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
   2300R – Washington Adventist Hospital
   2302A – University of Maryland Medical Center
   2304N – UM St. Joseph Medical Center
   2299A – MedStar Health
   2301R – Holy Cross Hospital
   2303R – Frederick Memorial Hospital
   2305A – University of Maryland Medical Center
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.
ICN Infrastructure Tools and Services
Update on Progress

August 12, 2015
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
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 provider's 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

<table>
<thead>
<tr>
<th><strong>Definition</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical Query Portal Enhancements</strong></td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td><strong>In-Context Notifications and Alerting</strong></td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td><strong>Care Profile View</strong></td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td><strong>Data Router</strong></td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td><strong>Standardized Risk Stratification Tools</strong></td>
</tr>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>
• 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

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

Deliverables
- Risk stratified patient analysis
- Care Profile view
- Care Mgmt tools
- Notifications
- New clinical data feeds for care management
- Performance metrics
- Consent management
- Richer clinical query portal information
- Care Profile view
- Notifications
- In-context alerts
- Care Alerts receive & create
- Consent management
- Richer clinical query portal information
- Care Profile view
- Performance metrics
- Consent management
- Performance metrics
- Statewide & regional analytics
- Risk stratified patient analysis
- Care Profile view
- Care Mgmt tools
- Notifications
- New clinical data feeds for care management
- Performance metrics
- Consent management
- Control of health data consent
- All providers have a patient-centric understanding of their health status

Statewide ICN Infrastructure Development Plan

In development with Regional Partnerships and others
ICN Infrastructure Concept

Statewide ICN Infrastructure Development Plan

**New Tools**
- Data Router / clinical data normalization
- Clinical portal enhancements
- CCDA / Care Plan parsing
- Privacy / consent management utility
- Identity management

**HIE Infrastructures**
- Encounter Notification Services (ENS)
- Medicare claims data
- Enrollment data, patient panels
- HIE clinical data

**Inputs**
- In context notification & alerting tools
- Risk stratification / predictive modeling tools
- Basic Care Management software
- Patient / provider relationship identification
- CRISP Reporting Services analytics (CRS)
- Clinical query portal
- Administrative / visit data (need ambulatory connectivity)
- PDMP
- Processed Case Mix data

**IT Stack**
- Working Version 1.4
<table>
<thead>
<tr>
<th>Goal</th>
<th>6-Month Goal Dec 31, 2015</th>
<th>12-Month Goal Jun 30, 2016</th>
<th>24-Month Goal Jun 30, 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICN Tools and Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deploy Router</td>
<td>Routing data from 40 total ambulatory practices to 2 care management programs / 150 practices</td>
<td>Router supporting 1,000 providers</td>
<td>Router supporting 5,000 providers</td>
</tr>
<tr>
<td>Consent Utility</td>
<td>Opt out for ambulatory data is made more granular and working / ENS opt out working</td>
<td>Opt out for ENS is working</td>
<td>3,000 people have opted out of ENS</td>
</tr>
<tr>
<td>Deploy Risk Stratification solution against case mix data</td>
<td>Risk stratification tool selection complete and production pilot underway for 4 partners / 10 partners</td>
<td>Risk stratification broadly available through reports and or query portal</td>
<td>Risk stratification includes clinical data inputs</td>
</tr>
<tr>
<td>Deploy uniform &quot;base&quot; approach for Health Risk Assessment</td>
<td>Build consensus among Steering Committee on uniform &quot;base&quot; approach to HRAs</td>
<td>TBD</td>
<td>TBD</td>
</tr>
<tr>
<td>Deploy standardized approach for Care Profile development and sharing</td>
<td>Steering Committee agrees on standardized approach to Care Profile, Care Alert development / live in portal</td>
<td>Care Profiles available prominently in the clinical query portal</td>
<td>TBD</td>
</tr>
<tr>
<td>Deploy approach for Care Plan viewing through HIE</td>
<td>Care Plan viewable through the clinical portal from 2 organizations / 4 organizations</td>
<td>Care Plans available for 10,000 patients</td>
<td>Care Plans available for 40,000 patients</td>
</tr>
<tr>
<td>Deploy In-Context Notifications</td>
<td>In context notifications in 4 EDs, for presence of a Care Plan or recent discharge / 10 EDs</td>
<td>In-context notifications available to 100 ambulatory providers</td>
<td>In-context notifications available to 5,000 ambulatory providers</td>
</tr>
<tr>
<td>Enhance Clinical Query Portal with new information</td>
<td>ENS Provider Subscription information available in Clinical Query Portal / with provider contact info</td>
<td>Provider Directory contact information integrated into Clinical Query Portal</td>
<td>Robust patient attribution information, for providers and care managers, feeding the Clinical Query Portal</td>
</tr>
<tr>
<td>Deploy Reporting &amp; Analytics tools for patient panels / attributed patients</td>
<td>Tableau access available to all hospitals, and used by 20 / 40</td>
<td>TBD</td>
<td>TBD</td>
</tr>
<tr>
<td></td>
<td>Regional Partnerships are meaningfully using CRS reports</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal</td>
<td>6-Month Goal Dec 31, 2015</td>
<td>12-Month Goal Jun 30, 2016</td>
<td>24-Month Goal Jun 30, 2017</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>---------------------------</td>
<td>-----------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td><strong>New Data Sources</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Sharing Framework</td>
<td>Pilot data Sharing Policy in place to enable use of All Payer Report / improved approach to 42 CFR Part 2 data agreed</td>
<td>PA addendum signed by a majority of hospitals</td>
<td>Advanced ability to filter on 42 CFR Part 2</td>
</tr>
<tr>
<td>ENS Panel Growth</td>
<td>An ENS message is sent for 55% of Medicare discharges / 60%</td>
<td>An ENS message is sent for 65% of Medicare discharges</td>
<td>An ENS message is sent for 80% of Medicare discharges</td>
</tr>
<tr>
<td>CMS Data availability</td>
<td>Partner with MHA and HSCRC to formally request data</td>
<td>CMS data in use</td>
<td></td>
</tr>
<tr>
<td>Admin / Visit Data growth</td>
<td>1,000 providers sending administrative data / 2,000</td>
<td>2,000 providers sending administrative data</td>
<td>5,000 providers sending administrative data</td>
</tr>
<tr>
<td>Ambulatory Clinical Data growth</td>
<td>500 ambulatory providers sending clinical data / 1,000</td>
<td>1,000 ambulatory providers sending clinical data</td>
<td>TBD</td>
</tr>
<tr>
<td>Increase SNF Connectivity</td>
<td>Steering committee agrees approach to coordinating with SNFs and data sharing</td>
<td>TBD</td>
<td>TBD</td>
</tr>
<tr>
<td><strong>Industry / Community Partner Engagement</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operational Practice Transformation Center</td>
<td>Initial funding and plan in place / statewide effort funded</td>
<td>TBD</td>
<td>TBD</td>
</tr>
<tr>
<td>Support Regional Partnerships</td>
<td>At least one goal or obligation is defined and agreed in an MOU for each regional partnership / plus 5 other than RPs</td>
<td>TBD</td>
<td>TBD</td>
</tr>
<tr>
<td>CRS / Tableau directly leveraged by strategic partners</td>
<td>At least 2 partners have direct access to Tableau in support of provider organizations / 6 partners</td>
<td>TBD</td>
<td>TBD</td>
</tr>
</tbody>
</table>
Questions
Appendix

1. Current Tools
2. New Tools and Services
Current Tools and Services
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
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
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 – 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 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

<table>
<thead>
<tr>
<th>Content Type / Source</th>
<th>Update Frequency</th>
<th>Care Profile Repository and Access Point</th>
<th>Access Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Demographics</td>
<td>Daily</td>
<td>CRISP Care Profile Repository</td>
<td>SSO Access through Query Portal</td>
</tr>
<tr>
<td>Clinical Alert Information</td>
<td>Daily</td>
<td>CRISP Care Profile Repository</td>
<td>API call from EHR</td>
</tr>
<tr>
<td>ENS Subscriber Information</td>
<td>Daily</td>
<td>CRISP Care Profile Repository</td>
<td>Link from ENS User Interface</td>
</tr>
<tr>
<td>ADT Data</td>
<td>Daily</td>
<td>CRISP Care Profile Repository</td>
<td></td>
</tr>
<tr>
<td>CRS Case Mix Data</td>
<td>Monthly</td>
<td>CRISP Care Profile Repository</td>
<td></td>
</tr>
<tr>
<td>Care Plan Availability Indicator</td>
<td>Daily</td>
<td>CRISP Care Profile Repository</td>
<td></td>
</tr>
</tbody>
</table>

- **Update Frequency**: Daily or Monthly
- **Care Profile Repository and Access Point**: CRISP Care Profile Repository
- **Access Methods**: SSO Access through Query Portal, API call from EHR, Link from ENS User Interface

= to be developed
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 - 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.

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

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

**PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET**
IN RE: THE APPLICATION FOR
ALTERNATIVE METHOD OF RATE
DETERMINATION
MEDSTAR HEALTH
BALTIMORE, MARYLAND

* BEFORE THE MARYLAND HEALTH
* SERVICES COST REVIEW
* COMMISSION
* DOCKET: 2015
* FOLIO: 2108
* 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 alternative method of rate determination
Medstar Health

Baltimore, Maryland

* Before the Maryland Health Services Cost Review Commission
* Docket: 2015
* Folio: 2109
* 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:

<table>
<thead>
<tr>
<th></th>
<th>Current Rate</th>
<th>Budgeted Volume</th>
<th>Approved Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Surgical Intensive Care</td>
<td>$1,714.92</td>
<td>12,791</td>
<td>$21,936,193</td>
</tr>
<tr>
<td>Coronary Care</td>
<td>$1,769.05</td>
<td>276</td>
<td>$488,016</td>
</tr>
<tr>
<td>Combined Rate</td>
<td>$1,716.09</td>
<td>13,067</td>
<td>$22,424,209</td>
</tr>
</tbody>
</table>

**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
ALTERNATIVE METHOD OF RATE
DETERMINATION
UNIVERSITY OF MARYLAND
MEDICAL CENTER
BALTIMORE, MARYLAND

BEFORE THE MARYLAND HEALTH
SERVICES COST REVIEW
COMMISSION
DOCKET: 2015
FOLIO: 2112
PROCEDING: 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
MEDICAL 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.
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.
Promoting Patient-Centered Approaches in the NAPM
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.
Need to know how to manage their specific health problems and work with a care team to stay out of the hospital.

All of the below, plus:
- Hospitals
- PCP & pharmacists
- Specialists
- Payers
- Faith & community organizations
- Caregiver support groups
- Social workers/case managers
- Long-term care providers
- Behavioral health providers
- DHMH/Local Health Departments

Need to know in general where to go for episodic or diagnostic care. How to play an active role in managing their health. Have a relationship with primary care provider.

All of the below, plus:
- Consumer advocacy groups
- Advocacy and support groups for chronic conditions

Need to know Maryland is doing something unique. How to get the right care, in the right place at the right time. Care options available and how to make their health care desires known.

All of the below, plus:
- News media
- MHBE/Connector Entities & Partner Organizations
- Members of town and county councils
- Local community activists
## Communication Strategy: Sample Recommended Strategies

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Stakeholders</td>
<td>Develop a statewide public education campaign to promote health and wellness.</td>
</tr>
</tbody>
</table>
| 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                       |
|                      | • 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?
<table>
<thead>
<tr>
<th>Applicant</th>
<th>Project Description</th>
<th>Cost</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Active Hospital Relocation Projects</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Washington Adventist Hospital – Takoma Park (Montgomery Co.)</td>
<td>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</td>
<td>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</td>
<td>Docketed Jan. 2015 Three opposing interested parties; Laurel, Regional, Medstar Montgomery, &amp; Holy Cross of Silver Spring City of Takoma Park is a participating entity Commissioner Phillips is Reviewer</td>
</tr>
<tr>
<td>Prince George’s Hospital Center - Cheverly (Prince George’s Co.)</td>
<td>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)</td>
<td>Estimated Cost: $651,223,000 Source of Funds: Equity: $0 Debt: $207M Other: $445M</td>
<td>Docketed April 2015 Two opposing Interested parties: Doctors Community &amp; Anne Arundel Prince George;s Co. HD is supportive interested party Commissioner Moffit is Reviewer</td>
</tr>
<tr>
<td>Sheppard Pratt at Ellicott City - Ellicott City (Howard Co.)</td>
<td>Relocation of special hospital-psychiatric (100 beds) to Elkridge</td>
<td>Estimated Cost: $102,653,372 Source of Funds: Equity: $18M Debt: $70M Other: $15M</td>
<td>Filed April 2015 Not yet docketed</td>
</tr>
<tr>
<td><strong>Other Active Hospital Projects</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anne Arundel Medical Center - Annapolis (Anne Arundel Co.)</td>
<td>Introduce cardiac surgery</td>
<td>Estimated Cost: $2,500,381 All cash</td>
<td>Docketed June 2015 Interested party filing in opposition by MedStar</td>
</tr>
<tr>
<td>University of Maryland Baltimore Washington Medical Center - Glen Burnie (Anne Arundel Co.)</td>
<td>Introduce cardiac surgery</td>
<td>Estimated Cost: $1,259,117 All cash</td>
<td>Docketed June 2015 Interested party filing in opposition by MedStar</td>
</tr>
<tr>
<td>Suburban Hospital - Bethesda (Montgomery Co.)</td>
<td>Major expansion &amp; renovation Replace ORs, create new main entrance, add nursing units to create more private rooms, expand support service &amp; mechanical space, shelled space, medical office space 300K SF in new consr. &amp; 18K in renovation</td>
<td>Estimated Cost: $200,550,831 Source of Funds: Equity: $91M Debt: $70M Other: $40M</td>
<td>Filed April 2015 Not yet docketed</td>
</tr>
<tr>
<td>Inactive Hospital Projects</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>University of Maryland Shore Medical Center at Easton - Easton (Talbot Co.)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relocation of general acute care hospital and special hospital unit for rehabilitation (126 beds) Approx. 2 miles NW of current site</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated Cost: $283,240,375</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Source of Funds:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equity: $10M</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Debt: $243M</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other: $31M</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Docketed Jan 2013</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inactive since 2014 – anticipated activation in late 2015</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| **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 |
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

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

Source: MHCC/CON Applications
## Relocation/Replacement Projects

<table>
<thead>
<tr>
<th></th>
<th>Source of Funds</th>
<th>Annual Interest/Depreciation/Amortization</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Equity</td>
<td>Debt</td>
</tr>
<tr>
<td><strong>SMCE</strong></td>
<td>$10M</td>
<td>$243M</td>
</tr>
<tr>
<td><strong>WAH</strong></td>
<td>$51M</td>
<td>$245M</td>
</tr>
<tr>
<td><strong>PGHC</strong></td>
<td>$0</td>
<td>$207M</td>
</tr>
<tr>
<td><strong>SP/EC</strong></td>
<td>$18M</td>
<td>$70M</td>
</tr>
</tbody>
</table>

*Source: CON Applications/Audited Financial Statements*
### Expansion/Renovation Projects

<table>
<thead>
<tr>
<th>Source</th>
<th>Equity</th>
<th>Debt</th>
<th>Other</th>
<th>Annual Interest/Depreciation/Amortization</th>
<th>Most Recent Post-Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>SMHC</td>
<td>$37M</td>
<td>$89M</td>
<td>$5M</td>
<td>$10M</td>
<td>$19M</td>
</tr>
<tr>
<td>Suburban</td>
<td>$91M</td>
<td>$70M</td>
<td>$40M</td>
<td>$16M</td>
<td>$31M</td>
</tr>
</tbody>
</table>

Source: CON Applications/Audited Financial Statements
The complete CON application filings for these projects can be found at:

http://mhcc.maryland.gov/mhcc/Pages/hcfs/hcfs_con/hcfs_conFiled_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.

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
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.