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February 2, 2018

VIA ELECTRONIC MAIL
AND HAND DELIVERY

Ruby Potter, Administrator
Maryland Health Care Commission
Center for Health Care Facilities
Planning & Development
4160 Patterson Avenue
Baltimore, MD 21215

Re: Anne Arundel Medical Center Mental Health Hospital
Docket No. 16-02-2375

Dear Ms. Potter:

Enclosed are an original and six copies of the Applicant's Response to Health Services Cost Review Commission Memorandum dated January 24, 2018 for filing in the above-referenced case.

Please let me know if you have any questions.

Sincerely,

Marta D. Harting

Marta D. Harting

MDH:rlh
Enclosures

Re: Anne Arundel Medical Center Mental Health Hospital Certificate of Need Application

(Docket No. 16-02-2375)

Applicant's Response to Health Services Cost Review Commission Memorandum Dated January 24, 2018

February 2, 2018

On September 22, 2017, the Maryland Health Care Commission (MHCC) requested the Health Services Cost Review Commission (HSCRC) to review the revenue and expense projections in the Certificate of Need Application (CON Application) and provide its opinion as to whether the project (AAMHH) is financially feasible. On November 9, 2017, the HSCRC requested the Reviewer to ask the Applicant to respond to several questions regarding financial feasibility, and the Applicant provided its responses to those questions on December 11, 2017, and UM BWMC replied on December 26, 2018. The MHCC provided the Applicant's responses and the reply by University of Maryland Baltimore Washington Medical Center (UM BWMC) to the HSCRC on December 28, 2017, and requested the HSCRC to provide its analysis by January 10, 2018. In a Memorandum dated January 24, 2018, the HSCRC provided its analysis to the MHCC. The HSCRC raised certain questions and concerns regarding the Applicant's revenue and expense projections that the HSCRC said it would need to closely analyze in setting rates for the AAMHH. By letter dated January 27, 2018, the Reviewer requested the Applicant to comment on the HSCRC's analysis. The Applicants comments are set forth below.

1. Revenue Projections

a. Partial Hospitalization Revenue

The HSCRC comments on the Applicant's revenue projections are largely focused on the partial hospitalization program. The Applicant projects *4,229* partial hospitalization visits in 2019, which is the number stated in the Applicant's December 11, 2017 responses to the HSCRC's questions. Table I (Statistical Projections) in the CON Application incorrectly stated 4,699 partial hospitalization visits in 2019. However, that error was not carried forward into the financial projections contained in Tables J and K; the financial projections in Tables J and K are based on the correct number of projected visits in 2019 (4,229), the number provided in the Applicant's December 11, 2017 responses to the HSCRC's questions.

The Applicant projects a 34% increase in partial hospitalization visits from 2019 to 2020, which is greater than the projected increase in inpatient cases. The Applicant assumed a greater increase in partial hospitalization visits due to the relocation of the current partial hospitalization program to the AAMHH building in 2020. As the space in the new building will be larger than the leased space currently housing the program, the Applicant expects to be able to serve more patients starting in the year of the relocation. The Applicant had difficulty finding adequate space for the current PHP program and had limited choices. Relocating the program to the AAMHH building will provide for a more integrated program, more capacity and a better environment for patients.

The partial hospitalization program is the only outpatient program that will be provided in the AAMHH building (until the shell space is completed for the additional outpatient programs described in the Applicant's August 1, 2016 Project Cost and Shell Space Updates). Accordingly, the Applicant estimated the rate per visit based on the Statewide median for the 25 similar partial hospitalization programs across all acute care hospitals in Maryland. As noted in the Applicant's December 11, 2017 response to the HSCRC questions, the facility charge per visit was assumed to be $422.12 in FY 2016 dollars based on the FY 2016 Statewide median. For FY2017, the actual Statewide median charge for partial hospitalization was $502.03. The rate assumed in the CON Application is *lower* than the statewide median, as shown in Table 1 below:

Table 1
Average Revenue per Partial Hospitalization Visit Services
For the Year Ended June 30, 2017

Hospital	Partial Hospitalization Revenue	Visits	Average Charge per Visit
Brook Lane	$742,385	3,729	$199
UM-Laurel	1,175,803	5,810	202
Sheppard Pratt	15,052,314	64,900	232
Calvert	506,642	2,173	233
MedStar St. Mary's	243,350	1,028	237
UM-Harford	260,725	1,089	239
UM-BWMC	366,256	1,349	272
UM-Dorchester	422,795	1,252	338
Frederick	927,622	2,221	418
MedStar Southern MD	793,531	1,729	459
Peninsula	708,212	1,512	468
JH Bayview	3,539,409	7,097	499
MedStar Union Mem	1,701,304	3,389	502
Adventist BH - ES	181,185	355	510
MedStar Harbor	272,940	525	520
Carroll	1,911,600	3,468	551
Sinai	436,593	789	554
UM-St. Joe	1,158,447	2,084	556
MedStar Montgomery	2,265,834	4,025	563
Washington Adventist	838,240	1,455	576
UM-PGHC	935,197	1,470	636
Levindale Geriatric	2,254,401	2,189	1,030
Bon Secours	1,924,264	1,686	1,141
UMMC	2,396,190	2,079	1,153
Johns Hopkins	4,891,435	3,703	1,321
Total	$45,906,672	121,105	$379
Statewide Median		68,629	$502

Source: HSCRC FY 2017 experience data for rate center PDC (Partial Hospitalization)

In Table 3 of its January 27, 2018 Memorandum, the HSCRC compared the projected partial hospitalization visit rate to the average charge per outpatient visits for Sheppard Pratt, Adventist Behavioral Health and Brooklane. The Applicant does not believe that this is an appropriate comparison for the following reasons:

1. Sheppard Pratt's 64,900 visits represent *all* outpatient visits and not just partial hospitalization services and therefore, is not comparable to MHH's partial hospitalization program.
2. As noted in the footnote to Table 3, Adventist Behavioral Health's average charge per outpatient visit is for *clinic services* and not just a partial hospitalization program and therefore is not a valid comparison.
3. Partial Hospitalization services are provided at acute care hospitals as well as psychiatric specialty hospitals and the services and cost structure would be consistent with AAMHH's program. Therefore, the charges for hospital based partial hospitalization only should be used as a basis for rate setting rather than using all outpatient services at Specialty Psychiatric Hospitals.

Partial hospitalization serves as a 'step-up' program for patients in outpatient programs who need more intensive treatment and as a 'step-down' program for patients on inpatient units who are transitioning back to outpatient care. Patients arrive in the morning and spend the day involved in individual and group therapeutic activities, attend school on site, and then return home each afternoon. The service is designed for both adolescents and adults between the ages of 13-17 and 18-60, and focuses on combining individual therapy, family therapy, behavioral interventions, occupational therapy, medication management, school advocacy, and systems coordination to facilitate keeping the child at home, in school, and in regular outpatient treatment. Intensive aftercare planning is a core component of the program and family participation is a critical element. Staff work with patients and families to optimize a transition back home.

PHP services are longer and more intensive than outpatient clinic visits. For example, PHP visits are 6.5 hours versus one hour for a clinic visit. Accordingly, the inclusion of Sheppard Pratt's data, which includes a combination of partial hospitalization visits *and* mental health clinic visits, and Adventist Behavioral Health clinic visits, to determine a reasonable charge for a distinctly different program is not an appropriate comparison. Given that the same service is offered at acute care hospitals in the State, the Applicant believes that the Statewide median is a better basis for setting a reasonable rate given the significant disparity in volumes and services at the Psychiatric Specialty hospitals.

b. IMD Issues

The HSCRC states that it is concerned that AAMHH could be considered by CMS to be part of the existing Pathways alcohol and drug treatment center located on the same campus as the mental health hospital, and thus deemed an "Institution for Mental Disease" (or "IMD") under Federal law for purposes of the prohibition on Federal financial participation in adult Medicaid psychiatric admissions. The Applicant respectfully submits that this concern is not well founded based on the CMS guidelines. Pathways and the proposed mental health hospital will be different types of health care providers. Pathways is licensed as an *intermediate care facility* under Maryland law, and the 40 beds at Pathways are *subacute beds* for the treatment of substance use disorders. The AAMHH will be separately licensed as a *special psychiatric hospital* under Maryland law and its 16 beds will be *acute care beds* for the treatment of psychiatric conditions. These two facilities provide care that is distinct both in type (substance use disorder treatment vs. inpatient psychiatric care) and level (subacute vs. acute) and operate

under entirely different licensing schemes under State law. Patients appropriate for admission to Pathways would not be appropriate for admission to AAMHH, and vice versa. While some efficiencies will be gained by sharing support functions like food service and housekeeping, from a clinical and patient care perspective, these two facilities will operate independently under their different licenses and subject to different state regulatory schemes. The CMS guidelines attached to the HSCRC memorandum make clear that "different types of providers, such as NFs [nursing facilities] and hospitals, *are considered independent from each other.* " Just as nursing facilities and hospitals are different types of providers, Pathways and the AAMHH will be different types of providers operating independently under different licenses.

The HSCRC suggests again that CMS might consider AAMHH to be an IMD because it will have shell space in which additional beds might be added in the future. As explained in the Applicant's December 11, 2017 response to the HSCRC's questions, there is no basis to deem AAMHH an IMD because of the shell space. Indeed, the CMS guidelines attached to the HSCRC's January 24, 2018 Memorandum only reinforce this conclusion. If CMS considered the *potential* for a facility with 16 beds or less to have more than 16 beds in the future as grounds upon which to deem it an IMD, its guidelines should reasonably be expected to provide for that consideration. There is nothing in the guidelines providing for this as a consideration in determining whether a facility is an IMD. Further, the guidelines explicitly state that "the IMD exclusion applies *only* to institutions with at least 17 beds." (§4390.A(3), emphasis supplied). The Applicant has identified specific *outpatient* mental health programs for which it plans to use *all* of the shell space in the building within the next 3-5 years, and has made clear in this review that it would consider using a portion of the shell space slated for an outpatient mental health program for additional beds only if the State is granted a waiver or other relief from the IMD exclusion in the future.

Although the Applicant intends the AAMHH to be an additional *non-IMD* resource for adult Medicaid inpatient psychiatric care in the state, being an IMD does not prevent the approval of this project or undercut the reimbursement rate assumed in AAMHH's financial projections. The Commission approved the conversion of a hospital-based psychiatric unit into an IMD in the Matter of Washington Adventist Hospital (Matter No. 13-15-2349) after the State became subject to the IMD exclusion and the Medicaid program began requiring the exhaustion of available non-IMD beds before approving an adult admission to an IMD. The HSCRC states that being an IMD would "potentially result[] in a large reduction in Medicaid reimbursement to less than the projected 83% of charges." However, there has been no "large" (or, indeed, any) reduction in the Medicaid reimbursement rate to the state's freestanding special psychiatric hospitals since the loss of Federal financial participation in adult Medicaid admissions to IMDs. As the Applicant explained in its December 11, 2017 response to the HSCRC questions, COMAR 10.09.95.07A requires the State's freestanding psychiatric hospitals to be reimbursed by Medicaid at 94% of the commercial rate. While that requirement is subject to an upper payment limit, that limit has not been reached to date and there is no basis here to project that it will be reached, let alone result in a "large reduction" in Medicaid reimbursement.[1]

Additionally, the HSCRC states that if the AAMHH was deemed an IMD, Medicare reimbursement "would likely be reduced as well." As explained in the Applicant's December

[1] If the upper payment limit is exceeded, under COMAR 10.09.95.07A(4), the per diem payment to each specialty psychiatric hospital would be decreased by the same proportion that the projected upper payment limit is exceeded.

11, 2017 response to the HSCRC questions, the IMD exclusion is a rule governing federal financial participation in the *Medical Assistance Program.* See 42 U.S.C. §1396d(a)(29)(B). The HSCRC does not explain its suggestion that being deemed an IMD could reduce Medicare reimbursement, and the Applicant is not aware of any basis upon which Medicare reimbursement could be impacted by such a designation.

2. Expense Projections

In its January 24, 2018 Memorandum, the HSCRC states the expenses used in the benchmarking analysis should be inflated from 2016 dollars to 2019 dollars to be consistent with the Applicant's uninflated CON projections. As noted in Attachment A of the Applicant's December 11, 2017 response to the HSCRC's questions, the basis for the expenses comparison was FY2017 for Sheppard Pratt and Brooklane and CY2016 for Adventist Behavioral Health. As a result there is only a two year timing difference, and not the three year timing difference suggested by the HSCRC in its Memorandum.

Assuming a 2% inflation factor, this would result in a 4% increase for Brooklane to adjust expenses to FY2019 dollars. The impact of this change is that the AAMHH's uninflated costs are $1.1 million less than Brooklane's in FY2022, not the $1.7 million indicated by the HSCRC. Brooklane's FY2017 cost per EIPD excluding physicians and capital costs was $885. Applying 2% annual inflation, Brooklane's cost per EIPD to convert to FY2019 dollars would result in $921 cost per EIPD ($885 x 1.02 x 1.02). This represents a $206 variance to AAMHH's cost per EIPD in FY2019 dollars ($921 - $715). In FY2022, the Applicant projects patient days of 5,477, so the variance in costs equates to $1.1 million ($206 x 5,477).

AAMHH's cost per EIPD are projected to be lower than Brooklane's costs and the other Psychiatric Specialty hospitals based on several factors that must be considered when comparing costs per EIPD across facilities. The majority of the variance between AAMHH and the other Psychiatric Specialty Hospitals is in the following areas:

- Overhead: AAMHH will leverage its existing infrastructure at Anne Arundel Health System (AAHS) including Pathways for administrative and dietary support functions. In addition, this will be a new facility and therefore, maintenance costs and plant operation costs will be less than at an existing facility.
- Clinic and Ancillary: As shown in the Table 4 of the January 27, 2018, the cost for clinic and ancillary services vary widely amount the existing Psychiatric Specialty Hospitals mainly due to the variance in services provided at the existing Psychiatric Specialty Hospitals. The cost per EIPD for clinic and ancillary services is as low as $60 at Washington Adventist to as high as $129 at Brooklane. The Applicant projected a $90 cost per EIPD. Both Sheppard Pratt and Brooklane provide inpatient adolescent psychiatric services and offer ancillary services such as electroconvulsive therapy. AAMHH will only treat an adult population in its inpatient services, and will not be providing electroconvulsive therapy. It is reasonable that AAMHH's costs would be lower than Sheppard Pratt and Brooklane in this category due to the variance in patient population and service offerings.

- Malpractice and Other: AAMHH, as a subsidiary of AAHS, will leverage its existing insurance captive platform to provide cost effective coverage for malpractice and other insurance.

The Applicant developed expense projections utilizing a zero-based budgeting approach by thoroughly evaluating clinical staffing ratios, general support staffing needs, and necessary drug and supply expenditure levels based on industry guidelines. AAHS has demonstrated to be a historically low cost provider and economies of scale for AAMHH are expected as a result of being part of that system. Further, AAMHH's location on the same campus as Pathways will enable efficiencies in certain non-clinical support services. The expense base for AAMHH was developed utilizing the following assumptions:

- IP Unit and PHP Staffing was developed using a zero based budget approach by identifying the FTEs necessary to effectively staff the unit and includes administrative oversight, an industry standard mix of RN and psych tech positions, therapists, social workers and discharge coordination and utilization review personnel. Staffing was priced using current market hourly rates trended for inflation for each year through the final projection year of FY23.
- Support Staffing was developed in the same zero based budget fashion to ensure adequate support for pharmacy, food and nutrition, safety and security as well as back office functions including reimbursement and financial services support. Staffing was priced using current market hourly rates and trended for inflation for each year through the final projection year of FY23.
- Drugs and Supply costs were projected using industry standard cost per case values for psychiatric services and trended for inflation for each year through the final projection year of FY23.
- Other costs including staff recruitment, training and orientation expenses, program accreditation as well as all Information Technology (IT) costs necessary to initiate and maintain the organization were projected using a variety of methods including zero based budgeting, historical trends and the applicant's own experience with other business units/functional departments.
- Capital costs including depreciation and financing costs are based on the proposed project cost and amortized over the useful life of the assets acquired.

Because AAHS has demonstrated to be a consistently low cost healthcare provider, operational efficiencies are assumed through the existing infrastructure in place at AAHS and by way of the proximity to the existing Pathways facility allowing for efficiencies in certain support services.

Lastly, the HSCRC used 2015 Medicare Cost Report data to compare the cost per EIPD between the Applicant's projections and 39 private psychiatric hospitals throughout the country with 16 beds, and concluded that the projected expenses for AAMHH are lower. The Applicant cannot comment on the expenses of unspecified hospitals in unspecified other states, or whether there is any basis upon which to compare them to AAMHH's expenses. Costs vary widely between states and regions. In addition, many other factors must be considered in making a comparison, including (among other things) whether the hospital is part of a larger health system in which it can take advantage of efficiencies and economies of scale and the hospital's successful track record in managing expenses.

The HSCRC recognized in its Memorandum that "Anne Arundel Medical System has shown a propensity to manage their operations appropriately in the past, and staff expects that it would continue to do so in the future." With this track record, the detailed zero based budgeting process that the Applicant utilized in this matter, and availability of expense data from other Maryland-based psychiatric hospitals for comparison, it is not necessary or appropriate to turn to mental health hospitals in other states for comparison.

3. Hospital-Based Unit Comparison

In the Summary paragraph of its January 24, 2018 Memorandum, the HSCRC staff states that it is concerned that the construction of a 16-bed psychiatric hospital "may not have sufficient economies of scale to provide services effectively or efficiently." The HSCRC staff then poses the question whether, "given the new Model, global budgets and emphasis on reducing avoidable utilization and excess capacity", it would be more prudent to establish a hospital-based psychiatric unit where the marginal costs could be lower, while also noting that both Medicare and Medicaid reimbursement would be higher for a hospital-based unit.

The HSCRC staff mischaracterizes this project in suggesting that it is simply the construction of a 16-bed mental health hospital. The new building will house a comprehensive and integrated mental health care program in one location that will incorporate inpatient psychiatric care, psychiatric partial hospitalization and other outpatient mental health programs, as well as referral and care coordination to community based support services. See CON Application at 14-16. Contrary to the suggestion that the project is somehow inconsistent with the new Model and the emphasis on reducing avoidable utilization, the integrated care model that this project will create will address a critical gap in mental health care services in Anne Arundel County – a gap that drives hospital admissions, readmissions and emergency department utilization – by providing a well-coordinated, accessible, affordable and accountable system for the delivery of mental health care services that is projected to generate more than $3 million in savings annually to the State's health care system. See CON Application at 12—13; 55. The AAMHH is projected to operate as one of the lowest cost inpatient psychiatric providers in the State on a case-mix adjusted basis, 33% below the statewide average and 43% lower relative to Sheppard Pratt where the majority of the transfers from AAMC currently go. See CON Application at 55-56. Further, the integration of inpatient and outpatient care at a single site and efficiencies related to placement post-discharge will result in a reduction in the average length of stay for the patients currently being transferred outside the County by 2 days. See CON Application pages 55-57. Accordingly, this project is entirely consistent with the emphasis in the new Model which focuses on managing Total Cost of Care through controlling health care spending in the State by providing high quality services in the lowest cost setting and reducing avoidable utilization.

After questioning whether the project is inconsistent with the new Model because it will *not* be hospital-based, the HSCRC staff then inconsistently notes that *Medicare and Medicaid programs would pay more for admissions if the project was a hospital-based unit*, The lower costs to these programs is another way in which this project is fully aligned with the State's objectives under the new Model, even more than a hospital-based unit would be.

The HSCRC staff also suggests in this paragraph that a hospital-based unit may be more in line with "reducing ... excess capacity" under the new Model than a freestanding psychiatric

hospital. The bed capacity is the same in either setting, so it is unclear what is meant by this statement. In any event, the adequacy/inadequacy of existing inpatient psychiatric capacity to meet the need in Anne Arundel County is not a question the HSCRC is charged with answering.[2]

Finally, regarding the HSCRC staff's concern that the project may not have sufficient economies of scale to operate efficiently, as described in detail above, AAMHH will leverage its position within AAHS to gain a variety of economies of scale and efficiencies in its operations.

4. Conclusion

The HSCRC concluded in its January 24, 2018 Memorandum that, based on its analysis of the Applicant's revenue and expense projections, it would closely analyze the projected revenue and expenses when setting rates for this facility. The Applicant believes that the information provided above addresses the HSCRC's questions and concerns stated in its Memorandum. As the HSCRC recognized, "Anne Arundel Medical System has shown a propensity to manage their operations appropriately in the past, and staff expects that it would continue to do so in the future." Accordingly, if the CON for AAMHH is approved by the MHCC, the Applicant looks forward to working with the HSCRC and providing the information set forth above, and any other necessary information to enable the HSCRC to set appropriate rates for the AAMHH.

[2] UM BWMC has not disputed the need for an additional 16 psychiatric beds in Anne Arundel County, just the setting in which they are offered.

AFFIRMATION

I solemnly declare and affirm under penalties of perjury that the facts stated in the foregoing Applicant's Response to Health Services Cost Review Commission Memorandum Dated January 24, 2018 are true and correct to the best of my knowledge, information and belief.

Date: 2/2/2018

Name: Jeanette Cross

Title: Managing Director

Berkeley Research Group

AFFIRMATION

I solemnly declare and affirm under penalties of perjury that the facts stated in the foregoing Applicant's Response to Health Services Cost Review Commission Memorandum Dated January 24, 2018 are true and correct to the best of my knowledge, information and belief.

Date: 2/1/18

Dawn K. Hurley

Name: Dawn K. Hurley

Title: Executive Director Behavioral Health

AFFIRMATION

I solemnly declare and affirm under penalties of perjury that the facts stated in the foregoing Applicant's Response to Health Services Cost Review Commission Memorandum Dated January 24, 2018 are true and correct to the best of my knowledge, information and belief.

Date: 2/1/18

Name: Catherine Yurkov

Title: VP Finance