AGREEMENT

BETWEEN

THE HEALTH SERVICES COST REVIEW COMMISSION

AND

UNIVERSITY OF MARYLAND MEDICAL SYSTEM

REGARDING

GLOBAL BUDGET REVENUE AND NON-GLOBAL BUDGET REVENUE

CONTENTS

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This Agreement, made this 3rd of July, 2014, between (the MARYLAND HEALTH SERVICES COST REVIEW COMMISSION (the "Commission," or "HSCRC") and University of Maryland Medical System ("Hospital System," or "UMMS") on behalf of the following subsidiary entities: University of Maryland Medical Center (including the Marlene and Stewart Greenebaum Cancer Center and the R Adams Cowley Shock Trauma Center), UM Baltimore Washington Medical Center, UM Charles Regional Medical Center, UM Rehabilitation and Orthopaedics Institute, University of Maryland Medical Center Midtown Campus, UM Harford Memorial Hospital, UM Upper Chesapeake Medical Center, and Queen Anne's FSE (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 System'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 System 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 GBR Revenue" (Approved Regulated GBR 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, each UMMS hospital agrees 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 Hospitals System 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 Hospitals agree that they will comply with these policies.

The HSCRC will carefully monitor each Hospital's activities under this Agreement, including any service discontinuations, shifts of services from each Hospital to other related or non-related hospitals or non-hospital providers, changes in each 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 has been established by CMMI and the State of Maryland. The HSCRC will adjust each Hospital's Approved Regulated Revenue as needed to ensure that each Hospital receives the revenue it needs to meet its obligations under this Agreement.

The Hospital System agrees to comply with the policies of the HSCRC with respect to any services it provides that are regulated by the HSCRC that are not covered under the GBR model. The services that are not covered by the GBR model (i.e., the Non-GBR services) and the associated Non-GBR revenue 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 the Hospital System in accordance with Section XII.

III. Revenue Governed by Agreement

This Agreement will apply to all of the inpatient and outpatient revenues of each Hospital in the Hospital System 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 that are excluded from the GBR model, as specified

in Appendix B, will be subject to the applicable HSCRC rate setting policies 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 Total Approved Regulated Revenue (TARR) for each Hospital, which shall mean the approved revenue for services covered by the GBR model, and the terms and provisions governing it, and the approved revenue associated with services that are not covered by the GBR model, for each Rate Year. The Total Approved Regulated Revenue and the associated Unit Rates for each Hospital will be set forth in each Hospital's Order Nisi for the particular Rate Year. Any revenues excluded from the GBR limits 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 GBR Revenue of each Hospital for the July 1, 2013 through June 30, 2014 period is specified in Appendix A. As shown in Appendix A, the Approved Regulated GBR Revenue includes several components: the Permanent Base Revenue, which may include permanent positive or negative adjustments, which is trended forward to establish the Approved Regulated GBR Revenue for RY 2014 through a series of Annual or Periodic adjustments for inflation, volume and other items including various assessments and settlements. Appendix A also identifies the approved revenue for services that are not covered by the GBR model (i.e., the Approved Regulated Non-GBR Revenue) and the Order Nisi for each Hospital for the particular Rate Year. Appendix B provides additional details regarding the Non-GBR revenues and services which are being approved pursuant to the applicable HSCRC rate setting policies. Appendix A and Appendix B will be updated as needed by the HSCRC on a periodic basis.

The Approved Regulated GBR Revenue of each Hospital may include permanent or temporary rate adjustments designed to provide each Hospital with funds it needs 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 A (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 of the Basic Components of each Hospital's Approved Regulated GBR Revenue

The HSCRC intends to develop the Approved Regulated GBR Revenue of each Hospital for any Rate Year subsequent to RY 2014 in the following way:

1. Initially, the HSCRC staff will determine the Base Approved Regulated GBR Revenue of each Hospital by adjusting each Hospital's approved revenue for the 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 GBR Revenue of each Hospital to establish the Approved Regulated GBR 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 associated with Potentially Avoidable Utilization (PAU) may not be updated based on the policies then applicable;

   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 each 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;

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

g. The revenue may include adjustments to reflect changes in the expected service volumes of each 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 each Hospital. The HSCRC staff and the relevant Work Group(s) will engage in efforts to 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 each 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 each Hospital's actual revenue and its approved revenue for the previous Rate Year (as described in Section V.); 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 GBR Revenue of each Hospital for the Rate Year. The Approved Regulated GBR Revenue may be further adjusted as described below for any Rate Year.

3. Other Adjustments

a. The HSCRC and the Hospital System 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.

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[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.**

b. The HSCRC may initiate a review of, or the Hospital System, on behalf of any Hospital may request an adjustment to any Hospital's Approved Regulated GBR 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 System and with other hospitals that adopt the GBR model to calculate and evaluate any volume increases experienced by each 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 the 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 contained in the final contract between CMMI and the State of Maryland.

V. Compliance

A. General Compliance Under the GBR Model

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 the Hospital exceeds the Approved Regulated GBR Revenue, the difference between the gross revenue charged and the Approved Regulated GBR Revenue will be subtracted from the Approved Regulated GBR Revenue that would

[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 Hospital will have the opportunity to submit supporting information and request an adjustment to its GBR Revenue Base.

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 corridor specified in Section B below will not be added to the Approved Regulated GBR Revenue for the subsequent Rate Year.

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 presents satisfactory evidence that it 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 presents satisfactory evidence that it 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. Overall Compliance Corridors

The overall compliance corridors (overcharge and undercharge) for the total Approved GBR Regulated Revenue and the Approved Regulated Non-GBR revenue will be .5%, with such amount subject to change from time to time in accordance with HSCRC policies. 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 within the boundaries of unit rate compliance that are specified above. Charges beyond the corridors shall be subject to penalties as specified in HSCRC regulations in COMAR 10.37.03.05.

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 the Hospital System will monitor each Hospital's market share on an ongoing basis by analyzing and identifying changes in the levels of each 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 System will also monitor the total level of revenues and services that are provided by each Hospital to Maryland residents who live outside of the Primary and Secondary service areas of each 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 each Hospital.

The HSCRC will make appropriate adjustments to each Hospital's Approved Regulated GBR 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 GBR Revenue of individual hospitals based on market share analysis for volume increases that are not offset by reductions in the Approved Regulated GBR Revenue(s) of other hospitals. The HSCRC also does not intend to make revenue adjustments based on market share changes that would discourage any 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 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 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 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 System on behalf of each 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 System 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, the Hospital System will provide the HSCRC with a brief written report designed to help the HSCRC to monitor each Hospital's compliance with this Agreement, to facilitate communication between the Hospital System 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 comparisons to MHAC/PPC targets;

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

[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.

d. Changes in market share;

e. Compliance with each 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 each Hospital and an assessment of whether each Hospital has been successful to date in achieving the needed Medicare payment reductions;

g. Trends in total regulated revenue for each 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 System 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 each 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 Hospital System; therefore, the HSCRC staff intends to work with hospital representatives to refine the monthly information reporting requirements to ensure that the Hospital System 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 each 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 each Hospital's PSA and SSA. In addition, the HSCRC staff will examine the performance of each 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 System 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 GBR Revenue Modifications

Each Hospital may request a reevaluation of its Approved GBR 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 System regarding modifications to the GBR constraint based on its ongoing review and monitoring of each 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 GBR 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 5.5 percent (5.50%) of the Hospital System's total revenue came from non-Maryland residents. If this percentage for any individual hospital 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.

	Out-of-State	
Hospital	Revenue	Percent
UMMC	91,000,451	7.33%
STC	20,825,218	11.04%
BWMC	7,338,009	1.95%
Charles Regional	5,233,973	3.83%
UMROI	5,296,637	4.60%
Midtown	3,447,313	1.59%
Harford	3,155,325	2.98%
Upper Chesapeake	10,333,223	3.64%
Queen Anne's	172,309	3.45%
University GBR Hospitals	146,802,458	5.50%

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 includes 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 Hospital 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 Potentially Avoidable Utilization. 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 System with a reasonable opportunity to cure the Hospital's 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 Hospitals.

B. Termination by Hospital

Each Hospital will have the right to transition to an alternative rate setting approach after giving six months of written notice to the 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 removal of infrastructure funding or other incentives from the revenue 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 Hospital.

D. Other Provisions Relative to the Hospital

This section is provided to include specific terms and conditions that are applicable to the particular Hospital that is part of this Agreement:

1. **UMMS**
   As illustrated in Appendix A, the GBR agreement for UMMS is structured to be a system wide agreement with sub-agreements for each UMMS Maryland hospital. The HSCRC will monitor compliance with the Global Budget target for each Hospital. However, the HSCRC will allow revenue to be redistributed among UMMS Hospitals for movement of services to achieve the desired goals of the new All-Payer model, following HSCRC rate setting protocols and HSCRC staff review. This structure will allow UMMS to potentially move services within the System to achieve the desired goals of the new waiver. Should UMMS move services from hospital to hospital, the GBR cap for each particular hospital will be adjusted accordingly after review by HSCRC staff; however the system wide GBR amount will not change.

2. UMMC

a. Categorical Cases

University of Maryland Medical Center (UMMC) has agreed to establish a global budget for Categorical Cases as outlined in Appendix B of this agreement. The budget for categorical cases will capture inpatient cases that include transplants, highly specialized cancer care, research cases as well as outpatient bone marrow transplant cases. UMMC will provide a prospective global budget for Maryland residents for Categorical cases, which shall be incorporated into the global budget of UMMC after review by HSCRC staff for reasonableness. UMMC shall report its actual experience on a monthly basis, including the number of cases, the DRG, severity level, total charges, and the actual cost of organ acquisition and drugs. The annual budget will provide for a rebasing and trend for these services, taking into account the higher of a 50% variable cost factor or the statewide variable cost factor for volume changes, if changed from current policies, actual costs of drugs and organ acquisition, and a fixed budget for hospital overhead associated with supplies, drugs and organ acquisition. Changes in volumes of services above or below the level budgeted, as well as increases in organ acquisition and drug costs, will be considered when developing the budget of a succeeding year.

b. Acute Care Transfers

UMMC plays a distinct role in the health care system by treating a large proportion of highly acute cases, accepting regional referrals, and serving as a center for clinical and technological innovation in the State. For global models to be successful in Maryland, UMMC must be seen as a statewide resource for tertiary and quaternary care. HSCRC staff believes that unique regulatory treatment must be given to specific clinical service lines at UMMC operating under a global model that will allow UMMC to function effectively within this new payment structure. By adapting the model to fit the needs of UMMC, more revenues can be included under global models, with the advantage of improving the predictability of revenue budgets along with the alignment of incentives to reduce avoidable volumes.

Under GBR, hospitals are incentivized to lower expenses and volume by taking measures to reduce avoidable utilization and promote care management and quality improvement. This may result in community hospitals transferring complex cases to UMMC in order to get patients the advanced care they need and reduce the high costs associated with those patients. Utilizing UMMC as a regional referral center may lower the total cost of care and improve outcomes for critically ill patients and thus be beneficial to the entire Maryland health system. UMMC must have the capacity to take on the possible influx of complex cases without facing financial penalty under a global model.

HSCRC staff is currently working with the industry to develop an approach to adjust GBR budgets of hospitals for changes in the level of transfers. HSCRC staff is evaluating transfers in from non-system hospitals to Johns Hopkins Hospital and University Hospital (including the

Shock Trauma Center). The approach under development will involve monitoring of transfers-in. If transfers-in from a particular hospital increase beyond a set percentage (e.g., population based adjustment), it is expected that a fixed dollar amount per case will be charged to the GBR budget of the transferring hospital and credited to the GBR budget of the UMMC. Conversely, it is expected that reductions in transfers would result in reductions in the UMMC budget and possible increases in a particular hospital's budget at a fixed allowance. The expected numbers of cases and costs might be rebased to reflect changing conditions and case mix. This model will allow community hospitals to provide patients the advanced care they need and shift those potentially expensive cases to UMMC at a predetermined cost, while also allowing UMMC to handle increasing numbers of severe cases when warranted.

HSCRC staff will work with the Hospital System to prepare a methodology and additional documentation regarding a base period for transfers in and a budget amount per transfer case for expected implementation in FY 2015. See Appendix B for further detail regarding Transfer-In payment methodology.

This policy will require continuing evaluation and refinement as the State gains more experience under the Model.

c. Out of State

Revenues for non-Maryland residents will be excluded from the global budgets for UMMC, including the Shock Trauma Center. Revenues excluded from the global budget will be subject to all rate setting policies of the HSCRC, except that volume changes will not be constrained by the global budget. Volume changes will not be subject to a fixed cost adjustment, except in the case of overhead related to supplies, drugs, and organ acquisition revenue centers.

For non-GBR revenues, approved revenues will be based on unit rates and volumes of services, and cost plus mark up plus fixed overhead 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. HSCRC recognizes that there may be adjustments to classification of revenues between in-state and out-of-state of prior months. The Hospital System on behalf of Hospitals 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. The HSCRC and the System on behalf of the Hospitals will monitor for any charging patterns that could shift revenues out of State and reduce charges under the GBR. The Hospitals will not be permitted to recover any underages from out of state charge shifts through the GBR.

Effective for the year beginning July 1, 2014, the HSCRC staff will develop a charge per case/episode amount for non-GBR revenues to ensure continuing efficiency levels. A charge per case/episode amount will be developed based on the permanent out-of-state revenue experience at

June 30, 2014. HSCRC staff and the Hospital will develop the amounts using state-wide weights with outlier definitions using LOS. 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 Hospitals 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.

d. Shock Trauma

Shock Trauma ("STC") plays a distinct role in the health care system by serving as the only Primary Adult Resource Center in the State of Maryland. The Shock Trauma Center is recognized as one of the international standard setters for injury care and prevention. It functions as a multidisciplinary clinical, education, and research institute dedicated to prevention and management of severe injury and its consequences. As the only center of its kind in Maryland, STC cannot be appropriately benchmarked or compared to other providers in the State. As such, STC (as defined in Appendix B) will require special analysis and consideration in making any market share adjustments. STC will also require special consideration in any efficiency evaluation. Should MIEMS dictate a change in field protocol, which significantly increases or decreases the volume at STC, a hospital specific market share calculation will be calculated and a market share adjustment will be made to STC if needed.

3. University of Maryland Medical Center Midtown Campus ("MTC")

a. Bon Secours and West Baltimore Services

MTC plays a significant role in health care delivery for West Baltimore that it shares with several other hospitals. Volume shifts among hospitals in West Baltimore can occur with changes in admitting patterns, Medicaid managed care enrollment, availability or resources, care coordination efforts, and other factors. HSCRC will work together with all of the hospitals in West Baltimore to develop an approach to monitor market share shifts. A market share adjustment approach is currently under development and will be applied. Special techniques may need to be applied to evaluate changes, including review of patient movement across hospitals using CRISP master patient indices

4. UM Rehab & Orthopaedics Institute (UMROI)

a. Market Share

UMROI plays a distinct role in the health care system by acting as a statewide resource for specialized rehabilitation services for orthopedics, neurological and post traumatic deficits. For global models to be successful in Maryland, UMROI must be seen as a statewide and regional resource for specialized rehabilitation services. Due its size & specialized nature, the HSCRC

recognizes that a standard market share calculation may not appropriately capture changes in patient volume. A focused review of market share will need to be undertaken, including possible consideration of non-acute care resources. This approach will require continuing evaluation and refinement as the State and the Hospital gain more experience under the Model.

5. **Charles Regional Medical Center ("CRMC")**

Revenues for regulated part B services will be excluded from the global budgets for CRMC. Revenues excluded from the global budget will be subject to all rate setting policies of the HSCRC, except that volume changes will not be constrained by the global budget. Volume changes will not be subject to a fixed cost adjustment.

6. **Upper Chesapeake Medical Center ("UCMC")**

In October 2013, UCMC opened its Cancer Center which provides outpatient oncology services including chemotherapy, infusions, and radiation therapy. As part of the GBR Revenue calculations, revenues were increased at UCMC and reduced at UMMC and Harford Memorial, recognizing the shift in resources provided within the System. HSCRC staff and the Hospital System will work together to ensure that this adjustment that has already been made is taken into account in evaluating market share changes in the UCMC service area.

7. **Queen Anne's Emergency Department ("QAED")**

In FY 2014, QAED obtained a level II Emergency Room designation. As a result of the emergency department's new status, patient care volumes that were historically sent to other facilities can now be treated at QAED. Due to the small size of the facility, it is anticipated that any changes in QAED market share will not reach the standard minimum threshold requirement in the statewide market share policy; thus, a special market adjustment is required.

HSCRC staff will work with QAED to monitor market share of emergency room visits in both its PSA and SSA. Should the facility experience a significant change in market share of emergency room visits, HSCRC staff will work with the Hospital System to adjust the global budget of the facility in accordance with this agreement and developing HSCRC policies.

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

If the Approved Regulated GBR Revenue is less than the Hospital's actual regulated revenue for the GBR services for the particular Rate Year, the amount of the shortfall will be subtracted from the Hospital's Approved Regulated GBR 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 Case ("CPC"): Hospitals that are under a charge per case agreement that is based on the total revenue per discharge.

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 GBR 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 GBR Revenue for the particular Rate Year. The HSCRC removes the One Time Adjustments from the Approved Regulated GBR Revenue in calculating Approved Regulated GBR 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 to its own performance and to the performance of other hospitals in a given year and on a year-to-year basis based 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 Total 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.

Categorical Cases: Cases that were previously excluded from the Charge Per Case limits due to the quaternary nature of the care and the variation in cost per case. The definition of these cases for Johns Hopkins Hospital is included in Appendix I.

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

Total Approved Regulated Revenue (TARR): The total approved revenue of the Hospital for the particular Rate Year including the Approved Regulated GBR Revenue and the Approved Regulated Non-GBR Revenue as specified in Appendix A.

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 center calculated pursuant to the HSCRC's Unit Rate compliance regulations 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: Alicia Cunningham by Robert A. Chrencik Date 7/3/14

Chief Executive Officer
University of MD Medical System

Attest: Carter Grisim by Donna Kuc Date 7/4/14

Executive Director
Health Services Cost Review Commission

Appendix A: Hospital's Base Revenue Components by Hospital

University GBR Hospitals

Hospital's Base Revenue Components

	University of Maryland	University of Maryland Shock Trauma	Baltimore Washington Medical Center	Charles Regional Medical Center[2]	Rehabilatition and Orthopaedics Institute	Midtown	Harford Memorial Hospital	Upper Chesapeake Medical Center	Queen Anne's FSE	Total University
A. Base Approved Revenue										
1. Approved Regulated Revenue	$1,192,843,953	$177,458,623	$393,555,941	$144,514,525	$118,349,210	$221,712,410	$103,938,098	$305,743,020	$4,912,838	$2,663,028,618
2. Increment (If any for GBR Investments) including in above amount	3,891,437	577,105	1,275,129	467,860	383,053	709,117	-	-	15,915	$7,319,615
3. Total Base Approved Revenue	1,192,843,953	177,458,623	393,555,941	144,514,525	118,349,210	221,712,410	103,938,098	305,743,020	4,912,838	$2,663,028,618
B. One Time Rate Adjustments and Annual Reversals (included in Approved Regulated Revenue above)										
1. Assessments that Reverse Annually [1]	64,547,434	10,297,648	18,224,310	6,696,546	5,833,289	10,965,792	5,216,052	14,953,970	-	$136,735,041
2. MHAC and QBR	612,166	-	(66,438)	89,848	103,643	407,000	166,032	245,094	-	$1,557,345
3. Other one-time adjustments	-	-	-	-	-	-	-	-	-	$0
4. Total one-time adjustments	65,159,600	10,297,648	18,157,872	6,786,394	5,936,932	11,372,792	5,382,084	15,199,064	-	138,292,386
C. Revenue Excluded from Approved Regulated Revenue Under GBR but Subject to Rate Regulation: Out of State	93,045,297	21,186,513	-	-	-	-	-	-	-	114,231,810
D. Total Approved Revenue (A + C)	$1,285,889,250	$198,645,136	$393,555,941	$144,514,525	$118,349,210	$221,712,410	$103,938,098	$305,743,020	$4,912,838	2,777,260,428

Note 1: Detail of FY 14 Assessments for Total Revenue

NSP I	$ 1,394,674	$ 203,608	$ 427,155	$ 142,303	$ 132,742	$ 210,343	$ 79,235	$ 199,866	$ -	$ 2,789,926
NSP II	1,394,908	203,608	427,155	142,303	132,742	210,342	116,944	317,378	-	2,945,380
HCCF	15,533,786	2,548,237	4,420,730	1,606,197	1,414,220	2,696,291	1,280,109	3,722,029	-	33,221,599
Deficit	32,655,309	5,356,934	9,293,309	3,376,564	2,972,994	5,668,175	2,691,061	7,824,493	-	69,838,838
MHIP	12,133,866	1,700,869	3,289,862	1,264,604	1,105,355	1,990,468	964,606	2,576,152	-	25,025,783
HSCRC User Fee	440,633	84,804	186,089	66,921	45,809	90,818	51,205	133,896	-	1,100,175
MHCC User Fee	283,068	54,473	119,530	42,984	29,427	58,335	32,891	86,006	-	706,714
Newborn Hearing Screening	108,010	-	60,480	54,670	-	41,020	-	94,150	-	358,330
Patient Safety or Crisp Funding	603,180	145,115	-	-	-	-	-		-	748,295
	$64,547,434	$10,297,648	$18,224,310	$6,696,546	$5,833,289	$10,965,792	$5,216,052	$14,953,970	$0	$136,735,041

Note 2: Revenues for regulated part B services at CRMC are exluded from the above Global Budget Revenue. Revenues for part B services at CRMC will be included in all issued rate orders.

Appendix B: General Description of Rate Setting Requirements for Out of State Revenue, Categorical Exclusions, and Transfer In cases

1. Out of State Revenue Data Sources and Order of Operations

The following methodology will be utilized to accurately report and reimburse out of state revenues:

Definition:

Patients with the international payer class and all non-international patients with valid non- Maryland residence zip codes. Consistency in reporting is critical. Hospitals agree to notify HSCRC of any changes in reporting. HSCRC and Hospitals will evaluate the need for a change in the Global Budget based on the nature and extent of any changes in reporting.

Data Sources:

Total Hospital Revenue: UMMS monthly financial data submission to HSCRC

Out of State Revenue: UMMS monthly financial data submission to HSCRC

Reconciliation:

Monthly reconciliations between financial data and case mix data of charges, payer, and in-state out-of-state totals will be submitted. Hospitals will promptly resubmit financial data as needed to correct for any known discrepancies

Charges:

Charges for out of state volume will be based on the unit rates provided in the Order Nisi. UMMS shall charge the same rates to out-of-state patients that it charges to Maryland residents.
The out of state revenue will be updated using the approved update factor less the efficiency adjustments applied for non-GBR revenues. All other applicable adjustments to rates will be made, including the application of quality policies, readmission shared savings adjustment, efficiency policies, and other policies of the Commission. Out-of-state revenues will not be subject to volume policies of HSCRC, except that overhead for supplies, drugs, and organ acquisition costs will be fixed.

2. Inpatient and Outpatient Categorical Data Sources and Order of Operations

The following methodology will be utilized to accurately report inpatient Categorical revenues:

Definition:

Solid Organ Transplants, Blood Marrow Transplants (Inpatient and Outpatient), Oncology Research, Oncology Transfers In, and Hematologic Malignancy cases. See Appendix J for detailed description of Categorical Cases

Data Sources:

Total Hospital Revenue: UMMS monthly financial data submission to HSCRC

Out of State Revenue: UMMS monthly financial data submission to HSCRC

Inpatient Categorical Patients: UMMS abstract data (in state). Outpatient BMT cases will need to be incorporated retroactively and proactively.

- Cases: UMMS abstract data
- DRG-SOI: UMMS abstract data
- Total Charges: UMMS abstract data

Organ Acquisition and Drug Costs for Categorical Patients: Actual acquisition costs will be reported for the applicable cases. Actual acquisition costs exclude hospital overhead and are net of any rebates, grants, incentives, free goods, or other discounts.

Reconciliation:

Monthly reconciliations between financial data and case mix data of charges, payer, and in-state out-of-state totals will be submitted. Hospitals will promptly resubmit financial data as needed to correct for any known discrepancies.

Allowed Charges:

UMMC will provide a prospective global budget for Maryland residents for Categorical Cases, which shall be incorporated into the global budget of UMMC after review by HSCRC staff for reasonableness. The annual budget will provide for a rebasing and trend for these services, taking into account the higher of a 50% variable cost factor or the statewide variable cost factor, if changed from the current policy, for volume changes plus actual costs of drugs and organ acquisition and maintaining a fixed amount of overhead not subject to a variable cost adjustment for supplies, drugs, and organ acquisition. Changes in volumes of services above or below the level budgeted, will be considered when developing the budget of a succeeding year. Changes in actual drug and organ acquisition costs will be accounted for through a prospective adjustment.

3. Transfers In From Acute Care Facilities

This methodology, still under development, will be utilized to accurately report and adjust the global budget for changes in transfers-in from acute care facilities. HSCRC staff will draft an agreement addendum to incorporate the methodology for transfers once the approach is completed.

4. Shock Trauma

The following methodology will be utilized to accurately identify Shock Trauma Cases:

Definition:

All patients treated at the Shock Trauma Center defined as:
Inpatient – Daily Hospital Service = 02 (Shock Trauma)
Outpatient – Reserve Flag = S (Shock Trauma)

Data Source:

HSCRC Abstract Data

Reconciliation:

Quarterly external reconciliations already in place

Appendix C: Potentially Avoidable Utilization Targets

Targets have been supplied through Commission policies.

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

Hospitals will be provided a demographic adjustment for GBR revenues based on the methodology adopted effective July 1, 2014 and as updated from time to time thereafter. UMMC will break out its performance into local, statewide referral, and out-of-state volumes to facilitate application of the policy.

Appendix E: Definition of Hospital's Service Area

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

1. The Primary Service Area (PSA) of the Hospital consists of the following zip codes (or counties):

See supplemental schedule 1 for zip code definitions by hospital

2. The Secondary Service Area of the Hospital consists of the following zip codes (or counties):

See supplemental schedule 1 for zip code definitions by hospital

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:

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

1. **UMMC & MTC** – All services for patients seen in Sleep Clinic, Center for Diabetes & Endocrinology (Clinic) and Infectious Disease Clinic were moved to University of MD Midtown Campus (MTC)
2. **UMMC and UCMC** – UMMC and UCMC opened an outpatient cancer facility during FY 2014, shifting resources from UMMC to UCMC in FY 2014 and FY 2015.
3. MTC -- The obstetrics program was discontinued in FY 2013.

C. Or: Each of the Hospitals listed below is not aware of any services that were shifted in whole or in part to unregulated settings

University of Maryland Medical Center (including the Marlene and Stewart Greenebaum Cancer Center and the R Adams Cowley Shock Trauma Center), UM Baltimore Washington Medical Center, UM Charles Regional Medical Center, UM Rehabilitation and Orthopaedics Institute, University of Maryland Medical Center Midtown Campus, UM Harford Memorial Hospital, UM Upper Chesapeake Medical Center, and Queen Anne's FSE

_____ _____

Signature of Officer of Hospital Date

_____ _____

Name (Please Print) E-Mail Address

_____

Title

_____

Telephone Number

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.

1. **UMMC** – University Care LLC (Ownership Interest); University of Maryland Faculty Practices, Inc. (Organizationally Related)

2. **MTC** – None

3. **HMH** – Upper Chesapeake Medical Services (Employed Physician Practices); Upper Chesapeake Health Rehab Services; Upper Chesapeake Residential House; Advanced/UCH Center Imaging (Ownership Interest); Harford Primary Care, LLC (Ownership Interest)

4. **UCMC** – Upper Chesapeake Medical Services (Employed Physician Practices); Upper Chesapeake Health Rehab Services; Upper Chesapeake Residential House; Advanced/UCH Center Imaging (Ownership Interest); Harford Primary Care, LLC (Ownership Interest)UMROI – Kernan Physical Therapy, Woodlawn , MD (unregulated)

5. **BWMC** – Baltimore Washington Emergency Physicians; North Arundel Development Corporation; Shipley's Choice Medical Park; Arundel Physicians Associates; NAH/Sunrise Severna Park, LLS; BW Health Services, LLC; North Arundel Senior Living, LLC; Baltimore Washington Imaging, LLC

6. **CRMC** – None

7. **QAED** - None

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 2014 Rate Year is as follows:
UMMC -.19%, Shock Trauma -.20%, BWMC -.20%, CRMC -.17%, UMROI -.03%, Midtown -.14%, Harford -.13%, UCMC -.15%

Appendix J: Categorical Cases for University of Maryland Medical Center

Following is the definition of categorical cases for University of Maryland Medical Center (UMMC) for use in updating global categorical budgets on an annual basis.

1. Solid Organ Transplants APR DRGS = 001, 002, 003, 006 or 440
   (any procedure = 5280, 5282, 5283, 4100, 4101, 4102, 4103, 4104, 4105, 4106, 4107, 4108 or 3751 Heart Transplantation 4109 or 336 or 3350, 3351, 3352, 5569, 5561, 5281, 5051, or 5059)

3. UMMC Oncology Center
   a. Transplant Cases (Reserve Flag = 1)
   b. Research Cases (Reserve Flag = 2)
   c. Hematological Cases (Reserve Flag = 3)
   d. Transfer in Cases (Reserve Flag = 4)

4. Outpatient Bone Marrow Transplant Patients need to be identified in the abstract data retroactively and prospectively

Supplemental 1: Primary & Secondary Service Area Zip Code Definitions by Hospital

UMMC (excl STC)	
PSA	**SSA**
Local Services	**Statewide Resource**
21201	
21202	
21216	
21217	
21223	
21229	
21230	

MTC	
PSA	**SSA**
(60% of Revenue)	(80% of Revenue)
21217	21202
21215	21206
21201	21213
21216	21230
21229	21225
21223	21224
21218	21228
21207	21212
	21205
	21211
	21061
	21133
	21239

HMH	
PSA	**SSA**
(60% of Revenue)	(80% of Revenue)
21001	21040
21078	21901
21903	21911
21904	21014
	21918
	21009
	21015
	21017

UCMC	
PSA	**SSA**
(60% of Revenue)	(80% of Revenue)
21014	21078
21040	21047
21015	21154
21009	21084
21001	21017
21050	21034
21085	

BWMC	
PSA	**SSA**
(60% of Revenue)	(80% of Revenue)
21061	21113
21122	21146
21060	21108
21144	21076
21225	21090
	21226
	21054
	21227

CRMC	
PSA	**SSA**
(60% of Revenue)	(80% of Revenue)
20646	20659
20602	20664
20601	20616
20603	20613
20640	20662
20695	20637
	20622
	20658
	20677

QAEC	
PSA	**SSA**
(60% of Revenue)	(80% of Revenue)
21617	21629
21666	21660
21638	21639
21619	21623
21658	21657
	21601