Closed Session Minutes
Of the
Health Services Cost Review Commission

APRIL 13, 2016

Upon motion made in public session, Chairman Sabatini called for adjournment into closed session to discuss the following items:

1. Update on Contract and Modeling of the All-Payer Model vis-à-vis the All-Payer Model Contract - Administration of Model Moving into Phase II – Authority General Provisions Article §3-103 and §3-104
2. Discussion on Planning for Model Progression - Authority General Provisions Article §3-103 and §3-104
3. Update on Hospital Rate Issue (JHH) – Authority General Provisions Article, §3-305(7)

The Closed Session was called to order at 11:14 a.m. and held under authority of §3-104 and §3-305(7) of the General Provisions Article.

In attendance in addition to Chairman Sabatini were Commissioners Bayless, Bone, Colmers, Jencks, Keane, and Wong.

In attendance representing Staff were Donna Kinzer, Steve Ports, Sule Gerovich, Jerry Schmith, Ellen Englert, Claudine Williams, Amanda Vaughn, Jessica Lee, Karthik Rao and Dennis Phelps.

Also attending were Deborah Gracey and Eric Lindeman, Commission Consultants, and Stan Lustman and Leslie Schulman, Commission Counsel.

Item One

Donna Kinzer, Executive Director, and Eric Lindeman, Commission Consultant, presented and the Commission discussed analyses of Medicare per beneficiary data.

Item Two

With the aid of Deborah Gracey, Commission Consultant, Ms. Kinzer presented and the Commission discussed potential approaches for moving the All-Payer Model forward as contemplated by the Model agreement.

Item Three

Jerry Schmith, Deputy Director Hospital Rate Setting, updated the Commission on the rate issue involving Johns Hopkins Hospital.

The Closed Session was adjourned at 2:11 p.m.

MINUTES OF THE
529th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

April 13, 2016

Chairman Nelson Sabatini called the public meeting to order at 11:12 am. Commissioners Victoria Bayless, George H Bone, M.D., John Colmers, Stephen F. Jencks, M.D., MPH, Jack C. Keane, and Herbert S. Wong, Ph.D. were also in attendance. Upon motion made by Commissioner Colmers and seconded by Commissioner Jencks, the meeting was moved to Executive Session. Chairman Sabatini reconvened the public meeting at 2:14 pm.

REPORT OF THE APRIL 13, 2016 EXECUTIVE SESSION

Mr. Dennis Phelps, Associate Director-Audit & Compliance, summarized the minutes of the April 13, 2016 Executive Session.

ITEM I

REVIEW OF THE MINUTES FROM THE MARCH 9, 2016 EXECUTIVE SESSION AND PUBLIC MEETING AND THE MARCH 29 EXECUTIVE SESSION CONFERENCE CALL

The Commission voted unanimously to approve the minutes of the March 9, 2016 Executive Session and Public Meeting and of the March 29, 2016 Executive Session conference call.

ITEM II

EXECUTIVE DIRECTOR'S REPORT

Ms. Donna Kinzer, Executive Director, noted that the Advisory Council ("Council") met for the third time to discuss and provide advice for consideration by the Department of Health and Mental Hygiene (DHMH) and HSCRC as Maryland continues to implement the All Payer Model and to makes plans for progression to focus on system wide costs and outcomes. The Council will add more depth to the concepts discussed before providing an interim report to the HSCRC and DHMH. The next meeting is scheduled for Monday April 18th at the Maryland Hospital Association offices.

Ms. Kinzer stated that Staff and the DHMH are continuing to work with the Center for Medicare and Medicaid Innovation (CMMI) on a potential amendment to the All Payer Model agreement to provide the approvals needed to support alignment activities that would allow hospitals to share savings and make available incentive payments to hospital based and community-based providers when quality is improved and avoidable utilization is reduced. Staff is also working to obtain data for use by providers in enhancing care delivery and providing additional resources to

complex and chronic care persons with the highest levels of need. Staff is hopeful that the new amendment will be approved by this summer.

Ms. Kinzer reported that the Duals Care Delivery Workgroup has met for the third time. This workgroup was formed by DHMH to develop potential models for dual eligible individuals (beneficiaries with both Medicare and Medicaid coverage). Payment models will need to dovetail with the progression of the All Payer Model.

Ms. Kinzer noted that Staff has been working with the University of Maryland population health center in developing the process for proposals, awards, and monitoring of rate adjustments to support up to $10 million that was authorized for population health work force support for workers from disadvantaged areas of the State. Staff is focused on implementing the adjustment as close to the beginning of FY 2017 as possible. Currently, a draft of applications for the support program has been sent to stakeholders for review and comments. Final comments are coming in this week.

Ms Kinzer reported that MedStar Health system experienced a serious attack on its information systems. She noted that as a result, MedStar data will be delayed and that staff does not have financial reports for the month of February. Staff expects to receive February reports in the near future. Staff also expects March reports and billings to be delayed. This will affect the timeliness of reporting to the Commission.

Ms. Kinzer reported that for the rest of the hospitals in the State, there was an increase of 7.38% in the All Payer total gross revenue over last year. Per Ms. Kinzer, key contributing factors for this increase are as follows:

- There were 21 working days in February in 2016 due to the Leap Year.
- February 2015 was the second coldest month on record, which may have kept people at home. February 2016 was warmer, had no snow, and there were a high number of hospitalizations associated with the flu.

Ms. Kinzer stated that each month Staff reports on unaudited results for regulated and unregulated profit levels. Staff is concerned that the unregulated reports are inaccurate and may include payments and subsidies to hospital based physicians such as hospitalists**.** Staff would like to ask the Maryland Hospital Association (MHA) task force to work with Staff to develop annual reporting that splits unregulated revenues and expenses for hospital-based physicians and providers (e.g., radiology, anesthesiology, ER, pathology, hospitalists) community based practices and providers (e.g., primary care providers, and physicians with privileges to work at the hospital (e.g., orthopedic surgery). This will help us more accurately report revenues and expenses associated with hospital operations.

Ms. Kinzer also noted that the Staff would like to work with the MHA task force in regards to charge variability. In the charge per case model, HSCRC calculated rate compliance on a three month rolling basis. In the current model, hospitals request relief if they will exceed charge

corridors beyond 5%. The staff would like to work with the MHA task force to make recommendations regarding a rolling corridor.

Ms. Kinzer stated that Staff is working with the Payment Models Workgroup on the annual update and other related payment issues.

Ms. Kinzer stated that Staff is working with the Performance Measurement Workgroup to finalize the Readmission Reduction Incentive Program and aggregate at risk revenue recommendations presented at the March Commission meeting. The final recommendation will be made at the May Commission meeting. The deadline for comments is April 29, 2016.

Ms. Kinzer noted that Staff is currently focused on the following activities:

- Reviewing implementation plans and conducting discussions regarding proposals, plans, and reports that have been provided to HSCRC for the purpose of assessing and understanding implementation progress and gaps, and readiness to accelerate community-based care coordination and management.
- Developing shared savings, readmission, and aggregate at risk recommendations.
- Organizing and preparing for the FY 2017 annual update.
- Reviewing several rate applications for capital that have been filed.
- Moving forward on updates to value based performance measures, including efficiency measures.
- Examining Medicare per capita costs and total cost of care, for purposes of monitoring and for progressing toward a focus on outcomes and costs across the health care system.
- Working with DHMH and stakeholders to focus on ensuring success of the All-Payer Model and providing a proposal for a new model no later than January 2017 as required under the Agreement with the CMS.
- Working on an All-Payer amendment for alignment activities.
- Working on a request to CMMI for Medicare data that can be used for care coordination, model monitoring, and other Model purposes.

Ms. Kinzer introduced Ms. Noi Reid as the new Chief of Quality Analysis.

ITEM III

NEW MODEL MONITORING

Dr. Alyson Schuster, PhD., Associate Director Performance Management, presented a quality report update on the Maryland Hospital Acquired Conditions program based upon potentially preventable complications and readmission data on discharges through December 2015.

Readmissions

- The All-Payer risk adjusted readmission rate was 12.87% for December 2015 YTD. This is a decrease of 7.15% from the December 2013 risk adjusted readmission rate.
- The Medicare Fee for Service risk adjusted readmission rate was 13.70% for December 2015 YTD. This is a decrease of 6.43% from the December 2013 YTD risk adjusted readmission rate.
- Based on the All-Payer Model Agreement, hospitals must reduce Maryland's readmission rate to or below the national Medicare readmission rate by 2018. The Readmission Reduction Incentive Program has set goals for hospitals to reduce their adjusted readmission rate by 9.3% during CY 2015 compared to CY 2013. Currently, only 14 out of 46 hospitals have reduced their risk adjusted readmission rate by more than 9.3%.

Potentially Preventable Complications (PPCs)

- The All-Payer risk adjusted PPC rate was 0.75 for December 2015 YTD. This is a decrease of 33.04% from the December 2013 YTD risk adjusted PPC rate.
- The Medicare Fee-for-Service risk adjusted PPC rate was 0.87 for December 2015 YTD. This is a decrease of 34.09% from the December 2013 risk adjusted PPC rate.
- These preliminary PPC results indicate that hospitals are on track for achieving the annual 6.89% PPC reduction required by CMMI to avoid corrective action.

Dr. Sule Gerovich Ph.D., Director Center for Population Based Methodologies, presented utilization trend reports reflecting the Equivalent Case-Mix Adjusted Discharges (ECMAD) growth for the calendar ending December 2015.

Dr. Gerovich reported that for the twelve months of the calendar year ended December 30, 2015, All Payer ECMAD growth increased by 0.06% over the same period in CY 2014. ECMAD growth for Maryland residents increased by 0.15%. This is made up of Maryland inpatient ECMAD decreasing by 0.43% and outpatient ECMAD increasing by 1.1%. ECMAD growth for non-residents decreased by 0.89%.

Dr. Gerovich reported that for the twelve months of the calendar year ended December 30, 2015, Medicare ECMAD growth increased by 2.00% over the same period in CY 2014. ECMAD growth for Maryland residents increased by 2.25%. This is made up of Maryland inpatient and outpatient ECMAD increasing by 1.51% and 4.03%. ECMAD growth for non-residents decreased by 1.07%.

ITEM IV

DOCKET STATUS CASES CLOSED

2317R- MedStar Health

2338A- Johns Hopkins Health System

ITEM V

DOCKET STATUS- OPEN CASES

2320N-Sheppard Pratt Health System

On November 24, 2015, Sheppard Pratt Hospital ('SPH") submitted a partial rate application to the Commission requesting rate for a new Behavioral Observation Service (OBV). Since May of 2011, SPH has operated an outpatient walk-in-clinic (Clinic) for individuals in psychiatric crisis. The goal of the Clinic is to provide rapid evaluation for safety and referral to appropriate levels of care for individuals who could be safely assessed in a clinic setting and who do not have medical issues other than detoxification requiring transfer to a setting with more robust medical management capabilities, i.e., an Emergency Department. OBV will be used to treat a cohort of individuals presenting at SPH's Clinic seeking inpatient treatment for co-occurring disorders, i.e., a psychiatric diagnosis in combination with active substance use disorder. SPH has been unable to determine the appropriate treatment setting for these individuals because they are inebriated or under the influence of drugs. SPH intends to use the OBV to safely detoxify these individuals, in an observation status. Once the individual is competent to be evaluated, a psychiatric evaluation will be completed to determine if their psychiatric condition warrants inpatient admission or other treatment options.

SPH requests that the new rate of $45.1358 be effective January 1, 2016.

After review of the application and analysis of the additional information provided by SPH and other sources, staff believes that the observation service for patients with co-occurring disorder requested by SPH will eliminate transfer to emergency departments, provide more efficient and effective patient care, and will save money for the Maryland health system.

Therefore, staff recommends that:

1. That an OBV rate of $45.1358 per hour be approved effective April 1, 2016 for patients with co-occurring disorder only; and
2. That the OBV rate not be rate realigned until a full year's experience has been reported in SPH's Annual Report.

The Commission voted unanimously to approve staff's recommendation.

2337-LifeBridge Health Inc.

On February 1, 2016, LifeBridge Health, Inc. (the "System") on behalf of Carroll Hospital Center ("Carroll") and Sinai Hospital ("Sinai") submitted a partial rate application to the Commission requesting that the rates of Carroll and Sinai be revised to reflect that the outpatient center at Carroll Hospital Cancer Center ("CHCC") will operate as an off-site provider-based child-site of Sinai for purposes of the federal 340B program. The System requests that:

1) $25.9 million be transferred from Carroll's Total Patient Revenue (TPR) cap to Sinai's Global Budget Revenue (GBR) cap, effective April 1, 2016;
2) The Commission approve new unit rates for CHCC services on Sinai's rate order, effective April 1, 2016;
3) The Commission exclude the revenue for the new unit rates for CHCC services from rate realignment; and
4) The Commission adjust rate order volumes in Carroll's and Sinai's rate orders to maintain a neutral impact to rate capacity as a result of the request.

Maryland 2015 legislation (Senate Bill 513) altered the definition of "hospital services" to include hospital outpatient services of a hospital that is designated as part of another hospital under the same merged asset system to make it possible for the hospital outpatient services to participate in the federal 340B Prescription Drug Discount program.
In order to avail itself of the new legislation, the System requests that effective April 1, 2016 outpatient services provided at CHCC located on the Carroll campus be approved to begin operations as part of the Sinai Oncology program. The outpatient center located at CHCC will be able to operate as an off-site provider-based child-site of Sinai in accordance with Medicare's rules for provider-based status. As a result of this request, the child-site at CHCC will be able to participate in the 340B outpatient drug discount program under Sinai's eligibility. The savings generated through the 340B program at the child-site of approximately $4.8 million will partially offset the 72% increase in drug costs at CHCC since 2012, which was not fully reflected in Carroll's TPR.

The System also requests that the rates approved on Sinai's rate order for the services provided at the CHCC child-site be those of CHCC for RY 2016. According to the application, savings of approximately $200K will be generated for Medicare patients, who are currently 50.4% of patients at CHCC.

The System requests that the revision of rates and revenue between Carroll and Sinai be effective April 1, 2016.

After review of the application, staff recommends that System's request be approved because: 1) it will enable Sinai to provide lower cost services to current oncology patients; and 2) it will generate future savings to the Maryland healthcare system and to additional oncology patients through lower drug costs at the CHCC location.

Staff recommends that the approval be contingent upon Sinai applying for and receiving provider-based status from the Centers for Medicare and Medicaid Services for outpatient services provided at the CHCC site.

Staff also recommends that the following rates and the associated revenue for services provided at the CHCC location be approved and added to Sinai's approved rate order and GBR effective

April 1, 2016:

1. A Clinic rate of $41.70 per RVU;
2. A Radiology-Therapeutic rate of $9.10 per RVU;
3. An OR Clinic rate of $20.44 per minute;
4. A rebundled Laboratory rate of $2.41 per RVU; and
5. Drug revenue of $12,441,570.

Commissioners moved that the effective date of the recommendation be amended to correspond to the effective date on which the amended regulation COMAR 10.37.10.07-1 (Federal 340B program) becomes effective.

The Commission voted unanimously to approve staff's recommendation as amended.

2340A- Johns Hopkins Health System

Johns Hopkins Health System, on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the "Hospitals"), filed an application on March 17, 2016 requesting continued participation in a global rate arrangement for cardiovascular and joint procedures services with Quality Health Management and to add pancreas and bariatric surgery procedures to the arrangements for a period of one year beginning May 1, 2016.

Staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for cardiovascular, joint, pancreas, and bariatric surgery procedures for one year beginning May 1, 2016, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation. Commissioner Colmers recused himself from the discussion and vote.

2341A-University of Maryland Medical Center

University of Maryland Medical Center (the "Hospital") filed an application on March 27, 2016 requesting approval to continue to participate in a global rate arrangement for liver, kidney, and lung and blood and bone marrow transplant services with Cigna Health Corporation for one year beginning June 1, 2016.

Staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for liver, kidney, lung and blood and bone marrow transplant services for one year beginning June 1, 2016, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

30 Day Extensions
2339R- Prince George's Hospital Center

The Commission voted unanimously to approve staff's request to extend the time for review on proceeding 2339R Prince George's Hospital Center for 30 days.

ITEM VI

UPDATE FACTOR DISCUSSION

Dr. Gerovich presented an update on the Payment Models Work Group activities (see "FY 2017 Payment Models Work Group Update" on the HSCRC website).

Dr. Gerovich noted that the Payment Models Work Group is focusing on:

- Proposed funding for high costs drugs using a portion of the inflation update for next year
- A revision to the readmission shared savings proposal to focus more on sepsis rates and Prevention Quality Indicators (PQIs)
- The need to consider a lower overall hospital update to offset expected growth in non-hospital Medicare costs.

Commissioner Jack Keane commented that staff should consider crafting a differential update to individual hospitals based on their performance in reducing potentially avoidable hospital utilization.

Mike Robbins, Senior Vice President Maryland Hospital Association (MHA), raised concerns with the staff's presentation regarding the potential of a "triggering event" under the Medicare total cost of care spending guardrail. He noted that if that event should occur, which would not be calculated until well into calendar year 2017, the State would first be given 90 days to provide an explanation for that potential total cost of care failure before any corrective action plan would have to be put in place. This differed from the staff presentation, which called for an immediate implementation of a corrective action plan following a "triggering event." Mr. Robbins pointed out that it is possible that the State could uncover an error in the CMMI calculation of the total cost of care, as errors were found in similar reviews a number of times under the old waiver. He further noted several areas where the current hospital savings calculation has not yet been accurately and completely calculated by CMMI. He cautioned the Commission against preemptively lowering the hospital update based on an inaccurate hospital and total cost of care savings factor.

ITEM VII

REQUEST BY MEDICAL ASSISTANCE PROGRAM TO MODIFY THE CALCULATION OF FY 2016 CURRENT FINANCING DEPOSITS

Dennis Phelps, Associate Director-Audit & Compliance, presented a final recommendation on the Medical Assistance Program's request to modify the calculation of current financing deposits for CY 2016 (See "Staff Recommendation Request by the Medical Assistance Program to Modify the Calculation of Current Financing Deposits CY 2016" on the HSCRC website).

The Medical Assistance Program (MAP) has been providing working capital advance monies (current financing) to hospitals for many years. As a result, MAP receives the prompt pay discount as per COMAR 10.37.10.26(B). MAP is unique among third-party payers in that it is a governmentally funded program that covers qualified poor residents of Maryland. As such, it deals, to a large extent, with retroactive coverage. Recognizing the uniqueness of MAP, the Commission allowed MAP to negotiate a special formula with the hospital industry to calculate its fair share of current financing monies. The Commission approved this alternative method of calculating current financing at its February 1, 1995 public meeting. Currently, MAP has approximately $95 million in current financing on deposit with Maryland hospitals.

As a result of the state budget crisis beginning in 2009, MAP requested, and the Commission approved, exceptions to MAP's approved alternative method of current financing calculation. MAP also proposed that changes be made to its current financing formula when its new claims processing system, which was projected to achieve a dramatic reduction in hospital receivables, was implemented.

MAP reported that its new claims processing system, Medicaid Enterprise Restructuring Project, has been terminated, and that there is currently no timeline for implementing a new claim processing system.

MAP has requested that a continuation of the modified current financing formula be used for CY 2016, i.e., that the CY 2015 current financing deposits at each hospital be increased by the HSCRC's final update factor (2.61%). In addition, MAP requested that a workgroup be assembled to develop a revised methodology for calculating the current financing deposit.

Staff recommended that the Commission approve MAP's request that CY 2016 current financing deposits at each hospital be increased by the HSCRC final update factor of 2.61%, but that the approval be contingent on MAP agreeing that the CY 2017 current financing deposits be calculated utilizing either a new permanent revised methodology developed by the workgroup or the methodology utilized by all other third party payers.

Mr. Robbins, representing MHA, expressed opposition to the Staff's recommendation.

After significant discussion, Commissioners unanimously approve the Staff's recommendation. The Commissioners also approved an additional motion that the Medicaid program would report back to the Commission within six months on the development of a new methodology for current financing deposits.

ITEM VIII

RECOMMENDATION ON FY 2017 NURSE SUPPORT II COMPETITIVE INSTITUTIONAL GRANTS

Ms. Claudine Williams, Associate Director Policy Analysis, presented staff's draft recommendations for the Nurse Support Program II (NSP II) FY 2017 Competitive Institutional Grants (See "Nurse Support Program II FY 2017 Competitive Institutional Grants" on the HSCRC website).

The draft recommendation summarizes the funding recommendations of the NSP II Competitive Grant Review Panel for FY 2017. It also provides a report on the activities of the NSP II workgroup, formed as part of the recommendations of the NSP II Outcomes Evaluation report for FY 2006 – FY 2015, as approved on January 14, 2015 by the HSCRC. With guidance from the workgroup, NSP II has undergone a reconfiguration with new initiatives to meet NSP II goals and has strengthened requirements for standardized data.

Since the mid-1980's, the HSCRC has funded programs to address the cyclical nursing workforce shortages. The Nurse Education Support Program evolved, first into the hospital-based NSP I program in 2001 and then into the nursing education based NSP II program in 2005. Over the last decade, the NSP I and NSP II programs worked in parallel pathways along separate tracks to ensure that nursing personnel and services are available to improve health and health care in Maryland. Since the 2012 NSP I Evaluation Report, the staff increasingly has looked for opportunities for these two programs to collaborate in meeting joint recommendations and objectives.

The staff draft recommendations on the NSP II funding for FY 2017 are as follows:

- The HSCRC and the Maryland Higher Education Commission (MHEC) staff members recommend that the NSP II Competitive Grant Review Panel Recommendation funding be approved at $15,737,431 for Competitive Institutional Grants, and $7,710,328 for new Statewide Initiatives for FY 2016.
- Due to timing and process of this review, staff of the HSCRC and MHEC request that the regular comment period of 60 days be waived so that the grants may become effective on July 1, 2105.

No Commission action is required as this is a draft recommendation.

ITEM IX

DRAFT RECOMMENDATION FOR CONTINUED SUPPORT OF THE MARYLAND SAFETY CENTER

Ms. Dianne Feeney, Associate Director Quality Initiative, presented staff's draft recommendations for continued support of the Maryland Patient Safety Center (MPSC or Center) (See "Draft Recommendations on Continued Financial Support for the Maryland Patient Safety Center for FY 2017" on the HSCRC website).

In 2004, the HSCRC adopted recommendations that made it a partner in the initiation of the MPSC by providing seed funding through hospital rates. The initial recommendations provided funding to cover 50% of the reasonable budgeted costs of the Center. The Commission receives a briefing and documentation annually on the progress of the MSPC in meeting its goal as well as an estimate of expected expenditures and revenues for the upcoming fiscal year.

Based on information presented to the Commission, and after evaluating the reasonableness of the budget items presented, staff provides the following draft recommendations on the MPSC funding support policy:

- HSCRC provide funding support for the MPSC in FY 2017 through an increase in hospital rates in the amount of $874,800, a $97,200 (10%) reduction from FY 2016;
- The MPSC continues to aggressively pursue other sources of revenue, including from other provider groups that benefit from the programs of the Center, to help support the Center into the future and maintain reasonable cash reserves;
- Going forward, HSCRC continues to decrease the dollar amount of support by a minimum of 10% per year, or greater amount contingent upon:

    1. How well the MPSC initiatives fit into and line up with a broader statewide plan and activities for patient safety; and
    2. Whether new MPSC revenues should offset HSCRC funding support.

No Commission action required as this is a draft recommendation

ITEM X

LEGAL REPORT

Regulations

Final Action

Rate Application and Approval Procedure- COMAR 10.37.10.07-1

The purpose of this action is to allow the Commission to set rates for outpatient services associated with the federal 340B Program in anticipation of the hospital's obtaining federal provider based status. This action was proposed for adoption in 43:02 Md. R 206 (January 22, 2016).

The Commission voted unanimously to approve the final adoption of the proposed regulation.

ITEM XI
LEGISLATIVE UPDATE

Mr. Steve Ports, Deputy Director Policy and Operations, presented a summary of the legislation of interest to the HSCRC (see" Legislative Wrap-up- April 13, 2016" on the HSCRC website).

The Bills included: 1) Senate Bill 108 Nurse Support Program Assistance Fund; 2) Senate Bill 513/House Bill 377 Maryland No-Fault Birth Injury Fund; 3) House Bill 510 Termination of MHIP and Transfer of Senior Prescription Drug Assistance Program; 4) Senate Bill 336/House Bill 1277 Hospital- Designation of Lay Caregivers; 5) Senate Bill 324/House Bill 309 Prince George's County Regional Medical Center Act of 2016; 6) Senate Bill 661/ House Bill 587 Hospital- Patient's Bill of Rights; 7) Senate Bill 12/ House Bill 1121 Health Care Facilities- Closures or Partial Closures of Hospital- County Board of Health Approval**;** 8) Hospital 601, House Bill 1189- Community Benefit Report- Disclosure of Tax Exemptions; 9) Senate Bill 707/ House - Certificate of Need, Rates, and Definition; 10) Senate Bill 574/ House Bill 869 Civil Actions – Noneconomic Damages – Catastrophic Injury; 11) Senate Bill 866/ Health Bill 1272 Health- Collaborations to Promote Provider Alignment; 12) Senate Bill 1032/ House Bill 929 Health Occupations- Prohibited Patient Referrals- Exceptions; 13) Senate Bill 739/ House Report 1422 Integrated Community Oncology Reporting Program; 14) House Bill 908 Establishment of Substance Use Treatment Programs- Requirements

ITEM XII
HEARING AND MEETING SCHEDULE

May 11, 2015	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room
June 8, 2015	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room

There being no further business, the meeting was adjourned at 4:38 pm.