IN THE MATTER OF	*	
	*	BEFORE THE
ANNE ARUNDEL MEDICAL CENTER MENTAL HEALTH HOSPITAL	*	
	*	MARYLAND HEALTH
	*	
Docket No. 16-02-2375	*	CARE COMMISSION
	*	

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UNIVERSITY OF MARYLAND
BALTIMORE WASHINGTON MEDICAL CENTER'S
COMMENTS ON ANNE ARUNDEL MEDICAL CENTER'S
CON APPLICATION PROPOSING THE ESTABLISHMENT OF
A SPECIAL PSYCHIATRIC HOSPITAL

University of Maryland Baltimore Washington Medical Center ("UM BWMC"), by its undersigned counsel and pursuant to COMAR § 10.24.01.08F, submits these comments addressing the Certificate of Need Application ("CON") and related materials filed by Anne Arundel Medical Center ("AAMC") proposing to establish a special psychiatric hospital.

INTRODUCTION

UM BWMC does not oppose the addition of inpatient psychiatric beds at AAMC, but the new capacity should be added in the existing acute care hospital. Instead, AAMC proposes to establish a new health care facility located several miles from the hospital, its emergency department ("ED"), and other important hospital services.

AAMC's proposal to establish an expensive special psychiatric hospital, which if expanded by a single bed, may be precluded from receiving payment for treating adult Medicaid patients, is not the most cost effective alternative to achieve the objective of increasing inpatient psychiatric services in Anne Arundel County. After analyzing the reasons AAMC advances for proposing to build an entirely new health care facility rather than use available space in its existing hospital, it is apparent that AAMC's decision is based on boosting its own revenue. In

short, AAMC proposes to build a new facility at three to four times the cost of converting space in its existing hospital so that it may maximize its revenue and not use a small portion of the hospital's substantial net income to offset the modest losses of a hospital-based unit. Meanwhile, other providers, including UM BWMC, are expanding psychiatric inpatient capacity within their hospitals within the confines of the HSCRC's market shift policy. Thus, these providers will be paid at 50% revenue variability, while AAMC's plan is to be paid at 100% of the charges at a special hospital.

UM BWMC asks the Maryland Health Care Commission to: (1) deny the proposed project as presented; and (2) urge AAMC to modify its Application to establish an inpatient psychiatric unit within the existing AAMC acute general hospital. In the event the Commission approves the proposed project, AAMC should not be permitted to add beds, and thus be subject to the federal exclusion for adult Medicaid patients in an Institution for Mental Disease ("IMD"), and should not be permitted to include shell space that comprises one-third of the building's space, without express Commission approval.

STATEMENT OF INTERESTED PARTY STATUS

UM BWMC is an "interested party" within the meaning of COMAR § 10.24.01.01B(20) because approval of AAMC's Application would adversely affect UM BWMC in an issue area over which the Commission has jurisdiction. UM BWMC is a provider of inpatient psychiatric services within Anne Arundel County. Presently, UM BWMC's inpatient unit includes 14 beds, but the service will be expanded to 24 beds within the next several months.

Aside from the unfairness of UM BWMC being paid 50% of revenue while AAMC would be paid 100% of its charges for the same service, approval of the proposed project also would: (1) cause UM BWMC to suffer a depletion of essential staffing for its existing inpatient

psychiatric unit; and, if the proposed facility is not permitted to receive Medicaid reimbursement for adult patients; and (2) cause UM BWMC to treat more adult Medicaid enrollees, which is more costly as well as producing lower physician services payments and greater need for UM BWMC to subsidize its physicians.

The current shortage of psychiatrists is well known and documented. Tara F. Bishop, *et al., Population of US Practicing Psychiatrists Declined, 2003-13, Which May Help Explain Poor Access to Mental Health Care,* 35 H. Aff. 7 (2016).[1] One reason for the shortage is that the Affordable Care Act has made behavioral health services more accessible to Americans by precluding insurers from denying coverage to people who have been diagnosed with mental illness. Also, fewer medical students are electing to pursue psychiatry. Like most providers, UM BWMC is experiencing great difficulty recruiting psychiatrists to serve its patients. AAMC's proposed program would make staffing even more difficult, especially since AAMC would have a competitive advantage with the benefit of full revenue for its special hospital while UM BWMC will receive substantially reduced revenue for the expansion portion of its inpatient psychiatric unit.

As explained in Section II.A below, if AAMC's proposed new facility becomes an IMD, such as by adding even a single bed, it may be precluded from receiving payment for treating adult Medicaid patients. In this event, UM BWMC would be the sole provider of inpatient psychiatric services for adult Medicaid patients in Anne Arundel County. The payment UM BWMC receives for physician services provided to Medicaid patients is significantly less than the compensation paid to the physicians. For example, in FY 2016, UM BWMC paid physician

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[1] http://content.healthaffairs.org/content/35/7/1271.abstract.

subsidies of $660,000 on account of psychiatric care provided to patients. UM BWMC receives approximately 14% less payment for physician services provided to Medicaid patients for psychiatric care than for the same services provided to patients with commercial payers.

In addition to the increased cost of physician subsidies related to more Medicaid psychiatric admissions, national data show that Medicare and Medicaid patients have a greater rate of readmission for mood disorders and schizophrenia than privately insured or uninsured patients. According to an analysis of 2012 data, Medicaid patients suffering from mood disorder had a readmission rate of 14.4%, while the rate of readmission was 9.1% for privately insured patients and 10.4% for uninsured patients. Kevin C Heslin and Audrey J. Weiss, *Hospital Readmissions Involving Psychiatric Disorders, 2012*, Healthcare Cost and Utilization Project, Statistical Brief 189 (2015), p. 7.[2] For schizophrenia, the differences were even greater, with Medicaid patients experiencing a 20.4% readmission rate, while privately insured patients were readmitted at a rate of 13.1% and uninsured patients at a rate of 11.8%. Under the Maryland GBR system, readmissions are more costly for hospitals. Thus, if UM BWMC treats more Medicaid patients as a result of AAMC's facility possibly becoming an IMD, the cost of the care at UM BWMC will increase.

ARGUMENT

I. AAMC CANNOT DEMONSTRATE THAT ITS PROPOSAL TO ESTABLISH A SPECIAL PSYCHIATRIC HOSPITAL WITH SUBSTANTIAL SHELL SPACE IS THE MOST COST EFFECTIVE ALTERNATIVE.

AAMC is required to demonstrate that the proposed project is the most cost effective alternative. Specifically, pursuant to COMAR § 10.24.01.08G(3)(c), the Commission must

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[2] http://www.hcup-us.ahrq.gov/reports/statbriefs/sb189-Hospital-Readmissions-Psychiatric-Disorders-2012.pdf

"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."

The Commission's form CON application requires an applicant to provide information about the alternatives it considered. Among other things, an applicant must fully explain the primary goals or objectives of the project and identify the alternative approaches to achieving the goals or objectives. For each alternative, the Commission requires an applicant to provide information on the level of effectiveness in goal or objective achievement and the costs of the alternative. The cost analysis must include development costs as well as "life cycle costs."

AAMC identified four goals:

(1) Eliminate the delays and barriers to timely 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 by establishing a comprehensive and integrated mental health care program that enables coordination with community-based 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.

AAMC Application, at 80.

AAMC stated that it considered three options to achieve its goals: (1) do nothing; (2) convert existing space in the acute general hospital; (3) construct a new facility on the Riva

Road site; and (4) construct a new facility in an unspecified location. AAMC determined that the third option – a new facility on the Riva Road site – is the most cost effective. However, as explained below, the Commission should find that converting existing hospital space, *i.e.*, the "hospital-based unit option," is the most cost effective alternative. In the event the Commission permits AAMC to build a new facility to develop inpatient psychiatric capacity, it should not permit the substantial shell space proposed by AAMC.

AAMC rejected the hospital-based unit option for several fallacious reasons, and it apparently disregarded several advantages to establishing the inpatient psychiatric unit in the hospital.

A. Establishing a Hospital-Based Inpatient Psychiatric Unit is More Cost Effective.

1. The hospital-based unit option will cost only a fraction of the cost of the proposed new facility.

AAMC recognizes that building the inpatient psychiatric unit within the existing acute general hospital would be much less costly than building an entirely new facility several miles from the existing hospital. AAMC estimates the cost of converting existing space would be between $6.5 million and $8.5 million. AAMC Application, at 82. By comparison, the estimated cost of the proposed new facility, as modified, is $25 million, three to four times more costly than converting existing space to achieve AAMC's goals. AAMC's August 1, 2016 Project Cost and Shell Space Updates (modified Table E).

2. AAMC fails to explain why space in the existing hospital is unsuitable for inpatient psychiatric capacity.

AAMC noted that the only potential space for the project in the hospital is on an elevated floor (the sixth floor of the North Hospital Pavilion), which it states is not ideal for a mental health locked unit, and that access for visitors and security for patients and visitors are inferior to

those that could be achieved in a new facility. However, as described in the Application, the proposed new facility also would use elevated floors (the second and third floors) for inpatient capacity. AAMC does not explain why it cannot make the space in the existing hospital as secure as the inpatient space in the proposed new facility.

3. Staff efficiency would be enhanced in the hospital-based unit option.

AAMC claims that the "ability to share staff across inpatient and partial hospital programs would be compromised" in the hospital-based unit option. AAMC does not analyze the staffing efficiencies that would be achieved by locating the inpatient psychiatric unit in the existing hospital. Presumably, there would be significant overall savings in staffing by taking advantage of the staffing infrastructure of the existing hospital, yet AAMC failed to describe or quantify any of these savings. By building a separate facility, AAMC will be forced to maintain redundant staff functions in both locations, including maintenance, admitting, food service, materials management, among others.

Perhaps more important than avoiding administrative and building staff redundancy, the hospital-based unit option would facilitate clinical staff integration. In particular, a hospital-based unit could share and coordinate clinical staff with AAMC's ED. Indeed, AAMC states that its need for inpatient psychiatric capacity is caused largely by visits to its ED, noting that in FY 2015 its ED experienced 2,420 visits of patients with a mental health diagnosis and generated more than 1,100 adult and pediatric transfers to an acute psychiatric unit outside of Anne Arundel County. AAMC Application, at 8. Yet, it selected a project option that divorces the inpatient psychiatric unit from the ED.

AAMC will need to staff its ED with mental health professionals and, given the distance between the ED and the proposed facility, AAMC will be unable to use the same staff in the new

facility. Also, the hospital-based unit option would permit AAMC to use the same mental health clinicians to treat patients in the inpatient psychiatric unit as well as patients with comorbidities who are being treated in MSGA beds. As AAMC acknowledges, many psychiatric patients suffer from comorbidities and require simultaneous treatments. AAMC Application, at 13. AAMC ignores these clinical integration benefits, and instead focuses solely on the possible benefit of coordinating outpatient and inpatient psychiatric staffing. While AAMC touts the benefits of combining inpatient and outpatient services, it does not explain why the outpatient services could not be moved to the acute care hospital campus rather than to the proposed new facility. Also, the only outpatient service that will be included initially in the proposed project is the partial hospitalization program, which is planned to occupy only a portion of the first floor of the proposed new facility. AAMC's Responses to May 3, 2016 Completeness Questions, Response to Question 12(a).

In sum, efficiency through staff-sharing is a strength of the hospital-based unit option, not a weakness as represented by AAMC. AAMC seemed to acknowledge the staffing advantage of the hospital-based unit option when it evaluated the options in its "Scoring Matrix." AAMC Application, at 81. Specifically, AAMC scored the hospital-based unit option with the highest score of "5" for both "staffing" and "support services," and it scored the proposed project as "3" and "1," respectively, for these considerations. The Commission should require AAMC to complete a Work Force Table (Table L) for the hospital-based unit option so that the Commission can evaluate the relative staff savings of the options.

4. *AAMC fails to support the need for expansion space and does not account for all space available for expansion on the existing hospital campus.*

AAMC notes that the sixth floor of the North Hospital Pavilion does not have space for future expansion, but it does not provide any information or analysis about space that may be available elsewhere in the hospital.

Moreover, AAMC does not show need for any bed capacity beyond the 16 beds it seeks in its Application. When forced by the Commission staff to justify the extensive proposed shell space in the proposed facility by showing additional need for beds, AAMC asserted that it may seek to add an adolescent psychiatric unit in the future. AAMC's Responses to June 23, 2016 Completeness Questions, Response to Question 3. AAMC noted that presently there is no adolescent unit in Anne Arundel County and that 90% of adolescent patients in the County are referred to Sheppard Pratt, approximately a one-hour drive away. *Id*. However, AAMC's analysis fails to account for the recently approved Sheppard Pratt at Elkridge project, which will include a 17-bed adolescent unit. *In re Sheppard Pratt at Elkridge*, Docket No. 15-13-2367. The new Sheppard Pratt hospital will be located in Howard County, approximately 1.5 miles from the Anne Arundel County line and 18 miles from AAMC.

5. *The hospital-based unit option would have no material effect on AAMC's financial feasibility.*

AAMC explains that it rejected the hospital-based unit option because the unit would not be sustainable over time due to projected losses of $1.28 million in Year 3. AAMC Application at 82. The reason for the projected losses is that the HSCRC informed AAMC that reimbursement for inpatient services would be subject to a 50% variable cost factor. *Id.* AAMC provides no detail or support for its financial projections. The Commission should require AAMC to show the full financial picture by requiring AAMC to complete Tables E–L for the

hospital-based option. If AAMC completes these tables, as it recently did in connection with the Baltimore Upper Shore Cardiac Surgery Review (Docket Nos. 15-02-2360, 15-02-2361), the financial projections for the entire hospital will show projected net income of at least $62.7 million in FY 2019. AAMC's November 7, 2016 Modification of CON Application for Cardiac Surgery Services, Table G, attached as **Exhibit 1**.

Thus, assuming AAMC is correct that it would sustain losses of $1.28 million for the hospital-based unit option, these losses would not be material to the overall financial feasibility of the hospital. Indeed, in the cardiac surgery CON review, AAMC has asserted that it is proper for it to reallocate revenue from other sources in the hospital to subsidize its proposed cardiac surgery program, which it projects will lose at least $3 million each year (more than twice the projected losses for the inpatient psychiatric service). AAMC's November 7, 2016 Modification of CON Application for Cardiac Surgery Services, at 8, 10-11 (Exh. 1).

Other area hospitals are also planning projects to meet the need for additional inpatient psychiatric capacity, but unlike AAMC, they are not prioritizing revenue goals. For example, UM BWMC recently received a determination from the Commission that a CON is not needed to expand its inpatient psychiatric capacity by ten beds. July 18, 2016 Determination of Coverage Request, attached as **Exhibit 2**. UM BWMC intends to proceed with the expansion project within the next several months. Under the agreement between the University of Maryland Medical System and the HSCRC regarding its global budget revenue ("GBR"), UM BWMC will be reimbursed for additional inpatient psychiatric volume at a 50% variable cost factor. Likewise, Doctors Community Hospital ("DCH") recently applied for a CON to establish a 16-bed inpatient psychiatric unit on the campus of its hospital, which will be regarded as part of the acute general hospital. *See* October 7, 2016 Certificate of Need Application filed by DCH,

Matter No. 16-16-2386. Like UM BWMC, DCH will be reimbursed for new services at a 50% variable cost factor. Also, MedStar Health recently announced plans to expand its behavioral health services at MedStar Harbor Hospital, a short distance from Anne Arundel County. As a hospital-based unit, the new MedStar expansion would be subject to the HSCRC's market shift policy.

If AAMC is permitted to build a new facility at a cost of $18 million more than using existing space in its acute general hospital based on a revenue enhancement rationale, then future applicants will be encouraged to use AAMC's approach rather than employ the more cost effective approaches of UM BWMC and DCH.

6. *The hospital-based unit option does not present any risk that AAMC may not be permitted to receive Medicaid reimbursement for treating adult inpatient psychiatric patients.*

One critically important factor that AAMC failed to address at all in its analysis of the hospital-based unit option is the potential impact of the federal law that limits Medicaid reimbursement for an IMD.

Since the establishment of the Medicaid program, Medicaid has excluded the use of federal Medicaid funds to pay for care provided to most patients in mental health and substance abuse disorder residential treatment facilities with more than 16 beds. This provision of the Medicaid law is known as the "IMD Exclusion" and is found in Title XIX of the Social Security Act. Specifically, the IMD exclusion prohibits "payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases" except for "inpatient psychiatric hospital services for individuals under age

21."[3] An IMD is defined as "a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services." 42 U.S.C. § 1396d(i). Thus, an inpatient psychiatric unit in AAMC, an acute general hospital, would not be subject to the IMD Exclusion, but the new facility AAMC proposes would be an IMD if it expanded by a single bed.

Apparently, AAMC accorded no weight to the advantage that, by definition, a hospital-based unit is not an IMD and its bed capacity can be expanded without any concern that it may be precluded from receiving Medicaid reimbursement for adult patients. This is surprising given that one of AAMC's four stated goals is that the inpatient mental health capacity is to be "available to serve all patients regardless of payor source, including Medicaid patients, without delay." AAMC Application, at 80. The loss that would occur if the facility became an IMD is significant – AAMC projects that 39.4% of the revenue for the new facility would be generated by Medicaid patients. AAMC Application, Table K (patient mix).

B. <u>The Inclusion of 17,132 Square Feet of Shell Space is Not Cost Effective.</u>

In the event the Commission approves AAMC's proposal to construct a new health care facility, it should not permit AAMC to include 17,132 square feet of shell space, comprising one-third of the functional area of the building. AAMC's August 1, 2016 Project Cost and Shell

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[3] The IMD exclusion was passed by Congress at a time when treatment for mental illness was primarily provided in institutional settings, built and maintained by states. The IMD exclusion was included in the Medicaid statute to ensure that states would continue to bear responsibility for the costs of long-term stays in these large institutions. In the past, Maryland has used numerous waivers to allow for some federal funding to be used to reimburse IMD facilities serving Medicaid eligible patients. However, recently some issues with IMD funding have emerged, resulting in the State having to fund all inpatient services provided to Medicaid patients aged 21 to 64 in IMDs.

Space Updates (modified Table B). AAMC must show that the inclusion of shell space is cost effective and that the addition of a third floor comprised completely of shell space is cost effective based on a net present value ("NPV") analysis, *i.e.*, it would be less costly to construct now rather than later. COMAR § 10.24.10.04B(16). AAMC cannot show that the additional cost involved in building the space later—if needed at all—is justified.

AAMC presented two NPV analyses. First, before modifying the design of the building, AAMC presented an analysis showing that it would cost approximately $675,000 more, on an NPV basis, to construct the third floor in Year 4, rather than include it with the original building costs. AAMC's Responses to May 3, 2016 Completeness Questions, Response to Question 12(d). The claimed additional cost amounts to less than four percent of the $17 million total project cost. After reducing the size of the building and increasing the project cost to $25 million, AAMC presented a second NPV analysis, which purports to show that the NPV difference in cost is $1,398,200. AAMC's Responses to June 23, 2016 Completeness Questions, Response to Question 1 and Exhibit 22. The second NPV analysis relies upon a new assumption that the construction of the third floor would cost 100% more based upon the complexity of constructing the space on top of an operating health care facility. AAMC provides a summary explanation for this aggressive assumption, but it provides no support for the accuracy of the complexity factor of 100%. The Commission should require AAMC to provide support for its assertion that adding a third floor later will cost twice as much as building it now.

As discussed above, there is no present need for eight additional beds. Also, without a condition requiring Commission approval for use of shell space, there would be no restriction on increasing bed count through waiver beds. COMAR § 10.24.01.03E(2) permits a special

hospital to expand bed capacity by the lesser of ten percent or ten beds every two years. In this way, the special hospital could become an IMD.

II. AS PROPOSED, THE PROJECT WOULD HAVE AN UNDUE ADVERSE IMPACT ON UM BWMC AND THE HEALTH CARE DELIVERY SYSTEM.

Under COMAR § 10.24.01.08G(3)(f), AAMC must show the impact of the proposed project on existing health care providers and on costs to the health care delivery system. As noted above, UM BWMC acknowledges that there is need for inpatient psychiatric capacity at AAMC as a hospital-based unit. Also, as part of a hospital-based unit, the additional beds would have a favorable impact on costs to the health care delivery system. However, as explained below, if approved as a new health care facility with the potential risk of not admitting adult Medicaid patients, the project would have an adverse impact on both UM BWMC and the costs to the health care delivery system.

A. <u>The IMD Exclusion is a Real Threat to AAMC's Ability to Treat Adult Medicaid Enrollees.</u>

AAMC's proposed project is limited to 16 beds because if it exceeds that number it will be deemed to be an IMD and will be subject to the IMD Exclusion.[4]

The Medicaid Emergency Psychiatric Demonstration (the "MEPD"), established under Section 2707 of the Affordable Care Act, provided states with federal matching funds for Medicaid payments for private psychiatric hospitals for emergency inpatient psychiatric care provided to Medicaid enrollees aged 21 to 64. The purpose of the demonstration was to test whether Medicaid programs could support higher quality care at a lower cost by reimbursing private psychiatric hospitals for services Medicaid would normally not reimburse due to the IMD

[4] As discussed in Section I.A.6 above, under federal law, an inpatient psychiatric unit in an acute general hospital cannot be deemed to be an IMD regardless of the number of beds.

exclusion. Maryland was one of 11 states chosen to participate in this demonstration, which was authorized for three years beginning in July 2012. Funding for the MEPD states was supposed to sunset in December 2015, but it unexpectedly expired on June 30, 2015.

Since the expiration of funding under the MEPD, Maryland has pursued several options for obtaining federal funding for services provided to Medicaid members aged 21 to 64 in an IMD. However, while efforts continue, there is no clear lasting solution to the IMD Exclusion problem in Maryland. According to the State's Behavioral Health Administration ("BHA"), the Medicaid shortfall for IMDs in FY 2016 was addressed through a transfer of $10 million from the MHIP fund balance to BHA. BHA Analysis of FY 2017 Maryland Executive Budget, at 35–36, attached as **Exhibit 3**. BHA states that "[i]f the State is unable to participate in the [MEPD] program within fiscal 2017 and no further IMD waiver is granted by CMS, it is unclear how the State will be able to continue to support inpatient and residential treatment for the Medicaid-eligible population without rationing these services." *Id*. at 36.

If AAMC's proposed facility were approved, built, and then expanded its bed capacity above 16 beds, *i.e.*, by at least one more bed, it would be deemed to be an IMD and may not receive Medicaid reimbursement for adult Medicaid patients if the IMD Exclusion has not been resolved.[5] The exclusion of Medicaid patients at AAMC's facility would impact UM BWMC by causing an increase in admissions of adult Medicaid psychiatric patients. As explained in the Statement of Interested Party Status, the cost of caring for Medicaid psychiatric patients is greater because the hospital readmission rate for certain Medicaid psychiatric patients is greater

[5] Under COMAR §10.24.01.03E(2), AAMC could expand the bed capacity every two years.

than for privately insured and uninsured patients. Under the GBR agreement, UM BWMC likely will lose revenue as a result of increased readmissions. Moreover, UM BWMC's obligation to pay physician subsidies will increase with more Medicaid patients.

More importantly, if AAMC's special hospital refused admission of adult Medicaid patients due to the IMD Exclusion, there would be an adverse impact on the health care delivery system. Adult Medicaid beneficiaries in AAMC's service area would be required to seek inpatient psychiatric care elsewhere, most likely outside of the County, thereby negating the positive impact of the new facility for this vulnerable population.

Even if AAMC's new facility were not deemed to be an IMD, the cost to the health care system of a special psychiatric hospital would be greater than if AAMC established an inpatient unit in its existing acute care hospital. As discussed above, a hospital-based inpatient unit would be reimbursed under AAMC's GBR agreement with a 50% variable cost factor, whereas the special hospital would receive 100% of its charges. Accordingly, the hospital-based unit option would be more beneficial to the health care delivery system. It is simply not good health planning policy to permit AAMC to improve its revenue by building a new facility that will cost $18 million more than the hospital-based unit option and will cost the health care delivery system more in charges.

B. To Ensure AAMC's Proposed Facility Admits Medicaid Patients at all Times, the Commission Should Impose Conditions on CON Approval.

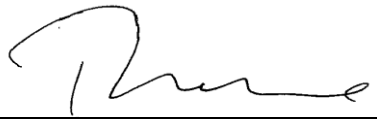
If the Commission approves AAMC's proposed project as a special psychiatric hospital, the Commission should take precautionary steps to ensure that the facility does not become an IMD unless the IMD Exclusion has been removed or is otherwise resolved permanently. The major risk of the facility becoming an IMD involves the addition of any new beds. Thus, the

Commission should require AAMC to seek approval before adding any additional beds, especially since the facility would otherwise be entitled to increase its bed count with little oversight by the Commission by using the bed waiver rule under COMAR §10.24.01.03E(2) (a health care facility that is not an acute general hospital may increase its bed count every two years). Also, in the event the Commission permits AAMC to include shell space in the facility, the Commission should impose a condition that would require AAMC to seek approval before using any shell space.

CONCLUSION

For the reasons set forth above, UM BWMC respectfully asks that the Commission deny AAMC's Application proposing to establish a special psychiatric hospital and urge AAMC to modify its Application to seek approval for an inpatient psychiatric unit in the existing acute general hospital. In the event the Commission approves AAMC's proposed project, UM BWMC requests that the Commission impose conditions, as described above, to prevent AAMC from being deemed an IMD.

Respectfully submitted,



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November 14, 2016

Table of Exhibits

Exhibit	Description
1	AAMC's November 7, 2016 Modification of CON Application for Cardiac Surgery Services
2	July 18, 2016 Determination of Coverage Request for UM BWMC Psychiatric Bed Expansion
3	BHA Analysis of FY 2017 Maryland Executive Budget

CERTIFICATE OF SERVICE

I hereby certify that on the 14th day of November 2016, a copy of the foregoing UM BWMC's Comments on Anne Arundel Medical Center's CON Application Proposing the Establishment of a Special Psychiatric Hospital Comments on AAMC's CON Application was sent via email and first-class mail to:

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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 CON Application Proposing the Establishment of a Special Psychiatric Hospital and its attachments are true and correct to the best of my knowledge, information, and belief.

November 14, 2016
Date

Kathleen McCollum
Senior Vice President, Clinical Integration and COO
UM BWMC

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011598-0021

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 CON Application Proposing the Establishment of a Special Psychiatric Hospital and its attachments are true and correct to the best of my knowledge, information, and belief.

November 14, 2016
Date

Rebecca Paesch
Vice President, Strategy and Business Development
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EXHIBIT 1

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
MODIFICATION TO CERTIFICATE OF NEED APPLICATION

Anne Arundel Medical Center, Inc. ("**AAMC**"), by its undersigned counsel, hereby submits this modification (this "**Modification**") of the above-captioned certificate of need application of AAMC to establish cardiac surgery services.[1]

This modification results from the project status conference of October 27, 2016, and provides the information requested in Commissioner Tanio's October 28 letter in regard thereto.

Respectfully submitted,

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[1] This Modification is submitted pursuant to COMAR 10.24.01.09A(2)(d).

INTRODUCTION

AAMC hereby submits revised versions of all financial schedules regarding revenues, expenses, and income for: (1) for its proposed cardiac surgery service (the "**Revised Cardiac Tables**"; and (2) its general hospital operation (the "**Revised Facility Tables**" and together with the Revised Facility Tables, the "**Revised Tables**"). The Revised Tables are enclosed as Exhibit 38.

This submission will first describe how the Revised Tables differ from those submitted in the original application, then will relate the Revised Tables – and the updated charts derived from those tables – to the project review criteria identified by Commissioner Tanio pursuant to his October 28, 2016 project status conference letter. The Revised Tables differ from the original application tables as follows:

Revised Cardiac Tables

The Revised Cardiac Tables now present the financial information for AAMC's proposed cardiac surgery service in two ways.

First, Table J-1 details the direct revenues and expenses to be generated by AAMC's proposed cardiac surgery service, as a service line, from billable charges.[2] That is, Table J-1 lists the projected income derived from charges to patients and payers for cardiac surgery at AAMC, comparing it to the direct costs of the proposed program.

Second, Table J-2 matches Table J-1, except that Table J-2ascribes to AAMC's proposed cardiac surgery service only the revenue AAMC expects to retain, as a facility, as a result of the service line revenue generated by AAMC's proposed cardiac surgery service. That is, Table J-2

[2] AAMC references the uninflated tables throughout this Modification, for consistency.

discounts the service line revenue generated by AAMC's proposed cardiac surgery service by 50%.[3]

The Revised Cardiac Tables do not reflect any change to estimated expenses or revenues of AAMC's proposed cardiac surgery service, other than as described above.[4]

Revised Facility Tables

The Revised Facility Tables show less revenue for AAMC as a whole for FY 2018 (the first full year of projected operation of the program), namely $502,597,216 in net operating revenue for FY 2018.[5] This change reflects guidance in the Health Services Cost Review Commission's August 24, 2016 memorandum (the "**HSCRC Memo**") that AAMC global budget revenue would increase, as a result of the project, by an amount equal to 50% of the revenue generated by AAMC's proposed cardiac surgery service. The Revised Facility Tables do not reflect any change to estimated expenses.[6]

The Revised Facility Tables do not change whether one views cardiac revenue under Table J-1 or Table J-2, because in either event, facility revenue is the same.

Context

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

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[3] As explained below, however, the HSCRC Memo has indicated that the HSCRC would permit AAMC to allocate additional revenue to the proposed cardiac surgery service, through the other resources provided in the GBR system for new projects.

[4] Commissioner Tanio's October 28 letter that this Modification should not include an update of AAMC's volume projections for its proposed cardiac surgery service. As a result, the financial projections enclosed in the Revised Tables are based on revenue and expenses generated at the level of volume AAMC anticipated as of February 20, 2015.

[5] *See* Table H (inflated).

[6] For consistency, the Revised Tables retained the assumptions underlying its original overall hospital financial projections, with the exception of a revision accounting for the effect of the market shift policy and the 50% variable cost factor identified in the HSCRC Memo.

of revenue the hospital is allowed to earn annually (a "**GBR Budget**"). At the same time, each hospital's individual service lines still generate billable revenue (at HSCRC approved rates) standing alone. The GBR Budget, then, is an aggregation of the revenue independently generated by each of the hospital's service lines. For example, as reflected in Exhibit 39, AAMC's estimates that its cardiac surgery service will have a charge per case of $37,501 generating charges of $11,147,964 (after accounting for transfer revenue). However, AAMC will need to decrease its charges across all hospital services to offset the excess revenue generated by the proposed cardiac surgery service.[7]

BWMC has recognized this distinction as well. For example, in its August 10, 2015 modification to its certificate of need application in this Review, BWMC noted that its "cardiac surgery charges to payers will increase by $11.8 million but the allowable GBR adjustment for UM BWMC will only be $4.6 million after consideration of the 50% revenue variability factor. As such, it is expected that hospital-wide rates at UM BWMC would need to decrease by the difference between these two numbers, or $7.2 million."[8]

The Commission should evaluate financial feasibility in this Review with this distinction in mind – the distinction between service line revenue and expenses for the proposed cardiac surgery programs, and overall GBR Budget of the hospital. The State Health Plan itself mandates both that a "cardiac surgery program…be financially feasible" ***and*** that it "not jeopardize the financial viability of the hospital."[9] To be financially feasible means, among other things, to

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[7] The process of rate realignment across the facility will also have a *de minimus* feedback effect on AAMC's proposed cardiac surgery program as well, as decreases in unit rates at the hospital level will decrease AAMC's charge per case for cardiac surgery, since those unit rates compose, in part, such charge per case figure.

[8] (internal citations omitted).

[9] COMAR 10.24.17.05(A)(7).

"generate revenues over total expenses for cardiac surgery, if utilization forecasts are achieved for cardiac surgery services."[10]

Here, AAMC will generate revenues over expenses for cardiac surgery, per Table J-1 While AAMC will need to decrease revenue overall at the hospital level to accommodate income from the cardiac surgery service, it will not jeopardize the financial viability of the hospital.

Even if, however, the State Health Plan is interpreted to require a positive GBR impact of AAMC's proposed cardiac surgery service, the HSCRC Memo has indicated that the HSCRC would permit AAMC to allocate to the proposed cardiac surgery service revenue through the other resources provided in the system for new projects. The HSCRC Memo specifically states that AAMC's proposed cardiac surgery service (1) will be financially feasible, and (2) can receive allocations from budget updates associated with "the population adjustment, capacity from reduced avoidable utilization"[11] and "the annual update process for individual hospital budgets."[12]

Therefore, as described in more detail in the remainder of this Modification, the Revised Tables demonstrate that AAMC's proposed cardiac surgery service is financially feasible – whether feasibility is measured on a service line basis or a GBR Budget basis – and that the program will realize savings for cardiac surgery patients and $11,394,078 in savings for the health care delivery system as a whole.

[10] COMAR 10.24.17.05(A)(7)(b)(iv).

[11] HSCRC Memo at p. 1.

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

COMAR 10.24.17.05A(4) – Cost Effectiveness

An applicant proposing establishment or relocation of cardiac surgery services shall demonstrate that the benefits of its proposed cardiac surgery program to the health care system as a whole exceed the cost to the health care system.

(a) An applicant that proposes new construction of one or more operating rooms, cardiac catheterization laboratories, or intensive care units, or any combination thereof, as necessary infrastructure for its proposed new cardiac surgery program shall document why existing resources at the applicant hospital cannot be used to accommodate the proposed cardiac surgery services.

(b) An applicant shall provide an analysis of how the cost of cardiac surgery services for cardiac surgery patients in its proposed service area and for the health care system will change as a result of the proposed cardiac surgery program, quantifying these changes to the extent possible.

(c) An applicant shall provide an analysis of how the establishment of its proposed cardiac surgery program will alter the effectiveness of cardiac surgery services for cardiac surgery patients in its proposed service area, quantifying the change in effectiveness to the extent possible. The analysis of service effectiveness shall include, but need not be limited to, the quality of care, care outcomes, and access to and availability of cardiac surgery services.

APPLICANT RESPONSE

(b)

Under this Modification, AAMC's proposed cardiac surgery service will decrease the cost of cardiac surgery for patients in AAMC's proposed service area. As identified in AAMC's original application, AAMC's proposed cardiac surgery service will have one of the lowest charges per case of any cardiac surgery program in Maryland, at an estimated $37,501 charge per case. AAMC's anticipated charge per case has not changed pursuant to this Modification.

10.24.17.05A(7) – Financial Feasibility

A proposed new or relocated cardiac surgery program shall be financially feasible and shall not jeopardize the financial viability of the hospital.

(a) Financial projections filed as part of a Certificate of Need application shall be accompanied by a statement containing each assumption used to develop the projections.

(b) An applicant shall document that:

(i) Its utilization projections for cardiac surgery are consistent with observed historic trends in the use of cardiac surgery by the population in the applicant's proposed service area;

(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;

(iii) Its staffing and overall expense projections for cardiac surgery are based on current expenditure levels and are consistent with utilization projections and with reasonably anticipated future staffing levels as experienced by the applicant hospital, or, if applicable, the recent experience of similar hospitals; and

(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.

APPLICANT RESPONSE

(a)

The Revised Tables are enclosed as Exhibit 38. AAMC retains all assumptions set forth in its original application, except for the following assumptions:

1. The increase in AAMC's GBR Budget resulting from AAMC's proposed cardiac surgery service will equal 50% of the charges generated by the proposed program, pursuant to the HSCRC market shift adjustment policy's 50% variable cost factor, rather than 85%.

2. Pursuant to the August 24, 2016 memorandum, the HSCRC will permit allocation of certain future adjustments to AAMC's global revenue, namely:

   A. The "population adjustment"[13]

   B. "Capacity from reduced avoidable utilization"[14]

   C. AAMC's existing and anticipated operating margin, i.e. "reallocation of overhead already funded in the system as evidenced by [AAMC's] profits"[15]

AAMC cannot provide, at this time, a breakdown of the relative expected contribution to AAMC's proposed cardiac surgery service of each of the above three revenue sources, for the simple reason that the HSCRC has not yet granted AAMC all the potential adjustments, nor has the HSCRC indicated its expectations of AAMC as to the relative allocation expected between these three sources. However, the GBR Budget impact of AAMC's proposed cardiac surgery service (negative $3,289,059) would be equivalent to only about 0.65% of AAMC's FY 2018 revenue ($502,597,216).[16] Therefore, any substantial general adjustment to GBR Budget revenue would offset the GBR Budget impact of AAMC's proposed cardiac surgery service.

(b) (iv)

Under this Modification, AAMC's proposed cardiac surgery service will generate excess revenues over total expenses for cardiac surgery by the third year of its existence, whether considered on a service line basis or considered on the basis of AAMC's GBR Budget.

As demonstrated in Table J-1, AAMC's proposed cardiac surgery service will generate an operating margin, standing alone, of $1,432,104 by FY 2018. That is, charges generated by

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[13] HSCRC Memo at p. 2.

[14] HSCRC Memo at p. 2.

[15] HSCRC Memo at p. 2.

[16] Table G – Net Operating Revenue

the proposed program will exceed the direct costs of the proposed program. The Commission should adopt this basis for analyzing financial feasibility for the following reasons.

First, doing so follows the language of the relevant section of the State Health Plan, COMAR 10.24.17.05(A)(7):

- COMAR 10.24.17.05A(7) distinguishes between the mandate that a "cardiac surgery program shall be financial feasible" and that the program "not jeopardize the financial viability of the hospital." That is, the State Health Plan distinguishes between the viability of the project itself, and the impact of the project on the hospital as a whole.
- COMAR 10.24.17.05A(7)(b)(iv) asks whether revenues will exceed expenses "***for cardiac surgery***" in particular. (emphasis added).
- COMAR 10.24.17.05A(7)(b)(iv) appears to refer to "a new or relocated cardiac surgery program" as the entity that must "generate excess revenues" ("***it*** will generate excess revenues…"). (emphasis added).

Second, doing so follows the State Health Plan philosophy of considering each proposed project on its own merits.

Third, this approach makes the most sense in the context of the new GBR system. The HSCRC has indicated that it will apply the market shift adjustment policy to volume generated by a new cardiac surgery program – meaning that a hospital establishing a new program receives a GBR Budget increase equivalent to only about half the revenue the program generates. Under a 50% variable cost factor for new revenue, any new service would operate at a loss unless expenses are implausibly low (and the HSCRC recognized this in its Memo by stating that one can allocate other revenue from other sources to open a financially feasible new service, as discussed in the "Financial Feasibility" section of this Modification).

BWMC has similarly acknowledged this problem in its own August 10, 2015 modification to its CON application. "Under the Global Budget Revenue agreements between the HSCRC and most Maryland hospitals, it is not possible to achieve financial feasibility of a new stand-alone cardiac surgery program because revenue can only be achieved through market share adjustments and certain other adjustments to revenue."[17] The premise behind BWMC's modification is that BWMC's proposed cardiac surgery service could only achieve financial feasibility, on a GBR Budget basis, when considering revenue generated by "the combination of the proposed program with the existing cardiac surgery program at UMMC"[18] – i.e. when combining BWMC's proposed program with the revenue generated outside BMWC, by UMMS' existing cardiac surgery programs.

Alternatively, if the feasibility of AAMC's proposed cardiac surgery service is judged on a GBR Budget basis, the HSCRC Memo states that AAMC's proposed cardiac surgery service will be financially feasible. Specifically the HSCRC has indicated that application of a 50% variable cost factor to AAMC's GBR Budget would not "impact the feasibility of the program" because "AAMC has other sources of revenue" in the GBR system "to apply to the project…"[19] These sources of funds include the following anticipated future adjustments to AAMC's GBR Budget by the HSCRC:

- The "population adjustment"[20]
- "Capacity from reduced avoidable utilization"[21]

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[17] BWMC Modification at p. 7, n.2

[18] BWMC Modification at p. 7.

[19] HSCRC Memo at p. 2.

[20] HSCRC Memo at p. 2.

[21] HSCRC Memo at p. 2.

- AAMC's existing and anticipated operating margin, i.e. "reallocation of overhead already funded in the system as evidenced by [AAMC's] profits"[22]

AAMC operating margin alone could suffice to fund the proposed cardiac surgery service, because this margin itself is larger than the projected difference between the expenses of AAMC's proposed cardiac surgery service and AAMC's anticipated GBR Budget increase associated with the service. That is, Table J-2 shows a margin of negative $3,289,059 for FY 2018. However, AAMC anticipates net income of $54,284,672 for FY 2018, as shown in Table G. Therefore, at the volumes AAMC projects, there is no scenario whereby AAMC's proposed cardiac surgery service would be not financially feasible under either the GBR Budget methodology or when considering the proposed program standing alone.

[22] HSCRC Memo at p. 2.

10.24.17.05(A)(8) – Preference in Comparative Reviews

In the case of a comparative review of applications in which all policies and standards have been met by all applicants, the Commission will give preference based on the following criteria.

(a) The applicant whose proposal is the most cost effective for the health care system.

(b) An applicant with an established record of cardiovascular disease prevention and early diagnosis programming that includes provisions for educating patients about treatment options.

(c) An applicant with an established record of cardiovascular disease prevention and early diagnosis programming, with particular outreach to minority and indigent patients in the hospital's regional service area.

(d) An applicant whose cardiac surgery program includes a research, training, and education component that is designed to meet a local or national need and for which the applicant's circumstances offer special advantages.

APPLICANT RESPONSE

(a)

This Modification reinforces AAMC's status as the most cost effective proposal for the health care system in this comparative review, for the following reasons.

First, since the Modification does not increase AAMC's projected charges for cardiac surgery, AAMC will still generate superior savings for cardiac surgery patients than BWMC. In its August 10, 2015 modification, BWMC, using a (flawed) rate center methodology calculation, estimated that AAMC will charge cardiac surgery patients $1,203 less per case than BWMC.[23] AAMC's more accurate case-mix adjusted calculations showed even greater superiority on

[23] *Compare* BWMC Exhibit 49 at Line 1 (BWMC rate center charge per case of $51,952) with BWMC Exhibit 50 at Line 1 (AAMC rate center charge per case of $50,749).

estimated charges: $37,501 per case for AAMC vs. $40,490 per case for BWMC, a $2989 difference (see enclosed Exhibit 40).[24]

Second, the Modification shows a wider gap between the amount AAMC expects to save the health care system, and the amount it expects BWMC to save. AAMC now projects total system savings of $11,394,078, as compared to $3,677,584 for BWMC, as shown on the enclosed Exhibit 40. The improved savings reflects the Modification's recognition of the 50% variable cost factor of the HSCRC market shift adjustment policy, resulting in a smaller AAMC projected GBR Budget revenue increase associated with the project, as reflected in Table H (net income).

[24] BWMC acknowledged its $40,490 charge per case in Table 30 of its modified application (at p. 11).

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.

APPLICANT RESPONSE

For the reasons articulated in the "Cost Effectiveness" and "Preference in Comparative Reviews" sections of this Modification, AAMC's proposed cardiac surgery service would be more cost effective than either the status quo or BWMC's proposed cardiac surgery service.

10.24.01.08G(3)(d) – Viability of the Proposal

The Commission shall consider the availability of financial and nonfinancial resources, including community support, necessary to implement the project within the time frames set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.

APPLICANT RESPONSE

For the reasons articulated in the "Financial Feasibility" section of this Modification, AAMC would have the financial resources necessary to sustain AAMC's proposed cardiac surgery service

10.24.01.08G(3)(f) – Impact on Existing Providers & the Health Care Delivery System

An applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the health planning region, including the impact on geographic and demographic access to services, on occupancy, on costs and charges of other providers, and on costs to the health care delivery system.

APPLICANT RESPONSE

The Revised Tables – and the updated charts derived from those tables – demonstrate that AAMC's proposed cardiac surgery service would generate even greater savings to the health care delivery system than originally projected.

The enclosed Exhibit 39 projects total health care expenditure savings of $11,394,078 resulting from AAMC's proposed cardiac surgery service, versus the $7.74 million originally projected. This improvement reflects the Revised Tables' reduction in overall AAMC revenue caused by the move from an 85% variable cost factor to a 50% variable cost factor.

These savings improve AAMC's case that AAMC's proposed cardiac surgery service would help Maryland's performance with regard to the Medicare Waiver.

As explained in its March 30, 2016 completeness response, Maryland's All-Payer Model Agreement with the Centers for Medicare and Medicaid Services requires Maryland to limit both (1) growth in Maryland hospital expenditures (the "**All-Payer Test**"); and (2) the growth in Medicare expenditures for Maryland Medicare beneficiaries (the "**Medicare Expenditure Test**"). The Medicare Expenditure Test is the harder test for Maryland.[25]

[25] The HSCRC cannot easily predict, and cannot control, Medicare expenditures at District of Columbia hospitals, let alone nationwide Medicare expenditures. Therefore, actual savings achieved in Medicare spending per beneficiary are more valuable to the HSCRC in preserving the Medicare Waiver. In contrast, Maryland currently has

Under the Modification, AAMC's proposed cardiac surgery service would provide Maryland with even greater improvements to the Medicare Expenditure Test while having almost no negative impact on the All-Payer Test.

Medicare will now save **$4,126,834** on FY 2018 hospital expenditures for Maryland residents, only spending an additional $2,835,819 (as opposed to the $4,820,900 originally projected) at AAMC, but saving (i) $1,849,373 at other Maryland hospitals (after market share adjustments), and (ii) $5,113,280 at District of Columbia hospitals.

REVISED Chart 37
Impact on the Medicare Waiver Test
Twelve Month Period Ended FY 2018*

Medicare Payment Increases: the Medicare Component of the Cardiac Surgery Program Adjustments to AAMC's GBR Target Budget	$2,835,819
Medicare Payment Decreases (1) the Medicare Component of the Market Shift Adjustments of the Maryland Cardiac Surgery Hospitals (Chart 53, Exhibit 41) (2) the Reduction in Payments to D.C. Hospital Total	 ($1,849,373) ($5,113,280) ($4,126,834)
Medicare Hospital Payments on behalf of Maryland Residents	$6,000,000,000
Favorable Impact on the Medicare Waiver Test	(0.00069)= (0.069%)[26]

AAMC's impact on the All-Payer test will also decline to a nominal $1,926,509, which is $3,901,788 less than the $5,828,297 originally estimated (see Exhibit 39).

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a wide cushion under the All-Payer Test. Moreover, the HSCRC has many levers to address the All-Payer Test, because that test measures only the revenues of Maryland hospitals.

[26] The actual Medicare Test is calculated on a calendar year basis. FY 2018 volumes were used here for illustrative purposes. However, the same favorable results would be found over a calendar basis using similar volumes

The assumptions and calculations underlying AAMC's above conclusions regarding the Medicare Waiver are set forth in Exhibit 41, enclosed.

CONCLUSION

Under the Modification, AAMC's proposed cardiac surgery service will (1) be financially feasible on a service line basis and a GBR Budget basis, (2) generate $11,394,078 in savings for the health care delivery system as a whole, and (3) be more cost-effective than an alternative program at BWMC, or the status quo. The Commission should therefore grant AAMC a certificate of need to establish a cardiac surgery service.

ANNE ARUNDEL MEDICAL CENTER

MODIFICATION TO CERTIFICATE OF NEED APPLICATION

Attestation by Victoria W. Bayless

Affirmation: I hereby declare and affirm under the penalties of perjury that the facts stated in the November 7, 2016 Modification to Certificate of Need Application, and its attachments, of Anne Arundel Medical Center are true and correct to the best of my knowledge, information, and belief.

Ms. Victoria W. Bayless

November 7, 2016
Date

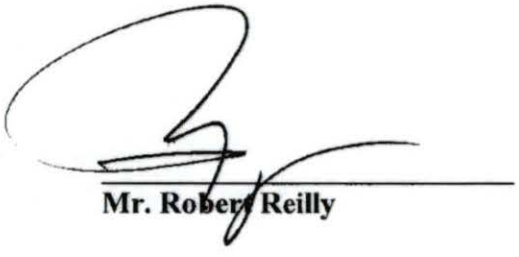
President/CEO Anne Arundel Medical Center
Title

ANNE ARUNDEL MEDICAL CENTER

MODIFICATION TO CERTIFICATE OF NEED APPLICATION

Attestation by Robert Reilly

Affirmation: I hereby declare and affirm under the penalties of perjury that the facts stated in the November 7, 2016 Modification to Certificate of Need Application, and its attachments, of Anne Arundel Medical Center are true and correct to the best of my knowledge, information, and belief.



Mr. Robert Reilly

November 7, 2016
Date

CFO, Anne Arundel Medical Center
Title

List of Exhibits

Exhibit 38

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 39

REVISED AAMC Cardiac Surgery Program System Savings Projection

EXHIBIT 39

	FY 2018 - Charges[1]				
	Cases	CPC	Revenue	VCF	Revenue @ VCF
AAMC Projected Open Heart Cases	337	$37,501	$12,637,820	50%	$6,318,910
Transfers	178	(8,370)	(1,489,856)	50%	(744,928)
Incremental Revenue	337	33,080	$11,147,964	50%	$5,573,982
Impact on OHS Hospitals:					
DC Hospitals[2,4]	(227)	$58,681	($13,320,587)	100%	($13,320,587)
Johns Hopkins Hospital	(69)	68,174	(4,704,001)	50%	(2,352,001)
University of Maryland Medical Center	(29)	69,878	(2,026,455)	50%	(1,013,227)
Washington Adventist Hospital	(6)	47,107	(282,643)	50%	(141,322)
Sinai Hospital	(3)	48,313	(144,938)	50%	(72,469)
MedStar Union Memorial Hospital	(2)	49,124	(98,249)	50%	(49,124)
UM St. Joseph Medical Center	(1)	38,659	(38,659)	50%	(19,330)
Total Estimated Charges	(337)	$61,174	($20,615,533)	82%	($16,968,060)
Net Savings to the Health Care System			**($9,467,568)**	**120%**	**($11,394,078)**

	FY 2018 - Payments[3]				
	Cases	Average Payment	Total Payment	VCF	Payment @ VCF
AAMC Projected Open Heart Cases	337	$37,501	$12,637,820	50%	$6,318,910
Transfers	178	(8,370)	(1,489,856)	50%	(744,928)
Incremental Revenue	337	33,080	$11,147,964	50%	$5,573,982
Estimated Payment @ 95.6% [3]		31,624	$10,657,454	50%	$5,328,727
Impact on Existing Cardiac Surgery Hospitals:					
DC Hospitals[2,4]	(227)	$58,681	($13,320,587)	100%	($13,320,587)
Maryland Hospitals					
Johns Hopkins Hospital	(69)	65,174	(4,497,025)	50%	(2,248,513)
University of Maryland Medical Center	(29)	66,803	(1,937,291)	50%	(968,645)
Washington Adventist Hospital	(6)	45,034	(270,207)	50%	(135,103)
Sinai Hospital	(3)	46,187	(138,561)	50%	(69,281)
MedStar Union Memorial Hospital	(2)	46,963	(93,926)	50%	(46,963)
UM St. Joseph Medical Center	(1)	36,958	(36,958)	50%	(18,479)
Total Estimated Payment	-337	$60,221	($20,294,555)	83%	($16,807,571)
Net Savings on Total Healthcare Spend			**($9,637,101)**	**119%**	**($11,478,844)**

Notes:

[1] MD Hospital CPC calculated as Hospital-specific total CPC @ CMI 1.00 (excluding categoricals and ODS, except for OB/normal newborns) multiplied by the

[2] DC Hospitals defined as Washington Hospital Center (221 cases) and George Washington University Hospital (6 cases)

[3] Payment discount is calculated at 4.4%, a blend of the 8% discount for Medicare (55.3% of cases) and no discount for non-Medicare cases (44.7%

[4] DC hospital payments estimated as a blend of payments for Medicare and non-Medicare payments in the same proportion. The Medicare

Exhibit 40

REVISED AAMC vs. BWMC System Savings Comparison - EXHIBIT 40

Aggregate Reduction in Charges to the System

	AAMC-CON	BWMC	Notes
GBR Target Budget Adjustment			
Hospital CPC @ CMI 1.00	$10,962	$11,911	FY2014 CPC @ CMI 1.00, using RY2013 CMI weights, v.29 (excludes 1-day stays and normal newborns)
Estimated Cardiac Surgery CMI	3.42	3.40	Per AAMC & BWMC CONs
Imputed Charge per OHS Case	$37,501	$40,490	
Total OHS Cases	337	228	Per AAMC & BWMC CONs
Subtotal: Incremental Charges	$12,637,820	$9,231,720	
Less: Existing Transfer Revenue	(1,489,856)	-	Per AAMC CON
Total Incremental Charges	$11,147,964	$9,231,720	
VCF	50%	50%	
GBR Adjustments	**$5,573,982**	**$4,615,860**	
Reduction of Maryland Hospital Target Budgets			
Hospital CPC @ CMI 1.00	$19,386	$19,412	
Estimated Cardiac Surgery CMI	3.42	3.40	
Imputed Charge per OHS Case	$66,318	$65,990	Weighted average of shifting hospital OHS CPCs (See System Savings Calculations)
OHS Cases Shifting from Maryland Hospitals	(110)	(198)	Per AAMC & BWMC CONs
Incremental Charge Reduction	($7,294,946)	($13,066,028)	
VCF	50%	50%	
GBR Adjustments	**($3,647,473)**	**($6,533,014)**	
Net Reduction in Charges at Maryland Hospitals	**$1,926,509**	**($1,917,154)**	All Payer Test
Reduction of Washington, D.C. Hospitals			
Payment per Case	$58,681	$58,681	
OHS Cases Shifting from DC Hospitals	(227)	(30)	Per AAMC & BWMC CONs
Incremental Charge Reduction	($13,320,587)	($1,760,430)	
VCF	100%	100%	
Reduction in Payments at DC Hospitals	**($13,320,587)**	**($1,760,430)**	
Total Reduction in Hospital Spending	**($11,394,078)**	**($3,677,584)**	Impact to total Healthcare Spend

Exhibit 41

EXHIBIT 41

Medicare Waiver Assumptions and Calculations – Revised AAMC Projections

1. Increased AAMC Revenue under the Project – All-Payers: $5,573,982

AAMC estimates that its GBR target budget will increase **$5,573,982** in FY 2018. AAMC derived this estimate by (a) calculating the total charges for its FY 2018 cardiac surgery cases (multiplying its charge per case by the estimated number of cases), (b) subtracting existing budgeted revenue for those patients[1], and (c) applying a 50% market share adjustment.

Chart 50 – REVISED

FY 2018 AAMC BUDGET INCREASE – TOTAL

	Step	Result
1	Estimated Cardiac Surgery Cases	337
2	Charge Per Case	$37,501
3	Aggregate Charges: (1) x (2)	$12,637,820
4	Existing Revenue from Transferred Patients	($1,489,856)
5	Incremental Budget Increase before MSA: (3) – (4)	$11,147,964
6	Market Share Adjustment	***50%***
7	Actual Incremental Budget Increase (5) x (6)	$5,573,982

[1] That is, for patients who are admitted to AAMC but are ultimately transferred to another hospital for cardiac surgery, AAMC's budget still includes revenue to provide care to those patients from admission through the time of transfer. So, for that subset of patients (admitted to AAMC then transferred for surgery), the estimated $37,501 charge per case is not all an incremental increase in revenue.

2. Increased AAMC Revenue – Medicare only: $2,835,823

AAMC estimates that the $5,573,991 increase in its FY 2018 target budget will include **$2,835,823** of additional expenditures by Medicare. This is based on the following analysis:

First, AAMC projected the total number of cardiac surgery cases at AAMC in FY 2018 if the Project is approved.

Second, AAMC projected the number of *Medicare* cardiac surgery cases at AAMC in FY 2018 if the Project is approved based on the projected volume shifts, by hospital, and projected population growth.

Third, AAMC applied case mix indexes (CMIs) for Medicare and for all payers to estimate the severity of Medicare cases, and thus the portion of the FY 2018 target budget increase attributable to Medicare patients.[2] AAMC multiplied the Medicare CMI by the estimated total number of FY 2018 Medicare cardiac surgery cases at AAMC to generate the case mix adjusted discharges (CMADs) for Medicare patients at AAMC. AAMC similarly multiplied the general CMI for all cardiac surgery cases – Medicare or non-Medicare – by the projected number of FY 2018 cardiac surgery cases at AAMC to generate the CMADs for all patients at AAMC.

Fourth, AAMC used the ratio of Medicare CMADs to total CMADs as the ratio of charges attributable to Medicare vs. total charges to derive the portion of AAMC's FY 2018 incremental budget increase attributable to Medicare.

Finally, AAMC applied Medicare's discount of 8% (6% HSCRC discount plus 2% sequestration discount) to derive Medicare's incremental increase in actual expenditures at AAMC.[3] The results are displayed on the chart below.

Chart 51 – REVISED

FY 2018 AAMC BUDGET INCREASE – MEDICARE

	Step	Result
1	Estimated Medicare Cardiac Surgery Cases	172
2	Medicare CMI	3.71
3	Medicare CMADs: (1) x (2)	638
4	Estimated Total Cardiac Surgery Cases	337
5	Total CMI	3.4209
6	Total CMADs: (4) x (5)	1152

[2] It would be incorrect to assume that Medicare cases would generate charges in portion to their number (i.e., 172 /337 = 51%). Although AAMC will have an *average* charge per case, Medicare cases will be more severe, requiring more resources and thus generating higher charges, while non-Medicare cases will be less severe, requiring fewer resources and thus generating lower charges.

[3] Under the Medicare differential, Medicare receives a 6% discount on charges. An additional 2% is withheld under the Budget Control Act of 2011 (sequestration).

7	Ratio of Medicare CMADs to Total CMADs: (3) / (6)	55.3%
8	Actual Incremental Budget Increase (Previous Table)	$5,573,982
9	Medicare Share of Incremental Increase in Budget: (7) x (8)	$3,082,412
10	Medicare Responsibility after 8% Discount	92%
11	Actual Increase in Medicare Expenditure: (9) x (10)	$2,835,819

3. Decreased Maryland Hospital Revenue (AAMC Excluded) – All-Payers: **$3,635,059**

AAMC estimates that other Maryland hospitals performing cardiac surgery will have an aggregate **$3,635,059** decrease in their FY 2018 GBR target budgets as a result of the projected volume shifts. AAMC derived this estimate for each hospital by: (a) calculating the average charge for each case shifting to AAMC (the product of AAMC's projected CMI times the after hospital's FY 2014 charge per CMAD), (b) multiplying that average charge per case by the number of cases shifted, and then (c) applying a market share adjustment of 50%.

Chart 52

FY 2018 MARYLAND HOSPITAL BUDGET DECREASE - TOTAL

	Step	UMMS	JHH	Other	Total
1	Average Charge per CMAD	$20,427	$19,929	$13,145	
2	CMI of Cases Lost to AAMC	3.4209	3.4209	3.4209	
3	Average Charge per Case Shifted: (1) x (2)	$69,878	$68,174	$44,971	
4	Cases Shifted	29	69	12	
5	Incremental Budget Decrease before MSA: (3) x (4)	$2,026,462	$4,704,006	$539,649	
6	Market Share Adjustment	50%	50%	50%	
7	Actual Incremental Budget Decrease: (5) x (6)	$1,013,231	$2,352,003	$269,825	$3,635,059

4. Decreased Maryland Hospital Revenue (AAMC Excluded) – Medicare only: **$1,849,373**

AAMC estimates that the $3,635,059 aggregate decrease in the FY 2018 target budgets of the other Maryland hospitals performing cardiac surgery will result in **$1,849,373 savings** in expenditures by Medicare. AAMC derived that estimate by applying the same ratio of Medicare vs. total charges to the $3.6 million aggregate decrease that is projected, and then applying the same Medicare discount.[4]

Chart 53

FY 2018 MARYLAND HOSPITAL BUDGET DECREASE - MEDICARE

	Step	Result
1	Actual Incremental Budget Decrease (Previous Table)	$3,635,059
2	Ratio of Medicare CMADs Lost to Total CMADs Lost	55.3%
3	Medicare Share of Incremental Decrease in Budget: (1) x (2)	$2,010,188
4	Medicare Responsibility after 8% Discount	92%
5	Actual Decrease in Medicare Expenditure: (3) x (4)	$1,849,373

[4] This symmetry makes sense. By definition, the CMADs of the Medicare cases gained by AAMC from other hospitals equal the CMADs of the Medicare cases lost by the other hospitals to AAMC.

5. Decreased Medicare Expenditure – Washington Hospital Center: **$5,113,280**

AAMC estimates that Medicare will *save* **$5,113,280** on cardiac surgery cases at Washington Hospital Center (WHC) in FY 2018 as volume is shifted to AAMC. AAMC derived this estimate by (a) calculating the average payment for each Medicare case shifted to AAMC (multiplying AAMC's projected CMI by WHC's payment per CMAD as derived from the MedPar data), then (b) multiplying that average payment per case by the number of cases projected to shift to AAMC.

Chart 54

FY 2018 MEDICARE SAVINGS - WASHINGTON HOSPITAL CENTER

	Step	Result - WHC
1	Average Payment per CMAD	$12,885.50
2	CMI of Cases Shifted to AAMC	3.4209
3	Average Payment per Case Shifted: (1) x (2)	$44,080
4	Cases Shifted	116
5	Medicare Savings	$5,113,280

EXHIBIT 2

Craig P. Tanio, M.D.
CHAIR

STATE OF MARYLAND

Ben Steffen
EXECUTIVE DIRECTOR

MARYLAND HEALTH CARE COMMISSION

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

July 18, 2016

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

Re: University of Maryland Baltimore Washington Medical Center
Determination of Coverage Request

Dear Mr. Dame:

I write in response to your July 11, 2016 letter, written on behalf of University of Maryland Baltimore Washington Medical Center (BWMC). The letter describes a modification of the capital project originally described in April 29, 2016 correspondence. That project, with an estimated cost of $3.5 million, was determined to require Certificate of Need ("CON") review and approval because it would add ten acute psychiatric beds at BWMC.

BWMC now states that it "will accept as a condition of non-coverage that it will cap the medical gas lines and remove headwalls for at least ten MSGA beds prior to placing the new psychiatric beds in service." You note that BWMC "intends to implement another project in early FY 2018 that will involve taking a number of MSGA beds out of service. However, even if the separate FY 2018 project does not proceed as expected, UM BWMC will cap the medical gas lines and remove headwalls for at least ten MSGA beds. As a result of the commitment, neither UM BWMC's physical bed capacity nor its licensed bed capacity will increase."

The project now described by BWMC involves the following elements: (1) elimination of ten beds of physical bed capacity through patient room alterations to at least ten patient rooms that contain medical/surgical/gynecological/addictions ("MSGA") beds; and (2) addition of ten acute psychiatric beds through the renovation of existing building space adjacent to the existing acute psychiatric unit. BWMC states that the first element of this project will occur before any additional acute psychiatric beds are placed into operation. A July 18 email from Rebecca Paesch, Vice President, Strategy and Business Development, stated that the estimated cost of this modified project is $3,538,344, of which $40,000 is estimated as the cost to cap the medical gas lines and remove headwalls of 10 MSGA beds.

In discussions with you and hospital staff, it was indicated that the timing of the completion of the renovation project that would allow for an increase in physical bed capacity used for acute psychiatric services and the initiation of the renovation project that would involve taking MSGA beds out of service was likely to be very close. Staff urges BWMC to coordinate the timing of these renovation projects so that it can avoid any increase in physical bed capacity while sparing the expense of disabling gas lines and removing headwalls separate and apart from previously anticipated expenses associated with removing MSGA bed capacity from service.

On the basis of the described modification in the project plan, I have determined that the project, as modified, does not require CON approval. If you have any questions concerning this matter, please call Kevin McDonald at 410-764-5982.

Sincerely,

Ben Steffen
Executive Director

cc: Kathleen McCollum, Senior Vice President, BWMC
Jerry Schmith, HSCRC
Jennifer Whitten, MHA
Patricia Nay, M.D., Executive Director, Office of Health Care Quality, DHMH
Jinlene Chan, M.D., M.P.H., Health Officer, Anne Arundel County
Kevin McDonald
Suellen Wideman, AAG

EXHIBIT 3

M00L
Behavioral Health Administration
Department of Health and Mental Hygiene

Operating Budget Data

($ in Thousands)

	FY 15 Actual	FY 16 Working	FY 17 Allowance	FY 16-17 Change	% Change Prior Year
General Fund	$839,520	$868,243	$886,256	$18,013	2.1%
Deficiencies and Reductions	0	-11,500	-820	10,680	
Adjusted General Fund	**$839,520**	**$856,743**	**$885,437**	**$28,693**	**3.3%**
Special Fund	50,035	60,462	53,806	-6,655	-11.0%
Deficiencies and Reductions	0	0	-1	-1	
Adjusted Special Fund	**$50,035**	**$60,462**	**$53,805**	**-$6,657**	**-11.0%**
Federal Fund	649,268	738,564	733,195	-5,369	-0.7%
Deficiencies and Reductions	0	0	-12	-12	
Adjusted Federal Fund	**$649,268**	**$738,564**	**$733,183**	**-$5,381**	**-0.7%**
Reimbursable Fund	8,284	10,744	7,796	-2,948	-27.4%
Adjusted Reimbursable Fund	**$8,284**	**$10,744**	**$7,796**	**-$2,948**	**-27.4%**
Adjusted Grand Total	**$1,547,108**	**$1,666,513**	**$1,680,220**	**$13,708**	**0.8%**

- After adjusting for fiscal 2016 reversions and a back of the bill reduction in health insurance, total funding for the Behavioral Health Administration (BHA) increases by $13.7 million (0.8%) over the fiscal 2016 working appropriation.

- There is a specified reversion of $11.5 million out of Medicaid reimbursements for behavioral health providers in fiscal 2016 due to lower than anticipated enrollment within the traditional Medicaid eligibility categories.

- A supplemental budget increases the fiscal 2017 allowance by $2.3 million to provide for a 2% community provider rate increase for substance use disorder treatment services to the uninsured to mirror the rate increase granted to other community behavioral health providers. That funding is not reflected in the data shown in the analysis.

Note: Numbers may not sum to total due to rounding.

For further information contact: Jordan D. More Phone: (410) 946-5530

Personnel Data

	FY 15 Actual	FY 16 Working	FY 17 Allowance	FY 16-17 Change
Regular Positions	2,900.85	2,900.55	2,800.85	-99.70
Contractual FTEs	215.66	221.60	210.03	-11.57
Total Personnel	**3,116.51**	**3,122.15**	**3,010.88**	**-111.27**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	192.07	6.86%
Positions and Percentage Vacant as of 12/31/15	297.50	10.26%

- The fiscal 2017 allowance contains a total reduction of 99.7 positions for BHA. One position is being added to Program Direction through a contractual conversion, while 100.7 positions are being abolished.

- The position abolitions are due to the privatization of the dietary and housekeeping functions at Springfield Hospital Center (56.0 and 21.0 positions, respectively), the privatization of the dietary function at the John L. Gildner Regional Institute for Children and Adolescents (RICA) (14.0 positions), a reduction from 38 to 34 beds at RICA – Baltimore (8.5 positions), and the transfer of 1.0 position to the Department of Information Technology. The remaining 0.2 position is a reduction of a partial position for dental services at Spring Grove Hospital Center. However, the privatization of the housekeeping function at Springfield is no longer moving forward, so these position reductions will be absorbed through vacancies throughout the rest of the department.

- Contractual employment decreases by 11.57 full-time equivalents (FTE) due to a number of changes. Student training food service positions and direct care aides each increase by 4.0 FTEs, while other food service staff decrease by 6.0 FTEs and security staff decrease by 4.5 FTEs. Other contractual reductions are for patient-based jobs and other employment.

- The overall vacancy rate for BHA increased between fiscal 2016 and 2017, mostly due to the hiring freeze instituted by the department for cost containment purposes in fiscal 2015. Budgeted turnover also increased by 0.94% in the allowance.

Analysis in Brief

Major Trends

Substance Use Prevention: The number of people served by prevention programming grew by 79,100 (19.7%) compared to fiscal 2014. The growth was in single service programming.

Substance Use Disorder Treatment Financing Driven by the Affordable Care Act Expansion: The expansion of eligibility for adults under the federal Affordable Care Act (ACA) has greatly increased the federal fund financing available for substance use disorder (SUD) treatment.

Community Mental Health Fee-for-service System – Enrollment and Utilization Trends: Enrollment growth in the fee-for-service (FFS) community mental health system was 9.2% in fiscal 2015, which is slightly under the enrollment growth over a five-year period from fiscal 2011 through 2015. Individuals eligible for Medicaid under the traditional eligibility categories have declined between fiscal 2014 and 2015, while adults newly eligible under the ACA expansion continue to increase. However, the growth in total service units, while strong, was below enrollment growth in fiscal 2015.

Community Mental Health Fee-for-service System – Expenditure Trends: Expenditures grew at 12.0% in fiscal 2015, outpacing growth over the last five years of 6.9%. This trend is due to an annualization of first-year costs associated with the ACA expansion population, the increasing number of individuals newly eligible for mental health services, as well as the fact that these individuals tend to be utilizing those services, such as inpatient psychiatric services, which are more expensive. However, the 100.0% federal funding rate for the ACA expansion population has limited the amount of State funds expended.

Outcomes for Community Behavioral Health Services: Outcome measures derived from interviews with clients served in outpatient settings for both mental health and SUD treatment vary depending on the condition of the client. Those clients with a co-occurring mental health and SUD exhibit the highest levels of homelessness, while clients with a SUD are more likely to be arrested and clients with a mental health condition are more likely to be unemployed.

Issues

The Heroin Epidemic: The use of heroin and heroin-related substances continues to be an epidemic in the State with heroin-related overdose deaths continuing to climb in fiscal 2015. Numerous efforts have focused on this issue, including most recently the Governor's Heroin and Opioid Emergency Task Force which issued its final recommendations in December 2015. There is a total of $4.8 million in the State budget related to these recommendations, including $3.1 million within BHA. However, funding for SUD treatment continues to be relatively flat, even with the provider rate increases provided by the Administration, and there is an especially acute need for more funding for residential treatment for those individuals committed to the Department of Health and Mental Hygiene (DHMH) under Section 8-507 of the Health – General Article. **The Department of Legislative Services (DLS) thus**

recommends that the funding appropriated for the Center of Excellence, as well as funding within the Department of Human Resources and the Department of Juvenile Services for a heroin screening tool, instead be utilized to fund residential treatment under Section 8-507. The department should also comment on the funding levels and bed availability that would be required under the Justice Reinvestment Coordinating Council bills.

Behavioral Health Integration – Furthering Financial Alignment: The integration of State mental health and SUD agencies and services is continuing, with FFS payments for SUD services being carved-out of HealthChoice under a single administrative service organization (ASO) since January 1, 2015. New information sharing arrangements have also been worked out between the ASO and the Medicaid Managed Care Organizations. However, SUD services for the uninsured continue to be financed on a grant-based system as opposed to FFS under the ASO, which is how mental health services for the uninsured are financed. The department has recently indicated that ambulatory SUD services will be transitioned within fiscal 2017, but other services will still remain in a grant-based system. **The department should comment on how it plans to ensure a smooth transition of ambulatory SUD treatment services to the ASO, and what plans it has for transferring the remaining grant-based funding to the ASO.**

Funding for Institutions for Mental Disease: The Medicaid Institutions for Mental Disease exclusion prohibits the use of federal Medicaid financing for care provided to most adult patients between the ages of 21 and 65 in mental health and SUD residential treatment and inpatient facilities larger than 16 beds. The State in prior years has used numerous waivers to seek federal reimbursement for these services. However, all waivers and programs have expired since the end of fiscal 2015. Currently, the department is seeking individual waivers for SUD services and mental health services, but neither waiver currently has a timeline for approval. **The department should comment on the current status of these waiver applications, and how it plans to fund inpatient psychiatric services without federal funds in fiscal 2017.**

Recommended Actions

1. Add language restricting Medicaid behavioral health provider reimbursements to that purpose.

2. Add budget bill language restricting funds for specified Heroin and Opioid Emergency Task Force Initiatives to only be spent on residential treatment services for Section 8-507 of the Health – General Article commitments.

Updates

Synar Compliance Improves Dramatically: A report was submitted in response to budget bill language from the 2015 *Joint Chairmen's Report* (JCR) on how the State would spend the Synar penalty funding in fiscal 2016 to ensure that no further penalty would be realized for the State. Based

on the most recent federal audit, the State's retailer violation rate has dropped so dramatically that the State will not incur a penalty within the fiscal 2017 budget.

Reports on Behavioral Health Expenditures by Medicaid Eligibility Improve, but More Needs to Be Done: A report was submitted in response to budget bill language within the 2015 JCR providing information on the utilization and expenditures for behavioral health services based upon the user's eligibility group under Medicaid. While this report is useful, more work needs to be done to produce a comprehensive report that would allow DLS to prepare more robust and confident expenditure projections. **Thus, DLS and DHMH will continue to work together throughout the 2016 interim to come up with a more comprehensive and complete dataset and reporting structure.**

M00L
Behavioral Health Administration
Department of Health and Mental Hygiene

Operating Budget Analysis

Program Description

The Behavioral Health Administration (BHA) is responsible for the treatment and rehabilitation of the mentally ill; individuals with drug, alcohol, and problem gambling addictions; and those with co-occurring addiction and mental illness. BHA reflects a merger of the former Mental Hygiene Administration (MHA) and the Alcohol and Drug Abuse Administration (ADAA).

In fiscal 2015, funding for Medicaid-eligible services for the mentally ill was moved from MHA into the Medical Care Programs Administration (MCPA). Further, in fiscal 2016 funding for substance use disorder services were transferred within MCPA from Program M00Q01.03 to M00Q01.10. However, for the purpose of reviewing the fiscal 2017 budget, the funding that is budgeted in M00Q01.10 is reflected in this analysis.

BHA will continue to perform the functions previously undertaken by MHA and ADAA. Namely:

- **For Mental Health Services –** planning and developing a comprehensive system of services for the mentally ill; supervising State-run psychiatric facilities; reviewing and approving local plans and budgets for mental health programs; providing consultation to State agencies concerning mental health services; establishing personnel standards; and developing, directing, and assisting in the formulation of educational and staff development programs for mental health professionals. In performing these activities the State will continue to work closely with local core service agencies (CSAs) to coordinate and deliver mental health services in the counties. There are currently 19 CSAs, some organized as part of local health departments, some as nonprofit agencies, and 2 as multicounty enterprises.

- **For Substance Use Disorder Services –** developing and operating unified programs for substance use disorder (SUD) research, training, prevention, and rehabilitation in cooperation with federal, State, local, and private agencies.

Performance Analysis: Managing for Results

1. Substance Use Prevention

State prevention services are provided through two types of programs:

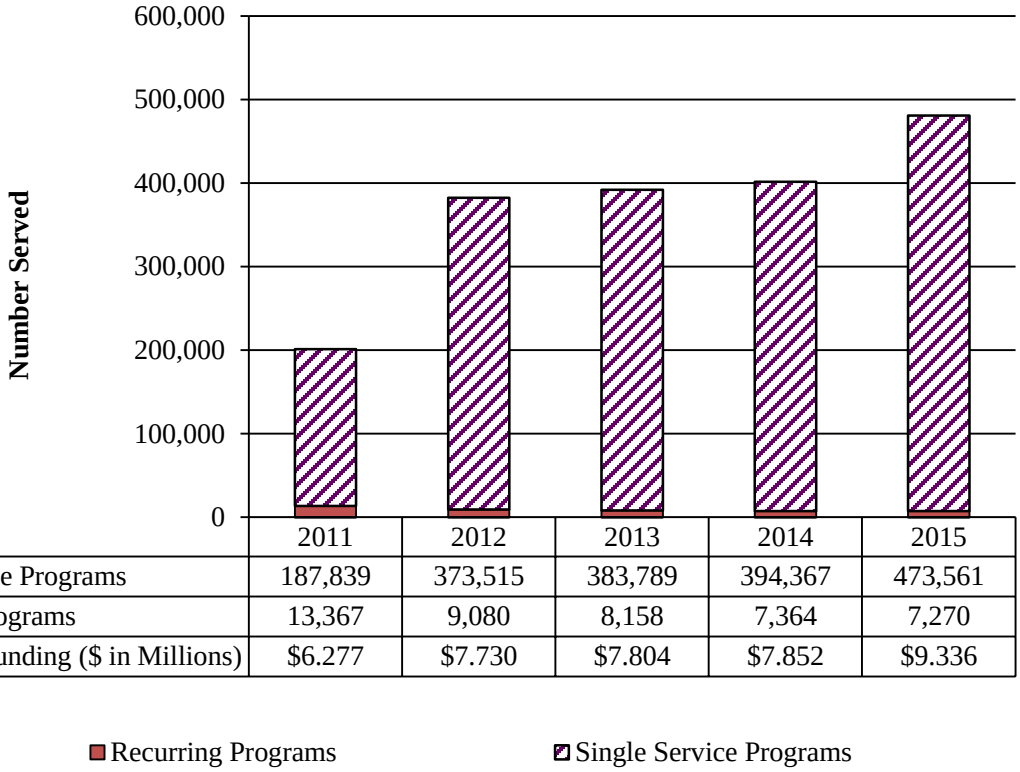
- **Recurring Prevention Programs –** *i.e.*, with the same group of individuals for a minimum of four separate occasions and with programming that is an approved Substance Abuse and Mental Health Services Administration (SAMHSA) evidence-based model. In fiscal 2015, a total of 284 recurring prevention programs were offered across the State, an increase of 27 from the prior year.

  Statewide, the successful completion rate for these types of programs is reported at 86%, a number that has varied little over the past decade. There is variation by county among programs in terms of successful completion. In fiscal 2015, for example, the successful completion rate varied from 100% in Caroline and Cecil counties to 83% in Washington County. It should be noted that since programming varies from one jurisdiction to the next, there is no universal definition of what is considered a "successful completion."

- **Single Service Programs –** such as presentations, speaking engagements, training, *etc*., that are provided to the same group on less than four separate occasions. Participant numbers are either known or estimated. In fiscal 2015, 1,294 single service prevention activities were offered in Maryland, an increase of 39 from the prior year.

As shown in **Exhibit 1**, prevention programming served almost 481,000 participants in fiscal 2015, 79,100 (19.7%) higher than served in fiscal 2014. Recurring programs continue to see a drop in people served, down 94 participants (1.3%) between fiscal 2014 and 2015, a decline that somewhat eased off from the prior year. Conversely, the number of participants served in single service programs grew by 79,194 between fiscal 2014 and 2015, or 20.1%.

Exhibit 1
Behavioral Health Administration-funded Prevention Programs
Fiscal 2011-2015



	2011	2012	2013	2014	2015
Single Service Programs	187,839	373,515	383,789	394,367	473,561
Recurring Programs	13,367	9,080	8,158	7,364	7,270
Prevention Funding ($ in Millions)	$6.277	$7.730	$7.804	$7.852	$9.336

Source: Behavioral Health Administration

In essence, after the significant growth in single service programming between fiscal 2011 and 2012 to reflect the change in program focus from individual-based programming to population-based programming/activities, prevention programming has somewhat stabilized in terms of activities funded. The change in focus required jurisdictions to spend 50% of their prevention award on "environmental strategies," *i.e.*, the establishment of, or changes to, written and unwritten community standards, codes, and attitudes influencing the incidence and prevalence of the abuse of alcohol, tobacco, and other drugs. Environmental strategies tend to be primarily single service activities, limiting the funding available for recurring programs. The broader reach of environmental programming, including mass media campaigns, boosts exposure to single service activities.

Prevention funding continues to increase because of the availability of federal Strategic Prevention Framework State Incentive Grant funds. This grant expired at the end of fiscal 2015.

However, BHA has been awarded new funding under the SAMSHA Partnership for Success grant that will allow them to continue and enhance the State prevention infrastructure and services provided through this program.

2. Substance Use Disorder Treatment Financing Driven by the Affordable Care Act Expansion

Exhibit 2 provides the number of adults who were recorded as receiving treatment through the Administrative Service Organization (ASO) during fiscal 2015, which was the first fiscal year within which reimbursement for services provided to individuals receiving care for a SUD condition through the Medicaid program was provided by the ASO as opposed to through the Medicaid Managed Care Organizations (MCO). As seen in the exhibit, almost half of the individuals receiving SUD treatment in fiscal 2015 were eligible for Medicaid under the Affordable Care Act (ACA) expansion, which increased the federal poverty level under which adults are eligible for Medicaid to 138%. While these individuals did receive SUD treatment prior to the ACA expansion, they did so under the Primary Adult Care (PAC) program, which was entirely financed by the State. Under ACA, these services are entirely financed by the federal government. This is especially significant since, as also seen in Exhibit 2, adults make up the vast majority of the population receiving SUD treatment.

Exhibit 2
SUD Treatment Data by Medicaid Eligibility and Age
Fiscal 2015

	Medicaid Eligibility			
Age	**Traditional***	**ACA Expansion**	**Total**	**% Expansion**
0-17	2,070	1	2,071	0.05%
18-64	23,486	25,425	48,911	51.98%
65 and Over	212	2	214	0.93%
Totals	**25,768**	**25,428**	**51,196**	**49.67%**
% Adult	91.14%	99.99%	95.54%	

ACA: Affordable Care Act
SUD: substance use disorder

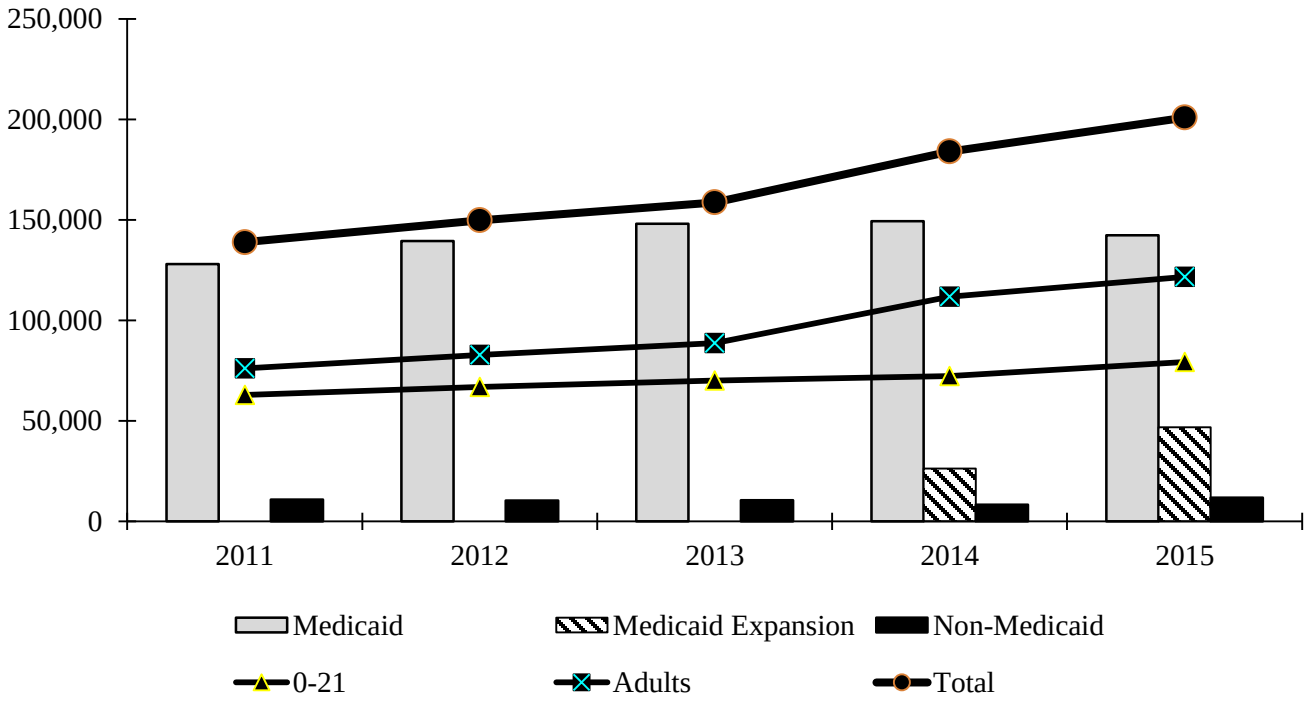
*Traditional includes all Medicaid coverage groups from before the ACA expansion.

Source: Behavioral Health Administration

3. Community Mental Health Fee-for-service System – Enrollment and Utilization Trends

As shown in **Exhibit 3**, total enrollment in the fee-for-service (FFS) community mental health system (Medicaid and non-Medicaid) has increased at an average annual rate of 9.7% between fiscal 2011 and 2015, which is similar to the 9.2% growth between fiscal 2014 and 2015.

Exhibit 3
Community Mental Health Services
Enrollment Trends
Fiscal 2011-2015



Note: Data for fiscal 2015 is incomplete. Enrollment counts may be duplicated across coverage types. Baltimore City capitation project is included.

Source: Department of Health and Mental Hygiene; Department of Legislative Services

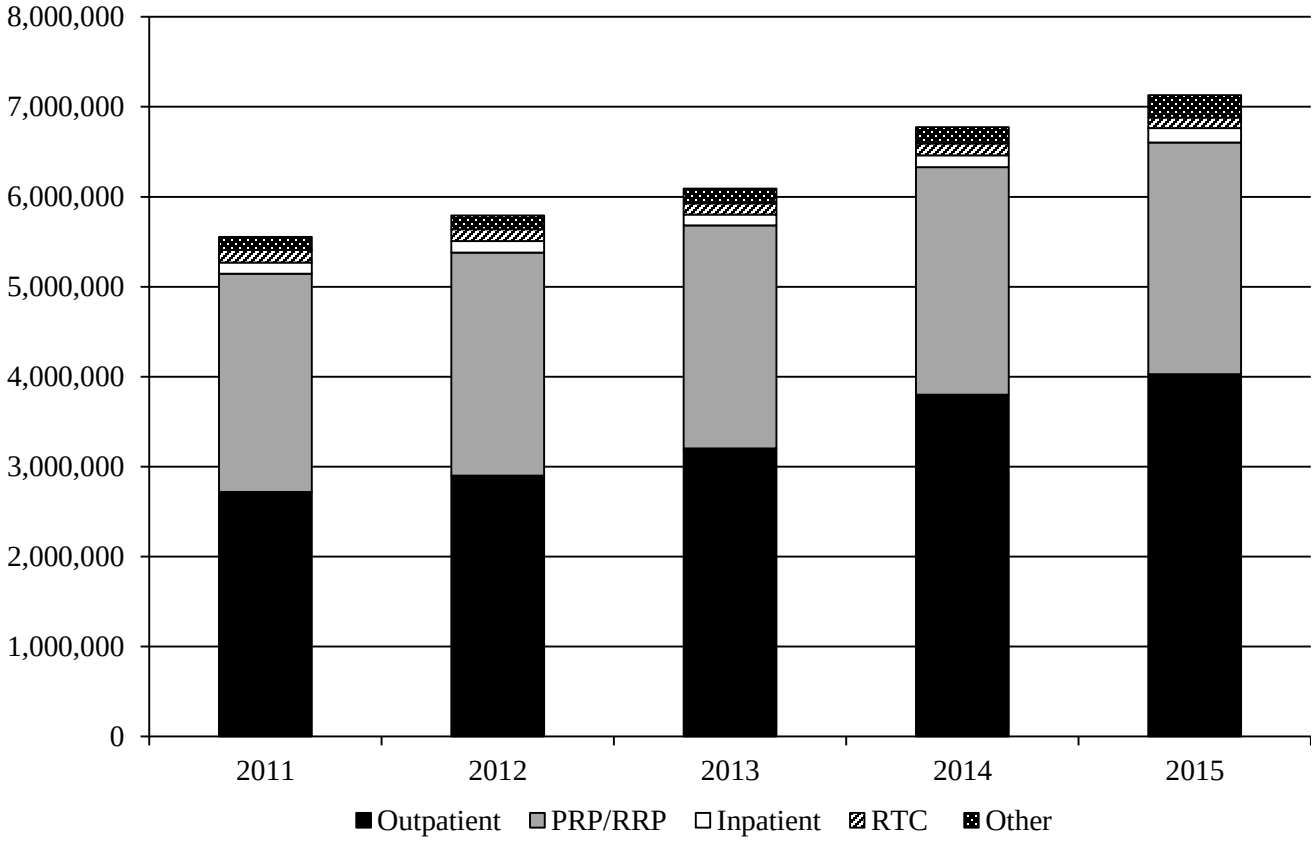
One major change in fiscal 2015 is the drop in the traditional Medicaid population. This eligibility category decreased by 4.7% between fiscal 2014 and 2015. This is most likely attributable to the Medicaid redeterminations which have resulted in fewer people renewing their Medicaid eligibility. However, this decrease was more than made up for in increases for the new ACA expansion population. This difference is particularly interesting because in the overall Medicaid program,

redetermination impacted the traditional and expansion populations alike. When both populations are blended together, the number of consumers using mental health services with some form of Medicaid coverage increases by 7.6% between fiscal 2014 and 2015. More potentially concerning, the non-Medicaid population rises by 1.9% over the period shown, with a sharp increase between fiscal 2014 and 2015 of 42.2%. Most of this increase is from children using services.

The exhibit also shows that enrollment growth over the period has been driven by adults (12.4% between fiscal 2011 and 2015), reflecting both prior strong growth in the PAC program, the State's fiscal 2009 expansion to parents of children in Medicaid, as well as the fiscal 2014 ACA expansion. Over the period shown, the number of adults in the program increases by 12.4% while the number of children increases by 6.0%. Adults make up 60.5% of total enrollment in fiscal 2015, compared to 54.8% in fiscal 2011. However, enrollment growth for children outpaces enrollment growth for adults between fiscal 2014 and 2015 at 9.7% compared to 8.8%, mostly due to the increase in uninsured children. **BHA should comment on the reasons why the number of uninsured children rose so dramatically in fiscal 2015.**

In terms of utilization of services, trends are shown in **Exhibit 4**. The exhibit shows that over the five-year period, total service units are up at an average annual rate of 6.4%. In fact, fiscal 2015 had the largest number of total service units in over 10 years, and the growth between fiscal 2014 and 2015 was 5.2%. This increase has been driven by increases in both outpatient services (up 10.3% over the period and 6.0% over the prior year) as well as other services including crisis, supported employment, and respite care (up 13.8% over the period and 35.7% over the prior year). In fact, all service types had increases in the total number of services over the prior year in fiscal 2015, with the exception of residential treatment, mainly reflecting the fact that the ACA expansion increased the number of services available to a population that previously had largely been unable to obtain them.

Exhibit 4
Community Mental Health Fee-for-service
Service Utilization Trends
Fiscal 2011-2015
(Units of Service)



PRP: Psychiatric Rehabilitation Program
RRP: Residential Rehabilitation Program
RTC: Residential Treatment Center

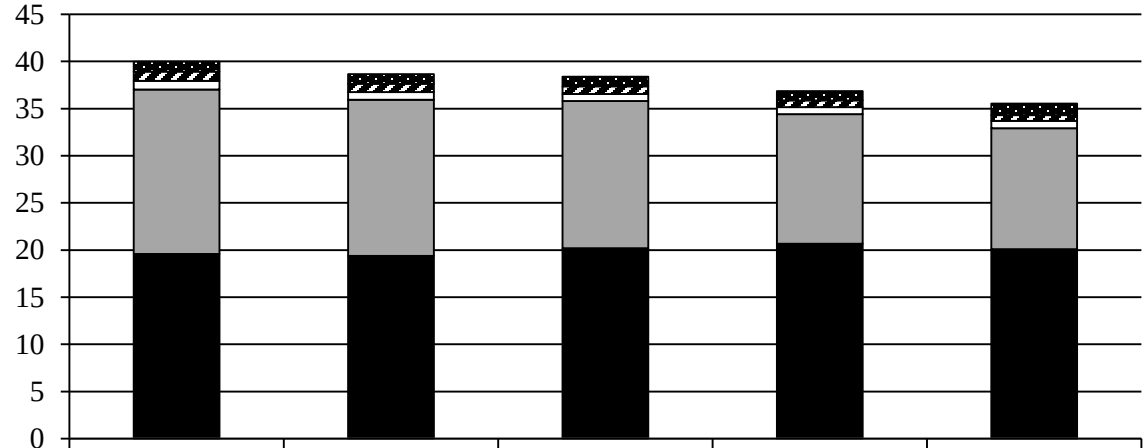
Note: Data for fiscal 2015 is incomplete. Total service unit data includes service units for the Baltimore City capitation project.

Source: Department of Health and Mental Hygiene; Department of Legislative Services

It is worth noting the difference between the enrollment growth in the system between fiscal 2011 and 2015 and contrasting that with the total service units provided in the same period. Over the time period, there has been a decline in the average number of services per capita for most of the more intensive services, such as inpatient, psychiatric and residential rehabilitation, and residential treatment, as seen in **Exhibit 5**. Traditional outpatient services increase over the time period by 0.7%, however, they decrease in fiscal 2015 by 2.9%. The largest increases in services per capita over the

time period by far are for the other services category at 3.8%, with a jump in fiscal 2015 of 24.2%. This includes mainly wraparound services such as crisis and respite care as well as supported employment. One notable trend in fiscal 2015, however, is the increase in inpatient services provided. While inpatient services declined over the period shown by 3.2%, they increased in fiscal 2015 by 10.0%, reversing a decline which had been occurring since fiscal 2009. This is concerning since inpatient services are the most expensive services on a per service basis and potentially are not eligible for federal match depending on the facility where the services are provided.

Exhibit 5
Community Mental Health Fee-for-service
Service Utilization Trends
Fiscal 2011-2015
(Services Per Capita)



	2011	2012	2013	2014	2015
Other	1.06	1.02	1.03	0.99	1.23
RTC	0.98	0.88	0.79	0.71	0.59
Inpatient	0.90	0.84	0.75	0.72	0.79
PRP/RRP	17.46	16.55	15.63	13.75	12.82
Outpatient	19.57	19.38	20.18	20.68	20.09

PRP: Psychiatric Rehabilitation Program
RRP: Residential Rehabilitation Program
RTC: Residential Treatment Center

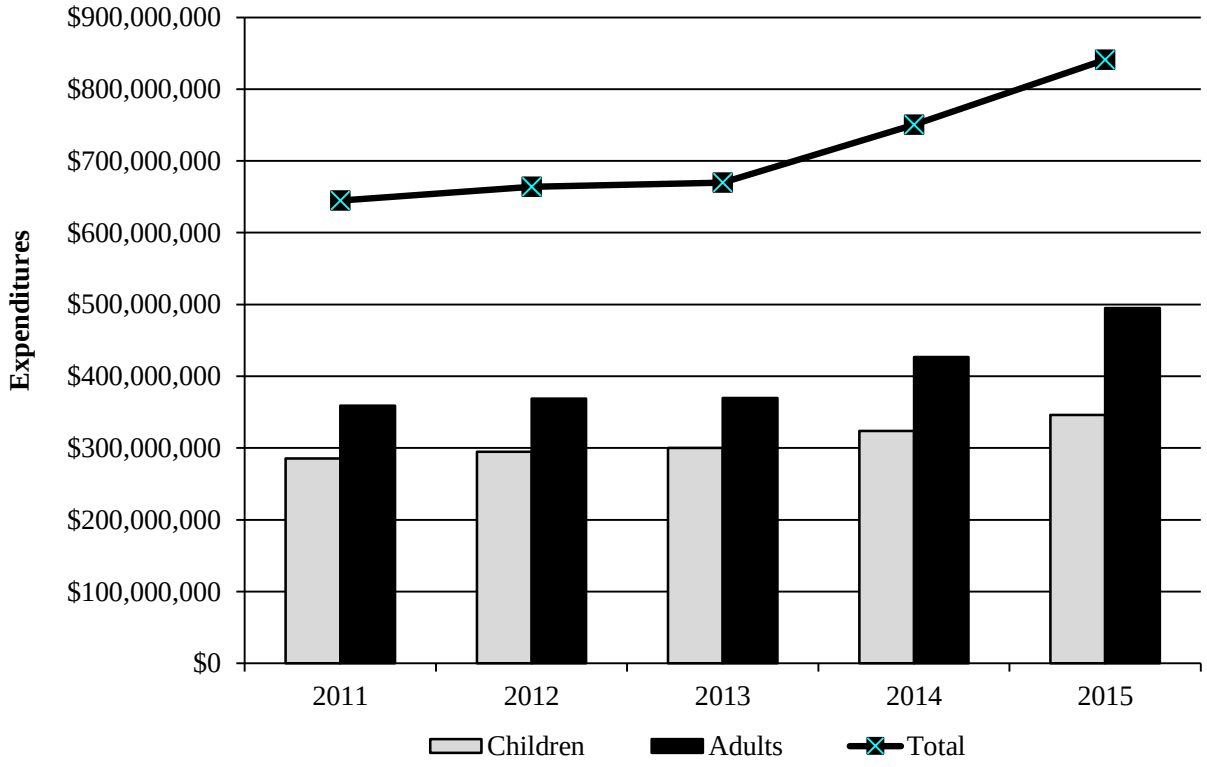
Note: Data for fiscal 2015 is incomplete. Total service unit data includes service units for the Baltimore City capitation project.

Source: Department of Health and Mental Hygiene; Department of Legislative Services

4. Community Mental Health Fee-for-service System – Expenditure Trends

Expenditure patterns historically mirror enrollment growth (**Exhibit 6**). Average annual expenditure growth over the fiscal 2011 to 2015 period is 6.9%. However, growth between fiscal 2014 and 2015 is 12.0%, which is mainly driven by the first full year of costs for the ACA expansion population and the increase in demand for services noted in the previous section.

Exhibit 6
Community Mental Health Fee-for-service Expenditures
Fiscal 2011-2015



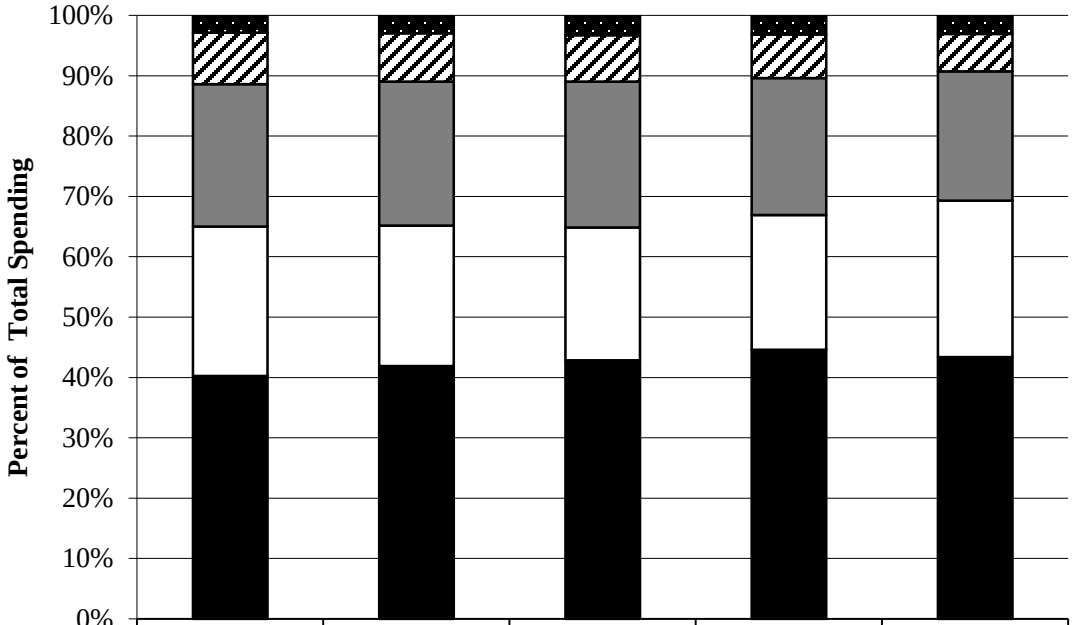
Note: Data for fiscal 2015 is incomplete. Total expenditure data includes expenditures for the Baltimore City capitation project.

Source: Department of Health and Mental Hygiene; Department of Legislative Services

Reflecting the changes in service utilization noted above, there has been a corresponding change in expenditure patterns between different services (**Exhibit 7**). All services, with the exception of residential treatment, had expenditure growth between fiscal 2014 and 2015, with the largest growth

being in inpatient services expenditures at 30.3%. This is mostly attributable to the ACA expansion population which, under the old PAC program, did not have access to these services. This growth is particularly troubling since, as explained in more detail in Issue 3, the State does not receive federal matching funds for inpatient services if they are provided within a specialty psychiatric hospital.

Exhibit 7
Community Mental Health Service Expenditures by Service Type
Fiscal 2011-2015



	2011	2012	2013	2014	2015
Other	$18,329,753	$19,699,732	$21,588,505	$23,761,643	$25,886,279
RTC	$55,193,989	$53,243,697	$50,740,960	$54,304,385	$52,303,651
PRP and RRP	$152,065,731	$158,366,382	$159,771,844	$170,161,634	$179,756,021
Inpatient	$159,818,003	$154,515,302	$145,656,749	$167,598,555	$218,298,269
Outpatient	$259,343,588	$277,934,562	$283,015,346	$334,820,189	$364,517,517

PRP: Psychiatric Rehabilitation Program
RRP: Residential Rehabilitation Program
RTC: Residential Treatment Center

Note: Data for fiscal 2015 is incomplete.

Source: Department of Health and Mental Hygiene; Department of Legislative Services

5. Outcomes for Community Behavioral Health Services

Outcome data from BHA's Outcomes Measurement System continues to be limited to outpatient clinics. However, they have now begun to collect information on those receiving outpatient services with both mental health and SUD conditions. The data presented in **Exhibit 8** is based on the most recent interview of clients, and in each situation asks whether or not the individual has either been homeless, arrested, or unemployed within the last six months. The percentages are the number of individuals who answered yes to these questions. As seen in the exhibit, the greatest problems are split amongst various populations. Homelessness and criminal justice involvement are highest amongst those with a SUD condition, with homelessness being especially acute for those with a co-occurring disorder. However, those with a mental health diagnosis are the most likely to be unemployed.

Exhibit 8
Outcome Measurement System Data
Fiscal 2015

	Homeless	Criminal Justice Involvement	Unemployment
Adult			
All	12.4%	6.7%	66.4%
MH	2.3%	3.5%	87.0%
SUD	12.9%	20.2%	54.3%
Co-occuring	18.2%	16.0%	64.5%
Children			
All	2.3%	4.1%	87.0%
MH	2.3%	3.5%	87.0%
SUD	4.2%	35.4%	85.8%
Co-occuring	3.1%	27.8%	89.2%

MH: mental health
SUD: substance use disorder

Source: Behavioral Health Administration

Fiscal 2016 Actions

Cost Containment

The fiscal 2016 budget contained an across-the-board reduction for all State agencies, which resulted in a 0.6% across-the-board general fund reduction for the Department of Health and Mental Hygiene (DHMH) totaling $27,215,000. Of this total amount, BHA was assigned a cost containment decrease of $2,639,890 in general funds. Actions undertaken to make up this cut include utilizing additional federal fund attainment in lieu of general funds ($1,375,000), decreasing funds for services for the uninsured ($450,000), and a 2% operating expenses reduction at all of the State psychiatric institutions ($814,890).

Further, there is a specified reversion in the Governor's fiscal 2017 budget plan of $11,500,000 from Medicaid behavioral health in fiscal 2016. These funds are available due to lower than anticipated spending on the traditional Medicaid population, due to declining enrollment within that population.

Proposed Budget

As shown in **Exhibit 9**, after adjusting for the fiscal 2016 specified reversion as well as fiscal 2017 back of the bill reductions, the fiscal 2017 allowance for BHA grows by $13.7 million (0.8%) over the fiscal 2016 working appropriation. Not included in these numbers is $2.3 million from Supplemental Budget No. 2. Including this amount, expenditures increase by $16.0 million, or 1.0%.

Exhibit 9
Proposed Budget
Department of Health and Mental Hygiene
Behavioral Health Administration
($ in Thousands)

How Much It Grows:	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2015 Actual	$839,520	$50,035	$649,268	$8,284	$1,547,108
Fiscal 2016 Working Appropriation	856,743	60,462	738,564	10,744	1,666,513
Fiscal 2017 Allowance	885,437	53,805	733,183	7,796	1,680,220
Fiscal 2016-2017 Amount Change	$28,693	-$6,657	-$5,381	-$2,948	$13,708
Fiscal 2016-2017 Percent Change	3.3%	-11.0%	-0.7%	-27.4%	0.8%

Where It Goes:

Personnel Expenses	
Employee and retiree health insurance	$4,299
Retirement contributions	3,899
Overtime	731
Workers' compensation premium assessment	433
Turnover adjustments	188
New position (1.0 full-time equivalent (FTE))	77
Other compensation	48
Other fringe benefit adjustments	-275
Abolished positions (100.7 FTEs)	-5,844
Community Behavioral Health Services	
Fee-for-Service Expenditures	
Regulated rate increase assumptions	14,787
Community provider rate increase (2%)	12,248
Enrollment and utilization: uninsured and State-funded	-5,551
Enrollment and utilization: Medicaid	-21,853
Grants and Contracts – Mental Health	
Care Management Entity funding	1,610
Maryland Collaboration for Homeless Enhancement Services Grant	1,427
Core Service Agency rate increase (2%)	1,260
Increase in Community Mental Health Service Block Grant (federal funds)	1,064
Administrative Service Organization contract	247
Expiring federal grants	-1,013
Core Service Agency various programming	-1,471
Grants and Contracts – Substance Use Disorders	
New federal grant funding	2,187
Increased federal grant funding	1,112
Synar penalty	-2,612
Program Direction	
Heroin Task Force initiatives	3,059
Prescription Drug Monitoring Program	441
Maryland Institute for Policy Analysis and Research	204
Facilities	
Privatization contracts	4,492
Purchase of care contracts at Spring Grove Hospital Center	701
Crownsville Hospital Center facility maintenance	-690
Non-personnel operating costs from privatized functions	-1,726
Other Changes	228
Total	**$13,708**

Note: Numbers may not sum to total due to rounding.

Across-the-board Reductions

The fiscal 2017 budget bill includes an across-the-board reduction for employee health insurance, based on a revised estimate of the amount of funding needed. For DHMH, the amount of these reductions is $1,424,451 in general funds, $132,440 in special funds, and $251,138 in federal funds across the entire department, of which $832,865 is in the BHA budget ($819,526 general funds, $1,266 special funds, $12,073 federal funds). There is an additional across-the-board reduction to abolish positions statewide, but the amounts have not been allocated by agency.

Personnel

Personnel expenditures net of back of the bill reductions increase by $3.6 million. The largest increases, consistent with other State agencies, are for employee and retiree health insurance contributions as well as retirement contributions at $4.3 million and $3.9 million, respectively. One new position within Program Direction also adds $76,936. This position is a contractual conversion of a program administrator position which assists homeless and mentally ill individuals with accessing entitlements and other supportive programs.

There is also an increase of $730,986 in overtime expenses. However, it should be noted that the current allowance for overtime is still below the most recent actual from fiscal 2015. During that year, overtime expenses across the agency totaled $13.7 million, which is in line with other recent historical trends. However, the current allowance only allots $9.6 million. This is problematic, both because the State hospital centers continue to be over capacity and because vacancy rates within the hospitals continue to be quite high. According to the most recent vacancy data, vacancy rates at the two largest hospital centers, Springfield and Spring Grove, are 13.8% and 11.9%, respectively.

The largest change in personnel expenditures is the decrease of $5.8 million for abolished positions. There are 100.7 positions abolished within BHA for a variety of reasons. A total of 77.0 positions are being abolished at Springfield Hospital Center due to the privatization of the dietary and housekeeping functions at the hospital. The position abolitions due to these privatizations are 56.0 and 21.0, respectively, with the majority of these positions being currently filled. However, due to an error in the calculations for the cost of the outsourced housekeeping contract, DHMH is no longer pursuing this specific privatization. The 21.0 position reduction, however, will still be made up with vacancies from throughout the department. More information on this is provided under the discussion of changes within the facilities.

There is also a decrease of 14.0 positions at the John L. Gildner Regional Institute for Children and Adolescents (RICA) due to the privatization of the dietary function at that facility as well. Personnel savings from all of the privatizations totals $5.5 million. A further 8.5 positions are being reduced at RICA – Baltimore due to a residential bed reduction from 38 to 34 beds, and 1.0 position is being transferred to the Department of Information Technology as part of the centralization of information technology functions across the State. The remaining 0.2 position is a reduction of a partial position for dental services at Spring Grove Hospital Center.

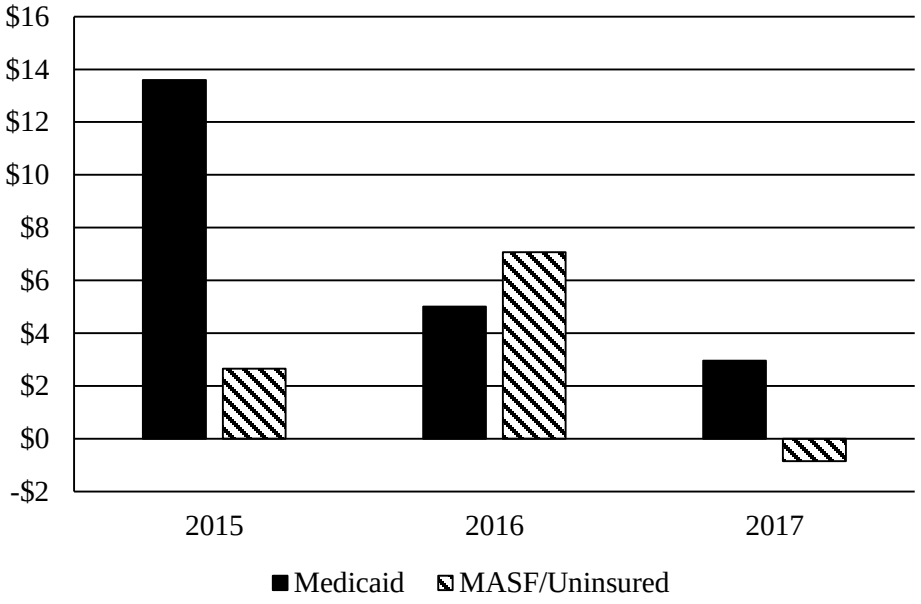
Community Behavioral Health Services

Fee-for-service Expenditures

Overall spending on FFS expenditures for behavioral health treatment, including services for those within the Medicaid program as well as the uninsured and State-funded services for the Medicaid-eligible, decreases by approximately $369,000. Most of this is due to reduced expenditures related to enrollment and utilization trends, falling $21.9 million, with a particularly sharp decrease in federal funds. There is also an assumed decrease of $5.6 million for the uninsured and State-funded services budget, which declines due to the fact that an extra $10.0 million added to the budget via budget amendment from the Maryland Health Insurance Plan (MHIP) fund is not continued into fiscal 2017. Beyond these reductions, there are rate increases for behavioral health providers. Regulated rate increase assumptions add $14.8 million to the budget, while a 2% community provider rate increase adds $12.2 million.

The Department of Legislative Services (DLS) estimate of the adequacy of State-supported funds to meet demand for FFS community behavioral health services is provided in **Exhibit 10**. Overall, the budget for Medicaid-eligible spending looks to be in balance when it comes to State-supported funding. Based on the most recent spending projections for fiscal 2015 and using projected enrollment growth, current utilization trends, and provider rate increases, it appears that the fiscal 2016 budget for behavioral health Medicaid services is slightly overfunded by $5.0 million in terms of State funding after taking into consideration the $11.5 million targeted reversion. The current fiscal 2015 accrual levels appear to be well above the level needed to closeout fiscal 2015, with a $13.6 million surplus projected. The fiscal 2017 budget also has a projected surplus of State funding at $3.0 million. However, for both fiscal 2016 and 2017, given the overall level of State funding, the surplus represents a variance of only 1.4% and 0.8%, respectively.

Exhibit 10
Projected General Fund Balances
Fiscal 2015-2017
($ in Millions)



MASF: Medical Assistance State Funded

Note: Excludes the Baltimore Capitation Project.

Source: Department of Health and Mental Hygiene; Department of Legislative Services

Funding for the uninsured as well as State-funded services for Medicaid-eligible individuals looks to be adequate as well. While there is a projected deficit within fiscal 2017, this represents only a 1.1% variance from the amount contained within the allowance. **Over the three years, there is a surplus of $30.4 million including Medicaid, Medicaid State-funded, and uninsured services.** However, there are two trends that happened within fiscal 2015 that could affect funding adequacy in both fiscal 2016 and 2017. First, as noted previously, the number of individuals receiving services for the uninsured increased dramatically in fiscal 2015, particularly for children. At this time, it is unclear why this increase occurred since there was not a corresponding decrease of children enrolled in Medicaid utilizing behavioral health services.

Second, within fiscal 2015 there was an unusually high utilization of inpatient mental health services within specialty psychiatric hospitals. Due to the federal exclusion of reimbursement for mental health or SUD services within an institution for mental disease (IMD), these inpatient services

must be entirely funded by the State. In fiscal 2015, inpatient utilization within an IMD was especially acute for the former PAC population, which prior to the ACA expansion did not have access to inpatient psychiatric services. Once that access was granted, these patients began presenting at much greater numbers at both acute care hospitals as well as psychiatric hospitals throughout the State. For those presenting at acute care, since they are within the ACA expansion population, the State was reimbursed at 100%. However, for those presenting at a specialty psychiatric hospital, the only federal reimbursement available was through a federal demonstration project, which only reimbursed at 50% and ended at the conclusion of fiscal 2015. In order to prevent spending from inflating at this rate again, BHA is currently monitoring the number of patients which can be admitted to a private psychiatric facility and encouraging those facilities to seek placement for patients within an acute care hospital prior to admission to the IMD facility. Without BHA utilizing this procedure, or obtaining additional federal funding through one of the waivers discussed in Issue 3, it is possible that the deficit in fiscal 2017 presented in Exhibit 10 could become much larger.

It is also worth noting that the Administration has utilized special funds from the surplus within the Senior Prescription Drug Assistance Program fund to offset general funds within the FFS programs for the uninsured. Currently, the appropriation is $8.3 million. However, DLS estimates that there is only $6.0 million available for this purpose (see the Medical Care Programs Administration analysis for additional detail). BHA will have to find additional sources of revenue in order to make up for this difference in fiscal 2017.

Grants and Contracts – Mental Health

Various grants and contracts for mental health providers increase by $3.1 million above the current working appropriation. The largest increase is $1.6 million for the Care Management Entity (CME) function. Previously, the Governor's Office for Children (GOC) ran a program that provided wraparound services for children with severe emotional disturbance in order to keep these children out of residential treatment facilities and in their homes and communities. During fiscal 2016, a budget amendment was processed which transferred $2.8 million for this program from GOC to BHA. For fiscal 2016, BHA will continue funding the contract that is currently in use by the State. However, in fiscal 2017, $4.4 million has been provided to the CSAs in order to switch from the current CME to a Targeted Case Management (TCM) system.

In particular, this switch seeks to take advantage of the State Plan Amendments that redefined TCM for children and adolescents and created the 1915(i) service array. The current TCM system already provides care coordination to youth with intensive needs who are eligible for Medicaid, and in particular the 1915(i) service array is available to support home and community-based plans of care for youth in the highest level of intensity who also meet financial eligibility requirements. By eliminating the CME and redirecting funds to the TCM system, the State intends to establish a more efficient system that also draws down the federal Medicaid match for TCM services for Medicaid-eligible children. The funding included in the fiscal 2017 allowance is to support the continuation of services at varying intensity levels for youth that are both eligible and ineligible for Medicaid, similar to those services provided by the CME, and is based on the historical costs of youth served by the CME.

Grants and Contracts – Substance Use Disorders

The major increases in grants and contracts for SUD services are for federal funding that is either new or enhanced in fiscal 2017. New grants total $2.2 million and include the Maryland Collaboration for Homeless Enhancement Services grant at $1.4 million (with an additional $1.4 million for the mental health component of this grant as well) and a grant of $794,300 for medication assisted treatment for heroin and prescription opioid addiction. Also, not included in these numbers, is an additional $2.3 million from Supplemental Budget No. 2. This supplemental added funds due to the fact that SUD services for the uninsured, which are currently provided through grants and contracts and not on a FFS basis, were not calculated into the rate increase for community providers in the allowance as originally submitted. These increases are partially offset by the decrease of $2.6 million for the Synar penalty. However, the State intends to continue funding the Synar program within the Prevention and Health Promotion Administration (PHPA) of DHMH. More on the Synar program and penalty can be found in Update 1.

Program Direction

The largest increase for Program Direction is $3.1 million for initiatives related to the Governor's Heroin and Opioid Emergency Task Force recommendations. The largest part of this funding at $1.0 million is to establish the Maryland Center of Excellence for Prevention and Treatment under the Behavioral Health Advisory Council in order to further study issues surrounding SUD and especially heroin and opioid addiction. Other major uses of these funds include a Good Samaritan Law Public Awareness Campaign ($700,000), providing recovery support specialists to assist pregnant women with substance use disorders ($622,000), and requiring mandatory registration and querying of the Prescription Drug Monitoring Program (PDMP) ($522,000). More on these items, including other items funded as part of the task force recommendations, can be found in Issue 1.

Facilities

The largest increase in the budgets for the State-operated hospital centers and facilities is $4.5 million for the privatization contracts for Springfield Hospital Center and RICA – Gildner. Overall, the cost of the contracts minus the savings from the abolished positions as well as the operating costs of those functions lowers the fiscal 2017 allowance by $2.7 million. However, some issues have been noticed with the privatization process for these contracts, in particular with the housekeeping contract at Springfield.

According to DHMH, both of the dietary contracts at Springfield and RICA – Gildner have been reviewed and certified by the Department of Budget and Management that they will save the amounts mandated by statute. However, at this time the amounts included in the budget are projections based on the costs of privatized food services at other State hospital centers. Since a Request for Proposals (RFP) cannot be issued until 60 days after employees have been notified, the actual costs of the contracts are unknown at this time.

One privatization has already been pulled back, which is the contract for housekeeping services at Springfield Hospital Center. This privatization is no longer moving forward due to an error in the

calculation of the costs of the contract based on the square footage of the facility. The State did not include in its estimate the correct size of the facility that would need to be maintained, and based on a revised cost estimate it is no longer feasible to privatize this service. However, while the Administration does not intend to move forward with the privatization of housekeeping services at this time, the reduction of 21 positions, as well as the cost differential, will now be absorbed through other vacancies throughout the department. **BHA should comment on the status of these contracts, when the RFP will be released by the State, and how the department intends to absorb the position reductions and other costs now that the housekeeping privatization is no longer moving forward.**

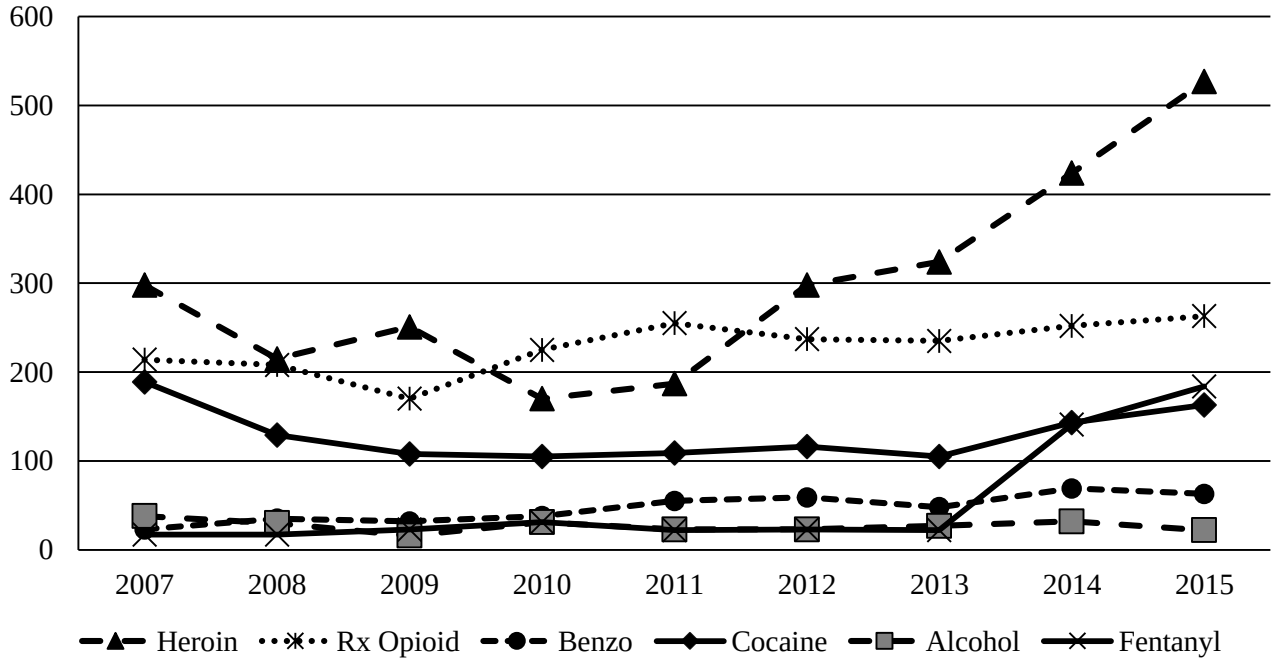
There is also a decrease of $690,000 in operating costs for the closed Crownsville Hospital Center. After a task force in the interim did not determine a reasonable use of the property, it is unclear how BHA and DHMH intend to dispose of the property to such an extent that no more upkeep will be necessary in fiscal 2017. **The department should comment on its future plans for the Crownsville Hospital Center.**

Issues

1. The Heroin Epidemic

Opioid use and overdose continues to be a serious and urgent public health issue. As seen in **Exhibit 11**, since 2007 heroin and/or prescription opioid drugs have been involved in the majority of the State's overdose deaths, with deaths related to fentanyl also increasing in 2014 and 2015. In fact, 2015, on a January through September year-to-date basis, is the highest year for overdose deaths in the time period shown. Various actions have been taken in an attempt to combat overdose deaths as well as heroin and opioid use throughout the State in recent years.

Exhibit 11
Overdose Deaths by Related Substance
January-September 2007-2015*



Rx: medical prescriptions

*2015 counts are preliminary.

Source: Department of Health and Mental Hygiene

Prescription Drug Monitoring Program

The PDMP, established by Chapter 166 of 2011, aims to reduce prescription drug misuse and diversion by creating a secure database of all Schedule II through V controlled dangerous substances prescribed and dispensed in the State. PDMP can make data on prescription opioids available to health care providers, pharmacists, patients, health occupations licensing boards, specific DHMH administrations, law enforcement, and PDMPs in other states. PDMP is integrated with Chesapeake Regional Information System for our Patients, the State-designated health information exchange.

According to DHMH, as of November 1, 2015, PDMP has 14,258 registered users and is averaging 20,000 patient queries per week. PDMP is interoperable with PDMPs in Virginia and West Virginia. In October 2015, PDMP began analyzing data to identify patients getting controlled substances from multiple providers and alerting providers. In December 2015, the PDMP Advisory Board made recommendations in its annual report regarding mandatory registration and use of PDMP by health care providers. The recommendations call for phasing in mandatory registration and use after taking steps to streamline user registration, educate providers, support provider workflow integration, and improve system capacity and data quality. A similar recommendation was provided by the Governor's Heroin and Opioid Emergency Task Force and would be implemented by HB 456 or SB 382.

Overdose Response Program

Chapter 299 of 2013 established the Overdose Response Program in DHMH to authorize certain individuals, through the issuance of a certificate, to administer naloxone to an individual experiencing opioid overdose when medical services are not immediately available. DHMH authorizes private and public entities to train and certify individuals to administer naloxone. As of June 2015, over 8,700 individuals were trained (34% of whom are law enforcement). In addition, over 8,000 doses of naloxone were dispensed and 145 administrations were reported. Chapter 356 of 2015 expanded the program to authorize standing orders for naloxone and provided additional legal protections for prescribers and administrators of naloxone.

Joint Committee on Behavioral Health and Opioid Use Disorders

Chapter 464 of 2015 established the Joint Committee on Behavioral Health and Opioid Use Disorders, comprising five senators and five delegates, to oversee the State's PDMP and State and local programs to treat and reduce opioid use disorders. The joint committee must review the final report of the Heroin and Opioid Emergency Task Force and review and monitor the activities of the Governor's Inter-Agency Heroin and Opioid Coordinating Council. The joint committee must also monitor the effectiveness of the State Overdose Prevention Plan; local overdose prevention plans and fatality review teams; strategic planning practices to reduce prescription drug abuse; and efforts to enhance overdose response laws, regulations, and training.

The joint committee has received briefings on the DHMH overdose prevention strategy; the Screening, Brief Intervention and Referral to Treatment Program; the funding of behavioral health

services; opioid use disorders and treatments; the activities of the Justice Reinvestment Coordinating Council (JRCC); the Baltimore Mayor's Heroin and Treatment Task Force; and the Heroin and Opioid Emergency Task Force.

Inter-Agency Heroin and Opioid Coordinating Council

In response to the State's heroin and opioid epidemic, the Governor issued an executive order in February 2015 establishing the Governor's Inter-Agency Heroin and Opioid Coordinating Council. The council, which is chaired by the Secretary of Health and Mental Hygiene, consists of representatives of the departments of State Police, Public Safety and Correctional Services, Juvenile Services, Education, and the Maryland Institute for Emergency Medical Services Systems. The council's duties include developing recommendations for policy, regulations, or legislation to facilitate improved sharing of public health and public safety information among State agencies. The council must update the Governor biannually on each agency's efforts to address heroin and opioid education, treatment, interdiction, overdose, and recovery. On behalf of the council, DHMH must submit an annual report to the Governor and the public in the form of the Inter-Agency Heroin and Opioid Coordination Plan. The council met on four occasions in 2015.

Heroin and Opioid Emergency Task Force

In February 2015, the Governor also established, by executive order, the Heroin and Opioid Emergency Task Force, which consists of the Lieutenant Governor; an appointee of the President of the Senate, the Speaker of the House, and the Attorney General; and seven members of the public. The task force must assist the Governor in establishing a coordinated statewide and multijurisdictional effort to prevent, treat, and significantly reduce heroin and opioid abuse and advise the Governor and the Director of Homeland Security on immediate steps to improve coordination between federal, State, and local law enforcement regarding the trafficking and distribution of heroin and opioids in the State. The task force held six regional summits throughout the State to hear input from concerned Marylanders who have been impacted by the heroin epidemic. Based on information provided at the summits, the task force established five workgroups: Access to Treatment and Overdose Prevention; Quality of Care and Workforce Development; Intergovernmental Law Enforcement Coordination; Drug Courts and Reentry; and Education, Public Awareness, and Prevention.

In August 2015, the task force submitted an interim report, which contained 10 recommendations for immediate implementation including earlier and broader incorporation of heroin and opioid prevention into the health curriculum, implementation of emergency department opioid prescribing guidelines, training for the Maryland State Police on the Good Samaritan Law, and establishing a faith-based addiction treatment database. The report also detailed how $2 million in additional treatment and prevention funding, earmarked by the legislature and released by the Governor for fiscal 2016, will be spent, including naloxone training and distribution to local health departments and local detention centers; overdose survivor outreach programs in hospital emergency departments; prescriber education; recovery housing and detoxification services for women with children; and increased bed capacity at the A.F. Whitsitt Center, a partially State-financed residential treatment facility on the Eastern Shore. Most of this funding is continued in the fiscal 2017 allowance.

On December 1, 2015, the task force submitted its final report to the Governor which included 33 recommendations in response to 7 key goals of the task force. Those recommendations are provided in **Exhibit 12**. Furthermore, approximately $4.8 million in general funds has been added to various agencies throughout the State to support some of the recommendations of the task force, including almost $3.1 million within BHA, as shown in **Exhibit 13**. Beyond this funding, the one recommendation that could greatly affect funding for SUD treatment is to review Medicaid rates for SUD treatment services every three years. DHMH indicates that they are currently working towards beginning this review. However, what is most troubling about the recommendations and the funding provided for the task force initiatives is how little of the funding is directed towards basic SUD treatment services, especially in areas where the State is aware that there are funding shortfalls. Outside of the rate increase for providers, State-supported funding for SUD treatment is entirely flat in fiscal 2017. Meanwhile, the recommendations would instead fund a new research entity with the Center of Excellence as well as screening tools at the Department of Human Resources (DHR) and the Department of Juvenile Services (DJS), all of which are either duplicative of State services already offered or should not be necessary given the resources that the State has already committed to these functions within the fiscal 2017 allowance.

Exhibit 12

Heroin and Opioid Emergency Task Force Recommendations

Expanding Access to Treatment

Implementing a Statewide Buprenorphine Access Expansion Plan

Reviewing the Substance Use Disorder Reimbursement Rates Every Three Years

Expanding Access to Treatment through Payments to Noncontracting Specialists and to Noncontracting Nonphysician Specialists

Improving Provider Panel Lists

Expanding Access to Training for Certified Peer Recovery Specialists

Providing Recovery Support Specialists to Assist Pregnant Women with Substance Use Disorders

Transitioning Inmates to Outpatient Addictions Aftercare and Community Providers

Incentivizing Colleges and Universities to Start or Expand Collegiate Recovery Programs

Enhancing Quality of Care

Requiring Mandatory Registration and Querying of the Prescription Drug Monitoring Program

Authorizing the Opioid-associated Disease Prevention and Outreach Program

Requiring and Publishing Performance Measures on Addiction Treatment Providers

Requiring Continuing Professional Education on Opioid Prescribing for the Board of Podiatric Medical Examiners and Board of Nursing and on Opioid Dispensing for the Board of Pharmacy

Requiring Drug Monitoring for Medicaid Enrollees Prescribed Certain Opioids Over an Extended Time

Boosting Overdose Prevention Efforts

Expanding Online Overdose Education and Naloxone Distribution

Implementing a Good Samaritan Law Public Awareness Campaign

Escalating Law Enforcement Options

Enacting a Maryland Racketeer Influenced and Corrupt Organization Statute

Creating a Criminal Penalty for Distribution of Heroin or Fentanyl Resulting in Fatal or Nonfatal Overdose

Creating a Multijurisdictional Maryland State Police Heroin Investigation Unit

Designating the High Intensity Drug Trafficking Area's Case Explorer the Central Repository for Maryland Drug Intelligence

Enhancing Interdiction of Drug-Laden Parcels

Strengthening Counter-Smuggling Efforts in Correctional Facilities

Reentry and Alternatives to Incarceration

Establishing a Day Reporting Center Pilot Program to Integrate Treatment into Offender Supervision

Expanding the Segregation Addictions Program in Correctional Facilities

Implementing a Swift and Certain Sanctions Grid for Probation and Parole

Institutionalizing a Substance Use Goal into the Maryland Safe Streets Initiative

Establishing a Recovery Unit at Correctional Facilities

Studying the Collateral Consequences of Maryland Laws and Regulations on Employment of Ex-offenders

Promoting Educational Tools for Youth, Parents, and School Officials

Creating a User-friendly Educational Campaign on School Websites

Training for School Faculty and Staff on Signs of Student Addiction

Promoting Evidence-based Prevention Strategies that Develop Refusal Skills

Support Student-based Film Festivals on Heroin and Opioid Abuse

Improving State Support Services

Implementing Comprehensive Heroin and Opioid Abuse Screening at the Department of Juvenile Services and the Department of Human Resources

Establishing the Maryland Center of Excellence for Prevention and Treatment under the Behavioral Health Advisory Council

Source: *Final Report of the Governor's Heroin and Opioid Emergency Task Force*

Exhibit 13
Funded Recommendations of the Heroin and Opioid Emergency Task Force
Fiscal 2017

Department of Health and Mental Hygiene	
Establishing the Maryland Center of Excellence for Prevention and Treatment under the Behavioral Health Advisory Council	$1,000,000
Implementing a Good Samaritan Law Public Awareness Campaign	697,653
Providing recovery support specialists to assist pregnant women with substance use disorders	622,622
Requiring mandatory registration and querying of the prescription drug monitoring program	522,245
Implementing a Statewide Buprenorphine Access Expansion Plan	206,480
Expanding online overdose education and naloxone distribution	10,000
Subtotal	***$3,059,000***
Department of Public Safety and Correctional Services	
Day reporting center through the Division of Parole and Probation – Central Region	540,000
Outpatient addictions aftercare at the Metropolitan Transition Center	358,000
Expand the segregated addictions program at the Maryland Correctional Training Center	138,000
Subtotal	***$1,036,000***
State Police (included within Supplemental Budget No. 2)	
Multi-jurisdictional State Police Heroin Investigation Unit	200,000
Designating HIDTA the Central Repository for Maryland drug intelligence	75,000
Subtotal	***$275,000***
Governor's Office of Crime Control and Prevention	
Safe Streets	180,000
Maryland State Department of Education	
Local school websites to promote drug and heroin awareness	100,000
Department of Juvenile Services and Department of Human Resources	
Screenings	100,000
Grand Total	**$4,750,000**

HIDTA: High Intensity Drug Trafficking Area

Source: State Budget

Justice Reinvestment Coordinating Council

Chapter 42 of 2015 established JRCC in the Governor's Office of Crime Control and Prevention (GOCCP). JRCC was tasked with convening a stakeholder workgroup and, using a data-driven approach, to develop a statewide framework of sentencing and corrections policies to further reduce the State's incarcerated population, reduce spending on corrections, and reinvest in strategies to increase public safety and reduce recidivism. JRCC's final report in December 2015 contained numerous recommendations and reinvestment strategies, and one of the major reinvestment priorities includes SUD and mental health treatment. SB 1005 and HB 1312 seek to codify many of these recommendations and reinvestment strategies.

One area in particular that these bills address is the process by which drug offenders can be committed to SUD treatment within DHMH under Section 8-507 of the Health – General Article. In particular, the legislation would change the timing by which defendants would be placed into treatment from "prompt placement" to 30 days. Based on a report requested through the 2014 *Joint Chairmen's Report* (JCR), it currently takes on average approximately 120 days to place a defendant into a residential treatment facility. Thus, if either of these bills were to be enacted into law as written, DHMH would need to place defendants about four times as quickly as they currently do. Further, it should be noted that the providers delivering the residential treatment have indicated that they could increase their intake of patients if appropriate funding were provided within the State budget. Currently, only $6 million is allocated for forensic placements into residential treatment under Section 8-507, which serves approximately 360 people. Even without a change in statute, it is apparent that there is not adequate funding within the current allowance to meet the demand for residential SUD treatment under this procedure. **DLS thus recommends that the funding appropriated for the Center of Excellence, as well as funding within DHR and DJS for a heroin screening tool, instead be utilized to fund residential treatment under Section 8-507. The department should also comment on the funding levels and bed availability that would be required under the JRCC bills.**

2. Behavioral Health Integration – Furthering Financial Alignment

For the past several years, DHMH has been working on the issue of integrating mental health and SUD care. The need to do this was prompted by observations that the previous service delivery system for mental health and SUD services was fragmented and suffered from a lack of connection (and coordination of benefits) with general medical services; had fragmented purchasing and financing systems with multiple, disparate public funding sources, purchasers, and payers; had uncoordinated care management including multiple service authorization entities; and had a lack of performance risk with payment for volume, not outcomes.

As part of the integration process, the State chose to move forward with an expanded carve-out of behavioral health services from the managed care system with added (though limited) performance risk. Specifically, all SUD services would be carved out from the MCOs and delivered as FFS through an ASO, joining specialty mental health services, which were already carved-out from managed care. The ASO contract includes limited risk for performance against set targets.

Some of the most visible signs of the integration include the merger of the former MHA and ADAA into the newly created BHA, as codified in Chapter 460 of 2014, as well as the reconfiguration of funding streams so that beginning with the fiscal 2016 budget funds for Medicaid-eligible specialty mental health and SUD services for Medicaid-eligible individuals are located in the Medicaid program, with funding for the uninsured/underinsured and for Medicaid-ineligible services located in BHA. Further, BHA finalized, and the Board of Public Works (BPW) approved, a contract for the new ASO, which took effect January 1, 2015.

The ASO is responsible for coordination with both local agencies and the MCOs in order to ensure appropriate referrals from the MCOs and coordination between the MCOs and behavioral health providers. The ASO is responsible for providing additional training to providers in terms of developing and enhancing provider competency in the areas of mental health and SUD services and how to seek authorizations and payments though the ASO.

The ASO contract contains various outcome-based standards, which the ASO will be held responsible for upholding. Beginning in year three of the contract, BHA will employ appropriate Healthcare Effectiveness Data and Information Set (HEDIS) measures in order to track the performance of the ASO against other states. There will be seven measures, six of which will be HEDIS-based, and a seventh that is State specific. For each measure, the State must be at or above the fiftieth percentile (or 70.0% for the State-specific measure). For each outcome standard not met, the ASO will repay to the State 0.0714% of the invoice amounts for the preceding 12 months. Thus, if all seven measures are missed, the total amount of damages is capped at 0.5% of the total contract. The measures to be used include:

- adherence to antipsychotic medications for individuals with schizophrenia;
- follow-up care for children prescribed attention deficit and hyperactive disorder medication;
- antidepressant medication management;
- plan all-cause readmission;
- mental health utilization – inpatient;
- initiation and engagement of alcohol and other drug dependence treatment; and
- the percentage of people in the specialty behavioral health system who have a primary care physician visit within a year (State specific).

Reporting on these standards is set for the beginning of fiscal 2017, with the average for each outcome standard determined at the end of 2016 and similar averages established each year thereafter. Further, it should be noted that while there are penalties for not performing to the outcome-based standards, there are no bonuses or inducement payments for exceeding them.

Two pieces of legislation enacted last session also further advanced the process of behavioral health integration in Maryland. The first, Chapter 328 of 2015, merged the Maryland Advisory Council on Mental Hygiene and the State Drug and Alcohol Abuse Council into the Behavioral Health Advisory Council in October 2015. The second, Chapter 469 of 2015, included numerous technical and clarifying changes to statute which were recommended by the BHA Integration Stakeholder Workgroup. These changes included a series of technical, clarifying, and updated changes related to the powers, duties, and responsibilities of BHA, as well as removing obsolete references to programming that is no longer administered by BHA and language that is no longer commonly used in the behavioral health community. Other changes included technical changes to eliminate inconsistencies between mental health and SUD services.

Information Sharing

One of the early issues with the integration process concerned the sharing of specialty behavioral health information between the MCOs and the ASO. The use and disclosure of protected health information (PHI) is governed, generally, by the Health Insurance Portability and Accountability Act (HIPAA). Under HIPAA, PHI may be disclosed for purposes of treatment, payment, and health care operations without patient consent. However, in nearly all cases, the disclosure of SUD treatment and prevention records is subject to the more restrictive and stringent standard of 42 Code of Federal Regulations (CFR) Part 2, which prohibits the disclosure of PHI absent specific authorization from the patient. With the transfer of SUD services from the MCOs to the ASO, HIPAA and 42 CFR Part 2 prevented the sharing of SUD treatment information without specified authorization between the MCOs and the ASO. In response to concerns about how this would impact care coordination activities for Medicaid members, the 2015 JCR required DHMH to describe the efforts conducted by the ASO and the MCOs to improve the exchange of information and coordination of care for Medicaid-eligible individuals who use specialty behavioral health services in the context of federal regulations governing data-sharing. This report was submitted to the budget committees on November 9, 2015.

In the report, DHMH notes that given the federal requirement on health information sharing, and in particular SUD treatment information, the department made the decision to obtain individual Release of Information (ROI) forms from Medicaid beneficiaries accessing SUD services. The ASO and the MCOs have worked collaboratively with SUD providers toward a goal of obtaining a signed consent form from every SUD services recipient willing to provide consent. All SUD programs and providers – as well as mental health providers delivering SUD services to Maryland Medicaid members – have been instructed to request an ROI form prior to the provision of SUD services. Completed forms allow the ASO to release authorization and claims data to the enrollee's MCO – along with providers specified by the patient – and thereby coordinate care across the continuum of care. The consent form is required to be updated by the patient annually. As of mid-September 2015, 78% of patients accessing SUD services had completed an ROI form, and only 1% of patients had elected not to consent and declined to complete the ROI.

Financing for SUD Services to the Uninsured

For the most part, the change to a FFS system under an ASO did not require any change to the specialty mental health services for the uninsured since this model is the same as the previous delivery model. However, it will create a significant change in the way in which SUD services for the uninsured are delivered throughout the State. Currently, these services are provided on a grant-based system through the Local Addictions Authorities (LAAs), who then either provide the services themselves or contract with other providers. With the transition of Medicaid-reimbursable SUD services from the MCOs to the ASO, the SUD services grants for the uninsured are the only treatment funds which are not reimbursed by the ASO on a FFS basis. Alignment of financing is a major goal of behavioral health integration, as this change will effectively create treatment on demand for eligible individuals for those services within the FFS model, which is much different from the previous grant-based and managed care system.

The transfer from the grant-based system to FFS for SUD services has been repeatedly pushed back. Currently, BHA has developed a plan to transfer the financing of some of these services from grants to FFS within fiscal 2017. The first half of fiscal 2017 will provide for a transition period where LAAs and other providers will have the opportunity to either switch to FFS or develop plans to help them prepare for the switch. Then, beginning on January 1, 2017, SUD ambulatory services will be moved to the ASO and a FFS model. These services include ambulatory withdrawal management, assessment, Level I Outpatient, Level II.1 Intensive Outpatient, and opioid treatment services. The estimated dollar amount of the transfer is approximately $25.2 million, which is approximately 30% of the amount of the grants. However, at this time there is currently no plan for the transfer of the other services and funding to the ASO, meaning that financing for these services will remain on a grant-based structure for the near future. **The department should comment on how it plans to ensure a smooth transition of ambulatory SUD treatment services to the ASO, and what plans it has for transferring the remaining grant-based funding to the ASO.**

3. Funding for Institutions for Mental Disease

The Medicaid IMD exclusion prohibits the use of federal Medicaid financing for care provided to most adult patients between the ages of 21 and 65 in mental health and SUD residential treatment and inpatient facilities larger than 16 beds. In the past, Maryland has used numerous waivers to allow for some federal funding to be used to reimburse IMD facilities for serving Medicaid eligible patients. The State has also used State-only funds to purchase bed capacity. However, recently some issues with IMD funding have emerged.

Last year, one of the first issues to arise was with the payment for residential SUD detoxification treatment. Previously, providers throughout the State had reported being paid for this service under the MCOs. However, once the ASO took over the payment system in January 2015, Medicaid began denying payments to these providers saying that under federal guidelines these facilities count as IMDs and are thus not eligible for Medicaid reimbursement. This caused numerous providers to lose their ability to claim reimbursement for these services. Last year, BHA and DHMH in a letter to the budget and policy committees noted that they would take numerous steps to help these providers, including

implementing another level of payment for partial hospitalization, which is a federally reimbursable service, as well as providing technical assistance to these providers and encouraging them to decrease their size to fit under the IMD exclusion. Since that time, the State has also been actively working to secure a waiver for residential SUD treatment within an IMD. DHMH and Medicaid have also been meeting biweekly with the federal Centers for Medicare and Medicaid Services (CMS) and their outside technical assistance consultants about the breadth and depth of services provided by Medicaid, and they note that the discussions have been productive and encouraging. Further discussions on the IMD waiver for SUD residential treatment services will also be a part of the renewal of the larger Medicaid HealthChoice waiver.

Beyond SUD services, the IMD exclusion also affects the ability of psychiatric inpatient and residential programs from claiming federal reimbursement for their services. The State recently sought a waiver from CMS for reimbursement for services rendered within an IMD for both mental health and SUD services, but was informed that CMS would only consider such a waiver for SUD services at this time. The State also participated in a program which provided federal reimbursement for inpatient mental health services, which was known as the ACA Emergency Psychiatric Demonstration (EPD). However, this program, as originally designed, expired at the end of fiscal 2015, resulting in funding shortfalls for private hospitals specializing in behavioral health treatment within the fiscal 2016 budget. In order to address this shortfall in fiscal 2016, DHMH authorized a transfer of $10 million from the MHIP fund balance to BHA to cover costs for this purpose. However, as mentioned earlier, BHA is still actively managing the number of patients who are admitted to a private psychiatric facility in order to keep spending contained.

CMS also recently promulgated new regulations where the federal government would provide reimbursement for services rendered within an IMD for the first 15 days of service for a particular individual for both SUD and mental health services. However, the regulations stipulated that this would only be for services financed through an MCO. While Maryland does have an MCO structure, the FFS behavioral health carve-out prevents Maryland from taking advantage of this new regulation.

Separately, the State is actively seeking to be involved with – and participate once again in – the EPD program now that it has been extended by Congress. One difficulty, however, is that CMS is currently working on how they will determine the cost neutrality of the EPD program, which is a new requirement within the extension of the EPD program. Without guidance from CMS on how cost neutrality is going to be determined, it is still unclear how the State would participate in the program and begin once again to draw down on EPD federal funds.

If the State is not able to participate in the EPD program within fiscal 2017 and no further IMD waiver is granted by CMS, it is unclear how the State will be able to continue to support inpatient and residential treatment for the Medicaid-eligible population without rationing these services. **The department should comment on the current status of these waiver applications and how it plans to fund inpatient psychiatric services without federal funds in fiscal 2017.**

Recommended Actions

1. Add the following language:

   All appropriations provided for program M00Q01.10 Medicaid Behavioral Health Provider Reimbursements are to be used for the purposes herein appropriated, and there shall be no budgetary transfer to any other program or purpose.

   Explanation: The language restricts Medicaid behavioral health provider reimbursements to that purpose.

2. Add the following section:

   SECTION XX: AND BE IT FURTHER ENACTED, That $1,000,000 of the general fund appropriation in Program M00L01.02 Community Services made for the purpose of establishing a Center of Excellence for Prevention and Treatment, $50,000 of the general fund appropriation in Program N00B00.04 General Administration – State made for the purpose of implementing a heroin screening tool, and $50,000 of the general fund appropriation in Program V00D02.01 Departmental Support made for the purpose of establishing a heroin screening tool may not be expended for those purposes and instead may only be transferred to, and expended in, Program M00L01.02 Community Services for the purpose of funding residential treatment services for defendants committed to the Department of Health and Mental Hygiene under Section 8-507 of the Health – General Article.

   Explanation: This section fences off appropriations made to implement recommendations from the Governor's Heroin and Opioid Emergency Task Force for the purpose of establishing the Center of Excellence for Prevention and Treatment as well as implementing heroin screening tools within the Department of Human Resources (DHR) and the Department of Juvenile Services (DJS), and restricts those funds to be expended only on residential treatment services for defendants committed to the Department of Health and Mental Hygiene under Section 8-507 of the Health – General Article. Both DHR and DJS already have screening tools for heroin, and the Center of Excellence is not necessary. Funding for commitments under Section 8-507 is currently not enough to meet the demands from the State courts for those placements.

Updates

1. Synar Compliance Improves Dramatically

As part of the agreement for accepting the federal Substance Abuse Prevention and Treatment (SAPT) block grant, the State has agreed to have federal regulators audit the State on the extent to which tobacco retailers are selling tobacco to minors in the State. This program is known as the Synar program. The limit on the retailer violation rate (RVR) is 20.0%. If a state exceeds this percentage, it must either pay an alternate penalty amount based on the RVR above the 20.0% limit or surrender SAPT funding. In the past two federal fiscal years, the State had an RVR of 24.1% and 31.4%, which resulted in alternative penalty payments in State fiscal 2015 and 2016, essentially requiring higher State expenditures on retail tobacco enforcement.

In response to these penalties, the fiscal 2016 budget bill included language which withheld $100,000 in general funds within BHA pending a report from DHMH containing information on the funding and outcome measures for Synar compliance programs. In particular, the report needed to include information on how funds related to the penalty were expended, the structure and nature of tobacco retailer compliance programs that utilize the penalty funds, how programs ensured future compliance with the federal Synar inspections of tobacco retailers, and whether additional regulatory or statutory changes are needed to ensure compliance. The report was submitted on December 16, 2015.

In the report, DHMH and BHA detailed how BHA jointly implemented compliance activities with PHPA, and developed a program through which local health departments (LHD) received grant funding based on the RVR, number of tobacco sales outlets, and population size of each jurisdiction. Through these grants, LHDs further partnered with local nongovernmental organizations to conduct education campaigns, increase awareness, and promote store-level staff training and compliance with the State youth access law. Minority Outreach and Technical Assistance organizations from the Office of Minority Health and Health Disparities were also funded to support LHD activities. Further partnerships were developed with the Legal Resource Center for Public Health Policy and the University of Maryland Carey School of Law, as well as with the Maryland Office of the Comptroller to further coordinate and facilitate better enforcement and educational outreach efforts. One full-time equivalent contractual position was also hired within PHPA to oversee Synar-related activities.

Compliance activities are expected to continue into the future to ensure that the State remains in compliance with the federal Synar statute. Funding has been placed within the PHPA budget utilizing funds from the Cigarette Restitution Fund to continue the program in fiscal 2017. DHMH also recently completed the required federal fiscal 2016 audit and the non-compliance rate was 13.8%, which is down from the previous year mark of 31.4%, demonstrating that the efforts of DHMH are having a positive effect.

2. Reports on Behavioral Health Expenditures by Medicaid Eligibility Improve, but More Needs to Be Done

With the numerous changes that have occurred within the Medicaid program, with different federal matching rates for different eligibility populations, it has become more difficult and complex to project spending, and especially the general/federal funding splits, for the behavioral health carve-out services, particularly with the reports that BHA previously provided for this purpose. Due to these concerns, the fiscal 2016 budget bill included language which withheld $100,000 in general funds within BHA pending a report from DHMH containing information on the utilization and expenditures for behavioral health services based upon the user's eligibility group under Medicaid. The language further stipulated that, beginning with the period ending June 30, 2015, the quarterly report that is produced by the ASO which oversees the public behavioral health system include a breakdown of data based on the user's eligibility group under Medicaid.

On September 1, 2015, DHMH submitted the report, which contained a new quarterly report that provided a breakdown of claims data based on some broad eligibility categories, including a breakout of adults who qualify for Medicaid under the federal ACA expansion. However, due to data limitations and timing, no data on SUD claims was included in the report. Since the initial report, DLS has received two other reports which seek to provide more detailed information on the behavioral health services. Medicaid has provided a report that contains both mental health and SUD treatment data on a monthly basis by eligibility category. Further, a quarterly report containing SUD services data was recently submitted separately to DLS. Both of these reports will continue to help DLS analysts prepare more robust and confident expenditure projections. However, more work needs to be done to produce a more comprehensive report and data set that serves the interests of all parties involved. **Thus, DLS and DHMH will continue to work together throughout the 2016 interim to come up with a more comprehensive and complete dataset and reporting structure.**

Appendix 1

Current and Prior Year Budgets

Current and Prior Year Budgets
DHMH – Behavioral Health Administration
($ in Thousands)

	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2015					
Legislative Appropriation	$812,166	$46,020	$513,232	$8,467	$1,379,885
Deficiency Appropriation	0	0	0	0	0
Cost Containment	-21,963	0	0	0	-21,963
Budget Amendments	49,974	4,823	142,705	600	198,102
Reversions and Cancellations	-656	-808	-6,669	-782	-8,915
Actual Expenditures	**$839,520**	**$50,035**	**$649,268**	**$8,284**	**$1,547,108**
Fiscal 2016					
Legislative Appropriation	$847,497	$48,452	$738,513	$7,944	$1,642,406
Budget Amendments	20,746	12,009	51	2,800	35,607
Working Appropriation	**$868,243**	**$60,462**	**$738,564**	**$10,744**	**$1,678,013**

Note: Numbers may not sum to total due to rounding.

Fiscal 2015

BHA's fiscal 2015 budget ended $167,223,158 above the legislative appropriation. General funds increased by $27,354,111, mostly through budget amendments. Large general fund budget amendments included the following:

- $33,098,243 in provider reimbursements tied to the migration of SUD services from the MCOs to the behavioral health carve-out;
- $7,742,155 for increased costs at State hospital centers, including costs for off grounds outpatient services, increased overtime, and other expenses;
- $5,220,516 for increased Medicaid State-funded services;
- $3,296,006 related to the fiscal 2015 cost-of-living adjustment (COLA) and annual salary review;
- $1,378,382 for centrally budgeted employee health insurance adjustments; and
- $729,351 for increases in the ASO contract.

These increases were offset by some decreases in general funds, including $21,963,184 for 2015 cost containment. Cost containment actions included:

- $11,381,536 in 2014 accrual that was no longer necessary either due to greater federal fund attainment or underspent general funds, which were credited towards the 2015 2% general reduction amount;
- $7,009,531 due to the January 2015 BPW action which lowered provider reimbursement rates increases from 4% to 2%, lowered the psychiatrist evaluation and management rates from 100% to 87% of Medicare, and swapped general funds for special funds from the Maryland Community Health Resources Commission;
- $2,880,017 removed by BPW in July 2014 to remove funding for inpatient hospital services no longer needed and to swap general funds with federal funds under the EPD waiver;
- $685,822 for a hiring freeze conducted across DHMH to obtain the amount necessary under the 2% general reduction; and
- $6,278 in lower operations costs for the office of the Deputy Secretary for Behavioral Health.

Budget amendments also removed general funds totaling $1,491,001 for contractual expenses, legal service costs and other adjustments in the central office and grant-based programs. A further

$656,357 in general funds were reverted in fiscal 2015, mostly due to increased federal fund revenue obtained through Medicaid-related administrative work.

Special funds increased by $4,014,923 above the legislative appropriation. This is mostly due to increases through budget amendments, including $3,000,000 to backfill cost containment actions, $1,529,071 in additional funding for the Supplemental Security Income/Social Security Disability Insurance, Outreach, Access, and Recovery housing initiative, and $294,115 for both the COLA and other miscellaneous expenses. These increases were partially offset by $808,263 in cancellations at the end of the year mainly due to lower than expected special fund revenue within the institutions.

Federal funds increased by $136,036,469 above the legislative appropriation. The largest increase was $114,308,443 in relation to the transfer of SUD services to the behavioral health carve-out. Other increases included $11,365,605 in additional SAPT block grant funding, $10,030,000 in additional funding under the EPD waiver, $6,974,283 in increased Medicaid provider reimbursements and federal matching activities, and $26,695 for the COLA. Of this amount, $6,668,557 was canceled at the end of the fiscal year mainly due to the end of the Alternatives to Psychiatric Residential Treatment Facilities for Children federal grant.

Reimbursable funds decreased by $182,345 from the legislative appropriation. Cancellations totaled $782,014 which were all tied to lower than expected expenditures on special populations. One reimbursable budget amendment added $599,669 to cover the cost of emergency preparedness enhancements for DHMH institutions.

Fiscal 2016

To date, the budget for BHA has increased by $35,606,944 above the legislative appropriation for fiscal 2016. General funds have increased by $20,746,188, of which the largest increase is for funds authorized through Section 48 of the fiscal 2016 budget bill. This includes $7,600,000 to maintain provider rates for community-based mental health providers as well as $2,000,000 for heroin treatment. Other general fund increases include $7,603,810 to realign funds with the cost containment strategy which was previously discussed, and $3,592,630 to restore the 2% salary reduction. There is one general fund decrease of $50,252 due to the transfer of funds for an assigned subobject.

Special funds increase by $12,009,488 above the legislative appropriation. This is due to an increase of $10,000,000 from the MHIP fund to pay for inpatient services which were previously covered under the EPD waiver, as well as $2,000,000 for the Synar penalty, which is consistent with the 2015 JCR. The remainder of the increase at $9,488 is for the 2% salary restoration. Federal funds also increase by $51,268 for the same reason. Reimbursable funds increase by $2,800,000 to cover costs related to the CME.

Appendix 2

Audit Findings

Thomas B. Finan Hospital Center

Audit Period for Last Audit:	July 1, 2011 – September 21, 2014
Issue Date:	February 5, 2015
Number of Findings:	0
Number of Repeat Findings:	0
% of Repeat Findings:	0%
Rating: (if applicable)	n/a

The audit did not disclose any findings.

Clifton T. Perkins Hospital Center

Audit Period for Last Audit:	February 17, 2012 – April 28, 2015
Issue Date:	September 18, 2015
Number of Findings:	1
Number of Repeat Findings:	1
% of Repeat Findings:	100%
Rating: (if applicable)	n/a

Finding 1: **Internal controls were not sufficient to ensure that all collections were deposited.**

*Bold denotes item repeated in full or part from preceding audit report.

Springfield Hospital Center

Audit Period for Last Audit:	July 29, 2011 – January 27, 2015
Issue Date:	October 6, 2015
Number of Findings:	1
Number of Repeat Findings:	0
% of Repeat Findings:	0%
Rating: (if applicable)	n/a

Finding 1: A management employee exercised virtually complete control over all aspects of the procurement and related invoice approvals for maintenance contracts, resulting in questionable activity with one contractor.

Spring Grove Hospital Center

Audit Period for Last Audit:	January 18, 2012 – February 16, 2015
Issue Date:	October 15, 2015
Number of Findings:	2
Number of Repeat Findings:	1
% of Repeat Findings:	50%
Rating: (if applicable)	n/a

Finding 1: **Controls were not established to ensure collections were properly accounted for and deposited.**

Finding 2: Spring Grove recordkeeping procedures for equipment were not in compliance with certain requirements.

*Bold denotes item repeated in full or part from preceding audit report.

Object/Fund Difference Report
DHMH – Behavioral Health Administration

Object/Fund	FY 15 Actual	FY 16 Working Appropriation	FY 17 Allowance	FY 16 - FY 17 Amount Change	Percent Change
Positions					
01 Regular	2,900.85	2,900.55	2,800.85	-99.70	-3.4%
02 Contractual	215.66	221.60	210.03	-11.57	-5.2%
Total Positions	**3,116.51**	**3,122.15**	**3,010.88**	**-111.27**	**-3.6%**
Objects					
01 Salaries and Wages	$ 241,095,287	$ 242,819,891	$ 247,208,258	$ 4,388,367	1.8%
02 Technical and Spec. Fees	12,582,054	10,600,242	14,797,978	4,197,736	39.6%
03 Communication	533,070	463,869	453,759	-10,110	-2.2%
04 Travel	214,653	311,956	247,860	-64,096	-20.5%
06 Fuel and Utilities	10,327,257	10,702,122	9,292,114	-1,410,008	-13.2%
07 Motor Vehicles	733,464	793,962	722,727	-71,235	-9.0%
08 Contractual Services	1,267,226,605	1,398,423,628	1,395,921,448	-2,502,180	-0.2%
09 Supplies and Materials	13,063,358	12,551,416	11,343,762	-1,207,654	-9.6%
10 Equipment – Replacement	372,167	277,599	184,396	-93,203	-33.6%
11 Equipment – Additional	129,792	5,543	9,630	4,087	73.7%
12 Grants, Subsidies, and Contributions	264,524	438,620	348,481	-90,139	-20.6%
13 Fixed Charges	565,713	623,888	522,814	-101,074	-16.2%
Total Objects	**$ 1,547,107,944**	**$ 1,678,012,736**	**$ 1,681,053,227**	**$ 3,040,491**	**0.2%**
Funds					
01 General Fund	$ 839,520,284	$ 868,243,374	$ 886,256,297	$ 18,012,923	2.1%
03 Special Fund	50,034,908	60,461,818	53,806,432	-6,655,386	-11.0%
05 Federal Fund	649,268,397	738,563,772	733,194,629	-5,369,143	-0.7%
09 Reimbursable Fund	8,284,355	10,743,772	7,795,869	-2,947,903	-27.4%
Total Funds	**$ 1,547,107,944**	**$ 1,678,012,736**	**$ 1,681,053,227**	**$ 3,040,491**	**0.2%**

DHMH: Department of Health and Mental Hygiene

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. The fiscal 2017 allowance does not include contingent reductions.

Fiscal Summary
DHMH – Behavioral Health Administration

Program/Unit	FY 15 Actual	FY 16 Wrk Approp	FY 17 Allowance	Change	FY 16 - FY 17 % Change
01 Deputy Secretary for Behavioral Health	$ 2,102,472	$ 1,929,618	$ 2,093,256	$ 163,638	8.5%
01 Behavioral Health Administration	327,924,246	338,600,797	342,440,306	3,839,509	1.1%
04 Thomas B. Finan Hospital Center	19,636,238	20,291,057	21,024,601	733,544	3.6%
05 Regional Institute For Children and Adolescents – Baltimore City	13,605,962	14,149,882	13,627,337	-522,545	-3.7%
07 Eastern Shore Hospital Center	19,524,451	19,532,938	20,142,104	609,166	3.1%
08 Springfield Hospital Center	74,806,549	75,247,099	74,760,356	-486,743	-0.6%
09 Spring Grove Hospital Center	84,667,087	81,793,842	86,142,716	4,348,874	5.3%
10 Clifton T. Perkins Hospital Center	63,284,983	62,900,708	65,423,977	2,523,269	4.0%
11 John L. Gildner Regional Institute for Children and Adolescents	11,721,627	12,104,730	11,661,246	-443,484	-3.7%
15 Services and Institutional Operations	2,260,384	1,931,769	1,286,737	-645,032	-33.4%
01 Medical Care Programs Administration	927,573,945	1,049,530,296	1,042,450,591	-7,079,705	-0.7%
Total Expenditures	**$ 1,547,107,944**	**$ 1,678,012,736**	**$ 1,681,053,227**	**$ 3,040,491**	**0.2%**
General Fund	$ 839,520,284	$ 868,243,374	$ 886,256,297	$ 18,012,923	2.1%
Special Fund	50,034,908	60,461,818	53,806,432	-6,655,386	-11.0%
Federal Fund	649,268,397	738,563,772	733,194,629	-5,369,143	-0.7%
Total Appropriations	**$ 1,538,823,589**	**$ 1,667,268,964**	**$ 1,673,257,358**	**$ 5,988,394**	**0.4%**
Reimbursable Fund	$ 8,284,355	$ 10,743,772	$ 7,795,869	-$ 2,947,903	-27.4%
Total Funds	**$ 1,547,107,944**	**$ 1,678,012,736**	**$ 1,681,053,227**	**$ 3,040,491**	**0.2%**

DHMH: Department of Health and Mental Hygiene

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. The fiscal 2017 allowance does not include contingent reductions.