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October 26, 2015

VIA E-MAIL
AND FIRST CLASS MAIL

Frances B. Phillips, RN, MHC
Commissioner Reviewer
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Adventist HealthCare, Inc. d/b/a Washington Adventist Hospital, Docket No. 13-15-2349; Response to Questions Concerning Revised Revenue and Expense Projections

Dear Commissioner Phillips:

On behalf of Adventist HealthCare, Inc. ("AHC"), d/b/a Washington Adventist Hospital ("WAH"), this letter will respond to the questions posed in your letter of October 22, 2015 concerning revised revenue and expense projections that accompanied our October 21, 2015 letter. Interlineated below are AHC's responses to those specific questions.

1. *What is included in the projections (current dollars and inflated) labeled Option 4 – The Project? Does it include both the proposed relocated hospital and special hospital – psychiatric, or just the relocated hospital?*

   Response: The pro forma document labeled "Option 4 -- The Project" relates to the White Oak relocated hospital only.

2. *Do the projections labeled Option 4 – Takoma Park (current and inflated) include just the proposed special hospital? If other services, which ones?*

   Response: The pro forma document labeled "Option 4 -- Takoma Park" includes not only the proposed special hospital (behavioral health unit and services), but other services comprised of the urgent care center, the Women's Center clinic, the Adventist

Rehabilitation Hospital unit (rental income), the FQHC operated by Community Clinics, Inc. (rental income) and Washington Adventist University (rental income).

3. *I have taken note of the recent loss by Maryland's Medicaid program of the waiver from the Institutions for Mental Diseases (IMD) exclusion, which has had a significant impact on Medicaid reimbursement of freestanding psychiatric hospitals larger than 16 beds, such as that proposed for Takoma Park.*

   a. *Do the projections submitted reflect this new reimbursement status? If not, please provide alternative projections that reflect this current reality.*

      Response: The projections that were submitted on October 21, 2015 include revenue as a free standing psychiatric hospital and include Medicaid reimbursement rates that are currently enumerated under COMAR 10.09.06.09, which states that Medicaid will reimburse free standing psychiatric hospitals at a rate of 94% of HSCRC set charges. This was the reimbursement assumed in the projections.

      As reflected in its earlier submissions, much of AHC's planning for the special hospital-psychiatric facility has been based on AHC's long-standing experience with Adventist Behavioral Health and Wellness Services ("ABH&WS"), which is the second-largest provider of such services in Maryland.[1]

   b. *Please provide the assumed payor mix for the special hospital-psychiatric and the actual per diem reimbursement rates by payor assumed for this facility. Provide these assumptions for both projected revenue and expense schedules (i.e., the one assuming Medicaid fee-for-service reimbursement at levels prior to loss of the IMD exclusion waiver and the schedule assuming Medicaid reimbursement at the levels available after the loss of the IMD exclusion waiver.*

      Response: The reimbursement for the free standing psychiatric inpatient services in Takoma Park was projected based on WAH's CY 2014 charge structure. WAH's current charge structure is aligned with the costs for providing these services and consistent with the per day charge level for the free standing psychiatric hospitals in the State, as well as the ABH&WS per diem charges, which are currently averaging $1,170 per day for CY2015 to date. The payor mix is assumed constant and updated for an annual inflation factor consistent with the

[1] ABH&WS currently operates 121 special hospital-psychiatric beds at two locations (106 beds in Rockville and 15 beds in Cambridge) and supports WAH's 40 acute psychiatric beds. After the relocation of the acute care hospital to White Oak, ABH&WS will operate 161 special hospital beds.

Global Budget Revenue (GBR) updates prior to 2019 and then updated 2.3% annually after removal from the GBR cap in 2019 and re-licensure to free standing psychiatric beds. Additionally, because WAH's uncompensated care is funded partially through rates and partially through statewide pooling -- while the methodology for free standing psychiatric hospitals is 100% through rates -- a one -- time adjustment to psychiatric rates of 5.74% has been made in FY 2019 to remove funding from the pooling that WAH receives and to put it into behavioral health Takoma Park rates. That amount was calculated by taking the percentage that WAH receives in pool funding above the amount built into rates (11% total funding - 5.26% amount in rates = 5.74%). It should be emphasized that the uncompensated care amount for WAH at White Oak was correspondingly reduced for the amount moved to the behavioral health rate structure so that there would be no duplication of that funding. The expected reimbursement is based on ABH&WS' current collection experience by payor. The initial special hospital-psychiatric rates and payor mix that were used for the projection are as shown below and are inflated and carried forward throughout the projection

Payer	CY 2014 Discharges	CY 2014 Days	CY 2014 Total Charges	CY 2014 Charge per day	Expected Reimbursement based on Free Standing Psych Reimbursement	Expected Reimbursement per Day	Payer Mix (Based on Charges)
Medicare	391	2,629	3,012,880	$ 1,146.02	1,950,718	$ 742.00	29.3%
Medicaid FFS (Ages 21-64)	423	2,498	2,875,267	1,151.03	2,702,751	1,081.97	27.9%
Medicaid FFS (Age <21)	38	217	239,491	1,103.64	225,121	1,037.43	2.3%
HMO	272	1,332	1,521,472	1,142.25	1,399,754	1,050.87	14.8%
Commercial and Other	267	1,393	1,617,806	1,161.38	1,488,381	1,068.47	15.7%
Self Pay	162	760	905,783	1,191.82	339,669	446.93	8.8%
MCO	13	97	119,187	1,228.73	109,652	1,130.43	1.2%
	1,566	8,926	$ 10,291,885	$ 1,153.02	$ 8,216,046	$ 920.46	100.0%

The average per diem charges for Inpatient psychiatric services for the duration of the projections are as shown below:

	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023
Total Projected IP Charges	$ 10,291,885	$ 10,415,161	$ 10,533,275	$ 10,854,255	$ 11,478,483	$ 12,126,600	$ 12,467,539	$ 12,818,064	$ 13,178,444	$ 13,548,956
Total Projected Days	8,926	8,686	8,729	8,773	8,817	8,861	8,905	8,950	8,995	9,040
Average Per Diem	$ 1,153	$ 1,199	$ 1,207	$ 1,237	$ 1,302	$ 1,369	$ 1,400	$ 1,432	$ 1,465	$ 1,499

In addition, the expense assumptions used for behavioral health services at Takoma Park can be found attached as Exhibit A. These projections and assumptions are currently a subset of the inflated Takoma Park projections that were submitted on October 21, 2015.

Notably, ABH&WS has experienced no adverse financial impact as a result of the loss of the waiver. The Department continues to reimburse Medicaid services at a rate of 94% and has identified funding for the program at a level that allows for a

cap that sufficiently covers ABH&WS's Adult Medicaid population at levels without reduction in payments or services. We also believe that, as the psychiatric hospital services in Takoma Park accepts involuntary patients, it is reasonable to project that current, necessary funding will be maintained. AHC's projections are based on the assumption that the same will be true for the facility that ABH&WS will operate in Takoma Park.

The above response reflects current reality and is the most reliable scenario relating to current funding. Indeed, there are no current facts that would support some different projection. Significantly, the State has taken proactive and successful action to allocate funds within the budget to ensure the cap is set at a level that covers the costs of these services, recognizing the need to maintain funding to freestanding psychiatric hospitals that provide such services to Medicaid beneficiaries including those who are involuntarily admitted. Moreover, AHC further notes that the loss of waiver may be temporary, with Maryland having requested, on July 27, 2015, an amendment to its § 1115 HealthChoice demonstration project. In its submission to CMS, the State emphasized the benefits to the health care delivery system offered by facilities such as the one proposed for Takoma Park, and AHC believes that it would be imprudent to assume that the amendment application will be denied or that the Department of Health and Mental Hygiene ("DHMH") would begin indefinitely denying funding for such services, particularly when it has not cut such funding to date.[2] In assessing current reality and how DHMH has responded in funding these services and submitting a waiver, AHC believes it is improbable that DHMH will indefinitely deny funding that renders special hospital services unavailable. The projections originally submitted reasonably take into account how DHMH has responded to this issue.

We also note that federal legislation, the *Improving Access to Emergency Psychiatric Care Act* (S. 599), is pending (having passed the Senate) that, if enacted, would address the loss of the waiver. That legislation, as well as reinstatement of the waiver, is strongly supported by Maryland's Congressional delegation (*see* Exhibit B, October 5, 2015 letter from Maryland's Senators and Congressmen to CMS).

Nonetheless, in the interest of being as responsive as possible, we have developed a "worst-case" scenario that assumes: (a) the pending, well-supported DHMH waiver application (with strong federal and state legislator support) is denied, (b)

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[2] A link to the DHMH webpage includes a relevant fact sheet, copy of the waiver application and related information. http://dhmh.maryland.gov/SitePages/IMD%20Exclusion%20Waiver.aspx. The DHMH waiver application in particular details DHMH's views concerning the importance of funding to serve this population in special hospitals.

pending, corrective federal legislation is not enacted and (c) DHMH is unable to identify additional sources of funding

That worst-case scenario took into account the following factors:

- DHMH currently budgets for Medicaid coverage of psychiatric patients at IMD waiver hospitals.
- Under the waiver, DHMH receives federal matching on IMD waiver payments of 50%, which means that DHMH covers 67% of the reimbursed amount and the federal government covers 33%.
- Permanent loss of the waiver without federal remedial legislation would result in DHMH losing the federal matching dollars on payments to free standing psychiatric facilities, with reimbursement of special hospital-psychiatric services potentially capped at 67% of current levels.
- The HSCRC has an uncompensated care (UCC) policy that covers special hospital-psychiatric facilities. The current and standard policy uses a three year average.[3]
- Hospital costs are variable. If current DHMH funding for Medicaid services is not maintained, expense reductions would be implemented.

Taking these factors into account, the worst-case assumptions were:

- Medicaid will continue to budget for coverage of psychiatric services at hospitals affected by the loss of the waiver from the IMD exclusion.
- DHMH would cap funding at 67% of the previously reimbursed amount.
- The HSCRC's UCC policy for freestanding psychiatric hospitals would address a reasonable amount of uncompensated care resulting from the loss of the waiver.

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[3] In the past when an almost identical issue was created through the DHMH imposed cap on Purchase of Care (POC) patients, the HSCRC made near real-time adjustments to uncompensated care funding levels for special hospital-psychiatric facilities to cover the increase in UCC due to the cap.

- ABH would realize a one-time expense efficiency to achieve reductions equivalent of approximately 1% of its non-capital related expenses.

Attached as Exhibit C is the impact for CY 2019 through 2023 under a worst case scenario. (We show CY 2019-2023 because WAH would continue to operate its psychiatric beds under the acute care hospital until the opening of the relocated hospital in 2019 and WAH is unaffected by the loss of the waiver). The consolidated financials for WAH and the Takoma Park campus still would show a positive margin beginning in the third year after opening of the new Hospital. Additionally, the annual impact would have an immaterial impact on the overall financial health of AHC and would not have any impact on its ability to secure financing for the project. It cannot be over-emphasized that this is the worst-case scenario, and that, if the IMD waiver were lost indefinitely, AHC would adapt as needed to changes in reimbursement and work across its organization to identify expense reductions and efficiencies to avoid any negative impact.

Even under this worst-case scenario, the Behavioral Health service line at Takoma Park would operate close to break-even.

c. *Please comment on the continued viability of the proposed special hospital-psychiatric and the overall project given this change in payment for Medicaid patients at IMDs.*

Response: As noted, the current reality as experienced by ABH&WS has been that no adverse financial impact has resulted from the loss of the waiver. AHC thus reasonably anticipates no adverse financial effect on the pro formas that it has developed for the Takoma Park facility, given that both the assumed payor mix and per diem reimbursement rates by payor have been established based on AHC's experience with the rate setting process and actual operation of existing psychiatric facilities. Payors currently funding psychiatric services at WAH will continue to fund services at ABH&WS' new facility and, just as ABH&WS receives sufficient reimbursement to operate viable facilities in Rockville and Cambridge, it reasonably has concluded that it will be able to manage revenue and expenses in the planned Takoma Park facility such that that facility, too, will be financially viable.

As noted, a worst-case projection would result in the Takoma Park -psychiatric service operating close to break-even. We provided this in response to the Reviewer's request. However, AHC respectfully submits that just as projections based on speculative and hypothetical future rate increases would be inappropriate, so, too, it would be neither reasonable nor appropriate for AHC to assume that reimbursement will be reduced beyond current actual levels or that

Medicaid reimbursement would be insufficient to fund covered, necessary services. Rather, what is appropriate is that which AHC has done -- to prepare and submit projections based on its actual experience, which includes its actual experience with Medicaid reimbursement since the loss of the waiver. Based on those current reality projections, AHC further respectfully asserts that the viability of the proposed special hospital-psychiatric facility and overall Project have not changed, and that they both will be financially viable.

Respectfully yours,

John F. Morkan III

JFM:pl
Attachments

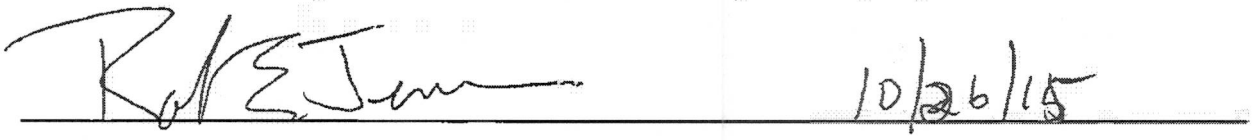
cc: **(via e-mail) (w/attachments)**
Paul Parker, Director
Kevin McDonald, Chief of the Certificate of Need Division
Joel Riklin, Program Manager
Ms. Ruby Potter, Health Facilities Coordination Office
Robert E. Jepson, Vice President, Business Development
Howard L. Sollins, Esq.

(via first class mail) (w/attachments)
Ulder Tillman MD, MPH, Health Officer
Montgomery County

(via e-mail and first class mail) (w/attachments)
Suellen Wideman, Assistant Attorney General
Thomas Dame, Esquire
Kurt J. Fischer, Esq.
Marta D. Harting, Esq.
Susan Silber, Esquire
Catherine S. Tunis, SOSCA President

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in this document are true and correct to the best of my knowledge, information and belief.



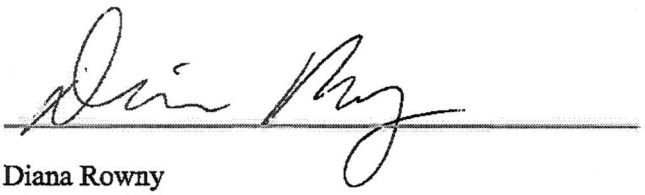
10/26/15

Robert E. Jepson
Vice President, Business Development
Washington Adventist Hospital

Date

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information and belief.



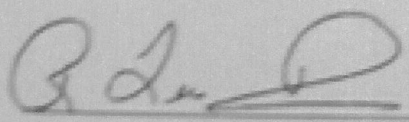
October 26 2015

Diana Rowny
Director of Finance
Washington Adventist Hospital

Date

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in this document are true and correct to the best of my knowledge, information and belief.



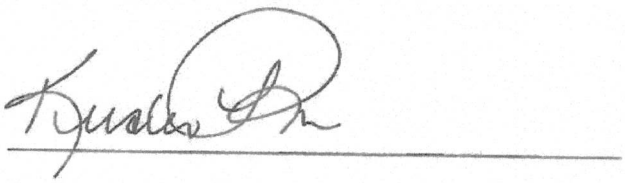
10/26/15

R. Lee Piekarz
Deloitte Financial Advisory Services, LLP

Date

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in this document are true and correct to the best of my knowledge, information and belief.



Kristen M. Pulio
Vice President, Revenue Management
Adventist HealthCare, Inc.

EXHIBIT
A

Option 4 - Behavioral Health Assumptions

Washington Adventist Hospital

(000's)

Volume Assumptions	2019 (P)	2020 (P)	2021 (P)	2022 (P)	2023 (P)
Behavioral Health					
Beds	40	40	40	40	40
Behavioral Health Admissions	1,582	1,590	1,598	1,608	1,614
Growth	-1.6%	0.5%	0.5%	0.6%	0.4%
ALOS	5.6	5.6	5.6	5.6	5.6
Patient Days	8,859	8,904	8,948	9,005	9,038
Occupancy	61%	61.0%	61.3%	61.7%	61.9%
ADC	24	24	25	25	25
Outpatient Adjustment Factor	1.2	1.2	1.2	1.2	1.2
Adjusted Patient Days (Less Newborn)	10,465	10,523	10,586	10,661	10,709
FTE Estimate:					
FTEs - Behavioral Health Specific	**62.1**	**62.1**	**62.1**	**62.1**	**63.1**
FTEs - Allocated (Security, Plant & Ops)	**6.8**	**6.8**	**6.8**	**6.8**	**6.8**
Contract Labor	**2.0**	**2.0**	**2.0**	**2.0**	**2.0**
FTE/AOB (Clinical)	**2.2**	**2.1**	**2.1**	**2.1**	**2.2**

Option 4 - Behavioral Health Assumptions

Washington Adventist Hospital

(000's)

Financial Assumptions	2019 (P)	2020 (P)	2021 (P)	2022 (P)	2023 (P)
Revenue:					
Inpatient Revenue	12,127	12,488	12,818	13,178	13,549
Inpatient Revenue per Admission	7,666	7,854	8,021	8,195	8,395
Price Increase	*-46.4%*	*2.5%*	*2.1%*	*2.2%*	*2.4%*
Outpatient Revenue	2,197	2,270	2,346	2,424	2,504
Gross Patient Revenue	**14,324**	**14,758**	**15,164**	**15,602**	**16,053**
Growth	-95.3%	3.0%	2.8%	2.9%	2.9%
Contractual Allowances	1,344	1,382	1,422	1,463	1,506
% of Gross Revenue (Less UCC)	*8.7%*	*8.8%*	*8.8%*	*8.8%*	*8.9%*
Charity Care	932	959	987	1,016	1,045
% of Gross Revenue (Less UCC)	*6.5%*	*6.5%*	*6.5%*	*6.5%*	*6.5%*
Net Patient Revenue (NPR)	**12,048**	**12,417**	**12,755**	**13,123**	**13,502**
Growth	*-95.3%*	*3.1%*	*2.7%*	*2.9%*	*2.9%*
Bad Debt Expense	715	735	757	778	801
% of Gross Revenue (Less UCC)	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*
NPR Less Bad Debt	**11,333**	**11,682**	**11,998**	**12,345**	**12,701**
Other Operating Revenue Adjusted	-	-	-	-	-
Variable Expenses:					
Salaries and Wages	4,979	5,091	5,206	5,323	5,522
Salaries and Wages/FTE	72,266	73,892	75,554	77,254	78,992
Wage Increase	N/A	2.25%	2.25%	2.25%	2.25%
Employee Benefits	1,046	1,069	1,093	1,118	1,160
As % of S&W	21.0%	21.0%	21.0%	21.0%	21.0%
Supplies	399	416	433	451	469
Supplies/Adjusted Admissions	214	221	229	237	245
Price Increase	N/A	3.5%	3.5%	3.5%	3.5%
Contract Labor	283	290	296	303	310
Wage/Hr	68.1	69.6	71.2	72.8	74.4
Growth	2.25%	2.25%	2.25%	2.25%	2.25%
Purchased Services	837	857	877	899	919
Purchased Services - Variable	443	455	466	478	490
PS/ Psych Admission	280	286	292	297	303
Price Increase	2.0%	2.0%	2.0%	2.0%	2.0%
Purchased Services - Fixed	216	220	225	229	234
Growth	2.0%	2.0%	2.0%	2.0%	2.0%
Purchased Services - Transport	177	182	186	191	196
Total Variable Expenses	**7,544**	**7,722**	**7,905**	**8,093**	**8,379**

Option 4 - Behavioral Health Assumptions

Washington Adventist Hospital

(000's)

Financial Assumptions	2019 (P)	2020 (P)	2021 (P)	2022 (P)	2022 (P)
Fixed Expense Assumptions - Hospital:					
General & Administrative	2.5%	2.5%	2.5%	2.5%	2.5%
Professional Fees	1.0%	1.0%	1.0%	1.0%	1.0%
Building and Maintenance	-93.0%	2.5%	2.5%	2.5%	2.5%
Insurance	1.0%	1.0%	1.0%	1.0%	1.0%
Other - Overhead Allocation	1.5%	1.5%	1.5%	1.5%	1.5%
Fixed Expenses - Hospital:					
General & Administrative	349	358	367	376	385
Insurance	72	73	73	74	75
Other - Overhead Allocation	702	715	726	737	748
Fixed Expenses	1,123	1,146	1,166	1,187	1,208
Growth	*-97.9%*	*2.0%*	*1.8%*	*1.8%*	*1.8%*
Fixed Expenses - Takoma Park					
Professional Fees	-	-	-	-	-
Building and Maintenance	641	657	674	690	708
Total Fixed Expenses	641	657	674	690	708
Growth	*N/A*	*2.5%*	*2.5%*	*2.5%*	*2.5%*
Fixed Expenses	**1,764**	**1,803**	**1,839**	**1,877**	**1,916**
	-96.7%	2.2%	2.0%	2.0%	2.0%

Option 4 - Behavioral Health Assumptions

Washington Adventist Hospital

(000's)

Income Statement	2019 (P)	2020 (P)	2021 (P)	2022 (P)	2023 (P)
Net Patient Revenue	11,333	11,682	11,998	12,345	12,701
Other Operating Revenue	-	-	-	-	-
Total Operating Revenues	**11,333**	**11,682**	**11,998**	**12,345**	**12,701**
Growth	*-95.3%*	*3.1%*	*2.7%*	*2.9%*	*2.9%*
Variable Expenses	7,544	7,722	7,905	8,093	8,379
Fixed Expenses	1,764	1,803	1,839	1,877	1,916
Total Operating Expenses	**9,308**	**9,525**	**9,744**	**9,970**	**10,295**
Growth	*-95.8%*	*2.3%*	*2.3%*	*2.3%*	*3.3%*
EBITDA	2,025	2,157	2,254	2,375	2,406
Margin	*17.9%*	*18.5%*	*18.8%*	*19.2%*	*18.9%*
Depreciation and Amortization	1,180	1,236	1,163	1,111	1,092
IT Depreciation	158	158	158	158	158
Interest Expense	791	933	916	901	875
Income (loss) from operations	**($105)**	**($170)**	**$16**	**$205**	**$281**
Margin	*-0.9%*	*-1.5%*	*0.1%*	*1.7%*	*2.2%*
Investment Income (Expense)	-	-	-	-	-
Non-Operating Interest Expense	-	-	-	-	-
Other Non-Operating Income (Expense)	-	-	-	-	-
Excess of Revenues over Expenses	**($105)**	**($170)**	**$16**	**$205**	**$281**

EXHIBIT
B

United States Congress

WASHINGTON, DC 20510

October 5, 2015

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 310G.05, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Mr. Slavitt:

We are writing in support of the state of Maryland's efforts to seek a waiver of the Institution for Mental Diseases (IMD) exclusion from the Centers for Medicare & Medicaid Services (CMS) as part of the state's HealthChoice program.

As you may know, Maryland was one of 11 states selected to participate in the three-year Medicaid Emergency Psychiatric demonstration, which provided federal matching payments for emergency psychiatric care provided to Medicaid enrollees between the ages of 21 and 64 in IMD facilities. Since available funding through the demonstration ended in June 2015, it has become increasingly difficult to access IMD beds for these Medicaid enrollees in Maryland, due to limited State General Funds. Earlier this year, Senators Cardin, Toomey and Collins introduced legislation (S. 599, *Improving Access to Emergency Psychiatric Care Act*) to extend the demonstration.

A waiver of the IMD exclusion would reinstate Maryland's ability to receive federal matching payments for acute psychiatric care provided by IMDs for Medicaid enrollees aged 21-64, and it would also extend this policy to include residential substance use disorder treatment. By allowing these Medicaid enrollees to receive services in IMD facilities dedicated to treating acute psychiatric and substance use disorders rather than hospital emergency departments and general acute care inpatient units, the waiver would promote access to high quality, specialized care in lower cost settings, generating savings at both the state and federal levels. The ability to treat patients in the most clinically appropriate, cost-effective manner possible is essential to Maryland's continued success in meeting the goals of its unique 5-year All-Payer Model, including lowering annual all-payer per capita total hospital cost growth and preventing unnecessary hospitalizations and readmissions.

Accordingly, we respectfully request your prompt review and careful consideration of Maryland's application for an amendment to its §1115 HealthChoice demonstration to provide federal matching payments for acute psychiatric care and substance use disorder treatment provided in IMDs.

Thank you for your consideration of our request.

Sincerely,

Benjamin L. Cardin
United States Senator

Barbara A. Mikulski
United States Senator

Steny H. Hoyer
Member of Congress

John P. Sarbanes
Member of Congress

John K. Delaney
Member of Congress

Elijah E. Cummings
Member of Congress

C.A. Dutch Ruppersberger
Member of Congress

Chris Van Hollen
Member of Congress

Donna F. Edwards
Member of Congress

EXHIBIT
C

Summary of Maximum Impact of IMD Waiver

	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023
Total Projected IP Charges	$ 12,126,600	$ 12,467,539	$ 12,818,064	$ 13,178,444	$ 13,548,956
Adult Medicaid %[1]	27.94%	27.94%	27.94%	27.94%	27.94%
Average Per Diem	$ 3,387,836	$ 3,483,085	$ 3,581,011	$ 3,681,692	$ 3,785,202
Payment with IMD waiver[1]	**$ 3,184,565**	**$ 3,274,099**	**$ 3,366,151**	**$ 3,460,790**	**$ 3,558,090**
State Funded	*2,124,105*	*2,183,824*	*2,245,223*	*2,308,347*	*2,373,246*
Federal Match (50%)	*1,060,460*	*1,090,275*	*1,120,928*	*1,152,443*	*1,184,844*
Payment without IMD waiver	**$ 2,124,105**	**$ 2,183,824**	**$ 2,245,223**	**$ 2,308,347**	**$ 2,373,246**
State Funded - Cap	*2,124,105*	*2,183,824*	*2,245,223*	*2,308,347*	*2,373,246*
Federal Match (0%)	-	-	-	-	-
Change in Reimbursement	**$ (1,060,460)**	**$ (1,090,275)**	**$ (1,120,928)**	**$ (1,152,443)**	**$ (1,184,844)**
Change in UCC funding based on current policy (3-year average)[3]	205,797	429,161	665,095	689,973	709,373
Expense reductions - 1% of behavioral health non-capital expenses	100,000	102,300	104,653	107,060	109,522
Maximum Estimated Impact of complete loss of IMD waiver	**$ (754,663)**	**$ (558,814)**	**$ (351,180)**	**$ (355,411)**	**$ (365,948)**

(1) IMD waiver only impacts Medicaid FFS for Adults 21-64
(2) Payment at 94% of charges per COMAR
(3) Current HSCRC policy funds uncompensated care for specialty hospitals using a rolling 3-year average.