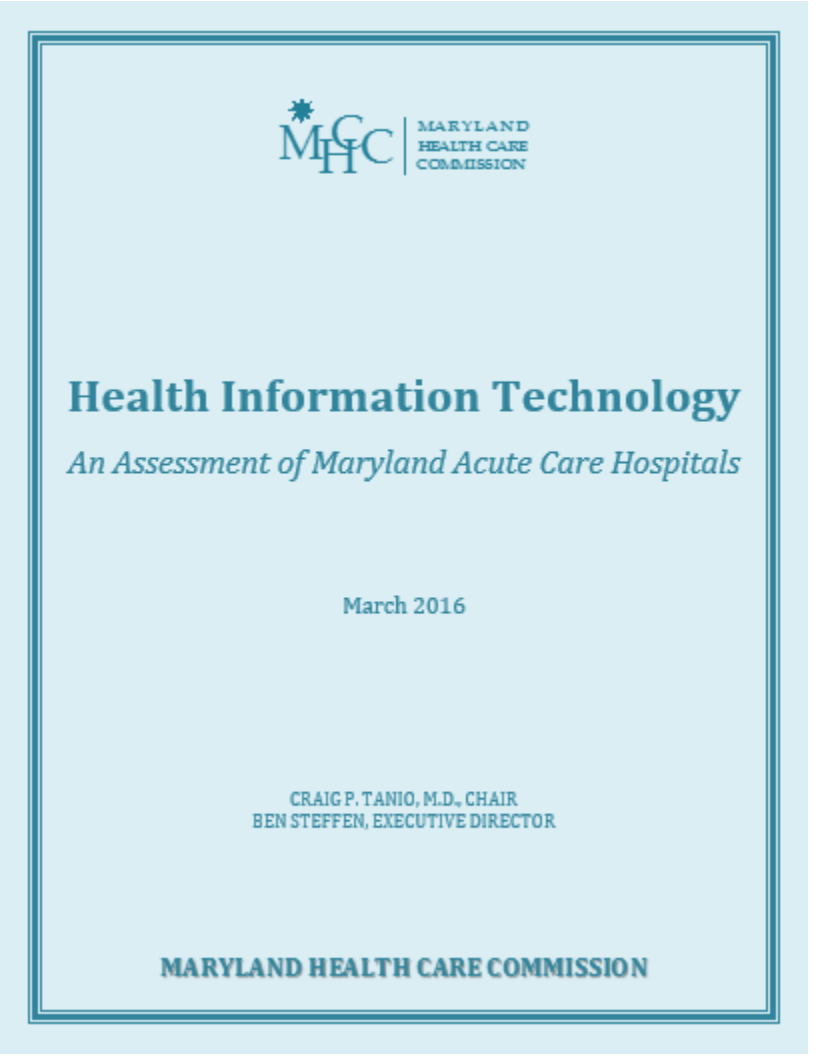
- Over the years, hospital Chief Information Officers (CIOs) report the assessment findings have influenced health IT adoption and encouraged competition around the diffusion of health IT within hospitals

- The MHCC uses the information to help hospital CIOs formulate recommendations for expanding health IT system functionality, developing policies around privacy and security, and crafting audit strategies

- Each year, MHCC enhances the assessment based on trends in the health care industry; next year, MHCC will identify cybersecurity activities of hospitals and assess how hospitals use health IT to support value-based care

The Hospital Health IT Assessment

- All 47 acute care hospitals in the State voluntarily participate; information is self-reported by CIOs
- Evaluates hospital adoption of health IT and implementation plans
- Identifies hospital participation in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs



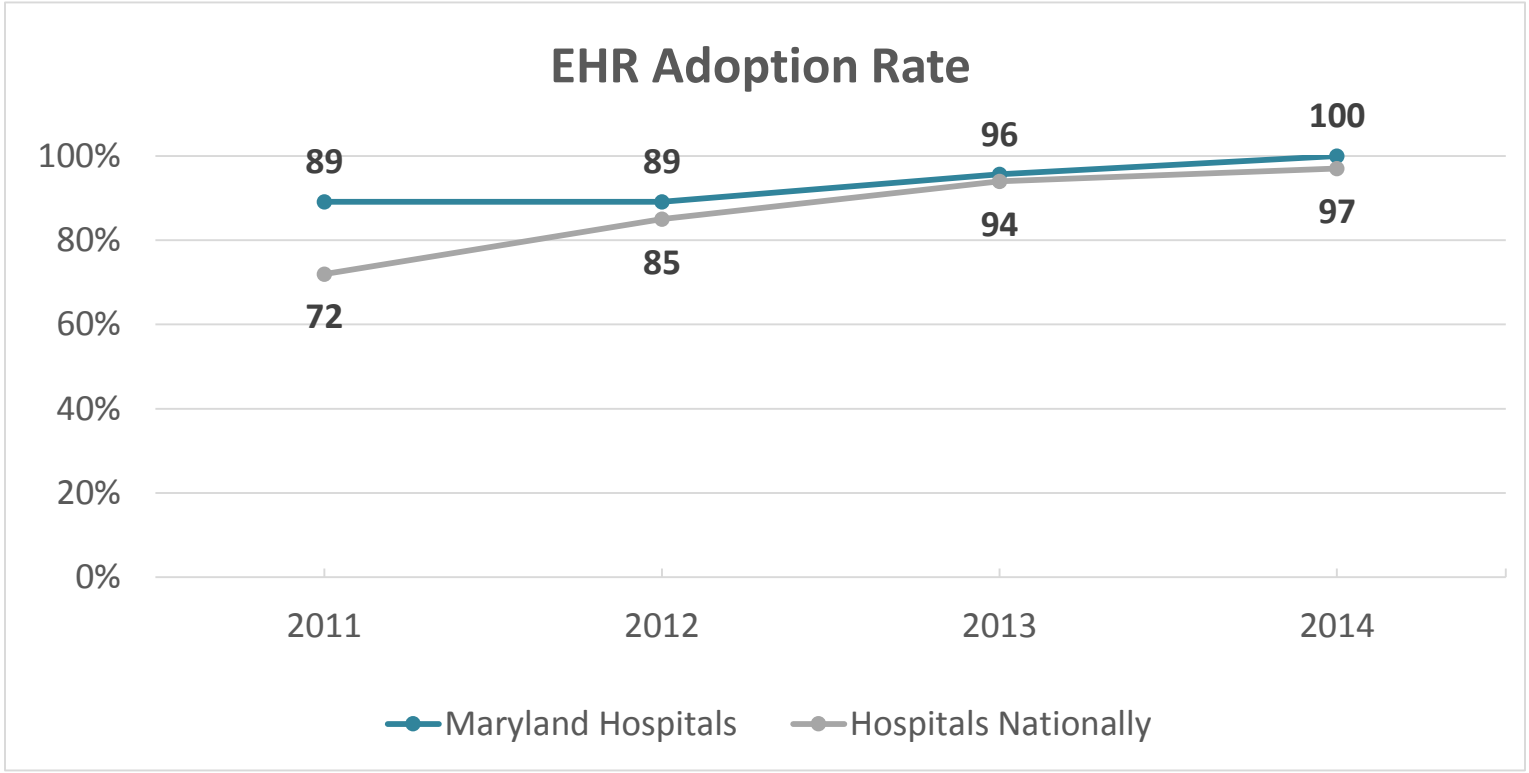
Types of Health IT Assessed

- EHRs
- Computerized physician order entry (CPOE)
- Electronic prescribing (e-prescribing)
- Electronic medication administration record (eMAR)
- Bar code medication administration (BCMA)
- Clinical decision support (CDS)
- Patient portals
- Telehealth
- Health information exchange (HIE)
- Population health management tools

Key Findings

EHRs

- All Maryland hospitals have implemented a certified EHR
- Three EHR systems are used by over 80 percent of hospitals:
  - Meditech
  - Cerner
  - Epic



Core EHR Components

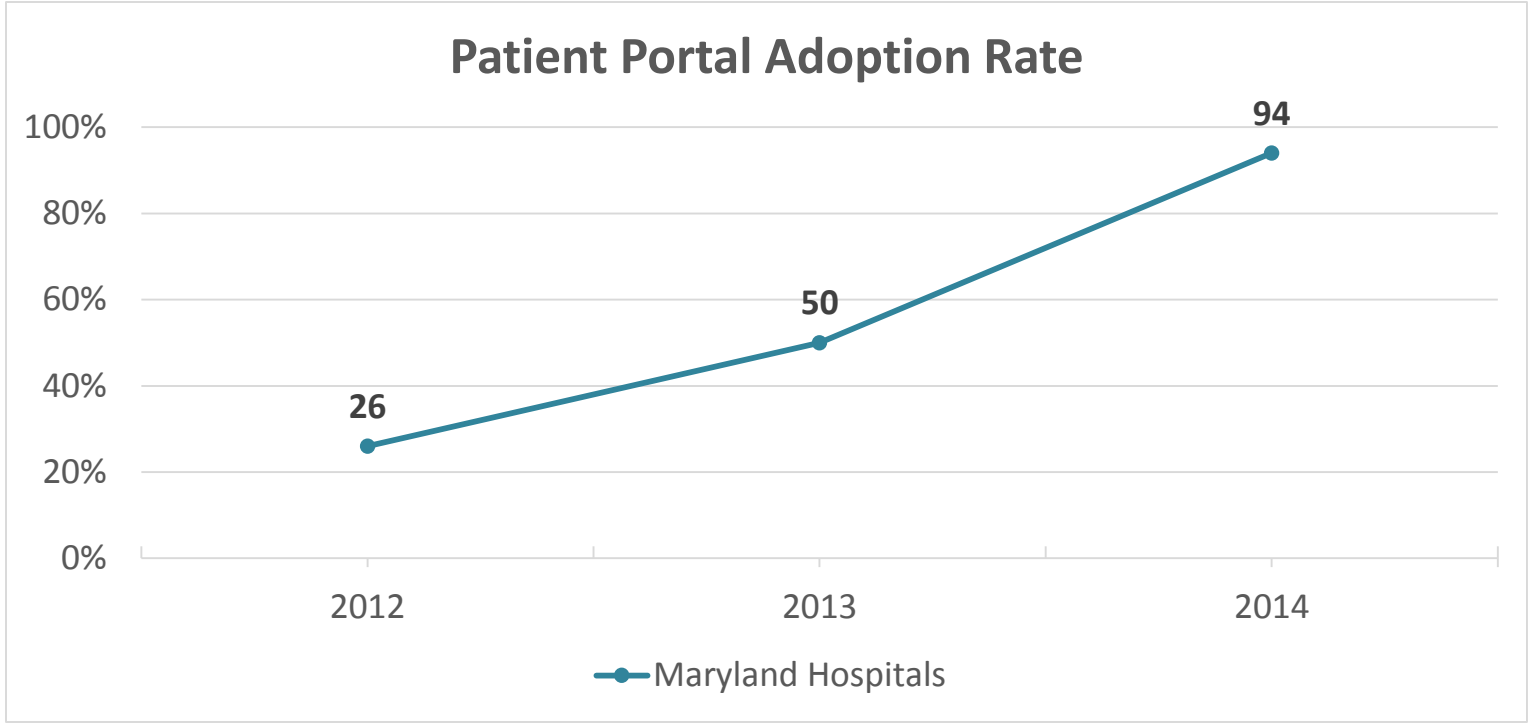
- All hospitals use three out of five EHR components identified in meaningful use
- e-Prescribing of discharge medications to external pharmacies grew by 37 percent from 2010 to 2014
- Hospital adoption of e-prescribing is expected to continue under health care reform

Core EHR Components %						
Technology		CPOE	CDS	eMARs	BCMA	e-Prescribing
Adoption Rate	2010 N=44	77	70	79	62	19
	2014 N=47	100	100	100	98	68
Growth Rate		7	7	6	12	37

Patient Portals

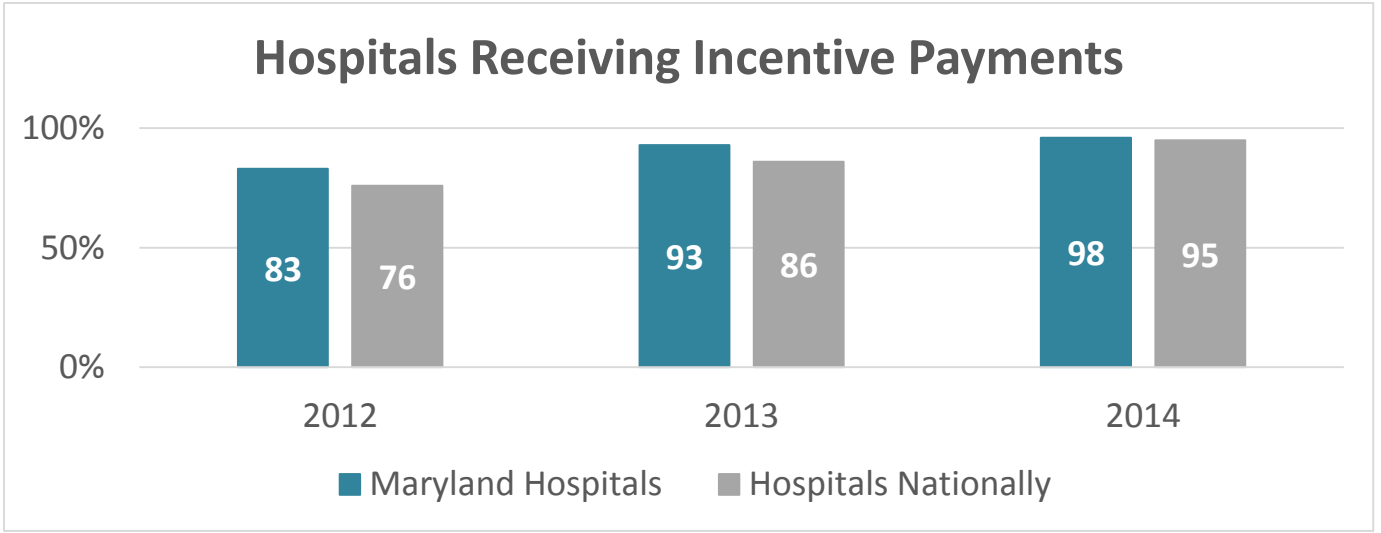
- Patient portal adoption increased most rapidly in recent years, growing at a rate of about 92 percent from 2012 to 2014

- The top three patient portal functionalities provided by most hospitals include:
  - Access visit summary
  - Check test results
  - Download information on hospital admission



Medicare & Medicaid EHR Incentive Programs

- Maryland continues to lead the nation in the percent of hospitals that have received EHR incentive payments
- Collectively, hospitals have received over $18B; Maryland hospitals have received approximately $272M
- About 32 percent of hospitals have been audited for meaningful use compliance by the federal government and there were no adverse findings; nationally, there have been over 600 audits of hospitals with a 4.9 percent failure rate



Incentive Payments - Combined N=47			
Hospital Type N=47	Share %		
	Medicare	Medicaid	Medicare & Medicaid
Health Systems N=24	44.2	55.2	47.4
Community Hospitals N=23	55.8	44.8	52.6

HIE

- Since 2013, hospital submission of radiology, transcribed, and laboratory data to CRISP increased by 22 percent
- Nearly 30 percent of hospitals implemented functionality over the past year to begin sending continuity of care documents (CCDs) to CRISP
- Most hospitals expressed interest in CRISP supporting radiology image sharing and eMOLST forms
- Five hospitals share clinical information with community-based HIEs that are registered with MHCC

Hospital Data Submission to CRISP
N=47

Type of Data	Hospitals %
ADT	100
Radiology *(Report)*	98
Transcribed *(Report)*	94
Laboratory	89
CCDs *(Patient-Level Summaries)*	30

Telehealth

- Approximately 64 percent of hospitals report having telehealth capabilities compared to 52 percent of hospitals nationally
- Since 2013, teleconsultations and emergency telehealth services has nearly tripled
- Use of interactive audio/video technology ranks highest

Telehealth Services
N=30

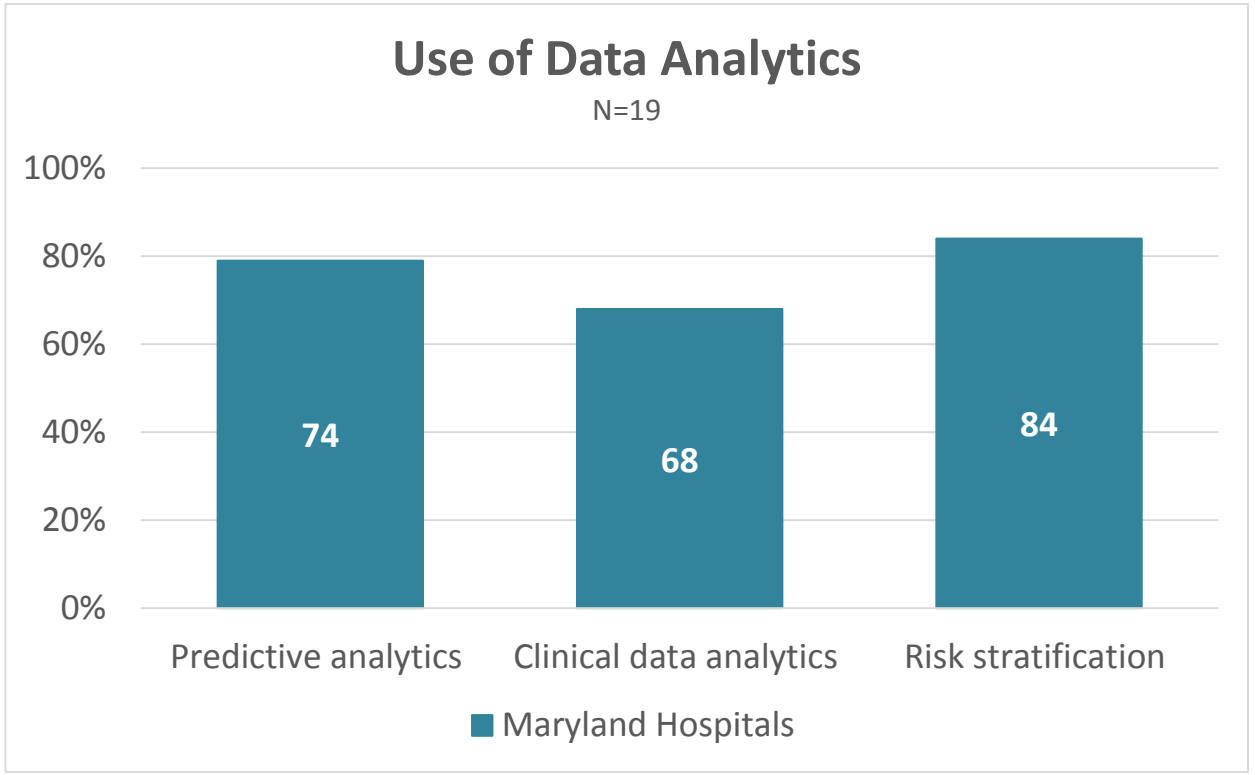
Type of Service	%
Teleradiology	83
Teleconsultation	69
Emergency	45
Remote Monitoring	41
Telediagnosis	34
Telebehavioral Health	17

Telehealth Technologies
N=30

Type of Technology	%
Interactive Audio/Video	52
Mobile Devices	21
Home Monitoring Devices	17

Population Health Management

- Roughly 40 percent of hospitals have implemented systems to support population health management
  - 10 academic hospitals
  - 9 community hospitals
- Over three quarters of hospitals began using data analytic tools in recent years
  - About 47 percent report using all three types of data analytics tools
- Around 36 percent of hospitals use electronic care plans



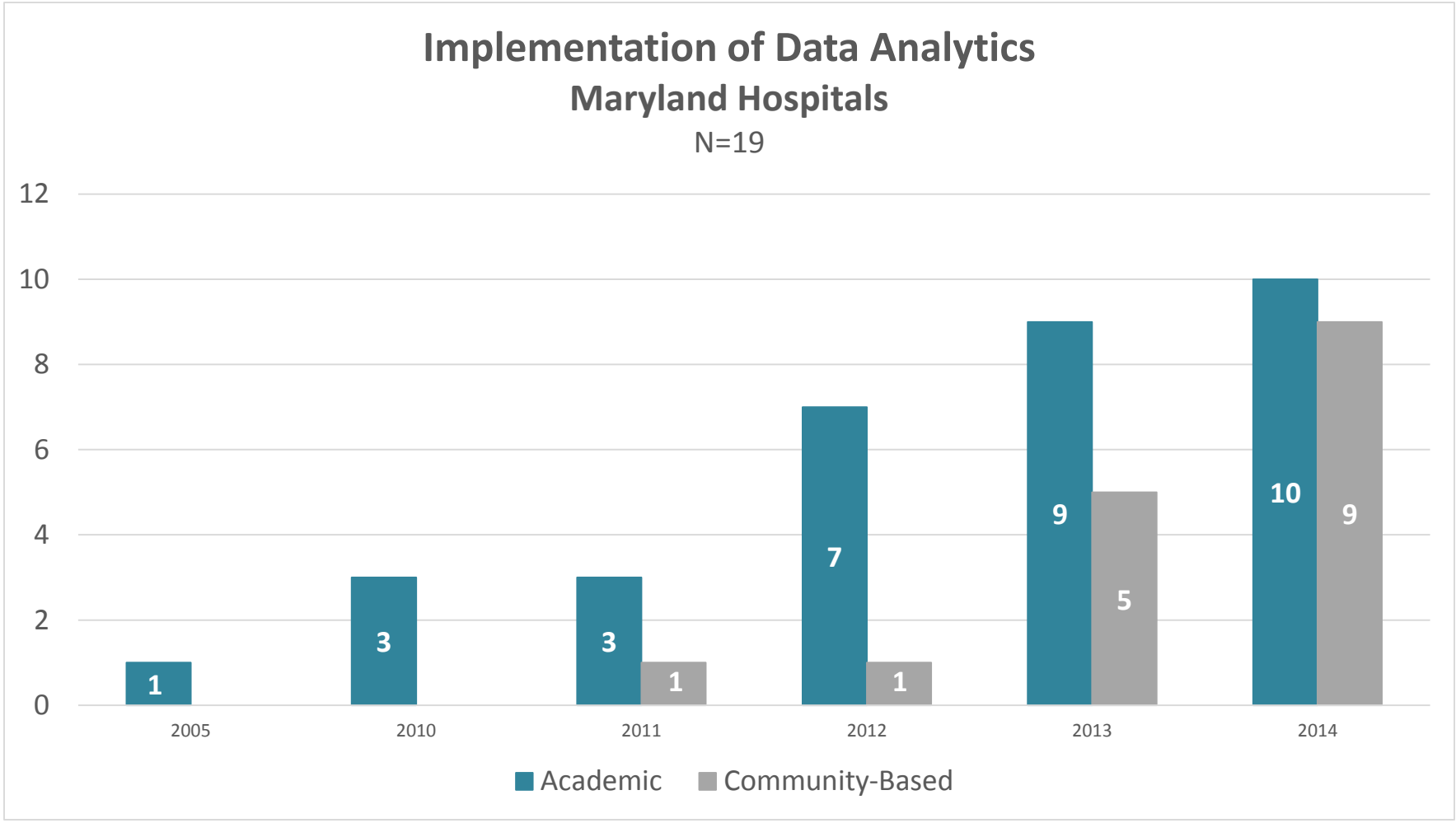
Thank You!

The MARYLAND
HEALTH CARE COMMISSION

Appendix

Patient Portal Functionalities Hospitals N=44	
Administrative	**%**
E-mail provider	30
Pay bill	32
Pre-register for services	14
Request electronic copy of medical record	27
Update insurance information	16
Clinical	
Accept patient-generated data	16
Access visit summary	93
Check test results	91
Download information on hospital admission	86
Renew/refill prescription	27
Self-management tools for chronic conditions	20

Appendix *(Continued…)*



MARYLAND HEALTH CARE COMMISSION

AGENDA

1. **APPROVAL OF MINUTES**

2. **UPDATE OF ACTIVITIES**

3. **ACTION**: Certificate of Conformance for Emergency and Elective Percutaneous Coronary Intervention Services: University of Maryland Shore Medical Center at Easton (Docket No. CC-15-20-0001)

4. **ACTION:**
   4) COMAR 10.24.16 – State Health Plan for Facilities and Services: Home Health Agency Services – Final Regulation
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MARYLAND HEALTH CARE COMMISSION

Overview of Upcoming Initiatives

(Agenda Item #10)


ENJOY THE REST OF
YOUR DAY