IN THE MATTER OF	*	BEFORE THE
	*	
ANNE ARUNDEL MEDICAL CENTER	*	MARYLAND HEALTH
	*	
Docket No. 15-02-2360	*	CARE COMMISSION
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UNIVERSITY OF MARYLAND
BALTIMORE WASHINGTON MEDICAL CENTER'S
COMMENTS ON ANNE ARUNDEL MEDICAL CENTER'S
MODIFICATION PURSUANT TO STATUS PROJECT CONFERENCE

University of Maryland Baltimore Washington Medical Center ("UM BWMC"), by its undersigned counsel and pursuant to COMAR § 10.24.01.09(A)(2)(d), submits these comments addressing the November 7, 20126 Modification to the Certificate of Need ("CON") Application filed by Anne Arundel Medical Center ("AAMC") proposing to establish a cardiac surgery program. For the reasons set forth below and in UM BWMC's filings throughout this review, UM BWMC respectfully requests that the Maryland Health Care Commission deny AAMC's application.

ARGUMENT

I. AAMC'S CON APPLICATION DOES NOT MEET THE FINANCIAL FEASIBILITY STANDARD FOR CARDIAC SURGERY SERVICES (COMAR § 10.24.17.05A(7))

COMAR § 10.24.17.05A(7) provides, in part:

> A proposed new or relocated cardiac surgery program shall be financially feasible and shall not jeopardize the financial viability of the hospital.
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> …
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> (b) An applicant shall document that:
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> …
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> (ii) Its revenue estimates for cardiac surgery are consistent with utilization projections and account for current charge levels, rates of reimbursement, contractual adjustments and discounts, bad debt, and charity care provision, for cardiac surgery, as experienced by similar hospitals;

…

(iv) Within three years or less of initiating a new or relocated cardiac surgery program, it will generate excess revenues over total expenses for cardiac surgery, if utilization forecasts are achieved for cardiac surgery services.

Id. AAMC's application and modification fail to meet this standard because AAMC has not demonstrated that its proposed cardiac surgery program "will generate excess revenues over total expenses for cardiac surgery." Id.

A. Each of AAMC's revenue and expense projections submitted in this review failed to demonstrate that its proposed cardiac surgery program will general excess revenues over total expenses.

Struggling to establish financial feasibility of its proposed program throughout this review, AAMC relied first on unsupportable assumptions, then on unexplained assumptions, and, finally, on an inaccurate and contradictory reading of the financial feasibility standard. The only revenue and expense projections AAMC has submitted without faulty revenue reimbursement assumptions demonstrate that its proposed cardiac surgery program will have negative net revenue for three years, and thus will not be financial feasible within the meaning of the applicable standard.

Original Revenue and Expense Projections

In its February 20, 2015 Application, AAMC based its revenue projections on the false assumption that its Global Budget Revenue ("GBR") would "be adjusted for incremental volume related to the project (incremental cardiac surgery revenue less transfer cases) at an 85% variable cost factor for the first three years of the project."[1] (AAMC Appl., p. 82; AAMC's original

[1] Although AAMC was wrong in its assumption about the amount of revenue that it may retain for the market shift, it did recognize in its original financial projections that financial

revenue and expense projection tables are attached as **Exhibit 1**.) As UM BWMC stated in its July 27, 2015 comments, this is incorrect. The Health Services Cost Review Commission ("HSCRC") policy for market shift adjustments to revenue uses a 50% revenue variability factor for incremental volumes. (UM BWMC Comments, Exhibit 5.) AAMC even acknowledged this in its original application, stating, "[w]hile the HSCRC's policies for applying and calculating the market share adjustments ("MSAs") are not fully established in the context of CON funding, the discussions and precedents regarding MSAs as of the preparation of the AAMC CON suggest that the MSAs for each of the JHH and the University of Maryland Medical Center will be calculated as 50% of the allowable charges of the relocated cases." (AAMC Appl. at p. 219.)

When all of AAMC's assumptions in its original application were held constant with the exception of revenue variability, and a 50% variable cost factor was applied, the AAMC cardiac surgery program was financially unfeasible, suffering operating losses in each year. (UM BWMC Comments, p. 28, Table 10).

In its August 25, 2015 response to comments, AAMC reasserted that it could "reasonably expect to retain 85% of the revenue generated by the AAMC's proposed program," citing the HSCRC's "flexibility to provide targeted funding through the annual update process for individual hospital budgets" and an April 8, 2014[2] letter from the HSCRC to AAMC in which the HSCRC made a nonspecific commitment to consider adjustments to AAMC's GBR

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feasibility must be demonstrated for the cardiac surgery program standing alone (*i.e.*, not after receiving subsidy from other hospital revenue).

[2] The letter, attached as Exhibit 30 to AAMC's Response to Comments, is dated April 8, 2012 on page 1, and April 8, 2014 on page 4. Based on its reference to GBR and the All-payer model, 2014 appears to be the correct date.

agreement, subject to a rate application and approval. (AAMC Response to Comments, p. 20, Ex. 30).

The HSCRC subsequently confirmed AAMC's projections for market shifts from Maryland hospitals and out-of-state providers were based on a false assumption. Its August 24, 2016 letter response to the Reviewer states:

> AAMC assumed that it would be able to retain 85% of the additional revenue associated with the cardiac surgery program. Under the current HSCRC policy for market shift changes of Maryland residents, hospitals with increased volumes that are taken from other Maryland hospitals are allowed to retain 50% of the revenue associated with the additional volume while hospitals that lose volume to other Maryland hospitals are allowed to retain 50% of the revenue associated with the lost volume.
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> * * * *
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> AAMC has projected that Maryland residents will comprise the 67% of its cardiac surgery cases that will come from D.C. and other out-of-state providers. Under the Hospital's GBR agreement, AAMC would be able to retain 50% of the cardiac surgery revenue associated with these Maryland residents.

(HSCRC Letter to Commissioner Tanio, August 24, 2016 ("HSCRC Letter"), attached as **Exhibit 2**, p. 1.)

October 17, 2016 Revenue and Expense Projections

Following the HSCRC's letter, the Reviewer requested "that AAMC provide revised versions of all the financial schedules previously submitted that fully conform with standard HSCRC policy with respect to retention of revenue generated from projected shifts in cardiac surgery case volume from hospitals with existing cardiac surgery programs to AAMC." (Commissioner Tanio Letter, October 5, 2016, attached as **Exhibit 3**.)

On October 17, 2016, AAMC submitted revised revenue and expense projections that showed revenue resulting from its cardiac surgery service line, adjusted by a 50% variable cost factor, and additional revenue that AAMC claimed would be reallocated from elsewhere in the

system.[3] (AAMC Letter, October 17, 2016, attached as **Exhibit 4**). AAMC falsely claimed, and its CFO affirmed, that these projections made no substantive change to its prior projections, and instead only added an additional revenue line to show that a portion of revenue was attributable to "reallocated revenue" from other resources provided in the system. (Id. p. 4.) This claim was directly contradicted by AAMC's prior filings, in which AAMC admitted that its projections assumed that its GBR would be adjusted for incremental volume at an 85% variable cost factor. (AAMC Appl., pp. 62, 160-164.)

Furthermore, a comparison of AAMC's October 17, 2016 projections to its initial application confirms that AAMC misrepresented the changes made. If AAMC's October 17 projections departed from the original application projections only by distinguishing revenue sources for its cardiac surgery service that were previously combined into a single line, then AAMC's inpatient services revenue for the entire facility should have remained constant. Instead, when AAMC adjusted its revenue to be consistent with HSCRC policy, the overall inpatient services revenue declined. AAMC's total inpatient services revenue decreased by $4.4 million in FY 2018 and $5.0 million in FY 2019 (comparing Table G, line 1.a., included with AAMC's original application, attached as Exhibit 1, and the same information included with the October 17, 2016 submission, attached as Exhibit 8). While AAMC's cardiac surgery service revenue remained consistent with its prior projections, this was a result of AAMC admittedly reallocating revenue from elsewhere in its system to cardiac surgery. A side-by-side comparison of AAMC's revenue assumptions and projections in its original application and its

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[3] Although AAMC's filing was stricken from this review, AAMC's history of making shifting, misleading, and incorrect projections is relevant to the review of AAMC's most recent modification.

October 17, 2016 submission further confirms that the original application calculated revenue based on an 85% variable cost factor, while the October 17, 2016 projections calculated revenue based on a 50% variable cost factor, as demonstrated in Table 1, attached as **Exhibit 5**.

November 7, 2016 Revenue and Expense Projections

The Reviewer struck AAMC's October 17, 2016 projections from the record on October 21, 2016. On October 27, 2016, the Reviewer held a Project Status Conference and requested that AAMC make a modification. The request is summarized in the Reviewer's October 28, 2016 Letter as follows:

> At the project status conference, I requested that AAMC modify its application to provide revised versions of all financial schedules regarding revenues, expenses, and income for: (1) its general hospital operation; and (2) specifically, for its proposed cardiac surgery service. These revenue projections need to reflect HSCRC's current policy (stated in its August 24, 2016 memorandum to me) to assume a 50% variable cost factor. The revised financial schedules must be accompanied by a detailed statement of the assumptions used in development of the modified financial schedules. This statement of assumptions must address and detail the way in which AAMC accounts for all of the revenue and expense changes it projects to result from its provision of cardiac surgery services, across all of the hospital's departments. Anne Arundel Medical Center should also file a statement that details how and why these schedules have changed in comparison to the revenue and projections filed by AAMC prior to docketing of its application.

(Commissioner Tanio Letter, October 28, 2016, **Exhibit 9**, p. 3.) In response, AAMC filed revised revenue projections on November 7, 2016. AAMC filed two versions of Table J, the revenue and expenses (uninflated) for the cardiac surgery service – Table J-1 and Table J-2.

Table J-1 portrays revenue as equal to billable charges, and thus fails to comply with the Reviewer's direction to assume a 50% variable cost factor, and fails to comply with the requirement of the financial feasibility standard that "revenue estimates for cardiac surgery [be] consistent with utilization projections and account for current charge levels, rates of

reimbursement, contractual adjustments and discounts, bad debt, and charity care provision, for cardiac surgery, as experienced by similar hospitals." COMAR § 10.24.17.04(A)(7)(ii).[4]

Table J-2 complies with the Reviewer's direction and COMAR § 10.24.17.04(A)(7)(ii). However, it demonstrates that AAMC's proposed cardiac surgery service line will not generate excess revenues over total expenses for cardiac surgery within three years, instead operating at losses of $3.7, $3.3, and $3.0 million in FY 2017, FY 2018, and FY 2019 respectively. Thus, AAMC's modification renders the project unapprovable because it fails to meet the financial feasibility standard for cardiac surgery services.

B. COMAR § 10.24.17.05A(7) requires an applicant to demonstrate feasibility based on retained revenue, not billable charges.

AAMC's modification suggests, for the first time, that AAMC can satisfy the financial feasibility standard by projecting revenue for cardiac surgery as billable charges, rather than actual retained revenue. AAMC's approach to financial feasibility should be rejected.[5] Following AAMC's logic, HSCRC would apportion an amount of revenue from AAMC's GBR consistent with AAMC's CPC and market shift, and would then apply a reduction across

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[4] AAMC's projection of revenue as billable charges is inconsistent with the financial feasibility standard. UM BWMC correctly projects revenue after applying a 50% variable cost factor. However, because the applicants are in a comparative review, if the Reviewer finds that AAMC may demonstrate revenue as projected in Table J-1, the Reviewer should similarly compare AAMC's projections to UM BWMC's program on a billable charge basis.

[5] Even AAMC's portrayal of purported operational revenue for cardiac surgery in Table J-1 is overstated. Distributing the cardiac surgery revenue reduction based on a 50% variable cost factor across the entire hospital would require AAMC to reduce rates across the hospital in order to achieve GBR compliance. As such, AAMC's $37,501 charge per case would be diluted by a proportional amount relative to the hospital rate decrease. In spreading the loss over the entire hospital, AAMC has not adjusted cardiac surgery rates for this required reduction, which results in overstated operational revenue for the program.

AAMC's GBR rates equal to 50% of the cardiac surgery revenue. However, the financial feasibility standard in the State Health Plan measures not what AAMC's financials would look like after the 50% variable cost factor is applied across the hospital's financials, but the true financial impact of the proposed new program on the hospital. At bottom, it is denial for AAMC to present financial projections that ignore the 50% reduction in cardiac surgery revenue or pretend that the 50% reduction is not tied to the cardiac surgery program.

AAMC's current approach also directly contradicts the direction of the Reviewer, based on the HSCRC's input, that AAMC's "revenue projections need to reflect HSCRC's current policy (stated in its August 24, 2016 memorandum to me) to assume a 50% variable cost factor." (Commissioner Tanio Letter, October 28, 2016, **Exhibit 9**, p. 3.) AAMC's approach is also contradicted by its prior filings. AAMC's February 20, 2015 and October 17, 2016 projections of revenue for its proposed cardiac surgery service line both calculated revenue to include the variable cost factor. (AAMC Appl., pp. 62, 160-164; AAMC Letter, October 17, 2016, Exh. 4, p. 3.) AAMC's approach also contradicts its approach to cost effectiveness in the same modification. In analyzing the impact and cost savings of its program, AAMC portrays the revenue saved based on a 50% variable cost factor applied to cardiac surgery revenue. (AAMC Modification, Exhibit 39.) AAMC should not be permitted to show that the cardiac surgery program will be feasible because it will generate revenue based on charges, while at the same time it suggests that the program will generate only half as much revenue when analyzing impact.

UM BWMC is not aware of any pending or recent CON applications for rate-regulated services that calculate revenue based on billable charges rather than actual revenue retained under GBR. AAMC's approach, if accepted, would render meaningless any State Health Plan

financial feasibility standard that differentiates between the feasibility of the program and the feasibility of the hospital – as long as the hospital remains feasible, AAMC's reading of financial feasibility would always render the program feasible (unless billable charges were implausibly and unrealistically low).

Furthermore, AAMC's suggestion the standard cannot be met under the new GBR system and therefore should be reinterpreted as referring to billable charges rather than revenue is misguided. The relevant State Health Plan Chapter, COMAR § 10.24.17 (the "SHP"), was amended with knowledge of the new GBR system, effective August 18, 2014. The Issues and Policies of the amended SHP provide, in part:

> In October 2013, the Maryland Department of Health and Mental Hygiene submitted an application for modernization of Maryland's all-payer model to the Centers for Medicare and Medicaid Services. CMS accepted the application for a new waiver model, and in January 2014, HSCRC began moving the hospital rate setting system away from a focus on the per case costs of inpatient discharges to a focus on per capita Medicare hospital costs. Ultimately, HSCRC will develop a payment model based on controlling the overall health care expenditures of Marylanders. Under the new payment model, growth in inpatient and outpatient expenditures will be limited by growth in the State's long-term gross state product. All hospitals falling within the scope of HSCRC rate regulation will have a population based budget agreement, a total patient revenue agreement, or a modified charge per episode agreement with HSCRC under the new rate regulation model by the end of FY 2015.

COMAR § 10.24.17, p. 8. This same SHP includes the financial feasibility standard that AAMC now suggests cannot be met under the GBR system. This means that the Commission recognized the change to hospital revenue calculations and still adopted the standard.

AAMC's inability to meet the financial feasibility standard if the variable cost factor is applied to its cardiac surgery revenue does not mean the standard should be reinterpreted. It also does not mean that only an applicant with an existing program to share revenue with, such as

UM BWMC, can meet the standard. AAMC correctly notes that the HSCRC has the ability to grant rate increases in GBR revenue if GBR methodology does not provide sufficient revenue. (HSCRC Letter, Exh. 2, p. 3.) Similarly, HSCRC has the authority to permit variable cost adjustments greater than 50%. Indeed, AAMC previously relied on an assumption that such an adjustment would be made for its program. (AAMC Appl., p. 82, assuming an 85% variable cost factor based on HSCRC's ability to make revenue adjustments). That the HSCRC has not agreed to make such an accommodation for AAMC does not render the financial feasibility standard impossible to meet. However, since the Reviewer has requested that the parties not seek such adjustments, and AAMC admits that it cannot be financially feasible without them, AAMC's application should be denied.

C. COMAR § 10.24.17.05A(7) does not create an exception based on a hospital's overall viability.

AAMC's alternative suggestion, that the financial feasibility standard can be met as long as the viability of the hospital as a whole is not jeopardized, ignores the express language that requires AAMC to demonstrate that the proposed project will "generate excess revenues over total expenses for cardiac surgery." COMAR § 10.24.17.05A(7)(iv)(emphasis added). Other State Health Plan chapters define financial feasibility in the manner AAMC suggests should apply here. For example, an applicant to establish acute inpatient rehabilitation services must meet the following financial feasibility standard:

> The hospital will generate excess revenues over total expense (including debt service expenses and plant and equipment depreciation), if the applicant's utilization forecast is achieved for the specific services affected by the project within five years or less of initiating operations with the exception that a hospital proposing an acute inpatient rehabilitation unit that does not generate excess revenues over total expenses, even if utilization forecasts are achieved for the services

> affected by the project, may demonstrate that the hospital's overall financial performance will be positive.

COMAR § 10.24.09.04(B)(iv)(6). This standard expressly states that if the applicant does not generate excess revenue over total expense for the specific service, the applicant may instead demonstrate that its overall performance of the hospital will be positive. Other State Health Plans similarly include a financial feasibility standard that expressly allow a broader approach to feasibility. *See* COMAR § 10.24.09.04.(b)(13) (Acute Care Hospital Services); COMAR § 10.24.11.05(B)(8)(General Surgical Services); COMAR § 10.24.12.04(14) (Acute Hospital Inpatient Obstetric Services). Had the Commission intended such an exception to be included in the Cardiac Surgery SHP, it would have included similar language.

AAMC has previously argued that the express language of the SHP financial feasibility standard may not be ignored. In its August 25, 2015 comments on UM BWMC's modification, AAMC stated, in part:

> [T]he State Health Plan criteria cannot be waived or ignored during this comparative review. The State Health Plan is a *bona fide* Maryland regulation with the force of law. And the revision to the State Health Plan implied by BWMC would work a revolution in the CON process: merged asset systems could leverage a profitable service in one part of the system to subsidize the creation of uneconomic facilities or services in another part of the system.

(AAMC Comments, August 25, 2015, p. 3.) UM BWMC's CON application projects revenue for its cardiac surgery service line across the UM Division of Cardiac Surgery, of which BWMC would become a member, adding a third location to the program. That Division "will generate excess revenues over total expenses for cardiac surgery." COMAR § 10.24.17.05A(7). AAMC, however, proposes that any program in its hospital can subsidize the creation of a cardiac surgery program that will generate loss of a minimum of $3 million in each year projected. This directly

contradicts the SHP financial feasibility standard's reference to revenue and expenses for cardiac surgery. COMAR § 10.24.17.05A(7)(iv).

AAMC's proposed interpretation of the financial feasibility criteria is also inapposite to the logic AAMC uses in its pending application for a CON for a new mental health hospital, filed March 29, 2016. In that application, AAMC proposes construction of a 16-bed special psychiatric hospital for a capital expenditure of $25 million. (AAMC Mental Health Hospital Application, August 1, 2016 Update, excerpt attached as **Exhibit 6.**) In evaluating the availability of more cost effective options, AAMC rejected locating the services on its existing campus through a renovation that would cost $6.5 to $8.5 million, a fraction of the cost of the proposed new hospital project. AAMC's rejection stems from its concern that, under GBR, providing psychiatric services as an inpatient service in an acute care facility, rather than as a new special psychiatric hospital, would result in revenue based on GBR and market share shift, and thus be subject to a 50% variable cost factor. AAMC states:

> Additionally, under GBR, as a new service in the hospital, the HSCRC has indicated that reimbursement would be subject to a 50 percent variable cost factor, which would create a negative operating margin. The operating margin in Year 3 for this option was a loss of $1.28 million or negative 38 percent. As such, the program would not be sustainable over time. This option would also have the undesired effect of increasing costs subject to the Medicare waiver. Accordingly, this option was not the preferred option as compared to option 3 which does not have these drawbacks.

(AAMC Mental Health Hospital CON Application, March 29, 2016, excerpt attached as **Exhibit 7**, p. 82.)

Unlike the Cardiac Surgery SHP, the State Health Plan Chapter for Psychiatric Services, COMAR § 10.24.07, does not contain a requirement that the service generate revenue over expenses. Thus, unlike in this review, AAMC has the ability to reallocate revenue from other

hospital revenue to support the program. Yet, AAMC determined, and attested, that it would be unsustainable to reallocate $1.28 million from other hospital revenue each year to support psychiatric beds, proposing to instead to make a capital expenditure that is a minimum of $18.5 million greater than the cost of renovating existing space to provide the same services. In this review, however, AAMC argues it should be permitted to absorb a loss of $3 million each year (more than twice the amount of the loss it attributes to providing psychiatric services on its existing campus), despite express regulatory language to the contrary.[6] The Reviewer should reject AAMC's selective interpretation of MHCC regulations and contradicting statements about its own ability to absorb revenue losses for new services.

D. AAMC fails to detail its revenue reallocation assumptions, and the limited adjustments described cannot sustain the loss generated by its proposed cardiac surgery service line.

Not only is AAMC's proposed reallocation of revenue insufficient to meet the financial feasibility standard, but AAMC also fails to give any meaningful detail about the assumptions that would support such a shift in revenue. AAMC's Table J-2 backtracks from AAMC's October 17, 2016 submission in which AAMC actually included that reallocated revenue from elsewhere in the hospital into its cardiac surgery program to offset operating losses. Instead, AAMC's revenue and expense projections for its cardiac surgery service line projects that its proposed cardiac surgery program would operate at a loss for a minimum of three years. (AAMC Modification, Table J-2.)

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[6] AAMC would be required to continue absorbing this loss each year since, assuming it commits to the Reviewer's request, it may not seek a rate increase related to its cardiac surgery program.

AAMC maintains that a "substantial general adjustment to GBR Budget revenue would offset the GBR Budget impact of AAMC's proposed cardiac surgery service line" – that is, AAMC proposes to shift revenue to its cardiac surgery program to offset the losses that the cardiac program would generate. (AAMC Modification, p. 8). A comparison between AAMC's modified Table G, which demonstrates revenue and expense projections for the entire hospital, uninflated, to the Table G submitted with its initial application, demonstrates that AAMC does in fact project that the hospital will absorb the losses generated by the cardiac surgery program. (Compare AAMC's February 20, 2015 Table G, line 1.a, Exh. 1, with the same line in AAMC's November 7, 2016 Table G, attached as **Exhibit 8**.) But AAMC does not comply with the Reviewer's direction to account for how this shift will be made with detailed assumptions, and does not show this shift in Table J.

The Reviewer's October 28, 2016 letter summarizing the project status conference explicitly requests that AAMC provide "a detailed statement of the assumptions used in development of the modified financial schedules" that "must address and detail the way in which AAMC accounts for all of the revenue and expense changes it projects to result from its provision of cardiac surgery services." (Commissioner Tanio Letter, October 28, 2016, attached as **Exhibit 9**.) Instead, AAMC states it "cannot provide, at this time, a breakdown of the relative expected contribution to AAMC's proposed cardiac surgery service of each of the [identified] three revenue sources for the simple reason that the HSCRC has not yet granted the AAMC all the potential adjustments, nor has the HSCRC indicated its expectations of AAMC as to the relative allocation expected between these three sources." (AAMC Modification, p. 8). The Reviewer should reject this excuse. Applicants routinely make assumptions related to revenue and GBR that are subject to HSCRC review and approval.

Furthermore, even if AAMC were permitted to shift revenue, an examination of the bare assumptions AAMC does make demonstrates that there is no viable way that the future adjustments identified by AAMC would reconcile the projected loss attributable to its cardiac surgery program, which is a minimum of $3.0 in each year projected. AAMC identified three components for future adjustments:

i. The population adjustment
ii. Capacity from reduced avoidable utilization
iii. AAMC's existing and anticipated operating margin, i.e. reallocation of overhead already funded in the system as evidenced by AAMC's profits

(AAMC Modification, pp. 10-11.) Since AAMC did not provide additional detail, as requested by the Reviewer, UM BWMC analyzed the adjustments AAMC identified and found that they would not allow AAMC to achieve financial feasibility for its cardiac surgery program.

(i) The population adjustment – potential resulting allocation to cardiac surgery service line: $31,320

The population adjustment is an Age and Potentially Avoidable Utilization ("PAU") adjusted percentage that the HSCRC determines based on predicted population growth and utilization trends in each hospital's identified service area. (See, e.g., HSCRC Memorandum Re; Global Budget Hospital Population and Demographic Adjustment Volume Allowance, June 30, 2014, attached as **Exhibit 10**.) It is recalculated each year based on updated data. *Id.* Since AAMC has provided no data, UM BWMC made a reasonable assumption that AAMC's population adjustment would remain consistent with its most recently approved demographic adjustment. For fiscal year 2017, AAMC received a population adjustment in rates of 0.48%. (HSCRC Demographic Adjustment by Hospital, Rate Year 2017 **Exhibit 11**.) This adjustment is applied globally across the hospital's revenue base. AAMC reflects total facility gross revenue in FY 2019 of $558.8 million (AAMC Modification, Table G). At this revenue base, a

population adjustment of 0.48% would represent a revenue increase of $2.7 million. Because cardiac surgery services would represent $6.5 million of that FY 2019 revenue base (AAMC Modification, Table J-2), AAMC can attribute 1.16% of the population adjustment, or $31,320, to cardiac surgery services. The remainder of the population adjustment would be charged through rates in other service lines throughout the hospital.

(ii) Capacity from reduced avoidable utilization – potential resulting allocation to cardiac surgery service line: $194,462

Regarding capacity from reduced avoidable utilization, AAMC could be referring to a number of different policies – namely, the Readmissions Reduction Incentive Program ("RRIP"), Potentially Avoidable Utilization (PAU)/Shared Savings, Maryland Hospital Acquired Conditions, or Quality Based Reimbursement. Each of these programs could have a multitude of downstream impacts on the hospital's financial performance.

The policy that AAMC could most likely influence to add revenue to the GBR base is RRIP, which calculates a scaling adjustment based on the better of each hospital's attainment or improvement during a given time period. (HSCRC Memorandum Re: RRIP Policy for Rate Year 2018 and RY 2017 Updates, June 30, 2016, attached as **Exhibit 12**.) Most recently, for FY 2017, AAMC received a RRIP penalty of 0.29% or $856,386. (HSCRC Readmission Reduction Incentive Program, Rate Year 2017, **Exhibit 13**.) To assume that AAMC would be able to reduce its readmissions performance with the addition of cardiac surgery services is questionable. However, even if AAMC had unlikely success, the policy is accompanied by a maximum reward of 1.00% of permanent inpatient revenue. (HSCRC Final Recommendations for the Aggregate Revenue Amount At-Risk under Maryland Hospital Quality Programs for Rate Year 2018 ("Aggregate Revenue at Risk," **Exhibit 14**, pp. 4-5.) Thus, for AAMC, this

maximum reward would be limited to $2.9 million across the entire GBR revenue base. Using the 1.16% referenced above, which represents cardiac surgery revenue as a percentage of total hospital revenue, this maximum reward on RRIP would translate into $33,640 for cardiac surgery services.

Alternatively, if AAMC was referring to the PAU/Shared Savings adjustment, this is a negative adjustment that nets against the update factor. (HSCRC Final Recommendations for the PAU Savings Policy for Rate Year 2017, June 8, 2016, **Exhibit 15**.) In FY 2017, AAMC's Calendar Year 2015 PAU percentage of 9.52% resulted in a negative adjustment of 0.47%, or $2.6 million. (Id. at p. 16.) PAU consists of readmissions and admissions for ambulatory care sensitive conditions as measured by the Agency for Health Care Research and Quality's Prevention Quality Indicators ("PQIs"). It would take a nearly impossible improvement in PAU in order for AAMC to erase the negative adjustment applied by the PAU/Shared Savings policy, much less produce a revenue enhancement.

Also, by opening a cardiac surgery program and attracting new patients from other areas, as AAMC projects it would do, AAMC would be welcoming additional PQIs into its hospital. This would make it much harder to show improvement and ultimately drive decreased adjustments on this policy. Cardiac patients would inherently be accompanied by Hypertension (PQI 07), Congestive Heart Failure (PQI 08), and Angina (PQI 13), as well as the possibility of increased readmissions.

Even if AAMC were able to achieve revenue rewards for each of these programs in the aggregate for fiscal year 2017, the awards are capped well below what AAMC would need to offset the losses of its cardiac surgery program. Maryland hospitals have maximum rewards for Quality Based Reimbursement of 1.0% of inpatient revenue, Maryland Hospital Acquired

Conditions reward of 1.0% of inpatient revenue, and RRIP of 1.0% of inpatient revenue. (Aggregate Revenue at Risk, **Exhibit 14**, pp. 4-5.) Thus, even if AAMC were to receive the maximum rewards under each program, achieving a rate adjustment of 3.0% of AAMC's $304.9 million projected FY 2019 inpatient revenue, or a $9.1 million reward, the allocation of that additional revenue to cardiac surgery services would be $106,100.

With a positive impact from the population adjustment of $31,000 and a best-case scenario PAU/quality-related adjustment of $106,000, the total identified positive adjustment for cardiac surgery services is $137,000, which would still leave a $2.86 million loss on cardiac surgery services, which AAMC would need to fund by allocating revenue from elsewhere in its hospital. Thus, the application of the best possible assumptions to the first two revenue components identified by AAMC does not even come close to reconciling the loss of $3 million that AAMC displays in FY 2019 in Table J-2.

(iii) AAMC's existing and anticipated operating margin, *i.e.*, reallocation of overhead already funded in the system as evidenced by AAMC's profits

AAMC identifies this vague component as a "catch-all," and has provided no detail on what programs the reallocation would come from or what the impact on those programs would be. Because AAMC has provided no details as to how it would propose to structure this reallocation of GBR, and has made no request to HSCRC, it is impossible for UM BWMC, the interested parties, and the Commission to analyze the appropriateness or feasibility of such a reallocation.

However, to the extent that AAMC suggests it will reallocate overhead already funded within the system, AAMC may be double counting this adjustment in its assumptions. In describing this potential source of revenue adjustment, AAMC relies upon HSCRC's August 24,

2016 letter, which states: "AAMC and BWMC could deliver cardiac surgery volumes with increases in revenue under the new payment model using the resources that are already provided in the system, including… *reallocation of overhead already funded in the system as evidenced by each hospital's profits* to cover the difference between marginal cost and fully allocated costs that includes existing overhead." (HSCRC Letter, Exh. 2, p. 2; AAMC Modification, p. 11) (italicized text quoted by AAMC).

AAMC's charge per case (CPC) already incorporates adjustment for overhead, as demonstrated in Table 2, below.

Table 2
AAMC Cardiac Surgery CPC Calculation

AAMC Average Charge per Case at CMI of 1.0 (AAMC Appl., p. 62)	$ 10,962
Average Case Mix of non-AMC OHS providers (AAMC Appl., p. 62)	x 3.4209
AAMC's Cardiac Surgery CPC used in CON financial projections	$ 37,501

This CPC is calculated based on actual FY 2015 charges and utilization.

This CPC includes an allocation for overhead. In FY 2015, AAMC was under the GBR rate methodology, with an approved cap of about $554 million. AAMC's FY 2015 GBR was established based on AAMC's FY 2014 experience, and AAMC's rates were set based on costs per unit as presented on the HSCRC Annual Filing, Schedule MA. (HSCRC AAMC Annual Filing, FY 2014, excerpt, attached as **Exhibit 16**.) In FY2014, AAMC reported $436.7M Level III costs on Schedule MA, prior to consideration of the Payor Differential, which increased reported costs to $479.2M. (Id.) Included in these reported costs, which are used to calculate GBR, are the overhead costs presented in Table 3 below.

Table 3
AAMC Overhead Costs included in FY 2015 GBR

Patient Care Overhead	$45,933,400

Other Overhead	52,409,300
Overhead Costs driving FY2015 GBR	$98,342,700

Because AAMC's GBR builds in these overhead costs, and because its charge per case is then calculated based on its GBR, overhead is already embedded into its charge per case, and thus already built into its $37,501 cardiac surgery CPC. AAMC's proposed allocation of $3.0 million (or $2.86 million if maximum awards for the other two incentives described above are achieved) to cardiac surgery to purportedly cover overhead costs would therefore double count overhead, and would be inconsistent with HSCRC rate adjustment methodology.

This analysis demonstrates that AAMC incorrectly asserts that the revenue allocation assumptions cannot be made at this time – rather, the application of reasonable assumptions to the components of potential revenue adjustment that AAMC identifies with any specificity demonstrates that the resulting revenue cannot even come close to reconciling the loss that AAMC projects for its cardiac surgery service line in Table J-2. AAMC's modified Table G may show sufficient operating profit to absorb the revenue loss that AAMC's cardiac surgery service line would generate. However, AAMC cannot demonstrate that such an absorption would be consistent with HSCRC methodology, or that it would meet MHCC's financial feasibility standard for cardiac surgery.

E. The Reviewer should require AAMC to make the commitment requested in the October 5, 2016 Letter.

In the October 5, 2016 letter, the Reviewer asked of each applicant:

> Is an authorized representative of the collaborating hospital willing to make a binding commitment that, if its partner applicant hospital is issued a CON to establish a new cardiac surgery program, the collaborating hospital will not approach HSCRC in the future to request an increase in global budgeted revenue that has, as any part of its basis, the lost revenue

> generated by cardiac surgery services that have shifted to its partner applicant hospital?

(Commissioner Tanio Letter, October 5, 2016, Exh. 3, p. 3.)

AAMC did not provide the requested commitment. AAMC instead committed that " if AAMC is issued a CON to establish a new cardiac surgery program, it will not approach the HSCRC in the future to request an increase in global budgeted revenue that has, as any part of its basis, the objective of obtaining additional revenue from the provision of cardiac surgery services." (AAMC Letter, October 17, 2016, **Exhibit 4**). AAMC expressly stated its understanding that the commitment would not prevent it from "allocating to the cardiac surgery program 'increases in revenue under the new payment model using the resources that are provided in the system'" and "allocating revenue to the cardiac surgery program in connection with future revisions to the HSCRC's GBR policy or rate methodologies." (Id., quoting HSCRC Letter, Exh. 2.)

AAMC's last reservation is overly vague, and does not prevent AAMC from requesting additional revenue where HSCRC policy would allow rate adjustments that AAMC would use to fund the operating loss generated by its cardiac surgery program. Furthermore, although AAMC states that it will be able to fund the operating loss generated by its proposed cardiac surgery program through certain resources already provided in the GBR system, even if the financial feasibility standard permitted this, the available resources are not sufficient to cover AAMC's projected loss. Thus, AAMC would have to rely on adjustments through this third, vague exception to its commitment. In light of this, and of AAMC's refusal to provide assumptions as to how it would achieve a reallocation of revenue to fund its proposed cardiac surgery program, the Reviewer should require AAMC to provide the commitment requested.

II. AAMC OVERSTATES THE IMPACT OF ITS PROPOSED PROGRAM ON THE HEALTH CARE DELIVERY SYSTEM – COMAR § 10.24.01.08G(3)(F)(4), COMAR §10.24.17.05A(4).

AAMC concedes that it will have an unfavorable impact on the requirement that Maryland maintain an annual limit on the all-payer total hospital revenue growth (the "All Payer Waiver Test"). (AAMC Modification, p. 17.) AAMC's projections of the savings its proposed program will generate for the Medicare Expenditure Test, which measures growth in Medicare expenditures for all Maryland Medicare beneficiaries, relies heavily on AAMC's assertion that 227 of its projected 337 cases, or 67% of its total volume, will be cases shifted from Washington, D.C. hospitals. (AAMC Modification, Exhibit 40; AAMC Appl., p. 92).

UM BWMC has previously addressed why AAMC's assumptions regarding D.C. volume, and the related cost savings to the system, appear greatly overstated. (*See* UM BWMC Comments on AAMC Application, July 27, 2015, pp. 6-19, 21-22; UM BWMC Response to AAMC Comments on UM BWMC Modification, September 28, 2015, pp. 4-10.) As stated in those comments, AAMC overestimates the volume it will be able to shift from Washington, D.C. hospitals, and fails to account for the fact that some of the cases it is treating as Washington, D.C. market shift may in fact have already shifted, or will soon shift, to the existing and revived cardiac surgery program at Prince George's Hospital Center ("PGHC").

Significantly, AAMC provided no documentation to support its assumption that it will receive any of the 120 referred cases it projects receiving from Cardiology Associates, a Cardiology practice owned by MedStar Health, the owner and operator of MedStar Washington Hospital Center. Instead, AAMC relies on the unsupported assertion that it can expect this practice to change its referral practice and refer to AAMC over MedStar. (AAMC Appl., pp. 77-80; AAMC Response to Completeness Questions, March 30, 2105, p. 18.) This assumption is

undermined by AAMC's own argument, in an effort to address Dimensions' concern that AAMC would shift cases away from the resurging PGHC program, that patients seek care "through relationships and reputation." (AAMC Response, July 29, 2016, p. 3.) AAMC provides no support for its assumption that it will be able to disrupt the relationship that the physicians of Cardiology Associates (employees of MedStar), or its patients, have with MedStar, and fails to provide even a letter of support from that group for AAMC's proposed project.

AAMC's assumption that 67% of its cases will be shifted from Washington, D.C. hospitals is also undermined by the experience of Suburban Hospital, which, like AAMC's proposed project, was developed in affiliation with Johns Hopkins Medicine. The HSCRC's August 24, 2016 letter gave the following warning:

> Finally, a look at prior CON cases can be instructive. For example, Suburban Hospital previously projected that it would perform more than 400 cardiac surgeries annually by 2008 in its cardiac surgery CON. Suburban is presently performing around 200 cardiac surgery cases annually. In spite of the fact that it is less expensive than Washington Hospital Center, it has been unable to attract a higher market share of these services historically.

(HSCRC Letter Exh. 2, p. 5.) As AAMC acknowledges, physician relationships form an important part of a referral base. In addition, HSCRC acknowledged that MedStar's Washington Hospital Center could be strongly incentivized to negotiate charge levels in an effort to retain the cardiac surgery volume that AAMC projects will shift to its new program. (Id., p. 4.) AAMC's assumption that it will be able to divert 227 cases from Washington, D.C. hospitals, including 120 cases from a single cardiology practice, absent any support, should not be credited, nor should AAMC's application receive credit for cost savings that would be attributable to such a shift.

Furthermore, as UM BWMC has previously noted, AAMC's assumptions fail to consider the resurgence of the PGHC cardiac surgery program. AAMC projects that no patients will shift from PGHC to AAMC, relying on PGHC's volume in CY 2012 and CY 2013, which was below 20 cases. (AAMC Appl., pp. 93-94.) Dimensions' June 24, 2016 supplement demonstrates that 110 cardiac surgery cases were performed at PGHC in CY 2015, and 107 in FY 2016, with an additional four cases scheduled to occur before the close of FY 2016. (Dimensions Supplement, June 25, 2016, p. 5). Between July 2014 and June 2016, 40% of PGHC's cardiac surgery cases came from zip codes in AAMC's proposed cardiac surgery service area. (Id., p. 8.)

Like AAMC's proposed program, Dimensions seeks to bring Maryland patients back from Washington, D.C., and similarly receives revenue for such cases based on market shift at a 50% variable cost factor. AAMC thus significantly overstates the Medicaid savings achieved for any volume that AAMC would shift from PGHC instead of from Washington, D.C. hospitals.

In an attempt to rebut Dimensions' concern that AAMC will shift volume from it, AAMC asserts that patients seek care "through relationships and reputation" rather than based on geographical convenience. (AAMC Response, July 29, 2016, p. 3.) AAMC has also claimed that it intends to seek patients whose physicians do not refer to PGHC, and thus that its program will not compete with the PGHC program. (Id., p. 3-4.) AAMC's statements directly contradict its own volume assumptions. AAMC assumes that it will be able to recapture cases from Washington, D.C. hospitals based on (1) its more convenient geographical location; and (2) referrals from MedStar cardiologists who currently refer to MedStar. (AAMC Appl., pp. 77-80, 82.)

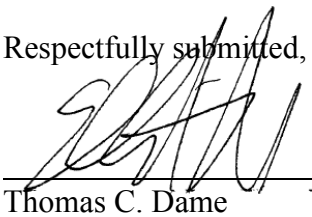
To the extent that patients seek care based on referral relationships, then AAMC's D.C. volume assumption is vastly overstated because it has no letter of support from MedStar

cardiologists, from whom it projects receiving 120 cases. If, as AAMC alleges, referral patterns are based in part on geographic proximity, then AAMC's volume, and related cost savings, are overstated because it fails to account for volume that has already shifted to PGHC. Also, while AAMC claims it has no intent to seek referrals from cardiologists currently referring cases to PGHC, this is not a binding commitment, and AAMC has freely admitted it will seek to interrupt the referral pattern of other cardiology practices (such as MedStar). Indeed, it *must* interrupt existing referral relationships since all cardiac surgery cases are currently being referred to existing cardiac surgery programs. Any volume AAMC shifts from PGHC will have a significantly lower cost savings than AAMC projects for D.C. volume shift in its modification.

CONCLUSION

For the reasons set forth above, UM BWMC respectfully asks that the Commission deny AAMC's Application proposing to establish a cardiac surgery program.

Respectfully submitted,



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November 14, 2016

Table of Exhibits

	Description
1	AAMC's original revenue and expense projection tables
2	HSCRC Letter to Commissioner Tanio, August 24, 2016
3	Commissioner Tanio Letter, October 5, 2016
4	AAMC Letter, October 17, 2016
5	October 17, 2016 projections calculated revenue based on a 50% variable cost factor
6	AAMC Mental Health Hospital Application, August 1, 2016 Update
7	AAMC Mental Health Hospital CON Application, March 29, 2016
8	AAMC's November 7, 2016 financial projections, excerpt
9	Commissioner Tanio Letter, October 28, 2016
10	HSCRC Memorandum Re; Global Budget Hospital Population and Demographic Adjustment Volume Allowance, June 30, 2014
11	HSCRC Demographic Adjustment by Hospital, Rate Year 2017
12	HSCRC Memorandum Re: RRIP Policy for Rate Year 2018 and RY 2017 Updates, June 30, 2016
13	HSCRC Readmission Reduction Incentive Program, Rate Year 2017
14	HSCRC Final Recommendations for the Aggregate Revenue Amount At-Risk under Maryland Hospital Quality Programs for Rate Year 2018
15	HSCRC Final Recommendations for the PAU Savings Policy for Rate Year 2017, June 8, 2016
16	HSCRC AAMC Annual Filing, FY 2014, excerpt

CERTIFICATE OF SERVICE

I hereby certify that on the 14th day of November 2016, a copy of the foregoing Comments on AAMC's Modification to CON Application Pursuant to Status Project Conference was sent via email and first-class mail to:

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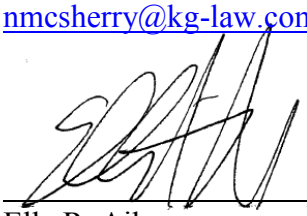

Ella R. Aiken

I hereby declare and affirm under the penalties of perjury that the facts stated in UM BWMC's Comments on Anne Arundel Medical Center's Modification Pursuant to Status Project Conference and its attachments are true and correct to the best of my knowledge, information, and belief.

November 14, 2016
Date

Alfred Pietsch
Senior Vice President and CFO
UM BWMC

#520226
011598-0019

EXHIBIT 1

TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table G should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table F and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2017**	**FY 2018**	**FY 2019**				
1. REVENUE										
a. Inpatient Services	$ 294,098,900	$ 292,960,600	$ 297,654,040	$ 305,351,269	$ 308,396,353	$ 309,946,875				
b. Outpatient Services	$ 239,409,200	$ 253,443,600	$ 254,587,463	$ 253,508,978	$ 253,514,841	$ 253,520,867				
Gross Patient Service Revenues	***$ 533,508,100***	***$ 546,404,200***	***$ 552,241,503***	***$ 558,860,247***	***$ 561,911,194***	***$ 563,467,742***	***$ -***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ 19,750,800	$ 22,623,500	$ 26,145,184	$ 26,414,590	$ 26,521,167	$ 26,575,438				
d. Contractual Allowance	$ 53,366,400	$ 60,024,200	$ 55,603,875	$ 56,473,164	$ 56,817,398	$ 56,992,890				
e. Charity Care	$ 8,912,500	$ 5,721,800	$ 2,774,084	$ 2,812,570	$ 2,827,796	$ 2,835,548				
Net Patient Services Revenue	***$ 451,478,400***	***$ 458,034,700***	***$ 467,718,360***	***$ 473,159,922***	***$ 475,744,833***	***$ 477,063,866***	***$ -***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues	$ 26,036,200	$ 25,995,000	$ 30,197,196	$ 30,157,196	$ 30,157,196	$ 30,157,196				
NET OPERATING REVENUE	***$ 477,514,600***	***$ 484,029,700***	***$ 497,915,556***	***$ 503,317,118***	***$ 505,902,029***	***$ 507,221,062***	***$ -***	***$ -***	***$ -***	***$ -***
2. EXPENSES										
a. Salaries & Wages (including benefits)	$ 222,592,080	$ 221,047,100	$ 228,259,601	$ 235,991,612	$ 237,393,158	$ 239,600,264				
b. Contractual Services	$ 2,851,345	$ 716,000	$ 245,942	$ 248,167	$ 248,664	$ 249,623				
c. Interest on Current Debt	$ 15,972,794	$ 15,182,000	$ 14,096,925	$ 13,555,176	$ 13,301,038	$ 13,041,376				
d. Interest on Project Debt										
e. Current Depreciation	$27,952,182	$29,211,500	$29,396,532	$ 29,452,079	$ 28,642,928	$ 28,502,319				
f. Project Depreciation				$ 315,319	$ 315,319	$ 315,319				
g. Current Amortization	$ 418,365	$ 392,500	$ 390,407	$ 307,008	$ 307,008	$ 307,008				
h. Project Amortization										
i. Supplies	$ 115,094,050	$ 117,119,100	$ 115,931,587	$ 107,621,203	$ 105,810,629	$ 102,989,400				
j. Other Expenses (Specify/add rows if needed)	$ 91,519,202	$ 88,249,400	$ 89,396,313	$ 84,703,874	$ 82,984,745	$ 80,555,423				
TOTAL OPERATING EXPENSES	***$ 476,400,018***	***$ 471,917,600***	***$ 477,717,307***	***$ 472,194,438***	***$ 469,003,487***	***$ 465,560,733***	***$ -***	***$ -***	***$ -***	***$ -***
3. INCOME										
a. Income From Operation	**$ 1,114,582**	**$ 12,112,100**	**$ 20,198,249**	**$ 31,122,679**	**$ 36,898,542**	**$ 41,660,330**	**$ -**	**$ -**	**$ -**	**$ -**
b. Non-Operating Income	$ 44,226,600	$ 27,091,100	$ (31,684,793)	$ 16,919,694	$ 20,690,944	$ 24,933,376				
SUBTOTAL	***$ 45,341,182***	***$ 39,203,200***	***$ (11,486,543)***	***$ 48,042,373***	***$ 57,589,486***	***$ 66,593,706***	***$ -***	***$ -***	***$ -***	***$ -***
c. Income Taxes										
NET INCOME (LOSS)	***$ 45,341,182***	***$ 39,203,200***	***$ (11,486,543)***	***$ 48,042,373***	***$ 57,589,486***	***$ 66,593,706***	***$ -***	***$ -***	***$ -***	***$ -***

TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table G should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table F and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2017**	**FY 2018**	**FY 2019**				
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare	40.2%	40.3%	39.6%	39.6%	39.6%	39.6%				
2) Medicaid	6.6%	9.3%	10.8%	10.8%	10.8%	10.8%				
3) Blue Cross	21.2%	19.3%	17.9%	17.9%	17.9%	17.9%				
4) Commercial Insurance	21.4%	27.0%	28.1%	28.1%	28.1%	28.1%				
5) Self-pay	3.1%	1.3%	0.9%	0.9%	0.9%	0.9%				
6) Other	7.5%	2.9%	2.7%	2.7%	2.7%	2.7%				
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days										
1) Medicare	40.2%	40.3%	39.6%	39.6%	39.6%	39.6%				
2) Medicaid	6.6%	9.3%	10.8%	10.8%	10.8%	10.8%				
3) Blue Cross	21.2%	19.3%	17.9%	17.9%	17.9%	17.9%				
4) Commercial Insurance	21.4%	27.0%	28.1%	28.1%	28.1%	28.1%				
5) Self-pay	3.1%	1.3%	0.9%	0.9%	0.9%	0.9%				
6) Other	7.5%	2.9%	2.7%	2.7%	2.7%	2.7%				
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table H should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table F. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2017**	**FY 2018**	**FY 2019**				
1. REVENUE										
a. Inpatient Services	$ 294,098,900	$ 292,960,600	$ 297,654,040	$ 321,669,672	$ 333,403,222	$ 343,850,658				
b. Outpatient Services	$ 239,409,200	$ 253,443,600	$ 254,587,463	$ 266,343,544	$ 273,009,784	$ 279,843,668				
Gross Patient Service Revenues	***$ 533,508,100***	***$ 546,404,200***	***$ 552,241,503***	***$ 588,013,216***	***$ 606,413,006***	***$ 623,694,326***	***$ -***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ 19,750,800	$ 22,623,500	$ 26,145,184	$ 27,751,628	$ 28,559,676	$ 29,332,638				
d. Contractual Allowance	$ 53,366,400	$ 60,024,200	$ 55,603,875	$ 58,103,361	$ 59,317,523	$ 60,385,271				
e. Charity Care	$ 8,912,500	$ 5,721,800	$ 2,774,084	$ 2,954,929	$ 3,045,124	$ 3,129,677				
Net Patient Services Revenue	***$ 451,478,400***	***$ 458,034,700***	***$ 467,718,360***	***$ 499,203,298***	***$ 515,490,682***	***$ 530,846,740***	***$ -***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues (Specify/add rows if needed)	$ 26,036,200	$ 25,995,000	$ 30,197,196	$ 31,203,328	$ 31,711,634	$ 32,230,107				
NET OPERATING REVENUE	***$ 477,514,600***	***$ 484,029,700***	***$ 497,915,556***	***$ 530,406,626***	***$ 547,202,316***	***$ 563,076,847***	***$ -***	***$ -***	***$ -***	***$ -***
2. EXPENSES										
a. Salaries & Wages (including benefits)	$ 222,592,080	$ 221,047,100	$ 228,259,601	$ 248,737,129	$ 256,786,669	$ 265,897,175				
b. Contractual Services	$ 2,851,345	$ 716,000	245,942	253,155	256,198	259,759				
c. Interest on Current Debt	$ 15,972,794	$ 15,182,000	14,096,925	13,555,176	13,301,038	13,041,376				
d. Interest on Project Debt	$ -	$ -								
e. Current Depreciation	$ 27,952,182	$ 29,211,500	29,396,532	29,452,079	28,642,928	28,502,319				
f. Project Depreciation	$ -	$ -		315,319	315,319	315,319				
g. Current Amortization	$ 418,365	$ 392,500	390,407	307,008	307,008	307,008				
h. Project Amortization	$ -	$ -								
i. Supplies	$ 115,094,050	$ 117,119,100	115,931,587	118,510,331	122,853,218	126,853,721				
j. Other Expenses (Specify/add rows if needed)	$ 91,519,202	$ 88,249,400	89,396,313	92,087,575	94,325,880	96,044,317				
TOTAL OPERATING EXPENSES	***$ 476,400,018***	***$ 471,917,600***	***$ 477,717,307***	***$ 503,217,771***	***$ 516,788,258***	***$ 531,220,993***	***$ -***	***$ -***	***$ -***	***$ -***
3. INCOME										
a. Income From Operation	**$ 1,114,582**	**$ 12,112,100**	**$ 20,198,249**	**$ 27,188,854**	**$ 30,414,058**	**$ 31,855,854**	**$ -**	**$ -**	**$ -**	**$ -**
b. Non-Operating Income	$ 44,226,600	$ 27,091,100	$ (31,684,793)	$ 16,716,597	$ 20,162,033	$ 23,870,184				
SUBTOTAL	***$ 45,341,182***	***$ 39,203,200***	***$ (11,486,543)***	***$ 43,905,451***	***$ 50,576,091***	***$ 55,726,038***	***$ -***	***$ -***	***$ -***	***$ -***
c. Income Taxes										
NET INCOME (LOSS)	***$ 45,341,182***	***$ 39,203,200***	***$ (11,486,543)***	***$ 43,905,451***	***$ 50,576,091***	***$ 55,726,038***	***$ -***	***$ -***	***$ -***	***$ -***

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table H should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table F. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2017**	**FY 2018**	**FY 2019**				
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare	40.2%	40.3%	39.6%	39.6%	39.6%	39.6%				
2) Medicaid	6.6%	9.3%	10.8%	10.8%	10.8%	10.8%				
3) Blue Cross	21.2%	19.3%	17.9%	17.9%	17.9%	17.9%				
4) Commercial Insurance	21.4%	27.0%	28.1%	28.1%	28.1%	28.1%				
5) Self-pay	3.1%	1.3%	0.9%	0.9%	0.9%	0.9%				
6) Other	7.5%	2.9%	2.7%	2.7%	2.7%	2.7%				
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days										
Total MSGA										
1) Medicare	40.2%	40.3%	39.6%	39.6%	39.6%	39.6%				
2) Medicaid	6.6%	9.3%	10.8%	10.8%	10.8%	10.8%				
3) Blue Cross	21.2%	19.3%	17.9%	17.9%	17.9%	17.9%				
4) Commercial Insurance	21.4%	27.0%	28.1%	28.1%	28.1%	28.1%				
5) Self-pay	3.1%	1.3%	0.9%	0.9%	0.9%	0.9%				
6) Other	7.5%	2.9%	2.7%	2.7%	2.7%	2.7%				
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***

TABLE J. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table J should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table I and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**				
1. REVENUE							
a. Inpatient Services	$ 6,618,453	$ 9,669,525	$ 11,225,855				
b. Outpatient Services							
Gross Patient Service Revenues	***$ 6,618,453***	***$ 9,669,525***	***$ 11,225,855***	***$ -***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ 269,393	$ 375,975	$ 430,236				
d. Contractual Allowance	$ 869,754	$ 1,213,863	$ 1,389,047				
e. Charity Care	$ 38,485	$ 53,711	$ 61,462				
Net Patient Services Revenue	***$ 5,440,821***	***$ 8,025,976***	***$ 9,345,110***	***$ -***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues	$ -	$ -	$ -				
NET OPERATING REVENUE	***$ 5,440,821***	***$ 8,025,976***	***$ 9,345,110***	***$ -***	***$ -***	***$ -***	***$ -***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ 3,042,302	$ 3,397,763	$ 3,582,372				
b. Contractual Services							
c. Interest on Current Debt							
d. Interest on Project Debt							
e. Current Depreciation							
f. Project Depreciation	$ 315,319	$ 315,319	$ 315,319				
g. Current Amortization							
h. Project Amortization							
i. Supplies	$ 1,687,904	$ 2,466,749	$ 2,873,906				
j. Other Expenses (Specify)	$ 1,899,518	$ 1,830,391	$ 1,702,183				
TOTAL OPERATING EXPENSES	**$ 6,945,043**	**$ 8,010,222**	**$ 8,473,780**	***$ -***	***$ -***	***$ -***	***$ -***
3. INCOME							
a. Income From Operation	**$ (1,504,222)**	**$ 15,755**	**$ 871,330**	***$ -***	***$ -***	***$ -***	***$ -***
b. Non-Operating Income							
SUBTOTAL	***$ (1,504,222)***	***$ 15,755***	***$ 871,330***	***$ -***	***$ -***	***$ -***	***$ -***
c. Income Taxes							
NET INCOME (LOSS)	***$ (1,504,222)***	***$ 15,755***	***$ 871,330***	***$ -***	***$ -***	***$ -***	***$ -***

TABLE J. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table J should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table I and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**				
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare	50.2%	51.9%	52.9%				
2) Medicaid	6.8%	6.8%	6.8%				
3) Blue Cross	9.3%	9.3%	9.3%				
4) Commercial Insurance	30.6%	28.9%	27.9%				
5) Self-pay	2.5%	2.5%	2.5%				
6) Other	0.6%	0.6%	0.6%				
TOTAL	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days							
Total MSGA							
1) Medicare	50.2%	51.9%	52.9%				
2) Medicaid	7.3%	7.3%	7.3%				
3) Blue Cross	9.0%	9.0%	9.0%				
4) Commercial Insurance	30.0%	28.4%	27.4%				
5) Self-pay	2.9%	2.9%	2.9%				
6) Other	0.6%	0.6%	0.6%				
TOTAL	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***

TABLE K. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table K should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table I. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**				
1. REVENUE							
a. Inpatient Services	$ 6,949,376	$ 10,394,740	$ 12,348,441				
b. Outpatient Services							
Gross Patient Service Revenues	***$ 6,949,376***	***$ 10,394,740***	***$ 12,348,441***	***$ -***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ 282,863	$ 404,173	$ 473,260				
d. Contractual Allowance	$ 913,242	$ 1,304,903	$ 1,527,952				
e. Charity Care	$ 40,409	$ 57,739	$ 67,608				
Net Patient Services Revenue	***$ 5,712,862***	***$ 8,627,925***	***$ 10,279,621***	***$ -***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues (Specify/add rows of needed)							
NET OPERATING REVENUE	***$ 5,712,862***	***$ 8,627,925***	***$ 10,279,621***	***$ -***	***$ -***	***$ -***	***$ -***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ 3,163,994	$ 3,601,628	$ 3,868,962				
b. Contractual Services							
c. Interest on Current Debt							
d. Interest on Project Debt							
e. Current Depreciation							
f. Project Depreciation	$ 315,319	$ 315,319	$ 315,319				
g. Current Amortization							
h. Project Amortization							
i. Supplies	$ 1,228,148	$ 2,095,246	$ 2,585,649				
j. Other Expenses (Specify/add rows of needed)	$ 2,442,273	$ 2,372,968	$ 2,251,816				
TOTAL OPERATING EXPENSES	***$ 7,149,734***	***$ 8,385,161***	***$ 9,021,745***	***$ -***	***$ -***	***$ -***	***$ -***
3. INCOME							
a. Income From Operation	**$ (1,436,872)**	**$ 242,764**	**$ 1,257,876**	**$ -**	**$ -**	**$ -**	**$ -**
b. Non-Operating Income							
SUBTOTAL	***$ (1,436,872)***	***$ 242,764***	***$ 1,257,876***	***$ -***	***$ -***	***$ -***	***$ -***
c. Income Taxes							
NET INCOME (LOSS)	***$ (1,436,872)***	***$ 242,764***	***$ 1,257,876***	***$ -***	***$ -***	***$ -***	***$ -***

TABLE K. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table K should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table I. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**				
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare	50.2%	51.9%	52.9%				
2) Medicaid	6.8%	6.8%	6.8%				
3) Blue Cross	9.3%	9.3%	9.3%				
4) Commercial Insurance	30.6%	28.9%	27.9%				
5) Self-pay	2.5%	2.5%	2.5%				
6) Other	0.6%	0.6%	0.6%				
TOTAL	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days							
1) Medicare	50.2%	51.9%	52.9%				
2) Medicaid	7.3%	7.3%	7.3%				
3) Blue Cross	9.0%	9.0%	9.0%				
4) Commercial Insurance	30.0%	28.4%	27.4%				
5) Self-pay	2.9%	2.9%	2.9%				
6) Other	0.6%	0.6%	0.6%				
TOTAL	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***

EXHIBIT 2

Health Services Cost Review Commission
4160 Patterson Avenue, Baltimore, Maryland 21215
Phone: 410-764-2605 · Fax: 410-358-6217
Toll Free: 1-888-287-3229
hscrc.maryland.gov

Date: August 24, 2016

To: Craig P. Tanio
Commissioner/Reviewer, MHCC

From: Donna Kinzer, Executive Director, HSCRC
Gerard J. Schmith, Deputy Director, Hospital Rate Setting, HSCRC

Subject: Applications for Certificates of Need to Establish Cardiac Surgery Services at Anne Arundel Medical Center (Docket No. 15-02-2360) and University of Maryland Baltimore Washington Medical Center (Docket No. 15-02-2361)

On July 15, 2016 you requested that we review and comment on the financial feasibility and underlying assumptions of proposed new Cardiac Surgery programs at Anne Arundel Medical Center (AAMC) and University of Maryland Baltimore Washington Medical Center (BWMC).

Per your request we will address each of the six specific questions outlined in your letter regarding the Certificate of Need (CON) applications for the two new proposed programs.

1. **Does either or both applications accurately reflect the shifts in revenue that will occur under the new payment model if the applicant hospitals succeed in building the cardiac surgery case volume they project?**

AAMC assumed that it would be able to retain 85% of the additional revenue associated with the cardiac surgery program. Under the current HSCRC policy for market shift changes of Maryland residents, hospitals with increased volumes that are taken from other Maryland hospitals are allowed to retain 50% of the revenue associated with the additional volume while hospitals that lose volume to other Maryland hospitals are allowed to retain 50% of the revenue associated with the lost volume. Additionally, under the HSCRC market shift policy, hospitals are not allowed to retain any of the increases in revenue related to volume increases that are not matched by reductions in other Maryland hospitals.

AAMC has projected that Maryland residents will comprise the 67% of its cardiac surgery cases that will come from D.C. and other out-of-state providers. Under the Hospital's GBR agreement, AAMC would be able to retain 50% of the cardiac surgery revenue associated with these Maryland residents. Verifying the AAMC projections requires analysis of Medicare data (which the HSCRC

obtains monthly), commercial data (which is reported to MHCC with a greater lag time), and estimates from Medicaid. Likewise, Systems associated with Maryland-based providers are required to provide the HSCRC with claims data for their DC-based facilities under the GBR agreement. AAMC could also retain 50% of the revenue related to the 33% of its projected volume for transfers from other Maryland hospitals. AAMC's assumption that it would be able to retain 85% of the cardiac surgery revenue is contrary to HSCRC policy on market shifts; however, as discussed below, AAMC has other sources of revenue to apply to the project and, therefore, we do not believe a change in this assumption would impact the feasibility of the program.

BWMC's assumption that it will retain 50% of the new revenue associated with the cardiac surgery program is consistent with HSCRC market shift policy.

2. **Is the revenue impact at each of the applicant hospitals correctly modeled and is the revenue impact correctly modeled for the hospitals that are projected to lose cardiac surgery case volume if the new cardiac surgery programs are put into operation?**

Please see answer to Question 1 for the revenue impact at the applicant hospitals.

The applicants correctly modeled the impacts on revenue for those hospitals projected to lose significant cardiac surgery case volume if the new cardiac surgery programs are put into operation. However, as discussed below, those assumptions do not address the possibility that the affected institutions will "backfill" the cases from other areas of Maryland or for other services.

3. **Does each application provide a plausible scenario for an overall reduction in the cost of producing cardiac surgery services in Maryland and a reduction in the charges that will be incurred by payers for cardiac surgery services in Maryland, if the hospital is authorized to establish cardiac surgery services and is successful in shifting the projected volumes of service to their lower cost hospitals? More specifically, does each application provide sufficient information for HSCRC staff to assess the following capabilities and, if so, what is HSCRC staff's assessment on:**
    a. **The capability of AAMC and the capability of BWMC to deliver cardiac surgery at the costs each hospital projects;**
    b. **The capability of AAMC and the capability of BWMC to deliver cardiac surgery with the increases in revenue that each hospital will realize under the payment model; and**
    c. **The capability of Maryland hospitals projected to lose cardiac surgery if either or both the AAMC and BWMC programs are approved to adjust their variable costs so that net income derived from this service will not be greatly affected?**

AAMC and BWMC could deliver cardiac surgery volumes with the increases in revenue under the new payment model using the resources that are provided in the system, including the population adjustment, capacity from reduced avoidable utilization, and reallocation of overhead already funded in the system as evidenced in each hospital's profits to cover the difference between marginal cost

and fully allocated costs that includes existing overhead. However, this would require a commitment from the hospitals to avoid seeking a rate increase in a separate action.

In certain cases related to replacement facilities, a hospital could secure a CON exemption by taking the "Pledge," which prevents a hospital from requesting an increase to revenue or patient charges related to the capital cost of the project in the future. However, in this case there is no such mechanism, per se, that would preclude a hospital from requesting a rate or revenue increase for an approved CON. If the hospital represents that it will not need an increase to accomplish the project during the CON process, the HSCRC staff would do all that it could to ensure that the hospital lived up to its statements. Under the current GBR methodology, hospitals have the right to approach the HSCRC to request an increase in their allowed GBR revenue if the GBR methodology does not provide sufficient revenue. Additionally, in the future, hospitals will be able to submit full rate applications requesting increases in rates if their approved GBR revenue is not sufficient. If not addressed in the CON process, this could leave the system open to unexpected hospital revenue increases from a new program.

Dimension Health Services (DHS) has provided the HSCRC with a proposed GBR arrangement that DHS believes will allow it to operate at a profit in the future based on a set of assumptions. One of DHS' assumptions is that DHS' cardiac surgery program will grow significantly over the next 5 years. AAMC draws some of its patients from Prince George's County, and this could impact the DHS program. While many of the patients that would be served in DHS' cardiac program may not be likely to travel to AAMC for services based on historic migration patterns, changes in volume levels at Washington Hospital Center resulting from a new program at AAMC may impact available capacity at Washington Hospital Center, making it more difficult for DHS to grow its volumes in the face of this increased capacity. Thus, there is the potential to directly or indirectly impact program volumes at DHS, and, therefore, its financial performance.

4. **If a hospital currently providing cardiac surgery services experiences a net reduction in revenue because of the loss of cardiac surgery volume resulting from the creation of a new cardiac surgery program at AAMC or BWMC, or at both hospitals and that hospital is unable to reduce its cost sufficiently to offset this lost revenue, will that hospital be able to approach HSCRC and seek rate relief, negating the projected savings in charges that the applicants project to result from their prospective proposals? Does the payment model or HSCRC policy prevent such an outcome? Are there mechanisms by which hospitals, within the context of this project review, can waive any "right" to seek such rate relief, thus assuring that systemic savings for Maryland payers achievable by shifting cardiac surgery case volume to lower charge hospitals will actually occur and be sustained? Are there other mechanisms that would help insure system savings that we have not considered?**

The CON process does not affect the rights of a competing or cooperating hospital to request rate increases to cover lost volumes in the event of a comprehensive rate review. The CON process does not limit this ability, unless specifically agreed to by hospitals during the CON process. Additionally, the savings may be undermined through "backfill," whereby the hospital losing market share secures market shift for patients from another service area of the State or for an alternative

service for patients from the State. Nevertheless, there could be an inherent advantage of moving lower severity patients out of high cost academic medical centers and teaching facilities into lower cost settings, thereby freeing up capacity for new procedures under development, referrals of patients for highly specialized services from outside the service area, and other high value activities without expanding capacity at the academic medical center or teaching facility. Therefore, the desirability of moving services out of these settings should be weighed in considering the ability to assure cost savings over time through reducing the need for capacity in these high cost environments.

5. **Does the shift of cardiac surgery case volume from Washington, D.C. hospitals to Maryland hospitals paid for by Medicare, which is more pronounced in the case presented by AAMC, have a concerning negative impact on the spending and savings targets HSCRC must meet under the Maryland waiver?**

The Maryland Medicare waiver targets limit the increase in total annual Medicare spending per Maryland Medicare enrollee. Under the targets, Maryland would benefit if the average Medicare payment for a cardiac surgery patient is lower compared to the current Medicare payment at Washington area hospitals. For those Medicare cardiac surgery patients treated at AAMC, the estimated Medicare payment could be lower depending on how much additional revenue AAMC were allowed to generate under its GBR Agreement.

Of more concern, if a new cardiac surgery program at either AAMC or BWMC would result in new cardiac surgery cases that were not previously performed, the waiver would be negatively impacted.

6. **Is it likely that the ability of D.C. hospitals to negotiate charge levels for cardiac surgery with individual payers will make it more difficult to shift volume away from these hospitals to new Maryland providers?**

In the current environment, it is not likely that the ability of D.C. hospitals to negotiate charge levels for cardiac surgery with individual commercial payers will make it more difficult to shift volume away from these hospitals to new Maryland providers. This is because patients and doctors make the decisions about where patients receive services and not payers. Further, out-of-pocket costs for a high cost procedure are generally not affected by the choice of facility. However, as physicians and patients become more price sensitive through the use of PCMHs, ACOs, episode payments, value-based insurance design, and other mechanisms, the point of emphasis may change. There is an increasing number of employers, for example, that are determining which facilities employees can use for tertiary procedures, using both cost and outcomes measures. CareFirst encourages its PCMH physicians to consider episode costs when referring patients. If Washington Hospital Center lowers its episode prices in response to competition from AAMC, it could potentially affect facility selection in a more price sensitive environment.

In a situation with no additional variables, Washington Hospital Center's net income could decrease by as much as half of the $12,000,000 in reduced revenue it may experience if AAMC's program were approved. This loss in net income would provide a strong incentive for Washington Hospital Center to negotiate with third parties to retain the cardiac surgery volume

that AAMC would be attempting to recapture, to backfill the same procedure from other areas of the state, or to backfill with some other service. The same analysis would apply to BWMC. The results are difficult to model in the short run. If the addition of the service at AAMC or BWMC results in increased volumes in the system due to increased supply, then system costs may be affected negatively. Conversely, if the outcome is slower growth, or contraction at high cost academic centers, then system costs may be affected positively, so long as the services produced by AAMC or BWMC are high quality efficient services with equal or better outcomes.

Finally, a look at prior CON cases can be instructive. For example, Suburban Hospital previously projected that it would perform more than 400 cardiac surgeries annually by 2008 in its cardiac surgery CON. Suburban is presently performing around 200 cardiac surgery cases annually. In spite of the fact that it is less expensive than Washington Hospital Center, it has been unable to attract a higher market share of these services historically. The recent overall statewide reduction in cardiac surgery also contributed to Suburban's much lower than projected cardiac surgery volumes.

Please advise if you have further questions.

EXHIBIT 3

STATE OF MARYLAND

Craig P. Tanio, M.D
CHAIR

Ben Steffen
EXECUTIVE DIRECTOR

MARYLAND HEALTH CARE COMMISSION

4160 PATTERSON AVENUE – BALTIMORE, MARYLAND 21215
TELEPHONE: 410-764-3460 FAX: 410-358-1236

October 5, 2016

By E-Mail and USPS

Jonathan Montgomery, Esquire
Gordon-Feinblatt LLC
233 East Redwood Street
Baltimore, Maryland 21202-3332

Thomas C. Dame, Esquire
Ella R. Aiken, Esquire
Gallagher, Evelius & Jones LLP
218 North Charles Street, Suite 400
Baltimore, Maryland 21201

Re: Baltimore Upper Shore Cardiac Surgery Review
Anne Arundel Medical Center (Docket No. 15-02-2360)
University of Maryland Baltimore Washington Medical Center
(Docket No. 15-02-2361)

Dear Counsel:

As you know, on August 24, 2016, Health Service Cost Review Commission ("HSCRC") staff responded to my request for comments on the above-referenced Certificate of Need applications. I am writing to seek commitments from each applicant regarding matters raised by HSCRC staff in its comments. I am also requesting commitments by the two respective institutions that are partnering/coordinating with each of the applicants: The Johns Hopkins Hospital ("JHH") with Anne Arundel Medical Center; and the University of Maryland Medical Center ("UMMC"), with University of Maryland Baltimore Washington Medical Center ("BWMC"). I have a specific request for information from AAMC that results from comments made by HSCRC staff. In addition, I give notice to all parties about my use of data in the review.

I request that the responses to my questions or request for updated information be submitted via e-mail in Portable Document Format ("PDF") format to all of the parties in this review, to Ms. Ruby Potter, and to others copied on this letter ruling or on the e-mail by which this ruling is also sent.

Issues raised by HSCRC that are common to the applicants.

Background and Question 1.

In its comments, HSCRC staff noted that each applicant hospital:

> could deliver cardiac surgery volumes with the increases in revenue under the new payment model using the resources that are provided in the system, including the population adjustment, capacity from reduced avoidable utilization, an reallocation of overhead already funded in the system as evidenced in each hospital's profits to cover the difference between marginal cost and fully allocated costs that includes existing overhead. However, this would require a commitment from the hospitals to avoid seeking a rate increase in a separate action. ... If the hospital represents that it will not need an increase [in approved revenue] to accomplish the project during the CON process, the HSCRC staff would do all that it could to ensure that the hospital lived up to its statements. Under the current GBR methodology, hospitals have the right to approach the HSCRC to request an increase in their allowed GBR revenue if the GBR methodology does not provide sufficient revenue. Additionally, in the future, hospitals will be able to submit full rate applications requesting increases in rates if their approved GBR revenue is not sufficient. If not addressed in the CON process, this could leave the system open to unexpected hospital revenue increases from a new program.

Therefore, my first question, for each applicant hospital is:

1: Is an authorized representative of the applicant hospital willing to make a binding commitment that, if the applicant hospital is issued a CON to establish a new cardiac surgery program, it will not approach HSCRC in the future to request an increase in global budgeted revenue that has, as any part of its basis, the objective of obtaining additional revenue from the provision of cardiac surgery services?

Background and Question 2.

In its comments, HSCRC staff also stated,

> The CON process does not affect the rights of a competing or cooperating hospital to request rate increases to cover lost volumes in the event of a comprehensive rate review. The CON process does not limit this ability, unless specifically agreed to by hospitals during the CON process. Additionally, the savings may be undermined through 'backfill,' whereby the hospital losing market share secures market shift from another service area of the State or for an alternative service for patients from the State. Nevertheless, there could be an

> inherent advantage of moving lower severity patients out of high cost academic medical centers and teaching facilities into lower cost settings, thereby freeing up capacity for the new procedures under development, referrals of patients for highly specialized services from outside the service area, and other high value activities without expanding capacity at the academic medical center or teaching facility. Therefore, the desirability of moving services out of those settings should be weighed in considering the ability to assure cost savings over time through reducing the need for capacity in these high cost environments.

AAMC projects in its application that a portion of the cardiac surgery cases originating in its service area would, in the absence of a cardiac surgery program at AAMC, otherwise be performed at JHH, and states that JHH and its medical staff will actively collaborate with AAMC in causing this "market shift" of cardiac surgery cases to AAMC. Similarly, BWMC projects that a portion of the cases originating in the BWMC service area would, in the absence of a program at BWMC, otherwise be performed at UMMC, with UMMC and its medical staff actively collaborating with BWMC in causing this market shift to BWMC.

In light of HSCRC's comments, my question to The Johns Hopkins Hospital and to University of Maryland Medical Center (each, the "collaborating hospital") follows:

2: Is an authorized representative of the collaborating hospital willing to make a binding commitment that, if its partner applicant hospital is issued a CON to establish a new cardiac surgery program, the collaborating hospital will not approach HSCRC in the future to request an increase in global budgeted revenue that has, as any part of its basis, the lost revenue generated by cardiac surgery services that have shifted to its partner applicant hospital?

My goal, in seeking responses to these two questions, is to obtain confirmation and a greater level of confidence that the system savings projected by the applicants through a shift in cardiac surgery case volume from higher charge to lower charge hospitals will be sustained if one or both of these CON applications are approved. Thus, in accordance with HSCRC staff's comments, I ask each applicant and its key collaborating hospital to impose limitations on their own future actions through binding written commitments made in the CON review process. I view this as an important way in which the Commission can assist HSCRC staff in ensuring that a hospital lives up to representations made in its CON application with respect to any future requests for increases in budgeted revenue based on the revenue impact associated with redistribution of cardiac surgery case volume.

HSCRC issue limited to AAMC.

Finally, HSCRC staff stated that "AAMC's assumption that it would be able to retain 85% of the cardiac surgery revenue" related to the 33% of its projected volume for transfers from other Maryland hospitals … is contrary to HSCRC policy on market shifts." I note that in its August 25, 2015 response to interested party comments regarding this inconsistency, AAMC

stated that it "can reasonably expect to retain 85% of the revenue generated by the AAMC's proposed program [based on indications by HSCRC] that, for new services, it [HSCRC] has the flexibility to provide targeted funding through the annual update process for individual hospital budgets." (DI #45GF, p. 19).

Given HSCRC staff's comment regarding this issue, I request that AAMC provide revised versions of all the financial schedules previously submitted that fully conform with standard HSCRC policy with respect to retention of revenue generated from projected shifts in cardiac surgery case volume from hospitals with existing cardiac surgery programs to AAMC.

Notice of use of HSCRC Discharge Database and District of Columbia Discharge Database in this review.

I intend to use information beginning with Calendar Year 2009 to the most recent quarter of information available from the HSCRC Discharge Database and from the District of Columbia Database in this review. **If either applicant or any party in this review does not have access to the HSCRC database, I recommend that you gain access to patient-level de-identified data by making the required application(s) found on HSCRC's website at:** http://www.hscrc.maryland.gov/hsp-data-request.cfm. **If you do not have access to the District of Columbia Discharge Database for this time period, you should obtain access by following the application procedure at:**
http://mhcc.maryland.gov/mhcc/pages/apcd/apcd_data_release/apcd_data_release_dcdischarge.aspx.

I want to remind all parties that this is a contested case and that the *ex parte* prohibitions in the Administrative Procedure Act, Maryland Code Ann., State Gov't §10-219, apply to this proceeding until the Commission issues a final decision.

Sincerely,

Craig Tanio, M.D.
Commissioner/Reviewer

cc: M. Natalie McSherry, Esquire
Christopher C. Jeffries, Esquire
Louis P. Malick, Esquire
John T. Brennan, Esquire
Stephanie Willis, Esquire
Donna Kinzer, Executive Director, HSCRC
Neil M. Meltzer, President & CEO

Jinlene Chan, M.D., MPH
Leana S. Wen, M.D., Baltimore City Health Commissioner
Gregory Wm. Branch, M.D., Baltimore County Health Officer
Leland Spencer, M.D., Caroline and Kent County Health Officer
Edwin F. Singer, L.E.H.S., Carroll County Health Officer
Stephanie Garrity, M.S., Cecil County Health Officer
Susan C. Kelly, R.S., Harford County Health Officer
Maura J. Rossman, M.D., Howard County Health Officer
Joseph A. Ciotola, M.D., Queen Anne's County Health Officer
Fredia Wadley, M.D., Talbot County Health Officer
Steven R. Schuh, Executive, Anne Arundel County
Paul Parker
Kevin McDonald
Suellen Wideman, AAG

EXHIBIT 4

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October 17, 2016

VIA HAND DELIVERY

Ms. Ruby Potter
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Anne Arundel Medical Center
Docket No. 15-02-2360

Dear Commissioner Tanio:

Enclosed please find Anne Arundel Medical Center's Response to the October 5, 2016 memorandum of Commissioner Tanio.

Sincerely,

Jonathan Montgomery

Enclosures

cc: M. Natalie McSherry, Esquire (via email)
Christopher C. Jeffries, Esquire (via email)
Louis P. Malick, Esquire (via email)
John T. Brennan, Esquire (via email)
Joel I. Suldan, Esquire (via email)
Jinlene Chan, M.D., MPH (via email)
Steve R. Schuh, Executive, Anne Arundel County (via email)
Mr. Paul Parker (via email)
Mr. Kevin McDonald (via email)
Suellen Wideman, AAG (via email)
AAMC Internal Distribution (via email)

IN THE MATTER OF	*	
ANNE ARUNDEL MEDICAL CENTER	*	
Docket No. 15-02-2360	*	
* * * * * * *		BEFORE THE
IN THE MATTER OF UNIVERSITY	*	MARYLAND HEALTH CARE
OF MARYLAND BALTIMORE	*	COMMISSION
WASHINGTON MEDICAL CENTER	*	
Docket No. 15-02-2361	*	

* * * * * * * * * * * *

ANNE ARUNDEL MEDICAL CENTER
REVISED TABLES & RESPONSE TO
BALTIMORE WASHINGTON MEDICAL CENTER OBJECTION

Anne Arundel Medical Center, Inc. ("**AAMC**"), by its undersigned counsel, hereby responds to the October 5, 2016 request of Commissioner Tanio (the "**Tanio Memo**") in regard to the input by the Health Services Cost Review Commission ("**HSCRC**"), namely, the HSCRC's August 24 memorandum to Commissioner Tanio (the "**HSCRC Memo**") in this Baltimore Upper Shore Cardiac Surgery Review (the "**Review**"). AAMC also hereby responds to the October 11, 2016 memorandum of Baltimore Washington Medical Center "(**BWMC**") objecting to the Tanio Memo.

I. Statements Regarding Revenue Requests

Enclosed please find statements pursuant to Questions 1 and 2 of the Tanio Memo. These statements are offered by Daniel B. Smith, Chief Financial Officer of Johns Hopkins Hospital, and Robert Reilly, Chief Financial Officer of Anne Arundel Medical Center. Both statements use the exact wording requested in the Tanio Memo.

II. The Revised Tables

Enclosed please find revised versions of AAMC financial schedules, namely revised Table G through Table K of AAMC's application (the "**Revised Tables**"), as requested by Commissioner Tanio.

Context helps in understanding the Revised Tables. AAMC, like other Maryland hospitals, operates under a global budget revenue system whereby the HSCRC sets the amount of revenue the hospital is allowed to earn annually, i.e. the aggregate revenue generated by each of AAMC's service lines. The HSCRC may adjust this budget in connection with particular service lines – for example, the HSCRC's market shift adjustment policy would permit AAMC's global budget revenue to increase by "50% of the cardiac surgery revenue" AAMC would generate.[1] The HSCRC may also adjust this budget on a global (non-service line) basis, for example through "the population adjustment, capacity from reduced avoidable utilization"[2] and the HSCRC's annual update to each hospital's budget to reflect inflation and the like. In that regard, the HSCRC Memo indicates that the HSCRC would also allow "reallocation of overhead already funded"[3] by AAMC's budget to AAMC's proposed cardiac surgery program "to cover the difference between marginal cost and fully allocated that includes existing overhead".[4]

AAMC's original financial projections for the cardiac surgery program combined both of the these revenue sources without distinguishing one from another, namely (1) revenue generated directly by the proposed cardiac surgery program, and (2) revenue allocated to the cardiac surgery program through use of "resources provided in the system" such as the demographic

[1] HSCRC Memo at p. 1.

[2] HSCRC Memo at p. 1.

[3] HSCRC Memo at p. 1

[4] HSCRC Memo at p. 2.

adjustment, as noted in the HSCRC Memo. In fact, in its July 27, 2015 comment on BWMC's application, AAMC acknowledged "the new 50% variable cost factor for market shift adjustments"[5], but noted that the HSCRC would permit AAMC to allocate to the program revenue through the other resources provided in the system for new projects, such as "the annual update process for individual hospital budgets."[6] AAMC acknowledges that its original financial presentation did not clearly distinguish between these two sources of program revenue, but the Revised Tables do just that.

Therefore, the Revised Tables now clearly distinguish between revenue allocated to the project pursuant to (1) the HSCRC's market shift policy, and (2) allocation of general budget increases received by AAMC. In other words, the Revised Tables do not add or subtract any revenue. The Revised Tables simply split out the previously described revenue into these two categories, as described in the HSCRC Memo and as requested by Commissioner Tanio. The Revised Tables now also reflect that this allocation of these general budget increases would not increase AAMC's entire facility revenue.

Just as the tables included in AAMC's original application, the Revised Tables continue to demonstrate that AAMC can build a financially feasible cardiac surgery program, a program which will deliver substantial savings to cardiac surgery patients and the health care system as a whole.

III. BWMC Objections

Commissioner Tanio should reject the objections to the Revised Tables presented in BWMC's memo for the following reasons.

---

[5] AAMC July 27, 2015 Comment on BWMC Application at p.15, n. 42.

[6] AAMC July 27, 2015 Comment on BWMC Application at p.15, n. 42.

First, the Revised Tables do not present material changes to the financial projections presented in AAMC's original application. The "bottom line" numbers of the cardiac surgery program have not changed. Rather, the Revised Tables simply clarify the portion of AAMC's projected revenue derived from the market shift policy as opposed to other allocations of revenue to the program permitted by the HSCRC. Moreover, early in this process, AAMC acknowledged "the new 50% variable cost factor for market shift adjustments"[7] for cardiac program revenue while at the same time noting that the HSCRC has the flexibility to provide targeted funding to AAMC's cardiac surgery program through the general update process for individual hospital budgets.[8] This is the same two-track revenue allocation process described in the HSCRC Memo. Therefore, the Revised Tables are not an "improper modification" of AAMC's application. Nor has AAMC "failed to document financial feasibility" as claimed by BWMC. Rather, the HSCRC has concluded that AAMC's cardiac surgery program would be financially feasible given the sources of revenue available for AAMC to allocate to the project[9], and the Revised Tables now reflect the financial projection methodology articulated in the HSCRC Memo.

Second, even if the Revised Tables did constitute a modification to AAMC's application (which they do not), such modifications are entirely permissible pursuant to a project status conference, which may be held at any time to identify "aspects of a proposed project that appear to be inconsistent with applicable standards and review criteria" and request "additional filings" in response[10], as acknowledged by BWMC.[11]

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[7] AAMC July 27, 2015 Comment on BWMC Application at p.15, n. 42.

[8] AAMC August 25, 2015 Response to Interested Party Comments

[9] HSCRC Memo at pp. 2-3.

[10] COMAR 10.24.01.09(A)(2); *see also* COMAR 10.24.01.08(E)(2).

[11] BWMC memorandum at p. 2 (citing COMAR 10.24.01.08(E)(2)).

In that regard, the certificate of need regulations do not specify the form in which a project status conference may be held. Arguably, the Tanio Memo constitutes a project status conference. This Review has been conducted by written filings exclusively to this point, without resort to hearings or oral argument. AAMC perceives no reason why this pattern should not continue or how an oral presentation of the Tanio Memo would help this Review. If Commissioner Tanio chooses to deem the Tanio Memo a project status conference, AAMC would not object to BWMC having the requisite seven days to respond. Otherwise, AAMC would be happy to submit the Revised Tables pursuant to a live project status conference if that is preferred.

BWMC's argument that a project status conference would be futile is absurd. The project status conference process exists precisely to give the Commission the benefit of each applicant's best case for obtaining a certificate of need. Here, the proposed creation of a new cardiac surgery program in the State of Maryland implicates important issues of public health and health care delivery, especially for the people of Anne Arundel County in need of these services. Although the Commission must certainly observe the procedural rules of the certificate of need process, this Review should be decided on substance, not BWMC's "gotcha" argument.

Moreover, the entire point of the project status conference process is to give applicants a chance to respond to concerns raised by the **reviewer or staff** about a project's consistency with review standards, not concerns raised in "written comments"[12] by other applicants (contra BWMC).[13] Further, as discussed above, the Revised Tables confirm that AAMC's proposed

[12] BWMC memorandum at p. 2.

[13] For example, in the Prince George's Regional Medical Center review, interested parties commented that the proposed replacement hospital project was too large, too costly, and too indifferent to the need for investment in Prince George's County's ambulatory care system. However, it was not until Commissioner Moffitt held a project review conference in May 2016 that the applicants modified the proposed project to address these concerns.

cardiac surgery program would be financially feasible.[14] This nullifies the key premise of BWMC's futility argument, namely that no revised financial projection of AAMC could demonstrate feasibility under the HSCRC's market shift policy.

IV. Conclusion

For all the foregoing reasons, AAMC is pleased to provide its and Johns Hopkins' commitments (enclosed) and the Revised Tables (enclosed), and requests that the Commission accept these submissions while rejecting BWMC's objections thereto.

Respectfully submitted,

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Attorneys for Anne Arundel Medical Center

Date: October 17, 2016

[14] Indeed, whether or how much either applicant's global budget increases in connection with a proposed new hospital service line does not determine the financial feasibility of that service line, only the revenue of the hospital as a whole. That is, the GBR system does not prevent the new service line from earning revenue and thus being viable as a service line. Rather, the GBR system requires the hospital decrease its charges for **all** service lines to remain within the global budget cap while absorbing the additional revenue associated with the new service line.

Revised Tables

TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table G should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table F and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	FY 2013	FY 2014	FY 2015	FY 2017	FY 2018	FY 2019				
1. REVENUE										
a. Inpatient Services	$ 294,098,900	$ 292,960,600	$ 297,654,040	$ 302,181,942	$ 303,973,116	$ 304,885,277				
b. Outpatient Services	$ 239,409,200	$ 253,443,600	$ 254,587,463	$ 253,953,060	$ 253,956,509	$ 253,960,054				
Gross Patient Service Revenues	***$ 533,508,100***	***$ 546,404,200***	***$ 552,241,503***	***$ 556,135,002***	***$ 557,929,625***	***$ 558,845,331***	***$ -***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ 19,750,800	$ 22,623,500	$ 26,145,184	$ 26,303,664	$ 26,366,353	$ 26,398,282				
d. Contractual Allowance	$ 53,366,400	$ 60,024,200	$ 55,603,875	$ 56,115,030	$ 56,317,572	$ 56,420,930				
e. Charity Care	$ 8,912,500	$ 5,721,800	$ 2,774,084	$ 2,796,724	$ 2,805,680	$ 2,810,240				
Net Patient Services Revenue	***$ 451,478,400***	***$ 458,034,700***	***$ 467,718,360***	***$ 470,919,584***	***$ 472,440,020***	***$ 473,215,880***	***$ -***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues	$ 26,036,200	$ 25,995,000	$ 30,197,196	$ 30,157,196	$ 30,157,196	$ 30,157,196				
NET OPERATING REVENUE	***$ 477,514,600***	***$ 484,029,700***	***$ 497,915,556***	***$ 501,076,780***	***$ 502,597,216***	***$ 503,373,076***	***$ -***	***$ -***	***$ -***	***$ -***
2. EXPENSES										
a. Salaries & Wages (including benefits)	$ 222,592,080	$ 221,047,100	$ 228,259,601	$ 235,991,612	$ 237,393,158	$ 239,600,264				
b. Contractual Services	$ 2,851,345	$ 716,000	$ 245,942	$ 248,167	$ 248,664	$ 249,623				
c. Interest on Current Debt	$ 15,972,794	$ 15,182,000	$ 14,096,925	$ 13,555,176	$ 13,301,038	$ 13,041,376				
d. Interest on Project Debt										
e. Current Depreciation	$27,952,182	$29,211,500	$29,396,532	$ 29,452,079	$ 28,642,928	$ 28,502,319				
f. Project Depreciation				$ 315,319	$ 315,319	$ 315,319				
g. Current Amortization	$ 418,365	$ 392,500	$ 390,407	$ 307,008	$ 307,008	$ 307,008				
h. Project Amortization										
i. Supplies	$ 115,094,050	$ 117,119,100	$ 115,931,587	$ 107,621,203	$ 105,810,629	$ 102,989,400				
j. Other Expenses (Specify/add rows if needed)	$ 91,519,202	$ 88,249,400	$ 89,396,313	$ 84,703,874	$ 82,984,745	$ 80,555,423				
TOTAL OPERATING EXPENSES	***$ 476,400,018***	***$ 471,917,600***	***$ 477,717,307***	***$ 472,194,438***	***$ 469,003,487***	***$ 465,560,733***	***$ -***	***$ -***	***$ -***	***$ -***
3. INCOME										
a. Income From Operation	**$ 1,114,582**	**$ 12,112,100**	**$ 20,198,249**	**$ 28,882,341**	**$ 33,593,728**	**$ 37,812,343**	**$ -**	**$ -**	**$ -**	**$ -**
b. Non-Operating Income	$ 44,226,600	$ 27,091,100	$ (31,684,793)	$ 16,919,694	$ 20,690,944	$ 24,933,376				
SUBTOTAL	***$ 45,341,182***	***$ 39,203,200***	***$ (11,486,543)***	***$ 45,802,036***	***$ 54,284,672***	***$ 62,745,719***	***$ -***	***$ -***	***$ -***	***$ -***
c. Income Taxes										
NET INCOME (LOSS)	***$ 45,341,182***	***$ 39,203,200***	***$ (11,486,543)***	***$ 45,802,036***	***$ 54,284,672***	***$ 62,745,719***	***$ -***	***$ -***	***$ -***	***$ -***

TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table G should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table F and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	FY 2013	FY 2014	FY 2015	FY 2017	FY 2018	FY 2019				
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare	40.2%	40.3%	39.6%	39.6%	39.6%	39.6%				
2) Medicaid	6.6%	9.3%	10.8%	10.8%	10.8%	10.8%				
3) Blue Cross	21.2%	19.3%	17.9%	17.9%	17.9%	17.9%				
4) Commercial Insurance	21.4%	27.0%	28.1%	28.1%	28.1%	28.1%				
5) Self-pay	3.1%	1.3%	0.9%	0.9%	0.9%	0.9%				
6) Other	7.5%	2.9%	2.7%	2.7%	2.7%	2.7%				
TOTAL	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*
b. Percent of Equivalent Inpatient Days										
1) Medicare	40.2%	40.3%	39.6%	39.6%	39.6%	39.6%				
2) Medicaid	6.6%	9.3%	10.8%	10.8%	10.8%	10.8%				
3) Blue Cross	21.2%	19.3%	17.9%	17.9%	17.9%	17.9%				
4) Commercial Insurance	21.4%	27.0%	28.1%	28.1%	28.1%	28.1%				
5) Self-pay	3.1%	1.3%	0.9%	0.9%	0.9%	0.9%				
6) Other	7.5%	2.9%	2.7%	2.7%	2.7%	2.7%				
TOTAL	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table H should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table F. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2017**	**FY 2018**	**FY 2019**				
1. REVENUE										
a. Inpatient Services	$ 294,098,900	$ 292,960,600	$ 297,654,040	$ 318,341,878	$ 328,648,242	$ 338,282,901				
b. Outpatient Services	$ 239,409,200	$ 253,443,600	$ 254,587,463	$ 266,809,830	$ 273,484,577	$ 280,326,773				
Gross Patient Service Revenues	***$ 533,508,100***	***$ 546,404,200***	***$ 552,241,503***	***$ 585,151,708***	***$ 602,132,819***	***$ 618,609,674***	***$ -***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ 19,750,800	$ 22,623,500	$ 26,145,184	$ 27,635,155	$ 28,397,122	$ 29,146,625				
d. Contractual Allowance	$ 53,366,400	$ 60,024,200	$ 55,603,875	$ 57,727,320	$ 58,792,706	$ 59,784,713				
e. Charity Care	$ 8,912,500	$ 5,721,800	$ 2,774,084	$ 2,938,290	$ 3,021,902	$ 3,103,103				
Net Patient Services Revenue	***$ 451,478,400***	***$ 458,034,700***	***$ 467,718,360***	***$ 496,850,944***	***$ 511,921,089***	***$ 526,575,234***	***$ -***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues (Specify/add rows if needed)	$ 26,036,200	$ 25,995,000	$ 30,197,196	$ 31,203,328	$ 31,711,634	$ 32,230,107				
NET OPERATING REVENUE	***$ 477,514,600***	***$ 484,029,700***	***$ 497,915,556***	***$ 528,054,271***	***$ 543,632,723***	***$ 558,805,340***	***$ -***	***$ -***	***$ -***	***$ -***
2. EXPENSES										
a. Salaries & Wages (including benefits)	$ 222,592,080	$ 221,047,100	$ 228,259,601	$ 248,737,129	$ 256,786,669	$ 265,897,175				
b. Contractual Services	$ 2,851,345	$ 716,000	245,942	253,155	256,198	259,759				
c. Interest on Current Debt	$ 15,972,794	$ 15,182,000	14,096,925	13,555,176	13,301,038	13,041,376				
d. Interest on Project Debt	$ -	$ -								
e. Current Depreciation	$ 27,952,182	$ 29,211,500	29,396,532	29,452,079	28,642,928	28,502,319				
f. Project Depreciation	$ -	$ -		315,319	315,319	315,319				
g. Current Amortization	$ 418,365	$ 392,500	390,407	307,008	307,008	307,008				
h. Project Amortization	$ -	$ -								
i. Supplies	$ 115,094,050	$ 117,119,100	115,931,587	118,510,331	122,853,218	126,853,721				
j. Other Expenses (Specify/add rows if needed)	$ 91,519,202	$ 88,249,400	89,396,313	92,087,575	94,325,880	96,044,317				
TOTAL OPERATING EXPENSES	***$ 476,400,018***	***$ 471,917,600***	***$ 477,717,307***	***$ 503,217,771***	***$ 516,788,258***	***$ 531,220,993***	***$ -***	***$ -***	***$ -***	***$ -***
3. INCOME										
a. Income From Operation	***$ 1,114,582***	***$ 12,112,100***	***$ 20,198,249***	***$ 24,836,500***	***$ 26,844,465***	***$ 27,584,347***	***$ -***	***$ -***	***$ -***	***$ -***
b. Non-Operating Income	$ 44,226,600	$ 27,091,100	$ (31,684,793)	$ 16,716,597	$ 20,162,033	$ 23,870,184				
SUBTOTAL	***$ 45,341,182***	***$ 39,203,200***	***$ (11,486,543)***	***$ 41,553,097***	***$ 47,006,498***	***$ 51,454,531***	***$ -***	***$ -***	***$ -***	***$ -***
c. Income Taxes										
NET INCOME (LOSS)	***$ 45,341,182***	***$ 39,203,200***	***$ (11,486,543)***	***$ 41,553,097***	***$ 47,006,498***	***$ 51,454,531***	***$ -***	***$ -***	***$ -***	***$ -***

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table H should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table F. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2017**	**FY 2018**	**FY 2019**				
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare	40.2%	40.3%	39.6%	39.6%	39.6%	39.6%				
2) Medicaid	6.6%	9.3%	10.8%	10.8%	10.8%	10.8%				
3) Blue Cross	21.2%	19.3%	17.9%	17.9%	17.9%	17.9%				
4) Commercial Insurance	21.4%	27.0%	28.1%	28.1%	28.1%	28.1%				
5) Self-pay	3.1%	1.3%	0.9%	0.9%	0.9%	0.9%				
6) Other	7.5%	2.9%	2.7%	2.7%	2.7%	2.7%				
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days										
Total MSGA										
1) Medicare	40.2%	40.3%	39.6%	39.6%	39.6%	39.6%				
2) Medicaid	6.6%	9.3%	10.8%	10.8%	10.8%	10.8%				
3) Blue Cross	21.2%	19.3%	17.9%	17.9%	17.9%	17.9%				
4) Commercial Insurance	21.4%	27.0%	28.1%	28.1%	28.1%	28.1%				
5) Self-pay	3.1%	1.3%	0.9%	0.9%	0.9%	0.9%				
6) Other	7.5%	2.9%	2.7%	2.7%	2.7%	2.7%				
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***

TABLE J. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table J should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table I and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**				
1. REVENUE							
a. Inpatient Services	$ 3,893,208	$ 5,687,956	$ 6,603,444				
b. Reallocated revenues - See Note 1	$ 2,725,245	$ 3,981,569	$ 4,622,411				
Gross Patient Service Revenues	***$ 6,618,453***	***$ 9,669,525***	***$ 11,225,855***	***$ -***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ 269,393	$ 375,975	$ 430,236				
d. Contractual Allowance	$ 869,754	$ 1,213,863	$ 1,389,047				
e. Charity Care	$ 38,485	$ 53,711	$ 61,462				
Net Patient Services Revenue	***$ 5,440,821***	***$ 8,025,977***	***$ 9,345,110***	***$ -***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues							
NET OPERATING REVENUE	***$ 5,440,821***	***$ 8,025,977***	***$ 9,345,110***	***$ -***	***$ -***	***$ -***	***$ -***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ 3,042,302	$ 3,397,763	$ 3,582,372				
b. Contractual Services							
c. Interest on Current Debt							
d. Interest on Project Debt							
e. Current Depreciation							
f. Project Depreciation	$ 315,319	$ 315,319	$ 315,319				
g. Current Amortization							
h. Project Amortization							
i. Supplies	$ 1,687,904	$ 2,466,749	$ 2,873,906				
j. Other Expenses (Specify)	$ 1,899,518	$ 1,830,391	$ 1,702,183				
TOTAL OPERATING EXPENSES	***$ 6,945,043***	***$ 8,010,222***	***$ 8,473,780***	***$ -***	***$ -***	***$ -***	***$ -***
3. INCOME							
a. Income From Operation	**$ (1,504,221)**	**$ 15,755**	**$ 871,330**	**$ -**	**$ -**	**$ -**	**$ -**
b. Non-Operating Income							
SUBTOTAL	***$ (1,504,221)***	***$ 15,755***	***$ 871,330***	***$ -***	***$ -***	***$ -***	***$ -***

TABLE J. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table J should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table I and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**				
c. Income Taxes							
NET INCOME (LOSS)	***$ (1,504,221)***	***$ 15,755***	***$ 871,330***	***$ -***	***$ -***	***$ -***	***$ -***

TABLE J. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table J should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table I and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**				
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare	50.2%	51.9%	52.9%				
2) Medicaid	6.8%	6.8%	6.8%				
3) Blue Cross	9.3%	9.3%	9.3%				
4) Commercial Insurance	30.6%	28.9%	27.9%				
5) Self-pay	2.5%	2.5%	2.5%				
6) Other	0.6%	0.6%	0.6%				
TOTAL	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days							
Total MSGA							
1) Medicare	50.2%	51.9%	52.9%				
2) Medicaid	7.3%	7.3%	7.3%				
3) Blue Cross	9.0%	9.0%	9.0%				
4) Commercial Insurance	30.0%	28.4%	27.4%				
5) Self-pay	2.9%	2.9%	2.9%				
6) Other	0.6%	0.6%	0.6%				
TOTAL	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***

Note 1: Per the HSCRC, revenue can be reallocated from other revenue sources (HSCRC Memorandum of 8/24/16 to MHCC)

TABLE K. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table K should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table I. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**				
1. REVENUE							
a. Inpatient Services	$ 4,087,868	$ 6,114,553	$ 7,263,789				
b. Reallocated revenues - See Note 1	$ 2,861,508	$ 4,280,187	$ 5,084,652				
Gross Patient Service Revenues	***$ 6,949,375***	***$ 10,394,740***	***$ 12,348,441***	***$ -***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ 282,863	$ 404,173	$ 473,260				
d. Contractual Allowance	$ 913,241	$ 1,304,902	$ 1,527,952				
e. Charity Care	$ 40,409	$ 57,739	$ 67,608				
Net Patient Services Revenue	***$ 5,712,862***	***$ 8,627,925***	***$ 10,279,621***	***$ -***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues (Specify/add rows of needed)							
NET OPERATING REVENUE	***$ 5,712,862***	***$ 8,627,925***	***$ 10,279,621***	***$ -***	***$ -***	***$ -***	***$ -***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ 3,163,994	$ 3,601,628	$ 3,868,962				
b. Contractual Services							
c. Interest on Current Debt							
d. Interest on Project Debt							
e. Current Depreciation							
f. Project Depreciation	$ 315,319	$ 315,319	$ 315,319				
g. Current Amortization							
h. Project Amortization							
i. Supplies	$ 1,228,148	$ 2,095,246	$ 2,585,649				
j. Other Expenses (Specify/add rows of needed)	$ 2,442,273	$ 2,372,968	$ 2,251,816				
TOTAL OPERATING EXPENSES	***$ 7,149,734***	***$ 8,385,161***	***$ 9,021,745***	***$ -***	***$ -***	***$ -***	***$ -***
3. INCOME							
a. Income From Operation	**$ (1,436,872)**	**$ 242,764**	**$ 1,257,876**	**$ -**	**$ -**	**$ -**	**$ -**
b. Non-Operating Income							
SUBTOTAL	***$ (1,436,872)***	***$ 242,764***	***$ 1,257,876***	***$ -***	***$ -***	***$ -***	***$ -***
c. Income Taxes							

TABLE K. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table K should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table I. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	FY 2017	FY 2018	FY 2019				
NET INCOME (LOSS)	*$ (1,436,872)*	*$ 242,764*	*$ 1,257,876*	*$ -*	*$ -*	*$ -*	*$ -*

TABLE K. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table K should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table I. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**				
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare	50.2%	51.9%	52.9%				
2) Medicaid	6.8%	6.8%	6.8%				
3) Blue Cross	9.3%	9.3%	9.3%				
4) Commercial Insurance	30.6%	28.9%	27.9%				
5) Self-pay	2.5%	2.5%	2.5%				
6) Other	0.6%	0.6%	0.6%				
TOTAL	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days							
1) Medicare	50.2%	51.9%	52.9%				
2) Medicaid	7.3%	7.3%	7.3%				
3) Blue Cross	9.0%	9.0%	9.0%				
4) Commercial Insurance	30.0%	28.4%	27.4%				
5) Self-pay	2.9%	2.9%	2.9%				
6) Other	0.6%	0.6%	0.6%				
TOTAL	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***

Note 1: Per the HSCRC, revenue can be reallocated from other revenue sources (HSCRC Memorandum of 8/24/16 to MHCC)

Johns Hopkins Hospital

Statement

#572814

Daniel B. Smith
Senior Vice President of Finance
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443-997-1312
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JOHNS HOPKINS
MEDICINE
JOHNS HOPKINS
HEALTH SYSTEM

Craig P. Tanio, M.D.
Chair, Maryland Health Care Commission
Reviewer, Baltimore Upper Shore Cardiac Surgery Review
4160 Patterson Avenue
Baltimore, MD 21215

October 14, 2016

Re: Baltimore Upper Shore Cardiac Surgery Review

Dear Dr. Tanio:

This letter is in response to correspondence to the applicants in the above-referenced matter, dated October 5, 2016. Question 2 is specifically addressed to The Johns Hopkins Hospital ("JHH") as the "collaborating hospital" in the Anne Arundel Medical Center application.

In response to Question 2, JHH commits that, if the Anne Arundel Medical Center is issued a CON to establish a new cardiac surgery program, JHH will not approach the HSCRC in the future to request an increase in global budgeted revenue that has as any part of its basis, the lost revenue generated by cardiac surgery services that have shifted to Anne Arundel Medical Center, our partner applicant hospital.

Please let us know if there is any additional information we can provide that would be helpful to your review.

Sincerely,

Daniel B. Smith

Anne Arundel Medical Center

Statement

#572814

Anne Arundel Medical Center

2001 Medical Parkway
Annapolis, Md. 21401
443-481-1000
TDD: 443-481-1235
askAAMC.org

October 17, 2016

VIA EMAIL & FEDERAL EXPRESS

Craig Tanio, M.D.
Chair/Reviewer
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Commissioner Tanio,

AAMC commits that, if AAMC is issued a CON to establish a new cardiac surgery program, it will not approach the HSCRC in the future to request an increase in global budgeted revenue that has, as any part of its basis, the objective of obtaining additional revenue from the provision of cardiac surgery services.

That is, per the HSCRC's memo, AAMC will not "seek a rate increase in a separate action" outside this certificate of need process, nor will it "approach the HSCRC to request an increase in [its] allowed GBR revenue if the GBR methodology does not provide sufficient revenue."

AAMC understands that this commitment does not prevent it from (per the HSCRC's Memo): (a) receiving global budget revenue increases for cardiac surgery "consistent with the HSCRC market shift policy" yielding an effective 50% variable cost factor for incremental cardiac surgery volume for both volume shifts among Maryland hospitals as well as in-migration of Maryland residents previously treated in the District of Columbia; (b) allocating to the cardiac surgery program "increases in revenue under the new payment model using the resources that are provided in the system"; or (c) similarly allocating revenue to the cardiac surgery program in connection with future revisions to the HSCRC's GBR policy or rate methodologies.

Sincerely,

Bob Reilly
Chief Financial Officer

Attestation

ANNE ARUNDEL MEDICAL CENTER

CARDIAC SURGERY PROGRAM CERTIFICATE OF NEED APPLICATION

RESPONSE TO TANIO MEMORANDUM

Attestation by Robert Reilly

Affirmation: I solemnly affirm under the penalties of perjury that the contents of this response are true to the best of my knowledge, information and belief.

October 17, 2016
Date

Signature

CFO, Anne Arundel Medical Center
Position/Title

EXHIBIT 5

Table 1
Calculation of Revenue Variability
AAMC February 20, 2015 Appl. to
AAMC November 7, 2016 Modification

		AAMC CON	AAMC Modification
FY2017 Cardiac Cases		241	241
FY2018 Cardiac Cases		337	337
Volume Growth	A	96	96
FY2017 Inpatient Charges		$ 6,618,453	$ 3,893,208
FY2018 Inpatient Charges		9,669,525	5,687,956
Charge Growth	B	$ 3,051,072	$ 1,794,748
AAMC Assumed Charge per Case (p. 62)		$ 37,501	$ 37,501
Incremental Cases (FY2018)	A	96	96
Revenue Growth at 100%	C	$ 3,600,096	$ 3,600,096
Revenue Variability Assumed	D = B/C	84.7%	49.9%
FY2018 Cardiac Cases		337	337
FY2019 Cardiac Cases		387	387
Volume Growth	E	50	50
FY2018 Inpatient Charges		$ 9,669,525	$ 5,687,956
FY2019 Inpatient Charges		11,225,855	6,603,444
Charge Growth	F	$ 1,556,330	$ 915,488
AAMC Assumed Charge per Case (p. 62)		$ 37,501	$ 37,501
Incremental Cases (FY2019)	E	50	50
Revenue Growth at 100%	G	$ 1,875,050	$ 1,875,050
Revenue Variability Assumed	H = F/G	83.0%	48.8%

EXHIBIT 6

ANNE ARUNDEL MEDICAL CENTER

CERTIFICATE OF NEED APPLICATION

Anne Arundel Medical Center Mental Health Hospital

AUGUST 1, 2016 PROJECT COST AND SHELL SPACE UPDATES

Anne Arundel Medical Center

#574453

Tab 1 – Summary of Mental Health Hospital CON Application Cost Updates

Tab 2 – Updated Application Pages (Changes Marked)

Tab 3 – Updated Application Pages (Clean)

Tab 4 – Affirmations

Tab 5 – Updated Exhibit 6 (Project Drawings)

Tab 6 – Updated Appendix 1 (CON Tables B-E, J, K)

Summary of Mental Health Hospital CON Application Cost Updates

The following updates have been made that impact the Total Capital Cost of the project:

- Continued refinement of the Concept of Operations based upon best practices which decreased the BGSF (building gross square feet)
- Application of "lean" principles to the design
- Anne Arundel County relocated the adjacent well project allowing for repositioning of the building to better utilize the natural grades
- Incorporated inflation using the MHCC document for Determining the Threshold for Required Approval of Changes in Certificate of Need Approved Capital Cost updated 5/12/2016.

The project operational and design program has been refined by continuing to apply best practices and "lean" principles based on further development and elaboration of the Concept of Operations by the clinical team with the design team members. [1] The adjacent county well project was relocated by the county to avoid interfering with the new facility and as a result, the lower level of the building was reconfigured along with site access from Harry Truman Parkway. A constructability analysis was performed by a construction management company in conjunction with the civil engineer.

TABLE B: DEPARTMENTAL GROSS SQUARE FEET AFFECTED BY PROPOSED PROJECT

Table B was updated to reflect the change in building gross square footage from 66,752 to 56,236.

TABLE C: CONSTRUCTION CHARACTERISTICS

Table C was updated to reflect the changes in construction characteristics.

[1] "Lean" principles incorporate continuous improvement progression focusing on reducing waste throughout the planning, design and construction processes while delivering a facility that is centered on efficient, safe and effective patient care.

TABLE D: ONSITE AND OFFSITE COSTS INCLUDED AND EXCLUDED IN MARSHALL VALUATION COSTS

Table D has been updated to reflect changes in design and construction techniques. Below is a summary of the changes.

	CON APPLICATION SUBMISSION	UPDATE	CHANGE
SITE PREPARATION COSTS			
Normal Site Preparation	$0	$0	$0
Utilities from Structure to Lot Line	$0	$0	$0
Subtotal included in Marshall Valuation Costs	**$0**	**$0**	**$0**
Site Demolition Costs	$40,000	$138,796	$98,796
Storm Drains/Water/Sewer	$150,000	$797,619	$647,619
Rough Grading	$80,000	$739,840	$659,840
Hillside Foundation	$0	$325,751	$325,751
Paving	$50,000	$205,648	$155,648
Exterior Signs	$25,000		-$25,000
Landscaping	$75,000	$123,970	$48,970
Walls	$30,000		-$30,000
Normal Site Preparation	$150,000	$64,612	-$85,388
Utilities from Structure to Lot Line	$121,545		-$121,545
Sediment & Erosion Control	$50,000		-$50,000
Site Work (ramps, curbs, sidewalks, courtyard)	$150,000		-$150,000
Subtotal On-Site excluded from Marshall Valuation Costs	**$936,545**	**$2,396,235**	**$1,474,690**
OFFSITE COSTS			
Roads	$10,000		-$10,000
Utilities	$40,000		-$40,000
Jurisdictional Hook-up Fees	$374,528	$374,528	$0
Other *(Specify/add rows if needed)*			
Subtotal Off-Site excluded from Marshall Valuation Costs	**$424,528**	**$374,528**	**-$50,000**

TOTAL Estimated On-Site and Off-Site Costs not included in Marshall Valuation Costs	**$1,361,073**	**$2,770,763**	**$1,424,690**
TOTAL Site and Off-Site Costs included and excluded from Marshall Valuation Service*	**$1,361,073**	**$2,770,763**	**$1,424,690**

TABLE E. PROJECT BUDGET

Table E has been update to reflect changes in design. Below is a summary of the changes.

		CON APPLICATION SUBMISSION	UPDATE	CHANGE
A. USE OF FUNDS				
1. CAPITAL COSTS				
a.	**Land Purchase**	**$0**	**$0**	**$0**
b.	**New Construction**			
(1)	Building	$12,790,057	$16,080,433	$3,290,376
(2)	Fixed Equipment			$0
(3)	Site and Infrastructure	$1,361,073	$2,770,763	$1,409,690
(4)	Architect/Engineering Fees	$1,373,350	$1,373,350	$0
(5)	Permits (Building, Utilities, Etc.)	$23,757	$23,757	$0
	SUBTOTAL	**$15,548,237**	**$20,248,303**	**$4,700,066**
c.	**Renovations**			
(1)	Building	$0	$0	$0
(2)	Fixed Equipment (not included in construction)	$0	$0	$0
(3)	Architect/Engineering Fees	$0	$0	$0
(4)	Permits (Building, Utilities, Etc.)	$0	$0	$0
	SUBTOTAL	**$0**	**$0**	**$0**
d.	**Other Capital Costs**			
(1)	Movable Equipment	$900,000	$900,000	$900,000
(2)	Contingency Allowance	$550,000	$1,750,000	$1,200,000
(3)	Gross interest during construction period	$0	$0	$0
(4)	Other *(minor equipment)*	$0	$0	$0
	Commissioning / Testing	$0	$375,000	$375,000
	IT / Integration	$0	$700,000	$700,000
	Exterior Courtyard / Hardscaping	$0	$500,000	$500,000
	SUBTOTAL	**$1,450,000**	**$4,225,000**	**$2,775,000**

	TOTAL CURRENT CAPITAL COSTS	**$16,998,237**	**$24,473,303**	**$7,4757066**
e.	**Inflation Allowance**	$0	$511,492	$511,492
	TOTAL CAPITAL COSTS	**$16,998,237**	**$24,984,795**	**$7,986,558**

MARSHAL VALUATION SERVICE ANALYSIS

The building cost estimate was updated based upon revised based civil and architectural plans dated 07.19.16 and modified design narratives for mechanical, plumbing, electrical, telecommunications and security. The project is targeted to achieve LEED Silver certification and the mechanical system includes the costs for a chilled beam system.

1. **MVS Allowable Cost Determination**

Base Cost	
Construction Quality	Good
Construction Class	A
Stories	4
Average Floor to Floor Height	14'-6"
Average Floor Area	14,059 SF
Base Cost per Square Foot	**$ 365.78**

Base Cost Adjustments	
Sprinkler System	$3.30/SF
Floor Area Multiplier	0.985
Story Height Multiplier	1.050
Current Cost Multiplier	1.020
Local Multiplier	1.040
MVS Allowable Cost per Square Foot	**$404.93**

MVS Allowable Construction Cost = $404.93 x 56.236 sf = **$22,771,643**

2. **MVS Differential Cost Analysis**

Dept.	Adjustment Factor	DGSF	Cost
Nursing Unit	1.06	14,593	$ 6,263,686
PHP	0.99	5,568	$ 2,232,102
Dietary	1.52	1,555	$ 957,092

Shell	0.5	17,132	$ 3,468,627
Mechanical	0.7	2,139	$ 606,301
Public	0.8	4,781	$ 1,548,775
Housekeeping	1.31	1,302	$ 690,656
Corridors	0.6	2,564	$ 622,944
Building Grossing Factor	0.5	6,602	$ 1,336,673
Subtotal		56,236	$17,726,855
Deduct Architect Fees (Sec.99 Pg.2)		-7.3%	-$ 1,294,060
Differential Construction Costs			**$ 16,432,795**

Differential Construction Cost per Square Foot **$292.21**

3. **Proposed Construction Cost**

Proposed Construction Cost (Revised Table E. Line A.1.b(1)) = $16,080,433

Proposed Cost per Square Foot = $16,080,433 / 56,236 bgsf = **$285.95**

4. **Cost Comparison**

In comparison, the Proposed Construction cost per square foot for the project of $285.95 is $118.98 below the MVS Allowable Construction cost per square foot of $404.93. See chart below.

	$/SF	Cost	Variance from MVS Allow
MVS Allowable Construction Cost	$ 404.93	$ 22,771,643	
Differential Construction Cost	$ 292.21	$ 16,432,721	- $ 112.72
Proposed Construction Budget	$ 285.95	$ 16,080,433	- $ 118.98

Given that the Proposed Construction Budget is below both the MVS Allowable Construction Cost and the Differential Construction Cost, the Proposed Construction Budget is reasonable.

EXHIBIT 7

ANNE ARUNDEL MEDICAL CENTER

CERTIFICATE OF NEED APPLICATION

Anne Arundel Medical Center Mental Health Hospital

March 29, 2016

(EXCERPT)

Anne Arundel Medical Center

10.24.01.08G(3)(c). Availability of More Cost-Effective Alternatives.

The Commission shall compare the cost effectiveness of the proposed project with the cost effectiveness of providing the service through alternative existing facilities, or through an alternative facility that has submitted a competitive application as part of a comparative review.

INSTRUCTIONS: Please describe the planning process that was used to develop the proposed project. This should include a full explanation of the primary goals or objectives of the project or the problem(s) being addressed by the proposed project. The applicant should identify the alternative approaches to achieving those goals or objectives or solving those problem(s) that were considered during the project planning process, including:

a) the alternative of the services being provided through existing facilities;

b) or through population-health initiatives that would avoid or lessen hospital admissions.

Describe the hospital's population health initiatives and explain how the projections and proposed capacities take these initiatives into account.

For all alternative approaches, provide information on the level of effectiveness in goal or objective achievement or problem resolution that each alternative would be likely to achieve and the costs of each alternative. The cost analysis should go beyond development costs to consider life cycle costs of project alternatives. This narrative should clearly convey the analytical findings and reasoning that supported the project choices made. It should demonstrate why the proposed project provides the most effective method to reach stated goal(s) and objective(s) or the most effective solution to the identified problem(s) for the level of costs required to implement the project, when compared to the effectiveness and costs of alternatives, including the alternative of providing the service through existing facilities, including outpatient facilities or population-based planning activities or resources that may lessen hospital admissions, or through an alternative facility that has submitted a competitive application as part of a comparative review.

Applicant Response:

In accordance with this Standard, there is no more cost effective alternative available to achieve the goals of the project.

As described above, AAMC has recognized the need to develop inpatient psychiatric capacity for several years. Vision 2020 – Living Healthier Together, AAMC's ten-year Strategic Plan, defines AAMC's mission to enhance the health of the people it serves. In 2014, consistent with its overall mission, AAMC developed its Strategic Plan for Behavioral Health to guide it in meeting the mental health and substance use needs in the community. Recognizing that access to quality, patient-centered behavioral healthcare services is key to having a favorable quality of life in the community, AAMC committed in this Strategic Plan to be a leader in promoting access to mental health and substance use healthcare services within a seamless, integrated medical, mental health and substance abuse continuum of care. One of the key elements of this Strategic Plan was the development of inpatient psychiatric services at AAMC, which the plan targets for FY 2017 – 2018.

AAMC's primary goals associated with this project include the following:

1. Eliminate the delays and barriers to timely inpatient psychiatric care that now result from 946 patient transfers to other facilities, almost all outside of Anne Arundel County.

2. Strengthen quality and continuity of mental health care in Anne Arundel County through by establishing a comprehensive and integrated mental health care program that enables coordination with community-based support services.

3. Consistent with AAMC's mission and demonstrated need, seek to ensure that AAMC's inpatient mental health capacity is available to serve all patients regardless of payor source, including Medicaid patients, without delay.

4. Reduce length of stay and admission rates, and leverage community based resources to the fullest extent possible.

As described above, the development of inpatient psychiatric capacity within AAMC's health system is also contemplated within its Master Facilities Plan, which shows two options for locating this program from a facilities standpoint. One potential location is shown within AAMC's acute care hospital in the North Tower, and the other location is shown in a new building to be constructed on the Riva Road property that AAMC leases from the County on a long term basis. Accordingly, with the project goals in mind, over the last nine months, AAMC undertook an extensive analysis of which option would be the best alternative to achieving the goals of the project. The analysis was undertaken by representatives of a wide range of AAMC departments with subject matter expertise including clinical, financial, facilities, operational, planning, and legal. The working group developed a decision matrix to compare and "score" the location options (in the hospital, the campus where Pathways is, as well as a "greenfield" option) against various criteria related to the goals of the project. See Chart 38 (page 81). This analysis strongly supports establishing a freestanding mental health hospital on the Riva Road property as the best alternative. The analysis behind the scoring shown on Chart 38 is described further below.

Chart 38
Scoring Matrix

	Inpatient Psych CON Decision Matrix Key Criteria	Relative Weight	Main Hospital		Riva Road Property		Greenfield	
			Rank	RxW	Rank	RxW	Rank	RxW
Quality	Program Quality	13	3	39	5	65	3	39
	QBR Impact	11	1	11	5	55	5	55
	Risk Management/ Patient Safety	12	1	12	5	60	5	60
Community	Patient Care Access	3	5	15	3	9	1	3
Workforce	Staffing	9	5	45	3	27	1	9
	Staff Satisfaction/Engagement	5	3	15	3	15	3	15
	Support Services	2	5	10	1	2	1	2
Growth	Capacity for Growth	6	1	6	3	18	5	30
	Partnering Opportunities	1	1	1	1	1	5	5
Finance	Cost (Building Cost)	7	5	35	5	35	1	7
	Operating Margin	10	5	50	5	50	3	30
	Life Cycle Costs	8	5	40	5	40	1	8
	Reimbursement (GBR)	4	1	4	3	12	5	20
	TOTAL		283		389		283	

Best outcome = 5
Average outcome, acceptable outcome = 3
Least desirable outcome = 1

AAMC explored the following four options to address the need for additional inpatient psychiatric capacity in Anne Arundel County:

1. **Option 1: Do Nothing**: As described at length in response to the Need standard (COMAR 10.24.01.08G(3)(b)), there is a demonstrated need for additional inpatient psychiatric capacity in AAMC's service area. Doing nothing to add inpatient psychiatric beds to AAMC and continuing to rely on existing facilities to meet this need was considered and rejected because it maintains the unacceptable status quo for the large volume of patients in need of inpatient psychiatric care who arrive at AAMC's ED and who must be transferred long distances to receive care. Accordingly, this option was not scored on the decision matrix (Chart 38).

2. **Option 2: Convert Existing Hospital Space**

An option to convert two existing acute-care patient units (approximately 14,326 SF) in the North Hospital Pavilion into 16 psychiatric beds was explored. The estimated total project cost range is $6.5 million to $8.5 million.

Although this is a possible option, there are several drawbacks. The only potential area that could be renovated for this program in the existing facility is on the sixth floor. Elevated floors are not ideal for a mental health locked unit for involuntary and voluntary admissions. The adjacencies, access for patients' visitors, and security for patients and visitors are inferior to those that could be achieved at a consolidated mental health and substance use campus. The ability to share staff across inpatient and partial hospital programs would be compromised. AAMC may need to add beds or multiple units to meet growing need, and the sixth floor location does not provide that option. Additionally, under GBR, as a new service in the hospital, the HSCRC has indicated that reimbursement would be subject to a 50 percent variable cost factor, which would create a negative operating margin. The operating margin in Year 3 for this option was a loss of $1.28 million or negative 38 percent. As such, the program would not be sustainable over time. This option would also have the undesired effect of increasing costs subject to the Medicare waiver. Accordingly, this option was not the preferred option as compared to option 3 which does not have these drawbacks.

3. **Option 3: Construct New Facility (*Selected option*)**

AAMC selected the option of establishing a freestanding mental health hospital on the Riva Road site over a hospital-based unit. Unlike a hospital-based option, this option enables AAMC to provide a comprehensive and integrated mental health care program at a single location that will incorporate inpatient psychiatric care, partial hospitalization, intensive outpatient programs, family support services, prevention programs, and referral to and care coordination with community-based support services. This option also supports better integration with community-based activities, including family and self-help programs to strengthen patient engagement, and patient advocacy organizations to encourage active involvement in community health.

Locating the unit outside of an acute care hospital enables the design team to prepare a pleasing, site-specific milieu while meeting the array of applicable codes and regulations as well as the therapeutic and safety needs for patients and staff. AAMC determined that this location strikes the right "balance between the safest possible healing environment and a non-institutional appearance that is correct for the unique conditions that exist in each and every facility."[23]

The land is currently leased from Anne Arundel County on a long-term basis and the lease allows for construction of a freestanding psychiatric hospital on the property with approval from the county.

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23 Hunt, James M and David M. Sine "Design Guide for the Build Environment of Behavioral Health Facilities," Edition 7.0, May 2015.

4. **Option 4: Redevelop Existing Site**

An option to build a psychiatric hospital on purchased property that would require demolition of an existing building was also explored. An advantage to the site would be that the health system would own the property as opposed to the long-term land lease with Anne Arundel County for the Riva Road property. The land acquisition, demolition and unforeseeable site conditions makes this a less favorable option. Additionally, there is substantial ongoing cost to support another satellite for the health system for couriers, materials management, technology infrastructure, personnel, etc.

A review of potential sites and conceptual estimates for this project indicate that the total capital investment would be in excess of $21.0 million. This option is not only more expensive to build, but also does not provide the numerous benefits afforded by co-locating multiple mental health and substance use services on a single site identified earlier.

As required by this Standard, AAMC also considered population health initiatives to avoid or lessen hospital admissions. AAMCs overall plan for mental health includes multiple population health initiatives (refer to page 14) and treatment collaborations to decrease the need for inpatient psychiatric care. Nevertheless, the need for additional inpatient psychiatric capacity persists.

Two programs in operation or in development will serve to facilitate earlier case detection and earlier outpatient intervention, with the ultimate impact of lessening avoidable inpatient utilization. These include use of a brief mental health and substance use questionnaire in AAMC's network of primary care clinics, and the use of a clinical navigator to field referrals for mental health intervention to a network of cooperating treatment providers. This program began in 2015 and has achieved 509 referrals as of January 31, 2016. This program will be developed further in the coming year with addition of a pilot project of primary care integration, and psychiatric consultation provided to primary care physicians managing psychotropic medications in primary care, with planned expansion to an increasing network of primary care practices in subsequent years.

AAMC will establish a psychiatric partial hospitalization program in FY 2016. It is projected that 15 to 20 percent of current ED visits historically resulting in an inpatient admission of either an adolescent or an adult will be averted through admission to psychiatric partial hospitalization, either from the ED or before presenting there at all. AAMC has taken this reduction into account in the analysis of expected ongoing need for inpatient admission from the ED. The additional impacts of psychiatric partial hospitalization on inpatient utilization are expected to be on length of stay and rates of readmission. AAMC's need analysis is based on an inpatient length of stay equal to that of Maryland acute care hospitals with inpatient psychiatric beds that also have psychiatric partial hospitalization available at their facilities as a step-down from inpatient care. The impact on readmission rates is difficult to quantify from current data, but is expected to be positive although marginal.

Crisis residential services are currently available in Anne Arundel County through Harbor House, which maintains beds in Glen Burnie and Edgewater. Diversion of avoidable

inpatient utilization through use of this service by Anne Arundel Crisis Response and mental health clinicians in the AAMC ED is already evident to some extent, and will be increased as it is employed in concert with partial hospitalization at AAMC starting this year.

In 2016, AAMC will focus on the target population by engaging behavioral health resources, skilled nursing facilities (SNFs), public and private sector care coordinators, and physicians to create a better-integrated and aligned community of practice, consistent with AAMC's Vision 2020 – Living Healthier Together. Collaborating with non-traditional partners in order to achieve its population health improvement goals, AAMC has engaged with UM BWMC in a Regional Partnership: the Bay Area Transformation Partnership (BATP). BATP addresses the community's behavioral health needs as well as social and medical needs. New collaborations will be formed and existing relationships will be expanded with community-based behavioral health resources and private and public sector providers of care management in order to improve outcomes for AAMC's target population.

Accordingly, establishing freestanding mental health hospital on the Riva Road property is the most cost-effective alternative to achieving the goals of the project. AAMC has taken into account the impact of population health initiatives that it will undertake to lessen admissions and length of stay in its need analysis demonstrating the need for 16 beds.

EXHIBIT 8

TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY (REVISED)

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table G should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table F and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	FY 2013	FY 2014	FY 2015	FY 2017	FY 2018	FY 2019				
1. REVENUE										
a. Inpatient Services - See Note 1	$ 294,098,900	$ 292,960,600	$ 297,654,040	$ 302,181,942	$ 303,973,116	$ 304,885,277				
b. Outpatient Services	$ 239,409,200	$ 253,443,600	$ 254,587,463	$ 253,953,060	$ 253,956,509	$ 253,960,054				
Gross Patient Service Revenues	***$ 533,508,100***	***$ 546,404,200***	***$ 552,241,503***	***$ 556,135,002***	***$ 557,929,625***	***$ 558,845,331***	$ -	$ -	$ -	$ -
c. Allowance For Bad Debt	$ 19,750,800	$ 22,623,500	$ 26,145,184	$ 26,303,664	$ 26,366,353	$ 26,398,282				
d. Contractual Allowance	$ 53,366,400	$ 60,024,200	$ 55,603,875	$ 56,115,030	$ 56,317,572	$ 56,420,930				
e. Charity Care	$ 8,912,500	$ 5,721,800	$ 2,774,084	$ 2,796,724	$ 2,805,680	$ 2,810,240				
Net Patient Services Revenue	***$ 451,478,400***	***$ 458,034,700***	***$ 467,718,360***	***$ 470,919,584***	***$ 472,440,020***	***$ 473,215,880***	$ -	$ -	$ -	$ -
f. Other Operating Revenues	$ 26,036,200	$ 25,995,000	$ 30,197,196	$ 30,157,196	$ 30,157,196	$ 30,157,196				
NET OPERATING REVENUE	***$ 477,514,600***	***$ 484,029,700***	***$ 497,915,556***	***$ 501,076,780***	***$ 502,597,216***	***$ 503,373,076***	$ -	$ -	$ -	$ -
2. EXPENSES										
a. Salaries & Wages (including benefits)	$ 222,592,080	$ 221,047,100	$ 228,259,601	$ 235,991,612	$ 237,393,158	$ 239,600,264				
b. Contractual Services	$ 2,851,345	$ 716,000	$ 245,942	$ 248,167	$ 248,664	$ 249,623				
c. Interest on Current Debt	$ 15,972,794	$ 15,182,000	$ 14,096,925	$ 13,555,176	$ 13,301,038	$ 13,041,376				
d. Interest on Project Debt										
e. Current Depreciation	$27,952,182	$29,211,500	$29,396,532	$ 29,452,079	$ 28,642,928	$ 28,502,319				
f. Project Depreciation				$ 315,319	$ 315,319	$ 315,319				
g. Current Amortization	$ 418,365	$ 392,500	$ 390,407	$ 307,008	$ 307,008	$ 307,008				
h. Project Amortization										
i. Supplies	$ 115,094,050	$ 117,119,100	$ 115,931,587	$ 107,621,203	$ 105,810,629	$ 102,989,400				
j. Other Expenses (Specify/add rows if needed)	$ 91,519,202	$ 88,249,400	$ 89,396,313	$ 84,703,874	$ 82,984,745	$ 80,555,423				
TOTAL OPERATING EXPENSES	***$ 476,400,018***	***$ 471,917,600***	***$ 477,717,307***	***$ 472,194,438***	***$ 469,003,487***	***$ 465,560,733***	$ -	$ -	$ -	$ -
3. INCOME										
a. Income From Operation	**$ 1,114,582**	**$ 12,112,100**	**$ 20,198,249**	**$ 28,882,341**	**$ 33,593,728**	**$ 37,812,343**	$ -	$ -	$ -	$ -
b. Non-Operating Income	$ 44,226,600	$ 27,091,100	$ (31,684,793)	$ 16,919,694	$ 20,690,944	$ 24,933,376				
SUBTOTAL	***$ 45,341,182***	***$ 39,203,200***	***$ (11,486,543)***	***$ 45,802,036***	***$ 54,284,672***	***$ 62,745,719***	$ -	$ -	$ -	$ -
c. Income Taxes										
NET INCOME (LOSS)	***$ 45,341,182***	***$ 39,203,200***	***$ (11,486,543)***	***$ 45,802,036***	***$ 54,284,672***	***$ 62,745,719***	$ -	$ -	$ -	$ -

TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY (REVISED)

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table G should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table F and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	FY 2013	FY 2014	FY 2015	FY 2017	FY 2018	FY 2019				
Note 1: Per the HSCRC, revenue can be reallocated from other revenue sources (HSCRC Memorandum of 8/24/16 to MHCC)										
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare	40.2%	40.3%	39.6%	39.6%	39.6%	39.6%				
2) Medicaid	6.6%	9.3%	10.8%	10.8%	10.8%	10.8%				
3) Blue Cross	21.2%	19.3%	17.9%	17.9%	17.9%	17.9%				
4) Commercial Insurance	21.4%	27.0%	28.1%	28.1%	28.1%	28.1%				
5) Self-pay	3.1%	1.3%	0.9%	0.9%	0.9%	0.9%				
6) Other	7.5%	2.9%	2.7%	2.7%	2.7%	2.7%				
TOTAL	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*
b. Percent of Equivalent Inpatient Days										
1) Medicare	40.2%	40.3%	39.6%	39.6%	39.6%	39.6%				
2) Medicaid	6.6%	9.3%	10.8%	10.8%	10.8%	10.8%				
3) Blue Cross	21.2%	19.3%	17.9%	17.9%	17.9%	17.9%				
4) Commercial Insurance	21.4%	27.0%	28.1%	28.1%	28.1%	28.1%				
5) Self-pay	3.1%	1.3%	0.9%	0.9%	0.9%	0.9%				
6) Other	7.5%	2.9%	2.7%	2.7%	2.7%	2.7%				
TOTAL	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY (REVISED)

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table H should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table F. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2017**	**FY 2018**	**FY 2019**				
1. REVENUE										
a. Inpatient Services - See Note 1	$ 294,098,900	$ 292,960,600	$ 297,654,040	$ 318,341,878	$ 328,648,242	$ 338,282,901				
b. Outpatient Services	$ 239,409,200	$ 253,443,600	$ 254,587,463	$ 266,809,830	$ 273,484,577	$ 280,326,773				
Gross Patient Service Revenues	***$ 533,508,100***	***$ 546,404,200***	***$ 552,241,503***	***$ 585,151,708***	***$ 602,132,819***	***$ 618,609,674***	***$ -***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ 19,750,800	$ 22,623,500	$ 26,145,184	$ 27,635,155	$ 28,397,122	$ 29,146,625				
d. Contractual Allowance	$ 53,366,400	$ 60,024,200	$ 55,603,875	$ 57,727,320	$ 58,792,706	$ 59,784,713				
e. Charity Care	$ 8,912,500	$ 5,721,800	$ 2,774,084	$ 2,938,290	$ 3,021,902	$ 3,103,103				
Net Patient Services Revenue	***$ 451,478,400***	***$ 458,034,700***	***$ 467,718,360***	***$ 496,850,944***	***$ 511,921,089***	***$ 526,575,234***	***$ -***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues (Specify/add rows if needed)	$ 26,036,200	$ 25,995,000	$ 30,197,196	$ 31,203,328	$ 31,711,634	$ 32,230,107				
NET OPERATING REVENUE	***$ 477,514,600***	***$ 484,029,700***	***$ 497,915,556***	***$ 528,054,271***	***$ 543,632,723***	***$ 558,805,340***	***$ -***	***$ -***	***$ -***	***$ -***
2. EXPENSES										
a. Salaries & Wages (including benefits)	$ 222,592,080	$ 221,047,100	$ 228,259,601	$ 248,737,129	$ 256,786,669	$ 265,897,175				
b. Contractual Services	$ 2,851,345	$ 716,000	245,942	253,155	256,198	259,759				
c. Interest on Current Debt	$ 15,972,794	$ 15,182,000	14,096,925	13,555,176	13,301,038	13,041,376				
d. Interest on Project Debt	$ -	$ -								
e. Current Depreciation	$ 27,952,182	$ 29,211,500	29,396,532	29,452,079	28,642,928	28,502,319				
f. Project Depreciation	$ -	$ -		315,319	315,319	315,319				
g. Current Amortization	$ 418,365	$ 392,500	390,407	307,008	307,008	307,008				
h. Project Amortization	$ -	$ -								
i. Supplies	$ 115,094,050	$ 117,119,100	115,931,587	118,510,331	122,853,218	126,853,721				
j. Other Expenses (Specify/add rows if needed)	$ 91,519,202	$ 88,249,400	89,396,313	92,087,575	94,325,880	96,044,317				
TOTAL OPERATING EXPENSES	***$ 476,400,018***	***$ 471,917,600***	***$ 477,717,307***	***$ 503,217,771***	***$ 516,788,258***	***$ 531,220,993***	***$ -***	***$ -***	***$ -***	***$ -***
3. INCOME										
a. Income From Operation	**$ 1,114,582**	**$ 12,112,100**	**$ 20,198,249**	**$ 24,836,500**	**$ 26,844,465**	**$ 27,584,347**	**$ -**	**$ -**	**$ -**	**$ -**
b. Non-Operating Income	$ 44,226,600	$ 27,091,100	$ (31,684,793)	$ 16,716,597	$ 20,162,033	$ 23,870,184				
SUBTOTAL	***$ 45,341,182***	***$ 39,203,200***	***$ (11,486,543)***	***$ 41,553,097***	***$ 47,006,498***	***$ 51,454,531***	***$ -***	***$ -***	***$ -***	***$ -***
c. Income Taxes										
NET INCOME (LOSS)	***$ 45,341,182***	***$ 39,203,200***	***$ (11,486,543)***	***$ 41,553,097***	***$ 47,006,498***	***$ 51,454,531***	***$ -***	***$ -***	***$ -***	***$ -***

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY (REVISED)

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table H should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table F. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2017**	**FY 2018**	**FY 2019**				
Note 1: Per the HSCRC, revenue can be reallocated from other revenue sources (HSCRC Memorandum of 8/24/16 to MHCC)										
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare	40.2%	40.3%	39.6%	39.6%	39.6%	39.6%				
2) Medicaid	6.6%	9.3%	10.8%	10.8%	10.8%	10.8%				
3) Blue Cross	21.2%	19.3%	17.9%	17.9%	17.9%	17.9%				
4) Commercial Insurance	21.4%	27.0%	28.1%	28.1%	28.1%	28.1%				
5) Self-pay	3.1%	1.3%	0.9%	0.9%	0.9%	0.9%				
6) Other	7.5%	2.9%	2.7%	2.7%	2.7%	2.7%				
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days										
Total MSGA										
1) Medicare	40.2%	40.3%	39.6%	39.6%	39.6%	39.6%				
2) Medicaid	6.6%	9.3%	10.8%	10.8%	10.8%	10.8%				
3) Blue Cross	21.2%	19.3%	17.9%	17.9%	17.9%	17.9%				
4) Commercial Insurance	21.4%	27.0%	28.1%	28.1%	28.1%	28.1%				
5) Self-pay	3.1%	1.3%	0.9%	0.9%	0.9%	0.9%				
6) Other	7.5%	2.9%	2.7%	2.7%	2.7%	2.7%				
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***

TABLE J-1. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE (REVISED)

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table J should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table I and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**				
1. REVENUE							
a. Inpatient Services	$ 7,557,221	$ 11,147,964	$ 12,980,221				
b. Outpatient Services	$ -	$ -	$ -				
Gross Patient Service Revenues	***$ 7,557,221***	***$ 11,147,964***	***$ 12,980,221***	***$ -***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ 264,503	$ 390,178	$ 454,308				
d. Contractual Allowance	$ 853,966	$ 1,259,720	$ 1,466,765				
e. Charity Care	$ 37,786	$ 55,740	$ 64,901				
Net Patient Services Revenue	***$ 6,400,966***	***$ 9,442,326***	***$ 10,994,247***	***$ -***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues							
NET OPERATING REVENUE	***$ 6,400,966***	***$ 9,442,326***	***$ 10,994,247***	***$ -***	***$ -***	***$ -***	***$ -***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ 3,042,302	$ 3,397,763	$ 3,582,372				
b. Contractual Services							
c. Interest on Current Debt							
d. Interest on Project Debt							
e. Current Depreciation							
f. Project Depreciation	$ 315,319	$ 315,319	$ 315,319				
g. Current Amortization							
h. Project Amortization							
i. Supplies	$ 1,687,904	$ 2,466,749	$ 2,873,906				
j. Other Expenses (Specify)	$ 1,899,518	$ 1,830,391	$ 1,702,183				
TOTAL OPERATING EXPENSES	***$ 6,945,043***	***$ 8,010,222***	***$ 8,473,780***	***$ -***	***$ -***	***$ -***	***$ -***
3. INCOME							
a. Income From Operation	**$ (544,076)**	**$ 1,432,104**	**$ 2,520,467**	**$ -**	**$ -**	**$ -**	**$ -**
b. Non-Operating Income							
SUBTOTAL	***$ (544,076)***	***$ 1,432,104***	***$ 2,520,467***	***$ -***	***$ -***	***$ -***	***$ -***
c. Income Taxes							

TABLE J-1. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE (REVISED)

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table J should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table I and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**				
NET INCOME (LOSS)	***$ (544,076)***	***$ 1,432,104***	***$ 2,520,467***	***$ -***	***$ -***	***$ -***	***$ -***

TABLE J-1. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE (REVISED)

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table J should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table I and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**				
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare	50.2%	51.9%	52.9%				
2) Medicaid	6.8%	6.8%	6.8%				
3) Blue Cross	9.3%	9.3%	9.3%				
4) Commercial Insurance	30.6%	28.9%	27.9%				
5) Self-pay	2.5%	2.5%	2.5%				
6) Other	0.6%	0.6%	0.6%				
TOTAL	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days							
Total MSGA							
1) Medicare	50.2%	51.9%	52.9%				
2) Medicaid	7.3%	7.3%	7.3%				
3) Blue Cross	9.0%	9.0%	9.0%				
4) Commercial Insurance	30.0%	28.4%	27.4%				
5) Self-pay	2.9%	2.9%	2.9%				
6) Other	0.6%	0.6%	0.6%				
TOTAL	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***

TABLE J-2. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE (REVISED AT 50% VCF)

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table J should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table I and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**				
1. REVENUE							
a. Inpatient Services	$ 3,778,611	$ 5,573,982	$ 6,490,110				
b. Outpatient Services	$ -	$ -	$ -				
Gross Patient Service Revenues	***$ 3,778,611***	***$ 5,573,982***	***$ 6,490,110***	***$ -***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ 132,251	$ 195,089	$ 227,154				
d. Contractual Allowance	$ 426,983	$ 629,860	$ 733,383				
e. Charity Care	$ 18,893	$ 27,870	$ 32,450				
Net Patient Services Revenue	***$ 3,200,483***	***$ 4,721,163***	***$ 5,497,124***	***$ -***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues							
NET OPERATING REVENUE	***$ 3,200,483***	***$ 4,721,163***	***$ 5,497,124***	***$ -***	***$ -***	***$ -***	***$ -***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ 3,042,302	$ 3,397,763	$ 3,582,372				
b. Contractual Services							
c. Interest on Current Debt							
d. Interest on Project Debt							
e. Current Depreciation							
f. Project Depreciation	$ 315,319	$ 315,319	$ 315,319				
g. Current Amortization							
h. Project Amortization							
i. Supplies	$ 1,687,904	$ 2,466,749	$ 2,873,906				
j. Other Expenses (Specify)	$ 1,899,518	$ 1,830,391	$ 1,702,183				
TOTAL OPERATING EXPENSES	***$ 6,945,043***	***$ 8,010,222***	***$ 8,473,780***	***$ -***	***$ -***	***$ -***	***$ -***
3. INCOME							
a. Income From Operation	**$ (3,744,559)**	**$ (3,289,059)**	**$ (2,976,657)**	**$ -**	**$ -**	**$ -**	**$ -**
b. Non-Operating Income							
SUBTOTAL	***$ (3,744,559)***	***$ (3,289,059)***	***$ (2,976,657)***	***$ -***	***$ -***	***$ -***	***$ -***
c. Income Taxes							

TABLE J-2. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE (REVISED AT 50% VCF)

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table J should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table I and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**				
NET INCOME (LOSS)	***$ (3,744,559)***	***$ (3,289,059)***	***$ (2,976,657)***	***$ -***	***$ -***	***$ -***	***$ -***

TABLE J-2. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE (REVISED AT 50% VCF)

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table J should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table I and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**				
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare	50.2%	51.9%	52.9%				
2) Medicaid	6.8%	6.8%	6.8%				
3) Blue Cross	9.3%	9.3%	9.3%				
4) Commercial Insurance	30.6%	28.9%	27.9%				
5) Self-pay	2.5%	2.5%	2.5%				
6) Other	0.6%	0.6%	0.6%				
TOTAL	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days							
Total MSGA							
1) Medicare	50.2%	51.9%	52.9%				
2) Medicaid	7.3%	7.3%	7.3%				
3) Blue Cross	9.0%	9.0%	9.0%				
4) Commercial Insurance	30.0%	28.4%	27.4%				
5) Self-pay	2.9%	2.9%	2.9%				
6) Other	0.6%	0.6%	0.6%				
TOTAL	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***

TABLE K-1. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE (REVISED)

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table K should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table I. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**				
1. REVENUE							
a. Inpatient Services	$ 7,935,082	$ 11,984,062	$ 14,278,243				
b. Outpatient Services	$ -	$ -	$ -				
Gross Patient Service Revenues	***$ 7,935,082***	***$ 11,984,062***	***$ 14,278,243***	***$ -***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ 277,728	$ 419,442	$ 499,739				
d. Contractual Allowance	$ 896,664	$ 1,354,199	$ 1,613,442				
e. Charity Care	$ 39,676	$ 59,921	$ 71,391				
Net Patient Services Revenue	***$ 6,721,015***	***$ 10,150,500***	***$ 12,093,672***	***$ -***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues (Specify/add rows of needed)							
NET OPERATING REVENUE	***$ 6,721,015***	***$ 10,150,500***	***$ 12,093,672***	***$ -***	***$ -***	***$ -***	***$ -***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ 3,163,994	$ 3,601,628	$ 3,868,962				
b. Contractual Services							
c. Interest on Current Debt							
d. Interest on Project Debt							
e. Current Depreciation							
f. Project Depreciation	$ 315,319	$ 315,319	$ 315,319				
g. Current Amortization							
h. Project Amortization							
i. Supplies	$ 1,228,148	$ 2,095,246	$ 2,585,649				
j. Other Expenses (Specify/add rows of needed)	$ 2,442,273	$ 2,372,968	$ 2,251,816				
TOTAL OPERATING EXPENSES	***$ 7,149,734***	***$ 8,385,161***	***$ 9,021,745***	***$ -***	***$ -***	***$ -***	***$ -***
3. INCOME							

TABLE K-1. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE (REVISED)

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table K should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table I. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**				
a. Income From Operation	**$ (428,720)**	**$ 1,765,339**	**$ 3,071,926**	**$ -**	**$ -**	**$ -**	**$ -**
b. Non-Operating Income							
SUBTOTAL	***$ (428,720)***	***$ 1,765,339***	***$ 3,071,926***	***$ -***	***$ -***	***$ -***	***$ -***
c. Income Taxes							
NET INCOME (LOSS)	***$ (428,720)***	***$ 1,765,339***	***$ 3,071,926***	***$ -***	***$ -***	***$ -***	***$ -***

TABLE K-1. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE (REVISED)

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table K should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table I. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**				
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare	50.2%	51.9%	52.9%				
2) Medicaid	6.8%	6.8%	6.8%				
3) Blue Cross	9.3%	9.3%	9.3%				
4) Commercial Insurance	30.6%	28.9%	27.9%				
5) Self-pay	2.5%	2.5%	2.5%				
6) Other	0.6%	0.6%	0.6%				
TOTAL	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days							
1) Medicare	50.2%	51.9%	52.9%				
2) Medicaid	7.3%	7.3%	7.3%				
3) Blue Cross	9.0%	9.0%	9.0%				
4) Commercial Insurance	30.0%	28.4%	27.4%				
5) Self-pay	2.9%	2.9%	2.9%				
6) Other	0.6%	0.6%	0.6%				
TOTAL	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***

TABLE K-2. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE (REVISED AT 50% VCF)

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table K should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table I. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**				
1. REVENUE							
a. Inpatient Services	$ 3,967,541	$ 5,852,681	$ 6,814,616				
b. Outpatient Services	$ -	$ -	$ -				
Gross Patient Service Revenues	***$ 3,967,541***	***$ 5,852,681***	***$ 6,814,616***	***$ -***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ 138,864	$ 204,844	$ 238,512				
d. Contractual Allowance	$ 448,332	$ 661,353	$ 770,052				
e. Charity Care	$ 19,838	$ 29,264	$ 34,073				
Net Patient Services Revenue	***$ 3,360,507***	***$ 4,957,221***	***$ 5,771,980***	***$ -***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues (Specify/add rows of needed)							
NET OPERATING REVENUE	***$ 3,360,507***	***$ 4,957,221***	***$ 5,771,980***	***$ -***	***$ -***	***$ -***	***$ -***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ 3,163,994	$ 3,601,628	$ 3,868,962				
b. Contractual Services							
c. Interest on Current Debt							
d. Interest on Project Debt							
e. Current Depreciation							
f. Project Depreciation	$ 315,319	$ 315,319	$ 315,319				
g. Current Amortization							
h. Project Amortization							
i. Supplies	$ 1,228,148	$ 2,095,246	$ 2,585,649				
j. Other Expenses (Specify/add rows of needed)	$ 2,442,273	$ 2,372,968	$ 2,251,816				
TOTAL OPERATING EXPENSES	***$ 7,149,734***	***$ 8,385,161***	***$ 9,021,745***	***$ -***	***$ -***	***$ -***	***$ -***
3. INCOME							

TABLE K-2. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE (REVISED AT 50% VCF)

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table K should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table I. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**				
a. Income From Operation	**$ (3,789,227)**	**$ (3,427,940)**	**$ (3,249,766)**	**$ -**	**$ -**	**$ -**	**$ -**
b. Non-Operating Income							
SUBTOTAL	***$ (3,789,227)***	***$ (3,427,940)***	***$ (3,249,766)***	***$ -***	***$ -***	***$ -***	***$ -***
c. Income Taxes							
NET INCOME (LOSS)	***$ (3,789,227)***	***$ (3,427,940)***	***$ (3,249,766)***	***$ -***	***$ -***	***$ -***	***$ -***

TABLE K-2. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE (REVISED AT 50% VCF)

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table K should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table I. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**				
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare	50.2%	51.9%	52.9%				
2) Medicaid	6.8%	6.8%	6.8%				
3) Blue Cross	9.3%	9.3%	9.3%				
4) Commercial Insurance	30.6%	28.9%	27.9%				
5) Self-pay	2.5%	2.5%	2.5%				
6) Other	0.6%	0.6%	0.6%				
TOTAL	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days							
1) Medicare	50.2%	51.9%	52.9%				
2) Medicaid	7.3%	7.3%	7.3%				
3) Blue Cross	9.0%	9.0%	9.0%				
4) Commercial Insurance	30.0%	28.4%	27.4%				
5) Self-pay	2.9%	2.9%	2.9%				
6) Other	0.6%	0.6%	0.6%				
TOTAL	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***

EXHIBIT 9

STATE OF MARYLAND

Craig P. Tanio, M.D
CHAIR

Ben Steffen
EXECUTIVE DIRECTOR

MARYLAND HEALTH CARE COMMISSION

4160 PATTERSON AVENUE – BALTIMORE, MARYLAND 21215
TELEPHONE: 410-764-3460 FAX: 410-358-1236

October 28, 2016

By E-Mail and USPS

Jonathan Montgomery, Esquire
Gordon-Feinblatt LLC
233 East Redwood Street
Baltimore, Maryland 21202-3332

Thomas C. Dame, Esquire
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Gallagher, Evelius & Jones LLP
218 North Charles Street, Suite 400
Baltimore, Maryland 21201

Re: Project Status Conference Summary
Baltimore Upper Shore Cardiac Surgery Review
Anne Arundel Medical Center (Docket No. 15-02-2360)
University of Maryland Baltimore Washington Medical Center
(Docket No. 15-02-2361)

Dear Counsel:

I am writing this letter to summarize the project status conference held today regarding applications filed by Anne Arundel Medical Center ("AAMC") and by the University of Maryland Baltimore Washington Medical Center ("BWMC") that seek to establish cardiac surgery services in the Baltimore Upper Shore Region. I called this project status conference, pursuant to COMAR 10.24.01.09A(2) to address aspects of AAMC's application that may be inconsistent with applicable standards and review criteria.

As I noted at the project status conference, there is certain information I desire from AAMC that may have constituted an impermissible modification unless the information is provided in a modification to an application that is made as the result of a project status conference. It is important that I have the best information available so that I can make the most fully informed recommendation to my fellow Commissioners. The information I desire may have a bearing on my findings with respect to three standards in the Cardiac Surgery Chapter of the State Health Plan and four general CON review criteria. The project review standards are: COMAR 10.24.17.05A(4), Cost Effectiveness; .05A(7), Financial Feasibility; and .05A(8), Preference in Comparative Reviews. The general review criteria are: COMAR

10.24.01.08G(3)(a), State Health Plan; .08G(3)(c), Availability of More Cost-Effective Alternatives; .08G(3)(d), Viability of the Proposal; and .08G(3)(f), Impact on Existing Providers & the Health Care Delivery System.

Present at the project status conference were the following representatives of the parties and Commission staff:

Applicant AAMC
Jonathan Montgomery, Esquire
Barry Rosen, Esquire
Victoria Bayless, CEO, AAMC
Robert Reilly, CFO, AAMC
Paula Widerlite, Chief Strategy Officer, AAMC
Anne Langley, Senior Director, Health Planning & Community Engagement, Johns Hopkins Medicine

Applicant BWMC
Thomas C. Dame, Esquire
Ella R. Aiken, Esquire
Karen Olscamp, Pres. & CEO, UM BWMC
Kathy McCollum, COO & Sr. V.P. for Clinical Integration, UM BWMC
Alfred Pietsch , CFO, UM UMBC
Alison G. Brown, Sr. V.P. & Chief Strategy Officer, UMMS
Dana Farrakhan, Sr. V.P., Strategy, Community & Business Development, UMMS
Andrew L. Solberg, A.L.S. Healthcare Consultant Services
Arin D. Foreman, KPMG

Interested Party Dimension Health Corporation d/b/a Prince George's Hospital Ctr.
M. Natalie McSherry, Esquire (via teleconference)
Carl Jean-Baptiste, JD, MBA, Senior Vice President & General Counsel
Jeffrey L. Johnson, MBA, FACHE, Sr. V.P., Strategic Planning & Business Development

Interested Party MedStar Health (MedStar Union Memorial Hospital; MedStar Washington Hospital Center)
John T. Brennan, Jr., Esquire (via teleconference)
Stephanie D. Willis, Esquire
John P. St. Leger, Esquire, MedStar (via teleconference)
Patricia Cameron, Sr. Policy Analyst, Government Affairs, MedStar

Commission Staff
Ben Steffen
Paul E. Parker
Kevin McDonald
Suellen Wideman, AAG
Siobhan K. Madison, AAG

Recommended Modification

At the project status conference, I requested that AAMC modify its application to provide revised versions of all financial schedules regarding revenues, expenses, and income for: (1) its general hospital operation; and (2) specifically, for its proposed cardiac surgery service. These revenue projections need to reflect HSCRC's current policy (stated in its August 24, 2016 memorandum to me) to assume a 50% variable cost factor. The revised financial schedules must be accompanied by a detailed statement of the assumptions used in development of the modified financial schedules. This statement of assumptions must address and detail the way in which AAMC accounts for all of the revenue and expense changes it projects to result from its provision of cardiac surgery services, across all of the hospital's departments. Anne Arundel Medical Center should also file a statement that details how and why these schedules have changed in comparison to the revenue and projections filed by AAMC prior to docketing of its application.

Next Steps

I request that AAMC let me know on or before 4:30 p.m. on Monday, October 31, 2016 whether it chooses to modify its application or whether it will go forward with its application as filed. If it chooses to modify the application as I have requested, it should also advise me of the estimated date by which it can file the modifications. If AAMC modifies its application, under COMAR 10.24.01.09A(2)(d), each interested party and participating entity will have seven days to file comments on the changes made pursuant to the project status conference.

Responses to Questions

Counsel for BWMC noted that AAMC's October 17 schedules, which were stricken from the record by my October 21, 2016 ruling, proposed that AAMC shift revenue from other hospital areas into its proposed cardiac surgery program. BWMC requested that, if such a shift of revenue were permitted, BWMC be given an opportunity to use the same method to show financial feasibility of its proposed program. I will reserve ruling on BWMC's request until I see the modification filing, if any, by AAMC.

Counsel for AAMC asked whether I wanted it to refile its and The Johns Hopkins Hospital's commitments that were contained in its October 17, 2016 filing. That is not necessary. My October 21, 2016 ruling left those commitments in the record of this review.

Counsel for MedStar asked whether the comments on AAMC's modification may point out other deficiencies in the application. As provided in COMAR 10.24.01.09A(2)(d), each party may file comments on changes in the AAMC application made pursuant to the project status conference.

Counsel for AAMC inquired whether I desired updated cardiac surgery case volume estimates. Counsel for BWMC and MedStar stated their views that an update of volume

projections by AAMC would be the equivalent of the filing of a new application. I do not want AAMC to update its volume projections.

Counsel for Dimensions inquired when I would rule on its motion to file supplemental comments on AAMC's application. I will rule on pending motions at a later date.

I again note that this is a contested case, to which the *ex parte* prohibitions in the Administrative Procedure Act, Maryland Code Ann., State Gov't §10-219, apply until the Commission issues a final decision.

Sincerely,

Craig Tanio, M.D.
Commissioner/Reviewer

cc: M. Natalie McSherry, Esquire
Christopher C. Jeffries, Esquire
Louis P. Malick, Esquire
John T. Brennan, Esquire
Stephanie Willis, Esquire
Donna Kinzer, Executive Director, HSCRC
Neil M. Meltzer, President & CEO, Sinai Hospital
Jinlene Chan, M.D., MPH
Leana S. Wen, M.D., Baltimore City Health Commissioner
Gregory Wm. Branch, M.D., Baltimore County Health Officer
Leland Spencer, M.D., Caroline and Kent County Health Officer
Edwin F. Singer, L.E.H.S., Carroll County Health Officer
Stephanie Garrity, M.S., Cecil County Health Officer
Susan C. Kelly, R.S., Harford County Health Officer
Maura J. Rossman, M.D., Howard County Health Officer
Joseph A. Ciotola, M.D., Queen Anne's County Health Officer
Fredia Wadley, M.D., Talbot County Health Officer
Steven R. Schuh, Executive, Anne Arundel County
Paul Parker
Kevin McDonald
Suellen Wideman, AAG
Siobhan K. Madison, AAG

EXHIBIT 10

HEALTH SERVICES COST REVIEW COMMISSION
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Toll Free: 1-888-287-3229
hscrc.maryland.gov

Memorandum

To: Hospital CFOs

From: Sule Calikoglu, Ph.D., Deputy Director, Research and Methodology SC

Date: June 30, 2014

Re: Global Budget Hospital Population and Demographic Adjustment Volume Allowance

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The following Table contains the updated demographic adjustment that will be used for hospitals under the Global Budget Revenue (GBR) agreement for the Rate Year 2015.

The HSCRC has developed a demographic adjustment to allow for hospital service volume changes due to population change as well as population aging, without allowing for increases in hospital service volume due to potentially avoidable utilization (PAU). The approach also uses a per capita efficiency factor to bring the overall demographic adjustment within the level provided under the new All-Payer Model for population growth. Please see the attached Appendix for technical details and supporting data tables.

If you have any questions, please email Dr. Sule Calikoglu at sule.calikoglu@maryland.gov.

Hospital ID	Hospital Name	ECMADs FY 2013	Hospital Population 2014	Unadjusted Population Growth 2015	Age Adjusted Growth 2015	Hospital All-Payer Percent PAU	Age& PAU Adjusted Growth 2015	Poulation and Demographic Adjustment Volume Allowance 2015
210001	MERITUS	21,622	115,889	0.54%	0.99%	17.17%	0.82%	**0.45%**
210002	UNIVERSITY OF MARYLAND	72,113	390,329	0.48%	0.85%	11.73%	0.75%	**0.41%**
210003	PRINCE GEORGE	14,925	139,167	0.40%	0.99%	15.14%	0.84%	**0.46%**
210004	HOLY CROSS	36,953	352,523	0.76%	1.44%	13.56%	1.24%	**0.68%**
210005	FREDERICK MEMORIAL	28,939	179,619	0.94%	1.63%	14.90%	1.39%	**0.76%**
210006	HARFORD	8,205	30,863	0.63%	1.29%	16.16%	1.08%	**0.59%**
210008	MERCY	35,791	145,455	0.49%	1.01%	9.75%	0.91%	**0.50%**
210009	JOHNS HOPKINS	82,106	574,213	0.41%	0.73%	12.92%	0.64%	**0.35%**
210010	DORCHESTER	4,178	15,275	-0.09%	0.15%	17.75%	0.12%	**0.07%**
210011	ST. AGNES	30,598	118,032	0.69%	1.32%	17.23%	1.09%	**0.60%**
210012	SINAI	48,239	203,900	0.48%	1.00%	14.13%	0.86%	**0.47%**
210013	BON SECOURS	8,467	24,982	-0.07%	0.06%	25.78%	0.04%	**0.02%**
210015	FRANKLIN SQUARE	36,270	141,169	0.57%	1.20%	16.26%	1.00%	**0.55%**
210016	WASHINGTON ADVENTIST	18,482	150,543	1.07%	2.37%	16.23%	1.99%	**1.09%**
210017	GARRETT COUNTY	2,928	19,829	-0.36%	-0.10%	11.41%	0.00%	**0.00%**
210018	MONTGOMERY GENERAL	14,436	111,189	0.96%	1.68%	14.25%	1.44%	**0.79%**
210019	PENINSULA REGIONAL	27,329	129,932	0.50%	0.86%	14.19%	0.74%	**0.40%**
210022	SUBURBAN	22,135	187,935	1.34%	2.29%	14.11%	1.96%	**1.07%**
210023	ANNE ARUNDEL	47,937	299,161	0.81%	1.54%	11.49%	1.36%	**0.74%**
210024	UNION MEMORIAL	30,383	105,236	0.67%	1.51%	15.47%	1.28%	**0.70%**
210027	WESTERN MARYLAND HEALTH SYSTEM	15,749	73,296	-0.26%	0.14%	15.06%	0.12%	**0.06%**
210028	ST. MARY	13,599	93,121	1.01%	1.56%	12.63%	1.37%	**0.75%**
210029	HOPKINS BAYVIEW MED CTR	34,537	145,857	0.52%	1.03%	15.15%	0.88%	**0.48%**
210030	CHESTERTOWN	3,889	17,952	0.21%	0.57%	19.37%	0.46%	**0.25%**
210032	UNION HOSPITAL OF CECIL COUNT	11,032	67,557	0.36%	0.99%	12.10%	0.87%	**0.47%**
210033	CARROLL COUNTY	18,070	88,236	0.32%	0.75%	15.33%	0.63%	**0.35%**
210034	HARBOR	15,324	62,886	0.57%	1.04%	15.71%	0.88%	**0.48%**
210035	CHARLES REGIONAL	12,354	92,701	0.86%	1.66%	18.78%	1.35%	**0.74%**
210037	EASTON	13,953	60,142	0.28%	0.82%	13.20%	0.71%	**0.39%**
210038	UMMC MIDTOWN	12,493	43,463	0.22%	0.56%	19.25%	0.45%	**0.25%**
210039	CALVERT	11,289	71,734	0.49%	0.85%	12.64%	0.74%	**0.40%**
210040	NORTHWEST	19,637	73,132	0.75%	1.50%	22.91%	1.16%	**0.63%**
210043	BALTIMORE WASHINGTON MEDICAL CENTER	33,236	146,659	1.03%	2.06%	17.92%	1.69%	**0.93%**
210044	G.B.M.C.	35,960	169,996	0.51%	0.92%	10.94%	0.82%	**0.45%**
210045	MCCREADY	813	2,815	-0.58%	-0.47%	12.95%	0.00%	**0.00%**
210048	HOWARD COUNTY	24,082	177,110	1.00%	1.62%	15.53%	1.37%	**0.75%**
210049	UPPER CHESAPEAKE HEALTH	25,498	108,151	0.73%	1.48%	13.00%	1.29%	**0.70%**
210051	DOCTORS COMMUNITY	16,308	125,315	1.02%	2.16%	20.69%	1.72%	**0.94%**
210055	LAUREL REGIONAL	8,508	62,374	0.76%	1.75%	15.35%	1.48%	**0.81%**
210056	GOOD SAMARITAN	25,803	79,629	0.70%	1.76%	19.14%	1.42%	**0.78%**
210057	SHADY GROVE	31,159	329,916	1.07%	1.64%	11.09%	1.46%	**0.80%**
210058	REHAB & ORTHO	8,014	41,822	0.74%	1.14%	8.33%	1.05%	**0.57%**
210060	FT. WASHINGTON	3,664	31,216	0.89%	2.14%	15.62%	1.80%	**0.99%**
210061	ATLANTIC GENERAL	6,238	23,687	0.48%	1.10%	11.69%	0.97%	**0.53%**
210062	SOUTHERN MARYLAND	20,037	167,992	0.84%	1.86%	18.49%	1.52%	**0.83%**
210063	UM ST. JOSEPH	29,233	118,938	0.72%	1.45%	12.69%	1.26%	**0.69%**
210087	GERMANTOWN	1,251	21,218	0.68%	0.87%	0.00%	0.87%	**0.48%**
210088	QUEEN ANNES	362	3,550	-0.21%	-0.54%	0.00%	0.00%	**0.00%**
210333	BOWIE HEALTH	883	16,037	0.15%	0.21%	0.00%	0.21%	**0.12%**
Total		**1,045,010**	**5,951,740**	**0.68%**	**1.30%**	**14.35%**	**1.10%**	**0.60%**

* ECMAD= Equivalent Case Mix Adjusted Discharges ; PAU= Potentially Avoidable Utilization

APPENDIX

Overview of the Demographic Adjustment under Global Revenue Models

Introduction

Under the new All-Payer Model in Maryland, hospitals have chosen to have their revenues regulated under global models in a system that focuses on meeting the three part aim of promoting better care, better health, and lower cost. In contrast to the previous Medicare waiver that focused on controlling increases in Medicare inpatient payments per case, the new All-Payer Model seeks to control increases in total hospital revenue per capita.

Central to the All-Payer Model are global revenue models that encourage hospitals to focus on population health and care improvement by prospectively establishing an annual revenue budget for each hospital. There are currently two global models being used: The Total Patient Revenue (TPR) model was expanded in 2008 and now includes 10 hospitals in more rural areas of the State. In 2013, the Global Budget Revenue (GBR) model, which was based on the TPR methodology, was introduced to all other hospitals in the State, including those in urban and suburban areas.

Under GBR and TPR, each hospital's total annual revenue is known at the beginning of the fiscal year. Total annual revenue is determined from a historical base period that is adjusted to account for several factors. In order to tie the global models to population and patient centered metrics and to provide for other changes required to the revenue budgets, the HSCRC makes a number of annual adjustments to the hospitals' global revenue budgets. The HSCRC has developed a demographic adjustment to recognize expected changes in hospital service volume due to population change as well as population aging, without allowing for increases in hospital service volume due to potentially avoidable utilization (PAU), which are defined as hospital care that is unplanned and can be prevented through improved care, care coordination, or effective community based care. The approach also uses a marginal cost factor for expected per capita efficiencies under the new Model to bring the overall demographic adjustment within the level provided under the new All-Payer Model for population growth.

This report outlines the demographic adjustment methodology that the HSCRC will implement for the update of global budgets of GBR hospitals in Maryland fiscal year 2015, which is similar to the approach used in establishing the fiscal year 2014 approved budgets. The TPR hospitals are operating under a demographic adjustment that is calculated in a manner similar to as the GBR method, using county level as opposed to zip code level estimates of population changes and aging along with adjustments reflecting expected efficiencies for reductions in avoidable utilization.

Overview of Demographic Adjustment Calculation

The GBR demographic adjustment calculation begins by determining a hospital's virtual patient service area (VPSA). A VPSA is determined by aggregating the hospital's service volume in each zip code for eight age groups in the State. The HSCRC uses this service area distribution to attribute population to each hospital based on the proportional amount of services it provides to patients in each zip code relative to services provided by all hospitals. The eight age cohorts within each zip code provide more specific cost trends than would otherwise result from an overall distribution since population growth trends and health care use within these cohorts differ significantly. In contrast to GBR hospitals, the TPR hospitals have more defined service areas, which allowed the HSCRC to use counties as a service area to calculate population growth for TPR hospitals.

The HSCRC then calculates the estimated population change for the attributed population using population projections (see data sources below). It also applies an age weight to each age/zip code cohort of the hospital's VPSA to adjust for the differences in cost per capita of each age cohort and to allow for changes resulting from aging of the population. However, a portion of the existing service volume is a result of PAU. The HSCRC removes this portion of the base volume when projecting each hospital's expected volume growth by reducing the age-adjusted growth percentage by that hospital's specific proportion of revenue that is associated with PAU. After removing PAU from the each hospital's demographic adjustment, the result is multiplied by a pro-rata factor that accounts for the expected per capita efficiencies to accomplish the overall savings target in the per capita growth rate to be applied. The result is the population driven volume growth that will be recognized in each GBR hospital's global budget (subject to agreement provisions) for the upcoming fiscal year.

Summary:

1. Calculate base population estimates for each hospital based on its share of volume, as measured by equivalent case-mix adjusted discharges, in a given zip code age cohort
2. Calculate age adjusted population growth rates by multiplying statewide age cost weights with zip/age population growth rates.
3. Calculate hospital specific age adjusted population growth by multiplying hospital specific base population by age adjusted population growth rates for each zip/age cohort and calculating total projected age adjusted population growth
4. Calculate final demographic adjustment by applying efficiency adjustments
    a. Reduce age adjusted population growth by hospital specific PAUs as a percent of total all-payer revenue
    b. Reduce PAU/age adjusted population growth by pro-rata per capita efficiency adjustment reduction

Demographic Adjustment Calculation Steps

This section provides the data sources used and a more detailed explanation of each step of the calculation.

Data Sources:

Volume estimates and total charges by age cohorts are calculated using HSCRC patient level inpatient and outpatient abstract data submitted on a monthly basis. All calculations involving volume and charges include only Maryland residents, determined by the reported billing zip code of the patient.

Zip code and age specific population estimates and projections were provided by Claritas for current year and 5-year population projections, since zip code level data are not available from the Department of State Planning.

Below are the detailed calculation steps:

STEP 1. Calculate base population estimates for each hospital based on its share of volume, as measured by equivalent case-mix adjusted discharges, in a given zip code/age cohort.

Step 1a: Calculate the base year total service volume of the hospital (inpatient and outpatient) for each zip code by each of the eight age cohorts based on Equivalent Case Mix Adjusted Discharges.

i. Measure the volume of inpatient services as total inpatient case mix adjusted discharges (CMADs) that occurred in the specified fiscal year.
ii. Measure the volume of outpatient services as follows:
    a. Calculate the Hospital Unit Charge as the average charge per CMAD for all of the hospital's inpatients that occurred in the specified fiscal year.
    b. Calculate the outpatient equivalent case mix adjusted discharges (ECMADs) as:

$$Outpatient\ ECMAD = \frac{Total\ Charges - Inpatient\ Charges}{Hospital\ Unit\ Charge}$$

iii. Sum inpatient CMADs and Outpatient ECMADs to determine total service volume of the hospital ECMADs for each zip code and age cohort.

Step 1b: Allocate the base population for each zip/age cohort.

Use the proportion of each hospital's ECMAD volumes in each zip/age cohort divided by the total ECMADs for all hospitals in that zip/age cohort to allocate a proportion of the population in each zip code to each hospital.

Example:

For Hospital A and Zip/Age Cohort J the base population would be calculated as:
Base Population$_{AJ}$ = Population$_J$ (ECMAD$_{AJ}$/ECMAD$_J$)*

STEP 2: Calculate age adjusted population growth rates.

Step 2a: Calculate the statewide age cost weight for each age cohort.
Relative age cost weights are applied to a hospital's allocated population and population estimates to arrive at cost weighted populations for the base year and the projection year to account for the age-weighted growth in the population. Age specific hospital cost weights are calculated at the state level as the ratio of average total hospital charges per capita for each statewide age cohort to the statewide average hospital charge per capita in the base year. The total hospital charges include charges for Maryland residents only. This calculation is illustrated below for the statewide [5-14] age cohort.

$$Age\ Cost\ Weight\ for\ [5\ to\ 14] Age\ Cohort = \frac{Total\ [5\ to\ 14]\ Hospitals'\ Charges/Population\ in\ Base\ Year}{Total\ [All\ cohorts] Hospitals'\ Charges\ /Population\ in\ Base\ Year}$$

Step 2b: Calculate age adjusted growth rates.
For each zip/age cohort, the estimated population growth rates are multiplied by the age cost weights to determine the cost weighted population growth rates.

For a Zip/Age Cohort J and Age Weight [5 to 14]:
Age Adjusted Population Growth Rate = Population Growth Rate$_J$ Age-Weight [5 to 14]*

STEP 3: Calculate hospital overall age adjusted growth.
The age adjusted projected population related volume growth is calculated by multiplying base population numbers by age adjusted growth rates from Step 2 for each zip/age cohort. The overall hospital specific age adjusted growth rate is the sum of the allocated age adjusted population for the projection period divided by the age adjusted allocated population for the base period. This is converted to a percentage after subtracting 1.

For Hospital A and Zip/Age Cohort J and Age-Weight [5 to 14:;
*Projected Population Growth = Base Population$_{AJ}$*Population Growth Rate$_J$* Age-Weight [5 to 14]*

Then overall Projected Population for Hospital A for all Zip/Age Cohorts = i…..z:

$$Overall\ Projected\ Population\ Growth\ Rate = \frac{Sum\ of\ (Projected\ Population\ Growth\ i \ldots z)}{Sum\ of\ (\ Base\ Population\ i \ldots . z)}$$

STEP 4: Calculate the appropriate volume growth by applying efficiency adjustments.

Step 4a: Reduce age adjusted overall projected growth by hospital specific overall PAU percentage of revenue.
The overall growth rate calculated in Step 3 is reduced by the PAU percentage of revenue that is calculated on a hospital specific basis by multiplying the growth rate by the PAU percentage of revenue. The policy result is that the hospital will not receive a demographic adjustment on any of its PAU revenues, which includes revenue from avoidable admissions, 30-day readmissions, observation or emergency department visits, as well as revenue from complications (see below

for additional information). PAU percentages of revenue are calculated at the hospital specific level by calculating the ratio of PAU revenue divided by total hospital revenue.

Step 4b: Reduce the PAU adjusted growth percentage for each hospital to achieve an allowance for demographic growth statewide that is lower than the overall growth allowed by the All-Payer Model.

The All-Payer Model provides for per capita growth, without any explicit adjustment for aging of the population. The preliminary result of Step 4a provides a demographic factor for each hospital that includes an age adjustment, and that has been reduced by a measure of potentially avoidable utilization. Without further adjustment, the age and PAU adjusted demographic factor statewide would produce an allowance for growth that is above the statewide allowance for growth in population. Therefore, an additional efficiency adjustment reduction percentage is applied to each hospital's age and PAU adjusted growth percentage to bring the allowance statewide to a level within the overall population increase percentage provided by the Model. For example, if the age and PAU adjusted allowance were 1.2% but the target population allowance was .6%, then all hospitals would receive an additional efficiency adjustment of 50%. This adjustment recognizes the ability to provide incremental volumes at a lower marginal cost or to further reduce avoidable volume to achieve the needed efficiency level of the per capita model.

Final Demographic Percentage: At the conclusion of Step 4b, the final demographic adjustment percentage has been calculated for each hospital in the State. After adding 1 to the percentage, this demographic growth rate is multiplied by each hospital's approved revenue from the base year to arrive at the population adjusted revenue for the target year.

Example Calculation

Below is an example calculation with just one zip code for a GBR hospital to arrive at the statewide per capita efficiency adjustment.

Zip Code	Age Cohort	Base Year ECMADs for Hospital	Total ECMADs for All Hospitals	Share of ECMADs	Base Population	Allocated Base Population	State Total Hospital Revenue per Capita	Age Cost Weights	Projected Population Growth Rate of Cohort	Age Adjusted Population Growth Rates	Hospital Age Adjusted Population Growth	Hospital Overall Age Adjusted Population Growth	Hospital PAU %	Hospital Specific PAU Adjusted Growth Rate	Statewide Per capita Efficiency Adjustment
		STEP 1a			Step1b		Step2a		Step2b		Step 3		Step 4		
A	B	C	D	E = C/D	F	G=F * E	H	I=H/H(total)	J	K=J*I	L=G*K	M=sum(L) /sum(G)	N	O=M*(1-N)	P=O*50%
00000	0-4	30	60	50%	3,713	1,857	$1,577	0.68	0.77%	0.52%	10				
00000	05-14	45	100	45%	23,471	10,562	$119	0.05	-0.07%	0.00%	(0)				
00000	15-44	100	210	48%	8,902	4,239	$3,798	1.63	-1.16%	-1.89%	(80)				
00000	45-55	20	35	57%	7,533	4,305	$2,822	1.21	1.18%	1.43%	61				
00000	55-64	25	40	63%	7,450	4,657	$3,413	1.46	0.16%	0.23%	11				
00000	65-74	25	30	83%	4,517	3,764	$5,162	2.21	2.73%	6.04%	227				
00000	75-84	55	70	79%	2,282	1,793	$7,337	3.14	2.42%	7.60%	136				
00000	85+	60	80	75%	1,044	783	$8,009	3.43	1.32%	4.53%	35				
Total	Total	360	625	58%	58,913	31,959	$2,335				401	1.3%	14%	1.08%	0.54%

Demographic Adjustment Considerations

The approach described above was arrived at after the HSCRC staff conducted additional analysis and received stakeholder input on various demographic variables. The stakeholder workgroup recommended an expanded number of age cohorts, which HSCRC staff has accepted and applied in the updated calculations. The eight age cohorts being used are: 0-4, 5-14, 15-44, 44-55, 55-64, 65-74, 75-84, 85+. The workgroup was also concerned about the initial calculation that used statewide PAU percentages in reducing age-adjusted weights. Staff responded by removing the PAU percentages from the weights and applying the overall PAU adjustment on a hospital specific basis. In the event that the demographic adjustment is not greater than 0%, the demographic adjustment is held at 0%, thereby providing no increase or decrease for the affected hospital. This approach may be adjusted in the future.

Calculation of the PAU Percentage for Each Hospital

PAU is defined as hospital care that is unplanned and can be prevented through improved care, care coordination, or effective community based care. Also, it can reflect cost increases that resulted from a potentially preventable complication occurring in a hospital. The HSCRC intends to continue to create new tools to refine the measurement of PAU.

For purposes of FY2014 and 2015, PAU was measured through three inpatient measures and one outpatient measure: 30 day all cause any hospital inpatient readmissions, inpatient prevention quality indicators (PQIs) as defined by the Agency for Healthcare Research and Quality (AHRQ), and inpatient potentially preventable conditions (PPCs) calculated under the Maryland Hospital Acquired Conditions policy. The measure also includes outpatient re-hospitalizations in the emergency room and observation occurring within 30 days of an inpatient admission.

The total cost of PAU was calculated for each hospital by summing the total cost associated with the discharges and visits indicated above. The PAU percentage was then calculated as the ratio of total PAU charges to the total charges for each hospital in the fiscal year base period. As described above, this PAU percentage was utilized to remove growth in the expected changes in hospital service volume due to population change as well as population aging, by not providing for increases in hospital service volume for growth in PAU.

Rate Year 2015 Supporting Data Results

1. Age Cost Weights - FY 2013

Age group	Population 2013	Inpatient Revenue	Outpatient Revenue	Total Revenue	Per Capita Revenue	FY 13 Age Cost Weights
0-4	371,334	$447,907,135	$139,043,726	$586,950,862	$1,581	0.68
5-14	2,347,063	$96,801,062	$185,339,044	$282,140,106	$120	0.05
15-44	890,201	$1,749,030,422	$1,649,167,754	$3,398,198,175	$3,817	1.64
45-54	753,340	$1,152,737,145	$978,209,702	$2,130,946,847	$2,829	1.21
55-64	745,045	$1,520,406,701	$1,019,280,809	$2,539,687,510	$3,409	1.46
65-74	451,737	$1,468,707,995	$852,941,786	$2,321,649,782	$5,139	2.20
75-84	228,153	$1,155,016,976	$503,027,306	$1,658,044,281	$7,267	3.11
85+	104,429	$637,069,486	$192,166,907	$829,236,393	$7,941	3.40
Total	**5,891,302**			**$13,746,853,957**	**$2,333**	**1.00**

***Total Revenue is based on MD Residents only. (updated since the previous analysis)**
***Population is based on Claritas Data**

2. State-Wide Age-Adjusted Population Growth

Age Cohort	Population 2014	Population 2019	Annual Growth Rate	Age Cost Weights	Age Weighted Growth Rate
0-4	364,846	365,032	0.0%	0.68	0.01%
5-14	2,367,336	2,393,555	0.2%	0.05	0.01%
15-44	886,762	834,278	-1.2%	1.64	-1.98%
45-54	775,593	854,098	1.9%	1.21	2.36%
55-64	746,031	748,717	0.1%	1.46	0.11%
65-74	470,688	604,404	5.1%	2.20	11.29%
75-84	233,876	270,773	3.0%	3.11	9.26%
85+	106,711	113,277	1.2%	3.40	4.09%
Total	**5,951,843**	**6,184,134**	**0.77%**	**1.00**	**1.36%**

*Population growth rates are based on Claritas Data

3. All Payer Potentially Avoidable Utilization FY 2013

Potentially Avoidable Utilization- All Payer Using CRISP ID-FY 2013

FY 2013		ALLPAYER -$								
		INPATIENT					OUTPATIENT		INPATIENT & OUTPATIENT	
Hospital ID	Hospital Name	Total Inpatient Discharges	%PQI	%Readmission	% PPC	% Total PAU	Total Outpatient Charges	% 30-Day ED/Observation Charges	Total PAU	% Total PAU
210001	MERITUS	$192,764,879	10.3%	14.0%	4.9%	25.7%	$107,759,787	1.9%	$51,600,590	17.2%
210002	UNIVERSITY OF MARYLAND	$1,034,396,785	2.6%	9.1%	4.8%	15.8%	$402,163,518	1.3%	$168,478,200	11.7%
210003	PRINCE GEORGE	$170,811,372	10.0%	9.9%	3.5%	20.8%	$74,811,565	2.3%	$37,187,432	15.1%
210004	HOLY CROSS	$322,831,396	6.1%	10.6%	4.2%	19.0%	$140,589,976	1.1%	$62,827,799	13.6%
210005	FREDERICK MEMORIAL	$195,322,415	11.1%	12.6%	4.4%	24.9%	$141,694,926	1.2%	$50,229,848	14.9%
210006	HARFORD	$51,863,659	11.9%	17.4%	4.7%	30.7%	$54,811,724	2.4%	$17,240,719	16.2%
210008	MERCY	$233,031,507	6.2%	11.4%	3.6%	18.9%	$238,819,452	0.8%	$45,987,029	9.7%
210009	JOHNS HOPKINS	$1,319,257,303	3.6%	12.7%	5.1%	20.2%	$789,313,162	0.8%	$272,424,434	12.9%
210010	DORCHESTER GENERAL	$26,582,401	23.1%	18.6%	3.0%	37.7%	$32,706,581	1.5%	$10,524,201	17.8%
210011	ST. AGNES	$243,314,760	11.2%	15.2%	4.8%	27.5%	$159,759,717	1.5%	$69,435,199	17.2%
210012	SINAI	$428,008,625	5.7%	13.0%	5.4%	21.9%	$255,271,007	1.1%	$96,530,926	14.1%
210013	BON SECOURS	$75,481,177	12.7%	26.9%	4.1%	37.8%	$46,157,491	6.1%	$31,355,494	25.8%
210015	FRANKLIN SQUARE	$285,256,375	10.8%	14.4%	4.2%	25.7%	$185,318,872	1.7%	$76,495,788	16.3%
210016	WASHINGTON ADVENTIST	$164,166,435	8.7%	13.7%	4.6%	23.9%	$86,638,586	1.6%	$40,699,412	16.2%
210017	GARRETT COUNTY	$19,360,642	13.7%	10.4%	4.1%	25.1%	$24,659,868	0.7%	$5,022,047	11.4%
210018	MONTGOMERY GENERAL	$89,820,257	9.5%	13.9%	5.2%	25.6%	$76,716,400	1.0%	$23,733,141	14.3%
210019	PENINSULA GENERAL	$239,525,278	8.5%	12.2%	5.6%	23.7%	$173,063,607	1.1%	$58,556,877	14.2%
210022	SUBURBAN	$185,393,142	6.3%	10.6%	6.0%	20.9%	$97,106,727	1.2%	$39,857,020	14.1%
210023	ANNE ARUNDEL	$306,809,646	8.0%	10.3%	4.0%	19.6%	$230,516,591	0.7%	$61,753,754	11.5%
210024	UNION MEMORIAL	$244,385,833	7.7%	12.7%	6.7%	24.8%	$162,796,792	1.4%	$62,989,595	15.5%
210027	WESTERN MARYLAND HEALTH SYSTEM	$187,675,091	9.3%	13.0%	5.3%	24.4%	$127,095,241	1.3%	$47,389,331	15.1%
210028	ST. MARY	$68,745,781	15.0%	13.5%	2.3%	26.6%	$86,082,954	1.5%	$19,560,584	12.6%
210029	HOPKINS BAYVIEW MED CTR	$319,143,338	8.8%	14.5%	4.9%	25.2%	$234,871,802	1.5%	$83,944,190	15.2%
210030	CHESTER RIVER HOSPITAL CENTER	$29,503,903	21.3%	18.7%	5.3%	37.9%	$29,604,648	1.0%	$11,449,620	19.4%
210032	UNION HOSPITAL OF CECIL COUNT	$69,072,681	10.7%	13.0%	5.3%	25.5%	$84,623,596	1.2%	$18,597,251	12.1%
210033	CARROLL COUNTY	$140,633,500	10.9%	14.6%	3.8%	26.1%	$107,807,118	1.3%	$38,097,158	15.3%
210034	HARBOR	$126,070,391	10.0%	13.6%	4.1%	24.2%	$76,740,880	1.7%	$31,863,722	15.7%
210035	CIVISTA	$75,433,187	15.9%	18.5%	3.8%	32.9%	$61,712,774	1.5%	$25,754,568	18.8%
210037	MEMORIAL AT EASTON	$96,717,508	13.0%	11.8%	3.0%	24.4%	$88,710,268	1.0%	$24,477,501	13.2%
210038	MARYLAND GENERAL	$107,899,179	8.4%	21.8%	3.6%	30.7%	$77,571,319	3.3%	$35,709,273	19.3%
210039	CALVERT	$67,839,359	13.8%	10.7%	3.9%	24.9%	$70,789,587	0.9%	$17,518,636	12.6%
210040	NORTHWEST	$143,315,084	16.1%	21.6%	6.3%	38.3%	$102,765,592	1.5%	$56,371,288	22.9%
210043	BALTIMORE WASHINGTON MEDICAL CENTER	$218,119,657	12.7%	16.7%	5.7%	29.8%	$158,267,329	1.5%	$67,466,805	17.9%
210044	G.B.M.C.	$203,533,231	8.0%	10.3%	5.7%	21.9%	$217,789,064	0.7%	$46,100,446	10.9%
210045	MCCREADY	$4,486,449	37.1%	15.6%	4.3%	49.0%	$13,382,397	0.9%	$2,313,420	12.9%
210048	HOWARD COUNTY	$170,255,194	9.6%	13.3%	4.8%	24.5%	$107,684,134	1.4%	$43,163,171	15.5%
210049	UPPER CHESAPEAKE HEALTH	$145,945,703	8.5%	13.1%	4.9%	23.9%	$138,459,329	1.5%	$36,961,384	13.0%
210051	DOCTORS COMMUNITY	$137,664,693	11.4%	18.3%	5.6%	31.8%	$78,815,849	1.3%	$44,781,266	20.7%
210055	LAUREL REGIONAL	$61,357,628	8.9%	16.1%	2.9%	24.8%	$41,818,409	1.5%	$15,842,138	15.4%
210056	GOOD SAMARITAN	$184,677,236	11.5%	18.2%	4.2%	29.7%	$112,731,397	1.8%	$56,930,732	19.1%
210057	SHADY GROVE	$225,297,389	4.4%	11.8%	2.7%	17.1%	$136,319,563	1.1%	$40,103,224	11.1%
210058	KERNAN	$51,092,789	0.0%	11.7%	3.8%	15.6%	$46,077,716	0.3%	$8,096,086	8.3%
210060	FT. WASHINGTON	$18,333,890	22.4%	18.2%	5.0%	37.9%	$28,224,598	1.2%	$7,273,355	15.6%
210061	ATLANTIC GENERAL	$38,938,556	15.1%	15.8%	3.2%	29.1%	$60,805,025	0.6%	$11,663,037	11.7%
210062	SOUTHERN MARYLAND	$161,076,262	11.7%	15.0%	5.0%	28.1%	$90,846,807	1.5%	$46,574,436	18.5%
210063	UM ST. JOSEPH MEDICAL CENTER	$208,229,613	5.4%	10.9%	5.5%	20.1%	$128,951,864	0.8%	$42,787,023	12.7%
	STATEWIDE	**$9,089,441,182**	**7.7%**	**13.0%**	**4.8%**	**23.0%**	**$5,989,225,609**	**1.2%**	**$2,163,719,150**	**14.3%**

* Readmissions are adjusted for Planned Admissions

3/18/2014

EXHIBIT 11

RY 2017 GBR and TPR Demographic Adjustments

✓

HOSPID	Hospital name	Payment Type	CY 2015 MD Resident Total Charges	CY 2015 MD Resident ECMADs	2016 Age Adjusted Population Growth	CY 2015 All-Payer Percent PAU	2016 Age& PAU Adjusted Growth	RY 2017 Demographic Adjustment
210023	ANNE ARUNDEL	GBR	$556,062,689	53,824	1.69%	9.10%	1.54%	**0.48%**
210061	ATLANTIC GENEI	GBR	$73,276,973	6,731	1.21%	8.93%	1.10%	**0.35%**
210043	BALTIMORE WAS	GBR	$400,742,045	33,174	1.43%	15.53%	1.21%	**0.38%**
210013	BON SECOURS	GBR	$104,054,347	6,072	0.16%	18.28%	0.13%	**0.04%**
210333	BOWIE HEALTH	GBR	$19,780,445	1,233	0.95%	0.00%	0.95%	**0.30%**
210039	CALVERT	TPR*	$142,252,096	10,568	0.98%	11.60%	0.86%	**0.52%**
210033	CARROLL COUN	TPR*	$243,133,250	18,487	1.72%	14.04%	1.47%	**0.51%**
210035	CHARLES REGIO	GBR	$145,912,998	11,132	2.24%	14.53%	1.91%	**0.60%**
210030	CHESTERTOWN	TPR*	$58,227,824	3,626	1.58%	13.70%	1.37%	**0.40%**
210051	DOCTORS COMM	GBR	$210,240,654	16,015	3.71%	16.66%	3.09%	**0.98%**
210010	DORCHESTER	TPR*	$52,759,247	3,482	0.53%	21.26%	0.41%	**0.41%**
210037	EASTON	TPR*	$183,662,283	13,682	0.68%	12.01%	0.60%	**0.41%**
210015	FRANKLIN SQUA	GBR	$494,182,776	39,762	0.82%	15.50%	0.69%	**0.22%**
210005	FREDERICK MEM	GBR	$331,583,308	28,390	1.99%	10.77%	1.78%	**0.56%**
210060	FT. WASHINGTOI	GBR	$42,358,541	3,812	2.84%	15.05%	2.41%	**0.76%**
210044	G.B.M.C.	GBR	$419,074,841	33,804	1.08%	8.36%	0.99%	**0.31%**
210017	GARRETT COUN	TPR*	$33,746,962	3,572	0.28%	9.27%	0.25%	**0.27%**
210087	GERMANTOWN	GBR	$13,132,308	1,077	0.78%	0.00%	0.78%	**0.25%**
210056	GOOD SAMARITA	GBR	$291,103,130	21,982	1.71%	15.80%	1.44%	**0.45%**
210034	HARBOR	GBR	$199,067,754	13,482	0.70%	13.20%	0.61%	**0.19%**
210006	HARFORD	GBR	$99,951,381	7,525	1.47%	17.88%	1.21%	**0.38%**
210004	HOLY CROSS	GBR	$440,398,556	36,748	1.56%	12.61%	1.36%	**0.43%**
210065	HOLY CROSS GE	GBR	$65,549,221	5,616	2.36%	12.61%	2.06%	**0.65%**
210029	HOPKINS BAYVIE	GBR	$537,334,833	38,424	0.92%	12.17%	0.81%	**0.26%**
210048	HOWARD COUNT	GBR	$282,277,981	25,813	2.04%	12.34%	1.79%	**0.56%**
210009	JOHNS HOPKINS	GBR	$1,715,715,634	99,201	0.91%	9.36%	0.83%	**0.26%**
210055	LAUREL REGION	GBR	$88,018,600	7,098	2.24%	13.64%	1.93%	**0.61%**
210064	LEVINDALE	GBR	$2,047,930	14	5.43%	0.00%	0.00%	**0.45%**
210045	MCCREADY	TPR*	$13,603,348	985	-2.16%	7.46%	-2.00%	**0.00%**
210008	MERCY	GBR	$470,417,109	38,906	1.06%	6.00%	0.99%	**0.31%**
210001	MERITUS	TPR*	$263,308,247	21,965	0.73%	12.29%	0.64%	**0.51%**

RY 2017 GBR and TPR Demographic Adjustments

✓

HOSPID	Hospital name	Payment Type	CY 2015 MD Resident Total Charges	CY 2015 MD Resident ECMADs	2016 Age Adjusted Population Growth	CY 2015 All-Payer Percent PAU	2016 Age& PAU Adjusted Growth	RY 2017 Demographic Adjustment
210018	MONTGOMERY C	GBR	$164,163,463	13,257	2.31%	12.19%	2.03%	**0.64%**
210040	NORTHWEST	GBR	$245,407,664	16,945	1.28%	16.30%	1.07%	**0.34%**
210019	PENINSULA REG	GBR	$329,869,518	27,786	0.82%	11.79%	0.72%	**0.23%**
210003	PRINCE GEORGE	GBR	$241,835,425	15,601	2.14%	13.82%	1.84%	**0.58%**
210088	QUEEN ANNES	GBR	$4,898,934	568	0.30%	0.00%	0.30%	**0.09%**
210058	REHAB & ORTHO	GBR	$98,912,534	6,325	1.04%	0.31%	1.04%	**0.33%**
210057	SHADY GROVE	GBR	$372,474,268	28,493	1.93%	10.40%	1.73%	**0.55%**
210012	SINAI	GBR	$688,979,053	43,734	0.89%	9.64%	0.80%	**0.25%**
210062	SOUTHERN MAR	GBR	$245,659,781	17,463	3.52%	17.27%	2.91%	**0.92%**
210011	ST. AGNES	GBR	$413,644,308	32,567	1.23%	14.38%	1.05%	**0.33%**
210028	ST. MARY	GBR	$165,813,978	14,474	1.85%	11.08%	1.65%	**0.52%**
210022	SUBURBAN	GBR	$263,592,264	22,263	2.48%	9.96%	2.23%	**0.71%**
210063	UM ST. JOSEPH	GBR	$389,171,488	31,501	1.45%	8.16%	1.33%	**0.42%**
210038	UMMC MIDTOWN	GBR	$198,463,291	10,811	0.43%	16.63%	0.36%	**0.11%**
210032	UNION HOSPITAL	TPR*	$141,779,140	9,795	1.81%	13.39%	1.56%	**0.59%**
210024	UNION MEMORIA	GBR	$390,880,820	28,383	1.62%	11.39%	1.44%	**0.45%**
210002	UNIVERSITY OF I	GBR	$1,394,838,099	71,427	1.00%	8.09%	0.92%	**0.29%**
210049	UPPER CHESAPE	GBR	$310,730,767	26,036	1.87%	11.73%	1.65%	**0.52%**
210016	WASHINGTON AD	GBR	$235,809,464	17,064	2.40%	13.23%	2.08%	**0.66%**
210027	WESTERN MARY	TPR*	$230,974,000	17,644	-0.22%	10.72%	-0.20%	**0.15%**
State Total			**$14,520,875,569**	**$1,058,339**	**1.51%**	**0.00%**	**1.33%**	**0.44%**

*TPR Hospital Demographic Adjustment is determined by county population growth.

EXHIBIT 12

State of Maryland
Department of Health and Mental Hygiene

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Gerard J. Schmith, Director
Center for Revenue and Regulation Compliance

To: Hospital CFOs

Cc: Case Mix Liaisons, Hospital Quality Contacts

From: Alyson Schuster, Ph.D., Associate Director – Performance Measurement

Date: June 30, 2016

Re: Readmissions Reduction Incentive Program (RRIP) Policy for Rate Year (RY) 2018 and RY 2017 Updates

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This memo summarizes the changes to the Readmission Reduction Incentive Program (RRIP) that will impact hospital rates in RY2018 as approved by the Commission on June 8, 2016. The Commission approved that the RY 2018 methodology would also be applied to RY 2017 (with previously approved RY 2017 improvement target of 9.3%). The updated RRIP methodology measures hospital performance based on the better of attainment or improvement. The final approved RRIP recommendation can be found on the HSCRC website (http://hscrc.maryland.gov/documents/commission-meeting/2016/06-08/HSCRC-Post-Meeting-Packet-2016-06-08.pdf)

1. Measuring the Better of Attainment or Improvement

The RRIP was modified to assess hospital performance based on the better of attainment or improvement due to concerns about hospitals with low readmission rates having less opportunity for improvement. Based on the assessment of several issues, the following program updates were approved to measure attainment and improvement reliably across hospitals (details contained in recommendation):

1) Hospital readmission rates should be adjusted for out-of-state readmissions for all payers based on a factor developed using Medicare data.
2) The hospital attainment benchmark should be set at the cutoff rate for the lowest 25th percentile, which would equal 11.85% for RY 2018 and 12.09% for RY 2017.
3) The reduction target should be set at 9.50 percent for CY 2016 performance period compared to CY 2013 readmission rates. The reduction target will remain

at the originally approved 9.30 percent for CY 2015 performance period compared to CY 2013 readmission rates.

2. Scaling and Magnitude of Revenue At-Risk

For the RY 2018 RRIP, as part of the Aggregate Revenue Amount At-Risk recommendation, the Commission approved scaled penalties of up to 2% and scaled rewards of up to 1% of inpatient revenue. These rewards and penalties are not revenue neutral.[1]

Appendix A contains the RY2018 preset scales for rewards and penalties linked to improvement and attainment performance levels. In addition, the steps for calculating the penalties and rewards for attainment and improvement are provided. The percent change comparing CY 2013 to CY 2016 will be rounded to two decimal places for the payment incentive.

3. Readmission Algorithm Changes for Hospital Readmission Reduction Incentive Program for RY 2018

For the RRIP methodology, performance is measured using the 30-day all-payer all hospital (both within and between hospitals) readmission rate with adjustments for patient severity (based upon discharge all-patient refined diagnosis-related group severity of illness [APR-DRG SOI]) and planned admissions. For RY2018, there were four changes made to the readmission measure:

1) Updated the transfer definition to add next day admissions to transfer counts (i.e., the first admission is counted as a transfer and is ineligible for readmission if the discharge date is the one day before the admission date). FY 2017 definition required transfers to be on the same day.
2) Suspended oncology discharges from the readmissions logic due to concerns that planned admission logic does not capture planned readmissions accurately for this service line.
3) Overrode the APR DRG grouper results for ensure all rehabilitation discharges are grouped under APR-DRG 860 and are ineligible for readmissions. After evaluating the options with the industry, HSCRC is using Type of Daily Service equal to 8 to recode APR DRG 860 and defines all these discharges as planned and ineligible for readmission. <u>This change was also made when the final results were run for RY 2017</u>.
4) Updated to the latest CMS Planned Admission Logic Version 4 (see Appendix B for changes).

In addition, Levindale and Holy Cross Germantown (attainment only) will be included in the RRIP for RY 2018. Figure 1 provides CY 2013 statewide readmission rates under the original RY 2017 and the revised RY 2018 methodology for comparison.

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1 Across all quality programs, the Commission approved a hospital maximum penalty guardrail of 3.5% of total revenue for RY2018.

See Appendix C for additional details on the HSCRC readmission measure specifications.

Figure 1: CY 2013 Readmission Rates

Rate Year Methodology	CY 2013 Unadjusted Readmission Rate
RY 2017	13.86%
RY 2018	12.93%

4. Measurement Periods and Grouper Versions

The base period for RY 2018 remains at CY 2013, which is run using version 32 of the APR grouper (ICD-9 compatible). The performance period is CY 2016, which is run using version 33 of the APR grouper (ICD-10 compatible).

5. Readmission Reduction Incentive Program Reporting

All summary reports and case level data for the RRIP program is sent to hospitals via the CRISP Reporting Services (CRS) Portal. Each hospital has a point-of-contact, the Chief Financial Officer or their designee, who is contacted by CRISP to approve requests for access. If you need access to quality reports, please send an email to CRISP Support (support@crisphealth.org) indicating the specific quality programs and whether you need summary reports or case level data.

- Base Period: An Excel workbook with the updated CY 2013 base period rates, CY 2016 improvement goal, updated normative values for calculating expected readmissions, and a data dictionary for the case level files will be sent by email to all persons receiving this memo. We are currently validating the final CY 2013 readmission rates with CRISP and anticipate sending out this workbook by mid-July. Preliminary readmission rates under the RY 2018 methodology are provided in Appendix D.

- Performance Period: All summary reports and case level data will be made available to hospitals/health systems through the CRISP Reporting Services (CRS) portal and ***not*** distributed through Repliweb/email. By mid-July we will have the final revised logic validated and provide the most up-to-date data to hospitals. Preliminary readmission rates under the RY 2018 methodology are provided in Appendix D.

If you have any questions, please email hscrc.quality@maryland.gov or call Dr. Alyson Schuster at 410-764-2673.

Appendix A: Readmission Payment Scale and Penalty/Reward Calculation Steps

RY 2018 RRIP Adjustments

The table below summarizes the scaling points for the improvement and attainment scales. All readmission rates used for the RRIP calculations are case-mix adjusted (this detail is omitted from the table headers).

Hospitals with a 20 percent or larger decline in CY 2016 readmission rates compared to CY 2013 base year rates will receive a positive adjustment of one percent of their inpatient revenue. Hospitals with a 10 percent or larger increase in their readmission rates will receive a negative adjustment of two percent of their inpatient revenue. Hospitals with performance between these two points will receive rewards and penalties based on their performance proportionate with the improvement target. For example, a hospital with 10 percent decline would receive 0.05 percent positive adjustment. A similar point scale is created to calculate rewards and penalties based on attainment rates. Hospitals with CY 2015 Readmission Rate lower than 10.61 percent will receive a positive adjustment of 1 percent inpatient revenue.

The final adjustment amounts are determined by the better of attainment or improvement (Columns C vs Column F).

RY 2018 Scaling Points
Improvement Target: CY 13-CY16 Change =-9.50%
Attainment Benchmark: CY 2016 Readmission Rate=11.85%

Improvement Payment Scale		Attainment Payment Scale	
All-Payer Readmission Rate Change CY13-CY16	RRIP % Inpatient Revenue Payment Adjustment	All Payer Readmission Rate CY16	RRIP % Inpatient Revenue Payment Adjustment
A	C	D	F
Lower	1.00%	Lower	1.00%
-20.0%	1.00%	10.61%	1.00%
-18.0%	0.81%	10.85%	0.81%
-15.0%	0.52%	11.20%	0.52%
-10.0%	0.05%	11.79%	0.05%
-9.5%	0.00%	11.85%	0.00%
-9.0%	-0.05%	11.91%	-0.05%
5.0%	-1.49%	13.57%	-1.49%
9.0%	-1.90%	14.05%	-1.90%
10.0%	-2.00%	14.16%	-2.00%
Higher	-2.00%	Higher	-2.00%

Appendix B: Planned Readmission Logic Changes Version 3 versus Version 4

CMS updated their Planned Readmissions Algorithm effective CY2016.

FUNDAMENTAL PRINCIPLES

1. A few specific, limited types of care are always considered planned (transplant surgery, maintenance chemotherapy/immunotherapy, rehabilitation);
2. Otherwise, a planned readmission is defined as a non-acute readmission for a scheduled procedure; and,
3. Admissions for acute illness or for complications of care are never planned.

LOGIC

1. A procedure is performed that is in one of the procedure categories that are always planned regardless of diagnosis;
2. The principal diagnosis is in one of the diagnosis categories that are always planned; or,
3. A procedure is performed that is in one of the potentially planned procedure categories and the principal diagnosis is not in the list of acute discharge diagnoses.

UPDATES

- Removed 5 CCS Categories
  - AHRQ CCS 47 - Diagnostic cardiac catheterization; coronary arteriography
  - AHRQ CCS 48 - Insertion; revision; replacement; removal of cardiac pacemaker or cardioverter/defibrillator
  - AHRQ CCS 62 - Other diagnostic cardiovascular procedures
  - AHRQ CCS 157 - Amputation of lower extremity
  - AHRQ CCS 169 - Debridement of wound; infection or burn
- Added 1 CCS Category
  - AHRQ CCS 1 - Incision and excision of CNS

EXPECTED IMPACT

Table 3.2.2 – Effect of Planned Readmission Algorithm on HWR Measure (July 2013-June 2014)

	HWR with Planned Readmission Version 3.0	HWR with Planned Readmission Version 4.0
Number of Admissions	6,843,808	6,843,808
Number of Unplanned Readmissions	1,042,729	1,059,655
Unplanned Readmission Rate	15.2%	15.5%
Number of Planned Readmissions	75,436	58,510
Planned Readmission Rate	1.1%	0.9%
% of Readmissions that are Planned	6.7%	5.2%

Tables with additional detail and specific codes needed for programming are available using zip files on the CMS website.

Appendix C: HSCRC CURRENT READMISSIONS MEASURE SPECIFICATIONS

1) Performance Metric

The methodology for the Readmissions Reduction Incentive Program (RRIP) measures performance using the 30-day all-payer all hospital (both intra and inter hospital) readmission rate with adjustments for patient severity (based on discharge all-patient refined diagnosis-related group severity of illness [APR-DRG SOI]) and planned admissions.

The measure is very similar to the readmission rate that will be calculated for the new All-Payer Model with a few exceptions. For comparing Maryland's Medicare readmission rate to the national readmission rate, the Centers for Medicare & Medicaid Services (CMS) will calculate an unadjusted readmission rate for Medicare beneficiaries. Since the Health Services Cost Review Commission (HSCRC) measure is for hospital-specific payment purposes, adjustments had to be made to the metric that accounted for planned admissions and SOI. See below for details on the readmission calculation for the program.

2) Adjustments to Readmission Measurement

The following discharges are removed from the numerator and/or denominator for the readmission rate calculations:

- Planned readmissions are excluded from the numerator based upon the CMS Planned Readmission Algorithm V. 4.0. The HSCRC has also added all vaginal and C-section deliveries and rehabilitation as planned using the APR-DRGs rather than principal diagnosis (APR-DRGs 540, 541, 542, 560, 860). Planned admissions are counted in the denominator because they could have an unplanned readmission.
- Discharges for newborn APR-DRG are removed.
- Oncology cases are removed prior to running readmission logic (APR-DRGs 41, 110, 136, 240, 281, 343, 382, 442, 461, 500, 511, 512, 530, 690, 691, 692, 693, 694, 680, 681).
- Rehabilitation cases as identified by APR-860 (which are coded after under ICD-10 based on type of daily service) are marked as planned admissions and made ineligible for readmission after readmission logic is run.
- Admissions with ungroupable APR-DRGs (955, 956) are not eligible for a readmission but can be a readmission for a previous admission.
- Hospitalizations within 30 days of a hospital discharge where a patient dies is counted as a readmission, however the readmission is removed from the denominator because there cannot be a subsequent readmission.
- Admissions that result in transfers, defined as cases where the discharge date of the admission is on the same or next day as the admission date of the

subsequent admission, are removed from the denominator counts. Thus, only one admission is counted in the denominator and that is the admission to the transfer hospital. It is this discharge date that is used to calculate the 30-day readmission window.

- Discharges from rehabilitation hospitals (provider ids Chesapeake Rehab 213028, Adventist Rehab 213029, and Bowie Health 210333).
- Holy Cross Germantown (attainment only) and Levindale are included in the program; and
- Starting Jan 2016, HSCRC is receiving information about discharges from chronic beds within acute care hospitals with the same data submissions. These discharges are excluded from RRIP for this year.
- In addition, the following data cleaning edits are applied:
    - Cases with null or missing Chesapeake Regional Information System unique patient identifiers (CRISP EIDs) are removed.
    - Duplicates are removed.
    - Negative interval days are removed.

HSCRC staff is revising case-mix data edits to prevent submission of duplicates and negative intervals, which are very rare. In addition, CRISP EID matching benchmarks are closely monitored. Currently, hospitals are required to have 9905 percent of inpatient discharges have a CRISP EID.

3) Details on the Calculation of Case-Mix Adjusted Readmission Rate

Data Source: To calculate readmission rates for RRIP, inpatient abstract/case-mix data with CRISP EIDs (so that patients can be tracked across hospitals) is used for the measurement period plus an extra 30 days. To calculate case-mix adjusted readmission rate for CY 2013 base period and CY 2016 performance period, data from January 1 through December 31, plus 30 days in January of the next year will be used.

SOFTWARE: APR-DRG Version 32 (ICD-9) and Version 33 (ICD-10)

Calculation:

$$\text{Risk-Adjusted Readmission Rate} = \frac{\text{(Observed Readmissions)}}{\text{(Expected Readmissions)}} \times \text{Statewide Readmission Rate}$$

Numerator: Number of observed hospital specific unplanned readmissions.
Denominator: Number of expected hospital specific unplanned readmissions based upon discharge APR-DRG and Severity of Illness. See below for how to calculate

expected readmissions adjusted for APR-DRG SOI.

Risk Adjustment Calculation:

- Calculate the Statewide Readmission Rate without Planned Readmissions.
    - Statewide Readmission Rate = Total number of readmissions with exclusions removed / Total number of hospital discharges with exclusions removed.
- For each hospital, calculate the number of observed unplanned readmissions.
- For each hospital, calculate the number of expected unplanned readmissions based upon discharge APR-DRG SOI (see below for description). For each hospital, cases are removed if the discharge APR-DRG and SOI cells have less than two total cases in the base period data (CY 2013).
- Calculate the ratio of observed (O) readmissions over expected (E) readmissions. A ratio of > 1 means there were more observed readmissions than expected based upon that hospital's case mix. A ratio < 1 means that there were fewer observed readmissions than expected based upon that hospital's case mix.
- Multiply O/E ratio by the statewide rate to get risk-adjusted readmission rate by hospital.

Expected Values:

The expected value of readmissions is the number of readmissions a hospital, given its mix of patients as defined by discharge APR-DRG category and SOI level, would have experienced had its rate of readmissions been identical to that experienced by a reference or normative set of hospitals. Currently, HSCRC is using state average rates as the benchmark.

The technique by which the expected value or expected number of readmissions is calculated is called indirect standardization. For illustrative purposes, assume that every discharge can meet the criteria for having a readmission, a condition called being "at risk" for a readmission. All discharges will either have no readmissions or will have one readmission. The readmission rate is the proportion or percentage of admissions that have a readmission.

The rates of readmissions in the normative database are calculated for each APR-DRG category and its SOI levels by dividing the observed number of readmissions by the total number of discharges. The readmission norm for a single APR-DRG SOI level is calculated as follows:

Let:
N = norm
P = Number of discharges with a readmission
D = Number of discharges that can potentially have a readmission
i = An APR DRG category and a single SOI level

$$N_i = \frac{P_i}{D_i}$$

For this example, this number is displayed as readmissions per discharge to facilitate the calculations in the example. Most reports will display this number as a rate per one thousand.

Once a set of norms has been calculated, they can be applied to each hospital. For this example, the computation is for an individual APR-DRG category and its SOI levels. This computation could be expanded to include multiple APR-DRG categories or any other subset of data, by simply expanding the summations.

Consider the following example for an individual APR DRG category.

Expected Value Computation Example

1 Severity of Illness Level	2 Discharges at Risk for Readmission	3 Discharges with Readmission	4 Readmissions per Discharge	5 Normative Readmissions per Discharge	6 Expected # of Readmissions
1	200	10	.05	.07	14.0
2	150	15	.10	.10	15.0
3	100	10	.10	.15	15.0
4	50	10	.20	.25	12.5
Total	**500**	**45**	**.09**		**56.5**

For the APR-DRG category, the number of discharges with readmission is 45, which is the sum of discharges with readmissions (column 3). The overall rate of readmissions per discharge, 0.09, is calculated by dividing the total number of discharges with a readmission (sum of column 3) by the total number of discharges at risk for readmission (sum of column 2), i.e., 0.09 = 45/500. From the normative population, the proportion of discharges with readmissions for each SOI level for that APR-DRG category is displayed in column 5. The expected number of readmissions for each SOI level shown in column 6 is calculated by multiplying the number of discharges at risk for a readmission (column 2) by the normative readmissions per discharge rate (column 5) The total number of readmissions expected for this APR-DRG category is the expected number of readmissions for the SOI.

In this example, the expected number of readmissions for this APR-DRG category is 56.5, compared to the actual number of discharges with readmissions of 45. Thus, the hospital had 11.5 fewer actual discharges with readmissions than were expected for this APR-DRG category. This difference can also be expressed as a percentage.

APR-DRGs by SOI categories are excluded from the computation of the actual and expected rates when there are only zero or one at risk admission statewide for the associated APR-DRG by SOI category.

Appendix D: Preliminary RY 2018 Case-Mix Adjusted Readmission Rates

Hospital ID	Hospital Name	Case-Mix Adjusted Readmission Rate			
		CY 2013	CY 2013 YTD (April)	CY 2016 YTD (April)	Percent Change
210023	Anne Arundel	12.10%	11.66%	10.26%	-11.99%
210061	Atlantic General	11.91%	12.27%	9.09%	-25.89%
210013	Bon Secours	19.10%	19.70%	13.90%	-29.43%
210039	Calvert	9.82%	10.42%	9.45%	-9.34%
210033	Carroll	12.18%	11.86%	11.14%	-6.06%
210051	Doctors	12.77%	12.59%	11.31%	-10.16%
210005	Frederick	10.60%	10.92%	9.51%	-12.91%
210060	Ft. Washington	13.06%	12.55%	10.14%	-19.19%
210017	Garrett	7.04%	7.01%	5.88%	-16.11%
210044	GBMC	11.19%	11.33%	10.09%	-10.96%
210065	HC-Germantown			9.18%	
210004	Holy Cross	11.32%	11.56%	11.78%	1.85%
210048	Howard County	11.80%	10.55%	10.55%	-0.04%
210029	JH Bayview	15.30%	15.14%	14.25%	-5.85%
210009	Johns Hopkins	14.68%	14.60%	12.86%	-11.93%
210055	Laurel Regional	13.89%	13.39%	11.39%	-14.93%
210064	Levindale	13.67%	12.34%	11.05%	-10.53%
210045	McCready	11.93%	11.69%	14.59%	24.80%
210015	MedStar Fr Square	12.94%	12.94%	11.77%	-9.07%
210056	MedStar Good Sam	14.45%	14.49%	11.94%	-17.59%
210034	MedStar Harbor	13.02%	12.42%	11.55%	-6.98%
210018	MedStar Montgomery	12.44%	12.00%	10.13%	-15.57%
210062	MedStar Southern MD	11.91%	11.78%	10.69%	-9.26%
210028	MedStar St. Mary's	12.69%	12.51%	10.38%	-17.02%
210024	MedStar Union Mem	14.35%	14.28%	11.90%	-16.68%
210008	Mercy	14.61%	14.25%	12.09%	-15.15%
210001	Meritus	11.83%	11.65%	10.78%	-7.47%
210040	Northwest	15.07%	14.99%	12.47%	-16.83%
210019	Peninsula	11.02%	10.69%	9.54%	-10.83%
210003	PG Hospital	10.67%	10.58%	9.67%	-8.55%
210057	Shady Grove	10.89%	11.61%	9.92%	-14.57%
210012	Sinai	14.27%	13.78%	12.05%	-12.55%
210011	St. Agnes	13.86%	13.35%	12.32%	-7.70%
210022	Suburban	11.14%	11.20%	10.76%	-3.93%
210043	UM-BWMC	14.15%	14.17%	12.59%	-11.15%

Hospital ID	Hospital Name	Case-Mix Adjusted Readmission Rate			
		CY 2013	CY 2013 YTD (April)	CY 2016 YTD (April)	Percent Change
210035	UM-Charles Regional	11.79%	11.26%	9.30%	-17.40%
210030	UM-Chestertown	13.20%	13.55%	13.88%	2.42%
210010	UM-Dorchester	11.37%	11.49%	9.69%	-15.67%
210037	UM-Easton	10.56%	10.21%	10.71%	4.87%
210006	UM-Harford	11.53%	12.05%	11.93%	-1.06%
210002	UMMC	14.38%	13.78%	12.74%	-7.57%
210038	UMMC Midtown	16.69%	16.40%	14.85%	-9.44%
210058	UMROI	7.70%	6.00%	7.27%	21.20%
210063	UM-St. Joe	11.76%	11.61%	10.49%	-9.62%
210049	UM-Upper Chesapeake	11.59%	11.26%	11.37%	0.99%
210032	Union of Cecil	9.80%	10.24%	10.80%	5.51%
210016	Washington Adventist	11.33%	11.78%	10.03%	-14.84%
210027	Western Maryland	12.41%	13.55%	10.55%	-22.11%

EXHIBIT 13

RY 2017 Readmission Reduction Incentive Program			Improvement Scaling				Attainment Scaling				Final Adjustment	
HOSPITAL NAME	FY 16 Permanent Inpatient Revenue	Percent Change In Case-mix Adjusted	Target	Over/Under Target	FY 17 Scaling	FY 17 Adjustment	Target (Best % 25 in CY15)	Over/Under Target	FY 17 Scaling	FY 17 Adjustment	FY17 Better of Attainment/Improvement	FY 17 Scaling %
			D	E=C-D	F	G	H	I	J	K		
ANNE ARUNDEL	$291,882,683	-6.62%	-9.3%	2.7%	-0.29%	-$856,386	12.12%	4.2%	-0.46%	-$1,354,253	-$856,386	-0.29%
ATLANTIC GENERAL	$37,750,252	-24.27%	-9.3%	-15.0%	1.00%	$377,503	12.12%	-10.0%	1.00%	$377,503	$377,503	1.00%
BALTIMORE WASHINGTON MEDICAL CENTER	$237,934,932	-8.63%	-9.3%	0.7%	-0.07%	-$173,421	12.12%	16.5%	-1.81%	-$4,295,530	-$173,421	-0.07%
BON SECOURS	$74,789,724	-22.18%	-9.3%	-12.9%	1.00%	$747,897	12.12%	34.4%	-2.00%	-$1,495,794	$747,897	1.00%
CALVERT	$62,336,014	-11.22%	-9.3%	-1.9%	0.22%	$137,271	12.12%	-7.1%	0.82%	$511,094	$511,094	0.82%
CARROLL COUNTY	$136,267,434	-3.01%	-9.3%	6.3%	-0.69%	-$937,201	12.12%	5.7%	-0.62%	-$849,303	-$849,303	-0.62%
CHARLES REGIONAL	$67,052,911	-8.88%	-9.3%	0.4%	-0.05%	-$30,756	12.12%	9.7%	-1.06%	-$710,464	-$30,756	-0.05%
CHESTERTOWN	$21,575,174	-14.07%	-9.3%	-4.8%	0.55%	$118,368	12.12%	12.6%	-1.38%	-$296,956	$118,368	0.55%
DOCTORS COMMUNITY	$132,614,778	-6.47%	-9.3%	2.8%	-0.31%	-$410,140	12.12%	17.2%	-1.87%	-$2,485,928	-$410,140	-0.31%
DORCHESTER	$26,999,062	-6.28%	-9.3%	3.0%	-0.33%	-$89,117	12.12%	10.8%	-1.18%	-$318,231	-$89,117	-0.33%
EASTON	$101,975,577	6.69%	-9.3%	16.0%	-1.75%	-$1,782,013	12.12%	5.0%	-0.55%	-$559,610	-$559,610	-0.55%
FRANKLIN SQUARE	$274,203,013	-7.05%	-9.3%	2.3%	-0.25%	-$675,389	12.12%	9.0%	-0.99%	-$2,709,023	-$675,389	-0.25%
FREDERICK MEMORIAL	$190,413,775	-4.60%	-9.3%	4.7%	-0.51%	-$977,105	12.12%	-5.7%	0.65%	$1,241,139	$1,241,139	0.65%
FT. WASHINGTON	$19,674,774	-16.77%	-9.3%	-7.5%	0.86%	$169,027	12.12%	24.5%	-2.00%	-$393,495	$169,027	0.86%
G.B.M.C.	$207,515,795	-4.61%	-9.3%	4.7%	-0.51%	-$1,064,485	12.12%	-3.6%	0.42%	$862,993	$862,993	0.42%
GARRETT COUNTY	$19,149,148	-1.29%	-9.3%	8.0%	-0.88%	-$167,557	12.12%	-19.7%	1.00%	$191,491	$191,491	1.00%
GOOD SAMARITAN	$160,795,606	-10.67%	-9.3%	-1.4%	0.16%	$253,081	12.12%	12.3%	-1.34%	-$2,160,914	$253,081	0.16%
HARBOR	$113,244,592	0.36%	-9.3%	9.7%	-1.06%	-$1,195,307	12.12%	17.0%	-1.85%	-$2,100,202	-$1,195,307	-1.06%
HARFORD	$45,713,956	-11.01%	-9.3%	-1.7%	0.20%	$90,002	12.12%	-7.2%	0.82%	$375,722	$375,722	0.82%
HOLY CROSS	$316,970,825	1.05%	-9.3%	10.4%	-1.13%	-$3,585,730	12.12%	12.3%	-1.34%	-$4,255,157	-$3,585,730	-1.13%
HOPKINS BAYVIEW MED CTR	$343,229,718	-8.26%	-9.3%	1.0%	-0.11%	-$391,289	12.12%	26.2%	-2.00%	-$6,864,594	-$391,289	-0.11%
HOWARD COUNTY	$165,683,744	-1.01%	-9.3%	8.3%	-0.91%	-$1,501,802	12.12%	7.2%	-0.79%	-$1,305,876	-$1,305,876	-0.79%
JOHNS HOPKINS	$1,244,297,900	-6.02%	-9.3%	3.3%	-0.36%	-$4,455,925	12.12%	27.5%	-2.00%	-$24,885,958	-$4,455,925	-0.36%
LAUREL REGIONAL	$60,431,106	-2.16%	-9.3%	7.1%	-0.78%	-$471,514	12.12%	23.6%	-2.00%	-$1,208,622	-$471,514	-0.78%
MCCREADY	$2,815,158	-18.31%	-9.3%	-9.0%	1.00%	$28,152	12.12%	-12.1%	1.00%	$28,152	$28,152	1.00%
MERCY	$214,208,592	-16.73%	-9.3%	-7.4%	0.85%	$1,829,580	12.12%	10.3%	-1.12%	-$2,406,100	$1,829,580	0.85%
MERITUS	$190,659,648	2.70%	-9.3%	12.0%	-1.31%	-$2,499,678	12.12%	11.4%	-1.24%	-$2,373,364	-$2,373,364	-1.24%
MONTGOMERY GENERAL	$75,687,627	-7.80%	-9.3%	1.5%	-0.16%	-$124,483	12.12%	5.8%	-0.63%	-$477,301	-$124,483	-0.16%

RY 2017 Readmission Reduction Incentive Program

HOSPITAL NAME	FY 16 Permanent Inpatient Revenue	Percent Change In Case-mix Adjusted	Improvement Scaling				Attainment Scaling				Final Adjustment	
			Target	Over/Under Target	FY 17 Scaling	FY 17 Adjustment	Target (Best % 25 in CY15)	Over/Under Target	FY 17 Scaling	FY 17 Adjustment	FY17 Better of Attainment/Improvement	FY 17 Scaling %
			D	E=C-D	F	G	H	I	J	K		
NORTHWEST	$114,214,371	-16.38%	-9.3%	-7.1%	0.81%	$928,955	12.12%	12.5%	-1.36%	-$1,558,385	$928,955	0.81%
PENINSULA REGIONAL	$242,318,199	-3.19%	-9.3%	6.1%	-0.67%	-$1,619,362	12.12%	0.0%	0.00%	-$12,085	-$12,085	0.00%
PRINCE GEORGE	$220,306,426	6.23%	-9.3%	15.5%	-1.70%	-$3,738,798	12.12%	23.9%	-2.00%	-$4,406,129	-$3,738,798	-1.70%
REHAB & ORTHO	$64,134,443	-2.16%	-9.3%	7.1%	-0.78%	-$80,018	12.12%	-21.7%	1.00%	$102,615	$102,615	0.16%
SHADY GROVE	$220,608,397	-4.12%	-9.3%	5.2%	-0.57%	-$1,248,641	12.12%	-0.1%	0.02%	$34,713	$34,713	0.02%
SINAI	$415,350,729	-11.94%	-9.3%	-2.6%	0.30%	$1,261,452	12.12%	11.8%	-1.29%	-$5,356,564	$1,261,452	0.30%
SOUTHERN MARYLAND	$156,564,761	-3.60%	-9.3%	5.7%	-0.62%	-$974,946	12.12%	26.7%	-2.00%	-$3,131,295	-$974,946	-0.62%
ST. AGNES	$232,266,274	-8.98%	-9.3%	0.3%	-0.04%	-$82,444	12.12%	12.6%	-1.38%	-$3,199,462	-$82,444	-0.04%
ST. MARY	$69,169,248	-13.10%	-9.3%	-3.8%	0.44%	$302,515	12.12%	6.3%	-0.69%	-$478,252	$302,515	0.44%
SUBURBAN	$193,176,044	-5.02%	-9.3%	4.3%	-0.47%	-$903,478	12.12%	5.8%	-0.63%	-$1,226,246	-$903,478	-0.47%
UM ST. JOSEPH	$234,223,274	-9.85%	-9.3%	-0.6%	0.06%	$148,146	12.12%	-4.3%	0.49%	$1,146,807	$1,146,807	0.49%
UMMC MIDTOWN	$126,399,313	-7.84%	-9.3%	1.5%	-0.16%	-$202,322	12.12%	36.9%	-2.00%	-$2,527,986	-$202,322	-0.16%
UNION HOSPITAL OF CECIL COUNT	$69,389,876	17.34%	-9.3%	26.6%	-2.00%	-$1,387,798	12.12%	26.6%	-2.00%	-$1,387,798	-$1,387,798	-2.00%
UNION MEMORIAL	$238,195,335	-16.33%	-9.3%	-7.0%	0.81%	$1,924,508	12.12%	6.6%	-0.72%	-$1,708,986	$1,924,508	0.81%
UNIVERSITY OF MARYLAND	$906,034,034	-8.43%	-9.3%	0.9%	-0.09%	-$860,116	12.12%	19.9%	-2.00%	-$18,120,681	-$860,116	-0.09%
UPPER CHESAPEAKE HEALTH	$135,939,076	-7.32%	-9.3%	2.0%	-0.22%	-$294,598	12.12%	-1.5%	0.18%	$238,931	$238,931	0.18%
WASHINGTON ADVENTIST	$155,199,154	1.65%	-9.3%	10.9%	-1.20%	-$1,857,099	12.12%	15.9%	-1.73%	-$2,689,949	-$1,857,099	-1.20%
WESTERN MARYLAND HEALTH SYSTEM	$167,618,972	-2.51%	-9.3%	6.8%	-0.74%	-$1,244,301	12.12%	14.2%	-1.55%	-$2,593,274	-$1,244,301	-0.74%
STATE	**$8,796,981,441**	**-7.13%**	**-9.3%**			**-$27,566,763**				**-$106,792,606**	**-$16,164,453**	
Total Penalties Statewide						-$35,883,218				-$111,903,766	-$28,810,995	
% Inpatient						0.00%				0.00%	0.00%	
Total Rewards Statewide						$8,316,456				$5,111,159	$12,646,542	
% Inpatient						0.00%				0.00%	0.00%	

Rehab and Ortho Revenue is adjusted to 16% of total FY 16 Permanent Inpatient Revenue

Percentages have been rounded for display. Final numbers are calculated using full values.

RY 2017 Readmission Reduction Incentive Program

HOSPITAL NAME	FY 16 Permanent Inpatient Revenue	CY13			CY 15			Percent Change In Case-mix Adjusted Rate
		YTD Case-mix Adjusted Readmission Rate	Total /Instate Medicare Readmission Rate	Case-mix Adjusted Rate With Out Of State Adjust	Case-mix Adjusted Rate	Total /Instate Medicare Readmission Rate	Case-mix Adjusted Rate With Out Of State Adjust	
ANNE ARUNDEL	$291,882,683	13.00%	1.03	13.37%	12.14%	1.04	12.64%	-6.62%
ATLANTIC GENERAL	$37,750,252	13.02%	1.09	14.15%	9.86%	1.11	10.91%	-24.27%
BALTIMORE WASHINGT	$237,934,932	15.29%	1.01	15.52%	13.97%	1.01	14.12%	-8.63%
BON SECOURS	$74,789,724	20.47%	1.01	20.69%	15.93%	1.02	16.29%	-22.18%
CALVERT	$62,336,014	10.61%	1.13	12.02%	9.42%	1.19	11.26%	-11.22%
CARROLL COUNTY	$136,267,434	12.97%	1.02	13.20%	12.58%	1.02	12.81%	-3.01%
CHARLES REGIONAL	$67,052,911	12.95%	1.10	14.19%	11.80%	1.13	13.30%	-8.88%
CHESTERTOWN	$21,575,174	14.78%	1.05	15.51%	12.70%	1.07	13.65%	-14.07%
DOCTORS COMMUNITY	$132,614,778	13.91%	1.06	14.70%	13.01%	1.09	14.20%	-6.47%
DORCHESTER	$26,999,062	12.58%	1.14	14.38%	11.79%	1.14	13.43%	-6.28%
EASTON	$101,975,577	11.66%	1.03	11.96%	12.44%	1.02	12.73%	6.69%
FRANKLIN SQUARE	$274,203,013	14.05%	1.00	14.12%	13.06%	1.01	13.22%	-7.05%
FREDERICK MEMORIAL	$190,413,775	11.51%	1.04	11.97%	10.98%	1.04	11.43%	-4.60%
FT. WASHINGTON	$19,674,774	13.95%	1.28	17.84%	11.61%	1.30	15.09%	-16.77%
G.B.M.C.	$207,515,795	11.94%	1.01	12.09%	11.39%	1.03	11.68%	-4.61%
GARRETT COUNTY	$19,149,148	7.73%	1.38	10.65%	7.63%	1.28	9.73%	-1.29%
GOOD SAMARITAN	$160,795,606	15.09%	1.01	15.17%	13.48%	1.01	13.61%	-10.67%
HARBOR	$113,244,592	13.97%	1.01	14.10%	14.02%	1.01	14.18%	0.36%
HARFORD	$45,713,956	12.44%	1.03	12.86%	11.07%	1.02	11.25%	-11.01%
HOLY CROSS	$316,970,825	12.37%	1.09	13.49%	12.50%	1.09	13.61%	1.05%
HOPKINS BAYVIEW MED	$343,229,718	16.35%	1.02	16.65%	15.00%	1.02	15.30%	-8.26%
HOWARD COUNTY	$165,683,744	12.92%	1.02	13.12%	12.79%	1.02	13.00%	-1.01%
JOHNS HOPKINS	$1,244,297,900	15.44%	1.08	16.60%	14.51%	1.07	15.45%	-6.02%
LAUREL REGIONAL	$60,431,106	14.81%	1.06	15.71%	14.49%	1.03	14.98%	-2.16%
MCCREADY	$2,815,158	13.05%	1.00	13.05%	10.66%	1.00	10.66%	-18.31%
MERCY	$214,208,592	15.60%	1.03	16.09%	12.99%	1.03	13.37%	-16.73%
MERITUS	$190,659,648	12.61%	1.05	13.27%	12.95%	1.04	13.50%	2.70%
MONTGOMERY GENERA	$75,687,627	13.47%	1.05	14.15%	12.42%	1.03	12.82%	-7.80%
NORTHWEST	$114,214,371	16.06%	1.00	16.13%	13.43%	1.02	13.63%	-16.38%
PENINSULA REGIONAL	$242,318,199	11.93%	1.07	12.73%	11.55%	1.05	12.13%	-3.19%
PRINCE GEORGE	$220,306,426	11.56%	1.26	14.56%	12.28%	1.22	15.02%	6.23%
REHAB & ORTHO	$64,134,443	9.70%	1.00	9.70%	9.49%	1.00	9.49%	-2.16%
SHADY GROVE	$220,608,397	11.89%	1.06	12.63%	11.40%	1.06	12.10%	-4.12%
SINAI	$415,350,729	15.24%	1.01	15.33%	13.42%	1.01	13.55%	-11.94%
SOUTHERN MARYLAND	$156,564,761	12.77%	1.21	15.42%	12.31%	1.25	15.35%	-3.60%
ST. AGNES	$232,266,274	14.93%	1.01	15.03%	13.59%	1.00	13.65%	-8.98%
ST. MARY	$69,169,248	13.43%	1.11	14.96%	11.67%	1.10	12.89%	-13.10%
SUBURBAN	$193,176,044	12.15%	1.07	13.06%	11.54%	1.11	12.83%	-5.02%
UM ST. JOSEPH	$234,223,274	12.69%	1.01	12.83%	11.44%	1.01	11.60%	-9.85%
UMMC MIDTOWN	$126,399,313	17.74%	1.01	17.86%	16.35%	1.02	16.60%	-7.84%
UNION HOSPITAL OF CE	$69,389,876	10.90%	1.16	12.61%	12.79%	1.20	15.35%	17.34%
UNION MEMORIAL	$238,195,335	15.31%	1.01	15.43%	12.81%	1.01	12.92%	-16.33%
UNIVERSITY OF MARYL	$906,034,034	15.30%	1.05	15.99%	14.01%	1.04	14.53%	-8.43%
UPPER CHESAPEAKE HE	$135,939,076	12.71%	1.01	12.87%	11.78%	1.01	11.94%	-7.32%
WASHINGTON ADVENTI	$155,199,154	12.13%	1.14	13.86%	12.33%	1.14	14.04%	1.65%
WESTERN MARYLAND H	$167,618,972	13.16%	1.07	14.14%	12.83%	1.08	13.84%	-2.51%
STATE	**$8,796,981,441**	**13.89%**			**12.90%**			**-7.13%**
					Benchmark		12.12%	

Rehab and Ortho Revenue is adjusted to 16% of total FY 16 Permanent Inpatient Revenue

Percentages have been rounded for display. Final numbers are calculated using full values.

EXHIBIT 14

FINAL Recommendations for the Aggregate Revenue Amount At-Risk under Maryland Hospital Quality Programs for Rate Year 2018

June 8, 2016

Health Services Cost Review Commission
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These final recommendations were approved by the commission on June 8, 2016.

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LIST OF ABBREVIATIONS

CMS	Centers for Medicare & Medicaid Services
CY	Calendar year
FFY	Federal fiscal year
FY	State fiscal year
HSCRC Health	Services Cost Review Commission
MHAC	Maryland Hospital-Acquired Conditions Program
PAU	Potentially avoidable utilization
PQI	Prevention quality indicator
QBR	Quality-based reimbursement
RRIP	Readmissions Reduction Incentive Program
RY	State rate year
VBP	Value-based purchasing

INTRODUCTION

The Maryland Health Services Cost Review Commission's (HSCRC's or Commission's) quality-based payment methodologies are important policy tools with great potential to provide strong incentives for hospitals to improve their quality performance over time. These quality-based payment programs hold amounts of hospital revenue at risk directly related to specified performance benchmarks. Maryland's Quality-Based Reimbursement (QBR) program employs measures that are similar to those in the federal Medicare Value-Based Purchasing (VBP) program. Because of its long-standing Medicare waiver for its all-payer hospital rate-setting system, special considerations were given to Maryland, including exemption from the federal Medicare quality-based programs. Instead, the HSCRC implements various Maryland-specific quality-based payment programs, which are discussed in further detail in the background section of this report.

Maryland entered into a new All-Payer Model Agreement with the Centers for Medicare & Medicaid Services (CMS) on January 1, 2014. One of the requirements under this new agreement is that the proportion of hospital revenue that is held at risk under Maryland's quality-based payment programs must be greater than or equal to the proportion that is held at risk under national Medicare quality programs. The Model Agreement also requires Maryland to achieve specific reduction targets in potentially preventable conditions and readmissions, in addition to the revenue at risk requirement. In an effort to meet these reduction targets, Maryland restructured its quality programs in such a way that financial incentives are established prior to the performance period in order to motivate quality improvement and the sharing of best practices while holding hospitals accountable for their performance.

The purpose of this report is to make recommendations for the amount of revenue that should be held at risk for rate year (RY) 2018. Except for some QBR measures that are based on CMS timelines, the performance year for Maryland's quality-based payments is a calendar year. The base year from which the improvement is calculated is the state fiscal year, and the adjustments are applied in the following rate year. For RY 2018, which starts in July 2017, the performance year is calendar year (CY) 2016, and base year is state fiscal year (FY) 2015. The timeline for the RY 2018 aggregate at risk recommendation was postponed to align with the RY 2018 Readmissions Reduction Incentive Program (RRIP) recommendations. Final recommendations for both policies may require alignment with the updated Shared Savings Policy to estimate the overall impact of all programs in tandem including shared savings adjustments, as staff is contemplating revisions to the shared savings policy.

BACKGROUND

1. Federal Quality Programs

Maryland's amount of revenue at risk for quality-based payment programs is compared against the amount at risk for the following national Medicare quality programs:

- The Medicare Hospital Readmissions Reduction Program, which reduces payments to inpatient prospective payment system hospitals with excess readmissions.[1]
- The Medicare Hospital-Acquired Condition Reduction Program, which ranks hospitals according to performance on a list of hospital-acquired condition quality measures and reduces Medicare payments to the hospitals in the lowest performing quartile.[2]
- The Medicare VBP program, which adjusts hospitals' payments based on their performance on the following four hospital quality domains: clinical care, patient experience of care, outcomes, and efficiency.[3]

Across these programs, 5.75 percent of inpatient revenue was at risk for federal fiscal year (FFY) 2016 and 6.0 percent in FFY 2017.

2. Maryland's Quality-Based Programs

As discussed in the introduction section of this report, Maryland is exempt from the federal Medicare hospital quality programs. Instead, Maryland implements the following quality-based payment programs:

- The QBR program employs measures in several domains, including clinical care, patient experience, outcomes, and patient safety. Since the beginning of the program, financial adjustments have been based on revenue neutral scaling of hospitals in allocating rewards and reductions based on performance, with the net increases in rates for better performing hospitals funded by net decreases in rates for poorer performing hospitals.[4] The distribution of rewards/penalties has been based on relative points achieved by the hospitals and were not known before the end of performance period. Starting in FY 2017, the QBR program revenue neutrality requirement was removed from the program, and payment adjustments were linked to a point-based scale (i.e., present payment scale) instead of relatively ranking hospitals, all of which was designed to provide hospitals with more predictable revenue adjustments based on their performance.

[1] For more information on the Medicare Hospital Readmissions Reduction Program, see https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html.
[2] For more information on the Medicare Hospital-Acquired Condition Reduction program, see https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/HAC-Reduction-Program.html.
[3] For information on the Medicare VBP program, see https://www.medicare.gov/hospitalcompare/Data/hospital-vbp.html.
[4] The term "scaling" refers to the differential allocation of a pre-determined portion of base regulated hospital revenue contingent on the assessment of the relative quality of hospital performance. The rewards (positive scaled amounts) or reductions (negative scaled amounts) are then applied to each hospital's revenue on a "one-time" basis (and not considered permanent revenue).

- The Maryland Hospital Acquired Conditions (MHAC) program measures hospital performance using 3M's potentially preventable complications. HSCRC calculates observed-to-expected ratios for each complication and compares them with statewide benchmarks and thresholds. This program was modified substantially in the CY 2014 performance period to align with the All-Payer Model Agreement. Revenue adjustments are determined using a preset payment scale. The revenue at risk and reward structure is based on a tiered approach that requires statewide targets to be met for higher rewards and lower reductions.
- Up to and including rate year 2016, the RRIP establishes a readmissions reduction target and rewards/penalties for hospitals. The statewide minimum improvement target is established to eliminate the gap between the national Medicare readmission rate and the Maryland Medicare readmission rate.
- In addition to the three programs described above, two additional quality-based payment adjustments are implemented to hospital revenues prospectively. The Readmission Shared Savings Program reduces each hospital's approved revenues prospectively based on its case-mix adjusted readmission rates. Potentially avoidable utilization (PAU) efficiency reductions are applied to global budgets to reduce allowed volume growth based on the percentage of revenue associated with PAU for each hospital. These adjustments are considered within the context of the update factor discussions, and measurement periods are based on a previous calendar year. For FY 2017, the measurement period will be based on the CY 2015 period.

The Commission approved the following amounts of inpatient revenue to be held at-risk for rate year 2016:

- QBR– A maximum penalty of 1.00 percent of inpatient revenue, with revenue-neutral scaled rewards up to 1.00 percent.
- MHAC– A maximum penalty of 4.00 percent of inpatient revenue if the statewide improvement target is not met; a 1.00 percent maximum penalty and rewards up to 1.00 percent if the statewide improvement target is met.
- RRIP– A reward of 0.50 percent of inpatient revenue for any hospital that improves its all-payer readmission rate by at least 6.76 percent.
- Readmission Shared Savings- An average reduction of 0.60 percent of total hospital revenue.

The Commission approved the following amounts to be held at-risk for RY 2017:

- QBR– A maximum penalty of 2.00 percent of inpatient revenue, with rewards scaled up to a maximum of 1.00 percent.
- MHAC– A maximum penalty of 3.00 percent of inpatient revenue if the statewide improvement target is not met; a 1.00 percent maximum penalty and rewards up to 1.00 percent if the statewide improvement target is met.

- RRIP– A maximum penalty of 2.00 percent of inpatient revenue, and a 1.00 percent maximum reward for hospitals that reduce readmission rates at or better than the minimum improvement target.
- Maximum penalty guardrail– A maximum penalty guardrail of 3.50 percent of total hospital revenue. This means, for example, that a hospital that received the maximum penalty for all three quality-based payment programs would have a maximum penalty of 7.00 percent inpatient revenue, which is equal to 4.20 percent of total hospital revenue. Staff used the Medicare aggregate amount at risk total as the benchmark for calculating the hospital maximum penalty guardrail (e.g. 6 percent * 58 percent of inpatient revenue).

ASSESSMENT

In order to develop the amount of revenue at risk for RY 2018, HSCRC staff consulted with CMS, conducted analyses, and solicited input from the Performance Measurement Workgroup.[5] During its January meeting, the Performance Measurement Workgroup reviewed (1) data comparing the amount of revenue at risk in Maryland with the national Medicare programs, and (2) staff's proposal for the amount at risk for RY 2018.

MHA's letter of 5/25/16 with comments on the May 2016 draft updated policies for the Readmission Reduction Incentive Program, Potentially Avoidable Utilization (PAU) Savings Program, and on Aggregate Revenue Amount at Risk for Hospital Quality Programs is provided in a separate attachment file entitled: ***Attachment I_ RRIP_PAU Shared Savings_Aggregate at Risk_2016.05.25_MHA HSCRC Letter Quality for FY2018_attachments.pdf.***

Aggregate Revenue At-Risk Comparison with Medicare Programs

After discussions with CMS, HSCRC staff performed analyses of both "potential" and "realized" revenue at risk. Potential revenue at risk refers to the maximum amount of revenue that is at risk in the measurement year. Realized risk refers to the actual amounts imposed by the programs. The comparison with the national amounts is calculated on a cumulative basis. Figure 1 compares the potential amount of revenue at risk in Maryland with the amount at risk in the national programs. The difference between the national Medicare and Maryland all-payer annual amounts are summed after each year's experience to compare the cumulative difference over the Model agreement term.

The top half of Figure 1 displays the percentage of potential inpatient revenue at risk in Maryland for all payers for each of Maryland's quality-based payment programs for rate years

[5] For more information on the Performance Measurement Workgroup, see http://www.hscrc.state.md.us/hscrc-workgroup-performance-measurement.cfm.

2014 through 2017. The bottom half of the figure displays the percentage of potential national Medicare inpatient revenue at risk for quality-based payment programs for FFYs 2014 through 2017. Due to efforts to align Maryland's quality-based payment programs with the national programs and the increasing emphasis on value-based payment adjustments, Maryland exceeded the national aggregate maximum at risk amounts in both RYs 2016 and 2017. Cumulatively, Maryland's maximum at risk total would be 8.49 percent higher than the nation in FFY 2017.

Figure 1. Potential Revenue at Risk for Quality-Based Payment Programs, Maryland Compared with the National Medicare Programs, 2014-2017

% of MD All Payer Inpatient Revenue	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
MHAC	2.00%	3.00%	4.00%	3.00%
RRIP			0.50%	2.00%
QBR	0.50%	0.50%	1.00%	2.00%
Shared Savings	0.41%	0.86%	1.35%	*4.30%**
GBR PAU	0.50%	0.86%	1.10%	*1.12%*
MD Aggregate Maximum At Risk	3.41%	5.22%	7.95%	12.41%

*Subject to change based on RY 2017 policy, which is to be finalized at June 2016 Commission meeting. Net Shared Savings Maximum penalty is 3.52 %.

Medicare National - Potential Inpatient Revenue at Risk Absolute Values

% of National Medicare Inpatient Revenue	**FFY 2014**	**FFY 2015**	**FFY2016**	**FFY2017**
HAC		1.00%	1.00%	1.00%
Readmissions	2.00%	3.00%	3.00%	3.00%
VBP	1.25%	1.50%	1.75%	2.00%
Medicare Aggregate Maximum At Risk	3.25%	5.50%	5.75%	6.00%
Cumulative MD-Medicare National Difference	**0.16%**	**-0.12%**	**2.08%**	**8.49%**

As Maryland's programs moved away from revenue neutral rewards and penalties and toward payment adjustments based on preset payment scales, the actual amounts imposed in quality-based programs differ from the maximum amounts established in the policies. For example, the maximum penalty is set to the lowest attainment score in the base year measurement. As hospitals improve their scores during the performance year, none of the hospitals may be subject to the maximum penalty when the payment adjustments are implemented. On the other hand, the national Medicare programs may make payment adjustments only to the lowest performing hospitals, limiting the reach of the performance-based adjustments. CMMI and HSCRC staff worked on a methodology to compare the total actual payment adjustments by summing the absolute average payment adjustments across all programs, namely aggregate realized at risk. Maryland is expected to meet or exceed both the potential and realized at risk amounts of the national Medicare programs. Figure 2 provides average adjustment amount comparison between Maryland and national programs. The overall aggregate average adjustments was 1.95 percent of the total inpatient revenue in FY2016, compared to 1.14 percent in the Medicare programs in

FY 2016. Based on the current recommendations, Maryland adjustments will go up to 4.31 percent as a result of higher PAU savings adjustments in RY 2017.

Figure 2. Realized Revenue at Risk for Quality-Based Payment Programs, Maryland Compared with the National Medicare Programs, 2014-2017

Maryland

% All Payer Inpatient Revenue	SFY 2014	SFY 2015	SFY 2016	SFY 2017
MHAC	0.22%	0.11%	0.18%	0.61%
RRIP			0.15%	0.42%
QBR	0.11%	0.14%	0.30%	0.51%
PAU Savings	0.29%	0.64%	0.93%	2.46%
GBR PAU:	0.28%	0.33%	0.39%	0.34%
MD Aggregate Maximum At Risk	**0.90%**	**1.22%**	**1.95%**	**4.31%**

Medicare National

% Medicare Inpatient Revenue	FFY 2014	FFY 2015	FFY2016	FFY2017*Estimated
HAC		0.22%	0.23%	0.23%
Readmits	0.28%	0.52%	0.51%	0.51%
VBP	0.20%	0.24%	0.40%	0.40%
Medicare Aggregate Maximum At Risk	**0.47%**	**0.97%**	**1.14%**	**1.14%**
Cumulative MD-US Difference	**0.43%**	**0.68%**	**1.49%**	**4.66%**

Figure 3 summarizes the statewide totals and average payment adjustments for Maryland hospitals for RY 2016. The first five blue columns display the results for each of the quality-based payment programs. The sixth blue column displays the aggregate amount of revenue at risk, summed across all five programs. The final blue column, "Net Adjustment Across all

Programs," represents the maximum penalty and reward for an individual hospital (rows 2 and 3) and the average absolute adjustments across all hospitals (row 4). The final row shows the total net adjustments, accounting for both penalties and rewards. While aggregate potential amount at risk was at 7.76 percent, the sum of average adjustments across all programs was 1.95 percent of inpatient revenue, which is higher than the estimated CMS rate of 1.01 percent. When we sum penalties and rewards across the hospital, the maximum penalty and reward received by one hospital was 1.95 percent, and 1.09 percent respectively. In RY 2016, the total net adjustments were $38.3 million, with $68.3 million in total penalties and $29.9 million in total rewards. When summarized at the hospital level, one hospital received a reduction of 1.95 percent of inpatient revenue across all the programs. The maximum reward received across all programs was 1.09 percent of hospital inpatient revenue.

Figure 3. Actual Revenue Adjustments and Potential at Risk Percent Inpatient Revenue for Maryland's Quality-Based Payment Programs, RY 2016

	MHAC	RRIP	QBR	Shared Savings	PAU	Aggregate (Sum of All Programs)	Net Hospital Adjustment Across all Programs
Potential At Risk (Absolute Value)	4.00%	0.50%	1.00%	1.16%	1.10%	7.76%	
Maximum Hospital Penalty	-0.21%	NA	-1.00%	-0.29%	-1.10%	-2.59%	-1.95%
Maximum Hospital Reward	1.00%	0.50%	0.73%	NA	NA	2.23%	1.09%
Average Absolute Level Adjustment	**0.18%**	**0.15%**	**0.30%**	**0.93%**	**0.39%**	**1.95%**	**0.70%**
Total Penalty	-$1,080,406	NA	-$12,880,046	-$27,482,838	-$26,900,004	-$68,343,293	
Total Reward	$7,869,585	$9,233,884	$12,880,046	NA	NA	$29,983,515	
Total Net Adjustments	**$6,789,180**	**$9,233,884**	**$0**	**-$27,482,838**	**-$26,900,004**	**-$38,359,778**	

Figure 4 summarizes preliminary statewide totals and average payment adjustments for Maryland hospitals for RY 2017 for the MHAC, RRIP, shared savings, and QBR programs. Figure 4 follows the same format as Figure 3. Reflecting higher amounts at risk approved for RRIP and QBR approved by the Commission for RY 2017 and staff proposal to increase the shared savings amount to 1.25 percent of total revenue, the aggregate maximum potential penalty is 12.41 percent. Year-to-date actual adjustment calculations for QBR is based on first six months of data update. MHAC and RRIP calculations are final reflecting corrections for the ICD-10 and updated FY 2016 permanent. The sum of average payment adjustments across all programs is 4.31 percent of inpatient revenue. On a hospital specific basis, the maximum reduction received by a single hospital is 2.52 percent of total revenue, and the maximum reward is 1.02 percent. On a statewide basis, the total impact of performance-based adjustments is -1.15 percent of the state total revenue (based on net PAU savings the net impact of is -0.54 percent).

Figure 4. Actual Revenue at Risk for Maryland's Quality-Based Payment Programs, RY 2017 Year-to-Date

	MHAC	RRIP	QBR***	PAU Savings***	Net PAU Savings***	Demographic Adjustment	State Aggregate	Hospital Net Impact % Total Revenue
	A	B	C	D	E	F	G=Sum(A-D and F)	
Potential At Risk (Absolute Value)	3.00%	2.00%	2.00%	4.30%	3.45%	1.12%	12.41%	
Maximum Hospital Penalty (% Inpatient Revenue)	-0.25%	-2.00%	-1.78%	-4.30%	-3.45%	-1.12%	-9.44%	-2.52%
Maximum Hospital Reward (% Inpatient Revenue)	1.00%	1.00%	1.00%	NA	NA	NA	3.00%	1.02%
Average Absolute Level Adjustment (% Inpatient Revenue)	0.42%	0.61%	0.51%	2.43%	1.50%	0.34%	4.31%	0.64%
Total Penalty	-$647,766	-$28,953,933	-$4,815,695	-$194,198,835	-$102,899,143	-$25,863,479	-$254,479,708	
Total Reward	$29,904,456	$12,946,597	$33,855,819	$0	$285,060	$0	$76,706,871	
Total Net Adjustments	$29,256,690	-$16,007,336	$29,040,124	-$194,198,835	$(100,678,086)	-$25,863,479	-$177,772,836	
% Total Revenue	0.19%	-0.10%	0.19%	-1.25%	-0.65%	-0.17%	-1.15%	

*Calculations are updated based on ICD-10 Correction for Rehab cases and updated Permanent Revenues for FY2016
**RRIP results reflect the proposed adjustments for FY2017 policy.
***QBR year-to-date results are preliminary estimates based on two quarters of new data due to data lag for measures from CMS. Staff will provide updated calculations for the final recommendation.
****Shared Savings are based on a 1.25 percent statewide reduction with protections for high socio-economic burden based on the final FY2017 recommendation.

In summary, Maryland outperformed the national programs in both the scope of the measurements and in the aggregate payment amounts at risk. Maryland hospitals improved their performance in reducing complications and more recently in improving readmissions. All-Payer Model financial success will depend on further reductions in PAU, and staff intends to shift more focus on potentially avoidable admissions in quality-based payment programs in the future and reduce penalties other areas. Staff will continue to discuss the appropriate amounts for quality-based payment programs with the Performance Measurement and Payment Models Workgroups.

See Appendix I for hospital-level results.

Maximum Revenue at Risk Hospital Guardrail

As the HSCRC increases the maximum revenue adjustments statewide, the potential for a particular hospital to receive large revenue reductions that may cause unmanageable financial risk has raised concerns. As hospitals improve quality in the state, the variation between individual hospitals is expected to decline, increasing the chances of a single hospital receiving the maximum penalties from all programs. Similar to the risk corridors in other VBP programs, a maximum penalty guardrail may be necessary to mitigate the detrimental financial impact of unforeseen large adjustments in Maryland programs. Given the increases in risk levels in other programs, a hospital-specific guardrail will provide better protection than a statewide limit. In RY 2017, the hospital maximum penalty guardrail was set at 3.50 percent of total hospital revenue.

RECOMMENDATION

Based on this assessment, HSCRC staff recommends the following maximum penalties and rewards for the QBR, MHAC and RRIP programs for RY 2018:

1. QBR: The maximum penalty should be 2.00 percent, while the maximum reward should be 1.00 percent.

   The maximum penalty matches the penalty in Medicare's VBP program and increases the incentive for hospitals to improve their Hospital Consumer Assessment of Healthcare Providers and Systems survey scores, which continue to be low compared with the nation.

2. MHAC: There should be a 3.00 percent maximum penalty if the statewide improvement target is not met; there should be a 1.00 percent maximum penalty and a reward up to 1.00 percent if the statewide improvement target is met.

3. RRIP: The maximum penalty should be 2.00 percent, and the reward should be 1.00 percent for hospitals that reduce readmission rates at or better than the minimum improvement.

4. Maximum penalty guardrail: The hospital maximum penalty guardrail should continue to be set at 3.50 percent of total hospital revenue.

5. The quality adjustments should be applied to inpatient revenue centers, similar to the approach used by CMS. HSCRC staff can apply the adjustments to hospitals' medical surgical rates to concentrate the impact of this adjustment on inpatient revenue, consistent with federal policies.

APPENDIX I. RY 2016 HOSPITAL-LEVEL SCALING RESULTS FOR QUALITY-BASED PAYMENT PROGRAMS

Appendix 1 contains the following figures for rate year 2016:

1. The consolidated revenue adjustments across all quality-based payment programs, by hospital
2. The adjustments for the quality-based reimbursement (QBR) program, by hospital
3. The adjustments for the Readmission Reduction Incentive Program (RRIP), by hospital
4. The adjustments for the Maryland Hospital-Acquired Conditions (MHAC) program, by hospital

Figure 1. Consolidated Adjustments for All Quality-Based Payment Programs for Rate Year 2016, by Hospital

Hospital Name	FY 2015 Permanent Inpatient Revenue	MHAC % Revenue Adjustment	RRIP % Revenue Adjustment	QBR % Revenue Adjustment	NET Shared Savings % Revenue Adjustment	PAU % Revenue Adjustment	Net Impact %	Net Impact $
SOUTHERN MARYLAND	$161,253,766	-0.21%	0.00%	-0.51%	-0.31%	-0.92%	-1.95%	$(3,138,427)
DORCHESTER	$23,804,066	0.00%	0.00%	-0.54%	-0.29%	-0.75%	-1.58%	$(374,986)
PRINCE GEORGE	$176,633,177	0.00%	0.00%	-1.00%	-0.30%	-0.27%	-1.57%	$(2,773,413)
GOOD SAMARITAN	$178,635,338	0.00%	0.00%	-0.46%	-0.39%	-0.31%	-1.15%	$(2,059,395)
ANNE ARUNDEL	$308,739,341	0.00%	0.00%	-0.42%	-0.23%	-0.35%	-1.00%	$(3,087,905)
CHARLES REGIONAL	$76,417,734	0.21%	0.00%	-0.06%	-0.37%	-0.85%	-1.07%	$(816,786)
UNION MEMORIAL	$239,732,514	0.00%	0.50%	-0.85%	-0.43%	-0.31%	-1.09%	$(2,602,721)
FRANKLIN SQUARE	$282,129,812	0.00%	0.00%	-0.35%	-0.28%	-0.30%	-0.93%	$(2,614,927)
HOLY CROSS	$319,832,140	0.00%	0.00%	-0.31%	-0.35%	-0.25%	-0.91%	$(2,900,125)
CARROLL COUNTY	$136,537,813	-0.17%	0.00%	0.31%	-0.24%	-0.70%	-0.80%	$(1,090,207)
HARBOR	$122,412,282	0.00%	0.00%	-0.36%	-0.33%	-0.18%	-0.87%	$(1,066,772)
WASHINGTON ADVENTIST	$160,049,373	0.00%	0.00%	-0.15%	-0.35%	-0.42%	-0.93%	$(1,484,691)
SUBURBAN	$182,880,097	0.00%	0.00%	-0.10%	-0.28%	-0.47%	-0.84%	$(1,534,715)
ATLANTIC GENERAL	$38,616,313	0.63%	0.00%	-0.72%	-0.33%	-0.41%	-0.82%	$(318,359)
BALTIMORE WASHINGTON MEDICAL CENTER	$224,082,798	0.00%	0.00%	0.42%	-0.36%	-0.72%	-0.67%	$(1,492,281)
FT. WASHINGTON	$17,901,765	0.95%	0.00%	-0.18%	-0.43%	-1.10%	-0.77%	$(137,591)
SHADY GROVE	$231,030,092	0.00%	0.00%	-0.22%	-0.22%	-0.29%	-0.72%	$(1,672,839)
DOCTORS COMMUNITY	$136,010,794	-0.17%	0.50%	0.10%	-0.27%	-0.88%	-0.72%	$(982,849)
GARRETT COUNTY	$18,608,187	0.00%	0.50%	-0.81%	-0.15%	-0.47%	-0.94%	$(173,989)
EASTON	$95,655,306	0.00%	0.00%	0.03%	-0.41%	-0.36%	-0.74%	$(707,029)
UMMC MIDTOWN	$137,603,928	0.00%	0.00%	-0.20%	-0.46%	-0.13%	-0.79%	$(1,089,137)
HOWARD COUNTY	$167,430,727	0.00%	0.00%	0.19%	-0.23%	-0.51%	-0.54%	$(910,182)
MERITUS	$188,367,776	0.05%	0.00%	0.01%	-0.21%	-0.27%	-0.41%	$(778,226)
FREDERICK MEMORIAL	$190,475,901	0.00%	0.00%	0.13%	-0.18%	-0.42%	-0.47%	$(889,726)
HARFORD	$46,774,506	0.00%	0.00%	0.15%	-0.35%	-0.37%	-0.58%	$(270,103)

Hospital Name	FY 2015 Permanent Inpatient Revenue	MHAC % Revenue Adjustment	RRIP % Revenue Adjustment	QBR % Revenue Adjustment	NET Shared Savings % Revenue Adjustment	PAU % Revenue Adjustment	Net Impact %	Net Impact $
UNIVERSITY OF MARYLAND	$869,783,534	0.00%	0.00%	-0.09%	-0.23%	-0.14%	-0.46%	$(3,997,336)
UNION HOSPITAL OF CECIL COUNT	$67,638,499	0.05%	0.00%	0.23%	-0.10%	-0.57%	-0.39%	$(263,934)
MONTGOMERY GENERAL	$87,866,458	0.00%	0.50%	-0.12%	-0.28%	-0.53%	-0.43%	$(380,174)
UPPER CHESAPEAKE HEALTH	$153,131,633	0.00%	0.00%	0.35%	-0.34%	-0.43%	-0.42%	$(636,439)
LAUREL REGIONAL	$77,138,956	0.00%	0.50%	-0.20%	-0.30%	-0.40%	-0.40%	$(310,923)
G.B.M.C.	$200,727,665	-0.14%	0.00%	0.20%	-0.29%	-0.23%	-0.45%	$(909,220)
JOHNS HOPKINS	$1,303,085,115	0.00%	0.00%	0.30%	-0.40%	-0.14%	-0.24%	$(3,063,257)
ST. AGNES	$238,960,906	0.05%	0.50%	-0.10%	-0.36%	-0.34%	-0.25%	$(592,138)
BON SECOURS	$75,937,922	0.47%	0.50%	-0.84%	-0.33%	0.00%	-0.20%	$(148,483)
PENINSULA REGIONAL	$232,896,408	0.16%	0.00%	0.08%	-0.20%	-0.13%	-0.09%	$(204,159)
HOPKINS BAYVIEW MED CTR	$354,237,613	0.37%	0.00%	0.15%	-0.25%	-0.19%	0.07%	$242,340
MERCY	$232,326,849	0.00%	0.50%	0.28%	-0.46%	-0.19%	0.13%	$293,111
WESTERN MARYLAND HEALTH SYSTEM	$182,494,313	0.00%	0.00%	0.73%	-0.15%	-0.11%	0.46%	$846,736
REHAB & ORTHO	$69,116,851	0.37%	0.00%	N/A	-0.42%	-0.15%	-0.20%	$(138,972)
NORTHWEST	$141,883,177	0.68%	0.50%	0.10%	-0.26%	-0.48%	0.55%	$775,801
SINAI	$428,400,532	0.32%	0.50%	0.28%	-0.34%	-0.19%	0.57%	$2,422,359
CHESTERTOWN	$29,287,619	0.53%	0.50%	0.15%	-0.23%	-0.25%	0.70%	$205,232
CALVERT	$67,061,373	0.63%	0.50%	0.11%	-0.13%	-0.54%	0.57%	$382,528
UM ST. JOSEPH	$230,010,193	0.58%	0.00%	0.58%	-0.32%	-0.26%	0.58%	$1,335,237
ST. MARY	$69,990,405	0.68%	0.50%	0.34%	-0.11%	-0.40%	1.01%	$710,270
MCCREADY	$ 3,571,064	1.00%	0.50%	N/A	-0.36%	-0.04%	1.09%	$39,024

Figure 2. Adjustments for the QBR Program for Rate Year 2016, by Hospital

Hospital Name	FY 2015 Permanent Inpatient Revenue	QBR Final Points	Scaling Basis	Revenue Impact of Scaling	Revenue Neutral Adjusted Revenue Impact of Scaling	Revenue Neutral Adjusted % Payment Adjustment
A	B	C	D	E=B*D	F	G=(B+F)/B-1
PRINCE GEORGE	$176,633,176.79	0.204	-1.000%	-$1,766,332	-$1,766,332	-1.000%
UNION MEMORIAL	$239,732,514.10	0.236	-0.848%	-$2,032,700	-$2,032,700	-0.848%
BON SECOURS	$75,937,921.77	0.237	-0.842%	-$639,466	-$639,466	-0.842%
GARRETT COUNTY	$18,608,187.37	0.243	-0.811%	-$150,839	-$150,839	-0.811%
ATLANTIC GENERAL	$38,616,312.78	0.262	-0.721%	-$278,422	-$278,422	-0.721%
DORCHESTER	$23,804,066.20	0.300	-0.536%	-$127,696	-$127,696	-0.536%
SOUTHERN MARYLAND	$161,253,765.94	0.306	-0.506%	-$815,828	-$815,828	-0.506%
GOOD SAMARITAN	$178,635,337.98	0.316	-0.457%	-$817,238	-$817,238	-0.457%
ANNE ARUNDEL	$308,739,340.58	0.324	-0.420%	-$1,297,299	-$1,297,299	-0.420%
HARBOR	$122,412,281.84	0.337	-0.355%	-$434,912	-$434,912	-0.355%
FRANKLIN SQUARE	$282,129,811.54	0.338	-0.351%	-$990,065	-$990,065	-0.351%
HOLY CROSS	$319,832,140.30	0.347	-0.309%	-$989,139	-$989,139	-0.309%
SHADY GROVE	$231,030,091.92	0.366	-0.215%	-$497,403	-$497,403	-0.215%
LAUREL REGIONAL	$77,138,956.35	0.369	-0.203%	-$156,364	-$156,364	-0.203%
UMMC MIDTOWN	$137,603,928.30	0.370	-0.199%	-$273,596	-$273,596	-0.199%
FT. WASHINGTON	$17,901,765.04	0.373	-0.183%	-$32,819	-$32,819	-0.183%
WASHINGTON ADVENTIST	$160,049,372.87	0.379	-0.153%	-$245,350	-$245,350	-0.153%
MONTGOMERY GENERAL	$87,866,457.56	0.387	-0.117%	-$102,775	-$102,775	-0.117%
ST. AGNES	$238,960,906.16	0.390	-0.099%	-$236,680	-$236,680	-0.099%
SUBURBAN	$182,880,097.32	0.391	-0.095%	-$174,048	-$174,048	-0.095%
UNIVERSITY OF MARYLAND	$869,783,533.93	0.392	-0.089%	-$777,220	-$777,220	-0.089%
CHARLES REGIONAL	$76,417,733.97	0.399	-0.057%	-$43,855	-$43,855	-0.057%

Hospital Name	FY 2015 Permanent Inpatient Revenue	QBR Final Points	Scaling Basis	Revenue Impact of Scaling	Revenue Neutral Adjusted Revenue Impact of Scaling	Revenue Neutral Adjusted % Payment Adjustment
MERITUS	$188,367,775.67	0.415	0.020%	$37,886	$23,050	0.012%
EASTON	$95,655,306.19	0.420	0.045%	$42,869	$26,081	0.027%
PENINSULA REGIONAL	$232,896,407.52	0.439	0.139%	$323,230	$196,651	0.084%
NORTHWEST	$141,883,177.42	0.446	0.169%	$240,213	$146,144	0.103%
DOCTORS COMMUNITY	$136,010,793.59	0.446	0.169%	$230,271	$140,095	0.103%
CALVERT	$67,061,372.88	0.447	0.174%	$116,461	$70,854	0.106%
FREDERICK MEMORIAL	$190,475,900.63	0.455	0.216%	$411,978	$250,644	0.132%
HOPKINS BAYVIEW MED CTR	$354,237,613.19	0.460	0.239%	$845,105	$514,157	0.145%
HARFORD	$46,774,506.17	0.461	0.245%	$114,535	$69,683	0.149%
CHESTERTOWN	$29,287,619.34	0.462	0.250%	$73,134	$44,494	0.152%
HOWARD COUNTY	$167,430,726.52	0.476	0.318%	$531,634	$323,443	0.193%
G.B.M.C.	$200,727,664.89	0.478	0.327%	$656,806	$399,596	0.199%
UNION HOSPITAL OF CECIL COUNT	$67,638,499.19	0.488	0.375%	$253,429	$154,185	0.228%
MERCY	$232,326,849.10	0.504	0.453%	$1,052,795	$640,513	0.276%
SINAI	$428,400,532.05	0.505	0.456%	$1,953,758	$1,188,653	0.277%
JOHNS HOPKINS	$1,303,085,115.22	0.512	0.490%	$6,390,980	$3,888,230	0.298%
CARROLL COUNTY	$136,537,812.51	0.516	0.510%	$696,104	$423,505	0.310%
ST. MARY	$69,990,405.25	0.525	0.554%	$387,680	$235,862	0.337%
UPPER CHESAPEAKE HEALTH	$153,131,633.20	0.531	0.583%	$892,707	$543,117	0.355%
BALTIMORE WASHINGTON MEDICAL CENTER	$224,082,797.59	0.552	0.684%	$1,533,183	$932,778	0.416%
UM ST. JOSEPH	$230,010,193.37	0.609	0.961%	$2,209,908	$1,344,493	0.585%
WESTERN MARYLAND HEALTH SYSTEM	$182,494,313.32	0.657	1.192%	$2,175,921	$1,323,816	0.725%
Statewide	**$8,904,474,715**			**$8,290,541**	**$0**	**0%**

Figure 3. Adjustments for the RRIP Program for Rate Year 2016, by Hospital

HOSPITAL NAME	FY 2015 Permanent Inpatient Revenue	CY 13 Base Year Risk-Adjusted Readmission Rate	CY 14 Performance Period Risk-Adjusted Readmission Rate	CY 14 Readmission Improvement	% Payment Adjustment	Revenue Impact of Scaling
A	B	C	D	E=D/C-1	H	I=H*B
MCCREADY	$3,571,064.06	11.82%	9.30%	-21.30%	0.50%	$17,855
ST. MARY	$69,990,405.25	12.09%	10.21%	-15.52%	0.50%	$349,952
CALVERT	$67,061,372.88	9.63%	8.16%	-15.30%	0.50%	$335,307
BON SECOURS	$75,937,921.77	18.43%	15.79%	-14.31%	0.50%	$379,690
DOCTORS COMMUNITY	$136,010,793.59	12.52%	10.77%	-13.97%	0.50%	$680,054
CHESTERTOWN	$29,287,619.34	13.29%	11.79%	-11.24%	0.50%	$146,438
NORTHWEST	$141,883,177.42	14.52%	13.11%	-9.70%	0.50%	$709,416
ST. AGNES	$238,960,906.16	13.43%	12.15%	-9.53%	0.50%	$1,194,805
UNION MEMORIAL	$239,732,514.10	13.78%	12.53%	-9.08%	0.50%	$1,198,663
MERCY	$232,326,849.10	13.96%	12.77%	-8.56%	0.50%	$1,161,634
MONTGOMERY GENERAL	$87,866,457.56	12.03%	11.11%	-7.58%	0.50%	$439,332
SINAI	$428,400,532.05	13.67%	12.67%	-7.34%	0.50%	$2,142,003
LAUREL REGIONAL	$77,138,956.35	13.18%	12.23%	-7.27%	0.50%	$385,695
GARRETT COUNTY	$18,608,187.37	7.21%	6.69%	-7.24%	0.50%	$93,041
HOPKINS BAYVIEW MED CTR	$354,237,613.19	14.71%	13.86%	-5.78%	0.00%	$0
PRINCE GEORGE	$176,633,176.79	10.04%	9.49%	-5.47%	0.00%	$0
G.B.M.C.	$200,727,664.89	10.67%	10.09%	-5.43%	0.00%	$0
UMMC MIDTOWN	$137,603,928.30	15.97%	15.16%	-5.07%	0.00%	$0
ANNE ARUNDEL	$308,739,340.58	11.99%	11.38%	-5.06%	0.00%	$0
HOWARD COUNTY	$167,430,726.52	11.81%	11.21%	-5.04%	0.00%	$0
UM ST. JOSEPH	$230,010,193.37	11.40%	10.83%	-4.97%	0.00%	$0

HOSPITAL NAME	FY 2015 Permanent Inpatient Revenue	CY 13 Base Year Risk-Adjusted Readmission Rate	CY 14 Performance Period Risk-Adjusted Readmission Rate	CY 14 Readmission Improvement	% Payment Adjustment	Revenue Impact of Scaling
ATLANTIC GENERAL	$38,616,312.78	11.65%	11.09%	-4.86%	0.00%	$0
HARBOR	$122,412,281.84	12.81%	12.28%	-4.15%	0.00%	$0
SHADY GROVE	$231,030,091.92	10.84%	10.42%	-3.87%	0.00%	$0
SOUTHERN MARYLAND	$161,253,765.94	11.39%	10.96%	-3.83%	0.00%	$0
GOOD SAMARITAN	$178,635,337.98	13.62%	13.10%	-3.80%	0.00%	$0
BALTIMORE WASHINGTON MEDICAL CENTER	$224,082,797.59	13.77%	13.30%	-3.38%	0.00%	$0
CARROLL COUNTY	$136,537,812.51	11.86%	11.53%	-2.77%	0.00%	$0
UNIVERSITY OF MARYLAND	$869,783,533.93	13.78%	13.55%	-1.63%	0.00%	$0
WESTERN MARYLAND HEALTH SYSTEM	$182,494,313.32	11.89%	11.73%	-1.31%	0.00%	$0
SUBURBAN	$182,880,097.32	10.94%	10.81%	-1.27%	0.00%	$0
FRANKLIN SQUARE	$282,129,811.54	12.63%	12.50%	-1.05%	0.00%	$0
HARFORD	$46,774,506.17	11.04%	10.95%	-0.80%	0.00%	$0
REHAB & ORTHO	$69,116,850.62	11.46%	11.47%	0.01%	0.00%	$0
JOHNS HOPKINS	$1,303,085,115.22	13.97%	13.97%	0.04%	0.00%	$0
UNION HOSPITAL OF CECIL COUNT	$67,638,499.19	9.77%	9.82%	0.51%	0.00%	$0
UPPER CHESAPEAKE HEALTH	$153,131,633.20	11.45%	11.59%	1.27%	0.00%	$0
FREDERICK MEMORIAL	$190,475,900.63	10.38%	10.51%	1.30%	0.00%	$0
MERITUS	$188,367,775.67	11.38%	11.53%	1.36%	0.00%	$0
FT. WASHINGTON	$17,901,765.04	12.53%	12.74%	1.65%	0.00%	$0
DORCHESTER	$23,804,066.20	11.07%	11.28%	1.89%	0.00%	$0
CHARLES REGIONAL	$76,417,733.97	11.57%	11.90%	2.82%	0.00%	$0
PENINSULA REGIONAL	$232,896,407.52	10.77%	11.08%	2.88%	0.00%	$0
HOLY CROSS	$319,832,140.30	11.12%	11.69%	5.09%	0.00%	$0

HOSPITAL NAME	FY 2015 Permanent Inpatient Revenue	CY 13 Base Year Risk-Adjusted Readmission Rate	CY 14 Performance Period Risk-Adjusted Readmission Rate	CY 14 Readmission Improvement	% Payment Adjustment	Revenue Impact of Scaling
WASHINGTON ADVENTIST	$160,049,372.87	10.79%	11.42%	5.77%	0.00%	$0
EASTON	$95,655,306.19	10.47%	11.93%	13.98%	0.00%	$0
	$8,977,162,630				**Rewards:**	**$9,233,884**

Figure 4. Adjustments for the MHAC Program for Rate Year 2016, by Hospital

Hospital Name	FY 2015 Permanent Inpatient Revenue	Final MHAC Score	% Payment Adjustment	Revenue Impact of Scaling
A	B	C	D	E
SOUTHERN MARYLAND	$161,253,765.94	0.40	-0.2069%	-$333,628
DOCTORS COMMUNITY	$136,010,793.59	0.41	-0.1724%	-$234,501
CARROLL COUNTY	$136,537,812.51	0.41	-0.1724%	-$235,410
G.B.M.C.	$200,727,664.89	0.42	-0.1379%	-$276,866
SUBURBAN	$182,880,097.32	0.47	0.0000%	$0
LAUREL REGIONAL	$77,138,956.35	0.48	0.0000%	$0
WASHINGTON ADVENTIST	$160,049,372.87	0.48	0.0000%	$0
ANNE ARUNDEL	$308,739,340.58	0.48	0.0000%	$0
HARBOR	$122,412,281.84	0.49	0.0000%	$0
MONTGOMERY GENERAL	$87,866,457.56	0.50	0.0000%	$0
DORCHESTER	$23,804,066.20	0.52	0.0000%	$0
PRINCE GEORGE	$176,633,176.79	0.52	0.0000%	$0
FREDERICK MEMORIAL	$190,475,900.63	0.53	0.0000%	$0
UNION MEMORIAL	$239,732,514.10	0.53	0.0000%	$0
FRANKLIN SQUARE	$282,129,811.54	0.54	0.0000%	$0
HOWARD COUNTY	$167,430,726.52	0.54	0.0000%	$0
HOLY CROSS	$319,832,140.30	0.54	0.0000%	$0
HARFORD	$46,774,506.17	0.54	0.0000%	$0
BALTIMORE WASHINGTON MEDICAL CENTER	$224,082,797.59	0.54	0.0000%	$0
GARRETT COUNTY	$18,608,187.37	0.55	0.0000%	$0
WESTERN MARYLAND HEALTH SYSTEM	$182,494,313.32	0.55	0.0000%	$0
JOHNS HOPKINS	$1,303,085,115.22	0.56	0.0000%	$0
UNIVERSITY OF MARYLAND	$869,783,533.93	0.57	0.0000%	$0

Hospital Name	FY 2015 Permanent Inpatient Revenue	Final MHAC Score	% Payment Adjustment	Revenue Impact of Scaling
A	B	C	D	E
UPPER CHESAPEAKE HEALTH	$153,131,633.20	0.57	0.0000%	$0
SHADY GROVE	$231,030,091.92	0.58	0.0000%	$0
GOOD SAMARITAN	$178,635,337.98	0.58	0.0000%	$0
UMMC MIDTOWN	$137,603,928.30	0.60	0.0000%	$0
EASTON	$95,655,306.19	0.60	0.0000%	$0
MERCY	$232,326,849.10	0.61	0.0000%	$0
UNION HOSPITAL OF CECIL COUNT	$67,638,499.19	0.62	0.0526%	$35,599
ST. AGNES	$238,960,906.16	0.62	0.0526%	$125,769
MERITUS	$188,367,775.67	0.62	0.0526%	$99,141
PENINSULA REGIONAL	$232,896,407.52	0.64	0.1579%	$367,731
CHARLES REGIONAL	$76,417,733.97	0.65	0.2105%	$160,879
SINAI	$428,400,532.05	0.67	0.3158%	$1,352,844
HOPKINS BAYVIEW MED CTR	$354,237,613.19	0.68	0.3684%	$1,305,086
REHAB & ORTHO	$69,116,850.62	0.68	0.3684%	$254,641
BON SECOURS	$75,937,921.77	0.70	0.4737%	$359,706
CHESTERTOWN	$29,287,619.34	0.71	0.5263%	$154,145
UM ST. JOSEPH	$230,010,193.37	0.72	0.5789%	$1,331,638
ATLANTIC GENERAL	$38,616,312.78	0.73	0.6316%	$243,893
CALVERT	$67,061,372.88	0.73	0.6316%	$423,546
ST. MARY	$69,990,405.25	0.74	0.6842%	$478,882
NORTHWEST	$141,883,177.42	0.74	0.6842%	$970,780
FT. WASHINGTON	$17,901,765.04	0.79	0.9474%	$169,596
MCCREADY	$3,571,064.06	0.83	1.0000%	$35,711
	$8,977,162,630			**$6,789,180**

APPENDIX II. FY 2017 YEAR-TO-DATE HOSPITAL-LEVEL CONSOLIDATED RESULTS (SORTED BY COLUMN J)

Hospital Name	FY 16 Permanent Total Revenue A	FY 16 Permanent Inpatient Revenue B	MHAC (Below Target) Finalized C	RRIP (Proposed) D	QBR YTD E	FY 17 Net Shared Savings (Proposed) F	Demographic Adjustment G	Net Impact % Inpatient H=Sum(C-G)	Net Impact $ I=H*B	Net Impact % Total Revenue J=I/A
REHAB & ORTHO	$117,875,574	$64,134,443	0.43%	1.00%	0.00%	0.44%	-0.01%	1.87%	$1,197,128	1.02%
UM ST. JOSEPH	$384,647,527	$234,223,274	0.59%	0.47%	0.86%	-0.59%	-0.20%	1.12%	$2,622,918	0.68%
MERCY	$491,288,212	$214,208,592	0.46%	0.85%	0.46%	-0.37%	-0.16%	1.25%	$2,673,146	0.54%
MCCREADY	$14,230,659	$2,815,158	1.00%	1.00%	0.00%	-1.09%	0.00%	1.74%	$49,019	0.34%
GARRETT COUNTY	$45,640,340	$19,149,148	1.00%	1.00%	0.39%	-1.84%	-0.06%	0.49%	$94,151	0.21%
CALVERT	$140,329,390	$62,336,014	0.95%	0.80%	0.61%	-1.64%	-0.26%	0.45%	$279,132	0.20%
UNIVERSITY OF MARYLAND	$1,289,991,934	$906,034,034	0.65%	-0.09%	0.32%	-0.66%	-0.13%	0.09%	$786,922	0.06%
SINAI	$698,636,216	$415,350,729	0.41%	0.30%	0.29%	-0.83%	-0.17%	0.00%	-$17,754	0.00%
UNION MEMORIAL	$411,630,821	$238,195,335	0.22%	0.81%	0.50%	-1.20%	-0.35%	-0.02%	-$56,234	-0.01%
PENINSULA REGIONAL	$413,594,890	$242,318,199	0.76%	-0.03%	0.64%	-1.33%	-0.17%	-0.13%	-$307,854	-0.07%
ATLANTIC GENERAL	$100,960,082	$37,750,252	0.27%	1.00%	0.46%	-1.68%	-0.30%	-0.25%	-$93,004	-0.09%
FREDERICK MEMORIAL	$350,725,799	$190,413,775	0.27%	0.63%	0.61%	-1.28%	-0.41%	-0.19%	-$363,148	-0.10%
ST. MARY	$168,090,518	$69,169,248	0.84%	0.44%	1.00%	-2.05%	-0.52%	-0.29%	-$201,302	-0.12%
G.B.M.C.	$423,026,290	$207,515,795	0.00%	0.39%	0.39%	-0.94%	-0.20%	-0.35%	-$729,128	-0.17%
UPPER CHESAPEAKE HEALTH	$319,063,053	$135,939,076	0.62%	0.15%	0.61%	-1.43%	-0.54%	-0.59%	-$802,069	-0.25%
HOPKINS BAYVIEW MED CTR	$610,423,590	$343,229,718	0.68%	-0.11%	0.36%	-1.23%	-0.21%	-0.52%	-$1,782,501	-0.29%
SUBURBAN	$290,002,663	$193,176,044	0.32%	-0.47%	0.86%	-0.83%	-0.40%	-0.51%	-$993,867	-0.34%
ANNE ARUNDEL	$553,902,629	$291,882,683	0.16%	-0.29%	0.50%	-0.89%	-0.31%	-0.83%	-$2,426,795	-0.44%

Hospital Name	FY 16 Permanent Total Revenue A	FY 16 Permanent Inpatient Revenue B	MHAC (Below Target) Finalized C	RRIP (Proposed) D	QBR YTD E	FY 17 Net Shared Savings (Proposed) F	Demographic Adjustment G	Net Impact % Inpatient H=Sum(C-G)	Net Impact $ I=H*B	Net Impact % Total Revenue J=I/A
FRANKLIN SQUARE	$488,282,513	$274,203,013	0.54%	-0.25%	0.36%	-1.23%	-0.24%	-0.82%	-$2,239,370	-0.46%
JOHNS HOPKINS	$2,178,990,299	$1,244,297,9	0.00%	-0.36%	0.32%	-0.72%	-0.16%	-0.92%	-$11,410,965	-0.52%
CHESTERTOWN	$53,997,130	$21,575,174	0.62%	0.55%	0.68%	-2.60%	-0.57%	-1.32%	-$284,855	-0.53%
FT. WASHINGTON	$46,558,629	$19,674,774	1.00%	0.86%	0.68%	-2.90%	-1.04%	-1.39%	-$274,323	-0.59%
SHADY GROVE	$374,624,719	$220,608,397	0.11%	-0.01%	0.29%	-1.12%	-0.37%	-1.11%	-$2,442,990	-0.65%
ST. AGNES	$413,273,339	$232,266,274	0.51%	-0.04%	0.39%	-1.77%	-0.33%	-1.23%	-$2,848,049	-0.69%
HARBOR	$190,199,181	$113,244,592	0.62%	-1.06%	0.57%	-1.16%	-0.16%	-1.18%	-$1,339,504	-0.70%
WESTERN MARYLAND HEALTH SYSTEM	$312,666,774	$167,618,972	0.11%	-0.74%	0.39%	-1.17%	0.00%	-1.36%	-$2,285,659	-0.73%
GOOD SAMARITAN	$283,376,592	$160,795,606	0.16%	0.16%	0.61%	-1.78%	-0.50%	-1.35%	-$2,176,921	-0.77%
HOWARD COUNTY	$284,424,840	$165,683,744	0.27%	-0.81%	0.93%	-1.39%	-0.45%	-1.46%	-$2,417,449	-0.85%
MONTGOMERY	$168,451,048	$75,687,627	0.43%	-0.16%	0.39%	-1.99%	-0.68%	-2.01%	-$1,520,611	-0.90%
CHARLES REGIONAL	$143,315,213	$67,052,911	0.30%	-0.05%	0.79%	-2.28%	-0.72%	-1.97%	-$1,321,070	-0.92%
NORTHWEST	$247,056,826	$114,214,371	0.22%	0.81%	-0.56%	-2.02%	-0.47%	-2.01%	-$2,296,947	-0.93%
HARFORD	$100,472,983	$45,713,956	0.92%	0.80%	0.18%	-3.37%	-0.59%	-2.07%	-$945,429	-0.94%
BALTIMORE WASHINGTON	$396,558,220	$237,934,932	0.46%	-0.07%	0.32%	-1.92%	-0.39%	-1.60%	-$3,798,510	-0.96%
EASTON	$192,089,981	$101,975,577	0.19%	-0.57%	0.29%	-1.55%	-0.16%	-1.81%	-$1,850,684	-0.96%
CARROLL COUNTY	$245,978,519	$136,267,434	0.19%	-0.65%	0.71%	-1.81%	-0.45%	-2.01%	-$2,734,704	-1.11%
UMMC MIDTOWN	$223,767,089	$126,399,313	0.38%	-0.16%	-0.89%	-1.22%	-0.13%	-2.03%	-$2,560,363	-1.14%
DORCHESTER	$49,366,715	$26,999,062	0.84%	0.03%	0.64%	-3.45%	-0.21%	-2.15%	-$581,802	-1.18%
BON SECOURS	$122,434,137	$74,789,724	0.00%	1.00%	-1.78%	-1.13%	-0.05%	-1.96%	-$1,463,774	-1.20%
MERITUS	$309,029,336	$190,659,648	0.22%	-1.27%	0.29%	-1.21%	-0.15%	-2.13%	-$4,059,537	-1.31%

Hospital Name	FY 16 Permanent Total Revenue A	FY 16 Permanent Inpatient Revenue B	MHAC (Below Target) Finalized C	RRIP (Proposed) D	QBR YTD E	FY 17 Net Shared Savings (Proposed) F	Demographic Adjustment G	Net Impact % Inpatient H=Sum(C-G)	Net Impact $ I=H*B	Net Impact % Total Revenue J=I/A
HOLY CROSS	$473,189,703	$316,970,825	0.62%	-1.13%	-0.33%	-1.13%	-0.31%	-2.29%	-$7,255,443	-1.53%
UNION HOSPITAL OF CECIL COUNTY	$153,588,495	$69,389,876	0.51%	-2.00%	0.46%	-2.05%	-0.56%	-3.63%	-$2,518,551	-1.64%
HOLY CROSS	$88,000,000	$57,164,163	0.0%	0.0%	0.0%	-2.21%	-0.31%	-2.53%	-$1,444,747	-1.64%
WASHINGTON ADVENTIST	$253,346,309	$155,199,154	-0.06%	-1.20%	0.25%	-1.13%	-0.55%	-2.69%	-$4,168,361	-1.65%
DOCTORS COMMUNITY	$226,236,757	$132,614,778	0.03%	-0.31%	0.18%	-2.32%	-1.12%	-3.54%	-$4,694,560	-2.08%
LAUREL REGIONAL	$101,288,035	$60,431,106	0.03%	-0.78%	-1.11%	-1.16%	-0.54%	-3.57%	-$2,154,785	-2.13%
SOUTHERN MARYLAND	$265,443,855	$156,564,761	0.00%	-0.62%	0.11%	-2.24%	-1.07%	-3.83%	-$5,994,345	-2.26%
PRINCE GEORGE	$278,868,894	$220,306,426	-0.25%	-1.70%	0.07%	-0.93%	-0.39%	-3.19%	-$7,032,536	-2.52%

EXHIBIT 15

Final Recommendations for the Potentially Avoidable Utilization Savings Policy for Rate Year 2017

June 8, 2016

Health Services Cost Review Commission
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These final recommendations were approved by the commission on June 8, 2016.

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LIST OF ABBREVIATIONS

ADI	Area deprivation index
ARR	Admission-Readmission Revenue Program
CMS	Centers for Medicare & Medicaid Services
CY	Calendar year
DRG	Diagnosis-related group
ECMAD	Equivalent case-mix adjusted discharge
FFY	Federal fiscal year
FY	Fiscal year
GBR	Global budget revenue
HSCRC	Health Services Cost Review Commission
IPPS	Inpatient prospective payment system
PAU	Potentially avoidable utilization
PQI	Prevention quality indicators
RRIP	Readmissions Reduction Incentive Program
RY	Rate year
SOI	Severity of Illness
TPR	Total patient revenue

INTRODUCTION

The Maryland Health Services Cost Review Commission (HSCRC or Commission) operates a potentially avoidable utilization (PAU) savings policy as part of its portfolio of value-based payment policies. This policy was formerly referred to as the readmission shared savings policy. The PAU savings policy is important for maintaining hospitals' focus on improving care and health for patients by reducing PAU and its associated costs. The PAU savings policy is also important for maintaining Maryland's exemption from the Centers for Medicare & Medicaid Services (CMS) quality-based payment programs, as this exemption allows the state to operate its own programs on an all-payer basis.

In this recommendation, staff is proposing to update the policy to incorporate an additional category of PAU, to increase the level of savings derived from the policy, and to specify the calculations and application of the policy in conjunction with the state fiscal year (FY) 2017 update. The purpose of this report is to present background information and supporting analyses for the PAU savings recommendations for rate year (RY) 2017. Based on the stakeholder comments, staff updated the measurement of socio-economic protection from percent of total case-mix adjusted volume for Medicaid patients to percent of inpatient case-mix adjusted volume for Medicaid and self-pay and charity patients. Data for the calculation of PAU is also updated to reflect the corrections made for ICD-10 rehab cases. Staff will finalize PAU percentages by the end of June 2016.

BACKGROUND

The United States ranks behind most countries on many measures of health outcomes, quality, and efficiency. Physicians face particular difficulties in receiving timely information, coordinating care, and dealing with administrative burden. Enhancements in chronic care— with a focus on prevention and treatment in the office, home, and long-term care settings—are essential to improving indicators of healthy lives and health equity. Such indicators include mortality amenable to health care and a healthy life expectancy at age 60. As a consequence of inadequate chronic care and care coordination, the healthcare system currently experiences an unacceptably high rate of preventable hospital admissions and readmissions. Maryland's new All-Payer Model was approved by CMS effective January 1, 2014. This Model is premised on the opportunity for Maryland and CMS to test whether an all-payer system that is accountable for the total hospital cost of care on a per capita basis is an effective model for advancing better care, better health, and reduced costs.

HSCRC, together with stakeholders, has adapted and developed a series of policies and initiatives aimed at improving care and care coordination, with a particular focus on reducing PAU.

Under the state's previous Medicare waiver, the Commission approved a shared savings policy on May 1, 2013, which reduced hospital revenues based on case-mix adjusted readmission rates[1] using specifications set forth in the HSCRC's Admission-Readmission Revenue (ARR) Program. Nearly all hospitals in the state were participating in the ARR program, which incorporated 30-day readmissions into a hospital episode rate per case, or in the Total Patient Revenue (TPR) system, a global budget for more rural hospital settings. Because Medicare policies are tied to a fee-for-service system, it receives savings when avoidable admissions are reduced. In contrast, Maryland's ARR and TPR systems locked in the savings, and Maryland was required to reduce approved revenues to ensure savings to purchasers, including Medicare, from the reductions in readmissions to maintain Maryland's exemption from the CMS Medicare Hospital Readmission Reduction Program. The Commission initiated a reduction of 0.20 percent of total revenues starting in FY 2014 to implement this policy. Under the new All-Payer Model, the Commission continued to use the savings adjustment to assure a focus on reducing readmissions, assure savings to purchasers, and to meet the exemption requirements for "revenue at risk" under Maryland's value-based programs.

For RYs 2014 and 2015, the HSCRC calculated a case-mix adjusted readmission rate based on ARR specifications[2] for each hospital for the previous calendar year.[3] The statewide savings percentage was converted to a required reduction in readmission rates, and each hospital's contribution to savings was determined by its case-mix adjusted readmission rates. Based on 0.20 percent annual savings, the total reduction percentage was 0.40 percent of total revenue in RY 2015.

For RY 2016, the HSCRC updated the methodology for calculating the savings reduction to use the case-mix adjusted readmission rate based on the specifications for the Readmissions Reduction Incentive Program (RRIP).[4] Based on 0.20 percent annual savings, the total reduction percentage was 0.60 percent of total revenue in RY 2016.

Exemption from CMS Quality-Based Payment Programs

Section 3025 of the Affordable Care Act[5] established the federal Medicare Hospital Readmission Reduction Program in federal fiscal year (FFY) 2013, which requires the Secretary of the U.S.

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[1] A readmission is an admission to a hospital within a specified time period after a discharge from the same or another hospital.
[2] Only same-hospital readmissions were counted, and stays of one day or less and planned admissions were excluded.
[3] The case-mix adjustment was based on a total of observed readmissions vs. expected readmissions, which is calculated using the statewide average readmission rate for each diagnosis-related group (DRG) severity of illness (SOI) cell and aggregated for each hospital.
[4] This measures 30-day all-cause, all hospital readmissions with planned admission and other exclusions.
[5] Patient Protection and Affordable Care Act, 124 Stat. 119 (2010) (codified as amended at 42 U.S.C. § 1395ww(q) (Supp. 2010)).

Department of Health and Human Services to reduce payments to inpatient prospective payment system (IPPS) hospitals with excess readmissions for patients in fee-for-service Medicare.[6] According to the IPPS rule published for FFY 2015, the Secretary is authorized to exempt Maryland hospitals from the Medicare Hospital Readmissions Reduction Program if Maryland submits an annual report describing how a similar program in the State achieves or surpasses the nationally measured results for patient health outcomes and cost savings under the Medicare program. As mentioned in other HSCRC quality-based payment recommendations reports, the new All-Payer Model changed the criteria for maintaining exemptions from the CMS programs. As part of the new All-Payer Model Agreement, the aggregate amount of revenue at risk in Maryland quality/performance-based payment programs must be equal to or greater than the aggregate amount of revenue at risk in the CMS Medicare quality programs. The PAU savings adjustment is one of the performance-based programs used for this comparison. This policy is intentionally different from the other quality-based programs that are scaled to provide rewards or penalties based on improvement or attainment levels in that it is designed to assure savings from the application of the policy.

ASSESSMENT

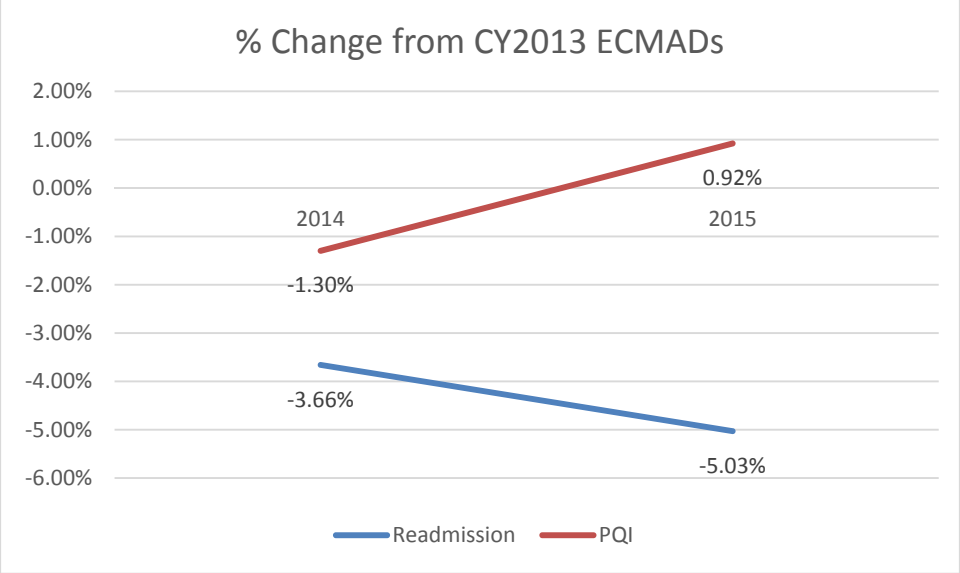
Alignment of Savings with Potentially Avoidable Utilization

With the introduction of the new All-Payer Model and global budgets, reducing PAU through improved care coordination and enhanced community-based care became a central focus. HSCRC provided additional revenue in global budgets over the last three years to bolster investments in care coordination resources and infrastructure. Infrastructure adjustments of 0.325 percent in FY 2014, 0.325 percent in FY 2015, and 0.40 percent in FY 2016 were included in most global budgets to enable the successful transition to the new model and provide funds for the needed investments. The total ongoing commitment for infrastructure is approximately $180 million for global budget revenue (GBR) hospitals—an amount approaching the statewide estimated operating costs for care coordination developed by consultants for the Care Coordination Workgroup.[7] These adjustments recognized the need for investment in care coordination, care management, population health improvement, and other requirements of global models. Successful care management and population health efforts will require hospitals to maintain and enhance their investments in addressing the needs of complex patients; improving and coordinating care for individuals with chronic conditions; integrating and coordinating care with other hospitals and non-hospital providers; and investing in IT, analytics, human resources, training, and alignment models to support these efforts.

[6] For more information on this program, see https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html.
[7] http://hscrc.maryland.gov/hscrc-workgroup-care-coordination.cfm

As the Model is premised on the ability to improve care and health, thereby reducing the pace of hospital cost increases, an intense focus needs to be placed on achieving these results that are both beneficial to patients and the system. HSCRC staff is proposing to focus the savings program more broadly on PAU. For FY 2017, HSCRC staff proposes to use the same definition of PAU that is used for the market shift calculations, incorporating both readmissions and admissions for ambulatory care sensitive conditions as measured by the Agency for Health Care Research and Quality's Prevention Quality Indicators (PQIs) [8]. Last year, the savings measure focused on readmissions, as the Commission was concerned about the slow rate of improvement in readmissions in Maryland. Calendar year (CY) 2015 trends indicate that readmission improvement is accelerating, while progress in reducing PQIs has been limited. Figure 1 below shows trends in readmissions and PQIs since CY 2013. While the CY 2015 equivalent case-mix adjusted readmission discharges (ECMADs) declined by 5.03 percent over CY 2013, PQIs increased by 0.92 percent, which was preceded by a 1.30 percent PQI reduction in CY 2014. Appendix I shows more detailed information on specific PQI trends.

Figure 1. Changes in Maryland's Readmission and PQI Rates over CY 2013



In addition to including PQIs in the savings methodology, alignment with PAU will change the focus of the readmissions measure from "sending" hospitals to "receiving" hospitals. In other words, the PAU methodology currently calculates the percentage of revenue associated with readmissions that occur at the hospital regardless of where the first (index) admission occurred. This is more consistent with the opportunities for savings under global budgets since the readmit hospital only accrues savings if the actual number of readmissions at that hospital decreases. This also incentivizes hospitals to collaborate with other area hospitals to reduce readmissions.

[8] PQIs measure inpatient admissions for ambulatory care sensitive conditions. For more information on these measures, see http://www.qualityindicators.ahrq.gov/modules/pqi_overview.aspx .

Alignment with PAU will also enable the measure to include observation stays in the calculation of both readmissions and PQIs. As the use of observation stays has increased over the past few years, HSCRC staff recommends including observation stays that are longer than 23 hours in avoidable utilization measures.

Proposed Required Revenue Reduction

HSCRC staff proposes to increase annual savings amount from 0.20 % to 0.45 % reductions, which will result in a statewide PAU savings adjustment of 1.25 percent of total hospital revenue. Because last year's statewide savings reduction of 0.60 percent is added back into rates, this represents an incremental reduction of 0.65 percent. Statewide required reductions in PAU are determined based on the proposed reduction in total revenue.

In the third year of the All-Payer Model, with its intense focus on improving care and health and reducing PAU, there is a need to provide increased savings from reducing PAU. This proposal provides these savings and also apportions the savings to hospitals with higher levels of PAU. Both of these policy outcomes are important as the federal government increases the pace of reductions in hospital payments under the Affordable Care Act, (which is discussed in more detail in the RY 2017 Balanced Update Draft Recommendation), and hospitals need to keep up/accelerate the pace in reducing avoidable utilization to achieve the care improvements that are essential for success under the All-Payer Model.

Figure 2. Proposed RY 2017 Statewide Savings

Statewide Savings	Formulas	
RY 2016 Total Approved Permanent Revenue	A	$15.4 billion
Proposed RY 2017 Incremental Revenue Adjustment %	B	-0.65%
Incremental Revenue Adjustment	E=C-D	-$100.6 million

The PAU savings adjustment has a number of advantages, including the following:

- Every hospital contributes to the PAU savings; however, the PAU savings are distributed in proportion to each hospital's PAU in the most recent year. See Appendix II for more information on PAU by hospital.
- The PAU savings adjustment amount is not related to an actual reduction in PAU during the rate year, hence providing an equitable reduction for quality improvement related to PAU reductions across all hospitals. Hospitals that reduce their PAU beyond the savings benchmark during the rate year will retain 100 percent of the difference between their actual reduction and the savings benchmark.
- When applied prospectively, the HSCRC sets the targeted dollar amount for savings, thus guaranteeing a fixed amount of savings.

Hospital Protections

The Commission and stakeholders are concerned about ensuring that hospitals that treat a higher proportion of disadvantaged patients have the needed resources for care delivery and improvement, while not excusing poor quality of care or care coordination because of higher deprivation. The HSCRC convened a subgroup to discuss risk-adjusting the readmissions measures for socio-demographic factors and evaluate the impact of the Area Deprivation Index (ADI) on readmission rates.[9] As the ADI is currently being updated with more recent data, more work is needed to understand the hospital-level impact of this specific measure. In the meantime, staff proposes to apply a methodology similar to last year's and to cap the PAU savings contributions at the state average if a hospital has a high proportion of disadvantaged populations. Last year, staff used the percentage of discharges for those aged 18 years and older with Medicaid as the payer as a measure of the proportion of disadvantaged patients. This year, staff proposes to update the measure to include the percentage of Medicaid and Self-pay or Charity ECMADs for inpatient and observation cases with 23 hour or longer stays, with protection provided to those hospitals in the top quartile.

Appendix III provides the results of the PAU savings policy based on the proposed 0.65 percent annual (1.25 percent total) reduction in total patient revenues with and without these protections.

Comments Received on Proposed Savings Policy Recommendation

MHA's letter of 5/25/16 with comments on the May 2016 draft updated policies for the Readmission Reduction Incentive Program, Potentially Avoidable Utilization (PAU) Savings Program, and on Aggregate Revenue Amount at Risk for Hospital Quality Programs is provided in a separate attachment file entitled: ***Attachment I_ RRIP_PAU Shared Savings Aggregate at Risk_2016.05.25_MHA HSCRC Letter Quality for FY2018_attachments.pdf.*** CareFirst submitted their comments as part of the update factor recommendation.

Future Expansion of PAU

Staff intends to continue its focus of adding categories of admissions to the PAU measures. We considered adding sepsis to the measure for FY 2017, but this will require more vetting and specification development. It also appears that there may be coding discrepancies among hospitals in identifying sepsis cases. Staff is recommending that hospitals with high levels of

[9] The original Area Deprivation Index was developed in 2003 by Gopal Singh, and has been widely disseminated by HIPxChange, which is sponsored by the University of Wisconsin-Madison. The ADI is a composite measure of the socioeconomic deprivation of a geographic location (like a Census-block). It reflects various socioeconomic indicators like the level of education of the population, the employment rate, median family income, home value, and percent of the population below 150 percent of the federal poverty level. Higher values of the index indicate higher levels of socioeconomic deprivation. For more information, see: https://www.hipxchange.org/ADI.

sepsis cases or apparent shifts in PQI coding take the opportunity to evaluate their coding. Staff may need to focus coding audit resources on these hospitals if we do not see progress in this area. Other areas of future focus for additional PAU measures include admissions from long-term care and post-acute settings, as well as unplanned medical admissions through the emergency department setting.

RECOMMENDATIONS

Based on this assessment, staff recommends the following for the PAU savings policy for RY 2017:

1. Align the measure with the PAU definitions used in the market shift adjustment, which is comprised of readmissions and PQIs (inclusive of observation cases that are greater than 23 hours).
2. Increase the annual value of the PAU savings amount from 0.20 percent to 0.45 percent. This will result in 1.25 percent of reduction in total revenue, which is a 0.65 percent net reduction in RY 2017.
3. Cap the PAU savings reduction at the statewide average reduction for hospitals with higher socio-economic burden.
4. Evaluate further expansion of PAU definitions for RY 2018 to incorporate additional categories of unplanned admissions.
5. Evaluate progress on sepsis coding and the apparent discrepancies in levels of sepsis cases across hospitals, including the need for possible independent coding audits.

APPENDIX I. ANALYSIS OF PQI TRENDS

PQIs—developed by the Agency for Healthcare Research and Quality—measure inpatient admissions for ambulatory care sensitive conditions. The following figure presents an analysis of the change in PQI rates between CYs 2014 and 2015. The table shows that 7 of the 13 PQIs measured increased during this time period. PQIs 10 (dehydration), 08 (heart failure), and 14 (uncontrolled diabetes) accounted for the majority of this increase. Of the PQIs that decreased, 05 (chronic obstructive pulmonary disease or asthma in older adults), 03 (diabetes long-term complications), and 11 (bacterial pneumonia) accounted for the majority of the decrease.

Appendix I. Figure 1. PQI Trends, CY 2014-CY 2015

PQI Admission Rate	CY 2014 PQI COUNT A	CY 2015 PQI COUNT B	CY 2014-2015 %CHANGE C=D/A	CY 2015-2014 PQI COUNT D=B-A	CY 2015 % CONTRIBUTION
PQI 15 Asthma in Younger Adults	1,188	1,070	-9.9%	-118	-10.85%
PQI 03 Diabetes Long-Term Complications	4,853	4,454	-8.2%	-399	-36.67%
PQI 05 Chronic Obstructive Pulmonary Disease or Asthma in Older Adults	13,826	13,327	-3.6%	-499	-45.86%
PQI 11 Bacterial Pneumonia	9,712	9,504	-2.1%	-208	-19.12%
PQI 02 Perforated Appendix	1,091	1,069	-2.0%	-22	-2.02%
PQI 07 Hypertension	2,887	2,873	-0.5%	-14	-1.29%
PQI 01 Diabetes Short-Term Complications	2,933	2,935	0.1%	2	0.18%
PQI 12 Urinary Tract Infection	7,446	7,603	2.1%	157	14.43%
PQI 08 Heart Failure	13,744	14,435	5.0%	691	63.51%
PQI 16 Lower-Extremity Amputation among Patients with Diabetes	773	822	6.3%	49	4.50%
PQI 10 Dehydration	4358	5,161	18.4%	803	73.81%
PQI 14 Uncontrolled Diabetes	629	957	52.1%	328	30.15%
PQI 13 Angina Without Procedure	571	889	55.7%	318	29.23%
Total PQI, Unduplicated	**64,011**	**65,099**	**1.7%**	**1,088**	**100%**

APPENDIX II. PERCENT OF REVENUE IN PAU BY HOSPITAL

The following figure presents the total non-PAU revenue for each hospital, total PAU revenue by PAU category (PQI, readmissions, and total), total hospital revenue, and PAU as a percentage of total hospital revenue for CY 2015. Overall, 12.14 percent of total statewide hospital revenue was for PAU. (Updated from the Draft Recommendation to incorporate ICD-10 corrections. Final numbers for RY 2017 rate orders will be published by the end of June 2016).

Appendix II. Figure 1. PAU a Percentage of Total Revenue by Hospital, CY 2015

Hospital Name	Non-PAU Revenue A	Readmission Revenue B	PQI Revenue C	Total PAU Revenue D=B+C	Grand Total Hospital Revenue E=A+D	% Readmission F=B/E	% PQI G=C/E	% PAU H=F+G
MERITUS	$278,758,032	$23,935,112	$16,539,435	$40,474,547	$319,232,579	7.50%	5.18%	12.68%
UNIVERSITY OF MARYLAND	$1,377,464,969	$124,801,439	$28,095,737	$152,897,176	$1,530,362,144	8.16%	1.84%	9.99%
PRINCE GEORGE	$239,882,933	$24,966,656	$15,411,410	$40,378,066	$280,260,999	8.91%	5.50%	14.41%
HOLY CROSS	$423,324,914	$43,016,259	$20,094,808	$63,111,066	$486,435,981	8.84%	4.13%	12.97%
FREDERICK MEMORIAL	$317,248,500	$22,847,968	$17,388,012	$40,235,980	$357,484,480	6.39%	4.86%	11.26%
HARFORD	$85,109,236	$10,887,383	$8,301,450	$19,188,833	$104,298,069	10.44%	7.96%	18.40%
MERCY	$471,837,685	$21,767,464	$10,694,324	$32,461,787	$504,299,472	4.32%	2.12%	6.44%
JOHNS HOPKINS	$2,009,019,808	$198,729,754	$42,322,463	$241,052,217	$2,250,072,025	8.83%	1.88%	10.71%
DORCHESTER	$42,913,840	$5,810,179	$6,099,254	$11,909,432	$54,823,272	10.60%	11.13%	21.72%
ST. AGNES	$357,085,002	$37,698,472	$25,327,535	$63,026,007	$420,111,009	8.97%	6.03%	15.00%
SINAI	$643,855,411	$54,805,585	$23,959,492	$78,765,077	$722,620,488	7.58%	3.32%	10.90%
BON SECOURS	$88,888,125	$15,008,008	$6,078,826	$21,086,833	$109,974,958	13.65%	5.53%	19.17%
FRANKLIN SQUARE	$420,619,700	$51,762,928	$30,126,699	$81,889,627	$502,509,327	10.30%	6.00%	16.30%
WASHINGTON ADVENTIST	$225,202,801	$23,610,443	$13,138,857	$36,749,299	$261,952,100	9.01%	5.02%	14.03%
GARRETT COUNTY	$42,130,137	$1,428,688	$2,998,235	$4,426,923	$46,557,060	3.07%	6.44%	9.51%
MONTGOMERY GENERAL	$148,145,664	$14,176,460	$8,239,791	$22,416,251	$170,561,915	8.31%	4.83%	13.14%
PENINSULA REGIONAL	$373,984,935	$29,899,934	$22,521,716	$52,421,650	$426,406,584	7.01%	5.28%	12.29%

Hospital Name	Non-PAU Revenue A	Readmission Revenue B	PQI Revenue C	Total PAU Revenue D=B+C	Grand Total Hospital Revenue E=A+D	% Readmission F=B/E	% PQI G=C/E	% PAU H=F+G
SUBURBAN	$269,251,785	$21,755,907	$10,402,538	$32,158,445	$301,410,230	7.22%	3.45%	10.67%
ANNE ARUNDEL	$516,488,974	$31,579,286	$22,787,257	$54,366,543	$570,855,517	5.53%	3.99%	9.52%
UNION MEMORIAL	$355,148,712	$33,572,118	$16,492,523	$50,064,641	$405,213,352	8.29%	4.07%	12.36%
WESTERN MARYLAND HEALTH SYSTEM	$289,308,265	$22,810,433	$14,351,484	$37,161,917	$326,470,182	6.99%	4.40%	11.38%
ST. MARY	$150,042,473	$10,201,193	$9,257,977	$19,459,170	$169,501,643	6.02%	5.46%	11.48%
HOPKINS BAYVIEW MED CTR	$516,803,980	$52,100,389	$24,399,968	$76,500,357	$593,304,337	8.78%	4.11%	12.89%
CHESTERTOWN	$51,364,263	$3,656,943	$4,942,230	$8,599,173	$59,963,436	6.10%	8.24%	14.34%
UNION HOSPITAL OF CECIL COUNT	$137,071,783	$11,514,876	$10,577,694	$22,092,570	$159,164,353	7.23%	6.65%	13.88%
CARROLL COUNTY	$218,972,313	$20,254,167	$16,823,734	$37,077,901	$256,050,214	7.91%	6.57%	14.48%
HARBOR	$175,672,868	$17,294,894	$10,450,553	$27,745,447	$203,418,315	8.50%	5.14%	13.64%
CHARLES REGIONAL	$128,961,719	$12,444,699	$10,535,610	$22,980,309	$151,942,028	8.19%	6.93%	15.12%
EASTON	$165,740,757	$12,503,629	$11,444,605	$23,948,234	$189,688,991	6.59%	6.03%	12.62%
UMMC MIDTOWN	$167,394,950	$25,932,131	$8,825,245	$34,757,377	$202,152,326	12.83%	4.37%	17.19%
CALVERT	$127,370,735	$7,752,786	$9,387,103	$17,139,889	$144,510,623	5.36%	6.50%	11.86%
NORTHWEST	$211,908,045	$24,266,540	$18,167,037	$42,433,576	$254,341,622	9.54%	7.14%	16.68%
BALTIMORE WASHINGTON MEDICAL CENTER	$342,411,318	$40,794,574	$25,500,029	$66,294,602	$408,705,920	9.98%	6.24%	16.22%
G.B.M.C.	$400,652,316	$24,235,115	$14,576,995	$38,812,110	$439,464,425	5.51%	3.32%	8.83%
MCCREADY	$13,226,530	$393,646	$699,421	$1,093,067	$14,319,597	2.75%	4.88%	7.63%
HOWARD COUNTY	$252,809,879	$23,143,070	$13,851,236	$36,994,306	$289,804,185	7.99%	4.78%	12.77%
UPPER CHESAPEAKE HEALTH	$284,683,721	$23,198,373	$16,258,058	$39,456,431	$324,140,153	7.16%	5.02%	12.17%
DOCTORS COMMUNITY	$188,832,099	$24,920,871	$15,482,969	$40,403,840	$229,235,939	10.87%	6.75%	17.63%
LAUREL REGIONAL	$79,169,945	$8,475,374	$4,792,072	$13,267,446	$92,437,391	9.17%	5.18%	14.35%
GOOD SAMARITAN	$249,094,825	$31,259,300	$17,277,581	$48,536,881	$297,631,706	10.50%	5.81%	16.31%

Hospital Name	Non-PAU Revenue A	Readmission Revenue B	PQI Revenue C	Total PAU Revenue D=B+C	Grand Total Hospital Revenue E=A+D	% Readmission F=B/E	% PQI G=C/E	% PAU H=F+G
SHADY GROVE	$345,873,078	$29,710,171	$14,228,530	$43,938,701	$389,811,779	7.62%	3.65%	11.27%
REHAB & ORTHO	$104,007,760	$341,828	$-	$341,828	$104,349,588	0.33%	0.00%	0.33%
FT. WASHINGTON	$40,693,732	$3,068,272	$4,358,517	$7,426,789	$48,120,521	6.38%	9.06%	15.43%
ATLANTIC GENERAL	$93,620,264	$4,390,104	$5,193,041	$9,583,145	$103,203,409	4.25%	5.03%	9.29%
SOUTHERN MARYLAND	$216,826,400	$27,065,827	$20,381,819	$47,447,646	$264,274,046	10.24%	7.71%	17.95%
UM ST. JOSEPH	$374,832,474	$22,943,101	$11,745,266	$34,688,367	$409,520,840	5.60%	2.87%	8.47%
HOLY CROSS GERMANTOWN*	$56,181,444	$6,750,014	$5,143,503	$11,893,518	$68,074,962	9.92%	7.56%	17.47%
GERMANTOWN	$13,564,670			$-	$13,564,670	0.00%	0.00%	0.00%
QUEEN ANNES	$5,095,489			$-	$5,095,489	0.00%	0.00%	0.00%
BOWIE HEALTH	$21,300,381			$-	$21,300,381	0.00%	0.00%	0.00%
	$14,109,849,635	$1,283,482,360	$665,672,639	$1,949,154,999	$16,059,004,635	7.99%	4.15%	12.14%

*Holy Cross Germantown will be combined with Holy Cross Hospital for PAU Savings calculations.

APPENDIX III. Modeling Results Proposed PAU Savings Policy Reductions For RY 2017

The following figure presents the proposed PAU savings reduction policy for each hospital for RY 2017 (FY 16 Total Permanent revenue and PAU percents are updated from draft recommendation. Final adjustments will be published by the end of June).

Appendix IV. Figure 1. Proposed PAU Savings Policy Reductions for RY 2017, by Hospital

Hospital Name	FY16 Total Permanent Revenue A	CY15 PAU % B	FY17 PAU Savings Adjustment C=(B*-10.63%)[10]	FY 17 PAU Savings Adjustments before Protection D=A*C	CY 15 % Inpatient ECMAD Medicaid &Selfpay Charity E	FY17 PAU Savings Adjustment with Protection F	FY 17 PAU Savings with Protections Revenue Impact G=A*F	FY2016 PAU Savings Adjustment H	Net Impact to RY 2017 Inflation Factor I=F-H	Net RY 17 Revenue Impact J=A*O
DORCHESTER	$49,366,715	21.72%	-2.31%	$(1,139,783)	23.78%	-2.31%	($1,139,783)	-0.42%	-1.89%	**$(932,671)**
BON SECOURS	$122,434,137	19.17%	-2.04%	$(2,495,066)	57.59%	-1.29%	($1,579,400)	-0.60%	-0.69%	**$(844,796)**
HARFORD	$100,472,983	18.40%	-1.96%	$(1,964,643)	17.98%	-1.96%	($1,964,643)	-0.42%	-1.53%	**$(1,540,409)**
SOUTHERN MARYLAND	$265,443,855	17.95%	-1.91%	$(5,065,179)	22.27%	-1.91%	($5,065,179)	-0.59%	-1.32%	**$(3,508,483)**
DOCTORS COMMUNITY	$226,236,757	17.63%	-1.87%	$(4,238,040)	19.33%	-1.87%	($4,238,040)	-0.56%	-1.31%	**$(2,965,417)**
UMMC MIDTOWN	$223,767,089	17.19%	-1.83%	$(4,089,088)	45.61%	-1.29%	($2,886,595)	-0.60%	-0.69%	**$(1,543,993)**
NORTHWEST	$247,056,826	16.68%	-1.77%	$(4,380,776)	20.24%	-1.77%	($4,380,776)	-0.63%	-1.14%	**$(2,817,106)**
GOOD SAMARITAN	$283,376,592	16.31%	-1.73%	$(4,911,550)	18.26%	-1.73%	($4,911,550)	-0.67%	-1.06%	**$(3,005,753)**
FRANKLIN SQUARE	$488,282,513	16.30%	-1.73%	$(8,457,030)	26.69%	-1.29%	($6,298,844)	-0.60%	-0.69%	**$(3,369,149)**
BALTIMORE WASHINGTON	$396,558,220	16.22%	-1.72%	$(6,836,537)	17.18%	-1.72%	($6,836,537)	-0.64%	-1.08%	**$(4,295,768)**

[10] PAU reduction= % PAU (12.14%) / Savings (-1.25%) + the statewide impact of Medicaid Protection (0.04%) = -10.63%.

Hospital Name	FY16 Total Permanent Revenue A	CY15 PAU % B	FY17 PAU Savings Adjustment C=(B*-10.63%)[10]	FY 17 PAU Savings Adjustments before Protection D=A*C	CY 15 % Inpatient ECMAD Medicaid &Selfpay Charity E	FY17 PAU Savings Adjustment with Protection F	FY 17 PAU Savings with Protections Revenue Impact G=A*F	FY2016 PAU Savings Adjustment H	Net Impact to RY 2017 Inflation Factor I=F-H	Net RY 17 Revenue Impact J=A*O
FT. WASHINGTON	$46,558,629	15.43%	-1.64%	$(763,718)	22.44%	-1.64%	($763,718)	-0.42%	-1.22%	**$(569,724)**
ST. AGNES	$413,273,339	15.00%	-1.59%	$(6,589,540)	21.56%	-1.59%	($6,589,540)	-0.60%	-0.99%	**$(4,102,853)**
CHARLES REGIONAL	$143,315,213	15.12%	-1.61%	$(2,303,733)	16.36%	-1.61%	($2,303,733)	-0.54%	-1.07%	**$(1,531,088)**
CARROLL COUNTY	$245,978,519	14.48%	-1.54%	$(3,785,726)	13.81%	-1.54%	($3,785,726)	-0.54%	-1.00%	**$(2,468,432)**
LAUREL REGIONAL	$101,288,035	14.35%	-1.53%	$(1,545,111)	29.90%	-1.29%	($1,306,616)	-0.60%	-0.69%	**$(698,887)**
PRINCE GEORGE	$278,868,894	14.41%	-1.53%	$(4,270,167)	45.25%	-1.29%	($3,597,409)	-0.56%	-0.73%	**$(2,039,951)**
CHESTERTOWN	$53,997,130	14.34%	-1.52%	$(823,006)	12.40%	-1.52%	($823,006)	-0.49%	-1.04%	**$(560,627)**
WASHINGTON ADVENTIST	$253,346,309	14.03%	-1.49%	$(3,777,493)	31.92%	-1.29%	($3,268,167)	-0.60%	-0.69%	**$(1,748,090)**
UNION HOSPITAL OF CECIL COUNT	$153,588,495	13.88%	-1.48%	$(2,265,797)	28.02%	-1.29%	($1,981,292)	-0.36%	-0.93%	**$(1,424,084)**
HARBOR	$190,199,181	13.64%	-1.45%	$(2,757,225)	33.93%	-1.29%	($2,453,569)	-0.60%	-0.69%	**$(1,312,374)**
HOLY CROSS	$473,189,703	13.53%	-1.44%	$(6,802,600)	22.06%	-1.44%	($6,802,600)	-0.68%	-0.76%	**$(3,587,331)**
HOLY CROSS GERMANTOWN	$88,000,000	13.53%	-1.44%	$(1,265,093)	23.98%	-1.44%	($1,265,093)	0.00%	-1.44%	**$(1,265,093)**
MONTGOMERY GENERAL	$168,451,048	13.14%	-1.40%	$(2,352,971)	15.17%	-1.40%	($2,352,971)	-0.50%	-0.90%	**$(1,509,878)**
HOPKINS BAYVIEW MED CTR	$610,423,590	12.89%	-1.37%	$(8,365,255)	29.06%	-1.29%	($7,874,464)	-0.60%	-0.69%	**$(4,211,923)**

Hospital Name	FY16 Total Permanent Revenue A	CY15 PAU % B	FY17 PAU Savings Adjustment C=(B*-10.63%)[10]	FY 17 PAU Savings Adjustments before Protection D=A*C	CY 15 % Inpatient ECMAD Medicaid &Selfpay Charity E	FY17 PAU Savings Adjustment with Protection F	FY 17 PAU Savings with Protections Revenue Impact G=A*F	FY2016 PAU Savings Adjustment H	Net Impact to RY 2017 Inflation Factor I=F-H	Net RY 17 Revenue Impact J=A*O
HOWARD COUNTY	$284,424,840	12.77%	-1.36%	$(3,858,866)	14.14%	-1.36%	($3,858,866)	-0.57%	-0.79%	**$(2,241,171)**
MERITUS	$309,029,336	12.68%	-1.35%	$(4,164,247)	18.67%	-1.35%	($4,164,247)	-0.60%	-0.75%	**$(2,305,550)**
EASTON	$192,089,981	12.62%	-1.34%	$(2,577,496)	17.32%	-1.34%	($2,577,496)	-0.52%	-0.82%	**$(1,581,849)**
UNION MEMORIAL	$411,630,821	12.36%	-1.31%	$(5,405,268)	17.66%	-1.31%	($5,405,268)	-0.62%	-0.69%	**$(2,852,296)**
PENINSULA REGIONAL	$413,594,890	12.29%	-1.31%	$(5,404,107)	18.16%	-1.31%	($5,404,107)	-0.53%	-0.78%	**$(3,213,316)**
UPPER CHESAPEAKE HEALTH	$319,063,053	12.17%	-1.29%	$(4,127,846)	10.86%	-1.29%	($4,127,846)	-0.49%	-0.81%	**$(2,579,263)**
CALVERT	$140,329,390	11.86%	-1.26%	$(1,768,963)	16.42%	-1.26%	($1,768,963)	-0.33%	-0.93%	**$(1,299,956)**
WESTERN MARYLAND HEALTH SYSTEM	$312,666,774	11.38%	-1.21%	$(3,782,668)	15.60%	-1.21%	($3,782,668)	-0.58%	-0.63%	**$(1,960,906)**
ST. MARY	$168,090,518	11.48%	-1.22%	$(2,050,952)	18.69%	-1.22%	($2,050,952)	-0.38%	-0.84%	**$(1,417,198)**
FREDERICK MEMORIAL	$350,725,799	11.26%	-1.20%	$(4,195,532)	11.03%	-1.20%	($4,195,532)	-0.50%	-0.70%	**$(2,440,515)**
SHADY GROVE	$374,624,719	11.27%	-1.20%	$(4,487,977)	19.76%	-1.20%	($4,487,977)	-0.53%	-0.67%	**$(2,509,843)**
SINAI	$698,636,216	10.90%	-1.16%	$(8,093,502)	24.05%	-1.16%	($8,093,502)	-0.66%	-0.50%	**$(3,462,623)**
SUBURBAN	$290,002,663	10.67%	-1.13%	$(3,288,524)	7.53%	-1.13%	($3,288,524)	-0.58%	-0.55%	**$(1,603,745)**
JOHNS HOPKINS	$2,178,990,299	10.71%	-1.14%	$(24,810,297)	23.04%	-1.14%	($24,810,297)	-0.73%	-0.41%	**$(9,001,453)**

Hospital Name	FY16 Total Permanent Revenue A	CY15 PAU % B	FY17 PAU Savings Adjustment C=(B*-10.63%)[10]	FY 17 PAU Savings Adjustments before Protection D=A*C	CY 15 % Inpatient ECMAD Medicaid &Selfpay Charity E	FY17 PAU Savings Adjustment with Protection F	FY 17 PAU Savings with Protections Revenue Impact G=A*F	FY2016 PAU Savings Adjustment H	Net Impact to RY 2017 Inflation Factor I=F-H	Net RY 17 Revenue Impact J=A*O
ANNE ARUNDEL	$553,902,629	9.52%	-1.01%	$(5,606,617)	12.02%	-1.01%	($5,606,617)	-0.54%	-0.47%	**$(2,608,775)**
GARRETT COUNTY	$45,640,340	9.51%	-1.01%	$(461,240)	19.56%	-1.01%	($461,240)	-0.24%	-0.77%	**$(352,014)**
ATLANTIC GENERAL	$100,960,082	9.29%	-0.99%	$(996,381)	11.51%	-0.99%	($996,381)	-0.36%	-0.63%	**$(634,652)**
UNIVERSITY OF MARYLAND	$1,289,991,934	9.99%	-1.06%	$(13,697,907)	29.87%	-1.06%	($13,697,907)	-0.60%	-0.46%	**$(5,957,955)**
G.B.M.C.	$423,026,290	8.83%	-0.94%	$(3,970,753)	9.87%	-0.94%	($3,970,753)	-0.41%	-0.53%	**$(2,246,614)**
UM ST. JOSEPH	$384,647,527	8.47%	-0.90%	$(3,462,843)	11.82%	-0.90%	($3,462,843)	-0.54%	-0.36%	**$(1,392,995)**
MCCREADY	$14,230,659	7.63%	-0.81%	$(115,452)	15.85%	-0.81%	($115,452)	-0.19%	-0.62%	**$(87,784)**
MERCY	$491,288,212	6.44%	-0.68%	$(3,361,106)	24.64%	-0.68%	($3,361,106)	-0.52%	-0.16%	**$(801,106)**
REHAB & ORTHO	$117,875,574	0.33%	-0.03%	$(41,040)	21.53%	-0.03%	($41,040)	-0.30%	0.27%	**$312,587**
Total	**$15,488,936,318**	**12.14%**	**-1.29%**	**$(199,807,279)**			**($194,157,796)**	**-0.60%**	**-0.65%**	**$(104,405,458)**
				Top Quartile=	21.37%					

EXHIBIT 16

HEALTH SERVICES COST REVIEW

ANNE ARUNDEL MEDICAL CENTER

FY 2014 Annual Filing

SUBMISSION

(EXCERPT)

REVENUE CENTER RATE SUMMARY

INSTITUTION NAME: Anne Arundel Medical Center
INSTITUTION NUMBER: 0023

BASE YEAR 6/30/2014
BUDGET YEAR 6/30/2015

			UNITS OF MEASURE	DIRECT EXPENSES	PAT CARE OVERHEAD EXPENSES	OTHER OVERHEAD EXPENSES	N/A	PHYSICIAN SUPPORT EXPENSES	RESIDENT INTERN EXPENSES	LEVEL I	CFA BLDG & GENRL EQUIPMENT	CFA DEPART-MENTAL	LEVEL II
	DESCRIPTION	CODE	COL 1	COL 2	COL 3	COL 4	COL 5	COL 6	COL 7	COL 8	COL 9	COL 10	COL 11
A1	Med/Surg Acute	MSG	68,647	37,966.8	8,123.2	9,017.5				55,107.5	12,682.9	60.3	67,850.7
2	Pediatric Acute	PED	1,196	1,139.6	85.2	268.1				1,492.9	23.5	1.1	1,517.5
3	Psychiatric Acute	PSY											
4	Obstetrics Acute	OBS	13,425	6,116.6	1,181.9	1,450.7				8,749.2	1,416.9	11.8	10,177.8
5	Definitive Observation	DEF	10,471	8,359.9	1,064.3	1,973.8				11,398.0	1,600.9	9.2	13,008.0
6	Med/Surg Intensive Care	MIS	4,966	5,928.3	768.2	1,399.9				8,096.4	1,218.9	197.1	9,512.5
7	Coronary Care	CCU											
8	Pediatric Intensive Care	PIC											
9	Neo-Natal Intensive Care	NEO	6,804	5,665.1	597.1	1,335.6				7,597.8	1,329.1	175.8	9,102.7
10	Burn Care	BUR											
11													
12	Shock Trauma	TRM											
13	Oncology	ONC											
14	Newborn Nursery	NUR	10,894	3,933.7	567.0	929.7				5,420.4	1,141.7		6,562.1
15	Premature Nursery	PRE											
16	Rehabilitation	RHB											
17	Intermediate Care	ICC											
18	Emergency Services	EMG	862,307	13,030.2	2,557.1	3,245.4				18,832.7	5,491.4	0.1	24,324.2
19	Clinical Services	CL	606,358	11,353.1	1,340.6	2,823.9				15,517.5	1,380.6	0.0	16,898.1
20	Observation	OBV	97,405	3,283.9	281.6	781.4				4,346.9	588.6	0.0	4,935.5
21	Psych. Day & Night Care	PDC											
22	Lithotripsy	LIT	18	29.4	3.0	10.3				42.7	0.4		43.1
23	Same Day Surgery	SDS	15,068	6,939.4	573.0	1,799.4				9,311.8	1,237.9	0.0	10,549.7
24	Free Standing Emergency	FSE											
25	Labor & Delivery Services	DEL	201,863	9,159.2	1,215.4	2,265.8				12,640.4	2,506.8	0.1	15,147.2
26	Operating Room	OR	2,359,110	23,858.7	3,890.0	7,040.5				34,789.2	7,816.3	2,066.0	44,671.5
27	Operating Room Clinic	ORC	53,554	42.3	98.0	16.5				156.9	217.8		374.7
28	Ambulance Services-Rebundled	AMR											
29	Anesthesiology	ANS											
30	Laboratory Services	LAB	18,495,435	10,938.8	1,086.3	3,100.7				15,125.9	1,478.9	341.9	16,946.7
31	Ambulatory Surgery (PBP)	AMS											
32	Electrocardiography	EKG	818,666	1,301.6	147.9	377.4				1,826.9	303.6	0.0	2,130.5
33	Electroencephalography	EEG	216,994	1,247.6	170.5	382.3				1,800.4	156.8		1,957.2
34	Radiology-Diagnostic	RAD	403,662	5,307.3	707.5	1,629.0				7,643.8	1,166.3	587.3	9,397.4
35	Radiology-Therapeutic	RAT	647,160	5,148.6	825.3	1,823.4				7,797.3	1,849.9	1,321.8	10,769.1
36	Nuclear Medicine	NUC	123,627	1,009.9	122.6	317.9				1,450.4	269.9	173.0	1,893.2
37	CT Scanner	CAT	873,076	1,700.4	158.9	517.2				2,376.5	146.8	29.3	2,552.6
38	Interventional Radiology/Cardiovascular	IRC	199,749	4,388.4	451.4	1,403.3				6,243.0	905.2	423.8	7,572.0
39	Respiratory Therapy	RES	3,091,067	3,468.4	149.2	841.9				4,459.6	221.6		4,681.2
40	Pulmonary Function Testing	PUL	241,147	373.1	26.6	113.1				512.8	51.3		534.1
41	Renal Dialysis	RDL	2,901	765.1	118.8	181.0				1,064.9	96.0		1,160.9
42	Physical Therapy	PTH	1,385,623	5,233.9	418.6	1,631.9				7,284.4	230.9	0.0	7,515.3
43	Occupational Therapy	OTH	244,675	959.0	53.6	277.5				1,290.1	56.4		1,346.5
44	Speech Language Pathology	STH	218,568	876.7	212.2	251.2				1,340.2	401.9		1,742.1
45	Organ Acquisition	OA											
46	Ambulatory Surgery	AOR											
47	Leukopheresis	LEU											
48	Hyperbaric Chamber	HYP	948	90.7	39.6	32.0				162.3	75.1		237.4
49	Audiology	AUD											
50	Transurethral Needle Ablation	TNA											
51	Magnetic Resonance Imaging	MRI	73,544	874.3	25.6	253.3				1,153.2	54.3	212.4	1,419.8
52	Oncology Clinic	OCL											
53	Transurethral Microwave Thermotherapy	TMT											
54	Admission Services	ADM	26,816		4,221.4	581.2				4,802.6			4,802.6
55	Med/Surg Supplies	MSS	48,315	62,037.9	4,837.3	1,212.6				68,087.8	967.1		69,054.9
56	Drugs Sold	CDS	40,315	41,915.3	9,824.4	3,123.8				54,863.6	840.6		55,704.2
57													
B	TOTAL		31,470,576	284,443.4	45,933.4	52,409.3				382,786.1	47,726.3	5,610.7	436,123.0

REVENUE CENTER RATE SUMMARY

INSTITUTION NAME: Anne Arundel Medical Center
INSTITUTION NUMBER: 0023

BASE YEAR 6/30/2014
BUDGET YEAR 6/30/2015

			OFC									
			DIRECT	PERCENTAGE	LEVEL III	PAYOR DIFFER-ENTIAL	LEVEL IV	CROSS SUBSIDY	MISC ADJ	HSCRC ADJ	ADJUST LEVEL IV	AVERAGE RATES
	DESCRIPTION	CODE	COL 1	COL 2	COL 3	COL 4	COL 5	COL 6	COL 7	COL 8	COL 9	COL 10
A1	Med/Surg Acute	MSG		91.0	67,941.7	6,603.6	74,545.3				74,545.3	1,082.7670
2	Pediatric Acute	PED		2.0	1,519.5	147.7	1,667.2				1,667.2	1,393.9697
3	Psychiatric Acute	PSY										
4	Obstetrics Acute	OBS		13.7	10,191.5	990.6	11,182.1				11,182.1	832.9334
5	Definitive Observation	DEF		17.4	13,025.4	1,266.0	14,291.4				14,291.4	1,364.8572
6	Med/Surg Intensive Care	MIS		12.8	9,525.3	925.8	10,451.1				10,451.1	2,103.6781
7	Coronary Care	CCU										
8	Pediatric Intensive Care	PIC										
9	Neo-Natal Intensive Care	NEO		12.2	9,114.9	885.9	10,000.8				10,000.8	1,469.8380
10	Burn Care	BUR										
11												
12	Shock Trauma	TRM										
13	Oncology	ONC										
14	Newborn Nursery	NUR		8.8	6,570.9	638.7	7,209.6				7,209.6	661.7940
15	Premature Nursery	PRE										
16	Rehabilitation	RHB										
17	Intermediate Care	ICC										
18	Emergency Services	EMG		32.6	24,356.8	2,367.4	26,724.2				26,724.2	30.9915
19	Clinical Services	CL		22.7	16,920.8	1,644.6	18,565.4				18,565.4	30.6179
20	Observation	OBV		6.6	4,942.1	480.4	5,422.5				5,422.5	55.8696
21	Psych. Day & Night Care	PDC										
22	Lithotripsy	LIT		0.1	43.2	4.2	47.4				47.4	2,634.5883
23	Same Day Surgery	SDS		14.2	10,563.9	1,026.8	11,590.7				11,590.7	769.2288
24	Free Standing Emergency	FSE										
25	Labor & Delivery Services	DEL		20.3	15,167.5	1,474.2	16,641.7				16,641.7	82.4406
26	Operating Room	OR		59.9	44,731.4	4,347.7	49,079.1				49,079.1	20.8041
27	Operating Room Clinic	ORC		0.5	375.2	36.5	411.7				411.7	7.6874
28	Ambulance Services-Rebundled	AMR										
29	Anesthesiology	ANS										
30	Laboratory Services	LAB		22.7	16,969.4	1,649.3	18,618.7				18,618.7	1.0067
31	Ambulatory Surgery (PBP)	AMS										
32	Electrocardiography	EKG		2.9	2,133.4	207.4	2,340.8				2,340.8	2.6593
33	Electroencephalography	EEG		2.6	1,959.8	190.5	2,150.3				2,150.3	9.9066
34	Radiology-Diagnostic	RAD		12.6	9,410.0	914.6	10,324.6				10,324.6	25.5772
35	Radiology-Therapeutic	RAT		14.4	10,783.5	1,048.1	11,831.6				11,831.6	18.2823
36	Nuclear Medicine	NUC		2.5	1,895.7	184.3	2,080.0				2,080.0	16.8250
37	CT Scanner	CAT		3.4	2,556.0	248.4	2,804.4				2,804.4	3.2121
38	Interventional Radiology/Cardiovascular	IRC		10.2	7,582.2	737.0	8,319.2				8,319.2	41.6481
39	Respiratory Therapy	RES		8.3	4,687.5	455.6	5,143.1				5,143.1	1.6638
40	Pulmonary Function Testing	PUL		0.8	564.9	54.9	619.8				619.8	2.5702
41	Renal Dialysis	RDL		1.6	1,162.5	113.0	1,275.5				1,275.5	439.6822
42	Physical Therapy	PTH		10.1	7,525.4	731.4	8,256.8				8,256.8	5.9589
43	Occupational Therapy	OTH		1.8	1,348.3	131.0	1,479.3				1,479.3	6.0450
44	Speech Language Pathology	STH		2.3	1,744.4	169.5	1,913.9				1,913.9	8.8373
45	Organ Acquisition	OA										
46	Ambulatory Surgery	AOR										
47	Leukopheresis	LEU										
48	Hyperbaric Chamber	HYP		0.3	237.7	23.1	260.8				260.8	275.1405
49	Audiology	AUD										
50	Transurethral Needle Ablation	TNA										
51	Magnetic Resonance Imaging	MRI		1.9	1,421.7	138.2	1,559.9				1,559.9	21.2108
52	Oncology Clinic	OCL										
53	Transurethral Microwave Thermotherapy	TMT										
54	Admission Services	ADM		6.4	4,809.0	467.4	5,276.4				5,276.4	196.7645
55	Med/Surg Supplies	MSS		92.6	69,147.5	6,720.8	75,868.3				75,868.3	1,570.2879
56	Drugs Sold	CDS		74.7	55,778.9	5,421.4	61,200.3				61,200.3	1,266.6955
57												
B	TOTAL			584.9	436,707.9	42,446.0	479,153.9				479,153.9	