AGREEMENT

BETWEEN

THE HEALTH SERVICES COST REVIEW COMMISSION

AND

<u>HOLY CROSS HEALTH</u>

REGARDING

GLOBAL BUDGET REVENUE AND NON-GLOBAL BUDGET REVENUE

CONTENTS

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This Agreement, made this 29th day of June, 2015, between the MARYLAND HEALTH SERVICES COST REVIEW COMMISSION (the "Commission" or "HSCRC") and Holy Cross Health (the "Hospital System") replaces and supersedes the Agreement between the HSCRC and Holy Cross Hospital under date of July 11, 2014, and is made on behalf of the following subsidiary entities: Holy Cross Hospital and Holy Cross Germantown Hospital (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 adjust the Hospitals' Approved Regulated Revenue as it deems necessary to ensure that the Hospital(s) receive(s) the revenue they needs 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 October 1, 2014 and will continue through June 30, 2015. On July 1, 2015, 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, 2014 through June 30, 2015 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, 2015. 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 permit it to operate efficiently and effectively in the public interest within the revenue constraints required by the GBR model.

2. The HSCRC staff will adjust the Base Approved Regulated Revenue of the Hospital that is subject to the GBR model to establish the Approved Regulated Revenue for the Rate Year(s) by applying a series of rate adjustments including the following:

a. The revenue will be adjusted to the Rate Year by multiplying it by 1 plus the annual Update Factor percentage(s) approved by the HSCRC for the Rate Year for hospitals operating under the GBR model. A portion of the revenues may not be updated, based on the policies then applicable, for revenues associated with Potentially Avoidable Utilization;

b. The revenue will be adjusted to reflect any performance-based purchasing rewards, penalties, scaling adjustments and hospital improvement targets contained in Appendix C that are applicable at the time to GBR hospitals. The HSCRC expects to develop additional value-based policies that will apply to GBR hospitals in the future. These policies will be incorporated into the annual update factor adjustment process;

c. The revenue will also be adjusted to reflect changes in the mix of the Hospital's payers or changes in approved differential amounts and uncompensated care levels;

d. The revenue will be adjusted to reflect the reversal of any previous one-time adjustments that were in effect during the year;

e. The revenue will be adjusted to reflect any adjustments pursuant to programs such as the readmissions reduction program's prescribed savings adjustment;[1]

f. The revenue will be adjusted to reflect any targeted revenue adjustments, if any, designed to ensure compliance with the limits of the new All-Payer model or the savings requirements established for the Medicare program in the final contract between CMMI and the State of Maryland;

g. The revenue may include adjustments to reflect changes in the expected service volumes of the Hospital that are driven by changes in the demographics as described in Appendix D. The policies governing demographic adjustments may be modified from time to time by the HSCRC. The demographic allowance may not be applied to revenues for Potentially Avoidable Utilization based on policies then applicable;

h. The revenue may include adjustments to reflect the relative efficiency of the Hospital. The HSCRC staff and the relevant Work Group(s) will engage in efforts to

[1] For SFY 2014 through 2018, the Hospital will be subject to a **Readmission Policy Adjustment.**

develop appropriate methods to measure and compare efficiency under the GBR model including measurements that will be applied on a per capita basis to ensure that hospitals that reduce their unnecessary volumes are not penalized on the basis of comparisons that focus exclusively on per case or per unit definitions of efficiency;

i. The revenue will be adjusted to reflect amounts or percentages that are imposed on the rates of all hospitals by the HSCRC to cover the costs of certain assessments.[2] These assessments will apply to the Hospital in the same manner in which they are applied to other hospitals;

j. The revenue will be adjusted to reflect revenue overages or underages pursuant to variances between the Hospital's actual revenue and its approved revenue for the previous Rate Year; and

k. The revenue may also be adjusted in other ways as needed to ensure that the revenue limits and performance improvements imposed by the final contract between CMMI and the State of Maryland are met.[3]

The result of these adjustments will be the amount of revenue which is herein referred to as the Approved Regulated Revenue of the Hospital for the Rate Year. The Approved Regulated Revenue may be further adjusted as described below for any Rate Year.

3. Other Adjustments

a. The HSCRC and the Hospital recognize that some services may be offered more effectively in an unregulated setting. When services covered by the GBR model are moved to an unregulated setting, the HSCRC staff will calculate and apply a reduction to the Hospital's Approved Regulated Revenue. At a minimum, the reduction will ensure that the shift provides a savings to the public and Medicare after taking into consideration the payment amounts likely to be made for the same services in an unregulated setting.

b. The HSCRC may initiate a review, or the Hospital System, on behalf of any Hospital may request an adjustment to the Hospital's Approved Regulated Revenue to reflect changes in the market share of that Hospital. The HSCRC staff and the relevant Work Group(s) will be engaged during CY 2014 (and thereafter) in efforts to develop and refine rate setting policies to appropriately adjust for the impact of market share changes. These policies will be designed to separate the impact of reductions in avoidable volumes and volume increases, to the extent possible, from market share changes.

c. The HSCRC staff will work with the Hospital and with other hospitals that adopt

[2] Health Care Coverage Fund, MHIP, Deficit Assessment, HSCRC and MHCC user fees, NSP, and CRISP are examples of such assessments currently in place and are subject to change by the Commission.

[3] For SFY 2014 through 2018, the Hospital will be subject to a **Readmission Policy Adjustment.**

the GBR model to calculate and evaluate any volume increases experienced by the Hospital and other hospitals that are induced by the expansion of health care coverage under the Affordable Care Act (“ACA”) in 2014 and 2015, for insured populations under the age of 65, net of reductions in volumes for uninsured populations. Based on the findings of this evaluation, the HSCRC staff may provide a one-time adjustment to the Hospital's Approved Regulated Revenue.[4]

d. The HSCRC staff will consider one-time adjustments to the Hospital’s regulated revenue for unanticipated events beyond the control of the Hospital that generate substantial increases in the Hospital’s utilization levels but only to the extent that the impact of such events on the Hospital materially and demonstrably exceeds the impact of similar events on other hospitals covered by the GBR model.

In summary, the GBR model is a new approach to hospital rate regulation in Maryland. The HSCRC and Hospital System, on behalf of the Hospitals agree to work together to address any significant unforeseen consequences of this Agreement to ensure that it meets the revenue constraints, savings targets and performance improvement requirements required by the final contract between CMMI and the State of Maryland.

V. Compliance

A. General and Overall Compliance

1. Each Hospital will be subject to any rate adjustments that are necessary to bring it into compliance with the Approved Regulated GBR Revenue. If the gross revenue charged by any Hospital exceeds the Approved Regulated GBR Revenue, the difference between the gross revenue charged and the Approved Regulated GBR Revenue, together with any penalties assessed, will be subtracted from the Approved Regulated GBR Revenue that would otherwise have been approved for the Hospital for the subsequent Rate Year. Conversely, if the gross revenue charged by the Hospital is less than the Approved Regulated GBR Revenue, the difference will be added to the Approved Regulated GBR Revenue of the Hospital for the subsequent Rate Year, except that undercharges below the corridors specified in this section of the Agreement and in Section B below will not be added to the Approved Regulated GBR Revenue for the subsequent Rate Year.

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[4] National estimates are projecting modest or little growth in hospital volumes resulting from expansion of access under ACA. However, HSCRC recognizes that the impact is unknown and that it is the intent of the HSCRC to provide a timely revenue adjustment for the impact of volume increases arising from the expansion of access to insurance. HSCRC staff will develop a methodology to identify such volume increase, and each Hospital will have the opportunity to submit supporting information and request an adjustment to its GBR Revenue Base.

2. Each Hospital agrees that it will not overcharge the limits of the Total Approved Regulated Revenue, and that it will take prompt action to gain compliance. In order to assure compliance, the HSCRC staff will apply penalties for charges exceeding the overall limits of the Approved Regulated GBR revenue, and such penalty amounts will be subtracted from the Approved Regulated GBR Revenue for the succeeding rate year as a one-time adjustment. Overcharge penalties will be applied based on the following tiers:

- For charges exceeding the limit up to .5% of the Approved Regulated GBR Revenue, there will be no penalty.
- For charges exceeding the limit from .51% up to 1%, there will be a 20% penalty applied.
- For charges exceeding the limit by more than 1%, there will be a 50% penalty applied.

The penalties will be summed and subtracted from the Approved Regulated GBR Revenue for the succeeding rate year. If the HSCRC staff determines that the Hospital intentionally overcharged, then the overcharge corridor exempting an overcharge of up to .5% will be eliminated, and a 20% penalty will be applied to the overcharge up to .5%.

3. For Non-Global Revenues that are included in the Total Approved Regulated Revenue, each Hospital must charge the same rates for Non-GBR that it charges for GBR Revenues. This may result in overall charge variations that are outside of the limits imposed by the GBR corridor. Nevertheless, the Hospital must monitor and adjust its revenues to stay within the overall limits of Total Approved Regulated Revenue. In order to ease the regulatory burden and allow for synchronizing the System, the following penalties will apply to Non-Global Revenues falling within the Total Approved Regulated Revenue for the Hospital:

- For charges exceeding the total approved revenue by more than 2%, calculated by multiplying actual units times approved rates, a 20% penalty will be applied.

Any penalty assessed will be subtracted from Total Approved Regulated Revenue for the succeeding Rate Year as a one-time adjustment.

3. Undercharges below the limit for Approved Regulated GBR Revenue will be subject to carryover limits, in order to assure the budgetary constraints of the All-Payer Model on a year-to-year basis. Undercharge limits will be applied as follows:

- For charges below the Approved Regulated GBR Revenue amount of up to .5% there will be no penalty.
- For charges below the Approved Regulated GBR Revenue amount of .51% up to 1%, 20% of the underage will not be added back to approved revenues as a one-time increase in revenues for the subsequent rate year.
- For charges below the Approved Regulated GBR Revenue amount below 1% and 2%, 50% of the underage will not be added back to approved revenues as a one-time increase in revenues

for the subsequent rate year.

- For charges below the Approved Regulated GBR Revenue amount below 2%, none of the underage will be added back to approved revenues as a one-time increase in revenues for the subsequent rate year.

5. Volume fluctuations near the end of the rate year may affect the Hospital's ability to comply with the overall corridors. The Hospital may submit a request for relief if there are unexpected volume fluctuations in the final months of the year. The HSCRC staff will review the request and make a determination whether to grant relief from the corridor.

B. Unit Rate Flexibility

Each Hospital will be expected to monitor and adjust its unit charges on an ongoing basis to ensure that it operates within the Annual Regulated GBR Revenue that is approved by the HSCRC under the GBR model and the revenue constraints that are applicable to its services that are regulated by the HSCRC and not covered by the GBR model. In order to facilitate each Hospital's compliance with these revenue constraints, the HSCRC will relax the unit rate compliance corridors that it generally applies to hospitals (and particular revenues) that are not governed by the GBR model. Specifically, each of the Hospitals will be permitted to charge at a level up to five percent (5%) above the approved individual unit rates without penalty. This limit may be extended to ten percent (10%) at the discretion of the HSCRC staff if the Hospital System, on behalf of the Hospitals, presents satisfactory evidence that the Hospital would not otherwise be able to achieve its approved total revenue for the Rate Year. Similarly, the Hospital will be permitted to charge at a level up to five percent (5%) below the approved individual unit rates without penalty if it needs to lower its charges to meet its revenue constraints. This limit may be extended to ten percent (10%) at the discretion of the HSCRC staff if the Hospital System, on behalf of a Hospital, presents satisfactory evidence that the Hospital needs this additional flexibility to meet its revenue constraints for the Rate Year. Each Hospital will generally need to spread rate adjustments across all centers, avoiding adjustments concentrated in a few rate centers, unless it has received approval from HSCRC staff for an alternative approach. Charges beyond the corridors shall be subject to penalties as specified in HSCRC regulations in COMAR 10.37.03.05.

C. December 31 Target

As indicated in Section V. A. above, each Hospital agrees that it will not overcharge the limits of the Approved Regulated GBR Revenue. In order to assure compliance with the All-Payer Model limits, each Hospital is provided a December 31 interim limit in Approved Regulated GBR Revenue of one-half of the total Approved Regulated GBR Revenue for the year, unless otherwise specified in the agreement. The Hospital agrees that it will maintain its charges at or below this limit in calculating revenue compliance for December 31 of the Rate Year.

VI. Monitoring of GBR Operation and Performance

The successful implementation of the GBR model will require strict adherence to the various revenue constraints, savings requirements, and performance targets that are contained in the final contract between CMMI and the State of Maryland. Therefore, the HSCRC will engage in a variety of monitoring and evaluation efforts to determine whether all of these requirements are being met and to ensure that it introduces any corrective actions that may be needed on a timely basis.

1. Market Share

The HSCRC and each Hospital will monitor the Hospital's market share on an ongoing basis by analyzing and identifying changes in the levels of the Hospital's patient volumes that are derived from its Primary Service Area (PSA) or Secondary Service Area (SSA) as defined in Appendix E. The HSCRC staff and the Hospital will also monitor the total level of services and revenues that are provided by the Hospital to Maryland residents who live outside of the Primary and Secondary service areas of the Hospital, or to patients who live outside of Maryland in other states or foreign countries, and will track (to the extent possible) any changes in in-migration and out-migration patterns and their effects on the Hospital.

The HSCRC will make appropriate adjustments in the Hospital's Approved Regulated Revenue based on significant changes in the Hospital's market share or service levels; provided, however, that the HSCRC does not intend to provide increases in the Approved Regulated Revenue of individual hospitals based on market share analysis for volume increases that are not offset by reductions in the Approved Regulated Revenue(s) of other hospitals. The HSCRC also does not intend to make revenue adjustments based on market share changes that would discourage the Hospital from reducing its level of Potentially Avoidable Utilization.

2. Case Mix/Severity Levels

The HSCRC will pay close attention to the overall case mix index and the severity levels within Diagnosis Related Groups ("DRGs") at each Hospital. If requested, the Hospital will demonstrate to the HSCRC that any reductions in its case mix index or its severity levels are not the result of deliberate efforts by the Hospital to deny, for inappropriate financial reasons, any services to particular patients, or treatments for particular conditions that fall within the scope of the medical capabilities of the Hospital and its attending medical staff. The HSCRC plans to review data from multiple sources, including The Chesapeake Regional Information System ("CRISP"), in its evaluation of case mix and severity changes at the Hospital and, more generally, in the hospital industry.

3. Changes in Ownership and Control and Related Service Relocations

Significant changes in the health care delivery system in each of the Hospital's Primary and Secondary Service Areas could influence the appropriateness of the Approved Regulated Revenue established for the Hospital under this Agreement. Therefore, the Hospital System on behalf of each

Hospital agrees to declare and describe, in Appendix G, any financial interest (or control) it holds in other hospitals or entities that provide services, including non-hospital services, in the Hospital's Primary and Secondary Service Areas, as of the Effective Date of this Agreement.

In addition, the Hospital System on behalf of each Hospital agrees to inform the HSCRC at least thirty (30) days in advance, in writing, or at the earliest practicable time thereafter, of any acquisitions or divestitures which it undertakes regarding such interests.[5] The HSCRC may request data from the Hospital, on a periodic or ongoing basis, regarding the utilization of the services provided by such related entities, to ensure that the Hospital complies with the GBR constraint through better management of its existing regulated services, and not by moving services from the HSCRC-regulated sector to unregulated sectors of the hospital or non-hospital environment in ways that do not comport with the objectives of the GBR model, the Three Part Aim, and the final contract between CMMI and the State of Maryland.

The Hospital will provide an annual disclosure and certification report, which is presented in Appendix F and Appendix G, regarding changes in the services it provides. The initial report will be due upon signing of this Agreement and additional reports will due on an annual basis within 30 days after the end of each subsequent Rate Year.

To the extent that the Hospital considers this information to be proprietary, it should be submitted to HSCRC in a separate document, clearly marking the materials as proprietary and confidential. HSCRC will maintain information so marked as confidential to the extent permitted by law giving consideration to the requirements for monitoring of the All-Payer model, This information will be made accessible to the federal government in carrying out its monitoring role regarding the All-Payer model, and to HSCRC auditors, and other parties conducting reviews and monitoring under this agreement.

4. Monthly Monitoring of Hospital

Within thirty (30) days after the end of every month during the Rate Years covered by this Agreement, each Hospital will provide the HSCRC with a brief written report designed to help the HSCRC to monitor the Hospital's compliance with this Agreement, to facilitate communication between the Hospital and the HSCRC staff, and to promote the success of the GBR model. This report should include the following information, which will be modified from time to time by HSCRC and the Hospital:

a. Year-to-date experience, for the current and prior year, for readmissions and comparisons of actual readmissions levels to targets, including inter-hospital readmissions experience from CRISP, for all payers combined and on a separate basis for Medicare;

b. Year-to-date experience for the current and prior year for Maryland Hospital Acquired Conditions ("MHACs")/Potentially Preventable Complications ("PPCs") and associated

[5] This would include the purchase or divestiture of physician practices, joint-venture arrangements with other providers to establish unregulated services that duplicate or could substitute for regulated services currently provided by the Hospital (such as, but not limited to, unregulated clinic, urgent care, or ambulatory surgery services), or other non-hospital services.

comparisons to MHAC/PPC targets;

c. Changes in payer mix year-to-date versus prior year;

d. Changes in market share;

e. Compliance with the Hospital's GBR constraint and the Hospital's plan to eliminate any revenue overages through charge reductions in the remainder of the Rate Year;

f. Trends in Medicare charges for the Hospital and an assessment of whether the Hospital has been successful to date in achieving the needed Medicare payment reductions;

g. Trends in total regulated revenue for the Hospital broken out between revenues covered by the GBR model and revenues not covered by it with the revenues covered by the GBR model further segregated into Medicare and non-Medicare components divided between Maryland and out-of-state components;

h. Trends in revenue per Equivalent Inpatient Admission ("EIPA")/Equivalent Case Mix Adjustment Discharge ("ECMAD");

i. Trends in costs, including cost per EIPA/ECMAD, including a discussion of changes in costs relative to reductions in volumes; and

j. Other information that the Hospital wishes to report regarding the successes, failures and ongoing challenges of implementing the GBR model and its related population health strategy. This supplemental information may include brief descriptions of the efforts (such as the use of emergency room care coordinators, transition care coordinators, case management, integration with community based programs, nursing home interventions, and coordination with physician delivery system changes) that the Hospital has undertaken which have been effective (or ineffective) in improving the efficiency, quality and/or processes of care. The objective of gathering such additional information is to develop a body of evidence that can be usefully shared with all Maryland hospitals that are operating under the GBR model.

The HSCRC recognizes that the collection and reporting of the information described above on a monthly basis may impose an unclear or excessive burden on the Hospitals; therefore, the HSCRC staff intends to work with hospital representatives to refine the monthly information reporting requirements to ensure that the Hospitals can provide the kinds of information needed by the HSCRC on a monthly basis without undue hardship.

VII. Evaluation of the Effectiveness of the GBR

As described above, the primary goal of the GBR model is to provide the Hospital with strong financial incentives to deliver medical care to its patients and its community in the most efficient and clinically effective ways that are consistent with the Three Part Aim.

The HSCRC staff shall evaluate the success of the GBR program established by this Agreement by measuring changes in the costs, quality and outcomes of medical care delivered by each Hospital. In these reviews, the HSCRC staff will pay particular attention to analyses of utilization trends pre-and post-implementation of the GBR model. The reviews will include evaluations of per capita hospital costs and, to the extent possible given data limitations, the total cost of health care in the Hospital's PSA and SSA. In addition, the HSCRC staff will examine the performance of the Hospital on the HSCRC's existing and future quality of care and outcomes metrics using existing standards and additional metrics that will be developed through the relevant Work Group(s).

The Hospital System, on behalf of the Hospitals, shall provide an annual report of its investment in infrastructure to promote the improvement of care delivery and reductions of Potentially Avoidable Utilization. This report will be due 90 days following the end of each fiscal year, and will include program descriptions, expenditures, and results.

VIII. Possible Future Modifications in the GBR Model to Achieve Improved Alignment of Incentives in the Health Care Delivery System

Under healthcare reform, a number of strategies are being considered to contain healthcare costs. For example, primary care medical homes, Accountable Care Organizations, and the bundling of services under single payment amounts are strategies that have been identified as possible ways to improve care while aligning providers for the efficient delivery of healthcare services. Health care reform efforts are progressing rapidly and may produce environmental changes that warrant some modifications to this Agreement. Therefore, the Hospital and the HSCRC staff agree to monitor such changes and to make changes in this Agreement, on a mutually acceptable basis, as needed in the future to accommodate or comply with future developments that are mandated or permitted by law and/or regulation.

IX. Other Potential Modifications

A. Approved Regulated Revenue Modifications

Each Hospital may request a reevaluation of its Approved Regulated Revenue for any Rate Year by submitting its request in writing to the HSCRC staff and including the supporting rationale and documentation for its request to the HSCRC staff. The HSCRC staff will make a determination to approve, modify, or deny the request of the Hospital under this agreement. When it deems necessary, the staff will prepare a recommendation regarding the request, and the HSCRC will review the staff recommendation and render a decision. Similarly, the HSCRC may open discussions with the Hospital regarding modifications to the GBR constraint based on its ongoing review and monitoring of the Hospital's operations, performance, market share changes and other factors. The HSCRC staff reserves the right to modify the GBR constraint in accordance with the terms of this agreement.

B. Approved Regulated Revenue Modifications Related to CON Projects

A Hospital may apply for and receive a "Certificate of Need" (CON) approval to provide a new service or to undertake a major capital project. In such instances, the Hospital may elect to petition the HSCRC staff for an associated adjustment to the Hospital's Approved Regulated Revenue. The Hospital will be expected to demonstrate to the satisfaction of the HSCRC staff that it is unable to provide the new service or to fund the major capital project within its existing revenue constraints. Requests of this kind will be evaluated by the HSCRC staff on a case-by-case basis. However, the Hospital must recognize that the new All-Payer Model that will be established in the final contract between CMMI and the State of Maryland limits the total amount of hospital revenue that can be approved within the State for any given period of time, and that this constraint will require any approvals of additional revenue for individual hospitals to pass highly stringent tests of financial and clinical necessity and to be funded by reductions in the revenue approved for other hospitals.

The HSCRC staff will work with the relevant Work Group(s) and MHCC to develop and refine 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 8.6 percent (8.6%) of the Hospital's total revenue came from non-Maryland residents. 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 evaluation and feedback on the results of the approaches, and to modify the approaches to improve the results.

XII. Termination and/or Renegotiation and Other Rights

A. Termination by the HSCRC

The HSCRC reserves the right to terminate this Agreement, with cause, at any time. For the purposes of this Agreement, "with cause" includes, but is not limited to, failure by the Hospital to provide high quality needed services as contemplated by this Agreement; the inappropriate shifting of hospital services to unregulated settings; failure to achieve total all payer or Medicare per capita revenue trends and/or performance targets that are consistent with the constraints and requirements imposed by the GBR model and the final contract between CMMI and the State of Maryland; or failure of the Hospital to comply with HSCRC regulations or policies.

The HSCRC will provide the Hospital with a reasonable opportunity to cure its failure to perform under this Agreement by adopting a corrective plan designed to eliminate the defects in its performance in a timely way. The corrective plan may include an immediate reduction in the Hospital's Approved Regulated Revenue; mandatory participation by the Hospital in a regional planning process focused on achieving the requirements of the All-Payer model; or other identified actions.

If the Hospital is unwilling to adopt the corrective plan described above, the HSCRC will have the right to terminate the Agreement with due consideration to the need of the Hospital to transition out of this Agreement and the need to maintain overall compliance with the requirements imposed on the State of Maryland by the final contract with CMMI. Termination of this Agreement for a Hospital does not, in and of itself, void this Agreement for the other Hospital.

B. Termination by Hospital System

Each Hospital will have the right to transition to an alternative rate setting approach after giving six months of written notice to HSCRC staff of its intent to change as of a specific date. The notice will provide a description of the Hospital's chief reasons for the proposed termination. The HSCRC staff will work with the Hospital to resolve any issues, including the possible recapture of volume support provided under this agreement, where volumes were decreased during the course of the agreement, or where infrastructure funding or other incentives were removed from the base. If the Hospital is transitioning to another model with a fixed revenue base, then these adjustments may not need to be evaluated. Any new agreement will need to be within the revenue limits and other performance tests and requirements imposed by the final contract between CMMI and the State of Maryland.

C. Other Rights

Nothing in this Agreement should be construed to prevent the HSCRC or Hospital System from undertaking any action that it is lawfully entitled to take, including exercising the right to initiate a full rate review by either the HSCRC or the Hospitals.

D. Other Provisions Relative to each Hospital

This section is provided to include terms and conditions applicable to a specific hospital:

<u>Holy Cross Hospital (“HCH”)</u>

1. Holy Cross Hospital is currently replacing beds under another Certificate of Need granted. HSCRC staff and the Hospital have not yet determined the impact of this project on the Global Budget of Holy Cross. Holy Cross and HSCRC staff will evaluate the impact through review of the CON application documents and a discussion with Holy Cross about how the capital costs should be treated under the new All-Payer Model. Any requested rate increase may require HSCRC approval. The MHCC and HSCRC will be evaluating capital policies under the new All-Payer model.
2. In order to assist in the tracking of potential market share changes between the Hospital and DC or Northern Virginia hospitals, Holy Cross will provide written periodic reports on cases transferred comparing the base period for calendar year 2013 to each subsequent year, noting the reasons for material changes.
3. The HSCRC and the Hospital expect for this agreement to be in place until June 30, 2016 or later, to allow the Hospital sufficient time to transition from CPE to GBR.
4. Holy Cross will work with the HSCRC staff to review the reporting requirements in the Global Budget agreement and provide assistance to HSCRC staff in developing standard formats and approaches that could be used industry wide. The HSCRC staff agrees to work with the industry to ensure that required reporting for this agreement does not result in an undue burden on the hospital staff.
5. HCH's GBR target will be adjusted prospectively in FY 2015 for anticipated volume shifts to HCGH. The prospective adjustment will commence on October 1, 2014 and be adjusted quarterly to reflect the most recent actual volume movement within the HCGH ESA (as defined in Appendix E).

HCGH is projecting revenue by quarter as follows in FY 2015:

	Rate Year 2015				
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
Volume Percent	0%	20%	35%	45%	100%
Annual Revenue (in thousands)	$63,775	$63,775	$63,775	$63,775	$63,775
Projected Quarterly Revenue	$0	$12,755	$22,321	$28,699	$63,775

HCGH revenue has been projected to have the following impact on HCH revenue:

	2015 Prospective Adjustment			
	Q2	Q3	Q4	Total
		(in thousands)		
% FY 2015 Revenue	20%	35%	45%	
Projected Revenue	$12,755	$22,321	$28,699	$63,775
2017 Projected Revenue (in 2015 dollars)	119,717	119,717	119,717	119,717
% of 2017 Revenue	11%	19%	24%	53%
Annual Impact of Redirected Services at Full Ramp Up	$34,439	$34,439	$34,439	$34,439
Projected Revenue Shift from Holy Cross	$3,669	$6,421	$8,256	$18,346
50% Variable Cost Factor	50%	50%	50%	50%
Holy Cross Prospective Adjustment*	$1,835	$3,211	$4,128	$9,173
Quarterly Reconciliation	January 31, 2015	April 30, 2015	July 31, 2014	

* Quarterly Adjustment will be modified based on actual experience from the previous quarter(s)

Holy Cross Health will reconcile actual revenue reductions related to volume shifts from the HCGH ESA quarterly in FY 2015.

Holy Cross Germantown Hospital ("HCGH")

6. HCGH, a 93-bed acute care hospital in Germantown, is expected to begin operations on October 1, 2014. HCGH will operate on a simplified Charge/Case model until such time as volumes reach maturity. It is anticipated that stabilization will be achieved in FY17, the third year of operations; at that time HCGH will move to a population based health reimbursement model.

   HCGH FY15 rates will be set at the HCH FY15 rate order. HCGH will remain linked to the HCH rate order until such time as volumes stabilize and HCGH transitions to a population health reimbursement model. HSCRC will monitor the impact of HCH rate realignment on HCGH revenue and determine if adjustments are necessary. HCGH's approved revenues will be based on unit rates and volumes of services, and cost plus mark-up plus fixed overhead percentage for supplies and drugs, as specified in the Order Nisi. HSCRC staff and the System on behalf of Hospitals will work to develop a monthly non-GBR revenue calculation that will provide a monthly accounting of total non-GBR revenues and rate compliance. The Hospital System on behalf of HCGH will provide both monthly and year-to-date revenue and rate compliance reports, adjusting for changes as necessary. The Hospital System, on behalf of the Hospitals, agrees to file these monthly reports 30 days after the end of the month, together with all other reports filed under the Agreement.

Effective for the year beginning July 1, 2015, if not before, the HSCRC staff will develop a charge per case/episode amount for non-GBR revenues to monitor continuing efficiency levels. A charge per case/episode monitoring amount will be developed based on the HCH revenue experience at June 30, 2014 or later, price leveled using applicable rate orders. The HSCRC and the Hospital System desire to maintain a monitoring approach that is simpler to maintain than the current CPC system. HSCRC staff and the System on behalf of the Hospital will work to develop a monthly charge per case reporting and monitoring approach. In the event that charge per case shows a pattern of deterioration for more than three months due to increasing resource use per case, the HSCRC will work with the Hospital System on behalf of the Hospital to promptly implement a limit in charge per case using the monitoring amounts already calculated.

HSCRC and the System will work towards inclusion of HCGH at the earliest date possible in the quality based reimbursement systems applicable to Maryland hospitals. This includes the QBR, MHAC, and readmission policies. The System and the staff will consider the opportunity to combine the results with HCH. At the latest, the HCGH will be subject to all quality based adjustments beginning in FY 2018, but HSCRC staff will seek to include the Hospital in the calculations earlier.

Initially, HCGH will be afforded the average uncompensated care levels of the State in its rates, neither contributing to nor receiving a distribution from the Statewide pool. HSCRC and the System will review the need for participation in the pool prior to FY 2018. At the current time, the plan is to continue to exclude the HCGH from contributions or distributions from the pool until FY 2017 or 2018, when it will have had an opportunity to have a full year of revenue to utilize in developing a predicted uncompensated care level.

HSCRC and the System will work towards including HCGH in a population based model or other incentive based approach consistent with the goals of the new All-Payer Model at the earliest date possible. When this occurs, HCGH will be entitled to the same rate adjustments as global budget hospitals, including a population adjustment and the inflation factor applied to global hospitals.

The revenues of HCGH will be updated for FY 2016 to reflect that it will commence with the payment of assessments effective July 1, 2015.

XIII. Definitions of Terms

Annual Update Factor: The update factor as approved by the Commission to apply to GBR hospitals in the State during the fiscal year, or a portion of the fiscal year.

Approved Regulated Revenue: For each Rate Year, the Hospital's approved revenue computed in accordance with this Agreement and specified in the Hospital's Order Nisi for the GBR for the particular Rate Year.

Approved Regulated Revenue Compliance and Related Adjustments: For each Rate Year, the Hospital's Approved Regulated Revenue will be compared to the Hospital's actual regulated revenue for the particular Rate Year. If the Approved Regulated Revenue exceeds the Hospital's actual regulated revenue, the amount of the excess will be added to the Hospital's Approved Regulated Revenue for the subsequent Rate Year as a One Time Adjustment.

If the Approved Regulated Revenue is less than the Hospital's actual regulated revenue, the amount of the shortfall will be subtracted from the Hospital's Approved Regulated Revenue for the subsequent Rate Year as a One Time Adjustment, except that undercharges below the corridor specified in subparagraph III. A will not be so included.

Base Approved Regulated Revenue: The total approved revenue of the Hospital for the initial year of the agreement as specified in Appendix A.

Charge per Episode ("CPE"): Hospitals that are under a charge per episode agreement that is based on discharges less readmissions.

Demographic Adjustment: The Demographic Adjustment is the calculation described in Appendix D and the adjustment factors shown therein that provide an adjustment to the Approved Regulated Revenue for population and age related volume changes. This factor will be updated on an annual basis.

Maryland Hospital Acquired Conditions Initiative: The HSCRC's Maryland Hospital Acquired Condition ("MHAC") measurement methodology that compares a hospital's risk-adjusted actual rate of MHAC to an expected or predicted rate of MHAC based on state-wide experience.

One Time Adjustments: The HSCRC makes one-time adjustments to the Hospital's rates in deriving the Hospital's Approved Regulated Revenue for the particular Rate Year The HSCRC removes the One Time Adjustments from the Approved Regulated Revenue in calculating Approved Regulated Revenue for a the subsequent Rate Year.

Potentially Avoidable Utilization ("PAU") includes utilization and revenue related to preventable admissions, readmissions (Inter and Intra hospital), Observation patients that would be reflected as a readmission if admitted, and Potentially Preventable Complications. Other categories of PAUs may be added by the HSCRC.

Quality-Based Reimbursement: The HSCRC's pay-for-performance initiative that links hospital performance (both relative and year-to-year) on a list of processes of care measures.

Rate Years: The Hospital's Rate Year corresponds to the State fiscal year that begins on July 1 each year and ends on June 30.

Readmission Policy Adjustment: In each Rate Year the derivation of the Hospital's Approved Regulated Revenue will include a Readmission Policy Adjustment calculated in accordance with HSCRC policies

Service Area: Primary and Secondary Service Areas represent the zip codes from which 75% of admissions are derived in the base period. This definition may be adjusted based on agreement between the Hospital and HSCRC.

Appendix E lists the Maryland zip codes and counties that make up the Hospital's Primary Service Area and its Secondary Service Area.

Unit Rates: The Approved Regulated Revenue per unit computed for each regulated revenue center in accordance with this Agreement as specified in the Hospital's Order Nisi for the particular Rate Year.

Unit Rate Compliance: The Hospital's compliance with its approved Unit Rate in each regulated revenue calculated pursuant to the HSCRC's Unit Rate compliance regulations; however, with relaxed corridors as described in this agreement.

In Witness whereof, the Parties have executed this Agreement and have this date caused their respective signatures to be affixed hereto:

Attest: Julie D. Keese by ______ Date 6/29/15

Chief Financial Officer
Holy Cross Health

Attest: ______ by ______ Date 6/30/15

Executive Director
Health Services Cost Review Commission

Appendix A: Hospital's Base Revenue Components and Order Nisi

A.	**Base Approved Regulated Revenue**		**$ 481,639,625**
	1.	Approved Regulated Revenue	$ 481,639,625
	2.	Increment (If Any) for GBR Investments included in above amount	$ 1,766,685
B.	**One Time Rate Adjustments and Annual Reversals (included in Approved Regulated Revenue above)**		
	1.	Assessments that Reverse Annually	$ 24,189,478
	2.	MHAC and QBR	$ (2,963,402)
	3.	Other one-time adjustments	$ None
	4.	Total one-time adjustments	$ 21,226,076
C.	**Holy Cross Germantown Charge Target – Subject to Rate Regulation, but is Currently Excluded From Approved Revenue Under the GBR**		$ 64,120,355
D.	**Total Approved Revenue Per Order Nisi**		**$ 481,639,625**

Appendix B: Revenues and Services Excluded from GBR Model and General Description of Rate Setting Requirements for Excluded Revenues

Holy Cross Germantown Hospital

Charges for HCGH will be based on the unit rates provided in the Order Nisi. Charges for supplies and drugs will be based on cost plus approved markup and a fixed percentage of overhead. The Hospital's revenue will be updated using the approved update factor less the efficiency adjustments applied for non-GBR revenues. Revenues will be adjusted at 100% variable, until FY 2018 or when the Hospital reaches its projected CON volumes, whichever comes earlier.

Effective for the year beginning July 1, 2015, if not before, the HSCRC staff will develop a charge per case/episode amount for HCGH revenues to monitor continuing efficiency levels. A charge per case/episode monitoring amount will be developed based on revenue experience at June 30, 2014 of HCH. The HSCRC and the Hospital System desire to maintain a monitoring approach that is simpler to maintain than the current CPC system. HSCRC staff and the Hospital System on behalf of HCGH will work to develop a monthly non-GBR charge per case reporting and monitoring approach. In the event that charge per case shows a pattern of deterioration for more than three months due to increasing resource use per case, the HSCRC will work with the Hospital System on behalf of the Hospital to promptly implement a limit in charge per case using the monitoring amounts already calculated.

No later than FY2018 HCGH will HCGH transition to the convening HSCRC Population Health based reimbursement model.

HCGH is projecting revenue by quarter as follows in FY 2015:

	Rate Year 2015				
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
Volume Percent	0%	20%	35%	45%	100%
Annual Revenue (in thousands)	$63,775	$63,775	$63,775	$63,775	$63,775
Projected Quarterly Revenue	$0	$12,755	$22,321	$28,699	$63,775

Appendix C: Potentially Avoidable Utilization Targets

To be determined by HSCRC and workgroup process. Estimated availability at end of February.

1. Targets

a. Readmission and Re-Hospitalization Reduction Targets

b. MHAC Targets

2. Policy References

3. Description of Methodologies Linking Achievement of Targets and Payment Levels

Appendix D: Demographic Adjustment

Hospital will be eligible for a demographic adjustment under the HSCRC policies in effect on an annual basis.

Appendix E: Definition of Hospital's Service Area

The HSCRC will use zip codes and/or counties for market analysis.

Holy Cross Hospital
75% PSA and SSA Zip Codes

Zip Code	County	Total Charges Fiscal 2013	Percent of Total Charges	HCH Defined PSA/SSA
20904	MONTGOMERY	$47,259,458	10.2%	PSA
20902	MONTGOMERY	37,501,944	18.4%	PSA
20906	MONTGOMERY	33,858,539	25.7%	PSA
20901	MONTGOMERY	24,500,675	31.0%	PSA
20910	MONTGOMERY	24,438,887	36.3%	PSA
20903	MONTGOMERY	11,337,903	38.8%	PSA
20783	PRINCE GEORGES	10,433,509	41.0%	PSA
20853	MONTGOMERY	9,139,960	43.0%	PSA
20705	PRINCE GEORGES	8,490,505	44.9%	PSA
20895	MONTGOMERY	8,151,145	46.6%	PSA
20912	MONTGOMERY	7,119,200	48.2%	PSA
20852	MONTGOMERY	6,642,350	49.6%	PSA
20878	MONTGOMERY	6,316,806	51.0%	SSA
20874	MONTGOMERY	6,073,416	52.3%	SSA
20877	MONTGOMERY	5,758,605	53.5%	SSA
20774	PRINCE GEORGES	5,757,728	54.8%	SSA
20707	PRINCE GEORGES	5,685,123	56.0%	PSA
20782	PRINCE GEORGES	5,684,984	57.3%	PSA
20785	PRINCE GEORGES	5,531,602	58.5%	SSA
20706	PRINCE GEORGES	5,426,877	59.6%	SSA
20905	MONTGOMERY	5,383,553	60.8%	PSA
20886	MONTGOMERY	5,197,354	61.9%	SSA
20866	MONTGOMERY	5,165,561	63.0%	PSA
20708	PRINCE GEORGES	5,163,943	64.2%	SSA
20770	PRINCE GEORGES	4,512,684	65.1%	PSA
20850	MONTGOMERY	4,503,614	66.1%	SSA
20772	PRINCE GEORGES	4,197,761	67.0%	SSA
20784	PRINCE GEORGES	4,126,297	67.9%	SSA
20740	PRINCE GEORGES	3,953,598	68.8%	PSA
20744	PRINCE GEORGES	3,792,442	69.6%	
20743	PRINCE GEORGES	3,763,180	70.4%	SSA
20721	PRINCE GEORGES	3,600,804	71.2%	SSA
20747	PRINCE GEORGES	3,488,959	72.0%	SSA
20735	PRINCE GEORGES	3,310,337	72.7%	
20851	MONTGOMERY	3,164,049	73.4%	PSA
20737	PRINCE GEORGES	3,031,552	74.0%	SSA
20879	MONTGOMERY	2,990,131	74.7%	SSA
20876	MONTGOMERY	2,813,616	75.3%	SSA

Holy Cross Germantown Hospital

20837	Montgomery County
20838	Montgomery County
20839	Montgomery County
20841	Montgomery County
20842	Montgomery County
20850	Montgomery County
20851	Montgomery County
20853	Montgomery County
20855	Montgomery County
20871	Montgomery County
20872	Montgomery County
20874	Montgomery County
20875	Montgomery County
20876	Montgomery County
20877	Montgomery County
20878	Montgomery County
20879	Montgomery County
20886	Montgomery County

Appendix F: Annual Disclosure and Certification Regarding Changes in Services Provided (Due 30 days after the end of the Rate Year)

A. The following services were shifted in whole or in part to unregulated settings not regulated by the HSCRC:

______**None**____

B. The following services were shifted in whole or in part to the regulated activities of other hospitals:

______**None**____

C. Or: The Hospital is not aware of any services that were shifted in whole or in part to unregulated settings.

Anne D. Gillis (signature) 6/29/15

Signature of Officer of Hospital Date

Anne D. Gillis
Name (Please Print)

CFO
Title

301-754-7035
Telephone Number

gillsa@holycrosshealth.org
E Mail Address

Appendix G: Hospital Financial Interest, Ownership, or Control of other Hospital or Non-Hospital Services Provided Within the Service Area

The Hospital owns, has a substantial financial interest in, controls, or is financially or organizationally related to the following provider organizations or systems.

Holy Cross Health Center in Silver Spring
Holy Cross Health Center in Gaithersburg
Holy Cross Health Center in Aspen Hill
Holy Cross Radiation Treatment Center
Private Home Services
Holy Cross Dialysis Center in Silver Spring
Holy Cross Dialysis Center at Woodmore in Mitchellville
Holy Cross Hospital Medical Adult Day Center
Maryland Physicians Care
Barry N. Rosenbaum practice (physician)
Trinity Health Home Care and Hospice
The Sanctuary at Holy Cross (Trinity Health Senior Living Communities)

In addition, we are currently negotiating with the following to provide services in a medical office building to be located adjacent to Holy Cross Germantown Hospital:
RadNet (imaging services)
MedAccess (urgent care services)

Appendix H: Calculation of Market Share

While the following calculation is not binding, it is suggested as a calculation that can be used to examine possible changes in market share given the complexities arising from evaluating shifts in market share under the incentives of population-based payment models. The HSCRC staff will instruct the appropriate Work Group(s) to examine this issue and to recommend policies to the HSCRC.

1. Volume of Services: In considering whether adjustments to the Hospital's Approved Regulated Revenue are warranted for shifts in market share, the changes in the service levels of the Hospital and of other hospitals in the Hospital's Service Area (i.e., its PSA and its SSA) will need to be calculated for selected services.   These service levels will be calculated for the Base Year and for each Rate Year.

2. The measure of the volume of service will be calculated for the Hospital and for each other applicable Hospital separately for inpatient and outpatient services

3. The outpatient services will be converted to an inpatient equivalent volume of services.

4. For each hospital, including the GBR Hospital, which provides services in the particular category of service, the Hospital's Volume of Service will be calculated as follows:

    a. The Inpatient Volume of Services will equal the number of case mix adjusted discharges (CMADs) of the Hospital's inpatients whose services are included in the particular category; and

    b. The Outpatient Volume of Services will be computed as follows:

        i. The Hospital's Unit Charge will be calculated as the average charge per CMAD over all of the Hospital's inpatients, excluding outliers.

        ii. The outpatient equivalent CMADs (ECMADs) will be calculated as the Hospital's total charges, exclusive of the charges of inpatients included in the count of CMADs, divided by the Unit Charge.

5. The Hospital's volume of service for the particular category of services will equal the sum of the number of CMADs calculated in Step 4(a) and the number of ECMADs calculated in Step 4(b).

6. The calculations described above will be performed separately for PAUs, in recognition that a primary objective of the Agreement is to reduce PAUs. The HSCRC will ensure that the Hospital is not penalized for its PAU reductions in the market share calculation.

7. The total volume of service of a particular category of services which are provided by several hospitals will equal the sum of the volume of services for each hospital as calculated above.

The HSCRC will continue to work with the Hospital and the relevant Work Group(s) on the methods for calculating service level and market share changes. The parties recognize that this effort is a "work in progress" and they will work cooperatively to improve the methods of evaluating changes in market share and changes in efficiency levels.

Appendix I: Readmission Policy Adjustment

The Hospital's readmission savings requirement for the Rate Year is as follows:
The readmissions savings requirement for the 2014 rate year applied to each Hospitals' rates is a -0.21%. Future year's rate reductions will be determined by HSCRC policy and in connection with work group activities.