

**BALTIMORE NURSING AND REHABILITATION, LLC**  
**CERTIFICATE OF NEED APPLICATION FILED APRIL 10, 2015**  
**MATTER NO. 15-24-2366**  
**RESPONSE TO COMMENTS SUBMITTED BY**  
**LIFEBRIDGE HEALTH, INC. DATED OCTOBER 5, 2015**

---

**.05A.(1) Bed Need**

The bed need in effect when the Commission receives a letter of intent for the application will be the need projection applicable to the review. The applicable bed need projection is for 2016 and was published in the Maryland Register on October 3, 2014. It shows a surplus of 500 CCF beds for Baltimore City. The Application therefore does not meet this standard.

**RESPONSE 1:**

As noted in the application response to this section on pages 18-19, the beds for which this CON seeks relocation approval are already included in the existing bed inventory as beds that were temporarily de-licensed by the Johns Hopkins Bayview Medical Center (JHBMC) on November 15, 2013. As beds already in the inventory, it is incumbent on BN&R to demonstrate need for the relocation pursuant to COMAR 10.24.08.05B(1), which it has, but not by itself to somehow fix the fact that there may be too many beds in the City. LifeBridge's statement that there are 500 too many beds is based upon the assumption that all of the 297 temporarily de-licensed beds (which includes the 80 de-licensed beds to be relocated under this application) shown in the calculation have been put back into licensure, and all 43 waiver beds have been applied (no information about these beds is available at this time). We note that the MHCC calculates total bed inventory as of July 1, 2014 at only 3,828 licensed and operational beds against a gross bed need projection of 4,048 beds. Adjustments for temporarily de-licensed and waiver beds and an adjustment for desired community services as a replacement for beds produces the negative net bed need number, but as noted the beds in question are already in the existing bed count and will not in any manner change the bed need calculation for the City. BN&R has demonstrated the need for these 80 beds at the proposed location in its application and completeness responses, and that is all it is required to do.

BN&R argues in its application (pages 18-19) that the bed need standard should not apply because it is proposing to relocate temporarily de-licensed beds. This is not correct, for the reasons stated in the Staff Report and Recommendation dated April 1, 2015, *In the Matter of Ingleside at King Farm*, Docket No. 14-15-2355, page 12 and Appendix 5, which are incorporated herein by reference. The main reason why the Commission has been willing, in some cases, to approve the relocation of temporarily de-licensed beds in a jurisdiction with a lack of projected bed need is the replacement and/or modernization of aging facilities. In

contrast, the Application proposes to use the temporarily de-licensed beds for an entirely new facility, not for the replacement or modernization of an existing nursing home.

## **RESPONSE 2:**

There is no Commission action for *In the Matter of Ingleside at King Farm*, Docket No. 14-15-2355 because the CON application was withdrawn prior to any Commission action. Therefore, the reference to an Ingleside “staff report” is not relevant, because the fact that there was no resolution of the matter means it can have no precedential or binding authority. Furthermore, the Responses to Completeness Questions Received on September 26, 2014, filed by Ingleside at King Farm and submitted on October 24, 2014, at page 11, contains a long list of projects in which the Commission granted approval of projects irrespective of the net bed need projection in the jurisdiction in which the facilities were located, because the beds requested were temporarily de-licensed and already in the Commission’s bed inventory. That is the case here. LifeBridge’s statement – that it is okay to try to renovate an aging plant but not to relocate to a new facility in a better location – makes no sense on its own, and does not reflect, but flies in the face of, long precedent in the reuse of temporarily de-licensed CCF beds.

BN&R has made several arguments as to why there is a need for the facility even though there is no projected bed need (see the June 9, 2015 Response to Completeness Questions dated May 11, 2015, pages 21-23), but these arguments do not withstand scrutiny:

1) BN&R argues that there are unmet needs for certain post-acute specialty services (dialysis, bariatric, etc.). These supposedly unmet needs are in fact being met by existing providers, as discussed below.

## **RESPONSE 3:**

LifeBridge indicates that the patient needs described and the patient volume estimated by BN&R can be met by the High Intensity Care Unit at Levindale (“HICU”). Indeed, this unit *does* accommodate patients who require dialysis and/or ventilator management, as well as complex medical conditions. However, HICU beds are licensed as *chronic hospital beds*, which are an entirely different class of licensure and operate at an average charge of \$ 1,579/day. This is in stark contrast to the charge per day projected for a CCF bed at Restore Health of \$534/day (Medicare rate).<sup>1</sup>

The patients whom BN&R seeks to serve at Restore Health are patients ready to be discharged from the acute care setting, and who require support for dialysis, or ventilator management, or have specialized care requirements but *who do not require the high intensity nursing resources of an acute or chronic hospital unit*; instead, these patients can be appropriately cared for in a

---

<sup>1</sup> Other charges can be incurred above the daily rate.

comprehensive care unit (long-term care) at a lower cost per day insofar as distinct accommodations and supports can be provided (TPN, NG tubes, wound care, dialysis care, ventilator management). Mid-Atlantic has demonstrated in the nursing homes that it operates that the nursing home setting can meet the needs of and provide high quality care to this patient population. With respect to ventilator and tracheostomy patients, for Mid-Atlantic in 2015 (as of August), of the weanable patients admitted 27% were completely off vents and decannulated. In addition, 82% of patients were successfully discharged to the home, of whom 75% went home with family on nocturnal ventilation only, 100% of trach training admissions were successfully discharged home, 100% of complex COPD only admission patients (without trachs) were successfully discharged home, and 78% of the long term care patients are stable. This occurs in a much lower cost setting relative to a chronic hospital unit. Stated simply, hospitals in Maryland have struggled to discharge patients who require these specialized services to nursing homes because most nursing homes in Maryland (CCFs) are not equipped or staffed to serve these patients. The goal is not to discharge these patients to a higher licensure facility where the charge per day is comparable to an acute care hospital day.

It is worth emphasizing that a considerable number of patients that BN&R expects to serve are patients *who already are in a chronic hospital bed* at the University of Maryland Midtown campus, but who could be cared for in a much lower cost service setting after clinical conditions stabilize and interventions are more routine. The unmet need is for a service setting that provides the right care, in the right setting, at the lowest possible cost. BN&R does not propose to open a chronic care hospital and the fact that a higher cost chronic care unit might be able to serve some of the patients is simply not relevant. Instead, Mid-Atlantic's new CCF facility will allow timely discharge from the hospital to a lower cost setting with the right resources to effectively manage their clinical care requirements.

2) BN&R argues that "the projected population for the elderly cohort will result in a significant increase in demand for nursing home care in Baltimore City facilities", corresponding to an additional need for 214 beds in Baltimore City from 2013 through 2019. Projected demographic changes through 2016 are already factored into the Commission's bed need projections. The additional need allegedly based on the projected population changes from 2016 to 2019 (three years), which equates to 107 beds. This is much less than the projected Baltimore City surplus of 500 nursing home beds. Although the Commission's projection of bed need includes an adjustment for the anticipated development of community-based services, the increasing focus on community health, home health, and tele-health is likely to further reduce the future need for these services.

#### **RESPONSE 4:**

- In its Completeness Questions (page 22), BN&R addressed bed need for 2019 because that is when the facility would be open and 2016 bed projections were not particularly relevant. BN&R presented estimates of 2019 bed need based on alternative assumptions including: (1) a stable use rate; and (2) a 1%/year use rate decline. BN&R projected total occupied beds for Baltimore City residents including occupied beds in facilities in Baltimore City and outside of Baltimore City. The more complete projection, by year, is presented below, using the 1% annual decline in use rate:

Nursing Home Utilization and Bed Need by Baltimore City Residents  
Based on 1%/Year Decline in Days per 1,000  
Includes utilization across all Maryland nursing homes

	<u>2013</u>	<u>2014</u>	<u>2015</u>	<u>2016</u>	<u>2017</u>	<u>2018</u>	<u>2019</u>
# occupied beds	3,869	3,865	3,860	3,846	3,852	3,848	3,844
# beds @ 95% occupancy	4,073	4,068	4,063	4,048	4,055	4,050	4,046

- The estimated bed need prepared by BN&R reflects the utilization by all Baltimore City residents and does not apply assumptions about what percentage may continue to be admitted to nursing homes outside Baltimore City. The estimate also reflects the assumption about expanded use of the nursing home setting, consistent with the vision of Restore Health and the patient populations it will serve.
- As more fully explained in the application and completeness responses, there continues to be an unmet need for higher resourced, lower cost beds that are staffed and equipped to meet the specialized needs of certain patient populations waiting to be discharged from hospitals, and designed to provide services that are now only available at much greater cost in acute and chronic care hospitals. The challenge in Maryland is to find cost effective ways to provide needed care while reducing the need for high cost care.

3) BN&R argues that there will be cost savings attributable to “substituting nursing home days for hospital days”. In fact, under the HSCRC’s Global Budget Revenue (“GBR”), hospitals would be paid the same amount if nursing home days (or even admissions) are substituted for hospital care, while nursing homes would be paid additional dollars for the nursing home dates, most of it by Medicare under the SNF payment system. The net effect of “substituting nursing home days for hospital days” all other things being equal, would be additional costs paid by the health care system, not savings.

#### **RESPONSE 5:**

It is critical for the State of Maryland to develop lower cost service settings as alternatives to the high cost capacity that now exists (i.e. acute or chronic hospital units). The State of Maryland is

fast approaching Phase II of the Demonstration Project, at which point it is likely that Maryland will be evaluated based on total costs of care per capita rather than on hospital costs of care, only. Successful performance will depend on having lower cost alternatives to acute hospital care and lower cost alternatives to chronic hospital care. Health planning should be focused on supporting high quality, lower cost alternative service settings.

The current Model agreement between the State of Maryland and CMS covers the period January 1, 2014 through December 31, 2018. The agreement contemplates that the State will file a request for an expanded per capita model before the end of Year 3 of the Model (December 31, 2016). Therefore it is clear that a new, and broader, model agreement will take effect at the time the new facility will be in its first year. If, as everyone expects, the new agreement covers all services, or at least all institutional services, it will include a requirement to keep Part A payments to ever more stringent levels. The ability to support hospital efforts to curtail unnecessary but expensive hospital services and meet a need at a lower cost alternative offered by this proposal will benefit efforts to meet the new Model, whatever form it takes.

One of the requirements of the current model agreement is that Maryland must reduce its 30-day unadjusted Medicare all-cause all-site hospital readmission rate to equal or less than the National rate. It is currently well above the national rate. It is almost certain that this requirement will remain in the new agreement when it starts in 2019. Mid-Atlantic's proven track record in reducing readmissions from nursing home, a nationwide problem, is well established, and is particularly needed in this area.

LifeBridge alleges that the transfers to the new facility and its efforts to reduce 30-day readmissions will simply and simplistically result in total cost increases, since hospitals under GBR agreements will not reduce their total charges even if the Restore Health facility is able to accept patients to get them out of the hospital earlier. That is an overly simplistic approach.

As noted on page 23 of the applicant's June 19, 2015 Completeness Response, the Medicare per diem proposed at the Restore Health facility in Baltimore will be \$534 (in current dollars) compared to med/surg per diem well over \$1,000 at the two UMMS hospitals in downtown Baltimore, not even counting the high cost of hospital ancillary services. The theory behind the GBR approach contains both carrot and stick. The carrot is that hospitals are expected to reduce potentially avoidable utilization (PAU), including reducing readmissions, and keep the revenue that remains in rates to provide funds for community based and other services designed to offer alternatives to hospital utilization. The stick is that hospitals actually lose revenue from their GBR

if they perform poorly on reducing readmissions, have poor quality measures or otherwise do not reduce PAU. Since 30-day readmissions are almost always PAU, the hospital does not benefit, but is penalized financially for failure to reduce PAU. The full view, as opposed to the simplistic view, supports the strategy to provide services at Restore Health to reduce total expenditures for hospitals under the GBR and make available more funding for these hospitals to dedicate to community health activities designed to attack the root causes of the truly extraordinarily high hospital and emergency department utilization rates experienced in West Baltimore.

West Baltimore is the neediest of all areas in the state for significant change, with utilization rates and costs more than double the statewide average according to data released by the Health Services Cost Review Commission. For example, West Baltimore residents use hospital emergency rooms on a **0.9:1 basis** compared to a statewide average of 0.37:1, with total per capita hospital charges of more than \$5,000, more than double the state average. See **Exhibit A**. The status quo is simply not acceptable for this area.

4) BN&R claims that it will reduce readmissions to hospitals. There is no evidence that BN&R would accomplish this, but in any case it should not require the construction of a new nursing home to do it. If such reductions can be accomplished through better skills, care management, protocols for effective communications, and protocols for symptom management in the nursing home, as BN&R asserts, then they can and should be attained through the capacity which is already available at existing comprehensive care facilities in Baltimore City.

#### **RESPONSE 6:**

We agree that in theory that should be possible, but it simply has not happened in most existing CCF facilities, whether in Maryland or elsewhere. You have to want change and adopt approaches and spend money to achieve it to make it happen. Business as usual never accomplishes change – it only preserves the status quo. Over the past 12 years, Mid-Atlantic has developed a proprietary care model focused on limiting hospital readmissions to reduce costs to the overall health care system. This care model has many components including but not limited to:

1. Use of electronic medical records and advanced data mining information systems at its facilities;
2. Use of Step-Up Units™ with highly trained staff to handle the care of residents when they have increased care needs;
3. Increased investment in staff, such as nurse practitioners in the facilities and nurse navigators to manage care post discharge; and
4. Investments in monthly readmission and care coordination meetings to insure the needs of each resident are being met.

While an operator can copy some of these elements if it is willing to spend the money, it is the experience of combining them all that has driven Mid-Atlantic's success managing down hospital readmissions. The best example is Mid-Atlantic's experience in the City of Philadelphia. Mid-Atlantic is the largest operator of skilled nursing facilities in the City of Philadelphia, operating five facilities that comprise over 1,100 beds. When MAHC acquired the facilities in 2011, the nursing home patients showed a readmission rate back to the discharging hospital of 40+%. Since the time when Mid-Atlantic began managing these facilities and implementing its care model to these facilities, the readmission rate has dropped dramatically and has been 14% year-to-date through August 2015. This rate is much lower than the Pennsylvania state average of 24%. MAHC's other Maryland facilities show a similar readmissions rate of 14%. Mid-Atlantic is confident it can use this same care model to drive similar results at the proposed facility. See the Response to questions 4 and 5 in the Response to Completeness Questions filed on June 19, 2015.

#### **.05A.(2) Medical Assistance Participation**

The applicant must agree to serve a proportion of Medicaid patient days that is at least equal to the proportion of Medicaid patient days in all other nursing homes in the jurisdiction, calculated as the weighted mean minus 15.5%. The Commission's latest calculations of the required participation rates were published in the Maryland Register on March 20, 2015, and show a required rate for 58.18% for Baltimore City. BN&R stated in its application that it would comply with this standard, the projections in Table G of the Application, at line 4.b.2, show a projected 47% Medicaid patient days. The Application therefore does not meet this standard.

#### **RESPONSE 7:**

This requirement is not applicable to BN&R. The Commission correctly withdrew its question on this issue because BN&R already had sufficiently demonstrated that it satisfied the requirements for the region, and is not required to meet the Medicaid percentage for the city, only the percentage for the region. It has done that. Moreover, given the location, it is expected that many of the patients for whom Medicare might be the primary payor will be dual-eligibles. See the Response to Completeness Questions dated May 11, 2015.

In Appendix E to its first response to completeness questions, in response to the staff's question 10, BN&R provided alternative hypothetical projections of revenues and expenses based on assumed proportions of Medicaid days equal to 69% and 66%, respectively. However, BN&R's response to question 10 indicates that it continues to expect the facility's payor mix to be similar to that of Fairfield Nursing and Rehabilitation in Anne Arundel County, which "maintains a focus on short stay rehabilitation in similar fashion to the proposed facility." As BN&R stated at Exhibit F to the Application:

Another key assumption is the payor mix at the facility. We have modeled our payor mix to be comparable to Fairfield, one of our Maryland-based facilities that has a similar resident



mix and is a similar size (96 beds). As mentioned elsewhere in the application, we have projected a 47.01% census for Medicaid which is the average of all the nursing homes in the jurisdiction within which the Facility operates. Beyond that, given the focus on aggressive return to home rehabilitation residents and other more acute conditions, we estimate a high percentage of patients (42%) to be Medicare patients. This is a similar percentage to the payor mix operating at Mid-Atlantic's Fairfield facility.

In other words, if BN&R succeeds in its declared objective of serving primarily short-stay, post-acute patients, for which Medicare is the primary payor, it will not meet the required minimum standard for serving Medicaid patients.

#### **RESPONSE 8:**

BN&R ran analyses and produced projections demonstrating that it would be financially feasible at the required percentage of Medicaid patients and agreed to execute a MOU with Medicaid. LifeBridge's bleating that BN&R cannot serve both Medicare and Medicaid patients (who as we noted above in the case of dual-eligibles are frequently both with Medicare being the payor for the first part of many CCF stays) has no merit.

#### **.05B.(1) New Construction – Bed Need**

An applicant for a facility involving new construction using beds currently in the Commission's inventory "must address in detail the need for beds to be developed in the proposed project" by submitting data on demographic changes in the target population, utilization trends, and "demonstrated unmet needs of the target population". Although BN&R has submitted certain data and has argued that there are unmet needs of the target population, it has not demonstrated that the beds to be developed are needed, and therefore does not meet this standard.

\* \* \*

[In its lengthy comments on this section of the SHP, Levindale argues its HICU can provide many of the difficult cases BN&R proposes to serve.]

#### **RESPONSE 9:**

See Response 3. The Levindale HICU is considered an acute care facility by CMS and is included in the Demonstration Model and has a GBR budget.<sup>2</sup> Levindale is a chronic hospital – and cares for a different patient than a Medicare SNF patient. They operate under different criteria and at much higher costs. The Levindale HICU does not provide the right level of care at the lowest possible cost. BN&R will.

Furthermore, LifeBridge's challenges to bed need ignore the following points:

---

<sup>2</sup> See **Exhibit B**, selected portions of Agreement Between The Health Services Cost Review Commission and LifeBridge Health Regarding Global Budget Revenue and Non-Global Budget Revenue.



- Existing capacity vs. new capacity – LifeBridge challenges the need for *new* bed capacity. In fact, the proposed facility will be using beds that are already in the existing inventory of beds. These are beds that were temporarily de-licensed, but are included in the “total bed inventory” documented in MHCC’s published projections. As noted earlier, the MHCC’s published bed need projections count “de-licensed beds” in its total bed inventory.
- Use rates - LifeBridge argues that BN&R has not adequately accounted for use rate declines likely to occur through community health, home health, and telehealth care models. In fact, BN&R’s projections incorporated a use rate decline, applying a 1% decline in use rates per year. This reflects assumptions about increased reliance on the home care setting, but also accounts for the expectation that hospitals will be leveraging the nursing home setting more heavily for post-acute services and episode management to reduce utilization and costs (see point below).
- New capabilities/new functions of the proposed nursing home – The proposed facility is designed to be a new model for nursing homes, a model designed to operate more broadly in the continuum of care and operate more closely with the hospital. It is designed explicitly to serve patients who are currently served in the hospital; this will create new demand for nursing home beds, justified by the fact that it will substitute for acute hospital days. The fact that there is “excess capacity” in existing nursing homes represents excess capacity only for the current functions that these nursing homes provide – the failing status quo. The nursing home capacity simply does not currently exist to meet the new demand being proposed for this new facility.
- Outmigration - MHCC’s demand projection for Baltimore City accounts for out-migration by reducing the outmigration by ½ and allocating those cases back to the City. COMAR 10.24.08.07A(3). This accounts for some, but not all, of the outmigration volume. While the historical pattern *has* been that more than 40% of Baltimore City patients over the age of 65 have utilized out of area facilities, this is not judged to be ideal and should not serve as the basis for projecting true demand. The real question raised by that statistic is *WHY?* Capacity planning should be based on the more optimal model of promoting locally-based care to support continuity of care with physicians and local access for families. If some Baltimore City facilities are underutilized, and residents leave the City for care, the response should be to fix the problem. BN&R proposes to do just that in a part of the City – West

Baltimore – in dire need of new responses and new service settings. The West Baltimore community is calling out for support. When the status quo does not work, change is the only acceptable answer.

- Under GBR, hospitals are expected to seek lower cost service settings for service delivery, including the nursing home setting. Hospitals are investing resources to formalize care protocols, improve care coordination and communications across settings, increase physician and RN presence in nursing homes, and incorporate tele-health systems to provide consultation services. All of these elements will encourage greater reliance on the nursing home setting. Nursing home utilization is likely to increase further when the three day qualifying hospital stay rule is waived through ACO models.

Worth noting is the recently published statistic from CMS based on a pilot program to reduce hospitalizations of nursing home patients through the use of tele-health service. Seven large health systems participated in this demonstration programs and adopted different approaches. According to CMS, roughly 45% of hospital readmissions involving Medicare or Medicaid enrollees in long term care facilities were determined to be “avoidable.” The Maryland agreement with CMS mandates reducing 30 day readmissions. As Maryland hospitals continue to develop effective care coordination models and strengthen the communications across facilities, nursing home occupancy rates in facilities that provide the right types of care can be expected to increase.

### **.05B.(3) Jurisdictional Occupancy**

The SHP standard states that the Commission “may approve a CON application for a new nursing home only if the jurisdictional occupancy for all nursing homes in that jurisdiction equals or exceeds a 90 percent occupancy level for at least the most recent 1 month period.” According to the latest information published by the Commission (Maryland Register, March 20, 2015), the jurisdictional occupancy rate for Baltimore City nursing homes was 87.81%. The Application therefore does not meet this standard.

Subsection (b) of the standard states that an application may show evidence why this rule should not apply, and BN&R made some arguments on this issue at pages 36-8 of the Application. It argues that the standard “appears to be aimed at new facilities proposing a bed increase” and therefore should not apply to a new facility using relocated temporarily de-licensed beds. There is no basis for ignoring this standard; it applies to the approval of “a new nursing home”, which the BN&R facility certainly would be. If a rationale is needed for applying the standard to such a project, it is the avoidance of unnecessary capital costs, which in this case would be approximately \$17 million.

### **RESPONSE 10:**

BN&R acknowledges that the most recent occupancy statistics for Baltimore City nursing homes show 87.8%, slightly below the threshold for approving a CON for a new nursing home BN&R

notes that none of the requested beds are new – just the location for them. However, BN&R has provided evidence as to why this rule should not apply based on the following:

- Existing nursing home capacity does not accommodate patient requirements which the proposed facility is designed and staffed to meet; therefore, excess capacity is not relevant to the evaluation of need for this facility. The fact that there is excess capacity of licensed nursing home beds across the entire city does not matter if existing nursing homes will not admit or cannot properly serve a significant segment of the patient population needing post-acute care. Existing nursing homes, in large measure, do not accommodate whole categories of patients defined by specialized care needs, and those nursing homes that do serve these patient populations typically operate at maximum capacity for these patient populations (e.g. care for bariatric patients). Therefore, current occupancy rates –which are just below the standard – are not an indicator of “available capacity” if they do not serve this population in need. Given that the new facility proposes to serve a population not currently served by most nursing homes, the occupancy threshold for approving a CON should not apply.
- Moreover, this occupancy rate masks the fact that more than 40% of Baltimore City residents utilize out-of-area nursing homes. In CY 2013, more than 2,800 nursing home placements for Baltimore City residents, age 65 and above, were arranged at facilities outside of Baltimore City *despite the availability of beds at nursing homes in Baltimore City*. This reliance on out-of-area nursing homes by more than 40% of the patients discharged is an indicator that service needs or quality expectations are currently not being met by many existing nursing homes in the local jurisdiction. Therefore, the jurisdictional occupancy by itself is not the measure of need, and should not apply. Even a modest reversal of the high outmigration rates would drive City occupancy well above 90%. A very straightforward look at how a change in outmigration may affect occupancy rates at Baltimore City nursing homes is presented below:
- Assuming a modest 10% of current volume that currently “out-migrates” were to be retained at high quality and better resourced local facilities in Baltimore City, the occupancy rate at Baltimore City nursing homes would increase to 91.8%.
- Assuming that 20% of current volume that currently “out-migrates” were to be retained at high quality and better resourced local facilities in Baltimore City, the occupancy rate at Baltimore City nursing homes would increase to 95.1%.

Impact Analysis  
Potential Shift of Baltimore City Residents Currently “Out-migrating” for Nursing Home Care  
Patients age 65+ years - CY2013

Actual	Total # Days in Baltimore City Nursing Homes	1,212,988 days
	Average Daily Census	3,323 patients
	# Nursing Home Beds	3,754 beds
	Occupancy %	88.5%
Actual	Outmigration of Age 65+: Patient Days	449,290 days
	Average Daily Census	1,231 patients
Opportunity potential: 10% shift to Baltimore City facilities		
	# Patient Days	44,929 days
	Average Daily Census	123 patients
	Resulting occupancy in Baltimore City	91.8%
Opportunity potential: 20% shift to Baltimore City facilities		
	# Patient Days	89,858 days
	Average Daily Census	246 patients
	Resulting occupancy in Baltimore City	95.1%

BN&R urges that the goal that should guide program efforts and capacity planning is to equip and upgrade local facilities to meet the demand for higher need patients, and to assure the high quality, low cost capacity to meet this need. Healthcare is changing, and nursing homes have to change with it to meet its new demands or be left behind. It is their choice. If a facility is unable or unwilling to meet the changing needs of patients, it can continue to serve existing patients but its occupancy rate will decline.

**Other CON Review Criteria**

**COMAR 10.24.01.08G(3)(b) – Need**

The standard states the Commission shall consider the applicable need analysis in the State Health Plan. As discussed above, the SHP need analysis shows a surplus of 500 nursing home beds in Baltimore City. The Application therefore does not meet this standard.

**RESPONSE 11:**

This comment is identical to LifeBridge’s first comment concerning .05A.(1) Bed Need, and therefore BN&R directs LifeBridge to its responses to that comment (Responses 1-5) above on pages 1-6.

**COMAR 10.24.01.08 (G)(c) – Availability of More Cost-Effective Alternatives**

The standard states that the Commission shall compare the cost effectiveness of the proposed project with the cost effectiveness of providing the service through alternative existing facilities. The Application does not meet this standard because the services proposed by BN&R can be provided more cost effectively by existing

providers. Since there is existing capacity at alternative facilities – including LifeBridge’s facilities – the services can be provided without the substantial capital costs required to build a new nursing home.

As previously noted, BN&R argues that there will be cost savings attributable to “substituting nursing home days for hospital days”. In fact, under the HSCRC’s Global Budget Revenue (GBR) hospitals would be paid the same amount if nursing home days (or even admissions) are substituted for hospital care, while nursing home would be paid additional dollars for the nursing home days, most of it by Medicare under the SNF payment system. The hospital inpatient per diem and observation rates cited by BN&R are used for charges to individual patients, but whether an individual patient is charged or not is relevant to the calculation of a hospital’s total budgeted revenue.

The net effect of “substituting nursing home days for hospital days” all other things being equal, would be additional costs to the healthcare system, not savings. BN&R effectively concedes this by stating: “Under the GBR model, this would make hospital budget dollars more available for reinvestment in the West Baltimore community.”

In particular, the short-term post-acute services proposed by BN&R can be provided more cost effectively by LifeBridge, especially in Levindale’s High Intensity Care Unit. Likewise, short-term rehabilitation services beyond those which can be provided in a nursing home can be provided more effectively by Sinai’s acute rehab unit. Both the Levindale HICU and the Sinai rehab unit are included in LifeBridge’s Global Budget Revenue Agreement with the HSCRC, so that (except for relatively minor adjustments) the provision of those services to additional patients would not generate additional costs to the health care system. In contrast, if BN&R were approved and provided the same services, there would be additional costs to the system equal to what Medicare and other payors would pay BN&R.

## **RESPONSE 12:**

LifeBridge argues that under GBR, the net effect of substituting nursing home days for hospital days would be to add costs to the health care system. BN&R has responded to this issue in Response 5. In addition, the MHCC should adopt a longer-term view and recognize that the proposed facility will better position Maryland for value-based care, reduce the total costs of care to payors and to consumers, and support Maryland’s performance on the Medicare waiver test which is expected to be in effect under the second phase of the Waiver which will start in 2019.

- CMS has identified bundled payment contracts and similar value-based payment models to be critical for physicians and hospitals to implement in the coming two years. The HSCRC, as well, has encouraged hospitals to position themselves for these new models. The only way for providers to succeed under these models is to utilize low cost, high quality service settings. The proposed nursing home will allow Maryland providers to reduce the total costs of care under these fixed price models and allow for shared savings distribution.
- Applicant has provided evidence that its nursing homes in Pennsylvania document notably low readmission rates of their nursing home patients to the hospital. The proposed facility

will help individual hospitals lower their readmission rates and avoid financial penalties and assist in the requirement that Maryland reduce its Medicare readmission rates to the national average. More broadly, readmission reduction is critical to quality of care improvements, patient satisfaction, and performance on the waiver test. The readmission rate is a core performance measure under the Waiver which is not being achieved.

- The proposed facility will provide an alternative setting for low acuity admissions, and will help hospitals reduce low acuity, preventable admissions (“PQI admissions”). When the three day qualifying stay rule is waived, Restore Health will serve as a lower cost setting to which these patients may be admitted directly.
- Medicare Advantage plans are expected to be more active in the Maryland market. The proposed nursing home will help lower the total costs of care and is expected to translate into savings both for payors and for consumers. Mid-Atlantic experience with Medicare Advantage plans in its Philadelphia facilities positions the proposed facility to be an active participant in these efforts.
- Longer-term, as acute care admissions continue to decline, the HSCRC can be expected to re-base the GBR budgets for individual hospitals. Ultimately, this will lead to capacity reductions at hospitals, the source of the greatest savings to the overall system.
- Finally, LifeBridge seems to have ignored the fact that reducing the total costs of care produces savings for the consumer, who is expected to bear an increasing percentage of health care costs. The creation of a lower cost service setting to substitute for hospital days of care will translate into lower spending for the consumer.

#### **COMAR 10.24.01.08(G)(3)(f) – Impact on Existing Providers and the Health Delivery System**

The standard states that an applicant must 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 access, occupancy, costs and charges of other providers, and on costs to the health care system. The discussion at pages 53 – 55 of the Application does not provide any information or any analysis of the impact of the project on existing providers. The application therefore does not meet this standard. BN&R argues, instead, that its services for “traditional, long stay patients” will be limited to those for which “demand is growing and/or supply is constrained” – notably dialysis and vent/dialysis. As discussed above, there is no overall growth in utilization projected in Baltimore City, and the services mentioned are not in fact constrained.

#### **RESPONSE 13:**

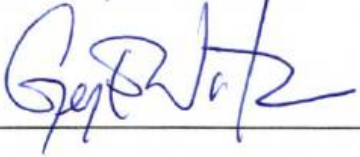
Please see Responses 3 and 9 distinguishing Levindale from the proposed facility, and the material in the Response to Completeness Question on page 37 (and the referenced table).

Furthermore, it is noteworthy that Levindale gets most of its admissions from Sinai. BN&R did not project any impact on Levindale because given the close relationship between Sinai and Levindale, which are located on the same campus as part of LifeBridge almost eight miles away from the proposed facility, any impact is expected to be minimal to non-existent. Even if a few referrals now made to Levindale are redirected to the proposed facility, the impact to Levindale is expected to be nonexistent given its large referral base. BN&R will not affect Levindale financially. Levindale has failed to provide anything evidencing any anticipated impact or adverse impact from the proposed facility.



### AFFIRMATION

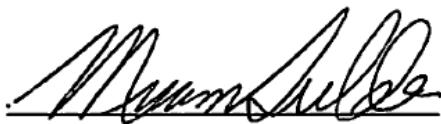
I hereby declare and affirm under the penalties of perjury that the facts stated in this response to completeness questions and its attachments are true and correct to the best of my knowledge, information, and belief.



---

### **AFFIRMATION**

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

A handwritten signature in black ink, appearing to read "M. M. L. B.", is written over a horizontal line.

## **TABLE OF EXHIBITS**

<b>EXHIBIT</b>	<b>DESCRIPTION</b>
<b>Exhibit A</b>	Use Rates By Region (Adjusted for Outmigration)
<b>Exhibit B</b>	Agreement Between The Health Services Cost Review Commission and LifeBridge Health Regarding Global Budget Revenue and Non-Global Budget Revenue (Selected Portions)

# **EXHIBIT A**

## Use Rates By Region (Adjusted for Outmigration)

Calendar 2014

Region	Population	Calendar Year 2014			Variance Above / (Below) Statewide		
		Inpatient Discharges Rate per 1,000	Emergency Department Visits per 1,000	Observation Visits per 1,000	Inpatient Discharges Rate per 1,000	Emergency Department Visits per 1,000	Observation Visits per 1,000
Baltimore City-West	248,818	179.25	913.75	70.40	72.52	537.14	37.38
Baltimore City-East	185,734	166.89	771.69	60.88	60.16	395.08	27.85
Dorchester	31,874	142.09	712.39	22.58	35.37	335.78	(10.44)
Anne Arundel-Baltimore	137,785	146.38	617.54	50.50	39.65	240.93	17.48
Wicomico	101,399	118.52	573.27	21.39	11.79	196.65	(11.63)
Somerset	24,455	106.76	512.33	26.18	0.04	135.72	(6.85)
Worcester	52,034	115.86	511.51	27.87	9.13	134.89	(5.15)
Baltimore City-North	190,488	133.39	506.36	45.93	26.67	129.75	12.91
Garrett	27,923	96.34	486.27	28.63	(10.38)	109.65	(4.40)
Kent	25,150	121.57	473.76	18.52	14.85	97.15	(14.50)
Allegany	76,120	130.17	459.26	42.19	23.44	82.65	9.16
Talbot	38,270	128.61	453.04	14.56	21.89	76.43	(18.46)
Caroline	34,082	120.19	447.97	16.62	13.47	71.36	(16.41)
St Marys	114,884	96.30	441.85	33.94	(10.42)	65.24	0.92
Baltimore-East	320,615	142.74	430.49	53.37	36.01	53.88	20.34
Queen Annes	44,320	99.40	426.13	16.41	(7.32)	49.51	(16.61)
Baltimore-West	292,940	132.04	409.31	37.83	25.32	32.70	4.81
Charles	149,134	92.72	405.63	29.28	(14.01)	29.01	(3.74)
Calvert	92,004	90.16	402.22	29.50	(16.56)	25.61	(3.52)
Cecil	102,836	96.77	398.44	37.20	(9.96)	21.83	4.18
Washington	149,025	122.00	387.08	45.54	15.27	10.46	12.51
Prince Georges-Central	262,771	102.79	336.60	35.22	(3.93)	(40.02)	2.19
Harford	249,230	104.44	312.97	51.30	(2.28)	(63.64)	18.28
Prince Georges-South	299,976	85.67	310.74	36.30	(21.06)	(65.87)	3.28
Carroll	158,442	102.11	295.98	33.00	(4.62)	(80.64)	(0.02)
Prince Georges-East	77,042	93.41	294.98	23.38	(13.32)	(81.63)	(9.64)
Anne Arundel	434,811	91.01	289.93	21.99	(15.71)	(86.68)	(11.04)
Frederick	253,346	91.54	279.25	27.29	(15.18)	(97.37)	(5.73)
Prince Georges-North	238,675	90.24	264.11	22.28	(16.49)	(112.51)	(10.74)
Baltimore-North	170,011	96.14	248.86	24.80	(10.59)	(127.75)	(8.22)
Montgomery	1,031,950	81.22	238.93	18.53	(25.50)	(137.68)	(14.50)
Howard	314,249	82.07	211.50	15.95	(24.65)	(165.12)	(17.08)
<b>Statewide Total</b>	<b>5,930,394</b>	<b>106.73</b>	<b>376.62</b>	<b>33.02</b>	-	-	-

<b>Eastern Shore Total</b>	<b>173,697</b>	<b>120.96</b>	<b>495.77</b>	<b>17.48</b>	<b>14.24</b>	<b>119.16</b>	<b>(15.54)</b>
----------------------------	----------------	---------------	---------------	--------------	--------------	---------------	----------------

Notes:

[1] Population Source: Neilson Claritas population estimates based on 2010 census numbers

[2] Source for utilization numbers: HSCRC Abstract data FY2014 final, FY2015 Q1&Q2 final

[3] Adjusted for outmigration using FY 2012 MedPar data. Calculated total charges divided by in-state charges for each county

**Statewide Emergency Department Use Rates by Region**  
Calendar Year 2014

**Calendar Year 2014**

Region	ED Use Rate	Outmigration	ED Use Rate Adjusted for Outmigration	vs. Statewide (#)	vs. Statewide (%)
Baltimore City-West	913.75	0.00%	913.75	514.79	129.03%
Baltimore City-East	771.69	0.00%	771.69	372.72	93.42%
Dorchester	712.39	1.53%	723.26	324.30	81.28%
Anne Arundel-Baltimore	617.54	1.00%	623.72	224.75	56.33%
Garrett	486.27	25.88%	612.12	213.16	53.43%
Wicomico	573.27	0.47%	575.98	177.01	44.37%
St Marys	441.85	17.35%	518.51	119.54	29.96%
Worcester	511.51	1.20%	517.65	118.68	29.75%
Kent	473.76	8.85%	515.68	116.71	29.25%
Somerset	512.33	0.34%	514.07	115.10	28.85%
Baltimore City-North	506.36	0.00%	506.36	107.39	26.92%
Caroline	447.97	10.84%	496.52	97.55	24.45%
Allegany	459.26	6.40%	488.67	89.70	22.48%
Cecil	398.44	22.46%	487.93	88.96	22.30%
Charles	405.63	17.10%	474.99	76.02	19.05%
Talbot	453.04	0.97%	457.42	58.45	14.65%
Calvert	402.22	13.09%	454.88	55.91	14.01%
Queen Annes	426.13	3.61%	441.51	42.54	10.66%
Baltimore-East	430.49	0.00%	430.49	31.52	7.90%
Prince Georges-Central	336.60	22.39%	411.95	12.98	3.25%
Baltimore-West	409.31	0.00%	409.31	10.34	2.59%
Washington	387.08	3.71%	401.45	2.48	0.62%
Prince Georges-South	310.74	22.39%	380.31	(18.66)	(4.68%)



Prince Georges-East	294.98	22.39%	361.01	(37.95)	(9.51%)
Prince Georges-North	264.11	22.39%	323.23	(75.74)	(18.98%)
Harford	312.97	0.00%	312.97	(86.00)	(21.55%)
Carroll	295.98	2.29%	302.76	(96.21)	(24.12%)
Frederick	279.25	6.34%	296.96	(102.01)	(25.57%)
Anne Arundel	289.93	1.21%	293.45	(105.51)	(26.45%)
Montgomery	238.93	12.53%	268.87	(130.10)	(32.61%)
Baltimore-North	248.86	0.00%	248.86	(150.11)	(37.62%)
Howard	211.50	0.65%	212.86	(186.10)	(46.65%)
<b>Statewide Total</b>	<b>376.62</b>	<b>5.94%</b>	<b>398.97</b>	<b>-</b>	<b>-</b>

Notes:

[1] Population Source: Neilson Claritas population estimates based on 2010 census numbers

[2] Source for utilization numbers: HSCRC Abstract data FY2014 final, FY2015 Q1&Q2 final

[3] Calculation for Outmigration adjustment: By County Total Charges divided by In-State Charges. Source MedPar 2012



Calendar Year 2014

Region	Population	Total Charges	Charge Per Capita	vs. Statewide (#)	vs. Statewide (%)
Baltimore City-West	248,818	\$1,258,530,198	\$5,058	\$2,533	100.31%
Baltimore City-East	185,734	843,103,706	4,539	\$2,014	79.77%
Dorchester	31,874	122,162,262	3,833	\$1,308	51.78%
Kent	25,150	90,595,986	3,602	\$1,077	42.66%
Baltimore City-North	190,488	681,598,029	3,578	\$1,053	41.71%
Anne Arundel-Baltimore	137,785	488,697,057	3,547	\$1,022	40.46%
Baltimore-East	320,615	1,124,023,390	3,506	\$981	38.84%
Baltimore-West	292,940	999,634,678	3,412	\$887	35.14%
Allegany	76,120	254,019,889	3,337	\$812	32.16%
Worcester	52,034	167,802,624	3,225	\$700	27.71%
Talbot	38,270	121,588,987	3,177	\$652	25.82%
Caroline	34,082	100,245,557	2,941	\$416	16.48%
Harford	249,230	718,913,362	2,885	\$359	14.24%
Cecil	102,836	288,843,375	2,809	\$284	11.24%
Somerset	24,455	68,058,560	2,783	\$258	10.22%
Carroll	158,442	437,676,652	2,762	\$237	9.40%
Wicomico	101,399	276,812,347	2,730	\$205	8.11%
Baltimore-North	170,011	429,718,519	2,528	\$3	0.10%
Garrett	27,923	69,261,743	2,480	(\$45)	(1.77%)
Queen Annes	44,320	109,731,914	2,476	(\$49)	(1.95%)
Washington	149,025	353,854,479	2,374	(\$151)	(5.96%)
Calvert	92,004	210,224,453	2,285	(\$240)	(9.51%)
St Marys	114,884	247,900,498	2,158	(\$367)	(14.54%)
Prince Georges-Central	262,771	562,144,038	2,139	(\$386)	(15.28%)
Anne Arundel	434,811	909,325,530	2,091	(\$434)	(17.18%)
Prince Georges-East	77,042	163,939,130	2,128	(\$397)	(15.73%)
Frederick	253,346	507,869,973	2,005	(\$520)	(20.61%)
Charles	149,134	281,608,292	1,888	(\$637)	(25.22%)

Howard	314,249	586,794,363	1,867	(\$658)	(26.05%)
Prince Georges-South	299,976	529,457,423	1,765	(\$760)	(30.10%)
Prince Georges-North	238,675	410,396,023	1,719	(\$806)	(31.90%)
Montgomery	1,031,950	1,560,100,360	1,512	(\$1,013)	(40.13%)
<b>Statewide Total</b>	<b>5,930,394</b>	<b>\$14,974,633,397</b>	<b>\$2,525</b>	<b>-</b>	<b>-</b>

Notes:

[1] Population Source: Neilson Claritas population estimates based on 2010 census numbers

[2] Source for utilization numbers: HSCRC Abstract data FY2014 final, FY2015 Q1&Q2 final

[3] Calculation for Outmigration adjustment: By County Total Charges divided by In-State Charges. Source MedPar 2012

# **EXHIBIT B**

**AGREEMENT**  
**BETWEEN**  
**THE HEALTH SERVICES COST REVIEW COMMISSION**  
**AND**  
**LIFEBRIDGE HEALTH**  
**REGARDING**  
**GLOBAL BUDGET REVENUE AND NON-GLOBAL BUDGET REVENUE**

**CONTENTS**

<b>I.</b>	<b>OVERVIEW .....</b>	<b>- 3 -</b>
<b>II.</b>	<b>TERM OF AGREEMENT .....</b>	<b>- 4 -</b>
<b>III.</b>	<b>REVENUE GOVERNED BY AGREEMENT .....</b>	<b>- 4 -</b>
<b>IV.</b>	<b>SPECIFICATION OF THE APPROVED REGULATED REVENUE OF THE HOSPITAL .....</b>	<b>- 5 -</b>
A.	OVERVIEW.....	- 5 -
B.	DETAILED DESCRIPTION OF THE OF THE BASIC COMPONENTS OF THE HOSPITAL’S APPROVED REGULATED REVENUE .....	- 5 -
<b>V.</b>	<b>COMPLIANCE .....</b>	<b>- 8 -</b>
A.	GENERAL COMPLIANCE UNDER THE GBR MODEL .....	- 8 -
B.	UNIT RATE FLEXIBILITY .....	- 8 -
C.	OVERALL COMPLIANCE CORRIDORS .....	- 9 -
<b>VI.</b>	<b>MONITORING OF GBR OPERATION AND PERFORMANCE .....</b>	<b>- 9 -</b>
<b>VII.</b>	<b>EVALUATION OF THE EFFECTIVENESS OF THE GBR .....</b>	<b>- 12 -</b>
<b>VIII.</b>	<b>POSSIBLE FUTURE MODIFICATIONS IN THE GBR MODEL TO ACHIEVE IMPROVED ALIGNMENT OF INCENTIVES IN THE HEALTH CARE DELIVERY SYSTEM.....</b>	<b>- 13 -</b>
<b>IX.</b>	<b>OTHER POTENTIAL MODIFICATIONS.....</b>	<b>- 13 -</b>
A.	APPROVED REGULATED REVENUE MODIFICATIONS.....	- 13 -
B.	APPROVED REGULATED REVENUE MODIFICATIONS RELATED TO CON PROJECTS.....	- 13 -
<b>X.</b>	<b>OUT-OF-AREA AND OUT-OF-STATE VOLUMES AND REVENUES .....</b>	<b>- 14 -</b>
<b>XI.</b>	<b>READMISSIONS, QUALITY AND REDUCTIONS OF POTENTIALLY AVOIDABLE UTILIZATION.....</b>	<b>- 14 -</b>
<b>XII.</b>	<b>TERMINATION AND/OR RENEGOTIATION AND OTHER RIGHTS.....</b>	<b>- 15 -</b>
A.	TERMINATION BY THE HSCRC .....	- 15 -
B.	TERMINATION BY HOSPITAL .....	- 15 -
C.	OTHER RIGHTS .....	- 16 -
D.	OTHER PROVISIONS RELATIVE TO THE HOSPITAL .....	- 16 -
<b>XIII.</b>	<b>DEFINITIONS OF TERMS .....</b>	<b>- 17 -</b>
	<b>APPENDIX A: HOSPITAL’S BASE REVENUE COMPONENTS AND ORDER NISI .....</b>	<b>- 19 -</b>
	<b>APPENDIX B: REVENUES AND SERVICES EXCLUDED FROM GBR MODEL AND GENERAL DESCRIPTION OF RATE SETTING REQUIREMENTS FOR EXCLUDED REVENUES.....</b>	<b>- 22 -</b>
	<b>APPENDIX C: POTENTIALLY AVOIDABLE UTILIZATION TARGETS .....</b>	<b>- 23 -</b>
	<b>APPENDIX D: DEMOGRAPHIC ADJUSTMENT .....</b>	<b>- 24 -</b>
	<b>APPENDIX E: DEFINITION OF HOSPITAL’S SERVICE AREA.....</b>	<b>- 25 -</b>
	<b>APPENDIX F: ANNUAL DISCLOSURE AND CERTIFICATION REGARDING CHANGES IN SERVICES PROVIDED (DUE 30 DAYS AFTER THE END OF THE RATE YEAR).....</b>	<b>- 26 -</b>
	<b>APPENDIX G: HOSPITAL FINANCIAL INTEREST, OWNERSHIP, OR CONTROL OF OTHER HOSPITAL OR NON-HOSPITAL SERVICES PROVIDED WITHIN THE SERVICE AREA .....</b>	<b>- 27 -</b>
	<b>APPENDIX H: CALCULATION OF MARKET SHARE .....</b>	<b>- 28 -</b>

APPENDIX I: READMISSION POLICY ADJUSTMENT .....	- 29 -
-------------------------------------------------	--------

**AGREEMENT  
BETWEEN  
THE HEALTH SERVICES COST REVIEW COMMISSION  
AND  
LIFEBRIDGE HEALTH  
REGARDING GLOBAL BUDGET REVENUE AND NON-GLOBAL BUDGET REVENUE**

This Agreement, made this 1st day of January, 2014, between (the MARYLAND HEALTH SERVICES COST REVIEW COMMISSION (the “Commission,” or “HSCRC”) and LifeBridge Health, Inc. (“Hospital System,” or “Lifebridge”) on behalf of the following subsidiary entities: Levindale Hebrew Geriatric Center and Hospital, Northwest Hospital Center and Sinai Hospital of Baltimore (individually a “Hospital” and collectively, the “Hospitals” each of which is, through this Agreement, adopting the Global Budget Revenue (“GBR”) model.

## **I. Overview**

The Global Budget Revenue (“GBR”) model is a revenue constraint and quality improvement system designed by the Maryland Health Services Cost Review Commission to provide hospitals with strong financial incentives to manage their resources efficiently and effectively in order to slow the rate of increase in health care costs and improve health care delivery processes and outcomes. The GBR model is consistent with the Hospital’s mission to provide the highest value of care possible to its patients and the communities it serves.

This Agreement is intended to promote the achievement of the goals of the Maryland All-Payer Model Agreement between the State of Maryland and the Center for Medicare & Medicaid Innovation (CMMI). The Hospital and HSCRC agree to modify this Agreement, if necessary, to ensure that it is consistent with the main provisions, objectives and requirements of the application that was filed with CMMI in October 2013, and meets the requirements of the final contract between CMMI and the State of Maryland.

The GBR model assures hospitals that adopt it that they will receive an agreed-on amount of revenue each year—i.e., the Hospital’s “Approved Regulated Revenue” (Approved Regulated Revenue) under the GBR system-- regardless of the number of Maryland residents they treat and the amount of services they deliver provided that they meet their obligations to serve the health care needs of their communities in an efficient, high quality manner on an ongoing basis. The GBR model removes the financial incentives that have encouraged hospitals to increase their volume of services and discouraged them from reducing their levels of “Potentially Avoidable Utilization” (PAU) and marginal services. It provides hospitals with much-needed flexibility to use their agreed-on global budgets to effectively address the “Three Part Aim” objectives of better care for individuals, higher levels of overall population health, and improved health care affordability.



In accepting this Agreement, the Hospitals agree to operate within the GBR's financial constraints and to comply with the various patient-centered and population-focused performance standards that have been or will be established by the HSCRC, including all of the existing components of the Maryland Hospital Acquired Conditions (MHAC) program, the Quality Based Reimbursement (QBR) program, the readmissions reduction program, and a number of other existing and future quality improvement programs. The Hospital agrees to cooperate with HSCRC in the collection and reporting of data needed to assess and monitor the performance of the GBR model and in the refinement of the GBR model and the related performance standards in the future. The HSCRC will delineate the performance standards and program refinements in policies that it will issue on a timely basis, and the Hospital agrees that it will comply with these policies.

The HSCRC will carefully monitor the Hospitals' activities under this Agreement, including any service discontinuations, shifts of services from any of the Hospitals to other related or non-related hospitals or non-hospital providers, changes in the Hospital's market share, and other relevant factors that are pertinent to the effective operation of the GBR model in accordance with the Three Part Aim and the final contract that is established by CMMI and the State of Maryland. The HSCRC will reasonably adjust the Hospitals' Approved Regulated Revenue as it deems necessary to ensure that the Hospital(s) receive(s) the revenue they need to meet their obligations under this Agreement.

The Hospitals agree to comply with the policies of the HSCRC with respect to any services they provide which are regulated by the HSCRC that are not covered under the GBR model. The services that are not covered by the GBR model are specified in Appendix B.

## **II. Term of Agreement**

This Agreement will become effective on July 1, 2013 and will continue through June 30, 2014. On July 1, 2014, and each year thereafter, the Agreement will renew for a one year period unless it is canceled by the HSCRC or by Hospital or Hospitals in accordance with Section XII.

## **III. Revenue Governed by Agreement**

This Agreement will apply to all of the inpatient and outpatient revenues of the Hospitals that are regulated by the HSCRC including those associated with services that are covered by the GBR model (i.e., the "GBR Revenue") and those that are not covered by the GBR model (i.e., the "Non-GBR Revenue"). The services and revenues that are not covered by the GBR model are delineated in Appendix B. Any services and revenue which are excluded from the GBR model, as specified in Appendix B, will be subject to the policies of the applicable rate setting policies of the HSCRC regarding unit rates, quality, efficiency, readmissions, variable cost factors (VCFs), volume/case mix governors and other policies that the HSCRC establishes for hospitals (or categories of revenue) that are not covered by the GBR model.

This Agreement will establish the Approved Regulated Revenue of the Hospital, which shall mean

the revenue for services covered by the GBR model, and the terms and provisions governing it and the revenue associated with services that are not covered by the GBR model, for each Rate Year. The Approved Regulated Revenue and the associated Unit Rates for the Hospital will be set forth in each Hospital's Order Nisi for the particular Rate Year. Any revenues excluded from the GBR limits, pursuant to Section B, are specified in Appendix B and will be identified in the Order Nisi.

#### **IV. Specification of the Approved Regulated Revenue of the Hospital**

##### **A. Overview**

The Approved Regulated Revenue of the Hospitals for the July 1, 2013 through June 30, 2014 period is specified in Appendix A. As shown in Appendix A, the Approved Regulated Revenue includes several components: the Permanent Base Revenue, which may include permanent positive or negative adjustments; and a series of other Annual or Periodic adjustments, assessments and settlements. Appendix A also identifies the approved revenue for services that are not covered by the GBR model and the Order Nisi for each Hospital for the particular Rate Year. Appendix A and Appendix B will be updated as needed by the HSCRC on a periodic basis.

The Approved Regulated Revenue of the Hospitals may include permanent or temporary rate adjustments designed to provide the Hospitals with funds needed to establish programs and capabilities that are essential to the effective implementation of the GBR model. These adjustments will be provided only to the extent that each Hospital demonstrates that it cannot reasonably afford to establish such activities without the additional resources. The amount, duration and purpose of any such adjustments will be clearly specified in Appendix B (and/or in accompanying documents) for the time period extending from the Effective Date of this Agreement through June 30, 2014. In addition, for any Rate Year beginning on or after July 1, 2014, each Hospital will provide the HSCRC with a prospective written description of the particular performance improvements it will seek to achieve through its use of the additional funds (if any) that are provided by these rate adjustments. Each Hospital will also provide the HSCRC with credible, retrospective documentation of the performance improvements that it actually achieves by its use of the additional funds.

##### **B. Detailed Description of the Basic Components of the Hospital's Approved Regulated Revenue**

The HSCRC will develop the Approved Regulated Revenue of each Hospital for any particular Rate Year in the following way:

1. Initially, the HSCRC staff will determine the Base Approved Regulated Revenue of the Hospital by adjusting the Hospital's approved revenue for a specified historical base period to reflect settlements and adjustments. These adjustments may include additional funding to support programs and capabilities to be established by the Hospital that are necessary to

policies that will appropriately address the financial issues raised by CON projects and other capital and service expansions. The HSCRC staff will make recommendations to the HSCRC regarding any requests from the Hospital for additional revenues for these reasons, when necessary.

## **X. Out-of-Area and Out-of-State Volumes and Revenues**

Significant changes in out-of-state volumes and volumes from outside each Hospital's PSA and SSA have the potential to positively or negatively affect the success of the GBR model. In FY 2013, approximately five percent (5.0%) of the Hospital's total revenue came from non-Maryland residents.

Hospital	Out of State	
	Revenue	Percent
Northwest Hospital Center	\$8,173,397	3.3%
Sinai Hospital of Baltimore	\$39,643,401	5.8%
Levindale Hebrew Geriatric Center Hospital	\$1,108,325	2.0%
<b>Lifebridge Health GBR Hospital Total</b>	<b>\$48,925,123</b>	<b>5.0%</b>

If this percentage changes materially during the term of this Agreement, the HSCRC staff and the Hospital will evaluate the causes of the change to ensure that the goals and objectives of this Agreement, the GBR model and the final contract between CMMI and the State of Maryland are not being undermined by such changes.

## **XI. Readmissions, Quality and Reductions of Potentially Avoidable Utilization**

The new All-Payer Model established in the final contract between CMMI and the State of Maryland will include specific requirements for readmission reductions and quality improvements. In addition, the success of the new model depends on the effectiveness of the Maryland hospitals in achieving reductions in PAU in general and, in particular, for Medicare. By July 1, 2014, the HSCRC staff will establish targets for reductions in PAU. The achievement of these targets will be tied to payment in a way that is consistent with the Three Part Aim of improving care and reducing cost. Appendix C will contain the annual PAU reduction targets for the Hospitals and the associated HSCRC payment adjustment policies.

As part of this process, each Hospital will prepare a periodic plan for Population Health Improvement and reductions on PAU. To the extent possible, the plans should rely on evidence based approaches to accomplish the goals. HSCRC will work with hospitals to promote evidence based, standardized, regionalized approaches in an effort to ensure effective means of providing needed infrastructure. HSCRC will also work with hospitals to develop processes to review these plans, provide

## Appendix A-1: Hospital's Base Revenue Components by Hospital

### Lifebridge GBR Hospitals Hospital's Base Revenue Components

	Sinai Hospital of Baltimore	Northwest Hospital Center	Levindale	Total Lifebridge
<b>A. Base Approved Revenue</b>				
1. Approved Regulated Revenue	\$702,036,456	\$250,019,982	\$54,535,652	\$1,006,592,090
2. Increment (If any for GBR Investments) including in above amount <sup>[2]</sup>	2,327,881	809,628	176,667	3,314,176
3. Total Base Approved Revenue	702,036,456	250,019,982	54,535,652	1,006,592,090
<b>B. One Time Rate Adjustments and Annual Reversals (included in Approved Regulated Revenue above)</b>				
1. Assessments that Reverse Annually <sup>[1]</sup>	33,656,356	11,921,884	633,122	46,211,362
2. MHAC and QBR	(405,978)	94,122	-	(311,856)
3. Other one-time adjustments	-	-	-	-
4. Total one-time adjustments	33,250,378	12,016,006	633,122	45,899,506
<b>C. Revenue Excluded from Approved Regulated Revenue Under GBR but Subject to Rate Regulation: Out of State</b>	0	0	0	0
<b>D. Total Approved Revenue (A + C)</b>	<u>\$702,036,456</u>	<u>\$250,019,982</u>	<u>\$54,535,652</u>	<u>\$1,006,592,090</u>
 Note 1: Detail of FY 14 Assessments				
NSP I	\$760,665	\$268,984	\$62,513	\$1,092,162
NSP II	760,665	268,984		\$1,029,649
HCCF	8,115,882	2,848,389		\$10,964,271
Deficit	17,061,301	5,987,917		\$23,049,218
MHIP	6,309,787	2,337,365	545,547	\$9,192,699
HSCRC User Fee	301,334	128,018	15,530	\$444,882
MHCC User Fee	193,562	82,227	9,532	\$285,321
Newborn Hearing Screening	153,160	-		\$153,160
	<u>\$33,656,356</u>	<u>\$11,921,884</u>	<u>\$633,122</u>	<u>\$46,211,362</u>

Note 2: Second Installment of GBR Infrastructure Funding due 7/1/14 for Sinai & Northwest